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How Well Visits Are Billed and What Happens if a Problem is Found?
Written by David Sprayberry MD

Medical billing is quite complex and is based on a process called coding. I will see if I can explain it in a way that makes sense. Think of your medical bill for an office visit as being similar to the bill you receive at a restaurant. Each service, procedure, lab, and screen is billed separately just like each menu item is billed separately at a restaurant.

When you go to your doctor for a visit, he or she is required to follow certain rules, called CPT and ICD-10 rules, for describing what happened during the visit (unless he does not accept any insurance and is paid directly by the patient for the visit). Each thing that is done during the visit has a code and each diagnosis has a code. The physician must report these codes to the insurance company in order to get paid for the work that was done. There are codes for well visits, codes for sick or problem visits, codes for each test, codes for each vaccine, and codes for each procedure. If these codes are not reported correctly, your doctor will not be paid for the visit. Many times they are reported correctly and your doctor still does not get paid correctly by the insurance company (which is generally due to a "mistake" by the insurance company). Most medical offices have one or more employees whose entire job is to report these codes and to make sure the insurance company or patient actually pays correctly for them.

At a well visit, the typical codes that are reported to the insurance company are the well visit code, codes for each vaccine, codes for the administration of each vaccine, and codes for each test or procedure (like hearing, vision, hemoglobin, lead testing, developmental screening). These codes are all linked to the diagnosis "well child". Depending on the insurance plan, some or all of these codes are "covered services" and are paid by the insurance company. Sometimes the insurance company requires the patient/parent to pay for all or part of a visit (either in the form of a co-pay, deductible, or because the insurance company doesn't cover a particular service). This depends completely on the contract between the patient/parent and the insurance company. The physician's office is required to collect from the patient/parent whatever the insurance company didn't pay.

What often causes confusion is when there is an illness or other problem that is addressed or treated at the same visit. For example, if I were to find an ear infection and treat it, I would be required to submit a code that told the insurance company I had taken care of a problem and done more than just the well visit. This is where the confusion for parents may start and here's why:

Many, if not most, insurance plans require the patient to pay for a portion of any services that are not part of the well visit. Depending on the plan, the patient may need to pay a co-pay or may pay the entire amount of the extra service if they have not met their deductible. Whether they need to pay this is determined by their insurance company, not their physician. The insurance companies have intentionally designed this system to create tension between the patient and physician, when, in reality, the insurance company has caused the need for the parent to pay the extra amount. The physician merely did her job and described the visit accurately to the insurance company.

To summarize, the physician reports the codes that describe what occurred at the visit to the insurance company. The insurance company reviews the codes and determines if the patient owes any additional fee to the physician. Whether the patient owes anything depends entirely on the patient's contract with the insurance company, not by the physician