# Molina Clinical Policy
# Peroral Endoscopic Myotomy (POEM) for Esophageal Achalasia
# Policy No. 385

**Last Approval: 04/08/2026**
**Next Review Due By: April 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. The coverage directive(s) and criteria from an existing National Coverage Determination (NCD) or Local Coverage Determination (LCD) will supersede the contents of this MCP and provide the directive for all Medicare members. References included were accurate at the time of policy approval and publication.

## OVERVIEW

**Esophageal Achalasia (EA)** is an esophageal motility disorder characterized by progressive degeneration of neurons in the esophageal myenteric plexuses, resulting in impaired relaxation of the lower esophageal sphincter (LES) and loss of peristalsis in the distal esophagus. These abnormalities lead to functional obstruction at the gastroesophageal junction and impaired emptying from the esophagus into the stomach, often resulting in food stasis. As disease progression is gradual, patients typically experience symptoms for years before seeking medical care and are often treated for other disorders, such as gastroesophageal reflux disease (GERD), before EA is diagnosed ([1]Spechler and Pandolfino 2026).

The typical clinical presentation for EA is progressive dysphagia of both solids and liquids and often accompanied by regurgitation. Some patients may also experience weight loss, chest pain, heart burn, or difficulty belching. While endoscopy may reveal esophageal dilation, food retention, or a tight appearing esophagogastric junction, these findings are not diagnostic of achalasia and the endoscopy may in fact be normal, especially in early stages of the disease. A standard or timed barium esophagram can be used to aid diagnosis but may also be unrevealing. According to the Chicago Classification system, EA is subtyped into type I, type II, and type III achalasia based on esophageal motility patterns seen during manometry. (Khashab et al. 2020; [1]Spechler and Pandolfino 2026).

The gold standard for diagnosing EA is high-resolution esophageal manometry (HRM), which shows incomplete relaxation of the LES manifested as elevated integrated relaxation pressure, and the absence of organized peristalsis. While there is currently no known cure for EA, treatment options may include pneumatic dilatation, myotomy, and botulinum toxin injections or pharmacologic therapy for patients who are poor candidates for invasive therapy. Laparoscopic Heller myotomy (LHM) with partial fundoplication is the most common operative procedure used to treat EA, which involves surgical incision of the LES muscle fibers to relieve obstruction. Pneumatic dilation, LHM, and peroral endoscopic myotomy are considered comparable effective therapies for patients with type I or type II achalasia ([2]Spechler and Pandolfino 2025; Oelschlager and Petersen 2024).

**Peroral Endoscopic Myotomy (POEM)** is a minimally invasive, endoscopic alternative to LHM for the treatment of EA, and a form of natural orifice transluminal endoscopic surgery, which is a minimally invasive surgical technique that avoids external incisions and instead accesses the internal organs through natural orifices. Like LHM, POEM works by disrupting the LES to relieve obstruction and improve esophageal emptying. Major society guidelines identify POEM as a first-line therapy for Type I and Type II achalasia—along with pneumatic dilation and surgical myotomy—and as the preferred treatment approach for Type III achalasia , as it can deliver a longer myotomy that is generally not possible with pneumatic dilation or LHM ([2]Spechler and Pandolfino 2025; Khashab 2025).

However, unlike LHM, which is frequently performed with fundoplication to reduce reflux, POEM does not include an anti-reflux procedure, leading to a higher incidence of GERD. Patients undergoing POEM should be counseled on the increased risk of post procedure reflux compared with other treatments such as LHM or pneumatic dilation. Other adverse events associated with POEM include pneumoperitoneum, subcutaneous emphysema, pneumothorax, mucosotomy, and bleeding ([2]Spechler and Pandolfino 2025; Khashab 2025).

## COVERAGE POLICY

### Medically Necessary

Peroral Endoscopic Myotomy (POEM) for the treatment of esophageal achalasia may be **considered medically necessary** when ALL the following criteria are met:

1. Member is 18 years of age or older

2. Absence of ALL the following contraindications:
   a. Significant coagulation disorders
   b. Severe erosive esophagitis
   c. Severe pulmonary disease
   d. Liver cirrhosis with portal hypertension
   e. Esophageal malignancy
   f. Prior esophageal interventions that may compromise submucosal integrity (e.g., esophageal irradiation, endoscopic mucosal resection, endoscopic submucosal dissection, or recent esophageal surgery)

3. Diagnosis of achalasia, established by high-resolution esophageal manometry, confirming ONE of the following:
   a. Elevated median integrated relaxation pressure (IRP) and one of the following manometric patterns:
      i. Type I: 100% failed peristalsis without panesophageal pressurization
      ii. Type II: 100% failed peristalsis with panesophageal pressurization in ≥20% of swallows
      iii. Type III: No normal peristalsis and ≥20% premature (spastic) swallows
   b. Inconclusive findings despite a timed barium esophogram indicating dilation of the esophagus, narrow esophagogastric junction, aperistalsis, and/or delayed emptying of barium AND an esophagogastric malignancy has been ruled out by appropriate means (e.g., upper endoscopy, endoscopic ultrasound with fine needle aspiration)

4. Member has been counseled on the risk of gastroesophageal reflux disease (GERD) and alternative treatments available with a lower incidence of post-procedure GERD, such as laparoscopic Heller myotomy and pneumatic dilation

5. Documentation of ALL the following:
   a. History and physical exam, including a standardized, validated symptom assessment indicating symptomatic esophageal achalasia (i.e., dysphagia to solids and liquids, heartburn unresponsive to a trial of proton pump inhibitor therapy)
   b. Eckardt symptom score > 3
   c. GERD has been objectively ruled out as the primary cause of dysphagia and/or heartburn by either of the following when symptoms of heartburn are present:
      i. Absence of reflux or esophagitis on endoscopy
      ii. 24-hour ambulatory esophageal pH monitoring rules out reflux

### Continuation of Therapy

1. Repeat POEM may be **considered medically necessary** for adults with an Eckardt symptom score > 3 and no contraindications, following a prior POEM on the opposite site of the esophagus that failed to relieve symptoms. **A new authorization request is required.**

### Not Medically Necessary

POEM for any indication other than esophageal achalasia 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, including the following:

1. Diverticular peroral endoscopic myotomy (D-POEM)
2. Gastric peroral endoscopic myotomy (G-POEM)
3. Zenker peroral endoscopic myotomy (Z-POEM)

**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

There is a moderate and growing body of evidence, including randomized controlled trials (RCTs), prospective and retrospective studies, systematic reviews, and meta-analyses, supporting the safety and efficacy of peroral endoscopic myotomy (POEM) for the treatment of esophageal achalasia (EA) in adults. When compared to established alternatives such as laparoscopic Heller myotomy (LHM) or pneumatic dilation (PD), POEM demonstrates comparable clinical outcomes and offers specific advantages in patients with type III achalasia.

***Randomized Controlled Trials***

Hugova et al. (2025) conducted a multicenter RCT comparing per-oral endoscopic myotomy (POEM) with laparoscopic Heller myotomy plus Dor fundoplication (LHM-Dor) on 241 patients (120 to POEM vs 121 to LHM-Dor). The five-year results were analyzed and found that POEM remained non-inferior to LHM-Dor, for long- term symptom control in patients with untreated idiopathic achalasia. Clinical success at five years 75.0% after POEM and 70.8% after LHM-Dor, with both groups showing similar improvements in Eckardt scores, quality of life measures, and lower esophageal sphincter relaxation on manometry. Objective gastroesophageal reflux was more frequent after POEM, reflected in higher rates of reflux esophagitis (41% versus 31%) and abnormal acid exposure on pH testing (62% versus 31%), although reflux symptoms were comparable and no cases of peptic stricture, Barrett's esophagus, or esophageal adenocarcinoma were reported. Overall, the findings indicate that POEM provides durable long-term efficacy comparable to LHM-Dor but carries a higher likelihood of objective reflux, supporting the need for ongoing reflux surveillance following POEM.

Ponds et al. (2019) conducted a RCT comparing the effect of POEM versus PD on symptom severity and treatment outcomes among patients with treatment-naive achalasia. The primary outcome of the trial was measuring success of the treatment as defined by a reduction in the patient's Eckardt score to less than or equal to 3 and the absence of severe complications or need for re-treatment. Notable secondary outcomes were complication rates, presence of reflux esophagitis based on endoscopy findings, esophageal acid exposure, reflux symptoms, and proton pump inhibitor use. One hundred and thirty patients were randomized and underwent treatment to receive POEM (n = 64) or PD (n = 66). One hundred and twenty-six completed the two-year study for a 95% completion rate. The primary outcome of treatment success occurred in 58 of 63 patients (92%) in the POEM group vs 34 of 63 (54%) in the pneumatic dilation group, a difference of 38% ([95% CI, 22%-52%]; $P < .001$). Outcomes were assessed at the 3 months, 1 year, and 2 years follow ups via symptoms and questionnaires, high-resolution manometry, and timed barium esophagogram. There were a total of 7 severe adverse events recorded, two of which were attributed to PD, the remaining five occurred independent of the study, with none being attributed to POEM. The most common minor adverse event attributed to POEM was reflux esophagitis, which was observed significantly more frequently in patients treated with POEM than with pneumatic dilation (22 of 54 patients [41%] in the POEM group, of whom 19 [35%] were assigned grade A-B and 3 [6%] were assigned grade C, vs 2 of 29 [7%] in the pneumatic dilation group, all of whom were assigned grade A; absolute difference, 34% [95% CI, 12%-49%]; P = .002). The authors conclude that POEM is effective and more successful at treating achalasia than PD; however, due to its more invasive nature and risk of reflux esophagitis that patients should be offered counseled in the risk and benefits of each procedure.

Kuipers et al. (2022) conducted a five year follow up analysis of the Ponds et al. (2019) RCT comparing POEM versus PD in treatment naïve achalasia. Patients available for five year follow up were 62 patients in the POEM group and 63 patients in the PD group. POE demonstrated superior long term success rates with 50 (81%) patients in the POEM group had treatment success, compared with 25 (40%) in the PD group, an adjusted absolute difference of 41% (95% CI 25-57; p<0·0001). Endoscopy results revealed patients still in clinical remission had reflux esophagitis in 14 (33%) of 42 patients in the POEM group (12 [29%] grade A or B, two [5%] grade C or D) versus two (13%) of 16 patients in the PD group (two [13%] grade A or B, none grade C or D; p=0·19). There were no severe adverse events between the two and five year follow ups for either procedure.

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

Sobral et al. (2024) conducted a systematic review and meta-analysis comparing POEM and LHM with fundoplication for the treatment of achalasia. The review included 20 retrospective observational studies published between 2010 and 2022, for a total of 5,139 participants (n = 5139), with 1,394 undergoing POEM and 3,745 undergoing LHM with fundoplication. Surgical and postoperative outcomes included clinical success (defined as an Eckardt score ≤ 3), operative time, intraoperative and postoperative complications (including Clavien-Dindo grades), length of stay (LOS), reintervention rates, postoperative pain, incidence of GERD symptoms, use of proton pump inhibitors (PPIs), and esophagitis. Statistical analysis utilized risk ratios (RR) and mean differences (MD), with significance defined as $p < 0.05$. POEM was found to have significantly shorter operative time (mean: 116.8 minutes vs. 150.5 minutes for LHM, MD -33.80, $p < 0.00001$) and reduced length of stay (mean: 2.1 days vs. 2.7 days, MD -0.55, $p = 0.0001$), though both outcomes showed high heterogeneity. Based on two studies, POEM also had lower postoperative pain, as measured by duration of analgesic use (mean: 1.6 days vs. 2.3 days, MD -0.91, $p = 0.03$). Clinical success was higher in the POEM group (91.2% vs. 82.3%, RR 1.08, $p = 0.010$) with low heterogeneity, though the postoperative Eckardt score did not differ significantly between groups when measured as a continuous variable. There were no statistically significant differences in intraoperative complications (11.1% for POEM vs. 8.9% for LHM, RR 1.21, $p = 0.48$), overall postoperative complications (7.7% vs. 5.7%, RR 0.89, $p = 0.62$), or complications corresponding to Clavien-Dindo grades I-IV. Reintervention rates were lower in the POEM group (10.7% vs. 17.4%), though this did not reach statistical significance (RR 0.62, $p = 0.06$). The occurrence of GERD symptoms, use of PPIs, and rates of esophagitis did not significantly differ between the two groups despite the lack of fundoplication in POEM. The authors note that while POEM does not include an anti-reflux mechanism, its less invasive nature may preserve esophageal function and limit reflux in some cases. The authors concluded that POEM and LHM are both safe and effective treatments for achalasia. POEM was associated with better outcomes regarding operative time, hospital stay, postoperative pain, and clinical success with a tendency toward fewer recurrences.

North and Tewari (2024) conducted a systematic review comparing POEM to LHM and pneumatic dilation (PD) in the treatment of EA. A total of 31 studies were included and analyzed, three of which were RCTs (Conte et al. 2020; Ponds et al. 2019; Werner et al. 2019). The medium to long term efficacy results were increased efficacy of POEM over PD, with additional statistically significant improvements in treatment success rates (100 vs. 50% with Eckardt < 3) noted in type III achalasia patients retrospectively at 1 year follow-up. POEM and LHM had similar efficacy in the medium to long term follow up, with a retrospective analysis of 98 patients observed significantly longer time to treatment failure in POEM groups compared to LHM despite no difference in Eckardt scores at 36 months. As far as symptom reoccurrence and retreatment rates, POEM had significantly less of each compared to PD. LHM and POEM lead to comparable symptom recurrence and re-treatment rates. Overall, evidence supports effective symptom improvement after POEM, with the improvement appearing to be especially beneficial in type III achalasia patients, the subtype that poses significant difficulties in treatment. POEM appears to be more likely to result in long lasting benefit without the need to undergo additional intervention. While results are generally equivalent between POEM and LHM patients, POEM seems superior to PD, with comparably low adverse event rates across all treatment modalities. Significantly higher POEM patients experience gastroesophageal reflux disease symptoms following the procedure, which may be managed conservatively compared to symptoms of achalasia using proton pump inhibitors. The authors emphasize that POEM and LHM require significant skill and experience to be carried out effectively. Additionally, the authors highlight the limitations of the analysis, being most study designs included are retrospective without matching, introducing the possibility of bias, few of the included studies undertook follow-up of POEM patients beyond 24 months compared to longer follow-up in LHM and PD patients leading to potential missed recurrence in POEM patients, and while financial implications were considered in this study no formal economic model was formulated. The authors suggest further high quality RCTs are needed to corroborate the findings and to reduce risk of bias.

Latha Kumar et al. (2023) conducted a systematic review comparing the clinical efficacy, safety, and postoperative outcomes of POEM versus LHM with fundoplication for the treatment of achalasia. The review included two RCTs, seven observational studies, and two systematic reviews, for a total population of 2,127 patients (n = 2127), with 981 undergoing POEM and 1,146 undergoing LHM with fundoplication. Overall, both POEM and LHM significantly improved symptoms as measured by the Eckardt score. Some individual studies noted a higher initial success rate and greater Eckardt score reduction in POEM compared to LHM, particularly in patients with achalasia type III and Chagas studies. But overall, there was no statistically significant difference in symptom relief or esophageal function improvement between POEM and LHM. POEM was associated with a shorter procedure time in several studies and generally fewer adverse events, although it varied across studies. Hospital stays were similar with some studies

reporting shorter stays with POEM. The review noted that while POEM may offer procedural advantages, such as less blood loss and shorter operative duration, the clinical impact of these differences remains modest. pH monitoring showed that abnormal esophageal acid exposure and elevated DeMeester score were significantly more common after POEM than LHM in multiple studies. For instance, in a retrospective cohort study (n = 88) by Sanaka et al. (2019), 48.4% of POEM patients had abnormal acid exposure compared to 13.6% of LHM patients ($p < 0.001$), and abnormal DeMeester scores were found in 54.8% vs. 17.4% respectively ($p = 0.005$). Endoscopic findings also supported this, with studies showing significantly higher rates of esophagitis following POEM. For example, in a single center RCT by de Moura et al. (2022), esophagitis rates were 64.6% in POEM patients at 12 months compared to 11.1% in LHM ($p = 0.002$). Despite the increased incidence of GERD, subjective GERD symptom scores were not consistently different between groups. Overall, the review found that POEM and LHM are similarly effective in relieving achalasia symptoms and improving esophageal function. POEM offers advantages in terms of shorter procedure time and possibly fewer adverse events, but it carries a higher risk of postoperative reflux and esophagitis due to the lack of fundoplication. The authors recommend that surgeons consider both the efficacy and risk of reflux when choosing between procedures and suggest that POEM may be especially beneficial in select subpopulations, such as those with type III achalasia.

Zhang et al. (2023) conducted a systematic review and meta-analysis on the mid- and long-term outcomes of POEM for the treatment of achalasia. Twenty-one studies were included, totaling 2, 698 patients, with a minimum follow up of two years. The pooled clinical success rates of POEM in studies with 2-, 3-, 4-, and 5-year follow-ups were 91.3% (95% confidence interval [CI] 88.4-93.6%), 90.4% (95% CI 88.1-92.2%), 89.8% (95% CI 83.6-93.9%), and 82.2% (95% CI 76.6-86.7%), respectively. The pooled long-term clinical success rates for type I, II, and III achalasia were 86.1% (95% CI 80.9-90.1%; I2 = 0%), 87.9% (95% CI 84.2-90.8%; I2 = 48.354%), and 83.9% (95% CI 72.5-91.2%; I2 = 0%), respectively. The pooled incidence of symptomatic reflux and reflux esophagitis was 23.9% (95% CI 18.7-29.9%) and 16.7% (95% CI 11.9-23.1%), respectively. The authors concluded that POEM is associated with a long-term clinical success of 82.2% after 5 years of follow-up; however, they recommended more high quality RCTs comparing POEM with LHM and PD with long term follow up periods are necessary to further demonstrate the long-term safety and efficacy of POEM.

Facciorusso et al. (2021) conducted a systematic review and network meta-analysis of first-line achalasia therapies. Three treatments were evaluated in 6 RCTs that compared the efficacy of PD (n=260), LHM (n=309), and POEM (n=176) in individuals with achalasia. LHM was compared to PD in four studies, POEM was compared to PD in one study, and POEM was compared to LHM in another. Overall, low-quality data, based mostly on direct evidence, supported the use of POEM over PD for one-year treatment success, whereas no meaningful difference between LHM and POEM was seen. POEM, LHM, and PD, respectively, had a 5.3%, 3.7%, and 1.5% incidence of severe esophagitis. Procedure-related major adverse events were 1.4%, 6.7%, and 4.2% after POEM, LHM, and PD, respectively. POEM and LHM are comparable in terms of efficacy and may increase treatment success when compared to PD, according to the authors, albeit with limited confidence in estimates.

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

Shiwaku et al. (2022) conducted a large-scale cohort study to assess the risk factors and long-term course of gastroesophageal reflux disease (GERD) and reflux esophagitis following POEM. A total of 2905 patients with achalasia-related esophageal motility disorders treated with POEM were analyzed for reflux esophagitis, severe reflux esophagitis (Los Angeles classification C or D), and symptomatic GERD across 14 high volume centers. Severe reflux esophagitis was diagnosed in 219 patients (7.5 %) and was associated with the risk factors of age ≥ 65 years (RR 1.72), previous treatments (RR 2.21), Eckardt score ≥ 7 (RR 0.68), sigmoid-type achalasia (RR 1.40), and esophageal myotomy > 10 cm (RR 1.59). Symptomatic GERD was diagnosed in 458 patients (15.9 %) and was associated with the risk factors of symptom duration ≥ 10 years (RR 1.28), achalasia diagnosis (RR 0.68), integrated relaxation pressure ≥ 26 (RR 0.60), and posterior myotomy (RR 0.80). were associated with symptomatic GERD. The incidence of symptomatic GERD was lower at 5-year follow-up compared with that after 1 year ($P = 0.04$), particularly in PPI users ($P < 0.001$). PPI use was also found to be more effective for reflux esophagitis at 5-year follow-up ($P = 0.03$) than after 1 year ($P = 0.08$). The authors concluded that while the rate of severe esophagitis was low after POEM, that previous treatments in older patients should be avoided prior to POEM to reduce the risk of contracting severe esophagitis post POEM procedure.

**National and Specialty Organizations**

The **American College of Gastroenterology (ACG)** (Vaezi et al. 2020) published evidence-based clinical guidelines on the diagnosis and treatment of achalasia in 2020. The Grading of Recommendations Assessment, Development, and Evaluation (GRADE) framework was used to rate the quality of the evidence and the strength of the recommendations. The two RCTs comparing POEM to LHM, or pneumatic dilation are included in the evidence review. The ACG issued the following recommendations based on their evaluation:

- POEM or LHM is more effective for type III achalasia when compared to PD
- POEM and PD have comparable symptom improvement in patients with types I or II achalasia
- POEM and LHM have comparable symptom improvement in patients with achalasia
- POEM is a safe option in patients with achalasia who have failed PD or LHM
- POEM is associated with a higher incidence of GERD when compared to LHM with fundoplication or PD

The **American Gastroenterological Association (AGA)** issued a Clinical Practice Update (Yang et al. 2024) reviewing current evidence and expert consensus on the use of peroral endoscopic myotomy (POEM) for achalasia. The AGA notes that POEM, laparoscopic Heller myotomy (LHM), and pneumatic dilation (PD) are all effective treatment options for individuals with Type I and Type II achalasia and recommends that the choice among these modalities be guided by shared decision making that incorporates patient characteristics, preferences, and local expertise. For Type III achalasia, the AGA identifies POEM as the preferred approach because it allows a longer, proximally extended myotomy to address spastic contractions. The AGA also advises that POEM is an appropriate option for patients with persistent or recurrent symptoms following prior myotomy and may offer advantages over PD in this setting. Decision regarding treatment should consider the cause of symptom reoccurrence, the risk of post procedure reflux, the likelihood of requiring additional interventions and patient preference.

The **American Society of Gastrointestinal and Endoscopic Surgeons (ASGE)** (Khashab et al. 2020) published an evidence-based guideline on the treatment of achalasia which was endorsed by both the American Neurogastroenterology and Motility Society and the Society of American Gastrointestinal and Endoscopic Surgeons. The methodological quality of systematic reviews was evaluated using the AMSTAR-2 tool, and the certainty of the body of evidence was rated as very low to high using the GRADE framework. ASGE rated the strength of each recommendation based on the overall quality of the evidence and an evaluation of the anticipated benefits and risks. ASGE utilized "we suggest" for weaker recommendations and "we recommend" for stronger ones. This guideline did not include either of the two RCTs of POEM that were available. ASGE issued the following recommendations in consideration of their analysis:

- “We suggest POEM as the preferred treatment for management of patients with type III achalasia." (Very low-quality evidence)
- "In patients with failed initial myotomy (POEM or LHM), we suggest PD or redo myotomy using either the same or an alternative myotomy technique (POEM or LHM)." (Very low-quality evidence)
- "We suggest that patients undergoing POEM are counseled regarding the increased risk of post-procedure reflux compared with PD and LHM. Based on patient preferences and physician expertise, post-procedure management options include objective testing for esophageal acid exposure, long-term acid suppressive therapy, and surveillance upper endoscopy." (Low quality evidence)
- We suggest that POEM and LHM are comparable treatment options for management of patients with achalasia types I and II, and the treatment option should be based on shared decision-making between the patient and provider." (Low quality evidence)

## SUPPLEMENTAL INFORMATION

**Eckardt Symptom Score (ESS)** is most frequently used for the evaluation of symptoms, stages, and efficacy of achalasia treatment. The ESS is a 4-item self-report scale measuring weight loss, chest pain, regurgitation, and dysphagia. Each item is graded on a score of 0 to 3 with a maximum score of 12. Score greater than or equal to 3 are considered active achalasia.

| Eckardt Score for Symptomatic Evaluation in Achalasia | | | | |
|---|---|---|---|---|
| **Score** | **Weight loss (kg)** | **Dysphagia** | **Retrosternal Pain** | **Regurgitation** |
| **0** | None | None | None | None |

| | | | | |
|---|---|---|---|---|
| **1** | < 5 | Occasional | Occasional | Occasional |
| **2** | 5-10 | Daily | Daily | Daily |
| **3** | > 10 | Each meal | Each meal | Each meal |

**Subtypes of achalasia** defined by the Chicago Classification Version 4.0 (CCv4.0) (Yadlapti et al. 2021).
Chicago Classification Version 4.0 is the current international standard for interpreting high resolution esophageal manometry. It was developed by a multidisciplinary working group of 52 experts representing 6 international motility societies in 20 countries, who met over 2 years to update diagnostic definitions and testing protocols. CCv4.0 emphasizes that manometric patterns must be interpreted together with symptoms and supportive testing such as timed barium esophagram or functional lumen imaging probe (FLIP) before diagnosis is considered clinically meaningful. The updated definitions below replace the 2015 Chicago classification v3.0 criteria

1. Type I (classic achalasia): 100% failed peristalsis with abnormal integrated relaxation pressure (IRP)
2. Type II (achalasia with panesophageal pressurization): 100% failed peristalsis with panesophageal pressurization in ≥ 20% of swallows and abnormal IRP
3. Type III (spastic achalasia): no evidence of peristalsis and ≥ 20% premature (spastic) swallows, with abnormal IRP

## CODING & BILLING INFORMATION

**CPT (Current Procedural Terminology)**

| Code | Description |
|---|---|
| **43497** | Lower esophageal myotomy, transoral (i.e., peroral endoscopic myotomy [POEM]) |
| **43499** | Unlisted procedure, esophagus |

**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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|---|---|
| **04/08/2026** | Policy revised. Updated definitions of achalasia Types I, II and III based on Chicago Classification Criteria CCv4.0. Updated Overview, Summary of Medical Evidence, Supplemental Section and References. IRO peer review on March 19, 2026, by a practicing physician board certified in Gastroenterology. |
| **04/09/2025** | Policy revised. Removed prescriber and administration requirements. Removed criteria requiring failed treatment prior to POEM or determination that POEM is the most appropriate treatment. IRO peer reviewed on March 26, 2025, by a practicing physician board certified in Gastroenterology. |
| **04/10/2024** | Policy reviewed. No changes to coverage criteria. |
| **04/13/2023** | Policy reviewed and updated. No changes to coverage criteria. |
| **04/13/2022** | Policy revised. Coverage position changed from E/I to medically necessary. Added coverage criteria and updated summary of evidence: systematic review and meta-analyses; Hayes's HTA (updated review in Jan 2022); updated SAGES guidelines. IRO peer reviewed on April 7, 2022, by a practicing physician board certified in Gastroenterology. |
| **12/08/2021** | Policy reviewed and updated, no changes in coverage criteria, updated references. Converted to new format. Notable revisions to the summary of evidence include: addition of relevant/updated systematic review and meta-analyses; addition of Hayes's comparative effectiveness review (updated review in April 2021); updated professional society guidelines and inclusion of relevant (ASGE; ISDE; SAGES) |
| **12/09/2020** | New policy. IRO Peer Review on 10/8/20 by a practicing physician board certified in Gastroenterology. |

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