Harvard Pilgrim Health Care | TUFTS Health Plan

Medical Necessity Guidelines:

Upper Gastrointestinal Endoscopy (Esophagogastroduodenoscopy, EGD)

Effective: September 1, 2025

Prior Authorization Required If REQUIRED, submit supporting clinical documentation pertinent to service request to the FAX numbers below	Yes ☐ No ☒
Notification Required IF REQUIRED, concurrent review may apply	Yes ☐ No ☒

Applies to:

Commercial Products

☒ Harvard Pilgrim Health Care Commercial products; 800-232-0816

☒ Tufts Health Plan Commercial products; 617-972-9409

CareLink℠ – Refer to CareLink Procedures, Services and Items Requiring Prior Authorization

Public Plans Products

☒ Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product); 888-415-9055

☒ Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans; 888-415-9055

☒ Tufts Health RITogether – A Rhode Island Medicaid Plan; 857-304-6404

☒ Tufts Health One Care – A dual-eligible product; 857-304-6304

Senior Products

☒ Tufts Health Plan Senior Care Options (SCO), (a dual-eligible product); 617-673-0965

☒ Tufts Medicare Preferred HMO, (a Medicare Advantage product); 617-673-0965

☒ Tufts Medicare Preferred PPO, (a Medicare Advantage product); 617-673-0965

Note: While you may not be the provider responsible for obtaining prior authorization or notifying Point32Health, as a condition of payment you will need to ensure that any necessary prior authorization has been obtained and/or Point32Health has received proper notification. If notification is required, providers may additionally be required to provide updated clinical information to qualify for continued service.

Overview

Esophagogastroduodenoscopy (EGD) is a test used to examine the lining of the esophagus, stomach, and the duodenum. EGD is also known as upper gastrointestinal endoscopy, gastroscopy, or upper endoscopy. EGD is indicated for the diagnosis of numerous conditions such as, but not limited to, Celiac disease, esophageal varices, esophagitis, gastritis, GERD, hiatal hernia, ulcers, Mallory-Weiss syndrome, and esophageal rings. EGD may also be indicated for the investigation of symptoms such as upper gastrointestinal symptoms and upper gastrointestinal bleeding. Abnormal imaging or caustic ingestion may also indicate the need for EGD.

Clinical Guideline Coverage Criteria

The Plan considers Esophagogastroduodenoscopy (EGD) medically necessary for the following (this list is NOT all inclusive):

1. Diagnostic/Evaluation for dyspepsia or upper abdominal symptoms:
    a. Celiac Disease
    b. Acute caustic ingestion
    c. Confirmation of gastric or esophageal ulcer, suspected neoplastic lesion, or upper GI tract stricture or obstruction

d. Dysphagia or odynophagia
e. Esophageal cancer evaluation post resection with signs or symptoms of loco-regional recurrence
f. Esophageal masses and diagnostic esophageal cancer biopsies
g. Familial adenomatous polyposis syndromes
h. Indeterminate colitis (differentiation of Crohn's disease from ulcerative colitis)
i. Irritable bowel syndrome when other studies have negative results
j. Persistent or recurrent esophageal reflux symptoms despite therapy
    i. Persistent (four weeks or greater) upper abdominal symptoms such as pain, nausea or vomiting that Fail to respond to medication therapy OR
    ii. Symptoms are associated with weight loss, GI bleeding, melena, anemia, anorexia or early satiety
k. Iron deficient anemia
l. Persistent vomiting of unknown cause
m. Recent or active GI bleeding
n. Suspected portal hypertension
o. Upper abdominal symptoms associated with other signs or symptoms suggesting serious organic disease or new onset symptoms in members over 50 years of age who are refractory to treatment with a proton pump inhibitor trial
p. Upper GI tissue or fluid sampling

2. High-risk screening for:
    a. Chronic (at least 5 years) gastro-esophageal reflux disease (GERD) at risk for Barrett's esophagus (BE) who have had no prior negative EGD screening.
    b. Cirrhosis and portal hypertension without prior variceal hemorrhage, especially those with platelet counts less than 140,000/mm3, or Child's class B or C disease.
    c. Symptomatic pernicious anemia
3. Therapeutic EGD treatment for:
    a. Achalasia management by botulinum toxin, balloon dilation
    b. Banding or sclerotherapy of varices
    c. Dilation of stenotic lesions
    d. Feeding or drainage tube placement
    e. Removal of foreign bodies or selected polypoid lesions
    f. Stenosing neoplasm palliative treatment by laser, multi-polar electrocoagulation, stent placement
    g. Treatment of bleeding lesions (ulcers, tumors, vascular abnormalities) by electrocoagulation, heater probe, laser photocoagulation, or injection therapy.
    h. Symptoms consistent with celiac disease
4. Sequential or periodic EGD for:
    a. Barrett's esophagus surveillance in the absence of dysplasia (every 3 years)
    b. Barrett's esophagus surveillance with high-grade dysplasia (every 3 months)
    c. Barrett's esophagus surveillance with low-grade dysplasia (yearly)
    d. Familial adenomatous polyposis (at time of colectomy or after age 30)
    e. Hereditary non-polyposis colorectal cancer
    f. Recurrence of adenomatous polyps in synchronous and metachronous sites (every 3 to 5 years)
5. Severe caustic esophageal injury
    a. Tylosis

Limitations

The Plan considers EGD as not medically necessary for all other indications in addition to the following:

1. EGD for confirmation of gastric band placement
2. EGD related to pre-evaluation of Members scheduled for bariatric surgery is not covered unless meeting one of the clinical criteria above
3. EGD related to sclerotherapy for bariatric indications (e.g., revision of Roux-en-Y procedure to address weight regain) as this is considered investigational and, therefore, not medically necessary

4. EGD related to endoscopic gastric suturing (e.g., with the Apollo Overstitch™ System) for revision of gastric bypass or as a primary bariatric procedure as these procedures are considered investigational and, therefore, not medically necessary
5. EGD related to placement of the TransPyloric Shuttle device for bariatric indications as this is considered investigational and, therefore, not medically necessary
6. Upper GI endoscopies to rule out celiac disease for the following:
    - Individuals with low risk of disease (for example infertility, GI symptoms with negative serology and without indicators of malabsorption, or osteoporosis without other evidence of malabsorption)

Codes

The following code(s) are associated with this service:

Table 1: CPT/HCPCS Codes

Code	Description
43200	Esophagoscopy, flexible, transoral; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)
43202	Esophagoscopy, flexible, transoral; with biopsy, single or multiple
43231	Esophagoscopy, flexible, transoral; with endoscopic ultrasound examination
43233	Esophagogastroduodenoscopy, flexible, transoral; with dilation of esophagus with balloon 30 mm diameter or larger) (includes fluoroscopic guidance, when performed)
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 esophagus
43238	Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s), (included endoscopic ultrasound examination limited to esophagus)
43239	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)
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 and/or jejunum as appropriate)
43259	Esophagogastroduodenoscopy, flexible, transoral; with endoscopic ultrasound examination, including the esophagus, stomach, and either the duodenum and/or jejunum as appropriate

List of Medically Necessary ICD-10 Codes

References:

1. ASGE Standards of Practice Committee, Early, DS., Ben-Menachem, T., et al. Appropriate use of GI endoscopy. Gastrointest Endosc. 2012; 75:1127.
2. ASGE Standards of Practice Committee, Shen, B., Khan, K., et al. The role of endoscopy in the management of patients with diarrhea. Gastrointest Endosc. 2010; 71(6):887-892.
3. De Palma, GD., Forestieri, P. Role of endoscopy in the bariatric surgery of patients. World J Gastroenterol. 2014; 20(24):7777-7784.
4. DeVault, KR., Castell, DO. American College of Gastroenterology. Updated guidelines for the diagnosis and treatment of gastroesophageal reflux disease. Am J Gastroenterol. 2005;100(1):190-200.
5. Gomez, V., Bhalla, R., Heckman, MG., Florit, PT., Diehl, NN., Rawal, B., Lynch, SA., Loeb, DS. Routine screening endoscopy before bariatric surgery: is it necessary? Bariatr Surg Pract Patient Care. 2014; 9(4):143-149.
6. Greenwald, DA., Cohen, J. Overview of upper gastrointestinal endoscopy (esophagogastroduodenoscopy). In: UpToDate, Howell, DA (Ed). UpToDate, Waltham, MA. Accessed October 19, 2023.
7. No authors listed. Endoscopy. The Merck Manual Online. Porter RS, Kaplan JL, Homeier BP, Beers MH, eds. Whitehouse Station, NJ: Merck Research Laboratories; updated February 2013. Available at: http://www.merck.com/mmpe/sec02/ch009/ch009c.html. Accessed October 19, 2023.
8. Wald, A. Etiology and evaluation of chronic constipation in adults. In: UpToDate, Talley, NJ (Ed). UpToDate,

Waltham, MA. Accessed October 19, 2023.

Approval And Revision History

December 21, 2022: Reviewed by the Medical Policy Approval Committee (MPAC) for integration between Harvard Pilgrim Health Care and Tufts Health Plan for effective date June 1, 2023. Prior Authorization removed from Tufts Health Plan. Criteria and coding updated

Subsequent endorsement date(s) and changes made:

- September 20, 2023: Reviewed by MPAC, renewed without changes
- November 2023: Unify name changed to One Care effective January 1, 2024
- August 30, 2024: Reviewed by MPAC, renewed without changes, effective October 1, 2024
- May 21, 2025: Reviewed by MPAC, addition of Tufts Senior Care Options and Tufts Medicare Preferred HMO and PPO as applicable products effective September 1, 2025. Harvard Pilgrim Health Care Stride Medicare Advantage, removed as an applicable product from template

Background, Product and Disclaimer Information

Medical Necessity Guidelines are developed to determine coverage for benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. We make coverage decisions using these guidelines, along with the Member's benefit document, and in coordination with the Member's physician(s) on a case-by-case basis considering the individual Member's health care needs.

Medical Necessity Guidelines are developed for selected therapeutic or diagnostic services found to be safe and proven effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in our service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. We revise and update Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Medical Necessity Guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern. For Tufts Health Together (Medicaid), coverage may be available beyond these guidelines for pediatric members under age 21 under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits of the plan in accordance with 130 CMR 450.140 and 130 CMR 447.000, and with prior authorization.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of this guideline is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to eligibility and benefits on the date of service, coordination of benefits, referral/authorization, utilization management guidelines when applicable, and adherence to plan policies, plan procedures, and claims editing logic.