



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

Carotid Sinus Baroflex Activation Device

0269T

0270T

0271T

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

Permanent Leadless Pacemaker, Ventricular
0388T

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

CLICK THE ENVELOPE ICON BELOW TO SUBMIT COMMENTS

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.

