Medical Policy

Blue Cross Blue Shield Blue Care Network of Michigan

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***Current Policy Effective Date: 9/1/26**
(See policy history boxes for previous effective dates)

Title: Reduction Mammaplasty (Breast Reduction) for Breast-Related Symptoms

Description

Macromastia, or gigantomastia, is a condition that describes breast hyperplasia or hypertrophy. Macromastia may result in clinical symptoms such as shoulder, neck, or back pain, or recurrent intertrigo in the mammary folds. In addition, macromastia may be associated with psychosocial or emotional disturbances related to the large breast size. Reduction mammaplasty is a surgical procedure designed to remove a variable proportion of breast tissue to address emotional and psychosocial issues and/or to relieve the associated clinical symptoms.

Medical Policy Statement

Reduction mammaplasty (breast reduction) for the treatment of macromastia is **established** when criteria are met.

Inclusionary and Exclusionary Guidelines

INDIVIDUAL SELECTION GUIDELINES

Individuals under the age of 18 years cannot give legal consent for surgery. The parent or legal guardian must support and authorize a reduction mammaplasty (breast reduction).

Emancipated minors may be extended individual consideration.

Inclusions:

***** Must meet A OR B**

A. Must meet both 1 and 2:
   1. Individual's breasts are fully grown (i.e., breast size stable for approximately one year)
   2. Removal of more than 500 grams of tissue from each breast

OR

B. Must meet 1, 2 and 3:
   1. One of the following (a or b or c) must be met:
      a. Pain
         i. Documented pain in the neck and/or shoulders or postural backache which must be of a minimum of 6 weeks **AND**
         ii. Failure of conservative therapy (e.g., an appropriate support bra, exercises, heat/cold treatments, non-steroidal anti-inflammatory agents or muscle relaxants)
      b. Shoulder grooving documented in medical record or by photograph
      c. Recurrent or chronic intertrigo between the breasts and the chest wall
   2. Individuals' breasts are fully grown (i.e., breast size stable for approximately one year)
   3. The amount of tissue to be removed from each breast must be greater than or equal to the 22nd percentile on the Schnur Scale

      *If one breast meets the tissue amount based on the Schnur Scale, (even if the other breast does not), this criterion is met.

If one breast meets the Schnur scale criteria, and all other criteria for breast reduction are met; breast tissue may be removed from the other breast in order to achieve symmetry.

The Schnur Sliding Scale (see below) is used by physicians to evaluate individuals being considered for breast reduction surgery.

Body surface area, along with average weight of breast tissue removed, is incorporated into the chart. If the individual's body surface area and weight of breast tissue removed fall below the 22nd percentile, then the surgery is not medically necessary. If the individual's body surface area and weight of breast tissue removed is above the 22nd percentile, then the surgery is considered medically necessary if other applicable criteria are met.

*Calculation of Body Surface Area

Body surface area = the square root of height (cm) times weight (kg) divided by 3600.

To convert pounds to kilograms, multiply pounds by 0.45.

To convert inches to meters, multiply inches by .0254.

To calculate body surface area (BSA) see:

< http://www-users.med.cornell.edu/~spon/picu/calc/bsacalc.htm >

Schnur Sliding Scale[12]

Body Surface Area (in meters squared)*	**Lower 22nd percentile** (Grams to be removed per breast)
1.35	199
1.40	218
1.45	238
1.50	260
1.55	284
1.60	310
1.65	338
1.70	370
1.75	404
1.80	441
1.85	482
1.90	527
1.95	575
2.00	628
2.05	687
2.10	750

Exclusions:

Reduction mammaplasty (breast reduction) when the above criteria are not met **OR** for either of the following indications because it is cosmetic in nature and not medically necessary:

- Surgery is being performed to treat psychological symptomatology or psychosocial complaints, in the absence of significant physical, objective signs.
- Surgery is being performed for the sole purpose of improving appearance.

CPT/HCPCS Level II Codes

Established codes:

19318

Other codes (investigational, not medically necessary, etc.):

N/A

Notes:

- *Code(s) may not be covered by all contracts or certificates. Please consult customer or provider inquiry resources at BCBSM or BCN to verify coverage.*
- *Individual policy criteria determine the coverage status of the CPT/HCPCS code(s) on this policy. Codes listed in this policy may have different coverage positions (such as established or experimental/investigational) in other medical policies.*

Background

Juvenile Breast Hypertrophy

Juvenile (or virginal) breast hypertrophy is a rare, incapacitating condition where rapid and continued breast growth occurs during puberty. It is often defined as a six-month period of extreme breast enlargement, superseded by a longer period of slower, but sustained breast growth. This enlargement may be unilateral or bilateral and can occur at any time during puberty.[1]

Macromastia

Macromastia, or gigantomastia, is a condition that describes breast hyperplasia or hypertrophy. Macromastia may result in clinical symptoms such as shoulder, neck, or back pain, or recurrent intertrigo in the mammary folds. Also, macromastia may be associated with psychosocial or emotional disturbances related to the large breast size.

Treatment

Reduction mammaplasty, also known as breast reduction, is a surgical procedure designed to remove a variable proportion of breast tissue to address emotional and psychosocial issues and/or relieve the associated clinical symptoms.

While literature searches have identified many articles that discuss the surgical technique of breast reduction and have documented that breast reduction is associated with relief of physical and psychosocial symptoms,[2-10] an important issue is whether breast reduction is a functional need or cosmetic. For some patients, the presence of medical indications is clear-cut: a clear documentation of recurrent intertrigo or ulceration secondary to shoulder grooving. For some patients, the documentation differentiating between a cosmetic and a medically necessary procedure will be unclear. Criteria for medically necessary breast reduction are not well-addressed in the published medical literature.

Some protocols on the medical necessity of breast reduction are based on the weight of removed breast tissue. The basis of weight criteria is not related to the outcomes of surgery, but

to surgeons retrospectively classifying cases as cosmetic or medically necessary. Schnur et al (1991), at the request of third-party payers, developed a sliding scale.[11] This scale was based on survey responses from 92 of 200 solicited plastic surgeons, who reported the height, weight, and amount of breast tissue removed from each breast from the last 15 to 20 reduction mammaplasties they had performed. Surgeons were also asked if the procedures were performed for cosmetic or medically necessary reasons. The data were then used to create a chart relating the body surface area and the cutoff weight of breast tissue removed that differentiated cosmetic and medically necessary procedures. Based on their estimates, those with a breast tissue removed weight above the twenty-second percentile likely had the procedure for medical reasons, while those below the fifth percentile likely had the procedure performed for cosmetic reasons; those falling between the cut points had the procedure performed for mixed reasons.

Schnur (1999) reviewed use of the sliding scale as a coverage criterion and reported that, while many payers had adopted it, many had also misused it.[12] Schnur pointed out that if a payer used weight of resected tissue as a coverage criterion, then if the weight fell below the fifth percentile, the breast reduction would be considered cosmetic; if above the twenty-second percentile, it would be considered medically necessary; and if between these cut points, it would be considered on a case-by-case basis. Schnur also questioned the frequent requirement that a woman be within 20% of her ideal body weight. While weight loss might relieve symptoms, durable weight loss is notoriously difficult and might be unrealistic in many cases.

Summary of Evidence

For individuals who have symptomatic macromastia who receive reduction mammaplasty (breast reduction), the evidence includes systematic reviews, of randomized controlled trials, cohort studies, and case series. Relevant outcomes are symptoms and functional outcomes. Studies have indicated that reduction mammaplasty is effective at decreasing breast-related symptoms such as pain and discomfort. There is also evidence that functional limitations related to breast hypertrophy are improved after breast reduction. These outcomes are achieved with acceptable complication rates. The evidence is sufficient to determine that the procedure results in an improvement in the net health outcome.

Rationale

Evidence reviews assess the clinical evidence to determine whether the use of a technology improves the net health outcome. Broadly defined, health outcomes are length of life, quality of life, and ability to function including benefits and harms. Every clinical condition has specific outcomes that are important to individuals and to managing the course of that condition. Validated outcome measures are necessary to ascertain whether a condition improves or worsens; and whether the magnitude of that change is clinically significant. The net health outcome is a balance of benefits and harms. The following is a summary of the key literature to date.

BREAST REDUCTION FOR MACROMASTIA - EFFICACY IN REDUCING SYMPTOMS
Review of Evidence

Systematic Reviews

Lin et al (2021) conducted a systematic review of 7 RCTs (N=285) comparing reduction mammaplasty with a control intervention (nonoperation or physiotherapy exercises) for the treatment of breast hypertrophy.[13] Four RCTs were included in meta-analyses reporting on change in pain, physical function, and psychological function after interventions. Statistically significant improvements were found in pain (standardized mean difference [SMD], -1.29; 95% confidence interval [CI], -1.63 to -0.96; p<.00001), physical function (SMD, 0.97; 95% CI, 0.69 to 1.25; p<.00001), and psychological function (SMD, -0.79; 95% CI, -1.07 to -0.52; p<.00001) after mammaplasty compared to the control intervention. The authors concluded that mammaplasty had a positive and significant effect on health-related quality of life, including pain, physical, and psychological functioning, in individuals with breast hypertrophy.

Table 1. RCTs Included in SR & M-A

Trial	Lin et al (2021)[13,]
Beraldo et al (2016)[14,a]	●
Iwuaguwu et al (2006)[7,]	●
Iwuaguwu et al (2006)[15,a]	●
Freire et al (2007)[16,a]	●
Saariniemi et al (2008)[10 9,]	●
Saariniemi et al (2009)[17,]	●
Sabino Neto et al (2008)[8a]	●

MA: meta-analyses; RCTs: randomized controlled trials; SR: systematic reviews.
[a] Included in M-A.

Table 2. SR & M-A Characteristics

Study	Dates	Trials	Participants	N (Range)	Design	Duration
Lin et al (2021)[13,]	2006-2016	7[a]	Individuals with breast hypertrophy (mean age, 32 to 46.4 years) receiving either reduction mammaplasty or control intervention (nonoperation or physiotherapy exercises, concentrating	285 (56 to 92)	RCT	4 to 7.8 months

			mostly on the upper body)			

MA: meta-analyses; RCTs: randomized controlled trials; SR: systematic reviews.
[a] Only 4 included in M-A.

Table 3. SR & M-A Results

Study	Change in Pain from Baseline	Improvement in Physical Function from Baseline	Change in Psychological Function from Baseline
Lin et al (2021)[13,]			
Total N	165 (2 studies)	221 (3 studies)	221 (3 studies)
SMD (95% CI)	-1.29 (-1.63 to -0.96)	0.97 (0.69 to 1.25)	-0.79 (-1.07 to -0.52)
p-value	<.00001	<.00001	<.00001
I^2 (p)	34% (.22)	42% (.18)	0% (.59)

CI: confidence interval; MA: meta-analyses; SMD: standardized mean difference; SR: systematic reviews.

Observational Studies

Singh and Losken (2012) reported on a systematic review of studies reporting outcomes after reduction mammaplasty.[18] In 7 studies reporting on physical symptoms (n range, 11 to 92 patients), reviewers found reduction mammaplasty improved functional outcomes including pain, breathing, sleep, and headaches. Additional psychological outcomes noted included improvements in self-esteem, sexual function, and quality of life. Torresetti et al (2022) conducted another systematic review to examine the potential association between bilateral breast reduction and improvement in lung function in women with macromastia.[19] The review included 15 studies published from 1974 to 2018 (n range, 1 to 50 patients). The findings showed that reduction mammaplasty can lead to changes in objective respiratory parameters, such as spirometric tests or arterial blood gas measurements, but the clinical significance of these changes was unclear.

Hernanz et al (2016) reported on a descriptive cohort study of 37 consecutive obese patients who underwent reduction mammoplasty for symptomatic macromastia, along with 37 age-matched women hospitalized for short-stay surgical procedures.[20] In the preoperative state, SF-36 physical health component subscore was significantly lower for patients with symptomatic macromastia (40) than for age-matched controls (53; P<.001), with differences in 5 of the 8 subscales. At 18 months postprocedure, there were no significant differences in any SF-36 subscores except the body pain subscale between patients who had undergone reduction mammoplasty and age-matched controls.

Kerrigan et al (2002) published the results of the BRAVO (Breast Reduction: Assessment of Value and Outcomes) study, a registry of 179 women undergoing reduction mammaplasty.[21] Women were asked to complete quality of life questionnaires and a physical symptom count both before and after surgery. The physical symptom count focused on the number of symptoms present that were specific to breast hypertrophy and included upper back pain, rashes, bra strap grooves, neck pain, shoulder pain, numbness, and arm pain. Also, the weight and volume of resected tissue were recorded. Results were compared with a control group of patients with breast hypertrophy, defined as size DD bra cup, and normal-sized breasts, who were recruited from the general population. The authors proposed that the presence of 2 physical symptoms might be an appropriate cutoff for determining medical necessity for breast reduction. For example, while 71.6% of the hypertrophic controls reported none or 1 symptom, only 12.4% of those considered surgical candidates reported none or 1 symptom. This observation is difficult to evaluate because the study did not report how surgical candidacy was determined. The authors also reported that none of the traditional criteria for determining medical necessity for breast reduction surgery (height, weight, body mass index , bra cup size, or weight of resected breast tissue) had a statistically significant relation with outcome improvement. The authors concluded that the determination of medical necessity should be based on patients' self-reported symptoms rather than more objectively measured criteria (e.g., weight of excised breast tissue).

Adverse Events

Thibaudeau et al (2010), conducted a systematic review to evaluate breastfeeding after reduction mammaplasty.[22] After a review of literature from 1950 through 2008, reviewers concluded that reduction mammaplasty does not reduce the ability to breastfeed. In women who have had reduction mammaplasty, breastfeeding rates were comparable in the first month postpartum to rates in the general population in North America.

Chen et al (2011) reported on a review of claims data to compare complication rates after breast surgery in 2,403 obese and ,5597 nonobese patients.[23] Of these patients, breast reduction was performed in 1,939 (80.7%) in the study group and in ,3569 (63.8%) in the control group. Obese patients had significantly more claims for complications within 30 days after breast reduction surgery (14.6%) than nonobese patients (1.7%; p<.001). Complications included inflammation, infection, pain, and seroma/hematoma development. Shermak et al (2011) reported on a review of claims data comparing complication rates by age after breast reduction surgery in 1,192 patients.[24] Infection occurred more frequently in patients older than 50 years of age (odds ratio , 2.7; p=.003). Additionally, women older than 50 years experienced more wound healing problems (odds ratio, 1.6; p=.09) and reoperative wound debridement (odds ratio, 5.1; p=.07). Other retrospective evaluations (2013, 2014) of large population datasets have reported increased incidences of perioperative and postoperative complications with high body mass index.[25,25]

Section Summary: Breast Reduction for Macromastia-Efficacy in Reducing Symptoms

Systematic reviews, randomized trials, and observational studies have shown that several measures of function and quality of life improve after breast reduction.

Juvenile Breast Hypertrophy

Wolfs winkle et al (2013)[1] discussed hyperplastic breast anomalies in the adolescent, including juvenile breast hypertrophy. The authors reviewed treatment for this rare but alarming

condition. Surgical options include reduction mammoplasty. The authors stressed that confirmation of breast growth stabilization is recommended as surgery in the active growth phase has been associated with recurrence of breast enlargement postoperatively.

Supplemental Information

The purpose of the following information is to provide reference material. Inclusion does not imply endorsement or alignment with the evidence review conclusions.

Practice Guidelines and Position Statements
Guidelines or position statements will be considered for inclusion in 'Supplemental Information if they were issued by, or jointly by, a US professional society, an international society with US representation, or National Institute for Health and Care Excellence (NICE). Priority will be given to guidelines that are informed by a systematic review, include strength of evidence ratings, and include a description of management of conflict of interest.

American Society of Plastic Surgeons
In 2011, the American Society of Plastic Surgeons (ASPS) issued practice guidelines and a companion document on criteria for third-party payers for reduction mammaplasty.[27,28] This guideline was updated and reaffirmed March 2021 and March 2022. Based on high quality evidence, the ASPS strongly recommends that "postmenarche female patients presenting with breast hypertrophy should be offered reduction mammaplasty surgery as first-line therapy over nonoperative therapy based solely on the presence of multiple symptoms rather than resection weight." The guideline goes on to state that "reduction mammaplasty surgery is considered standard of care for symptomatic breast hypertrophy." The companion document notes that medical records should document the symptoms associated with the hypertrophy the patient has experienced, and lists the following:

- "Documentation may include pain that patient experiences in the neck, back, or breasts related to movement
- Difficulties in daily activities such as grocery shopping, banking, using transportation, preparing meals, feeding, showering, etc
- Documentation of any secondary complications or infections that may have occurred as a result of hypertrophy or macromastia including intertrigo, chronic rash, cervicalgia, dorsalgia, or kyphosis
- Documentation of prior procedures or therapies may be included but not required for approval
- Photographs demonstrating the patient's breast appearance, possible shoulder grooves and kyphosis can be included in the medical documentation
- Significant scientific evidence supports non-operative therapies should not be required prior to approval of the procedure."

U.S. Preventive Services Task Force Recommendations
Not applicable

Ongoing and Unpublished Clinical Trials

Some currently unpublished trials that might influence this review are listed in Table 4.

Table 4. Summary of Key Trials

NCT No.	Trial Name	Planned Enrollment	Completion Date
Ongoing			
NCT04889469	Indications for Breast Reduction in the Public Health Care System	2000	Aug 2031

Regulatory Status:

Breast reduction is a surgical procedure and, as such, is not subject to regulation by the U.S. Food and Drug Administration.

Government Regulations
National:

There is no national coverage determination (NCD) on this topic. In the absence of an NCD, coverage decisions are left to the discretion of the local Medicare carriers.

Local:

Wisconsin Physicians Service Insurance Corporation (WPS)
Local Coverage Determination (LCD): Cosmetic and Reconstructive Surgery (L39051)
Original effective date 11/14/2021 Revision 10/13/24
[Note: following is information in the LCD that is specific to breast reduction]

Indications for specific surgical procedure

1. Breast reconstruction of the affected and the contralateral unaffected breast following a medically necessary mastectomy is covered.
2. Removal or revision of a breast implant whether placed for reconstructive or cosmetic reasons, is considered medically necessary when it is removed for one of the following reasons:[26]

a. Mechanical complication of breast prosthesis; including rupture or failed implant, and/or implant extrusion.
b. Infection or inflammatory reaction due to a breast prosthesis; including infected breast implant, or rejection of breast implants.
c. Other complication of internal breast implant; including siliconoma, granuloma, interference with diagnosis of breast cancer, and/or painful capsular contracture with disfigurement.

3. Breast Reduction is the surgical reshaping of the breasts to reduce or lift enlarged or sagging breasts. Cosmetic surgery to reshape the breasts to improve appearance is not a Medicare benefit.

   Macromastia (breast hypertrophy) is an increase in the volume and weight of breast tissue relative to the general body habitus. Breast hypertrophy may adversely affect other body systems: musculoskeletal, respiratory, and integumentary. Unilateral hypertrophy may result in symptoms following contralateral mastectomy.

   Medical necessity for a breast reduction is limited to circumstances in which:

   - There are signs and/or symptoms resulting from the enlarged breasts (macromastia) that have not responded adequately to non-surgical interventions,
   - To improve or correct asymmetry following cancer surgery on one breast.

   Note: either the involved breast or contralateral breast may be treated to achieve symmetry.
   Note: For coverage indications for contralateral reconstruction of an unaffected breast following a medically necessary mastectomy, refer to the CMS Internet-Only Manual, Pub. 100-03, Medicare National Coverage Determinations Manual, Chapter 1, Part 2, §140.2.

   Non-surgical interventions preceding breast reduction should include as appropriate, but are not limited to, the following:

   - Determining the macromastia is not due to an active endocrine or metabolic process.
   - Determining the symptoms are refractory to appropriately fitted supporting garments, or following unilateral mastectomy, persistent with an appropriately fitted prosthesis or reconstruction therapy at the site of the absent breast.
   - Determining that dermatologic signs and/or symptoms are refractory to, or recurrent following, a completed course of medical management.

   A medically reasonable and necessary breast reduction could be indicated in the presence of significantly enlarged breasts and the presence of at least one of the following signs and/or symptoms:

   - Back, neck or shoulder pain from macromastia and unrelieved by 6 months of:
   - Conservative analgesia,
   - Supportive measures (garment, etc.),
   - Physical Therapy, or
   - Significant arthritic changes in the cervical or upper thoracic spine, optimally managed with persistent symptoms and/or significant restriction of activity, or
   - Intertriginous maceration or infection of the inframammary skin refractory related to dermatologic measures.
   - Permanent shoulder grooving with skin irritation by supporting garment (bra strap).

   The amount of breast tissue to be removed must be proportional to the body surface area (BSA) per the Schnur18 scale below. If the individual's body surface area and weight of breast tissue removed fall above the 22nd percentile, then the surgery is considered medically reasonable and necessary with the appropriate criteria. If only one breast meets the Schnur

scale criteria; breast tissue may be removed from the other breast in order to achieve symmetry.

Schnur Scale:

Body Surface Area (m2)	Average grams of tissue per breast to be removed
1.40-1.50	218-260
1.51–1.60	261-310
1.61-1.70	311-370
1.71-1.80	371-441
1.81-1.90	442-527
1.91-2.00	528-628
2.01-2.10	629-750
2.11-2.20	751-895
2.21-2.30	896-1068
2.31-2.40	1069-1275
2.41-2.50	1276-1522
2.51-2.60	1523-1806
2.61-2.70	1807-2154
2.71-2.80	2155-2568
2.81-2.90	2569-3061
2.91-3.00	3062-3650

Wisconsin Physicians Service Insurance Corporation (WPS)
Local Coverage Determination (LCD): Cosmetic and Reconstructive Surgery (L34698)
Original effective date 10/01/2015
Revision effective date 01/01/2021; Revision ending date 11/13/2021
Retirement Date 11/13/2021

(The above Medicare information is current as of the review date for this policy. However, the coverage issues and policies maintained by the Centers for Medicare & Medicare Services [CMS, formerly HCFA] are updated and/or revised periodically. Therefore, the most current CMS information may not be contained in this document. For the most current information, the reader should contact an official Medicare source.)

Related Policies

- Reconstructive Breast Surgery and Management of Breast Implants

References

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The articles reviewed in this research include those obtained in an Internet based literature search for relevant medical references through April 2026, the date the research was completed.

Joint BCBSM/BCN Medical Policy History

Policy Effective Date	BCBSM Signature Date	BCN Signature Date	Comments
6/27/02	6/27/02	6/27/02	Joint policy established
7/20/04	7/20/04	6/30/04	Routine maintenance
3/23/06	3/23/06	3/23/06	Routine maintenance
7/1/08	5/17/08	5/18/08	Routine maintenance
11/1/08	8/19/08	9/23/08	Criteria updated
3/1/09	12/9/08	12/30/08	Routine maintenance, added weight/height chart, BMI calculator and link
9/1/10	6/15/10	6/15/10	Criteria Updated, removed BMI calculator and link
9/1/11	6/21/11	6/21/11	Routine maintenance
7/1/13	4/16/13	4/22/13	Routine maintenance; reformatted description, rationale and references to mirror BCBSA. Title changed from “Breast Reduction Mammoplasty” to “Reduction Mammaplasty for Breast-Related Symptoms”.
11/1/14	8/21/14	8/25/14	Routine maintenance
7/1/16	4/19/16	4/19/16	Routine maintenance
7/1/17	4/18/17	4/18/17	Routine maintenance
7/1/18	4/17/18	4/17/18	Routine maintenance
7/1/19	6/24/19		Routine maintenance Revision to inclusions: statement regarding reduction mammaplasty surgery in patients under the age of 18 years; criterion for minimum tissue removal of 1000mg without requirement of functional issues changed to 500gm; clarification of criteria under functional issues/conservative therapies; “breasts are fully grown” further defined to “breast size stable over one year”.

9/1/20	6/16/20		Routine maintenance Changes to inclusions: only one functional issue is required; if one breast meets criteria per Schnur scale, that criterion is met. If one breast meets all criteria, other breast may be reduced for symmetry. Addition: description of adolescent macromastia, Ref 23
9/1/21	6/15/21		Routine maintenance Code 19318 was revised Verbiage changes in title, medical policy statement, background section, summary from “reduction mammaplasty” to “breast reduction”.
9/1/22	6/21/22		Routine maintenance.
9/1/23	6/13/23		Routine maintenance (jf) Vendor managed NA
1/1/24	10/17/23		Routine maintenance (jf) Vendor managed NA Revision of Medical Policy Statement Gender affirming language removed
9/1/24	6/11/24		Routine maintenance (jf) Vendor managed NA
9/1/25	6/17/25		Routine maintenance (jf) Vendor managed NA Edit to MPS: “safety and effectiveness” removed Patients removed and replaced with individuals Ref Added: 8,13,14,15,16,17
9/1/26	6/16/26		Routine maintenance (jf,mk) Vendor managed NA **Original Title:** Breast Reduction for Breast-Related Symptoms **Title Change:** Reduction Mammaplasty (Breast Reduction) for Breast-Related Symptoms

			• Edits to inclusions and exclusions for clarity. • Medical Policy Statement edited to remove statement stating this procedure established when “Performed in conjunction with medically necessary breast reconstruction for the purposes of attaining breast symmetry” as this is not appropriate for this policy. Moved this statement to the Reconstructive Breast Surgery and Management of Breast Implants medical policy. MPS now reflect the focus of this policy.

Next Review Date: 2nd Qtr., 2027

BLUE CARE NETWORK BENEFIT COVERAGE
POLICY: REDUCTION MAMMAPLASTY (BREAST REDUCTION) FOR BREAST-RELATED SYMPTOMS

Coverage Determination:

Commercial HMO (includes Self-Funded groups unless otherwise specified)	Covered; policy criteria apply.
BCNA (Medicare Advantage)	See Government Regulations section.
BCN65 (Medicare Complementary)	Coinsurance covered if primary Medicare covers the service.