Minimally Invasive Gastroesophageal Reflux Disease (GERD) Procedures

Guideline Number: MPG389.05
Approval Date: February 23, 2024

➲ Terms and Conditions

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Related Medicare Advantage Coverage Summary

- Gastroesophageal and Gastrointestinal (GI) Services and Procedures

Policy Summary

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Overview

EsophyX™ is a device for performing transoral incisionless fundoplication surgery (TIF) for treating gastroesophageal reflux disease. This procedure reconstructs the valve at the top of the stomach that helps prevent acid reflux.

Benefits are not available for endoluminal treatment for Gastroesophageal Reflux Disease (GERD) using the Stretta® procedure, the Bard EndoCinch™ Suturing System, Plicator™, Enteryx® or similar treatments as these procedures are not considered reasonable and necessary for the diagnosis or treatment of an injury or disease. Coverage is not available for LINX® Reflux Management System, which is not a true endoluminal treatment but is also not considered reasonable and necessary for the diagnosis or treatment of an injury or disease.

Currently, these procedures other than TIF are considered non-covered due to the fact that current peer-reviewed literature does not support the long-term efficacy and long-term safety of the services. Claims will be denied as "not proven effective."

Guidelines

For TIF, coverage is not extended to:

- Any patient who has recurrent symptoms or other evidence of failure following a prior TIF. These procedures (repeat TIF) would be considered investigational at this time.
- Any patient with a hiatal hernia greater than 2 cm, except where the hernia has been reduced to 2 cm or less by a successful laparoscopic hernia reduction procedure prior to the TIF procedure. (Based on (FDA) approval).
- Any GERD patients with BMI > 35, esophagitis LA grade > B, Barrett's esophagus > 2 cm, and presence of achalasia or esophageal ulcer or has not been on an appropriate trial of proton pump inhibitors.

Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this guideline does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws

that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

CPT Code	Description
43210	Esophagogastroduodenoscopy, flexible, transoral; with esophagogastric fundoplasty, partial or complete, includes duodenoscopy when performed
43257	Esophagogastroduodenoscopy, flexible, transoral; with delivery of thermal energy to the muscle of lower esophageal sphincter and/or gastric cardia, for treatment of gastroesophageal reflux disease
43284	Laparoscopy, surgical, esophageal sphincter augmentation procedure, placement of sphincter augmentation device (i.e., magnetic band), including cruroplasty when performed (Non-covered)
43289	Unlisted laparoscopy procedure, esophagus
43499	Unlisted procedure, esophagus
43999	Unlisted procedure, stomach
49999	Unlisted procedure, abdomen, peritoneum and omentum

References

CMS Local Coverage Determinations (LCDs) and Articles

LCD	Article	Contractor	Medicare Part A	Medicare Part B
L34434 Upper Gastrointestinal Endoscopy and Visualization	A56389 Billing and Coding: Upper Gastrointestinal Endoscopy and Visualization	Palmetto	AL, GA, NC, SC, TN, VA, WV	AL, GA, NC, SC, TN, VA, WV
L35080 Select Minimally Invasive GERD Procedures	A56863 Billing and Coding: Select Minimally Invasive GERD Procedures	NGS	CT, IL, MA, ME, MN, NH, NY, RI, VT, WI	CT, IL, MA, ME, MN, NH, NY, RI, VT, WI
L34659 Endoscopic Treatment of GERD	A56395 Billing and Coding: Endoscopic Treatment of GERD	WPS	IA, IN, KS, MI, MO, NE	IA, IN, KS, MI, MO, NE
L34540 Stretta Procedure	A57039 Billing and Coding: Stretta Procedure	CGS	KY, OH	KY, OH
L34553 Stretta Procedure	A56703 Billing and Coding: Stretta Procedure	Palmetto	AL, GA, NC, SC, TN, VA, WV	
L35350 Upper Gastrointestinal Endoscopy (Diagnostic and Therapeutic)	A57414 Billing and Coding: Upper Gastrointestinal Endoscopy (Diagnostic and Therapeutic)	Novitas	AR, CO, DC, DE, LA, MD, MS NJ, NM, OK, PA, TX	AR, CO, DC, DE, LA, MD, MS NJ, NM, OK, PA, TX

CMS Benefit Policy Manual

Chapter 4; § 180.3 Unlisted Service or Procedure

Other(s)

LINX™ Reflux Management System for the Treatment of Gastroesophageal Reflux Disease (GERD)
U.S. Food and Drug Administration (FDA) EndoCinch™
U.S. Food and Drug Administration (FDA) Plicator™
U.S. Food and Drug Administration (FDA) Enteryx®
U.S. Food and Drug Administration (FDA) Durasphere®
U.S. Food and Drug Administration (FDA) EsophyX®
U.S. Food and Drug Administration (FDA) SerosaFuse® Fasteners

Guideline History/Revision Information

Revisions to this summary document do not in any way modify the requirement that services be provided and documented in accordance with the Medicare guidelines in effect on the date of service in question.

Date	Summary of Changes
02/23/2024	**Supporting Information** • Updated *References* section to reflect the most current information • Archived previous policy version MPG389.04

Purpose

The Medicare Advantage Policy Guideline documents are generally used to support UnitedHealthcare Medicare Advantage claims processing activities and facilitate providers' submission of accurate claims for the specified services. The document can be used as a guide to help determine applicable:

- Medicare coding or billing requirements, and/or
- Medical necessity coverage guidelines; including documentation requirements.

UnitedHealthcare follows Medicare guidelines such as NCDs, LCDs, LCAs, and other Medicare manuals for the purposes of determining coverage. It is expected providers retain or have access to appropriate documentation when requested to support coverage. Please utilize the links in the References section above to view the Medicare source materials used to develop this resource document. This document is not a replacement for the Medicare source materials that outline Medicare coverage requirements. Where there is a conflict between this document and Medicare source materials, the Medicare source materials will apply.

Terms and Conditions

The Medicare Advantage Policy Guidelines are applicable to UnitedHealthcare Medicare Advantage Plans offered by UnitedHealthcare and its affiliates.

These Policy Guidelines are provided for informational purposes, and do not constitute medical advice. Treating physicians and healthcare providers are solely responsible for determining what care to provide to their patients. Members should always consult their physician before making any decisions about medical care.

Benefit coverage for health services is determined by the member specific benefit plan document* and applicable laws that may require coverage for a specific service. The member specific benefit plan document identifies which services are covered, which are excluded, and which are subject to limitations. In the event of a conflict, the member specific benefit plan document supersedes the Medicare Advantage Policy Guidelines.

Medicare Advantage Policy Guidelines are developed as needed, are regularly reviewed and updated, and are subject to change. They represent a portion of the resources used to support UnitedHealthcare coverage decision making. UnitedHealthcare may modify these Policy Guidelines at any time by publishing a new version of the policy on this website. Medicare source materials used to develop these guidelines include, but are not limited to, CMS National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), Medicare Benefit Policy Manual, Medicare Claims Processing Manual, Medicare Program Integrity Manual, Medicare Managed Care Manual, etc. The information presented in the Medicare Advantage Policy Guidelines is believed to be accurate and current as of the date of publication and is provided on an "AS IS" basis. Where there is a conflict between this document and Medicare source materials, the Medicare source materials will apply.

You are responsible for submission of accurate claims. Medicare Advantage Policy Guidelines are intended to ensure that coverage decisions are made accurately based on the code or codes that correctly describe the health care services provided. UnitedHealthcare Medicare Advantage Policy Guidelines use Current Procedural Terminology (CPT®), Centers for Medicare and

Medicaid Services (CMS), or other coding guidelines. References to CPT® or other sources are for definitional purposes only and do not imply any right to reimbursement or guarantee claims payment.