Coverage of any medical intervention discussed in a Dean Health Plan medical policy is subject to the limitations and exclusions outlined in the member's benefit certificate or summary plan description (SPD) and applicable state and/or federal laws.

Breast Implant Removal, Revision, or Reimplantation MP9580

Covered Service: Yes– Coverage for breast reconstruction and breast prosthesis following mastectomy or lumpectomy is governed by federal and/or state mandates (e.g. Women's Health and Cancer Rights Act 1998)

Prior Authorization Required: Breast implant removal, revision, or reimplantation associated with breast reconstruction following a mastectomy **AND** the procedure will be coded as such **does not** require prior authorization (see 1.0). All other breast implant removal, revision or reimplantation procedures **require** prior authorization.

Additional Information: For procedures related to female breast reduction and reduction mammaplasty see Female Breast Reduction Surgery and Reduction Mammaplasty MP9582. For procedures related to male gynecomastia surgery see Male Gynecomastia Surgery MP9581 . For breast implant surgery related to gender reassignment surgery see Gender Affirmation Procedures MP9642. For other breast surgeries see Plastic and Reconstructive Surgery MP9022 .

Coverage of all stages of reconstruction of the breast on which a mastectomy was performed and surgery and reconstruction of the other breast to produce a symmetrical appearance is required by applicable state and federal laws.

Reimplantation, when the original reason for implants was cosmetic, and not associated with a previous medically necessary mastectomy, is cosmetic and therefore, not covered.

Medicare Policy: Prior authorization is dependent on the member's Medicare coverage. Prior authorization is not required for Dean Care Gold and Select when this service is provided by participating providers. If a member has Medicare primary and Dean Health Plan as secondary coverage, a prior authorization is required.

BadgerCare Plus Policy: Dean Health Plan covers when BadgerCare Plus also covers the benefit.

Coverage of any medical intervention discussed in a Dean Health Plan medical policy is subject to the limitations and exclusions outlined in the member's benefit certificate or summary plan description (SPD) and applicable state and/or federal laws.

Dean Health Plan Medical Policy:

1.0 Unilateral or bilateral breast implant removal, revision or reimplantation when it is associated with breast reconstruction following mastectomy **AND** the procedure will be coded as such **does not** require prior authorization.

2.0 Breast implant removal or revision and is considered medically necessary when documentation in the medical record indicates **EITHER** of the following criteria are met, and initial implantation was not related to a procedure that was considered not medically necessary (see section 4.0):

2.1 The previous augmentation was with (a) **saline** implant(s) and **ONE** of the following criteria are also met:

2.1.1 Previous medically necessary implant, post mastectomy

2.1.2 Recurrent infection, not amenable to or unresponsive to treatment

2.1.3 Uncontrolled bleeding

2.1.4 Extrusion of the implant through the skin

2.1.5 Baker Class IV capsular contraction causing severe pain

2.1.6 Severe capsular contraction that interferes with routine mammography

2.1.7 Interference with the diagnostic evaluation of a suspected breast cancer or treatment of known breast cancer

2.1.8 Granuloma

2.1.9 Tissue necrosis secondary to implant

2.1.10 Breast implant-associated anaplastic large cell lymphoma

2.2 The previous augmentation was with (a) **silicone** implant(s) and **ONE** of the following criteria are also met:

2.2.1 Previous medically necessary implant, post mastectomy

2.2.2 Ruptured or leaking implant, confirmed on imaging studies (e.g., mammography, ultrasound or magnetic resonance imaging)

2.2.3 Recurrent infection, not amenable to or unresponsive to treatment

2.2.4 Uncontrolled bleeding

2.2.5 Extrusion of the implant through the skin

2.2.6 Baker Class IV capsular contraction causing severe pain

2.2.7 Severe capsular contraction that interferes with routine mammography

2.2.8 Interference with the diagnostic evaluation of a suspected breast cancer or treatment of known breast cancer

2.2.9 Siliconoma or granuloma

2.2.10 Tissue necrosis secondary to the implant

2.2.11 Breast implant-associated anaplastic large cell lymphoma

3.0 If medical necessity criteria for removal of a breast implant are met **unilaterally** (e.g. if criteria of 1.0, 2.0 or 3.0 are met), then removal of the implant in the other breast is covered if both are to be removed at the same time.

4.0 Removal, revision, or reimplantation of saline or silicone implants for the following reasons are generally considered not medically necessary:

4.1 Insertion or replacement is or was performed as a cosmetic or not medically necessary procedure

4.2 Breast implant malposition

4.3 Unsatisfactory aesthetic outcome

4.4 Patient desire for change of implant

	Committee/Source	Date(s)
Document Created:	Medical Policy Committee/Health Services Division	October 19, 2022
Revised:	Medical Policy Committee/Health Services Division	November 15, 2023
Reviewed:	Medical Policy Committee/Health Services Division Medical Policy Committee/Health Services Division	October 18, 2023 November 15, 2023

Published: 01/01/2024

Effective: 01/01/2024