Gynecomastia Surgery

Policy Number: MP.012.20
Effective Date: July 1, 2025

➲ Instructions for Use

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Related Commercial/Individual Exchange Policies

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

Community Plan Policy

- Gynecomastia Surgery

Application

UnitedHealthcare Commercial

This Medical Policy applies to UnitedHealthcare Commercial benefit plans.

UnitedHealthcare Individual Exchange

This Medical Policy applies to Individual Exchange benefit plans.

Coverage Rationale

➲ See Benefit Considerations

A mastectomy to treat Gynecomastia in a male under the age of 18 is considered reconstructive and medically necessary when all of 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)
- Gynecomastia must be present for at least two years
- 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

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 member specific benefit plan document 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; refer to the protocol titled Medical Records Documentation Used for Reviews.

Definitions

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

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.

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).

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 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.

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).

Benefit Considerations

Most benefit plans explicitly exclude coverage for treatment of benign Gynecomastia. However, some states require coverage.

Refer to the member specific benefit plan document to determine availability of benefits for these procedures.

Clinical Evidence

In a 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.

In 2018, Nuzzi and colleagues studied the effect of surgical treatment for gynecomastia on the quality of life in adolescents through surveys. The surveys were distributed to adolescents ages 12-21 with gynecomastia and male controls. The surveys consisted of the short-form 36v2 (SF-36), Rosenberg Self-Esteem Scale (RSES), and Eating-Attitudes Test-26. Surveys were completed at baseline, postoperatively, six months, one year, three- and five-year follow-ups. Participants in the study were 64 unaffected male controls. For the five SF-36 domains: general health, vitality, social functioning, role-emotional, and mental health, the individuals with gynecomastia scored significantly worse than controls and on the RSES. Postoperative improvements were noted in the scores of the RSES and the four SF-36 domains physical functioning, role-physical, bodily pain, and social functioning. Gynecomastia subjects scored similarly to controls in all SF-36 domains and the RSES postoperatively. Limitations in the study consist of the need for follow-up BMI data and the lack of comparison between baseline physical activity and the SF-36 survey, which confirms that the subjects have the potential for physical activity. Additional limitations include the sample size, risk for bias, and recruitment from a single, large tertiary care facility. The authors concluded that surgical treatment of gynecomastia improves the quality of life for adolescents, especially those overweight individuals with severe gynecomastia, and measurable improvements in psychosocial and physical functioning are evident.

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 individual's demographics, surgical outcomes, and complications. A total of 1787 individuals were identified, 204 pediatric and 1583 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 and European Academy of Andrology (ASA/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 2016 ASPS's recommendations for gynecomastia surgery for adolescents:

- Unilateral or bilateral grade II or grade III gynecomastia present (per modified McKinney and Simon, Hoffman, and Kohn scales).
  - Continues more than one year following pathological sources ruled out.
  - Continues after six months of failed medical treatment for pathological gynecomastia.
- Unilateral or bilateral grade IV gynecomastia present (per modified McKinney and Simon, Hoffman, and Kohn scales).
  - Continues more than six months following pathological reasons ruled out.
  - Continues after six months of failed medical treatment for pathological gynecomastia.
- Pain and discomfort due to the distention and stiffness from the hypertrophied breast. Gynecomastia may cause considerable psychological anguish, particularly in adolescents struggling with matters associated with sexual identity and self-image.

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

07/01/2025	**Related Policies *and* Applicable Codes**
	• Removed reference link to the Medical Policy titled *Panniculectomy and Body Contouring Procedures*
	Coverage Rationale
	• Replaced language indicating "a mastectomy for treating Gynecomastia *on a* male *member* is considered reconstructive and medically necessary when all the [listed] criteria are met" with "a mastectomy to treat Gynecomastia *in a* male is considered reconstructive and medically necessary when all of the [listed] criteria are met"
	• Revised coverage criteria for a mastectomy to treat Gynecomastia in a male:
	  ○ Replaced criterion requiring "an appropriate evaluation of medical causes *with* supporting laboratory testing has been normal; *if so*, *lab tests might* include but are not limited to the [listed tests], *must be performed*" with "an appropriate evaluation of medical causes *when* supporting laboratory testing has been normal; *supporting laboratory testing may* include but is not limited to the [listed tests]"
	  ○ Revised list of supporting laboratory tests:
	  ▪ Update list of examples of hormone testing; added "thyroid function studies, sex-hormone binding globulin"
	  ▪ Added "alpha-fetal protein"
	  ▪ Removed "thyroid function studies"
	Supporting Information
	• Updated *Clinical Evidence* and *References* sections to reflect the most current information
	• Archived previous policy version MP.012.19

Instructions for Use

This Medical Policy 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 policy, 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 Medical Policy is provided for informational purposes. It does not constitute medical advice.

This Medical Policy 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 InterQual® criteria, to assist us in administering health benefits. 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.