Medical Coverage Policy | Removal of Non-Covered Implantable Devices

EFFECTIVE DATE: 10|01|2015
POLICY LAST UPDATED: 05|19|2015

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 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
Artificial Intervertebral Disc
22864
22865

Esophageal Sphincter Augmentation Device
0393T

Gastric Electrical Stimulator

43648
43882
64595

Implantable Hearing Aid
69711

*The Audiant™ bone conductor is a type of electromagnetic bone conduction hearing device. While this product is no longer actively marketed, patients with existing Audiant devices may require replacement, removal, or repair.

Neurostimulator System for Treatment of Central Sleep Apnea (Codes Effective January 1, 2016)
0428T
0429T
0430T

Occipital Nerve Stimulator
64570

Peripheral Subcutaneous Field Stimulator
0284T

Permanent Cardiac Contractility System (Codes Effective January 1, 2016)
0412T
0413T

Commercial Only
Subcutaneous Implantable Cardioverter Defibrillator
33272

RELATED POLICIES
Coverage of Complications Following a Non-covered Service
Preauthorization via Web-Based Tool for Procedures

PUBLISHED
Provider Update, July 2015

REFERENCES
Not applicable