

Policy: MP203

Section: Medical Benefit Policy

Subject: Radiofrequency Ablation for Barrett's Esophagus

I. Policy: Radiofrequency Ablation for Barrett's Esophagus

II. Purpose/Objective:

To provide a policy of coverage regarding Radiofrequency Ablation for Barrett's Esophagus

III. Responsibility:

- A. Medical Directors
- B. Medical Management

IV. Required Definitions

1. Attachment – a supporting document that is developed and maintained by the policy writer or department requiring/authoring the policy.
2. Exhibit – a supporting document developed and maintained in a department other than the department requiring/authoring the policy.
3. Devised – the date the policy was implemented.
4. Revised – the date of every revision to the policy, including typographical and grammatical changes.
5. Reviewed – the date documenting the annual review if the policy has no revisions necessary.

V. Additional Definitions

Medical Necessity or Medically Necessary means Covered Services rendered by a Health Care Provider that the Plan determines are:

- a. appropriate for the symptoms and diagnosis or treatment of the Member's condition, illness, disease or injury;
- b. provided for the diagnosis, and the direct care and treatment of the Member's condition, illness disease or injury;
- c. in accordance with current standards of good medical treatment practiced by the general medical community.
- d. not primarily for the convenience of the Member, or the Member's Health Care Provider; and
- e. the most appropriate source or level of service that can safely be provided to the Member. When applied to hospitalization, this further means that the Member requires acute care as an inpatient due to the nature of the services rendered or the Member's condition, and the Member cannot receive safe or adequate care as an outpatient.

Medicaid Business Segment

Medical Necessity shall mean a service or benefit that is compensable under the Medical Assistance Program and if it meets any one of the following standards:

- (i) The service or benefit will, or is reasonably expected to, prevent the onset of an illness, condition or disability.
- (ii) The service or benefit will, or is reasonably expected to, reduce or ameliorate the physical, mental or development effects of an illness, condition, injury or disability.
- (iii) The service or benefit will assist the Member to achieve or maintain maximum functional

capacity in performing daily activities, taking into account both the functional capacity of the Member and those functional capacities that are appropriate for members of the same age.

DESCRIPTION: The **Barrx System** consists of a high-powered radiofrequency energy generator and balloon. The balloon is entirely bipolar, and provides circumferential ablation to the esophagus to rapidly ablate the abnormal esophageal epithelium, while limiting thermal injury to the surrounding tissue. After approximately 1 month post-procedure, re-epithelization begins, and abnormal cells are replaced with squamous epithelium.

INDICATIONS:

The Plan considers the use of the Barrx System medically necessary for those with documented evidence of Barrett's Esophagus with low-grade dysplasia.

Radiofrequency ablation as an alternative to esophagectomy is considered to be medically necessary when high-grade dysplasia is confirmed by endoscopy and life-expectancy is greater than one year.

EXCLUSIONS: The Plan does **NOT** provide coverage for the Barrx System as a treatment for any other indication because it is considered **experimental, investigational or unproven**. Although the device is FDA approved, there is insufficient evidence in the peer-reviewed published medical literature to establish the effectiveness of this treatment on health outcomes when compared to established treatments or technologies

Note: A complete description of the process by which a given technology or service is evaluated and determined to be experimental, investigational or unproven is outlined in MP 15 - Experimental Investigational or Unproven Services or Treatment.

CODING ASSOCIATED WITH: Radiofrequency Ablation for Barrett's Esophagus

The following codes are included below for informational purposes and may not be all inclusive. Inclusion of a procedure or device code(s) does not constitute or imply coverage nor does it imply or guarantee provider reimbursement. Coverage is determined by the member specific benefit plan document and any applicable laws regarding coverage of specific services. Please note that per Medicare coverage rules, only specific CPT/HCPCS Codes may be covered for the Medicare Business Segment. Please consult the CMS website at www.cms.gov or the local Medicare Administrative Carrier (MAC) for more information on Medicare coverage and coding requirements.

43229 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) [when specified as radiofrequency ablation]

43270 Esophagogastroduodenoscopy, flexible, transoral; with ablation of tumor(s), polyp(s) or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed) [when specified as radiofrequency ablation]

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LINE OF BUSINESS:

Eligibility and contract specific benefits, limitations and/or exclusions will apply. Coverage statements found in the line of business specific benefit document will supersede this policy. For Medicare, applicable LCD's and NCD's will supercede this policy. For PA Medicaid Business segment, this policy applies as written.

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Standards of Practice Committee, Wani S, Qumseya B, et al. Endoscopic eradication therapy for patients with Barrett's esophagus-associated dysplasia and intramucosal cancer. *Gastrointest Endosc*. Apr 2018;87(4):907-931 e909.

This policy will be revised as necessary and reviewed no less than annually.

Devised: 06/2007

Revised: 5/15 (added indication)

Reviewed: 7/08, 7/09, 6/10, 6/11, 6/12, 6/13, 6/14, 6/16, 6/17, 5/18, 5/19