Guide to help with patient questions about colonoscopy

Media outlets have recently published articles critical of physician payments. The national GI societies are working to set the record straight and help reporters, patients, and policymakers understand the complexities of the system and the value of gastroenterologists and tests like colonoscopy.

Do I even need a colonoscopy? Is there a cheaper test that would be just as good for colon cancer screening?

Colonoscopy is a safe, well-tolerated and potentially life-saving exam. The GI societies recommend colonoscopy for colorectal cancer screening beginning at age 50 for all average risk people due to its ability to examine the entire colon and find and remove polyps (growths in the colon) during the same procedure. There are cheaper screening tests, but if the screening test is positive, the patient must return to the doctor for a colonoscopy to check for cancers and remove any polyps. Some tests only find cancer once it has developed, while colonoscopy is a preventive exam that identifies precancerous polyps and removes them before they turn into cancer. **A 2012 study in the New England Journal of Medicine showed a 53% decline in deaths for patients who underwent colonoscopy and had precancerous polyps removed.**

If a patient is considered average risk and no polyps are found during a colonoscopy, the exam does not need to be repeated for 10 years while other screening tests need to be repeated more often, some of them yearly.

How much does a colonoscopy cost? What charges are included in my colonoscopy bill?

The cost of a colonoscopy varies based on a number of factors including the individual health of the patient and their needs, which informs the decision as to where the procedure is performed, and whether the procedure is a screening exam for colon cancer or diagnostic (to evaluate symptoms such as bleeding) and if a lesion is removed or a biopsy (tissue sample) is taken.

A billed charge is the amount that a physician, hospital, or other healthcare entity charges for the specific procedures or services provided to the patient. Reimbursement is the amount paid to the physician, hospital, or other entity by an insurance company and/or the patient for a particular procedure or service provided to the patient. For example, with a patient covered by Medicare, on average, Medicare reimburses physicians about $220 for conducting a screening colonoscopy. (The New York Times article was inaccurate in the $531 figure they quoted and issued a correction on June 30, 2013.)

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Reimbursement depends on the patient's insurance provider and the provider contract. Patients should review their health insurance plan for specific details including if the doctor is within their insurance company's list of "in-network" providers. If they are not and are considered "out of network," the cost to the patient may be significantly higher.

Following is a list of charges that are typically included when colonoscopy is performed. Patients may receive one or multiple bills for different elements of the procedure from different practice and hospital providers.

- ► Bowel or colon prep kit
- ► Colonoscopy – There are different classifications for the procedure based on the patient's health:
  - Screening colonoscopy (patient has no symptoms, no biopsy or lesion removal)
  - Diagnostic colonoscopy (the patient has symptoms)
  - Colonoscopy and biopsy (tissue sample is taken)
- ► Lesion removal colonoscopy (lesion/polyp is removed)
- ► Sedation
  - Whether sedation is used or not
  - Type of sedation used
  - Administration – with or without an anesthesiologist or nurse anesthetist
- ► Pathology (tissue/lesion examination by a pathologist after the procedure)
- ► Facility (where the procedure is performed)
  - Hospital
  - Ambulatory surgery center
  - Doctor's office

Why is a colonoscopy more expensive at a hospital than when it is performed in a doctor's office or ambulatory surgery center (ASC)?

A colonoscopy can be performed in a number of settings including a hospital, ASC, or a doctor's office. Where a colonoscopy is performed is typically determined by the individual health of the patient, the type of procedure, and where the physician asked to provide the service practices.

A patient considered high risk, may need the additional resources available in a hospital setting where procedure costs are typically higher. A lower-cost ASC or doctor's office is appropriate for the majority of patients who are otherwise in overall good health.

Why does a colonoscopy cost less in one state versus in another state? Is colonoscopy less expensive in other countries?

Health care, like other expenses, is more costly in some parts of the country. This regional price variation also determines what a physician is paid. Medicare and private insurance carriers adjust payment rates based on regional price variations in areas such as salaries, supplies, and building expenses necessary for maintaining practice operations and performing physician services. For example, it will cost more to run a practice in New York City than in a small town in Nebraska.

The cost of health care and all medical services (not just GI procedures and colonoscopy) vary widely between countries, therefore direct cost comparisons between the U.S. and other countries are very difficult. There are many factors that contribute to the cost variance including different insurance systems, different approaches to facility charges and reimbursements, different ways to control costs, the complexity of the health care systems, and differences in cost of living.

What costs will my insurance provider/Medicare cover? Why do I still have to pay for some costs of the colonoscopy?

Reimbursement depends on the patient's insurance provider and the provider contract. Patients should review their health insurance plan for specific details including if the doctor is within their insurance company's list of "in-network" providers. If they are not and are considered "out of network," the cost to the patient may be significantly higher.

In 2000, Medicare started paying for colonoscopy for people age 50 and older. The Patient Protection and Affordable Care Act, passed in 2010, waives the coinsurance and deductible for many colorectal cancer screening tests, including colonoscopy. An oversight in the 2010 law still held patients financially responsible for a 20% copay for a screening colonoscopy if a polyp was removed because polyp removal changed the procedure from a "screening" test (which is covered under the Affordable Care Act) to a "therapeutic" exam (polyp removal). Patients with Medicare coverage must still pay a coinsurance (but not a deductible) when a polyp is removed as a result of a screening colonoscopy. The GI societies are working on changing cost sharing for screening colonoscopy for Medicare beneficiaries.

In 2013, the federal government issued an important clarification on preventive screening benefits under the Affordable Care Act. Patients with certain private insurance plans will no longer be liable for cost sharing when a precancerous colon polyp is removed during a screening colonoscopy. This ensures that colorectal cancer screening is available to privately insured patients at no additional cost, as intended by the new health care law. Patients should review their health insurance plan for specific details, including whether their plan falls under this guidance.

Finally, colonoscopies that are performed to evaluate specific problems, such as intestinal bleeding or anemia, are not classified by private insurers and Medicare as screening procedures, and may not be eligible for waiver of deductible and copay requirements.

Can I have a colonoscopy without sedation since anesthesia costs so much?

In many cases, colonoscopy can be done without sedation. However, sedation is used to make patients comfortable during the procedure. Having a colonoscopy with or without sedation may also depend on the individual health of the patient and should be discussed with your doctor. Many patients prefer to be sedated during the exam. Depending on the type of sedation used, there may or may not be an extra charge for this portion of the service. Patients should discuss the available options with their physician and specifically ask about the cost of the various sedation options.