OHCA Guideline

<table>
<thead>
<tr>
<th>Medical Procedure Class:</th>
<th>Reduction Mammoplasty</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial Implementation Date:</td>
<td>1/19/2016</td>
</tr>
<tr>
<td>Last Review Date:</td>
<td>2/17/2021</td>
</tr>
<tr>
<td>Effective Date:</td>
<td>2/22/2021</td>
</tr>
<tr>
<td>Next Review/Revision Date:</td>
<td>February 2024</td>
</tr>
</tbody>
</table>

* This document is not a contract, and these guidelines do not reflect or represent every conceived situation. Although all items contained in these guidelines may be met, this does not reflect, or imply, any responsibility of this agency or department to change the plan provision to include the stated service as an eligible benefit.

☐ New Criteria  ✔ Revision of Existing Criteria

Summary

Purpose: To provide guidelines to assure medical necessity and consistency in the prior authorization process.

Description

Reduction mammoplasty/mammaplasty is a surgical procedure designed to remove a variable proportion of breast tissue. The justification for reduction mammoplasty should be based on the probability of relieving the clinical signs and symptoms of symptomatic breast hypertrophy. OHCA considers breast reduction surgery cosmetic unless breast hypertrophy is causing significant pain, paresthesia or ulceration.

CPT Code Requiring Prior Authorization (PA)

19318 (see CPT manual for full code description)

Approval Criteria

Reduction Mammoplasty is considered medically appropriate when ALL of the following are met:

A. Member has persistent symptoms affecting daily activities for at least one year as indicated by at least TWO of the following:
   1. Back, neck or shoulder pain not related to other causes such as arthritis, poor posture, acute strains, excessive weight, etc.; OR
   2. Upper extremity neuropathy; OR
   3. Painful kyphosis documented by x-rays; OR
   4. Pain/discomfort/ulceration from bra straps cutting into shoulders; OR
   5. Infra mammary intertrigo unresponsive to medical management; OR
   6. Difficulty sleeping or breathing due to weight of the breasts; AND

B. Photographic documentation confirms severe breast hypertrophy; AND

C. Member has undergone an evaluation by a qualified provider (M.D., D.O., Physician Assistant or Nurse Practitioner) who has determined that ALL of the following criteria are met:
   1) There is reasonable likelihood that the member’s symptoms are primarily due to macromastia; AND
   2) Reduction mammoplasty is likely to result in improvement of the chronic pain and/or other symptoms; AND
   3) Pain symptoms persist as documented by the qualified provider despite at least a 3-month trial of the following therapeutic measures (a-c):
a) Analgesic/non-steroid anti-inflammatory drugs (NSAIDS) interventions (if not contraindicated); **AND**
b) Physical therapy/exercises/posturing maneuvers; **AND**
c) Supportive devices (e.g. proper bra support, wide straps); **AND**

D. Candidates for breast reduction should be at least 18 years of age. Requests for members under 18 years old will be considered on an individual basis, due to the sensitive nature of performing procedures on the developing breast; **AND**

E. Women 40 years of age or older are required to have a mammogram that was negative for cancer performed within the year prior to the date of the planned reduction mammoplasty; **AND**

F. Member should have a BMI of less than 30; **AND**

G. Member should be a non-smoker or should not have smoked within the past 6 weeks as documented by the surgeon. If questionable, should obtain a cotinine or carboxyhemoglobin level.

Note: Ptosis, nipple distortion, breast asymmetry and impaired self-esteem are not considered as medically necessary indications for breast reduction.

References

1. Oklahoma Health Care Authority; Policies & Rules, OAC 317:30-3-1; 317:30-5-8