Upper GI Endoscopy

Adjudication Guideline

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Approved by:	Responsible:	Related Adjudication Guidelines:
Daman	Medical Standards & Research	N/A

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1. Abstract

1.1 For Members

Upper GI endoscopy is a procedure in which a doctor uses an endoscope a flexible tube with a camera to see the lining of your upper GI tract. Upper GI endoscopy can be used to identify and treat many different diseases such as gastroesophageal reflux disease, ulcers, cancer, and inflammation, or swelling.

1.2 For Medical Professionals

Esophagogastroduodenoscopy (EGD), also known as upper gastro-intestinal (GI) endoscopy, upper endoscopy, or gastroscopy and refers to examination of the oesophagus, stomach, and upper duodenum (first part of the small intestine) by means of a flexible fibre-optic endoscope.

It is used to investigate and treat the cause(s) of abdominal pain, dysphagia, gastro-oesophageal reflux disease (GERD), hematemesis, persistent nausea and vomiting, as well as occult and obscure Upper GI bleeding.

2. Scope

The scope of this adjudication rule is to highlight the medical necessity and coverage of upper GI endoscopy for all health insurance plans administered by Daman subject to policy terms and conditions.

3. Adjudication Policy

3.1 Eligibility / Coverage Criteria

- **Gastritis:**
  Failure of medical therapy (e.g., poor response to H2-receptor antagonists/proton pump inhibitors/Helicobacter pylori therapy) four weeks course in duodenal ulcer & 8 weeks for gastric ulcer.

- **Dyspepsia & one of the following:**
  - Age 60 years or older.
  - Endoscopic evaluation of patients <60 years is reserved for patients with any one of the following:
    - Clinically significant weight loss (>5 percent usual body weight over 6 to 12 months).
    - Overt gastrointestinal bleeding; Melena/Hematemesis/Active rectal bleed.

- **Treatment of rapidly progressive features** such as suspected hemodynamic instability due to shock/bleeding considering relative contraindications.

- **Use of NSAIDs** - 8 weeks course.

- **Suspected malignancies** defined by more than one other alarm feature as shown below:
  - Dysphagia or odynophagia.
  - Family history of upper GI cancer in first-degree relative.
  - History of gastric surgery.
  - Iron deficiency anaemia once other causes are ruled out.
  - Vomiting.
  - Unexplained weight loss of more than 3 kg (6.6 lb.) since symptoms began.

- **Dysphagia** and one of the following:
  - Bleeding/Coughing up blood.
  - Eosinophilic esophagitis, suspected, and need for biopsy.
  - Foreign body, known or suspected.
  - Malignant compression and need for stent placement.
  - Mechanical obstruction, suspected, due to clinical signs or results of radiographic testing (e.g., Schatzki ring, vascular ring, oesophageal stricture, gastric outlet obstruction).
  - Upper GI malignancy features.

- **Treatment and monitoring of malignancies such as:**
  - Ablation of polyp, tumour, or other lesions
  - Assessment of response following completed chemoradiation for squamous cell oesophageal or esophagogastric junction cancer

- Dilation of malignant stricture
- Endoscopic mucosal resection or submucosal dissection of oesophageal or esophagogastric junction cancer (high-grade dysplasia (Tis), carcinoma limited to lamina propria or muscularis mucosa (T1a), or superficial submucosa carcinoma (T1b) without lymph vascular invasion

- **Peptic ulcer disease with 1 or more of the following:**
  - Blood in stool- black tarry stool
  - Definitive diagnosis of Helicobacter pylori infection required with all the following:
    - Empirical trial of treatment inappropriate because of history of adverse drug reactions.
    - Results of non-invasive tests for Helicobacter pylori negative or indeterminate, consider previous treatment by asking the provider for the medical history in the system i.e. pharmacological treatment done for at least 4 weeks prior to the request.
  - History of UGI surgery, gastrointestinal tract anomalies, or complicated antral, pyloric, or duodenal ulcer with scarring or gastric outlet obstruction.
  - Iron deficiency anaemia.

- **Gastric ulcer and one or more of the following:**
  - Dysplasia on initial biopsy.
  - Family history of gastric cancer.
  - Ulcer appearance on initial endoscopy large or suspicious for malignancy.
  - Ulcer appearance on UGI barium study suspicious for malignancy.
  - Ulcer not associated with NSAID usage for 4 weeks.

- **After treatment of duodenal ulcer, with one or more of the following:**
  - Incomplete clinical response to treatment.
  - Ulcer initially greater than 2 cm in diameter.

- **Gastroesophageal reflux disease symptoms and one or more of the following:**
  - Anaemia.
  - Dysphagia.
  - Epigastric mass on examination.
  - Failure of medical therapy (e.g., poor response to empiric twice-daily proton pump inhibitor for 4 to 8 weeks).
  - Gastrointestinal bleeding.
  - Male 50 years or older with 5 years or more of gastroesophageal reflux disease symptoms and one or more of the following:
    - Elevated BMI - 30 & above.
    - Hiatal hernia.
    - Intra-abdominal distribution of fat.
    - Nocturnal reflux symptoms.

        - Tobacco use.
    - Recurrent vomiting.
    - Severe erosive esophagitis, known, and need for follow-up after therapy.
    - Unexplained Weight loss of more than 3 kg (6.6 lb.) since symptoms began.

- **Achalasia.**

- **Barrett oesophagus:** Kindly refer to Table 1 to know the condition and its recommendation. Endoscopic resection and/or ablation (i.e., cryoablation, radiofrequency, or photodynamic therapy) for high-grade dysplasia (Tis) or mucosal tumours that do not invade submucosa (T1a).

Table.1 Upper GI indication for Barrett's oesophagus evaluation and monitoring:

Condition	Recommendation
Nondysplastic Barrett oesophagus (metaplastic columnar or glandular epithelium) on previous endoscopy	UGI endoscopy with 4-quadrant biopsy every 3 to 5 years
Low grade Dysplasia	Repeat UGI endoscopy at 6 months to reconfirm diagnosis, then annually
High grade dysplasia	Every 3 months for year 1, every 6 months for 2 years, then annually

- **Crohn's disease, Duodenal disease (Celiac disease, tumors).**

- **Caustic ingestion with symptoms.**

- **Stent placement for obstruction due to intrinsic or extrinsic compression.**

- **Tumor debulking or ablation**

- **Esophageal varices: Need for ligation or sclerosis of known esophageal varices.**

- **Gastrointestinal bleeding**:

    - Blood in stools, and negative colonoscopy.
    - Blood in stools, and positive nasogastric tube aspirate.
    - Hematemesis.

- Lower gastrointestinal bleeding, with indeterminate colonoscopy, and clinical presentation suggests UGI source (e.g., dyspepsia, reflux, NSAID use, peptic ulcer disease, liver disease, alcohol abuse).
- Melena.
- Persistent occult bleeding after negative endoscopies and need for repeat test- 6 month.
- Recurrent bleeding evident, with history of UGI bleeding or ulcer.

- **Iron deficiency anaemia and 1 or more of the following:**
  - Dyspepsia.
  - Patient is male or postmenopausal female.
  - Source of blood not found on colonoscopy.
  - Nausea and vomiting, unexplained.
  - Odynophagia.

Contraindications for Upper GI Endoscopy
Possible perforation
Medically unstable patients
Unwilling patients
Anticoagulation
Pharyngeal diverticulum

Eligible Clinician specialty:

Eligible Clinician
Gastroenterology
General surgery/Gastroenterology
Paediatric surgery/Gastroenterology
Clinicians with privilege in performing endoscopy

3.2 Requirements for Coverage

- The Questionnaire must be filled and submit the required documents for preauthorization request for Upper GI.
- ICD and CPT codes must be coded to the highest level of specificity.
- Failure to submit, upon request or when requesting a clinical history, indication the need for testing will result in rejection of claim.

3.3 Non-Coverage

- Upper GI will not be covered for visitor's plan.
- Upper GI is not covered if contraindicated.
- Complications from diagnosis that is general exclusion for that plan (ex. Alcoholic liver cirrhosis) will not be covered.
- If Clinician specialty other than mention category will not be covered.

3.4 Payment and Coding Rules

Kindly apply regulator's payment rules and regulations and relevant coding manuals for ICD, CPT.

4. Denial Codes

Code	Code Description
MNEC-003	Service is not clinically indicated based on good clinical practice
MNEC-004	Service is not clinically indicated based on good clinical practice, without additional supporting diagnoses/activities
MNEC-005	Service /supply may be appropriate, but too frequent
NCOV-003	Service(s) is (are) not covered
CODE-010	Activity/diagnosis inconsistent with clinician specialty

5. Appendices

5.1 References

- https://www.uptodate.com/contents/approach-to-the-adult-with-dyspepsia#H59602579
- https://www.uptodate.com/contents/approach-to-the-evaluation-of-dysphagia-in-adults
- https://www.asge.org/docs/default-source/education/practice_guidelines/docdyspepsia_aip.pdf?sfvrsn=bdc94951_6
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- https://www.uptodate.com/contents/peptic-ulcer-diseasemanagement
- https://emedicine.medscape.com/article/185856-overview#showall
- https://emedicine.medscape.com/article/1610470-overview#showall
- https://reference.medscape.com/article/169974-workup#showall
- http://www.childrenshospital.org/conditions-and-treatments/conditions/e/esophagealatresia/diagnosis-and-treatment
- https://emedicine.medscape.com/article/934420-workup#c7

5.2 Revision History

Date	Change(s)
13/05/2022	Release of V1.0
10/01/2023	Release of V1.1 Questionnaire link update
31/12/2024	Release of V2.0 Format changes, general review.