ROCKY MOUNTAIN GASTROENTEROLOGY

Colonoscopy Billing: What you need to know

The Affordable Care Act that 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 limitations 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 copays and deductibles.

As a service to our patients, RMG will work with you and your personal insurance provider to determine what your individual benefits may cover. However, we encourage our patients to also contact their insurance company directly to clarify coverage of their procedure.

Our practice has created this document to sort through some of the confusion and misinformation, as well as a guide for which questions to ask, to fully understand your individual responsibility.

Here is what you need to know:

Colonoscopy Categories:

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 preoperative process. Before the procedure, you should know your colonoscopy category. After establishing what type of procedure you are having, you can do some research.

- **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.

Who will bill me & how will I know what I owe?

You may receive bills from separate entities associated with your procedure, such as the physician, facility, anesthesia, pathologist, and/or laboratory. Rocky Mountain Gastroenterology can only provide you with information associated with our fees.

RMG will contact your insurance company to verify your benefits. However, if you would like to contact your insurance company directly, here is the information you should gather to help understand how your insurance may process your claim for your procedure.

Gather your personal coding information.

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

If you would like to call your insurance carrier to verify benefits & coverage, ask the following questions. (You will need to give the insurance representative your preoperative CPT and diagnosis codes.)

- *Is the procedure and diagnosis covered under my policy?* ☐ **No** ☐ **Yes**
- *Will the diagnosis code be processed as preventative, surveillance, or diagnostic and what are my benefits for that service?*

Diagnostic / Medical Necessary Benefits

Deductible:_____
Coinsurance Responsibility: _____
Facility in Network: ☐ **No** ☐ **Yes**

- *Are there age and/or frequency limits for my colonoscopy?* *(example: one every ten years over the age of 50, one every two years for personal history of polyps beginning at age 45, etc.)*

Preventative/Wellness/Routine Colonoscopy Benefits:

☐ **No** ☐ **Yes** ***If yes:*** _____
Deductible: _____
Coinsurance Responsibility: _____

- *If the physician removes a polyp, will this change my out-of-pocket responsibility?* *(A biopsy/polyp removal may change a screening benefit to a medical necessity benefit – carriers vary on this policy.)*

  ☐ **No** ☐ **Yes**

Representative's Name: _____

Call Reference #: _____ Date: _____

Please feel free to call RMG's billing department at 303.205.1090 with any questions. The billing representatives are a great source of information and are happy to help if you are struggling to understand your financial obligations, and can work with you to set up payment arrangements on your out-of-pocket amount if necessary.

Can the physician change, add or delete my diagnosis so it 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.

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 physician's medical assistant.

What if my insurance company tells me that Rocky Mountain Gastro 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.