Medical Policy

Gynecomastia Surgery

Policy Number: OCA 3.48
Version Number: 17
Version Effective Date: 11/01/16

Product Applicability

<table>
<thead>
<tr>
<th>Well Sense Health Plan</th>
<th>Boston Medical Center HealthNet Plan</th>
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</thead>
<tbody>
<tr>
<td>☑ New Hampshire Medicaid</td>
<td>☑ MassHealth</td>
</tr>
<tr>
<td>☑ NH Health Protection Program</td>
<td>☑ Qualified Health Plans/ConnectorCare</td>
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<td></td>
<td>☑ Senior Care Options ◊</td>
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</table>

Notes:
+ Disclaimer and audit information is located at the end of this document.
◊ The guidelines included in this Plan policy are applicable to members enrolled in Senior Care Options only if there are no criteria established for the specified service in a Centers for Medicare & Medicaid Services (CMS) national coverage determination (NCD) or local coverage determination (LCD) on the date of the prior authorization request. Review the member’s product-specific benefit documents at www.SeniorsGetMore.org to determine coverage guidelines for Senior Care Options.

Policy Summary

Surgical treatment for gynecomastia is considered medically necessary for specific medical conditions when Plan criteria are met for a male member (including a member born with male reproductive organs and/or with typical male karyotype with only one [1] X chromosome). When applicable Plan criteria are NOT met, the Plan considers the surgery cosmetic; see Plan policy, Cosmetic, Reconstructive, and Restorative Services (policy number OCA 3.69), for the product-specific definitions of cosmetic services, cosmetic surgery, and/or reconstructive surgery and procedures. Plan prior authorization is required. Review the Plan policy, Breast Reduction Mammoplasty (policy number OCA 3.44), for Plan medical criteria for reduction mammoplasty with symptomatic macromastia for a female member (including a member born with female reproductive organs and/or with typical female

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karyotype with two [2] X chromosomes). The Plan will review all requests for breast reconstruction for gender reassignment, including breast augmentation for male-to-female (MtF) members and mastectomy for female-to-male (FtM) members, using the medical criteria included in the Gender Reassignment Surgery medical policy, policy number OCA 3.11 (rather than other Plan medical policies related to the requested breast procedures).

It will be determined during the Plan’s prior authorization process if the service is considered medically necessary for the requested indication. See Plan policy, Medically Necessary (policy number OCA 3.14), for the product-specific definitions of medically necessary treatment.

Description of Item or Service

Gynecomastia Surgery: Mastectomy for gynecomastia (unilateral or bilateral) is the surgical removal of glandular breast tissue in a male (including an individual born with male reproductive organs and/or with typical male karyotype with only one [1] X chromosome). A mastectomy for gynecomastia may be performed with an open incision or through minimally invasive endoscopic techniques. Severe gynecomastia might require larger incisions involving resection of skin and nipple transposition. The surgery is performed by a plastic surgeon or general surgeon.

Medical Policy Statement

The Plan considers surgical treatment for gynecomastia medically necessary for a male member (including a member born with male reproductive organs and/or with typical male karyotype with only one [1] X chromosome) when ALL of the following criteria are 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 items 1 through 3:

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

   ‡ Note: The Plan will review all requests for breast reconstruction procedures for gender reassignment using the medical criteria included in the Gender Reassignment Surgery 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/m²; 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’s syndrome with documentation of abnormal chromosome analysis; OR

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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 with no signs of spontaneous involution with BOTH of the following criteria met, as specified below in item (a) and item (b):

(a) Six (6) consecutive months of failed conservative treatment that includes correction of any underlying causes (including hormonal); 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

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† 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 (as specified in the Definitions section); 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 (as specified in the Definitions section); AND

(7) Medical record clearly excludes substance abuse, supplements, herbal products, and recreational hormones (including steroids) from contributing to the gynecomastia

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. See the member’s applicable benefit documents available at www.bmchp.org for BMC HealthNet Plan members, www.SeniorsGetMore.org for Senior Care Options members, and www.wellsense.org for Well Sense Health Plan members.

Limitations

Surgical treatment for unilateral or bilateral gynecomastia is considered a cosmetic service when Plan criteria specified in this policy are not met.

1. 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 (according to the Gynecomastia Scale); OR

   b. Pseudogynecomastia; OR

   c. Gynecomastia that is expected to resolve; OR

   d. Gynecomastia caused by substance abuse; OR

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

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f. To treat psychological distress related to the condition or symptoms.

2. 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 (including 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 Reassignment Surgery medical policy (policy number OCA 3.11) rather than this Plan policy.

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

Definitions

**Cosmetic Services:** Those services that are performed for the primary purpose of altering or improving physical appearance and that do not constitute reconstructive and restorative services. Services that meet the definition of reconstructive and restorative services are not considered cosmetic. See Plan policy, Cosmetic, Reconstructive, and Restorative Services (policy number OCA 3.69), for the product-specific definitions of cosmetic services.

**Gynecomastia:** Unilateral or bilateral, benign enlargement of the breast in a male (including an individual born with male reproductive organs and/or with typical male karyotype with only one [1] X chromosome) due to ductal and/or stromal proliferation of the glandular component of the breast. Gynecomastia results from an altered estrogen-androgen balance, in favor of estrogen, or increased breast sensitivity to a normal circulating estrogen level. Gynecomastia can be idiopathic, pathologic, or physiologic.

1. **Idiopathic:** Unknown cause of gynecomastia.

2. **Pathologic:** Enlargement of the glandular tissue of the breast related to androgen deficiency and estrogen excess. Pathological gynecomastia can be caused by certain medications (anabolic steroids, cannabinoids, psychotropics, antihypertensives and estrogens for prostatic/testicular carcinoma), and other conditions such as testicular or pituitary tumors, some syndromes of hypogonadism in a male (including an individual born with male reproductive organs and/or with typical male karyotype with only one [1] X chromosome), genetic disorders, congenital endocrine conditions (Klinefelter syndrome), and cirrhosis of the liver.

3. **Physiologic:** Enlargement of the glandular tissue of the breast that is usually seen in infants, pubescent adolescents, and elderly individuals. Physiologic gynecomastia occurs most frequently during times of hormonal changes in males (including individuals born with male reproductive organs and/or with typical male karyotype with only one [1] X chromosome).
reproductive organs and/or with typical male karyotype with only one [1] X chromosome) caused by an altered estrogen/androgen balance on breast tissue or from the increased sensitivity to a normal estrogen level.

**Gynecomastia Scale:** The American Society of Plastic Surgeons (ASPS) recommends using the Gynecomastia Scale (adapted from the McKinney scale and the Simon, Hoffman, and Kohn scale) to classify the severity of gynecomastia, as specified below:

<table>
<thead>
<tr>
<th>Grade</th>
<th>Description</th>
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<tbody>
<tr>
<td>I</td>
<td>Small breast enlargement with localized button of tissue around the areola</td>
</tr>
<tr>
<td>II</td>
<td>Moderate breast enlargement exceeding areola boundaries with edges that are indistinct from the chest</td>
</tr>
<tr>
<td>III</td>
<td>Moderate breast enlargement exceeding areola boundaries with edges that are distinct from the chest with skin redundancy present</td>
</tr>
<tr>
<td>IV</td>
<td>Marked breast enlargement with skin redundancy and feminization of the breast</td>
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</table>

**Intertrigo (also known as Intertriginous Dermatitis):** An inflammatory, superficial skin disorder involving any area of the body where opposing skin surfaces may touch and rub, such as the creases of the neck, between the toes, or in the skin folds of the groin, axilla, and breasts (especially if large and pendulous). The condition is characterized by skin reddening, maceration, burning, and itching. There may also be secondary infections, as well as erosions, fissures, and exudation.

**Klinefelter Syndrome:** Klinefelter syndrome is the most common chromosomal disorder associated with hypogonadism and infertility in males (including individuals born with male reproductive organs and/or with typical male karyotype with only one [1] X chromosome). It is defined classically by a 47, XXY karyotype with variants demonstrating additional X and Y chromosomes. The syndrome is characterized by hypogonadism (small testes, azoospermia/oligospermia), gynecomastia at late puberty, psychosocial problems, hyalinization and fibrosis of the seminiferous tubules, and elevated urinary gonadotropins.

**Pseudogynecomastia (also known as Lipomastia):** Enlargement of the breast adipose tissue without increase in glandular tissue that is usually secondary to fat accumulation occurring in individuals who are obese.

**Reconstructive and Restorative:** (a) Those services that are performed for the primary purpose of improving, repairing, restoring, or correcting a physical functional impairment, or relieving pain, resulting from any of the following: accidental traumatic injury, post-therapeutic intervention (e.g., radiation or chemotherapy), birth abnormality, congenital defect, disease process, or anatomic variants; or (b) post-mastectomy services for eligible members. See Plan policy, *Cosmetic, Reconstructive, and Restorative Services* (policy number OCA 3.69), for the product-specific definitions of reconstructive and restorative services.
### 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 States 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). Because 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 Medical Policy Statement section and Limitation section 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 the Applicable Coding section of this Plan policy. Coverage for services is subject to benefit eligibility under the member’s benefit plan. Please refer to the member’s benefits document in effect at the time of the service to determine coverage or non-coverage as it applies to an individual member. See Plan reimbursement policies for Plan billing guidelines.

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description: Code Covered When Medically Necessary</th>
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<tbody>
<tr>
<td>19300</td>
<td>Mastectomy for gynecomastia</td>
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### Clinical Background Information

Gynecomastia is a benign breast condition that accounts for 65% of breast abnormalities in males (including individuals born with male reproductive organs and/or with typical male karyotype with only one [1] X chromosome) that can occur at any age, but 40% of cases occur in adolescent boys that are 14 to 15.5 years of age. In most cases breast enlargement and/or benign gynecomastia spontaneously resolves by age 18, making treatment unnecessary. Gynecomastia during puberty is not uncommon and in 90% of cases regresses within 3 years of onset.

Gynecomastia can be classified based on etiology. Idiopathic gynecomastia accounts for approximately 75% of cases. Physiologic gynecomastia occurs primarily in newborns and in adolescents at puberty. In the newborn, the neonatal breast results from the action of maternal estrogens, placental estrogens, or both in concert; the increased breast tissue usually disappears in a few weeks. Adolescent gynecomastia is common during puberty; adolescent gynecomastia usually regresses between the age of 18 and 20 years but residual gynecomastia may be present in one or both breasts.
Pathologic gynecomastia is due to testosterone deficiency, increased estrogen production, or increased conversion of androgens to estrogens. The pathological conditions associated with gynecomastia include congenital anorchia, androgen resistance, defects of testosterone synthesis, Klinefelter syndrome, viral orchitis, trauma, castration, hyperthyroidism, adrenal disease, liver disorders, carcinoma of the lung, renal failure, true hermaphroditism, and malnutrition.

Many pharmacological drugs can cause gynecomastia. These agents can be categorized by their mechanisms of action and include the following, as specified below in items 1 through 4:

1. Drugs that act like estrogens, such as diethylstilbestrol, birth control pills, digitalis, and estrogen-containing cosmetics; or

2. Drugs that enhance endogenous estrogen formation, such as gonadotropins and clomiphene; or

3. Drugs that inhibit testosterone synthesis and/or action, such as ketoconazole, metronidazole, cisplatin, spironolactone and cimetidine; or

4. Drugs that act by unknown mechanisms, such as isoniazid, methyldopa, captopril, tricyclic antidepressants, diazepam, calcium channel blockers, growth hormone, anti-retroviral agents, marijuana, and heroin

Evaluation of patients with gynecomastia should include a careful drug history, measurement and examination of the testes, evaluation of liver function, and endocrine workup. When the primary cause of gynecomastia can be identified and corrected, the breast enlargement usually subsides quickly and eventually is resolved. Medical management is most successful when the gynecomastia is of recent onset and is caused by testosterone deficiency. Testosterone administration can cause dramatic improvement in men with testicular failure. When the gynecomastia is of long duration and the primary cause cannot be identified or corrected, surgical intervention may be indicated.

The surgical management for gynecomastia in males (including individuals born with male reproductive organs and/or with typical male karyotype with only one [1] X chromosome) has two (2) objectives: The restoration of the normal breast contour and clarifying any suspicious breast lesions. The age of the patient and grade of severity determine the indication for surgery. Procedures commonly used in the treatment of gynecomastia include mastectomy, subtotal mastectomy, subcutaneous mastectomy, reduction mammoplasty, and suction assisted lipectomy or liposuction combined with excision of glandular tissue. When suction lipectomy or liposuction is performed as a sole method of treatment for gynecomastia, only adipose tissue is removed. Suction lipectomy reduces the overall breast size and may result in improved appearance, but it does not remove the glandular tissue and, therefore, may not correct the gynecomastia.
Complications of mastectomy for gynecomastia can include any of the following conditions: hematoma, breast asymmetry, nipple or areola necrosis and/or inversion, infection, sensory changes, scar deformity and contour deformity. Generally, post-operative compression garments are applied for 2 weeks and the final results may not be appreciated until 12 months following the procedure.

At the time of the Plan’s most recent policy review, no national coverage determination (NCD) was found for gynecomastia surgery from the Centers for Medicare & Medicaid Services (CMS). A local coverage determination (LCD), Cosmetic and Reconstructive Surgery (L4698), is available for review. If applicable, review the CMS NCD for mammography for men and women, NCD for Mammograms (220.4). Determine the applicable CMS criteria in effect for this service in an NCD or LCD on the date of the prior authorization request for a Senior Care Options member.

References


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### Original Approval Date

| Regulatory Approval: N/A | Internal Approval: 12/06/05: Initial approval by Q&CMC |

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<thead>
<tr>
<th>Original Effective Date* and Version Number</th>
<th>Policy Owner</th>
<th>Approved by</th>
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<tr>
<td>02/06/05 Version 1</td>
<td>Medical Policy Manager as Chair of Medical Policy, Criteria, and Technology Assessment Committee (MPCTAC) and member of Quality Improvement Committee (QIC)</td>
<td>Quality and Clinical Management Committee (Q&amp;CMC)</td>
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*Effective Date for the BMC HealthNet Plan Commercial Product(s): 01/01/12

*Effective Date for the Well Sense Health Plan New Hampshire Medicaid Product(s): 01/01/13

*Effective Date for the Senior Care Options Product(s): 01/01/16

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

### Policy Revisions History

<table>
<thead>
<tr>
<th>Review Date</th>
<th>Summary of Revisions</th>
<th>Revision Effective Date and Version Number</th>
<th>Approved by</th>
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<tr>
<td>01/03/06</td>
<td>Revised clinical coverage criteria.</td>
<td>Version 2</td>
<td>01/03/06: Q&amp;CMC</td>
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<tr>
<td>02/06/07</td>
<td>Updated references.</td>
<td>Version 3</td>
<td>02/06/07: Q&amp;CMC</td>
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<td>12/01/07</td>
<td>No changes.</td>
<td>Version 4</td>
<td>01/08/08: MPCTAC 01/22/08: Utilization Management Committee (UMC) 02/19/08: QIC</td>
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<tr>
<td>01/27/09</td>
<td>No changes.</td>
<td>Version 5</td>
<td>01/27/09: MPCTAC 01/27/09: UMC 02/25/09: QIC</td>
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<tr>
<td>05/26/09</td>
<td>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.</td>
<td>Version 6</td>
<td>05/26/09: MPCTAC 05/26/09: UMC 07/22/09: QIC</td>
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<td>05/01/10</td>
<td>No changes.</td>
<td>Version 7</td>
<td>05/25/10: MPCTAC 06/23/10: QIC</td>
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<tr>
<td>05/01/11</td>
<td>No changes to criteria. Updated references and coding.</td>
<td>Version 8</td>
<td>05/18/11: MPCTAC 06/22/11: QIC</td>
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<tr>
<td>05/01/12</td>
<td>No changes made to clinical criteria or applicable codes. References updated.</td>
<td>Version 9</td>
<td>05/16/12: MPCTAC 06/27/12: QIC</td>
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<tr>
<td>07/30/12 Off cycle review for Well Sense Health Plan. Deleted text related to Massachusetts products. Updated references.</td>
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<tr>
<td>06/01/13 Review for effective date 10/01/13. Deleted CPT code 15877 from the applicable code list. Revised Definitions section.</td>
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<tr>
<td>04/01/14 Review for effective date 06/01/14. 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.</td>
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<tr>
<td>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</td>
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Policy Revisions History

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<tr>
<th>Date</th>
<th>Description</th>
<th>Effective Date</th>
<th>Authorizing Entity</th>
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<tbody>
<tr>
<td>11/25/15</td>
<td>Review for effective date 01/01/16. Updated template with list of applicable products and notes. Revised language in the Applicable Coding section.</td>
<td>01/01/16 Version 15</td>
<td>MPCTAC (electronic vote) 12/09/15: QIC</td>
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<td>04/01/16</td>
<td>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.</td>
<td>08/01/16 Version 16</td>
<td>MPCTAC 05/23/16: QIC</td>
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<tr>
<td>09/28/16</td>
<td>Review for effective date 11/01/16. Administrative changes to clarify language related to gender.</td>
<td>11/01/16 Version 17</td>
<td>MPCTAC (electronic vote) 10/12/16: QIC</td>
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Last Review Date
09/28/16

Next Review Date
04/01/17

Authorizing Entity
QIC

Other Applicable Policies:
Medical Policy - *Breast Reconstruction*, policy number OCA 3.43
Medical Policy - *Breast Reduction Mammoplasty in Females*, policy number OCA 3.44
Medical Policy - *Cosmetic, Reconstructive, and Restorative Services*, policy number OCA 3.69
Medical Policy - *Experimental and Investigational Treatment*, policy number OCA 3.12
Medical Policy - *Gender Reassignment Surgery*, policy number OCA 3.11
Medical Policy - *Mastopexy*, policy number OCA 3.717
Medical Policy - *Medically Necessary*, policy number OCA 3.14
Reimbursement Policy - *Bilateral and Multiple Procedure Reductions*, policy number 4.607
Reimbursement Policy - *Free Standing Surgical Facility Services*, policy number 4.114
Reimbursement Policy - *General Billing and Coding Guidelines*, policy number 4.31

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Reimbursement Policy - *General Billing and Coding Guidelines*, policy number WS 4.17
Reimbursement Policy - *General Clinical Editing and Payment Accuracy Review Guidelines*, policy number 4.108
Reimbursement Policy - *General Clinical Editing and Payment Accuracy Review Guidelines*, policy number WS 4.18
Reimbursement Policy - *Outpatient Hospital*, policy number 4.17
Reimbursement Policy - *Physician and Non Physician Practitioner Services*, policy number 4.608
Reimbursement Policy - *Physician and Non Physician Practitioner Services*, policy number WS 4.28
Reimbursement Policy - *Professional Bilateral and Multiple Procedure Reductions*, policy number: WS 4.24

**Reference to Applicable Laws and Regulations**


**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 standards.

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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.

*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.