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Breast

Preauthorization Inconsistencies Prevail in Reduction Mammaplasty

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Background: Despite evidence documenting the physical and psychological benefits of breast reduction, third-party payer approval remains a cumbersome process. The objective of this study was to assess differences in medical necessity criteria for reduction mammaplasty among US insurance carriers while analyzing trends in claim denials and appeals.

Methods: The medical necessity criteria for reduction mammaplasty were retrieved from seven large health insurance carriers. Data were extracted from each policy, including claim requirements for approval. Additionally, prospective data on claims and denials submitted from January through August 2022 were collected from The Auctus Group, a medical consulting firm.

Results: All the policies have been updated since January 2020. Five of the seven policies specifically listed what documentation was required for preauthorization approval, with five third-party payers requiring photograph documentation. Policies required documentation of one to three symptoms lasting from 6 weeks to 1 year. All companies reported a tissue resection estimate threshold, but cutoffs varied. Of 380 reduction mammaplasties performed, 158 (41.6%) received a denial on initial insurance submission. Considering appeals, a total of 216 denials were reviewed with an average of 1.37 denials per patient. Of the 158 initial denials, 104 (65.8%) of these were from claims that received preauthorization. In 12 cases, third-party payers stated that no prior authorization was necessary yet still denied the claim.

Conclusions: Wide variability exists in medical necessity criteria for reduction mammaplasty policies among major insurance carriers. These nuances introduce inefficiencies for practices contributing to high denial and appeal rates while delaying surgical care for patients. *(Plast Reconstr Surg Glob Open 2023; 11:e5361; doi: 10.1097/GOX.0000000000005361; Published online 26 October 2023.)*

INTRODUCTION

Breast reduction is one of the most commonly performed plastic surgery procedures in the United States, with nearly 100,000 cases performed annually.[1] Despite substantial evidence documenting the physical and psychological benefit of reduction mammaplasty in patients with symptomatic breast hypertrophy, many patients are unable to obtain insurance coverage for their procedure. Preauthorization and claim approval remains a cumbersome process as the medical necessity criteria from insurance providers are often misaligned with current evidence-based medicine.[1,2] For example, although the recently updated *American Society of Plastic Surgeons Evidence-Based Clinical Practice Guidelines* state there is strong evidence to offer reduction mammaplasty surgery as the first-line therapy over nonoperative modalities based on the presence of multiple symptoms alone, many patients are required to trial nonoperative therapy before obtaining insurance coverage.[3] In addition to these inconsistencies, there is a variability among the medical necessity criteria across major insurance providers, creating difficulties for patients, surgeons, and administrative staff.[2] In some cases, patients resort to switching insurance providers to obtain insurance approval.

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Medical necessity criteria policies have become increasingly stringent, albeit divergent among insurance companies.[4] Although prior working groups have created summations of useful clinical documentation and ancillary information in an attempt to improve prior authorization and claim approval rates while easing the submission process, these broad recommendations are likely to miss subtleties that could result in denials or significant delays in treatment.[5] The objective of this study was to assess the medical necessity criteria for seven major US insurance carriers and examine primary data from a medical billing consultant group to characterize trends in claims and denials for reduction mammaplasty requests with the secondary aim of better-informing surgeons, clinical staff, and office administrators on the nuanced requisites to obtain approval for surgery and receive reimbursements.

Takeaways

Question: Are medical necessity criteria for reduction mammaplasty clearly delineated among US insurance carriers?

Findings: Medical necessity criteria are often ambiguous and, in many cases, lack specificity. Furthermore, there are differences among the policies of different third-party payers. Primary data demonstrated an initial denial rate of 41.6%.

Meaning: Wide variability exists in medical necessity criteria for reduction mammaplasty policies among major insurance carriers. These nuances introduce inefficiencies for practices contributing to high denial and appeal rates while delaying surgical care for patients.

METHODS

With the assistance of health care consulting agency Karen Zupko & Associates, representative national health insurance companies were selected for detailed review of medical necessity criteria for breast reduction (CPT 19318). The health insurance companies selected were United Health Care, Aetna, Cigna, Blue Cross Blue Shield (BCBS) California, BCBS Florida, BCBS New York, and BCBS Texas. Policies were encountered by conducting a web-based query to obtain the publicly available policy. Various data points were extracted from the policies, including requirements for documentation, billing codes, age cutoffs, symptoms, trial of conservative therapy, photographs, tissue resection weight, and recency of an update. Specific mention of postoperative pathological analysis and handling of liposuction were also assessed. Furthermore, the length of the policies and supporting references were quantified.

To supplement this review, we worked collaboratively with The Auctus Group, a multiservice medical consulting and billing group with a national clientele, who prospectively collected data on all of their clients with breast reduction claims (CPT 19318) from January 2022 through August 2022. These data included whether claims were preauthorized, were for professional services or facility charges, or were made for a surgeon that was either in-network or out-of-network. Average days to payment were included in the study. The number of denials and cited cause for denial were recorded. Microsoft Excel (version 7; Seattle, Wash.) was used for performing descriptive statistics where appropriate.

RESULTS

A total of seven policies discussing medical necessity for breast reduction from major health insurance companies in the United States were reviewed. All policies had been updated at least once since January 2020. Policies ranged from 995 to 5672 words in length (mean 3128.4) and cited anywhere from six to 84 references (mean 32.3) from the primary literature to support their policies. All policies described applicable CPT codes for reduction mammaplasty with variable specificity and detail. Only five of the seven policies specifically listed what documentation was required for preauthorization approval. Three carriers (BCBS California, BCBS Florida, and BCBS Texas) described in extensively more detail what documentation was necessary for preauthorization review by listing explicit requirements and/or checklists (Table 1). Photograph documentation was required for five (71.4%) of the polices; however, one additional company stated it may request photographs in certain cases after a preliminary review of documentation. Only three (42.9%) policies delineated an age cutoff of 18 years or older as being a requirement for approval. Two polices described that completion of breast growth may qualify a patient for coverage. One of these policies defined the completion of breast growth as stability in size for 1 year duration, whereas the other policy provided no definition.

Policies required a range of symptoms to be present to obtain approval for reduction mammaplasty. Three policies required just one symptom, two symptoms were necessary for an additional two carriers, and three or more symptoms must be present in an additional policy.

Table 1. Structural Characteristics of Major Third-party Payer Medical Necessity Criteria for Breast Reductions

Insurance Provider	Name of Policy	Applicable CPT Codes Listed	Specific Documentation Requirements Listed	Length of Policy (Words)	No. References to Literature
United Health Care	Breast Reduction Surgery	Yes	Yes	1654	6
Aetna	Reduction Mammoplasty	Yes	No	5672	84
Cigna	Breast Reduction	Yes	No	2572	42
BCBS of Florida	Reduction Mammoplasty	Yes	Yes	995	15
BCBS of New York	Reduction Mammoplasty	Yes	Partial	4021	37
BCBS of Texas	Reduction Mammoplasty	Yes	Yes	3716	21
BCBS of California	Reduction Mammoplasty	Yes	Yes	3269	21

One company did not explicitly mention a numerical requirement for symptoms needed for preauthorization approval for surgery. Furthermore, the timing of required symptoms varied widely (6 weeks to 1 year). Furthermore, five insurance providers required a trial of conservative therapy. Three deemed a 6-week trial necessary, whereas the other two insurance companies requested at least 3 months of conservative measures before approving a claim.

All companies reported a tissue resection to estimate threshold for approval, which varied in its cutoff based on the patient body surface area. The majority (85.7%) used the Schnur Sliding Scale and have incorporated it into the policy. One insurance company (BCBS California) indicated that although most resections should be at least 500–600 g, cases below this threshold could be approved based on the Schnur Sliding Scale. Generally, all policies used the 22nd percentile as the threshold for approval, but there is some variability to how patients in the fifth to 22nd percentile are treated among the policies. There were slight variations in the Schnur Sliding Scale tables listed in the policies including variations in weight requirements for tissue resection for a given body surface area amongst the different third-party payers. Only one company delineated in the guidelines that ultimate insurance coverage of the procedure may be based on the postoperative pathology report quantifying the realized tissue resection weight.

Preoperative mammography was only mentioned in one policy. Most medical necessity criteria policies stated that reduction mammaplasty by liposuction alone did not meet approval criteria for coverage. One provider did not make explicit commentary on liposuction for breast reduction, but indicated that techniques not explicitly mentioned in the policy were considered investigational and implied they would not be covered (Table 2).

Data on a total of 380 reduction mammaplasty cases were collected during the study timeframe. Of these, 158 cases had a denial after initial submission to the insurance company (41.6%) (Fig. 1). Of the 158 initial denials, 104 (65.8%) of these cases were from claims that had already received prior authorization from the third-party payer. An additional 12 (7.6%) denials occurred from third-party payers that had explicitly stated that no prior authorization was required. Accounting for the subsequent appeals, a total of 216 denials were issued by insurance companies for these cases with an average of 1.37 denials per patient. The most frequently cited reasons for claim denial were for additional medical records (n = 80, 37%), noncovered charges (n = 61, 28.2%), and lack of medical necessity (n = 26, 12%). Over 25% of claims were denied twice by insurance providers and required secondary appeals. Nearly 10% of claims were denied three times and required tertiary appeals. One case (0.63%) was denied four times and was approved on the quaternary appeal (Fig. 2). Eventually, all claims received approval, though some cases required multiple appeals.

Distribution of denials was equally dispersed amongst claims that were in-network versus out-of-network and claims for facility charges versus professional charges. The average claim-to-payment period for claims where these data were available was 45.3 days (n = 36).

DISCUSSION

Our study evaluates the most updated medical necessity criteria for reduction mammoplasty among seven major insurance carriers. This review highlighted high levels of variation and ambiguity in medical necessity policies amongst these third-party payers. Ambiguous or unclear policies lead to high rates of claim denials and create increased administrative burden with subsequent appeals to obtain payment. As our findings suggest, many claims are denied not just once, but multiple times, with most reasons for denial being inadequate information supplied to the insurance company. Although practices might not be supplying the appropriate details to third-party payers, all the practices included in this analysis were working with a practice management group ensuring the integrity of their claim submissions. Thus, denials from this analysis were attributed to insufficiently detailed medical necessity policies or third-party payer-related inefficiencies (or intentional delays) in claim approval. Although the denial rate of over 40% is concerning, it is well within the range of what has previously been described in the literature. Boukovalas et al report high denial rates for preauthorization claims in reduction mammaplasty with denial rates in some instances above 60%.[2]

Variability between different insurance providers represents a considerable obstacle to surgeons and practices that have a diverse payer mix.[1,6,7] These subtle nuances can be the difference between a claim being approved or denied and a patient's inability to have surgery. Despite high levels of administrative work to obtain preauthorization for a reduction mammaplasty claim, receiving preauthorization does not necessarily mean that a claim will be paid. In fact, our data suggest that in reduction mammaplasty claims that received preauthorization preoperatively, over 65% of these claims were subsequently denied payment and required appeal. In these instances, practices had explicit documentation of preauthorization approval from the insurance providers. In these scenarios, no further documentation or effort should be required, given the procedure is done in accordance with the agreed upon circumstances. Instances of subsequent appeal demonstrate that although there are rules in place, third-party payers are not following the guidelines. These findings represent significant and unnecessary administrative, financial, and temporal burden for practices and practice managers.

Although each of the insurance policies reviewed in this study are publicly available, over 25% of the policies did not explicitly list the documentation required for claim approval. In a review of 63 insurance providers, Rawes et al found that 10% of providers had no published policy of medical necessity for breast reductions.[5] These data further affirm our belief that standardized preauthorization criteria among insurance carriers is needed to enable efficient delivery of needed surgical care without unnecessary delays. If medical necessity criteria and policies are

Table 2. Medical Necessity Criteria as Described by Policies of Included Third-party Payers

Insurance Provider	Age of Patient or Timing	No. Symptoms Required for Coverage	Timing of Symptoms	Conservative Therapy Required	Photographs Required	Tissue Resection Weight Requirement	Postoperative Pathology	Liposuction Only	Cosmetic Designation when:
United Health Care	Not mentioned	Not clearly delineated	Not mentioned	Not mentioned	No	Yes	Not mentioned	Not covered	Surgery affects appearance but fails to improve function
Aetna	Must be 18 y or have completed breast growth (defined)	2	1 y	Yes	Yes	Yes	Not mentioned	Not covered as experimental	Asymptomatic patients
Cigna	Must be 18 y or have completed breast growth (not defined)	1	Not mentioned	Not mentioned	Yes	Yes	Not mentioned	Not covered as unproven	For appearance or psychosocial benefits
BCBS of Florida	Not mentioned	2	6 wk	Yes	Yes	Yes	Not mentioned	Not covered as experimental	Medical necessity criteria not met or correction of previous cosmetic surgery
BCBS of New York	Not mentioned	1	3 mo	Yes	May be requested	Yes	Not mentioned	Not covered as not medically necessary	Poor posture, breast asymmetry, pendulousness, clothes fitting improperly, nipple-areola distortion
BCBS of Texas	Must be 18 y or older	3	6 wk	Yes	Yes	Yes	May be requested	Not covered as experimental/unproven	For appearance or psychosocial benefits
BCBS of California	Not mentioned	1	6 wk	Yes	Yes	Yes	Not mentioned	Not explicitly stated but treatments not discussed are considered investigational	Medical necessity criteria not met

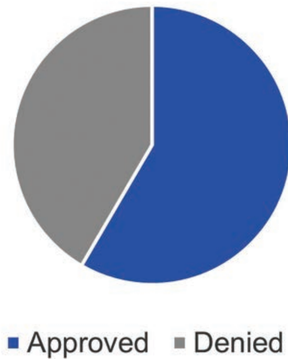

Fig. 1. Approval rates for initial claim submissions for CPT 19318. From a total of 380 initial claim submissions, 158 (41.6%) were denied.

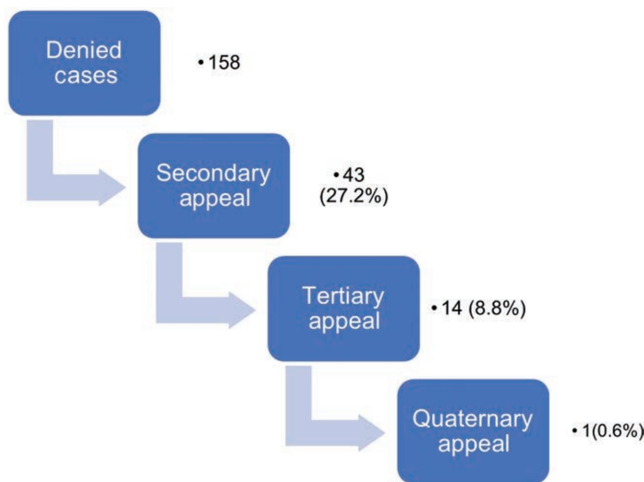

Fig. 2. Claim denials and subsequent appeals. Eventually, all claims received approval, though some cases required multiple appeals.

not explicitly documented, inefficiencies plagued by claim denials and subsequent appeals are inevitable. Third-party insurance providers should explicitly outline their coverage requirements for unique groups such as the pediatric population, who are not often mentioned in current policies, though data document substantial benefit for patients receiving these operations.[8] All third-party payers should make medical necessity policies available to patients and surgeons. The more detailed and unambiguous these policies can be, the more efficient the entire insurance submission and approval process will become. In their report, Rawes et al compile a comprehensive list of items to be included in documentation provided to insurance providers.[5] Although such an approach may be a useful initial framework, variations among providers may lead to delays for patients that otherwise would qualify for surgery. Thus, we advocate understanding the patient's insurance company's policy and tailoring the documentation based on what is standard for that specific third-party payer.

It is well known that preoperative postmenarche symptoms are the biggest predictor of candidacy for reduction mammoplasty.[9] However, there was a wide discrepancy among insurance providers on the number of symptoms required for preauthorization. This ranged from ambiguous descriptions to three or more symptoms being required with a stronger preference for resection weight volume measurements. Multiple other studies have described denials typically linked to an insufficient tissue resection weight rather than a lack of symptoms.[7,10,11] This is particularly alarming as the criteria of medical necessity established by insurance providers do not align with the data in the literature or with national plastic surgery guideline statements.[5] Because of this, denial rates range from 21% to 62% for private insurers.[2] Although the current American Society of Plastic Surgeons Evidence-based Clinical Practice Guidelines discusses postmenarche as one threshold for generalizability of many of the recommendations, insurance carriers do not commonly utilize this terminology, but instead either give an age cutoff or an ambiguous "completion of breast growth" statement that is not well defined by the policy. If uniformity of preauthorization policies is not an achievable goal, third-party payers should at least adopt common, standardized terminology and definitions to demystify inconsistencies and ambiguity.

Practices must also take responsibility for high denial rates and be thoughtful in analyzing their own trends and data regarding denials related to not meeting medical necessity criteria. In instances where the policies are available, surgeons should ensure to understand the policies and can reduce administrative burden by not submitting preauthorization requests until appropriate clinical benchmarks are met and required documentation collected (Fig. 3).[12] With the introduction of advanced electronic health record shortcuts and tools, more resources are available to surgeons and practices today. Leveraging technology may serve practices and institutions well in maintaining compliance with documentation standards for different insurance companies. Checklists integrated into the electronic health record that are specific to the patient's insurance carrier can help providers and office staff ensure all documentation and criteria are met before submission of the preauthorization claim.[13] Groups outside of plastic surgery are trialing artificial intelligence tools to help construct appeal letters and reduce human-hours related to handling and processing denials and appeals which may help reduce administrative burden for practices.[14] Although these interventions may provide assistance, they may not ultimately resolve the underlying issue, as the findings from this study suggest that providing insurance companies with the appropriate required documentation may be insufficient for obtaining initial claim approval and payment.

Even for practices following third-party payer-established preauthorization guidelines, denials for breast reduction claims are occurring at high rates, creating unnecessary administrative burdens. Such findings make

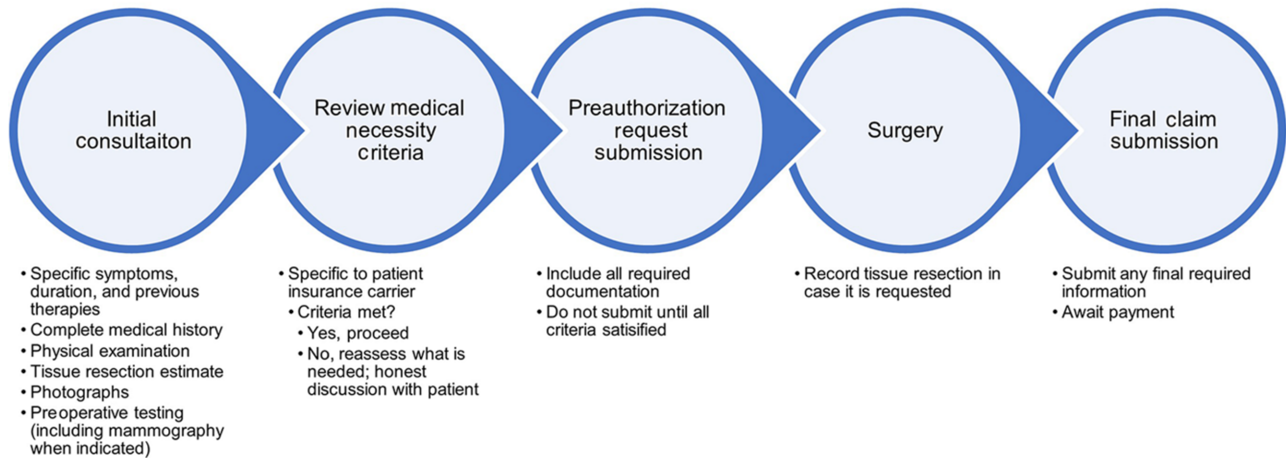

Fig. 3. Clinical pathway for patients presenting with the chief complaint of symptomatic macromastia when seeking a preauthorization. Surgeons should complete a thorough history and physical exam providing explicit documentation of symptoms in addition to taking photographs. The surgeon should subsequently review the medical necessity criteria for that patient based on their insurance provider. Only once all criteria are met, should a preauthorization claim be submitted.

it difficult to predict which insurance providers will approve a reduction mammaplasty for patients who might consider changing carriers during open enrollment periods. Strong advocacy is needed to reduce these inefficiencies for plastic surgery practices, as this problem has been documented longitudinally across time.[1,2,5,7,15] Consensus forums should investigate whether current metrics for tissue resection weight such as the Schnur scale require modification or if new metrics are needed that more accurately describe potential symptomatic relief following reduction mammoplasty. Ultimately, representative plastic surgeons from the national governing bodies and societies should be involved in an update of the third-party payer criteria, and a reform is needed to standardize criteria among insurance carriers.

This study is not without its limitations. Only seven major insurance companies were reviewed; however, they were each specifically chosen to provide geographical variance and capture large segments of the third-party payer market. Data on denial rates may be biased, as these practices are already working with a medical consulting group to improve their practice management. Thus, the reported appeals and denials may represent an underestimate of denial and appeal trends nationally. This only further proves the need for criteria reform. Large, national, multipractice studies are needed to completely classify these trends so that advocacy efforts can be more appropriately targeted. Ultimately, the goal should be to efficiently and safely provide needed surgical care for patients experiencing debilitating symptoms of macromastia while minimizing undue delay and administrative burden.[16]

CONCLUSIONS

Wide variability exists in medical necessity criteria for reduction mammaplasty policies among major US insurance carriers, and high rates of denials exist for initial claims, even in cases of preauthorization. Attention is warranted to improve these inefficiencies as it ultimately leads to delays for patients receiving medically beneficial surgical treatment for symptomatic macromastia.

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DISCLOSURES

John Gwin is the CEO of The Auctus Group, a medical consulting group. Karen Zupko is the CEO of KarenZupko and Associates, Inc., a medical consulting group. The other authors have no financial interest to declare.

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