

Breast Reduction Surgery (for New Mexico Only)

Policy Number: CS012NM.B
Effective Date: June 1, 2025

[Instructions for Use](#)

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Related Policies
• Breast Reconstruction (for New Mexico Only)
• Cosmetic and Reconstructive Procedures (for New Mexico Only)
• Gender Dysphoria Treatment (for New Mexico Only)
• Gynecomastia Surgery (for New Mexico Only)

Application

This Medical Policy only applies to the state of New Mexico.

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 \(for New Mexico Only\)](#).

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
06/01/2025	<p data-bbox="337 201 873 235">Related Policies and Applicable Codes</p> <ul data-bbox="337 235 1433 296" style="list-style-type: none"><li data-bbox="337 235 1433 296">• Removed reference link to the Medical Policy titled <i>Panniculectomy and Body Contouring Procedures (for New Mexico Only)</i> <p data-bbox="337 296 662 329">Supporting Information</p> <ul data-bbox="337 329 922 363" style="list-style-type: none"><li data-bbox="337 329 922 363">• Archived previous policy version CS012NM.A

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.