MEDICAL POLICY STATEMENT

Original Effective Date	Next Annual Review Date	Last Review / Revision Date
06/01/2009	02/01/2017	02/11/2016

Policy Name	Policy Number
Mastectomy for Gynecomastia	MM-0002

Policy Type		
☒ Medical	☐ Administrative	☐ Payment

Medical Policy Statements prepared by CSMG Co. and its affiliates (including CareSource) are derived from literature based on and supported by clinical guidelines, nationally recognized utilization and technology assessment guidelines, other medical management industry standards, and published MCO clinical policy guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any Evidence of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

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A. SUBJECT

Mastectomy for Gynecomastia

B. BACKGROUND

Gynecomastia is the benign proliferation, either unilateral or bilateral, of glandular tissue of the breast in males. This develops most often in the setting of altered estrogen/androgen balance or increased sensitivity of breast tissue to estrogen.

Causes may include among others) androgen deficiency states (e.g. treatments for prostate carcinoma), congenital disorders (e.g. Kleinfelter's Syndrome (47XXY)), medications (estrogen replacement therapy, calcium channel blockers, cimetidine, phenothiazines, spironolactone, theophylline, HAART for HIV/AIDS), chronic medical conditions (e.g. cirrhosis, chronic kidney disease), tumors (e.g. adrenal or testicular) or endocrine disorders (e.g., hyperthyroidism).

As a result of this hormonal imbalance medical therapy may be offered in the treatment of gynecomastia (i.e. anti-estrogens, androgens, or aromatase inhibitors). Gynecomastia should not be confused with pseudo-gynecomastia which is usually transient and resolves in 6-24 months.

C. DEFINITIONS

- **Persistent pubertal gynecomastia**: The persistence of breast enlargement following the end of puberty and occasionally lasting into adulthood.
- **Pseudo-gynecomastia:** Enlargement of the breast due to fat deposition (without glandular involvement), typically occurring in the setting of obesity.
- **Pubertal gynecomastia:** A benign process occurring most commonly between the ages of 10 to 13 typically followed by regression in most cases.

D. POLICY

Medical Necessity Criteria:

I. Mastectomy for Gynecomastia is considered medically necessary when **1 OR MORE** of the following criteria are met:

A. Postpubertal male and **ALL** of the following criteria are met:

1. Gynecomastia has been present for **12 months or greater**
2. Gynecomastia has not regressed after cessation of medications (see above) *for a minimum of six months* (i.e.) which are known to cause this condition, or medications cannot be discontinued for patient benefit
3. Mammography or needle biopsy results reflect no evidence of breast cancer
4. There is no evidence of other medical causes for gynecomastia, as indicated by normal results for **ALL** of the following tests:
   - 4.1 Hormone evaluation (i.e. testosterone, luteinizing hormone, follicle-stimulating hormone, estradiol, prolactin, beta-human chorionic gonadotropin)
   - 4.2 Liver enzymes
   - 4.3 Serum creatinine
   - 4.4 Thyroid function tests
   - 4.5 Functional impairment is documented (i.e. chronic skin irritation, pain, paresthesias)

B. Pubertal male and **ALL** of the following:

1. Functional impairment (i.e. chronic skin irritation, pain, paresthesias, related psychological disorder requiring therapy
2. Gynecomastia present for **2 OR MORE years**
3. Preoperative photographs are provided

C. Mastectomy for Gynecomastia is considered **NOT MEDICALLY NECESSARY** under the following circumstances:

1. If the above listed criteria are not met.
2. Breast enlargement resulting from obesity.

Liposuction: to perform mastectomy for Gynecomastia is considered investigational and **NOT MEDICALLY NECESSARY**

Reconstructive Surgery:

Mastectomy for gynecomastia is **CONSIDERED RECONSTRUCTIVE** if it meets the following criteria:

- Is performed on abnormal structures of the breast arising from congenital defects or the result of trauma or disease of the breast
- Is associated with physical-functional impairment which can be improved by the surgery

CONDITIONS OF COVERAGE

HCPCS

CPT

AUTHORIZATION PERIOD

E. RELATED POLICIES/RULES

F. REVIEW/REVISION HISTORY

Date Issued:	06/01/2009
Date Reviewed:	06/01/2009, 07/01/2011, 11/01/j2011, 02/01/2015, 02/11/2016
Date Revised:	11/01/2011, 02/01/2015

G. REFERENCES

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This guideline contains custom content that has been modified from the standard care guidelines and has not been reviewed or approved by MCG Health, LLC.

The Medical Policy Statement detailed above has received due consideration as defined in the Medical Policy Statement Policy and is approved.

Independent medical review – 1/2015