UnitedHealthcare

UnitedHealthcare® Commercial
Coverage Determination Guideline

BREAST REDUCTION SURGERY

Guideline Number: CDG.004.18 **Effective Date**: November 1, 2019

Instructions for Use

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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

COVERAGE RATIONALE

See Benefit Considerations

Indications for Coverage

Most UnitedHealthcare plans have a specific exclusion for breast reduction surgery except as required by the Women's Health and Cancer Rights Act of 1998. Refer to 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 following 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 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.

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.

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- 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)*; 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.

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CPT Code*	Required Clinical Information
Breast Reduction Surgery	

19318	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
	• 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

**For code description, see the Applicable Codes section.*

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

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

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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 related to a health condition. 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. Covered Health Care Services include dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures.

For the purposes of this section, "cleft palate" means a condition that may include cleft palate, cleft lip, or other craniofacial anomalies associated with cleft palate.

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 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

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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

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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.

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 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.

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GUIDELINE HISTORY/REVISION INFORMATION

Date	Action/Description
11/01/2019	**Coverage Rationale** • Removed language pertaining to "potential required documentation" **Documentation Requirements** • Updated documentation requirements for reduction mammoplasty to include language relocated from *Coverage Rationale* section **Supporting Information** • Archived previous policy version CDG.004.17

INSTRUCTIONS FOR USE

This Coverage Determination 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 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 Coverage Determination Guideline is provided for informational purposes. It does not constitute medical advice.

This Coverage Determination Guideline may also be applied to Medicare Advantage plans in certain instances. In the absence of a Medicare National Coverage Determination (NCD), Local Coverage Determination (LCD), or other Medicare coverage guidance, CMS allows a Medicare Advantage Organization (MAO) to create its own coverage determinations, using objective evidence-based rationale relying on authoritative evidence (Medicare IOM Pub. No. 100-16, Ch. 4, §90.5).

UnitedHealthcare may also use tools developed by third parties, such as the MCG™ Care Guidelines, to assist us in administering health benefits. 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.

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.

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