Blount Memorial Hospital

Screening vs. Diagnostic Colonoscopy

Understanding the bill for your procedure

A ***screening colonoscopy*** is a procedure for a patient who has no symptoms. Screening procedures are performed for the purpose of testing for the presence of colorectal cancer or polyps. Medicare and most third-party payers cover screening services without a co-pay or deductible.

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."*

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 to your deductible or co-insurance.

A ***diagnostic colonoscopy*** is a procedure performed as a result of any abnormal finding, sign or symptom. Any symptom such as a 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 preventative screening benefit. If you have a history of colon polyps your colonoscopy now is a "surveillance of the colon" and is considered diagnostic.

Expect to receive three or four bills for your procedure:

- Facility fee
- Physician services
- Anesthesia
- Pathology

Billing - 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 documentation and your medical history. It is not dictated by your insurance benefit or your insurance company.