

**Colonoscopy: Screening or Diagnostic?**

Your insurance policy may be written with different levels of benefits for preventive versus diagnostic or therapeutic colonoscopy services. This means there are instances in which you may think your procedure will be billed as a “screening”, when in actuality it will be billed as therapeutic. How can you determine what category your colonoscopy falls into?

**Colonoscopy Categories:**

**Diagnostic/Therapeutic Colonoscopy:**

Patient has past and/or present gastrointestinal symptoms, polyps, GI disease, iron deficiency anemia and/or any other abnormal tests. Any colonoscopy which follows a positive Cologuard test is considered a diagnostic colonoscopy.

**Preventive Colonoscopy with Screening Diagnosis:**

Patient is asymptomatic (no gastrointestinal symptoms either past or present), over the age of 45, 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).

**Surveillance/High Risk Screening Colonoscopy:**

Patient is asymptomatic (no gastrointestinal symptoms either past or present), has a personal history of GI, personal and/or family history of colon polyps, and/or cancer. Patients in this category are required to undergo colonoscopy surveillance at shortened intervals (e.g., every 2-5 years). *\*While Medicare considers this a High Risk/Screening, most commercial carriers consider it surveillance and, therefore, the claim is subject to deductibles and/or coinsurance amounts.*

Before your procedure, you should know your colonoscopy category. After establishing which one applies to you, you can do some research with your insurance company regarding your coverage and what your out-of-pocket expense will be.

Your primary care physician may refer you for a “screening” colonoscopy but there may be a misunderstanding of the word screening. You must have no symptoms at all for your colonoscopy to be billed as a screening service.

**Can the physician change, add or delete my diagnosis so I can be considered eligible for colon screening?** In short, no! The patient encounter is documented in your medical record from information you have provided as well as what is obtained during our pre-procedure history and assessment. It is a binding legal document which cannot be altered to facilitate better insurance coverage. Patients need to understand 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. This is considered insurance fraud and punishable by law with fines and/or jail time.

**What if my insurance company tells me the doctor can change, add or delete a CPT or diagnosis code?** Sadly, this happens a lot. Often, the representative will tell the patient; “if the doctor had coded this as a screening, it would have been covered differently.” 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 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 investigate the information given. The usual outcome is the rep ends up calling the patient back and explaining that the member services representative should never suggest a physician change their billing of a procedure to anything other than exactly what was done, and why.