Gynecomastia Surgery

Policy Number: MP.012.22
Effective Date: June 1, 2026

➲ Instructions for Use

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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 individual under the age of 18 years 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 examination and/or mammography
- Persistent Gynecomastia after cessation of prescribed medications, nutritional supplements, and appropriate screening(s) of nonprescription 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 2 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., β-human chorionic gonadotropin, thyroid function studies, sex hormone–binding globulin, estradiol, follicle-stimulating hormone, luteinizing hormone, prolactin, testosterone)
  - Liver enzymes
  - Serum creatinine
  - α-fetal protein

A mastectomy to treat Gynecomastia in a male individual aged 18 years or 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 examination and/or mammography
- Persistent Gynecomastia after cessation of prescribed medications, nutritional supplements, and appropriate screening(s) of nonprescription 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., β-human chorionic gonadotropin, thyroid function studies, sex hormone–binding globulin, estradiol, follicle-stimulating hormone, luteinizing hormone, prolactin, testosterone)
  - Liver enzymes
  - Serum creatinine
  - α-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 guidelines 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.

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, and performing basic life functions (Medicare, 2023).

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

American Society of Plastic Surgeons' Gynecomastia scale (American Society of Plastic Surgeons, 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 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. Physiological Gynecomastia is common in newborns, adolescents, and older men. Treatment is directed at minimizing emotional distress and physical discomfort. Nonphysiological 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 the use of 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 individuals. 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

Fung et al. (2025) conducted a systematic review and meta-analysis following PRISMA guidelines to evaluate the effect of tranexamic acid (TXA) in mastectomy with or without breast reconstruction. Thirteen studies including 2,115 patients were analyzed, with 44% receiving TXA administered intravenously, orally, or topically at various perioperative times. The primary outcomes were postoperative hematoma and seroma, analyzed using Mantel-Haenszel odds ratios and inverse-variance mean differences. TXA significantly reduced postoperative hematoma occurrence [2.4% vs 5.5%; OR 0.40, 95% CI (0.23-0.70), p = 0.001].Seroma rates did not differ significantly between TXA and control groups [OR 0.82, 95% CI (0.61-1.10), p = 0.19].The authors concluded that TXA reduces hematoma rates in mastectomy and breast reconstruction when combined with prior review data and does not increase thromboembolic risk in this cohort. secondary outcomes measured were superficial incisional or deep incisional surgical site infection SSI, drain output, drain duration, implant explanations and thromboembolic events. Earlier drain removal by 1.2 days was noted for patients with TXA as compared to control groups. The meta-analysis did not demonstrate a significant impact of TXA on SSIs., seroma formation or implant explanation. Limitations included limited data collection across primary outcomes, heterogeneous data with variable TXA timing, route, and dosage, and differing assessment methods for hematoma and seroma.

Shariat et al. (2025) conducted a systematic review and meta-analysis of randomized controlled trials evaluating gynecomastia and breast pain in prostate cancer patients receiving androgen receptor pathway inhibitors (ARPIs) compared with androgen deprivation therapy (ADT) and assessing prophylactic tamoxifen and radiotherapy. Eighteen RCTs including 5,036-5,773 patients were analyzed, involving ARPIs such as enzalutamide, darolutamide, and apalutamide. The primary outcomes were incidence of gynecomastia and breast pain. ARPI monotherapy significantly increased gynecomastia (pooled RR 5.19, 95% CI 3.58-7.51, p < 0.001) and breast pain (pooled RR 12.77, 95% CI 6.38-25.54, p < 0.001) compared with ADT monotherapy. ARPI plus ADT therapy showed no significant difference in gynecomastia (RR 1.27, 95% CI 0.84-1.93, p = 0.2) or breast pain (RR 1.47, 95% CI 0.79–2.74, p = 0.223) versus ADT alone. Prophylactic tamoxifen 20 mg/day reduced gynecomastia (RR 0.21, 95% CI 0.10-0.43, p < 0.001) and breast pain (RR 0.17, 95% CI 0.09-0.30, p < 0.001), while radiotherapy also lowered gynecomastia (RR 0.44, 95% CI 0.33-0.60, p < 0.001) and breast pain (RR 0.68, 95% CI 0.50-0.94, p = 0.018).The authors concluded that prophylactic tamoxifen or radiotherapy significantly reduced gynecomastia and breast pain caused by bicalutamide monotherapy and suggested considering prophylactic treatment when administering ARPI monotherapy to prostate cancer patients. Limitations included small sample sizes, inability to perform subgroup analyses by ARPI type or timing, missing data from key RCTs, and restriction of prophylactic treatment evidence to bicalutamide monotherapy, limiting generalizability.

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 the 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 the 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 (Methodological Index for Nonrandomized Studies) to assess the methodological quality. The results demonstrated 18 studies that included 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%-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 in two individuals. Both studies demonstrated a high surgeon satisfaction rate, and one showed a high satisfaction rate among individuals. 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 nonrandomized case series urging better quality are necessary.

Innocenti and associates (2022) performed a systematic review of the literature related to incidences of complications with different surgical approaches for the treatment of gynecomastia correction. In total, 94 articles were obtained, consisting of 7,294 individuals who were analyzed. Three groups were created: aspiration techniques, consisting of 874 individuals (11.98%); surgical excision techniques, consisting of 2,764 individuals (37.90%); and combined techniques, consisting of 3,656 individuals (50.12%). The notable complications for each group totaled 1,407. There were 847 (30.64%) in the surgical excision techniques group, 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 with surgical excision alone; however, the lack of single clinical classification and presence of several surgical methods represent 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 in individuals taking spironolactone, antiandrogens, 5-α reductase inhibitors, lipid-lowering drugs, and psychotropic drugs. In men receiving antiandrogens, there was an increased risk of gynecomastia [odds ratio (OR), 17.38; 95% CI, 11.26-26.82; six trials; 9,599 individuals] and 5-α reductase inhibitors compared with controls (OR, 1.77; 95% CI, 1.53-2.06; seven series out of six trials; 34,860 individuals). Compared with controls, use of spironolactone in mixed-gender populations was considered to have substantially higher odds of having gynecomastia (OR, 8.39; 95% CI, 5.03-13.99; 14 trials; 3,745 individuals). There was a noteworthy variance in the odds of having gynecomastia in an evaluation between risperidone and quetiapine (OR, 4.32; 95% CI, 1.31-14.27; three trials; 343 individuals); however, no placebo-controlled trials concentrating on the risk of gynecomastia in individuals taking antipsychotic drugs were obtainable. Antiandrogens, 5-α 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 1,112 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, which was 2.4%. Those who routinely used drain placement had 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: the modified Benelli technique vs subcutaneous mastectomy using periareolar incision. Participants were divided into two groups regarding their surgical technique. Group A consisted of 75 participants undergoing surgical treatment with subcutaneous mastectomy using periareolar incision, and group B included 75 participants being managed with 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 with 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, through surveys, on the quality of life in adolescents. The surveys were distributed to adolescents aged 12 to 21 years with gynecomastia and male controls. The surveys consisted of the 36-Item Short Form Survey version 2 (SF-36v2), Rosenberg Self-Esteem Scale (RSES), and Eating Attitudes Test-26. Surveys were completed at baseline and post operation as well as 6 months, 1

year, and 3- and 5-year follow-ups. Participants in the study were 64 unaffected male controls. For the five SF-36v2 domains, which were general health, vitality, social functioning, role-emotional, and mental health, the participants 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-36v2 domains of physical functioning, role-physical, bodily pain, and social functioning. Participants with gynecomastia scored similarly to controls in all SF-36v2 domains and the RSES post operation. Limitations in the study consist of the need for follow-up body mass index data and lack of comparison between baseline physical activity and the SF-36v2 survey, which confirms that the participants had 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 in adolescents, especially 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 in adults and pediatric patients to produce two cohorts that underwent surgical repair of gynecomastia. The study's goal was to assess patients' demographics, surgical outcomes, and complications. A total of 1,787 patients were identified: 204 pediatric patients and 1,583 adult male patients. The mean ages were 15.8 and 39.6 years, 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. However, children and adolescents required double mean operative times compared with 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 of 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 in which a comprehensive diagnostic workup is necessary, it should be accomplished by a specialist (very low quality).
- The patient's medical history is recommended to incorporate information involving the onset and duration of gynecomastia, sexual development and function, and administration or use of substances associated with gynecomastia (moderate quality).
- The physical examination should identify signs of undervirilization or systemic disease (high quality).
- Breast examination should confirm the presence of palpable glandular tissue to differentiate from lipomastia (pseudogynecomastia) 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 testosterone, estradiol, sex hormone–binding globulin, luteinizing hormone, follicle-stimulating hormone, thyroid-stimulating hormone, prolactin, human chorionic gonadotropin, α-fetal protein, 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/use 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, aromatase inhibitors, or nonaromatizable androgens for treating gynecomastia, in general, is not recommended (low quality).
- Surgical treatment is only for patients with persistent gynecomastia that 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 state:

- Unilateral or bilateral grade II or grade III gynecomastia present (per modified McKinney and Simon, Hoffman, and Kohn scales)
  - Continues more than 1 year following pathological sources ruled out
  - Continues after 6 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 6 months following pathological reasons ruled out
  - Continues after 6 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 experiencing 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 23, 2026)

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Policy History/Revision Information

Date	Summary of Changes
06/01/2026	**Supporting Information** • Updated *Clinical Evidence* and *References* sections to reflect the most current information • Archived previous policy version MP.012.21

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, 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.