

FAQ Patient Financial Policy

Who can I speak with or call for help with by bill?

Please call our Business Office at (717) 397-7085. Or you may ask our receptionist to speak with a representative of our Business Office. We are happy to explain charges, patient balances, insurance transactions, payment arrangements, or what ever else we can do to help our patients.

You may also receive a bill from a hospital, which is independent from our office.

- Lancaster General Health System Patient Financial Services 717-544-4953
- Lancaster Regional Medical Center Business Office 717-291-8075
- Heart of Lancaster Regional Medical Center Business Office 717-625-5760

How much do I really owe?

- For **office services** you will receive a statement detailing charges for your visit upon check-out. Our staff will inform you of co-pays, deductibles or other amounts we expect you own then.
- For **maternity services**, upon request a Business Office representative will review expected charges and patient obligations with you.
- For **scheduled surgeries**, our staff will send you an estimate of charges. Please contact your insurance company to determine payment coverage for these
- For **hospital based services** you will receive a statement for the portion of the charges you owe after your insurance(s) have paid or denied the charges for your services. Please keep in mind you will receive a separate bill from the hospital.
- Please call our Business Office at (717) 397-7085 for additional help.

Do you participate in my insurance?

We participate in most local insurances. Please contact your insurance company at the telephone number provided on your benefit card. There are rare instances when we participate with an insurance company, but not every plan they offer. If we do not participate, you insurance company may call this an “*out of network provider*” or “*non-par provider*”. We are happy to see patients whose insurance OGL does not participate with or whose insurance lists OGL as out of network. We will provide a receipt and documentation of your services which enables you to be reimbursed by your insurance.

Why can't you tell me what my insurance covers?

Insurance companies have dramatically changed the way health care services are provided and paid for. Unfortunately we deal with added requirements and new insurance procedures daily. We know that insurance and health plans can be very complicated and hard to understand. A single insurance company may offer dozens of different plans and employer funded health benefits may apply their own unique payment limitations. Therefore, we are unable to absolutely predict all coverage or payment situations. The physicians and midwives of OGL recommend care based on the best evidence based standards and in the interests of your health and well being. This may or may not be covered or paid for by your insurer. Often there are benefit limitations on what your carrier will pay and what you are responsible for. You have a right to thoroughly discuss this and the alternatives with your provider to make an informed choice of the health care services you wish to receive. **Services not paid by your insurance or health plan (often called non-covered services) are the responsibility of the patient.**

What if a service is not a covered benefit?

Services not covered by your insurance or health plan are your responsibility. Please be prepared to make payment at the conclusion of your office visit. Many insurance plans require the patient to be informed when benefits may not cover a service. Medicare requires the **Advance Beneficiary Notification (or ABN)** form to be completed prior to the visit. Other insurers require a documented notice or a **Waiver of Financial Liability**. We may mail one of these forms to you, or provide one at our Reception Desk depending on your insurance coverage and the services which the appointment is scheduled for.

What if I cannot pay?

The Business Office staff can make a monthly payment plan for your charges. We have experience with unique circumstances, and would be happy to assist you.

What if my insurance coverage changes?

Frequently insurance coverage from employer groups or government programs change. It is your responsibility to report changes to us. We will submit corrected claims, however, insurers may deny coverage. In such cases the charges for services are the patient's responsibility and are payable upon receipt of a statement. Therefore accurate and current information is helpful to us all. We must have correct policy, group identification and/or claim numbers, etc. along with a correct billing address. Please let us know, as soon as possible, if you have any change in insurance, employment, address or phone number.

I received a bill from a doctor whom I did not see. Why??

The hospitals send laboratory testing and x-rays to another physician to study and interpret. You will receive a bill directly from those physician groups for those professional services.

Although your OB-GYN provider obtains the specimen for your PAP tests, these are processed by a cytology laboratory and interpreted by a pathologist. You will receive a separate bill for these services.

Most surgical procedures require an anesthesiologist for the comfort and safety of the patient. You will receive a bill directly from the anesthesiologist for their professional services.

What is “coding” or “CPT”?

So that insurance carriers and 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 provider services to 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 providers and insurances alike. All insurance company contracts with our providers, and the federal Health Insurance Portability and Accountability Act, August 1996 (HIPAA) require we adhere to the CPT system.

What does the Annual Well Woman Exam include?

The Annual Well Woman Exam includes:

- Comprehensive history and physical: Your provider will ask you a few questions about your sexual, medical and family history and then will perform a physical exam to check your overall health.

- Breast exam: Your provider will inspect and palpate your breasts and your underarms while your arms are in various positions.
- Pelvic exam & pap smear: Your provider will examine your reproductive organs for problems and check you for cervical cancer.
- Wellness Counseling: Issues such as diet and exercise, smoking, self breast exam, menopausal symptoms and hormones.
This is sometimes called a “preventative health service”.

Why should I have an annual exam if my insurance only covers this every other year?

The purpose of your physician and/or midwife’s recommendation to have a periodic “pap, pelvic and breast exam” is to screen for potential reproductive health problems, including breast 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.

Why do you bill me and not my insurance for the annual well-woman exam?

Your health insurance plan may not provide coverage for preventive services. This is a benefit issue designed by your insurer or employer, and is not a choice by our practice. 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.

Why do you use codes? What is CPT?

So that insurance carriers and 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 provider services to 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 providers and insurances alike. All insurance company contracts with our providers, and the federal Health Insurance Portability and Accountability Act, August 1996 (HIPAA) require we adhere to the CPT system.

Why can’t you include everything in just one charge for each visit?

An office visit is reported to the insurance carrier using the appropriate visit code that identifies the service according to CPT standards. Other services outside of the office visit, such as laboratory tests, the collection of the pap smear specimen, bone density testing, etc must be reported separately and billed according to these industry accepted standards.

What is billed separate from the well woman exam?

- CPT excludes (and lists separately) the Pap test, the Hemocult test, ultrasound imaging, laboratory tests, and dxa scan (or bone density testing).
- CPT also excludes provider services related to a problem or illness, with further history of the problem, physical examination, diagnostic testing or treatment provided, as necessary.

What happens to the billing if the provider discovers an abnormality during my annual well woman exam – or if I also want to talk about another medical problem at the same time I’m here for my annual check-up?

The CPT coding system referred to in the previous section directs providers 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.”

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 standards of the CPT coding system. Accordingly, the charges for an encounter that includes both “wellness” and “problem-oriented” services must be separated:

- The preventive “wellness” exam, which includes a history and other questions related to your overall reproductive 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 physician or midwife performs when he or she does 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 service 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 have to pay 2 copays if my insurance plan covers both preventive and problem-related office visits?

That is a question to ask your insurance carrier. Some carriers require that the patient pay a portion of each service. Other carriers apply the copay 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. **As a courtesy to our patients, OB-GYN of Lancaster’s policy is to only collect one copay at the time of your visit, and to bill your insurance for the other.** If your insurance denies coverage for this, we will assign this to the patient’s responsibility and invoice you.

Paying two copays does not mean the provider gets more money than they would have for the same set of services. The insurance carrier determines the “reasonable and customary” amount to pay the provider. If your benefit plan includes a copay, that amount is subtracted from the amount the insurance carrier has agreed to pay the provider. Copays are not designed to pay the physician more, but rather to share the cost of care between the patient and the insurance plan.

While it may not seem fair that your insurance carrier requires you to share the costs of both services, one benefit to addressing both your annual exam and your medical problem 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 annual well woman exam (preventive service) in with the "problem-oriented" services and bill it all to the insurance carrier with one code?

OB-GYN of Lancaster is committed to providing the highest quality care in a caring, courteous and compassionate way, yet in a cost-effective, 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 provider for submitting a false claim against a health care benefit program – an action recently defined as violation of federal law, as amended by HIPAA.

What hospitals do you use, and will they accept my insurance?

OGL uses Lancaster General Health System's Women's & Babies Hospital for all obstetrical services and some gynecological services. We also use Lancaster General Hospital and Lancaster Regional Medical Center for gynecological surgeries and other services. Our physicians also have privileges at The Heart of Lancaster Regional Medical Center in Lititz. These facilities participate in most of the same insurances which OGL does, and our surgery scheduling staff will make every effort to coordinate your care with a facility that does participate with your insurance. Not all services are available at all of these hospitals, and some specialists (such as the anesthesiologist) may have different participation. As you consider treatment options, contact your insurance company or employer to understand your coverage benefits. If you have a facility preference, please discuss this with your provider as you consider treatment options.

The following telephone numbers may help:

- Lancaster General Health System Patient Financial Services 717-544-4953
- Lancaster Regional Medical Center Business Office 717-291-8075
- Heart of Lancaster Regional Medical Center Business Office 717-625-5760

My insurance requires prior authorization, how do I get that?

Call your insurance company at the telephone number listed on your benefit card. It is your responsibility to notify your provider if your insurance requires prior authorization or pre-certification. The OGL surgery schedulers will obtain pre-certification or prior authorization for surgical services which we schedule on your behalf. Please be aware that most insurance companies will grant authorization with the statement "authorization is not a guarantee of payment". Services not paid due to this are the responsibility of the patient.

What will the surgery cost?

The OGL surgery schedulers will provide a price estimate for scheduled surgery and include this in the surgery preparations. If you are expecting (or an obstetrical patient) a member of our Business Office is available upon request to discuss the charges for delivery and help you with financial preparations.

- Lancaster General Hospital maintains a "Price Estimate Tel Line" at 717-544-7961
- Lancaster Regional Medical Center Price Estimates at 717-291-8279
- Heart of Lancaster Regional Medical Center Price Estimates at 717-625-6538