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MVP FASTFAX News for Providers

PREVENTATIVE SERVICES: COLORECTAL CANCER SCREENING

As designated by the Affordable Care Act (ACA), MVP Health Care does not require copays, deductibles or coinsurance for Colorectal Cancer Screening when these services are the primary reason for a visit and/or a procedure. A screening colonoscopy is defined as a test for a patient who has no signs or symptoms of disease.

The screening colonoscopy consultation, the screening colonoscopy and all related physician, facility, anesthesia and pathology services will be paid in full with no patient responsibility if billed in accordance with these billing requirements.

FACILITY BILLING (UB-04):

Bills from facilities may include all services associated with the primary service (colonoscopy). The colonoscopy must be billed with a **-33** modifier or a screening diagnosis code when it is a screening colonoscopy.

When a colonoscopy starts as a screening but turns into a diagnostic colonoscopy due to a finding, modifier **-PT** should be billed.

When the primary service (Colonoscopy) is billed with one of these modifiers, all services on the facility claim will be paid in full. The diagnosis codes (listed below) are *not* required on these claims.

PHYSICIAN BILLING (1500):

When claims are submitted from the physician, there may be multiple claims received for the primary service of colonoscopy. Examples include the pre-colonoscopy consultation, physician services, anesthesia and pathology: All services related to the screening colonoscopy must have one of the following diagnosis codes on the *claim line level in the principal diagnosis position*.

Z12.10	Z12.11	Z12.12	Z12.13	Z80.0	Z83.71	Z83.79
Z85.030	Z85.038	Z85.040	Z85.048	Z85.060	Z85.068	Z85.09

As above under Facility Billing, the colonoscopy code should continue to be billed with a modifier 33 or PT as appropriate. For the additional services (pre-colonoscopy consultation, physician services, anesthesia and pathology), one of the above diagnosis codes MUST be on the claim line in order to be paid in full.

Claims will still be subject to clinical edits and bundling. Some products may not be subject to Federal Healthcare Reform; providers should check the member's benefits to determine if Federal healthcare reform applies to their plan.

Exclusion: For Medicare, MVP follows the Centers for Medicare and Medicaid Services (CMS) guidelines for preventive services.

If you have any questions about this notice, please contact your Professional Relations Representative or Customer Care Center for Provider Services at 1-800-684-9286.

MVP® HEALTH CARE