I. POLICY/CRITERIA

A. The following are covered for the purpose of evaluation, diagnosis or treatment of gastroparesis:

1. Upper Endoscopy - to confirm the presence of gastric stasis by the finding of retained food after an overnight period of fasting. Also to exclude mechanical obstruction or mucosal disease as a cause of impaired gastric emptying.
2. Gastric emptying scintigraphy (GES)
3. Gastroduodenal manometry – for patients who have evidence of gastric stasis by a scintigraphic study without an identifiable cause
4. Gastric pacing (gastric pacemaker) and gastric electrical stimulation is covered according to InterQual® criteria when provided in accordance with the Humanitarian Device Exemption (HDE) specifications of the U.S. Food and Drug Administration (FDA). [http://www.fda.gov/MedicalDevices/ProductsandMedicalProcedures/DeviceApprovalsandClearances/HDEApprovals/ucm161827.htm](http://www.fda.gov/MedicalDevices/ProductsandMedicalProcedures/DeviceApprovalsandClearances/HDEApprovals/ucm161827.htm)
5. Botulinum toxin (Botox) for gastroparesis is available only as an alternative for patients who would otherwise require daily total parenteral nutrition (TPN) in the home. Botulinum toxin and TPN will not be authorized together for treatment of gastroparesis. Patients using botulinum toxin must meet the same criteria required for TPN. To determine if patient meets criteria for botulinum toxin, submit the TPN [prior authorization form](http://www.fda.gov/MedicalDevices/ProductsandMedicalProcedures/DeviceApprovalsandClearances/HDEApprovals/ucm161827.htm) and Botulinum Toxin [prior authorization form](http://www.fda.gov/MedicalDevices/ProductsandMedicalProcedures/DeviceApprovalsandClearances/HDEApprovals/ucm161827.htm) to the Pharmacy department for review.

B. The following are NOT covered for evaluation and diagnosis of gastroparesis as they are considered to be experimental and investigational:

1. Cutaneous electrogastrogram (EGG)
2. Electronic barostat
3. MRI
4. Wireless capsule monitoring system (i.e. Smart pill)
C. Primary treatment of gastroparesis includes dietary manipulation and administration of antiemetic and prokinetic agents. The following treatments are NOT covered for the treatment of gastroparesis:

1. Gastric pacing (gastric pacemaker) and gastric electrical stimulation is considered to be experimental and investigational for any reason other than those listed in I, A above.
2. Use of botulinum toxin for the treatment of gastroparesis is considered to be experimental and investigational unless the criteria in I.A.5 above are met.

II. MEDICAL NECESSITY REVIEW

☒ Required* ☐ Not Required ☐ Not Applicable

* Prior authorization is required for gastric pacing (gastric pacemaker), gastric electrical stimulation and botulinum toxin. No prior authorization is required or testing.

Note: Botulinum toxin is authorized through the Pharmacy department.

III. APPLICATION TO PRODUCTS

Coverage is subject to member’s specific benefits. Group specific policy will supersede this policy when applicable.

☒ HMO/EPO: This policy applies to insured HMO/EPO plans.
☒ POS: This policy applies to insured POS plans.
☒ PPO: This policy applies to insured PPO plans. Consult individual plan documents as state mandated benefits may apply. If there is a conflict between this policy and a plan document, the provisions of the plan document will govern.
☒ ASO: For self-funded plans, consult individual plan documents. If there is a conflict between this policy and a self-funded plan document, the provisions of the plan document will govern.
☒ INDIVIDUAL: For individual policies, consult the individual insurance policy. If there is a conflict between this medical policy and the individual insurance policy document, the provisions of the individual insurance policy will govern.
☒ MEDICARE: Coverage is determined by the Centers for Medicare and Medicaid Services (CMS); if a coverage determination has not been adopted by CMS, this policy applies.
☒ MEDICAID/HEALTHY MICHIGAN PLAN: For Medicaid/Healthy Michigan Plan members, this policy will apply. Coverage is based on medical necessity criteria being met and the appropriate code(s) from the coding section of this policy being included on the Michigan Medicaid Fee Schedule located at: http://www.michigan.gov/mdch/0,1607,7-132-2945,42542,42543,42546,42551-159815--,00.html. If there is a discrepancy between this policy and the Michigan Medicaid Provider Manual located at: http://www.michigan.gov/mdch/0,1607,7-132-2945,5100-87572--,00.html, the Michigan Medicaid Provider Manual will govern. For Medical Supplies/DME/Prosthetics and Orthotics, please refer to the Michigan Medicaid Fee Schedule to verify coverage.
IV. DESCRIPTION

Gastroparesis (delayed gastric emptying) is a digestive disorder in which the motility of the stomach is either abnormal or absent. Clinical symptoms that suggest gastroparesis include nausea, vomiting, and postprandial abdominal fullness.

The diagnosis of gastroparesis is based on the presence of appropriate symptoms/signs, delayed gastric emptying, and the absence of an obstructing structural lesion in the stomach or small intestine.

Primary treatment of gastroparesis includes dietary manipulation and administration of antiemetic and prokinetic agents.

V. CODING INFORMATION

ICD-10 Codes that may apply:
- E08.43 Diabetes mellitus due to underlying condition with diabetic autonomic (poly)neuropathy
- E09.43 Drug or chemical induced diabetes mellitus with neurological complications with diabetic autonomic (poly)neuropathy
- E10.43 Type 1 diabetes mellitus with diabetic autonomic (poly)neuropathy
- E11.43 Type 2 diabetes mellitus with diabetic autonomic (poly)neuropathy
- E13.43 Other specified diabetes mellitus with diabetic autonomic (poly)neuropathy
- K31.84 Gastroparesis
- R11.0 – R11.2 Nausea and vomiting

CPT/HCPCS Codes:
- 78264 Gastric emptying study
- 78265 Gastric emptying imaging study (eg, solid, liquid, or both); with small bowel transit
- 78266 Gastric emptying imaging study (eg, solid, liquid, or both); with small bowel and colon transit, multiple days
- 91020 Gastric motility (manometric) studies
- 43235 Esophagogastroduodenoscopy, flexible, transoral; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)
- 43236 Esophagogastroduodenoscopy, flexible, transoral; with directed submucosal injection(s), any substance
- 43239 Esophagogastroduodenoscopy, flexible, transoral; with biopsy, single or multiple
- 43245 Esophagogastroduodenoscopy, flexible, transoral; with dilation of gastric/duodenal stricture(s) (eg, balloon, bougie)
43253  Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic ultrasound-guided transmural injection of diagnostic or therapeutic substance(s) (eg, anesthetic, neurolytic agent) or fiducial marker(s) (includes endoscopic ultrasound examination of the esophagus, stomach, and either the duodenum or a surgically altered stomach where the jejunum is examined distal to the anastomosis)

Prior authorization required
J0585  Injection, onabotulinumtoxinA, 1 unit
J0586  Injection, abobotulinumtoxinA, 5 units
J0587  Injection, rimabotulinumtoxinB, 100 units
J0588  Injection, incobotulinumtoxinA, 1 unit

43647  Laparoscopy, surgical; implantation or replacement of gastric neurostimulator electrodes, antrum
43881  Implantation or replacement of gastric neurostimulator electrodes, antrum, open
64590  Insertion or replacement of peripheral or gastric neurostimulator pulse generator or receiver, direct or inductive coupling

L8679  Implantable neurostimulator, pulse generator, any type
L8680  Implantable neurostimulator electrode, each
L8688  Implantable neurostimulator pulse generator, dual array, non-rechargeable, includes extension

No prior authorization required
43648  Laparoscopy, surgical; revision or removal of gastric neurostimulator electrodes, antrum
43882  Revision or removal of gastric neurostimulator electrodes, antrum, open
64595  Revision or removal of peripheral or gastric neurostimulator pulse generator or receiver
95980  Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance, and patient measurements) gastric
95981  Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance, and patient measurements) gastric
95982  Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance, and patient measurements) gastric

Not Covered:
43252  Esophagogastroduodenoscopy, flexible, transoral; with optical endomicroscopy
91112  Gastrointestinal transit and pressure measurement, stomach through colon, wireless capsule, with interpretation and report
91132  Electrogastrography, diagnostic, transcutaneous
91133  Electrogastrography, diagnostic, transcutaneous; with provocative testing
91299  Unlisted diagnostic gastroenterology procedure - when billed for electronic barostat

(Explanatory notes must accompany claims billed with unlisted codes.)

See also:
Stimulation Therapy and Devices medical policy #91468

VI. REFERENCES

AMA CPT Copyright Statement:
All Current Procedure Terminology (CPT) codes, descriptions, and other data are copyrighted by the American Medical Association.

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Priority Health’s medical policies are intended to serve as a resource to the plan. They are not intended to limit the plan’s ability to interpret plan language as deemed appropriate. Physicians and other providers are solely responsible for all aspects of medical care and treatment, including the type, quality, and levels of care and treatment they choose to provide.

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