CIGNA MEDICAL COVERAGE POLICIES- GASTROINTESTINAL ENDOSCOPIC PROCEDURE

Esophagogastroduodenoscopy (EGD)

Effective Date: November 05, 2026

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.

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Esophagogastroduodenoscopy (EGD) Guidelines

Guideline Page

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General Guidelines (EGD-0)

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- The Gastrointestinal Endoscopy Program applies an evidence-based approach to evaluate the most appropriate care for each individual. This evaluation requires submission of medical records pertinent to the treatment and/or services being requested by the provider.
- If the medical records provided do not provide sufficiently detailed information to understand the individual's current clinical status, then the medical necessity for the request cannot be established and the request cannot be approved.
- A pertinent clinical evaluation since the new onset or change in symptoms is required prior to considering gastrointestinal endoscopy services:
  - A pertinent clinical evaluation should include the following:
    - A detailed history and physical examination
    - Appropriate laboratory studies
    - Pertinent imaging studies
    - Pathology reports
    - Procedure reports
    - Reports from other providers participating in the treatment of the relevant condition
  - For an established individual, a meaningful technological contact (telehealth visit, telephone call, electronic mail or messaging) since the onset or change in symptoms can serve as a pertinent clinical evaluation
- A recent clinical evaluation may be deferred if the individual is undergoing guideline-supported, scheduled follow-up imaging or other designated procedural evaluation. Exceptions due to routine surveillance indications are addressed in the applicable condition-specific guideline sections.
- The Gastrointestinal Endoscopy Program reserves the right to change and update the policy as new evidence emerges. The policy undergoes a formal review at least annually. The policy is based upon major national and international association and society guidelines and criteria, peer-reviewed literature, major treatises, as well as input from health plans, and practicing academic and community-based physicians.
- This policy is not intended to supersede or replace sound medical judgment, but instead, should facilitate the identification of the most appropriate treatment given the individual's clinical condition. This guideline is written to cover most gastrointestinal endoscopic indications. However, the guideline may not be applicable in certain clinical circumstances. Physician judgment may override the policy. Clinical decisions, including treatment decisions, are the responsibility of the individual and his/her

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provider. Clinicians are expected to use independent medical judgment, which takes into account the clinical circumstances to determine individual management decisions

- All time intervals in this guideline refer to upper endoscopy, unless otherwise stated.
- Requests for Open-Access Endoscopy must meet criteria according these guidelines.
- Endomicroscopy
  - At the current time, endomicroscopy is considered investigational and experimental
- EGD-included Procedures
  - All requests for an EGD are evaluated based on whether the request meets guideline criteria for an EGD.
  - Endoscopic Ultrasound
    - An endoscopic ultrasound (EUS) is a specialized procedure using a scope with ultrasound to create images of the digestive tract lining or other organs, such as the liver or pancreas.
    - The coding for an EUS includes an EGD[32]. The routine unbundling of EUS into separate codes for EUS and diagnostic EGD is not supported.
    - EUS is not a delegated service at this time.
  - Endoscopic retrograde cholangiopancreatography
    - Endoscopic retrograde cholangiopancreatography (ERCP) is a procedure to diagnose and treat problems in the liver, gallbladder, bile ducts, and pancreas combining x-ray and the use of an endoscope.
    - Performing ERCP does not automatically require a separate EGD service. Automatically billing separate codes for ERCP and diagnostic EGD is not supported. Requests for EGD to be performed at the same time as ERCP will be adjudicated based on whether the request meets guideline criteria for a separate EGD.
    - ERCP is not a delegated service at this time.
- New and Emerging Technologies
  - Requests related to new and emerging technologies will be considered to determine whether they meet evidence-based guidelines.
    - If a specific CPT code does not exist for the new technology, the CPT code submitted with the request will be considered based on its typical procedure application.
  - Procedures that are inconsistent with established clinical standards or are requested solely for data collection and not for direct clinical management, are not supported.
- State and federal legislations may need to be considered in the review of gastrointestinal endoscopy requests.

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Health Equity Considerations

Health equity is the highest level of health for all individuals; health inequity is the avoidable difference in health status or distribution of health resources due to the social conditions in which individuals are born, grow, live, work, and age. Social determinants of health are the conditions in the environment that affect a wide range of health, functioning, and quality of life outcomes and risks. Examples include the following: safe housing, transportation, and neighborhoods; racism, discrimination, and violence; education, job opportunities, and income; access to nutritious foods and physical activity opportunities; access to clean air and water; and language and literacy skills.

Evidence Discussion

Advances in endoscopic imaging modalities continue to refine the diagnostic yield and therapeutic decision-making in gastrointestinal (GI) diseases. Two emerging technologies are confocal laser endoscopy and endoscopic ultrasound (EUS). Both have shown increasing clinical value in diagnostic and interventional roles across a spectrum of GI pathologies. [6,32]

Confocal laser endomicroscopy (CLE) enables in vivo histologic assessment during endoscopy, providing real time cellular imaging of mucosal surfaces. CLE has demonstrated clinical utility in several areas, including surveillance of Barrett's esophagus, assessment of inflammatory bowel disease (IBD), and detection of gastric intestinal metaplasia and early gastric cancer. However, CLE's integration into routine clinical practice should be supported by structured training and validated image interpretation criteria.[6]

In parallel, endoscopic ultrasound (EUS) continues to serve as a cornerstone in the evaluation and staging of GI and pancreatobiliary diseases. In a 2025 update, EUS indications were further refined and stratified based on diagnostic value and therapeutic impact.[32]

Both CLE and EUS represent high-impact tools when applied under appropriate clinical indications. Their integration into endoscopic protocols should be governed by evidence-based criteria. Use of these technologies should be periodically reviewed and updated as further evidence and consensus guidelines evolve.[6,32]

Dyspepsia/Upper Abdominal Symptoms (EGD-1.1)

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Dyspepsia is defined by the American College of Gastroenterology (ACG) and Canadian Association of Gastroenterology (CAG) as predominant epigastric pain lasting **at least one month**. This can be associated with any other upper gastrointestinal symptom such as epigastric fullness, nausea, vomiting, early satiety, or heartburn, provided epigastric pain is the individual's primary concern.

EGD is medically necessary in individuals with dyspepsia and ONE of the following:

- New-onset symptoms in individuals ≥60 years of age
- Individuals <60 years of age without red flag symptoms for EITHER of the following:
  - Failure of a trial of empiric acid suppression therapy for 4 weeks with daily dosed proton pump inhibitor (PPI)* OR appropriately dosed potassium-competitive acid blockers (PCABs)

    Note:

    *Proton pump inhibitor (PPI) should be taken daily unless there is a documented history of allergy or intolerance to PPI use (in which case a different acid suppression therapy should be tried)

  - Failure after an initial "test and treat" approach for H. pylori
    - Post-treatment eradication of H.pylori should be confirmed 4 weeks after therapy completion using non-invasive methods (e.g., urea breath test or fecal antigen test) OR
    - Invasive biopsy-based testing to ensure H.Pylori eradication can be considered in high-risk clinical scenarios (examples: large gastric ulcers or gastric MALT lymphoma).
- Any age with presence of ANY of the following red flag symptoms associated with dyspeptic or upper abdominal symptoms:
  - Family history of any of the following upper gastrointestinal (UGI) malignancies in a first-degree relative:
    - Esophageal
    - Gastric
      - For asymptomatic individuals with a family history of gastric cancer, see: **Gastric Intestinal Metaplasia (GIM) (EGD-1.6)**
    - Duodenal

- Documentation of unintentional weight loss of ≥10 lbs. or ≥5% of body weight over 6 months or less, without an identifiable reason
- GI bleeding presumed to be upper gastrointestinal (UGI) in origin by ONE of the following:
  - History and/or physical examination (e.g., black tarry stool/melena, hematemesis; not hemorrhoidal bleeding)
  - Laboratory data (e.g., elevated BUN associated with GI blood loss, positive fecal occult blood, FIT testing as may be included in Cologuard®)
- Iron-deficiency anemia presumed to be UGI in origin, as manifested by low hematocrit or hemoglobin AND ONE of the following:
  - Low serum iron
  - Low serum ferritin (≤45 ng/mL or < lab lower limit if higher than 45 ng/mL)
  - Elevated serum iron binding capacity
  - Low serum transferrin saturation
- Documentation of dysphagia
- Odynophagia characterized by chest pain on swallowing
- Persistent vomiting of unknown cause ≥7 days and/or clinical suspicion of cyclic vomiting syndrome
- Abnormal imaging study suggesting organic disease in ONE of the following:
  - Esophagus
  - Stomach
  - Duodenum
- Clinical suspicion of malignancy as evidenced by ONE OR MORE of the following:
  - Abdominal pain with associated weight loss
  - GI bleeding
  - Anorexia
  - Cachexia
  - A palpable intra-abdominal mass or lymphadenopathy noted on physical examination

- Symptoms that are considered functional in origin:
  - EGD is medically necessary once to rule out organic disease especially if symptoms are unresponsive to therapy, or recur that are different from the original symptoms
- For isolated belching, bloating, and/or abdominal distention, see: **General and Therapeutic EGD (EGD-1.7)**.

Background and Supporting Information

- Dyspepsia/Upper abdominal symptoms

- "Test and treat" approach is a strategy for addressing dyspepsia in which H. pylori is investigated and treated if found. If dyspepsia is resolved with this approach, further diagnostics may not be medically necessary.
- 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. 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.

The following approaches were offered by the American Gastroenterological Association (AGA) as Best Practice Advice in evaluation and management of belching, abdominal bloating, and distension:

- Clinical history and physical examination findings and impedance pH monitoring can help to differentiate between gastric and supra-gastric belching.
- Rome IV criteria should be used to diagnose primary abdominal bloating and distention.
- Carbohydrate enzyme deficiencies may be ruled out with dietary restriction and/or breath testing. In a small subset of at-risk individuals, small bowel aspiration or biopsy may be warranted.
- Serologic testing may rule out celiac disease in individuals with bloating and, if serologies are positive, a small bowel biopsy should be done to confirm the diagnosis.
- Abdominal imaging and upper endoscopy should be restricted to individuals with alarm features, recent worsening symptoms, or an abnormal physical examination.
- Gastric emptying studies should not be ordered routinely for bloating and distention, but may be considered if nausea and vomiting are present.
- Whole gut motility and radiopaque transit studies should be restricted to individuals with refractory lower GI symptoms and suspected neuromyopathic conditions.
- When abdominal bloating and distention may be related to constipation or difficult evacuation, anorectal physiology testing is suggested to rule out a pelvic floor disorder.

Evidence Discussion

Dyspepsia/Upper Abdominal Symptoms

Endoscopy remains an invasive procedure that is relatively expensive, despite its value in differentiation between organic and functional etiologies of dyspepsia. Thus selective use in high-risk individuals is the most cost-effective approach.

The 2017 joint guidelines from the American College of Gastroenterology (ACG) and the Canadian Association of Gastroenterology (CAG) recommended that individuals aged

60 years or older that presented with dyspeptic symptoms should first undergo an upper gastrointestinal endoscopy (EGD) to exclude organic pathology. For individuals under the age of 60, upper gastrointestinal endoscopy is not medically necessary, unless the individual fails non-invasive management or alarm symptoms arise.[2]

The ACG/CAG guidelines recommended a non-invasive test-and-treat strategy for Helicobacter pylori. If the test is positive, eradication therapy should be initiated. If the test is negative or symptoms persist after eradication, an empiric trial of proton pump inhibitor (PPI) therapy is advised. [2]

The American Society for Gastrointestinal Endoscopy (ASGE) supports a similar approach, emphasizing that EGD should be reserved for individuals with dyspepsia who are unresponsive to initial therapy or who present with alarm symptoms such as weight loss, anemia, or dysphagia. EGD is particularly valuable for identifying mucosal pathology, peptic ulcer disease, malignancy, or other structural lesions.[15]

Newer pharmacologic options, such as potassium-competitive acid blockers (PCABs), have shown promise in the treatment of dyspepsia. A recent AGA Clinical Practice Update supports the integration of PCABs (vonoprazan) as an alternative to proton pump inhibitors (PPIs), particularly in individuals with persistent symptoms despite traditional therapy. PCABs have demonstrated superior acid suppression, faster onset of action, and potential for improved outcomes for H. pylori eradication and functional dyspepsia.[9]

Individuals presenting with epigastric pain suggestive of pancreatic or biliary disease (e.g., pain radiating to the back, jaundice, elevated liver enzymes) should undergo cross-sectional (abdominal ultrasound, computed tomography [CT], or magnetic resonance imaging [MRI] imaging before esophagogastroduodenoscopy [EGD]). Cross sectional imaging modalities like CT and MRI provide comprehensive visualization of the pancreas, biliary tree, and surrounding structures. The American College of Gastroenterology (ACG) endorse the use of cross-sectional imaging studies to evaluate individuals with suspected pancreatic or biliary disorders. Implementing cross-sectional imaging before EGD in these individuals ensures a more accurate diagnosis and appropriate management.[2,101,114]

GERD (Gastro-esophageal reflux disease) (EGD-1.2)

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Gastroesophageal reflux disease (GERD) is defined by the American College of Gastroenterology (ACG) as the presence of symptoms or mucosal damage resulting from the abnormal reflux of gastric contents into the esophagus. The two primary categories of GERD are the following: **typical GERD**, which includes hallmark symptoms such as heartburn and/or regurgitation, and **atypical GERD**, which encompasses less common manifestations such as chronic cough, hoarseness, and chest pain.

Typical GERD

- EGD is medically necessary for typical GERD with EITHER of the following:
  - Failure to respond to ANY of the following:
    - An 8-week trial of a once-daily empiric proton pump inhibitors (PPIs)*
    - A 4-week trial of a twice-daily PPIs*
    - A trial of appropriately dosed potassium-competitive acid blockers (PCABs)

    Note: *Proton pump inhibitor (PPI) should be taken daily unless there is a documented history of allergy or intolerance to PPI use (in which case a different acid suppression therapy should be tried)
  - Return of typical GERD symptoms after discontinuation of provider-directed, appropriate anti-secretory medical therapy with ANY of the following:
    - An 8-week trial of a once-daily empiric proton pump inhibitors (PPIs)*
    - A 4-week trial of a twice-daily PPIs*
    - A trial of appropriately dosed potassium-competitive acid blockers (PCABs)
- EGD is medically necessary if ANY of the following accompany GERD symptoms:
  - Documentation of dysphagia
  - Odynophagia characterized by chest pain on swallowing
  - Documentation of unintentional weight loss of ≥10 lbs. or ≥5% of body weight over 6 months or less, without an identifiable reason
  - Hematemesis
  - GI bleeding presumed to be UGI in origin by ONE of the following:
    - History and/or physical examination (e.g., black tarry stool/melena, hematemesis; not hemorrhoidal bleeding)

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        - Laboratory data (e.g., elevated BUN associated with GI blood loss, positive fecal occult blood, FIT testing as may be included in Cologuard®)
    - Iron-deficiency anemia presumed to be UGI in origin, as manifested by low hematocrit or hemoglobin AND ONE of the following:
        - Low serum iron
        - Low serum ferritin (≤45 ng/mL or <lab lower limit if higher than 45 ng/mL)
        - Elevated serum iron binding capacity
        - Low serum transferrin saturation
    - For concerns related to Barrett's esophagus (see: **Barrett's Esophagus (EGD-1.3)**)
    - Persistent vomiting of unknown cause ≥7 days

Atypical GERD

Chest Pain Attributed to Reflux (Non-cardiac Chest Pain)

- If accompanied by typical GERD symptoms, refer to typical GERD indications above
- If not accompanied by typical GERD symptoms,
    - Diagnostic testing should be based on a structured assessment of cardiac risk
        - ECG is required to assess both acute and stable chest pain before an EGD may be considered.
    - EGD is medically necessary for an individual referred from a cardiologist for GI work-up
    - Additional testing is not required, but may include:
        - Functional testing (exercise ECG, stress echocardiography, stress nuclear myocardial perfusion [MPI], or stress cardiac magnetic resonance [CMR] imaging) or anatomic testing (coronary computed tomography angiography [CCTA]),
        - Chest radiographs may not lead to a diagnosis that requires intervention, and its use should be guided by clinical suspicion

Extra-Esophageal Reflux

- Extra-esophageal symptoms of GERD include symptoms of chronic cough, throat-clearing, hoarseness, globus sensation, asthma, and/or laryngitis
- For extra-esophageal reflux accompanied by typical GERD symptoms (heartburn, regurgitation), EGD is medically necessary when:
    - There is failure to respond to an 8-12 week trial of PPI therapy twice daily
- For extra-esophageal reflux not accompanied by typical GERD symptoms, EGD is medically necessary for ANY of the following:

- Evaluation has been performed by the appropriate specialty (e.g., ENT, pulmonary, or allergy evaluation as indicated) OR
- There is failure to respond to an 8-12 week trial of PPI therapy twice daily

Additional Indications

- Evaluation of individuals who are PPI-dependent* and being considered for endoscopic or surgical anti-reflux procedures (e.g., Nissen fundoplication)

Note:

*Proton pump inhibitor (PPI) should be taken daily unless there is a documented history of allergy or intolerance to PPI use (in which case a different acid suppression therapy should be tried)

- Evaluation of individuals with recurrent symptoms after endoscopic or surgical anti-reflux procedures
- Placement of wireless pH monitoring
- One-time 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

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Note:

*Proton pump inhibitor (PPI) should be taken daily unless there is a documented history of allergy or intolerance to PPI use (in which case a different acid suppression therapy should be tried)

- 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

Background and Supporting Information

- GERD
  - Individual choice to defer a trial of physician-directed acid suppression therapy, in the absence of known drug intolerance or contraindication, is not of itself an indication to perform upper endoscopy.
  - 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 medically necessary 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.

- 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 medically necessary.
  - See: **GERD (Gastro-esophageal reflux disease) (EGD-1.2)** for specific instances in which evaluation of extra-esophageal symptoms with EGD is medically necessary
- 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 red flag symptoms.

Evidence Discussion

Gastroesophageal reflux disease (GERD) is a common condition characterized by the reflux of stomach contents into the esophagus, leading to symptoms or complications. **Typical symptoms** include heartburn and regurgitation, which are usually sufficient for a presumptive diagnosis and can be managed with proton pump inhibitors (PPIs). PPIs remain the first-line treatment, but potassium-competitive acid blockers (PCABs), such as vonoprazan, offer more potent acid suppression and may be beneficial in severe erosive esophagitis. **Atypical or extraesophageal symptoms**—such as chronic cough, hoarseness, asthma-like symptoms, and non-cardiac chest pain—require further evaluation, especially in the absence of classic symptoms.[9,11-13]

Alarm symptoms such as dysphagia, odynophagia, weight loss, gastrointestinal bleeding, anemia, and persistent vomiting indicate the need for esophagogastroduodenoscopy (EGD) to rule out complications like strictures, Barrett's esophagus, or malignancy.[11-13]

Individuals who are PPI dependent and are being considered for surgical or endoscopic anti reflux procedures would need an EGD preoperatively to assess anatomy and rule out other organic disease. Also, individuals who have recurrent symptoms after anti reflux procedures would need an EGD to rule out any complications that arise due to the anti reflux procedure.[11-13]

One-time EGD can be considered in individuals with functional symptoms in order to rule out organic disease.[11-13]

Placement of wireless pH monitoring is an indication for EGD as some individuals have persistent symptoms despite treatment and pH monitoring may be necessary to prove the individual does indeed have reflux.[11-13]

Barrett's Esophagus (EGD-1.3)

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- **Screening** for Barrett's Esophagus
  - Screening is considered medically necessary for individuals with chronic GERD symptoms (defined as weekly symptoms for 5 or more years) AND at least 3 of the following risk factors:
    - Age ≥50 years
    - Caucasian race
    - Male sex
    - Obesity
    - History of tobacco smoking
    - Family history of a first-degree relative with Barrett's esophagus or esophageal adenocarcinoma
  - If non-invasive screening (e.g., esophageal sponge) is positive:
    - proceed with endoscopic and histologic confirmation of Barrett's esophagus
- **Surveillance** for Barrett's Esophagus
  - If initial endoscopic screening suggests Barrett's Esophagus (defined as an extension of salmon-colored mucosa into the tubular esophagus ≥1cm) and biopsy is negative for intestinal metaplasia:
    - One-time repeat endoscopy is considered medically necessary in 1-2 years to rule out Barrett's Esophagus
  - If endoscopic screening is negative for Barrett's Esophagus:
    - Repeat endoscopy to evaluate for the presence of Barrett's Esophagus is considered not medically necessary
  - In diagnosed Barrett's esophagus with no dysplasia on screening EGD (non-dysplastic Barrett's esophagus or NDBE):
    - Repeat EGD is considered medically necessary in 3 to 5 years
  - If findings are indefinite for dysplasia on screening EGD:
    - Repeat EGD is considered medically necessary within 6 months
      - If repeat EGD yields a diagnosis of non-dysplastic Barrett's epithelium (NDBE), follow surveillance intervals for NDBE
      - If repeat EGD yields a diagnosis of low-grade dysplasia, follow surveillance intervals for low-grade dysplasia
      - If repeat EGD continues to demonstrate Barrett's esophagus indefinite for dysplasia, continue surveillance annually

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- If findings reveal low-grade dysplasia on screening EGD, and it is elected to pursue endoscopic surveillance instead of treatment:
  - Repeat EGD is considered medically necessary at 6 and 12 months from diagnosis, then annually
- If treated for low-grade dysplasia:
  - EGD is considered medically necessary at 1 and 3 years following complete eradication, then every 2 years thereafter
- If treated for high-grade dysplasia, intramucosal carcinoma, or submucosal carcinoma:
  - EGD is considered medically necessary at 3, 6, 12, 18, and 24 months following complete eradication, then annually thereafter
- If recurrence of metaplasia or dysplasia is discovered:
  - Refer to the surveillance for Barrett's esophagus guidelines above

Background and Supporting Information

- Sleeve gastrectomy may contribute to altered esophageal physiology and increased reflux exposure, potentially elevating the risk for Barrett's esophagus and esophageal adenocarcinoma, even in the absence of GERD symptoms. Individualized risk assessment and symptom evaluation should guide decisions regarding post-operative surveillance.

Evidence Discussion

Screening with upper endoscopy is medically necessary in individuals with chronic gastroesophageal reflux disease (GERD), which is defined as symptoms for 5 or more years and at least 3 established risk factors for Barrett's esophagus (BE) and esophageal adenocarcinoma (EAC). These risk factors include individuals who are male, non-Hispanic white race, age >50 years, history of smoking, obesity, or a family history of Barrett's esophagus (BE) or esophageal adenocarcinoma in a first-degree relative.[3,23,37]

A diagnosis of BE requires salmon-colored mucosa with intestinal metaplasia of at least 1 cm in length. If visual changes suggestive of BE are present but pathology is negative, repeat endoscopy in 1-2 years is appropriate. For individuals with nondysplastic BE, surveillance endoscopy every 3 to 5 years is recommended.[3,14,37,96,98]

Endoscopic surveillance is indicated in individuals with BE at intervals dictated by the degree of dysplasia noted on previous biopsies.[3,37,96]

Endoscopy can be repeated within 6 months in individuals with BE indefinite for dysplasia. 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.3 If opting for endoscopic surveillance in individuals with BE with low-grade dysplasia (LGD), repeat EGD at 6 month, 12 months and annually thereafter.[18,37,96]

Endoscopic eradication therapy (EET) is indicated in individuals with Barrett's esophagus (BE) with confirmed low-grade dysplasia (LGD) and high-grade dysplasia (HGD).[3,17,23]

Post-endoscopic complete eradication surveillance is defined as 2 consecutive negative EGDs, achieved via: [2,16]

- Post-ablative therapy
- Submucosal resection
- Submucosal dissection of malignancy

Endoscopic surveillance is indicated in individuals with BE who have completed successful EET. Timeframe for endoscopic surveillance is based on National Society Guidelines.[3,14,17,96]

Gastric Ulcer (EGD-1.4)

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- Surveillance EGD is medically necessary 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 proton pump inhibitor (PPI*) treatment and/or an appropriate course of H.pylori therapy

    Note: *Proton pump inhibitor (PPI) should be taken daily unless there is a documented history of allergy or intolerance to PPI use (in which a different acid suppression therapy should be tried)
  - In individuals who remain symptomatic despite 8-12 weeks of proton pump inhibitor (PPI*) treatment and/or an appropriate course of H. pylori therapy to rule out refractory peptic ulceration, non-peptic benign etiologies, and occult malignancy

    Note: *Proton pump inhibitor (PPI) should be taken daily unless there is a documented history of allergy or intolerance to PPI use (in which a different acid suppression therapy should be tried)
  - In individuals with gastric ulcer without a clear etiology (e.g., no non-steroidal inflammatory drug (NSAID) use, no H. pylori, etc.)
  - In individuals with gastric ulcer who did not undergo biopsy at the index endoscopy due to enhanced risk or inability to perform biopsy for medical reasons (e.g., active bleeding, coagulopathy, etc.)
  - In individuals diagnosed with gastric ulcer via radiologic imaging
  - In individuals with giant gastric ulcers (>3cm), or refractory ulcers (fail to heal despite 8-12 weeks in therapy):
    - Surveillance EGD is medically necessary every 8-12 weeks until healing is documented
  - In individuals with a history of gastric ulcer who underwent Billroth II gastrectomy
    - A one-time surveillance EGD is medically necessary at 10-15 years post-surgery to evaluate for gastric remnant cancer

Evidence Discussion

Gastric ulcers are a common gastrointestinal condition with a broad differential that includes Helicobacter pylori infection, non-steroidal inflammatory drug (NSAID) use, and malignancy.[4,81,97]

Esophagogastroduodenoscopy (EGD) remains the cornerstone of diagnosis and management, particularly when there is failure to respond to therapy, presence of alarm symptoms, or suspicion for malignancy.[4,81,97]

For those individuals with an ulcer diagnosed by EGD, repeat EGD (surveillance) is medically necessary if [4,81,97]:

- the gastric ulcer appears endoscopically suspicious for malignancy (even if biopsies are benign)
- the individuals who remains symptomatic despite appropriate course of therapy to rule out refractory ulceration
- there is a gastric ulcer without a clear etiology
- an individual did not undergo biopsy at the index endoscopy
- an individual has giant ulcers (>3 cm).
- an individual has a persistent ulcer seen on EGD; surveillance EGD every 8-12 weeks until healing is documented.
- EGD should also be performed in individuals with gastric ulcer diagnosed via radiologic imaging.

Duodenal Ulcer (EGD-1.5)

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- Surveillance EGD is medically necessary for ANY of the following:
  - In individuals with duodenal ulceration who experience persistent symptoms despite 8-12 weeks of proton pump inhibitor (PPI*) treatment and/or an appropriate course of H.pylori therapy, specifically to rule out refractory peptic ulcers and ulcers with non-peptic etiologies

    Note: *Proton pump inhibitor (PPI) should be taken daily unless there is a documented history of allergy or intolerance to PPI use (in which case a different acid suppression therapy should be tried)
  - In individuals with giant duodenal ulceration (>2 cm), or refractory ulcers (fail to heal despite 8-12 weeks in therapy):
    - Surveillance EGD is medically necessary every 8-12 weeks until healing is documented

Evidence Discussion

Duodenal ulcers may be caused by infection with Helicobacter pylori bacteria (H. pylori), use of non-steroidal inflammatory drugs (NSAIDs), acid-peptic disease, neoplasm, and other chronic inflammatory disease. In individuals with established duodenal ulcer, EGD may be medically necessary[97]:

- 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)
- In individuals with giant duodenal ulceration (>2 cm), or refractory ulcers (fail to heal despite 8-12 weeks in therapy): Surveillance EGD should be performed every 8-12 weeks until healing is documented.

As more than 90% of duodenal ulcers heal with 4 weeks of PPI therapy, the above recommendations have been created to survey individuals with high risk for developing complications or neoplasm.[97]

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Gastric Intestinal Metaplasia (GIM) (EGD-1.6)

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Gastric intestinal metaplasia (GIM) is a precancerous condition characterized by the replacement of normal gastric epithelium with intestinal-type epithelium. It typically arises as a consequence of chronic gastric inflammation, commonly due to Helicobacter pylori infection or autoimmune metaplastic atrophic gastritis. It is characterized by transformation of gastric mucosa into intestinal-type epithelium, and ultimately cascades toward gastric adenocarcinoma.

Gastric Intestinal Metaplasia (GIM) may be classified by:

- Extent of mucosal involvement:
  - In focal intestinal metaplasia (IM), only a small localized area of the stomach shows metaplastic changes
  - In extensive intestinal metaplasia, more than one area of the stomach is affected.
- Degree of cellular transformation:
  - Complete IM (Type I) is the initial metaplastic change, and is characterized by gastric mucosa that resembles cells of the small intestine
  - Incomplete IM (Types II/III) is a more advanced progression toward dysplasia, in which the gastric mucosa more closely resembles cells of the colon
- Stage or grade of dysplasia
  - In low-grade dysplasia cells display early architectural modification but are not changing aggressively
  - In high-grade dysplasia the cells are not yet invasive but exhibit more complex architectural modification including branching and budding. High-grade dysplasia warrants consideration for therapeutic intervention due to risk of progression to cancer.

High-risk individuals are defined by ONE of the following:
- Having a first-degree relative (parent, sibling, child) with gastric cancer
- Being born in or emigrated from high-incidence regions:
  - East Asia
  - Latin America
  - Eastern Europe
- Belonging to high-risk racial or ethnic group:
  - East Asian
  - Latino/a

- Black
- Indigenous American Indian/Alaska Native

- Documentation of GIM with high-risk endoscopic stigmata (e.g., mucosal nodularity)
- EGD is medically necessary as follows:
  - In GIM with high-grade dysplasia
    - EGD may be repeated immediately to confirm high-grade dysplasia, and then is medically necessary every 6 months
  - In GIM with low-grade dysplasia
    - EGD every 12 months
  - In GIM with no dysplasia
    - High-risk individuals
      - EGD is medically necessary within 1 year for risk stratification and surveillance
      - EGD is medically necessary every 3-5 years from the baseline or after risk stratification
    - Incomplete IM
      - EGD is medically necessary every 3-5 years from baseline or after risk stratification
    - Complete IM
      - Further surveillance EGD is not medically necessary
    - Extensive IM (involving gastric body plus incisura and/or antrum)
      - EGD is medically necessary every 3-5 years from baseline or after risk stratification
      - EGD is medically necessary every 1-2 years for individuals with extensive IM and has a first degree (parent, sibling, child) family history of gastric cancer
    - Focal IM
      - Further surveillance EGD is not medically necessary
    - Individuals not identified as high-risk
      - Further surveillance EGD is not medically necessary
  - One-time follow-up EGD is medically necessary within 1 year for documented concern regarding the completeness of the baseline endoscopy (e.g., biopsies from only one region of the stomach)
  - One-time EGD screening is medically necessary for gastric cancer in an asymptomatic individual age ≥45 years or 10 years before the diagnosis of gastric cancer in the youngest affected first-degree relative with ANY of the following risk factors:

    - Having a first-degree relative (parent, sibling, child) with gastric cancer
    - Being born in or emigrated from high-incidence regions:
        - East Asia
        - Latin America
        - Eastern Europe
    - Belonging to high-risk race or ethnic group:
        - East Asian
        - Latino/a
        - Black
        - Indigenous American Indian/Alaska native
- Qualifying circumstances:
    - If GIM is identified after gastric cancer screening, follow-up EGD surveillance intervals are based on dysplasia stage
    - If no GIM is identified after one-time gastric cancer screening, further EGD screening is not medically necessary
    - See: **Genetic Syndromes (EGD-1.16)** for individuals with known genetic syndromes

Evidence Discussion

Gastric Intestinal Metaplasia (GIM) is a recognized premalignant condition, often arising from chronic inflammation due to Helicobacter pylori infection or autoimmune gastritis. GIM is associated with an increased risk of progression to gastric adenocarcinoma, particularly in individuals with specific histologic and demographic risk factor.[99,100]

The 2025 American College of Gastroenterology (ACG) Clinical Guideline recommends that all patients with GIM undergo systematic biopsy sampling. Histologic subtype (complete vs. incomplete) and extent (limited vs. extensive) should be reported to inform risk stratification and surveillance planning.[99]

Both the American College of Gastroenterology (ACG) and the American Gastroenterological Association (AGA) have acknowledged that certain racial and ethnic groups, as well as foreign-born individuals from regions with high gastric cancer incidence, are at elevated risk for gastric cancer.[99,100]

The ACG 2025 guideline explicitly states that gastric cancer incidence is 2- to 13-fold higher in non-White populations in the U.S., particularly among first-generation immigrants from high-incidence regions such as East Asia, Latin America, and Eastern Europe.[99]

The guideline recommends endoscopic surveillance every three years for individuals with gastric intestinal metaplasia (GIM) who also meet one or more high-risk criteria, including:[99]

- A family history of gastric cancer in a first-degree relative,
- Being foreign-born from a high-incidence country,
- Belonging to a high-risk racial or ethnic group, including East Asian, Latino/a, Black, and American Indian/Alaska Native individuals

Similarly, the AGA Clinical Practice Update reinforces that first-generation immigrants from high-incidence regions and non-White racial and ethnic groups should be considered for gastric cancer screening and surveillance. The AGA emphasizes that endoscopy remains the gold standard for both screening and surveillance in these high-risk populations, and that surveillance intervals should be tailored based on histologic findings and individual risk profiles.[99,100]

These updates reflect a growing recognition of gastric cancer disparities in the U.S. and the need for personalized, risk-based approaches to screening and surveillance.

General and Therapeutic EGD (EGD-1.7)

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The following are medically necessary indications for EGD:

- Evaluation of documented dysphagia
- Evaluation of odynophagia characterized by chest pain on swallowing
- Persistent vomiting of unknown cause ≥7 days and/or suspicion of cyclic vomiting syndrome
- GI bleeding presumed to be upper gastrointestinal (UGI) in origin by ONE of the following:
  - History and/or physical examination (e.g., black tarry stool/melena, hematemesis; not hemorrhoidal bleeding)
  - Laboratory data (e.g., elevated BUN associated with gastrointestinal (GI) blood loss, positive fecal occult blood, FIT testing as may be included in Cologuard®)
- Iron-deficiency anemia presumed to be UGI in origin, as manifested by low hematocrit or hemoglobin AND one of the following:
  - Low serum iron
  - Low serum ferritin (≤45 ng/mL or <lab lower limit if higher than 45 ng/mL)
  - Elevated serum iron binding capacity
  - Low serum transferrin saturation
- If the above criteria for iron deficiency anemia are met and a colonoscopy is planned for evaluation of iron-deficiency anemia, an EGD can be added and performed on the same date of service if requested.
- To assess acute injury after caustic ingestion
  - Examples include: strong acids (sulfuric, hydrochloric, nitric), alkalines (lye, sodium hydroxine, oven cleaner, drain cleaner, disc batteries, ammonia, bleach).
- Screening for esophageal cancer after prior 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 individuals with a history of ulcer disease scheduled for organ transplantation, anticipation of long-term anticoagulation, or NSAID therapy.
- Esophageal evaluation is medically necessary when there is a high index of suspicion for active infectious or immune-mediated disease contributing to esophageal dysfunction, as evidenced by ONE OR MORE of the following clinical scenarios:
  - Recent antibiotic or corticosteroid use (oral or inhaled)
  - Immunocompromised status

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- Presence of bullous dermatoses
- Presence of lichen planus
- Autoimmune disease
- Recent travel to Central/South America and high suspicion of Chagas disease

- To assess diarrhea in individuals suspected of having small bowel disease:
  - EGD with small bowel biopsy is medically necessary in individuals with chronic diarrhea (≥ 28 days) when a diagnostic work-up has been completed to determine the underlying cause and malabsorption or inflammation is suspected.
    - The diagnostic work-up must include at least one of the following:
      - Fecal calprotectin and/or lactoferrin to assess for inflammatory bowel disease
      - Stool analysis for giardia PCR or giardia antigen
    - If concern for Celiac Disease, see: **Celiac Disease (EGD-1.18)**
    - EXCEPTION: HIV and Graft-vs.-Host Disease: in the absence of a diagnosis on flexible sigmoidoscopy, an EGD is medically necessary.
- Removal of foreign bodies within reach of endoscope
- Removal or serial endoscopic treatments of known lesions, including ablation
  - Known polyp(s) which have not yet been removed
  - Bleeding lesions (such as known AVM, ulcers, or tumors requiring ablation, cautery, or other treatment)
- Placement of a feeding or drainage tube
  - Examples include: Peroral, percutaneous endoscopic gastrostomy, percutaneous endoscopic jejunostomy
- Dilation, stenting, and other therapeutic interventions for initial and serial treatment of benign or malignant stenotic lesions
  - Examples include: use of transendoscopic balloon dilators, dilation systems using guidewires, electrocoagulation, stents
- Endoscopically directed injection of medications or other therapeutic agents
  - Examples include: endoscopic dilation, Botulinum toxin (Botox®) injection for achalasia
- Diagnosis and management of eosinophilic esophagitis
  - See: **Eosinophilic Esophagitis (EOE) (EGD-1.17)**
- Intra-operative evaluation of anatomic reconstructions
  - Examples include: Evaluation of anastomotic leak and patency, fundoplication formation, pouch configuration during bariatric surgery
- For confirmation and specific histologic diagnosis of radiologically demonstrated lesions involving the UGI tract

- Examples include: suspected neoplastic lesions of the esophagus, stomach, or duodenum, gastric or esophageal ulceration, upper tract stricture, or obstruction
  - EGD is NOT medically necessary 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
- For sampling of tissue or fluid when clinically appropriate
  - Examples include: biopsy of small bowel for suspected celiac disease when appropriate (see: **Celiac Disease (EGD-1.18)** for indications), suspected upper GI infection, collection of gastric or duodenal fluid for analysis, suspected upper GI Crohn's (see: **Inflammatory Bowel Disease (IBD) (EGD-1.19)**.
  - For specific indications (like Barrett's esophagus, diarrhea, etc.) for which guidelines exist, follow the specific guideline for that condition
  - Carbohydrate enzyme deficiencies (e.g., disaccharidase deficiency) should be ruled out with dietary restriction and/or breath testing. In the small subset of at-risk individuals who do not respond to dietary restriction, small bowel aspiration or biopsy may be warranted
  - For evaluation of small intestinal bacterial overgrowth (SIBO), EGD with duodenal fluid collection is medically necessary when BOTH of the following criteria are met:
    - Breath testing (e.g., lactulose or glucose breath test) is negative or inconclusive; AND
    - Clinical suspicion for SIBO remains high based on persistent or unexplained symptoms
- Evaluation and treatment of gastric outlet obstruction
  - Generally characterized by epigastric pain and vomiting after meals (signs and symptoms may include nausea, vomiting, epigastric pain, unintentional weight loss, abdominal distention, early satiety)
- EGD is medically necessary when belching, bloating, and/or abdominal distension is accompanied by ANY of the following:
  - History of malignancy with a likelihood or propensity to metastasize to the abdomen
  - Fever (≥101 degrees Fahrenheit)
  - Elevated WBC >10,000, or above the upper limit of normal for the particular lab reporting the result
  - Palpable mass of clinical concern and/or without benign features
  - GI bleeding, overt or occult, not obviously hemorrhoidal
  - Abdominal tenderness documented as moderate or severe
  - Suspected complication of bariatric surgery

  - New onset of symptoms at age ≥60 years
  - Unintentional weight loss of ≥10 lbs. or ≥5% of body weight over 6 months or less, without an identifiable reason
- Management of operative complications
  - Examples include: dilation of anastomotic strictures, stenting of anastomotic disruption, fistula, or leak

Evidence Discussion

Upper gastrointestinal endoscopy (EGD) is a useful tool for the clinical evaluation of numerous disorders in the upper gastrointestinal (GI) tract.[1]

The expanding list of accepted indications for EGD include evaluation and/or management of dysphagia, odynophagia, gastroesophageal reflux symptoms, upper abdominal symptoms, and gastrointestinal (GI) bleeding; screening, surveillance, and endoscopic management of preneoplastic conditions. [1]

EGD is also useful for evaluation of diseases in which the presence of upper gastrointestinal (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. [1]

The American Gastroenterological Association (AGA) Clinical Practice Update by Reddy et al. highlights therapeutic EGD roles in managing esophageal manifestations of systemic diseases such as eosinophilic esophagitis (EoE), lymphocytic esophagitis, and systemic sclerosis.[102]

EGD also facilitates the removal of foreign bodies, food bolus, and tissue samples for biopsy. Additionally, it facilitates the treatment of lesions, placement of feeding tubes, and management of stenosis. [1,103]

While EGD is not routinely used to diagnose small intestinal bacterial overgrowth (SIBO), the American College of Gastroenterology (ACG) guideline notes its role in obtaining small bowel aspirates for culture in select cases. This is particularly relevant when breath testing is inconclusive or when precise microbial quantification is needed. EGD may also be used to evaluate structural abnormalities contributing to small intestinal bacterial (SIB), such as blind loops or strictures. [1,104]

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Upper GI Polyp Treatment and Follow-up (EGD-1.8)

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Upper endoscopy (EGD) is medically necessary for gastric polyps as follows:

- **Adenomatous gastric polyps**
  - Complete resection is supported upon histologic detection
  - After compete resection
    - Initial repeat EGD in 1 year
    - Subsequent surveillance EGD every 3-5 years
- **Hyperplastic gastric polyps**
  - If unresected and **no dysplasia present**
    - <10 mm in size, surveillance EGD is not medically necessary unless concerning features are present
    - ≥10 mm in size, repeat EGD in 1 year
  - After resection
    - If **no dysplasia**, repeat EGD in 1 year
    - For persistent, incompletely resected polyp(s), repeat EGD in 1 year following complete resection
    - For dysplasia identified in the resected polyp, repeat EGD at 1 year
  - If mucosal sampling detects intestinal metaplasia **without dysplasia** within a hyperplastic polyp, see: **Gastric Intestinal Metaplasia (EGD-1.6)**
  - If mucosal sampling detects gastric atrophy **without dysplasia** within a hyperplastic polyp, see: **Atrophic Gastritis (EGD-1.9)**

Note:

Hyperplastic polyps without dysplasia generally do not require additional surveillance. However, in the course of endoscopy for hyperplastic gastric polyps, the standard of care should include mucosal sampling.

  - **Dysplasia present**
    - EGD can be repeated annually if requested
  - EGD is medically necessary to remove suspicious appearing gastric polyps >0.5cm in size when benign histology has not been determined at the time of initial endoscopy.

Endoscopic surveillance of upper gastrointestinal tract in **Familial Adenomatous Polyposis (FAP)** is guided by lesion characteristics, including: size, histologic subtype, and grade of dysplasia.

- **Fundic Gland (FP) or Adenomatous Polyps (AP)**
  - Polyp(s) <1cm, nondysplastic or with low grade dysplasia
    - For **fundic gland polyps**, EGD is medically necessary in 3 years
    - For **adenomatous polyps**, EGD is medically necessary in 1 year
  - Polyp(s) ≥1cm, nondsyplastic or with low grade dysplasia
    - EGD is medically necessary in 1 year
      - If resection is incomplete or piecemeal, EGD is medically necessary at 6 months
  - Polyp(s) of any size with high grade dysplasia
    - EGD is medically necessary in 3-6 months
- **Polypoid mounds in the proximal stomach**
  - Nondysplastic or low grade dysplasia
    - EGD is medically necessary at 3-6 months
  - High grade dysplasia
    - Refer for complete surgical resection
- **Adenocarcinoma, intramucosal or invasive**
  - Refer for evaluation for possible gastrectomy
- For screening and surveillance of individuals with genetic syndromes, see: **Genetic Syndromes (EGD-1.16)**

- Follow up of **duodenal polyp(s)** (sporadic duodenal tumors not associated with genetic syndromes)
  - **Superficial non-ampullary duodenal tumors**
    - EGD is medically necessary 3 months after initial treatment
      - If no recurrence on EGD after initial treatment, repeat EGD is indicated in 1 year
  - **Ampullary duodenal tumors**
    - EGD is indicated within 3 months of initial treatment
      - Repeat EGD is indicated at 6 and 12 months after initial treatment, and yearly thereafter for 5 years
  - Note: if a duodenal adenoma is detected, a colonoscopy is also medically necessary
  - For resection of previously biopsied adenomatous or dysplastic polyp(s), see: **General and Therapeutic EGD (EGD-1.7)**

  - For screening and surveillance of individuals with genetic syndromes, see: **Genetic Syndromes (EGD-1.16)**
- Sequential or periodic EGD is NOT medically necessary for surveillance of malignancy in individuals with:
  - Fundic gland polyps
  - Previous gastric operations for benign disease
  - Surveillance of healed benign disease such as esophagitis and gastric or duodenal ulcer

Evidence Discussion

Hyperplastic gastric polyps are generally considered benign, but size and histologic features influence management. According to the American College of Gastroenterology (ACG) Clinical Guideline by Morgan et al., hyperplastic polyps ≥ 10 mm warrant complete endoscopic resection, as biopsy alone may miss foci or dysplasia or early gastric cancer.[99] This is particularly important in individuals with multiple polyps or those with underlying gastric intestinal metaplasia (GIM) or atrophic gastritis, which elevate cancer risk.

Post resection follow-up upper endoscopy is medically necessary in cases where:[99]
- The polyp was ≥10 mm
- Histology revealed dysplasia or incomplete resection
- The surrounding mucosa showed premalignant changes (e.g., GIM or atrophy)

Surveillance intervals should be determined based on histologic risk stratification, including the presence of incomplete GIM, corpus extension, or high risk ethnicity or family history.[99]

The American Gastroenterological Association (AGA) Clinical Practice update by Shah et al., emphasized that individuals at increased risk for gastric cancer such as those with hereditary syndrome, including Familial Adenomatous Polyposis (FAP) require tailored surveillance strategies. In these populations, upper endoscopy is not only diagnostic but also therapeutic and preventative.[100]

For individuals with FAP, the National Comprehensive Cancer Network (NCCN) Guidelines recommended:[45]
- Surveillance intervals should be based on the most severe findings in either the gastric or duodenal mucosa, whichever requires most frequent monitoring. This approach ensures that high-risk lesions are not missed due to compartmentalized surveillance.

Atrophic Gastritis (EGD-1.9)

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Upper endoscopy (EGD) is medically necessary for individuals with atrophic gastritis based on Operative Link Gastritis Assessment (OLGA) staging as follows:

- OLGA stages 0 and 1
  - Routine surveillance EGD is not medically necessary
- OLGA Stage 2
  - EGD is medically necessary every 3 years when BOTH high-risk features are present:
    - Having a first-degree relative (parent, sibling, child) with gastric cancer
    - Belonging to a high-risk race or ethnic group (e.g., East Asian, Latino/a, Black, Indigenous American Indian/Alaska Native) or being born in or emigrated from high-incidence regions (e.g., East Asia, Latin America, Eastern Europe).
- OLGA stage 3 or 4
  - EGD is medically necessary every 2-3 years
  - EGD is medically necessary annually when the following high risk feature is present:
    - Having a first-degree relative (parent, sibling, child) with gastric cancer

Upper endoscopy (EGD) is medically necessary every 3 years for the following:
- Autoimmune atrophic gastritis (Autoimmune Metaplastic Atrophic Gastritis)

Background and Supporting Information
- Atrophic Gastritis
  - OLGA score:

	Atrophy score	Corpus			
		No atrophy	Mild atrophy	Moderate atrophy	Severe atrophy
Antrum	No atrophy (score 0) (including incisura angularis)	Stage 0	Stage I	Stage II	Stage II
	Mild atrophy (score 1) (including incisura angularis)	Stage I	Stage I	Stage II	Stage III

	Atrophy score	Corpus			
	Moderate atrophy (score 2) (including incisura angularis)	Stage II	Stage II	Stage III	Stage IV
	Severe atrophy (score 3) (including incisura angularis)	Stage III	Stage 0	Stage IV	Stage IV

Evidence Discussion

The OLGA staging system is a histopathologic tool used to assess the severity and distribution of atrophic gastritis, which is a precursor to gastric cancer. It stratifies patients into stages 0 through IV, with higher stages indicating greater risk for gastric neoplasia. The use of OLGA scoring has become increasingly relevant in guiding decisions about EGD surveillance.[99,100]

The American College of Gastroenterology (ACG) 2025 guideline recommends that individuals with histologically confirmed advanced atrophic gastritis (OLGA III–IV) undergo periodic EGD surveillance due to their elevated risk for gastric neoplasia. For individuals with OLGA stage II, the ACG suggests individualized decision-making, especially if other risk factors are present (e.g., family history of gastric cancer, incomplete intestinal metaplasia, or multifocal lesions). While routine surveillance may not be universally recommended for OLGA II, the presence of additional risk factors may tip the balance toward EGD follow-up.[99]

The American Gastroenterological Association (AGA) 2025 Clinical Practice Update supports the use of OLGA staging for risk stratification and surveillance planning. It recommends high-quality upper endoscopy with systematic biopsies for individuals at increased risk, including those with OLGA III–IV. The AGA also highlights that individuals with severe atrophic gastritis or multifocal intestinal metaplasia—features often seen in OLGA II–IV—should be considered for surveillance every three years, though shorter intervals may be appropriate in high-risk cases. Importantly, the AGA advises that surveillance decisions should be personalized, considering the individual's overall risk profile, including ethnicity, family history, and histologic findings.[100]

Pernicious Anemia (EGD-1.10)

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- EGD is medically necessary within 6 months of the diagnosis of pernicious anemia
  - Diagnosis of pernicious anemia as demonstrated by:
    - Vitamin B12 level below normal (<300 pg/mL) or elevated MMA (methylmalonic acid) AND one of the following:
      - Positive for anti-IF antibodies (intrinsic factor) OR
      - Positive for anti-parietal cell antibodies OR
      - Other laboratory findings consistent with Vitamin B12 deficiency including elevated MCV (mean corpuscular volume) and hypersegmented neutrophils seen on CBC OR
      - Other laboratory findings consistent with gastric atrophy (i.e., elevated fasting serum gastrin or decreased serum Pepsinogen I)
- Follow-up examinations indicated only for the development of new symptoms
  - If atrophic gastritis is found, refer to **Atrophic Gastritis (EGD-1.9)**.

Evidence Discussion

Pernicious anemia (PA) can be seen as a late manifestation of autoimmune gastritis (AIG), also referred to as autoimmune metaplastic atrophic gastritis. It results from immune-mediated destruction of gastric parietal cells, leading to intrinsic factor deficiency and subsequent vitamin B12 malabsorption. The diagnosis of PA is supported by laboratory findings including low serum vitamin B12 (<300 pg/mL), elevated methylmalonic acid (MMA), hypersegmented neutrophils on peripheral smear, elevated mean corpuscular volume (MCV), and the presence of anti-parietal cell and anti-intrinsic factor antibodies.[4,105]

Individuals with newly diagnosed pernicious anemia should undergo EGD with biopsies to confirm atrophic gastritis and rule out neoplasia.[4,105]

The American Gastroenterological Association (AGA) recommends performing EGD at the time of pernicious anemia diagnosis as a best practice point, even though the optimal surveillance interval remains undefined. Similarly, the American Society for Gastrointestinal Endoscopy (ASGE) advises EGD within six months of diagnosis, with consideration for ongoing surveillance in patients with additional risk factors.[4,105]

Gastric Subepithelial and Neoplastic Tumors (EGD-1.11)

GI.GST.0001.11.A
v2.0.2026

Gastrointestinal stromal tumors (GISTs)

Annual endoscopic surveillance with EGD is medically necessary for GISTs smaller than 2 cm when surgical resection is not performed, to monitor for progression in size or changes in features.

Gastric neuroendocrine neoplasms (g-NENs)

Following resection, surveillance EGD is medically necessary every 6–12 months for the first 3 years, and then annually, to detect recurrence or new neoplastic growths.

Gastric marginal zone lymphoma (MALT-type)

After successful Helicobacter pylori eradication, EGD is medically necessary every 3 months for the first 2 years, then every 6 months thereafter (optimal long-term interval has not been definitively established).

Evidence Discussion

Gastric tumors encompass a diverse group of neoplasms with variable malignant potential, including gastrointestinal stromal tumors (GISTs), gastric neuroendocrine neoplasms (g-NENs), and gastric marginal zone lymphoma of mucosa-associated lymphoid tissue (MALT lymphoma). While their biology and clinical behavior differ, surveillance with esophagogastroduodenoscopy (EGD) is essential to monitor recurrence, progression, or malignant transformation.[46]

Gastrointestinal stromal tumors (GISTs) smaller than 2 cm are typically low risk for malignancy, but annual surveillance is recommended to assess changes in size or endoscopic appearance.[106]

Gastric neuroendocrine neoplasms (g-NENs) require close post-resection monitoring due to the potential for recurrence or development of new lesions. Initial surveillance should be performed at short intervals to detect early changes, followed by annual endoscopic evaluations. This approach facilitates timely identification of disease progression or recurrence and is particularly important in individuals with type I g-NENs, which are often multifocal and associated with chronic atrophic gastritis or autoimmune condition.[107]

Gastric marginal zone lymphoma of mucosa-associated lymphoid tissue (MALT lymphoma) may regress following successful Helicobacter pylori eradication. However, close follow-up with esophagogastroduodenoscopy (EGD) is essential, particularly within the first few years post-treatment, to monitor for persistent disease or recurrence. Surveillance should include periodic endoscopic evaluation with biopsies, as early detection of residual or recurrent lymphoma significantly influences management and outcomes.[108]

Early identification of progression across these tumor types enables timely intervention, potentially reducing morbidity and mortality associated with advanced disease.

Bariatric Surgery (EGD-1.14)

GI.BS.0001.14.A
v2.0.2026

- Pre-operative endoscopic evaluation of the bariatric surgery individual is medically necessary
- Post-operative endoscopic evaluation is medically necessary 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
  - Weight gain after an initial post-operative weight loss

Evidence Discussion

Bariatric surgery in appropriately selected individuals results in a significant and durable weight loss and improvement in weight-related comorbidities. Upper gastrointestinal endoscopy has been shown to be a useful procedure in the management of individuals considering bariatric surgery and those who have undergone a bariatric procedure.[110]

Preoperative upper endoscopy (EGD) can identify individuals with asymptomatic anatomic findings that may alter surgical planning. Individuals with symptoms of GERD, or any postprandial symptoms, and/or who chronically use antisecretory medications should have an upper GI endoscopy prior to bariatric surgery. Multiple published studies have demonstrated that routine EGD before surgery can identify conditions including hiatal hernia, esophagitis, ulcers, Helicobacter pylori infection, and tumors.[36]

Indications for endoscopy in the post-bariatric surgery patient include those with symptoms of nausea, vomiting, and abdominal pain most commonly, as well as symptoms of dumping syndrome. Upper endoscopy is valuable in the diagnosis of marginal ulcers, fistulae, postsurgical GERD, hiatal hernia, and partial or complete anastomotic obstruction. Stomal stenosis, bezoars, GI bleeding and anemia post surgery can be diagnosed and/or managed endoscopically. Failure to lose weight or regaining weight after initial weight loss may indicate anatomic complications that require further intervention.[109]

Known Malignancies (EGD-1.15)

GI.KM.0001.15.A
v2.0.2026

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

Evidence Discussion

Upper intestinal endoscopy (EGD) may be appropriate when malignancy is known of the esophagus, stomach, or duodenal/small bowel for the purposes of management of complications, treatment, evaluation of ongoing or new symptoms, surveillance for recurrence, or for planning procedures. Liang, et. al. stated, "conventional video endoscopy is the gold standard for diagnosing a wide range of upper GI malignancies". EGD allows for visualization, and potentially sampling, staging, or removal of lesions if found.[90]

Genetic Syndromes (EGD-1.16)

GI.GS.0001.16.A
v2.0.2026

For asymptomatic individuals with a family history of gastric cancer, see: **Gastric Intestinal Metaplasia (GIM) (EGD-1.6)**

- **Lynch Syndrome**

  Note: Screening begins at the stated age as indicated below, or 5 years before the youngest age of diagnosis of colorectal cancer in an affected family member, whichever occurs first

  - For all mutations (MLH1/MSH2, MSH6/PMS2)
    - EGD is medically necessary beginning at age 30 years, every 2-3 years
- **Juvenile Polyposis Syndrome** (defined as individuals with 5 or more juvenile polyps in the colorectum or any juvenile polyps in other parts of the GI tract, or evidence of SMAD4 or BMPRI1A mutations, or positive family history of juvenile polyposis syndrome)
  - EGD is medically necessary beginning at age 12
    - If polyps are present, repeat yearly
    - If no polyps, repeat every 2 years
- **Peutz-Jeghers Syndrome** (defined as individuals with perioral or buccal pigmentation and/or 2 or more histologically characteristic hamartomatous polyps, or family history of PJS, or STK11 mutations)
  - EGD is medically necessary beginning at age 8
    - If polyps are present, can be repeated every 2-3 years
      - Shorter intervals may be medically necessary based on polyp size, number, and pathology.
    - If no polyps are discovered, repeat at age 18, then every 2-3 years, or earlier if any symptoms occur.
- **Hereditary Gastric Cancer** (Hereditary Diffuse Gastric Cancer-HDGC Syndrome/ CDH-1 mutation or family history of hereditary gastric cancer)
  - EGD is medically necessary beginning at age 40 or 10 years before the earliest cancer in the family, up to every 6 months.
- **Biallelic Mismatch Repair Deficiency** (BMMRD)
  - EGD is medically necessary annually, beginning at age 8

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- **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 is medically necessary beginning at age 30 or at the onset of recognition of the disease
- **Cowden Syndrome** (PTEN Hamartoma Tumor Syndrome)
  - EGD is medically necessary 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 medically necessary
- **Classical Familial Polyposis (FAP)/Attenuated FAP**
  - EGD is medically necessary beginning at age 20 years
    - EGD before 20 years of age when EITHER of the following are met:
      - Individual has undergone a colectomy prior to the age of 20 years OR
      - Request is prior to a planned colectomy
    - See **Spigelman Stage** for follow-up imaging intervals of duodenal polyps
- **MUTYH-Associated Polyposis (MAP)**
  - EGD is medically necessary beginning at age 30
  - See **Spigelman Stage** for follow-up imaging intervals
- **Li-Fraumeni Syndrome** (defined as a syndrome inherited in an autosomal-dominant manner, associated with germline mutations in TP53, and resulting in an increased susceptibility to a variety of cancers)
  - EGD is medically necessary every 2-5 years beginning at age 25 (or 5 years before the earliest known gastric cancer in the family.
- Spigelman Stage
  - Follow-up imaging is medically necessary depending on Spigelman Stage of duodenal polyposis as follows (using point system):

Polyps	1 Point	2 Points	3 Points
Number	≤4	5-20	>20
Size	0-≤4	5-10	>10
Histology	Tubular	Tubulovillous	Villous
Dysplasia	Mild	Moderate	Severe

Spigelman Stage	Total Points	Surveillance Interval
0	0	Every 3-5 years
I	≤4	Every 2-3 years
II	5-6	Every 1-2 years
III	7-8	Every 6-12 months
IV	9-12	Every 3-6 months (if surgery not chosen)

Evidence Discussion

- Cancer genetics summaries focus on the genetics of specific cancers that are inherited cancer syndromes.[45,90]
- The goal and benefit of cancer surveillance is to identify a genetics-predisposed neoplastic process earlier in the course than standard procedure surveillance/ screening recommendations in the absence of a genetic syndrome.[45,90]
- The genetics of specific cancers include syndrome-specific information on the risk implications of a family history of cancer, the prevalence and characteristics of cancer-predisposing variants, known modifiers of genetic risk, opportunities for genetic testing, outcomes of genetic counseling and testing, and interventions available for people with increased cancer risk resulting from an inherited predisposition.[45,90]
- Endoscopy and colonoscopy surveillance recommendations are based on the recommended surveillance intervals for the specific genetic defect when possible, or presence of a genetic-associated specific neoplasm in the absence of genetic assessment.[45,90]
- If a positive neoplastic finding is identified via surveillance, subsequent endoscopic testing is based on the shorter interval of either the genetic syndrome specific surveillance guideline or specific tumor follow-up oncology recommendations.[45,90]
- As this is a rapidly changing field, clinical judgment in conjunction with recommended guidelines for specific genetic tumor syndromes are considered when supported by national guidelines.[45,90]

Eosinophilic Esophagitis (EoE) (EGD-1.17)

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- Initial EGD is medically necessary for diagnosis of suspected eosinophilic esophagitis in ANY of the following:
  - Individuals with typical GERD symptoms refractory to treatment with proton pump inhibitors (PPI)
  - Symptoms of dysphagia or food bolus obstruction
  - Individuals with esophageal symptoms and a history of atopic disease (such as atopic dermatitis, asthma, or food allergy)
  - Individuals with esophageal symptoms and an absolute eosinophil count >1500
- Repeat EGD is medically necessary for ANY of the following:
  - After 8 weeks of dietary or pharmacological EoE treatment:
    - To assess treatment response in individuals with an established diagnosis of EoE
    - For individuals where a high index of suspicion exists for a diagnosis of EoE, initial histology was not diagnostic, and there exists endoscopic features of EoE or typical symptoms suggestive of EoE
  - After 1 year of treatment for EoE:
    - For individuals where a high index of suspicion exists for a diagnosis of EoE, initial histology was not diagnostic, there exists NO endoscopic features of EoE, and symptoms typical of EoE have been present
  - Any time significant symptoms recur while on any previously effective treatment
  - Annual EGD surveillance (once per year) for the evaluation of disease stability or progression in individuals with established EoE
  - For endoscopic dilation of symptomatic fibrostenotic disease

Background and Supporting Information

- Eosinophilic Esophagitis (EoE)
  - Eosinophilic esophagitis (EoE) is a chronic, immune/antigen-mediated, esophageal disease of increasing recognition and prevalence predominantly in male children and adults. EoE is characterized clinically by symptoms related to esophageal dysfunction and histologically by eosinophil-predominant inflammation (at least 15 eosinophils per high power field). Three pathologic sub-types vary from mild expression to fibrostenotic disease. Clinical manifestations include solid food

dysphagia, food impaction, antacid-refractory central chest pain, upper abdominal pain, and GERD-like symptoms.
    - Disease severity, defined by the Index of Severity of Eosinophilic Esophagitis (I-SEE; mild [1 to 6 points], moderate [7 to 14 points] or severe [15 points or higher]) is determined by presentation and associated complications (symptom frequency, food impaction, hospitalization), endoscopic features (edema, furrows, exudates, rings, strictures), and histologic burden of eosinophils per high power field.
    - There is a strong association of eosinophilic esophagitis with allergic conditions such as food allergies, environmental allergies, asthma, and atopic dermatitis. Only recently, however, has targeted EoE treatment been FDA-indicated. Of note, symptoms may not always correlate with histological activity.
- Eosinophilic Gastrointestinal Disorders (EGIDs) other than EoE (eosinophilic esophagitis)
    - Non-EoE Eosinophilic gastrointestinal disorders (EGIDs) included eosinophilic gastritis (EoG), eosinophilic enteritis (EoN), and eosinophilic colitis (EoC). They are characterized by pathologic eosinophilic infiltration of the stomach, small intestine, or colon leading to organ dysfunction and clinical symptoms.
    - The initial laboratory evaluation is similar between EGID and other GI diseases. Peripheral eosinophilia, iron deficiency, or hypoalbuminemia should raise clinical suspicion of EGID.
- More than a third of those with esophageal symptoms associated with esophageal eosinophilia will respond to PPI treatment. Notable is a condition called PPI-REE where clinical and histologic findings present similar to EoE but complete remission is achieved with PPI use.

Evidence Discussion

Upper endoscopy allows direct visualization of the esophagus, providing an opportunity to identify characteristic endoscopic features of EoE such as edema, furrows, rings, exudates, and strictures. Biopsy specimens obtained during EGD allow for histological assessment, confirming the presence of eosinophil-predominant inflammation, a hallmark of EoE. EGD also enables monitoring of treatment response over time by assessing changes in endoscopic features and histological findings. This can guide treatment decisions, including the initiation of pharmacological or dietary therapy, and the need for endoscopic interventions such as dilation of strictures.[31,47]

The risks of using EGD in the evaluation of EoE include EGD risks in general, namely that it is an invasive procedure that requires sedation or anesthesia, posing inherent risks associated with anesthesia administration, including respiratory depression and allergic reactions. There is also the risk of complications such as perforation, bleeding, and aspiration. EGD is resource-intensive, requiring specialized equipment,

trained personnel, and facility infrastructure, which may limit accessibility and increase healthcare costs.[31,47]

While upper endoscopy plays a crucial role in the diagnosis and management of EoE, its use should be balanced against the potential risks and benefits. Close monitoring of individual safety, appropriate patient selection, and adherence to established guidelines are essential to ensure optimal outcomes in this population. When used appropriately, it can help guide diagnosis, treatment and management of EoE.[31,47]

Celiac Disease (EGD-1.18)

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Screening for Celiac Disease

- EGD is medically necessary for individuals with positive serologies as follows:
  - Individuals with elevated TTG IgA in the setting of normal total IgA level OR
  - Individuals with IgA deficiency and a positive TTG IgG or deamidated IgG
    - Elevated TTG IgG, deamidated gliadin IgG should not be considered positive screens in individuals with normal total IgA levels
    - HLA test results does not preclude the need for celiac serology
  - Individuals with positive endomysial IgA antibody
- EGD is medically necessary for individuals with negative serologies but high index of suspicion for Celiac disease based on symptoms AND at least one of the following risk factors:
  - Diagnosis of one of the following associated conditions:
    - autoimmune thyroid disease
    - autoimmune liver disease
    - primary biliary cirrhosis
    - type 1 diabetes mellitus (DM)
    - Addison's disease
    - dermatitis herpetiformis
    - idiopathic peripheral neuropathy
    - Sjögren's syndrome
    - juvenile idiopathic arthritis
    - idiopathic dilated cardiomyopathy
  - First-degree relative with celiac disease
  - Down syndrome
  - Turner syndrome
  - Williams syndrome
  - Microscopic colitis (collagenous and lymphocytic)

Individuals on a Gluten-Free Diet

- EGD is medically necessary in the following scenarios:
  - Seroconversion with gluten challenge OR

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- Individual develops significant symptoms after at least two weeks on gluten-containing diet and ALL of the following:
  - Serologies remain negative after at least two weeks on gluten-containing diet AND
  - Individuals have permissive HLA/haplotype

Known Celiac Disease

- EGD is medically necessary in known celiac disease in the following scenarios:
  - Inadequate biopsies on initial scope
    - One-time repeat EGD to obtain appropriate number of small bowel biopsies
  - EGD with small bowel biopsy can be repeated two years after starting a gluten-free diet to assess for mucosal healing regardless of symptoms
  - EGD with small bowel biopsy in individuals with persistent symptoms despite at least 6 months of compliance with gluten-free diet
- For assessment of diarrhea in conditions other than celiac disease, see: **General and Therapeutic EGD (EGD-1.7)**

Background and Supporting Information

- Celiac disease is an immune-mediated systemic disorder elicited by gluten in genetically susceptible individuals. The spectrum of symptoms is quite heterogeneous and can manifest at any age after gluten is introduced into the diet. This may include a variable combination of intestinal and extra-intestinal symptoms, and can overlap with functional GI conditions such as irritable bowel syndrome or Non-celiac gluten sensitivity (NCGS). In the latter, symptoms typically occur soon after ingestion of gluten-containing foods and disappear with a strict gluten-free diet. However, there are no antibodies nor enteropathy present as in celiac disease.
- Common symptoms can include abdominal pain, bloating, nausea, diarrhea, constipation, reflux, fatigue, headache, joint pains, and muscle aches. Surveys estimate the prevalence of NCGS to be anywhere from 0.6-6% of the US population.
- Another important distinction should be made between celiac disease and wheat allergy. Signs and symptoms of wheat allergy can include swelling of the mouth, itching, and hives. This is more common in individuals who also have other atopic conditions.
- Additional screening tests/serologies:
  - Permissive genetics/HLA alone should not be used as sole rationale for proceeding with EGD
  - Isolated elevation in deamidated gliadin IgA levels should never be used as sole criteria for positive screen
- Initial EGD should obtain at least 4 biopsies from distal duodenum and 1 from bulb

- Chronic abdominal pain or diarrhea (>30 days) as their only symptoms, and no evidence of elevated biomarkers associated with celiac disease, is not an indication for EGD

Evidence Discussion

The diagnosis of celiac disease (CD) incorporates both serologic and histologic data. Serologic testing consists of measuring tissue transglutaminase (TTG) IgA while on a gluten-containing diet with concomitant or prior measurement of total IgA levels to ensure that the individual is not IgA deficient. Individuals with an elevated TTG IgA should then undergo an esophagogastroduodenoscopy (EGD) with duodenal biopsy to confirm the diagnosis. Due to the fact the TTG IgA in individuals without IgA deficiency has a high negative predictive value when the pretest probability is low moderate, CD can be considered as adequately ruled out in this scenario without undergoing an EGD.[55,56,95]

The specificity of the TTG IgA ranges between 96-100% with sensitivity variable between 63-93%. Therefore, in individuals who carry a >5% chance of having celiac disease, EGD with duodenal biopsy should be considered even with a negative serology. This includes certain genetic and autoimmune conditions as well as first-degree relatives of individuals with CD. This is based on the sensitivity of TTG IgA serology, risk of verification bias on studies assessing celiac testing, the possibility of seronegative celiac disease, and differential diagnosis with other enteropathies. If an individual is IgA deficient, then IgG serology with either deamidated gliadin peptide (DGP) and/or TTG should be measured.[55,56,95]

Genetic testing is not required for diagnosis in all cases, but in select circumstances can be helpful, such as in the context of serologic-histologic discrepancy and in individuals who have already started a gluten-free diet. If negative, celiac disease can be considered as effectively ruled out.[55,56,95]

Since histologic abnormalities in celiac disease can be patchy, at least four biopsies should be obtained in the post-bulbar duodenum and at least 1-2 from the duodenal bulb. This results in approximately 96% sensitivity in diagnosing celiac disease.[55,56,95]

A gluten-free diet (GFD) is the only effective therapy for CD, and intestinal biopsies are the only way to document mucosal healing of the intestine. This takes time after starting a GFD, and does not always correlate with either serologies nor symptoms. Given that the lack of mucosal healing can be associated with increased risk of lymphoproliferative malignancy, bone disease, and refractory celiac disease (RCD). In the United States, a study demonstrated that the median time from implementing a GFD to achieving mucosal healing was three years; as such, a follow-up biopsy after two years of GFD to assess for mucosal healing appears reasonable.[55,56,95]

Inflammatory Bowel Disease (IBD) (EGD-1.19)

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EGD is medically necessary in the initial evaluation of individuals with suspected upper GI tract inflammatory bowel disease (IBD) in the following clinical scenarios:

- Clinical features suggestive of Crohn's disease (i.e. chronic diarrhea, upper abdominal symptoms/dyspepsia, unintentional weight loss) AND one of the following:
  - Elevated biomarkers (ESR, CRP, fecal calprotectin, or lactoferrin) OR
  - Cross-sectional or imaging studies (CT abdomen, CT abdomen/pelvis, or MRI abdomen) are suspicious for Crohn's disease.

EGD is medically necessary for individuals with inflammatory bowel disease (IBD) in the following clinical scenarios:

- Active upper GI tract Crohn's disease: For assessment of disease activity and/or treatment decisions, including assessment for mucosal healing on therapy
- Individuals with Crohn's disease with new upper GI tract symptoms (e.g. epigastric pain, nausea/vomiting).
- Suspected upper GI/small bowel recurrence after resection
- Immunocompromised individuals with upper GI symptoms (esophageal infection-candida, CMV, HSV)
- Individuals with indeterminate colitis with upper GI symptoms
- Prior to colectomy in individuals with ulcerative colitis
- Abnormal radiologic finding (e.g. small bowel thickening or fistula on imaging)
- Individuals who have undergone a colectomy with ileal pouch-anal anastomosis (IPAA) and are now suspected of having Crohn's disease of the pouch

Evidence Discussion

- The diagnosis of inflammatory bowel disease (IBD) is based on a combination of clinical presentation (abdominal pain, diarrhea, weight loss, fatigue) and endoscopic, radiologic, histologic, and pathologic findings. The initial evaluation of suspected inflammatory bowel disease (IBD) includes a thorough laboratory workup to assess inflammation, anemia, and malnutrition. This evaluation is complemented by stool tests to rule out infections and to further evaluate inflammation. These non-invasive tests should be performed prior to proceeding with invasive diagnostic procedure, such as endoscopy, to confirm the diagnosis.[68,69,70,71,72,73,74,75,76]

- Upper GI tract involvement involving the esophagus, stomach and duodenum, occurs in up to 16% of patients with Crohn's disease, irrespective of upper GI symptoms. Dysphagia, odynophagia, pyrosis, nausea, epigastric pain, dyspepsia, anorexia, weight loss and vomiting are the more frequently reported upper GI symptoms in individuals with inflammatory bowel disease (IBD). Upper endoscopy is a valuable diagnostic tool in the initial evaluation of inflammatory bowel disease (IBD), particularly when there are indications of upper GI tract involvement or when differentiating between various GI conditions. Upper endoscopy with biopsies should be performed in individuals with Crohn's disease, to evaluate disease activity and response to therapy. EGD is indicated for individuals with symptomatic indeterminate colitis.[68,69,70,71,72,73,74,75,76]
- In individuals with ulcerative colitis, an EGD is indicated if there are abnormal radiologic findings that raise concern for Crohn's disease. Upper endoscopy is indicated in individuals with ulcerative colitis, if there is a suspicion of a change in diagnosis to Crohn's disease. EGD can be approved in a subset of individuals with ulcerative colitis who have undergone total proctocolectomy with IPAA, and are now suspected of having Crohn's disease of the pouch. This enables the evaluation of the upper GI tract for Crohn's involvement, which can impact management and therapeutic decisions.[68,69,70,71,72,73,74,75,76]

Esophageal Varices (EGD 1.20)

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This guideline addresses endoscopic identification and interventional management of esophageal varices in an individual for whom the clinical goals are variceal eradication and prevention of recurrence.

- Initial upper endoscopy (EGD) to screen for gastroesophageal varices is medically necessary in ANY of the following:
  - Individuals with cirrhosis and evidence of decompensation
    - Clinical features of liver decompensation may include any of the following: ascites, hepatic encephalopathy, variceal bleeding
  - Individuals with known or suspected cirrhosis and imaging evidence of portal hypertension (e.g, portosystemic collaterals, splenomegaly, recanalized umbilical vein)
  - Individuals with compensated advanced chronic liver disease (cACLD) and non-invasive markers of clinically significant portal hypertension (CSPH) including ANY of the following:
    - Liver stiffness measurement (LSM) ≥25 kPa by Transient Elastography (TE)
    - LSM ≥20 kPa with platelet count <150,000/μL
    - Absence of reliable TE, but with clinical concern for CSPH based on labs or imaging
- If no varices are seen on initial EGD:
  - Repeat EGD in 2 years if liver disease remains active
  - Repeat EGD in 3 years if liver disease is stable or quiescent
- If varices are found on initial EGD:
  - Repeat EGD every 1 year if liver disease remains active
  - Repeat EGD every 2 years if liver disease is stable or quiescent
- If there is liver decompensation:
  - Surveillance EGD every 1 year
- For bleeding esophageal varices:
  - Acute variceal bleeding (initial or recurrent) necessitates urgent endoscopic intervention
  - After intervention for acute variceal bleeding achieves hemostasis, one-time follow-up endoscopy is medically necessary on a time-frame determined by the treating provider.
- After confirmed eradication of esophageal varices:

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- First EGD performed 3-6 months after eradication, then every 6-12 months indefinitely

Evidence Discussion

Cirrhosis is a histological diagnosis however the introduction of the term "Compensated Advanced Chronic Liver Disease" (cACLD) better represents the clinical spectrum from severe liver fibrosis to compensated cirrhosis in asymptomatic individuals. The development of "clinically significant portal hypertension" (CSPH), defined as a "Hepatic Venous Pressure Gradient" (HPVG) of >10 mmHg, increases the risk of liver decompensation and the development of varices. Individuals progress from compensated cirrhosis to decompensated cirrhosis with the development of ascites, hepatic encephalopathy, or variceal bleeding.[111-113]

HPVG measurement is obtained invasively and is generally not readily available. As such, it was historically advised that all cirrhotic individuals be endoscopically screened for varices. However, recent guidelines from the American Association for the Study of Liver Disease and Baveno VII) have now shifted recommendations to those based on: noninvasive risk stratification of individuals with cACLD and CSPH, and; early intervention with nonselective beta blockers (NSBB) to prevent liver decompensation.[111-113]

Liver stiffness measurement (LSM) with transient elastography (TE) provides guidance in individuals who are at risk for cACLD. LSM <10 kPa essentially rules out cACLD, and serial LSM every 2-3 years may be reasonable to monitor these low risk individuals. LSM > 20kPa characterizes cACLD. There remains uncertainty between the range 10-20 kPa. The addition of platelet counts to the LSM further clarifies when CSPH has developed and requires therapeutic intervention.[111-113]

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