Special Report: Why a Hospital Bill Costs What It Costs

Reader's Digest investigates the shocking ways we overpay up to thousands of dollars on medical expenses, and how you can understand where your money is going.

By Kimberly Hiss from Reader's Digest Magazine | September 2012

While the value of a house is based on an assessment, and the cost for an antique is determined by an appraisal, a full explanation of medical costs is hard to come by. After we asked 18 health-industry sources, we learned that no one seems to know the whole story. But one point was clear: Paying attention to the billing process may save you money.

Here, four eye-opening facts about medical bills—and how to use that knowledge to save money on your health care.

1. Hospital prices are shockingly complex.

Considering that industry analysts claim that hospital price calculations are arbitrary, we asked hospitals nationwide a simple question: How do you calculate your sticker prices? Five declined to comment or didn't provide an answer, leaving Murray Askinazi, senior vice president and CFO of Lawrence Hospital Center in Bronxville, New York, to offer this explanation: For an outpatient MRI, as an example, his hospital calculates its charge based on such factors as the cost of buying or leasing the machinery, the wear and tear on that machine, staff salaries, the climate control and electric bill, cleaning costs, local competitive pricing, and other costs related to the hospital's overhead, like malpractice insurance.

Surprisingly, medical services can vary wildly from one hospital to the next. The median charge for acute appendicitis admissions at 289 medical centers and hospitals throughout California, for example, ranged from $1,529 to almost $183,000, an Archives of Internal Medicinestudy reported in April. Within San Francisco alone, the range between the lowest and highest charge was nearly $172,000.

But hospital sticker prices matter only to a limited extent because they typically get trumped by a higher power: the amounts that insurance companies are willing to pay for those services. The figures are determined by a negotiated contract that dictates the rate at which the companies will reimburse the hospital on the patient's behalf. (In addition, the rates paid by Medicare and Medicaid, Askinazi adds, often fail to cover the hospital's cost of providing the service in the first place, which means some of those costs are often shifted to commercially insured patients.)

Now, all those factors affect the math for one simple outpatient test. For an inpatient hospital stay, those computations sprout into an intricate vine in which every service (from radiology to pathology) generates its own charges. The hospital also has facility charges, covering room and board, certain room-use fees (such as the operating room), and nursing services, all of which get consolidated into the bill sent to you and your insurance company.

As technology advances, those charges rise. Palmer had a client from Louisville, Kentucky, who was astonished to receive a charge of $45,330 for a prostate surgery and an overnight stay (insurance would cover only $4,845). The billing department told Palmer that the steep price was not only because it was a robotic procedure but also because patients who receive the high-tech surgery shortly after the hospital starts offering it are helping to recoup the facility's equipment costs.

To save money: Shop around. Compare prices in advance. *"When you schedule your procedure, say 'This is my insurance. How much will this cost me?'" advises Healthcare Blue Book's Jeffrey Rice. "If the hospital can't tell you, that's a warning sign they might not be a good deal; once you make two or three calls, you can usually find a good-value facility." To learn what a reasonable price should be, check out the free, online cost-comparison tool from Healthcare Blue Book (healthcarebluebook.com), which lists "fair" rates in your zip code based on the average insurance reimbursement fee. Also try FAIR Health (fairhealthconsumer.org), a nonprofit that lists estimates of providers' charges for services in your area plus how much of that charge insurance should cover if you go out of network. Research your own resources. For a more precise prediction of a procedure's cost with your insurance policy, check your insurance company's website, which may provide a members-only cost-comparison tool, says Nancy Metcalf, Consumer Reports senior program editor and health insurance expert. Some hospitals post procedure charges on their sites as well.*

2. Coding is so tricky, even doctors don't get it.

Unlike the corner gas pump, CT scan machines and syringes don't have visible price tags, making it hard for patients and doctors alike to know their cost. "Most physicians are in the dark about costs," Dr. Epperly says. "I did a procedure this morning to put a scope into a patient's stomach, and I don't know how much she'll get charged—I'm focused on what to do as a physician to help people. I just filled out the form and put down what we did; my coder is the person who will translate that into money."

So we asked coders—trained specialists certified by the AAPC (formerly the American Academy of Professional Coders)—what happens next. In a nutshell: Medical billing runs on three sets of universal codes: one for diagnoses (ICD-9), one for procedures (CPT), and one for durable medical goods and certain services (HCPCS). It's the job of the coder—who can be one of many coders in a hospital billing department or an office manager doubling as a coder in a neighborhood practice—to translate every single illness, treatment, and pair of crutches into a

number. Those codes are critically important because they help dictate the rest of the payment stream that follows.

It's a complex task. CPT codes, for example, are listed in a city-phone-book-size manual in which even an MRI has about 60 variations. "Sometimes I'll look at the information and think, I don't know what the hell kind of code I'm supposed to use here," says one clinician who does her own coding. "There's so much to consider, and it can be open to interpretation." Many clinicians still write their patients' progress notes on paper, sometimes carbon copy forms with areas for handwritten notes and boxes listing corresponding code choices to be checked off. "People are busy, and a check mark could end up on line one versus line two, and doctors' handwriting is notoriously sloppy, so a 2 could be misinterpreted as a 3," says Dena Bravata, MD, chief medical officer for Castlight Health, a cost transparency company.

Some medical professionals don't have a firm grasp of coding to begin with. In 2010, a 71-year-old cancer patient in Florida paid his physician $10,000 for injection treatments through an implanted pump because his insurance claims were denied. Turns out, the physician's wife and office manager doing the billing were using the wrong codes. Instead of coding for only the injection therapy, they'd been coding for the actual surgery to implant the pump—ten times per month for over a year.

The system is only getting more complicated. As science generates new diagnoses and treatments, the American Medical Association issues more codes. In October 2014—for the first time since 1977—the government will institute an upgrade of ICD-9 codes to ICD-10, bumping the number of diagnosis codes to more than 144,000 from about 13,600. Professional coders are already preparing. While many predict billing delays, some are so concerned about the transition, they're forecasting a Y2K of coding. "It's going to be a major catastrophe," says Pat Palmer of Medical Billing Advocates. "There will be glitches everywhere, and I foresee a huge increase in errors."

To save money: Ask up front. *Coding is typically too technical for a layperson to grasp: It would be like going to a grocery store and seeing aisles of bar codes without the products they're attached to, says Richard Gundling, vice president of health-care financial practices for the Healthcare Financial Management Association. But it's useful to learn the codes for your care. "The doctor's office can often give you the CPT code for a procedure in advance," says Gundling. "It might change if anything in your treatment changes, but at least it would give you a frame of reference." You can give that code to your insurance company or your hospital when you ask for a price estimate. Some cost-comparison tools, like FAIR Health's, allow you to search by CPT code. Question the code. A coding error could be to blame for an outrageously high bill. (Sometimes codes are listed on bills, sometimes not.) If your bill includes codes, check if they jibe with the ones you got from your doctor beforehand. If a bill has codes without corresponding descriptions, call the billing department to make sure they match the procedure you got (or look them up on FAIR Health's site) or enlist the help of a patient advocacy group that has coding specialists.*

3. Supplies and appointments are hard to track.

Even with regular audits and billing software to ensure accuracy, hospital bills are subject to honest human error. One common problem: getting charged for something that didn't happen. Say you're in the hospital for surgery, and a CT scan scheduled for Tuesday morning got canceled because your condition changed. "Eight out of ten times, that charge is still going to show up on that bill because it was put into the system and not taken out," says Palmer.

Other errors include double billing or charging for items you didn't use. "I remember watching a few catheterization procedures," says June Morgan, a coding educator specialist with the AAPC. "As additional supplies are pulled, the person who hands them to the doctor tells someone else the part number so it can be added to the bill. But sometimes it's hard to hear the part number, and it has to be repeated, so you can see how the patient could be billed for supplies not used, or not billed for supplies used, or billed for duplicate supplies."

In still other instances, "sometimes supplies are pulled for a procedure like an echocardiogram before the patient arrives," Morgan says. "If the patient cancels or is a no-show, the supplies should be returned and credited to his or her account. But sometimes the staff just uses those supplies on another patient instead, leaving the charges on the wrong account."

To save money: Maintain a patient log. *Avoid mistaken charges by noting what happens during your hospital stay. Granted, when you're laid up, you're not thinking about billing. But to the extent possible, you or a family member could keep a notepad by your bed and record the tests and medications you receive—and any that are canceled—along with the dates.*

Plus, keep track of the time. *Some charges, like those for time in the operating room, are determined by the minute. Have a family member note when you go into and come out of surgery, suggests Palmer. "ORs may cost $200 per minute, so if you're billed for two hours but your husband knows you came out after one, that's thousands of dollars in savings." The recovery room, where per-minute charges are also used, is another area to pay attention to. "Sometimes patients get stuck in recovery simply because nobody is available to take them to their regular room," says Palmer.*

Bring your own supplies. *Everyday items could mean more bucks on a bill than you expect, says Palmer, who has seen $10 charged for a diaper in a nursery and $119 for an egg-crate pad given to a patient who required support in bed. "If you end up needing one of these regular supplies," she advises, "just have a family member get it from a drugstore or bring it from home."*

Finally, get an itemized statement. *A typical hospital bill divides charges into broad categories, such as Laboratory, Radiology, or Pathology, without much detail. Palmer advises that you request a detailed itemized statement—which can be 15 pages or longer—that breaks*

out each specific charge. If you don't understand an item, ask the billing department to make sure it matches the care you received.

4. Not every doctor is in your network.

Many doctors bill patients independently from the hospital they work in—and they're not necessarily in your insurance network just because the facility is. Recently, a New York patient whose finger had been severed by a table saw went to an in-network emergency room but got stuck with an $83,000 bill from the out-of-network plastic surgeon who reattached the finger. Another New York patient scheduling heart surgery confirmed that both the hospital and the surgeon would be in-network, which should have left only a co-pay. But a nonparticipating surgeon assisted, resulting in a surprise $7,516 bill from just that physician.

Providers may not know (and are not required to inform patients beforehand) whether they are in-network. "We use the term RAPE," says Cindy Holtzman of the Georgia-based Medical Refund Service. "It stands for Radiologist, Anesthesiologist, Pathologist, and ER doctor; that's how we were taught in billing advocacy workshops to remember which specialties are most likely to be phantom billers that could be out-of-network."

To save money: Ask who's in. *For a scheduled procedure, ask in advance whether any specialists you'll need, such as the anesthesiologist, are in-network (and request only those who are). "You can't always arrange it ahead of time, but if possible, do it," says Metcalf. "It's too late when you're lying on the gurney."*

Add admission-form language. *At the hospital, attach a statement to your admission paperwork that says you'll pay for nonparticipating providers only if you're notified in advance. Best-case scenario, your hospital will honor it outright. If not, you'll be in a stronger position to dispute potential charges down the road.*

Contest the charge. *If you get an outrageous out-of-network bill, use out-of-network reimbursement data from sources like FAIR Health to negotiate with your insurance company for better coverage, says Jennifer Jaff, executive director of Advocacy for Patients with Chronic Illness (who herself saved $1,100 on a colonoscopy and endoscopy this way). You can also ask your insurance company to cover an out-of-network physician at your in-network rate, a strategy that Palmer has used successfully.*

http://www.rd.com/health/healthcare/special-report-why-a-hospital-bill-costs-what-it-costs/