



Preparing for your Flex Sig Procedure

Flexible Sigmoidoscopy

Rectal Endoscopic Ultrasound

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. Two weeks prior to your procedure please contact your prescribing medical office regarding blood thinning medication hold to ensure no delay in scheduling. 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 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, hard candy, chewing tobacco, or nicotine pouches.
NO smoking cigarettes, marijuana, cigars, pipes or E-cigarettes.
NO recreational or illegal drugs 72 hours prior to your procedure.**

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 exam.

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.



DIABETIC & WEIGHT LOSS MEDICATION INFORMATION

FOR PATIENTS WITH DIABETES CONTROLLED BY INSULIN OR ORAL MEDICATIONS

We recommend using sugar-free liquid for your bowel preparation. Options include Gatorade Zero, Propel & Crystal Light.

It is important to keep your blood sugar controlled when you are preparing for your procedure. Below are general recommendations for peri-operative diabetes management. Please call your healthcare provider who manages your diabetes with additional questions regarding diabetes medication.

Check your blood sugar regularly throughout the prep process, including bedtime **AND** the morning of your procedure. If your blood sugar is less than 60, you may take a glucose tablet and/or call your health care provider who prescribes your diabetes medication for further instructions.



The day before your procedure:

- * Take your oral medications as usual.
- * Be sure to drink any clear liquids necessary to maintain your blood sugar.
- * Insulin: If you take insulin with meals: you should skip the insulin you would usually take with meals.



The evening before your procedure:

- * **Oral medications:** continue usual dosage until midnight.
- * **Insulin:** If you usually take long-acting insulin in the evening (e.g. lantus or glargine), you may take your usual dose of long-acting insulin in the evening before your procedure.



The morning of your procedure:

- * **Oral medications:** Do not take any diabetes pills on the day of your procedure.
- * **Insulin:** If you usually take long-acting insulin in the morning (e.g. lantus or glargine), please take between one-third and one-half of your usual morning dose.



Insulin Pump:

- * Discontinue BOLUS insulin dosing on the day prior to the procedure and on the day of the procedure. Continue BASAL insulin infusion rate throughout the preparation process and on the procedure day.

FOR PATIENTS TAKING THE FOLLOWING MEDICATIONS

<i>Generic Name</i>	<i>Trade Name</i>	<i>Dosing</i>	<i>Instructions</i>
Dulaglutide	Trulicity	Weekly	STOP TAKING 1 WEEK PRIOR TO PROCEDURE
Exenatide (ext. release)	Bydureon BCise	Weekly	STOP TAKING 1 WEEK PRIOR TO PROCEDURE
Exenatide	Byetta	Daily	STOP TAKING 2 DAYS PRIOR TO PROCEDURE
Liraglutide	Victoza, Saxenda	Daily	STOP TAKING 2 DAYS PRIOR TO PROCEDURE
Lixisenatide	Adiyxin	Daily	STOP TAKING 2 DAYS PRIOR TO PROCEDURE
Phentermine	Adipex-p, Lomaira	Daily	STOP TAKING 1 WEEK PRIOR TO PROCEDURE
Semaglutide	Rybelsus	Daily	STOP TAKING 2 DAYS PRIOR TO PROCEDURE
Semaglutide	Ozempic, Wegovy	Weekly	STOP TAKING 1 WEEK PRIOR TO PROCEDURE
Tirzepatide	Mounjaro, Zepbound	Weekly	STOP TAKING 1 WEEK PRIOR TO PROCEDURE
Canagliflozin	Invokana	Daily	STOP TAKING 3 DAYS PRIOR TO PROCEDURE
Dapagliflozin	Farxiga	Daily	STOP TAKING 3 DAYS PRIOR TO PROCEDURE
Empagliflozin	Jardiance	Daily	STOP TAKING 3 DAYS PRIOR TO PROCEDURE
Ertugliflozin	Steglatro	Daily	STOP TAKING 4 DAYS PRIOR TO PROCEDURE

Procedure Billing: What You Need to Know



You may receive invoices from separate entities associated with any scheduled procedure such as:

*** Facility * Anesthesia * Pathology and/or laboratory * RMG Physician**

RMG will contact your insurance company to verify your benefits, but we can only provide you with the information associated with our RMG Physician fees.

For all procedures, facility services are billed directly by the facility. Please contact the facility for information.

Anesthesia services are billed separately by another company. 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.

Colonoscopy Billing

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.

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.***

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 your insurance company to fully understand your individual responsibility.

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 undergone a colonoscopy in past 10 years.

● **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 intervals (example every 2-5 years.)

● **Diagnostic / Therapeutic Colonoscopy:**

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

Contacting Your Insurance Company

We encourage 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 your 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.

1.) Is the procedure/diagnosis covered under my policy? Yes No

2.) Will the diagnosis code be processed as a preventative screening, surveillance, or diagnostic... and what are my benefits for that service?

Colonoscopies may fall under different categories (ex: screening vs. diagnostic) But all other procedures will be considered diagnostic.

Diagnostic / Medical Necessary Benefit:

Deductible: _____

Co-insurance responsibility: _____

Facility in Network? Yes No

3.) Are there age and/or frequency limits for my colonoscopy? (example: one every 10 years over the age of 45, one every two years for personal history of polyps beginning at age 45, etc.)

Preventative/Wellness/Routine Colonoscopy Benefits:

Yes No If yes: _____

Deductible: _____

Co-insurance responsibility: _____

4.) If the physician removes a polyp, will this change my out-of-pocket responsibility?

Yes No

(A biopsy/polyp removal may change a screening benefit to a medical necessity benefit - carriers vary on this policy.)

Representative's Name: _____ Call Reference #: _____

Frequently Asked Questions about Procedure Billing

Can the physician change, add 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 before 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.