



Solving for Surprise Preventive Services Billing is Harder Than it Seems: The Stories of Mary, Roberto, and Ashley

The following are three examples contrasting the difference between a true preventive visit with \$0 member cost-share and visits that were thought to be 'preventive' by a member, but actually were not.

Case 1: Mary

Mary is a 50-year-old female who presents to her primary care provider for a preventive yearly physical exam. She is generally healthy, but a bit overweight. She has no chronic illnesses and she's not on any medications other than some over-the-counter supplements. She's due for her screening mammogram and has never had a colon cancer screening test. She is also in an age group where hepatitis C screening is recommended. And, because she is a female greater than 45 years of age, the US Preventive Services Task Force (USPSTF) recommends routine lipid (cholesterol panel) screening. Finally, because Mary is overweight, current guidelines recommend screening her for diabetes.

During her examination, Mary voices no concerns, and her provider discovers no new medical issues.

Mary's provider appropriately orders a screening mammogram, a fasting blood sugar test to screen for diabetes, a cholesterol panel, and hepatitis C antibody screening. Her provider also makes a referral for a routine colonoscopy to screen for colon cancer.

A few weeks later, after completing these tests and receiving the results, she receives an EOB (explanation of benefits) in the mail from her insurance company. Mary is happy to discover that her services have all been paid in full by her insurance company with no out of pocket costs! Mary not only feels better about going in for her preventive exam, but also feels that her insurance company and provider have truly kept their word about providing preventive services with no out of pocket expenses. So, why did this work out so well for Mary?

1. Mary truly presented for a preventive visit. She had no concerns that would have prompted her provider to consider more testing, and her well-informed provider understood exactly the screening studies that were appropriate for her age and risk profile. Her provider knew that many tests are not appropriate to order as screening studies and, therefore, her charges were covered from the first dollar. This could have turned out very differently, as we'll see with the next case.

Case 2: Roberto

Roberto is a 63-year-old recently retired gentleman who presents to his primary care provider for a preventive yearly physical. Like Mary in our first vignette, he generally feels well most of the time, but has been experiencing some dizziness and intermittent chest pain over the last three months. He's also felt some fatigue. Also, and unlike Mary, Roberto has some pre-existing conditions that place him at increased risk, including diabetes, high blood pressure, and high cholesterol. He is on medications for these conditions.

As a 63-year-old gentleman with diabetes, high blood pressure and high cholesterol, his provider appropriately wants to check some labs to see how his diabetes, high blood pressure, and high cholesterol have been doing with an A1C test, metabolic panel (to check kidney and other metabolic functions), urinalysis, and a cholesterol panel. Since he already has multiple conditions, some of these studies would not be considered screening tests but, rather, tests to follow up on (or for surveillance of) his chronic health conditions. Like Mary, Roberto is due for hepatitis C screening. He had a colonoscopy at age 55 which was completely normal, so he wouldn't need another colon screening exam until he was 65. For men aged 55 to 69 years, the decision to undergo periodic prostate-specific antigen (PSA)-based screening for prostate cancer should be an individual one. Roberto speaks with his provider, engages in shared decision-making, and decides to have the screening. He voices no prostate-related concerns.

During the physical examination, Roberto's provider notices that he is quite pale and has a very rapid heart rate. His respiratory rate is even a bit elevated. Even though the rest of his exam is normal, Roberto's provider is concerned regarding her findings as well as Roberto's concern about recent chest pain, dizziness and fatigue. She additionally orders a chest Xray due to his respiratory rate, EKG due to his recent chest pain history, and complete blood count (CBC) to check for anemia due to his fatigue and pale appearance on examination. As far as the screening studies Roberto is due for, his provider orders a hepatitis C antibody test and PSA.

Thankfully, after his clinic workup, Roberto's chest pain, dizziness and fatigue were not proven to be related to a serious cause, but when he opened up his EOB (explanation of benefits) 4 weeks later, he couldn't believe what he saw. Although the insurance company paid for the actual clinic preventive visit and the provider's services, he was still stuck with an \$850.00 out-of-pocket balance. Roberto thought he was doing the right thing and that he was just going in for a routine preventive visit and expected all of these charges to be completely covered. So, what went wrong? Why weren't Roberto's expectations met?

1. Although Both Roberto and his provider's intentions were good and aligned, Roberto's visit wasn't completely preventive. Early in the visit, Roberto triggered a problem-oriented visit by voicing concerns including chest pain and fatigue. He was also due to have follow-up studies in relation to his chronic health issues, including diabetes, high blood pressure, and high cholesterol. Since these were not screening studies and intended for surveillance of his chronic conditions, they were not subject to 100% reimbursement under preventive services. So, while Roberto's clinic visit, hepatitis C and PSA tests were covered at 100%, his other studies were not. This is a very common scenario in Members who present for preventive visits which also combine follow-up for chronic conditions or, in addition, are redirected to evaluate acute complaints, which was the case for Roberto.

Case 3: Ashley

Ashley is a 26-year-old generally healthy female who makes an appointment with her OB/GYN provider (also her PCP), for a routine well-woman preventive visit. She's due for a pap test (cervical cancer screening), among other screening studies, and needs refill of her birth control pills.

Prior to her visit, her provider, wishing to be more efficient by obtaining her labs ahead of time, sends her to the clinic laboratory two weeks prior to her visit for several "routine" laboratory studies including a TSH (thyroid function test), CBC (blood count), metabolic panel (to check kidney function and electrolytes), urinalysis, cholesterol panel and vitamin D level.

Two weeks later, Ashley visits her PCP. Her physical exam is completely normal, and her birth control pills are refilled. In addition, during the visit, Ashley admitted that she's having some difficulty quitting smoking on her own and asked if her provider could help. In addition to brief counseling, her provider gives Ashley a prescription for a smoking cessation medication called Chantix®. Finally, Ashley's PCP goes over her completely normal lab tests with her and answers all of her related questions.

A month later, Ashley, well on her way to quitting smoking once and for all, is feeling rather good about her situation, having more energy since she's been able to cut down from 1-1/2 packs to just ½ pack per day thanks, in part, to her provider's advice and the medication. A few days later she receives her EOB (explanation of benefits) from the preventive visit in the mail. When she opens the envelope, her heart sinks. In "The Amount You Owe Provider" section she sees a \$450.00 charge for all of the labs her provider ordered. Not believing what she's seeing on the EOB, she calls her insurer's Member Services Department and verifies that the charges she owes the provider are, in fact, correct. The representative states that none of the labs ordered were considered "preventive" for her age and risk profile. Trying to help the best she can, the representative states that the next time she has a similar visit, to possibly prevent this from happening again, she can call the insurance company ahead of time to make certain her labs will be covered.

Ashley, a server at a popular Milwaukee restaurant, has been temporarily laid off due to the COVID pandemic for the past 3 months. Her rent is 6 weeks late and she has no idea how she's going to pay this bill. How could this have happened during a preventive visit that was supposed to be "free?"

1. This is probably one of the worst possible scenarios. Ashley, having had complete trust that her medical provider had her best interests at heart, felt like she had been betrayed. She simply followed her PCP's instructions. Had she known she was going to be charged for her labs, she would never have had them drawn in the first place. Now, saddled with this bill, she feels that the system really let her down. "Affordable Care Act?" "What's affordable about it when my insurance company barely paid for anything?" she ponders. "Why do I even have insurance in the first place?"

In Ashley's case, the problem didn't lie with her or her insurer. Her charges resulted solely from the actions of her PCP. If we unpack this case further, it's clear that Ashley, an otherwise healthy young woman, didn't require any of the laboratory studies that were ordered. First, there is no evidence-based reason to screen for thyroid disease in an otherwise asymptomatic person. There was also no reason to order a complete blood count, metabolic panel, or a vitamin D level. Even the cholesterol panel was unnecessary due to her age and

risk profile. Currently, no guidelines support routine screening of lipids in young adults aged 20-35 years without risks of coronary heart disease. The science tells us that ordering screening tests without evidence of clear benefit is costly and can even be harmful.

So, why would Ashley's PCP order unnecessary tests? There are many possible reasons. Here are a few common ones:

- Failure to remain up to date with the latest evidence-based screening guidelines
- Prior training or practice habits
- Practice inertia
- Fear of litigation (fear of missing a diagnosis)
- Provider apathy or indifference in helping to control health care costs in general or for her patients, specifically