Capital Health PLAN

An Independent Licensee of the Blue Cross and Blue Shield Association

# CLINICAL CRITERIA FOR UM DECISIONS

## Outpatient Screening and Diagnostic Colonoscopies

**Included codes:**

| | |
|---|---|
| CPT: | 44388 – 44394, 44397, 44401 - 44408, 45355, 45378 – 45393, 45398 |
| HCPCS: | G0105, G0121 |
| ICD9PC: | 45.22, 45.23, 45.25, 45.42, 45.43 |

Capital Health Plan (CHP) follows U. S. Preventive Services Task Force (USPSTF) and American Cancer Society (ACS) recommendations for colorectal cancer screening and recommends:

- Periodic endoscopic colon cancer screening for all individuals who are age 45-75, who are average or increased risk;
- Screeing and surveillance for colon cancer in adults aged 76 to 85 years should be advised with consideration of the patient's overall health and prior screening history.

CHP provides coverage for outpatient colonoscopy, for members meeting the medical necessity criteria below, in the interval that is specified.

**Average Risk: includes individuals age 45 - 85 years who meet the following criteria:**

- No symptoms
- Has personal history of hyperplastic lesions that were in the sigmoid or rectum
- No personal history of colorectal cancer
- No personal history of Inflammatory Bowel Disease (Ulcerative Colitis or Crohn's colitis)

→ Colonoscopy every 10 years, no sooner than 9 years

**Increased Risk: includes individuls who have a personal history of adenomatous polyps on prior colonoscopy, long-standing Inflammatory Bowel Disease, a personal history of colon cancer, or relevant family history of colon cancer or polyps.**

| Risk Factor | Colonoscopy Surveillance Interval |
|---|---|
| Polyp on baseline or surveillance colonoscopy | Surveillance interval specified in "Baseline Colonoscopy" and "First Surveillance Colonoscopy" findings below |

| | | |
|---|---|---|
| Long history (more than eight years) of Inflammatory Bowel Disease (Ulcerative Colitis or Crohn's colitis) | → | Screening interval per advice of GI specialist or surgeon |
| Personal history of colon cancer | → | Screening interval per advice of GI specialist or surgeon |

## Screening Intervals Based on Family History –

| Family History | | Colonoscopy Surveillance Interval |
|---|---|---|
| • No family history of colorectal cancer or adenomatous polyps<br>• Has first degree relative with colon cancer or Low Risk Adenomas (1-2 tubular adenomas <10mm) diagnosed at age 61 or older<br>• Has no more than one second degree relative (grandparent, aunt, or uncle) with colon cancer<br>• Has one or more third degree relative(s) (great-grandparent or cousin) with colon cancer<br>• Has nonspecific family history with personal history of prior colonoscopies being normal | → | Colonoscopy every 10 years, no sooner than 9 years |
| First-degree relative (parent, sibling or offspring) who had colon cancer or High Risk Adenomas (have villous histology, or high grade dysplasia, or ≥ 10mm, or 3 or more) diagnosed at age 60 or younger. | → | Colonoscopy starting at age 40 or 10 years younger than the earliest diagnosis in their family, whichever comes first, and repeated colonoscopy every 5 years |
| Two or more related second degree relatives (grandparent, aunt or uncle) with colon cancer at any age | → | Colonoscopy starting at age 40 or 10 years younger than the earliest diagnosis in their family, whichever comes first, and repeat colonoscopy every 5 years |
| Family history of familial adenomatous polyposis (FAP) or a family history of Hereditary Nonpolyposis Colorectal Cancer (HNPCC) | → | Screening interval per advice of GI specialist or surgeon |

# Screening and Surveillance Intervals Based on Endoscopic Findings-

## Baseline Colonoscopy- most advanced finding(s)

Note: the recommendations assume that the colonoscopy was adequate, complete and that all visible lesions were completely removed.

| Baseline Colonoscopy Result | Colonoscopy Surveillance Interval |
|---|---|
| • No polyps<br>• Small (less than 10mm) hyperplastic polyps in the rectum or sigmoid | Colonoscopyevery 10 years, no sooner than 9 years. |
| • 1 or 2 small (less than 10mm) tubular adenomas *<br>• Hyperplastic polyps proximal to sigmoid colon | Colonoscopy in 5 – 10 years<br>* Evidence supports interval of longer than 5 years for most patients.Time between tests should be based on other factors such as family history, and patient and doctor preferences. |
| • Sessile serrated polyp(s) < 10mm with no dysplasia | Colonoscopy in 5 years |
| • 1 or more tubular adenomas ≥10mm each or 3-10 tubular adenomas<br>• 1 or more tubulovillous or villous adenomas<br>• Adenoma with high grade dysplasia<br>• Sessile serrated polyp(s) ≥ 10mm<br>• Sessile serrated polyp with dysplasia<br>• Traditional serrated adenoma | Colonoscopy in 3 years |
| • Greater than 10 adenomas | Colonoscopy in less than 3 years |
| • Serrated polyposis syndrome (at least 5 serrated polyps proximal to the sigmoid, with 2 or more ≥ 10mm<br>• Any serrated polyps proximal to the sigmoid with family history of serrated polyposis syndrome<br>• > 20 serrated polyps of any size throughout the colon) | Colonoscopy in 1 year |
| Large adenomas, ≥ 2 cm | Screening interval per advice of GI specialist or surgeon |

## First Surveillance Colonoscopy- most advanced finding(s)

Note: the recommendations assume that the colonoscopy was adequate, complete and that all visible lesions were completely removed.

| Baseline Colonoscopy Finding | First Surveillance Finding | Interval for Second Surveillance (years) |
|---|---|---|
| Low-risk Adenoma (LRA) ( 1–2 tubular **adenomas** <10 mm in diameter) | HRA | 3 |
| | LRA | 5 |
| | No adenoma | 10* |
| High-risk Adenoma (HRA) (villous histology, or high grade dysplasia, or ≥ 10mm, or 3 or more adenomas) | HRA | 3 |
| | LRA | 5 |
| | No Adenoma | 5** |

Note: If any adenomatous lesion are removed piecemeal, follow up interval per the advice of GI specialist or surgeon.

* In accordance with the Task Force, CHP recommends that patients with low-risk adenomas (LRA) at baseline, and negative findings at the first surveillance, have the the next surveillance in 10 years.

**If the findings on the second surveillance are negative, there is insufficent evidence to make a recommendation for the follow up interval.

Justification should be provided if screening is considered outside the specified parameters in the following circumstances:

1. Questionable or incomplete removal of lesions
2. Prior exam with poor bowel preparation (various preps defined below). Reasons for poor prep should be documented in patient's chart.

Poor prep but procedure completed: solid or semi solid debris throughout the bowel that cannot be cleared effectively but which still permits intubation to cecum
Poor prep resulting in failed procedure: solid debris that cannot be cleared effectively and prevents intubation to cecum.
Adequate: collections of semi-solid debris that are cleared with washing/suction
Excellent: no or minimal solid stool and only clear fluid requiring suction

## REFERENCES


1. https://www.guideline.gov/summaries/summary/38454
2. https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/colorectal-cancer-screening2?ds=1&s=colon cancer
3. http://www.aafp.org/afp/2015/0115/p93.html
4. http://gi.org/guideline/guidelines-for-colonoscopy-surveillance-after-screening-and-polypectomy-a-consensus-update-by-the-us-multi-society-task-force-on-colorectal-cancer/
5. https://www.cancer.org/health-care-professionals/american-cancer-society-prevention-early-detection-guidelines/colorectal-cancer-screening-guidelines.html


Medical Necessity Approvals to be made by:

- ☑ Medical Director
- ☑ Physician Reviewer
- ☑ Utilization Management Nurse
- ☑ Nurse Reviewer
- ☑ Authorized CCD staff when UM criteria are met

These criteria apply to the following products when determined to be included in the member's benefit package:

- ☑ Commercial

Approved QIMT: 6/9/11 (effective 9/1/11)

Revised and/or re-approved QIMT: 3/1/12, 6/21/12, 1/3/13, 1/16/14, 1/15/15, 10/27/16, 3/29/18, 8/16/18

Approved by G & A Committee: 11/3/16, 11/30/17

Re-approved by UMWG: 11/7/19

*Capital Health Plan reserves the right to make changes to these criteria at any time to accommodate changes in medical necessity and industry standards.*