

Important Information Regarding Annual Preventive Exams and Insurance Coverage

The following is a quick information sheet to help our patients understand what may be covered (and what may not be covered) by their insurance plan when it comes to preventive health services.

The purpose of your health care provider's recommendation to have a periodic preventive exam is to screen for potential health problems, including breast and testicular cancer. It is important to have these exams regularly so that any problems you may have can be treated early when they are easier to cure and have caused less damage.

This screening typically includes the following activities:

- 1) Basic history and physical: Your health care provider will ask you a few questions about your sexual, medical and family history and then will perform a very basic physical exam to check your overall health.
- 2) For female patients – your health care provider will perform a breast exam by inspecting and palpating your breasts and your underarms while your arms are in various positions.
- 3) Also for female patients – your health care provider will perform a pelvic exam with Pap smear by examining your reproductive organs for problems and check you for cervical cancer.
- 4) For our mail patients – your health care provider will perform a prostate exam by performing a digital rectal exam to check for prostate cancer.

Your health insurance plan may not provide coverage for preventive services. Many traditional insurance plans only cover services to treat known problems or to diagnose a problem when there are other presenting symptoms. Most HMO plans and many PPO and POS plans do cover preventive services. If you have any questions about whether preventive or “screening” services are covered under your health insurance plan, we encourage you to talk with the benefits representative at the employer who provides your insurance coverage, or to talk with a customer service representative at your health plan.

Billing for Preventive Services

So that all insurance carriers and all providers “talk the same language” when submitting claims for payment, the health care industry uses a system designed by the American Medical Association to report physician services to the health insurance plans. Each one of the codes in this system (called Current Procedural Terminology, or CPT for short) has a specific definition that is universally recognized by physicians and payers alike.

The preventive examination is reported to the insurance carrier using the appropriate preventive visit code that identifies the services outlined above for your specific age group. Any services outside of those identified above, such as laboratory tests, the collection of the Pap smear specimen, Hemocult, hemoglobin, etc., must be reported separately according to these industry accepted standards.

What happens to the billing if the health care provider discovers an abnormality during my exam – or if I also want to talk with the health care provider about another medical concern at the same time I am here for my annual check up?

The CPT coding system referred to in the previous section provides instructions to physicians and their billing staff on this issue. It states “If an abnormality is encountered or a pre-existing condition is addressed in the process of performing this preventive medicine service, and if the abnormality is significant enough to require the key components of a problem-oriented (evaluation) of the patient, then the appropriate Office/Outpatient code should **also** be reported”. (CPT 2002, Professional Edition, page 29)

Does that mean I will be charged for two office visits?

We are legally required to bill the insurance carrier in a manner that represents the services actually provided to you, using the industry accepted billing and coding standards, outlined on the previous page. Accordingly, the charges for an encounter that includes both “wellness” and “problem-oriented” services must be broken into:

- The preventive “wellness” exam, which includes a history and other questions related to your overall health and well-being and
- The “problem-oriented” exam, with questions related to the history of your problem or illness, with further physical examination, diagnostic testing or treatment provided, as necessary.

Since there is no single “visit” code that describes the work the health care provider performs when they do **both** a preventive service and a problem oriented service, providers are instructed to charge two separate “visit” codes (similar to charging for a visit and a procedure when both are performed during the same encounter).

Generally, the problem oriented visit results in a lower level charge than you would have received if the total visit was just focused on the medical problem, since only the **additional** work for evaluating the problem is counted towards determining what this charge should be.

Does this mean I might have to pay 2 co-pays if my insurance plan covers both preventive and problem related office visits?

This is a question to ask your insurance carrier. Some carriers require that the patient pay a portion of each service. Other carriers apply the co-pay to just one service and pay their full fee schedule amount on the other. It just depends on what type of insurance coverage you have.

Some patient erroneously believe that paying two co-pays means that the health care provider gets more money than they would have for the same set of services. Keep in mind that the insurance carrier determines what is the “reasonable and customary” amount to pay the health care provider. If your plan includes a co-pay, that amount is **subtracted** from the amount the insurance carrier has agreed to pay. Co-pays are not designed to pay the physician more. They are designed to share the designated payment to the health care provider between the patient and the insurance plan.

While it may not seem fair that your insurance carrier requires you to contribute to the payment for both services, one benefit to addressing both your annual exam and your other medical concerns at the same time is that it saves you the **other** expenses associated with making a separate trip to the doctor’s office for an evaluation of the problem.

Why can’t you just include the preventive service in with the “problem-oriented” services and bill it all to the insurance carrier with one code?

Our office is committed to providing health care services in a cost-effective, comprehensive, patient-friendly yet legal and ethical manner. Intentionally misrepresenting the services that were provided to you when billing them to your insurance carrier could result in charges to your physician of submitting a false claim against a health care benefit program – an action recently defined as a violation of federal law, as amended with the Health Insurance Portability and Accountability Act, August 1996.

We thank you, for choosing us to assist you with your health care needs. As always, providing high quality health care to you is and remains our primary purpose. If you have any questions about this information, please feel free to talk with our billing department for more information.

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