


<b>MEDICAL POLICY</b>	<b>Breast Implant Removal (Medicare Only)</b>	
<b>Effective Date: 6/1/2020</b>   <div style="text-align: right;">6/1/2020</div>	Section: SUR	Policy No: 448
	Medical Policy Committee Approved Date: 5/2020	
Medical Officer	Date	

See Policy CPT/HCPCS CODE section below for any prior authorization requirements

**SCOPE:**

Providence Health Plan, Providence Health Assurance, Providence Plan Partners, and Ayin Health Solutions as applicable (referred to individually as “Company” and collectively as “Companies”).

**APPLIES TO:**

Medicare Only

**MEDICARE POLICY CRITERIA**

The following Centers for Medicare & Medicaid Service (CMS) guidelines should be utilized for medical necessity coverage determinations. Click the link provided in the table below to access applicable medical necessity criteria. All listed guidelines apply.

Service	Medicare Guidelines
<i>Breast Implant Removal</i>	<ul style="list-style-type: none"> <li>Local Coverage Determination (LCD): Plastic Surgery (<a href="#">L37020</a>)<sup>1</sup></li> <li>Local Coverage Article: Billing and Coding: Plastic Surgery (<a href="#">A57222</a>)<sup>2</sup></li> </ul>

**CPT/HCPCS CODES**

<b>Medicare Only</b>	
Prior Authorization Required	
19328	Removal of intact mammary implant
19330	Removal of mammary implant material
19340	Immediate insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction
19342	Delayed insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction

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19370	Open periprosthetic capsulotomy, breast
19371	Periprosthetic capsulectomy, breast
19380	Revision of reconstructed breast

## INSTRUCTIONS FOR USE

Company Medical Policies serve as guidance for the administration of plan benefits. Medical policies do not constitute medical advice nor a guarantee of coverage. Company Medical Policies are reviewed annually and are based upon published, peer-reviewed scientific evidence and evidence-based clinical practice guidelines that are available as of the last policy update. The Companies reserve the right to determine the application of Medical Policies and make revisions to Medical Policies at any time. Providers will be given at least 60-days notice of policy changes that are restrictive in nature.

The scope and availability of all plan benefits are determined in accordance with the applicable coverage agreement. Any conflict or variance between the terms of the coverage agreement and Company Medical Policy will be resolved in favor of the coverage agreement.

## REGULATORY STATUS

### Mental Health Parity Statement

Coverage decisions are made on the basis of individualized determinations of medical necessity and the experimental or investigational character of the treatment in the individual case.

## REFERENCES

- Centers for Medicare & Medicaid Services. Local Coverage Determination (LCD): Plastic Surgery (L37020). <https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=37020>. Published 2017. Accessed 3/18/2020.
- Centers for Medicare & Medicaid Services. Local Coverage Article: Billing and Coding: Plastic Surgery (A57222). <https://www.cms.gov/medicare-coverage-database/details/article-details.aspx?articleId=57222>. Published 2019. Accessed 3/18/2020.