Harvard Pilgrim Health Care | TUFTS Health Plan

Medical Necessity Guidelines: **Peroral Endoscopic Myotomy for Treatment of Esophageal Achalasia (POEM)**

Effective: April 1, 2023

Prior Authorization Required If REQUIRED, submit supporting clinical documentation pertinent to service request.	Yes ☐ No ☒

Applies to:

Commercial Products

☒ Harvard Pilgrim Health Care Commercial products; 800-232-0816
☒ Tufts Health Plan Commercial products; 617-972-9409
CareLink℠ – Refer to CareLink Procedures, Services and Items Requiring Prior Authorization

Public Plans Products

☒ Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product); Fax 888-415-9055
☒ Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans; Fax 888-415-9055
☒ Tufts Health RITogether – A Rhode Island Medicaid Plan; Fax 857-304-6404
☒ Tufts Health Unify* – OneCare Plan (a dual-eligible product); Fax 857-304-6304
*The MNG applies to Tufts Health Unify members unless a less restrictive LCD or NCD exists.

Senior Products

☐ Harvard Pilgrim Health Care Stride Medicare Advantage; Fax 617-673-0965
☐ Tufts Health Plan Senior Care Options (SCO), (a dual-eligible product); Fax 617-673-0965
☐ Tufts Medicare Preferred HMO, (a Medicare Advantage product); Fax 617-673-0965
☐ Tufts Medicare Preferred PPO, (a Medicare Advantage product); Fax 617-673-0965

Overview

Peroral Endoscopic Myotomy (POEM) is an endoscopic procedure for the management of achalasia. POEM is an endoscopic procedure, which creates a tunnel in the submucosal layer of the esophagus and proximal stomach. Through this submucosal tunnel, an esophageal and gastric myotomy are made using a flexible endoscope. The procedure is performed perorally, without any incisions in the chest or abdomen.

POEM should only be performed by appropriately trained, experienced physicians in high-volume centers. These centers must have the available staff to address any potential adverse events from POEM immediately, including but not limited to gastrointestinal or cardio-thoracic complications.

Clinical Guideline Coverage Criteria

POEM may be considered medically necessary for adults (18 years and older) with symptomatic achalasia when **ALL** of the following criteria are met:

1) The Member has a confirmed diagnosis of Type III esophageal achalasia
2) The Member has failure of a previous treatment for achalasia (e.g. Botox, pneumatic dilation)
3) The Member has none of the following contraindications to POEM:
    a. Severe erosive esophagitis
    b. Significant coagulation disorders
    c. Liver cirrhosis with portal hypertension
    d. Severe pulmonary disease
    e. Esophageal malignancy

f. Prior therapy that may compromise the integrity of the esophageal mucosa or lead to submucosal fibrosis, including recent esophageal surgery, radiation, endoscopic mucosal resection, or radiofrequency ablation

Codes

The following code(s) are associated with this service:

Table 1: CPT/HCPCS Codes

CPT/ HCPCS Codes	Description
43497	Lower esophageal myotomy, transoral (i.e., peroral endoscopic myotomy [POEM])

References:

1. Lois A, Oelschlager B, Wright A, Templeton A, Flum D, Farjah F. Use and Safety of Per-Oral Endoscopic Myotomy for Achalasia in the US. JAMA Surg. 2022;157(6):490. doi:10.1001/jamasurg.2022.0807.
2. Kahrilas PJ, Katzka D, Richter JE. Clinical Practice Update: The Use of Per-Oral Endoscopic Myotomy in Achalasia: Expert Review and Best Practice Advice From the AGA Institute. Gastroenterology. 2017 Nov;153(5):1205-1211. doi: 10.1053/j.gastro.2017.10.001. Epub 2017 Oct 6. PMID: 28989059; PMCID: PMC5670013.

Approval And Revision History

January 18, 2023: Reviewed by the Medical Policy Approval Committee (MPAC) as a new coverage guideline for effective date: April 1, 2023

Background, Product and Disclaimer Information

Medical Necessity Guidelines are developed to determine coverage for benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. We make coverage decisions using these guidelines, along with the Member's benefit document, and in coordination with the Member's physician(s) on a case-by-case basis considering the individual Member's health care needs.

Medical Necessity Guidelines are developed for selected therapeutic or diagnostic services found to be safe and proven effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in our service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. We revise and update Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Medical Necessity Guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern. For Tufts Health Together (Medicaid), coverage may be available beyond these guidelines for pediatric members under age 21 under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits of the plan in accordance with 130 CMR 450.140 and 130 CMR 447.000, and with prior authorization.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of this guideline is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to eligibility and benefits on the date of service, coordination of benefits, referral/authorization, utilization management guidelines when applicable, and adherence to plan policies, plan procedures, and claims editing logic.