BREAST REDUCTION SURGERY

Policy Number: SURGERY 032.23 T2 **Effective Date**: October 1, 2018

Table of Contents **Page**

Related Policies

- Breast Reconstruction Post Mastectomy
- Breast Repair/Reconstruction Not Following Mastectomy
- Cosmetic and Reconstructive Procedures
- Gender Dysphoria Treatment
- Gynecomastia Treatment
- In-Network Exceptions for Breast Reconstruction Surgery Following Mastectomy
- Panniculectomy and Body Contouring Procedures

INSTRUCTIONS FOR USE

This Clinical Policy provides assistance in interpreting Oxford benefit plans. Unless otherwise stated, Oxford policies do not apply to Medicare Advantage members. Oxford reserves the right, in its sole discretion, to modify its policies as necessary. This Clinical Policy is provided for informational purposes. It does not constitute medical advice. The term Oxford includes Oxford Health Plans, LLC and all of its subsidiaries as appropriate for these policies.

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 Clinical Policy is based. In the event of a conflict, the member specific benefit plan document supersedes this Clinical Policy. 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 Clinical Policy. Other Policies may apply.

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.

CONDITIONS OF COVERAGE

Applicable Lines of Business/Products	This policy applies to Oxford Commercial plan membership.
Benefit Type	General Benefits Package
Referral Required (Does not apply to non-gatekeeper products)	No
Authorization Required (Precertification always required for inpatient admission)	Yes[1]
Precertification with Medical Director Review Required	Yes[1]
Applicable Site(s) of Service (If site of service is not listed, Medical Director review is required)	Inpatient, Outpatient
Special Considerations	[1]Precertification with review by a Medical Director or their designee.

BENEFIT CONSIDERATIONS

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

Breast reduction surgery following mastectomy to achieve symmetry is covered as part of the Women's Health and Cancer Rights Act (WHCRA). Refer to the policy titled Breast Reconstruction Post-Mastectomy for additional information.

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.

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 policy, it is important to refer to the member specific benefit plan document to determine benefit coverage.

COVERAGE RATIONALE

Indications for Coverage

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 Definition 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 member specific benefit plan documents.

- 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)*
- 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 (m^2)	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

Body Surface (m^2)	Lower 5th Percentile	Lower 22nd Percentile
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.

Cosmetic Surgery: Defined by the American Society of Plastic Surgeons, "is performed to reshape normal structures of the body in order to improve the patient's appearance and self-esteem."

Functional/Physical or Physiological Impairment: A 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.

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 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 may apply.

Note: Coding for suction lipectomy is addressed in the policy titled Panniculectomy and Body Contouring Procedures.

CPT Code	Description
19318	Reduction mammoplasty

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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
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

The foregoing Oxford policy has been adapted from an existing UnitedHealthcare Coverage Determination Guideline (CDG) that was researched, developed and approved by the UnitedHealthcare Coverage Determination Committee. [*CDG.004.15*]

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

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

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

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

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.

POLICY HISTORY/REVISION INFORMATION

Date	Action/Description
10/01/2018	• Updated coverage rationale/appendix; added instruction to clarify the Du Bois formula is used to calculate body surface area (BSA) • Archived previous policy version SURGERY 032.22 T2