EviCore
By EVERNORTH

# Gastroenterology Tip Sheet

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

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

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

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## General Background Information

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

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

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## Key Clinical Details for Common Gastroenterology Requests

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

### EGD (Esophagogastroduodenoscopy)

- Alarm symptoms
- Prior EGD results
- Pathology results
- Treatment with PPI (e.g., omeprazole) or PCAB therapy, when appropriate, per guideline criteria (must include: frequency, duration, and outcome)
    - Example: Reflux symptoms persist despite omeprazole once daily for 8 weeks

- Results of prior workup by other disciplines, if relevant
    - Example: Prior evaluation by a cardiologist if EGD is requested to assess chest pain
- Risk factors, when relevant
    - Example: Family history of Barrett's esophagus in a patient referred for screening EGD

## Capsule Endoscopy

**Crohn's Disease**

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

**Gastrointestinal Bleeding**

- Documentation of the type and nature of the suspected bleeding
    - Example: Melena, observed blood per rectum
- Prior EGD and colonoscopy findings

## Diagnostic or Therapeutic Colonoscopy

- Alarm symptoms
- Prior colonoscopy results
- Pathology results
- Recent lab test results and prior workup
- Risk factors
    - Example: Personal history of colon polyps or colorectal cancer
- Diarrhea – specify acute vs. chronic; include prior relevant lab and stool studies
- Nature of bleeding, if present
    - Example: positive stool occult blood, melena, bright red blood, etc.
- Results of prior abnormal imaging studies
- BBPS (Boston Bowel Prep Scale) score or prior colonoscopy report if early repeat is requested for inadequate preparation
- Details of any genetic syndromes
    - Example: Known genetic mutations, etc.

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**Additional information and resources can be found here:**

Provider's Hub | EviCore by Evernorth

Provider Resources | EviCore by Evernorth