CLINICAL MEDICAL POLICY	
Policy Name:	Colorectal Cancer Screening
Policy Number:	MP-059-MD-PA
Responsible Department(s):	Medical Management
Provider Notice/Issue Date:	09/01/2024; 10/01/2023; 08/01/2023; 08/01/2022; 07/16/2021; 03/19/2021; 03/16/2020; 05/06/2019; 08/01/2018; 05/01/2018; 08/01/2017
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Products:	Highmark Wholecare℠ Medicaid
Application:	All participating hospitals and providers
Page Number(s):	1 of 12

Policy History

Date	Activity
10/01/2024	Provider Effective date
08/21/2024	QI/UM Committee review
08/21/2024	Annual Review: No changes to clinical criteria. Updated 'Summary of Literature' and 'Reference Sources' sections.
11/01/2023	Provider Effective date
09/20/2023	QI/UM Committee review
09/20/2023	Urgent Review: Removed the following HCPCS codes from the 'Coding Requirements' section: G0104, G0105, G0106, G0120, G0121, G0122, G0328
09/01/2023	Provider Effective date
06/21/2023	QI/UM Committee review
086/21/2023	Annual Review: Adjusted colorectal screening cut-off age from 85 to 75 per USPSTF guidance. Added USPSTF guidance to 'Governing Bodies Approval' section. Updated 'Summary of Literature' and 'Reference Sources' sections.
09/01/2022	Provider Effective date
06/15/2022	QI/UM Committee review

06/15/2022	Annual Review: No changes to clinical criteria. The following bullet-points added to Contraindications: *Risk of procedure outweighs benefits* & *Consent is unable to be obtained.* The following bullet-point has been removed from Contraindications: *Severe psychiatric disorder*. Added TAG determination information. Updated Summary of Literature and Reference Sources sections. Updated the code description for the following CPT codes (per AMA guidance): 44389, 44392, 44394, 45333, 45334, 45378, 45380, 45382, 45384, & 45385.
08/16/2021	Provider Effective Date
06/16/2021	QI/UM Committee review
06/16/2021	Urgent Revision: Updated Cologuard minimum age indications from 50 to 45 years of age per USPSTF and manufactures guidelines.
05/12/2017	Initial policy developed

Disclaimer

Highmark Wholecare℠ medical policy is intended to serve only as a general reference resource regarding coverage for the services described. This policy does not constitute medical advice and is not intended to govern or otherwise influence medical decisions.

Policy Statement

Highmark Wholecare℠ may provide coverage under the medical-surgical benefits of the Company's Medicaid products for medically necessary colorectal cancer screening procedures.

This policy is designed to address medical necessity guidelines that are appropriate for the majority of individuals with a particular disease, illness or condition. Each person's unique clinical circumstances warrant individual consideration, based upon review of applicable medical records.

(Current applicable Pennsylvania Health Choices Agreement Section V. Program Requirements, B. Prior Authorization of Services, 1. General Prior Authorization Requirements.)

Definitions

Average-Risk Population – Patient population defined as having no personal history of adenomatous polyps, colorectal cancer, or inflammatory bowel disease (Crohn's disease and Ulcerative Colitis); no family history of colorectal cancer or adenomatous polyps, familial adenomatous polyposis, or hereditary nonpolyposis colorectal cancer.

High-Risk Population – Patient population defined as having a first-degree relative (sibling, parent, or child) who has had colorectal cancer or adenomatous polyps; OR family history of familial adenomatous polyposis; OR family history of hereditary non-polyposis colorectal cancer; OR family history of MYH-associated polyposis in siblings; OR diagnosis of Cowden syndrome.

In Vivo Analysis – A technique described as real-time additional imaging that utilizes chromoendoscopy, confocal microscopy, fiberoptic analysis and narrow band. The imaging is used during the endoscopic procedure to improve analysis of gastrointestinal lesions.

Procedures

Highmark Wholecare℠ considers preventive colorectal cancer screening tests medically necessary for average-risk individuals aged 45 years of age and older, continuing until age 75, or when recommended by a physician. (*Screening and surveillance for colon cancer in adults aged 76 to 85 years should be advised with consideration of the individual's overall health and prior screening history.*)

1. The following preventive routine colon cancer screening tests may be considered medically necessary:
    - Fecal Occult Blood Test (FOBT) using guaiac-based FOBT (gFOBT) or immunochemical-based FOBT (iFOBT) – annually
    - Double contrast barium enema (DCBE) - every 5 years
    - Anal PAP Smear - annually
    - Flexible sigmoidoscopy – one every 5 years
    - Colonoscopy – one every 10 years
    - Computed tomography colonography (CTC) – every 5 years
    - Fecal DNA (Cologuard) (FIT-DNA) (may require a Program Exception; see *Governing Bodies Approval* section below)
      Fecal DNA testing using Cologuard may be considered medically necessary once (1) every three (3) years for individuals who meet ALL of the following criteria:
        1) Age 45-75; AND
        2) Individual shows no signs or symptoms of colorectal disease, including but not limited to, lower gastrointestinal pain, blood in stool, positive fecal occult blood test (FOBT) or fecal immunochemical testing (iFOBT); AND
        3) No prior history of abnormal fecal DNA testing; AND
        4) Specifically for individuals who are at average risk for developing colorectal cancer:
            a. No personal history of adenomatous polyps colorectal cancer or inflammatory bowel disease (Ulcerative Colitis and Crohn's disease); AND
            b. No family history of colorectal cancer or adenomatous polyps, familial adenomatous polyposis, or hereditary nonpolyposis colorectal cancer.

Note: When a screening test results in the diagnosis of colorectal adenomas or cancer, screening guidelines are no longer applicable.

Note: Both Cologuard (CPT 81528) and CT colonography (CPT code 74263) require a Program Exception. The ordering physician must provide a supporting statement indicating why the requested therapy or device is medically necessary, and the alternative options have been or are likely to be ineffective, adversely affect patient compliance, or cause an adverse reaction (see '*Governing Bodies Approval*' section below).

2. Increased-Risk or High-Risk Individuals
   Colorectal cancer screening for individuals at increased-risk or high-risk of developing colorectal cancer is considered medically necessary. Coverage will be provided for individuals at increased-risk

or high-risk of developing colorectal cancer at ANY age and at ANY frequency when recommended by the treating healthcare provider. An individual is considered at increased- or high-risk when ANY of the following conditions exist:

A. A personal history of colorectal cancer or adenomatous polyps; OR
B. A personal history of inflammatory bowel disease (ulcerative colitis or Crohn's disease); OR
C. A strong family history of colorectal cancer or polyps; OR
D. A known family history of a hereditary colorectal cancer syndrome such as familial adenomatous polyposis or hereditary nonpolyposis colon cancer; OR
E. A personal history of radiation to the abdomen or pelvic area to treat a prior cancer.

3. Contraindications

Relative or absolute contraindications for colon cancer screening by colonoscopy may include:

- Procedure risks outweigh benefits
- When consent is unable to be obtained
- If there is suspected peritonitis or intestinal perforation or intestinal adhesions
- Toxic megacolon
- Severe cardiovascular disease
- Pregnancy
- Known or suspected colonic perforation
- Fulminant colitis or severe inflammatory bowel disease with ulceration
- Patients on chronic anticoagulation
- Severe chronic lung disease patients who are at risk for undergoing sedation

Contraindications listed for Cologuard per the manufacturer include:

- Individuals with a history of colorectal cancer, adenomas, or other related cancers
- Individuals who have had a positive result from another colorectal cancer screening method within the last six (6) months
- Individuals who have been diagnosed with a relevant familial (hereditary) cancer syndrome such as hereditary non-polyposis colorectal cancer syndrome or Lynch syndrome, Peutz-Jeghers syndrome, MYH-Associated Polyposis (MAP), Gardner's syndrome, Turcot's (or Crail's) syndrome, Cowden's syndrome, juvenile polyposis, Cronkhite-Canada syndrome, neurofibromatosis, or familial hyperplastic polyposis
- Individuals who have been diagnosed with a condition that is associated with high risk for colorectal cancer. These include but are not limited to:
    - Inflammatory bowel Disease (IBD)
    - Chronic Ulcerative Colitis (CUC)
    - Crohn's disease
    - Familial adenomatous polyposis (FAP)
    - Family history of colorectal cancer

4. The following are considered not medically necessary for colorectal cancer screening by colonoscopy:
    - Magnetic resonance imaging (MRI) colonography
    - Wireless capsule endoscopy (see Highmark Wholecare℠ medical policy MP-038-MD-PA '*Capsule Endoscopy*' for coverage guidelines)
    - In vivo analysis of colorectal polyps (e.g., chromoendoscopy, confocal laser [fluorescent] endomicroscopy, narrow banded imaging and fiberoptic polyp analysis)
    - Urine based test for the detection of adenomatous polyps (e.g. PolypDX)

5. Post-payment Audit Statement
   The medical record must include documentation that reflects the medical necessity criteria and is subject to audit by Highmark Wholecare℠ at any time pursuant to the terms of your provider agreement.

6. Place of Service
   The proper place of service for all colorectal cancer screening methods is outpatient.

7. Related Policies
   - MP-010-MD-PA Testing for Genetic Disease
   - MP-018-MD-PA Genetic Testing for Lynch Syndrome, Familial Adenomatous Polyposis (FAP), Attenuated FAP and MYH-associated Polyposis
   - MP-038-MD-PA Capsule Endoscopy

Governing Bodies Approval

As of October 19, 2019, the U.S. Food and Drug Administration (FDA) approved the noninvasive colorectal cancer screening test Cologuard for eligible average-risk individuals aged 45 years and older (The ASCO Post, 2019).

The use of a colorectal screening device outside of listed FDA guidelines will require approval from a Medical Director.

The U.S. Preventative Task Force (USPSTF) recommends the following colorectal cancer screening guidance:

- For asymptomatic adults 45 years to 75 years who are at average risk of colorectal cancer (ie, 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 and screening should be stopped varies based on a patient's health status (eg, life expectancy, comorbid conditions), prior screening status, and individual preferences. Limited evidence suggests that harms from colonoscopy, such as perforation and bleeding, and extra-colonic 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.

- In adults 86 years or older, evidence on benefits and harms of colorectal cancer screening is lacking, and competing causes of mortality likely preclude any survival benefit that would outweigh the harms of screening.

CMS

The Centers for Medicare and Medicaid Services (CMS) have published the following determinations:

- NCD Fecal Occult Blood Test (190.34)

- NCD Colorectal Cancer Screening Tests (210.3)
- LCD Diagnostic Colonoscopy (L38812)
- LCA Billing and Coding: Diagnostic Colonoscopy (A58428)

The Pennsylvania Department of Human Services Technology Assessment Group (TAG) workgroup meets quarterly to discuss issues revolving around new technologies and technologies or services that were previously considered to be a program exception. During this meeting, decisions are made as to whether or not certain technologies will be covered and how they will be covered. TAG's decisions are as follow:

- Option #1: Approved - Will be added to the Fee Schedule
- Option #2: Approved as Medically Effective - Will require Program Exception
- Option #3: Approved with (or denied due to) Limited/Minimal Evidence of Effectiveness - Will require Program Exception
- Option #4: Denied - Experimental/Investigational

In May 2017, the TAG workgroup assigned Cologuard an Option #2, specifically for CPT code 81528. In November 2011, the TAG workgroup assigned CT colonography an Option #3, specifically for CPT code 74263.

Program Exception

Both Cologuard and CT colonography require a Program Exception. The ordering physician must provide a supporting statement indicating why the requested therapy or device is medically necessary, and the alternative options have been or are likely to be ineffective, adversely affect patient compliance, or cause an adverse reaction.

Summary of Literature

Colorectal cancer, also known as bowel cancer, colon cancer, or rectal cancer, is any cancer that affects the colon and rectum. Colorectal cancer is the third most common cancer in the United States and is the second leading cause of death among all sexes. Deaths caused by colorectal cancer have declined in recent years due to medical advances, and the numbers of diagnoses in people younger than 50 are rising, due to improvements in screening (Brazier & Villines, 2022).

The five-year survival rate of colorectal cancer when detected in the early stages is 92%, however, the five-year survival rate is decreased to 11% in patients diagnosed after the cancer has metastasized. Nearly 90% of CRC cases are found in persons aged 50 and older.

Colorectal cancer screening can detect cancer, precancerous polyps, and other colon abnormalities. Polyps are believed to develop into cancer over an extended period of time. With colorectal cancer screening, these polyps can be removed before the polyps can develop into cancer.

The American Cancer Society (ACS), the U.S. Preventive Services Task Force (USPSTF), the American College of Gastroenterology (ACG), the Centers for Disease Control and Prevention (CDC) and the National Comprehensive Cancer Network (NCCN) all recommend that people at average risk of colorectal cancer start regular screening at age 45. This can be done either with a sensitive test that looks for signs of cancer

in a person's stool (a stool-based test), or with an exam that looks at the colon and rectum (a visual exam). Average risk is defined as adults 45 years and older who do not have signs or symptoms of colorectal cancer and who are at average risk for colorectal cancer (ie, 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]) (USPSTF, 2021). The ACG recommends that the "ideal" screening tools because they are noninvasive, have high sensitivity and are readily available, convenient, and inexpensive.

An advantage of initiating screening at age 45 years instead of 50 years includes reduced colorectal cancer risk due to early detection of colorectal cancer in this age group. Over time, detection and removal of polyps in individuals age 45–49 years would reduce the incidence of colorectal cancer in those age 50 years and older (ACG, 2021).

The screening technology for colorectal cancer falls into two broad categories, structural tests and stool/fecal-based tests. Structural tests include the following:

- **Colonoscopy** - the most complete screening procedure and is considered the current gold standard for assessing the sensitivity of detecting neoplasia for other screening modalities. The general consensus is that a 10-year interval is appropriate for most average-risk individuals who had a high-quality normal colonoscopy, defined as an exam complete to the cecum with bowel preparation adequate to detect polyps greater than 5 mm in size. Colonoscopy is also indicated as follow-up of abnormal findings from other screening modalities—stool-based tests, flexible sigmoidoscopy (biopsy-proven adenoma), or CT colonography.
- **Flexible sigmoidoscopy** - Compared to colonoscopy, sigmoidoscopy requires no sedation and less bowel preparation, but is limited to examination of the distal colon. Flexible sigmoidoscopy should be performed using a scope 60 cm or longer. Polyps identified should be biopsied by trained personnel to determine if they are hyperplastic, adenomatous, or sessile serrated. Patients with lesions larger than 1 cm should be referred directly to colonoscopy, since these lesions are almost always adenomatous polyps, which are associated with a risk of proximal colonic neoplasms.
- **Computed Tomographic (CT) Colonography** - also known as virtual colonoscopy or CTC, is evolving as a promising technique for CRC screening. CT colonography has the advantages of being noninvasive and not requiring sedation. The risk of test-related complications is also very low, however, a positive finding requires a colonoscopy, and extra-colonic findings. Available data indicate that CT colonography may be useful for the detection of larger polyps. If one or two lesions that are 6 to 9 mm are detected, CT colonographic surveillance at year 3 or colonoscopy is recommended. If more than three polyps that are 6 to 9 mm in size or lesions greater than or equal to 10 cm are detected, colonoscopic surveillance is recommended.
  (NCCN, 2022)

Stool/fecal based screening tests include the following:

- **Fecal Occult Blood Test (FOBT)** - recommended annually when used alone, or once at 3 years when used in combination with flexible sigmoidoscopy. Annual FOBT should not be performed in combination with colonoscopy in an average-risk patient. Any positive result on FOBT, however, should be followed up with colonoscopy. It is important for FOBT alone to be performed annually, because the sensitivity in detecting advanced adenomas in a single test is fairly low. FOBT of a single specimen obtained at digital rectal examination (DRE) is not recommended due to

exceptionally low sensitivity. Two types of FOBTs are currently available: guaiac-based and immunochemical:

- ***Guaiac-based fecal occult blood test (gFOBT)*** - the most common stool test in use for CRC screening. One major disadvantage of gFOBT is that it may miss tumors that bleed in smaller amounts, intermittently, or not at all. Another limitation is the high false-positive rate resulting from reaction with non-human heme in food and blood from the upper gastrointestinal (GI) tract. To compensate for intermittent limitations, gFOBT should be performed on three successive stool specimens obtained while the patient adheres to a prescribed diet.
- ***Fecal Immunochemical Test (FIT)*** - directly detects human globin within hemoglobin. Unlike guaiac FOBT, FIT does not require dietary restrictions, and a single testing sample is sufficient.

- **FIT-DNA–Based or Multitarget Stool DNA Test (Cologuard)** - screens for the presence of known DNA alterations. The NCCN Colorectal Screening Panel recommends the inclusion of mt-sDNA–based testing as a potential screening modality in average-risk individuals, but data to help determine adherence to/participation rates of screening and how mt-sDNA testing may fit into an overall screening program are limited. A rescreening interval of every 3 years has been suggested and is approved by the FDA.
  (NCCN, 2024)

NCCN recommendation for screening of individuals at average risk should begin at age 45 after available options have been discussed. Recommended options include: colonoscopy every 10 years; annual high-sensitivity guaiac-based testing or FIT, or mt-sDNA-based testing (every 3 years); flexible sigmoidoscopy every 5 to 10 years; or CT colonography every 5 years (NCCN, 2024).

It is recommended by the NCCN that a surveillance program be established for individuals considered to be at increased risk for colorectal cancer. The surveillance plan should include a colonoscopy in adults with a history of adenomas aged 45 to 75 years, who may have a life expectancy of 10 or more years. Surveillance of individuals between ages 76 and 85 years should be individualized and include a discussion of risks and benefits of continued colonoscopy based on comorbidity status, estimated life expectancy, and finding on the last or most recent colonoscopy (NCCN, 2024).

Individuals with high-risk polyps (advanced or multiple polyps) should have a repeat colonoscopy in 3 years, although some data suggest that intervals of 5 years may be appropriate. If the examination is normal, subsequent surveillance colonoscopies are recommended in 5 years. These intervals may be individualized based on the colonic preparation and completeness of polypectomy based on endoscopy, histology, and pathology reports. It is appropriate to reassess risk, including contributing medical and personal factors, number and characteristics of adenomatous polyps, and family history at each interval prior to and following procedures (NCCN, 2024).

The most recent guideline on colorectal cancer screening from the USPSTF concluded that in adults age 76–85 years, the decision to screen for colorectal cancer should be an individualized, taking into account the patient's overall health and screening history. The guideline specifies that screening would be most appropriate for those not previously screened, those healthy enough to undergo treatment of cancer is detected, and those without substantially limited life expectancy. In adults age 86 years and above, screening is not recommended because of competing causes of mortality (ACG, 2021).

Conventional colonoscopy is performed with white light and has limited ability to differentiate between benign versus neoplastic lesions. Multiple imaging techniques have been developed in order to improve the identification of premalignant lesions in colorectal cancer prevention. These techniques include tools used an adjunct to colonoscopy such as chromoendoscopy, electronic chromoendoscopy, contrast laser endomicroscopy, fiberoptic analysis, multi-band and narrow band imaging. Several technologies have obtained FDA approval.

However, research has failed to identify any form of in vivo analysis of colorectal polyps as being superior to existing colorectal cancer screening procedures. In 2010, a multi-center trials was conducted comparing high definition chromocolonoscopy or high definition white light colonoscopy. The authors reported that yield for advanced neoplasm detection was similar. They concluded that their findings did not provide support for the routine use of high-definition chromocolonoscopy for colorectal cancer screening in average risk individuals (Kahi, Boland, Dominitz, et al., 2016).

There has been new developments in the use of urine based test to analyze metabolic biomarkers in the urine for precancerous polyps. The test utilizes a proprietary algorithm that generates the PolypDx test results. The results are reported as either positive indicating a strong likelihood of a polyp being present; or negative indicating the low likelihood of a polyp being present. Results are available within two weeks and are delivered via email or fax. A validation study was performed reporting on overall survival, disease-specific survival, and test accuracy. However, the review of professional society's position statements did not include recommendations for urine based testing (Wang, Tso, Wong, Sadowski, Fedorak, 2014).

Coding Requirements

Procedure Codes

CPT Code	Description
44388	Colonoscopy through stoma; diagnostic, including collection of specimen(s)by brushing or washing, when performed (separate procedure)
44389	Colonoscopy through stoma; with biopsy, single or multiple
44392	Colonoscopy through stoma; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps
44394	Colonoscopy through stoma; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique
45330	Sigmoidoscopy, flexible; diagnostic, with or without collection of specimen(s) by brushing or washing when performed (separate procedure)
45331	Sigmoidoscopy, flexible; with biopsy, single or multiple
45333	Sigmoidoscopy, flexible; with removal of tumor(s), polyps(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
45338	Sigmoidoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique
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)

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)
74263	Computed tomographic (CT) colonography, screening, including post processing (virtual colonoscopy)
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
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)
82274	Blood, occult, by fecal hemoglobin determination by immunoassay, qualitative, feces, 1-3 simultaneous determinations

Noncovered Procedure Codes

Approval requests for noncovered procedure codes will be reviewed by a Medical Director on a case-by-case basis.

CPT/ HCPCS Code	Description
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)
88375	Optical endomicroscopic image(s), interpretation and report, real-time or referred, each endoscopic session

Diagnosis Codes

ICD-10 Code	Description
Z00.00	Encounter for general adult medical examination without abnormal findings
Z00.01	Encounter for general adult medical examination with abnormal findings
Z12.10	Encounter for screening for malignant neoplasm of intestinal tract, unspecified
Z12.11	Encounter for screening for malignant neoplasm of colon
Z12.12	Encounter for screening for malignant neoplasm of rectum
Z80.0	Family history of malignant neoplasm of digestive organs
Z83.71	Family history of colonic polyps
Z85.00	Personal history of malignant neoplasm of unspecified digestive organs
Z85.01	Personal history of malignant neoplasm of esophagus
Z85.020	Personal history of malignant carcinoid tumor of stomach

Z85.028	Personal history of other malignant neoplasm of stomach
Z85.030	Personal history of malignant carcinoid tumor of large intestine
Z85.038	Personal history of other malignant neoplasm of large intestine
Z85.040	Personal history of malignant carcinoid tumor of rectum
Z85.048	Personal history of other malignant neoplasm of rectum, rectosigmoid junction, and anus
Z85.810	Personal history of malignant neoplasm of tongue
Z85.818	Personal history of malignant neoplasm of other sites of lip, oral cavity, and pharynx
Z85.819	Personal history of malignant neoplasm of unspecified site of lip, oral cavity, and pharynx
Z86.010	Personal history of colonic polyps

Reimbursement

Participating facilities will be reimbursed per their Highmark Wholecare℠ contract.

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