enterra medical®

Gastric Electrical Stimulation

2026 CODING AND PAYMENT GUIDE

Humanitarian Device: The Enterra® Therapy System for gastric electrical stimulation is authorized by Federal law for use in treatment of chronic intractable (drug refractory) nausea and vomiting secondary to gastroparesis of diabetic or idiopathic etiology. The effectiveness of this device for this use has not been demonstrated.

The Enterra System must be implanted in an IRB-approved facility.

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For questions please contact Enterra Medical at 1-855-768-3772 or email reimbursement@enterramedical.com.

ICD-10-CM[1] Diagnosis Codes

Diagnosis codes are used by both physicians and hospitals to document the indication for the procedure. Enterra Medical Gastrointestinal Electronic Stimulation (GES) is intended to treat the symptoms of chronic intractable nausea and vomiting secondary to gastroparesis of diabetic or idiopathic etiology. Because symptom codes are generally not acceptable as the principal diagnosis, the principal diagnosis is coded to the underlying conditions as shown.

Diabetic Gastroparesis[2]	**Diabetic Gastroparesis**	
	E10.43	Type 1 diabetes mellitus with diabetic autonomic (poly)neuropathy
	E11.43	Type 2 diabetes mellitus with diabetic autonomic (poly)neuropathy
	E13.43	Other specified diabetes mellitus with diabetic autonomic (poly)neuropathy[3]
	plus	
	K31.84	Gastroparesis
	Gastroparesis due to Secondary Diabetes[4]	
	E08.43	Diabetes mellitus due to underlying condition with diabetic autonomic (poly)neuropathy
	E09.43	Drug or chemical induced diabetes mellitus with neurological complications with diabetic autonomic (poly)neuropathy
	plus	
	K31.84	Gastroparesis
Idiopathic Gastroparesis	**K31.84**	Gastroparesis
Attention to Device[5]	**Z45.42**	Encounter for adjustment and management of neurostimulator
Neurostimulator Status[6]	**Z96.82**	Presence of neurostimulator

1. Centers for Disease Control and Prevention, National Center for Health Statistics. International Classification of Diseases, Tenth Comprehensive Listing ICD-10-CM Files, 2025 Release of ICD-10-CM, https://www.cdc.gov/nchs/icd/icd-10-cm/files.html.
2. Diabetic gastroparesis involves two codes, one for diabetes and one for gastroparesis. The diabetes code is always sequenced before the code for gastroparesis.
3. "Other specified" types of diabetes include diabetes mellitus due to genetic defects in insulin action and post-pancreatectomy diabetes mellitus, as well as diabetes mellitus "type 1.5". Coding Clinic, 3rd Q 2018, p.4-5.
4. Secondary diabetes is caused by some other condition or event. ICD-10-CM manual notes provide code sequencing instructions. In diabetes due to an underlying condition, e.g., cystic fibrosis or pancreatic cancer, the other condition is coded separately and sequenced before the code for diabetes. In drug or chemical induced diabetes, e.g., diabetes due to long-term steroid use, sequencing depends on whether diabetes resulted from poisoning or overdose or was the result of an adverse effect of the drug.
5. Code Z45.42 is used as the primary diagnosis when patients are seen for routine device maintenance, such as periodic device checks and programming, as well as routine device replacement.
   A secondary diagnosis code is then used for the underlying condition. ICD-10-CM Official Guidelines for Coding and Reporting FY 2025, I.C.21.c.7.
6. Code Z96.82 is a status code, assigned to indicate that the patient currently has an implanted neurostimulator that was placed during a prior encounter. This code is not assigned during the same encounter in which the neurostimulator is implanted, replaced, removed, revised, interrogated, or programmed. ICD-10-CM Official Guidelines for Coding and Reporting FY 2025. I.C.21.c.3.

Hospital Outpatient Coding and Payment

CPT® Code[1]	Description	Status Indicator	APC	Medicare National Average Payment[2]	Private/ Commercial
Insertion/Battery Replacement					
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	J1	5464	$19,820	Contractual
43647	Laparoscopy, surgical; implantation orreplacement of gastric neurostimulator electrodes, antrum	J1	5463	$11,384	Contractual
43235	Esophagogastroduodenoscopy, flexible, transoral; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure).	T	5301	$927	Contractual
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	N	N/A	Packaged	Contractual
C1767	Generator, neurostimulator (implantable), non-rechargeable	N/A	N/A	Report with Revenue Code 278 and device charges	Report with Revenue Code 278 and device charges
C1778	Lead, neurostimulator (implantable)				
Revision or Removal					
64595	Revision or removal of peripheral, sacral, or gastric neurostimulator pulse generator or receiver with detachable connection to electrode array	J1	5461	$3,571	Contractual
43648	Laparoscopy, surgical; revision or removal of gastric neurostimulator electrodes, antrum	J1	5362	$10,860	Contractual
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	Q1	5733	$61	Contractual
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	Q1	5741	$38	Contractual

Status Indicators for Hospital Outpatient

Status Indicator[3]	Description
J1	Services paid through Comprehensive APC
T	Procedure or Service, Multiple Procedure Reduction Applies
N	Items and Services Packaged into APC Rates S Procedure or service
Q1	This indicates that if it's billed on the same date as a service with an "S," "T," or "V" status indicator, the Q1 code is bundled (packaged) and will not be paid separately. If billed without an "S," "T," or "V" service on the same day, payment is made at the normal Ambulatory Payment Classification (APC) rate

1. CPT copyright 2025 American Medical Association. All rights reserved. CPT® is a registered trademark of the American Medical Association.
2. Centers for Medicare and Medicaid Services. CMS-1834-F:Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs. CY 2026 NFRM Addendum B.
3. Centers for Medicare and Medicaid Services. CMS-1834-F:Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs. CY 2025 NFRM Addendum D1.

HCPCS Level II C-Codes and L-Codes

Healthcare Common Procedure Coding System (HCPCS) Level II codes represent items and nonphysician services that are not represented by Level I CPT codes. Below are two types of HCPCS Level II device codes: C-codes, which are used on Medicare outpatient facility claims, and L-codes, primarily used by commercial insurance providers.

These codes are utilized by the entity that purchased and supplied the medical device to the patient. For implantable devices, that is generally the facility. Medicare requires hospitals to document C-codes on their outpatient claims when reporting devices used in device-intensive procedures. Although the L-codes are generally reported by non-Medicare payers, some payers request the use of the device C-Codes. Facilities should verify which code set is required with each payer. The facility claim may also qualify for a separate reimbursement payment with some commercial payors, commonly called an "implant carve-out", in addition to the reimbursement for the procedure billed.

Device	HCPCS Code[1]	Code Description
Medicare Hospital Outpatient Payment System C-Codes		
Pulse Generator (non-rechargeable)	**C1767**	Generator, neurostimulator (implantable), non-rechargeable
Lead	**C1778**	Lead, neurostimulator (implantable)
L Codes for Orthotics & Devices (often used by Commercial Payers, not Medicare)		
Pulse Generator	**L8679**	Implantable neurostimulator pulse generator, any type
	L8688	Implantable neurostimulator pulse generator, dual array, non-rechargeable, includes extension
Lead	**L8680**	Implantable neurostimulator electrode, each

1.Healthcare Common Procedure Coding System (HCPCS) Level II codes, including device C-codes, are maintained by the Centers for Medicare and Medicaid Services. https://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/HCPCS-Quarterly-Update.

Ambulatory Surgical Center Coding and Payment

CPT® Code[1]	Description	Status Indicator	Medicare National Average Payment[2]	Private/ Commercial	Multiple Procedure Discounting[3]
Insertion/Battery Replacement					
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	J8	$16,244	Contractual	N
43647	Laparoscopy, surgical; implantation orreplacement of gastric neurostimulator electrodes, antrum	J8	$9,997	Contractual	N
43235	Esophagogastroduodenoscopy, flexible, transoral; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure).	A2	$498	Contractual	Y
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	N/A	N/A	Contractual	N/A
C1767	Generator, neurostimulator (implantable), non-rechargeable	N/A	Note: ASCs do not report HCPCS II device codes	Report with Revenue Code 278 and device charges	N/A
C1778	Lead, neurostimulator (implantable)				
Revision or Removal					
64595	Revision or removal of peripheral, sacral, or gastric neurostimulator pulse generator or receiver with detachable connection to electrode array	A2	$2,003	Contractual	Y
43648	Laparoscopy, surgical; revision or removal of gastric neurostimulator electrodes, antrum	G2	$5,120	Contractual	Y

Status Indicators for Ambulatory Surgical Centers

Status Indicator[4]	Description
J8	Device intensive procedure; paid at adjusted rate
G2	Non-office based surgical procedure added in CY 2008 or later; payment based on OPPS relative payment weight.
A2	Surgical Procedure on ASC list in CY 2007; payment based on OPPS relative payment weight

1. CPT copyright 2025 American Medical Association. All rights reserved. CPT® is a registered trademark of the American Medical Association.
2. Centers for Medicare and Medicaid Services. CMS-1834-FC: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs. CY 2026 NFRM ASC Addendum.
3. When multiple procedures are reported, payment is usually made at 100% for the first procedure and 50% for the second and all subsequent procedures. Such procedures subject to this discounting are marked "Y". However, procedures marked "N" are not subject to discounting and paid at 100% in full, regardless of whether they are submitted with other procedures.
4. Centers for Medicare and Medicaid Services. CMS-1834-FC: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs. CY 2026 NFRM ASC Addendum DD1.

ICD-10-PCS[1] Procedure Codes

Procedure	ICD-10-PCS Code	Description
Neurostimulator Generator Implantation[2,3,4]	**0JH80DZ**	Insertion of multiple array stimulator generator into abdomen subcutaneous tissue and fascia, open approach
Neurostimulator Generator Removal[4]	**0JPT0MZ**	Removal of stimulator generator from trunk subcutaneous tissue and fascia, open approach
	0JPT3MZ	Removal of stimulator generator from trunk subcutaneous tissue and fascia, percutaneous approach
Generator Replacement	Two codes are required to identify a device replacement: one code for implantation of the new device and one code for removal of the old device.[3]	
Generator Revision[5,6]	**0JWT0MZ**	Revision of stimulator generator in trunk subcutaneous tissue and fascia, open approach
	0JWT3MZ	Revision of stimulator generator in trunk subcutaneous tissue and fascia, percutaneous approach
Lead Implantation[7]	**0DH60MZ**	Insertion of stimulator lead into stomach, open approach
	0DH64MZ	Insertion of stimulator lead into stomach, percutaneous endoscopic approach
Lead Removal[7]	**0DP60MZ**	Removal of stimulator lead from stomach, open approach
	0DP64MZ	Removal of stimulator lead from stomach, percutaneous endoscopic approach
Lead Replacement	Two codes are required to identify a device replacement: one code for implantation of the new device and one code for removal of the old device.[8]	
Lead Revision[7,9]	**0DW60MZ**	Revision of stimulator lead in stomach, open approach
	0DW64MZ	Revision of stimulator lead in stomach, percutaneous endoscopic approach

1. U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. International Classification of Diseases, Tenth Revision, Procedure Coding System (ICD-10-PCS). https://www.cms.gov/medicare/coding-billing/icd-10-codes. 2026 ICD-10-PCS files.
2. Body part value 8-Abdomen is shown because the Enterra® generator is typically placed into the subcutaneous tissue of the abdomen. Other body part values are also available for sites such as subcutaneous tissue of chest and subcutaneous tissue of back.
3. Device value D-Multiple Array Stimulator Generator is shown because Enterra® is a dual array non-rechargeable generator. See also the ICD-10-PCS Device Key. "Multiple array" includes dual array neurostimulator generators for which two leads are connected to one generator. Do not assign default value M-Stimulator Generator.
4. Placement of a neurostimulator generator is shown with the approach value 0 Open because creating the pocket requires surgical dissection and exposure. Removal also usually requires surgical dissection to free the device.
5. The ICD-10-PCS codes shown can be assigned for opening the pocket for generator revision, as well as reshaping or relocating the pocket while re-inserting the same generator. However, there are no ICD-10-PCS codes specifically defined for revising the subcutaneous portion of a lead. Because these services usually involve removing and re-inserting the generator as well, they can also be represented by the ICD-10-PCS generator revision codes.
6. Approach value X-External is also available for external generator manipulation without opening the pocket, e.g.. to correct a flipped generator.
7. Approach value 0-Open is used when lead procedures are performed via laparotomy and approach value 4 -Percutaneous Endoscopic is used when lead procedures are performed via laparoscopy.
8. Coding Clinic, 3rd Q 2014, pp.19-20.
9. For Lead Revision, the ICD-10-PCS codes refer to surgical revision of leads within the intra-abdominal space or gastric tissue, e.g.. repositioning. For revision of the subcutaneous portion of the lead, see Generator Revision.

Hospital Inpatient Coding and Payment

Medicare MS-DRG Assignments

Under Medicare's MS-DRG methodology for hospital inpatient payment, each inpatient stay is assigned to one diagnosis-related group (DRG), based on the ICD-10-CM diagnosis codes reported and ICD-10-PCS codes assigned to the procedures.

Only one MS-DRG is assigned for each inpatient stay, regardless of the number of procedures performed. The MS-DRGs shown are those typically assigned to the following scenarios.

Procedure	Scenario		MS- DRG[1]	MS-DRG Title[1,2]	Medicare National Rate[1]
Implantation or Replacement: Whole System	Generator plus leads	Diabetic gastroparesis	040	Peripheral/Cranial Nerve and Other Nervous System Procedures W MCC	$28,097
			041	Peripheral/Cranial Nerve and Other Nervous System Procedures W CC or Peripheral Neurostimulator	$15,999
			042	Peripheral/Cranial Nerve and Other Nervous System Procedures W/O CC/MCC	$12,572
		Idiopathic gastroparesis	981	Extensive OR Procedure Unrelated to Principal Diagnosis W MCC	$34,141
			982	Extensive OR Procedure Unrelated to Principal Diagnosis W CC	$17,890
			983	Extensive OR Procedure Unrelated to Principal Diagnosis W/O CC/ MCC	$12,472
Implantation or Replacement: Leads Only or Generator Only	Leads only (one or more) (either approach) or Generator only	Diabetic gastroparesis	040	Peripheral/Cranial Nerve and Other Nervous System Procedures W MCC	$28,097
			041	Peripheral/Cranial Nerve and Other Nervous System Procedures W CC or Peripheral Neurostimulator	$15,999
			042	Peripheral/Cranial Nerve and Other Nervous System Procedures W/O CC/MCC	$12,572
		Idiopathic gastroparesis	981	Extensive OR Procedure Unrelated to Principal Diagnosis W MCC	$34,141
			982	Extensive OR Procedure Unrelated to Principal Diagnosis W CC	$17,890
			983	Extensive OR Procedure Unrelated to Principal Diagnosis W/O CC/ MCC	$12,472
Removal (without replacement)	Whole system (generator plus leads) or Leads only (one or more)		040	Peripheral/Cranial Nerve and Other Nervous System Procedures W MCC	$28,097
			041	Peripheral/Cranial Nerve and Other Nervous System Procedures W CC or Peripheral Neurostimulator	$15,999
			042	Peripheral/Cranial Nerve and Other Nervous System Procedures W/O CC/MCC	$12,572
	Generator only		These codes are not considered "significant procedures" for the purpose of DRG assignment. A non-surgical (i.e., medical) DRG is assigned to the stay according to the principal diagnosis.		
Revision	Leads only (one or more)		981	Extensive OR Procedure Unrelated to Principal Diagnosis W MCC	$34,141
			982	Extensive OR Procedure Unrelated to Principal Diagnosis W CC	$17,890
			983	Extensive OR Procedure Unrelated to Principal Diagnosis W/O CC/MCC	$12,472
	Generator only		These codes are not considered "significant procedures" for the purpose of DRG assignment. A non-surgical (i.e., medical) DRG is assigned to the stay according to the principal diagnosis.		

1. Centers for Medicare and Medicaid Services. CMS 1833-F: Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals (IPPS) and the Long Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year (FY) 2026 Rates.
2. W MCC = with Major Complications and Comorbidities; W CC = with Complications and Comorbidities; W/O CC/MCC = without Complications and Comorbidities or without Major Complications and Comorbidities.

Physician Coding and Payment

CPT® Code[1]	Description	Work RVUs[2]	Total RVUs[3]	Payment Rate[2,3]	Global Period[2]
Insertion or Replacement					
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	4.97	7.99	$268	10
43647	Laparoscopy, surgical; implantation or replacement of gastric neurostimulator electrodes, antrum	Contractor Priced	Contractor Priced	Contractor Priced	YYY
43235	Esophagogastroduodenoscopy, flexible, transoral; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure).	2.04	3.31	$111	0
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	0.78	1.24	$42	XXX
Revision or Removal					
64595	Revision or removal of peripheral, sacral, or gastric neurostimulator pulse generator or receiver with detachable connection to electrode array	3.7	6.28	$211	10
43648	Laparoscopy, surgical; revision or removal of gastric neurostimulator electrodes, antrum	Contractor Priced	Contractor Priced	Contractor Priced	YYY
Programming Analysis or Adjustment					
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	0.29	1.31 *Physician Office Non-Facility*	$44 *Physician Office Non-Facility*	XXX
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	0.63	1.93 *Physician Office Non-Facility*	$65 *Physician Office Non-Facility*	XXX

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2. CY 2026 MPFS CMS-1832-F, Addendum B. Global Period YYY = the global period is to be set by the contractor. Global Period XXX = the global concept does not apply.
3. RVUs and payment for CPT 95981 and 95982 are stated as Total Non-Facility RVUs given these activities most commonly occur in the physician office. All other Total RVUs are listed as Total Facility RVUs.

Programming device adjustments

After the Enterra Therapy System is implanted, chronic follow-up care should continue based on individual patient needs. If medically necessary, these visits may include a patient assessment, device data review and programming changes. If an office visit is also conducted when the device is checked, it may be appropriate to bill for that separately. In order to bill for the clinic visit, the Evaluation & Management (E/M) criteria must be separate and identifiable from the device programming activity and modifier-25 may be appropriate to use with the E/M code.[1]

Payment for lead placement/revision/removal

For CPT code 43647 and 43648, CMS has determined that rather than setting a national RVU for the code, it should be "contractor priced." That is, CMS is requesting that each local Medicare Area Contractor (MAC) assign both RVU's and payment. MACs will establish RVUs and payment amounts for these services, generally on an individual case basis following review of documentation such as an operative report.

When assigning RVUs and payment, payors and administrators will often look to procedures that are similar in terms of work and effort involved as a proxy or crosswalk for the code. It is always up to the provider to determine the most appropriate comparison procedure, and to support that recommendation with detailed documentation. One potential comparison procedure to consider is a laparoscopic Nissen fundoplication:

CPT Code[2]	Description	Work RVUs[3]	Total RVUs[3]	Payment Rate[3,4]	Global Period[3]
43280	Laparoscopy, surgical, esophagogastric fundoplasty (e.g., Nissen, Toupet procedures)	17.65	30.28	$1,016	90

Many hospitals and physician groups also use RVUs to set physician payment rates and follow a similar process of reviewing a comparison procedure that is similar in terms of work and effort to establish a rate. The American College of Surgeons recommends listing two or three factors that make the unlisted procedure the same work, or more/less difficult than the comparison code. Then, document the established fee for the comparison CPT code and indicate a recommended fee for the unlisted CPT code based on the percentage of more or less work required.[5]

1. American Medical Association. Guide to Reporting CPT Modifier 25. Accessed March 14, 2025, at https://www.ama-assn.org/system/files/reporting-CPT-modifier-25.pdf.
2. CPT copyright 2025 American Medical Association. All rights reserved. CPT® is a registered trademark of the American Medical Association.
3. CY 2026 MPFS CMS-1832-F, Addendum B. Global Period YYY = the global period is to be set by the contractor. Global Period XXX = the global concept does not apply.
4. RVUs and payment for CPT 95981 and 95982 are stated as Total Non-Facility RVUs given these activities most commonly occur in the physician office. All other Total RVUs are listed as Total Facility RVUs.
5. Simon, K. et al. Unlisted procedures: Strategies for successful reimbursement. American College of Surgeons Bulletin. Accessed March 14, 2025, at https://www.facs.org/media/3pqhpnxk/2017_08_unlisted.pdf.

	Gastric Electrical Stimulation (GES)	Laparoscopic Nissen fundoplication
Code	43647	43280
Definition	Laparoscopy, surgical; implantation or replacement of gastric neurostimulator electrodes, antrum	Laparoscopy, surgical, esophagogastric fundoplasty (eg, Nissen, Toupet procedures)
Work/Total RVUs	–	17.65/30.28
Procedure Description	Under general anesthesia, surgical laparoscopy is performed. A supraumbilical incision is made, and the abdomen is entered using standard techniques for laparoscopy. Pneumoperitoneum is initiated. Two to five working trocar ports are placed in the abdominal wall. The viscera are inspected. The stomach is visualized, and the leads are introduced into the abdominal cavity via one of the trocars. Two leads are then implanted into the muscle layer between the serosa and the submucosa of the gastric antrum, using the needle attached to each lead. To prevent penetration into the lumen of the stomach, the guide needle is driven parallel to the surface. Intraoperative gastroscopy may be performed simultaneously by a separate physician to monitor for possible mucosal penetration. Once the lead is in good position, the lead is anchored to the serosal surface of the stomach and the guide needle is removed. The second lead is implanted parallel to the initial lead, separated by approximately 1 cm. The proximal ends of the leads are guided out of the abdominal cavity through a trocar into the area where a subcutaneous pocket will house the gastric neurostimulation pulse generator (creation of the subcutaneous pocket and implantation of the gastric neurostimulation pulse generator is covered by code 64590). The leads are connected to the gastric neurostimulation pulse generator and the impedance of the system is tested. The gastric neurostimulation generator is anchored to the fascia. After implantation of the gastric stimulator and confirmation of hemostasis, the trocars are removed, the pneumoperitoneum decompressed, and the surgical wounds are closed. Postoperative X-rays of the abdominal area are taken. Source: CPT Assistant, March 2007, p. 4	Following induction of general endotracheal anesthesia, the patient is placed in a low lithotomy position with the head of the table elevated 30 to 45 degrees. The knees are slightly flexed and placed in well-padded stirrups, so that the surgeon can stand between the patient's legs for optimal access to the upper portion of the abdomen. The abdomen is insufflated with carbon dioxide gas introduced through tubing attached to a Verres needle inserted into the abdomen. The resulting pneumoperitoneum is maintained throughout the procedure at a pressure of 12-14 mm HG. The Verres needle is replaced with a laparoscope, and the interior of the abdomen is examined under direct vision. Four more ports are placed for the procedure, including one placed near the xiphoid process (lower end of the sternum). Exact port placement can vary, depending on the surgeon's preference. The first steps in the procedure are focused on exposing the esophageal hiatus and the esophagogastric junction. Using a fan-shaped retractor, the caudate lobe of the liver is held toward the anterior abdominal wall to expose the hepatogastric omentum. In most patients, a natural window or opening is usually present in the omentum there. The tissue at the edge of the window is incised to expose the right crus muscle. Dissection is continued on the medial side of the right crus that allows visualization of the esophagus, the esophageal hiatus (opening in the diaphragm), and hiatal hernia, if present. The right and left crus muscles are sequentially dissected from attachments. The next steps are performed to free the entire circumference of the esophagus so that the fundal flap can be placed around it. The fundus of the stomach is mobilized next by dividing the short gastric vessels at that location. Then the esophagus is mobilized by dissection through the soft tissues of (Continued) the hiatus. With the esophagus and fundus held aside, sutures are placed in both crus muscles below the esophagus to bring them together to close the hiatal hernia. Then the fundoplasty is performed. The posterior wall of the fundus is grasped and brought behind the esophagus. Then the anterior wall of the fundus is positioned on the anterior esophagus so that the two structures together encircle it. A bougie or dilator may be passed into the esophagus and advanced through the esophagogastric junction to ensure the wrap is not too tight during the suturing process. Sutures are passed through the left and right sides of the fundus, including stitches between them in the anterior wall of the esophagus, to close the fundal wrap around the esophagus. If inserted, the bougie is removed. The operative area is irrigated, and the solution is removed using suction. Instruments are removed, the pneumoperitoneum is reversed, and the trocars are removed from each port. The port wounds may be closed with a single layer of sutures. Source: CPT Assistant, December 2002, p. 1.

If you have reimbursement questions regarding the Enterra Therapy Procedure, please contact us at reimbursement@enterramedical.com or 1-855-768-3772.

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REIMB-00660, Rev E

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