

Important Information Regarding Annual Well Woman Exams and Insurance Coverage



The physicians, midwives, nurse practitioners and staff of OB-GYN of Lancaster value the trust and responsibility you place in us to care for you. We acknowledge our nation's healthcare and insurance systems are very complex. This pamphlet is to help you learn more about the annual well women exam, what may be covered (and what may not be covered) by your insurance plan when it comes to preventive health services.

If you have questions, please ask to speak with a member of our Business Office or the provider during your exam. Our Business Office may also be reached at 717-397-7085.

The purpose of your physician or other provider'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.

The Annual Well Women 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.

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.

What if a service is not a covered benefit?

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.

Billing for Preventive Services

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.

The "well woman" 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, bone density testing, etc must be reported separately and billed according to these industry accepted standards.

What is billed separate from the well women exam?

- Pap test, the Hemocult test, ultrasound imaging, laboratory tests, and dexa scan (bone density testing) are separate charges.
- There is a separate charge for obtaining specimens for testing, as well as processing and interpretation of the specimen.
- Provider services related to a problem or illness, with further history of the problem, physical examination, diagnostic testing and/or treatment as necessary, are billed separately.

We use the latest Pap technology called Thin Prep & HPV testing. If your insurance does not cover these tests, you may be responsible for the costs. If you choose not to use this technology, tell your provider in advance.

What happens to the billing if the provider discovers an abnormality during my 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 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.

For more information visit our web site at <http://www.obgynoflanaster.yourmd.com/>

Other credible sources of information about women’s health include:

The American College of Obstetricians and Gynecologists, www.acog.org

The US Department of Health and Human Services, www.womenshealth.gov

We thank you for choosing our physicians, certified nurse midwives, certified registered nurse practitioners and staff as partners for your healthcare needs. As always, providing high quality healthcare to you is and remains our primary purpose.

If you have any questions about this information, please feel free to ask your provider or call our Business Office at 717-390-7085 for more information.

The Providers and Staff

