Policy Number	**SUR716.010**
Policy Effective Date	**05/15/2026**

Mastopexy

Table of Contents
Coverage
Policy Guidelines
Description
Rationale
Coding
References
Policy History

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 **is considered cosmetic** except when performed as part of a medically necessary breast reconstruction.

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 remove excess skin and tighten the surrounding tissue to reshape and support the new breast contour. (2) The areola can become enlarged over time and a breast lift will reduce this as well. The object of mastopexy is to achieve a profile that is more youthful and uplifted. A woman's breasts often change over time, losing their youthful shape and firmness. These changes and loss of skin elasticity can result from pregnancy, breastfeeding, weight fluctuations, aging, gravity and hereditary. Breast lift surgery does not significantly change the size of your breast or round out the upper part of the breast. If fuller breasts are needed then consider a breast lift with a breast augmentation. 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

This policy is based on a review of coverage guidance from the Centers for Medicare and Medicaid Services (CMS) on cosmetic and reconstructive surgery specific to mastopexy/mammopexy. (1)

Centers for Medicare and Medicaid Services

CMS does not currently have a national coverage determination on mastopexy/mammopexy, however a local coverage determination on cosmetic and reconstructive surgery (L35090) (1) includes the following on a listing of procedures that are considered to be cosmetic: "Mammapexy unrelated to breast reconstruction following a medically necessary mastectomy."

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®) ©2025 American Medical Association: Chicago, IL.

References

Centers for Medicare and Medicaid Services

1. Centers for Medicare and Medicaid Services. National Coverage Determination for Cosmetic and Reconstructive Surgery (L35090) (Revision 9) (July 11, 2021). Available at <https://www.cms.gov> (accessed March 19, 2026).

Other

2. Breast Lift (mastopexy). American Society of Plastic Surgeons. Available at: <https://www.plasticsurgery.org> (accessed April 17, 2026

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 <https://www.cms.hhs.gov>.

Policy History/Revision	
Date	**Description of Change**
05/15/2026	Document updated. Coverage unchanged. Reference 2 added.
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.