

Breast Reduction Surgery (for North Carolina Only)

Policy Number: CSNC.MP.004.06
Effective Date: June 1, 2025

[Instructions for Use](#)

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Related Policies

- [Breast Reconstruction \(for North Carolina Only\)](#)
- [Cosmetic and Reconstructive Procedures \(for North Carolina Only\)](#)
- [Gynecomastia Surgery \(for North Carolina Only\)](#)
- [Panniculectomy Surgery \(for North Carolina Only\)](#)

Application

This Medical Policy only applies to the state of North Carolina.

Coverage Rationale

For medical necessity clinical coverage criteria, refer to the [North Carolina Medicaid \(Division of Health Benefits\) Clinical Coverage Policy, Physician: 1A-12, Breast Surgeries](#).

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 |

References

North Carolina Medicaid, Division of Health Benefits, Physician Clinical Coverage Policies, Breast Surgeries, 1A-12. Available at: <https://medicaid.ncdhhs.gov/1a-12-breast-surgeries/download?attachment>. Accessed April 16, 2025.

Policy History/Revision Information

| Date | Summary of Changes |
|------------|--|
| 11/01/2025 | Related Policies <ul style="list-style-type: none"> • Updated reference link to reflect the current policy title for <i>Panniculectomy Surgery (for North Carolina Only)</i> |

| Date | Summary of Changes |
|------------|---|
| 06/01/2025 | <ul style="list-style-type: none"> <li data-bbox="337 128 971 163">• Routine review; no change to coverage guidelines <li data-bbox="337 163 982 195">• Archived previous policy version CSNC.MP.004.05 |

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.