

Clinical Policy: Reduction Mammoplasty and Gynecomastia Surgery

Reference Number: LA.CP.MP.51c

Date of Last Revision: 1/23

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. Gynecomastia surgery is the surgical correction of over-developed or enlarged breasts in those with a male reproductive system.

When the procedure is not reconstructive and is performed solely for the purpose of altering the appearance of the breast, reduction mammoplasty 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. A diagnosis of Macromastia, all of the following:
 1. Member/enrollee is ≥ 16 years of age or/or Tanner stage V of Tanner staging of sexual maturity (See Appendix A for Tanner Staging);
 2. For adolescents, no breast growth equivalent to a change in cup size for at least 6 months;
 3. The estimated amount of breast tissue to be removed meets the minimum weight requirement based on the members/enrollee'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;
 - B. Member/enrollee has at least at of the following symptoms for at least a 12-week duration:
 1. Chronic breast pain;
 2. Headache;
 3. Neck, shoulder, or back pain;
 4. Shoulder grooving from bra straps;
 5. Upper extremity paresthesia due to brachial plexus compression syndrome, secondary to the weight of the breasts being transferred to the shoulder strap area;
 6. Thoracic kyphosis;
 7. Persistent skin condition such as intertrigo in the inframammary fold that is unresponsive to medical management;
 8. Congenital breast deformity;
 9. There is a reasonable likelihood that the symptoms are primarily due to macromastia; and

CLINICAL POLICY

Reduction Mammoplasty and Gynecomastia Surgery

10. The amount of breast tissue to be removed is reasonably expected to alleviate the symptoms

C. *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 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 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;
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 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

CLINICAL POLICY

Reduction Mammoplasty and Gynecomastia Surgery

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. Physiologic gynecomastia is common in newborns, adolescents, and in individuals with a male reproductive system older than 50 years of age. In newborns and adolescents, it generally resolves spontaneously without intervention. In older individuals with a male reproductive system, 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 those with a female reproductive system

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

CLINICAL POLICY

Reduction Mammoplasty and Gynecomastia Surgery

Tanner Stage	Breast	Pubic Hair
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 Scale¹³ – body surface area and estimated minimum cutoff weight for breast tissue per breast to be removed.

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:

- 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

CLINICAL POLICY
Reduction Mammoplasty and Gynecomastia Surgery



2019, 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 and may not support medical necessity. 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	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	Revision 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.	10/22	1/14/23
Changed Last Revision Date to Date of Last Revision in header. Added Revision to Date in revision log. In Policy/Criteria section, added criteria for Macromastia with 3 criteria. Removed sections II removal of breast implants, III mastectomy, IV reconstructive breast surgery. Removed “male” in gynecomastia surgery. Changed references to correct Appendix. Updated background to remove “men” and replace to those with a male reproductive system. Added	1/23	4/10/23

Reviews, Revisions, and Approvals	Revision Date	Approval Date
Appendix A Criteria for distinguishing Tanner stages and Appendix B schnur Sliding Scale		

References

1. Louisiana Department of Health. Professional Services Provider Manual: Chapter Five of the Medicaid Services Manual. Page 37 Section 5.1. Issued 2/1/2012. Accessed at: <https://www.lamedicaid.com/provweb1/providermanuals/manuals/PS/PS.pdf>
2. American Society of Plastic Surgeons. Evidence-based Clinical Practice Guideline: Reduction Mammoplasty. <https://www.plasticsurgery.org/for-medical-professionals/quality/evidence-based-clinical-practice-guidelines>. Published 2011. Accessed May 26, 2022.
3. American Society of Plastic Surgeons. Breast reduction-reduction mammoplasty: What is breast reduction surgery? <https://www.plasticsurgery.org/reconstructive-procedures/breast-reduction>. Accessed May 26, 2022.
4. American Society of Plastic Surgeons. ASPS recommended insurance coverage criteria for third-party payers. Reduction mammoplasty. <https://www.plasticsurgery.org/for-medical-professionals/health-policy/recommended-insurance-coverage-criteria> Published 2011. (Reaffirmed October 2021). Accessed May 26, 2022.
5. American Society of Plastic Surgeons. ASPS recommended insurance coverage criteria for third-party payers. Gynecomastia. <https://www.plasticsurgery.org/for-medical-professionals/health-policy/recommended-insurance-coverage-criteria> Published 2002. (Reaffirmed June 2015). Accessed May 26, 2022.
6. Braunstein GD, Anawalt BD. Management of gynecomastia. UpToDate. www.uptodate.com. Updated May 10, 2021. Accessed May 26, 2022.
7. Chadbourne EB, Zhang S, Gordon MJ, et al. Clinical outcomes in reduction mammoplasty: a systematic review and meta-analysis of published studies. *Mayo Clin Proc.* 2001;76(5):503-510. doi: 10.4065/76.5.503.
8. Cornell University, Critical Care Pediatrics. Body surface area. <http://www-users.med.cornell.edu/~spon/picu/calc/bsacalc.htm>. Accessed May 26, 2022.
9. Dickson G. Gynecomastia. *Am Fam Physician.* 2012;85(7):716-722.
10. Hansen J., Chang S. Overview of breast reduction. UpToDate. www.uptodate.com. Updated February 17, 2021. Accessed May 26, 2022.
11. Kustin J, Rebar RW. Menstrual disorders in the adolescent age group. *Prim Care.* 1987;14(1):139-166.
12. 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):404-406.
13. Schnur PL, Hoehn JG, Ilstrup DM, Cahoy MJ, Chu CP. Reduction mammoplasty: cosmetic or reconstructive procedure? *Ann Plast Surg.* 1991;27(3):232-237. doi:10.1097/00000637-199109000-00007
14. Schnur, PL. Reduction mammoplasty – The Schnur sliding scale revisited. *Annals of Plast Surg.* 1999 Jan;42(1):107-8. doi: 10.1097/00000637-199901000-00020.
15. Rockwell, WB, Daane SP. Breast reduction techniques and outcomes: a meta-analysis. *Aesthetic Surgery Journal.* 1999;19(4):293-303.

16. American College of Obstetrician and Gynecologists. (ACOG) Committee Opinion Number 686. Breast and Labial Surgery in Adolescents. <https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2017/01/breast-and-labial-surgery-in-adolescents>. Published May 2016 (reaffirmed 2020). Accessed May 26, 2022.
17. Taylor SA. Gynecomastia in children and adolescents. UpToDate. www.uptodate.com. Updated April 14, 2021. Accessed May 26, 2022.
18. Qin F, Si L, Zhang H, et al. Management of gestational gigantomastia with breast reconstruction after mastectomy: case report and literature review. J Int Med Res. 2020;48(6):300060520920463. doi:10.1177/0300060520920463
19. Local coverage determination: Cosmetic and reconstructive surgery (L38914). Centers for Medicare and Medicaid Services. <https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?lcdId=38914&ver=20>. Published July 11, 2021. (Updated May 13, 2022). Accessed May 31, 2022.

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. LHCC 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.

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 LHCC administrative policies and procedures.

This clinical policy is effective as of the date determined by LHCC. 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. LHCC 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. This clinical policy is not intended to

CLINICAL POLICY
Reduction Mammoplasty and Gynecomastia Surgery



recommend treatment for members. Members 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 LHCC has no control or right of control. Providers are not agents or employees of LHCC.

This clinical policy is the property of LHCC. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

©2020 Louisiana Healthcare Connections. All rights reserved. All materials are exclusively owned by Louisiana Healthcare Connections and are protected by United States copyright law and international copyright law. No part of this publication may be reproduced, copied, modified, distributed, displayed, stored in a retrieval system, transmitted in any form or by any means, or otherwise published without the prior written permission of Louisiana Healthcare Connections. You may not alter or remove any trademark, copyright or other notice contained herein. Louisiana Healthcare Connections is a registered trademark exclusively owned by Louisiana Healthcare Connections.