



REIMBURSEMENT POLICY STATEMENT OHIO MEDICAID

Original Issue Date		Next Annual Review	Effective Date
06/01/2017		05/15/2018	06/01/2017
Policy Name			Policy Number
Screening and Surveillance for Colorectal Cancer			PY-0072
Policy Type			
Medical	Administrative	Pharmacy	REIMBURSEMENT

Reimbursement Policies prepared by CSMG Co. and its affiliates (including CareSource) 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.

In addition to this Policy, Reimbursement of services is subject to member benefits and eligibility on the date of service, medical necessity, adherence to plan policies and procedures, claims editing logic, provider contractual agreement, and applicable referral, authorization, notification and utilization management guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any federal or state coverage mandate, Evidence of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

This Policy does not ensure an authorization or Reimbursement of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced herein. If there is a conflict between this Policy and the plan contract (i.e., Evidence of Coverage), then the plan contract (i.e., Evidence of Coverage) will be the controlling document used to make the determination.

CSMG Co. and its affiliates may use reasonable discretion in interpreting and applying this Policy to services provided in a particular case and may modify this Policy at any time.

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A. SUBJECT

Screening and Surveillance for Colorectal Cancer

B. BACKGROUND

Reimbursement policies are designed to assist you when submitting claims to CareSource. They are routinely updated to promote accurate coding and policy clarification. These proprietary policies are not a guarantee of payment. Reimbursement for claims may be subject to limitations and/or qualifications. Reimbursement will be established based upon a review of the actual services provided to a member and will be determined when the claim is received for processing. Health care providers and their office staff are encouraged to use self-service channels to verify member's eligibility.

It is the responsibility of the submitting provider to submit the most accurate and appropriate CPT/HCPCS code(s) for the product or service that is being provided. The inclusion of a code does not imply any right to reimbursement or guarantee claims payment.

CareSource will reimburse participating providers for medically necessary and preventive screening tests for colorectal cancer as required by state requirements through criteria based on recommendations from the U.S. Preventive Services Task Force (USPSTF) and the American College of Gastroenterology (ACG). Applicable clinical criteria for the following colorectal cancer screening health services are described in the corresponding medical policy entitled "Screening and Surveillance for Colorectal Cancer":

- Air Contrast Barium Enema (ACBE) every 5 years;
- Flexible sigmoidoscopy every 5 years in combination with fecal occult blood testing (FOBT) or fecal immunochemical testing (FIT) every 3 years.
- Multi-targeted stool DNA test (Cologuard) every 3 years when clinical criteria are met; (see the "Screening and Surveillance for Colorectal Cancer policy")
- Screening Colonoscopy every 10 years in average risk patients.
- Screening Colonoscopy every 24 months in high risk patients
- FOBT or FIT annually

C. DEFINITIONS

See corresponding CareSource medical policy titled, "Screening and Surveillance for Colorectal Cancer": <https://www.caresource.com/documents/medicaid-screening-and-surveillance-for-colorectal-cancer/>

D. POLICY

CareSource will reimburse providers for Screening and Surveillance for Colorectal Cancer utilized through Medicaid when approved by CareSource.

- I. Medicaid screening and surveillance for colorectal cancer are reimbursed based on the Medicaid fee schedule.
- II. If required, providers must submit their prior authorization number their claim form, as well as appropriate HCPCS and/or CPT codes along with appropriate modifiers in accordance with CMS.



E. CONDITIONS OF COVERAGE

Reimbursement is dependent on, but not limited to, submitting approved HCPCS and CPT codes along with appropriate modifiers. Please refer to: <http://jfs.ohio.gov/>

- The following list(s) of codes is provided as a reference. This list may not be all inclusive and is subject to updates. Please refer to the above referenced sources for the most current coding information.

CPT Codes	
Code	Description
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
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)
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
45386	Colonoscopy, flexible; with transendoscopic balloon dilation
45389	Colonoscopy, flexible; with endoscopic stent placement (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
45390	Colonoscopy, flexible; with endoscopic mucosal resection
45393	Colonoscopy, flexible; with decompression (for pathologic distention) (e.g., volvulus, megacolon), including placement of decompression tube, when performed
45398 81528	Colonoscopy, flexible; with band ligation(s) (e.g., hemorrhoids) 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)



AUTHORIZATION PERIOD

If applicable, reimbursement is dependent upon products and services frequency, duration and timeframe set forth by Medicaid.

F. RELATED POLICIES/RULES

Screening and Surveillance for Colorectal Cancer, MM-0040 (Medicaid)

G. REVIEW/REVISION HISTORY

	DATE	ACTION
Date Issued	06/01/2017	
Date Revised		
Date Effective	06/01/2017	

H. REFERENCES

1. Ohio Department of Medicaid. (2016, May 16). Retrieved May 16, 2016, from <http://medicaid.ohio.gov/FOROHIOANS/CoveredServices.aspx#669179-preventive-exams-and-screenings>

The Reimbursement Policy Statement detailed above has received due consideration as defined in the Reimbursement Policy Statement Policy and is approved.