Clinical Policy: Reduction Mammoplasty and Gynecomastia Surgery

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Date of Last Revision: 07/23
Effective Date: 10/01/23

Coding Implications
Revision Log

See 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 to reduce the weight, mass, and size of the breast in those with a female reproductive system.[1-2] Gynecomastia surgery is the surgical correction of over-developed or enlarged breasts in those with a male reproductive system.[3]

Note: *For breast surgeries pertaining to gender affirmation, refer to CP.MP.95 Gender Affirming Procedures.*

Policy/Criteria

I. It is the policy of health plans affiliated with Centene Corporation® that reduction mammoplasty is **medically necessary** when the criteria in A or B below are met:

A. *Macromastia,* all of the following*:*

1. One of the following:
   a. Member/enrollee is ≥ 18 years of age;
   b. Member/enrollee is < 18 years of age and both of the following:
      i. Tanner stage V of Tanner staging of sexual maturity (See Appendix A for Tanner Staging);
      ii. No breast growth equivalent to a change in cup size for at least six months;
2. The estimated amount of breast tissue to be removed meets the minimum weight requirement based on the member/enrollee's body surface area (BSA) per Appendix B, adapted from the Schnur Sliding Scale.
   Note: 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. If the weight of resected tissue falls below the 22nd percentile of weight to be removed per BSA (the minimum cutoff in the Schnur Sliding Scale in Appendix B), a medical director will review the request on a case-by-case basis;
3. Member/enrollee has at least two of the following persistent symptoms, affecting activities of daily living for at least one year:
   a. Headaches associated with neck and upper back pain;
   b. Pain in neck, shoulders, arm, or upper back not related to other causes (e.g., poor posture, acute strains, poor lifting technique);
   c. Breast pain;
   d. Painful kyphosis documented by X-rays;
   e. Pain/discomfort/ulceration/grooving from bra straps cutting into shoulders;
   f. Paresthesia of upper extremities due to brachial plexus compression syndrome;
   g. Intertrigo;
   h. Significant discomfort resulting in severe restriction of physical activities;

4. Physician evaluation has determined all of the following:
   a. Pain is unresponsive to conservative treatment as evidenced by physician documentation of therapeutic measures including at least two of the following:
      i. Analgesic/non-steroidal anti-inflammatory drugs (NSAIDs);
      ii. Physical therapy/exercise when skeletal pathology is present;
      iii. Supportive devices (e.g., proper bra support, wide bra straps);
      iv. Medically supervised weight loss program;
      v. Chiropractic care or osteopathic manipulative treatment;
      vi. Orthopedic or spine surgeon evaluation of spinal pain;
   b. The pain is not associated with another diagnosis (e.g., arthritis);
   c. There is a reasonable likelihood that the member/enrollee's symptoms are primarily due to macromastia;
   d. Reduction mammoplasty is likely to result in improvement of the chronic pain;
   e. Members/enrollees ≥ 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;

B. *Gigantomastia of Pregnancy*
   1. Member/enrollee has gigantomastia of pregnancy, accompanied by *any* of the following complications, and delivery is not imminent:
      a. Massive infection;
      b. Significant hemorrhage;
      c. Tissue necrosis with slough;
      d. Ulceration of breast tissue;
      e. Intertriginous maceration or infection of the inframammary skin refractory to dermatologic measures.

II. It is the policy of health plans affiliated with Centene Corporation that gynecomastia surgery is considered **medically necessary** when the criteria in A or B are met:

A. *Adolescents < 18 years of age*, all of the following:
   1. One of the following:
      a. Gynecomastia persists more than one year after pathological causes are ruled out in adolescents with unilateral or bilateral grade II or III gynecomastia (per Appendix C);
      b. Gynecomastia persists more than six months after pathological causes are ruled out in adolescents with unilateral or bilateral grade IV gynecomastia (per Appendix C);
   2. Persists without improvement after appropriate treatment for at least six months for any underlying cause, as applicable, including discontinuation of gynecomastia-inducing drugs and/or substances;
   3. Presence of pain and discomfort due to distention and tightness of the hypertrophied breast(s) that has not responded to medical management;
   4. Adult testicular size is attained;

B. *Adults ≥ 18 years of age,* 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 more than three months after pathological causes are ruled out;

4. Persists without improvement after appropriate treatment for at least six months for any underlying cause, as applicable, including appropriate discontinuation of gynecomastia-inducing drugs and/or substances;
5. Presence of pain and discomfort due to distention and tightness of the hypertrophied breast(s) that has not responded to medical management.

Medical Record Documentation Requirements
Medical records must accompany all requests for reduction mammoplasty and gynecomastia procedures, along with detailed documentation supporting the medical necessity of breast reduction, which should include height and weight information. When applicable, there must be documented evidence of conservative therapies attempted to substantiate that the condition is refractory to treatment. Photographic documentation may be requested to support written documentation.[4-5]

Background
Reduction mammoplasty is the surgical reduction of breast size. It was originally adopted in medical practice in the 1920s.[6] 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.[1,7]

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 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.[1,7]

Gestational gigantomastia is a rare clinical condition, characterized by rapid and disproportionate enlargement of the breasts during pregnancy. Patients present with massive enlargement of the breasts accompanied by possible thinning of the skin, tissue necrosis, infection, and hemorrhage. Treatment methods include medical therapy and surgery. When conservative treatment is ineffective or patients present with complications, (e.g., massive hemorrhage, ulceration, or breast necrosis), a surgical approach is indicated. Currently available surgical interventions are either breast reduction or mastectomy with delayed reconstruction.[8]

Gynecomastia is the benign proliferation of glandular breast tissue in those with a male reproductive system.[5,9-10] Physiologic gynecomastia is common in newborns, adolescents, and those older than 50 years of age.[9] In newborns and adolescents, it generally resolves spontaneously without intervention.[10] In the older age group, decreasing free-testosterone levels can contribute to physiologic gynecomastia. However, this older age group is less likely to present for evaluation and treatment than adolescents.[9-10]

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.[3,9-10]

Appendices

Appendix A

Criteria for distinguishing Tanner stages 1 to 5 in those with a female reproductive system[11]:

Tanner Stage	Breast	Pubic Hair
1 (Prepubertal)	No palpable glandular tissue or pigmentation of areola; elevation of areola only	No pubic hair; short, fine villus 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[12]:

Body Surface Area (m^2)	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

Body Surface Area (m^2)	Weight of tissue to be removed per breast (grams)
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[5]:

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

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2022, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT® Codes	Description
19300	Mastectomy for gynecomastia
19318	Breast reduction

Reviews, Revisions, and Approvals	Revision Date	Approval Date
Policy developed. Specialist reviewed	06/12	08/12
References reviewed and updated. Specialist reviewed.	06/19	07/19
Added note to reference CP.MP.95 for breast surgeries pertaining to gender affirming procedures. Added criteria for breast reduction for	06/20	07/20

Reviews, Revisions, and Approvals	Revision Date	Approval Date
females that cup size has not changed in 6 months. Added criteria for adolescent males requiring that adult testicular size has been attained. References reviewed and updated.		
Revised description of CPT-19318. Replaced all instances of "member" with "member/enrollee"	04/21	
Annual review. Deleted "for non-cosmetic reasons" from the policy statement in I, as it is redundant given the symptom criteria required. Replaced "and/or" with "or" in I.A.1. Reworded paragraph under Medical Record Documentation Requirements for both reduction mammoplasty and gynecomastia, and changed requirement of photographic documentation to "photographic documentation may be requested to support written documentation." References reviewed and updated. Changed "review date" in the header to "date of last revision" and "date" in the revision log header to "revision date." Specialist reviewed.	07/21	07/21
In I.A.2., changed "No change in cup size for at least 6 months" to "For adolescents, no breast growth equivalent to a change in cup size for at least 6 months." Updated background regarding gigantomastia of pregnancy with no impact on criteria.	09/21	09/21
Annual review completed. Changed "women" to "members/enrollees" in I.A.5.c. Added I.B.5. to gigantomastia of pregnancy criteria. Language references in the criteria, description and background sections changed from "male" and/or "female" to "those with a male reproductive system" and/or "those with a female reproductive system." References reviewed and updated.	07/22	07/22
Annual review. Criteria I.A.1. updated for criteria for members/enrollees ≥ 18 years of age and members/enrollees < 18 years of age. Criteria I.A.2. updated to include note regarding medical director review on case-by-case basis when weight of tissue to be resected is less than the 22nd percentile minimum based on the Schnur Sliding Scale. Criteria I.A.3.b. updated to include pain in arm. Criteria II.A.1. updated to align with ASPS guidance regarding length of time gynecomastia persists in adolescents < 18 years. Criteria II.B.3. updated to align with ASPS guidance for length of time gynecomastia persists in adults ≥ 18 years. Removed Criteria II.B.6. regarding malignancy being ruled out. Minor rewording in background with no impact on criteria. ICD-10 codes removed. References reviewed and updated. Reviewed by internal specialist and external specialist.	07/23	07/23

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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.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

Note: For Medicaid members/enrollees, 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/enrollees, 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.