AMERICAN SOCIETY OF PLASTIC SURGEONS

ASPS Recommended Insurance Coverage Criteria for Third-Party Payers

Gynecomastia

BACKGROUND

Founded in 1931, the American Society of Plastic Surgeons® (ASPS®) is the largest organization of plastic surgeons in the world. ASPS represents physicians certified by the American Board of Plastic Surgery, Inc.® (ABPS) or the Royal College of Physicians and Surgeons of Canada.

DEFINITIONS

Gynecomastia is defined as the presence of an abnormal proliferation of breast tissue in males. It is a common breast lesion accounting for more than 65 percent of male breast disorders. Gynecomastia has a broad range of causes that are classified as either physiological or pathological, although in many cases no specific cause can be found. In true gynecomastia, the breast enlargement is due to glandular breast tissue; in pseudogynecomastia, the breast enlargement is secondary to fat accumulation; and both glandular and fat tissue are present in mixed gynecomastia.

Physiologic gynecomastia occurs most frequently during times of male hormonal changes, resulting from the effect of an altered estrogen/androgen balance on breast tissue or from the increased sensitivity of breast tissue to a normal estrogen level.

- Pubertal gynecomastia is a common condition with an overall incidence of 38 percent in males 10 to 16 years of age, increasing to 65 percent at age 14, and dropping to 14 percent in 16 year old boys. During adolescence, 75 percent of the gynecomastia cases are bilateral but the breasts are often affected to different degrees. Pubertal gynecomastia often regresses spontaneously in six months, 75 percent within two years of onset, and 90 percent resolve within three years of onset.

- In adults, gynecomastia is associated with increasing age due to the progressive testicular hypofunction, an increase in body fat, and an increase in the estrogen/androgen ratio.

Pathological gynecomastia is associated with both androgen deficiency and estrogen excess. Both causes may be correlated to medications, diseases related to endocrinologic abnormalities, tumors, chronic disease, chromosomal abnormalities, familial disorders, and miscellaneous other conditions. While always a concern when a mass is present, breast cancer accounts for only 0.2 percent of all malignancies in male patients. A suspicious mass or lesion requires biopsy.

Cosmetic and Reconstructive Surgery

For reference, the following definitions of cosmetic and reconstructive surgery were adopted by the American Medical Association in 1989:

Cosmetic surgery is performed to reshape *normal* structures of the body in order to improve the patient's appearance and self-esteem.

Reconstructive surgery is performed on *abnormal* structures of the body, caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease. It is generally performed to improve function, but may also be done to approximate a normal appearance.

INDICATIONS

The surgical treatment of gynecomastia has two objectives: reconstruction of the male chest contour, and histological clarification of suspicious breast lesions. The age of the patient, consistency, grade, and the presence of unilateral or bilateral breast development determine the indication for surgery. Prior to surgical consult, the gynecomastia patient should undergo a complete history and physical exam and appropriate diagnostic testing to determine the underlying cause of 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.

RECOMMENDED INSURANCE COVERAGE CRITERIA FOR ADOLESCENTS

1. Unilateral or bilateral grade II or grade III gynecomastia present (per modified McKinney and Simon, Hoffman and Kohn scales)
   - persists more than 1 year after pathological causes ruled out
   - persists after 6 months of unsuccessful medical treatment for pathological gynecomastia
2. Unilateral or bilateral grade IV gynecomastia present (per modified McKinney and Simon, Hoffman and Kohn scales)
   - persists more than 6 months after pathological causes ruled out
   - persists after 6 months of unsuccessful medical treatment for pathological gynecomastia
3. Pain and discomfort due to the distention and tightness from the hypertrophied breast

Gynecomastia may cause considerable psychological distress, especially in adolescents who are struggling with issues related to sexual identity and self-image.

RECOMMENDED INSURANCE COVERAGE CRITERIA FOR ADULTS

1. Breast biopsy is indicated when malignancy is suspected
2. Unilateral or bilateral grade III or IV gynecomastia present (per modified McKinney and Simon, Hoffman and Kohn scales)
   - persists more than 3 to 4 months after pathological causes ruled out
   - persists after 3 to 4 months of unsuccessful medical treatment for pathological gynecomastia
3. Pain and discomfort due to the distention and tightness from the hypertrophied breast

Prolonged presence of breast enlargement in the male patient leads to the development of periductal fibrosis and stromal hyalinization, preventing regression of breast tissue and causing pain and discomfort due to the distention and tightness from the hypertrophied breast.

Applicable ICD-9 Codes

611.1 Hypertrophy of breast
611.71 Mastodynia
611.72 Lump/mass in breast

PROCEDURES

The correction of gynecomastia involves removing the abnormal hypertrophic breast tissue and associated surrounding subcutaneous tissue so that the breast has a more normal male appearance. The specific surgical technique will vary depending on the degree of breast hypertrophy present and the amount of fat tissue versus breast tissue removed. A circumareolar incision to remove breast tissue may be adequate for a thin person with a small amount of hypertrophy. A reduction mammaplasty or subcutaneous mastectomy with skin reduction may be required for patients with larger hypertrophic breasts. There are times when a gynecomastia procedure will require a more extensive mastectomy. Suction assisted lipectomy may be used as the primary method of removing excess tissue or as an adjunctive procedure to contour the anterior chest wall.

Applicable CPT Coding

19101 Biopsy of breast – incisional
19120 Excision of breast mass
19140 Mastectomy for gynecomastia
19182 Subcutaneous mastectomy
19318 Breast Reduction
15877 Suction assisted lipectomy, trunk
Bilateral cases will be coded with the -50 modifier.

DOCUMENTATION

Clinical indications for correction of gynecomastia should be documented by the surgeon in the history and physical exam. Photographs are often used to document the preoperative conditions and aid the surgeon in planning surgery. In some cases they may record physical signs of deformity; however, they do not substantiate symptoms and should only be used by third-party payers in conjunction with other recorded documentation.

POSITION STATEMENT

It is the position of the American Society of Plastic Surgeons that reconstructive surgery to correct gynecomastia should be covered by third-party payers when performed to relieve specific symptomatology or signs of deformity related to excessive breast size. Weight or amount of breast tissue removed should not be used as the only criteria to determine insurance coverage for correction of gynecomastia.

REFERENCES

1. Bowers, S.P., Pearlman, N.W., McIntyre, R.C., Jr., Finlayson, C.A., Huerd, S. Cost-effective management of gynecomastia. *Am. J. Surg.* 176:638-41, 1998.
2. Colombo-Benkmann, M., Buse, B., Stern, J., Herfarth, C. Indications for and results of surgical therapy for male gynecomastia. *Am. J. Surg.* 178:60-3, 1999.
3. Courtiss, E.H. Gynecomastia: Analysis of 159 patients and current recommendations for treatment. *Plast. Reconstr. Surg.* 79:740-53, 1987.
4. Gasperoni, C., Salgerello, M., Gasperoni, P. Technical refinements in surgical treatment of gynecomastia. *Ann. Plast. Surg.* 44:455-58, 2000.
5. McGrath, M.H., Mukerji, S. Plastic surgery and the teenage patient. *J. Pediatr. Adolesc. Gynecol.* 13:105-118, 2000.
6. McKinney, P., Lewis, V.L., Jr. "Gynecomastia" in Grabb and Smith's Plastic Surgery, 5th Edition, in Press.
7. Morselli, P.G. "Pull-through": a new technique for breast reduction in gynecomastia. *Plast. Reconstr. Surg.* 97:450-54, 1996.
8. Neuman, J.F., Kaiser Permanente Medical Center, Fontana, CA., USA. Evaluation and treatment of gynecomastia. *American Family Physician.* 55:1835-44, 1849-50, 1997.
9. Pensler, J.M., Silverman, B.L., Sanghavi, M., Goolsby, C., Speck, G., Brizio-Molteni, L., Molteni, A. Estrogen and progesterone receptors in gynecomastia. *Plast. Reconstr. Surg.* 106:1011-13.
10. Sher, E.S., Migeon, C.J., Berkovitz, G.D. Evaluation of boys with marked breast development at puberty. *Clin. Pediatr.* 37:367-71, 1998.
11. Simon, B.E., Hoffman, S., Kahn, S. Classification and surgical correction of gynecomastia. *Plast. Reconstr. Surg.* 51:48-52, 1973.
12. Smoot, E. C. Eccentric skin resection and purse-string closure for skin reduction with mastectomy for gynecomastia. *Ann. Plast. Surg.* 41:378-83, 1998.

Approved by the ASPS Board of Directors, March 2002.

AMERICAN SOCIETY OF PLASTIC SURGEONS

444 East Algonquin Road • Arlington Heights, IL 60005-4664 • 847-228-9900 • www.plasticsurgery.org