KAISER PERMANENTE® Mid-Atlantic States	**Breast Reduction Surgery and Gynecomastia Surgery Medical Coverage Policy**

Utilization *ALERT*

- Prior to use of this MCP for evaluation of medical necessity, benefit coverage MUST be verified in the member's EOC or benefit document
- For Medicare members, please refer to CMS guidelines through requirements as reflected in the Medicare Coverage Database.
- Note: After searching the Medicare Coverage Database, if no NCD/LCD/LCA is found, then use the policy referenced above for coverage guidelines

I. Diagnosis: Macromastia and Gynecomastia

II. Specialty: Plastic and Reconstructive Surgery

III. Benefit Alert

A. KFHP coverage for plastic and reconstructive surgery is contractually limited to procedures intended to significantly improve physical function. Procedures and services intended to improve or maintain appearance, not expected to significantly improve physical function, are considered cosmetic and usually excluded contractually.

B. Inform patients that certain plastic surgery procedures may not be covered benefits because of specific exclusions in their or their employer's contract with KFHP. Note that a patient's contract (Evidence of Coverage or EOC) may differ significantly by his/her governing jurisdiction, which includes Maryland, Virginia, District of Columbia, Federal, Medicaid, and Medicare. Imaging and testing necessary to establish a diagnosis are covered services if the diagnostic services are ordered by a Kaiser Permanente affiliated physician.

C. Patients with questions about their plastic and reconstructive surgery benefit should be encouraged to contact Member Services.

IV. History and Physical

Documentation of the following is recommended:

A. Significant change in bra size over the previous 2 years.
B. Musculoskeletal pain (shoulder, neck, arm, or back pain) for six or more months.
C. History with attention to prescription and illicit drug usage. Breast enlargement is often concurrent with usage of hormones, anti-androgens, anti-ulcer medications, cancer treatments, cardiovascular medications, drugs of abuse etc.
D. Physical Examination with attention to height, weight, macromastia, bra size, back, neck, shoulder, arm pain, breast exam, neurological exam, shoulder grooving, intertrigo.

V. Recommended Therapeutic Measures Prior to Referral

A. Recommended Therapeutic Measures Prior to Referral for Macromastia

1. Patients should discontinue causative drug(s), if feasible, and be re-evaluated in 3 months;
2. For patients with musculoskeletal pain: documented trial of NSAIDs x 6 weeks OR Physical therapy with a home exercise and treatment protocol OR back/neck health education class are recommended before surgery;
3. For patients with skin infections, a trial of anti-infective treatment, topical and/or systemic, for 3 or more months AND counseling of the patient on personal hygiene measures;
4. Recommend custom-fitted support undergarments (adequate bra supports and wide strap);
5. Women 40 years of age or older are required to have a mammogram that was negative for cancer performed within the year prior to the date of the planned reduction mammoplasty.
6. Documentation of severity of patient's symptoms and impact on quality of life;
7. Patient should be at least one year postpartum and have stopped breast feeding for 6 months or more; and
8. In addition to the above criteria, obese patients (BMI greater than 35) must receive nutrition education for 3 or more months, as follows:
    a. Documentation of attendance of professional nutrition class such as KPMAS Nutrition for Weight Control; and
    b. Documentation and completion of two or more individual professional nutrition counseling sessions are required.

B. Recommended Therapeutic Measures Prior to Referral for Gynecomastia

1. Post pubertal male with one year or more of gynecomastia or prepubertal male with 24 months or more of gynecomastia and **ALL** of the following:
    a. The tissue to be removed is glandular breast tissue and not the result of obesity or puberty.
    b. The gynecomastia is classified as Grade II, III or IV per the American Society of Plastic Surgeons classification.
    c. Functional impairment (Functional impairment is defined as a direct and measurable reduction in physical performance of an organ or body part) AND one of the following
        i. Gynecomastia persisting greater than 12 to 24 months despite treatment for a known underlying causative medical condition (e.g., androgen deficiency, endocrine disorders, increased estrogen secretion, Klinefelter syndrome); **OR**
        ii. Idiopathic gynecomastia persisting beyond 24 months when underlying hormonal or medical causes have been excluded by appropriate laboratory testing (e.g., thyroid function studies, testosterone, beta subunit human chorionic gonadotropin (HCG), estradiol, prolactin); **OR**
        iii. Medication-induced (e.g., bicalutamide, cimetidine, human growth hormone, ketoconazole, nifedipine, spironolactone) gynecomastia that does not resolve after six months of cessation of the drug therapy.

d. Mammography or needle biopsy results show no evidence of breast cancer.
e. No evidence of other medical causes for gynecomastia, as indicated by normal results for **ALL** of the following:
    i. Hormone evaluation (i.e., testosterone, luteinizing hormone, follicle-stimulating hormone, estradiol, prolactin, beta-human chorionic gonadotropin), liver enzymes. serum creatinine, thyroid function tests.

2. In addition to the above criteria, obese patients (BMI greater than 35) must receive nutrition education for 3 or more months, as follows:
    a. Documentation of attendance of professional nutrition class such as KPMAS Nutrition for Weight Control; and
    b. Documentation and completion of two or more individual professional nutrition counseling sessions are required.

VI. Clinical Guidelines for Consultation or Referral to Plastic and Reconstructive Surgery

A. Suspected Malignancy: Patients with suspected malignancy should be immediately referred to the appropriate specialist(s) for evaluation and management.
B. Psychosocial Issues: Patients with impaired social functioning or psychological distress related to their breast size should be referred to Behavioral Health.
C. Male Gynecomastia: surgical mastectomy either unilateral or bilateral, is a cosmetic procedure and is not a covered benefit, **except** for:
    1. A male patient with a diagnosis of breast cancer
    2. Male Gynecomastia secondary to Androgen Deprivation Therapy (cover surgery or radiation). For other drug interactions causing male gynecomastia, medical therapy should be directed at correcting the cause, such as discontinuation of drugs that cause gynecomastia, and weight reduction.
    3. Patients who meet criteria in Section V, B.
D. Unilateral mammoplasty: Unilateral mammoplasty is a cosmetic procedure and is not customarily a covered benefit **except** in cases of carcinoma of the breast where reduction-unilateral mammoplasty is a mandated covered benefit for patients requesting surgery for reduction of the contralateral non affected breast.
E. Bilateral mammoplasty: Reduction mammoplasty may be evaluated for coverage as medically necessary reconstructive surgery and referral to plastic and reconstructive surgery is medically appropriate for a symptomatic patient who meets all of the following criteria:
    1. Macromastia;
    2. Post pubertal female
    3. At least 1 year postpartum and 6 months after cessation of breast feeding;
    4. Documentation of at least 2 of 7 MAJOR SIGNS/SYMPTOMS unresponsive to medical treatment and affect activities of daily living for at least 6 months: neck pain ***OR*** back pain ***OR*** shoulder pain ***OR*** upper extremity numbness ***OR*** arm pain or with grooving from bra straps ***OR*** persistent intertrigo with redness and erythema, with or without ulceration, below the breasts. ***AND***

5. Medical records indicate the presence of pain symptoms are caused by macromastia and are not secondary to primary musculoskeletal condition such as arthritis, spondylitis, degenerative arthritis of the spine, fibromyalgia, or polymyalgia rheumatica.

VII. Plastic and Reconstruction Surgery Referral for Medically Necessary Surgery

A. Plastic and Reconstructive Surgeon evaluates patient and documents:
1. Distance of nipple position below sternal notch;
2. Estimate of the amount of breast tissue to be removed; and
3. Verifies that reduction mammoplasty is likely to result in improvement in the signs and symptoms unresponsive to conservative medical treatment.

B. Coverage of bilateral breast reduction mammoplasty will be limited to medically necessary reconstructive surgery for patients who:
1. Meet criteria listed in section VI, E; *and*
2. Breast tissue estimated for removal is significantly disproportionate to the individual's body surface area and is calculated above the 22nd percentile on the Schnur Sliding Scale chart.

Table 1. Schnur Sliding Scale

Schnur Sliding Scale (Reduction Mammoplasty: Cosmetic or Reconstructive Procedure) (Annals of Plastic Surgery, Vol. 27, Number 3, September, 1991)			
Body Surface Area (m^2)	**Estimated Amt of Tissue to be Removed Each Breast (grams)**	**Body Surface Area (m^2)**	**Estimated Amt of Tissue to be Removed Each Breast (grams)**
1.35	199	1.85	482
1.40	218	1.90	527
1.45	238	1.95	575
1.50	260	2.00	628
1.55	284	2.05	687
1.60	310	2.10	750
1.65	338	2.15	819
1.70	370	2.20	895
1.75	404	2.25	978
1.80	441	>2.30	over 1000 grams

Table 2. Classification of Gynecomastia

Gynecomastia Practice Criteria based on the recommendation by American Society of Plastic Surgeons (ASPS), adapted from McKinney and Simon, Hoffman, and Kohn scales.

Gynecomastia Grading Scale	
Grade I	Small breast enlargement with localized button of tissue that is concentrated around the areola.
Grade II	Moderate breast enlargement exceeding areola boundaries with edges 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 present.
Grade IV	Marked breast enlargement with skin redundancy and feminization of the breast.

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Effective June 01, 2016, state filing is no longer required per Maryland House Bill HB 798 – Health Insurance – Reporting

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*The Regional Utilization Management Committee received delegated authority in 2011 to review and approve designated Utilization Management and Medical Coverage Policies by the Regional Quality Improvement Committee.

Note: Kaiser Permanente Mid-Atlantic States (KPMAS) include referral and authorization criteria to support primary care and specialty care practitioners, as appropriate, in caring for members with selected conditions. Whenever possible, Medical Coverage Policies are evidence-based and may also include expert opinion. Medical Coverage Policies are not intended or designed as a substitute for the reasonable exercise of independent clinical judgment by a practitioner in any particular set of circumstances for an individual member.

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