Easy Choice Health Plan, Inc.

Harmony Health Plan of Illinois, Inc.

Missouri Care, Inc.

'Ohana Health Plan, a plan offered by
WellCare Health Insurance of Arizona, Inc.

WellCare Health Insurance of Illinois, Inc.

WellCare Health Plans of New Jersey, Inc.

WellCare Health Insurance of Arizona, Inc.

WellCare of Florida, Inc.

WellCare of Connecticut, Inc.

WellCare of Georgia, Inc.

WellCare of Kentucky, Inc.

WellCare of Louisiana, Inc.

WellCare of New York, Inc.

WellCare of South Carolina, Inc.

WellCare of Texas, Inc.

WellCare Prescription Insurance, Inc.

Windsor Health Plan

Windsor Rx Medicare Prescription Drug Plan

Mastectomy for Gynecomastia

Policy Number: HS-062

Original Effective Date: 11/20/2008

Revised Date(s): 11/24/2009; 11/12/2010; 10/6/2011; 11/1/2012; 12/5/2013; 12/4/2014

APPLICATION STATEMENT

The application of the Clinical Coverage Guideline is subject to the benefit determinations set forth by the Centers for Medicare and Medicaid Services (CMS) National and Local Coverage Determinations and state-specific Medicaid mandates, if any.

DISCLAIMER

The Clinical Coverage Guideline is intended to supplement certain standard WellCare benefit plans. The terms of a member's particular Benefit Plan, Evidence of Coverage, Certificate of Coverage, etc., may differ significantly from this Coverage Position. For example, a member's benefit plan may contain specific exclusions related to the topic addressed in this Clinical Coverage Guideline. When a conflict exists between the two documents, the Member's Benefit Plan always supersedes the information contained in the Clinical Coverage Guideline. Additionally, Clinical Coverage Guidelines relate exclusively to the administration of health benefit plans and are NOT recommendations for treatment, nor should they be used as treatment guidelines. The application of the Clinical Coverage Guideline is subject to the benefit determinations set forth by the Centers for Medicare and Medicaid Services (CMS) National and Local Coverage Determinations and state-specific Medicaid mandates, if any. *Note: The lines of business (LOB) are subject to change without notice; consult www.wellcare.com/Providers/CCGs for list of current LOBs.*

BACKGROUND

Applicable To:

- ☑ Medicaid
- ☑ Medicare

Mastectomy for gynecomastia is a surgical procedure performed to remove glandular breast tissue from a male with enlarged breasts.

1. Mastectomy (including reconstruction if necessary) for gynecomastia is considered medically necessary and a covered benefit when ALL of the following criteria are met:

- The tissue removed is glandular breast tissue and not the result of obesity, adolescence, or reversible effects of a drug treatment which can be discontinued (this would include drug-induced gynecomastia remaining unresolved six months after cessation of the causative drug therapy); **AND**
- Appropriate diagnostic evaluation has been done for possible underlying etiology; **AND**
- Patient has pain or tenderness directly related to the breast tissue and is documented in the medical record which has a clinically significant impact upon activities of daily living and has been refractory to a trial of analgesics or anti-inflammatory agents (for a reasonable time period adequate to assess therapeutic effects); **AND**
- Pre-operative photographs are provided; **AND,**
- Member is 18 months post-attainment of Tanner V pubertal staging.

2. Conditions that may be associated with gynecomastia include, but are not limited to:

- Documented androgen deficiency;
- Chronic liver disease that causes decreased androgen availability;
- Klinefelter's syndrome (47XYY);
- Adrenal tumors that cause androgen deficiency or increased secretion of estrogen;
- Brain tumors that cause androgen deficiency;
- Testicular tumors causing androgen deficiency or tumor secretion of estrogen;
- Endocrine disorders e.g., hyperthyroidism.

True gynecomastia is a result of a variety of conditions causing a hormonal imbalance and results in the growth of glandular breast tissue in males. This condition should not be confused with pseudo-gynecomastia, which is an enlargement of the breast due to fat deposition. According to the American Society of Plastic Surgeons, gynecomastia is usually a transient phenomenon in up to 60 to 70 percent of pubescent boys and is considered a normal part of male adolescence. The peak incidence occurs at 14 to 14 1/2 years, and spontaneously resolves in one to two years after onset. For this reason, clinical observation for a 12-24 month period of time is sometimes employed by treating physicians. However, about 30 to 40 percent of adult men have been found to have gynecomastia. Frequently, the cause is unknown and not due to tumors of the endocrine system or drug-induced side effects. True gynecomastia, which has an unknown cause, is usually long-standing. Medical and laboratory investigation is frequently unnecessary to determine a cause. In such cases, surgery is the only treatment alternative. Gynecomastia that is unilateral in post-adolescent age groups or that has a rapid onset is frequently associated with an underlying pathology. For this reason, careful clinical evaluation is warranted to rule out possible pathological

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etiologies, prior to any surgical interventions. In such cases, when doctors are able to determine the cause of the gynecomastia and address it appropriately, spontaneous resolution of the gynecomastia usually occurs over a short period of time.

Gynecomastia has been linked to several disorders affecting the endocrine system, as well as being a side effect from certain drugs. Frequently, treating the underlying condition, such as removal of a tumor or changing medications, will resolve gynecomastia. Such conservative measures should be attempted prior to any surgical approach to gynecomastia. Some drugs associated with the occurrence of gynecomastia include, but are not limited to:

- Estrogens;
- Androgens;
- Spironolactone;
- Digitalis preparations;
- Flutamide;
- Ketoconazole;
- Cimetidine.

Drugs of abuse that can also be associated with the development of gynecomastia include: steroids, alcohol, and marijuana. The medical literature indicates that gynecomastia is due to the stimulated growth of glandular breast tissue and does not significantly affect the disposition of fatty tissue. Therefore, mastectomy for gynecomastia must focus on the removal of glandular tissue underlying the condition. The use of liposuction as a method of mastectomy for gynecomastia has not been proven to remove glandular tissue and is not considered an acceptable alternative to standard surgical approaches.

Gynecomastia, being a proliferative condition of the male breast, can occasionally lead to concern about the development of carcinomatous changes in the breast. In some cases, biopsy results do not lead to a clear distinction between noncancerous and cancerous breast tissue. In such cases, mastectomy is indicated regardless of patient age to properly address those concerns.

POSITION STATEMENT

Applicable To:

- ☑ Medicaid
- ☑ Medicare

Mastectomy for gynecomastia **is considered medically necessary and a covered benefit**, regardless of the member's age, *when there is legitimate concern that a breast mass may represent breast carcinoma*. Mammography may be conducted to determine the need for surgery in some instances.

NOTE: The use of liposuction to perform mastectomy for gynecomastia **is considered investigational and NOT medically necessary and is NOT a covered benefit.**

Mastectomy for gynecomastia **is NOT a covered benefit** when performed for cosmetic reasons.

CODING

Covered CPT®* Code

19300	Mastectomy for gynecomastia

Covered ICD-9 Procedure codes

85.41	Unilateral simple mastectomy
85.42	Bilateral simple mastectomy

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DRAFT ICD-10-PCS Codes

0HTT0ZZ Resection of Right Breast, Open Approach
0HTU0ZZ Resection of Left Breast, Open Approach
0HTV0ZZ Resection of Bilateral Breast, Open Approach

Non-Covered CPT®* Code

15877 Suction Assisted Lipectomy - Trunk

Non-Covered ICD-9 Procedure codes

86.83 Liposuction

NON-COVERED DRAFT ICD-10-PCS Codes

Refer to the following ICD-10-PCS table(s) for specific PCS code assignment based on physician documentation.

NOTE: Per ICD-10-PCS Coding Guidelines, "ICD-10-PCS codes are composed of seven characters. Each character is an axis of classification that specifies information about the procedure performed. Within a defined code range, a character specifies the same type of information in that axis of classification. One of 34 possible values can be assigned to each axis of classification in the seven-character code".

0J0 Alteration of Posterior Neck Subcutaneous Tissue and Fascia

HCPCS Codes Not applicable

Covered ICD-9-CM Diagnosis Codes

611.1 Hypertrophy of Breast; Gynecomastia

Covered ICD-10-CM Diagnosis Codes

N62 Hypertrophy of breast

REFERENCES

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MEDICAL POLICY COMMITTEE HISTORY AND REVISIONS

Date	Action
12/4/2014	• Approved by MPC. No changes.
12/5/2013	• Approved by MPC. Included criteria regarding Tanner V pubertal staging.
11/1/2012	• Approved by MPC. No changes.
12/1/2011	• New template design approved by MPC.
10/6/2011	• Approved by MPC. Reformatted references; no major changes.