All right. Well, welcome everyone to the second peer-to-peer event in our series of three. Our goal with these events was to give you an opportunity to learn from each other and to to share some of the strategies that were really impactful in some of our participating clinics. We will be requesting some additional stories from from all of you in the very near future as we prepare for the upcoming rapid Action collaborative for our 4th and final cohort of screened. So our idea there is to have some conversations with you about some very specific topics that have been impactful in your own organizations, record those conversations and then pull some sound bites from those that we can use in, in our rapid action collaborative with our last group.

Today's call, however, will be focusing on sharing the new cost share guidance for colorectal cancer screening and this has been a really hot topic for some of our participating clinics and we wanted to make sure that everyone had the same information.

And so Jon Gardner is our presenter today, he is the network administrator for Quality Health Associates of North Dakota and the data manager and analyst for the screened program. He did a ton of work to pull this information together and so I will turn it over to him to explain some of those changes. And some of the upcoming expectations with coverage for colorectal cancer screening. Thank you, John.

Thanks Nikki.

As Nikki mentioned, I am, I do have an IT background, but certainly an interest in in this program and. And it was certainly interested in in learning more about how the this cost sharing works for colorectal cancer screening. Since we've been working on this work, so. So I I'll attempt today here to share what I've learned. And we'll be speaking. I'll be speaking to this topic that seems to very frequently come up in conversations. Regarding insurance coverage for colorectal cancer screening and colonoscopies in in general. And these are the the topics that I'll be going over today.

Colorectal cancer is the 4th most common and second most deadly of all cancers in the United States. It is also the only type of cancer with multiple easy at home screening modalities. However, for a long time, persons on nearly any insurance plan have been surprised with unexpected bills after routine preventive colorectal cancer screening procedures. They might go to sleep for regular screening, colonoscopy and wake up with a huge bill for diagnostic or therapeutic colonoscopy due to findings or additional procedures that took place during the screening.

One of the goals of the Affordable Care Act, the ACA is a comprehensive health care reform law enacted in March 2010, is to lower the costs of healthcare and to make affordable health insurance available to more people. Section 4104 of the ACA explicitly waives the beneficiary coinsurance and deductible for certain covered preventive services identified by the US Preventive Services Task Force the USPSTF. Including colonoscopy, sigmoidoscopy and fecal occult blood testing. Well, the goal of section 4104 of the ACA was to eliminate the coinsurance and deductibles for covered services. Diagnostic or therapeutic colonoscopies have continued to be subject to coinsurance and deductible costs to beneficiaries. To address this, the Biden and been excuse me, the Biden administration issued guidance in January of

2022 clarifying the patient cost sharing for preventive benefits under the ACA. Under this guidance, a colonoscopy scheduled as a screening procedure, per the USPSTF recommendations, should not result in cost sharing for items and services integral to performing the procedure, including polyp removal and pathology. In addition, the guidance states that follow up. Colonoscopy is an integral part of the preventive screening without which the screening would not be complete. So colonoscopies and related procedures scheduled and performed as a result of a positive stool based test such as fit IFOBT or the multi targeted stool DNA test. Cologuard should not result in cost sharing.

So how does the insurance company know which procedures should or should not result in cost sharing? For non Medicare patients, when a screening colonoscopy converts to a diagnostic or therapeutic procedure for a non Medicare patient, the provider must document that the intent of the procedure was preventive for the patients insurance to process that claim without out of pocket expense in accordance with the ACA. So CPT developed modifier 33 in response to the ACA. This allows providers to indicate which services or claims should be considered of. Considered preventative. For example, if a surgeon performing a screening colonoscopy finds and removes a polyp with a snare, use CPT code 45385 and Append modifier 33 to that CPT code. This modifier should be used to identify preventive services rated A or B by the USPSTF. CRC screening in all adults aged 50 to 75 is rated A and CRC screening in all adults ages 45 to 49 is rated B. Additional procedures and office visits performed as a result of a spot positive stool test, such as a follow up colonoscopy and removal of polyps should all be coded with modifier 33 to identify that follow up procedure as part of the preventive screening. That should not result in cost sharing.

Now for Medicare patients. The Hick picks modifier HCPCS modifier PT should be used instead.

Earlier I mentioned that non grandfathered plans under the ACA must implement this guidance. So what about grandfathered health plans? A grandfathered health plan is a health insurance policy purchased on or before March 23rd, 2010 and may not include rights and protections provided under the Affordable Care Act if it is a group health plan, the date the patient joined May not reflect the date the plan was purchased or created. So how does a patient know if they're health insurance is grandfathered? According to the ACA, a health plan must disclose whether it believes it is a grandfathered plan. A plan or health insurance coverage must include a statement in the plan materials provided to a participant or beneficiary that the plan believes it is a. It is a grandfathered health plan, as defined in the Affordable Care Act. In addition to statements like this, all Affordable Care Act plans are identified with a metallic level, such as bronze, silver, gold and platinum. These metallic levels pertain roughly to the actuarial value of the plan. If the health plan does not have one of those designations, it is very likely a grandfathered plan. If you or your patient does not know whether the insurance plan is grandfathered, it is best to call the number on the back of the insurance card.

While this guidance also does not apply to Medicare plans, Congress has passed the removing barriers to. Removing barriers to colorectal cancer screening act in December of 2020, which reduces cost sharing for Medicare patients if polyps were found and removed during a screening colonoscopy. This bill is implemented in a phased approach, increasing the benefit by 5% every two years and eliminating all

cost sharing by 2030. As a reminder, the Hick Picks modifier PT should be used on services that should be identified as preventive for the patient to gain this benefit.

We've discussed patient benefits with Medicare or those with non grandfathered plans, but what about everyone else? There are approximately 54,000 uninsured adults in North Dakota and over 2000 of those are at risk for developing colorectal cancer. Colonoscopies are expensive and cost is certainly a barrier to screening. The cost for a screening colonoscopy alone without adequate health insurance generally falls between 1700 and $4800, depending on the area and the provider. In North Dakota, there is a program that can help this uninsured population. The North Dakota colorectal Cancer Screening Initiative is a program similar to women's way and provides colorectal cancer screening with no out of pocket costs for those who are eligible based on income. Encourage your patients who may qualify to contact our enrollment specialists using the toll free number here. Please let us know if you have any questions about this program.

We went over quite a bit of information today from the Affordable Care Act. The new guidance provided by the Biden administration, appropriately billing preventive procedures and the screening initiative for uninsured and underinsured populations.

Does anybody have any questions or comments before we move on?

John, this is Nikki. And we had a few join a little bit later and one of the things that I think has been. Really important or really I don't know if controversial is the right word, but confusing. And you clarified very well in slide #6. In regard to how the the second step of a screening where you use a positive or where you use a stool test and have a positive result and then have a follow up colonoscopy, could you repeat this slide for the benefit of everyone? I just think if if even if you weren't quite listening, there's a lot to catch in this information.

Yep, absolutely.

So so ultimately, how does the insurance company know which procedures should or should not result in cost sharing and in particular procedures that should be considered preventative by the USPSTF? So for non Medicare patients? When a screening colonoscopy, uh may convert to a diagnostic or therapeutic procedure of the provider, must document that the intent of the procedure was preventive for the patients insurance to process that claim without out of pocket expense.

So CPT developed modifier 33 in response to the ACA, and that allows providers to indicate which services or claims should be considered preventative. For example, if a surgeon performing a screening colonoscopy finds and removes a polyp with a snare, we'll use CPT code 45385 and append modifier 33. So this modifier can be used to identify any preventive services rated A or B by the USPSTF.

Additional procedures and office visits performed as a result of a positive stool test, such as a follow up colonoscopy and removal of polyps, should be coded with modifier 33 to identify that follow up procedure as part of the preventive screening and should not result in cost sharing for the patient.

Thank you.

Absolutely. Any other questions or comments? I see several people did join a little bit. A little bit late. Is there anything else that you would like me to go over again? We do have some extra time today.

In order to speak, if you click on your microphone symbol, I probably has a line through it, but if you click on it, you would be unmuted. Or you're welcome to use the chat.

John, this is Judy and I'm from QHA. But I was just wondering with having clinics on here, what is the current process? This is all very confusing, very confusing for the providers, very confusing for the person that's getting the screening. But I was just kind of curious, what is the current process to make sure that? Let's say my insurance, whether or not it's going to result in any type of copay or dot and write down today. If I were to have, let's say, screening colonoscopy, what's the? Current process that clinics are using.

You know, I I I guess I can't speak for the clinics as to their individual processes, but ideally the clinic would. I would check with the insurance and with the with the patient to identify what those costs are going to be on prior to those procedures being performed. And in particular, you know. Paying attention to whether the patients health insurance is a grandfathered plan or not is probably going to be the biggest. Umm indicator if you will, of whether those follow up procedures are going to be billed or not. As long as everything is is billed correctly, such as with the the modifier 33 or PT for Medicare plans. If the patient is on Medicaid. The the base Medicaid program does not cover. The the follow up colonoscopies as far as I'm aware. Or additional services like that unless they are. On a Medicare expansion plan that does include that and unfortunately I don't have much details on that.

So really identifying the insurance is going to be the biggest thing to determine what costs are going to be and. You know which items will be billed for and which ones won't. I hope that answers that question.

Thanks John.

Umm. You know, a similar question has been brought up over time in regard to Cologuard. And one of the nice services that EXACTSCIENCES offers is that. The patient and the provider or the patient, with or without the provider, can call the exact sciences 800 number and ask for them to speak with the. With their insurance company and so that becomes a 3 way call sometimes when in regard to certain. Umm. Procedures or certain products like Cologuard. Those at Cologuard have all of that information in. There are steeped in it. That's their specialty. And so they're able to ask those questions in a way to get the right answer from the insurance company. And so for your patients who are using Cologuard, if cost share is a question for them. And they're uncomfortable calling the number on the back of their insurance card

because they feel like they won't ask the right questions. They can certainly call the Cologuard 800 number and get that assistance. And they're happy to do that 24 hours a day, seven days a week.

Yeah, that's absolutely a great resource to have as well. And I believe Cologuard will even establish a, A where they call it a 3 way call, so that the patient, Cologuard and the insurance company is on the line at the same time to make sure all of the questions are answered.

Exactly. I'm sorry I didn't make that clear. Thank you for clarifying.

So if there are no additional questions. This slide includes all of the OR many of the resources that I used to to bring this information to you. Feel free to. To dig through those if you'd like, but if you have any questions or if. Or if there's other resources that you would like to to see, I'll be happy to to dig them out for you.

So until next time, if you have any questions or concerns, please feel concerns, please feel free to contact Nikki or myself and we'll be happy to answer them or at least try to find the answers for you.

We hope that you join us for our next peer-to-peer event coming up on September 20th at noon, that is noon central time and. This particular event will feature uh, the. Population health nurse and clinic manager from Jacobson Memorial Hospital Care Center and clinics, and they will just be sharing their huge success. The strategies that they used to improve their screening rates. And so we are looking forward to that. Please make sure that you use the link in the invite that we send. Apparently there was some issues this morning with the calendar invite, so not sure why those differ. We'll try to figure that out, but the link in the peer-to-peer sharing virtual event series notification or that we send in the e-mail that is the correct link.

So thank you all for joining today. We hope you have a very productive day. Thank you. Thank you.