Harvard Pilgrim Health Care | TUFTS Health Plan

Medical Necessity Guidelines:

Gynecomastia Surgery

Effective: July 1, 2024

Prior Authorization Required If REQUIRED, submit supporting clinical documentation pertinent to service request to the FAX numbers below	Yes ☒ No ☐
Notification Required IF REQUIRED, concurrent review may apply	Yes ☐ No ☒

Applies to:

Commercial Products

☐ Harvard Pilgrim Health Care Commercial products; 800-232-0816

☐ Tufts Health Plan Commercial products; 617-972-9409

CareLink℠ – Refer to CareLink Procedures, Services and Items Requiring Prior Authorization

Public Plans Products

☐ Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product); 888-415-9055

☐ Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans; 888-415-9055

☐ Tufts Health RITogether – A Rhode Island Medicaid Plan; 857-304-6404

☐ Tufts Health One Care – A dual-eligible product; 857-304-6304

Senior Products

☒ Harvard Pilgrim Health Care Stride Medicare Advantage; 888-609-0692

☐ Tufts Health Plan Senior Care Options (SCO), (a dual-eligible product); 617-673-0965

☐ Tufts Medicare Preferred HMO, (a Medicare Advantage product); 617-673-0965

☐ Tufts Medicare Preferred PPO, (a Medicare Advantage product); 617-673-0965

Note: While you may not be the provider responsible for obtaining prior authorization or notifying Point32Health, as a condition of payment you will need to ensure that any necessary prior authorization has been obtained and/or Point32Health has received proper notification. If notification is required, providers may additionally be required to provide updated clinical information to qualify for continued service.

Overview

Gynecomastia is a benign proliferation of the male breast. It is caused by an imbalance in the ratio of male hormone (testosterone) to female hormone (estrogen). The condition is often associated with pain or tenderness and is characterized by growth of the glandular tissue or by an accumulation of fatty tissue deposits. Pathological gynecomastia is caused by conditions that decrease the production of testosterone or increase the activity of estrogen. Some specific conditions that are associated with gynecomastia include Klinefelter's syndrome, hyperthyroidism and hypogonadism.

Clinical Guideline Coverage Criteria

Harvard Pilgrim Health Care uses guidance from the Centers for Medicare and Medicaid Services (CMS) for coverage determinations for its Medicare Advantage plan members. CMS National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), Local Coverage Articles (LCAs) and documentation included in the Medicare manuals are the basis for coverage determinations where available. For **Harvard Pilgrim Health Care Medicare Advantage** plan members, the following criteria is used: LCD - Cosmetic and Reconstructive Surgery (L39051) (cms.gov) and Article - Billing and Coding: Cosmetic and Reconstructive Surgery (A58774) (cms.gov)

Limitations

Harvard Pilgrim Stride[SM] (HMO) Medicare Advantage considers gynecomastia surgery as cosmetic for all other indications. In addition, HPHC does not cover gynecomastia surgery when:

1. Psychological distress is the primary reason for surgery
2. There is a history of substance abuse (e.g., marijuana, heroin, amphetamines), cirrhosis or chronic alcohol abuse, and/or use of supplements/herbal products/hormones that can cause gynecomastia, and these substances have not been prescribed by a licensed clinician to treat a medical condition
3. Liposuction is the sole surgical procedure requested to treat the gynecomastia
4. Treatment is determined to be cosmetic (primarily to improve or reshape the member's appearance)

Codes

The following code(s) require prior authorization:

Table 1: CPT/HCPCS Codes

Code	Description
19300	Mastectomy for gynecomastia

Approval And Revision History

February 2020: Reviewed by the Medical Policy Clinical Committee (MPCC); references updated

Subsequent endorsement date(s) and changes made:

- January 2021: Reviewed by MPCC; references updated
- January 19, 2022: Reviewed by Medical Policy Approval Committee (MPAC), supporting information updated
- November 16, 2023: Reviewed by MPAC, template updated, updated criteria, effective January 1, 2024
- December 1, 2023: reviewed and approved by UM Committee effective January 1, 2024
- June 13, 2024: Reviewed by UM Committee, updated LCD link effective July 1, 2024
- June 20, 2024: Reviewed by MPAC, updated LCD link effective July 1, 2024

Background, Product and Disclaimer Information

Medical Necessity Guidelines are developed to determine coverage for benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. We make coverage decisions using these guidelines, along with the Member's benefit document, and in coordination with the Member's physician(s) on a case-by-case basis considering the individual Member's health care needs.

Medical Necessity Guidelines are developed for selected therapeutic or diagnostic services found to be safe and proven effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in our service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. We revise and update Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Medical Necessity Guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern. For Tufts Health Together (Medicaid), coverage may be available beyond these guidelines for pediatric members under age 21 under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits of the plan in accordance with 130 CMR 450.140 and 130 CMR 447.000, and with prior authorization.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of this guideline is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to eligibility and benefits on the date of service, coordination of benefits, referral/authorization, utilization management guidelines when applicable, and adherence to plan policies, plan procedures, and claims editing logic.