

Making Sense of the 2011 Screening Colonoscopy Changes

BY AMY FASTI

Perplexed about the new rules on preventative services that came into effect this year? You are not alone. Confusion has been swirling on all fronts, including payers, providers, and patients. This facet of healthcare reform is aimed at encouraging patients to get screenings in order to discover health issues at an early and treatable stage.



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The Patient Protection and Affordable Care Act (PPACA) requires all job-related health plans or individual health insurance policies to cover screening colonoscopies without any cost sharing for patients between the ages of 50-75 years old. All commercial payers must follow the PPACA once they renew or change their plan on or after September 23, 2010. If the patient's health plan has already renewed or changed (many did on January 1, 2011), then the insurance company must comply with the law. If the plan is "grandfathered," these benefits may not apply. Grandfathered plans are exempt from the changes in the act, but they must disclose this in plan materials so that consumers are aware.

Keep in mind that this benefit only applies to screening, which means that the patient is not experiencing any symptoms, such as abdominal pain or rectal bleeding. If the patient has symptoms, then it is no longer a screening colonoscopy and the patient's plan will determine any possible financial liability.

While CMS and the majority of commercial payers include a personal history with no current symptoms as a screening, there are some commercial payers that have categorized this as a diagnostic/medical procedure and therefore are not applying the "free screening" benefits to the patient's claim. Hopefully in time, these payers will be mandated to comply with the definition of a screening colonoscopy to include personal history.

Both from a consumer and provider standpoint, the safest way to ensure that the procedure is covered with no patient liability is to check with the insurance carrier. Verification of benefits is a critical step in the process for any procedure as it confirms coverage as well as any potential cost sharing. If the insurance carrier states that the screening is covered, but with patient liability (copay/coinsurance/deductible), ask them to justify it. Is it because the patient is not between 50-75 years old? Did the patient's plan not yet renew for 2011 and therefore the PPACA does not apply? If the answer does not appear to be in alignment with the PPACA mandate, then further question why they are not following the new regulations. Most carriers are aware of the law, but there could be some that are still lagging behind.

Effective January 1, 2011, Medicare reimburses the screening 100% as long as the procedure remains a screening. If the screening colonoscopy becomes a therapeutic procedure in which a polyp is removed for biopsy, the patient would be responsible for 20% coinsurance; however, Medicare will waive the deductible portion in this case. While Medicare will not waive the full patient liability when a screening colonoscopy becomes therapeutic, commercial payers under PPACA will. Regardless of the outcome of the scheduled screening, if a patient (between the ages of 50-75 years) has a commercial plan that complies with PPACA, there should be no cost sharing and the insurance company should pay the full contracted rate.

If you are an out-of-network provider, your patients will not reap the benefits of PPACA. The regulations only apply to in-network claims. Patients, who may have gone to an out-of-network provider previously, may begin to rethink their choice in provider in an effort to eliminate their cost for screenings.

Modifiers are used to signal the payer to process the claim appropriately.

- For commercial payers, the 33 modifier should be appended to the CPT. The 33 modifier will trigger the payer's system to acknowledge the case was scheduled as a screening, and will therefore process without patient liability.
- Use the PT modifier when billing Medicare for a screening that has turned into a therapeutic code.
- Do not use the PT modifier for a Medicare claim that remains a screening (e.g. G0105, G0121). Since G0105 and G0121 are specifically for screenings, Medicare does not want the PT modifier, as the claim will process with no cost to the patient.

Most payers have updated their systems to accept the 33 modifier, but there are still a few carriers that are not able to process them with the modifier. The majority of these will process the claim without patient liability, but their system is setup to identify the screening by the primary diagnosis code (e.g., V76.51).

Understanding the rules of the "free colonoscopy" is important. But there are other things to consider to assure that you, as a provider, and your patients experience the intended benefits. Share the knowledge with patients and physicians. Talk to the physicians in the community so that they are armed with the regulations. As a provider, participate in community health fairs or events to increase awareness.

From the perspective of the business office, identify key points in the process

(continued on page 16)

that are critical to determining if the procedure should be covered with no patient liability. Scheduling should be complete and accurate, including the primary diagnosis for the procedure. If the patient is experiencing symptoms, then the patient's individual health plan will determine the cost sharing, as this would not fall under PPACA guidelines. Understanding the reason for the procedure is crucial in correctly verifying the benefits. If the patient appears to fit the qualification for a screening colonoscopy without cost sharing, but the insurance carrier does not agree, don't be afraid to challenge the insurance representative. Sometimes they are wrong.

Document the benefits information in the practice management system – many systems have specific fields for this. This facilitates communication with the patient during reminder calls or registration. Educate staff on the regulations so that they can communicate clearly and confidently to the patients. But it is also important to encourage patients to contact their

insurance company directly to confirm their coverage and liability.

Monitor the different payers to ensure that claims are processed as expected. Spot check claims with 33 modifiers to verify that they were paid at the contracted rate by the insurance carrier. Keep a list of the different payers so that you can be assured all are processing correctly. Determine that Medicare is also processing their screening codes (G0105, G0121) with no cost sharing. Check claims that were processed with PT modifiers.

If you discover that any of the insurance carriers are not paying as expected, contact them immediately and be persistent until they resolve the issues, whether that be on one claim or an across the board system issue. Stand your ground with insurance carriers, albeit in a professional manner. After all, you are only asking for what is appropriate and due for services provided.

Screening colonoscopies are covered under PPACA. However, not all services considered to be preventive are

covered in the law, so it is important that patients contact their insurance carriers to determine if there is patient financial responsibility.

The overall goal of the PPACA is to encourage patients to undergo screenings, barring financial barriers. It won't be long before insurance carriers pass the cost of this benefit to consumers with increased premiums. Regardless, if it is included as a benefit for patients who fit the criteria, it leads to the conclusion that more people will get screened, and in the end possibly saves more lives.

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