Why am I Being Charged for Services That Were Part of My Annual Visit or Preventive Care?

The *Affordable Care Act* expanded coverage for preventive care and screening services. It eliminated the assessment of co-pays, co-insurance amounts, and deductibles for preventive, well care, annual exams and certain preventive screenings when it is determined that these services are being provided to prevent illness and detect first signs of disease.

The United States Preventive Services Task Force (USPSTF) A and B Recommendations is a list of preventive and screening services that are available to patients in ACA-qualified plans not subject to deductibles, co-pays or co-insurance. ACA-qualified health plans and insurers may require a co-payment or a deductible for some of the laboratory tests and services not included on the list of USPTF recommendations. Insurance companies are only required to cover services that are classified as preventive and found on the USPSTF recommendations list.

If your doctor believes that ordering one or more of the recommended services is medically necessary, then you may be eligible to receive these services free of any deductible, co-insurance or co-pay. However, if you were previously treated for a disorder or have a known ailment, then some of the tests may be considered diagnostic or specifically related to the treatment of your condition or disease and not ordered by the physician as a preventive or screening service. In that situation, you may be subject to a deductible, co-payment or co-insurance.

***Preventive* is defined as a medicine, procedure or other treatment that is designed to stop disease or ill health from occurring.**

For example, children visit their pediatricians for periodic well child care and immunizations. This type of service is not associated with an existing chronic disease or disorder, or an acute medical condition.

***Diagnostic* is defined as treating an ailment after it has occurred.**

For example, individuals aged 50 years and above are sometimes referred for screening colonoscopies. If during the course of a colonoscopy your physician discovers a polyp or some other ailment, then the exam is considered diagnostic and not screening (preventive) as originally indicated.

The way that Medicare or your insurance company knows that you have a particular disorder is through a claims history search or through the diagnosis that is reported on the claim forwarded to the payer by your physician. Physicians and hospitals are required by law to report the type of service that they are performing and the diagnosis/diagnoses related to the services being provided to you; they must be as accurate as possible with the reporting of services and diagnoses to public and private payers.

For example, if you present to your physician's office for an annual exam and you were diagnosed with diabetes and hypothyroidism years ago, then some of your labs ordered during the course of the exam may not be considered preventive. Those tests listed on the USPSTF recommendations are considered preventive only if they are truly not being ordered as a means of monitoring a current illness or previously diagnosed disorder.

Despite the services covered by your plan, you should always follow the advice of your physicians when seeking medical care and services. Your physician knows best what types of services and tests to order and will take into account your current symptoms, previous medical history, family medical history, and other factors. **Your decision to follow-through with a service or test should never be based on the suggestion of payers, but always on sound medical advice.**

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