MedStar Health, Inc.
POLICY AND PROCEDURE MANUAL

Policy Number: PA.022.MH
Last Review Date: 11/08/2018
Effective Date: 01/01/2019

PA.022.MH – Breast Reduction and Mastectomy for Gynecomastia

This policy applies to the following lines of business:
- ✓ MedStar Employee (Select)
- ✓ MedStar CareFirst PPO

MedStar Health considers a **Breast reduction and Mastectomy for Gynecomastia** medically necessary for the following indications:

Breast Reduction in the Female:
Breast Reduction is considered reconstructive and medically necessary for members with symptomatic macromastia when *ALL* of the following criteria are met:

1. The amount of breast tissue anticipated to be removed is at least 350 grams per breast, or a total of 700 grams. Alternatively, for persons with small body habitus with a body surface area (BSA) equal to or less than 1.65, the estimated amount of breast tissue to be removed may be proportionally less, according to the Schnur Sliding Scale. Photographs must be submitted to confirm severe breast hypertrophy.
2. Documentation of a negative mammogram within the last two years for women over 40 years old.
3. According to the American Society of Plastic Surgeons (ASPS) guidelines, two or more of the following associated symptoms are present for at least 12 months:
    - Documented history of upper back, neck and shoulder pain
    - Chronic breast pain due to weight of the breasts
    - Thoracic kyphosis, acquired
    - Documented history of recurrent or current intertrigo unresponsive to medical management (i.e. appropriate hygiene, appropriate prescription medications, appropriate professionally fitted support bra, etc.)
    - Shoulder grooving from bra straps
    - Headache
    - Backache, unspecified
    - Congenital breast deformity
    - Upper extremity paresthesia due to brachial plexus compression syndrome secondary to the weight of the breasts being transferred to the shoulder-strap area
    - For at least three months, the member has had on-going evaluations and failed conservative treatment for her symptoms by a PCP or a non-surgical

specialist and chronic causes unrelated to the breast have been ruled out. Conservative therapeutic treatment may include the following measures: analgesics/non-steroidal anti-inflammatory drugs (NSAIDs) interventions, physical therapy, exercises, posturing maneuvers, appropriate support bra, wide bra straps, heat or cold application, etc.

Mastectomy for Male Gynecomastia:
Surgery for unilateral or bilateral gynecomastia is considered medically necessary and therefore covered when *ALL* of the following criteria are met:

1. The member has pain and discomfort due to the distention and tightness from the hypertrophied breast which is refractory to medical treatment; and
2. The member meets the ASPS classification of gynecomastia criteria for Grade II, III, or IV;
    - Grade I: Small breast enlargement with localized button of tissue around the areola
    - Grade II: Moderate breast enlargement exceeding areola boundaries with dges that are indistinct from the chest
    - Grade III: Moderate breast enlargement exceeding areola boundaries with edges that are distinct from the chest with skin redundancy
    - Grade IV: Marked breast enlargement with skin redundancy and feminization of the breast

    and
3. Breast tissue is glandular tissue (gynecomastia) and not excess fatty tissue as documented by physical examination; and
4. Contributing factors for pathological gynecomastia have been treated for at least six months or have been ruled out; and
5. Male is 18 years of age or older; and
    Note: Surgery is generally not recommended until adult testicular size is attained, as there may be re-growth of the breast tissue if the surgery is performed before puberty is substantially completed (Tanner 5). If adult size is not attained by 18 years of age, genetic disorders need to be excluded.
6. If gynecomastia is induced by pharmacological agents, one of the following criteria must be met:
    - The member was taking prescribed medication that is believed to be contributory and gynecomastia has not improved within three months of stopping the offending agent;

      Or
    - The member is taking prescribed medications that are believed to be contributory but which cannot be discontinued because there is no alternative medication

PA.022.MH – Breast Reduction and Mastectomy for Gynecomastia

Policy Number: PA.022.MH
Last Review Date: 11/08/2018
Effective Date: 01/01/2019

Limitations:

1. Breast Reduction is considered not medically necessary and therefore not covered for:
    - Members with breasts that are not fully developed
    - Members without persistent signs or symptoms
    - Breast Reduction performed solely for cosmetic purposes (improve self-esteem or appearance)
2. Experimental/Investigational
    - Breast Reduction or Mastectomy for Gynecomastia by Liposuction as the sole procedure is considered experimental/investigational
3. All other indications not listed above

Background

Reduction Mammoplasty is an intervention used for the treatment of macromastia. Macromastia, excessive breast size, is recognized as a medical condition that cause physical symptoms, including: pain in the neck, upper back and shoulders, chronic breast pain, frequent headaches, thoracic kyphosis, grooving of the shoulder due to bra straps, upper extremity paresthesia and difficulty sleeping and exercising. Reduction mammoplasty often performed in the outpatient setting, but may require a hospital admission.

Gynecomastia is a benign enlargement of the male breast due to hormonal imbalance (decreased testosterone and increase estrogen activity). This imbalance can occur at times of hormonal change, infancy, adolescence, or old age. Male breast growth can also be caused by medications, illicit drugs, physiologic changes, genetic disorders, and medical conditions which alter the balance of hormones.

Codes:

CPT Codes	
Code	Description
19300	Mastectomy for gynecomastia
19318	Reduction mammoplasty

References

1. American Society of Plastic Surgeons. Practice Parameters: Gynecomastia. Approved by the Executive Committee of Plastic Surgeons®, February 2004. http://www.plasticsurgery.org/Documents/medical-professionals/health-policy/key-issues/Gynecomastia-PP.pdf
2. American Society of Plastic Surgeons. Reduction Mammaplasty: ASPS

Recommended Insurance Coverage Criteria for Third-Party Payers. Approved by the Executive Committee of the ASPS®, May 2011. http://www.plasticsurgery.org/Documents/medical-professionals/health-policy/insurance/Reduction_Mammaplasty_Coverage_Criteria.pdf
3. Carey, Charles C., et al.: Body Surface Calculator, The Washington Manual of Medical Therapeutics. (Philadelphia: Lippincott Williams & Wilkins, 1998);.562. http://www.bcbst.com/providers/calculator.asp
4. Govrin-Yehudain j, Kogan L, Cohen H, et al.: Familial juvenile hypertrophy of the breast. J Adolesc Health. 2004 Aug; 35(2): 151-155. https://www.ncbi.nlm.nih.gov/pubmed/15261644
5. Gray LN. Update on experience with liposuction breast reduction. Plast Reconstr Surg. 2001 Sep 15;108(4):1006-1010; discussion 1011-3. . https://www.ncbi.nlm.nih.gov/pubmed/11547163
6. Gynecomastia, In: Pediatric Surgery Update, Vol. 17 No.03, September 2001. http://home.coqui.net/titolugo/PSU17301.pdf
7. Hayes Health Technology Brief. Mastectomy for Gynecomastia. Archived August 06, 2013.
8. Hu C, Kneusel R, Barnes G. MedCalc: Body Surface Area, Body Mass Index (BMI). At: MedCalc.com. Last modified: January 27, 2010. http://www.medcalc.com/body.html
9. Johnson RE, Kermitt CA, Murad MH. Gynecomastia – evaluation and current treatment options. Ther Clin Risk Manag. 2011;7:145-148. doi: 10.2147/TCRM.S10181. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3071351/pdf/tcrm-7-145.pdf
10. Johnson RE, Murad MH. Gynecomastia: pathophysiology, evaluation, and management. Mayo Clin Proc. 2009 Nov; 84(11): 1010-1015. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2770912/pdf/mayoclinproc_84_11_008.pdf
11. Kalliainen LK, American Society of Plastic Surgeons (ASPS) Health Policy Committee. ASPS clinical practice guideline summary on reduction mammaplasty. Plast Reconstr Surg. 2012 Oct; 130(4):785-789. https://www.ncbi.nlm.nih.gov/pubmed/23018692
12. Kerrigan C, Collins ED, Kim HM, et al. Reduction mammoplasty: defining medical necessity. Med Decis Making. 2002 May-June; 22(3): 208-217. https://www.ncbi.nlm.nih.gov/pubmed/12058778
13. Kwee RM, van den Bosch MA, El Ouamari M, et al: Contrast-enhanced breast ultrasonography reveals an unusual breast tumor in a male patient with gynecomastia. J Ultrasound Med. 2006 Oct; 25(10):1347-1351. http://www.jultrasoundmed.org/content/25/10/1347.full.pdf+html
14. Ladizinski B, Lee KC, Nutan FN, et al. Gynecomastia: etiologies, clinical presentations, diagnosis, and management. South Med J. 2014 Jan;107(1):44-

49. doi: 10.1097/SMJ.0000000000000033. https://www.ncbi.nlm.nih.gov/pubmed/24389786
15. Matarasso A: Suction Mammoplasty: use of suction lipectomy alone to reduce large breasts. Clin Plast Surg. 2002 Jul; 29(3): 433-443. http://www.ncbi.nlm.nih.gov/pubmed/12365643
16. Nguyen JT; Wheatley MJ, Schnur PL et al. Reduction mammoplasty: a review of managed care medical policy coverage criteria. 2008 Apr;121(4):1092-1100. doi: 10.1097/01.prs.0000304238.43482.9c.https://www.ncbi.nlm.nih.gov/pubmed/18349625
17. Rahmani S, Turton P, Shaaban A, et al. Overview of gynecomastia in the modern era and the Leeds Gynaecomastia Investigation algorithm. Breast J. 2011 May-Jun;17(3):246-255. doi: 10.1111/j.1524-4741.2011.01080.x. Epub 2011 Apr 8. https://www.ncbi.nlm.nih.gov/pubmed/21477170
18. Schnur, Paul L, et al., "Reduction Mammaplasty: Cosmetic or Reconstructive Procedure?" Annals of Plastic Surgery. Sept 1991; 27 (3): 232-7.
19. The Merck Manual [Internet]. Diagrammatic representation of Tanner stages I to V of human breast maturation, In: Female Reproductive Endocrinology. Last full review/revision: August 2016.. ©2009-2015, Merck Sharp & Dohme Corp. Available at: http://www.merckmanuals.com/professional/gynecology_and_obstetrics/female_reproductive_endocrinology/female_reproductive_endocrinology.html

Disclaimer:
MedStar Health medical payment and prior authorization policies do not constitute medical advice and are not intended to govern or otherwise influence the practice of medicine. The policies constitute only the reimbursement and coverage guidelines of MedStar Health and its affiliated managed care entities. Coverage for services varies for individual members in accordance with the terms and conditions of applicable Certificates of Coverage, Summary Plan Descriptions, or contracts with governing regulatory agencies.

MedStar Health reserves the right to review and update the medical payment and prior authorization guidelines in its sole discretion. Notice of such changes, if necessary, shall be provided in accordance with the terms and conditions of provider agreements and any applicable laws or regulations.