



EFFECTIVE DATE: 06|01|2015
POLICY LAST UPDATED: 12|20|2016

OVERVIEW

The intent of this policy is to document the criteria and prior authorization requirement for the removal of surgically implanted devices that are considered not medically necessary.

MEDICAL CRITERIA

BlueCHiP for Medicare and Commercial Products

Removal of a not medically necessary surgically implanted device is considered medically necessary for the following indications:

- complication
- infection

PRIOR AUTHORIZATION

BlueCHiP for Medicare and Commercial Products

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

POLICY STATEMENT

BlueCHiP for Medicare and Commercial Products

Removal of a not medically necessary surgically implanted device is considered medically necessary when medical criteria are met.

Reimplantation of the device is considered not medically necessary, as the initial implantation was 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 medical criteria are met:

BlueCHiP for Medicare and Commercial Products

Aortic Counterpulsation Ventricular Assist System and components (New codes effective 1/1/2017)

0455T

0456T

0457T

0458T

Artificial Intervertebral Disc

22865

Carotid Sinus Baroflex Activation Device

0269T

0270T

0271T

Chest Wall Respiratory Sensor Electrode

0468T (New code effective 1/1/2017)

Esophageal Sphincter Augmentation Device

43285 (New code effective 1/1/2017)

Gastric Electrical Stimulator

43648

43882

64595

Interstitial Glucose Sensor

0447T (New code effective 1/1/2017)

Neurostimulator System for Treatment of Central Sleep Apnea

0428T

0429T

0430T

Occipital Nerve Stimulator

64570

Permanent Cardiac Contractility System

0412T

0413T

Permanent Leadless Pacemaker, Ventricular

0388T

Vagus Nerve Blocking Therapy (Service will require preauthorization effective 10/1/2017)

0314T

0315T

RELATED POLICIES

Coverage of Complications Following a Non-covered Service

Preauthorization via Web-Based Tool for Procedures

PUBLISHED

Provider Update, February 2017

Provider Update, July 2015

REFERENCES

Not applicable

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