Gynecomastia Surgery (for Idaho Only)

Policy Number: CS051ID.C
Effective Date: April 1, 2026

➲ Instructions for Use

Table of Contents **Page**

Related Policies

- Breast Reduction Surgery (for Idaho Only)
- Cosmetic and Reconstructive Procedures (for Idaho Only)
- Panniculectomy Surgery (for Idaho Only)

Application

This Medical Policy only applies to the state of Idaho, including Idaho Medicaid Plus plans.

Coverage Rationale

A mastectomy to treat Gynecomastia in a male aged 18 and over is considered reconstructive and medically necessary when all the following criteria are met:

- Gynecomastia stage II, III, or IV with moderate to severe chest pain causing a Functional or Physical Impairment (the inability to participate in athletic events, sports, or social activities is not considered to be a Functional or Physical or physiological Impairment)
- Glandular breast tissue is the primary cause of Gynecomastia as opposed to fatty deposits (pseudogynecomastia) and is documented on physical exam and/or mammography
- Persistent Gynecomastia after cessation of prescribed medications, nutritional supplements, and appropriate screening(s) of non-prescription and/or recreational drugs or substances that have a known side effect of Gynecomastia (examples include but are not limited to testosterone, marijuana, asthma drugs, phenothiazines, anabolic steroids, cimetidine, and calcium channel blockers)
- An appropriate evaluation of medical causes when supporting laboratory testing has been normal; supporting laboratory testing may include but is not limited to the following:
  - Hormone testing (e.g., beta-human chorionic gonadotropin, thyroid function studies, sex hormone binding globulin, estradiol, follicle-stimulating hormone, luteinizing hormone, prolactin, testosterone)
  - Liver enzymes
  - Serum creatinine
  - Alpha-fetal protein

Note: Regardless of age, if a tumor or neoplasm is suspected, a breast ultrasound and/or mammogram may be performed with further management as indicated.

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.

Definitions

Check the definitions within the federal, state, and contractual requirements that supersede the definitions below.

Functional or Physical Impairment: A Functional or Physical or physiological Impairment causes deviation from the normal function of a tissue or organ. This results in a significantly limited, impaired, or delayed capacity to move, coordinate actions, or perform physical activities and is exhibited by difficulties in one or more of the following areas: physical and motor tasks, independent movement, performing basic life functions (Medicare, 2023).

Gynecomastia: Gynecomastia is breast enlargement in boys or men due to a benign (non-cancerous) increase in breast tissue (Endocrine Society, 2022).

American Society of Plastic Surgeons' Gynecomastia scale (ASPS, 2015):

- 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 indistinct from the chest with skin redundancy present.
- Grade IV: Marked breast enlargement with skin redundancy and feminization of the breast.

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 (for Idaho Only).

CPT Code	Description
19300	Mastectomy for gynecomastia

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Description of Services

Gynecomastia is a benign proliferation of glandular breast tissue in men. Physiologic Gynecomastia is common in newborns, adolescents, and older men. Treatment is directed at minimizing emotional distress and physical discomfort. Nonphysiologic Gynecomastia may be caused by chronic conditions including but not limited to cirrhosis, hypogonadism, and renal insufficiency; use of medications, supplements, or illicit drugs; and, rarely, tumors. Discontinuing using contributing medications and treating underlying diseases is the standard of practice. Medications, such as estrogen receptor modulators, and surgery, have a role in treating Gynecomastia in select patients. Mastectomy is the surgical removal of glandular breast tissue through an open incision or, more recently, through minimally endoscopic techniques. Cases considered severe may require larger incisions (Dickson, 2012).

Clinical Evidence

In 2024 a Hayes Evidence Analysis Research Brief was conducted to summarize the volume of publications and to determine whether there is adequate published peer-reviewed literature to evaluate the evidence related to mastectomy for treating gynecomastia. The search uncovered eight abstracts evaluating mastectomy for treatment of gynecomastia, all of which were single-arm studies. Two studies evaluated mastectomy alone, and six studies evaluated mastectomy combined with liposuction. Based on a review of full-text clinical practice guidelines and position statements, guidance appears to confer no/unclear support for mastectomy for treatment of gynecomastia.

In a systematic review, Prasetyono and colleagues (2022) examined the variations in surgical approaches to gynecomastia and pseudogynecomastia including liposuction-assisted gynecomastia surgery performed through minimal incision. This systematic review was appraised using MINORS to assess the methodological quality. The results demonstrated 18 studies with 244 individuals with an average age of 23.13 years. Consistent improvement in quality of life in terms of satisfaction after surgery, along with easy handling to remove breast tissues via a small incisional design, was demonstrated with liposuction. However, the complication rates were inconsistent for liposuction throughout the studies (range = 0.06 to 26.67%). For liposuction-assisted surgery, the reoperation rate was between 0.6 and 25%. The two studies identified as 'good quality' discussed the laser-assisted liposuction technique, which showed a minor seroma complication for two individuals. Both studies demonstrated a high surgeon satisfaction rate, and one showed a high patient satisfaction rate. The authors concluded that the small incisional design for breast parenchymal removal in gynecomastia assisted by liposuction showed an excellent technical approach for consistent improvement in quality of life. Larger, good-quality methods of non-randomized case series urging better quality are necessary.

Innocenti and associates (2022) performed a systematic review of the literature related to incidences of complications for different surgical approaches for the treatment of gynecomastia correction. In total, 94 articles were obtained consisting of 7294 individuals being analyzed. Three groups were created: aspiration techniques, consisting of 874 individuals (11.98%); surgical excision techniques, consisting of 2764 individuals (37.90%); and combined techniques, consisting of 3656 individuals (50.12%). The notable complications for each group totaled 1407. In the surgical excision techniques group, there were 847 (30.64%), 130 (14.87%) in the aspiration techniques group, and 430 (11.76%) in the combined techniques group. The authors concluded that the combined use of surgical excision and aspiration techniques reduces the rate of complications compared to that of the surgical excision alone; however, the lack of single clinical classification and presence of several surgical methods represents a bias in the literature review.

In 2021, Trinchieri et al. conducted a systematic review and meta-analysis of randomized clinical trials concerning treatment-related gynecomastia for individuals taking spironolactone, antiandrogens, 5 alpha-reductase inhibitors, lipid-lowering, and psychotropic drugs through a systematic review and meta-analysis of randomized clinical trials. For men receiving antiandrogens, there was an increased risk of gynecomastia (OR = 17.38, 95% CI: 11.26 to 26.82; 6 trials, 9599 participants) and 5 alpha-reductase inhibitors compared to controls (OR = 1.77, 95% CI: 1.53 to 2.06; 7 series out of 6 trials, 34860 participants). Compared to controls, using spironolactone in mixed-gender populations were considered to have substantially higher odds of having gynecomastia (OR = 8.39, 95% CI: 5.03 to 13.99; 14 trials, 3745 participants). There was a noteworthy variance in the odds of having gynecomastia in an evaluation between risperidone and quetiapine (OR = 4.32, 95% CI: 1.31 to 14.27; 3 trials, 343 participants), however; no placebo-controlled trials concentrating on the risk of gynecomastia for individuals taking antipsychotic drugs was obtainable. Antiandrogens, 5 alpha reductase inhibitors, and spironolactone are associated with an increased risk of developing gynecomastia.

Holzmer and colleagues, (2020) conducted a comprehensive review of the literature regarding the surgical management of gynecomastia to analyze surgical practice patterns and trends pertaining to the grade and severity of gynecomastia. The primary data points were the complication rate, including hematoma, seroma, infection, necrosis, drain use, gynecomastia grade, and surgical intervention. A total of 1112 individuals received surgical treatment for gynecomastia, with the most used technique being skin-sparing mastectomy with or without liposuction, followed by mastectomy with skin reduction. The most common complication noted was hematoma formation which comprised 5.8% of complications, followed by seroma, 2.4%. Those who routinely utilized drain placement demonstrated a higher rate of hematoma/seroma formation (9.78% vs. 8.36%; p = 0.0051). However, a limitation is a large discrepancy in the percentage of grade III individuals found in each group (50.23% vs. 4.36%; p = 0.0000). The authors concluded that there is a wide range of surgical techniques for treating gynecomastia. No definitive, universally accepted algorithm exists showing the ideal surgical approach for treating gynecomastia based on severity. An individualized approach based on gynecomastia grade and individual preference should assist the surgeon in providing the best outcomes.

A randomized controlled trial was conducted by Mohamad in 2019 to compare operative techniques; modified Benelli technique vs. subcutaneous mastectomy using periareolar incision. Participants were divided into two groups regarding their surgical technique. Group A consisted of 75 individuals undergoing surgical treatment with subcutaneous mastectomy using periareolar incision, and group B included 75 individuals being managed by the modified Benelli technique. The outcome of the trial demonstrated that the modified Benelli technique; had a lower operating time and retained a cosmetically acceptable position of the areola; however, there was much pleating of the skin compared to the periareolar incision. The authors concluded that the modified Benelli technique offers a reasonably simple surgical approach with an aesthetically positive outcome to treat gynecomastia with a low rate of complications and recurrences.

Zavlin et al. (2017) performed a retrospective analysis from the American College of Surgeons National Surgical Quality Improvement Program databases for adults and pediatrics to produce two cohorts that underwent surgical repair of gynecomastia. The study's goal was to assess an individual's demographics, surgical outcomes and complications. A total

of 1,787 individuals were identified, 204 pediatric and 1,583 adult males. The mean ages were 15.8 and 39.6 respectively. The results demonstrated low surgical (3.9 and 1.9%) and medical (0.0 and 0.3%) complications within the standardized 30-day postoperative period. Children and adolescents, however, required double mean operative times compared to adults (111.3 vs. 56.7 min). The authors concluded that operative gynecomastia treatment remains a safe modality across all age groups.

Clinical Practice Guidelines

American Society of Andrology (ASA)/European Academy of Andrology (EAA)

- The existence of an underlying pathology should be considered for gynecomastia in adulthood. The recommendation is to identify an apparent cause for gynecomastia in adulthood, including the use of medication recognized to be related to gynecomastia, which should not preclude a detailed investigation (moderate quality).
- Initial screening is suggested to rule out lipomastia, apparent breast cancer, or testicular cancer, which may be completed by a general practitioner or another clinical professional (very low-quality).
- In those cases where a comprehensive diagnostic workup is necessary, it should be accomplished by a specialist (very low-quality).
- The individual's medical history is recommended to incorporate information involving the onset and duration of gynecomastia, sexual development and function, and administration or abuse of substances associated with gynecomastia (moderate quality).
- The physical examination should identify signs of under-virilization or systemic disease (high quality).
- Breast examination should confirm the presence of palpable glandular tissue to differentiate from lipomastia (pseudo-gynecomastia) and rule out the suspicion of malignant breast tumor (high quality).
- The physical examination should involve the assessment of the genitalia to rule out the presence of a palpable testicular tumor and to identify testicular atrophy (high quality).
- Genitalia examination assisted by a testicular ultrasound, as the detection of a testicular tumor by palpation has low sensitivity (low quality).
- A set of evaluations may incorporate T, E2, SHBG, LH, FSH, TSH, prolactin, hCG, AFP, and liver adrenal function tests (low quality).
- Breast imaging may assist when the clinical examination is vague (low quality).
- If the clinical picture is suspect of a malignant lesion, a core needle biopsy should be completed (low quality).
- Watchful waiting should occur after treatment of underlying pathology or cessation of the administration/abuse of substances connected with gynecomastia (low quality).
- Treatment should be offered exclusively to men with established testosterone insufficiency (moderate quality).
- The use of selective estrogen receptor modulators (SERMs), aromatase inhibitors (Ais), or non-aromatizable androgens for treating gynecomastia, in general, is not recommended (low quality).
- Surgical treatment is only for individuals with persistent gynecomastia, which does not regress naturally or through subsequent medical therapy. The magnitude and type of surgery depend on the size of breast enlargement and the quantity of adipose tissue (low quality) (Kanakis et al., 2019).

American Society of Plastic Surgeons (ASPS)

The ASPS's recommendations for gynecomastia surgery for adults:

- Breast biopsy is suggested when malignancy is presumed.
- Unilateral or bilateral grade III or IV gynecomastia present (per modified McKinney and Simon, Hoffman, and Kohn scales).
  - Continues for more than 3 to 4 months following pathological reasons ruled out.
  - Continues after 3 to 4 months of failed medical therapy for pathological gynecomastia.
- Pain and discomfort due to the distention and stiffness from the hypertrophied breast (ASPS, 2016).

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 9, 2025)

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Policy History/Revision Information

Date	Summary of Changes
05/01/2026	**Related Policies** • Updated reference link to reflect the current policy title for *Panniculectomy Surgery (for Idaho Only)*

04/01/2026	**Medical Records Documentation Used for Reviews**
	• Removed reference link to the guidelines titled *Medical Records Documentation Used for Reviews*
	• Added language to indicate:
	  ○ 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 CS051ID.B

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.

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