



Gastric Pacing and Gastric Electrical Stimulation (GES) for Gastroparesis

LOB(s): <input checked="" type="checkbox"/> Commercial <input checked="" type="checkbox"/> Medicare	State(s): <input checked="" type="checkbox"/> Idaho <input checked="" type="checkbox"/> Montana <input checked="" type="checkbox"/> Oregon <input checked="" type="checkbox"/> Washington <input type="checkbox"/> Other:
<input checked="" type="checkbox"/> Medicaid	<input checked="" type="checkbox"/> Oregon

Enterprise Policy

PacificSource is committed to assessing and applying current regulatory standards, widely-used treatment guidelines, and evidenced-based clinical literature when developing clinical criteria for coverage determination. Each policy contains a list of sources (references) that serves as the summary of evidence used in the development and adoption of the criteria. The evidence was considered to ensure the criteria provide clinical benefits that promote patient safety and/or access to appropriate care. Each clinical policy is reviewed, updated as needed, and readopted, at least annually, to reflect changes in regulation, new evidence, and advancements in healthcare.

Clinical Guidelines are written when necessary to provide guidance to providers and members in order to outline and clarify coverage criteria in accordance with the terms of the Member's policy. This Clinical Guideline only applies to PacificSource Health Plans, PacificSource Community Health Plans, and PacificSource Community Solutions in Idaho, Montana, Oregon, and Washington. Because of the changing nature of medicine, this list is subject to revision and update without notice. This document is designed for informational purposes only and is not an authorization or contract. Coverage determinations are made on a case-by-case basis and subject to the terms, conditions, limitations, and exclusions of the Member's policy. Member policies differ in benefits and to the extent a conflict exists between the Clinical Guideline and the Member's policy, the Member's policy language shall control. Clinical Guidelines do not constitute medical advice nor guarantee coverage.

Background

Gastroparesis is a chronic gastric motility disorder, most commonly diabetic or idiopathic in etiology, characterized by delayed gastric emptying of solid meals in the absence of mechanical obstruction. Symptoms may include bloating, abdominal distension, nausea, and vomiting; severe or prolonged disease may result in dehydration, malnutritional, and poor glycemic control.

Gastric Pacing or Gastric Electrical Stimulation is used to treat chronic, intractable, or medication-refractory nausea and vomiting associated with diabetic or idiopathic gastroparesis.

Criteria

Commercial

Prior authorization is required.

I. Initial implantation of Gastric Electric Stimulation

A. PacificSource considers Gastric Electric Stimulation to be medically necessary when **ALL** of the following criteria is met:

1. Member is 18 years of age or older

2. Severe, refractory symptoms (e.g., frequent nausea or vomiting resulting in dehydration, weight loss, or hospitalization)
3. Diagnosis of chronic gastroparesis of diabetic or idiopathic etiology, confirmed by a standardized gastric emptying scintigraphy (e.g., four (4)-hour protocol where available)
4. Active management of glycemic controls for members with diabetes, when applicable
5. Failure of greater to or equal to three (3) months of medical and dietary management such as:
 - a. Dietary modification (e.g., low-fat, low-fiber/low-residue, small frequent meals or texture modification, liquid nutrient supplementation, etc.)
 - b. Pharmaceutical therapy (e.g., antiemetics and prokinetics)

II. Revision or Removal of Gastric Electric Stimulation

- A. PacificSource considers gastric pacing revision or removal medically necessary when the original device met PacificSource placement criteria and **ONE** of the following complications associated with gastric pacing is present:
1. Bowel obstruction
 2. Gastric wall perforation
 3. Infection
 4. Lead dislodgement
 5. Lead erosion into the small intestine
 6. Device not providing any clinical improvement

III. Replacement of Gastric Electric Stimulation

- A. PacificSource considers replacement of a gastric pacing device medically necessary when the original device met PacificSource placement criteria and replacement is required for battery depletion (generally no more frequently than every five to ten years) or device malfunction not correctable with reprogramming

Medicaid

PacificSource Community Solutions (PCS) follows the general coverage, limitations, and exclusions outlined in OARs 410-141-3820, 410-141-3825, and 410-120-1200. Relevant coverage guidance, including but not limited to Guideline Note 227 of the Health Evidence Review Commission (HERC) Prioritized List of Health Services; as well as any applicable Oregon Administrative Rules (OARs) may be used to determine coverage of Gastric Pacing and Gastric Electrical Stimulation (GES) for Gastroparesis.

PacificSource Community Solutions (PCS) follows the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) coverage requirements in OAR 410-151-0000 through 410-151-0003 for EPSDT beneficiaries. Relevant coverage guidance, including but not limited to Guideline Note 227, may be used to assist in informing a determination of medical necessity and medical appropriateness during the individual case review. A case-by-case review for EPSDT Medical Necessity and EPSDT Medical Appropriateness as defined in OAR 410-151-0001 is required prior to denying. Refer to the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) policy for details.

Medicare

PacificSource Medicare follows CMS guidelines and criteria. In the absence of CMS guidelines and criteria, PacificSource Medicare will follow the PacificSource commercial criteria above for determination of coverage for gastric pacing and gastric electrical stimulation (GES) for gastroparesis.

Experimental/Investigational/Unproven

PacificSource considers Gastric Electrical Stimulation (GES) or gastric pacing experimental, investigational, or unproven for any indications other than those listed above including, but not limited to the following:

- Initial treatment for gastroparesis
- Temporary trial of gastric pacing
- Treatment of obesity

Coding Information

The following list of codes are for informational purposes only and may not be all-inclusive. Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement.

43647 Laparoscopy, surgical; implantation or replacement of gastric neurostimulator electrodes, antrum

43648 Laparoscopy, surgical; revision or removal of gastric neurostimulator electrodes, antrum

43881 Implantation or replacement of gastric neurostimulator electrodes, antrum, open

43882 Revision or removal of gastric neurostimulator electrodes, antrum, open

64590 Insertion or replacement of peripheral or gastric neurostimulator pulse generator or receiver, direct or inductive coupling

64595 Revision or removal of peripheral or gastric neurostimulator pulse generator or receiver

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Related Policies

Bariatric Surgery

Clinical Criteria Used in UM Decisions

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)

New and Emerging Technologies - Coverage Status

References

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American Gastroenterological Association (AGA). (2025). Clinical Practice Guideline on Management of Gastroparesis. <https://doi.org/10.1053/j.gastro.2025.08.004>

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Camilleri, M., & Sanders, K. M. (2022). Gastroparesis. *Gastroenterology*, 162(1), 68–87.e1. <https://doi.org/10.1053/j.gastro.2021.10.028>

Gourcerol, G., et al. (2023). Gastric electrical stimulation versus per-oral pyloromyotomy for the treatment of nausea and vomiting associated with gastroparesis: An observational study of two cohorts. *Neurogastroenterology & Motility*, 35(7), e14565. <https://doi.org/10.1111/nmo.14565>

Hasler, W. (2025). Management of *gastroparesis*. UpToDate.

Lal, N., Livemore, S., Dunne, D., & Khan, I. (2023). Gastric electrical stimulation with the Enterra system: A systematic review. <https://ichgcp.net/clinical-trials-registry/publications/173215>

Oregon Health Authority. Oregon Administrative Rules (OARs). Health Systems: Medical Assistance Programs – Chapter 410 <https://secure.sos.state.or.us/oard/displayChapterRules.action?selectedChapter=87>

Oregon Health Plan. The Health Evidence Review Commission (HERC). Prioritized List of Health Services <https://www.oregon.gov/oha/HSD/OHP/Pages/Prioritized-List.aspx>

symplr Evidence Analysis (formerly Hayes Knowledge Center). (December 7, 2022). Health Technology Assessment: Gastric Electrical Stimulation for Gastroparesis.

Appendix

Policy Number:

Effective: 7/1/2021

Next review: 8/1/2027

Policy type: Enterprise

Author(s):

Depts: Health Services

Applicable regulation(s): 42 CFR § 422.101(b-c); OARs 410-141-3820, 410-141-3825, 410-141-3830, 410-151-0000 through 0003

OPs Approval: 6/2026