

**EFFECTIVE DATE:** 06|01|2021  
**POLICY LAST UPDATED:** 02|12|2021

## 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 are covered when applicable medical criteria are met:

Removal of Surgically Implanted Devices		Medicare Advantage Plans Criteria	Commercial Products Criteria
CPT Code	Code Description		
<b>Aortic Counterpulsation Ventricular Assist System and Components</b>			
0455T	<b>Removal</b> of permanently implantable aortic counterpulsation ventricular assist system; complete system (aortic counterpulsation device, vascular hemostatic seal, mechano-electrical skin interface and electrodes)	Removal Only	Removal Only
0456T	<b>Removal</b> of permanently implantable aortic counterpulsation ventricular assist system; aortic counterpulsation device and vascular hemostatic seal	Removal Only	Removal Only
0457T	<b>Removal</b> of permanently implantable aortic counterpulsation ventricular assist system; mechano-electrical skin interface	Removal Only	Removal Only
0458T	<b>Removal</b> of permanently implantable aortic counterpulsation ventricular assist system; subcutaneous electrode	Removal Only	Removal Only
<b>Artificial Intervertebral Disc</b>			
22865	<b>Removal</b> of total disc arthroplasty (artificial disc), anterior approach, single interspace; lumbar	Removal Only	Removal Only
<b>Carotid Sinus Baroflex Activation Device</b>			
0269T	<b>Revision or removal</b> of carotid sinus baroflex activation device; total system (includes generator replacement, unilateral or bilateral lead replacement, intra-operative interrogation, programming, and repositioning, when performed)	Medical Necessity and Removal	Medical Necessity and Removal
0270T	<b>Revision or removal</b> of carotid sinus baroflex activation device; lead only, unilateral (includes intra-operative interrogation, programming, and repositioning, when performed)	Medical Necessity and Removal	Medical Necessity and Removal
0271T	<b>Revision or removal</b> of carotid sinus baroflex activation device; pulse generator only (includes intra-operative interrogation, programming, and repositioning, when performed)	Medical Necessity and Removal	Medical Necessity and Removal
<b>Chest Wall Respiratory Sensor Electrode</b>			
0468T	<b>Removal</b> of chest wall respiratory sensor electrode or electrode array	Removal Only	Removal Only
<b>Esophageal Sphincter Augmentation Device</b>			

43285	Removal of esophageal sphincter augmentation device	Removal Only	Removal Only
<b>Gastric Electrical Stimulator</b>			
43648	Revision or removal of gastric neurostimulator electrodes, antrum	Gastric Electrical Stimulator - Insertion and Removal	Gastric Electrical Stimulator - Insertion and Removal
43882	Revision or removal of gastric neurostimulator electrodes, antrum, open	Gastric Electrical Stimulator - Insertion and Removal	Gastric Electrical Stimulator - Insertion and Removal
64595	Revision or removal of peripheral or gastric neurostimulator pulse generator or receiver	Gastric Electrical Stimulator - Insertion and Removal	Gastric Electrical Stimulator - Insertion and Removal
<b>Interstitial Glucose Sensor</b>			
0447T	Removal of implantable interstitial glucose sensor from subcutaneous pocket via incision	Removal Only	Removal Only
0448T	Removal of implantable interstitial glucose sensor with creation of subcutaneous pocket at different anatomic site and insertion of new implantable sensor, including system activation	Glucose Monitoring - Continuous and Removal	Glucose Monitoring - Continuous (insertion is not medically necessary) and Removal
<b>Note:</b>	Authorization requirement added to Medicare Advantage Plans and Commercial Products 5/1/2021 for code 0448T		
<b>Intracardiac Ischemia Monitoring System</b>			
0530T	Removal of intracardiac ischemia monitoring system, including all imaging supervision and interpretation; complete system (electrode and implantable monitor)	Removal Only	Removal Only
0531T	Removal of intracardiac ischemia monitoring system, including all imaging supervision and interpretation; electrode only	Removal Only	Removal Only
0532T	Removal of intracardiac ischemia monitoring system, including all imaging supervision and interpretation; complete system implantable monitor only	Removal Only	Removal Only
<b>Neurostimulation System for Posterior Tibial Nerve</b>			
0588T	Revision or removal of integrated single device neurostimulation system including electrode array and receiver or pulse generator, including analysis, programming, and imaging guidance when performed, posterior tibial nerve (New Code Effective 1/1/2020)	Medical Necessity and Removal	Medical Necessity and Removal
<b>Neurostimulator System for Treatment of Central Sleep Apnea</b>			
0428T	Removal of neurostimulator system for treatment of central sleep apnea; pulse generator only	Removal Only	Removal Only

0429T	<b>Removal</b> of neurostimulator system for treatment of central sleep apnea; sensing lead only	Removal Only	Removal Only
0430T	<b>Removal</b> of neurostimulator system for treatment of central sleep apnea; stimulation lead only	Removal Only	Removal Only
0431T	<b>Removal and replacement</b> of neurostimulator system for treatment of central sleep apnea, pulse generator only	New Technology and Miscellaneous Services (insertion is not covered) and Removal	New Technology and Miscellaneous Services (insertion is not medically necessary) and Removal
<b>Note:</b>	Authorization requirement added to Medicare Advantage Plans and Commercial Products 5/1/2021 for code 0431T		
<b>Occipital Nerve Stimulator</b>			
64570	<b>Removal</b> of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse generator	Removal Only	Removal Only
<b>Permanent Cardiac Contractility System</b>			
0412T	<b>Removal</b> of permanent cardiac contractility modulation system; pulse generator only	Removal Only	Removal Only
0413T	<b>Removal</b> of permanent cardiac contractility modulation system; transvenous electrode (atrial or ventricular)	Removal Only	Removal Only
0414T	<b>Removal and replacement</b> of permanent cardiac contractility modulation system pulse generator only	Medical Necessity and Removal	Medical Necessity and Removal
<b>Note:</b>	Authorization requirement added to Medicare Advantage Plans and Commercial Products 5/1/2021 for code 0414T		
<b>Sinus Tarsi Implant</b>			
0510T	<b>Removal</b> of sinus tarsi implant	Removal Only	Removal Only
0511T	<b>Removal and reinsertion</b> of sinus tarsi implant	Medical Necessity and Removal	Medical Necessity and Removal
<b>Note:</b>	Authorization requirement added to Medicare Advantage Plans and Commercial Products 5/1/2021 for code 0511T		
<b>Substernal Implantable Defibrillator</b>			
0573T	<b>Removal</b> of substernal implantable defibrillator electrode (New Code Effective 1/1/2020)	Removal Only	Removal Only
0580T	<b>Removal</b> of substernal implantable defibrillator pulse generator only (New Code Effective 1/1/2020)	Removal Only	Removal Only
<b>Note:</b>	Authorization requirement added to Medicare Advantage Plans 5/1/2021 for codes 0573T and 0580T		
<b>Transperineal Periurethral Balloon Continence Device</b>			
0550T	Transperineal periurethral balloon continence device; <b>removal</b> , each balloon	Removal Only	Removal Only

<b>Vagus Nerve Blocking Therapy</b>			
0314T	Vagus nerve blocking therapy (morbid obesity); laparoscopic <b>removal</b> of vagal trunk neurostimulator electrode array and pulse generator	Removal Only	Removal Only
0315T	Vagus nerve blocking therapy (morbid obesity); <b>removal</b> of pulse generator	Removal Only	Removal Only
<b>Anterior Segment Intraocular Nonbiodegradable Drug-eluting System</b>			
0661T	<b>Removal and reimplantation</b> of anterior segment intraocular nonbiodegradable drug-eluting implant (New code effective 7/1/2021)	Medical Necessity and Removal	Medical Necessity and Removal

## RELATED POLICIES

Coverage of Complications Following a Non-covered Service

Gastric Electrical Stimulation – Insertion

Glucose Monitoring - Continuous

Medical Necessity

Medicare Advantage Plans National and Local Coverage Determinations

New Technology and Miscellaneous Services

Prior Authorization – Cardiology and Radiology Services

Prior Authorization via Web-Based Tool for Procedures

## PUBLISHED

Provider Update, April 2021

Provider Update, April 2020

Provider Update, October 2019

Provider Update, April 2018

Provider Update, February 2017

## REFERENCES

Not applicable

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