BlueCross BlueShield of Alabama

Name of Blue Advantage Policy:

Gynecomastia Surgery

Policy #: 114
Latest Review Date: February 2025
Category: Surgery

BACKGROUND:

Blue Advantage *medical policy does not conflict with Local Coverage Determinations (LCDs), Local Medical Review Policies (LMRPs) or National Coverage Determinations (NCDs) or with coverage provisions in Medicare manuals, instructions or operational policy letters. In order to be covered by Blue Advantage, the service shall be reasonable and necessary under Title XVIII of the Social Security Act, Section 1862(a)(1)(A). The service is considered reasonable and necessary if it is determined that the service is:*

1. *Safe and effective;*
2. *Not experimental or investigational*;*
3. *Appropriate, including duration and frequency that is considered appropriate for the service, in terms of whether it is:*
   - *Furnished in accordance with accepted standards of medical practice for the diagnosis or treatment of the patient's condition or to improve the function of a malformed body member;*
   - *Furnished in a setting appropriate to the patient's medical needs and condition;*
   - *Ordered and furnished by qualified personnel;*
   - *One that meets, but does not exceed, the patient's medical need; and*
   - *At least as beneficial as an existing and available medically appropriate alternative.*

In accordance with Title XVIII of the Social Security Act, Section 1862 (a)(10), cosmetic surgery or expenses incurred in connection with such surgery are not covered except as required for the prompt repair of accidental injury or for improvement of the functioning of a malformed body member.

Routine costs of qualifying clinical trial services with dates of service on or after September 19, 2000, which meet the requirements of the Clinical Trials NCD, are considered reasonable and necessary by Medicare. Providers should bill* ***Original Medicare* *for covered services that are related to* ***clinical trials*** *that meet Medicare requirements (Refer to Medicare National Coverage Determinations Manual, Chapter 1, Section 310 and Medicare Claims Processing Manual, Chapter 32, Sections 69.0-69.11).*

POLICY:

Effective for dates of service on or after April 9, 2021:

Blue Advantage will treat **mastectomy for gynecomastia** as a **covered benefit** for adult patients (≥ 18 years of age) with symptoms that have persisted for one year OR adolescent patients (≤18 years of age) with symptoms that have persisted for at least two years when ALL of the following criteria are met:

- Glandular breast tissue confirming true gynecomastia is documented on physical examination and/or mammography (medical records must contain frontal and lateral view preoperative photographs); AND
- Gynecomastia is classified as Grade II, III or IV per the American Society of Plastic Surgeons classification; AND
- Gynecomastia is associated with persistent breast discomfort despite the use of analgesics; AND
- Presence of an underlying pathologic process (e.g., breast, adrenal or testicular tumors, kidney or liver disease) has been ruled out; AND
- Use of potential gynecomastia-inducing drugs and substances has been identified and discontinued for at least one year when medically appropriate; AND
- Hormonal causes have been excluded by appropriate laboratory testing and, if present, have been treated for at least one year prior to surgery. These include but are not limited to the following, as confirmed by laboratory testing:
    - Hyperthyroidism (e.g., thyroid stimulating hormone [TSH])
    - Excess estrogen (e.g., excess estradiol)
    - Prolactinomas (e.g., prolactin)
    - Hypogonadism (e.g., testosterone, human chorionic gonadotropin [hCG], and/or luteinizing hormone [LH])

Blue Advantage will treat **mastectomy for gynecomastia** as a **non-covered benefit** in all other circumstances, including but not limited to the following:

- Pubertal gynecomastia with tender palpable breast tissue or fatty tissue.
- Gynecomastia surgery to improve the appearance of the male breast or to alter the contours of the chest wall.
- Surgery to remove excess adipose (fat) tissue (pseudogynecomastia).
- Use of liposuction to perform gynecomastia surgery.

Blue Advantage does not approve or deny procedures, services, testing, or equipment for our members. Our decisions concern coverage only. The decision of whether or not to have a certain test, treatment, or procedure is one made between the physician and their patient. Blue Advantage administers benefits based on the members' contract and medical policies. Physicians should always exercise their best medical judgment in providing the care they feel is most appropriate for their patients. Needed care should not be delayed or refused because of a coverage determination.

DESCRIPTION OF PROCEDURE OR SERVICE:

Gynecomastia is the benign enlargement of the male breast, either due to increased adipose tissue, glandular tissue, fibrous tissue, or a combination of all three. This condition should not be confused with pseudogynecomastia, which is an enlargement of the male breast due to excess fat deposition. Gynecomastia can be attributed to physiologic, pathologic, or pharmacologic causes. Physiologically, in newborns, breast development may be associated with galactorrhea. It is also seen with aging and teenage boys. Causes of pathologic gynecomastia may include testicular and pituitary tumors, chronic liver disease, genetic disorders/congenital endocrine conditions (Klinefelter's disease) and kidney failure.

In adults, it has been suggested that approximately 45-50% of cases are associated with an underlying pathology. Adolescent gynecomastia is considered a normal variation of puberty that rarely persists and typically spontaneously regresses within 18 to 24 months. If adolescents have surgical therapy before completion or at near completion of their puberty, the hormonal imbalance that caused the gynecomastia may cause recurrence. Especially in children and youths, most cases of gynecomastia have no absolute indication for therapeutic intervention, as they are temporary and show a high number of spontaneous remissions.

The most common cause of gynecomastia in the male is puberty. It accounts for more than 65 percent of male breast disorders. The condition may occur in one or both breasts and begins as a small lump beneath the nipple, which may be tender. Gynecomastia during puberty is not uncommon, is self-limiting and usually resolves spontaneously within two years. The etiology appears to be related to an increase in estrogens, a decrease in androgens or some alteration in the estrogen-androgen level. Gynecomastia may also result as a side effect from certain drugs, including, but not limited to, estrogens, androgens, spironolactone, digitalis preparations, flutamide, ketoconazole, cimetidine, anabolic steroids, alcohol, amphetamines, and marijuana.

Careful clinical evaluation is warranted to rule out possible pathological etiologies prior to any surgical intervention. When a cause of the gynecomastia is determined and addressed appropriately, spontaneous resolution of the gynecomastia usually occurs over a short period.

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. A variety of surgical techniques have been described as being used to perform mastectomy for gynecomastia, including direct excision, liposuction or a combination of both.

KEY POINTS:

This has been updated regularly with searches of the PubMed database. The most recent literature update was performed through December 17, 2024.

Summary of Evidence
The medical literature indicates that gynecomastia is due to the stimulated growth of glandular breast tissue and does not significantly affect the disposition of fatty tissue. Therefore, mastectomy for gynecomastia should focus on the removal of glandular tissue underlying the condition. The use of liposuction as a method of mastectomy for gynecomastia has not been sufficiently proven to remove glandular tissue and is not considered an acceptable alternative to standard surgical approaches.

Practice Guidelines and Position Statements
The American Society of Plastic Surgeons
The American Society of Plastic Surgeons (ASPS) issued practice criteria for third-party payers in 2002, which was reaffirmed in 2015. 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 the ASPS, in adolescents, surgical treatment for unilateral or bilateral grade II or III gynecomastia may be appropriate if the gynecomastia persists for more than one year after pathological causation is ruled out (or six months if grade IV) and continues after six months if medical treatment is unsuccessful. In adults, surgical treatment for unilateral or bilateral grade III or grade IV gynecomastia is ruled out and continues after three to four months after pathological causation is ruled out and continues after three to four 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.

American Society of Andrology
In 2019, the American Society of Andrology, in collaboration with the European Academy of Andrology, released clinical practiceguidelines on gynecomastia evaluation and management.7,

Their recommendation related to surgical intervention is as follows:
"We suggest surgical treatment only for patients with long-lasting GM [gynecomastia], which does not regress spontaneously orfollowing medical therapy. The extent and type of surgery depend on the size of breast enlargement, and the amount of adiposetissue [weak recommendation, low quality of evidence]."

U.S. Preventive Services Task Force Recommendations
Surgery for gynecomastia is not a preventive service.

KEY WORDS:
Gynecomastia, mastectomy

APPROVED BY GOVERNING BODIES:
Removal of breast tissue is a surgical procedure and, as such, is not subject to regulation by the U.S. Food and Drug Administration.

BENEFIT APPLICATION:
Coverage is subject to member's specific benefits. Group-specific policy will supersede this policy when applicable.

CURRENT CODING
CPT Codes

19300	Mastectomy for gynecomastia

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6. American Society of Plastic Surgeons. ASPS Recommended Insurance Coverage Criteria for Third-Party Payers: Gynecomastia. 2002 (affirmed 2015); www.plasticsurgery.org/Documents/Health-Policy/Positions/Gynecomastia_ICC.pdf
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POLICY HISTORY:

Adopted for Blue Advantage, March 2005
Available for comment May 1-June 14, 2005
Medical Policy Group, May 2006
Medical Policy Group, May 2007
Medical Policy Group, November 2008
Medical Policy Group, May 20110
Medical Policy Group, November 2011
Medical Policy Group, July 2013
Medical Policy Group, February 2015
Medical Policy Group, April 2016
Medical Policy Group, June 2016
Available for comment July 5 through August 18, 2016
Medical Policy Group, March 2017
Medical Policy Group, March 2018
Medical Policy Group, March 2019
Medical Policy Group, February 2020
Medical Policy Group, February 2021
Medical Policy Group, February 2022
Medical Policy Group, February 2023
UM Committee, December 2023: Policy approved by UM Committee for use for Blue Advantage business.
Medical Policy Group, February 2024

UM Committee, February 2024: Annual review of policy approved by UM Committee for use for Blue Advantage business.
Medical Policy Group, February 2025
UM Committee, February 2025: Annual review of policy approved by UM Committee for use for Blue Advantage business.

This medical policy is not an authorization, certification, explanation of benefits, or a contract. Eligibility and benefits are determined on a case-by-case basis according to the terms of the member's plan in effect as of the date services are rendered. All medical policies are based on (i) research of current medical literature and (ii) review of common medical practices in the treatment and diagnosis of disease as of the date hereof. Physicians and other providers are solely responsible for all aspects of medical care and treatment, including the type, quality, and levels of care and treatment.

This policy is intended to be used for adjudication of claims (including pre-admission certification, pre-determinations, and pre-procedure review) in Blue Cross and Blue Shield's administration of plan contracts.