GASTROHEALTH

Endoscopic procedure billing information
WHAT YOU NEED TO KNOW

Colonoscopy Categories

The Affordable Care Act, passed in March 2010, allows for several preventative services, such as colonoscopies, to be covered at no cost to the patient. However, there are strict guidelines used to determine which category of colonoscopy can be defined as a preventative service (screening vs. diagnostic). These guidelines may exclude those patients with a history of gastrointestinal issues from taking advantage of the procedure at no cost. In cases like these, patients may be required to pay co-pays, deductibles, and co-insurance.

Although your primary care provider may refer you for a "screening" colonoscopy, you may not qualify for the "preventative colonoscopy screening" category.

- **Diagnostic / Therapeutic Colonoscopy** – Patient has present gastrointestinal symptoms, colon polyps, or gastrointestinal disease requiring evaluation or treatment by colonoscopy.
- **Surveillance / High Risk Colonoscopy** – Patient is asymptomatic (no present gastrointestinal symptoms) and has a personal history of gastrointestinal disease (such as diverticulitis, Crohn's Disease or ulcerative colitis), colon polyps, and/or cancer. Patients in this category are required to undergo colonoscopy surveillance at shortened intervals (usually every 2-5 years.)
- **Preventative Colonoscopy Screening** – Patient is asymptomatic (no gastrointestinal symptoms,) is 50 years old or older, and has no personal history of gastrointestinal disease, colon polyps, and/or cancer. Patients in this category have not undergone a colonoscopy within the last 10 years.

Medicare covers screening colonoscopies. Effective January 1, 2011 Medicare will not apply the annual deductible or co-insurance to screening colonoscopies.

If a Medicare patient is scheduled for a screening colonoscopy and during the procedure a polyp is found or the physician needs to take a biopsy, this procedure is no longer considered a screening. Medicare requires that the procedure be billed as a diagnostic colonoscopy. In this situation, the patient will become responsible for the Medicare co-insurance of 20%.

Many commercial insurances will cover screening colonoscopies, but there are a few insurances and contracts that will not cover screening procedures. Depending on your insurance coverage you may or may not have a deductible and/or co-pays or co-insurance.

If a patient with commercial insurance is scheduled for a screening colonoscopy and during the procedure a polyp is found or the physician needs to take a biopsy, this procedure is no longer considered a screening. The coverage of a diagnostic colonoscopy depends on your particular plan's benefits design. You may be responsible for deductibles and/or co-insurance. Please contact the phone number on your insurance card to receive specific information about your coverage for our services. **Use the worksheet on subsequent pages to keep notes about what you learn.**

We are legally obligated when we bill Medicare and private insurance carrier to follow their billing policies based on the medical information available to us.

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To determine the category of your colonoscopy and approximate insurance benefits, please follow the steps below:

Obtain the preoperative diagnosis code(s) from the scheduler, medical assistant, or nurse.

CPT: 45380/45378 **Diagnosis(es):** _____

Please note that these are not the final diagnosis codes which will be submitted to your insurance. Final codes cannot be determined until after your procedure occurs.

Call your insurance carrier and verify your benefits and coverage by asking the following questions:
Is the procedure and diagnosis covered under my policy? ☐ Yes ☐ No

Will the diagnosis code be processed as:
☐ Preventative (screening)
☐ Surveillance
☐ Diagnostic

If my procedure will be a preventive (screening procedure,) are there age or frequency limitations for my colonoscopy? (e.g., one every ten years over the age of 50, one every two years for a personal history of polyps beginning at age 45, etc.) ☐ Yes ☐ No

If YES, list limitations here_____

If the provider removes a polyp or takes a biopsy, will this change my out-of-pocket responsibility?
☐ Yes ☐ No
(A biopsy or polyp removal may change a screening benefit to a medical benefit, which means more out-of-pocket expenses. Carriers vary on this policy.)

Obtain the following information from your insurance representative:

Today's Date_____Representative's Name_____

Deductible_____Amount of deductible met_____

Co-insurance Responsibility_____Facility Co-Payment_____

Facility in network? ☐ Yes ☐ No

Call Reference Number_____

After talking to your insurance provider, you may call Gastro Health billing line at 425-977-4620 with any questions or concerns. **It is not customary for physicians and/or clinic staff to discuss billing issues with patients.**

Frequent Questions:

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

No. The patient encounter is documented as a medical record from information you have provided, as well as an evaluation and assessment by the provider. It is a binding legal document that cannot be changed to facilitate better insurance coverage, doing so could represent insurance fraud and void our contracts with payors. However, if a patient notices an error in the medical record (e.g., date of birth, medication dosage, history notation, etc.,) they may request a correction/amendment by contacting the provider's office directly.

What if my insurance company tells me that Gastro Health can change, add, or delete a diagnosis code?

The practice of changing, adding, or deleting codes to gain better insurance reimbursement is strictly not allowed. However, if the insurance representative believes that your procedure was billed incorrectly, please document the date and time of the call, name of the insurance representative with whom you spoke, phone number to include extension, and the reason for or rationale of the discrepancy. Then contact Gastro Health billing line at 425-977-4620 to facilitate a coding review of your records. This may take multiple months to complete.

Patient billing explanation

You may receive multiple bills after your procedure. Procedures *may* generate the following charge(s):

Professional Fee: This is a customary fee related to the Gastro Health's physician skill and expertise.

Facility Fee: This is a customary fee related to infrastructure of the endoscopy center to include overhead, equipment, medications, supplies, and ancillary salaries.

Pathology Technical Fee: This is a customary fee for the processing of any biopsy(s) taken by physicians.

Pathologist Fee: This is a customary fee for the pathologist's interpretation of the pathology slides.

Anesthesia fee: This is a customary fee for the anesthesia portion of your procedure. These fees are generated by Lake Washington Anesthesia and a third-party company called Change Billing. Their phone numbers are: 1-800-242-5080 or 425-386-3336.

Interpreting EOB

Your insurance company may send you an EOB or explanation of benefits after your procedure. This is not a bill from Gastro Health, and we admit that this can be confusing. Consider it informational and not necessarily representative of what you owe as often times EOBs arrive prior to insurance's processing all claims.