COMPUTED TOMOGRAPHIC COLONOGRAPHY

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INSTRUCTIONS FOR USE

This Medical Management Guideline provides assistance in interpreting UnitedHealthcare benefit plans. When deciding coverage, the member specific benefit plan document must be referenced. The terms of the member specific benefit plan document [e.g., Evidence of Coverage (EOC) and Schedule of Benefits (SOB)] may differ greatly from the standard benefit plan upon which this Medical Management Guideline is based. In the event of a conflict, the member specific benefit plan document supersedes this Medical Management Guideline. All reviewers must first identify member eligibility, any federal or state regulatory requirements, and the member specific benefit plan coverage prior to use of this Medical Management Guideline. Other Policies and Guidelines may apply. UnitedHealthcare reserves the right, in its sole discretion, to modify its Policies and Guidelines as necessary. This Medical Management Guideline is provided for informational purposes. It does not constitute medical advice.

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

Member benefit coverage and limitations may vary based on the member’s benefit plan Health Plan coverage provided by or through UnitedHealthcare of California, UnitedHealthcare Benefits Plan of California, UnitedHealthcare of Oklahoma, Inc., UnitedHealthcare of Oregon, Inc., UnitedHealthcare Benefits of Texas, Inc., or UnitedHealthcare of Washington, Inc.

BENEFIT CONSIDERATIONS

Essential Health Benefits for Individual and Small Group

For plan years beginning on or after January 1, 2014, the Affordable Care Act of 2010 (ACA) requires fully insured non-grandfathered individual and small group plans (inside and outside of Exchanges) to provide coverage for ten categories of Essential Health Benefits ("EHBs"). Large group plans (both self-funded and fully insured), and small group ASO plans, are not subject to the requirement to offer coverage for EHBs. However, if such plans choose to provide coverage for benefits which are deemed EHBs, the ACA requires all dollar limits on those benefits to be removed on all Grandfathered and Non-Grandfathered plans. The determination of which benefits constitute EHBs is made on a state by state basis. As such, when using this guideline, it is important to refer to the member specific benefit plan document to determine benefit coverage.

COVERAGE RATIONALE

Computed tomographic colonography is proven and medically necessary for any of the following:

- As a diagnostic tool for symptomatic patients who are unable to undergo a complete colonoscopy (such as patients with an obstructive tumor and others who may be unable to tolerate the procedure)
- Patients on anticoagulation therapy who cannot safely discontinue treatment and would be at risk of bleeding from a more invasive procedure
• As a screening test for colon cancer

Computed tomographic colonography is unproven and not medically necessary as a diagnostic tool for the following:
• Crohn's disease
• Diverticulitis

There is insufficient evidence to support the use of computed tomographic colonography in the diagnosis of Crohn's disease and diverticulitis. Widespread use of computed tomographic colonography in Crohn's disease is currently not supported due to the potential of false-negative findings. Computed tomographic colonography was compared to conventional colonoscopy in patients with symptomatic diverticular disease. While use of CTC for diverticulitis is more promising, there was only one study available for review involving 50 patients. Further studies are needed to determine the safety and efficacy of computed tomographic colonography as a follow-up diagnostic tool for Crohn's disease or diverticulitis.

APPLICABLE CODES

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this guideline does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

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<th>CPT Code</th>
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<td>74261</td>
<td>Computed tomographic (CT) colonography, diagnostic, including image post processing; without contrast material</td>
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<tr>
<td>74262</td>
<td>Computed tomographic (CT) colonography, diagnostic, including image post processing; with contrast material(s) including non-contrast images, if performed</td>
</tr>
<tr>
<td>74263</td>
<td>Computed tomographic (CT) colonography, screening, including image post processing</td>
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DESCRIPTION OF SERVICES

Colonoscopy is the "gold standard" screening test; however, it is invasive and frequently requires sedation or anesthesia, so screening rates are low.

Computed tomography colonography (CTC), also referred to as virtual colonoscopy, is perceived by some persons to be a less invasive method of colon cancer screening than optical colonoscopy. It has been developed to obtain detailed 2-dimensional (2D) and 3-dimensional (3D) colonoscopic images of the colon and rectum using helical computed tomography (CT). These images are then reconstructed to produce computer-generated 3D images suitable for interpretation by a gastrointestinal radiologist. If suspicious lesions are detected, the patient usually undergoes further testing, including possible biopsy, by conventional colonoscopy. Since CTC is believed by some to be less invasive than conventional colonoscopy and does not require sedation, it may be more acceptable to patients and thereby improve compliance with colorectal cancer (CRC) screening recommendations.

Computed tomographic colonography may not detect lesions <6mm in size which could result in delay in treatment and/or conversion to colonoscopy.

CLINICAL EVIDENCE

**Colorectal Cancer**

In a systematic review and meta-analysis for the US Preventive Services Task Force, Lin, et al. reviewed the effectiveness, diagnostic accuracy, and harms of screening for CRC which included CTC. Based on 7 studies of CTC with bowel preparation (n = 5,328), the per-person sensitivity to detect adenomas ≥10 mm ranged from 67% to 94%, and specificity ranged from 96% to 98%. The per-person sensitivity to detect adenomas 6 mm and larger ranged from 73% to 98%, and specificity ranged from 89% to 91%. Two studies (N = 1,169) evaluated CTC without bowel preparation. Although the data were limited, the sensitivity of CTC without bowel preparation to detect adenomas 6 mm and larger appeared to be lower than the sensitivity of CTC protocols including bowel preparation. Evidence suggested little to no risk of serious adverse events, including perforation, from CTC based on 11 prospective studies (n = 10,272) performed in screening populations. The authors concluded that multiple screening tests, including CTC, have differing levels of evidence to support their use in CRC screening, ability to detect CRC and
precursor lesions, and risk of serious adverse events in average-risk adults. They make no endorsement regarding a preferred screening modality (2016).

Pickhardt et al. (2011) performed a systematic review and meta-analysis of studies assessing the sensitivity of CTC and optical colonoscopy (OC) for detecting CRC. Forty-nine studies provided data on 11,151 patients. The sensitivity of CTC was 96.1%. The sensitivity of OC, derived from a subset of 25 studies including 9223 patients, was 94.7%. No heterogeneity (bias across studies) was observed with CTC, whereas a moderate degree of heterogeneity was found with OC. The authors concluded that CTC is highly sensitive for CRC, especially when both cathartic and tagging agents are combined in the bowel preparation.

A meta-analysis by Chaparro et al. (2009) evaluated the diagnostic accuracy of CTC for the detection of polyps and colorectal tumors in 47 studies (10,546 patients) that compared CTC to the reference standard of conventional colonoscopy (CC). Overall per-poly-poly sensitivity of CTC was 59% (56–61%), for polyps 6–9 mm in size and 76% (73–79%) for polyps larger than 9 mm. Overall CTC specificity was 83%. The authors concluded that CTC is highly specific for the detection of colorectal polyps and tumors larger than 10 mm in size. However, growths of this size would require CC or surgery for removal.

Stoop et al. (2012) reported on a population-based randomized trial that compared the participation and diagnostic yield of colonoscopy and non-cathartic CTC in average-risk individuals (n=2,258) in a population-based program of CRC screening. Subjects were randomly allocated (2:1) to primary screening for CRC by colonoscopy or by CTC. Based on the study results, the authors concluded that participation in CRC with CTC was significantly better than with colonoscopy, but colonoscopy identified significantly more advanced neoplasia per 100 participants than CTC. The diagnostic yield for advanced neoplasia per 100 subjects was similar for both strategies, which appears to indicate that both techniques can be used for population-based screening for CRC. The authors also noted that cost-effectiveness and perceived burden should be taken into account.

A prospective study by Graser et al. (2008) compared the performance characteristics of 5 different screening tests for the detection of advanced colon cancer. The tests included CTC, colonoscopy, flexible sigmoidoscopy, fecal immunochemical stool testing (FIT) (n= 285) and fecal occult blood testing (FOBT) (n=276). Participants completing the study totaled 307. Each participant collected stool samples for FOBT and FIT prior to endoscopy. After CTC, patients had a colonoscopy and flexible sigmoidoscopy. Lesions were rated as positive if they were detected by both CTC and colonoscopy. Lesions were also considered positive if the lesion was within the same size category or if there was a deviation of no more than one size category. Only polyps detected in the rectum and sigmoid colon were included for analysis of flexible sigmoidoscopy. A total of 221 adenomas were detected in patients receiving CTC and colonoscopy. The sensitivities for adenomas of all sizes was much higher for colonoscopy, with 212 of 221 (95.9%) lesions detected compared with 155 adenomas (70.1%) detected by CTC. In contrast, CTC detected 31 of 33 (93.9%) lesions in the large adenoma group and 43 of 46 (93.5%) lesions in the advanced colon cancer group. Compared with colonoscopy, the sensitivity was 100% and 97.8% respectively. In contrast, for adenomas ≥10 mm, sigmoidoscopy identified 68%, FIT identified 33.3% and FOBT identified 23.8%. The authors concluded that CTC performs equally as well as colonoscopy in detecting advanced adenomas.

Kim et al. (2007) compared primary CTC in 3120 consecutive adults to primary optical colonoscopy (OC) screening in 3163 consecutive adults. The main outcome measures included detection of advanced neoplasia (advanced adenomas and carcinomas) and total number of harvested polyps. Primary CTC and OC screening resulted in similar detection rates for advanced neoplasia (3.2% for CTC and 3.4% for OC), although the numbers of polypectomies (561 CTC vs. 2434 OC) and complications were considerably smaller in the CTC group (7 colonic perforations/ OC group vs. zero CTC group). The authors therefore concluded that these findings support the use of CTC as a primary screening test before therapeutic OC.

Regge et al. (2009) conducted a multicenter, cross-sectional study to assess the accuracy of CTC in detecting advanced CRC. There were 937 asymptomatic patients who were at increased risk of CRC. Each patient underwent both CTC followed by colonoscopy on the same day. Sensitivity and specificity of CTC in detecting advanced neoplasia (for example, advanced adenoma or CRC) ≥6 mm was the main outcome measurement. CTC identified 151 of 177 participants with advanced neoplasia 6 mm or larger (sensitivity 85.3%). CTC correctly classified results as negative for 667 of 760 participants without these lesions (specificity 87.8%). The positive and negative predictive values were 61.9% and 96.3% respectively. The authors concluded that CTC had a negative predictive value of 96.3% compared with colonoscopy and is potentially as effective as colonoscopy for screening persons at increased risk.

The United States Preventive Services Task Force (USPSTF) stated that it found "convincing evidence that screening for CRC in adults aged 50 - 75 years reduces CRC mortality." It noted, however, a lack of head-to-head studies demonstrating that any of the screening strategies are more effective than others and that the screening tests have varying levels of evidence supporting their effectiveness, as well as different strengths and limitations. In particular, USPSTF noted that there is "a growing body of evidence on the test performance characteristics of CT colonography"
but there is a lack of evidence regarding potential harms, particularly in regard to incidental findings. It called for more consistent and complete reporting, in studies with longer-term follow-up, of the downstream consequences of initial detection, subsequent workup, and definitive treatment of extracolonic findings for better understanding of the net benefit associated with this screening approach (2016).

The U.S. Multi-Society Task Force of Colorectal Cancer (MSTF), which represents the American College of Gastroenterology, the American Gastroenterological Association, and The American Society for Gastrointestinal Endoscopy, recommends that clinicians offer CRC screening beginning at age 50 with adjustments recommended based on race and family history. They also rank CRC screening tests in 3 tiers based on performance features, costs, and practical considerations. While colonoscopy is the preferred method, the MSTF suggests clinicians explore other screening options using this approach (Rex et al., 2017):

- Tier 1: Colonoscopy every 10 years and annual fecal immunochemical test (FIT).
- Tier 2: CT colonography every 5 years, FIT–fecal DNA test every 3 years, and flexible sigmoidoscopy every 5 to 10 years.
- Tier 3: Capsule colonoscopy every 5 years

In its 2017 Colorectal Cancer Screening guidelines, the National Comprehensive Cancer Network (NCCN) stated the following:
- CT is evolving as a promising technique and is considered a primary CRC screening modality.
- Available data indicate that CTC may be useful for the detection of larger polyps.
- Data on optimal frequency, polyp size leading to referral for colonoscopy, and protocol for evaluating extra-colonic lesions are evolving.
- The American College of Radiology has recommended that the reporting of polyps < 5mm in size is not necessary. However, if polyps of this size are reported, the decision to refer for colonoscopy with polypectomy versus surveillance colonoscopy should be individualized.

Other Intestinal Disorders

**Crohn’s Disease**

Ichikawa, et al. retrospectively examined the performance of CTC for noncolorectal cancerous conditions. A total of 47 examinations were performed on 44 patients with the following illnesses/conditions: impossible or incomplete colonoscopy (n=15), 7 diverticular disease (7), noncolorectal malignancy (6), Crohn’s disease (6), suspected submucosal tumor on colonoscopy (4), ischemic colitis (2), various other diseases (4). Colonic findings were diagnosed on CTC in 36 examinations, and extracolonic findings were identified in 35 of 44 patients. In all, 17 patients had undergone colonoscopy previously, 9 (52.9%) of whom did not require further colonoscopy per CTC. Five patients underwent colonoscopy after CTC. The authors concluded that CTC examinations could be performed safely. Unlike colonoscopy or CT without preparation, CTC revealed colonic and extracolonic findings and may reduce the indication of colonoscopy in patients with noncolorectal cancerous conditions (2011).

In a comparative study of 16 patients by Biancone et al. (2003), the findings from virtual colonoscopy (VC) were compared to CC for assessing postoperative recurrence of Crohn’s disease. CC showed perianastomotic recurrence in 15 of 16 patients while VC detected 11 of the 15 patients. CC identified stenosis in 8 of the 16 while VC detected stenosis in 7 of the 16 patients; therefore, there was a false-negative reading in 1 of the 16 patients. The authors therefore concluded that although the widespread use of VC in Crohn’s disease is currently not indicated because of possible false-negative findings, this technique may represent an alternative to CC in noncompliant postsurgical patients with a rigid stenosis not allowing passage of the endoscope.

**Diverticulitis**

In a prospective study by Hjern et al. (2007), 50 patients diagnosed with diverticulitis were assessed to determine whether CTC is a viable alternative to colonoscopy. Participants underwent CTC immediately followed by CC. The results were blinded to the examiners. Diverticular disease was found in 48 of the 50 (96%) patients utilizing CTC and in 45 of 50 (90%) patients with CC. These results indicate that CTC can provide at least the same level of accuracy as CC. The authors concluded that CTC appears to have a better diagnostic potential for imaging of diverticular disease-specific findings when compared with colonoscopy, and is a reasonable alternative in follow-up of patients with symptomatic diverticular disease. The study design, however, did require that the CTC be completed prior to CC which may have introduced a biased response favoring CTC. In addition, residual gas from CTC may have contributed to greater discomfort during the subsequent colonoscopy. Further studies are needed to determine the efficacy of CTC as a follow-up diagnostic tool for diverticulitis.

A study conducted by Obana et al. (2013), enrolled a total of 52 patients with the aim of evaluating the ability of contrast-enhanced computed tomography (CE-CT) in the detection of colonic diverticular bleeding (CDB). Patients were enrolled based on their ability to undergo both a CE-CT and a total colonoscopy. The patients were also known to have hematochezia and were clinically suspected of CDB. The detection rate for CE-CT was only 15.4%. The detection
rate for the total colonoscopy was 38.5%. Based on the results this study concluded that though CE-CT may play a complementary role to colonoscopy in patients with suspected CDB it is not recommended for all cases due to the low detection rate demonstrated during the course of the study. Optical colonoscopy still remains the primary recommended screening tool.

With colonoscopy being the standard, Chabok et al. (2013) conducted a prospective comparative study assessing CTC in the follow-up of diverticulitis, evaluating patient acceptance and diagnostic accuracy for diverticular disease, adenomas and cancer in 108 individuals. Half received colonoscopy first, followed immediately by CTC. The other half had the examinations in the reverse order, with results blinded to the examiners. The success rate was 91% and 86% for colonoscopy and CTC, respectively. Examination time was equal for both methods. While 83% of the participants received sedation during colonoscopy, they experienced colonoscopy as more painful and uncomfortable. Diverticulosis and polyps were detected in 94% and 20% with colonoscopy and in 94% and 29% with CTC, respectively. Sensitivity and specificity for CTC in the detection of diverticulosis was 99% and 67%, with a good agreement. Regarding detection of polyps, the sensitivity and specificity were 47% and 75%, respectively. The authors concluded that CTC was less painful and unpleasant and can be used for colonic investigation in the follow-up of diverticulitis. It is considered a viable alternative, especially in cases of incomplete colonoscopy or in a situation with limited colonoscopy resources.

**Ulcerative Colitis**

Prabhakar et al. (2015) performed a study comparing the findings of CTC to CC in patients with ulcerative colitis (UC). Participants (n=20) with known UC per biopsy and in clinical remission underwent CTC and CC within 1 week of each test. The results were blinded to the examiners. Sensitivity and specificity on CTC for detecting granular appearance were 81.0% and 73.8%, respectively; and for pseudopolyps were 82.1% and 84.5%, respectively. Loss of haustral folds, wall thickening, pericolonic vascularity, and pericolonic lymph nodes seen on CTC were found to correlate with intraluminal findings seen on CC. Participants preferred CTC over CC. The authors concluded that CTC can be used as an alternative to CC for evaluating patients with UC who are in remission.

In its 2013 guidelines addressing colonoscopic surveillance for prevention of CRC in individuals with ulcerative colitis, Crohn’s disease or adenomas, the National Institute for Health and Clinical Excellence (NICE) stated the following:

- Consider CTC as a single examination if colonoscopy is not clinically appropriate (e.g., because of comorbidity or because colonoscopy cannot be tolerated).
- Consider double contrast barium enema as a single examination if CTC is not available or not appropriate.
- Consider CTC or double contrast barium enema for ongoing surveillance if colonoscopy remains clinically inappropriate, with a discussion of the risks and benefits.

**Professional Societies**

**American College of Radiology (ACR)**

The 2014 revision of the ACR Practice Parameters for the Performance of Computed Tomography (CT) Colonography in Adults lists the following indications and contraindications for a CTC examination which include, but are not limited to:

**Indications**

- Screening examination in individuals who are at average or moderate risk for developing colorectal carcinoma. Screening of individuals who are at moderate risk for colorectal cancer may be managed individually based on clinical context or local practice patterns.
- Surveillance examination in patients with a history of previous colonic neoplasm, depending on the appropriate clinical context
- Diagnostic examination in symptomatic patients, particularly in the setting of incomplete colonoscopy, including, but not limited to, those with the following:
  - Abdominal pain
  - Diarrhea
  - Constipation
  - Gastrointestinal bleeding
  - Anemia
  - Intestinal obstruction
  - Weight loss
- Following incomplete screening, surveillance, or diagnostic colonoscopy and for characterization of colorectal lesions indeterminate on optical colonoscopy
- Patients who may be at increased risk for complications during optical colonoscopy (e.g., advanced age, anticoagulant therapy, sedation risk, prior incomplete colonoscopy)
- Follow-up of patients with a colonic stoma or after colectomy. Intubation of the stoma should be performed with caution to avoid colonic injury or perforation.
- Prior to laparoscopic surgery for colorectal cancer in order to accurately localize the tumor or search for synchronous lesions
Contraindications

- The relative contraindications or conditions that require caution in performing a CTC examination include, but are not limited to, the following:
  - Symptomatic acute colitis
  - Acute diarrhea
  - Recent acute diverticulitis
  - Recent colorectal surgery
  - Symptomatic colon-containing abdominal wall hernia
  - Recent deep endoscopic biopsy or polypectomy/mucosectomy
  - Known or suspected colonic perforation
  - Symptomatic or high-grade small bowel obstruction

- CTC is not indicated for the following:
  - Routine follow-up of inflammatory bowel disease
  - Hereditary polyposis or nonpolyposis cancer syndromes
  - Evaluation of anal canal disease
  - The pregnant or potentially pregnant patient (Refer to the ACR–SPR Practice Parameter for Imaging Pregnant or Potentially Pregnant Adolescents and Women with Ionizing Radiation.)

American Cancer Society (ACS)

The ACS – colorectal cancer (CRC) guidelines (published in collaboration with the US Multi-Society Task Force and the American College of Radiology) recommend CRC screening of average-risk adults beginning at age 50 years. CTC is an acceptable screening test which is recommended every 5 years if the initial CTC is negative for significant polyps. However, if current studies detect polyps larger than 5 mm, the patient should be referred for colonoscopy. Additionally, CTC surveillance could be offered to those patients who would benefit from screening but either decline colonoscopy or who are not good candidates for colonoscopy for one or more reasons. If colonoscopy is contraindicated because the patient is not likely to benefit from screening due to life-limiting comorbidity, then neither CTC nor any other CRC screening test would be appropriate (2014).

U.S. FOOD AND DRUG ADMINISTRATION (FDA)

Helical CT scanners are regulated by the FDA as Class II devices, and numerous systems have met all requirements of the 510(k) approval process. The complete list of commercially available helical CT scanners is too extensive for inclusion here; however, major manufacturers of devices used in the studies selected for detailed review include Siemens Medical Solutions, General Electric Medical Systems, and Philips Medical Systems.


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GUIDELINE HISTORY/REVISION INFORMATION

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<td>Updated supporting information to reflect the most current clinical evidence and references; no change to coverage rationale or list of applicable codes</td>
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