

**Upper Peninsula Health Plan  
Utilization Management Criteria for Medical Necessity  
Cosmetic vs. Reconstructive Surgery:  
Reduction Mammoplasty**

*Applicable to the following product lines: Upper Peninsula Health Plan (UPHP) Medicaid, Healthy Michigan Plan (HMP), Children's Special Health Care Services (CSHCS) and MICHild*

**Cosmetic surgery** is performed to reshape normal structures of the body in order to improve the patient's appearance and self-esteem.<sup>2</sup>

***Cosmetic Surgery is not a UPHP benefit.***

**Reconstructive surgery** is performed on abnormal structures of the body, caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease. It is generally performed to improve function, but may also be done to approximate a normal appearance.<sup>2</sup> **Reconstructive surgery may or may not be a UPHP benefit depending on the medical necessity and requires prior authorization for coverage.**

**Reduction Mammoplasty** is the surgical reshaping of the breast to reduce or lift enlarged or sagging breasts.<sup>3</sup> It may be cosmetic or reconstructive. Cosmetic reduction mammoplasty is not a UPHP benefit.

**Reconstructive Reduction Mammoplasty** is a UPHP benefit when medically necessary to relieve debilitating clinical signs and symptoms of macromastia. It is UPHP's intent that the primary care provider (PCP) will attempt management of the condition with noninvasive measures before considering surgery. The signs and symptoms must be unresponsive to conservative treatment before approval of reduction mammoplasty.

**Authorization Specifics:**

- Prior Authorization requests must include documentation to show the medical necessity criteria are met.
- Documentation must include medical records of prior treatments for the condition(s) identified.
- Preoperative photos, nude, waist to shoulder, frontal and lateral, must accompany a prior authorization request. These may be provided by the member or requesting provider.

**Criteria**

1. The member has debilitating symptoms solely due to macromastia and:
  - Condition interferes with employment, or
  - Causes significant disability or psychological trauma, as documented by psychiatric evaluation, or
  - It is a component of reconstructive surgery for congenital deformity or trauma, or
  - It contributes to a major health problem, including, but not limited to:
    - Chronic intertrigo, dermatitis, or ulceration caused by breast folds
    - Confirmed diagnosis of acquired kyphosis, compensatory lordosis, or scoliosis
    - Shoulder grooving from bra straps
    - Neck, shoulder, back or chest pain
2. The member must be:

- 18 years of age or older, and
- Not pregnant, and
- Not delivered a child within the past year, and
- Tobacco free for 6 weeks before surgery and 4 weeks after surgery

*\*Exception: In cases where juvenile hypertrophy is present, the age requirement may be waived. This will be evaluated on a case by case basis.*

3. Morbid obesity (BMI>35), if present, unresponsive to medically supervised weight loss management.

**Weight Loss Program:**

A minimum of 6 months demonstrated compliance by the member with a physician-supervised weight reduction program. The weight reduction program must include:

- PCP visits dedicated solely to weight loss management at least monthly to include:
  - ◆ Review, discuss and adjust each weight loss strategy
  - ◆ Weigh member and determine BMI
  - ◆ Document progression each strategy (Diet, Activity, Behavior)
- Dietary management (provided through a dietician, nutritionist, health education expert or other appropriate professional):
  - ◆ Individually planned diet to create 500 to 1000 calories/day deficit
  - ◆ Dietary consultation
- Physical activity plan (can be provided through an appropriate professional):
  - ◆ Physical therapy assessment
- Behavioral health interventions as appropriate:
  - ◆ Stress management
  - ◆ Stimulus control

4. The PCP submits request to UPHP Clinical Services for approval of medical necessity for reduction mammoplasty:

\*UPHP Prior Authorization Form

\*Documentation from medical records that member has met above criteria

\*Medical records must document response to previously prescribed interventions, and substantiate the condition being refractory to noninvasive therapies.

***Bibliography***

1. Michigan Department of Health and Human Services – Medicaid Provider Manual – Practitioner Chapter, Section 12,12.3 Cosmetic Surgery, July 1, 2018.
2. American Society of Plastic Surgeons: Reduction Mammoplasty: ASPS Recommended Insurance Coverage Criteria for Third Party Payers. Approved May 2011, reaffirmed October 2017.
3. U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services Local Coverage Determinations (LCD) for Cosmetic and Reconstructive Surgery (L34698, January 1, 2018).

**Criteria approvals by UPHP Clinical Advisory Committee:**

Approved 6-11-2002; revised 9-9-2003; reviewed with no revisions 9-7-2004; revised 9-20-2005; revised 9-12-2006; revised 9-11-2007; reviewed with no revisions 9-9-2008; revised 9-8-2009; revised 9-8-2010; reviewed with no revisions 9-14-2011, 9-12-2012, 9-11-2013, 9-10-2014, 9-9-2015, revised 12-9-2015, 9-14-2016, revised 9-13-2017, 9-12-2018