

# Medical Policy



## Colorectal Cancer Screening

Policy Number: PG0065

Last Reviewed Date: 04/01/2025

Last Revised: 04/01/2025

HMO AND PPO

ELITE (MEDICARE ADVANTAGE)

MARKETPLACE

### 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:

☒ Professional

☒ 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. CRC 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 (i.e., 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 CRC 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. A radiologist interprets the results. 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 individual, 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 individual 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 individuals 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.

### **Genetic and Biomarker Cancer Screening**

Genetic and biomarker cancer screening tests are designed for asymptomatic individuals that are at an average risk level for cancer, or for individuals that are known to be at a higher risk to develop a specific cancer. Genetic

and biomarker cancer screening tests aim to identify the presence of cancer before symptoms appear and when treatment is often most effective. These tests are not currently diagnostic for cancer, but typically determine if an individual has an increased chance that cancer is present. Screening tests for colorectal cancer may be performed by analyzing specific DNA present in fecal matter or peripheral blood. Cancer screening tests may also be performed on urine samples to screen for bladder cancer and colon polyps.

#### **Septin9 (SEPT9) (e.g., Epi proColon, ColoVantage)**

Septin9 (SEPT9) DNA methylated assay for the early detection of colorectal cancer (e.g., 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.

#### **Shield (Guardant Health Inc.)**

The Shield test is a qualitative, in vitro diagnostic test intended to detect colorectal cancer derived alterations in cell-free DNA from blood collected in the Guardant Shield Blood Collection Kit. Shield is intended for colorectal cancer screening in individuals at average risk of the disease, age 45 years or older. Patients with a positive result should be followed by colonoscopy. Shield is not a replacement for diagnostic colonoscopy or for surveillance colonoscopy in high-risk individuals. This test is performed at Guardant Health, Inc. There is insufficient evidence to demonstrate the clinical utility of this test for colon cancer screening.

#### **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:**

##### **Paramount Commercial Insurance Plans and Elite (Medicare Advantage) Plans**

##### **Paramount Commercial Insurance Plans**

- **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, G0105 and G0121) do not require prior authorization.**
- **Cologuard™ stool-based DNA test (81528) and Cologuard Plus™ (0464U), does not require prior authorization.**
- **In vivo analysis (44799, 45999, 88375) of colorectal polyps, Septin9 (SEPT9) (e.g., Epi proColon, ColoVantage) (81327), ColonSentry® (81479), Shield (0537U), Urine-based screening for precancerous colonic polyps (e.g., PolypDx™) (0002U) and blood-based protein biomarker panels (e.g., BeScreened™-CRC) (0163U), blood-based biomarker testing (G0327), for colorectal cancer screening are non-covered procedures, not an all-inclusive listing.**
- **Effective 1/1/2023, when an individual initially has a non-invasive stool-based screening test (FOBT or MT-sDNA test) and gets a positive result, a follow-up colonoscopy is covered as a screening test. Identify the complete colorectal cancer screening context by adding the KX modifier to the claim for the screening colonoscopy.**

##### **Elite (Medicare Advantage) Plans**

- **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.**
- **Cologuard™ stool-based DNA test (81528) and Cologuard Plus™ (0464U), does not require prior authorization.**

- In vivo analysis (44799, 45999, 88375) of colorectal polyps, Septin9 (SEPT9) (e.g., Epi proColon, ColoVantage) (81327), ColonSentry® (81479), Shield (0537U), Urine-based screening for precancerous colonic polyps (e.g., PolypDx™) (0002U) and blood-based protein biomarker panels (e.g., BeScreened™-CRC) (0163U) for colorectal cancer screening are non-covered procedures, not all-inclusive listing.
- Effective 7/1/2021 - Procedure G0327 - added documentation and coverage criteria for Elite (Medicare Advantage Plans blood-based biomarker testing per CMS mandate. Effective 12/1/2021 prior authorization required for G0327.
- Effective 1/1/2023, when an individual initially has a non-invasive stool-based screening test (FOBT or MT-sDNA test) and gets a positive result, a follow-up colonoscopy is covered as a screening test. Identify the complete colorectal cancer screening context by adding the KX modifier to the claim for the screening colonoscopy.

**Related Policies:**

- PG0137 Preventive Services for Preventive services mandated by the Patient Protection and Affordable Care Act covered at 100% with no cost sharing.

**Reimbursement Guidelines: See details below**

**COVERAGE CRITERIA:**

**Paramount Commercial Insurance Plans and Elite (Medicare Advantage) Plans**

Paramount covers colorectal cancer screening for all adults aged 45 to 85 years. Several recommended screening tests are available. Clinicians and individuals 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), pre-procedure 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 (i.e., 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, routine CRC screening is individualized, screening should be stopped varies based on a individual's health status (e.g., 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.

The decision to screen for colorectal cancer in adults aged 76 to 85 years should be an individual one, taking into account the individual's overall health and prior screening history.

- Adults in this age group who have never been screened for colorectal cancer are more likely to benefit.
- Screening would be most appropriate among adults who meet both of the following indications:
  - Are healthy enough to undergo treatment if colorectal cancer is detected
  - Do not have co-morbid conditions that would significantly limit their life expectancy

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, re-screening may be performed using colonoscopy in 3 years

### **The Cologuard – Multi-target Stool DNA (sDNA) Screening Test for average risk individuals:**

Screening stool or fecal DNA (deoxyribonucleic acid, sDNA) testing detects molecular markers of altered DNA that are contained in the cells shed by colorectal cancer and pre-malignant colorectal epithelial neoplasia into the lumen of the large bowel. Through the use of selective enrichment and amplification techniques, sDNA tests are designed to detect very small amounts of DNA markers to identify colorectal cancer or pre-malignant colorectal neoplasia. The Cologuard™ – multi-target sDNA test is a proprietary in vitro diagnostic device that incorporates both sDNA and fecal immunochemical test techniques and is designed to analyze individuals' stool samples for markers associated with the presence of colorectal cancer and pre-malignant colorectal neoplasia. CPT code 81528 - Oncology (colorectal) screening, quantitative real-time target, and signal amplification of 10 DNA markers (KRAS mutations, promoter methylation of NDRG4 and BMP3) and fecal hemoglobin, utilizing stool, algorithm reported as a positive or negative result. CPT code 0464U Oncology (colorectal) screening, quantitative real-time target and signal amplification, methylated DNA markers, including LASS4, LRRC4 and PPP2R5C, a reference marker ZDHHC1, and a protein marker (fecal hemoglobin), utilizing stool, algorithm reported as a positive or negative result (Cologuard Plus™).

Reimbursement of colorectal cancer screening with DNA analysis of stool samples is allowed every 3 years as a screening technique in individuals at average risk of colorectal cancer, when ALL the following is met:

- Age 45 to 75 years, and,
- 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 (gFOBT) or fecal immunochemical test (iFOBT)), and,
- No prior history of abnormal fecal DNA test, and,
- At average risk of developing colorectal cancer (no personal history of adenomatous polyps, colorectal cancer, or inflammatory bowel disease, including Crohn's Disease and ulcerative colitis; no family history of colorectal cancers or adenomatous polyps, familial adenomatous polyposis, or hereditary nonpolyposis colorectal cancer).

Reimbursement is not allowed for colorectal cancer screening with DNA analysis of stool samples for all other indications.

Reimbursement is not allowed for screening with DNA analysis of stool samples at an interval of less than 3 years.

If the screening test result is abnormal (positive), then a colonoscopy should be performed to complete CRC screening.

There is not enough research to show that stool DNA testing with any test other than Cologuard® is an effective way to screen for colon cancer and can improve health outcomes for individuals. Therefore, stool DNA testing using any test other than Cologuard is considered experimental/investigational.

### **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 an individual 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)
- Individuals 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; and
    - Every 1 year until age 24 years; (16) and
    - Every 2 years from age 24 to 34 years; and
    - Every 3 years from age 34 to 44 years; and
    - No less than every 3 years thereafter. 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 Individuals 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 individuals who meet any of the following criteria, may not be all-inclusive:

- An individual 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 individuals 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 individual 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 individuals 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 individuals 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 individuals 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 individuals 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 individuals with hyperplastic polyps, surveillance colonoscopy is covered as follows:
  - For individuals 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 individuals 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 individuals 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 individuals 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.
- Individuals 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)
- Individuals 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 individuals with any of the above risk factors for colorectal cancer.

### **Limitations**

- Repeat colonoscopy (or other screening procedures) for individuals with small hyperplastic polyps performed at intervals less than that for average risk individuals is not covered. Individuals 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 individuals 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 individuals 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 individuals 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 (Medicare Advantage) Plan as its use is experimental/investigational.

### **Paramount Commercial Insurance Plans and Elite (Medicare Advantage) Plans**

Paramount does not cover the following tests for any indication, including, but not limited to, the screening, diagnosis, or surveillance of colorectal cancer, as its use is experimental/investigational, not an all-inclusive listing:

- In vivo analysis (44799, 45999, 88375) of colorectal polyps (e.g., chromoendoscopy (also known as chromoscopy and chromocolonoscopy), fiberoptic polyp analysis, narrow band imaging, and confocal fluorescent endomicroscopy (also known as confocal fluorescent endomicroscopy and optical
- Endomicroscopy))
- Blood-based protein biomarker panels (e.g., BeScreened™-CRC) (e.g., ColonSentry®) (81479) (excluding Elite (Medicare Advantage) Plans, procedure G0327\*)
- Urine-based screening for precancerous colonic polyps (e.g., PolypDx™)

**Elite (Medicare Advantage) Plans** 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 (Medicare Advantage) Plans: G0327, blood-based biomarker test is an appropriate CRC screening test once every 3 years for Elite (Medicare Advantage) Plans individuals when performed in a Clinical Laboratory Improvement Act (CLIA)-certified laboratory, ordered by a treating physician, and when the following requirements are met.

The individual is:

- Aged 45-85 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.

### **Paramount Commercial Insurance Plans**

G0327, blood-based biomarker, is non-covered.

### **Reimbursement Guidelines:**

#### **Paramount Commercial Insurance Plans and Elite (Medicare Advantage) Plans**

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)

### **Related to Preventive Coverage:**

Paramount reimburses for preventive colonoscopy in accordance with state mandates and CMS guidelines. Colonoscopies, which are initiated as a screening colonoscopy, during which a polyp/tumor or other procedure due to an abnormality is discovered, should be considered a preventive service.

- The preventive colonoscopy diagnosis should be entered as the primary diagnosis and the diagnosis codes for any discovered pathology should be entered as the secondary diagnosis on all subsequent claim lines
- 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 (including, not all inclusive, anesthesia, associated laboratory testing) 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
  - Preventive Colonoscopy Screening
    - Does not require modifier PT to be billed.
  - High Risk Colonoscopy Screening
    - Does not require modifier PT to be billed.
  - Diagnostic Colonoscopy Service
    - When billed with modifier PT will be treated as preventive.
    - Modifier not billed indicates the service is diagnostic.
- If an abnormal or positive non-invasive stool-based screening test or direct visualization screening test is obtained, bill the follow-up Colonoscopy as a preventive service with modifier PT. No copay will apply.
- The screening Z code should also be listed first on the claim for a follow-up colonoscopy conducted after a positive noninvasive stool-based screening test or direct visualization test (e.g., sigmoidoscopy, CT colonography).
- 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.
- Append modifier –33 (Preventive Service) to the anesthesia CPT code 00812 when you supply a separately payable anesthesia service with a screening colonoscopy (G0105 and G0121) to waive patient cost share.
- Patient cost share for moderate sedation services (reported with G0500 or 99153) is waived when given with and in support of a screening colonoscopy service and when reported with modifier –33. When a screening colonoscopy becomes a diagnostic colonoscopy, report moderate sedation services (G0500 or 99153) with only the –PT modifier.

### **CODING/BILLING INFORMATION:**

**The appearance of a code in this section does not necessarily indicate coverage. Codes that are covered**

may have selection criteria that must be met. Payment for supplies may be included in payment for other services rendered.

CPT CODES	
0002U	Oncology (colorectal), quantitative assessment of three urine metabolites (ascorbic acid, succinic acid, and carnitine) by liquid chromatography with tandem mass spectrometry (LC-MS/MS) using multiple reaction monitoring acquisition, algorithm reported as likelihood of adenomatous polyps (PolypDx™) Not Covered
0091U	Oncology (colorectal) screening, cell enumeration of circulating tumor cells, utilizing whole blood, algorithm, for the presence of adenoma or cancer, reported as a positive or negative result. (Includes FirstSightCRC CellMax Life) Not Covered
0163U	Oncology (colorectal) screening, biochemical enzyme-linked immunosorbent assay (ELISA) of 3 plasma or serum proteins (teratocarcinoma derived growth factor-1 [TDGF-1, Cripto-1], carcinoembryonic antigen [CEA], extracellular matrix protein [ECM]), with demographic data (age, gender, CRC-screening compliance) using a proprietary algorithm and reported as likelihood of CRC or advanced adenomas (new code effective 4/1/20) (BeScreened™-CRC) Not Covered
0421U	Oncology (colorectal) screening, quantitative real-time target and signal amplification of 8 RNA markers (GAPDH, SMAD4, ACY1, AREG, CDH1, KRAS, TNFRSF10B, and EGLN2) and fecal hemoglobin, algorithm reported as a positive or negative for colorectal cancer risk (Includes Colosense by Geneoscopy) (Effective 01/01/24) Not Covered
0464U	Oncology (colorectal) screening, quantitative real-time target and signal amplification, methylated DNA markers, including LASS4, LRRC4 and PPP2R5C, a reference marker ZDHHC1, and a protein marker (fecal hemoglobin), utilizing stool, algorithm reported as a positive or negative result (Cologuard Plus™)
0537U	Oncology (colorectal cancer), analysis of cell-free DNA (cfDNA) for epigenomic patterns, next-generation sequencing, >2500 differentially methylated regions (DMRs), plasma, algorithm reported as positive or negative. (Shield - Guardant Health Inc.) (Effective 4/1/2025) Not Covered
44388	Colonoscopy through stoma; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)
44389	Colonoscopy through stoma; with biopsy, single or multiple
44390	Colonoscopy through stoma; with removal of foreign body
44391	Colonoscopy through stoma; with control of bleeding (e.g., injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)
44392	Colonoscopy through stoma; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery
44394	Colonoscopy through stoma; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique
44401	Colonoscopy through stoma; with ablation of tumor(s), polyps(s), or other lesion(s) (includes pre-and-post-dilation and guide wire passage, when performed)
44799	Unlisted procedure, small intestine
45330	Sigmoidoscopy, flexible; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)
45331	Sigmoidoscopy, flexible with biopsy, single or multiple
45332	Sigmoidoscopy, flexible; with removal of foreign body(s)
45333	Sigmoidoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps
45334	Sigmoidoscopy, flexible; with control of bleeding, any method
45335	Sigmoidoscopy, flexible; with directed submucosal injection(s), any substance
45337	Sigmoidoscopy, flexible; with decompression (for pathologic distention) (e.g., volvulus, megacolon), including placement of decompression tube, when performed
45338	Sigmoidoscopy, flexible with removal of tumor(s), polyp(s), or other lesion(s) by snare technique

45340	Sigmoidoscopy, flexible; with transendoscopic balloon dilation
45341	Sigmoidoscopy, flexible; with endoscopic ultrasound examination
45342	Sigmoidoscopy, flexible; with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(s)
45346	Sigmoidoscopy, flexible; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre-and post-dilation and guide wire passage, when performed)
45378	Colonoscopy, flexible; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)
45379	Colonoscopy, flexible; with removal of foreign body(s)
45380	Colonoscopy, flexible; with biopsy, single or multiple
45381	Colonoscopy, flexible; with directed submucosal injection(s), any substance
45382	Colonoscopy, flexible; with control of bleeding, any method
45384	Colonoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps
45385	Colonoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique
45388	Colonoscopy, flexible; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre-and post-dilation and guide wire passage, when performed)
45391	Colonoscopy, flexible; with endoscopic ultrasound examination limited to the rectum, sigmoid, descending, transverse, or ascending colon and cecum, and adjacent structures
45392	Colonoscopy, flexible; with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(s), includes endoscopic ultrasound examination limited to the rectum, sigmoid, descending, transverse, or ascending colon and cecum, and adjacent structures
45999	Unlisted procedure, rectum
74263	Computed tomographic (CT) colonography, screening, including image postprocessing
74270	Radiologic examination, colon; contrast (e.g., barium) enema, with or without KUB
74280	Radiologic examination, colon; air contrast with specific high-density barium, with or without glucagon
81327	SEPT9 (Septin9) (e.g., colorectal cancer) methylation analysis Not Covered
81401	Molecular pathology procedure, Level 2 (e.g., 2-10 SNPs, 1 methylated variant, or 1 somatic variant [typically using non-sequencing target variant analysis], or detection of a dynamic mutation disorder/triplet repeat)
81479	Unlisted molecular pathology procedure
81528	Oncology (colorectal) screening, quantitative real-time target, and signal amplification of 10 DNA markers (KRAS mutations, promoter methylation of NDRG4 and BMP3) and fecal hemoglobin, utilizing stool, algorithm reported as a positive or negative result. (Cologuard)
82270	Blood, occult, by peroxidase activity (e.g., guaiac), qualitative; feces, consecutive collected specimens with single determination, for colorectal neoplasm screening (i.e., patient was provided 3 cards or single triple card for consecutive collection) (Fecal Occult Blood Tests)
82274	Blood, occult, by fecal hemoglobin determination by immunoassay, qualitative, feces, 1-3 simultaneous determinations (Fecal Occult Blood Tests)
88375	Optical endomicroscopic image(s), interpretation, and report, real-time or referred, each endoscopic session Not Covered
<b>HCPCS CODES</b>	
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
<del>G0122</del>	<del>Colorectal cancer screening; barium enema Deleted code 1/1/2025</del>
G0327	Colorectal cancer screening; blood-based biomarker, effective 7/1/2021

<b>G0328</b>	<b>Colorectal cancer screening; fecal-occult blood test, immunoassay, 1-3 simultaneous determinations (Fecal Occult Blood Tests)</b>
<b>MODIFIERS</b>	
<b>33</b>	<b>Preventive Services</b>
<b>KX</b>	<b>Requirements specified in the medical policy have been met (modifier KX should be append when exceptions are in effect and the member/patient qualifies for an exception)</b>
<b>PT</b>	<b>Colorectal cancer screening test; converted to diagnostic test or other procedure</b>

**REVISION HISTORY EXPLANATION: ORIGINAL EFFECTIVE DATE: 03/15/2006**

<b>Date</b>	<b>Explanation &amp; Changes</b>
<b>03/15/07</b>	<ul style="list-style-type: none"> <li>No change</li> </ul>
<b>04/15/08</b>	<ul style="list-style-type: none"> <li>Updated references</li> </ul>
<b>04/15/09</b>	<ul style="list-style-type: none"> <li>No change</li> </ul>
<b>04/01/11</b>	<ul style="list-style-type: none"> <li>Updated</li> </ul>
<b>10/14/14</b>	<ul style="list-style-type: none"> <li>Changed title from Colonoscopy and Sigmoidoscopy Diagnostic/Screening to Colorectal Cancer Screening</li> <li>Codes removed 44388, 44389, 44390, 44391, 44392, 44393, 44394, &amp; 44397</li> <li>Codes added 44799, 45999, 74270, 74280, 81401, 82270, 82274, S3890 &amp; G0328</li> <li>Policy reviewed and updated to reflect most current clinical evidence per Medical Policy Steering Committee</li> </ul>
<b>11/21/14</b>	<ul style="list-style-type: none"> <li>Cologuard™ stool-based DNA test (S3890) is covered without prior authorization per CMS guidelines for Elite members only</li> <li>Policy reviewed and updated to reflect most current clinical evidence per The Technology Assessment Working Group (TAWG).</li> </ul>
<b>12/02/14</b>	<ul style="list-style-type: none"> <li>Added new 2015 HCPCS code G0464</li> </ul>
<b>11/12/15</b>	<ul style="list-style-type: none"> <li>Removed effective 12/31/14 deleted codes 45339, 45345, 45355, 45383, 45387</li> <li>Added effective 1/1/15 new codes 45346, 45388</li> <li>Added codes 81479 (ColonSentry®) &amp; 88375 (In Vivo Analysis of Colorectal Polyps)</li> <li>Policy reviewed and updated to reflect most current clinical evidence per TAWG</li> </ul>
<b>12/17/15</b>	<ul style="list-style-type: none"> <li>Added effective 1/1/16 new codes 81528</li> <li>Policy reviewed and updated to reflect most current clinical evidence per TAWG</li> </ul>
<b>11/08/16</b>	<ul style="list-style-type: none"> <li>Code S3890 deleted effective 12/31/15</li> <li>Policy reviewed and updated to reflect most current clinical evidence per Medical Policy Steering Committee</li> </ul>
<b>03/24/17</b>	<ul style="list-style-type: none"> <li>Added effective 1/1/17 new code 81327 as covered for Advantage only per ODM guidelines and non-covered for HMO, PPO, Individual Marketplace, &amp; Elite</li> <li>Policy reviewed and updated to reflect most current clinical evidence per The Technology Assessment Working Group (TAWG)</li> </ul>
<b>04/11/17</b>	<ul style="list-style-type: none"> <li>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, &amp; Advantage</li> <li>Policy reviewed and updated to reflect most current clinical evidence per Medical Policy Steering Committee</li> </ul>
<b>06/01/17</b>	<ul style="list-style-type: none"> <li>Added/clarified verbiage regarding two main types of FOBT tests: fecal immunochemical testing (FIT) and guaiac based fecal occult blood test</li> </ul>
<b>09/27/18</b>	<ul style="list-style-type: none"> <li>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).</li> <li>Urine-based testing (e.g., PolypDx) is non-covered for colorectal cancer screening for all product lines</li> </ul>

	<ul style="list-style-type: none"> <li>Policy reviewed and updated to reflect most current clinical evidence per The Technology Assessment Working Group (TAWG).</li> </ul>
01/01/2021	<ul style="list-style-type: none"> <li>Medical policy placed on the new Paramount Medical Policy Format</li> </ul>
06/01/2021	<ul style="list-style-type: none"> <li>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.</li> <li>Added documentation and coverage criteria for Elite/ Medicare Plan blood-based biomarker testing per CMS mandate, G0327.</li> <li>Policy reviewed and updated to reflect most current clinical evidence</li> </ul>
09/23/2021	<ul style="list-style-type: none"> <li>Added the Cologuard™ – Multi-target Stool DNA (sDNA) Screening Test coverage criteria</li> <li>Added documentation related to blood-based biomarker tests coverage/noncoverage</li> </ul>
02/03/2023	<ul style="list-style-type: none"> <li>Medical Policy updated to reflect Medicaid coverage to Anthem as of 02/01/2023</li> </ul>
02/15/2023	<ul style="list-style-type: none"> <li>The age criteria requirement for Blood-based protein biomarker test, G0327, changed from a minimum of age of 50 to 45, for the Medicare Advantage Plans, with an effective date of 1/1/2023</li> </ul>
04/04/2023	<ul style="list-style-type: none"> <li>Added the facility scope, "X," to the medical policy</li> </ul>
02/01/2024	<ul style="list-style-type: none"> <li>Medical policy placed on the new Paramount Medical Policy format</li> </ul>
05/01/2024	<ul style="list-style-type: none"> <li>Added allowance for a preventive cancer screening following a positive non-invasive stool-based screening test</li> <li>Added Reimbursement Guidelines</li> <li>Age criteria expanded to 85 from 75</li> <li>Added noncovered procedures 0091U and 0421U. see PG0043 Experimental/Investigational Procedures/Services</li> </ul>
4/1/2025	<ul style="list-style-type: none"> <li>Medical Policy reviewed and updated to reflect the most current clinical evidence</li> <li>Removed deleted code G0122, effective 1/1/2025</li> <li>Added codes G0105 and G0121 covered without a prior authorization for Commercial product lines, effective 4/1/2025</li> <li>Added non-covered code 0537U, effective 4/1/2025</li> <li>Added code 0464U (Cologuard Plus™), effective 1/1/2025</li> </ul>

**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/providers/medical-policies/policy-library>

## REFERENCES/RESOURCES

Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals> <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs>

National Physician Fee Schedule Relative Value File Calendar Year XXXX, Centers for Medicare & Medicaid Services (CMS) <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files>

NCCI Policy Manual for Medicare Services, current version, Chapter 1, General Correct Coding Policies <https://www.cms.gov/files/document/medicare-ncci-policy-manual-2023-chapter-1.pdf>

American Medical Association, *Current Procedural Terminology (CPT®)* and associated publications and services <https://www.ama-assn.org/amaone/cpt-current-procedural-terminology>

Centers for Medicare and Medicaid Services, Healthcare Common Procedure Coding System, HCPCS Release and Code Sets <https://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/HCPCS-Quarterly->

## [Update](#)

Centers for Medicare & Medicaid Services (CMS), ICD-10-CM Official Guidelines for Coding and Reporting <https://www.cms.gov/medicare/coding/icd10>

Centers of Medicare & Medicaid Services (CMS), Medicare Claims Processing Manual, Chapter 23-Fee Schedule administration and coding Requirements <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c23.pdf>

Centers for Medicare & Medicaid Services (CMS), National Correct Coding Initiative (NCCI) Policy Manual for Medicare Services <https://www.cms.gov/medicare-medicare-coordination/national-correct-coding-initiative-ncci/ncci-medicare>

Center for Medicare and Medicaid Services, Medicare NCCI Medically Unlikely Edits (MUEs) <https://www.cms.gov/medicare/coding-billing/national-correct-coding-initiative-ncci-edits/medically-unlikely-edits>  
U.S. Preventive Services Task Force, <https://www.uspreventiveservicestaskforce.org/uspstf/>

Hayes, Inc., <https://www.hayesinc.com/>

Industry Standard Review