Breast reduction coding should be straightforward, not confusing

By Raymond Janevicius, MD

Breast reductions are very common procedures in plastic surgery practice. One CPT code, 19318, is used to report these procedures, but there are some areas of confusion in breast reduction coding.

What's global

CPT code 19318 describes a unilateral breast reduction. This code includes:
- Incisions and elevation of flaps
- Nipple-areolar complex preservation
- Areolar size reduction
- Resection of tissue
- Nipple repositioning
- Flap transposition
- Wound closure
- 90 days of uncomplicated postoperative care

These are the elements of a breast reduction. Reporting any of these components separately would be unbundling. For example, one should not code for an intermediate repair (1203X), as layered closure of all wounds is considered an essential component of a breast reduction.

What about free nipple grafts?

A woman who undergoes a breast reduction procedure has an expectation that she will have nipples and areolae at the completion of the procedure. Breast reduction includes preservation of the nipple-areolar complexes on a pedicle.

If a free nipple graft technique is used, then the harvest and grafting of the nipple-areolar complexes is included in the global procedure described with code 19318. Full thickness skin grafting (15200, 15201) is not separately reportable. Grafting of the nipple-areolar complexes is not considered a nipple-areolar reconstruction (19350) either.

Wide spectrum

Code 19318 is used for all breast reductions. As with many CPT codes, it describes a wide spectrum of procedures with varying degrees of difficulty. A 500-gram breast reduction in a patient with minimal ptosis is a much less involved procedure than a 2,500-gram reduction with free nipple grafting in a patient with grade 3 ptosis. Each procedure is described with code 19318. This is literally a “one size fits all” code.

Since CPT codes are inextricably associated with reimbursement, a surgeon will be paid the same amount for each of these procedures. Is this fair? Of course not, but this is the way the system works. Payers do not have “sliding scales” for each CPT code depending upon difficulty of procedure; they have a fixed amount that they reimburse for each CPT code.

If you feel that, in highly selected cases, a particular breast reduction you perform is far more difficult than the usual breast reduction, use the “increased procedural services” modifier, “-22.” Some payers may reimburse more in these cases. This issue should be addressed and resolved preoperatively, during the written pre-authorization process (see below).

Liposuction

If in the course of the breast reduction, the surgeon uses suction assisted lipectomy (SAL) to reduce some of the breast tissue, this is considered a “technique,” and is not separately reportable. Whether a scalpel is used to excise tissue, or SAL is used to reduce tissue, this is considered part of the breast reduction procedure.

If liposuction alone is used to perform the breast reduction (i.e., no flaps elevated, no areolar reduction, no nipple-areolar repositioning), this procedure is reported with code 19318-52. Append the “reduced services” modifier, “-52” to indicate that not all components of the “standard” breast reduction are performed.

Many carriers will not cover breast reduction by liposuction alone, as they consider it “experimental,” “investigational” or “unproven.” When pre-authorizing these procedures, it is imperative that the surgeon indicate that the breast reduction will be performed with liposuction alone. Some carriers require that the procedure be reported with the liposuction code, 15877. This should all be clarified preoperatively, to help prevent post-procedure denials.

Bilateral procedures

The vast majority of breast reductions are bilateral, and payers are not consistent in their reporting preferences. By CPT rules, a bilateral breast reduction is reported:

19318 Right breast reduction
19318-50 Left breast reduction

Some payers, including Medicare, require a one-line entry, indicating that the entire procedure reported is a bilateral procedure:

19318-50 Bilateral breast reduction
Other payers may require the “right” and “left” designation:

19318-RT  Right breast reduction
19318-LT  Left breast reduction

Some carriers in our area (Chicago) will not pay unless the procedures are reported:

19318-RT  Right breast reduction
19318-59-51-LT  Left breast reduction

Determine your carrier coding requirements during the pre-authorization process.

**Always preauthorize**

Breast reductions are elective procedures, and payers have varying coverage criteria, which are becoming more and more stringent. Generally they require pain (neck, shoulders, neck) secondary to macromastia and physical evidence of macromastia (photos, measurements). Some criteria, however, do not make clinical sense, but are part of the specific insurance policy. Some payers require the following before breast reduction is considered a covered procedure:

- Persistent, non-seasonal, refractory inframammary intertrigo
- Pain: shoulders, neck, back
- Ulnar nerve paresthesias
- Significant shoulder grooving or ulceration
- Several weeks to several months of physical therapy, including a home maintenance program
- Anti-inflammatory medications, including “proof” that the patient has taken them
- “Symptomatic measures,” including application of heat and cold
- Weight reduction
- Minimum amount of breast tissue excised (not fat tissue or liposuction aspirate)

Although the literature does not support many of these criteria for breast reduction coverage, many insurance plans demand certain requirements be met before consideration for coverage. It is critical that all breast reductions be pre-authorized in writing prior to surgery. Medicare may not pre-authorize breast reduction procedures. It is important to have these patients sign an ABN (Advance Beneficiary Notice) prior to performing surgery.

Be accurate with the pre-authorization letter. Consider, for example, a payer that has a requirement for a minimum amount of breast tissue excised. If that amount is indicated on the pre-authorization letter, but the surgeon does not remove that amount of tissue (as documented on the pathology report), the procedure may not be reimbursed. This includes not only the surgeon’s fee, but the hospital and anesthesia fees. Also note that many payers require documentation (on the pathology report) that breast tissue is excised, not adipose tissue.

‘**But some payers just don’t cover breast reductions**’

Yes, even with all appropriate medical indications and correct coding, breast reductions are not covered procedures under many insurance plans. This is not a medical necessity issue nor a coding issue; this is a payer rationing issue.

In these cases the surgeon must address breast reduction surgery with the patient in the same way cosmetic procedures are addressed.

— Dr. Janevicius is the society’s representative to the AMA CPT Advisory Committee.