TUFTS Health Plan

Upper GI Endoscopy Authorization Form

Applies to:

☒ Tufts Health Plan Commercial Plans products; Fax: 617.972.9409
☒ Tufts Health Public Plans products
- ☒Tufts Health Direct – Health Connector; Fax: 888.415.9055
- ☒Tufts Health Together – A MassHealth Plan; Fax: 888.415.9055
- ☐Tufts Health Unify – OneCare Plan; Fax: 781.393.2607
- ☒Tufts Health RITogether — A Rhode Island Medicaid Plan; Fax: 857.304.6404

☒ Tufts Health Freedom Plan products; Fax: 617.972.9409

This form should be completed by the person who has a thorough knowledge of the Member's current clinical presentation and his/her treatment history. Please complete all sections. Omissions, generalities, and illegibility will result in the form being returned for completion or clarification. Please refer to the Medical Necessity Guidelines Upper GI Endoscopy: Certain Elective Procedures for further information.

Member Name:		Member DOB:	Date of Request:
Member ID#:	Dx/ICD:		Procedure Code(s):
Provider Name:		Provider TAX ID#:	Provider Phone #:
Provider Fax #:		Provider NPI #:	
Facility Name:		Provider Signature:	

Tufts Health Plan may authorize coverage of an Upper GI Endoscopy when the Member meets **ONE** of the following criteria sets. Please check all that apply.

☐ **A. Esophageal Disease**

☐ 1. Dysphagia or odynophagia associated with **ONE** of the following:
- ☐ a. New onset or worsening symptoms of difficulty/pain with swallowing
- ☐ b. Weight loss
- ☐ c. Need for therapeutic intervention for a stricture or for achalasia

☐ 2. GERD with:
- ☐ a. Persistent symptoms of GERD such as heartburn or regurgitation, **AND** inadequate response to Proton-pump inhibitors (PPIs) administered for at least 4 weeks **or**;
- ☐ b. History of GERD for one year or longer at time of EGD request **or**;
- ☐ c. Weight loss, anemia, abnormal radiological study of esophagus/stomach, GI bleeding, early satiety or recurrent vomiting

☐ 3. Surveillance in Members with established Barrett's esophagus according to intervals based on pathology:
- ☐ a. High-grade dysplasia on prior biopsies: EGD with biopsy will be covered every 3 months **or**;
- ☐ b. Low-grade dysplasia on prior biopsies: EGD 6 months after initial biopsy and if still low grade dysplasia will be covered annually thereafter if no change in pathology **or**;
- ☐ c. No dysplasia on prior biopsy: cover 2 EGDs with biopsy in one year and if normal pathology remains, every three years thereafter

☐ 4. Abnormal radiological study of esophagus or stomach

☐ 5. Esophageal varices:
- ☐ a. Initial screening for esophageal or gastric varices with a new diagnosis of CIRRHOSIS, regardless of liver disease, with **ANY** of the following:
  - ☐ 1. Ascites
  - ☐ 2. Bilirubin over 2.0
  - ☐ 3. Albumin less than 3.5
  - ☐ 4. Prothrombin Time greater than 1.7
  - ☐ 5. Encephalopathy
  - ☐ 6. A fibrosis score 2 or greater
- ☐ b. Treatment of varices by sclerotherapy or endoscopic variceal ligation (EVL) in Member who has had documented bleeding from esophageal varices (active or in past) **or**;
- ☐ c. For Members with high risk of esophageal variceal bleed, with no prior history of bleeding, the Member must have **one or more** of the risk factors listed below:
  - ☐ 1. Medium to large varices on prior screening EGD; **or**
  - ☐ 2. Red marks such as red wale lines or red spots seen on screening or on prior EGD; **or**
  - ☐ 3. Child's B or C cirrhosis (significant functional compromise or decompensated liver disease)
- ☐ d. Repeat screenings may be covered under the following conditions:

☐ 1. If compensated cirrhosis (stable clinically and without bleeding) and no varices on initial screen, EGD may be covered every THREE years **or**;
☐ 2. If compensated cirrhosis and varices on initial EGD, a repeat EGD will be covered every two years, only for Members not on beta blockers **or**;
☐ 3. If decompensated cirrhosis (unstable clinical status) EGD may be covered annually

☐ 6. Corrosive injuries to esophagus (unlimited)

☐ 7. Eosinophilic Esophagitis (EoE) may be covered when **ANY** of the following are met:
- ☐ a. Initial EGD evaluation for suspected diagnosis; **or**
- ☐ b. Follow-up in 8 weeks for response to INITIAL pharmacologic treatment; **or**
- ☐ c. Follow-up in 8 weeks for response to INITIAL six-food elimination diet (SFED), but NOT for subsequent surveillance with food group re-introduction, which is based on clinical response; **or**
- ☐ d. For initial and re-evaluation of esophageal stricture associated with EoE

☐ **B. Anemia:**
- ☐ 1. Vitamin B-12 deficiency **or**;
- ☐ 2. Iron deficiency defined as a documented ferritin below normal for laboratory and/or a Fe/TIBC saturation below 20%

☐ **C. Gastric Ulcer**
- ☐ 1. Follow-up after 1-2 month of treatment with PPI/H-2 blocker (to confirm healing and/or rule out malignant ulcer)

☐ **D. Persistent Upper Abdominal Symptoms**
- ☐ 1. Symptoms for at least 4 weeks (e.g. pain, nausea or vomiting) and **either:**
  - ☐ a. Fails to respond to maximum PPI's (twice daily dosing) **OR** reinstitution of PPI therapy after one successful course **or**;
  - ☐ b. Symptoms are associated with weight loss, GI bleeding, melena, anemia, anorexia or early satiety

☐ **E. Celiac Disease**
- ☐ 1. Positive serology for celiac sprue by IgA tissue transglutaminase (IgA-tTG), IgA endomysial antibody (IgA EMA) **or** IgG-tTG or IgG-EMA may be substituted for Members with IgA deficiency; **or**
- ☐ 2. Any **one** of the following criteria:
  - ☐a. GI symptoms consistent with chronic malabsorption, including chronic diarrhea or steatorrhea, abdominal distension, and weight loss **or**;
  - ☐b. Otherwise unexplained iron, folate, or vitamin D deficiency, calcium deficiency, or secondary hyperparathyroidism with osteoporosis or osteomalacia **or**;
  - ☐c. In absence of other causes: persistent aminotransferase elevation, short stature, delayed puberty, recurrent fetal loss/infertility, epilepsy or ataxia **or;**
  - ☐d. GI symptoms, with a diagnosis of an associated high-risk conditions, such as, Type-1 Diabetes Mellitus or other autoimmune endocrinopathies (such as autoimmune thyroiditis); first and second degree relatives with celiac disease; Turner, Down or William syndromes; IgA deficiency, or Dermatitis Herpetiformis (skin condition strongly associated with celiac disease)
- ☐3. A repeat Upper GI Endoscopy may be covered with one of the following indications:
  - ☐ a. The Member fails to respond to gluten-free diet; **or**
  - ☐ b. Diagnosis of celiac disease is uncertain on initial testing and needs to be confirmed by a re-biopsy

☐ **F. Involuntary Weight Loss**
- ☐ 1. Weight loss of 10 pounds or more in 12 weeks or less without a dietary or illness related explanation

☐ **G. Diarrhea ,** when **all** of the following are met:
- ☐ 1. Greater than 3 weeks duration **and**
- ☐ 2. Negative stool studies for infection, including O & P if indicated **and**
- ☐ 3. After completion of lower bowel work-up, including flexible sigmoidoscopy or colonoscopy **and**
- ☐ 4. For Members under 40 years old, with a history consistent with irritable bowel syndrome, failure of fiber and anti-spasmodic to relieve diarrhea

☐ **H. Increased Risk for Gastric Cancer,** when the Member has **one** of the following risk factors:
- ☐ 1. Positive diagnosis of familial adenomatous polyposis; **or**
- ☐ 2. Positive diagnosis of hereditary nonpolyposis colorectal cancer; **or**
- ☐ 3. Positive family history of gastric cancer; **or**
- ☐ 4. Positive diagnosis of gastric hyperplasia