Medical Policy

Breast Reduction Mammoplasty

Policy Number: OCA 3.44
Version Number: 16
Version Effective Date: 11/01/16

Product Applicability

- All Plan+ Products

Well Sense Health Plan
- New Hampshire Medicaid
- NH Health Protection Program

Boston Medical Center HealthNet Plan
- MassHealth
- Qualified Health Plans/ConnectorCare/Employer Choice Direct
- Senior Care Options ◊

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

Reduction mammoplasty is considered medically necessary for symptomatic macromastia when Plan criteria are met for a female member (or a member born with female reproductive organs and/or with typical female karyotype with two [2] X chromosomes). See the Plan policy, Gynecomastia Surgery (policy number OCA 3.48), rather than this policy for applicable medical criteria for the surgical removal of glandular breast tissue for a male member (or a member born with male reproductive organs and/or typical male karyotype with only one [1] X chromosome). The Plan will review all requests for breast reconstruction procedures for gender reassignment, including 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 procedure.

Plan prior authorization is required. It will be determined during the Plan’s prior authorization process if the procedure is considered medically necessary for the requested indication. See the Plan’s policy, *Medically Necessary* (policy number OCA 3.14), for the product-specific definitions of medically necessary treatment. Refer to the following Plan policies for information regarding additional breast procedures: *Breast Reconstruction* (policy number OCA 3.43) and *Mastopexy* (policy number OCA 3.717).

### Description of Item or Service

**Reduction Mammoplasty/Mammaplasty:** Surgical excision of a substantial portion of breast tissue, including the skin and underlying glandular tissue, to achieve a proportionate reduction in breast size using standard calculations based on body surface area (BSA).

### Medical Policy Statement

The Plan considers reduction mammoplasty to be medically necessary for symptomatic macromastia or when the procedure is related to breast reconstruction after lumpectomy or mastectomy for a female member (or a member born with female reproductive organs and/or with typical female karyotype with two [2] X chromosomes). Applicable Plan 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 1 or item 2. (Note: The treating provider should discuss with the member the breast feeding considerations related to breast reduction mammoplasty as a component of the evaluation for surgery.)

1. **Reduction Mammoplasty for Macromastia:**

   ALL of the following criteria must be met, as specified below in items a through g:

   a. Full physical maturity (Tanner stage V) has been reached for a female member (or a member born with female reproductive organs and/or with typical female karyotype with two [2] X chromosomes); ‡ AND

      ‡ Note: The Plan will review 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.

   b. Pediatric member is 15 years of age or older on the date of service with a breast size that has been stable for at least 12 calendar months before the surgery; AND
c. The minimum weight of breast tissue planned for removal is greater than or equal to the amounts listed in the Plan’s modified Schnur Sliding Scale chart (shown in the Definitions section of this policy) based on the member’s total body surface area (BSA); AND

d. Documentation includes at least TWO (2) of the following clinical findings, as specified below in items (1) through (8):

   (1) Symptoms of persistent pain in the upper back, neck, and/or shoulders that have interfered with activities of daily living for at least six (6) calendar months, and pain is unresponsive to conservative treatments that include but are not limited to physical therapy and pharmacotherapies (e.g., anti-inflammatory and analgesics);

   (2) Intractable cervicodorsal myositis (i.e., inflammation of the back and neck muscles) for at least six (6) calendar months and the condition is unresponsive to medical therapy;

   (3) Tissue ulcerations, dermatitis (e.g., intertrigo), and/or eczema of the inframammary fold are unresponsive to dermatological treatment;

   (4) Upper extremity paresthesia due to brachial plexus compression syndrome;

   (5) Painful and permanent shoulder grooving (defined as deep grooves in the shoulder with pain and discomfort from bra straps) despite the use of a support bra with weight distributing straps;

   (6) Gigantomastia in pregnancy when delivery is not imminent;

   (7) Chronic breast pain (defined as breast pain lasting six [6] calendar months or longer) due to breast weight that is unresponsive to conservative treatments such as support garments;

   (8) Painful thoracic kyphosis documented by radiographs;

e. The treating provider has determined that the member has a reasonable prognosis of symptomatic relief after reduction mammoplasty; AND

f. Comorbid etiologies of the member’s symptoms (as specified above) have been ruled out; AND

g. Member 40 years of age or older has had a mammogram within 12 calendar months from the date of the planned reduction mammoplasty in both breasts that was negative for cancer; OR
2. **Reduction Mammoplasty as Part of Breast Reconstruction after Mastectomy or Lumpectomy:**

BOTH of the following criteria must be met, as specified below in item a. and item b:

a. Reduction mammoplasty will be performed to reduce the size of an unaffected breast to bring it into symmetry with a breast reconstructed after mastectomy or lumpectomy; AND

b. Member has had a mammogram within 12 calendar months from the date of the planned reduction mammoplasty that was negative for cancer, including the unaffected side if used to create symmetry after breast surgery related to breast cancer (unless the reduction mammoplasty is performed concurrently with the breast surgery related to breast cancer treatment)

See Plan policies *Breast Reconstruction* (policy number OCA 3.43) and *Mastopexy* (policy number OCA 3.717) for medical guidelines and applicable coding for additional procedures related to breast reconstruction after mastectomy or lumpectomy.

**Limitations**

1. The Plan considers suction assisted lipectomy or liposuction as a sole method of surgical treatment for reduction mammoplasty to be cosmetic and not medically necessary. 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.

2. Breast reduction surgery is considered cosmetic and not medically necessary for poor posture, breast asymmetry, pendulousness, problems with clothes fitting properly, nipple-areola distortion, or psychological considerations.

3. A request for breast reduction mammoplasty for a member younger than age 15 on the date of service requires Medical Director review.

See the Plan’s 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.

**Definitions**

**Gigantomastia:** A rare condition of massive diffuse enlargement of the breast during pregnancy. The resulting hypertrophy is not only grotesquely deforming, but also may preclude ambulation or progress to skin ulceration, infection, or massive bleeding from dilated subcutaneous veins; these complications...
may be life threatening. The etiology is unknown, but the disease is believed to represent an abnormal end-organ (breast) response to the normal rise in progesterone level as pregnancy progresses.

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.

Macromastia (also known as Breast Hypertrophy): The development of abnormally large breasts in a female (or an individual born with female reproductive organs and/or with typical female karyotype with two [2] X chromosomes) that are distinguished from large, normal breasts by the presence of persistent, painful symptoms and other physical signs such as upper neck and back pain, shoulder grooving, postural backache, and brachial plexus syndrome.

Schnur Sliding Scale: Method used to determine if the proposed amount of tissue resection to reduce breast size is appropriate in comparison to body size. Using this method, the body surface area (BSA) is compared to the proposed weight of breast tissue to be removed. Within a particular body surface area range, the amount of breast tissue proposed for removal must be at least as much as the amount outlined in the chart below to be considered medically necessary. The Plan uses a modified Schnur Sliding Scale based on a range of the calculated body surface area (BSA).

The DuBois and DuBois formula is used to calculate the BSA:

\[
\text{BSA} (\text{m}^2) = 0.20247 \times \text{Height (m)}^{0.725} \times \text{Weight (kg)}^{0.425}
\]

Further details regarding this formula can be accessed at: http://www.medcalc.com/body.html

<table>
<thead>
<tr>
<th>Body Surface Area (BSA) in Meters Squared</th>
<th>Minimum Amount of Tissue Removal Required per Breast in Grams</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.35-1.58</td>
<td>200</td>
</tr>
<tr>
<td>1.59-1.75</td>
<td>300</td>
</tr>
<tr>
<td>1.76-1.87</td>
<td>400</td>
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<tr>
<td>1.88-1.97</td>
<td>500</td>
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<tr>
<td>1.98-2.06</td>
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<td>2.07-2.13</td>
<td>700</td>
</tr>
<tr>
<td>2.14 and above</td>
<td>750</td>
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</tbody>
</table>

Breast Reduction Mammoplasty

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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>
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<tr>
<th>CPT Code</th>
<th>Description: Code Covered When Medically Necessary</th>
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<tbody>
<tr>
<td>19318</td>
<td>Reduction mammoplasty</td>
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</table>

Clinical Background Information

Macromastia can cause significant clinical manifestations when excessive breast weight adversely affects the supporting structures of the shoulders, neck, and trunk. This condition can sometimes lead to debilitating conditions that include chronic shoulder pain, chronic neck pain, chronic back pain, skin rash and infection to the area under the breast, painful shoulder grooving from bra straps, and/or decreased activity levels. These conditions may be improved by reduction mammoplasty surgery, with associated clinical signs and symptoms alleviated in appropriately chosen cases.

Members considering reduction mammoplasty who have been determined to be appropriate candidates for a bariatric procedure are encouraged to pursue the bariatric surgery before proceeding with the reduction mammoplasty. Massive weight loss before the reduction mammoplasty has been associated with increased patient satisfaction with reduction mammoplasty results, while massive weight loss following reduction mammoplasty has been associated with decreased patient satisfaction with the reduction mammoplasty results. See Plan policy, Bariatric Surgery (policy number OCA 3.49).

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At the time of the Plan’s most recent policy review, the following applicable clinical guidelines were found from the Centers for Medicare & Medicaid Services (CMS) for breast surgery: National Coverage Determination (NCD) for Breast Reconstruction Following Mastectomy (140.2), NCD for Mammograms (220.4), Local Coverage Determination (LCD) for Cosmetic and Reconstructive Surgery (L34698), and LCD for Reduction Mammaplasty (L35001). No CMS clinical guidelines were identified specifically for mastopexy surgery during the policy review process. Verify if applicable CMS criteria are in effect for the requested breast procedure in an NCD or LCD on the date of the prior authorization request for a Senior Care Options member.

References


Breast Reduction Mammoplasty

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Breast Reduction Mammaplasty

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<table>
<thead>
<tr>
<th>Original Approval Date</th>
<th>Original Effective Date* and Version Number</th>
<th>Policy Owner</th>
<th>Approved by</th>
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<tr>
<td>Regulatory Approval: N/A</td>
<td>06/09/06 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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<td>Internal Approval: 09/06/05</td>
<td>06/09/06 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 title was Breast Reduction Mammoplasty in Females from 06/09/16 to 10/31/16. The policy title was changed to Breast Reduction Mammoplasty as of 11/01/16.

<table>
<thead>
<tr>
<th>Review Date</th>
<th>Summary of Revisions</th>
<th>Revision Effective Date and Version Number</th>
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<tr>
<td>05/09/06</td>
<td>Removed the requirement for a pre-operative mammogram to be submitted prior to authorization.</td>
<td>Version 2</td>
<td>05/09/06: Q&amp;CMC</td>
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<tr>
<td>05/08/07</td>
<td>Updated clinical criteria, template, added coding, and references.</td>
<td>Version 3</td>
<td>06/14/07: MPCTAC 06/26/07: Utilization Management Committee (UMC) 07/12/07: QIC</td>
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<td>05/13/08</td>
<td>Added information on how to calculate the BSA based upon the DuBois Formula.</td>
<td>Version 4</td>
<td>05/13/08: MPCTAC 05/20/08: UMC 05/28/08: QIC</td>
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<td>05/26/09</td>
<td>Clarified clinical criteria for shoulder grooving.</td>
<td>Version 5</td>
<td>05/26/09: MPCTAC 05/26/09: UMC 06/24/09: QIC</td>
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<tr>
<td>05/01/10</td>
<td>No criteria changes. Updated references.</td>
<td>Version 6</td>
<td>05/25/10: MPCTAC 06/23/10: QIC</td>
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<tr>
<td>05/01/11</td>
<td>No criteria changes. Updated</td>
<td>Version 7</td>
<td>05/18/11: MPCTAC</td>
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Breast Reduction Mammoplasty

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<table>
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<th>Description</th>
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<tr>
<td>05/01/12</td>
<td>Note added at end of Clinical Background Information related to a patient considering both bariatric surgery and reduction mammoplasty. References updated.</td>
<td>Version 8</td>
<td>05/16/12: MPCTAC 06/27/12: QIC</td>
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<tr>
<td>07/30/12</td>
<td>Off cycle review for Well Sense Health Plan. Reformatted Clinical Guideline Statement and revised references.</td>
<td>Version 9</td>
<td>08/03/12: MPCTAC 09/05/12: QIC</td>
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<td>04/01/13</td>
<td>Review for effective date of 08/01/13. Revised Summary, Description of Item or Service, and Clinical Background Information sections. Revised language in introductory paragraph of Applicable Coding section. Revised and added limitations. Updated criteria in Medical Policy Statement section (formerly titled Clinical Guideline Statement section). Moved definition of Schnur Sliding Scale from Clinical Background Information section to the Definitions section. Added text to gigantomastia definition. Referenced the following Plan policies: Medically Necessary, Mastopexy, Breast Reconstruction, Bariatric Surgery, Gynecomastia Surgery, and Cosmetic, Reconstructive, and Restorative Services. Updated references. Changed name of policy category from “Clinical Coverage Guidelines” to “Medical Policy.”</td>
<td>08/01/13 Version 10</td>
<td>04/17/13: MPCTAC 05/16/13: QIC</td>
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<td>06/01/13</td>
<td>Review for effective date of 09/01/13. Revised text in Medical Policy Statement section. Deleted CPT code 15877 from applicable code list.</td>
<td>09/01/13 Version 11</td>
<td>06/19/13: MPCTAC 07/18/13: QIC</td>
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<td>04/01/14</td>
<td>Review for effective date 08/01/14. Revised Medical Policy Statement section. Updated the definition of the Schnur Sliding Scale and the References section.</td>
<td>08/01/14 Version 12</td>
<td>04/16/14: MPCTAC 05/14/14: QIC</td>
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<td>04/01/15</td>
<td>Review for effective date 06/01/15. Removed Commonwealth Care, Commonwealth Choice, and Employer Choice from the list of applicable</td>
<td>06/01/15 Version 13</td>
<td>04/15/15: MPCTAC 05/13/15: QIC</td>
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**Policy Revisions History**

<table>
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<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</td>
<td>11/18/15: MPCTAC</td>
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<td>12/09/15: QIC</td>
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<td>04/01/16</td>
<td>Review for effective date 06/01/16. Revised the Clinical Background Information, References, and Reference to Applicable Laws and Regulations sections.</td>
<td>06/01/16</td>
<td>04/20/16: MPCTAC</td>
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<td>05/23/16: QIC</td>
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<tr>
<td>09/28/16</td>
<td>Review for effective date 11/01/16. Revised policy title and made administrative changes to clarify language related to gender.</td>
<td>11/01/16</td>
<td>09/30/16: MPCTAC</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 - *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 - *Gynecomastia Surgery*, policy number OCA 3.48
- Medical Policy - *Mastopexy*, policy number OCA 3.717
- Medical Policy - *Medically Necessary*, policy number OCA 3.14

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Medical Policy - *Skin Substitutes in the Outpatient Setting*, policy number OCA 3.710
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
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**


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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.

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