HAP CareSource™

REIMBURSEMENT POLICY STATEMENT
Michigan Marketplace

Policy Name & Number	Date Effective
Diagnostic Colonoscopy and/or Sigmoidoscopy-MI MP-PY-1595	07/01/2025
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.

In addition to this policy, reimbursement of services is 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. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased, or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any federal or state coverage mandate, Evidence of Coverage or Certificate of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other plan policies and procedures.

This policy does not ensure an authorization or reimbursement of services. Please refer to the plan contract (often referred to as the Evidence of Coverage or Certificate of Coverage) for the service(s) referenced herein. Except as otherwise required by law, if there is a conflict between the Administrative Policy Statement and the plan contract, then the plan contract will be the controlling document used to make the determination. We may use reasonable discretion in interpreting and applying this policy to services provided in a particular case and we may modify this Policy at any time.

According to the rules of Mental Health Parity Addiction Equity Act (MHPAEA), coverage for the diagnosis and treatment of a behavioral health disorder will not be subject to any limitations that are less favorable than the limitations that apply to medical conditions as covered under this policy.

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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 can include patient signs or symptoms in the lower gastrointestinal tract (eg, constipation, rectal bleeding, blood in stool, diarrhea), polyps within the past 10 years, or other positive-stool-based tests or computed tomography (CT) colonographies that require follow-up. Similarly, some screening procedures can become diagnostic procedures if practitioners find health issues to address (eg, mass needing biopsy, polyps) while performing initial screening procedures. Both screening and diagnostic procedures are performed similarly using the same equipment so it is imperative to maintain thorough documentation in the member's medical records to substantiate medical necessity of these 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 physician 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. HAP 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. HAP 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. HAP CareSource develops reimbursement policy guidelines following evaluation and validation of provider billing in accordance with various methodologies (eg, CPT publications, AMA publications, Medicare). HAP 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 HAP 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. HAP CareSource reserves the right to request medical record documentation from providers.

The REIMBURSEMENT Policy Statement detailed above has received due consideration as defined in the REIMBURSEMENT Policy Statement Policy and is approved.

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		
Date Effective	07/01/2025	
Date Archived		

H. References

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2. Colonoscopy ACG: A-0129. MCG. 28th ed. Updated March 14, 2024. Accessed March 12, 2025. www.careguidelines.com
3. Colonoscopy. American Cancer Society. Accessed March 12, 2025. www.cancer.org
4. Diagnostic X-Ray Tests, Diagnostic Laboratory Tests, and Other Diagnostic Tests: Conditions. 42 CFR § 410.32 (2024).
5. Flexible sigmoidoscopy. Mayo Clinic. Accessed March 12, 2025. www.mayoclinic.org
6. *HAP Marketplace Evidence of Coverage*. HAP CareSource; 2025. Accessed March 12, 2025. www.CareSource.com
7. *HAP Marketplace Provider Manual.* HAP CareSource; 2025. Accessed March 12, 2025. www.CareSource.com
8. LCD Reference Article: Billing and Coding: Colonoscopy and Sigmoidoscopy-Diagnostic. Medicare Coverage Database; 2019. LCA ID A56394. Revised January 1, 2025. Accessed March 12, 2025. www.cms.gov
9. Local Coverage Determination: Colonoscopy and Sigmoidoscopy-Diagnostic. Medicare Coverage Database; 2015. LCD ID L34614. Revised August 29, 2024. Accessed March 12, 2025. www.cms.gov
10. Sigmoidoscopy ACG: A-0128. MCG. 28th ed. Updated March 14, 2024. Accessed March 12, 2025. www.careguidelines.com