



MASSACHUSETTS

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Surgical and Transesophageal Endoscopic Procedures to Treat Gastroesophageal Reflux Disease Prior Authorization Request Form #956 Medical Policy #920 Surgical and Transesophageal Endoscopic Procedures to Treat Gastroesophageal Reflux Disease

Please use this form to assist in identifying members who meet Blue Cross Blue Shield of Massachusetts' (BCBSMA's) medical necessity criteria for Surgical and Transesophageal Endoscopic Procedures to Treat Gastroesophageal Reflux Disease. For members who do not meet the criteria, submit a letter of medical necessity with a request for [Clinical Exception \(Individual Consideration\)](#). Once completed, fax to:

Medical and Surgical: 1-888-282-0780	Medicare Advantage: 1-800-447-2994
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CLINICAL DOCUMENTATION
Copies of clinical documentation that supports the medical necessity criteria for [Surgical and Transesophageal Endoscopic Procedures to Treat Gastroesophageal Reflux Disease](#) must be submitted with this form. **If the patient does not meet all the criteria listed below, please submit a letter of medical necessity explaining why an exception is justified.**

Patient Information	
Patient Name:	Today's Date:
BCBSMA ID#:	Date of Treatment:
Date of Birth:	Place of Service: Outpatient <input type="checkbox"/> Inpatient <input type="checkbox"/>

Physician Information	Facility Information
Name:	Name:
Address:	Address:
Phone #:	Phone #:
Fax#:	Fax#:
NPI#:	NPI#:

MAGNETIC ESOPHAGEAL SPHINCTER AUGMENTATION

Please check off if the procedure being requested is the following:	
Magnetic esophageal sphincter augmentation.	<input type="checkbox"/>

Please check off if the patient meets ALL of the following criteria:	
Patient has a history of severe GERD for ≥1 year with daily symptoms, AND	<input type="checkbox"/>
Patient has tried and failed optimal non-surgical management of symptoms, including lifestyle modification, weight loss (if indicated), and daily proton pump inhibitor use for ≥ 6 months, AND	<input type="checkbox"/>
Patient has proven gastroesophageal reflux by either endoscopy, ambulatory pH monitoring, AND	<input type="checkbox"/>

Patient has evidence of adequate peristalsis by manometry or barium esophagram	<input type="checkbox"/>
None of the following contraindications are present:	<input type="checkbox"/>
• Morbid obesity (BMI >35)	<input type="checkbox"/>
• Suspected or known allergies to metals such as iron, nickel, titanium, or stainless steel	<input type="checkbox"/>
• Grade C or D (LA classification) esophagitis	<input type="checkbox"/>
• Scleroderma	<input type="checkbox"/>
• Esophageal stricture or gross esophageal anatomic abnormalities	<input type="checkbox"/>
• Suspected or confirmed esophageal or gastric cancer	<input type="checkbox"/>
• Prior esophageal or gastric surgery or endoscopic intervention.	<input type="checkbox"/>

TRANSORAL INCISIONLESS FUNDOPLICATION (TIF) (IE, ESOPHYX®)

Please check off if the procedure being requested is the following:	
Transoral incisionless fundoplication (TIF) (ie, EsophyX®).	<input type="checkbox"/>

Please check off if the patient meets ALL of the following criteria:	
Patient has a history of severe GERD for ≥1 year with daily symptoms, AND	<input type="checkbox"/>
Patient has tried and failed optimal non-surgical management of symptoms, including lifestyle modification, weight loss (if indicated), and daily proton pump inhibitor use for ≥ 6 months, AND	<input type="checkbox"/>
Patient has proven gastroesophageal reflux by either endoscopy, ambulatory pH monitoring, or barium esophagram, AND	<input type="checkbox"/>
None of the following contraindications are present:	<input type="checkbox"/>
• Hiatal hernia >2cm in axial height and >2cm in greatest transverse dimension	<input type="checkbox"/>
• Morbid obesity (BMI >35)	<input type="checkbox"/>
• Esophagitis grade C or D	<input type="checkbox"/>
• Barrett's esophagus > 2 cm	<input type="checkbox"/>
• Non-healing esophageal ulcer	<input type="checkbox"/>
• Fixed esophageal stricture or narrowing	<input type="checkbox"/>
• Portal hypertension and/or varices	<input type="checkbox"/>
• Active gastro-duodenal ulcer disease	<input type="checkbox"/>
• Gastric outlet obstruction or stenosis	<input type="checkbox"/>
• Gastroparesis	<input type="checkbox"/>
• Prior esophageal surgery	<input type="checkbox"/>

• Scleroderma	<input type="checkbox"/>
• Suspected or confirmed esophageal or gastric cancer.	<input type="checkbox"/>

Note: Transesophageal radiofrequency to create submucosal thermal lesions of the gastroesophageal junction (ie, the Stretta® procedure) is considered INVESTIGATIONAL as a treatment of gastroesophageal reflux disease.

Note: Endoscopic submucosal implantation of a prosthesis or injection of a bulking agent (eg, polymethylmethacrylate beads, zirconium oxide spheres) is INVESTIGATIONAL as a treatment of gastroesophageal reflux disease.

CPT CODES/ HCPCS CODES

Please check off all the relevant CPT codes:		
43210	Esophagogastroduodenoscopy, flexible, transoral; with esophagogastric fundoplasty, partial or complete, includes duodenoscopy when performed	<input type="checkbox"/>
43284	Laparoscopy, surgical, esophageal sphincter augmentation procedure, placement of sphincter augmentation device (ie, magnetic band), including cruroplasty when performed	<input type="checkbox"/>

Providers should enter the relevant diagnosis code(s) below:

Code	Description	
		<input type="checkbox"/>
		<input type="checkbox"/>

Providers should enter other relevant code(s) below:

Code	Description	
		<input type="checkbox"/>
		<input type="checkbox"/>