Preparing for your Flex Sig Procedure

ROCKY MOUNTAIN GASTROENTEROLOGY

- ☐ Flexible Sigmoidoscopy
- ☐ Flexible Sigmoidoscopy with HEMWELL
- ☐ Flexible Sigmoidoscopy with EGD

If you did not do so at the time of scheduling, let us know if you take any blood thinning medications (Coumadin, Eliquis, Plavix, Pradaxa, Warfarin, Xarelto) or start any after scheduling your procedure.
We will need to obtain authorization from your prescribing physician, and will follow up with you on specific instructions. Do not stop heart/blood pressure/regular medication unless your doctor instructs you to do so. You may continue taking a baby aspirin (81 mg) without interruption.

1 DAY PRIOR TO PROCEDURE

Purchase 2 Fleets brand enemas (*SALINE VERSION ONLY*) from pharmacy or drug store.

- **FLEX SIG. or FLEX SIG. WITH HEMWELL: NO SOLID FOODS 8 HOURS PRIOR TO PROCEDURE.**
  You may continue to drink clear liquids, up until 4 hours prior to your procedure.
- **FLEX SIG. WITH EGD: NO SOLID FOODS AFTER 10:00PM THE NIGHT PRIOR TO PROCEDURE.**
  You may continue to drink clear liquids, up until 4 hours prior to your procedure.

ON THE DAY OF PROCEDURE

STOP **STOP ALL LIQUIDS 4 HOURS PRIOR TO PROCEDURE**

2 HOURS Prior to procedure — **Use the first enema.**

1 HOUR Prior to procedure — **Use the second enema.**

FOR BEST RESULTS:
Hold each enema ***for 3-5 minutes*** *before expelling*

NO gum, or hard candy or chewing tobacco.
NO smoking cigarettes, marijuana, cigars, pipes or E-cigarettes.
Bring a list of your medications: If you take baby aspirin routinely, or medicine for your heart, blood pressure, seizure disorder, or pain disorder you may take these medications with a small amount of water. However, you must be done with all oral intake 4 HOURS before the procedure.
If you have diabetes, hold oral diabetic medications and short-acting insulin on the morning of procedure. Take half of your normal dose of long-acting or basal insulin, depending on your morning glucose level. If your blood sugar is above 300 in the morning of the procedure, we will be unable to proceed with the examination.
Bring your ID and a copy of your current insurance card: These items are required for check-in.

YOU MUST BE ACCOMPANIED BY AN ADULT FRIEND OR RELATIVE TO DRIVE YOU HOME AFTER THE PROCEDURE. YOU MAY NOT DRIVE, OR GO HOME BY TAXI/BUS/UBER/LYFT. HAVING YOUR DRIVER REMAIN AT THE CENTER WILL HELP EXPEDITE THE DISMISSAL PROCESS. IF YOU DO NOT HAVE A DRIVER, YOUR PROCEDURE WILL BE CANCELLED.

ALL NO-SHOWS, LATE CANCELLATIONS & LATE RESCHEDULES WITHIN 48 BUSINESS HOURS WILL RESULT IN A $150 FEE.
IF YOU NEED TO MAKE CHANGES TO YOUR APPOINTMENT - YOU MUST CALL RMG AND SPEAK TO A REPRESENTATIVE. CANCELLING OR CHANGING YOUR APPOINTMENT THROUGH THE PORTAL WILL NOT REFLECT ON OUR SCHEDULE, AND YOU WILL BE SUBJECTED TO THE SERVICE FEE.

BILLING FOR YOUR UPCOMING PROCEDURE

You may receive invoices from 3 separate entities associated with any scheduled procedure, including:

RMG PHYSICIAN BILLING: RMG will contact your insurance company to verify your benefits, however, we can only provide you with the information associated with our RMG Physician fees. If you would like an estimate prior to your procedure, call our RMG Billing office at **303-205-1090 option 2.**

***Please note**: If the physician finds a polyp(s), these will be removed for pathology testing. If a polyp or biopsy specimen is sent to pathology, charges may apply and will be billed through RMG.*

FACILITY BILLING: ➡ **ALL PROCEDURE CENTERS are managed by external entities separate from RMG.** Therefore, you must speak with the facility directly to obtain the information associated with the facility fees. We have listed all of the facility phone numbers on our website at **www.RockyMountainGastro.com/billing-information**

***Please note:** RMG is NOT responsible for collecting facility fees for your procedure at any location, as they are billed & collected directly by the facility. Any money collected by the facility at time of service, is only applied to the facility fee & will not be applied towards any other fees associated with your procedure.*

ANESTHESIA BILLING: ➡ **ANESTHESIA SERVICES are managed by external entities separate from RMG.** If your procedure is scheduled at Arapahoe, Aurora, Lakewood or North Denver Endoscopy Centers, Crown Point Surgery Center, Centennial Health Medical Plaza, call **1-800-242-5080** for anesthesia services & information. If your procedure is at a local hospital, contact that hospital directly.

Please be advised of all costs prior to your procedure.
NO-SHOWS, LATE CANCELLATIONS & LATE RESCHEDULES WITHIN 48 BUSINESS HOURS WILL RESULT IN A $150 FEE.

Contacting Your Insurance Company

For all procedures, you should be prepared to pay any amount up to your deductible, plus any applicable co-insurance amounts. RMG encourages all of our patients to contact your insurance company directly to understand your benefits and any out-of-pocket costs for all of your procedures. Obtain the facility name from your scheduler, and ask your insurance company the following questions to understand how your insurance may process your claim for your procedure.

The correct coding of a procedure is driven by the physician & your medical history; it is NOT dictated by your insurance company or your insurance benefits.

While colonoscopies may fall under different categories *(screening / surveillance / diagnostic)* ALL OTHER PROCEDURES are considered to be diagnostic.

Is the physician & facility in my insurance network?	**Yes** _____ **No** _____
Will the procedure be processed as: Preventative screening; surveillance; or diagnostic? What is procedure code?	**Screening Surveillance Diagnostic CODE:** _____
Is the procedure/diagnosis code covered under my policy?	**Yes** _____ **No** _____
Will that change if the physician removes a polyp or a biopsy?	**Yes** _____ **No** _____
If the physician removes a polyp or specimen for a biopsy, will this also change my out-of-pocket responsibility?	**Yes** _____ **No** _____ **If so, how?** _____
What is my deductible amount? How much have I met?	**Deductible:** _____ **How much I have met:** _____
	Co-insurance responsibility: _____

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

Colonoscopy Billing

The Affordable Care Act was passed in March 2010, which 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.

And there are now strict and changing guidelines on which colonoscopies are defined as preventative service (screening.) These guidelines may exclude many patients with gastrointestinal histories or family 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 or may not cover. However, we encourage all of our patients to also contact their insurance company directly to clarify coverage of their procedure.***

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 your procedure, you should know your colonoscopy category. After establishing what type of procedure you are having, we encourage you to do research and contact your insurance.

- **Preventative Colonoscopy Screening:**
  Patient is asymptomatic (no gastrointestinal symptoms either past or present), over the age of 45, no personal or family history of gastrointestinal disease, colon polyps, and/or cancer. Patient has not had a colonoscopy or used a ColoGuard test in past 10 years.

  ***Please note**: A polyp/biopsy removal may change your screening benefit to a medical necessity benefit. Insurance carriers vary on provided coverage for this scenario. Please contact your insurance company prior to your procedure.*

- **Surveillance / High Risk Colonoscopy:**
  Patient is asymptomatic (no gastrointestinal symptoms either past or present), but has a personal history of gastrointestinal disease, colon polyps, and/or cancer, and family history of cancer and/or polyps. Patients in this category are required to undergo colonoscopy surveillance at shortened internals (example every 2-5 years.) Not all insurance companies cover 100% of these procedures.

- **Diagnostic / Therapeutic Colonoscopy:**
  Patient has past and/or present gastrointestinal symptoms, polyps, cancer, or gastrointestinal disease.
  This colonoscopy is NOT considered preventative and therefore NOT included in the provision of the Affordable Care Act.

Frequently Asked Questions about Procedure Billing

Can the physician change, add or delete my diagnosis so it can be considered a screening?

NO. The patient encounter is documented as a medical record from the information you provided as well as an evaluation & assessment from the physician. It is a legally binding 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 charge 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 (example: date of birth, medication dosage, history notation, etc. patient may complete the "Request for Correction/Amendment of Protected Health Information" form & forward it to physician.

What if my insurance company tells me that RMG 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 the physician coded the procedure with a "screening" diagnosis, it would be covered 100%. However, further questioning of the representative will reveal 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 45 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 and we will perform an audit of the billing and investigate the information you were given. Often the outcome results in the insurance company calling the patient back and explaining the member services representative should never suggest a physician change their billing to produce better benefit coverage.