CareSource

MEDICAL POLICY STATEMENT
GEORGIA MEDICAID

Policy Name	Policy Number	Date Effective
Mastectomy for Gynecomastia	MM-0847	05/01/2020-08/31/2021

Policy Type			
MEDICAL	Administrative	Pharmacy	Reimbursement

Medical Policy Statement 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 androgen deficiency (e.g. treatments for prostate carcinoma), congenital disorders (e.g. Kleinfelter's Syndrome (47XXY)), medications including herbal products (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).

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 14 typically followed by regression in most cases.
- **Pubertal male**: Onset of secondary sexual characteristics that is measured using the Tanner stages; puberty includes stages II, III, and IV
- **Precocious puberty in males:** Onset of secondary sexual characteristics before the age of nine
- **Postpubertal male:** Male who completes milestones for stage V in the Tanner stages
- **Tanner stages:** Sexual maturity rating of secondary sexual characteristics

D. Policy

A. Prior authorization is required
B. Mastectomy for gynecomastia is indicated for a postpubertal male who is 18 years of age or older and meets ALL of the following criteria:
   1. Gynecomastia persists for at least 2 years AND
   2. Documentation supports a review of laboratory tests for conditions related to hormones, liver, kidney, and thyroid function AND
   3. Documentation supports that a breast malignancy was ruled out AND
   4. Gynecomastia persists without improvement after:
      a. Discontinuing the use of contributing medications (prescription, recreational, or performance enhancing) or medications were unable to be discontinued AND
      b. Underlying conditions were assessed and treated i.e. cystic fibrosis, ulcerative colitis, cirrhosis, hyperthyroidism, chronic renal insufficiency, testicular neoplasms, hypogonadism AND

5. Documentation supports a functional impairment such as severe pain, significant negative psychosocial impact, or psychological distress

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.

D. Mastectomy for gynecomastia is considered reconstructive (not covered) if surgery is Intended to be performed on abnormal structures of the breast arising from congenital defects or the result of trauma or disease of the breast.

E. Conditions of Coverage

F. Related Polices/Rules

G. Review/Revision History

	DATE	ACTION
Date Issued		
Date Revised		
Date Effective	05/01/2020	New policy
Date Archived	08/31/2021	This Policy is no longer active and has been archived. Please note that there could be other Policies that may have some of the same rules incorporated and CareSource reserves the right to follow CMS/State/NCCI guidelines without a formal documented Policy

H. References

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3. American Society of Plastic Surgeons. (n.d.). Briefing Paper: Plastic Surgery for Teenagers. Retrieved August 5, 2019, from https://www.plasticsurgery.org/news/briefing-papers/briefing-paper-plastic-surgery-for-teenagers
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5. Anawalt, B., & Braunstein, G. (2019, February). Clinical features, diagnosis, and evaluation of gynecomastia in adults.Retrieved August 5, 2019, from https://www.uptodate.com/contents/clinical-features-diagnosis-and-evaluation-of-gynecomastia-in-adults?search=gynecomastia surgery&topicRef=7467&source=see_link
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stages&source=search_result&selectedTitle=1~103&usage_type=default&display_rank=1#H10
8. Marshall, W., & Tanner, J. (1970). Variations in the Pattern of Pubertal Changes in Boys. *Archives of Disease in Childhood*, *45*(13), 13-23.

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

Independent medical review – 8/2019

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Date Issued 05/01/2020 DCH Approved 1/28/2020