

GYNECOMASTIA TREATMENT

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Related Commercial Policies
<ul style="list-style-type: none"> Cosmetic and Reconstructive Procedures Panniculectomy and Body Contouring Procedures
Community Plan Policy
<ul style="list-style-type: none"> Gynecomastia Treatment

INSTRUCTIONS FOR USE

This Coverage Determination Guideline provides assistance in interpreting UnitedHealthcare benefit plans. 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 Coverage Determination Guideline is based. In the event of a conflict, the member specific benefit plan document supersedes this Coverage Determination Guideline. 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 Coverage Determination Guideline. Other Policies and Coverage Determination Guidelines may apply. UnitedHealthcare reserves the right, in its sole discretion, 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 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.

BENEFIT CONSIDERATIONS

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

For self-funded plans with SPD language other than fully-insured Generic COC language, please refer to the member specific benefit plan document for coverage.

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 guideline, it is important to refer to the member specific benefit document to determine benefit coverage.

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/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/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 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. 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 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.
- Gynecomastia or breast enlargement with moderate to severe chest pain that is causing a functional/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/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

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. (2011 Generic COC)

Congenital Anomaly (California only): A physical developmental defect that is present at birth

Cosmetic Procedures: Procedures or services that change or improve appearance without significantly improving physiological function, as determined by UHC (2011 Generic COC).

Cosmetic Procedures (California only): Procedures or services are performed to alter or reshape normal structures of the body in order to improve the Covered Person's appearance

Functional/Physical Impairment: A physical/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 to treat a medical condition or to improve or restore physiologic function. Reconstructive procedures include surgery or other procedures which are associated with 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 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. (2007- 2011 Generic COC)

Reconstructive Procedures (California only): Reconstructive procedures to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease. Reconstructive procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not a changed or improved physical appearance for cosmetic purposes only, but rather to improve function and/or to create a normal appearance, to the extent possible. Covered Health Services include dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures.

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 Coverage Determination Guidelines may apply.

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

CPT Code	Description
19300	Mastectomy for gynecomastia

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REFERENCES

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

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GUIDELINE HISTORY/REVISION INFORMATION

Date	Action/Description
06/01/2017	<ul style="list-style-type: none">Routine review; no change to coverage rationale or list of applicable codesArchived previous policy version CDG.012.04