Reduction Mammoplasty/Mastopexy
SRG-015

Iowa Medicaid Program	Prior Authorization	**Effective Date**	07/01/2008
Revision Number	16	**Last Reviewed**	07/17/2026
Reviewed By	Medicaid Medical Director	**Next Review**	07/16/2027
Approved By	Medicaid Clinical Advisory Committee	**Approved Date**	07/24/2020

Criteria

Prior authorization is required.

Reduction mammoplasty/mastopexy is considered medically necessary when **ALL** the following are met:

1. The member is at least 18 years of age and diagnosed with macromastia. Younger ages would be evaluated on a case-by-case basis, based on demonstrated medical necessity, through the prior authorization process.
2. **ALL** of the following conditions and/or symptoms must be present for at least a **recent** continuous 6-month trial with documented failure of appropriate conservative management. Conservative management must include physical therapy to improve core strength. Adherence to physical therapy needs to be documented by the licensed physical therapist. The use of a supportive bra and/or weight loss attempt for persons with BMI over 30 must be documented.
   a. Recurrent or persistent symptomatic submammary intertriginous rash; **AND**
   b. Chronic back, neck, shoulder, or breast pain; **AND**
   c. Persistent shoulder grooving despite the use of support devices such as appropriate support bra, wide strap bra, or similar item.
3. At least **ONE** of the following conditions and/or symptoms present:
   a. Chronic headaches; **OR**
   b. Sleeping problems; **OR**
   c. Loss of sensation in the breast, arms, fingers; **OR**
   d. Difficulty exercising.
4. Weight of tissue planned to be removed from each breast **MUST** be guided by the Schnur Sliding Scale as outlined on next page.

Schnur Sliding Scale

Body Surface Area (m2)	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	1,068
2.35	1,167
2.40	1,275
2.45	1,393
2.50	1,522
2.55	1,662
2.60	1,806
2.65	1,972
2.70	2,154
2.75	2,352
2.80	2,568
2.85	2,804
2.90	3,061
2.95	3,343
3.00	3,650
3.05	3,985

Body Surface Area (m2)	Average grams of tissue per breast to be removed
3.10	4,351
3.15	4,750
3.20	5,186
3.25	5,663
3.30	6,182
3.35	6,750
3.40	7,369
3.45	8,045
3.50	8,783
3.55	9,589
3.60	10,468
3.65	11,428
3.70	12,476
3.75	13,619
3.80	14,867
3.85	16,230
3.90	17,717
3.95	19,340
4.00	21,112
4.05	23,045
4.10	25,156
4.15	27,459
4.20	29,972
4.25	32,716
4.30	35,710
4.35	38,977
4.40	42,543
4.45	46,435
4.50	50,682
4.55	55,316
4.60	60,374
4.65	65,893
4.70	71,915
4.75	78,487
4.80	85,658

Coding

The following list of codes is provided for reference purposes only and may not be all inclusive. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment, nor does the exclusion of a code imply that its association to the HCPCS/CPT code is inappropriate.

HCPCS	Description
19316	Mastopexy.
19318	Reduction mammoplasty.

Compliance

1. Should conflict exist between this policy and applicable statute, the applicable statute shall supersede.
2. Federal and State law, as well as contract language, including definitions and specific contract provisions or exclusions, take precedence over medical policy and must be considered first in determining eligibility for coverage.
3. Medical technology is constantly evolving, and Iowa Medicaid reserves the right to review and update medical policy on an annual and as-needed basis.

Medical necessity guidelines have been developed for determining coverage for member benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in the service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. Criteria are revised and updated annually, or more frequently if new evidence becomes available that suggests needed revisions.

References

Evidence-based Clinical Practice Guideline: Reduction Mammaplasty. American Society of Plastic Surgeons. 2022.

Reduction Mammoplasty. Local Coverage Determination. CMS LCD 35001. For services performed on or after 02/01/2024.

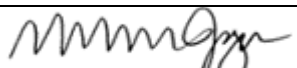
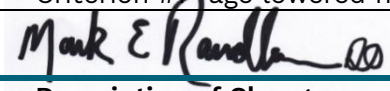
Hansen J. Chag S. Overview of Breast Reduction. UpToDate. Topic Last Updated May 2, 2025. Accessed May 7, 2026.

Reduction Mammoplasty. ACG: A-0274 (AC). MCG 29th Edition Ambulatory Care Guidelines. Last Update: . 6/13/2025 Accessed J 5/7/2026.

Development of utilization management criteria may also involve research into other state Medicaid programs, other payer policies, consultation with experts and review by the Medicaid Clinical Advisory Committee (CAC). These sources may not be referenced individually unless they are specifically published and are otherwise applicable to the criteria at issue.

Criteria Change History

Change Date	Changed By	Description of Change	Version
[mm/dd/yyyy]			[#]
Signature			

Change Date	Changed By	Description of Change	Version
07/17/2026	CAC	Annual Review.	16
Signature			
William (Bill) Jagiello, DO			
Change Date	**Changed By**	**Description of Change**	**Version**
07/18/2025	CAC	Annual Review. References updated.	15
Signature			
William (Bill) Jagiello, DO			
Change Date	**Changed By**	**Description of Change**	**Version**
07/19/2024	CAC	Annual Review.	14
Signature			
William (Bill) Jagiello, DO			
Change Date	**Changed By**	**Description of Change**	**Version**
07/21/2023	CAC	Annual Review.	13
Signature			
William (Bill) Jagiello, DO			
Change Date	**Changed By**	**Description of Change**	**Version**
07/15/2022	CAC	Annual review. Added Compliance section.	12
Signature			
William (Bill) Jagiello, DO			
Change Date	**Changed By**	**Description of Change**	**Version**
07/16/2021	CAC	Annual Review.	11
Signature			
William (Bill) Jagiello, DO			
Change Date	**Changed By**	**Description of Change**	**Version**
07/17/2020	Medical Director	Revised criterion #4.	10
Signature			
William (Bill) Jagiello, DO			
Change Date	**Changed By**	**Description of Change**	**Version**
08/23/2019	CAC	Criterion #1 age lowered from 22 to 18.	9
Signature			
Mark E. Randleman, DO			
Change Date	**Changed By**	**Description of Change**	**Version**

Criteria Change History

10/12/2016	Policy	Criterion #1 removed “exception to policy for less than 22 years of age” and added “evaluated on a case-by-case basis, based on demonstrated medical necessity, through the prior authorization process”.	8
Signature			

Change Date	Changed By	Description of Change	Version
07/15/2016	Medical Director	Criterion #1 added “exception to policy for age less than 22 years of age”. Criterion #2 added paragraph on conservative management. Added Schnur Sliding Scale. Added References.	7
Signature			

Change Date	Changed By	Description of Change	Version
07/17/2015	CAC	Added last paragraph in References.	6
Signature			

Change Date	Changed By	Description of Change	Version
07/14/2015	Medical Director	Added plastic surgery reference.	5
Signature			

Change Date	Changed By	Description of Change	Version
07/18/2014	Medical Director	Formatting changes.	4
Signature			

Change Date	Changed By	Description of Change	Version
10/04/2013	Policy	Criterion #2c added “or similar item”.	3
Signature			

Change Date	Changed By	Description of Change	Version
07/19/2013	CAC	Change criterion #2-a to be recurrent or persistent symptomatic, remove causing cellulitis, skin necrosis, and/or ulceration. Change criterion #4 to remove average from weight.	2
Signature			

Change Date	Changed By	Description of Change	Version
01/18/2013	CAC	Criterion #1 added “diagnosed with macromastia”. Removed criterion #5.	1
Signature			

CAC = Medicaid Clinical Advisory Committee