HEALTHHELP®

A WNS COMPANY

Upper Endoscopy (Diagnostic and Therapeutic)

L35350

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Covered Indications

Endoscopy procedures can only be allowed if abnormal signs or symptoms or known disease are present.

1. Indications which support esophagogastroduodenoscopies (EGD[s]) for diagnostic purpose(s) are as follows:
    i. Upper abdominal distress which persists despite an appropriate trial of therapy;
    ii. Upper abdominal distress associated with symptoms and/or signs suggesting serious organic disease (e.g., prolonged anorexia and weight loss);
    iii. Dysphagia or odynophagia;
    iv. Esophageal reflux symptoms which are persistent or recurrent despite appropriate therapy;
    v. Persistent vomiting of unknown cause;
    vi. Other systemic diseases in which the presence of upper GI pathology might modify other planned management. Examples include patients with a history of GI bleeding who are scheduled for organ transplantation; long term anticoagulation; and chronic non-steroidal therapy for arthritis;
    vii. X-ray findings of:
        a. A suspected neoplastic lesion, for confirmation and specific histologic diagnosis;
        b. Gastric or esophageal ulcer; or
        c. Evidence of upper gastrointestinal tract stricture or obstruction.
    viii. The presence of gastrointestinal bleeding:
        a. In most actively bleeding patients or those recently stopped;
        b. When surgical therapy is contemplated;
        c. When re-bleeding occurs after acute self-limited blood loss or after endoscopic therapy;
        d. When portal hypertension or aortoenteric fistula is suspected; or

e. For presumed chronic blood loss and for iron deficiency anemia when colonoscopy is negative.

ix. When sampling of duodenal or jejunal tissue or fluid is indicated;

x. To assess acute injury after caustic agent ingestion; or

xi. Intraoperative EGD when necessary to clarify location or pathology of a lesion.

2. Indications which support EGD(s) for therapeutic purpose(s) are as follows:

i. Treatment of bleeding from lesions such as ulcers, tumors, vascular malformations (e.g., electrocoagulation, heater probe, laser photocoagulation or injection therapy);

ii. Treatment of bleeding from lesions such as ulcers, tumors, vascular malformations (e.g., electrocoagulation, heater probe, laser photocoagulation or injection therapy);

iii. Sclerotherapy for bleeding from esophageal or proximal gastric varices or banding of varices;

iv. Foreign body removal;

v. Removal of selected polypoid lesions;

vi. Placement of feeding tubes (oral, percutaneous endoscopic gastrostomy, percutaneous endoscopic jejunostomy);

vii. Dilation of stenotic lesions (e.g., with transendoscopic balloon dilators or dilating systems employing guidewires); or

viii. Palliative therapy of stenosing neoplasms (e.g., laser, bipolar electrocoagulation, stent placement).

3. Sequential or periodic diagnostic upper GI endoscopy may be indicated for an appropriate number of procedures for active or symptomatic conditions.

i. For follow-up of selected esophageal, gastric or stomal ulcers to demonstrate healing (frequency of follow-up EGDs is variable, but every two to four months until healing is demonstrated is reasonable);

ii. For follow-up in patients with prior adenomatous gastric polyps (approximate frequency of follow-up EGDs would be every one to four years depending on the clinical circumstances, with occasional patients with sessile polyps requiring every six-month surveillance initially);

iii. For follow-up for adequacy of prior sclerotherapy or banding of esophageal varices (approximate frequency of follow-up EGDs is very variable depending on the state

of the patient but every six to twenty-four months is reasonable after the initial sclerotherapy/banding sessions are completed);

iv. For follow-up of Barrett's esophagus (approximate frequency of follow-up EGDs is one to two years with biopsies, unless dysplasia or atypia is demonstrated, in which case a repeat biopsy in two to three months might be indicated); or

v. For follow-up in patients with familial adenomatous polyposis (approximate frequency of follow-up EGDs would be every two to four years, but might be more frequent, such as every six to twelve months if gastric adenomas or adenomas of the duodenum were demonstrated).

4. The endoscopic retrograde cholangiopancreatography (ERCP) procedure is generally indicated for certain biliary and pancreatic conditions.

i. ERCP may be useful in traumatic pancreatitis to accurately localize the injury and provide endoscopic drainage;

ii. ERCP may be useful in pancreatic duct stricture evaluation;

iii. ERCP may be useful for the extraction of bile duct stones in severe gallstone induced pancreatitis;

iv. ERCP may be useful in detecting pancreatic ductal changes in chronic pancreatitis and also the presence of calcified stones in the ductal system. A pancreatogram may be performed and is likely to be abnormal in chronic alcoholic pancreatitis but less so in non-alcoholic induced types;

v. ERCP may be useful in detecting gallstones in symptomatic patients whose oral cholecystogram and gallbladder ultrasonograms are normal; and

vi. ERCP may be indicated in patients with radiologic imaging suggestive of common bile duct stones or other potential pathology.

Limitations

1. Indications for which EGD(s) are generally **NOT** covered by Medicare are as follows:

a. Distress which is chronic, non-progressive, atypical for known organic disease, and is considered functional in origin (there are occasional exceptions in which an endoscopic examination may be done once to rule out organic disease, especially if symptoms are unresponsive to therapy);

b. Uncomplicated heartburn responding to medical therapy;

c. Metastatic adenocarcinoma of unknown primary site when the results will not alter management;

d. X-ray findings of:

i. asymptomatic or uncomplicated sliding hiatal hernia;

ii. uncomplicated duodenal bulb ulcer which has responded to therapy; or

e. Deformed duodenal bulb when symptoms are absent or respond adequately to ulcer therapy;

f. Routine screening of the upper gastrointestinal tract;

g. Patients without current gastrointestinal symptoms about to undergo elective surgery for non-upper gastrointestinal disease; or

h. When lower G.I. endoscopy reveals the cause of symptoms, abnormal signs or laboratory tests (e.g., colonic neoplasm with iron deficiency anemia). Exceptions can be considered if medical necessity for this procedure can be demonstrated.

2. Sequential or periodic diagnostic EGD is **NOT** indicated for:

a. Surveillance for malignancy in patients with gastric atrophy, pernicious anemia, treated achalasia, or prior gastric operation;

b. Surveillance of healed benign disease such as esophagitis, gastric or duodenal ulcer; or

c. Surveillance during chronic repeated dilations of benign strictures unless there is a change in status.

3. ERCP is generally **NOT** indicated for the following:

i. ERCP is generally not indicated for the diagnosis of pancreatitis except for gallstone pancreatitis;

ii. ERCP is not usually indicated in early stages or in acute pancreatitis and could possibly exacerbate it;

Procedure Code Table

Table 1. LCD L35350 Upper Gastrointestinal Endoscopy (Diagnostic and Therapeutic) Associated Procedure Codes

Code	Description
43235	Esophagogastroduodenoscopy, flexible, transoral; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)
43237	Esophagogastroduodenoscopy, flexible, transoral; with endoscopic ultrasound examination limited to the esophagus, stomach or duodenum, and adjacent structures

Code	Description
43238	Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s), (includes endoscopic ultrasound examination limited to the esophagus, stomach or duodenum, and adjacent structures)
43239	Esophagogastroduodenoscopy, flexible, transoral; with biopsy, single or multiple
43242	Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s) (includes endoscopic ultrasound examination of the esophagus, stomach, and either the duodenum or a surgically altered stomach where the jejunum is examined distal to the anastomosis)
43252	Esophagogastroduodenoscopy, flexible, transoral; with optical endomicroscopy
43253	Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic ultrasound-guided transmural injection of diagnostic or therapeutic substance(s) (eg, anesthetic, neurolytic agent) or fiducial marker(s) (includes endoscopic ultrasound examination of the esophagus, stomach, and either the duodenum or a surgically altered stomach where the jejunum is examined distal to the anastomosis)
43259	Esophagogastroduodenoscopy, flexible, transoral; with endoscopic ultrasound examination, including the esophagus, stomach, and either the duodenum or a surgically altered stomach where the jejunum is examined distal to the anastomosis

Coverage and Tracking Information

Table 1. LCD L35350 Upper Gastrointestinal Endoscopy (Diagnostic and Therapeutic) Coverage Areas

Service Level	Covered States
Inpatient	CO, NM, OK, TX, AR, LA, MS, DE, DC, MD, NJ, PA
Outpatient	CO, NM, OK, TX, AR, LA, MS, DE, DC, MD, NJ, PA

Table 2. LCD L35350 Upper Gastrointestinal Endoscopy (Diagnostic and Therapeutic) Tracking Information

Information	Description
Revision Effective Date	For services performed on or after 10/17/2019
Original Effective Date	For services performed on or after 10/01/2015

References

[1] Centers for Medicare and Medicaid Services. (2019). Local Coverage Determination (LCD) Upper Gastrointestinal Endoscopy (Diagnostic and Therapeutic) L35350 . Retrieved: January 2023. https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?lcdId=35350&ver=60

Definitions

Achalasia is a condition in which the muscles of the lower part of the esophagus fail to relax, preventing food and liquid from passing into the stomach.
Anorexia is a prolonged loss of appetite.
Aortoenteric fistula (AEF) are abnormal connections between the aorta or its major arterial branches and the GI tract and can occur with or without previous aortic surgery.
Barrett's esophagus: is a metaplastic change of the esophageal epithelium from normal stratified squamous to columnar with goblet cells, resulting from chronic inflammation and repair. The presence of metaplastic epithelium increases risk for esophageal dysplasia and cancer.
Cholecystogram is an x-ray procedure used to look for gallstones in the gallbladder or bile duct.
Dysphagia refers to any difficulty with swallowing, including occult or asymptomatic impairments. Dysphagia is classified according to the location of the problem as oropharyngeal (localized to the oral cavity or pharynx, not just the oropharynx) or esophageal. It may also be classified as mechanical (due to a structural lesion of the foodway) or functional (caused by a physiologic abnormality of foodway function).
Esophagogastroduodenoscopy (EGD) is a procedure to examine the inside of the esophagus, stomach, and duodenum.
Endoscopic retrograde cholangiopancreatography (ERCP) is a procedure that uses an endoscope to examine and x-ray the pancreatic duct, hepatic duct, common bile duct, duodenal papilla, and gallbladder.
Familial Adenomatous Polyposis (FAP) is an inherited disease of the large intestine marked by the formation especially in the colon and rectum of numerous glandular polyps which typically become malignant if left untreated.
Gastroesophageal reflux disease (GERD) is a condition, in which stomach contents, including gastric acid, refluxes into the esophagus, which causes troublesome symptoms, complications, or both. GERD may lead to esophagitis. Erosive esophagitis also called reflux esophagitis, is inflammation of the lining of the esophagus, caused by irritation of the esophagus and inflammation of the lining of the esophagus from stomach acid. Mild erosive esophagitis is classified as Los Angeles grade A/B, while severe erosive esophagitis is classified as Los Angeles grade C/D. Esophagitis is classified in severity by the Los Angeles Classification
Iron deficiency anemia is the most common type of anemia occurring when the body doesn't have enough iron, which the body needs to make hemoglobin.
Odynophagia: is pain while swallowing.
Pancreatitis is inflammation of the pancreas.
Pernicious anemia is a decrease in red blood cells that occurs when the intestines cannot properly absorb vitamin B12.

Portal hypertension is elevated blood pressure in the portal vein and the smaller veins that branch off from it. The portal venous system drains blood from the stomach, intestines, pancreas and spleen into the liver through the portal vein.

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Purpose

The purpose of the HealthHelp's clinical guidelines is to assist healthcare professionals in selecting the medical service that may be appropriate and supported by evidence to safely improve outcomes. Medical information is constantly evolving, and HealthHelp reserves the right to review and update these clinical guidelines periodically. HealthHelp reserves the right to include in these guidelines the clinical indications as appropriate for the organization's program objectives. Therefore the guidelines are not a list of all the clinical indications for a stated procedure, and associated Procedure Code Tables may not represent all codes available for that state procedure or that are managed by a specific client-organization.

Clinician Review

These clinical guidelines neither preempt clinical judgment of trained professionals nor advise anyone on how to practice medicine. Healthcare professionals using these clinical guidelines are responsible for all clinical decisions based on their assessment. All Clinical Reviewers are instructed to apply clinical indications based on individual patient assessment and documentation, within the scope of their clinical license.

Payment

The use of these clinical guidelines does not provide authorization, certification, explanation of benefits, or guarantee of payment; nor do the guidelines substitute for, or constitute, medical advice. Federal and State law, as well as member benefit contract language (including definitions and specific contract provisions/exclusions) take precedence over clinical guidelines and must be considered first when determining eligibility for coverage. All final determinations on coverage and payment are the responsibility of the health plan. Nothing contained within this document can be interpreted to mean otherwise.

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