Coverage for a

Follow-up Colonoscopy

Summary Guide for Providers and Medical Offices

IMPORTANT COVERAGE CHANGE:

Starting in 2023, Medicare, ACA and commercial plans will now cover, as part of preventive care and screening, a follow-up colonoscopy after a non-invasive stool-based test returns a positive or abnormal result for patients 45 years of age and older.

This change recognizes that a follow-up colonoscopy is a key part of the colorectal screening process, due to the need for visual confirmation of a positive or abnormal result, and means that beneficiaries aged 45 and older will not have out-of-pocket costs for both a non-invasive stooled based test and, if needed, the follow up colonoscopy.

This resource from Fight Colorectal Cancer (Fight CRC) provides information about the critical regulatory change, what it means for providers, and how to code the change correctly.

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aga American Gastroenterological Association

FIGHT COLORECTAL CANCER

VTAAC Vermonters Taking Action Against Cancer

Why did this change occur?

In pursuit of broader focus on cancer incidence and death reduction, the federal government announced a rule change to remove cost sharing for follow-up colonoscopies after positive or abnormal results from a stool-based test, which can have a significant impact that reduces costs for individuals and encourages more people to take charge of their colorectal health.

What does this change mean for providers?

Commercial, federal and state insurance plans that are required to follow U.S. Preventive Services Task Force (USPSTF) guidance are now legally required to provide full coverage for these screening colonoscopies. **Providers can assure patients that if they choose to complete a stool-based testing for colorectal cancer screening, the colonoscopy is fully covered after a positive result.** Some patients may seek their primary healthcare services from providers of specialties outside of gastroenterology, including internal medicine, family medicine, gynecology and more. It is important that ALL PROVIDERS are made aware of these cost-saving changes so that patients are informed on how best to address their colorectal health.

Coding This Change *Correctly*

Due to the passage of the Affordable Care Act (ACA), Medicare and most third-party payers are required to cover services given an "A" or "B" rating by USPSTF without a copay or deductible, but the correct CPT and ICD-10-CM codes must be submitted to trigger coverage at 100% for the patient. Please ensure that you, your fellow providers, and administrative staff are made aware of these changes.

COMMERCIAL & MEDICAID EXPANSION

add *modifier* **33**

MEDICARE

with HCPCS code G0105 or G0121

add *modifier* **KX**

Commercial Plans and Medicaid	Medicare
For commercial and Medicaid patients, **add modifier 33 to each CPT code submitted on the claim**. If modifier 33 is not added, the colonoscopy will not be recognized as a screening service and the patient will be inappropriately billed.	Use modifier KX with HCPCS code G0105 or G0121 for screening colonoscopy for patients following a non-invasive stool based test for patients with Medicare. **If polyps are removed, use the appropriate CPT code with modifier PT. Coinsurance applies when polyps are removed.**

Complex Coding Case?

See the American Gastroenterological Association's (AGA) coding guide for colorectal cancer screening to learn more, including what to do with complex coding cases.

What happens if a patient receives an unexpected bill?

Colonoscopy following a positive stool-based test:	Screening colonoscopy when a polyp was removed:
a. Patient should contact their insurance provider to begin the appeals process. b. Tell them the U.S. Department of Labor (DOL) issued new guidance that health plans and insurers "must cover and may not impose cost sharing with respect to a colonoscopy conducted after a positive non-invasive stool-based screening test" for plan or policy years beginning on or after May 31, 2022. c. See questions 6 (page 9) and 7 (page 12) of the DOL FAQ About Affordable Care Act Implementation.	a. Patient should contact their insurance provider to begin the appeals process. b. Tell them the U.S. Department of Health and Human Services (HHS) issued guidance that "the plan or issuer may not impose cost-sharing with respect to a polyp removal during a colonoscopy performed as a screening procedure." c. See question 5 of the HHS Affordable Care Act Implementation FAQs.

Patients have a right to file a complaint with the State Insurance Commissioner. Patients also have a right to file a complaint at the federal level, with the Department of Health & Human Services, for states without an external review process.

COLORECTAL CANCER Screening *Process*

There are two screening pathways for average risk individuals, depicted below.

All tests in Path B, including the follow-up colonoscopy, should now be covered by Medicare, ACA and commercial plans.

PATH A

- Healthcare provider recommends screening at 45
- The patient picks a colonoscopy
- Patient bowel preparation
  Completed 24H prior to procedure
  - **Polyps found, removed**
    Sent to pathology
    - Cancer Prevented
      Patient returns in 3-5 years
    - Diagnosis Provided
      Treatment begins
  - No Polyps found
    Patient returns in 10 years

PATH B

- Healthcare provider recommends screening at 45
- The patient picks a stool test
  a fecal occult blood test (FOBT), fecal immunochemical test (FIT) or Stool DNA Test (Cologuard)
  - **Positive/Abnormal**
    If it's positive or abnormal, patient is referred to a gastroenterologist for a follow up colonoscopy.
    *A follow up colonoscopy is part of the screening process; this is not a diagnostic procedure.
  - Negative Results
    Patient returns in 1-3 years
- Follow-up Colonoscopy
  The patient picks up their prep. Completed 24H prior to procedure
- Polyps found, removed
  Sent to pathology
  - Cancer Prevented
    Patient returns in 3-5 years
  - Diagnosis Provided
    Treatment begins

"When I turned 50 my doctor recommended a non-invasive colorectal cancer screening test due to my busy lifestyle and inability to miss a day of work. I did the test and it came back positive. The day before my scheduled colonoscopy, I received a call telling me that I had to pay nearly $1,000 before they would perform the test. I almost didn't go in, but thankfully I did because I was diagnosed with stage III colorectal cancer."

— YLA FLORES
Stage III colorectal cancer

Policy **Timeline**

January 2022

DOL, HHS, and Treasury say that ACA compliant commercial plans must fully cover a follow-up colonoscopy after an abnormal or positive result from a non-invasive stool-based screening test as part of preventive health.

Commercial plans and issuers must provide coverage without cost sharing or plan or policy years beginning on or after May 31, 2022. [3]

January 2023 →

These policy changes are now all in effect, meaning the **follow-up colonoscopy must be provided for plan years beginning on or after May 31, 2022** (e.g., January 1, 2023 for calendar year plans). [5]

*Exception: Grandfathered plans

May 2021

USPSTF updated its recommendation for colorectal cancer screening. The USPSTF continues to recommend with an "A" rating screening for colorectal cancer in all adults aged 50 to 75 years and **extended its recommendation with a "B" rating to adults aged 45 to 49 years**.[2]

November 2022

Centers for Medicare & Medicaid Services (CMS) announces that it will start covering colorectal cancer screening beginning at age 45 and now covers as a preventive service a follow-on screening colonoscopy after a non-invasive stool-based test returns a positive result, which means that beneficiaries should not have out-of-pocket costs for either test.[4]

1. https://www.cdc.gov/chronicdisease/programs-impact/pop/colorectal-cancer.htm#:~:text=%2424.3%20BILLION&text=Colorectal%20cancer%20has%20the%20second,of%20all%20cancer%20treatment%20costs.&text=The%20cost%20for%20medical%20services,%240.6%20billion%20for%20prescription%20drugs.
2. https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/colorectal-cancer-screening
3. https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-xxix.pdf
4. https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2023-medicare-physician-fee-schedule-final-rule
5. https://www.healthcare.gov/glossary/grandfathered-health-plan/#:~:text=An%20individual%20health%20insurance%20policy,under%20the%20Affordable%20Care%20Act.

Colorectal Cancer *Facts & Stats*

Promoting colorectal health screening can increase equity and save lives.

1. Colorectal cancer also disproportionately affects communities of color in the U.S.
   * Black Americans are about 20% more likely to get colorectal cancer and about 40% more likely to die from it compared to most groups.
   * Indigenous communities in the U.S have higher incidence of colorectal cancer than their white counterparts.
   * Less than 50% of Asian Americans are up-to-date with colorectal cancer screening.
2. Colorectal cancer is currently the second-leading cause of cancer deaths in the U.S.
3. 1 in 23 men and 1 in 26 women will be diagnosed with colorectal cancer.
4. 1 in 3 people are not up-to-date with colorectal cancer screening even though affordable, take-home testing options exist.
5. The CDC estimates that 68% of deaths from colorectal cancer could be avoided if all eligible people got screened.

Questions?

Please reach out to Fight CRC at Advocacy@FightCRC.org with any questions.

Additional Resources

About Fight CRC

SCAN HERE

Or visit ***FightCRC.org/About***

AGA Coding FAQ

SCAN HERE

Or visit ***FightCRC.org/g/2ZANn0Ee049***

CRC Facts and Stats

SCAN HERE

Or visit ***FightCRC.org/colorectal-cancer/facts-stats***