BOSTON MEDICAL CENTER HEALTHNet PLAN
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WELL SENSE HEALTH PLAN
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Medical Policy

Mastopexy

Policy Number: OCA 3.717
Version Number: 18
Version Effective Date: 12/01/21

Product Applicability	☒ **All Plan+ Products**
WellSense Health Plan	**Boston Medical Center HealthNet Plan**
☒ NH Medicaid	☒ MassHealth ACO
☒ NH Medicare Advantage	☒ MassHealth MCO
	☒ Qualified Health Plans/ConnectorCare/Employer Choice Direct
	☒ Senior Care Options

+ Note: Disclaimer and audit information is located at the end of this document.

Policy Summary

Mastopexy or breast lift surgery is considered **medically necessary** for specific medical conditions when Plan criteria are met. Plan prior authorization is required. If applicable medical criteria are NOT met, the surgery is considered cosmetic.

The Plan complies with coverage guidelines for all applicable state-mandated benefits and federally-mandated benefits that are medically necessary for the member's condition. Review the Plan's *Cosmetic, Reconstructive, and Restorative Services* medical policy, policy number OCA 3.12, for guidelines on the use autologous fat grafts to treat HIV-associated lipodystrophy syndrome according to Massachusetts mandated benefits, as specified in Chapter 233 of the Acts of 2016, An Act Relative to HIV Associated Lipodystrophy Syndrome Treatment. Other applicable medical policies include: *Breast Reconstruction* medical policy, policy number OCA 3.43; *Breast Reduction Surgery* medical policy, policy number OCA 3.44; *Gender Affirmation Services* medical policy, policy number OCA 3.11; and *Gynecomastia Surgery* medical policy OCA 3.48.

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Clinical Criteria

Mastopexy or breast lift surgery is considered medically necessary as part of breast reconstruction related to breast cancer treatment or when used to treat another medical condition. The treating provider should discuss with the member **breast feeding considerations** related to mastopexy during the evaluation for surgery. The treating provider must verify that the member is an acceptable surgical candidate (with evaluation of the member's high-risk indicators, if any, such as morbid obesity, tobacco use, cardiac history, comorbidities, and related past medical/surgery history). The Plan's applicable medical necessity criteria must be met and documented in the member's medical record (including preoperative photographs, which will be submitted as part of the prior authorization review process if requested by the Plan), as specified below in EITHER item 1 or item 2:

1. **Mastopexy as Part of Breast Reconstruction Related to Breast Cancer Treatment:**

   BOTH of the following applicable criteria must be met for a member after a diagnosis of breast cancer, as specified below in item a and item b:

   a. The mastopexy will be performed on the affected breast and/or unaffected contralateral breast to create symmetry (either oncoplastic mastopexy or mastopexy following a mastectomy or lumpectomy) in a member who has undergone at least ONE (1) of the following therapies/procedures, as specified below in items (1) through (4):

      (1) Breast conservation therapy (BCT); OR

      (2) Lumpectomy; OR

      (3) Mastectomy; OR

      (4) Other diagnostic procedures causing deformity of the breast in connection with breast cancer, evaluation of breast cancer or suspected breast cancer, or to prevent development of breast cancer in high risk patients; AND

   b. Member has had a mammogram within 12 calendar months of the date of the planned mastopexy that was negative for cancer, including mammography on the unaffected side if mastopexy will be done on the unaffected breast to create symmetry after breast surgery related to breast cancer (unless oncoplastic mastopexy is performed concurrently with the breast surgery related to breast cancer treatment and then the criterion requiring a mammogram negative for cancer would not be applicable); OR

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2. **Mastopexy to Treat Other Medical Conditions:**

   BOTH of the following applicable criteria must be met when mastopexy will be performed on the affected breast and/or unaffected contralateral breast to create symmetry to treat a member's medical condition (other than breast reconstruction related to breast cancer treatment), as specified below in item a and item b:

   a. The member has at least ONE (1) of the following conditions, as specified below in items (1) through (4):

      (1) Breast agenesis; OR

      (2) Medically refractory inframammary hidradenitis; OR

      (3) Poland syndrome; OR

      (4) Pre-menarchal breast bud injury; AND

   b. If the member is 40 years of age or older, the member has had a mammogram within 12 calendar months from the date of the mastopexy that was negative for cancer in both breasts.

Limitations and Exclusions

Mastopexy is considered a cosmetic service when the Plan's medical necessity criteria specified in the Clinical Criteria section of this policy are NOT met.

Variations

The Plan uses guidance from the Centers for Medicare & Medicaid Services (CMS) for medical necessity and coverage determinations for Senior Care Options (SCO) members and WellSense Medicare Advantage HMO members, including but not limited to national coverage determinations (NCDs), local coverage determinations (LCDs), local coverage articles (LCAs), and documentation included in Medicare manuals. At the time of the Plan's most recent policy review, no CMS clinical guidelines were identified specifically for mastopexy. CMS NCD 140.2 includes nationally covered indications for breast reconstruction following mastectomy and LCD L35001 includes guidelines for reduction mammaplasty. Verify CMS guidelines in effect on the date of the prior authorization request. When there is no guidance from CMS for the requested service, Plan-adopted clinical review criteria will be used to determine the medical necessity of the service.

Applicable Coding

The Plan uses and adopts up-to-date Current Procedural Terminology (CPT) codes from the American Medical Association (AMA), International Statistical Classification of Diseases and Related Health

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Problems, 10th revision (ICD-10) diagnosis codes developed by the World Health Organization and adapted in the United Stated by the National Center for Health Statistics (NCHS) of the Centers for Disease Control under the U.S. Department of Health and Human Services, and the Health Care Common Procedure Coding System (HCPCS) established and maintained by the Centers for Medicare & Medicaid Services (CMS). Since the AMA, NCHS, and CMS may update codes more frequently or at different intervals than Plan policy updates, the list of applicable codes included in this Plan policy is for informational purposes only, may not be all inclusive, and is subject to change without prior notification. Whether a code is listed in the Applicable Coding section of this Plan policy does not constitute or imply member coverage or provider reimbursement. Providers are responsible for reporting all services using the most up-to-date industry-standard procedure and diagnosis codes as published by the AMA, NCHS, and CMS at the time of the service.

Providers are responsible for obtaining prior authorization for the services specified in the Clinical Criteria section and Limitation and Exclusions section of this Plan policy, even if an applicable code appropriately describing the service that is the subject of this Plan policy is not included in this Applicable Coding section. Review the Plan's reimbursement policies for Plan billing guidelines. Coverage for services is subject to benefit eligibility under the member's benefit plan in effect at the time of the service. Member benefit documents are available at the following websites: www.bmchp.org for BMC HealthNet Plan members, www.SeniorsGetMore.org for Senior Care Options members, www.wellsense.org for WellSense New Hampshire Medicaid members, and www.WellSense.org/Medicare for WellSense Medicare Advantage HMO members.

CPT Code	Description: Code Covered When Medically Necessary
19316	Mastopexy

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Policy History

Original Approval Date	Original Effective Date* and Version Number	Policy Owner	Original Policy Approved by
Regulatory Approval: N/A Internal Approval: 05/26/09: Medical Policy, Criteria, and Technology Assessment Committee (MPCTAC) 05/26/09: Utilization Management Committee (UMC) 07/22/09: Quality Improvement Committee (QIC)	10/01/09 Version 1	Medical Policy Manager as Chair of MPCTAC	MPCTAC, UMC, and QIC

*Effective Date for the BMC HealthNet Plan Commercial Product(s): 01/01/12
*Effective Date for the WellSense Health Plan New Hampshire Medicaid Product(s): 01/01/13
*Effective Date for the Senior Care Options Product(s): 01/01/16

Policy Revisions History			
Review Date	**Summary of Revisions**	**Revision Effective Date and Version Number**	**Approved by**
04/01/10	No changes.	Version2	04/27/10: MPCTAC 05/26/10: QIC
04/01/11	No changes to codes or criteria. Updated references.	Version 3	04/20/11: MPCTAC 05/25/11: QIC
04/01/12	Updated criteria to include provisions of Women's Health and Cancer Right's Act of 1998.	Version 4	04/18/12: MPCTAC 06/27/12: QIC
07/30/12	Off cycle review for WellSense Health Plan. Revised Summary statement. Updated references.	Version 5	08/03/12: MPCTAC 09/05/12: QIC
04/01/13	Review for effective date of 08/01/13. Added references. Revised Summary, Limitations, and Clinical Background Information sections, added criterion in	08/01/13 Version 6	04/17/13: MPCTAC 05/16/13: QIC

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Policy Revisions History			
	Medical Policy Statement section. Referenced the following Plan policies: *Medically Necessary*, *Breast Reconstruction*, *Gynecomastia Surgery,* and *Cosmetic, Reconstructive, and Restorative Services*. Revised language of introductory paragraph of Applicable Coding section. Deleted product-specific definitions.		
06/01/13	Review for effective date of 09/01/13. Added note to Medical Policy Statement section and updated Definitions section.	09/01/13 Version 7	06/19/13: MPCTAC 07/18/13: QIC
04/01/14	Review for effective date 08/01/14. Reformatted and revised the Medical Policy Statement section, including revised requirements for mammograms before mastopexy. Revised Definitions and References sections.	08/01/14 Version 8	04/16/14: MPCTAC 05/14/14: QIC
04/01/15	Review for effective date 06/01/15. Removed Commonwealth Care, Commonwealth Choice, and Employer Choice from the list of applicable products because the products are no longer available. Updated Summary section. Made administrative changes to the Medical Policy Statement section and stated that preoperative photographs may be required upon request during the Plan prior authorization process.	06/01/15 Version 9	04/15/15: MPCTAC 05/13/15: QIC
11/25/15	Review for effective date 01/01/16. Updated template with list of applicable products and notes. Revised language in the Applicable Coding section.	01/01/16 Version 10	11/18/15: MPCTAC 11/25/15: MPCTAC (electronic vote) 12/09/15: QIC
04/01/16	Review for effective date 06/01/16. Revised the Clinical Background Information, References, and Reference to Applicable Laws and Regulations sections.	06/01/16 Version 11	04/20/16: MPCTAC 05/23/16: QIC
09/28/16	Review for effective date 11/01/16. Administrative changes made to clarify language related to gender.	11/01/16 Version 12	09/30/16: MPCTAC (electronic vote) 10/12/16: QIC

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Policy Revisions History			
04/01/17	Review for effective date 05/08/17. Administrative changes made to the Medical Policy Statement section. Updated Summary, Definitions, Clinical Background Information, References, and References to Applicable Laws and Regulations sections.	05/08/17 Version 13	04/19/17: MPCTAC
05/01/18	Review for effective date 06/01/18. Administrative changes made to the Policy Summary, Medical Policy Statement, Limitations, Definitions, References, and Other Applicable Policies sections.	06/01/18 Version 14	05/16/18: MPCTAC
04/01/19	Review for effective date 05/01/19. Administrative changes made to the Limitations, References, Other Applicable Policies, and Reference to Applicable Laws and Regulations sections.	05/01/19 Version 15	04/18/19: MPCTAC (electronic vote)
04/01/20	Review for effective date 05/01/20. Administrative changes made to the References and Reference to Applicable Laws and Regulations sections.	05/01/20 Version 16	04/15/20: MPCTAC
04/01/21	Review for effective date 05/01/21. Administrative changes made to the References section.	05/01/21 Version 17	04/21/21: MPCTAC
11/01/21	Review for effective date 12/01/21. Adopted new medical policy template; removed administrative sections, the Medical Policy Statement section renamed the Clinical Criteria section, and the Limitations section renamed the Limitations and Exclusions section. Added WellSense Medicare Advantage HMO as an applicable product effective 01/01/22. Administrative changes made to the Policy Summary, Clinical Criteria, Limitations and Exclusions, Applicable Coding, and References sections.	12/01/21	11/17/21: MPCTAC

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Next Review Date

04/01/22

Authorizing Entity

MPCTAC

Disclaimer Information: +

Medical Policies are the Plan's guidelines for determining the medical necessity of certain services or supplies for purposes of determining coverage. These Policies may also describe when a service or supply is considered experimental or investigational, or cosmetic. In making coverage decisions, the Plan uses these guidelines and other Plan Policies, as well as the Member's benefit document, and when appropriate, coordinates with the Member's health care Providers to consider the individual Member's health care needs.

Plan Policies are developed in accordance with applicable state and federal laws and regulations, and accrediting organization standards (including NCQA). Medical Policies are also developed, as appropriate, with consideration of the medical necessity definitions in various Plan products, review of current literature, consultation with practicing Providers in the Plan's service area who are medical experts in the particular field, and adherence to FDA and other government agency policies. Applicable state or federal mandates, as well as the Member's benefit document, take precedence over these guidelines. Policies are reviewed and updated on an annual basis, or more frequently as needed. Treating providers are solely responsible for the medical advice and treatment of Members.

The use of this Policy is neither a guarantee of payment nor a final prediction of how a specific claim(s) will be adjudicated. Reimbursement is based on many factors, including member eligibility and benefits on the date of service; medical necessity; utilization management guidelines (when applicable); coordination of benefits; adherence with applicable Plan policies and procedures; clinical coding criteria; claim editing logic; and the applicable Plan – Provider agreement.

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