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Colonoscopy: What you need to know!

The Affordable Care Act passed in March 2010 allowed for several preventative services, such as colonoscopies, to be covered at no cost to the patient. However, there are many caveats that prevent patients from taking advantage of this provision. One example is a “grandfather” clause; where insurance companies have two years before offering preventative services at no cost. There are now strict and changing guidelines on which colonoscopies are defined as a preventative service (screening). These guidelines may exclude many patients with gastrointestinal histories from taking advantage of the service at no cost. Patients may be required to pay co-pays and deductibles. Our practice has created this document to sort through some of the confusion and misinformation out there. Here is what you need to know:

Colonoscopy Categories:

Diagnostic/therapeutic colonoscopy

Patient has past and/or present gastrointestinal symptoms, polyps, or gastrointestinal disease.

Surveillance/ High Risk Screening Colonoscopy

Patient is asymptomatic (no gastrointestinal symptoms either past or present), has a personal history of gastrointestinal disease, colon polyps, and/or cancer. Patients in this category are required to undergo colonoscopy surveillance at shortened intervals (e.g. every 2-5 years).

Preventive Colonoscopy Screening

Patient is asymptomatic (no gastrointestinal symptoms either past or present), over the age of 50, has no personal or family history of gastrointestinal disease, colon polyps, and/or cancer. The patient has not undergone a colonoscopy within the last 10 years. Your primary care physician may refer you for a “screening” colonoscopy; however, you may not qualify for the “screening” category. This is determined in the pre-operative process. *Before the procedure, you should know your colonoscopy category.* After establishing what type of procedure you are having, you can do some research.

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Who will bill me?

You may receive bills from separate entities associated with your procedure, such as the physician, facility, pathologist, and/or laboratory. Atlanta Center for Gastroenterology, PC and Atlanta Endoscopy Center, LTD can only provide you with information associated with our fees.

How will I know what I will owe?

Gather your personal coding information

Obtain the preoperative CPT and diagnosis codes as well as the facility name from the scheduler.

Call your insurance carrier and verify the benefits and coverage by asking the following questions. *(note: you will likely 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 preventative, surveillance, or diagnostic and what are my benefits for that service? (Benefits vary based on how the insurance company recognizes the diagnosis).

Diagnostic/Medical Necessary Benefit:

Deductible: _____ Coinsurance Responsibility: _____

Facility in Network: Yes No

Preventative/Wellness/Routine Colonoscopy Benefits:

Are there age and/or frequency limits for my colonoscopy? (e.g. one every 10 years over age 50, one every 2 years for a personal history of polyps beginning at age 45, etc) No Yes if so; _____

Deductible: _____ Coinsurance Responsibility: _____

3. If the physician removes a polyp, will this change my out of pocket responsibility? (A biopsy or polyp removal may change a screening benefit to a medical necessity benefit: more out of pocket expenses. Carriers vary on this policy.) No Yes

Representative's Name: _____ **Call Reference #:** _____ **Date:** _____

Call our billing department at 404-296-1986 with any questions or concerns. They are a great source of information and are happy to help if you are struggling to understand your financial obligations.

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However, it is still necessary for you to first call your insurance company and ask 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 as a medical record from information you have provided as well as an evaluation and assessment from the physician. It 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 a physician from altering a chart or bill for the sole purpose of coverage determination. This is considered insurance fraud and punishable by law.

What if my insurance company tells me that ACG and/or AEC can change, add, or delete a CPT or diagnosis code?

This is actually a common occurrence. Often 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 it applies to the patient. Remember, many insurance carriers only consider a patient over the age of 50 with no personal or family history as well as no past or present gastrointestinal symptoms as a “screening” (V76.51).

If you are given this information, please document the date, name, and phone number of the insurance representative. Next, contact our billing department who will perform an audit of the billing and investigate the information given. Often the outcome results in the insurance company calling the patient back and explaining that the member services representative should never suggest a physician change their billing to produce better benefit coverage.

