Molina Clinical Policy
Gastric Electrical Stimulation
Policy No. 414

Last Approval: 10/14/2026
Next Review Due By: October 2027

DISCLAIMER

This Molina Clinical Policy (MCP) is intended to facilitate the Utilization Management process. Policies are not a supplementation or recommendation for treatment. Providers are solely responsible for the diagnosis, treatment, and clinical recommendations for the member. It expresses Molina's determination as to whether certain services or supplies are medically necessary, experimental, investigational, or cosmetic for purposes of determining appropriateness of payment. The conclusion that a particular service or supply is medically necessary does not constitute a representation or warranty that this service or supply is covered (e.g., will be paid for by Molina) for a particular member. The member's benefit plan determines coverage – each benefit plan defines which services are covered, which are excluded, and which are subject to dollar caps or other limits. Members and their providers will need to consult the member's benefit plan to determine if there are any exclusion(s) or other benefit limitations applicable to this service or supply. If there is a discrepancy between this policy and a member's plan of benefits, the benefits plan will govern. In addition, coverage may be mandated by applicable legal requirements of a State, the Federal government or CMS for Medicare and Medicaid members. CMS's Coverage Database can be found on the CMS website. References included were accurate at the time of policy approval and publication.

OVERVIEW

Gastroparesis, or delayed gastric emptying, is a disorder in which the stomach fails to empty its contents at a normal rate. This condition can cause symptoms such as bloating, abdominal discomfort, nausea, vomiting, and early satiety. In severe cases, complications can lead to weight loss, dehydration, electrolyte imbalances, and malnutrition. Initial management typically involves conservative approaches such as dietary modification, pharmacologic therapy, and optimization of glycemic control in patients with diabetes. Supportive interventions, including intravenous hydration or nutritional supplementation, may also be required. When symptoms of chronic intractable (drug-refractory) nausea and vomiting persist despite these measures, the condition is considered refractory (FDA 2000; Hasler 2025).

Gastric electrical stimulation (GES) is a treatment option for refractory gastroparesis focused primarily on reducing chronic intractable nausea and vomiting. The therapy involves implanting electrodes into the gastric wall, usually along the greater curvature of the stomach. These electrodes are connected to a small, battery-powered pulse generator, which is implanted in a subcutaneous pocket in the abdominal wall. The device is programmed externally to optimize therapy for each patient. The procedure is most commonly performed laparoscopically, although an open approach may be used if necessary. Once activated, the generator delivers electrical pulses to the stomach wall. GES is a form of neuromodulation and is not a true gastric pacemaker. It does not entrain gastric slow waves or consistently accelerate gastric emptying (Hasler 2025; Shanker et al. 2021).

The precise mechanism of action of GES remains unclear. Initially, it was thought that electrical impulses may improve the rate of gastric emptying; however, this has not been consistently demonstrated. Symptom improvement may instead result from neuromodulation, in which stimulation of the vagal afferent pathways influence central nausea and vomiting centers. Some studies also suggest that GES may enhance gastric accommodation, which could contribute to symptom relief (Hasler 2025; Shanker et al. 2021).

Regulatory Status

The Enterra Therapy System (Enterra Medical), received U.S. Food and Drug Administration (FDA) approval in 2000 under a Humanitarian Device Exemption (HDE) for the treatment of chronic, intractable (drug resistant) nausea and vomiting secondary to diabetic or idiopathic gastroparesis in patients aged 18 to 70 years (FDA 2000). Temporary GES, in which endoscopically placed cardiac pacing leads are connected to an external stimulator, has also been studied as a less invasive method to assess response prior to permanent implantation. This is an off-label use, as the only FDA-approved configuration requires intramuscular placement of pacing leads within the gastric antrum.

On October 20, 2023, the FDA granted supplemental approval (H990014/S227) under the existing Humanitarian Device Exemption for the Enterra II System. This approval added Magnetic Resonance Imaging (MRI) Conditional labeling, allowing patients with the Enterra II System to safely undergo MRI examinations of the head and upper or lower extremities under specified conditions.

GES has also been investigated as a potential therapy for patients with obesity. In this context, stimulation is intended to induce early satiety and reduce appetite, leading to weight loss. However, the mechanisms underlying these effects are not well understood, and no GES devices are currently approved by the FDA for the treatment of obesity.

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COVERAGE POLICY

Gastric electrical stimulation for the treatment of refractory gastroparesis may be **considered medically necessary** when ALL the following criteria are met:

1. Member is age 18 or older

2. Diagnosis of refractory gastroparesis with diabetic or idiopathic etiology

3. Co-morbid or contributing factors to delayed gastric emptying are either eliminated or well controlled prior to delayed gastric emptying study and initial diagnosis of gastroparesis, including documented optimal glycemic control in members with diabetes, as hyperglycemia may delay gastric emptying

4. Delayed gastric emptying, confirmed via validated breath test *OR* a 4-hour gastric emptying study (i.e., scintigraphy) defined by > 10% retention at 4 hours measured directly, not mathematically derived
    a. Member must be free of any medication that can cause gastroparesis (e.g., glucagon-like peptide-1 [GLP-1] medications, opioids, etc.) for at least 2 months prior to the study unless clinically infeasible (e.g., opioid use in severe, chronic, intractable pain)

5. Symptoms persist for ≥ 1 year despite ALL the following medical management:
    a. Dietary modification
    b. Refractory to, intolerant to, or has contraindications to the use of at least one drug from *both* of the following classes:
        i. Antiemetic medication(s) (e.g., antihistamines, serotonin receptor antagonists, and dopamine receptor antagonists) such as granisetron or ondansetron
        ii. Prokinetic medication(s) (e.g., cholinergic agonists, motilin receptor agonists, and dopamine receptor antagonists) such as metoclopramide

Limitations and Exclusions

Gastric electrical stimulation is considered **experimental, investigational, and unproven** due to insufficient evidence in the peer-reviewed medical literature to establish long-term safety, efficacy, and effect on net health outcomes for ALL the following:

1. Treatment of conditions other than chronic refractory gastroparesis, including obesity
2. Use in pregnant individuals
3. Temporary GES in which leads are placed endoscopically
4. Concurrent use with glucagon-like peptide-1 (GLP-1) medications

DOCUMENTATION REQUIREMENTS: Molina Healthcare reserves the right to require that additional documentation be made available as part of its coverage determination; quality improvement; and fraud; waste and abuse prevention processes. Documentation required may include, but is not limited to, patient records, test results and credentials of the provider ordering or performing a drug or service. Molina Healthcare may deny reimbursement or take additional appropriate action if the documentation provided does not support the initial determination that the drugs or services were medically necessary, not investigational, or experimental, and otherwise within the scope of benefits afforded to the member, and/or the documentation demonstrates a pattern of billing or other practice that is inappropriate or excessive.

SUMMARY OF MEDICAL EVIDENCE

Gastroparesis

Evidence in published peer-reviewed medical literature examining the safety and efficacy of permanent gastric electrical stimulation (GES) for the treatment of refractory gastroparesis consists of observational studies, case series, retrospective studies, and a small number of randomized controlled trials. Because certain medications—including glucagon-like peptide-1 (GLP-1) receptor agonists such as semaglutide—can slow gastric emptying and produce gastroparesis-like symptoms that often resolve after discontinuation, it is essential to confirm true refractory disease

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with a medication-free gastric emptying study prior to considering GES implantation (Chaudry et al. 2024). A published case report described resolution of delayed gastric emptying and symptom improvement within six weeks of stopping weekly semaglutide, underscoring the need for an adequate medication washout period before testing (Kalas et al. 2021).

Randomized Controlled Trials

Ducrotte et al. (2020) conducted a large, multicenter, randomized, double-blind, crossover trial (NCT00903799) that studied the efficacy of GES using the Enterra device in patients with chronic (>12 months) refractory vomiting, with or without gastroparesis. A total of 172 patients were randomized to double-blind groups that received either 4 months of stimulation or no stimulation, followed by crossover to the alternate treatment. The primary endpoints were vomiting frequency (vomiting score) and quality of life, while secondary endpoints included changes in digestive symptoms, nutritional status, gastric emptying, and glycemic control. Across both phases, vomiting frequency was significantly reduced in all groups when stimulation was active compared to when the device was turned off. However, active stimulation did not accelerate gastric emptying and was not associated with improvements in quality of life measured by the Hospital Anxiety and Depression Scale.

McCallum et al. (2013) performed a prospective, multicenter, double-blind, randomized, crossover study evaluating the efficacy and safety of GES for chronic vomiting in patients with idiopathic gastroparesis. Thirty-two subjects were implanted with the Enterra GES system and initially received 1.5 months of unblinded ON stimulation. Participants were then randomized in a double-blind manner to two consecutive 3-month crossover periods, during which the device was either ON or OFF, followed by 4.5 months of unblinded ON stimulation. The primary endpoint was weekly vomiting frequency (WVF). Significant reductions in WVF were observed during the initial unblinded ON phase (61.2% reduction from baseline, $P < 0.001$) and maintained at the 1-year follow-up (87% reduction, $P < 0.001$). In contrast, the blinded 3-month crossover periods showed only a non-significant difference between ON and OFF phases. The authors suggested this may reflect either a placebo effect or a carryover effect, as the absence of a washout period could have allowed residual benefits of stimulation to persist during the OFF phase.

McCallum et al. (2010) conducted a prospective, multicenter, randomized, controlled, crossover study (NCT00157755) to evaluate the effects of GES with the Enterra system in patients with diabetic gastroparesis. Eligibility criteria included more than 7 episodes of vomiting per week, delayed gastric emptying confirmed by scintigraphy (> 60% retention at 2 hours and > 10% at 4 hours), symptoms lasting at least 12 months, and refractoriness or intolerance to prokinetic and antiemetic medications used for a minimum of one month, unless contraindicated. A total of 55 patients with refractory diabetic gastroparesis were enrolled and underwent implantation of the Enterra system. Following implantation, all patients received 6 weeks of stimulation (ON phase), followed by randomization to 3-month crossover periods with the device ON or OFF. This was followed by an additional 4.5 months of unblinded stimulation (ON phase). Results showed a 57% reduction in weekly vomiting frequency (WVF) compared with baseline during the initial ON period ($P < 0.001$), which was maintained at one year with a 67.8% reduction ($P < 0.001$). However, during the blinded 3-month crossover phase, there was no significant difference in WVF between the ON and OFF groups.

Abell et al. (2003) conducted an early randomized, double-blind crossover trial evaluating GES for medically refractory gastroparesis. Thirty-three patients aged 19 to 65 years (17 diabetic, 16 idiopathic) were enrolled. Eligibility criteria included more than 7 episodes of vomiting per week, delayed gastric emptying confirmed by scintigraphy (>60% retention at 2 hours and >10% at 4 hours), presence of symptoms for 12 months or greater, and refractoriness or intolerance to at least two of three classes of prokinetic drugs and two of three classes of antiemetics. After implantation, patients were randomized to stimulation ON or OFF for one month in a crossover design. Following this blinded phase, all participants received unblinded stimulation and were reassessed at 6 and 12 months. The primary outcomes evaluated were vomiting frequency, patient preference for ON vs. OFF, upper gastrointestinal symptoms, quality of life, gastric emptying, and adverse events. During the initial double-blind period, subjects reported significantly reduced vomiting in the ON period as opposed to the OFF ($P < 0.05$), with patient preference aligning with these results. In the open-label phase, participants continued to demonstrate significant reductions in vomiting frequency at both 6 and 12 months ($P < 0.05$). Complications including infection led to explanation or revision of the device in five patients.

Systematic Reviews and Meta-Analyses

Rajamanuri et al. (2021) performed a systematic review of literature published over the prior 10 years examining gastroparesis and GES. A total of 12 studies were included in the analysis. Overall, the evidence suggested that GES

was effective in reducing symptoms of gastroparesis in adults (pediatric populations were excluded). Reported benefits included improvements in nausea, vomiting, abdominal bloating, weight loss, and quality of life (QOL). Many studies showed significant gains in QOL and Gastroparesis Cardinal Symptom Index (GCSI) scores, though some reported no substantial QOL improvement. Several studies also noted significant weight gain following therapy. Meta-analyses and randomized controlled trials (RCTs), compared with open-label studies, tended to show more consistent positive outcomes for QOL. Additional observed benefits included reduced inflammatory markers, improved insulin levels in diabetic patients, and shorter hospital stays. The authors concluded that while gastric pacemakers demonstrate variable effects across symptoms, the overall evidence indicates potential efficacy. However, they emphasized the need for further RCTs, particularly evaluating idiopathic and post-surgical gastroparesis.

Levinthal and Bielefeldt (2017) conducted a systematic review and meta-analysis evaluating the effectiveness of GES in gastroparesis. Five randomized controlled studies compared periods with the device ON versus OFF and found no significant difference in total symptom severity (TSS) scores between conditions (P = 0.15). In contrast, 16 open-label studies demonstrated a substantial reduction in TSS (P < 0.001). When comparing treatment modalities, symptom improvements were also observed with medical therapy, placebo arms, and botulinum toxin injections. The authors also noted considerable variability in baseline symptom severity across studies, which strongly influenced treatment outcomes. This heterogeneity limits the ability to draw definitive conclusions regarding the true efficacy of GES.

Non-Randomized Studies, Retrospective Reviews, and Other Evidence
Cassidy et al. (2024) reported outcomes from a single-center cohort of 157 patients who underwent GES between 2012 and 2018 using a structured multidisciplinary selection protocol. All patients had objectively confirmed delayed gastric emptying while off opioids, cannabinoids and GLP-1 agonists, and had failed at least six months of medical therapy that included two classes of prokinetic and antiemetic agents along with dietician guided behavioral medication. Additional exclusion criteria included prior gastric surgery, active tobacco use, metal allergy, medical noncompliance and MRI requirements. GES implantation was performed robotically by a single surgeon with a standardized electrode placement and postoperative programming. Baseline demographics reflected a predominantly idiopathic (59.2%) and diabetic (36.3%) population, mostly female, with long standing symptoms. GCSI scores were available for all patients preoperatively, 141 patients at one year, and 110 patients at five years. Symptom severity across all nine GCSI items and all three subscales improved significantly at one year and remained improved at five years. Total GCSI decreased from 3.7 preoperatively to 1.3 at one year and 1.4 at five years. Use of prokinetic, antiemetic, and neuromodulator medications declined over follow-up, and gastroparesis related hospitalizations fell from 58% of patients preoperatively to 12.8% at one year and 14.5% at five years, with a corresponding reduction in annual hospitalization frequency. Patient satisfaction was high, with 87.1% satisfied or very satisfied at one year and 79.7% at five years. Device-related events were infrequent. Five patients underwent explantation, twelve required generator exchange, and even required reoperation for lead displacement or erosion. No differences in outcomes were observed between idiopathic and diabetic subgroups. Several limitations were noted. This is a single-center study with all procedures performed by one surgeon, which may limit generalizability. Loss to follow-up was substantial, and hospitalization data may be incomplete if admissions occurred outside of the institution or were coded without gastroparesis related diagnoses. The study did not capture detailed information of diabetes severity, and the predominance of idiopathic gastroparesis may underestimate potential benefit in diabetic patients. Overall, despite these limitations, the findings support the role of GES as a treatment option for carefully selected patients with medically refractory gastroparesis when managed within a structured multidisciplinary protocol.

Gourcerol et al. (2023) completed an observational study comparing GES to gastric perioral endoscopic myotomy (G-POEM) in patients with nausea and vomiting from gastroparesis. Sixty-four patients with medically refractory gastroparesis with nausea and vomiting were included in the study. Data was aggregated from the Enterra cohort and the G-POEM cohort. Both independent open-labeled cohorts followed patients for 24 months. Of the 64 patients included in the study, (n=34) were treated with GES and (n=30) were treated with G-POEM. The authors defined the clinical response as a decrease of ≥1 point in the nausea and vomiting score and the absence of a switch from one to the other technique before the end of the 24 months. Clinical response was noted in 21/34 (61.7%) in patients treated with GES and in 21/30 (70%); p=0.60) patients treated with G-POEM. At the 24 month follow up, mean scores of nauseas and vomiting subscale decreased in the GES cohort (from 3.0 to 1.6; p=0.001) as well at the G-POEM cohort (from 2.6 to 1.2; p=0.001). However, when adjusted from baseline (0.28 [-0.77; 0.19]; p=0.24) there was no difference between the groups. At 24 months the authors did not see a significant difference in the efficacy of GES and G-POEM with medically refractive gastroparesis with predominant nausea and vomiting. Both cohorts had improved symptomatic and quality of life scores at 24 months. The authors noted several limitations to the study. Patients treated

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with GES had higher nausea and vomiting sub scores and worse quality of life at baseline as compared to the patients treated with G-POEM, however other characteristics were comparable. There was a lack of randomization and blinding, a small sample size and different scales were used between the two cohorts. At the conclusion of the study, it remains unknown if GES or G-POEM is more effective for gastroparesis with refractory nausea and vomiting.

Szarka et al. (2008) completed a validation study evaluating a non-radioactive [^{13}C]-spirulina platensis gastric emptying breath test (GEBT) using a standardized, shelf-stable 238 k-Cal solid meal(100 mg [^{13}C]-spirulina platensis, freeze dried egg mix, saltine crackers, and water). Simultaneous scintigraphy served as the reference standard in 38 healthy volunteers and 129 patients with suspected delayed gastric emptying. Breath samples were collected at 45, 90, 120, 150, 180, and 240 minutes. The GEBT demonstrated reproducibility comparable to scintigraphy, with imprecision largely reflecting normal physiologic variation. Using a limited set of four breath samples, the test accurately categorized gastric emptying at 80% specificity, combined 45- and 180-minute samples were 93% sensitive for accelerated emptying, while combined 150- and 180-minute samples were 89% sensitive for delayed emptying. The authors concluded that this [^{13}C]-spirulina platensis GEBT with an off-the-shelf standardized meal is a valid, practical method for assessing solid gastric emptying in both clinical and research settings.

Obesity

There is insufficient published evidence to support the efficacy and safety of GES therapy for promoting weight loss among patients with morbid obesity. Small clinical trials have reported positive outcomes in weight loss and maintenance of weight loss along with minimal complications. The most notable trial, the SHAPE trial, evaluated the difference in the percentage of excess weight loss (EWL) between the control and treatment groups and found EWL was the same for both groups.

Shikora et al. (2009) conducted a prospective, randomized, placebo-controlled, double-blind, multicenter study (NCT00200083) called The SHAPE trial compared implantable gastric stimulation therapy with a standard diet and behavioral therapy regimen in 190 participants with obesity by evaluating the difference in the percentage of EWL between the control and treatment groups. All patients underwent implantation with the implantable gastric stimulator and were randomized to 1 of 2 treatment groups: the control group (stimulation off) or treatment group (stimulation on). The patients were evaluated monthly. All individuals who enrolled in this study agreed to consume a diet with a 500-kcal/d deficit and to participate in monthly support group meetings. The procedure resulted in no deaths and a low complication rate. The primary endpoint of a difference in weight loss between the treatment and control groups was not met. The control group lost 11.7% +/- 16.9% of excess weight and the treatment group lost 11.8% +/- 17.6% (P = .717) according to an intent-to-treat analysis. The authors noted that although implantable gastric stimulation as a surgical option for the treatment of morbid obesity is a less complex procedure than current bariatric operations, the results of the present study do not support its application.

National and Specialty Organizations

The **American Gastroenterological Association** (AGA) published *AGA Clinical Practice Guideline on Management of Gastroparesis* (Staller et al. 2025), which recommend against the use of a 2-hour (or shorter) gastric emptying study compared with a 4-hour gastric emptying study to evaluate for delayed gastric emptying (low certainty of evidence), as performing a full 4-hour study can reclassify some patients who appear normal at 2 hours. The AGA urges that measurements should be obtained directly at 4 hours to maximize accuracy, instead of being derived mathematically. The AGA urges that conditions and medications that may affect gut motility (e.g., hyperglycemia, glucagon-like peptide-1 receptor agonists, opioid medications) are modified when possible before issuing a diagnosis of gastroparesis. Regarding gastric electrical stimulation GES, the panel issued a conditional recommendation against its routine use (very low certainty of evidence) in refractory gastroparesis. The guidelines state that GES has a place in medically refractory gastroparesis, but that patients should be counseled that GES comes with potential adverse events and mainly improves nausea and vomiting, not abdominal pain. Additionally, a risk benefit analysis should be done for each individual patient to assess whether GES is the right treatment.

The **American College of Gastroenterology** (ACG) issued an update to the 2013 ACG official practice guidelines on gastroparesis. Recommendation 15 states: “Gastric electric stimulation (GES) may be considered for control of GP symptoms as a humanitarian use device (HUD) (conditional recommendation, low quality of evidence)” (Camilleri et al. 2022).

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The **National Institute of Diabetes and Digestive and Kidney Diseases** (2018) states that GES may be effective for some patients whose nausea and vomiting do not improve with dietary changes or medications.

The **National Institute for Health and Care Excellence** (2014) published guidance on GES for gastroparesis noting that current evidence on efficacy and safety supports the use of GES as a treatment for chronic, intractable nausea and vomiting due to gastroparesis.

The **American Neurogastroenterology and Motility Society and the Society of Nuclear Medicine** established a standardized protocol for solid meal gastric emptying scintigraphy to address prior variability in meal composition, imaging frequency/duration, and reference ranges across institutions. The recommended method uses a low-fat egg white meal (approximately 120 grams liquid egg whites labeled with 0.5 to 1.0 mCi 99mTc-sulfur colloid, 2 slices of white toast, 30 grams strawberry jam, and 120 mL water) with anterior /posterior or left anterior oblique imaging at 0, 1, 2, and 4 hours after meal ingestion. Normative values, derived from a multicenter study of 123 healthy subjects, define delayed gastric emptying as >90% retention at one hour, >60% retention at two hours, or >10% retention at 4 hours. The 4-hour point is particularly useful for discriminating delayed emptying, as it separates true delayed gastric emptying from normal variation. Adoption of this protocol improves test reliability, inter-institutional comparability, and clinical utility (Abell et al. 2008).

CODING & BILLING INFORMATION

CPT (Current Procedural Terminology)

Code	Description
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, sacral, or gastric neurostimulator pulse generator or receiver, requiring pocket creation and connection between electrode array and pulse generator or receiver
64595	Revision or removal of peripheral, sacral, or gastric neurostimulator pulse generator or receiver, with detachable connection to electrode array
95980	Electronic analysis of implanted neurostimulator pulse generator system (e.g., rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient measurements) gastric neurostimulator pulse generator/transmitter; intraoperative, with programming
95981	Electronic analysis of implanted neurostimulator pulse generator system (e.g., rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient measurements) gastric neurostimulator pulse generator/transmitter; subsequent, without reprogramming
95982	Electronic analysis of implanted neurostimulator pulse generator system (e.g., rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient measurements) gastric neurostimulator pulse generator/transmitter; subsequent, with reprogramming

HCPCS (Healthcare Common Procedure Coding System)

Code	Description
C1767	Generator, neurostimulator (implantable), non-rechargeable
C1778	Lead, neurostimulator (implantable)
L8679	Implantable neurostimulator, pulse generator, any type
L8680	Implantable neurostimulator electrode, each
L8688	Implantable neurostimulator pulse generator, dual array, non-rechargeable, includes extension

CODING DISCLAIMER: Codes listed in this policy are for reference 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. Listing of a service or device code in this policy does not guarantee coverage. Coverage is determined by the benefit document. Molina adheres to Current Procedural Terminology (CPT®), a registered trademark of the American Medical Association (AMA). All CPT codes and descriptions are copyrighted by the AMA; this information is included for

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informational purposes only. Providers and facilities are expected to utilize industry standard coding practices for all submissions. When improper billing and coding is not followed, Molina has the right to reject/deny the claim and recover claim payment(s). Due to changing industry practices, Molina reserves the right to revise this policy as needed.

APPROVAL HISTORY

10/14/2026	Policy revised. Delayed gastric emptying criterion updated to align with the 2025 AGA Clinical Practice Guideline by requiring confirmation with a standardized 4-hour gastric emptying study. Added requirements for documentation of optimal glycemic control in members with diabetes. IRO Peer Reviewed on September 4, 2026 by a practicing physician board-certified in Gastroenterology, Internal Medicine.
10/08/2025	Policy revised. Added criteria specification that member must be free of any medication that can cause gastroparesis at least 2 months prior to gastric emptying study. Added GLP-1 as a contraindication to GES. Updated Overview, Summary of Medical Evidence, and References. IRO Peer Review on September 30, 2025, by a practicing physician board-certified in Internal Medicine, Gastroenterology.
10/09/2024	Policy reviewed, no changes to criteria. Updated Overview, Summary of Evidence, and References.
10/12/2023	Policy reviewed, no changes to criteria. Updated Overview and Summary of Evidence due to retirement of policy MCP 243.
06/14/2023	Policy reviewed, no changes to criteria. Updated Summary of Medical Evidence and Reference sections.
06/08/2022	New policy. IRO peer reviewed in May 2022 by a board-certified physician practicing in Gastroenterology.

REFERENCES

1. Abell TL, Camilleri M, Donohoe K. et al. American Neurogastroenterology and Motility Society and the Society of Nuclear Medicine. Consensus recommendations for gastric emptying scintigraphy: A joint report of the American Neurogastroenterology and Motility Society and the Society of Nuclear Medicine. J Nucl Med Technol. 2008 Mar;36(1):44-54. doi: 10.2967/jnmt.107.048116. Epub 2008 Feb 20. PMID: 18287197.
2. Abell T, McCallum R, Hocking M, et al. Gastric electrical stimulation for medically refractory gastroparesis. Gastroenterology. 2003 Aug;125(2):421-8. doi: 10.1016/s0016-5085(03)00878-3. PMID: 12891544.
3. Camilleri M, Kuo B, Nguyen L, et al. ACG Clinical Guideline: Gastroparesis. Am J Gastroenterol. 2022 Aug 1;117(8):1197-1220. doi: 10.14309/ajg.0000000000001874. Epub 2022 Jun 3. PMID: 35926490; PMCID: PMC9373497.
4. Cassidy DJ, Gerull W, Zike VM, Awad MM. Clinical outcomes of a large, prospective series of gastric electrical stimulation patients using a multidisciplinary protocol. J Am Coll Surg. 2024 Oct 1;239(4):341-346. doi: 10.1097/XCS.0000000000001105. Epub 2024 Apr 29. PMID: 38682813; PMCID: PMC11392156.
5. Chaudhry A, Gabriel B, Noor J, et al. Tendency of semaglutide to induce gastroparesis: A case report. Cureus. 2024 Jan 19;16(1):e52564. doi: 10.7759/cureus.52564. PMID: 38371020; PMCID: PMC10874596.
6. Ducrotte P, Coffin B, Bonaz B, et al.; ENTERRA Research Group. Gastric electrical stimulation reduces refractory vomiting in a randomized crossover trial. Gastroenterology. 2020 Feb;158(3):506-514.e2. doi: 10.1053/j.gastro.2019.10.018. Epub 2019 Oct 21. PMID: 31647902.
7. Gourcerol G, Gonzalez JM, Bonaz B, et al. Gastric electrical stimulation versus per-oral pyloromyotomy for the treatment of nausea and vomiting associated with gastroparesis: An observational study of two cohorts. Neurogastroenterol Motil. 2023 Jul;35(7):e14565. doi: 10.1111/nmo.14565. Epub 2023 Mar 24. PMID: 36961085.
8. Hasler WL. Electrical stimulation for gastroparesis. Updated October 15, 2025. Accessed August 26, 2026. http://www.uptodate.com.
9. Hayes. Gastric electrical stimulation for gastroparesis Health technology assessment. Published October 26, 2018. Updated December 7, 2022. Accessed August 26, 2026. https://evidence.hayesinc.com/.
10. Kalas MA, Galura GM, McCallum RW. Medication-induced gastroparesis: A case report. J Investig Med High Impact Case Rep. 2021 Jan-Dec;9:23247096211051919. doi: 10.1177/23247096211051919. PMID: 34663102; PMCID: PMC8529310.
11. Levinthal DJ, Bielefeldt K. Systematic review and meta-analysis: Gastric electrical stimulation for gastroparesis. Auton Neurosci. 2017 Jan;202:45-55. doi: 10.1016/j.autneu.2016.03.004. Epub 2016 Apr 11. PMID: 27085627.
12. McCallum RW, Sarosiek I, Parkman HP, et al. Gastric electrical stimulation with Enterra therapy improves symptoms of idiopathic gastroparesis. Neurogastroenterol Motil. 2013 Oct;25(10):815-e636. doi: 10.1111/nmo.12185. Epub 2013 Jul 29. PMID: 23895180; PMCID: PMC4274014.
13. McCallum RW, Snape W, Brody F, et al. Gastric electrical stimulation with Enterra therapy improves symptoms from diabetic gastroparesis in a prospective study. Clin Gastroenterol Hepatol. 2010 Nov;8(11):947-54; quiz e116. doi: 10.1016/j.cgh.2010.05.020. Epub 2010 Jun 9. PMID: 20538073.
14. National Institute for Health and Care Excellence (NICE). Gastroelectrical stimulation for gastroparesis. HealthTech guidance. [HTG341]. Published May 28, 2014. accessed August 26, 2026. https://www.nice.org.uk/guidance
15. National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK). Gastroparesis. Published January 2018. Accessed August 26, 2026. https://www.niddk.nih.gov/health-information/digestive-diseases/gastroparesis/treatment.
16. Rajamanuri M, Mannava SM, Chhabra J, et al. A systematic review of the therapeutic role of gastric pacemakers in adults with gastroparesis. Cureus [Internet]. 2021 Sep 21 [cited 2023 May 22];13(9):e18152. doi: 10.7759/cureus.18152. PMID: 34584813; PMCID: PMC8457417.
17. Shanker A, Bashashati M, Rezaie A. Gastric electrical stimulation for treatment of refractory gastroparesis: The current approach to management. Curr Gastroenterol Rep. 2021 Jan 22;23(2):2. doi: 10.1007/s11894-020-00803-0. PMID: 33483775; PMCID: PMC7822763.
18. Shikora SA, Bergenstal R, Bessler M, et al. Implantable gastric stimulation for the treatment of clinically severe obesity: Results of the SHAPE trial. Surg Obes Relat Dis. 2009 Jan-Feb;5(1):31-7. doi: 10.1016/j.soard.2008.09.012. Epub 2008 Oct 1. PMID: 19071066.
19. Staller K, Parkman HP, Greer KB. et al. AGA Clinical Guidelines Committee. AGA clinical practice guideline on management of gastroparesis. Gastroenterology. 2025 Oct;169(5):828-861. doi: 10.1053/j.gastro.2025.08.004. PMID: 40976635.
20. Szarka LA, Camilleri M, Vella A. et al. A stable isotope breath test with a standard meal for abnormal gastric emptying of solids in the clinic and in research. Clin Gastroenterol Hepatol. 2008 Jun;6(6):635-643.e1. doi: 10.1016/j.cgh.2008.01.009. Epub 2008 Apr 14. PMID: 18406670;

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PMCID: PMC3739971.
21. United States Food and Drug Administration (FDA). Humanitarian device exemption (HDE) database (product code LNQ, docket number 00M-1451). Gastric electrical stimulation (GES) sys. Issued March 31, 2000. Accessed August 26, 2026. https://www.fda.gov.
22. United States Food and Drug Administration (FDA). Humanitarian Device Exemption (HDE): Enterra II Intestinal Stimulator. Product code LNQ. (H990014/S227). Issued October 20, 2023. Accessed September 4, 2026. https://www.fda.gov.

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