MEDICAL POLICY

POLICY TITLE	SURGICAL TREATMENT OF BILATERAL GYNECOMASTIA
POLICY NUMBER	MP-1.129

Original Issue Date (Created):	**July 26, 2011**
Most Recent Review Date (Revised):	**March 25, 2014**
Effective Date:	**June 1, 2014**

I. POLICY

Reduction mammoplasty or mastectomy for the condition of male gynecomastia may be considered **medically necessary** when **all** of the following conditions are met:

- A male with significant breast tissue present for over two years who demonstrates functional impairment; and
- A history of achievement of Tanner stage four or five for a minimum of one year; and
- Excess breast tissue is glandular and not fatty tissue. (This must be confirmed by mammogram or tissue pathology); and
- Other causes of gynecomastia have been ruled out, including reversible drug treatments, or obesity.

Note: Mastectomy for male gynecomastia is considered **medically necessary**, *regardless of patient age*, when there is legitimate concern that a breast mass may represent breast carcinoma.

Cross-reference:

MP-1.004 Cosmetic and Reconstructive Surgery
MP-1.113 Reduction Mammoplasty

II. PRODUCT VARIATIONS

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[N] = No product variation, policy applies as stated
[Y] = Standard product coverage varies from application of this policy, see below

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[N] Capital Cares 4 Kids	[N] Indemnity
[N] PPO	[N] SpecialCare
[N] HMO	[N] POS
[N] SeniorBlue HMO	[Y] FEP PPO*
[N] SeniorBlue PPO	

* Refer to FEP Medical Policy Manual MP-7.01.13 Surgical Treatment of Bilateral Gynecomastia. The FEP Medical Policy manual can be found at: www.fepblue.org

III. DESCRIPTION/BACKGROUND

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Bilateral gynecomastia refers to the 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 (i.e., conditions causing either estrogen excess or testosterone deficiency such as liver disease or an endocrine disorder)
- A side effect of certain drugs
- Associated with 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

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 prevents regression of the breast tissue. Surgical removal of the breast tissue, using either surgical excision or liposuction may be considered if the above conservative therapies are not effective or possible and the gynecomastia does not resolve spontaneously or with aging.

IV. RATIONALE

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This policy is updated periodically with searches of the MEDLINE database. The most recent literature search was performed for the period of September 2012 through August 2013. The following is a summary of the key findings to date.

As noted above, coverage eligibility for treatment of bilateral gynecomastia is largely a contract/benefits issue, related to the distinction between cosmetic and reconstructive services. The surgical procedure may involve surgical excision (i.e., mastectomy) or more recently, liposuction has been used. (1, 2) In some instances, adolescent gynecomastia may be reported as tender or painful, and the presence of these symptoms may be presented as a rationale for the medical necessity of surgical treatment. However, the pain associated with adolescent gynecomastia is typically self-limiting or responds to analgesic therapy.

In order to demonstrate improvement in health outcomes, controlled trials are needed that report clinically important outcomes such as improvement in functional status. No such trials were identified on literature search.

Ongoing Clinical Trials

No clinical trials were identified that addressed surgery for gynecomastia in a search of online site ClinicalTrials.gov on September 9, 2013.

Summary

Bilateral gynecomastia refers to the benign enlargement of the male breast, 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 may be considered if conservative therapies are not effective or possible.

There are no randomized controlled trials on surgical treatment of bilateral gynecomastia that address functional impairment. Since conservative therapy should adequately address any physical pain or discomfort and gynecomastia does not typically cause functional impairment, surgical treatment of bilateral gynecomastia is considered not medically necessary.

Practice Guidelines and Position Statements

The American Society of Plastic Surgeons (ASPS) issued practice criteria for third-party payers. (3) In this document, the ASPS classified gynecomastia with 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 the ASPS, in adolescents, surgical treatment for unilateral or bilateral grade II or grade III gynecomastia may be appropriate if the gynecomastia persists for more than 1 year after pathological 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 grade IV gynecomastia may be appropriate if the gynecomastia persists for more than 3-4 months after pathological causation is ruled out and continues after 3-4 months of medical treatment that is unsuccessful. The ASPS also indicates surgical treatment of gynecomastia may be appropriate when distention and tightness cause pain and discomfort.

V. DEFINITIONS

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NA

VI. BENEFIT VARIATIONS

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The existence of this medical policy does not mean that this service is a covered benefit under the member's contract. Benefit determinations should be based in all cases on the applicable contract language. Medical policies do not constitute a description of benefits. A member's individual or group customer benefits govern which services are covered, which are excluded, and which are subject to benefit limits and which require preauthorization. Members and providers should consult the member's benefit information or contact Capital for benefit information.

VII. DISCLAIMER

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Capital's medical policies are developed to assist in administering a member's benefits, do not constitute medical advice and are subject to change. Treating providers are solely responsible for medical advice and treatment of members. Members should discuss any medical policy related to their coverage or condition with their provider

and consult their benefit information to determine if the service is covered. If there is a discrepancy between this medical policy and a member's benefit information, the benefit information will govern. Capital considers the information contained in this medical policy to be proprietary and it may only be disseminated as permitted by law.

VIII. CODING INFORMATION

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Note: This list of codes may not be all-inclusive, and codes are subject to change at any time. The identification of a code in this section does not denote coverage as coverage is determined by the terms of member benefit information. In addition, not all covered services are eligible for separate reimbursement.

Covered when medically necessary:

CPT Codes®								
19300								

ICD-9-CM Diagnosis Code*	Description
175.0 – 175.9	Malignant Neoplasm of Male Breast
198.81	Secondary Malignant Neoplasm of Breast
233.0	Carcinoma in situ of Breast
238.3	Neoplasm of uncertain behavior Breast
611.1	Hypertrophy of Breast

*If applicable, please see Medicare LCD or NCD for additional covered diagnoses.

The following ICD-10 diagnosis codes will be effective October 1, 2015:

ICD-10-CM Diagnosis Code*	Description
C50.021	Malignant neoplasm of nipple and areola, right male breast
C50.022	Malignant neoplasm of nipple and areola, left male breast
C50.029	Malignant neoplasm of nipple and areola, unspecified male breast
C50.121	Malignant neoplasm of central portion of right male breast
C50.122	Malignant neoplasm of central portion of left male breast
C50.129	Malignant neoplasm of central portion of unspecified male breast

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ICD-10-CM Diagnosis Code*	Description
C50.221	Malignant neoplasm of upper-inner quadrant of right male breast
C50.222	Malignant neoplasm of upper-inner quadrant of left male breast
C50.229	Malignant neoplasm of upper-inner quadrant of unspecified male breast
C50.321	Malignant neoplasm of lower-inner quadrant of right male breast
C50.322	Malignant neoplasm of lower-inner quadrant of left male breast
C50.329	Malignant neoplasm of lower-inner quadrant of unspecified male breast
C50.421	Malignant neoplasm of upper-outer quadrant of right male breast
C50.422	Malignant neoplasm of upper-outer quadrant of left male breast
C50.429	Malignant neoplasm of upper-outer quadrant of unspecified male breast
C50.521	Malignant neoplasm of lower-outer quadrant of right male breast
C50.522	Malignant neoplasm of lower-outer quadrant of left male breast
C50.529	Malignant neoplasm of lower-outer quadrant of unspecified male breast
C50.621	Malignant neoplasm of axillary tail of right male breast
C50.622	Malignant neoplasm of axillary tail of left male breast
C50.629	Malignant neoplasm of axillary tail of unspecified male breast
C50.821	Malignant neoplasm of overlapping sites of right male breast
C50.822	Malignant neoplasm of overlapping sites of left male breast
C79.81	Secondary malignant neoplasm of breast
D05.00	Lobular carcinoma in situ of unspecified breast
D05.01	Lobular carcinoma in situ of right breast
D05.02	Lobular carcinoma in situ of left breast
D05.10	Intraductal carcinoma in situ of unspecified breast
D05.11	Intraductal carcinoma in situ of left breast
D05.12	Intraductal carcinoma in situ of left breast
D05.80	Other specified type of carcinoma in situ of unspecified breast
D05.81	Other specified type of carcinoma in situ of right breast
D08.82	Other specified type of carcinoma in situ of left breast
D05.90	Unspecified type of carcinoma in situ of unspecified breast
D05.91	Unspecified type of carcinoma in situ of right breast
D05.92	Unspecified type of carcinoma in situ of left breast
D48.60	Neoplasm of uncertain behavior of unspecified breast
D48.61	Neoplasm of uncertain behavior of right breast
D48.62	Neoplasm of uncertain behavior of left breast
N62	Hypertrophy of breast

*If applicable, please see Medicare LCD or NCD for additional covered diagnoses.

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IX. REFERENCES

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1. *Rohrich RJ, Ha RY, Kenkel JM et al. Classification and management of gynecomastia: defining the role of ultrasound-assisted liposuction. Plast Reconstr Surg 2003; 111(2):909-23; discussion 24-5.*
2. *Goes JC, Landecker A. Ultrasound-assisted lipoplasty (UAL) in breast surgery. Aesthetic Plast Surg 2002; 26(1):1-9.*
3. *American Society of Plastic Surgeons. ASPS Recommended Insurance Coverage Criteria for Third-Party Payers. 2002. Available online at: http://www.plasticsurgery.org/Documents/medical-professionals/health-policy/insurance/Gynecomastia-Insurance-Coverage.pdf.* Accessed January 21, *2014.*

X. POLICY HISTORY

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MP 1.129	**CAC 7/26/11** New Policy. Information regarding male gynecomastia removed from MP-1.013, Reduction Mammoplasty, and separate policy created. No change to policy criteria.
	CAC 8/28/12 Consensus. No change to policy statements. References updated. FEP variation added to reference exclusion section of 2012 FEP Administrative Manual Chapter 16. Removed benefit information. Codes reviewed 8/22/12 klr
	07/30/13-CAC consensus review list, Administrative code review complete.
	CAC 3/25/14 Consensus. No change to policy statements. References updated. Rationale section added.

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