



CIGNA MEDICAL COVERAGE POLICY

The following Coverage Policy applies to all plans administered by CIGNA Companies including plans administered by Great-West Healthcare, which is now a part of CIGNA.

Subject Surgical Treatment of Gynecomastia

Effective Date 10/15/2009
Next Review Date 10/15/2010
Coverage Policy Number 0195

Table of Contents

Coverage Policy	1
General Background	2
Coding/Billing Information	4
References	4
Policy History	6

Hyperlink to Related Coverage Policies

INSTRUCTIONS FOR USE

Coverage Policies are intended to provide guidance in interpreting certain **standard** CIGNA HealthCare benefit plans as well as benefit plans formerly administered by Great-West Healthcare. Please note, the terms of a participant's particular benefit plan document [Group Service Agreement (GSA), 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 participant'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 participant's benefit plan document **always supercedes** 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 group 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. 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. Proprietary information of CIGNA. Copyright ©2009 CIGNA

Coverage Policy

Coverage for the surgical treatment of gynecomastia is dependent on benefit plan language, may be subject to the provisions of a cosmetic and/or reconstructive surgery benefit, and may be governed by state mandates. Under many benefit plans, the surgical treatment of gynecomastia is not covered when performed solely for the purpose of altering appearance or self-esteem or to treat psychological symptomatology or psychosocial complaints related to one's appearance. In addition, gynecomastia surgery is specifically excluded under some benefit plans. Please refer to the applicable benefit plan document to determine benefit availability and terms, conditions and limitations of coverage.

If coverage for the surgical treatment of gynecomastia is available, the following conditions of coverage apply.

CIGNA covers the surgical treatment of gynecomastia as 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, prolactinomas 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.

CIGNA does not cover suction lipectomy or ultrasonically-assisted suction lipectomy (liposuction) as a sole method of treatment for gynecomastia, because such treatment is considered unproven in the treatment of gynecomastia.

CIGNA does not cover surgical treatment of gynecomastia under EITHER of the following conditions, as it 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 breast wall
- when performed solely to treat psychological or psychosocial complaints

General Background

Gynecomastia is a benign enlargement of the male breast due to the proliferation of glandular breast tissue. The condition is common and occurs in 50% to 70% of boys during puberty; 30% to 65% of men have palpable breast tissue (Narula and Carlson, 2007). It may affect one breast or both breasts as a painful, tender mass beneath the areola or as a painless, progressive enlargement of the breast. When the primary cause of gynecomastia is identified and corrected, the condition usually subsides within months; pubertal gynecomastia usually resolves spontaneously.

True gynecomastia results either from altered estrogen-androgen balances in breast tissue or from increased sensitivity of breast tissue to estrogen (Lester, 2009). The disease may be physiological or pathologic. Physiological gynecomastia occurs most frequently during three periods of life when male hormonal changes occur: in newborns, in puberty and with aging. In cases of newborn enlargement, maternal or placental estrogens are the underlying cause. Pubertal male breast-tissue enlargement occurs in about 60–70% of adolescents, with onset at a median age of 14 years. In approximately 90% of patients, pubertal gynecomastia resolves spontaneously within a few months to years. The condition may or may not be associated with a functional impairment, such as pain. Patients who develop significant pain or tenderness may be suitable candidates for medical therapy. According to the American Society of Plastic Surgeons (ASPS), pubertal gynecomastia often regresses spontaneously in six months; 75% of cases resolve within two years of onset, and 90% resolve within three years of onset. The most severe disorder, described as pubertal macromastia, is characterized by breast tissue greater than 4 cm in diameter; this condition may persist into adulthood, is commonly associated with an underlying endocrinopathy (Griffin and Wilson, 2003) and is less likely to resolve spontaneously (Neumann, 1997; Greydanus, et al., 2006). Gynecomastia also occurs as part of the normal aging process as a result of an increase in body fat, progressive primary testicular failure and/or an increase in the estrogen-androgen ratio. Most cases of physiological gynecomastia are considered normal findings, requiring no treatment.

Gynecomastia is also associated with several other conditions. Men who use anabolic steroids to enhance athletic performance often demonstrate gynecomastia. Gynecomastia has been reported to be a common side effect of certain therapies for prostate cancer, including nonsteroidal anti-androgen monotherapy. The use of illegal drugs such as marijuana and heroin, and other substances including methadone and alcohol, has also been linked to gynecomastia. Additionally, gynecomastia is associated with androgen deficiency and/or estrogen excess and may result from the use of medications (e.g., estrogens, androgens, calcium channel

blockers, antihypertensives, digitalis preparations, aldactone), endocrine abnormalities (e.g., hyperthyroidism), tumors (e.g., testicular), chronic disease (e.g., cirrhosis of the liver), chromosomal abnormalities (e.g., Klinefelter's syndrome) and other familial disorders. Approximately one-third of adolescents with Klinefelter's syndrome develop enlarged breasts, however, only about 10% of those cases have breast enlargement that requires surgery (National Institutes of Health, 2004). Although less than 1% of all breast carcinomas occur in men (NCI, 2007), patients with Klinefelter's syndrome have a higher risk of developing breast cancer than either the general population or even other patients with idiopathic gynecomastia. Idiopathic gynecomastia carries no increased risk of breast cancer.

Distinguishing between enlargement of breast tissue and pseudogynecomastia (i.e., caused by adipose tissue) can be challenging. In true gynecomastia, the breast enlargement results from glandular tissue. In pseudogynecomastia, the breast enlargement is the result of 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 ASPS 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] (Braunstein, 2007). 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.

Suction-assisted lipectomy 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 suction lipectomy is performed as a sole method of treatment for gynecomastia, only adipose tissue is removed. The suction lipectomy 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 has recently emerged as 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.

Summary

Surgical treatment of gynecomastia involves removing the glandular breast tissue and is generally reserved for patients who demonstrate irreversible fibrotic changes, continued growth and pain. Surgical treatment typically includes direct resection of the glandular breast tissue; in some cases, suction-assisted lipectomy has been performed as an adjunct procedure. Ultrasound-assisted suction lipectomy has been proposed by some authors as providing minimal scarring and efficient removal of both glandular breast tissue and fibrotic tissue; however, further clinical trials are needed to support improved long-term outcomes compared to standard surgical methods.

Coding/Billing Information

Note: This list of codes may not be all-inclusive.

Covered when medically necessary:

CPT [®] * Codes	Description
19300	Mastectomy for gynecomastia
19304	Mastectomy, subcutaneous

ICD-9-CM Diagnosis Codes	Description
611.1	Hypertrophy of breast
611.71	Mastodynia
758.7	Klinefelter's syndrome
	Multiple/Varied

Not covered when performed as a sole method of treatment for gynecomastia:

CPT* Codes	Description
15877	Suction assisted lipectomy; trunk

*Current Procedural Terminology (CPT[®]) © 2008 American Medical Association: Chicago, IL.

References

1. American Academy of Cosmetic Surgery. 2006 Guidelines for Liposuction. Accessed August 29, 2008. Available at URL address: <http://www.cosmeticsurgery.org/Media/2006%20Liposuction%20Guidelines.pdf#search=%222006%20guidelines%20for%20liposuction%22>
2. American Society of Plastic Surgeons (ASPS). Recommended criteria for third-party coverage: Gynecomastia. 1994 Jun. Accessed August 18, 2009. Available from URL address: http://www.plasticsurgery.org/medical_professionals/health_policy/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=21426
3. American Society of Plastic Surgeons (ASPS). Gynecomastia. Male breast reduction. 2006 ASPS/PSEF. Accessed August 18, 2009. Available at URL address: http://www.plasticsurgery.org/public_education/procedures/Gynecomastia.cfm

4. Arca MJ, Caniano DA. Breast disorders in the adolescent patient. *Adolesc Med Clin.* 2004 Oct;15(3):473-85.
5. Bembo SA. Gynecomastia: its features, and when and how to treat it. *Cleve Clin J Med.* 2004 Jun;71(6):511-7.
6. Braunstein GD. Clinical practice. Gynecomastia. *N Engl J Med.* 2007 Sep 20;357(12):1229-37.
7. 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).
8. 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.
9. 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.
10. Evans GFF, Anthony T, Turnage RH, Schumpert TD, Levy KR, Amirkhan RH, Cambell TJ, Lopez J, Appelbaum AH. The diagnostic accuracy of mammography in the evaluation of male breast disease. *Am J Surg.* 2001 Feb;181(2):96-100.
11. Fruhstorfer BH, Malata CM. A systematic approach to the surgical treatment of gynaecomastia. *Br J Plast Surg.* 2003 Apr;56(3):237-46.
12. Gabra HO, Morabito A, Bianchi A, Bowen J. Gynaecomastia in the adolescent: a surgically relevant condition. *Eur J of Pediatr Surg.* 2004 Feb;14(1):3-6.
13. Graf R, Auersvald 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. Greydanus DE, Matytsina L, Gains M. Breast disorders in children and adolescents. *Prim Care.* 2006 Jun;33(2):455-502.
15. Griffen JE, Wilson JD. Disorders of the testes and the male reproductive tract. Abnormalities in estrogen metabolism. Gynecomastia. In: Larsen PR, Kronenberg HM, Melmed S, Polonsky KS, editors. *Williams Textbook of Endocrinology.* 10th ed. Ch. 18. Philadelphia, PA: Elsevier; 2003. p. 741-746,753.
16. 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.
17. Handschin AE, Bietry D, Hüsler R, Banic A, Constantinescu M. Surgical management of gynecomastia-- a 10-year analysis. *World J Surg.* 2008 Jan;32(1):38-44.
18. Heymann WR. Liposuction in men. *J Am Acad Dermatol.* Aug 2006;55(2):311-2.
19. 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.
20. Khan HN, Blamey RW. Endocrine treatment of physiological gynecomastia. *BMJ.* 2003 Nov;327(7422):1050.
21. Lester SC. The Breast. In: Kumar: Robbins and Cotran Pathologic Basis of Disease, Professional Edition, 8th ed. Copyright 2009 Saunders. Ch 23.
22. McGrath MH, Schooler WG. Elective plastic surgical procedures in adolescence. *Adolesc Med Clin.* 2004 Oct;15(3):487-502.

23. McLeod DG, Iversen P. Gynecomastia in patients with prostate cancer: A review of treatment options. *Urology*. 2000 Nov;56(5):713-20.
24. Narula HS, Carlson HE. Gynecomastia. *Endocrinol Metab Clin North Am*. Jun 2007;36(2):497-519.
25. National Cancer Institute. Male breast cancer (PDQ®) treatment. General information. Modified 7/2007. Accessed August 19, 2009. Available at URL address: <http://www.cancer.gov/cancertopics/pdq/treatment/malebreast/healthprofessional>
26. Neuman JF. Evaluation and treatment of gynecomastia. *Am Fam Physician*. 1997 Apr;55(5):1849-50.
27. 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.
28. Persichetti P, Berloco M, Casadei RM, Marangi GF, Di Lella F, Nobili AM. Gynecomastia and the complete circumareolar approach in the surgical management of skin redundancy. *Plast Reconstr Surg*. 2001 April;107(4):948-54.
29. 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.
30. Venkatesh BS. Gynecomastia. *eMedicine specialties: Medicine, ob/gyn, psychiatry and surgery: endocrinology*. Updated December 22, 2008. Accessed August 19, 2009. Available at URL address: <http://www.emedicine.com/med/topic934.htm>
31. Walgenbach KJ, Riabikhin AW, Galla TJ, Bannasch H, Voigt M, Andree C, Horch RE, Stark GB. Effect of ultrasonic assisted lipectomy (UAL) on breast tissue: histological findings. *Aesthetic Plast Surg*. 2001 Mar;25(2):85-8.
32. Wilson JD. Endocrine disorders of the breast. Gynecomastia. In: Kasper DL, Braunwald E, Fauci A, Hauser S, Longo D, Jameson JL, editors. *Harrison's Principles of Internal Medicine*. New York, NY: McGraw-Hill Professional; 2001. Chapter 337.
33. Wise GJ, Roorda AK, Kalter R. Male breast disease. *J Am Coll Surg*. 2005 Feb;200(2):255-69.

Policy History

Pre-Merger Organizations	Last Review Date	Policy Number	Title
CIGNA HealthCare	10/15/2008	0195	Surgical Treatment of Gynecomastia
Great-West Healthcare	7/28/2006	95.234.04	Breast Surgery, Mastectomy for Gynecomastia

"CIGNA" and the "Tree of Life" logo are registered service marks of CIGNA Intellectual Property, Inc., licensed for use by CIGNA Corporation and its operating subsidiaries. All products and services are provided exclusively by such operating subsidiaries and not by CIGNA Corporation. Such operating subsidiaries include Connecticut General Life Insurance Company, CIGNA Behavioral Health, Inc., Intracorp, and HMO or service company subsidiaries of CIGNA Health Corporation and CIGNA Dental Health, Inc. In Arizona, HMO plans are offered by CIGNA HealthCare of Arizona, Inc. In California, HMO plans are offered by CIGNA HealthCare of California, Inc. and Great-West Healthcare of California, Inc. In Connecticut, HMO plans are offered by CIGNA HealthCare of Connecticut, Inc. In North Carolina, HMO plans are offered by CIGNA HealthCare of North Carolina, Inc. In Virginia, HMO plans are offered by CIGNA HealthCare Mid-Atlantic, Inc. All other medical plans in these states are insured or administered by Connecticut General Life Insurance Company.

Connecticut General Life Insurance Company has acquired the business of Great-West Healthcare from Great-West Life & Annuity Insurance Company (GWLA). Certain products continue to be provided by GWLA (Life, Accident and Disability, and Excess Loss). GWLA is not licensed to do business in New York. In New York, these products are sold by GWLA's subsidiary, First Great-West Life & Annuity Insurance Company, White Plains, N.Y.