

## MEDICAL POLICY

<b>POLICY TITLE</b>	<b>SURGICAL TREATMENT OF GYNECOMASTIA</b>
<b>POLICY NUMBER</b>	<b>MP 1.129</b>

<b>CLINICAL BENEFIT</b>	<input type="checkbox"/> MINIMIZE SAFETY RISK OR CONCERN. <input checked="" type="checkbox"/> MINIMIZE HARMFUL OR INEFFECTIVE INTERVENTIONS. <input type="checkbox"/> ASSURE APPROPRIATE LEVEL OF CARE. <input type="checkbox"/> ASSURE APPROPRIATE DURATION OF SERVICE FOR INTERVENTIONS. <input type="checkbox"/> ASSURE THAT RECOMMENDED MEDICAL PREREQUISITES HAVE BEEN MET. <input type="checkbox"/> ASSURE APPROPRIATE SITE OF TREATMENT OR SERVICE.
<b>Effective date:</b>	<b>5/1/2026</b>

### POLICY

Surgical removal of breast tissue, such as mastectomy or liposuction, as a treatment of gynecomastia, is considered **investigational** due to the lack of functional impairment. There is insufficient evidence to support a general conclusion concerning the health outcomes or benefits associated with the above procedures for these indications.

#### ***Cross-References:***

**MP 1.004 Cosmetic and Reconstructive Surgery**

**MP 1.013 Reduction Mammoplasty for Breast-Related Symptoms**

### PRODUCT VARIATIONS

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

**FEP PPO** - Refer to FEP medical policy manual. The FEP medical policy manual can be found at: [fepblue.org/benefit-plans/medical-policies-and-utilization-management-guidelines/medical-policies](http://fepblue.org/benefit-plans/medical-policies-and-utilization-management-guidelines/medical-policies).

### DESCRIPTION/BACKGROUND

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**

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

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- 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.

### RATIONALE

#### 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. Conservative therapy should adequately address any physical pain or discomfort, and gynecomastia does not typically cause functional impairment. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

### DEFINITIONS

NA

### DISCLAIMER

*Capital Blue Cross' medical policies are used to determine coverage for specific medical technologies, procedures, equipment, and services. These medical policies do not constitute medical advice and are subject to change as permitted by law or applicable clinical evidence from independent treatment guidelines. Treating providers are solely responsible for medical advice and treatment of members. These policies are not a guarantee of coverage or*

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payment. Payment of claims is subject to a determination regarding the member's benefit program and eligibility on the date of service, and a determination that the services are medically necessary and appropriate. Final processing of a claim is based upon the terms of contract that applies to the members' benefit program, including benefit limitations and exclusions. If a provider or a member has a question concerning this medical policy, please contact Capital Blue Cross' Provider Services or Member Services.

### CODING INFORMATION

**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.

#### Investigational therefore not covered:

Procedure Codes							
19300							

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

### REFERENCES

1. Rohrich RJ, Ha RY, Kenkel JM, et al. Classification and management of gynecomastia: defining the role of ultrasound-assisted liposuction. *Plast Reconstr Surg.* Feb 2003; 111(2): 909-23; discussion 924-5. PMID 12560721
2. Góes JC, Landecker A. Ultrasound-assisted lipoplasty (UAL) in breast surgery. *Aesthetic Plast Surg.* 2002; 26(1): 1-9. PMID 11891589
3. Fagerlund A, Lewin R, Ruffolo G, et al. Gynecomastia: A systematic review. *J Plast Surg Hand Surg.* 2015; 49(6): 311-8. PMID 26051284
4. 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
5. 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
6. Liu C, Tong Y, Sun F, et al. Endoscope-Assisted Minimally Invasive Surgery for the Treatment of Glandular Gynecomastia. *Aesthetic Plast Surg.* Dec 2022; 46(6): 2655-2664. PMID 35237883
7. American Society of Plastic Surgeons. *ASPS Recommended Insurance Coverage Criteria for Third-Party Payers: Gynecomastia.* 2002 (affirmed 2015)
8. 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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### POLICY HISTORY

<b>MP 1.129</b>	<b>02/14/2020 Consensus Review.</b> No changes to policy statements. Coding reviewed. References updated.
	<b>02/16/2021 Consensus Review.</b> No change to policy statement. Coding reviewed. References updated.
	<b>04/19/2022 Consensus Review.</b> No change to policy statement. Coding reviewed. Updated FEP, references.
	<b>03/24/2023 Minor Review.</b> 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.
	<b>04/01/2024 Consensus Review.</b> No change in policy statement. Background updated. References added.
	<b>03/21/2025 Major Review.</b> Surgery for gynecomastia changed from medically necessary to investigational. Policy Guidelines removed. Background, Rationale, Benefit Variation, Disclaimer and References updated.
	<b>07/15/2025 Administrative Update.</b> Removed Benefit Variations Section and updated Disclaimer.
	<b>01/21/2026 Consensus.</b> No change to policy statement.

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