Corporate Medical Policy

Gynecomastia

Description of Procedure or Service

Gynecomastia is a benign enlargement of the male breast that is caused by an imbalance in the ratio of circulating male hormone (testosterone) to female hormone (estrogen). Gynecomastia occurs with normal hormonal changes during puberty or aging, but can also be associated with other conditions or drugs that alter physiologic responses. Gynecomastia is characterized by the growth of glandular tissue within the breast, the growth of glandular tissue and fatty tissue deposits, or by an accumulation of fatty tissue alone. The condition is sometimes associated with pain or tenderness that warrants medical intervention; more often, patients seek treatment due to social concerns and/or embarrassment.

Benefit Application

This medical policy relates only to the services or supplies described herein. Please refer to the Member’s Benefit Booklet for availability of benefits.

Policy Statement

GEHA will provide coverage for surgical treatment of gynecomastia when it is determined to be medically necessary because the medical criteria and guidelines as documented below have been demonstrated.

When surgical treatment for gynecomastia is covered

Surgical treatment of gynecomastia may be considered medically necessary when ALL of the following have been demonstrated:

A. Gynecomastia or breast enlargement with moderate to severe chest pain that is causing a functional/physical impairment. The inability to participate in athletic events, sports or social activities is not considered to be a functional/physical or physiological impairment.

B. Grade 3 or 4 gynecomastia

C. No prior history of prescribed medications and appropriate screening(s) of non-prescription and/or recreational drugs or substances that have a known side effect of gynecomastia (examples include but are not limited to the following: testosterone, marijuana, asthma drugs, phenothiazines, anabolic steroids, cimetidine and calcium channel blockers) OR where indicated, discontinuation of medications, nutritional supplements, and non-prescription medications or that have a known side effect of gynecomastia or breast enlargement and the breast size did not regress after 6 or more months of discontinuation OR prescription medication that contributes to gynecomastia is required and there is no acceptable alternative medication.

D. The breast enlargement must be present for at least 2 years. Glandular breast tissue is the primary cause of gynecomastia as opposed to fatty deposits and is documented on physical exam and/or diagnostic imaging.
E. No other medical causes that would be indicated by an appropriate medical workup (see guidelines within this policy).

**When treatment for Gynecomastia is not covered**

A. Medical treatments and surgery to alter a perceived abnormal appearance, or for psychological reasons, are considered cosmetic and are not covered. The fact that a covered person may suffer psychological consequences or socially avoidant behavior as a result of benign gynecomastia does not classify surgery (or other procedures done to relieve such consequences or behavior) as a medically necessary reconstructive procedure.

B. Gynecomastia is not generally a congenital anomaly and thus is not covered as reconstructive in the absence of functional/physical impairment; any unusual mitigating circumstances must be assessed on an individual basis for medical necessity.

C. When excessive breast development is due to non-covered therapies or illicit drugs, e.g., anabolic steroids or marijuana.

D. When gynecomastia is caused by obesity (BMI>30), unless it is documented that the member has failed to respond to conservative measures which must include participation in a clinically supervised, comprehensive weight loss and exercise program for at least 6 months.

E. When coverage criteria documented above have not been demonstrated.

F. Suction lipectomy or ultrasound assisted liposuction as a sole method of treatment is not covered for treatment of gynecomastia.

**Physician documentation**

A. Current history and physical,
B. Past medical history including medications,
C. Clinical records documenting the indications listed as criteria within this clinical coverage policy,
D. Tried and failed treatments,
E. A letter of medical necessity.

**Policy Guidelines**

Individual medical necessity assessments may be required in the case of certain infrequent clinical scenarios, including but not limited to:

A. Gynecomastia as a result of testicular cancer with chemotherapy;
B. Gynecomastia with family history of breast cancer/ BRCA status;
C. Gynecomastia with biopsy results positive for ADH (atypical ductal hyperplasia) or DCIS (ductal carcinoma in situ).

A work up of gynecomastia to identify pathologic conditions should be done first to exclude testicular tumors, inadvertent chronic estrogen ingestion, fibromas or lipomas, drugs affecting androgen or estrogen production, anorchia or acquired testicular failure, Klinefelter syndrome, etc. In routine transient pubertal gynecomastia, reassurance and psychosocial support, weight loss, and physical activity are appropriate measures. In most cases, such surgery would be considered a cosmetic
procedure. Medical therapy should be aimed at correcting any reversible causes (e.g., drug discontinuance, weight loss).

Laboratory test would generally be expected to include, but would not be limited to: Hormone evaluation (i.e., testosterone, luteinizing hormone, follicle-stimulating hormone, estradiol, prolactin, beta-human chorionic gonadotropin) Liver enzymes, serum creatinine, and thyroid function tests.

The American Society of Plastic Surgeons (ASPS) (2015) recommends the following classification scale in their practice parameters for gynecomastia:

- 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 indistinct from the chest with skin redundancy present.
- Grade IV: Marked breast enlargement with skin redundancy and feminization of the breast.

**Background**

Gynecomastia occurs in a large percent of boys to some degree, usually during the first stages of puberty. Gynecomastia may be unilateral or bilateral and occurs most frequently in mid to later stages of puberty. Gynecomastia lasts generally at least 2 years. In few instances the breast tissue progresses to the point of Tanner stage 3 or 4 female breast development. It is in such instances that spontaneous regression is less likely and surgical intervention is more likely to be pursued, particularly when the breast is pendulous and hypertrophy is a significant somatic problem (Ambulatory Care Guidelines, 2018).

Bilateral gynecomastia refers to the benign enlargement of the male breasts on both sides. 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, is sometimes implemented when symptomatic findings or pathologic causes are encountered and conservative therapies are not effective or possible. Conservative therapy should adequately address any physical pain or discomfort and gynecomastia does not typically cause functional impairment. Due to this, surgical treatment of bilateral gynecomastia is usually considered not medically necessary.

Drugs account for about 20% of gynecomastia cases in men. As a number of factors can alter the estrogen: androgen ratio, several pathophysiologic mechanisms are associated with drugs causing this disorder. Antiandrogens, protease inhibitors, and nucleoside reverse transcriptase inhibitors are the most common drug causes of gynecomastia, whereas first-generation antipsychotics, spironolactone, verapamil, and cimetidine are less common causes. Other drugs have been reported rarely as causes. Treatment may involve switching to an alternative agent or may require surgery or irradiation if the causative agent cannot be discontinued (Bowman et. al., 2012) (Deepinder, et. al., 2012).

The evidence on the efficacy and safety of surgery for gynecomastia suggests that overall, the surgeries are safe, and that the majority of patients are satisfied with the cosmetic outcome. In general, there
appears to be fewer complications and a faster recovery associated with minimally invasive procedures. Patients requiring large or extensive resections have higher complication rates, and have higher rates of postoperative scarring. Predictors of a higher rate of complications and less satisfactory outcomes include the need for removal of large amounts of tissue and being overweight.

Zavlin, et. al. (2017) performed a retrospective analysis of the American College of Surgeons National Surgical Quality Improvement Program adult and pediatric databases to produce two cohorts that underwent gynecomastia surgical repair. The two populations were compared for comorbidities, perioperative details, and complication rates. Multivariate analyses helped detect risk factors associated with adverse events. A total of 204 pediatric and 1583 adult male patients were identified. Mean ages were 15.8 and 39.6 years, respectively. A BMI of 28.2 in the latter cohort revealed an overweight adult population. Preoperative comorbidities (0.0–4.9% in children, 0.0–6.4% in adults) and American Society of Anesthesiologists scores (ASA 1 + 2: 98.5 and 82.7%) symbolized a healthy population. Procedures were subsequently performed mostly as outpatient (84.3 and 93.9%) and with short hospitalization durations (0.27 and 0.06 days). It was concluded that operative gynecomastia treatment remains a safe treatment modality across all age groups. Patients with known preoperative medical or surgical comorbidities necessitate more extensive perioperative assessment and monitoring.

A recent Hayes research report (2019) analyzing literature databases over a 10 year span found insufficient published evidence to assess the safety and/or impact on health outcomes or patient management of liposuction as a stand-alone procedure for reduction mammoplasty in patients with macromastia.

In a small prospective case series, Qutob et al. (2010) evaluated the efficacy and safety of the use of a VABD and liposuction to treat gynecomastia in 36 patients with grade I or II disease (mean age 33.3 years, range 16 to 88; bilateral, 22; unilateral, 14). The patients were followed at 6 to 8 weeks after surgery. Patient satisfaction (poor, average, good, or excellent) was ascertained, and the surgeon-assessed result was evaluated in a visual analog scale (VAS) (scale 0-10 where 0 is worst outcome, and 10 is best). The VAS considered symmetry, scarring, and natural appearance. There were no (0%) conversions to open surgery. The average operative time was 50.3 min (range 30 to 80). There was 1 (3%) intraoperative complication in which a small area of the areola was sucked into the Mammotome and required excision. At follow-up, 34 (94%) patients reported excellent satisfaction while 2 (6%) had residual gynecomastia requiring revision surgery. Three (8%) patients had small transient hematomas at follow-up. The mean VAS score was 7.9 (range 4 to 9). While these results are promising, confirmation of the efficacy and safety of this technique is needed in prospective randomized controlled trials.

**Regulatory Status**

Reduction mammoplasty is a procedure; therefore, not subject to Food and Drug Administration (FDA) regulation. However, any medical devices, drugs, biologics, or tests used as a part of this procedure may be subject to FDA regulation.

The following list of codes are intended for reference purposes only, is not an all-inclusive code listing, and does not imply that the service is covered or non-covered. Applicable codes include but are not limited to:

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<th>CPT Code</th>
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19300 Mastectomy for gynecomastia (this is the appropriate code for mastectomy for gynecomastia. However, if liposuction is used as an adjunct to mastectomy, it should not be separately coded. Liposuction is considered a technique or "method" of the procedure and constitutes part of the global code of breast tissue excision.)

**Scientific references**


**Policy implementation and updates**

Feb 2018 Revision of background and clarity of coverage criteria with additional requirements

Feb 2019 Added criteria of no other medical causes. Clarified suction lipectomy as not covered. Clarified guidelines for medical assessment and/or workup.

Jan 2020 Revision of background with reference formatting. No changes to coverage.

Feb 2021 Removal of required refractory infection criteria as well as photo documentation.