# Breast Reduction Surgery

**Policy Number**: CS012.AB
**Effective Date**: June 1, 2025

➲ Instructions for Use

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**Related Community Plan Policies**

- Breast Reconstruction
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## Application

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

| State | Policy/Guideline |
|---|---|
| Idaho | Breast Reduction Surgery (for Idaho Only) |
| Indiana | None |
| Kansas | Breast Reduction Surgery (for Kansas Only) |
| Kentucky | Breast Reduction Surgery (for Kentucky Only) |
| Nebraska | Breast Reduction Surgery (for Nebraska 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 Mammaplasty, Female
- Reduction Mammaplasty, Female, Adolescent

Click here to view the InterQual® criteria.

**Note**: For reduction mammaplasty related to gynecomastia, refer to the Medical Policy titled Gynecomastia Surgery.

## Medical Records Documentation Used for Reviews

Benefit coverage for health services is determined by the federal, state, or contractual requirements, and applicable laws that may require coverage for a specific service. Medical records documentation may be required to assess whether the member meets the clinical criteria for coverage but does not guarantee coverage of the service requested; refer to the

guidelines titled Medical Records Documentation Used for Reviews.

## 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.

| 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 |
|---|---|
| 04/01/2026 | **Template Update**<br>• Removed content/language pertaining to the state of Louisiana |
| 10/01/2025 | **Application**<br>***Nebraska***<br>• Added language to indicate this Medical Policy does not apply to the state of **Nebraska**; refer to the state-specific policy version |
| 07/01/2025 | **Template Update**<br>• Removed content/language pertaining to the state of Mississippi |
| 06/01/2025 | **Application**<br>***Idaho*** and ***Kansas***<br>• Added language to indicate this Medical Policy does not apply to the states of Idaho and Kansas; refer to the state-specific policy versions<br>**Related Policies *and* Applicable Codes**<br>• Removed reference link to the Medical Policy titled *Panniculectomy and Body Contouring Procedures*<br>**Medical Records Documentation Used for Reviews**<br>• Added language to indicate:<br>  ○ Benefit coverage for health services is determined by the federal, state, or contractual requirements, and applicable laws that may require coverage for a specific service<br>  ○ Medical records documentation may be required to assess whether the member meets the clinical criteria for coverage but does not guarantee coverage of the service requested; refer to the guidelines titled Medical Records Documentation Used for Reviews<br>**Supporting Information**<br>• Archived previous policy version CS012.AA |

## 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, 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.