Allied Digestive Health

Colonoscopy: Screening, Surveillance or Diagnostic?

Your insurance policy may be written with different levels of benefits for preventive versus diagnostic or therapeutic colonoscopy services. This means that there are instances in which you may think your procedure will be billed as a "screening" when it actually has to 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.

Surveillance/High Risk Screening Colonoscopy: Patient is asymptomatic (no gastrointestinal symptoms either past or present), has a personal history of GI disease, colon polyps, and/or cancer. Patients in this category are required to undergo colonoscopy surveillance at shortened intervals (every 2-5 years, for instance).

Preventive Colonoscopy with 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).

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 in regard to 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 that I can be considered eligible for colon screening?

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 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. This is considered insurance fraud and punishable by law with fines and/or jail time.

What if my insurance company tells me that the doctor can change, add or delete a CPT or diagnosis code?

Sadly, 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 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 that 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.