Welcome!

KCC Billing & Coding Webinar:
Preventive Care Should Be FREE –
What Kentuckians Should Know

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HEALTH LITERACY KENTUCKY

Poll:

- Have you or a family member received a surprise bill for a preventive service that you thought would be free?

- Have you heard from partners, clients, patients, etc. about them receiving a surprise bill for a preventive service that you thought would be free?

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Since 2014, federal law requires most health plans to cover in-network preventive care at no cost to the patient.

A lack of clear rules for providers and insurers has resulted in patients getting stuck paying out-of-pocket costs for care that should be free.

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What Preventive Services Should Be FREE?

Covered services are different for adults, women, and children. The full list of services can be found here: https://www.healthcare.gov/coverage/preventive-care-benefits/

- Vaccinations
- Annual wellness exams
- Blood pressure screening
- Cholesterol screening
- Depression screening
- Mammograms for breast cancer
- Pap smears for cervical cancer
- Colonoscopies or stool-testing for colorectal cancer
- Low-dose CT scans for lung cancer
- Help to quit smoking (some insurers)

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Which Insurers Are Required to Cover Preventive Services at No Cost?

Almost all plans offered through employers or sold on kynect are required to cover preventive care at no cost to the patient. Individual plans not sold through kynect (such as short-term plans, sharing plans, and “grandfathered” plans) may not cover free preventive care.

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Angela Criswell

Director, Quality Screening & Program Initiatives

GO2 For Lung Cancer

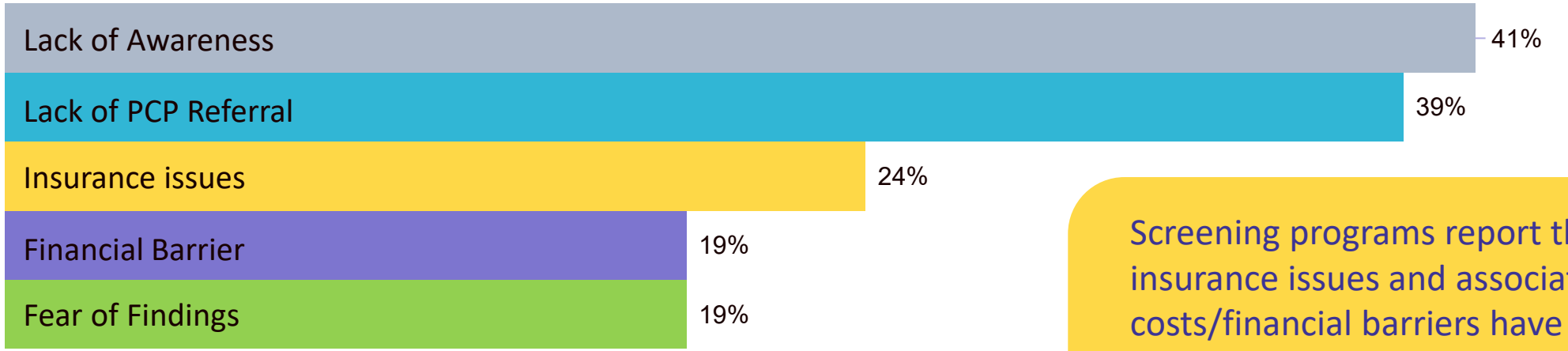
GO2 FOR LUNG CANCER
EXCELLENCE IN HEALTHCARE DELIVERY

Navigating the coverage labyrinth

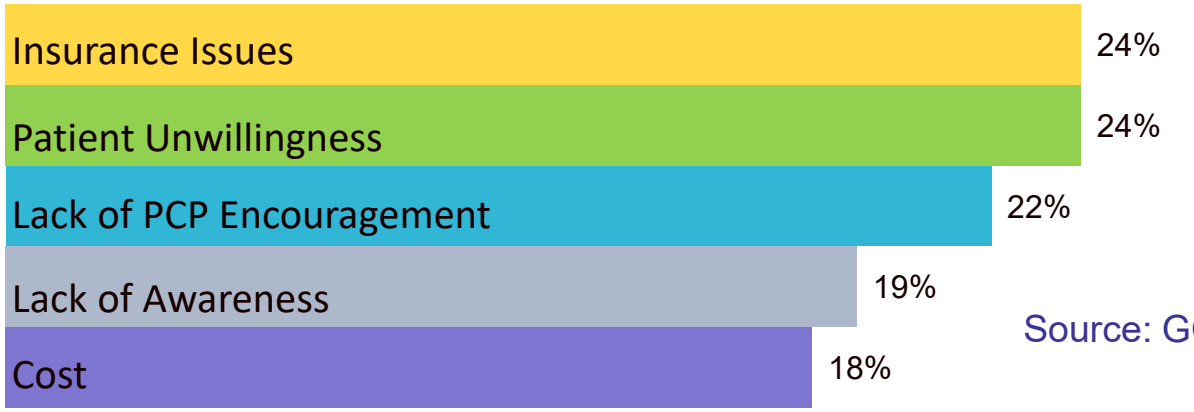
Sometimes feels like:

Why Surprise Billing Matters

Barriers to Screening Uptake



Barriers to Screening Adherence



Screening programs report that insurance issues and associated costs/financial barriers have a significant **impact on patient participation** in the screening process.

Source: GO_2 Foundation 2019 Screening Centers of Excellence Data Survey
N=99; unaided responses

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Coding Complexity = Patient Cost

- Lung Cancer Screening CPT Code 71271—proximity to diagnostic chest CT codes can create confusion
- Payer variation in required ICD-10 codes to establish medical necessity.

Use of ICD-10 code other than what payer requires can trigger denial or coverage as diagnostic rather than preventive service.

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ICD-10 Codes for G0296 & 71271

CMS Allowable ICD-10 Diagnosis Codes:

- **Z87.891** Personal history of nicotine dependence
- **F17.210** Nicotine dependence, cigarettes, uncomplicated
- **F17.211** Nicotine dependence, cigarettes, in remission
- **F17.213** Nicotine dependence, cigarettes, with withdrawal
- **F17.218** Nicotine dependence, cigarettes, with other nicotine-induced disorders
- **F17.219** Nicotine dependence, cigarettes, with unspecified nicotine-induced disorders

- Some **commercial** insurers have required use of **Z12.2** (Encounter for screening for malignant neoplasm for respiratory organs).
- Payer-specific billing strategies may be needed to minimize coverage denials and delays.

Site of service reviews for MR/CT services: Commercial plans

Frequently asked questions

Overview

We're focused on working toward achieving better health outcomes, improving patient experience and lowering the cost of care. Our site of service medical necessity reviews may help minimize out-of-pocket costs for our members and help improve cost efficiencies for the overall health care system, while still providing access to safe, quality health care.

Outpatient MR/CT procedures – Site of service utilization review guideline

For UnitedHealthcare commercial benefit plans, except UnitedHealthcare Oxford benefit plans, you can find the utilization review guideline we use to facilitate magnetic resonance (MR)/computed tomography (CT) site of service medical necessity reviews at **UHCprovider.com/policies** > Commercial Policies > **Medical & Drug Policies and Coverage Determination Guidelines for UnitedHealthcare Commercial Plans** > [Search for] Magnetic Resonance Imaging (MRI) and Computed Tomography (CT) Scan – Site of Care – Commercial Utilization Review Guideline.

For UnitedHealthcare Oxford benefit plans, you can find the clinical policy we'll use to facilitate MRI/CT site of service medical necessity reviews at **UHCprovider.com/policies** > Commercial Policies > **UnitedHealthcare® Oxford Clinical, Administrative and Reimbursement Policies** > [Search for] Magnetic Resonance Imaging (MRI) and Computed Tomography (CT) Scan – Site of Care – Oxford Clinical Policy.

Frequently asked questions

Why did UnitedHealthcare choose these particular procedures?

We conducted careful reviews to determine which procedures can be performed safely and effectively at locations other than an outpatient hospital setting, consistent with the terms of our members' benefit plans. The out-of-pocket cost for plan members may be significantly less, depending on the location where a procedure is performed.

Key points

- Site of service medical necessity reviews will only be done if the magnetic resonance (MR)/computed tomography (CT) procedure is requested to be performed in an outpatient hospital setting
- Site of service medical necessity reviews apply to UnitedHealthcare commercial plans, including Oxford, Neighborhood Health Partnership, UnitedHealthcare of the River Valley commercial benefit plans. These reviews do not apply to UnitedHealthcare West or Sierra at this time.
- Effective for dates of service on or after **Jan. 1, 2022,** site of service medical ncessity reviews will apply to care providers in Kentucky
- The Massachusetts site of service medical necessity review implementation is delayed until further notice
- Site of service medical necessity reviews currently do not apply to care providers in Alaska, Connecticut (as of Aug. 1, 2021, such reviews no longer apply to care providers in Connecticut for procedures rendered to Oxford commercial benefit plan members), Iowa, Maine, Maryland, Massachusetts, New Hampshire, Texas, Utah, Vermont or Wisconsin.

United Healthcare

United Healthcare

Magnetic Resonance Imaging (MRI) and Computed Tomography (CT) Scan – Site of Service

Guideline Number: URG-13.08
Effective Date: April 1, 2022

Instructions for Use

Table of Contents Page

Related Commercial Policies

- Breast Imaging for Screening and Diagnosing Cancer
- Computed Tomographic Colonography
- Preventive Care Services

Coverage Rationale

An advanced radiologic imaging procedure in the hospital outpatient department is considered medically necessary for individuals who meet any of the following criteria:

- Under 18 years of age
- Require obstetrical observation
- Require perinatology services
- Have a known contrast allergy
- Have a known chronic disease undergoing active treatment or surveillance for which direct comparison to prior hospital-based imaging is required for care planning
- Pre-procedure imaging which is done within 24 hours of the interventional or surgical procedure and is an integral part of the planned procedure

An advanced radiologic imaging procedure in the hospital outpatient department is considered medically necessary when there are no geographically accessible appropriate alternative sites for the individual to undergo the procedure, including but not limited to the following:

- Moderate or deep sedation or general anesthesia is required for the procedure; or
- The equipment for the size of the individual is not available; or
- Open magnetic resonance imaging is required because the member has a documented diagnosis of claustrophobia and/or severe anxiety

An advanced radiologic imaging procedure in the hospital outpatient department is considered medically necessary when imaging in a physician's office or freestanding imaging center would reasonably be expected to delay care and adversely impact health outcome.

All other advanced radiologic imaging procedures in the hospital outpatient department are considered not medically necessary.

Site of Service Restriction Includes Lung Cancer Screening

Guideline History/Revision Information

Date	Summary of Changes

04/01/2022	**Documentation Requirements**
	• Updated list of applicable CPT codes with associated documentation requirements:
	  ○ Added 71271
	  ○ Removed 77021
	Applicable Codes
	• Added CPT code 71271
	• Removed CPT code 77021
	Supporting Information
	• Updated *References* section to reflect the most current information
	• Archived previous policy version URG-13.07

Additional Payers with Site of Service Restrictions:

- Anthem
- Cigna
- Aetna

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EXCELLENCE IN HEALTHCARE DELIVERY

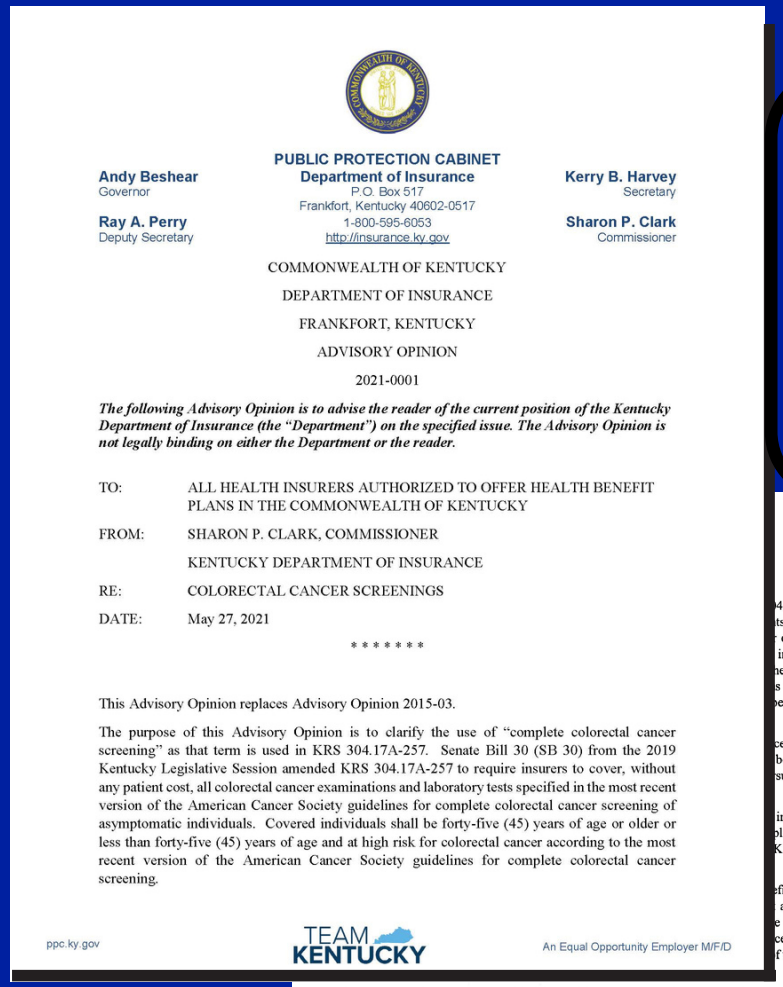
Colon Cancer Prevention Project

Dr. Whitney Jones

Founder, Colon Cancer Prevention Project

Jason Baird

Founder, Limestone Group



PUBLIC PROTECTION CABINET

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Ray A. Perry
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Secretary

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Commissioner

COMMONWEALTH OF KENTUCKY

DEPARTMENT OF INSURANCE

FRANKFORT, KENTUCKY

ADVISORY OPINION

2021-0001

The following Advisory Opinion is to advise the reader of the current position of the Kentucky Department of Insurance (the "Department") on the specified issue. The Advisory Opinion is not legally binding on either the Department or the reader.

TO: ALL HEALTH INSURERS AUTHORIZED TO OFFER HEALTH BENEFIT PLANS IN THE COMMONWEALTH OF KENTUCKY

FROM: SHARON P. CLARK, COMMISSIONER
KENTUCKY DEPARTMENT OF INSURANCE

RE: COLORECTAL CANCER SCREENINGS

DATE: May 27, 2021

* * * * * * * *

This Advisory Opinion replaces Advisory Opinion 2015-03.

The purpose of this Advisory Opinion is to clarify the use of "complete colorectal cancer screening" as that term is used in KRS 304.17A-257. Senate Bill 30 (SB 30) from the 2019 Kentucky Legislative Session amended KRS 304.17A-257 to require insurers to cover, without any patient cost, all colorectal cancer examinations and laboratory tests specified in the most recent version of the American Cancer Society guidelines for complete colorectal cancer screening of asymptomatic individuals. Covered individuals shall be forty-five (45) years of age or older or less than forty-five (45) years of age and at high risk for colorectal cancer according to the most recent version of the American Cancer Society guidelines for complete colorectal cancer screening.

ppc.ky.gov

TEAM KENTUCKY

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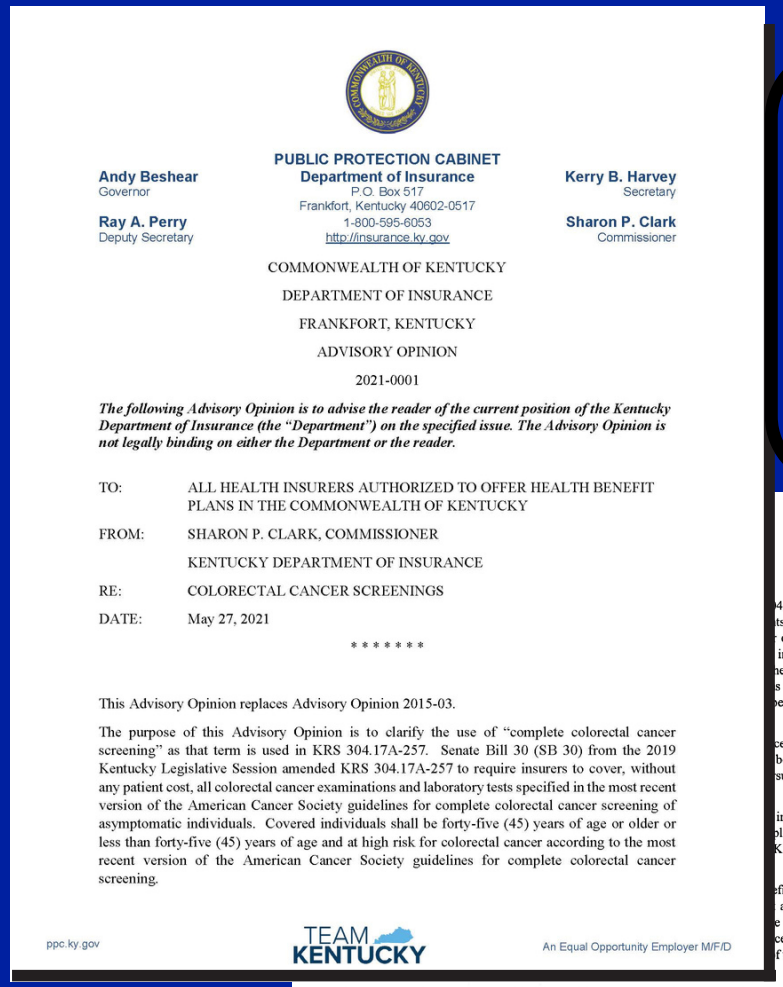
> For example, if a Fecal immunochemical Test (FIT) or a DNA stool test result indicates that the insured needs further testing to complete colorectal cancer screening, such as a colonoscopy, then the FIT or DNA stool test and the screening completion colonoscopy shall be covered as preventative services, and no deductible, coinsurance, or any other cost-sharing amount shall be billed to the insured.

Please contact the Department's Health and Life Insurance and Managed Care Division at (502) 564-6088 with any questions about this Advisory Opinion.

Sharon P. Clark

Sharon P. Clark, Commissioner
Kentucky Department of Insurance

Colon Cancer Prevention Project



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Sharon P. Clark

Sharon P. Clark, Commissioner
Kentucky Department of Insurance

"In addition to the passage of SB30 in the 2019 Session, House Bill 108 was passed into law in the 2021 Session that mandates the Kentucky Medicaid Program and Medicaid health plans adhere to the same colorectal cancer coverage for their insured. Medicaid will now adhere to KRS 304.17A-257 and KRS 304.17A-259 per the language of HB-108 amending KRS 205.522.

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Colonoscopies following a positive stool- or blood-based test are screening tests for Kentucky members

Published: May 1, 2021 - **Administrative**

Note that the information below only applies to Anthem Blue Cross and Blue Shield local Commercial plans in Kentucky, Kentucky Medicaid, and the Kentucky Government Employees Association. Also note that is guidance may differ from Medicare.

Kentucky is a unique state regarding the legislative measures passed related to colorectal cancer screenings. We are providing information on how these measures affect stool- or blood-based testing and the billing of screening vs. diagnostic colonoscopies.

First, to be eligible for stool- or blood-based testing, individuals must be asymptomatic and of average risk. Colorectal cancer screening using these methods is **a two-part screening test,** as illustrated below.

Colorectal cancer screening of individuals who are asymptomatic and of average risk		
Step 1	**Result**	**Step 2**
Appropriate testing such as: • fecal immunochemical tests (FITs) • multi-target stool DNA test (aka Cologuard®)	Positive	A completion ***screening*** colonoscopy. *This test is not considered diagnostic.*

A completion screening colonoscopy following a positive stool- or blood-based test is not separate, but rather an integral screening process of individuals who are, at this point, still asymptomatic and remain at normal risk.

This is not to be confused with a diagnostic colonoscopy appropriate for individuals with symptoms, elevated risks (Crohns' or colitis), or prior personal histories of colon polyps or colon cancers that require colonoscopy-based examinations.

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Anthem | KENTUCKY Provider Communications

Updated preventive care guidance regarding screening colonoscopies

Published: Mar 1, 2022 - **Administrative**

On January 10, 2022, updated Preventive Care Guidance was released by the Departments of Labor, Health and Human Services (HHS), and the Treasury. This new guidance applies to most of Anthem Blue Cross and Blue Shield (Anthem)'s ACA-compliant non-grandfathered health plans when services are provided in-network. This new guidance indicates:

On May 18, 2021, the 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. In its "Practice Considerations" section detailing screening strategies, the Final Recommendation Statement provides: "When stool-based tests reveal abnormal results, follow up with colonoscopy is needed for further evaluation…. Positive results on stool-based screening tests require follow up with colonoscopy for the screening benefits to be achieved." Additionally, the Final Recommendation Statement provides with respect to direct visualization tests: "Abnormal findings identified by flexible sigmoidoscopy or CT colonography screening require follow-up colonoscopy for screening benefits to be achieved."

For a follow-up colonoscopy after a positive non-invasive stool-based screening test or direct visualization screening test for colorectal cancer, in-network providers should code the claim as a screening colonoscopy rather than as a diagnostic colonoscopy.

Providers can contact the provider service number on the back of the member ID card to determine if a member's plan includes this benefit.

807-0322-PN-CNT

URL: https://providernews.anthem.com/kentucky/article/updated-preventive-care-guidance-regarding-screening-colonoscopies-6

Featured In:
March 2022 Anthem Provider News - Indiana, March 2022 Anthem Provider News - Kentucky, March 2022 Anthem Provider News - Missouri, March 2022 Anthem Provider News - Ohio, March 2022 Anthem Provider News - Wisconsin

UPDATE 2022

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Q7: Are plans and issuers required to cover, without the imposition of any cost sharing, a follow-up colonoscopy conducted after a positive non-invasive stool-based screening test or direct visualization test (e.g., sigmoidoscopy, CT colonography)?

Yes. A plan or issuer must cover and may not impose cost sharing with respect to a colonoscopy conducted after a positive non-invasive stool-based screening test or direct visualization screening test for colorectal cancer for individuals described in the USPSTF recommendation. As stated in the May 18, 2021 USPSTF recommendation, the follow-up colonoscopy is an integral part of the preventive screening without which the screening would not be complete.[31] The follow-up colonoscopy after a positive non-invasive stool-based screening test or direct visualization screening test is therefore required to be covered without cost sharing in accordance with the requirements of PHS Act section 2713 and its implementing regulations.

JANUARY 10TH, 2022

FAQS ABOUT AFFORDABLE CARE ACT IMPLEMENTATION PART 51, FAMILIES FIRST CORONAVIRUS RESPONSE ACT AND CORONAVIRUS AID, RELIEF, AND ECONOMIC SECURITY ACT IMPLEMENTATION

Q8: When must plans and issuers begin providing coverage without cost sharing for a follow-up colonoscopy after a positive non-invasive stool-based screening test or direct visualization test based on the new USPSTF recommendation?

Plans and issuers must provide coverage without cost sharing consistent with the May 18, 2021 USPSTF recommendation regarding colorectal cancer screening and in accordance with the requirements under PHS Act section 2713 for plan years (in the individual market, policy years) beginning on or after the date that is one year after the date the recommendation was issued. In this case, the recommendation is considered to have been issued as of May 31, 2021, so plans and issuers must provide coverage without cost sharing for plan or policy years beginning on or after May 31, 2022.[32]

I have a positive stool test. Will I get billed for my follow up colonoscopy?

Let's clear up the confusion, Kentucky!

Did you get a positive result from a take-home stool test like Cologuard or FIT? If so, you need a colonoscopy as soon as possible to complete your process for colon cancer screening. Kentucky law says **this type of follow-up colonoscopy must be covered by your health insurance company.** If you receive a surprise bill for this type of procedure, contest the bill with your insurance company, referencing the Kentucky legislation below.

THE AFFORDABLE CARE ACT

A health plan or issuer **must cover and may not impose cost sharing** with respect to a colonoscopy conducted after a positive non-invasive stool-based screening test or direct visualization screening test for colorectal cancer for individuals described in the recommendation from the US Preventative Services Task Force.

THE KY DEPARTMENT OF INSURANCE (KRS 304.17A-257)

All screening colonoscopies must be coded as such regardless of what is found (polyps, tumors, mucosal abnormalities) and regardless of what intervention is performed as a result. **FIT or DNA stool test and screening colonoscopy shall be covered as preventative services, and no deductible, coinsurance, or any other cost-sharing amount shall be billed to the insured.**

FOR KY MEDICAID PATIENTS (KRS 205.522)

The Department for Medicaid Services and any managed care organization contracted to provide Medicaid benefits pursuant to this chapter **shall comply with the provisions of KRS 304.17A-257** (above).

Need more information?

Colon Cancer Prevention Project

KickingButt.org 502-272-2397

In partnership with:

KCP Kentucky Cancer Program
kycancerprogram.org
(502) 852-6318

Kentucky Cancer Consortium
kycancerc.org
859-323-3534

kycancerlink.org
(877) 597-4655

Provider's Guide to Coding and Billing a Follow-Up Colonoscopy

Let's clear up the confusion!

In Kentucky, all preventative colonoscopies following a positive stool-based test like FIT or Cologuard must be coded, covered, and billed as a **screening colonoscopy,** not as a diagnostic.

THE AFFORDABLE CARE ACT

A health plan or issuer **must cover and may not impose cost sharing** with respect to a colonoscopy conducted after a positive non-invasive stool-based screening test or direct visualization screening test for colorectal cancer for individuals described in the USPSTF recommendation.

THE KY DEPARTMENT OF INSURANCE* (KRS 304.17A-257)

- Insurers must cover, **without any patient cost,** all colorectal cancer examinations and laboratory tests specified in the most recent version of the American Cancer Society guidelines for complete colorectal cancer screening of asymptomatic individuals.
- All screening colonoscopies must be coded as such regardless of what is found (polyps, tumors, mucosal abnormalities) and regardless of what intervention is performed as a result. **FIT or DNA stool test and screening colonoscopy shall be covered as preventative services, and no deductible, coinsurance, or any other cost-sharing amount shall be billed to the insured.**

FOR KY MEDICAID PATIENTS (KRS 205.522)

The Department for Medicaid Services and any managed care organization contracted to provide Medicaid benefits pursuant to this chapter **shall comply with the provisions of KRS 304.17A-257** (above).

*Provisions of this statute apply to fully funded insured health benefit plans as defined in KRS 304.17A-005(22)

Need more information?

Colon Cancer Prevention Project

KickingButt.org 502-272-2397

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kycancerc.org
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AGA

New Coding Guidlines

Insurance coverage	
Commercial insurance	Pays for both the stool-based test and colonoscopy (including polyp removal) after a positive stool test if it was done
Commercial insurance	Pays for both the stool-based test and colonoscopy (including polyp removal) after a positive stool test if it was done after May 31, 2022. For tests performed before May 31, 2022, the stool-based test is covered at 100%, but patients might have to pay some of the costs for the colonoscopy.

Medicare	
FIT: G0328	Colorectal Cancer Screening; Immunoassay, Fecal-Occult Blood Test, 1-3 Simultaneous Determinations
FOBT: G0107	Colorectal Cancer Screening; Fecal-Occult Blood Test, 1-3 Simultaneous Determinations
Multi-target stool DNA test: G0464	Colorectal cancer screening; stool-based DNA and fecal occult hemoglobin (e.g., KRAS, NDRG4 and BMP3)

Commercial insurance	
FIT: 82274	Blood, occult, by fecal hemoglobin determination by immunoassay, qualitative, feces, 1-3 simultaneous determinations
FOBT: 82270	Blood, occult, by peroxidase activity (eg, guaiac), qualitative; feces, consecutive collected specimens with single determination, for colorectal neoplasm screening (ie, patient was provided 3 cards or single triple card for consecutive collection)
Multi-target stool DNA test: 81528	Oncology (colorectal) screening, quantitative real-time target and signal amplification of 10 DNA markers (KRAS mutations, promoter methylation of NDRG4 and BMP3) and fecal hemoglobin, utilizing stool, algorithm reported as a positive or negative result

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HHS Finalizes Physician Payment Rule Strengthening Access to Behavioral Health Services and Whole-Person Care

On November 1, the Centers for Medicare and Medicaid Services (CMS) finalized a proposed rule to ensure Medicare beneficiaries won't face out-of-pocket costs if they need a colonoscopy after getting a positive result on a noninvasive colorectal cancer screening test.

Noninvasive screening tests, such as FIT or Cologuard® are great options for average-risk patients to complete colorectal cancer screening. But for those who receive a positive result, screening is not complete until they undergo a colonoscopy. Ensuring that cost is not a barrier will help increase access to colorectal cancer screening and ultimately save lives!

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www.coloncancerpreventionproject.org

Understanding the problem from a consumer perspective.

What can consumers do?

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01

Contact your insurer and your provider for clarification.

Ask them to review that the codes are correct. Sometimes your provider can submit a corrected claim using codes that identify the service(s) as preventive based on the insurer's claim submission guidelines.

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02

If you are covered through your workplace, talk to your HR department or employer.

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03

Appeal the insurer determination.

This means you ask your insurer to conduct a full and fair review of the decision.

Here are some resources:

- Kentucky Department of Insurance (DOI) (call 800-595-6053 or complete the online form)
- Attorney General (AG) (call (502)696-5389 or 888-432-9257 [select option #3] or complete this online form:
- Contact your legal aid. Find out what program covers your county here.

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Understanding the problem from a health provider perspective.

What can health providers do?

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Why are patients being charged for preventive care?

Patient schedules preventive services but the healthcare provider determines that it is diagnostic. Patient may not realize it.

Patients are ineligible for specific preventive services because they already have symptoms, a past diagnosis, or history

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Why are patients being charged for preventive care?

Even if a provider codes a service as preventive if there are symptoms insurers may override the coding to be diagnostic.

There is no clear guidance on specific codes that providers should use when billing for preventive care to ensure full insurance coverage

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What Can Healthcare Providers Do?

Document in the medical record that the intention of the service is preventive.

Educate the patient that when symptoms are present, the service is no longer considered preventive and may include additional co-pays or deductibles.

Inform patients on what to do if they receive a surprise bill for services that were supposed to be preventive.

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Potential Solutions:
What can policymakers do?

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Require insurers to provide a complete list of free preventive care services to members annually and post the list of covered services online.

Support and enhance existing state statutes that address no cost-sharing for preventive services (e.g. colorectal cancer screening).

Establish a workgroup led by DOI to work with stakeholders in identifying solutions.

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Require provider education on accurate coding for preventive services.

Require consumer education on their right to free preventive care.

Allow employees with self-funded plans to opt-in

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Questions?

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