Clinical Review Criteria
Gynecomastia

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Criteria
For Medicare Members
See Local Coverage Article: Cosmetic vs. Reconstructive Surgery (A52729)

For Non-Medicare Members
Kaiser Permanente has elected to use the Mastectomy for Gynecomastia (KP-0273) MCG* for medical necessity determinations.

*MCG manuals are proprietary and cannot be published and/or distributed. However, on an individual member basis, Kaiser Permanente can share a copy of the specific criteria document used to make a utilization management decision. If one of your patients is being reviewed using these criteria, you may request a copy of the criteria by calling the Kaiser Permanente Clinical Review staff at 1-800-289-1363.

The following information was used in the development of this document and is provided as background only. It is not to be used as coverage criteria. Please only refer to the criteria listed above for coverage determinations.

Background
Gynecomastia is a unilateral or bilateral enlargement of the male breast due to benign proliferation of glandular elements. Pubertal gynecomastia resolves without intervention in the majority of cases. Gynecomastia in postpubertal males may be due to persistent pubertal gynecomastia, medications, liver disease, kidney disease, testicular tumors, or endocrine disorders. The cause remains undetermined in about 25% of cases. Male breast cancer is uncommon and usually presents as a discrete breast mass.

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MPC Medical Policy Committee

Revision History

Codes
CPT: 19300