MY SCREENING IS 100% COVERED — WHY DID I GET A BILL?

— By **Wendy Fabin,** Highmark Blue Cross Blue Shield customer advocate/certified coding associate

It's a common and frustrating problem: After a screening that you were sure your health plan covered at 100%, you get a bill.

Why?

In my role as a customer advocate at Highmark Blue Cross Blue Shield, I support participants navigating that exact situation every day. I help them understand the difference between preventive and diagnostic procedures and how billing codes are used to provide the information Highmark uses to pay benefits.

So how can you know whether or not to plan for a bill after a procedure? I have four tips for you:

1. UNDERSTAND YOUR PREVENTIVE SCHEDULE.

Preventive exams are an important factor in maintaining health. These services generally include your annual wellness exam, yearly immunizations such as pneumonia and flu vaccines, and scheduled screenings. To better understand these benefits, review your preventive schedule. Everything that you qualify for on that schedule will be covered at 100% of the allowed amount.

If the preventive exam uncovers an issue that leads to a diagnosis and treatment, those procedures are paid according to your medical benefits, which can include a co-pay, deductible or co-insurance.

For example, a colonoscopy screening is a procedure to see if you have any issues, like polyps, or confirm that everything is okay. Your GuideStone® medical plan would cover this screening at 100% payment as a routine preventive benefit.

But, as I mentioned above, the issue becomes more complicated when the procedure moves beyond preventive care. If your doctor saw something in your blood work and sent you to have a colonoscopy as a result, then your screening becomes a diagnostic procedure, which is paid with a different cost-sharing formula. The same would be true if they found something during a screening and, as a result, needed you to come back for a second colonoscopy six months later — the first screening would be preventive and the second screening would be diagnostic. Plus, depending on your plan, you may also be responsible for a co-pay or portion of a deductible or co-insurance.

2. KNOW MORE ABOUT YOUR PLAN THAN YOUR DOCTOR DOES.

Many people mistakenly assume their doctor's office knows how much their medical plan will pay toward a procedure. The fact is that most providers rely on the patient to understand his or her own insurance coverage. There are so many different types of benefits, and people may be at different places with their deductible, so it's impossible for the doctor or the doctor's staff to know these details for every individual. This is your health and your finances, so in that respect it makes sense that you should be the one getting the information you need to make your own decisions.

If you want to know more about your cost for any medical visit, test or procedure, consult with a Highmark Member Service representative at 1-866-472-0924 to ensure you understand what's covered before saying yes. We are happy to help you understand your coverage so you can make informed decisions.

3. LEARN THE CODES.

What can you do to avoid the health plan equivalent of buyer's remorse? Spend time understanding your doctor's orders and how his or her office will bill your health plan for the services.

We always want people to do what's right for their health. But with screenings and many other procedures, know that you have choices. If your doctor says something isn't urgent, you have time to call us at Highmark Member Service so we can help you understand potential costs and manage your budget accordingly. Ask your doctor's office for the billing codes so we can check your benefits with greater confidence.

Your medical providers submit two codes with each claim:

1. **A procedure code** — This describes what will be done and tells us where to look in your benefits to see whether you have coverage and what costs you might be responsible for under your plan.

2. **A diagnosis code** — This describes why the procedure is being done. Some procedures are diagnostic-specific, meaning a procedure may be covered under one diagnosis code but not under another.

The more information you provide, the better we can explain your coverage situation. We can't guarantee what you may have to pay, because there are so many extenuating circumstances, but we can at least give you a better idea of what to expect.

This works in the other direction too — we can let you know if there are questions you should ask your doctor. For example, if you go in for a routine physical and your doctor wants to have blood work done, then you want to ask, "Is this the routine blood work like a glucose screening and lipid profile, or are you adding something with a diagnostic code, which may involve cost issues I want to know about?"

4. COMPARE CLAIMS TO BILLS.

If you think there's been an error, please contact us right away. There are many things that can happen during the treatment process that will affect the codes used on the claim.

For example, if we're talking to you before a procedure happens, then we're providing information you'll need to talk with your doctor about and to understand any costs. With a routine physical exam and routine lab work, for example, if the doctor wants to add a liver function test or kidney profile, we let the member know those aren't on the preventive schedule, so they can have that conversation with the doctor.

Lab work is an area where plans may differ — certain blood tests may be listed under routine benefits on one plan but not on another. We can help clarify what is covered under routine and what isn't for your specific plan.

However, if you receive an explanation of benefits (EOB) letter with a denial of coverage, we advise you to wait until you receive a bill from your provider and then contact us. With the bill in hand, it's easier for your Highmark customer advocate to call that billing office and talk to them on your behalf. In many cases, they'll send it back for review and put the account on hold for 30 days while the review happens. In the meantime, sometimes it also makes sense to call the doctor's office. If a doctor ordered blood work and a member went to an outside facility, there are cases where it does come down to the doctor calling and telling that facility, "No, it should be this diagnostic code instead of that one," and then they resubmit the claim with the new code.

As a certified coding associate, I understand how your health coverage can be confusing and feel overwhelming sometimes — that's why it's my goal to make sure you have a complete understanding of your coverage before you receive treatment.

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