Sentara® Health Plans

Medicaid

Ingestible Devices, Medical 344

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Effective Date	1/1/2026
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Coverage Policy	Medical 344
Version	3

All requests for authorization for the services described by this medical policy will be reviewed per Early and Periodic Screening, Diagnostic and Treatment (EPSDT) guidelines. These services may be authorized under individual consideration for Medicaid members under the age of 21-years if the services are judged to be medically necessary to correct or ameliorate the member's condition. Department of Medical Assistance Services (DMAS), Supplement B - EPSDT (Early and Periodic Screening, Diagnosis and Treatment) Manual.*.

Description & Definitions:

Ingestible Device used for nonpharmacological treatment of Chronic idiopathic constipation (CIC). The capsule shaped device mechanically stimulates the colon by vibrating and inducing a bowel movement.

Other common names: Vibrant Gastro system, transient device for constipation

Criteria:

Ingestible Devices (Vibrant Gastro system): Current role remains uncertain, based on review of existing evidence, there are currently no clinical indications for this technology. Therefore, not medically necessary for any clinical indications.

Document History:

Revised Dates:

- 2025: September – Implementation date of January 1, 2026. No change new format references updated.
- 2025: October – New format, no criteria change

Reviewed Dates:

- 2024: October – no changes references updated

Origination Date: November 2023

Coding:

Medically necessary with criteria:

Coding	Description
	None

Considered Not Medically Necessary:

Coding	Description
9268	Programmer for transient, orally ingested capsule

A9269	Programmable, transient, orally ingested capsule, for use with external programmer, per month

The preceding codes are included above for informational purposes only and may not be all inclusive. Additionally, inclusion or exclusion of a treatment, procedure, or device-code(s) does not constitute or imply member coverage or provider reimbursement.

Policy Approach and Special Notes: *

- Coverage
  - See the appropriate benefit document for specific coverage determination. Member specific benefits take precedence over medical policy.
- Application to products
  - Policy is applicable to Sentara Health Plan Virginia Medicaid Products
- Authorization requirements
  - Precertification required by Plan
- Special Notes:
  - This medical policy express Sentara Health Plan's determination of medically necessity of services, and they are based upon a review of currently available clinical information. These policies are used when no specific guidelines for coverage are provided by the Department of Medical Assistance Services of Virginia (DMAS). Medical Policies may be superseded by state Medicaid Plan guidelines. Medical policies are not a substitute for clinical judgment or for any prior authorization requirements of the health plan. These policies are not an explanation of benefits.
  - Medical policies can be highly technical and complex and are provided here for informational purposes. These medical policies are intended for use by health care professionals. The medical policies do not constitute medical advice or medical care. Treating health care professionals are solely responsible for diagnosis, treatment and medical advice. Sentara Health Plan members should discuss the information in the medical policies with their treating health care professionals. Medical technology is constantly evolving and these medical policies are subject to change without notice, although Sentara Health Plan will notify providers as required in advance of changes that could have a negative impact on benefits.
  - The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) covers services, products, or procedures for children, if those items are determined to be medically necessary to "correct or ameliorate" (make better) a defect, physical or mental illness, or condition (health problem) identified through routine medical screening or examination, regardless of whether coverage for the same service or support is an optional or limited service under the state plan. Children enrolled in the FAMIS Program are not eligible for all EPSDT treatment services. All requests for authorization for the services described by this medical policy will be reviewed per EPSDT guidelines. These services may be authorized under individual consideration for Medicaid members under the age of 21-years if the services are judged to by medically necessary to correct or ameliorate the member's condition. EPSDT Supplement B (updated 5.19.22)_Final.pdf
  - Service authorization requests must be accompanied by sufficient clinical records to support the request. Clinical records must be signed and dated by the requesting provider withing 60 days of the date of service requested.

References:

Including but not limited to: Specialty Association Guidelines; Government Regulations; Winifred S. Hayes, Inc; UpToDate; Literature Review; Specialty Advisors; National Coverage Determination (NCD); Local Coverage Determination (LCD).

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Vibrant. (2025). Retrieved 8 2025, from Vibrant Gastro: https://vibrantgastro.com/

Vibrant System (Vibrant Gastro Inc.) for Treatment of Chronic Idiopathic Constipation. (2025, 8). Retrieved 8 2025, from Hayes: https://evidence.hayesinc.com/report/eer.vibrant5797

Keywords:

SHP, Ingestible, VIBRANT, constipation