



Medica Central Utilization Management Policy

Title: Male Gynecomastia Surgery MP9581 (III-SUR.31)

Effective Date: 07/01/2024

This policy was developed with input from specialists in plastic surgery, general surgery, and endocrinology and endorsed by the Medical Policy Committee.

IMPORTANT INFORMATION – PLEASE READ BEFORE USING THIS POLICY

These services may or may not be covered by all Medica Central plans. Coverage is subject to requirements in applicable federal or state laws. Please refer to the member's plan document for other specific coverage information. If there is a difference between this general information and the member's plan document, the member's plan document will be used to determine coverage. With respect to Medicare, Medicaid, and other government programs, this policy will apply unless these programs require different coverage.

Members may contact Medica Customer Service at the phone number listed on their member identification card to discuss their benefits more specifically. Providers with questions may call the Provider Service Center. Please use the Quick Reference Guide on the Provider Communications page for the appropriate phone number. <https://mo-central.medica.com/Providers/SSM-employee-health-plan-for-IL-MO-OK-providers>

Medica Central coverage policies are not medical advice. Members should consult with appropriate health care providers to obtain needed medical advice, care, and treatment.

PURPOSE

To promote consistency between utilization management reviewers by providing the criteria that determines the medical necessity.

BACKGROUND

I. Definitions

- A. **Gynecomastia** is the presence of an abnormal development of glandular breast tissue in males. Gynecomastia in adolescents is very common, estimated to affect up to 40% of 12 to 16 year old boys. In most cases, breast development is minimal and spontaneously regresses two to three years later. Breast development may be bilateral or unilateral. Gynecomastia may be due to a variety of causes, including Klinefelter's syndrome, congenital hypogonadism, hermaphroditism, testicular trauma, a breast tumor, ingestion of any of a variety of prescription medications, contact with family members who use estrogen creams, abuse of anabolic steroids, abuse of heroin, malnutrition, liver disease, or treatment with chemotherapy. Treatment of gynecomastia depends on the cause.

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- B. **Pseudogynecomastia** refers to breast enlargement due to the accumulation of fat. Pseudogynecomastia often affects obese boys and men. It can be treated by weight loss or liposuction.
- II. Comments
 - A. Member demand exists for gynecomastia surgery in the absence of functional signs and symptoms, solely to improve the member's perception of their appearance.
 - B. The factors that distinguish appearance-related requests from medically necessary requests are symptoms and physical findings caused by excess breast tissue mass.

BENEFIT CONSIDERATIONS

1. Prior authorization **is required** for gynecomastia surgery. Please see the prior authorization list for product specific prior authorization requirements.
2. Coverage may vary according to the terms of the member's plan document.
3. Cosmetic surgery is generally an exclusion in the member's plan document. Surgery performed solely to improve appearance of the male breast, to alter contours of the breast wall, or to treat psychological or psychosocial complaints are cosmetic and therefore, *not covered*.
4. Surgery for the treatment of pseudogynecomastia is cosmetic and therefore *not covered*.
5. The use of liposuction to perform gynecomastia surgery is cosmetic and therefore *not covered*.
6. If the Medical Necessity Criteria and Benefit Considerations are met, The Health Plan will authorize benefits within the limits in the member's plan document.
7. If it appears that the Medical Necessity Criteria and Benefit Considerations are not met, the individual's case will be reviewed by the medical director or an external reviewer. Practitioners are advised of the appeals process in their Provider Administrative Manual.
8. Refer to the Utilization Management Policy, *Female Breast Reduction Surgery – Reduction Mammoplasty*, for coverage of surgery for macromastia in women.

MEDICAL NECESSITY CRITERIA

- I. Male gynecomastia surgery is considered medically necessary when documentation in the medical record indicates that **one of the following** criteria are met:
 - A. Pubertal (adolescent) onset gynecomastia when **all of the following** are met:
 1. The condition has been present for at least two years
 2. Glandular breast tissue confirming true gynecomastia is documented on physical exam and/or mammography
 3. The gynecomastia is classified as Grade II, III or IV per the American Society of Plastic Surgeons classification (*See Appendix 1*)
 4. The condition is associated with persistent breast pain, despite the use of analgesics
 5. The use of potential gynecomastia-inducing drugs and substances has been identified and discontinued for at least one year, when medically appropriate
 6. Hormonal causes, including hyperthyroidism, estrogen excess, prolactinomas and hypogonadism have been excluded by appropriate laboratory testing (e.g., with levels of thyroid stimulating hormone [TSH], estradiol, prolactin, testosterone and/or luteinizing hormone [LH]) and, if present, have been treated for at least one year before surgery has been considered

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7. Other medical causes have been ruled out, as indicated by normal laboratory results (e.g., liver and kidney function studies/enzymes)
8. Photographs are required.
- B. Post pubertal-onset gynecomastia when **all of the following** are met:
 1. The condition has been present for at least one year
 2. Glandular breast tissue confirming true gynecomastia is documented on physical exam and/or mammography
 3. The gynecomastia is classified as Grade III or IV per the American Society of Plastic Surgeons classification (*See Appendix 1*)
 4. The condition is associated with persistent breast pain, despite the use of analgesics
 5. The use of potential gynecomastia-inducing drugs and substances has been identified and discontinued for at least one year, when medically appropriate
 6. Hormonal causes, including hyperthyroidism, estrogen excess, prolactinomas and hypogonadism have been excluded by appropriate laboratory testing (e.g., with levels of thyroid stimulating hormone [TSH], estradiol, prolactin, testosterone and/or luteinizing hormone [LH]) and, if present, have been treated for at least one year before surgery has been considered
 7. Other medical causes have been ruled out, as indicated by normal laboratory results (e.g., liver and kidney function studies/enzymes)
 8. Photographs are required.

CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS)

- For Medicare members, refer to the following, as applicable at:
<https://www.cms.gov/medicare-coverage-database/new-search/search.aspx>

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APPENDIX 1

The American Society of Plastic Surgeons (ASPS) recommends using a scale adapted from the McKinney and Simon, Hoffman and Khan scales to characterize the severity of gynecomastia:

Grade I	Unilateral breast nodular enlargement, minor but visible breast enlargement without skin redundancy.
Grade II	Moderate breast enlargement exceeding areola boundaries with edges that are indistinct from the chest.
Grade III	Moderate breast enlargement exceeding areola boundaries with edges that are distinct from the chest with skin redundancy present.
Grade IV	Marked breast enlargement with skin redundancy and feminization of the breast.