MASSACHUSETTS

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Medical Policy

Surgical and Non-surgical Treatment of Gynecomastia

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Policy Number: 661

BCBSA Reference Number: N/A
NCD/LCD: N/A

Related Policies

Plastic Surgery, #068

Policy[1]

Commercial Members: Managed Care (HMO and POS), PPO, and Indemnity Medicare HMO Blue℠ and Medicare PPO Blue℠ Members

Adolescent Patients

Unilateral or bilateral surgical treatment of gynecomastia may be considered **MEDICALLY NECESSARY** for mid to late pubertal adolescents when **ALL** of the following criteria are met:

- Grade II or higher gynecomastia by physical examination (per modified McKinney and Simon, Hoffman and Kohn scales*), **AND**
- Patient is experiencing breast pain or tenderness, **AND**
- Excess breast tissue is glandular, not fatty tissue as confirmed by physical exam, mammogram or tissue pathology, **AND**
- Gynecomastia persists more than 1 year after pathological conditions have been ruled out or persists after 6 months of unsuccessful medical treatment of pathologic gynecomastia, **AND**
- Medical record clearly excludes substance abuse, supplements, herbal products, and recreational hormones (including steroids) from contributing to the gynecomastia.

Note: *Adolescent gynecomastia is common during puberty, and most cases resolve within 1 year.*

Adult Patients

Unilateral or bilateral surgical treatment of gynecomastia may be considered **MEDICALLY NECESSARY** for individuals **with** Klinefelter's syndrome and grade III or higher gynecomastia by physical examination (per modified McKinney and Simon, Hoffman and Kohn scales*).

Unilateral or bilateral surgical treatment of gynecomastia may be considered **MEDICALLY NECESSARY** for individuals **without** Klinefelter's syndrome when **ALL** of the following criteria are met:

- Grade III or higher gynecomastia by physical examination (per modified McKinney and Simon, Hoffman and Kohn scales*), **AND**
- Patient is experiencing breast pain or tenderness, **AND**
- Excess breast tissue is glandular, not fatty tissue as confirmed by physical exam, mammogram or tissue pathology, **AND**
- Gynecomastia persists more than 6 months after pathological conditions have been ruled out or persists after 6 months of unsuccessful medical treatment of pathologic gynecomastia, **AND**
- Medical record clearly excludes substance abuse, supplements, herbal products, and recreational hormones (including steroids) from contributing to the gynecomastia.

***Gynecomastia Scale adapted from the McKinney and Simon, Hoffman and Kohn scales**[1]
- Grade I Small breast enlargement with localized button of tissue that is concentrated 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 present.
- Grade IV Marked breast enlargement with skin redundancy and feminization of the breast.

Treatment of gynecomastia with cold-induced lipolysis/cryolipolysis is considered **INVESTIGATIONAL**.

Treatment of pseudogynecomastia, including but not limited to cold-induced lipolysis/cryolipolysis, surgical excision under general anesthesia, liposuction or a combination of both is considered **NOT MEDICALLY NECESSARY**.

Prior Authorization Information

Inpatient
- For services described in this policy, precertification/preauthorization **IS REQUIRED** for all products if the procedure is performed **inpatient**.

Outpatient
- For services described in this policy, see below for products where prior authorization **might be required** if the procedure is performed **outpatient**.

	Outpatient
Commercial Managed Care (HMO and POS)	Prior authorization is **not required**.
Commercial PPO and Indemnity	Prior authorization is **not required**.
Medicare HMO Blue℠	Prior authorization is **not required**.
Medicare PPO Blue℠	Prior authorization is **not required**.

CPT Codes / HCPCS Codes / ICD Codes

Inclusion or exclusion of a code does not constitute or imply member coverage or provider reimbursement. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage as it applies to an individual member.

Providers should report all services using the most up-to-date industry-standard procedure, revenue, and diagnosis codes, including modifiers where applicable.

The following codes are included below for informational purposes only; this is not an all-inclusive list.

The above medical necessity criteria MUST be met for the following codes to be covered for Commercial Members: Managed Care (HMO and POS), PPO, Indemnity, Medicare HMO Blue and Medicare PPO Blue:

CPT Codes

CPT codes:	Code Description
19300	Mastectomy for gynecomastia

The following ICD Diagnosis Codes are considered medically necessary when submitted with the CPT code above if medical necessity criteria are met:

ICD-10 Diagnosis Codes

ICD CM diagnosis codes:	Code Description
N62	Hypertrophy of breast
Q98.4	Klinefelter syndrome, unspecified

Description

Bilateral Gynecomastia

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 three. Bilateral gynecomastia may be associated with any of the following:

- An underlying hormonal disorder (ie, 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, ie,
  - 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 prevent regression of the breast tissue. Surgical removal of the breast tissue, using surgical excision or liposuction, may be considered if the conservative therapies above are not effective or possible and the gynecomastia does not resolve spontaneously or with aging.

Summary

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.

For individuals with bilateral gynecomastia who receive surgical treatment, the evidence includes case series. 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 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.

Policy History

Date	Action
5/1/2024	Annual policy review. References added. Policy statement unchanged. 5/1/2024.
1/2023	Annual policy review. PA information section clarified to include Medicare.
7/2022	Annual policy review. No references added. Policy statement unchanged.
6/2022	Clarified prior authorization information. Prior Authorization not required effective 6/1/2022. Clarified coding information.
4/2021	Annual policy review. Summary and references updated. Policy statement(s) unchanged.
1/2021	Medicare information removed. See MP #132 Medicare Advantage Management for local coverage determination and national coverage determination reference.
5/2020	Policy updated with literature review through April 2020, references added. Policy statements unchanged.
7/2018	Medical Policy Administration literature review through February 2018. New investigational indications described. Clarified coding information. Effective 7/1/2018.
10/2014	New medical policy describing medically necessary indications. Effective October 1, 2014.

Information Pertaining to All Blue Cross Blue Shield Medical Policies

Click on any of the following terms to access the relevant information:
Medical Policy Terms of Use
Managed Care Guidelines
Indemnity/PPO Guidelines
Clinical Exception Process
Medical Technology Assessment Guidelines

References

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2. 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
3. Goes JC, Landecker A. Ultrasound-assisted lipoplasty (UAL) in breast surgery. Aesthetic Plast Surg. Jan-Feb 2002; 26(1): 1-9. PMID 11891589
4. Abdelrahman I, Steinvall I, Mossaad B, et al. Evaluation of Glandular Liposculpture as a Single Treatment for Grades I and II Gynaecomastia. Aesthetic Plast Surg. Oct 2018; 42(5): 1222-1230. PMID 29549405
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. Fagerlund A, Lewin R, Rufolo G, et al. Gynecomastia: A systematic review. J Plast Surg Hand Surg. 2015; 49(6): 311-8. PMID 26051284
7. American Society of Plastic Surgeons. ASPS Recommended Insurance Coverage Criteria for Third-Party Payers: Gynecomastia. 2002 (affirmed 2015); https://www.plasticsurgery.org/Documents/Health- Policy/Positions/Gynecomastia_ICC.pdf. Accessed November 17, 2020.

Endnotes

[1] Based on expert opinion