Introduction

A colonoscopy uses a flexible lighted tube to examine the colon and rectum. A colonoscopy can be used as a preventive test to screen for colon cancer or polyps. It can also be done as a diagnostic procedure when symptoms or lab tests suggest there might be a problem in the rectum or colon. In some cases, minor procedures may be done during a colonoscopy, such as taking a biopsy or destroying an area of unhealthy tissue (a lesion). Preventive colonoscopy is done for people who are not having any symptoms or problems with the colon or rectum. The decision to do a preventive colonoscopy is usually based on age and family history. The US Preventive Services Task Force has highly recommended that all adults be screened for colon cancer between the ages of 50 and 75. This guideline applies only to people of average risk. Colonoscopy is only one of the screening tests that can be used. This benefit coverage guideline provides general information about how the health plan decides whether a colonoscopy is covered under the preventive or diagnostic (medical) benefits.

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.
<table>
<thead>
<tr>
<th>Indication</th>
<th>Coverage Statement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive screening colonoscopy</td>
<td>Preventive screening colonoscopy procedures are covered under the preventive care benefits in plans that include a preventive benefit.</td>
</tr>
<tr>
<td></td>
<td>• Preventive screenings are for people that are at average risk and have no symptoms.</td>
</tr>
<tr>
<td></td>
<td>• The original intent of the colonoscopy determines the benefit under which it is paid.</td>
</tr>
<tr>
<td></td>
<td>• A colonoscopy done for screening in the absence of symptoms, based on age and risk factors, is covered under the preventive benefit even if polyps or other abnormalities are found and removed or treated.</td>
</tr>
<tr>
<td>Medical colonoscopy (eg, diagnostic, therapeutic, surveillance)</td>
<td>Medical colonoscopy procedures are covered under the medical benefits.</td>
</tr>
<tr>
<td></td>
<td>• A medical colonoscopy for a specific illness, injury or a set of symptoms is considered diagnostic, therapeutic, or a surveillance procedure</td>
</tr>
<tr>
<td></td>
<td>• A colonoscopy for individuals who have an increased or high risk of polyps or a current or prior diagnosis of colon cancer is considered surveillance after the initial study</td>
</tr>
<tr>
<td>Not medically necessary indications for diagnostic colonoscopy³</td>
<td>Diagnostic colonoscopy is generally not indicated for the following conditions:</td>
</tr>
<tr>
<td></td>
<td>• Acute diarrhea</td>
</tr>
<tr>
<td></td>
<td>• Chronic abdominal pain</td>
</tr>
<tr>
<td></td>
<td>• Chronic, stable irritable bowel syndrome</td>
</tr>
<tr>
<td></td>
<td>• Routine follow-up of inflammatory bowel disease except for cancer surveillance in chronic ulcerative colitis and Crohn colitis</td>
</tr>
<tr>
<td></td>
<td>• Upper GI tract bleeding or melena with a demonstrated upper GI source</td>
</tr>
<tr>
<td></td>
<td>*Note: see note on Screening colonoscopy under Coding section for IBD</td>
</tr>
</tbody>
</table>

**Coding**
Correctly coding screening colonoscopies is essential to ensure accurate payment. The codes below are used by the plan to identify screening colonoscopies and associated services.

<table>
<thead>
<tr>
<th>Codes</th>
<th>ICD (CM) Diagnosis (to ensure accurate reimbursement it is recommended to bill one of the diagnosis codes listed below in the PRIMARY diagnosis field)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colonoscopy</td>
<td>Screening for patients at average risk beginning at age 50:</td>
</tr>
<tr>
<td>• CPT: 45378, 45380, 45381, 45384, 45385, 45388, 45390, 45391</td>
<td>Z12.10, Z12.11, Z12.12, Z80.0, Z83.71, Z83.79</td>
</tr>
<tr>
<td>• HCPCS: G0105, G0121</td>
<td>Screening for patients under age 50, at increased risk for colon cancer due to a strong family history of colon cancer:</td>
</tr>
<tr>
<td></td>
<td>Z80.0, Z83.71, Z83.79, Z84.81</td>
</tr>
<tr>
<td></td>
<td>Screening colonoscopy for patients with personal history of inflammatory bowel disease (Crohn disease or ulcerative colitis) will be recognized as preventive with a screening diagnosis in the primary position, and a disease specific diagnosis in secondary position:</td>
</tr>
<tr>
<td></td>
<td>Z12.10, Z12.11, Z12.12</td>
</tr>
<tr>
<td>Sedation</td>
<td>No diagnosis code required with S0285</td>
</tr>
<tr>
<td>• CPT: 00812, 99152, 99153</td>
<td></td>
</tr>
<tr>
<td>• HCPCS: G0500</td>
<td></td>
</tr>
<tr>
<td>Pathology</td>
<td>D12.6, D37.4, D49.0, K63.5</td>
</tr>
<tr>
<td>• CPT: 88305 (colon polyp[s])</td>
<td>Z12.10-Z12.12, Z84.81</td>
</tr>
<tr>
<td>Colonoscopy Consultation</td>
<td>No diagnosis code required with S0285</td>
</tr>
<tr>
<td>• HCPCS: S0285*</td>
<td></td>
</tr>
<tr>
<td>*For services on and after 1/1/17</td>
<td></td>
</tr>
</tbody>
</table>

Note: CPT codes, descriptions and materials are copyrighted by the American Medical Association (AMA). HCPCS codes, descriptions and materials are copyrighted by Centers for Medicare Services (CMS).

**Coding Screening Colonoscopy Services**

Benefit coverage for a given colonoscopy procedure is based on a combination of the procedure code (CPT, HCPCS) and the diagnosis code (ICD-10) selected by the provider and submitted on the claim. A colonoscopy procedure may be covered as a preventive screening or a medical intervention for identified symptoms or findings. This guideline provides clinical indications for determining whether a colonoscopy is preventive or medical. Screening, diagnostic, and surveillance indications for colonoscopy are based on guidelines from a variety of specialty societies and government organizations.
Ancillary Colonoscopy Services

Effective 01/01/2016, all non-grandfathered (NGF) health plans will provide coverage for ancillary services directly associated with a covered screening colonoscopy, including:

- The professional charge for the provider performing the colonoscopy
- A pre-procedure evaluation
- Facility or ambulatory surgical center services
- Anesthesia services, when medically necessary
- Pathologist services to evaluate any polyps removed during the screening colonoscopy

Related Information

Professional Guidelines for a Preventive Screening Colonoscopy Based on Risk Stratification

<table>
<thead>
<tr>
<th>Risk level</th>
<th>American Cancer Society (ACS)</th>
<th>National Comprehensive Cancer Network (NCCN)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average risk</td>
<td>Individuals with no first-degree relatives having a history of CRC or adenomatous polyps and has not experienced these problems personally.</td>
<td>Individuals 50 years or older with no personal history of adenoma or colorectal cancer, or inflammatory bowel disease and a negative family history.</td>
</tr>
<tr>
<td>Increased risk</td>
<td>Individuals who have a personal history of CRC or adenomas, a family history of CRC or adenomas diagnosed in any first-degree relative before age 50, or in two or more first-degree relatives diagnosed at any age (if not a hereditary syndrome). According to the ACS, individuals who have a personal history of CRC or adenomatous polyp require regular surveillance, not screening.</td>
<td>Individuals with personal history of adenomatous polyps/sessile serrated polyps (SSP), colorectal cancer (CRC), or inflammatory bowel disease as well as those with a positive family history of CRC or advanced adenomatous polyps.</td>
</tr>
<tr>
<td>Hereditary/high risk</td>
<td>Individuals who have a personal history of CRC or adenomas, a family history of CRC or adenomas</td>
<td>Individuals who have had CRC before the age of 50 years; those with family</td>
</tr>
<tr>
<td>Risk level</td>
<td>American Cancer Society (ACS)</td>
<td>National Comprehensive Cancer Network (NCCN)</td>
</tr>
<tr>
<td>------------</td>
<td>--------------------------------</td>
<td>---------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>diagnosed in any first-degree relative before age 50, or in two or more first-degree relatives diagnosed at any age (if not a hereditary syndrome). According to the ACS, individuals who have a personal history of CRC or adenomatous polyp require regular surveillance, not screening.</td>
<td>history of multiple cases of CRC or HNPCC related cancers; personal or family history of polyposis; or individuals with HNPCC/Lynch syndrome.</td>
</tr>
</tbody>
</table>

CRC: Colorectal cancer

**Definition of Terms**

**Colonoscopy:** A colonoscopy is a procedure that permits the direct examination of the mucosa of the entire colon by using a flexible lighted tube. The procedure is done with sedation in a hospital outpatient department, in a clinic, or an office facility. During the colonoscopy a doctor can biopsy and remove pre-cancerous polyps and some early stage cancers and also diagnose other conditions or diseases.

General definitions of procedure indications from various specialty societies, including the ACA:

- A screening colonoscopy is done to look for disease, such as cancer, and treat early conditions, if indicated, in people without symptoms.

- A diagnostic colonoscopy is done to confirm or rule out a condition in a person who is symptomatic or who is believed to have a specific condition based on other clinical information.

- A surveillance colonoscopy is the follow-up to check for the return of a disease in a person who was previously treated for the disease and is now believed to be free of the disease.

**Patient Protection and Affordable Care Act (PPACA):** The comprehensive health care reform law enacted in March 2010. The Affordable Care Act included 10 essential benefits that must be covered by all health insurance plans including preventive and wellness services.

**Preventive health services:** Health care services designated for the prevention and early detection of illness in asymptomatic people. This generally includes routine physical examinations, screening examinations, tests, immunizations, and counseling designed to maintain and improve health. Note: Preventive medicine evaluation and management (E/M) services have specific preventive medicine CPT codes.
**Preventive intervention:** Interventions provided to people who have signs of health risks in order to prevent or delay the onset of illness or injury. This includes taking action to modify an effect, to prevent or slow the course of illness or disease through behavior and or lifestyle changes, and to increase patient participation in health outcomes and disease management.

**U.S. Preventive Services Task Force (USPSTF):** An independent panel of non-Federal experts in prevention and evidence-based medicine composed of primary care providers. The USPSTF grades its recommendations based on the strength of evidence and magnitude of net benefit (benefits minus harms). These guidelines are for average risk individuals. The Plan covers USPSTF recommendations graded A or B as preventive benefits on most plans offered.

**Alaska State Statute**

Alaska has a specific state statute (AS21.42.377) that requires health care insurers to provide insurance coverage for the costs of colorectal cancer screening examinations and laboratory tests as specified in the American Cancer Society guidelines for colorectal cancer screening of asymptomatic individuals. Coverage shall be provided for all colorectal screening examinations and tests that are administered at a frequency identified in the American Cancer Society guidelines for colorectal cancer. More information regarding covered and non-covered services and other administrative criteria is found at: [http://www.akleg.gov/basis/statutes.asp](http://www.akleg.gov/basis/statutes.asp)

**Oregon State Statute**

Oregon has a specific state law (House bill 2560) that requires health benefit plans to provide coverage for all colorectal screening examinations and laboratory tests assigned either a grade of A or a grade of B by the United States Preventive Services Task Force (USPSTF). More information regarding covered and non-covered services and other administrative criteria can be found at the following link: [https://olis.leg.state.or.us/liz/2015R1/Measures/Overview/HB2560](https://olis.leg.state.or.us/liz/2015R1/Measures/Overview/HB2560).

**References**


### History

<table>
<thead>
<tr>
<th>Date</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>01/12/16</td>
<td>New Benefit Coverage Guideline. This guideline provides the indications for colonoscopy services based on whether the procedure is a preventive screening or medical intervention for a known condition. State regulations that may impact coverage are included in the additional information.</td>
</tr>
<tr>
<td>07/01/16</td>
<td>Interim update, approved June 14, 2016. Clarified statement under Preventive Screening to indicate benefits will be paid based on intent: eg, if a screening colonoscopy is performed and polyps are discovered and removed/biopsied, services will be paid as preventive screening.</td>
</tr>
<tr>
<td>12/09/16</td>
<td>Policy moved to new format. No changes to content or coverage.</td>
</tr>
<tr>
<td>Date</td>
<td>Comments</td>
</tr>
<tr>
<td>------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>04/19/17</td>
<td>Coding update. HCPCS code S0285 added to policy for preventive services 1/1/17 and beyond; CPT codes 99202 and 99212 no longer accepted after 12/31/16 for preventive services, as noted in Coding section.</td>
</tr>
<tr>
<td>05/01/17</td>
<td>Annual review; changes approved April 11, 2017. No change to benefit coverage guideline statements. Added CPT codes 45381, 45390 and 45391.</td>
</tr>
<tr>
<td>06/13/17</td>
<td>Coding update, removed diagnosis codes Z00.00 and Z00.01.</td>
</tr>
<tr>
<td>10/01/17</td>
<td>Coding update, added CPT codes 99152 and 99153.</td>
</tr>
<tr>
<td>11/07/17</td>
<td>Coding update, added HCPCS code G0500.</td>
</tr>
<tr>
<td>01/15/19</td>
<td>Minor update, removed 12.04.506 from Related Policies as it was archived.</td>
</tr>
<tr>
<td>02/01/19</td>
<td>Annual Review, approved January 22, 2019. No change to benefit coverage guideline statements. One reference added other references updated. Remove pre-op assessment in coding section.</td>
</tr>
</tbody>
</table>

**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). ©2019 Premera All Rights Reserved.

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Toll free 855-332-4535, Fax 425-918-5592; TTY 800-842-5357
Email AppealsDepartmentInquiries@Premera.com

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail, fax, or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW, Room S909, HHH Building
Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at:

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