Clinical UM Guideline

Subject:	Colonoscopy		
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Description

This document addresses colonoscopy, an endoscopic procedure which allows direct visual inspection of the entire colon and rectum. Additionally, biopsy or excision of polyps or other abnormalities are possible during the colonoscopy procedure.

Colonoscopy must be distinguished from CT colonography, an imaging procedure that provides indirect visualization of the colon and rectum using CT scans. This document does not address CT Colonography.

Clinical Indications

Note: ***The parenthetical numbers in the Clinical Indications section refer to the source documents cited in the References section below.***

Medically Necessary:

A. **Screening Colonoscopy in Average Risk Populations** (that is, asymptomatic individuals without specific risk factors including no personal history of adenomas, sessile serrated polyps [SSPs], colorectal cancer, inflammatory bowel disease, or cystic fibrosis, and no family history of colorectal cancer).
   1. Colonoscopy to detect colorectal cancer and adenomatous polyps is appropriate:
      a. Beginning at age 45 years; (13, 22, 29, 38) **and**
      b. Every 10 years thereafter. (11)

   or
   2. For individuals with a personal history of a hyperplastic, non-sessile serrated polyp (non-SSP) removed at colonoscopy, measuring less than 1 cm and in the rectum and sigmoid only, the first follow up colonoscopy is appropriate in 10 years. (15, 18, 21)

   or
   3. For individuals with a personal history of a negative stool-based test:
      a. If prior screening was conducted using a guaiac-based or an immunohistochemical test, re-screening may be performed with colonoscopy in 1 year; (21) **or**
      b. If prior screening test was conducted using Cologuard, re-screening may be performed using colonoscopy in 3 years.

B. **Surveillance Colonoscopy in At-Risk Populations**
   1. Individuals who have a personal history of a positive stool based (guaiac-based, immunohistochemical or Cologuard fecal DNA) test and the confirmatory colonoscopy was positive for cancer or pre-cancerous polyp, surveillance may be appropriate based on clinical findings. (21)
   2. *Colorectal Cancer:* For those with a personal history of colorectal cancer that has been resected with curative intent, colonoscopy is appropriate for any of the following:

a. To rule out synchronous neoplasms; no less than 3 months after cancer resection, if no unresectable metastases are found during surgery. Alternatively, colonoscopy can be performed intraoperatively, or preoperatively if non-obstructing tumor; (2, 14, 15, 21, 29) **or**
b. 1 year after the curative resection if a complete preoperative colonoscopy was performed, or no less than 3 months after curative resection if there was no or incomplete preoperative colonoscopy, or 1 year following the colonoscopy that was performed to clear the colon of synchronous disease; (2, 14, 15, 21, 30) **or**
c. No less than 2 years after the "1 year" follow up colonoscopy, if examination was normal. (2, 3, 14, 15, 21, 30)
d. For this specific group, colonoscopy may be repeated thereafter at an interval of no less than 3 years, based on previous findings. (2, 3, 14, 15, 21, 30)

3. *Adenomatous Polyps or Sessile Serrated Polyps (SSP):* Those who have a personal history of one or more adenomatous polyps or SSPs removed at colonoscopy are managed according to the findings (that is, considering number of polyps and pathology). Colonoscopy may be appropriate in any of the following:
   a. For those with 1 or 2 small (less than 1 cm) tubular adenomas or SSPs without cytologic dysplasia, the first follow-up colonoscopy is appropriate in no less than 5 years; (2, 11, 15, 18, 21) **or**
   b. For individuals with a history of any of the following, the first follow-up colonoscopy is appropriate 3 years after the initial polypectomy:
      i. 3 to 9 adenomatous polyps and/or SSPs; (11, 21, 22) **or**
      ii. Any adenoma or SSP greater than or equal to 1 cm; (11, 21) **or**
      iii. Any adenoma with villous or tubulovillous features; (11, 21) **or**
      iv. Any adenoma with high-grade dysplasia; (11, 21) **or**
      v. Any SSP with cytologic dysplasia (2, 11, 15, 18, 21)

   or
   c. For those with 10 or more adenomas on a single examination, the first follow-up colonoscopy is appropriate less than 3 years after the initial polypectomy based on clinical judgment; (2, 15, 18, 22) **or**
   d. For those with a malignant adenoma (with invasive cancer), a large sessile adenoma, or an incomplete colonoscopy, a short interval between the initial and follow up colonoscopy is appropriate based on clinical judgment; **or**
   e. For those with sessile adenomas that are removed piecemeal, the first follow-up colonoscopy is appropriate at no less than 2 months to verify complete removal. (2, 15, 21, 26)
      Note: The timing of the subsequent colonoscopy is dependent upon the pathology and the number of adenomas detected at the "follow-up colonoscopy." For example, if the first "follow-up colonoscopy" is normal or only 1 or 2 small (less than 1cm) tubular adenomas are found, then the next colonoscopy can be in 10 years. (21)
4. *Serrated Polyposis Syndrome (SPS)*
   a. For individuals with serrated polyposis syndrome, colonoscopy is appropriate as follows:
      i. Colonoscopy with polypectomy until all polyps greater than or equal to 5 mm are removed; (22) **and**
      ii. Then colonoscopy no less than every year depending on the number and size of polyps. (22).
5. *Colonic Adenomatous Polyposis of Unknown Etiology:* For individuals with a personal history of colonic adenomatous polyposis of unknown etiology (without known APC or biallelic MUTYH mutations), colonoscopy is appropriate as follows:

a. For those with a personal history of more than 10 but less than 100 small (less than 1 cm) adenomas which are manageable by colonoscopy and polypectomy, colonoscopy is appropriate no less than every year. Repeat colonoscopy performed at a shorter interval is appropriate if residual polyps are present. (22)

6. *Inflammatory Bowel Disease (chronic ulcerative colitis or Crohn's colitis) and related conditions:*
   a. For individuals with inflammatory bowel disease, colonoscopy is appropriate as follows:
      i. Surveillance colonoscopy beginning no less than 8 years after onset of colitis, and repeated no less than 1 year thereafter; (2, 8, 15, 21) **or**
      ii. For those with primary sclerosing cholangitis (PSC), begin surveillance colonoscopy at the time of diagnosis and then undergo yearly colonoscopy thereafter; (8, 21, 31) **or**
      iii. When individual has undergone endoscopic resection of a visible dysplastic lesion, the next surveillance colonoscopy should occur at 3–6 months. (17, 20)
7. *Cystic Fibrosis:* Research has shown an increased risk of colorectal cancer in individuals with cystic fibrosis. Studies have also demonstrated that individuals with cystic fibrosis who underwent transplant had a higher incidence of digestive tract tumors:
   a. For individuals with a personal history of cystic fibrosis and no history of solid organ transplant:
      i. Colonoscopy beginning at age 40; (22) **and**
      ii. Rescreening in 5 years if normal; (22) **or**
      iii. Repeat in 3 years if colonoscopy reports adenomatous polyps; (22)

   or

   b. For individuals with a personal history of cystic fibrosis and a solid organ transplant:
      i. Colonoscopy beginning at age 30 years; (22) **or** within 2 years of the transplantation; **and**
      ii. Rescreening in 5 years if normal; **or**
      iii. Repeat in 3 years if colonoscopy reports adenomatous polyps.
8. *Increased Risk Based on Personal History of Childhood, Adolescent and Young Adult Cancer:*
   a. For individuals with a personal history of childhood, or adolescent and young adult cancer (age 15-39 years at the time of initial cancer diagnosis) treated with chemotherapy (without radiation therapy):
      i. Colonoscopy beginning at age 35; (22) **or**
      ii. 10 years after age of chemotherapy, (whichever comes first); (22) **and**
      iii. For this specific group, colonoscopy may be repeated every 5 years. (22)

   or

   b. For individuals with a personal history of childhood, adolescent or young adult cancer treated with radiation of the abdominopelvic field, (that is, abdomen, pelvis, spine [lumbar, sacral, whole] or total body irradiation [TBI]), (with or without chemotherapy);
      i. Colonoscopy beginning at age 30; (22, 44) **or**
      ii. 5 years after treatment (whichever occurs last); (22, 44) **and**
      iii. For this specific group, colonoscopy may be repeated every 5 years. (22, 44)

C. **Screening Colonoscopy in Higher Risk Populations**

1. *Family History of Colorectal Cancer or Adenomas:* The vast majority of those with increased risk are in this category. Screening colonoscopy is appropriate for a person with a family history indicating any of the following:
   a. One first degree relative (parent, sibling or child) with colorectal cancer diagnosed at any age; (2, 18, 22, 29)

i. Colonoscopy beginning at age 40; (2, 18, 22, 29) **o**r
ii. Colonoscopy beginning at an age 10 years younger than the age at diagnosis of the youngest affected relative, whichever comes first. (2, 18, 22, 29) **and**
iii. For this specific group, colonoscopy may be repeated no less than every 3 years depending on findings. (2, 18, 22)

or

b. One second and one third-degree relative with colorectal cancer at any age;
i. Colonoscopy beginning at age 45; (22) **and**
ii. For this specific group, colonoscopy may be repeated every 10 years, depending on findings. (22)

or

c. One first-degree relative with confirmed advanced adenoma(s) (for example, high-grade dysplasia, greater than or equal to 1 cm, villous or tubulovillous histology, traditional serrated adenoma [TSA]) or advanced SSPs/SSLs (greater than or equal to 1 cm, dysplasia) at any age:
i. Colonoscopy beginning at age 40 or at age of onset of adenoma in affected relative, whichever is first. (21, 22) **and**
ii. For this specific group, colonoscopy may be repeated no less than every 5 years, or if positive, repeat per colonoscopy findings. (21, 22)
Note: Increased numbers of affected first-degree relatives influences risk much more than affected second-degree relatives or third-degree relatives. However, when combined with a positive first-degree family history, a positive second- and third-degree family history can significantly increase risk. (21)

2. *Familial adenomatous polyposis (FAP):* In this autosomal dominant syndrome, affected persons have a risk of colorectal cancer approaching 100%. The average age of adenoma appearance is 16, and the average age of colon cancer is 39. Most affected individuals develop more than 100 adenomas. Thus early and regular screening is appropriate for any of the following. (2)
a. For those *with a genetic diagnosis of FAP, or who are at risk for this diagnosis* but genetic testing has not been done or is not feasible:
i. Offer genetic counseling, as specific genetic abnormalities can be identified in approximately 80% of affected individuals. This can then be used to screen other family members; (29) **and**
ii. Annual sigmoidoscopy or colonoscopy beginning at an age no less than 10 years: (2, 22) **and**
a) With an appropriately timed colectomy indicated when polyps develop; (2, 22, 29) **or**
b) If no polyps develop, annual sigmoidoscopy to age 40 then no less than every 3 years thereafter. (2)

or

b. For the family members of those with *FAP who do not have specific genetic evidence or clinical manifestations* of the disease:
i. In the older, unscreened relatives of a person newly diagnosed with FAP, colonoscopy is appropriate for the first screening examination; (23) **and**
ii. Annual screening sigmoidoscopy until age 40 if no polyps develop; (23) **and**
iii. An appropriately timed colectomy indicated if polyps develop. (8, 23)
Note: While the above is applicable to individuals with FAP and their families, there are variants of this syndrome, *attenuated adenomatous polyposis coli (AAPC)* (also referred to as attenuated FAP) and MYH-associated polyposis. The genetic mutations leading to these variants differ from

that in the typical FAP individual. These variants are associated with a variable number of adenomas (usually 20 to 100), a tendency toward right sided lesions, and an age of onset of colorectal cancer that is approximately 10 years later than for others with FAP. As with FAP, genetic counseling for these individuals and early and regular screening is warranted. It is recommended that this screening begin in the late teens or early 20s, depending on the age of polyp expression in the family. (35)

3. *Lynch Syndrome, also known as Hereditary Non-Polyposis Colorectal Cancer (HNPCC):* For individuals with a genetic or clinical diagnosis of, or who are at increased risk for Lynch Syndrome, colonoscopy is appropriate as follows:
   a. For individuals who are MLH1, MSH2 and EPCAM mutation carriers:
      i. No less than every year beginning at an age no less than 20 years old or no less than 2 years prior to the earliest colon cancer in a first-degree relative if it is diagnosed before age 25; (10, 23) **or**
   b. For individuals who are MSH6 and PMS2 mutation carriers:
      i. No less than every year beginning at an age no less than 25years old or no less than 2 years prior to the earliest colon cancer in a first-degree relative if it is diagnosed before age 30. (23)
4. *Serrated Polyposis Syndrome (SPS)*
   a. For individuals with a family history of serrated polyposis syndrome, colonoscopy is appropriate in the first-degree relative of the individual with serrated polyposis syndrome at the earliest of the following:
      i. Age 40; (23) **or**
      ii. Same age as the youngest diagnosis of serrated polyposis if uncomplicated by cancer; (23) **or**
      iii. Ten years earlier than earliest diagnosis in family of colorectal cancer complicating serrated polyposis. (23)
         a) Following baseline exam, repeat colonoscopy every 5 years if no polyps are found; (23) **or**
         b) If proximal serrated polyps or multiple adenomas are found, consider colonoscopy no less than every year. (23)
5. *Colonic Adenomatous Polyposis of Unknown Etiology:* For individuals with a family history of colonic adenomatous polyposis of unknown etiology (without known APC or biallelic MUTYH mutations), colonoscopy is appropriate as follows:
   a. Individual with a first-degree relative diagnosed with 100 or more adenomas prior to age 40 years:
      i. Colonoscopy beginning at an age no less than 10 years; (23) **and**
      ii. Every 1 year until age 24 years; (23) **and**
      iii. Every 2 years from age 24 to 34 years; (23) **and**
      iv. Every 3 years from age 34 to 44 years; (23) **and**
      v. No less than every 3 years thereafter. (23)

   or

   b. Individual with a first-degree relative diagnosed with more than 10 but less than 100 adenomas, colonoscopy is appropriate no less than every 3 years beginning at the same age as the youngest diagnosis of polyposis in the family, if uncomplicated by cancer or by age 40, whichever is earliest. If multiple polyps found, then colonoscopy no less than every year depending on the type, number and size of polyps. (23) **or**
   c. Individual with a first-degree relative diagnosed with more than 100 adenomas at age 40 or older, colonoscopy is appropriate no less than every 2 years, starting at age 40 years if uncomplicated by

cancer. If multiple polyps found, then colonoscopy no less than every year depending on the type, number and size of polyps. (23)

Not Medically Necessary:
Other indications for screening or surveillance colonoscopy, not listed above, are considered **not medically necessary.**

Diagnostic Colonoscopy

Medically Necessary:
A. Diagnostic colonoscopy is indicated for the evaluation of any of the following:
1. An abnormality on barium enema or other imaging study that is likely to be clinically significant (filling defect, stricture); (3) **or**
2. Unexplained gastrointestinal tract bleeding such as: (3)
   a. Hematochezia; (3) **or**
   b. Melena after an UGI tract source has been excluded; (3) **or**
   c. Presence of fecal occult blood; (3) **or**
   d. Unexplained iron deficiency anemia; (3)

or
3. A suspicion of inflammatory bowel disease, which may be manifested by abdominal pain, fever, diarrhea, bloody diarrhea, elevated erythrocyte sedimentation rate, etc.; **or**
4. Clinically significant diarrhea of unexplained origin after other appropriate work up; (3) **or**
5. A metastatic adenocarcinoma of unknown primary origin when colon cancer is suspected; **or**
6. Intraoperative identification of a lesion not apparent at surgery (for example, polypectomy site, location of a bleeding site). (3) **or**
7. Diverticulitis following resolution of a complicated episode or after a first episode of uncomplicated diverticulitis when a high-quality colonoscopy has not been performed recently (within 1 year). (12; 25; 27)

Not Medically Necessary:
A. Other indications for diagnostic colonoscopy, not listed above are considered **not medically necessary,** including but not limited to the following:
1. Chronic, stable irritable bowel syndrome; (3) **and**
2. Chronic abdominal pain; (3) **and**
3. Acute diarrhea; (3) **and**
4. Routine follow-up of inflammatory bowel disease except for cancer surveillance in chronic ulcerative colitis and Crohn's colitis; (3) **and**
5. Upper GI tract bleeding or melena with a demonstrated upper GI source. (3)

Therapeutic Colonoscopy

Medically Necessary:
A. Therapeutic colonoscopy is generally indicated for any of the following:
1. Removal of foreign body; (3) **or**

2. Balloon dilation of stenotic lesions (for example, anastomotic strictures); (3) **or**
3. Excision of colonic polyps; (3) **or**
4. Decompression of sigmoid volvulus or an acute nontoxic megacolon; (3) **or**
5. Palliative treatment of stenosing or bleeding neoplasms (for example, laser, electrocoagulation, stenting); (3) **or**
6. Treatment of bleeding from such lesions as vascular malformation, ulceration, neoplasia, and polypectomy site (for example, electrocoagulation, heater probe, laser or injection therapy); (3) **or**
7. Pre-operative "marking" for localization of a lesion. (3)

Not Medically Necessary:
Other indications for therapeutic colonoscopy, not listed above are considered **not medically necessary.**

Coding

The following codes for treatments and procedures applicable to this document are included below for informational purposes. Inclusion or exclusion of a procedure, diagnosis or device code(s) does not constitute or imply member coverage or provider reimbursement policy. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

When services may be Medically Necessary when criteria are met:

CPT	
44388	Colonoscopy through stoma; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)
44389	Colonoscopy through stoma; with biopsy, single or multiple
44390	Colonoscopy through stoma; with removal of foreign body(s)
44391	Colonoscopy through stoma; with control of bleeding, any method
44392	Colonoscopy through stoma; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps
44394	Colonoscopy through stoma; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique
44401	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)
44402	Colonoscopy through stoma; with endoscopic stent placement (including pre- and post-dilation and guide wire passage, when performed)
44403	Colonoscopy through stoma; with endoscopic mucosal resection
44404	Colonoscopy through stoma; with directed submucosal injection(s), any substance
44405	Colonoscopy through stoma; with transendoscopic balloon dilation
45378	Colonoscopy, flexible; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)
45379	Colonoscopy, flexible; with removal of foreign body(s)
45380	Colonoscopy, flexible; with biopsy, single or multiple
45381	Colonoscopy, flexible; with directed submucosal injection(s), any substance
45382	Colonoscopy, flexible; with control of bleeding, any method

45384	Colonoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps
45385	Colonoscopy, flexible; with removal of tumor(s), polyps(s), or other lesion(s) by snare technique
45386	Colonoscopy, flexible; with transendoscopic balloon dilation
45388	Colonoscopy, flexible; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)
45389	Colonoscopy, flexible; with endoscopic stent placement (includes pre- and post-dilation and guide wire passage, when performed)

HCPCS

G0105	Colorectal cancer screening; colonoscopy on individual at high risk
G0121	Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk

ICD-10 Diagnosis

All diagnoses

When services are Not Medically Necessary:
For the procedure codes listed above when criteria are not met or for situations designated in the Clinical Indications section as not medically necessary.

Discussion/General Information

Screening, surveillance and diagnostic indications for colonoscopy are based on guidelines from a variety of specialty societies and government organizations. The source for each of the indications listed above is indicated by the referenced citation.

Generally speaking, screening refers to an effort or program which is used to detect a condition in an asymptomatic individual so that early detection and treatment can be provided for those who test positive for the condition. Surveillance refers to the systematic identification and evaluation of individuals considered to be at increased risk for the occurrence or recurrence of a condition or disease (for example; colorectal cancer or adenomatous polyps. Diagnostic testing is typically done to confirm or rule out a condition in an individual who is symptomatic or who, for some other reason, is believed to have a specific condition.

Several organizations have published recommendations for colorectal cancer screening and provided guidance on when colorectal cancer screening should be initiated. The U.S. Multi-Society Task Force of Colorectal Cancer (USMSTF), which represents the American College of Gastroenterology, the American Gastroenterological Association, and The American Society for Gastrointestinal Endoscopy recommends that African Americans at average risk for colorectal cancer begin screening at 45 years of age because of an increased incidence of colorectal cancer in this population (Rex, 2018). The collaborative guideline developed by the American Cancer Society, US Multi-Society Task Force on Colorectal Cancer, and the American College of Radiology as well as the USMSTF on Colorectal Cancer recommends that individuals at average risk for the development of colorectal cancer begin screening at 50 years of age (Levin, 2008, Rex, 2017). Similarly, the National Comprehensive Cancer

Network (NCCN) guidelines on colorectal cancer screening recommend that colorectal cancer screening of average-risk individuals begin at age 45 years (NCCN, 2021).

In 2018, the American Cancer Society (ACS) included several recommendations regarding colorectal cancer screening. For individuals at average risk, the society issued a "strong recommendation" that screening being at age 50 using one of several screening techniques: colonoscopy, sigmoidoscopy, CT colonography, multi-target stool DNA testing, fecal immunochemical testing or high-sensitivity guaiac-based stool testing. The "strong recommendation" signifies that "benefits of adherence to the intervention outweigh the undesirable effects and that most patients would choose the intervention". The society also recommended that individuals considered to be at average risk for colorectal cancer should begin screening at age 45 years. However, this was a "qualified recommendation" indicating that "there is clear evidence of benefit (or harm) but less certainty either about the balance of benefits and harms or about patients' values and preferences, which could lead to different individual decisions". In support of its "qualified recommendation", the ACS cites SEER (Surveillance, Epidemiology, and End Results) data which demonstrated a 22% relative increase (from 5.9 to 7.2 cases per 100,000 person-years) in the incidence of colorectal cancer between 2000 and 2013 for individuals between 40 to 49 years of age. However, other factors such as environmental influences, including but not limited to diet, and rising obesity rates, may have played a part in the increase in colorectal cancer in individuals between 45 to 49 years of age. Also, while it may be reasonable to assume that screening individuals younger than the age of 50 will produce similar results as screening individuals older than 50 years of age for colorectal cancer, the ACS recommendations did not provide any direct evidence of this assertion. Instead, the ACS recommendations were based on modeling studies on the natural history of colorectal neoplasia and the performance of colorectal screening. The authors of the ACS guidelines acknowledge that some assumptions must be made in order for the guidelines to improve population health. Some of these assumptions are that screening tests are as effective in younger individuals as in older individuals, that there will be 100% adherence to the screening recommendations (Wolf, 2018).

In response the to 2018 ACS recommendation that colorectal cancer (CRC) screening be initiated in average risk individuals beginning at age 45 years, the USMSTF released an updated statement on colorectal cancer screening. In the updated statement the USMSTF maintained its position that colorectal cancer screening for average-risk persons begin at age 45 years in African Americans and at age 50 years in other groups. In support of these recommendations, the USMSTF also stated that:

> Evidence from screening studies to support lowering the screening age is very limited at this time. Based on the modeling study used to support the ACS recommendation, the MSTF recognizes that lowering the screening age to 45 may improve early detection and prevention of CRC. The MSTF expects the new ACS recommendation to stimulate investigation that will clarify the benefits and risks of earlier screening.
>
> As the MSTF has previously noted and discussed, rates of colorectal cancer are increasing in Americans down to age 20 years. Beginning screening at 45 years addresses only part of the increasing risk of colorectal cancer in young persons. For all persons under 50 years, it remains critical to promptly assess symptoms consistent with colorectal cancer. In particular, rectal bleeding and unexplained iron deficiency anemia have substantial predictive value for colorectal cancer and should be thoroughly evaluated (USMSTF 2018)

The United States Preventive Services Task Force (USPSTF, 2021) guidelines on screening for colorectal cancer are unique in that they provide age-based guidance on when routine colonoscopy screening should be initiated and terminated. The updated USPSTF recommendations state that screening colonoscopy begin at age 45 years and continue to age 75 years. This is a change from the prior version, which indicated the lower threshold for screening colonoscopy as 50 years of age. The update is based on emerging evidence that colorectal cancer cases in persons younger than age 50 years have been slowly increasing (for reasons that are not entirely understood). According to the USPSTF, the number of individuals diagnosed with colorectal cancer at age 45 years today is similar to the number of individuals diagnosed with colorectal cancer at age 50 years in 1992. As part of the USPSTF review, an updated modelling study was commissioned to explore the benefits and harms of colorectal cancer screening in adults younger than 50 years. According to the analysis, lowering the age of screening from 50 to 45 years results in approximately 2 to 3 additional cases and 1 additional death due to colorectal cancer being averted per 1,000 adults screened. The harms of screening, generally resulting from colonoscopy (such as bleeding and bowel perforation), either as the screening test or as follow-up for positive findings detected by other screening tests, have not been carefully evaluated in younger individuals, but are estimated by the USPSTF to be "small". For individuals 76 to 85 years of age, the USPSTF concluded that the benefits of screening for colorectal cancer diminish while the risk of experiencing serious associated harms increase. Therefore, the decision to screen for colorectal cancer in individuals between 76 and 85 years of age "should be an individual one, taking into account the patient's overall health and prior screening history". For this group, the USPSTF has indicated that "screening would be most appropriate among adults who (1) are healthy enough to undergo treatment if colorectal cancer is detected and (2) do not have comorbid conditions that would significantly limit their life expectancy". The USPSTF recommends against the use of colorectal cancer screening in adults 85 years of age or older (USPSTF, 2016).

Colonoscopy is considered the gold standard for colon cancer surveillance. Surveillance intervals (which provide guidance on how frequently a colonoscopy should be repeated), are based upon the individual's risk factors (for example, the individual's personal medical history, family history of colorectal cancer and the results of earlier colonoscopies). Surveillance with earlier and more frequent colonoscopy is recommended for individuals who are at increased risk for colorectal cancer.

Due to advances in next-generation sequencing (NGS) technology, multigene tests which simultaneously analyze a set of genes that are associated with a specific family cancer phenotype or multiple phenotypes are being explored as a means to create colonoscopy surveillance recommendations. With regards to using multigene testing to develop colonoscopy surveillance recommendations, the NCCN has indicated it "recognizes that data to support the surveillance recommendations for these particular genes are evolving at this time" and that "caution should be used when implementing final colonoscopy surveillance regimens in context of patient preferences and new knowledge that may emerge" (NCCN, Genetic/Familial High-Risk Assessment Colorectal, 2023).

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History

Status	Date	Action
Revised	08/10/2023	Medical Policy & Technology Assessment Committee (MPTAC) review. Revised MN criteria section A - Screening Colonoscopy in Average Risk Populations to include individuals with no personal history of cystic fibrosis. Revised MN criteria section B - Surveillance Colonoscopy in At-Risk Populations to include criteria for individuals with personal history of cystic fibrosis and individuals at increased risk based on personal history of childhood, adolescent and young adult cancer. Revised MN criteria section C-Screening Colonoscopy in Higher Risk Populations bullet #1 Family History of Colorectal Cancer or Adenomas to consider colonoscopy MN in a first degree relative (parent, sibling or child) with colorectal cancer diagnosed at

		any age and for one second and third-degree relative with colorectal cancer at any age. Updated Discussion/General Information and References sections. Revised formatting throughout document.
Revised	08/11/2022	MPTAC review. In medically necessary criteria for Surveillance Colonoscopy in At-Risk Populations: (1) revised bullets # 3-b-1 and #3-c in section on adenomatous polyps or SSP; (2) revised criteria for inflammatory bowel disease by adding bullet #6-a-iii. In section on Diagnostic Colonoscopy, added medically necessary criteria for individuals with a history of diverticulitis. Also updated the parenthetical numbering following each criterion, as needed. Updated References and History sections.
Reviewed	08/12/2021	MPTAC review. In the Clinical Indications section, updated the parenthetical numbering following each criterion, as needed. Updated References and History sections. Updated Coding section to add CPT codes 44388, 44389, 44390, 44391, 44392, 44391, 44401, 44402, 44403, 44404, 44405.
Revised	05/25/2021	MPTAC review. Updated MN statement to revise age for beginning colonoscopy to detect colorectal cancer and adenomatous polyps from 50 to 45. Removed note from MN section. Updated Discussion and References sections.
Revised	08/13/2020	MPTAC review. In the Clinical Indications section, revised criteria in section C1 (Screening Colonoscopy in Higher Risk Populations on Screening Colonoscopy in Higher Risk Populations, Family History of Colorectal Cancer or Adenomas). Updated References and History sections. Reformatted Coding section.
Reviewed	08/22/2019	MPTAC review. Updated the Description, Discussion/General Information and References sections.
Reviewed	03/21/2019	MPTAC review. Updated the References and History sections.
Revised	07/26/2018	MPTAC review. In Clinical Indications section, updated the parenthetical numbering following each criterion, as needed. Updated the Discussion/General Information, References and History sections.
	05/03/2018	The document header wording updated from "Current Effective Date" to "Publish Date."
Reviewed	08/03/2017	MPTAC review. Minor format changes to Clinical Indications section. Updated Discussion/General Information, References and History sections. Updated Coding section to remove G6024, G6025 deleted 12/31/2015.
Revised	05/04/2017	MPTAC review. In the Medically Necessary position statement, bullet A3 was revised to indicate that for individuals at average risk, if prior CRC screening was conducted using Cologuard and the results were negative, then the next re-screening may be performed using colonoscopy in 3 years. Minor language and/or formatting changes in sections A and B of the Medically Necessary criteria. Updated the Discussion/General Information, References and History sections.
Revised	05/05/2016	MPTAC review. Revised the following sections of the Medically Necessary criteria: (1) Screening Colonoscopy in Average Risk Populations; (2) Surveillance Colonoscopy in At-Risk Populations – Adenomatous Polyps; (3)

		Surveillance Colonoscopy in At-Risk Populations – Inflammatory Bowel Disease (chronic ulcerative colitis or Crohn's colitis) and related conditions; (4) Screening Colonoscopy in Higher Risk Populations - Family History of Colorectal Cancer or Adenomas; (5) Diagnostic Colonoscopy and (6) Therapeutic Colonoscopy. Also, as appropriate, throughout the document, revised statements with an age range to include the phrase "no less than" and removed the word "should" from the document. Updated the References and History sections. Removed ICD-9 codes from Coding section.
Revised	05/07/2015	MPTAC review. Revisions include but are not limited to the following: Criteria divided into 5 general categories: (1) Screening -Average Risk; (2) Screening-Higher Risk; (3) Surveillance – At Risk; (4) Diagnostic; and (5) Therapeutic Colonoscopy. *Section A Screening Colonoscopy - Average Risk Populations:* Clarified that medically necessary criteria for average risk individuals includes sessile serrated polyps (SSPs). Added criteria for colonoscopy based on a stool based test. Removed the words "left-sided" from the criterion for individual with a personal history of hyperplastic, non-SSP less than 1 cm removed at colonoscopy. *Section B Surveillance Colonoscopy - At Risk Populations* revised to address individuals with a personal history of a positive stool based test. Clarified that the medically necessary criteria for adenomatous polyps includes sessile serrated polyps (SSPs). Moved a portion of the medically necessary criteria addressing serrated polyposis syndrome and a portion of criteria addressing colonic adenomatous polyposis of unknown etiology to Section B Surveillance Colonoscopy - At Risk (criteria was unchanged). Revised and moved medically necessary criteria for Inflammatory Bowel Disease to Section B Surveillance Colonoscopy-At Risk section. *Section C Screening Colonoscopy in Higher Risk Populations:* Revised medically necessary criteria addressing family history of colorectal cancer or adenomas and the medically necessary criteria for Lynch Syndrome. In the *Not Medically Necessary* section, clarified this section includes surveillance colonoscopy. Updated Description, Discussion and Reference sections.
	01/21/2015	Updated Coding section with 01/01/2015 CPT and HCPCS changes; removed 45383, 45387 deleted 12/31/2014.
Revised	05/15/2014	MPTAC review. Expanded criteria for screening colonoscopy in average risk individuals to include those with history of hyperplastic, right-sided non-SSP. In section on screening colonoscopy in higher risk individuals, revised criteria for the following: (1) adenomatous polyps; (2) family history of colorectal cancer or adenoma and (3) inflammatory bowel disease. Added new medically necessary criteria for colonic adenomatous polyposis of unknown etiology.
Revised	05/09/2013	MPTAC review. Expanded medically necessary criteria to address: (1) Individuals with personal history of hyperplastic, left-sided, non-SSP; (2) Individuals with a family history of CRC or adenomas and (3) serrated polyposis syndrome (SPS). Inserted or deleted "and" or "or" in the criteria as needed to provide clarity. Updated review date and References.

Revised	05/10/2012	MPTAC review. Expanded medically necessary criteria for individuals with FAP to include annual colonoscopy beginning at ages 10-12 years. Updated review date, References and History sections.
Reviewed	05/19/2011	MPTAC review. Updated review date, References and History sections.
Revised	05/13/2010	MPTAC review. Criteria updated based on the National Comprehensive Cancer Network. Guidelines on Colorectal Cancer Screening V1.2010 and the 2010 American Gastroenterological Association (AGA) Position Paper on Screening Patients with Inflammatory Bowel Disease (IBD) for Colorectal Cancer. Updated review date, References and History sections.
Reinstated	02/25/2010	MPTAC review. Reinstated document which was archived on November 19, 2009. Grammatical and typographical corrections made to clinical indications.
Historic	11/19/2009	Not to be used for dates of service on or after 11/19/2009.
Reviewed	05/21/2009	MPTAC review. Added references to the following guidelines and noted where they were applicable in the patient selection criteria: (1) American College of Gastroenterology guidelines for colorectal cancer screening (2008); (2) National Comprehensive Cancer Network. Colorectal Cancer Screening V1.2009; (3) US Preventive Services Task Force. Screening for colorectal cancer (2008). Also, in the patient selection criteria for FAP, added information to the *"Note"* to clarify that MYH-associated is the same as attenuated FAP. Minor formatting changes. No substantive change to patient selection criteria. Updated review date, description, discussion/general information and history sections.
Revised	05/15/2008	MPTAC review. Revised the patient selection criteria to reflect the recommendations made in the Screening and Surveillance for the Early Detection of Colorectal Cancer and Adenomatous Polyps, 2008: A Joint Guideline from the American Cancer Society, the US Multi-Society Task Force on Colorectal Cancer, and the American College of Radiology. Updated review date, rationale and references sections.
Reviewed	05/17/2007	MPTAC review. Updated references, coding, and review date.
Revised	06/08/2006	MPTAC revision. For clinical indication, Family History of Colorectal Cancer or Adenoma, criteria updated to two or more first-degree relatives.
Reviewed	03/23/2006	MPTAC annual review. References updated.
	11/17/2005	Added reference for Centers for Medicare & Medicaid Services (CMS) - National Coverage Determination (NCD).
Revised	04/28/2005	MPTAC review. Revision based on Pre-merger Anthem and Pre-merger WellPoint Harmonization.

Pre-Merger Organizations	**Last Review Date**	**Document Number**	**Title**
Anthem BCBS West Region Utilization Management Policy	08/12/2004	UMR.003	Colorectal Cancer Screening

WellPoint Health Networks, Inc.	12/02/2004	Clinical Guideline	Colonoscopy