



COVERAGE OF COLONOSCOPY IN NEVADA UNDER THE AFFORDABLE CARE ACT'S PREVENTION BENEFIT

BACKGROUND

According to the Centers for Disease Control and Prevention (CDC), Nevada's colorectal cancer screening rate is 58%ⁱ for people ages 50-75 who report being "up-to-date" with colorectal cancer screening, far below the Healthy People 2020 goal of 70.5% or the 80% by 2018 goal set forth by the National Colorectal Cancer Roundtable. This includes having had a fecal occult blood test (FOBT) during the previous year, a sigmoidoscopy within the previous five years and a FOBT within the previous three years, or a colonoscopy within the previous 10 years.ⁱⁱ

Each of these USPSTFⁱⁱⁱ recommended colorectal cancer screening methods are covered as a preventive service without any patient cost-sharing, such as copays or deductibles, under the Affordable Care Act's (ACA) Essential Health Benefits.^{iv} This requirement became effective for new plans sold or renewed on or after September 23, 2010.^v

Research has shown that out-of-pocket costs, such as copays, deductibles, and co-insurance, may prevent some individuals from obtaining preventive services, such as colorectal cancer screening.^{vi} By eliminating cost-sharing for those preventive health services recommended as most effective by the USPSTF, the ACA has tried to remove barriers to these evidence-based services. However in the case of colonoscopy, there are instances when a service initiated as a preventive screening can result in unexpected cost-sharing for that patient. These instances include: 1) removal of a polyp during screening colonoscopy; 2) colonoscopy performed as part of a two-step screening following a positive stool blood test; or 3) colonoscopy performed on an individual at higher risk for colon cancer that requires earlier or more frequent screening.

SCREENING COLONOSCOPY AND POLYP REMOVAL

Most colorectal cancers result from abnormal growths (adenomatous polyps) in the lining of the colon that become cancerous over time. Because most of these polyps can be identified and removed during a colonoscopy, in many cases, colorectal cancer is preventable through timely screening. Polyp removal is a routine part of screening taking place in approximately half of screening colonoscopies for patients who are at average risk of developing colorectal cancer. Of the polyps removed, about half are adenomatous polyps, which have the potential to become cancerous. Physicians cannot reliably distinguish adenomatous polyps from harmless, benign polyps during colonoscopy, and so typically remove all polyps identified during a screening colonoscopy.^{vii}

METHODS

Research was completed using the “Coverage of Colonoscopies Under the Affordable Care Act’s Prevention Benefit” report dated September 2012 and published in partnership by The Henry J. Kaiser Family Foundation, American Cancer Society, and National Colorectal Cancer Roundtable (NCCRT).^{viii} Interviews were then conducted with benefits and claims representatives from insurance companies offering plans within the Nevada Health Exchange as well as with two other plans available to residents within the state. Additional research was completed through online provider resources made available by each insurance company; this research often supplemented details in cases where company representatives were unable or unwilling to provide information on coverages and claims payment procedures.

THE COST OF COLORECTAL CANCER IN THE UNITED STATES

The Centers for Disease Control and Prevention (CDC) notes that if everyone aged 50 – 75 had regular screening tests for colorectal cancer, at least 60% of deaths from this cancer could be avoided.^{ix} Additionally, regular screening is known to provide the opportunity to remove polyps before they become cancer, and to help find many cancers at an earlier or localized stage when they are easier and less expensive to treat.

The NCCRT published a white paper in 2007 identifying the cost-savings of increasing colorectal cancer screening as evaluated through Medicare spending. The report documented that one-year treatment cost for a patient with metastatic (late-stage) colorectal cancer can be as high as \$310,000 per year. The Medicare reimbursement rate for screening colonoscopy, as of June 2015, was less than 0.2% of the estimated annual late-stage treatment cost at just \$579 (inclusive of professional and facility fees).^x Healthcare Bluebook estimates the fair price of screening colonoscopy in northern Nevada at just over \$1,800 or \$2,100 with polyp removal/biopsy, and at \$1,400 and \$1,600 respectively for southern Nevada.^{xi} The highest of these costs is just 0.7% of the estimated annual treatment cost.

Researchers developed a cost model that explores how increased colorectal cancer screening among pre-Medicare eligible adults (aged 50 – 64) could translate to lower Medicare costs through earlier detection and treatment, specifically polypectomy and treatment of early stage cancer. The results show that the earlier regular screening begins, age 50 for average risk patients, the greater the cost savings. Colonoscopy screening translated to approximately \$15 billion in savings, and stool blood test screening came in at \$13.3 billion in Medicare savings.^{xii} It can then be concluded that removing barriers to colorectal cancer screening by colonoscopy, such as cost-sharing, can greatly reduce the cost burden of colorectal cancer.



SCREENING COLONOSCOPY AND COST-SHARING IN NEVADA

The Nevada Division of Insurance adheres to the guidelines of the ACA, and notes that “most [plans] will cover at no charge (within network)” preventive benefits including “colorectal cancer screenings with polyp removal for those over 50.”^{xiii} The word “most” is important in that statement as it has been found that there are varying practices for coverage of screening colonoscopy with polyp removal within Nevada.

While the federally-administered Medicare program wasn’t surveyed for the purpose of this report, the program’s billing procedures impact an estimated 380,000 Nevadans.^{xiv} Medicare’s coverage of screening colonoscopy is at 100%, however screening colonoscopy that includes polypectomy imposes cost-sharing, with 80% of the cost covered by Medicare and 20% co-insurance paid by the patient. This cost is estimated to be up to \$300.^{xv}

Six of the seven surveyed insurance providers indicated that they cover screening colonoscopy at 100% with no cost-sharing regardless of whether there is polyp removal during the procedure. However, through additional questions, it was determined that patients may be charged for the colonoscopy or polypectomy based on how the physician’s office codes the procedure for billing purposes.

There are several codes in place to denote a colonoscopy was initiated as a preventive screening service. Current Procedural Terminology (CPT) modifiers can be appended to CPT billing codes when processing claims. The CPT Modifier 33 was created to aid in compliance with the ACA guidelines prohibiting cost-sharing for preventive services and can be appended to CPT billing codes for screening colonoscopy. The CPT Modifier PT is specific to colorectal cancer screening and is to be used when a service began as a colorectal cancer screening test and was moved to a diagnostic test due to findings during the screening. Providers can append this modifier to a procedure code for diagnostic testing that is reported instead of screening colonoscopy. Additional codes used to indicate diagnosis for patient encounters are ICD-9 or V-codes. (As of Oct. 1, 2015 updated ICD-10 codes will replace ICD-9 codes.) Specific ICD-9 codes are used to indicate screening colonoscopy versus diagnostic colonoscopy.

Usage of CPT modifiers varies across insurance companies. Additionally, how insurance companies bill based on ICD-9 codes vary. As indicated in the previous table, four of the seven surveyed insurance companies bill screening colonoscopy under the preventive screening benefit, i.e., no cost-sharing for the patient. One company, Anthem, acknowledges the screening colonoscopy as a preventive service under the ACA guidelines and imposes no cost-sharing for that portion of the service, however in some older plans a patient may be billed for the polypectomy portion of the service through their deductible. And yet another organization, PEPP, references both CPT modifiers and ICD-9 codes but imposes no cost-sharing for screening colonoscopy regardless of polypectomy and regardless of whether billing codes such as the CPT modifiers are used.

Use of Billing Codes to Designate Preventive Screening & Resulting Cost-Sharing

Insurance Company	Use of CPT 33 Modifier	Use of CPT PT Modifier	Use of ICD-9/ ICD-10 Codes	Coverage Policy
Anthem/Blue Cross*	Not a factor in billing for colonoscopy screening.	Advises usage of PT Modifier to indicate polyp removal during preventive screening service	Bills based on ICD-9 codes. However in some older plans, if polyp removal is indicated, regardless of usage of ICD-9 codes for preventive service, polyp removal portion of the service will be charged.	Colonoscopy covered at 100%, polyp removal applied to deductible in some plans.
Prominence*	Not indicated as a factor.	Not indicated as a factor.	Pays as it is billed. If provider uses ICD-9 code to denote preventive service there is not cost-sharing, regardless of polyp removal.	Covered at 100% regardless of polyp removal.
Health Plan of Nevada*	33 Modifier can be reported but is not used in making preventive care benefit determinations.	Not indicated as a factor.	Pays as it is billed. If provider uses ICD-9 code to denote preventive service there is not cost-sharing, regardless of polyp removal.	Covered at 100%, including polyp removal, if billed using appropriate preventive service codes.
Nevada Health Co-Op*	No response.	No response.	No response.	No response.
Assurant*	Not indicated as a factor.	Not indicated as a factor.	Pays as it is billed. If provider uses ICD-9 code to denote preventive service there is not cost-sharing, regardless of polyp removal.	Covered at 100%, including polyp removal, if billed using appropriate preventive service codes.
Humana*	Recognizes 33 Modifier in billing.	Recognizes PT Modifier in billing.	Pays as it is billed. If provider uses ICD-9 code to denote preventive service there is not cost-sharing, regardless of polyp removal.	Covered at 100%, including polyp removal, if billed using appropriate preventive service codes.
Public Employees' Benefits Program (PEBP)	Looks at 33 Modifier, however the billing process is not dependent on that modifier.	Not indicated as a factor.	All ICD-9 codes are looked for, however PEBP covers colonoscopy at 100% under the screening benefit.	Covered at 100%, including polyp removal, regardless of coding.

* Insurance plans offered on the Nevada Health Exchange and ACA compliant.

In January 2015 the Centers for Medicare and Medicaid Services (CMS) clarified that anesthesia services furnished in conjunction with preventive screening colonoscopy are also covered with no cost-sharing to Medicare and Medicaid patients. In such cases CMS advises those anesthesia professionals to use the CPT 33 Modifier to ensure the service is identified as preventive.^{xvi} Health and Human Services (HHS) issued similar guidance in May 2015 clarifying that ACA-compliant health plans or issuers cannot impose cost-sharing for anesthesia services performed in conjunction with preventive screening colonoscopies.^{xvii}

One area identified as unclear in terms of cost-sharing and coverage is the cost of pathology incurred when polypectomy or other biopsy is performed during preventive screening colonoscopy. Pathology costs vary based on the number of polyps removed during the screening and the number of biopsies sent for testing, but can range from several hundred dollars to upwards of \$2,000, as estimated by some gastroenterology billing professionals. These costs may or may not be covered by a patient’s insurer, and cost-sharing may apply as well.

COST-SHARING IN OTHER CIRCUMSTANCES

Colonoscopy performed as part of a two-part screening after a positive stool blood test is an area of coverage that three of the insurance companies had no information to provide. Two other companies indicated that this type of colonoscopy was identified as diagnostic, as the patient is no longer asymptomatic, and does not fall under the preventive screening benefit. PEBP, a non-exchange insurance program, does cover this type of colonoscopy at 100% under the screening benefit, however this coverage is only available to State employees.

There is additional variation in screening colonoscopy for those considered high-risk. For the purposes of this report, high-risk screening colonoscopy was identified as being provided to patients under 50 with a family history of colorectal cancer or those patients that require screening colonoscopy at intervals less than every 10 years as recommended by their primary care provider.

Cost-Sharing for Colonoscopy in High-Risk Patients

Insurance Company	High-Risk Screening Colonoscopy Coverage
Anthem/Blue Cross*	Colonoscopy performed on those under 50 and deemed high-risk due to family history is considered diagnostic and cost-sharing is imposed. High-risk patients requiring screening colonoscopy at intervals less than 10 years can receive one every three to five years based on risk and past pathology with no cost-sharing. African Americans can begin screening colonoscopy at 45 with no cost-sharing.
Prominence*	Patients under 50 with a family history and considered high risk by their doctor have no cost-sharing. High-risk patients requiring screening at intervals less than 10 years also have no cost-sharing. Services are considered preventive.
Health Plan of Nevada*	No information was available for screening colonoscopy for high-risk patients under 50. However, follow up colonoscopies at intervals less than the recommended 10 years due to previous polyp removal are considered and billed as diagnostic.

Nevada Health Co-Op*	No information provided.
Assurant*	No information was available for screening colonoscopy for high-risk patients under 50. Advisement online indicates that colonoscopy in those considered at-risk may not be covered at 100% because the service is considered "diagnostic" rather than "preventive."
Humana*	Higher risk patients "may be eligible" for additional screening at varying intervals based on risk factor. Varies by plan.
Public Employees' Benefits Program (PEBP)	As long as a provider bills for the procedure using the correct ICD-9 code indicating family history or other high-risk diagnosis PEBP allows colonoscopy under the preventive screening benefit at 100%. This includes subsequent colonoscopies at intervals less than 10 years.

CONCLUSION

While the ACA has provisions to ensure screening colonoscopy is covered with no cost-sharing for those insured under ACA-compliant health plans, there is still slight discrepancy among insurers in Nevada when polypectomy is involved. While most consider polypectomy during a screening colonoscopy to be a part of that screening service and will cover the service with no cost-sharing, the burden rests upon providers to ensure the billing codes provided to those insurers indicate all services rendered were part of the preventive screening service.

Additionally, screening colonoscopy that results in polypectomy may incur costs to the patient if their insurer doesn't cover the pathology costs as part of the preventive screening service. As mentioned previously, Medicare patients will have cost-sharing imposed regardless of how providers code the service based on the program's cost-sharing guidelines. Patients at higher risk for colon cancer or those that are considering stool blood testing as a primary screening method should check with their insurance provider to confirm coverage of screening colonoscopy as either preventive or diagnostic and the level of cost-sharing imposed.

While there has been some legislative work at the state level to eliminate cost-sharing for screening colonoscopy in the instance of polyp removal, such as in Connecticut and Maine, no state has effectively extended this law to cover all insured citizens within that state. It is suggested that many are looking to the federal government to clarify the issue or that state policymakers feel they do not have the clinical expertise to weigh in on the issue.^{xviii} In March 2015 the "Removing Barriers to Colorectal Cancer Screening Act," H.R. 1220 and S. 624, was introduced to remove the Medicare co-insurance requirement for screening colonoscopy with polypectomy. Championed by numerous cancer control advocates including American Cancer Society Cancer Action Network, the bill had 115 co-sponsors and was in the House Energy and Commerce Subcommittee on Health for review as of June 2015. Passage of this bill at the federal level could impact guidelines for coverage at the state level or for ACA-compliant health plans in the future.

ⁱ 2012 BRFSS Survey Data collected by Behavioral Risk Factor Surveillance System (BRFSS) sponsored by the Centers for Disease Control and Prevention.

ⁱⁱ HealthyPeople.gov at <http://www.healthypeople.gov/2020/topicsobjectives2020/nationalsnapshot.aspx?topicid=5>.

ⁱⁱⁱ The USPSTF is an independent panel of non-Federal experts in prevention and evidence-based medicine and is composed of primary care providers. The USPSTF works to improve the health of all Americans by making evidence-based recommendations about clinical preventive services, such as screenings, and assigns each recommendation a letter grade (an A, B, C, or D grade or an I statement) based on the strength of the evidence and the balance of benefits and harms of a preventive service.

^{iv} Healthcare.gov at <https://www.healthcare.gov/glossary/essential-health-benefits/>

^v The ACA preventive services requirements do not apply to “grandfathered” health plans that were in existence prior to March 23, 2010, as long as such plans continue to meet certain standards for grandfathered plans. Patients might also face unexpected cost-sharing if they don’t realize they are covered under a grandfathered health plan.

^{vi} Kaiser Family Foundation, 2013 Kaiser Women’s Health Survey, <http://kff.org/health-reform/fact-sheet/preventive-services-covered-by-private-health-plans/>

^{vii} ACSCAN.org at http://www.acscan.org/content/wp-content/uploads/2015/04/Increasing_Colorectal_Cancer_Screening_-_Saving_Lives_an.pdf

^{viii} NCCRT, <http://nccrt.org/wp-content/uploads/NCCRT.pdf>

^{ix} CDC.gov at http://www.cdc.gov/cancer/colorectal/pdf/Basic_FS_Eng_Color.pdf

^x As provided by Gastroenterology Consultants, Reno, Nev.

^{xi} Healthcare Bluebook estimates based on zip codes 89504 and 89119, evaluating colonoscopy (screening) and colonoscopy (biopsy) at https://www.healthcarebluebook.com/page_Default.aspx

^{xii} ACSCAN.org at http://www.acscan.org/content/wp-content/uploads/2015/04/Increasing_Colorectal_Cancer_Screening_-_Saving_Lives_an.pdf

^{xiii} Nevada Division of Insurance, <http://doi.nv.gov/Health-Rate-Review/FAQs/>

^{xiv} Kaiser Family Foundation at <http://kff.org/medicare/state-indicator/total-medicare-beneficiaries/>

^{xv} ACS-CAN “Eliminating Medicare Beneficiary Cost Sharing for Screening Colonoscopy” Fact Sheet, <http://www.acscan.org/content/wp-content/uploads/2015/04/Eliminating-Medicare-Beneficiary-Cost-Sharing-for-Screening-Colonoscopy.pdf>

^{xvi} Centers for Medicare and Medicaid Services at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8874.pdf>

^{xvii} American Gastroenterological Association at http://www.gastro.org/news_items/2015/5/11/anesthesia-covered-as-part-of-screening-colonoscopy

^{xviii} ACSCAN.org at http://www.acscan.org/content/wp-content/uploads/2015/04/Increasing_Colorectal_Cancer_Screening_-_Saving_Lives_an.pdf