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 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.

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

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 for information regarding your specific jurisdiction at https://www.cms.gov.

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.

<table>
<thead>
<tr>
<th>Commercial Managed Care (HMO and POS)</th>
<th>Outpatient</th>
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<tbody>
<tr>
<td>Prior authorization is required.</td>
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</tbody>
</table>
Prior authorization is **not required**.

Prior authorization is **required**.

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**

<table>
<thead>
<tr>
<th>CPT codes:</th>
<th>Code Description</th>
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<tbody>
<tr>
<td>19300</td>
<td>Mastectomy for gynecomastia</td>
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</table>

**ICD-10 Procedure Codes**

<table>
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<tr>
<th>ICD-10 PCS procedure codes:</th>
<th>Code Description</th>
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<tbody>
<tr>
<td>0HBT0ZZ</td>
<td>Excision of Right Breast, Open Approach</td>
</tr>
<tr>
<td>0HBT3ZZ</td>
<td>Excision of Right Breast, Percutaneous Approach</td>
</tr>
<tr>
<td>0HBU0ZZ</td>
<td>Excision of Left Breast, Open Approach</td>
</tr>
<tr>
<td>0HBU3ZZ</td>
<td>Excision of Left Breast, Percutaneous Approach</td>
</tr>
<tr>
<td>0HBV0ZZ</td>
<td>Excision of Bilateral Breast, Open Approach</td>
</tr>
<tr>
<td>0HBV3ZZ</td>
<td>Excision of Bilateral Breast, Percutaneous Approach</td>
</tr>
</tbody>
</table>

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**

<table>
<thead>
<tr>
<th>ICD-9-CM diagnosis codes:</th>
<th>Code Description</th>
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<tbody>
<tr>
<td>N62</td>
<td>Hypertrophy of breast</td>
</tr>
<tr>
<td>Q98.4</td>
<td>Klinefelter syndrome, unspecified</td>
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**Description**

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.

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. Bilateral gynecomastia may be associated with any of the following:
An underlying hormonal disorder (i.e., conditions causing either estrogen excess or testosterone deficiency such as liver disease or an endocrine disorder)

- A side effect of certain drugs
- Obesity
- Related to specific age groups, i.e.
  - 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 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. Surgical removal of the breast tissue, using either surgical excision or liposuction, may be considered if the above conservative therapies are not effective or possible and the gynecomastia does not resolve spontaneously or with aging.

Pseudogynecomastia refers to benign male breast enlargement due to excess subareolar fat. Surgical excision under general anesthesia, liposuction or a combination of both are standard treatment options for pseudogynecomastia.

Cold-induced lipolysis/cryolipolysis is a noninvasive treatment for pseudogynecomastia that is used to reduce or destroy fat cells by freezing. Exposure to very cold temperature causes cell death of subcutaneous fat tissue, without damage to the overlying skin.

**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**

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**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
2. McKesson’s InterQual® medical necessity criteria for male reduction mammoplasty.

Endnotes
1 Based on expert opinion