RMHP Gastric Electrical Stimulation - Neurostimulator; Gastric Pacing

MCG Health
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AUTH: RMHP_AC_5017 (AC)

Link to Codes

Clinical Indications for Procedure

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- For **ALL RMHP plans**, the healthcare device is/was needed for the appropriate care of the Member because of **ALL** of the following
    - Please select the reason (s) the Member requires **gastric electrical stimulation,** also called **gastric pacing,** and related services **ALL** of the following
        - The Member has chronic intractable nausea and vomiting secondary to gastroparesis of diabetic or idiopathic etiology.
        - The Member has diagnostic imaging results demonstrating significantly delayed gastric emptying.
        - The Member is refractory or intolerant of prokinetic and antiemetic medications
        - The device being requested is FDA approved for use in gastric neurostimulation to treat gastroparesis.

Definitions

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Gastric pacing (gastric pacemaker) entails the use of a set of pacing wires attached to the stomach and an external electrical device that provides a low-frequency, high-energy stimulation to entrain the stomach at a rhythm of 3 cycles per minute. However, the gastric pacemaker is cumbersome and problematic for chronic use because of external leads. A newer, implantable device (the Enterra Therapy System by Medtronic, Minneapolis, MN) was developed to provide gastric electrical stimulation.

Unlike gastric pacing, the Enterra delivers a high-frequency (12 cycles per minute), low-energy stimulation to the stomach. This stimulating frequency does not entrain the stomach, and therefore does not normalize gastric dysrhythmias; hence, the term gastric electrical stimulation is employed to differentiate between the Enterra and gastric pacing. With gastric electrical stimulation, electrodes are implanted in the serosa of the stomach laparoscopically or during a laparotomy, and are connected to the pulse generator that is implanted in a subcutaneous pocket.

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United Healthcare Commercial and Individual Exchange Medical Policy Gastrointestinal Motility Disorders, Diagnosis and Treatment, Policy Number 2024T0415B, Effective Date January 1, 2024, reviewed 4/18/2024

United Healthcare Medicare Advantage Coverage Summary, Gastroesophageal and Gastrointestinal (GI) Services and Procedures, Policy Number MCS039.10, Approval Date, January 18, 2024, effective date March 1, 2024 reviewed 4/18/2024.

UnitedHealthcare Community Plan Medical Policy, Gastrointestinal Motility Disorders, Diagnosis and Treatment, Policy Number: CS046.P, Effective Date April 1,2024, reviewed 4/18/20224

No NCD/LCD/LCA exists per CMS Medicare Coverage Database 4/18/2024.

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Policy History

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History Summary: See archived versions and tracking spreadsheet for details. Policy developed 11/14/2007 with annual reviews, updates and committee approvals thereafter through 2023.

2024 Annual review and updates

Codes

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