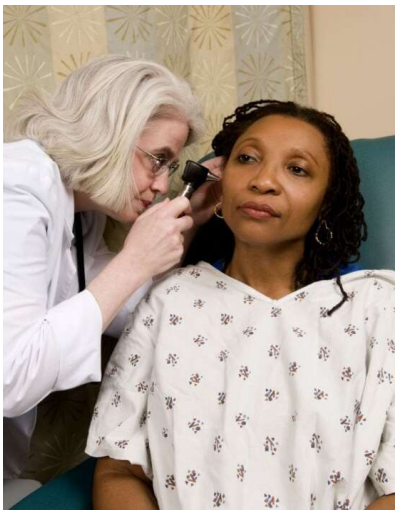
COMMON GROUND
HEALTHCARE COOPERATIVE

Preventive Care versus Diagnostic Service Scenarios

Understanding why no cost share ($0 out of pocket) applies to some services received with your annual visit but not others can be challenging. The following examples may help you to understand the difference between preventive care services with no cost share ($0 out of pocket) and services that are diagnostic.

Scenario 1:

Annual preventive care visit with primary care provider (PCP) for 50-year-old female



The patient is generally healthy (no chronic illnesses and no prescription medications), but a bit overweight. During the visit, the patient voices no concerns, and the in-network provider discovers no new medical issues.

The patient is due for:

- A screening mammogram (based on age and gender)
- A colon cancer screening test (based on age)
- Hepatitis C screening (based on age)
- Routine lipid (cholesterol panel) screening (based on age and gender)
- Diabetes screening (based on weight)

The provider makes a referral for a Cologuard or a routine colonoscopy to screen for colon cancer and orders:

- A screening mammogram
- A fasting blood sugar test (to screen for diabetes)
- A cholesterol panel
- Hepatitis C antibody screening

After completing these tests and receiving the results, the patient receives an explanation of benefits (EOB) from the insurance company. They are happy to see that the insurer paid 100% of the allowed amount for all services. They owe no out-of-pocket costs for the services.

Why did this work out so well for the patient?

- All aspects of the annual visit were preventive care.
- The patient had no concerns that would have prompted the provider to consider more testing.
- The provider understood the preventive care screening studies that were appropriate for the patient's age and risk profile.

Scenario 2:

Annual preventive care visit with primary care provider (PCP) for 63-year-old male

The patient generally feels well most of the time. However, they have been feeling fatigued and dizziness at times with intermittent chest pain during the last three months. The patient also has some pre-existing conditions that place them at increased risk for diabetes, high-blood pressure, and high cholesterol. The patient is on medication for these conditions.

The in-network provider wants to check some labs to see how the patient's diabetes, high-blood pressure, and high cholesterol are doing. The provider also recommends a periodic prostate-specific antigen (PSA)-based screening for prostate cancer (based on age and gender). The patient and provider engage in a discussion, and they decide based on risk factors the patient should have the PSA-based screening.

During the physical examination, the provider notices that the patient is quite pale. The patient has a rapid heart rate, and the respiratory rate is elevated. Even though the rest of the patient's exam is normal, the provider is concerned about these findings and the recent chest pain, dizziness, and fatigue.

The patient is due for:

- Hepatitis C screening (based on age)
- PSA-based screening (based on age and gender)

The provider orders:

- A1C test
- Chest x-ray (due to the respiration rate)
- Cholesterol panel
- Complete blood count (CBC) to check for anemia (due to the patient's fatigue and paleness)
- EKG (due to chest pain history)
- Hepatitis C screening
- Metabolic panel (to check kidney and other metabolic functions)
- PSA-based screening
- Urinalysis

After the clinic workup, the provider notifies the patient that their chest pain, dizziness, and fatigue were not proven to be related to a serious cause.

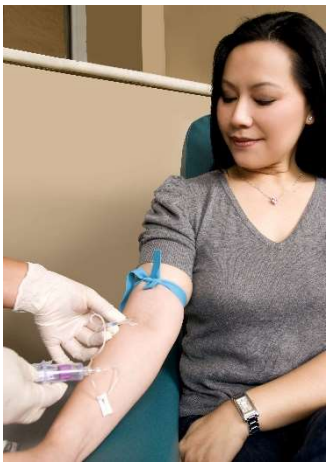
When the patient receives the explanation of benefits (EOB), they are unhappy to discover that out-of-pocket costs applied to most of the services. Only the annual preventive care visit, hepatitis C screening, and PSA-based screening were covered at 100% of the allowed amount.

Why did cost sharing (copayments, deductible and/or coinsurance) apply?

- The visit was not completely preventive care because the patient voiced concerns about symptoms they were experiencing (chest pain and fatigue).
- Since the patient already has multiple conditions (diabetes, high blood pressure, and high cholesterol), the tests to follow up on these chronic health issues are considered diagnostic. As a result, out-of-pocket cost sharing applied to the diagnostic tests.

Scenario 3:

Routine well-woman preventive visit with OB/GYN provider for 26-year-old female



The patient is due for a pap test (cervical cancer screening), some other screening studies, and needs a refill of birth control pills.

Prior to the visit, the in-network provider orders labs for several "routine" laboratory studies and requests the patient get these done two weeks prior to the scheduled well-woman preventive care visit.

The provider orders:

- Complete blood count (CBC)
- Metabolic panel (to check kidney function and electrolytes)
- TSH (thyroid function test)
- Urinalysis, cholesterol panel and vitamin D level

When the patient receives the well-woman visit, the physical exam is normal and birth control pills are refilled. During the visit, the provider asks about the patient's lifestyle. The patient admits they smoke and have not been able to quit. The provider briefly counsels the patient about quitting and prescribes a smoking cessation medication. Finally, the provider goes over the results of the lab tests (all completely normal) and answers all related questions.

When the explanation of benefits (EOB) arrives, the patient is upset to see that out-of-pocket cost sharing applied to all of the tests received. Only the annual preventive care visit was covered at 100% of the allowed amount.

Why did cost sharing (copayments, deductible and/or coinsurance) apply?

- None of the labs ordered were considered "preventive" for the patient's age and risk profile.
- The patient is healthy, and no evidence-based reason existed to order the tests. No guidelines support routine lab screening for adults aged 20-35 years who do not have risk factors of disease.

Why would the provider order the tests?

Many possible reasons exist, but here are a few common ones:

- The provider was not up to date with the latest evidence-based screening guidelines. They ordered the tests based on prior training or practice habits.
- They may fear being sued for missing a diagnosis.
- They may not be aware of the out-of-pocket cost impact on the patient.

Tip – Always verify your benefits before receiving services. Check your *Certificate of Coverage* to see your plan's benefits, limitations, and exclusions. You can find it on our website at CommonGroundHealthcare.org/Coverage-Details.