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 Subject: Upper GI Endoscopy: Celiac Disease Diagnosis
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Clinical Documentation and Prior Authorization Required	√	Type of Review - Case Management	
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		Administrative Process (Internal Use Only)	MD

Note: Background, product, and disclaimer information is located at the end of this document.

Effective January 1, 2008, Tufts Health Plan began to require prior authorization for certain elective upper GI endoscopy procedures for Members 18 to 55 years of age. This Medical Necessity Guideline is to be used when an Upper GI Endoscopy is requested for the diagnosis of celiac sprue.

Overview

An upper GI endoscopy (EGD) is a procedure that uses a lighted, flexible endoscope to see inside the upper GI (gastrointestinal) tract. The upper GI tract includes the esophagus, stomach, and duodenum.

Coverage Guidelines for Initial Procedures

Tufts Health Plan may authorize the coverage of an upper GI endoscopy for the diagnosis of Celiac Sprue when the member meets **one** of the following criteria:

- Positive serology for celiac sprue by IgA tissue transglutaminase (IgA-tTG), IgA endomysial antibody (IgA-EMA) or IgG-tTG or IgG-EMA may be substituted for members with IgA deficiency
- Any **one** of the following criteria:
 - GI symptoms consistent with chronic malabsorption, including chronic diarrhea or steatorrhea, abdominal distension, and weight loss
 - Otherwise unexplained iron, folate, or vitamin D deficiency, calcium deficiency, or secondary hyperparathyroidism with osteoporosis or osteomalacia.
 - In absence of other causes: persistent aminotransferase elevation, short stature, delayed puberty, recurrent fetal loss/infertility, epilepsy or ataxia.
 - GI symptoms, with a diagnosis of an associated high-risk conditions, such as, Type-1 Diabetes Mellitus or other autoimmune endocrinopathies (such as autoimmune thyroiditis); first and second degree relatives with celiac disease; Turner, Down, or William syndromes; IgA deficiency, or Dermatitis Herpetiformis (skin condition strongly associated with celiac disease)

Limitations

- In individuals with low risk of disease (for example, isolated osteoporosis, infertility, irritable bowel GI symptoms), and a negative serology.
- Osteoporosis without additional evidence of malabsorption

Coverage Guidelines for Repeat Procedures

Tufts Health Plan may authorize the coverage of a repeat upper GI endoscopy for members with one of the following:

- The member fails to respond to gluten-free diet
- Diagnosis of celiac sprue is uncertain on initial testing and needs to be confirmed by re-biopsy.

Codes

The following CPT codes require prior authorization:

Code	Description
43200	Esophagoscopy, rigid or flexible; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)
43202	Esophagoscopy, rigid or flexible; with biopsy, single or multiple
43234	Upper gastrointestinal endoscopy, simple primary examination (e.g., with small diameter flexible endoscope) (separate procedure)
43235	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)
43239	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with biopsy, single or multiple

References

1. Green, P. and C. Cellier, Celiac disease, New England Journal of Medicine. 2007(357):1731-1743.
2. Hadziselimovic, F. and A. Wolfe, Institute for Diagnosing Celiac Disease, Letter to the editor NEJM 2007(358): 747-748.
3. Kanoff, M. American Gastroenterological Association (AGA) Institute of Medical position statement on the diagnosis and management of celiac disease. Gastroenterology 2006: 131(6): 1981-2002.
4. National Institutes of Health, NIH consensus statement on Celiac disease. NIH Consensus and State-of-the-Science Statements. June 28-30, 2004:(21)1.

Approval History

Reviewed by the Medical Affairs Medical Policy Committee on August 5, 2009 for January 1, 2010 effective date.

Background, Product and Disclaimer Information

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

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

Medical Necessity Guidelines apply to all fully insured Tufts Health Plan products unless otherwise noted in this guideline or the Member's benefit document. This guideline does not apply to Tufts Health Plan Medicare Preferred or to certain delegated service arrangements. For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Medical Necessity Guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern. Applicable state or federal mandates will take precedence. Providers in the New Hampshire service area are subject to CIGNA HealthCare's provider arrangement for the purpose of CareLinkSM.

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