

# Gynecomastia Treatment

Guideline Number: CDG.012.11  
Effective Date: January 1, 2021

[Instructions for Use](#)

Table of Contents	Page
<a href="#">Coverage Rationale</a> .....	1
<a href="#">Documentation Requirements</a> .....	2
<a href="#">Definitions</a> .....	2
<a href="#">Applicable Codes</a> .....	3
<a href="#">References</a> .....	4
<a href="#">Guideline History/Revision Information</a> .....	4
<a href="#">Instructions for Use</a> .....	4

<p><b>Related Commercial Policies</b></p> <ul style="list-style-type: none"> <li><a href="#">Cosmetic and Reconstructive Procedures</a></li> <li><a href="#">Panniculectomy and Body Contouring Procedures</a></li> </ul>
<p><b>Community Plan Policy</b></p> <ul style="list-style-type: none"> <li><a href="#">Gynecomastia Treatment</a></li> </ul>

## Coverage Rationale

### Indications for Coverage

Most UnitedHealthcare plans have a specific exclusion for treatment of Benign Gynecomastia. Refer to the [Coverage Limitations and Exclusions](#) section.

### *Criteria for a Coverage Determination that Surgery is Reconstructive and Medically Necessary*

Mastectomy or suction lipectomy for treatment of Benign Gynecomastia for a male member under age 18 when all the following criteria are met:

- Gynecomastia or breast enlargement with moderate to severe chest pain that is 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.
- Persistent gynecomastia after cessation of prescribed medications 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 the following: testosterone, marijuana, asthma drugs, phenothiazines, anabolic steroids, cimetidine and calcium channel blockers).
- The breast enlargement must be present for at least 2 years and appropriate evaluation of medical causes with supporting laboratory testing has been normal. If so, lab tests which might include, but are not limited to the following must be performed:
  - Hormone testing (e.g., beta-human chorionic gonadotropin, estradiol, follicle-stimulating hormone, luteinizing hormone, prolactin, testosterone)
  - Liver enzymes
  - Serum creatinine
  - Thyroid function studies

Mastectomy or suction lipectomy for treatment of Benign Gynecomastia for a male member age 18 and up when all the following criteria are met:

- Discontinuation of medications, nutritional supplements, and non-prescription medications or substances (examples include, but are not limited to the following: testosterone, marijuana, asthma drugs, phenothiazines, anabolic steroids, cimetidine and calcium channel blockers) that have a known side effect of gynecomastia or breast enlargement and the breast size did not regress after discontinuation of use as appropriate.

- Glandular breast tissue is the primary cause of gynecomastia as opposed to fatty deposits (pseudo gynecomastia) and is documented on physical exam and/or mammography.
- Gynecomastia or breast enlargement with moderate to severe chest pain that is 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.
- Appropriate evaluation of medical causes with supporting laboratory testing has been normal. If so, lab tests which might include, but are not limited to the following must be performed:
  - Hormone testing (e.g., beta-human chorionic gonadotropin, follicle-stimulating hormone, estradiol, luteinizing hormone, prolactin, testosterone)
  - Liver enzymes
  - Serum creatinine
  - Thyroid function studies

Note: Regardless of age, if a tumor or neoplasm is suspected, a breast ultrasound and/or mammogram may be performed. As indicated, a breast biopsy may also be performed.

## Coverage Limitations and Exclusions

UnitedHealthcare excludes Cosmetic Procedures from coverage including but not limited to the following:

- Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. The fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery (or other procedures done to relieve such consequences or behavior) as a reconstructive procedure.
- [Treatment](#) of Benign Gynecomastia when specifically excluded in the member specific benefit plan document.

## Documentation Requirements

Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The documentation requirements outlined below are used to assess whether the member meets the clinical criteria for coverage but do not guarantee coverage of the service requested.

CPT Code*	Required Clinical Information
<b>Gynecomastia Treatment</b>	
19300	Medical notes documenting all of the following: <ul style="list-style-type: none"> <li>• History of the medical condition</li> <li>• Frontal and lateral colored photos of the torso including expected outcome</li> <li>• Treatment plan for proposed surgery</li> <li>• Clinical studies that address the physical and/or physiological abnormality</li> <li>• Functional deficits and associated conditions and complications</li> <li>• Pertinent medication history and laboratory results</li> </ul>

\*For code description, see the [Applicable Codes](#) section.

## Definitions

The following definitions may not apply to all plans. Refer to the member specific benefit plan document for applicable definitions.

**Benign Gynecomastia:** The development of abnormally large breasts in males. It is related to the excess growth of breast tissue (glandular), rather than excess fat tissue. (In most cases, breast enlargement and/or Benign Gynecomastia spontaneously resolves by age 18 making treatment unnecessary. Gynecomastia during puberty is not uncommon and in 90% of cases regresses within 3 years of onset.)

**Congenital Anomaly:** A physical developmental defect that is present at the time of birth, and that is identified within the first twelve months of birth.

**Cosmetic Procedures:** Procedures or services that change or improve appearance without significantly improving physiological function.

**Cosmetic Procedures (California only):** Procedures or services that are performed to alter or reshape normal structures of the body in order to improve your appearance.

**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.

**Reconstructive Procedures:** Reconstructive Procedures when the primary purpose of the procedure is either of the following:

- Treatment of a medical condition
- Improvement or restoration of physiologic function

Reconstructive Procedures include surgery or other procedures which are related to an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not a changed or improved physical appearance.

Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. The fact that you may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery (or other procedures done to relieve such consequences or behavior) as a reconstructive procedure.

**Reconstructive Procedures (California only):** Reconstructive Procedures to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to do either of the following:

- To improve function
- To create a normal appearance, to the extent possible

Reconstructive Procedures include surgery or other procedures which are related to a health condition. The primary result of the procedure is not a changed or improved physical appearance for cosmetic purposes only, but rather to improve function and/or to create a normal appearance, to the extent possible. Covered Health Care Services include dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures.

For the purposes of this section, "cleft palate" means a condition that may include cleft palate, cleft lip, or other craniofacial anomalies associated with cleft palate.

## 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 guideline 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 the member specific benefit plan document 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 Coverage Determination Guideline titled [Panniculectomy and Body Contouring Procedures](#).

CPT Code	Description
19300	Mastectomy for gynecomastia

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## References

- Ali O, Donohue PA. Gynecomastia. In: Kliegman RM, Stanton BF, Geme JW, Schor NF, Behrman RE, eds. Nelson Textbook of Pediatrics. 19th ed. Philadelphia, Pa: Saunders Elsevier; 2011:chap 579.
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- Mayo Clinic: Diseases and Conditions. Gynecomastia (enlarged breasts in men). January 22, 2014.
- MCG™ Care Guidelines, 24<sup>th</sup> edition, 2020. Mastectomy for Gynecomastia. ACG: A-0273.
- Narula HS, Carlson HE. Gynecomastia. Endocrinol Metab Clin North Am. 2007/36:497-519. NIH Medline Plus. Updated December 19, 2014.

## Guideline History/Revision Information

Date	Summary of Changes
01/01/2021	<p><b>Coverage Rationale</b></p> <ul style="list-style-type: none"><li>Revised list of Cosmetic Procedures excluded from coverage; removed “liposuction as the sole procedure for Gynecomastia”</li></ul> <p><b>Supporting Information</b></p> <ul style="list-style-type: none"><li>Archived previous policy version CDG.012.10</li></ul>

## Instructions for Use

This Coverage Determination Guideline provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the member specific benefit plan document must be referenced as the terms of the member specific benefit plan may differ from the standard plan. In the event of a conflict, the member specific benefit plan document governs. Before using this guideline, please check the member specific benefit plan document and any applicable federal or state mandates. UnitedHealthcare reserves the right to modify its Policies and Guidelines as necessary. This Coverage Determination Guideline is provided for informational purposes. It does not constitute medical advice.

This Coverage Determination Guideline may also be applied to Medicare Advantage plans in certain instances. In the absence of a Medicare National Coverage Determination (NCD), Local Coverage Determination (LCD), or other Medicare coverage guidance, CMS allows a Medicare Advantage Organization (MAO) to create its own coverage determinations, using objective evidence-based rationale relying on authoritative evidence ([Medicare IOM Pub. No. 100-16, Ch. 4, §90.5](#)).

UnitedHealthcare may also use tools developed by third parties, such as the MCG™ Care Guidelines, to assist us in administering health benefits. UnitedHealthcare Coverage Determination Guidelines 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.

For self-funded plans with SPD language other than fully-insured Generic COC language, please refer to the member specific benefit plan document for coverage.