Priority Health	BILLING POLICY No. 143
ENDOSCOPIC TREATMENT FOR GERD	
Date of origin: Sept 2025	**Review dates: 8/2026**

POLICY OVERVIEW

This policy provides guidelines for billing, coding, and documentation, ensuring claims are processed according to contractual agreements and industry standards. Endoscopic treatment of gastroesophageal reflux disease (GERD) refers to minimally invasive procedures performed during upper endoscopy to address reflux symptoms and complications when medical therapy and lifestyle changes fail. These techniques aim to restore the anatomical barrier between the esophagus and stomach, reducing acid reflux without the need for open surgery

DEFINITIONS

Gastroesophageal reflux disease (GERD) is a common disorder characterized by heartburn and other symptoms related to reflux of stomach acid into the esophagus. Endoscopic treatments were developed for the treatment of GERD in patients whose symptoms could not be managed non-operatively with pharmacologic therapy. Advancements in endoscopic and laparoscopic surgery have expanded the options for patients with GERD who are referred for surgical/endoscopic intervention.

Surgical and endoscopic intervention should be considered only after extensive initial evaluation and medical therapy by primary care and specialty physicians. For patients who have 1) failed medical management, 2) have complications of GERD, or 3) have extra-esophageal manifestations (asthma, hoarseness, cough, chest pain, aspiration), anti-reflux surgery may be an appropriate option.
There are two types of endoscopic treatments for GERD: Transoral incisionless fundoplication (TIF) and The Stretta radiofrequency energy procedure.

MEDICAL POLICY

Gerd and Barrett's Esophagus #91483

FOR MEDICARE

For indications that do not meet criteria of NCD, local LCD or specific medical policy, a Pre-Service Organization Determination (PSOD) will need to be completed. Click here for additional details on PSOD.

POLICY SPECIFIC INFORMATION

Coding specifics

Certain services that are integral components of endoscopic procedures cannot be reported separately. These services include, but are not limited to, venous access (e.g., CPT code 36000), infusion/injection (e.g., CPT codes 96360-96379), non-invasive oximetry (e.g., CPT codes 94760 and 94761), and anesthesia provided by the surgeon.

Per CPT Professional codebook instructions, surgical endoscopy includes diagnostic endoscopy. A diagnostic endoscopy HCPCS/CPT code should not be reported with a surgical endoscopy code.

Control of bleeding is an integral component of endoscopic procedures and cannot be reported separately. If it is necessary to repeat an endoscopy to control bleeding at a separate patient encounter on the same date of service, the HCPCS/CPT code for endoscopy for control of bleeding is separately reportable with modifier 78 indicating that the procedure required return to the operating room (or endoscopy suite) for a related procedure during the postoperative period.

Code	Description
43210	Esophagogastroduodenoscopy, flexible, transoral; with esophagogastric fundoplasty, partial or complete, includes duodenoscopy when performed (when billed for EsophyX System)
43257	Esophagogastroduodenoscopy, flexible, transoral; with delivery of thermal energy to the muscle of lower esophageal sphincter and/or gastric cardia, for treatment of gastroesophageal reflux disease (when billed for Stretta System) *Not covered for Priority Health Medicare*

Place of Service

22 – Outpatient Hospital
24 – Ambulatory Surgical Center
Coverage will be considered for services furnished in the appropriate setting to the patient's medical needs and condition. Authorization may be required. Click here for additional information

Modifiers

To report esophagogastroscopy where the duodenum is deliberately not examined (eg, judged clinically not pertinent), or because the clinical situation precludes such exam (eg, significant gastric retention precludes safe exam of duodenum), append modifier 52 if repeat examination is not planned, or modifier 53 if repeat examination is planned.

Priority Health follows standard billing and coding guidelines which include CMS NCCI. Modifiers should be applied when applicable based on this guidance and only when supported by documentation.

Incorrect application of modifiers will result in denials. The modifier list below may not be an all-inclusive list. Please see our provider's manual page for modifier use here.

Documentation requirements

Complete and thorough documentation to substantiate the procedure performed is the responsibility of the Provider. In addition, the Provider should consult any specific documentation requirements that are necessary for any applicable defined guidelines.

Reimbursement rates

Find reimbursement rates for the codes listed on this page in our standard fee schedules for your contract. Go to the fee schedules (login required).

REFERENCES

LCD - Endoscopic Treatment of GERD (L34659)

MEDICAL POLICY - TRANSESOPHAGEAL ENDOSCOPIC THERAPIES FOR GASTROESOPHAGEAL REFLUX DISEASE (GERD) (TRANSORAL ICISIONLESS FUNDOPLICATION - TIF)

EndoscopicTreatmentforGERD.pdf

Medicare NCCI 2025 Coding Policy Manual – Chapter 6

DISCLAIMER

CMS and/or MDHHS guidelines apply unless otherwise specified in this policy or provider manual. Where such guidance is absent, this policy applies. Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements are appropriate to procedure; diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS), and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standards, compliant codes defined by CPT, HCPCS, and revenue codes for all claim submissions. CPT, HCPCPS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

CHANGE / REVIEW HISTORY

Date	Revisions made
August 2026	Added policy description, definitions, table for the CPT codes