Your Questions Answered

AGE 45 IT'S THE LAW

COLORECTAL CANCER SCREENING COVERAGE LAW IN KENTUCKY

Kentuckians at average risk ,with fully-funded[1] health plans, are eligible for colorectal cancer screenings beginning at age **45** to age 75 (76-85 talk to healthcare professional) at no out-of-pocket cost through their in-network health care provider AND laboratory services.

Thanks to a Kentucky law (KRS 304.17A-257) that was revised in 2015 and 2019, if your patient has a positive result from a screening FIT or stool DNA test, most health plans should still consider the follow-up colonoscopy as a screening colonoscopy, with no out-of-pocket co-pay or deductible beginning at age 45 for average risk patients.

Who is COVERED under this law?

- Kentuckians who have fully-funded[1] health benefit plans
- Kentuckians who have Medicaid or who have insurance through one of Kentucky's contracted Managed Care Organizations to provide Medicaid services

Who is NOT COVERED under this law?

- Kentuckians who have self-funded[2] health benefit plans governed by ERISA
    - Self-funded health benefit plan: Health insurance plan in which the sponsoring organization (usually the employer) assumes the financial risk for paying for covered services provided to its enrollees (Examples: Ford or GE)
    - Specific coverage depends upon health plan. Different health plans will cover different guidelines for colorectal cancer screening services such as FIT, Cologuard, screening and diagnostic colonoscopy, sigmoidoscopy and/or EGD.
- Kentuckians who are uninsured
- Kentuckians who are covered by Medicare

What do I ask the insurance company when I call to find out if they are covered under this law?

- Call the customer service phone number on the insurance card
- Is this patient's insurance plan considered "self-funded" or "fully-funded by the Department of Insurance?"
- If self funded:
    - Which colorectal cancer screenings are covered?
    - What age can an average risk person begin screening?
    - Are there any co-pays or deductibles for colorectal cancer screening?
    - If a polyp is removed during a colonoscopy, is it still considered a screening colonoscopy?
    - If a patient has a positive fecal test and needs a colonoscopy as follow-up, is that colonoscopy considered a screening colonoscopy?

What is covered at no out-of-pocket cost for those who have fully-funded OR Medicaid/Medicaid MCO health plans and are using in-network providers and laboratory services?
All American Cancer Society approved tests for Colorectal Cancer Screening including but not limited to:

- FIT Test
- DNA Stool kit (link)
- Colonoscopy (Preventive/Screening not diagnostic)
- For a complete list follow the link here

If a patient is using an in-network provider, is it ever possible that they would have an "out-of-pocket" cost or deductible?
If the anesthesiologist or laboratory services are out-of-network, a patient may receive a bill for this part of the services. When in doubt, call patient's insurer to confirm coverage prior to the procedure by calling the customer service number on the back of the insurance card.

If a positive FIT or Stool DNA (e.g. "Cologuard") is received, is the follow-up colonoscopy still considered a screening procedure?
Yes - these are all considered to be screening procedures included in a complete screening cycle (rather than diagnostic) and should be submitted with the appropriate billing code(s) for a screening procedure with a modifier code to identify that it is still a preventative service, and ICD-10 codes.

If a polyp is removed during a screening colonoscopy, is it still considered a screening procedure?
Yes – This should be submitted with the appropriate billing code(s) for a screening procedure with a modifier code to identify that it is still a preventative service, and ICD-10 codes

What is a complete screening cycle for colorectal cancer screening?
Eligible patients of AVERAGE RISK can have:

- A Highly sensitive fecal immunochemical test (FIT) every 12 months + 1 day. If the FIT is positive and fit the clinical criteria, then a follow-up screening colonoscopy
- A Multi-targeted Stool DNA (e.g. Cologuard) every 3 years + 1 day. If the Stool DNA is positive and fit the clinical criteria, then a follow-up screening colonoscopy
- A Screening Colonoscopy (every 10 years)
- CT Colonography (virtual colonoscopy) every 5 years. If the CT colonography is positive, then a follow-up screening colonoscopy
- Flexible sigmoidoscopy (FSIG) every 5 years. If the FSIG is positive, then follow-up screening colonoscopy

What does Medicare cover?

Age 50 and older:

- Screening colonoscopy every 10 years for average risk
- Multi-target stool DNA lab test once every 3 years for average risk,
- Screening barium enema every 4 years for average risk
- Fecal occult blood tests every 12 months for average risk
- Screening flexible sigmoidoscopies every 4 years for average risk

What kinds of co-payments or deductibles should Medicare patients expect?

- Call the patient's insurance company.
- Be sure to use your ICD-10 Codes, Preventative Service Screening codes, modifier codes.
- Call ??? (Lindy?) 555-555-5555 or email thebestcodingsource

References:

1. Fully-funded health benefit plan: Individual, small and large group health insurance plans in which the insurer assumes the financial risk of paying for covered services. The Kentucky Department of Insurance regulates these plans.
2. Self-funded health benefit plan: Health insurance plan in which the sponsoring organization (usually the employer) assumes the financial risk for paying for covered services provided to its enrollees (Examples: Ford or GE).