Gynecomastia Surgery (for Kentucky Only)

Policy Number: CS051KY.08
Effective Date: July 1, 2023

Instructions for Use

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Related Policies

- Cosmetic and Reconstructive Procedures (for Kentucky Only)
- Panniculectomy and Body Contouring Procedures (for Kentucky Only)

Application

This Medical Policy only applies to the state of Kentucky.

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.

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 8, 2023)

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Policy History/Revision Information

Date	Summary of Changes
07/01/2023	**Coverage Rationale** • Replaced references to “mammoplasty” with “mammaplasty” **Supporting Information** • Archived previous policy version CS051KY.07

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, please 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) for substance use, in administering health benefits. If InterQual does not have applicable criteria, UnitedHealthcare may also use UnitedHealthcare Medical Policies, Coverage Determination Guidelines, or Utilization Review Guidelines that have been approved by the Kentucky Department for Medicaid Services. The UnitedHealthcare Medical Policies, Coverage Determination Guidelines, or Utilization Review 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.

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