MEDICAL POLICY

POLICY TITLE	**ESOPHAGOGASTRODUODENOSCOPY (EGD)**
POLICY NUMBER	**MP 2.402**

CLINICAL BENEFIT	☐ **MINIMIZE SAFETY RISK OR CONCERN.** ☒ **MINIMIZE HARMFUL OR INEFFECTIVE INTERVENTIONS.** ☐ **ASSURE APPROPRIATE LEVEL OF CARE.** ☐ **ASSURE APPROPRIATE DURATION OF SERVICE FOR INTERVENTIONS.** ☐ **ASSURE THAT RECOMMENDED MEDICAL PREREQUISITES HAVE BEEN MET.** ☐ **ASSURE APPROPRIATE SITE OF TREATMENT OR SERVICE.**
Effective date:	**7/1/2026**

POLICY

Esophagogastroduodenoscopy (EGD) is considered medically necessary and, therefore, covered in the following situations when any of the medical necessity criteria listed below under diagnostic, therapeutic, or surveillance/periodic EGD are met:

- As the initial method of evaluation of symptoms as an alternative to radiographic studies
- Following an unsuccessful empirical trial of therapy for a suspected benign digestive disorder
- If a change in management is probable based on results of EGD
- When a primary therapeutic procedure is contemplated

Diagnostic EGD

- Upper abdominal distress (pain or discomfort) that persists despite an appropriate trial of therapy (e.g., acid suppression with proton-pump inhibitors [PPI])
- Upper abdominal distress (pain or discomfort) associated with symptoms and/or signs suggesting structural disease (e.g., prolonged anorexia and weight loss) or new-onset symptoms in individuals older than 50 years of age
- Dysphagia (difficulty or discomfort in swallowing) or odynophagia (painful swallowing)
- Esophageal reflux symptoms that persist or recur despite appropriate therapy
- Persistent vomiting of unknown cause
- Other systemic diseases in which the presence of upper gastrointestinal (GI) pathology might modify other planned management (e.g., individuals with a history of GI bleeding who are scheduled for organ transplantation, long-term anticoagulation, and chronic nonsteroidal therapy for arthritis, and those with cancer of the head and neck)
- Familial adenomatous polyposis syndromes
- Confirmation and specific histologic diagnosis of radiologically demonstrated lesions:
    - Suspected neoplastic lesion

  - Gastric or esophageal ulcer
  - Upper tract stricture or obstruction
- The presence of GI bleeding for any of the following: Active or recent GI bleeding
  - In individuals actively bleeding or those recently stopped
  - When surgical therapy is contemplated
  - When re-bleeding occurs after acute self-limited blood loss or after endoscopic therapy
  - When portal hypertension or aortoenteric fistula is suspected
  - Presumed chronic blood loss and iron deficiency anemia when the clinical situation suggests an upper GI source or when colonoscopy does not provide an explanation
- When sampling of duodenal or jejunal tissue or fluid is indicated
- To assess acute injury after caustic agent ingestion
- Individuals suspected of having small-bowel disease (e.g., celiac disease)
- Intraoperative evaluation of anatomic reconstructions typical of modern foregut surgery (e.g., evaluation of anastomotic leak and patency, fundoplication formation, pouch configuration during bariatric surgery)
- Pernicious anemia 6 months after diagnosis or at the development of upper GI symptoms

Therapeutic EGD

- Suspected portal hypertension or cirrhosis to document or treat esophageal varices
- Bleeding lesions such as ulcers, tumors, vascular abnormalities (e.g., electrocoagulation, heater probe, laser photocoagulation, or injection therapy)
- Removal of foreign bodies
- Removal of selected lesions
- Esophageal stricture dilation/management of achalasia (e.g., botulinum toxin, balloon dilation)
- Placement of feeding or drainage tubes (e.g., peroral, percutaneous endoscopic gastrostomy, percutaneous endoscopic jejunostomy)
- Dilation and stenting of stenotic lesions (e.g., with transendoscopic balloon dilators or dilation systems using guidewires)
- Palliative treatment of stenosing neoplasms (e.g., laser, multipolar electrocoagulation, stent placement)

- Endoscopic therapy of intestinal metaplasia
- Management of operative complications (e.g., dilation of anastomotic strictures, stenting of anastomotic disruption, fistula, or leak in selected circumstances)

Premalignant Condition

- Barrett esophagus (BE):
    - Without dysplasia, every 3 to 5 years
    - Indeterminate for dysplasia, a repeat EGD to clarify presence and grade of dysplasia
    - Low-grade dysplasia (LGD), a repeat EGD in 6 months to confirm LGD, then yearly
    - High-grade dysplasia (HGD), every 3 months for 1 year; after 1 year of no cancer detection, repeat EGD at lengthened intervals.
- Caustic ingestion: beginning at 15 to 20 years following the acute injury, at an interval of every 1 to 3 years
- Tylosis: beginning at 30 years of age, at an interval of every 1 to 3 years
- Gastric epithelial polyps:
    - Beginning at 1 year after removal of adenomatous gastric polyps to assess recurrence at the prior excision site, new or previously missed polyps, and/or supervening early carcinoma:
        - If the results of this examination are negative, every 3 to 5 years
        - High-grade dysplasia and early gastric cancer, EGD at individualized intervals
- Familial adenomatous polyposis (FAP) and hereditary nonpolyposis colorectal cancer (HNPCC):
    - Beginning at the time of a colectomy or after 30 years of age:
        - If no adenomas, repeat EGD in 5 years
        - Duodenal and periampullary adenomas, at intervals based on stage of disease
        - Papillary adenomas in individuals with advanced adenomas or dysplasia after complete excision, EGD with multiple biopsies every 6 months for a minimum of 2 years; thereafter every 3 years
    - HNPCC, EGD surveillance will be covered
- Gastric intestinal metaplasia:

    - Confirmed gastric intestinal metaplasia with high-grade dysplasia
- Mucosa-associated lymphoid tissue (MALT) lymphoma:
    - Every 3 to 6 months for the first 2 years after *Helicobacter pylori* eradication; after the first 2 years, every 6 to 12 months.

Esophageal Varices

- Compensated cirrhosis with no varices on initial screening EGD, another EGD every 2 to 3 years. If the individual has small varices, another endoscopy every 1 to 2 years.
- Cirrhosis secondary to alcohol abuse or decompensated liver disease with no findings of varices on the initial screening endoscopy, periodic EGD yearly for the screening of development of esophageal varices.
- A yearly endoscopy for small varices accompanied by high-risk stigmata (red wale marks or red spots) on screening endoscopy.

An EGD is considered **investigational** as there is insufficient evidence to support a general conclusion supporting the health outcomes or benefits associated with this procedure for treatment of conditions such as the following:

- For the evaluation of symptoms that are considered functional in origin (i.e., no physiologic cause for GI complaints is found, even after extensive evaluation)
- Metastatic adenocarcinoma of unknown primary site when the results will not alter management.
- Radiographic findings of:
    - Asymptomatic or uncomplicated sliding hiatal hernia
    - Uncomplicated duodenal bulb ulcer that has responded to therapy
    - Deformed duodenal bulb when symptoms are absent or respond adequately to ulcer therapy
- Prior to bariatric surgery in asymptomatic individuals
- Routine screening in asymptomatic individuals
- Screening or evaluation of colorectal cancer not associated with familial adenomatous polyposis (FAP) syndrome

Sequential or periodic EGD is considered **investigational** as there is insufficient evidence to support a general conclusion supporting the health outcomes or benefits associated with this procedure for treatment of conditions such as the following:

- Surveillance for malignancy in individuals with gastric atrophy, pernicious anemia, fundic gland or hyperplastic polyps, gastric intestinal metaplasia, or previous gastric operations for benign disease
- Surveillance of healed benign disease, such as esophagitis and gastric or duodenal ulcer
- Repeat EGD for individuals with a prior normal or negative EGD, if symptoms remain unchanged
- Surveillance EGD for individuals with adequate sampling or removal of nondysplastic gastric polyps

Cross-Reference:
MP 1.015 Bariatric Surgery
MP 1.118 Endoscopic Radiofrequency Ablation for Cryoablation for Barrett's Esophagus
MP 2.093 Confocal Laser Endomicroscopy

PRODUCT VARIATIONS

This policy is only applicable to certain programs and products administered by Capital Blue Cross and subject to benefit variations. Please see additional information below.

FEP PPO - Refer to FEP medical policy manual. The FEP medical policy manual can be found at: fepblue.org/benefit-plans/medical-policies-and-utilization-management-guidelines/medical-policies.

DESCRIPTION/BACKGROUND

ESOPHAGOGASTRODUODENOSCOPY
Esophagogastroduodenoscopy (EGD), also known as an upper gastrointestinal (GI) endoscopy, involves examining the lining of the upper part of the GI tract, which includes the esophagus, stomach, and duodenum (first portion of the small intestine). EGD involves the use of a thin, flexible tube called an endoscope, which has its own lens and light source and projects images on a video monitor.

An EGD is often indicated for evaluation and treatment of abdominal symptoms. Some diagnostic indications may include abdominal symptoms, difficulty and/or painful swallowing, GI bleed, esophageal reflux, and suspected neoplasm. Therapeutic indications may include stricture dilation, removal of foreign body, treatment of bleeding lesions, sclerotherapy of varices, and removal of selected lesions.

An EGD can evaluate, diagnose, and manage various GI problems, including difficult or painful swallowing, pain in the stomach or abdomen, GI bleed, ulcers, and tumors. Tiny instruments can be passed through an opening in the endoscope to obtain tissue samples, coagulate

bleeding sites, dilate or stretch a narrowed area, or perform other treatments.

EGD can be used to periodically monitor individuals with esophageal varices or premalignant conditions (i.e., Barrett esophagus, caustic ingestion, tylosis, gastric epithelial polyps, familial adenomatous polyposis, or hereditary nonpolyposis colorectal cancer).

RATIONALE

BARRETT ESOPHAGUS (BE)

For individuals with BE who are undergoing surveillance and receive CLE with targeted biopsy, the evidence includes several randomized controlled trials (RCTs), observational studies, systematic reviews, and meta-analyses. Evidence from RCTs has suggested that CLE has similar or higher sensitivity than standard endoscopy for identifying areas of dysplasia. More prospective RCTs and high-quality meta-analyses are needed. The evidence is insufficient to determine that this technology results in an improvement in the net health outcome.

A single-center crossover RCT was published by Dunbar et al. (2009). Forty-six individuals with BE were enrolled, and 39 (95%) completed the study protocol. Of these, 23 were undergoing BE surveillance, and 16 had BE with suspected neoplasia. All individuals received endoscopy-based CLE and standard endoscopy, in random order. One endoscopist performed all CLE procedures, and another endoscopist performed all standard endoscopy procedures; endoscopists were blinded to the finding of the other procedure. During the standard endoscopy procedure, biopsy specimens were taken of any discrete lesions followed by four-quadrant random biopsy (every 1 cm for suspected neoplasia, every 2 cm for BE surveillance). During the CLE procedure, only lesions suspicious of neoplasia were biopsied. Endoscopists interpreted CLE images using the Confocal Barrett's Classification system, developed in a previous research study. Histopathologic analysis was the reference standard. Among the 16 study completers with suspected high-risk dysplasia, there were significantly fewer biopsies per individual with CLE (mean, 9.8 biopsies per individual) than with standard endoscopy (mean, 23.9 biopsies per individual; P=0.002). Although there were fewer biopsies, the mean number of biopsy specimens showing HGD or cancer was similar in the two groups (3.1 during CLE vs 3.7 during standard endoscopy). The diagnostic yield for neoplasia was 33.7% with CLE and 17.2% with standard endoscopy. None of the 23 individuals undergoing BE for surveillance had HGD or cancer. The mean number of mucosal specimens obtained for individuals in this group was 12.6 with white-light endoscopy and 1.7 with CLE (P<0.001).

Sharma et al. (2011) published an international, multicenter RCT that included 122 consecutive individuals presenting for surveillance of BE or endoscopic treatment of HGD or early carcinoma. Individuals were randomly assigned to both standard white-light endoscopy and narrow-band imaging. Following these two examinations, done in a blinded fashion, the location of lesions was unblinded and, subsequently, all individuals underwent pCLE. All examinations involved a presumptive diagnosis of suspicious lesions. Also, in both groups, after all evaluations were performed, all suspicious lesions were biopsied, as well as random locations (four quadrants every 2 cm). The histopathologic analysis was the reference standard. Twenty-one individuals were excluded from the analysis. Of the remaining 101 individuals, 66

(65%) were found on histopathologic analysis to have no dysplasia, four (4%) had low-grade dysplasia, six (6%) had HGD, and 25 (25%) had early carcinoma. Sensitivity of CLE plus white-light endoscopy for detecting HGD or early carcinoma was 68.3% (95% CI, 60.0%–76.7%), which was significantly higher than white-light endoscopy alone (34.2%; 95% CI, 25.7%–42.7%; *P*=0.002). However, specificity of CLE plus white-light endoscopy was significantly lower (87.8%; 95% CI, 85.5%–90.1%) than white-light endoscopy alone (92.7%; 95% CI, 90.8%–94.6%; *P*<0.001). For white-light endoscopy alone, the PPV was 42.7% (95% CI, 32.8%–52.6%) and NPV was 89.8% (95% CI, 87.7%–92.0%). For white-light endoscopy with pCLE, the PPV was 47.1% (95% CI, 39.7% to 54.5%) and NPV was 94.6% (95% CI, 92.9% to 96.2%). White-light endoscopy alone missed 79 (66%) of 120 areas with HGD or early carcinoma, and white-light endoscopy plus CLE missed 38 (32%) of 120 areas. On a per-individual basis, 31 individuals were diagnosed with HGD or early carcinoma. White-light endoscopy alone failed to identify four of these individuals (sensitivity, 87%), whereas white-light endoscopy plus CLE failed to identify two individuals (sensitivity, 93.5%).

The single RCT in a systematic review by Ypsilantis et al. published by Wallace et al. (2012) included individuals with BE who were undergoing ablation. After an initial attempt at ablation, individuals were randomly assigned to follow up with high-definition white-light endoscopy or high-definition white-light endoscopy plus CLE. The primary outcome was the proportion of optimally treated individuals, defined as those with no evidence of disease at follow-up, and those with residual disease who were identified and treated. Trial enrollment was halted after an interim analysis showed no difference between groups and higher than expected residual BE in both arms. Among the 119 individuals enrolled at the interim analysis, 15 (26%) of 57 in the high-definition white-light endoscopy group and 17 (27%) of 62 in the high-definition white-light endoscopy plus CLE group were optimally treated; the difference was not statistically significant. Moreover, other outcomes were similar in the two groups.

Canto et al. (2014) reported on a single-blind, multicenter trial conducted at academic centers with experienced endoscopists. It included consecutive individuals undergoing endoscopy for routine BE surveillance or for suspected or known neoplasia. Individuals were randomly assigned to high-definition white-light endoscopy with random biopsy (n=98) or white-light endoscopy with endoscopy-based CLE and targeted biopsy (n=94). In the white-light endoscopy-only group, four-quadrant random biopsy samples were taken every 1 to 2 cm over the entire length of the BE for individuals undergoing surveillance and every 1 cm for individuals with suspected neoplasia. In the CLE group, biopsy specimens were obtained only when there was CLE evidence of neoplasia. Final pathologic diagnosis was the reference standard. A per-individual analysis of diagnostic accuracy for diagnosing BE-related neoplasia found a sensitivity of 40% with white-light endoscopy only and 95% with white-light endoscopy plus CLE. Specificity was 98% with white-light endoscopy only and 92% with white-light endoscopy plus CLE. When the analysis was done on a per-biopsy specimen basis and when CLE was added, sensitivity was substantially higher, and specificity was slightly lower. The median number of biopsies per individual was significantly higher in the white-light endoscopy group (four biopsies) compared with the CLE group (two biopsies; *P*<0.001).

The investigators analyzed the number of cases in which CLE resulted in a different diagnosis. Thirty-two (34%) of 94 individuals in the white-light plus CLE group had a correct change in dysplasia grade after CLE compared with initial endoscopic findings. Six (19%) of the 32 individuals had lesions, and the remaining 26 did not. In 21 of the 26 individuals without lesions, CLE changed the plan from biopsy to no biopsy. The remaining 62 (65%) of 94 individuals in the white-light endoscopy plus CLE group had concordant diagnoses with both techniques. Because the trial was conducted at academic centers and used endoscopy-based CLE, findings may not be generalizable to other clinical settings or to pCLE.

In a meta-analysis, Gupta et al. (2014) evaluated the diagnostic accuracy of the CLE-based targeted biopsies detecting high-grade dysplasia (HGD)/adenocarcinoma compared with four-quadrant random biopsies. Seven studies with 345 individuals and 3080 lesions were included in the meta-analysis. For the diagnosis of HGD/adenocarcinoma, the pooled sensitivity was 68% (95% confidence interval [CI], 64%–73%), and pooled specificity was 88% (95% CI, 87%–89%). The per-individual analysis among four studies was a pooled sensitivity of 86% (95% CI, 74%–96%) and a pooled specificity of 83% (95% CI, 77%–88%). The meta-analysis concluded that CLE is not an acceptable replacement for biopsy techniques for the diagnosis of HGD/esophageal adenocarcinoma in BE.

In a meta-analysis, Xiong et al. (2016) evaluated the accuracy of CLE for diagnosis of neoplasia in BE. Fourteen studies were included covering 789 with 4047 lesions. The per-individual analysis among seven studies was a pooled sensitivity of 89% (95% CI, 82%–94%) and a pooled specificity of 83% (95% CI, 78%–86%). The per-lesion analysis among 10 studies was a pooled sensitivity of 77% (95% CI, 73%–81%) and a pooled specificity of 89% (95% CI, 87%–90%). Richardson et al. (2019) conducted a prospective study at eight centers in the United States to compare pCLE to conventional histology using the Seattle Protocol (random four-quadrant biopsy) to identify intestinal metaplasia among 172 individuals undergoing screening or surveillance endoscopy for BE. Endoscopists recruited for the study were early users of CLE with less than 2 years of experience and no formal pathology training. All individuals underwent a standardized endoscopy with white light and narrow band imaging evaluation, identification of landmarks, and recording of columnar-lined esophagus visualized according to the Prague classification. Individuals then received fluorescein followed by optical biopsy; images were interpreted both in real time and immediately following the procedure. After CLE images were acquired, esophageal biopsies were taken via the Seattle Protocol. Endoscopists were able to identify intestinal metaplasia among 99 individuals (57.6%) using CLE compared to 46 individuals (27%) using the Seattle Protocol (P<0.0001). Dysplasia was identified in six individuals using CLE compared with two individuals using the Seattle Protocol (both of which were also identified via CLE). Confocal laser endomicroscopy also identified significantly more individuals with intestinal metaplasia compared to the Seattle Protocol among those with visible columnar lined esophagus (75 vs. 31 individuals, respectively; P<0.0001), but not among those without columnar lined esophagus (24 vs. 15 individuals; P=0.067). Identification of intestinal metaplasia was not found to be significantly different when comparing CLE with expert review.

Vithayathil et al. (2022) conducted a randomized crossover trial of standard high-resolution white-light Seattle protocol endoscopy or autofluorescence imaging-guided pCLE in individuals referred for surveillance of nondysplastic BE or flat dysplasia at two high-volume tertiary centers in the United Kingdom. A total of 154 individuals were recruited, of whom eight were excluded based on presence of clear macroscopic lesions consistent with BE-related neoplasia upon first endoscopy. An additional individual was excluded due to a protocol breach (use of chromoendoscopy) and 11 individuals withdrew consent. A total of 134 individuals completed both arms of the study, with crossover occurring after a 6- to 12-week interval. Endoscopists were blinded to the endoscopy and histology results of the pretrial endoscopy and other study arm. In the per-lesion analysis, optical diagnosis by CLE had a sensitivity and specificity for HGD/intramucosal cancer (IMC) of 69.2% and 73.2%, respectively. In the per-individual analysis, there was no difference in the sensitivity of CLE for dysplasia compared with Seattle protocol for HGD/IMC (76.5% for both; *P*=1.00) or all grades of dysplasia (74.3% vs. 80.0%, respectively; *P*=0.48). The specificity of CLE was 60.7% for HGD and 66.7% for all grades of dysplasia. Use of a three-biomarker panel consisting of one or more of optical dysplasia on CLE, aberrant p53 on immunohistochemistry, and/or aneuploidy on flow cytometry was associated with a per-individual sensitivity and specificity of 94.1% and 49.6% for HGD and 91.4% and 56.6% for all grades of dysplasia, respectively. The authors concluded that CLE has similar diagnostic accuracy for dysplasia compared with standard Seattle protocol endoscopy. In addition, the use of molecular biomarkers can further improve diagnostic accuracy. Several study limitations were noted: (1) it cannot be excluded that prior biopsy sites may have appeared as irregularities on second endoscopy due to the crossover study design, (2) sensitivity for detecting dysplasia was inconsistent across endoscopists, and (3) results may not be generalizable to general practice centers.

In the American Society for Gastrointestinal Endoscopy (ASGE) technology status evaluation report, confocal laser endomicroscopy is considered an emerging technology with the potential to significantly reduce the number of biopsies in BE and irritable bowel disorder. Confocal laser endomicroscopy can provide surrogate real-time histological information of the bile duct and within the pancreatic cysts. ASGE concluded, "Before the technology can be widely accepted, many further studies are needed to determine its clinical efficacy and evaluate its cost-effectiveness and its utilization in both academic and community settings."

Practice Guidelines

National guidelines continue to recommend four-quadrant random biopsies for individuals with BE undergoing surveillance.

In 2016, the American Gastroenterological Association (AGA) published a clinical practice update expert review on the diagnosis and management of low-grade dysplasia in BE. Regarding the use of other advanced endoscopic imaging techniques, the guideline stated that the use of confocal laser endomicroscopy "cannot be recommended in the routine clinical management" of individuals undergoing surveillance.

In 2019, the ASGE published a guideline on screening and surveillance of BE that recommends against routine use of CLE compared with white-light endoscopy with Seattle protocol biopsy sampling in individuals with BE undergoing surveillance.

In 2022, the American College of Gastroenterology (ACG) published an updated clinical guideline for the diagnosis and management of BE and noted that in centers with a high prevalence of neoplasia or dysplasia, confocal endomicroscopy may be helpful in targeting biopsies and guiding therapy, although the value above that of high-definition white light is unclear. The guidelines did not include a recommendation for white light endoscopy plus CLE.

DEFINITIONS/BACKGROUND

N/A

DISCLAIMER

Capital Blue Cross' medical policies are used to determine coverage for specific medical technologies, procedures, equipment, and services. These medical policies do not constitute medical advice and are subject to change as permitted by law or applicable clinical evidence from independent treatment guidelines. Treating providers are solely responsible for medical advice and treatment of members. These policies are not a guarantee of coverage or payment. Payment of claims is subject to a determination regarding the member's benefit program and eligibility on the date of service, and a determination that the services are medically necessary and appropriate. Final processing of a claim is based upon the terms of contract that applies to the members' benefit program, including benefit limitations and exclusions. If a provider or a member has a question concerning this medical policy, please contact Capital Blue Cross' Provider Services or Member Services.

CODING INFORMATION

Note: This list of codes may not be all-inclusive, and codes are subject to change at any time. The identification of a code in this section does not denote coverage as coverage is determined by the terms of member benefit information. In addition, not all covered services are eligible for separate reimbursement.

Covered when medically necessary:

Procedure Codes							
43233	43235	43236	43237	43238	43239	43240	43241
43242	43243	43244	43245	43246	43247	43248	43249

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Procedure Codes							
43250	43251	43253	43254	43255	43259	43266	43270

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POLICY HISTORY

MP 2.402	**New policy creation**