

BREAST REDUCTION SURGERY

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Table of Contents	Page
INSTRUCTIONS FOR USE	1
BENEFIT CONSIDERATIONS	1
COVERAGE RATIONALE	1
DEFINITIONS	3
APPLICABLE CODES	4
REFERENCES	5
GUIDELINE HISTORY/REVISION INFORMATION	5

- Related Commercial Policies**
- [Breast Reconstruction Post Mastectomy](#)
 - [Cosmetic and Reconstructive Procedures](#)
 - [Gender Dysphoria Treatment](#)
 - [Gynecomastia Treatment](#)
 - [Panniculectomy and Body Contouring Procedures](#)
- Community Plan Policy**
- [Breast Reduction Surgery](#)

INSTRUCTIONS FOR USE

This Coverage Determination Guideline provides assistance in interpreting UnitedHealthcare benefit plans. When deciding coverage, the member specific benefit plan document must be referenced. The terms of the member specific benefit plan document [e.g., Certificate of Coverage (COC), Schedule of Benefits (SOB), and/or Summary Plan Description (SPD)] may differ greatly from the standard benefit plan upon which this Coverage Determination Guideline is based. In the event of a conflict, the member specific benefit plan document supersedes this Coverage Determination Guideline. All reviewers must first identify member eligibility, any federal or state regulatory requirements, and the member specific benefit plan coverage prior to use of this Coverage Determination Guideline. Other Policies and Coverage Determination Guidelines may apply. UnitedHealthcare reserves the right, in its sole discretion, to modify its Policies and Guidelines as necessary. This Coverage Determination Guideline is provided for informational purposes. It does not constitute medical advice.

UnitedHealthcare may also use tools developed by third parties, such as the MCG™ Care Guidelines, to assist us in administering health benefits. The MCG™ Care Guidelines are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.

BENEFIT CONSIDERATIONS

Before using this guideline, please check the member specific benefit plan document and any federal or state mandates, if applicable.

For self-funded plans with SPD language other than fully-insured Generic COC language, please refer to the member specific benefit plan document for coverage.

Essential Health Benefits for Individual and Small Group

For plan years beginning on or after January 1, 2014, the Affordable Care Act of 2010 (ACA) requires fully insured non-grandfathered individual and small group plans (inside and outside of Exchanges) to provide coverage for ten categories of Essential Health Benefits (“EHBs”). Large group plans (both self-funded and fully insured), and small group ASO plans, are not subject to the requirement to offer coverage for EHBs. However, if such plans choose to provide coverage for benefits which are deemed EHBs, the ACA requires all dollar limits on those benefits to be removed on all Grandfathered and Non-Grandfathered plans. The determination of which benefits constitute EHBs is made on a state by state basis. As such, when using this guideline, it is important to refer to the member specific benefit plan document to determine benefit coverage.

COVERAGE RATIONALE

California Mandate for Medically Necessary Surgery

The State of California requires that all breast reduction surgeries be reviewed for medical necessity. Benefits will be provided if the breast reduction meets the [Criteria for a Coverage Determination as Reconstructive](#) identified below.

Indications for Coverage

Breast reduction surgery following mastectomy to achieve symmetry is covered as part of the Women's Health and Cancer Rights Act (WHCRA). Please refer to the Coverage Determination Guideline titled [Breast Reconstruction Post Mastectomy](#).

Breast reconstruction may be covered under certain circumstances for the surgical treatment of gender dysphoria. Please refer to the member specific benefit plan document for coverage.

All plans cover breast reduction surgeries that qualify under the Women's Health and Cancer Rights Act of 1998. If a surgery does not qualify under the Women's Health and Cancer Rights Act of 1998, certain plans may allow breast reduction surgery which we determine to treat a physiologic functional impairment. However, certain plans exclude breast reduction surgery even if it treats a physiologic functional impairment. Refer to the member specific benefit plan document to determine coverage.

For Plans that Cover Breast Reduction Surgery that Treat a Physiologic Functional Impairment (Including California Reviews for Medical Necessity)

Criteria for a Coverage Determination as Reconstructive

Breast reduction surgery is considered reconstructive and medically necessary when the following criteria are met and a physiologic functional impairment is identified:

- Macromastia is the primary etiology of the member's Functional Impairment or impairments (as defined in the [Definitions](#) section below). The following are examples of Functional Impairments that must be attributable to Macromastia to be considered (not an all-inclusive list):
 - Severe skin excoriation/intertrigo unresponsive to medical management
 - Severe restriction of physical activities that meets the definition of Functional Impairment below
 - Signs and symptoms of nerve compression that are unresponsive to medical management (e.g., ulnar paresthesias)
 - Acquired kyphosis that is attributed to Macromastia
 - Chronic breast pain due to weight of the breasts
 - Upper back, neck, or shoulder pain
 - Shoulder grooving from bra straps
 - Headache;and
- The amount of tissue to be removed plots above the 22nd percentile; or
- If the amount of tissue to be removed plots between the 5th and 22nd percentiles, the procedure may be either reconstructive or cosmetic; the determination is based on the review of the information provided; and
- The proposed procedure is likely to result in significant improvement of the Functional Impairment.

The following documentation should be available for review:

- Reduction mammoplasty documentation should include the evaluation and management note for the date of service and the note for the day the decision to perform surgery was made. The member's medical record must contain, and be available for review on request, the following information:
 - Height and weight
 - Body surface area (BSA)
 - Photographs that document Macromastia

Coverage Limitations and Exclusions

Some states require benefit coverage for services that UnitedHealthcare considers Cosmetic Procedures, such as repair of external congenital anomalies in the absence of a Functional Impairment. Please refer to the member specific benefit plan document.

- Cosmetic Procedures are excluded from coverage. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. The fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery (or other procedures done to relieve such consequences or behavior) as a reconstructive procedure.
- Any procedure that does not meet the reconstructive criteria above in the [Indications for Coverage](#) section (e.g., psychological or social reasons, breast size asymmetry unless post mastectomy, exercise).
- Breast reduction surgery is cosmetic when done to improve appearance without improving a functional/physiologic impairment.
- The use of liposuction as the sole procedure for breast reduction surgery is considered cosmetic.

Appendix

This Schnur chart may be used to assess whether the amount of tissue (per breast) that will be removed is reasonable for the body habitus, and whether the procedure is cosmetic or reconstructive in nature.

- If the amount plots above the 22nd percentile and the member has a Functional Impairment, the procedure is reconstructive.
- If the amount plots below the 5th percentile, the procedure is cosmetic.
- If the amount plots between the 5th and 22nd percentiles, the procedure may be either reconstructive or cosmetic based on review of information.

To calculate body surface area (BSA), see:

- <http://www.calculator.net/body-surface-area-calculator.html> (use Du Bois formula); or
- Du Bois formula:
 - $BSA = 0.007184 \times W^{0.425} \times H^{0.725}$
 Du Bois D, Du Bois EF. A formula to estimate the approximate surface area if height and weight be known. Arch Intern Med. 1916; 17(6):863-871.

Modified Schnur Nomogram Chart

Body Surface (m2)	Lower 5th Percentile	Lower 22nd Percentile
1.35	127	199
1.40	139	218
1.45	152	238
1.50	166	260
1.55	181	284
1.60	198	310
1.65	216	338
1.70	236	370
1.75	258	404
1.80	282	441
1.85	308	482
1.90	336	527
1.95	367	575
2.00	401	628
2.05	439	687
2.10	479	750
2.15	523	819
2.20	572	895
2.25	625	978
2.30	682	1,068
2.35	745	1,167
2.40	814	1,275
2.45	890	1,393
2.50	972	1,522
2.55	1,062	1,662

DEFINITIONS

The following definitions may not apply to all plans. Refer to the member specific benefit plan document for applicable definitions.

Congenital Anomaly: A physical developmental defect that is present at the time of birth, and that is identified within the first twelve months of birth.

Congenital Anomaly (California only): A physical developmental defect that is present at birth.

Cosmetic Procedures: Procedures or services that change or improve appearance without significantly improving physiological function. (2018 UnitedHealthcare Insurance Company Generic COC)

Cosmetic Procedures: Procedures or services that change or improve appearance without significantly improving physiological function, as determined by us. The fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery (or other procedures done to relieve such consequences or behavior) as a reconstructive procedure. (2001 – 2011 UnitedHealthcare Insurance Company Generic COC)

Cosmetic Procedures (California only): Procedures or services that are performed to alter or reshape normal structures of the body in order to improve the Covered Person's appearance.

Functional/Physical or Physiological Impairment: Functional/Physical or Physiological Impairment causes deviation from the normal function of a tissue or organ. This results in a significantly limited, impaired, or delayed capacity to move, coordinate actions, or perform physical activities and is exhibited by difficulties in one or more of the following areas: physical and motor tasks; independent movement; performing basic life functions.

Macromastia (Breast Hypertrophy): An increase in the volume and weight of breast tissue relative to the general body habitus.

Reconstructive Procedures: Reconstructive Procedures when the primary purpose of the procedure is either of the following:

- Treatment of a medical condition.
- Improvement or restoration of physiologic function.

Reconstructive Procedures include surgery or other procedures which are related to an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not a changed or improved physical appearance.

Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. The fact that you may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery (or other procedures done to relieve such consequences or behavior) as a reconstructive procedure.

Reconstructive Procedures (California only): Reconstructive Procedures to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to do either of the following:

- To improve function.
- To create a normal appearance, to the extent possible.

Reconstructive Procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not a changed or improved physical appearance for cosmetic purposes only, but rather to improve function and/or to create a normal appearance, to the extent possible.

APPLICABLE CODES

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this guideline does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Coverage Determination Guidelines may apply.

Note: Coding for suction lipectomy is addressed in the Coverage Determination Guideline titled [Panniculectomy and Body Contouring](#).

CPT Code	Description
19318	Reduction mammoplasty
<i>CPT® is a registered trademark of the American Medical Association</i>	
ICD-10 Diagnosis Code	Description
N62	Hypertrophy of breast
ICD-10 Procedure Code	Description
0HBT0ZZ	Excision of right breast, open approach
0HBT3ZZ	Excision of right breast, percutaneous approach

ICD-10 Procedure Code	Description
0HBU0ZZ	Excision of left breast, open approach
0HBU3ZZ	Excision of left breast, percutaneous approach
0HBV0ZZ	Excision of bilateral breast, open approach
0HBV3ZZ	Excision of bilateral breast, percutaneous approach

REFERENCES

American Society of Plastic Surgeons. Reduction Mammoplasty. Practice Parameters. May 2011.

American Society of Plastic Surgeons. Reduction Mammoplasty Recommended Criteria for Third-Party Payer Coverage from the American Society of Plastic Surgeons (ASPS). May 2011.

MCG™ Care Guidelines. 22nd edition, 2018. Reduction Mammoplasty (Mammoplasty). ACG: A-0274 (AC).

Schnur PL, Hoehn JG, Ilstrup DM, et al. Reduction mammoplasty: cosmetic or reconstructive procedure? Ann Plast Surg. 1991 Sep; 27 (3):232-7.

UnitedHealthcare Insurance Company Generic Certificate of Coverage 2001.

UnitedHealthcare Insurance Company Generic Certificate of Coverage 2007.

UnitedHealthcare Insurance Company Generic Certificate of Coverage 2011.

UnitedHealthcare Insurance Company Generic Certificate of Coverage 2018.

Wisconsin Physicians Service Insurance Corporation. Cosmetic and Reconstructive Surgery (L34698). Effective 11/15/2010, revised 03/01/14. Available at: <http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx>. Accessed April 4, 2018.

GUIDELINE HISTORY/REVISION INFORMATION

Date	Action/Description
09/01/2018	<ul style="list-style-type: none"> Updated coverage rationale/appendix; added instruction to clarify the Du Bois formula is used to calculate body surface area (BSA) Updated supporting information to reflect the most current references Archived previous policy version CDG.004.14