# MEDICAL POLICY

| POLICY TITLE | SURGICAL TREATMENT OF GYNECOMASTIA |
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| POLICY NUMBER | MP 1.129 |

| CLINICAL BENEFIT | ☐ MINIMIZE SAFETY RISK OR CONCERN.<br>☐ MINIMIZE HARMFUL OR INEFFECTIVE INTERVENTIONS.<br>☐ ASSURE APPROPRIATE LEVEL OF CARE.<br>☐ ASSURE APPROPRIATE DURATION OF SERVICE FOR INTERVENTIONS.<br>☐ ASSURE THAT RECOMMENDED MEDICAL PREREQUISITES HAVE BEEN MET.<br>☐ ASSURE APPROPRIATE SITE OF TREATMENT OR SERVICE. |
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| **Effective Date:** | **8/1/2024** |



## I. POLICY

Reduction mammoplasty or mastectomy for the condition of male gynecomastia in **adults** may be considered **medically necessary** when the following are met:

- Grade III or IV gynecomastia as defined by the American Society of Plastic Surgeons (ASPS) (see Policy Guidelines) that
  - persists more than 4 months after pathological causes ruled out; **OR**
  - persists despite at least 4 months of medical treatment for pathological gynecomastia; **AND**
- Pain and discomfort due to the distention and tightness from the hypertrophied breast; **AND**
- Excess breast tissue is confirmed by mammogram or biopsy to be glandular and not fatty tissue

Reduction mammoplasty or mastectomy for the condition of male gynecomastia in **adolescents** may be considered **medically necessary** when the following are met:

- Grade II or III gynecomastia as defined by the ASPS (see Policy Guidelines) that
  - persists more than 1 year after pathological causes ruled out; **OR**
  - persists despite at least 6 months of medical treatment for pathological gynecomastia; **OR**
- Grade IV gynecomastia as defined by the ASPS (see Policy Guidelines) that
  - persists more than 6 months after pathological causes ruled out; **OR**
  - persists despite at least 6 months of medical treatment for pathological gynecomastia; **AND**
- Pain and discomfort due to the distention and tightness from the hypertrophied breast; **AND**

- Excess breast tissue is confirmed by mammogram or biopsy to be glandular and not fatty tissue

**Note:** Mastectomy for male gynecomastia is considered **medically necessary**, *regardless of patient age*, when there is legitimate concern that a breast mass may represent breast carcinoma.

### Policy Guidelines

There are several classifications of gynecomastia. As per the ASPS, "The surgical treatment of gynecomastia has two objectives: reconstruction of the male chest contour, and histological clarification of suspicious breast lesions. The age of the patient, consistency, grade, and the presence of unilateral or bilateral breast development determine the indication for surgery. Prior to surgical consult, the gynecomastia patient should undergo a complete history and physical exam and appropriate diagnostic testing to determine the underlying cause of the gynecomastia. Surgical resection for adolescent gynecomastia may be withheld for at least one year as many of these cases will spontaneously resolve."

The ASPS classification of gynecomastia is as follows:

Grade I: Small breast enlargement with localized button of tissue around the areola

Grade II: Moderate breast enlargement exceeding areola boundaries with edges that are indistinct from the chest

Grade III: Moderate breast enlargement exceeding areola boundaries with edges that are distinct from the chest with skin redundancy

Grade IV: Marked breast enlargement with skin redundancy and feminization of the breast

***Cross-references:***

**MP 1.004** Cosmetic and Reconstructive Surgery
**MP 1.013** Reduction Mammoplasty for Breast-Related Symptoms

## II. PRODUCT VARIATIONS TOP

This policy is only applicable to certain programs and products administered by Capital Blue Cross and subject to benefit variations as discussed in Section VI. Please see additional information below.

**FEP PPO** - Refer to FEP Medical Policy Manual. The FEP Medical Policy manual can be found at: https://www.fepblue.org/benefit-plans/medical-policies-and-utilization-management-guidelines/medical-policies

## III. DESCRIPTION/BACKGROUND TOP

Bilateral gynecomastia is a benign enlargement of the male breast, either due to increased adipose tissue, glandular tissue, fibrous tissue, or a combination of all 3. Surgical removal of the

breast tissue, using either surgical excision or liposuction, may be considered if conservative therapies are not effective or possible.

### Bilateral Gynecomastia

Gynecomastia is a benign enlargement of the male breast, either due to increased adipose tissue, glandular tissue, fibrous tissue, or a combination of all three. Surgical removal of the breast tissue, using either surgical excision or liposuction, may be considered if conservative therapies are not effective or possible.

Bilateral gynecomastia may be associated with any of the following:

- An underlying hormonal disorder (i.e., conditions causing either estrogen excess or testosterone deficiency such as liver disease or an endocrine disorder)
- An adverse effect of certain drugs
- Obesity
- Related to specific age groups, i.e.:
  - Neonatal gynecomastia, related to action of maternal or placental estrogens
  - Adolescent gynecomastia, which consists of transient, bilateral breast enlargement, which may be tender
  - Gynecomastia of aging, related to the decreasing levels of testosterone and relative estrogen excess

### Treatment

Treatment of gynecomastia involves consideration of the underlying cause. For example, treatment of the underlying hormonal disorder, cessation of drug therapy, or weight loss may all be effective therapies. Gynecomastia may also resolve spontaneously, and adolescent gynecomastia may resolve with aging.

Prolonged gynecomastia causes periductal fibrosis and stromal hyalinization, which prevents the regression of the breast tissue. Surgical removal of the breast tissue, using surgical excision or liposuction may be considered if the above conservative therapies are not effective or possible and the gynecomastia does not resolve spontaneously or with aging.

### Regulatory Status

Removal of the breast tissue is a surgical procedure and, as such, is not subject to regulation by the U.S. Food and Drug Administration.

## IV. RATIONALE

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### Summary of Evidence

For individuals with bilateral gynecomastia who receive surgical treatment, the evidence includes nonrandomized studies. Relevant outcomes are symptoms, functional outcomes, health status measures, quality of life, and treatment-related morbidity. Because there are no randomized controlled trials (RCTs) on functional outcomes after surgical treatment of bilateral

gynecomastia, it is not possible to determine with a high level of confidence whether surgical treatment improves symptoms or functional impairment. However, The American Society of Plastic Surgeons (ASPS) recommends surgery when pathological causes have been ruled out and/or medical treatment is unsuccessful.

## V. DEFINITIONS TOP

NA

## VI. BENEFIT VARIATIONS TOP

The existence of this medical policy does not mean that this service is a covered benefit under the member's health benefit plan. Benefit determinations should be based in all cases on the applicable health benefit plan language. Medical policies do not constitute a description of benefits. A member's health benefit plan governs which services are covered, which are excluded, which are subject to benefit limits, and which require preauthorization. There are different benefit plan designs in each product administered by Capital Blue Cross. Members and providers should consult the member's health benefit plan for information or contact Capital Blue Cross for benefit information.

## VII. DISCLAIMER TOP

*Capital Blue Cross' medical policies are developed to assist in administering a member's benefits, do not constitute medical advice and are subject to change. Treating providers are solely responsible for medical advice and treatment of members. Members should discuss any medical policy related to their coverage or condition with their provider and consult their benefit information to determine if the service is covered. If there is a discrepancy between this medical policy and a member's benefit information, the benefit information will govern. If a provider or a member has a question concerning the application of this medical policy to a specific member's plan of benefits, please contact Capital Blue Cross' Provider Services or Member Services. Capital Blue Cross considers the information contained in this medical policy to be proprietary and it may only be disseminated as permitted by law.*

## VIII. CODING INFORMATION TOP

**Note:** This list of codes may not be all-inclusive, and codes are subject to change at any time. The identification of a code in this section does not denote coverage as coverage is determined by the terms of member benefit information. In addition, not all covered services are eligible for separate reimbursement.

**Covered when medically necessary:**

| Procedure Codes | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 19300 | | | | | | | | |

| ICD-10-CM Diagnosis Code | Description |
|---|---|
| N62 | Hypertrophy of breast |

## IX. REFERENCES

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4. *Goes JC, Landecker A. Ultrasound-assisted lipoplasty (UAL) in breast surgery. Aesthetic Plast Surg 2002; 26(1):1-9*
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6. *Nuzzi LC, Firriolo JM, Pike CM, et al. The Effect of Surgical Treatment for Gynecomastia on Quality of Life in Adolescents. J Adolesc Health. Dec 2018; 63(6):759-765. PMID 30279103*
7. *Rohrich RJ, Ha RY, Kenkel, JM et al. Classification, and management of gynecomastia: defining the role of ultrasound-assisted liposuction. Plast Reconstr Surg 2003; 111(2):909-23; discussion 24-5*
8. *Prasetyono TOH, Budhipramono AG, Andromeda I. Liposuction Assisted Gynecomastia Surgery With Minimal Periareolar Incision: a Systematic Review. Aesthetic Plast Surg. Feb 2022; 46(1): 123-131. PMID 34379157*
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10. *Kanakis GA, Nordkap L, Bang AK, et al. EAA clinical practice guidelines-gynecomastia evaluation and management. Andrology. Nov 2019; 7(6): 778-793. PMID 31099174*
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13. *Pinelli M, De Maria F, Ceccarelli P, et al. Gynecomastia: an uncommon, destabilizing condition of the male adolescent. Our therapeutic choice. Acta Biomed. 2023;94(2):e2023055. PMID: 37092627*
14. *Blue Cross Blue Shield Association Medical Policy Reference Manual. 7.01.13 Surgical Treatment of Bilateral Gynecomastia. March 2024*

## X. POLICY HISTORY

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| **MP 1.129** | **02/14/2020 Consensus Review.** No changes to policy statements. Coding reviewed. References updated. |

# MEDICAL POLICY

| POLICY TITLE | SURGICAL TREATMENT OF GYNECOMASTIA |
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| POLICY NUMBER | MP 1.129 |

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| | **02/16/2021 Consensus Review.** No change to policy statement. Coding reviewed. References updated. |
| | **04/19/2022 Consensus Review.** No change to policy statement. Coding reviewed. Updated FEP, references. |
| | **03/24/2023 Minor Review.** Adolescent and Adult criteria separated. Criteria revised to include ASPS gynecomastia scale, removal of Tanner stage, incorporation of pain and discomfort, and addition of additional criteria that symptoms are refractory to medical treatment and persist beyond 4-12 months, depending on age and conditions. Policy Guidelines section extensively revised. Background, Rationale and References updated. |
| | **04/01/2024 Consensus Review.** No change in policy statement. Background updated. References added. |

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