

(70113)

Medical Benefit		Effective Date: 04/01/15	Next Review Date: 11/19
Preauthorization	Yes	Review Dates: 11/14, 11/15, 11/16, 11/17, 11/18	

Preauthorization is required.

The following protocol contains medical necessity criteria that apply for this service. The criteria are also applicable to services provided in the local Medicare Advantage operating area for those members, unless separate Medicare Advantage criteria are indicated. If the criteria are not met, reimbursement will be denied and the patient cannot be billed. Please note that payment for covered services is subject to eligibility and the limitations noted in the patient's contract at the time the services are rendered.

Populations	Interventions	Comparators	Outcomes
Individuals: <ul style="list-style-type: none"> • With bilateral gynecomastia 	Interventions of interest are: <ul style="list-style-type: none"> • Surgical treatment 	Comparators of interest are: <ul style="list-style-type: none"> • Conservative treatment 	Relevant outcomes include: <ul style="list-style-type: none"> • Symptoms • Functional outcomes • Health status measures • Quality of life • Treatment-related morbidity

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.

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.

POLICY

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.

Refer also to the Cosmetic vs. Reconstructive Surgery or Services Protocol.

BACKGROUND

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 (i.e., 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, 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

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.

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.

Services that are the subject of a clinical trial do not meet our Technology Assessment Protocol criteria and are considered investigational. *For explanation of experimental and investigational, please refer to the Technology Assessment Protocol.*

It is expected that only appropriate and medically necessary services will be rendered. We reserve the right to conduct prepayment and postpayment reviews to assess the medical appropriateness of the above-referenced procedures. **Some of this protocol may not pertain to the patients you provide care to, as it may relate to products that are not available in your geographic area.**

REFERENCES

We are not responsible for the continuing viability of web site addresses that may be listed in any references below.

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/HealthPolicy/Positions/Gynecomastia_ICC.pdf. Accessed January 9, 2018.