Breast Reduction Surgery

A. Required documentation to facilitate the authorization process referral requests must include ALL the following:

1. Detailed physical exam including patient’s height and weight; AND
2. Physical or physiological functional deficits related to macromastia; AND
3. Appropriate clinical diagnostic studies/tests/interventions to confirm the degree of the impairment; AND
4. Practitioner statement of how the patient’s symptoms related to macromastia will be measurably resolved by the requested breast reduction procedure; AND
5. Surgeon’s estimated amount of breast tissue to be removed; AND
6. Photographs of the macromastia and associated deformity/anomaly including photographic evidence of related skin breakdown or infections.

B. Criteria for Medical Necessity

Breast reduction mammoplasty is considered medically necessary when ALL the following criteria have been met:

1. The patient is at least 18 years of age and breast growth is complete; AND

2. Member should have at least two (2) of the following symptoms despite a 3-month trial of therapeutic measures except where indicated:
   a. Back/neck/shoulder pain – pain in the back, neck or shoulder is considered one symptom
   b. Breast pain
   c. Paresthesias of hands/arms in ulnar distribution
   d. Pain/discomfort/skin ulceration related to permanent shoulder grooving from bra straps
   e. Ongoing skin breakdown under breasts from overlying breast tissue with soft tissue infection, tissue necrosis, or hemorrhage or hidradenitis unresponsive to dermatological treatments and conservative measures for a period of at least 6 months.

3. Symptoms persist as documented by the practitioner despite at least a three (3) month trial of at least two (2) of the following therapeutic measures:
   a. Physical therapy OR
   b. Chiropractic treatment; OR
   c. Medically supervised weight loss; OR
   d. Analgesic/non-steroid anti-inflammatory drugs (NSAIDS); OR
   e. Prescribed topical treatment for dermatological symptoms; OR
   f. Supportive devices (i.e. proper bra support, wide bra straps).

4. The potential causes of the above conditions/symptoms (#2) other than breast size have been evaluated and ONE of the following apply:
a. Other causes have been thoroughly evaluated and ruled out (e.g., intervertebral disc disorder, arthritis and rheumatologic disorders); OR
b. Breast size has been documented as exacerbating the underlying condition and contributing to symptoms.

5. The primary care physician, physiatrist or chiropractor has documented:
   a. Reasonable likelihood that member’s symptoms are primarily due to macromastia, **AND**
   b. Reduction mammoplasty is likely to improve symptoms.

6. Weight has been stable for 6-12 months.

7. The amount of breast tissue to be removed must be in accordance with Schnur criteria. The Schnur Scale (Appendix A) is a guideline to determine the estimated amount of breast tissue to be removed as it relates to the BSA of the patient. To calculate body surface, area refer to:
   a. Estimates within a reasonable margin to the Schnur scale number of grams of tissue may be authorized by the reviewing MM nurse.
   b. Cases with borderline criteria per the Schnur criteria will only be considered if the member has been evaluated by Physical Medicine and Rehab and felt to have failed conservative treatment.
   c. If the amount of tissue to be removed is <70% of that recommended by the Schnur scale a medical director must make the decision about medical necessity.

8. For women over age 40, a negative screening mammogram within the previous year is required.

9. Coverage is limited to one procedure per lifetime of member’s plan coverage.

**C. Indications Considered Experimental, Investigational, or not Medically Necessary**

1. Breast reduction mammoplasty is not considered medically indicated for improved body image or relief of psychological symptoms.

2. Women with a previous history of reduction mammoplasty under plan coverage.

**CPT/HCPCS Codes:**

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   19318  Reduction mammoplasty
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**REFERENCES:**


