

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.

Background

Gynecomastia occurs in up to 75 per cent 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.

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.

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.

The evidence base on surgery for gynecomastia is somewhat weak and limited to observational case series studies. Clinical outcomes other than complications were not routinely addressed. The existing studies reflect a variety of approaches and describe multiple individual techniques. The studies in existing literature generally have small patient numbers, and employ varying classification systems for gynecomastia. In addition, the etiology of the condition has varied among patients in these studies. The majority have a retrospective design, lack controls, and the extent and length of follow-up is often unclear. All of these factors limit the ability to effectively evaluate and compare outcomes between studies.

Nevertheless, the evidence suggests that surgery for gynecomastia is considered an appropriately safe option for carefully selected patients with symptomatic persistent disease who have not responded to medical therapy and the surgery is performed by a surgeon with experience in the selected technique.

Regulatory Status

Mastectomy is a procedure and therefore not subject to FDA regulation.

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. 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 discontinuation of use as appropriate.
- C. 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.
- D. No other medical causes that would be indicated by an appropriate medical workup (see guidelines 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 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 is not covered as a method for treating gynecomastia.

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. Surgical intervention is not considered appropriate except for severe or prolonged cases where there is no apparent regression for more than 2 years, and pubertal development is nearly completed or completed. 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). Furthermore, there is insufficient evidence that surgical removal is more effective than conservative management for pain due to gynecomastia.

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) 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.

Physician documentation

- Current history and physical,
- Past medical history including medications,
- Clinical records documenting the indications listed as criteria within this clinical coverage policy,
- Tried and failed treatments,
- Color photos with date stamp,
- A letter of medical necessity.

Applicable codes include but are not limited to:

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

Ambulatory Care Guidelines: Mastectomy for Gynecomastia. Milliman Care. Updated January 30, 2018. Accessed January 3, 2019.

American Society of Plastic Surgeons (ASPS). Practice Parameters: Gynecomastia. February 2004. Available at: http://www.plasticsurgery.org/Documents/Medical_Professionals/Gynecomastia-PP.pdf. Accessed January 3, 2019.

Bowman JD, Kim H, Bustamante JJ. Drug-induced gynecomastia. *Pharmacotherapy*. 2012 Dec; 32(12):1123-40. doi: 10.1002/phar.1138. Epub 2012 Nov 16. Review.

Deepinder F, Braunstein GD. Drug-induced gynecomastia: an evidence-based review. *Expert Opin Drug Saf*. 2012 Sep; 11(5):779-95. doi: 10.1517/14740338.2012.712109. Epub 2012 Aug 6. Review.

Goes JC, Landecker A. Ultrasound-assisted lipoplasty (UAL) in breast surgery. *Aesthetic Plast Surg*. Jan Feb 2002;26(1):1-9.

Health Technology Brief: Mastectomy for Gynecomastia. Hayes. Updated July 12, 2012. Accessed January 3, 2019. Janevicius, R. "CPT Corner: Gynecomastia." Plastic Surgery News, October/November 1994.

Narula HS, Carlson HE. Gynaecomastia-pathophysiology, diagnosis and treatment. Nat Rev Endocrinol. 2014 Nov;10(11):684-698.

Nuttall FQ, Warriar RS, Gannon MC. Gynecomastia and drugs: a critical evaluation of the literature. Eur J Clin Pharmacol. 2015 May; 71(5):569-78. doi: 10.1007/s00228-015-1835-x. Epub 2015 Apr 2.

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. |