STATE OF IOWA DEPARTMENT OF
Health AND Human
SERVICES

CT Colonography
RAD-002

Iowa Medicaid Program:	Prior Authorization	**Effective Date:**	1/20/2009
Revision Number:	9	**Last Rev Date:**	1/19/2024
Reviewed By:	Medicaid Medical Director	**Next Rev Date:**	1/17/2025
Approved By:	Medicaid Clinical Advisory Committee	**Approved Date:**	10/21/2016

Criteria

CT colonography is considered medically necessary when **ONE** of the following is met:

1. Documentation of colonic obstruction due to obstructive or stenosing lesions which would inhibit passing of the colonoscope, **OR**
2. Failed previous attempt at colonoscopy due to inability to tolerate procedure or anatomy, **OR**
3. Documentation of the member's inability to safely tolerate the sedation required for conventional colonoscopy.

Coding

The following list of codes is provided for reference purposes only and may not be all inclusive. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment, nor does the exclusion of a code imply that its association to the HCPCS code is inappropriate.

CPT	Description
74261	CT colonography, diagnostic, including image post-processing without contrast material.
74262	CT colonography, diagnostic, including image post-processing with contrast material(s) including non-contrast images, if performed.
74263	CT colonography, screening, including image post-processing.

Compliance

1. Should conflict exist between this policy and applicable statute, the applicable statute shall supersede.
2. Federal and State law, as well as contract language, including definitions and specific contract provisions or exclusions, take precedence over medical policy and must be considered first in determining eligibility for coverage.
3. Medical technology is constantly evolving and Iowa Medicaid reserves the right to review and update medical policy on an annual or as-needed basis.

Medical necessity guidelines have been developed for determining coverage for member benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. Medical necessity guidelines are developed for selected physician administered medications found to be safe and proven to be effective in a limited, defined population or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in the service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. Criteria are revised and updated annually, or more frequently if new evidence becomes available that suggests needed revisions.

References

EncoderPro Optum 360.

Final Recommendation Statement Colorectal Cancer: Screening United States Preventive Services Task Force. June 15, 2016.

Development of utilization management criteria may also involve research into other state Medicaid programs, other payer policies, consultation with experts and review by the Medicaid Clinical Advisory Committee (CAC). These sources may not be referenced individually unless they are specifically published and are otherwise applicable to the criteria at issue.

Criteria Change History

Change Date	Changed By	Description of Change	Version

Signature

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Signature

Change Date	Changed By	Description of Change	Version
1/19/2024	CAC	Annual review.	9

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William (Bill) Jagiello, DO 

Change Date	Changed By	Description of Change	Version
1/20/2023	CAC	Annual review.	8

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Criteria Change History (continued)

Change Date	Changed By	Description of Change	Version
1/21/2022	CAC	Annual review. Formatting changes.	7
Signature William (Bill) Jagiello, DO			
Change Date	**Changed By**	**Description of Change**	**Version**
10/15/2021	CAC	Annual review. Formatting changes.	6
Signature William (Bill) Jagiello, DO			
Change Date	**Changed By**	**Description of Change**	**Version**
10/16/2020	CAC	Changed from ETP to PA. Changed title to "CT Colonography". Updated references.	5
Signature William (Bill) Jagiello, DO			
Change Date	**Changed By**	**Description of Change**	**Version**
10/21/2016	CAC	Changed title to "Colonography". Reworded criteria #2 and #3.	4
Signature C. David Smith, MD			
Change Date	**Changed By**	**Description of Change**	**Version**
10/9/2015	Medical Director	Formatting changes for clarity and addition of development reference.	3
Signature			
Change Date	**Changed By**	**Description of Change**	**Version**
10/17/2014	Medical Director	Inclusion of codes and references.	2
Signature			
Change Date	**Changed By**	**Description of Change**	**Version**
7/19/2013	CAC	Change criteria to "must meet ONE of the following". Combined criteria #2 and #3.	1
Signature			