KAISER PERMANENTE®

Kaiser Foundation Health Plan of Washington

Clinical Review Criteria
Gynecomastia

Criteria

For Medicare Members

Source	Policy
CMS Coverage Manuals	None
National Coverage Determinations (NCD)	None
Local Coverage Determinations (LCD)	Plastic Surgery (L37020)
Local Coverage Article (LCA)	Billing and Coding: Plastic Surgery (A57222)

For Non-Medicare Members

Plastic Surgery credentials are preferred for mammoplasty to treat gynecomastia. Surgery may be medically necessary when the following criteria are met:

Kaiser Permanente has elected to use the Mastectomy for Gynecomastia (KP-0273 v2 eff 04.01.2022) MCG* Care Guideline for medical necessity determinations. For access to the MCG Clinical Guidelines criteria, please see the MCG Guideline Index through the provider portal under Quick Access.

If requesting this service, please send the following documentation to support medical necessity:

- Last 6 months of clinical notes from primary care provider or specialist, addressing the indications described in the medical necessity criteria

***MCG manuals are proprietary and cannot be published and/or distributed**. However, on an individual member basis, Kaiser Permanente can share a copy of the specific criteria document used to make a utilization management decision. If one of your patients is being reviewed using these criteria, you may request a copy of the criteria by calling the Kaiser Permanente Clinical Review staff at 1-800-289-1363.

The following information was used in the development of this document and is provided as background only. It is provided for historical purposes and does not necessarily reflect the most current published literature. When significant new articles are published that impact treatment option, Kaiser Permanente will review as needed. This information is not to be used as coverage criteria. Please only refer to the criteria listed above for coverage determinations.

Background

Gynecomastia is a unilateral or bilateral enlargement of the male breast due to benign proliferation of glandular elements. Pubertal gynecomastia resolves without intervention in the majority of cases. Gynecomastia in post pubertal males may be due to persistent pubertal gynecomastia, medications, liver disease, kidney disease, testicular tumors, or endocrine disorders. The cause remains undetermined in about 25% of cases. Male breast cancer is uncommon and usually presents as a discrete breast mass.

Back to Top

Applicable Codes

Considered Medically Necessary when criteria in the applicable policy statements listed above are met:

CPT® Codes	Description
19300	Mastectomy for gynecomastia

***Note:** Codes may not be all-inclusive. Deleted codes and codes not in effect at the time of service may not be covered.

****To verify authorization requirements for a specific code by plan type, please use the **Pre-authorization Code Check**.

Date Created	Date Reviewed	Date Last Revised
01/05/2016	01/05/2016[MPC], 11/01/2016[MPC], 09/05/2017[MPC], 08/07/2018[MPC], 08/06/2019[MPC], 08/04/2020[MPC], 08/03/2021[MPC], 08/02/2022[MPC], 08/01/2023[MPC], 06/04/2024[MPC], 06/03/2025[MPC]	02/04/2025

[MPC] Medical Policy Committee

Revision History	Description
12/19/2017	Added Plastic Surgery LCD L37020
08/04/2020	Added Medicare LCA A57222
11/02/2021	MPC approved modifications to the hybrid criteria for non-Medicare members. Requires 60-day notice, effective date 04/01/2022.
02/04/2025	MPC approved to endorse credentialing preferences for Mastectomy. 60-day notice is not required.

Back to Top