FEP 7.01.13 Surgical Treatment of Bilateral Gynecomastia

Effective Date: July 15, 2018

Related Policies: None

Surgical Treatment of Bilateral Gynecomastia

Description

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. Surgical removal of the breast tissue, using either surgical excision or liposuction, may be considered if conservative therapies are not effective or possible.

FDA REGULATORY STATUS

Removal of the breast tissue is a surgical procedure and, as such, is not subject to regulation by the U.S. Food and Drug Administration.

POLICY STATEMENT

Surgical removal of breast tissue, such as mastectomy or liposuction, as a treatment of gynecomastia, is considered **not medically necessary** due to the lack of a functional impairment.

BENEFIT APPLICATION

Experimental or investigational procedures, treatments, drugs, or devices are not covered (See General Exclusion Section of brochure).

RATIONALE

Summary of Evidence

For individuals with bilateral gynecomastia who receive surgical treatment, the evidence includes case series. Relevant outcomes are symptoms, functional outcomes, health status measures, quality of life, and treatment-related morbidity. Because there are no randomized controlled trials on surgical treatment of bilateral gynecomastia, it is not possible to determine whether surgical treatment improves symptoms or functional impairment. Conservative therapy should adequately address any physical pain or discomfort, and gynecomastia does not typically cause functional impairment. The evidence is insufficient to determine the effect of the technology on health outcomes.

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SUPPLEMENTAL INFORMATION

Practice Guidelines and Position Statements

The American Society of Plastic Surgeons (ASPS) issued practice criteria for third-party payers in 2002, which was affirmed in 2015.[4] ASPS classified gynecomastia using the following scale, which was "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."

According to ASPS, in adolescents, surgical treatment for "[u]nilateral or bilateral grade II or III gynecomastia" may be appropriate if the gynecomastia "persists for more than 1 year after pathological causation is ruled out" (or 6 months if grade IV) and continues "after 6 months of unsuccessful medical treatment for pathological gynecomastia." In adults, surgical treatment for "[u]nilateral or bilateral grade III or IV gynecomastia" may be appropriate if the gynecomastia "persists for more than 3 or 4 months after pathological causes ruled out [and continues] after 3 or 4 months of unsuccessful medical treatment for pathological gynecomastia." ASPS also indicated that surgical treatment of gynecomastia may be appropriate when distention and tightness cause "pain and discomfort."

U.S. Preventive Services Task Force Recommendations

Not applicable.

Medicare National Coverage

There is no national coverage determination (NCD). In the absence of an NCD, coverage decisions are left to the discretion of local Medicare carriers.

REFERENCES

1. Rohrich RJ, Ha RY, Kenkel JM, et al. Classification and management of gynecomastia: defining the role of ultrasound-assisted liposuction. *Plast Reconstr Surg.* Feb 2003;111(2):909-923; discussion 924-925. PMID 12560721
2. Goes JC, Landecker A. Ultrasound-assisted lipoplasty (UAL) in breast surgery. *Aesthetic Plast Surg.* Jan-Feb 2002;26(1):1-9. PMID 11891589
3. Fagerlund A, Lewin R, Rufolo G, et al. Gynecomastia: A systematic review. *J Plast Surg Hand Surg.* Dec 2015;49(6):311-318. PMID 26051284
4. American Society of Plastic Surgeons. ASPS Recommended Insurance Coverage Criteria for Third-Party Payers: Gynecomastia. 2002 (affirmed 2015); https://www.plasticsurgery.org/Documents/Health-Policy/Positions/Gynecomastia_ICC.pdf. Accessed January 9, 2018.

POLICY HISTORY

Date	Action	Description
September 2012	New Policy	Surgical treatment of bilateral gynecomastia is considered **not medically necessary**.
December 2013	Update Policy	Literature review through August 2013, no new references added. Policy statement and summary unchanged.
March 2015	Update Policy	Policy updated with literature review. Policy statement unchanged.

March 2017	Update Policy	Policy updated with literature review; reference 3 added. Policy statement unchanged.
June 2018	Update Policy	Policy updated with literature review through December 11, 2017; reference 4 updated. Policy statement unchanged.