KAISER PERMANENTE®
Mid-Atlantic States

Breast Implant Removal

Medical Coverage Policy

Utilization *ALERT*

- Prior to use of this MCP for evaluation of medical necessity, benefit coverage MUST be verified in the member's EOC or benefit document.
- For Medicare members, please refer to CMS guidelines through Medicare Coverage Database requirements.

I. Procedure / Service: Breast Implant Removal
Related Medical Coverage Policies: For transgender members without the diagnoses listed in section II, please see Transgender Surgery Medical Coverage Policies for DC (separate) or Maryland + Virginia situs members.

II. Diagnoses

A. Revision of cosmetic augmentation mammoplasty;
B. Breast reconstruction following a medically necessary mastectomy (e.g., mastectomy for breast cancer or a prophylactic mastectomy)

III. Specialty: Plastic Surgery

IV. Indications for Breast Implant Removal
Kaiser Permanente considers the removal of breast implants medically necessary for members who meet the following selection criteria:

A. For members who have undergone either cosmetic augmentation mammoplasty or breast reconstruction following a medically necessary mastectomy (e.g., mastectomy for breast cancer or prophylactic mastectomy for breast cancer risks), removal of a breast implant and capsulectomy or capsulotomy is a covered medical treatment for any of the following indications:
1. Extrusion of implant through skin;
2. Implants complicated by recurrent infections;
3. Implants with Baker Class III or Baker Class IV contracture;
4. Implants with severe contracture that interferes with mammography;
5. Intra- or extra-capsular rupture of implants;
6. Breast cancer in the implanted breast or remnant, or in the contralateral breast, where implant removal is necessary to excise the breast cancer; *and*
7. Breast implant-associated anaplastic large cell lymphoma or suspicion of diagnosis based on clinical evaluation.

B. If criteria are met for removal of breast implant on one side, coverage is provided for the other breast (removal of the implant and capsulectomy or capsulotomy) if removal on both sides occurs at the same time.

V. Exclusions/Restrictions

A. For diagnosis or treatment of autoimmune disease, the following procedures are not covered:
1. IgG (immunoglobulin) testing in connection with silicone implants (the development of IgG antibodies is neither specific to silicone implants nor indicative of autoimmune disorders);
2. Removal of silicone implants for autoimmune disease unless the member meets at least one of the selection criteria listed above (e.g., rupture of silicone-gel filled implant, etc.).

B. Reinsertion of breast implant is not covered if the implants were originally inserted for cosmetic purposes, even after a medically necessary removal (as in section IV. A)

VI. Referral Procedure

Request for the removal of breast implants for any of the following indications requires medical review:
- Baker Class III or IV contracture associated with severe pain that does not follow a medically necessary mastectomy;
- Implant removal for a lumpectomy that can be performed with the implant in place.

VII. Indications for Replacement and Reinsertion of Breast Implant

Insertion of breast implants, after a medically necessary removal, are covered for:

A. Replacement of breast implants inserted due to mastectomy for breast cancer or a prophylactic mastectomy;

B. Initial or replacement of breast implants for women with Poland's Syndrome

VIII. Baker Class Grading for Capsular Contractures

Class I	Augmented breast feels soft as a normal breast.
Class II	Augmented breast is less soft, and implant can be palpated but is not visible.
Class III	Augmented breast is firm, implant is palpable, and the implant (or distortion) is visible.
Class IV	Augmented breast is hard, painful, cold, tender, and distorted.

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Approval History

Date approved by RUMC*	**Date filed with the State of Maryland**	**Date of Implementation** (Ten days after filing)
05/29/2015	06/02/2015	06/15/2015
05/27/2016	05/31/2016	06/10/2016

Approval History

Effective June 01, 2016, state filing is no longer required per Maryland House Bill HB 798 – Health Insurance – Reporting

Date approved by RUMC	**Date of Implementation**
06/01/2017	06/01/2017
05/29/2018	05/29/2018
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*The Regional Utilization Management Committee received **delegated authority** to review and approve designated Utilization Management and Medical Coverage Policies by the Regional Quality Improvement Committee in 2011.

Note: Kaiser Permanente Mid-Atlantic States (KPMAS) include referral and authorization criteria to support primary care and specialty care practitioners, as appropriate, in caring for members with selected conditions. Whenever possible, Medical Coverage Policies are evidence-based and may also include expert opinion. Medical Coverage Policies are not intended or designed as a substitute for the reasonable exercise of independent clinical judgment by a practitioner in any particular set of circumstances for an individual member.

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