GASTRIC ELECTRICAL STIMULATION
Corporate Medical Policy

File name: Gastric Electrical Stimulation
File code: UM.NS.06
Origination: 2007
Last Review: 2/2014 (ICD-10 remediation only)
Next Review: 7/2014
Effective Date: 2/01/2012

Document Precedence

Blue Cross and Blue Shield of Vermont (BCBSVT) Medical Policies are developed to provide clinical guidance and are based on research of current medical literature and review of common medical practices in the treatment and diagnosis of disease. The applicable group/individual contract and member certificate language determines benefits that are in effect at the time of service. Since medical practices and knowledge are constantly evolving, BCBSVT reserves the right to review and revise its medical policies periodically. To the extent that there may be any conflict between medical policy and contract language, the member’s contract language takes precedence.

Medical Policy

Description

Gastric electrical stimulation is a surgical procedure where an implantable device, also referred to as a gastric pacemaker, is implanted in the stomach wall to electrically pace the gastric musculature. Gastric electrical stimulation has been used to treat chronic drug-refractory nausea and vomiting secondary to gastroparesis, and for management of obesity.

Two devices are currently manufactured: the Enterra system (Medtronic Corporation) for gastroparesis and the Transcend device (Transneuronix Corporation) for obesity. The Enterra system was granted FDA approval under the “humanitarian device exemption” with an anticipated benefit to less than 4000 patients. The Transcend device is not FDA approved but it is available in Europe and undergoing clinical trials in the United States.

Gastroparesis is a chronic disorder of gastric motility characterized by delayed emptying of a solid meal. Symptoms include bloating, abdominal distension, nausea, and vomiting. When severe and chronic, gastroparesis can be associated with dehydration, poor nutritional status and poor glycemic control in diabetics. Gastroparesis is most commonly associated with diabetes, but may also be attributable to connective tissue disorders, Parkinson’s disease, chronic pseudo-obstruction, and psychological pathologic conditions or it may be idiopathic. Standard therapy consists of hydration, dietary manipulations, nutritional
supplementation, and pharmacologic therapy with prokinetic agents such as metoclopramide and antiemetic agents such as granisetron or odansetron. Severe cases may require enteral alimentation via a jejunal feeding tube or total parental nutrition.

Because of the limited population anticipated for the Enterra system clinical trials have been limited in size. However, several authors have noted a substantial reduction in episodes of vomiting, improved nutritional status, improved glucose control in diabetics, and decreased hospitalizations.

Policy
Gastric electrical stimulation is considered medically necessary in the treatment of chronic intractable nausea and vomiting secondary to severe gastroparesis of diabetic or idiopathic etiology when the following criteria are met:

- Patient is refractory, intolerant or has contraindications to the use of prokinetic and antiemetic medications; and
- Delayed gastric emptying as documented by standard scintigraphic imaging of solid food.

Gastric electrical stimulation is considered investigational in all other indications including, but not limited to, the treatment of obesity. (See BCBSVT policy on Bariatric Surgery for Morbid Obesity)

Administrative and Contractual Guidance

Benefit Determination Guidance
Prior approval is required and benefits are subject to all terms, limitations and conditions of the subscriber contract.

For New England Health Plan (NEHP) members an approved referral authorization is required.

Benefits for FEP members may vary. Please consult the FEP Service Plan Brochure.

Coverage varies according to the member’s group or individual contract. Not all groups are required to follow the Vermont legislative mandates. Member Contract language takes precedence over medical policy when there is a conflict.

If the member receives benefits through a self-funded (ASO) group, benefits may vary or not apply. To verify benefit information, please refer to the member’s plan documents or contact the customer service department.

Audit Information
BCBSVT reserves the right to conduct audits on any provider and/or facility to ensure compliance with the guidelines stated in the medical policy. If an audit identifies
instances of non-compliance with this medical policy, BCBSVT reserves the right to recoup all non-compliant payments.

**Billing and Physician Documentation Information**

Click the links below for attachments, coding tables & instructions.

*Attachment 1- CPT (procedure) Code list & Instructions*  
*Attachment 2- Eligible Diagnosis Codes*

**Eligible Providers**

General Surgeons (MD, DO)

**Related Policies**

Bariatric Surgery

**Policy Implementation/Update information**

<table>
<thead>
<tr>
<th>Date</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>02/2007</td>
<td>New Policy</td>
</tr>
<tr>
<td>03/2008</td>
<td>Policy reformatted to match BCBSA Medical Policy format and reviewed by CAC.</td>
</tr>
<tr>
<td>07/2009</td>
<td>Medical necessity criteria clarified and aligned with Anthem Blue Cross (New Hampshire) 0162T Code deleted and removed from Appendix.</td>
</tr>
</tbody>
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**Scientific Background and Reference Resources**


8. Anthem (WellPoint) Blue Cross and Blue Shield Medical Policy 2011, Gastric Electrical Stimulation.


Approved by BCBSVT Medical Directors

Date Approved

Spencer Borden MD
Chair, Medical Policy Committee

Robert Wheeler MD
Chief Medical Officer
### Attachment I  
**CPT Code list & Instructions**

<table>
<thead>
<tr>
<th>Code Type</th>
<th>Number</th>
<th>Description</th>
<th>Policy Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPT</td>
<td>43647</td>
<td>Laparoscopy, surgical; implantation or replacement of gastric neurostimulator electrodes, antrum</td>
<td>Prior Approval Required</td>
</tr>
<tr>
<td>CPT</td>
<td>43648</td>
<td>Laparoscopy, surgical, revision or removal of gastric neurostimulator electrodes, antrum</td>
<td>Prior Approval Required</td>
</tr>
<tr>
<td>CPT</td>
<td>43881</td>
<td>Implantation or replacement of gastric neurostimulator electrodes, antrum, open</td>
<td>Prior Approval Required</td>
</tr>
<tr>
<td>CPT</td>
<td>43882</td>
<td>Revision or removal of gastric neurostimulator electrodes, antrum, open</td>
<td>Prior Approval Required</td>
</tr>
<tr>
<td>CPT</td>
<td>64590</td>
<td>Insertion or replacement of peripheral or gastric neurostimulator pulse generator or receiver, direct or inductive coupling</td>
<td>Prior Approval Required for covered ICD-9 and ICD-10 diagnosis codes</td>
</tr>
<tr>
<td>CPT</td>
<td>64595</td>
<td>Revision or removal of peripheral or gastric neurostimulator pulse generator or receiver</td>
<td>Prior Approval Required for covered ICD-9 and ICD-10 diagnosis codes</td>
</tr>
<tr>
<td>CPT</td>
<td>95980</td>
<td>Electronic analysis of implanted neurostimulator pulse generator</td>
<td>Prior Approval required</td>
</tr>
<tr>
<td>CPT</td>
<td>95981</td>
<td>Subsequent, without reprogramming</td>
<td>Prior Approval required</td>
</tr>
<tr>
<td>CPT</td>
<td>95982</td>
<td>Subsequent, with reprogramming</td>
<td>Prior Approval required</td>
</tr>
</tbody>
</table>

The following codes may be considered medically necessary when applicable criteria have been met.
<table>
<thead>
<tr>
<th>HCPCS</th>
<th>C1767</th>
<th>Generator, neurostimulator, implantable, non-rechargeable</th>
<th>Prior Approval Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>HCPCS</td>
<td>C1778</td>
<td>Lead, neurostimulator, implantable</td>
<td>Prior Approval Required</td>
</tr>
<tr>
<td>HCPCS</td>
<td>C1820</td>
<td>Generator, neurostimulator (implantable), with rechargeable battery and charging system</td>
<td>Prior Approval Required</td>
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<tr>
<td>HCPCS</td>
<td>L8680</td>
<td>Implantable neurostimulator electrode (with any number of contact points), each</td>
<td>Prior Approval Required</td>
</tr>
<tr>
<td>HCPCS</td>
<td>L8688</td>
<td>Implantable neurostimulator pulse generator, dual array, non-rechargeable, includes extension</td>
<td>Prior Approval Required</td>
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</tbody>
</table>

The following codes will be denied as Investigational

<table>
<thead>
<tr>
<th>CPT</th>
<th>0155T</th>
<th>Laparoscopy, surgical; implantation or replacement of gastric stimulation electrodes, lesser curvature (i.e. morbid obesity)</th>
<th>Investigational</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPT</td>
<td>0156</td>
<td>Laparoscopy, surgical; revision or removal of gastric stimulation electrodes, lesser curvature (i.e. morbid obesity)</td>
<td>Investigational</td>
</tr>
<tr>
<td>CPT</td>
<td>0157T</td>
<td>Laparotomy, implantation or replacement of gastric stimulation electrodes, lesser curvature (i.e. morbid obesity)</td>
<td>Investigational</td>
</tr>
<tr>
<td>CPT</td>
<td>0158T</td>
<td>Laparotomy, revision or removal of gastric stimulation electrodes, lesser curvature (i.e. morbid obesity)</td>
<td>Investigational</td>
</tr>
</tbody>
</table>

Type of Service: Medicine, surgical
Place of Service: inpatient, outpatient

Attachment II
Click HERE for Applicable ICD (diagnosis) code list