HEALTHHELP®

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2026 Colonoscopy

Specialty Services

ENDO-COLON-HH

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Last Review Date: 12/17/2025
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Guideline Initiated: 08/05/2020

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Contraindications for Routine Screening Colonoscopy

Contraindications for a routine screening colonoscopy include multiple screening strategies simultaneously (eg, stool DNA testing every 3 years **AND** virtual colonoscopy screening every 5 years).[1]

Contraindications to Colonoscopy

Contraindications to having a colonoscopy include **ANY** of the following:

1. Absolute contraindication, including **ANY** of the following:
    a. Acute abdomen
    b. Bowel injury and repair
    c. Bowel perforation is documented or suspected from symptoms.
    d. Diverticulitis, acute episode that is symptomatic.
    e. Hemodynamic instability
    f. Inflammatory bowel disease (IBD), acute episode
    g. Patient refusal
    h. Peritonitis is suspected.
    i. Recent myocardial infarction
    j. Recent surgery with colonic anastomosis
    k. Risk to patient outweighs benefits of procedure
2. Comorbid conditions that are active and increase risk (eg, abdominal aneurysm, area adhesions, post procedure in-area).

References: [2]

[1]For specialty society recommendations, see: American Cancer Society (ACS), "American Cancer Society Guideline for Colorectal Cancer Screening," available: www.cancer.org/health-care-professionals/american-cancer-society-prevention-early-detection-guidelines/colorectal-cancer-screening-guidelines.html and the U.S. Preventive Services Task Force (USPSTF) Bulletin, "U.S. Preventive Services Task Force Final Recommendation on Screening for Colorectal Cancer," available: www.uspreventiveservicestaskforce.org.

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Colonoscopy

Colonoscopy Related National Coverage Determination (NCD)/ Local Coverage Determination (LCD)

Please refer to https://www.cms.gov/medicare-coverage-database/search.aspx if applicable to the individual's healthplan membership.

Type/ID Number	Title
NCD 100.2	Endoscopy
LCD 33671	Diagnostic Colonoscopy
LCD 34005	Colonoscopy/Sigmoidoscopy/Proctosigmoidoscopy
LCD 34213	Diagnostic and Therapeutic Colonoscopy
LCD 34454	Colonoscopy/Sigmoidoscopy/Proctosigmoidoscopy
LCD 34614	Colonoscopy and Sigmoidoscopy-Diagnostic
LCD 38812	Diagnostic Colonoscopy

Colonoscopy Guideline

Screening

A screening colonoscopy is considered medically appropriate when the documentation demonstrates **ANY** of the following situations:

1. Average risk individuals for routine screening for colorectal cancer (CRC) when **ANY** of the following are true:
    a. Age 45 to 75 years and **ANY** of the following:
        i. **NO** colonoscopy in the last 10 years
        ii. **NO** sigmoidoscopy in the last 5 years (with/without annual immunochemical or guaiac-based fecal occult blood testing [gFOBT])
        iii. Hyperplastic polyp(s) with **NO** evidence of colonoscopy in the last 10 years.
        iv. Stool based testing (eg, Cologuard) greater than 3 years ago **AND NO** prior colonoscopy
    b. Age 76 years and older:
        i. The role of this therapy is uncertain/unclear in the current evidence. Requests for this therapy require review by a physician reviewer, medical director and/or the individual's healthplan.

References: [1] [19] [16] [22] [9] [17] [21] [13] [15] [4]

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2. High risk individuals for screening for colorectal cancer and **ANY** of the following:
    a. Cowden syndrome is known; colonoscopy is recommended starting at age 35 years, unless symptomatic or close relative with colorectal cancer (CRC), then start 5 to 10 years before the earliest known CRC in the family **AND** interval colonoscopy every 5 years.
    b. Family history of familial adenomatous polyposis; colonoscopy is recommended at puberty, then every 12 months. If no adenomas found, colonoscopy every 2 years starting at 16 years old.
    c. Family history of hereditary non-polyposis (eg, Lynch syndrome, Li-Fraumeni syndrome) colorectal cancer (HNPCC); colonoscopy is recommended starting at 20 years old or 2 to 5 years before the earliest CRC if it is diagnosed before 25 years old **AND** interval colonoscopy every 1 to 2 years.
    d. First-degree relative (child, parent, sibling) who was diagnosed with colon cancer at age 59 years or younger: colonoscopy is recommended starting at age 40 years or 10 years before the youngest affected relative, whichever is earlier **AND** interval colonoscopy every 5 years.
    e. First-degree relative with hyperplastic (serrated) polyposis syndrome; colonoscopy is recommended starting at age 40 years or 10 years before the youngest affected relative, whichever is earlier **AND** interval colonoscopy every 5 years.
    f. Juvenile polyposis syndrome **AND** age 12 or older with evidence of polyps on previous screening with **NO** evidence of colonoscopy in last 12 months.
    g. Juvenile polyposis syndrome **AND** age 12 or older with **NO** evidence of polyps on previous screening and **NO** evidence of colonoscopy in last 24 months.
    h. MUTYH-associated polyposis in siblings; colonoscopy is recommended starting at age 25 years **AND** interval colonoscopy every 1 to 2 years.
    i. Peutz-Jeghers syndrome **AND** age 8 or older with **NO** evidence of colonoscopy in the past 24 months, if polyp(s) were previously found. If **NO** history of polyp(s) **AND** age 18 or older with **NO** evidence of colonoscopy in the last 36 months.
    j. Second (aunt/uncle, grandparent, nephew/niece) or third-degree (first cousins, great-grandchildren, great-grandparents) relative with history of colorectal cancer; colonoscopy is recommended to start at age 45 years **AND** interval colonoscopy every 10 years.

References: [19] [1] [13] [15] [6] [3] [4] [14] [18]

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Diagnostic Testing

Diagnostic testing colonoscopy may be medically appropriate when the medical record demonstrates **ANY** of the following signs and symptoms:

1. Barium enema or other imaging is abnormal.
   References: [23]
2. Fecal immunochemical test (FIT), FIT DNA test or Fecal occult blood test is positive.
   References: [23]
3. High risk for colorectal cancer (eg, adenomatous polyps or CRC personal/family history [diagnosed before age 60 years], inflammatory bowel disease history, hereditary CRC syndrome is suspected or known, prior abdominal/pelvic radiation cancer treatment history) and **ALL** of the following:
   a. **ANY** of the following:
      i. Colorectal surgery planned and colonoscopy recommended to view entire colon and remove all polyps intraoperatively.
      ii. Curative resection for colon or rectal cancer and **ANY** of the following:
         A. 1 year or less post-op and **NO** evidence of colonoscopy **OR** at least 1 year has passed after colonoscopy to ensure the rest of the colon/ rectum was clear.
         B. Post-operative colonoscopy results were normal and **NO** evidence of colonoscopy within 3 years.
         C. Prior 2 colonoscopy results were normal and **NO** evidence of colonoscopy in previous 5 years.
      iii. **NO** colonoscopy within 1 year after primary resection of colon or rectal cancer, to exclude new lesions.
      iv. **NO** evidence of colonoscopy within 3 to 6 months, following low anterior resection for rectal cancer to look for signs of recurrence (eg, abdominal pain, change in bowel habits, constipation, diarrhea, iron deficiency anemia and rectal bleeding).
      v. Post-operative colonoscopy (within 1 year) was normal, **NO** unresectable metastases were found during surgery, and **NO** evidence of subsequent follow-up colonoscopy within 3 years.
   b. Colon and/or rectal cancer diagnosis

   References: [23] [12] [4] [10] [7] [13]

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4. Inflammatory bowel disease (IBD) is suspected or known **AND** high risk for colorectal cancer (eg, adenomatous polyps or CRC personal/family history [diagnosed before age 60 years], inflammatory bowel disease [IBD] history, hereditary CRC syndrome is suspected or known, prior abdominal/pelvic radiation cancer treatment history) with **ANY** of the following:
    a. Chronic ulcerative colitis, Crohn's disease or other forms of IBD **AND NO** evidence of colonoscopy in the past year.
    b. IBD with primary sclerosing cholangitis (PSC) **AND NO** evidence of colonoscopy in the past year (beginning at the time of PSC diagnosis).
    c. Initial colonoscopy
    d. Surveillance colonoscopy needed **AND NO** evidence of colorectal cancer screening in the past 12 months.

    References: [23]
5. Iron deficiency anemia
    References: [23]
6. Polyps, with **ANY** of the following:
    a. Adenomas total over 10 on a single exam **AND NO** evidence of colonoscopy within 1 year of polyps removal.
    b. History of incomplete resection of a polyp during the last colonoscopy
    c. Hyperplastic rectal or colon polyp(s) that are less than 10 mm **AND NO** evidence of colonoscopy in the last 10 years.
    d. Piecemeal resection of a large polyp 2 cm or more **AND NO** evidence of colonoscopy in the last 6 months.
    e. Polypectomy, initial, within the last 3 years and adenomas have been completely removed and **ALL** the following:
        i. Adenomas that are **ANY** of the following:
            A. Adenomas, 3 to 10
            B. Adenoma is more than 1 cm.
            C. Adenoma(s) with high grade dysplasia or villous features (eg, villous/tubulovillous polyp)
        ii. **ANY** of the following:
            A. At least 5 years since prior colonoscopy (following polypectomy) was normal

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B. Prior colonoscopy showed only 1 or 2 small tubular adenomas with low grade dysplasia.

C. **NO** colonoscopy in the last 3 years

f. Sessile serrated polyp(s), 1 to 2 that are less than 10mm **AND NO** evidence of colonoscopy in the last 5 years.

g. Sessile serrated polyp(s), 3 to 10 sessile serrated adenomas **AND NO** evidence of colonoscopy in the last 3 years.

h. Sessile serrated polyp(s) that are removed in pieces **AND NO** evidence of colonoscopy within 3 to 6 months following adenoma removal.
(**NOTE:** *if entire adenoma has been removed, further testing should be based on the physician's judgment)*.

i. Sessile serrated polyp(s) that is more than 10mm **AND NO** evidence of colonoscopy in the last 3 years.

j. Sessile serrated polyp(s) with dysplasia **AND NO** evidence of colonoscopy in the last 3 years.

k. Tubular adenomas, 1 to 2 small (less than 1 cm) with low grade dysplasia **AND NO** evidence of colonoscopy within the past 7 to 10 years after polyp removal.

References: [23] [4] [5]

7. Symptoms, when prior imaging or testing is non-diagnostic or indeterminate, include **ANY** of the following:

   a. Abdominal pain

   b. Bowel habit changes (eg, color, constipation, diarrhea, frequency)

   c. Rectal bleeding

References: [23] [11]

NOTE
Time between tests is based on other factors such as prior colonoscopy findings, quality of bowel preparation during prior colonoscopy, family history and individual and physician preferences.

Full-Spectrum Endoscopy (FUSE) Colonoscopy

For a full-spectrum endoscopy (FUSE) colonoscopy:

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1. The role of this therapy is uncertain/unclear in the current evidence. Requests for this therapy require review by a physician reviewer, medical director and/or the individual's healthplan.

References: [8]

Colonoscopy Procedure Codes

Table 1. Colonoscopy Associated Procedure Codes

CODE	DESCRIPTION
45378	Colonoscopy, flexible; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)
45380	Colonoscopy, flexible; with biopsy, single or multiple

Colonoscopy Summary of Changes

Colonoscopy guideline from 2025 to 2026 had the following changes:

Table 1. 2026 Colonoscopy Summary of Changes

Date	Type of Change	Summary

12/17/2025	Annual Review	• Added the following to "High risk individuals for screening for colorectal cancer" per current research:
		  ▪ Cowden syndrome
		  ▪ MUTYH-associated polyposis
		• Combined "Family history positive for colorectal cancer or adenomatous polyps" with "Hereditary non-polyposis colorectal cancer (HNPCC), Lynch syndrome, and polyposis syndrome" and renamed to "High risk individuals for screening for colorectal cancer" per current research
		• Moved "Hyperplastic polyps" to "average risk individuals" per current research
		• Moved the following to "high risk individuals" per current research:
		  ▪ Hyperplastic (serrated) polyposis syndrome
		  ▪ Juvenile polyposis
		  ▪ Peutz-Jehgers syndrome
		• Removed LCD 36868 as it is retired
		• Removed the following from "High risk individuals for screening for colorectal cancer" per current research:
		  ▪ First-degree relative who was diagnosed at 60 years of age or older
		  ▪ Second-degree relative, two related

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Colonoscopy Definition Section

Adenoma is a benign tumor formed from glandular structures in epithelial tissue.
Attenuated familial adenomatous polyposis (AFAP) is a milder form of Familial Adenomatous Polyposis (FAP), an inherited condition that increases the risk of developing colon and rectal cancer. It is characterized by a reduced number of polyps in the colon and rectum compared to classic FAP, typically fewer than 100, and a later age of onset for colorectal cancer.
Average risk means an individual's chances of developing the disease are not significantly higher than the general population. Specifically, average risk is defined as having no personal history of colorectal cancer, polyps, inflammatory bowel disease (IBD), or a family history or genetic predisposition to high-risk colorectal cancer syndromes. Average risk individuals are typically recommended to start screening for colorectal cancer at age 45.
Cologuard is a non-invasive, at-home stool DNA test used for colon cancer screening. It's designed for adults age 45 and older who are at average risk for colon cancer. The test works by detecting specific DNA alterations and blood in the stool, which may indicate the presence of colon cancer or precancerous polyps.
Colonoscopy is a medical procedure that examines the inside of the colon (large intestine) using a thin, flexible tube called a colonoscope. The colonoscope has a small camera and light at its tip, allowing the doctor to visualize the colon and detect any abnormalities
Colon polyp is a growth on the inner lining of the colon or rectum. They can be either benign (non-cancerous) or precancerous, meaning they have the potential to develop into colon cancer. Polyps are common, and many are harmless, but some types can grow into cancer if not removed.
Cowden syndrome, also known as Cowden's disease or multiple hamartoma syndrome, is a rare genetic disorder characterized by multiple benign growths called hamartomas, along with an increased risk of certain cancers, particularly breast, thyroid, and endometrial cancers. It's an autosomal dominant disorder, meaning a child only needs to inherit one copy of the mutated gene to be affected.
Crohn's disease is a chronic inflammatory bowel disease (IBD) that causes inflammation of the digestive tract. It can affect any part of the GI tract from the mouth to the anus, but most commonly affects the small intestine and the beginning of the large intestine. This inflammation can lead to ulcers, pain, and other symptoms.
Dysplasia refers to abnormal development or growth of cells, tissues, or organs, resulting in a change in their structure or function. It's essentially a precancerous condition where cells exhibit abnormal features under a microscope, but they haven't become cancerous.
Familial adenomatous polyposis (FAP) is a rare, inherited condition characterized by the development of hundreds to thousands polyps (abnormal growths) in the colon and rectum, significantly increasing the risk of developing colorectal cancer, often before age 40 if left untreated.

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Fecal immunochemical test (FIT) is a screening test for colon cancer and other gastrointestinal conditions. It detects hidden blood in the stool, which can be an early sign of these conditions. The FIT uses antibodies to specifically bind to human hemoglobin, a protein in red blood cells, allowing it to detect blood even if it's not visible to the naked eye.

Guaiac fecal occult blood test (gFOBT) is a diagnostic test used to detect hidden blood in the stool. It's a type of fecal occult blood test (FOBT) that uses a chemical substance called guaiac to detect the presence of blood in a stool sample, even if it's not visible to the naked eye.

Hereditary nonpolyposis colorectal cancer (HNPCC), also known as Lynch syndrome, is an inherited disorder that increases the risk of developing colorectal cancer and other cancers, often before age 50, due to mutations in DNA mismatch repair genes.

High risk includes individuals with history of adenomatous polyps, a personal history of colorectal cancer (CRC), a family history of CRC or adenomatous polyps diagnosed in a relative before age 60 years, a personal history of inflammatory bowel disease, a confirmed or suspected hereditary CRC syndrome, or a history of abdominal or pelvic radiation for a previous cancer.

Hyperplasia is an increase in the number of cells in a tissue or organ, resulting in its enlargement. It's different from hypertrophy, which is an increase in the size of individual cells. Hyperplasia can be caused by various factors, including normal physiological processes or pathological conditions.

Hyperplastic polyp is a non-cancerous, benign growth that develops on the inner lining of the colon or stomach. They are characterized by an increase in the number of cells (hyperplasia) and are generally considered harmless. While often found during routine colonoscopies, they are typically not cancerous and don't pose a significant risk of developing into cancer.

Hyperplastic Polyposis Syndrome is characterized by the development of multiple hyperplastic colon and rectal polyps. Although hyperplastic polyps are typically considered to be benign, it is now known that individuals with HPS have a higher risk for colon and rectal cancer.

Inflammatory bowel disease (IBD) refers to a group of chronic inflammatory conditions that affect the digestive tract, primarily the intestines. The two most common types are Crohn's disease and ulcerative colitis. Both diseases cause inflammation, leading to a range of symptoms and potentially damaging the intestines over time.

Iron deficiency anemia is a type of anemia caused by a lack of iron in the body, which leads to reduced red blood cell production or reduced hemoglobin levels. This means the body can't adequately deliver oxygen to tissues and organs, resulting in symptoms like fatigue, weakness, and shortness of breath.

Juvenile Polyposis Syndrome (JPS) is an autosomal dominant condition characterized by multiple hamartomatous polyps throughout the gastrointestinal tract.

Li fraumeni syndrome (LFS) is an inherited disorder that significantly increases the risk of developing various cancers, often at a young age. It is caused by a mutation in the TP53 gene, which is responsible for preventing tumors.

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Lynch syndrome also known as hereditary nonpolyposis colorectal cancer (HNPCC), is an inherited condition that significantly increases the risk of developing various cancers, primarily colorectal and endometrial cancers, but also cancers of the stomach, small intestine, pancreas, ovaries, and more. It's caused by mutations in genes responsible for DNA mismatch repair, leading to genetic instability and increased cancer risk.

MUTYH-associated polyposis (MAP) is a rare, inherited condition causing an increased risk of colon and rectal cancer, along with the development of polyps (abnormal growths) in the colon. It's caused by mutations in the MYH gene, which plays a role in DNA repair.

Peutz-Jeghers syndrome (PJS) is a familial polyposis inherited as an autosomal dominant trait that is characterized by numerous polyps in the stomach, small intestine and colon along with melanin-containing spots on the skin and mucous membranes especially the lips and gums.

Piecemeal resection refers to the endoscopic removal of a large or complex lesion, like a polyp, in multiple, smaller pieces rather than as a single unit.

Polypectomy is the surgical removal of a polyp.

Polyposis syndromes are genetic disorders that predispose individuals to develop numerous polyps (abnormal growths) in the gastrointestinal tract, significantly increasing the risk of colorectal cancer.

Polyps are mucosal or submucosal abnormal tissue growths.

Recurrence is a new occurrence of something that happened or appeared before.

Resection is the process of cutting out tissue or part of an organ.

Primary sclerosing cholangitis (PSC) is a chronic liver disease where the bile ducts become inflamed and scarred, leading to narrowing and eventual blockages. This inflammation and scarring cause bile to back up in the liver, damaging liver cells and potentially leading to cirrhosis, liver failure, and an increased risk of liver cancer.

Sessile serrated polyp (SSP), also known as a sessile serrated adenoma (SSA), is a pre-cancerous growth on the lining of the large intestine (colon). Serrated polyps, including sessile ones, are abnormal growths that appear "saw-toothed" under a microscope. While not cancerous themselves, they can potentially develop into colon cancer if not removed completely.

Sigmoidoscopy is a medical procedure where a thin, flexible tube with a camera is inserted into the rectum to examine the lower part of the colon, including the rectum and sigmoid colon. This procedure helps doctors visualize the lower part of the colon, identify abnormalities like polyps or tumors, and collect tissue samples for biopsy.

Tubular adenoma is a non-cancerous growth (polyp) that forms in the lining of the colon or rectum. It is characterized by:

- Benign nature: most tubular adenomas are non-cancerous, although they have the potential to develop into cancer.
- Dysplasia: the cells show abnormal growth patterns, known as dysplasia, which can indicate an increased risk of cancer.

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- Location: they are typically found in the colon or rectum.
- Tubular shape: the cells grow in long, tube-like structures.

Ulcerative colitis (UC) is a chronic inflammatory bowel disease (IBD) that causes inflammation and ulcers in the lining of the large intestine (colon and rectum). It's characterized by repeated episodes of inflammation followed by periods of remission where symptoms disappear. UC primarily affects the inner lining of the colon, unlike Crohn's disease, which can affect any part of the digestive tract.

Villous adenoma is a type of polyp (abnormal growth) in the colon or rectum that has a villous structure, characterized by finger-like projections. It's considered a precancerous condition because it can potentially develop into colorectal cancer if left untreated.

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Disclaimer section

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The purpose of the HealthHelp's clinical guidelines is to assist healthcare professionals in selecting the medical service that may be appropriate and supported by evidence to safely improve outcomes. Medical information is constantly evolving, and HealthHelp reserves the right to review and update these clinical guidelines periodically. HealthHelp reserves the right to include in these guidelines the clinical indications as appropriate for the organization's program objectives. Therefore the guidelines are not a list of all the clinical indications for a stated procedure, and associated Procedure Code Tables may not represent all codes available for that state procedure or that are managed by a specific client-organization.

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National and Local Coverage Determination (NCD and LCD)

NOTICE
To ensure appropriate review occurs to the most current NCD and/or LCD, always defer to https://www.cms.gov/medicare-coverage-database/search.aspx.

Background

National Coverage Determinations (NCD) and Local Coverage Determinations (LCD) are payment policy documents outlined by the Centers for Medicare and Medicaid Services (CMS) and the government's delegated Medicare Audit Contractors (MACs) that operate regionally in jurisdictions.

CMS introduced variation between different jurisdictions/Medicare Audit Contractors (MACs) and their associated covered code lists with the transition to ICD 10. The variation resulted in jurisdictions independently defining how codes are applied for exclusions, limitations, groupings, ranges, etc. for the medical necessity indications outlined in the NCD and LCD. Due to this variation, there is an inconsistent use/application of codes and coverage determinations across the United States between the different MACs.

In addition, **WITHOUT** notice, CMS can change the codes that indicate medical necessity and the format of the coverage determinations/associated documents (eg, Articles). This is an additional challenge for organizations to keep up with ongoing, unplanned changes in covered codes and medical necessity indications.

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Medical Necessity Codes

Due to the variation in code application between jurisdictions/MACs and that updates can happen without notification, HealthHelp is not able to guarantee full accuracy of the codes listed for any Coverage Determination, and advises that prior to use, the associated Coverage Determination Articles are reviewed to ensure applicability to HealthHelp's programs and any associated NCDs and LCDs.

For Internal Use Only:

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