Coverage of Mastectomy in Gynecomastia

Adjudication Guideline

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Medical

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Abstract

For Members

Gynecomastia is an enlargement of male breast(s).Some of the common causes are hormonal imbalance, side effect of drugs or obesity.

For Medical Professionals

Gynecomastia can be categorised into three types:

a. **True Gynecomastia** is the benign enlargement of the male breast with firm/glandular tissue extending concentrically beyond the nipple (sub areolar). Clinically, it presents as a soft mobile tender sub areolar mass.

b. **Pseudo-Gynecomastia** which is due to adipose tissue which lead to breast enlargement in male (usually bilateral).

c. **Physiological Gynecomastia,** it has tri-modal peaks at infancy, pubescent adolescence and older/elderly men which is common.

Coverage of Mastectomy in Gynecomastia

Scope

The scope of this adjudication rule highlights the coverage criteria of Mastectomy for Gynecomastia, for all health insurance plans administered by Daman subject to policy terms and conditions.

Adjudication Policy

Eligibility / Coverage Criteria

1. Medical Professionals:

The Questionnaire has to be filled or submit the required documents mentioned in the questionnaire while submitting for preauthorization request for Mastectomy for Gynecomastia.

2. Criteria's for Mastectomy for Gynecomastia, when all the below criteria's are documented:

   a) Age 18 years of age / older or completion of puberty (Tanner 5)
   b) Body mass index (BMI) of:
      a) Less than 30 kg/m^2;
      b) BMI >30 with documented failed conservative measure which includes weight loss program and exercise program for 6 months.
   c) Gynecomastia with Klinefelter's syndrome
   d) Mammogram or Ultrasound or Histopathology Biopsy (FNAC/ VACNB / Core biopsy)
   e) Estradiol level or testicular ultra-sonogram (if the serum Estradiol level is elevated)
   f) Persistent pain and/or physical discomfort from the breast despite clear documentation of the use of analgesics for at least six (6) months.
   g) Medically refractory skin breakdown or intertrigo resistant
   h) If applicable, the use of any Gynecomastia causing drugs or Over The Counter (OTC) products under the direction of a licensed clinician to treat a medical condition have been discontinued for at least 6 months with persistent symptoms, or it is well-documented that the medication cannot be safely discontinued;
   i) Gynecomastia is documented as Grade III or IV based on the American Society of Plastic Surgeons(ASPS) Gynecomastia Scale (as specified in the Definitions section);
   j) Medical record clearly excludes substance abuse, supplements, herbal products, and recreational hormones (including steroids) from contributing to the Gynecomastia.

3. Eligible clinician specialties to bill mastectomy for gynecomastia

Eligible clinician
General surgery
Plastic surgery

Requirements for Coverage

- ICD and CPT codes must be coded to the highest level of specificity.
- Failure to submit, upon request or when requesting a clinical history, indication the need for testing will result in rejection of claim.
- Will be covered only for medical necessity.

Coverage of Mastectomy in Gynecomastia

Non-Coverage

- Mastectomy for Gynecomastia will not be covered for visitors plan as per policy terms and conditions.
- Will be considered cosmetic if the eligible criteria's are not met.
- Grade I or II Gynecomastia (according to the ASPS Gynecomastia Scale) is not covered.
- Pseudo Gynecomastia (excess adipose tissue) is not covered.
- Gynecomastia that is expected to resolve (i.e., a result of a developmental condition expected to resolve with time – i.e., adolescence) is not covered.
- Gynecomastia caused by substance abuse, result of supplements, herbal products, or hormones (including steroids) that are not prescribed by a licensed clinician to treat a medical condition is not covered.
- When the primary reason for wanted Gynecomastia surgery is to treat psychological distress related to the condition is not covered.

Payment and Coding Rules

Please apply DOH payment rules and regulations and relevant coding manuals for ICD, CPT.

Denial codes

Code description
Service is not clinically indicated based on good clinical practice
Service is not clinically indicated based on good clinical practice, without additional supporting diagnoses/activities
Service /supply may be appropriate , but too frequent
Service(s) is (are) not covered
Payment is included in allowance for another service

Appendices

A. References

- https://bestpractice.bmj.com/topics/en-gb/869
- https://emedicine.medscape.com/article/120858-treatment#d1
- https://bestpractice.bmj.com/topics/en-gb/869
- https://www.cancer.org/cancer/breast-cancer/about/what-is-breast-cancer.html
- http://www.radiologyassistant.nl/en/p49a3cce262026/pathology-of-the-male-breast.html
- https://bestpractice.bmj.com/topics/en-us/716/investigations
- https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3265148/
- https://bestpractice.bmj.com/topics/en-gb/869/investigations
- https://bestpractice.bmj.com/topics/en-us/716/investigations
- https://emedicine.medscape.com/article/1273437-workup#showall
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- https://emedicine.medscape.com/article/1947145-treatment#showall
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- https://bestpractice.bmj.com/topics/en-gb/869/treatment-algorithm
- https://bestpractice.bmj.com/topics/en-us/716/treatment-algorithm
- http://www.aamj.eg.net/journals/pdf/2204.pdf
- https://bestpractice.bmj.com/topics/en-us/869/differentials
- https://bestpractice.bmj.com/topics/en-gb/717/investigations

B. Questionnaire:

https://www.damanhealth.ae/main/pdf/support/Questionnaire/MastectomyinGynecomastiaQuestionnaire.pdf

C. Revision History

Date	Change(s)
September 26th, 2018	Release of V1.0
10-01-2023	Questionnaire link update