

Gynecomastia Surgery (for Kansas Only)

Policy Number: CS051KS.03
Effective Date: June 1, 2026

[Instructions for Use](#)

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Related Policies

- [Breast Reduction Surgery \(for Kansas Only\)](#)
- [Cosmetic and Reconstructive Procedures \(for Kansas Only\)](#)
- [Gender Dysphoria Treatment \(for Kansas Only\)](#)

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.](#)

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.

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)

Policy History/Revision Information

Date	Summary of Changes
06/01/2026	<p data-bbox="337 457 1040 491">Medical Records Documentation Used for Reviews</p> <ul data-bbox="337 491 1495 827" style="list-style-type: none"><li data-bbox="337 491 716 525">• Added language to indicate:<ul data-bbox="386 525 1495 827" style="list-style-type: none"><li data-bbox="386 525 1438 583">○ 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<li data-bbox="386 583 1495 642">○ 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<li data-bbox="386 642 1463 701">○ The patient's medical record must contain documentation that fully supports the medical necessity for the requested services<li data-bbox="386 701 1393 760">○ This documentation includes but is not limited to relevant medical history, physical examination, and results of pertinent diagnostic tests or procedures<li data-bbox="386 760 1425 827">○ Documentation supporting the medical necessity should be legible, maintained in the patient's medical record, and must be made available upon request <p data-bbox="337 827 662 861">Supporting Information</p> <ul data-bbox="337 861 927 894" style="list-style-type: none"><li data-bbox="337 861 927 894">• Archived previous policy version CS051KS.02

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 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.