

Maryland CDC Colorectal Cancer Program Policies and Procedures

March 5, 2010

Roles and Responsibilities

The Maryland CDC Colorectal Cancer (CRC) Program is a cooperative agreement with the Centers for Disease Control and Prevention (CDC) that began in July 2009 and is designed to increase population-based CRC screening among persons 50 years and older in Maryland. Screening efforts are to be focused on persons in Baltimore City 50 years and older with low incomes and inadequate or no health insurance coverage for CRC screening.

The Maryland Department of Health and Mental Hygiene (DHMH) is the recipient of CDC funds for the Screening Program. DHMH shall:

- interface with CDC on all program aspects of the Program;
- distribute grant awards and funds for screening to the Sites (see below);
- convene the CRC Medical Advisory Committee;
- develop policies and procedures for the program consistent with the CDC requirements;
- assist the Sites in developing their Site-specific procedures;
- develop data systems, collect data from the Sites, and report data to CDC; and
- take responsibility for site visits, quality assurance, fiscal oversight, and reporting to CDC.

The screening “Sites” shall:

- Comply with Grant Agreement between DHMH and the Site, including, but not limited to:
 - hire and supervise the designated “administrative case manager” for each Site’s program;
 - perform in-reach and out-reach to identify clients potentially eligible for screening;
 - determine eligibility, enroll, and case manage the clients for their CRC screening and after-care;
 - enter into an electronic database and report to DHMH the Site’s clinical and fiscal data; and
 - manage the administrative and fiscal components of the DHMH grant.

The Medical Case Manager at the Sites shall:

- take the medical and legal responsibility for screening clients for CRC;
- make medical decisions about the client and assume liability for those decisions;
- obtain informed consent before the colonoscopy or other medical procedure; and
- perform procedures according to contract specifications, including reporting clinical results and billing information.

As the Program develops, there may be additional roles and responsibilities required by the CDC and not covered above that will be discussed with the Sites to determine how to address them.

Maryland CDC CRC Program Policies and Procedures

Program Coverage and Rates

a. The following CRC tests for screening or surveillance, or for diagnostic or follow-up services shall be reimbursable. The allowed CPT codes and their Medicare rates are found in the Procedures Manual, Section 9--Contract and Billing, Section 9B.

- i. Fecal occult blood testing: guaiac-based or fecal immunochemical testing;
- ii. Sigmoidoscopy including colonoscopist fees, facility fees; anesthesiology; pharmacy;
- iii. Colonoscopy (with and without biopsy(ies))including colonoscopist fees, facility fees; anesthesiology; pharmacy;
- iv. Barium enema, double contrast;
- v. Office visits related to colonoscopy: Pre colonoscopy or post colonoscopy visit or both, if provider requests;
- vi. Bowel preparation products;
- vii. Pathology fees including technical component and professional component; special stains and immunocytochemistry;
- viii. Pre colonoscopy: EKG and bloodwork, if deemed necessary and listed in Attachment 9B, or with approval of DHMH and CDC; and
- ix. Other pre-colonoscopy testing with prior approval by DHMH and CDC.

b. The following shall not be reimbursable without prior approval by DHMH (and by CDC):

- i. Screening tests recommended by the Medical Case Manager at an interval sooner than recommended in Attachment 1;
- ii. CTs (computerized tomographs) as a primary screening test or for staging or other purposes;
- iii. Surgery or Surgical staging, unless specifically required and approved by the Medical Advisory Committee to provide a histological diagnosis of cancer;
- iv. Any treatment related to the diagnosis of colorectal cancer;
- v. Any care or services for complications that result from screening or diagnostic test provided by the program;
- vi. Evaluation of symptoms for patients who present for CRC screening but are found to have gastrointestinal symptoms;
- vii. Diagnostic services for clients who had an initial positive screening test performed outside of the program, including a positive fecal occult blood test;
- viii. Evaluation of underlying medical conditions prior to colonoscopy if such evaluation includes chest X-rays, coagulation studies, treadmill testing, pulmonary function tests, or cardiology or pulmonary consultation (patients medically cleared for colonoscopy may return for enrollment into the program after clearance);
- ix. Management of medical conditions including inflammatory bowel disease (e.g., surveillance colonoscopies and medical therapy);
- x. Genetic testing for patients who present with a history suggestive of a HNPCC or FAP;
- xi. Co-pays or deductibles for individuals with healthcare insurance; and
- xii. Use of propofol as anesthesia during endoscopy. (If propofol is used during endoscopy procedures, reimbursement will be based on the rate for standard anesthesia routinely used at that facility.)

c. Payment rates:

- i. Services are reimbursable at the Health Services Cost Review Commission (HSCRC) rate for HSCRC regulated services, or, for unregulated services, at a rate no higher than the Medicare rate for the Region.
- ii. CDC funds shall **not** pay the co-payment or deductible fees for a patient who otherwise has insurance coverage for CRC screening services.

Policies	Procedures
General Focus	
<ul style="list-style-type: none"> • Sites shall focus screening efforts on asymptomatic people between the age of 50 and 64 years who are at average risk of CRC: <ul style="list-style-type: none"> ○ No personal or family history of CRC or adenomas ○ No history of inflammatory bowel disease (ulcerative colitis or Crohn’s colitis) ○ No personal or family history of genetic syndromes (see below) • Sites shall refer ineligible clients to appropriate medical care and shall note the number of ineligible clients who contact the program, the reason for ineligibility, and the site to which the person was referred. 	<p>≥ 75% of screening services should be spent on screening people at average risk.</p> <p>Sites will have lists of referrals sites where ineligible clients may be referred. Sites will have a data collection form on which to record ineligibles and the site of referral.</p>
Residence, Age, Income	
<p>Sites shall enroll clients for CRC screening by colonoscopy if they meet the program’s requirements for:</p> <ul style="list-style-type: none"> • Residence: resident of Baltimore City (or, with DHMH approval, resident of Maryland outside Baltimore City) • Age: <ul style="list-style-type: none"> • if average risk: 50 to 64 years old, or 65+ years old with DHMH approval • if at increased risk due to family or personal history (see below): 18 to 64 years old, or 65+ years old with DHMH approval • Income (household income): <ul style="list-style-type: none"> • ≤250% of Federal Poverty Guideline 	<p>Sites will obtain verbal documentation of residence in Baltimore City, age, risk, and household income ≤ 250% of the Federal Poverty Guideline as minimum eligibility for screening.</p> <p>Sites will contact DHMH to obtain approval to screen if the client is outside of these guidelines.</p>

Policies	Procedures
Insurance	
<p>Sites shall enroll clients who are:</p> <ul style="list-style-type: none"> • uninsured, • insured with Medicare Part A only, or • insured with other commercial insurance that does not cover CRC screening; <p>Sites shall not pay co-pays or deductibles for clients with insurance</p>	<p>Sites will interview clients about their insurance status and record it on the data collection form. Those not eligible will be referred to other sites for care.</p>
Family History	
<p>Sites shall not enroll clients who have been <i>previously diagnosed with</i> a genetic syndrome associated with CRC (FAP or HNPCC).</p> <p>Sites shall not enroll clients with a <i>family history</i> of a genetic syndrome associated with CRC (FAP or HNPCC).</p>	<p>Sites will refer the person to sites that offer genetic testing and management. If the person is found NOT to have FAP or HNPCC based on genetic testing, then the person may reapply to enroll in the program.</p>
<p>Sites shall enroll clients with increased risk because of a family history of a first degree relative (FDR) with CRC or polyps, either adenomatous, hyperplastic, or other/unknown type.</p>	<p>Sites will screen people with increased CRC risk according to Attachment 1.</p>
Personal History	
<p>Sites shall enroll for surveillance colonoscopy clients with CRC previously diagnosed <i>outside</i> of the project or who were in the CDC Screening Demonstration Program who otherwise meet eligibility criteria.</p>	<ul style="list-style-type: none"> • Sites will enroll clients diagnosed with CRC for colonoscopy, as recommended by their Medical Case Manager at intervals detailed in Attachment 1. Sites will refer clients with gastrointestinal symptoms and a past personal history of CRC back to their prior source of health care or referred to a provider on a list of referrals (See Symptoms and Signs, below).
<p>Sites shall not enroll clients <i>previously diagnosed with</i> a genetic syndrome associated with CRC (FAP or HNPCC).</p>	<ul style="list-style-type: none"> • Sites will tell clients who have <i>prior</i> diagnosed FAP or HNPCC that they should continue in the care of their prior provider or be referred to a provider on a list of referrals.
<p>Sites shall not enroll clients with IBD/ ulcerative colitis/ Crohn's colitis.</p>	<ul style="list-style-type: none"> • Sites will attempt to obtain more information on clients who report unspecified “colitis” before denying enrollment. • Sites will refer clients who come to the program who have <i>prior</i> diagnosed IBD back to their prior source of health care or refer to a provider on a list of referrals.

Policies	Procedures
<p>Sites shall enroll clients with a personal history of polyps, either adenomatous, hyperplastic, or other/unknown type.</p>	<p>Sites will enroll clients with a history of adenoma(s), hyperplastic polyp(s) or other/unknown type of polyps for surveillance colonoscopy at an interval recommended in Attachment 1.</p> <p>For clients with past history of adenomas, hyperplastic polyps, or of polyps of unknown type or unknown number:</p> <ul style="list-style-type: none"> • Sites will try to determine the type and number of polyps found in the past and the clinician’s recommended interval; clients will be eligible if the colonoscopy in the program will be <i>at or later than</i> the recommended time of recall for colonoscopy. See Attachment 1. • Clients for whom sites cannot determine the number and type of polyps will assume they were adenoma(s) and follow recall guidelines of the program. See Attachment 1.
<p>Sites shall refer clients who may not benefit from screening (e.g., people with advanced age or people with short-life expectancy due to extreme co-morbidity) to providers for clearance prior to colonoscopy.</p>	<ul style="list-style-type: none"> • Sites will make clinics/providers who will refer clients to the screening program aware of the priority population for this program and the restrictions on clients who may not benefit from screening such as those with short life expectancy or extreme co-morbidity; they will ask clinics/providers NOT to refer these clients the program and will make clinics/providers aware that the program will NOT cover additional procedures and consults for colonoscopy clearance. • Sites will ask potentially eligible clients about their co-morbidity(ies) using the data collection form and will refer those with co-morbidities to the person’s primary care provider or to endoscopists for evaluation prior to colonoscopy; sites will NOT cover additional procedures for clearance for colonoscopy (e.g., treadmill, pulmonary function testing, chest X-ray) without prior approval by the DHMH.

Policies	Procedures
<p>Symptoms and Signs</p> <p>Prior to enrolling a client <i>who is otherwise eligible by criteria above</i>, Sites shall evaluate each client for symptoms.</p> <p>People with significant gastrointestinal symptoms or signs are not eligible for screening services through the CRCCP. Symptoms and signs that would preclude eligibility for the program include, but are not limited to:</p> <ol style="list-style-type: none"> 1. Rectal bleeding, bloody diarrhea, or blood in the stool within the past 6 months (bleeding that is known or suspected to be due to hemorrhoids after clinical evaluation would not prevent a client from receiving CRC screening services); 2. Prolonged change in bowel habits (e.g., diarrhea or constipation for more than two weeks that has not been clinically evaluated); 3. Persistent abdominal pain; 4. Symptoms of bowel obstruction (e.g., abdominal distension, nausea, vomiting, severe constipation); 5. Significant unintentional weight loss of 10% or more of starting body weight; or 6. Mass in the abdomen or rectum on physical exam. 	<ul style="list-style-type: none"> • Sites will make clinics/providers that will refer clients to the screening program aware of the restrictions on symptomatic clients and will ask clinics/providers NOT to refer clients to the program who have symptoms listed in Column 1 or who have a mass on physical exam. • Sites will ask potentially eligible clients about their recent GI symptoms (see data forms); • Sites will refer a person who reports a GI symptom listed in Column 1 or an asymptomatic person who is found to have a rectal or abdominal mass to a provider on the Referral List; sites will record the reason for exclusion from the program. • People presenting with symptoms listed in Column 1 need a complete evaluation by a clinician to determine the cause of their symptoms. This evaluation, and any potential subsequent treatment, is beyond the scope of this program. If a client has been referred, medically evaluated, and cleared for colorectal cancer screening, then the site may enroll the client in the program if all eligibility criteria are met including the determination that symptoms were not from CRC. • For individual cases when clients present with minor symptoms that are not listed in Column 1, the Site should consult with the DHMH regarding eligibility.

Policies	Procedures
<p>Prior CRC Screening</p> <p>Provided the client meets the above residency, income, insurance, risk history, health, and symptom eligibility criteria, the person shall be eligible for colonoscopy if s/he:</p> <ul style="list-style-type: none"> • Was never screened for CRC in past; • Is at average risk and had: <ul style="list-style-type: none"> ◦ Colonoscopy in past with no CRC or adenomas found <i>and</i> it has been <i>at least 10 years</i> since last colonoscopy; ◦ Flexible sigmoidoscopy or double contrast barium enema (DCBE) negative for polyps or CRC <i>at least 5 years</i> ago; ◦ Negative FOBT <i>at least 1 year</i> ago and no colonoscopy, flexible sigmoidoscopy, or DCBE that would exclude the person; • Is at increased risk and needs screening or surveillance colonoscopy: <ul style="list-style-type: none"> ◦ Family history of CRC or adenoma(s) (see Attachment 1 for age and interval). ◦ Personal history of colonoscopy in past with finding of adenoma(s) or unknown type of polyps, now in need of repeat colonoscopy (See Attachment 1 for eligible interval). ◦ Was screened with <i>inadequate colonoscopy</i> within the CDC CRC Screening Program 	<ul style="list-style-type: none"> • Sites will interview clients to determine past CRC screening to determine eligibility. Sites will attempt to document prior screening results. Sites will record this information on the Screening Forms. • A person with recent fecal occult blood testing that is positive for blood is not eligible for the program and should be referred for diagnostic testing.
<p>Inadequate Colonoscopy in the Program</p> <p>Sites shall obtain from the Medical Case Manager the recommended procedure (e.g. repeat colonoscopy or DCBE) and its timing following a colonoscopy with inadequate bowel prep or when the endoscopist failed to reach the cecum.</p>	<ul style="list-style-type: none"> • Sites will obtain and record in the Medical Record the Medical Case Manager’s recommendation for completing the screening after inadequate colonoscopy. Sites will schedule a repeat colonoscopy or other procedure to complete screening.

Policies	Procedures
<p>Unplanned Events/Complications</p> <ul style="list-style-type: none"> • If an unplanned event or complication occurs during or within 30 days after the procedure, Sites shall obtain information and notify DHMH by e-mail or telephone. DHMH shall notify CDC on the next monthly call • If there is a serious complication including but not limited to: colon perforation, stroke, heart attack, or death, the Site shall notify DHMH within 24 hours of being made aware of the event/complication. DHMH shall notify CDC on the next working day. • Confirmed complications that result in an emergency room visit, hospitalization, or death shall be reported in the client’s medical record and in the clinical database record. 	<ul style="list-style-type: none"> • Sites will instruct clients to call the endoscopist if any bleeding, abdominal pain, fainting, etc. occurs after the procedure; if the complication or unplanned even occurs after hours or in an emergency situation, clients should be instructed to follow their endoscopist’s instruction, call 911, or go to an emergency room. • Sites will tell clients to identify themselves as a participant in the CDC CRC Screening Program • Sites will give the clients a program number to call to report the unplanned event/complication. • Sites will send a follow up letter with results and recall recommendations to clients screened. • Sites will contact clients at 30 days after procedure to ascertain current health status and unplanned events/complications. • Sites will record specific information in the medical record and in the client’s clinical database record.
<p>Tracking and Reminder Systems</p> <p>Sites shall implement client tracking and reminder system(s) to support screening adherence, provision of appropriate and timely follow-up of abnormal screening results, monitoring for complications after endoscopy, DCBE, or rescreening.</p>	<ul style="list-style-type: none"> • Sites will maintain a paper system for recalling clients unless a recall system will be found in the DHMH-provided data management system.

Policies	Procedures
Diagnosis and Treatment for Cancer or Complications	
<ul style="list-style-type: none"> • Sites shall case manage and attempt to obtain coverage to pay for further diagnosis and treatment of clients found to have cancer, suspected cancer, or who need removal/resection of complex, “worrisome” adenoma(s). • Sites shall case manage and attempt to obtain coverage to pay for treatment of clients who experience an unplanned event or complication felt to be due to colonoscopy. 	<ul style="list-style-type: none"> • Sites will identify, in advance, personnel who will assist the client in applying for Medicaid (Maryland Medical Assistance). • Sites will discuss, in advance, with their administration the possibility of putting the program clients under the hospital’s uncompensated care policy so that the client will not get any bills for the hospitalization/operating room/in-client pharmacy bills. • Sites will discuss, in advance, with appropriate surgeons/oncologists/radiation oncologists issues of payment for care and will have worked out a plan. • Sites will help the client apply for Medical Assistance. • If not eligible for Medical Assistance, sites will work with DHMH to try to get eligible client’s care paid for by the Maryland Cancer Fund (if funding is available). • If these are not possible, then Sites will work with hospital, providers, pharmacy, Med Bank, etc. to assure client gets diagnosis/treatment. • Sites will record the client outcome (surgery/treatment/findings, etc.) and the source(s) of payment in the client’s medical record and in fields provided in the client database.
Data Management	
<ul style="list-style-type: none"> • Sites shall enter required data regarding demographics, risk and screening history, clinical screening and diagnostic procedures and findings, and complications in a database provided by DHMH • Sites shall enter or provide to DHMH required data regarding patient-level reimbursement cost data related to screening and program-related activities of staff. • Sites shall establish appropriate billing procedures to handle receipt, approval and payment of bills. • Sites shall establish internal procedures to account for program expenditures of personnel, fringe, and administration and report to DHMH for reimbursement. 	<ul style="list-style-type: none"> • DHMH will provide program-specific software for client data and sites will install the software and enter data in a timely manner. • Sites will submit data to DHMH when required and work with DHMH staff to resolve edit errors on the data. • DHMH will send data to CDC per CDC guidelines

Eligibility for the program is summarized in Attachment 2, Summary of Eligibility for CRC Screening in the CDC Colorectal Cancer Control Program, January 2010

**1A_Attachment 1: Guidelines for Screening and Surveillance for Early Detection of Colorectal Polyps and Cancer+
Colorectal Cancer (CRC) Medical Advisory Committee, Maryland Department of Health and Mental Hygiene
March 2009**

Identify the person’s *most advanced* Risk Category (first column), and read across for the Recommendation

Risk Category	Recommendation	Age to Begin	Interval^{&}	Reference⁺
Inadequate Colonoscopy				
“Inadequate colonoscopy,” that is, colonoscopy didn’t reach cecum or patient had inadequate bowel preparation; any risk category	Repeat colonoscopy or perform other screening, as recommended by provider		As soon as indicated by colonoscopist; assure adequate preparation before repeat test or other procedure ^{&}	
Average Risk⁺⁺				
All people who are asymptomatic and not in the categories below ⁺⁺	Colonoscopy*	Age 50 years	Colonoscopy ^{&} every 10 years	Winawer-- US Multi-Society Task Force, Gastro 2003 Maryland CRC Medical Advisory Committee, 2006
People with small and limited number of rectal hyperplastic polyps ^{^ ++}	Colonoscopy	At time of initial polyp diagnosis	Colonoscopy ^{&} every 10 years	Winawer-US Multi-Society Task Force and ACS, 2006
Increased Risk of Adenocarcinoma of the Colon or Rectum—Moderate Risk: Family History				
Colorectal cancer (CRC) or adenomatous polyp(s) (or polyp of unknown histology) in first degree relative [@] (FDR) at <60 years old or in two or more FDRs of any ages	Colonoscopy	Age 40 years or 10 years before the youngest case in the family, whichever is earlier	Colonoscopy ^{&} every 5-10 years	ACS, 2003
CRC or adenomatous polyp(s) (or polyp of unknown histology) in one FDR who was diagnosed at age ≥60 years	Colonoscopy	Age 40 years	As for Average Risk persons if no CRC or adenomas found	ACG, 2000

Risk Category	Recommendation	Age to Begin	Interval ^{&}	Reference ⁺
Increased Risk: Personal history of endometrial or ovarian cancer				
Personal history of cancer of the ovary or endometrium diagnosed at <50 years old ^{@@}	Colonoscopy	At time of diagnosis of ovarian or endometrial cancer	If no CRC or adenomas on screening, repeat every 3-5 years (or sooner if findings)	Maryland CRC Medical Advisory Committee 2007
Increased Risk: Personal history of radiation therapy to colon or rectum				
Personal history of radiation therapy to colon or rectum (e.g., radiation to prostate, cervix, uterus, rectum, etc.)	Colonoscopy &&	Age appropriate for CRC risk category, or begin 3-5 years after radiation, whichever is earlier.	If no CRC or adenomas on screening, repeat in 3-5 years (or sooner if findings)	Maryland CRC Medical Advisory Committee 2007
Increased Risk—High Risk				
Family history of familial adenomatous polyposis (FAP)	Early surveillance with colonoscopy, counseling to consider genetic testing, and referral to a specialty center	Puberty	If polyposis is confirmed by genetic testing <i>and</i> colonoscopy or by colonoscopy alone, colectomy is indicated. These clients are best referred to a center with experience in the management of FAP	ACS, 2003
Family history of hereditary non-polyposis colon cancer (HNPCC)	Colonoscopy and counseling to consider genetic testing	Age 21	If genetic test positive or if client has not had genetic testing, colonoscopy every 1-2 years until age 40, then every year . These clients are best referred to a center with experience in the management of HNPCC.	ACS, 2003

Risk Category	Recommendation	Age to Begin	Interval ^{&}	Reference ⁺
Personal history of inflammatory bowel disease (IBD): ulcerative colitis-pancolitis/left-sided colitis; and Crohn's colitis	Colonoscopy with biopsies for dysplasia	8 years after the start of pancolitis; 12-15 years after the start of left-sided colitis	<p>Clients are best referred to a center with experience in the surveillance and management of IBD, number of biopsies needed, frequency of repeat colonoscopy, etc.</p> <p>Colonoscopy every 1-2 years (every year if pancolitis)</p> <p>If client is found to have <i>only</i> proctitis or proctosigmoiditis with biopsies negative for colitis proximal to 35 cm, then colonoscopy every 5 years.</p>	<p>IBD Study Group, 2005⁷</p> <p>Maryland CRC Medical Advisory Committee, 2008</p>
Increased Risk: Personal history of polyps—"Surveillance Colonoscopies"				
People with sessile or flat adenomas that are removed piecemeal ; people with pathological evidence of incomplete removal of an adenoma or where endoscopist is uncertain that the polypectomy was complete	Colonoscopy	At time of initial polyp diagnosis	Consider follow-up at short intervals (2-6 months) to verify complete removal. Once complete removal has been established, subsequent surveillance should be individualized based on the endoscopist's judgment.	<p>Winawer-US Multi-Society Task Force and ACS, 2006,</p> <p>Maryland CRC Medical Advisory Committee, 2008</p>
People with >10 adenomas of any size	Colonoscopy	At time of initial polyp diagnosis	Colonoscopy at less than 3 years ; interval based on clinical judgment	Winawer-US Multi-Society Task Force and ACS, 2006
People with <ul style="list-style-type: none"> • one or more large adenoma(s) (>=1 cm); • 3-10 adenomas of any size or histology; OR • 1 or more adenomas of any size with: <ul style="list-style-type: none"> ○ villous or tubulovillous histology; ○ serrated adenoma histology; or ○ high grade dysplasia^^ 	Colonoscopy	At time of initial polyp diagnosis	Colonoscopy ^{&} in 3 years after initial polyp removal; if this colonoscopy is negative for adenomas or CRC, or shows only 1-2 small tubular adenomas without high grade dysplasia then repeat colonoscopy in 5 years ; if no adenomas then, the patient can thereafter be screened as per average risk guidelines	Winawer-US Multi-Society Task Force and ACS, 2006

Risk Category	Recommendation	Age to Begin	Interval ^{&}	Reference ⁺
People with 1-2 small (<1 cm), tubular adenomas with NO villous histology and NO high grade dysplasia	Colonoscopy	At time of initial polyp diagnosis	Colonoscopy ^{&} 5-10 years after initial polyp removal (timing within the 5-10 year interval should be based on other clinical factors such as prior colonoscopy findings, family history, and preferences of the patient and judgment of the physician)	Winawer-US Multi-Society Task Force and ACS, 2006
People with multiple or large hyperplastic polyps suggestive of hyperplastic polyposis syndrome [^]	Colonoscopy	At time of initial polyp diagnosis	Colonoscopy every 6-12 months . These clients are best referred to a center with experience in the management of this syndrome	Maryland CRC Medical Advisory Committee, 2006
People with one or more polyps of unknown size or histology (e.g., ablated polyps, polyps was lost; or histology still unknown after attempts to obtain the information from prior endoscopist or patient's primary care provider)	Colonoscopy	At time of initial polyp diagnosis	Colonoscopy within 5 years of initial polyp(s) removal (number of years based on information on number, size, etc. and judgment of the physician); if normal or only hyperplastic polyps found on that colonoscopy, then screening as per average risk recommendations, above	Maryland CRC Medical Advisory Committee, 2006

Risk Category	Recommendation	Age to Begin	Interval ^{&}	Reference ⁺
Increased Risk: Personal history of colorectal cancer—“Surveillance Colonoscopy”				
Personal history of CRC--curative-intent resection of invasive colorectal adenocarcinoma	Colonoscopy	At time of diagnosis	<ol style="list-style-type: none"> a. Clear colorectum of synchronous neoplasia in the perioperative period (if non-obstructed, clear with colonoscopy; if obstructed, DCBE or CT colonography pre-operatively and colonoscopy 3-6 months post op) b. After clearing for synchronous disease and treatment of CRC, perform colonoscopy in 1 year. c. If normal, perform colonoscopy in 3 years d. If still normal, colonoscopy in 5 years^{&} e. If rectal cancer, consider endoscopic ultrasound or flexible sigmoidoscopy at 3-6 month intervals for the first two years after resection. <p>Shorter intervals may be indicated based on findings or on patient’s age, family history, or tumor testing indicating possible HNPCC.</p>	Rex--US Multi-Society Task Force and ACS, 2006

Risk Category	Recommendation	Age to Begin	Interval ^{&}	Reference ⁺
Increased Risk: Personal history of <i>other</i> cancers—“Surveillance Procedures”				
Personal history of anal cancer (for example, squamous cell carcinoma)	Colonoscopy	At time of diagnosis	<p>Surveillance for CRC</p> <ul style="list-style-type: none"> a. Clear colorectum of synchronous neoplasia in the perioperative period (if non-obstructed, clear with colonoscopy; if obstructed, DCBE or CT colonography pre-operatively and colonoscopy 3-6 months post op) b. Full colonoscopy should be repeated every 5 years or earlier based on findings other than anal cancer (that is, family history or personal history of adenocarcinoma, adenomas, etc.) <p>Surveillance for further anal cancer</p> <ul style="list-style-type: none"> a. Perform DRE between 8-12 weeks after completion of primary treatment with chemotherapy. b. If complete remission, perform DRE, anoscopy and inguinal node palpation every 3-6 months for 5 years. If T3-T4 or inguinal node positive, consider chest x-ray, pelvic CT annually for 3 years. c. If persistent disease or progressive disease after treatment, perform inguinal node palpation and CT scan every 3-6 months for 5 years. 	<p>NCCN v,1,2008 http://www.nccn.org/professionals/physician_gls/PDF/anal.pdf and per Medical Case Manager surgeon/oncologist/radiation oncologist</p> <p>Maryland CRC Medical Advisory Committee, 2008</p>
Personal history of carcinoid, cloacogenic carcinoma, squamous cell cancer of rectum, etc.			Surveillance for CRC and for the other cancer(s) per Medical Case Manager recommendation+++	Maryland CRC Medical Advisory Committee, 2008

+ **References for Recommendations:**

1. Smith RA, Cokkinides V, Eyre, HJ. American Cancer Society guidelines for early detection of cancer, 2003. *CA Cancer J Clin* 2003; 53:27-43.
2. Rex DK, Johnson DA, Lieberman DA, Burt, RW, and Sonnenberg A. Colorectal cancer prevention 2000: screening recommendations of the American College of Gastroenterology. *Am J Gastroenterology* 2000; 95: 868-877.
3. Rex DK, Bond JH, Winawer S, et al. Quality in the Technical Performance of Colonoscopy and the Continuous Quality Improvement Process for Colonoscopy: Recommendations for the US Multi-Society Task Force on Colorectal Cancer. *Am J Gastroenterology* 2002; 97:1296-1308.
4. Winawer SJ, Fletcher R, Rex D, et al. Colorectal cancer screening and surveillance: Clinical guidelines and rationale—Update based on new evidence. *Gastro* 2003; 124:544-560.
5. Winawer SJ, Zauber AG, Fletcher RH, et al. Guidelines for colonoscopy surveillance after polypectomy: A consensus update by the US Multi-Society Task Force on Colorectal Cancer and the American Cancer Society. *CA Cancer J Clin* 2006; 56:143-159 The US Multi-Society Task Force guidelines have been endorsed by the Colorectal Cancer Advisory Committee of the American Cancer Society and by the governing boards of the American College of Gastroenterology, the American Gastroenterological Association, and the American Society for Gastrointestinal Endoscopy.
6. Rex DK, Kahi CJ, Levin B, et al. Guidelines for colonoscopy surveillance after cancer resection: A consensus update by the American Cancer Society and US Multi-Society Task Force on Colorectal Cancer. *CA Cancer J Clin* 2006; 56:160-167. The US Multi-Society Task Force guidelines have been endorsed by the Colorectal Cancer Advisory Committee of the American Cancer Society and by the governing boards of the American College of Gastroenterology, the American Gastroenterological Association, and the American Society for Gastrointestinal Endoscopy.
7. Itzkowitz SH, Present DH; Crohn's and Colitis Foundation of America Colon Cancer in IBD Study Group, 2005. Consensus conference: Colorectal cancer screening and surveillance in inflammatory bowel disease. *Inflamm Bowel Dis.* 2005 Mar; 11(3):314-21.

& Interval is based on the findings of an **adequate** colonoscopy and asymptomatic client. If the endoscopist either fails to reach the cecum **or** determines that the preparation of the colon was inadequate for visualization, the colonoscopy should be considered **inadequate** and the colonoscopy repeated as soon as feasible. Symptomatic patients should be screened for CRC based on clinician judgment. If there are findings, shorter screening intervals are allowed under CRF funding (e.g., per Medical Advisory Committee: people with family history of CRC in multiple FDR or <60 years of age may be screened every **5 years**; people with 2 small tubular adenomas may return **within 3** years; people with 1 small tubular adenoma may return at 5 years; people with large, multiple, or villous adenomas may return **within 3** for surveillance; and people with past CRC could continue colonoscopy at another 3 year interval).

++ Average risk includes those people found to have limited number of small **hyperplastic** (or serrated hyperplastic polyps) but not found to have adenomatous polyps or CRC.

* Reserve double contrast barium enema (DCBE) and CT colonography for screening in situations where client and provider discuss and determine that the DCBE or CT colonography is indicated for the individual client; client, provider, and payer should discuss the additional procedures needed to follow up on findings and agree to the timing and type of future screenings recommended/covered. If chosen for screening and no findings, DCBE should be repeated in 5 years. Digital rectal exam should be performed at the time of colonoscopy or sigmoidoscopy.

^ Definition of hyperplastic polyposis suggested is: (1) at least five histologically diagnosed hyperplastic polyps proximal to the sigmoid colon of which 2 are greater than 1 cm in diameter, or; (2) any number of hyperplastic polyps occurring proximal to the sigmoid colon in an individual who has a first-degree relative with hyperplastic polyposis, or; (3) greater than 20 hyperplastic polyps of any size distributed throughout the colon.

+++ Recommendations for rescreening intervals for adenocarcinoma of the colon and rectum and counseling of risk for cancer that is *other than adenocarcinoma* should be made by the Medical Case Manager (examples include squamous cell carcinoma of rectum/anus, carcinoid, cloacogenic carcinoma)

^^ “High grade dysplasia” includes severe dysplasia, carcinoma in situ, and intramucosal carcinoma.

@ First degree relative is a mother, father, sister, brother, or child of the person.

&& In some cases when only the rectum and sigmoid need examination, a sigmoidoscopy is sufficient for screening.

@@ Women with ovarian or endometrial cancer diagnosed at age 50 or older should be considered average risk for screening unless they have other risk factors

**Attachment 2. Summary of Eligibility for CRC Screening in the
CDC Colorectal Cancer Control Program
April 2010**

Character-istic	Eligible for Colonoscopy (Screening or Surveillance)	Ineligible for Program
Residence	Baltimore City resident <ul style="list-style-type: none"> ▪ Verbal report to verify residence 	Residence address outside of Baltimore City
Income	Household income \leq 250% of the Federal Poverty Guideline (FPG) <ul style="list-style-type: none"> • Verbal report to verify income 	Household income >250% of the FPG
Insurance Status	<ul style="list-style-type: none"> • Uninsured • Medicare part A only • Insured but no coverage for CRC screening procedures 	<ul style="list-style-type: none"> • Medicare parts A&B • Medical Assistance • Insured with coverage for CRC screening (program cannot pay co-pays or deductibles. Even if client meets income criteria and does not have money to pay co-pay or deductible, the client is not eligible.)
Age and Risk Factors	<p>50—64 years and at average risk of CRC Average risk is defined as:</p> <ul style="list-style-type: none"> • no personal or family history of CRC or adenomas; and • no personal history of Inflammatory Bowel Disease (IBD), FAP or HNPCC, endometrial or ovarian cancer <p>18—64 years if increased risk of CRC due to the following:*</p> <ul style="list-style-type: none"> • personal history of colorectal adenomas or polyps of unknown type • personal history of CRC previously diagnosed <i>outside</i> of the program who are asymptomatic and have had curative treatment • CRC diagnosed within the program • personal history of ovarian or endometrial cancer • family history of first degree relative with CRC, adenomas or polyps of unknown type <p>65+ years with DHMH approval</p> <p><i>*See Attachment 1 for age to begin screening in those at increased risk</i></p>	<ul style="list-style-type: none"> • <18 years old • IBD (ulcerative colitis or Crohn’s disease)** • Personal history of Familial Adenomatous Polyposis (FAP) or Hereditary non-polyposis colorectal cancer (HNPCC) • Family history of FAP or HNPCC in first degree relative • 18-49 with history of hyperplastic polyps • 65+ years unless approved by DHMH <p>** people with non-specific “colitis” may be eligible if confirmed that they have not had IBD</p>
Health Status and Advanced Age	<ul style="list-style-type: none"> • Healthy people • People with co-morbid medical conditions (for example, severe heart or lung disease) and people of “advanced age” <i>if cleared by medical provider for colonoscopy</i> 	<ul style="list-style-type: none"> • People whose medical provider doesn’t clear for screening colonoscopy because of co-morbid conditions or advanced age • Co-morbid conditions that require procedures that are beyond the capability of the program to gain clearance for colonoscopy (for example, cardiac treadmill test; pulmonary function tests, extensive blood work, etc.)

Character-istic	Eligible for Colonoscopy (Screening or Surveillance)	Ineligible for Program
Symptom s/ Signs	<ul style="list-style-type: none"> Signs and symptoms NOT listed in column to the right as Ineligible for the program exclusions; signs and symptoms <i>if cleared by medical provider for colonoscopy</i> as NOT being suggestive of CRC 	<p>Anyone with the following:</p> <ul style="list-style-type: none"> Rectal bleeding, bloody diarrhea, or blood in the stool within the past 6 months (bleeding that is known or suspected to be due to hemorrhoids after clinical evaluation would not prevent a client from receiving CRC screening services); Prolonged change in bowel habits (e.g., diarrhea or constipation for more than two weeks that has not been clinically evaluated); Persistent abdominal pain; Symptoms of bowel obstruction (e.g., abdominal distension, nausea, vomiting, severe constipation); Significant unintentional weight loss of 10% or more of starting body weight; or Mass in the abdomen or rectum on physical exam.
Past screening	<p>Provided the client meets the above residency, income, insurance, risk history, health, and symptom eligibility criteria, the person shall be eligible for colonoscopy if s/he:</p> <ul style="list-style-type: none"> Was never screened for CRC in past; Is at average risk and had: <ul style="list-style-type: none"> Colonoscopy in past with no CRC or adenomas found <i>and it has been at least 10 years</i> since last colonoscopy; Flexible sigmoidoscopy or double contrast barium enema (DCBE) negative for polyps or CRC <i>at least 5 years</i> ago; Negative FOBT <i>at least 1 year</i> ago and no colonoscopy, flexible sigmoidoscopy, or DCBE that would exclude the person; Is at increased risk and needs screening or surveillance colonoscopy: <ul style="list-style-type: none"> Family history of CRC or adenoma(s) (see Attachment 1 for age and interval). Personal history of colonoscopy in past with finding of adenoma(s) or unknown type of polyps, now in need of repeat colonoscopy (See Attachment 1 for eligible interval). Was screened with <i>inadequate colonoscopy</i> within the Program 	<ul style="list-style-type: none"> Past positive flexible sigmoidoscopy or DCBE now needing diagnostic testing <i>Up to date screening</i> with either colonoscopy, FOBT plus flexible sigmoidoscopy, sigmoidoscopy or DCBE according to the Program Guidelines—See Attachment 1: <ul style="list-style-type: none"> Negative FOBT in past year flexible sigmoidoscopy or DCBE within past 5 years; Colonoscopy with colonoscopy recall date (per Program Guidelines--See Attachment 1) <i>later</i> than the date of proposed screening/surveillance in the City program Recent positive FOBT