Virtual Colonoscopy/CT Colonography

Policy # 00136
Original Effective Date: 09/18/2002
Current Effective Date: 01/01/2017

Applies to all products administered or underwritten by Blue Cross and Blue Shield of Louisiana and its subsidiary, HMO Louisiana, Inc. (collectively referred to as the “Company”), unless otherwise provided in the applicable contract. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.

When Services May Be Eligible for Coverage
Coverage for eligible medical treatments or procedures, drugs, devices or biological products may be provided only if:

- Benefits are available in the member’s contract/certificate, and
- Medical necessity criteria and guidelines are met.

Screening
Based on review of available data, the Company may consider computed tomography (CT) colonography as a screening technique for colorectal cancer at intervals of one test every five years to be eligible for coverage.

Patient Selection Criteria
Coverage eligibility for computed tomography (CT) colonography will be considered when all of the following criteria are met:

- Age 50 to 85 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 or fecal immunochemical test), AND
- At Average risk of developing colorectal cancer (no personal history of adenomatous polyps, colorectal cancer (CRC), or inflammatory bowel disease, including Crohn’s disease and ulcerative colitis; no family history of colorectal cancers, familial adenomatous polyposis, or hereditary nonpolyposis colorectal cancer).

Diagnostic
Based on review of available data, the Company may consider computed tomography (CT) colonography to be eligible for coverage.

Patient Selection Criteria
Coverage eligibility for computed tomography (CT) colonography will be considered when any of the following criteria are met:

- Patients who cannot undergo conventional complete colonoscopy; or
- Patients with an incomplete conventional colonoscopy because of colonic stenosis or obstruction.

Note: Computed tomography (CT) colonography should be performed with a minimum 16-row detector computed tomography scanner.

When Services Are Considered Investigational
Note: Coverage is not available for investigational medical treatments or procedures, drugs, devices or biological products.
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Based on review of available data, the Company considers computed tomography (CT) colonography when patient selection criteria are not met to be investigational.*

Background/Overview
Computed tomography colonography, also known as “virtual colonoscopy,” is an imaging technique of the colon. CT colonography has been investigated as an alternative to conventional endoscopic (“optical”) colonoscopy, specifically as an alternative screening technique for colon cancer.

Computed tomography colonography, also known as “virtual colonoscopy,” is an imaging technique of the colon involving thin-section helical CT to generate high-resolution 2-dimensional axial images of the colon. Three-dimensional images, which resemble the endoluminal images obtained with conventional endoscopic colonoscopy, are then reconstructed offline. Computed tomography colonography has been investigated as an alternative to conventional endoscopic (“optical”) colonoscopy, specifically as an alternative screening technique for colon cancer. While CT colonography requires a full bowel preparation, similar to conventional colonoscopy, no sedation is required, and the examination is less time-consuming. However, the technique involves gas insufflation of the intestine, which may be uncomfortable to the patient, and training and credentialing of readers may be needed to achieve optimal performance.

FDA or Other Governmental Regulatory Approval
Centers for Medicare and Medicaid Services (CMS)
On May 12, 2009, the Centers for Medicare and Medicaid Services published a decision memo for CT colonography screening that states “The evidence is inadequate to conclude that CT colonography is an appropriate colorectal cancer screening test under §1861(pp)(1) of the Social Security Act. CT colonography for colorectal cancer screening remains noncovered.”

Rationale/Source
This medical policy was developed through consideration of peer-reviewed medical literature generally recognized by the relevant medical community, U.S. Food and Drug Administration approval status, nationally accepted standards of medical practice and accepted standards of medical practice in this community, Blue Cross and Blue Shield Association technology assessment program (TEC) and other non-affiliated technology evaluation centers, reference to federal regulations, other plan medical policies, and accredited national guidelines.

References
2. Blue Cross and Blue Shield Association Technology Evaluation Center (TEC). CT colonography (“virtual colonoscopy”) for colon cancer screening, TEC Assessments 2004; Volume 19, Tab 8.
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09/11/2002 Medical Policy Committee review
09/18/2002 Managed Care Advisory Council approval
10/05/2004 Medical Director review
11/29/2004 Managed Care Advisory Council approval
07/07/2006 Format revision, including addition of FDA and or other governmental regulatory approval and rationale/source. Coverage eligibility unchanged
11/01/2006 Medical Director review
01/07/2009 Medical Director review
01/14/2009 Medical Policy Committee approval. Title changed from “Virtual Colonoscopy/CT Colonography as a Screening Test for Colorectal Cancer” to “Virtual Colonoscopy/CT Colonography” Coverage changed from investigational to eligible for coverage with criteria.
01/07/2010 Medical Director review
01/20/2010 Medical Policy Committee approval. No change to coverage. Coding revision.
01/06/2011 Medical Director review
01/19/2011 Medical Policy Committee approval. No change to coverage
02/02/2012 Medical Policy Committee review
02/15/2012 Medical Policy Implementation Committee approval. Coverage eligibility unchanged.
01/03/2013 Medical Policy Committee review
01/09/2013 Medical Policy Implementation Committee approval. Coverage eligibility unchanged.
01/09/2014 Medical Policy Committee review
01/15/2014 Medical Policy Implementation Committee approval. Coverage eligibility unchanged.
02/05/2015 Medical Policy Committee review
02/18/2015 Medical Policy Implementation Committee approval. Coverage eligibility unchanged.
08/03/2015 Coding update: ICD10 Diagnosis code section added; ICD9 Procedure code section removed.
02/04/2016 Medical Policy Committee review
02/17/2016 Medical Policy Implementation Committee approval. No change to coverage.
11/03/2016 Medical Policy Committee review
11/16/2016 Medical Policy Implementation Committee approval. Coverage statement and criteria added for screening, existing coverage statement and criteria specified as diagnostic.
01/01/2017 Coding update: Removing ICD-9 Diagnosis Codes

Next Scheduled Review Date: 11/2017

Coding
The five character codes included in the Blue Cross Blue Shield of Louisiana Medical Policy Coverage Guidelines are obtained from Current Procedural Terminology (CPT®), copyright 2015 by the American Medical Association (AMA). CPT is developed by the AMA as a listing of descriptive terms and five character identifying codes and modifiers for reporting medical services and procedures performed by physician.

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Blue Cross Blue Shield of Louisiana Medical Policy Coverage Guidelines should refer to the most current Current Procedural Terminology which contains the complete and most current listing of CPT codes and descriptive terms. Applicable FARS/DFARS apply.

CPT is a registered trademark of the American Medical Association.

Codes used to identify services associated with this policy may include (but may not be limited to) the following:

<table>
<thead>
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<th>Code Type</th>
<th>Code</th>
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<tbody>
<tr>
<td>CPT</td>
<td>74261, 74262, 74263</td>
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<tr>
<td>HCPCS</td>
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<td>ICD-10 Diagnosis</td>
<td>C18.0-C18.9, K50.012, K50.112, K50.812, K50.912, K56.60, Z12.11</td>
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*Investigational – A medical treatment, procedure, drug, device, or biological product is Investigational if the effectiveness has not been clearly tested and it has not been incorporated into standard medical practice. Any determination we make that a medical treatment, procedure, drug, device, or biological product is Investigational will be based on a consideration of the following:

A. whether the medical treatment, procedure, drug, device, or biological product can be lawfully marketed without approval of the U.S. FDA and whether such approval has been granted at the time the medical treatment, procedure, drug, device, or biological product is sought to be furnished; or

B. whether the medical treatment, procedure, drug, device, or biological product requires further studies or clinical trials to determine its maximum tolerated dose, toxicity, safety, effectiveness, or effectiveness as compared with the standard means of treatment or diagnosis, must improve health outcomes, according to the consensus of opinion among experts as shown by reliable evidence, including:

1. Consultation with the Blue Cross and Blue Shield Association technology assessment program (TEC) or other nonaffiliated technology evaluation center(s);

2. Credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community; or

3. Reference to federal regulations.

**Medically Necessary (or "Medical Necessity") - Health care services, treatment, procedures, equipment, drugs, devices, items or supplies that a Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

A. In accordance with nationally accepted standards of medical practice;

B. Clinically appropriate, in terms of type, frequency, extent, level of care, site and duration, and considered effective for the patient's illness, injury or disease; and

C. Not primarily for the personal comfort or convenience of the patient, physician or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For these purposes, “nationally accepted standards of medical practice” means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of Physicians practicing in relevant clinical areas and any other relevant factors.

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NOTICE: Medical Policies are scientific based opinions, provided solely for coverage and informational purposes. Medical Policies should not be construed to suggest that the Company recommends, advocates, requires, encourages, or discourages any particular treatment, procedure, or service, or any particular course of treatment, procedure, or service.