EviCore
By EVERNORTH

Gastroenterology Tip Sheet

A common reason for the denial of a requested procedure is that the information submitted to EviCore is incomplete or inadequate for our medical reviewers to make an informed decision regarding the appropriateness of the procedure. This tip sheet is designed to inform requesters of the type of information EviCore reviewers need to adjudicate a case.

This document is intended as a general guide and does not replace the clinical guidelines. Examples are illustrative, and submitted documentation should reflect the patient's actual clinical course.

More detailed information is available in our evidence-based guidelines:
Gastroenterology Guidelines | EviCore by Evernorth
(Use the table of contents to navigate to condition-specific guidelines or use CTRL+F to search by clinical indication or symptom.)

General Background Information

Specific elements of a patient's medical record that are commonly required to establish medical necessity include, but are not limited to:

- Recent virtual or in-person clinical evaluation, including a detailed history and physical examination
- Specific purpose of the requested study (clinical indication)
- Details of all conservative care to date, including duration, frequency and outcome
- Relevant procedure reports
- Relevant pathology reports
- Relevant laboratory studies
- Relevant imaging studies
- Reports from other providers involved in the treatment of the condition

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Key Clinical Details for Common Gastroenterology Requests

(The following elements should be documented in the clinical record and included in submitted materials, as applicable.)

EGD (Esophagogastroduodenoscopy)

- Specific indication for the EGD
- Recent office visit notes with current symptoms, duration, relevant history and exam findings, and alarm symptoms, if present
- Relevant treatment trials, including medication, frequency, duration, and outcome
    - **Example of complete documentation: Took omeprazole once daily for 8 weeks, but heartburn persisted.**

- Prior EGD or capsule endoscopy reports and pathology results
- Relevant laboratory, imaging, specialty evaluation, and other diagnostic results
- Relevant medical history, comorbidities, and risk factors

Capsule Endoscopy

Crohn's Disease

- Clinical features consistent with Crohn's Disease
    - Example: Diarrhea, abdominal pain
- Prior imaging and endoscopic procedure results

Gastrointestinal Bleeding

- Specific indication for the capsule endoscopy
- Recent office visit notes with current symptoms, duration, relevant history and exam findings
- **Suspected Crohn's disease:** Supporting clinical features and relevant laboratory, imaging, endoscopic, or pathology results
- **Suspected GI bleeding:** Description of bleeding, relevant laboratory results, and prior evaluation
- Prior EGD and colonoscopy reports
- Other relevant GI evaluation supporting the need for small-bowel visualization

Diagnostic or Therapeutic Colonoscopy

- Specific indication for the colonoscopy
- Recent office visit notes with current symptoms, duration, relevant history and exam findings, and alarm symptoms, if present
- **Polyp surveillance:** Dates and reports of all prior colonoscopies, including findings and polyp number, size, and pathology/type
- **Chronic diarrhea:** Duration and relevant laboratory, stool study, and prior evaluation results
- **Iron deficiency anemia or GI bleeding:** Relevant laboratory results, description of bleeding, and prior evaluation
- Relevant imaging or other diagnostic results
- **Early repeat for inadequate bowel preparation:** Prior colonoscopy report with the BBPS score or description of inadequate prep
- Relevant family history, genetic syndrome, or genetic testing results

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Additional information and resources can be found here:

Provider's Hub | EviCore by Evernorth

Provider Resources | EviCore by Evernorth