



REIMBURSEMENT POLICY STATEMENT

Arkansas PASSE

Policy Name & Number	Date Effective
Screening and Surveillance for Colorectal Cancer-AR PASSE-PY-1426	07/01/2024
Policy Type	
REIMBURSEMENT	

Reimbursement Policies prepared by CareSource and its affiliates are intended to provide a general reference regarding billing, coding and documentation guidelines. Coding methodology, regulatory requirements, industry-standard claims editing logic, benefits design and other factors are considered in developing Reimbursement Policies.

In addition to this Policy, Reimbursement of services is subject to member benefits and eligibility on the date of service, medical necessity, adherence to plan policies and procedures, claims editing logic, provider contractual agreement, and applicable referral, authorization, notification and utilization management guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any federal or state coverage mandate, Evidence of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

This Policy does not ensure an authorization or Reimbursement of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced herein. If there is a conflict between this Policy and the plan contract (i.e., Evidence of Coverage), then the plan contract (i.e., Evidence of Coverage) will be the controlling document used to make the determination.

CareSource and its affiliates may use reasonable discretion in interpreting and applying this Policy to services provided in a particular case and may modify this Policy at any time.

According to the rules of Mental Health Parity Addiction Equity Act (MHPAEA), coverage for the diagnosis and treatment of a behavioral health disorder will not be subject to any limitations that are less favorable than the limitations that apply to medical conditions as covered under this policy.

Table of Contents

A.	Subject	2
B.	Background	2
C.	Definitions.....	2
D.	Policy	2
E.	Conditions of Coverage	4
F.	Related Policies/Rules	4
G.	Review/Revision History	4
H.	References	4

A. Subject

Screening and Surveillance for Colorectal Cancer

B. Background

In the United States, colorectal cancer (CRC) ranks second to lung cancer as a cause of cancer mortality and is the third most commonly occurring cancer in both men and women with approximately twenty percent (20%) higher incidence rates among African Americans. CRC incidence and mortality rates have declined over previous decades driven by changes in risk factors, early detection of cancer through screening, removal of precancerous polyps with colonoscopy, and advances in surgical/treatment approaches.

Appropriate screening reduces colorectal cancer mortality in adults 45 years of age or older. The benefit of the early detection of and intervention for colorectal cancer declines with age, but it is recommended by both the American College of Gastroenterology and the American Society for Gastrointestinal Endoscopy that screening begin at 45 years of age. Individuals 75 years of age and older are recommended to work with a primary care physician to determine if continued screening is appropriate and/or recommended.

C. Definitions

- **Risk** – Agents or situations known to increase development of a condition. Per American Cancer Society guidelines:
 - **Low** – Certain factors are not present, including a personal or family history of colorectal cancer, certain types of polyps, inflammatory bowel disease (eg, ulcerative colitis, Crohn’s disease), or radiation to abdomen or pelvic area to treat prior cancer, and/or a confirmed or suspected hereditary colorectal cancer syndrome (eg, familial adenomatous polyposis (FAP), or Lynch syndrome)
 - **High or Increased** – Any of the factors seen above are present.
- **Colorectal Cancer Screening** – Testing for early-stage colorectal cancer and precancerous lesions in asymptomatic members with an average risk.
- **Surveillance for Colorectal Cancer** – Close observation for members who are at increased or high risk for colorectal cancer.

D. Policy

I. Colorectal Cancer Screening

- A. Prior authorization is not required for participating providers.
- B. Benefit coverage is for members at least 45 years of age or less than 45 years of age if at risk for colorectal cancer.
- C. Screening for colorectal cancer claims must be submitted with one of the following ICD-10 codes:
 1. Z12.10 – Encounter for screening for malignant neoplasm of intestinal tract, unspecified
 2. Z12.11 – Encounter for screening for malignant neoplasm of colon
 3. Z12.12 – Encounter for screening for malignant neoplasm of rectum
 4. Z12.13 – Encounter for screening for malignant neoplasm of small intestine

D. The following are reimbursable (not an all-inclusive list):

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

1. Highly sensitive fecal immunochemical test (FIT)
 2. Highly sensitive guaiac-based fecal occult blood test (gFOBT)
 3. Multi-targeted stool DNA test (mt-sDNA)
 4. Colonoscopy
 5. Flexible sigmoidoscopy (FSIG)
 6. CT colonography (virtual colonoscopy)
 - a. Reimbursable when the following conditions are met:
 01. Only indicated when an instrument/fiberoptic colonoscopy of the entire colon is incomplete due to an inability to pass the colonoscopy proximally.
 02. When ordered or performed by qualified personnel.
 03. Final report must address all structures of the abdomen afforded review in a regular CT of the abdomen and pelvis.
 - b. Exclusions for reimbursement:
 01. When used for screening or in the absence of signs or symptoms of disease, regardless of family history or other risk factors for the development of colonic disease.
 02. When used as an alternative to instrument/fiberoptic colonoscopy for screening or in the absence of signs or symptoms of disease.
 03. Since any colonography with abnormal or suspicious findings would require a subsequent instrument/fiberoptic colonoscopy for diagnosis (eg, biopsy) or for treatment (eg, polypectomy), virtual colonography is not reimbursable when used as an alternative to an instrument/fiberoptic colonoscopy, even though performed for signs or symptoms of disease.
 04. CT colonography procedure codes are counted against the member's annual lab and X-ray benefit limit.
 - E. A follow-up colonoscopy is reimbursed as part of the screening process when a non-colonoscopy test is positive.
 - F. Screening with plasma or serum markers is not covered.
- II. Colonoscopy Surveillance for Colorectal Cancer
- A. Prior authorization is not required for participating providers.
 - B. Surveillance for colorectal cancer claim must be submitted with one of the following ICD-10 codes:
 1. Z84.81 – Family history of carrier of genetic disease
 2. Z15.89 – Genetic susceptibility to other disease
 3. Z83.71 – Family history of colonic polyps
 4. Z85.038 – Personal history of other malignant neoplasm of large intestine
 5. Z85.048 – Personal history of other malignant neoplasm of rectum, rectosigmoid junction, and anus
 6. Z80.0 – Family history of malignant neoplasm of digestive organs
 7. Z86.010 – Personal history of colonic polyps
 8. Z92.3 – Personal history of irradiation or radiation therapy
 9. K50 through K52 category codes – Noninfective enteritis and colitis.

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

E. Conditions of Coverage

Reimbursement is dependent on, but not limited to, submitting HCPCS and CPT codes along with appropriate modifiers.

F. Related Policies/Rules

NA

G. Review/Revision History

DATE		ACTION
Date Issued	03/29/2023	Approved at Committee.
Date Revised	05/10/2023 03/27/2024	Removed information re: PT modifier. Approved at Committee. Annual review, references updated. Approved at Committee.
Date Effective	07/01/2024	
Date Archived		

H. References

1. American Cancer Society guideline for colorectal cancer screening. Revised November 17, 2020. Accessed February 8, 2024. www.cancer.org
2. Coverage-Applicability, ARK. CODE ANN. § 23-79-1202 (2023).
3. Gupta S, Lieberman D, Anderson JC, et al. Recommendations for follow-up after colonoscopy and polypectomy: a consensus update by the US Multi-Society Task Force on Colorectal Cancer. *Gastrointest Endosc.* 2020;91(3):463-485.e5. doi:10.1053/j.gastro.2019.10.026
4. *Provider-Led Arkansas Shared Savings Entity (PASSE) Program Provider Manual, I.* Arkansas Dept of Human Services; 2024. Accessed February 8, 2024. www.humanservices.ar.gov
5. Qaseem A, Harrod CS, Crandall CJ, Wilt TJ. Screening for colorectal cancer in asymptomatic average-risk adults: a guidance statement from the American College of Physicians (version 2). *Ann Intern Med.* 2023;176(8):1017-1144. doi:10.7326/M23-0779.
6. Screening for colorectal cancer: US Preventive Services Task Force recommendation statement. *JAMA.* 2021;325(19):1965-1977. doi:10.1001/jama.2021.6238
7. Wilkins T, McMechan D, Talukder A. Colorectal cancer screening and prevention. *Am Fam Physician.* 2018;97(10):658-665. Accessed February 12, 2024. www.aafp.org

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