Clinical Policy: Reduction Mammoplasty and Gynecomastia Surgery

Reference Number: LA.CP.MP.51c
Last Review Date: ~~8~~10/22~~11/21~~

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 in ~~women~~ to reduce the weight, mass, and size of the breast. those with a female reproductive system. Gynecomastia surgery is the surgical correction of over-developed or enlarged breasts in those with a male reproductive system.~~Gynecomastia surgery is the surgical correction of over-developed or enlarged breasts in men.~~

When the procedure is not reconstructive and is performed solely for the purpose of altering the appearance of the breast, reduction mammaplasty and removal of breast implants shall be considered cosmetic and not medically necessary.

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

Policy/Criteria

I. It is the policy of Louisiana Healthcare Connections that reduction mammoplasty females for non-cosmetic indications is **medically necessary** when the criteria in A or B below are met:

A. Reduction mammoplasty for purposes other than reconstruction all of the following*:*

1. Pubertal breast development is complete;
2. A diagnosis of macromastia with at least 2 of the following symptoms for at least a 12-week duration:
   a. Chronic breast pain
   b. Headache
   c. Neck, shoulder, or back pain
   d. Shoulder grooving from bra straps
   e. Upper extremity paresthesia due to brachial plexus compression syndrome, secondary to the weight of the breasts being transferred to the shoulder strap area
   f. Thoracic kyphosis
   g. Persistent skin condition such as intertrigo in the inframammary fold that is unresponsive to medical management
   h. Congenital breast deformity;
3. There is a reasonable likelihood that the symptoms are primarily due to macromastia; and
4. The amount of breast tissue to be removed is reasonably expected to alleviate the symptoms

B. *Gigantomastia of Pregnancy*
The member/enrollee 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.
5. Intertriginous maceration or infection of the inframammary skin refractory to medical management

II. It is the policy of Louisiana Healthcare Connections that removal of breast implants for purposes other than reconstruction is considered medically necessary for the following indications:
A. Visible capsular contracture causing pain (Baker Grade IV)
B. Diagnosed or suspected implant rupture
C. Local or systemic infection
D. Siliconoma or granuloma
E. Implant extrusion
F. Interference with the diagnosis or treatment of breast cancer
G. Breast implant-associated anaplastic large cell lymphoma

III. It is the policy of Louisiana Healthcare Connections that mastectomy or breast conserving surgery is considered medically necessary when all of the following criteria are met:
A. A high risk of breast cancer, as defined by one or more of the following:
    1. Positive genetic mutation that is known or likely to confer a high risk of breast cancer (e.g., BRCA1 and BRCA2) where risk-reducing mastectomy is recommended by National Comprehensive Cancer Network guidelines; or
    2. Significant family history, as defined by meeting the family history criteria listed under "Breast and Ovarian Cancer" within the "Genetic Testing" policy in Attachment A; or
    3. Prior thoracic radiation therapy at an age less than 30 years old; and
B. A life expectancy greater than or equal to 10 years.

IV. It is the policy of Louisiana Healthcare Connections that reconstructive breast surgery is considered medically necessary after therapeutic intervention (e.g., mastectomy) or trauma resulting in significant loss of breast tissue.
A. The following services are considered medically necessary:
    1. Reconstruction of the affected breast;
    2. Reconstruction of the contralateral breast to produce a symmetrical appearance;
    3. Prostheses (implanted, external, or both); and
    4. Treatment of complications of the reconstruction.
B. All prosthetic implants must be FDA approved and used in compliance with all FDA requirements at the time of the surgery.

V. It is the policy of Louisiana Healthcare Connections that male gynecomastia surgery is considered medically necessary when the criteria in A or B are met:
A. *Adolescents < 18 years*
Adolescent members with unilateral or bilateral grade II, III, or IV gynecomastia (per Appendix A), 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.
4. Adult testicular size is attained.

B. Adults ≥ 18 years, meets all of the following:
1. Unilateral or bilateral grade III or IV gynecomastia (per Appendix A);
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 those with a male reproductive system~~men~~. Physiologic gynecomastia is common in newborns, adolescents, and in individuals with a male reproductive system ~~men~~ older than 50 years of age. In newborns and adolescents, it generally resolves spontaneously without intervention. In older individuals with a male reproductive system~~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
Gynecomastia Scale adapted from the McKinney and Simon, Hoffman and Kohn scales:

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

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CPT®* Codes	Description
19300	Mastectomy for gynecomastia

CPT®* Codes	Description
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
Converted corporate to local policy.	2/2021	
Replaced Custom Centene criteria I.A and II with LDH criteria I.A-IV. Criteria I.B remained.	11/2021	3/26/22
Changed "women" " and "men" to those with a female reproductive system and those with a male reproductive system respectively, added additional criteria under I, section B. "5.Intertriginous maceration or infection of the inframammary skin refractory to medical management. References reviewed and updated.~~:~~	~~8~~10/22	

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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

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