BREAST REDUCTION SURGERY

Guideline Number: MMG012.S **Effective Date**: July 1, 2019

Instructions for Use

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Related Benefit Interpretation Policies

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- Gender Dysphoria (Gender Identity Disorder) Treatment

COVERAGE RATIONALE

See Benefit Considerations

Indications for Coverage

Most UnitedHealthcare West plans have a specific exclusion for breast reduction surgery except as required by the Women's Health and Cancer Rights Act of 1998. See the "Coverage Limitations and Exclusions" section.

For plans that include breast reduction surgery benefits, the following are eligible for coverage as reconstructive and medically necessary when the criteria are met:

- Following mastectomy to achieve symmetry (per WHCRA); or
- Macromastia is the primary etiology of the member's Functional Impairment or impairments.
  - 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; 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.

Potential Required Documentation:

- Reduction Mammoplasty documentation should include:
  - The evaluation and management note for the date of service
  - The note for the day the decision to perform surgery was made.
- The member's medical record must be available upon request and must contain:
  - Height and weight

- Body Surface Area (BSA)
- Photographs that document Macromastia

Coverage Limitations and Exclusions

UnitedHealthcare West 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.
- Procedures that do not meet the reconstructive criteria in the Indications for Coverage section, (e.g., 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)*; 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

DOCUMENTATION REQUIREMENTS

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 documentation requirements outlined below are used to assess whether the member meets the clinical criteria for coverage but do not guarantee coverage of the service requested.

Required Clinical Information
Breast Reduction Surgery

Medical notes documenting **all** of 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
  - Macromastia is the primary etiology of the member's functional impairment
    - With a diagnosis of macromastia include high quality color photograph(s); all photos must be labeled with the date taken and the applicable case number obtained at time of notification, or member's name and ID number on the photograph(s)
      Note: Submission of color photos are required and can be submitted via the external portal at www.uhcprovider.com/paan or via email at CCR@uhc.com; faxes of color photos will not be accepted.
  - Description of physiologic functional impairments (e.g., back pain, grooving from bras straps, skin breakdown, etc.)
  - Previous conservative measures, response and duration
  - Amount of breast tissue to be removed per breast

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 Defect (California Only): A condition present at birth.

Cosmetic Services and Surgery (CA only): Cosmetic Surgery and Cosmetic Services are not covered. Cosmetic Surgery and Cosmetic Services are defined as surgery and services performed to alter or reshape normal structures of the body in order to improve appearance. Drugs, devices and procedures related to Cosmetic Surgery or Cosmetic Services are not covered. Surgeries or services that would ordinarily be classified as cosmetic will not be reclassified as reconstructive, based on a Member's dissatisfaction with his or her appearance.

Cosmetic Services and Surgery (OK, OR, TX and WA only): Cosmetic Surgery and Cosmetic Services are not covered. Cosmetic Surgery and Cosmetic Services are defined as surgery and services performed to alter or reshape normal structures of the body in order to improve appearance. Drugs, devices and procedures related to Cosmetic Surgery or Cosmetic Services are not covered. Surgeries or services that would ordinarily be classified as cosmetic will not be reclassified as reconstructive, based on a Member's dissatisfaction with his or her appearance, as influenced by that Member's underlying psychological makeup or psychiatric condition.

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 (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 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.

Reconstructive Surgery: Reconstructive Surgery is covered to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease. The purpose of

reconstructive surgery is to correct abnormal structures of the body to improve function. [Check member specific benefit plan documents (EOC/SOB).]

Women's Health and Cancer Rights Act of 1998, § 713 (a): "In general - a group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan, that provides medical and surgical benefits with respect to a Mastectomy shall provide, in case of a participant or beneficiary who is receiving benefits in connection with a Mastectomy and who elects breast reconstruction in connection with such Mastectomy, coverage for (1) reconstruction of the breast on which the Mastectomy has been performed; (2) surgery and reconstruction of the other breast to produce symmetrical appearance; and (3) prostheses and physical complications all stages of Mastectomy, including lymphedemas in a manner determined in consultation with the attending physician and the patient."

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 Guidelines may apply.

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

CPT Code	Description
19318	Reduction mammoplasty

ICD-10 Diagnosis Code	Description
N62	Hypertrophy of breast
N65.1	Disproportion of reconstructed 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
0H0T0ZZ	Alteration of Right Breast, Open Approach
0H0U0ZZ	Alteration of Left Breast, Open Approach
0H0V0ZZ	Alteration of Bilateral Breast, Open Approach

BENEFIT CONSIDERATIONS

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, some plans may allow breast reduction surgery if we determine the surgery will treat a physiologic functional impairment. However, some plans exclude breast reduction surgery even if it treats a physiologic functional impairment. Refer to the member specific benefit plan document to determine coverage.

California Mandate for Medically Necessary Surgery

California requires that all breast reduction surgeries be reviewed for medical necessity. Coverage will be provided if the breast reduction meets the reconstructive criteria identified below.

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

REFERENCES

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

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

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 on April 2, 2019.

Women's Health and Cancer Rights Act of 1998. Available at: https://www.cms.gov/cciio/programs-and-initiatives/other-insurance-protections/whcra_factsheet.html Accessed April 2, 2019

GUIDELINE HISTORY/REVISION INFORMATION

Date	Action/Description
07/01/2019	**Template Update** • Added *Documentation Requirements* section **Related Policies** • Added reference link to the Medical Management Guideline titled *Cosmetic and Reconstructive Procedures* **Applicable Codes** • Added ICD-10 diagnosis code N65.1 • Added ICD-10 procedure codes 0H0T0ZZ, 0H0U0ZZ, and 0H0V0ZZ **Supporting Information** • Archived previous policy version MMG012.R

INSTRUCTIONS FOR USE

This Medical Management Guideline provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the member specific benefit plan document must be referenced as the terms of the member specific benefit plan may differ from the standard benefit plan. In the event of a conflict, the member specific benefit plan document governs. Before using this guideline, please check the member specific benefit plan document and any applicable federal or state mandates. UnitedHealthcare reserves the right to modify its Policies and Guidelines as necessary. This Medical Management 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. UnitedHealthcare West Medical Management 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.

Member benefit coverage and limitations may vary based on the member's benefit plan Health Plan coverage provided by or through UnitedHealthcare of California, UnitedHealthcare Benefits Plan of California, UnitedHealthcare of Oklahoma, Inc., UnitedHealthcare of Oregon, Inc., UnitedHealthcare Benefits of Texas, Inc., or UnitedHealthcare of Washington, Inc.