

Medical Policy



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***Current Policy Effective Date: 11/1/26**
(See policy history boxes for previous effective dates)

Title: Reconstructive Breast Surgery and Management of Breast Implants

Description

Reconstructive breast surgery is a surgical procedure that is designed to restore the normal appearance of the breast after surgery, accidental injury, or trauma. Breast reconstruction is distinguished from purely cosmetic procedures by the presence of a medical condition, e.g., breast cancer or trauma, which leads to the need for breast reconstruction.

Medical Policy Statement

Breast reconstruction procedures, e.g., breast reduction on the contralateral breast to achieve breast symmetry, capsular reconstruction, implant insertion and aesthetic flat closure, are **established** when criteria are met.

Removal of breast implant(s) is/are **established** when criteria are met.

Post-explantation procedures are **established** when criteria are met.

Inclusionary and Exclusionary Guidelines

Breast Reconstruction

Capsular Reconstruction ONLY (not including implant removal) Inclusions:

- Repair of Capsular contracture
 - Baker Class III contracture (only if the initial implant was for reconstructive purposes)
 - Baker Class IV contracture

Exclusions:

- All other conditions

Whole breast reconstruction Inclusions:

Breast reconstruction, including but not limited to breast reduction, implant insertion, or aesthetic flat closure, on the affected breast and/or contralateral breast to achieve symmetry for any **one** of the conditions listed below:

- Reconstruction for those who qualify for a medically necessary risk-reducing mastectomy*
 - Risk-reducing mastectomy considerations: (Please note this list is not all inclusive and is subject to change. See NCCN for updates*)
 - Chest wall radiation before age 30 years
 - Compelling family history
 - Those with a pathogenic/likely pathogenic variant in high-penetrance breast cancer susceptibility gene (please see NCCN *Genetic/Familial High-Risk Assessment: Breast, Ovarian, Pancreatic, and Prostate* for updates):
 - BRCA1, BRCA2, CDH1, PALB2, PTEN, STK11, and TP53
 - Personal diagnosis of Cowden syndrome in individuals with pathogenic/likely pathogenic variant identified. For those with clinical Cowden syndrome, consideration should be based on family history
 - Personal diagnosis of Li-Fraumeni syndrome
 - Congenital defects, such as breast agenesis or with surgical correction of chest wall deformity causing functional deficit in Poland Syndrome
 - Mastectomy (including radical, modified radical, subcutaneous, simple and partial) due to current diagnosis of breast cancer
 - Medically necessary mastectomy secondary to family or personal history of cancer of the breast
 - Accidental injury/trauma to the breast(s)
 - After implant removal when:
 - The implant is removed for cancer or suspected cancer associated with the implant as indicated in the chart below.
- OR**
- The implant removal meets “Implant Removal” criteria below and the original implant was placed for reconstructive purposes
 - Revision of breast reconstructive surgery is established when the purpose of the revision is not solely cosmetic. Reconstructive surgery is a breast cancer rehabilitative service intended to restore physical appearance and to ameliorate the debilitating effects of breast cancer treatment.

**Note: Blue Cross Blue Shield of Michigan and Blue Care Network follow National Comprehensive Cancer Network (NCCN) 2A and above recommendations. Due to frequent NCCN updates, please refer to the appropriate guideline for the most recent standards and intended coverage.*

Exclusions:

- Breast reconstruction that does not meet the above criteria

Implant Removal (only on the affected breast unless the individual was diagnosed with Breast Implant-Associated Anaplastic Large Cell Lymphoma (BIA-ALCL)/suspected BIA/ALCL or other cancers associated with the breast implant capsule)

Inclusions:

Documentation of one of the following:

- Baker Class III contractures (only if the initial implant was for reconstructive purposes)
- Baker Class IV contracture
- Recurrent infection
- Extrusion
- Silicone implant rupture
- Saline implant rupture (only if the initial implant was for reconstructive purposes)
- Surgery or radiation therapy for a new or recurrent diagnosis of breast cancer
- Breast Implant-Associated Anaplastic Large Cell Lymphoma (BIA-ALCL). Bilateral removal is covered if requested
- Suspected BIA-ALCL (symptoms of pain, swelling, redness or lump in the area of the implant; seroma; asymmetry of the breast). Bilateral removal is covered if requested
- B-cell lymphoma associated with the breast implant capsule. Bilateral removal is covered if requested
- Squamous Cell Carcinoma associated with the breast implant capsule. Bilateral removal is covered if requested.
- Textured-surface breast implant, when the surgeon determines it is in the best interest of the patient
- Implants or tissue expanders that have been withdrawn from the market at the request of the FDA (i.e., Allergan BIOCELL®)

Exclusions:

- Not meeting the above criteria
- Preventative explantation in asymptomatic individuals to reduce remote risk of anaplastic large cell lymphoma, B cell lymphoma, or squamous cell carcinoma
- Prophylactic removal not associated with textured surface implants
- See chart below for indications where removal of breast implants are considered not medically necessary

Post-explantation Procedures**Inclusions:**

- Reimplantation of implants when the original surgery was for reconstructive purposes
- Autologous reconstruction when the original surgery was for reconstructive purposes

Exclusions:

- Not meeting the above criteria
- See chart below for indications where post-explantation procedures are considered not medically necessary

The following chart should facilitate determination of the medical necessity of implant removal and post-explantation procedures. Yes, indicates that the implant removal would be considered medically necessary, given the symptoms, type of implant, and original indication for implantation..:

Indication for Removal	Original surgery was for <u>reconstructive</u>	Original surgery was for <u>reconstructive</u>	Original surgery was for <u>cosmetic</u> purposes using silicone implant	Original surgery was for <u>cosmetic</u> purposes using saline implant
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	purposes using silicone implant	purposes using saline implant		
Systemic Illness –				
• Connective tissue disease	No	No	No	No
• Autoimmune disease	No	No	No	No
• Rheumatic conditions	No	No	No	No
• Neurologic symptoms	No	No	No	No
• Fibromyalgia	No	No	No	No
• Chronic fatigue syndrome	No	No	No	No
• Patient anxiety	No	No	No	No
Absolute Medical Indications				
• Implant Rupture*	Yes	Yes	Yes	No
• Due to Baker Class IV contracture	Yes	Yes	Yes	Yes
• Recurrent infection	Yes	Yes	Yes	Yes
• BIA-ALCL Diagnosis	Yes	Yes	Yes	Yes
• Suspected BIA-ALCL based on symptoms	Yes	Yes	Yes	Yes
• B-cell lymphoma associated with the breast implant capsule	Yes	Yes	Yes	Yes
• Squamous Cell Carcinoma associated with the breast implant capsule	Yes	Yes	Yes	Yes
• Extruded implant	Yes	Yes	Yes	Yes
• Surgery or radiation therapy for breast cancer	Yes	Yes	Yes	Yes
• Other Indications				
• Due to Baker Class III contracture	Yes	Yes	No	No
• Due to Pain**	No	No	No	No
• Textured-surface breast implants, when the surgeon determines it is in the best interest of the patient	Yes	Yes	Yes	Yes
• To reduce remote risk of anaplastic large cell lymphoma in individuals with smooth surface breast implants	No	No	No	No
• To reduce remote risk of B cell lymphoma	No	No	No	No
• To reduce remote risk of Squamous Cell Carcinoma	No	No	No	No

Post-Explantation Procedures				
Reimplantation of implants	Yes	Yes	No	No
Autologous reconstruction	Yes	Yes	No	No

*Rupture of implants requires documentation with an imaging study, such as mammography, MRI or ultrasonography. Lack of imaging confirmation of rupture in association with persistent local symptoms requires a case-by-case consideration.

**Pain as an isolated symptom is an inadequate indication of implant removal. The pain should be related to the Baker Classification or a diagnosis of rupture.

CPT/HCPCS Level II Codes

Established codes:

L8600*	C1789**	S2066	S2067	S2068	
11920	11921	11922	14301***	14302***	
19301	19302	19303	19305	19306	19307
19316	19318	19325	19328	19330	19340
19342	19350	19355	19357	19361	19364
19367	19368	19369	19370	19371	19380
19396					
19499***					

****Note: Codes may not be considered a medical benefit but may be considered a facility benefit. Claims should be submitted with a revenue code.***

*****Note: Code C1789 may not be covered by all contracts or certificates. Please consult customer or provider inquiry resources at BCBSM or BCN to verify coverage.***

****** When used to represent aesthetic flat closure***

Other codes (investigational, not medically necessary, etc.):

N/A

Notes:

- Code(s) may not be covered by all contracts or certificates. Please consult customer or provider inquiry resources at BCBSM or BCN to verify coverage.*
- Individual policy criteria determine the coverage status of the CPT/HCPCS code(s) on this policy. Codes listed in this policy may have different coverage positions (such as established or experimental/investigational) in other medical policies.*

Background

Reconstructive Breast Surgery

Reconstructive breast surgery is defined as a surgical procedure that is designed to restore the normal appearance of the breast after surgery, accidental injury, or trauma. Breast reconstruction is distinguished from purely cosmetic procedures by the presence of a medical condition, e.g., breast cancer or trauma, which leads to the need for breast reconstruction.

The most common indication for reconstructive breast surgery is prior mastectomy; in fact, benefits for reconstructive breast surgery in these individuals are a mandated benefit in many states. Breast reconstruction may include surgery on the non-affected breast (including breast reduction or augmentation) for achieving symmetry of both the affected and the contralateral breast. Breast reconstruction may also be medically necessary, not cosmetic, when performed to correct congenital defects such as the complete absence of breast tissue (Poland's syndrome), developmental abnormalities, trauma, infection or following other therapeutic surgeries, such as breast reduction procedures.

The breast may be reconstructed using autologous tissues, such as a free flap, a latissimus dorsi flap, or more commonly, using a transverse rectus abdominis flap. Nipple areola reconstruction or nipple tattooing may also be considered reconstructive breast surgery. Since the purpose of reconstructive breast surgery is to restore the normal appearance of the breast, on some occasions procedures are performed on the contralateral, normal breast to achieve symmetry, such as mastopexy and reduction mammoplasty. These procedures fall into the category of reconstructive breast surgery when performed in conjunction with a contralateral mastectomy for cancer with associated reconstruction.

Breast reconstruction services may include the insertion of breast implants or the use of autologous tissue. Breast implants are not lifetime devices. Eventually, most patients will need to undergo at least one or more surgical procedures for routine implant replacement. This may be necessary for reasons ranging from breast implant deflation to medical complications including implant hardening or encapsulation, as well as leaking or frank rupture. Capsular contracture is the most common local complication of breast implantation.

Breast contractures are typically graded according to the Baker Classification system:

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

For individuals who do not desire reconstruction with autologous tissue or implants, aesthetic flat closure (also called post-mastectomy chest wall reconstruction) is an option. It can be done at the time of mastectomy (immediate) or a few months afterward (delayed). During an aesthetic flat closure, a surgeon removes extra skin, pockets of fat, or excess tissue and tightens and smooths out the remaining tissue to create a flat chest wall contour. Sometimes, after immediate flat closure, some individuals need a second procedure to minimize a scooped-out look or smooth out divots or indentations.³⁹

Complications of Breast Implants

Complications of breast implants are common and may require explantation. Determining the medical necessity of explantation requires documentation of the type of implant and its original indication, whether reconstructive or cosmetic. The underlying principle is that cosmetic implants require explantation only for absolute medical indications that pose significant health

consequences, while the criteria for explantation of reconstructive implants are broader. Complications can be subdivided into local and systemic.

Summary of Evidence

For individuals who have undergone breast surgery or who have experienced injury or trauma to the breast who receive breast reconstruction surgery, the evidence includes case series. Relevant outcomes are overall survival, disease-specific survival, morbid events, functional outcomes, health status measures, quality of life, treatment-related mortality, and treatment-related morbidity. The evidence supports the conclusion that breast reconstruction improves psychosocial outcomes, such as anxiety, social functioning, and perception of body image. The evidence is sufficient to determine that the technology results in an improvement in the net health outcome.

For individuals with breast implants and documented implant rupture, infection, extrusion, Baker contracture, cancer associated with breast implant, suspected BIA-ALCL, or surgical or radiation treatment of breast cancer who receive breast implant explantation the evidence includes case series. Relevant outcomes are overall survival, disease-specific survival, morbid events, functional outcomes, health status measures, quality of life, treatment-related mortality, and treatment-related morbidity. Local complications of breast implants are common and may require explantation. The medical necessity of implant explantation is dependent on the type of implant, the indication for removal, and the original indication for implantation. The evidence is sufficient to determine that the technology results in an improvement in the net health outcome.

For asymptomatic individuals with breast implants without documented implant rupture, infection, extrusion, Baker contracture, cancer associated with breast implant, or surgical treatment of breast cancer who receive preventive breast implant explantation of smooth surface breast implants to reduce remote risk of anaplastic large cell lymphoma (ALCL), the evidence includes prospective and retrospective epidemiological cohort studies, case series, and systematic reviews. Relevant outcomes are overall survival, disease-specific survival, morbid events, functional outcomes, health status measures, quality of life, treatment-related mortality, and treatment-related morbidity. Systematic reviews of epidemiological studies and government regulatory epidemiologic databases have evaluated the risk of breast implant-associated (BIA)-ALCL. Estimates varied widely, with the highest incidence associated with textured implant products that are no longer marketed in the United States. No cases occurred solely in the context of a smooth surface breast implant. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals with breast implants without documented implant rupture, infection, extrusion, Baker contracture, cancer associated with the breast implant, or surgical treatment of breast cancer who undergo preventive explantation of textured-surface breast implants to reduce the risk of breast implant-associated anaplastic large cell lymphoma, the American Association of Plastic Surgeons published evidence-based recommendations in 2023 on the management and prevention of BIA-ALCL. They stated that in some patients with macrot textured implants, there may be a relative indication for explantation. They went on to state that the final decision for explantation with or without capsulectomy should be shared between patient and surgeon following an evaluation of the patient's goals balanced against the perceived benefits of the

surgery and an individual surgical risk assessment. The evidence is sufficient to determine that the technology results in an improvement in the net health outcome.

For individuals with breast implants without documented implant rupture, infection, extrusion, Baker contracture, cancer associated with breast implant, or surgical treatment of breast cancer who receive preventive breast implant explantation to reduce remote risk of B cell lymphoma associated with the breast implant, the evidence includes case reports. Relevant outcomes are overall survival, disease-specific survival, morbid events, functional outcomes, health status measures, quality of life, treatment-related mortality, and treatment-related morbidity. Recent case reports and small case series (N=3 to 8 cases) have described B cell lymphomas occurring in individuals with breast implants. More data are needed to determine if breast implants are associated with an increased risk of B cell lymphoma. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals with breast implants without documented implant rupture, infection, extrusion, Baker contracture, cancer associated with breast implant, or surgical treatment of breast cancer who receive preventive breast implant explantation to reduce remote risk of BIA-squamous cell carcinoma (SCC), the evidence includes 2 systematic reviews of a few case reports. Relevant outcomes are overall survival, disease-specific survival, morbid events, functional outcomes, health status measures, quality of life, treatment-related mortality, and treatment-related morbidity. Recent case reports and small case series have described BIA-SCC occurring in individuals with breast implants, albeit it is a very rare occurrence. More data are needed to determine if breast implants are associated with an increased risk of squamous cell carcinoma. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

Rationale

Evidence reviews assess the clinical evidence to determine whether the use of a technology improves the net health outcome. Broadly defined, health outcomes are length of life, quality of life, and ability to function including benefits and harms. Every clinical condition has specific outcomes that are important to individuals and to managing the course of that condition. Validated outcome measures are necessary to ascertain whether a condition improves or worsens; and whether the magnitude of that change is clinically significant. The net health outcome is a balance of benefits and harms. The following is a summary of the key literature to date.

Breast Reconstruction Surgery

Clinical Context and Therapy Purpose

The purpose of breast reconstruction surgery in individuals who have undergone breast surgery or who have experienced injury or trauma to the breast is to provide a treatment option that is an alternative to usual treatment without reconstructive breast surgery.

Review of Evidence

Complications of breast implants are common and may require explantation.⁴ Determining the medical necessity of explantation requires documentation of the type of implant and its original indication, i.e., whether reconstructive or cosmetic. The basic underlying principle is that cosmetic implants require explantation only for absolute medical indications that pose significant health consequences, while the criteria for explantation of reconstructive implants are broader. Since the purpose of reconstructive implants is the restoration of normal breast appearance, in a small subset of patients explantation may be warranted in cases of unsatisfactory aesthetic outcome.

Complications can be subdivided into local or systemic complications. Local complications include implant contracture, rupture, extrusion, or infection, breast implant-associated anaplastic large cell lymphoma (BIA-ALCL), or other cancers, including squamous cell carcinoma (SCC) and various lymphomas, that develop in the scar tissue (capsule) that forms around the breast implants. Extrusion, rupture of a silicone implant, recurrent infection, or confirmed or suspected BIA-ALCL are considered absolute medical indications for explantation in all cases, whether the implant was originally cosmetic or not. Explantation of a ruptured saline implant is considered medically necessary only in the setting of prior reconstruction. Since normal saline is physiologic, rupture poses no health threat, and explantation would not be considered medically necessary in patients with cosmetic implants.

However, a ruptured saline implant compromises the aesthetic outcome and thus explantation may be considered appropriate in cases of reconstructive implants.

Rupture of the breast implant may be difficult to document, but physical exam, mammography, ultrasonography, or magnetic resonance imaging has been used. There is no consensus on which method affords the best sensitivity and specificity.^{5,6,7} Although it has been suggested that older implants are associated with a higher incidence of rupture, there is no consensus that screening implants for rupture is warranted. Specifically, in the hearings on breast implants by the U.S. Food and Drug Administration (FDA), held in 1992, the FDA did not recommend screening for asymptomatic ruptures.

Instead, workup for a potential rupture is typically initiated at the onset of local symptoms, such as sudden change in the size or consistency of an implant, or the development of local pain.

Kandi et al⁴⁰ summarized the growing trend of opting out of breast reconstruction post-mastectomy, known as “going flat”. Individuals who choose this option seek a flat, smooth chest contour rather than reconstruction with implants or tissue flaps. Factors influencing this choice include personal comfort, a desire to avoid further surgeries, and aesthetic preferences. The piece emphasized the importance of patient autonomy and encourages clear communication with surgeons to achieve a satisfactory outcome for those choosing not to reconstruct.

Section Summary: Breast Reconstruction Surgery

Breast reconstruction is intended for patients undergoing mastectomy for breast cancer, or who have an injury or trauma to the breasts. For the general population of women undergoing mastectomy, the evidence supports the conclusion that breast reconstruction improves psychosocial outcomes, such as anxiety, social functioning, and perception of body image.

Breast Implant Explantation in Individuals with Implant Rupture, Infection, Extrusion, Baker Contracture, Cancer Associated with Breast Implant or Surgical Treatment of Breast Cancer

Clinical Context and Therapy Purpose

The purpose of breast explantation in individuals with implant rupture, infection, extrusion, Baker contracture, cancer associated with breast implant or surgical treatment of breast cancer is to provide a treatment option that is an alternative to usual treatment without expantation.

Review of Evidence

Local complications of breast implants are frequent and may require removal of the implant. Contracture is the most common local complication of breast implants. Contractures are somewhat subjective findings, and can be graded according to the Baker classification

Grade IV contractures interfere with adequate mammography screening and are the cause of local symptoms, and thus their presence constitutes a health risk.⁹ Therefore, explantation may be considered medically necessary in all cases, regardless of whether the implant was originally inserted for cosmetic or reconstructive purposes. Grade III contractures, which describe firm, palpable implants, do not interfere with mammography; therefore, explantation of these implants is not considered an absolute indication for explantation. However, since Grade III contractures have an impact on the normal appearance of the breast, explantation may be appropriate in implants inserted for reconstructive purposes, since the goal of restoration of the normal appearance of the breast is not achieved.

In 2016, the World Health Organization designated BIA-ALCL as a rare T-cell lymphoma that can develop following breast implants. Data suggest that BIA-ALCL occurs more frequently with breast implants with textured surfaces than in those with smooth surfaces. BIA-ALCL patients most commonly present with a peri-prosthetic fluid collection or capsular mass at an average of eight to ten years following implantation. Other symptoms include breast enlargement or swelling, change in breast shape or change in the look or feel of the area around the implant. Patients with confirmed BIA-ALCL should undergo removal of the implant and surrounding scar capsule. In rare cases, BIA-ALCL may metastasize; treatment may include chemotherapy, radiotherapy, and lymph node dissection. Therefore, explantation is considered medically necessary in all suspected or diagnosed cases of BIA-ALCL regardless of whether the implant was originally inserted for cosmetic or reconstructive purposes.

Rarely, other histological types of lymphoma are reported in association with breast implants. There have been anecdotal cases of extranodal NK/T-cell lymphoma, nasal type, and 6 cases of B-cell lymphoma including follicular lymphoma, intravascular large-cell lymphoma, diffuse large B-cell lymphoma, marginal zone lymphoma, and plasmablastic lymphoma. Evans et al (2020), in an effort to expand understanding of the rare B-cell lymphoma presentation, described clinical and pathological features in 3 additional individuals. The authors stated that determining the etiology and risk factors for B-cell lymphomas associated with breast implants

is highly challenging, given the limited number of reported cases.²⁹ Explantation may be considered medically necessary in all cases of lymphoma associated with breast implants, regardless of whether the implant was originally inserted for cosmetic or reconstructive purposes.

The U.S. Food and Drug Administration (FDA) provided an update on March 22, 2023 on reports of squamous cell carcinoma (SCC) in the scar tissue (capsule) that forms around breast implants. The FDA is aware of 19 cases of SCC in the capsule around the breast implant from published literature. While the FDA continues to believe that occurrences of SCC in the capsule around the breast implant may be rare, the cause, incidence and risk factors remain unknown.³ Explantation may be considered medically necessary in all cases of SCC in the capsule of the breast implant regardless of whether the implant was originally inserted for cosmetic or reconstructive purposes.

Potential systemic complications of implants, most prominently various connective tissue diseases or chronic fatigue syndrome, have been controversial in the past. In particular, it had been hypothesized that leakage of silicone, due either to an implant rupture or to “bleeding” of silicone through an intact capsule, may incite an autoimmune response with the development of systemic symptoms. However, large epidemiologic studies have not demonstrated that women with breast implants are overrepresented among all those with connective tissue disease.^{10,11,12,13} In addition, there are inadequate empiric studies to demonstrate that removal of breast implants is associated with resolution of systemic symptoms. As a result of this evidence, there is not considered to be a relationship between silicone breast implants and systemic disease, particularly connective tissue disease.

Patients with cosmetic implants may develop breast cancer. While lumpectomy can be accomplished without removal of the implant, in general, explantation as an adjunct to surgical treatment for breast cancer would be considered medically necessary. However, explantation is not necessary in patients who are undergoing chemotherapy or radiation therapy for breast cancer.

Once an implant has been removed, patients who have originally undergone reconstructive implantation are candidates for additional reconstructive breast surgery, either insertion of another breast implant, or for autologous reconstruction of the breast, as described here. Patients who have originally undergone implantation of a cosmetic breast implant are not candidates for additional reconstructive breast surgery after explantation.

Section Summary: Breast Implant Explantation in Individuals with Implant Rupture, Infection, Extrusion, Baker Contracture, Cancer Associated with Breast Implant or Surgical Treatment of Breast Cancer

Local complications of breast implants are common and may require explantation. The medical necessity of implant explantation is dependent on the type of implant, the indication for removal, and the original indication for implantation.

Preventive Breast Implant Explantation to Reduce Remote Risk of Anaplastic Large Cell Lymphoma

Clinical Context and Therapy Purpose

The purpose of breast implant explantation in asymptomatic individuals is to reduce remote risk of anaplastic large cell lymphoma (ALCL).

Anaplastic large cell lymphoma is a form of T-cell, non-Hodgkin lymphoma. According to National Comprehensive Cancer Network (NCCN) Consensus Guidelines published in 2019, breast implant-associated ALCL (BIA-ALCL) is commonly indolent and slow-growing, with an excellent prognosis (overall survival rate 94% and 91% at 3 and 5 years, respectively), especially when treated with surgery.¹⁴ The most common presentation is a large spontaneous periprosthetic fluid collection occurring at least 1 year and on average 7 to 10 years following implantation.

Review of Evidence

Systematic Reviews

Lynch et al (2021) conducted a systematic review of epidemiological studies of the risk of BIA-ALCL.¹⁵ In addition to published literature, the study authors collected regulatory agency epidemiologic data, including from the FDA’s Manufacturer User Facility Device Experience (MAUDE) database and the American Society of Plastic Surgeons (ASPS) Patient Registry and Outcomes For breast Implants and Anaplastic large cell lymphoma (ALCL) etiology and Epidemiology (PROFILE) registry.

Eight studies met inclusion criteria (Table 1). The heterogeneity of reported data prevented meta-analysis and limited the calculation of combined risk estimates. The authors presented estimates by geographic location and by device. Two studies conducted in the US provided data to calculate the incidence rate, with estimates ranging from 1.46 per 100,000 person-years to 0.203 per 100,000 person-years (2.03 per million). The patient-specific cumulative risk within the US market ranged from 1.79 per 1,000 to 2.82 per 1,000. In the US, FDA estimates ranged from 1 in 3,817 to 1 in 30,000.

The authors concluded that population-based cohort studies and government databases consistently revealed an association between textured-surface breast implants and the incidence of BIA-ALCL. There was significant global geographic and manufacturer-specific variation in the risk of disease, but the data confirmed that Allergan textured devices carry substantially higher risk profiles than other devices regardless of population studied. No cases occurred solely in the context of a smooth surface breast implant. The evidence was limited by incomplete clinical data and a lack of long-term follow-up. The authors recommended greater standardization of reporting outcomes, and improving long-term follow-up to help establish more robust data.

Table 1. Epidemiological Studies Included in Lynch et al (2021)¹⁵,

Study	Location	Study Design	Years	ALCL Cases	Sample Size
Largent et al (2011) ¹⁶	US	Retrospective cohort	1994-2007	3	NR
McGuire et al (2016) ¹⁷	US	Prospective cohort	Through-2014	8	17,656

Cordeiro et al (2020) ¹⁸	US	Retrospective cohort	1992-2019	10	3,456
Nelson et al (2020) ¹⁹	US	Retrospective cohort	1991-2017	11	9373
De Boer et al (2018) ²⁰	The Netherlands	Retrospective cohort	1990-2016	43	3000
Campanale et al (2018) ²¹	Italy	Retrospective cohort	2015-2017	22	10,000,000
Loch-Wilkinson et al (2019) ²²	Australia	Retrospective cohort	2015-2019	104	NR
Doren et al (2018) ²³	US	Case Series	1996-2015	100	3,000,000

ALCL: anaplastic large cell lymphoma; NR: not reported.

Additional systematic reviews have similarly concluded that while rare, the incidence of BIA-ALCL is increasing, but limitations in the evidence base preclude an accurate estimation of its incidence.^{24,25,26}

Regulatory Epidemiologic Database

In 2023, McCarthy et al published an updated report from the PROFILE registry.²⁷ From August 2012 to August 2020, a total of 330 suspected or confirmed cases of BIA-ALCL were reported to the registry, including 144 cases newly reported since the 2018 publication included in the systematic reviews discussed above. All cases occurred in individuals with a history of a textured device; there were no cases reported in an individuals with a confirmed smooth-only device history.

Section Summary: Preventive Breast Implant Explantation to Reduce Remote Risk of Anaplastic Large Cell Lymphoma

Systematic reviews of epidemiological studies and government regulatory epidemiologic databases have evaluated the risk of BIA-ALCL. Estimates varied widely, with the highest incidence associated with textured implant products that are no longer marketed in the US. The certainty of the evidence is limited by insufficient follow-up duration to assess risk and lack of standardization of clinical outcome data collection. Additionally, there is no evidence evaluating whether removal of implants reduces ALCL risk, and there are known risks of explantation surgery.

Preventive Breast Implant Explantation to Reduce Remote Risk of B Cell Lymphoma

Clinical Context and Therapy Purpose

The purpose of breast implant explantation in asymptomatic individuals is to reduce the remote risk of B cell lymphoma.

Review of Evidence

Case Reports

Recent case reports and small case series (N=3 to 8 cases) have described B cell lymphomas occurring in individuals with breast implants.^{28,29,30} More data are needed to determine if breast implants are associated with an increased risk of B cell lymphoma.

Section Summary: Preventive Breast Implant Explantation to Reduce Remote Risk of B Cell Lymphoma

The evidence is limited to case reports and small case series describing occurrences of B cell lymphoma in individuals with breast implants.

Preventive Breast Implant Explantation to Reduce Remote Risk of Squamous Cell Carcinoma (SCC)

Clinical Context and Therapy Purpose

The purpose of breast implant explantation in asymptomatic individuals is to reduce the remote risk of squamous cell carcinoma.

Review of Evidence

Systematic Reviews

Niraula et al (2023) conducted a systematic review of published cases of BIA-SCC to describe the relevant clinical data and outcomes.³¹ The review included 14 articles with 18 known cases of BIA-SCC with symptoms typically emerging around 21 years after breast implantation. The estimated 6-month mortality rate was 11.1%, while the 12-month mortality rate was 23.8%. However, the authors note that the 6-month mortality rate should be interpreted cautiously due to the limited sample size. Additionally, they state that the rate is lower than what the ASPS has reported without a clear rationale for this discrepancy.

Santanelli et al (2024) conducted a systematic review of epidemiological studies and case series of the risk of BIA-SCC to estimate prevalence, incidence rate (IR), and risk.³² The authors reported that the U.S. BIA-SCC prevalence is estimated as 0.61 per 100,000 (95% CI, 0.2:100,000 to 1.3:100,000), with a lifetime risk of 1:164,884 (95% CI, 0.2:100,000 to 5.6:100,000), and an IR of 0.002 per 100,000 person-years.

Regulatory Epidemiologic Database

As of March 22, 2023, the FDA recommends that any suspected or confirmed cases of BIA-SCC, lymphomas, or any other cancers around the breast implant be reported to the FDA's MAUDE database and the device manufacturer and the ASPS PROFILE registry.³³

Section Summary: Preventive Breast Implant Explantation to Reduce Remote Risk of Squamous Cell Carcinoma

The evidence is limited to case reports and small case series describing occurrences of BIA-SCC in individuals with breast implants.

Supplemental Information

Practice Guidelines and Position Statements

Guidelines or position statements will be considered for inclusion in 'Supplemental Information' if they were issued by, or jointly by, a US professional society, an international society with US representation, or National Institute for Health and Care Excellence (NICE). Priority will be

given to guidelines that are informed by a systematic review, include strength of evidence ratings, and include a description of management of conflict of interest.

American Association of Plastic Surgeons

In 2023, The American Association of Plastic Surgeons published a consensus statement on breast implant-associated anaplastic large-cell lymphoma (BIA-ALCL).¹ Recommendations were based on a systematic review of the literature and focused on textured-surface breast implants. Recommendations relevant to this evidence opinion included the following:

- "Use of macrotextured breast implants should be discontinued and surveillance of patients who received breast implants, smooth and textured surface, should be employed."
- "Implant manufacturers should disclose publicly or for independent academic analysis, their internal surveillance data, detailing both the number of BIA-ALCL cases reported to them and their country-specific and global sales and implantation figures for their respective breast implants."
- "No change in the use of smooth-surface breast implants is warranted at this time based upon BIA-ALCL."
- "Currently available evidence is sufficient to determine that the association of textured breast implants to BIA-ALCL does meet the definition of causation based on the Bradford Hill criteria."
- "An en bloc capsulectomy with explantation, resection of associated masses and excision of involved lymph nodes is recommended for patients with BIA-ALCL, when deemed appropriate as part of a multidisciplinary evaluation."
- "Based on the potential for risk reduction, prophylactic explantation of macrotextured surface implants can be deemed reasonable. Furthermore, after implementing a risk stratification and surveillance plan, coupled with an informed discussion about the benefits of surgery, it may also be considered reasonable for explantation of any type of textured implant...It's important to differentiate between the notion of a procedure being reasonable—referring to the potential to mitigate risk—and it being advisable. While we acknowledge the reasonableness of these procedures, the determination of their advisability rests solely with the discretion of the surgeon in consultation with the patient." The panel further noted, "Importantly, this was based on a consensus recommendation as evidence remains limited on risk reduction. Different textured implants carry very different risks for BIA-ALCL, and patients differ in their comorbidities and risk tolerance. The final decision for explantation with or without capsulectomy should be shared between patient and surgeon following an evaluation of the patient's goals balanced against the perceived benefits of the surgery and an individual surgical risk assessment."
- "Prophylactic explantation of the contralateral textured breast implant is recommended in patients with a confirmed BIA-ALCL diagnosis due to the risk of unrecognized or occult bilateral disease."
- "Preemptive notification of the risk of developing BIA-ALCL is recommended for all patients with textured breast implants."

American College of Radiology

In 2023, the American College of Radiology published Appropriateness Criteria for initial imaging in asymptomatic and symptomatic individuals with breast implants.³⁴ This was most recently updated in 2025.³⁵ The document includes the following statements as listed in Table 2:

Table 2. Key Recommendations of ACR Appropriateness Criteria Related to Breast Implant Evaluation

Key recommendations
Imaging is usually not appropriate for initial imaging in an asymptomatic female or transfeminine adult patient of any age for saline breast implant evaluation.
US breast is usually appropriate for initial imaging in a female or transfeminine adult patient younger than 30 years of age with saline breast implant and suspected implant rupture.
US breast is usually appropriate for initial imaging in a female or transfeminine adult patient 30 to 39 years of age with saline breast implant and suspected implant rupture. The panel did not agree on recommending diagnostic DBT or diagnostic mammography in this clinical scenario. There is insufficient medical literature to conclude whether or not these patients would benefit from these two modalities in this scenario. Imaging in this patient population is controversial but may be appropriate.
Diagnostic DBT and diagnostic mammography are usually appropriate for initial imaging in a female or transfeminine adult patient age 40 years or older with saline breast implant and suspected implant rupture. These procedures are alternative (i.e., only one of these two procedures will be ordered).
Imaging is usually not appropriate for initial imaging in an asymptomatic female or transfeminine adult patient of any age for silicone breast implant evaluation less than 5 years after implant placement.
Initial imaging with US breast or MRI breast without IV contrast is usually appropriate for an asymptomatic female or transfeminine adult of any age for silicone breast implant evaluation at 5 to 6 years after implant placement. Follow-up imaging is performed every 2 to 3 years after initial negative imaging.
MRI breast without IV contrast is usually appropriate for initial imaging in a female or transfeminine adult younger than 30 years of age for silicone breast implant evaluation with a suspected implant complication. The panel did not agree on recommending US breast in this clinical scenario.

ACR: American College of Radiology; DBT: digital breast tomosynthesis; IV: intravenous; MRI: magnetic resonance imaging; US: ultrasound.

National Comprehensive Cancer Network (NCCN) Guidelines Version 4.2026 Breast Cancer included a section in their breast cancer guidelines that was titled “Principles of Breast Reconstruction Following Surgery” which included the following relevant statements: ³⁶

- Breast reconstruction is elective and patients may choose to not have breast reconstruction. Individual patients present preoperatively with a variety of factors that may impact the choice of reconstruction, the risk of complications, donor site morbidity, and aesthetic result. Each of these factors must be taken into account, along with patient desire, to choose the optimal method of reconstruction.
- Selection of reconstruction option is based on an assessment of cancer treatment, patient body habits, obesity, smoking history, comorbidities, and patient concerns.
- The patient may have a strong feeling towards one form of reconstruction after being given the options. Breast reconstruction should be a shared decision.

Breast implant-associated anaplastic large cell lymphoma (BIA-ALCL) There exists an association between certain types of textured breast implants and BIA-ALCL. The risk appears to vary based on the method of texturing. Patients with a past or current history of textured implants should follow up with their reconstructive surgeon.³⁶

In 2019, NCCN published consensus guidelines on the diagnosis and treatment of BIA ALCL but these guidelines did not address preventive explantation of implants to reduce risk. ¹⁴

**NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) T-Cell Lymphomas
Version 2.2026 — Breast Implant-Associated Anaplastic Large Cell Lymphoma (BIA-
ALCL):³⁷**

Definition:

- BIA-ALCL is an uncommon and emerging PTCL most frequently arising around a textured surface breast implant or in a patient with a history of a textured surface device.
- BIA-ALCL commonly presents with delayed periprosthetic effusion and breast asymmetry occurring greater than 1 year (average, 7–9 years) after implantation. Rarely, BIA-ALCL can present with a mass, regional lymphadenopathy, overlying skin rash, and/or capsular contracture.
- The majority of patients with BIA-ALCL exhibit an indolent clinical course with slow progression of disease and an excellent prognosis.
- Regional lymph node metastasis and more rarely distant organ and bone marrow metastasis may be seen in advanced stages.

GENERAL PRINCIPLES OF BIA-ALCL

Goals of therapy should be individualized but often include the following:

- Generally, complete surgical resection alone of the implant, capsule, and associated mass is used in earlier stage disease confined to the periprosthetic scar capsule.
- May consider immediate or delayed breast reconstruction with autologous tissue or smooth surface breast implants.
- Local disease relapse may be amenable to re-excision surgery alone without requiring systemic therapies

U.S. Preventive Services Task Force Recommendations

Not applicable

Ongoing and Unpublished Clinical Trials

Some currently unpublished trials that might influence this review are listed in Table 3.

Table 3. Summary of Key Trials

NCT No.	Trial Name	Planned Enrollment	Completion Date
<i>Ongoing</i>			
NCT04220970	Breast Implant-associated Anaplastic Large Cell Lymphoma (BIA-ALCL) Registry	150	June 2032 (recruiting)
NCT06510205 ^a	Post-Market Clinical Follow-up for Mentor Breast Implants	5000	Dec 2034 (recruiting)
<i>Unpublished</i>			
NCT05017337	A Translational Study of Breast-implant associated anaplastic Large Cell Lymphoma and Capsular Contracture	100	Jul 2024 (unknown)

NA: not applicable; NCT: national clinical trial.

Regulatory Status

In July 2019, Allergan voluntarily recalled Natrelle Biocell textured breast implants and tissue expanders from the market. The recall notice stated, "Allergan is taking this action as a precaution following notification of recently updated global safety information concerning the uncommon incidence of breast implant-associated anaplastic large cell lymphoma (BIA-ALCL) provided by the U.S. Food and Drug Administration (FDA)."² Smooth surfaced implants are not affected by this recall. FDA and other health authorities have not recommended removal or replacement of textured breast implants or tissue expanders in asymptomatic individuals.

In October 2021, FDA issued additional orders restricting the sale and distribution of breast implants.³ The orders required new labeling including a boxed warning, a patient decision checklist, updated silicone gel-filled breast implant rupture screening recommendations, a device description with a list of specific materials used in the device, and a patient device card. FDA recommended that the boxed warning include the following components:

- Breast implants are not considered lifetime devices;
- The chance of developing complications increases over time;
- Some complications will require more surgery;
- Breast implants have been associated with the development of a cancer of the immune system called BIA-ALCL;
- BIA-ALCL occurs more commonly in patients with textured breast implants than smooth implants, and deaths have occurred from BIA-ALCL; and
- Breast implants have been associated with systemic symptoms.

The orders apply to the following devices:

- IDEAL IMPLANT Structured Saline Breast Implants (company ended operations on 5/30/23)
- Mentor Saline-Filled and Spectrum Breast Implants
- Inamed (now Allergan) Natrelle Saline Filled Breast Implants
- Inamed (now Allergan) Natrelle Silicone Filled Breast Implants
- Mentor MemoryShape Silicone Gel-Filled Breast Implants
- Mentor MemoryGel Silicone Gel-Filled Breast Implants
- Sientra OPUS Silicone Gel Breast Implants

Government Regulations

National:

National Coverage Determination (NCD) for Breast Reconstruction Following Mastectomy (140.2)

Publication Number 100-3, Manual Section Number 140.2

Effective Date of this Version: 1/1/1997

Indications and Limitations of Coverage

Reconstruction of the affected and the contralateral unaffected breast following a medically necessary mastectomy is considered a relatively safe and effective non cosmetic procedure. Accordingly, program payment may be made for breast reconstruction surgery following removal of a breast for any medical reason. Program payment may not be made for breast

reconstruction for cosmetic reasons. (Cosmetic surgery is excluded from coverage under §1862(a)(10) of the Act.)

CMS: The Women's Health and Cancer Rights ACT of 1998. Applies when individual is receiving benefits in connection with a mastectomy and individual requests breast reconstruction, coverage must be provided for:

- Reconstruction of the breast on which the mastectomy has been performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prosthesis (e.g., breast implant)
- Treatment for physical complications of the mastectomy, including lymphedema.

Local: Wisconsin Physicians Service Insurance Corporation

Local Coverage Determination (LCD): Cosmetic and Reconstructive Surgery (L39051)

Original effective date: For services performed on or after 10/13/2024

Revision effective date: N/A

[Note: This LCD is not quoted in full. The information quoted is related to the topic of this medical policy. Please refer to the LCD for complete information.]

A. According to the American Society of Plastic and Reconstructive Surgeons, the specialty of plastic surgery includes reconstructive and cosmetic procedures:

Reconstructive surgery is performed on abnormal structures of the body, caused by congenital defects, developmental abnormalities, trauma, infection, tumors, involutional defects, or disease. It is generally performed to improve function, but may also be done to approximate a normal appearance.

Cosmetic surgery is performed to reshape normal structures of the body in order to improve the patient's appearance and self-esteem.

Per the Medicare Benefit Policy Manual cosmetic surgery or expenses incurred in connection with such surgery, for the sole purpose of improving one's appearance, is not covered.

B. Indications for specific surgical procedures:

1. Breast reconstruction of the affected and the contralateral unaffected breast following a medically necessary mastectomy is covered.
2. Removal or revision of a breast implant is considered medically necessary when it is removed for one of the following reasons:
 - a. Mechanical complication of breast prosthesis; including rupture or failed implant, and/or implant extrusion.
 - b. Infection or inflammatory reaction due to a breast prosthesis; including infected breast implant, or rejection of breast implants.
 - c. Other complication of internal breast implant; including siliconoma, granuloma, interference with diagnosis of breast cancer, and/or painful capsular contracture with disfigurement.

Medical necessity for a breast reduction is limited to circumstances in which:

- There are signs and/or symptoms resulting from the enlarged breasts (macromastia) that have not responded adequately to non-surgical interventions,
- To improve or correct asymmetry following cancer surgery on one breast.

Note: either the involved breast or contralateral breast may be treated to achieve symmetry.

Note: For coverage indications for contralateral reconstruction of an unaffected breast following a medically necessary mastectomy, refer to the CMS Internet-Only Manual, Pub. 100-03, Medicare National Coverage Determinations Manual, Chapter 1, Part 2, §140.2.

Tattooing to correct color defects of the skin may be considered reconstructive when performed in connection with a payable post-mastectomy reconstruction, or for reconstruction following trauma or removal of cancer from an eyelid, eyebrow or lip(s).

Women's Health and Cancer Rights Act of 1998³⁸

Fact Sheet: Women's Health and Cancer Rights Act

The Women's Health and Cancer Rights Act of 1998 (WHCRA) provides protections for individuals who elect breast reconstruction after a mastectomy. Under WHCRA, group health plans offering mastectomy coverage must provide coverage for certain services relating to the mastectomy, in a manner determined in consultation with the attending physician and the patient.

The required coverage includes:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

Under WHCRA, mastectomy benefits may be subject to annual deductibles and coinsurance consistent with those established for other benefits under the plan or coverage.

Group health plans, health insurance companies and HMOs covered by the law must provide written notification to individuals of the coverage required by WHCRA upon enrollment and annually thereafter.

Additional consumer information on WHCRA is available in the publication *Your Rights After A Mastectomy*.

Information for group health plans and employers on WHCRA and other health benefit law requirements is available in the publication *Compliance Assistance Guide – Health Benefits Coverage Under Federal Law*.

(The above Medicare information is current as of the review date for this policy. However, the coverage issues and policies maintained by the Centers for Medicare & Medicaid Services [CMS, formerly HCFA] are updated and/or revised periodically. Therefore, the most current CMS information may not be contained in this document. For the most current information, the reader should contact an official Medicare source.)

Related Policies

- Cosmetic and Reconstructive Surgery
 - Reduction Mammoplasty (Breast Reduction) for Breast-Related Symptoms
 - Surgical Treatment for Male Gynecomastia
 - Skin and Tissue Substitutes
-

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The articles reviewed in this research include those obtained in an Internet based literature search for relevant medical references through June, 2026, the date the research was completed.

Joint BCBSM/BCN Medical Policy History

Policy Effective Date	BCBSM Signature Date	BCN Signature Date	Comments
7/1/07	5/10/07	7/1/07	This policy combines the policies Breast Implant and Breast Reconstruction Surgery policies.
9/1/08	07/28/08	7/3/08	Maintenance CPT Codes deleted: L8000, L8001, L8002, L8010, L8015, L8020, L8030, L8035, L8039 CPT Codes added: C1789, S2066, S2067, S2068
9/1/09	6/16/09	6/16/09	Routine maintenance
7/1/11	4/19/11	5/3/11	Routine maintenance
3/1/14	12/10/13	1/6/14	Routine maintenance
11/1/14	8/21/14	8/25/14	Routine maintenance; added procedure code 11921
3/1/16	12/10/15	12/10/15	Routine maintenance
3/1/17	12/13/16	12/13/16	Routine maintenance
3/1/18	12/12/17	12/12/17	Routine maintenance
9/1/18	7/9/18	6/25/18	Routine maintenance. Added BIA-ALCL indications for implant removal; rationale updated.
9/1/19	7/25/19		Routine maintenance. Added "removal of textured-surface implants if recommended by surgeon"; rationale updated.
9/1/20	6/16/20		Routine maintenance. CPT code 19304 was deleted 1/1/20. New indications for removal: radiation therapy, BIOCELL products. New indication for replacement: reconstruction following BIA-ALCL treatment.
9/1/21	6/15/21		Routine maintenance Code update: 19324 and 19366 deleted; other codes with nomenclature changes.

9/1/22	6/21/22		Routine maintenance. LCD was retired 11/13/21.
3/1/23	12/20/22		LCD L39051 added (jf)
9/1/23	6/13/23		Routine maintenance (jf) Vendor Managed NA
11/1/23	8/23/23		Routine maintenance (jf) Vendor Managed: NA Inclusions: added post removal procedures (previously addressed in table only). Added "B-cell lymphoma within the capsular tissue of the implant" Added ref 1 and 15
3/1/24	12/19/23		• Edits to the description section and inclusions added about capsular contracture (jf). • Vendor Managed: NA • Edit title: add "and" remove / • Title Change: From Reconstructive Breast Surgery/ Management of Implants changed to Reconstructive Breast Surgery and Management of Implants.
11/1/24	8/26/24		Routine maintenance (jf) Vendor Managed: NA Ref Added: 2,13, 14 -Addition of Squamous Cell Carcinoma to the policy background under local complications. -Addition of Squamous Cell Carcinoma (SCC) to the policy background, inclusions and chart POST JUMP-edits to inclusions and exclusions of breast cancer reconstruction and diagnosis of suspicious of cancer. -Added suspected BIA-ALCL under Implant Removal

			-Pg. 7 Indication for removal chart edited Post-Removal Procedure removed
3/1/25	1/3/25		Minor Edits (jf) Vendor managed: NA Ref Added: 1,10,20 • Added aesthetic flat closure language in the description, rationale, MPS, and inclusions • added *** When used to represent aesthetic flat closure • Removal of safety and effectiveness from MPS • Added the following codes as EST: 14301,14302, and 19499 to represent aesthetic flat closure
11/1/25	8/19/25		Routine maintenance (jf) Vendor Managed: NA Added under inclusions: Reconstruction for those who qualify for a medically necessary risk-reducing mastectomy • Description added and background separated, movement of policy language and formatting to assist with flow with new format • MPS edited: New Format language removed, “have been”, added “when criteria are met” and “is” • Added when post explantation procedures are considered medically necessary • Added the exclusions of preventative explantation in asymptomatic individual to reduce the risk for certain cancers • Ref added: 14,15,16,17,18,19,20,21,

			22,23,24,25,26,27,28,29,30,31,32,33
3/1/26	12/16/25		• Minor Edits (jf) • Vendor Managed: NA • Addition to inclusionary criteria and edits to MPS
9/1/26	6/16/26		• Minor Edits (jf/mk) • Vendor Managed: NA • Edit to MPS: Added "breast reduction on the contralateral breast to achieve breast symmetry" • Edit to Inclusion: Added: "but not limited to breast reduction, implant insertion, or"
11/1/26	8/18/26		• Routine Maintenance (jf/mk) • Vendor Managed: NA • Added Ref: 25 • Added new inclusion under whole breast reconstruction

Next Review Date: 3rd Qtr, 2027

BLUE CARE NETWORK BENEFIT COVERAGE
POLICY: RECONSTRUCTIVE BREAST SURGERY AND MANAGEMENT OF BREAST
IMPLANTS

I. Coverage Determination:

Commercial HMO (includes Self-Funded groups unless otherwise specified)	Covered, policy guidelines apply
BCNA (Medicare Advantage)	See Government Regulations section.
BCN65 (Medicare Complementary)	Coinsurance covered if primary Medicare covers the service.