For every patient, understanding the fees, insurance coverage, and out of pocket expense is important aspect to your medical care. We have put together the following information to help you understand.

Insurance

We participate in many health plans and file insurance forms provided we have your insurance assignment on file. It is the patient's responsibility to pay any deductible, co-pay, co-insurance, or any amount not paid by the health insurance. If we do not participate with your primary insurance plan, full payment is requested at the time of service for physician charges. As a courtesy, we will submit a claim to your insurance for all charges incurred, however, you are responsible for paying all charges within 30 days of service regardless of what your insurance covers.

Un-insured patients are responsible for all charges at the time of service.

Your insurance coverage is an agreement between you and your insurance company. Financial responsibility rests with the patient for deductibles, co-insurance, and non-covered services. It is very important for you to be aware of the requirements of your health insurance policy. Our staff tries to be helpful, but we cannot fully know everything about the various types of insurance plans available. If you have questions about your coverage and benefits, call your insurance company's member services department (listed on the back of your insurance card) or contact your employer's human resources department.

Managed care plans (eg. HMO plans) in particular have many rules that you and your physician need to follow. For example, you will most likely need a referral or authorization from your primary care doctor before you see a specialist or have testing done. Failure to do so can potentially leave you responsible for all the charges. In majority of the cases, the insurance company will not allow your primary care doctor to authorize the visit retroactively. When your physician gives you a written order for testing or referral to a specialist, do not assume that these services have been cleared through your insurance plan.

For any endoscopic procedure, the patient's insurance company determines the deductible and co-payment amounts. The patient is financially responsible for these amounts.

Office Visit Fees

For an office visit, you will receive charges from Comprehensive Digestive Institute of Nevada for the professional services of your physician. The level of service and associated charges are determined by the physician based on the medical complexity, reason for visit, and extensiveness of the treatment plan of your condition. Tests performed in the office will incur charges as well. If you are covered by a health insurance plan in which we participate, you will typically only receive a bill for these services if your co-pay was not paid during your visit.

Endoscopy Procedure Fees

You can expect to incur up to four charges for different fees associated with your procedure.

1. Physician professional fee – from Comprehensive Digestive Insitute of Nevada. This is the charge for the physician who performed your procedure.

2. Facility fee – from the Outpatient Surgery Center or from the hospital where the procedure is performed; the charge is for the use of the facility and includes the use of equipment, medications, and nursing staff.
3. Pathology – from the diagnostic lab used to examine and analyze collected biopsy specimens, if any are obtained.
4. Anesthesia Fee – from the anesthesiologist if monitored anesthesia care (MAC) is provided during the procedure.

COLONOSCOPY

Insurance coverage for colonoscopy procedures sometimes can be less predictable. There are several variables that affect how these claims are required to be coded. Below is a snapshot of the most common scenarios. If you are scheduled for a colonoscopy, we recommends that you call your insurance plan and ask how your particular plan pays for these procedures. We are not able to change the coding to accommodate the highest benefit level of your plan---requesting us to do that is asking us to file a false claim.

- **Screening Colonoscopy** – a colonoscopy for a patient **aged 50 and over**, without abdominal/gastrointestinal signs or symptoms, without high-risk factors (to include personal/family history of polyps and/or colon cancer), and without abnormal findings found during the procedure.

Colonoscopy types that *may* fall under the medical benefit of a patient's plan…..

- **Screening Colonoscopy (that turns diagnostic)** – a colonoscopy for a patient **aged 50 and over**, without abdominal/gastrointestinal signs or symptoms, without high-risk factors (to include personal/family history of polyps and/or colon cancer), BUT abnormal findings **are** found during procedure (polypectomy/biopsy performed). Unfortunately, this situation can't be predicted ahead of time. If polyps are removed, any future colonoscopy procedures will be considered "surveillance" since the patient now has personal history.
- **Surveillance Colonoscopy (high-risk)** – a colonoscopy for a patient aged 18 and over, WITH high-risk factors (to include personal/family history of polyps and/or colon cancer), regardless of findings (normal or abnormal).
- **Diagnostic Colonoscopy -** a colonoscopy for a patient aged 18 and over, WITH abdominal/gastrointestinal signs or symptoms, regardless of findings (normal or abnormal).

Medicare patients – Medicare pays for colonoscopy screenings at 100% IF no polyps are removed (even if there is family or personal history). However, if polyps are found or biopsies are taken, Medicare will process the claim as "medical" and is subject to the Medicare coinsurance.

It is important to know that even though you are being "screened," it doesn't necessarily mean that your screening type will fall under the *Preventive* criteria of your particular insurance plan.