REIMBURSEMENT POLICY STATEMENT
Arkansas PASSE

Policy Name & Number	Date Effective
Colorectal Cancer Screening-AR PASSE-PY-1426	09/01/2026
Policy Type	
REIMBURSEMENT	

Reimbursement Policies are intended to provide a general reference regarding billing, coding, and documentation guidelines. Coding methodology, regulatory requirements, industry-standard claims editing logic, benefits design, and other factors are considered in developing Reimbursement Policies. Reimbursement Policies do not guarantee authorization or payment for services. Coverage and payment determinations are subject to member benefits and eligibility on the date of service, medical necessity, adherence to plan policies and procedures, claims editing logic, provider contractual agreements, and applicable referral, authorization, notification, and utilization management guidelines.

Please refer to the plan contract (e.g., Evidence of Coverage, Member Handbook) for the service(s) referenced herein. Except as otherwise required by law, if there is a conflict between the Reimbursement Policy and the plan contract and/or provider agreement, then the plan contract and/or provider agreement will be the controlling document used to make the determination. Reasonable discretion may be used in interpreting and applying this policy to services provided in a particular case and the policy may be modified at any time. Reimbursement policies may be superseded by federal and state laws and regulations, as applicable. In the case of a discrepancy between the Policy Statement's effective date and any applicable legal or regulatory requirement, the law or regulation will govern.

Coverage for mental health and substance use disorder (MH/SUD) benefits are provided at the same level as coverage for medical and surgical (M/S) benefits, as required by the Mental Health Parity and Addiction Equity Act (MHPAEA). MH/SUD benefits are not subject to limits or requirements that are more restrictive than those that apply to M/S benefits.

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A. Subject
Colorectal Cancer Screening

B. Background
In the United States, colorectal cancer (CRC) is the second most common cause of cancer deaths in men and women combined. CRC mortality rates have declined over previous decades driven by changes in risk factors, early detection of cancer through screening, removal of precancerous polyps with colonoscopy, and advances in surgical/treatment approaches.

Appropriate screening reduces colorectal cancer mortality in adults 45 years of age or older. The benefit of early detection and intervention for colorectal cancer declines with age, however, the US Preventive Services Task Force (USPSTF) and the American Cancer Society recommend that screening begins at 45 years of age. Individuals over 75 years of age should consult with their primary care physician to determine if continued screening is appropriate and/or recommended.

C. Definitions
- **Colorectal Cancer Screening** – Testing for early-stage colorectal cancer and precancerous lesions in asymptomatic members with an average risk.
- **Risk** – Agents or situations known to increase development of a condition. Per American Cancer Society guidelines:
  - **Average** – Certain factors are not present, including a personal or family history of colorectal cancer, certain types of polyps, inflammatory bowel disease (eg, ulcerative colitis, Crohn's disease), radiation to abdomen or pelvic area to treat prior cancer, and/or a confirmed or suspected hereditary colorectal cancer syndrome (eg, familial adenomatous polyposis (FAP), or Lynch syndrome)
  - **High or Increased** – Any of the factors seen above are present.
- **Surveillance for Colorectal Cancer** – Close observation for members at increased or high-risk for colorectal cancer.

D. Policy
I. Colorectal Cancer Screening
A. A review of medical necessity is not required for participating providers.
B. Coverage includes colorectal cancer examinations and laboratory tests for
1. Members 45 years of age or older.
2. Members less than 45 years of age at high-risk for colorectal cancer.
3. Members experiencing or meeting the following criteria or symptoms of colorectal cancer as determined by a physician:
a. bleeding from the rectum or blood in the stool
b. a change in bowel habits, such as diarrhea, constipation, or narrowing of the stool, that lasts more than 5 days
c. the need for a follow-up colonoscopy

C. Screening for colorectal cancer claims must be submitted with 1 of the following ICD-10 codes:

1. Z12.10 – Encounter for screening for malignant neoplasm of intestinal tract, unspecified
2. Z12.11 – Encounter for screening for malignant neoplasm of colon
3. Z12.12 – Encounter for screening for malignant neoplasm of rectum
4. Z12.13 – Encounter for screening for malignant neoplasm of small intestine

D. The following are reimbursable (not an all-inclusive list):
   1. Highly sensitive fecal immunochemical test (FIT) annually
   2. Highly sensitive guaiac-based fecal occult blood test (gFOBT) annually
   3. Multi-targeted stool DNA test (mt-sDNA) every 1-3 years per USPSTF guidelines
   4. Flexible sigmoidoscopy (FSIG) every 5 years
   5. Colonoscopy every 10 years
   6. CT colonography (virtual colonoscopy) every 5 years
      a. Reimbursable when the following conditions are met:
         01. Only indicated when an instrument/fiberoptic colonoscopy of the entire colon is incomplete due to an inability to pass the colonoscopy proximately.
         02. When ordered or performed by qualified personnel.
         03. Final report must address all structures of the abdomen afforded review in a regular CT of the abdomen and pelvis.
      b. Exclusions for reimbursement:
         01. When 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.
         02. When used as an alternative to instrument/fiberoptic colonoscopy for screening or in the absence of signs or symptoms of disease.
         03. Since any colonography with abnormal or suspicious findings would require a subsequent instrument/fiberoptic colonoscopy for diagnosis (eg, biopsy) or for treatment (eg, polypectomy), virtual colonography is not reimbursable when used as an alternative to an instrument/fiberoptic colonoscopy, even though performed for signs or symptoms of disease.
         04. CT colonography procedure codes are counted against the member's annual lab and X- ray benefit limit.

E. A follow-up colonoscopy is reimbursed as part of the screening process when a non-colonoscopy test is positive.
F. Screening with plasma or serum markers is not covered.

II. Colonoscopy Surveillance for Colorectal Cancer
   A. A review of medical necessity is not required for participating providers.
   B. Surveillance for colorectal cancer claim must be submitted with 1 of the following ICD-10 codes:
      1. K50 through K52 category codes – Noninfective enteritis and colitis.
      2. Z15.060 – Genetic susceptibility to colorectal cancer
      3. Z15.89 – Genetic susceptibility to other disease
      4. Z80.0 – Family history of malignant neoplasm of digestive organs
      5. Z83.71 – Family history of colonic polyps

6. Z84.81 – Family history of carrier of genetic disease
7. Z85.038 – Personal history of other malignant neoplasm of large intestine
8. Z85.048 – Personal history of other malignant neoplasm of rectum, rectosigmoid junction, and anus
9. Z86.010 – Personal history of colonic polyps
10. Z92.3 – Personal history of irradiation or radiation therapy

E. Conditions of Coverage
Reimbursement is dependent on, but not limited to, submitting HCPCS and CPT codes along with appropriate modifiers.

F. Related Policies/Rules
N/A

G. Review/Revision History

	DATE	ACTION
Date Issued	03/29/2023	Approved at Committee.
Date Revised	05/10/2023 03/27/2024 08/13/2025 06/17/2026	Removed information re: PT modifier. Approved at Committee. Annual review. Added D.I.B.3, references updated. Approved at Committee. Added Z15.060 to D.II.B. Approved at Committee.
Date Effective	09/01/2026	
Date Archived		

H. References

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3. Key statistics for colorectal cancer. American Cancer Society. Revised January 14, 2026. Accessed May 6, 2026. www.cancer.org
4. Patel SG, May FP, Anderson JC, et al. Updates on age to start and stop colorectal cancer screening: recommendations from the U.S. Multi-Society Task Force on Colorectal Cancer. *Gastroenterology*. 2022;162(1):285-299. doi:10.1053/j.gastro.2021.10.007
5. *Physician Provider Manual, II*. Arkansas Dept of Human Services; 2025. Accessed July 24, 2025. www.humanservies.arkansas.gov
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7. Qaseem A, Harrod CS, Crandall CJ, Wilt TJ. Screening for colorectal cancer in asymptomatic average-risk adults: a guidance statement from the American College of Physicians (version 2). *Ann Intern Med*. 2023;176(8):1017-1144. doi:10.7326/M23-0779.
8. Screening and surveillance for colorectal cancer. American Society of Colon and Rectal Surgeons. Accessed May 6, 2026. www.fascrs.org

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10. Wilkins T, McMechan D, Talukder A. Colorectal cancer screening and prevention. *Am Fam Physician*. 2018;97(10):658-665. Accessed May 6, 2026. www.aafp.org