Breast Reduction Surgery (for Mississippi Only)

Policy Number: CS012MS.Z
Effective Date: July 1, 2024

➲ Instructions for Use

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Application

This Medical Policy only applies to the state of Mississippi.

Coverage Rationale

Mississippi CAN (Coordinated Access Network)

For medical necessity clinical coverage criteria for Breast Reduction Surgery, refer to the Mississippi Division of Medicaid Administrative Code, Title 23, Part 203, Rule 4.18: Reduction Mammoplasty.

Mississippi CHIP (Children's Health Insurance Program)

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 Mississippi 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 Mississippi Only).

CPT Code	Description
19318	Breast reduction

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

References

Mississippi Division of Medicaid Administrative Code, Title 23, Part 203, Rule 4.18: Reduction Mammoplasty. Available at: https://medicaid.ms.gov/wp-content/uploads/2024/02/Entire-AdminstrativeCode-eff.-2.1.24.pdf. Accessed March 4, 2024.

Policy History/Revision Information

Date	Summary of Changes
07/01/2024	**Applicable Codes** • Removed CPT code 19316 • Revised description for CPT code 19318 **Supporting Information** • Updated *References* section to reflect the most current information • Archived previous policy version CS012MS.Y

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. 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.