

EFFECTIVE DATE: 07|01|2026
POLICY LAST UPDATED: 01|07|2026

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.

Removal of Implantable Devices

RELATED POLICIES

Bariatric Surgery

Baroreflex Stimulation Devices

Centers for Medicare and Medicaid Services National and Local Coverage Determinations

Coverage of Complications Following a Non-Covered Service

Gastric Electrical Stimulation – Insertion

Implantable Bone Conduction and Bone Anchored Hearing Aids

Implantation of Anterior Segment Intraocular Nonbiodegradable Drug-Eluting System

Medical Necessity

Medicare Advantage Plans National and Local Coverage Determinations

New Technology and Miscellaneous Services

Percutaneous and Subcutaneous Tibial Nerve Stimulation

Phrenic Nerve Stimulation for Central Sleep Apnea

Prior Authorization of Cardiology and Radiology Services

Prior Authorization of Services, Treatments or Procedures

Spinal Cord Stimulation

Subtalar Arthroereisis

PUBLISHED

Provider Update, February 2026

Provider Update, June 2025

Provider Update, March/August 2024

Provider Update, January/April 2023

Provider Update, May/December 2022

Provider Update, April 2021

REFERENCES

Not applicable

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