



MEDICAL POLICY STATEMENT OHIO MEDICAID

Policy Name	Policy Number	Date Effective	
Mastectomy for Gynecomastia	MM-0002	1/1/2020	
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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Table of Contents

A. Subject.....	2
B. Background.....	2
C. Definitions.....	2
D. Policy.....	2
E. Conditions of Coverage.....	3
F. Related Polices/Rules.....	3
G. Review/Revision History.....	3
H. References.....	3



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. Klinefelter'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.

D. Policy

A. Prior authorization is required.

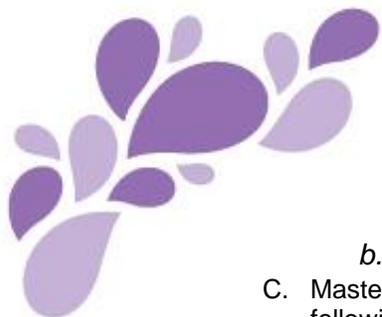
B. *Mastectomy for gynecomastia may be indicated for 1 or more of the following):*

1. *Postpubertal **male** and ALL of the following:*

- Functional impairment (eg, chronic skin irritation, pain, related psychological disorder requiring therapy)*
- Gynecomastia did not regress after cessation of medications (eg, calcium channel blockers, cimetidine, phenothiazines, spironolactone, theophylline) known to cause condition, or medications cannot be discontinued.*
- Mammography or needle biopsy results show no evidence of breast cancer.*
- No evidence of other medical causes for gynecomastia, as indicated by normal results for ALL of the following:*
 - Hormone evaluation (ie, testosterone, luteinizing hormone, follicle-stimulating hormone, estradiol, prolactin, beta-human chorionic gonadotropin)*
 - Liver enzymes*
 - Serum creatinine*
 - Thyroid function tests*

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

- Functional impairment (eg, chronic skin irritation, pain, related psychological disorder requiring therapy)*



b. Gynecomastia present for 2 or more years

- 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.

- C. **Reconstructive Surgery:** Mastectomy for gynecomastia is considered reconstructive if it meets the following criteria:
 - 1. Is performed on abnormal structures of the breast arising from congenital defects or the result of trauma or disease of the breast
 - 2. Is associated with physical-functional impairment which can be improved by the surgery

E. Conditions of Coverage

F. Related Policies/Rules

G. Review/Revision History

DATE		ACTION
Date Issued	6/1/2009	
Date Revised	06/01/2009, 07/01/2011, 11/01/2011, 02/01/2014, 02/11/2015, 02/01/2016 9/27/2017	Language change to include <i>Gynecomastia did not regress after cessation of medications (eg, calcium blockers, cimetidine, phenothiazines, spironolactone, theophylline; updated references.</i>
	8/21/2019	Removed liposuction as investigational. Clarified PA requirement
Date Effective	1/1/2020	

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>
4. Anawalt, B., & Braunstein, G. (2019, January). Management of gynecomastia. Retrieved August 5, 2019, from https://www.uptodate.com/contents/management-of-gynecomastia?search=gynecomastia_surgery&source=search_result&selectedTitle=1~150&usage_type=default&display_rank=1
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



6. Cuhaci, N., Polat, S. B., Evranos, B., Ersoy, R., & Cakir, B. (2014, March). Gynecomastia: Clinical evaluation and management. Retrieved August 5, 2019, from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3987263/>
7. MCG Health 23rd edition, (2019, February) ACG:A-0273 Mastectomy for Gynecomastia. Retrieved August 19, 2019 from <https://careweb.careguidelines.com/ed23/index.html>

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.

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