Colonoscopy

I. Description
Colonoscopy is a visual examination of the lining of the colon with a fiberoptic endoscope. The endoscope is inserted through the anus and rectum and advanced through the large intestine under direct vision using the scope’s optical system. Instrumentation can be passed through the scope for taking biopsies and removing polyps or suspicious lesions.

Colonoscopy is one modality used for colorectal cancer screening. It allows for full structural examination of the colon and rectum in a single session and for the detection of both colorectal polyps and cancers with biopsy or polypectomy. The following criteria/guidelines for the use of colonoscopy for screening of individuals at increased risk for colorectal cancer (CRC) and for surveillance reflect the recommendations of the American Cancer Society and the US Multi-Society Task Force on Colorectal Cancer (USMSTF), which is comprised of representatives of the American College of Gastroenterology, American Gastroenterological Association and American Society of Gastrointestinal Endoscopy.

II. Criteria/Guidelines
A. Screening Colonoscopy
   1. Screening colonoscopy is covered (subject to Limitations and Administrative Guidelines) to detect colorectal cancer (CRC) and adenomatous polyps (adenomas) in asymptomatic individuals at average risk, i.e., those without specific risk factors or family history of colorectal cancer or adenomas, beginning at age 50 years or 45 years for African Americans, and every 10 years thereafter until age 75.
   2. Screening colonoscopy is covered (subject to Limitations and Administrative Guidelines) to detect colorectal cancer and adenomas in high risk individuals as follows:
      a. Family history of CRC or adenomas
         i. For individuals with one first degree relative (parent, sibling or child) with CRC or adenoma diagnosed before the age of 60 or two or more first-degree relatives with CRC or adenomas at any age, screening colonoscopy is covered beginning at age 40, or beginning at age 10 years younger than the age at diagnosis of the youngest affected relative, whichever comes first and every 5 years thereafter.
         ii. For individuals with one first degree relative with CRC or adenoma diagnosed at greater than or equal to age 60 years or two second degree relatives (grandparent, ...
aunt or uncle) with CRC or adenoma, screening colonoscopy is covered beginning at age 40 and every 10 years thereafter. NOTE: Individuals may choose to be screened with any recommended form of testing (see Colorectal Screening policy).

b. For individuals with genetic or clinical diagnosis of Lynch syndrome, also called hereditary nonpolyposis colon cancer (HNPCC), screening colonoscopy is covered beginning at age 20 to 25 years or ten years before the youngest case in the immediate family and every one to two years thereafter to age 40 when annual screening is covered.

c. For individuals with first degree relatives with serrated polyposis syndrome, also called hyperplastic polyposis syndrome, screening colonoscopy is covered at age 40, same age as the earliest diagnosis in the family of serrated polyposis if uncomplicated by CRC or 10 years earlier than earliest diagnosis in the family if complicated by CRC (whichever is earliest) and every five years if no polyps found.

d. For individuals with inflammatory bowel disease, chronic ulcerative colitis, and Crohn’s colitis, screening colonoscopy is covered beginning eight years after the onset of pancolitis or 12 to 15 years after the onset of left-sided colitis and every one to two years thereafter with biopsy to detect dysplasia.

B. Surveillance Colonoscopy

1. Surveillance colonoscopy is covered (subject to Limitations and Administrative Guidelines) for asymptomatic patients after CRC resection as follows:

   a. Three to six months after cancer resection, if no unresectable metastases are found during surgery, to rule out synchronous neoplasms. Alternatively, colonoscopy can be performed intraoperatively, or preoperatively if non-obstructing tumor.

   b. One year after the curative resection (or one year following the colonoscopy that was performed to clear the colon of synchronous disease).

   c. Three years after the “one year” follow-up colonoscopy, if examination was normal and 5 years thereafter if the “three year” colonoscopy was normal.

2. Surveillance colonoscopy is covered (subject to Limitations and Administrative Guidelines) for asymptomatic patients with a personal history of adenomas* at prior colonoscopy as follows:

   a. For patients with one to two small (less than one centimeter) tubular adenomas, surveillance colonoscopy is covered five to ten years after the initial polypectomy (the precise time within this interval should be based on other clinical factors such as colonoscopy findings, family history, and the preferences of the patient and the judgment of the physician). If there are no adenomas on the first surveillance colonoscopy, the second surveillance colonoscopy is covered in ten years.

   b. For patients with three to ten adenomas or one adenoma greater than or equal to one centimeter or any adenoma with villous features or high-grade dysplasia that have been completely removed, surveillance colonoscopy is covered three years after the initial polypectomy. If the follow-up colonoscopy is normal or shows only one to two small tubular adenomas with low-grade dysplasia, then the interval for the subsequent colonoscopy is covered every five years.

   c. For patients with greater than 10 adenomas on a single examination, surveillance colonoscopy is covered less than three years after the initial polypectomy.
d. For patients with sessile adenomas that are removed piecemeal, surveillance colonoscopy is covered two to six months following the initial polypectomy to verify complete removal. Once complete removal has been established based on endoscopic and pathologic assessments, subsequent surveillance needs to be individualized based on the physician’s judgment.

e. For patients who meet the clinical criteria for serrated polyposis syndrome, colonoscopy is covered every year. Clinical criteria include the following:
   i. At least five serrated polyps proximal to the sigmoid colon, of which two or more are greater than or equal to ten millimeters
   ii. Any number of serrated polyps proximal to the sigmoid colon in an individual who has a first degree relative with serrated polyposis syndrome
   iii. Greater than 20 serrated polyps of any size, distributed throughout the colon

f. For patients with hyperplastic polyps, surveillance colonoscopy is covered as follows:
   i. For patients with any number of hyperplastic polyps in the rectosigmoid that are each individually less than 10 millimeters, surveillance colonoscopy is covered 10 years after the initial polypectomy.
   ii. For patients with three or less hyperplastic polyps proximal to the sigmoid colon that are each 5 millimeters or less, surveillance colonoscopy is covered 10 years after the initial polypectomy.
   iii. For patients with four or more hyperplastic polyps proximal to the sigmoid colon that are of any size, surveillance colonoscopy is covered 5 years after the initial polypectomy. A longer subsequent follow-up interval may be appropriately applied when a follow-up exam shows improvement in findings, i.e., a reduction in the number of lesions.
   iv. For patients with any number of hyperplastic polyps proximal to the sigmoid colon that are each greater than 5 millimeters, surveillance colonoscopy is covered 5 years after the initial polypectomy. A longer subsequent follow-up interval may be appropriately applied when a follow-up exam shows improvement in findings, i.e., a reduction in the size of lesions.

*NOTE: Sessile serrated polyps (SSPs) are managed in the same manner as adenomas.

C. Diagnostic Colonoscopy

Diagnostic colonoscopy is covered (subject to Limitations and Administrative Guidelines) for the evaluation of the following:
1. An abnormality discovered by barium enema that is likely to be clinically significant, such as a filling defect or stricture.
2. Unexplained gastrointestinal bleeding
3. Unexplained recent persistent change in bowel habit
4. Hematochezia that is not from the rectum or a perianal source
5. Melena after an upper gastrointestinal source has been excluded
6. Presence of fecal occult blood
7. Unexplained iron deficiency anemia
8. Suspected inflammatory bowel disease manifested by abdominal pain, fever, diarrhea, elevated sedimentation rate, etc.
9. Chronic inflammatory bowel disease of the colon when a more precise determination of the extent of disease will influence management
10. Clinically significant diarrhea of unexplained origin after appropriate work-up
11. Intraoperative identification of the site of a lesion that cannot be detected by palpation or gross inspection at surgery
12. Suspected disease of the terminal ileum
13. Metastatic adenocarcinoma of unknown primary when colon cancer is suspected
14. Acute colonic ischemia/ischemic bowel disease
15. Patients with streptococcus bovis endocarditis

D. Therapeutic Colonoscopy
Therapeutic colonoscopy is covered for the following:
1. Balloon dilation of stenotic lesions (e.g., anastomotic strictures)
2. Decompression of pseudo-obstruction of the colon
3. Palliative treatment of stenosing or bleeding neoplasms (e.g., laser, electrocoagulation, stenting)
4. Treatment of sigmoid volvulus
5. Treatment of bleeding from such lesions as vascular malformations/anomalies, ulceration, neoplasia or polypectomy site (e.g., electrocoagulation, heat probe, laser or injection therapy)
6. Preoperative “marking” for localization of a lesion
7. Removal of a foreign body

III. Limitations
A. Repeat colonoscopy (or other screening procedures) for patients with small hyperplastic polyps performed at intervals less than that for average risk individuals is not covered. Individuals with small hyperplastic polyps are considered to have normal colonoscopy and should have colonoscopy or other screening options performed at intervals recommended for average-risk individuals. An exception is patients with a hyperplastic polyposis syndrome who are at increased risk for adenomas and CRC and need to be identified for intensive follow-up.
B. Discontinuation of surveillance colonoscopy should be considered in patients with serious comorbidities who have life expectancies of less than 10 years according to the physician’s judgment.
C. Diagnostic colonoscopy is not covered for the following conditions:
1. Chronic, stable irritable bowel syndrome
2. Acute limited diarrhea
3. Hemorrhoids
4. Metastatic adenocarcinoma of unknown primary site in the absence of colonic symptoms and when a definitive site of origin will not influence management
5. Routine follow-up of inflammatory bowel disease
6. Upper gastrointestinal bleeding or melena with a demonstrated upper gastrointestinal source
7. Bright red rectal bleeding in patients with a convincing anorectal source via direct examination, anoscopy, or sigmoidoscopy AND no other symptoms suggestive of a more proximal bleeding source
D. The routine use of anesthesia services for patients without high risk situations who are undergoing standard colonoscopy procedures is not covered. (See Anesthesia Services for Gastrointestinal Endoscopy Procedures policy.)

IV. Administrative Guidelines
A. Precertification is not required for colonoscopy when the above criteria are met. HMSA will from time to time perform retrospective reviews using the above criteria to validate if services rendered meet payment determination criteria. Supporting documentation including, but not limited to, gastroenterology notes, previous colonoscopy procedure reports and pathology reports with number and type of polyp (e.g., adenomatous, hyperplastic), features of polyp (e.g., tubular, villous), and degree of dysplasia (e.g., low grade, high grade) must be maintained in the patient’s medical record and must be made available to HMSA on request.

B. When both an upper and lower endoscopy are required for a patient, medical literature has established that it is both safe and efficient to do these concurrently. In addition, this is the professional standard of care and the most appropriate and cost effective delivery of the service. Therefore, if the two procedures are not going to be done on the same day, the medical record should clearly document the medical necessity for splitting the services and those records must be made available for review upon request.

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<thead>
<tr>
<th>CPT Procedure Code</th>
<th>Code Description</th>
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<tbody>
<tr>
<td>44388</td>
<td>Colonoscopy through stoma; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)</td>
</tr>
<tr>
<td>44389</td>
<td>With biopsy, single or multiple</td>
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<tr>
<td>44390</td>
<td>With removal of foreign body</td>
</tr>
<tr>
<td>44391</td>
<td>With control of bleeding (e.g., injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)</td>
</tr>
<tr>
<td>44392</td>
<td>With removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery</td>
</tr>
<tr>
<td>44393</td>
<td>With ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique</td>
</tr>
<tr>
<td>44394</td>
<td>With removal of tumor(s), polyp(s), or other lesion(s) by snare technique</td>
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<tr>
<td>44397</td>
<td>With transendoscopic stent placement (includes predilation)</td>
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<tr>
<td>45355</td>
<td>Colonoscopy, rigid or flexible, transabdominal via colotomy, single or multiple</td>
</tr>
<tr>
<td>45378</td>
<td>Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimen(s) by brushing or washing, with or without colon decompression (separate procedure)</td>
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<tr>
<td>45379</td>
<td>With removal of a foreign body</td>
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<td>45380</td>
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Colonoscopy, flexible, proximal to splenic flexure;

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<td>45381</td>
<td>With directed submucosal injection(s), any substance</td>
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<td>45382</td>
<td>Colonoscopy, flexible, proximal to splenic flexure; with control of bleeding (eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)</td>
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<tr>
<td>45383</td>
<td>Colonoscopy, flexible, proximal to splenic flexure; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique</td>
</tr>
<tr>
<td>45384</td>
<td>Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery</td>
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<td>45385</td>
<td>Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique</td>
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<td>45386</td>
<td>With dilation by balloon, 1 or more strictures (do not report 45386 in conjunction with 45387)</td>
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<td>45387</td>
<td>With transendoscopic stent placement (includes predilation)</td>
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<td>45391</td>
<td>With endoscopic ultrasound examination (do not report 45391 in conjunction with 45330, 45341, 45342, 45378, 76872)</td>
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<td>45392</td>
<td>With transendoscopic ultrasound guided intramural or transmural fine needle aspiration (biopsy(s))</td>
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**HCPCS Procedure Code**

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<th>Code</th>
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<tr>
<td>G0105</td>
<td>Colorectal cancer screening; colonoscopy on individual at high risk</td>
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<tr>
<td>G0121</td>
<td>Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk</td>
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**ICD-10 Code**

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<th>Description</th>
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<tr>
<td>Z80.0</td>
<td>Family history of malignant neoplasm of digestive organs</td>
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<tr>
<td>Z83.71</td>
<td>Family history of colonic polyps</td>
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<tr>
<td>Z84.81</td>
<td>Family history of carrier of genetic disease</td>
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<td>Z12.12</td>
<td>Encounter for screening for malignant neoplasm of rectum</td>
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<tr>
<td>Z12.11</td>
<td>Encounter for screening for malignant neoplasm of colon</td>
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**V. Important Reminder**

The purpose of this Medical Policy is to provide a guide to coverage. This Medical Policy is not intended to dictate to providers how to practice medicine. Nothing in this Medical Policy is intended to discourage or prohibit providing other medical advice or treatment deemed appropriate by the treating physician.
Benefit determinations are subject to applicable member contract language. To the extent there are any conflicts between these guidelines and the contract language, the contract language will control.

This Medical Policy has been developed through consideration of the medical necessity criteria under Hawaii’s Patients’ Bill of Rights and Responsibilities Act (Hawaii Revised Statutes §432E-1.4), generally accepted standards of medical practice and review of medical literature and government approval status. HMSA has determined that services not covered under this Medical Policy will not be medically necessary under Hawaii law in most cases. If a treating physician disagrees with HMSA’s determination as to medical necessity in a given case, the physician may request that HMSA reconsider the application of the medical necessity criteria to the case at issue in light of any supporting documentation.

VI. References