ForwardHealth
Wisconsin serving you

Update
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Affected Programs: BadgerCare Plus, Medicaid
To: Ambulatory Surgery Centers, Federally Qualified Health Centers, Hospital Providers, Nurse Practitioners, Physician Assistants, Physician Clinics, Physicians, Rural Health Clinics, HMOs and Other Managed Care Programs

New Prior Authorization Approval Criteria for Reduction Mammoplasty

This *ForwardHealth Update* introduces new prior authorization (PA) approval criteria for reduction mammoplasty effective for PA requests received on and after July 1, 2015.

General Coverage Information

Reduction mammoplasty (breast reduction surgery) for female members with breast hypertrophy (enlarged breasts) is covered by ForwardHealth with prior authorization (PA). This *ForwardHealth Update* describes new PA approval criteria for reduction mammoplasty for PA requests received on and after July 1, 2015.

Reduction mammoplasty is clinically indicated for women 18 years of age or older with breast hypertrophy if **all** of the following are true:

- There is significant physical functional impairment.
- The procedure can be reasonably expected to improve the physical functional impairment.
- Signs and/or symptoms resulting from the breast hypertrophy have not responded adequately to any non-surgical interventions.

Surgery is considered cosmetic unless breast hypertrophy is causing significant pain, paresthesias, or ulceration (see the following selection criteria). Reduction mammoplasty for asymptomatic members is considered cosmetic and noncovered.

Prior Authorization

All reduction mammoplasties require PA. ForwardHealth has established clinical criteria for approval of a PA request for reduction mammoplasty. Reduction mammoplasties that do not meet the PA approval criteria are considered noncovered. Any charges related to a noncovered reduction mammoplasty will not be reimbursed.

Prior Authorization Approval Criteria

At least one of the following criteria must be met for PA requests to be approved for reduction mammoplasty:

- The member has persistent symptoms in **at least two** of the following anatomical body areas affecting daily activities for at least one year:
  - ✓ Headaches.
  - ✓ Pain in neck.
  - ✓ Pain in shoulders.
  - ✓ Pain in upper back.
  - ✓ Painful kyphosis documented by X-rays.
- The member has severe submammary intertrigo that is refractory to conventional medications and measures used to treat intertrigo or the member has shoulder grooving with ulceration unresponsive to conventional therapy.

In addition, all of the following criteria must be met for PA requests to be approved for reduction mammoplasty:

- There is documentation from a primary care physician and other providers, as appropriate (e.g., physiatrist, orthopedic surgeon), showing the diagnosis and evaluation of symptoms that prompted this request, which confirms that the following criteria have been met:
  - ✓ There is a reasonable likelihood that the member's symptoms are primarily due to macromastia.
  - ✓ Reduction mammoplasty is likely to result in improvement of the chronic pain.
  - ✓ Pain symptoms persist, as documented by the physician, despite at least a three-month trial of therapeutic measures such as:
    - Analgesic/non-steroidal anti-inflammatory drugs (NSAIDs) interventions.
    - Physical therapy/exercises/posturing maneuvers.
    - Supportive devices (e.g., proper bra support, wide bra straps).
- If the woman is 40 years of age or older, she has had a negative (for cancer) mammogram that was performed within the year prior to the date of the planned reduction mammoplasty.
- The surgeon has estimated the amount (in grams) of breast tissue (not fatty tissue) to be removed from each breast and that amount meets the medical necessity criteria determined using the Schnur Sliding Scale chart calculations. Refer to the Attachment of this *Update* for the body surface area formulas and Schnur Sliding Scale chart.

Chronic intertrigo, eczema, dermatitis, and/or ulceration in the infra-mammary fold are not necessarily considered medically necessary indications for reduction mammoplasty. In order to be considered medically necessary, the condition must be severe and unresponsive to dermatological treatments (e.g., antibiotics or antifungal therapy) and conservative measures (e.g., good skin hygiene, adequate nutrition) for a period of six months or longer.

Prior Authorization Request Documentation Requirements

The following must be documented on the PA request:

- Height and weight of the member.
- Approximate amount of tissue (in grams) to be removed from each breast.

Prior authorization requests that do not include this information will be returned to the provider for more information.

When requesting PA, submission of photographic documentation that confirms severe breast hypertrophy is not required but must be available upon request.

Approved PA requests for reduction mammoplasty are valid for 12 months.

Claim Submission

Providers should use *Current Procedural Terminology* procedure code 19318 (Reduction mammoplasty) when submitting claims for reduction mammoplasty. The diagnosis code for breast hypertrophy must be indicated.

How to Submit a Prior Authorization Request

All of the following must be included as part of a PA request for reduction mammoplasty:

- A completed Prior Authorization Request Form (PA/RF), F-11018 (05/13).
- A completed Prior Authorization/Physician Attachment (PA/PA), F-11016 (07/12).
- Documentation supporting the criteria in the Prior Authorization Approval Criteria section of this *Update*.

Providers may submit PA requests via the ForwardHealth Portal at *www.forwardhealth.wi.gov/*, which includes the capability to upload PA attachment forms and additional supporting clinical documentation.

Providers may refer to the Provider Portal Prior Authorization User Guide, which is available on the Portal at

www.forwardhealth.wi.gov/WIPortal/content/Provider/userguides/userguides.htm.spage, for instructions on submitting PA attachments.

Providers may submit PA requests by fax to ForwardHealth at 608-221-8616 or by mail to the following address:

ForwardHealth
Prior Authorization
Ste 88
313 Blettner Blvd
Madison WI 53784

For complete PA information, refer to the Physician service area of the Online Handbook.

Information Regarding Managed Care Organizations

This *Update* contains fee-for-service policy and applies to services members receive on a fee-for-service basis only. For managed care policy, contact the appropriate managed care organization. Managed care organizations are required to provide at least the same benefits as those provided under fee-for-service arrangements.

The *ForwardHealth Update* is the first source of program policy and billing information for providers.

Wisconsin Medicaid, BadgerCare Plus, SeniorCare, and Wisconsin Chronic Disease Program are administered by the Division of Health Care Access and Accountability, Wisconsin Department of Health Services (DHS). The Wisconsin AIDS Drug Assistance Program and the Wisconsin Well Woman Program are administered by the Division of Public Health, Wisconsin DHS.

For questions, call Provider Services at (800) 947-9627 or visit our website at *www.forwardhealth.wi.gov/*.

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ATTACHMENT
Body Surface Area Formulas and Schnur Sliding Scale Chart

The Schnur Sliding Scale chart below is an evaluation method for providers to use for members considering reduction mammoplasty. Body Surface Area (BSA), along with the threshold for the average weight of breast tissue removed, is incorporated into the Schnur Sliding Scale chart to indicate the medical necessity of reduction mammoplasty. The surgeon estimates the minimum amount (in grams) of breast tissue be removed or anticipated to be removed from each breast, based on the member's BSA from the Schnur Sliding Scale. To calculate BSA, refer to *www-users.med.cornell.edu/~spon/picu/calc/bsacalc.htm* or use one of the following formulas.

Body Surface Area Formulas
BSA (m^2) = ([height (in) x weight (lb)]/3131)½
BSA (m^2) = ([height (cm) x weight (kg)]/3600)½

Schnur Sliding Scale	
Body Surface Area	**Threshold Value for the Average Grams of Tissue per Breast to Be Removed**
1.35	199
1.40	218
1.45	238
1.50	260
1.55	284
1.60	310
1.65	338
1.70	370
1.75	404
1.80	441
1.85	482
1.90	527
1.95	575
2.00	628
2.05	687
2.10	750
2.15	819
2.20	895
2.25	978
2.30	1068
2.35	1167
2.40	1275
2.45	1393
2.50	1522
2.55	1662