

Breast Reduction Surgery

Policy Number: CS012.AA
Effective Date: July 1, 2024

[➔ Instructions for Use](#)

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Related Community Plan Policies
<ul style="list-style-type: none"> Breast Reconstruction Cosmetic and Reconstructive Procedures Gender Dysphoria Treatment Gynecomastia Surgery Panniculectomy and Body Contouring Procedures
Commercial Policy
<ul style="list-style-type: none"> Breast Reduction Surgery

Application

This Medical Policy does not apply to the states listed below; refer to the state-specific policy/guideline, if noted:

State	Policy/Guideline
Indiana	None
Kentucky	Breast Reduction Surgery (for Kentucky Only)
Louisiana	Breast Reduction Surgery (for Louisiana Only)
Mississippi	Breast Reduction Surgery (for Mississippi Only)
New Jersey	Breast Reduction Surgery (for New Jersey Only)
New Mexico	Breast Reduction Surgery (for New Mexico Only)
North Carolina	Breast Reduction Surgery (for North Carolina Only)
Ohio	Breast Reduction Surgery (for Ohio Only)
Pennsylvania	Breast Reduction Surgery (for Pennsylvania Only)
Tennessee	Breast Reduction Surgery (for Tennessee Only)

Coverage Rationale

Breast reduction surgery is considered reconstructive and medically necessary in certain circumstances. For medical necessity clinical coverage criteria, refer to the InterQual® CP: Procedures:

- Reduction Mammoplasty, Female
- Reduction Mammoplasty, Female, Adolescent

[Click here to view the InterQual® criteria.](#)

Note: For reduction mammoplasty related to gynecomastia, refer to the Medical Policy titled [Gynecomastia Surgery](#).

Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by federal, state, or contractual requirements and

applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

Note: Coding for suction lipectomy is addressed in the Medical Policy titled [Panniculectomy and Body Contouring Procedures](#).

CPT Code	Description
19318	Breast reduction

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Diagnosis Code	Description
N62	Hypertrophy of breast
N65.1	Disproportion of reconstructed breast

Policy History/Revision Information

Date	Summary of Changes
07/01/2024	<p>Application New Mexico</p> <ul style="list-style-type: none">Added reference link to state-specific policy version <p>Applicable Codes</p> <ul style="list-style-type: none">Removed CPT code 19316 <p>Supporting Information</p> <ul style="list-style-type: none">Archived previous policy version CS012.Z

Instructions for Use

This Medical Policy provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the federal, state or contractual requirements for benefit plan coverage must be referenced as the terms of the federal, state or contractual requirements for benefit plan coverage may differ from the standard benefit plan. In the event of a conflict, the federal, state or contractual requirements for benefit plan coverage govern. Before using this policy, please check the federal, state or contractual requirements for benefit plan coverage. UnitedHealthcare reserves the right to modify its Policies and Guidelines as necessary. This Medical Policy is provided for informational purposes. It does not constitute medical advice.

UnitedHealthcare may also use tools developed by third parties, such as the InterQual® criteria, to assist us in administering health benefits. The UnitedHealthcare Medical Policies are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.