OHCA Guideline

Medical Procedure Class:	Mastectomy Surgery for Gynecomastia
Initial Implementation Date:	11/01/2012
Last Review Date:	09/19/2019
Effective Date:	10/01/2019
Next Review/Revision Date:	10/01/2022

* This document is not a contract, and these guidelines do not reflect or represent every conceived situation. Although all items contained in these guidelines may be met, this does not reflect, or imply, any responsibility of this agency or department to change the plan provision to include the stated service as an eligible benefit.

☐ New Criteria ☒ Revision of Existing Criteria

Summary

Purpose:	To provide guidelines to assure medical necessity and consistency in the prior authorization process.

Definitions

Glandular – Having the characteristics or function of a gland.
Gynecomastia – The presence of an abnormal proliferation (enlargement) of breast tissue in males.
Klinefelter Syndrome – A genetic disorder in males characterized by two X chromosomes and one Y chromosome, resulting in hormonal imbalances and gynecomastia.
Pathologic Gynecomastia – An abnormal proliferation of breast tissue in males associated with androgen deficiency and estrogen excess resulting from medications, diseases, tumors, chromosomal abnormalities, etc.
Physiologic Gynecomastia – An abnormal proliferation of breast tissue in males occurring during times of male hormonal changes.
Pseudo-gynecomastia – An abnormal proliferation of the male breast due to fatty tissue deposits without glandular proliferation.
Pubertal Gynecomastia – A physiologic enlargement of the glandular breast tissue that occurs in some boys during puberty.
True Gynecomastia – An enlargement of the male breast due to glandular breast tissue.

Description

Gynecomastia Scale (Grading scale adopted by the American Society of Plastic Surgeons)

- Grade I – Small breast enlargement with localized button of tissue that is concentrated around the areola.
- 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.

CPT Codes Covered Requiring Prior Authorization (PA)

19300 – Mastectomy for gynecomastia

Approval Criteria

I. GENERAL

A. Medical necessity must be met. All documentation submitted to request services or substantiate previously provided services must demonstrate through adequate objective medical records, evidence sufficient to justify the member's needs for the service, in the most cost-effective manner, in accordance with the OAC 317:30-3-1.
B. Documentation requirements include:
    1. Documentation to support an indicated diagnosis from section **II.A-C** below and the necessity for a mastectomy.

II. INDICATIONS

A mastectomy to surgically treat gynecomastia will be considered when:

A. Member has Klinefelter syndrome; **OR**

B. Pubertal-Onset Gynecomastia
    1. Unilateral or bilateral; **AND**
    2. Grade II, III, or IV; **AND**
    3. Has persisted for at least one year; **AND**
    4. Meets ALL of the following criteria:
        a. Persistent for at least one year after pathological causes have been ruled out or treated; **AND**
        b. Appropriate discontinuation of gynecomastia-inducing drugs and/or substances for at least six months; **AND**
        c. Persistent breast pain despite analgesics and/or anti-inflammatory agents; **AND**
        d. Functional impairment exists, including significantly limited, impaired, or delayed capacity to move, coordinate actions, difficulty in performing physical and motor tasks, independent movement, or performing basic life functions; **AND**
        e. Glandular breast tissue is documented by physical exam and/or mammogram, confirming true gynecomastia and not pseudo-gynecomastia; **AND**
        f. BMI less than the 95th percentile for children and teens of the same age and gender; **AND**
        g. Preoperative photographs are provided; **OR**

C. Post Pubertal-Onset Gynecomastia
    1. Unilateral or bilateral; **AND**
    2. Grade III or IV; **AND**
    3. Has persisted for at least six months; **AND**
    4. Meets ALL of the following criteria:
        a. Persistent for at least six months after pathological causes have been ruled out; **AND**
        b. Persistent for at least one year after pathological causes have been treated; **AND**

c. Appropriate discontinuation of gynecomastia-inducing drugs and/or substances for at least six months; **AND**
d. Persistent breast pain despite analgesics and/or anti-inflammatory agents; **AND**
e. Functional impairment exists, including significantly limited, impaired, or delayed capacity to move, coordinate actions, difficulty in performing physical and motor tasks, independent movement, or performing basic life functions; **AND**
f. Glandular breast tissue is documented by physical exam and/or mammogram, confirming true gynecomastia and not pseudo-gynecomastia; **AND**
g. BMI < 30; **AND**
h. Preoperative photographs are provided

Additional Information

- Requests for a mastectomy for gynecomastia outside of this guideline will be referred for medical director review.

References

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