GYNECOMASTIA TREATMENT

Policy Number: SURGERY 026.19 T2

Effective Date: June 1, 2020

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Related Policies

- Cosmetic and Reconstructive Procedures
- Panniculectomy and Body Contouring Procedures

CONDITIONS OF COVERAGE

Applicable Lines of Business/Products

This policy applies to Oxford Commercial plan membership.

Benefit Type

General benefits package

Referral Required

(Does not apply to non-gatekeeper products)

No

Authorization Required

(Precertification always required for inpatient admission)

Yes

Precertification with Medical Director Review Required

Yes

Applicable Site(s) of Service

(If site of service is not listed, Medical Director review is required)

Inpatient, Outpatient, Office

Special Considerations

Participating providers in the office setting: Precertification is required for services performed in the office of a participating provider. Non-participating/out-of-network providers in the office setting: Precertification is not required, but is encouraged for services provided for out-of-network services performed in the office. If precertification is not obtained, Oxford will review for out of network benefits and medical necessity after the service is rendered.

COVERAGE RATIONALE

Indications for Coverage

Most Oxford 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 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 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 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
Oxford excludes Cosmetic Procedures from coverage including but not limited to the following:
- Liposuction as the sole procedure for Gynecomastia
- 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.

DOCUMENTATION REQUIREMENTS

Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The documentation requirements outlined below are used to assess whether the member meets the clinical criteria for coverage but do not guarantee coverage of the service requested.

<table>
<thead>
<tr>
<th>Required Clinical Information</th>
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<tr>
<td><strong>Gynecomastia Treatment</strong></td>
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<tr>
<td>Medical notes documenting <strong>all</strong> of the following:</td>
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<tr>
<td>- History of the medical condition</td>
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<td>- Frontal and lateral colored photos of the torso</td>
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<td>- Treatment plan for proposed surgery, including expected outcome</td>
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<tr>
<td>- Clinical studies that address the physical and/or physiological abnormality</td>
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<tr>
<td>- Functional deficits and associated conditions and complications</td>
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<tr>
<td>- Pertinent medication history and laboratory results</td>
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</table>
DEFINITIONS

The following definitions may not apply to all plans. Refer to the member specific benefit plan document for applicable definitions.

**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.

**Cosmetic Surgery**: Defined by the American Society of Plastic Surgeons, "is performed to reshape normal structures of the body in order to improve the patient's appearance and self-esteem."

**Functional or Physical Impairment**: A physical or functional 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.

**Reconstructive Surgery**: Defined by the American Society of Plastic Surgeons, "is performed on abnormal structures of the body, caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease. It is generally performed to improve function, but may also be done to approximate a normal appearance."

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 the member specific benefit plan document 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 may apply.

**Note**: Coding for suction lipectomy is addressed in the Clinical Policy titled: Panniculectomy and Body Contouring Procedures.

<table>
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<tr>
<th>CPT Code</th>
<th>Description</th>
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<tr>
<td>19300</td>
<td>Mastectomy for gynecomastia</td>
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*CPT® is a registered trademark of the American Medical Association*

REFERENCES

The foregoing Oxford policy has been adapted from an existing UnitedHealthcare national policy that was researched, developed and approved by UnitedHealthcare Coverage Determination Committee. [CDG.012.09]

Gynecomastia and hormones.
Gynecomastia in Infants, Children, and Adolescents.

POLICY HISTORY/REVISION INFORMATION

<table>
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<tr>
<th>Date</th>
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<tr>
<td>06/01/2020</td>
<td>Coverage Rationale</td>
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<td>• Revised list of services excluded from coverage; added “liposuction as the sole</td>
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<td>procedure for Gynecomastia”</td>
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<td>Supporting Information</td>
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INSTRUCTIONS FOR USE

This Clinical Policy provides assistance in interpreting UnitedHealthcare Oxford standard benefit plans. When deciding coverage, the member specific benefit plan document must be referenced as the terms of the member specific benefit plan may differ from the standard plan. In the event of a conflict, the member specific benefit plan document governs. Before using this policy, please check the member specific benefit plan document and any applicable federal or state mandates. UnitedHealthcare Oxford reserves the right to modify its Policies as necessary. This Clinical Policy is provided for informational purposes. It does not constitute medical advice.

The term Oxford includes Oxford Health Plans, LLC and all of its subsidiaries as appropriate for these policies. Unless otherwise stated, Oxford policies do not apply to Medicare Advantage members.

UnitedHealthcare may also use tools developed by third parties, such as the MCG™ Care Guidelines, to assist us in administering health benefits. UnitedHealthcare Oxford Clinical Policies 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.