

Subject: Upper Gastrointestinal Endoscopy (Esophagogastroduodenoscopy, EGD)

Background: Esophagogastroduodenoscopy (EGD) is a test used to examine the lining of the esophagus, stomach, and the duodenum. EGD is also known as upper gastrointestinal endoscopy, gastroscopy, or upper endoscopy. EGD is indicated for the diagnosis of numerous conditions such as, but not limited to, Celiac disease, esophageal varices, esophagitis, gastritis, GERD, hiatal hernia, ulcers, Mallory-Weiss syndrome, and esophageal rings. EGD may also be indicated for the investigation of symptoms such as upper gastrointestinal symptoms and upper gastrointestinal bleeding. Abnormal imaging or caustic ingestion may also indicate the need for EGD.

Policy and Coverage Criteria:

Harvard Pilgrim Health Care (HPHC) considers Esophagogastroduodenoscopy (EGD) medically necessary for the following (this list is NOT all inclusive):

- Diagnostic/Evaluation for:
 - Celiac Disease
 - Lynch Syndrome
 - Acute injury following caustic ingestion
 - Confirmation of gastric or esophageal ulcer, suspected neoplastic lesion, or upper GI tract stricture or obstruction
 - Dyspepsia when any of the following are present:
 - Chronic GI bleeding
 - Epigastric mass
 - Iron deficient anemia
 - Persistent vomiting
 - Progressive difficulty swallowing
 - Progressive unintentional weight loss with nausea or vomiting
 - Early satiety with weight loss
 - Suspicious barium meal (Upper GI series)
 - Dysphagia or odynophagia
 - Esophageal cancer evaluation post resection with signs or symptoms of loco-regional recurrence
 - Esophageal masses and diagnostic esophageal cancer biopsies
 - Familial adenomatous polyposis syndromes
 - Indeterminate colitis (differentiation of Crohn's disease from ulcerative colitis)
 - Irritable bowel syndrome when other studies have negative results
 - Persistent or recurrent esophageal reflux symptoms despite therapy
 - Persistent upper abdominal symptoms not resolved by therapy
 - Persistent vomiting of unknown cause
 - Recent or active GI bleeding
 - Suspected portal hypertension
 - Upper abdominal symptoms associated with other signs or symptoms suggesting serious organic disease or new onset symptoms in members over 50 years of age who are refractory to treatment with a proton pump inhibitor trial
 - Upper GI tissue or fluid sampling
- High-risk screening for:

- Chronic (at least 5 years) gastro-esophageal reflux disease (GERD) at risk for Barrett's esophagus (BE) who have had no prior negative EGD screening.
- Cirrhosis and portal hypertension without prior variceal hemorrhage, especially those with platelet counts less than 140,000/mm³, or Child's class B or C disease.
- Symptomatic pernicious anemia
- Symptoms consistent with celiac disease
- Therapeutic EGD treatment for:
 - Achalasia management by botulinum toxin, balloon dilation
 - Banding or sclerotherapy of varices
 - Dilation of stenotic lesions
 - Feeding or drainage tube placement
 - Removal of foreign bodies or selected polypoid lesions
 - Stenosing neoplasm palliative treatment by laser, multi-polar electrocoagulation, stent placement
 - Treatment of bleeding lesions (ulcers, tumors, vascular abnormalities) by electrocoagulation, heater probe, laser photocoagulation, or injection therapy.
- Sequential or periodic EGD for:
 - Barrett's esophagus surveillance in the absence of dysplasia (every 3 years)
 - Barrett's esophagus surveillance with high-grade dysplasia (every 3 months)
 - Barrett's esophagus surveillance with low-grade dysplasia (yearly)
 - Familial adenomatous polyposis (at time of colectomy or after age 30)
 - Hereditary non-polyposis colorectal cancer
 - Recurrence of adenomatous polyps in synchronous and metachronous sites (every 3 to 5 years)
 - Severe caustic esophageal injury
 - Tylosis (every 1 to 3 years beginning at age 30)

Harvard Pilgrim Health Care (HPHC) considers EGD **not** medically necessary for the following conditions and situations:

- Confirmation of gastric band placement
- Diagnosing laryngopharyngeal reflux
- Evaluation of metastatic adenocarcinoma of unknown primary site when the results will not alter disease management
- Prior to bariatric surgery when asymptomatic
- Repeat EGD when prior EGD was normal and symptoms have not changed
- Routine screening
- Surveillance for malignancy in Members with gastric atrophy, pernicious anemia, or prior gastric operations for benign disease
- Surveillance of healed benign disease, achalasia, aerodigestive squamous cell cancer, gastric intestinal metaplasia, or post sampling or removal of non-dysplastic gastric polyps
- Routine evaluation of abdominal pain in children without other signs/symptoms of severe organic disease
- Surveillance during repeated dilations of benign strictures unless there is a change in status
- Evaluation of radiographical findings of:
 - Asymptomatic or uncomplicated sliding hiatal hernia
 - Deformed duodenal bulb when symptoms are absent or respond adequately to ulcer therapy
 - Uncomplicated duodenal ulcer that has responded to therapy

Supporting Information:

EGD is a diagnostic procedure used to diagnose and treat conditions of the upper gastrointestinal tract. An endoscope is guided through the individual's mouth, throat, esophagus, stomach, and into the duodenum. The endoscope contains a video camera which allows the physician to visually examine the upper gastrointestinal

HPHC policies are based on medical science, and written for the majority of people with a given condition.

Coverage described in this policy is standard under most HPHC plans. Specific benefits may vary by product and/or employer group. Please reference appropriate member materials (e.g., Benefit Handbook, Certificate of Coverage) for member-specific benefit information.

tract. The endoscope may also be used to guide the physician in obtaining biopsies, remove foreign objects, or perform other therapeutic procedures.

Merck (2013) lists absolute contraindications to endoscopy to include shock, acute MI, peritonitis, acute perforation, and fulminant colitis. Relative contraindications include poor individual cooperation, coma (unless individual is intubated), and cardiac arrhythmias or recent MI.

Gomez et al (2014) conducted an observational, retrospective study of 232 individuals who underwent EGD prior to bariatric surgery. Analysis of the EGD results showed abnormal findings in 143 individuals (61.6%). However, only 35 (15.1%) of the individuals in the population had medical management altered and 4 (1.7%) individuals had surgical management altered due to the abnormal findings. Gomez et al concluded that alternative methods for screening for common GI conditions should be considered in this population since the findings rarely change surgical management.

De Palma et al (2014) indicate that the chosen bariatric surgery may be changed if a specific upper gastrointestinal finding is identified during EGD. However, the value of routine endoscopy before bariatric surgery in asymptomatic individuals remains controversial. De Palma notes that the "weak clinical relevance of the majority of lesions discovered on routine EGDs and the cost and invasiveness of the procedure, as well as the amount of secondary unnecessary workup prompted by irrelevant findings, several authors have instead advocated a non-endoscopic approach for asymptomatic patients."

Thakkar et al (2007) conducted a systematic review on EGD in children with abdominal pain. The authors stated that the diagnostic yield of EGD in children with abdominal pain of unknown origin is low. The effect of EGD on change in treatment, quality of life, improvement of abdominal pain, and cost-effectiveness is unknown. Further studies are needed to clarify the value of EGD in children with abdominal pain.

In UpToDate's Etiology and evaluation of chronic constipation in adults, Wald, A. states that endoscopic evaluation should only be performed in selected individuals with chronic constipation. According to systematic review, there is "insufficient evidence to support the use of endoscopy in the routine evaluation of individuals with constipation without alarm features such as hematochezia, weight loss of ≥ 10 pounds, a family history of colon cancer or inflammatory bowel disease, anemia, positive fecal occult blood tests, or acute onset of constipation in elderly persons. Thus, empiric treatment (individual education, trial of dietary changes, and a trial of fiber) without diagnostic testing can be considered when alarm features are absent."

The American Society for Gastrointestinal Endoscopy (ASGE) recommends that EGD is generally indicated for evaluation of the following:

- Upper abdominal symptoms that persist despite appropriate therapy.
- Upper abdominal symptoms associated with other symptoms or signs suggesting serious organic disease or in individuals over the age of 45
- Dysphagia or odynophagia
- Esophageal reflux symptoms that are persistent or recurrent despite appropriate therapy
- Persistent vomiting of unknown cause
- Other diseases in which the presence of upper GI pathological conditions may not modify other planned management
- Familial adenomatous polyposis syndromes
- Confirmation and specific histological diagnosis of radiologically demonstrated lesions: suspected neoplastic lesion, gastric or esophageal ulcer, upper tract stricture or obstruction

- Gastrointestinal bleeding in individuals with active or recent bleeding or for presumed chronic blood loss and for IDA when the clinical situation suggests an upper GI source or when colonoscopy results are negative
- When sampling of tissue or fluid is indicated
- In individuals with suspected portal hypertension to document or treat esophageal varices
- To assess acute injury after caustic ingestion
- Treatment of bleeding lesions such as ulcers, tumors, vascular abnormalities
- Banding or sclerotherapy of varices
- Removal of foreign bodies
- Removal of selected polypoid lesions
- Placement of feeding or drainage tubes
- Dilation of stenotic lesions
- Management of achalasia
- Palliative treatment of stenosing neoplasms
- Sequential or periodic surveillance for malignancy in individuals with pre-malignant conditions such as Barrett's esophagus

The ASGE recommends that EGD is not generally indicated for evaluation of the following:

- Symptoms considered functional in origin
- Metastatic adenocarcinoma of unknown primary site when the results will not alter management
- Radiographical findings of asymptomatic or uncomplicated sliding hiatal hernia, uncomplicated duodenal ulcer that has responded to therapy, deformed duodenal bulb when symptoms are absent or respond adequately to ulcer therapy
- Sequential or periodic surveillance for malignancy in individuals with gastric atrophy, pernicious anemia, or prior gastric operations for benign disease
- Sequential or periodic surveillance of healed benign disease such as esophagitis or gastric duodenal ulcer
- Sequential or periodic surveillance during repeated dilations of benign strictures unless there is a change in status

The ASGE Standards of Practice Committee state that "acute diarrheal illnesses are generally caused by infectious agents involving the lower part of the GI tract. Routine use of esophagogastroduodenoscopy (EGD) in these self-limited disorders is therefore not indicated. In the absence of significant findings on laboratory studies and lower endoscopy, an upper GI evaluation for small-bowel disease should be considered in individuals with chronic diarrhea. The differential diagnosis in these individuals includes celiac disease, *Giardia* infection, Crohn's disease, eosinophilic gastroenteropathy, Whipple's disease, intestinal amyloid, and pancreatic insufficiency."

The ASGE guideline on the role of endoscopy in the assessment and treatment of esophageal cancer states that endoscopy is recommended in the diagnosis and management of esophageal cancer. Additionally, individuals presenting with signs or symptoms of loco-regional recurrence following resection of esophageal cancer should undergo endoscopy for evaluation.

The American College of Gastroenterology's guidelines for the diagnosis and treatment of GERD (DeVault and Castell, 2005) stated that "[i]f the patient's history is typical for uncomplicated GERD, an initial trial of empirical therapy (including lifestyle modification) is appropriate. Endoscopy at presentation should be considered in patients who have symptoms suggesting complicated disease, those at risk for Barrett's esophagus ... Endoscopy is the technique of choice used to identify suspected Barrett's esophagus and to diagnose complications of GERD. Biopsy must be added to confirm the presence of Barrett's epithelium and to evaluate for dyspepsia". The ASGE Standards of Practice Committee recommends upper endoscopy if the results are likely to influence management of the individual, if empiric treatment for a suspected benign disorder has been unsuccessful, if the

procedure can be used as alternative to radiographic evaluation, or if therapeutic maneuver may be needed. Additionally, upper endoscopy may be indicated if the results would alter the management of disease.

Coding:

Codes are listed below for informational purposes only, and do not guarantee member coverage or provider reimbursement. The list may not be all-inclusive. Deleted codes and codes which are not effective at the time the service is rendered may not be eligible.

CPT® Code	Description
43200	Esophagoscopy, flexible, transoral; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)
43202	Esophagoscopy, flexible, transoral; with biopsy, single or multiple
43235	Esophagogastroduodenoscopy, flexible, transoral; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)
43237	Esophagogastroduodenoscopy, flexible, transoral; with endoscopic ultrasound examination limited to esophagus
43238	Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s), (included endoscopic ultrasound examination limited to esophagus)
43239	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)
43242	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 and/or jejunum as appropriate)
43259	Esophagogastroduodenoscopy, flexible, transoral; with endoscopic ultrasound examination, including the esophagus, stomach, and either the duodenum and/or jejunum as appropriate

List of medically necessary ICD-10 Codes

Billing Guidelines:

Member's medical records must document that services are medically necessary for the care provided. Harvard Pilgrim Health Care maintains the right to audit the services provided to our members, regardless of the participation status of the provider. All documentation must be available to HPHC upon request. Failure to produce the requested information may result in denial or retraction of payment.

References:

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Summary of Changes:

Date	Change
10/20	Annual Review; no changes
9/20	Coding updated
3/20	Coding updated
3/19	Policy expanded for Lynch Syndrome and Celiac disease
12/18	Indications clarified
2/18	ICD 10 coding reviewed and updated.
9/17	Coding update
01/17	Background revised. Additional indications added to policy coverage criteria as medically necessary. Additional coding added as medically necessary.

Approved by Medical Policy Committee: 11/10/20

Approved by Clinical Policy Operational Committee: 7/15; 1/17; 9/17, 2/18, 11/18, 3/19, 4/20, 9/20, 11/20

Policy Effective Date: 11/30/20

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