

## MEDICAL POLICY STATEMENT OHIO MEDICARE ADVANTAGE

Policy Name	Policy Number	Date Effective
Mastectomy for Gynecomastia	MM-0848	1/1/2020
Policy Type		
<b>MEDICAL</b>	Administrative	Pharmacy
		Reimbursement

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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).

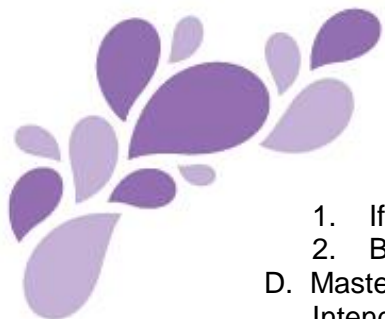
As a result of this hormonal imbalance medical therapy may be offered in the treatment of gynecomastia (i.e. anti-estrogens, androgens, or aromatase inhibitors).

## 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

- 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 Policies/Rules

#### G. Review/Revision History

DATE		ACTION
Date Issued	8/21/2019	
Date Revised		
Date Effective	1/1/2020	New Policy
Date Archived	1/1/2021	

#### 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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**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*