Colonoscopy

Screening versus *Diagnostic*

Screening colonoscopy is a preventive procedure performed on an asymptomatic (no symptoms) patient for the purpose of testing for colorectal cancer or colon polyps.

The Affordable Care Act (ACA) requires private health insurers to cover recommended preventive services without any patient cost-sharing, such as copays and deductibles.

Diagnostic Colonoscopy is performed because of a sign or symptom such as diarrhea, rectal bleeding, iron deficiency anemia, abdominal pain, personal history of polyps, or an abnormal finding on another test.

Unlike a screening colonoscopy, you may be required to pay a deductible or coinsurance for a diagnostic colonoscopy.

Questions for Your Insurance Company:

Date: _____

Insurance Rep. Name: _____

Call reference #: _____

1. Is the Physician in network?
2. Is the Facility (Ambulatory Surgery Center) in network?
3. Is a Prior-Authorization needed for my procedure?
4. What is my deductible amount? How much of my deductible have I met this year?
5. What is the estimated out-of-pocket expense for a *screening* colonoscopy?
6. What if the Provider takes a biopsy or removes a polyp, how does that affect my coverage?
7. What is my estimated out-of-pocket expense for a *diagnostic* colonoscopy?
8. What is the estimated facility out-of-pocket expense?
9. What is the estimated out-of-pocket expense for Anesthesia (Sedation)?
10. What is the estimated Pathology out-of-pocket expense?

Frequently Asked Questions

I have Medicare – what is my screening benefit?

- Every 10 years* for average risk asymptomatic patients.
- Every 2 years for *high-risk* asymptomatic patients.
  Medicare defines *high-risk* as:
  - Family history of polyps or colorectal cancer
  - Personal history of polyps or colorectal cancer
  - Personal History of Inflammatory bowel disease (IBD), including Crohn's disease or ulcerative colitis
- If the procedure is considered diagnostic, there is no timeframe.

I have commercial/private insurance - where can I find my screening benefits?

- You should contact your insurance company directly, using the information on the back of your insurance card.

How many bills can I expect to receive?

- You will always receive at least two bills.
  - One bill for *professional* services with at least three charges covering your Provider, Anesthesiologist (MD) and Certified Nurse Anesthetists (CRNA). If pathology is complete, the technical component will be billed by MNGI.
  - A second bill for the *facility* charges (place of service) which covers the use of the facility, equipment, supplies, and non-physician staff.
    Note: These two bills will have two separate account numbers
- Additionally, if clinical findings necessitate a biopsy, then you will receive a separate bill from (*Hospital Pathology Associates*) for the reading/interpreting of Pathology Laboratory's services.

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

- **NO,** the physician cannot modify any diagnosis so that you can be considered for a screening colonoscopy. Patients need to understand that strict government and insurance company policies, as well as coding guidelines prevent physicians from altering a chart or bill for the sole purpose of better coverage determination. This is considered insurance fraud and is punishable by law.

I came for a Preventative Screening Colonoscopy, but they found something. What now?

- The benefits will depend on your insurance policy. We recommend you contact your insurance company for information specific to your insurance plan.

How will I know which CPT codes will be used?

- You can find the price quote for the procedure which includes the CPT codes most used on our website https://www.mngi.com/price-quotes