KAISER PERMANENTE

Review Criteria
Georgia Region

DEPARTMENT **QUALITY RESOURCE MANAGEMENT**		CRITERIA NUMBER	01-53
SECTION **UTILIZATION MANAGEMENT**		EFFECTIVE DATE	1/25/2021 4/25/2012
TITLE	**Breast Reduction Mammoplasty**	REVIEW DATES	1/25/2021 2/28/2023
		REVISION DATE	1/5/2022
POLICY TYPE **New** **xReviewed** **Revised**		PAGE NUMBER	Page 1 of 2

DIAGNOSIS/CONDITION:
CPT-4/ HCPCS CODE AND DESCRIPTION: INDICATORS

Guideline Information:
Identifier:QRM_1574 **Title: Reduction Mammoplasty**
Short Identifier:A-0274 **Age Category: A - ADULT**
Product/Content: Ambulatory Care - Authorization LOS: NA

Clinical Indications for Procedure
Edit Title
Add New Top Level Node

- Reduction mammaplasty may be indicated when ALL of the following are present(ct)(ct)(ct):
  - Predicted removal of a minimum of 450 grams of breast tissue from each breast(ct)(ct)
  - Significant interference with activities of daily living, directly attributable to large breast size, including 2 or more of the following(ct):
    - Chronic breast pain
    - Persistent redness and erythema (intertrigo) below breasts
    - Upper or lower back pain
    - Thoracic kyphosis
    - Shoulder pain
    - Severe bra strap grooving or ulceration of shoulder
    - Arm numbness consistent with brachial plexus compression syndrome
    - Cervical pain
    - Nipple position greater than 21 cm below suprasternal notch
  - Failure to relieve symptoms with nonsurgical treatment that includes 1 or more of the following:
    - Trial of nonsteroidal anti-inflammatory drugs to treat pain in the neck, shoulder, upper or lower back, or breast, as well as a trial of PT.

- Wound care for skin ulceration.
- Topical and oral antifungal agents for intertrigo
- Medically supervised weight loss program for overweight or obese patient
- No evidence of breast cancer(ct)
- BMI less than or equal to 32

Pictures needed in the clinical record to support medical necessity review.

Approval

Luke Beno MD
Physician Program Director Quality Resource Management

Date

Date