Medical Policy
Endoscopic Radiofrequency Ablation or Cryoablation for Barrett Esophagus

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Policy Number: 218
BCBSA Reference Number: 2.01.80 (For Plans internal use only)
NCD/LCD: NA

Related Policies
• Oncologic Applications of Photodynamic Therapy, Including Barrett Esophagus, #454
• Confocal Laser Endomicroscopy, #618

Policy
Commercial Members: Managed Care (HMO and POS), PPO, and Indemnity Medicare HMO BlueSM and Medicare PPO BlueSM Members

Radiofrequency ablation may be considered MEDICALLY NECESSARY for treatment of Barrett esophagus with high-grade dysplasia.

Radiofrequency ablation may be considered MEDICALLY NECESSARY for treatment of Barrett esophagus with low-grade dysplasia, when the initial diagnosis of low-grade dysplasia is confirmed by two pathologists.

Radiofrequency ablation is considered INVESTIGATIONAL for treatment of Barrett esophagus when the above criteria are not met, including but not limited to Barrett esophagus in the absence of dysplasia.

Cryoablation is considered INVESTIGATIONAL for Barrett esophagus, with or without dysplasia.

Prior Authorization Information
Inpatient
• For services described in this policy, precertification/preauthorization IS REQUIRED for all products if the procedure is performed inpatient.

Outpatient
• For services described in this policy, see below for products where prior authorization might be required if the procedure is performed outpatient.
Outpatient

<table>
<thead>
<tr>
<th>Commercial Managed Care (HMO and POS)</th>
<th>Prior authorization is <strong>not required</strong>.</th>
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</thead>
<tbody>
<tr>
<td>Commercial PPO and Indemnity</td>
<td>Prior authorization is <strong>not required</strong>.</td>
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<tr>
<td>Medicare HMO Blue\textsuperscript{SM}</td>
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<tr>
<td>Medicare PPO Blue\textsuperscript{SM}</td>
<td>Prior authorization is <strong>not required</strong>.</td>
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### CPT Codes / HCPCS Codes / ICD Codes

Inclusion or exclusion of a code does not constitute or imply member coverage or provider reimbursement. Please refer to the member’s contract benefits in effect at the time of service to determine coverage or non-coverage as it applies to an individual member.

Providers should report all services using the most up-to-date industry-standard procedure, revenue, and diagnosis codes, including modifiers where applicable.

The following codes are included below for informational purposes only; this is not an all-inclusive list.

The above **medical necessity criteria MUST** be met for the following codes to be covered for Commercial Members: Managed Care (HMO and POS), PPO, Indemnity, Medicare HMO Blue and Medicare PPO Blue:

#### CPT Codes

<table>
<thead>
<tr>
<th>CPT codes:</th>
<th>Code Description</th>
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<tbody>
<tr>
<td>43229</td>
<td>Esophagoscopy, flexible, transoral; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)</td>
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</table>

#### ICD-10 Diagnosis Codes

<table>
<thead>
<tr>
<th>ICD-10-CM Diagnosis codes:</th>
<th>Code Description</th>
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<tbody>
<tr>
<td>D13.0</td>
<td>Benign neoplasm of esophagus</td>
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<tr>
<td>K22.710</td>
<td>Barrett's esophagus with low grade dysplasia</td>
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<tr>
<td>K22.711</td>
<td>Barrett's esophagus with high grade dysplasia</td>
</tr>
<tr>
<td>K22.719</td>
<td>Barrett's esophagus with dysplasia, unspecified</td>
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### Description

**Management of Barrett Esophagus**

The management of Barrett Esophagus (BE) includes the treatment of gastroesophageal reflux disease and surveillance endoscopy to detect progression to high-grade dysplasia (HGD) or adenocarcinoma. The finding of HGD or early-stage adenocarcinoma warrants mucosal ablation or resection (either endoscopic mucosal resection [EMR] or esophagectomy).

EMR, either focal or circumferential, provides a histologic specimen for examination and staging (unlike ablative techniques). One 2007 study provided long-term results for EMR in 100 consecutive patients with early Barrett-associated adenocarcinoma (limited to the mucosa).\textsuperscript{1} The 5-year overall survival was 98% and, after a mean of 36.7 months, metachronous lesions were observed in 11% of patients. In a review by Pech and Ell (2009), the authors stated that circumferential EMR of the entire segment of BE leads to a stricture rate of 50%, and recurrences occur at a rate of up to 11%.\textsuperscript{2}

**Ablative Techniques**

Available mucosal ablation techniques include several thermal (multipolar electrocoagulation [MPEC], argon plasma coagulation [APC], heater probe, neodymium-doped yttrium aluminum garnet [Nd:YAG] laser, potassium titanyl phosphate [KTP]-YAG laser, diode laser, argon laser, cryoablation) or nonthermal (5-aminolevulinic acid, photodynamic therapy) techniques. In a randomized phase 3 trial reported by
Overholt et al (2005), photodynamic therapy was shown to decrease significantly the risk of adenocarcinoma in BE.\(^3\) (Photodynamic therapy for BE is discussed in policy #454.

The CryoSpray Ablation system uses a low-pressure spray for applying liquid nitrogen through an upper endoscope. Cryotherapy allows for the treatment of uneven surfaces; however, a disadvantage of the treatment is the uneven application inherent in spraying the cryogen.

The HALO system uses radiofrequency energy and consists of 2 components: an energy generator and an ablation catheter. The generator provides rapid (ie, <1 second) delivery of a predetermined amount of radiofrequency energy to the catheter. The HALO90 or the HALO360 is inserted into the esophagus with an endoscope, using standard endoscopic techniques. The HALO90 catheter is plate-based and used for focal ablation of areas of BE up to 3 cm. HALO360 uses a balloon catheter that is sized to fit the individual's esophagus and is inflated to allow for circumferential ablation.

Radiofrequency ablation affects only the most superficial layer of the esophagus (ie, the mucosa), leaving the underlying tissues unharmed. Measures of efficacy for the procedure are the eradication of intestinal metaplasia and the postablation regrowth of the normal squamous epithelium. (Note: The eradication of intestinal metaplasia does not leave behind microscopic foci). Reports of the efficacy of the HALO system in ablating BE have been as high as 70% (comparable with alternative methods of ablation [eg, APC, MPEC]), and even higher in some reports. The incidence of leaving behind microscopic foci of intestinal metaplasia has been reported to be between 20% and 44% with APC and 7% with MPEC; studies using the HALO system have reported 0%. Another potential advantage of the HALO system is that it is an automated process that eliminates operator-dependent error, which may be seen with APC or MPEC.

The risk of treating HGD or mucosal cancer solely with ablative techniques is undertreatment for approximately 10% of patients with undetected submucosal cancer, in whom esophagectomy would have been required.\(^2\)

Summary
In Barrett esophagus (BE), the normal squamous epithelium is replaced by specialized columnar-type epithelium, known as intestinal metaplasia. Intestinal metaplasia is a precursor to adenocarcinoma and may be treated with mucosal ablation techniques such as radiofrequency ablation (RFA) or cryoablation.

For individuals who have BE with high-grade dysplasia (HGD) who receive endoscopic RFA, the evidence includes a randomized controlled trial (RCT) comparing radical endoscopic resection with focal endoscopic resection followed by RFA, one RCT comparing RFA with surveillance alone, and a systematic review evaluating RCTs and a number of observational studies, some of which compared RFA with other endoscopic treatment modalities. Relevant outcomes are change in disease status, morbid events, and treatment-related morbidity and mortality. The available evidence has shown that using RFA to treat BE with HGD is at least as effective in eradicating HGD as other techniques, with a lower progression rate to cancer, and may be considered an alternative to esophagectomy. Evidence from at least one RCT has demonstrated higher rates of eradication than surveillance alone. The evidence is sufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who have BE with low-grade dysplasia (LGD) who receive endoscopic RFA, the evidence includes at least 3 RCTs comparing RFA with surveillance alone, a number of observational studies, and systematic reviews of these studies. Relevant outcomes are change in disease status, morbid events, and treatment-related morbidity and mortality. For patients with confirmed LGD, evidence suggests that RFA reduces progression to HGD and adenocarcinoma. The evidence is sufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who have BE without dysplasia who receive endoscopic RFA, the evidence includes single-arm studies reporting outcomes after RFA. Relevant outcomes are change in disease status, morbid events, and treatment-related morbidity and mortality. The available studies have suggested that nondysplastic metaplasia can be eradicated by RFA. However, the risk-benefit ratio and the net effect of
RFA on health outcomes are unknown. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who have BE with or without dysplasia who receive endoscopic cryoablation, the evidence includes noncomparative studies and systematic reviews of those studies reporting outcomes after cryoablation. Relevant outcomes include change in disease status, morbid events, and treatment-related morbidity and mortality. These studies have generally demonstrated high rates of eradication of dysplasia. Recent observational studies comparing RFA with cryoablation show similar outcomes. However, there are no RCTs comparing cryoablation with surgical care or RFA. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

### Policy History

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<thead>
<tr>
<th>Date</th>
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<tbody>
<tr>
<td>1/2023</td>
<td>Annual policy review. Description, summary, and references updated. Policy statements unchanged.</td>
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<tr>
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</tr>
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<td>Annual policy review. New references added</td>
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<td>12/2016</td>
<td>Annual policy review. New references added</td>
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<tr>
<td>1/2016</td>
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<tr>
<td>7/2014</td>
<td>Annual policy review. New references added.</td>
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<tr>
<td>5/2014</td>
<td>Updated Coding section with ICD10 procedure and diagnosis codes. Effective 10/2015.</td>
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<tr>
<td>1/2014</td>
<td>Updated to add new CPT code 43229 and remove deleted code 43228</td>
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