Advanced Radiology℠

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# #KnowBeforeYouGo

## Information You Need to Make Informed Health Care Decisions

References

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# #KnowBeforeYouGo

## Information You Need to Make Informed Health Care Decisions

Health Care is complex, expensive, stressful… and necessary. According to a recent survey, 72 percent of patients said they are confused by their explanation of benefits and 70 percent are confused by their medical bills. Health Care costs continue to rise as consumers face greater freedom and responsibility for their Health Care choices. What action should Health Care consumers take, and how will they get the help they will inevitably need to make the choices that serve them best?

Informed and engaged consumers make better choices. Being proactive about managing your Health Care, and its costs, will help deliver the quality of care you expect and deserve.

Advanced Radiology has created this document as a reference for anyone in need of medical imaging services. It provides valuable information on obtaining radiologic care, how you and your health insurance can cover the cost, as well as patient safety and support tools available to you and your provider. If, after reading it, you still have questions, we encourage you to contact us at 203.337.XRAY (9729), or Contact@AdRad.com

# Know Your Terms

## A glossary of important terms you'll need to understand

**Co-insurance:** Coinsurance is the percentage of the cost of health services that you pay, usually after you have met your deductible. Coinsurance is one of the costs that make up the total that you will spend out-of-pocket on health expenses, along with copays, your deductible, and premiums. A common coinsurance split is 80/20, with your health insurance company paying 80% of the cost and you paying 20%.[1]

**Contracted Rate:** Most health insurance companies have contracts with networks of hospitals and other providers. In that contract are negotiated rates for different services. For example, your health insurance provider may have a negotiated rate of $500 for a specific exam. The contracted rate is usually lower than what the provider would charge an uninsured person.[2]

**Co-pay:** A co-pay is one of the ways you may share the cost of health services with your health insurance provider. Co-payments are flat fees that you pay for services, such as an appointment or a prescription. Co-pays are also typically smaller amounts of money, like $20 or $30.[1]

**Coverage:** Having health insurance coverage means you have insurance under a private or public health plan.[1] It is important to note that having healthcare coverage does not mean that all healthcare expenses will be paid by your insurance provider. **Please contact your insurance carrier to learn the specifics of your plan.**

**CPT codes:** Current Procedural Terminology codes, or CPT® codes, are five-digit codes that define the specific exam, procedure, or service that you receive. The codes are used by insurers to help determine the amount of reimbursement that a provider will receive for services provided.[3]

**Deductible:** The amount you pay for covered health care services before your insurance plan starts to pay. For example, with a $2,000 deductible, you pay the first $2,000 of covered services yourself.

**Explanation of Benefits:** An explanation of benefits (EOB) is a statement sent by a health insurance company to covered individuals explaining what medical treatments and/or services were paid for on their behalf. The EOB is not a bill.

**Formulary:** A list of prescription drugs covered by a prescription drug plan or another insurance plan offering prescription drug benefits. Also called a drug list. Drugs on a formulary are typically grouped into tiers. The tier that your medication is in determines your portion of the drug cost. A typical drug benefit includes three or four tiers: Tier 1 usually includes generic medications; Tier 2 usually includes preferred brand-name medications; Tier 3 usually includes non-preferred brand-name medications; Tier 4 (if one exists in your plan) usually includes specialty and biosimilar medications. A medication may be placed in tier 3 or 4 if it is new and not yet proven to be safe or effective, or if there is a similar drug on a lower tier of the formulary that may provide you with the same benefit at a lower cost.[3]

**Health Savings Account (HSA):** A type of savings account that sets aside money on a pre-tax basis to pay for qualified medical expenses. By using untaxed dollars in an HSA to pay for deductibles, co-payments, co-insurance, and some other expenses, you can lower your overall health care costs. An HSA can be used only if you have a High Deductible Health Plan (HDHP) — generally any health plan with a deductible of at least $1,350 for an individual or $2,700 for a family.[1]

**HIPAA:** The Health Insurance Portability and Accountability Act, or HIPAA, is the legislation that provides data privacy and security provisions for safeguarding medical information.

**Network:** The facilities, providers, and suppliers your health insurer or plan has contracted with to provide health care services. A doctor or other provider is "In Network" if they have a contract with your insurance provider.[1]

**Out-of-pocket:** the amount of money customers spend out of pocket on health services in a given year. All health insurance plans are required to have an out-of-pocket limit, which is federally mandated. The 2019 limit is $7,900 for individual plans and $15,800 for family plans. However, your plan may have a lower out-of-pocket maximum. Plans that are more expensive tend to have lower out-of-pocket maximums.[4]

**Participation:** A provider, doctor, or hospital that enters into a contract to participate in a health plan, usually requiring reduced rates from the provider.

**Policyholder:** A policyholder is the person who owns the insurance policy. As the policyholder, you can also add more people to your policy, depending on your relationship. Most policies automatically cover all residents of your household who are related to you by marriage, blood, or adoption. While they won't be "policyholders" necessarily, they will be covered under the same policy.

**POS (Place of Service):** The setting in which a service was provided. The Centers for Medicare & Medicaid Services (CMS) maintain POS codes used throughout the health care industry.

**Pre-Authorization:** Approval from a health insurance plan that may be required before you get a service or fill a prescription in order for the service or prescription to be covered by your plan.[5]

**Prescription Drugs:** Drugs and medications that, by law, require a prescription.[1]

**Preventative benefits:** Routine health care that may include some screening exams, check-ups, and patient counseling to prevent illnesses, disease, or other health problems.[1]

**Secondary Insurance/Payer:** If you have Medicare and other health insurance or coverage, each type of coverage is called a payer. When there is more than one payer, "coordination of benefits" rules decide which one pays first. The primary payer pays what it owes on your bills first, and then sends the rest to the secondary payer. The secondary payer only pays if there are costs the primary insurer did not cover. The secondary payer may not pay all the uncovered costs. If your employer insurance is the secondary payer, you may need to enroll in Medicare Part B before your insurance will pay.[4]

**Self-pay (for insured vs. uninsured):** A cash payment direct from a patient to a healthcare provider. Most insurance plans do not allow doctors to accept direct payment from a patient, even if the patient wants to self-pay. Insurance policies often contain a clause that mandates that the insurance company be billed directly for any covered services provided to their insureds. There are rare situations when it may be useful to self-pay. Please contact your provider to discuss your specific coverage and situation.

# Know Your Health Insurance Policy

## How you and your insurance provider pay for your health care

If you have ever purchased a health insurance policy, you understand just how complex (and confusing) they can be. Multiple financial elements and opaque industry jargon can make it very difficult for consumers to navigate their way through choosing a plan and assessing their financial responsibility when faced with a medical bill. Combine that with the fact that the largest medical bills occur in situations when patients and their families feel most stressed and vulnerable, and it becomes clear that patient education and assistance is as important clinical safety and expertise.

### Where Do Your Health Care Dollars Go?

**Plan Premiums** are the "entry fees" for health insurance and are paid by all policyholders. If you get your Health Care through your employer, a portion of your premium may be paid by the company. Premiums are simply the cost of purchasing an insurance policy. They do not apply to your deductible, and do not apply directly to the cost of your care.

**Deductibles** are the cumulative amounts each covered individual or family must pay before an insurance plan begins to pay out against claims. Individual health plan policyholders pay for their Health Care in full until their cumulative expenses meet their deductible amount. After meeting their deductible, insurance pays for all or a percentage of Health Care costs, depending on whether or not the plan requires co-insurance (see below). For example, if your plan has a co-insurance requirement of 20%, once your deductible has been met, you pay only 20% of costs going forward, until the maximum out-of-pocket limit is reached, after which your insurance plan pays 100% of costs.

Family health plans have both individual and family deductibles. Once an individual meets their individual deductible amount,

Health Care expenses are then applied to their family deductible until that is also met. Health Care expenses of other family members are treated the same way. Once the family has collectively met its family deductible, insurance pays for all or a percentage of Health Care costs, depending on whether or not they have a plan requiring co payments or co-insurance. For example, If their plan has a co-insurance requirement of 20%, the policyholder pays only 20% of costs going forward, until the maximum out-of-pocket limit is reached, after which insurance pays 100% of costs.

**Co-payments** (or "co-pays") are flat fees for receiving care, paid by the patient at the time of service, with the remaining balance covered by their insurance company. Copayments usually **DO NOT** count toward your deductible amount.

**Co-insurance** means that costs are shared between the policyholder and insurance provider, with a typical plan requiring the policyholder to contribute 20% of all costs. Once the policyholder's expenses reach an out-of-pocket maximum, costs are 100% paid by the insurance plan.

**Pre-Authorization** (also known as pre-certification or prior authorization) may be required by your insurance company for selected exams or procedures before you receive them, except in an emergency. Pre-authorization means that your insurance provider has determined that the care is medically necessary. Receiving pre-authorization is NOT a guarantee that your health insurance or plan will cover the cost of the procedure.

Preauthorization may take anywhere from a few hours to a few weeks, depending on your insurance carrier, Health Care provider, and the prescribed procedure. If you have the procedure or exam before receiving preauthorization, you may be held responsible for the entire cost of the service. In some cases, this could amount to several thousand dollars. If it is not an emergency, be sure to check with your insurance provider whether or not preauthorization is necessary. If it is, wait until you have preauthorization to schedule your procedure.

## Types of health insurance plans

**Preferred Provider Organization** (PPO) health plans are one of the most popular types of plans in the Individual and family health insurance market. PPO plans allow you to visit whatever in-network physician or Health Care provider you wish without first requiring a referral from a primary care physician. PPOs form contracts with medical providers, such as hospitals and doctors, to create a network of participating providers. Patients pay less if they use providers that belong to the plan's network. They may still use doctors, hospitals, and providers outside of the network, though that will incur additional cost.

**Point-Of-Service** (POS) plans are types of managed care health insurance plan. They combines characteristics of the health maintenance organization (HMO) and the preferred provider organization (PPO). The POS is based on a managed care foundation—lower medical costs in exchange for choice that is more limited. Like an HMO, participants designate an in-network physician to be their primary care provider. However, like a PPO, patients may receive care from non-network providers, at greater out-of-pocket costs. Policyholders may also be responsible for co-payments, coinsurance, and an annual deductible.

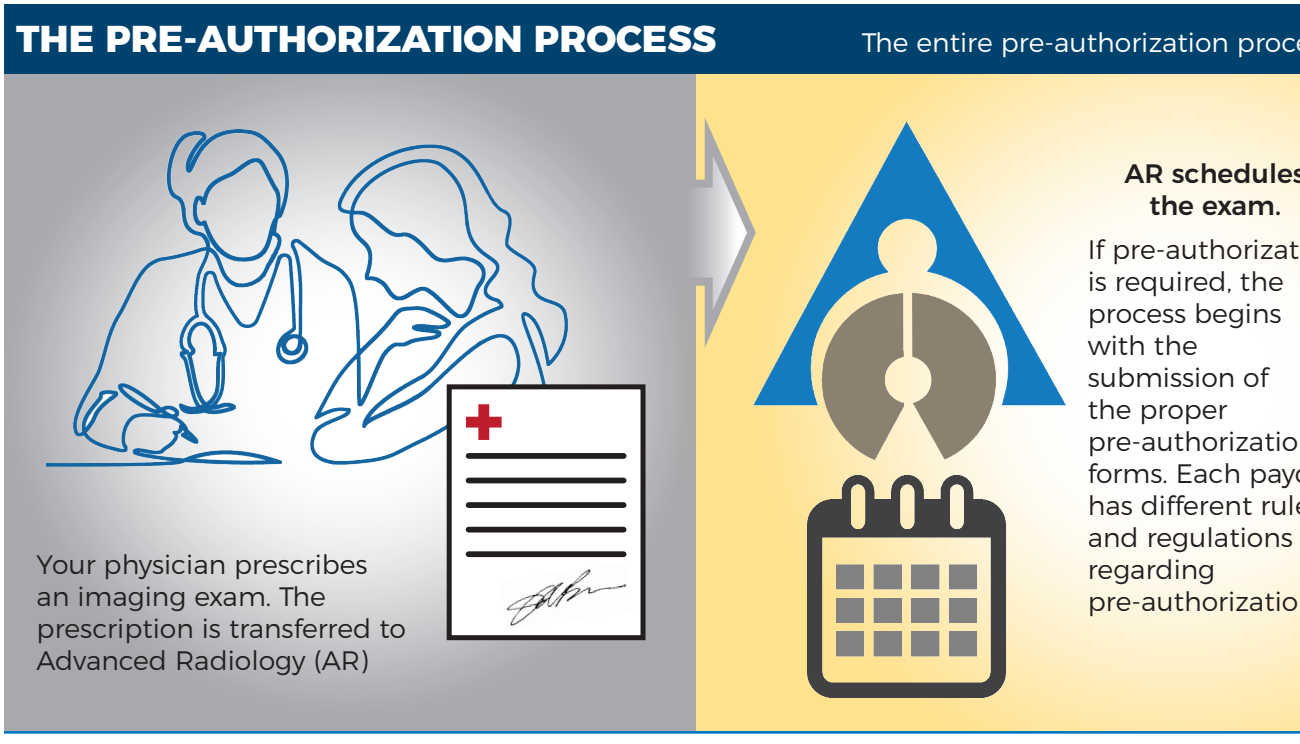
## Federal and State Government Health Coverage (Medicare, Medicaid)

**Medicare** is the federal health insurance program for people who are 65 or older, certain younger people with disabilities, and people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant, sometimes called ESRD. There are different parts of Medicare, which help cover specific services:

**Medicare Part A** (Hospital Insurance) covers inpatient hospital stays, care in a skilled nursing facility, hospice care, and some home health care physician services.

**Medicare Part B** (Medical Insurance) covers certain doctors' services, outpatient care, medical supplies, and preventive services.

**Medicare Part C** is another name for Medicare Advantage. Medicare Part C is administered by private insurance companies contracted with Medicare. It covers everything that Medicare Parts A and B cover, and may cover extra benefits as



well, though it may also have different cost sharing amounts.

**Medicare Part D** (prescription drug coverage) adds prescription drug coverage to Original Medicare coverage, some Medicare Cost Plans, some Medicare Private-Fee-for-Service Plans, and Medicare

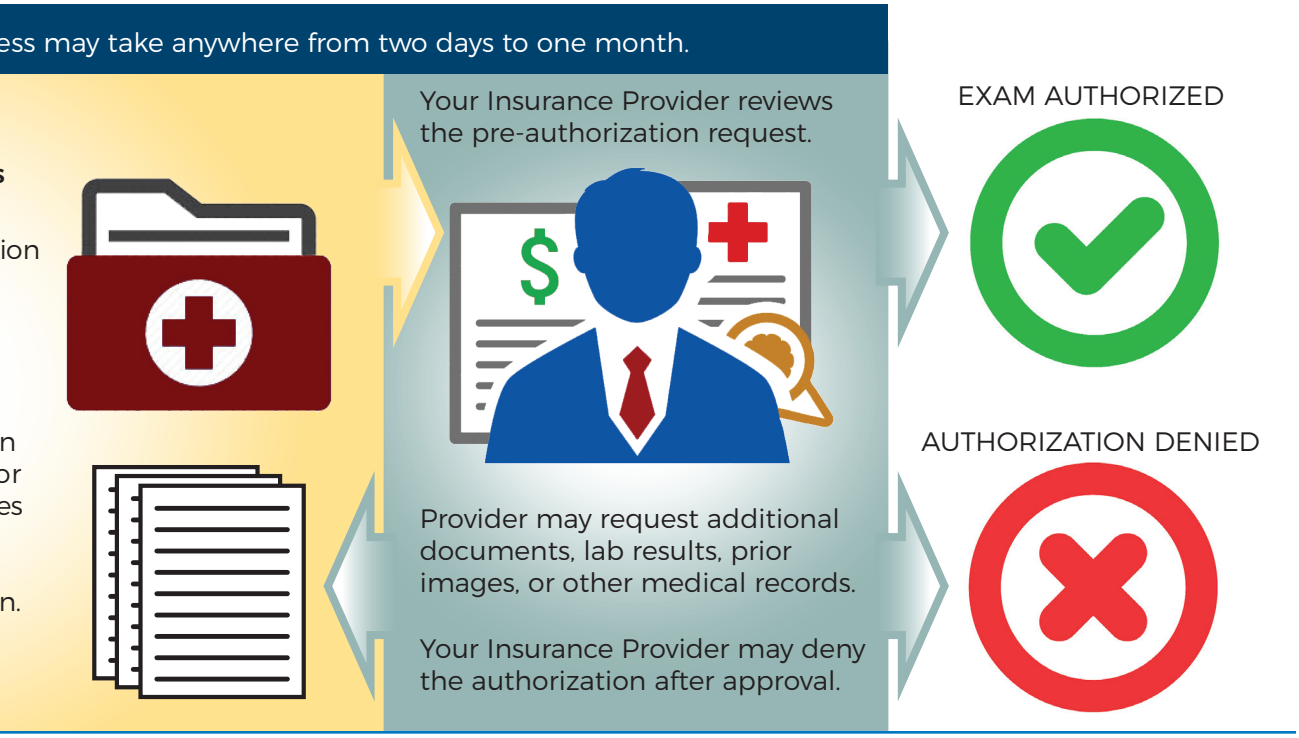
**Medical Savings Account Plans** are offered by insurance companies and other private companies approved by Medicare. Medicare Advantage Plans may also offer prescription drug coverage that follows the same rules as Medicare Prescription Drug Plans.

**Medicaid** provides health coverage to millions of Americans, including eligible low-income adults, children, pregnant women, elderly adults and people with disabilities. Medicaid is administered by states, according to federal requirements. The program is funded jointly by states and the federal government.

## Health Care Sharing Ministries

**A health care sharing ministry is not health insurance**, and most HCSMs make this clear. Instead, they are faith-based organizations that operate on a voluntary cost-sharing basis. Membership in an HCSM may include prohibiting the use of tobacco, alcohol, and in some cases, certain prescription drugs. There is often the expectation that members attend group worship regularly.

**Advanced Radiology does not participate with any health care sharing ministries.**



## If You Are Uninsured

If you do not have health insurance or if your insurance policy does not cover an examination or procedure that you still wish to have, you should ask your provider about self-pay pricing during the scheduling or pre-registration process. Most providers that work closely with insurance carriers are trained to assist patients in determining possible out-of-pocket expenses. Providers may also work with you on a reasonable payment plan if/when needed. However, most insurance plans do not allow doctors to accept direct payment from a patient, even if the patient wants to self-pay. Insurance policies often contain a clause that mandates that the insurance company be billed directly for any covered services provided to their insureds. Please inquire during the scheduling or pre-registration process and have someone review your insurance benefits and how they apply to diagnostic imaging.

**For further information, please call Advanced Radiology's Billing Specialists at 1.203.696.3692.**

**When scheduling your exam, it is critical to know whether it will be "paid for" by your insurance plan, versus merely "covered," or in the worst case, not covered at all.**

**Paid for:** Your health insurance plan will pay the cost of the service without the charge being applied to your deductible.

**Covered:** Your health insurance plan "covers" the necessary service, but may require a co-insurance payment or apply the cost to your deductible. If your deductible has not yet been met, you may be responsible for all or part of the cost of the procedure.

**Not covered:** If your plan does not cover the specified service, or if the service has been denied pre-authorization, you will be responsible for the entire cost of the procedure.

**Insurance plans are unique to each individual. Before scheduling an appointment for any procedure, we encourage you to check with your insurance carrier for specific details about your plan and its benefits.**

| **Advanced Radiology participates with the following health plans**<br>(reported as of August 1, 2019) |
| --- |
| AARP - Medicare Complete UHC |
| Aetna |
| Aetna Medicare |
| Anthem and Anthem Medicare |
| Anthem Federal |
| Cigna (eviCore) |
| GEHA |
| GWH - Cigna PPO - OPN Access |
| ConnectiCare (Individual / Small Group) |
| ConnectiCare (Large Group) |
| ConnectiCare Medicare |
| Harvard Pilgrim |
| Innovative Health Care |
| Medicare |
| Medicaid |
| UHC / Oxford |
| UHC / Oxford Medicare |
| UMR |
| WellCare |

# Know Your Exam

## From referral to follow-up, a little knowledge can improve your experience.

Most medical imaging exams, with the exception of screening mammograms, require a prescription from a referring physician. This may be your primary care physician, or a specialist you are seeing for a specific condition. All prescriptions must be signed and dated by the referring physician to be valid. Certain types of medical professionals, including chiropractors, naturopaths, and other non-MD practitioners are limited in the type of imaging exams they may prescribe.

### Scheduling Your Appointment

Your prescription may be delivered to an imaging provider (like Advanced Radiology) digitally, sent via fax, or given to you directly as a paper document. It will contain patient information (name, date of birth, contact information, and insurance), referring physician information (name, phone number, signature, and date), and the exam to be performed.

Once received, Advanced Radiology will contact you to schedule your appointment and to obtain any necessary pre-exam screening information. Most medical imaging exams require pre-screening for your safety.

At the time your appointment is scheduled, you will be given an arrival time and an exam time. Your arrival time will usually be 15 minutes prior to your exam time, to allow necessary paperwork updates to be completed. If your exam requires you to drink contrast material, you may be asked to arrive as much as one hour before your exam to give the contrast enough time to travel through your system. Your exam time is when you will be escorted to the exam room.

You will receive any additional instructions specific to your exam at the time you schedule your appointment. These will include what to wear, who should

accompany you, and any necessary dietary instructions. It is important that you follow these instructions so that we may provide the highest-quality, most accurate, and safest exam possible.

Please bring with you a current photo ID, such as a driver's license. If the information on your driver's license does not match the information on your prescription, your exam may have to be rescheduled or cancelled. You should also bring your health insurance card, a list of current medication with dosages (including over-the-counter medications), and payment for any expenses not covered by your insurance.

You should also bring to your appointment any prior imaging you have had done related to your current condition. We ask this so we may compare prior images to the latest images and understand any interim changes to your condition. It is very important that prior images be made available. Advances in technology and security allow medical imaging to be shared digitally (with a patient's permission), making it faster and more convenient.

## Your Appointment

Upon arrival at your appointment time, you will be asked to complete or update your medical history. Though this may seem repetitive and unnecessary, it is extremely important to your safety that we be made aware of any changes to your history that may have occurred between your last visit and your current visit.

Once you are checked in, you will be escorted to your Technologist, who will confirm your personal and exam information with you, and perform the imaging.

Communication between patients and staff is important to the success of your exam. If at any point during your visit you should have a question, please do not hesitate to ask.

## Your Modality

Each different type of medical imaging uses a different method of scanning, or "modality." Each modality is unique with regard to the images it produces, equipment it uses, and conditions it helps radiologists diagnose. Your referring physician will prescribe the modality he or she feels is most appropriate for your diagnosis.

**X-Ray** uses a very small dose of ionizing radiation to produce images. It is commonly used to diagnose fractured bones or joint dislocation. X-rays are the fastest and easiest way to view and assess bone fractures, injuries and joint abnormalities.

**3D Breast Tomosynthesis,** the most advanced form of **mammography,** uses low-dose x-ray to detect cancer early, when it is most treatable.

**Ultrasound** uses sound waves to produce images of the body's internal structures. It does not use ionizing radiation and has no known harmful effects. It is often used to diagnose unexplained pain, swelling and infection, and may be used to provide imaging guidance to needle biopsies or to evaluate blood flow.

**Bone Densitometry,** a.k.a. Dual-Energy X-ray Absorptiometry or DEXA, uses a very small dose of ionizing radiation to produce pictures of the inside of the body. It is the most commonly used and the most standard method for diagnosing osteoporosis.


**Magnetic Resonance Imaging (MRI)** uses a powerful magnetic field, radio waves and digital processing to produce detailed images of the body's internal structures that are clearer, more detailed and more likely to accurately characterize disease than other imaging methods. It is used to evaluate a wide variety of conditions. MRI is noninvasive and does not use ionizing radiation.

**Computed Tomography (CT)** uses x-rays to to create detailed cross-sectional images of the body's internal structures. CT images can be reformatted in multiple planes and can also be used to create three-dimensional images. CT scanning is often the best method for detecting many different cancers. CT is fast, painless, noninvasive and accurate.

**Positron Emission Tomography / Computed Tomography (PET/CT)** uses small amounts of radioactive material to evaluate organ and tissue function. By identifying changes at the cellular level, PET may detect the onset of disease before other exams can. A PET/CT scan combiines information on body functions, like metabolism, with anatomic information, helping doctors pinpoint abnormal metabolic activity. The combined exams can provide more accurate diagnoses than the two scans performed separately.

# Know About Quality and Safety

## A continual focus on patient safety and clinical quality is priority one.

Nothing is more important to a patient than safety. The same goes for our doctors, technologists, and staff. During those times when you need medical care, you should not have to consider whether your health care professionals will provide that care safely.

Your radiologists, technologists, and their support teams play an important role in your health by acting as expert consultants to your referring physician (the doctor who prescribed your testing) by selecting the most appropriate exams and properly performing those exams with the highest quality and safety.

Advanced Radiology employs a host of tools to assist us in delivering imaging care as safely as possible. Here are just a few:

### The American College of Radiology

(ACR) is a nonprofit professional society with more than 38,000 member professionals, whose standards define principles for the delivery of high quality imaging care. ACR members are providers of safe patient care. The ACR Appropriateness Criteria® are evidence-based guidelines to assist referring physicians and other providers in making the most appropriate imaging or treatment decision for each specific patient's clinical condition. Employing these guidelines helps providers enhance quality of care and contribute to the most effective use of radiology.

### Image Wisely and Image Gently

ACR®
AMERICAN COLLEGE OF RADIOLOGY

The American College of Radiology and the Radiological Society of North America formed the Joint Task Force on Adult Radiation Protection to address concerns about the surge of public exposure to ionizing radiation from medical imaging. The Joint Task Force collaborated with the American Association of Physicists in Medicine and the American Society of Radiologic Technologists to create the Image Wisely campaign with the objective of lowering the amount of radiation used in medically necessary imaging studies and eliminating unnecessary procedures.

Image Wisely encourages practitioners to optimize the amount of radiation used in medically necessary imaging studies, and to eliminate unnecessary procedures.

Through the Image Wisely program, thousands of imaging professionals across the U.S. annually renew their pledge to make patient safety and health their number one priority, and to communicate with fellow providers to ensure that patients receive the minimum radiation necessary to acquire a diagnostic-quality image during each examination.

Image Wisely offers resources and information to radiologists, medical physicists, other imaging practitioners, and patients. Many radiology professionals have volunteered their knowledge and expertise to make this initiative possible.

**All Advanced Radiology Technologists participate in the Image Wisely program.**

The Image Gently Alliance began as a committee within the Society for Pediatric Radiology and grew into a coalition of Health Care organizations dedicated to providing safe, high quality pediatric imaging worldwide. Its primary objective is to raise awareness in the imaging community of the need to adjust radiation dose when imaging children.


The mission of the Image Gently Alliance is, through advocacy, to improve safe and effective imaging care of children worldwide.

Dosewatch*

**GE's DoseWatch** application retrieves, tracks and reports radiation dose and automatically organizes the data for practice management. The software includes tools to compare doses between facilities, across systems and among exam protocols.

**iCare** is Advanced Radiology's proprietary internal safety and quality monitoring and reporting system. The application was developed to support and enhance third party monitoring and reporting. For this effort, we were awarded a 2018 Imaging Innovation Award. iCare Reporting allows us to track, analyze, and continually improve the safety of our processes and procedures. The system also provides the tools with which Advanced Radiology aggregates clinical information, which is then used to identify trends, educate staff, and improve outcome performance.

iCARE

**In addition to these efforts, all Advanced Radiology staff undergo regular, periodic training in High Performance Reliability, Patient Service, Workplace Safety, and Protected Patient Information Confidentiality.**

**The entire Advanced Radiology team is continually focused on meeting stringent safety standards, ensuring high clinical quality, and delivering a consistently positive patient experience.**

## ACR Accreditation

**ACR Accreditation is recognized as the gold standard in medical imaging. By displaying the gold seals of ACR Accreditation, we demonstrate to our patients, payers and referring physicians that we are committed to providing the safest and best quality care possible.**

# Know Your Exam Results

## Our secure, online Patient Portal provides easy access to images, reports, and more...

We understand that waiting for results can be stressful. That's why Advanced Radiology makes images and reports available through our secure, online Patient Portal. Images and reports are available to you 72 hours after they have been submitted by our Radiologist. This gives your doctor time for review in preparation for discussing results with you. On our Patient Portal you can also send and receive secure messages, request appointments, track medications, and access necessary forms prior to your appointment.

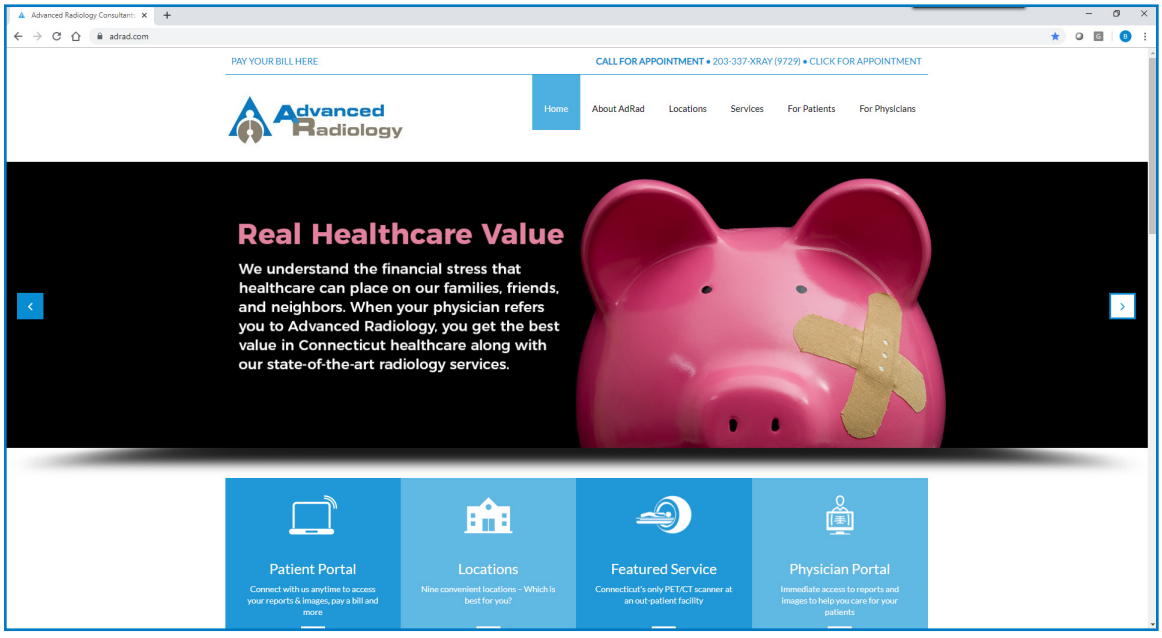

**www.MyInfo.AdRad**

# Know Advanced Radiology

## Connecticut's leading independent Radiology practice...

Advanced Radiology Consultants, Connecticut's leading independent radiology practice, has served the Northeast for more than 110 years. We are committed to providing exceptional care through our convenient, comfortable, state-of-the-art imaging centers and the expertise of our sub-specialty trained radiologists and modality-specific technologists. Our staff delivers exceptional service with a truly caring attitude through our dedication to the best possible patient experience. Advanced Radiology provides its patients and referring physicians with secure, easy access to images and reports via any internet-connected device.

For further information, call **203.337.XRAY (9729)**, or visit **AdRad.com**.



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