Clinical Review Criteria
Reduction Mammoplasty Surgery

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Criteria
For Medicare Members

<table>
<thead>
<tr>
<th>Source</th>
<th>Policy</th>
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<tbody>
<tr>
<td>National Coverage Determinations (NCD)</td>
<td>None</td>
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<tr>
<td>Local Coverage Determinations (LCD)</td>
<td>Local Coverage Determination – Plastic Surgery (L37020)</td>
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<tr>
<td>Local Coverage Article</td>
<td>None</td>
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</tbody>
</table>

For Non-Medicare Members

Kaiser Permanente has elected to use the Reduction Mammoplasty (Mammoplasty) (KP-0274) MCG* for medical necessity determinations. Please see MCG Guideline Index for access to criteria:
https://kpwa.access.mcg.com/index.

*The MCG are proprietary and cannot be published and/or distributed. However, on an individual member basis, Kaiser Permanente can share a copy of the specific criteria document used to make a utilization management decision. If one of your patients is being reviewed using these criteria, you may request a copy of the criteria by calling the Kaiser Permanente Clinical Review staff at 1-800-289-1363 or access the MCG Guideline Index using the link provided above.

If requesting this service, please send the following documentation to support medical necessity:
- Last 6 months of clinical notes from requesting provider &/or specialist (primary care physician)
- Physical Therapy notes if applicable
- Plastic surgery consultation
- Most recent height & weight

Background

Reduction mammoplasty surgery is a covered benefit under Kaiser Permanente benefit packages when it is determined to be for medical rather than cosmetic reasons. This benefit was added by Kaiser Permanente on 11/1/83. Over the years several modifications have been made to the criteria. The main purpose of the criteria is to differentiate cosmetic from medical indications for the procedure.

Evidence and Source Documents

10/2012
Baasch M, Nielsen SF, Engholm G, Lund K Breast cancer incidence subsequent to surgical reduction of female breast. Br J Cancer April 1990; 73 (7): 961-961 1240 patients w surgical intervention for breast hypertrophy. Followed between 1943 and 1971. 32 cases of cancer identified by 1990. Expected number was 52.55 yielding a relative risk factor (RR) of 0.61. The greatest reduction was seen in women who had 600 or more grams or more
of breast tissue. In the group who had the operation before the age of 20, 4 cases of breast cancer developed, compared to the expected 2.23, to give an RR of 1.79.


Survey of 285 consecutive female patients who had reduction mammaplasty between 1988 - 1993. Also, Chart reviews were conducted. Mean age was 40 and average follow-up was 37 months. 185 returned completed surveys and were included in the analysis. The most common complaints were: shoulder grooving (90%), back pain (82%), shoulder pain (78%), and neck pain (65%). The average amount of breast tissue removed was 855 gm from each breast (range 148 - 3,717 gm total). Most patients (97%) had improvement of symptoms. No statistically significant difference between obese and non-obese patients in outcomes or symptom relief and put into question the use of weight guidelines or bra-cup size reduction validation. The amount of breast tissue removed did not alter the outcome of surgery or relief of symptoms. The amount of breast tissue removed to relieve symptoms will vary with height, weight and bra-cup size for each patient. This puts into question the requirement of a maximum amount of breast tissue to be removed. Increase in complications when greater than 1,000 gm was removed from each breast. Overall patient satisfaction was high (95%, happy or very happy).

McMahan JD, Wolfe JA, Cromer BA, Ruberg RL. Lasting success in teenage reduction mammaplasty. Ann of P Surg September 1995; 35(3): 227-231 86 female patients less than 20 years of age. 48 contacted and returned questionnaire. Primary questions were: does the breast tissue grow back, what are the effects of future pregnancies and weight gain and do the potential consequences of surgery overshadow the early pain relief. Patient age range: 15 - 19.9. Average range of follow-up was 5.9 yr (range 1.4-20.4). 72% reported regrowth of tissue. 11 patients had been pregnant since their surgery: 5 did not breast feed, 3 were unable to and 2 were still pregnant. The greatest improvements were seen in their presurgical symptoms, ability to increase their physical activity, and improvement in their self-esteem. None seemed to have problems with sexual pleasure from their breasts. Davis GM, Ringler SL, Short K, Sherrick d, Bengtson BP. Reduction Mammaplasty: Long-term efficacy, morbidity and patient satisfaction Plast Recon Surg 96: 1106-1110 780 female patients who had reduction mammoplasties between 1981 and 1992. 406 responded to a retrospective questionnaire. The mean age was 38 yr. Follow-up average 4.7 yr. 60% of the study population was 5-10 kg over their ideal body weight as determined by the Metropolitan Life Insurance Company Statistical Bulletin (1985). Average reduction was 676 gram per breast (range 120-4200 gm). Conclusion was that women found that their preoperative symptoms were corrected by the surgery. Major complications are uncommon. Minor complications (50% of the women) are tolerated by the women. Thirty-seven women became pregnant following their operation. Of this population 68 % (25) successfully breast-fed their infants. Patients who lost nipple sensitivity were most likely to be dissatisfied with the procedure. Seitchik MW. Reduction Mammaplasty: Criteria for insurance coverage. Plast Recon Surg May 1995: 1029-1032 The guidelines by which insurer determine eligibility for coverage of reduction mammaplasty must rely largely on subjective materials: reported patient symptoms, interpretation of photographs, determination of the amount of breast mass to be removed surgically. The author has attempted to find relationships between body weight and resected specimen weight that may be more objective.

100 consecutive reduction mammoplasties beginning 1991 recorded pre-op weight and height. The weight of resected breast tissue was obtained in the OR. Reduction planned for 46 to 70 kg body weight bra size of mid-B to small C. Above 70kg sizes ranged to a small D. Follow-up questionnaire 6 months postoperative. Based on his analysis he was unable to develop a model which would accurately predict preoperatively the amount of breast mass required to be removed to achieve the target bra size. He also felt that insurance company excise breast weight to determine eligibility for coverage was arbitrary.