Prospective review is recommended/required. Please check the member agreement for preauthorization guidelines.

Prospective review is not required.

Description

The esophagus is normally lined by squamous epithelium. Barrett’s esophagus is a condition in which the normal squamous epithelium is replaced by specialized columnar-type epithelium known as intestinal metaplasia, in response to irritation and injury caused by gastroesophageal reflux disease (GERD). Barrett’s esophagus occurs in the distal esophagus, may be of any length, focal or circumferential, and can be visualized by the endoscopist as being a different color than the background squamous mucosa. Confirmation of Barrett’s esophagus requires biopsy of the columnar epithelium and microscopic identification of intestinal metaplasia.

The current management of Barrett’s esophagus includes treatment of GERD, and surveillance endoscopy to detect progression to high-grade dysplasia or adenocarcinoma. The finding of low-grade dysplasia typically warrants only follow-up and surveillance biopsies, whereas the finding of high-grade dysplasia or early-stage adenocarcinoma warrants mucosal ablation or resection (either endoscopic mucosal resection [EMR] or esophagectomy).

Mucosal ablation techniques that are available consist of one of several thermal (multipolar electrocoagulation [MPEC], argon plasma coagulation [APC], heater probe, Nd:YAG laser, KTP-YAG laser, diode laser, argon laser, and cryoablation) or nonthermal (5-aminolevulinic acid [5-ALA] and photofrin photodynamic therapy [PDT]) techniques.

PDT has been the only therapy shown in a randomized Phase III trial to significantly decrease the risk of carcinoma in Barrett’s esophagus. Two hundred and eight patients with high-grade dysplasia were randomized to PDT and omeprazole versus omeprazole alone. At 24 months’ follow-up, 77% of patients treated with PDT had complete ablation of high-grade dysplasia versus 39% in the control group (p<0.0001) and occurrence of adenocarcinoma within a follow-up time of 3.6 years was 13% in the PDT group versus 20% in the control group (p<0.006) However, the use of PDT for Barrett’s esophagus
with high-grade dysplasia has decreased dramatically recently, due to the fact that is relatively expensive and associated with a high complication rate, including photosensitivity and esophageal stricture formation in up to 30% of patients treated with this method.

The CryoSpray Ablation™ System (formerly the SprayGenix™ Cryo Ablation System, CSA Medical, Inc.) uses a low-pressure spray for spraying liquid nitrogen through an upper endoscope. Cryotherapy allows for treatment of uneven surfaces, however, disadvantages include the uneven application inherent in spraying the cryogen.

Radiofrequency ablation of high-grade dysplasia in Barrett’s esophagus has been shown to be at least as effective in eradicating high-grade dysplasia as other ablative techniques with a lower progression rate to cancer, and may be considered as an alternative to esophagectomy.

More data are required concerning the use of RFA for the eradication of low-grade dysplasia and nondysplastic Barrett’s esophagus. Longer follow-up is needed to show that eradication will persist, and that the benefits will outweigh potential complications in these patients who show a lower rate of progression to adenocarcinoma than those with high-grade dysplasia.

Data for the efficacy of cryoablation of Barrett’s esophagus with or without dysplasia are limited. The studies consist of small numbers of patients with short-term follow-up, and therefore this approach is considered investigational.

Policy:

Radiofrequency ablation may be considered medically necessary for treatment of Barrett’s esophagus with high-grade dysplasia. Radiofrequency ablation for Barrett’s esophagus with high-grade dysplasia may be used in combination with endoscopic mucosal resection of nodular/visible lesions. The diagnosis of high-grade dysplasia should be confirmed by two pathologists prior to radiofrequency ablation.

Radiofrequency ablation is considered not medically necessary for treatment of Barrett’s esophagus with low-grade dysplasia or Barrett’s esophagus in the absence of dysplasia due to lack of peer-reviewed literature that supports efficacy.

Cryoablation is considered not medically necessary for Barrett’s esophagus, with or without dysplasia due to lack of peer-reviewed literature that supports efficacy.

Coverage:

Benefits may vary between groups/contracts. Please refer to the appropriate member certificate/subscriber agreement for applicable surgery coverage/benefits.
Coding:

There is no CPT code specific to radiofrequency or cryoablation of tissue in the esophagus. These procedures would likely be coded using one of the following CPT codes:

43228 43257 43258 43499.

Published:

Provider Update, Jun 2011

References:


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