curative

TITLE:	BREAST REDUCTION SURGERY AND GYNECOMASTIA SURGERY POLICY
POLICY #:	MM-PNP-056
VERSION #:	01
DEPARTMENT:	MEDICAL MANAGEMENT
ORIGINAL EFFECTIVE DATE:	4/12/2024
CURRENT REVISION DATE:	N/A

1. PURPOSE

This policy will be used to inform medical necessity decisions related to authorization requests for breast reduction surgery and gynecomastia surgery.

2. SCOPE

Medical UM Department

3. DEFINITIONS

N/A

4. RESPONSIBILITIES

Medical UM Department

5. POLICY

Medical Necessity

Reduction Mammoplasty

Curative considers breast reduction surgery medically necessary for non-cosmetic indications for women aged 18 or older or for whom growth is complete (i.e., breast size stable over one year) when *any* of the following criteria (A, B, or C) is met:

Macromastia: *all* the following criteria must be met:

. Member has persistent symptoms in at least two of the anatomical body areas below, directly attributed to macromastia and affecting daily activities for at least 1 year:

- Headaches;
- Pain in neck;
- Pain in shoulders;
- Pain in upper back;
- Painful kyphosis documented by X-rays;
- Pain/discomfort/ulceration from bra straps cutting into shoulders;
- Skin breakdown (severe soft tissue infection, tissue necrosis, ulceration hemorrhage) from overlying breast tissue;

- Upper extremity paresthesia *and*
- *All* of the following criteria are met:
    - Member has severe breast hypertrophy, documented by high-quality color frontal-view and side-view photographs; *and*
    - There is a reasonable likelihood that the member's symptoms are primarily due to macromastia; *and*
    - Reduction mammoplasty (also spelled as 'mammaplasty') is likely to result in improvement of the chronic pain; *and*
    - Pain symptoms persist as documented by the physician despite at least a 3-month trial of therapeutic measures such as:
    - Analgesic/non-steroidal anti-inflammatory drugs (NSAIDs) interventions and/or muscle relaxants
    - Dermatological therapy of ulcers, necrosis, and refractory infection
    - Physical therapy/exercises/posturing maneuvers
    - Supportive devices (e.g., proper bra support, wide bra straps)
    - Chiropractic care or osteopathic manipulative treatment
    - Medically supervised weight loss program
    - Orthopedic or spine surgeon evaluation of spinal pain; *and*
    - Women 50 years of age or older are required to have a mammogram that was negative for cancer performed within the two years prior to the date of the planned reduction mammoplasty; *and*
    - The surgeon estimates that at least the following amounts (in grams) of breast tissue, not fatty tissue, will be removed from each breast, based on the member's body surface area (BSA) calculated using the Mosteller formula.

Note: Breast reduction surgery may be considered medically necessary for women meeting the symptomatic criteria specified above, regardless of BSA, with more than 1 kg of breast tissue to be removed per breast.

Note: Chronic intertrigo, eczema, dermatitis, and/or ulceration in the infra-mammary fold in and of themselves are not considered medically necessary indications for reduction mammoplasty. The condition not only must be unresponsive to dermatological treatments (e.g., antibiotics or antifungal therapy) and conservative measures (e.g., good skin hygiene, adequate nutrition) for a period of 6 months or longer, but also must satisfy criteria stated in section I above.

Gigantomastia of Pregnancy:

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

- Massive infection; *or*
- Significant hemorrhage; *or*
- Tissue necrosis with slough; *or*
- Ulceration of breast tissue; *or*

Asymmetry:

For medical necessity criteria for surgery to correct breast asymmetry, see Breast Reconstructive Surgery.

Experimental, Investigational, or Unproven

The following procedures are considered experimental, investigational, or unproven because there is insufficient evidence of its effectiveness, or its effectiveness has not been established:

- Combined arthroscopic shaver and liposuction for the treatment of adolescent gynecomastia.
- Liposuction-only reduction mammoplasty
- Radiotherapy (for the prevention or management of gynecomastia recurrence)
- Vacuum-assisted breast biopsy system for treatment of gynecomastia.

Cosmetic

Gynecomastia Surgery

Curative considers breast reduction, surgical mastectomy, or liposuction for gynecomastia, either unilateral or bilateral, a cosmetic surgical procedure. Medical therapy should be aimed at correcting any reversible causes (e.g., drug discontinuance). Furthermore, there is insufficient evidence that surgical removal is more effective than conservative management for pain due to gynecomastia.

- Breast reduction surgery is considered cosmetic for all indications not listed in section I, .
- Reduction mammoplasty for asymptomatic members is considered cosmetic.

6. PROCEDURE

N/A

7. TRAINING REQUIREMENT

7.1. All Medical UM associates are responsible for reading and comprehending this procedure. Employees are also responsible for contacting management or Privacy and Compliance with any questions or concerns regarding the information contained within this procedure.

8. ENFORCEMENT

Violations of this controlled document will cause the imposition of sanctions in accordance with the Curative sanctions-controlled document. This may include verbal/written warning, suspension, up to termination of employment or volunteer, intern, contractor status with Curative. Additional civil, criminal, and equitable remedies may apply.

9. DOCUMENTATION

Documentation, in the form of a prescription written by the physician, documented by high-quality color front-view and side-view photographs.

10. REFERENCE DOCUMENTS AND MATERIALS

10.1. Related Policies

10.1.1. Cosmetic Surgery

10.1.2. Breast Reconstructive Surgery

10.1.3. Breast and Ovarian Cancer Susceptibility Gene Testing, Prophylactic Mastectomy, and Prophylactic Oophorectomy

10.1.4. Transgender Reassignment Surgery

11. COLLABORATING DEPARTMENTS

N/A

12. DOCUMENT CONTROL

APPROVED BY:		
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(Printed Name)	**(Date)**	**(Signature)**

REVISION HISTORY			
Date	**Author**	**Version**	**Comments**
			Initial Version

APPENDICES

Any applicable attachments, resources or other materials should be included as appendices in this section. Label each appendix as follows:

Appendix A:

N/A