Gynecomastia Surgery (for Ohio Only)

Policy Number: CS051OH.A
Effective Date: October 1, 2023

Instructions for Use

Table of Contents **Page**

Related Policies

- Cosmetic and Reconstructive Procedures (for Ohio Only)
- Panniculectomy and Body Contouring Procedures (for Ohio Only)

Application

This Medical Policy only applies to the state of Ohio. Any requests for services that are stated as unproven or services for which there is a coverage or quantity limit will be evaluated for medical necessity using Ohio Administrative Code 5160-1-01.

Coverage Rationale

Surgical treatment of gynecomastia is considered reconstructive and medically necessary in certain circumstances.
For medical necessity clinical coverage criteria, refer to the InterQual® CP: Procedures:

- Reduction Mammaplasty, Male
- Reduction Mammaplasty, Male (Adolescent)

Click here to view the InterQual® criteria.

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 policy 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 federal, state, or contractual requirements 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 in the Medical Policy titled Panniculectomy and Body Contouring Procedures (for Ohio Only).

CPT Code	Description
19300	Mastectomy for gynecomastia

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Description of Services

Gynecomastia is a benign proliferation of glandular breast tissue in men. Physiologic gynecomastia is common in newborns, adolescents, and older men. Treatment is directed at minimizing emotional distress and physical discomfort. Non-physiologic gynecomastia may be caused by chronic conditions including but not limited to cirrhosis, hypogonadism, and renal insufficiency; use of medications, supplements, or illicit drugs; and, rarely, tumors. Discontinuing using contributing medications and treating underlying diseases is the standard of practice. Medications, such as estrogen receptor modulators and surgery, have a role in treating gynecomastia in select patients. Mastectomy is the surgical removal of glandular breast tissue through an open incision or, more recently, through minimally endoscopic techniques. Cases considered severe may require larger incisions (Dickson, 2012).

U.S. Food and Drug Administration (FDA)

This section is to be used for informational purposes only. FDA approval alone is not a basis for coverage.

Surgeries for the treatment of gynecomastia are procedures and therefore not regulated by the FDA. Refer to the following website for additional information: http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfPMN/pmn.cfm. (Accessed February 8, 2023)

References

Ohio Administrative Code/5160/Chapter 5160-1-01. Medicaid medical necessity: definitions and principles. Available at: https://codes.ohio.gov/ohio-administrative-code/rule-5160-1-01. Accessed March 29, 2023.

Policy History/Revision Information

Date	Summary of Changes

10/01/2023	**Title Change/Template Update**
	• Previously titled *Gynecomastia Treatment (for Ohio Only)*
	• Changed policy type classification from "Coverage Determination Guideline" to "Medical Policy"
	Application
	• Added language to indicate any requests for services that are stated as unproven or services for which there is a coverage or quantity limit will be evaluated for medical necessity using *Ohio Administrative Code, Rule 5160-1-01 Medicaid Medical Necessity: Definitions and Principles*
	Coverage Rationale
	• Revised language to indicate surgical treatment of gynecomastia is considered reconstructive and medically necessary in certain circumstances; for medical necessity clinical coverage criteria, refer to the InterQual® CP: Procedures:
	  ○ Reduction Mammaplasty, Male
	  ○ Reduction Mammaplasty, Male (Adolescent)
	Supporting Information
	• Added *Description of Services* and *FDA* sections
	• Updated *References* section to reflect the most current information
	• Removed *Definitions* section
	• Archived previous policy version CS051OH.L – P

Instructions for Use

This Medical Policy provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the federal, state (Ohio Administrative Code [OAC]) or contractual requirements for benefit plan coverage must be referenced as the terms of the federal, state (OAC) or contractual requirements for benefit plan coverage may differ from the standard benefit plan. In the event of a conflict, the federal, state (OAC) or contractual requirements for benefit plan coverage govern. Before

using this policy, please check the federal, state (OAC) or contractual requirements for benefit plan coverage. UnitedHealthcare reserves the right to modify its Policies and Guidelines as necessary. This Medical Policy is provided for informational purposes. It does not constitute medical advice.

UnitedHealthcare uses InterQual® for the primary medical/surgical criteria, and the American Society of Addiction Medicine (ASAM) for substance use, in administering health benefits. If InterQual® does not have applicable criteria, UnitedHealthcare may also use UnitedHealthcare Medical Policies, Coverage Determination Guidelines, and/or Utilization Review Guidelines that have been approved by the Ohio Department for Medicaid Services. The UnitedHealthcare Medical Policies, Coverage Determination Guidelines, and Utilization Review 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.