Gastroenterology

1. MCG Criteria Used

Clinical Criteria: MCG Care Guidelines, 30th Edition

- Gastrointestinal Bleeding, Upper: Inpatient Admission (MCG ORG: M-180 ISC, 30th Edition)
- Gastrointestinal Bleeding, Lower: Inpatient Admission (MCG ORG: M-182 ISC, 30th Edition)
- Colonoscopy: Ambulatory Care Criteria (MCG ACG: A-0129 AC, 30th Edition)

Applicable CPT / HCPCS Codes:

CPT / HCPCS Code	Description
43239, 43241, 43244, 43245, 43246, 43247, 43248, 43249, 43250, 43251, 43255, 43259, 43270	Upper GI endoscopy (EGD): diagnostic and therapeutic procedures including biopsy, dilation, hemostasis, foreign body removal, variceal band ligation, ablation, and ultrasound
43460, 43761	Gastric balloon tamponade and repositioning of gastrostomy tube; emergency procedures for variceal hemorrhage management
45378-45393, 45398, 45399	Colonoscopy: diagnostic and therapeutic procedures including biopsy, polypectomy (hot and cold snare), ablation, hemostasis (thermal coagulation, clipping, band ligation), dilation, and stent placement
45300-45342	Flexible sigmoidoscopy with or without biopsy, polypectomy, or other therapeutic intervention, as alternative or adjunct to colonoscopy
74174, 74175, 74261-74263	CT colonography (virtual colonoscopy) and CT angiography of the abdomen and pelvis for evaluation of GI bleeding source and colonic pathology
78278, 78290, 78291	Nuclear medicine GI bleeding and gastric emptying studies: radionuclide tagged RBC scan for active GI bleeding localization
36901-36909, 37241, 37242, 37243, 37244	Transcatheter visceral angiography and embolization procedures for GI bleeding from arterial source (eg, superior mesenteric artery, inferior mesenteric artery, celiac axis)
36430, 36440, P9010-P9022	Blood product transfusions: packed red blood cells, fresh frozen plasma, platelets, and cryoprecipitate for management of anemia and coagulopathy in GI bleeding
J0895, J1200, J2150, J2430, J3490	Injectable vasoactive and pharmacologic agents: desmopressin (J0895), diphenhydramine, meperidine, octreotide (J2430), and other agents used in management of GI bleeding and endoscopy
J2270, J2550, J3010, A4550	Proton pump inhibitors and antibiotic prophylaxis agents administered parenterally during hospitalization for upper GI bleeding; surgical and procedural supplies
99213-99215, 99231-	Evaluation and management services: outpatient office visits for

CPT / HCPCS Code	Description
99233, 99291-99292	colonoscopy indication assessment; inpatient subsequent care and critical care visits for GI bleeding management

2. Statement of Rationale

Akido Labs uses the criteria in MCG Care Guidelines (30th Edition) to supplement the general Medicare criteria regarding gastroenterology services, including inpatient admissions for acute upper and lower gastrointestinal (GI) bleeding and ambulatory care determinations for colonoscopy, where Medicare coverage criteria are not fully established or require additional clinical specificity. MCG criteria are used to ensure consistency in reviewing the conditions to be met for coverage of gastroenterology services and to determine when such services are medically necessary.

Gastrointestinal bleeding is among the most common causes of acute inpatient admission in the Medicare Advantage population, where anticoagulant and antiplatelet use, portal hypertension from chronic liver disease, and higher prevalence of peptic ulcer disease and diverticulosis substantially elevate both incidence and severity. Analysis of national hospital discharge data shows 90.8% of Medicare-insured patients presenting to the emergency department with a principal diagnosis of upper GI bleeding are admitted to inpatient care, compared with 50.4% of commercially insured patients. For lower GI bleeding, 58.0% of Medicare-insured emergency department patients are admitted to inpatient care, compared with 16.1% commercially. The mean inpatient length of stay is 4.4 days for upper GI bleeding and 3.9 days for lower GI bleeding. Colonoscopy is a foundational procedure in this population, serving roles in colorectal cancer screening (beginning at age 45 for average-risk individuals), polyp surveillance, diagnostic evaluation of GI bleeding, and therapeutic management of identified lesions. Absent consistent, evidence-based criteria, there is material risk of both inappropriate denial of medically necessary inpatient GI hemorrhage care and inappropriate approval or denial of colonoscopy procedures that could result in delayed colorectal cancer diagnosis or unnecessary procedural risks in a medically complex elderly population.

Potential Clinical Harms:

- **Upper GI Bleeding:** Inappropriate denial of inpatient admission for acute upper GI bleeding in a patient with hemodynamic instability, variceal hemorrhage, or high-risk peptic ulcer endoscopic features (active bleeding, nonbleeding visible vessel, adherent clot) could result in uncontrolled hemorrhage, exsanguination, or death outside a monitored setting. Patients with variceal bleeding require ICU-level management with vasoactive medications, antibiotics, and urgent endoscopy within 12 hours. Patients with high-risk nonvariceal bleeding require high-dose intravenous proton pump inhibitor therapy and endoscopic hemostatic therapy. Denial of inpatient status for these presentations eliminates access to the multidisciplinary, time-sensitive interventions required to prevent rebleeding and mortality. Patients with cirrhosis and upper GI bleeding face a 30-day readmission rate of 30.4% even with appropriate inpatient care; premature discharge would substantially worsen this risk.
- **Lower GI Bleeding:** Inappropriate denial of inpatient admission for lower GI bleeding with hemodynamic instability, persistent active bleeding despite initial colonoscopic treatment, high-risk colonoscopy findings (diverticulum with active bleed, adherent clot, nonbleeding visible vessel), or suspected ischemic colitis could result in uncontrolled hemorrhage, bowel ischemia progression, or delayed surgical intervention. Patients on anticoagulation at the time of lower GI bleeding, and those with active malignancy, are at significantly higher

risk for 30-day readmission; denial of inpatient-level management for these patients increases the risk of adverse outcomes and emergency rehospitalization. The Oakland Score provides a validated framework for identifying patients who are safe for discharge with outpatient colonoscopy, but only for lower-risk presentations; the MCG criteria address the higher-acuity presentations requiring inpatient care that fall outside this low-risk threshold.

- **Colonoscopy:** Inappropriate denial of colonoscopy for clinically indicated indications could result in delayed diagnosis of colorectal cancer (a leading cause of cancer mortality), missed detection of advanced precancerous polyps requiring removal, inadequate evaluation of GI bleeding sources, delayed assessment of inflammatory bowel disease activity or complications, and failure to provide guideline-recommended cancer surveillance in high-risk patients (e.g., Lynch syndrome, familial adenomatous polyposis, personal history of colorectal cancer or advanced adenomas). Colorectal cancer is among the most preventable malignancies when detected and treated at early stages; delayed or denied colonoscopy access in a Medicare Advantage population with disproportionately elevated colorectal cancer risk has direct mortality implications. Conversely, inappropriate approval of colonoscopy in the absence of clinical indications exposes elderly patients to procedural risks including perforation (0.04% to 0.08% for screening, up to 8% for therapeutic procedures) and bleeding, particularly in anticoagulated patients.

Clinical Benefits:

- **Evidence-based admission thresholds:** MCG criteria provide specific, validated thresholds for inpatient admission for GI bleeding (e.g., hemodynamic instability, shock index above 1, Glasgow-Blatchford score above 1 for upper GI bleeding, active bleeding persisting despite observation care, high-risk endoscopic findings) that reduce unwarranted variation and support clinically appropriate, individualized determinations distinguishing inpatient-appropriate from observation-appropriate or outpatient-appropriate presentations.
- **Validated risk stratification tools:** MCG criteria incorporate established risk stratification tools (Glasgow-Blatchford Score for upper GI bleeding, Oakland Score for lower GI bleeding, Pneumonia Severity Index-equivalent frameworks) that align with current specialty society guidelines from the American College of Gastroenterology (ACG), American Society for Gastrointestinal Endoscopy (ASGE), and British Society of Gastroenterology (BSG), ensuring coverage determinations reflect current evidence-based practice.
- **Colonoscopy indication specificity:** The MCG A-0129 Colonoscopy guideline, supported by 175 published peer-reviewed articles and 41 specialty society guidelines, provides granular, evidence-based indications for colonoscopy across screening, surveillance, diagnostic, and therapeutic categories. This specificity enables accurate determinations for a procedure covering a wide spectrum of clinical scenarios from average-risk screening (age 45 and older) to high-risk surveillance (hereditary polyposis syndromes, Lynch syndrome, inflammatory bowel disease with dysplasia) to urgent therapeutic intervention (GI bleeding, large bowel obstruction, volvulus).
- **CMS Two-Midnight Rule support:** MCG GI bleeding criteria help clinicians document patient-specific clinical factors (ongoing transfusion requirements, hemodynamic compromise, need for repeat endoscopy, anticoagulation reversal) that justify inpatient status across 2 or more midnights for Medicare beneficiaries whose clinical complexity warrants inpatient-level care.
- **Reduction of unwarranted variation and disparities:** Standardized MCG criteria reduce care disparities by applying consistent evidence-based thresholds across diverse patient populations, facilities, and geographic regions, supporting equitable coverage determinations for GI services in the Medicare Advantage population.

3. Explanation of Supplementation

Basis for Use:

Original Medicare clinical criteria are not fully established and require supplementation to ensure consistent medical necessity determinations for specific gastroenterology services, including inpatient admissions for acute upper and lower GI bleeding and ambulatory care authorization for colonoscopy. While Medicare statutes establish the general 'reasonable and necessary' standard and CMS has issued National Coverage Determinations for certain colonoscopy indications (particularly colorectal cancer screening), these NCDs do not fully specify the clinical thresholds required to distinguish inpatient-appropriate from observation-appropriate GI bleeding presentations, nor do they address the full breadth of diagnostic, surveillance, and therapeutic colonoscopy indications relevant to the Medicare Advantage population.

Applicable Medicare References:

- Social Security Act Section 1862(a)(1): 'Reasonable and necessary' standard for coverage of items and services
- Medicare Benefit Policy Manual, Chapter 1: Inpatient Hospital Services Covered Under Part A (CMS IOM Publication 100-02)
- Medicare Benefit Policy Manual, Chapter 6: Hospital Services Covered Under Part B (CMS IOM Publication 100-02)
- Medicare Benefit Policy Manual, Chapter 15: Covered Medical and Other Health Services (CMS IOM Publication 100-02)
- Medicare Program Integrity Manual, Chapter 6, Section 6.5: Medical Review of Inpatient Hospital Claims for Part A Payment (CMS IOM Publication 100-08)
- Code of Federal Regulations: 42 CFR 412.3 (Admissions); 42 CFR 419.22 (Hospital services excluded from outpatient PPS); 42 CFR 422.101 (Requirements relating to basic benefits)
- Conditions of Participation: Discharge Planning (42 CFR 482.43)
- National Coverage Determination NCD 100.3 (Colorectal Cancer Screening): Establishes Medicare coverage for screening colonoscopy for average-risk beneficiaries every 10 years (and at any interval for high-risk beneficiaries), but does not address clinical thresholds for diagnostic, surveillance, or therapeutic colonoscopy indications beyond the basic screening framework.
- For acute upper and lower GI bleeding inpatient admissions, no specific NCD or LCD fully establishes clinical admission thresholds; Original Medicare criteria are not fully established for these conditions, requiring supplementation by MCG criteria.
- Medicare Coverage Database: https://www.cms.gov/medicare-coverage-database/search.aspx

Within the above statutes and regulations, coverage criteria for specific GI inpatient and ambulatory services are not fully established, and the use of MCG Care Guidelines, as indicated above, is necessary to provide additional clinical specificity to evaluate the member's circumstances as outlined in the medical history, physician recommendations, and clinical notes. Specifically, MCG criteria assist in determining:

- Patient stability for inpatient admission versus alternatives (e.g., observation care, emergency department treatment, outpatient endoscopy) for acute upper and lower GI bleeding, based on hemodynamic parameters, endoscopic findings, risk stratification scores (Glasgow-Blatchford Score, Oakland Score), and response to initial resuscitation;

- Appropriateness of inpatient level of care based on evidence-based clinical thresholds, including hemoglobin transfusion triggers, endoscopic high-risk features (active variceal hemorrhage, peptic ulcer with nonbleeding visible vessel, diverticular bleed with adherent clot), need for ICU-level monitoring, and requirement for vasoactive medications or reversal agents;
- Expected clinical course and medical necessity of continued inpatient stay, including identification of complications (e.g., rebleeding, transfusion-dependent anemia, coagulation abnormalities, emergency surgery, organ injury) that require stay extensions beyond the goal length of stay of 2 days;
- Medical necessity of colonoscopy across the full range of covered clinical indications: colorectal cancer screening for average-risk patients age 45 and older; high-risk screening for patients with hereditary syndromes (Lynch syndrome, familial adenomatous polyposis, PTEN hamartoma tumor syndrome, Peutz-Jeghers syndrome) or family history of colorectal cancer; post-polypectomy and post-cancer resection surveillance at evidence-based intervals; diagnostic evaluation of GI bleeding, altered bowel habits, and iron deficiency anemia; and therapeutic intervention for bleeding, polyp removal, obstruction, volvulus, and inflammatory bowel disease complications;
- Appropriateness of alternative diagnostic modalities (e.g., CT colonography, flexible sigmoidoscopy, fecal occult blood testing, stool DNA/RNA testing) when colonoscopy is not the most appropriate initial test.

The use of MCG Care Guidelines ensures consistency in reviewing the conditions to be met for coverage of gastroenterology services. Use of these criteria to supplement the coverage criteria noted above provides clinical benefits by helping ensure GI inpatient care and diagnostic services are not incorrectly denied when medically appropriate, nor incorrectly approved when not reasonable and necessary.

4. Summary of Clinical Evidence

Background

Gastrointestinal Bleeding, Upper (MCG ORG: M-180 ISC)

Upper gastrointestinal (GI) bleeding originates proximal to the ligament of Treitz and encompasses a broad spectrum of etiologies including peptic ulcer disease (most common), esophageal and gastric varices, Mallory-Weiss tears, erosive esophagitis or gastritis, Dieulafoy lesions, angiodysplasia, gastric antral vascular ectasia, and malignancy. Among Medicare-insured patients presenting to the emergency department with a principal diagnosis of upper GI bleeding, 90.8% are admitted to inpatient care, compared with 50.4% of commercially insured patients, reflecting the substantially higher disease burden in the Medicare Advantage population. Analysis of an all-payer database shows a mean length of stay of 4.4 days. The high inpatient admission rate in Medicare-insured patients reflects the clinical complexity of this population, including higher rates of anticoagulant use, cirrhosis and portal hypertension, and hemodynamic fragility. Patients with decompensated cirrhosis and upper GI bleeding face a 30-day readmission rate approximately twice that of noncirrhotic patients (30.4% vs 15.0%), and metastatic solid tumor and decompensated cirrhosis are independent risk factors for 30-day readmission following upper GI hemorrhage.

Gastrointestinal Bleeding, Lower (MCG ORG: M-182 ISC)

Lower gastrointestinal (GI) bleeding originates distal to the ligament of Treitz and includes diverticular bleeding (most common cause in older adults), angiodysplasia, ischemic colitis, colorectal cancer, hemorrhoids, inflammatory bowel disease, and post-polypectomy bleeding. Among Medicare-insured patients presenting to the emergency department with a principal

diagnosis of lower GI bleeding, 58.0% are admitted to inpatient care, compared with 16.1% of commercially insured patients. Analysis of an all-payer database shows a mean length of stay of 3.9 days. The Oakland Score is a validated prediction tool for identifying patients with lower GI bleeding who are safe for discharge with outpatient colonoscopy, with a sensitivity of 96% and specificity of 32% at a threshold of 10 or fewer points, and 98% sensitivity at 8 or fewer points; however, patients who do not meet low-risk Oakland Score thresholds require inpatient evaluation. Factors independently associated with 30-day readmission include anticoagulation at the time of lower GI bleeding and active malignancy.

Colonoscopy (MCG ACG: A-0129 AC)

Colonoscopy allows for direct visualization of the colonic mucosa throughout the entire colon; if polyps are discovered, polypectomy can also be performed during the procedure. It is invasive and carries risks including perforation and bleeding. Estimates of the incidence of iatrogenic perforation range from 0.04% to 0.08% for screening colonoscopies, 0.016% to 0.8% for diagnostic colonoscopies, and 0.02% to 8% for therapeutic colonoscopies. The MCG A-0129 Colonoscopy guideline encompasses a uniquely broad evidence base of 175 published peer-reviewed articles, 41 specialty society or other evidence-based guidelines, 2 Cochrane systematic reviews, and 6 book sections, reflecting the procedural and diagnostic complexity of colonoscopy across its many clinical indications. Colorectal cancer is the second leading cause of cancer death in the United States; colonoscopy with polypectomy has been shown to reduce colorectal cancer mortality by 25% in patients with low-risk adenomas and by 53% compared with the general population in patients with adenomatous polyps removed and followed over a median of 15.8 years.

Evidence Summary

Gastrointestinal Bleeding, Upper (MCG ORG: M-180 ISC)

The MCG Upper GI Bleeding guideline (30th Edition) is supported by 4 published peer-reviewed articles, 2 specialty society or other evidence-based guidelines, and 7 book sections. Key evidence includes:

- A textbook and specialty society guidelines state that patients with upper GI bleeding should be admitted for inpatient care if they have risk factors for rebleeding or mortality, including anemia requiring transfusion, hemodynamic instability, or advanced liver disease. A textbook and a consensus guideline state that patients with acute variceal hemorrhage require inpatient care and management in the ICU.
- A specialty society guideline recommends that endoscopy be performed within 24 hours for acute urgent (non-low-risk, nonelective) patients with suspected nonvariceal bleed and within 12 hours for emergent cases (persistent hemodynamic compromise or moderate-to-large-volume hematemesis). Specialty society guidelines recommend that patients with suspected acute variceal bleeding undergo upper endoscopy within 12 hours of presentation.
- A randomized controlled trial of 516 hemodynamically stable patients (mean age 71 years, mean Glasgow-Blatchford score 13.7) with high-risk upper GI bleeding compared endoscopy within 6 hours with endoscopy within 24 hours and found no difference in 30-day mortality, persistent or recurrent bleeding, or length of hospital stay, supporting the 24-hour endoscopy window for hemodynamically stable patients.
- Specialty society guidelines suggest that patients with a Glasgow-Blatchford score (GBS) of 0 or 1 may be safely discharged from the emergency department with outpatient scheduling of endoscopy. An evidence-based specialty society analysis found that a GBS of 0 to 1 had a 99% sensitivity with a lower bound of the 95% confidence interval of 98%, supporting safe discharge without inpatient admission for very-low-risk presentations.
- A meta-analysis of 5 studies (1,965 adult patients) randomized to restrictive (hemoglobin 7 or 8 g/dL) or liberal blood transfusion thresholds found that the restrictive group had lower

risks for all-cause mortality and rebleeding, supporting current specialty society recommendations for a restrictive red blood cell transfusion threshold of 7 g/dL for patients with upper GI bleeding.

- Adjusted analysis of 82,290 adult patients (56% older than 65 years) admitted with acute upper GI bleeding found that metastatic cancer was an independent risk factor for 30-day readmission. Analysis of 176,977 adult patients admitted for nonvariceal upper GI bleeding reported a 21% 30-day readmission rate with a 2-fold higher rate among patients with decompensated cirrhosis compared with noncirrhotic patients, supporting the MCG readmission risk assessment elements.
- Analysis of national hospital discharge data shows 31% of hospitalized adult patients with upper GI bleeding as the principal diagnosis were discharged in 2 days or less, supporting the MCG goal length of stay of 2 days.

Gastrointestinal Bleeding, Lower (MCG ORG: M-182 ISC)

The MCG Lower GI Bleeding guideline (30th Edition) is supported by 3 specialty society or other evidence-based guidelines and 5 book sections. Key evidence includes:

- Analysis of national hospital discharge data shows 58.0% of Medicare-insured patients presenting to the emergency department with lower GI bleeding are admitted to inpatient care, compared with 16.1% of commercially insured patients, underscoring the substantially higher acuity profile of the Medicare Advantage population for this condition.
- Specialty society guidelines (ACG 2023, British Society of Gastroenterology 2019) recommend colonoscopy as the preferred test for patients with lower GI bleeding who have a high probability of a colonic source, given its ability to identify the bleeding source in the absence of active bleeding, achieve hemostasis when active bleeding is present, and prevent recurrent bleeding. Studies demonstrate that colonoscopy establishes a diagnosis in 74% to 100% of patients with lower GI bleeding, compared with 40% to 70% for radionuclide scanning and 35% to 72% for angiography.
- The Oakland Score is a validated prediction tool for identifying patients with lower GI bleeding who are safe for discharge from the emergency department with outpatient scheduling of colonoscopy. An Oakland Score of 10 or fewer points identified patients safe for discharge with a sensitivity of 96% and specificity of 32%; a threshold of 8 or fewer points had a sensitivity of 98% and specificity of 16%. Safe discharge was defined as absence of rebleeding after 24 hours of clinical stability and absence of transfusion, therapeutic intervention, in-hospital death, or readmission for lower GI bleeding at 28-day follow-up.
- Analysis of a cohort of 271 inpatients with lower GI bleeding found, after multivariate analysis, that anticoagulation at the time of lower GI bleeding and active malignancy were independently associated with all-cause 30-day readmission, supporting the MCG readmission risk assessment.
- Analysis of 358,335 patients admitted with lower GI bleeding who did not require surgical intervention found 25% were discharged in 2 days or less. National discharge data shows 32% of hospitalized adult patients with lower or unidentified GI bleeding as the principal diagnosis were discharged in 2 days or less, supporting the MCG goal length of stay of 2 days.

Colonoscopy (MCG ACG: A-0129 AC)

The MCG Colonoscopy guideline (30th Edition) is supported by 175 published peer-reviewed articles, 41 specialty society or other evidence-based guidelines, 2 Cochrane systematic reviews, and 6 book sections. Key evidence by indication category includes:

- Colorectal cancer screening and surveillance: Evidence demonstrates at least moderate certainty of at least moderate net benefit (Grade A1) for colonoscopy in patients with suspected colorectal cancer because of symptoms (e.g., altered bowel habits,

hematochezia) and for initial evaluation and staging of known colorectal cancer. A systematic review of 81 studies in patients with colorectal cancer diagnosed before age 50 reported that hematochezia, abdominal pain, and altered bowel habits were the most common presenting signs and symptoms. Patients who have been treated for colorectal cancer with curative intent require routine surveillance after treatment, with more intensive surveillance within the first 1 to 3 years after initial treatment. A 20-year longitudinal cohort study reported a 14% risk reduction in colorectal cancer mortality in men following adenoma removal by colonoscopy. A prospective cohort study of 2,602 patients with adenomas removed by colonoscopy, with median follow-up of 15.8 years, showed a 53% reduction in mortality from colorectal cancer compared with the general population.

- High-risk screening (hereditary syndromes): Expert consensus and specialty society guidelines support annual colonoscopy for Lynch syndrome patients; a prospective multicenter cohort study of 1,126 Lynch syndrome patients who underwent 3,474 colonoscopies found that colorectal cancers detected by follow-up colonoscopies had significantly lower tumor stages than those detected by symptoms. A 20-year longitudinal cohort study of 41,188 patients in the US Cystic Fibrosis Patient Registry reported a 6-fold increase in colorectal cancer incidence in nontransplanted patients and a 30-fold increase in transplanted patients compared with the general population, supporting enhanced colonoscopic surveillance in this group.
- Polyp surveillance: Recommended surveillance colonoscopy intervals for patients with colon polyps are based on multiple large prospective cohort studies demonstrating that specific lesion characteristics (polyp size, type, and number) are associated with risk of developing additional lesions and colon cancer. Subsequent surveillance colonoscopy is associated with reduced risk for new colorectal cancer and fatal colorectal cancer for specific patients. An evidence-based specialty society guideline recommends that colonoscopy be repeated within 1 year in cases of inadequate bowel preparation, or sooner if advanced neoplasia is detected.
- GI bleeding evaluation: Evidence demonstrates at least moderate certainty of at least moderate net benefit (Grade A1) for colonoscopy in the evaluation of lower GI bleeding. Colonoscopy is the preferred test for patients with a high probability of a colonic source, with diagnostic yield of 74% to 100% compared with 40% to 70% for radionuclide scanning. Endoscopic therapies including epinephrine injection, thermal coagulation, and endoscopic clipping or band ligation can be used to control bleeding. Specialty society guidelines recommend colonoscopy for evaluation of occult lower GI bleeding and for melena when esophagogastroduodenoscopy fails to reveal a source.
- Inflammatory bowel disease (IBD): While no direct evidence shows that cancer screening in IBD patients prolongs survival, indirect evidence via case-control studies and other data supports surveillance colonoscopy. A series of 259 patients with Crohn's disease undergoing surveillance colonoscopy every 1 to 2 years found that 7% had dysplasia or cancer on initial screening, and there was a 25% risk of detecting dysplasia or cancer by the 10th colonoscopy, supporting the MCG indication for colonoscopy in IBD surveillance.
- Stent placement for malignant obstruction: A meta-analysis of 10 studies (793 patients) found that use of self-expanding metallic stents for palliative therapy of obstructing colorectal cancer was associated with a reduced risk of operative mortality and increased long-term survival compared with surgery. A separate meta-analysis (451 patients) found that colonic stenting was associated with reduced hospital stay, lower postoperative mortality and complications, and less need for stoma creation as a bridge to surgery.

Rationale (from MCG)

The following rationale statements are drawn directly from the applicable MCG Care Guidelines, 30th Edition (ISC guidelines M-180 and M-182, and ACG guideline A-0129), and apply to all three gastroenterology guidelines covered in this section:

Use of these MCG care guidelines helps the clinician identify patient-specific complex clinical factors that make it reasonable to expect a necessity for hospital care across 2 or more midnights. The evidence-based clinical criteria assist the clinician in the decision to appropriately admit a patient to inpatient care. For Medicare enrollees, MCG care guidelines also support the clinician in the decision to appropriately admit a patient to inpatient care when there is not an expectation of 2 or more midnights of hospital care (e.g., CMS Two-Midnight Rule exceptions).

Use of these evidence-based clinical criteria to support decision-making around the need for inpatient GI treatment is of clinical benefit to the patient and is crucial for quality patient care. Use of evidence-based clinical criteria ensures patients receive the most appropriate care for their specific condition, reduces unnecessary risks, promotes recovery, and provides a standard that can reduce disparities in care. Evidence-based clinical criteria not only help align treatment decisions with best practice, but they can also help reduce unwarranted variation in care by fostering consistency and equality in healthcare provision across regions and facilities.

For colonoscopy, this MCG care guideline may overlap CMS guidance located in CMS statutes and regulations. For Medicare Advantage beneficiaries, before referring to MCG care guidelines, users should first follow all guidance related to this topic located in CMS National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), and other statutes and regulations. Content used in MCG care guidelines may be used to supplement but does not replace, modify, or supersede existing Medicare regulations or applicable NCDs or LCDs.

Appropriate use of the evidence-based clinical criteria in conjunction with the Supplemental Medicare Criteria ensures Medicare patients receive full access to Medicare benefits (e.g., inpatient GI care, covered colonoscopy procedures), without risk of delay or decreased access, based on variables such as clinical severity of illness, length of provision of medically necessary hospital-level care, or satisfaction of specified Medicare criteria as directed by CMS. Use of these criteria will help ensure that the patient receives necessary care in the appropriate setting.

These guidelines supplement but do not replace, modify, or supersede existing Medicare regulations or applicable National Coverage Determinations (NCDs) or Local Coverage Determinations (LCDs).

Related CMS Coverage Guidance (as cited in MCG 30th Edition):

- Code of Federal Regulations (CFR): 42 CFR 412.3; 42 CFR 419.22; 42 CFR 422.101
- Internet-Only Manual (IOM) Citations: CMS IOM Publication 100-02, Medicare Benefit Policy Manual, Chapter 1: Inpatient Hospital Services Covered Under Part A; Chapter 6: Hospital Services Covered Under Part B; Chapter 15: Covered Medical and Other Health Services; CMS IOM Publication 100-08, Medicare Program Integrity Manual, Chapter 6, Section 6.5: Medical Review of Inpatient Hospital Claims for Part A Payment
- National Coverage Determination NCD 100.3: Colorectal Cancer Screening (colonoscopy coverage for Medicare beneficiaries)
- Medicare Coverage Determinations: Medicare Coverage Database

Reference Lists

References with Citation Summary -- Gastrointestinal Bleeding, Upper: Inpatient Admission (MCG ORG: M-180 ISC, 30th Edition)

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5. Public Accessibility

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