Breast Reduction Surgery (for Tennessee Only)

Guideline Number: CS012TN.V
Effective Date: August 1, 2021

Instructions for Use

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Related Policies

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Application

This Coverage Determination Guideline applies to Medicaid only plans in the state of Tennessee.

Rationale

See Benefit Considerations

Indications for Coverage

Breast reduction surgery is considered reconstructive and medically necessary when the following criteria are met:

- Following mastectomy to achieve symmetry; or
- Prior to the mastectomy to preserve the viability of the nipple; or
- Macromastia is the primary etiology of the member's Functional Impairment(s):
  - 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
    - Headache
    - Severe restriction of physical activities due to Functional Impairment:
      - 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;

    and
  - The amount of tissue to be removed:
    - Plots above the 22nd percentile; or
    - 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

Documentation Requirements

Provide medical notes documenting the following:

- History of the medical condition(s) requiring treatment or surgical intervention and all of the following:
  - Chief complaint, history of the complaint, and physical exam
  - Previous evaluations and diagnostic tests results used to rule out orthopedic, neurologic, rheumatologic, endocrine or metabolic causes
  - Member's bra size, height, weight
- Description of physiologic functional impairments and etiology (e.g., back pain, grooving from bras straps, skin breakdown, etc.)
  - With a diagnosis of macromastia, include high-quality color image(s)
    - Note: All images must be labeled with the:
      - Date taken
      - Applicable case number obtained at time of notification, or the member's name and ID number on the image(s)
    - Submission of diagnostic imaging is required via the external portal at www.uhcprovider.com/paan; faxes will not be accepted
- Previous conservative measures, response, and duration
- Amount of breast tissue to be removed per breast
- Reduction mammoplasty documentation should include the:
  - Evaluation and management note for the date of service
  - Note for the day the decision to perform surgery was made

Coverage Limitations and Exclusions

UnitedHealthcare excludes Cosmetic Procedures from coverage including but not limited to the following:

- Breast reduction surgery when done to improve appearance without improving a Functional/Physiologic Impairment
- Liposuction as the sole procedure for breast reduction surgery
- 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.
- Procedures that do not meet the reconstructive criteria in the Indications for Coverage section, e.g., psychological or social reasons, breast size asymmetry unless post mastectomy, exercise

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)*
- 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

Body Surface (m2)	Lower 5th Percentile	Lower 22nd Percentile
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

Check the definitions within the member benefit plan document that supersede the definitions below.

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.

Cosmetic Procedures: Procedures or services that change or improve appearance without significantly improving physiological function.

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.

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 policy 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 federal, state, or contractual requirements 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 Guidelines may apply.

Note: Coding for suction lipectomy is addressed in the Coverage Determination Guideline titled Panniculectomy and Body Contouring Procedures (for Tennessee Only).

CPT Code	Description
19318	Reduction mammaplasty

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Diagnosis Code	Description
N62	Hypertrophy of breast
N65.1	Disproportion of reconstructed breast

ICD Procedure Code	Description
0HBT0ZZ	Excision of Right Breast, Open Approach
0HBT3ZZ	Excision of Right Breast, Percutaneous Approach
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
0H0T0ZZ	Alteration of Right Breast, Open Approach
0H0U0ZZ	Alteration of Left Breast, Open Approach
0H0V0ZZ	Alteration of Bilateral Breast, Open Approach

Benefit Considerations

Under certain circumstances, breast reconstruction may be covered for the surgical treatment of gender dysphoria. Please check the federal, state or contractual requirements for benefit coverage.

References

American Society of Plastic Surgeons. Reduction Mammaplasty Recommended Criteria for Third-Party Payer Coverage from the American Society of Plastic Surgeons (ASPS). May 20, 2011.

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

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

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 February 3, 2021.

Guideline History/Revision Information

Date	Summary of Changes
08/01/2021	• Routine review; no change to coverage guidelines • Archived previous policy version CS012TN.U

Instructions for Use

This Coverage Determination Guideline provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the federal, state or contractual requirements for benefit plan coverage must be referenced as the terms of the federal, state or contractual requirements for benefit plan coverage may differ from the standard benefit plan. In the event of a conflict, the federal, state or contractual requirements for benefit plan coverage govern. Before using this guideline, please check the federal, state or contractual requirements for benefit plan coverage. UnitedHealthcare reserves the right 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 InterQual® criteria, to assist us in administering health benefits. The UnitedHealthcare Coverage Determination 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.