



REIMBURSEMENT POLICY STATEMENT

Georgia Medicaid

Policy Name & Number	Date Effective
Diagnostic Colonoscopy and/or Sigmoidoscopy-GA MCD-PY-1598	08/01/2025
Policy Type	
REIMBURSEMENT	

Reimbursement Policies prepared by CareSource and its affiliates 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 agreement, 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 documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other 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) for the service(s) referenced herein. If there is a conflict between this Policy and the plan contract (i.e., Evidence of Coverage), then the plan contract (i.e., Evidence of Coverage) will be the controlling document used to make the determination. CareSource and its affiliates may use reasonable discretion in interpreting and applying this Policy to services provided in a particular case and 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 utilize the same equipment, so it is imperative to maintain thorough documentation in the member's medical records to substantiate medical necessity of these tests and differentiate between screening and diagnostic services.

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. CareSource follows the Georgia Department of Community Health (DCH) *Provider Manuals* and information, as well as the Georgia Code. Any information provided in those sources supersede this policy, which is provided as a courtesy only.

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. 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. Refer to the appropriate DCH provider manual for assistance with documentation.
- II. CareSource follows DCH 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 as a diagnostic service, not a preventive health care service.
- III. If, during a screening colonoscopy and/or sigmoidoscopy, a lesion or growth is detected that results in a biopsy or removal, the appropriate diagnostic procedure classified with biopsy or removal should be billed, not screening codes. All procedures must be performed by a Doctor of Medicine or Osteopathy.

E. Conditions of Coverage

- I. ICD-10 codes must be coded to the highest level of specificity.
- II. CareSource reserves the right to request medical record documentation from providers.

F. Related Policies/Rules

Medical Necessity Determinations

G. Review/Revision History

	DATE	ACTION
Date Issued	03/26/2025	New policy. Approved at Committee.
Date Revised		
Date Effective	08/01/2025	
Date Archived		

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

H. References

1. American Society for Gastrointestinal Endoscopy Standards of Practice Committee; Early DS, Ben-Menachem T, Decker G, et al. Appropriate use of GI endoscopy. *Gastrointest Endosc.* 2012;75(6):1127-1131. doi:10.1016/j.gie.2012.01.1
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. Flexible sigmoidoscopy. Mayo Clinic. Accessed March 12, 2025. www.mayoclinic.org
5. *Policies and Procedures for Physician Services, Part II.* Georgia Department of Community Health. Revised January 1, 2025. Accessed March 12, 2025. www.mmis.georgia.gov
6. Sigmoidoscopy ACG: A-0128. MCG. 28th ed. Updated March 14, 2024. Accessed March 12, 2025. www.careguidelines.com

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Approved DCH 05/07/2025

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