Breast Reduction Surgery (for Louisiana Only)

Policy Number: CS012LA.U
Effective Date: July 1, 2024

➲ Instructions for Use
Content mandated by Louisiana Department of Health

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Application

This Medical Policy 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

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
- 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

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Diagnosis Code	Description
N62	Hypertrophy of breast

Diagnosis Code	Description
N65.1	Disproportion of reconstructed breast

References

Department of Health, Professional Services Provider Manual, Chapter Five of the Medicaid Services Manual, Issued September 13, 2016. https://www.lamedicaid.com/provweb1/providermanuals/manuals/PS/PS.pdf. Accessed March 14, 2024.

Policy History/Revision Information

Date	Summary of Changes
07/01/2024	**Applicable Codes** • Removed CPT code 19316 **Supporting Information** • Archived previous policy version CS012LA.T

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.