FECAL OCCULT BLOOD TEST

Policy Number: CMP - 023
Effective Date: January 21, 2017

Table of Contents

<table>
<thead>
<tr>
<th>Table of Contents</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>BACKGROUND</td>
<td>1</td>
</tr>
<tr>
<td>POLICY</td>
<td>3</td>
</tr>
<tr>
<td>REFERENCES</td>
<td>4</td>
</tr>
<tr>
<td>POLICY HISTORY/REVISION HISTORY</td>
<td>4</td>
</tr>
</tbody>
</table>

INSTRUCTIONS FOR USE
This Medical Policy provides assistance in interpreting UnitedHealthcare benefit plans. When deciding coverage, the enrollee specific document must be referenced. The terms of an enrollee’s document (e.g., Certificate of Coverage (COC) or Summary Plan Description (SPD)) may differ greatly. In the event of a conflict, the enrollee's specific benefit document supersedes this Medical Policy. All reviewers must first identify enrollee eligibility, any federal or state regulatory requirements and the plan benefit coverage prior to use of this Medical Policy. Other Policies and Coverage Determination Guidelines may apply.
UnitedHealthcare reserves the right, in its sole discretion, to modify its Policies and Guidelines as necessary. This Medical Policy is provided for informational purposes. It does not constitute medical advice.

UnitedHealthcare may also use tools developed by third parties, such as the MCG™ Care Guidelines, to assist us in administering health benefits. The MCG™ Care Guidelines are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.

BACKGROUND

Colorectal cancer (CRC) is one of the leading causes of cancer death in men and women in the United States. The American Cancer Society estimates there will be 103,170 new cases of colon cancer and 40,290 new cases of rectal cancer in the United States in 2012. The majority of CRCs are adenocarcinomas, and other cell types include carcinoid tumors, lymphomas, and soft tissue tumors including gastrointestinal stromal tumors and sarcomas. Patients with advanced CRC often present with symptoms including a change in bowel habits lasting for more than a few days, narrowing of stool caliber, dark or blood-tinged stool, rectal bleeding, abdominal pain, fatigue and weight loss. Nonetheless, the current standard of care is screening of asymptomatic persons to prevent CRC.
For CRC screening purposes, patients are divided into average-risk, increased risk and high-risk categories. Patients at increased risk include those with CRC, certain kinds of colon polyps, or a first-degree relative with CRC. The high-risk category includes persons with inflammatory bowel disease (ulcerative colitis and Crohn’s disease), and hereditary syndromes associated with CRC, such as Lynch syndrome, Peutz-Jeghers syndrome and juvenile polyposis syndrome. Although patients with increased or high risk for CRC tend to undergo earlier, more frequent and more invasive screening, most CRCs are detected in patients with average risk.

For average-risk persons, the US Multi-Society Task Force on Colorectal Cancer suggests either colonoscopy every 10 years, flexible sigmoidoscopy every 5 years, air-contrast barium enema or computed tomographic colonography every 5 years, fecal DNA testing at uncertain intervals or fecal occult blood testing (FOBT) every year. In the past, stool testing centered on specimens obtained during digital rectal examinations by a healthcare provider. This practice did not detect intermittent bleeding from mucosal lesions in the colon.

Currently, fecal testing is performed with test kits patients take home for a 2- or 3-day sample collection, which they return to the healthcare provider’s office or laboratory. The FOBT detects the presence of trace amounts of blood in stool. The procedure is performed by testing one or several small samples of one, two or three different stool specimens. Test results are either positive or negative, and all positive results are to be followed with colonoscopy; there is no repeat testing for positive results.

Persons with positive FOBT results have a risk of colorectal cancer three to four times higher than persons with negative test results. It has been estimated guaiac fecal occult blood tests decrease cancer mortality 15-33% over a decade. A limitation of FOBT compared to colonoscopy is poor sensitivity for advanced adenomas (polyps over 10 mm or having microscopic features associated with progression to cancer). Another drawback is that some patients do not follow through on recommendations for colonoscopy when they receive a positive FOBT result. Sensitivity of screening varies depending on the type of test kit used and the number of samples a patient submits.

There are two main types of FOBT kits. One is based on guaiac testing and the other is an immunochemical test that is also called immunochemical fecal occult-blood testing (iFOBT). The iFOBT does not react with foods or vitamins and is less likely to yield positive results for upper gastrointestinal tract bleeding.

The American Cancer Society recommends average-risk patients begin annual FOBT screening at age 50. The American College of Gastroenterology recommends African Americans should begin screening for CRC at age 45. The United States Preventive Services Task Force does not recommend routine screening for persons aged 76 to 85 and advises against screening persons over the age of 85. The recommended interval for FOBT rescreening is one year. Although screening focuses largely on patients over the age of 50, colon cancer does occur in patients under the age of 50 without a genetic predisposition. Most cases of young-onset CRC present with rectal bleeding and abdominal pain. Because these patients tend to have advanced disease at diagnosis, aggressive workup is considered prudent in symptomatic young patients.

The FOBT may be performed with or without evidence of iron deficiency anemia, which may be related to gastrointestinal blood loss. The range of causes for blood loss include inflammatory causes, including acid-peptic disease, non-steroidal anti-inflammatory drug use, hiatal hernia, Crohn's disease, ulcerative colitis, gastroenteritis, and colon ulcers. It is also seen with infectious causes, including hookworm, strongyloides, ascariasis, tuberculosis, and enteroamebiasis. Vascular causes include angiodysplasia, hemangiomas, varices,
blue rubber bleb nevus syndrome, and watermelon stomach. Tumors and neoplastic causes include lymphoma, leiomyosarcoma, lipomas, adenocarcinoma and primary and secondary metastases to the GI tract. Drugs such as nonsteroidal anti-inflammatory drugs also cause bleeding. There are extra gastrointestinal causes such as hemoptysis, epistaxis, and oropharyngeal bleeding. Artifactual causes include hematuria, and menstrual bleeding. In addition, there may be other causes such as coagulopathies, gastrostomy tubes or other appliances, factitial causes, and long distance running.

**POLICY**

For the following CPT code(s) in Table 1, the patient should have a diagnosis (ICD-10-CM) code(s) listed in the attached table below.

**Table 1. HCPCS Codes (Alphanumeric, CPT® AMA)**

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>82272</td>
<td>Blood, occult, by peroxidase activity (e.g., guaiac), qualitative, feces, 1-3 simultaneous determinations, performed for other than colorectal neoplasm screening</td>
</tr>
</tbody>
</table>

**ICD-10 Diagnosis Codes (Proven)**

Limitations

1. The FOBT is reported once for the testing of up to three separate specimens (comprising either one or two tests per specimen).
2. In patients who are taking non-steroidal anti-inflammatory drugs and have a history of gastrointestinal bleeding but no other signs, symptoms, or complaints associated with gastrointestinal blood loss, testing for occult blood may generally be appropriate no more than once every three months.

When testing is done for the purpose of screening for colorectal cancer in the absence of signs, symptoms, conditions, or complaints associated with gastrointestinal blood loss, report the HCPCS code for colorectal cancer screening; fecal-occult blood test, 1-3 simultaneous determinations should be used.
REFERENCES

   on/colorectal-cancer-early-detection-acs-recommendations. Updated June 24, 2016. (Accessed: October 1,
   2016).

2. Whitlock EP, Lin JS, Liles E. Screening for colorectal cancer: a targeted, updated systematic review for the U.S.

3. Levin B, Lieberman DA, McFarland B, et al. Screening and surveillance for the early detection of colorectal
   cancer and adenomatous polyps, 2008: a joint guideline from the American Cancer Society, the US Multi-


7. Dozois EJ, Boardman LA, Suwanthanma W. Young-onset colorectal cancer in patients with no known genetic
   predisposition. Can we increase early recognition and improve outcome? Medicine (Baltimore). 2008;87(5):259-
   263.


POLICY HISTORY/REVISION HISTORY

<table>
<thead>
<tr>
<th>Date</th>
<th>Action/Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>01/21/2017</td>
<td>Updated ICD10 codes as per CMS recommendations. Removed ICD9 code file.</td>
</tr>
</tbody>
</table>
guidelines from version 2012 to 2016.                                                |
| 10/01/2015 | Removed ICD9 table. Embedded ICD9/ ICD10 PDF files.                                |