INSURANCE COVERAGE FOR BREAST REDUCTION

Breast Reduction is a surgical procedure that lifts and reduces the size of very large breasts. The goal of the operation is to relieve the symptoms of neck, back, and shoulder pain that are caused by abnormally large breasts. Breast Reduction has a very high success rate and satisfaction rate among patients.

Since Breast Reduction is considered reconstructive surgery to correct a developmental abnormality, it is by definition a medically necessary procedure. A true Breast Reduction is not a cosmetic procedure. Whether or not your insurance company will allow all or part of the fees for Breast Reduction depends on their particular policies. Medical billing and insurance is very complicated. This document will provide some advice on how to streamline this process.

Dr. Sloan is not a provider for any insurance company (out of network), and therefore we do not file your claim for you. One thing that this means is that the insurance company will send the check to you, not the doctor. We will provide all the necessary information you need to file your own claim with your insurance company. If you have any questions, you can contact us for assistance by calling 501-224-1300.

Steps to take prior to appointment:

1) Review your insurance policy. It is the manual that was provided to you when you received your insurance card. Look under the paragraph titled **"Exclusions"** and see if Breast Reduction is listed as an "Exclusion". If your insurance company lists Breast Reduction as an "Exclusion" they **will not cover** the procedure under any circumstances, even if it is medically necessary.

2) If Breast Reduction is not listed as an "Exclusion" in your policy, then it is considered a covered benefit if certain criteria are met. It is not only the size of the breast that is important, but certain physical complaints must be present to qualify. Also some insurance companies will need documentation from your primary care physician or another specialist. They may also have you undergo physical therapy or provide other documentation before they will pay for the procedure. Often your insurance company's web site will provide all this information. If not, call them.

3) Call your insurance company. Keep a record of every conversation you have with them. Obtain the name of the person with whom you spoke, the time, date, and a detailed account of what the Representative said to you. Ask the following questions:

- Do you pay for Breast Reduction?
- Do you require pre-authorization?
- Do you require pre-certification?
- Do you pay for out of network providers?
- What percentage do you pay for an out of network provider?

4) Decide whether you need a mammogram according to the following criteria:

- Women between 35 and 39 years of age need a mammogram prior to surgery.
- Women between 40 and 49 years of age need a mammogram every two years.
- Women 50 years of age and older should have a mammogram every year.
- If there is a family history of breast cancer in your sister or mother, then you should have a mammogram every year after age 35.

5) Call our office to make an appointment for your initial consultation. Please bring necessary medical records and all the information that you have collected from your insurance company to your appointment. With this information we will be able to determine whether Breast Reduction is a medically indicated procedure and the likelihood that your insurance company will pay benefits to you. There are never any guarantees that they will actually pay for it, therefore, we will have you sign a waiver of benefits in the office at your consultation appointment.

6) After surgery, we will give you two sets of the following documents:

- The HCFA 1500 claim form (red original and a copy).
- Operative note
- Pathology report
- Photo Documentation
- Out of Network Waiver of Benefits

All of the above forms need to be mailed to your insurance company. The address can be found in the upper right hand corner of the HCFA1500 form or on the back of your insurance card. Keep copies for your own records, but be careful and make sure you send the **original red HCFA1500 claim form**. The insurance company will not accept a photocopy of this form. Copies of all the other documents are acceptable. We highly recommend that you send these documents to your insurance company by certified mail. This requires the signature of the person receiving your information. Insurance companies have an uncanny knack for "never receiving" your correspondence.

7) Once mailed, allow 10 to 14 business days for processing the claim. Then start calling the insurance company. The number can be found on your insurance card. Be sure to document who you spoke with and when. You may call them as often as you feel necessary until you have received your reimbursement. Arkansas law requires that clean medical insurance claims be paid within ***30 days*** of the filing date.

If you do not feel that you are getting the response you deserve, then write a letter of complaint to the insurance company and send by certified mail. Also send a copy of the letter to the Arkansas Insurance Commissioner at:

Arkansas Insurance Department
Consumer Services Division
1200 West Third Street
Little Rock, AR 72201-1904

Thank you,
Aesthetic Plastic Surgery, LLC
Gene Sloan, MD, FACS