

Breast Reduction Surgery (for Kentucky Only)

Policy Number: CS012KY.08

Effective Date: September 1, 2023

[Instructions for Use](#)

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Application

This Medical Policy only applies to the state of Kentucky.

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 \(for Kentucky Only\)](#).

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 Coverage Determination Guideline titled [Panniculectomy and Body Contouring Procedures \(for Kentucky Only\)](#).

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
09/01/2023	<p>Coverage Rationale</p> <ul style="list-style-type: none"> Replaced references to “mammoplasty” with “mammaplasty” Added instruction to refer to the Medical Policy titled <i>Gynecomastia Surgery (for Kentucky Only)</i> for reduction mammaplasty related to gynecomastia <p>Applicable Codes</p> <ul style="list-style-type: none"> Added CPT code 19316 <p>Supporting Information</p> <ul style="list-style-type: none"> Archived previous policy version CS012KY.07

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 uses InterQual for the primary medical/surgical criteria, and the American Society of Addiction Medicine (ASAM) for substance use, in administering health benefits. If InterQual does not have applicable criteria, UnitedHealthcare may also use UnitedHealthcare Medical Policies, Coverage Determination Guidelines, or Utilization Review Guidelines that have been approved by the Kentucky Department for Medicaid Services. The UnitedHealthcare Medical Policies, Coverage Determination Guidelines, or Utilization Review 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.