Geisinger

POLICIES AND PROCEDURE MANUAL

Policy: MP055

Section: Medical Benefit Policy

Subject: Mastectomy for Gynecomastia

Applicable Lines of Business

Commercial	**X**	**CHIP**	**X**
Medicare	**X**	**ACA**	**X**
Medicaid	**X**		

I. Policy: Mastectomy for Gynecomastia

II. Purpose/Objective:

To provide a policy of coverage regarding Mastectomy for Gynecomastia

III. Responsibility:

A. Medical Directors
B. Medical Management

IV. Required Definitions

1. Attachment – a supporting document that is developed and maintained by the policy writer or department requiring/authoring the policy.
2. Exhibit – a supporting document developed and maintained in a department other than the department requiring/authoring the policy.
3. Devised – the date the policy was implemented.
4. Revised – the date of every revision to the policy, including typographical and grammatical changes.
5. Reviewed – the date documenting the annual review if the policy has no revisions necessary.

V. Additional Definitions

Medical Necessity or Medically Necessary means Covered Services rendered by a Health Care Provider that the Plan determines are:

a. appropriate for the symptoms and diagnosis or treatment of the Member's condition, illness, disease or injury;
b. provided for the diagnosis, and the direct care and treatment of the Member's condition, illness disease or injury;
c. in accordance with current standards of good medical treatment practiced by the general medical community.
d. not primarily for the convenience of the Member, or the Member's Health Care Provider; and
e. the most appropriate source or level of service that can safely be provided to the Member. When applied to hospitalization, this further means that the Member requires acute care as an inpatient due to the nature of the services rendered or the Member's condition, and the Member cannot receive safe or adequate care as an outpatient.

Medicaid Business Segment

Medically Necessary — A service, item, procedure, or level of care that is necessary for the proper treatment or management of an illness, injury, or disability is one that:

- Will, or is reasonably expected to, prevent the onset of an illness, condition, injury or disability.
- Will, or is reasonably expected to, reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury or disability.

- Will assist the Member to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the Member and those functional capacities that are appropriate for Members of the same age

Gynecomastia - The American Society of Plastic Surgeons (ASPS) defines gynecomastia as:

- Grade I Small breast enlargement with localized button of tissue that is concentrated around the areola.
- 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 distinct from the chest with skin redundancy present.
- Grade IV Marked breast enlargement with skin redundancy and feminization of the breast.

REQUIRES PRIOR AUTHORIZATION BY A PLAN MEDICAL DIRECTOR or Designee:

Commercial and Medicaid Business Segment:
For those product lines in which surgical treatment of gynecomastia is not specifically excluded, the following criteria will be used to determine eligibility for coverage. All must be met:

- Member is of age 18 years or older or puberty is substantially completed; and
- Gynecomastia meets ASPS Grade II, III, or IV definition (see Definitions Section); and
- Condition is present for no less than 2 years and contributing factors have been treated for at least 6 months; and
- Excess breast tissue is glandular and not fatty, confirmed by mammogram and/or tissue histology; and
- Other causes including obesity (BMI greater than or equal to 35) or reversible drug therapy have been ruled out; and
- The member must be excluded from, or failed treatment of, an underlying hormone disorder; and
- Excessive breast development is not due to non-covered therapies or illicit drug use

Mastectomy for gynecomastia is considered medically necessary, regardless of age, when there is a clinically concern that a breast mass may represent breast carcinoma.

LIMITATIONS:
Medicare Business Segment: Payment may be made for mastectomy for gynecomastia if it is documented that the tissue is primarily breast tissue and not adipose (fatty) tissue. However, if the tissue removed is primarily fatty tissue, the surgery is classified as cosmetic and is not eligible for payment per the current Centers for Medicare Services (CMS) guidelines.

TPA: Individual benefits may vary by employer as outlined in the applicable benefit documents.

EXCLUSIONS:
Mastectomy or liposuction to correct gynecomastia when **NOT COVERED** per the **Exclusions Section**, of the contract specific applicable benefit document.

Medicaid Business Segment:
Any requests for services, that do not meet criteria set in the PARP, may be evaluated on a case by case basis.

Note: A complete description of the process by which a given technology or service is evaluated and determined to be experimental, investigational or unproven is outlined in MP 15 - Experimental Investigational or Unproven Services or Treatment.

CODING ASSOCIATED WITH: Mastectomy for gynecomastia
The following codes are included below for informational purposes and may not be all inclusive. Inclusion of a procedure or device code(s) does not constitute or imply coverage nor does it imply or guarantee provider reimbursement. Coverage is determined by the member specific benefit plan document and any applicable laws regarding coverage of specific services. Please note that per Medicare coverage rules, only specific CPT/HCPCS Codes may be covered for the Medicare Business Segment. Please consult the CMS website at www.cms.gov or the local Medicare Administrative Carrier (MAC) for more information on Medicare coverage and coding requirements

19300 Mastectomy for gynecomastia

LINE OF BUSINESS:
Eligibility and contract specific benefit limitations and/or exclusions will apply. Coverage statements found in the line of business specific benefit document will supercede this policy. For Medicare, applicable LCD's and NCD's will supercede this policy. For PA Medicaid Business segment, this policy applies as written.

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This policy will be revised as necessary and reviewed no less than annually**.**

Devised: 3/20/98

Revised: 10/99, 03/02, 7/03 (sub-cert reference), 8/04; 8/05 (revised Exclusions); 8/06: 8/08 (wording), 7/16 (Gender Language); 11/16; 11/17 (clarify criteria)

Reviewed: 03/03; 8/07; 8/09; 6/10, 6/11, 6/12, 6/13, 6/14, 11/15, 11/18, 11/19, 11/20, 11/21, 11/22, 11/23

Prior authorization and/or pre-certification requirements for services or items may apply. Pre-certification lists may be found in the member's contract specific benefit document. Prior authorization requirements can be found at https://www.geisinger.org/health-plan/providers/ghp-clinical-policies

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