

Gynecomastia (Surgical Treatment)

MPM 7.0

Disclaimer	Refer to the member's specific benefit plan and <i>Schedule of Benefits</i> to determine coverage. This may not be a benefit on all plans or the plan may have broader or more limited benefits than those listed in these criteria.
Description	<p>Gynecomastia is the benign proliferation of glandular breast tissue in males. Surgical procedures commonly used to remove the glandular breast tissue include mastectomy and reduction mammoplasty. Fatty tissue alone does not meet the definition of gynecomastia.</p> <p>This Medical Policy is limited to males. For females, refer to MPM 2.5 for information on breast reduction mammoplasty</p>
Coverage Determination	<p>Prior Authorization/Benefit Certification is required. Logon to Pres Online to submit a request at https://ds.phs.org/preslogin/index.jsp</p> <p>The following criteria must be met:</p> <ol style="list-style-type: none">I. Surgical treatment of bilateral gynecomastia for males age 18 years and over:<ol style="list-style-type: none">A. Request for surgical treatment for bilateral gynecomastia must meet both of the criteria below.<ol style="list-style-type: none">1. Grade II, III or IV gynecomastia, per the "Gynecomastia Scale" used by the American Society of Plastic Surgeons (see "Medical Terms" on page 3);<li style="text-align: center;">AND2. One of the criteria below:<ol style="list-style-type: none">a. Any proven or suspected malignancy; orb. Continuous intractable breast pain refractory to six months of analgesic treatment, and caused by true gynecomastia. (Intermittent pain or pain with pressure or touch will not be considered); orc. For gynecomastia related to prescription drug use, one of the following apply:<ul style="list-style-type: none">• Reversible side effects of a drug have been ruled out or it has been determined that the causative drug cannot be discontinued; or• Persistent gynecomastia after the causative drug has been discontinued or adjusted.^{1,2,4}

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II. Surgical treatment of gynecomastia in a juvenile

- A. Bilateral or unilateral gynecomastia in a juvenile must be diagnosed by a pediatric endocrinologist (to consider possible medical treatment and have other underlying causes investigated, as is medically appropriate).

AND

- B. **One** of the following conditions must be met:
1. Gynecomastia that does not respond to medical treatment or that is secondary to an endocrine disorder such as true hermaphroditism or Klinefelter's Syndrome; **or**
 2. A significant psychological disorder related to the gynecomastia, based on a mental health evaluation by an In-network psychiatrist or psychologist;^{1,2,4}

AND

- C. The patient must have sufficient sexual characteristic maturity to be Tanner Developmental Stage 3 to 5. The Tanner stages define physical measurements of development in children based on primary and secondary sex characteristics (see "Medical Terms" on page 3, second table.) Gynecomastia developed at younger stages of maturity may resolve as the patient matures.⁷ Surgical interventions should be timed to avoid unnecessary revisions.⁶

III. Surgical treatment of unilateral gynecomastia

Surgical correction for unilateral gynecomastia is covered, even when the Gynecomastia Scale requirements are not met.

Exclusions

1. Surgical treatment for males with breast enlargement solely related to obesity is not a covered benefit.
2. Surgical treatment for asymptomatic gynecomastia related to aging is not a covered benefit.
3. Cosmetic surgery performed primarily to improve appearance or self-esteem is not a covered benefit.
4. Use of liposuction in the surgical treatment of gynecomastia is not a covered benefit.
5. Surgical treatment is not covered if the gynecomastia is due to non-prescribed or illegal drug use.

Background

Gynecomastia is the benign proliferation of glandular breast tissue in males. The pathophysiological process of gynecomastia involves an imbalance between free estrogen and free androgen actions in the breast tissue, which can occur through multiple mechanisms.

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During mid to late puberty, more estrogen may be produced by the testes and peripheral tissues before testosterone secretion reaches adult levels, resulting in pubertal gynecomastia. Pubertal gynecomastia often resolves without treatment.⁷

In adults, gynecomastia is associated with increasing age. Causes include conditions resulting in increased serum estrogen (obesity, liver disease, hyperthyroidism), decreased testosterone synthesis (pituitary disease, congenital or acquired primary gonadal failure), androgen resistance, renal failure, and as a side effect of numerous drugs (examples: marijuana, cimetidine, anabolic steroids). A thorough history, physical exam and appropriate laboratory evaluation may reveal treatable or explanatory causes, and may include a workup for breast cancer. Breast biopsy is indicated when malignancy is suspected.⁴

Medical Terms**Gynecomastia Scale
Used by the American Society of Plastic Surgeons⁴**

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

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Classification of Sex Maturity Stages in Boys⁵

SMR Stage	Pubic Hair	Penis	Testes
1	None	Preadolescent	Preadolescent
2	Scanty, long, slightly pigmented	Slight enlargement	Enlarged scrotum, pink, texture altered
3	Darker, starts to curl, small amount	Longer	Larger
4	Resembles adult type but less in quantity; coarse, curly	Larger; glans and breadth increase in size	Larger, scrotum dark
5	Adult distribution, spread to medial surface of thighs	Adult size	Adult Size

SMR = sexual maturity rating

Adapted from Tanner JM: *Growth in Adolescence*, 2nd ed. Oxford, England, Blackwell Scientific Publications, 1962

Coding

The coding listed in this Medical Policy is for reference only. Covered and non-covered codes are within this list.

CPT Codes	Description
19300	Mastectomy for gynecomastia
19318	Reduction mammoplasty

ICD-9© Procedure Codes	Description
175.0	Malignant neoplasm of male breast, nipple and areola
175.9	Malignant neoplasm of male breast, other and unspecified site
198.81	Secondary malignant neoplasm of other specified sites, breast
233.0	Carcinoma in situ of breast
611.1	Hypertrophy of breast
611.71	Mastodynia
611.72	Lump or mass in breast
758.7	Klinefelter's syndrome

Not every Presbyterian health plan contains the same benefits. Please refer to the member's specific benefit plan and *Schedule of Benefits* to determine coverage.

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- References:**
1. Milliman Care Guidelines®, Copyright © 2009 Milliman Care Guidelines LLC, Ambulatory Care, 13th Edition. Mastectomy for Gynecomastia, 02-05-09.
 2. DynaMed Editorial Team. Gynecomastia. Last updated 06/18/09.
 3. Hayes Search & Summary. Copyright © 2008 Winifred S. Hayes, Inc. Mastectomy for Male Gynecomastia. December 22, 2008.
 4. American Society of Plastic Surgeons: ASPS Recommended Insurance Coverage Criteria for Third-Party Payers, Gynecomastia. Approved by the ASPS Board of Directors, March 2002.
 5. Behrman, Richard E., Kliegman Robert M., and Jenson Hal B., eds. Nelson Textbook of Pediatrics, 17th Edition. Copyright © 2004 WB Saunders.
 6. Sadove AM, van Aalst, JA Congenital and acquired pediatric breast anomalies: a review of 20 years' experience. *Plast. Reconstr. Surg.* 115:1039, 2005.
 7. Braunstein, GD. Gynecomastia. *N Engl J Med* 357:12; September 20, 2007.

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This Medical Policy is intended to represent clinical guidelines describing medical appropriateness and is developed to assist Presbyterian Health Plan and Presbyterian Insurance Company, Inc. (Presbyterian) Health Services staff and Presbyterian medical directors in determination of coverage. This Medical Policy is not a treatment guide and should not be used as such.

For those instances where a member does not meet the criteria described in these guidelines, additional information supporting medical necessity is welcome and may be utilized by the medical director in reviewing the case. Please note that all Presbyterian Medical Policies are available online at our website at: <http://www.phs.org/phs/healthplans/providers/healthservices/Medical/index.htm>