

Evidence Based Guideline

Colon Cancer Screening

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Last Review:	4/2008

Description of Procedure or Service

When colorectal cancer is diagnosed at an early, localized state, five-year survival is 90%, yet only 37% of incident cases are diagnosed while still localized. The same methods used to detect colorectal cancers at early, curable stages can also identify and remove adenomas, which give rise to colorectal cancer. Methods for early detection can therefore actually prevent colorectal cancer.

Definitions of Early Detection Methods are as follows:

- Fecal Occult Blood Test (FOBT) - FOBT is a laboratory procedure that refers to the implementation of the protocol for collecting and testing six samples from three consecutive stools at home. Prior to testing with a guaiac-based test, individuals are instructed to avoid non-steroidal anti-inflammatory drugs such as ibuprofen, naproxen, or aspirin (more than one adult aspirin per day) for seven days prior to testing; to avoid vitamin C in excess of 250 mg from either supplements or citrus fruits and juices for three days before testing; and to avoid red meats for three days before testing.
- Fecal immunochemical tests (FIT) - employs the use of antibodies to detect the globin portion of human hemoglobin in stool. Because globin is degraded during passage through the upper GI tract, the FIT is specific for bleeding that is limited to the colon and rectum.
- Digital Rectal Examination (DRE) - DRE is part of a physical examination which refers to the palpation of the anus and lower rectum by the practitioner using a gloved finger. DRE is a method for identifying masses in the anal canal or lower rectum. A single test of a stool sample in the clinical setting (as, for instance, is often done with the stool sample collected on the fingertip during a DRE) is not an adequate substitute for the recommended procedure of collecting two samples from three consecutive specimens.
- Flexible Sigmoidoscopy - Flexible sigmoidoscopy refers to a surgical procedure that allows direct visual examination of the distal portion of the colorectum by a trained examiner using a flexible 60- cm endoscope following a satisfactory cleansing of the descending and sigmoid colon and rectum.
- Double Contrast Barium Enema (DCBE) - DCBE refers to a procedure that allows radiologic examination of the entire colorectum by instilling both barium and air to define the contours of the colorectal mucosa.
- Colonoscopy - Colonoscopy refers to a surgical procedure that allows direct visual examination of the entire colorectum using a colonoscope. Ideally, the colonoscopic examination should be extended to the cecum.
- Screening CT (computed tomography) Colonography (Virtual Colonoscopy) - CT colonography is now recommended as an alternative to colonoscopy. However it must be done more frequently than colonoscopy and may need to be followed by a colonoscopy if abnormalities are detected. It requires the same prep as a screening colonoscopy but does not use the colonoscope and does not require sedation.

Colon Cancer Screening

This guideline does not address the following:

Diagnostic CT Colonography (Virtual Colonoscopy). Please see Diagnostic Imaging Management policies at <http://www.bcbsnc.com/services/medical-policy/dim-policies.cfm>. or

Fecal DNA testing. Please see policy titled, Genetic Testing for Colon Cancer..

*****Note: This Evidence Based Guideline is complex and technical. For questions concerning the technical language and/or specific clinical indications for its use, please consult your physician.**

Evidence Based Guideline for Colon Cancer Screening

Colonoscopy may be appropriate for any nonsymptomatic individual who is:

- A. At least 50 years of age, **or**
- B. Less than 50 years of age and at increased or high risk for colorectal cancer according to the most recently published colorectal cancer screening guidelines of the American Cancer Society or guidelines adopted by the North Carolina Advisory Committee on Cancer Coordination and Control.*
- C. According to 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. (*CA Cancer J Clin.* 2008;58) for average-risk women and men ages 50 and older, the following tests are recommended options for colorectal cancer screening:
 1. Fecal Occult Blood Test or Fecal immunochemical Test (FOBT or FIT and Flexible Sigmoidoscopy) -FOBT or FIT annually and flexible sigmoidoscopy every 5 years. Flexible sigmoidoscopy together with FOBT or FIT is preferred compared with FOBT or FIT or flexible sigmoidoscopy alone.
 2. Flexible Sigmoidoscopy - Every 5 years;
 3. Fecal Occult Blood Test or Fecal Immunochemical Test- Annually;
 4. Colonoscopy - Every 10 years;
 5. Screening CT Colonography (Virtual Colonoscopy) - Every 5 years;
 6. Double Contrast Barium Enema - Every 5 years.

Based on the American Cancer Society Guidelines on Screening and Surveillance for the Early Detection of Colorectal Adenomas and Cancer (refer to *CA Cancer J Clin* 2006;56:16-17) and Guidelines for Colonoscopy Surveillance after Polypectomy: A Consensus Update by the US MultiSociety Task Force on Colorectal Cancer and the American Cancer Society (refer to *CA Cancer J Clin* 2006;56:143-149), patients at increased or high risk for colorectal cancer include:

- A. Women or men at increased risk:
 1. People with one or two small (less than 1 cm) tubular adenoma with only low-grade dysplasia; 5 to 10 years after the initial polypectomy, recommend colonoscopy. If the exam is normal, then a colonoscopy should be repeated every 5-10 years at the physician's discretion.

Colon Cancer Screening

2. People with 3 to 10 adenomas, or any large (1 cm or greater) adenoma, or adenomas with high-grade dysplasia or villous change. Within 3 years after the initial polypectomy, recommend colonoscopy. If normal, repeat examination in 3 to 5 years; if normal, then a colonoscopy should be repeated every 5-10 years at the physician's discretion.
3. People with more than 10 adenomas at one examination should be screened more frequently (less than 3 years) as determined by the clinician's clinical judgement. The possibility of an underlying familial syndrome should be considered.
4. Personal history of curative-intent resection of colorectal cancer. Within 1 year after cancer resection, recommend colonoscopy. If normal, repeat examination in 3 to 5 years; if normal then, repeat examination every 5 years.
5. Either colorectal cancer or adenomatous polyps, in any first-degree relative before age 50, or in two or more first-degree relatives at any age (if not a hereditary syndrome). Age 40, or 10 years before the youngest case in the immediate family, recommend colonoscopy every 5 - 10 years. Colorectal cancer in relatives more distant than first-degree does not increase risk substantially above the average risk group
6. People with a diagnosis of hereditary nonpolyposis colorectal cancer (HNPCC) or those people who are at risk for HNPCC should have a colonoscopy every one-two years. It is recommended that screening should begin at the age of 20 - 25 years old or 10 years prior to the youngest family member diagnosed with colon cancer, whichever comes first.

B. Women or men at high risk:

1. Family history of familial adenomatous polyposis (FAP) at puberty. Recommend early surveillance with endoscopy.
2. Family history of hereditary non-polyposis colon cancer (HNPCC) at age 21. Recommend colonoscopy.
3. Inflammatory bowel disease, chronic ulcerative colitis, Crohn's disease; cancer risk begins to be significant 8 years after the onset of pancolitis, or 12 - 15 years after the onset of left sided colitis. Recommend colonoscopy with biopsies for dysplasia every 1 - 2 years.

Medical Evidence regarding Colon Cancer Screening indicates it is not recommended in the following situations

- When the patient does not meet the criteria outlined above.

Benefits Application

Please refer to certificate for availability of benefit. This guideline relates only to the services or supplies described herein. Benefits may vary according to benefit design; therefore certificate language should be reviewed before applying the terms of the policy.

This guideline addresses only colon cancer screening and does not apply to patients with signs or symptoms that may be related to diseases or conditions of the colon.

Colonoscopy and sigmoidoscopy are considered surgical procedures.

Colon Cancer Screening

Billing/Coding/Physician Documentation Information

This policy may apply to the following codes. Inclusion of a code in this section does not guarantee that it will be reimbursed. For further information on reimbursement guidelines, please see Administrative Policies on the Blue Cross Blue Shield of North Carolina web site at www.bcbsnc.com. They are listed in the Category Search on the Medical Policy search page.

Applicable codes: 45330, 45378, 74263, 74280, 82270, 82272, 82274, G0104, G0105, G0106, G0120, G0121, G0122, G0328.

Medical Term Definitions

Not applicable

Scientific Background and Reference Sources

Rex DK, Johnson DA, Lieberman DA, et al. ACG recommendations on colorectal cancer screening for average and higher risk patients in clinical practice. *Amer Journ of Gastroenterology*. 2000 April; 95(4):868-877.

Large-Bowel Tumors. The Merck Manual of Diagnosis and Therapy. Web site <http://www.merck.com/pubs/mmanual/section3/chapter34/34d.htm> 11/21/2000

Winawer SJ. Colorectal Cancer: The Importance of Early Detection. Web site <http://www.cdc.gov/cancer/colorctl/colorect.htm> 11/04/1999

National Guideline Clearinghouse (NGC) Guideline Synthesis. Screening for Colorectal Cancer. Web site <http://www.guideline.gov/COMPARISONS/CRCScreen2.asp> 9/8/2000

Medical Policy Advisory Group - 12/2000

Specialty Matched Consultant Advisory Panel - 3/2001

*General Statutes of North Carolina enacts: Section 1. Article 51 of Chapter 58; 58-3-179 for Coverage for colorectal cancer screening. *CA A Cancer Journal for Clinicians*, 2001; American Cancer Society Guidelines on Screening and Surveillance for the Early Detection of Colorectal Adenomas and Cancer: Average-Risk Women and Men Ages 50 and Older; 51:48 and American Cancer Society Guidelines on Screenings and Surveillance for the Early Detection of Colorectal Adenomas and Cancer: Women and Men at Increased Risk or at High Risk; 51:50.

CA A Cancer Journal for Clinicians, 2002; 52:8-22. American Cancer Society Guidelines for the Early Detection of Cancer (2002). Smith, RA, Cokkinides, V, von Eschenbach, AC, Levin, B, Cohen, C, Runowicz, CD, Sener, S, Saslow, D, Eyre, HJ.

Specialty Matched Consultant Advisory Panel, 6/2002

Specialty Matched Consultant Advisory Panel, 5/2004

Smith, RA, Cokkinides, V, Eyre, HJ. (2006). American Cancer Society Guidelines for the Early Detection of Cancer, 2006. Retrieved 2/1/06 from <http://www.caonline.amcancersoc.org>. *CA A Cancer Journal for Clinicians*, 2006; 52:8-22.

Colon Cancer Screening

Specialty Matched Consultant Advisory Panel, 4/2006

Winawer SJ, Zauber AG, Fletcher RH, et al. (2006). Guidelines for colonoscopy surveillance after polypectomy: A consensus update by the US Multi-Society Task Force on colorectal cancer and the American Cancer Society. Retrieved 2/26/08 from <http://caonline.amcancersoc.org/cgi/content/full/56/3/143>. *CA Cancer J Clin.* 56:143-159.

Levin B, Lieberman DA, McFarland B, et al. 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. Retrieved 5/20/08 at <http://caonline.amcancersoc.org/cgi/content/full/58/3/130>. *CA Cancer J Clin.* 2008:58

Specialty Matched Consultant Advisory Panel, 4/2008..

Policy Implementation/Update Information

- 12/00 New policy issued. Reviewed by Medical Policy Advisory Group. Approve.
- 5/01 Specialty Matched Consultant Advisory Panel review. Added to list of diagnoses in When Colonoscopy Is Not Covered.
- 1/02 Policy revised to include General Statutes of North Carolina enacts: Section 1. Article 51 of Chapter 58; 58-3-179 for Coverage for colorectal cancer screening. Guidelines were taken from the American Cancer Society and the North Carolina Advisory Committee on Cancer Coordination and Control for colorectal cancer screening. Policy name changed from Colonoscopy.
- 3/02 Added 82274 to the Billing/Coding Section and to the System Application Guidelines.
- 6/02 Specialty Matched Consultant Advisory Panel. Revised the "Description" section of the policy to include FOBT as a laboratory procedure, DRE as part of a physical examination, flexible sigmoidoscopy and colonoscopy as a surgical procedure. Under "Policy Guidelines" section added the statement that colonoscopy and sigmoidoscopy are considered surgical procedures.
- 1/03 Codes 45355 and 45379 - 45385 removed from the Billing/Coding section of the policy. Statement added to Billing/Coding section that medical records may be ordered. System codes revised.
- 3/04 Benefits Application and Billing/Coding sections updated for consistency. Individual CPT codes listed for CPT code ranges G0104-G0107 under Billing/Coding section.
- 6/10/04 Specialty Matched Consultant Advisory Panel review. Under the section When Colon Cancer Screening is covered, A. second bullet, changed wording from "screened as per average risk guidelines" to "screened as per standard guidelines for the risk category". Removed the sentence "Medical policy will be updated as appropriate." from Policy Guidelines section. This is standard for all Medical Policy. References added. Notification 6/10/2004. Effective date 8/12/2004.
- 10/28/04 New HCPCS code G0328 added to policy.
- 5/22/06 Specialty Matched Consultant Advisory Panel review 4/20/2006. Added additional bullet under "When Covered" section "Women or Men at Increased Risk" to indicate "People with a diagnosis of hereditary nonpolyposis colorectal cancer (HNPCC) or those people who are at risk for HNPCC should have a colonoscopy every one-two years. It is recommended that screening

Colon Cancer Screening

should begin at the age of 20 - 25 years old or 10 years prior to the youngest family member diagnosed with colon cancer, whichever comes first." Added references to Fecal immunochemical test (FIT) as appropriate in the "Description of Procedure or Service" and the "When Covered" section. Updated references in policy to the American Cancer Society Guidelines for the Early Detection of Cancer, 2006. References added.

8/28/06 Medical Policy changed to Evidence Based Guideline.

1/3/07 Added new 2007 HCPCS code, G0394. Deleted HCPCS code, G0107.

2/26/07 Added CPT code 82272 to "Billing/Coding" section.

6/16/08 Specialty Matched Consultant Advisory Panel review 4/30/08. Added Screening CT Colonography (Virtual Colonoscopy) information to "Description" section and to the "Evidence Based Guideline for Colon Cancer Screening" section. Added reference to 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" and the "Guidelines for Colonoscopy Surveillance after Polypectomy: Update by the US Multi-Society Task Force on Colorectal Cancer and the American Cancer Society" to the "Evidence Based Guideline" section and updated increased or high risk guidelines accordingly. References added

3/2/09 Removed deleted HCPCS codeG0394 from the "Billing/Coding" section. (btw)

3/2/10 Added new CPT code, 74263 to "Billing/Coding" section. Removed deleted CPT code 0066T (btw)

Medical policy is not an authorization, certification, explanation of benefits or a contract. Benefits and eligibility are determined before medical guidelines and payment guidelines are applied. Benefits are determined by the group contract and subscriber certificate that is in effect at the time services are rendered. This document is solely provided for informational purposes only and is based on research of current medical literature and review of common medical practices in the treatment and diagnosis of disease. Medical practices and knowledge are constantly changing and BCBSNC reserves the right to review and revise its medical policies periodically.