

Gynecomastia Surgery (for Kansas Only)

Policy Number: CS051KS.01

Effective Date: June 1, 2025

[Instructions for Use](#)

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Application

This Medical Policy only applies to the state of Kansas.

Coverage Rationale

Surgical treatment of gynecomastia is considered reconstructive and medically necessary in certain circumstances. For medical necessity clinical coverage criteria, refer to the InterQual® CP: Procedures:

- Reduction Mammoplasty, Male
- Reduction Mammoplasty, Male (Adolescent)

[Click here to view the InterQual® criteria.](#)

Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by federal, state, or contractual requirements and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

Note: Coding for suction lipectomy is addressed in the Medical Policy titled [Panniculectomy and Body Contouring Procedures \(for Kansas Only\)](#).

CPT Code	Description
19300	Mastectomy for gynecomastia

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U.S. Food and Drug Administration (FDA)

This section is to be used for informational purposes only. FDA approval alone is not a basis for coverage.

Surgeries for the treatment of gynecomastia are procedures and therefore not regulated by the FDA. Refer to the following website for additional information: <http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfPMN/pmn.cfm>. (Accessed February 2, 2024)

Policy History/Revision Information

Date	Summary of Changes
06/01/2025	<ul style="list-style-type: none"><li data-bbox="337 207 617 235">• New Medical Policy

Instructions for Use

This Medical Policy provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the federal, state, or contractual requirements for benefit plan coverage must be referenced as the terms of the federal, state, or contractual requirements for benefit plan coverage may differ from the standard benefit plan. In the event of a conflict, the federal, state, or contractual requirements for benefit plan coverage govern. Before using this policy, please check the federal, state, or contractual requirements for benefit plan coverage. UnitedHealthcare reserves the right to modify its policies and guidelines as necessary. This Medical Policy is provided for informational purposes. It does not constitute medical advice.

UnitedHealthcare uses InterQual® for the primary medical/surgical criteria, and the American Society of Addiction Medicine (ASAM) criteria for substance use disorder (SUD) services, in administering health benefits. If InterQual® does not have applicable criteria, UnitedHealthcare may also use UnitedHealthcare Medical Policies that have been approved by the Kansas Department of Health and Environment. The UnitedHealthcare Medical Policies are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.