Medical Policy

Joint Medical Policies are a source for BCBSM and BCN medical policy information only. These documents are not to be used to determine benefits or reimbursement. Please reference the appropriate certificate or contract for benefit information. This policy may be updated and is therefore subject to change.

***Current Policy Effective Date: 1/1/24**
(See policy history boxes for previous effective dates)

Title: Surgical Treatment for Male Gynecomastia

Description/Background

Bilateral gynecomastia (GM) is a benign enlargement of the male breast, either due to increased adipose tissue, glandular tissue, fibrous tissue, or a combination of all 3 and accounts for more than 65 percent of male breast disorders. GM has a broad range of causes that are classified as either physiological or pathological, although in many cases no specific cause can be found.

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
- Medical conditions including:
  - Hypogonadism, liver and kidney function

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.

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.

Medical Policy Statement

The safety and effectiveness of mastectomy for male gynecomastia have been established. It is a useful therapeutic option when specific criteria are met.

Inclusionary and Exclusionary Guidelines

Inclusions:
Glandular breast tissue, and the tissue is ≥ 2 cm in size by either physical examination and/or radiographic imaging, and one of the following:

- Pubertal or adolescent gynecomastia of more than 2 years duration and member has reached full puberty, **OR**
- Non-adolescent gynecomastia due to irreversible causes.

Exclusions:
Surgical treatment for enlarged breasts is considered cosmetic in the following situations:

- Gynecomastia that results from obesity, the effect of non-prescribed drugs or the effect of drugs that can be discontinued.
- Pubertal or adolescent gynecomastia of less than 2 years duration or the member has not reached full puberty.
- Glandular breast tissue < 2 cm in size.
- Non-glandular or fatty breast enlargement.
- Liposuction to perform mastectomy for gynecomastia.

CPT/HCPCS Level II Codes *(Note: The inclusion of a code in this list is not a guarantee of coverage. Please refer to the medical policy statement to determine the status of a given procedure.)*

Established codes:

19300

Other codes (investigational, not medically necessary, etc.):

15877

Note: Code(s) may not be covered by all contracts or certificates. Please consult customer or provider inquiry resources at BCBSM or BCN to verify coverage.

Rationale

Gynecomastia is not life-threatening but it can cause significant emotional distress. Most cases take months or years to resolve. Young people with gynecomastia become depressed, isolated, refuse to participate in any activity that involves removing the shirt and have low self-esteem. There is also a small risk of breast cancer.

According to The American Society of Plastic Surgeons, pubertal gynecomastia often regresses spontaneously in 6 months, 75 percent of cases resolve within 2 years of onset and 90 percent resolve within 3 years of onset. Medical literature supports mastectomy for treatment of gynecomastia in males when the tissue is glandular and over 2 centimeters in size. As adolescent gynecomastia can resolve spontaneously prior to the end of puberty, removal of the glandular tissue is recommended only after it has been present for 2 years and the male has reached full puberty, based on sexual characteristic maturity.

Dickson (2012) defines gynecomastia as a benign proliferation of glandular breast tissue in men. Physiologic gynecomastia is reported as being common in newborns, adolescents, and older men. Although it is self-limited, treatment can minimize emotional distress and physical discomfort. Nonphysiologic gynecomastia may be caused by chronic conditions (e.g., cirrhosis, hypogonadism, renal insufficiency); use of medications, supplements, or illicit drugs; and, rarely, tumors. Discontinuing use of contributing medications and treating underlying disease are the mainstay of treatment. Medications, such as estrogen receptor modulators, and surgery have a role in treating gynecomastia in select patients. Treatment should be pursued early and should be directed by the patient.

Choi et al (2017) reported on a study of 1454 patients, 71 were adolescents. Subcutaneous mastectomy with liposuction was performed for adolescent individuals who had gynecomastia for more than 3 years and showed psychosocial distress. Most of the subjects were satisfied with the results. The authors concluded that liposuction and/or surgical removal of glandular tissue is an acceptable treatment for adolescent gynecomastia in selective individuals who have had gynecomastia for 3 years and have experienced psychosocial distress.

Vandeven et al (2019) discussed the recommended treatments for gynecomastia (GM). Gynecomastia is classified into 4 grades depending on the amount of breast enlargement, skin excess and ptosis. Treatment of GM consists of first treating any underlying condition that is contributing to the condition (i.e. breast cancer, obesity, hypogonadism, diseases of the liver, adrenal or thyroid, renal failure, malnutrition, hormonal imbalances). Discontinue any medications that have been shown to contribute to GM (i.e. digoxin, thiazides, estrogens, phenothiazines, theophylline, some chemotherapy medications). Address any abnormality found on physical exam. If the underlying condition is identified and treated, and the condition persists, surgical treatment can be considered.

Braunstein et al (2023; Up-To-Date) reviewed gynecomastia in the adult male and defines gynecomastia as a benign proliferation of the glandular tissue of the male breast which is

caused by an increase in the ratio of estrogen to androgen activity. It is categorized as physiologic (occurring normally during infancy, puberty, and older age) or pathologic (due to drugs or disorders such as androgen deficiency, testicular tumors, hyperthyroidism, and chronic kidney disease). In adult men seeking consultation for gynecomastia, approximately 40 percent of cases of gynecomastia are due to persistent pubertal gynecomastia or medications and 25 percent are idiopathic. True gynecomastia should be differentiated from pseudogynecomastia (lipomastia), which refers to fat deposition without glandular proliferation and from breast carcinoma. The management of gynecomastia depends upon its etiology, duration, severity, and the presence or absence of tenderness. The recommended initial therapy includes: (1) a breast examination (to distinguishing true gynecomastia [enlargement of the glandular tissue] from pseudogynecomastia [excessive adipose tissue]), (2) observation (many patients with recent onset [<6 months] often resolves spontaneously), (3) discontinuation of causative medications, and (4) treating underlying medical problems associated with gynecomastia. Potential indications for early medical therapy include significant breast enlargement (>4 cm in diameter in young men), pain, tenderness, and embarrassment that interfere with the patient's normal daily activities. The duration of gynecomastia is a major factor that influences the management approach. For gynecomastia that does not resolve within 3 months (using these measures) and is accompanied with pain and tenderness, medical therapy is the next step. Surgical intervention should be considered in men whose gynecomastia does not regress spontaneously, is causing considerable discomfort or psychological distress, or is longstanding (greater than 12 months) and in which the fibrotic stage has been reached. Surgical approaches include a combination of direct surgical excision of the glandular tissue and liposuction of any coexisting adipose tissue. More extensive cosmetic surgery, including skin excision, is required for patients with marked gynecomastia or who develop excessive sagging of the breast tissue.

Taylor (2022; Up-To-Date) examined gynecomastia in children and adolescents. Pubertal gynecomastia is a physiologic enlargement of the glandular breast tissue that occurs in some males during puberty. In most studies, it occurs in >50 percent of male adolescents (range 4 to 69 percent). The wide range is related to differences in study population, diagnostic criteria, and observer technique. The prevalence of pubertal gynecomastia peaks during mid-puberty, coinciding with peak height velocity at age 12 to 14 years, pubic hair sexual maturity rating (Tanner stage) 3 to 4, and testicular volumes of 8 to 10 mL bilaterally. It is usually bilateral (64 percent of cases in the largest cross-sectional study). Adolescents with pubertal gynecomastia usually complain of a mass or lump behind the nipple. The enlargement occurs gradually and should not exceed 4 cm (1.6 inches) in diameter. Palpable fibroglandular enlargement ≥4 cm (1.6 inches) in diameter or rapidly progressive glandular enlargement may be associated with an underlying disorder. The breast may be tender for approximately 6 months after onset, but tenderness gradually resolves as the glandular tissue undergoes fibrosis and the inflammatory reaction and stretching of tissues diminish. When left untreated, pubertal gynecomastia regresses substantially or resolves in >70 percent of patients after 1 year, although it may take up to 3 years for some patients. Gynecomastia that persists for ≥1 year or after age 17 years is less likely to spontaneously regress. The history and examination of children and adolescents with gynecomastia focus on clinical features of pathologic causes of gynecomastia. Management includes discontinuation of any drugs, medication, or herbal therapies that are known to be associated with gynecomastia. Targeted laboratory and imaging studies should be performed if the initial evaluation suggests an underlying cause other than drug/medication exposure. Pharmacologic therapy for pubertal gynecomastia in adolescents is not routinely recommended. The US Food and Drug Administration (FDA) has not approved any drug for

this indication. Surgical therapy may be warranted for adolescents with physiologic gynecomastia which is >3 cm (1.2 inches) in diameter, unresponsive to medical therapy, persists for more than 2 years or after age 16 years, or is associated with embarrassment that interferes with normal daily activities. Before surgery is performed, biochemical evaluation (early morning human chorionic gonadotropin [hCG], estradiol, testosterone, luteinizing hormone [LH], dehydroepiandrosterone sulfate [DHEAS]) may be warranted (if not already performed) to avoid delaying diagnosis of a pathologic condition that has clinical implications (e.g., requires specific directed treatment, affects fertility).

Removal of fatty tissue is considered to be cosmetic. Breast enlargement resulting from obesity is not considered appropriate for mastectomy.

Supplemental Information

PRACTICE GUIDELINES AND POSITION STATEMENTS
The American Society of Plastic Surgeons (ASPS; 2002) issued practice criteria (affirmed 2015) for third-party payers. ASPS classified gynecomastia using the following scale, which was "adapted from the McKinney and Simon, Hoffman and Kohn scales":

- "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."

According to ASPS, in adolescents, surgical treatment for unilateral or bilateral grade II or III gynecomastia may be appropriate if the gynecomastia persists for more than 1 year after pathologic causation is ruled out (or 6 months if grade IV) and continues after 6 months if medical treatment is unsuccessful. In adults, surgical treatment for unilateral or bilateral grade III or IV gynecomastia may be appropriate if the gynecomastia persists for more than 3 or 4 months after pathologic causation is ruled out and continues after 3 or 4 months of medical treatment that is unsuccessful. ASPS also indicated that surgical treatment of gynecomastia may be appropriate when distention and tightness cause pain and discomfort.

The European Academy of Andrology (2019) suggests surgical treatment only when patients have long-lasting gynecomastia, which does not regress spontaneously or respond to medical therapy. The extent and type of surgery depend on the size of breast enlargement, and the amount of adipose tissue.

Government Regulations
National:
There is no national coverage determination.

Local:

Wisconsin Physician Service (WPS), LCD 39051 **Cosmetic and Reconstructive Surgery**. For services performed on or after 11/14/21.

Mastectomy for gynecomastia

Gynecomastia is the excessive growth of the male mammary glands. These conditions can cause significant clinical manifestations when the excessive breast weight adversely affects the supporting structures of the shoulders, neck, and trunk.

Mastectomy with nipple preservation or reduction mammoplasty is considered reconstructive and a covered service for males with gynecomastia Grade III and IV or abnormal breast development with redundancy.

- Persists more than 3 to 4 months after the pathological causes are ruled out (e.g. not limited to testosterone deficiency, testicular tumor, liver disease, or drug induced).
- Persists after 3 to 4 months of unsuccessful medical treatment for pathological gynecomastia.
- Pain or tenderness directly related to the breast tissue which has a clinically significant impact upon activities of daily living.
- Clinical symptoms refractory to a trial of analgesics or anti-inflammatory agents.
- For significant clinical manifestations when the excessive breast weight adversely affects the supporting structures of the shoulders, neck and trunk.

American Society of Plastic Surgeons' gynecomastia scale:

- 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

(The above Medicare information is current as of the review date for this policy. However, the coverage issues and policies maintained by the Centers for Medicare & Medicare Services [CMS, formerly HCFA] are updated and/or revised periodically. Therefore, the most current CMS information may not be contained in this document. For the most current information, the reader should contact an official Medicare source.)

Related Policies

- Cosmetic and Reconstructive Surgery
- Reconstructive Breast Surgery/Management of Breast Implants
- Reduction Mammoplasty for Breast-Related Symptoms

References

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17. Wise, Gilbert J., MD, et al., "Male Breast Disease,” *Journal of the American College of Surgeons*, Volume 200, Issue 2, 2005, pp. 255-268.

The articles reviewed in this research include those obtained in an Internet based literature search for relevant medical references through 8/4/23, the date the research was completed.

Joint BCBSM/BCN Medical Policy History

Policy Effective Date	BCBSM Signature Date	BCN Signature Date	Comments
12/1/02	12/1/02	12/1/02	Joint policy established
5/24/04	5/24/04	6/15/04	Routine maintenance
9/7/05	9/7/05	8/27/05	Routine maintenance
9/1/06	7/10/06	5/24/06	Routine maintenance
9/1/07	7/1/07	8/29/07	Routine maintenance
9/1/08	7/25/08	9/1/08	Routine maintenance
1/1/10	10/13/09	10/13/09	Routine maintenance
1/1/12	10/11/11	11/9/11	Routine maintenance
3/1/13	12/11/12	12/31/12	Routine maintenance
7/1/14	4/10/14	4/15/14	Routine maintenance
9/1/15	6/19/15	7/16/15	Routine maintenance
9/1/16	6/21/16	6/21/16	Routine maintenance
9/1/17	6/20/17	6/20/17	Routine maintenance
9/1/18	6/19/18	6/19/18	Routine maintenance
9/1/19	6/18/19		Routine maintenance
1/1/20	10/15/19		• Routine maintenance • Title changed from “Mammoplasty for Male Gynecomastia”
1/1/21	10/20/20		Routine maintenance
1/1/22	10/19/21		Routine maintenance
1/1/23	10/18/22		Routine maintenance (slp)
1/1/24	10/17/23		• Routine maintenance (slp) • Vendor managed: N/A

Next Review Date: 4th Qtr, 2024

BLUE CARE NETWORK BENEFIT COVERAGE
POLICY: SURGICAL TREATMENT FOR MALE GYNECOMASTIA

I. Coverage Determination:

Commercial HMO (includes Self-Funded groups unless otherwise specified)	Covered; criteria apply.
BCNA (Medicare Advantage)	Refer to the Medicare information under the Government Regulations section of this policy.
BCN65 (Medicare Complementary)	Coinsurance covered if primary Medicare covers the service.

II. Administrative Guidelines:

- The member's contract must be active at the time the service is rendered.
- Coverage is based on each member's certificate and is not guaranteed. Please consult the individual member's certificate for details. Additional information regarding coverage or benefits may also be obtained through customer or provider inquiry services at BCN.
- The service must be authorized by the member's PCP except for Self-Referral Option (SRO) members seeking Tier 2 coverage.
- Services must be performed by a BCN-contracted provider, if available, except for Self-Referral Option (SRO) members seeking Tier 2 coverage.
- Payment is based on BCN payment rules, individual certificate and certificate riders.
- Appropriate copayments will apply. Refer to certificate and applicable riders for detailed information.
- CPT - HCPCS codes are used for descriptive purposes only and are not a guarantee of coverage.