Colonoscopy

I. Policy

University Health Alliance (UHA) will reimburse for colonoscopy when it is determined to be medically necessary and when it meets the medical criteria guidelines (subject to limitations and exclusions) indicated below.

For colorectal cancer (CRC) screening of individuals at average risk of colorectal cancer, please refer to the Colorectal Cancer Screening policy.

For guidelines of genetic testing as related to colonoscopy, please refer to Genetic Testing for Lynch Syndrome/Colorectal Cancer and Polyposis Syndromes policy.

II. Criteria/Guidelines

A. Screening Colonoscopy

1. For colorectal cancer (CRC) screening of individuals at average risk, please refer to the Colorectal Cancer Screening policy.

2. Screening colonoscopy is covered (subject to Limitations/Exclusions 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 colorectal cancer 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) 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).
      
      iii. All patients should be asked before age 40 years about family history to identify those at increased risk. The following questions are reasonable: Have any blood relatives had CRC or an adenoma? If so, how many, and were these first-degree relatives (parent, sibling, or child) or second-degree relatives (grandparent, cousin, niece, or nephew)? Questions should be repeated periodically and interpreted keeping in mind family size (which, if small, can cause false-negative reports) and the possibility of uncertain paternity.

   b. For individuals with genetic or clinical diagnosis of Lynch Syndrome, also called hereditary nonpolyposis colon cancer (HNPCC), or with first-degree relatives affected by Lynch syndrome, screening colonoscopy is covered beginning at age 20 to 25 years or ten years before the youngest case in the immediate family (whichever is earlier) 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.

e. If a high risk patient declines screening colonoscopy, alternative screening should be offered after the limitations of alternative testing are discussed.

B. Surveillance Colonoscopy

1. Surveillance colonoscopy is covered (subject to Limitations/Exclusions 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 five years thereafter if the “three year” colonoscopy was normal.

2. Surveillance colonoscopy is covered (subject to Limitations/Exclusions 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.

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

g. If colonoscopy is complete to the cecum and the preparation ultimately is deemed inadequate, colonoscopy (generally with a more aggressive preparation regimen) is covered within one year. When advanced neoplasia is detected, an interval shorter than one year is indicated. (NOTE: Preliminary assessment of preparation quality should be made in the rectosigmoid colon. If the preparation is clearly inadequate to allow polyp detection greater than 5 mm, the procedure should be terminated and rescheduled or alternatively, additional bowel cleansing can be attempted for colonoscopy to proceed that day).

C. Diagnostic Colonoscopy

1. Diagnostic colonoscopy is covered (subject to Limitations/Exclusions and Administrative Guidelines) for the evaluation of the following:

a. An abnormality discovered by barium enema that is likely to be clinically significant, such as a filling defect or stricture

b. Unexplained or unclear source of gastrointestinal bleeding

c. Unexplained recent persistent change in bowel habit

d. Hematochezia that is not from the rectum or a perianal source

e. Melena after an upper gastrointestinal source has been excluded

f. Presence of fecal occult blood

g. Unexplained iron deficiency anemia

h. Suspected inflammatory bowel disease manifested by abdominal pain, fever, diarrhea, elevated sedimentation rate, etc.

i. Chronic inflammatory bowel disease of the colon when a more precise determination of the extent of disease will influence management
j. Clinically significant diarrhea of unexplained origin after appropriate work-up
k. Intraoperative identification of the site of a lesion that cannot be detected by palpation or gross inspection at surgery
l. Suspected disease of the terminal ileum
m. Metastatic adenocarcinoma of unknown primary when colon cancer is suspected
n. Acute colonic ischemia/ischemic bowel disease
o. Patients with streptococcus bovis endocarditis

D. Therapeutic Colonoscopy

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

NOTE:

This UHA payment policy is a guide to coverage, the need for prior authorization and other administrative directives. It is not meant to provide instruction in the practice of medicine and it should not deter a provider from expressing his/her judgment.

Even though this payment policy may indicate that a particular service or supply is considered covered, specific provider contract terms and/or members’ individual benefit plans may apply, and this policy is not a guarantee of payment. UHA reserves the right to apply this payment policy to all UHA companies and subsidiaries.

UHA understands that opinions about and approaches to clinical problems may vary. Questions concerning medical necessity (see Hawaii Revised Statutes §432E-1.4) are welcome. A provider may request that UHA reconsider the application of the medical necessity criteria in light of any supporting documentation.

III. Limitations/Exclusions

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. Virtual colonoscopy, (i.e., CT colonography) is not covered for screening except as outlined in UHA’s Virtual Colonoscopy policy.

E. The services of an anesthesiologist are covered only for special indications as outlined in UHA’s Anesthesia Services for Gastrointestinal Endoscopic Procedures policy.

### IV. Administrative Guidelines

A. Prior authorization is not required for colonoscopy when the above criteria are met.

B. UHA will from time to time perform retrospective reviews using the above criteria to validate if services rendered meet payment determination criteria. Supporting documentation includes, but is 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 UHA on request.

C. 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 Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>44388</td>
<td>Colonoscopy through stoma; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)</td>
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<tr>
<td>44389</td>
<td>Colonoscopy through stoma; with biopsy, single or multiple</td>
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<tr>
<td>44390</td>
<td>Colonoscopy through stoma; with removal of foreign body(s)</td>
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<tr>
<td>44391</td>
<td>Colonoscopy through stoma; with control of bleeding, any method</td>
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<tr>
<td>44392</td>
<td>Colonoscopy through stoma; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps</td>
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<tr>
<td>44394</td>
<td>Colonoscopy through stoma; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique</td>
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<tr>
<td>44401</td>
<td>Colonoscopy through stoma; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)</td>
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<td>44402</td>
<td>Colonoscopy through stoma; with endoscopic stent placement (including pre- and post-dilation and guide wire passage, when performed)</td>
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<td>Colonoscopy, flexible; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)</td>
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<td>Colonoscopy, flexible; with removal of foreign body(s)</td>
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<td>Colonoscopy, flexible; with biopsy, single or multiple</td>
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<td>Colonoscopy, flexible; with directed submucosal injection(s), any substance</td>
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<td>Colonoscopy, flexible; with control of bleeding, any method</td>
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<td>Colonoscopy, flexible; with transendoscopic balloon dilation</td>
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<td>Colonoscopy, flexible; with endoscopic ultrasound examination limited to the rectum, sigmoid, descending, transverse, or ascending colon and cecum, and adjacent structures</td>
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<td>45392</td>
<td>Colonoscopy, flexible; with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(s), includes endoscopic ultrasound examination limited to the rectum, sigmoid, descending, transverse, or ascending colon and cecum, and adjacent structures</td>
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### V. Policy History

**Policy Number:** MPP-0043-120301  
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