Medical Coverage Policy | Removal of Implantable Devices

EFFECTIVE DATE: 01|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
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
Phrenic Nerve Stimulation for Central Sleep Apnea
Prior Authorization – Cardiology and Radiology Services
Prior Authorization via Web-Based Tool for Procedures
Subtalar Arthroereisis

PUBLISHED
Provider Update, May 2022
Provider Update, April 2021
Provider Update, April 2020
Provider Update, October 2019
Provider Update, April 2018

REFERENCES
Not applicable