Gynecomastia Treatment

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Instructions for Use

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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 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 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 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 West 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.

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.

Required Clinical Information
Gynecomastia Treatment
Medical notes documenting all of the following: • History of the medical condition • Frontal and lateral colored photos of the torso • Treatment plan for proposed surgery including expected outcome • Clinical studies that address the physical and/or physiological abnormality • Functional deficits and associated conditions and complications • Pertinent medication history and laboratory results

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 Defect: A physical developmental defect that is present at birth

Cosmetic Services and Surgery (California only): Cosmetic surgery and cosmetic services are defined as surgery and services performed to alter or reshape normal structures of the body in order to improve appearance. Drugs, devices and procedures related to cosmetic surgery or cosmetic services are not covered. Surgeries or services that would ordinarily be

classified as cosmetic will not be reclassified as reconstructive, based on a Member's dissatisfaction with his or her appearance.

Cosmetic Services and Surgery (OR, OK, TX and WA only): Cosmetic surgery and cosmetic services are not covered. Cosmetic surgery and cosmetic services are defined as surgery and services performed to alter or reshape normal structures of the body in order to improve appearance. Drugs, devices and procedures related to cosmetic surgery or cosmetic services are not covered

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: Reconstructive surgery is covered to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease. The purpose of reconstructive surgery is to correct abnormal structures of the body to improve function or create a normal appearance to the extent possible.

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 guideline 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 and Guidelines may apply.

Note: Coding for suction lipectomy is addressed on the Medical Management Guideline titled Panniculectomy and Body Contouring Procedures.

CPT Code	Description
19300	Mastectomy for gynecomastia

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References

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Guideline History/Revision Information

Date	Summary of Changes
01/01/2021	**Template Update** • Reformatted policy; transferred content to new template **Coverage Rationale** • Revised list of Cosmetic Procedures excluded from coverage; removed "liposuction as the sole procedure for Gynecomastia" **Definitions** • Updated definition of "Cosmetic Services and Surgery (California only)" **Supporting Information** • Archived previous policy version MMG052.M

Instructions for Use

This Medical Management Guideline provides assistance in interpreting UnitedHealthcare 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 guideline, please check the member specific benefit plan document and any applicable federal or state mandates. UnitedHealthcare reserves the right to modify its Policies and Guidelines as necessary. This Medical Management Guideline is provided for informational purposes. It does not constitute medical advice.

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

Member benefit coverage and limitations may vary based on the member's benefit plan Health Plan coverage provided by or through UnitedHealthcare of California, UnitedHealthcare Benefits Plan of California, UnitedHealthcare of Oklahoma, Inc., UnitedHealthcare of Oregon, Inc., UnitedHealthcare Benefits of Texas, Inc., or UnitedHealthcare of Washington, Inc.