Medical Coverage Policy

Gastric Electrical Stimulation

☐ Device/Equipment ☐ Drug ☐ Medical ☒ Surgery ☐ Test ☐ Other

Effective Date:	3/1/2011	Policy Last Updated:	4/3/2012

☐ **Prospective review is recommended/required. Please check the member agreement for preauthorization guidelines.**

☒ **Prospective review is not required.**

Description:
Gastric electrical stimulation uses an implantable device designed to treat chronic, drug-refractory nausea and vomiting secondary to gastroparesis of diabetic or idiopathic etiology. The device may be referred to as a gastric pacemaker.

The condition gastroparesis is caused when food and secretions do not empty from the stomach normally due to paralysis of the muscles in the stomach. Nausea and vomiting with abdominal pain and bloating may occur. Although gastroparesis is most often caused by diabetes, in up to 40 percent of the cases, the cause may not be known. Medications, previous stomach surgery, anorexia, bulimia, neurological conditions (e.g., Parkinson's disease, stroke, or brain injury), or diseases such as lupus or scleroderma may also be a cause.

At this time, gastric electrical stimulation is **not medically necessary** as there is insufficient peer-reviewed scientific literature that demonstrates that the procedure/service is effective. Without an appropriate control group, the contribution of a placebo effect to the treatment group cannot be excluded. Though there is scarce literature about long-term outcome of severe gastroparesis, follow-up case series of those who require tube feeding suggest an overall improvement over time. Given the high costs involved, the unknown mechanism of action, and the absence of rigorous well-controlled randomized trials, caution should be exercised before embracing GES as a standard of care.

Medical Criteria:
Not applicable.

Policy:
Gastric electrical stimulation is considered **not medically necessary** as there is insufficient medical literature to support the efficacy of this treatment.

Prior authorization is required for removal of the device.

Coverage:
Benefits may vary between groups/contracts. Please refer to the Evidence of Coverage or Subscriber Agreement for applicable surgery services and **"Services Not Medically necessary**" benefit.

Coding:

The following codes are considered **not medically necessary**:
43647
43881
95999
0157T
43659

Removal may be medically necessary and requires preauthorization; revision is always not medically necessary.
43648
43882
64595
43659
43999

When the following codes are used for gastric electrical stimulation, they are **not medically necessary**. When used for other procedures, not specific to gastric electrical stimulation, they may be **medically necessary**.
64590
95980
95981
95982

Also known as:
Enterra Therapy System

Related topics:
CPT Category III Codes

Published:
Policy Update, May 2007
Provider Update, July 2008
Provider Update, September 2009
Provider Update, August 2010
Provider Update, August 2011
Provider Update, July 2012

References:
Blue Cross and Blue Shield Association Medical Policy Reference Manual 7.01.73 Gastric Electrical Stimulation 10.20.11. Accessed 04/18/2012
http://bluewebportal.bcbs.com/global_assets/special_content/medical_policy/policymanual/policy.html?pnum=70173

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.