Surgical Treatment of Gynecomastia

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Coverage Policy

Coverage for the surgical treatment of gynecomastia is dependent on benefit plan language, may be subject to the provisions of a cosmetic and/or reconstructive surgery benefit, and may be governed by state mandates. Under many benefit plans, the surgical treatment of gynecomastia is not covered when performed solely for the purpose of altering appearance or self-esteem or to treat psychological symptomatology or psychosocial complaints related to one’s appearance. In addition, gynecomastia surgery is specifically excluded under some benefit plans. Please refer to the applicable benefit plan document to determine benefit availability and terms, conditions and limitations of coverage.

If coverage for the surgical treatment of gynecomastia is available, the following conditions of coverage apply.

Reduction mammoplasty or mastectomy for the surgical treatment of gynecomastia is considered medically necessary for EITHER of the following conditions:

- Klinefelter’s syndrome
- Either pubertal (adolescent) onset gynecomastia that has persisted for at least two years OR post-pubertal-onset gynecomastia that has persisted for one year, when ALL of the following criteria are met:
  - Glandular breast tissue confirming true gynecomastia is documented on physical exam and/or mammography.
The gynecomastia is classified as Grade II, III or IV per the American Society of Plastic Surgeons classification.

The condition is associated with persistent breast pain, despite the use of analgesics.

The use of potential gynecomastia-inducing drugs and substances has been identified and discontinued for at least one year, when medically appropriate.

The gynecomastia persists, despite correction of any underlying causes.

Hormonal causes, including hyperthyroidism, estrogen excess, hyperprolactinemia and hypogonadism have been excluded by appropriate laboratory testing (e.g., with levels of thyroid stimulating hormone [TSH], estradiol, prolactin, testosterone and/or luteinizing hormone [LH]) and, if present, have been treated for at least 12 months before surgery has been considered.

Reduction mammoplasty or mastectomy for the surgical treatment of gynecomastia for ANY other indication is considered not medically necessary.

Reduction mammoplasty or mastectomy for the surgical treatment of gynecomastia for EITHER of the following indications is considered cosmetic in nature and not medically necessary:

- when performed solely to improve appearance of the male breast or to alter contours of the chest wall
- when performed solely to treat psychological or psychosocial complaints

Liposuction or ultrasonically-assisted liposuction (suction lipectomy) as a sole method of treatment for gynecomastia is considered experimental, investigational, or unproven.

Liposuction or ultrasonically-assisted liposuction (suction lipectomy) used in conjunction with reduction mammoplasty or mastectomy for the treatment of gynecomastia is considered integral to the primary procedure and will not be separately reimbursed.

**Overview**

This Coverage Policy addresses reduction mammoplasty, mastectomy and liposuction for the treatment of gynecomastia.

**General Background**

Gynecomastia is the benign proliferation of glandular breast tissue in males. It differs from proliferation of breast tissue in females in that there is no terminal alveolar development in response to progesterone. Gynecomastia is characterized by a mass or ridge of glandular tissue that is symmetrically distributed around the areolar-nipple complex. It can generally be detected when the glandular tissue is >0.5 cm (0.2 inches) in diameter. Gynecomastia may be tender to palpation early in the course. It is usually bilateral, but some patients present with unilateral enlargement or bilateral enlargement with one side larger than the other or enlarging weeks to months before the other. The distinct mass of glandular tissue, central location, and symmetrical shape distinguish gynecomastia from other causes of male breast enlargement in children and adolescents. In children and adolescents, gynecomastia is common during the neonatal period and during puberty. Gynecomastia is uncommon in pre-pubertal boys.

Pathologic gynecomastia is rare in children and adolescents but may be associated with substantial morbidity (e.g., testicular, adrenal, or pituitary tumors). Pathologic gynecomastia usually is associated with other abnormalities on physical examination or clinical features that are not characteristic of physiologic gynecomastia.

The majority of cases of gynecomastia in children and adolescents are physiologic. Neonatal gynecomastia is physiologic and presumably related to placental transformation of androgens to estrogens, which enter the fetal circulation and stimulate glandular proliferation. It usually regresses spontaneously and completely within the first year of life. Pubertal gynecomastia is a physiologic enlargement of the glandular breast tissue that occurs in some boys during puberty. Adolescents with pubertal gynecomastia usually complain of a mass or lump behind the nipple. The breast may be tender for approximately six months after onset, but tenderness gradually resolves
as the glandular tissue undergoes fibrosis and the inflammatory reaction and stretching of tissues diminish. Pubertal gynecomastia regresses substantially or resolves in >70 percent of patients after one year if left untreated. Gynecomastia that persists for ≥1 year or after age 17 years generally does not spontaneously regress.

Primary (hypergonadotropic) hypogonadism accounts for approximately 8 percent and secondary (hypogonadotropic) hypogonadism accounts for approximately 2 percent of cases of gynecomastia in adult patients seeking consultation for gynecomastia. Klinefelter syndrome, polysomy X, is the most common congenital cause of primary hypogonadism and often presents during adolescence. As many as 70 percent of patients with Klinefelter syndrome have gynecomastia, which usually is slowly progressive (Taylor, 2016).

A careful breast examination is the first step to distinguishing true gynecomastia (enlargement of the glandular tissue) from pseudogynecomastia (excessive adipose tissue). In mixed gynecomastia, the breast enlargement is due to both glandular and adipose tissue. The physician can at times determine the differences through physical examination of the breast. Mammography and ultrasound can also be used to separate true gynecomastia from pseudogynecomastia. Therefore, diagnosis of true gynecomastia should be documented through physical examination and/or mammography.

The ASPS recommends using a scale adapted from the McKinney and Simon, Hoffman and Khan scales to characterize the severity of gynecomastia:

<table>
<thead>
<tr>
<th>Grade</th>
<th>Description</th>
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<tbody>
<tr>
<td>Grade II</td>
<td>Moderate breast enlargement exceeding areola boundaries with edges that are indistinct from the chest</td>
</tr>
<tr>
<td>Grade III</td>
<td>Moderate breast enlargement exceeding areola boundaries with edges that are distinct from the chest with skin redundancy present</td>
</tr>
<tr>
<td>Grade IV</td>
<td>Marked breast enlargement with skin redundancy and feminization of the breast</td>
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</tbody>
</table>

Hormone testing may be necessary to determine the cause of the condition and may include thyroid stimulating hormone (TSH), estradiol, prolactin, testosterone and/or luteinizing hormone (LH). Treating the primary cause of gynecomastia involves the identification of a causative agent and discontinuation of its use when medically appropriate, which will often result in resolution of the condition. Treatment essentially consists of correction of the underlying disorder, removal of the causative drug (if applicable) and, in some cases, the additional use of pharmaceutical agents to treat the condition and/or its symptoms. These agents include antiestrogens, aromatase inhibitors and danazol (androgen) to inhibit gonadotropin secretion.

In the absence of resolution, further medical or surgical treatment may be considered. Conditions of gynecomastia that persist for longer than one year are less likely to be reversed by medical management, because of increased stromal hyalinization, dilatation of the ducts and a marked reduction in proliferation. Medical therapies have been found most effective in the proliferative phase of gynecomastia. In most cases, once inactive fibrotic tissue develops, medical intervention is less successful.

Surgical treatment involves removing the glandular breast tissue and is generally reserved for patients who demonstrate irreversible fibrotic changes, continued growth and pain. Procedures commonly used in the treatment of gynecomastia include mastectomy, subtotal mastectomy, subcutaneous mastectomy and reduction mammoplasty.

Suction-assisted lipectomy (liposuction) has been performed as an adjunct surgical procedure in some cases, although its use is limited in cases that are severe or in breasts that are fibrous. When liposuction is performed as a sole method of treatment for gynecomastia, only adipose tissue is removed. Liposuction reduces the overall breast size and may result in improved appearance, but it does not remove the glandular tissue and, therefore, does not correct the gynecomastia. Ultrasound-assisted suction lipectomy is a proposed method of treatment for
gynecomastia. Proponents contend it improves the removal of dense, fibrous male breast tissue and offers minimal external scarring (Esme, et al., 2007; Hodgson, et al., 2005; Rohrich, et al., 2003). These methods of treatment, however, are not well-supported in the peer-reviewed, published, scientific literature and are not considered an acceptable alternative to standard surgical approaches for the removal of glandular tissue for the treatment of true gynecomastia.

The American Board of Internal Medicine’s (ABIM) Foundation Choosing Wisely® Initiative (2017)
No relevant information found.

Use Outside of the US
No relevant information found.

Coding/Billing Information

Note: 1) This list of codes may not be all-inclusive.
2) Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement.

Considered Medically Necessary when criteria in the applicable policy statements listed above are met:

<table>
<thead>
<tr>
<th>CPT® Codes</th>
<th>Description</th>
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<tbody>
<tr>
<td>19300</td>
<td>Mastectomy for gynecomastia</td>
</tr>
<tr>
<td>19304</td>
<td>Mastectomy, subcutaneous</td>
</tr>
<tr>
<td>19318</td>
<td>Reduction mammoplasty</td>
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</tbody>
</table>

Considered Experimental/Investigational/Unproven when performed as a sole method of treatment for gynecomastia:

<table>
<thead>
<tr>
<th>CPT® Codes</th>
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<tbody>
<tr>
<td>15877</td>
<td>Suction assisted lipectomy; trunk</td>
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Not Separately Reimbursed when performed in conjunction with reduction mammoplasty or mastectomy for the treatment of gynecomastia:

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References


