ROCKFORD GASTROENTEROLOGY ASSOCIATES

Most Frequently Asked Questions Regarding Billing Coverage

Please contact your insurance company to verify your benefits before testing.

Verify that both Rockford Gastroenterology and Rockford Endoscopy Center are in network with your insurance plan.
Federal Tax ID#: 36-3081482
NPI# for RGA: 1447207741 NPI# for Rockford Endoscopy: 1871536763

Colonoscopy Categories

Diagnostic/Therapeutic Colonoscopy

Patient has present gastrointestinal symptoms, polyps, or gastrointestinal disease. Diagnosis Codes: varies depending on condition – not covered under preventative/screening benefits.

Surveillance/High Risk Screening Colonoscopy

Patient is asymptomatic (no gastrointestinal symptoms), **has a personal history of gastrointestinal disease**, **colon polyps**, and/or cancer. Patients in this category are required to undergo colonoscopy surveillance at shortened intervals (e.g. every 2-5 years).

Preventative Colonoscopy Screening

Patient is asymptomatic (no gastrointestinal symptoms) over the age of 50, has no personal or family history of gastrointestinal disease, colon polyps, and/or cancer. The patient has not undergone a colonoscopy within the last 10 years. Diagnosis Code: Z12.11

Your **Primary Care Physician** (**PCP**) may refer you for a "screening" colonoscopy; however, you may not qualify for the "screening" category. This is determined in the pre-procedure process. Before the procedure, you should know your colonoscopy category.

Rockford Gastroenterology Associates will bill your insurance company for our services as a courtesy to you. Please be aware that your individual health insurance policy is a contract between you and your insurance company and we are not a party to that contract. Some of our services may not be covered by your insurance policy and we will not be aware of your unique situation when we order testing or procedures for you. By presenting for care, you agree that you are responsible for all services and charges, regardless of your insurance status. If any services are rendered that are not covered by your insurance, we are not able to alter your claim, change your diagnosis, or report a service other than what was performed for the sole purpose of obtaining insurance payment. You will be responsible for payment of any balance not covered by insurance.

Because we are a specialty clinic, some insurance plans may require that you have your PCP submit referrals through them for approval (this is not a doctor to doctor referral). Your PCP will send a request directly to your insurance company for approval that will allow you to be seen at our office. This process is not required by all insurance companies.

Please check your plan requirements and proceed as follows:

- Call your insurance company to find out if you need a PCP referral.
- If you do need a PCP referral, call your PCP and request that they submit a referral directly to your insurance company, referring you to our office.
- Upon approval, your insurance company will notify your PCP and Rockford Gastroenterology Associates.
- Without an approved PCP referral, your insurance company may deny payment and you will be responsible for any charges incurred.

If you have further billing questions, please contact our Patient Accounts Dept. at 815-484-7975.
For scheduling questions, please contact our Scheduling Dept at 815-397-7340.

You will receive separate bills for pathology and/or anesthesia administered services.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in- network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services
If you have an emergency medical condition and get emergency services from an out-of- network provider or facility, the most the provider or facility may bill you is your plan's in- network cost-sharing amount (such as copayments and coinsurance). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center
When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed. If you get other services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have these protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.
- Generally, your health plan must:
  - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you think you've been wrongly balanced or surprise billed for services received at Rockford Gastroenterology Associates, you may contact the RGA Patient Accounts team at 815.397.7340.

For more information about your rights under federal law visitor cms.gov/nosurprises/consumers or phone the no surprises help desk at 1-800-985-3059.