



MASSACHUSETTS

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Medical Policy

Surgical and Non-surgical Treatment of Gynecomastia

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Policy Number: 661

BCBSA Reference Number: None

NCD/LCD: Local Coverage Determination (LCD): Cosmetic and Reconstructive Surgery (L34698)

Related Policies

Plastic Surgery, #068

Policy¹

Commercial Members: Managed Care (HMO and POS), PPO, and Indemnity

Adolescent Patients

Unilateral or bilateral surgical treatment of gynecomastia may be considered **MEDICALLY NECESSARY** for mid to late pubertal adolescents when **ALL** of the following criteria are met:

- Grade II or higher gynecomastia by physical examination (per modified McKinney and Simon, Hoffman and Kohn scales*), **AND**
- Patient is experiencing breast pain or tenderness, **AND**
- Excess breast tissue is glandular, not fatty tissue as confirmed by physical exam, mammogram or tissue pathology, **AND**
- Gynecomastia persists more than 1 year after pathological conditions have been ruled out or persists after 6 months of unsuccessful medical treatment of pathologic gynecomastia, **AND**
- Medical record clearly excludes substance abuse, supplements, herbal products, and recreational hormones (including steroids) from contributing to the gynecomastia.

Note: Adolescent gynecomastia is common during puberty, and most cases resolve within 1 year.

Adult Patients

Unilateral or bilateral surgical treatment of gynecomastia may be considered **MEDICALLY NECESSARY** for patients **with** Klinefelter's syndrome and grade III or higher gynecomastia by physical examination (per modified McKinney and Simon, Hoffman and Kohn scales*).

Unilateral or bilateral surgical treatment of gynecomastia may be considered **MEDICALLY NECESSARY** for patients **without** Klinefelter's syndrome when **ALL** of the following criteria are met:

- Grade III or higher gynecomastia by physical examination (per modified McKinney and Simon, Hoffman and Kohn scales*), **AND**
- Patient is experiencing breast pain or tenderness, **AND**
- Excess breast tissue is glandular, not fatty tissue as confirmed by physical exam, mammogram or tissue pathology, **AND**
- Gynecomastia persists more than 6 months after pathological conditions have been ruled out or persists after 6 months of unsuccessful medical treatment of pathologic gynecomastia, **AND**
- Medical record clearly excludes substance abuse, supplements, herbal products, and recreational hormones (including steroids) from contributing to the gynecomastia.

***Gynecomastia Scale adapted from the McKinney and Simon, Hoffman and Kohn scales¹**

- 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.

Treatment of gynecomastia with cold-induced lipolysis/cryolipolysis is considered [INVESTIGATIONAL](#).

Treatment of pseudogynecomastia, including but not limited to cold-induced lipolysis/cryolipolysis, surgical excision under general anesthesia, liposuction or a combination of both is considered [NOT MEDICALLY NECESSARY](#).

Medicare HMO BlueSM and Medicare PPO BlueSM Members

Medical necessity criteria and coding guidance for **Medicare Advantage members living in Massachusetts** can be found through the link below.

Coverage Indications

Mastectomy for gynecomastia (19300)

Gynecomastia is the excessive growth of the male mammary glands. These conditions can cause significant clinical manifestations when the excessive breast weight adversely affects the supporting structures of the shoulders, neck, and trunk. Payment may be made for this procedure if it is documented that the tissue is primarily breast tissue and not just adipose (fatty tissue).

[Local Coverage Determinations \(LCDs\) for National Government Services, Inc.](#)

Local Coverage Determination (LCD): Cosmetic and Reconstructive Surgery (L34698)

Note: To review the specific LCD, please remember to click “accept” on the CMS licensing agreement at the bottom of the CMS webpage.

For medical necessity criteria and coding guidance for **Medicare Advantage members living outside of Massachusetts**, please see the Centers for Medicare and Medicaid Services website at <https://www.cms.gov> for information regarding your specific jurisdiction.

Prior Authorization Information

Inpatient

- For services described in this policy, precertification/preauthorization **IS REQUIRED** for all products if the procedure is performed **inpatient**.

Outpatient

- For services described in this policy, see below for products where prior authorization **might be required** if the procedure is performed **outpatient**.

	Outpatient
Commercial Managed Care (HMO and POS)	Prior authorization is required .
Commercial PPO and Indemnity	Prior authorization is not required .
Medicare HMO BlueSM	Prior authorization is required .
Medicare PPO BlueSM	Prior authorization is not required .

CPT Codes / HCPCS Codes / ICD Codes

Inclusion or exclusion of a code does not constitute or imply member coverage or provider reimbursement. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage as it applies to an individual member.

Providers should report all services using the most up-to-date industry-standard procedure, revenue, and diagnosis codes, including modifiers where applicable.

The following codes are included below for informational purposes only; this is not an all-inclusive list.

The above **medical necessity criteria MUST** be met for the following codes to be covered for **Commercial Members: Managed Care (HMO and POS), PPO, Indemnity, Medicare HMO Blue and Medicare PPO Blue:**

CPT Codes

CPT codes:	Code Description
19300	Mastectomy for gynecomastia

ICD-10 Procedure Codes

ICD-10 PCS procedure codes:	Code Description
0HBT0ZZ	Excision of Right Breast, Open Approach
0HBT3ZZ	Excision of Right Breast, Percutaneous Approach
0HBU0ZZ	Excision of Left Breast, Open Approach
0HBU3ZZ	Excision of Left Breast, Percutaneous Approach
0HBV0ZZ	Excision of Bilateral Breast, Open Approach
0HBV3ZZ	Excision of Bilateral Breast, Percutaneous Approach

The following ICD Diagnosis Codes are considered medically necessary when submitted with the CPT code above if **medical necessity criteria** are met:

ICD-10 Diagnosis Codes

ICD-9-CM diagnosis codes:	Code Description
N62	Hypertrophy of breast
Q98.4	Klinefelter syndrome, unspecified

Description

Bilateral Gynecomastia

Bilateral gynecomastia is a 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 (ie, conditions causing either estrogen excess or testosterone deficiency such as liver disease or an endocrine disorder)
- An adverse effect of certain drugs
- Obesity
- Related to specific age groups, ie,
 - 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

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

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. Pseudogynecomastia treatment is not medically necessary because adipose fatty tissue is being removed and not breast tissue.

Cold-induced lipolysis/cryolipolysis is an emerging modality that is being investigated for nonsurgical treatment of pseudogynecomastia. There is limited published literature that reported on a small number of patients. Larger controlled studies are needed to evaluate the effectiveness of the procedure. At the present time, the evidence is insufficient to permit conclusions concerning the effect of cold-induced lipolysis/cryolipolysis on health outcomes. Therefore, cold-induced lipolysis/cryolipolysis is considered investigational.

Policy History

Date	Action
5/2020	Policy updated with literature review through April 2020, references added. Policy statements unchanged.
7/2018	Medical Policy Administration literature review through February 2018. New investigational indications described. Clarified coding information. Effective 7/1/2018.
10/2014	New medical policy describing medically necessary indications. Effective October 1, 2014.

Information Pertaining to All Blue Cross Blue Shield Medical Policies

Click on any of the following terms to access the relevant information:

[Medical Policy Terms of Use](#)

[Managed Care Guidelines](#)

[Indemnity/PPO Guidelines](#)

[Clinical Exception Process](#)

[Medical Technology Assessment Guidelines](#)

References

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2. McKesson's InterQual® medical necessity criteria for male reduction mammoplasty.
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11. Kasielska-Trojan A, Antoszewski B. Gynecomastia Surgery-Impact on Life Quality: A Prospective Case-Control Study. *Ann Plast Surg*. 2017 Mar;78(3):264-268.

Endnotes

¹ Based on expert opinion