MEDICAL POLICY STATEMENT
GEORGIA MEDICARE ADVANTAGE

Policy Name		Policy Number	Date Effective
Mastectomy for Gynecomastia		MM-1106	01/01/2021
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.

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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. 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.
- **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

I. Prior authorization is required.

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

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

III. Mastectomy for Gynecomastia is considered not medically necessary under the following circumstances:
A. If the above listed criteria are not met; or
B. If breast enlargement is a result of obesity.

IV. Mastectomy for gynecomastia is considered reconstructive (not covered) if it is 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	10/14/2020	
Date Revised		
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H. References

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