Clinical Policy: Upper GI Endoscopy for GERD

Reference Number: WA.CP.MP.509
Last Review Date: 06/24
Effective Date: 08/01/24

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

This policy describes the medical necessity guidelines for diagnostic upper gastro-intestinal (UGI) endoscopy for gastroesophageal reflux disease (GERD).

Policy/Criteria

I. It is the policy of Coordinated Care of Washington, Inc., in accordance with the Health Care Authority's Health Technology Assessment and Health Care Authority Billing Guidelines, that diagnostic UGI endoscopy for GERD is considered **medically necessary** for either of the following conditions:

A. Failure of an adequate trial of medical treatment to improve or resolve symptoms, or
B. Presence of alarm symptoms:
   i. Persistent dysphagia or odynophagia
   ii. Persistent vomiting of unknown origin
   iii. Evaluation of epigastric mass
   iv. Confirmation and specific histological diagnosis of radiologically demonstrated lesions
   v. Evaluation of chronic blood loss and iron deficiency anemia when an UGI source is suspected or when colonoscopy results are negative
   vi. Progressive unintentional weight loss

Background

This policy is based entirely on Washington State Health Care Authority (HCA) Health Technology Assessment (HTA) and Health Care Authority Billing Guidelines.

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2019, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT® Codes	Description
43200	Esophagoscopy, flexible, transoral; diagnostic, incl collection of specimen
43202	Esophagoscopy, flexible, transoral; w biopsy

CPT® Codes	Description
43235	EGD, flexible, transoral; diagnostic, incl collection of specimen
43237	EGD, flexible, transoral; w/ endoscopic ultrasound exam limited to the esophagus, stomach or duodenum and adjacent structures
43238	EGD, flexible, transoral; w/ transendoscopic ultrasound-guided intramural or transmural fine need aspiration/biopsy (includes endoscopic ultrasound of esophagus, stomach or duodenum)
43239	EGD, flexible, transoral; w biopsy
43242	EGD, flexible, transoral; w/ transendoscopic ultrasound-guided intramural or transmural fine need aspiration/biopsy (includes endoscopic ultrasound of esophagus, stomach and duodenum)

Reviews, Revisions, and Approvals	Date	Approval Date
Policy developed.	09/19	09/19
Annual review. References updated. CPT 43200, 43202 and 43239 added.	07/20	08/20
Annual review. Removed reference to gastro-intestinal symptoms in the Description and Section II to mirror Billing Guideline. References updated. Replaced all instances of "member" with "member/enrollee".	06/21	07/21
Annual review. Detailed alarm symptoms. Updated reference.	05/22	06/22
Annual review. References reviewed and updated. Section II. A. language updated to mirror billing guidelines.	05/23	06/23
Annual review. References reviewed and updated. CPT codes 43237, 43238 and 43242 added per billing guidelines. Description and section I. updated to reflect diagnostic endoscopy per billing guidelines. Removed section II. header and use of InterQual guidelines; converted policy to billing guidelines/HTA only.	06/24	06/24

References

1. Liu, R., Kriz, H., Thielke, A., Vandergriff, S., King, V. Center for Evidence-based Policy (Oregon Health & Science University). Upper Endoscopy for Gastroesophageal Reflux Disease & Upper Gastrointestinal Symptoms. Washington Health Technology Assessment. April 12, 2012.
2. Washington State Health Care Authority. Physician-related Services/Health Care Billing Guide. https://www.hca.wa.gov/assets/billers-and-providers/Physician-related-services-bg-20240401.pdfRevision effective April 1, 2024.

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and

accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/Enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

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Note: For Medicaid members/enrollees, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.