MEDICAL POLICY – 2.01.533
Upper Gastrointestinal (UGI) Endoscopy for Adults

Effective Date: Jan. 1, 2020
Last Revised: Nov. 26, 2019
Replaces: N/A

RELATED MEDICAL POLICIES:
2.01.38 Transesophageal Endoscopic Therapies for Gastroesophageal Reflux Disease

Select a hyperlink below to be directed to that section.

POLICY CRITERIA | DOCUMENTATION REQUIREMENTS | CODING
RELATED INFORMATION | EVIDENCE REVIEW | REFERENCES | HISTORY

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Introduction

Upper gastrointestinal (UGI) endoscopy is a procedure that looks at the tissues lining the esophagus, stomach and the first part of the small intestine (duodenum). It uses a flexible tube-like tool called an endoscope that contains fibers that transmit light and magnify the image. The scope is inserted through the mouth and the procedure is usually performed with light, intravenous anesthesia. The scope is used to search for cause(s) of severe heartburn, difficulty swallowing, reflux, persistent vomiting, and bleeding. This tool can also be used to remove polyps or stones from the bile duct.

Note: The Introduction section is for your general knowledge and is not to be taken as policy coverage criteria. The rest of the policy uses specific words and concepts familiar to medical professionals. It is intended for providers. A provider can be a person, such as a doctor, nurse, psychologist, or dentist. A provider also can be a place where medical care is given, like a hospital, clinic, or lab. This policy informs them about when a service may be covered.

Policy Coverage Criteria
<table>
<thead>
<tr>
<th>Condition</th>
<th>Medical Necessity</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Malignant indications</strong></td>
<td><strong>Upper gastrointestinal (UGI) endoscopy may be considered medically necessary for patients 19 years of age and older for any of the following indications:</strong></td>
</tr>
<tr>
<td></td>
<td>- Dysplasia</td>
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<tr>
<td></td>
<td>- Esophageal cancer</td>
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<tr>
<td></td>
<td>- Familial adenomatous polyposis (FAP)</td>
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<tr>
<td></td>
<td>- Gastric cancer</td>
</tr>
<tr>
<td></td>
<td>- History of Lynch Syndrome or hereditary nonpolyposis colorectal cancer (HNPCC)</td>
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<tr>
<td></td>
<td>- Head/neck cancer</td>
</tr>
<tr>
<td></td>
<td>- In situations where clinical features are highly suspicious for UGI malignancy (eg, epigastric mass found on x-ray, abnormal barium study, and others)</td>
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<td></td>
<td>- Barrett esophagus (Metaplastic columnar or glandular epithelium) (see surveillance criteria below)</td>
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<tr>
<td></td>
<td>- Patients with prior adenomatous gastric polyps or sessile polyps (rare)</td>
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<td></td>
<td>- One evaluation for positive CDH1 mutation</td>
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<td></td>
<td>- Strong family history of gastrointestinal cancer</td>
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<tr>
<td></td>
<td>- Tylosis (genetic disorder which predisposes one to esophageal cancer)</td>
</tr>
<tr>
<td><strong>Alarm symptoms</strong></td>
<td><strong>Upper gastrointestinal (UGI) endoscopy may be considered medically necessary for patients 19 years of age and older when performed for evaluation of ANY of the following alarm symptoms that may be associated with an UGI source:</strong></td>
</tr>
<tr>
<td></td>
<td>- Anemia (iron deficiency anemia and negative colonic evaluation)</td>
</tr>
<tr>
<td></td>
<td>- Bleeding from the rectum or in stool that may be bright red or dark colored</td>
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<td></td>
<td>- Epigastric mass is found on examination</td>
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<td></td>
<td>- Persistent vomiting of unknown cause, including vomiting blood</td>
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<td></td>
<td>- Swallowing that is difficult (dysphagia)</td>
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<tr>
<td></td>
<td>- Unintentional weight loss of 3 kg (approx. 6.6 lbs.) or more since symptoms started</td>
</tr>
<tr>
<td>**Follow-up of known non-</td>
<td><strong>Upper gastrointestinal (UGI) endoscopy may be considered medically necessary for patients 19 years of age and older</strong></td>
</tr>
<tr>
<td>malignant conditions**</td>
<td></td>
</tr>
<tr>
<td>Condition</td>
<td>Medical Necessity</td>
</tr>
<tr>
<td>------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| **Gastroesophageal reflux (GERD) or dyspepsia symptoms** | when performed for evaluation of ANY of the following indications that may be associated with a UGI source:  
- Anorexia of unknown cause  
- Persistent non-cardiac chest pain  
- Follow-up of known erosive esophagitis - (May need follow up UGI to evaluate for Barrett after course of therapy)  
- Esophageal varices, with or without bleeding (see Cirrhosis below for ongoing screening)  
- History of gastric surgery  
- Non-steroidal anti-inflammatory drug (NSAID) use is stopped yet symptoms continue  
- Swallowing that is difficult (dysphagia)  
- Swallowing that is painful (odynophagia) |
| **Other upper gastrointestinal (UGI) indications** | Upper gastrointestinal (UGI) endoscopy may be considered medically necessary for patients 19 years of age and older when:  
- Performed for evaluation of GERD or dyspepsia (heartburn) symptoms that are present for at least 3 months AND  
  - Persist despite 4 -8 weeks of treatment with daily proton pump inhibitor (PPI) therapy  
  - Persist despite 6-12 weeks of treatment with a histamine H2-receptor antagonist (H2 blocker- only if patient refuses or cannot tolerate a PPI) |
| | Upper gastrointestinal (UGI) endoscopy may be considered medically necessary for patients 19 years of age and older for any of the following indications:  
- Achalasia  
- Barrett esophagus (BE) surveillance based on the cell pathology:  
  - High-grade dysplasia: repeat UGI every 3 months after initial biopsy for 1 year, then annually  
  - Other grades of dysplasia: repeat UGI no more frequently than annually |
<table>
<thead>
<tr>
<th>Condition</th>
<th>Medical Necessity</th>
</tr>
</thead>
<tbody>
<tr>
<td>No dysplasia (metaplasia):</td>
<td>- Repeat UGI one time within 12 months after initial biopsy; then every 3 years if pathology unchanged</td>
</tr>
<tr>
<td>Celiac disease (duodenal disease):</td>
<td>- GI symptoms that are consistent with chronic malabsorption (such as diarrhea, weight loss, flatulence, bloating, and abdominal pain) AND Serology tests (antibody levels) are positive for celiac disease</td>
</tr>
<tr>
<td>Cirrhosis upon initial diagnosis,</td>
<td>- One UGI endoscopy to screen for esophageal varices, then no more frequently than annually for ongoing screening</td>
</tr>
<tr>
<td>Crohn disease that involves the esophagus,</td>
<td>- Gastric, peptic, esophageal ulcer confirmation when: Conservative medical management was tried and failed to relieve symptoms (eg, cessation of NSAIDs, trial of appropriate medication) OR Conservative medical management is contraindicated</td>
</tr>
<tr>
<td>stomach or duodenum</td>
<td></td>
</tr>
<tr>
<td>Gastric, peptic, esophageal ulcer</td>
<td></td>
</tr>
<tr>
<td>Screen for Barrett in a male patient aged 50</td>
<td>- Elevated body mass index (BMI)</td>
</tr>
<tr>
<td>years or older with 5 years or more of GERD</td>
<td>- Excess abdominal fat (intra-abdominal fat distribution)</td>
</tr>
<tr>
<td>symptoms and 1 or more of the following:</td>
<td>- Hiatal hernia</td>
</tr>
<tr>
<td>Tobacco use</td>
<td>- Night-time symptoms of reflux</td>
</tr>
<tr>
<td>Patients scheduled for bariatric surgery</td>
<td>- Patients scheduled for organ transplantation</td>
</tr>
<tr>
<td>(NOTE: if member’s contract excludes bariatric surgery, then UGI is not covered, unless the member meets another medical necessity criterion in this policy)</td>
<td></td>
</tr>
<tr>
<td>Condition</td>
<td>Medical Necessity</td>
</tr>
<tr>
<td>-----------</td>
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</tbody>
</table>
| • Pernicious anemia symptoms (such as fatigue, shortness of breath, pale skin, red tongue, lightheadedness, and numbness/tingling/pins and needles in hands and feet) when blood tests are inconclusive  
• Post cardiac ablation for treatment of arrhythmias (irregular heart rhythms)  
• UGI tract stricture or obstruction |  

Any other condition not addressed in this policy

Upper gastrointestinal (UGI) endoscopy is considered not medically necessary when criteria are not met for a documented clinical indication.

Upper gastrointestinal (UGI) endoscopy is considered not medically necessary when:
• Performed for evaluation of UGI symptoms that are chronic, non-progressive, atypical for known organic disease, and are considered functional in origin (infrequent exceptions exist when a one-time endoscopic examination may be done to rule out organic disease, in cases where symptoms are unresponsive to therapy)  
• Performed for evaluation of uncomplicated heartburn that responds to conservative medical management  
• Performed for evaluation of heartburn that had initially responded to treatment with a PPI but then symptoms returned  
• Performed for evaluation of UGI conditions/diagnoses when the endoscopy results will not alter management  
• Performed for evaluation of x-ray findings showing any of the following:  
  o Deformed duodenal bulb that is asymptomatic or has responded to ulcer therapy  
  o Duodenal bulb ulcer that is uncomplicated and has responded to therapy  
  o Sliding hiatal hernia that is asymptomatic or uncomplicated  
• Performed as routine screening of the upper gastrointestinal (UGI) tract in the absence of a clinical indication
Documentation Requirements

Clinical notes for member 19 years or older documenting:

- Malignant indications or alarm symptoms
- High risk conditions needing follow up (e.g., erosive esophagitis, anorexia of unknown cause, esophageal varices, history of gastric surgery, swallowing that is difficult or painful, etc.)
- GERD or indigestion that has lasted at least three months that continues despite trial of appropriate therapy:
  - 4-8 weeks of daily proton pump inhibitor (PPI) therapy
  OR
  - 6-12 weeks of treatment with a histamine H2-receptor antagonist (H2 blocker only if patient refuses or cannot tolerate a PPI)
- Other gastrointestinal (GI) indications (e.g., achalasia, Barrett esophagus surveillance based on cell pathology, celiac disease with GI symptoms consistent with chronic malabsorption and positive serology test, etc.)

Coding

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPT</td>
<td></td>
</tr>
<tr>
<td>43235</td>
<td>Esophagogastroduodenoscopy, flexible, transoral; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)</td>
</tr>
<tr>
<td>43238</td>
<td>Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s), (includes endoscopic ultrasound examination limited to the esophagus, stomach or duodenum, and adjacent structures)</td>
</tr>
<tr>
<td>43239</td>
<td>Esophagogastroduodenoscopy, flexible, transoral; with biopsy, single or multiple</td>
</tr>
<tr>
<td>43242</td>
<td>Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s) (includes endoscopic ultrasound examination of the esophagus, stomach, and either the duodenum or a surgically altered stomach where the jejunum is examined distal to the anastomosis)</td>
</tr>
</tbody>
</table>

Related Information
Consideration of Age

There is very little incidence and evidence of upper endoscopy in pediatrics. The age stated in the policy is for men older than 50 years with chronic GERD symptom and additional risk factors. This criterion is based on the 2012 American College of Physicians clinical guidelines for upper endoscopy.

Definitions of Terms

**Achalasia**: An esophageal motility disorder involving the smooth muscle of the esophagus and the lower esophageal sphincter (LES).

**Barrett esophagus**: Gastroesophageal reflux disease (GERD) damages the esophageal epithelium and the normal squamous epithelium is replaced by metaplastic columnar or glandular epithelium. This predisposes the person to esophageal adenocarcinoma.

**Crohn’s or Crohn disease**: A type of inflammatory bowel disease (IBD) that may affect any part of the gastrointestinal tract from mouth to anus. This may also be known as Crohn syndrome or regional enteritis.

**Celiac disease**: An autoimmune digestive disorder, also known as celiac sprue or gluten-sensitive enteropathy. When foods with gluten are eaten, the body’s reaction causes damage to the intestinal lining.

**Cirrhosis**: Scarring of the liver because of injury or long-term disease. The most common causes in the U.S. are chronic alcoholism and hepatitis. A small number of people with cirrhosis get liver cancer (see esophageal varices).

**Dyspepsia**: A chronic or recurrent pain or discomfort centered in the upper abdomen; patients with predominant or frequent (more than once a week) heartburn or acid regurgitation (see GERD).

**Dysphagia**: This term applies to difficulty or inability to swallow.

**Esophagogastroduodenoscopy (EGD)**: This term may be used in place of upper gastrointestinal endoscopy.

**Esophageal varices**: Abnormally enlarged veins in the lower part of the esophagus, usually formed in the presence of a clot or when scar tissue in the liver obstructs blood flow.
**Gastrointestinal:** A broad term relating to the organs and muscles of the digestive system (e.g., esophagus, stomach, small/large intestine).

**Gastroesophageal reflux disease (GERD):** A digestive disorder affecting the lower esophageal sphincter (LES) (see dyspepsia).

**Odynophagia:** The sensation of burning, squeezing pain when swallowing.

**Medical management:** Non-invasive interventions such as acid suppressive medications, nutritional counseling for dietary changes (to avoid foods that trigger symptoms), weight loss counseling, environmental changes (e.g., elevating the head of bed) and others.

**Serology tests:** Blood tests that look for specific antibodies in the serum of the blood. These tests are used to diagnose certain disease conditions, such as celiac disease.

**Tylosis:** A rare autosomal dominant syndrome that causes thickened skin on the palms of the hands and soles of the feet, associated with increased risk of esophageal squamous cell carcinoma.

**Histamine 2 Receptor Antagonists (H2RA, or H2 blockers) Use**

These medications have not been shown to heal esophagitis. A trial of standard dose H2 blockers may be used as a substitute for a trial of PPI therapy only if the member cannot tolerate PPIs or has a contraindication to their use. Both H2RA and PPI medications treatment regimens are shown in **Table 1**.

**Table 1. Treatment of Erosive and Nonerosive Gastroesophageal Reflux Disease**

<table>
<thead>
<tr>
<th>Medication</th>
<th>Low Dose (adult, oral)</th>
<th>Standard Dose (adult, oral)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Histamine 2 Receptor Antagonists</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Famotidine (Pepcid)</td>
<td>10 mg twice daily¶</td>
<td>20 mg twice dailyΔ</td>
</tr>
<tr>
<td>Ranitidine (Zantac)</td>
<td>75 mg twice daily¶</td>
<td>150 mg twice dailyΔ</td>
</tr>
<tr>
<td>Nizatidine (Axid)</td>
<td>75 mg twice daily¶</td>
<td>150 mg twice daily</td>
</tr>
<tr>
<td>Cimetidine (Tagamet)</td>
<td>200 mg twice daily¶</td>
<td>400 mg twice dailyΔ</td>
</tr>
</tbody>
</table>
### Medication

<table>
<thead>
<tr>
<th>Medication</th>
<th>Low Dose (adult, oral)</th>
<th>Standard Dose (adult, oral)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Proton Pump Inhibitors</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Omeprazole (Prilosec)</td>
<td>20 mg daily¶</td>
<td>40 mg daily</td>
</tr>
<tr>
<td>Lansoprazole (Prevacid)</td>
<td>15 mg daily¶</td>
<td>30 mg daily</td>
</tr>
<tr>
<td>Esomeprazole (Nexium)</td>
<td>20 mg daily</td>
<td>40 mg daily</td>
</tr>
<tr>
<td>Pantoprazole (Protonix)</td>
<td>20 mg daily¶</td>
<td>40 mg daily</td>
</tr>
<tr>
<td>Dexlansoprazole (Dexilant)</td>
<td>Not available</td>
<td>30 mg daily, 60 mg daily</td>
</tr>
<tr>
<td>Rabeprazole (Aciphex)</td>
<td>10 mg daily◊</td>
<td>20 mg daily</td>
</tr>
</tbody>
</table>

GERD: gastroesophageal reflux disease; US: United States.

* Histamine 2 receptor antagonists require dose adjustment in the setting of renal insufficiency.
¶ Available without a prescription (over the counter) in the US.
Δ The daily dose for initial healing of esophagitis with erosions and symptoms of GERD in the US prescribing information is up to twice the standard dose shown in this table.
◊ Strength not available in US. Available elsewhere.

Prepared with data from:

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### Evidence Review

In the absence of a clear cancer diagnosis, professional societies indicate that conservative medical management of gastrointestinal symptoms should be the first intervention before an invasive diagnostic test such as an upper gastrointestinal (UGI) endoscopy.² ³ ⁶

### Description

Upper gastrointestinal (UGI) endoscopy also known as esophagogastroduodenoscopy (EGD) and gastroscopy is a procedure that examines the upper gastrointestinal tract using a flexible tube-like instrument containing light transmitting fibers that return a magnified image directly or by video. The instrument is inserted through the mouth permitting visual inspection of the esophagus, stomach and first part of the small intestine (upper duodenum). Primarily a diagnostic tool, the endoscope is used to search for cause(s) of severe heartburn (dyspepsia),
difficulty swallowing (dysphagia), gastroesophageal reflux disease (GERD), persistent vomiting, and frank GI bleeding. Certain therapeutic procedures can be performed using an endoscope such as removal of polyps, papilla and removal of stones from the bile duct. UGI endoscopy is usually performed under light sedation using an intravenous medication.

Non-cardiac Chest Pain (NCCP)

NCCP describes pain in the chest area that is similar to heart muscle pain (also called angina) in patients who have undergone a cardiac workup and were found not to have heart disease. NCCP occurs in men and women of all ages as well as children. Because of the anatomy of the chest cavity with the heart and esophagus resting near each other, pain from either organ may be similar, which makes it hard to differentiate the pain source. Patients who continue to have chest pain after a cardiac work up fails to provide evidence of heart disease may need a GI work up. The American College of Gastroenterology makes a strong recommendation stating that “a cardiac cause should be excluded in patients with chest pain before the commencement of a gastrointestinal evaluation.”

Surveillance for Barret Esophagus

Surveillance for esophageal adenocarcinoma is recommended for those diagnosed with Barrett esophagus. However, there are few data to guide recommendations about management and surveillance, and many issues are controversial. In 2015 guidelines from the American College of Gastroenterology (ACG) and a consensus statement from an international group of experts (Benign Barrett’s and CAncer Taskforce) on the management of Barrett esophagus were published. ACG recommendations for surveillance are stratified by the presence of dysplasia. When no dysplasia is detected, ACG has reported the estimated risk of progression to cancer for patients ranges from 0.2% to 0.5% per year and ACG has recommended endoscopic surveillance every 3 to 5 years. For low-grade dysplasia, the estimated risk of progression is about 0.7% per year, and ACG has recommended endoscopic therapy or surveillance every 12 months. For high-grade dysplasia, the estimated risk of progression is about 7% per year, and ACG has recommended endoscopic therapy. The Benign Barrett’s and CAncer Taskforce consensus group did not endorse routine surveillance for people with no dysplasia and was unable to agree on surveillance intervals for low-grade dysplasia.
Practice Guidelines and Position Statements

American College of Physicians (ACP)

In December of 2012, the American College of Physicians (ACP) published clinical guidelines for upper endoscopy. The best practice recommendations from the professional organization follow.

**Best Practice Advice 1**

Upper endoscopy is indicated in men and women with heartburn and any of the following alarm symptoms:

- Anemia
- Bleeding
- Dysphagia
- Recurrent vomiting
- Weight loss

**Best Practice Advice 2**

Upper endoscopy is indicated in men and women with:

- Typical gastroesophageal reflux disease (GERD) symptoms that persist despite a therapeutic trial of 4 to 8 weeks of twice-daily proton-pump inhibitor therapy.

- Severe erosive esophagitis after a 2-month course of proton-pump inhibitor therapy to assess healing and rule out Barrett esophagus. Recurrent endoscopy after this follow-up examination is not indicated in the absence of Barrett esophagus.

- History of esophageal stricture that have recurrent symptoms of dysphagia

**Best Practice Advice 3**

Upper endoscopy may be indicated:
• In men older than 50 years with chronic GERD symptoms (symptoms for more than 5 years) and additional risk factors (nocturnal reflux symptoms, hiatal hernia, elevated body mass index, tobacco use, and intra-abdominal distribution of fat) to detect esophageal adenocarcinoma and Barrett esophagus.

• For surveillance evaluation in men and women with a history of Barrett esophagus. In men and women with Barrett esophagus and no dysplasia, surveillance examinations should occur at intervals no more frequently than 3 to 5 years. More frequent intervals are indicated in patients with Barrett esophagus and dysplasia.

American College of Gastroenterology (ACG)

The American College of Gastroenterology (ACG) developed guidelines\(^7\) for the diagnosis and management of GERD. The relevant guideline information follows:

Establishing the Diagnosis of Gastroesophageal Reflux Disease (GERD) from the ACG Recommendations

The diagnosis of GERD is made using some combination of symptom presentation, objective testing with endoscopy, ambulatory reflux monitoring, and response to antisecretory therapy.

1. A presumptive diagnosis of GERD can be established in the setting of typical symptoms of heartburn and regurgitation. Empiric medical therapy with a PPI is recommended in this setting. (Strong recommendation, moderate level of evidence)

2. Patients with non-cardiac chest pain suspected due to GERD should have diagnostic evaluation before institution of therapy. (Conditional recommendation, moderate level of evidence) A cardiac cause should be excluded in patients with chest pain before the commencement of a gastrointestinal evaluation (Strong recommendation, low level of evidence)

3. Barium radiographs should not be performed to diagnose GERD (Strong recommendation, high level of evidence)

4. Upper endoscopy is not required in the presence of typical GERD symptoms. Endoscopy is recommended in the presence of alarm symptoms and for screening of patients at high risk for complications. Repeat endoscopy is not indicated in patients without Barrett’s
esophagus in the absence of new symptoms. (Strong recommendation, moderate level of evidence)

5. Routine biopsies from the distal esophagus are not recommended specifically to diagnose GERD. (Strong recommendation, moderate level of evidence)

6. Esophageal manometry is recommended for preoperative evaluation, but has no role in the diagnosis of GERD. (Strong recommendation, low level of evidence)

7. Ambulatory esophageal reflux monitoring is indicated before consideration of endoscopic or surgical therapy in patients with GERD, as part of the evaluation of patients refractory to PPI therapy, and in situations when the diagnosis of GERD is in question. (Strong recommendation, low level evidence). Ambulatory reflux monitoring is the only test that can assess reflux symptom association (Strong recommendation, low level of evidence)

8. Ambulatory reflux monitoring is not required in the presence of short or long-segment Barrett’s esophagus to establish a diagnosis of GERD. (Strong recommendation, moderate level of evidence)

9. Screening for Helicobacter pylori infection is not recommended in GERD. Eradication of H. pylori infection is not routinely required as part of antireflux therapy (Strong recommendation, low level of evidence)

Table 2. Diagnostic Testing for GERD and Utility of Tests

<table>
<thead>
<tr>
<th>Diagnostic Test</th>
<th>Indication</th>
<th>Highest Level of Evidence</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>PPI trial</td>
<td>Classic symptoms, no warning signs</td>
<td>Meta-analysis</td>
<td>Negative trial does not rule out GERD</td>
</tr>
<tr>
<td>Barium swallow</td>
<td>Not for GERD diagnosis. Use of evaluation of dysphagia.</td>
<td>Case-control</td>
<td>Do not use unless evaluating for complication (stricture, ring)</td>
</tr>
<tr>
<td>Endoscopy</td>
<td>Alarm symptoms, screening of high-risk patients, chest pain</td>
<td>Randomized control trial</td>
<td>Consider early for elderly, those at risk for Barrett’s, non-cardiac chest pain, patients unresponsive to PPI</td>
</tr>
<tr>
<td>Esophageal biopsy</td>
<td>Exclude non-GERD causes for symptoms</td>
<td>Case-Control</td>
<td>Not indicated for diagnosis of GERD</td>
</tr>
<tr>
<td>Diagnostic Test</td>
<td>Indication</td>
<td>Highest Level of Evidence</td>
<td>Recommendation</td>
</tr>
<tr>
<td>---------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
<td>----------------------------</td>
<td>--------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Esophageal manometry</td>
<td>Preoperative evaluation for surgery</td>
<td>Observational</td>
<td>Not recommended for GERD diagnosis. Rule out achalasia / scleroderma-like esophagus pre-op</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ambulatory reflux monitoring</td>
<td>Preoperatively for non-erosive disease. Refractory GERD symptoms, GERD diagnosis in question</td>
<td>Observational</td>
<td>Correlate symptoms with reflux, document abnormal acid exposure or reflux frequency</td>
</tr>
</tbody>
</table>

GERD = gastroesophageal reflux disease; PPI = proton pump inhibitor

**American Society for Gastrointestinal Endoscopy (ASGE)**

In 2015, the ASGE\(^8\) published updated SOP recommendations for esophagogastroduodenoscopy (EGD) with specific indications.

Esophagogastroduodenoscopy is generally indicated for evaluating:

A. Upper abdominal symptoms that persist despite an appropriate trial of therapy

B. Upper abdominal symptoms associated with other symptoms or signs suggesting serious organic disease (e.g., anorexia and weight loss) or in patients aged > 45 years

C. Dysphagia or odynophagia

D. Esophageal reflux symptoms, which are persistent or recurrent despite appropriate therapy

E. Persistent vomiting of unknown cause

F. Other diseases in which the presence of upper GI pathology might modify other planned management. Examples include patients who have a history of ulcer or GI bleeding who are scheduled for organ transplantation, long-term anti-coagulation, or chronic non-steroidal anti-inflammatory drug therapy for arthritis, and those with cancer of the head and neck.

G. Familial adenomatous polyposis syndromes

H. For confirmation and specific histological diagnosis of radiologically demonstrated lesions:
   1. Suspected neoplastic lesion
   2. Gastric or esophageal ulcer
3. Upper tract stricture or obstruction

I. Gastrointestinal bleeding:
   1. In patients with active or recent bleeding
   2. For presumed chronic blood loss and for iron deficiency anemia when the clinical situation suggests an upper GI source or when colonoscopy is negative

J. When sampling of tissue or fluid is indicated

K. In patients with suspected portal hypertension to document or treat esophageal varices

L. To assess acute injury after caustic ingestion

M. Treatment of bleeding lesions such as ulcers, tumors, vascular abnormalities (eg, electrocoagulation, heater probe, laser photocoagulation or injection therapy)

N. Banding or sclerotherapy of varices

O. Removal of foreign bodies

P. Removal of selected polypoid lesions

Q. Placement of feeding or drainage tubes (peroral, percutaneous endoscopic gastrostomy PEG, percutaneous endoscopic jejunostomy)

R. Dilation of stenotic lesions (eg, with transendoscopic balloon dilators or dilation systems by using guide wires)

S. Management of achalasia (eg, botulinum toxin, balloon dilation)

T. Palliative treatment of stenosing neoplasms (eg, laser, multi-pol lar electrocoagulation, stent placement)

U. Endoscopic therapy of intestinal metaplasia

V. Intraoperative evaluation of anatomic reconstructions typical of modern foregut surgery (eg, evaluation of anastomotic leak and patency, fundoplication formation, pouch configuration during bariatric surgery)

W. Management of operative adverse events (eg, dilation of anastomotic strictures, stenting of anastomotic disruption, fistula, or leak in selected circumstances)
Esophagastroduodenoscopy is generally not indicated for evaluating:

A. Symptoms that are considered functional in origin (there are exceptions in which an endoscopic examination may be done once to rule out organic disease, especially if symptoms are unresponsive to therapy)

B. Metastatic adenocarcinoma of unknown primary site when the results will not alter management

C. Radiographic findings of:
   1. Asymptomatic or uncomplicated sliding hiatal hernia
   2. Uncomplicated duodenal ulcer that has responded to therapy
   3. Deformed duodenal bulb when symptoms are absent or respond adequately to ulcer therapy

Sequential or periodic EGD may be indicated:

A. Surveillance for malignancy in patients with pre-malignant conditions (eg Barrett’s esophagus)

Sequential or periodic EGD is generally not indicated for:

A. Surveillance for malignancy in patients with gastric atrophy, pernicious anemia, or fundic gland or hyperplastic polyps, gastric intestinal metaplasia, or prior gastric operations for benign disease

B. Surveillance of healed benign disease such as esophagitis or gastric or duodenal ulcer

C. Surveillance during repeated dilation of benign strictures unless there is a change in status

**Medicare National Coverage**

The coverage statement is that “Endoscopic procedures are covered when reasonable and necessary for the individual patient”.5
References


### History

<table>
<thead>
<tr>
<th>Date</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>06/10/13</td>
<td>New policy. Add to Utilization Management section. Policy approved with 90-day hold for provider notification. The policy effective date is October 1, 2013.</td>
</tr>
<tr>
<td>08/15/13</td>
<td>Update Related Policies. Remove 2.01.520 and add 2.01.20.</td>
</tr>
<tr>
<td>09/05/13</td>
<td>Coding update. CPT code 43252 removed from policy as it pertains to another policy (2.01.87).</td>
</tr>
<tr>
<td>08/11/14</td>
<td>Annual Review.Changed the title to Upper Gastrointestinal (UGI) Endoscopy for Adults, for ease of finding the document. Policy extensively re-written. Policy statements reorganized but intent is unchanged. Revised “adult” to patients of 19 years old and older. Policy updated with literature search through June, 2014. Reference to using MCG as a tool to guide determinations is removed. References 6-10 added; others renumbered/removed. New CPT codes 43233, 43253, 43254, 43266, 43270 added for 2014. Policy statements changed as noted.</td>
</tr>
<tr>
<td>10/13/14</td>
<td>Interim Update. Removed Policy statement under UGI Tract Symptoms header that states “interferes with activities of daily living on 3 or more days a week”. Extensive editorial changes to consolidate and simplify criteria in the policy statements. Clarification for non-cardiac chest pain (NCCP) added to the rationale section. Reference 5 added; others renumbered. Policy statements revised, intent is unchanged.</td>
</tr>
<tr>
<td>Date</td>
<td>Comments</td>
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<tr>
<td>12/22/14</td>
<td>Interim Update. Policy reclassified, renumbered from 11.01.504 to 2.01.533 and moved from UM section to Medicine section. Reference 1 removed; others renumbered and broken hyperlinks repaired. Policy statements unchanged.</td>
</tr>
<tr>
<td>05/12/15</td>
<td>Annual Review. Policy updated with literature search through April, 2015. Added esophageal varices with or without bleeding to the Follow Up of Known Conditions list. Added new cirrhosis diagnosis to the Other Indications list. Cirrhosis added to Definition of Terms. Added AASLD recommendations to Practice Guidelines and Position Statements section. References 10,13 added; others renumbered. Policy statements changed as noted. Remove informational CPT codes: 43233-34, 43237, 43240-41, 43243-43256; 43258-59; 43270; remove ICD-9 diagnosis codes, as they do not affect policy adjudication.</td>
</tr>
<tr>
<td>06/02/15</td>
<td>Update Related Policies. Remove 2.01.81 as it was archived.</td>
</tr>
<tr>
<td>12/07/15</td>
<td>Update Related Policies. Remove 6.01.33 and 7.02.500 as they were archived.</td>
</tr>
<tr>
<td>02/09/16</td>
<td>Annual Review. No change in coverage statements. Removed reference 6, Medicare LCD no longer available.</td>
</tr>
<tr>
<td>08/01/16</td>
<td>Interim Review, approved July 12, 2016. Added information on histamine 2 receptor antagonists and table to Related Information section; reference 13 added. Policy moved into new format; no change to policy statements.</td>
</tr>
<tr>
<td>01/01/17</td>
<td>Interim Review, approved December 13, 2016. Clarified the description for bleeding in the Alarm Symptoms and GI bleeding sections of the policy. Changed “gastric bypass surgery” to “bariatric surgery” under the section listing Other Upper Gastrointestinal (UGI) Indications.</td>
</tr>
<tr>
<td>02/03/17</td>
<td>Minor update. Replaced the acronym “EGD” with “UGI” within policy section for purposes of consistency. No other changes; policy statements remain the same.</td>
</tr>
<tr>
<td>01/01/18</td>
<td>Annual Review, approved December 12, 2017. Modified criteria to include surveillance for individuals with cirrhosis. Clarified UGI not covered for bariatric surgery when bariatric surgery is contractually excluded, unless other symptoms are present. Completely reorganized policy criteria. No references added. Removed CPT code 43236.</td>
</tr>
<tr>
<td>03/09/18</td>
<td>Minor edit; added Documentation Requirements section.</td>
</tr>
<tr>
<td>09/01/18</td>
<td>Interim Review, approved August 10, 2018. Minor edit; added surveillance criteria for Barrett’s esophagus no dysplasia (metaplasia). Re-added Consideration of Age information, which was inadvertently removed during a previous update.</td>
</tr>
<tr>
<td>12/01/18</td>
<td>Annual Review, approved November 6, 2018. Minor editing and formatting for clarity. References 13-14 added. No change to policy statements.</td>
</tr>
<tr>
<td>01/01/19</td>
<td>Interim Review, approved December 19, 2018. Reference 15 added. Added positive CDH1 mutation indication.</td>
</tr>
<tr>
<td>Date</td>
<td>Comments</td>
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</tr>
<tr>
<td>12/01/19</td>
<td>Interim Review, approved November 26, 2019. This policy effective date was updated to January 1, 2020.</td>
</tr>
</tbody>
</table>

**Disclaimer:** This medical policy is a guide in evaluating the medical necessity of a particular service or treatment. The Company adopts policies after careful review of published peer-reviewed scientific literature, national guidelines and local standards of practice. Since medical technology is constantly changing, the Company reserves the right to review and update policies as appropriate. Member contracts differ in their benefits. Always consult the member benefit booklet or contact a member service representative to determine coverage for a specific medical service or supply. CPT codes, descriptions and materials are copyrighted by the American Medical Association (AMA). ©2019 Premera All Rights Reserved.

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  • Qualified sign language interpreters
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  • Qualified interpreters
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Toll free 855-332-4535, Fax 425-918-5992. TTY 800-843-5357
Email AppealsDepartmentInquiries@Premera.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW, Room S09F, HHH Building
Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD)

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