Colorectal Cancer Screening
Policy Number: PG0065
Last Review: 06/01/2021

GUIDELINES

➢ This policy does not certify benefits or authorization of benefits, which is designated by each individual policyholder terms, conditions, exclusions and limitations contract. It does not constitute a contract or guarantee regarding coverage or reimbursement/payment. Self-Insured group specific policy will supersede this general policy when group supplementary plan document or individual plan decision directs otherwise.

➢ Paramount applies coding edits to all medical claims through coding logic software to evaluate the accuracy and adherence to accepted national standards.

➢ This medical policy is solely for guiding medical necessity and explaining correct procedure reporting used to assist in making coverage decisions and administering benefits.

SCOPE
X Professional
X Facility

DESCRIPTION
Colorectal cancer (CRC) is the third leading cause of cancer death for both men and women. CRC is most frequently diagnosed among persons aged 65 to 74 years. It is estimated that 10.5% of new colorectal cancer cases occur in persons younger than 50 years. Incidence of CRC (specifically adenocarcinoma) in adults aged 40 to 49 years has increased by almost 15% from 2000-2002 to 2014-2016. In 2016, 25.6% of eligible adults in the US had never been screened for colorectal cancer and in 2018, 31.2% were not up to date with screening. Detection and removal of polyps through CRC screening provides an opportunity to reduce the occurrence of the disease. In addition, early detection can provide an opportunity for reducing the case fatality rate of those individuals with previously undetected CRC.

The evidence is convincing that appropriate screening reduces colorectal cancer mortality in adults 45-75 years of age. The benefit of early detection of and intervention for colorectal cancer declines after 75 years of age.

Screening Tests – Colorectal Cancer Screenings are generally covered as preventive health care services when they are provided during an annual or other periodic preventive physical or wellness exam for the purpose of preventing diseases or conditions in asymptomatic persons. CDC Preventive screenings are for individuals aged 45 to 75 years at average risk of colorectal cancer who have no symptoms. Average risk is considered those who do not have a family history of colorectal cancer, have no known genetic disorders that predispose them to a high risk of colorectal cancer (ie, Lynch syndrome or familial adenomatous polyposis), have no previous adenomatous polyp(s), have no previous history of colorectal cancer, or no personal history of inflammatory bowel disease (IBD).

Direct Visualization Tests - Direct visualization tests to screen for CDC include colonoscopy, flexible sigmoidoscopy and CT colonography.

Colonoscopy
A colonoscopy allows direct mucosal inspection of the entire colon along with same session biopsy sampling or polypectomy in case of pre-cancerous polyps and some early-stage cancers. Colonoscopy permits detection and removal of polyps and biopsy of cancer throughout the colon. Beginning at age 45, colonoscopy is recommended in average-risk individuals every ten years.

Sigmoidoscopy
Flexible sigmoidoscopy is an endoscopic procedure that examines the lower half of the colon lumen. It is generally performed without sedation and with a more limited bowel preparation than a standard
colonoscopy. A flexible sigmoidoscopy is generally recommended every five years beginning at age 45. Positive test findings should be followed up with a colonoscopy.

**Computed Tomographic (CT) Colonography**
Virtual colonoscopy, also known as computed tomographic colonography (CTC), is a test used to examine the colon. This test is used for screening (e.g., colorectal cancer [CRC]) and as a diagnostic tool (e.g., colorectal polyps, CRC). It involves the use of helical computed tomography (CT) and computer generated images to produce high-resolution two- and three-dimensional (3D) images of the colon and rectum. The results are interpreted by a radiologist. While virtual colonoscopy requires a full bowel preparation, similar to conventional colonoscopy, no sedation is required, and the examination is less time consuming. However, gas insufflation of the intestine, which may be uncomfortable to the patient, and interpretation of the images is described as difficult and time consuming. Unlike colonoscopy and flexible sigmoidoscopy, CT colonography may reveal extracolonic findings that require additional workup. If suspicious lesions are detected, the patient generally must undergo further testing via conventional colonoscopy.

**Stool-Based Tests** - Stool-based tests include the high-sensitivity guaiac fecal occult blood test (gFOBT), fecal immunochemical test (FIT), and stool DNA test.

**Fecal Occult Blood Test (FOBT) & Fecal Immunochemical Testing (FIT)**
Both high-sensitivity gFOBT and FIT detect blood in the stool; however, they use different methods. FOBT and FIT are noninvasive tests that detect hidden (occult) blood in the stool, based on chemical detection of blood. Such blood may come from anywhere along the digestive tract and for that reason additional types of tests may be ordered. Blood in the stool may be the only symptom of early cancer. A colonoscopy will be needed if the test is positive.

**Stool-Based DNA Test**
Stool-based deoxyribonucleic acid (DNA) testing, also referred to as FIT-DNA, is performed on stool samples that are submitted to a laboratory after being collected by patients at home. Stool DNA tests detect DNA biomarkers for cancer in cells shed from the lining of the colon and rectum into stool. Currently, the only stool DNA test approved by the US Food and Drug Administration is a multitarget stool DNA test that also includes a FIT component, referred to as sDNA-FIT.

**Double Contrast Barium Enema (DCBE)**
DCBE, also called a lower gastrointestinal (GI) exam, is an x-ray examination of the large intestine (colon and rectum). The colon is filled with contrast material containing barium, which causes the colon to show up clearly on an x-ray. In a DCBE study, the colon is filled with barium, then drained and filled with air to provide a detailed view of the inner surface of the colon, which makes it easier to see colon polyps and/or CRC.

**In Vivo Analysis**
In vivo analysis can be described as real time additional imaging that has been suggested for use as an adjunct to endoscopic procedures. The methods include, but may not be limited to, chromoendoscopy, confocal microscopy, fiberoptic analysis and narrow band imaging. The techniques are utilized during the endoscopic procedures and purportedly improve analysis of the lesions in the colon. Due to the lack of supporting evidence within the published, peer-reviewed literature, use of these technologies as an adjunct to colonoscopy remains unproven.

**Septin9 (SEPT9) (eg, Epi proColon, ColoVantage)**
Septin9 (SEPT9) DNA methylated assay for the early detection of colorectal cancer (eg, Epi proColon, ColoVantage) is a plasma based test that detects methylated Septin9 DNA, which is purportedly a marker of the presence of colorectal cancer. It is designed for those who have avoided established CRC screening methods such as colonoscopy, FOBT or fecal immunochemical test (FIT). This test is not intended to replace established CRC tests.

**ColonSentry**
ColonSentry® (Innovative Diagnostic Lab, Richmond, VA) is a test that measures the expression of seven gene
biomarkers in the blood that are proposed to be early warning signs of colon cancer. The risk for colorectal cancer then calculated based on the expression of these genes. There is insufficient evidence to demonstrate the clinical utility of this test for colon cancer screening.

**POLICY**

**HMO, PPO, Individual Marketplace**

- Fecal occult blood testing (FOBT) (82270, 82274), sigmoidoscopy (45330-45346), double contrast barium enema (DCBE) (74270, 74280), computed tomographic (CT) colonography, screening (74263) & colonoscopy (44388-44394, 44401, 45378-45392) do not require prior authorization.
- Cologuard™ stool-based DNA test (81528) does not require prior authorization.
- In vivo analysis (44799, 45999, 88375) of colorectal polyps, Septin9 (SEPT9) (eg, Epi proColon, ColoVantage) (81327), ColonSentry® (81479), Urine-based screening for precancerous colonic polyps (eg, PolypDx™) (0002U) and blood-based protein biomarker panels (eg, BeScreened™-CRC) (0163U), blood-based biomarker testing (G0327), for colorectal cancer screening are non-covered procedures.

**Elite/ProMedica Medicare Plan**

- Fecal occult blood testing (FOBT) (82270, G0328), sigmoidoscopy (G0104), double contrast barium enema (DCBE) (G0106, G0120), computed tomographic (CT) colonography, screening (74263), & colonoscopy (G0105, G0121) do not require prior authorization.
- Code G0122 is non-covered.
- Cologuard™ stool-based DNA test (81528) does not require prior authorization.
- In vivo analysis (44799, 45999, 88375) of colorectal polyps, Septin9 (SEPT9) (eg, Epi proColon, ColoVantage) (81327), ColonSentry® (81479), Urine-based screening for precancerous colonic polyps (eg, PolypDx™) (0002U) and blood-based protein biomarker panels (eg, BeScreened™-CRC) (0163U) for colorectal cancer screening are non-covered procedures.
- **Effective 7/1/2021** added documentation and coverage criteria for Elite/ProMedica Medicare Plan blood-based biomarker testing per CMS mandate, G0327

**Advantage**

- Fecal occult blood testing (FOBT) (82270, 82274), sigmoidoscopy (45330-45346), double contrast barium enema (DCBE) (74270, 74280), computed tomographic (CT) colonography, screening (74263) & colonoscopy (44388-44394, 44401, 45378-45392) do not require prior authorization.
- Cologuard™ stool-based DNA test (81528) does not require prior authorization.
- Septin9 (SEPT9) (eg, Epi proColon, ColoVantage) (81327) does not require prior authorization.
- In vivo analysis (44799, 45999, 88375) of colorectal polyps, ColonSentry® (81479), Urine-based screening for precancerous colonic polyps (eg, PolypDx™) (0002U) and blood-based protein biomarker panels (eg, BeScreened™-CRC) (0163U), blood-based biomarker testing (G0327), for colorectal cancer screening are non-covered procedures.

(See terms of coverage below)

Refer to PG0182 Virtual Colonoscopy for CT Colonography (74263) coverage determination. Refer to PG0137 Preventive Services for Preventive services mandated by the Patient Protection and Affordable Care Act covered at 100% with no cost sharing.

**COVERAGE CRITERIA**

HMO, PPO, Individual Marketplace, Elite/ProMedica Medicare Plan, Advantage

**Routine Screening**
Paramount covers colorectal cancer screening for all adults aged 45 to 75 years. Several recommended screening tests are available. Clinicians and patients may consider a variety of factors in deciding which test may be best for each person. For example, the tests require different frequencies of screening, location of screening (home or office), methods of screening (stool-based or direct visualization), preprocedure bowel preparation, anesthesia or sedation during the test, and follow-up procedures for abnormal findings.

Colorectal cancer screening is recommended to asymptomatic adults 45 years or older who are at average risk of colorectal cancer (ie, no prior diagnosis of colorectal cancer, adenomatous polyps, or inflammatory bowel disease; no personal diagnosis or family history of known genetic disorders that predispose them to a high lifetime risk of colorectal cancer [such as Lynch syndrome or familial adenomatous polyposis]). In adults aged 76 to 85 years, the age at which the balance of benefits and harms of colorectal cancer screening becomes less favorable and screening should be stopped varies based on a patient’s health status (eg, life expectancy, comorbid conditions), prior screening status, and individual preferences. Limited evidence suggests that harms from colonoscopy, such as perforation and bleeding, and extracolonic findings on CT colonography increase with age. Modeling studies estimate that generally, few additional life-years are gained when screening is extended past age 75 years among average-risk adults who have previously received adequate screening.

Recommended screening strategies include:

- High-sensitivity guaiac fecal occult blood test (HSgFOBT) (82270) or fecal immunochemical test (FIT) (82274, G0328) every year
- Stool DNA-FIT every 1 to 3 years (FIT-DNA, Cologuard™) (81528)
- Computed tomography colonography every 5 years (74263)
- Flexible sigmoidoscopy every 5 years (44388, 45330, 45331, 45333, 45338, 45346, G0104)
- Flexible sigmoidoscopy every 10 years + annual FIT
- Colonoscopy screening every 10 years (44389, 44392, 44394, 45378, 45380, 45381, 45384, 45385, 45388, G0105, G0121)
  - If prior screening was conducted using a guaiac-based or an immunohistochemical test, rescreening may be performed with colonoscopy in 1 year
  - If prior screening test was conducted using Cologuard, rescreening may be performed using colonoscopy in 3 years

High-Risk Testing
Colorectal cancer testing with flexible sigmoidoscopy, double contrast barium enema, or colonoscopy as frequently as every 1 to 3 years and/or prior to 45 years of age is medically necessary for members with any of the following risk factors for colorectal cancer, not all-inclusive:

- A first-degree relative (sibling, parent, child) who has had colorectal cancer or adenomatous polyps (screening is considered medically necessary beginning at age 40 years, or 10 years younger than the earliest diagnosis in their family, whichever comes first) (colonoscopy may be repeated no less than every 3 years depending on findings)
- Family history of familial adenomatous polyposis (screening is considered medically necessary beginning at puberty)
- Family history of hereditary non-polyposis colorectal cancer (HNPCC) (screening is considered medically necessary beginning at age 20 years)
- Family history of MYH-associated polyposis in siblings (screening is considered medically necessary beginning at age 25 years)
- Diagnosis of Cowden syndrome (screening is considered medically necessary beginning at age 35 years)
- Members affected by Lynch syndrome or individuals at risk (first-degree relatives of those affected), screening colonoscopy is covered every 1 to 2 years, beginning between ages 20 to 25 or 2 to 5 years before the youngest age of diagnosis of CRC in the family if diagnosed before age 25 years.
- Family history of serrated polyposis syndrome, in the first-degree relative (screening is considered medically necessary at age 40 or the same age as the youngest diagnosis of serrated polyposis if
uncomplicated by cancer or ten years earlier than the earliest diagnosis in family of colorectal cancer complicated serrated polyposis.

- Family history of colonic adenomatous polyposis of unknown etiology:
  - Individual with a first-degree relative diagnosed with 100 or more adenomas prior to age 40 years:
    - Colonoscopy beginning at an age no less than 10 years; (16) and
    - Every 1 year until age 24 years; (16) and
    - Every 2 years from age 24 to 34 years; (16) and
    - Every 3 years from age 34 to 44 years; (16) and
    - No less than every 3 years thereafter. (16) or
  - Individual with a first-degree relative diagnosed with more than 10 but less than 100 adenomas, colonoscopy is appropriate no less than every 3 years beginning at the same age as the youngest diagnosis of polyposis in the family, if uncomplicated by cancer or by age 40, whichever is earliest. If multiple polyps found, then colonoscopy no less than every year depending on the type, number and size of polyps. (16) or
  - Individual with a first-degree relative diagnosed with more than 100 adenomas at age 40 or older, colonoscopy is appropriate no less than every 2 years, starting at age 40 years if uncomplicated by cancer. If multiple polyps found, then colonoscopy no less than every year depending on the type, number and size of polyps.

**Surveillance - For members who are at a personal history increase or high risk for colorectal cancer.**

Colorectal cancer surveillance with colonoscopy, flexible sigmoidoscopy or double contrast barium enema is medically necessary and may be as frequently as every year for members who meet any of the following criteria, may not be all-inclusive:

- Member has inflammatory bowel disease (including ulcerative colitis or Crohn's disease) (colorectal cancer surveillance is considered medically necessary as frequently as every year)
- Personal history of adenomatous polyps (surveillance is considered medically necessary and may be as frequently as every 2 years)
  - For members with one to two small (less than one centimeter) tubular adenomas or SSP without cytologic dysplasia, surveillance colonoscopy is covered five to ten years after the initial polypectomy (the precise time within this interval should be based on other clinical factors such as colonoscopy findings, family history, and the preferences of the member and the judgment of the physician). If there are no adenomas or SSPs on the first surveillance colonoscopy, the second surveillance colonoscopy is covered in ten years.
  - For members with three to ten adenomas and/or SSPs, one adenoma or SSP greater than or equal to one centimeter, any adenoma with villous features or high-grade dysplasia, SSP with cytologic dysplasia, or traditional serrated adenoma that have been completely removed, surveillance colonoscopy is covered three years after the initial polypectomy. If the follow-up colonoscopy is normal or shows only one to two small tubular adenomas with low-grade dysplasia, then the interval for the subsequent colonoscopy is covered every five years.
  - For members with greater than 10 adenomas and/or SSPs on a single examination, surveillance colonoscopy is covered less than three years after the initial polypectomy.
  - For members with incomplete or piecemeal polypectomy or polypectomy of large sessile polyps, repeat colonoscopy is covered two to six months following the initial polypectomy when necessary to verify complete removal. Once complete removal has been established based on endoscopic and pathologic assessments, subsequent surveillance needs to be individualized based on the physician's judgment.
  - For members who meet the clinical criteria for serrated polyposis syndrome, colonoscopy is covered every year. Clinical criteria include the following:
    - At least five serrated polyps proximal to the sigmoid colon, of which two or more are greater than or equal to ten millimeters
    - Any number of serrated polyps proximal to the sigmoid colon in an individual who has a first degree relative with serrated polyposis syndrome
    - Greater than 20 serrated polyps of any size, distributed throughout the colon
  - For members with hyperplastic polyps, surveillance colonoscopy is covered as follows:
For members with any number of hyperplastic polyps in the rectosigmoid that are each individually less than 10 millimeters, surveillance colonoscopy is covered 10 years after the initial polypectomy.

For members with three or less hyperplastic polyps proximal to the sigmoid colon that are each 5 millimeters or less, surveillance colonoscopy is covered 10 years after the initial polypectomy.

For members with four or more hyperplastic polyps proximal to the sigmoid colon that are of any size, surveillance colonoscopy is covered 5 years after the initial polypectomy. A longer subsequent follow-up interval may be appropriately applied when a follow-up exam shows improvement in findings, i.e., a reduction in the number of lesions.

For members with any number of hyperplastic polyps proximal to the sigmoid colon that are each greater than 5 millimeters, surveillance colonoscopy is covered 5 years after the initial polypectomy. A longer subsequent follow-up interval may be appropriately applied when a follow-up exam shows improvement in findings, i.e., a reduction in the size of lesions.

- Members who have a personal history of a positive stool based (guaiac-based, immunohistochemical or Cologuard fecal DNA) test and the confirmatory colonoscopy was positive for cancer or pre-cancerous polyp (surveillance is considered medically necessary as frequently as every year)
- Personal history of colorectal cancer (surveillance is considered medically necessary as frequently as every year)
- Diagnosis of Cowden syndrome (screening is considered medically necessary beginning at age 35 years)
- Members affected by Lynch syndrome or individuals at risk (first-degree relatives of those affected), screening colonoscopy is covered every 1 to 2 years, beginning between ages 20 to 25 or 2 to 5 years before the youngest age of diagnosis of CRC in the family if diagnosed before age 25 years.

Paramount considers annual FOBT, alone or in conjunction with sigmoidoscopy, medically necessary for testing of members with any of the above risk factors for colorectal cancer.

**Limitations**

- Repeat colonoscopy (or other screening procedures) for members with small hyperplastic polyps performed at intervals less than that for average risk individuals is not covered. Members with small hyperplastic polyps are considered to have normal colonoscopy and should have colonoscopy or other screening options performed at intervals recommended for average-risk individuals. An exception are members with a hyperplastic polyposis syndrome who are at increased risk for adenomas and CRC and need to be identified for intensive follow-up.
- Discontinuation of surveillance colonoscopy should be considered in members with serious comorbidities who have life expectancies of less than 10 years according to the physician’s judgment.
- Diagnostic colonoscopy is not covered for the following conditions:
  - Chronic, stable irritable bowel syndrome
  - Chronic abdominal pain
  - Acute limited diarrhea
  - Hemorrhoids
  - Metastatic adenocarcinoma of unknown primary site in the absence of colonic symptoms and when a definitive site of origin will not influence management
  - Routine follow-up of inflammatory bowel disease
  - Upper gastrointestinal bleeding or melena with a demonstrated upper gastrointestinal source
  - Bright red rectal bleeding in members with a convincing anorectal source via direct examination, anoscopy, or sigmoidoscopy AND no other symptoms suggestive of a more proximal bleeding source

Septin9 (SEPT9) (e.g., Epi proColon, ColoVantage) (81327) is non-covered for HMO, PPO, Individual Marketplace and Elite/ProMedica Medicare Plan as its use is experimental, investigational, or unproven.

While there is insufficient evidence in the published medical literature to demonstrate the safety, efficacy and long-term outcomes of Septin9 (SEPT9) (e.g., Epi proColon, ColoVantage) (81327), The Ohio Department of Medicaid requires this procedure be covered for Advantage members, Prior Authorization required.
Paramount does not cover the following tests for any indication, HMO, PPO, Individual Marketplace, Elite/ProMedica Medicare Plan and Advantage, including, but not limited to, the screening, diagnosis or surveillance of colorectal cancer, as its use is experimental, investigational, or unproven:

- In vivo analysis (44799, 45999, 88375) of colorectal polyps (e.g., chromoendoscopy, fiberoptic polyp analysis, narrow band imaging, and confocal fluorescent endomicroscopy)
- Blood-based protein biomarker panels (eg, BeScreened™-CRC) (eg, ColonSentry®) (81479) (excluding Elite/ProMedica Medicare Plan, procedure G0327*)
- Urine-based screening for precancerous colonic polyps (eg, PolypDx™)

* Over the last several years, blood-based biomarker tests have emerged as another potential non-invasive option for the early detection of CRC. The blood-based biomarker measured in a person’s blood can be an indicator of a process, such as CRC disease risk or progression. Elite/ProMedica Medicare Plan: blood-based biomarker test is an appropriate CRC screening test once every 3 years for Elite/ProMedica Medicare Plan Members when performed in a Clinical Laboratory Improvement Act (CLIA)-certified laboratory, ordered by a treating physician, and when the following requirements are met.

The patient is:

- Aged 50-85 years
- Asymptomatic (no signs or symptoms of colorectal disease including but not limited to lower gastrointestinal pain, blood in stool, positive guaiac fecal occult blood test, or fecal immunochemical test); and,
- At average risk of developing CRC (no personal history of adenomatous polyps, or inflammatory bowel disease, including Crohn’s Disease and ulcerative colitis; no family history of CRCs or adenomatous polyps, familial adenomatous polyposis, or hereditary nonpolyposis CRC).

The blood-based biomarker screening test must have:

- FDA market authorization with an indication for CRC screening; and,
- Proven test performance characteristics for a blood-based screening test with both sensitivity greater than or equal to 74% and specificity greater than or equal to 90% in the detection of CRC compared to the recognized standard (accepted as colonoscopy at this time), based on the pivotal studies included in the FDA labeling.

The currently available Epi proColon® test does not meet the criteria for an appropriate blood-based biomarker CRC screening test. Based on the evidence at this time, we will non-cover the Epi proColon® test.

An incomplete colonoscopy is defined as the inability to examine proximal to the splenic flexure. This is indicated by reporting one of the following modifiers appended to the appropriate colonoscopy code:

- Modifier –53 (discontinued procedure)
- Modifier –73 (discontinued outpatient hospital/ASC procedure prior to the administration of anesthesia)
- Modifier –74 (discontinued outpatient hospital/ASC, procedure after the administration of anesthesia)

Modifier PT indicates that a colorectal cancer-screening test (i.e. 45330, 45378) was converted to a diagnostic test or therapeutic procedure (45379-45392, 45331-45346). Adding Modifier PT to all service lines related to the procedure when a screening colonoscopy or flexible sigmoidoscopy becomes a diagnostic service or therapeutic procedure on the same date of service will waive the deductible for the related surgical services. No copay will apply.

Only a single colonoscopy procedure will be allowed for reimbursement when both screening and diagnostic colonoscopies are reported, and/or when two types of screening colonoscopies are reported.
CODING/BILLING INFORMATION
The inclusion or exclusion of a code in this section does not necessarily indicate coverage. Codes referenced in
this clinical policy are for informational purposes only.
Codes that are covered may have selection criteria that must be met.
Payment for supplies may be included in payment for other services rendered.

<table>
<thead>
<tr>
<th>CPT CODES</th>
</tr>
</thead>
<tbody>
<tr>
<td>0002U</td>
</tr>
<tr>
<td>0163U</td>
</tr>
<tr>
<td>44388</td>
</tr>
<tr>
<td>44389</td>
</tr>
<tr>
<td>44390</td>
</tr>
<tr>
<td>44391</td>
</tr>
<tr>
<td>44392</td>
</tr>
<tr>
<td>44394</td>
</tr>
<tr>
<td>44401</td>
</tr>
<tr>
<td>44799</td>
</tr>
<tr>
<td>45330</td>
</tr>
<tr>
<td>45331</td>
</tr>
<tr>
<td>45332</td>
</tr>
<tr>
<td>45333</td>
</tr>
<tr>
<td>45334</td>
</tr>
<tr>
<td>45335</td>
</tr>
<tr>
<td>45337</td>
</tr>
<tr>
<td>45338</td>
</tr>
<tr>
<td>45340</td>
</tr>
<tr>
<td>45341</td>
</tr>
<tr>
<td>45342</td>
</tr>
<tr>
<td>45346</td>
</tr>
<tr>
<td>45378</td>
</tr>
<tr>
<td>45379</td>
</tr>
<tr>
<td>45380</td>
</tr>
<tr>
<td>45381</td>
</tr>
<tr>
<td>45382</td>
</tr>
<tr>
<td>45384</td>
</tr>
<tr>
<td>Code</td>
</tr>
<tr>
<td>----------</td>
</tr>
<tr>
<td>45385</td>
</tr>
<tr>
<td>45388</td>
</tr>
<tr>
<td>45391</td>
</tr>
<tr>
<td>45392</td>
</tr>
<tr>
<td>45999</td>
</tr>
<tr>
<td>74263</td>
</tr>
<tr>
<td>74270</td>
</tr>
<tr>
<td>74280</td>
</tr>
<tr>
<td>81327</td>
</tr>
<tr>
<td>81401</td>
</tr>
<tr>
<td>81479</td>
</tr>
<tr>
<td>81528</td>
</tr>
<tr>
<td>82270</td>
</tr>
<tr>
<td>82274</td>
</tr>
<tr>
<td>88375</td>
</tr>
</tbody>
</table>

**HCPCS CODES**

- **G0104** Colorectal cancer screening; flexible sigmoidoscopy
- **G0105** Colorectal cancer screening; colonoscopy on individual at high risk
- **G0106** Colorectal cancer screening; alternative to G0104, screening sigmoidoscopy, barium enema
- **G0120** Colorectal cancer screening; alternative to G0105, screening colonoscopy, barium enema
- **G0121** Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk
- **G0122** Colorectal cancer screening; barium enema
- **G0327** Colorectal cancer screening; blood-based biomarker, effective 7/1/2021
- **G0328** Colorectal cancer screening; fecal-occult blood test, immunoassay, 1-3 simultaneous determinations

---

**Paramount reserves the right to review and revise our policies periodically when necessary. When there is an update, we will publish the most current policy to [https://www.paramounthealthcare.com/services/providers/medical-policies/](https://www.paramounthealthcare.com/services/providers/medical-policies/).**

---

**REVISION HISTORY EXPLANATION**

**ORIGINAL EFFECTIVE DATE: 03/15/2006**

<table>
<thead>
<tr>
<th>Date</th>
<th>Explanation &amp; Changes</th>
</tr>
</thead>
<tbody>
<tr>
<td>03/15/07</td>
<td>• No change</td>
</tr>
<tr>
<td>04/15/08</td>
<td>• Updated references</td>
</tr>
<tr>
<td>04/15/09</td>
<td>• No change</td>
</tr>
<tr>
<td>04/01/11</td>
<td>• Updated</td>
</tr>
</tbody>
</table>

PG0065 – 06/01/2021
<table>
<thead>
<tr>
<th>Date</th>
<th>Changes</th>
</tr>
</thead>
</table>
| 10/14/14  | - Changed title from Colonoscopy and Sigmoidoscopy Diagnostic/Screening to Colorectal Cancer Screening  
            - Codes removed 44388, 44389, 44390, 44391, 44392, 44393, 44394, & 44397  
            - Codes added 44799, 45999, 74270, 74280, 81401, 82270, 82274, S3890 & G0328  
            - Policy reviewed and updated to reflect most current clinical evidence per Medical Policy Steering Committee |
| 11/21/14  | - Cologuard™ stool-based DNA test (S3890) is covered without prior authorization per CMS guidelines for Elite members only  
            - Policy reviewed and updated to reflect most current clinical evidence per The Technology Assessment Working Group (TAWG). |
| 12/02/14  | - Added new 2015 HCPCS code G0464  
            - Removed effective 12/31/14 deleted codes 45339, 45345, 45355, 45383, 45387  
            - Added effective 1/1/15 new codes 45346, 45388  
            - Added codes 81479 (ColonSentry®) & 88375 (In Vivo Analysis of Colorectal Polyps)  
            - Policy reviewed and updated to reflect most current clinical evidence per per TAWG |
| 11/08/16  | - Code S3890 deleted effective 12/31/15  
            - Policy reviewed and updated to reflect most current clinical evidence per Medical Policy Steering Committee |
| 03/24/17  | - Added effective 1/1/17 new code 81327 as covered for Advantage only per ODM guidelines and non-covered for HMO, PPO, Individual Marketplace, & Elite  
            - Policy reviewed and updated to reflect most current clinical evidence per The Technology Assessment Working Group (TAWG) |
| 04/11/17  | - Deleted effective 12/31/15 code G0464 removed. Cologuard™ stool-based DNA test (81528) is also covered without prior authorization for HMO, PPO, Individual Marketplace, & Advantage  
            - Policy reviewed and updated to reflect most current clinical evidence per Medical Policy Steering Committee |
| 06/01/17  | - Added/clarified verbiage regarding two main types of FOBT tests: fecal immunochemical testing (FIT) and guaiac based fecal occult blood test |
| 09/27/18  | - Colorectal cancer screening beginning at age 45 is considered a medically necessary preventive service for African Americans. For an average risk individual age 50 years and older, Paramount covers as medically necessary CT Colonography (74263) every 5 years (Refer to PG0182 Virtual Colonoscopy).  
            - Urine-based testing (e.g., PolypDx) is non-covered for colorectal cancer screening for all product lines  
            - Policy reviewed and updated to reflect most current clinical evidence per The Technology Assessment Working Group (TAWG). |
| 01/01/2021| - Medical policy placed on the new Paramount Medical Policy Format |
| 06/01/2021| - Effective 5/18/2021 the USTPF recommended colorectal cancer screening beginning at age 45 (instead of 50), as determined to be considered a medically necessary preventive service.  
            - Added documentation and coverage criteria for Elite/ProMedica Medicare Plan blood-based biomarker testing per CMS mandate, G0327.  
            - Policy reviewed and updated to reflect most current clinical evidence |

**REFERENCES/RESOURCES**

Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services

Ohio Department of Medicaid

PG0065 – 06/01/2021

Centers for Medicare and Medicaid Services, Healthcare Common Procedure Coding System, HCPCS Release and Code Sets


Industry Standard Review

Hayes, Inc.

Industry Standard Review