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1.0 Description of the Procedure, Product, or Service

Gynecomastia is an abnormal enlargement of the mammary glands (breasts) in the male. They may at times secrete milk.

2.0 Eligible Recipients

2.1 General Provisions

To be eligible, NCHC recipients must be enrolled on the date of service.

3.0 When the Procedure, Product, or Service Is Covered

3.1 General Criteria

- a. NCHC covers procedures, products, and services related to this policy when they are medically necessary and
- b. the procedure, product, or service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the recipient's needs;
- c. the procedure, product, or service can be safely furnished, and no equally effective and more conservative or less costly treatment is available; **AND**
- d. the procedure, product, or service is furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

3.2 Specific Criteria

Benefits are available for removal of breast tissue in the male for gynecomastia when all of the following conditions have been met:

- a. Male is over 18 years of age (male gynecomastia is not uncommon in adolescent males, and generally resolves without treatment), or male is over 17 years of age with significant breast tissue for over two years;
- b. Excess breast tissue is glandular and not fatty tissue. (This is confirmed by clinical exam, mammogram, and/or tissue pathology);
- c. Other causes of gynecomastia have been ruled out, including obesity, adolescence or reversible drug treatments (when drugs can be discontinued);
- d. Excessive breast development is not due to uncovered therapies or illicit drugs, e.g., anabolic steroids or marijuana; and
- e. The recipient has documented and significant medical symptoms not resolved by more conservative treatment.

4.0 When the Procedure, Product, or Service Is Not Covered

4.1 General Criteria

Procedures, products, and services related to this policy are not covered when

- a. the recipient does not meet the eligibility requirements listed in **Section 2.0**;
- b. the recipient does not meet the medical necessity criteria listed in **Section 3.0**;
- c. the procedure, product, or service unnecessarily duplicates another provider's procedure, product, or service; or
- d. the procedure, product, or service is experimental or investigational.

4.2 Specific Criteria

Benefits are not applicable when the criteria in **Subsection 3.2** have not been met.

5.0 Requirements for and Limitations on Coverage

5.1 Prior Approval

- a. Prior approval is required for excision of gynecomastia
- b. A letter of medical necessity signed and dated by the surgeon and submitted to DMA's vendor prior to rendering the surgery.

Documentation must include:

- a. Recipient demographics(NCHC ID number and mailing address)
- b. Recipient's height, weight, and date of birth
- c. Date of onset (when condition first appeared)
- d. Pre-operative photographs are helpful, but not required.

6.0 Providers Eligible to Bill for the Procedure, Product, or Service

To be eligible to bill for procedures, products, and services related to this policy, providers shall

- a. meet NCHC qualifications for participation;
- b. be currently enrolled with NCHC; **AND**
- c. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

7.0 Additional Requirements

7.1 Compliance

Providers must comply with all applicable federal, state, and local laws and regulations, including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements.

8.0 Policy Implementation/Revision Information

Original Effective Date: July 1, 2010

Revision Information:

Date	Section Revised	Change
July 1, 2010		Policy Conversion: Implementation of Session Law 2009-451, Section 10.32 “NC HEALTH CHOICE/PROCEDURES FOR CHANGING MEDICAL POLICY.”

Attachment A: Claims-Related Information

Reimbursement requires compliance with all NCHC guidelines.

A. Claim Type

Professional (CMS-1500/837P transaction)

Institutional (UB-04/837I transaction)

B. Diagnosis Codes

Providers must bill the ICD-9-CM diagnosis codes(s) to the highest level of specificity that supports medical necessity.

The diagnosis code to be used for Excision of Gynemastia is: 611.1.

C. Procedure Code(s)

CPT Code
19300

ICD-9-CM Procedure Codes
85.31
85.32

Note: For females, the claim pends for possible cosmetic, unless the diagnosis is 611.1 (hypertrophy of breast.). For males, it will deny if prior approval is not obtained

D. Modifiers

Providers are required to follow applicable modifier guidelines.

E. Billing Units

The appropriate procedure code(s) used determines the billing unit(s).

F. Place of Service

Inpatient Hospital, Outpatient Hospital, ASC

G. Co-payments

Co-payment(s) may apply to covered prescription drugs and services..

H. Reimbursement

Providers must bill their usual and customary charges.