

Coverage of Mastectomy in Gynecomastia

Adjudication Guideline

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1. Abstract

1.1 For Members

Gynecomastia is a benign enlargement of glandular breast tissue in males. It can occur during puberty, with ageing, because of a medical condition, or because of medications, hormones, supplements, or other substances.

Many pubertal cases improve without surgery. Mastectomy may be covered when true gynecomastia is long-lasting, reversible causes have been assessed and treated where possible, and the condition causes documented physical symptoms or complications that justify surgery.

Coverage remains subject to the member's benefits and any applicable prior-authorization requirements.

1.2 For Medical Professionals

Gynecomastia refers to benign proliferation of glandular breast tissue in males and should be differentiated from pseudogynecomastia, which represents fatty breast enlargement without glandular proliferation.

The condition may be categorized as:

- A. **True Gynecomastia:** Benign proliferation of glandular breast tissue, typically palpable beneath the nipple-areolar complex.
- B. **Pseudo-Gynecomastia:** Enlargement caused predominantly by adipose tissue without clinically significant glandular proliferation.
- C. **Physiological Gynecomastia:** Occurs during infancy, puberty, and older age and often resolves spontaneously.
- D. **Secondary Gynecomastia:** May be associated with hypogonadism, Klinefelter syndrome, thyroid, liver or renal disease, testicular or other tumors, medications, anabolic steroids, recreational hormones, supplements, or substance exposure.

Evaluation of underlying etiologies is essential before consideration of surgical intervention.

2. Scope

This adjudication guideline outlines the coverage criteria and documentation requirements for mastectomy for gynecomastia for healthcare providers and members under all health insurance plans administered by Daman, subject to applicable policy terms and conditions.

3. Adjudication Policy

3.1 Eligibility / Coverage Criteria

Mastectomy for gynecomastia may be considered medically necessary when all applicable coverage criteria are met and supported by the completed questionnaire and relevant clinical documentation.

- True gynecomastia is clinically confirmed and differentiated from pseudo gynecomastia.
- The condition is persistent and has not adequately regressed following appropriate assessment, observation, or management of reversible causes.
- Clinically significant symptoms, physical complications, or functional impairment are documented.
- The treating surgeon documents the proposed procedure and medical-necessity rationale.

The Gynecomastia Preauthorization Questionnaire must be completed and submitted with the preauthorization request. Alternatively, all required clinical documents specified in the questionnaire must be submitted.

Requirements for Pre-approval for Mastectomy for Gynecomastia

Mastectomy for gynecomastia may be considered medically necessary when all of the following criteria are met and documented:

- **Completion of puberty (Tanner Stage V) and persistent gynecomastia for at least 12 months** despite evaluation and management of reversible or contributing causes.
- **Body Mass Index (BMI):**
 - Less than **30 kg/m²**; OR
 - **30 kg/m² or greater** with documented unsuccessful weight-loss and exercise measures for at least **six (6) months**.
- **Gynecomastia severity** is documented as **Grade III or Grade IV** according to the **American Society of Plastic Surgeons (ASPS) Gynecomastia Classification Scale**.
- **Diagnostic evaluation** confirms true gynecomastia and excludes alternative diagnoses, including pseudogynecomastia, breast cyst, breast mass, or malignancy.
 - Mammography, breast ultrasound, and/or histopathological assessment shall be performed when clinically indicated.
- **Hormonal and testicular evaluation** has been completed when clinically indicated, including:
 - Serum estradiol testing; and
 - Testicular ultrasound in the presence of elevated estradiol levels or findings suggestive of testicular pathology.

- **Assessment of underlying and contributing causes** has been completed and documented, including evaluation for:
 - Klinefelter syndrome;
 - Endocrine disorders;
 - Medication-induced gynecomastia;
 - Substance use;
 - Herbal products and dietary supplements;
 - Recreational hormone use; and
 - Anabolic steroid use.
- The member continues to experience **at least one** of the following despite appropriate conservative management:
 - Persistent breast pain, tenderness, or physical discomfort for at least **six (6) months**; OR
 - Medically refractory skin breakdown, intertrigo, or other dermatologic complications despite appropriate treatment; OR
 - Functional impairment attributable to breast enlargement.
- When gynecomastia is associated with a prescribed medication or over-the-counter (OTC) product:
 - The offending agent has been discontinued, substituted, or otherwise addressed for at least **six (6) months**, where clinically feasible, with persistent symptoms; OR
 - Documentation confirms that discontinuation or substitution is not medically appropriate.
- Documentation confirms that potential contributing factors have been appropriately assessed and addressed where clinically indicated.

Eligible clinician specialties to bill mastectomy for gynecomastia

The procedure must be performed by a licensed Specialist or Consultant in Plastic Surgery or General Surgery, practising within the approved scope of practice and holding the required clinical privileges at the healthcare facility.

Eligible Clinician
General Surgery
General Surgery/ Surgical Critical Care
General Surgery/ Vascular
General Surgery/Plastic Surgery
Plastic Surgery

3.2 Requirements for Coverage

- A completed Preauthorization Request Form or Gynecomastia Questionnaire must be submitted with the required supporting clinical documentation.
- The medical record must support the diagnosis, severity of gynecomastia, previous management, and medical necessity for the requested procedure.
- Documentation must demonstrate that the Eligible Criteria for Mastectomy for Gynecomastia specified in this policy have been met.
- Relevant laboratory, imaging, pathology, and other diagnostic reports must be submitted when clinically indicated.
- Requests for repeat, revision, or corrective procedures must include documented medical necessity and supporting records from the previous procedure.
- ICD-10 and CPT codes must be reported to the highest applicable level of specificity and supported by the medical record.
- Incomplete or insufficient documentation may result in rejection of the preauthorization request or claim.
- Coverage is subject to medical necessity and applicable policy terms and conditions.

3.3 Non-Coverage

- Mastectomy for gynecomastia will not be covered under Visitor Plans, as per applicable policy terms and conditions.
- Mastectomy for gynecomastia is not covered when the Eligible Criteria for specified in this policy are not met.
- Gynecomastia that is expected to resolve spontaneously, including physiologic pubertal gynecomastia, is not covered.
- Gynecomastia resulting from substance abuse, or from the use of supplements, herbal products, recreational hormones, or anabolic steroids that are not prescribed by a licensed clinician for the treatment of a medical condition, is not covered.
- Mastectomy for gynecomastia is not covered when psychological distress related to the condition is the sole indication for surgery.

3.4 Payment and Coding Rules

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

4. Denial Codes

Code	Code description
MNEC-003	Service is not clinically indicated based on good clinical practice
MNEC-004	Service is not clinically indicated based on good clinical practice, without additional supporting diagnoses/activities
MNEC-005	Service /supply may be appropriate, but too frequent
NCOV-003	Service(s) is (are) not covered
PRCE-002	Payment is included in allowance for another service

5. Appendices

5.1 References

- <https://www.uptodate.com/contents/clinical-features-diagnosis-and-evaluation-of-gynecomastia-in-adults?>
- <https://bestpractice.bmj.com/topics/en-gb/869>
- <https://www.ncbi.nlm.nih.gov/books/NBK279105/>
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- <https://journals.lww.com/prsgo/fulltext/10.1097/gox.0000000000003161~surgical-management-of-gynecomastia-a-comprehensive-review>
- [https://www.jprasurg.com/article/S1748-6815\(22\)00079-1/abstract](https://www.jprasurg.com/article/S1748-6815(22)00079-1/abstract)
- <https://www.aafp.org/afp/2012/0401/p716>

5.2 Revision History

Date	Change(s)
26/09/2018	Release of V1.0
30/09/2026	Release of V1.1 General Content review Template Updated

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