Breast Reduction Surgery

Guideline Number: MMG012.AA
Effective Date: June 1, 2024

➲ Instructions for Use

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- Cosmetic, Reconstructive, or Plastic Surgery
- Gender Dysphoria (Gender Identity Disorder) Treatment

Coverage Rationale

➲ See Benefit Considerations

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. Refer to the member's specific benefit plan document for applicable coverage.

Breast reduction surgery is considered reconstructive and medically necessary in certain circumstances. For medical necessity clinical coverage criteria, refer to the InterQual® CP: Procedures:
- Reduction Mammaplasty, Female
- Reduction Mammaplasty, Female, Adolescent

Click here to view the InterQual® criteria.

Note: For reduction mammaplasty related to gynecomastia, refer to the Medical Management Guideline titled Gynecomastia Surgery.

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 the following:
• Diagnosis
• History of the medical condition(s) requiring treatment or surgical intervention, including:
    ○ History of chief complaint and associated symptoms
    ○ Estimated risk of breast cancer

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Required Clinical Information
Breast Reduction Surgery

• Physical exam including member's height and weight
• Reports of recent imaging studies and applicable diagnostic tests (within 1 year), including to rule out:
  ○ Tumor or malignant changes of the breast
  ○ Orthopedic, neurologic, rheumatologic, endocrine, or metabolic condition
• Description of physiologic functional impairments and etiology (e.g., back pain, grooving from bras straps, skin breakdown, paresthesias, etc.)
• For a diagnosis of macromastia, include high quality color photograph(s):
  ○ All photograph(s) must be labeled with the:
    ▪ Date taken
    ▪ Applicable case number obtained at time of notification or member's name and ID number on the photograph(s)
  ○ **Note**: Submission of color image(s)are required and can be submitted via the external portal at www.uhcprovider.com/paan; faxes will not be accepted
• Physicians plan of care, including estimated volume of breast tissue per breast to be removed

Definitions

Women's Health and Cancer Rights Act of 1998, 29 U.S.C. § 1185b: "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) all stages of 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 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
19316	Mastopexy

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

Benefit Considerations

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 member's specific benefit plan document for applicable 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, 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.

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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.

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)

For breast surgery for treatment of gender dysphoria, refer to the Medical Management Guideline titled Gender Dysphoria Treatment Excluding California and Washington.

References

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 January 17, 2024.

Guideline History/Revision Information

Date	Summary of Changes
06/01/2024	**Coverage Rationale** • Added instruction to refer to the member specific benefit plan document for applicable coverage and exclusions for breast reduction surgery **Documentation Requirements** • Updated list of required clinical information: ○ Added “physician’s plan of care, including estimated volume of breast tissue per breast to be removed” ○ Removed “reduction mammaplasty 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, and the physician’s plan of care, including estimated volume of breast tissue per breast to be removed” **Applicable Codes** • Removed CPT code 19316 **Supporting Information** • Archived previous version policy MMG012.Z

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 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 InterQual® criteria, 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.

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