Episode 12: Breaking Down the Mystery of the Medical Bill

Note: This is a machine transcription. Please excuse any punctuation or other weirdness:)

Intro:

When you check your mail and see the bill from your provider is your first reaction to toss it on the table with the promise to review later? Or are you filled with dread thinking you need a PhD just to understand what it all means?

There is no doubt that receiving a medical bill can bring on anxiety, especially since it can be hard to predict what you'll be charged for a doctor's visit, a procedure or any other medical service.

If you get an alarmingly high bill, you might feel too overwhelmed to deal with it. If it's a small bill, you might be tempted to pay it without giving it a once-over, just to make it go away. But it's worth scrutinizing every bill you receive, given that error rates can be as high as 80%.

It's get real time, let's tackle this topic and make it simple to understand so next time you get that bill…you'll have the knowledge you need to review and address any concerns.

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Get Savvy with your host, Sandy Kibling, a healthcare professional changing how healthcare knowledge is shared.

Podcast

Hello and welcome Episode 12: Breaking Down the Mystery of The Medical Bill.

What we will discuss:

1. The price estimate - Charges versus Allowables

2. Understanding your Explanation of Benefits (EOB)

- This is essential to making sure your providers office and insurance company are billing correctly for the services you received. Not verifying can potentially cost you money.

3. What are your options if you need to troubleshoot a medical bill?

Let's dig in!

Did you know? Studies have shown that four out of five bills contain errors that could result in inflated medical charges.

Here are a few examples:

- A biller might enter an incorrect diagnostic code indicating that a patient had an X-ray done on both legs, when, in reality, only one leg was imaged.

- Perhaps there was a typo, a single saline drip is noted as 10 instead of one.

· Incomplete or incorrect information for a patient or provider can result in errors in billing such as noting the wrong product – example let's say you have Anthem, and they note you are in the Pathways product when you really have the PPO product. This could result in out of network issues, higher cost to you and overall, just a hassle to try and get it cleared up.

- Biller accidentally bills for the same service more than once (known as duplicate billing).

- Finally, information from the doctor's notes may also get lost or misinterpreted by a billing department.

While it can be a pain, it is important to check to make sure you are not overpaying as we all know healthcare is expensive enough already.

Price Estimate - Charges versus Allowables

In Episode 11 Pricing Your Procedure & Tips for Reducing Medical Costs, we discussed the key questions to ask when requesting a price estimate, so make sure and check that out. In this case we are going to assume you have the price estimate in hand.

This document will vary from practice to practice depending on which Electronic Health Record System they use. Typically, this document shows the charges and the allowables. Now these may be called different things for example…Charges may be referred to as UCR or Usual Customary Rate and Allowable may be Patient Portion or Patient responsibility.

Not to make it confusing but I want to help you better understand what is being referenced.

For this case we will refer to it as charges and allowables.

Let talk about the difference between the two.

Charge – is the price the provider submits to the insurance company.

Allowable – is what the provider is allowed to accept for payment.

Example: Let's say you have a 45-minute visit with your provider as an established patient. The provider charges $300 but per their contract with the insurance company, they are only allowed to accept $192 based on the contract terms. Therefore, they cannot bill you for the additional $108…the difference between $300-$192.

Now this can be confusing especially if the providers office gives you the estimate of all your charges for services and you are looking at the charge column thinking this is what you owe? You may also think…is the provider trying to pull a fast one on you?

The truth is your providers office has to create a charge master that they use to charge insurance companies as they all pay differently.

What you can rest assured of is your providers office has contract language that states they must accept the allowable charge and cannot charge you above that.

So once your procedure is complete and the providers office has billed the insurance company, you should receive an Explanation of Benefits.

What is an Explanation of Benefits (EOB)

An Explanation of Benefits or (EOB) is the insurance company's written explanation regarding a claim showing what they paid and what you must pay based on your plan, deductible and out of pocket maximum.

- It is important to note that an EOB is not a bill.
- It will explain any charges that you still owe or may have already paid (in the form of a copay at the time the medical care was received).
- If you owe additional money after the insurance company has paid its portion, the medical provider will send a separate bill, which should match your portion listed on the EOB.

Breaking Down Your EOB with 6 Key Points

To better understand how to read your EOB. We are going to review a sample EOB and talk through the 6 key areas to focus on. I will provide a one pager resource that breaks down these 6 points as a reference I will link to in the show notes.

EOB Sample

Much like the price estimate, the EOB's will vary in format based on different insurance company's systems that distribute these EOBs, but the content should remain the same. The sample in the resource I mentioned will be for Anthem.

EOB 6 key Points

1. Explanation of Health Care Benefits

The top of the EOB form gives the incidentals, like dates, names, claim number, insurance plan identification and provider information.
This is always good to check as any errors such as the wrong date of service or incorrect insurance company can result in a denial from your insurance resulting in a delay of payment.
Remember these billers deal with so many patients and different insurances a day it is easy for them to confuse you with someone else.

2. Provider Responsibility Amount

The grid section breaks down payment information. You'll see how much the provider charged, followed by any adjustments made per their agreement with your insurance company resulting in "Allowed Amount" column. A provider's charges will always be higher than the allowed amount. This does not impact you as the provider will only be paid the allowed amount based on their contract terms they negotiated with the insurance company as we discussed earlier.

3. Patient Non-Covered Amount

Depending upon your plan, some services aren't covered. Those charges would be indicated in that column.
An example of this might be an Ophthalmology/Optometry visit. Most services will be covered except for the refraction test (determines exactly what prescription you need in your glasses or contact lenses.) Most insurance companies don't cover this and if this were the case for you, it would be noted in this column

4. Co-Insurance Amount
Deductible, copayment, and coinsurance are cost sharing amounts that are your responsibility in this column. The next column is usually the amount your insurance company paid the provider on your behalf.

As a reminder the co-insurance kicks in once you have met your deductible at say 80% insurance covers and 20% you cover.

5. Amount You Owe

The most important part of the EOB is the amount you owe. When you get a bill from the provider, the amount charged should match this number.
Remember this is the explanation of benefits the bill from the provider will come later.

6. Patient Benefit Summary

In the summary section, you'll see any additional notes about how your claim was processed, plus a running tally of your cost sharing amounts for the year. Also pay close attention to the notes as to why they may not be covering the cost you believe should be covered.
Usually there is a code such as D4 Medically Not Necessary. If you believe this is not the case, contact your health insurance company to determine what proof they need via documents and or medical notes from your doctor to have your case reconsidered.

Just as a reminder, if you are a visual person make sure and check out the EOB resource that will show you an example of an EOB with the 6 key points we just reviewed. I will link to this in the show notes.

Review Your EOB Or It Can Cost YOU Money

Remember there is a high error rate when it comes to billing as we discussed in the beginning. I always recommend…Trust but verify.

Check the statement for two very important reasons:

1) Ensure your insurance company accurately applied your coverage against medical services rendered, and

2) Verify your medical provider correctly reported the treatment you received. By familiarizing yourself with the format and the terminology of an EOB, you will be able to confirm whether the statement is accurate.

Reviewing Your EOB?

1) You can always ask your providers office or facility for an itemized list for services provided. An itemized bill will include a line for each service and medical supply you received, with the dollar amount for each one.

As you are reviewing that itemized list, it is important to note at a high level how your provider is billing for services provided. A providers office uses a 5-digit code for each service provided. There are over 150,000 codes to choose from so this where those billing errors can come into play.

There are a few types of codes, so let's review:

- HCPCS Level I codes, or CPT (Current Procedural Terminology) codes, are used by all U.S. providers, and they consist of five digits that correspond to different procedures or tests. They're often called service codes on your bill.

- HCPCS Level II codes correspond to supplies or products used during your visit. Examples include a boot for your foot or an arm sling device to support your arm after shoulder surgery. Many times, these codes start with a letter instead of a number, but they're also called service codes.

- ICD-10 codes) International Classification of Diseases) used to identify diagnoses. In the U.S., every billed service that 5-digit CPT code has to link to an ICD code to make sure the treatment matches the diagnosis. ICD codes can be 3-7 characters. Example: K50.013, Crohn's disease of small intestine with fistula

- Revenue codes are specific to a facility and are usually 3-4 digits. The revenue code tells an insurance company whether the procedure was performed in the emergency room, operating room or another department. They identify the dollar amount linked with a procedure. Example if you see a revenue code for the ER and you were seen in an outpatient facility you want to appeal this as an ER visit will likely be more costly.

If you want more detail on a HCPCS or CPT codes, to make sure you're being billed for the care you received, you can use the free Medicare code lookup. Ignore the pricing information listed unless you're a Medicare recipient since Medicare's pricing is typically much lower than what private insurers pay. Enter the code on your bill, select "All Modifiers," and hit submit for an explanation of the code.

Common errors we did talk about earlier but…let's review a few more to make sure you are clear on what to look for:

- Coding errors: The person entering codes used the code for a brand name drug when you took a cheaper, generic one. Or your sprained ankle was coded as a break.

- Duplicate charges or inflated quantities: You're charged for the same service multiple times. Or a coder adds an extra zero, and you end up being charged for 100 pills instead of 10.

- Treatments you didn't receive: While you were in the hospital, your doctor scheduled you for an MRI, but then decided you didn't need it. The test might still end up on your bill if no one removed it from your chart.

- Incorrect surgery times: Operating room time is charged by the minute. If the time you spent in surgery is marked down incorrectly by a coder, you could be paying more than you should. If the time listed on the bill seems off, ask to see your medical record to see when your surgery started and stopped.

- Wrong room fee charges: For hospital stays, it's not uncommon for someone who stayed in a shared room to be charged a private room fee. Sometimes, coders also mark down the wrong number of days, inflating bills.

- Insurance issues: Your health insurance denies you coverage — either incorrectly or legitimately.

1) If you identify an error, contact the insurance company to notify them of errors. The more specific you can be the more success you will have in resolving the issue. While customer service representatives try to assist they are not always familiar with all terms and certainly not with your situation.

2) Submit a written appeal/dispute to the insurance company. You can usually find the form to do this on your insurance portal or you can call the member services number on the back of your card.

3) Contact the medical provider's billing department to advise of any mistakes and obtain an appeals form. Ask them to troubleshoot with your insurance company if the error was on their end.

4) Submit a written appeal/dispute to the provider.

Now you may be wondering how long this process takes as you don’t want to end up in collections. Typically, you have anywhere between 3-6 months before a provider or hospital sends a bill to collections. Always call your providers office to verify as practices policies may vary.

Also if you are going through the appeal process write a letter to your provider explaining this and request that they put your account on hold. Most cases a providers office or hospital will do this for 30-90 days. Make sure you do it in writing or email with read receipt and keep copies for proof.

**It's important to keep a log of names, dates, telephone, and reference numbers for each insurance and/or provider contact related to your claim.

If the bill is correct but you are concerned about paying the bill you can work with your provider or hospital to discuss a payment plan or discounted rate. (Episode 11 has more details on this topic) If you are looking for a discounted rate it is important to research a fair price for the service. You can use Healthcare Bluebook to determine a fair price and use this in your negotiation, there is a free version I will link to in the show notes.

I hope this information has proven helpful. Make sure and check the resources and they link to additional articles that you might find helpful.

Next time we will discuss, Patient Navigators who support you by helping to remove barriers to care by identifying critical resources and helping navigate through health care services and systems.

Until then Get Savvy!