GI North

1505 Northside Blvd, Suite 4000 Cumming, GA 30041
404/446-0600 Fax: 404/446-0601

DO YOU KNOW THE DIFFERENCE BETWEEN SCREENING COLONOSCOPY AND DIAGNOSTIC?

The Affordable Care Act passed in March 2010 allowed for several preventative services, such as colonoscopy, to be covered at no cost to the patient. As of Feb. 25, 2013 – The federal government has issued an important clarification on preventive screening benefits under the Affordable Care Act. Patients with private insurance will no longer be liable for cost sharing when a pre-cancerous colon polyp is removed during screening colonoscopy. This ensures colorectal cancer screening is available to privately insured patients at no additional cost, as intended by the new healthcare law. Patients with Medicare coverage must still pay a coinsurance when a polyp is removed as a result of the screening colonoscopy. That only applies to average screening, not high risk screening. Medicare still covers high risk screening at the same rate as average risk screening but commercial payer may not. Some will impose standard benefits to those patients with a personal history of polyps, cancer, or GI disease.

Colonoscopy Categories:

Diagnostic/Therapeutic Colonoscopy: Patient has past and / or present gastrointestinal symptoms, polyps, GI Disease, Iron deficiency anemias and/or any other abnormal tests.

Surveillance/High Risk Screening Colonoscopy: Patient is asymptomatic (no gastrointestinal symptoms either past or present), has a personal history of GI disease, personal and /or family history of colon polyps, and /or cancer. Patients in this category are required to undergo colonoscopy surveillance at shortened intervals.

Preventive Colonoscopy Screening Diagnosis: Patient is asymptomatic (no gastrointestinal symptoms either past or present), over the age of 50, has no personal or family history of GI disease, colon polyps, and /or cancer. The patient has not undergone a colonoscopy within the last 10 years.

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-operative process. Before your procedure, you should know your colonoscopy category. After establishing which procedure you are having, you can do some research.

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 the information you have provided as well as what is obtained during taking our pre-procedure history and assessment. It is 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 physicians from altering a chart or bill for the solo purpose of coverage determination. This is considered insurance fraud and is punishable by law with fines and / or jail time.

What if my insurance company tells me that the doctor can change, add, and delete a CPT 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 over the age of 50 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 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 that the member services representative should never suggest a physician change their billing to produce better benefit coverage.