Clinical Policy: Breast Surgeries

Reference Number: NC.CP.MP.501
Date of Last Revision: 02/2026

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

This policy describes the medical necessity requirements for breast surgeries including mastectomy/breast conserving surgery, male gynecomastia, prophylactic mastectomy, reduction mammoplasty and breast reconstructive surgery. Mastectomy or breast conserving surgery is covered based on the policy criteria outlined below.

Policy/Criteria

I. It is the policy of Carolina Complete Health that mastectomy for ***male gynecomastia*** is medically necessary when the following criteria are met:

A. **One** of the following:
   1. An adult member has a history of gynecomastia that persists for more than three (3) months after pathological causes are ruled out; **OR**
   2. An adolescent's gynecomastia persists more than six (6) months after pathological causes are ruled out;

B. The excessive tissue is glandular and not fatty tissue as confirmed by clinical exam, **AND** either ultrasound or mammogram;

C. Other causes of gynecomastia such as obesity, adolescence, and drug treatments (gynecomastia resolves with the discontinuation of the medication) have been ruled out;

D. The excessive breast tissue development is not caused by medications, non-covered therapies, alcohol, or use of illicit drugs such as marijuana or anabolic steroids, etc. (gynecomastia resolves with the discontinuation of the illicit drug usage);

E. The member's body mass index (BMI) is less than or equal to than 30 (http://www.halls.md/ideal-weight/body.htm) **OR** has participated in a clinically supervised weight loss and exercise program for more than 6 consecutive months;

F. The member has a documented history of significant medical symptoms due to the gynecomastia that are not resolved by conservative treatments.

G. The following medical documentation has been submitted:
   1. Height (in inches), weight (in pounds), and age;
   2. Unclothed pre-operative photographs from the chin to the waist (or lowest extent of breasts, if lower), including standing frontal and side views with arms straight down at the sides;
   3. Medical record documentation of objective signs and symptoms and their duration; prior medical management, including the member's current medications; endocrine study results; and confirmation that the excessive tissue is glandular;
   4. A list of subjective symptoms caused by breast enlargement with supporting medical record documentation of significant medical symptoms;

5. Evidence of exclusion of other medical problems that may cause or contribute to the significant medical symptoms as documented in the medical record; **and**
6. Medical record documentation by the requesting surgeon that the excessive breast tissue is not caused by medications, non-covered therapies, alcohol, or usage of illicit drugs such as marijuana or anabolic steroids.

NOTE for I.D*: Exception can be made for gynecomastia caused by psychotropic medication which the prescribing physician has documented cannot be discontinued.*

II. It is the policy of Carolina Complete Health that ***prophylactic mastectomy*** is medically necessary when **all** of the following apply:

A. **One** of the following:
   1. **One** of the following applies:
      a. Breast biopsy indicates that the member is at high risk for breast cancer, that is, has atypical hyperplasia or lobular carcinoma-in-situ (LCIS), which may also be an indication for bilateral mastectomy;
      b. Personal history of breast cancer (invasive ductal, invasive lobular, or ductal carcinoma-in-situ) in the contralateral breast;
      c. Personal positive BRCA1or BRCA2 genetic testing;
      d. Personal history of contralateral breast cancer in a pre-menopausal woman
   2. **Two or more** of the following apply:
      a. Family history strongly suggestive of an autosomal dominant pattern of inheritance of a genetic mutation predisposing to breast cancer and/or ovarian cancer;
      b. Immediate family history of breast cancer (mother, sister, daughter, brother, father);
      c. Personal history of ovarian cancer or history of a first-degree relative with ovarian cancer;
      d. Severe benign disease (such as fibrocystic disease or post-traumatic fat necrosis) that interferes with the ability to read mammograms as documented by a radiologist or extensive mammographic abnormalities (such as calcifications) that adequate biopsy or excision is impossible.

B. The following documentation has been submitted:
   1. History and physical;
   2. Diagnoses;
   3. Medical records to demonstrate the above criteria is met;
   4. Plan of treatment, containing any planned reconstruction

III. It is the policy of Carolina Complete Health that ***unilateral reduction mammoplasty*** is covered in cases of congenital absence or loss of significant female breast tissue of the contralateral breast subsequent to trauma or medically necessary (cancer or high cancer risk) mastectomy.

IV. It is the policy of Carolina Complete Health that ***reduction mammoplasty*** is **medically necessary** when the criteria in A **OR** B below are met:

A. ***Macromastia or gigantomastia,*** **all** of the following*:*
   1. Member is ≥18 years of age OR

2. Member is <18 years of age and both of the following:
   a. Tanner stage V of Tanner staging of sexual maturity (See Appendix A for Tanner Staging).
   b. No breast growth equivalent to a change in cup size for at least 6 months; AND
3. The estimated amount of breast tissue to be removed meets the minimum weight requirement based on the member's body surface area (BSA) per Appendix B listed below, adapted from the Schnur Sliding Scale (see note below).
4. Member has **at least two** (2) of the following symptoms, affecting activities of daily living:
   a. Headaches associated with neck and upper back pain;
   b. Pain in neck, shoulders, arm or upper back not related to other causes (e.g., poor posture, acute strains, poor lifting techniques);
   c. Breast pain from excessive breast tissue not related to other causes;
   d. Painful kyphosis documented by X-rays;
   e. Pain/discomfort/ulceration/grooving from bra straps cutting into shoulders;
   f. Paresthesia of upper extremities due to brachial plexus compression syndrome;
   g. Intertrigo of the inframammary folds;
   h. Significant discomfort resulting in severe restriction of physical activities.
5. Physician evaluation has determined **ALL** of the following:
   a. Pain is unresponsive to conservative treatment as evidenced by physician documentation of therapeutic measures including at least **two** of the following:
      a. Analgesic/non-steroidal anti-inflammatory drugs (NSAIDs);
      b. Physical therapy/exercise when skeletal pathology is present;
      c. Supportive devices (e.g., proper bra support, wide bra straps);
      d. Medically supervised weight loss program;
      e. Chiropractic care or osteopathic manipulative treatment;
      f. Orthopedic or spine surgeon evaluation of spinal pain;
   b. Symptoms are not associated with another diagnosis, (e.g., arthritis);
   c. One of the following:
      a. ≥ 40 years of age and mammogram negative for cancer performed within the year prior to the date of the planned reduction mammoplasty procedure.
      b. < 40 years of age with symptoms of breast cancer or high-risk factors for breast cancer and mammogram negative for cancer performed within the year prior to the date of the planned reduction mammoplasty procedure;
      c. < 40 years of age with no symptoms of breast cancer and no high-risk factors for breast cancer;

B. ***Gigantomastia of Pregnancy***

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

1. Massive infection;
2. Significant hemorrhage;
3. Tissue necrosis with slough;
4. Ulceration of breast tissue.
5. Intertriginous maceration or infection of the inframammary skin refractory to dermatologic measures.

Note: *The DuBois and DuBois body surface calculator (found here: http://www-users.med.cornell.edu/~spon/picu/calc/bsacalc.htm) may be used to calculate BSA if only height and weight are given; If the weight of resected tissue falls below the 22nd percentile of weight to be removed per BSA (the minimum cutoff in the Schnur Sliding Scale in Appendix B), a medical director will review the request on a case-by-case basis;*

V. It is the policy of Carolina Complete Health that ***breast reconstructive surgery of the affected breast*** is reasonable and medically necessary when documentation (including photographs) confirms severe disfigurement resulting from surgical complications, trauma, disease, or Poland Syndrome. Reduction, mastopexy, and/or augmentation of the contralateral breast as reasonable and medically necessary when documentation demonstrates that procedure is necessary for the repair of breast asymmetry caused by mastectomy or medically necessary lumpectomy in association with the primary mastectomy procedure for the following conditions:

A. Member requires reconstruction due to **one** of the following:
   1. Malignant neoplasm of the breast;
   2. Secondary malignant neoplasm of the breast;
   3. Carcinoma in situ of the breast, either lobular or ductal; or
   4. Congenital absence of the breast (Poland's syndrome).
   5. Prophylactic mastectomy when the applicable criteria are met.

B. If required, breast implants, including tissue expanders and implant materials, are covered when surgically placed in the area where the natural breast tissue has been removed for a medically necessary mastectomy or to achieve symmetry after medically necessary breast surgery.

C. Nipple reconstruction and/or tattooing are also covered when criteria in V.A. above are met.

D. If needed, periprosthetic capsulotomy or capsulotomy procedures are covered for contractions or adhesions following reconstruction surgery when the contractions or adhesions are caused by medically necessary chemotherapy or radiation treatments for breast cancer.

VI. It is the policy of Carolina Complete Health that the breast surgeries listed below are **not covered**:

A. Breast implants when used for breast enlargement for cosmetic purposes;
B. Removal of mammary implants or mammary implant material for cosmetic purposes;
C. Augmentation mammaplasty with or without prosthesis for cosmetic purposes;
D. Correction of inverted nipples;
E. Preparation of moulage for custom breast implants;
F. Periprosthetic capsulotomy and periprosthetic capsulectomy procedures following augmentation;
G. Breast reduction except when the medical necessity criteria are met;
H. Mastopexy except when the medical necessity criteria are met.

Coding Implications

This clinical policy references Current Procedural Terminology (CPT). CPT is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2021, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT CODE	Description
19300	Mastectomy for gynecomastia
19301	Mastectomy, partial (e.g., lumpectomy, tylectomy, quadrantectomy, segmentectomy)
19302	Mastectomy, partial (e.g., lumpectomy, tylectomy, quadrantectomy, segmentectomy); with axillary lymphadenectomy
19303	Mastectomy, simple, complete
19305	Mastectomy, radical, including pectoral muscles, axillary lymph nodes
19306	Mastectomy, radical, including pectoral muscles, axillary and internal mammary lymph nodes (Urban type operation)
19307	Mastectomy, modified radical, including axillary lymph nodes, with or without pectoralis minor muscle, but excluding pectoralis major muscle
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 (e.g., saline, silicone gel)
19340	Insertion of breast implant on same day of mastectomy (i.e., immediate)
19342	Insertion or replacement of breast implant on separate day from mastectomy
19350	Nipple/areola reconstruction
19357	Tissue expander placement in breast reconstruction, including subsequent expansion(s)
19361	Breast reconstruction; with latissimus dorsi flap
19364	Breast reconstruction; with free flap (e.g., fTRAM, DIEP, SIEA, GAP flap)
19367	Breast reconstruction; with single-pedicled transverse rectus abdominis myo cutaneous (TRAM) flap
19368	Breast reconstruction; with single-pedicled transverse rectus abdominis myo cutaneous (TRAM) flap, requiring separate microvascular anastomosis (supercharging)
19369	Breast reconstruction; with bipedicled transverse rectus abdominis myo cutaneous (TRAM) flap
19370	Revision of peri-implant capsule, breast, including capsulotomy, capsulorrhaphy, and/or partial capsulectomy

CPT CODE	Description
19371	Peri-implant capsulectomy, breast, complete, including removal of all intracapsular contents
19380	Revision of reconstructed breast (e.g., 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)
11920	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.0 sq cm or less

Appendices

Appendix A

- Criteria for distinguishing Tanner stages 1 to 5 in those with a female reproductive system[10]:

Tanner Stage	Breast	Pubic Hair
1 (Prepubertal)	No palpable glandular tissue or pigmentation of areola; elevation of areola only	No pubic hair; short, fine villus hair only
2	Glandular tissue palpable with elevation of breast and areola together as a small mound; areola diameter increased	Sparse, long pigmented terminal hair chiefly along the labia majora
3	Further enlargement without separation of breast and areola; although more darkly pigmented, areola still pale and immature; nipple generally at or above mid-plane of breast tissue when individual is seated upright	Dark, coarse, curly hair, extending sparsely over mons
4	Secondary mound of areola and papilla above breast	Adult-type hair, abundant but limited to mons and labia
5 (Adult)	Recession of areola to contour of breast; development of Montgomery's glands and ducts on the areola; further pigmentation of areola; nipple generally below mid-plane of breast tissue when individual is seated upright; maturation independent of breast size	Adult-type hair in quantity and distribution; spread to inner aspects of the thighs in most racial groups

Appendix B

- Adapted from Schnur Sliding Scale – body surface area and estimated minimum cutoff weight for breast tissue per breast to be removed[13]:

Body Surface Area (m^2)	Weight of tissue to be removed per breast (grams)	Body Surface Area (m^2)	Weight of tissue to be removed per breast (grams)
1.35	199	1.40	218

Body Surface Area (m^2)	Weight of tissue to be removed per breast (grams)
1.45	238
1.50	260
1.55	284
1.60	310
1.65	338
1.70	370
1.75	404
1.80	441
1.85	482

Body Surface Area (m^2)	Weight of tissue to be removed per breast (grams)
1.90	527
1.95	575
2.00	628
2.05	687
2.15	819
2.20	895
2.25	978
≥ 2.30	1000

Reviews, Revisions, and Approvals	Revision Date	Approval Date
Carolina Complete Health policy developed to address coverage for reduction mammoplasty and updates to gynecomastia.	02/26	02/26

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Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved.

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