Name of Policy:
Gynecomastia Surgery

Policy #: 114
Category: Surgery
Latest Review Date: July 2013
Policy Grade: D

Background/Definitions:
As a general rule, benefits are payable under Blue Cross and Blue Shield of Alabama health plans only in cases of medical necessity and only if services or supplies are not investigational, provided the customer group contracts have such coverage.

The following Association Technology Evaluation Criteria must be met for a service/supply to be considered for coverage:
1. The technology must have final approval from the appropriate government regulatory bodies;
2. The scientific evidence must permit conclusions concerning the effect of the technology on health outcomes;
3. The technology must improve the net health outcome;
4. The technology must be as beneficial as any established alternatives;
5. The improvement must be attainable outside the investigational setting.

Medical Necessity means that health care services (e.g., procedures, treatments, supplies, devices, equipment, facilities or drugs) that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury or disease or its symptoms, and that are:

1. In accordance with generally accepted standards of medical practice; and
2. Clinically appropriate in terms of type, frequency, extent, site and duration and considered effective for the patient’s illness, injury or disease; and
3. Not primarily for the convenience of the patient, physician or other health care provider; and
4. Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient’s illness, injury or disease.
Description of Procedure or Service:
Gynecomastia is the development of prominent breast tissue in the male. It can be further defined as the presence of an abnormal proliferation of breast tissue in males. The most common cause of gynecomastia in the male is puberty. It accounts for more than 65 percent of male breast disorders. In true gynecomastia, the breast enlargement is due to glandular breast tissue; in pseudogynecomastia, the breast enlargement is secondary to fat accumulation. 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 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.

Pharmacological causes are related to side effects of many drugs. Examples of these drugs include anabolic steroids, cannabinoids, psychotropics, antihypertensives and estrogens for prostatic/testicular carcinoma.

Some men and boys have fat on their chest that makes it look as though they have breasts. This condition is called pseudogynecomastia, and is not the same as gynecomastia. Pectoral hypertrophy can also be confused with gynecomastia.

Policy:
Mastectomy for gynecomastia meets Blue Cross and Blue Shield of Alabama’s medical criteria for coverage for:
- Adult and mid to late pubertal (age 14 to 20) male patients with non-tender, palpable breast tissue;
- Adult male patients with recent onset of progressive breast enlargement with or without tenderness;
- Patients with Klinefelter’s Syndrome.

The following information will be used to determine if true gynecomastia is present (except in those patients with Klinefelter’s Syndrome). True gynecomastia is defined as the presence of glandular tissue and not fatty tissue:
- Full history that includes conditions present for at least 12 months on an adolescent, medication history to include drugs, alcohol, and specific questions regarding hepatic dysfunction, testicular insufficiency (decreased libido or impotence), pulmonary symptoms suggestive of lung cancer, and hyperthyroidism;
- Physical exam that includes description of palpation of breast, evidence of any alteration of expected secondary sexual characteristics, and testicular, liver, and thyroid examination;
- Work-up of any abnormal findings;
• Medical evaluation to exclude endocrinopathy;
• Pre-op photos;
• Post-operatively, a pathology report may be requested to confirm the presence of glandular tissue as **removal of fatty tissue is considered cosmetic.**

For an adult male with recent onset of progressive breast enlargement, with or without tenderness and mid to late pubertal patients, the following **additional information** will be used to determine true gynecomastia versus other etiologies. **True gynecomastia is defined as the presence of glandular tissue and not fatty tissue:**

• Emphasis on drug-induced gynecomastia (with discontinuance of the drug, if possible, for one month with re-evaluation);
• Measurement of serum chorionic gonadotropin, testosterone, estradiol, and luteinizing hormone is required when no underlying cause is apparent;
• If reports result in diagnosis of idiopathic gynecomastia, the condition may be monitored for six months.

**Mastectomy for gynecomastia does not meet** Blue Cross and Blue Shield of Alabama’s coverage criteria for:

• **Pubertal gynecomastia with tender palpable breast tissue or fatty tissue;**
• **Drug related gynecomastia** (these may include but not limited to: androgens and anabolic steroids, oral and topical estrogens, spironolactone, methyldopa, phenytoin, cimetidine, digitalis, psychoactive agents, alcohol, marijuana);
• **Removal of fatty tissue.**

Blue Cross and Blue Shield of Alabama will **not cover** mastectomy for gynecomastia performed by liposuction ONLY.

*Blue Cross and Blue Shield of Alabama 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 his/her patient. Blue Cross and Blue Shield of Alabama administers benefits based on the members' contract and corporate 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.*
Key Points:
Pubertal gynecomastia is a common condition with an overall incidence of 38 percent in males 10 to 16 years of age, increasing to 65 percent at age 14, and dropping to 14 percent in 16-year-old boys. During adolescence, 75 percent of the gynecomastia cases are bilateral by the breasts are often affected to different degrees. Pubertal gynecomastia often regresses spontaneously in six months, 75 percent within two years of onset, and 90 percent resolve within three years of onset.

For diagnosis of the condition, which is obvious, the etiology must be determined. This is achieved by the history, physical examination, and appropriate laboratory evaluation. There must be a review of systems, monitoring for organ changes in the liver, testes, prostate, adrenal, pituitary, lungs and thyroid. A complete drug history must be taken. A physical examination includes checking the listed organs and breasts. Laboratory studies may need to include liver function studies or urine studies for 17-ketosteroids, androgens, and gonadotropic hormones. Consultation with an endocrinologist may be valuable for evaluation of these patients. The presence of an underlying tumor (breast or testicular) needs to be excluded. If puberty is the cause, it is best to wait as long as two years to allow spontaneous regression to occur. This information is per Grabb and Smith’s Plastic Surgery.

Laiturt et al discussed the treatment of adolescent gynecomastia and partly due to a lack of information in the literature for severe cases of gynecomastia. The review was based on the author’s use of inferior pedicle reduction mammoplasty and subcutaneous mastectomy in adolescents with gynecomastia. Data was collected for a 10-year period and this included 20 patients. Eight patients had bilateral inferior pedicle reduction mammoplasty, and 12 patients underwent either unilateral or bilateral subcutaneous mastectomy. Mean amount of tissue removed after bilateral reduction mammoplasty was 275.1 g. Mean follow-up was 18.8 months. The authors concluded that many adolescents with true gynecomastia have mild or self-limited disease; operative treatment may provide significant benefit to the remainder. Milder grades of gynecomastia can be managed with subcutaneous mastectomy. Selected severe cases can be safely and effectively treated with reduction mammoplasty.

Fan et al (2009) and Qutob et al (2010) reported on endoscopic subcutaneous mastectomy or minimally invasive excision. According to Fan et al, the use of endoscopic subcutaneous mastectomy without skin excision was introduced as a new standard surgical technique for Grade IIB and III gynecomastia. At the writing of the article, 125 breasts had undergone the procedure. The authors found that endoscopic subcutaneous mastectomy is a new choice for the treatment of gynecomastia. Qutob et al studied the use of a vacuum-assisted biopsy device (VABD) and liposuction to provide minimally invasive approach. Thirty-six male patients with Grade I and II gynecomastia were recruited (22 bilateral and 14 unilateral). All underwent mammotome excision and liposuction, with no conversions to open procedure. Minimum follow-up time was two months. Thirty-four had excellent results and two required a redo procedure. The authors concluded that this new, minimally invasive, surgical approach for gynecomastia gave excellent results with minimal morbidity.

In 2010, Petty et al analyzed outcomes of ultrasound-assisted liposuction using an arthroscopic shaver to remove breast tissue. This method was then compared with other techniques for the
management of gynecomastia. A retrospective study of a total of 227 males divided into four
groups: open incision (n=45), open incision plus liposuction (n=56), liposuction only (n=50), and
liposuction plus arthroscopic shaver (n=76). Photographs and medical records were used to
compare the results of these different procedures. Liposuction plus the arthroscopic shaver had
the overall highest mean score based on appearance, symmetry, residual tissue and prominent
scarring. The liposuction alone is unable to remove the glandular/fibrous breast tissue seen in
many of these cases. In conclusion, it was noted that higher quality studies are needed to
determine the safety and effectiveness of ultrasound-assisted lipectomy with an arthroscopic
shaver.

Autologous Platelet Gel During Breast Surgery
Anzarut et al (2007) reported on their assessment of the effectiveness of topical application of
completely autologous platelet gel during breast surgery to reduce postoperative wound drainage.
Tissue sealants are being used to reduce postoperative wound drainage and improve surgical
outcomes. There are few randomized, double-blind, controlled trials assessing the efficacy of
these agents. One hundred eleven (111) patients were included in this within-patient,
randomized, patient and assessor-blinded, controlled trial to assess the use of completely
autologous platelet gel in bilateral reduction mammaplasty. Patients were randomized by
applying the gel to either the left or right breast after hemostasis was achieved; the other breast
received no treatment. The primary outcome was the difference in wound drainage over 24
hours. Secondary outcomes included subjective and objective assessments of pain and wound
healing. Results revealed that there were no statistically significant differences in the drainage,
level of pain, size of open areas, clinical appearance, degree of scar pliability, or scar erythema.
The authors concluded that these results do not support the use of completely autologous platelet
gel to improve outcomes after reduction mammaplasty.

Practice Guidelines and Position Statements
The American Society of Plastic Surgeons (ASPS) has published the following regarding
surgical treatment of gynecomastia. There are two objectives: reconstruction of the male chest
contour, and histological clarification of suspicious breast lesions. The age of the patient,
consistency, grade, and the presence of unilateral or bilateral breast development determine the
indication for surgery. Prior to surgical consult, the gynecomastia patient should undergo a
complete history and physical exam and appropriate diagnostic testing to determine the
underlying cause of the gynecomastia.

Gynecomastia Scale adapted from the McKinney and Simon, Hoffman and
Kohn scales:

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<th>Grade</th>
<th>Description</th>
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<tr>
<td>Grade I</td>
<td>Small breast enlargement with localized button of tissue that is concentrated around the areola.</td>
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<tr>
<td>Grade II</td>
<td>Moderate breast enlargement exceeding areola boundaries with edges that are indistinct from the chest.</td>
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<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>
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<tr>
<td>Grade IV</td>
<td>Marked breast enlargement with skin redundancy and feminization of the breast.</td>
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Key Words:
Gynecomastia, mastectomy

Approved by Governing Bodies:
Not applicable

Benefit Application:
Coverage is subject to member’s specific benefits. Group specific policy will supersede this policy when applicable.

ITS: Home Policy provisions apply
FEP contracts: FEP does not consider investigational if FDA approved. Will be reviewed for medical necessity. Special benefit consideration may apply. Refer to member’s benefit plan. Pre-certification/Pre-determination requirements: Not applicable

Current Coding:
CPT codes:

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<td>19300</td>
<td>Mastectomy for gynecomastia</td>
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References:
1. AAFP Core Educational Guidelines, American Family Physician, August 1999, Vol. 60, No. 2.

Policy History:
Medical Policy Group, May 2003 (1)
Medical Policy Administration Committee, May 2003
Available for comment August 13-September 26, 2003
Medical Policy Group, November 2004
Medical Policy Group, May 2006 (1)
Medical Policy Group, May 2007 (1)
Medical Policy Group, November 2008 (1)
Medical Policy Group, May 2010 (1) Key Points updated, references added
Medical Policy Group, May 2011 (3); Key Points and References updated
Medical Policy Group, November 2011 (1) Update to Key Points; no change in policy statement
Medical Policy Group, July 2013 (1) Update to References; no change in policy statement

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.