

General questions

What are “out of pocket” expenses?

Your out-of-pocket expenses are established by the terms of your insurance plan and are a combination of your deductible, copayments, and coinsurance:

- Your **copayment** is a flat fee that you pay (due at the time of service) each time you have a health-related service. For example, you may have to pay \$15 for each clinic visit or \$25 each time you have a prescription filled.
- Your **deductible** is the amount you must pay each year for health-related expenses before your insurance policy or health plan begins paying
- Your **coinsurance** is a percentage of the cost of covered health-related services after you have met your deductible. Usually, coinsurance is 20% to 30% of what your health plan approves. Your health plan will pay the remaining 70% to 80%

If I have more than one health insurance policy, will you bill those insurance companies also?

Yes. If you have given us information about all your policies, we will bill those insurance companies after your primary insurance company has made its payment.

How will I know what I’m expected to pay for?

Call the customer service phone number listed on your insurance card to ask about what your policy does or does not cover. You are expected to pay your copayment, deductible, coinsurance, and also the total charges for services that your insurance company does not cover.

You are expected to pay the amount listed as “patient responsibility” within 30 days of receipt of your bill.

What if I have trouble paying my bills?

We are happy to offer you a variety of payment plan options, all at no interest. Call our Patient Financial Services Office at 507.646.1399

Questions about Hospital billing

What is included in my hospital bill?

Your bill includes charges for most services you received at the hospital. However, you will also receive a separate bill from providers who were involved in your care and who are part of their own professional group. Examples include:

- Consulting Radiology for interpretation of x-rays, CT, MRIs
- Hospital Pathology Associates for examination and interpretation of specimens removed during a procedure or surgery
- Regional Anesthesia for administration and/or oversight of anesthesia and sedation services
- Allina for daily physician visits during inpatient stays, if your primary doctor is a member of the Allina physician group.

Can I get an estimate of my expenses before I enter the hospital if I’m planning an elective procedure or surgery?

- Yes. We do provide good-faith estimates on request. This estimate will show our current charges that will be billed to your insurance company for the procedure, but it’s important to keep in mind that your course of treatment may change and additional procedures may be required that are not provided in the estimate.
- You will then need to check with your insurance company regarding what your individual policy will cover.
- From that information, you can determine approximately what your out of pocket expenses might be (copay + deductible + coinsurance + services not covered by your policy up to the amount listed in your policy as your annual maximum out of pocket amount)

Questions about Clinic billing

How does my insurance company know what services I receive during my exam?

Each service a patient receives during an office visit is identified by a code.

- The International Classification of Diseases (ICD-9) codes, defined by the World Health Organization, are used to identify a patient's diagnosis.
- Current Procedural Terminology (CPT) codes, defined by the American Medical Association, are used to describe any procedures that were performed during a patient's visit.

Your billing statement includes the appropriate code for the procedures performed and diagnosis during your examination. If you have questions regarding the codes on your billing statement, call Patient Financial Services at 507.646.1399.

May I request a change in the coding for services provided?

Coding must reflect what happens during your medical visit and match what is recorded in your medical record. Federal law requires appropriate, accurate coding. Sometimes a patient believes (or is told) that if a different code had been used, he/she would have coverage for a specific procedure. However, it is fraudulent and illegal to change codes solely to obtain reimbursement. It is very important to understand your coverage, in advance, so that you will not be surprised if a specific service is not covered by your policy.

How will I be charged if I have a routine exam and need to discuss a new problem during the same visit?

We will submit a charge for each service to your insurance company.

Will my insurance company pay for both services during the same visit?

This depends on your individual insurance policy.

- Medicare does not cover "routine exams"
- Some insurance policies will require that you pay two copays.

It is your responsibility to check with your insurer to determine what they will cover

Why does my bill describe my visit as a "level"

Levels of service describe the complexity of the visit, the nature of the patient's individual condition, paperwork requirements, and the type of exam and counseling. Charges are based on the level of service provided, rather than the amount of time you spend with your provider.

For example, a simple "nurse only" visit for a blood pressure check would likely be a Level 1. However, a physician visit to address and manage multiple chronic conditions might be a Level 5.

Charges may vary depending on whether you are new to our clinic or specialty. Below is the range of charges (for Levels 1 through 5) that we submit to insurance companies.

- New patient: \$99 - \$466*
- Established patient: \$46 - \$327*

**Prices effective January 1, 2012 through December 31, 2012*

Why am I getting a hospital bill if I was never admitted to the hospital?

This is because you received a "hospital based" service, such as a lab or x-ray, during your visit. Government regulations require that we send a separate hospital bill for those services.

What are diagnostic services?

Diagnostic services are those that evaluate specific symptoms or manage an existing disease. Sometimes a service begins as a screening exam, but becomes a diagnostic exam when a significant problem is found or is identified by the patient during the exam that may require treatment. An example would be a screening mammogram in which the patient identifies a specific area of concern; the mammogram is then coded as a diagnostic exam.

Does insurance cover diagnostic services?

Insurance coverage for diagnostic services varies among insurers. Coverage for some medical services may require preapproval from your insurer. It is important to check your policy and address questions, in advance, with your insurer. Generally, Medicare pays for diagnostic services. Medicare limits payment for some medical services, and you may be responsible for payment of non-covered services.

What are preventive services?

Preventive (also referred to as screening) services are designated to detect an undiagnosed disease, when the patient has no signs or symptoms. Preventive services include physical examinations for patients who don't have specific health problems, cancer-screening tests, bone mass measurements, and others.

What is included in a preventive exam?

- Included: A physical exam, screening for physical and mental health problems, a discussion of health risks related to your life style, your health history, your family's health history, and advice about obtaining preventive screening options appropriate for your age, gender, and health risk. These may include things like mammogram, colonoscopy, eye exam, etc.
- Not included: Assessment or treatment of a medical problem or chronic problem

Does insurance cover preventive services?

Insurance coverage for preventive services varies among insurers. It is important to check your insurance policy for a list of preventive services covered and not covered and also to consider any time limitations required to obtain a preventive service. Some insurers may require a specific time period to elapse before repeating a preventive medical service. Address coverage questions with your insurer. It is best to make certain, in advance, whether you have coverage for a service. Medicare provides limited coverage for preventive services.

What preventive services does Medicare cover?

Medicare covers the following services on a periodic basis:

- Tests for breast cancer, cervical cancer, vaginal cancer, and colorectal cancer
- Bone mass measurements
- Flu, pneumonia, and Hepatitis B shots
- Prostate cancer screening, including digital rectal exam and Prostate Specific Antigen (PSA) test.

For further information on Medicare coverage available, visit <http://www.medicare.gov/publications> and select the "Medicare and You" link.

What is a Medicare Annual Wellness Visit?

The Medicare Annual Wellness Visit is a discussion of your risk factors. It is not a complete physical exam and does NOT replace your annual physical exam with your regular health care provider each year. It is an annual visit that Medicare will pay in full.

There are strict guidelines set by Medicare that we must follow for the Medicare Annual Wellness Visit. Only the following items will be included in the visit:

- Review of your medical and family history
- Assessment of your functional ability and level of safety at home
- Potential risks, especially for depression and other mood disorders
- Height, weight, and body mass index
- Blood pressure

If you have other health concerns, such as diabetes, heart disease, high blood pressure, abdominal pain, headaches, or back pain, these will NOT be covered by the Medicare Annual Wellness Visit benefit. If you and your health care provider decide to address your other health concerns at this appointment, you may be responsible for any deductible, co-pays, or co-insurance that may occur from the additional charges.

A complete physical exam is NOT a covered preventive benefit under Medicare. If you have a Medicare Supplement policy, you may have coverage for this service. Check with your insurance company regarding your benefits prior to your appointment.

