

## **Colonoscopy: What you need to know**

The Affordable Care Act, passed in March 2010, allows for certain preventative services, such as colonoscopies, to be covered at no cost to the patient. **However, there are strict guidelines that address circumstances under which a colonoscopy is considered preventative.** This means that sometimes a procedure will be viewed by an insurance carrier as diagnostic when a patient is under the impression that it was preventative (screening).

You might be entitled to a different level of benefits under your insurance policy for diagnostic services than for preventative services. Some insurance carriers require patients with gastrointestinal histories to meet a deductible and / or make a copayment.

**We encourage you to contact your insurance carrier prior to your procedure.** To help you understand which type of colonoscopy best describes your procedure, please review the information below.

### ***Colonoscopy Categories:***

**Diagnostic/Therapeutic Colonoscopy:** Patient has past and/or present gastrointestinal symptoms, polyps, GI disease, iron deficiency anemia and/or any other abnormal tests.

**Surveillance/High Risk Screening Colonoscopy:** Patient is asymptomatic (no gastrointestinal symptoms either past or present), has a personal history of GI disease, colon polyps, and/or cancer. Patients in this category are required to undergo colonoscopy surveillance at shortened intervals (every 2-5 years, for instance).

**Preventive Colonoscopy with Screening Diagnosis:** Patient is asymptomatic (no gastrointestinal symptoms either past or present), over the age of 50, has no personal or family history of GI 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 to our practice for a “screening” colonoscopy, but you might not qualify for the “screening” category. This is determined by the physician prior to your procedure. The determination is based upon past medical history, current symptoms, and / or information obtained from a referring physician. ***Before the procedure, you should know your colonoscopy category.*** After establishing the type of procedure that you are having, you can contact your insurance carrier to determine if your procedure will be covered and what your out-of-pocket expense will be. It is important to be specific in an inquiry to your insurance carrier. The diagnosis code and procedure code can be obtained from the physician’s medical assistant if

necessary. Also, be sure to indicate that the procedure will not be performed in an outpatient setting; Virginia Endoscopy Group is considered an “office” location.

***Can the physician change, add or delete my diagnosis so that I can be considered eligible for colon screening?***

No. The patient encounter is documented in your medical record from information you have provided as well as what is obtained during our pre-procedure history and assessment. 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 the doctor can change, add, or delete a CPT or diagnosis code?***

Unfortunately this is 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%. Further questioning of the representative will reveal that the “screening” diagnosis can only be amended if it applies to the patient. 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”.

If you are given this information, please document the date, name, and phone number of the insurance representative. Next, contact our billing department at 804-330-4901. An audit will be performed to review the billing and investigate the information given. Often the outcome results in the insurance company calling the patient back to explain that an insurance carrier should not ever suggest a physician change their billing to produce better benefit coverage. The billing of a procedure should not be changed unless the changes more accurately describe the reason for service exactly which services were performed.

- **If you have any questions or concerns regarding your insurance benefits and coverage, please contact your insurance carrier.**
- **Our business office staff can be reached at (804) 330-4901. We are happy to assist in reviewing coverage and benefit information provided by your insurance carrier.**

*Thank you for your cooperation*