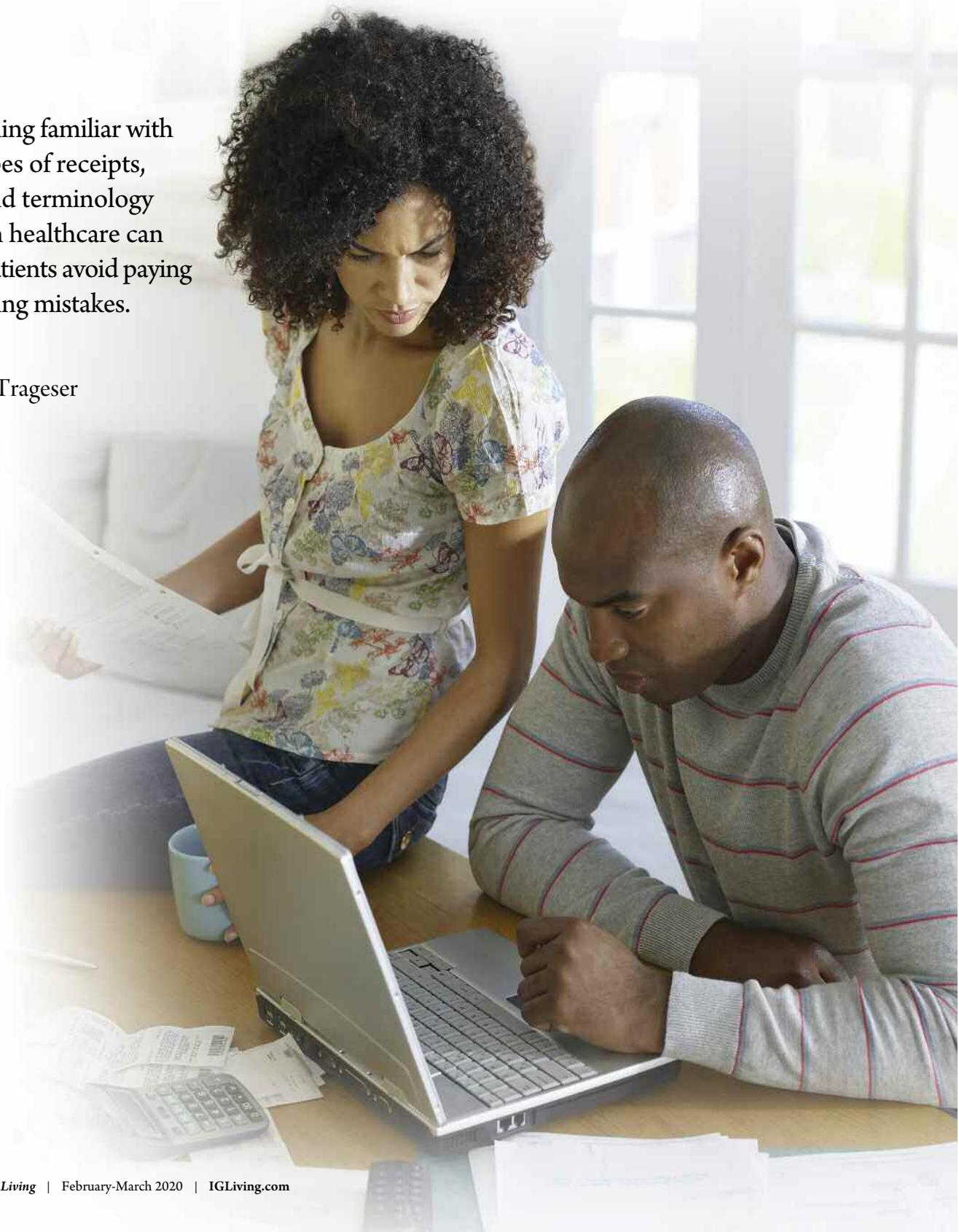# A Guide to Decoding Medical Bills

Becoming familiar with the types of receipts, bills and terminology used in healthcare can help patients avoid paying for billing mistakes.

By Jim Trageser

TACKLING BILLING paperwork for medical care is certainly not the worst part of dealing with a chronic illness, but it does add to what is already a very stressful situation. The structure of bills can be confusing, explanations are usually full of unfamiliar jargon and prices can seem disconnected from reality. Fortunately, numerous resources are available to assist patients and their families in making sense of what they're being charged so, in the event of a dispute, they are at least able to operate from a position of relative knowledge.

And, patients are likely going to need that knowledge since recent studies indicate 80 percent to 90 percent of bills reviewed contain a billing error, adding up to some $68 billion a year in illegitimate charges.[1] Therefore, patients clearly need to be informed and vigilant to protect their financial health while also dealing with their physical health.[2]

Getting Organized

When dealing with a chronic disease or condition involving frequent doctor, clinic and hospital visits, there are going to be a *lot* of bills. And, there will be a lot of other forms and paperwork, too.

Specifically, there are three financial forms associated with each medical visit that should be tracked and reconciled:

1) A receipt from the doctor's office, clinic or hospital the day of the exam detailing treatment received and containing the International Classifications of Diseases (ICD)-10 codes they will use to bill insurance. Patients should be sure to ask for this before they leave.

2) The insurance company's explanation of benefits (EOB) detailing what the doctor, clinic or hospital is claiming for that visit. This is typically sent by mail or email to patients a week or two after the visit.

3) The actual bill. There may be multiple bills from a single hospital visit since the doctors and labs may be separate business entities.

The best way to navigate financial forms and ensure there are no overcharges is for patients to get organized. It is important to be able to tie visits to bills to ensure patients pay only for services received.

The American Society of Clinical Oncology has created a guide for tracking and checking medical bills.[3] Its website, Cancer.net, suggests marking every appointment on a calender and keeping a log of all tests and procedures performed each visit. Also, every prescription should be listed, including the name of the drug, prescribing physician and the dosage and amount prescribed (number of pills or volume of liquid). This is also true for shots, pills or liquid prescriptions given by the doctor or nurse during a visit since patients will be billed for those as well.

With this information, patients can then start charting the treatment received against what is billed. This can be a handwritten chart or a computer spreadsheet. (Making it even easier for users of Microsoft Office is a free template form designed for its Excel spreadsheet that can be downloaded at templates.office.com/en-us/Patient-s-medical-bill-tracker-TM01071388.)

Patients will also want to have a system for saving all paperwork so, if there is a dispute, they have the documentation to back up their position. Visit receipts should be stapled or paperclipped to the insurance forms and the eventual bill for that visit, and they should be safely stored for at least three years (since medical costs are generally deductible on federal and state taxes).

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What the Law Says

Hospitals, clinics and doctor office billing practices are governed by a variety of laws that require certain disclosures to patients. One of the most important laws is the Health Insurance Portability and Accountability Act (HIPAA). Passed by Congress in 1996 (and updated since), HIPAA declared patients' medical information belongs to them. Therefore, patients have the right to see a copy of all protected health information (PHI) a doctor, hospital or insurance company has on file about them, including an itemized version of any bill with a line-by-line breakdown of all charges being assessed.[4] Further, if patients request a digital copy of their PHI, they cannot be charged for it. However, the billing agency *is* allowed to charge a reasonable fee to cover the cost of printing a physical copy.

Common Terms on EOBs and Medical Bills

- Actual charge: This is the amount a physician, clinic or hospital normally charges for a given procedure. The amount may be more than the negotiated rate that is actually paid. If an in-network provider is used, patients will not be responsible for the difference.

- Adjustments: These are discounts negotiated with a physician's group or hospital by patients' insurers.

- Allowed benefit: This represents the payment the insurer has negotiated with the doctor for any particular procedure. Any in-network physician has agreed to honor this amount and cannot charge patients more.

- Annual and lifetime limits: While the Affordable Care Act prohibits most plans from putting dollar-amount caps on coverage, grandfathered policies and benefits not classified as "life essential" may still have annual or lifetime limits. Once these limits are reached, patients are responsible for all additional charges.

- Billed charges: This represents the total amount providers charge the insurance company (and the patient) for a visit. It may be lower than the total charge shown if there are adjustments listed.

- Coinsurance: This is a type of plan for which a percentage of patients' costs is paid. Often, patients pay 20 percent, and the insurers pay 80 percent.

- Coordination of benefits: This is a provision that reduces benefits under a plan if coverage also exists under another plan (i.e., both parents have insurance through work).

- Co-pay: This is a set amount patients pay at the time of an appointment. Some plans have a cap on the maximum a client has to pay in co-pays over the course of a year.

- Deductible: Many insurance and other healthcare plans offer a lower monthly premium in exchange for customers accepting an annual deductible, which is a set amount of money the patient must pay out of pocket before the insurance or health plan begins to cover costs. The deductible usually resets each calendar year (meaning patient contributions go back to zero on Jan. 1). Plans may include either an individual or family deductible, or both. Each policy will contain details on this.

- Maximum benefit amount: Some plans include a cap on the amount they will pay in a specific year, and this is often tied to a specific benefit. For instance, prescriptions commonly have a maximum benefit amount.

- Maximum reimbursable charge: This is the most an insurer will pay for a procedure performed at an out-of-network facility. Patients are responsible for any amount over this.

- Out-of-pocket maximums: Some managed-care plans define a maximum amount members must pay for healthcare in any given year. Any amount above this is paid for by the insurer.

- Prior authorization: Sometimes known as a precertification, this process requires the physician to notify the insurer before scheduling some types of procedures. Once approved, charges cannot be denied.

Another important part of HIPAA is an update that dictates medical bills use ICD-10 codes for diagnoses and treatment.[5] ICD-10 is a very detailed list of all diagnoses and procedures for which a doctor can bill. Every bill must include an ICD-10 code for each charge. There are numerous free online sources where patients can look up ICD-10 codes to ensure they match what is included on their receipt and/or bill. For instance, at www.icd10data.com, patients can type in the code from their bill and find exactly what the diagnosis or procedure is.

Also under HIPAA, upon completion of any medical visit, patients are entitled to a printed list of all procedures conducted. While patients will likely not receive an actual bill that day, they should never leave the office without an official record of what was done: exam, tests, injections, drugs administered, referrals, etc.

Before leaving the clinic, doctor office or hospital, patients should look over the treatment record to make sure it reflects what they experienced or observed (although it may be just a list of ICD-10 codes since there is no law requiring bills or records must be easy to understand[6]). If patients have any questions about what is on a receipt, they should raise their concerns at that time. It is much more difficult to have that receipt corrected after the fact.

What Is Owed

After a doctor visit and before the bill arrives, patients will receive an EOB from their insurance company. Cigna Insurance on its website defines an EOB as "a statement of the medical services you received and details on how you and your plan will share costs."

Patients should compare their EOB to their calendar or journal entry for that visit, as well as their visit receipt, and make sure the insurance company was accurately billed for the treatment received. Every ICD-10 code on the EOB should be compared with their appointment record, and they should match.[7]

Specifically, patients should check these items on the EOB for accuracy:

• Is the patient's name spelled correctly? (Claims can be denied for misidentification.)

• Are the facilities all correctly identified as in-network?

• Are co-pays accurate?

The EOB will also list how much the insurance company is paying, as well as any balance the patient owes (if any). Progress toward meeting the policy's deductible will also be noted.

If patients have any doubts about the accuracy of the EOB's financial statements, they should contact their insurer immediately.

When the bill itself arrives, it should be compared to the EOB. Patients should only be billed for what the EOB indicates the patient owes. Again, if there is any discrepancy, the insurer and doctor's office, clinic or hospital that sent the bill should be contacted immediately.

Know the Terminology

Patients need to understand terminology used on bills, and this is where things can get the most confusing. As mentioned previously, there is no law that requires doctor offices, clinics or hospitals to use plain English when billing patients or their insurance companies.

However, many insurers now post a glossary of terms on their website to assist patients. Cigna's glossary is located at www.cigna.com/glossary, while Blue Cross/Blue Shield's glossary is located at www.bcbs.com/learn/glossary. Each insurer may use slightly different terminology, or it may use it differently, so while most terms (see Common Terms on EOBs and Medical Bills) are generally understood, patients are advised to check their own insurer's glossary. Many insurers include a glossary with their EOB or their annual policy statement.

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Diligence Will Prove Worthwhile

With the staggering amount of money billed for illegitimate charges, patients must perform due diligence before paying medical bills. This means documenting visits and double-checking for consistency among visit receipts, EOBs and bills. By doing so and making an effort to understand the confusing terminology used by the healthcare industry, patients can ensure they keep as much of their hard-earned money as possible in their own pockets. ◪

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