BlueCross BlueShield of North Carolina

Medicare Part C Medical Coverage Policy

Breast Implant Removal

Origination: July 31, 1992
Review Date: July 19, 2023
Next Review: July 2025

******This policy applies to all Blue Medicare HMO, Blue Medicare PPO, Blue Medicare Rx members, and members of any third-party Medicare plans supported by Blue Cross NC through administrative or operational services. ******

DESCRIPTION OF PROCEDURE OR SERVICE

The surgical removal of inflatable, saline-filled and silicone gel-filled prostheses is performed through sub-mammary or peri-areolar incisions.

POLICY STATEMENT

Coverage will be provided for breast implant removal when it is determined to be medically necessary, as outlined in the below guidelines and medical criteria.

BENEFIT APPLICATION

Please refer to the member's individual Evidence of Coverage (EOC) for benefit determination. Coverage will be approved according to the EOC limitations if the criteria are met.

Coverage decisions will be made in accordance with:

- The Centers for Medicare & Medicaid Services (CMS) National Coverage Determinations (NCDs);
- General coverage guidelines included in Original Medicare manuals unless superseded by operational policy letters or regulations; and
- Written coverage decisions of local Medicare carriers and intermediaries with jurisdiction for claims in the geographic area in which services are covered.

Benefit payments are subject to contractual obligations of the Plan. If there is a conflict between the general policy guidelines contained in the Medical Coverage Policy Manual and the terms of the member's particular Evidence of Coverage (EOC), the EOC always governs the determination of benefits.

INDICATIONS FOR COVERAGE

A. **Preauthorization by the Plan Review is required;**

B. Removal is covered due to complications from an implantation. Treatment for one (1) or more of the following conditions is considered to be medically necessary:
    1. Mechanical complication of breast prosthesis (i.e., rupture/leakage, broken or failed implant, implant extrusion);
    2. Infection or inflammatory reaction due to breast prosthesis; including infected breast implant or rejection of breast implant;
    3. Other complication of internal breast implant; including siliconoma, granuloma, interference with diagnosis of breast cancer, painful capsular contracture with disfigurement.

C. Breast Implant Removal may also be covered even when the implant insertion was not a covered service or when the removal is "not related to" the initial implantation. Complications requiring treatment after the member has been discharged from the hospital stay in which they received the implant are covered when reasonable and necessary. Coverage could be provided for subsequent inpatient stays or outpatient treatment. (Example: treatment of an infection at the surgical site that occurred following discharge from the hospital.)

D. All stages of reconstruction are covered for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance (The Women's Health and Cancer Rights Act of 1998). https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/whcra_factsheet

WHEN COVERAGE WILL NOT BE APPROVED

A. Breast malposition/asymmetry for cosmetic purposes.
B. Treatments of acute complications of a non-covered breast implant insertion if the services could be expected to have been included in the global fee, as postoperative visits.
C. Follow-up care and treatment of complications for a non-covered implant insertion that occur during the hospital stay for the implant insertion are not covered services.
D. After removal of a failed implant for complications, reinsertion not related to a previous mastectomy should be considered on a case-by-case basis and sent to the Medical Director for review.

BILLING/ CODING/PHYSICIAN DOCUMENTATION INFORMATION

This policy may apply to the following codes. Inclusion of a code in the section does not guarantee reimbursement.

Applicable codes: *19328, 19330, 19370, 19371, 19380, L8600*

The Plan may request medical records for determination of medical necessity. When medical records are requested, letters of support and/or explanation are often useful but are not sufficient documentation unless all specific information needed to make a medical necessity determination is included.

References:

1. Medicare Local Coverage Determination for Cosmetic and Reconstructive Surgery – LCD 34698; Effective Date 10/01/2015. Accessed via www.cms.gov. Retired on 11/13/2021.
2. Medicare Local Coverage Determination for Cosmetic and Reconstructive Surgery—LCD L33428; Effective Date: 10/1/2015. Accessed via www.cms.gov. Viewed on 06/27/2023.
3. Medicare Benefit Manual, Revision effective 11/6/14, Ch. 16, sections 120 and 180 accessed via www.cms.gov on 06/27/2023.

Policy Implementation/Update Information:
Revision Dates: November 26, 2001; February 18, 2004; August 24, 2005
September 2009: Removed Baker Classification & sever pain indication- not required by CMS.
Revision Dates: 1/05/11: No revisions or coding changes identified, policy is current with CMS guidelines.
Revision Date: 05/15/2013: Annual Review, Minor edits for clarification purposes.
Revision Date: 05/20/2015: Annual Review; Revised Benefit Application section for policy format consistency; Section: When Coverage Will Not Be Approved-removed item B, no longer CMS guidance referencing this as a limitation for coverage; NCD reference removed since no language within policy that references this CMS guidance. No CMS coverage criteria updates, no other revision to policy. October 29, 2015 updated LCD due to ICD-10 update only.
Revision Date: May 17, 2017: Annual Review. No updates to coverage criteria. Minor revisions only.
Revision Date: April 17, 2019; Annual Review. No updates to coverage criteria. Minor Revisions Only.
Revision Date: September 18, 2019; Staff Clarification. Removed Medical Director Review Requirement.
Revision Date: May 19, 2021; Annual Review/Staff Clarification Addition of When Coverage Will Not be Approved "D. After removal of a failed implant for complications, reinsertion not related to a previous mastectomy should be considered on a case by case basis and sent to the Medical Director for review."
Revision Date; July 21, 2021; Staff Update; Added: Indications for Coverage: D. All stages of reconstruction are covered for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance. (The Women's Health and Cancer Rights Act of 1998).
Revision Date: July 19, 2023: Annual Review; No CMS Update; Minor Revisions only.

Approval Dates:

Medical Coverage Policy Committee: July 19, 2023

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