n00310

Breast Implant Removal and/or Replacement Medical Policy

Values

Accountability ● Integrity ● Service Excellence ● Innovation ● Collaboration

Abstract Purpose:

Network Health Plan/Network Health Insurance Corporation/Network Health Administrative Services, LLC's (NHP/NHIC/NHAS/NH TPA) utilization management (UM) team, applies review guidelines for determinations involving medical necessity for breast implant removal and/or replacement. The purpose of this policy is to provide guidance to the utilization management staff and medical directors for decision making related to the medical necessity of the removal or replacement of breast implants.

Policy Detail:

Refer to the appropriate Certificate of Coverage, Evidence of Coverage, Summary Plan Description, Individual and Family Policy to determine eligibility and coverage because Employer Group/Plan Sponsor and government contracts may vary. NHP/NHIC/NHAS follows Medicare's National/Local (Wisconsin area) Coverage Determinations for its Medicare Advantage membership. In the absence of a Medicare National/Local Coverage Determination this medical policy would apply to our Medicare Advantage membership.

I. Description

   A. This is a procedure in which saline or silicone gel breast implants are surgically removed or replaced with saline or silicone filled implants. Capsulotomy is an incision(s) made into the scar tissue barrier or capsule to release the pocket that the implant resides in.

II. Medical Indications/Criteria: Removal or replacement of a breast implant will be considered medically necessary when meeting **ANY** of the following criteria:

   A. Recurrent infection (local or systemic) directly related to the presence of the prosthesis is present, **OR**;

   B. Intracapsular or extracapsular silicone implant ruptures, deflates or leaks, substantiated by clear evidence on physical exam and/or the incident is confirmed by mammography, ultrasound, CT scan or MRI study, **OR**;

   C. Severe contracture of the capsule or scar tissue is present **OR**;

      1. Examples include:

         a. Severe capsule contracture that interferes with mammography

b. Pain related to a Bakers stage IV capsular contracture

D. Breast asymmetry in individuals that develop visible distortions due to Bakers class III contracture or rupture of an implant placed due to a personal history of mastectomy, lumpectomy or for treatment of breast cancer, **OR**;

E. Implant interferes clinically with breast cancer detection or the treatment of breast cancer, **OR**;

F. Implant extrusion **OR**;

G. Late hyperinflation of the implant and ultrasound evidence of fluid accumulation around the implant suggesting ALCL (Primary Anaplastic Large-Cell Lymphoma associated with breast implants), **OR**;

H. Individuals demonstrating cutaneous hypersensitivity-like reactions associated with breast implants who have failed conservative treatments, such as topical or oral corticosteroids and/or antibiotics.

III. Coverage

A. Breast implant removal and/or replacement will be covered for breast reconstruction related to a covered mastectomy, surgery and reconstruction of the contralateral breast to produce symmetrical appearance when related to a breast cancer diagnosis to the extent required under the Women's Health and Cancer Rights Act.

B. NHP/NHIC/NHAS follows CMS National Coverage Determinations (NCD) and Local Coverage Determinations (LCD) for application to its Medicare Advantage membership.

C. Individual certificate or evidence of coverage might exclude coverage of services for complications following cosmetic or non-covered procedures and would supersede this medical policy

IV. Limitations/Exclusions:

A. The removal/replacement of a breast implant placed for cosmetic reasons, not meeting the medical indications above will not be covered.

B. The removal/replacement of ruptured, deflated or leaking saline implants placed for cosmetic reasons is considered not medically necessary.

C. The removal/replacement of intact silicone gel-filled breast implants is considered experimental/investigational/unproven when performed solely for suspected autoimmune or connective tissue disease or for breast cancer prevention.

D. The removal/replacement of any type of breast implant related to personal anxiety or pain when the criteria outlined above has not been met is not medically necessary.

E. The removal/replacement of any type of breast implant is considered not medically necessary when the criteria outlined above has not been met.

Definitions:

None

Regulatory Citations:

UM2

Related Policies:

None

Related Documents:

CPT Codes*:

19328	Removal of intact mammary implant
19330	Removal of mammary implant material
19357	Breast reconstruction, immediate or delayed, with tissue expander, including subsequent expansion
19361	Breast reconstruction with latissimus dorsi flap, without prosthetic implant
19364	Breast reconstruction with free flap
19366	Breast reconstruction with other technique
19367	Breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM), single pedicle, including closure of donor site
19368	Breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM), single pedicle, including closure of donor site; with microvascular anastomosis (supercharging)
19369	Breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM), double pedicle, including closure of donor site
19370	Open periprosthetic capsulotomy, breast
19371	Periprosthetic capsulectomy, breast
19380	Revision of reconstructed breast
19396	Preparation of moulage for custom breast implant
L8600	Implantable breast prosthesis, silicone or equal
*CPT codes are subject to change as codes are retired or new ones developed	

References:

1. Lalani, L, Zenn, M, Sexton, D. Breast Implant Infections. Up to Date. September 9, 2020.
2. Nahabedian, M, Gutowksi, K. Complications of Reconstructive and Aesthetic Breast Surgery. Up to Date. October 14,2021, Literature review current through May 2025
3. MCG, General Recovery Guidelines 30th edition-General Surgery or Procedure GRG: SG-GS (ISC GRG)

Disclaimer:

Contract language as well as state and federal laws take precedence over any medical policy. Network Health coverage documents (i.e., Certificate of Coverage, Evidence of Coverage, Summary Plan Descriptions) outline contractual terms of the applicable benefit plan for each line of business and will be considered first in determining eligibility. Not all Network Health coverage documents are the same. Coverage may differ. Our Medicare membership follows applicable Centers for Medicare and Medicaid Services (CMS) coverage statements including National Coverage Determinations (NCD) and Local Coverage Determinations (LCD). Please refer to the CMS website at www.cms.gov.

Network Health reserves the right to review and update our medical policies on occasion as medical technologies are constantly evolving. The documentation of any brand name of a test, product and/or procedure in a medical policy is in no way an endorsement of that product; it is for reference only. Network Health's medical policies are for guidance and not intended to prevent the judgement of the reviewing medical director(s) nor dictate to health care providers how to practice medicine.

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