



## Medicare Part C Medical Coverage Policy

### Breast Implant Removal

**Origination:** July 31, 1992  
**Review Date:** April 17, 2019  
**Next Review:** April, 2021

***\*\*\*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-aureolar 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 (E.O.C.) for benefit determination. Coverage will be approved according to the E.O.C. limitations if the criteria are met.

Coverage decisions will be made in accordance with:

- The Centers for Medicare & Medicaid Services (CMS) national coverage decisions;
- General coverage guidelines included in original Medicare manuals unless superseded by operational policy letters or regulations; and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 (E.O.C.), the E.O.C. always governs the determination of benefits.

### **INDICATIONS FOR COVERAGE**

- A. Preauthorization by the Plan Review is required;**
- B. Removal is covered when it is reasonable and medically necessary due to complications from an implantation, including but not limited to:**

1. Mechanical complication of breast prosthesis (i.e., rupture/leakage, 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.)

### **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.

### **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](http://www.cms.gov). Viewed LCD on 4/3/19.
2. Medicare Benefit Manual, Revision effective 11/6/14, Ch. 16, sections 120 and 180 accessed via [www.cms.gov](http://www.cms.gov) on 4/3/19.

#### 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.

**Approval Dates:**

Medical Coverage Policy Committee: September 18, 2019

Policy Owner: Carolyn Wisecarver, RN, BSN  
Medical Policy Coordinator