UHA
HEALTH INSURANCE

Reduction Mammoplasty

I. Policy

University Health Alliance (UHA) will reimburse for reduction mammoplasty services when they are determined to be medically necessary and when they meet the medical criteria guidelines (subject to limitations and exclusions) indicated below.

II. Criteria/Guidelines

A. UHA considers breast reduction surgery cosmetic unless breast hypertrophy is causing significant pain, orthopedic dysfunction, paresthesias, or ulceration (see selection criteria below). Reduction mammoplasty for asymptomatic members is considered cosmetic.

B. Reduction mammoplasty is covered (subject to Limitation/Exclusions and Administrative Guidelines) when one or more of the following well documented clinical indications and/or physical findings are present:

1. Six week or more history of pain in upper back, neck, or shoulders that is due to weight of the breasts and:
    a. Is not primarily attributable to another diagnosis (e.g., arthritis); and
    b. Is not relieved by conservative therapy (e.g., use of a support bra, exercises, heat/cold treatment, nonsteroidal anti-inflammatory agents or muscle relaxants, chiropractic care or osteopathic manipulative treatment, physical therapy, medically supervised weight loss); and
    c. Results in documented work loss and/or interference with activities of daily living.
    d. Reduction mammoplasty is likely to result in improvement of the chronic pain
2. Upper extremity paresthesias with documented macromastia as direct causation
3. Intertrigo between or under the pendulous breast and chest wall is not responding to appropriate conservative treatment;
    a. Chronic intertrigo, eczema, dermatitis, and/or ulceration in the infra-mammary fold in and of themselves are not considered medically necessary indications for reduction mammoplasty. The condition not only must be unresponsive to dermatological treatments (e.g., antibiotics or antifungal therapy) and conservative measures (e.g., good skin hygiene, adequate nutrition) for a period of 6 months or longer, but also must satisfy criteria stated as above.

NOTE:

This UHA payment policy is a guide to coverage, the need for prior authorization and other administrative directives. It is not meant to provide instruction in the practice of medicine, and it should not deter a provider from expressing his/her judgment.

Even though this payment policy may indicate that a particular service or supply is considered covered, specific provider contract terms and/or members' individual benefit plans may apply, and this policy is not a guarantee of payment. UHA reserves the right to apply this payment policy to all UHA companies and subsidiaries.

UHA understands that opinions about and approaches to clinical problems may vary. Questions concerning medical necessity (see Hawaii Revised Statutes §432E-1.4) are welcome. A provider may

request that UHA reconsider the application of the medical necessity criteria in light of any supporting documentation.

III. Limitations/Exclusions

A. Breast reduction surgery does not meet payment determination when the primary purpose for the reduction mammoplasty is to address poor posture, headaches, breast asymmetry, pendulousness, and problems with clothes fitting, nipple-areolar distortion, or psychosocial issues.

B. Reduction mammaplasty is not covered for breasts that are in a state of rapid flux (i.e., adolescence, lactation).

C. Liposuction-only reduction mammoplasty is not covered because of insufficient evidence of its effectiveness.

D. Breast reduction surgery in the context of gender dysphoria is covered in the UHA policy on Gender Identity Services.

E. Women 50 years of age or older are required to have a mammogram that was negative for cancer performed within the two years prior to the date of the planned reduction mammoplasty. Consideration for mammography should be given in all cases in the context of personal and family history.

IV. Administrative Guidelines

A. Prior authorization is required.

B. To request prior authorization, please submit via UHA's online portal. If a login has not been established, you may contact UHA at 808-532-4000 to establish one.

C. The following documentation must be submitted with your prior authorization request:

1. Description of symptoms and specific therapies that have been tried and failed; and
2. The patient's height and weight and the anticipated amount of breast tissue to be removed; and
3. Photographs or digital images if provider feels inclusion supports documentation for necessity.

CPT Code	Description
19318	Reduction mammoplasty

V. Policy History

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