TEUSHealth
Policy and Analytics

Why Is Cost-Sharing So Often Incorrectly Billed For Preventive Services?

Part 1: Preventive Care Benefits 101

Quantitative Imaging Workshop

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Tia Goss Sawhney
DrPH, FSA, MAAA

Quiz

The Affordable Care Act (ACA) requires that all health plans cover all preventive services without patient costs.

- ☐ Yes
- ☐ No

Quiz

The Affordable Care Act (ACA) requires that all health plans cover all preventive services without patient costs.

- ☐ Yes
- ☑ No

ACA Requirements Apply to Certain Health Plans

Individual health insurance plans purchased through exchanges or otherwise state regulated

- The insurance premiums are often subsidized under ACA

Group health insurance plans*

- Small and large employment-based groups
- Where the group pays an insurance premium

Self-funded group health plans*

- Where the group directly pays the healthcare and administration cost

*** There are exclusions**

- "Grandfathered" plans are that were in existence on March 23, 2010 and have stayed basically the same
- For contraceptive coverage for religious organizations

What is a grandfathered plan? How do I know if I have one? | KFF,
Birth control benefits and reproductive health care options in the Health Insurance Marketplace® | HealthCare.gov

ACA Requirements Do Not Apply to Various Health Plans

ACA grandfathered plans

Medicare

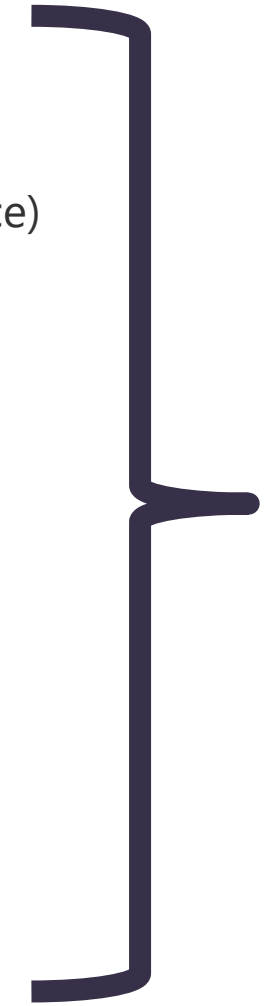
- Traditional Part A and Part B (aka, fee-for-service)
- Managed Advantage (Part C)
- Part D

Medicaid

- Fee-for-service
- Managed Medicaid

Other government health plans, including

- VA plan
- Self-funded group plans covering government employees



These plans often cover preventive services, without cost sharing, but they are not required to be fully aligned with ACA plan requirements

Quiz

Everyone covered under an ACA plan is entitled to an annual wellness visit.

- ☐ Yes
- ☐ No

Quiz

Everyone covered under an ACA plan is entitled to an annual wellness visit.

- ☐ Yes
- ☑ No

Men are not entitled to annual wellness visit; most plans, however, offer men an annual wellness visit.

ACA Requires Certain Preventive Services

Four broad categories

- **Evidence-based preventive services** *for adults* that have a rating of "A" or "B" in the current recommendations of USPSTF
- **Immunizations** that are recommended and determined to be for routine use by the ACIP
- **Services for women** not addressed by the other recommending bodies as recommended by HRSA in conjunction with the Women's Preventive Services Initiative (WPSI)
- **Services for children and youth** recommended by the HRSA's Bright Futures Project

Preventive Services Covered by Private Health Plans under the Affordable Care Act | KFF

Health Plans (including employers) Can Add Services

Commercial health plans can expand the scope of preventive benefits at-will for non-HSA-qualified plans

The IRS allows expanded preventive benefits for HSA-qualified high-deductible plans

IRS Allowed Additional Services

Preventive Care for Specified Conditions	For Individuals Diagnosed with
Angiotensin Converting Enzyme (ACE) inhibitors	Congestive heart failure, diabetes, and/or coronary artery disease
Anti-resorptive therapy	Osteoporosis and/or osteopenia
Beta-blockers	Congestive heart failure and/or coronary artery disease
Blood pressure monitor	Hypertension
Inhaled corticosteroids	Asthma
Insulin and other glucose lowering agents	Diabetes
Retinopathy screening	Diabetes
Peak flow meter	Asthma
Glucometer	Diabetes
Hemoglobin A1c testing	Diabetes
International Normalized Ratio (INR) testing	Liver disease and/or bleeding disorders
Low-density Lipoprotein (LDL) testing	Heart disease
Selective Serotonin Reuptake Inhibitors (SSRIs)	Depression
Statins	Heart disease and/or diabetes

Additional Preventive Care Benefits Permitted to be Provided by a High Deductible_n-19-45.pdf (irs.gov)

Services May Be Covered as a Medical or Rx Benefit

The Medical or Rx benefit distinction impacts site of care and accessibility

Example: Medicare Vaccines

Part B	Part D
Covid	Must cover all commercially available vaccines when they're reasonable and necessary to prevent illness, except those covered by Part B.
Influenza	
Pneumococcal	
Hepatitis B	

Note: about 20% of Medicare beneficiaries do not have Part D.

Medicare Part D Charts - Chronic Conditions Data Warehouse (ccwdata.org),
MLN908764 – Medicare Part D Vaccines (cms.gov)

Plans Administrators Have Different Coding Rules

The rules are found in the administrator's Provider Billing Manual

Claims billing companies and clearinghouses should apply the rules

Medicare Part B: Vaccine Coverage

Medicare Part B provides preventive coverage only for certain vaccines. These include:

- Influenza: once per flu season (codes 90630, 90653, 90656, 90662, 90673-74, 90682, 90685-88, 90756, Q2035, Q2037, Q2039)
- Pneumococcal: (codes 90670, 90732, once per lifetime with high-risk booster after 5 years)
- Hepatitis B: for persons at intermediate- to high-risk (codes 90739- 90740, 90743-90744, 90746-90747)

Administration services for these preventive vaccines are reported to Medicare using HCPCS codes as follows:

- G0008 administration of influenza virus vaccine
- G0009 administration of pneumococcal vaccine
- G0010 administration of Hepatitis B vaccine

The diagnosis code to report with these preventive vaccines is:

- Z23 Encounter for immunization

Other immunizations are covered under Medicare Part B only if they are directly related to the treatment of an injury or direct exposure (such as antirabies treatment, tetanus antitoxin, or booster vaccine, botulin antitoxin, antivenin, or immune globulin)

Coding: Medicare Part B and Part D Vaccine Coverage | AAFP

The Coding Rules are Complex

They involve

- Procedure code
- Primary diagnosis code
- Presence or absence of secondary diagnosis code(s)
- Age
- Sex
- Time since last procedure
- Patient's risk
- The results of a screening

Example

The screening-status of a colonoscopy can be conveyed by procedure code (G0105, G0121), procedure modifier code (33), or diagnosis code (Z12.1*).

Different health plans have different rules as to what code(s) to use.