COMMON QUESTIONS REGARDING COLON EXAMS

HOW SHOULD PROVIDERS HANDLE THE PREVENTATIVE, VERSUS DIAGNOSTIC, PROCEDURE WHEN POLYPS ARE FOUND AND REMOVED DURING A COLONOSCOPY?

- From the DOL/HHS FAQ Q5: **If a colonoscopy is scheduled and performed as a screening procedure pursuant to the USPTF recommendation, is it permissible for a plan or issuer to impose cost-sharing for the cost of a polyp removal during the colonoscopy?**
  No. Based on clinical practice and comments received from the American College of Gastroenterology, American Gastroenterological Association, American Society of Gastrointestinal Endoscopy, and the Society for Gastroenterology Nurses and Associates, polyp-removal is an integral part of a colonoscopy. Accordingly, the plan or issuer may not impose cost-sharing with respect to a polyp removal during a colonoscopy performed as a screening procedure. On the other hand, a plan or issuer may impose cost-sharing for a treatment that is not a recommended preventive service, even if the treatment results from a recommended preventive service.
  https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-xii.pdf
- Note: the colonoscopy and removal must be performed at the same time to qualify as preventive. A later scheduled removal will not be covered as preventive.
- Generally, a 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. In the context of colorectal cancer, this definition indicates that the “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 the procedure.
- To view the current recommendations to ensure it is preventative, providers can visit:
  https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/colorectal-cancer-screening2
- If there is a reason that a provider would like to do a colonoscopy, like a patient complaint, then it is likely to no longer be a screening.
- It is important to note that the US Preventive Task Force (USPTF) is currently updating the guidelines on colorectal screening. There is no information on the potential update, but providers may wish to follow this to stay up-to-date on the guidelines. They can be found at:
  https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryDraft/colorectal-cancer-screening3

WHEN A PATIENT RECEIVES A POSITIVE FIT TEST, IS THE FOLLOW-UP COLONOSCOPY CONSIDERED PREVENTATIVE OR DIAGNOSTIC?

- Possibly, if the FIT Test was conducted as a preventative screening and the colonoscopy is within the allowable preventative time frames. Based on practice standards - including American Cancer Society colorectal cancer screening guidelines - the screening is not complete without a colonoscopy, however the USPTF has NOT directly stated whether this remains preventive or not.

COMMON QUESTIONS CONTINUED...

ARE ALL GAPS CLOSED IN THE DIAGNOSIS AND COST SHARING?

- For plans that are required to provide Essential Health Benefits (individual and most group plans, but not all) the removal of polyps during a screening colonoscopy and their testing in the lab must be covered without cost sharing as part of the Preventive Services EHB. However, here are some circumstances under which that might not be the case:
    - If the provider or facility is out of network, then that provider or service might not be covered.
    - If the there is an anesthesiologist, they could be out of network, even if the facility and other involved providers are in-network.

- HB 1065, protecting patients from surprise billing, would likely protect most patients from this circumstance. However, if the patient is in a self-funded plan, their employer may not have opted to bring their plan under the protections of this bill, which is voluntary for self-funded employer plans.

DOES CURRENT WASHINGTON STATE LAW ALLOW FOR A POLYP TO CHANGE THE PROCEDURE FROM PREVENTATIVE TO DIAGNOSTIC?

- There is no specific Washington law outside of the USPTF/ACA requirements. However, Washington has specifically adopted the USPTF recommendations at RCW 48.43.043:
- Colorectal cancer examinations and laboratory tests – Required benefit coverage.

(1) Health plans issued or renewed on or after July 1, 2008, must provide benefits or coverage for colorectal cancer examinations and laboratory tests consistent with the guidelines or recommendations of the United States Preventive Task Force or the federal Centers for Disease Control and Prevention. Benefit coverage must be provided:

(a) For any of the colorectal screening examinations and tests in the selected guidelines or recommendations, at a frequency identified in such guidelines or recommendations, as deemed appropriate by the patient's physician after consultation with the patient; and

(b) To a covered individual who is:

(i) At least fifty years old; or

(ii) Less than fifty years old and at high risk or very high risk for colorectal cancer according to such guidelines or recommendations.

(2) To encourage colorectal cancer screenings, patients and health care providers must not be required to meet burdensome criteria or overcome significant obstacles to secure such coverage. An individual may not be required to pay an additional deductible or coinsurance for testing that is greater than an annual deductible or coinsurance established for similar benefits. If the health plan does not cover a similar benefit, a deductible or coinsurance may not be set at a level that materially diminishes the value of the colorectal cancer benefit required.

(3) (a) A health carrier is not required under this section to provide for a referral to a nonparticipating health care provider, unless the carrier does not have an appropriate health care provider that is available and accessible to administer the screening exam and that is a participating health care provider with respect to such treatment.

(b) If a health carrier refers an individual to a nonparticipating health care provider pursuant to this section, screening exam services or resulting treatment, if any, must be provided at no additional cost to the individual beyond what the individual would otherwise pay for services provided by a participating provider.