Breast Reduction Surgery (for Louisiana Only)

Guideline Number: CS012LA.R
Effective Date: May 1, 2021

Instructions for Use

Content mandated by Louisiana Department of Health

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Application

This Coverage Determination Guideline only applies to the state of Louisiana. The coverage rationale contained in this policy represents Louisiana Medicaid coverage policy and is set forth below in accordance with State requirements.

Coverage Rationale

Indications for Coverage

Reduction mammoplasty for purposes other than reconstruction is considered medically necessary when all of the following criteria are met:

- Pubertal breast development is complete
- A diagnosis of macromastia with at least 2 of the following symptoms for at least a 12-week duration:
  - Chronic breast pain
  - Headache
  - Neck, shoulder, or back pain
  - Shoulder grooving from bra straps
  - Upper extremity paresthesia due to brachial plexus compression syndrome, secondary to the weight of the breasts being transferred to the shoulder strap area
  - Thoracic kyphosis
  - Persistent skin condition such as intertrigo in the inframammary fold that is unresponsive to medical management
  - Congenital breast deformity
- There is a reasonable likelihood that the symptoms are primarily due to macromastia; and
- The amount of breast tissue to be removed is reasonably expected to alleviate the symptoms

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	Reduction mammaplasty

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

ICD Procedure Code	Description
0HBT0ZZ	Excision of Right Breast, Open Approach
0HBT3ZZ	Excision of Right Breast, Percutaneous Approach
0HBU0ZZ	Excision of Left Breast, Open Approach
0HBU3ZZ	Excision of Left Breast, Percutaneous Approach
0HBV0ZZ	Excision of Bilateral Breast, Open Approach
0HBV3ZZ	Excision of Bilateral Breast, Percutaneous Approach
0H0T0ZZ	Alteration of Right Breast, Open Approach
0H0U0ZZ	Alteration of Left Breast, Open Approach
0H0V0ZZ	Alteration of Bilateral Breast, Open Approach

References

Lousiana Department of Health, Professional Services Provider Manual, Chapter Five of the Medicaid Services Manual, Issued February 1, 2012. https://www.lamedicaid.com/provweb1/providermanuals/manuals/PS/PS.pdf. Accessed April 8, 2021.

Guideline History/Revision Information

Date	Summary of Changes
05/01/2021	**Template Update** • Added language to indicate content is mandated by the Louisiana Department of Health **Application** • Added language to indicate the coverage rationale contained in this policy represents Louisiana Medicaid coverage policy and is set forth in accordance with State requirements **Coverage Rationale** • Revised coverage rationale to reflect guidelines set forth in the *Louisiana Department of Health Professional Services Provider Manual* **Supporting Information** • Removed *Definitions* and *Benefit Considerations* sections • Updated *References* section to reflect the most current information • Archived previous policy version CS012LA.Q

Instructions for Use

This Coverage Determination Guideline 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 guideline, 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 Coverage Determination Guideline 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 Coverage Determination Guidelines 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.