Capital Health PLAN℠

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MEDICAL COVERAGE GUIDELINES (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
SNOMED:	8180007, 12350003, 25732003, 34264006, 73761001, 174158000, 235150006, 235151005, 310634005, 367535003, 425672002, 425937002, 427459009, 443998000, 444783004, 446521004, 446745002, 447021001, 709421007, 710293001, 713154003

Capital Health Plan (CHP) follows U. S. Preventive Services Task Force (USPSTF) and American Cancer Society 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;
- Screening and surveillance of individulas who are age 76 – 85 based on physician judgment in recognition of increased risk of complications in older adults and consideration of patient preference, prior screenng history, existing comorbidities and life expectancy.
- Screening is not recommended for individuals over age 85.

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:**

	Colonoscopy every 10 years, no sooner than 9 years

- No symptoms
- No personal history of colorectal cancer
- No personal history of Inflammatory Bowel Disease (Ulcerative Colitis or Crohn's colitis)
- No history of family cancer syndrome (e.g., FAP, HNPCC)

Increased Risk: Includes individuals who have a prior colonoscopy showing multiple (i.e., ≥ 3) adenomatous polyps, or a large (≥10mm) adenoma or lesion with high grade dysplasia, a personal history of long-standing Inflammatory Bowel Disease, a personal history of colon cancer, or relevant family history of colon cancer or High Risk Adenomas, or a family cancer syndrome.

Risk Factor	Colonoscopy Surveillance Interval
Polyp on baseline or colonoscopy	Surveillance interval specified in "Baseline Colonoscopy" and "First Surveillance Colonoscopy" findings below
Long history of Inflammatory E (e.g., ulcerative colitis, Crohn's	Screening interval per advice of GI specialist or surgeon
Personal history of - • Colon cancer • Genetic syndromes such Adenomatous Polypos Lynch syndrome (Here polyposis Colorectal	Screening interval per advice of GI specialist or surgeon

Screening and Surveillance Intervals Based on Endoscopic Findings-

Baseline Colonoscopy-

Interval for follow up should be based on most advanced finding(s)

Note:

• The recommendations assume that the colonoscopy was adequate, completed to cecum and that all visible lesions were completely removed.

Baseline Colonoscopy Result — Colonoscopy Surveillance Interval

Piecemeal removal of any lesion: If any adenomatous lesion is removed piecemeal, If interval not specificed then follow up interval per the advice of GI specialist or surgeon.

No lesions or normal pathology

- No polyps
- Normal or non-neoplastic histology

→ Colonoscopy in 10 years

Hyperplastic polyp

- Hyperplastic polyp - 20 or fewer, all < 10 mm

→ Colonoscopy in 10 years

- Hyperplastic polyp - more than 20, all < 10 mm
- Hyperplastic polyp - ≥ 10 mm

→ Colonoscopy in 3 – 5 years

Sessile Serrated Adenoma

- Sessile serrated adenoma - 1 or 2, < 10 mm

→

- Sessile serrated adenoma - ≥ 10 mm
- Sessile serrated adenoma - with high grade dysplasia

→ Colonoscopy in 5 - 10 years

Colonoscopy in 3 years

- Sessile serrated adenoma - ≥ 20 mm
- Sessile serrated adenoma - required peicemeal resection for removal

→ Colonoscopy in 6 months

Traditional Serrated Adenoma

- Traditional serrated adenoma - < 20 mm

→ Colonoscopy in 3 years

- Tradtional serrated adenoma - with high grade dysplasia

- Tradtional serrated adenoma - ≥ 20 mm
- Traditional serrated adenoma - required peicemeal resection for removal

→ Colonoscopy in 6 months

Tubular Adenoma

- Tubular adenoma - 1 or 2, all < 10 mm

→ Colonoscopy in 7 – 10 years

- Tubular adenoma - 3 or 4, all < 10 mm

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- Tubulovillous adenoma- ≥ 10 mm
- Tubulovillous adenoma- with high grade dysplasia

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- Tubular adenoma- 5 to 10, all < 10 mm
- Tubular adenoma - ≥ 10 mm
- Tubular adenoma - with high grade dysplasia

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- Tubulovillous adenoma- ≥ 20 mm
- Tubulovillous adenoma - required p

resection for removal

- Tubular adenoma- ≥ 20 mm
- Tubular adenoma - required peicemeal resection for removal

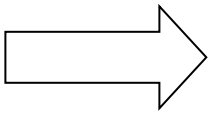
→

Tubulovillous Adenoma

- Tubulovillous adenomas- 1 or more

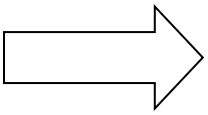
Villous Adenoma

- Villous adenoma - 1 or more
- Villous adenoma - ≥ 10 mm
- Villous adenoma with high grade dysplasia



Colonoscopy in 3 years

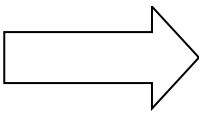
- Villous adenoma - ≥ 20 mm
- Villous adenoma - required peicemeal resection for removal



Colonoscopy in 6 months

Multiple Adenomas

- > 10 adenomas (of any variety) found on a single exam



Colonoscopy in 3 years

Colonoscopy in 6 months

Colonoscopy in 3 - 5 years

Colonoscopy in 1 year

Colonoscopy in 3 years

Colonoscopy in 6 months

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. If any adenomatous lesion is removed piecemeal, follow up interval is 6 months.

Baseline Colonoscopy Finding	First Surveillance Finding	Interval for Second Surveillance (years)
Low-risk Adenoma (LRA) (1 - 2 tubular adenomas, all <10 mm)	No adenoma	10*
	LRA	7
	HRA	3
High-risk Adenoma (HRA) (any villous histology, or high grade dysplasia, or ≥ 10 mm, or 3 or more adenomas)	No Adenoma	5**
	LRA	5
	HRA	3

Note:

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

Screening Intervals Based on Family History -

Family History	Colonoscopy Surveillance Interval

- No family history of c

or

adenomatous polyps
- First degree relative (offspring) with 1 - 2 Low Risk 10 mm each, without villous high grade dysplasia)
- No more than one se relative (grandparent with colon cancer
- One or more third de (great-grandparent or cancer
- Has nonspecific fami personal history of pr being normal

Colonoscopy every 10 years, no sonner than 9 years

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One first-degree relative (parent, sibling or offspring) who had colon cancer or High Risk Adenomas (any villous histology, or high grade dysplasia, or ≥ 10 mm, or 3 or more) **diagnosed before age 60**

Two or more related second degree relatives (grandparent, aunt or uncle) with colon cancer **diagnosed at any age**.

One first-degree relative (parent, sibling or offspring) who had colon cancer or High Risk Adenomas (any villous histology, or high grade dysplasia, or ≥ 10 mm, or 3 or more) **diagnosed at age 60 or older**

Family history of genetic syndromes such as familial adenomatous polyposis (FAP) or a family history of Hereditary Nonpolyposis Colorectal Cancer (HNPCC)

Two first-degree relatives (parent, sibling or offspring) who had colon cancer or High Risk Adenomas (any villous histology, or high grade dysplasia, or ≥ 10 mm, or 3 or more) **diagnosed 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.

Colonoscopy starting at age 40 or 10 years younger than the earliest diagnosis in their family, whichever comes first, and repeat colonoscopy every 10 years.

Colonoscopy starting at age 40 or 10 years younger than the earliest diagnosis in their family, whichever comes first, and repeat colonoscopy every 10 years.

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.

Screening interval per advice of GI specialist or surgeon

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

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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, 5/14/20, 12/10/20, 12/9/21, 12/8/22, 12/14/23

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