Coverage of any medical intervention discussed in a Prevea360 Health Plan medical policy is subject to the limitations and exclusions outlined in the member's benefit certificate or policy.

Diagnostic, Therapeutic and Surveillance Colonoscopy  

**MP9510**

**Covered Service:**  Yes–when meets criteria below

**Prior Authorization Required:**  No

**Additional Information:**  Screening colonoscopies are covered under Preventative Services and their use is not addressed in this policy.

An appropriate diagnosis code must appear on the claim. Claims will deny in the absence of an appropriate diagnosis code.

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**Prevea360 Health Plan Medical Policy:**

1.0 Proctosigmoidoscopy, sigmoidoscopy or colonoscopy with or without biopsy/ablation/resection for diagnosis, surveillance or treatment **does not require** prior authorization and is considered medically necessary when performed in the appropriate clinical scenario for **ANY** of the following indications:

1.1 Diagnostic colonoscopy is needed to evaluate members with signs or symptoms of colorectal cancer or other gastrointestinal diseases, as demonstrated by **ANY** of the following:

   1.1.1 An abnormality exists on barium enema or other imaging study which is likely to be clinically significant (eg. filling defect, stricture); OR
   1.1.2 Inflammatory bowel disease is clinically suspected and confirmation is needed; OR
   1.1.3 Clinically significant diarrhea of unexplained origin is present despite other appropriate work up; OR
   1.1.4 A metastatic adenocarcinoma of unknown primary origin is present and colon cancer is suspected; OR
   1.1.5 For intraoperative identification of a lesion not apparent at surgery (eg, polypectomy site, location of a bleeding site); OR
   1.1.6 To determine the cause of unexplained gastrointestinal tract bleeding when proctosigmoidoscopy, sigmoidoscopy or colonoscopy is the clinically appropriate test.

1.2 Therapeutic colonoscopy is needed, as demonstrated by **ANY** of the following:

   1.2.1 For removal of foreign body; OR
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1.2.2 For balloon dilation of stenotic lesions (eg, anastomotic strictures); OR
1.2.3 For excision of colonic polyps; OR
1.2.4 To decompress sigmoid volvulus or an acute nontoxic megacolon; OR
1.2.5 For palliative treatment of stenosing or bleeding neoplasms (eg, laser, electrocoagulation, stenting); OR
1.2.6 In treatment of bleeding from lesions such as vascular malformation, ulceration, neoplasia, and polypectomy site; OR
1.2.7 For pre-operative "marking" for localization of a lesion.

1.3 Surveillance colonoscopy is needed, as demonstrated by ANY of the following:

1.3.1 Member has a personal history of a positive stool based test and the confirmatory colonoscopy was positive for cancer or pre-cancerous polyp, and surveillance is appropriate; OR
1.3.2 For members with a personal history of colorectal cancer that has been resected with curative intent and surveillance is appropriate; OR
1.3.3 For members with a personal history of one or more adenomatous polyps or sessile serrated polyps removed at colonoscopy and surveillance colonoscopy is appropriate based upon clinical findings and appropriate guidelines; OR
1.3.4 For members with a personal history of one or more large (>1cm) hyperplastic polyps removed at colonoscopy and surveillance colonoscopy is appropriate based upon clinical findings and appropriate guidelines; OR
1.3.5 For members with a history of colonic adenomatous polyposis of unknown etiology (without known APC or biallelic MUTYH mutations) and surveillance colonoscopy is appropriate based upon clinical findings and appropriate guidelines; OR
1.3.6 For members with inflammatory bowel disease or related conditions (eg chronic ulcerative colitis, Crohn's colitis, primary sclerosing cholangitis) and surveillance colonoscopy is appropriate based on clinical findings and appropriate guidelines.

2.0 Proctosigmoidoscopy, sigmoidoscopy or colonoscopy are considered not medically necessary and therefore are not covered service when the criteria of 1.0 have not been met, or when performed for other indications in the absence of signs or symptoms of colorectal cancer or other gastrointestinal disease, including but not limited to the following:

2.1 Evaluation of unspecified diarrhea or acute diarrhea
2.2 Evaluation of unspecified abdominal pain or chronic abdominal pain
2.3 Evaluation of right lower quadrant pain or left lower quadrant pain
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2.4 Evaluation of gastro-esophageal reflux disease without esophagitis
2.5 Evaluation of chronic, stable irritable bowel syndrome

**Committee/Source**  
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