AAVBC

AMERICAN ACADEMY OF VALUE BASED CARE

Ulcerative Colitis

Quick Reference Guide

2026

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1 CLINICAL SNAPSHOT

Definition: Ulcerative colitis (UC) is a chronic immune-mediated inflammatory bowel disease characterized by **continuous mucosal inflammation beginning in the rectum and extending proximally through the colon**.[1,2] Disease extent is classified as **proctitis** (rectum only), **left-sided colitis** (rectum to splenic flexure), or **pancolitis** (extends proximal to splenic flexure).[1,3] Based on the most proximal extent of inflammation documented by colonoscopy and histopathology.

ICD-10 Codes:

Category **K51** — anatomic location and complication required for billing specificity.[4] **K51.0x** (pancolitis), **K51.2x** (proctitis), **K51.3x** (rectosigmoiditis), **K51.4x** (inflammatory polyps), **K51.5x** (left-sided colitis), **K51.8x** (other UC), **K51.9x** (unspecified — AVOID when extent is known). **Fifth-character complication codes**: **11** (rectal bleeding), **12** (intestinal obstruction), **13** (fistula), **14** (abscess), **18** (other), **19** (unspecified complications).[4] **TRAP**: **Z87.19** (personal history of digestive disease) applies ONLY after curative total proctocolectomy — UC in remission with intact colon remains **K51.x.**[4] **Concurrent comorbidities to code: M07.6x** (peripheral arthropathy — ~11% of UC), **K83.0** (PSC — ~2.5%), **I82.4x** (DVT — UC carries 2–4× VTE risk), **M80.x/M81.x** (osteoporosis from steroid exposure), **F32.x** (depression).[5,6]

Prevalence and Burden: UC affects approximately **600,000–900,000 individuals** in the United States with prevalence **~238 per 100,000.**[1,7] Bimodal age distribution — peak incidence between ages 15–35 and a second peak between 50–70 — makes the Medicare population clinically significant.[1,8] **Elderly-onset UC (≥60) carries significantly higher complication rates**: **C. difficile infection** (11.0% vs 5.4% younger-onset), **CMV infection** (OR 2.9), **colorectal cancer** (3.2% vs 0.9%), and **all-cause mortality** (7.0% vs 1.0%).[8] **UC-associated VTE risk is 2–4× the general population** (HR 2.12, 95% CI 2.02–2.23);[6] CRC risk after 20 years of UC is ~4.5% with 1.7-fold higher risk vs general population; patients with PSC carry up to 5× CRC risk requiring annual surveillance.[1,6] During annual review, follow FY 2026 ICD-10-CM Official Guidelines by confirming UC as an active diagnosis when it requires ongoing monitoring, evaluation, treatment, surveillance, medication management, or GI follow-up.[9]

HCC/RAF V28 Mapping

ICD-10 CODE(S)	HCC CATEGORY (V28)[4,10,11]	RAF (CNA)	DOCUMENTATION REQUIREMENT
K51.00, K51.011–K51.019 (Universal/ Pancolitis)	HCC 81 — Ulcerative Colitis	**0.244**	Active pancolitis confirmed by colonoscopy with histopathology[13,14]
K51.20, K51.211–K51.219 (Ulcerative Proctitis)	HCC 81	**0.244**	**Inflammation limited to rectum** (≤18 cm from anal verge); **most common pattern in elderly-onset UC**[8]
K51.30, K51.311–K51.319 (Rectosigmoiditis)	HCC 81	**0.244**	**Colonoscopy confirming rectum + sigmoid involvement**[13]

ICD-10 CODE(S)	HCC CATEGORY (V28)[4,10,11]	RAF (CNA)	DOCUMENTATION REQUIREMENT
K51.50, K51.511–K51.519 (Left-sided colitis)	HCC 81	**0.244**	**Colonoscopy confirming inflammation from rectum to splenic flexure**;[13] most common pattern in elderly-onset UC[5]
K51.90, K51.911–K51.919 (Unspecified)	HCC 81	**0.244**	TRAP: most common UC coding error. Use ONLY when extent is genuinely unknown **When colonoscopy documents extent, use K51.0x/K51.2x/K51.3x/K51.5x — K51.90 is a** missed-specificity flag
Z87.19 (personal history of digestive disease)	No HCC	—	TRAP: Personal history of other digestive system diseases applies **ONLY after curative total proctocolectomy.** UC in remission with an intact colon is still an active diagnosis — use **K51.x. Incorrect Z87.19 use drops the entire HCC 81** classification

ABBREVIATIONS: ACG = American College of Gastroenterology; AGA = American Gastroenterological Association; CMS = Centers for Medicare & Medicaid Services; CNA = Community Non-Dual Eligible, Aged; HCC = Hierarchical Condition Category; IBD = inflammatory bowel disease; RAF = Risk Adjustment Factor; UC = ulcerative colitis; V28 = CMS-HCC Model Version 28. *Annual value illustrative at AAVBC representative MA base rate ~$10,402/year, applied at CMS-HCC 2026 model normalization factor 1.067 for PY2026; actual plan payment varies by county and contract

RAF values represent the Community Non-Dual Eligible Aged (CNA) coefficient from the 2026 CMS-HCC model; values vary across patient populations based on eligibility and care setting

DOCUMENTATION: ACTIVE UC IN REMISSION

UC in remission with an intact colon is still coded as active UC: K51.x, not Z87.19. Use Z87.19 only after curative total proctocolectomy or when there is no ongoing UC treatment, monitoring, surveillance, or GI follow-up.

Risk-Adjusted Care Resources

UC care spans **induction and maintenance pharmacotherapy, endoscopic surveillance (every 1–2 years for left-sided/extensive disease, annually for PSC patients)**,[1,2] **management of extraintestinal manifestations (peripheral arthritis, PSC, uveitis, pyoderma)**,[5] **and steroid-sparing pharmacotherapy** as a primary VBC priority.[2,15] First-line therapy backbone: **oral and topical mesalamine** for mild-to-moderate UC;[2,14] **advanced therapies for moderate-to-severe disease per AGA 2024 Living Guideline** (vedolizumab, ustekinumab, anti-IL-23 agents preferred in elderly; infliximab + biosimilars; adalimumab + biosimilars; upadacitinib and tofacitinib warning in ≥65.[8,13,14] Cost-smart anchors include adalimumab biosimilars (~$550/2 pens) and infliximab biosimilars.[19]

CLINICAL PEARL: JAK INHIBITORS REQUIRE CAREFUL RISK ASSESSMENT

Tofacitinib and upadacitinib carry FDA boxed warnings for serious infections, malignancy, major adverse cardiovascular events (MACE), thrombosis, and mortality. Older adults, particularly those **≥65 years**, current or former smokers, and patients with cardiovascular risk factors may have increased risk. Before initiating therapy, document smoking history, cardiovascular risk profile, prior malignancy, infection history, vaccination status, and shared decision-making regarding risks and benefits. Coordination with gastroenterology is essential when considering these agents in older adults.[24-29]

Risk-Adjusted Care Resources per Patient/Year[4,10,11]

RAF weight × $10,402.34 MA base rate = estimated annual care coordination support per documented HCC11

Active UC (any K51.x)

$2,538

HCC 81 · RAF 0.244

RAF values represent the Community Non-Dual Eligible Aged (CNA) coefficient from the 2026 CMS-HCC model; 15 values vary across patient populations based on eligibility and care setting

AAVBC PERSPECTIVE

Standard clinical teaching focuses on general GI presentations such as bloody diarrhea, urgency, and tenesmus. However, there are several GI conditions common in older adults including ischemic colitis, *Clostridioides difficile* colitis, NSAID-induced colitis, and segmental colitis associated with diverticulosis can closely mimic these ulcerative colitis signs and symptoms.
Distinguishing these entities is critical because management differs substantially, and inappropriate immunosuppression in an infectious colitis can lead to serious harm. Another commonly overlooked point is that ulcerative colitis **remains an active chronic diagnosis even during prolonged remission.** Clinical documentation should reflect the ongoing disease process and continued surveillance needs, particularly when the colon remains intact.

2 RECOGNITION AND DIAGNOSIS

Medicare - Covered Diagnostic and Surveillance Workup

Include diagnostic, flare-evaluation, surveillance, biologic-safety, and steroid-exposure monitoring tests that support UC care. Verify CPT codes and coverage annually.

TEST	COVERAGE	FREQUENCY	CPT CODE	CLINICAL INDICATION
Diagnostic colonoscopy with biopsy[1,13]	Covered for symptomatic workup	Diagnostic; ASUC; surveillance per protocol	45378/ 45380	**Gold standard for UC diagnosis and extent assessment,**[13] histopathology confirms continuous mucosal inflammation
Surveillance colonoscopy — chromoendoscopy or HD-WLE[1,13]	Covered as high-risk screening Part B (G0105) every 2 years	Every 1–2 years for left-sided/extensive UC ≥8 yrs; annually for PSC	G0105/ 45378	UC patients **≥8 years after diagnosis with left-sided or extensive disease require surveillance colonoscopy**. Patients with **PSC require annual surveillance beginning at PSC diagnosis**
Fecal calprotectin[13]	Covered Part B	Symptom-prompted or surveillance between endoscopy	83993	**Fecal calprotectin >250 µg/g with symptoms should prompt urgent GI referral.** Useful for distinguishing inflammatory from non-inflammatory symptoms and monitoring disease activity[13]
Stool studies (C. difficile, calprotectin, GI pathogens)[20]	Covered Part B for symptomatic flare	Per flare evaluation	87324 (C. diff toxin); 87505 (multiplex PCR)	**Mandatory in any UC flare prior to treatment escalation.** Elderly-onset UC carries an increased risk of **C. difficile infection**, and infection may coexist with inflammatory activity[20]
CBC, CMP, CRP, ESR[20]	Covered Part B	Per flare evaluation; serial during induction	85025, 80053, 86140, 85652	**CRP >30 mg/L is associated with severe inflammatory activity.** Trending CBC, CRP, and metabolic markers helps identify patients at risk for hospitalization, corticosteroid exposure, or escalation of care[20]

TEST	COVERAGE	FREQUENCY	CPT CODE	CLINICAL INDICATION
Pre-biologic screening labs (latent TB, HBV, HCV)[14]	Covered Part B as medically necessary	Before any biologic/ advanced therapy	Various	**Complete TB and hepatitis screening before initiating biologic or JAK inhibitor therapy.** Document immunity status and treatment of latent infection prior to immunosuppression[14]
DEXA scan (osteoporosis screening)[2]	Covered Part B per USPSTF	Per indication; consider if cumulative steroid exposure	77080	Patients with UC exposed to corticosteroids have increased risk of bone loss. DXA screening is recommended when cumulative steroid exposure is present[2,15]

ABBREVIATIONS: AGA = American Gastroenterological Association; ASUC = acute severe ulcerative colitis; AWV = annual wellness visit; CBC = complete blood count; CMP = comprehensive metabolic panel; CRP = C-reactive protein; DEXA = dual-energy X-ray absorptiometry; ESR = erythrocyte sedimentation rate; HBV = hepatitis B virus; HCV = hepatitis C virus; HD-WLE = high-definition white-light endoscopy; IGRA = interferon-gamma release assay; PSC = primary sclerosing cholangitis; TB = tuberculosis; TNF = tumor necrosis factor; TST = tuberculin skin test; USPSTF = United States Preventive Services Task Force

CLINICAL PEARL

Do not escalate immunosuppression until C. difficile is excluded in new/worsening bleeding, urgency, or diarrhea.

Subtle Early Signs in Older Adults (>65)

SIGN/SYMPTOM	CLINICAL SIGNIFICANCE
Bloody diarrhea or chronic mucoid stools	Cardinal UC presentation. In older adults, **do not attribute bleeding to hemorrhoids, diverticular disease, or anticoagulation alone** without objective evaluation. Colonoscopy remains the diagnostic standard; pyuria or bacteriuria does not exclude underlying UC[1,11]
Tenesmus, urgency, increased stool frequency[1]	Common presentation of elderly-onset UC, particularly proctitis or left-sided disease. **New-onset urgency or rectal symptoms warrant stool studies and GI referral**, especially when symptoms persist beyond a self-limited infectious course[8,11]

SIGN/SYMPTOM	CLINICAL SIGNIFICANCE
Chronic mild-to-moderate symptoms in known UC patient appearing 'controlled'[2]	**Symptomatic remission does not equal endoscopic remission.** Persistent inflammation may continue despite mild symptoms and is associated with future flares, corticosteroid exposure, hospitalization, and colorectal cancer risk. Treat-to-target goals include mucosal healing[2]
C. difficile infection in known UC patient[5]	Elderly-onset UC carries an elevated risk of C. difficile infection. **Any acute flare should prompt stool C. difficile testing before treatment escalation**, as infection and inflammatory activity frequently coexist[8,20]
New peripheral joint pain in known UC[5]	Peripheral arthropathy is the most common extraintestinal manifestation of UC and may parallel bowel activity. **Document and code associated arthropathy (M07.6x) when present** and assess for worsening intestinal inflammation
Jaundice, elevated alk-phos, or abnormal LFTs in UC[5]	Consider **primary sclerosing cholangitis (PSC)**, an important UC-associated condition. PSC substantially increases colorectal cancer risk and may alter surveillance recommendations. Prompt GI/hepatology evaluation is warranted[6]

ABBREVIATIONS: ASUC = acute severe ulcerative colitis; C. diff = Clostridioides difficile; CRC = colorectal cancer; EIM = extraintestinal manifestation; LFTs = liver function tests; PSC = primary sclerosing cholangitis; UC = ulcerative colitis

CLINICAL PEARL

Mild symptoms do not equal mild disease. Elderly patients with 2–3 bloody stools/day may still have extensive endoscopic inflammation and need calprotectin/GI referral as the safety net.

CLINICAL PEARL: DISTINGUISH UC FROM CROHN'S DISEASE

Ulcerative colitis is limited to the colon and rectum, begins in the rectum, extends continuously, and primarily affects the mucosa/submucosa. **Crohn's disease** can affect any part of the GI tract from mouth to anus, often with skip lesions, and involves transmural inflammation through the full bowel wall. This deeper tissue involvement makes Crohn's more likely to cause strictures, fistulas, abscesses, obstruction, perianal disease, and malabsorption. UC complications more commonly center on severe colitis, toxic megacolon, colorectal cancer risk, bleeding, PSC association, and colectomy risk.

Geriatric Risk Factors

FACTOR	RISK SIGNAL	NOTES
Elderly-onset UC (age ≥60)[5]	**C. difficile infection** (11.0% vs 5.4% younger-onset), **CMV infection** (OR 2.9), **colorectal cancer** (3.2% vs 0.9%), and **all-cause mortality** (7.0% vs 1.0%)[8]	**Higher complication rates than younger-onset UC;** lower threshold for hospitalization and proactive surveillance
Former smoking[1]	OR 1.79[1]	**Risk factors remain despite smoking cessation.** Prior smoking history should be documented during risk assessment
Frailty/sarcopenia[10,12]	**Stronger predictors of poor outcomes** than disease activity indices[10,12]	**Document frailty, functional status, and fall risk.** Therapy intensity should be individualized[10,12]
Cumulative corticosteroid exposure[2,15]	Osteoporosis; serious infections[15]	**DXA screening and osteoporosis prevention are essential** in older patients. Avoid repeated corticosteroid exposure when possible[15]
Thiopurine exposure (AZA, 6-MP) in ≥65[23]	**Increased lymphoma and non-melanoma skin cancer risk** with older age[23]	**Avoid as first-line** therapy in elderly patients when safer biologic options are available[23]
JAK inhibitors (upadacitinib, tofacitinib)[24,25]	FDA boxed warning:* **serious infection, MACE, VTE, malignancy, and herpes zoster**[24,25]	Tofacitinib 5 vs 10 mg showed increased risk in older populations. **Assess cardiovascular and VTE risk before initiation**[20]
Polypharmacy and NSAID use[10]	**NSAIDs may worsen UC** and increase hospitalization risk[10]	**Review medication lists at every visit.** Consider safer analgesic alternatives whenever possible
Long-standing UC ≥8 years (left-sided or extensive)[1]	CRC risk **4–5× higher** than the general population[1]	**Surveillance colonoscopy every 1–3 years** per ACG/AGA recommendations. Consider **HD-WLE or chromoendoscopy** when available[25]
Concurrent PSC[5]	Up to 5× CRC risk[6]	**Annual surveillance colonoscopy beginning at PSC diagnosis**[1,5]

ABBREVIATIONS: AZA = azathioprine; 6-MP = 6-mercaptopurine; AGA = American Gastroenterological Association; CRC = colorectal cancer; CV = cardiovascular; HD-WLE = high-definition white-light endoscopy; HZV = herpes zoster virus; JAK = Janus kinase; MACE = major adverse cardiovascular events; NMSC = non-melanoma skin cancer; NSAIDs = nonsteroidal anti-inflammatory drugs; OR = odds ratio; PSC = primary sclerosing cholangitis; TNF = tumor necrosis factor; UC = ulcerative colitis
***Consult FDA labels for the most up-to-date dosage information, contraindications, and drug-drug interactions**

Diagnostic Thresholds

TEST/MARKER	DIAGNOSTIC CRITERION	NOTES
Colonoscopy with biopsy[1,13]	**Continuous mucosal inflammation extending proximally from the rectum**; histopathology confirms active UC [13]	**Gold-standard test for diagnosis and disease extent assessment.** Required for accurate disease classification and documentation
Fecal calprotectin[13]	Sensitivity 0.89, specificity 0.81 at **≥50 µg/g**[13]	**Fecal calprotectin >250 µg/g with symptoms should prompt urgent GI referral.** Useful for monitoring disease activity between endoscopic evaluations[25]
Truelove & Witts ASUC criteria[20]	**≥6 bloody stools/day PLUS any of: HR >90 temp >37.8 °C; Hgb <10.5 g/dL; CRP >30 mg/L**[20]	**Hospitalization is recommended for patients meeting ASUC criteria.** Mortality remains clinically significant despite modern therapy[20]
Oxford rescue-therapy criteria (day 3 of IV steroids)[20]	>8 stools/day **OR** 3–8 stools/day + CRP >45 mg/L[20]	**Day-3 assessment identifies patients requiring rescue therapy.** Consider infliximab or cyclosporine escalation rather than prolonged ineffective corticosteroids[20]
Toxic megacolon criteria[26]	**Colonic dilation >6 cm** plus abdominal radiographic findings and **systemic toxicity** (fever, tachycardia, leukocytosis, anemia)[26]	**Medical and surgical emergency.** Requires immediate specialist involvement and inpatient management required[26]
Mayo Endoscopic Subscore[13]	0 (normal) → 3 (severe inflammation)[25]	**Endoscopic remission (Mayo 0–1) is the preferred treatment target.** Symptom improvement alone does not confirm mucosal healing[2,5,15]
Ulcerative Colitis Endoscopic Index of Severity (UCEIS)[13]	**0–8 composite score** based on vascular pattern, bleeding, erosions, and ulcer[25]	Provides a **more granular and reproducible assessment of endoscopic severity** than Mayo scoring and is increasingly used in clinical trials and specialist practice

ABBREVIATIONS: AGA = American Gastroenterological Association; ASUC = acute severe ulcerative colitis; CRP = C-reactive protein; HR = heart rate; UCEIS = Ulcerative Colitis Endoscopic Index of Severity

Clues to Dig Deeper

CLINICAL CLUE	WHY IT MATTERS	NEXT DIAGNOSTIC STEP
Patient in clinical remission but persistent fatigue, mild urgency, or borderline calprotectin[2]	**Symptomatic remission does not equal endoscopic remission.** Persistent inflammation may continue despite minimal symptoms[2]	**Fecal calprotectin >250 µg/g should prompt GI referral** and reassessment for objective inflammation[13]
New rectal bleeding in elderly UC patient — even mild[20]	**Do not assume hemorrhoids or diverticular disease.** Elderly-onset UC patients have increased rates of C. difficile infection and colorectal neoplasia[8]	Obtain stool studies, CRP, and fecal calprotectin; consider Truelove & Witts criteria if symptoms are worsening[20]
Steroid-dependent UC (cannot taper below prednisone 20 mg/day)[2,14]	**Indicates inadequate steroid-sparing therapy.** Repeated corticosteroid exposure increases osteoporosis, infection, hyperglycemia, and VTE risk[15]	**Urgent GI reassessment for advanced therapy optimization**[2,14]
New peripheral arthritis or skin lesion in known UC[5]	**May represent an extraintestinal manifestation of active disease.** EIM activity frequently parallels bowel inflammation[6,19]	**Document and code associated manifestations** and evaluate for worsening intestinal inflammation[6,19]
Elevated alk-phos or jaundice in UC[5]	**Consider primary sclerosing cholangitis (PSC).** PSC substantially increases colorectal cancer risk and surveillance requirements[6]	**MRCP and hepatology referral**; monitor alkaline phosphatase trends and confirm diagnosis[6]
Truelove & Witts ASUC criteria met[20]	**Acute severe UC is a medical emergency.** Delayed escalation increases colectomy risk and mortality[20,26]	**Hospital admission for IV corticosteroids and specialist management.** Evaluate for rescue therapy if Oxford criteria are met on day 3[20]

ABBREVIATIONS: AGA = American Gastroenterological Association; ASUC = acute severe ulcerative colitis; AE = adverse event; CRC = colorectal cancer; CRP = C-reactive protein; ED = emergency department; EIM = extraintestinal manifestation; ERCP = endoscopic retrograde cholangiopancreatography; LFT = liver function test; MRCP = magnetic resonance cholangiopancreatography; PSC = primary sclerosing cholangitis; UC = ulcerative colitis

Disease Staging and Severity Matrix

*UC severity should be assessed using a combination of **clinical symptoms, objective inflammation, and need for escalation**. In primary care, the goal is to recognize whether the patient is in **remission/low activity**, having a **mild flare**, progressing to **moderate disease**, or showing features of **severe UC/acute severe UC (ASUC)** that require urgent GI or hospital-level care. Formal scoring tools such as **Truelove & Witts** and **Mayo Score** can support severity classification when available, but clinical deterioration should not wait for endoscopy.*

DISEASE ACTIVITY CATEGORY	PRACTICAL MARKERS	ACTION REQUIRED
Clinical remission/low activity	No meaningful abdominal pain; **stool frequency at baseline**; no rectal bleeding; no urgency or nocturnal stools; weight stable; no fever or systemic toxicity; no recent ED visit/hospitalization; biomarkers normal or improving when available. Endoscopic remission may be documented as **Mayo 0–1** when known	**Continue maintenance plan**. Reconfirm UC extent, remission status, medication adherence, steroid-free status, surveillance colonoscopy interval, and GI follow-up plan. Monitor symptoms, CBC/iron indices, CRP/fecal calprotectin when clinically indicated
Mild UC[1]	**<4 stools/day** with minimal blood; mild urgency or cramping; no fever, tachycardia, anemia, dehydration, or systemic toxicity; CRP normal or mildly elevated[1]	**Check objective inflammation** and rule out infection before assuming flare: stool studies including **C. difficile**, CBC, CRP, fecal calprotectin. Optimize oral/topical 5-ASA when appropriate and coordinate GI follow-up if symptoms persist, bleeding develops, biomarkers rise, or steroid use is being considered[14]
Moderate UC[1]	**4–6 stools/day** with visible blood; urgency, abdominal discomfort, reduced function, or mild systemic symptoms; CRP/fecal calprotectin elevated; possible anemia, weight loss, or repeated steroid need; Mayo subscore may be **2** when endoscopy is available[1]	**Refer to GI for reassessment and treatment escalation.** Document stool frequency, bleeding, urgency, biomarker trend, C. difficile result, medication adherence, prior therapies, steroid exposure, and nutrition/hydration status. Consider steroid-sparing strategy if recurrent flares or repeated prednisone bursts[14]
Severe UC[1,20]	**>6 bloody stools/day** plus systemic signs such as fever, tachycardia, anemia, elevated CRP, dehydration, significant abdominal pain, weight loss, or impaired oral intake; Mayo subscore may be **3** when endoscopy is available[1]	**Urgent GI evaluation; consider hospital-level care.** Assess hydration, anemia, infection, VTE risk, medication exposure, and complications. Avoid outpatient delay if systemic toxicity is present. Document need for urgent escalation, possible IV corticosteroids/rescue therapy per GI, and VTE prophylaxis if hospitalized[20]

DISEASE ACTIVITY CATEGORY	PRACTICAL MARKERS	ACTION REQUIRED
Acute severe UC/ fulminant disease (ASUC)[20]	**Truelove and Witts severe criteria:** ≥6 bloody stools/day plus systemic toxicity such as fever, tachycardia, anemia, or elevated inflammatory markers. May include severe abdominal pain, dehydration, vomiting, hypoalbuminemia, or failure of outpatient therapy[20]	**Hospitalize/urgent specialist management.** Rule out **C. difficile, CMV when immunosuppressed, ischemic colitis, obstruction, perforation, and toxic megacolon.** Requires urgent GI involvement, IV corticosteroids when appropriate, rescue therapy if nonresponse, colorectal surgery consultation when indicated, and inpatient VTE prophylaxis unless contraindicated[26]
Toxic megacolon/ complicateddisease[26]	Colonic dilation **>6 cm** with systemic toxicity; abdominal distension, severe pain, fever, tachycardia, leukocytosis, altered mental status, peritonitis, perforation risk, or shock[26]	**Emergency referral/surgical consultation.** Hold antidiarrheals/opioids when suspected. Immediate imaging, labs, stool testing, IV fluids, broad inpatient management, urgent GI and colorectal surgery involvement. Document that infection, obstruction, perforation, ischemia, and malignancy have been assessed[26]

ABBREVIATIONS: AGA = American Gastroenterological Association; ASUC = acute severe ulcerative colitis; CRP = C-reactive protein; HR = heart rate; MMX = multimatrix formulation; UC = ulcerative colitis

Truelove and Witts Severe Criteria — ASUC Threshold

Truelove & Witts severe UC/ASUC is generally defined as ≥6 bloody stools/day plus at least one systemic toxicity marker: fever, tachycardia, anemia, or elevated ESR. CRP is commonly used in modern ASUC assessment but was not part of the original criteria.[20]

REQUIRED CRITERION	SEVERE/ASUC THRESHOLD	NEXT DIAGNOSTIC STEP
Bloody stools	**≥6 bloody stools/day**	This is the entry criterion for **acute severe UC**
PLUS at least ONE systemic toxicity marker	**Fever, tachycardia, anemia, or elevated ESR**	If **≥6 bloody stools/day** are present with **any one systemic toxicity marker**, treat as **ASUC/ hospital-level disease** and escalate urgently

System Toxicity Markers - Ranges and Values

MARKER	SEVERE CRITERIA VALUE	DOCUMENTATION
Temperature/fever	**>37.8 °C/≥100 °F**	Document fever, timing/pattern, infection assessment, and whether systemic toxicity is present
Heart rate/tachycardia	**>90 beats/min**	Document resting pulse, hydration status, pain severity, medication contributors, and sepsis assessment
Hemoglobin/anemia	**<10.5 g/dL or <105 g/L**	Document anemia severity and whether bleeding/inflammation is contributing
ESR	**>30 mm/hr**	Document elevated inflammatory marker supporting severe disease
CRP	**Not part of the original Truelove and Witts criteria, but often used in modern ASUC assessment**	Document CRP trend when available; elevated CRP supports objective inflammation and escalation

Mayo Criteria

The Mayo Score is a UC disease-activity scoring system that assesses stool frequency, rectal bleeding, endoscopic appearance, and physician global assessment, with each domain scored 0–3 for a total full Mayo Score of 0–12.[13] *For QRG purposes, the most PCP-facing component is often the Mayo endoscopic subscore, because it objectively documents mucosal activity: Mayo 0–1 = remission/low activity; Mayo 2 = moderate disease; Mayo 3 = severe disease.*

MAYO SCORE AND SUBSCORE	WHAT IT MEANS IN UC	DOCUMENTATION
Full Mayo Score: 0–12	Composite UC activity score using **stool frequency, rectal bleeding, endoscopic findings, and physician global assessment**, each scored 0–3	Do not just write "UC stable." Document **stool frequency, bleeding, objective inflammation, colonoscopy/ Mayo result, therapy, and GI plan**
Partial Mayo Score: 0–9	Uses stool frequency, rectal bleeding, and physician global assessment; excludes endoscopy	Useful for visit-based monitoring when colonoscopy is not available; document symptom trend and whether objective markers were ordered/ reviewed
Mayo endoscopic subscore 0	Normal/inactive mucosa	Supports **endoscopic remission**; still document active **K51.x** if patient has intact colon and ongoing treatment/ surveillance

MAYO SCORE AND SUBSCORE	WHAT IT MEANS IN UC	DOCUMENTATION
Mayo endoscopic subscore 1	**Mild activity:** erythema, decreased vascular pattern, mild friability	Document as **mild endoscopic activity** or near-remission; continue surveillance and GI plan
Mayo endoscopic subscore 2	**Moderate activity:** marked erythema, absent vascular pattern, friability, erosions	Supports **active moderate UC**; document extent, symptoms, biomarkers, treatment escalation, and GI follow-up
Mayo endoscopic subscore 3	**Severe activity:** spontaneous bleeding and/or ulceration	Supports **severe UC**; document urgent escalation, infection exclusion, steroid/rescue therapy plan, hospitalization risk, and complication assessment

DOCUMENTATION

Clinical remission reflects symptom control; endoscopic remission reflects mucosal healing. The two do not always occur together. Failure to document both may overlook ongoing intestinal inflammation in otherwise asymptomatic patients or lead to unnecessary treatment escalation when symptoms are driven by non-inflammatory causes. Separate documentation improves disease activity assessment, risk stratification, treatment planning, and long-term surveillance.

Common Oversights

OVERSIGHT/SHORTCUT	WHY IT MATTERS — WHAT TO DO INSTEAD
Assuming worsening diarrhea represents a UC flare	In older adults, **C. difficile infection, ischemic colitis, NSAID-induced colitis, and segmental colitis associated with diverticulosis** can closely mimic a UC flare. Exclude infectious and alternative causes before escalating immunosuppressive therapy
Missing VTE prophylaxis during acute UC hospitalizations	Active UC combined with acute hospitalization creates a hypercoagulable state, expanding deep vein thrombosis (DVT) and pulmonary embolism (PE) risk by **2–4×**. **Action:** Mandate chemical VTE prophylaxis for all hospitalized adults with active UC unless an absolute contraindication (e.g., severe, life-threatening hemorrhage) exists. Explicitly document any clinical rationale for holding prophylaxis[6]

OVERSIGHT/SHORTCUT	WHY IT MATTERS — WHAT TO DO INSTEAD
Treating clinical remission as equivalent to endoscopic remission[2]	**Symptom control does not always equal mucosal healing.** Document clinical remission separately from **endoscopic remission** when colonoscopy/Mayo score or UCEIS is available. Persistent endoscopic inflammation can still drive relapse risk, CRC risk, steroid exposure, and treatment escalation[2]
Prolonged corticosteroid maintenance (>3 months)[2,15]	**Steroids are for induction, not maintenance**. Prolonged or repeated steroid use should trigger documentation of **steroid-sparing rationale,** GI coordination, bone protection, infection risk, glucose/BP monitoring, and DEXA when appropriate[15]
Initiating thiopurines in patient ≥65[17]	In older adults, thiopurines carry higher risks, including **lymphoproliferative disorders, non-melanoma skin cancer, infections, and medication intolerance**. Document risk/benefit discussion, alternatives, dermatology/skin cancer counseling when used, and GI rationale[23]
JAK inhibitor (upadacitinib, tofacitinib) initiation in ≥65 without first-line failure[24,25]	JAK inhibitors require careful selection because of MACE, VTE, malignancy, serious infection, and herpes zoster risk. Confirm prior therapy history, cardiovascular/VTE risk, vaccination status, and GI rationale before documenting continuation or initiation[24,25]
NSAID use in known UC patient[10]	**NSAIDs** may **worsen** UC symptoms or contribute to flare/hospitalization risk. Document NSAID avoidance counseling and recommend safer options when appropriate, such as acetaminophen or topical/local therapies, while coordinating with GI/rheumatology for inflammatory pain[10]
Attributing new rectal bleeding to hemorrhoids without colonoscopy in elderly patient[1,5]	**New rectal bleeding in an older adult should not be assumed to be hemorrhoids.** Consider UC flare, colorectal cancer, ischemic colitis, infectious colitis, diverticular bleeding, and medication-related bleeding. Document stool studies, CBC/iron indices, colonoscopy/GI referral, and return precautions[5]

ABBREVIATIONS: ACG = American College of Gastroenterology; AE = adverse event; AGA = American Gastroenterological Association; CRC = colorectal cancer; CV = cardiovascular; HCC = Hierarchical Condition Category; JAK = Janus kinase; MACE = major adverse cardiovascular events; NMSC = non-melanoma skin cancer; NSAIDs = nonsteroidal anti-inflammatory drugs; PY = person-years; TNF = tumor necrosis factor; UC = ulcerative colitis; UCEIS = Ulcerative Colitis Endoscopic Index of Severity; VTE = venous thromboembolism

Key Differentials in Elderly

PRESENTATION	CLINICAL SIGNIFICANCE	KEY TESTS
Bloody diarrhea[20]	Could represent **UC flare**, C. difficile colitis, other infectious colitis, ischemic colitis, medication-related bleeding, or colorectal cancer. Elderly patients need earlier objective evaluation[20]	Order **stool studies including C. difficile**, CBC, CRP, fecal calprotectin when available; review anticoagulants/NSAIDs; arrange **urgent GI evaluation/colonoscopy** when bleeding persists or inflammatory markers are elevated[20,25]
Chronic diarrhea in elderly UC[5]	Not all diarrhea is active UC. Consider **C. difficile**, microscopic colitis, bile-acid diarrhea, small intestinal bacterial overgrowth, CMV in immunosuppressed patients, medication effects, and colorectal malignancy[5]	Stool studies including **C. difficile**, fecal calprotectin/CRP, medication review, CBC/CMP; colonoscopy with biopsies if persistent, unexplained, bloody, or associated with weight loss/anemia
Tenesmus/urgency only[1]	Can reflect **proctitis or distal UC activity**, but also infectious proctitis, anorectal disease, pelvic floor dysfunction, radiation injury, or anorectal malignancy[1]	Consider **sigmoidoscopy or colonoscopy**, STI testing if applicable, rectal exam when appropriate, and GI referral if persistent or bleeding
Segmental colitis associated with diverticulosis (SCAD)[4,10,11]	SCAD can mimic UC but has different distribution and management. In older adults, diverticulosis-associated inflammation may be mistaken for IBD flare[4]	Colonoscopy with **extent assessment and histopathology**; document whether inflammation is segmental/diverticular-associated versus continuous UC pattern; coordinate with GI before labeling as UC progression
Toxic megacolon presentation[26]	Emergency presentation of severe UC, severe C. difficile colitis, ischemic colitis, or CMV colitis. Red flags include **severe abdominal pain, distension, fever, tachycardia, leukocytosis, systemic toxicity, or colonic dilation**[23]	Immediate ED/hospital evaluation; abdominal imaging for colonic dilation, CBC/CMP/CRP, stool studies including **C. difficile**, CT abdomen/pelvis when indicated, urgent GI and surgical consultation

ABBREVIATIONS: CBC = complete blood count; CMV = cytomegalovirus; CRC = colorectal cancer; CRP = C-reactive protein; CT = computed tomography; SBBO = small bowel bacterial overgrowth; SCAD = segmental colitis associated with diverticulosis; STI = sexually transmitted infection; UC = ulcerative colitis

Comorbidity Screening

CONDITION	PREVALENCE/ASSOCIATION	SCREENING APPROACH
Peripheral arthropathy	Most common EIM in UC; may present with large-joint pain, inflammatory back symptoms, or symptoms that track with bowel activity	Ask about **joint pain, swelling, morning stiffness, and inflammatory back pain** at annual visits and during flares; document as UC-related when clinically supported; refer to rheumatology if persistent, inflammatory, or function-limiting
Primary sclerosing cholangitis	Occurs in a minority of UC patients but carries increased **cholangiocarcinoma and colorectal cancer risk**[6]	Trend **alkaline phosphatase/LFTs**; if cholestatic pattern or symptoms occur, coordinate **MRCP/ERCP per hepatology** and GI surveillance planning. Document PSC linkage when present[6]
Venous thromboembolism[6]	UC carries increased VTE risk, especially during **active flare and hospitalization**[6]	Assess mobility, hospitalization status, prior VTE, dehydration, steroid exposure, and active inflammation; document **VTE prophylaxis for all UC hospitalizations unless contraindicated** and anticoagulation plan if DVT/PE occurs
Osteoporosis[2,15]	Risk is higher with **recurrent or prolonged corticosteroid exposure**, older age, malnutrition, and chronic inflammation[15]	Order/review **DEXA** when steroid exposure is recurrent/prolonged or age-risk is present; document calcium/vitamin D counseling, fall-risk review, and bone-protection plan; consider bisphosphonate therapy when fracture risk warrants[2]
Depression[5,6]	Common in IBD and often underrecognized, especially with chronic symptoms, steroid exposure, pain, and functional limitation[6]	Screen with **PHQ-2/PHQ-9 and GAD-7**; document impact on adherence, sleep, function, and flare coping; coordinate behavioral health and medication therapy when indicated[6]
Colorectal cancer[1]	CRC risk rises with **longer disease duration, greater extent, persistent inflammation, family history, dysplasia, and PSC**[1]	Document last colonoscopy, disease duration, extent, inflammation history, dysplasia history, and PSC status; coordinate **surveillance colonoscopy with chromoendoscopy or high-definition white light** per GI interval[13]

CONDITION	PREVALENCE/ASSOCIATION	SCREENING APPROACH
C. difficile infection[5]	UC patients, especially older adults and those with recent antibiotics, hospitalization, or immunosuppression, have increased risk; infection can mimic or trigger flare[5]	Test for **C. difficile during suspected flare or new/worsening diarrhea** before treatment escalation; document stool testing and treatment plan if positive; coordinate with GI for recurrent infection[20]
Steroid-induced hyperglycemia/new diabetes[15]	Corticosteroids can worsen glucose control, especially in older adults or patients with prediabetes/diabetes[15]	Monitor **A1c and glucose** during repeated or prolonged steroid exposure; document steroid indication, dose, taper plan, and glucose-management plan; coordinate PCP/endocrinology support when needed

ABBREVIATIONS: AGA = American Gastroenterological Association; CRC = colorectal cancer; DVT = deep vein thrombosis; EIM = extraintestinal manifestation; HD-WLE = high-definition white-light endoscopy; HbA1c = glycated hemoglobin; HR = hazard ratio; IBD = inflammatory bowel disease; IDSA = Infectious Diseases Society of America; LFT = liver function test; MRCP = magnetic resonance cholangiopancreatography; PHQ = Patient Health Questionnaire; PSC = primary sclerosing cholangitis; UC = ulcerative colitis; VTE = venous thromboembolism

RED FLAG — EMERGENCY/ACTIVATE CRISIS RESPONSE

- **Acute severe UC (Truelove & Witts criteria)** — ED transfer for IV corticosteroids; 3-month mortality 0.84% with prompt management[20]
- **Toxic megacolon** — colonic dilation >6 cm + systemic toxicity; emergent surgical consult; subtotal colectomy with ileostomy if no rapid improvement[23]
- **Perforation or peritonitis** — acute abdomen; emergent surgical evaluation
- **Massive lower GI hemorrhage** — ED transfer for resuscitation and endoscopic/surgical intervention[20]
- **Fulminant C. difficile colitis in known UC** — IV vancomycin or fidaxomicin; surgical consult for refractory disease[20]

RED FLAG — URGENT (24–72 HOURS)

- **Steroid-dependent UC (cannot taper below prednisone 20 mg/day)** — urgent GI referral for advanced therapy initiation per AGA 2024/ACG 2025[2,14]
- **Calprotectin >250 µg/g with symptoms** — urgent GI referral for endoscopic reassessment[25]
- **New jaundice or elevated alk-phos in UC** — workup for PSC (~2.5%); MRCP or ERCP per hepatology[6]
- **Functional decline on advanced therapy** — review for serious infection, immune-related AE, drug-drug interaction[15]
- **Stalled response to first-line advanced therapy** — GI referral for therapy switch per AGA 2024 sequencing[14]

3 MEAT DOCUMENTATION AND ESSENTIALS

UC documentation should reflect disease extent, activity, treatment, surveillance status, and clinically relevant comorbidities. Common documentation pitfalls include defaulting to **K51.90** when disease extent is known, using **Z87.19** in patients with an intact colon, and failing to document extraintestinal manifestations or treatment-related risks. The MEAT framework below links documentation to ongoing monitoring, evaluation, treatment, and surveillance needed to support continuity of care, quality reporting, and appropriate coding.

*Case vignette: A 72-year-old patient with **left-sided ulcerative colitis** on mesalamine 2.4 g/day presents to primary care with increased stool frequency, urgency, and intermittent rectal bleeding for 2 weeks. PCP recognizes a possible UC flare, orders stool studies, reviews inflammatory markers, and arranges expedited GI evaluation. Colonoscopy confirms **moderate active left-sided disease, Mayo subscore 2**, and vedolizumab is initiated as steroid-sparing therapy.*

MONITOR: Increased stool frequency **(4–5/day from baseline 1–2/day),** urgency, intermittent hematochezia, fecal calprotectin **480 µg/g,** and **CRP 28 mg/L** support active inflammation. **C. difficile negative;** infection reviewed before escalation. Prior steroid bursts documented; current mesalamine adherence and response reviewed.

EVALUATE: Colonoscopy (5/20): Colonoscopy: Mayo subscore **2**, consistent with moderate active inflammation extending through the left colon; Disease extent, severity, biopsy results, dysplasia status, and surveillance interval reviewed. Pre-biologic safety workup completed, including TB and hepatitis B screening, vaccination review, and bone-health assessment given recurrent steroid exposure.

ASSESS: Active left-sided ulcerative colitis with rectal bleeding, moderate disease activity. Code: K51.511. Symptoms, biomarkers, and colonoscopy support active UC flare requiring treatment escalation and GI management. Document relevant comorbidities when present, including steroid-related osteopenia/osteoporosis, iron-deficiency anemia, VTE risk/history, PSC, inflammatory arthropathy, uveitis, pyoderma gangrenosum, and depression/anxiety.

TREAT:

- **Continue mesalamine 2.4 g/day** during induction unless GI recommends otherwise; document adherence and tolerance
- **Initiate vedolizumab 300 mg IV induction** per GI plan, then maintenance every 8 weeks; document drug, dose, route, interval, start date, response, and adverse effects
- **Avoid further prednisone exposure when possible;** document steroid-sparing rationale due to recurrent steroid bursts and bone/VTE risk
- **Bone protection:** calcium/vitamin D counseling, DEXA monitoring, fall-risk review, and bisphosphonate discussion if indicated
- **Referral/coordination:** GI manages biologic therapy and surveillance; refer to rheumatology if inflammatory joint symptoms emerge, hepatology/GI if PSC suspected, and hematology if recurrent or unexplained VTE
- **Return precautions:** worsening bleeding, fever, severe abdominal pain, dehydration, inability to tolerate PO, syncope, or rapid increase in stool frequency

Clinical Documentation Elements

- **Specify disease extent:** Document anatomic extent from colonoscopy or GI report and use the most specific ICD-10 code available: **K51.20–K51.21 (ulcerative proctitis), K51.50–K51.51 (left-sided colitis), K51.00–K51.01 (pancolitis), and K51.80–K51.81 (other ulcerative colitis).** Avoid **K51.90–K51.91 (unspecified UC)** when disease extent is known
- **Document activity vs remission:** State whether UC is **active, clinically quiescent, in clinical remission, or in endoscopic remission**. If remission is documented, support it with symptoms, steroid status, biomarkers, colonoscopy/Mayo score when available, and ongoing surveillance plan
- **Document complication status:** Use the most specific UC code supported by the visit — for example, **rectal bleeding, intestinal obstruction, abscess, fistula, or other complication** when present. Avoid vague "UC" documentation when symptoms or complications are active
- **Link treatment to UC:** Document medication name, dose, route, interval, adherence, response, and monitoring. Examples: mesalamine dose, prednisone taper details, vedolizumab induction/maintenance schedule, adverse effects, infection screening, and GI plan
- **Code concurrent EIMs and related conditions:** Document and link relevant extraintestinal manifestations or complications, including **peripheral arthropathy, PSC, uveitis, pyoderma gangrenosum, iron-deficiency anemia, osteoporosis from steroid exposure, VTE, and depression/anxiety** when clinically supported
- **Document VTE risk and prophylaxis:** UC confers increased VTE risk, especially during active flare or hospitalization. Document VTE history/risk, prophylaxis during hospitalization when applicable, and coordination if recurrent VTE occurs
- **Do not overuse "history of UC:"** Patients with an intact colon who remain on treatment, monitoring, or surveillance should generally have active **K51.x documentation**, even when clinically stable or in remission. Reserve **Z87.19** for true history-only situations where UC is no longer actively treated, monitored, or surveilled

DOCUMENTATION IS COMPREHENSIVE CODING

UC in clinical remission still requires an **active K51.x diagnosis** when the patient has an intact colon and ongoing treatment, monitoring, or surveillance. Clinical remission does not necessarily indicate **endoscopic remission**, and persistent mucosal inflammation may remain present despite symptom control. Annual documentation should support the ongoing diagnosis with **disease extent, activity/remission status, current therapy, objective markers of inflammation (fecal calprotectin, CRP, colonoscopy findings), surveillance plans, and GI follow-up.** Accurate documentation reflects the patient's continued risk for relapse, colorectal neoplasia, treatment-related complications, and ongoing care needs.

4 TREATMENT AND REFERRAL QUICK GUIDE

Ulcerative colitis treatment follows a GI-directed pathway: confirm active inflammation, define disease extent and severity (mild, moderate, severe, or acute severe ulcerative colitis), and select steroid-sparing therapy based on efficacy, safety, comorbidities, and patient goals.[2] In value-based primary care, PCPs support outcomes by recognizing disease progression early, monitoring objective markers such as fecal calprotectin, avoiding repeated steroid courses, addressing treatment-related risks and extraintestinal manifestations, and coordinating timely GI referral when escalation criteria are met.[2,10]

Therapy Escalation Criteria

ACG 2025/AGA 2024-Aligned Treatment and Referral Recommendations

TRIGGER	ACTION
New UC presentation — mild/moderate, no complications[14]	**Oral mesalamine + topical mesalamin**e if proctitis or left-sided extent; **reassess at 8 weeks**[14]
Inadequate response to optimized 5-ASA at 8 weeks[2,14]	**Urgent GI referral for advanced therapy initiatio**n — vedolizumab, ustekinumab, or anti-IL-23 preferred in elderly per AGA 2024/ACG 2025[2,14]
Steroid-dependent UC (cannot taper below 20 mg prednisone)[14]	**Urgent GI referral for advanced therapy;** steroid-sparing is a primary VBC priority[2,15]
Calprotectin >250 µg/g with symptoms[25]	**Urgent GI referral for endoscopic reassessment**;[25] trend calprotectin during therapy escalation
Acute severe UC (Truelove & Witts criteria)[20]	**ED transfer for IV corticosteroids, urgent GI involvement, and surgical consultation when indicated**[20]
Toxic megacolon (colonic dilation >6 cm + systemic toxicity)[26]	**Emergent surgical consult** — subtotal colectomy with ileostomy if no rapid improvement[26]
Long-standing UC ≥8 yrs left-sided/extensive[1]	**Surveillance colonoscopy every 1–2 years** per ACG/AGA;[1] chromoendoscopy[25]
PSC diagnosis in UC patient[6]	**Annual surveillance colonoscopy from PSC diagnosis**; coordinate hepatology for LFT trending and ERCP per protocol

ABBREVIATIONS: 5-ASA = 5-aminosalicylic acid; ACG = American College of Gastroenterology; AGA = American Gastroenterological Association; ASUC = acute severe ulcerative colitis; CRC = colorectal cancer; ED = emergency department; ERCP = endoscopic retrograde cholangiopancreatography; HD-WLE = high-definition white-light endoscopy; LFT = liver function test; PSC = primary sclerosing cholangitis; UC = ulcerative colitis; VBC = value-based care
***Consult FDA labels for the most up-to-date dosage information, contraindications, and drug-drug interactions**

AAVBC PERSPECTIVE

Steroid-free management is a priority especially for older adults; safety-first advanced therapy selection matters. Steroid minimization is needed because older adults have amplified risks of osteoporosis, diabetes, cataracts, and serious infection.

Advanced Therapy in Elderly

AGENT	EVIDENCE/OUTCOME	ELDERLY SAFETY PROFILE
Vedolizumab (anti-α4β7) — PREFERRED[2,14,16]	Superior to adalimumab in some outcomes; favorable efficacy with **lower systemic immunosuppression**[15,16]	**Gut-selective mechanism; no increased MACE or VTE signal.** Favorable biologic choice in older adults[2,14]
Ustekinumab (anti-IL-12/23) — PREFERRED[2,14]	Effective for induction and maintenance; durable response profile[15]	Lowest infection risk among advanced therapies in older adults[15]
Anti-IL-23 (guselkumab, risankizumab, mirikizumab) — PREFERRED[2,14]	Favorable efficacy and steroid-sparing potential[14]	Limited long-term data, but favorable early safety profile[2]
Infliximab (anti-TNF)[14]	**Rapid onset of action**; useful in acute severe UC and rescue therapy[14]	Higher infection risk and hospitalization risk than gut-selective biologics
Adalimumab (anti-TNF)[14]	Effective but generally lower ranking than newer biologics[14]	**Screen for latent TB and hepatitis B before initiation.** Increased infection vigilance required[1]
Upadacitinib (JAK inhibitor)[14,24,25]	High efficacy and rapid symptom improvement[14]	**FDA boxed warning: serious infection, MACE, VTE, malignancy, and herpes zoster.** Reserve for carefully selected patients[24,25]
Tofacitinib (JAK inhibitor)[24,25]	Earlier-generation JAK inhibitor[14]	Avoid in patients with elevated cardiovascular or thromboembolic risk when alternatives are available[24,25]

AGENT	EVIDENCE/OUTCOME	ELDERLY SAFETY PROFILE
Ozanimod/Etrasimod (S1P receptor modulators)[14]	Oral treatment option with favorable efficac[14]	**Requires cardiac and ophthalmologic assessment before initiation.** Medicare-age safety data remain limited[14]

ABBREVIATIONS: aHR = adjusted hazard ratio; ASUC = acute severe ulcerative colitis; AV = atrioventricular; CV = cardiovascular; FDA = Food and Drug Administration; JAK = Janus kinase; MACE = major adverse cardiovascular events; NMA = network meta-analysis; OR = odds ratio; PY = person-years; RR = relative risk; S1P = sphingosine-1-phosphate; TNF = tumor necrosis factor; VTE = venous thromboembolism
***Consult FDA labels for the most up-to-date dosage information, contraindications, and drug-drug interactions**

CLINICAL PEARL

Age alone should not delay biologic therapy. Preferred elderly options include vedolizumab, ustekinumab, and anti-IL-23 agents; use JAK inhibitors/thiopurines cautiously in patients with elevated infection, malignancy,cardiovascular, or thrombotic risk.[18,21]

Non-Pharmacologic Care and Supportive Interventions

INTERVENTION	TARGET/RECOMMENDATION	NOTES
Dietary optimization during active symptoms	Small, frequent meals; lower-residue/ low-fiber pattern during flares; avoid known trigger foods; maintain hydration and protein intake	May reduce urgency, cramping, bloating, and stool frequency during flares. Diet supports symptom control but does **not** replace UC anti-inflammatory therapy
Alcohol avoidance	Avoid alcohol during active flares, dehydration, steroid use, hepatobiliary disease/PSC, or immunosuppressive therapy changes	**Alcohol may worsen diarrhea, dehydration, sleep, adherence, and medication tolerability. C**ounsel patients to avoid alcohol when symptoms are active or medications are being adjusted
Stool studies including C. difficile at every flare[20]	Mandatory in any UC flare[20]	**Exclude C. difficile before escalating immunosuppression.** Elderly-onset UC patients have higher infection rates[5]
Dietary optimization during active symptoms	Small, frequent meals; lower-residue/ low-fiber pattern during flares; avoid known trigger foods; maintain hydration and protein intake	May reduce urgency, cramping, bloating, and stool frequency during flares. Diet supports symptom control but does **not** replace UC anti-inflammatory therapy

INTERVENTION	TARGET/RECOMMENDATION	NOTES
Fecal calprotectin monitoring[25]	**≥250 µg/g with symptoms should prompt GI referral**[25]	Useful for monitoring disease activity between endoscopic evaluations;[25] covered Part B (CPT 83993)
Surveillance colonoscopy[1]	**Every 1–2 years for high-risk patients; every 1–3 years for long-standing disease**[1,6]	Chromoendoscopy or HD-WLE preferred when available[25]
Pre-biologic vaccination and screening[14]	Latent TB, HBV, HCV, influenza, COVID, herpes zoster[14]	Complete screening and vaccination before biologic or JAK inhibitor initiation[14]
DEXA scan and bone protection[2,15]	**DXA screening for cumulative steroid exposure**[15]	**33% steroid-induced osteoporosis;**[15] bone protection should be addressed proactively
Depression screening and management[5,6]	PHQ-2/PHQ-9 at every visit[6]	**Mental health conditions are common and frequently under-recognized in IBD**[6]
NSAID avoidance[10]	Avoid NSAIDs when possible[10]	NSAIDs may trigger disease activity and hospitalization[10]
Geriatric assessment (G8/CGA)[12]	**Assess frailty before treatment escalation**[21,22]	**Frailty predicts hospitalization and adverse outcomes better than age alone**

ABBREVIATIONS: AGA = American Gastroenterological Association; CGA = comprehensive geriatric assessment; CMV = cytomegalovirus; DEXA = dual-energy X-ray absorptiometry; G8 = Geriatric 8; HBV = hepatitis B virus; HCV = hepatitis C virus; HD-WLE = high-definition white-light endoscopy; HEDIS = Healthcare Effectiveness Data and Information Set; HR = hazard ratio; IGRA = interferon-gamma release assay; LMWH = low-molecular-weight heparin; NSAIDs = nonsteroidal anti-inflammatory drugs; OMW = Osteoporosis Management in Women; PHQ = Patient Health Questionnaire; PSC = primary sclerosing cholangitis; PY = person-years; UC = ulcerative colitis; VTE = venous thromboembolism

Medication Safety and Key Interactions

DRUG/CLASS	INTERACTION/TOXICITY	CLINICAL ACTION
Mesalamine (5-ASA)[14]	Interstitial nephritis (rare)[14]	**Monitor renal function.** No dose adjustment required for age alone[14]
Oral corticosteroids[15]	**High rates of adverse events in older adults**, including osteoporosis, infection, hyperglycemia, cataracts, and VTE[15]	**Use for induction only—not maintenance therapy.** Document steroid-sparing rationale and address bone protection[2,15]

DRUG/CLASS	INTERACTION/TOXICITY	CLINICAL ACTION
Budesonide MMX[14]	Lower systemic exposure than conventional corticosteroids[2]	Preferred over systemic corticosteroids when topical disease activity allows
Vedolizumab[14,16]	No increased MACE or VTE signal; lower systemic immunosuppression burden[15]	**Preferred biologic in many elderly patients.** Favorable safety profile and biosimilar availability
Ustekinumab[14,15]	**Lowest infection risk among advanced therapies** in older adults[15]	**Preferred in elderly patients when clinically appropriate.** Favorable value-based care profile
Anti-TNF (infliximab, adalimumab)[14]	Latent TB reactivation; HBV reactivation; lymphoma; CHF exacerbation; injection/infusion reactions[14]	**Screen for latent TB and hepatitis B before initiation.** Biosimilars may improve cost-effectiveness[14]
Upadacitinib/Tofacitinib (JAK inhibitors)[24,25]	**FDA boxed warning:** serious infection, MACE, VTE, malignancy, herpes zoster, and lipid changes[24,25]	**Reserve for carefully selected patients.** Perform lipid assessment and evaluate cardiovascular/VTE risk before initiation[24,25]
Thiopurines (AZA, 6-MP)[17]	Age-amplified lymphoma and myelotoxicity risk[17]	**Generally avoid as first-line therapy in elderly patients.** Newer biologics are often preferred[23]
NSAIDs[21,22]	May trigger UC flares and hospitalization[10]	**Avoid in known UC whenever possible.** Consider acetaminophen or topical analgesics instead
S1P receptor modulators (ozanimod, etrasimod)[14]	Bradycardia and AV block risk; cardiac monitoring considerations[14]	**Obtain baseline ECG when indicated.** Monitor cardiac risk before treatment initiation[14]

ABBREVIATIONS: 6-MP = 6-mercaptopurine; AE = adverse event; AGA = American Gastroenterological Association; ACG = American College of Gastroenterology; aHR = adjusted hazard ratio; AV = atrioventricular; AZA = azathioprine; CHF = congestive heart failure; CV = cardiovascular; ECG = electrocardiogram; ESRD = end-stage renal disease; FDA = Food and Drug Administration; HBV = hepatitis B virus; HZV = herpes zoster virus; IL = interleukin; JAK = Janus kinase; MACE = major adverse cardiovascular events; NMSC = non-melanoma skin cancer; NSAIDs = nonsteroidal anti-inflammatory drugs; OR = odds ratio; PY = person-years; S1P = sphingosine-1-phosphate; TB = tuberculosis; TNF = tumor necrosis factor; UC = ulcerative colitis; VBC = value-based care; VTE = venous thromboembolism

∗Consult FDA labels for the most up-to-date dosage information, contraindications, and drug-drug interactions

When to Refer

CRITERION	SPECIALIST	URGENCY
Acute severe UC (Truelove & Witts); toxic megacolon; perforation; massive hemorrhage[20,26]	Emergency department/GI/ surgery	**Emergent**
Steroid-dependent UC; inadequate 5-ASA response at 8 weeks[14]	Gastroenterology for advanced therapy	**Urgent (1–2 weeks)**
Calprotectin >250 µg/g with symptoms[25]	Gastroenterology for endoscopic reassessment	**Urgent (within 2 weeks)**
New jaundice or elevated alk-phos in known UC[6]	Hepatology — workup for PSC	**Urgent (within 1–2 weeks)**
Long-standing UC ≥8 yrs left-sided/extensive[1]	Gastroenterology — surveillance colonoscopy	**Routine — every 1–2 years**
PSC diagnosis in UC[6]	Gastroenterology — annual surveillance colonoscopy	**Routine — annually from PSC diagnosis**
Pre-biologic vaccination and screening[14]	Primary care + gastroenterology	**Routine — before advanced therapy initiation**
Functional decline, polypharmacy, G8 ≤14[12]	Geriatrics/comprehensive geriatric assessment	**Urgent — before next therapy decision**
Severe disease, surgical candidacy[27]	Colorectal surgery (ASCRS guideline)	**Urgent — multidisciplinary**

ABBREVIATIONS: 5-ASA = 5-aminosalicylic acid; ASCRS = American Society of Colon and Rectal Surgeons; G8 = Geriatric 8; GI = gastroenterology; PSC = primary sclerosing cholangitis; UC = ulcerative colitis

Follow-Up Timing

STAGE/CATEGORY	FREQUENCY	LABS/MONITORING
Mild UC in remission on 5-ASA[14]	PCP every **3–6 months;** GI per shared plan[14]	Symptom review; CBC, CMP, CRP as indicated; **fecal calprotectin when symptoms change**; medication adherence flares[25]
Moderate-to-severe UC on advanced therapy — induction[14]	**Every 2–4 weeks during induction.** Monthly during early maintenance[14]	CBC, CMP, CRP, fecal calprotectin; **steroid exposure**; treatment response; therapy-specific monitoring[14,20]

STAGE/CATEGORY	FREQUENCY	LABS/MONITORING
Moderate-to-severe UC — maintenance[14]	Every **3 -6 months**[14]	Disease activity; CBC, CMP, CRP; **infection surveillance**; medication tolerance and adherence
UC ≥8 years left-sided or extensive[1]	Surveillance colonoscopy every **1–2 years**[1]	**Dysplasia surveillance**; disease extent; inflammation status; biopsy review[25]
UC with concurrent PSC[5]	**Annual surveillance colonoscopy**[6]	LFTs; PSC monitoring; **GI/ hepatology coordination**
Post-total proctocolectomy with IPAA[27]	Per surgical and GI plan[27]	**Pouchitis symptoms**; nutritional status; surveillance as indicated

ABBREVIATIONS: CBC = complete blood count; CMP = comprehensive metabolic panel; CRP = C-reactive protein; DEXA = dual-energy X-ray absorptiometry; HD-WLE = high-definition white-light endoscopy; IPAA = ileal pouch-anal anastomosis; JAK = Janus kinase; LFTs = liver function tests; MRCP = magnetic resonance cholangiopancreatography; PSC = primary sclerosing cholangitis; TNF = tumor necrosis factor; UC = ulcerative colitis

Comorbidity Management — Primary Care Role

COMORBIDITY	APPROACH	CAUTION
Osteoporosis from steroid exposure (M81.0)[2,15]	**Obtain DXA screening for cumulative steroid exposure.** Ensure calcium/vitamin D supplementation; consider bisphosphonate therapy when fracture risk warrants[2]	**33% risk of steroid-induced osteoporosis.** HEDIS Osteoporosis Management in Women measure supports documentation[15]
VTE risk (I82.4x/I26.x)[6]	**Provide pharmacologic VTE prophylaxis during hospitalization unless contraindicated**[6]	UC carries a **2–4× increased VTE risk**, and JAK inhibitors may further increase thromboembolic risk[6]
Depression (F32.x)[5,6]	**Screen with PHQ-2/PHQ-9 at routine visits.** Refer for psychotherapy and/or pharmacologic treatment when indicated[6]	**Frequently under-recognized in IBD** and associated with worse quality of life and adherence
Steroid-induced hyperglycemia/new DM (E11.x)[15]	**Monitor HbA1c and glucose trends during corticosteroid exposure.** Coordinate glycemic management when needed[15]	Older adults are more vulnerable to steroid-related metabolic complications
Peripheral arthropathy (M07.6x)[6]	**Document and code associated arthropathy.** Consider rheumatology referral for persistent, progressive, or asymmetric symptoms[6]	Peripheral arthropathy affects approximately **11% of UC patients** and often parallels bowel activity

COMORBIDITY	APPROACH	CAUTION
Primary sclerosing cholangitis (K83.0)[6]	**Trend alkaline phosphatase and liver function tests.** Coordinate hepatology follow-up and ensure surveillance colonoscopy remains current[6]	**PSC increases colorectal cancer risk up to 5-fold.** Annual surveillance colonoscopy begins at PSC diagnosis
Anemia (D50.x/D63.0)[20]	**Check iron studies, vitamin B12, and folate.** Treat the underlying cause rather than empiric iron alone[20]	**Iron-deficiency anemia is common in active UC** and may persist despite relatively mild GI symptoms
Vaccination status[14]	Update pneumococcal, influenza, herpes zoster, HBV, and COVID-19 vaccinations before advanced therapy whenever possible[14]	Live vaccines are generally contraindicated after immunosuppression begins

ABBREVIATIONS: DM = diabetes mellitus; HbA1c = glycated hemoglobin; HBV = hepatitis B virus; HCV = hepatitis C virus; HEDIS = Healthcare Effectiveness Data and Information Set; HR = hazard ratio; IBD = inflammatory bowel disease; JAK = Janus kinase; LFT = liver function test; LMWH = low-molecular-weight heparin; MRCP = magnetic resonance cholangiopancreatography; OMW = Osteoporosis Management in Women; PHQ = Patient Health Questionnaire; PSC = primary sclerosing cholangitis; UC = ulcerative colitis; VTE = venous thromboembolism

Cost-Smart Options

BRAND (EST. COST)	GENERIC/ ALTERNATIVE (EST. COST)	MO. SAVINGS	COST-SMART TIP
Brand adalimumab (Humira) (~$5,800/mo)	**Adalimumab biosimilars** (Amgevita, Hadlima, Hyrimoz, others); ballpark cash price may start ~$550/2 pens depending on product, pharmacy, and coverage	**~$2000– $3,000/ mo**	**Consider biosimilars first** when clinically appropriate[14]
Brand infliximab (Remicade) (~$1,900/100-mg vial; ~$4,000–$6,000/infusion)	**Infliximab biosimilars** (Renflexis, Inflectra, Avsola); biosimilar vial cost as low as ~$115–$600/vial at VA/ institutional pricing; infusion cost varies by site of care, dose, and payer contract	**~$1,500–$4,000/ infusion**	**Infliximab biosimilars are generally considered clinically equivalent** and may substantially reduce cost[14]

BRAND (EST. COST)	GENERIC/ ALTERNATIVE (EST. COST)	MO. SAVINGS	COST-SMART TIP
Vedolizumab (Entyvio) (~$7,200/ dose)	No lower-cost generic equivalent currently; **payer/site-of-care optimization** (home infusion, subcutaneous formulation) may reduce total cost	**~$500–$2,000/ dose** (site-of-care shift)	**Preferred biologic in many older adults** because of its gut-selective mechanism, lower systemic immunosuppressio n burden, and no increased MACE or VTE signal
Ustekinumab (Stelara) (~$22,650/90-mg syringe)	**Ustekinumab biosimilars** (ustekinumab-auub, ustekinumab-ttwe with interchangeable status); cost depends on payer formulary and route/site of care; expect ≥30% reduction from reference price	**~$6,800–$11,300/ dose** (est. 30–50% reduction)	**Favorable safety profile in older adults**; among advanced therapies, often valued for lower infection risk; two biosimilars now have FDA interchangeable status, enabling pharmacy-level substitution[2]
Repeated systemic corticosteroid courses (~$200–$500/course but high downstream costs)	**Budesonide MMX** for appropriate mild-to-moderate UC induction (~$400/course), or timely transition to steroid-sparing advanced therapy	**~$5,000–$30,000/yr** (avoided hospitalizations, fractures, infections)	**Avoid prolonged systemic steroids**; reducing steroid exposure may lower fracture, infection, diabetes, cataract, VTE, and hospitalization risk
Brand mesalamine products (~$400–$800/mo)	**Generic mesalamine** formulations when clinically appropriate and covered	**~$200–$600/mo**	**Generic mesalamine is usually the most cost-effective first-line option** for mild-to-moderate UC; match oral/ rectal formulation to disease extent

BRAND (EST. COST)	GENERIC/ ALTERNATIVE (EST. COST)	MO. SAVINGS	COST-SMART TIP
Delayed escalation after 5-ASA failure (high flare/hospitalization costs ~$10,000–$50,000/admission)	**Early GI referral and steroid-sparing therapy** after inadequate response or steroid dependence	**~$10,000–$50,000/ avoided hospitalization**	**Preventing flares, ASUC admissions, and readmissions** may provide greater value than medication cost alone.
Unplanned UC hospitalization/ readmission (~$15,000–$50,000/ admission)	**Post-discharge PCP follow-up**, medication reconciliation, biologic access support, and infection review	~$10,000–$40,000/avoided readmission	**Early follow-up after ASUC or flare hospitalization** can reduce readmission risk by catching steroid taper issues, biologic delays, C. difficile recurrence, dehydration, and adverse effects

ABBREVIATIONS: ACG = American College of Gastroenterology; AGA = American Gastroenterological Association; MMX = multimatrix formulation; UC = ulcerative colitis

AAVBC PERSPECTIVE

Cost-smart UC care is not about choosing the least expensive therapy—it is about selecting the most appropriate therapy for the patient's disease severity, age, comorbidities, and safety profile. Biosimilars provide clinically equivalent outcomes to reference biologics and may substantially reduce costs. In older adults, therapies with lower infection and systemic immunosuppression risk may provide additional value by reducing treatment-related complications, hospitalizations, and corticosteroid exposure.

Patient Education and Adherence

DOCUMENTATION — PATIENT EDUCATION

Document the following education topics, the patient and caregiver(s) present, materials provided, and patient understanding (teach-back method):

- **Disease extent and severity:** Document discussion of disease location, activity status, and implications for treatment and surveillance
- **Clinical vs. endoscopic remission:** Document that symptom improvement does not always indicate mucosal healing and that ongoing monitoring may still be required
- **Advanced therapy counseling:** Document rationale for biologic/small-molecule therapy, expected benefits, infection risks, and adherence expectations
- **Steroid-sparing strategy:** Document why prolonged corticosteroid use is discouraged and the plan to minimize steroid exposure
- **Vaccination and pre-biologic screening:** Document review of vaccination status and screening for TB, hepatitis B, and other required safety assessments before immunosuppression
- **Colorectal cancer surveillance:** Document recommended colonoscopy intervals and the importance of ongoing surveillance despite symptom control
- **Bone health counseling:** Document calcium/vitamin D recommendations, DXA screening when indicated, and fracture-prevention strategies for steroid-exposed patients
- **VTE awareness:** Document education regarding symptoms of DVT/PE and the increased thromboembolic risk associated with active disease and hospitalization
- **What to report between visits:** New rectal bleeding, worsening diarrhea, nocturnal symptoms, weight loss, fever, dehydration, or medication side effects

What makes ulcerative colitis patient education unique is the disconnect that can occur between symptom control and ongoing intestinal inflammation, the need for lifelong surveillance, and the risks associated with prolonged corticosteroid exposure. Education should emphasize disease monitoring, medication adherence, colorectal cancer surveillance, infection prevention, and recognition of symptoms that require urgent attention.[21,22]

Quality Metrics Tie-In

*No UC-specific HEDIS or CMS Star Rating measure exists. UC performance is reflected through relevant **MIPS quality measures**, **Medicare ACO quality priorities**, and general Medicare Advantage measures such as **vaccination, hepatitis B screening before anti-TNF therapy, colorectal cancer screening, medication reconciliation after hospitalization, readmission reduction, osteoporosis management, diabetes/BP/statin measures, fall-risk reduction, and post-discharge follow-up**.*

MEASURE	STANDARD	NOTES
MIPS Measure #275 — IBD: assessment of hepatitis B virus status before initiating anti-TNF therapy	**Denominator:** Patients initiating anti-TNF therapy **Numerator:** HBsAg and anti-HBc documented before treatment initiation or documented reason not performed	**Anti-TNF agents increase HBV reactivation risk. Verify HBV screening before biologic initiation and document results, vaccination status, and GI treatment plan**[6,14]
MIPS Measure #490 — Appropriate intervention for immune checkpoint inhibitor-related diarrhea/colitis	**Denominator:** Patients receiving immune checkpoint inhibitors who develop grade ≥2 diarrhea/colitis **Numerator:** Appropriate evaluation and management documented	**Not UC-specific**, but important because immune-mediated colitis can mimic a UC flare. Consider oncology treatment history when evaluating worsening diarrhea[15]
Colorectal Cancer Screening — HEDIS COL-E/CMS Star C02[1]	**Denominator:** Average-risk adults aged 45–75 years. **Numerator:** Guideline-recommended colorectal cancer screening completed[1]	Distinct from UC dysplasia surveillance. Patients with longstanding UC require GI-directed surveillance colonoscopy beyond routine population screening recommendations[1,6]
Medication Reconciliation Post-Discharge — HEDIS MRP/CMS Star C17 [14]	**Denominator:** Patients discharged from an inpatient stay **Numerator:** Medication reconciliation completed within 30 days of discharge[14]	Particularly important after **ASUC hospitalization,** steroid taper initiation, biologic changes, infection treatment, anticoagulation, or other high-risk medication transitions. Post-discharge medication reconciliation is critical
Plan All-Cause Readmissions — HEDIS PCR/CMS Star C18[20]	**Denominator:** Adults discharged from an acute inpatient stay **Numerator:** Unplanned readmission within 30 days (lower is better) **Exclusions:** Planned readmission[20]	UC flare readmissions, ASUC, C. difficile superinfection, steroid complications, biologic access delays, and poor discharge planning can directly affect plan performance
Osteoporosis Management in Women Who Had a Fracture — HEDIS OMW/CMS Star C10[15]	**Denominator:** Women aged 67–85 with fracture **Numerator:** Bone mineral density testing or osteoporosis treatment within 6 months[15]	Supports documentation of steroid-related osteoporosis risk in older UC patients. Document **steroid exposure, DXA/BMD, fracture history, calcium/vitamin D plan, and osteoporosis therapy** when indicated

MEASURE	STANDARD	NOTES
Diabetes Care — Blood Sugar Controlled — HEDIS GSD/CMS Star C12[15]	**Denominator:** Patients with diabetes included in the measure population **Numerator:** Most recent HbA1c meets measure target[15]	Relevant because corticosteroids can worsen hyperglycemia or reveal steroid-induced diabetes. Document **A1c trend, glucose monitoring, steroid exposure, and medication adjustment** during/after steroid courses
Care for Older Adults — Medication Review — HEDIS COA/CMS Star C08[12]	**Denominator:** Enrollees ≥66 years **Numerator:** Annual medication review documented **Exclusions:** Hospice[12]	Particularly important in older adults with polypharmacy, biologic/JAK inhibitor therapy, corticosteroid exposure, anticoagulation, and multimorbidity. Document **medication review, NSAID avoidance, pain plan, falls, and functional status** when clinically relevant[12]
Care for Older Adults — Pain Assessment — HEDIS COA/ CMS Star C098[12]	**Denominator:** Enrollees ≥66 years **Numerator:** Annual medication review documented **Exclusions:** Hospice[12]	Chronic abdominal pain, arthropathy, osteoporosis-related pain, and functional limitations may affect quality of life and adherence. Document pain assessment, management plan, falls risk, and functional impact

QUALITY OUTCOME:

*When primary care recognizes persistent or steroid-dependent ulcerative colitis and escalates promptly to GI for biologic or small-molecule therapy consideration, patients are more likely to avoid prolonged corticosteroid exposure, prevent flares and hospitalization, and maintain long-term disease control. The highest-value PCP actions are to **document steroid-sparing rationale**, complete **pre-biologic screening/vaccination review**, and reinforce **lifelong colorectal cancer surveillance** when indicated.*

DOCUMENTATION

When a treatment escalation is reached GI consultation or shared decision-making, document the recommendation, the clinical reasoning (extent, severity, prior therapy failures, pre-biologic screening results, frailty/CGA findings), the patient's expressed preferences, and the agreed plan. Anchor surveillance documentation to active K51.x throughout disease activity AND remission — Z87.19 applies ONLY after total proctocolectomy.

5 CODING REMINDERS AND CASE EXAMPLES

Coding Specificity

ELEMENT	DOCUMENTATION REQUIREMENT
Anatomic extent[4,10,11]	Document from colonoscopy — pancolitis (**K51.0x**), proctitis **(K51.2x)**, rectosigmoiditis **(K51.3x)**, left-sided colitis **(K51.5x)**, other **(K51.8x).**[7] **Avoid K51.9x (unspecified)** when extent is documented
Complication status (5th character)[4,10,11]	11 (rectal bleeding), 12 (intestinal obstruction), 13 (fistula), 14 (abscess), 18 (other), 19 (unspecified complications);[4] document active complications at the encounter
Using Z87.19 (history) for a patient in remission with intact colon[4,10,11]	**Remission is still active UC when the patient has an intact colon and ongoing treatment, monitoring, or surveillance.** Use active **K51.x** when UC requires maintenance therapy, biomarkers, surveillance colonoscopy, or GI follow-up. Reserve **Z87.19** for true history-only disease, such as after curative total proctocolectomy/no ongoing UC management[7]
Activity vs remission[2,4]	UC in remission is still UC — use K51.x;[4,10,11] document clinical AND endoscopic remission separately (Mayo subscore 0–1 or UCEIS <2)[13]
Concurrent EIMs[6]	Peripheral arthropathy M07.6x,[6] PSC K83.0,[6] uveitis, pyoderma gangrenosum — code each linked to UC; supports complete clinical complexity
VTE risk and prophylaxis[6]	UC carries 2–4× VTE risk (HR 2.12);[2] document I82.4x with laterality when DVT or I26.x with PE; document prophylaxis during hospitalization or flares
Steroid exposure status[15]	Document current or prior prolonged **corticosteroid exposure (Z79.52** when applicable), DXA findings, **osteopenia/osteoporosis (M81.0)**, and bone-protection strategies to support steroid-sparing management[15]

ABBREVIATIONS: DVT = deep vein thrombosis; EIM = extraintestinal manifestation; HR = hazard ratio; PE = pulmonary embolism; PSC = primary sclerosing cholangitis; UC = ulcerative colitis; UCEIS = Ulcerative Colitis Endoscopic Index of Severity; VTE = venous thromboembolism

Annual Clinical Review and Confirmation

- **Annual review:** Active UC (K51.x) must be reassessed annually with MEAT documented;[4] patients in clinical or endoscopic remission with intact colon remain K51.x — Z87.19 applies only after curative total proctocolectomy
- **Visit modality:** Face-to-face or synchronous audio-video telehealth qualifies when it supports meaningful clinical evaluation; chart updates without an encounter do not satisfy MEAT

- **Clinical context:** Under CMS-HCC V28, K51.x maps to HCC 81;[10,11] all K51 subcodes carry the same HCC map regardless of extent or complication specificity — but documenting extent and complication accurately supports clinical traceability[4,10,11]
- **Avoid rollover:** Do not copy forward last year's UC note without updating disease activity (clinical and endoscopic), current therapy, comorbidity/EIM status, surveillance plan, and pre-biologic screening — silent rollover will likely misrepresent the care being delivered

Good Documentation is Comprehensive Coding

EHR SHORTCUT/RISK	PREFERRED DOCUMENTATION LANGUAGE
"UC, stable"/"UC"	**'Ulcerative colitis, left-sided, with rectal bleeding (K51.511),** Mayo endoscopic subscore 2 on 06/04/2026; fecal calprotectin 480 µg/g and CRP 28 mg/L; C. difficile negative; urgent GI referral placed'
Defaulting to K51.90 when colonoscopy documents extent[7]	**'Active left-sided ulcerative colitis with rectal bleeding (K51.511),** extent confirmed on colonoscopy; moderate endoscopic activity, Mayo 2; symptoms include 4–5 stools/day, urgency, and intermittent hematochezia'[5]
Using Z87.19 in a patient in remission with intact colon[7]	**Left-sided ulcerative colitis in clinical/endoscopic remission, intact colon,** on vedolizumab maintenance; no bleeding, no urgency, stool frequency at baseline; surveillance colonoscopy due 04/2027 **— active K51.x retained** because disease requires ongoing treatment and surveillance[4,10,13]
'On steroids' without rationale or sparing plan[15]	'**UC flare treated with prednisone taper,** currently 20 mg daily → 15 mg daily; steroid exposure reviewed after 2 bursts in 12 months; DEXA/bone-protection plan documented; **vedolizumab initiated as steroid-sparing therapy** to avoid prolonged corticosteroid exposure'[2,15]
'UC, on biologic'[14]	**'Active left-sided UC (K51.511), on vedolizumab 300 mg IV q8 weeks after** AGA 2024–preferred induction in older adult; last infusion 05/29/2026; tolerating therapy without infusion reaction or serious infection; response monitored by stool frequency, bleeding, weight, CRP, and fecal calprotectin'[14,16]
'Symptoms controlled'[2]	**'UC in clinical remission**: 1–2 stools/day, no rectal bleeding, no urgency, no nocturnal stools; weight stable; no steroid use; maintenance therapy continued; **endoscopic remission/ surveillance status documented** per colonoscopy/GI plan'[2,13]

EHR SHORTCUT/RISK	PREFERRED DOCUMENTATION LANGUAGE
'Arthritis in UC patient'[6]	**Peripheral arthropathy related to ulcerative colitis (M07.6x linked to K51.x),** symmetric large-joint pain without erosive disease; symptoms reviewed; NSAID avoidance discussed; rheumatology referral placed if persistent or inflammatory features progress'[6]
"Anemia" with no etiology	**Iron-deficiency anemia secondary to UC-related chronic blood loss/inflammation,** Hgb 10.8 g/dL, ferritin 18 ng/mL; iron replacement started; CBC/iron indices to be monitored; UC flare management coordinated with GI
"Steroids tapered" with no comorbidity flagging	**Prednisone tapered over 8 weeks for UC flare;** cumulative steroid exposure reviewed; osteopenia/osteoporosis risk addressed with DEXA, calcium/vitamin D, fall-risk counseling, and steroid-sparing biologic plan

ABBREVIATIONS: AGA = American Gastroenterological Association; ASUC = acute severe ulcerative colitis; DEXA = dual-energy X-ray absorptiometry; MACE = major adverse cardiovascular events; OR = odds ratio; TNF = tumor necrosis factor; UC = ulcerative colitis; VTE = venous thromboembolism

Brief Case Examples

✓ SUCCESS — COMPREHENSIVE DOCUMENTATION

Patient: 72-year-old patient with elderly-onset UC (**K51.50** left-sided colitis diagnosed at age 64) presents with increased stool frequency (4–5/day), urgency, and minimal hematochezia for 2 weeks. Primary care ordered calprotectin (480 µg/g) and stool C. diff (negative), and referred urgently to GI. Repeat colonoscopy showed Mayo subscore 2 left-sided activity.

Documentation: 'Active left-sided ulcerative colitis with rectal bleeding, moderate activity (Mayo 2): **K51.511** — Mayo subscore 2 per colonoscopy 5/20; calprotectin 480 µg/g (5/14); CRP 28 mg/L; C. diff negative. Advanced therapy initiated — vedolizumab 300 mg IV at weeks 0, 2, 6 then q8 weeks per AGA 2024 / ACG 2025 (preferred in elderly: gut-selective, OR 0.68 for serious infection vs anti-TNF, no MACE/VTE signal).Steroid-sparing rationale: cumulative prior steroid exposure with 2 bursts in past 12 months; DEXA T-score −1.8 (**M81.0**). Pre-biologic screening: IGRA negative, HBV/HCV negative, varicella IgG positive. Concurrent: depression mild — PHQ-9 8 (**F32.0**); G8 14 → CGA placed.'

Outcome: HCC 81 (active IBD) supported with extent and complication specificity (**K51.511**); concurrent osteoporosis (**M81.0**) and depression **(F32.0**) coded; pre-biologic screening documented; steroid-sparing rationale supports HEDIS DAE; surveillance colonoscopy on schedule (≥8 yrs left-sided).

⚠ PITFALL — INSUFFICIENT DOCUMENTATION

Documentation as written: '**History of UC.' Coded as Z87.19**. Patient is in clinical remission with intact colon, on mesalamine 2.4 g/day maintenance, last colonoscopy 14 months ago showed Mayo 1. No history of steroid exposure; no DEXA on file despite 3 cumulative steroid bursts in the past 24 months. Vaccination status not reviewed. No record of fecal calprotectin or surveillance plan.

Consequence: Z87.19 does NOT map to any HCC; using it during active UC, even in remission with an intact colon, removes HCC 81 support. Missing comorbidity codes (M81.0 osteoporosis, Z79.52 long-term steroid use) understate clinical complexity. No documented surveillance plan or pre-biologic readiness — gap in HEDIS COL-E and DAE measure documentation.

RAF Impact: Lost HCC 81 documentation (CNA RAF 0.244 ≈ $2,538/year illustrative) missed concurrent comorbidity coding for steroid-induced osteoporosis and steroid exposure further understates complexity.

Fix: Update problem list and assessment: 'Active left-sided ulcerative colitis in endoscopic remission (Mayo 1) — **K51.50** (intact colon, on maintenance therapy); long-term oral corticosteroid use status — **Z79.52** (3 bursts in past 24 months; steroid-induced osteopenia — DEXA pending (**M85.80**); surveillance colonoscopy due at 24 months given ≥8 yrs left-sided disease per ACG/AGA.'[1] Document MEAT for each at the next encounter; reserve Z87.19 only for post-total-proctocolectomy.

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