LifeWise
Health Plan of Washington

MEDICAL POLICY – 2.01.533

Upper Gastrointestinal (UGI) Endoscopy in Adults

Effective Date:	Sep. 1, 2026
Last Revised:	Jul. 14, 2026
Replaces:	N/A

RELATED MEDICAL POLICIES:

2.01.38	Transesophageal Endoscopic Therapies for Gastroesophageal Reflux Disease
7.01.137	Magnetic Esophageal Sphincter Augmentation to Treat Gastroesophageal Reflux Disease
7.01.596	Adjunctive Techniques for Screening, Surveillance, and Risk Classification of Barrett Esophagus and Esophageal Dysplasia

The Site of Service Medical Necessity criteria within this policy DO NOT apply to Indian Health Services (IHS) facilities.
Please refer to the medical necessity criteria for the procedure only.

Select a hyperlink below to be directed to that section.

POLICY CRITERIA | DOCUMENTATION REQUIREMENTS | CODING
RELATED INFORMATION | EVIDENCE REVIEW | REFERENCES | HISTORY

∞ Clicking this icon returns you to the hyperlinks menu above.

Introduction

Upper gastrointestinal (UGI) endoscopy is a procedure that looks at the tissues lining the esophagus, stomach and the first part of the small intestine (duodenum). It uses a flexible tube-like tool called an endoscope that contains fibers that transmit light and magnify the image. The scope is inserted through the mouth and the procedure is usually performed with light, intravenous anesthesia. The scope is used to search for the cause(s) of severe heartburn, difficulty swallowing, reflux, persistent vomiting, and bleeding. This tool can also be used to remove polyps or stones from the bile duct.

Note: The Introduction section is for your general knowledge and is not to be taken as policy coverage criteria. The rest of the policy uses specific words and concepts familiar to medical professionals. It is intended for providers. A provider can be a person, such as a doctor, nurse, psychologist, or dentist. A provider also can be a place where medical care is given, like a hospital, clinic, or lab. This policy informs them about when a service may be covered.

Policy Coverage Criteria

We will review for medical necessity this elective diagnostic procedure.

We also will review the site of service for medical necessity. Site of service is defined as the location where the diagnostic or surgical procedure is performed, such as an off campus-outpatient hospital or medical center, an on campus-outpatient hospital or medical center, an ambulatory surgical center, or an inpatient hospital or medical center.

Site of Service for Elective Diagnostic or Surgical Procedures	Medical Necessity
Medically necessary sites of service: • **Ambulatory surgical center**	**Certain elective diagnostic or surgical procedures will be covered in the most appropriate, safe, and cost-effective site. This is the preferred medically necessary site of service for certain elective diagnostic or surgical procedures.**

• **Off campus-outpatient hospital/medical center**
• **On campus-outpatient hospital/medical center**
	Certain elective diagnostic or surgical procedures will be covered in the most appropriate, safe, and cost-effective site. An elective diagnostic or surgical procedure performed in a hospital outpatient department may be considered medically necessary if there is no access to an ambulatory surgical center due to one of the following criteria:
	• There is no qualifying ASC within 30 miles that can provide the necessary care due to one of the following:
	  ○ There is no geographically accessible ASC that has the necessary equipment to perform the procedure; or
	  ○ There is no geographically accessible ASC available at which the individual's physician has privileges; or
	  ○ An ASC's specific guideline prohibits the use of the ASC related to the individual's health condition or weight, or
	• Individual is aged 18 or younger, or
	• The service being performed is in conjunction with an additional service that requires the use of a hospital outpatient department, and the procedures are being performed in the same operative session

Site of Service for Elective Diagnostic or Surgical Procedures	Medical Necessity
	OR • Individual has a clinical condition which puts them at increased risk for complications including any of the following (this list may not be all inclusive): ○ **Anesthesia Risk** ▪ ASA classification III or higher (see **Related Information**) ▪ Personal history of complication of anesthesia ▪ Documentation of alcohol dependence or history of cocaine use ▪ Prolonged surgery (>3 hours) ○ **Cardiovascular Risk** ▪ Uncompensated chronic heart failure (NYHA class III or IV; see **Related Information** ▪ Recent history of myocardial infarction (MI) (<3 months) ▪ Poorly controlled, resistant hypertension* ▪ Recent history of cerebrovascular accident (< 3 months) ▪ Increased risk for cardiac ischemia (drug eluting stent placed < 1 year or angioplasty <90 days) ▪ Symptomatic cardiac arrhythmia despite medication ▪ Significant valvular heart disease ○ **Liver Risk** ▪ Advanced liver disease (MELD Score > 8)** ○ **Pulmonary Risk** ▪ Chronic obstructive pulmonary disease (COPD) (FEV1 <50%) ▪ Poorly controlled asthma (FEV1 <80% despite treatment) ▪ Moderate to severe obstructive sleep apnea (OSA)*** ○ **Renal Risk** ▪ End stage renal disease (on dialysis) ○ **Other** ▪ Morbid obesity (BMI ≥ 50) ▪ Pregnancy

Site of Service for Elective Diagnostic or Surgical Procedures	Medical Necessity
	▪ Bleeding disorder (requiring replacement factor, blood products, or special infusion product [DDAVP**** does not meet this criterion]) ▪ Anticipated need for transfusion(s) *3 or more drugs to control blood pressure **https://reference.medscape.com/calculator/meld-score-end-stage-liver-disease ***Moderate-AHI≥15 and ≤ 30, Severe-AHI ≥30 ****DDAVP-Deamino-Delta-D-Arginine Vasopressin (Desmopressin)
• **Off campus-outpatient hospital/medical center** • **On campus-outpatient hospital/medical center**	**These sites of service are considered not medically necessary for certain elective diagnostic or surgical procedures when the site of service criteria listed above are not met.**
• **Inpatient hospital/medical center**	**This site of service is considered not medically necessary for this elective diagnostic or surgical procedure**

This policy only applies to individuals aged 19 and older

Condition	Medical Necessity
Malignant indications	**Upper gastrointestinal (UGI) endoscopy may be considered medically necessary for any of the following indications:** • Barrett esophagus (Metaplastic columnar or glandular epithelium) (see **surveillance criteria** below) • Dysplasia • Esophageal cancer • Familial adenomatous polyposis (FAP) • Gastric cancer • Head/neck cancer • History of Lynch Syndrome or hereditary nonpolyposis colorectal cancer (HNPCC)

Condition	Medical Necessity
	• In situations where clinical features are highly suspicious for UGI malignancy (e.g., epigastric mass found on x-ray, abnormal barium study, and others) • Individuals with prior adenomatous polyps or sessile polyps (rare) (gastric, duodenal, esophagus) • One evaluation for positive CDH1 mutation • Family history of gastric, esophageal, or duodenal cancer in a first degree relative* • Tylosis (rare genetic disorder which predisposes one to esophageal cancer) *First degree relative is defined as an individual's parent, sibling, or child
Alarm symptoms	**Upper gastrointestinal (UGI) endoscopy may be considered medically necessary when performed for evaluation of ANY of the following alarm symptoms that may be associated with an UGI source:** • Iron deficiency anemia • Bleeding from the rectum or in stool that may be bright red or dark colored • Epigastric mass is found on examination • Persistent vomiting of unknown cause, including vomiting blood • Swallowing that is difficult (dysphagia) • Unintentional weight loss of 3 kg (approx. 6.6 lbs.) or more since symptoms started
Follow-up of known non-malignant conditions	**Upper gastrointestinal (UGI) endoscopy may be considered medically necessary when performed for evaluation of ANY of the following indications that may be associated with a UGI source:** • Anorexia of unknown cause • Evaluation of individuals with suspected portal hypertension or cirrhosis to document or treat esophageal varices (see Cirrhosis below for **ongoing screening**) • Follow-up of known eosinophilic esophagitis • Follow-up of known erosive esophagitis -(May need follow up UGI to evaluate for Barrett after 2-month course of therapy)

Condition	Medical Necessity

	• For therapeutic banding (ligation) or sclerotherapy of esophageal varices, then:
	  ○ Repeat UGI until eradication of varices is complete, then surveillance in the following intervals:
	  ▪ One to 3 months after eradication is completed, then
	  ▪ Every 6 to 12 months thereafter to monitor for recurrence
	• For treatment of bleeding from lesions such as ulcers (e.g., electrocoagulation, heater probe, laser photocoagulation, or injection therapy)
	• History of gastric surgery
	• Non-steroidal anti-inflammatory drug (NSAID) use is stopped yet symptoms continue (e.g., long term use for arthritis)
	• Persistent non-cardiac chest pain
	• Swallowing that is difficult (dysphagia)
	• Swallowing that is painful (odynophagia)

Gastroesophageal reflux (GERD) or dyspepsia symptoms	**Upper gastrointestinal (UGI) endoscopy may be considered medically necessary when:** • Performed for evaluation of GERD or dyspepsia (heartburn) symptoms that are present for at least 3 months **AND** ○ Persist despite 8 weeks of continuous treatment with daily proton pump inhibitor (PPI) therapy

Other upper gastrointestinal (UGI) indications	**Upper gastrointestinal (UGI) endoscopy may be considered medically necessary for any of the following indications:**
	• Achalasia
	• Barrett esophagus (BE) surveillance based on the cell pathology:
	  ○ High-grade dysplasia: repeat UGI every 3 months after initial biopsy for 1 year, then annually thereafter
	  ○ Low grade dysplasia: repeat UGI at 6 months, then surveillance at 12 months and annually thereafter
	  ○ No dysplasia (metaplasia): repeat UGI one time within 12 months after initial biopsy; then every 3 years if pathology unchanged

Condition	Medical Necessity

	• Cirrhosis upon initial diagnosis, one UGI endoscopy to screen for esophageal varices, then no more frequently than annually for ongoing screening or surveillance
	• Crohn disease that involves the esophagus, stomach, or duodenum
	• Eating or drinking (ingestion) of a caustic agent
	• Removal of a foreign body that is known or suspected
	• Gastric, peptic, esophageal ulcer confirmation when:
	  ○ Conservative medical management was tried and failed to relieve symptoms (e.g., cessation of NSAIDs, trial of appropriate medication)
	  OR
	  ○ Conservative medical management is contraindicated
	• Follow-up UGI for gastric, peptic, or esophageal ulcer every 2 months until healed
	• Individuals planned for organ transplantation where the presence of upper GI pathology might modify their management
	• Performed for endoscopic ultrasound guided fine needle aspiration/biopsy(s) of adjacent organs or structures (e.g., esophagus, stomach, duodenum, pancreas, liver, etc.)
	• Performed for preoperative endoscopic evaluation of an individual prior to bariatric surgery (If member's contract excludes bariatric surgery, then UGI is not covered, unless the member meets another medical necessity criterion in this policy)
	• Individuals with newly diagnosed (within one year) pernicious anemia
	• Post cardiac ablation for treatment of arrhythmias (irregular heart rhythms)
	• Screening for Barrett in a male individual aged 50 years or older with 5 years or more of GERD symptoms and 1 or more of the following:
	  ○ Elevated body mass index (BMI) (BMI greater than or equal to 30 kg/m^2)
	  ○ Excess abdominal fat (intra-abdominal fat distribution)
	  ○ Hiatal hernia

Condition	Medical Necessity
	○ Night-time symptoms of reflux ○ Tobacco use • To assess diarrhea in individuals suspected of having small-bowel disease (e.g., celiac disease) or inflammatory bowel disease • UGI tract stricture or obstruction
Any other condition not addressed in this policy	**Upper gastrointestinal (UGI) endoscopy is considered not medically necessary when criteria are not met for any of the above documented clinical indications.** **Upper gastrointestinal (UGI) endoscopy is considered not medically necessary when:** • Performed for evaluation of UGI symptoms that are chronic, non-progressive, atypical for known organic disease, and are considered functional in origin (infrequent exceptions exist when a one-time endoscopic examination may be done to rule out organic disease, in cases where symptoms are unresponsive to therapy) • Performed for evaluation of uncomplicated heartburn that responds to conservative medical management • Performed for evaluation of UGI conditions/diagnoses when the endoscopy results will not alter management • Performed for evaluation of x-ray findings showing any of the following: ○ Deformed duodenal bulb that is asymptomatic or has responded to ulcer therapy ○ Duodenal bulb ulcer that is uncomplicated and has responded to therapy ○ Sliding hiatal hernia that is asymptomatic or uncomplicated • Performed as routine screening of the upper gastrointestinal (UGI) tract in the absence of a clinical indication • Performed for surveillance of healed benign disease (e.g., gastric or duodenal ulcer) • Performed for surveillance of individuals with gastric intestinal metaplasia • Performed for confirming helicobacter pylori eradication

Documentation Requirements

Clinical notes for an individual 19 years of age or older documenting:

- Malignant indications or alarm symptoms
- High risk known non-malignant conditions needing follow-up or treatment (e.g., suspected portal hypertension or cirrhosis, eosinophilic esophagitis, erosive esophagitis, anorexia of unknown cause, esophageal varices, treatment of bleeding from lesions such as ulcers, history of gastric surgery, swallowing that is difficult or painful, etc.)
- GERD or indigestion that has lasted at least three months that continues despite trial of:
  - 8 weeks of continuous daily proton pump inhibitor (PPI) therapy
- Other gastrointestinal (GI) indications (e.g., achalasia, Barrett esophagus surveillance based on cell pathology, ulcer confirmation and follow-up, for preoperative endoscopic evaluation prior to bariatric surgery, to assess diarrhea in individuals suspicious of having small bowel disease (e.g., celiac disease) or IBD, etc.)

Coding

Code	Description
CPT	
43235	Esophagogastroduodenoscopy, flexible, transoral; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)
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)

Related Information

Consideration of Age

There is very little incidence and evidence of upper endoscopy in pediatrics. The age stated in the policy is for men older than 50 years with chronic GERD symptom and additional risk factors. This criterion is based on the 2012 American College of Physicians clinical guidelines for upper endoscopy.

Definitions of Terms

Achalasia: An esophageal motility disorder involving the smooth muscle of the esophagus and the lower esophageal sphincter (LES).

Barrett esophagus: Gastroesophageal reflux disease (GERD) damages the esophageal epithelium, and the normal squamous epithelium is replaced by metaplastic columnar or glandular epithelium. This predisposes the person to esophageal adenocarcinoma.

Crohn's or Crohn disease: A type of inflammatory bowel disease (IBD) that may affect any part of the gastrointestinal tract from mouth to anus. This may also be known as Crohn syndrome or regional enteritis.

Celiac disease: An autoimmune digestive disorder, also known as celiac sprue or gluten-sensitive enteropathy. When foods with gluten are eaten, the body's reaction causes damage to the intestinal lining.

Cirrhosis: Scarring of the liver because of injury or long-term disease. The most common causes in the U.S. are chronic alcoholism and hepatitis. A small number of people with cirrhosis get liver cancer (see **esophageal varices**).

Dyspepsia: A chronic or recurrent pain or discomfort centered in the upper abdomen; individuals with predominant or frequent (more than once a week) heartburn or acid regurgitation (see **GERD**).

Dysphagia: This term applies to difficulty or inability to swallow.

Esophagogastroduodenoscopy (EGD): This term may be used in place of upper gastrointestinal endoscopy.

Esophageal varices: Abnormally enlarged veins in the lower part of the esophagus, usually formed in the presence of a clot or when scar tissue in the liver obstructs blood flow.

Gastrointestinal: A broad term relating to the organs and muscles of the digestive system (e.g., esophagus, stomach, small/large intestine).

Gastroesophageal reflux disease (GERD): A chronic digestive disorder affecting the lower esophageal sphincter (LES) where stomach contents flow back up into the esophagus causing irritation and symptoms such as heartburn and regurgitation, and non-cardiac chest pain. (see **dyspepsia**).

Odynophagia: The sensation of burning, squeezing pain when swallowing.

Medical management: Non-invasive interventions such as acid suppressive medications, nutritional counseling for dietary changes (to avoid foods that trigger symptoms), weight loss counseling, environmental changes (e.g., elevating the head of bed) and others.

Serology tests: Blood tests that look for specific antibodies in the serum of the blood. These tests are used to diagnose certain disease conditions, such as celiac disease.

Tylosis: A rare autosomal dominant syndrome that causes thickened skin on the palms of the hands and soles of the feet, associated with increased risk of esophageal squamous cell carcinoma.

Histamine 2 Receptor Antagonists (H2RA, or H2 blockers) Use

These medications have not been shown to heal esophagitis. A trial of standard dose H2 blockers may be used as a substitute for a trial of PPI therapy only if the member cannot tolerate PPIs or has a contraindication to their use. Both H2RA and PPI medications treatment regimens are shown in **Table 1**.

Table 1. Initial Treatment of Gastroesophageal Reflux Disease

Medication	Low Dose (adult, oral)	Standard Dose (adult, oral)
Histamine 2 Receptor Antagonists*		
Famotidine (Pepcid)	10 mg twice daily¶	20 mg twice daily¶
Nizatidine (Axid)	75 mg twice daily§	150 mg twice daily
Cimetidine (Tagamet)	200 mg twice daily¶	400 mg twice daily
Proton Pump Inhibitors		

Medication	Low Dose (adult, oral)	Standard Dose (adult, oral)
Omeprazole (Prilosec)	Not recommended	20 mg daily¶
Lansoprazole (Prevacid)	15 mg daily¶	30 mg daily
Esomeprazole (Nexium)	20 mg daily¶	40 mg daily
Pantoprazole (Protonix)	20 mg daily	40 mg daily
Dexlansoprazole (Dexilant)	Not available	30 mg daily
Rabeprazole (Aciphex)	10 mg daily‡	20 mg daily

GERD: gastroesophageal reflux disease; US: United States.
* Histamine 2 receptor antagonists require dose adjustment in the setting of renal insufficiency.
¶ Available without a prescription (over the counter) in the US.
§ Not available in US. Consult local product availability.
‡ In some countries, dose strength is limited to certain dose forms (eg, sprinkle capsule), which may be costlier. Consult local product availability.
Prepared with data from:
Kahrilas PJ, et al. American Gastroenterological Association Medical Position Statement on the management of gastroesophageal reflux disease. Gastroenterology 2008; 135:1383.
Anon. American Gastroenterological Association Institute Technical Review on the Management of Gastroesophageal Reflux Disease. Gastroenterology 2008; 135:1392.
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Evidence Review

In the absence of a clear cancer diagnosis, professional societies indicate that conservative medical management of gastrointestinal symptoms should be the first intervention before an invasive diagnostic test such as an upper gastrointestinal (UGI) endoscopy.[12,17,24]

Description

Upper gastrointestinal (UGI) endoscopy also known as esophagogastroduodenoscopy (EGD) and gastroscopy is a procedure that examines the upper gastrointestinal tract using a flexible tube-like instrument containing light transmitting fibers that return a magnified image directly or by video. The instrument is inserted through the mouth permitting visual inspection of the esophagus, stomach, and first part of the small intestine (upper duodenum). Primarily a diagnostic tool, the endoscope is used to search for cause(s) of severe heartburn (dyspepsia), difficulty swallowing (dysphagia), gastroesophageal reflux disease (GERD), persistent vomiting, and frank GI bleeding. Certain therapeutic procedures can be performed using an endoscope

such as removal of polyps, papilla, and removal of stones from the bile duct. UGI endoscopy is usually performed under light sedation using an intravenous medication.

Non-cardiac Chest Pain (NCCP)

NCCP describes pain in the chest area that is similar to heart muscle pain (also called angina) in individuals who have undergone a cardiac workup and were found not to have heart disease. NCCP occurs in men and women of all ages as well as children. Because of the anatomy of the chest cavity with the heart and esophagus resting near each other, pain from either organ may be similar, which makes it hard to differentiate the pain source. Individuals who continue to have chest pain after a cardiac work up fails to provide evidence of heart disease may need a GI work up. The American College of Gastroenterology makes a strong recommendation stating that "a cardiac cause should be excluded in patients with chest pain before the commencement of a gastrointestinal evaluation".[1]

Surveillance for Barret Esophagus

Surveillance for esophageal adenocarcinoma is recommended for those diagnosed with Barrett esophagus.[5] However, there are few data to guide recommendations about management and surveillance, and many issues are controversial. In 2015 guidelines from the American College of Gastroenterology (ACG)[19] and a consensus statement from an international group of experts (Benign Barrett's and Cancer Taskforce) on the management of Barrett esophagus were published.[17] ACG recommendations for surveillance are stratified by the presence of dysplasia. When no dysplasia is detected, ACG has reported the estimated risk of progression to cancer for individuals ranges from 0.2% to 0.5% per year and ACG has recommended endoscopic surveillance every 3 to 5 years. For low-grade dysplasia, the estimated risk of progression is about 0.7% per year, and ACG has recommended endoscopic therapy or surveillance every 12 months. For high-grade dysplasia, the estimated risk of progression is about 7% per year, and ACG has recommended endoscopic therapy.[19] The Benign Barrett's and Cancer Taskforce consensus group did not endorse routine surveillance for people with no dysplasia and was unable to agree on surveillance intervals for low-grade dysplasia.[17]

Practice Guidelines and Position Statements

American College of Physicians (ACP)

In December of 2012, the American College of Physicians (ACP) published clinical guidelines for upper endoscopy for gastroesophageal reflux disease.[8] The best practice recommendations from the professional organization follow.

Best Practice Advice 1

Upper endoscopy is indicated in men and women with heartburn and any of the following alarm symptoms:

- Anemia
- Bleeding
- Dysphagia
- Recurrent vomiting
- Weight loss

Best Practice Advice 2

Upper endoscopy is indicated in men and women with:

- Typical gastroesophageal reflux disease (GERD) symptoms that persist despite a therapeutic trial of 4 to 8 weeks of twice-daily proton-pump inhibitor therapy.
- Severe erosive esophagitis after a 2-month course of proton-pump inhibitor therapy to assess healing and rule out Barrett esophagus. Recurrent endoscopy after this follow-up examination is not indicated in the absence of Barrett esophagus.
- History of esophageal stricture that have recurrent symptoms of dysphagia

Best Practice Advice 3

Upper endoscopy may be indicated:

- In men older than 50 years with chronic GERD symptoms (symptoms for more than 5 years) and additional risk factors (nocturnal reflux symptoms, hiatal hernia, elevated body mass index, tobacco use, and intra-abdominal distribution of fat) to detect esophageal adenocarcinoma and Barrett esophagus.
- For surveillance evaluation in men and women with a history of Barrett esophagus. In men and women with Barrett esophagus and no dysplasia, surveillance examinations should occur at intervals no more frequently than 3 to 5 years. More frequent intervals are indicated in patients with Barrett esophagus and dysplasia.

American College of Gastroenterology (ACG)

In 2022, the American College of Gastroenterology (ACG) updated their 2013 guidelines[40] for the diagnosis and management of GERD. The relevant guideline information follows:

Establishing the Diagnosis of Gastroesophageal Reflux Disease (GERD) from the ACG Recommendations

The diagnosis of GERD is made using some combination of symptom presentation, objective testing with endoscopy, ambulatory reflux monitoring, and response to antisecretory therapy.

1. For patients with classic GERD symptoms of heartburn and regurgitation who have no alarm symptoms, an 8-week trial of empiric PPIs once daily before a meal is recommended. (Strong recommendation, moderate level of evidence.)
2. Attempting to discontinue PPIs in patients whose classic GERD symptoms respond to an 8-week empiric trial of PPIs is recommended. (Conditional recommendation, moderate level of evidence.)
3. A diagnostic endoscopy is recommended, ideally after PPIs are stopped for 2-4 weeks, in patients whose classic GERD symptoms do not respond adequately to an 8-week empiric trial of PPIs or whose symptoms return when PPIs are discontinued. (Strong recommendation, low level of evidence.)
4. In patients who have chest pain without heartburn and who have had adequate evaluation to exclude heart disease, objective testing for GERD (endoscopy and/or reflux monitoring) is recommended. (Conditional recommendation, low level of evidence.)

5. Use of a barium swallow solely as a diagnostic test for GERD is not recommended. (Conditional recommendation, low level of evidence.)

6. Endoscopy as the first test for evaluation of patients presenting with dysphagia or other alarm symptoms (weight loss and GI bleeding) and for patients with multiple risk factors for Barrett's esophagus is recommended. (Strong recommendation, low level of evidence.)

7. In patients for whom the diagnosis of GERD is suspected but not clear, and endoscopy shows no objective evidence of GERD, reflux monitoring is recommended to be performed off therapy to establish the diagnosis. (Strong recommendation, low level evidence.)

8. Reflux monitoring off therapy solely as a diagnostic test for GERD in patients known to have endoscopic evidence of Los Angeles (LA) grade C or D reflux esophagitis or in patients with long-segment Barrett's esophagus is not recommended. (Strong recommendation, low level of evidence.)

Table 2. Diagnostic Testing for GERD and Utility of Tests

Diagnostic Test	Indication	Highest Level of Evidence	Recommendation
PPI trial	Classic symptoms, no warning signs.	Meta-analysis	Negative trial does not rule out GERD.
Barium swallow	Not for GERD diagnosis. Use of evaluation of dysphagia.	Case-control	Do not use unless evaluating for complication (stricture, ring).
Endoscopy	Alarm symptoms, screening of high-risk patients, chest pain.	Randomized control trial	Consider early for elderly, those at risk for Barrett's, non-cardiac chest pain, patients unresponsive to PPI
Esophageal biopsy	Exclude non-GERD causes for symptoms.	Case-Control	Not indicated for diagnosis of GERD.
Esophageal manometry	Preoperative evaluation for surgery.	Observational	Not recommended for GERD diagnosis. Rule out achalasia/ scleroderma-like esophagus pre-op.
Ambulatory reflux monitoring	Preoperatively for non-erosive disease. Refractory GERD symptoms, GERD diagnosis in question.	Observational	Correlate symptoms with reflux, document abnormal acid exposure or reflux frequency.

GERD=gastroesophageal reflux disease; PPI=proton pump inhibitor

In 2024, the ACG in their Clinical Guideline: Treatment of *Helicobacter pylori* infection[51] made the following recommendation:

- "All patients who are treated for *H. pylori* infection should undergo a test of cure with an appropriately conducted urea breath test, fecal antigen test, or biopsy-based test at least four weeks after completion of therapy."

They note serological testing should not be used to confirm eradication as antibody levels can remain detectable for months to years after successful eradication of *H. pylori* infection.

American Society for Gastrointestinal Endoscopy (ASGE)

In 2012, the ASGE[6] published guidelines for standards of practice (SOP) recommendations for the appropriate use of esophagogastroduodenoscopy (EGD) with the following indications.

Esophagogastroduodenoscopy is generally indicated for evaluating:

A. Upper abdominal symptoms that persist despite an appropriate trial of therapy

B. Upper abdominal symptoms associated with other symptoms or signs suggesting serious organic disease (e.g., anorexia and weight loss) or in patients aged > 45 years

C. Dysphagia or odynophagia

D. Esophageal reflux symptoms, which are persistent or recurrent despite appropriate therapy

E. Persistent vomiting of unknown cause

F. Other diseases in which the presence of upper GI pathology might modify other planned management. Examples include patients who have a history of ulcer or GI bleeding who are scheduled for organ transplantation, long-term anti-coagulation, or chronic non-steroidal anti-inflammatory drug therapy for arthritis, and those with cancer of the head and neck.

G. Familial adenomatous polyposis syndromes

H. For confirmation and specific histological diagnosis of radiologically demonstrated lesions:

    1. Suspected neoplastic lesion

2. Gastric or esophageal ulcer

3. Upper tract stricture or obstruction

I. Gastrointestinal bleeding:

1. In patients with active or recent bleeding

2. For presumed chronic blood loss and for iron deficiency anemia when the clinical situation suggests an upper GI source or when colonoscopy is negative

J. When sampling of tissue or fluid is indicated

K. In patients with suspected portal hypertension to document or treat esophageal varices

L. To assess acute injury after caustic ingestion

M. Treatment of bleeding lesions such as ulcers, tumors, vascular abnormalities (e.g., electrocoagulation, heater probe, laser photocoagulation, or injection therapy)

N. Banding or sclerotherapy of varices

O. Removal of foreign bodies

P. Removal of selected polypoid lesions

Q. Placement of feeding or drainage tubes (peroral, percutaneous endoscopic gastrostomy PEG), percutaneous endoscopic jejunostomy)

R. Dilation of stenotic lesions (e.g., with transendoscopic balloon dilators or dilation systems by using guide wires)

S. Management of achalasia (e.g., botulinum toxin, balloon dilation)

T. Palliative treatment of stenosing neoplasms (e.g., laser, multi-polar electrocoagulation, stent placement)

U. Endoscopic therapy of intestinal metaplasia

V. 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)

W. Management of operative adverse events (e.g., dilation of anastomotic strictures, stenting of anastomotic disruption, fistula, or leak in selected circumstances)

Esophagogastroduodenoscopy is generally not indicated for evaluating:

A. Symptoms that are considered functional in origin (there are exceptions in which an endoscopic examination may be done once to rule out organic disease, especially if symptoms are unresponsive to therapy)

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

C. Radiographic findings of:

    1. Asymptomatic or uncomplicated sliding hiatal hernia

    2. Uncomplicated duodenal ulcer that has responded to therapy

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

Sequential or periodic EGD may be indicated:

A. Surveillance for malignancy in patients with pre-malignant conditions (e.g. Barrett's esophagus)

Sequential or periodic EGD is generally not indicated for:

A. Surveillance for malignancy in patients with gastric atrophy, pernicious anemia, fundic gland or hyperplastic polyps, gastric intestinal metaplasia, or prior gastric operations for benign disease

B. Surveillance of healed benign disease such as esophagitis or gastric or duodenal ulcer

C. Surveillance during repeated dilation of benign strictures unless there is a change in status

In 2025, ASGE published a guideline on the diagnosis and management of GERD: summary and recommendations. In it, the applicable guidelines state:

- In patients with GERD symptoms, the ASGE recommends upper endoscopy in those with alarm symptoms (dysphagia, odynophagia, weight loss, GI bleeding, persistent vomiting, or unexplained iron deficiency) (Strong Strength of Recommendation and Moderate quality evidence)
- In patients with GERD symptoms but no alarm symptoms, ASGE suggests endoscopic evaluation in those with Barret Esophagus risk factors (family history of Barrett Esophagus or esophageal adenocarcinoma; GERD plus another risk factor [greater than or equal to 50 years, male sex, white race, smoking, or obesity]) (Conditional recommendation, low-quality evidence)
- In patients with symptomatic and confirmed GERD with predominant heartburn symptoms, the ASGE recommends medical management with PPIs at the lowest possible dose for the shortest possible period of time while initiating discussion about long-term management options. (Strong Strength of Recommendation, Moderate quality evidence)
- In patients with suboptimal clinical response to PPI therapy, the ASGE suggests testing for CYP2C19 polymorphism and adjusting PPI dosage and selection accordingly. (Conditional Strength of Recommendation, Very low quality of evidence).

Medicare National Coverage

The coverage statement is that "Endoscopic procedures are covered when reasonable and necessary for the individual patient".[26]

References

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History

Date	Comments
06/10/13	New policy. Add to Utilization Management section. Policy approved with 90-day hold for provider notification. The policy effective date is October 1, 2013.
08/15/13	Update Related Policies. Remove 2.01.520 and add 2.01.20.
09/05/13	Coding update. CPT code 43252 removed from policy as it pertains to another policy (2.01.87).
08/11/14	Annual Review. Changed the title to Upper Gastrointestinal (UGI) Endoscopy for Adults, for ease of finding the document. Policy extensively re-written. Policy

Date	Comments
	statements reorganized but intent is unchanged. Revised "adult" to patients of 19 years old and older. Policy updated with literature search through June, 2014. Reference to using MCG as a tool to guide determinations is removed. References 6-10 added; others renumbered/removed. New CPT codes 43233, 43253, 43254, 43266, 43270 added for 2014. Policy statements changed as noted.
10/13/14	Interim Update. Removed Policy statement under UGI Tract Symptoms header that states "interferes with activities of daily living on 3 or more days a week". Extensive editorial changes to consolidate and simplify criteria in the policy statements. Clarification for non-cardiac chest pain (NCCP) added to the rationale section. Reference 5 added; others renumbered. Policy statements revised, intent is unchanged.
12/22/14	Interim Update. Policy reclassified, renumbered from 11.01.504 to 2.01.533 and moved from UM section to Medicine section. Reference 1 removed; others renumbered and broken hyperlinks repaired. Policy statements unchanged.
05/12/15	Annual Review. Policy updated with literature search through April, 2015. Added esophageal varices with or without bleeding to the Follow Up of Known Conditions list. Added new cirrhosis diagnosis to the Other Indications list. Cirrhosis added to Definition of Terms. Added AASLD recommendations to Practice Guidelines and Position Statements section. References 10,13 added; others renumbered. Policy statements changed as noted. Remove informational CPT codes: 43233-34, 43237, 43240-41, 43243-43256; 43258-59; 43270; remove ICD-9 diagnosis codes, as they do not affect policy adjudication.
06/02/15	Update Related Policies. Remove 2.01.81 as it was archived.
12/07/15	Update Related Policies. Remove 6.01.33 and 7.02.500 as they were archived.
02/09/16	Annual Review. No change in coverage statements. Removed reference 6, Medicare LCD no longer available.
08/01/16	Interim Review, approved July 12, 2016. Added information on histamine 2 receptor antagonists and table to Related Information section; reference 13 added. Policy moved into new format; no change to policy statements.
01/01/17	Interim Review, approved December 13, 2016. Clarified the description for bleeding in the Alarm Symptoms and GI bleeding sections of the policy. Changed "gastric bypass surgery" to "bariatric surgery" under the section listing Other Upper Gastrointestinal (UGI) Indications.
02/03/17	Minor update. Replaced the acronym "EGD" with "UGI" within policy section for purposes of consistency. No other changes; policy statements remain the same.
01/01/18	Annual Review, approved December 12, 2017. Modified criteria to include surveillance for individuals with cirrhosis. Clarified UGI not covered for bariatric surgery when bariatric surgery is contractually excluded, unless other symptoms are present. Completely reorganized policy criteria. No references added. Removed CPT code 43236.

Date	Comments
03/09/18	Minor edit; added Documentation Requirements section.
09/01/18	Interim Review, approved August 10, 2018. Minor edit; added surveillance criteria for Barrett's esophagus no dysplasia (metaplasia). Re-added Consideration of Age information, which was inadvertently removed during a previous update.
12/01/18	Annual Review, approved November 6, 2018. Minor editing and formatting for clarity. References 13-14 added. No change to policy statements.
01/01/19	Interim Review, approved December 19, 2018. Reference 15 added. Added positive CDH1 mutation indication.
06/01/19	Annual Review, approved May 14, 2019. Added medically necessary statement: post cardiac ablation for the treatment of arrhythmias. References updated, added and reorganized. Minor edits for clarity.
12/01/19	Interim Review, approved November 26, 2019. This policy effective date was updated to January 1, 2020.
04/01/20	Delete policy, approved March 10, 2020. This policy will be deleted effective July 2, 2020, replaced with policy 10.01.530.
07/02/20	Delete policy.
11/01/20	Policy reinstated effective February 5, 2021 approved October 22, 2020. Policy reviewed. References added. Policy statement regarding patients scheduled for bariatric surgery changed to not medically necessary.
06/01/21	Criteria clarification; added two-month course of therapy under criteria for follow-up of known erosive esophagitis.
11/01/21	Annual Review, approved October 21, 2021. Policy reviewed. References updated. References added. Policy statement unchanged.
06/01/22	Annual Review, approved May 10, 2022. Policy reviewed. References updated. Reference added. Modified UGI medically necessary policy statement for GERD or dyspepsia symptoms to now state persists despite 8 weeks of continuous daily PPI therapy OR performed for evaluation of GERD or dyspepsia symptoms that have returned after PPI therapy has been discontinued. Deleted statement on H2 blocker therapy. Added medically necessary statement for follow-up of known eosinophilic esophagitis. Changes are effective for dates of service on or after September 2, 2022.
09/01/22	Interim Review, approved August 9, 2022. Added therapeutic banding (ligation) or sclerotherapy of esophageal varices as medically necessary.
01/01/23	Interim Review, approved December 13, 2022. References added. Preoperative UGI prior to bariatric surgery was changed from not medically necessary to medically necessary. Clarifications made to surveillance schedule for esophageal varices. Added UGI is medically necessary to assess diarrhea in individuals suspicious of having small bowel disease (e.g., celiac disease) or IBD. Removed the former policy criteria on celiac disease. Added UGI for treatment of bleeding lesions such as ulcers (e.g., electrocoagulation, injection therapy) is medically necessary. Added follow-up UGI for

Date	Comments
	gastric, peptic, or esophageal ulcer every 2 months until healed is medically necessary. Added UGI performed for surveillance of healed benign disease (e.g., gastric or duodenal ulcer) is considered not medically necessary. Other minor edits made to policy statements, but intent of the statements was unchanged. Changed the wording from "patient" to "individual" throughout the policy for standardization.
02/01/23	Interim Review, approved January 10, 2023. References added. Added UGI when performed for surveillance of individuals with gastric intestinal metaplasia is considered not medically necessary. Other minor edits made for clarity only; intent of the policy statements is unchanged.
10/01/23	Annual Review, approved September 12, 2023. Policy reviewed. References added. Added policy statement that UGI is considered medically necessary when performed for endoscopic ultrasound guided fine needle aspiration/biopsy(s) of adjacent organs or structures (e.g., esophagus, stomach, duodenum, pancreas, liver, etc.)
03/01/24	Interim Review, approved February 12, 2024. Under condition of other UGI indications added criterion for BE surveillance based on the cell pathology: low grade dysplasia: repeat UGI at 6 months, then surveillance at 12 months and annually thereafter. Removed criterion of other grades of dysplasia.
05/01/24	Annual Review, approved April 9, 2024. Policy reviewed. References added. Clarified that UGI is considered medically necessary for family history of gastric, esophageal, or duodenal cancer in a first degree relative and modified the policy statement that UGI may be considered medically necessary for the evaluation of the alarm symptom of iron deficiency anemia for greater clarity.
01/01/25	Minor update to related policy. 7.01.167 was replaced with 7.01.596 Adjunctive Techniques for Screening, Surveillance, and Risk Classification of Barrett Esophagus and Esophageal Dysplasia.
09/01/25	Annual Review, approved August 12, 2025. Policy reviewed. References added and updated. Added policy statement that UGI is considered not medically necessary for confirming helicobacter pylori eradication. Clarified that policy statement UGI is considered medically necessary for "Individuals with prior adenomatous gastric polyps or sessile polyps includes "gastric, duodenal, and esophagus" not just "gastric" alone. Otherwise, policy statements are unchanged.
12/01/25	Interim Review, approved November 11, 2025. Effective for dates of service on or after March 4, 2026, following 90-day provider notification. Changed policy title from "for Adults" to "In Adults". Site of Service Ambulatory Service Center (ASC) Select Diagnostic or Surgical Procedures criteria added.
02/01/26	Interim Review, approved January 13, 2026. Modified existing UGI may be considered medically necessary policy statement for pernicious anemia symptoms to" Individuals with newly diagnosed (within one year) pernicious anemia."
02/24/26	Policy effective date updated from March 4, 2026, to May 1, 2026, due to a business decision based on operational readiness.

Date	Comments
03/27/26	Policy effective date updated from May 1, 2026, to July 1, 2026, due to a business decision based on operational readiness.
06/01/26	Minor update. Added header to indicate that site of service review does not apply to Indian Health Services (IHS) facilities.
06/16/26	Policy effective date updated from July 1, 2026, to September 1, 2026, due to a business decision based on operational readiness.
08/01/26	Interim Review, approved July 14, 2026. References added. Removed criterion for UGI performed for evaluation of the return of GERD or dyspepsia symptoms after PPI therapy has been discontinued. Updated ASGE Practice and Position statement.

Disclaimer: This medical policy is a guide in evaluating the medical necessity of a particular service or treatment. The Company adopts policies after careful review of published peer-reviewed scientific literature, national guidelines and local standards of practice. Since medical technology is constantly changing, the Company reserves the right to review and update policies as appropriate. Member contracts differ in their benefits. Always consult the member benefit booklet or contact a member service representative to determine coverage for a specific medical service or supply. CPT codes, descriptions and materials are copyrighted by the American Medical Association (AMA). ©2026 Premera All Rights Reserved.

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