CareSource

REIMBURSEMENT POLICY STATEMENT
Marketplace

Policy Name & Number	Date Effective
Diagnostic Colonoscopy and/or Sigmoidoscopy-MP-PY-1594	09/01/2026
Policy Type	
REIMBURSEMENT	

Reimbursement Policies are intended to provide a general reference regarding billing, coding, and documentation guidelines. Coding methodology, regulatory requirements, industry-standard claims editing logic, benefits design, and other factors are considered in developing Reimbursement Policies. Reimbursement Policies do not guarantee authorization or payment for services. Coverage and payment determinations are subject to member benefits and eligibility on the date of service, medical necessity, adherence to plan policies and procedures, claims editing logic, provider contractual agreements, and applicable referral, authorization, notification, and utilization management guidelines.

Please refer to the plan contract (e.g., Evidence of Coverage, Member Handbook) for the service(s) referenced herein. Except as otherwise required by law, if there is a conflict between the Reimbursement Policy and the plan contract and/or provider agreement, then the plan contract and/or provider agreement will be the controlling document used to make the determination. Reasonable discretion may be used in interpreting and applying this policy to services provided in a particular case and the policy may be modified at any time. Reimbursement policies may be superseded by federal and state laws and regulations, as applicable. In the case of a discrepancy between the Policy Statement's effective date and any applicable legal or regulatory requirement, the law or regulation will govern.

Coverage for mental health and substance use disorder (MH/SUD) benefits are provided at the same level as coverage for medical and surgical (M/S) benefits, as required by the Mental Health Parity and Addiction Equity Act (MHPAEA). MH/SUD benefits are not subject to limits or requirements that are more restrictive than those that apply to M/S benefits.

This policy applies to the following Marketplace(s):			
☒ **Georgia**	☒ **Indiana**	☒ **Ohio**	☒ **West Virginia**

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A. Subject
Diagnostic Colonoscopy and/or Sigmoidoscopy

B. Background
Colonoscopies and sigmoidoscopies pertain to procedures that involve direct visual examination of the lower gastrointestinal tract using a flexible tube fitted with a camera. The procedures identify polyps, tumors, and other intestinal irregularities or health issues and are performed by medical professionals, typically gastroenterologists or colorectal surgeons. Both procedures are valuable tools in diagnosing and monitoring gastrointestinal conditions. Specific clinical indications and area of examination determine which procedure will be utilized.

There are different billing procedures for screening versus diagnostic colonoscopies and sigmoidoscopies. Screening procedures are typically performed as part of preventive services for cancer or other health issues. Diagnostic procedures may be performed in the presence of symptoms, abnormal findings, prior abnormal screening results, or other clinical indications supporting diagnostic evaluation. Some screening procedures can become diagnostic procedures when abnormal findings are identified requiring intervention, biopsy, polypectomy, or additional evaluation. Both screening and diagnostic procedures utilize the same equipment, so providers must maintain thorough documentation in the member's medical record to substantiate medical necessity of these tests and differentiate between screening and diagnostic tests.

This policy exclusively pertains to diagnostic colonoscopies and does not apply to preventive screenings that follow US Preventive Services Task Force (USPSTF) or other preventive guidelines. Refer to the appropriate Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) codes for screenings (ie, G0104, G0105, G0121). Providers are encouraged to use modifiers when procedures meet modifier criteria.

C. Definitions
- **Colonoscopy** – A procedure in which a provider inserts a flexible tube fitted with a camera through the anus into the rectum to examine the entire length of the colon from the rectum to the cecum and may include the terminal ileum allowing for screening and diagnosis of health issues.
- **Sigmoidoscopy** – A procedure similar to a colonoscopy that examines the lower third of the large intestine, the rectum, sigmoid colon and possibly a portion of the descending colon, for screening and diagnosing health conditions.

D. Policy
I. CareSource requires appropriate documentation of medical necessity and valid diagnosis codes for reimbursement of diagnostic colonoscopies and sigmoidoscopies. Claims submitted without supporting medical necessity or correct coding will be denied. Documentation requirements include
   A. an assessment of the member by the ordering provider as related to the complaint for that visit
   B. relevant medical history

C. results of pertinent tests/procedures, if known, or if results are normal or did not provide a diagnosis during a diagnostic colonoscopy, the symptom(s) for which the endoscopy was performed
D. signed and dated office visit record/operative report
E. precise areas scoped and depth reached during the procedure

II. CareSource follows Centers for Medicaid and Medicare Services (CMS) guidelines regarding billing for diagnostic colonoscopies and sigmoidoscopies.
A. Reimbursement requests must include a procedure code with a diagnosis code that best describes the condition for which the service was performed.
B. If the service begins as a screening procedure but results in a diagnostic or therapeutic procedure at the same operative session, health care providers should report an appropriate screening International Classification of Diseases (ICD) diagnosis code as the primary diagnosis and the diagnostic or abnormal finding ICD diagnosis code as the secondary or subsequent diagnosis.
C. If the member is symptomatic or the claim for these services indicates a primary diagnosis of something other than preventive or wellness, colonoscopy examinations will be covered under a diagnostic benefit, not a Preventive Health Care Services benefit.

E. Conditions of Coverage

I. ICD-10 codes must be coded to the highest level of specificity. CareSource develops reimbursement policy guidelines following evaluation and validation of provider billing in accordance with various methodologies (eg, CPT publications, AMA publications, Medicare). CareSource uses clinical editing software to evaluate the accuracy of diagnosis and procedure codes on submitted claims to ensure that claims are processed consistently, accurately and efficiently and strives to follow the prevailing National Correct Coding Initiative (NCCI) edits as maintained by CMS. Coding industry standards, such as the *CPT Manual*, *CCI* and input from medical specialty societies, are used to review multiple aspects of a claim for coding reasonableness, including diagnosis to procedure matching, currently valid CPT/HCPCS codes, modifier usage or bundling issues. Any specific claim is subject to current CareSource claim logic and other established coding benchmarks. Any consideration of a provider's claim payment concern regarding clinical edit logic will be based upon review of generally accepted coding standards and the clinical information particular to the specific claim in question.

II. CareSource reserves the right to request medical record documentation from providers.

F. Related Policies/Rules

Medical Necessity Determinations
Modifiers

G. Review/Revision History

	DATE	ACTION
Date Issued	03/26/2025	New policy. Approved at Committee.

Date Revised	06/17/2026	Review: updated background and references. Approved at Committee.
Date Effective	09/01/2026	
Date Archived		

H. References

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