Clinical Policy: Reduction Mammoplasty and Gynecomastia Surgery

Reference Number: CP.MP.51 [Coding Implications](#Coding_Implications)

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[Revision Log](#Revision_Log)

**See** [Important Reminder](#Important_Reminder) **at the end of this policy for important regulatory and legal information.**

# Description

Reduction mammoplasty, also known as breast reduction surgery, is a surgical procedure in women to reduce the weight, mass, and size of the breast. Gynecomastia surgery is the surgical correction of over-developed or enlarged breasts in men.

## Policy/Criteria

1. It is the policy of health plans affiliated with Centene Corporation that reduction mammoplasty in females for non-cosmetic indications is **medically necessary** when the criteria in A or B below are met:
2. *Macromastia:*
   1. Member is ≥ 16 years of age and/or Tanner stage V of Tanner staging of sexual maturity (See Appendix A for Tanner Staging);
   2. The estimated amount of breast tissue to be removed meets the minimum weight requirement based on the member’s body surface area (BSA) per Appendix B, adapted from the Schnur Sliding Scale. The DuBois and DuBois body surface calculator (found here: <http://www-users.med.cornell.edu/~spon/picu/calc/bsacalc.htm>) may be used to calculate BSA if only height and weight are given;
   3. Member has at least two (2) of the following persistent symptoms, affecting activities of daily living for at least one year:
      1. Headaches associated with neck and upper back pain;
      2. Pain in neck, shoulders, or upper back not related to other causes (e.g., poor posture, acute strains, poor lifting techniques);
      3. Breast pain;
      4. Painful kyphosis documented by X-rays;
      5. Pain/discomfort/ulceration/grooving from bra straps cutting into shoulders;
      6. Paresthesia of upper extremities due to brachial plexus compression syndrome
      7. Intertrigo;
      8. Significant discomfort resulting in severe restriction of physical activities; *and*
   4. Member has undergone an evaluation by a physician who has determined that all of the following criteria are met:
      1. Pain is unresponsive to conservative treatment as evidenced by physician documentation of therapeutic measures including at least two of the following:
         1. Analgesic/non-steroidal anti-inflammatory drugs (NSAIDs);
         2. Physical therapy/exercise when skeletal pathology is present;
         3. Supportive devices (e.g., proper bra support, wide bra straps);
         4. Medically supervised weight loss program;
         5. Chiropractic care or osteopathic manipulative treatment;
         6. Orthopedic or spine surgeon evaluation of spinal pain;
      2. The pain is not associated with another diagnosis, e.g. arthritis;
      3. There is a reasonable likelihood that the member’s symptoms are primarily due to macromastia;
      4. Reduction mammoplasty is likely to result in improvement of the chronic pain;
      5. Women ≥ 40 years of age are required to have a mammogram that was negative for cancer performed within the year prior to the date of the planned reduction mammoplasty procedure.
3. *Gigantomastia of Pregnancy*

The member has gigantomastia of pregnancy, accompanied by *any* of the following complications, and delivery is not imminent:

* 1. Massive infection;
  2. Significant hemorrhage;
  3. Tissue necrosis with slough;
  4. Ulceration of breast tissue.

1. It is the policy of health plans affiliated with Centene Corporation that male gynecomastia surgery is considered **medically necessary** when the criteria in A or B are met:
2. *Adolescents < 18 years*

Adolescent members with unilateral or bilateral grade II, III, or IV gynecomastia (per Appendix C), and meets all of the following:

* 1. Persists for at least two years after pathological causes are ruled out;
  2. Persists without improvement after appropriate treatment for at least six months for any underlying cause, including discontinuation of gynecomastia-inducing drugs and/or substances;
  3. Experiences pain and discomfort due to the distention and tightness from the hypertrophied breast(s) that has not responded to medical management.

1. *Adults ≥ 18 years,* meets all of the following:
   1. Unilateral or bilateral grade III or IV gynecomastia (per Appendix C);
   2. Glandular breast tissue is the primary cause of the gynecomastia;
   3. Persists for at least one year after pathological causes are ruled out;
   4. Persists without improvement after appropriate treatment for at least six months for any underlying cause, including appropriate discontinuation of gynecomastia-inducing drugs and/or substances;
   5. Experiences pain and discomfort due to the distention and tightness from the hypertrophied breast(s) that has not responded to medical management;
   6. Malignancy has been ruled out.

**Medical Record Documentation Requirements**

Medical records must accompany all requests for reduction mammoplasty procedures. Photographic documentation must be provided, along with detailed documentation supporting the medical necessity of breast reduction, which will include height and weight information. When applicable, there must be documented evidence of conservative therapies attempted in order to substantiate the condition being refractory to treatment.

## Background

## Reduction mammoplasty is the surgical reduction of breast size. It was originally adopted in medical practice in the 1920s. The surgery was proposed as a means of alleviating physical problems associated with excessive breast size and breast ptosis. Among these problems are pain in the neck, upper and lower back, shoulder, arm, and breast; headaches; paresthesia of the upper extremities; intertrigo (inflammation of skin folds); itching; striae; difficulty exercising; postural changes; inability to find appropriate clothing; bra strap grooving; difficulty sleeping; and psychological illnesses including anxiety and depression. Radiographic evidence of chronic postural changes has also been demonstrated. Reduction mammoplasty is also performed for many patients who request surgery to address breast deformities or asymmetry.

Several procedures are available to accomplish breast reduction. Each procedure has its own unique approach to breast reshaping through various methods of skin incisions and resection patterns. Currently, the two surgical approaches to reduction mammoplasty that are most widely used are the Wise pattern reduction mammoplasty and vertical pattern breast reduction. The Wise pattern reduction mammoplasty is most commonly used in the United States, and the vertical pattern breast reduction is more popular in Europe. Both are pedicle-based procedures, with the Wise pattern scars entirely below the nipple and the vertical pedicle scars above the nipple. A crescent-shaped mass of tissue is removed from the inferior portion of each breast, and the skin is resected and sutured. Both grafting and pedicle- based techniques are used in cases where it is necessary to reposition the nipple-areola complex. These procedures seek to preserve the blood and nerve supply to the nipple- areola complex and create a symmetrical and natural appearance, while reducing breast volume and weight. Care is also taken to avoid scars that may be visible when the patient is clothed.

Gynecomastia is the benign proliferation of glandular breast tissue in men. Physiologic gynecomastia is common in newborns, adolescents, and men older than 50 years of age. In newborns and adolescents, it generally resolves spontaneously without intervention. In older men, decreasing free-testosterone levels can contribute to physiologic gynecomastia. However, they are less likely to present for evaluation and treatment than adolescents.

Non-physiologic gynecomastia can occur at any age and can be a result of a medical condition, medication use, or substance abuse. Persistent pubertal gynecomastia is the most common cause of non-physiologic gynecomastia. It generally resolves six months to two years after onset. However, if symptoms persist after two years, or after 17 years of age, further evaluation is needed to determine cause and appropriate treatment. Medications such as antipsychotics, antiretrovirals, and prostate cancer therapies are common triggers, as well as non-prescription drugs such as performance-enhancing supplements and anabolic steroids. Common medical conditions that can cause gynecomastia include Klinefelter’s syndrome, adrenal tumors, brain tumors, chronic liver disease, androgen deficiency, endocrine disorders, and testicular tumors.

**Appendices**

**Appendix A**

Criteria for distinguishing Tanner stages 1 to 5 in females

| **Tanner Stage** | **Breast** | **Pubic Hair** |
| --- | --- | --- |
| 1  (Prepubertal) | No palpable glandular tissue or pigmentation of areola; elevation of areola only | No pubic hair; short,  fine vellous hair only |
| 2 | Glandular tissue palpable with elevation of breast and areola together as a small mound; areola diameter increased | Sparse, long pigmented  terminal hair chiefly along the labia majora |
| 3 | Further enlargement without separation of  breast and areola; although more darkly pigmented, areola still pale and immature; nipple generally at or above mid-plane of breast tissue when individual is seated upright | Dark, coarse, curly hair,  extending sparsely over mons |
| 4 | Secondary mound of areola and papilla above breast | Adult-type hair, abundant but limited to mons and labia |
| 5  (Adult) | Recession of areola to contour of breast;  development of Montgomery’s glands and ducts on the areola; further pigmentation of areola; nipple generally below mid-plane of breast tissue when individual is seated upright; maturation independent of breast size | Adult-type hair in quantity and distribution; spread to inner aspects of the thighs in most racial groups |

**Appendix B**

Adapted from Schnur Sliding Scale – body surface area and estimated minimum cutoff weight for breast tissue per breast to be removed.

| **Body Surface Area (m2)** | **Weight of tissue to be removed per breast (grams)** |
| --- | --- |
| 1.35 | 199 |
| 1.40 | 218 |
| 1.45 | 238 |
| 1.50 | 260 |
| 1.55 | 284 |
| 1.60 | 310 |
| 1.65 | 338 |
| 1.70 | 370 |
| 1.75 | 404 |
| 1.80 | 441 |
| 1.85 | 482 |
| 1.90 | 527 |
| 1.95 | 575 |
| 2.00 | 628 |
| 2.05 | 687 |
| 2.15 | 819 |
| 2.20 | 895 |
| 2.25 | 978 |
| ≥ 2.30 | 1000 |

Appendix C

Gynecomastia Scale adapted from the McKinney and Simon, Hoffman and Kohn scales:

1. Grade I: Small breast enlargement with localized button of tissue that is concentrated around the areola
2. Grade II: Moderate breast enlargement exceeding areola boundaries with edges that are indistinct from the chest
3. Grade III: Moderate breast enlargement exceeding areola boundaries with edges that are distinct from the chest with skin redundancy present
4. Grade IV: Marked breast enlargement with skin redundancy and feminization of the breast

**Coding Implications**

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| **CPT®\* Codes** | **Description** |
| --- | --- |
| 19300 | Mastectomy for gynecomastia |
| 19318 | Reduction mammoplasty |

**ICD-10-CM Diagnosis Codes that Support Coverage Criteria**

| **ICD-10-CM Code** | **Description** |
| --- | --- |
| G44.89 | Other headache syndrome |
| G54.0 | Brachial plexus disorders |
| L30.4 | Erythema intertrigo |
| M25.511 - M25.519 | Pain in shoulder |
| M40.00 - M40.05 | Postural kyphosis |
| M40.10 - M40.15 | Other secondary kyphosis |
| M40.202 - M40.205 | Unspecified kyphosis |
| M40.292 - M24.295 | Other kyphosis |
| M54.2 | Cervicalgia |
| M54.9 | Dorsalgia, unspecified |
| N62 | Hypertrophy of breast |
| N64.4 | Mastodynia |
| Q98.4 | Klinefelter’s syndrome, unspecified |

| **Reviews, Revisions, and Approvals** | **Date** | **Approval Date** |
| --- | --- | --- |
| Policy developed. Specialist reviewed | 06/12 | 08/12 |
| Restructured order of criteria | 07/13 | 08/13 |
| Combined pain in neck, shoulders or upper back into one bullet point and added breast pain, paresthesia, and intertrigo to criteria point A.2. Changed A.3.a to two of the following. Changed gynecomastia surgery from not medically necessary to medically necessary when meeting criteria.  Specialist reviewed | 08/14 | 09/14 |
| Changed “Authorization Protocols” to “Medical Record Documentation Requirements”. Converted to new template | 09/15 | 09/15 |
| Table formatting updated  I.A.3.a added that headaches are associated with neck and upper back pain; I.A.3.b added that pain is not related to other causes; I.A.4.a added medically supervised weight loss and orthopedic evaluation as options. Added ICD-10 codes. | 08/16 | 09/16 |
| Reworded I.A.2. for clarity. Added “Significant discomfort resulting in severe restriction of physical activities” to I.A.3 based on UpToDate patient selection criteria. | 09/17 | 09/17 |
| Added “chiropractic care or osteopathic manipulative treatment” under I.A.4. | 07/18 | 07/18 |
| References reviewed and updated. Specialist reviewed. | 06/19 | 07/19 |

### References

1. American Society of Plastic Surgeons. Evidence-based Clinical Practice Guideline: Reduction Mammoplasty. 2011. Accessed at: <http://www.plasticsurgery.org/Documents/medical-professionals/health-policy/evidence-practice/Reduction%20Mammaplasty_%20Evidence%20Based%20Guidelines_v5.pdf>
2. American Society of Plastic Surgeons. Plastic surgery procedures. Accessed at: <http://www.plasticsurgery.org/Patients_and_Consumers/Procedures.html>

## American Society of Plastic Surgeons. Practice Parameters – Gynecomastia. Feb 2004. Accessed at: <http://www.plasticsurgery.org/Documents/medical-professionals/health-policy/evidence-practice/Gynecomastia-PP.pdf>

1. American Society of Plastic Surgeons. Reduction mammoplasty: ASPS recommended insurance coverage criteria for third-party payers. May 2011. Accessed at: <http://www.plasticsurgery.org/Documents/medical-professionals/health-policy/insurance/Reduction_Mammaplasty_Coverage_Criteria.pdf>
2. American Society of Plastic Surgeons. ASPS recommended insurance coverage criteria for third-party payers. Gynecomastia. March 2002. Reaffirmed June 2015. <https://www.plasticsurgery.org/Documents/Health-Policy/Positions/Gynecomastia_ICC.pdf>
3. Braunstein GD, Anawalt BD. Management of gynecomastia. In: UpToDate, Matsumoto AM (Ed), UpToDate, Waltham, MA. Accessed 06/05/19.
4. Chadbourne EB, Zhang S, et al. Clinical outcomes in reduction Mammoplasty: a systematic review and meta-analysis of published studies. Mayo Clin Proc. 2001 May;76(5):503-10. Accessed at:
5. Cornell University, Critical Care Pediatrics. Body surface area. <http://www-users.med.cornell.edu/~spon/picu/calc/bsacalc.htm>
6. Dickson G. Gynecomastia. Am Fam Physician. 2012 Apr 1;85(7):716-722.
7. Hansen J., Chang S. Overview of breast reduction. In: UpToDate. Chagpar AB, Butler CE (Eds), UpToDate, Waltham, MA. Accessed 06/06/19.
8. Kustin J, Rebar RW: Menstrual disorders in the adolescent age group, Primary Care 14:139, 1987.
9. Li RZ, Xia Z, Lin HH, Wen Y, Wu J, Wang HW. Childhood gynecomastia: a clinical analysis of 240 cases. Zhongguo Dang Dai er Ke Za Zhi 2007;9(5):404-6.
10. Ross GT: Disorders of the ovary and female reproductive tract. In Wilson JD, Foster DS (Eds): Textbook of Endocrinology, 7th ed. Philadelphia, WB Saunders, 1985, p206.
11. Schnur, PL, et al., Reduction Mammaplasty: Cosmetic or Reconstructive Procedure? Annals of Plastic Surgery. Sept 1991; 27 (3): 232-7.
12. Schnur, PL. Reduction mammoplasty – The Schnur sliding scale revisited. Annals of Plastic Surgery*.* Jan 99; 42(1):107-108.
13. Speroff L, Glass RH, Kase N; Clinical Gynecologic Endocrinology and Infertility, 3rd ed, Baltimore, Williams & Wilkins, 1983, p 377.
14. American College of Obstetrician and Gynecologists. (ACOG) Committee Opinion Number 686. Breast and Labial Surgery in Adolescents. Jan.2017
15. Taylor SA. Gynecomastia in children and adolescents. In: UpToDate. Blake D, Geffner ME (Eds), UpToDate, Waltham, MA. Accessed June 7, 2019

**Important Reminder**

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

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**Note: For Medicaid members**, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

**Note: For Medicare members,** to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at <http://www.cms.gov> for additional information.

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