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

Effective Date: Jan. 1, 2018
Last Revised: Dec. 12, 2017
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 | CODING | RELATED INFORMATION
EVIDENCE REVIEW | REFERENCES | HISTORY

∞ Clicking this icon returns you to the hyperlinks menu above.

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>Malignant indications</td>
<td>Upper gastrointestinal endoscopy (UGI) may be considered medically necessary for patients 19 years of age and older for</td>
</tr>
<tr>
<td>Condition</td>
<td>Medical Necessity</td>
</tr>
<tr>
<td>-----------</td>
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</tr>
<tr>
<td>any of the following indications:</td>
<td></td>
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<tr>
<td>- Dysplasia</td>
<td></td>
</tr>
<tr>
<td>- Esophageal cancer</td>
<td></td>
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<tr>
<td>- Familial adenomatous polyposis (FAP)</td>
<td></td>
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<tr>
<td>- Gastric cancer</td>
<td></td>
</tr>
<tr>
<td>- History of Lynch Syndrome or hereditary nonpolyposis colorectal cancer (HNPCC)</td>
<td></td>
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<tr>
<td>- Head/neck cancer</td>
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<tr>
<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>
<td></td>
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<tr>
<td>- Barrett’s esophagus (Metaplastic columnar or glandular epithelium)</td>
<td></td>
</tr>
<tr>
<td>- Patients with prior adenomatous gastric polyps or sessile polyps (rare)</td>
<td></td>
</tr>
<tr>
<td>- Strong family history of gastrointestinal cancer</td>
<td></td>
</tr>
<tr>
<td>- Tylosis</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Alarm symptoms</th>
<th>Upper gastrointestinal endoscopy (UGI) may be considered medically necessary for patients 19 years of age and older when:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Performed for evaluation of ANY of the following alarm symptoms that may be associated with an UGI source:</td>
<td></td>
</tr>
<tr>
<td>- Anemia (iron deficiency anemia and negative colonic evaluation)</td>
<td></td>
</tr>
<tr>
<td>- Bleeding from the rectum or in stool that may be bright red or dark colored</td>
<td></td>
</tr>
<tr>
<td>- Epigastric mass is found on examination</td>
<td></td>
</tr>
<tr>
<td>- Persistent vomiting of unknown cause, including vomiting blood</td>
<td></td>
</tr>
<tr>
<td>- Swallowing that is difficult (dysphagia)</td>
<td></td>
</tr>
<tr>
<td>- Unintentional weight loss of 3 kg (approx. 6.6 lbs.) or more since symptoms started</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Follow-up of known conditions</th>
<th>Upper gastrointestinal endoscopy (UGI) may be considered medically necessary for patients 19 years of age and older when:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Performed for evaluation of ANY of the following indications</td>
<td></td>
</tr>
<tr>
<td>- Anorexia of unknown cause</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 | Upper gastrointestinal endoscopy (UGI) may be considered medically necessary for patients 19 years of age and older when:  
  • Performed for evaluation of GERD symptoms that are present for at least 3 months  
  AND  
  • Persist despite 4-8 weeks of treatment with daily proton pump inhibitor (PPI) therapy  
  OR  
  • Persist despite 6-12 weeks of treatment with a histamine H2-receptor antagonist (H2 blocker- only if patient refuse or cannot tolerate a PPI) |
| Other upper gastrointestinal (UGI) indications | Upper gastrointestinal endoscopy (UGI) may be considered medically necessary for patients 19 years of age and older for any of the following indications:  
  • Achalasia  
  • Barrett’s 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  
  • Celiac disease (duodenal disease):  
    • GI symptoms that are consistent with chronic malabsorption (such as diarrhea, weight loss, flatulence, bloating, and abdominal pain)  
  AND |
<table>
<thead>
<tr>
<th>Condition</th>
<th>Medical Necessity</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Serology tests (antibody levels) are positive for celiac disease</td>
<td>• Cirrhosis upon initial diagnosis, one UGI endoscopy to screen for esophageal varices, then no more frequently than annually for surveillance</td>
</tr>
<tr>
<td>• Crohn disease that involves the esophagus, stomach or duodenum</td>
<td>• Gastric, peptic, esophageal ulcer confirmation when:</td>
</tr>
<tr>
<td>• Eating or drinking (ingestion) of a caustic agent</td>
<td>• Conservative medical management was tried and failed to relieve symptoms (eg, cessation of NSAIDs, trial of appropriate medication)</td>
</tr>
<tr>
<td>• Eating or drinking (ingestion) of a foreign body that is known or suspected</td>
<td>• Conservative medical management is contraindicated</td>
</tr>
<tr>
<td>• Screening for Barrett’s in a male patient aged 50 years or older</td>
<td>• Eating or drinking (ingestion) of a foreign body that is known or suspected</td>
</tr>
<tr>
<td>with 5 years or more of GERD symptoms and 1 or more of the following:</td>
<td>• Screening for Barrett’s in a male patient aged 50 years or older with 5 years or more of GERD symptoms and 1 or more of the following:</td>
</tr>
<tr>
<td>• Elevated body mass index (BMI)</td>
<td>• Elevated body mass index (BMI)</td>
</tr>
<tr>
<td>• Excess abdominal fat (intra-abdominal fat distribution)</td>
<td>• Excess abdominal fat (intra-abdominal fat distribution)</td>
</tr>
<tr>
<td>• Hiatal hernia</td>
<td>• Hiatal hernia</td>
</tr>
<tr>
<td>• Night-time symptoms of reflux</td>
<td>• Night-time symptoms of reflux</td>
</tr>
<tr>
<td>• Tobacco use</td>
<td>• Tobacco use</td>
</tr>
<tr>
<td>• Patients scheduled for bariatric surgery (NOTE: if member’s contract</td>
<td>• Patients scheduled for organ transplantation</td>
</tr>
<tr>
<td>excludes bariatric surgery, then UGI is not covered, unless the member</td>
<td>• 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)</td>
</tr>
<tr>
<td>meets another medical necessity criterion in this policy).</td>
<td>• UGI tract stricture or obstruction</td>
</tr>
<tr>
<td>• Patients scheduled for organ transplantation</td>
<td></td>
</tr>
<tr>
<td>• Upper gastrointestinal endoscopy (UGI) is considered not medically</td>
<td>Upper gastrointestinal endoscopy (UGI) is considered not medically necessary when criteria are not met for a documented clinical indication.</td>
</tr>
<tr>
<td>necessary when criteria are not met for a documented clinical indication.</td>
<td></td>
</tr>
</tbody>
</table>
Upper gastrointestinal endoscopy (UGI) 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:
  - Deformed duodenal bulb that is asymptomatic or has responded to ulcer therapy
  - Duodenal bulb ulcer that is uncomplicated and has responded to therapy
  - 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

### 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>Esophagastroduodenoscopy, flexible, transoral; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)</td>
</tr>
<tr>
<td>43238</td>
<td>Esophagastroduodenoscopy, 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</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>--------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>adjacent structures)</td>
</tr>
<tr>
<td>43239</td>
<td>Esophagogastroduodenoscopy, flexible, transoral; with biopsy, single or multiple journeys</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**

**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:** Abroad term relating to the organs and muscles of the digestive system (eg, 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 (eg, 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.

**Place of Service**

Upper gastrointestinal endoscopy is a diagnostic or therapeutic procedure that is performed in an ambulatory surgery center, or an inpatient or outpatient hospital setting.

**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>
<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
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 workup fails to provide evidence of heart disease may need a GI workup. 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”.

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 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>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>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 2012, the ASGE 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 structural disease (eg, anorexia and weight loss) or new-onset symptoms in patients older than 50 years of age

C. Dysphagia or odynophagia
D. Esophageal reflux symptoms that persist or recur 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 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 does not provide an explanation

J. When sampling of tissue or fluid is indicated

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

L. To assess acute injury after caustic ingestion

M. To assess diarrhea in patient suspected of having small-bowel disease (eg celiac disease)

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

O. Removal of foreign bodies

P. Removal of selected lesions

Q. Placement of feeding or drainage tubes (peroral, percutaneous endoscopic gastrostomy, percutaneous endoscopic jejunostomy)
R. Dilation and stenting of stenotic lesions (eg, with transendoscopic balloon dilators or
dilation systems using guide wires)

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

T. Palliative treatment of stenosing neoplasms (eg, laser, multi-polar 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 complications (eg, dilation of anastomotic strictures, stenting of
anastomotic disruption, fistula, or leak in selected circumstances)

Esophagogastroduodenoscopy 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 or symptoms recur that are different in nature from
the original symptoms)

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 for:

A. Surveillance for malignancy in patients with pre-malignant conditions (eg Barrett's
esophagus, polyposis syndromes, gastric adenomas, tylosis or previous caustic ingestion)
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

**Medicare National Coverage**

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

**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 01, 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>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</td>
</tr>
<tr>
<td>Date</td>
<td>Comments</td>
</tr>
<tr>
<td>------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</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>
</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). ©2018 Premera All Rights Reserved.

**Scope:** Medical policies are systematically developed guidelines that serve as a resource for Company staff when determining coverage for specific medical procedures, drugs or devices. Coverage for medical services is subject to the limits and conditions of the member benefit plan. Members and their providers should consult the member
benefit booklet or contact a customer service representative to determine whether there are any benefit limitations applicable to this service or supply. This medical policy does not apply to Medicare Advantage.
Discrimination Is Against the Law

Premera Blue Cross complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Premera does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

Premera:
- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Civil Rights Coordinator.

If you believe that Premera has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:
Civil Rights Coordinator - Complaints and Appeals
PO Box 91102, Seattle, WA 98111
Toll free 855-332-4535, Fax 425-918-5992, TTY 800-842-5357
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)

Getting Help in Other Languages

This Notice has Important Information. This notice may have important information about your application or coverage through Premera Blue Cross. There may be key dates in this notice. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information and help in your language at no cost. Call 800-722-1471 (TTY: 800-842-5357).

Arabic (Arabic):
يوجد هذا الإشعار معلومات هامة. قد يحتوي هذا الإشعار معلومات مهمة بخصوص طبلك أو المعلمة التي تسرد المصادر عليها من خلال Premera Blue Cross. قد تكون هناك ترجمة مهنية من المعلومات المذكورة في هذا الإشعار. قد تحتاج لإجراء ترجمة معينة للغة على عناوين المسلسلات الصغيرة أو السيرة في ذلك الكاتب. يرجى اتباع المصادر على هذه المعلومات والمذكورة يتطلب ذلك دون تكلفة إضافية. إتصل بنا: 800-722-1471 (TTY: 800-842-5357).

中文 (Chinese):
本通知有重要的信息。本通知可能有关於您透过 Premera Blue Cross 提交的申请或保险的重要信息。本通知可能有重要日期。您可能需要在截止日期之前采取行动，以保留您的健康保险或费用补助。您有权利免费以您的母语得到本讯息和帮助。请拨电话 800-722-1471 (TTY: 800-842-5357)。


Kreyòl ayisyen (Creole): Avis sila a gen Enfòmasyon Enpòtan ladan. Avis sila a kapab genyen enfòmasyon enpòtan konsènan aplikasyon w lan oswa konèsan kouvèti asirans lan atravé Premera Blue Cross. Kapab genyen dat k enpòtan nan avisi sila a. Ou ka gen pou pran kék akson avan sèten dat limit pou ka kenbe kouvèti asirans sante w lan oswa pou yo ka ede w avèk deparans yon. Se dwa w pou resewa enfòmasyon sa a ak asistans nan lang ou pale a, san ou pa gen pou peye pou sa. Rate nan 800-722-1471 (TTY: 800-842-5357).


Ilokano (Ilocano): Daytoy a Pakdaad ket naglaon iti Napateg nga Impormasion. Daytoy a pakdaad labal na nga adda ket naglaon iti napateg nga impormasion maipanggep iti aplikasyonyo wenny coverage babaen iti Premera Blue Cross. Daytoy ket mabalin dagiti importante a pelsa iti daytoy a pakdaad. Mabilin nga adda rumbeng nga aramideng nga adda sakaab dagiti particular a naituding nga aldaw tapno mapagtalaineyo ti coverage ti salun-ayyo wenny tungol kadagit gastos. Adda karbengayo a mangala ti daytoy nga impormasion ken tungol iti bukdoyo a pagasao nga awan ti bayadanyo. Tumawag ti numero nga 800-722-1471 (TTY: 800-842-5357).

Premera Blue Cross  cornerstone in your health coverage

Información importante.

Este aviso contiene información importante. Es posible que este aviso contenga información importante acerca de su solicitud o cobertura a través de Premera Blue Cross. Es posible que haya fechas claves en este aviso. Es posible que deba tomar alguna medida antes de determinadas fechas para mantener su cobertura médica o ayuda con los costos. Usted tiene derecho a recibir esta información y ayuda en su idioma sin costo alguno. Llame al 800-722-1471 (TTY: 800-842-5357).

Espanol (Spanish):
Este aviso contiene información importante. Es posible que este aviso contenga información importante acerca de su solicitud o cobertura a través de Premera Blue Cross. Es posible que haya fechas claves en este aviso. Es posible que deba tomar alguna medida antes de determinadas fechas para mantener su cobertura médica o ayuda con los costos. Usted tiene derecho a recibir esta información y ayuda en su idioma sin costo alguno. Llame al 800-722-1471 (TTY: 800-842-5357).

Tagalog (Tagalog):

Thai (Thai):
ประกาศนี้อาจมีข้อมูลที่สําคัญเกี่ยวกับการการสมัครหรือขอบเขตประกันสุขภาพของคุณหรือการช่วยเหลือที่คุณอาจต้องการ.

Română (Romanian):

Русский (Russian):
Настоящее уведомление содержит важную информацию. Это уведомление может содержать важную информацию о вашем заявлении или страховом покрытии через Premera Blue Cross. В настоящем уведомлении могут быть указаны ключевые даты. Вам, возможно, потребуется принять меры к определенным предельным срокам для сохранения страхового покрытия или помощи с расходами. Вы имеете право на бесплатное получение этой информации и помощь на вашем языке. Звоните по телефону 800-722-1471 (TTY: 800-842-5357).

日本語 (Japanese):
この通知には重要な情報が含まれています。この通知には、Premera Blue Crossの申請または補償範囲に関する重要な情報が含まれている場合があります。この通知には記載されている情報がある重要な日をご確認ください。健康保険や無料サポートを維持するには、特定の期日までに行動を取らなければならない場合があります。ご希望の言語による情報とサポートが無料で提供されます。0800-722-1471 (TTY: 800-842-5357)までお電話ください。

한국어 (Korean):
본 통지서에서는 중요한 정보가 들어 있습니다. 즉 이 통지서는 귀하의 신청에 관련하여 Premera Blue Cross를 통해 커버리지를 관련 정보를 포함하고 있을 것입니다. 본 통지서에는 책임이 되는 날짜들이 있을 수 있습니다. 귀하의 권리 및 커버리지를 재시도하거나 또는 풀리그하기 위해서 일정한 마감일까지 조치를 취해야 할 필요가 있을 수 있습니다. 귀하의 이러한 정보와 도움은 귀하의 언어에 비용 부담없이 염을 수 있는 권리가 있습니다. 800-722-1471 (TTY: 800-842-5357)로 전화하십시오.

Português (Portuguese):
Este aviso poderá conter informações importantes. Este aviso poderá conter informações importantes a respeito de sua aplicação ou cobertura por meio do Premera Blue Cross. Poderão existir datas importantes neste aviso. Talvez seja necessário que você tome providências dentro de determinados prazos para manter sua cobertura de saúde e ajuda de custos. Você tem o direito de obter esta informação e ajuda em seu idioma e sem custos. Ligue para 800-722-1471 (TTY: 800-842-5357).

Polski (Polish):

Punjabi (Punjabi):
ਨੋਿਟਿਸ ਦਾ ਉਤਕਰਸ਼ ਐਲਾਨ

فارسی (Farsi):
این اعلامیه مربوط به اطلاعات مهم می‌باشد. این اعلامیه متضمن می‌باشد که شما به‌طور معمول به شرکت‌های به‌طور فریم‌بندی شده‌اند یا از طریق پایگاه‌های خرید شده‌اند و یا از طریق شرکت‌هایی که مشتریان را تحت فرمانری از این شرکت‌ها می‌باشند. شما می‌توانید از این اطلاعات و کمک‌هایی که به شما می‌دهند به‌طور رایگان دریافت نمایید. (800-842-5357) برقرار نمایید.

Tiếng Việt (Vietnamese):