BlueCross BlueShield of Arizona
An Independent Licensee of the Blue Cross and Blue Shield Association

MEDICAL COVERAGE GUIDELINES
SECTION: SURGERY

ORIGINAL EFFECTIVE DATE: 12/16/05
LAST REVIEW DATE: 11/26/13
LAST CRITERIA REVISION DATE:
ARCHIVE DATE:

REDUCTION MAMMOPLASTY/MASTECTOMY FOR THE TREATMENT OF MALE GYNECOMASTIA

Coverage for services, procedures, medical devices and drugs are dependent upon benefit eligibility as outlined in the member's specific benefit plan. This Medical Coverage Guideline must be read in its entirety to determine coverage eligibility, if any.

The section identified as "Description" defines or describes a service, procedure, medical device or drug and is in no way intended as a statement of medical necessity and/or coverage.

The section identified as "Criteria" defines criteria to determine whether a service, procedure, medical device or drug is considered medically necessary or experimental or investigational.

State or federal mandates, e.g., FEP program, may dictate that any drug, device or biological product approved by the U.S. Food and Drug Administration (FDA) may not be considered experimental or investigational and thus the drug, device or biological product may be assessed only on the basis of medical necessity.

Medical Coverage Guidelines are subject to change as new information becomes available.

For purposes of this Medical Coverage Guideline, the terms "experimental" and "investigational" are considered to be interchangeable.

Description:

Gynecomastia:
Benign enlargement of the male breast as the result of an abnormal increase in glandular tissue. Most often, breast enlargement occurs during adolescence. Other causes can be medications (e.g., cimetidine, spironolactone, marijuana, steroids), increased prolactin levels, liver disease, adrenal or pituitary tumors and genetic disorders. It may present unilaterally or bilaterally as a painful, tender mass beneath the areolar region or as a painless, progressive enlargement of the breast. Surgical treatment includes reduction mammoplasty, mastectomy and/or liposuction.

Reduction Mammoplasty:
Breast reduction surgery performed to decrease breast size by removing breast tissue; includes open procedure (mastectomy) or liposuction.

Mastectomy:
Open, surgical excision of the breast to remove breast tissue.

REDUCTION MAMMOPLASTY/MASTECTOMY FOR THE TREATMENT OF MALE GYNECOMASTIA (cont.)

Criteria:

- Reduction mammoplasty/mastectomy for the treatment of gynecomastia is considered ***medically necessary*** with preoperative documentation of **ALL** of the following:

  1. Individual is male and **ONE** of the following:

     - 18 years of age and older, **or**
     - Under 18 years of age **and** is three or more years beyond onset of puberty

  2. Gynecomastia has persisted 3 years beyond documented presentation to physician
  3. Gynecomastia is greater than 4cm in diameter by physical examination
  4. The condition is symptomatic, (e.g., painful, tender breasts)
  5. Gynecomastia is **not** the result of **ANY** of the following:

     - Obesity
     - Use of medications which can safely be discontinued *
     - Illicit drug use *
     - Underlying disease or condition ** (as documented by appropriate diagnostic tests, e.g., serum testosterone, estrogen, progesterone, prolactin, cortisol, TSH) to include, *but not limited to:*

       - Carcinoma (lung, adrenal, testicular)
       - Chronic liver disease
       - Chronic renal failure
       - Hyper or hypo-thyroidism
       - Hyperprolactinemia
       - Hypogonadism
       - Pituitary adenomas

* If medications and/or illicit drug use have been discontinued and the gynecomastia does not resolve, all other criteria must be met to fulfill medical necessity criteria.

** If the underlying disease or condition is under treatment and the gynecomastia does not resolve, all other criteria must be met to fulfill medical necessity criteria.

- Reduction mammoplasty/mastectomy for the treatment of gynecomastia for all other indications not previously listed is considered ***cosmetic, not medically necessary*** and ***not eligible for coverage***.

REDUCTION MAMMOPLASTY/MASTECTOMY FOR THE TREATMENT OF MALE GYNECOMASTIA (cont.)

Resources:

1. 7.01.13 BCBS Association Medical Policy Reference Manual. Surgical Treatment of Bilateral Gynecomastia. Re-issue date 10/10/2013, issue date 12/01/1995.

2. Abaci A, Buyukgebiz A. Gynecomastia: review. *Pediatr Endocrinol Rev.* 2007 Sep;5(1):489-499.

3. American Society of Plastic Surgeons. Position Paper: Gynecomastia recommended insurance coverage. 03/2002.

4. External Consultant Review. Pediatrics. 06/14/2004.

5. Handschin AE, Bietry D, Husler R, Banic A, Constantinescu M. Surgical Management of Gynecomastia-a 10-year Analysis. *World J Surg.* 2007 Nov 17.

6. InterQual ® Care Planning Criteria Procedures Adult. Reduction Mammoplasty, Male.

7. Mentz HA, Ruiz-Razura A, Newall G, Patronella CK, Miniel LA. Correction of gynecomastia through a single puncture incision. *Aesthetic Plast Surg.* 2007 May-Jun;31(3):244-249.

8. Solomon A. Kaplan MD. Pubertal Gynecomastia. *Clinical Pediatric Endocrinology.*

9. Textbook of Pediatrics 15th Edition. The Endocrine System, Part XXVI; Section 5, Chapter 537: Disorders of the Gonads.