Understanding fees, insurance coverage and out of pocket expenses for your procedure

Fees

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

1. Physician professional fee – from Southwest Gastroenterology. This is the charge for the physician who performed your procedure.

2. Facility fee – from Southwest Endoscopy, an Ambulatory Surgery Center or from the hospital where the procedure is performed; the charge is for the use of the endoscopy facility or hospital and includes the use of endoscopic equipment, medications, and nursing staff.

3. Pathology – from the lab used to examine polyps or biopsy specimens, if any are obtained.

4. Anesthesia Fee – from Southwest Gastroenterology if monitored anesthesia care (MAC) is provided. This charge is for the nurse anesthetist who administrates MAC.

Generally speaking, having a procedure at Southwest Endoscopy, an Ambulatory Service Center (ASC) offers a lower cost alternative compared to having a procedure at a hospital. Southwest Endoscopy is certified by Medicare and we follow strict guidelines for quality and patient safety. Our state-of-the-art facility and equipment combined with experienced staff focusing on endoscopic procedures offer our patients a very positive care experience. Southwest Endoscopy is owned and operated by the doctors of Southwest Gastroenterology Associates. If you have any further questions, please call our business office at 505-999-1600.

Click Here for Southwest Endoscopy Procedure Fees

Insurance Coverage

UPPER ENDOSCOPY (EGD)

Upper Endoscopy procedures are generally covered by insurance when recommended to investigate symptoms **(they are never covered as screenings)**.

COLONOSCOPY

Be advised that insurance coverage for colonoscopy procedures is 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, Southwest Gastroenterology recommends that you call your insurance provider 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**, with NO GI signs or symptoms, NO high-risk factors (to include personal/family history of polyps and/or colon cancer), and NO abnormal findings are 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**, with NO GI signs or symptoms, NO high-risk factors (to include personal/family history of polyps and/or colon cancer), and 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 GI 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.

Remember…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.

Click Here for a List of Participating Insurance Plans

Out-of-pocket expenses

A patient's share of the cost of a procedure, the "out-of-pocket expense", is defined by the patient's insurance policy. Out-of-pocket expenses include deductibles and co-payments for outpatient endoscopic procedures. Deductibles can be annual or per procedure. Co-payments for outpatient endoscopic surgery are usually higher than for office visits. Almost all plans, including HMOs and PPOs, have deductibles and co-payments for ambulatory surgery. Call your insurance provider to determine your deductible, how much of that deductible remains, and the co-payment for ambulatory surgery.

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

Self- Pay

If you are scheduling a procedure that is not covered by insurance, then, subject to any available discounts, you will be responsible for 100% of the charges for your service. The average charges of the local hospitals can be significantly higher than the average charges of an independently-owned ASC (Ambulatory Surgery Center). Southwest Endoscopy offers a 30% discount to self-pay; uninsured patients who elect to pay in full. We also offer a flat fee payment plan with a 50% prepayment due on the day of your procedure. To schedule an appointment, call our office at (505) 999-1600.