



## Medical Coverage Policy

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# Gynecomastia Surgery

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## Related Coverage Resources

[Reduction Mammoplasty](#)

### INSTRUCTIONS FOR USE

The following Coverage Policy applies to health benefit plans administered by Cigna Companies. Certain Cigna Companies and/or lines of business only provide utilization review services to clients and do not make coverage determinations. References to standard benefit plan language and coverage determinations do not apply to those clients. Coverage Policies are intended to provide guidance in interpreting certain standard benefit plans administered by Cigna Companies. Please note, the terms of a customer's particular benefit plan document [Group Service Agreement, Evidence of Coverage, Certificate of Coverage, Summary Plan Description (SPD) or similar plan document] may differ significantly from the standard benefit plans upon which these Coverage Policies are based. For example, a customer's benefit plan document may contain a specific exclusion related to a topic addressed in a Coverage Policy. In the event of a conflict, a customer's benefit plan document always supersedes the information in the Coverage Policies. In the absence of a controlling federal or state coverage mandate, benefits are ultimately determined by the terms of the applicable benefit plan document. Coverage determinations in each specific instance require consideration of 1) the terms of the applicable benefit plan document in effect on the date of service; 2) any applicable laws/regulations; 3) any relevant collateral source materials including Coverage Policies and; 4) the specific facts of the particular situation. Each coverage request should be reviewed on its own merits. Medical directors are expected to exercise clinical judgment and have discretion in making individual coverage determinations. Coverage Policies relate exclusively to the administration of health benefit plans. Coverage Policies are not recommendations for treatment and should never be used as treatment guidelines. In certain markets, delegated vendor guidelines may be used to support medical necessity and other coverage determinations.

## Overview

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

## Coverage Policy

**Coverage for the surgical treatment of gynecomastia varies across plans. Refer to the customer's benefit plan document for coverage details.**

**Mastectomy or reduction mammoplasty 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.

**Mastectomy or reduction mammoplasty for the surgical treatment of gynecomastia for ANY other indication is considered not medically necessary.**

**Mastectomy or reduction mammoplasty 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.**

## 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. Klinefelter's syndrome (XXY) is associated with a 50-fold increase in male breast cancer incidence compared to XY males. As many as 70 percent of patients with Klinefelter syndrome have gynecomastia, which usually is slowly progressive (Taylor/UpToDate, 2022; Ionescu, et al., 2022).

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 American Society of Plastic Surgeons (ASPS, 2015) recommends using a scale adapted from the McKinney and Simon, Hoffman and Khan scales to characterize the severity of gynecomastia:

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

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.

### Literature Review

Holzmer et al. (2020) conducted a review of the current literature and evaluated 17 studies. Key data points included gynecomastia grade, surgical intervention, rate of complication, including hematoma, seroma, infection, and necrosis, and drain use. A total of 1112 patients underwent surgical treatment for gynecomastia. Skin-sparing mastectomy with or without liposuction was the most frequently used procedure followed by mastectomy

with skin reduction. Major complication rates ranged from 0% to 33%, with hematoma formation being most common (5.8%) followed seroma (2.4%). There was a higher rate of hematoma/seroma formation among authors who routinely utilized drain placement (9.78% versus 8.36%; p = 0.0051); however, this is likely attributable to the large discrepancy in percentage of grade III patients found in each group (50.23% versus 4.36%; p = 0.0000). The authors noted a wide variety of surgical techniques exist for the treatment of gynecomastia.

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.

Innocenti et al. (2022) conducted a systematic review of the literature to assess the incidence of complications with all proposed techniques and for combined procedures versus single approach procedures in gynecomastia correction. A total number of 94 articles was obtained for 7294 patients analyzed. Patients were divided into three groups: aspiration techniques, consisting in 874 patients (11, 98%), surgical excision techniques, consisting in 2764 patients (37, 90%), and combined techniques, consisting in 3656 patients (50,12%). The authors concluded that the combined use of surgical excision and aspiration techniques seems to reduce the rate of complications compared to surgical excision alone, but the lack of unique classification and the presence of several surgical techniques still represents a bias in the literature review.

### Professional Societies/Organizations

**American Society of Plastic Surgeons (ASPS):** The ASPS has developed a series of papers outlining the Society's position on recommended insurance Coverage Criteria for third-party payer coverage. Gynecomastia (June 2015) Coverage Criteria states that the surgical treatment of gynecomastia has 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. It includes recommended insurance coverage criteria for adolescents and adults.

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

### Use Outside of the US

European Academy of Andrology (EAA) Clinical Practice Guidelines on Gynecomastia Evaluation and Management (Kanakis, et al., 2019) suggest surgical treatment only for patients with long-lasting GM, which does not regress spontaneously or following medical therapy. The extent and type of surgery depend on the size of breast enlargement, and the amount of adipose tissue.

## Medicare Coverage Determinations

Contractor	Determination Name/Number	Revision Effective Date
NCD	No Determination found	
LCD	Cosmetic and Reconstructive Surgery (L38914)	07/11/2021
LCD	Cosmetic and Reconstructive Surgery (L35090)	07/11/2021
LCD	Cosmetic and Reconstructive Surgery (L39051)	11/14/2021

	<b>Contractor</b>	<b>Determination Name/Number</b>	<b>Revision Effective Date</b>
	Insurance Corporation		
LCD	Noridian Healthcare Solutions, LLC	Plastic Surgery (L35163)	10/01/2019
LCD	Noridian Healthcare Solutions, LLC	Plastic Surgery (37020)	10/01/2019

Note: Please review the current Medicare Policy for the most up-to-date information.  
 (NCD = National Coverage Determination; LCD = Local Coverage Determination)

## Coding 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:**

<b>CPT®* Codes</b>	<b>Description</b>
19300	Mastectomy for gynecomastia

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

<b>CPT®* Codes</b>	<b>Description</b>
15877	Suction assisted lipectomy; trunk

**Not Separately Reimbursed when performed in conjunction with mastectomy or reduction mammoplasty for the treatment of gynecomastia:**

<b>CPT®* Codes</b>	<b>Description</b>
15877	Suction assisted lipectomy; trunk

\*Current Procedural Terminology (CPT®) ©2021 American Medical Association: Chicago, IL.

## References

1. Acharya SV. Clinical features, presentation and hormonal parameters in patients with pubertal gynecomastia. J Family Med Prim Care. 2021 Feb;10(2):648-651.
2. American Society of Plastic Surgeons (ASPS). Cosmetic procedures, Gynecomastia surgery. Accessed August 2022. Available from URL address: <https://www.plasticsurgery.org/cosmetic-procedures/gynecomastia-surgery>
3. American Society of Plastic Surgeons (ASPS). Health Policy. ASPS Recommended Insurance Coverage Criteria for Third-Party Payers. Gynecomastia. June 2015. Accessed August 2022. Available from URL address: <https://www.plasticsurgery.org/for-medical-professionals/health-policy/recommended-insurance-coverage-criteria>

4. American Society of Plastic Surgeons (ASPS). For Medical Professionals. Quality Resources. ASPS Evidence-Based Clinical Practice Guidelines. Reduction Mammoplasty. (Public comment through June 15, 2020.) Accessed August 2022. Available from URL address: <https://www.plasticsurgery.org/for-medical-professionals/quality>  
<https://www.plasticsurgery.org/for-medical-professionals/quality/evidence-based-clinical-practice-guidelines>
5. Baumann K. Gynecomastia - Conservative and Surgical Management. *Breast Care (Basel)*. 2018 Dec;13(6):419-424.
6. Braunstein GD. Clinical practice. Gynecomastia. *N Engl J Med*. 2007 Sep 20;357(12):1229-37.
7. Braunstein GD. Management of gynecomastia. In: UpToDate, Matsumoto AM (Ed). UpToDate. Waltham, MA. Literature review current through June 2022. Topic last updated May 10, 2021.
8. Bromley HL, Dave R, Lord N, Wright P, Rowland M, Gandhi A. Gynaecomastia: when and why to refer to specialist care. *Br J Gen Pract*. 2021 Mar 26;71(705):185-188.
9. Dicker AP. The safety and tolerability of low-dose irradiation for the management of gynaecomastia caused by antiandrogen monotherapy. *Lancet Oncol*. 2003 Jan;4(1).
10. Di Lorenzo G, Autorino R, Perdona S, De Placido S. Management of gynaecomastia in patients with prostate cancer: a systematic review. *Lancet Oncol*. 2005 Dec;6(12):972-9.
11. Endocrine Society. Endocrine Library. Gynecomastia. Updated January 23, 2022. Accessed August 2022. Available from URL address: <https://www.endocrine.org/patient-engagement/endocrine-library/gynecomastia>
12. Esme DL, Beekman WH, Hage JJ, Nipshagen MD. Combined use of ultrasonic-assisted liposuction and semicircular periareolar incision for the treatment of gynecomastia. *Ann Plast Surg*. 2007 Dec;59(6):629-34.
13. Graf R, Auerswald A, Damasio RC, Rippel R, de Araujo LR, Bigarelli LH, Franck CL. Ultrasound-assisted liposuction: an analysis of 348 cases. *Aesthetic Plast Surg*. 2003 Mar;27(3):146-53.
14. Hammond DC. Surgical correction of gynecomastia. *Plast Reconstr Surg*. 2009 Jul;124(1 Suppl):61e-68e.
15. Hammond DC, Arnold JF, Simon AM, Capraro PA. Combined use of ultrasonic liposuction with the pull-through technique for the treatment of gynecomastia. *Plast Reconstr Surg*. 2003 Sep;112(3):891-5.
16. Handschin AE, Bierry D, Hüsler R, Banic A, Constantinescu M. Surgical management of gynecomastia--a 10-year analysis. *World J Surg*. 2008 Jan;32(1):38-44.
17. Hodgson EL, Fruhstorfer BH, Malata CM. Ultrasonic liposuction in the treatment of gynecomastia. *Plast Reconstruct Surg*. 2005 Aug;116(2):646-53;discussion 654-5.
18. Holzmer SW, Lewis PG, Landau MJ, Hill ME. Surgical Management of Gynecomastia: A Comprehensive Review of the Literature. *Plast Reconstr Surg Glob Open*. 2020 Oct 29;8(10):e3161.
19. Hurwitz DJ, Davila AA. Contemporary Management of Gynecomastia. *Clin Plast Surg*. 2022 Apr;49(2):293-305.
20. Innocenti A, Melita D, Dreassi E. Incidence of Complications for Different Approaches in Gynecomastia Correction: A Systematic Review of the Literature. *Aesthetic Plast Surg*. 2022 Feb 9.

21. Ionescu S, Nicolescu AC, Marincas M, Madge OL, Simion L. An Update on the General Features of Breast Cancer in Male Patients-A Literature Review. *Diagnostics (Basel)*. 2022 Jun 26;12(7):1554.
22. Iwuagwu OC, Calvey TA, Ilsley D, Drew PJ. Ultrasound guided minimally invasive breast surgery (UMIBS): a superior technique for gynecomastia. *Ann Plast Surg*. 2004 Feb;52(2):131-3.
23. Johnson RE, Murad MH. Gynecomastia: pathophysiology, evaluation, and management. *Mayo Clin Proc*. 2009 Nov;84(11):1010-5.
24. Kanakis GA, Nordkap L, Bang AK, et al. (American Society of Andrology and European Academy of Andrology) EAA clinical practice guidelines-gynecomastia evaluation and management. *Andrology*. 2019;7(6):778-793.
25. Li CC, Fu JP, Chang SC, Chen TM, Chen SG. Surgical Treatment of Gynecomastia: Complications and Outcomes. *Ann Plast Surg*. 2011 Jun 27.
26. Maroney JC, Dannheim K, Hollowell ML, Labow BI, Rogers-Vizena CR. Incidental Pathologic Findings in Young Men with Gynecomastia. *Plast Reconstr Surg*. 2022 Mar 1;149(3):608-613.
27. McNamara CT, Nuzzi LC, Firriolo JM, Walsh LR, Massey GG, et al. Complications and Quality of Life following Gynecomastia Correction in Adolescents and Young Men. *Plast Reconstr Surg*. 2022 Jun 1;149(6):1062e-1070e.
28. Mayo Clinic. Patient Care & Health Information. Diseases & Conditions. Enlarged breasts in men (gynecomastia). October 16, 2021. Accessed August 2022. Available at URL address: <https://www.mayoclinic.org/diseases-conditions/gynecomastia/symptoms-causes/syc-20351793>
29. Pensler JM, Silverman BL, Sanghavi J, Goolsby C, Speck G, Brizio-Molteni L, Molteni A. Estrogen and progesterone receptors in gynecomastia. *Plast Reconstr Surg*. 2000 Oct;106(5):1011-3.
30. Prasetyono TOH, Andromeda I, Budhipramono AG. Approach to gynecomastia and pseudogynecomastia surgical techniques and its outcome: a systematic review. *J Plast Reconstr Aesthet Surg*. 2022 May;75(5):1704-1728.
31. Rohrich RJ, Ha RY, Kenkel JM, Adams WP Jr. Classification and management of gynecomastia: defining the role of ultrasound-assisted liposuction. *Plast Reconstr Surg*. 2003 Feb;111(2):909-23;discussion 924-5.
32. Taylor SA. Gynecomastia in children and adolescents. In: UpToDate, Blake D, Geffner M (Ed). UpToDate. Waltham, MA. Literature review current through June 2022. Topic last updated June 10, 2022.
33. Todorova ZP, Stefanova EM, Todorov IP. Causes and psychological impact of gynecomastia in boys and adolescents. *Endokrynol Pol*. 2021;72(6):670-671.
34. Trinchieri A, Perletti G, Magri V, Stamatou K, Trinchieri M, Montanari E. Drug-induced gynecomastia: A systematic review and meta-analysis of randomized clinical trials. *Arch Ital Urol Androl*. 2021 Dec 21;93(4):489-496.

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