Breast Reduction Surgery (for New Jersey Only)

Policy Number: CS012NJ.S
Effective Date: August 1, 2023

Instructions for Use

Table of Contents **Page**

Related Policies

- Breast Reconstruction (for New Jersey Only)
- Cosmetic and Reconstructive Procedures (for New Jersey Only)
- Gender Dysphoria Treatment (for New Jersey Only)
- Gynecomastia Surgery (for New Jersey Only)
- Panniculectomy and Body Contouring Procedures (for New Jersey Only)

Application

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

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 (for New Jersey 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.

Note: Coding for suction lipectomy is addressed in the Medical Policy titled Panniculectomy and Body Contouring Procedures (for New Jersey Only).

CPT Code	Description
19316	Mastopexy
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

08/01/2023	**Coverage Rationale**
	• Revised language pertaining to medical necessity clinical coverage criteria; replaced reference to the:
	  ○ "InterQual® CP: Procedures, Reduction *Mammoplasty*, Female" with "InterQual® CP: Procedures, Reduction *Mammaplasty*, Female"
	  ○ "InterQual® CP: Procedures, Reduction *Mammoplasty*, Female, Adolescent" with "InterQual® CP: Procedures, Reduction *Mammaplasty*, Female, Adolescent"
	• Added instruction to refer to the Medical Policy titled *Gynecomastia Surgery (for New Jersey Only)* for reduction mammaplasty related to gynecomastia
	Applicable Codes
	• Added CPT code 19316
	• Removed list of ICD-10 procedure codes: 0HBT0ZZ, 0HBT3ZZ, 0HBU0ZZ, 0HBU3ZZ, 0HBV0ZZ, 0HBV3ZZ, 0H0T0ZZ, 0H0U0ZZ, and 0H0V0ZZ
	Supporting Information
	• Archived previous policy version CS012NJ.R

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.