Cohere Medical Policy - Esophagogastroduodenoscopy (EGD)

Clinical Guidelines for Medical Necessity Review

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Important Notices

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Medical Necessity Criteria

Service: Esophagogastroduodenoscopy (EGD)

Recommended Clinical Approach

Esophagogastroduodenoscopy (EGD) is an upper intestinal endoscopy technique used to examine, obtain samples, or treat pathological conditions of the upper intestinal tract. EGD is performed with a lighted, flexible, fiberoptic instrument, usually less than 12 mm in diameter, passed through the cricopharynx. The patient receives conscious sedation, and a topical anesthetic may be applied to the posterior pharynx. The entire esophagus, stomach, and duodenum can be visualized with EGD. Endoscopic ultrasound (EUS) or transendoscopic ultrasound uses a transducer at the end of an endoscope to obtain high-resolution images that improve visualization of the gastrointestinal tract and allow evaluation of adjacent structures, including the pancreas and biliary tree.

Diagnostic EGD is used to visualize the oropharynx, esophagus, stomach, and proximal duodenum and is useful for detecting conditions such as focal benign or malignant lesions, diffuse mucosal changes, luminal obstruction, abnormal motility, and extrinsic compression by contiguous structures.[1] A diagnostic EGD allows the examiner to visualize abnormalities detectable by the technique and to photograph and collect a biopsy sample as appropriate. An endoscopic Doppler probe can be used as an adjunct diagnostic modality to assess the treatment's local blood supply efficacy and to stratify patients at higher risk of repeat upper gastrointestinal bleeding (UGIB). Pulsatile Doppler signals can indicate the presence and path of bleeding vessels. The probe can also determine if vessels were appropriately coagulated following endoscopic hemostasis. The absence of a Doppler signal is consistent with successful hemostasis of a bleeding lesion. Lesions with a persistent dopplerable signal have a higher risk for rebleeding.[2]

EGD is generally considered a safe procedure, although bleeding, perforation, infection, acute pancreatitis[3], and sedation-related complications[4] following the procedure have been reported in rare instances.[5]

Medical Necessity Criteria

Indications

- ➔ **Esophagogastroduodenoscopy (EGD)** is considered appropriate if **ANY** of the following is **TRUE**[1,6,24,26]:
  - Gastroesophageal reflux disease (GERD) symptoms (e.g., heartburn, regurgitation, or chest pain) that persist despite treatment[5-6]; **OR**
  - A single screening exam for GERD with **AT LEAST THREE** of the following risk factors for concurrent Barrett's esophagus[1,5]:
    - Prolonged GERD for more than 5 years; **OR**
    - The age of the patient is greater than 50 years; **OR**
    - Male gender; **OR**
    - Hiatal hernia[7-8]; **OR**
    - Current or past tobacco use; **OR**
    - Obesity; **OR**
    - Family history of Barrett's esophagus in a first-degree relative; **OR**
    - Family history of esophageal adenocarcinoma in a first-degree relative; **OR**
  - Planning for anti-reflux surgery[9]; **OR**
  - Nausea that is persistent and unexplained[6]; **OR**
  - Vomiting that is persistent and unexplained[5-6]; **OR**
  - Atypical chest pain after cardiac disease has been ruled out[6]; **OR**
  - Heartburn with alarm symptoms (e.g., anemia, GI bleeding, unexplained weight loss)[8,10]; **OR**
  - Prolonged anorexia[5]; **OR**
  - Unexplained weight loss[5]; **OR**
  - Effects of nonsteroidal anti-inflammatory drug (NSAID) use[11]; **OR**
  - Barrett's esophagus is present, and the patient requires **ALL** of the following[12]:
    - Routine surveillance of non-dysplastic disease every 3 to 5 years[1,13]; **AND**
    - Reassessment during treatment to eliminate dysplasia (e.g., ablation, mucosal resection, mucosal dissection) every 3 to 6 months[12]; **AND**
    - Surveillance after completion of treatment for dysplasia when **ANY** of the following is **TRUE**[1]:

    - For low-grade dysplasia - every 6 months for 1 year, then annually thereafter; **OR**
    - For high-grade dysplasia - every 3 months for 1 year, then every 6 months for 1 year, then annually thereafter; **OR**
- Swallowing symptoms including, but not limited to, **ANY** of the following:
    - Difficulty swallowing (e.g., dysphagia); **OR**
    - Pain while swallowing (odynophagia); **OR**
- Esophageal dysmotility based on barium radiography or esophageal manometry, when suggestive of achalasia[14]; **OR**
- Confirmation and specific histologic diagnosis of radiologically demonstrated lesions, including, but not limited to, **ANY** of the following[14-17]:
    - Protrusions/growths from, within, or extrinsic to the mucosal wall; **OR**
    - Excavated lesions, such as erosions, ulcers, or diverticula; **OR**
    - Other mucosal abnormalities, including thickened fold(s) or asymmetric/symmetric narrowing(s) (stenoses/strictures); **OR**
- Clarification of location or pathology of a lesion during surgery[18]; **OR**
- Evaluation for possible gastric or duodenal polyps in patients with familial adenomatous polyposis or other at-risk hereditary syndromes (e.g., Lynch syndrome, juvenile polyposis syndrome, Peutz-Jegher's syndrome, MUTYH-Associated Polyposis [MAP], Li-Fraumeni syndrome, Cowden syndrome, hereditary gastric cancer syndrome)[19]; **OR**
- The patient is less than 60 years of age and has dyspepsia with **ANY** of the following:
    - Negative *Helicobacter pylori* test and no response to proton pump inhibitor (PPI) therapy[6,20-21]; **OR**
    - Equivocal results from non-invasive *Helicobacter pylori* testing and need for gastric biopsy[21-22]; **OR**
    - A one-time screening in a patient with a family history of upper GI malignancy in a first-degree relative; **OR**
    - Lymphadenopathy (e.g., supraclavicular, periumbilical); **OR**

- Palpable abdominal mass; **OR**
- Alarm symptoms (e.g., anemia, GI bleeding, unexplained weight loss, dysphagia/odynophagia); **OR**

- The patient is 60 years of age or older and has dyspepsia; **OR**
- Peptic ulcer disease with **ANY** of the following[23-24]:
  - Persistent or recurrent symptoms despite treatment; **OR**
  - Recent identification of gastric or duodenal ulcer, to document ulcer healing after treatment for at least 2 months, even without symptoms; **OR**
- Erosive reflux esophagitis with **ANY** of the following[2,23]:
  - Persistent or recurrent symptoms despite appropriate GERD treatment; **OR**
  - To document healing after treatment of LA grade C or D esophagitis and to exclude the development of Barrett's esophagus; **OR**
- Surveillance as determined by the endoscopist for or suspected recurrence of prior upper GI cancer or pre-cancer, including **ANY** of the following[23]:
  - Squamous cell carcinoma of the esophagus; **OR**
  - Adenocarcinoma of the esophagus; **OR**
  - Adenocarcinoma or mucosa-associated lymphoma (MALT) of the stomach; **OR**
  - Adenocarcinoma of duodenum or ampulla; **OR**
  - Stromal/neuroendocrine tumor of the esophagus, stomach, or duodenum; **OR**
  - Other subepithelial pre-malignant lesion of the esophagus, stomach, or duodenum; **OR**
  - Adenomatous polyp of stomach, duodenum, or ampulla; **OR**
  - Dysplasia (low or high grade) in patients with gastric intestinal metaplasia or chronic atrophic gastritis; **OR**
- Confirmed or suspected eosinophilic esophagitis (EoE) for **ANY** of the following[25]:
  - Initial exam for suspected EoE for evaluation of dysphagia, GERD symptoms refractory to PPI therapy, or history of esophageal food bolus impaction; **OR**
  - Follow-up exam to reassess esophageal histology for confirmed EoE, after treatment (e.g., food allergen

restriction, PPI therapy, steroid therapy, anti-interleukin therapy); **OR**
    - Follow-up exam to reassess esophagus when symptoms recur on previously effective therapy; **OR**
- Evaluation of chronic diarrhea to identify an upper GI etiology (e.g., celiac disease) when small bowel disease is suspected; **OR**
- Suspected celiac disease based on **ANY** of the following[26]:
    - Typical signs or symptoms (e.g., abdominal pain, diarrhea, constipation, weight loss without intent, iron deficiency anemia); **OR**
    - Abnormal celiac serology including **ANY** of the following:
        - Elevated tissue transglutaminase immunoglobulin A (TTG IgA) with normal total IgA; **OR**
        - Elevated endomysial IgA with normal total IgA; **OR**
        - Elevated deamidated anti-gliadin IgG with IgA deficiency; **OR**
    - The patient is at a high-risk based on celiac human leucocyte antigen (HLA) analysis; **OR**
- Known celiac disease with **ANY** of the following[26]:
    - The patient has been on a gluten-free diet for at least 1 year and requires histologic confirmation of remission; **OR**
    - Symptoms persist despite adherence to a gluten-free diet for at least 6 months; **OR**
- Acute injury including, but not limited to, **ANY** of the following:
    - Caustic agent ingested; **OR**
    - Sharp foreign object ingested[27]; **OR**
- Evaluation for esophagogastric varices (swollen veins [varices] in the esophageal or gastric wall) due to suspicion for or confirmation of liver cirrhosis or portal hypertension[28]; **OR**
- Routine screening (every 3 years) or surveillance (every 1-2 years) of non-bleeding esophagogastric varices[28-29]; **OR**
- Evaluation of GI bleeding and **ANY** of the following:
    - Upper GI symptoms; **OR**
    - Presumed chronic blood loss (iron deficiency anemia, positive fecal occult blood test, or both) when colonoscopy is negative[30]; **OR**
    - Active bleeding is present (hematemesis, melena, or hematochezia); **OR**

- Recent active bleeding (within 72 hrs) and etiology remains unknown; **OR**
- Suspected aorto-enteric fistula; **OR**
- Re-bleeding occurs after recent endoscopic therapy; **OR**
- Surgery is being considered; **OR**

◆ Suspected inflammation of the upper gastrointestinal (GI) tract from etiologies including, but not limited to, inflammatory myositis, Crohn's disease, ulcerative colitis, inflammatory bowel disease (IBD), and acute graft versus host disease[31-32]; **OR**

◆ Conditions in which upper GI pathology might modify other planned management, such as patients with **ANY** of the following[5]:

- Organ transplantation is planned; **OR**
- Long-term anticoagulation therapy; **OR**
- Long-term nonsteroidal anti-inflammatory drug therapy for arthritis; **OR**
- Cancer of the head and neck; **OR**
- Bariatric surgery is planned; **OR**[33]

◆ EGD with endoscopic ultrasound is considered appropriate with **ANY** of the following[38-50]:

- **ANY** of the following diagnostic indications *not requiring* intramural or transmural fine needle aspiration/biopsy:
  - When initial ultrasound, CT scan, or MRI is nondiagnostic or inconclusive and clinical suspicion remains high for **ANY** of the following known or suspected conditions:
    - ◆ Cholelithiasis; **OR**
    - ◆ Choledocholithiasis; **OR**
    - ◆ Biliary stricture or obstruction; **OR**
    - ◆ Structural or congenital abnormality; **OR**
  - For local and regional staging of confirmed malignancy involving the esophagus, stomach, duodenum, duodenal ampulla, bile duct, pancreas or jejunum when diagnostic imaging is insufficient or indeterminate; **OR**
  - For evaluation of possible etiologies for unexplained acute or recurrent pancreatitis; **OR**

- **ANY** of the following diagnostic indications *that include* intramural or transmural fine needle aspiration/biopsy of/for:
    - Tumor/mass/sub-epithelial lesions involving the upper GI tract (esophagus, stomach, duodenum, duodenal ampulla, jejunum); **OR**
    - Tumor/mass/lesions/cysts involving regional adjacent organs (lung, liver, gallbladder, bile duct, pancreas); **OR**
    - Regional lymph nodes (e.g., mediastinal, peri-esophageal, pre-carinal, peri-gastric, peri-biliary, peri-pancreatic) for **ANY** of the following scenarios:
        - When enlarged or suspicious for tumor infiltration and sampling might change management; **OR**
        - When normal in size and random sampling might change staging designation; **OR**
        - when lymphadenopathy is of unknown origin, sampling is likely to affect patient management, and no superficial lymph nodes are easily accessible for percutaneous sampling; **OR**
    - Confirmation of suspected autoimmune pancreatitis when diagnostic imaging and/or serologic testing is inconclusive; **OR**
    - Exclusion or confirmation of chronic pancreatitis as a possible etiology for chronic unexplained upper abdominal pain; **OR**
- **ANY** of the following *therapeutic* indications:
    - For bile duct or pancreatic duct access to achieve drainage or other therapy (e.g., stent placement, stone removal) if access could not be achieved by ERCP; **OR**
    - For drainage of symptomatic abdominal fluid collections that can be accessed transmurally from the esophagus, stomach or duodenum, including

abscesses, bilomas, pseudocysts, or other pancreatic fluid collections; **OR**

- For creation of a gastroenterostomy for **ANY** of the following:
  - relieve/palliate symptoms from gastric outlet obstruction when surgery is not feasible; **OR**
  - facilitate access to the duodenal papilla via stomach or small bowel segment that has been excluded by prior surgery; **OR**
- For transmural injection of therapeutic agents (e.g., ethanol, phenol) including **ANY** of the following:
  - Neurolytic agent (e.g., botulinum toxin, ethanol, phenol) into the celiac plexus for ANY of the following:
    - Palliate chronic pain related to upper abdominal cancer (including pancreatic cancer); **OR**
    - Relieve chronic pain related to chronic pancreatitis that is unresponsive to medical therapy; **OR**
    - Identify/predict surgical success in patients with median arcuate ligament syndrome (MALS)[51-53]; **OR**
  - Botulinum toxin into the esophageal muscularis for treatment of achalasia; **OR**
- For transmural delivery of targeted cancer treatment (e.g., radiofrequency ablation, chemotherapy); **OR**
- For transmural placement of fiducial markers in tumors for surveillance or presurgical marking.

Non-Indications

➔ **Diagnostic esophagogastroduodenoscopy (EGD)** is not considered appropriate if **ANY** of the following is **TRUE**[1,6,24,26]:

- Blockage in the esophagus, stomach, or duodenum is previously established; **OR**
- Surveillance of healed, benign disease, such as gastric or duodenal ulcer or benign esophageal strictures[1]; **OR**
- Confirming *Helicobacter pylori* eradication; **OR**

- Cancer surveillance in patients with pernicious anemia, treated achalasia, or prior gastric resection[1]; **OR**
- Patients with significant cardiac arrhythmia or recent (within the last 3-6 months) myocardial infarction[1]; **OR**
- Perforated bowel; **OR**
- Peritonitis; **OR**
- Toxic megacolon in an unstable patient; **OR**
- Perforated viscus is known or suspected; **OR**
- Before bariatric surgery in asymptomatic individuals; **OR**
- Confirming placement of gastric band; **OR**
- Diagnosing laryngopharyngeal reflux; **OR**
- Optical endomicroscopy is requested.

*Note: Patients undergoing dilations, percutaneous endoscopic gastrostomy [PEG], polypectomy, endoscopic sphincterotomy, endoscopic ultrasound-guided fine-needle aspiration [FNA], laser ablation, and coagulation are at higher risk for bleeding, and adjustment of anticoagulation may be necessary.

Level of Care Criteria

Inpatient or Outpatient

Procedure Codes (CPT/HCPCS)

CPT/HCPCS Code	Code Description
43239	Esophagogastroduodenoscopy, 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 the esophagus, stomach or duodenum, and adjacent structures

43238	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 or a surgically altered stomach where the jejunum is examined distal to the anastomosis)
43252	Esophagogastroduodenoscopy, flexible, transoral; with optical endomicroscopy
43253	Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic ultrasound-guided transmural injection of diagnostic or therapeutic substance(s) (eg, anesthetic, neurolytic agent) or fiducial marker(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)
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.

Medical Evidence

Sengupta et al. (2024) documented the recommendations of a panel of experts from the American College of Gastroenterology and the Society of Abdominal Radiology, comparing the advantages and limitations of endoscopic versus radiologic diagnostic examinations in patients with gastrointestinal bleeding. The authors noted that unless contraindicated, the evaluation of non-variceal upper gastrointestinal bleeding begins with EGD, with the ideal timing for the procedure being within 24 hours of presentation due to the increased risk of mortality when performed greater than 24-36 hours.[37]

The European Society of Gastrointestinal Endoscopy (ESGE) published a technical review of endoscopic ultrasound in 2022. The authors discussed several scenarios wherein endoscopic ultrasound is the optimal diagnostic or therapeutic modality, such as the drainage of fluid collections, biopsy of suspicious lesions, and surveillance and staging of neoplasms.[38]

A 2022 American Society of Gastrointestinal Endoscopy (ASGE) standards of practice review of adverse events associated with EGD found this procedure to be well-tolerated and safe, with more than 7 million esophagogastroduodenoscopies taking place each year in the United States. The overall incidence of the most insidious complications, including perforation, cardiopulmonary sequelae, and bleeding, remains extraordinarily low. Rates of perforation, for example, have been estimated at 1 in 25,000. Bleeding requiring emergency department care or inpatient stay for resolution has been evaluated at 80 in 100,000 patients within 30 days of the EGD.[5]

The American College of Gastroenterologists (ACG) and the American Gastroenterological Association (AGA) have published several recent guidelines pertaining to the use of EGD in high-volume clinical scenarios, such as peptic disease, Barrett's esophagus, and celiac disease. This robust guidance has been utilized where appropriate to synthesize this policy.[1,6,24,26]

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Clinical Guideline Revision History/Information

Original Date: February 6, 2025		
Review History		
Version 2	3/13/2025	• Added indications for endoscopic ultrasound (previously absent) and endoscopic injections (previously absent). • Changed policy title to "Esophagogastroduodenoscopy [EGD]" - prior title was considered less inclusive of current range of indications . • Rewrote medical evidence section for relevance. • Added references