DRAFT Medical Coverage Policy | Removal of Implantable Devices

EFFECTIVE DATE: 01|01|2027
POLICY LAST UPDATED: 09|02|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.

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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
*Please refer to tab "Removal ONLY" for codes that are for utilized for removal ONLY of implantable devices. For all other codes that are utilized for an intervention AND/OR removal of implantable devices, please refer to tab, "Intervention AND-OR Removal."

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/June/August/September 2026
Provider Update, June 2025
Provider Update, March/August 2024
Provider Update, January/April 2023
Provider Update, May/December 2022

REFERENCES
Not applicable

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This medical policy is made available to you for informational purposes only. It is not a guarantee of payment or a substitute for your medical judgment in the treatment of your patients. Benefits and eligibility are determined by the member's subscriber agreement or member certificate and/or the employer agreement, and those documents will supersede the provisions of this medical policy. For information on member-specific benefits, call the provider call center. If you provide services to a member which are determined to not be medically necessary (or in some cases medically necessary services which are non-covered benefits), you may not charge the member for the services unless you have informed the member and they have agreed in writing in advance to continue with the treatment at their own expense. Please refer to your participation agreement(s) for the applicable provisions. This policy is current at the time of publication; however, medical practices, technology, and knowledge are constantly changing. BCBSRI reserves the right to review and revise this policy for any reason and at any time, with or without notice. Blue Cross & Blue Shield of Rhode Island is an independent licensee of the Blue Cross and Blue Shield Association.