

COVERAGE OF COLONOSCOPIES UNDER THE AFFORDABLE CARE ACT'S PREVENTION BENEFIT



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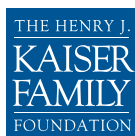
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The American Cancer Society is dedicated to eliminating cancer as a major health problem by saving lives, diminishing suffering and preventing cancer through research, education, advocacy and service. Founded in 1913 and with national headquarters in Atlanta, the Society has 13 regional divisions and local offices in 3,400 communities, involving millions of volunteers across the United States.

The National Colorectal Cancer Roundtable, established by the American Cancer Society and the Centers for Disease Control and Prevention, is a national coalition of public, private, and voluntary organizations, as well as invited individuals, dedicated to reducing the incidence of and mortality from colorectal cancer. The Roundtable works through coordinated leadership, strategic planning, and leveraging the expertise of its membership. The ultimate goal of the Roundtable is to increase the use of proven colorectal cancer screening tests among the entire population for whom screening is appropriate.

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Introduction

The Affordable Care Act (ACA) requires private health insurers to cover recommended preventive services without any patient cost-sharing, such as copays and deductibles.¹ The ACA requires coverage of services with an “A” or “B” recommendation from the United States Preventive Services Task Force (USPSTF), an independent panel of clinicians and scientists.^{*} Recommended services include screening for diabetes, obesity, cholesterol, and various cancers including colorectal cancer, as well as counseling for drug and tobacco use and healthy eating, among others. This requirement took effect for new plans sold or renewed on or after September 23, 2010. An estimated 54 million Americans received expanded coverage of preventive services under the ACA in 2011.²

Although many factors affect use of preventive services, out-of-pocket costs are a barrier to seeking recommended screening tests, counseling, and immunizations. An extensive body of research shows that individuals—including the insured—are less likely to seek health services when they have to pay out-of-pocket costs.³ By eliminating cost-sharing, the ACA has tried to remove barriers to important preventive services. Yet, there are reports that many asymptomatic adults undergoing screening for cancer have been billed for services they expected would be covered under the ACA’s provision that eliminates cost sharing for A- and B-rated preventive services.

This report explores how private insurers[†] are approaching cost-sharing for colorectal cancer screening, which received an “A” rating from the USPSTF.⁴ Patients can encounter unexpected cost-sharing for screening colonoscopy under three different clinical circumstances: 1) when a polyp is detected and removed during a screening colonoscopy; 2) when a colonoscopy is performed as part of a two-step screening process following a positive stool blood test; and 3) when the individual is at increased risk for colorectal cancer and may receive earlier or more frequent screening compared with average risk adults.[‡] To explore this issue, interviews were conducted with a variety of stakeholders and regulatory officials familiar with the implementation of this new benefit. Based on their reports, it appears that, under all three scenarios, there is significant variation in whether insured consumers receive colorectal cancer screening with no cost-sharing. Those interviewed reported that they had received complaints

^{*} 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 conducts scientific evidence reviews of a broad range of clinical preventive health care services (such as screening, counseling, and preventive medications) and develops recommendations for primary care clinicians and health systems. These recommendations are published in the form of “Recommendation Statements.” An A or B rating from USPSTF means that there is high certainty that the net benefit is moderate to substantial and that the USPSTF recommends the service.

[†] This report does not explore how cost-sharing for preventive services is addressed in the Medicare program. See Appendix A for additional details on cost-sharing for colonoscopy in Medicare.

[‡] 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.

from consumers who faced unexpected cost-sharing for screening colonoscopy. Some indicated that cost-sharing for a screening colonoscopy has generated the most complaints of any of the ACA's new consumer protections.

Methodology

Interviews were conducted with state health insurance regulators, state consumer assistance program directors, medical directors of major insurance companies, medical experts, insurance billing experts, and patients to gather qualitative research using a convenience sample. Those interviewed included medical directors of seven major insurers in four states—California, Connecticut, New Mexico, and Washington, as well as billing staff of two medical group practices in New Mexico and South Carolina. Interviews were also conducted with department of insurance staff, including regulators and consumer assistance program personnel, in six states – Connecticut, Georgia, Maine, North Carolina, Oregon, South Carolina – as well as the Connecticut Office of the Healthcare Advocate. All interviews were conducted between March and June 2012. Stories of patient experiences were collected by staff of the American Cancer Society and the American Cancer Society's National Colorectal Cancer Roundtable. Information included in the report from the interviews was compiled and re-verified by interviewees to ensure an accurate reflection of interview discussion. Patient names were changed for inclusion in this report.

Colorectal Cancer in the United States

Colorectal cancer is the third most common cancer and cause of death from cancer in men and women in the United States.⁵ It is estimated that over 143,000 people will be diagnosed with colorectal cancer and almost 52,000 will die from this disease in 2012. Treatment costs can be very high, especially for advanced forms of colorectal cancer. Estimates suggest that about \$12.2 billion is spent on treatment for colorectal cancer each year in the United States, and annual treatment costs for an advanced case may exceed \$300,000 for a year.⁶

Costs associated with advanced treatment and premature deaths due to colorectal cancer are largely avoidable. Regular screening can identify colorectal cancer at early stages when it is easiest and least expensive to treat and when the possibility of cure is the greatest. In addition, regular screening can actually prevent colon cancer by detecting and removing precancerous polyps (abnormal growths in the lining of the colon), eliminating the possibility that they may progress to cancer. The USPSTF and other expert medical and scientific panels issue evidence-based recommendations about colorectal cancer screening.⁷ Yet, many Americans do not receive colorectal screenings as recommended and one in three adults between the ages of 50 and 75 were not up-to-date with recommended colorectal cancer screening in 2010.⁸

Colonoscopy is one of the more expensive preventive services covered under the ACA; charges can range from \$1,000 to \$2,000 or more.⁹ Adults concerned about their liability for these charges could be discouraged from seeking screening. In a recent survey of the National Colorectal Cancer Screening Network, which represents public health and health care professionals who deliver such services, 80 percent of respondents indicated they were aware of problems with insured patients encountering

unexpected cost-sharing for screening colonoscopy.¹⁰ In the same survey, 70 percent of respondents said they thought the potential of unexpected costs would deter some individuals from being screened.

Screening Colonoscopy and Cost-Sharing: Results from Three Scenarios

Asymptomatic individuals (that is, adults showing no signs or symptoms of disease) may encounter unexpected cost-sharing for a screening colonoscopy in three clinical circumstances described below.

1. Polyp Removal During Screening Colonoscopy

Most colorectal cancers result from abnormal growths (“adenomatous polyps”) in the lining of the colon that become cancerous over time.¹¹ Because most of these polyps can be identified and removed during a colonoscopy, in many cases, colorectal cancer is preventable through timely screening.^{12,13}

Polyp Removal. Bill, who lives in Arizona, has health insurance that covers preventive services without cost-sharing. Both his insurance agent and plan materials indicated that colonoscopy would be fully covered. As recommended by his doctor, Bill went for a routine screening colonoscopy. During the exam, the doctor identified and removed two benign polyps. Soon after, Bill received a bill from his insurer for \$1,100 indicating that his deductible would apply for this procedure. He disputed the charge and his insurer eventually reversed its decision.

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.^{14,15} 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.

USPSTF recommendations – The USPSTF recommendations underscore that removal of polyps is central to making screening colonoscopy a highly effective preventive health care service. According to the USPSTF, “[s]creening for colorectal cancer reduces mortality through detection and treatment of early-stage cancer and *detection and removal of adenomatous polyps*” (emphasis added).¹⁶

Despite its inherently preventive nature and frequent occurrence, polyp removal during screening colonoscopy is sometimes subject to cost-sharing by private health plans. Inconsistency in how insurers define covered “screening” services (that is, whether or not the intent of the exam in an asymptomatic adult is superseded by clinical findings), as well as non-standard billing code practices of insurers and providers, contribute to this result.

Definition of screening – According to medical experts, screening is defined by the population to which a test is applied (i.e., individuals who are asymptomatic), not the findings that result from the test itself.¹⁷ In the context of colorectal cancer, this definition indicates that “screening” would describe a colonoscopy that is routinely performed on an asymptomatic person for the purpose of testing for the presence of colorectal cancer or colorectal polyps. Whether a polyp or cancer is ultimately found should not change the screening intent of that procedure.

This definition of screening is widely accepted in the medical and public health arenas, but is not consistently captured as such within the current medical billing and coding system and is not necessarily embraced by all health plans. Several insurers interviewed reported that cost-sharing should be determined by whether patients were asymptomatic at the time they underwent colonoscopy—i.e., the procedure was for screening – even if a polyp was removed. Other insurers said while they consider screening colonoscopies to be a preventive service regardless of polyp removal, their claims payment systems apply cost-sharing depending on how providers code the procedure.

Variation in coding practices – Claims submitted to a health insurer for reimbursement must be accompanied by billing codes that identify the service provided. So far, no consistent coding methodology is used either by all private insurers or providers to identify the preventive care and screening services that must be provided without cost-sharing as a result of the ACA. As one billing expert noted, this isn't surprising if one considers that the current coding methodologies were first developed when health insurance tended not to cover preventive care.

Recently there have been efforts by the American Medical Association (AMA) to modify the Current Procedural Terminology (CPT) coding system to clearly designate preventive services that should be covered without cost-sharing. In direct response to the new ACA requirement, CPT modifier 33 was created to allow providers to identify to insurance payers and providers that the service was preventive under applicable laws, and that patient cost-sharing does not apply. The AMA writes that the modifier “may be used when a service was initiated as a preventive service, which then resulted in a conversion to a therapeutic service. The most notable example of this is screening colonoscopy (code 45378), which results in a polypectomy (code 45383).”¹⁸ (See Appendix A for further discussion of coding methodology.)

Insurers vary, however, in the coding methods they use and in what codes their claims payment systems can accommodate. Some insurers have encouraged providers to use CPT modifier 33, but another medical director cautioned that claims systems vary widely and not all insurers' systems are designed to use this modifier. Insurers might also direct providers to indicate that the colonoscopy was a screening service through use of ICD-9 diagnosis codes known as “V” codes. However doctors can vary in the diagnosis code they assign (or the order in which they assign multiple diagnosis codes) when a screening colonoscopy involves polyp removal.

Insurers also vary in the guidance they offer providers on how to code screening colonoscopy with polypectomy. For example, a representative of one large group practice described the variation in coding guidance received from the dozen private health insurers that cover the group's patients: five insurers indicated that practices should code all screening colonoscopies as a preventive service, whether or not polyps are removed, so the insurers will know to waive cost-sharing; two insurers advised practices to code screening colonoscopies as therapeutic when polyps are removed; and the remaining five insurers had offered no guidance on this issue.

Insurer payment practices vary – Interviews with medical directors for seven major health insurers in four states found variation in how insurers impose cost-sharing when a polyp is removed during a screening colonoscopy. Four insurers always waive cost-sharing. According to one, “[w]e don’t care what the reasons are; if it’s a colonoscopy, we’re not going to impose cost-sharing.” Three other insurers waive cost-sharing if the provider codes the procedure to indicate a screening colonoscopy. One of the insurers that always waives cost-sharing has recently arrived at this decision and previously viewed polypectomy as therapeutic. This insurer is working on a new system to identify the intent of the screening colonoscopy, even when a polyp is found and participating providers code the procedure differently.

Insurer Payment Practices for Screening Colonoscopy with Polyp Removal

State/Insurer	Insurer Imposes Cost-sharing?
New Mexico	
Insurer A	No
Insurer B	No
Insurer C	No
Connecticut	
Insurer D	Depends on provider coding
Insurer E	Depends on provider coding
California	
Insurer F	No
Washington	
Insurer G	Depends on provider coding

Three other insurers that always waive cost-sharing have adjusted their claims payment systems to provide full coverage for colonoscopy with polyp removal regardless of how the provider codes. Their medical directors reported that this was a business decision, made in the absence of federal guidance regarding the ACA requirement, adopted to reduce provider and enrollee complaints, appeals, and their associated administrative burdens. One director commented this approach also simplified the “impossible” task of distinguishing between preventive services and diagnostic services that left patients “caught in the middle.” These insurers stressed the clinical importance of promoting screening to prevent colorectal cancer. As one put it, “[i]f this is really about prevention and about patients ... it’s just the right thing to do.”

Another medical director echoed this sentiment, “[Polyp removal] is exactly why you’re doing this ... If you take that polyp out, you have prevented the cancer.” Even so, his plan imposes cost-sharing when providers do not code the procedure using CPT modifier 33. Although the insurer has encouraged providers to code the service as preventive, in practice, not all of them use this modifier and when they don’t, patients may owe hundreds of dollars or more when cost-sharing is applied.

2. Colonoscopy as Follow-up to a Positive Stool Blood Test, other Colorectal Cancer Screening Test

The USPSTF gives an “A” recommendation to two other colorectal cancer screening procedures in addition to colonoscopy – high-sensitivity fecal occult blood test (FOBT) and flexible sigmoidoscopy for most adults 50 years of age until 75 years of age.[§] For these procedures, the USPSTF recommends high-sensitivity FOBT on an annual basis or flexible sigmoidoscopy every 5 years combined with high-sensitivity FOBT every 3 years. A high-sensitivity FOBT detects microscopic bleeding that patients would otherwise not notice because it is not visible in the stool. These other procedures are less invasive, pose lower risk of complication, and may be elected by patients and providers for other reasons, such as local test availability or quality and patient preference.

USPSTF recommendations – With respect to these procedures, the USPSTF notes that “follow-up of positive screening test results *requires* colonoscopy regardless of the screening test used” (emphasis added).¹⁹ This is because a positive FOBT indicates the possible presence of a cancer or adenomatous polyp, but the screening process is not complete until the patient undergoes a colonoscopy to determine if the initial test was a true or false positive.

Insurers have adopted different approaches regarding cost-sharing for a screening colonoscopy following a positive FOBT. They vary based on whether the colonoscopy is considered part of the colorectal screening exam, or a separate, diagnostic procedure.

Screening continuum – According to medical experts, cancer screening may be best understood as a stepwise continuum that typically begins with a clinician’s recommendation that an individual without symptoms get tested and concludes with the outcome of the test(s). As one put it, “screening is not a single test, but rather a cascade of events.”²⁰ The USPSTF recommendations are consistent with this notion, writing that “[c]olonoscopy is a *necessary step* in any screening program that reduces mortality from colorectal cancer” (emphasis added).²¹

This suggests that follow-up colonoscopy after a positive FOBT is integral to the screening process and a necessary component of screening. The 2008 Joint Guidelines issued by the American Cancer Society, the United States Multisociety Task Force on Colorectal Cancer (ACS/MSTF) and the American College of Radiology reinforce the importance of the screening continuum by emphasizing that patients with a positive FOBT need follow-up colonoscopy.²² From a prevention perspective, a screening test would not be considered successful if the follow-up colonoscopy were not performed to identify cancer and/or remove polyps that may have caused the positive FOBT in the first place.

Not all providers or insurers subscribe to this concept of the screening continuum. Some regard colonoscopy as a diagnostic service if it follows a positive FOBT. In their view the patient seeking the colonoscopy is no longer asymptomatic; the blood in the stool test (even though the patient was not

[§] These recommendations do not apply to individuals with specific inherited syndromes (the Lynch syndrome or familial adenomatous polyposis) or those with inflammatory bowel disease.

aware of it before the test) is a sign that additional testing is needed. Interestingly, however, the FOBT can sometimes yield a false positive reading, and a follow-up colonoscopy would show normal results. In such cases, the health plan might apply cost-sharing to the follow-up colonoscopy which would have been free of cost-sharing had the patient chosen colonoscopy in the first place.

Insurer payment practices vary – Four insurers reported that they do not impose cost-sharing for a colonoscopy following a positive FOBT, while three insurers always impose cost-sharing. Despite believing that a follow-up colonoscopy would be diagnostic, one medical director noted that his company does not match screenings to positive lab tests so, in practice, the patient might avoid cost-sharing if the doctor codes it as a screening procedure.

Insurer Payment Practices for Screening Colonoscopy Following Positive FOBT

State/Insurer	Insurer Imposes Cost-sharing?
New Mexico	
Insurer A	No
Insurer B	No
Insurer C	Yes
Connecticut	
Insurer D	No
Insurer E	Yes
California	
Insurer F	No
Washington	
Insurer G	Yes

3. Screening Colonoscopy in Individuals at Increased Risk

For the general population, the USPSTF recommends a screening colonoscopy every 10 years, beginning at age 50 and ending at age 75.²³ However, some individuals are at increased risk for colorectal cancer because they have a family or personal history of the disease or of adenomatous colon polyps. Based on the nature of the family or personal history, screening before the age of 50 and/or at higher frequency (e.g., 5 years vs. 10 years) may be recommended; for other patients screening initiation and frequency remains the same, but the individual is advised to have a screening colonoscopy rather than other testing options. With the exception of individuals with exceptionally high risk due to inherited genetic

Surveillance – Personal History. Sarah, who lives in New Hampshire, has a history of colon polyps and receives routine colonoscopies every 5 years. At her most recent screening, she confirmed with her provider that the screening would be covered at no charge to her under the new provisions of the ACA. He said he thought it would, but had heard of patients being charged if polyps were removed. So Sarah asked her insurer, who said colonoscopies were fully covered even if polyps were removed. Sarah went ahead with the procedure. A few weeks later, her insurance statement indicated her deductible applied, and Sarah owed \$1,300. She also received a bill for over \$600.00 from the anesthesiologist. Sarah learned her screening had been coded as “diagnostic” based on her personal history, and was therefore billable. She notified her insurer that this was a routine “surveillance” colonoscopy and should be fully covered under the ACA preventive benefit. Eventually she was able to get all charges removed but wonders if other patients would be as informed and capable of self-advocating.

syndromes, most individuals at increased risk still will not develop colorectal cancer in their lifetime and, like average risk individuals, will be asymptomatic at the time of their screening exams.

Screening for individuals who are at an increased risk due to a personal history of colorectal cancer or adenomatous polyps is also referred to as “surveillance screening” and may be coded as diagnostic despite the fact that the patient is asymptomatic. In addition, asymptomatic adults at high risk for other reasons (i.e., family history) may also have their exams coded as diagnostic even though the USPSFT would still consider such an exam to be a screening service, as noted below.

In the case of women at higher risk for breast cancer, a mammography examination may be more extensive, involving more images than would be taken for an average risk woman. This more intensive procedure is traditionally coded as a “diagnostic” mammogram instead of a “screening” mammogram, even though the patient is asymptomatic and her screening is scheduled at regular intervals. State Consumer Assistance Programs report receiving complaints from women who are at increased risk for breast cancer and who have faced unexpected cost-sharing for annual mammograms.

Adults at increased risk for colorectal cancer have complained that insurers unexpectedly imposed cost-sharing for their regular screening colonoscopies. This was true even though the surveillance colonoscopy is the same procedure that would be performed on an average-risk adult. As is the case with polyp removal, coding practices vary for colonoscopies conducted for adults at higher risk. Insurers may or may not require special coding practices to indicate that the colonoscopy was performed as a screening or preventive measure on an asymptomatic individual who is at increased risk for colorectal cancer.

USPSTF recommendations – The USPSTF recommendations for colorectal cancer screening focus primarily on its use among the general population at average risk for developing the disease.

USPSTF recommendations also make mention of subpopulations who are at higher risk for colorectal cancer because of their family or personal history. Regarding family history, the USPSTF writes, “The recommendations do apply to those with first-degree relatives who have had colorectal adenomas or cancer, although for those with first-degree relatives who developed cancer at a younger age or those with multiple affected first-degree relatives, an earlier start to screening may be reasonable.”²⁴

For individuals with a personal history of colon polyps, the recommendations state, “When the screening test results in the diagnosis of clinically significant colorectal adenomas or cancer, the patient will be followed by a surveillance regimen and recommendations for screening are no longer applicable.” Though it does not elaborate, the statement does not seem to suggest that patients with such personal history should not receive regular screening exams, rather that such patients may require different screening regimens compared to the average risk population.

The USPSTF recommendations also do not elaborate on what is considered to be “clinically significant colorectal adenomas or cancer,” although the criteria are well described in the literature. Surveillance guidelines issued by the ACS/MSTF go into greater detail about what is and is not clinically significant, (see box) and conclude that surveillance regimens are screening regimens since the patient is asymptomatic.^{25,26,27}

ACS/MSTF Colorectal Cancer Surveillance Guidelines

1. **Patients with small rectal hyperplastic polyps** should be considered to have normal colonoscopies, and therefore the interval before the subsequent colonoscopy should be 10 years. An exception is patients with a hyperplastic polyposis syndrome. They are at increased risk for adenomas and colorectal cancer and need to be identified for more intensive follow up.
2. **Patients with only one or two small (<1cm) tubular adenomas with only low-grade dysplasia** should have their next follow-up colonoscopy in 5 to 10 years. The precise timing within this interval should be based on other clinical factors (such as prior colonoscopy findings, family history, and the preferences of the patient and judgment of the physician.)
3. **Patients with 3 to 10 adenomas, or any adenoma ≥ 1 cm, or any adenoma with villous features, or high-grade dysplasia** should have their next follow-up colonoscopy in 3 years providing that piecemeal removal has not been done and the adenoma(s) are completely removed. If the follow-up colonoscopy is normal or shows only one or two small tubular adenomas with low-grade dysplasia, then the interval for the subsequent examination should be 5 years.
4. **Patients who have more than 10 adenomas at one examination** should be examined at a shorter (<3 years) interval established by clinical judgment, and the clinician should consider the possibility of an underlying familial syndrome.
5. **Patients with sessile adenomas that are removed piecemeal** should be considered for follow up at short intervals (2 to 6 months) to verify complete removal. Once complete removal has been established, subsequent surveillance needs to be individualized based on the endoscopist's judgment. Completeness of removal should be based on both endoscopic and pathologic assessments.
6. **More intensive surveillance is indicated when the family history may indicate hereditary nonpolyposis colorectal cancer.**

Insurer payment practices vary – Among the insurers interviewed, one always imposes cost-sharing for colonoscopy screening of high-risk adults when it is performed prior to age 50 or more frequently than every 10 years; three never impose cost-sharing; and two impose cost-sharing based on how the provider codes the procedure. One insurer waives cost-sharing for the initial screening colonoscopy for a high-risk adult, even if it takes place prior to age 50, but not for subsequent screens ordered more frequently than every 10 years.

The medical director for one plan that does not impose cost-sharing noted that screening is particularly important for individuals at an increased risk. In contrast, medical directors for the plans that impose cost-sharing described surveillance colonoscopies as “diagnostic.” One explained that the procedure is diagnostic because it is the result of a prior history of colorectal cancer and because the increased frequency of screening, such as 5 years, falls outside of the USPSTF recommendations.

Another medical director complained that the USPSTF guidelines are “gray” and leave much to be interpreted by insurers in making coverage and cost-sharing determinations. He suggested that cost-sharing determinations are also problematic for other preventive services provided to asymptomatic adults, such as mammography screening for breast cancer, and concluded that “colonoscopy is not going to be the only issue.” At the same time, he acknowledged that his insurer’s claims system does not track time intervals between colonoscopies, so depending on how the doctor codes the procedure, a patient at increased risk who receives more frequent colonoscopy screening might still avoid cost-sharing.

Insurer Payment Practices for Screening Colonoscopy in High-Risk Individuals

State/Insurer	Insurer Imposes Cost-sharing?
New Mexico	
Insurer A	No
Insurer B	No
Insurer C	Yes if screened more frequently than every 10 years
Connecticut	
Insurer D	No
Insurer E	Depends on provider coding
California	
Insurer F	Yes
Washington	
Insurer G	Depends on provider coding

Screening Colonoscopy, Cost-Sharing, and Regulatory Guidance: Observations from the States

State officials are generally aware of consumer confusion and unexpected cost-sharing as a result of consumer complaints related to screening colonoscopies. The Connecticut Office of the HealthCare Advocate and the North Carolina Health Insurance Smart NC, both Consumer Assistance Program (CAP) grantees, said that cost-sharing for a screening colonoscopy has generated more consumer complaints than any of the ACA's new consumer protections. Yet, in other states, such as South Carolina, insurance regulators have heard few, if any, complaints.**

A handful of state legislatures have considered new legislation addressing the issue of cost-sharing for screening colonoscopy to clarify when cost-sharing must be waived in one or more of these clinical circumstances. Recently, in response to consumer complaints, Connecticut passed a law to prohibit health insurers from imposing a deductible for colonoscopy that was initially undertaken as a screening procedure.²⁸ The Connecticut law becomes effective in January 2013 and will apply to all insurance policies (including grandfathered policies) but will not reach self-insured group health plans^{††} which are not regulated by states. The Connecticut law also does not specify that other forms of cost-sharing, such as coinsurance, must be waived. Similar legislation was introduced in Vermont to clarify that cost-sharing should be waived for screening colonoscopy when recommended for high-risk patients, when colon polyps are removed, and in other circumstances, but this bill did not advance.²⁹ In Virginia, legislation also was introduced, but did not pass, that prohibited cost-sharing on any diagnostic service

** However, consumers may not always complain to state insurance regulators; staff at one large group gastroenterology practice in South Carolina reported receiving as many as 4-5 complaints daily on this issue.

†† A self-insured group health plan (or a 'self-funded' plan as it is also called) is one in which the employer assumes the financial risk for providing health care benefits to its employees. Most self-insured health plans are regulated by the federal government under the Employment Retirement Income Security Act (ERISA). State insurance laws do not apply to self-insured health plans.

performed as a result or in conjunction with an ACA mandated preventive service, such as polyp removal during a screening colonoscopy or a biopsy performed as follow up to a screening mammogram.³⁰

Several years prior to the ACA, Maine passed a law to require health care providers to bill an insurer for a screening colonoscopy as the primary procedure even if a polyp is removed when the provider recommends the colonoscopy as a screening test.³¹ The Maine law only applies to fully insured health plans, not self-insured employer-sponsored plans, and only addresses polyp removal, not the two other clinical scenarios described earlier in the paper, where unexpected cost-sharing can arise.

Beyond legislation, guidance might also be provided by state insurance regulators. So far, however, no state regulators have taken formal steps to clarify how health insurance claims for screening colonoscopy should be submitted or covered under the ACA. Some state regulators expressed concern they do not have the clinical expertise to intervene in provider coding practices which underlie many of the issues related to cost-sharing by consumers. CAP staff who help consumers appeal denied health insurance claims suggest that inconsistent coding by providers reinforces inconsistency in coverage. For example, CAP staff in North Carolina reported less success in reducing cost-sharing for a consumer when a provider codes a screening colonoscopy as diagnostic.

State regulators in Oregon have encouraged insurers to take a more proactive role educating their providers on how to code screening colonoscopy. The Department hopes insurers and providers will work collaboratively so that providers would use a coding modifier to indicate screening colonoscopy. Regulators continue to monitor this issue.

In general, state regulators appear to be looking to the federal government for direction. In Georgia, for example, regulators said they are awaiting further guidance in order to move ahead on this issue. Other state regulators and CAP staff also indicated they have reached out to HHS for further guidance and do not want to “get ahead of HHS” on this matter. When asked how to resolve this issue, one regulator suggested that a clearer definition of screening, specifically in the context of the three circumstances described above, would be helpful and could prompt insurers to provide clear, consistent guidance about coding.

To date, the federal government has not issued guidance on how insurers should define “screening” colonoscopy for purposes of eliminating cost-sharing under the ACA. In a different context and prior to the ACA, the Internal Revenue Service (IRS) issued guidance regarding the coverage of preventive services in tax-preferred high-deductible health plans with health savings accounts (HSA-eligible HDHPs). In 2004 the IRS specified that screening colonoscopy was a preventive service eligible for first-dollar coverage under these plans and specifically noted that the “removal of polyps during a diagnostic colonoscopy is preventive care.”³² By contrast, Medicare waives cost-sharing for screening colonoscopy, although Medicare payment rules specify that coinsurance will apply when removal of polyps occurs during the procedure. Legislation has been introduced in Congress to change this practice.³³

Conclusion

While many individuals have benefited from the new ACA rule to cover preventive health services and screening with no cost-sharing, there are cases where lack of clarity has meant that coverage does not work as expected. Consumer complaints about unexpected cost-sharing for colorectal cancer screening, in particular, have caught the attention of health plans, providers, regulators, and consumer advocates.

Regulations to implement the ACA preventive care benefit specified a process for identifying services that would be subject to the no-cost-sharing rule, i.e., an “A” or “B” recommendation from USPSTF. However, the case of cancer screening – and colorectal cancer screening in particular – illustrates that other factors may influence how insurers define covered preventive services. In particular inconsistent use of medical terminology continues to affect how providers and insurers describe screening procedures in certain circumstances or for certain patients. Provider coding practices and insurance claims processing systems don’t use consistent methods to identify procedures for which cost-sharing should be waived. As a result, insurers have not consistently applied the new ACA preventive care benefit to screening colonoscopy if a polyp is removed, if the procedure follows a positive FOBT, or if a person is at increased risk for such reasons as a family history.

Some insurers have acted on their own to resolve the confusion by waiving cost-sharing for all colonoscopy procedures. According to medical directors, this approach fosters patient compliance with colorectal cancer screening recommendations and largely eliminates complaints by consumers and providers. This approach has the advantage of simplicity and promotes consistency of coverage for this preventive care benefit. Other approaches may also work, though not all insurers appear ready to change coverage and payment policies in the absence of further regulatory guidance. State regulators seem generally reluctant to offer guidance at this point and, in any case, do not have jurisdiction to clarify coverage for self-insured group health plans.

As a standard for “defining” covered preventive services, the USPSTF review process distinguishes those preventive services that are evidence-based and a “good buy” for the general population. However, the USPSTF process typically does not address the nuances of these services, nor how they would be applied to groups at higher than average risk. Further, the USPSTF is not charged with developing recommendations on technical issues in insurance coverage or claims processing. Additional guidance is needed to crosswalk the USPSTF recommendations into more explicit rules for what health insurance policies must cover.

The federal government could issue further guidance to improve clarity and make more consistent health insurance coverage of recommended cancer screening services. It could:

- Provide additional specificity as to when consumers are eligible to receive cancer screening procedures with no cost-sharing. In the case of colorectal cancer screening, guidance could address whether cost-sharing should be waived when polyps are removed and when colonoscopy is provided as a follow up to a positive FOBT; for colorectal, breast, and other cancer screening

procedures, guidance could also address whether cost-sharing should be waived when screening is provided to asymptomatic patients at higher risk.

- Issue guidance to providers, health plans, and insurers on coding methods so that procedures are consistently identified and covered.
- Coordinate with state insurance regulators and state Consumer Assistance Programs to collect complaints data, as well as data from insurers and group health plans, to monitor implementation of this benefit and recognize whether further adjustments may be necessary.

Stakeholders have raised the need for further guidance on implementation of other ACA preventive care benefits, as well, to clarify the definition of covered services, who should receive them, and when. For example, in response to recent USPSTF recommendations on the screening for and management of obesity in adults, representatives of health plans and insurers have raised questions about the specific services that must be covered. HHS reportedly is considering whether to issue additional guidance on how the ACA requirement applies for this benefit.³⁴

In the absence of federal guidance, the new preventive care benefit may continue to be inconsistently applied for at least some procedures.

Appendix A - Different Approaches to Insurance Billing Codes for Screening Colonoscopy

Insurance billing codes for screening colonoscopy have two components. The first describes the procedure (CPT code) indicating the exact service that was provided. A family of CPT codes applies to colonoscopy. For example, code 45378 applies to a colonoscopy in which no polyp is detected, while codes 45380-45385 apply to colonoscopy that involves an intervention (e.g., 45385 is the code for colonoscopy with polypectomy.) A second component of the code – either a CPT modifier or a separate diagnostic (ICD-9) code – can differentiate between colonoscopies that were initiated as screening and those that were not.

In response to the ACA's new preventive services requirement, the American Medical Association, which maintains the CPT coding system, developed CPT modifier "33" to indicate when a procedure is initiated as a preventive service. Modifier 33 can be added to the procedure code; so for a patient who sought a screening colonoscopy that resulted in polyp removal, the service would be coded as 45385-33. The doctor's payment is increased when the polyp is removed to reflect the added work, but modifier 33 signals the insurance claims processing system to waive the deductible or other cost-sharing that might otherwise apply to the procedure.

Not all insurers and providers use the CPT modifier 33 today. Some instead use a combination of procedure codes and diagnostic codes to indicate a screening colonoscopy for which cost-sharing should be waived.

All medical bills require a second code (ICD-9 code) which describes the patient's diagnosis or clinical condition. In general, the ICD-9 coding system classifies the disease or injury associated with the procedure that was provided. A subset of ICD-9 codes (V codes) is used when the patient does not have a disease or injury, including when they seek preventive care. More than one diagnosis code may be submitted for a given procedure. For example, doctors could submit V76.51 as the primary diagnosis code for a screening colonoscopy that involves removal (CPT code 45385). The V code indicates the screening intent of the procedure. The doctor might also submit as a secondary diagnostic code to indicate the type of polyp; for example 211.3 indicates a benign neoplasm of the colon was found. In this example, the primary diagnosis code indicates the intent of the procedure at its outset, while the secondary diagnosis code indicates the finding of the polyp. However coding practices vary; some doctors might submit, or insurers might require, ICD-9 code 211.3 *instead* of the V code.

Medicare also uses CPT and ICD-9 codes, though its rules are somewhat different. Even before the ACA, Medicare waived the annual deductible for colorectal cancer screening. Medicare uses modifier "PT" to indicate a preventive service. In addition, when deductibles were first waived for colonoscopy, Medicare instructed providers to use a special "G" code (G0121) for screening colonoscopy for an average risk individual. However, Medicare instructs providers to use G codes only for screening colonoscopy in which no polyp is found. If a polyp is found and removed, providers are to use only a combination of CPT and ICD9 codes. If the patient came for a screening colonoscopy and was asymptomatic, CMS instructs providers to use V76.51 as the primary diagnosis code and 211.3 as the secondary diagnosis code.¹ Under Medicare rules and federal law, cost sharing is only waived for screening colonoscopy when no polyp is removed. Legislation to change this rule has been introduced in Congress.

¹ See MLN Matters #SE0746, "Coding for Polypectomy Performed During Screening Colonoscopy or Flexible Sigmoidoscopy, at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE0746.pdf>

End Notes

¹ Patient Protection and Affordable Care Act, P.L. 111-148, § 1001 (establishing § 2713 of the Public Health Service Act) (codified at 42 U.S.C. § 300gg-13 (2006)).

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⁴ Screening for colorectal cancer: U.S. Preventive Services Task Force recommendation statement. Ann Intern Med 2008;149:627-37.

⁵ Siegel R, Naishadham D, Jemal A. Cancer statistics, 2012. CA: A Cancer Journal for Clinicians 2012;62:10-29.

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⁸ Smith RA, Cokkinides V, Brawley OW. Cancer screening in the United States, 2012: A review of current American Cancer Society guidelines and current issues in cancer screening. CA: A Cancer Journal for Clinicians 2012.

⁹ See for example Colonoscopy Costs and Pricing Information. 2012. (Accessed August 1, 2012, 2012, at colonoscypcosts.com.) See also How much does colonoscopy cost? 2008. (Accessed August 1, 2012, 2012, at health.costhelper.com/colonoscopy.html.) It is difficult to get precise charge and cost information related to colonoscopy because it is not standardized and reports are anecdotal. However, most published references are within and above the range described above. At Costhelper.com dozens of consumers have posted the charges and co—pays they incurred, with highly variable charges even when grouping procedures based upon normal exams vs. those with polypectomy.

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¹² Zauber AG, Winawer SJ, O'Brien MJ, et al. *Colonoscopic polypectomy and long-term prevention of colorectal-cancer deaths*. N Engl J Med 2012;366:687-96.

¹³ Winawer SJ, Zauber AG, Ho MN, et al. *Prevention of colorectal cancer by colonoscopic polypectomy*. The National Polyp Study Workgroup. N Engl J Med 1993;329:1977-81.

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²⁹ VT H.B. 601 (2012).

³⁰ VA H.B. 705 (2012); VT H.B. 601 (2012).

³¹ ME Public Law No. 516 (2008).

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³⁴ <http://www.kaiserhealthnews.org/features/insuring-your-health/2012/obesity-guidelines-michelle-andrews-071012.aspx?referrer=search>



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