HEALTH INSURANCE EXCHANGE POLICY STATEMENT

Original Effective Date	Next Annual Review Date	Last Review / Revision Date
02/23/2016	2/23/2017	02/23/2016

Policy Name	Policy Number
Screening and Surveillance for Colorectal Cancer	MM-0040

Policy Type		
☒ Medical	☐ Administrative	☐ Payment

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A. SUBJECT

Screening and Surveillance for Colorectal Cancer

B. BACKGROUND

Of malignancies affecting both men and women in the US colorectal carcinoma (CRC) is the 3rd most common resulting in over 50,000 deaths annually and rising to the 2nd leading cause of cancer deaths overall.

Uncommon before the age of 40 the incidence rises successively especially after the age of 50. Over the past two decades there has been a gradual decline in the incidence of CRC likely as a result of increased screening promoting identification and removal of early-stage cancer and adenomatous polyps.

The evidence is convincing that appropriate screening reduces colorectal cancer mortality in adults 50-75 years of age. Screening strategies have centered on the use of endoscopic exams (colonoscopy and flexible sigmoidoscopy), radiologic imaging (double contrast barium enema (DCBE), and computed tomography (CT Colonography) scanning and stool tests (fecal occult blood testing (FOBT) and Fecal Immunochemical Testing (FIT)); or abnormal DNA constituents (Fecal DNA). Positive screening by stool testing, radiographic tests and sigmoidoscopy is following by colonoscopy.

Over the past decade the relative utility of screening techniques has demonstrated a trend toward declining rates of flexible sigmoidoscopy and double contrast barium enema. Rates of colonoscopy have increased during this time frame while the use of stool blood tests have remained relatively constant.
Various expert medical and scientific panels have established clinical guidelines which support screening colonoscopy based on patient age and risk stratification, separating individuals of "average" risk from those at "increased or high" risk. The USPSF has specifically been tasked with determining the effectiveness and value for preventative and screening tests made available through the Affordable Care Act (effective September 2010).

A screening colonoscopy is generally recommended every 10 years for asymptomatic patients between the age of 50-75 having no history of colon cancer, polyps, or other gastrointestinal disease. Based on the recommendation of the USPSTF when screening test result in the diagnosis of clinically significant colorectal adenomas or cancer, the patient should be "followed by a surveillance regimen and recommendations for screening are no longer applicable."

C. DEFINITIONS

- **Colonoscopy:** an endoscopic procedure allowing direct inspection of the lining of the entire colon with biopsy sampling and/or removal of polyps or early stage cancers
- **CT Colonography:** also known as "virtual colonoscopy" utilizing advanced computed tomography (CT) to produce 2 and 3 dimensional images of the colon and rectum.
- **Double Contrast Barium Enema (DCBE):** also called "air contrast barium enema" during which air and liquid contrast are inserted into the colon and x-rays are taken.
- **Fecal DNA Testing:** a stool test that measures abnormal sections of DNA (mutations) from cancer or polyp cells.
- **Fecal Immunochemical Testing: (FIT or iFOBT):** a home screening test unaffected by food or medicines that utilizes a chemical reaction with hemoglobin to detect human blood from the lower intestine.
- **Fecal Occult Blood Testing (FOBT):** a home screening test that detects hidden blood arising from anywhere in the digestive tract in the stool through a chemical reaction.
- **Flexible Sigmoidoscopy;** an endoscopic examination of the lower half of the colon
- **Monitoring Colonoscopy:** the evaluation of individuals after diagnosis or treatment for CRC.
- **Screening Colonoscopy:** the evaluation for CRC in individuals without symptoms.
- **Multi-Targeted Stool DNA (Cologuard)**: a home screening test utilizing an algorithmic analysis of stool DNA amplified by polymerase chain reaction (PCR) in combination with a fecal immunochemical test (FIT) test.
- **Surveillance Colonoscopy:** periodic colonoscopy on an individual with a prior history of adenoma(s) or CRC to remove polyps (missed previously or which have developed since prior examination)

D. POLICY

I. Screening for CRC in members at **average risk:**
CareSource will cover as medically necessary preventive the following screening tests for members at average risk for CRC between 50-75 years of age (ending at 76th birthday):
A. Screening Colonoscopy every 10 years
B. Flexible sigmoidoscopy every 5 years in combination with FOBT or FIT every 3 years
C. ACBE every 5 years
D. FOBT or FIT yearly

II. Screening for CRC in members at **high risk:**
For high-risk members defined as having **ONE** of the following:

A. A first degree relative (sibling, parent or child) who has had colorectal cancer or an adenomatous polyp
B. A family history of familial adenomatous polyposis
C. Inherited risk through a family history of hereditary nonpolyposis colorectal cancer (HNPCC) or familial adenomatous polyposis (FAP)
D. A personal history of adenomatous polyps
E. A personal history of colorectal cancer
F. A personal history of inflammatory bowel disease including Crohn's disease or ulcerative colitis.

Note: CareSource will cover as medically necessary preventative screening colonoscopy every 24 months.

III. **Surveillance** in members following **resection of CRC**
Although individuals with adenomatous polyps or CRC require surveillance following removal and/or resection the USPSTF did not address evidence for the effectiveness of any particular regimen.

For individuals with first-degree relatives who developed cancer at a younger age or those with multiple affected first-degree relatives, the USPSTF submits that an earlier start to screening may be reasonable. For patients under the age of 50 considered to be at high risk CareSource requires the provider submit documentation of family history or other risk indicators

IV. **Other Screening Tests:**
A. **CT Colonography**: The USPSTF concludes that the evidence assessing the balance of benefits and harms cannot be determined for this screening tool. CareSource considers the use of CT Colongraphy for screening purpose of CRC to be unproven for improving health outcomes and not medically necessary.
B. **Multi-targeted Stool DNA (Cologuard)**: CareSource considers the use of stool DNA testing for the purpose of screening for CRC to be unproven for improving health outcomes and not medically necessary.

CONDITIONS OF COVERAGE
HCPCS
CPT

AUTHORIZATION PERIOD
No prior authorization is required for participating providers.

E. RELATED POLICIES/RULES

F. REVIEW/REVISION HISTORY

Date Issued: 2/23/2016
Date Reviewed: 2/23/2016
Date Revised:

G. REFERENCES

1. Center for Disease Control and Prevention: http://www.cdc.gov/cancer/colorectal/statistics/
2. US Preventative Services Task Force: http://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/colorectal-cancer-screening

3. American Cancer Society: Colorectal Cancer Prevention and Early Detection http://www.cancer.org/cancer/colonandrectumcancer/moreinformation/colonandrectumcancerearlydetection/colorectal-cancer-early-detection-acs-recommendations
4. 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; CA Cancer J Clin 2008;58:130–160.
5. Meissner HI, Breen N, Klabunde CN,Vernon SW. Patterns of colorectal cancer screening uptake among men and women in the United States. Cancer Epidemiol Biomarkers Prev 2006;15:389–394.
6. Hayes GTE Report: Cologuard; Published 10/16/2014.

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

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