

Barriers to Preventive Cancer Screenings due to Coding and Billing of Claims

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Background

Federal regulations require that most health plans cover preventive health without cost sharing being incurred by the insured when services are provided by an in-network provider. In October 2016, CMS awarded a grant to the Kentucky Department of Insurance to examine the application of this requirement to the five major health insurance carriers in the state.

Goals and Objectives

- To evaluate compliance with the preventive health coverage requirements of the ACA;
- To track barriers to compliance and monitor areas of non-compliance; and
- To educate consumers, providers, and insurers on preventive benefits and potential billing and coding issues.

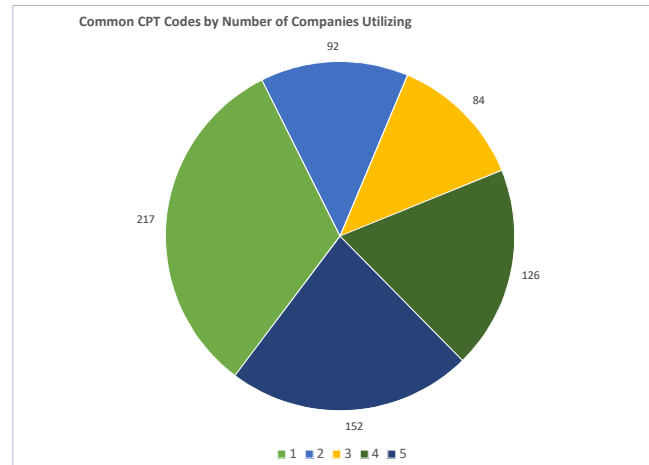
Methods

The Department performed targeted market conduct examinations on the practices of five carriers offering fully insured health plans in Kentucky to ensure compliance with federal requirements for coverage of preventive health benefits.

The data was imported into Audit Command Language software and stratified by coding to identify the claim as a preventive service, many of which relate to cancer prevention. Data was collected regarding carrier claim logic related to covered preventive benefits. Sample sizes were based on guidelines defined in the NAIC *Market Regulation Handbook*. The claim data provided by the carriers included the entire universe of paid claims for a two-year period.

Results

Carriers use a combination of CPT and ICD codes to determine if a service is a preventive service. Multiple variables are utilized in the billing of health claims processing. Medical coding, billing, and payment of a claim is based on CPT codes along with one or more ICD codes. The rules for assigning appropriate code(s) are complex due to guidance for preventive services not being issued at the billing code level. Although CPT and ICD codes are standardized, different code combinations may be used for the same or similar services. Additionally, while preventive services are defined, the definitions do not include the applicable codes for each service.

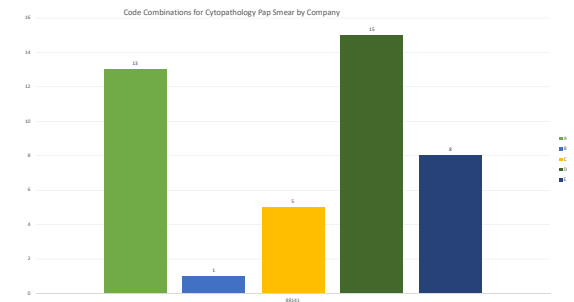


The exams revealed 671 unique CPT codes used for identifying preventive claims and of those only 152 are shared among the carriers examined, therefore less than 25% of codes that can be used by a billing office are paid as preventive for each carrier. The exams also showed 217 CPT codes that were unique to a single carrier.

All companies inappropriately applied cost sharing (copay, cost sharing, or deductible) to claims that should have had none due to their preventive status. 52% of total allowed amounts were paid by Kentucky patients during the exam period.

Example

A Cytopathology PAP smear screening is considered preventive as one of the best ways to prevent cervical cancer by detecting abnormal cells before they become cancerous. The graph below shows the codes for which it is covered at 100% (therefore no cost sharing for insureds) vary dramatically amongst companies.



Conclusion

We determined that the preventive health care claims coding logic varies dramatically by carrier. This results in confusion for members & providers and in errors in the payment of these claims resulting in unexpected bills. A consistent understanding and application of the various forms of guidance is needed to decrease financial barriers and communicate effectively about the opportunities to receive preventive health care without cost sharing as afforded under the Affordable Care Act.