Gynecomastia Treatment (for Louisiana Only)

Guideline Number: CS051LA.I
Effective Date: April 1, 2020

Instructions for Use

Table of Contents Page

Application

This Coverage Determination Guideline only applies to the state of Louisiana.

Coverage Rationale

Indications for Coverage

Most UnitedHealthcare plans have a specific exclusion for treatment of Benign Gynecomastia. See Coverage Limitations and Exclusions section below.

Criteria for a Coverage Determination that Surgery is Reconstructive and Medically Necessary

Mastectomy or suction lipectomy for treatment of Benign Gynecomastia for a male member under age 18 when all of the following criteria are met:

- Gynecomastia or breast enlargement with moderate to severe chest pain that is causing a Functional or Physical Impairment. The inability to participate in athletic events, sports or social activities is not considered to be a Functional or Physical or physiological Impairment.
- Persistent gynecomastia after cessation of prescribed medications and appropriate screening(s) of non-prescription and/or recreational drugs or substances that have a known side effect of gynecomastia (examples include but are not limited to the following: testosterone, marijuana, asthma drugs, phenothiazines, anabolic steroids, cimetidine and calcium channel blockers).
- The breast enlargement must be present for at least 2 years and appropriate evaluation of medical causes with supporting laboratory testing has been normal. If so, lab tests, which might include but are not limited to the following, must be performed:
  - Hormone testing (e.g., beta-human chorionic gonadotropin, estradiol, follicle-stimulating hormone, luteinizing hormone, prolactin, testosterone)
  - Liver enzymes
  - Serum creatinine
  - Thyroid function studies

Mastectomy or suction lipectomy for treatment of Benign Gynecomastia for a male member age 18 and up when all of the following criteria are met:

- Discontinuation of medications, nutritional supplements, and non-prescription medications or substances (examples include but are not limited to the following: testosterone, marijuana, asthma drugs, phenothiazines, anabolic steroids, cimetidine and calcium channel blockers) that have a known side effect of gynecomastia or breast enlargement and the breast size did not regress after discontinuation of use as appropriate.
- Glandular breast tissue is the primary cause of gynecomastia as opposed to fatty deposits (pseudo gynecomastia) and is documented on physical exam and/or mammography.
- Gynecomastia or breast enlargement with moderate to severe chest pain that is causing a Functional or Physical Impairment. The inability to participate in athletic events, sports or social activities is not considered to be a Functional or Physical or physiological Impairment.
- Appropriate evaluation of medical causes with supporting laboratory testing has been normal. If so, lab tests which might include, but are not limited to the following, must be performed:
  - Hormone testing (e.g., beta-human chorionic gonadotropin, follicle-stimulating hormone, estradiol, luteinizing hormone, prolactin, testosterone)
  - Liver enzymes
  - Serum creatinine
  - Thyroid function studies

Note: Regardless of age, if a tumor or neoplasm is suspected, a breast ultrasound and/or mammogram may be performed. As indicated, a breast biopsy may also be performed.

Coverage Limitations and Exclusions

UnitedHealthcare excludes Cosmetic Procedures from coverage including but not limited to the following:

- Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. The fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery (or other procedures done to relieve such consequences or behavior) as a reconstructive procedure.
- Treatment of Benign Gynecomastia when specifically excluded in the member specific benefit plan document.

Definitions

Check the definitions within the member benefit plan document that supersede the definitions below.

Benign Gynecomastia: The development of abnormally large breasts in males. It is related to the excess growth of breast tissue (glandular), rather than excess fat tissue. (In most cases, breast enlargement and/or Benign Gynecomastia spontaneously resolves by age 18 making treatment unnecessary. Gynecomastia during puberty is not uncommon and in 90% of cases regresses within 3 years of onset.)

Congenital Anomaly: A physical developmental defect that is present at the time of birth, and that is identified within the first twelve months of birth.

Cosmetic Procedures: Procedures or services that change or improve appearance without significantly improving physiological function.

Functional or Physical Impairment: A Functional or Physical or physiological Impairment causes deviation from the normal function of a tissue or organ. This results in a significantly limited, impaired, or delayed capacity to move, coordinate actions, or perform physical activities and is exhibited by difficulties in one or more of the following areas: physical and motor tasks; independent movement; performing basic life functions.

Reconstructive Procedures: Reconstructive Procedures when the primary purpose of the procedure is either of the following:

- Treatment of a medical condition
- Improvement or restoration of physiologic function

Reconstructive Procedures include surgery or other procedures which are related to an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not a changed or improved physical appearance.

Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. The fact that you may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery (or other procedures done to relieve such consequences or behavior) as a Reconstructive Procedure.

Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by federal, state, or contractual requirements and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

Note: Coding for suction lipectomy is addressed in the Coverage Determination Guideline titled Panniculectomy and Body Contouring Procedures (for Louisiana Only).

CPT Code	Description
19300	Mastectomy for gynecomastia

References

Ali O, Donohue PA. Gynecomastia. In: Kliegman RM, Stanton BF, Geme JW, Schor NF, Behrman RE, eds. Nelson Textbook of Pediatrics. 19th ed. Philadelphia, Pa: Saunders Elsevier; 2011:chap 579.

Ansstas, G, Ansstas, M, Griffing, G, Gynecomastia. Medscape. Updated July 14, 2016. Updated March 21, 2017.

Gynecomastia and hormones. Sansone A et al., Endocrine. (2017).

Gynecomastia in Infants, Children, and Adolescents. Leung AKC et al., Recent Pat Endocr Metab Immune Drug Discov. (2017)

Mayo Clinic: Diseases and Conditions. Gynecomastia (enlarged breast in men). January 22, 2014.

MCG™ Care Guidelines, [24th edition, 2020]. Mastectomy for Gynecomastia. ACG: A-0273.

Narula HS, Carlson HE. Gynecomastia. Endocrinol Metab Clin North Am. 2007/36:497-519. NIH Medline Plus. Updated December 19, 2014.

Guideline History/Revision Information

Date	Summary of Changes
04/01/2021	**Template Update** • Removed *Related Policies* and *CMS* sections • Updated *Instructions for Use*; replaced reference to "MCG™ Care Guidelines" with "InterQual® criteria"
02/01/2021	**Template Update** • Reformatted policy; transferred content to new template
04/01/2020	**References** • Replaced reference to "MCG™ Care Guidelines, *23rd* edition, *2019*" with "MCG™ Care Guidelines, [*24th* edition, *2020*]" **Supporting Information** • Archived previous policy version CS051LA.H

Instructions for Use

This Coverage Determination Guideline provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the federal, state or contractual requirements for benefit plan coverage must be referenced as the terms of the federal, state or contractual requirements for benefit plan coverage may differ from the standard benefit plan. In the event of a conflict, the federal, state or contractual requirements for benefit plan coverage govern. Before using this guideline, please check the federal, state or contractual requirements for benefit plan coverage. UnitedHealthcare reserves the right to modify its Policies and Guidelines as necessary. This Coverage Determination Guideline is provided for informational purposes. It does not constitute medical advice.

UnitedHealthcare may also use tools developed by third parties, such as the InterQual® criteria, to assist us in administering health benefits. The UnitedHealthcare Coverage Determination Guidelines are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.