APPLICATION STATEMENT

The application of the Clinical Coverage Guideline is subject to the benefit determinations set forth by the Centers for Medicare and Medicaid Services (CMS) National and Local Coverage Determinations and state-specific Medicaid mandates, if any.

DISCLAIMER
The Clinical Coverage Guideline is intended to supplement certain standard WellCare benefit plans. The terms of a member’s particular Benefit Plan, Evidence of Coverage, Certificate of Coverage, etc., may differ significantly from this Coverage Position. For example, a member’s benefit plan may contain specific exclusions related to the topic addressed in this Clinical Coverage Guideline. When a conflict exists between the two documents, the Member’s Benefit Plan always supersedes the information contained in the Clinical Coverage Guideline. Additionally, Clinical Coverage Guidelines relate exclusively to the administration of health benefit plans and are NOT recommendations for treatment, nor should they be used as treatment guidelines. The application of the Clinical Coverage Guideline is subject to the benefit determinations set forth by the Centers for Medicare and Medicaid Services (CMS) National and Local Coverage Determinations and state-specific Medicaid mandates, if any. Note: The lines of business (LOB) are subject to change without notice; consult www.wellcare.com/Providers/CCGs for list of current LOBs.

BACKGROUND

The technique for computed tomography colonography (CTC) involves the following steps: (1) bowel cleansing; (2) colon insufflation; (3) image acquisition; and (4) image processing and interpretation (Isenberg et al., 2003). Patients undergo CTC in a radiology suite equipped with a computed tomography (CT) scanner and instrumentation for insufflating the colon with air or carbon dioxide. To obtain optimal images of the bowel lumen, the colon should be clean, dry, and distended as for standard colonoscopy. Before imaging, patients usually require a full, cathartic bowel preparation to cleanse the colon of residual stool, which can simulate or obscure polyps. Most clinicians recommend a 48-hour low-residue diet and an over-the-counter preparation of phosho-soda and bisacodyl, which leaves less residual fluid in the bowel compared with a polyethylene glycol electrolyte solution. Additionally, newer protocols may require barium and/or a water-soluble oral contrast to tag residual stool and opacify colonic fluid. The colon is then insufflated with room air via a rectal tube to the maximum level tolerated by the patient, and a scout film prior to full image acquisition confirms adequate insufflation. Carbon dioxide may be substituted for room air, which may reduce patient discomfort, but adds to the complexity and cost of the procedure.  

Helical CT scanning is performed in a single breath-hold, usually using 5 mm collimation and reconstruction intervals of 2 mm to 3 mm with the patient in both the supine and prone positions to redistribute the gas into segments of the colon that may have collapsed. New multidetector (4, 8, or 16 channel) CT scanners can scan faster (less than 15 seconds, which means a shorter breath-hold), and use thinner reconstruction intervals and collimations for finer anatomic detail and higher-resolution imaging. “Electronic cleansing” can be achieved by using software that digitally removes any opacified residual colonic fluid from CT scans. The data from the CT scans are displayed as 2D and/or 3D images. The 3D rendered views of the colon simulate endoluminal views obtained during colonoscopy. Usually, but not always, 2D images on a computer workstation are used for lesion identification, and when a suspicious area is encountered, a 3D view can be used for further examination. To obtain the 3D view, the CT data are processed on the same workstation equipped with specialized software. The resulting virtual environment and endoluminal “fly-through” allow the radiologist to view the entire colon relatively quickly (typical reading times may be 10 minutes or less). This is advantageous, since helical CT technology produces so many slices that the reader needs the computer post-processing to efficiently analyze all the data. The 3D “virtual reality” environment also allows viewing of the hidden surfaces of folds and flexures from different angles. For example, using 2D and 3D images together allows differentiation between complex haustral folds and polyps, and between retained stool and polyps. 

While CTC data sets can be evaluated using a primary 2D or a primary 3D approach, the alternate viewing technique must be available for rapid correlation and characterization of any suspicious findings. Furthermore, the combined use of both 2D and 3D visualization techniques most likely is superior to the evaluation of 3D or 2D views alone. There is no general consensus on whether a primary 2D or primary 3D approach should be used. Primarily, it depends on the radiologist’s preferences and the capabilities of the workstation. Since sedation is not required during the CTC examination, the patient is free to leave the CT suite immediately, without the need for observation or recovery, and is able to resume normal activities such as eating, working, or driving. Although CT imaging takes less time than colonoscopy, CTC is a time-consuming process comprised of scanning (20 minutes), image processing (30 minutes), and image interpretation (20 minutes or longer). The time required to obtain CTC results may be shortened with the introduction of faster software and hardware, automated analysis, and increased practitioner experience. CTC usually is performed with the patient in both the prone and supine positions, because using both has been found to reveal the highest number of lesions. However, this doubles the radiation dose to the patient. Currently, CTC is performed with multi-detector row CT scanners, which tend to have a higher effective dose than single-dose CT scanners. 

Position Statements. The United States Preventive Services Task Force (USPSTF) states that evidence is
insufficient to assess the benefits and harms of CT colonography and fecal DNA testing as screening modalities for colorectal cancer.\(^5\) The American College of Radiology, the American Gastroenterological Association and the American Society for Gastrointestinal Endoscopy support the use of CT colonography in adults for uses other than screening purposes.\(^4,6,7\)

**POSITION STATEMENT**

**Applicable To:**
- Medicaid – Florida, Georgia, Hawaii, Kentucky
- Medicare – Easy Choice Health Plan, Florida, Georgia, Hawaii, Kentucky

*NOTE: For all other lines of business, please refer to the current contracted vendor for Radiology / Imaging requests.*

Virtual colonoscopy is considered medically necessary when the following criteria are met:

1. A diagnostic or surveillance instrument colonoscopy of the entire colon is incomplete due to the inability to fully pass the colonoscope proximally; **AND,**
2. A repeat attempt is not indicated; **AND,**
3. Member safety is at risk (see below); **AND,**
4. The incomplete colonoscopy is due to one of the following:
   a. An obstructions neoplasm; **OR,**
   b. Intrinsc scarring, stricture, aberrant anatomy, or obstruction from prior surgery, radiation, or diverticular disease; **OR,**
   c. Extrinsic compression

*NOTE: There are few absolute contraindications to instrument colonoscopy. Relative contraindications do not create medical necessity for using CT colonography as a screening procedure, and the above indications must still be met.*

The following relative contraindications to instrument colonoscopy may be indications for CT colonography if well documented in the medical record and the member’s primary physician and the colonoscopist agree on the increased risk to the member:

- Severe coagulopathy
- Long-term anticoagulation
- Increased sedation risk (such as from severe COPD or previous anesthesia adverse reaction).

CT colonography is also indicated for the evaluation of a submucosal abnormality detected on colonoscopy or other imaging study. (CMS, 2008).

CT colonography is not medically necessary when:

- Used for screening; **OR,**
- Used as an alternative to instrument colonoscopy for screening or in the absence of signs or symptoms of disease; **OR,**
- 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; **OR,**
- Following an incomplete colonoscopy if the reason for the colonoscopy is other than one of those described above.

*NOTE: CT colonography should be performed soon after the failed standard colonoscopy, if appropriate, so that the patient will not have to endure repeat colonic preparation (CMS, 2008).*

**CODING**
Covered CPT® Codes
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

Non Covered CPT® Codes
74263  Computed tomographic (CT) colonography, screening including image postprocessing

HCPCS Level II © Codes – Not applicable.

ICD-9-CM Procedure Codes – Not applicable.

Covered Draft ICD-10-PCS Codes – Not applicable.

Covered ICD-9-CM Diagnosis Codes when the above criterion are met
153.0 - 153.8  Malignant neoplasm of colon, hepatic flexure, transverse, descending, sigmoid, cecum, appendix, ascending, splenic flexure, or other specified site(s)
154.0 - 154.8  Malignant neoplasm of rectosigmoid junction, rectum, anal canal, anus and other specified site(s)
197.5  Secondary malignant neoplasm of large intestine or rectum
211.3 - 211.4  Benign Neoplasm of colon, rectum and anal canal
230.3 - 230.6  Carcinoma in situ of colon, rectum, anal canal or anus
235.2  Neoplasm of uncertain behavior of stomach, intestines, and rectum
235.5  Neoplasm of uncertain behavior of anal canal, sphincter or anus
552.8  Abdominal Wall hernia, obstructed (entrapment of colonic loops)
560.2  Volvulus
562.10  Diverticulosis of colon without hemorrhage
562.11  Diverticulitis of colon without hemorrhage
562.12  Diverticulosis of colon with hemorrhage
562.13  Diverticulitis of colon with hemorrhage
555.9  Ulcerative colitis or Crohn’s disease
560.81  Postoperative Intestinal or peritoneal adhesions with obstruction
560.89  Other specified intestinal obstruction
793.4  Nonspecific (abnormal) findings on radiological and other examination of gastrointestinal tract
V10.05  Personal history of malignant neoplasm, large intestine
V10.06  Personal history of malignant neoplasm, rectum, rectosigmoid junction and anus
V12.72  Personal History of colonic polyps
V12.79  Personal History of other diseases of digestive system
V16.0  Family history of Malignant Neoplasm of gastrointestinal tract.
V18.51  Family history of digestive disorders (familial adenomatous polyposis)
V58.61  Long-term (current) use of anticoagulants [that cannot be interrupted]
V67.00  Follow-up Exam following surgery, unspecified
V67.01  Follow-up Exam following radiotherapy

Non-Covered ICD-9-CM Diagnosis Codes
556.9  Toxic megacolon
789.00 - 789.09  Acute abdominal pain
V76.41  Special screening for malignant neoplasms; rectum
V76.51  Special screening for malignant neoplasms, colon

Covered Draft ICD-10-CM Diagnosis Codes
C18.0 - C18.9  Malignant neoplasm of colon
C19  Malignant neoplasm of rectosigmoid junction
C20  Malignant neoplasm of rectum
C21.0 - C21.8  Malignant neoplasm of anus and anal canal
C78.5 Secondary malignant neoplasm of large intestine and rectum
D01.0 - D01.3 Carcinoma in situ of other and unspecified digestive organs
D12.0 - D12.9 Benign neoplasm of colon, rectum, anus, and anal canal
D37.1 - D37.5 Neoplasm of uncertain behavior of stomach, small intestine, appendix, colon, rectum
D37.8 Neoplasm of uncertain behavior of other specified digestive organs
D37.9 Neoplasm of uncertain behavior of digestive organ, unspecified
K45.0 Other specified abdominal hernia with obstruction, without gangrene
K50.00 - K52.9 Non-infective enteritis and colitis
K56.2 Volvulus
K57.00 - K57.93 Diverticular disease of the intestine
K63.5 Poly of colon
K66.5 Intestinal adhesions [bands] with obstruction (postprocedural)(post infection)
K66.69 Other intestinal obstruction
K63.5 Poly of colon
R93.3 Abnormal findings on diagnostic imaging of other parts of digestive tract
Z08 Encounter for follow-up examination after completed treatment for malignant neoplasm
Z09 Encounter for follow-up examination after completed treatment for conditions other than malignant neoplasm
Z79.01 Long term (current) use of anticoagulants
Z80.0 Family history of malignant neoplasm of digestive organs
Z83.71 Family history of colonic polyps
Z85.038 Personal history of other malignant neoplasm of rectum, rectosigmoid junction and anus
Z85.048 Personal history of other malignant neoplasm of rectum, rectosigmoid junction and anus
Z86.010 Personal history of colonic polyps
Z87.19 Personal history of other diseases of the digestive system

Non-Covered Draft ICD-10-CM Diagnosis Codes
K51.90 - K51.919 Megacolon, not elsewhere classified
R10 Abdominal and pelvic pain
Z12.1 Encounter for screening for malignant neoplasm of intestinal tract


REFERENCES

MEDICAL POLICY COMMITTEE HISTORY AND REVISIONS

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<td>7/9/2015</td>
<td>Approved by MPC. Coding changes only.</td>
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<tr>
<td>8/7/2014</td>
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<tr>
<td>8/9/2013</td>
<td>Reinstated for markets where CareCore is not a vendor.</td>
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<td>5/3/2012</td>
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