UnitedHealthcare Medicare Advantage

Implantation of Anti-Gastroesophageal Reflux Device (NCD 100.9)

Guideline Number: MPG152.06
Approval Date: March 10, 2021

➲ Terms and Conditions

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Related Medicare Advantage Coverage Summary
- Gastroesophageal and Gastrointestinal (GI) Services and Procedures

Policy Summary

➲ See Purpose

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 procedure and/or diagnosis 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.

CPT Code	Description
43284	Laparoscopy, surgical, esophageal sphincter augmentation procedure, placement of sphincter augmentation device (i.e., magnetic band), including cruroplasty when performed (Non-covered)

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CPT Code	Description
43285	Removal of esophageal sphincter augmentation device (Non-covered)-(i.e., LINX system)
43289	Unlisted laparoscopy procedure, esophagus
43499	Unlisted procedure, esophagus

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References

CMS National Coverage Determinations (NCDs)

NCD 100.9 Implantation of Anti-Gastroesophageal Reflux Device

CMS Local Coverage Determinations (LCDs) and Articles

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.

LCD	Article	Contractor	Medicare Part A	Medicare Part B
L34434 Upper Gastrointestinal Endoscopy and Visualization	A56389 Billing and Coding: Upper Gastrointestinal Endoscopy and Visualization	Palmetto	AL, GA, NC, SC, TN, VA, WV	AL, GA, NC, SC, TN, VA, WV
L35080 Select Minimally Invasive GERD	A56863 Billing and Coding: Select Minimally Invasive GERD Procedures	NGS	CT, IL, MA, ME, MN, NH, NY, RI, VT WI	CT, IL, MA, ME, MN, NH, NY, RI, VT WI
N/A	A55749 Response to Comments: Select Minimally Invasive GERD Procedures	NGS	CT, IL, MA, ME, MN, NH, NY, RI, VT WI	CT, IL, MA, ME, MN, NH, NY, RI, VT WI
L35094 Services That Are Not Reasonable and Necessary Retired 07/01/2020	A56967 Billing and Coding: Services That Are Not Reasonable and Necessary Retired 07/01/2020	Novitas	CO, NM, OK, TX, AR, LA, MS, DE, MD, NJ, PA	CO, NM, OK, TX, AR, LA, MS, DE, MD, NJ, PA
L36219 Non-Covered Services Retired 06/30/2020	A55607 Additional Information Required for Coverage and Pricing for Category III CPT® Codes Retired 06/30/2020	Noridian	AS, CA, GU, HI, MP, NV	AS, CA, GU, HI, MP, NV
L35008 Non-Covered Services Retired 06/30/2020	A55681 Additional Information Required for Coverage and Pricing for Category III CPT® Codes Retired 06/30/2020	Noridian	AK, AZ, ID, MT, ND, OR, SD, WA, UT, WY	AK, AZ, ID, MT, ND, OR, SD, WA, UT, WY
L33777 Noncovered Services Retired 07/01/2020	A57743 Billing and Coding: Noncovered Services Retired 07/01/2020	First Coast	FL, PR, VI	FL, PR, VI

CMS Benefit Policy Manual

Chapter 4; § 180.3 Unlisted Service or Procedure

CMS Transmittal(s)

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

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UnitedHealthcare Commercial Policy

Minimally Invasive Procedures for Gastroesophageal Reflux Disease (GERD) and Achalasia

Other(s)

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.

Date	Summary of Changes
04/01/2021	**Template Update** • Reformatted policy; transferred content to new template
03/10/2021	**Supporting Information** • Updated *References* section to reflect the most current information; no change to guidelines • Archived previous policy version MPG152.05

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 NCDs, LCDs, LCAs, 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.

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

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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.

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