THE DIFFERENCE BETWEEN A DIAGNOSTIC COLONOSCOPY AND A SCREENING COLONOSCOPY

Patients are often scheduled for a screening colonoscopy, but present with GI symptoms. However, they are surprised when they receive their insurance statement assigning a co-pay or applying the fee to their deductible since this was submitted as a diagnostic colonoscopy. In some cases, the insurance company is informing the patient that the claims were billed incorrectly, placing the practice in a very difficult position. To prevent this from occurring, our practice has taken the initiative to educate our patients as well as the referring physicians regarding the definition of a screening versus a diagnostic colonoscopy.

The patient with **NO GI symptoms** is referred for a **screening colonoscopy** for the following reasons:

- Patient age 50 or over with no high risk factors (may be age 45 for African-Americans).
- Patient has personal history of colon cancer or colon polyps or inflammatory bowel disease (Crohn's or Ulcerative Colitis).
- Patient has family history (first degree relative) of colon cancer or colon polyps.

*****This will be coded and billed as a screening procedure***

The patient is referred for a **diagnostic colonoscopy** because of the following symptoms:

- Blood in stool/heme-positive stool/positive Cologuard
- Iron deficiency anemia
- Change in bowel habits such as constipation or diarrhea
- Persistent abdominal pain
- Other, specified.

*****This will be coded and billed as a diagnostic procedure/testing***

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 as a medical record from information you have provided as well as what is obtained in 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.

WHAT IF MY INSURANCE COMPANY TELLS ME THAT THE DOCTOR CAN CHANGE, ADD OR DELETE THE CPT CODE OR DIAGNOSIS CODE? This happens a lot. Often the representative will tell the patient that if the "doctor had coded this as a screening; it would have been covered differently." However, further questioning of the representative will reveal that the "screening" diagnosis can only be amended if it applies to the patient. Remember, that many insurance carriers only consider a patient age 50 or older with no personal or family history as well as no past or present GI symptoms as screening (Z12.11). These records may be audited by your insurance company at their request. If you are given this information, please document the date, name, and phone number of the 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 the representative should have never suggested a physician change their billing to better benefit coverage.

If your insurance plan has a high deductible, you may be asked to make a deposit prior to your procedure. For fees, deposits, or an explanation of this form, please call our central business office at **727-347-0005**.

Further information on colonoscopy can be obtained on our website www.gastrofl.com.

_____ _____

Patient Signature Date

Colonoscopy Notification Statement

Know What You Will Owe

Colonoscopy CPT Procedure Code(s):_____

☐ SCREENING COLONOSCOPY

Diagnosis Code(s) & Description(s):_____

Patient is currently asymptomatic (no gastrointestinal symptoms either past or present).

☐ DIAGNOSTIC/THERAPEUTIC COLONOSCOPY

Diagnosis Code(s) & Description(s):_____

Patient has past and/or present gastrointestinal symptoms, GI disease, iron deficiency anemia, and/or other abnormal test.

YOUR PRIMARY CARE PHYSICIAN MAY REFER YOU FOR A "SCREENING" COLONOSCOPY BUT THERE MAY BE A MISUNDERSTANDING OF THE WORD SCREENING. THIS WILL BE DETERMINED IN THE PRE-PROCEDURE PROCESS. BEFORE YOUR PROCEDURE, YOU SHOULD KNOW YOUR COLONOSCOPY CATEGORY. AFTER ESTABLISHING WHICH PROCEDURE YOU ARE HAVING, YOU CAN DO SOME RESEARCH.

Who will bill me?

You may receive several bills for each entity associated with your procedure, such as the physician, facility, anesthesia, pathologist and/or laboratory. Each of these bills for their part in the procedure and are not connected to the physician billing. We can only provide you with the information associated with our fees.

How will I know what I owe?

Call your insurance carrier and verify the benefits and coverage by asking the following questions. Codes for your procedure are listed above. You will need to give the insurance representative the pre-operative procedure code(s) and the diagnosis code(s).

1. Is the procedure covered under my policy? ____Yes ____No
2. Will the diagnosis code be processed as preventative, surveillance, or diagnostic and what are my benefits for that service? Results vary based on how the insurance company recognizes the diagnosis.
   <u>Diagnostic/Medical Necessity Benefits</u>
   Deductible: _____ Coinsurance Responsibility:_____
   Facility in Network: ____Yes _____No
   Preventive/Wellness/Routine Colonoscopy Benefits:
   Are there age and/or frequency limits for my colonoscopy? For example, one every 10 years over the age of 50, one every two years for a personal history of polyps beginning at age 40 etc.
   ____No ____Yes if so: _____

   Deductible: _____ Coinsurance Responsibility:_____
3. If the physician removes a polyp, will this change your out of pocket responsibility? A biopsy or polyp removal may change a screening benefit to a medical necessity benefit which equals more out of pocket expenses. Carriers vary on this policy.
   ____No ____Yes

Representative's Name:_____ Call Ref # _____ Date:_____