

Clinical UM Guideline

Subject: Upper Gastrointestinal Endoscopy in Adults
Guideline #: CG-MED-59
Status: Revised

Publish Date: 04/16/2025
Last Review Date: 02/20/2025

Description

This document addresses indications for upper gastrointestinal (GI) endoscopy in adults. This document does not address upper gastrointestinal (GI) endoscopy in children, wireless capsule endoscopy, virtual endoscopy or in vivo analysis of gastrointestinal lesions via endoscopy.

Note: Please see the following related documents for additional information:

- CG-MED-70 Wireless Capsule Endoscopy for Gastrointestinal Imaging and the Patency Capsule
- CG-SURG-70 Gastric Electrical Stimulation
- CG-SURG-83 Bariatric Surgery and Other Treatments for Clinically Severe Obesity
- CG-SURG-101 Ablative Techniques as a Treatment for Barrett's Esophagus
- SURG.00047 Transendoscopic Therapy for Gastroesophageal Reflux Disease, Dysphagia or Gastroparesis

Clinical Indications

Medically Necessary:

I. Diagnostic Esophagogastroduodenoscopy (EGD) in Adults

EGD for diagnostic purposes for adults aged 18 years or older is considered **medically necessary** for any of the following indications:

A. Upper abdominal signs or symptoms:

1. Gastroesophageal reflux symptoms that persist or recur following an appropriate trial of therapy (for example, proton pump inhibitors) for 2 months or more; **or**
2. Persistent vomiting of unknown cause; **or**
3. New-onset dyspepsia in individuals 50 years of age or older; **or**
4. Unexplained dysphagia or odynophagia; **or**
5. Signs or symptoms suggesting structural disease of the upper gastrointestinal tract such as anorexia, weight loss, early satiety, or persistent nausea; **or**
6. Postoperative bariatric surgery with persistent abdominal pain, nausea, or vomiting despite counseling and behavior modification related to diet adherence; **or**

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- 7. Recent or active gastrointestinal bleed; **or**
- 8. Unexplained anemia due to either blood loss or malabsorption from a mucosal process; **or**
- 9. To assess symptoms suspicious for inflammatory bowel disease (for example, bloody diarrhea); **or**
- B. Intraoperative evaluation of anatomic reconstructions typical of modern foregut surgery (for example, evaluation of anastomotic leak and patency, fundoplication formation, pouch configuration during bariatric surgery); **or**
- C. For confirmation and specific histologic diagnosis of radiologically demonstrated lesions, including, but not limited to:
 - 1. Suspected neoplastic lesion; **or**
 - 2. Gastric or esophageal ulcer; **or**
 - 3. Upper tract stricture or obstruction; **or**
- D. Documentation of esophageal varices in individuals with suspected portal hypertension or cirrhosis; **or**
- E. To assess acute injury after caustic ingestion; **or**
- F. To identify upper gastrointestinal etiology of lower gastrointestinal symptoms, such as diarrhea, in individuals suspected of having small-bowel disease (for example, celiac disease); **or**
- G. To evaluate persons with radiographic findings suggestive of achalasia.

II. Therapeutic EGD in Adults

EGD for therapeutic purposes for adults aged 18 years or older is considered **medically necessary** for any of the following indications:

- A. Treatment of bleeding from lesions such as ulcers, tumors, vascular malformations (for example, electrocoagulation or injection therapy); **or**
 - B. For esophageal varices using endoscopic variceal ligation:
 - 1. Variceal ligation may be repeated every 1 to 8 weeks until varices are eradicated; **and**
 - 2. Sclerotherapy may be performed in individuals when variceal ligation is technically difficult; **or**
 - C. Removal of foreign body (including food impaction); **or**
 - D. Removal of selected polypoid or submucosal lesions; **or**
 - E. Placement of feeding tubes (per oral when unguided placement unsuccessful, or percutaneous); **or**
 - F. Dilation of stenotic lesions of the esophagus, pylorus or duodenum (for example, with transendoscopic balloon dilators or dilating systems employing guidewires); **or**
 - G. Dilation for adults with eosinophilic esophagitis who have a dominant esophageal stricture or ring and remain symptomatic despite medical therapy; **or**
 - H. Management of achalasia (for example, dilatation or treatment with botulinum toxin injection); **or**
 - I. Endoscopic placement of self-expandable metal stents (SEMS) for palliative treatment of malignant gastric or biliary obstruction in individuals with poor performance status or inoperable disease; **or**
 - J. Management of gastroduodenal dysmotility when symptoms persist despite optimal medical and dietary management; **or**
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- K. Palliative therapy of stenosing neoplasms; **or**
- L. Endoscopic resection for individuals with Barrett's esophagus and *any* of the following (ablative treatment of Barrett's esophagus is addressed in CG-SURG-101 Ablative Techniques as a Treatment for Barrett's Esophagus):
 - 1. Low-grade dysplasia; **or**
 - 2. Flat high-grade dysplasia; **or**
 - 3. Intestinal metaplasia;**or**
- M. Endoscopic resection or radiofrequency ablation for individuals with stage T1a esophageal adenocarcinoma.

III. Screening EGD in Adults

Screening EGD for adults aged 18 years or older is considered **medically necessary** for *any* of the following indications:

- A. Individuals with familial adenomatous polyposis:
 - 1. Starting at age 25 years; **and**
 - 2. Subsequent follow up every 6 months to 4 years depending on the Spigelman Stage classification (0-III) of duodenal polyposis (see Table 2.);**or**
- B. Individuals with Lynch syndrome:
 - 1. Starting at age 30 years; **and**
 - 2. Subsequent follow up every 2 to 4 years;**or**
- C. Screening for Barrett's esophagus (BE) and esophageal adenocarcinoma (EAC) may be considered in individuals with:
 - 1. Chronic symptoms of gastroesophageal reflux disease (GERD) such as heartburn or acid regurgitation (weekly symptoms for 5 or more years); **and**
 - 2. Three or more risk factors for BE (see Discussion/General Information section).

IV. Sequential or Periodic Diagnostic EGD in Adults

Sequential or periodic diagnostic EGD for adults aged 18 years or older is considered **medically necessary** for *any* of the following indications:

- A. For surveillance of individuals with portal hypertension or compensated cirrhosis who meet *any* of the following criteria:
 - 1. With small varices or high-risk stigmata ("red wale markings"), every 1 to 2 years; **or**
 - 2. Without varices, every 2 to 3 years; **or**
 - 3. Secondary to alcohol abuse or decompensated liver disease, annually; **or**

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- B. Following esophageal variceal eradication, surveillance in the following intervals:
 - 1. 1 to 3 months following initial eradication; **and**
 - 2. Every 6 to 12 months thereafter to monitor for recurrence;**or**
- C. In individuals with Barrett's esophagus in *any* of the following scenarios:
 - 1. Without dysplasia, endoscopic surveillance should take place at intervals of 3 to 5 years; **or**
 - 2. With confirmed low-grade dysplasia, endoscopic surveillance of metaplastic gastric tissue may be performed every 6-12 months (endoscopic therapy is preferred); **or**
 - 3. With confirmed high-grade dysplasia and comorbidities that preclude endoscopic eradication therapy, endoscopic surveillance of metaplastic gastric tissue may be performed every 3 months.

Not Medically Necessary:

EGD for adults aged 18 years or older is considered **not medically necessary** when the above criteria are not met, and for all other indications, including but not limited to the following:

- A. Screening of *any* of the following:
 - 1. Asymptomatic upper gastrointestinal tract of an average risk individual; **or**
 - 2. Follow-up screening for Barrett's esophagus after a prior EGD screening examination was negative for Barrett's esophagus; **or**
 - 3. Aerodigestive cancer;**or**
- B. Surveillance for *any* of the following:
 - 1. Healed benign disease (for example, esophagitis, gastric or duodenal ulcer); **or**
 - 2. Gastric atrophy; **or**
 - 3. Pernicious anemia; **or**
 - 4. Fundic gland or hyperplastic polyps; **or**
 - 5. Gastric intestinal metaplasia; **or**
 - 6. Previous gastric operations for benign disease; **or**
 - 7. Achalasia;**or**
- C. Radiographic findings of *any* of the following:
 - 1. Asymptomatic or uncomplicated sliding hiatal hernia; **or**
 - 2. Uncomplicated duodenal ulcer that has responded to therapy; **or**
 - 3. Deformed duodenal bulb when symptoms are absent or respond adequately to ulcer therapy;**or**
- D. Confirming *Helicobacter pylori* eradication; **or**
- E. Isolated pylorospasm, known congenital hypertrophic pyloric stenosis, constipation and encopresis, or inflammatory bowel disease responding to therapy; **or**
- F. Prior to bariatric or non-gastroesophageal surgery in asymptomatic individuals; **or**
- G. Metastatic adenocarcinoma of unknown primary site when the results will not alter management; **or**

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- H. Obtaining tissue samples from endoscopically normal tissue to diagnose GERD or exclude Barrett's esophagus in adults; **or**
- I. Symptoms that are considered functional in origin; **or**
- J. To evaluate benign appearing, uncomplicated duodenal ulcers identified on radiologic imaging; **or**
- K. When there is clinical evidence of acute perforation.

Coding

The following codes for treatments and procedures applicable to this guideline are included below for informational purposes. Inclusion or exclusion of a procedure, diagnosis or device code(s) does not constitute or imply member coverage or provider reimbursement policy. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

When services may be Medically Necessary when criteria are met:

CPT

43233	Esophagogastroduodenoscopy, flexible transoral; diagnostic, 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)
43236	Esophagogastroduodenoscopy, flexible transoral; with directed submucosal injection(s), any substance [other than injections related to gastroesophageal reflux or dysphagia]
43239	Esophagogastroduodenoscopy, flexible transoral; with biopsy, single or multiple
43241	Esophagogastroduodenoscopy, flexible transoral; with insertion of intraluminal tube or catheter
43243	Esophagogastroduodenoscopy, flexible transoral; with injection sclerosis of esophageal/gastric varices
43244	Esophagogastroduodenoscopy, flexible transoral; with band ligation of esophageal/gastric varices
43245	Esophagogastroduodenoscopy, flexible transoral; with dilation of gastric/duodenal stricture(s) (eg, balloon, bougie)
43246	Esophagogastroduodenoscopy, flexible transoral; with directed placement of percutaneous gastrostomy tube
43247	Esophagogastroduodenoscopy, flexible transoral; with removal of foreign body(s)
43248	Esophagogastroduodenoscopy, flexible transoral; with insertion of guide wire followed by passage of dilator(s) through esophagus over guide wire
43249	Esophagogastroduodenoscopy, flexible transoral; with transendoscopic balloon dilation of esophagus (less than 30 mm diameter)
43250	Esophagogastroduodenoscopy, flexible transoral; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps

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43251	Esophagogastroduodenoscopy, flexible transoral; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique
43254	Esophagogastroduodenoscopy, flexible transoral; with endoscopic mucosal resection
43255	Esophagogastroduodenoscopy, flexible transoral; with control of bleeding, any method
43266	Esophagogastroduodenoscopy, flexible transoral; with placement of endoscopic stent (includes pre- and post-dilation and guide wire passage, when performed)
43270	Esophagogastroduodenoscopy, flexible transoral; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed) [other than ablation related to Barrett's esophagus]
0652T	Esophagogastroduodenoscopy, flexible, transnasal; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)
0653T	Esophagogastroduodenoscopy, flexible, transnasal; with biopsy, single or multiple
0654T	Esophagogastroduodenoscopy, flexible, transnasal; with insertion of intraluminal tube or catheter

ICD-10 Diagnosis

All diagnoses

When services are Not Medically Necessary:

For the procedure codes listed above when criteria are not met or for situations designated in the Clinical Indications section as not medically necessary.

Discussion/General Information

Upper GI endoscopy, or EGD, is usually performed to evaluate symptoms of persistent upper abdominal pain, nausea, vomiting, difficulty swallowing, or bleeding from the upper GI tract. This procedure is more accurate than diagnostic imaging for detecting inflammation, ulcers, or tumors of the esophagus, stomach and duodenum and can detect early cancer. EGD can also distinguish between benign and malignant conditions when biopsies of suspicious areas are obtained. EGD uses a flexible fiber-optic scope with a light and camera to examine the upper part of the GI system. Channels in the scope support the delivery of water, air, or suction and permit introduction of medical instruments to perform biopsies, cautery, or other procedures. The scope is inserted through the mouth into the upper GI tract allowing for visualization of the esophagus, stomach, and duodenum through the camera.

The quality of evidence concerning the safety and efficacy of EGD is lacking for the majority of the most common uses of the technology. In an effort to provide safe recommendations to guide clinical practice in the use of EGD, the American Society for Gastrointestinal Endoscopy (ASGE), the American Gastroenterological Association (AGA), and the American College of Gastroenterology (ACG) have established practice guidelines based largely on consensus within these respective specialty medical societies.

In 2012, the ASGE published a broad guideline entitled: Appropriate use of GI Endoscopy. The guideline contains several position statements based on a critical review of available evidence as well as expert consensus.

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The ASGE has also published several indication-specific guidelines such as: The Role of Endoscopy in Barrett's Esophagus and other Premalignant Conditions of the Esophagus (2012), The Role of Endoscopy in Gastrointestinal Obstruction and Gastroparesis (2011), The Role of Endoscopy in Dyspepsia (2015), The Role of Endoscopy in the Management of Benign and Malignant Gastrointestinal Obstruction (2021), and The Role of Endoscopy in the Diagnosis of Malignancy in Biliary Strictures of Undetermined Etiology (2023). The indication-specific guidelines also contain recommendations based on consensus and a review of the literature. Each recommendation was graded on the quality of the supporting evidence in accordance with the definitions in Table 1 shown below at the bottom of this discussion section. The ACG has also published indication-specific clinical practice guidelines on the use of endoscopy in commonly encountered clinical scenarios, such as: Diagnosis and Management of Barrett's Esophagus: an Updated ACG Guideline (Shaheen 2022), Diagnosis and Management of Achalasia (Vaezi, 2020), and Gastroparesis (Camilleri, 2022). The ACG's recommendations are graded in accordance with the same definitions as the ASGE, which appear in Table 1 below. The medically necessary indications in this clinical guideline are largely consistent with ASGE, ACG and AGA recommendations that are graded as 'moderate' to 'high' quality where the ACG has not considered the recommendation 'conditional' ("uncertainty about the tradeoffs") or the AGA has not considered the recommendation 'weak' ("recommendation not suitable for quality or performance measure"). Where there was discordance, criteria are based on expert consensus.

An AGA guideline (Wang, 2021) provides advice regarding surveillance intervals using endoscopy after removal of dysplastic lesions and early GI cancers with endoscopic submucosal dissection. These criteria are also based on expert consensus, and the authors acknowledge that the level of evidence available to support much of the surveillance advice is generally low.

Screening for Barrett's esophagus

Major gastroenterological specialty societies recommend screening only for individuals at high risk for development of Barrett's esophagus (BE) or esophageal adenocarcinoma (EAC).

The ACG guideline for diagnosis and management of Barrett's esophagus (Shaheen, 2022) includes the following statement on screening:

We suggest a single screening endoscopy for patients with chronic GERD symptoms and 3 or more additional risk factors for BE, including male sex, age >50 years, White race, tobacco smoking, obesity, and family history of BE or EAC in a first-degree relative (strength of recommendation: conditional; quality of evidence: very low).

The ASGE (2012) guideline states that: "Risk factors for BE and EAC include male sex, white race, age older than 50 years, family history of BE, increased duration of reflux symptoms, smoking, and obesity".

Neither the ACG (Shaheen, 2022) nor the ASGE (2012) recommend screening the general population for Barrett's esophagus.

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The AGA clinical practice guideline for endoscopic eradication therapy of BE (Rubenstein, 2024) does not address screening or surveillance.

Lynch syndrome

Lynch syndrome predisposes individuals to multiple cancers including gastric and small bowel due to germline pathogenic variants in the DNA mismatch repair genes MLH1, MSH2, MSH6, or PMS2 or the EPCAM gene. For individuals with these variants, NCCN recommends upper GI surveillance with high-quality EGD starting at age 30–40 years and repeat every 2–4 years (category 2A recommendation). Similar surveillance recommendations for Lynch syndrome have been made by the ACG (Syngal, 2015) and the European Society of Digestive Oncology (ESDO) (Vangala, 2018). Several studies have demonstrated that endoscopic screening detects upper GI cancers, precancerous lesions, and other clinically actionable findings that favor its use to reduce the burden of morbidity and mortality in individuals with Lynch syndrome (Ceravolo, 2021; Farha, 2022; Kumar, 2020; Ladigan-Badura, 2021; Vedantam, 2023).

GERD

Gastroesophageal reflux disease (GERD) is defined as “symptoms or complications resulting from the reflux of gastric contents into the esophagus or beyond, into the oral cavity (including larynx) or lung” (Flores, 2019). Increased BMI, waist circumference or weight are associated with the presence of GERD (Katz, 2013; Flores, 2019). Typical symptoms of GERD include dyspepsia, epigastric pain, early satiety, belching, and bloating (Katz, 2013). As noted by Brethauer (2014) “treatment of GERD is initially medical with acid suppression but if symptoms are refractory to medical therapy or if there is an associated anatomic etiology for the GERD, surgical revision may be required”.

The ACG 2022 guideline on GERD (Katz, 2022) notes that “There is no gold standard for the diagnosis of GERD. Thus, the diagnosis is based on a combination of symptom presentation, endoscopic evaluation of esophageal mucosa, reflux monitoring, and response to therapeutic intervention.” For patients with classic GERD symptoms of heartburn and regurgitation who have no alarm symptoms, ACG recommends an 8-week trial of empiric proton pump inhibitors (PPIs) once daily before a meal. The AGA (Yadlapati, 2022) concurs and further finds that “if troublesome heartburn, regurgitation, and/or non-cardiac chest pain do not respond adequately to a PPI trial or when alarm symptoms exist, clinicians should investigate with endoscopy.” The ACG recommendation on upper endoscopy for diagnosing GERD is as follows:

Upper endoscopy is the most widely used objective test for evaluating the esophageal mucosa. For patients with GERD symptoms who also have alarm symptoms such as dysphagia, weight loss, bleeding, vomiting, and/or anemia, endoscopy should be performed as soon as feasible. The endoscopic findings of EE [erosive esophagitis] and Barrett’s esophagus are specific for the diagnosis of GERD.

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Table 1. Quality of Evidence Grading of Recommendations Assessment, Development and Evaluation (GRADE) System (AGA, 2011; ASGE, 2015; ASGE, 2018).

‘High’	Further research is very unlikely to change our confidence in the estimate of effect.
‘Moderate’	Further research is likely to have an important impact on our confidence in the estimate of effect and may change the estimate.
‘Low’	Further research is very likely to have an important impact on our confidence in the estimate of effect and is likely to change the estimate.
‘Very Low’	Any estimate of effect is very uncertain.

Table 2. Spigelman Stage classification (0-IV) of duodenal polyposis (Brosens, 2005).

Spigelman classification	Endoscopic frequency
Stage 0	4 years
Stage I	2-3 years
Stage II	1-3 years
Stage III	6-12 months
Stage IV	Surgical evaluation

References

Peer Reviewed Publications:

1. Brosens LA, Keller JJ, Offerhaus GJ et al. Prevention and management of duodenal polyps in familial adenomatous polyposis. *Gut*. 2005; 54(7):1034-1043.
2. Ceravolo AH, Yang JJ, Latham A, et al. Effectiveness of a surveillance program of upper endoscopy for upper gastrointestinal cancers in Lynch syndrome patients. *Int J Colorectal Dis*. 2022; 37(1):231-238.
3. Farha N, Hrabe J, Sleiman J, et al. Clinically actionable findings on surveillance EGD in asymptomatic patients with Lynch syndrome. *Gastrointest Endosc*. 2022; 95:105-14.
4. Flores L, Krause C, Pokala B, et al. Novel therapies for gastroesophageal reflux disease. *Curr Probl Surg*. 2019; 56(12):100692.
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6. Kumar S, Dudzik CM, Reed M, et al. Upper endoscopic surveillance in Lynch syndrome detects gastric and duodenal adenocarcinomas. *Cancer Prev Res*. 2020; 13:1047–1054.
7. Vedantam S, Katona BW, Sussman DA, Kumar S. Outcomes of upper endoscopy screening in Lynch syndrome: a meta-analysis. *Gastrointest Endosc*. 2023; 97(1):2-10.

Government Agency, Medical Society, and Other Authoritative Publications:

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2. ASGE Standards of Practice Committee; Banerjee S, Cash BD, Dominitz JA, et al. The role of endoscopy in the management of patients with peptic ulcer disease. *Gastrointest Endosc*. 2010; 71(4):663-668.
3. ASGE Standards of Practice Committee; Chandrasekhara V, Early DS, Acosta RD, et al. ASGE guideline: modifications in endoscopic practice for the elderly. *Gastrointest Endosc*. 2013; 78(1):1-7.
4. ASGE Standards of Practice Committee; Early DS, Ben-Menachem T, Decker GA, et al. Appropriate use of GI endoscopy. *Gastrointest Endosc*. 2012; 75(6):1127-1131.
5. ASGE Standards of Practice Committee; Evans JA, Chandrasekhara V, Chathadi KV, et al. The role of endoscopy in the management of premalignant and malignant conditions of the stomach. *Gastrointest Endosc*. 2015; 82(1):1-8.
6. ASGE Standards of Practice Committee; Evans JA, Early DS, Fukami N, et al. The role of endoscopy in Barrett's esophagus and other premalignant conditions of the esophagus. *Gastrointest Endosc*. 2012; 76(6):1087-1094.
7. ASGE Standards of Practice Committee; Evans JA, Muthusamy VR, Acosta RD, et al. The role of endoscopy in the bariatric surgery patient. *Surg Obes Relat Dis*. 2015; 11(3):507-517.
8. ASGE Standards of Practice Committee; Fujii-Lau LL, Thosani NC, Al-Haddad M, et al. The role of endoscopy in the diagnosis of malignancy in biliary strictures of undetermined etiology: summary and recommendations. *Gastrointest Endosc*. 2023; 98:685-693.
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History

Status	Date	Action
Revised	02/20/2025	Medical Policy & Technology Assessment Committee (MPTAC) review. Added MN criteria for screening EGD for individuals with Lynch syndrome. Revised formatting in Clinical Indications section. Revised Discussion/General Information and References sections.
Revised	06/06/2024	MPTAC review. Revised clinical indications in MN statement on screening EGD in adults at risk for Barrett's esophagus and removed male sex.
Revised	05/09/2024	MPTAC review. Added proton pump inhibitors as an example of appropriate trial of therapy to MN statement on diagnostic EGD in adults in Clinical Indications section. Revised Discussion/General Information and References sections.
Revised	05/11/2023	MPTAC review. Revised Clinical Indications section to remove references to "life-limiting comorbidities."
Reviewed	11/10/2022	Corrected spelling error in MN criteria. MPTAC review. Updated Discussion/General Information and References sections.
Reviewed	11/11/2021	MPTAC review. Updated Discussion/General Information and References sections.
	07/01/2021	Updated Coding section with 07/01/2021 CPT changes; added 0652T, 0653T, 0654T.

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Revised	11/05/2020	MPTAC review. Removed list of risk factors related to screening for Barrett's esophagus from clinical indications in MN statement on screening EGD in adults. Updated Discussion/General Information section. Reformatted Coding section.
Revised	05/14/2020	Medical Policy & Technology Assessment Committee (MPTAC) review. In Clinical Indications section, updated "SURG.00106 Ablative Techniques as a Treatment for Barrett's Esophagus" to new guideline number "CG-SURG-101 Ablative Techniques as a Treatment for Barrett's Esophagus." Updated Discussion/General Information, and References sections.
Revised	06/06/2019	MPTAC review. In Sequential or Periodic Diagnostic EGD in Adults section of Clinical Indications, changed "and" to "or" in criterion A.1. Updated Description, Discussion/General Information, and References sections. Updated Coding section; removed CPT 43238, 43242, 43253.
Revised	09/13/2018	Medical Policy & Technology Assessment Committee (MPTAC) review. Title changed to Upper Gastrointestinal Endoscopy in Adults. Revised MN criteria in Diagnostic Esophagogastroduodenoscopy (EGD) in Adults section. Added MN criteria for age requirement in all indications. Removed MN criteria for screening EGD in pediatric individuals. Added NMN criteria for age requirement in all indications. Updated Description, Discussion/General Information, and References sections.
Revised	11/02/2017	MPTAC review. Updated header language from "Current Effective Date" to "Publish Date." Added therapeutic indications to the document. Revised Title, Position Statement and Coding sections. Updated Rationale and References.
New	09/13/2017	MPTAC review. Initial document development.

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