What's Covered? *Demystifying Cost-Sharing for Colorectal Cancer Screening* (January 2024)

Quality Health Associates of North Dakota

Routine Screening Tests	FIT or iFOBT	FIT-DNA or mt-sDNA (Cologuard®)	Screening Colonoscopy	Follow-on Colonoscopy	Preventive Diagnostic Colonoscopy	Surveillance or Diagnostic Colonoscopy
			Screening procedure with no diagnosis or tissue removal		Screening or Follow-on procedure with diagnosis or tissue removal	
Screening Interval	**1 Year**	**3 Years**	**10 Years**			**2 Years**[a]
Private Insurance Affordable Care Act (ACA) Plans, also known as "Metallic" plans. Most HSA plans are also in this category.	100%	100%	100%	100% Modifier [c] **33**	100% Modifier [c] **33**	See plan documentation [b]
Private Insurance Non-ACA Plans, also known as "grandfathered" plans.	See plan documentation [b]					
NDPERS PPO/Basic Grandfathered Health Plan by Sanford Health Plan	100%	$200 benefit towards screening once per benefit year. See plan documentation [b]			See plan documentation [b]	
North Dakota Medicaid and Medicaid Expansion Medicaid beneficiaries may be subject to Client Share[d]	100%	100%	100%	100%	100%	100%
Medicare Part B **Medicare Advantage** plans may require Advance Notice or Preauthorization. [e]	100%	100%	100%	100% Modifier [c] **KX**	85% through 2026 90% through 2029 then 100% from 2030 Modifier [c] **PT**	100%
North Dakota Colorectal Cancer Screening Initiative (NDCRCSI) Serving uninsured and underinsured at participating clinics.	100%	100%	100%	100%	100%	100%

[a] *Medicare Part B and Medicaid covers a colonoscopy every 24 months for above-average risk factors. Other insurance plans may differ.*

[b] *Coverage of services by each individual or group insurance plan may differ. See the specific plan documentation or call the number on the back of the insurance card to verify coverage.*

[c] *CPT® and HCPCS code billing modifiers must be used with these plans to guarantee coverage of certain preventive services. See the following page for additional information.*

[d] *Medicaid beneficiaries may be subject to Client Share (Recipient Liability). See the Fact Sheet (https://www.hhs.nd.gov/sites/www/files/documents/DHS%20Legacy/fact-sheet-medicaid-recipient-liability.pdf) for details.*

[e] *Refer to the United Health Care Provider Administrative Guides (https://www.uhcprovider.com/en/admin-guides.html) for Advance Notice or Preauthorization requirements.*

As the statutes regarding coverage of preventive services such as colorectal cancer screening change over time, our practices regarding coding and billing must be reviewed to accommodate the changes. After the Affordable Care Act was implemented in 2010, CPT® and HCPCS billing codes were introduced to support these changes in the law. The following are some of the billing modifiers that are often used in conjunction with colorectal cancer screening.

Billing Modifier	Applies to	Description
33	• Commercial • Medicaid • Medicaid Expansion • NDPERS	For commercial, Medicaid and Medicaid Expansion patients, billing modifier 33 should be used with a **follow-on colonoscopy** – that is, a colonoscopy performed as a second step of screening after a positive non-invasive screening test, such as FIT, FOBT, or Cologuard®. This modifier should be added to all related codes including the related office visits, pathology, and anesthesia. When used properly with a non-grandfathered plan, this code will eliminate coinsurance costs to the patient for the colonoscopy and all related services.
KX	• Medicare • Medicare Advantage	Medicare's HCPCS billing modifier KX is similar to modifier 33 for a **follow-on colonoscopy** and should be used with HCPCS codes G0105 or G0121 following a positive non-invasive test to eliminate coinsurance costs to the patient.
PT	• Medicare • Medicare Advantage	Coinsurance will still apply with Medicare **when polyps are removed** during a follow-on colonoscopy, but the cost to the patient can be reduced by 80% when using the billing modifier PT with those procedure codes. This benefit is implemented in a phased approach that will eliminate coinsurance entirely by the year 2030.
52	• Commercial • Medicaid • Medicaid Expansion • Medicare • Medicare Advantage • NDPERS	What happens if a patient or provider chooses colonoscopy for routine colorectal cancer screening, but the colonoscopy is **incomplete** due to poor colonoscopy prep? This is a very common scenario but should not prevent the patient from completing colorectal cancer screening. Billing modifier 52 identifies a colonoscopy that was performed but not completely due to poor prep by the patient. An explanation must be provided with this modifier. This modifier should reduce or eliminate coinsurance, however, each plan may differ in coverage for incomplete screenings.
53	• Commercial • Medicaid • Medicaid Expansion • Medicare • Medicare Advantage • NDPERS	This modifier is like modifier 52 but instead identifies a procedure that was **discontinued** due to extenuating clinical circumstances or those that may threaten the well-being of the patient. An explanation must be provided with this modifier. This modifier may reduce the coinsurance, however, each plan may differ in coverage for incomplete screenings.