Insurance Information for Screening Vs Diagnostic Colonoscopy

The definition of a “screening colonoscopy” per the Centers for Medicare & Medicaid Services (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 in your medical record may change your insurance benefit from a screening to a diagnostic colonoscopy.

Even if your procedure begins as a screening, if the doctor finds a polyp or tissue that has to be removed for pathological testing or if you are diagnosed with a GI problem, your insurance company may no longer consider this a “screening” test and your benefits may change.

It is important to note that your insurance coverage and the amount considered “patient responsibility” by your insurance company is typically different for diagnostic and screening colonoscopies. The patient usually pays more out of pocket when a procedure is considered diagnostic. Your specific insurance coverage will determine what portion of the charges you are responsible for, if any. It is your responsibility to know your insurance benefits. Please contact your insurance company with benefit questions prior to your procedure.

Here are some questions that you can ask your insurance company before your procedure:

1. Will I owe a deductible, co-insurance or co-pay for a screening colonoscopy? For a diagnostic colonoscopy?
2. If my procedure begins as a screening and turns into a diagnostic procedure, how will my benefits change?
3. Do I have benefits for anesthesia during this procedure (CPT code 00810)?

Remember to take notes and get the name of the representative with whom you speak, and a reference number for your call if possible. After speaking to your insurance company if you still have questions feel free to call our billing department at: (724) 891-2750.