Overview
The implantation of an anti-gastroesophageal reflux device is a surgical procedure for the treatment of gastroesophageal reflux, a condition in which the caustic contents of the stomach flow back into the esophagus. The procedure involves the implantation of this special device around the esophagus under the diaphragm and above the stomach, which is secured in place by a circumferential tie strap.

Guidelines
The implantation of this device may be considered reasonable and necessary in specific clinical situations where a conventional valvuloplasty procedure is contraindicated. The implantation of an anti-gastroesophageal reflux device is covered only for patients with documented severe or life threatening gastroesophageal reflux disease whose conditions have been resistant to medical treatment and who also:
- Have esophageal involvement with progressive systemic sclerosis; or
- Have foreshortening of the esophagus such that insufficient tissue exists to permit a valve reconstruction; or
- Are poor surgical risks for a valvuloplasty procedure; or
- Have failed previous attempts at surgical treatment with valvuloplasty procedures.

APPLICABLE CODES
The following list(s) of 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.

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>43284</td>
<td>Laparoscopy, surgical, esophageal sphincter augmentation procedure, placement of sphincter augmentation device (i.e., magnetic band), including cruroplasty when performed (Non-covered)</td>
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<tr>
<td>43285</td>
<td>Removal of esophageal sphincter augmentation device (Non-covered)-(i.e., LINX system)</td>
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<tr>
<td>43289</td>
<td>Unlisted laparoscopy procedure, esophagus</td>
</tr>
<tr>
<td>43499</td>
<td>Unlisted procedure, esophagus</td>
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</table>

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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 LCDs, NCDs, 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 below 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.

REFERENCES

CMS National Coverage Determinations (NCDs)
NCD 100.9 Implantation of Anti-Gastroesophageal Reflux Device

CMS Local Coverage Determinations (LCDs)

All LCDs pertaining to unlisted CPT code 43499 address a variety of indications. None of these LCDs specifically address the implantation of an anti-gastroesophageal reflux device; therefore, they are not listed in this document. There are no LCDs for CPT code 43289.

CMS Local Coverage Determinations (LCDs) and Articles

<table>
<thead>
<tr>
<th>LCD</th>
<th>Article</th>
<th>Contractor</th>
<th>Medicare Part A</th>
<th>Medicare Part B</th>
</tr>
</thead>
<tbody>
<tr>
<td>L35080 (Select Minimally Invasive GERD)</td>
<td>A56863 Billing and Coding: Select Minimally Invasive GERD Procedures</td>
<td>National Government Services, Inc.</td>
<td>CT, IL, MA, ME, MN, NH, NY, RI, VT WI</td>
<td>CT, IL, MA, ME, MN, NH, NY, RI, VT WI</td>
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<td>L35094 (Services That Are Not Reasonable and Necessary)</td>
<td>A56967 Billing and Coding: Services That Are Not Reasonable and Necessary</td>
<td>Novitas Solutions, Inc.</td>
<td>CO, NM, OK, TX, AR, LA, MS, DE, MD, NJ, PA</td>
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<tr>
<td>L36219 (Non-Covered Services)</td>
<td>A55607 Additional Information Required for Coverage and Pricing for Category III CPT® Codes</td>
<td>Noridian Healthcare Solutions, LLC</td>
<td>AS, CA, GU, HI, MP, NV</td>
<td>AS, CA, GU, HI, MP, NV</td>
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<tr>
<td>L35008 (Non-Covered Services) Noridian</td>
<td>A55681 Additional Information Required for Coverage and Pricing for Category III CPT® Codes</td>
<td>Noridian Healthcare Solutions, LLC</td>
<td>AK, AZ, ID, MT, ND, OR, SD, WA, UT, WY</td>
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<td>L33777 (Noncovered Services)</td>
<td>A57743 Billing and Coding: Noncovered Services</td>
<td>First Coast Service Options, Inc.</td>
<td>FL, PR, VI</td>
<td>FL, PR, VI</td>
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CMS Benefit Policy Manual
Chapter 4; § 180.3 Unlisted Service or Procedure

CMS Transmittal
Transmittal 146, Change Request 1884, Dated 10/29/2001

UHC Commercial Policy
Minimally Invasive Procedures for Gastroesophageal Reflux Disease (GERD)

Other
LINX™ Reflux Management System for the Treatment of Gastroesophageal Reflux Disease (GERD)
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.

<table>
<thead>
<tr>
<th>Date</th>
<th>Supporting Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>03/11/2020</td>
<td>• Updated References section to reflect the most current information</td>
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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.

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*For more information on a specific member's benefit coverage, please call the customer service number on the back of the member ID card or refer to the Administrative Guide.