Colonoscopy Categories

Your primary care physician may refer you for a "screening" colonoscopy...however, you may not qualify for the "screening" category. This is determined in the preoperative process. Before your procedure, you should know your colonoscopy category. After establishing what type of procedure you are having, we encourage you to do research and contact your insurance

Preventative Colonoscopy "Screening":

Patient is asymptomatic (no gastrointestinal symptoms either past or present), 45+ years old, no personal or family history of gastrointestinal disease, colon polyps, and/or cancer. Patient has not had a colonoscopy or used a Cologuard test in the past 10 years.

***Please note**: A polyp/biopsy removal may change your screening benefit to a medical necessity benefit. Insurance carriers vary on provided coverage for this scenario. Please contact your insurance company prior to your procedure.*

Surveillance / High Risk Colonoscopy:

Patient is asymptomatic (no gastrointestinal symptoms either past or present), but has a personal history of gastrointestinal disease, colon polyps, and/or cancer, and family history of cancer and/or polyps. Patients in this category are required to undergo colonoscopy surveillance at shortened internals (i.e. every 2-5 years). Not all insurance companies cover 100% of these procedures.

Diagnostic / Therapeutic Colonoscopy:

Patient has past and/or present gastrointestinal symptoms, polyps, cancer, or gastrointestinal disease. This colonoscopy type is NOT considered preventative "screening".

Frequently Asked Questions about Procedure Billing

Can the physician change, add or delete my diagnosis so it can be considered a screening?

NO. Patients need to understand that strict government and insurance company documentation and coding guidelines prevent a physician from altering a charge or bill for the sole purpose of coverage determination. This is considered insurance fraud and punishable by law.

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

This is actually a common occurrence. Often, insurance representatives will tell a patient that if the physician coded the procedure with a "screening" diagnosis, it would be covered 100%. However, further questioning of the representative will reveal the "screening" diagnosis can only be amended if it applies to the patient. Remember, many insurance carriers only consider a patient 45+ years old, with no personal or family history, as well as no past or present gastrointestinal symptoms as a screening.

Coding

All coding for colonoscopies start as procedure code (CPT) 45378-DIAGNOSTIC COLONOSCOPY. The diagnosis code (ICD-10) will vary depending on the reason for procedure. If the procedure is a true **"preventative colonoscopy screening"** a modifier "**33**- PREVENTIVE SERVICES" will be added to the coding, to signal a "screening". The insurance company will use the both diagnosis code and modifier to determine if procedure is preventative or diagnostic.

If the provider needs to preform a polyp/biopsy removal or any other variation of a colonoscopy during the procedure, the coding will change to the appropriate CPT. If the procedure started as **"preventative colonoscopy screening"** a modifier "33" will be added to the coding to signal a "screening" to the insurance.