# Molina Clinical Policy
# Gastroesophageal Reflux Disease (GERD) Treatment
# Policy No. 337

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

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## OVERVIEW

**Gastroesophageal reflux disease (GERD)** is a chronic condition characterized by persistent symptoms or mucosal damage caused by an abnormal reflux of gastric contents into the esophagus. Causes of GERD include lower esophageal sphincter (LES) weakness, hiatal hernia, temporary LES relaxation, alterations in the gastroesophageal pressure gradient, and impaired esophageal clearance or motility (Kahrilas 2024). Diagnosis of GERD is typically based on clinical symptoms alone; however, minimally invasive testing may be required in select patients. Conventional management of GERD includes lifestyle changes (e.g., dietary adjustments, weight loss), pharmacologic therapy (e.g., antacids, histamine 2 receptor antagonists [H2RAs], and PPIs), endoscopic procedures, and surgical intervention (Hayes 2026).

For surgical interventions, laparoscopic or robotic fundoplication is considered the current gold standard. A number of minimally invasive therapies for GERD have been developed; however, the long-term efficacy of these techniques has not been well established (Fass 2026; Schwaitzberg 2026). These can be broadly classified into the following categories:

- **Radiofrequency energy (Stretta procedure)** is delivered to the LES and gastric cardia with the goal of improving GERD symptoms. The procedure is thought to decrease gastroesophageal junction (GEJ) compliance, reduce transient LES relaxations, decrease esophageal acid sensitivity, and improve gastroparesis, though its exact mechanism of action remains unclear (Hayes 2026; Triadafilopoulos 2025).
- **Endoscopic suturing techniques**, such as transoral fundoplication (TIF), use fasteners or staples to remodel the GEJ, thereby enhancing the barrier against reflux. Endoscopic stapling involves clamping and stapling the esophagus to the stomach proximal to the GEJ (e.g., Bard EndoCinch, EsophyX, MUSE, GERDx).
- **Injection and implantation of bulking agents or magnetic augmentation** may be injected or implanted around the LES to decrease transient relaxations and reduce reflux (e.g., Plexiglas, Durasphere, and insertion of magnetic beads [LINX]) ([2]Hayes 2025).
- **Implanted electrical stimulation devices** are designed to normalize the LES through neuromodulation (e.g., Endostim neurostimulation therapy). The Endostim device consists of a subcutaneously implanted pulse generator connected to a bipolar lead that delivers electrical stimulation to the LES ([1]Hayes 2025).

### Regulatory Status

In 2000, the Stretta System, a minimally invasive device that utilizes radiofrequency to induce tissue remodeling, was FDA-cleared through the 510(k) premarket notification process under 510(k) number K000245. The system is regulated as a Class II device under product code GEI.

Endoscopic suture/plication systems are regulated as Class II devices under product code ODE; notable FDA-cleared devices include the Bard EndoCinch Suturing System (K003956), EsophyX System (K071651), MUSE System (K143634), and GERDX System (K233240). The LINX Reflux Management System was FDA-approved in 2012 through the premarket approval (PMA) process under PMA number P100049. The system is regulated as a Class III device under product code LEI.

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Durasphere (P980053) is FDA-approved as an injectable bulking agent for stress incontinence but is not approved for the treatment of GERD. Additionally, the Plexiglas and Endostim systems are not FDA-approved or cleared for the treatment of GERD in the United States.

## COVERAGE POLICY

Minimally invasive therapies for gastroesophageal reflux disease (GERD) (e.g., radiofrequency techniques, endoscopic suturing and stapling, injection and implantation of bulking agents or insertion of magnetic beads, and implanted stimulation devices) are considered **experimental, investigational, and unproven** due to insufficient evidence in peer-reviewed medical literature to establish long-term safety, efficacy, and effect on net health outcomes

**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

The overall quality of the evidence supporting minimally invasive therapies for GERD is low. Limitations include relatively small sample sizes, lack of blinding, short-term follow-up, inconsistent comparators, and methodological flaws. These limitations apply across modalities including radiofrequency techniques, endoscopic suturing and stapling, injection or implantation of bulking agents or magnetic beads, and implanted stimulation devices. Large, well-designed randomized controlled trials (RCTs) comparing these therapies with established surgical options such as laparoscopic fundoplication and optimized medical management strategies (over a long period of follow-up) are needed to establish their safety, efficacy, and appropriate patient selection.

***Systematic Reviews and Meta-Analyses***

Pasam et al. (2023) conducted a systematic review and network meta-analysis to compare the outcomes of surgical versus endoscopic therapies for GERD. The review included 27 RCTs for a total of 3,515 adult patients with GERD. Therapies included laparoscopic Nissen, Toupet, and anterior fundoplication, transoral incisionless fundoplication (TIF), radiofrequency energy (Stretta), and magnetic sphincter augmentation (LINX), compared with either sham procedures, another intervention, or proton pump inhibitor (PPI) therapy. Outcomes were assessed for up to 12 months and included GERD health-related quality of life (GERD-HRQL), cessation of PPI use, esophagitis, lower esophageal sphincter pressure (LESP), and percentage of time with an esophageal pH < 4 on 24-hour monitoring. Esophagitis was evaluated in 14 studies (1,876 patients), with no significant difference between TIF and Nissen (odds ratio [OR] 1.14, 95% confidence interval [CI] 0.17-7.74), Toupet (OR 1.51, 95% CI 0.21-10.93), or anterior fundoplication (OR 0.55, 95% CI 0.21-15.79). TIF resulted in a significantly greater percentage time of pH < 4 compared to Nissen fundoplication (mean difference [MD] 4.72, 95% CI 0.71-8.73) indicating worse esophageal acid exposure; compared to anterior or Toupet fundoplication, the differences were not statistically significance. LESP was evaluated in 13 studies (1,203 patients). TIF and all surgical fundoplication procedures produced significantly higher LESP compared to PPI therapy or sham, whereas radiofrequency energy did not. Stretta resulted in significantly lower LESP than TIF (MD -9.23, 95% CI -13.89 to -4.58), Nissen (MD -9.00, 95% CI -14.55 to -3.45), Toupet (MD -6.83, 95% CI -12.50 to -1.15), and anterior fundoplication (MD -7.53, 95% CI -13.35 to -1.71). Cessation of PPI use was evaluated in 9 studies (552 patients) and there were no significant differences with TIF, Stretta, or LINX compared to sham. GERD-HRQL was evaluated in 5 studies (208 patients). Both TIF and Stretta produced significantly better GERD-HRQL scores compared to PPI therapy or sham treatment, and TIF and Stretta were not significantly different compared to each other (MD -3.81, 95% CI, -10.65 to 3.04). Evidence for LINX was limited and only included one RCT. For adverse events, TIF complications included perforation, laceration, bleeding, pleural effusion, and dysphasia. LINX complications included dysphagia, odynophagia, recurrent GERD, device erosion, migration, bead separation, and removal. Surgical fundoplication was associated with dysphagia and gas bloating, particularly following Nissen fundoplication. Significant heterogeneity was noted for percentage time with pH < 4 ($I^2$ = 65.4%, p = 0.009) and LESP $I^2$ = 69.6%, p = 0.001). Other limitations include the inability to blind procedural trials, variations in procedural techniques and patient selection, lack of individual patient data, differences in hiatal hernia eligibility between

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endoscopic and surgical trials, and predominantly short-term evidence for endoscopic procedures. The authors concluded that TIF produced short-term LESP and esophagitis outcomes comparable with surgical fundoplication but was inferior to Nissen fundoplication for esophageal acid exposure, and that TIF did not demonstrate significantly different short-term outcomes compared with surgical fundoplication procedures.

### Radiofrequency Energy (Stretta System)

***Non-Randomized Studies, Retrospective Reviews, and Other Evidence***

Kalapala et al. (2017) assessed short outcomes (3 months) from a prospective randomized study comparing the Stretta treatment with PPIs. A total of 20 patients with symptomatic GERD and abnormal esophageal acid exposure and esophagitis were included in the study. The primary measure was improvement in quality of life (QOL) and decrease in the frequency and severity of GERD symptoms. The mean age of the patients was 39 (± 15) years and controls were 34 (± 11) years. At 3 months, 80% of Stretta patients reported improvement in QOL compared to 40% in the control group. At the end of 3 months, significant improvement in GERD symptom scores for heartburn, regurgitation, chest pain, and cough compared with the control group were observed. After Stretta treatment, 60% of the patients stopped taking PPIs whereas there was no change in the control group. Almost 80% of the patients on Stretta treatment were satisfied with the treatment compared to 30% of the patients in the control group. RCTs with larger patient populations and longer follow-up periods are needed to further assess Stretta.

### Endoscopic Plication or Suturing or Stapling

***Randomized Controlled Trials***

Kalapala et al. (2021) conducted a randomized, double-blinded, sham-controlled trial evaluating the GERD-X endoscopic full-thickness fundoplication (EFTP) device in 70 PPI-treated patients with GERD. The primary endpoint was improvement in the GERD-HRQL score. A ≥50% reduction in GERD-HRQL score at 3 months was defined as treatment success. Secondary outcomes assessed at 3, 6, and 12 months included GERD-HRQL scores, reflux symptom scores, PPI usage, and endoscopic findings. In-person assessments were performed at 3, 6, and 12 months and included GERD-HRQL scoring and esophagogastroduodenoscopy (EGD). High-resolution manometry and 24-hour pH impedance monitoring were performed at 3 and 12 months. At 3 months, 65.7% of the EFTP group achieved the primary endpoint compared with only 2.9% in the sham group ($p<0.001$). Significant improvements in GERD-HRQL scores persisted at 6 and 12 months. Although 24-hour pH impedance monitoring in the EFTP group showed partial improvement at both 3 and 12 months, these differences did not reach statistical significance. However, the EFTP arm demonstrated fewer total reflux episodes in 24 hours compared to baseline, with continued improvement through 12 months. When compared to the sham arm, the reduction in reflux episodes in the EFTP group approached statistical significance at 3 months ($p=0.072$) and 12 months ($p=0.051$). By study completion, 63% of patients in the EFTP group had discontinued PPIs versus 11% in the sham group. The average procedure time for EFTP was 17.4 ± 4 minutes. No major adverse events were reported in either group. The authors concluded that while EFTP demonstrated clinical benefit, larger prospective trials with long-term follow-up are needed to establish its role in GERD management.

***Systematic Reviews and Meta-Analyses***

Shahzil et al. (2024) conducted a systematic review and meta-analysis to evaluate EFTP versus sham procedures for the treatment of refractory GERD. The review included 3 RCTs for a total 272 participants, with 136 assigned to EFTP, using the GERDx or Plicator systems, and 136 assigned to sham. All participants were receiving long-term PPI therapy and 1 trial enrolled patients who developed GERD after peroral endoscopic myotomy. While follow-up ranged from 3 to 12 months, meta-analysis focused on 3-month outcomes. EFTP was found to significantly reduce PPI use compared with sham (relative risk ratio [RR] 0.51, 95% CI 0.35-0.73, $p = 0.0002$, $I^2 = 54\%$). Clinically meaningful improvement in quality of life, measured with GERD-HRQL at 3 months, occurred more often after EFTP than sham (RR 15.81, 95% CI 1.40-178.71, $p = 0.03$, $I^2 = 74\%$); however, the confidence interval was very wide and heterogeneity was high. Objective acid-exposure outcome measures were less favorable, as mean DeMeester scores did not differ significantly between groups (MD -12.57, 95% CI -35.12 to 9.98, $p = 0.27$, $I^2 = 97\%$). Percentage time with esophageal pH < 4 after a 7-day PPI washout also did not differ significantly between the groups (MD – 7.49, 95% CI -20.19 to 5.20, $p = 0.25$, $I^2 = 99\%$). While the total number of reflux episodes was significantly lower after EFTP than sham (MD -43.78 episodes, 95% CI -83.91 to -3.65, $p = 0.03$, I2 =89%), when separated by reflux type, neither acid reflux episodes nor non-acid reflux episodes differed significantly between the two groups. The authors reported that these findings suggest symptomatic benefits may result from reduced reflux volume or frequency rather than normalization of esophageal acid exposure. Limitations include only 3 RCTs, relatively small and variable sample sizes, substantial heterogeneity for several outcomes, varying endpoints and follow-up durations, and the inclusion of a physiologically distinct post-POEM population. The authors concluded that EFTP significantly reduces PPI use, total reflux episodes, and GERD

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symptoms compared to sham, but it does not significantly improve objective DeMeester scores or esophageal acid-exposure time.

***Non-Randomized Studies, Retrospective Reviews, and Other Evidence***
De Moura et al. (2018) evaluated long-term results of 47 patients non-responsive to PPIs who underwent endoluminal plication (n=26) or polymer injection (n=21) for the treatment of GERD. The number of patients with no response to endoscopic treatment with reintroduction of PPIs increased in time for both techniques. There was symptomatic improvement up to 12 months, with progressive loss of this trending up to 60 months for both procedures. GERD-HRQL scores demonstrated total response in both procedures at one, three, six and 12 months. The 60-month analysis showed an increased number of patients with no response in both groups. The quality of life assessment (SF-36) showed benefit in polymer injection up to three months and showed a higher rate of complications. There were no deaths. There was healing of esophagitis at three months in 45% of patients in polymer injection and 40% in endoluminal plication. There was no improvement in manometric or pH findings. The authors concluded that endoscopic therapies were ineffective in controlling GERD in the long term.

Trad et al. (2018) described five-year outcomes for the transoral incisionless fundoplication (TIF 2.0) EsophyX vs Medical PPI Open label (TEMPO) clinical trial regarding safety, durability, and cost-effectiveness for TIF 2.0. A total of 63 patients with chronic GERD refractory to PPI therapy, absent or ≤2 cm hiatal hernia, and abnormal esophageal acid exposure were randomized to the TIF group or PPI group. Following the 6-month evaluation, all patients in the PPI group elected for crossover to TIF. Of 63 patients, 60 were available at one year, 52 at three years, and 44 at five years for evaluation. Troublesome regurgitation was eliminated in 88% of patients at one year, 90% at three years, and 86% at five years. Resolution of troublesome atypical symptoms was achieved in 82% of patients at one year, 88% at three years, and 80% at five years. No serious adverse events occurred. There were three reoperations by the end of the five-year follow-up. At the five-year follow-up, 34% of patients were on daily PPI therapy as compared with 100% of patients at screening. The total GERD Health-related quality-of-life score improved by decreasing from 22.2 to 6.8 at five years ($P < .001$). Patient selection had a narrow scope with a focus on ideal surgical candidates that had long-term documentation of reflux, continued symptoms with optimized medical therapy, and a desire for surgical intervention. The authors concluded that in this patient population, the TIF procedure provided safe and sustained long-term elimination of troublesome GERD symptoms. Study limitations include small patient population, stringent patient selection, and non-randomization to another endoscopic procedure or surgical procedure for GERD.

**Injection and Implantation of Bulking Agent or Insertion of Magnetic Beads**
***Systematic Reviews and Meta-Analyses***
Kamel et al. (2026) conducted a systematic review and meta-analysis comparing magnetic sphincter augmentation (MSA), using the LINX device, with surgical (Nissen or Toupet) fundoplication for adults with GERD. The review included 12 observational studies, with 8 being retrospective and 4 being prospective. The authors did not provide total population or individual sample sizes, and there were no RCTs. Follow-up ranged from 30 days to 7 years. Five studies contributed to GERD-HRQL data and there was no significant difference between MSA and fundoplication (MD 0.67, 95% CI -0.57 to 1.91, $p = 0.29$, $I^2 = 68\%$). Six studies evaluated postoperative PPI use and found no significant difference between MSA and fundoplication (OR 0.70, 95% CI 0.30-1.67, $p = 0.40$, $I^2 = 85\%$). Nine studies reported on dysphagia outcomes, with no significant difference between MSA and fundoplication (OR 1.12, 95% CI 0.59-2.14, $p = 0.72$, $I^2 = 72\%$). MSA significantly improved the ability to belch (OR 6.78, 95% CI 4.49-10.22, $p < 0.00001$, $I^2 = 43\%$) and ability to vomit (OR 5.85, 95% CI 2.39-14.33, $p = 0.0001$, $I^2 = 82\%$) and reduced gas bloating risk (OR 0.43, 95% CI 0.25-0.75, $p = 0.003$, $I^2 = 54\%$). Limitations include the reliance on observational studies, substantial heterogeneity, variation in study populations and follow-up duration, exclusion of non-English studies, and lack of data regarding long-term complications. The authors concluded that MSA and fundoplication provide comparable efficacy for GERD symptom control, quality of life, postoperative PPI use, and dysphagia, while MSA provides advantages in preserving the ability to belch and vomit and reduce gas bloating. RCTs with standardized follow-up are needed to better define comparative outcomes and long-term safety of MSA.

***Non-Randomized Studies, Retrospective Reviews, and Other Evidence***
Louie et al. (2026) reported the 5-year outcomes of a prospective, multicenter cohort study evaluating MSA, using the LINX device, for GERD in adults. Participants underwent laparoscopic MSA due to persistent GERD symptoms despite acid-suppression therapy and abnormal esophageal acid exposure. A total of 136 out of an original 200 participants were available for long-term follow-up. The primary effectiveness endpoint was clinical success, defined as a $\geq$ 50% improvement in total GERD-HRQL score compared with baseline, while PPIs were discontinued. At 12 months, 84.3%

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of participants achieved ≥ 50% GERD-HRQL improvement, declining to 81.6% at 60 months. Of the 81 participants who underwent objective pH testing, median DeMeester scores decreased from 29 to 11.4 ($p < 0.0001$), while median percentage of time with esophageal pH < 4 decreased from 91.5 to 3.2% ($p < 0.0001$). At 5 years, DeMeester scores were normalized (< 14.7) in 67.9% of participants, acid-exposure time was normalized (≤ 5.3%) in 70.4% of participants, moderate-to-severe heartburn declined from 82.0% of participants at baseline to 12.9% ($p < 0.0001$), and moderate-to-severe regurgitation declined from 59.8% at baseline to 4.9% of participants ($p < 0.0001$). Overall, 84.8% of participants had completely discontinued PPIs and 90.4% were free from daily PPI use at 5 years. Additionally, extraesophageal symptoms were reported by 61.9% participants at baseline versus 26.6% at 5 years. At 5 years, 4.7% of participants reported at least daily, bothersome dysphagia compared with 20.3% at baseline. Device related serious adverse events occurred in 5.5% (11/200) of participants through 60 months. Twenty-six patients underwent explantation due to recurrent or worsening GERD symptoms, pain, erosion, dysphagia, recurrent hiatal hernia, achalasia, and/or bloating, leading to an overall explant rate of 13%. Two deaths occurred but were unrelated to MSA. Limitations include incomplete long-term follow-up and lack of randomization. Additionally, participants whose devices were removed were excluded from subsequent GERD-HRQL analyses which may impact the reliability of long-term effectiveness data. The authors concluded that MSA provided durable 5-year improvement in GERD symptoms, quality of life, acid exposure, and PPI independence with relatively few long-term side effects, but also emphasized that more than 1 in 8 patients required device removal during follow-up.

### Implanted Stimulation Devices

***Non-Randomized Studies, Retrospective Reviews, and Other Evidence***

Paireder (2019) reported on an observational prospective single-center study for 37 patients who underwent laparoscopic lower esophageal electrical stimulation therapy at the Medical University of Vienna. All patients considered for the study met clinical indication for anti-reflux surgery. Initial preoperative evaluation included upper GI endoscopy and esophageal function testing that included high-resolution impedance manometry. This study had some significant limitations including small sample size, the need for hiatal hernia repair for 62.2% of the patients, and technical problems with device malfunction due to lead leakage in four patients requiring device removal and conversion to fundoplication. Malfunction at this high a rate is concerning for the overall safety of the device. The significant limitations of this study do not support the use of laparoscopic lower esophageal electrical stimulation therapy.

### National and Specialty Organizations

The **American College of Gastroenterology (ACG)** published updated *Clinical Guideline for the Diagnosis and Management of Gastroesophageal Reflux Disease* in 2022. The disease continues to be one of the most common seen by gastroenterologists, surgeons, and primary care physicians. Understanding of its presentations and enhancements in diagnosing GERD have evolved along with approaches of patient management. The ACG notes that while PPIs are the standard medical treatment for GERD, several publications have highlighted adverse events which lead to concerns about the safety and efficacy of long-term use of PPIs, including overprescribing. Recent data show promise for surgical and endoscopic interventions. The ACG recommends consideration of MSA as an alternative to laparoscopic fundoplication for patients with regurgitation who fail medical management. This was graded as a strong recommendation based on a moderate level of evidence. The ACG recommends consideration of TIF for patients with "troublesome regurgitation or heartburn who do not wish to undergo anti-reflux surgery" and who do not have severe esophagitis or hiatal hernia > 2 cm. This is a conditional recommendation based on a low level of evidence. Regarding radiofrequency energy (Stretta), the ACG recommends against its use as an alternative to medical or surgical anti-reflux therapies, noting that the procedure is "inconsistent and highly variable." This is a conditional recommendation based on a low level of evidence (Katz et al. 2022).

The **American Gastroenterological Association (AGA)** published the *AGA Clinical Practice Update on the Personalized Approach to the Evaluation and Management of GERD: Expert Review* to outline a personalized diagnostic and therapeutic approach to GERD symptoms (Yadlapati et al. 2022). According to the AGA, both laparoscopic fundoplication and magnetic sphincter augmentation are effective surgical options for patients with proven GERD. Additionally, TIF is "an effective endoscopic option in carefully selected patients." Candidacy for invasive anti-reflux procedures include confirmatory evidence of pathologic GERD, the exclusion of achalasia, and an assessment of esophageal peristaltic function.

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The **AGA** published a *Clinical Practice Update on the Diagnosis and Management of Extraesophageal GERD*. For patients with extraesophageal reflux, the AGA notes that data on surgical management shows a poor response and less predictability, and that symptoms may improve only in highly selected patients. Additionally, the existing data are generally of low quality, and there are no RCTs comparing anti-reflux surgery with medical therapy in the treatment of laryngopharyngeal reflux or cough. Studies are needed to make meaningful conclusions about MSA or endoscopic therapies for GERD, and surgery should only be considered in highly selected patients (Chen et al. 2023).

The **Society of American Gastrointestinal and Endoscopic Surgeons (SAGES)** published *Guidelines for the Surgical Treatment of GERD*, which assessed outcomes of anti-reflux surgery versus medical management of GERD in adults and children, robotic versus laparoscopic fundoplication, complete versus partial fundoplication, and minimal versus maximal dissection in pediatric patients (Slater et al. 2021). Based on 105 randomized control and non-randomized comparative studies between 2004-2019, anti-reflux surgery was found in association with superior short-term quality of life compared to PPI; however, short-term symptom control was not significantly superior. A total of 28% of patients undergoing operative treatment continued PPI treatment. The review also found similar outcomes with robotic and laparoscopic fundoplication. Compared to total fundoplication, partial fundoplication was associated with higher rates of prolonged PPI usage. No statistically significant difference for long-term symptom control or long-term dysphagia was identified. Minimal dissection during fundoplication was associated with lower reoperation rates than maximal dissection. The conclusion found is that the available evidence has high risk of bias and that additional high-quality RCTs are needed to determine the safety and efficacy for surgical decision making in the treatment of GERD.

The **SAGES** published a *Multi-Society Consensus Conference and Guideline on the Treatment of GERD* (Slater et al. 2023). Based on data from 9 short-term observational studies involving MSA, the SAGES panel recommends that adults with GERD may be treated with either Nissen fundoplication or MSA. However, this is a conditional recommendation based on a very low certainty of evidence. The panel also noted that while MSA has shown improved outcomes over PPI therapy in the short term, the negative effects and long-term data are not available. Regarding TIF, the panel suggests that patients may benefit from fundoplication over TIF 2.0, which is an expert opinion, not a GRADE recommendation, due to lack of evidence. Regarding Stretta, the panel suggests that patients may benefit from surgical fundoplication over Stretta, which is a conditional recommendation based on a very low certainty of evidence. The panel highlights that "there is significantly more long-term data available for fundoplication than there is for Stretta," and notes a potential placebo effect and lack of evidence for objective reflux control.

The **American Society for Gastrointestinal Endoscopy (ASGE)** published a *Clinical Practice Guideline on the Diagnosis and Management of GERD* (ASGE Standards of Practice Committee 2025). In patients with confirmed GERD, hiatal hernia $\leq$ 2 cm, and Hill grade I or II, the ASGE conditionally recommends TIF as an alternative to chronic medical management in select patients with chronic or refractory GERD, based on low-quality evidence. For patients with hiatal hernia > 2 cm and Hill grade III or IV, evaluation for combined hiatal hernia repair and TIF may be considered following multidisciplinary review, although this is based on very low-quality evidence. The ASGE states that Stretta may be considered in patients with confirmed GERD, hiatal hernia < 2 cm, Hill grade I or II, and when endoscopic or surgical fundoplication is unavailable or not feasible, although evidence for Stretta is low to very low quality.

The **National Institute for Health and Care Excellence (NICE)** (2019) published guidance on the treatment of GERD in their Clinical Guideline, *Gastroesophageal Reflux Disease and Dyspepsia in Adults: Investigation and Management [CG184]*. The guideline does not include information on RF energy, endoscopic suturing techniques, bulking agents, or implanted stimulation devices.

## CODING & BILLING INFORMATION

**CPT (Current Procedural Terminology)**

| Code | Description |
|---|---|
| **43210** | Esophagogastroduodenoscopy, flexible, transoral; with esophagogastric fundoplasty, partial or complete, includes duodenoscopy when performed |
| **43284** | Laparoscopy, surgical, esophageal sphincter augmentation procedure, placement of sphincter augmentation device (i.e., magnetic band), including cruroplasty when performed |
| **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 |

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| | |
|---|---|
| **43289** | Unlisted laparoscopy procedure, esophagus |
| **43499** | Unlisted procedure, esophagus |
| **43999** | Unlisted procedure, stomach |

**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 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

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|---|---|
| **10/14/2026** | Policy reviewed. No changes to coverage criteria. |
| **10/08/2025** | Policy reviewed. No changes to coverage criteria. |
| **10/09/2024** | Policy reviewed, no changes to criteria, updated Summary of Medical Evidence and References. IRO Peer Review on September 9, 2024 by a practicing physician board-certified in Internal Medicine; Gastroenterology. |
| **10/12/2023** | Policy reviewed. No changes to coverage criteria, |
| **10/12/2022** | Policy reviewed. No changes to coverage criteria |
| **10/13/2021** | Policy reviewed. No changes to coverage criteria |
| **09/16/2020** | Policy reviewed. No changes to coverage criteria. |
| **03/11/2019** | New policy. AMR Peer Review on January 7, 2019, by a practicing, board certified physician with a specialty in Gastroenterology. |

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