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FEES FOR COLONOSCOPY: WHAT YOU NEED TO KNOW

In principle, the Affordable Care Act passed in March 2010 mandated coverage without cost to patients for several preventative services, such as colonoscopy. In reality, there are numerous exclusions, which preclude full coverage benefits, i.e., without patient obligation for payment. One example is a “grandfather” clause, where insurance companies were granted a two year moratorium prior to mandating “no-cost” benefits for preventative services. In addition, individual carriers utilize unique and often counterintuitive criteria to define the colonoscopy exam as either a “preventative” service (screening) or as a “diagnostic/therapeutic” service. These criteria may preclude eligibility for “no-cost” preventative exams for patients with prior personal gastrointestinal diseases, such as personal history of polyps, colon cancer or inflammatory bowel disease. These restrictive guidelines often mean that some patients may be required to pay co-payments and deductibles.

Even with commercial insurance, the coverage for preventative exams, such as screening colonoscopy is treated differently by virtually every carrier. There is a wide spectrum of benefits for preventative care – the benefits may be meager or comprehensive, depending on your insurance provider and specific policy coverage with commercial carriers, such as Blue Cross Blue Shield, Aetna, Cigna, and United Healthcare, or government plans, such as Medicare or a Medicare-replacement plan.

The information provided in this document will focus on the commercial plans. Please keep in mind that these are general guidelines and your coverage may be different for your particular plan.

COLONOSCOPY CODING DEFINITIONS

Diagnostic/Therapeutic Colonoscopy:

This term indicates that a patient had **previous** and/or present gastrointestinal symptoms, polyps, or gastrointestinal disease. This colonoscopy exam is not considered as a “screening” exam due to the exclusionary history. Deductibles and co-payments usually apply.

Screening Colonoscopy/Preventative Colonoscopy:

This nomenclature applies when the patient is [a] asymptomatic (no gastrointestinal symptoms - either past or present), [b] is over the age of 50, [c] has neither personal nor family history of gastrointestinal disease, colon polyps, and/or colon cancer AND [d] has **not** undergone a colonoscopy within the prior 10 years. Any ongoing symptoms, such as change in bowel habits, diarrhea, constipation, rectal bleeding, anemia, etc., which are documented in the medical record as rationale for the colonoscopy will likely change the procedure from a “screening” to a “diagnostic” colonoscopy. If a polyp was found during either a **previous** screening or surveillance colonoscopy, your insurance carrier **may** deem the next procedure as “diagnostic/therapeutic,” thereby resulting in out-of-pocket charges. **Please note: If you have had a colonoscopy in the past 10 years and the result indicated that you had colon polyps, you are NOT eligible for a “screening” colonoscopy. This prior history of colon polyps/colon cancer may alter the coding of your colonoscopy as a “surveillance” exam, and may be considered “diagnostic” by your insurance provider.**

Surveillance/High Risk Screening Colonoscopy:

This code is utilized for a patient free of gastrointestinal symptoms - either past or present, **AND** has a personal and/or familial history of gastrointestinal disease, colon polyps, and/or cancer. Patients in this category are typically recommended to undergo colonoscopy exams at shortened intervals (e.g., every 2-5 years). While your primary care physician may refer you for a “screening” colonoscopy, you **may not** qualify for the “screening” category based on the carrier’s criteria. Your financial obligation will be determined in the pre-operative process. Specifically, this means that **before** your appointment for the procedure, you should expect to be fully informed of your colonoscopy coding status, and as appropriate, the estimated out-of-pocket liability.

FREQUENTLY ASKED QUESTIONS

❖ How will I know what I will owe?

- **Collect your personal coding information** - Obtain the preoperative CPT and diagnosis codes, as well as the facility name from the practice scheduler.

- **Call your insurance carrier and verify the benefits and coverage by asking the following questions:**

Note: You will need to give the insurance representative your preoperative CPT and Diagnosis codes.

1. Is the procedure and diagnosis covered under my policy? Yes No
2. Will the diagnosis code be processed as a screening/preventative, surveillance, or diagnostic and what are my benefits for that service? Benefits vary based on how the insurance company recognizes the diagnosis code.
3. Diagnostic/Medical Necessary Benefits:
Deductible: _____ Coinsurance Responsibility: _____
Facility in Network: Yes No
4. Preventative/Wellness/Routine Colonoscopy Benefits:
Are there age and/or frequency limits for my colonoscopy? (e.g., every ten years over the age of 50, OR every two years for a personal history of polyps beginning at age 45, etc.)
No Yes, if so: _____
Deductible: _____ Coinsurance Responsibility: _____
5. If the physician removes a polyp, will this change my out-of-pocket responsibility? Rarely, a biopsy or polyp removal may change a “screening” benefit to a medical/”diagnostic” benefit. Carriers often vary on this policy. No Yes
6. Representative’s Name: _____ Call Reference #: _____ Date: _____

Call your gastroenterologist’s office with any questions or concerns. The business staff can be a great source of information and is eager to help you understand your financial obligations. However, in order to receive the most accurate responses, it is necessary for you to call your insurance company and obtain answers for the above questions.

❖ Can the physician change, add, or delete my diagnosis so that I can be considered a colon screening?

No! The patient encounter is documented in the medical record as the summary of your physician’s evaluation and assessment, based on information he/she collected during your visit. The medical record is a binding legal document that cannot be changed to facilitate better insurance coverage.

Patients need to understand that strict government and insurance company documentation and coding guidelines prevent any physician from altering a chart or bill for the sole purpose of coverage determination. This violation is considered insurance fraud and punishable by law.

However, if a patient notices an error in the medical record, e.g., date of birth, medication dosage, history notation, etc., he/she may request a correction/amendment by completing the “Request for Correction/Amendment of Protected Health Information” form and forwarding it to the surgery center and to your gastroenterologist or colorectal surgeon.

❖ **What if my insurance company tells me that my provider can change, add, or delete a CPT or diagnosis code?**

This is surprisingly a common occurrence. Occasionally, member service representatives will tell a patient that “if only the physician coded it with a “screening” diagnosis it would have been covered at 100%.” However, further questioning of the representative will reveal that the “screening” diagnosis can **only** be amended if criteria are met. Remember, some insurance carriers may only consider the patient over the age of 50 without personal or family history or past or present gastrointestinal symptoms as a “screening” exam.

If you are given this explanation, please document the **date**, **name**, and **phone number** of the insurance representative. Please contact our billing department and we will further investigate the information provided. In our experience, the most frequent outcome is that the more senior insurance employee will call the patient and explain that the member services representative should not have suggested that a physician change his/her coding to produce better benefit coverage.

❖ **Who will bill me?**

You may receive bills from separate entities involved with your care, e.g., the physician, the endoscopy facility, the anesthesia service provider, pathology and/or laboratory services.

Endoscopy Consultants and/or Georgia Endoscopy Center can only provide information associated with **our** fees - fees for the facility and/or technical component. Our insurance verification specialist will contact you at least 5 business days before your procedure with an estimated “out-of-pocket” cost for the **facility** charges.

For more information about pathology billing you can contact QDX at (866) 909-7284.

For more information about anesthesia billing you can contact North Perimeter Anesthesia at (678) 460-7762.