BlueCross BlueShield of Vermont
An Independent Licensee of the Blue Cross and Blue Shield Association.

Gastric Electrical Stimulation
Corporate Medical Policy

File Name: Gastric Electrical Stimulation
File Code: UM.NS.06
Origination: 2007
Last Review: 07/2020
Next Review: 07/2021
Effective Date: 11/01/2020

Description/Summary

Gastric electrical stimulation (GES) is performed using an implantable device designed to treat chronic drug-refractory nausea and vomiting secondary to gastroparesis of diabetic, idiopathic or post-surgical etiology. GES has also been investigated as a treatment of obesity. The device may be referred to as a gastric pacemaker.

Policy

Coding Information

Click the links below for attachments, coding tables & instructions. Attachment I - CPT® Code List & Instructions

When a service is considered investigational

Gastric electrical stimulation is considered **investigational** for the treatment of gastroparesis of diabetic, idiopathic, or post-surgical etiology.

Gastric electrical stimulation is considered **investigational** for the treatment of obesity.

Reference Resources

1. Blue Cross Blue Shield Association (BCBSA) MPRM 7.01.73, reviewed 03/2020.

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, or employer's benefit plan if

an ASO group, 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/employer benefit plan language, the member's contract/employer benefit plan language takes precedence.

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.

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.

NEHP/ABNE members may have different benefits for services listed in this policy. To confirm benefits, please contact the customer service department at the member's health plan.

Federal Employee Program (FEP): Members may have different benefits that apply. For further information please contact FEP customer service or refer to the FEP Service Benefit Plan Brochure. It is important to verify the member's benefits prior to providing the service to determine if benefits are available or if there is a specific exclusion in the member's benefit.

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 an Administrative Services Only (ASO) group, benefits may vary or not apply. To verify benefit information, please refer to the member's employer benefit plan documents or contact the customer service department. Language in the employer benefit plan documents takes precedence over medical policy when there is a conflict.

Policy Implementation/Update information

02/2007	New Policy
03/2008	Policy reformatted to match BCBSA Medical Policy format and reviewed by CAC.

07/2009	Medical necessity criteria clarified and aligned with Anthem Blue Cross (New Hampshire) 0162T Code deleted and removed from Appendix.
8/2011	Policy presented in new format. References expanded and updated. Added HCPCS coding. Revised ICD-9 codes. Deleted unlisted procedure CPT code. Added ICD-10 Diagnosis codes where applicable. Codes reviewed and approved by Medical/clinical coder SAR 9/26/11.
2/2014	ICD-10 remediated. New standard language added (document precedence, Audit information, Group and ASO language).
5/2014	Updated policy effective: 10/2014. Adopted BCBSA policy 7.01.73. Investigational for all indications. "C" code for neurostimulators kept in BCBSVT policy since they correlate with primary procedure. Category III codes 0155T-0158T removed- deleted in 2012002E
2/2017	Rearranged policy to align with Association as this is an adopted policy. No change to position statements. Updated references. No changes to coding updated coding table to reflect all codes require PA.
06/2018	Reviewed medical policy with no changes to policy statements.
06/2019	Reviewed medical policy. References 8 and 9 added. No changes to policy statements.
07/2020	Reviewed BCBSA MPRM 7.01.73, updated references, policy statement remains unchanged.

Eligible providers

Qualified healthcare professionals practicing within the scope of their license(s).

Approved by BCBSVT Medical Director(s) Date Approved

Joshua Plavin, MD, MPH, MBA
Chief Medical Officer

Kate McIntosh, MD, MBA, FAAP
Senior Medical Director

Attachment I
CPT® Code List & Instructions

Code Type	Number	Description	Policy Instructions
The following codes will be denied Investigational			
CPT®	43647	Laparoscopy, surgical; implantation or replacement of gastric neurostimulator electrodes, antrum	Requires Prior Approval
CPT®	43648	Laparoscopy, surgical, revision or removal of gastric neurostimulator electrodes, antrum	Requires Prior Approval
CPT®	43881	Implantation or replacement of gastric neurostimulator electrodes, antrum, open	Requires Prior Approval
CPT®	43882	Revision or removal of gastric neurostimulator electrodes, antrum, open	Requires Prior Approval
CPT®	64590	Insertion or replacement of peripheral or gastric neurostimulator pulse generator or receiver, direct or inductive coupling	Requires Prior Approval
CPT®	64595	Revision or removal of peripheral or gastric neurostimulator pulse generator or receiver	Requires Prior Approval
CPT®	95980	Electronic analysis of implanted neurostimulator pulse generator	Requires Prior Approval
CPT®	95981	Subsequent, without reprogramming	Requires Prior Approval
CPT®	95982	Subsequent, with reprogramming	Requires Prior Approval
HCPCS	C1767	Generator, neurostimulator, implantable, non-rechargeable	Requires Prior Approval
HCPCS	C1778	Lead, neurostimulator, implantable	Requires Prior Approval

HCPCS	C1820	Generator, neurostimulator (implantable), with rechargeable battery and charging system	Requires Prior Approval
HCPCS	L8680	Implantable neurostimulator electrode (with any number of contact points), each	Requires Prior Approval
HCPCS	L8685	Implantable neurostimulator pulse generator, single array, rechargeable, includes extension	Requires Prior Approval
HCPCS	L8686	Implantable neurostimulator pulse generator, single array, non-rechargeable, includes extension	Requires Prior Approval
HCPCS	L8687	Implantable neurostimulator pulse generator dual array, rechargeable, includes extension	Requires Prior Approval
HCPCS	L8688	Implantable neurostimulator pulse generator, dual array, non-rechargeable, includes extension	Requires Prior Approval