Clarifying Preventive vs. Diagnostic Services

How do you determine when a service is considered preventive, screening, routine, or diagnostic? First in healthcare benefits there are a few terms that are synonymous. They are: *Preventive*; *Screening*; and *Routine*.

***Preventive* service** – Service provided to help a person avoid becoming sick in the first place. A service is considered preventive when it is performed when there are NO signs or symptoms present before the service or there isn't any indication that the person is not well/healthy. This type of service falls under the Preventive Benefit.

In certain instances a person may have a service performed because another personal family member has had a particular illness or condition which could mean the person is at a greater risk and should be screened. Typically a diagnosis of "Family history of…" will be seen for this situation. This type of service also falls under the Preventive Benefit.

Screening service – Service provided to a person who does not have any symptoms, previous abnormal findings, or a past history of a disease. A screening tests for a disease that has not yet manifested itself and the screening's primary purpose is for early detection so treatment can begin as quickly as possible. This type of service falls under the Preventive Benefit.

Routine service – Service recommended by a physician to a person who is healthy as far as they know prior to and at the time of service. The service screens for something that may not be causing any symptoms. In other words, there are no known problems, symptoms, or conditions for that person prior to the time of service. This type of service falls under the Preventive Benefit.

However, the terms noted above all differ from a diagnostic service.

Diagnostic service – Service provided when a person is already having symptoms or problems or has had the same or similar problems in the past. The service, test, or procedure is needed to assist in determining the illness or condition causing the symptoms. In short, a problem exists or has existed before that needs further investigation into its nature and severity. This type of service falls under most plans Major Medical benefits for lab tests or x-rays. Other situations where a diagnosis of "Personal history of…" is given would also fall under the diagnostic service classification since the diagnosis for the condition currently being treated indicates that the problem/condition previously existed for the same person.

These definitions are key in determining when the medical service you are getting falls under your health care coverage as a routine/preventive/screening service or a diagnostic service.

When a claim for services is submitted by a provider that may fall under these categories, certain pieces of information given by the provider indicate and clarify why the service was needed. Those informational pieces are: the diagnosis given by the provider for the particular service and the procedure code being billed by that provider. This information along with the service definitions stated above is then reviewed by the claim processor to determine the benefit to apply.

You may be asking yourself, why does it matter? The answer to this question is that the different categories typically get different benefit levels and may or may not be payable at all depending on whether a network or non-network provider is seen.

When a routine/preventive/screening service is obtained from and billed by your plan's network provider, it may be payable at 100% without any deductible or co-pays. You must be sure to see an in-network provider to get the service paid at 100%. However, please note that not every routine/preventive/screening service is covered by your plan. Please refer to your Summary Plan Document (SPD) and your plan's Schedule of Benefits for specific covered services.

In addition, if you see a non-network provider for these services, they may be subject to satisfying your plan's deductible and paid at the lower co-insurance percentage stated in your plan's Schedule of Benefits, or they may not be payable at all.

However, like any other medical service, a diagnostic service performed by either an in-network or non-network provider is typically subject to satisfying a deductible and/or applying to the co-insurance percentage stated in your plan's Schedule of Benefits. Typically this type of service isn't paid at 100% until AFTER you have completely satisfied the deductible and the out-of-pocket amount stated in the plan's Schedule of Benefits.

This information is being shared with you to help you gain a better understanding of when a service is considered as either Preventive or Diagnostic.

Additional information regarding these services can be found in your plan's SPD on your employee portal. You may also call us, People 1st Health Strategies, Inc., at 1-866-881-0676 and a member of our Customer Service team will assist you with any other needed clarifications.