Breast Reduction Surgery (for Nebraska Only)

Policy Number: CS012NE.AB
Effective Date: June 1, 2025

➲ Instructions for Use

Table of Contents **Page**

Related Policies

- Breast Reconstruction (for Nebraska Only)
- Cosmetic and Reconstructive Procedures (for Nebraska Only)
- Gynecomastia Surgery (for Nebraska Only)

Application

This Medical Policy only applies to the State of Nebraska.

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 Nebraska Only).

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

CPT® is a registered trademark of the American Medical Association

Diagnosis Code	Description
N62	Hypertrophy of breast

Diagnosis Code	Description
N65.1	Disproportion of reconstructed breast

Policy History/Revision Information

Date	Summary of Changes
11/01/2025	**Related Policies** • Updated reference link to reflect the current policy title for *Gynecomastia Surgery (for Nebraska Only)*
10/01/2025	• Created state-specific policy version for the state of Nebraska (no change to coverage guidelines)
07/01/2025	**Template Update** • Removed content/language pertaining to the state of Mississippi

06/01/2025	**Application**
	Idaho and ***Kansas***
	• Added language to indicate this Medical Policy does not apply to the states of Idaho and Kansas; refer to the state-specific policy versions
	Related Policies *and* Applicable Codes
	• Removed reference link to the Medical Policy titled *Panniculectomy and Body Contouring Procedures*
	Medical Records Documentation Used for Reviews
	• Added language to indicate:
	  ○ 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
	Supporting Information
	• 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, 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.