Medical Coverage Policy | Removal of Non Covered Implantable Devices

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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