

# BREAST REDUCTION SURGERY

**Guideline Number:** CDG.004.02

**Effective Date:** July 1, 2014

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## INSTRUCTIONS FOR USE

*This Coverage Determination Guideline provides assistance in interpreting certain standard UnitedHealthcare benefit plans. When deciding coverage, the enrollee specific document must be referenced. The terms of an enrollee's document (e.g., Certificates of Coverage (COCs), Schedules of Benefits (SOBs), or Summary Plan Descriptions (SPDs), and Medicaid State Contracts) may differ greatly from the standard benefit plans upon which this guideline is based. In the event of a conflict, the enrollee's specific benefit document supersedes these guidelines. All reviewers must first identify enrollee eligibility, any federal or state regulatory requirements and the plan benefit coverage prior to use of this guideline. Other coverage determination guidelines and medical policies may apply. UnitedHealthcare reserves the right, in its sole discretion, to modify its coverage determination guidelines and medical policies as necessary. This Coverage Determination Guideline 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.*

## COVERAGE RATIONALE

### Plan Document Language

Before using this guideline, please check enrollee's specific plan document and any federal or state mandates, if applicable.

### **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 (such as maternity benefits), 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 enrollee's specific plan document to determine benefit coverage.

## **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](#) for additional information.

**Criteria for a Coverage Determination as Reconstructive:** Breast reduction surgery is considered reconstructive and medically necessary when the following criteria are met:

- A. 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**

- B. The amount of tissue to be removed plots above the 22nd percentile; or
- C. 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
- D. Diagnostic tests, if done, have ruled out other causes of the functional impairment; and
- E. The proposed procedure is likely to result in significant improvement of the functional impairment

The following documentation may be requested as part of the 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 enrollee'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 enrollee's plan specific documents.

1. 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.

2. 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.
3. Breast reduction surgery is cosmetic when done to improve appearance without improving a functional/physiologic impairment.
4. 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 that will be removed is reasonable for the body habitus, and whether the procedure is cosmetic or reconstructive in nature.

1. If the amount plots above the 22<sup>nd</sup> percentile and the member has a functional impairment, the procedure is reconstructive.
2. If the amount plots below the 5<sup>th</sup> percentile, the procedure is cosmetic.
3. If the amount plots between the 5<sup>th</sup> and 22<sup>nd</sup> percentiles, the procedure may be either reconstructive or cosmetic based on review of information.

To calculate body surface area (BSA) see <http://www-users.med.cornell.edu/~spon/picu/calc/bsacalc.htm>

OR

$$BSA = (W^{0.425} \times H^{0.725}) \times 0.007184$$

(weight is in kilograms and the height is in centimeters.)

### **Modified Schnur Nomogram Chart**

Body Surface (m2)	Lower 5 <sup>th</sup> Percentile	Lower 22 <sup>nd</sup> 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

Body Surface (m2)	Lower 5 <sup>th</sup> Percentile	Lower 22 <sup>nd</sup> Percentile
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

**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 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. (2001 – 2011 UHC Generic COC)

**Cosmetic Procedures (California Only):** Procedures or services 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:** Physical/functional 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 to treat a medical condition or to improve or restore physiologic function. 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.

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. (2007- 2011 UHC Generic COC)

Examples of a reconstructive procedure include, but are not limited to:

- Surgery to correct cleft lip, cleft palate, or combinations of the two.
- Scar revision when the scar has caused a contracture and is limiting motion of a body part.
- Breast reconstruction after mastectomy, including tattooing to create a nipple.
- Blepharoplasty (i.e., upper eyelid surgery) when there is significant visual impairment.

**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. 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 Current Procedural Terminology (CPT<sup>®</sup>) codes and Healthcare Common Procedure Coding System (HCPCS) codes listed in this guideline are for reference purposes only. Listing of a service code in this guideline does not imply that the service described by this code is a covered or non-covered health service. Coverage is determined by the enrollee specific benefit 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 claims payment. Other policies and coverage determination guidelines may apply. This list of codes may not be all inclusive.

CPT<sup>®</sup> is a registered trademark of the American Medical Association.

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

Limited to specific procedure codes?	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
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CPT <sup>®</sup> Procedure Code	Description
19318	Reduction mammoplasty

ICD-9 Procedure Code	Description
85.31	Unilateral reduction mammoplasty
85.32	Bilateral reduction mammoplasty

Limited to specific diagnosis codes?	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
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ICD-9 Diagnosis Code	Description
611.1	Hypertrophy of breast

### ICD-10 Codes

In preparation for the transition from ICD-9 to ICD-10 medical coding on **October 1, 2015\***, a sample listing of the ICD-10 CM and/or ICD-10 PCS codes associated with this policy has been provided below for your reference. This list of codes may not be all inclusive and will be updated to reflect any applicable revisions to the ICD-10 code set and/or clinical guidelines outlined in this policy. \*The effective date for ICD-10 code set implementation is subject to change.

ICD-10 Diagnosis Code (Effective 10/01/15)	Description
N62	Hypertrophy of breast

ICD-10 Procedure Code (Effective 10/01/15)	Description
0HB.T0ZZ	Excision of right breast, open approach
0HB.T3ZZ	Excision of right breast, percutaneous approach
0HB.U0ZZ	Excision of left breast, open approach

ICD-10 Procedure Code (Effective 10/01/15)	Description
0HB.U3ZZ	Excision of left breast, percutaneous approach
0HB.V0ZZ	Excision of bilateral breast, open approach
0HB.V3ZZ	Excision of bilateral breast, percutaneous approach

Limited to place of service (POS)?	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
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Limited to specific provider type?	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
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Limited to specific revenue codes?	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
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## REFERENCES

1. American Society of Plastic Surgeons. Reduction Mammoplasty Recommended Criteria for Third-Party Payer Coverage from the American Society of Plastic Surgeons (ASPS). March 9, 2002a. Available at: <http://www.plasticsurgery.org>. Accessed on April 29, 2014.
2. American Society of Plastic Surgeons. Reduction Mammoplasty. Practice Parameters. March 9, 2002b. Available at: <http://www.plasticsurgery.org>. Accessed on April 29, 2014.
3. MCG™ Care Guidelines. 18th edition, 2014. Reduction Mammoplasty (Mammoplasty). ACG: A-0274 (AC)
4. Wisconsin Physicians Service Insurance Corporation. Cosmetic and Reconstructive Surgery (L30733). 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 29, 2014
5. Schnur PL, Hoehn JG, Ilstrup DM, et al. Reduction mammoplasty: cosmetic or reconstructive procedure? Ann Plast Surg. 1991 Sep;27 (3):232-7.

## GUIDELINE HISTORY/REVISION INFORMATION

Date	Action/Description
7/09/2014	<ul style="list-style-type: none"> <li>• Corrected typographical error in indications for coverage/criteria for a coverage determination as reconstructive: <ul style="list-style-type: none"> <li>○ Updated list of examples of functional impairments that must be attributable to macromastia; replaced “upper back, neck, and shoulder pain” with “upper back, neck, <b>or</b> shoulder pain”</li> </ul> </li> </ul>
07/01/2014	<ul style="list-style-type: none"> <li>• Revised coverage rationale: <ul style="list-style-type: none"> <li>○ Removed documentation requirements</li> <li>○ Revised indications for coverage/criteria for a coverage determination as reconstructive <ul style="list-style-type: none"> <li>▪ Updated list of examples of functional impairments that must be attributable to macromastia: <ul style="list-style-type: none"> <li>• Added: <ul style="list-style-type: none"> <li>- Chronic breast pain due to weight of the breasts</li> <li>- Upper back, neck, <b>and</b> or shoulder pain</li> <li>- Shoulder grooving from bra straps</li> <li>- Headache</li> </ul> </li> <li>• Removed language requiring “<i>objective documentation in office notes</i>” for:</li> </ul> </li> </ul> </li> </ul> </li> </ul>

Date	Action/Description
07/01/2014	<ul style="list-style-type: none"> <li>- Signs and symptoms of nerve compression that are unresponsive to medical management (e.g. ulnar paresthesias)</li> <li>- Acquired kyphosis that is attributed to macromastia</li> <li>• Replaced: <ul style="list-style-type: none"> <li>- “Severe skin excoriation unresponsive to medical management” with “severe skin excoriation/<b>intertrigo</b> unresponsive to medical management”</li> <li>▪ Replaced criteria requiring “the amount of tissue to be removed plots above the 22<sup>nd</sup> percentile <i>and the member has a functional impairment, the procedure is probably reconstructive</i>” with “the amount of tissue to be removed plots above the 22<sup>nd</sup> percentile”</li> </ul> </li> <li>○ Removed definition of reconstructive procedures for California plan members (refer to Definitions section of policy for applicable details)</li> <li>○ Added language to indicate documentation may be requested as part of the review process: <ul style="list-style-type: none"> <li>▪ 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 enrollee’s medical record must contain, and be available for review on request, the following information: <ul style="list-style-type: none"> <li>- Height and weight</li> <li>- Body Surface Area (BSA)</li> <li>- Photographs that document macromastia.</li> </ul> </li> </ul> </li> <li>○ Updated/expanded list of applicable coverage limitations and exclusions to include use of liposuction as the sole procedure for breast reduction surgery is considered cosmetic</li> <li>○ Removed benefit considerations language specific to ASO plans</li> <li>• Updated Appendix/information for using Schnur Nomogram Chart: <ul style="list-style-type: none"> <li>○ Replaced language indicating “if the amount of tissue to be removed plots above the 22<sup>nd</sup> percentile and the member has a functional impairment, the procedure <b>is probably reconstructive</b>” with “if the amount of tissue to be removed plots above the 22<sup>nd</sup> percentile and the member has a functional impairment, the procedure <b>is reconstructive</b>”</li> <li>○ Replaced language indicating “if the amount of tissue to be removed plots between the 5<sup>th</sup> and 22<sup>nd</sup> percentiles, the procedure may be either reconstructive or cosmetic” with “if the amount of tissue to be removed plots between the 5<sup>th</sup> and 22<sup>nd</sup> percentiles, the procedure may be either reconstructive or cosmetic <i>based on review of information</i>”</li> <li>○ Reformatted Schnur Nomogram Chart</li> </ul> </li> <li>• Revised definitions: <ul style="list-style-type: none"> <li>○ Added definition of “macromastia”</li> <li>○ Removed definition of “sickness”</li> </ul> </li> <li>• Archived previous policy version CDG.004.01</li> </ul>