Breast Reduction Surgery

Policy Number: MP.004.26
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Instructions for Use

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Application

UnitedHealthcare Commercial

This Medical Policy applies to all UnitedHealthcare Commercial benefit plans.

UnitedHealthcare Individual Exchange

This Medical Policy applies to Individual Exchange benefit plans in all states except for Colorado.

Coverage Rationale

See Benefit Considerations

Most UnitedHealthcare plans have a specific exclusion for breast reduction surgery except as required by the Women's Health and Cancer Rights Act of 1998. Refer to the member's specific plan document for applicable coverage.

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.

Documentation Requirements

Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The documentation requirements outlined below are used to assess whether the member meets the clinical criteria for coverage but do not guarantee coverage of the service requested.

CPT Codes*	Required Clinical Information
Breast Reduction Surgery	

19316
19318
	Medical notes documenting **all** of the following:
	• Diagnosis
	• History of the medical condition(s) requiring treatment or surgical intervention, including:
	  ○ History of chief complaint and associated symptoms
	  ○ Estimated risk of breast cancer
	• Physical exam including member's height and weight
	• Reports of recent imaging studies and applicable diagnostic tests (within 1 year), including to rule out:
	  ○ Tumor or malignant changes of the breast
	  ○ Orthopedic, neurologic, rheumatologic, endocrine, or metabolic condition
	• Description of physiologic functional impairments and etiology (e.g., back pain, grooving from bras straps, skin breakdown, paresthesias, etc.)
	• For a diagnosis of macromastia, include high quality color photograph(s):
	  ○ All photograph(s) must be labeled with the:
	  ▪ Date taken
	  ▪ Applicable case number obtained at time of notification or member's name and ID number on the photograph(s)
	  ○ **Note**: Submission of color image(s)are required and can be submitted via the external portal at www.uhcprovider.com/paan; faxes will not be accepted
	• **Reduction mammaplasty** documentation should include:
	  ○ The evaluation and management note for the date of service
	  ○ The note for the day the decision to perform surgery was made
	  ○ Physicians plan of care, including estimated volume of breast tissue per breast to be removed

*For code descriptions, refer to the Applicable Codes section.

Definitions

Women's Health and Cancer Rights Act of 1998, 29 U.S.C. § 1185b: "In general - a group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan, that provides medical and surgical benefits with respect to a Mastectomy shall provide, in case of a participant or beneficiary who is receiving benefits in connection with a Mastectomy and who elects breast reconstruction in connection with such Mastectomy, coverage for (1) all stages of reconstruction of the breast on which the Mastectomy has been performed; (2) surgery and reconstruction of the other breast to produce symmetrical appearance; and (3) prostheses and physical complications of Mastectomy, including lymphedemas in a manner determined in consultation with the attending physician and the patient."

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 guideline 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 the member specific benefit plan document 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.

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

Benefit Considerations

Most UnitedHealthcare plans have a specific exclusion for breast reduction surgery except as required by the Women's Health and Cancer Rights Act of 1998. Refer to the member's specific plan document for applicable coverage.

All plans cover breast reduction surgeries that qualify under the Women's Health and Cancer Rights Act of 1998. If a surgery does not qualify under the Women's Health and Cancer Rights Act of 1998, some plans may allow breast reduction surgery if we determine the surgery will treat a physiologic functional impairment. However, some plans exclude breast reduction surgery even if it treats a physiologic functional impairment. Refer to the member specific benefit plan document to determine coverage.

For breast surgery for treatment of gender dysphoria refer to the Medical policy titled Gender Dysphoria Treatment.

References

Women's Health and Cancer Rights Act of 1998. Available at: https://www.cms.gov/cciio/programs-and-initiatives/other-insurance-protections/whcra_factsheet.html. Accessed January 9, 2023.

Policy History/Revision Information

Date	Summary of Changes
03/01/2024	**Related Policies** • Updated reference link to reflect current policy title for *Gender Dysphoria Treatment*
10/01/2023	**Application** ***Individual Exchange Plans*** • Removed language indicating this Medical Policy does not apply to Individual Exchange benefit plans in the states of Massachusetts, Nevada, and New York **Supporting Information** • Archived previous policy version MP.004.25

Instructions for Use

This Medical Policy provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the member specific benefit plan document must be referenced as the terms of the member specific benefit plan may differ from the standard plan. In the event of a conflict, the member specific benefit plan document governs. Before using this policy, please check the member specific benefit plan document and any applicable federal or state mandates. 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.

This Medical Policy may also be applied to Medicare Advantage plans in certain instances. In the absence of a Medicare National Coverage Determination (NCD), Local Coverage Determination (LCD), or other Medicare coverage guidance, CMS allows a Medicare Advantage Organization (MAO) to create its own coverage determinations, using objective evidence-based rationale relying on authoritative evidence (Medicare IOM Pub. No. 100-16, Ch. 4, §90.5).

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.