SCREENING COLONOSCOPY vs. DIAGNOSTIC COLONOSCOPY

If you are here today because you were sent to our office for a "Screening Colonoscopy" or you have seen the provider 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 of services.

The CMS "Screening Initiatives" passed in January 2011 dictates that patients undergoing a "screening colonoscopy" will not be held to their co-insurance or deductible responsibilities.

The definition of a "screening colonoscopy" per CMS guidelines is as follows: A colonoscopy being performed on a patient who has no signs or symptoms in the lower GI anatomy PRIOR to the scheduled test.

Any symptom such as change in bowel habits, diarrhea, constipation, bleeding, anemia, etc., prior to the procedure and noted as a symptom by the provider in your medical record may change your benefits from a screening to a diagnostic colonoscopy. *We cannot change your medical record after you have been seen.* We cannot change the fact that you have had symptoms prior to your procedure.

Please note: If you have had a colonoscopy within the past 10 years and the result indicated you had colon polyps, you may NOT be eligible for "screening initiative" benefits. You have a prior history of polyps. Your colonoscopy is now considered a "surveillance of the colon" and may be considered diagnostic. You may have been healthy and have had no symptoms since your last colonoscopy, but you have what is considered a pre-existing nature of polyps and therefore, are not eligible for a "screening". If your colonoscopy has been over 10 years, and you are over the age of 50, you are eligible for a "screening colonoscopy" regardless of your history. It is your responsibility to know your insurance benefits. Please contact your insurance company with benefit questions prior to your procedure.

Please be advised that if you are a true "screening colonoscopy" and during the procedure your provider finds a polyp or tissue that has to be removed for pathological testing, or if you are diagnosed with a GI problem, the procedure is no longer a "screening" but becomes "diagnostic". Please be aware that any polyp that is found may be pre-cancerous and must be removed. Your insurance benefits may change. The correct coding of your procedure(s) is driven by your provider and your medical record. It is not dictated by your benefits or the insurance company.

**Please note these guidelines are not necessarily in line with our providers belief for proper patient care, however they are upheld as required by CMS Policies and Procedures.*