UnitedHealthcare Oxford

Diagnostic And Therapeutic Colonoscopy Guidelines
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Guideline

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Guideline

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General Guidelines (COLON-0)

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- The Gastrointestinal Endoscopy Program applies an evidence-based approach to evaluate the most appropriate care for each individual. This evaluation requires submission of medical records pertinent to the treatment and/or services being requested by the provider.
- If the medical records provided do not provide sufficiently detailed information to understand the individual's current clinical status, then the medical necessity for the request cannot be established and the request cannot be approved.
- A pertinent clinical evaluation since the new onset or change in symptoms is required prior to considering gastrointestinal endoscopy services:
  - A pertinent clinical evaluation should include the following:
    - A detailed history and physical examination
    - Appropriate laboratory studies
    - Pertinent imaging studies
    - Pathology reports
    - Procedure reports
    - Reports from other providers participating in the treatment of the relevant condition
  - For an established individual, a meaningful technological contact (telehealth visit, telephone call, electronic mail or messaging) since the onset or change in symptoms can serve as a pertinent clinical evaluation
- A recent clinical evaluation may be deferred if the individual is undergoing a guideline-supported, scheduled follow-up imaging or other designated procedural evaluation. Exceptions due to routine surveillance indications are addressed in the applicable condition-specific guideline sections.
- The Gastrointestinal Endoscopy program reserves the right to change and update the policy as new evidence emerges. The policy undergoes a formal review at least annually. The policy is based upon major national and international association and society guidelines and criteria, peer reviewed literature, major treatises, as well as input from health plans, and practicing academic and community-based physicians.
- This policy is not intended to supersede or replace sound medical judgment, but instead, should facilitate the identification of the most appropriate treatment given the individual's clinical condition. This policy is written to cover most gastrointestinal endoscopic indications. However, the policy may not be applicable in certain clinical circumstances. Physician judgment may override the policy. Clinical decisions, including treatment decisions, are the responsibility of the individual and his/her

provider. Clinicians are expected to use independent medical judgment, which takes into account the clinical circumstances to determine individual management decisions
- All time intervals in the guideline refer to colonoscopy, unless otherwise stated.
- Requests for Open-Access Colonoscopy must meet criteria according these guidelines.
- New and Emerging Technologies
  - Requests related to new and emerging technologies will be considered to determine whether they meet evidence-based guidelines.
    - If a specific CPT code does not exist for a new technology, the CPT code submitted with the request will be considered based on its typical procedure application.
  - Procedures are not supported that are inconsistent with established clinical standards or are requested solely for data collection and not used in direct clinical management.
- State and federal legislations may need to be considered in the review of gastrointestinal endoscopy requests.
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Health Equity Considerations

Health equity is the highest level of health for all individuals; health inequity is the avoidable difference in health status or distribution of health resources due to the social conditions in which individuals are born, grow, live, work, and age. Social determinants of health are the conditions in the environment that affect a wide range of health, functioning, and quality of life outcomes and risks. Examples include the following: safe housing, transportation, and neighborhoods; racism, discrimination, and violence; education, job opportunities, and income; access to nutritious foods and physical activity opportunities; access to clean air and water; and language and literacy skills.

Surveillance after Polypectomy (COLON-3)

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- The proper application of surveillance guidelines requires information regarding the size, number, and histologic findings from the initial baseline colonoscopy.
- First surveillance colonoscopy intervals after polypectomy:
  - **Adenomatous Polyps:**
    - If no polyps found on screening or other colonoscopy: 10 years (average risk)
    - 1-2 tubular adenomas <10mm: 7-10 years
    - 3-4 tubular adenomas <10mm: 3-5 years
    - 5-10 tubular adenomas <10mm: 3 years
    - One or more tubular adenomas ≥10mm: 3 years
    - Adenoma with tubulovillous or villous histology: 3 years
    - Adenoma with high-grade dysplasia: 3 years
    - >10 adenomas on a single examination: 1 year
    - Piecemeal resection of adenoma ≥20mm: 6 months
  - **Hyperplastic polyps:**
    - All polyps located in the rectum and/or sigmoid colon:
      - <20 polyps, size <10mm: Repeat in 10 years
    - Polyps located proximal to the sigmoid colon:
      - <20 polyps, size <10mm: Repeat in 10 years
      - Polyps ≥10mm: Repeat in 5-10 years
    - ≥20 polyps
      - Follow Serrated Polyposis Syndrome guidelines (**Genetic Syndromes (COLON-17)**)
  - **Sessile Serrated Polyps (SSP):**
    - 1-2 polyps <10mm in size: Repeat in 5-10 years
    - 3-4 polyps <10mm in size: Repeat in 3-5 years
    - 5-10 polyps <10mm in size: Repeat in 3 years
    - Polyp ≥10mm: Repeat in 3 years
    - Isolated polyp containing dysplasia: Repeat in 3 years
    - Piecemeal resection of SSP >20mm: Repeat in 6 months
    - See also: Serrated Polyposis Syndrome in **Genetic Syndromes (COLON-17)**

- **Traditional Serrated Adenoma:**
  - Repeat in 3 years

- Second surveillance colonoscopy (stratified by baseline and first surveillance adenoma findings):
  - **If Baseline Colonoscopy/Polypectomy Findings show 1-4 tubular adenomas <10 mm:**
    - First surveillance colonoscopy findings:
      - Normal colonoscopy:
        - Second surveillance colonoscopy: Repeat in 10 years
      - 1-2 tubular adenomas <10mm:
        - Second surveillance colonoscopy: Repeat in 7-10 years
      - 3-4 tubular adenomas <10mm:
        - Second surveillance colonoscopy: Repeat in 3-5 years
      - Adenoma ≥10mm in size:
        - Second surveillance colonoscopy: Repeat in 3 years
      - Adenoma with tubulovillous or villous history:
        - Second surveillance colonoscopy: Repeat in 3 years
      - Adenoma with high-grade dysplasia:
        - Second surveillance colonoscopy: Repeat in 3 years
      - 5-10 adenomas <10mm:
        - Second surveillance colonoscopy: Repeat in 3 years
  - **For any of the following scenarios on baseline colonoscopy/polypectomy:**
    - Adenoma ≥10mm
    - Adenoma with tubulovillous or villous pathology
    - Adenoma with high-grade dysplasia
    - 5-10 adenomas <10mm
      - First surveillance colonoscopy findings:
        - Normal colonoscopy:
          - Second surveillance colonoscopy: Repeat in 5 years
        - 1-2 tubular adenomas <10mm:
          - Second surveillance colonoscopy: Repeat in 5 years
        - 3-4 tubular adenomas <10mm:

        - Second surveillance colonoscopy: Repeat in 3-5 years
    - Adenoma ≥10mm:
        - Second surveillance colonoscopy: Repeat in 3 years
    - Adenoma with tubulovillous histology:
        - Second surveillance colonoscopy: Repeat in 3 years
    - Adenoma with high-grade dysplasia:
        - Second surveillance colonoscopy: Repeat in 3 years
    - 5-10 adenomas <10mm:
        - Second surveillance colonoscopy: Repeat in 3 years
- **If baseline colonoscopy shows: Adenoma or SSP >20mm with piecemeal resection:**
    - Second surveillance: 1 year from the first surveillance colonoscopy
    - Third surveillance: 3 years from the second surveillance colonoscopy

    Note: In this scenario, if any surveillance study after the initial polypectomy reveals local recurrence, subsequent examinations can be performed at 6 month intervals until there is no local recurrence. Once a clear resection site is documented, the next follow-up is at 1 year, and the subsequent follow-ups are at 3 year intervals.

- **Duodenal Adenoma** (sporadic duodenal tumors not associated with genetic syndromes)
    - If an ampullary adenoma or duodenal adenoma is found on EGD, a concomitant colonoscopy is also medically necessary.
    - See: **Upper GI Polyp Treatment and Follow-Up (EGD-1.8)** for EGD indications

Evidence Discussion

Colonoscopy is considered the standard of care for both routine colorectal cancer (CRC) screening and surveillance following CRC treatment or polyp removal. The risk of metachronous advanced neoplasia is closely linked with findings on prior colonoscopy.[20]

Individuals with no dysplasia detected are categorized as the lowest risk, whereas those with polyps are risk-stratified based on the histology, number, location, and size of polyps detected.[81,82]

The most recent and widely accepted recommendations are outlined in the U.S Multi-Society Task Force on Colorectal Cancer consensus update, "Recommendations for Follow-Up after Colonoscopy and Polypectomy." These guidelines represent the current standard for surveillance after polypectomy.[20]

The primary goals of colonoscopy in both screening and post-polypectomy surveillance are to reduce the incidence of colorectal cancer and associated mortality. The updated 2020 guidelines provide recommendations for follow-up strategies toward achievement of those outcomes.[20]

Surveillance of Colorectal Cancer and Resected Lesions (COLON-4)

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- If colonoscopy was not completed pre-operatively (e.g., because of an obstructing lesion)
  - Repeat colonoscopy 3-6 months post-surgery, for clearance
- For individuals who have undergone curative surgical resection, colonoscopy is medically necessary in the following scenarios:
  - Successful peri-operative clearing colonoscopy at diagnosis or subsequent colonoscopy:
    - Colonoscopy 1 year after the surgery or one year after the clearing colonoscopy (assuming clearing colonoscopy occurred post-surgery)
      - If an advanced adenoma (villous polyp, high-grade dysplasia, or any polyp >1 cm) is found, repeat colonoscopy in 1 year
      - If no advanced adenoma is found, repeat colonoscopy in 3 years (or 4 years from the surgery or clearing colonoscopy)
      - Repeat next colonoscopy in 5 years (9 years from the surgery or clearing colonoscopy)
      - Subsequent colonoscopies at 5 year intervals
  - Successful curative resection (based on histopathological criteria) of colonic dysplasia or adenocarcinoma via submucosal resection (SMR) or submucosal dissection (SMD):
    - Adenoma with low grade dysplasia or sessile serrated polyp without dysplasia:
      - Colonoscopy 1 year after resection
      - Second follow-up colonoscopy 3 years after the first surveillance
    - Traditional serrated adenoma, sessile serrated polyp with dysplasia, adenoma high grade dysplasia, carcinoma in situ, intramucosal carcinoma, or dysplasia in the setting of IBD:
      - Colonoscopy 6-12 months after resection
      - Second follow-up colonoscopy 1 year after the first surveillance
      - Subsequent colonoscopy 3 years after second surveillance
    - T1b (submucosal invasion) adenocarcinoma:
      - Colonoscopy 3-6 months after resection
      - Second follow-up colonoscopy 6-12 months after the first surveillance

    - Subsequent colonoscopy 1 year after second surveillance
- In individuals with stage IV colon cancer managed nonoperatively with complete clinical response, initiate colonoscopy surveillance from first documentation of complete response OR at the request of the treating oncologist
- For individuals with genetic syndromes that predispose to colorectal cancer, see: **Genetic Syndromes (COLON-17)**
- Additional surveillance of rectal cancer:
    - In addition to the above surveillance colonoscopies, a sigmoidoscopy or EUS can be performed at prescribed intervals.
        - These surveillance strategies are beyond the scope of the current guideline, which only references colonoscopy.
- See: **Inflammatory Bowel Disease (COLON-5)** for surveillance of dysplasia

Evidence Discussion

For obstructing colonic lesions in which colonoscopy was not completed, perform perioperative colonoscopy within 3-6 month interval post surgery to help clear the colon of synchronous cancer and resection of pre-cancerous polyps.[1,6]

For those who have undergone curative resection of colorectal cancer and had, at time of diagnosis, a complete colonoscopy to rule out metachronous lesions may have a subsequent surveillance colonoscopy:[1,6]

- 1 year after surgery
- Then repeat surveillance 3 years after surgery (4 years from the surgery or clearing colonoscopy)
- Then repeat colonoscopy in 5 years (9 years from the surgery or clearing colonoscopy)
- Subsequent surveillance intervals every 5 years thereafter

Additional surveillance of rectal cancer:[1,6]

- In addition to the above surveillance colonoscopies, a sigmoidoscopy or EUS can be performed at prescribed intervals (i.e., every 3-6 months for the first 2-3 years after surgery).
- These surveillance strategies are beyond the scope of the current guideline, which only references colonoscopy.

Successful curative resection (based on histopathologic criteria) of colonic dysplasia or adenocarcinoma via submucosal resection (SMR) or submucosal dissection (SMD)[84]

- Adenoma with low grade dysplasia or sessile serrated polyp without dysplasia:[84]
    - Colonoscopy 1 year after resection
    - Second follow-up colonoscopy, 3 years after the first surveillance

- Traditional serrated adenoma, sessile serrated polyp with dysplasia, adenoma high grade dysplasia, carcinoma in situ, intramucosal carcinoma, or dysplasia in the setting of IBD:[84]
  - Colonoscopy 6-12 months after resection
  - Second follow-up colonoscopy 1 year after the first surveillance
  - Subsequent colonoscopy 3 years after second surveillance
- T1b (submucosal invasion) adenocarcinoma:[84]
  - Colonoscopy 3-6 months after resection
  - Second follow-up colonoscopy 6-12 months after the first surveillance
  - Subsequent colonoscopy 1 year after second surveillance

Inflammatory Bowel Disease (COLON-5)

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- Colonoscopy is medically necessary for assessment of disease activity and/or treatment decisions, including assessment for mucosal healing on therapy
- Post-surgery for Inflammatory Bowel Disease
  - Evaluation of pouchitis, as clinically indicated
  - After partial colectomy or partial ileocolectomy
    - Examination of the neoterminal ileum 6-12 months after surgery to risk-stratify individuals who may be affected by endoscopic recurrence
- Screening and surveillance for dysplasia in established ulcerative colitis
  - Average risk individuals with ulcerative colitis
    - Begin screening 8 years after symptom onset (includes individuals with pancolitis, and left-sided colitis)
    - Continue surveillance colonoscopy every 1-3 years
    - Individuals with isolated ulcerative proctitis do not appear to be at increased risk of colon cancer. Thus, surveillance is not recommended in this group.
  - Elevated risk individuals with ulcerative colitis:
    - Begin annual surveillance beginning immediately upon diagnosis in the following high risk individuals:
      - Active inflammation
      - Anatomic abnormality such as a stricture or multiple pseudopolyps
      - Prior history of dysplasia
      - Family history of CRC in a first-degree relative
      - History of primary sclerosing cholangitis
  - If dysplasia is discovered or a lesion is present which needs follow-up evaluation:
    - If a polypoid or non-polypoid dysplastic lesion has been removed:
      - Colonoscopy surveillance at 1-6 months, then at 12 months, and then yearly
- Screening and surveillance for dysplasia in established Crohn's Disease of the colon:
  - Colonoscopy every 1-3 years in individuals with colonic Crohn's Disease, beginning 8 years after symptom onset
- Chronic inflammatory bowel disease in remission (endoscopic or histologic)
  - Routine follow-up is not medically necessary except for dysplasia/cancer surveillance as above
- Surveillance of pouchitis

- Annual colonoscopy for surveillance of an ileo-anal pouch is medically necessary for individuals with a history of any of the following:
  - Colorectal dysplasia
  - Colon cancer
  - Primary sclerosing cholangitis
- If dysplasia is discovered or a lesion is present requiring follow up beyond annual surveillance:
  - Colonoscopy is medically necessary at 1-6 months and again at 6-12 months
    - Continued intensive surveillance is medically necessary until 2 consecutive negative colonoscopy exams, after which standard colonoscopy surveillance guidelines apply.

Evidence Discussion

Colonoscopy with biopsies is an essential tool in the assessment and management of individuals with suspected Inflammatory Bowel Disease (IBD). Colonoscopy is medically necessary to evaluate disease activity, determine mucosal healing, and guide therapeutic decision in individuals with established IBD.[55]

Endoscopic evaluation of the surgically altered bowel may also be required to assess for recurrent disease, complications, and treatment response.[81]

Screening and subsequent surveillance colonoscopy to detect dysplasia in individuals with long-standing IBD is a cornerstone of cancer prevention. Current guidelines recommend initiating surveillance colonoscopy approximately 8 years after diagnosis of colonic IBD, with subsequent surveillance intervals determined by individual risk factors.[48,50,55,67-69]

Individuals with ulcerative colitis and primary sclerosing cholangitis (PSC) should undergo a screening colonoscopy at the time of diagnosis of ulcerative colitis and surveillance annually thereafter. Annual surveillance is also recommended for high risk individuals with ulcerative colitis with anatomic abnormality such as a stricture or multiple pseudopolyps, prior history of dysplasia or family history of CRC in a first-degree relative. After complete removal of endoscopically resectable polypoid or nonpolypoid dysplastic lesions, surveillance colonoscopy is recommended.[48,50,67-69]

Irritable Bowel Syndrome/Change in Bowel Habits (COLON-6)

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- Colonoscopy is medically necessary for individuals with suspected or established IBS when **either** of the following are met:
  - **Presence of alarm features or red flags, including but not limited to:**
    - Unintentional weight loss defined as loss of ≥10 lbs. or ≥5% of body weight over 6 months or less, without an identifiable reason
    - New onset of IBS symptoms after age 50
    - New or unexplained change in bowel habits including frequent passage of stool that awakens from sleep
    - Abdominal pain that awakens the individual from sleep
    - Sigmoidoscopy does not reveal a local source of bleeding such as hemorrhoids or anal fissure
    - Iron-deficiency anemia as manifested by a low hematocrit and/or hemoglobin AND one of the following:
      - Low serum iron
      - Low serum ferritin (≤45 ng/mL or <lab lower limit if higher than 45 ng/mL)
      - Elevated serum iron-binding capacity
      - Low serum transferrin saturation
    - Positive inflammatory markers (e.g., C-reactive protein (CRP), erythrocyte sedimentation rate (ESR), fecal calprotectin, fecal lactoferrin)
  - **High-risk history or findings, such as:**
    - Family history of colorectal polyps, cancer, or with a known genetic predisposition to colonic cancer
    - Imaging or sigmoidoscopy findings suggestive of underlying organic disease requiring further evaluation (e.g., inflammatory bowel disease, adenomatous polyp)
- Colonoscopy is medically necessary in individuals with symptoms of Irritable Bowel Syndrome (IBS) in the absence of alarm features, when a diagnostic work-up has been completed to exclude other conditions.The diagnostic work-up must include at least one of the following:

Note: The specific tests required are determined by the individual's clinical presentation and Irritable Bowel Syndrome (IBS) subtype which may be: constipation-predominant IBS (IBS-C), diarrhea-predominant (IBS-D), mixed (alternating constipation and diarrhea) IBS (IBS-M), or unclassified IBS (IBS-U).

- For constipation-predominant IBS (IBS-C):
  - Complete blood count (CBC)
- For diarrhea-predominant or mixed IBS (IBS-D or IBS-M) at least one of the following:
  - Fecal calprotectin and/or fecal lactoferrin to assess for inflammatory bowel disease
  - Serologic testing for celiac disease with IgA tissue transglutaminase
    - IgG-tTG or IgG deaminated gliadin peptides can be used for IgA-deficient individuals
  - Stool analysis for giardia PCR or giardia antigen
- For unclassified IBS (IBS-U):
  - CBC
  - Fecal calprotection and/or fecal lactoferrin, guided by whether symptoms lean toward constipation or diarrhea spectrum
  - Consider serologic testing for celiac disease if symptoms suggest gluten sensitivity or overlap with IBS-D/M features
- If the diagnosis is inconclusive or suggestive of IBD after the above studies, colonoscopy is medically necessary.

Evidence Discussion

Irritable Bowel Syndrome (IBS) is a chronic functional gastrointestinal disorder characterized by recurrent abdominal pain, bloating, abdominal distention, and altered bowel habits. The condition significantly impacts quality of life and presents with variable symptoms that can fluctuate in severity and frequency from day to day and between individuals. IBS is classified into four subtypes based on predominant bowel movement patterns: IBS-C (constipation-predominant), IBS-D (diarrhea-predominant), IBS-M (mixed type, alternating between constipation and diarrhea), and IBS-U (unclassified, where symptoms do not clearly fit into the other categories). Understanding these subtypes is essential for tailoring effective management strategies for each individual.[61,86,90]

The diagnosis of IBS is established using the Rome IV criteria, which require:

- Recurrent abdominal pain, on average at least 1 day per week in the last 3 months, associated with two or more of the following: [61,86,90]
  - Defecation (symptoms improve or worsen with bowel movement)
  - Change in stool frequency
  - Change in form or appearance of stool

IBS is understood within the broader category of functional gastrointestinal disorders, which are strongly influenced by the gut-brain axis. Although IBS itself is not categorized

as a psychiatric disorder within the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), the manual provides an important framework for understanding its overlap with psychiatric conditions. A subset of individuals with IBS met criteria for somatic symptom disorder (SSD), given the chronicity of gastrointestinal symptoms and associated cognitive, emotional, and behavioral responses. This diagnostic overlap underscores the role of psychosocial factors in symptom expression and persistence. Moreover, the DSM-5 highlights that somatic symptom disorder does not require symptoms to be medically unexplained, thereby directly applying to conditions such as IBS where organic pathology may not account for symptom burden. This framework emphasizes how physiological distress, anxiety, and depression can amplify symptom severity, functional impairment and healthcare utilization in IBS. [70]

The ACG states, "colonoscopy is not medically necessary for individuals under 45 years old who present with symptoms consistent with IBS and do not have alarm features.The guideline emphasizes that in the absence of red flags, routine diagnostic testing (including colonoscopy) is unlikely to yield significant findings and may lead to unnecessary procedures and costs. Instead, the focus should be on positive diagnostic criteria (such as Rome IV) and symptom-based management, including dietary modifications, pharmacologic therapy, and psychological interventions as appropriate. [61,90]

Constipation (COLON-7)

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- Colonoscopy is medically necessary:
  - For the following alarm symptoms:
    - Rectal bleeding

      Note:
      - The nature of rectal bleeding should be specified (e.g., bright red blood per rectum, melena, hematochezia, etc. See: **GI Bleeding (COLON-9)**
    - Positive fecal occult blood test /Heme-positive stool
    - Iron-deficiency anemia as manifested by a low hematocrit and/or hemoglobin AND one of the following:
      - Low serum iron
      - Low serum ferritin (≤45 ng/mL or <lab lower limit if higher than 45 ng/mL)
      - Elevated serum iron-binding capacity
      - Low serum transferrin saturation
    - Unintentional weight loss is defined as loss of ≥10 lbs. or ≥5% of body weight over 6 months or less, without an identifiable reason
    - Individuals ≥45 years who have not previously had colon cancer screening via colonoscopy
    - For dilation of benign colon strictures or creation of percutaneous cecostomy when clinically appropriate

      Note:
      - Note: the nature of the stricture should be specified (e.g., anastomotic stricture in the sigmoid)
    - In selected individuals, if there is a documented concern for obstruction secondary to cancer, stricture, or extrinsic compression
    - If surgery is being considered for the treatment of constipation

Evidence Discussion

Per American Society for Gastrointestinal Endoscopy (ASGE) guidelines, colonoscopy is not medically necessary for the initial evaluation of individuals with symptoms of chronic constipation in the absence of alarm features or suspicion of organic disease.[72] In general, the yield of colonoscopy for isolated constipation is low and comparable to that of asymptomatic individuals undergoing colonoscopy for routine colorectal cancer screening.[72]

Colonoscopy for constipation is medically necessary for individuals with associated alarm symptoms, including iron deficiency anemia, heme-positive stool, rectal bleeding, weight loss, and age ≥45 years old with no prior colonoscopy.[72]

Colonoscopy is also medically necessary if there is a concern for obstruction, if surgery is being considered to treat constipation, or for dilation of strictures.[72]

Diarrhea, Stool Urgency/Incontinence (COLON-8)

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- For individuals with chronic diarrhea (≥28 days)
  - Colonoscopy is medically necessary after completion of at least one of the following:
    - Fecal calprotectin and/or lactoferrin to assess for inflammatory bowel disease
    - Stool analysis for giardia PCR or giardia antigen
    - Serological testing for celiac disease with IgA tissue transglutaminase
      - IgG-tTG or IgG deaminated gliadin peptides can be used for IgA-deficient individuals.
  - If the diagnosis is inconclusive or suggestive of IBD after the above studies, colonoscopy is medically necessary.
- For individuals with acute diarrhea (<28 days):
  - Immunocompetent individuals:
    - Stool and laboratory tests, including tests for the presence of microbial pathogens, are the initial studies for the evaluation of clinical scenarios suggestive of infectious diarrhea
    - Colonoscopy is generally not medically necessary for the initial evaluation of acute diarrhea in this setting, unless:
      - Findings on sigmoidoscopy are inconclusive
        - Results should be provided
      - Symptoms persist and fail to respond to empirical therapy
        - Type of therapy should be provided
      - The diagnosis is inconclusive after routine blood and stool studies
        - Results of these studies should be provided
      - There is significant blood loss
        - Nature of blood loss should be specified
  - Immunocompromised individuals:
    - Stool testing for pathogens is the first-line evaluation
    - Colonoscopy is considered medically necessary if stool studies fail to reveal a cause and symptoms persist. In addition, cytomegalovirus infection (CMV) diagnosed by PCR, viral culture, or positive serology may not be indicative of tissue-invasive disease and endoscopic biopsy may be needed.

Stool urgency

- Colonoscopy is medically necessary in the presence of new or persistent stool urgency AND one or more of the following:
  - New onset after age > 60
    - Individuals ≥ 45 years who have not previously had colon cancer screening via colonoscopy
  - Persistent sensation of incomplete stool evacuation
  - Persistent narrowing of the stool
  - Recent blood in the stool and/or iron deficiency anemia
  - Unexplained abdominal pain of at least moderate severity
  - Unintentional weight loss is defined as loss of ≥10 lbs. or ≥5% of body weight over 6 months or less, without an identifiable reason
  - High risk: inflammatory bowel disease, personal or family history of colon cancer, or of precancerous genetic syndromes

Stool incontinence

- Colonoscopy is medically necessary in the evaluation of fecal incontinence when accompanied by one or more of the following risk factors:
  - History of obstetric injury, including prolonged labor, post-episiotomy (including mediolateral episiotomy), documented obstetric anal sphincter injury (OASIS), third-or fourth-degree perineal lacerations, or instrument-assisted delivery with vacuum or forceps
  - Prior anorectal surgery (e.g., anal fissure, anal fistula, hemorrhoid removal)
  - Prior proctectomy
  - History of pelvic radiation
  - Females of advanced age with decreased mobility

Background and Supporting Information

- In the immunocompromised individual (e.g., HIV), evidence indicates that colonoscopy has a higher diagnostic yield than sigmoidoscopy.

Evidence Discussion

Chronic diarrhea is defined as diarrhea for greater than or equal to 28 days, whereas acute diarrhea is defined as diarrhea less than 28 days in duration. Both acute and chronic diarrhea have many etiologies including infection, inflammation, or malabsorption.[72]

Colonoscopy is medically necessary in the evaluation of chronic diarrhea after baseline work-up has been completed, and studies are inconclusive or suggestive of inflammatory bowel disease.[72,75]

In immunocompetent individuals with acute diarrhea, colonoscopy is medically necessary if the baseline work-up including labs, stool testing, and sigmoidoscopy are negative or inconclusive, or there is concern for significant lower gastrointestinal bleeding.[72]

Immunocompromised individuals are at increased risk of gastrointestinal pathology. Colonoscopy should be performed (rather than sigmoidoscopy) to increase diagnostic yield in immunocompromised individuals if stool studies do not reveal an etiology or when symptoms do not respond to treatment.[72]

In individuals presenting with chronic diarrhea or signs of malabsorption, testing for celiac disease is a necessary component of the evaluation. The recommended initial screening test is serum IgA tissue transglutaminase (tTG-IgA) along with a total IgA level to account for possible IgA deficiency. If the tTG-IgA test is positive, confirmation by duodenal biopsy is warranted to establish the diagnosis.[96]

Stool (fecal/bowel) urgency is defined in adults as the sudden and often intense need to defecate. Individuals may report "near accidents" associated with the need to move bowels but inability to "hold it" without accidental loss of stool.[76,78]

Stool (fecal/bowel) incontinence is defined in adults by the American Society of Colon and Rectal Surgeons (ASCRS) as impaired ability to control the release of gas and stool at a desired time. Fecal incontinence is approximately twice as common among women, 30% of whom are older than age 65. The symptoms of fecal incontinence can range from minor changes in the ability to control gas to complete loss of control of solid stool without warning. Symptoms may occur intermittently or daily, may be exacerbated by a change in the consistency of stool, and may be associated with stool urgency and/or a patient's altered awareness of their need to stool. After complete history and physical examination, evaluation may include: endorectal ultrasound, anorectal manometry, electromyography of pudendal nerves, defecography.[74,78]

GI Bleeding (COLON-9)

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- Colonoscopy is medically necessary for the evaluation of bleeding of suspected lower GI origin in the following clinical scenarios:
  - Documented positive occult blood, melena, or hematochezia not suggestive of outlet-type bleeding
  - Documented overt GI bleeding (observed blood per rectum, melena, or black tarry stool excluding hematemesis)
  - For signs and symptoms suggesting outlet-type bleeding (e.g., scant hematochezia, blood on toilet paper, small amount of blood on outside of stool)
    - Individuals age less than 40 years, colonoscopy is medically necessary when:
      - In the presence of alarm symptoms of unintentional weight loss or bowel habit changes, or if criteria for colonoscopy is met by other guidelines (e.g., iron-deficiency anemia, etc.)
      - Sigmoidoscopy does not reveal a local source of bleeding such as hemorrhoids or anal fissure
      - Findings on sigmoidoscopy or imaging suggest a need for further evaluation (e.g., inflammatory bowel disease, adenomatous polyp, etc.)
      - For elevated risk individuals with family history of colorectal polyps or cancer or other genetic predisposition to colonic cancer
    - Individuals age 40 years or older, colonoscopy is medically necessary
- Iron-deficiency anemia as manifested by a low hematocrit and/or hemoglobin AND one of the following:
  - Low serum iron
  - Low serum ferritin (≤45 ng/mL or <lab lower limit if higher than 45 ng/mL)
  - Elevated serum iron-binding capacity
  - Low serum transferrin saturation

Evidence Discussion

Lower GI bleeding (LGIB) accounts for 20-30% of major GI bleeding cases. The severity of LGIB can range from minor to life-threatening, and its incidence increases with age, making age as an important factor in determining appropriate diagnostic and therapeutic strategies.[26,27,77]

The characteristics of rectal bleeding should be carefully assessed. In individuals under age 40 with symptoms suggestive of outlet-type bleeding (e.g., bright red blood on toilet paper or stool surface) and no alarm features (such as iron deficiency anemia,

weight loss, or family history of colorectal cancer), flexible sigmoidoscopy may be considered as the initial evaluation. If sigmoidoscopy does not identify a source or if findings suggest more proximal pathology, colonoscopy is medically necessary.[26,27,77]

In individuals over age 40 years, colonoscopy should be the initial diagnostic test, given the increased risk of significant pathology such as neoplasia.[26,27,77]

Regardless of age, colonoscopy is medically necessary in individuals with the following:[26,27,77]

- melena
- hematochezia not suggestive of outlet-type bleeding
- positive fecal occult blood tests
- iron deficiency anemia

Abdominal Pain (COLON-10)

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- With respect to colonoscopy indications, isolated abdominal pain is usually localized to the lower abdomen. In general, isolated abdominal pain is a poor indication for colonoscopy but can be considered medically necessary in individual cases:
  - In **individuals ≥45 years of age**, colonoscopy is medically necessary if no prior screening or diagnostic colonoscopy has been performed.
    - A recent negative colonoscopy (for colon cancer screening or for other diagnostic/investigative purposes) reduces the need for repeat colonoscopy in the context of isolated abdominal pain or irritable bowel-type symptomatology, unless new alarm symptoms are present.
  - In **individuals <45 years of age**, colonoscopy may be medically necessary only if alarm symptoms are present.
    - See alarm symptoms under, **Irritable Bowel Syndrome/Change in Bowel Habits (COLON-6)** for colonoscopy indications.

Evidence Discussion

The goal of evaluating abdominal pain is to distinguish benign functional causes (e.g., irritable bowel syndrome) from serious pathology such as colorectal cancer, inflammatory bowel disease (IBD), gastrointestinal bleeding, or obstruction, which may require urgent intervention.[78]

A thorough history and physical exam should guide the diagnostic approach, with attention to the following:[78]

- Alarm symptoms including:
  - Rectal bleeding
  - Unintentional weight loss
  - Abdominal pain that awakens individual from sleep
  - Unexplained change in bowel habits
- Risk factors, such as:
  - Family history of colorectal cancer or with a known genetic predisposition to colonic cancer

Initial noninvasive work-up typically includes the following:[78]

- CBC
- Electrolytes
- Inflammatory markers (CRP, ESR)
- Stool calprotectin

- Liver function tests (LFTs)
- Lipase
- Iron studies
- Celiac serologies

In individuals aged 45 and over , the risk of malignancy increases, and screening colonoscopy is recommended if not previously performed.[78]

While colonoscopy is a valuable diagnostic and therapeutic tool, it carries a low but real risk of serious events, estimated at approximately 3 per 1000 screening colonoscopies. Those include adverse events of sedation-related complications, bleeding, and perforation.[78]

Older individuals are at a higher rate of serious adverse events, and careful risk-benefit assessment is advised.[78]

Unexplained Weight Loss (COLON-11)

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- Unintentional weight loss is defined as loss of ≥10 lbs. or ≥5% of body weight over 6 months or less, without an identifiable reason
  - colonoscopy as requested
- See also: **Unexplained Weight Loss (ONC-30.2)** in the Oncology Imaging Guidelines

Evidence Discussion

Unintentional weight loss is defined as an involuntary reduction of ≥10 lbs. or ≥5% of body weight over 6 months or less, without an identifiable reason. Gastrointestinal (GI) etiologies account for a substantial proportion of unexplained weight loss. Among these, inflammatory bowel disease (IBD), pancreatic cancer, and colorectal cancer are notable organic causes, while functional GI disorders such as irritable bowel syndrome (IBS) are also frequently implicated.[63,87]

Initial evaluation should include a comprehensive history, physical examination, and baseline laboratory studies. Suggested laboratory tests may include a complete blood count (CBC), comprehensive metabolic panel (CMP), thyroid-stimulating hormone (TSH), hemoglobin A1C, celiac serologies, and inflammatory markers such as ESR and c-reactive protein.[63,87]

Colonoscopy may be medically necessary in individuals with unexplained weight loss when accompanied by additional concerning features, including:[63,88]

- Lower abdominal pain
- Iron deficiency (with or without anemia)
- Gastrointestinal (GI) bleeding (overt OR occult)
- Change in bowel habits (diarrhea, constipation, or alternating pattern)
- Palpable abdominal mass

Abnormal Radiologic Study (COLON-12)

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- Colonoscopy is medically necessary when radiologic or other diagnostic imaging studies reveal abnormalities suggestive of colorectal pathology. The following criteria must be met:
  - The abnormality must be clearly documented in the medical record, including a description of the radiologic finding (e.g., colon wall thickening, colonic mass, or other structural changes).

Evidence Discussion

Radiologic findings such as colon wall thickening, colonic masses, or other structural abnormalities often warrant direct visualization and tissue sampling via colonoscopy. These findings may represent a range of conditions, including colorectal cancer, inflammatory bowel disease, or benign strictures, and cannot be reliably diagnosed or excluded by imaging alone.[78]

The 2024 American Society for Gastrointestinal Endoscopy (ASGE)/American College of Gastroenterology (ACG) Quality Indicators for Colonoscopy emphasize colonoscopy as the first-line diagnostic tool for evaluating suspected colorectal pathology identified on imaging.[78]

Colonoscopy is considered appropriate when imaging abnormalities are not explained by benign conditions, or when clinical symptoms persist despite empirical therapy. The updated guidelines also reinforce the importance of documenting the indication and expected impact on management, aligning with best practices for quality and safety in endoscopy.[78]

Repeat Colonoscopy for Inadequate Preparation (COLON-13)

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- Inadequate preparation on colonoscopy for screening or surveillance:
  - For cases in which the Boston Bowel Preparation Scale (BBPS) score is not available:
    - Repeat examination as per the endoscopist with documentation from prior colonoscopy report indicating the inadequacy of the preparation and the need for earlier-than-usual follow-up.
  - For BBPS score of 0 or 1 in any segment of the colon or a total score of 0 to 5:
    - Repeat examination as per the endoscopist
- Adequate preparation on colonoscopy for screening or surveillance
  - For a BBPS (Boston Bowel Prep Scale) score of 2 or 3 in all segments of the colon:
    - Repeat examination as per screening or surveillance guidelines

Evidence Discussion

The adequacy of bowel preparation is essential for optimal colonoscopy performance. Quality of a bowel preparation is defined as adequate when standard screening or surveillance intervals can be assigned based on the findings of the colonoscopy. The ability to detect adenomas and advanced adenomas is significantly hampered by inadequate bowel preparation.[79]

Patient-reported assessment of their own bowel preparation adequacy is unreliable. The Boston Bowel Preparation Scale (BBPS) has been found to be the most reliable and thoroughly validated. When a screening/surveillance colonoscopy is performed, the assessment of bowel preparation quality should be based on all segments of the colon. The endoscopist may exercise judgment in determining the adequacy of bowel preparation based on the overall likelihood of missing a clinically meaningful lesion.[79]

The ASGE/ACG recommends bowel preparation adequacy as a priority quality indicator for colonoscopy, with a performance target of 90% adequacy. When the bowel preparation is deemed inadequate to allow assigning standard screening or surveillance intervals, ASGE/ACG recommend completing a colonoscopy within 12 months for screening or surveillance colonoscopies. However, when the bowel preparation is deemed inadequate and the indication is for alarm symptoms (e.g., GI blood loss) or a positive nonendoscopic colorectal cancer screening test (e.g., fecal immunochemical

test), a colonoscopy with adequate bowel preparation should occur as soon as possible. The timing of the repeat colonoscopy should consider the date of onset of symptoms or the date when a nonendoscopic screening test was found to be positive.[79]

Bowel preparation adequacy is defined as BBPS ≥6 with each segment score of 2 OR 3.

General and Therapeutic Colonoscopy (COLON-14)

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- Removal of a foreign body
  - The nature of the suspected foreign body should be provided (e.g., battery, etc.)
- Treatment of a known bleeding source (e.g., radiation proctitis, arteriovenous malformation, etc.)
- Excision of a known colonic lesion
  - This would apply to a known polyp not previously resected. Documentation of the nature of the retained polyp should be provided (e.g., large polyp for which endoscopic mucosal resection is being planned)
  - For colon polyp surveillance, see: **Surveillance after Polypectomy (COLON-3)**
  - For surveillance after surgical or submucosal resection (SMR) or submucosal dissection (SMD), see: **Surveillance After Diagnosis of Colorectal Cancer (COLON-4)**
- Therapeutic treatment of megacolon or colonic volvulus
  - Documentation of the history should be provided
- Balloon-dilation of stenotic lesions
  - The nature of the stenosis should be specified (e.g., dilation of an anastomotic sigmoid stricture)
- Palliative treatment of stenosing or bleeding neoplasms
  - The type of neoplasm and location should be specified
- Marking a neoplasm for localization
  - The type of neoplasm and location should be specified
- Intra-operative colonoscopy for site identification at time of surgery
  - The nature of the planned surgical procedure should be specified (e.g., surgical treatment of a lesion)
- Colonoscopy via stoma is medically necessary to evaluate stoma complications (e.g., hernia, retraction, prolapse, stenosis, fistula, etc.)
- For change in bowel habits (CIBH), see: **Irritable Bowel Syndrome/Change in Bowel Habits (COLON-6)**

Background and Supporting

- Eosinophilic Gastrointestinal Disorders (EGIDs) other than EoE (eosinophilic esophagitis)
  - Non-EoE Eosinophilic gastrointestinal disorders (EGIDs) included eosinophilic gastritis (EoG), eosinophilic enteritis (EoN), and eosinophilic colitis (EoC). They are characterized by pathologic eosinophilic infiltration of the stomach, small intestine, or colon leading to organ dysfunction and clinical symptoms.
  - The initial laboratory evaluation is similar between EGID and other GI diseases. Peripheral eosinophilia, iron deficiency, or hypoalbuminemia should raise clinical suspicion of EGID.

Evidence Discussion

Colonoscopy is a direct visual examination of the lining of the large intestine using a flexible endoscope. The procedure allows inspection of the entire colon, from the rectum to the cecum, and may include the examination of the terminal ileum. A colonoscopy, by definition, must examine the colon proximal to the splenic flexure. The colonoscope is inserted via the anus or stoma, and then advanced under direct vision.[78]

A therapeutic colonoscopy is medically necessary for:[78]

- Removal of a foreign body
- Treatment of bleeding from such lesions as vascular anomalies, ulceration, and neoplasia
- Excision of a colon polyp
- Balloon dilation of a stenotic lesion
- Decompression of a sigmoid volvulus and/or an acute non-toxic megacolon or pseudo-obstruction associated with Ogilvie's Syndrome
- Palliative treatment of a stenosing or bleeding neoplasm
- Marking a neoplasm of localization
- Intraoperative colonoscopy for site identification at time of surgery
- Repair of a perforation when it is expected that such repair will most likely avoid further surgical intervention and further sugical intervention is not needed

Colonoscopy is contraindicated if the individual has:[89]

- Fulminant colitis
- Acute severe diverticulitis
- Suspected perforated viscus
  - A therapeutic colonoscopy by a trained endoscopist capable of repairing a perforation site may be allowed when the clinical findings and imaging studies strongly indicate that a perforation has occurred and the suspected site of the perforation allows for endoscopic repair

Genetic Syndromes (COLON-17)

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- **Lynch Syndrome** (Screening colonoscopy begins at the stated age as indicated below, or 5 years before the youngest age of diagnosis of colorectal cancer in an affected family member, whichever occurs first)
  - MLH1/MSH2 Mutation:
    - Annual colonoscopy beginning at age 20
  - MSH6/PMS2 Mutation:
    - Annual colonoscopy beginning at age 25
  - Deletions of upstream epithelial cell adhesion molecule gene (EpCAM):
    - Annual colonoscopy beginning at age 20
- **Li-Fraumeni Syndrome** (defined as a syndrome inherited in an autosomal-dominant manner, associated with germline mutations in TP53, and resulting in an increased susceptibility to a variety of cancers)
  - Colonoscopy every 2-5 years beginning at age 25 (or 5 years before the earliest known colon cancer in the family)
- **Polyposis Syndromes**
  - Familial Adenomatous Polyposis (confirmed by a mutation in the Adenomatous Polyposis Coli gene):
    - Annual colonoscopy beginning at age 10
  - Attenuated Familial Adenomatous (FAP):
    - Annual colonoscopy beginning at age 18
  - MUTYH-associated polyposis:
    - Annual colonoscopy beginning at age 25
  - Juvenile Polyposis Syndrome (defined as individuals with 5 or more juvenile polyps in the colorectum or any juvenile polyps in other parts of the GI tract, or evidence of SMAD4 or BMPRI1A mutations)
    - Colonoscopy beginning at age 12
      - If polyps are present, repeat yearly
      - If no polyps, repeat every 2 years
  - Serrated Polyposis Syndrome (defined as individuals with at least one of the following criteria: at least 5 serrated polyps proximal to the sigmoid colon with 2 or

more of these being ≥10 mm in size, any number of serrated polyps proximal to the sigmoid colon in an individual with a first-degree relative diagnosed with serrated polyposis, or more than 20 serrated polyps of any size distributed throughout the colon)

- Colonoscopy yearly

- Puetz-Jeghers Syndrome (individuals with perioral or buccal pigmentation and/or 2 or more histologically characteristic hamartomatous polyps, or family history of PJS, or STK11 mutations):
  - Colonoscopy beginning at age 8
    - If polyps are present, can be repeated every 3 years
    - If no polyps are discovered, repeat at age 18, then every 3 years, or earlier if any symptoms occur
- Cowden Syndrome (individuals with PTEN gene mutations, history of multiple gastrointestinal hamartomas or ganglioneuromas):
  - Colonoscopy beginning at age 15
    - If polyps are present, repeat as requested
    - If no polyps are discovered, colonoscopy can be repeated every 2 years

- **Family Colon Cancer X Syndrome** (individuals who meet Amsterdam I criteria* but lack genetic mutation findings):
  - Colonoscopy every 3 years beginning 10 years before the age at diagnosis of the youngest affected relative.
- **Hereditary Gastric Cancer** (Hereditary Diffuse Gastric Cancer-HDGC Syndrome):
  - Colonoscopy beginning at age 40. Interval has not been established.
- **Biallelic Mismatch Repair Deficiency (BMMRD)**
  - Colonoscopy annually beginning at age 6
    - Once polyps are found, colonoscopy is recommended every 6 months.
  - All heterozygous family members are eligible for Lynch Syndrome Screening (See above for Lynch Syndrome)
- **CHEK2 mutation**
  - Colonoscopy every 5 years beginning at age 40 years (or 10 years prior to the age at which at first-degree relative was diagnosed with colorectal cancer)
- **Cystic Fibrosis**
  - Individuals who have NOT received a solid organ transplant:
    - Colonoscopy every 5 years beginning at age 40 years
      - If any adenomatous polyps are found on colonoscopy, repeat colonoscopy within 3 years

        - Subsequent intervals based on the most recent endoscopic examination
    - Individuals who are ≥30 years of age and HAVE received a solid organ transplant:
        - Colonoscopy every 5 years beginning within 2 years of transplant (unless there is a negative colonoscopy within the past 5 years)
            - If any adenomatous polyps are found on colonoscopy, repeat colonoscopy within 3 years
            - Subsequent intervals based on the most recent endoscopic examination

Background and Supporting Information

- Lynch syndrome is caused by germline variants in one of the DNA mismatch repair (MMR) genes (MLH1, MSH2, MSH6, PMS2) or by deletions in the epithelial cell adhesion molecule gene (EpCAM). This increases susceptibility to colorectal, endometrial, and other tumors.
- High Risk Screening:
    - If there is no information regarding the pathology of the first-degree relative's polyp, it cannot be assumed that the adenomas or polyps were advanced, unless surgery was required to remove the polyp.
- *Amsterdam I Criteria
    - At least three relatives with colorectal cancer (CRC)
    - All of the following criteria should be present:
        - One should be a first-degree relative of the other two
        - At least two successive generations must be affected
        - At least one of the relatives with CRC must have received the diagnosis before the age of 50 years
        - Familial adenomatous polyposis should be excluded
        - Tumors should be verified by pathologic examination

Evidence Discussion

Cancer genetics summaries focus on the genetics of specific cancers that are inherited cancer syndromes.[65]

The goal and benefit of cancer surveillance is to identify a genetics-predisposed neoplastic process earlier in the course than standard procedure surveillance/screening recommendations in the absence of a genetic syndrome.[65]

The genetics of specific cancers include syndrome-specific information on the risk implications of a family history of cancer, the prevalence and characteristics of cancer-predisposing variants, known modifiers of genetic risk, opportunities for genetic testing,

outcomes of genetic counseling and testing, and interventions available for people with increased cancer risk resulting from an inherited predisposition.[65]

Endoscopy and colonoscopy surveillance recommendations are based on the recommended surveillance intervals for the specific genetic defect when possible, or presence of a genetic-associated specific neoplasm in the absence of genetic assessment.[65]

If a positive neoplastic finding is identified via surveillance, subsequent endoscopic testing is based on the shorter interval of either the genetic syndrome specific surveillance guideline or specific tumor follow-up Oncology recommendations.[65]

As this is a rapidly changing field, clinical judgment in conjunction with recommended guidelines for specific genetic tumor syndromes are considered when supported by national guidelines.[65]

Colonoscopy After Noninvasive Testing (COLON-18)

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- Colonoscopy is medically necessary after an abnormal result on a noninvasive colon cancer screening test (e.g., fecal occult blood test (FOBT), fecal immunochemical test (FIT), serum-based screening test, or stool-based DNA test such as Cologuard®)
- Colonoscopy is medically necessary if the individual had a prior negative screening colonoscopy, but later received an abnormal result on a noninvasive colon cancer screening test (as listed above)

Evidence Discussion

Occult Blood and Positive Cologuard

Options for colon cancer screening other than colonoscopy include non-invasive options. These options are fecal occult blood tests, FIT (fecal immunochemical test), serum-based tests, and multitarget stool based DNA tests (Cologuard®). Colonoscopy is indicated for positive result of any of the above tests. Screening tests should be performed starting at age 45 and older with an average risk of colon cancer. FIT testing should be done annually, cologuard every 3 years.[31-33,36]

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Guideline

References

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