MEDICAL POLICY STATEMENT
OHIO MEDICAID

Policy Name		Policy Number	Date Effective
Mastectomy for Gynecomastia		MM-0002	01/01/2021-08/31/2021
Policy Type			
MEDICAL	Administrative	Pharmacy	Reimbursement

Medical Policy Statement prepared by CareSource and its affiliates 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.

Medical Policy Statements prepared by CareSource and its affiliates do not ensure an authorization or payment of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced in the Medical Policy Statement. If there is a conflict between the Medical Policy Statement and the plan contract (i.e., Evidence of Coverage), then the plan contract (i.e., Evidence of Coverage) will be the controlling document used to make the determination.

According to the rules of Mental Health Parity Addiction Equity Act (MHPAEA), coverage for the diagnosis and treatment of a behavioral health disorder will not be subject to any limitations that are less favorable than the limitations that apply to medical conditions as covered under this policy.

Table of Contents

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

I. Prior authorization is required.
   A. Medical necessity is based on MCG Health guidelines.

II. Mastectomy for gynecomastia is considered not medically necessary under the following circumstances:
   A. If the above listed criteria are not met; or
   B. Breast enlargement resulting from obesity.

III. Mastectomy for gynecomastia is considered reconstructive (not covered) if it meets the following criteria:
   A. Is performed on abnormal structures of the breast arising from congenital defects or the result of trauma or disease of the breast, or
   B. Is associated with physical-functional impairment which can be improved by the surgery

E. Conditions of Coverage

F. Related Polices/Rules

G. Review/Revision History

	DATE	ACTION
Date Issued	06/01/2009	
Date Revised	06/01/2009 07/01/2011 11/01/2011 02/01/2014 02/11/2015 02/01/2016 09/27/2017 08/21/2019	Language change to include *Gynecomastia did not regress after cessation of medications (eg, calcium blockers, cimetidine, phenothiazines, spironolactone, theophylline; updated references.* Removed liposuction as investigational. Clarified PA requirement
Date Effective	08/19/2020 01/01/2021	Annual Review – no changes
Date Archived	8/31/2021	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

1. G. Dickson. (2012, April 1). Gynecomastia. *American Family Physician*, *85*(7), 716-722
2. Klein, D. A., Emerick, J. E., Slyvester, J. E., & Vogt, K. S. (2017, November 1). Disorders of Puberty: An Approach. *American Family Physician*, *96*(9), 590-599.
3. American Society of Plastic Surgeons. (n.d.). Briefing Paper: Plastic Surgery for Teenagers. Retrieved August 5, 2019, from www.plasticsurgery.org
4. Anawalt, B., & Braunstein, G. (2019, January). Management of gynecomastia. Retrieved August 7, 2020 from www.uptodate.com
5. Cuhaci, N., Polat, S. B., Evranos, B., Ersoy, R., & Cakir, B. (2014, March). Gynecomastia: Clinical evaluation and management. Retrieved August 5, 2019, from www.ncbi.nlm.nih.gov
7. MCG Health 24th edition. (2021) ACG:A-0273 Mastectomy for Gynecomastia. Retrieved August 7, 2020 from www.mcg.com
8. Taylor, S. (2020, April 1). Gynecomastia in children and adolescents. Retrieved August 7, 2020 from www.uptodate.com

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