BOSTON MEDICAL CENTER HEALTHNet PLAN

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WELL SENSE HEALTH PLAN

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Medical Policy

Gynecomastia Surgery

Policy Number: OCA 3.48
Version Number: 23
Version Effective Date: 12/01/21

Product Applicability	☒ **All Plan+ Products**
WellSense Health Plan	**Boston Medical Center HealthNet Plan**
☒ NH Medicaid	☒ MassHealth ACO
☒ NH Medicare Advantage	☒ MassHealth MCO
	☒ Qualified Health Plans/ConnectorCare/Employer Choice Direct
	☒ Senior Care Options

+ Note: Disclaimer and audit information is located at the end of this document.

Policy Summary

Unilateral or bilateral surgical treatment for gynecomastia is considered **medically necessary** for specific medical conditions when Plan criteria are met. The Plan complies with coverage guidelines for all applicable state-mandated benefits and federally-mandated benefits that are medically necessary for the member's condition. Plan prior authorization is required.

The Plan complies with coverage guidelines for all applicable state-mandated benefits and federally-mandated benefits that are medically necessary for the member's condition. Review the Plan's *Cosmetic, Reconstructive, and Restorative Services* medical policy, policy number OCA 3.12, for guidelines on the use autologous fat grafts to treat HIV-associated lipodystrophy syndrome according to Massachusetts mandated benefits, as specified in Chapter 233 of the Acts of 2016, An Act Relative to HIV Associated Lipodystrophy Syndrome Treatment. Other applicable medical policies include: *Breast Reconstruction* medical policy, policy number OCA 3.43; *Breast Reduction Surgery* medical policy, policy number OCA 3.44; *Gender Affirmation Services* medical policy, policy number OCA 3.11; and *Mastopexy* medical policy, policy number OCA 3.717.

+ *Plan* refers to Boston Medical Center Health Plan, Inc. and its affiliates and subsidiaries offering health coverage plans to enrolled members. The Plan operates in Massachusetts under the trade name Boston Medical Center HealthNet Plan and in other states under the trade name Well Sense Health Plan.

Clinical Criteria

The Plan considers unilateral or bilateral surgical treatment for gynecomastia to be medically necessary for a member (i.e., a member born with male reproductive organs and/or with typical male karyotype with only one [1] X chromosome) when the condition is related to HIV-associated lipohypertrophy or another medical condition. The treating provider must verify that the member is an acceptable surgical candidate (with evaluation of the member's high-risk indicators, if any, such as morbid obesity, tobacco use, cardiac history, comorbidities, and related past medical/surgery history). The Plan's applicable medical necessity criteria must be met and documented in the member's medical record (including preoperative photographs, which will be submitted as part of the prior authorization review process if requested by the Plan), as specified below in EITHER item A (for gynecomastia from HIV-associated lipohypertropy) or item B (for gynecomastia from other medical conditions):

A. Gynecomastia from HIV-Associated Lipohypertrophy:

1. Criteria for BMC HealthNet Plan Members for the Treatment of HIV-associated Lipodystrophy with Gynecomastia Surgery: ǂ

   In accordance with Massachusetts state-mandated benefits, the Plan covers medically necessary treatment to correct or repair disturbances of body composition caused by HIV-associated lipodystrophy syndrome (including but not limited to reconstructive services such as surgical treatment for gynecomastia to reduce lipohypertrophy of the chest) for a BMC HealthNet Plan member (i.e., Massachusetts resident enrolled in the Plan's MassHealth, Qualified Health Plans, or Senior Care Options product). Gynecomastia surgery for the treatment of HIV-associated lipohypertrophy of the chest is considered medically necessary when ALL of the following criteria are met, as specified below in items a through e:

   a. The BMC HealthNet Plan member has a diagnosis of HIV or AIDS with HIV-associated lipodystrophy syndrome; AND

   b. Conservative treatment and pharmacotherapy have failed to treat the condition or are not appropriate for the member's condition (as determined by the treating provider);∞ AND

      ∞ For pharmacotherapy, see the Plan's applicable pharmacy policies available at www.bmchp.org for prior authorization guidelines and medical necessity criteria for the BMC HealthNet Plan covered drug list (categorized by medical drug name), including but not limited to the Plan's *Egrifta®* pharmacy policy, policy number 9.032.

   c. The member's HIV-associated lipodystrophy syndrome has caused disturbances of body composition of the chest and surgical treatment for gynecomastia is medically necessary to treat the member's HIV-associated lipodystrophy (and not solely a cosmetic procedure to enhance the member's appearance); AND

d. Liposuction is not sufficient as a sole treatment to correct the lipodystrophy of the chest; AND

e. Surgery treatment for gynecomastia is expected to correct or repair the disturbance(s) of body composition of the chest caused by HIV-associated lipodystrophy syndrome; OR

ǂ Note: See the Plan's *Cosmetic, Reconstructive, and Restorative Services* medical policy, policy number OCA 3.69, for medical necessity guidelines for dermal filler injections for the treatment of HIV-associated facial lipoatrophy syndrome or other surgical treatment for HIV-associated lipodystrophy syndrome.

2. Criteria for WellSense Health Plan Members for the Treatment of HIV-associated Lipodystrophy with Gynecomastia Surgery:

Applicable criteria and product-specific definitions for cosmetic, reconstructive, and restorative services included in the Plan's *Cosmetic, Reconstructive, and Restorative Services* medical policy, policy number OCA 3.69, will be used to determine the medical necessity of the requested treatment of HIV-associated lipodystrophy according to the member's benefit coverage guidelines.

B. Gynecomastia from Other Medical Conditions for All Plan Products:

The Plan considers unilateral or bilateral surgical treatment for gynecomastia medically necessary when ALL of the following applicable criteria are met, as specified below in items 1 through 3:

1. Member (i.e., a member born with male reproductive organs and/or with typical male karyotype with only one [1] X chromosome) is 17 years of age or older on the date of service;ǂ AND

ǂ Note: The Plan will review all requests for breast reconstruction procedures for gender reassignment using the medical criteria included in the Plan's *Gender Affirmation Services* medical policy, policy number OCA 3.11, rather than other Plan medical policies related to the requested breast procedure.

2. Body mass index (BMI) of less than 35 kg/m^2; AND

3. Unilateral or bilateral gynecomastia with ONE (1) of the following conditions, as specified below as item a or item b:

a. Diagnosis of Klinefelter syndrome with documentation of abnormal chromosome analysis; OR

b. ALL of the following clinical signs/symptoms, as specified below in items (1) through (7):

(1) Excess breast tissue that is negative for breast cyst or tumor as confirmed by clinical exam, mammogram, ultrasound, core needle biopsy, or open biopsy; AND

(2) Excess breast tissue is glandular, not fatty tissue as confirmed by physical exam, mammogram or tissue pathology; AND

(3) Appropriate diagnostic evaluation has been done for possible underlying etiology with ONE (1) of the following findings, as specified below in item (a) or item (b):

(a) Normal estradiol level or normal testicular ultrasonogram (if the serum estradiol level is elevated) with clinical examination findings that do not suggest a testicular neoplasm; OR

(b) An endocrine abnormality (e.g., hypogonadism, testicular tumors, hyperthyroidism) with the gynecomastia persisting despite optimal medical treatment (such as tamoxifen or radiation therapy to suppress painful gynecomastia in men undergoing androgen-suppression therapy for the treatment of prostate cancer); AND

(4) Member has at least ONE (1) of the following conditions, as specified below as item (a) or item (b):

(a) Persistent pain and/or physical discomfort from the breast despite the use of analgesics; OR

(b) Medically refractory skin breakdown or intertrigo that is resistant to conservative and non-surgical treatment; AND

(5) Presence of the condition for at least 24 consecutive months for pubertal (adolescent) onset gynecomastia or post-pubertal (adult) onset gynecomastia that has persisted for at least 12 consecutive months~~ł~~ with no signs of spontaneous involution with BOTH of the following criteria met, as specified below in item (a) and item (b): ¤

(a) At least six (6) consecutive months of failed conservative treatment that includes correction of any underlying causes of gynecomastia (including hormonal) and the discontinuation of medications, substances, and supplements that have a known side effect of breast enlargement, and the member's breast size did not regress after conservative treatment; AND

(b) If applicable, the use of any gynecomastia-causing drugs have been discontinued for at least six (6) consecutive months with persistent symptoms, or the medication cannot be safely discontinued because there is no acceptable alternative to the medication; AND

- ¤ Note: Adolescent gynecomastia is common during puberty, and most cases spontaneously regress within 12 to 24 months.

(6) Unilateral or bilateral gynecomastia is classified as follows according to the member's age on the date of service, EITHER item (a) or item (b):

(a) Grade II, III, or IV for members under age 18 on the date of service or based on the American Society of Plastic Surgeons (ASPS) Gynecomastia Scale; OR

(b) Grade III, or IV for members age 18 or older on the date of service or based on the American Society of Plastic Surgeons (ASPS) Gynecomastia Scale; AND

(7) Documentation in the member's medical record clearly excludes substance abuse and the use of controlled substances that can cause breast enlargement; excludes the use of supplements, herbal products, and hormones (recreational or prescribed, including steroids) which may be contributing to the gynecomastia; and all of the member's medications are deemed noncontributory.

Plan note: If a tumor or neoplasm is suspected, a breast ultrasound and/or mammogram may be performed. As indicated, a breast biopsy may also be medically necessary. Mastectomy for gynecomastia is considered medically necessary, regardless of age, when there is legitimate concern that a breast mass may represent breast carcinoma.

Limitations and Exclusions

ANY of the following limitations applies to gynecomastia surgery, as specified below in items 1 through 4:

1. Surgical treatment for unilateral or bilateral gynecomastia is considered a cosmetic service when applicable Plan criteria specified in the Medical Policy Statement section of this policy are NOT met.

2. The Plan does NOT consider the surgical treatment of gynecomastia to be medically necessary for ANY of the following conditions, as specified below in items a through f:

   a. Grade I gynecomastia (i.e., small breast enlargement with localized button of tissue around the areola); OR

   b. Pseudogynecomastia; OR

   c. Gynecomastia that is expected to resolve; OR

d. Gynecomastia caused by substance abuse or use of a controlled substance that can cause breast enlargement (e.g., alcohol, amphetamines, heroin, marijuana, methadone); OR

e. Gynecomastia as a result of nutritional supplements, herbal products, medications/substances (including hormones, including steroids) that are not prescribed by a licensed clinician to treat a medical condition; OR

f. To treat psychological distress related to the condition or symptoms (when applicable medical necessity criteria in the Medical Policy Statement section are NOT met); OR

3. The Plan considers suction assisted lipectomy or liposuction as a sole method of surgical treatment for gynecomastia to be cosmetic and not medically necessary when performed to improve the appearance of the breast for a male member (or a member born with male reproductive organs and/or with typical male karyotype with only one [1] X chromosome). The Plan will review all requests for breast reconstruction procedures for gender reassignment using the medical criteria included in the *Gender Affirmation Services* medical policy, policy number OCA 3.11, rather than this Plan policy.

4. A request for gynecomastia surgery for a member less than age 17 on the date of service requires Medical Director review.

Variations

The Plan uses guidance from the Centers for Medicare & Medicaid Services (CMS) for medical necessity and coverage determinations for Senior Care Options (SCO) members and WellSense Medicare Advantage HMO members, including but not limited to national coverage determinations (NCDs), local coverage determinations (LCDs), local coverage articles (LCAs), and documentation included in Medicare manuals. At the time of the Plan's most recent policy review, no CMS clinical guidelines were identified specifically for gynecomastia. Verify CMS guidelines in effect on the date of the prior authorization request. When there is no guidance from CMS for the requested service, Plan-adopted clinical review criteria will be used to determine the medical necessity of the service.

Applicable Coding

The Plan uses and adopts up-to-date Current Procedural Terminology (CPT) codes from the American Medical Association (AMA), International Statistical Classification of Diseases and Related Health Problems, 10th revision (ICD-10) diagnosis codes developed by the World Health Organization and adapted in the United Stated by the National Center for Health Statistics (NCHS) of the Centers for Disease Control under the U.S. Department of Health and Human Services, and the Health Care Common Procedure Coding System (HCPCS) established and maintained by the Centers for Medicare & Medicaid Services (CMS). Since the AMA, NCHS, and CMS may update codes more frequently or at different intervals than Plan policy updates, the list of applicable codes included in this Plan policy is for informational purposes only, may not be all inclusive, and is subject to change without prior notification. Whether a code is listed in the Applicable Coding section of this Plan policy does not

constitute or imply member coverage or provider reimbursement. Providers are responsible for reporting all services using the most up-to-date industry-standard procedure and diagnosis codes as published by the AMA, NCHS, and CMS at the time of the service.

Providers are responsible for obtaining prior authorization for the services specified in the Clinical Criteria and Limitation and Exclusions sections of this Plan policy, even if an applicable code appropriately describing the service that is the subject of this Plan policy is not included in this Applicable Coding section. Review the Plan's reimbursement policies for Plan billing guidelines. Coverage for services is subject to benefit eligibility under the member's benefit plan in effect at the time of the service. Member benefit documents are available at the following websites: www.bmchp.org for BMC HealthNet Plan members, www.SeniorsGetMore.org for Senior Care Options members, www.wellsense.org for WellSense New Hampshire Medicaid members, and www.WellSense.org/Medicare for WellSense Medicare Advantage HMO members.

CPT Code	Description: Code Covered When Medically Necessary
19300	Mastectomy for gynecomastia

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Policy History

Original Approval Date	Original Effective Date* and Version Number	Policy Owner	Original Policy Approved by
Regulatory Approval: N/A Internal Approval: 12/06/05	02/06/05 Version 1	Medical Policy Manager as Chair of Medical Policy, Criteria, and Technology Assessment Committee (MPCTAC)	Quality and Clinical Management Committee (Q&CMC)

*Effective Date for the BMC HealthNet Plan Commercial Product: 01/01/12
*Effective Date for the WellSense New Hampshire Medicaid Product: 01/01/13
*Effective Date for the Senior Care Options Product: 01/01/16
*Effective Date for the WellSense Medicare Advantage HMO Product: 01/01/22

(Policy formerly titled *Surgical Treatment for Male Gynecomastia* until 08/01/13.)

Policy Revisions History			
Review Date	**Summary of Revisions**	**Revision Effective Date and Version Number**	**Approved by**
01/03/06	Revised clinical coverage criteria.	Version 2	01/03/06: Q&CMC
02/06/07	Updated references.	Version 3	02/06/07: Q&CMC
12/01/07	No changes.	Version 4	01/08/08: MPCTAC 01/22/08: Utilization Management Committee (UMC) 02/19/08: Quality Improvement Committee (QIC)

Policy Revisions History			
01/27/09	No changes.	Version 5	01/27/09: MPCTAC 01/27/09: UMC 02/25/09: QIC
05/26/09	Added definition for reconstructive and restorative services changed the definition for cosmetic services and clarified that suction assisted lipectomy or liposuction as a sole method of treatment is considered cosmetic. Effective date of changes is 10/01/09.	Version 6	05/26/09: MPCTAC 05/26/09: UMC 07/22/09: QIC
05/01/10	No changes.	Version 7	05/25/10: MPCTAC 06/23/10: QIC
05/01/11	No changes to criteria. Updated references and coding.	Version 8	05/18/11: MPCTAC 06/22/11: QIC
05/01/12	No changes made to clinical criteria or applicable codes. References updated.	Version 9	05/16/12: MPCTAC 06/27/12: QIC
07/30/12	Off cycle review for Well Sense Health Plan. Deleted text related to Massachusetts products. Updated references.	Version 10	08/03/12: MPCTAC 09/05/12: QIC
04/01/13	Review for effective date of 08/01/13. Revised title, updated references, and deleted definition of Cosmetic Service. Revised clinical criteria in Medical Policy Statement section (formerly titled Clinical Guideline Statement section). Updated Summary, Definitions and Clinical Background Information sections. Referenced the following Plan policies: *Medically Necessary*, *Mastopexy*, *Breast Reconstruction*, *Bariatric Surgery*, and *Cosmetic, Reconstructive, and Restorative Services*. Revised language of introductory paragraph of Applicable Coding section. Changed name of policy category from "Clinical Coverage Guidelines" to "Medical Policy."	08/01/13 Version 11	04/17/13: MPCTAC 05/16/13: QIC
06/01/13	Review for effective date 10/01/13. Deleted CPT code 15877 from the applicable code list. Revised Definitions section.	10/01/13 Version 12	06/19/13: MPCTAC 07/18/13: QIC
04/01/14	Review for effective date 06/01/14.	06/01/14	04/16/14: MPCTAC

Policy Revisions History			
	Added description of gynecomastia surgery to the Description of Item or Service section. Moved definition of gynecomastia from the Description of Item or Service section to the Definitions section. Updated references.	Version 13	05/14/14: QIC
04/01/15	Review for effective date 08/01/15. Updated Summary, Definitions, and References sections. Removed Commonwealth Care, Commonwealth Choice, and Employer Choice from the list of applicable products because the products are no longer available. Revised criteria in the Medical Policy Statement section. Added to Medical Policy Statement section that preoperative photographs may be required upon request during the Plan prior authorization process.	08/01/15 Version 14	04/15/15: MPCTAC 05/13/15: QIC
11/25/15	Review for effective date 01/01/16. Updated template with list of applicable products and notes. Revised language in the Applicable Coding section.	01/01/16 Version 15	11/18/15: MPCTAC 11/25/15: MPCTAC (electronic vote) 12/09/15: QIC
04/01/16	Review for effective date 08/01/16. Revised criteria in the Medical Policy Statement section. Updated Clinical Background Information, References, and References to Applicable Laws and Regulations sections.	08/01/16 Version 16	04/20/16: MPCTAC 05/23/16: QIC
09/28/16	Review for effective date 11/01/16. Administrative changes to clarify language related to gender.	11/01/16 Version 17	09/30/16: MPCTAC (electronic vote) 10/12/16: QIC
04/01/17	Review for effective date 07/08/17. Revised criteria in the Medical Policy Statement and Limitations sections. Administrative changes made in the Summary, Definitions, References, and References to Applicable Laws and Regulations sections.	07/08/17 Version 18	04/19/17: MPCTAC
05/01/18	Review for effective date 06/01/18. Administrative changes made to the Policy Summary, Medical Policy	06/01/18 Version 19	05/16/18: MPCTAC

Policy Revisions History			
	Statement, Limitations, References, and Other Applicable Policies sections.		
04/01/19	Review for effective date 05/01/19. Administrative changes made to the References, Other Applicable Policies, and Reference to Applicable Laws and Regulations sections.	05/01/19 Version 20	04/18/19: MPCTAC (electronic vote)
04/01/20	Review for effective date 05/01/20. Administrative changes made to the References and Reference to Applicable Laws and Regulations sections.	05/01/20 Version 21	04/15/20: MPCTAC
04/01/21	Review for effective date 05/01/21. Administrative changes made to the Policy Summary, Medical Policy Statement, Limitations, and References sections.	05/01/21 Version 22	04/21/21: MPCTAC
11/01/21	Review for effective date 12/01/21. Adopted new medical policy template; removed administrative sections, the Medical Policy Statement section renamed the Clinical Criteria section, and the Limitations section renamed the Limitations and Exclusions section. Added WellSense Medicare Advantage HMO as an applicable product effective 01/01/22. Administrative changes made to the Policy Summary, Clinical Criteria, Limitations and Exclusions, Applicable Coding, and References sections.	12/01/21 Version 23	11/17/21: MPCTAC

Next Review Date

04/01/22

Authorizing Entity

MPCTAC

Disclaimer Information: +

Medical Policies are the Plan's guidelines for determining the medical necessity of certain services or supplies for purposes of determining coverage. These Policies may also describe when a service or supply is considered experimental or investigational, or cosmetic. In making coverage decisions, the Plan uses these guidelines and other Plan Policies, as well as

the Member's benefit document, and when appropriate, coordinates with the Member's health care Providers to consider the individual Member's health care needs.

Plan Policies are developed in accordance with applicable state and federal laws and regulations, and accrediting organization standards (including NCQA). Medical Policies are also developed, as appropriate, with consideration of the medical necessity definitions in various Plan products, review of current literature, consultation with practicing Providers in the Plan's service area who are medical experts in the particular field, and adherence to FDA and other government agency policies. Applicable state or federal mandates, as well as the Member's benefit document, take precedence over these guidelines. Policies are reviewed and updated on an annual basis, or more frequently as needed. Treating providers are solely responsible for the medical advice and treatment of Members.

The use of this Policy is neither a guarantee of payment nor a final prediction of how a specific claim(s) will be adjudicated. Reimbursement is based on many factors, including member eligibility and benefits on the date of service; medical necessity; utilization management guidelines (when applicable); coordination of benefits; adherence with applicable Plan policies and procedures; clinical coding criteria; claim editing logic; and the applicable Plan – Provider agreement.