Mass General Brigham
Health Plan

Medical Necessity Guidelines
Breast Surgeries

Policy Number: 010

Contents

Overview

The purpose of this document is to describe the guidelines Mass General Brigham Health Plan utilizes to determine medical appropriateness for breast surgery. The treating specialist must request prior authorization for breast surgery procedures. Prior authorization is required for all breast reduction and reconstruction surgeries, implant removal, nipple repair, and gynecomastia surgery and for mastectomy/lumpectomy procedures requiring an inpatient admission.

Medicare Advantage

Prior Authorization Required	Yes ☐ No ☒
Prior Authorization Required	19301, 19302, 19340, 19369

Mass General Brigham Health Plan uses guidance from the Centers for Medicare and Medicaid Services (CMS) for medical necessity determinations for its Medicare Advantage plan members. National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), Local Coverage Articles (LCAs), and documentation included in the Medicare manuals are the basis for medical necessity determinations. When there is no guidance from CMS for the requested service, Mass General Brigham Health Plan's medical policies are used for medical necessity determinations. **At the time of Mass General Brigham Health Plan's most recent policy review, the following NCDs and LCDs describe criteria for breast surgeries:**

- **NCD - Breast Reconstruction Following Mastectomy (140.2)**
- **LCD - Reduction Mammaplasty (L35001)**
- **LCD - Cosmetic and Reconstructive Surgery (L39506)**
- **LCD - Cosmetic and Reconstructive Surgery (L38914)**
- **LCD - Cosmetic and Reconstructive Surgery (L35090)**
- **LCD - Cosmetic and Reconstructive Surgery (L33428)**
- **LCD - Cosmetic and Reconstructive Surgery (L39051)**
- **LCD - Plastic Surgery (L35163)**
- **LCD - Plastic Surgery (L37020)**

Mass General Brigham ACO

Prior Authorization Required	Yes ☒ No ☐
Prior Authorization not Required	19340, 19370
Not covered	11922, 19355

Mass General Brigham Health Plan uses guidance from MassHealth for medical necessity determinations for its Mass General Brigham ACO members. When there is no guidance from MassHealth for the requested service, Mass General Brigham Health Plan's medical policies are used for medical necessity determinations. **At the time of Mass General Brigham Health Plan's most recent policy review, MassHealth has medical necessity guidelines on the following:**

- **Breast Reconstruction and Breast Implant Removal**
- **Mastectomy for Gynecomastia**
- **Reduction Mammoplasty**

One Care and Senior Care Options (SCO)

Prior Authorization Required	Yes ☐ No ☒
Prior Authorization Required	19301, 19302, 19340, 19369

Mass General Brigham Health Plan uses guidance from CMS for medical necessity determinations for its One Care and SCO plan members. NCDs, LCDs, LCAs, and documentation included in the Medicare manuals are the basis for medical necessity determinations. When there is no guidance from CMS for the requested service, or

the member does not meet all of the medical necessity criteria for the requested service, Mass General Brigham Health Plan uses medical necessity guidelines from MassHealth. **See Medicare Advantage criteria and exclusions above. If Medicare Advantage criteria are not met, then MassHealth criteria are applied.**

Commercial and Qualified Health Plans

Prior Authorization Required	Yes ☒ No ☐
Prior Authorization not Required	19340, 19370

Breast Reconstruction Surgery

Mass General Brigham Health Plan covers breast reconstruction, augmentation, reduction, implant removal, and gynecomastia surgery when it is recommended by the member's primary care physician or referring surgeon, the requested procedure can reasonably be expected to resolve the medical condition or complication and functional impairment, and the request meets medical necessity criteria indicated below. Mass General Brigham Health Plan reserves the right to deny coverage for any breast surgery procedures that:

1. Do not meet coverage criteria;
2. Are not in accordance with the Women's Health and Cancer Rights Act of 1998 (WHCRA);
3. Are considered cosmetic, performed primarily to improve a person's appearance, and not medically necessary.

Breast Reconstruction Related to Breast Cancer Treatment

Mass General Brigham Health Plan covers mastectomy/lumpectomy for cancer and for cancer-related prophylaxis in accordance with the benefits described in the individual benefit handbook or coverage of benefits when the attending physician determines that mastectomy is medically necessary. This includes prophylactic mastectomy for BRCA carriage or another well-defined genetic predisposition to breast cancer.

Mass General Brigham Health Plan covers breast reconstruction in accordance with the WHCRA. Mass General Brigham Health Plan provides coverage for:

- Reconstruction of the breast on which a mastectomy/lumpectomy has been performed;
- Surgery and reconstruction of the other breast to produce symmetrical appearance;
- Prosthesis and treatment of physical complications at all stages of a mastectomy/lumpectomy, including lymphedema; and
- Tattooing of an areola as part of a nipple reconstruction following mastectomy/lumpectomy.

Breast Reconstruction Related to Gender Affirming Procedures

Mass General Brigham Health Plan covers medically necessary mastectomy or breast augmentation mammoplasty for gender incongruence (dysphoria) when a member meets relevant medical necessity criteria for coverage under the Gender Affirming Procedures medical policy.

Breast Reconstruction Related to Other Medical Conditions

Photo documentation is required.

Mass General Brigham Health Plan covers medically necessary breast reconstruction surgery including but not limited to augmentation, reduction mammoplasty, and mastopexy in the following instances:

1. For treatment of a member with:

a. Severe disfigurement due to congenital chest wall deformities causing functional impairments such as in Poland syndrome or Amazia (absence of breast tissue when the nipple is present); OR

b. Repair of severe breast asymmetry due to accidental injury, burns, and trauma.

Reduction Mammoplasty, Female Members

Medical necessity for reduction mammoplasty in female members is determined through InterQual® criteria, which Mass General Brigham Health Plan has customized to include requiring photo documentation, a question about the member's age, mammogram requirements for members aged 50 or older, and adding the exclusions. To access the criteria, log into Mass General Brigham Health Plan's provider website at MassGeneralBrighamHealthPlan.org and click the InterQual® Criteria Lookup link under the Resources Menu.

Mass General Brigham Health Plan considers members less than 18 years of age eligible for reduction mammoplasty when they have reached full physical maturity i.e., tanner stage V, typically age 15 and older and when all other InterQual® criteria are met.

Mammogram Requirements

Only women fifty years or older must have a negative mammogram for cancer performed within two years prior to the date of the planned surgery. This must be evidenced by one of the following:

i. Copy of the mammogram report; or

ii. Verbal or written confirmation from a MD/RN/PA in the surgeon's or PCP's office; or

iii. Verbal report from office support staff following instructions from MD/RN/PA (one of whom has reviewed the report).

Note: Coverage for reduction mammoplasty is limited to one procedure per member per lifetime.

Breast Implant Removal

Medical necessity for breast implant removal is determined through InterQual® criteria, which Mass General Brigham Health Plan has customized to require photo documentation. To access the criteria, log into Mass General Brigham Health Plan's provider website at MassGeneralBrighamHealthPlan.org and click the InterQual® Criteria Lookup link under the Resources Menu.

Nipple Surgery/Repair

Mass General Brigham Health Plan covers medically necessary nipple surgery/repair when there is medical record documentation supporting the following:

1. An inverted nipple is causing a demonstrated inability to breast feed and the requested procedure can reasonably be expected to restore this lost functionality; or

2. Nipple inversion causing chronic bleeding, discharge, scabbing or infection; or

3. Other nipple procedures are authorized when they are medically necessary part of a Mass General Brigham Health Plan authorized breast reconstruction procedure which may include nipple tattooing.

Reduction Mammoplasty, Male (Gynecomastia Surgery)

Medical necessity for reduction mammoplasty in male members is determined through InterQual® criteria, which Mass General Brigham Health Plan has customized to include requiring photo documentation and adding exclusions. To access the criteria, log into Mass General Brigham Health Plan's provider website at MassGeneralBrighamHealthPlan.org and click the InterQual® Criteria Lookup link under the Resources Menu.

Exclusions

Mass General Brigham Health Plan does not provide coverage for breast surgery for conditions that do not meet the criteria noted, including but not limited to:

1. Breast surgeries or procedures performed solely to enhance a member's appearance or to counteract appearance that occurs through the natural aging process, in the absence of any signs or symptoms of functional abnormalities and/or associated medical complication is considered cosmetic and is not a covered benefit, unless specifically noted in the coverage criteria.
2. Breast surgeries or procedures performed primarily for psychological or emotional reasons.
3. Mastopexy for breast reconstruction unless it is for cancer-related mastectomy/lumpectomy or severe deformity due to Poland's syndrome/breast trauma, or for gender affirming procedures.
4. Replacement of an implant that has been removed for medical necessity that had been originally placed for cosmetic purposes is not a covered benefit.
5. Surgical treatment for gynecomastia is not considered medically necessary for any of the following reasons:
    a. There is laboratory drug screen evidence of illicit substance use that can cause gynecomastia (e.g. marijuana, heroin, amphetamines); or
    b. There is a history of alcohol use disorder; or
    c. There is a history of the use of supplements/herbal products/hormones that can cause gynecomastia, and which have not been prescribed by a licensed clinician to treat a medical condition; or
    d. Treatment of pseudogynecomastia (breast enlargement secondary to fatty tissue).
6. Breast surgeries not specifically noted as covered procedures in this medical policy or in the Gender Affirming Procedures Policy.
7. Subsequent breast surgeries that are not part of an approved staged reconstruction plan and are intended for the sole purpose of cosmetic enhancement.

Definitions

Capsular contracture- Baker Scale:

- Grade I — the breast is normally soft and appears natural in size and shape
- Grade II — the breast is a little firm, but appears normal
- Grade III — the breast is firm and appears abnormal
- Grade IV — the breast is hard, painful to the touch, and appears abnormal

Gynecomastia**:** Abnormal proliferation of breast tissue in males.

Gynecomastia Scale adapted from the McKinney and Simon, Hoffman and Kohn scales

- 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 IIA Moderate breast enlargement exceeding areola boundaries with edges that are indistinct from the chest without skin redundancy

- Grade IIB Moderate breast enlargement exceeding areola boundaries with edges that are indistinct from the chest with skin redundancy

- 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

Breast Reduction Table: Based on a table adapted from a study by Schnur (1991).

Relevant Regulations

Women's Health and Cancer Rights Act of 1998

Sec. 713. Required Coverage for Reconstructive Surgery Following Mastectomies.

(a) In General - A group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan, that provides medical and surgical benefits with respect to a mastectomy shall provide, in a case of a participant or beneficiary who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with such mastectomy, coverage for:
   - All stages of reconstruction of the breast on which the mastectomy has been performed;
   - Surgery and reconstruction of the other breast to produce a symmetrical appearance;
   - Prostheses and physical complications of all stages of mastectomy, including lymphedemas; in a manner determined in consultation with the attending physician and the patient. Such coverage may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and as are consistent with those established for other benefits under the plan or coverage. Written notice of the availability of such coverage shall be delivered to the participant upon enrollment and annually thereafter.

(b) **Notice** - A group health plan and a health insurance issuer providing health insurance coverage in connection with a group health plan shall provide notice to each participant and beneficiary under such plan regarding the coverage required by this section in accordance 1078 with regulations promulgated by the Secretary. Such notice shall be in writing and prominently positioned in any literature or correspondence made available or distributed by the plan or issuer and shall be transmitted:
   - In the next mailing made by the plan or issuer to the participant or beneficiary;
   - As part of any yearly informational packet sent to the participant or beneficiary; or
   - Not later than January 1, 1999; whichever is earlier.

(c) **Prohibitions** - A group health plan, and a health insurance issuer offering group health insurance coverage in connection with a group health plan, may not:
   - Deny to a patient eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the plan, solely for the purpose of avoiding the requirements of this section; and
   - Penalize or otherwise reduce or limit the reimbursement of an attending provider or provide incentives (monetary or otherwise) to an attending provider, to induce such provider to provide care to an individual participant or beneficiary in a manner inconsistent with this section. 1079

(d) **Rule of Construction** - Nothing in this section shall be construed to prevent a group health plan or a health insurance issuer offering group health insurance coverage from negotiating the level and type of reimbursement with a provider for care provided in accordance with this section.

Related Policies

- Reconstructive and Cosmetic Procedures
- Gender Affirming Procedures
- Dermatology Provider Payment Policy Guideline

Codes

The following codes are included below for informational purposes only; inclusion of a code does not constitute or imply coverage or reimbursement.

Authorized Code	Code Description
11920	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.0 sq cm or less
11921	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.1 to 20.0 sq cm
11922	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; each additional 20.0 sq cm, or part thereof (List separately in addition to code for primary procedure)
11970	Replacement of tissue expander with permanent implant
11971	Removal of tissue expander without insertion of implant
15771	Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, and/or legs; 50 cc or less injectate
15772	Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, and/or legs; each additional 50 cc injectate, or part thereof (List separately in addition to code for primary procedure)
19300	Mastectomy for gynecomastia
19301	Mastectomy partial
19302	Mastectomy partial w/axillary lymphadenectomy
19316	Mastopexy
19318	Breast reduction
19325	Breast augmentation with implant
19328	Removal of intact breast implant
19330	Removal of ruptured breast implant, including implant contents (eg, saline, silicone gel)
19342	Insertion or replacement of breast implant on separate day from mastectomy
19350	Nipple/areola reconstruction
19355	Correction of inverted nipples
19357	Tissue expander placement in breast reconstruction, including subsequent expansion(s)
19361	Breast reconstruction; with latissimus dorsi flap
19364	Breast reconstruction; with free flap (eg, fTRAM, DIEP, SIEA, GAP flap)
19367	Breast reconstruction; with single-pedicled transverse rectus abdominis myocutaneous (TRAM) flap
19368	Breast reconstruction; with single-pedicled transverse rectus abdominis myocutaneous (TRAM) flap, requiring separate microvascular anastomosis (supercharging)

19369	Breast reconstruction; with bipedicled transverse rectus abdominis myocutaneous (TRAM) flap
19370	Revision of peri-implant capsule, breast, including capsulotomy, capsulorrhaphy, and/or partial capsulectomy
19371	Peri-implant capsulectomy, breast, complete, including removal of all intracapsular contents
19380	Revision of reconstructed breast (eg, significant removal of tissue, re-advancement and/or re-inset of flaps in autologous reconstruction or significant capsular revision combined with soft tissue excision in implant-based reconstruction)
19396	Preparation of moulage for custom breast implant

Effective Dates

July 2026: Ad hoc review. Reformatted policy. Updated breast implant removal section to reference customized subset, which has been reinstated. Updated code list.
March 2026: Annual review. Renamed "MassHealth Variation" as "Mass General Brigham ACO Variation". Updated Breast Implant Removal section to reference InterQual® subset and deleted relevant exclusions. Sunset customized Breast Implant Removal IQ subset. Updated code list.
.January 2026: Ad hoc review. Updated prior authorization table and added variation for OneCare and SCO members. Updated hyperlinks to NCDs and LCDs.
May 2025: Ad hoc review. Added NCD and LCDs and updated references.
April 2025: Ad hoc review. Added exclusion.
January 2025: Annual review. Clarified InterQual® customizations under Reduction Mammoplasty, Female Members and Reduction Mammoplasty, Male Members. Simplified description of Breast Implant Removal InterQual® customization.
November 2024: Ad hoc review. Customized InterQual® criteria added under Breast Implant Removal.
October 2024: Ad hoc review. MassHealth Variation added.
January 2024: Annual review. Medicare Advantage added to table. Medicare Variation added. Codes updated. References updated.
January 2023: Annual review. The following changes were made:

- Under Coverage Guidelines; added clarifying statement about following MassHealth medical necessity criteria.
- Under Breast Reconstruction Surgery; added coverage language to include nipple surgery/repair, and mastopexy.
- Under Gender Affirming Procedures; added mastopexy. Added term "incongruence" to align with WPATH.
- Under Breast Reconstruction Related to Other Medical Conditions; added amazia as additional medical condition.
- Edited Nipple Repair subheading to include surgery. Added #2 under subheading.
- Clarified exclusion #3 to include Gender Affirming Procedure.
- References updated.

January 2022: Annual review.
December 2020: Ad hoc review. Updated Table on Page 1 to add prior authorization language for certain Mastectomy criteria. Revised Coverage Guidelines criteria to create separate subheadings and criteria for Reconstruction Surgery, Breast Reconstruction Related to Breast Cancer Treatment, Breast Reconstruction Related to Gender Affirming Procedures, and Breast Reconstruction Related to Other Medical Conditions. Under Exclusions, revised "Mastopexy for breast reconstruction unless it is for cancer related mastectomy/lumpectomy" to state "Mastopexy for breast reconstruction unless it is for cancer-related

mastectomy/lumpectomy or severe deformity due to Poland's Syndrome or Breast Trauma". Under Definitions section, removed Cup Size.
January 2020: Annual review. Updated references.
January 2019: Annual review.
April 2018: Ad hoc review. Added codes.
December 2017: Annual review.
May 2017: Ad hoc review. Added "photo documentation is required" to subheads Reduction Mammoplasty, Female Members, and to Reduction Mammoplasty, Male (Gynecomastia Surgery).
February 2017: Ad hoc review. Changes reflect the addition of InterQual® breast reconstruction surgeries, breast implant removal, reduction mammoplasty (male), reduction mammoplasty (female), and mastectomy criteria.
September 2016: Annual review.
September 2015: Annual review. Coverage for ruptured saline implant removal and replacement when placed for certain medical conditions, clarity regarding overlap and consistency with Gender Reassignment Surgery Medical Policy added
September 2014: Annual review. New medically necessary indicators added.
May 2013: Annual review. Added physical maturity to breast reduction criteria; added breast implant removal & surgery for gynecomastia criteria.
June 2012: Annual review. No changes.
May 2011: Annual review.
April 2010: Annual review.
April 2009: Annual review.
April 2008: Annual review.
April 2007: Annual review.
May 2006: Annual review.
May 2005: Effective date.

References

American Society of Plastic Surgeons (ASPS), Recommended Insurance Coverage Criteria for Third-Party Payers: Reduction Mammaplasty. 2011; reaffirmed 2021. Accessed 3/13/25 at http://www.plasticsurgery.org/Medical_Professionals/Health_Policy_and_Advocacy/Health_Policy_Resources/Recommended_Insurance_Coverage_Criteria.html 2018.

American Society of Plastic Surgeons. Reduction Mammaplasty. Practice Parameters. March 9, 2002b. Available at URL address: http://www.plasticsurgery.org.

American Society of Plastic Surgeons. Consumer's Guide to Breast Reduction Breast Reduction Assessment of Value and Outcomes (BRAVO) Study. Accessed April 2008. Available at URL address: http://www.plasticsurgery.org/public_education/BRAVO-Guide-to-Breast-Reduction.cfm

Ansstas G. Gynecomastia Treatment & Management: Approach Considerations, Pharmacologic Therapy, Breast Surgery. Emedicine.medscape.com. https://emedicine.medscape.com/article/120858-treatment. Published 2018. Accessed November 27, 2019

Division of Medical Assistance Guidelines for Medical Necessity Determination for Breast Reconstruction and intact breast implant removal, March 3, 2018.

Division of Medical Assistance Guidelines for Medical Necessity Determination for Reduction Mammoplasty, July 7, 2019.

Division of Medical Assistance Guidelines for Medical Necessity Determination for Mastectomy for Gynecomastia, February 22, 2012, retrieved 1/12

Schnur PL, Schnur DP, Petty PM, Hanson TJ, Weaver Al. Reduction mammoplasty: an outcome study. Plast Reconstr Surg. 1997 Sep;100(4):875-83.

Schnur, Paul L, et al., "Reduction Mammaplasty: Cosmetic or Reconstructive Procedure?" Annals of Plastic Surgery. Sept 1991; 27 (3): 232-7.

Chadbourne EB, Ahang S, Gordon MJ, et al. Clinical outcomes in reduction mammaplasty: a systematic review and met analysis of published studies. *Mayo Clinic Proceedings* 76:m503-510, 2001.

Kerrigan CL, Collins ED, Kim HM, et al. Reduction mammaplasty: Defining medical necessity. Medical Decision Making. Vol. 22(3) (pp 208-217), 2002.

Krieger LM, Lesavoy MA. Managed Care's Methods for Determining Coverage of Plastic Surgery Procedures: The Example of Reduction Mammaplasty. Plastic Reconstructive Surgery 2000; 107: 1234-1240.

Nguyen J, Wheatley M, Schnur P, Nguyen T, Winn S. Reduction mammaplasty: A review of managed care medical policy coverage criteria. Plastic and Reconstructive Surgery Vol 121 (4) PP 1092-1100, 2008.

Hayes. Health Technology Assessment. Autologous Fat Grafting for Breast Reconstruction After Breast Cancer Surgery. Dallas, TX: Hayes; Annual Review 2020 Oct 21.

Hayes, Reduction Mammoplasty for breast Hypertrophy. Literature search of Medline and Embase completed February 7, 2007. Accessed 2018.

Hayes, Reduction Mammoplasty. Literature search of Medline and Embase completed December 8, 2008. Accessed 2018.

Hayes, Reduction Mammoplasty for Macromastia in Adolescents. November 26, 2012.

Holzmer SW, Lewis PG, Landau MJ, Hill ME. Surgical Management of Gynecomastia: A Comprehensive Review of the Literature. Plast Reconstr Surg Glob Open. 2020 Oct 29;8(10):e3161. doi: 10.1097/GOX.0000000000003161. PMID: 33173677; PMCID: PMC7647635.

National Government Services. Local Coverage Determination (LCD): Reduction Mammaplasty (L35001). Revision Effective Date: 11/07/2019. Available: Medical Policies - NGSMEDICARE

Qutob O, Elahi B, Garimella V, Ihsan N, Drew PJ. Minimally invasive excision of gynaecomastia- a novel and effective surgical technique. Ann R Coll Surg Engl. 2010 April 92 (3):198-200.

Sollie M. Management of gynecomastia-changes in psychological aspects after surgery-a systematic review. Gland Surg. 2018;7(Suppl 1):S70-S76.

U.S. Food and Drug Administration (FDA). Medical Devices. Breast Implants. 2019 Apr 2. Accessed at: https://www.fda.gov/MedicalDevices/ProductsandMedicalProcedures/ImplantsandProsthetics/BreastImplants/default.htm.

U.S. Food and Drug Administration (FDA). Medical Devices. Risk of Breast Implants. 2019 Mar 22. Accessed at: https://www.fda.gov/medicaldevices/productsandmedicalprocedures/implantsandprosthetics/breastimplants/ucm064106.htm.