

Clinical Policy: Mastectomy for Pubertal Gynecomastia

Reference Number: TX.CP.MP.571

Last Review Date: 09/24

[Coding Implications](#)

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

Description

Gynecomastia is a benign condition in males, characterized by proliferation of glandular elements resulting in concentric enlargement of one or both breasts. During puberty, there may be a transient relative imbalance between estrogen and testosterone, leading to gynecomastia. This condition usually resolves by age 18 years when normal adult androgen/estrogen ratios are achieved. Surgical removal of the breast glandular tissue should be considered in males who have had persistent pubertal gynecomastia and have completed or nearly completed puberty and for whom the condition poses medical or mental health risks.

Common triggers for gynecomastia are medications such as certain antipsychotics, anti-retrovirals, and prostate cancer therapies, as well as non-prescription drugs such as performance-enhancing supplements, anabolic steroids and the excessive use of marijuana. Common medical conditions that can cause gynecomastia include Klinefelter syndrome, adrenal tumors, brain tumors, chronic liver disease, androgen deficiency, endocrine disorders, and testicular tumors.

This policy applies to the following products: STAR, STAR Health, STAR Kids, STAR+PLUS, and CHIP.

Policy/Criteria

- I. It is the policy of Superior HealthPlan that mastectomy for pubertal gynecomastia is **medically necessary** for members meeting the following criteria:
 - A. Males who are 20 years of age and younger.
 - B. The gynecomastia classification (grade II, III, or IV) as defined by the American Society of Plastic Surgeons classification.
 - C. Evidence that puberty is near completion, as indicated by both of the following:
 1. 95 percent of adult height achieved, based on bone age.
 2. Tanner stage V has been achieved.
 - D. Evidence that the member has been off gynecomastia-related drugs or other substances for a minimum of one year when this has been identified as the cause of the gynecomastia and yet the gynecomastia has persisted.
 - E. Evidence that the member had a work-up for hormonal causes of gynecomastia, including hyperthyroidism, hypogonadism, and prolactinomas.
 - F. Evidence that, if a hormonal cause of the gynecomastia was discovered, the member had appropriate treatment for one year and yet the gynecomastia has persisted.
 - G. Evidence of a psychiatric or psychological assessment performed by a psychiatrist or psychologist which documents a significant negative psychosocial impact on the member as a result of the gynecomastia.
 - H. Member's history and treatment plan including planned surgical procedure and timelines.
 - I. Identification of which breast or breasts require mastectomy.

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Coding Implications

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CPT® Codes	Description
19300	Mastectomy for pubertal gynecomastia

HCPSC Codes	Description
N/A	

ICD-10-CM Diagnosis Codes that Support Coverage Criteria

ICD-10-CM Code	Description
N/A	

Reviews, Revisions, and Approvals	Date	Approval Date
Policy Created.	12/15	12/15
STAR Kids added to products. Grammatical edits. Updated references and signatories.	12/16	12/16
Updated revision date, references, and signatories.	12/17	12/17
Annual Review. Updated Review Date, references and signatories	10/18	10/18
Updated to new template from TX.UM.71 (TX.CP.MP.571 nomenclature implementation 10/1/19). Updated references.	10/19	10/19
Annual Review. Updated References.	09/20	09/20
Annual Review. Updated References.	09/21	09/21
Annual Review. References Updated.	09/22	09/22
Annual Review. References Updated.	09/23	9/23
Annual Review. References Updated.	09/24	09/24

References

1. Texas Medicaid Provider Procedures Manual, Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook, 9.2.44.2.3 Mastectomy for Pubertal Gynecomastia, August 2024
2. CP.MP.51 Reduction Mammoplasty and Gynecomastia Surgery.

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3. American College of Plastic Surgeons, Gynecomastia Practice Parameters, February 2004. Reaffirmed July 2015.
4. UpToDate, “Management of Gynecomastia”, June 2024

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

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This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at <http://www.cms.gov> for additional information.

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