

Medical Necessity Guidelines: Upper GI Endoscopy: Certain Elective Procedures

Effective: August 19, 2020

Prior Authorization Required	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
If <u>REQUIRED</u> , submit supporting clinical documentation pertinent to service request.	
<p>Applies to: COMMERCIAL Products <input checked="" type="checkbox"/> Tufts Health Plan Commercial products; Fax: 617.972.9409 <input checked="" type="checkbox"/> Tufts Health Freedom Plan products; Fax: 617.972.9409 • CareLinkSM – Refer to CareLink Procedures, Services and Items Requiring Prior Authorization</p> <p>TUFTS HEALTH PUBLIC PLANS Products <input checked="" type="checkbox"/> Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product); Fax: 888.415.9055 <input checked="" type="checkbox"/> Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans; Fax: 888.415.9055 <input checked="" type="checkbox"/> Tufts Health RITogether – A Rhode Island Medicaid Plan; Fax: 857.304.6404 <input checked="" type="checkbox"/> Tufts Health Unify* – OneCare Plan (a dual-eligible product); Fax: 857.304.6304 *The MNG applies to Tufts Health Unify members unless a less restrictive LCD or NCD exists.</p> <p>SENIOR Products • Tufts Health Plan Senior Care Options (SCO), (a dual-eligible product) – Refer to the Tufts Health Plan SCO Prior Authorization List • Tufts Medicare Preferred HMO, (a Medicare Advantage product) – Refer to the Tufts Medicare Preferred HMO Prior Authorization and Inpatient Notification List</p>	

Note: While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you will need to make sure that prior authorization has been obtained.

Tufts Health Plan requires prior authorization for certain elective upper gastrointestinal (GI) endoscopy procedures for Members 18 years of age and older. Please complete the [Upper GI Authorization Form](#) when requesting coverage and send to the fax number indicated above.

OVERVIEW

An upper GI endoscopy (also called EGD) is a procedure that uses a lighted, flexible endoscope to see inside the upper GI tract. The upper GI tract includes the esophagus, stomach, and duodenum—the first part of the small intestine.

CLINICAL COVERAGE CRITERIA

Tufts Health plan will cover an upper GI endoscopy when **ONE** of the following criteria sets is met.

A. Esophageal Disease

1. Dysphagia (difficulty swallowing) or odynophagia (pain with swallowing) associated with one of the following:
 - a. New onset or worsening of symptoms of difficulty or 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** an inadequate response to Proton-pump inhibitors (PPIs) administered for at least 4 weeks; **or**
 - b. History of GERD for one year or longer at the time of EGD request; **or**
 - c. Weight loss, anemia, abnormal radiological study of esophagus or stomach, GI bleeding, early satiety or recurrent vomiting
3. Surveillance of 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
 - 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
 - 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 for a Member with a diagnosis of CIRRHOSIS, regardless of liver disease etiology, as evidenced by **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 Members 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 following high risk factors:
 - 1. Medium to large varices on prior screening EGD
 - 2. Red marks such as red wale lines or red spots seen on screening or on prior EGD
 - 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
 - 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)
 - 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
 - b. Follow-up in 8 weeks for response to INITIAL pharmacologic treatment
 - 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
 - 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

- Follow-up after one-two month of treatment with PPI or 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** reinstatement 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 disease 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
 - b. Diagnosis of celiac disease is uncertain on initial testing and needs to be confirmed by re-biopsy

F. Involuntary Weight Loss

- 1. Weight loss of 10 pounds or more in 12 weeks or less without dietary or illness related explanation

G. Diarrhea

When all the following criteria sets are met:

- 1. Greater than three 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 who have a history consistent with irritable bowel syndrome, failure of fiber and anti-spasmodic to resolve diarrhea

H. Increased Risk for Gastric Cancer

When the Member has one of the following risk factors:

- 1. Positive diagnosis of familial adenomatous polyposis
- 2. Positive diagnosis of hereditary nonpolyposis colorectal cancer
- 3. Positive family history of gastric cancer
- 4. Positive diagnosis of gastric hyperplasia

LIMITATIONS

- Tufts Health Plan does not cover upper GI endoscopies for the following indications:
 - EGD related to pre-evaluation of Members scheduled for bariatric surgery is not covered unless meeting one of the clinical criteria above
 - EGD related to sclerotherapy for bariatric indications (e.g. revision of Roux-en-Y procedure to address weight regain) as this is considered investigational and, therefore, not medically necessary
 - EGD related to endoscopic gastric suturing (e.g. with the Apollo Overstitch™ System) for revision of gastric bypass or as a primary bariatric procedure as these procedures are considered investigational and, therefore, not medically necessary
 - EGD related to placement of the TransPyloric Shuttle device for bariatric indications as this is considered investigational and, therefore, not medically necessary
- Tufts Health Plan does not cover upper GI endoscopies to rule out celiac disease for the following:
 - Individuals with low risk of disease (for example infertility, GI symptoms with negative serology and without indicators of malabsorption, or osteoporosis without other evidence of malabsorption)

CODES

The following CPT codes require prior authorization:

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
43231	Esophagoscopy, flexible, transoral; with endoscopic ultrasound examination

Code	Description
43233	Esophagogastroduodenoscopy, flexible, transoral; with dilation of esophagus with balloon 30_mm diameter or larger) (includes fluoroscopic guidance, when performed)
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 the esophagus, stomach or duodenum, and adjacent structures
43239	Esophagogastroduodenoscopy, flexible, transoral; with biopsy, single or multiple
43259	Esophagogastroduodenoscopy, flexible, transoral; with endoscopic ultrasound examination, including the esophagus, stomach, and either the duodenum or a surgically altered stomach where the jejunum is examined distal to the anastomosis

REFERENCES

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2. Guadalupe Garcia-Tsao, Arun J. Sanyal, Norman D. Grace, William Carey, and the Practice Guidelines Committee of the American Association for the Study of Liver Diseases, the Practice and Parameters Committee of the American College of Gastroenterology, "Prevention and Management of Gastroesophageal Varices and Variceal Hemorrhage in Cirrhosis," American Journal Gastroenterology 2007;102:2086-2102
3. American Society for Gastrointestinal Endoscopy (ASGE). Practice guideline. The Role of Endoscopy in Dyspepsia. 2007; 66:1071-1075. Update version 2015;82:227-232
4. ASGE. Practice guideline. Role of Endoscopy in the Management of GERD. 2007; 66-219-224. Update version 2015; 81:1305-1310.
5. ASGE. Practice guideline. The Role of Endoscopy in the Management of Obscure Gastrointestinal Bleeding. 2003; 58: 650-655. Update version 2010; 72:471-479. Last accessed September 17, 2020
6. ASGE. Practice guideline. Role of Endoscopy in the Bariatric Surgery Patient; 2008; 68: 1-10. Update version 2015; 81:1063-1072. Last accessed September 17, 2020
7. UpToDate, "Treatment of Eosinophilic Esophagitis" and "Dietary Management of Eosinophilic Esophagitis." December 2014 updated articles, with literature update March 2017.
8. Morgan MD. Gastric intestinal hyperplasia. UpToDate. Waltham, MA: UpToDate Inc. uptodate.com. Accessed October 5, 2017.
9. Hayes, Inc. OverStitch Endoscopic Suturing System (Apollo Endosurgery Inc.). Hayes Clinical Research Response. September 18, 2019. Last accessed September 19, 2020

APPROVAL HISTORY

October 24, 2007: Reviewed by the Medical Affairs Medical Policy Committee for January 1, 2008 effective date.

Subsequent endorsement date(s) and changes made:

- January 8, 2008: Additional diagnoses added to list.
- June 18, 2009: Additional diagnoses and criteria added.
- July 1, 2010: Reviewed my MSPAC Medical Policy-Medical Affairs. UGI for Celiac disease combined with new THP MNG for Upper GI Procedures to create one MNG. InterQual® Criteria will be retired.
- August 2010: Reviewed by Medical Affairs-Medical Policy. New category "Increased Risk for Gastric Cancer" added to coverage, effective January 1, 2011.
- February 2011: Added to (A-6)-Esophageal Disease, coverage for corrosive injuries to esophagus; Added to (B-4)-Anemia, coverage for Members over the age of 50 with criteria.
- October 25, 2012: Reviewed at MSPAC. Clarified Iron deficiency anemia language. CPT code 43234 deleted for year ending 2012 and to be removed by December 31, 2012.
- August 14, 2013: Reviewed by Integrated Medical Policy Advisory Committee (IMPAC), added/clarified wording at the request of Dr. Wild to: A) GERD 2a.)-PPI dose language clarified.
- November 25, 2013: Reviewed by IMPAC, renewed without changes.
- December 19, 2013: New AMA CPT codes 43233, 43253, 43254, 43266 and 43270 added for year beginning January 1, 2014.
- September 10, 2014: Reviewed by IMPAC, renewed without changes.

- March 11, 2015: Reviewed by IMPAC, Medical Necessity Guideline for Network Health-Commercial and Network Health-Medicaid products effective June 1, 2015.
- September 2015: Branding and template change to distinguish Tufts Health Plan products in "Applies to" section. Added Tufts Health Freedom Plan products, effective January 1, 2016.
- October 14, 2015: Reviewed by IMPAC. Additional criteria added to section A.5 for 'esophageal or gastric varices in a Member with a diagnosis of 'cirrhosis'. Criteria for Beta Blocker removed from section A.5c. New criteria added under Esophageal Disease, section A.7, for Eosinophilic Esophagitis (EoE). Section (B) criteria(s) 3 through 4 removed (Iron deficiency anemia with or without FOBT). Section H.1 (pernicious anemia) and H.2 (s/p partial gastrectomy) removed. Corresponding form updated to reflect changes effective April 1, 2015.
- December 9, 2015: Reviewed by IMPAC:. CPT codes 43231, 43237, 43259 added for an effective date of April 1, 2016. CPT codes 43253, 43254, 43266, 43270 removed. Melena added for clarification to Section D. 1(b).
- September 14, 2016: Reviewed by IMPAC; age requirement changed from ages 18-55 to 18 years of age and older effective January 1, 2017.
- October 24, 2016: Reviewed by IMPAC, renewed without changes.
- April 2017: Added RITogether Plan product to template. For MNGs applicable to RITogether, effective date is August 1, 2017.
- October 11, 2017: Reviewed by IMPAC, positive diagnosis of gastric hyperplasia added as a risk factor under section H.4.
- September 12, 2018: Reviewed by IMPAC, renewed without changes
- October, 2018: Template and disclaimer updated
- January 9, 2019: Reviewed by IMPAC, update to "Limitations" section.
- June 19, 2019: Reviewed by IMPAC, update to "Limitations" section, addition of EGD for placement of TransPyloric Shuttle as a limitation
- September 18, 2019: Reviewed by IMPAC, renewed without changes
- August 19, 2020: Reviewed by IMPAC, renewed without changes
- September 17, 2020: Fax number for Unify updated

BACKGROUND, PRODUCT AND DISCLAIMER INFORMATION

Medical Necessity Guidelines are developed to determine coverage for benefits, and are published to provide a better understanding of the basis upon which coverage decisions are made. We make coverage decisions using these guidelines, along with the Member's benefit document, and in coordination with the Member's physician(s) on a case-by-case basis considering the individual Member's health care needs.

Medical Necessity Guidelines are developed for selected therapeutic or diagnostic services found to be safe and proven effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in our service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. We revise and update Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Medical Necessity Guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of this guideline is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to eligibility and benefits on the date of service, coordination of benefits, referral/authorization, utilization management guidelines when applicable, and adherence to plan policies, plan procedures, and claims editing logic.

[Provider Services](#)