

## Medical Coverage Policy | Removal of Implantable Devices



**EFFECTIVE DATE:** 02|01|2023

**POLICY LAST UPDATED:** 10|19|2022

### OVERVIEW

The intent of this policy is to document the criteria and prior authorization requirement for the removal of surgically implanted devices.

### MEDICAL CRITERIA

#### Medicare Advantage Plans and Commercial Products

##### Removal Only

Removal Only of a surgically implanted device is considered medically necessary when:

- the insertion of the device was determined to be medically necessary.

Removal Only of a surgically implanted device is considered medically necessary when:

- the insertion of the device was determined to be NOT medically necessary, and one of the following indications is present:
  - complication, OR
  - infection

##### Removal and Reinsertion, Replacement or Revision of a Device

In instances where the appropriate Current Procedural Terminology (CPT) code for removal of a device represents the removal AND/OR reinsertion, replacement or revision of a device:

- the removal must be reviewed using the above removal criteria,
- the reinsertion/replacement/revision must be reviewed to determine medical necessity.
  - Note: In most instances, the criteria from the Medical Necessity policy would be used for review of reinsertion/replacement/revision. However, in other instances, a medical policy may exist for the specific device, or the New Technology and Miscellaneous Services policies can be referenced. Please see Related Policies section.

### PRIOR AUTHORIZATION

#### Medicare Advantage Plans and Commercial Products

Prior authorization is required for Medicare Advantage Plans and recommended for Commercial Products and is obtained via the online tool for participating providers. See the Related Policies section.

### POLICY STATEMENT

#### Medicare Advantage Plans and Commercial Products

Removal of a surgically implanted device is considered medically necessary when medical criteria are met.

Reimplantation of the device is considered not medically necessary, when the initial implantation was determined to be not medically necessary.

### COVERAGE

Benefits may vary between groups/contracts. Please refer to the appropriate Benefit Booklet, Evidence of Coverage or Subscriber Agreement for applicable surgery benefits/coverage.

### BACKGROUND

Not applicable

### **CODING**

The following codes, in the attached grid below, are covered when applicable medical criteria are met for Medicare Advantage Plans and Commercial Products coverage.

#### 2023 Removal of Implantable Devices

### **RELATED POLICIES**

Bariatric Surgery  
Coverage of Complications Following a Non-Covered Service  
Gastric Electrical Stimulation – Insertion  
Glucose Monitoring – Continuous  
Implantable Bone Conduction and Bone Anchored Hearing Aids  
Medical Necessity  
Medicare Advantage Plans National and Local Coverage Determinations  
New Technology and Miscellaneous Services  
Phrenic Nerve Stimulation for Central Sleep Apnea  
Prior Authorization of Cardiology and Radiology Services  
Prior Authorization via Web-Based Tool for Procedures  
Subtalar Arthroereisis

### **PUBLISHED**

Provider Update, May/December 2022  
Provider Update, April 2021  
Provider Update, April 2020  
Provider Update, October 2019

### **REFERENCES**

Not applicable

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