Instructions for use

The following coverage policy applies to health benefit plans administered by Cigna. Coverage policies are intended to provide guidance in interpreting certain standard Cigna benefit plans and are used by medical directors and other health care professionals in making medical necessity and other coverage determinations. Please note the terms of a customer’s particular benefit plan document may differ significantly from the standard benefit plans upon which these coverage policies are based. For example, a customer’s benefit plan document may contain a specific exclusion related to a topic addressed in a coverage policy.

In the event of a conflict, a customer’s benefit plan document always supersedes the information in the coverage policy. In the absence of federal or state coverage mandates, benefits are ultimately determined by the terms of the applicable benefit plan document. Coverage determinations in each specific instance require consideration of:

1. The terms of the applicable benefit plan document in effect on the date of service
2. Any applicable laws and regulations
3. Any relevant collateral source materials including coverage policies
4. The specific facts of the particular situation

Coverage policies relate exclusively to the administration of health benefit plans. Coverage policies are not recommendations for treatment and should never be used as treatment guidelines.

This evidence-based medical coverage policy has been developed by eviCore, Inc. Some information in this coverage policy may not apply to all benefit plans administered by Cigna.

These guidelines include procedures eviCore does not review for Cigna. Please refer to the Cigna CPT code list for the current list of high-tech imaging procedures that eviCore reviews for Cigna.

CPT® (Current Procedural Terminology) is a registered trademark of the American Medical Association (AMA). CPT® five digit codes, nomenclature and other data are copyright 2017 American Medical Association. All Rights Reserved. No fee schedules, basic units, relative values or related listings are included in the CPT® book. AMA does not directly or indirectly practice medicine or dispense medical services. AMA assumes no liability for the data contained herein or not contained herein.
## Esophagastroduodenoscopy (EGD)

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>EGD-0: General Guidelines</td>
<td>3</td>
</tr>
<tr>
<td>EGD-1: Indications for EGD</td>
<td>3</td>
</tr>
<tr>
<td>EGD-2: Non-indications for EGD</td>
<td>10</td>
</tr>
</tbody>
</table>
EGD-0: General Guidelines

- These guidelines are for initial procedures unless otherwise stated; requests for follow-up should be forwarded for Medical Director Review.

EGD-1: Indications for EGD

- Dyspepsia/Upper Abdominal Symptoms
  - EGD indicated
    - New-onset symptoms in individuals ≥ 60 years of age.
    - Any age with presence of ANY of the following alarm symptoms:
      - Family history of UGI malignancy in a first-degree relative
      - Unintended weight loss > 5%
      - Anorexia
      - GI bleeding or iron-deficiency anemia
      - Dysphagia
      - Odynophagia
      - Persistent vomiting
      - Abnormal imaging study suggesting organic disease
      - Clinical suspicion of malignancy
      - A palpable mass or lymphadenopathy
    - Individuals < 60 years of age without alarm symptoms
      - EGD if failure of an initial “test and treat” approach for H. pylori or a trial of empiric therapy for 4 weeks with a proton pump inhibitor (PPI)
      *See Background and Supporting Information: Dyspepsia

- GERD (Gastro-esophageal reflux disease)
  - Indications for Endoscopy
    - ANY of the following symptoms suggestive of complicated disease:
      - Dysphagia or odynophagia
      - Unintentional weight loss > 5%
      - Hematemesis
      - Evidence of GI bleeding or anemia
      - Multiple risk factors for Barrett’s esophagus (see section on Barrett’s esophagus)
      - Failure to respond to appropriate anti-secretory medical therapy
      - Finding of a mass, stricture, or ulcer on imaging studies (CT, MRI, US)
      - Persistent vomiting (≥ 7 days)
      - Evaluation of individuals before, or with recurrent symptoms after, endoscopic or surgical anti-reflux procedures
      - Placement of wireless pH monitoring
      - Repeat EGD in individuals found to have erosive esophagitis (Los Angeles Classification B, C, or D) after an 8 - 12 week course of PPI therapy to exclude Barrett’s esophagus or dysplasia
      - Non-cardiac chest pain (cardiac etiology has been ruled out), after a 4 week trial of twice daily PPI therapy
      *See Background and Supporting Information: GERD
Barrett’s Esophagus

Screening for Barrett’s Esophagus is appropriate in the following settings:

- **Males with:**
  - > 5 years of symptoms and/or weekly symptoms (e.g. gastroesophageal reflux disease symptoms, including heartburn, dysphagia, regurgitation, sometimes unexplained chest pain thought to be reflux-induced) AND
  - 2 or more of the following risk factors:
    - Age > 50 years
    - Caucasian race
    - Presence of central obesity (waist > 102 cm. or 40 in., waist-hip ratio of > 0.9)
    - Current or past history of smoking
    - Confirmed history of Barrett’s esophagus or esophageal adenocarcinoma in first degree relative

- **Females**
  - Given the lower risk of esophageal adenocarcinoma in females with chronic GERD, screening for females is generally not recommended
  - Screening can be considered in individual cases if 3 or more risk factors are present, including:
    - Age > 50 years
    - Caucasian race
    - Chronic and/or frequent GERD
    - Central obesity (waist circumference > 88cm or 34.5 in. or waist-hip ratio of > 0.8
    - Current or past smoking
    - Confirmed family history of Barrett’s Esophagus or Esophageal adenocarcinoma in a first degree relative.

If initial endoscopy suggests Barrett’s Esophagus (defined as an extension of salmon-colored mucosa into the tubular esophagus ≥ 1cm) and biopsy is negative for intestinal metaplasia:

- Endoscopy can be repeated in 1-2 years to rule out Barrett’s Esophagus
  - See Background and Supporting Information: Barrett’s Esophagus

If initial endoscopy is negative for Barrett’s Esophagus, repeating endoscopy to evaluate for the presence of Barrett’s Esophagus is NOT indicated.

Surveillance for Barrett’s Esophagus

- Initial pathology findings suggestive of, or indefinite for, dysplasia of any grade should be confirmed by a second pathologist. Preferably, at least one of the pathologists should have specialized expertise in gastrointestinal pathology. Subsequent treatment and follow-up requests do not require review by two pathologists.
- If no dysplasia on initial screening EGD:
  - Repeat examinations in 3-5 year intervals
  - See Background and Supporting Information: Barrett’s Esophagus
If pathology is indefinite for dysplasia:
- Repeat EGD in 3-6 months
If indefinite dysplasia persists:
- Repeat EGD every 12 months
If pathology shows low-grade dysplasia:
- Repeat endoscopy in 8-12 weeks under maximum acid suppression (PPI twice daily)
- If LGD persists, and endoscopic surveillance is chosen rather than eradication therapy, surveillance EGD can be performed every 6 months times two, then annually, unless there is reversion to nondysplastic Barrett’s
If pathology shows high-grade dysplasia:
- Endoscopic therapy
  - NOTE: Active therapy with the intention of endoscopic ablation is at the discretion of the endoscopist
Post-Ablative Therapy for Barrett’s Esophagus (following complete eradication of Barrett’s epithelium, defined as 2 consecutive negative EGD’s)
- If treated for high-grade dysplasia or intramucosal adenocarcinoma:
  - EGD every 3 months for 1 year, then every 6 months for 1 year, then annually
- If treated for low-grade dysplasia:
  - If complete eradication is achieved, an initial post-eradication EGD can be performed at 3-6 months. Surveillance by EGD is then continued every year for 2 years, and then every 3 years thereafter
  - If complete eradication is not achieved, then surveillance EGD is every 6 months for 1 year after the last endoscopy, then annually for 2 years, then every 3 years thereafter
- If recurrence of metaplasia or dysplasia is discovered:
  - Refer to pre-treatment guidelines

Gastric Ulcer
- Surveillance EGD is indicated for ANY of the following:
  - In individuals whose gastric ulcer appears endoscopically suspicious for malignancy even if biopsies are benign, after 8-12 weeks of treatment (PPI and/or H. pylori treatment)
  - In individuals who remain symptomatic despite an appropriate course of therapy (PPI and/or H. pylori treatment) to rule out refractory peptic ulceration, non-peptic benign etiologies, and occult malignancy
  - In individuals with gastric ulcer who did not undergo biopsy at the index endoscopy for any reason (e.g., active bleeding, coagulopathy, etc.)
  - In individuals diagnosed with gastric ulcer via radiologic imaging
  - In individuals with giant ulcers (>3cm) to document healing
  - In individuals with refractory ulcers (fail to heal despite 8-12 weeks in therapy). Surveillance EGD can be continued until healing is documented.
  - See Background and Supporting Information: Gastric Ulcer
- **Duodenal Ulcer**
  - Surveillance EGD can be considered for ANY of the following:
    - In individuals with duodenal ulceration who experience persistent symptoms despite an appropriate course of therapy, specifically to rule out refractory peptic ulcers and ulcers with non-peptic etiologies
      - (symptoms include dyspepsia, epigastric pain sometimes with radiation to the back or to the right or left upper quadrants, nausea and/or vomiting, early satiety, belching, fullness)
    - Giant duodenal ulceration (> 2 cm) to document healing
    - Refractory ulcers: Surveillance EGD until healing is documented
      - See **Background and Supporting Information: Duodenal Ulcer**

- **Gastric Intestinal Metaplasia (GIM)**
  - Surveillance EGD for persons with GIM who are at increased risk of gastric cancer due to Asian heritage or family history of gastric cancer. Intervals have not been established
  - GIM with high-grade dysplasia:
    - Immediately, and then every 6 months
  - GIM with low-grade dysplasia:
    - Every 12 months
  - GIM identified in both the antrum and body of the stomach:
    - Every 3 years

- **Evaluation of dysphagia or odynophagia**
- **Persistent vomiting of unknown cause**
- **GI Bleeding**
  - To assess acute injury after caustic ingestion
  - Screening for esophageal cancer after caustic ingestion:
    - EGD every 2 years beginning 10 years after caustic ingestion insult
  - Other diseases in which the presence of UGI pathology would modify other planned management, such as persons with a history of ulcer disease scheduled for organ transplantation, anticipation of long-term anticoagulation, or NSAID therapy
  - Persons with cirrhosis/portal hypertension to assess or treat esophageal varices
  - To assess diarrhea in individuals suspected of having small bowel disease (e.g., celiac)
    - EGD with small bowel biopsy indicated in individuals with chronic diarrhea or suspected malabsorption after inconclusive evaluation including colonoscopy with biopsy, or in individuals with positive celiac serology
      - EXCEPTION: HIV and Graft-vs.-Host Disease: in the absence of a diagnosis on flexible sigmoidoscopy, an EGD can be performed
    - EGD with small bowel biopsy can be repeated in 2 years to assess for mucosal healing in celiac disease, or with recurrent symptoms despite 6 months of a gluten-free diet
Removal of foreign bodies
Removal or endoscopic treatment of known lesions
Placement of a feeding or drainage tube
Dilation and stenting of stenotic lesions
Management of achalasia
Diagnosis and management of Eosinophilic Esophagitis
Intra-operative evaluation of anatomic reconstructions
For confirmation and specific histologic diagnosis of radiologically demonstrated lesions (*See Non-indications)
For sampling of tissue or fluid when clinically appropriate
Gastric polyp treatment and follow-up
- Adenomatous gastric polyps
  - Endoscopy 1 year after resection, followed by surveillance EGD every 3-5 years
  - Hyperplastic gastric polyps resected, with and without dysplasia
    - Repeat EGD in 1 year
      - If polyp persists or dysplasia is present, and it is resected, repeat EGD in 1 year
      - If there is no residual polyp, then no further follow-up
Pernicious anemia
- EGD should be performed within 6 months of the diagnosis of pernicious anemia with follow-up examinations only for the development of new symptoms
GIST (Gastrointestinal Stromal Tumors)
- Annual EUS/EGD surveillance of GISTs smaller than 2 cm if surgical resection is not performed, to determine progression of size or changes in echo features
Gastric Neuroendocrine Neoplasms
- After resection, can be re-evaluated every 6-12 months for the first 3 years, then annually
Mucosa-Associated Lymphoid Tissue Lymphoma (MALT)
- Follow-up after successful H. pylori treatment
  - Endoscopy up to every 3 months for the first 2 years and then up to every 6 months thereafter (optimal surveillance interval has not been defined)
Evaluation and treatment of gastric outlet obstruction
Bariatric Surgery
- Pre-operative endoscopic evaluation of the bariatric surgery individual
- Post-operative endoscopic evaluation for the following symptoms:
  - Nausea or vomiting
  - Abdominal pain
  - Post-op GERD
  - Dumping Syndrome
- Diarrhea and nutritional deficiencies
- Endoscopic intervention for treatment of stenosis, removal of foreign body material, bezoars, management of fistulae and leaks
- Bleeding or anemia
- Failure to lose weight or to regain weight after an initial post-operative weight loss

Known Esophageal Malignancy
- Endoscopy as felt clinically indicated by the ordering provider for the management of complications, treatment, evaluation of ongoing or new symptoms, and surveillance for recurrence

Known Gastric Malignancy
- EGD as felt clinically indicated by the ordering provider for the endoscopic management of complications, ongoing or new symptoms, treatment, and surveillance for recurrence

Known Duodenal or Small Bowel Malignancy
- EGD as felt clinically indicated by the ordering provider for the management of complications, treatment, ongoing or new symptoms, and surveillance for recurrence

Genetic Syndromes
- Lynch Syndrome
  - For all mutations (MLH1/MSH2, MSH6/PMS2)
    - EGD beginning at age 30 years, every 2-3 years
- Juvenile Polyposis Syndrome
  - EGD at age 12 years. If polyps are present, repeat yearly. If no polyps, repeat every 2 years.
- Peutz-Jeghers Syndrome
  - EGD at age 8 years. If polyps present, can be repeated every 3 years. If no polyps, repeat at age 18 years, then every 3 years, or earlier if any symptoms occur.
- Hereditary Gastric Cancer (Hereditary Diffuse Gastric Cancer-HDGC Syndrome)
  - EGD beginning 10 years before the earliest cancer in the family, up to every 6 months.
- BMMRD (Biallelic Mismatch Repair Deficiency)
  - EGD annually, beginning at age 8 years
- Tylosis (Rare autosomal dominant disorder characterized by hyperkeratosis of the palms and feet, with lifetime risk of esophageal cancer of 40% in Americans)
  - Annual EGD beginning at age 30 years or at the onset of recognition of the disease
- Cowden Syndrome (PTEN Hamartoma Tumor Syndrome)
  - EGD beginning at age 15 years
  - Repeat surveillance every 2 years
  - If polyps present, follow-up EGD at the discretion of the endoscopist, depending on the number of polyps, as felt indicated.
- Classical Familial Polyposis (FAP)/Attenuated FAP
  - EGD Beginning at age 25 years (before 20 years of age if patient has undergone a colectomy prior to the age of 20 years)
  - See **Spigelman Stage** for follow-up imaging intervals
- MAP (MUTYH-Associated Polyposis)
  - EGD beginning at age 30 years
  - See **Spigelman Stage** for follow-up imaging intervals
- Spigelman Stage
  - Follow-up imaging depending on Spigelman Stage of duodenal polyposis as follows (using point system):

<table>
<thead>
<tr>
<th>Polyps</th>
<th>1 Point</th>
<th>2 Points</th>
<th>3 Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
<td>&lt;4</td>
<td>5-20</td>
<td>&gt;20</td>
</tr>
<tr>
<td>Size</td>
<td>0-&lt;4</td>
<td>5-10</td>
<td>&gt;10</td>
</tr>
<tr>
<td>Histology</td>
<td>Tubular</td>
<td>Tubulovillous</td>
<td>Villous</td>
</tr>
<tr>
<td>Dysplasia</td>
<td>Mild</td>
<td>Moderate</td>
<td>Severe</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Spigelman Stage</th>
<th>Total Points</th>
<th>Surveillance Interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>0</td>
<td>Every 4 years</td>
</tr>
<tr>
<td>I</td>
<td>≤ 4</td>
<td>Every 2-3 years</td>
</tr>
<tr>
<td>II</td>
<td>5-6</td>
<td>Every 1-3 years</td>
</tr>
<tr>
<td>III</td>
<td>7-8</td>
<td>Every 6-12 months</td>
</tr>
<tr>
<td>IV</td>
<td>9-12</td>
<td>Every 3-6 months (if surgery not chosen)</td>
</tr>
</tbody>
</table>
**EGD-2: Non-indications for EGD**

- Symptoms that are considered functional in origin:
  - EGD may be done ONCE to rule out organic disease especially if symptoms are unresponsive to therapy, or recur that are different from the original symptoms

- Metastatic adenocarcinoma of unknown primary site when the results will not alter management

- To evaluate radiologic findings for:
  - Asymptomatic or uncomplicated sliding hiatal hernia
  - Uncomplicated duodenal ulcer that has responded to therapy
  - Deformed duodenal bulb when symptoms are absent or respond to therapy

- Sequential or periodic EGD for surveillance of malignancy in individuals with:
  - Gastric atrophy
  - Pernicious anemia (See above indication for pernicious anemia)
  - Fundic gland polyps
  - Previous gastric operations for benign disease
  - Surveillance of healed benign disease such as esophagitis and gastric or duodenal ulcer

- Endomicroscopy
  - At the current time, endomicroscopy is considered investigational and experimental

**Background and Supporting Information**

- Dyspepsia/Upper abdominal symptoms
  - Studies comparing “test and treat” approach with endoscopy have reported no difference in symptom control, with most studies also showing increased cost with an “initial endoscopy” approach (ASGE). A potential advantage of negative endoscopy in the evaluation of dyspeptic individuals is a reduction in anxiety and an increase in individual satisfaction, yet there is little evidence to suggest significant improvement with outcomes by this approach (ASGE)
  - There is a significant difference in guidelines proffered by the ACG and ASGE. ACG guidelines (2017) establish the age for endoscopy with new symptoms at > 60 years, rather than 50 years for the ASGE, and in fact, do not recommend endoscopy even in the presence of alarm symptoms for most individuals < 60 years of age because of a low positive predictive value for detecting UGI malignancy in this age group

- Barrett’s Esophagus
  - If initial endoscopy is negative for Barrett’s Esophagus, repeating endoscopy to evaluate for the presence of Barrett’s Esophagus is NOT indicated
  - If initial examination shows BE but no dysplasia, follow-up endoscopy in one year is NOT indicated. Follow prescribed guidelines
GERD
- If the individual’s history is consistent with typical or uncomplicated GERD, an initial trial of empiric medical therapy is appropriate before consideration of endoscopy in most individuals.
- Endoscopy is not indicated for the evaluation of individuals with suspected extra-esophageal manifestations of GERD who present with symptoms such as choking, coughing, asthma, hoarseness, laryngitis, chronic sore throat, or dental erosions.
- (ASGE) Given that the majority of these individuals will not have endoscopic evidence of erosive esophagitis, especially when taking empiric medical therapy for GERD, the routine use of EGD to evaluate extra-esophageal symptoms of GERD is NOT recommended.
- There is a paucity of outcomes research to suggest that early or even once-in-a-lifetime EGD has a favorable effect on the management, course, or health-related quality of life of individuals with typical symptoms of GERD without alarm features (ASGE).

Gastric Ulcer
- The rationale for surveillance has been that some individuals with endoscopically benign-appearing gastric ulcerations may eventually be shown to have gastric cancer. However, the efficacy of surveillance is unclear. An analysis of the Clinical Outcomes Research Initiative database found that approximately 25% of individuals diagnosed with gastric ulceration undergo repeat endoscopy despite the fact that multiple studies have found limited yield in identifying malignancy with surveillance endoscopy (ASGE).

Duodenal Ulcer
- More than 90% of duodenal ulcers heal with 4 weeks of PPI therapy.
References


