

Effective: October 1, 2026

<p>Prior Authorization Required If <u>REQUIRED</u>, submit supporting clinical documentation (electronically recommended or by fax)</p>	<p>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p>
<p>Applies to:</p> <ul style="list-style-type: none"> • Harvard Pilgrim Health Care Commercial products • Tufts Health Direct (THP Direct) <p>We recommend submitting prior authorization electronically. If you opt to submit prior authorization requests via fax, please refer to this reference chart for the appropriate fax number (varies by product).</p> <p>For details on all our products, please visit the Our Plans page on our provider website. For additional Prior Authorization and Notification details on other lines of business not listed on our Medical Necessity Guidelines page, please also reference our Prior Authorization Resources page.</p>	

Note: While you may not be the provider responsible for obtaining prior authorization or notifying Point32Health, as a condition of payment you will need to ensure that any necessary prior authorization has been obtained and/or Point32Health has received proper notification. If notification is required, providers may additionally be required to provide updated clinical information to qualify for continued service.

Overview

Colonoscopy is an endoscopic procedure in which a colonoscope—a thin, flexible tube equipped with a camera—is inserted through the anus to directly see the mucosal lining of the rectum and entire colon. This procedure allows for the detection and evaluation of abnormalities, including inflammation, polyps, and malignant or premalignant lesions.

Colorectal cancer (CRC) is among the most common malignancies in the United States and remains a leading cause of cancer-related mortality. For 2026, an estimated 158,850 new cases of colorectal cancer and 55,230 deaths are projected nationwide. Widespread colorectal cancer screening has contributed to substantial declines in CRC incidence and mortality among adults aged 50 years and older over the past several decades. In the United States, colonoscopy is considered the gold standard for colorectal cancer (CRC) screening in individuals at average risk for developing CRC. Screening colonoscopy plays a critical role in the early detection and removal of precancerous lesions and early-stage cancers, thereby reducing CRC incidence and mortality.

Colonoscopy is also used diagnostically to evaluate signs or symptoms suggestive of colorectal disease, such as gastrointestinal bleeding, iron deficiency anemia, or changes in bowel habits, and to assess individuals with abnormal results from other CRC screening tests. In addition, colonoscopy is utilized for post treatment surveillance following the detection and removal of cancerous or precancerous lesions, as well as for monitoring certain chronic conditions affecting the colon and rectum.

Clinical indications for screening, diagnostic, and surveillance colonoscopy are guided by evidence based recommendations from specialty societies and governmental organizations. Coverage determinations for the indications outlined in this medical necessity guideline are aligned with these guidelines, and when supported by the member’s clinical presentation, medical history, and risk factors.

Clinical Guideline Coverage Criteria

The Plan considers colonoscopies as reasonable and medically necessary for the following:

Screening Colonoscopies- Average-Risk Members

1. For average risk, asymptomatic Members when all of the following are met:
 - a. Member is 45 years of age or older (every 10 years, beginning at age 45, provided prior colonoscopy was normal);
 - b. There is no personal history of any of the following:
 - c. Colorectal cancer (CRC);
 - d. Adenomatous polyps or sessile serrated lesions;
 - e. Inflammatory bowel disease;
 - f. No family history of colorectal cancer or advanced adenomas in a first-degree relative.

Surveillance Colonoscopies – Increased or High-Risk Members

1. The Member has a personal history of colorectal cancer and any of the following apply:
 - a. Colonoscopy is medically necessary for surveillance following curative resection of CRC:
 - i. To rule out synchronous lesions if not previously performed;
 - ii. At 1 year following curative resection;
 - iii. At 3 years after the 1-year exam if findings are normal;
 - iv. Every 5 years thereafter, based on findings and clinical judgement.
2. The Member has a personal history of Adenomatous polyps or sessile serrated lesions and all the following apply:
 - a. Surveillance intervals are determined based on prior colonoscopy findings as seen below:
 - i. 1–2 small (<10 mm) tubular adenomas without high grade dysplasia. Repeat colonoscopy in 7-10 years;
 - ii. 3–10 adenomas, any adenoma \geq 10 mm, villous features, or high grade dysplasia. Repeat colonoscopy in 3 years;
 - iii. >10 adenomas on a single examination. Repeat colonoscopy < 3 years, based on clinical judgement.
3. There is a family history of colorectal cancer or advanced adenomas and any the following apply:
 - a. The Member has one first-degree relative with CRC or advanced adenoma diagnosed at any age:
 - i. Screening initiation at age 40 or 10 years earlier than the age of diagnosis of the youngest affected relative (whichever comes first) (Frequency: every 5 years or more frequently based on findings).
4. The Member has Inflammatory Bowel Disease (Ulcerative Colitis or Crohn’s Colitis)
 - a. Surveillance colonoscopy should begin 8 years after onset of colitis;
 - b. Repeated every 1-3 years, depending on risk factors and findings;
 - c. Members with primary sclerosing cholangitis; annual colonoscopy beginning at diagnosis.

Diagnostic Colonoscopy– Increased or High-Risk Members

1. Members are considered “high risk” due to certain medical conditions, including:
 - Amebiasis
 - Infectious gastroenteritis and colitis
 - Tuberculosis of other organs (including intestinal)
 - HIV disease
 - Streptococcus/Enterococcus as cause of diseases
 - Malignant neoplasm of colon
 - Malignant neoplasm of rectosigmoid junction
 - Malignant neoplasm of rectum
 - Malignant neoplasm of anus and anal canal
 - Malignant neoplasm of other digestive organs
 - Gastrointestinal stromal tumors (GIST)
 - Malignant neuroendocrine tumors

- Malignant neoplasm of other ill-defined sites
- Secondary malignant neoplasm of lymph nodes
- Secondary malignant neoplasm of digestive organs
- Disseminated/unspecified malignant neoplasm
- Carcinoma in situ of digestive organs
- Carcinoma in situ of colon/rectum/anus
- Benign neoplasm of colon/rectum/anus
- Benign neoplasm of other digestive organs
- Benign neuroendocrine tumors
- Neoplasm of uncertain behavior (digestive organs)
- Neoplasm of unspecified behavior
- Iron deficiency anemia
- Acute posthemorrhagic anemia
- Cystic fibrosis
- Phakomatoses / hereditary cancer syndromes
- Infective endocarditis
- Hereditary hemorrhagic telangiectasia
- Crohn's disease
- Chronic diarrhea of unknown etiology after initial evaluation
- Ulcerative colitis
- Noninfective gastroenteritis and colitis
- Vascular disorders of intestine
- Intestinal obstruction/ileus
- Diverticular disease of intestine
- Irritable bowel syndrome
- Functional intestinal disorders
- Diseases of anus and rectum
- Other diseases of intestine
- Postprocedural digestive complications
- Other digestive system diseases (includes GI bleeding)
- Acanthosis nigricans
- Bladder disorders (incl. fistula)
- Female genital tract fistulas
- Nausea and vomiting
- Other digestive symptoms (e.g., change in bowel habits)
- Abnormal imaging findings
- Foreign body in alimentary tract
- Screening for malignant neoplasms
- Genetic susceptibility to malignant neoplasm
- Family history of malignant neoplasm
- Family history of digestive disorders
- Personal history of malignant neoplasm
- Personal history of benign neoplasm
- Unexplained gastrointestinal bleedings, including hematochezia and melena after exclusion of upper GI source
- Abnormal findings on imaging suggestive of colorectal pathology
- Suspected or established inflammatory bowel disease

Therapeutic Colonoscopy

1. Therapeutic colonoscopy is indicated for any of the following:
 - a. Polyp removal
 - b. To stop bleeding
 - c. Stricture or obstruction treatment
 - d. Tumor ablation
 - e. Foreign body removal
 - f. Decompression

Limitations

The Plan considers Colonoscopies as not medically necessary for all other indications in addition to the following:

1. Routine screening at intervals more frequent than recommended without clinical justification
2. Evaluation of chronic, stable irritable bowel syndrome without alarm features (e.g., weight loss, fever, or anemia).
3. Chronic abdominal pain in the absence of concerning symptoms
4. Acute, self-limited diarrhea

Codes

The following codes are considered medically necessary when submitted with an appropriate ICD-10 diagnosis code:

Table 1: CPT/HCPCS Codes

Code	Description
45385	Colonoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique
45380	Colonoscopy, flexible; with biopsy, single or multiple
45378	Colonoscopy, flexible; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)

[Medically Necessary ICD-10 Codes](#)

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Approval And Revision History

May 20, 2026: Reviewed by the Medical Policy Approval Committee (MPAC), effective October 1, 2026.

Background, Product and Disclaimer Information

Medical Necessity Guidelines are developed to determine coverage for benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. We make coverage decisions using these guidelines, along with the Member's benefit document, and in coordination with the Member's physician(s) on a case-by-case basis considering the individual Member's health care needs.

Medical Necessity Guidelines are developed for selected therapeutic or diagnostic services found to be safe and proven effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in our service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. We revise and update Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Medical Necessity Guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern. For Tufts Health Together (Medicaid), coverage may be available beyond these guidelines for pediatric members under age 21 under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits of the plan in accordance with 130 CMR 450.140 and 130 CMR 447.000, and with prior authorization.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of this guideline is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to eligibility and benefits on the date of service, coordination of benefits, referral/authorization, utilization management guidelines when applicable, and adherence to plan policies, plan procedures, and claims editing logic.