HEALTHHELP®

A WNS COMPANY

2024 Colonoscopy

Specialty Services

P_

Last Review Date: 01/30/2024
Previous Review Date: 02/16/2023
Guideline Initiated Date: 08/05/2020

HEALTHHELP®

A WNS COMPANY

Table of Contents

Colonoscopy

NCD 100.2
See also, **NCD 100.2**: Endoscopy at https://www.cms.gov/medicare-coverage-database/search.aspx *if applicable to individual's healthplan membership*.

Colonoscopy Guideline

Screening

A screening colonoscopy is considered medically appropriate when the documentation demonstrates **ANY** of the following situations: [1] [13]

I. Average risk individuals for routine screening for colorectal cancer (CRC) when **ANY** of the following are true: [1] [16]

A. Age 45 to 75 years and **ANY** of the following: [12] [20]

1. **NO** colonoscopy in the last 10 years
2. **NO** sigmoidoscopy in the last 5 years (with/without annual immunochemical or guaiac-based fecal occult blood testing [gFOBT])
3. Stool based testing (eg, Cologuard™) > 3 years ago **AND NO** prior colonoscopy

B. Age 76 years and older [7]

- The role of this therapy is uncertain/unclear in the current evidence. Requests for this therapy require review by a physician reviewer, medical director and/or the individual's healthplan.

II. Family history positive for colorectal cancer or adenomatous polyps in **ANY** of the following situations: [16]

A. First-degree relative (parent/full or sibling/child) age 59 years or younger: colonoscopy is recommended at age 40 years or 10 years before the youngest affected relative, whichever is earlier **AND** interval colonoscopy every 5 years after.

B. First-degree relative who was diagnosed at 60 years of age or older: colonoscopy is recommended at age 40 years or 10 years before the youngest affected relative, whichever is earlier.

C. Second-degree relative, third-degree relative(s) or first-degree relative without adenomatous polyp: treat as average risk individuals; colonoscopy is preferred screening.

D. Second-degree relatives, two related, any age: colonoscopy is recommended every 5 years beginning at age 45 years.

III. Hereditary non-polyposis colorectal cancer (HNPCC), Lynch Syndrome and Polyposis syndromes with **ANY** of the following: [3] [18]

A. Attenuated familial adenomatous polyposis (AFAP), based on personal history **AND** age 18 or older with **NO** evidence of colonoscopy in last 12 months.

B. Familial adenomatous polyposis (FAP), based on personal or family history and **AND** age 10 or older with **NO** evidence of colonoscopy in last 12 months.

C. Hyperplastic polyp(s) with **NO** evidence of colonoscopy in the last 10 years.

D. Hyperplastic (serrated) polyposis syndrome with **NO** evidence of colonoscopy in last 12 months.

E. Juvenile polyposis syndrome **AND** age 12 or older with evidence of polyps on previous screening with **NO** evidence of colonoscopy in last 12 months.

F. Juvenile polyposis syndrome **AND** age 12 or older with **NO** evidence of polyps on previous screening and **NO** evidence of colonoscopy in last 24 months.

G. Lynch syndrome, at risk or affected by, based on personal or family history **AND** age 20 or older with **NO** evidence of colonoscopy in last 12 months. [14] [11]

H. MYH-associated polyposis (MAP), based on family history, mutation status known or unknown **AND** age 25 years or older with **NO** evidence of colonoscopy in last 12 months.

I. MAP, based on personal history **AND** age 25 or older with **NO** evidence of colonoscopy in last 12 months.

J. Peutz-Jeghers syndrome **AND** age 8 or older with **NO** evidence of colonoscopy in the past 24 months, if polyp(s) were previously found. If **NO** history of polyp(s) **AND** age 18 or older with **NO** evidence of colonoscopy in the last 36 months.

Diagnostic Testing

Diagnostic testing colonoscopy may be medically appropriate when the medical record demonstrates **ANY** of the following signs and symptoms: [21]

I. Abnormal barium enema or other imaging

II. Fecal Immunochemical Test (FIT), FIT DNA test or Fecal occult blood test, positive

III. High risk for colorectal cancer (eg, adenomatous polyps or CRC personal/family history [diagnosed before age 60 years], inflammatory bowel disease history, hereditary CRC syndrome is known or suspected, prior abdominal/pelvic radiation cancer treatment history) and **ALL** of the following:

A. Colon and/or rectal cancer diagnosis [13] [10]

B. **ANY** of the following: (*__NOTE:__ *Time between tests may be shorter if polyps are found or there is reason to suspect hereditary non-polyposis colon rectal cancer [HNPCC].*)

1. Colorectal surgery planned and colonoscopy recommended to view entire colon and remove all polyps intraoperatively. [3]

2. Curative resection for colon or rectal cancer and **ANY** of the following: [8]

i. 1 year or less post-op and **NO** evidence of colonoscopy **OR** at least 1 year has passed after colonoscopy to ensure the rest of the colon/rectum was clear.

ii. Postoperative colonoscopy results were normal and **NO** evidence of colonoscopy within 3 years.

iii. Prior 2 colonoscopy results were normal and **NO** evidence of colonoscopy in previous 5 years.

3. **NO** colonoscopy within 1 year after primary resection of colon or rectal cancer, to exclude new lesions. [5]

4. **NO** evidence of colonoscopy within 3 to 6 months, following low anterior resection for rectal cancer to look for signs of recurrence (eg, abdominal pain, change in bowel habits, constipation, diarrhea, iron deficiency anemia and rectal bleeding).

5. Post-operative colonoscopy (within 1 year) was normal, **NO** unresectable metastases were found during surgery, and **NO** evidence of subsequent follow-up colonoscopy within 3 years.

IV. Inflammatory bowel disease (IBD), suspected or known **AND** high risk for colorectal cancer (eg, adenomatous polyps or CRC personal/family history [diagnosed before age 60 years], inflammatory bowel disease [IBD] history, hereditary CRC syndrome is known or suspected, prior abdominal/pelvic radiation cancer treatment history) with **ANY** of the following: [15] [6]

A. Chronic ulcerative colitis, Crohn's disease or other forms of IBD **AND NO** evidence of colonoscopy in the past year.

B. IBD with primary sclerosing cholangitis (PSC) **AND NO** evidence of colonoscopy in the past year (beginning at the time of PSC diagnosis).

C. Initial colonoscopy

D. Surveillance colonoscopy needed **AND NO** evidence of colorectal cancer screening in the past 12 months.

V. Iron deficiency anemia

VI. Polyps, with **ANY** of the following: [4] [3]

A. Polypectomy, initial, within the last 3 years and adenomas have been completely removed and **ALL** the following:

1. Adenomas that are **ANY** of the following:

a. Adenomas, 3 to 10

b. Adenoma that is more than 1 cm.

c. Adenoma(s) with high grade dysplasia or villous features (eg, villous/tubulovillous polyp)

2. **ANY** of the following:

a. At least 5 years since prior colonoscopy (following polypectomy) was normal.

b. Prior colonoscopy showed only 1 or 2 small tubular adenomas with low grade dysplasia.

c. **NO** colonoscopy in the last 3 years

B. Adenomas total over 10 on a single exam **AND NO** evidence of colonoscopy within 1 year of polyps removal.

C. History of incomplete resection of a polyp during the last colonoscopy

D. Hyperplastic rectal or colon polyp(s) that are less than 10 mm **AND NO** evidence of colonoscopy in the last 10 years.

E. Piecemeal resection of a large polyp ≥2 cm **AND NO** evidence of colonoscopy in the last 6 months.

F. Sessile serrated polyp(s), 1 to 2 that are less than 10mm **AND NO** evidence of colonoscopy in the last 5 years.

G. Sessile serrated polyp(s), 3 to 10 sessile serrated adenomas **AND NO** evidence of colonoscopy in the last 3 years.

H. Sessile serrated polyp(s) that are removed in pieces **AND NO** evidence of colonoscopy within 3 to 6 months following adenoma removal.

(**NOTE:** *if entire adenoma has been removed, further testing should be based on the physician's judgment)*.

I. Sessile serrated polyp(s) that is more than 10mm **AND NO** evidence of colonoscopy in the last 3 years.

J. Sessile serrated polyp(s) with dysplasia **AND NO** evidence of colonoscopy in the last 3 years.

K. Tubular adenomas, 1 to 2 small (less than 1 cm) with low grade dysplasia **AND NO** evidence of colonoscopy within the past 7 to 10 years after polyp removal.

VII. Symptoms, when unexplained by prior imaging or testing, include **ANY** of the following:

A. Abdominal pain

B. Bowel habit changes (eg, color, constipation, diarrhea, frequency)

C. Rectal bleeding [9]

NOTE
Time between tests should be based on other factors such as prior colonoscopy findings, quality of bowel preparation during prior colonoscopy, family history and individual and physician preferences.

Full-Spectrum Endoscopy (FUSE) Colonoscopy

For a full-spectrum endoscopy (FUSE) colonoscopy:

- The role of this therapy is uncertain/unclear in the current evidence. Requests for this therapy require review by a physician reviewer, medical director and/or the individual's healthplan.

LCD 34614
See also, **LCD 34614**: Colonoscopy and Sigmoidoscopy-Diagnostic at https://www.cms.gov/medicare-coverage-database/search.aspx *if applicable to individual's healthplan membership*.

LCD 34005
See also, **LCD 34005**: Colonoscopy/Sigmoidoscopy/Proctosigmoidoscopy at https://www.cms.gov/medicare-coverage-database/search.aspx *if applicable to individual's healthplan membership*.

LCD 34454
See also, **LCD 34454**: Colonoscopy/Sigmoidoscopy/Proctosigmoidoscopy at https://www.cms.gov/medicare-coverage-database/search.aspx *if applicable to individual's healthplan membership*.

LCD 34213
See also, **LCD 34213**: Diagnostic and Therapeutic Colonoscopy at https://www.cms.gov/medicare-coverage-database/search.aspx *if applicable to individual's healthplan membership*.

LCD 36868
See also, **LCD 36868**: Diagnostic and Therapeutic Colonoscopy at https://www.cms.gov/medicare-coverage-database/search.aspx *if applicable to individual's healthplan membership*.

LCD 33671
See also, **LCD 33671**: Diagnostic Colonoscopy at https://www.cms.gov/medicare-coverage-database/search.aspx *if applicable to individual's healthplan membership*.

LCD 38812
See also, **LCD 38812**: Diagnostic Colonoscopy at https://www.cms.gov/medicare-coverage-database/search.aspx *if applicable to individual's healthplan membership*.

Contraindications or Exclusions for Routine Screening Colonoscopy

Contraindications or exclusions for a routine screening colonoscopy include multiple screening strategies simultaneously (eg, stool DNA testing every 3 years **AND** virtual colonoscopy screening every 5 years).[1]

Contraindications or Exclusions to Colonoscopy

Contraindications or exclusions to having a colonoscopy include **ANY** of the following: [2] [17]

I. Absolute contraindication, including **ANY** of the following:
   - A. Acute abdomen
   - B. Bowel injury and repair
   - C. Bowel perforation is documented or suspected from symptoms. [19]
   - D. Diverticulitis, acute episode that is symptomatic.
   - E. Hemodynamic instability
   - F. Inflammatory bowel disease (IBD), acute episode
   - G. Patient refusal
   - H. Peritonitis is suspected.
   - I. Recent myocardial infarction
   - J. Recent surgery with colonic anastomosis
   - K. Risk to patient outweighs benefits of procedure

II. Comorbid conditions that are active and increase risk (eg, abdominal aneurysm, area adhesions, post procedure in-area).

[1]For specialty society recommendations, see: American Cancer Society (ACS), "American Cancer Society Guideline for Colorectal Cancer Screening," available: www.cancer.org/health-care-professionals/american-cancer-society-prevention-early-detection-guidelines/colorectal-cancer-screening-guidelines.html and the U.S. Preventive Services Task Force (USPSTF) Bulletin, "U.S. Preventive Services Task Force Final Recommendation on Screening for Colorectal Cancer," available: www.uspreventiveservicestaskforce.org.

Procedure Codes

Table 1. Colonoscopy Associated Procedure Codes

CODE	DESCRIPTION
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

Colonoscopy Summary of Changes

Colonoscopy clinical guidelines from 2023 to 2024 had the following version changes:

- Changes under contraindications or exclusions for routine screening colonoscopy:
  - "Ages 76 to 85 years (routine cancer screening is made on a case-by-case basis and includes factors such as life expectancy of less than 10 years)" and "Ages 86 years and older" were removed since there is now an "age 76 years and older" indication on the screening section of the guideline.
  - Obesity and smoking were removed.
- Changes under diagnostic testing section:
  - "African American" indication was removed.
  - Examples of high risk are listed next to the "high risk for colorectal cancer" indication.
  - Fecal Immunochemical Test (FIT), FIT DNA test or Fecal occult blood test, positive indication was added.
  - "Inflammatory bowel disease (IBD) and high risk" was updated to "Inflammatory bowel disease (IBD), suspected or known AND high risk for colorectal cancer (eg, adenomatous polyps or CRC personal/family history [diagnosed before age 60 years], inflammatory bowel disease history, hereditary CRC syndrome is known or suspected, prior abdominal/pelvic radiation cancer treatment history)"
  - "Piecemeal resection of a large polyp $\geq$ 2 cm **AND NO** evidence of colonoscopy in the last 6 months" was added.
- Changes under screening section:
  - "Age 76 years and older" indication was added.
  - "Peutz-Jeghers syndrome AND age 8 or older AND NO evidence of colonoscopy in the past 24 months if polyp(s) were previously found. If NO history of polyp(s) AND age 18 or older with NO evidence of colonoscopy in the last 36 months" updated to "Peutz-Jeghers syndrome AND age 8 or older with NO evidence of colonoscopy in the past 24

months, if polyp(s) were previously found. If NO history of polyp(s) AND age 18 or older with NO evidence of colonoscopy in the last 36 months"

- "Stool based testing (eg, Cologuard) > 3 years ago **AND NO** prior colonoscopy" indication was added.

Colonoscopy Definition section

Adenoma is a benign tumor formed from glandular structures in epithelial tissue.
Attenuated familial adenomatous polyposis is an inherited condition that increases the chance to develop cancer of the large intestine (colon) and rectum. It is a milder form of classic familial adenomatous polyposis (FAP).
Colonoscopy is a procedure in which a flexible fiber-optic instrument is inserted through the anus in order to examine the colon.
Colon polyp is a small clump of cells that form on the lining of the colon or rectum that are mostly harmless but can develop into cancer.
Computed tomography (CT) refers to a computerized X-ray imaging procedure in which a three-dimensional image of a body structure is revealed through a series of cross-sectional images or "slices."
Crohn's disease is an inflammatory bowel disease (IBD) that causes inflammation of the digestive tract. Symptoms include abdominal pain, severe diarrhea, fatigue, weight loss and malnutrition.
Dysplasia describes the presence of abnormal cells within a tissue or organ. Dysplasia is not cancer, but may become cancer. Dysplasia can be mild, moderate or severe, depending on the degree of cell change under a microscope and the percentage of tissue or organ affected.
Fecal immunochemical test (FIT) is a screening tool for colon cancer that tests for hidden blood in the stool, which can be an early sign of cancer.
Guaiac fecal occult blood test is a test that checks for occult (microscopic) blood in the stool. Small samples of stool are placed on a special card coated with a chemical substance called guaiac and sent to a laboratory for testing. The combination of guaiac and hydrogen peroxide cause the stool sample to change color. If blood is present in the stool, the color changes to blue.
High risk includes individuals with history of adenomatous polyps, a personal history of colorectal cancer (CRC), a family history of CRC or adenomatous polyps diagnosed in a relative before age 60 years, a personal history of inflammatory bowel disease, a confirmed or suspected hereditary CRC syndrome, or a history of abdominal or pelvic radiation for a previous cancer.
Hyperplasia is the enlargement of an organ or tissue caused by an increase in the reproduction rate of its cells, often as an initial stage in the development of cancer.
Inflammatory bowel disease (IBD) is the name for a group of conditions that cause the digestive system to become inflamed (red, swollen, and sometimes painful). The most common types

of IBD are ulcerative colitis and Crohn's disease all causing similar symptoms, including diarrhea, abdominal pain and fever.

Iron deficiency anemia is the most common type of anemia occurring when the body doesn't have enough iron, which the body needs to make hemoglobin.

Juvenile Polyposis Syndrome (JPS) is an autosomal dominant condition characterized by multiple hamartomatous polyps throughout the gastrointestinal tract.

Lynch syndrome is an inherited condition that increases the risk of colon cancer, endometrial cancer and several other cancers. Lynch syndrome has historically been known as hereditary nonpolyposis colorectal cancer (HNPCC).

MYH-associated polyposis is an inherited condition characterized by the development of multiple adenomatous (abnormal growth) colon polyps and has an increased risk of colorectal cancer. This condition is a milder form of familial adenomatous polyposis (FAP).

Peutz-Jeghers syndrome (PJS) is a familial polyposis inherited as an autosomal dominant trait that is characterized by numerous polyps in the stomach, small intestine and colon along with melanin-containing spots on the skin and mucous membranes especially the lips and gums.

Polypectomy is the surgical removal of a polyp.

Resection is the process of cutting out tissue or part of an organ.

Sclerosing cholangitis is a rare disease that attacks the bile ducts causing scarring which slowly narrows the left and right bile duct until bile backs up into the liver and starts to damage it.

Sigmoidoscopy is an examination of the sigmoid colon by means of a flexible tube inserted through the anus.

Ulcerative colitis is a chronic inflammatory bowel disease (IBD) in which abnormal reactions of the immune system cause inflammation and ulcers on the inner lining of the large intestine.

Colonoscopy Reference section

[1] American Cancer Society. (2020). American Cancer Society Guideline for Colorectal Cancer Screening. *American Cancer Society*. Retrieved: August, 2023. https://www.cancer.org/cancer/types/colon-rectal-cancer/detection-diagnosis-staging/acs-recommendations.html

[2] Brewington, J.P. & Pope, J.B.(2020). Colonoscopy. G.C. Fowler (Ed.). *Pfenninger and Fowler's Procedures for Primary Care* (4). (pp. 623-638). Philadelphia, PA: Elsevier, Inc.

[3] Garber, J.J., Chung, D.C. (2021). Colonic Polyps and Polyposis Syndromes. M. Feldman & L.S. Friedman (Eds.). *Sleisenger and Fordtran's Gastrointestinal and Liver Disease* (11), (pp. 2076-2107.e10). Philadelphia, PA: Elsevier Inc.

[4] Gupta, S., Lieberman, D., . . . Rex, D.K. (2020). Recommendations for Follow-Up After Colonoscopy and Polypectomy: A Consensus Update by the US Multi-Society Task Force on Colorectal Cancer. *Gastrointestinal Endoscopy, 91*(3), 463-485. e5.

[5] Hardiman, K.M., Felder, S.I., . . . Feingold, D.L. (2021). The American Society of Colon and Rectal Surgeons Clinical Practice Guidelines for the Surveillance and Survivorship Care of Patients After Curative Treatment of Colon and Rectal Cancer. *American Society of Colon and Rectal Surgeons*. Retrieved: August 2023. https://fascrs.org/ascrs/media/files/Surveillance-and-Survivorship-CPG.pdf

[6] Huguet, J.M., Suarez, P., . . . Sempere, J. (2017). Endoscopic recommendations for colorectal cancer screening and surveillance in patients with inflammatory bowel disease: Review of general recommendations. *World Journal of Gastrointestinal Endoscopy, 9*(6), 255-262.

[7] Issaka, R. B., Chan, A. T., . . . Gupta, S. (2023). AGA Clinical Practice Update on Risk Stratification for Colorectal Cancer Screening and Post-Polypectomy Surveillance: Expert Review. *Journal of Gastroenterology, 165*, 1280-1291.

[8] Kahi, C.J., Boland, C.J., . . . Rex, D.K. (2016). Colonoscopy Surveillance after Colorectal Cancer Resection: Recommendations of the US Multi-Society Task Force on Colorectal Cancer. *The American Journal of Gastroenterology, 111*(3), 337-346.

[9] Karuppasamy, K., Kapoor, B.S., . . . Lorenz, J.M. (2021). ACR Appropriateness Criteria Radiologic Management of Lower Gastrointestinal Tract Bleeding: 2021 Update. *Journal of the American College of Radiology, 18*(5S), S139-S152.

[10] Meyerhardt, J.A., Mangu, P.B., . . . Benson, A.B. (2013). Follow-Up Care, Surveillance Protocol, and Secondary Prevention Measures for Survivors of Colorectal Cancer: American Society of Clinical Oncology Clinical Practice Guideline Endorsement. *Journal of Clinical Oncology, 31*(35), 4465-4470.

[11] National Institute for Health and Care Excellence. (2017). Molecular testing strategies for Lynch syndrome in people with colorectal cancer. *National Institute for Health and Care Excellence (NICE)*. Retrieved: August 2023. https://www.nice.org.uk/guidance/dg27/resources/molecular-testing-strategies-for-lynch-syndrome-in-people-with-colorectal-cancer-pdf-1053695294917

[12] Patel, S.G., May, F.P., . . . Robertson, D J. (2022). Updates on Age to Start and Stop Colorectal Cancer Screening: Recommendations From the U.S. Multi-Society Task Force on Colorectal Cancer. *Gastroenterology, 162*(1), 285-299.

[13] PDQ Screening and Prevention Editorial Board. (2021). Colorectal Cancer Prevention- Health Professional Version. *National Cancer Institute*. Retrieved: August 2023. https://www.cancer.gov/types/colorectal/hp/colorectal-prevention-pdq

[14] Rubenstein, J.H., Enns, R., . . . Barkun, A. (2015). American Gastroenterological Association Institute Guideline on the Diagnosis and Management of Lynch Syndrome. *Gastroenterology, 149*(3), 777-782.

[15] Seyedian, S.S., Nokhostin, F., . . . Malamir, M.D. (2019). A review of the diagnosis, prevention, and treatment methods of inflammatory bowel disease. *Name of Journal, 12*(2), 113-122.

[16] Shaukat, A., Kahi, C., . . . Douglas, K. (2021). ACG Clinical Guidelines: Colorectal Cancer Screening 2021. *The American Journal of Gastroenterology, 116*(3), 458-479.

[17] Stauffer, C.M. & Pfeifer, C. (2022). Colonoscopy. *National Library of Medicine*. Retrieved: August 2023. https://www.ncbi.nlm.nih.gov/books/NBK559274/

[18] Syngal, S., Brand, R., . . . Burt, R. (2015). ACG Clinical Guideline: Genetic Testing and Management of Hereditary Gastrointestinal Cancer Syndromes. *The American Journal of Gastroenterology, 110*(2), 223-262.

[19] Thomas-Gibson, S. & Haycock, A. (2019). O.J. Garden. & S. Paterson-Brown (Eds.). *Colorectal Surgery: A Companion to Specialist Surgical Practice*(6), (pp. 14-25). China: Elsevier Limited.

[20] U. S. Preventative Services Task Force (USPSTF). (2021). Colorectal Cancer: Screening. *U. S. Preventative Services Task Force*. Retrieved: August 2023. https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/colorectal-cancer-screening#bootstrap-panel--10

[21] Vogel, J.D., Felder, S.I., . . . Paquette, I.M. (2022). The American Society of Colon and Rectal Surgeons Clinical Practice Guidelines for the Management of Colon Cancer. *American Society of Colon and Rectal Surgeons*. Retrieved: August, 2023. https://fascrs.org/ascrs/media/files/downloads/2022-Colon-Cancer-CPG.pdf

Disclaimer & Legal Notice

Purpose

The purpose of the HealthHelp's clinical guidelines is to assist healthcare professionals in selecting the medical service that may be appropriate and supported by evidence to safely improve outcomes. Medical information is constantly evolving, and HealthHelp reserves the right to review and update these clinical guidelines periodically. HealthHelp reserves the right to include in these guidelines the clinical indications as appropriate for the organization's program objectives. Therefore the guidelines are not a list of all the clinical indications for a stated procedure, and associated Procedure Code Tables may not represent all codes available for that state procedure or that are managed by a specific client-organization.

Clinician Review

These clinical guidelines neither preempt clinical judgment of trained professionals nor advise anyone on how to practice medicine. Healthcare professionals using these clinical guidelines are responsible for all clinical decisions based on their assessment. All Clinical Reviewers are instructed to apply clinical indications based on individual patient assessment and documentation, within the scope of their clinical license.

Payment

The use of these clinical guidelines does not provide authorization, certification, explanation of benefits, or guarantee of payment; nor do the guidelines substitute for, or constitute, medical advice. Federal and State law, as well as member benefit contract language (including definitions and specific contract provisions/exclusions) take precedence over clinical guidelines and must be considered first when determining eligibility for coverage. All final determinations on coverage and payment are the responsibility of the health plan. Nothing contained within this document can be interpreted to mean otherwise.

Registered Trademarks (®/™) and Copyright (©)