Cohere Medical Policy - Computed Tomography (CT), Colonography

Clinical Policy for Medical Necessity Review

Version: 4
Cohere Health UMC Approval Date: August 21, 2025
Last Annual Review: August 21, 2025
Revision: Not Applicable
Next Annual Review: August 21, 2026

Important Notices

Notices & Disclaimers:

GUIDELINES ARE SOLELY FOR COHERE'S USE IN PERFORMING MEDICAL NECESSITY REVIEWS AND ARE NOT INTENDED TO INFORM OR ALTER CLINICAL DECISION-MAKING OF END USERS.

Cohere Health, Inc. ("**Cohere**") has published these clinical guidelines to determine the medical necessity of services (the "**Guidelines**") for informational purposes only, and solely for use by Cohere's authorized "**End Users**". These Guidelines (and any attachments or linked third-party content) are not intended to be a substitute for medical advice, diagnosis, or treatment directed by an appropriately licensed healthcare professional. These Guidelines are not in any way intended to support clinical decision-making of any kind; their sole purpose and intended use is to summarize certain criteria Cohere may use when reviewing the medical necessity of any service requests submitted to Cohere by End Users. Always seek the advice of a qualified healthcare professional regarding any medical questions, treatment decisions, or other clinical guidance. The Guidelines, including any attachments or linked content, are subject to change at any time without notice.

Other Notices:

Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein.

Policy Information:

Specialty Area: Diagnostic Imaging
Policy Name: Cohere Medical Policy - Computed Tomography (CT), Colonography
Type: [**X**] Adult (18+ yo) | [**X**] Pediatric (0-17 yo)

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Medical Necessity Criteria

***Service*: Computed Tomography (CT), Colonography**

Cohere Health takes an evidence-based approach to reviewing imaging and procedure requests, meaning that sufficient clinical information must be provided at the time of submission to determine medical necessity. Documentation must include a recent and detailed history, physical examination related to the onset or change in symptoms, relevant lab results, prior imaging, and details of previous treatments. Advanced imaging or procedures should be requested after a clinical evaluation by the treating provider, which may include a referral to a specialist. A recent clinical evaluation may not be necessary if the request is supported by relevant guidelines.

- When a specific clinical indication is not explicitly addressed in the Cohere Health medical policy, medical necessity will be determined based on established clinical best practices, as supported by evidence-based literature, peer-reviewed sources, professional society guidelines, and state or national recommendations, unless otherwise directed by the health plan.
- Requests submitted without clinical documentation, or those that do not align with the provided clinical information—such as mismatched laterality, body part, or CPT code—may be denied for lack of medical necessity due to insufficient or inconsistent clinical information.
- Repeat diagnostic testing due to technical issues—such as patient motion, incomplete exams, or incorrect imaging sequences—may not be considered medically necessary, as it is the responsibility of the imaging center to deliver appropriate, high-quality studies as originally authorized. Similarly, repeat imaging requested at a different facility based solely on provider preference will not be approved for medical necessity.
- When there are multiple diagnostic or therapeutic procedures requested simultaneously or within the past three months, each will be reviewed independently. Clinical documentation must clearly justify all of the following:

    - The medical necessity of each individual request
    - Why prior imaging or procedures were inconclusive or why additional/follow-up studies are needed
    - How the results will impact patient management or treatment decisions
- Requests involving adjacent or contiguous body parts may be considered not medically necessary if the documentation demonstrates that the patient's primary symptoms can be adequately assessed with a single study or procedure.
- Cohere Health evaluates imaging exams based on medical necessity, regardless of contrast use. If an initial non-contrast study is completed and the radiologist later determines that contrast is needed to clarify a finding, the original authorization number may be used—provided the contrast-enhanced exam is performed at the same imaging center and within the original request's validity period, unless otherwise directed by the health plan.

Description

Computed tomography (CT) colonography (also known as virtual colonoscopy) is a diagnostic imaging procedure that uses detailed images of the colon and rectum. The procedure typically begins with bowel preparation to cleanse the colon, followed by the insertion of a small tube into the rectum to gently inflate the colon with air or carbon dioxide. Images are obtained while the patient lies in different positions on the CT scanner, such as on the back and stomach. Specialized software reconstructs the CT images into a two- or three-dimensional view of the colon's interior, allowing visualization of the mucosal surface and detection of abnormalities such as polyps or masses.[1] The procedure should be conducted in a facility compliant with the standards of the American College of Radiology (ACR), and performed by a physician trained in CT colonography.[2]

Medical Necessity Criteria

Indications

Computed tomography (CT) colonography is considered appropriate if **ANY** of the following is **TRUE**:

- The procedure is a screening for colorectal cancer, and **ALL** of the following:
  - **ANY** of the following:
    - The patient is at average risk for colorectal cancer, and **ALL** of the following:
      - The patient is 45-85 years of age[3]; **AND**
      - The patient has no personal history of colorectal predisposing conditions (e.g., colorectal cancer, adenomatous polyps, inflammatory bowel disease); **AND**
      - The patient has no known hereditary syndrome (e.g., Lynch syndrome, familial adenomatous polyposis); **AND**
      - The patient has no known family history of colorectal cancer or advanced adenoma in a first-degree relative; **OR**
    - The patient is at moderate or increased risk for colorectal cancer, and **ALL** of the following[4]:
      - **ANY** of the following:
        - The patient has one first-degree relative with colorectal cancer or an advanced adenoma diagnosed before age 60; **OR**
        - The patient has two or more first-degree relatives with colorectal cancer or advanced adenoma at any age; **AND**
      - **ANY** of the following:
        - The patient is no more than 10 years younger than the age of the youngest affected relative at their diagnosis; **OR**
        - The patient is greater than or equal to 40 years of age; **AND**
  - **ANY** of the following:
    - The procedure is an initial screening; **OR**
    - The patient had a prior CT colonography at least 5 years ago[5,6]; **OR**
- Post-surgical follow-up of a patient for a colonic stoma or after a colectomy[2]; **OR**
- Before colorectal cancer surgery for the identification of the tumor or to search for synchronous lesions[2]; **OR**
- **ALL** of the following:

- Colonoscopy is contraindicated or incomplete due to **ANY** of the following reasons:
  - Prior optical colonoscopy was incomplete due to **ANY** of the following[2,5]:
    - An obstructing neoplasm; **OR**
    - Intrinsic scarring; **OR**
    - Stricture; **OR**
    - Redundant or tortuous colon; **OR**
    - Spasm; **OR**
    - Obstruction from prior surgery, radiation, or diverticular disease; **OR**
    - Extrinsic compression; **OR**
  - The patient is at increased risk for complications during an optical colonoscopy due to **ANY** of the following[2]:
    - Anticoagulant use that cannot be safely reversed before the procedure; **OR**
    - Coagulopathy; **OR**
    - Complications from prior optical colonoscopy; **OR**
    - Increased risk of bowel perforation; **OR**
    - Sedation risk as indicated by an American Association of Anesthesiologists (ASA) Physical Status classification of IV or above[7]; **OR**
    - The patient is 76 to 85 years of age, and medical necessity is determined based on symptoms or risk factors[8]; **AND**
- **ANY** of the following:
  - Evaluation of a submucosal abnormality detected on colonoscopy or another imaging study; **OR**
  - The procedure is for surveillance in moderate and high-risk individuals as defined by **ALL** of the following:
    - Documented discussion with the patient that optical colonoscopy is considered the gold standard in this setting; **AND**
    - **ANY** of the following**:**
      - Biopsy-proven precancerous polyps on prior colonoscopy; **OR**
      - Prior therapeutic abdominal or pelvic radiation - every 5 years beginning at age 35 for at-risk survivors or 10 years after the completion of radiotherapy (whichever occurs last)[9]; **OR**

        - Personal or family history (first or second-degree relative) of hereditary syndromes that do NOT cause polyposis, including **ANY** of the following:
            - Bloom syndrome; **OR**
            - PTEN hamartoma tumor syndrome (PHTS) when colonoscopy is contraindicated; **OR**
- The procedure is a diagnostic examination in symptomatic patients with **ALL** of the following[2]:
    - Documented discussion with the patient that optical colonoscopy is considered the gold standard in this setting; **AND**
    - The patient has signs or symptoms suggesting colorectal cancer, including **ANY** of the following[2]:
        - The positive test result indicates a relative elevation in risk (e.g., positive fecal immunochemical test, positive fecal occult blood test [FOBT]); **OR**
        - Iron-deficiency anemia; **OR**
        - Weight loss; **OR**
        - Hematochezia (Blood in stool); **OR**
- Repeat imaging (defined as a repeat request following recent imaging of the same anatomic region with the same or similar modality) will be considered reasonable and necessary if **ALL** the following are **TRUE**:
    - There are no established guidelines; **AND**
    - **ANY** of the following:
        - There are new or worsening symptoms not addressed in the guidelines, such that repeat imaging would influence treatment; **OR**
        - There is need for a one-time clarifying follow-up of a prior indeterminate finding; **OR**
        - In the absence of change in symptoms, there is an established need for monitoring which would influence management.

Non-Indications

Computed tomography (CT) colonography is **NOT** considered appropriate if **ANY** of the following is **TRUE**:

- The patient has undergone advanced imaging of the same body part within 3 months without undergoing treatment or developing new or worsening symptoms[10]; **OR**
- Attempted colonoscopy within 48 hours; **OR**
- Known or suspected current colon perforation[2,11]; **OR**
- Routine follow-up of inflammatory bowel disease[2,11]; **OR**
- Hereditary polyposis or Lynch syndromes (applies to virtual colonoscopy as it is unlikely to provide clinical benefit)[2,11]; **OR**
- Evaluation of anal canal disease (e.g., perianal fissure).[2,11]

*NOTE: CT Colonography should not be performed if the patient has symptomatic acute conditions such as colitis, diarrhea, recent acute diverticulitis, abdominal wall hernia, history of recent colorectal surgery, high-grade or symptomatic small bowel obstruction, or history of recent colonoscopic biopsy, polypectomy. The imaging center and the ordering provider should consider these conditions prior to ordering a CT colonography.[2,11]
**NOTE: The referring professional and radiologist should discuss the risks and benefits of contrast media administration, including possible prophylaxis, in patients with chronic or worsening kidney disease or severe renal failure.

Definitions

First-degree relative: A relative who shares approximately 50% of your genes (e.g., a parent, sibling, or child).[4]

Second-degree relative: A relative who shares approximately 25% of your genes (e.g., a grandparent, grandchild, aunt, uncle, niece, nephew, or half-sibling).[4]

Average risk: Individuals with no personal history of colorectal cancer, adenomatous polyps, inflammatory bowel disease, hereditary colorectal syndromes, other colorectal predisposing conditions, or first-degree relative family history of colorectal cancer.[4,6]

Moderate or increased risk: Individuals with one first-degree relative with colorectal cancer or an advanced adenoma diagnosed before age 60, or two or more first-degree relatives with colorectal cancer or adenomatous polyps at any age.[4,6]

High-risk: Individuals with a hereditary colorectal cancer syndrome (such as Lynch syndrome, familial adenomatous polyposis, or hereditary polyposis or nonpolyposis), or with long-standing inflammatory bowel disease involving the colon.[4,6]

Disclaimer on Radiation Exposure in Pediatric Populations

Due to the heightened sensitivity of pediatric patients to ionizing radiation, minimizing exposure is paramount. At Cohere, we are dedicated to ensuring that every patient, including the pediatric population, has access to appropriate imaging following accepted guidelines. Radiation risk is dependent mainly on the patient's age at exposure, the organs exposed, and the patient's sex, though there are other variables. The following technical guidelines are provided to ensure safe and effective imaging practices:

Radiation Dose Optimization: Adhere to the lowest effective dose principle for pediatric imaging. Ensure that imaging protocols are specifically tailored for pediatric patients to limit radiation exposure.[12,13]

Alternative Modalities: Prioritize non-ionizing imaging options such as ultrasound or MRI when clinically feasible, as they are less likely to expose the patient to ionizing radiation. For instance, MRI or ultrasound should be considered if they are more likely to provide an accurate diagnosis than CT, fluoroscopy, or radiography.[12,13]

Cumulative Dose Monitoring: Implement systems to track cumulative radiation exposure in pediatric patients, particularly for those requiring multiple imaging studies. Regularly reassess the necessity of repeat imaging based on clinical evaluation.[12,13]

CT Imaging Considerations: When CT is deemed the best method for achieving a correct diagnosis, use the lowest possible radiation dose that still yields reliable diagnostic images.[12,13]

Cohere Imaging Gently Guideline

The purpose of this guideline is to act as a potential override when clinically indicated to adhere to Imaging Gently and Imaging Wisely guidelines and As Low As Reasonably Possible (ALARA) principles.[12,13]

Level of Care Criteria

Inpatient or Outpatient

Procedure Codes (CPT/HCPCS)

CPT/HCPCS Code	Code Description
74261	Computed tomography (CT) colonography, diagnostic; without contrast material, with image post-processing
74262	Computed tomography (CT) colonography, diagnostic; with contrast material and non-contrast images, with image post-processing
74263	Computed tomographic (CT) colonography, screening, including image postprocessing
76380	Computed tomography, limited or localized follow-up study

Medical Evidence

Jain et al. (2022) outline the updated colorectal cancer (CRC) screening strategies recommended by the United States Preventive Services Task Force (USPSTF) in 2021. Average-risk individuals should start screening at age 45. The Task Force suggests several screening methods: high-sensitivity guaiac fecal occult blood test (HSgFOBT), fecal immunochemical test (FIT), multi-target stool DNA (mt-sDNA) test, computed tomographic (CT) colonography (virtual colonoscopy), flexible sigmoidoscopy, flexible sigmoidoscopy with FIT, or traditional colonoscopy. Numerous emerging and innovative screening approaches are being researched and are on the horizon for primary screening in average-risk individuals. These include blood-based screening or "liquid biopsy," colon capsule endoscopy, urinary metabolomics, and stool-based microbiome testing to detect colorectal polyps or CRC. Compared to traditional colonoscopy, the advantages of CT colonography include a lower risk of complications, less invasive, sedation not required, and the clinician being able to visualize the entire colon. In addition, CT colonography requires a less frequent testing interval than stool-based modalities and is relatively safe for individuals with medical comorbidities that preclude colonoscopy. Same-day endoscopic evaluation may also be performed if indicated.[14]

Gupta et al. (2022) review CRC screening for identifying polyps and cancer within the colon. The sensitivity for detecting lesions greater than or equal to 1 cm varies between 67 and 94%, while specificity ranges from 86 to 98%. Notably, an estimated incidence of potentially significant extracolonic findings necessitating further investigation, ranging from 3.4–26.9%, with 1.3–11.4% possibly requiring follow-up due to incomplete characterization. Several studies have shown superior sensitivity in detecting colorectal cancer compared to colonoscopy, mainly when the endoscopist is unaware of CT colonography results. Repeat screening every 5 years is recommended by the USPSTF.[15]

Shaukat et al. (2022) discuss CT colonography to facilitate the identification and pinpointing of polyps and cancers within the colon through a reconstructed 3D or 4D visualization. Two extensive trials have evaluated the diagnostic efficacy of CT colonography against optical colonoscopy conducted on the same day. One study involving 1233 individuals at average

risk showcased CT colonography's test characteristics, revealing 92% sensitivity and 96% specificity for adenomas measuring 10mm or larger as detected by optical colonoscopy. Additionally, it demonstrated 86% sensitivity and 80% specificity for adenomas measuring 6mm or larger. The National CT Colonography Trial (NCTC), sponsored by the American College of Radiology Imaging Network (ACRIN), comprised 2600 asymptomatic participants undergoing same-day CT colonography and optical colonoscopy. Results revealed a sensitivity of 84% for adenomas or colorectal cancer (CRC) measuring 10mm or larger, with a specificity of 85%. Furthermore, a sensitivity of 70% was observed for adenomas measuring 6mm or larger, with a specificity of 86%. A notable critique of CT colonography is the failure to report lesions smaller than 6mm, the clinical significance of which remains uncertain.[16]

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Policy Revision History/Information

Original Date: April 29, 2022		
Review History		
Version 2	08/02/2024	Annual review and policy restructure.
Version 3	10/30/2024	Edited repeat imaging criteria language.
Version 4	08/21/2025	Annual review. Minor adjustments were made to the indications in alignment with ACR guidelines. A few indications were repositioned to the beginning of the policy and no longer require a failed or contraindicated optical colonoscopy: the screening section, post-surgical follow-up for stoma or post-colectomy, and pre-surgery to search for tumor or lesions. The screening section was updated to better differentiate risk and age groups. Indications for the timeline of evaluating polyps were removed, as these indications are better suited for optical colonoscopy, not CT colonography. The repeat imaging section was updated to the revised standard language. Relative contraindications were removed from the non-indications section and placed in the notes section. Literature review - Description section updated and References added.