UnitedHealthcare Community Plan

UnitedHealthcare® Community Plan
Medical Policy

Gynecomastia Surgery (for Florida Only)

Policy Number: CS051FL.R
Effective Date: June 1, 2026

Instructions for Use

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Related Policies

- Breast Reduction Surgery
- Cosmetic and Reconstructive Procedures
- Gender Dysphoria Treatment
- Panniculectomy Surgery

Application

This Medical Policy only applies to the state of Florida.

Coverage Rationale

For medical necessity clinical coverage criteria for gynecomastia surgery, refer to the Florida Medicaid: Integumentary Services Coverage Policy.

Medical Records Documentation Used for Reviews

Benefit coverage for health services is determined by the federal, state, or contractual requirements, and applicable laws that may require coverage for a specific service. Medical records documentation may be required to assess whether the member meets the clinical criteria for coverage but does not guarantee coverage of the services requested.

The patient's medical record must contain documentation that fully supports the medical necessity for the requested services. This documentation includes, but is not limited to, relevant medical history, physical examination, and results of pertinent diagnostic tests or procedures. Documentation supporting the medical necessity should be legible, maintained in the patient's medical record, and must be made available upon request.

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 Surgery.

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 23, 2026)

References

Florida Medicaid Agency for Health Care Administration. Integumentary Services Coverage Policy. June 2016. Available at: https://www.flrules.org/gateway/readRefFile.asp?refId=6758&filename=59G-4.032%20Integumentary%20Services%20Coverage%20Policy.pdf. Accessed March 23, 2026.

Policy History/Revision Information

Date	Summary of Changes

06/01/2026	**Medical Records Documentation Used for Reviews**
	• Added language to indicate:
	  ○ Benefit coverage for health services is determined by the federal, state, or contractual requirements, and applicable laws that may require coverage for a specific service
	  ○ Medical records documentation may be required to assess whether the member meets the clinical criteria for coverage but does not guarantee coverage of the service requested
	  ○ The patient's medical record must contain documentation that fully supports the medical necessity for the requested services
	  ○ This documentation includes but is not limited to relevant medical history, physical examination, and results of pertinent diagnostic tests or procedures
	  ○ Documentation supporting the medical necessity should be legible, maintained in the patient's medical record, and must be made available upon request
	Supporting Information
	• Archived previous policy version CS051FL.Q

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, 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 may also use tools developed by third parties, such as the InterQual® criteria, to assist us in administering health benefits. 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.

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