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 **888-717-5383** 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.