DIGESTIVE CARE PHYSICIANS, LLC

SCREENING COLONOSCOPY vs. DIAGNOSTIC COLONOSCOPY

If you are here today because you were sent by your physician for a “Screening Colonoscopy” or you have seen one of our providers and he/she recommends a colonoscopy, please read this form in its entirety. You need to be fully educated on the state and federal guidelines for reimbursement services.

The CMS **“Preventative Screening”** initiative passed in January, 2011 dictates that patients undergoing a **“screening colonoscopy”** will not be held to their coinsurance or deductible responsibilities.

The definition of a “screening colonoscopy” per CMS guidelines is as follows:

> *“A colonoscopy being performed on a* ***patient who does not have any signs or symptoms in the lower GI anatomy PRIOR*** *to the scheduled test.”*

Any symptom such as change in bowel habits, diarrhea, constipation, rectal bleeding, anemia, etc. prior to the procedure and noted as a symptom by the physician in your medical record may change your benefit from a screening to a diagnostic colonoscopy.

Please Note: If you have had a colonoscopy within the last 10 years and the result indicated you had colon polyps, you are **NOT** eligible for a Preventative Screening Benefit. You have prior history of colon polyps. Your colonoscopy is now a “surveillance of the colon” and is considered diagnostic.

If you are und the age of 50 and are for a screening colonoscopy, you may not be eligible for Preventative Screening Benefits. ***It is your responsibility to know your insurance policy. Please contact your insurance company with benefit questions prior to your procedure.***

Please be advised that if during the procedure your doctor finds a polyp or tissue that must be removed for pathological testing, these specimens are **NOT** covered by the Preventative Screening Benefit and will be applied toward your deductible or coinsurance.

Expect to receive 3 or 4 bills for your procedure:

- Physicians Services
- Anesthesia
- Pathology
- Facility Fee

We make every effort to code correctly for your procedure with the correct modifiers and diagnoses. The correct coding of a procedure is driven by the physician and your medical history. It is not dictated by your insurance benefit or the insurance company.