CIGNA MEDICAL COVERAGE POLICY

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

Subject **Surgical Treatment of Gynecomastia**

Effective Date 10/15/2011
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Coverage Policy Number 0195

Table of Contents

Hyperlink to Related Coverage Policies

Breast Biopsy Procedures Including Sentinel Node Biopsy

INSTRUCTIONS FOR USE

*Coverage Policies are intended to provide guidance in interpreting certain **standard** CIGNA HealthCare benefit plans. Please note, the terms of a customer'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 customer'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 customer'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 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. In certain markets, delegated vendor guidelines may be used to support medical necessity and other coverage determinations. Proprietary information of 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 surgical treatment of gynecomastia for ANY other indication because it is considered not medically necessary.

CIGNA does not cover surgical treatment of gynecomastia for EITHER of the following indications because each 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 chest wall
- when performed solely to treat psychological or psychosocial complaints

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.

General Background

Gynecomastia is a benign enlargement of the male breast and is due to the proliferation of glandular breast tissue. The condition is common and occurs in 50–70% 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 (glandular breast tissue) 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 and 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, 2011), 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.

Treatment of gynecomastia first requires making a diagnostic distinction between true gynecomastia and pseudogynecomastia. 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 when used to report the treatment of gynecomastia:

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

Cosmetic /Not Medically Necessary/Not Covered:

CPT* Codes	Description
19300	Mastectomy for gynecomastia
19304	Mastectomy, subcutaneous

ICD-9-CM Diagnosis Codes	Description
V50.1	Other plastic surgery for unacceptable cosmetic appearance

Unproven/Not Covered when performed as a sole method of treatment for gynecomastia:

CPT* Codes	Description
15877	Suction assisted lipectomy; trunk

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

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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