



COLORECTAL CANCER SCREENING*

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Status: Current

**Note: The former medical policy #91484 - Virtual Colonoscopy has been incorporated into this medical policy.*

I. BACKGROUND:

Colorectal cancer (CRC) causes over 57,000 deaths in the United States annually, making it the second most lethal type of cancer. Widespread screening for colorectal cancer could prevent many of these deaths since prognosis improves dramatically with early detection and treatment. Colon cancer prevention should be the primary goal of CRC screening. Tests that are designed to detect both early cancer and adenomatous polyps should be encouraged if resources are available and patients are willing to undergo an invasive test. Existing screening methods include both invasive and non-invasive tests with varying sensitivities and specificities. Commonly used tests include the fecal occult blood test (FOBT), flexible sigmoidoscopy, barium enema, traditional colonoscopy and virtual colonoscopy.

II. POLICY/CRITERIA:

A. General Screening:

Beginning at age 50, both men and women at average risk for developing colorectal cancer should begin screening as discussed in the Priority Health Preventive Health Care Guidelines located at:
<http://www.priorityhealth.com/classesresources/stayinghealthy/preventivecare/>.
Testing includes fecal occult blood (FOB), flexible sigmoidoscopy, colonoscopy and barium enema.

B. Advanced Screening and Evaluation Guidelines:

The following cancer screening guidelines are adapted from the Screening and Surveillance for the Early Detection of Colorectal Cancer and Adenomatous Polyps, 2008: A Joint Guideline from the American Cancer Society, the US Multi-Society Task Force on Colorectal Cancer, and the American College of Radiology.

1. **Patients with small rectal hyperplastic polyps** should be considered to have normal colonoscopies, and therefore the interval before the subsequent colonoscopy should be 10 years. An exception is patients with a hyperplastic polyposis syndrome. They are at increased risk for



adenomas and colorectal cancer and need to be identified for more intensive follow up.

2. **Patients with only one or two small (<1 cm) tubular adenomas with only low-grade dysplasia** should have their next follow-up colonoscopy in 5 to 10 years. The precise timing within this interval should be based on other clinical factors (such as prior colonoscopy findings, family history, and the preferences of the patient and judgment of the physician).
3. **Patients with 3 to 10 adenomas, or any adenoma > 1 cm, or any adenoma with villous features, or high-grade dysplasia** should have their next follow-up colonoscopy in 3 years providing that piecemeal removal has not been done and the adenoma(s) are completely removed. If the follow-up colonoscopy is normal or shows only one or two small tubular adenomas with low-grade dysplasia, then the interval for the subsequent examination should be 5 years.
4. **Patients who have more than 10 adenomas at one examination** should be examined at a shorter (<3 years) interval established by clinical judgment, and the clinician should consider the possibility of an underlying familial syndrome.
5. **Patients with sessile adenomas that are removed piecemeal** should be considered for follow up at short intervals (2 to 6 months) to verify complete removal. Once complete removal has been established, subsequent surveillance needs to be individualized based on the endoscopist's judgment. Completeness of removal should be based on both endoscopic and pathologic assessments.
6. **More intensive surveillance is indicated when the family history may indicate an inherited colorectal cancer syndrome such as hereditary nonpolyposis colorectal cancer (HNPCC) or Familial Adenomatous Polyposis (FAP).** See the National Comprehensive Cancer Guidelines (NCCN) for specific screening information for these conditions (www.NCCN.org).

C. Additional colorectal cancer screening tests:

1. **Computed tomography colonography (CTC)*** also referred to as virtual colonoscopy, has been developed as a noninvasive means to obtain detailed three-dimensional colonoscopic images of the colon and rectum. This procedure involves the collection of high-resolution two-dimensional images of the cleansed and insufflated colon and rectum using helical CT. If suspicious lesions are detected, the patient usually undergoes further testing by conventional colonoscopy. Virtual colonoscopy does not require sedation, but does require a bowel cleansing preparation and rectal probe for insufflation of the colon.
 - a. CTC is a covered benefit for those patients in whom a flexible colonoscopy, **performed within the prior 2 months**, of the entire



colon is incomplete due to an inability to pass the colonoscope proximally. Failure to advance the colonoscope may be secondary to an obstructing neoplasm, stricture, tortuosity, spasm, redundant colon, diverticulitis, extrinsic compression or aberrant anatomy/scarring from prior surgery. If failure of colonoscopy is due to incomplete bowel preparation then CTC is **not a covered benefit**.

- b. CTC using magnetic resonance imaging (MRI) (also known as MRI colonography) is considered experimental and investigational for the screening or diagnosis of colorectal cancer, inflammatory bowel disease, or other indications because its value for these indications has not been established.
- c. CTC is **not a covered benefit** for standard colorectal cancer screening. There is no evidence that virtual colonoscopy improves patient management or disease outcomes for colorectal cancer. Conventional colonoscopy remains the gold standard for colorectal cancer screening and is a covered benefit.

2. Fecal DNA Screening

Fecal DNA testing is performed on stool samples that are submitted to a laboratory after being collected by patients at home. Fecal DNA testing is **NOT a covered benefit**. There is insufficient data upon which to determine screening intervals for negative testing and this test has not been shown to have high sensitivity for both cancer and adenomatous polyps. A positive Fecal DNA test would need to be followed up with colonoscopy

III. MEDICAL NECESSITY REVIEW

- Required for Computed Tomography Colonography (CTC)*
- Not Required
- Not Applicable

IV. APPLICATION TO PRODUCTS

Coverage is subject to member's specific benefits. Group specific policy will supersede this policy when applicable.

- ❖ **HMO/EPO:** *This policy applies to insured HMO/EPO plans.*
- ❖ **POS:** *This policy applies to insured POS plans.*
- ❖ **PPO:** *This policy applies to insured PPO plans.*
- ❖ **ASO:** *For self-funded plans, consult individual plan documents. If there is a conflict between this policy and a self-funded plan document, the provisions of the plan document will govern.*



- ❖ **INDIVIDUAL:** *For individual policies, consult the individual insurance policy. If there is a conflict between this medical policy and the individual insurance policy document, the provisions of the individual insurance policy will govern.*
- ❖ **MEDICARE:** *Coverage is determined by the Centers for Medicare and Medicaid Services (CMS).*
- ❖ **MEDICAID:** *If there is a discrepancy between this policy and the Michigan Medicaid Provider Manual and the Michigan Medicaid Fee Schedule, the Michigan Medicaid Provider Manual and the Michigan Medicaid Fee Schedule at: http://www.michigan.gov/mdch/0,1607,7-132-2945_42542_42543_42546_42551-159815--_00.html will govern.*
- ❖ **MICHILD:** *For MICHILD members, this policy will apply unless MICHILD certificate of coverage limits or extends coverage.*

V. CODING INFORMATION

ICD9 Codes:

The ICD9 codes below support colorectal cancer screening as a preventive service (not subject to deductible) when billed with one of the following CPT/HCPCS procedure codes in the subsequent section:

- V10.00 Personal history of malignant neoplasm - gastrointestinal tract, unspecified
- V10.01 Personal history of malignant neoplasm - Tongue
- V10.02 Personal history of malignant neoplasm - Other and unspecified oral cavity and pharynx
- V10.03 Personal history of malignant neoplasm - Esophagus
- V10.04 Personal history of malignant neoplasm - Stomach
- V10.05 Personal history of malignant neoplasm - Large intestine
- V10.06 Personal history of malignant neoplasm - rectum, rectosigmoid junction, and anus
- V16.0 Family history of malignant neoplasm - Gastrointestinal tract
- V76.41 Special screening for malignant neoplasms of the rectum
- V76.51 Special screening for malignant neoplasms of the colon

CPT/HCPCS Procedure Codes

- 45330 Sigmoidoscopy, flexible; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)
- 45331 Sigmoidoscopy, flexible; with biopsy, single or multiple
- 45333 Sigmoidoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery
- 45334 Sigmoidoscopy, flexible; with control of bleeding (eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)
- 45338 Sigmoidoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique
- 45339 Sigmoidoscopy, flexible; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique
- G0104 Colorectal cancer screening; flexible sigmoidoscopy



- 45378 Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimen(s) by brushing or washing, with or without colon decompression (separate procedure)
- 45380 Colonoscopy, flexible, proximal to splenic flexure; with biopsy, single or multiple
- 45382 Colonoscopy, flexible, proximal to splenic flexure; with control of bleeding (eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)
- 45383 Colonoscopy, flexible, proximal to splenic flexure; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique
- 45384 Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery
- 45385 Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique
- G0105 Colorectal cancer screening; colonoscopy on individual at high risk
- G0121 Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk
- 74270 Radiologic examination, colon; contrast (eg, barium) enema, with or without KUB
- 74280 Radiologic examination, colon; air contrast with specific high density barium, with or without glucagon
- G0106 Colorectal cancer screening; alternative to G0104, screening sigmoidoscopy, barium enema
- G0120 Colorectal cancer screening; alternative to G0105, screening colonoscopy, barium enema
- G0122 Colorectal cancer screening; barium enema
- 82270 Blood, occult, by peroxidase activity (eg, guaiac), qualitative; feces, consecutive collected specimens with single determination, for colorectal neoplasm screening (ie, patient was provided 3 cards or single triple card for consecutive collection)
- 82274 Blood, occult, by fecal hemoglobin determination by immunoassay, qualitative, feces, 1-3 simultaneous determinations
- G0328 Colorectal cancer screening; fecal occult blood test, immunoassay, 1-3 simultaneous determinations

Pre-authorization required:

Note: American Imaging Management (AIM) provides prior authorization medical necessity review services on behalf of Priority Health for participating providers. Prior authorization for out-of-network providers must be requested through Priority Health.

- 74261 Computed tomographic (CT) colonography, diagnostic, including image postprocessing; without contrast material



74262 Computed tomographic (CT) colonography, diagnostic, including image postprocessing; with contrast material(s) including non-contrast images, if performed

Not covered:

74263 Computed tomographic (CT) colonography, screening, including image postprocessing

Special Notes: Priority Health's Technology Assessment Committee reviewed Virtual Colonoscopy for colorectal cancer screening on March 5, 2004 and recommended non-coverage.

VI. REFERENCES

Guidelines for colonoscopy surveillance after polypectomy: a consensus update by the US Multi-Society Task Force on Colorectal Cancer and the American Cancer Society. *CA Cancer J Clin.* 2006 May-Jun;56(3):143-59

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"Virtual Colonoscopy" HAYES, Inc. February 2008



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