I. Description

Female breast hypertrophy, or macromastia, is the development of abnormally large breasts in the female. This condition can cause significant clinical manifestations when the excessive breast weight adversely affects the supporting structures of the shoulders, neck and trunk. Macromastia is distinguished from large, normal breasts by the presence of persistent symptoms such as shoulder, neck, or back pain, shoulder grooving, or intertrigo. This condition can be improved and the associated signs and symptoms can be alleviated by reduction mammoplasty surgery.

Reduction mammoplasty is the surgical excision of a substantial portion of the breast, including the skin and underlying glandular tissue, until a clinically normal size is obtained.

II. Criteria/Guidelines

Reduction mammoplasty for women with fully developed breasts is covered (subject to Limitation/Exclusions and Administrative Guidelines) when at least two of the following clinical indications and/or physical findings are present and have failed to respond to appropriate conservative therapy:

A. Chronic breast pain due to weight of the breasts.
B. Intertrigo, unresponsive to medical management.
C. Upper back, neck and shoulder pain.
D. Backache
E. Thoracic kyphosis
F. Shoulder grooving from bra straps.
G. Upper extremity paresthesia due to brachial plexus compression syndrome secondary to the weight of the breasts being transferred to the shoulder strap area.
III. Limitations/Exclusions

A. Reduction mammaplasty does not meet payment determination for women with poor posture, headaches, breast asymmetry, pendulousness, problems with clothes fitting and nipple-areolar distortion.
B. Reduction mammaplasty is not covered for breasts that are in a state of rapid flux (e.g., adolescence, lactation).

IV. Administrative Guidelines

A. Precertification is required. To precertify, please complete HMSA's Precertification Request and mail or fax the form as indicated.
B. The following documentation must be submitted with your precertification request:
   1. Photographs or digital images; and
   2. Description of symptoms and specific therapies that have been tried and failed; and
   3. The patient’s height and weight and the anticipated amount of breast tissue to be removed.

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V. Important Reminder

The purpose of this Medical Policy is to provide a guide to coverage. This Medical Policy is not intended to dictate to providers how to practice medicine. Nothing in this Medical Policy is intended to discourage or prohibit providing other medical advice or treatment deemed appropriate by the treating physician.

Benefit determinations are subject to applicable member contract language. To the extent there are any conflicts between these guidelines and the contract language, the contract language will control.

This Medical Policy has been developed through consideration of the medical necessity criteria under Hawaii’s Patients’ Bill of Rights and Responsibilities Act (Hawaii Revised Statutes §432E-1.4), generally accepted standards of medical practice and review of medical literature and government approval status. HMSA has determined that services not covered under this Medical Policy will not be medically necessary under Hawaii law in most cases. If a treating physician disagrees with HMSA’s determination as to medical necessity in a given case, the physician may request that HMSA reconsider the application of the medical necessity criteria to the case at issue in light of any supporting documentation.
VI. References