

UPMC Health Plan POLICY AND PROCEDURE MANUAL

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SUBJECT: Reduction Mammoplasty
INDEX TITLE: Medical Management
ORIGINAL DATE: June 2002

This policy applies to the following lines of business: (Check those that apply.)

Commercial:					
HMO ()		POS ()		PPO ()	
Fully Insured ()		Self-funded/ASO ()		HSA ()	
Medicare Select ()		Medicare Supplement ()			
DPW-MA:					
Health Choices ()			Voluntary ()		All (X)
CMS-MA:					
OH ()		WV ()		PA ()	All (X)
HMO ()	PPO (X)	Specialty Needs Plan (X)		Part D ()	PFFS (X)
PID-CHIP:					
Free ()			Sub ()		All (X)
APPLICABLE TO:					
Community Care ()			Work Partners ()		

I. POLICY

It is the policy of UPMC Health Plan to cover female reduction mammoplasty and mastectomy for male gynecomastia when they are medically necessary and covered under the member's benefit plan.

UPMC Health Plan recognizes Reduction Mammoplasty as appropriate and consistent with good medical practice when performed as reconstructive surgery. Reconstructive surgery is generally performed to improve function or alleviate clinical symptoms, but may also be done to approximate normal appearance. Coverage will be considered after review on an individual basis for the indications detailed in this policy.

All stages of reconstruction of the breast and procedures of the opposite breast to restore symmetry, including treatment of complications are considered medically necessary following a medically necessary mastectomy and therefore do not require prior authorization.

All denials that are based on medical necessity and appropriateness are made by a UPMC Health Plan Medical Director (Medical Director).

II. DEFINITIONS

N/A

III. PURPOSE

The purpose of this policy is to identify criteria for coverage of Reduction Mammoplasty.

IV. SCOPE

This policy applies to various UPMC Health Plan Departments as indicated by the Benefit and Reimbursement Committee. These include, but are not limited to, Medical Management, Benefit Configuration and Claims departments.

V. PROCEDURE

A. Medical Description

Gynecomastia is excessive development of the breasts in males. This usually is the result of hormonal imbalance or treatment with certain drugs (including some antihypertensives, over-the-counter medicines, illegal drugs, tumors or disease, for example genetic disorders like Klinefelters).

Macromastia is distinguished from large, normal breasts by the presence of persistent, painful symptoms and physical signs. This condition can be improved and the associated clinical signs and symptoms can be alleviated by reduction mammoplasty. This includes “virginal hypertrophy”

Reduction Mammoplasty is the surgical excision of a substantial portion of the breast, including the skin and underlying glandular tissue, until a clinically normal size is achieved.

Reduction Mammoplasty is often performed in the outpatient setting, but may require a hospital admission.

While there are some published articles concerning the use of liposuction as the sole procedure for breast reduction, none compare the outcomes of liposuction alone to standard excisional reduction mammoplasty. Due to the paucity of scientific data concerning suction mammoplasty, it is not possible to draw conclusions concerning health outcomes, particularly with respect to the impact of this procedure on mammography results.

Tanner 5 is stage 5 of the “Tanner Stages”. Tanner Stages are stages of sexual development or Sexual Maturity Ratings. These stages give physicians a way of evaluating a child’s sexual development.

Virginal Hypertrophy is a relatively rare condition leading to gigantomastia in one or both breasts in pre- pubertal females.

B. Specific Indications

Reduction Mammoplasty in the Female

Reduction Mammoplasty is considered reconstructive surgery and medically necessary for symptomatic macromastia members 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 700gms,
AND
2. The member has symptoms adversely affecting activities of daily living (ADLs) and quality of life that are directly attributable to macromastia and have not or is unlikely to respond to conservative measures.

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. Presence of symptoms that is refractory to medical treatment,
AND
2. **All** of the following medically necessary criteria are met:
 - Presence of breast pain/tenderness,
 - Breast tissue is glandular tissue (gynecomastia) and not excess fatty tissue as documented by a physical examination,
 - Contributing factors have been treated or excluded for at least 6 months,
 - Radiographic studies (ultrasound or mammogram) are negative for tumor or cyst,
 - Male is 18 years of age or older.Note: Surgery is generally not recommended until adult testicular size is attained, as there may be regrowth 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.
AND
3. At least **one** of the following criteria is met:
 - The member is not taking any prescribed medications,
 - The member is taking prescribed medications that are considered non-contributory,
 - The member is taking prescribed medication that is believed to be contributory and gynecomastia has not improved with in three (3) months of stopping the offending agent.
 - The member is taking prescribed medications that are believed to be contributory but cannot be discontinued because there is no alternative medication.

Refer to Variations section.

C. Limitations

The following are considered not medically necessary and therefore not covered:

1. Members with breasts that are not fully developed,
2. The absence of persistent signs or symptoms,

3. Female reduction mammoplasty and mastectomy for male gynecomastia performed solely for cosmetic purposes,
4. Breast Reduction by Liposuction as the sole procedure is considered investigational.

D. Information Required for Review

In order to assess medical necessity for reduction mammoplasty, adequate information must be furnished by the treating physician. Necessary information includes at least the following:

1. Age of the member,
2. A letter of medical necessity, with the physician's evaluation of the member's condition, including signs and symptoms of functional abnormalities,
3. Photographs (anterior and lateral views) of the member that clearly illustrate the need for the procedure,
4. Breast size /measurements,
5. Documentation of symptoms adversely affecting activities of daily living (ADLs) and quality of life that are directly attributable to macromastia and have not or is unlikely to respond to conservative measures.
6. A description of the proposed procedure, technique including the estimated amount of tissue to be removed from each breast.

Note: The amount of breast tissue to be removed should be at least 350 grams per breast or a total resection of 700 grams when significant asymmetry is present.

Mastectomy for Gynecomastia

In addition to the applicable information above, the following documentation should also be provided for mastectomy for gynecomastia:

1. Documentation of any attempts at conservative treatment that have proven unsuccessful, e.g., supportive measures such as garments, physical therapy, and conservative analgesia.
2. Documentation in history to include determination that macromastia is not due to an active endocrine or metabolic process.

Refer to Variations section.

E. Review Process

1. The Medical Management staff assigned to review obtains the clinical information to determine if there is adequate clinical information. If the case does not meet the established criteria, it is referred to a Medical Director.
2. If referred, the Medical Director determines if the requested service is medically necessary and appropriate.
3. The Medical Management staff completes the review process and communicates the review decision according to the Timeliness of UM Decisions policy for the member's benefit plan.

G. Variations

CHIP Product

Mastectomy for Male Gynecomastia is not covered.

H. Records Retention

Records Retention for UPMC Health Plan documents, regardless of medium are provided within the UPMC Health System Policy and as indicated in the UPMC Insurance Services Division Policy and Procedure.

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Disclaimer:

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