

# GYNECOMASTIA TREATMENT

**Policy Number:** SURGERY 026.16 T2

**Effective Date:** June 1, 2018

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## Related Policies

- [Cosmetic and Reconstructive Procedures](#)
- [Panniculectomy and Body Contouring Procedures](#)

## INSTRUCTIONS FOR USE

This Clinical Policy provides assistance in interpreting Oxford benefit plans. Unless otherwise stated, Oxford policies do not apply to Medicare Advantage members. Oxford reserves the right, in its sole discretion, 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.

When deciding coverage, the member specific benefit plan document must be referenced. The terms of the member specific benefit plan document [e.g., Certificate of Coverage (COC), Schedule of Benefits (SOB), and/or Summary Plan Description (SPD)] may differ greatly from the standard benefit plan upon which this Clinical Policy is based. In the event of a conflict, the member specific benefit plan document supersedes this Clinical Policy. All reviewers must first identify member eligibility, any federal or state regulatory requirements, and the member specific benefit plan coverage prior to use of this Clinical Policy. Other Policies may apply.

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

## 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 <sup>1, 2</sup>
Precertification with Medical Director Review Required	Yes <sup>1, 2</sup>
Applicable Site(s) of Service (If site of service is not listed, Medical Director review is required)	Inpatient, Outpatient, Office
Special Considerations	<sup>1</sup> Precertification is required for services covered under the Member's General benefits package when performed in the office of a participating provider. For out of network services performed in the office, which are covered under the Member's General benefits package, Oxford may review for medical necessity. <sup>2</sup> Precertification with review by a Medical Director or their designee.

## BENEFIT CONSIDERATIONS

Before using this policy, please check the member specific benefit plan document and any federal or state mandates, if applicable.

### **Essential Health Benefits for Individual and Small Group**

For plan years beginning on or after January 1, 2014, the Affordable Care Act of 2010 (ACA) requires fully insured non-grandfathered individual and small group plans (inside and outside of Exchanges) to provide coverage for ten categories of Essential Health Benefits ("EHBs"). Large group plans (both self-funded and fully insured), and small group ASO plans, are not subject to the requirement to offer coverage for EHBs. However, if such plans choose to provide coverage for benefits which are deemed EHBs, the ACA requires all dollar limits on those benefits to be removed on all Grandfathered and Non-Grandfathered plans. The determination of which benefits constitute EHBs is made on a state by state basis. As such, when using this policy, it is important to refer to the member specific benefit plan document to determine benefit coverage.

## COVERAGE RATIONALE

### **Indications for Coverage**

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

- **Mastectomy or suction lipectomy for treatment of Benign Gynecomastia for a male patient under age 18 is considered reconstructive and medically necessary 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 as defined below in the Definitions section. The inability to participate in athletic events, sports or social activities is not considered to be a functional or physical or physiological impairment.
  - No prior history 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. If so, lab tests which might include, but are not limited to, the following must be performed:
    - Thyroid function studies
    - Testosterone
    - Beta subunit HCG
- **Mastectomy or suction lipectomy for treatment of Benign Gynecomastia for a male patient age 18 and up is considered reconstructive and medically necessary 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 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.
  - Gynecomastia or breast enlargement with moderate to severe chest pain that is causing a Functional or Physical Impairment as defined below in the Definitions section. The inability to participate in athletic events, sports or social activities is not considered to be a functional or physical or physiological impairment.
  - Review of test results that have been performed to rule out certain diseases or other causes of gynecomastia (examples include but are not limited to blood tests, e.g., hormone levels estrogen, testosterone, liver and kidney function studies/enzymes).
  - Glandular breast tissue is the primary cause of gynecomastia as opposed to fatty deposits and is documented on physical exam and/or mammography.

#### ***Additional Information***

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.

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**

- Treatment of Benign Gynecomastia when specifically excluded in the member specific benefit plan document.
- Treatment of Benign Gynecomastia when not specifically excluded in the member specific benefit plan document and the above criteria is not met.
- Most medical and surgical treatments for Benign Gynecomastia are considered cosmetic. Medical treatments and surgery to alter a perceived abnormal appearance, or for psychological reasons, are considered cosmetic and are not covered. The fact that a Covered Person may suffer psychological consequences or socially avoidant behavior

as a result of Benign Gynecomastia does not classify surgery (or other procedures done to relieve such consequences or behavior) as a reconstructive procedure.

## 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.

**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 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 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.

CPT Code	Description
19300	Mastectomy for gynecomastia

*CPT® is a registered trademark of the American Medical Association*

**Note:** Coding for suction lipectomy is addressed in the policy titled [Panniculectomy and Body Contouring Procedures](#).

## 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.012.07]

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. Updated March 21, 2017.

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

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

## POLICY HISTORY/REVISION INFORMATION

Date	Action/Description
06/01/2018	<ul style="list-style-type: none"> <li>Replaced references to "Functional/Physical Impairment" with "Functional or Physical Impairment"</li> <li>Updated supporting information to reflect the most current references</li> <li>Archived previous policy version SURGERY 026.15 T2</li> </ul>