BlueCross BlueShield Federal Employee Program.

FEP Medical Policy Manual

FEP 2.04.29 Analysis of Human DNA or RNA in Stool Samples as a Technique for Colorectal Cancer Screening

Annual Effective Policy Date: April 1, 2026

Original Policy Date: March 2015

Related Policies:

2.04.150 - Serologic Genetic and Molecular Screening for Colorectal Cancer
2.04.29 - Analysis of Human DNA or RNA in Stool Samples as a Technique for Colorectal Cancer Screening
6.01.32 - Virtual Colonoscopy/Computed Tomography Colonography

Analysis of Human DNA or RNA in Stool Samples as a Technique for Colorectal Cancer Screening

Description

Description

Detection of DNA or RNA abnormalities associated with colorectal cancer (CRC) in stool samples has been proposed as a screening test for CRC. This technology is another potential alternative to currently available screening approaches, such as fecal occult blood testing, fecal immunochemical testing (FIT), and colonoscopy. The currently available stool tests combine FIT and DNA or RNA analysis and are referred to as FIT-DNA or FIT-RNA in this review, though other publications use terms such as stool DNA (sDNA)-FIT, multitarget stool DNA (mt-sDNA) or multitarget stool RNA (mt-sRNA) test.

OBJECTIVE

The objective of this evidence review is to evaluate whether testing of stool DNA or RNA improves the net health outcome for asymptomatic individuals at average risk of CRC who are undergoing routine CRC screening.

POLICY STATEMENT

DNA or RNA analysis of stool samples can be considered **medically necessary** as a screening technique for colorectal cancer in individuals at average risk of colorectal cancer who have not been screened by another colorectal cancer screening method within the last year.

Combination testing of DNA or RNA analysis of stool samples with other methods of colorectal cancer screening within a year is **investigational.**

DNA or RNA analysis of stool samples is considered **investigational** for all other indications.

POLICY GUIDELINES

None

BENEFIT APPLICATION

Experimental or investigational procedures, treatments, drugs, or devices are not covered (See General Exclusion Section of brochure).

Benefit or contractual restrictions regarding preventive medicine may apply when testing is performed as part of a screening test. Some Plans may have contract language that incorporates concepts of cost-effectiveness or "least costly alternative" which might limit use of FIT-DNA or FIT-RNA screening tests.

FDA REGULATORY STATUS

Table 1. FDA Approved Colorectal Cancer Screening Tests Evaluating DNA or RNA in Stool Samples

Device	Manufacturer	Original Date Approved	Pivotal study	Original PMA number	PAS identifier(s)	Indication(s)
Cologuard™	Exact Sciences Corporation	Aug 2014	NCT01260168	P130017	P130017 S029/ PAS001; clinicaltrials.gov registry not listed	'intended for the qualitative detection of colorectal neoplasia associated DNA markers and for the presence of occult hemoglobin in human stool. A positive result may indicate the presence of colorectal cancer (CRC) or advanced adenoma (AA) and should be followed by diagnostic colonoscopy. Cologuard is indicated to screen adults of either sex, 45 years or older, who are at typical average-risk for CRC. Cologuard is not a replacement for diagnostic colonoscopy or surveillance colonoscopy in high risk individuals.'
Cologuard Plus™	Exact Sciences Corporation	Oct 2024	NCT04144738	P230043	NA	'intended for the detection of colorectal neoplasia-associated DNA markers and for the presence of occult hemoglobin in human stool. The Cologuard Plus test is performed on samples collected using the Cologuard Plus Collection Kit. A positive result may indicate the presence of colorectal cancer (CRC) or advanced precancerous lesions (APL)

						and should be followed by colonoscopy. The Cologuard Plus test is indicated to screen adults 45 years or older, who are at average risk for CRC. The Cologuard Plus test is not a replacement for diagnostic colonoscopy or surveillance colonoscopy in high-risk individuals.'
Colosense	Geneoscopy, Inc	May 2024	NCT04739722	P230001	P230001 / PAS001; NCT04739722	'intended for the detection of colorectal neoplasia associated RNA markers and for the presence of occult hemoglobin in human stool. ColoSense is for use with the ColoSense Collection Kit, the ColoSense Test Kit, the ColoSense Software, and the following instruments: Polymedco Immunochemical Fecal Occult Blood Test (iFOBT) Analyzer; bioMerieux EMAG Nucleic Acid Extraction System; and Bio-Rad QXDx Droplet Digital Polymerase Chain Reaction (ddPCR) System. ColoSense is a single-site test performed at Geneoscopy, Inc. A positive ColoSense result may indicate the presence of colorectal cancer (CRC), advanced adenomas (AA) or serrated precancerous lesions (SPL) and should be followed by a colonoscopy. ColoSense is indicated as a screening test for adults, 45 years of age or older, who are at average-risk for developing CRC. ColoSense is not a replacement for diagnostic colonoscopy or surveillance colonoscopy in high-risk individuals.

PMA: Premarket Approval; PAS: Post-approval Study

RATIONALE

Summary of Evidence

For individuals who are asymptomatic and at average risk of colorectal cancer (CRC) who receive fecal immunochemical testing (FIT)-DNA, the evidence includes screening studies comparing the original and next-generation version of the FIT-DNA (using colonoscopy as the reference standard) to FIT alone, 3 systematic reviews of screening studies, and modeling studies. Relevant outcomes are overall survival and disease-specific survival. The screening studies have reported that both the original and the next-generation FIT-DNA tests have higher sensitivity and lower specificity than FIT. There are no studies directly assessing health outcomes such as overall survival or disease-specific survival. The screening interval for the test has not been confirmed nor is there evidence on the adherence of the test at a recommended screening interval. Effective screening for CRC requires a screening program with established screening intervals and appropriate follow-up for positive tests. Clinical utility of FIT-DNA is based on modeling studies. These studies have demonstrated that the diagnostic characteristics of FIT-DNA are consistent with decreases in CRC mortality that are in the range of other accepted modalities. FIT-DNA every 3 years is less effective than most other accepted screening strategies, while FIT-DNA every year is close to the efficacy of colonoscopy every 10 years. The evidence is sufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who are asymptomatic and at average risk of colorectal cancer (CRC) who receive fecal immunochemical testing (FIT)-RNA, the evidence includes a screening study comparing the FIT-RNA (using colonoscopy as the reference standard) to FIT alone. Relevant outcomes are overall survival and disease-specific survival. The screening study reported that the FIT-RNA test has higher sensitivity and lower specificity than FIT. There are no studies directly assessing health outcomes such as overall survival or disease-specific survival. The screening interval for the test has not been confirmed nor is there evidence on the adherence of the test at a recommended screening interval. Effective screening for CRC requires a screening program with established screening intervals and appropriate follow-up for positive tests. Clinical utility of FIT-RNA is based on the similar performance characteristics of FIT-RNA compared to FIT-DNA so that FIT-DNA modeling studies are also of relevance for FIT-RNA. The evidence is sufficient to determine that the technology results in an improvement in the net health outcome.

SUPPLEMENTAL INFORMATION

Practice Guidelines and Position Statements

Guidelines or position statements will be considered for inclusion in 'Supplemental Information' if they were issued by, or jointly by, a US professional society, an international society with US representation, or National Institute for Health and Care Excellence (NICE). Priority will be given to guidelines that are informed by a systematic review, include strength of evidence ratings, and include a description of management of conflict of interest.

American Cancer Society

In 2018, the American Cancer Society updated its guidelines for CRC screening for average-risk adults.[31,] Regular screening with either a structural examination (ie, colonoscopy) or a high-sensitivity stool-based test is recommended to start in adults who are age 45 years and older (qualified recommendation) or who are age 50 years and older (strong recommendation). Recommendations for screening with stool-based tests include FIT repeated every year, high-sensitivity guaiac-based fecal occult blood test repeated every year, or multitarget stool DNA test repeated every 3 years.

American College of Physicians

In 2023, the American College of Physicians (ACP) released updated guidance on screening for CRC in asymptomatic, average-risk adults.[32,] The ACP stated that "Clinicians should not use stool DNA, computed tomography colonography, capsule endoscopy, urine, or serum screening tests for colorectal cancer". A guidance statement of approved tests is as follows: "Clinicians should select among a fecal immunochemical or high-sensitivity guaiac fecal occult blood test every 2 years, colonoscopy every 10 years, or flexible sigmoidoscopy every 10 years plus a fecal immunochemical test every 2 years as a screening test for colorectal cancer".

American Gastroenterological Association

In 2022, the AGA published a clinical practice update commentary that reviewed the evidence on noninvasive CRC screening options.[33,] Similar to the U.S. Multi-Society task force, the ACG recommends FIT-DNA every 3 years as an average-risk option for CRC screening. The commentary compares this recommendation to that of the U.S. Preventive Services Task Force (USPSTF), which recommends FIT-DNA every 1 to 3 years.

In 2023, the AGA published a clinical practice update reviewing risk stratification for CRC screening and post-polypectomy surveillance.[34,] Similar to other guidelines, the following best practice advice was provided: "Screening options for individuals at average risk for CRC should include colonoscopy, fecal immunochemical test (FIT), flexible sigmoidoscopy plus FIT, multitarget stool DNA test, and computed tomography colonography, based on availability and individual preference."

Multi-Society Task Force on Colorectal Cancer

A U.S. Multi-Society task force representing the American College of Gastroenterology, the American Gastroenterological Association (AGA), and the American Society for Gastrointestinal Endoscopy (2017) provided recommendations for CRC screening.[35,] The recommended first-tier tests for individuals with average risk were colonoscopy every 10 years, and for individuals who decline colonoscopy, annual FIT. Recommended second-tier tests in patients who declined the first-tier tests were computed tomography colonography every 5 years, FIT-DNA every 3 years, or flexible sigmoidoscopy every 5 to 10 years. Capsule colonoscopy was listed as a third-tier test. The task force recommended, "[computed tomography] colonography every 5 years or FIT-fecal DNA every 3 years (strong recommendation, low-quality evidence), or flexible sigmoidoscopy every 5 to 10 years (strong recommendation, high-quality evidence) in patients who refuse colonoscopy and FIT." In 2022, a focused update to the 2017 CRC screening recommendations from the task force was published that addressed the age to begin and stop CRC screening in average-risk individuals.[36,] The task force now suggests CRC screening in average-risk individuals aged 45 to 49 years. Unchanged from 2017 are the following recommendations: a) offer CRC screening to all average-risk individuals aged 50 to 75 years, b) consider starting or continuing screening for individuals aged 76 to 85 years on an individualized basis (depending on patient and disease factors), and c) screening is not recommended after age 85 years.

National Comprehensive Cancer Network

The National Comprehensive Cancer Network (NCCN) guideline (v.2.2025) for colorectal cancer (CRC) screening includes the use of fecal immunochemical testing (FIT)-DNA and FIT-RNA-based testing to screen patients with an average risk for colon cancer.[6,] Following a negative test, the recommendation is to rescreen with any modality in 3 years. Use of FIT-DNA and FIT-RNA-based testing is not described for the screening of high-risk individuals. Follow-up colonoscopy is recommended within 9 months after a positive test.

U.S. Preventive Services Task Force Recommendations

In 2021, the U.S. Preventive Services Task Force published updated recommendations for CRC screening in asymptomatic, average risk adults (defined as no prior diagnosis of CRC, adenomatous polyps, or inflammatory bowel disease; no personal diagnosis or family history of known genetic disorders that predispose them to a high lifetime risk of CRC [such as Lynch syndrome or familial adenomatous polyposis]).[1,] The USPSTF recommended universal screening for average-risk adults aged 45 to 49 years (B recommendation) and for adults aged 50 to 75 years (A recommendation). For adults aged 76 to 85 years, the USPSTF recommends selective screening due to the small magnitude of net benefit (C Recommendation). The USPSTF reviewed evidence for 6 screening strategies, including FIT-DNA. They do not recommend one screening strategy over another, and noted the lack of direct evidence on clinical outcomes when comparing screening strategies. Clinical considerations noted for FIT-DNA testing appear in Table 2.

Table 2. U.S. Preventative Services Task Force Considerations for Fecal Immunochemical-DNA Testing

Recommended screening interval	Efficacy	Other considerations
1 to 3 years	• Improved sensitivity compared with FIT per 1-time application of screening test • Specificity is lower than that of FIT, resulting in more false-positive results, more follow-up colonoscopies, and more associated adverse events per FIT-DNA screening test compared with per FIT test • Modeling suggests that screening every 3 years does not provide a favorable balance of benefits and harms compared with other stool-based screening options (annual FIT or FIT-DNA every 1 or 2 years) • Insufficient evidence about appropriate longitudinal follow-up of abnormal findings after a negative follow-up colonoscopy • No direct evidence evaluating the effect of FIT-DNA on colorectal cancer mortality	• Harms from screening with FIT-DNA arise from colonoscopy to follow-up abnormal FIT-DNA results • Can be done with a single stool sample but involves collecting an entire bowel movement • Requires good adherence over multiple rounds of testing • Does not require bowel preparation, anesthesia or sedation, or transportation to and from the screening examination (test is performed at home)

FIT: fecal immunochemical testing.

Medicare National Coverage

In 2014, a Centers for Medicare & Medicaid Services decision memo indicated Medicare Part B will cover the Cologuard test once every 3 years for beneficiaries who meet all of the following criteria:[37,]

"Age 50 to 85 years, and

- Asymptomatic (no signs or symptoms of colorectal disease including but not limited to lower gastrointestinal pain, blood in stool, positive guaiac fecal occult blood test or fecal immunochemical test), and
- At average risk of developing colorectal cancer(no personal history of adenomatous polyps, colorectal cancer, or inflammatory bowel disease, including Crohn"s Disease and ulcerative colitis; no family history of colorectal cancers or adenomatous polyps, familial adenomatous polyposis, or hereditary nonpolyposis colorectal cancer)."

As noted in the Centers for Medicare & Medicaid Services decision memo, the optimal screening interval for Cologuard is unknown. In the interim, Centers for Medicare & Medicaid Services has indicated it will cover Cologuard every 3 years as previously specified and would reevaluate the screening interval after the FDA post-approval study is completed.

REFERENCES

1. Davidson KW, Barry MJ, Mangione CM, et al. Screening for Colorectal Cancer: US Preventive Services Task Force Recommendation Statement. JAMA. May 18 2021; 325(19): 1965-1977. PMID 34003218
2. Shaukat A, Kahi CJ, Burke CA, et al. ACG Clinical Guidelines: Colorectal Cancer Screening 2021. Am J Gastroenterol. Mar 01 2021; 116(3): 458-479. PMID 33657038
3. Food and Drug Administration. SUMMARY OF SAFETY AND EFFECTIVENESS DATA (SSED): Cologuard. August 2014. Accessed Oct 23, 2025.
4. Food and Drug Administration. SUMMARY OF SAFETY AND EFFECTIVENESS DATA (SSED): Cologuard Plus. October 2024. Accessed Oct 22, 2025.
5. Food and Drug Administration. SUMMARY OF SAFETY AND EFFECTIVENESS DATA (SSED): ColoSense. May 2024. Accessed Oct 21, 2025.
6. National Comprehensive Cancer Network (NCCN). NCCN Clinical Practice Guidelines in Oncology: Colorectal Cancer Screening. Version 2.2025. https://www.nccn.org/professionals/physician_gls/pdf/colorectal_screening.pdf. Accessed October 23, 2025.
7. Dolatkhah R, Dastgiri S, Jafarabadi MA, et al. Diagnostic accuracy of multitarget stool DNA testing for colorectal cancer screening: A systematic review and meta-analysis. Gastroenterol Hepatol. Dec 2022; 45(10): 753-766. PMID 35101601
8. Redwood DG, Asay ED, Blake ID, et al. Stool DNA Testing for Screening Detection of Colorectal Neoplasia in Alaska Native People. Mayo Clin Proc. Jan 2016; 91(1): 61-70. PMID 26520415
9. Imperiale TF, Ransohoff DF, Itzkowitz SH, et al. Multitarget stool DNA testing for colorectal-cancer screening. N Engl J Med. Apr 03 2014; 370(14): 1287-97. PMID 24645800
10. Lidgard GP, Domanico MJ, Bruinsma JJ, et al. Clinical performance of an automated stool DNA assay for detection of colorectal neoplasia. Clin Gastroenterol Hepatol. Oct 2013; 11(10): 1313-8. PMID 23639600
11. Ahlquist DA, Taylor WR, Mahoney DW, et al. The stool DNA test is more accurate than the plasma septin 9 test in detecting colorectal neoplasia. Clin Gastroenterol Hepatol. Mar 2012; 10(3): 272-7.e1. PMID 22019796
12. Lin JS, Perdue LA, Henrikson NB, Bean SI, Blasi PR. Screening for Colorectal Cancer: An Evidence Update for the U.S. Preventive Services Task Force. Evidence Synthesis No. 202. AHRQ Publication No. 20-05271-EF-1. Rockville, MD: Agency for Healthcare Research and Quality; 2021.
13. Cooper GS, Markowitz SD, Chen Z, et al. Performance of multitarget stool DNA testing in African American patients. Cancer. Oct 01 2018; 124(19): 3876-3880. PMID 30193399
14. Ebner DW, Johnson HA, Estes C, et al. Multi-Target Stool DNA and the Fecal Immunochemical Test: A Systematic Review and Meta-Analysis on Test Performances. Am J Prev Med. Aug 2025; 69(2): 107654. PMID 40379061
15. Imperiale TF, Porter K, Zella J, et al. Next-Generation Multitarget Stool DNA Test for Colorectal Cancer Screening. N Engl J Med. Mar 14 2024; 390(11): 984-993. PMID 38477986
16. Imperiale TF, Kisiel JB, Itzkowitz SH, et al. Specificity of the Multi-Target Stool DNA Test for Colorectal Cancer Screening in Average-Risk 45-49 Year-Olds: A Cross-Sectional Study. Cancer Prev Res (Phila). Apr 2021; 14(4): 489-496. PMID 33436397
17. Imperiale TF, Lavin PT, Marti TN, et al. Three-Year Interval for the Multi-Target Stool DNA Test for Colorectal Cancer Screening: A Longitudinal Study. Cancer Prev Res (Phila). Feb 06 2023; 16(2): 89-97. PMID 36205504
18. Rao AK, Kalra S, Tran D, et al. The Utility of Multitarget Stool DNA Testing in Community-Based Clinical Practice. Am J Gastroenterol. Apr 08 2025. PMID 40197618
19. Olson JE, Kirsch EJ, Edwards V DK, et al. Colorectal cancer outcomes after screening with the multi-target stool DNA assay: protocol for a large-scale, prospective cohort study (the Voyage study). BMJ Open Gastroenterol. 2020; 7(1): e000353. PMID 32128228
20. Anderson JC, Robinson CM, Hisey WM, et al. Colorectal Neoplasia Detection in Individuals With Positive Multitarget Stool DNA Tests: Data From the New Hampshire Colonoscopy Registry. J Clin Gastroenterol. May-Jun 2022; 56(5): 419-425. PMID 33973962
21. Berger BM, Kisiel JB, Imperiale TF, et al. Low Incidence of Aerodigestive Cancers in Patients With Negative Results From Colonoscopies, Regardless of Findings From Multitarget Stool DNA Tests. Clin Gastroenterol Hepatol. Apr 2020; 18(4): 864-871. PMID 31394289
22. Mark Fendrick A, Borah BJ, Burak Ozbay A, et al. Life-years gained resulting from screening colonoscopy compared with follow-up colonoscopy after a positive stool-based colorectal screening test. Prev Med Rep. Apr 2022; 26: 101701. PMID 35106276
23. Knudsen AB, Rutter CM, Peterse EFP, et al. Colorectal Cancer Screening: An Updated Modeling Study for the US Preventive Services Task Force. JAMA. May 18 2021; 325(19): 1998-2011. PMID 34003219
24. D'Andrea E, Ahnen DJ, Sussman DA, et al. Quantifying the impact of adherence to screening strategies on colorectal cancer incidence and mortality. Cancer Med. Jan 2020; 9(2): 824-836. PMID 31777197
25. Weiser E, Parks PD, Swartz RK, et al. Cross-sectional adherence with the multi-target stool DNA test for colorectal cancer screening: Real-world data from a large cohort of older adults. J Med Screen. Mar 2021; 28(1): 18-24. PMID 32054393
26. Kisiel JB, Eckmann JD, Limburg PJ. Multitarget Stool DNA for Average Risk Colorectal Cancer Screening: Major Achievements and Future Directions. Gastrointest Endosc Clin N Am. Jul 2020; 30(3): 553-568. PMID 32439088
27. Barzi A, Lenz HJ, Quinn DI, et al. Comparative effectiveness of screening strategies for colorectal cancer. Cancer. May 01 2017; 123(9): 1516-1527. PMID 28117881
28. Johnson DH, Kisiel JB, Burger KN, et al. Multitarget stool DNA test: clinical performance and impact on yield and quality of colonoscopy for colorectal cancer screening. Gastrointest Endosc. Mar 2017; 85(3): 657-665.e1. PMID 27884518
29. Berger BM, Schroy PC, Dinh TA. Screening for Colorectal Cancer Using a Multitarget Stool DNA Test: Modeling the Effect of the Intertest Interval on Clinical Effectiveness. Clin Colorectal Cancer. Sep 2016; 15(3): e65-74. PMID 26792032

30. Barnell EK, Wurtzler EM, La Rocca J, et al. Multitarget Stool RNA Test for Colorectal Cancer Screening. JAMA. Nov 14 2023; 330(18): 1760-1768. PMID 37870871
31. Wolf AMD, Fontham ETH, Church TR, et al. Colorectal cancer screening for average-risk adults: 2018 guideline update from the American Cancer Society. CA Cancer J Clin. Jul 2018; 68(4): 250-281. PMID 29846947
32. Qaseem A, Harrod CS, Crandall CJ, et al. Screening for Colorectal Cancer in Asymptomatic Average-Risk Adults: A Guidance Statement From the American College of Physicians (Version 2). Ann Intern Med. Aug 2023; 176(8): 1092-1100. PMID 37523709
33. Burke CA, Lieberman D, Feuerstein JD. AGA Clinical Practice Update on Approach to the Use of Noninvasive Colorectal Cancer Screening Options: Commentary. Gastroenterology. Mar 2022; 162(3): 952-956. PMID 35094786
34. Issaka RB, Chan AT, Gupta S. AGA Clinical Practice Update on Risk Stratification for Colorectal Cancer Screening and Post-Polypectomy Surveillance: Expert Review. Gastroenterology. Nov 2023; 165(5): 1280-1291. PMID 37737817
35. Rex DK, Boland CR, Dominitz JA, et al. Colorectal Cancer Screening: Recommendations for Physicians and Patients From the U.S. Multi-Society Task Force on Colorectal Cancer. Gastroenterology. Jul 2017; 153(1): 307-323. PMID 28600072
36. Patel SG, May FP, Anderson JC, et al. Updates on Age to Start and Stop Colorectal Cancer Screening: Recommendations From the U.S. Multi-Society Task Force on Colorectal Cancer. Gastroenterology. Jan 2022; 162(1): 285-299. PMID 34794816
37. Centers for Medicare and Medicaid Services (CMS). Colorectal Cancer Screening Tests. 2023; https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?ncdid=281&ncdver=7. Accessed October 23, 2025.

POLICY HISTORY - THIS POLICY WAS APPROVED BY THE FEP® PHARMACY AND MEDICAL POLICY COMMITTEE ACCORDING TO THE HISTORY BELOW:

Date	Action	Description
March 2015	New policy	
December 2016	Replace policy	Policy updated with literature review through September 1, 2016: references 5, 7-8, and 13-14. References deleted. Policy statement changed from investigational to medically necessary for average risk patients. DNA analysis of stool samples is considered investigational for all other indications. Policy only applies to FIT-DNA.
March 2018	Replace policy	Policy updated with literature review through September 11, 2017; references 9-10, and 16 added. Policy statements unchanged.
March 2019	Replace policy	Policy updated with literature review through September 6, 2018; reference 17 added; reference 15 updated. Policy statements unchanged.
March 2020	Replace policy	Policy updated with literature review through September 9, 2019; no references added, reference on NCCN updated. Policy statements unchanged.
March 2021	Replace policy	Policy updated with literature review through August 20, 2020; references added. Policy statements unchanged.
March 2022	Replace policy	Policy updated with literature review through September 26, 2021; references added. Policy statements unchanged.
March 2023	Replace policy	Policy updated with literature review through September 22, 2022; references added. Minor editorial refinements to policy statements; intent unchanged.
March 2024	Replace policy	Policy updated with literature review through September 21, 2023; references added. Policy statements unchanged.
March 2025	Replace policy	Policy updated with literature review through September 12, 2024; references added. Cologuard Plus and Colosense added to evidence review and policy statements as medically necessary. Title expanded to include RNA tests.
March 2026	Replace policy	Policy updated with literature review through October 23, 2025; references added. Policy statements unchanged.