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Policy Effective Date	**06/15/2024**
Policy End Date	**12/31/2025**

Mastopexy

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Related Policies (if applicable)
SUR717.001: Gender Assignment Surgery and Gender Reassignment Surgery with Related Services
SUR716.011: Reconstructive Breast Surgery
SUR716.009: Breast Implant, Removal and/or Insertion

Disclaimer

Carefully check state regulations and/or the member contract.
Each benefit plan, summary plan description or contract defines which services are covered, which services are excluded, and which services are subject to dollar caps or other limitations, conditions or exclusions. Members and their providers have the responsibility for consulting the member's benefit plan, summary plan description or contract to determine if there are any exclusions or other benefit limitations applicable to this service or supply. **If there is a discrepancy between a Medical Policy and a member's benefit plan, summary plan description or contract, the benefit plan, summary plan description or contract will govern.**

Coverage

Mastopexy, with or without breast implant insertion**,** including revisions of previous augmentation or mastopexy procedures done for cosmetic indications, **is considered cosmetic and not eligible for benefit coverage.**

Policy Guidelines

None.

Description

Breast ptosis describes the sagging or drooping of the breast, also known as pendulous breasts.

Background
Breast Ptosis

Breast ptosis occurs as a result of gravity and the loss of elasticity in the dermis layer of skin, due either to or as a result of:

- Age,
- Multiple pregnancies,
- Dramatic weight loss, or
- Loss of mass resulting from postpartum atrophy.

Breast ptosis has been graded and modified by numerous physicians. The most commonly used system is as follows:

- Grade I (mild ptosis): nipple just below inframammary fold but still above the lower pole of breast.
- Grade II (moderate ptosis): nipple further below inframammary fold but still with some lower pole tissue below nipple.
- Grade III (severe ptosis): nipple well below inframammary fold and no lower pole tissue below nipple.

Pseudoptosis (or false ptosis) is a condition in which the nipple is at the level of the breast fold but the breast tissue itself has drooped lower. This is often observed in postpartum breast atrophy.

Mastopexy

Mastopexy (breast lift) is a plastic reconstruction performed to correct ptosis or drooping and sagging of the breast. The object of mastopexy is to achieve a firmer and more youthful-appearing breast while minimizing visible scars. To achieve this end result, multiple procedures and modifications of the mastopexy technique have been suggested, including endoscopic techniques and laser surgery. If there is inadequate breast tissue to achieve the desired breast size, a saline-filled implant may be placed beneath the breast at the same time. This type of correction is considered as cosmetic (aesthetic) surgery, by reshaping a normal structure of the body, in this case the breast, to improve the patient's appearance.

This medical policy does not address the use of mastopexy when part of the operative treatment plan for breast reconstruction (reconstructive mammaplasty) and contralateral breast surgery following:

- Specific techniques for breast cancer treatment, accidental injury or trauma; or
- Prophylactic mastectomy for benign disease or cancer risk.

Regulatory Status

Mastopexy is a surgical procedure and, as such, is not subject to regulation by the U.S. Food and Drug Administration (FDA).

Rationale

The policy was created in 1992 based upon peer reviewed scientific literature and has been periodically updated, with the most recent search of the PubMed database performed through March 24, 2023. The following is a summary of the key literature evaluated.

Medical policies assess the clinical evidence to determine whether the use of a technology improves the net health outcome. Broadly defined, health outcomes are length of life, quality of life (QoL), and ability to function--including benefits and harms. Every clinical condition has specific outcomes that are important to patients and to managing the course of that condition. Validated outcome measures are necessary to ascertain whether a condition improves or worsens; and whether the magnitude of that change is clinically significant. The net health outcome is a balance of benefits and harms.

To assess whether the evidence is sufficient to draw conclusions about the net health outcome of a technology, 2 domains are examined: the relevance and the quality and credibility. To be relevant, studies must represent one or more intended clinical use of the technology in the intended population and compare an effective and appropriate alternative at a comparable intensity. For some conditions, the alternative will be supportive care or surveillance. The quality and credibility of the evidence depend on study design and conduct, minimizing bias and confounding that can generate incorrect findings. The randomized controlled trial (RCT) is preferred to assess efficacy; however, in some circumstances, nonrandomized studies may be adequate. RCTs are rarely large enough or long enough to capture less common adverse events and long-term effects. Other types of studies can be used for these purposes and to assess generalizability to broader clinical populations and settings of clinical practice.

Determinations of whether a proposed therapy would be considered cosmetic should always be interpreted in the context of the specific benefit language. Should there be a functional impairment, a treatment would be considered medically necessary and thus not subject to contractual definitions of cosmetic. Mastopexy, outside of reconstructive and contralateral breast reconstruction, is considered cosmetic.

Clinical Studies and Reviews

Mastopexy is considered within the realm of cosmetic surgeries for women, according to Spring et al. (2015) and DeSouza et al. (2018). (1, 2) Spring et al. reviewed the augmentation mastopexy techniques for safe and effective combined procedures, challenges of the procedure, and potential complications. (2) They concluded that while simultaneous breast augmentation and mastopexy is a common procedure, this combined procedure is most often considered to be one of the most difficult cosmetic breast procedures.

Revisionary breast surgery was studied by Grewal and Fisher (2013) in 134 patients from a single clinic. (3) This category of cosmetic surgery is sought to improve or correct prior breast augmentation, mastopexy-augmentation, and breast reduction. Three categories were identified as the cause for the secondary surgery: 1) the surgeon’s operative plan was flawed and/or involved a technical error, which was 73% of the revision requests; 2) an independent factor occurred such as ptosis or capsular contracture; or 3) there was a combination of both.

The most frequent revision indication for aesthetic implant patients were development of ptosis (42%), capsular contracture (29%), and lower-pole deformities (19%). Twenty-six percent had a combination of issues. Revision of those previously having reduction mammaplasty was due to volume loss from over-resection (40%), nipple-areola loss (27%), and breast asymmetry (27%). The average interval from original cosmetic surgery to revision was 8 years.

Spear et al. (2003) published an 8-year retrospective review of patients undergoing revision of a previous augmentation or mastopexy of one practice. (4) The data collected included the original implant type (if applicable) and mastopexy type, new implant type (if applicable), location of revision, indication for revision, and interval from the original surgical procedure(s). Of the 20 patients' records reviewed, there was a revision of 34 previously performed breast augmentations or mastopexies. Of the 20, 5 patients underwent a revision of a prior revision. Concurrently, a review of all primary augmentations or mastopexies was done on 40 patients. Indications for desired revisions included were capsular contracture, nipple ptosis/malposition, implant malposition, dissatisfaction of prior surgery, dissatisfaction of implant, scarring, breast ptosis, and patient preference. The average interval from prior original procedure to revision was 7 years.

Lorentzen et al. (2021) noted that breast cancer is the most common cancer diagnosed in women, and early stages are treated with lumpectomy and irradiation. Irradiation, however, results in reduced vascularization and fibrosis, which may influence the cosmetic outcome unfavorably and increase complications after subsequent surgery on irradiated breasts. Patients with significant asymmetry after treatment may desire corrective reduction mammoplasty or mastopexy; however, this may be associated with increased complication rates. In a systematic review and meta-analysis, these investigators examined post-operative complication rates following bilateral reduction mammoplasty or mastopexy in women who had undergone unilateral lumpectomy and irradiation. PubMed, Medline, Embase and Cochrane databases were searched for eligible studies. After screening titles and abstracts, a total of 14 full text studies were reviewed, and 7 of these were included in the analysis. The meta-analysis showed a significantly higher complication rate in the irradiated breast compared to the non-irradiated breast, rate ratio 4.82 (95 % CI: 1.58 to 14.70, p = 0.006). The complication rate was 54% in the irradiated breast (58/107) compared to 8% (9/107) in the non-irradiated breast (p = 0.034). The authors concluded that the findings of this study suggested that reduction mammoplasty or mastopexy in the previously irradiated breast was associated with a significantly increased risk of complications. Careful patient selection and information are paramount in the treatment of this patient group. (5)

Summary of Evidence

For individuals who seek cosmetic mastopexy, with or without breast implant insertion, there are no true medical indications. Mastopexy is performed primarily for aesthetic reasons. The exception to this is reconstructive mammaplasty and contralateral breast surgery when done for disease, prophylaxis, accidental injury or trauma. A mastopexy may be essential to achieving symmetry for those clinical conditions. There are few studies available addressing the medical necessity of mastopexy for non-cancer or post-mastectomy indications. Benefit determinations

should be based in all cases on the applicable contract language. If there are any conflicts between these guidelines and the contract language, the contract language will prevail.

Practice Guidelines and Position Statements

There are no practice guidelines and position statements identified that would likely influence this medical policy.

Ongoing and Unpublished Clinical Trials

A search of ClinicalTrials.gov in March 2023 did not identify any ongoing or unpublished trials that would likely influence this medical policy.

Coding

Procedure codes on Medical Policy documents are included **only** as a general reference tool for each policy. **They may not be all-inclusive.**

The presence or absence of procedure, service, supply, or device codes in a Medical Policy document has no relevance for determination of benefit coverage for members or reimbursement for providers. **Only the written coverage position in a Medical Policy should be used for such determinations.**

Benefit coverage determinations based on written Medical Policy coverage positions must include review of the member's benefit contract or Summary Plan Description (SPD) for defined coverage vs. non-coverage, benefit exclusions, and benefit limitations such as dollar or duration caps.

CPT Codes	19316
HCPCS Codes	None

*Current Procedural Terminology (CPT®) ©2023 American Medical Association: Chicago, IL.

References

1. Spring MA, Hartmann EC, Stevens WG. Strategies and challenges in simultaneous augmentation mastopexy. Clin Plast Surg. Oct 2015; 42(4):505-518. PMID 26408440
2. DeSouza MM, Jewell AD, Grief SN, et al. Plastic surgery for women. Prim Care. Dec 2018; 45(4):705-717. PMID 30401351
3. Grewal NS, Fisher J. Why do patients seek revisionary breast surgery? Aesthet Surg J. Feb 2013; 33(2):237-244. PMID 23388645
4. Spear SL, Low M, Ducic I. Revision augmentation mastopexy: indications, operations, and outcomes. Ann Plast Surg. Dec 2003; 51(6):540-546. PMID 14646644
5. Lorentzen AK, Lock-Andersen J, Matthiessen LW, et al. Reduction mammoplasty and mastopexy in the previously irradiated breast-- a systematic review and meta-analysis. J Plast Surg Hand Surg. 2021; 55(6):330-338. PMID 33630696

Centers for Medicare and Medicaid Services (CMS)

The information contained in this section is for informational purposes only. HCSC makes no representation as to the accuracy of this information. It is not to be used for claims adjudication for HCSC Plans.

The Centers for Medicare and Medicaid Services (CMS) does not have a national Medicare coverage position. Coverage may be subject to local carrier discretion.

A national coverage position for Medicare may have been developed since this medical policy document was written. See Medicare's National Coverage at <http://www.cms.hhs.gov>.

Policy History/Revision	
Date	**Description of Change**
06/15/2024	Reviewed. No changes.
06/01/2023	Document updated with literature review. Coverage unchanged. Reference 5 added.
12/01/2022	Document updated with literature review. Coverage unchanged. No new references added.
10/01/2021	Reviewed. No changes.
01/15/2021	Document updated with literature review. Coverage unchanged. No new references added.
10/15/2019	Reviewed. No changes.
01/15/2019	Document updated with literature review. Coverage unchanged. References 1-3 added, several removed.
07/15/2017	Reviewed. No changes.
05/15/2016	Document updated with literature review. Coverage unchanged.
10/01/2015	Reviewed. No changes.
03/01/2014	Document updated with literature review. The following was added to the coverage statement, “including revisions of previous augmentation or mastopexy procedures done for cosmetic indications.”
06/15/2008	Policy reviewed without literature review; new review date only.
11/15/2004	Revised/updated entire document.
01/01/1996	Revised/updated entire document.
10/01/1994	Revised/updated entire document.
07/01/1992	New medical document.