



## Tips for Understanding and Dealing with Medical Bills

When it comes to dealing with medical bills, there is no “one size fits all” solution. However, if you review your bills, talk about your concerns, and negotiate with your healthcare providers and insurance company, dealing with and paying your medical bills can become more manageable.

### How to make sense of a medical bill

You should carefully review any medical bill that you receive before paying it; however, medical bills can be very complex and difficult to understand. The following are items you will typically see on a medical bill that you receive from a medical provider:

- **Account Number:** a unique account number assigned to you, which you should provide when you refer to this bill
- **Statement Date:** the date that your healthcare provider *printed* the bill
- **Service Date(s):** the date(s) you received services or supplies
- **Description:** a short explanation about the services or supplies you received
- **Charges:** the full price of the provider’s services or supplies before the amount that the insurance has agreed to pay is factored in
- **Adjustment:** the amount that the provider or facility has written off (not charged for) due to billing agreements with the insurance company
- **Billed Charges:** the total charges the provider expects to be paid by you or your insurance
- **Insurance Payments:** the amount your insurance pays
- **Patient Payments:** the amount that you have paid for services from the provider
- **Patient Responsibility:** the amount you are responsible for paying the provider
- **Balance / Amount Due:** the amount due to the healthcare provider
- **Payable to:** the name of the person or facility that you pay

Before you pay the amount due, examine the bill and compare it to the payments you have made, read the description of services you received, and review what your insurance has paid. If your insurance has not made a payment, this could mean that your insurance was not yet billed or that payment was denied, so it is a good idea to contact the provider to find out what happened. Do not forget to check the statement date on your bill. If you have made a recent payment to your provider, it might not be reflected on the bill.

### How to understand an Explanation of Benefits (EOB)

Once you review the medical bill from your provider, compare the amount you are being billed to the amount your insurance company says you are responsible for on the Explanation of Benefits document from your insurance company. An EOB is not the same as a medical bill, though it can



look a lot like a one. An EOB is a document *from your insurance company*. You might receive it by mail or view it electronically on your insurance company's website. An EOB explains which treatment or services your health provider billed to your insurance company, the amount the insurance company has agreed to pay your provider, and the amount of the patient's financial responsibility.

The purpose of an EOB is make sure that you are informed about your healthcare costs. You may or may not receive an EOB, depending on what type of health coverage you have. People who are enrolled in Original Medicare will receive a "Medicare Summary Notice" every three months that lists all services received, which is similar to an EOB. Medicare Advantage enrollees will receive a Part C EOB. Whether you receive an EOB for Medicaid services depends on what type of Medicaid you are enrolled in and the state where you live.

The following items can typically be seen on an EOB:

- **Member name, subscriber ID, group number:** your name and insurance information
- **Claim Number:** your unique ID number used by your *insurance* provider to track your account information
- **Date of Service:** the date you received the services or supplies
- **Provider Name:** the name of the provider you visited for services or medical equipment
- **Type of service:** describes the service you received (for example, "office – medical") and is usually paired with a "procedure number"
- **Service Code or "procedure number":** identifies the specific services or supplies you received from your healthcare provider. Health care providers bill insurance companies using codes to identify certain services.
- **Total Amount or "Amount Billed":** the full cost of services billed by the provider
- **Amount Allowed:** the maximum amount that your health insurance will pay for a service
- **Not Covered:** the amount your health insurance does not cover, which you will be responsible for paying
- **Covered by Plan or "Network Savings":** the amount your insurance has saved you
- **Deductible:** the amount you will pay for your covered services before your insurance plan starts to pay
- **Copayment:** a fixed amount that you will pay for a service after you pay your deductible
- **Coinsurance:** the percentage of cost you pay for a service after you have paid your deductible
- **Total Payment or "Amount We Paid":** the amount the health insurance company has paid to the provider
- **Checks Issued:** the payments from your health insurance to the healthcare provider
- **Reason Description Code:** if you are denied coverage for any listed item, this code provides the reason(s) that your health insurance will not provide coverage, and is usually briefly explained in the "notes" section of an EOB
- **Total Patient Responsibility:** this is what you owe to the healthcare provider, and what you will use to make sure your provider's medical bill accurately reflects what you owe

### What you need to know about "service codes" on an EOB

The service codes that you may see on your EOB can be one of three types:

- *International Classification of Diseases (ICD)*: represent the doctor's diagnosis and the patient's condition. ICD codes are helpful in properly noting diseases in health records, and can provide information to insurance companies about whether a procedure or treatment was medically necessary
- *Current Procedure Terminology (CPT)* codes: used to document medical procedures that were performed by the provider.
- *Healthcare Common Procedure Coding System (HCPCS)* codes: used for services, procedures, and equipment not covered in the CPT codes.

On medical bills, the diagnosis and procedure codes need to match each other. For example, if you are diagnosed with the flu, but your ankle is x-rayed, your claim may be rejected to cover the cost of the x-ray because the diagnosis and procedure do not match.

### **How to handle mistakes in billing codes**

If your provider used the wrong billing code, your insurance company may deny the claim. To resolve this, you may want to contact the provider directly and ask them to bill your insurance using the correct code or to help you match the codes and services. The American Medical Association has a free CPT code lookup option on their website, but users are limited to five free searches per day, and sign-in is required. You may not be able to find a free list of these codes published anywhere, but some third party sources publish full lists for a fee.

If you do not agree with or understand your EOB, contact your health insurance company as soon as possible. If your insurance company incorrectly denies coverage for a service or treatment, please see our fact sheets and other information about insurance appeals on the CLRC website.

## **Comparing and Clarifying Your Medical Bill**

### **If you believe that there is an error on your medical bill, contact your medical provider**

A provider can help clarify why you received a certain charge or may even help you resolve an issue with your insurance company. When you first contact a provider, you may request that your bill be *put on hold from collections* and that your status be changed to *pending* while you investigate the charges. However, laws vary by state and your provider may not have to honor your request to put your bill on hold. In that case, ask the billing department to make a note that you are disputing this bill and request a *line-item* or *detailed bill*. Line item bills detail every single charge—even down to the number of aspirin given during a hospital stay.

### **Compare the detailed bill to your other records**

If you disagree with a bill and have requested a line-item bill, compare the items billed with your medical records and EOBs. When you review your bill, you may want to do the following:

- verify the dates noted on the bill;
- compare the codes in your medical records against your detailed bill to make sure you were not charged for any services you did not receive;
- look for data entry errors, like duplicate charges or an extra zero being added onto an item;
- look for “upcoding” – this is explained in further detail below;
- look for procedures or medications that may have been ordered and cancelled before you received them, but are still showing up on your bill

### **What you need to know about upcoding**

Upcoding is when you are billed for services that are more significant or expensive than those you actually received. This can happen accidentally, if your diagnosis codes and procedure codes do not match, or purposely, when the health care provider knowingly changes the codes for the procedures that were performed so they are paid more by the insurance company.

If you do not understand your bill, *always* ask your health care provider questions. You can also hire a professional bill reviewing company, though you do have to pay for these services. A professional bill reviewer can help find errors in standard billing practices and can even help with negotiating a payment plan. A bill reviewer can: 1) check the diagnosis codes to see if anything has been upcoded; 2) determine if charges were added that are already contained in other bundled charges; and 3) have the expertise to know what prices are beyond the industry standard.

### **Beware of Balance Billing**

When health care providers contract with an insurance company to become part of their network, one of the things that they negotiate in the contract is the rate that the provider will accept from the health plan for covered medical services. When your insurance, whether private insurance, Medicare, or Medicaid, pays the in-network provider, they are paying a contracted rate that the provider has agreed to accept as payment in full. For example, a provider's service may cost \$500, but they may agree by contract to be paid \$300 by your insurance for that service. The \$300 is the contracted rate between your provider and insurance company. You will not be billed for the balance, which in this case is \$200. To bill you for the balance ("balance billing") would violate the contract between the provider and the insurance company.

On the other hand, if you see an out-of-network provider or receive care that is not covered by your policy, you can be held liable for the full cost of the service. In those cases, balance billing is acceptable because the provider does not have a contract with your insurance company and/or has not agreed to accept a certain rate. Some insurance plans will pay out-of-network providers, but usually the reimbursement rate is low. Using the example above, if the provider's service costs \$500, he is out-of-network, and your insurance plan offers to pay him \$100, the out-of-network provider can balance bill you for the \$400 balance that your insurance plan did not pay.

### **Surprise Bills**

If you have been careful to schedule medical treatment at an in-network provider or hospital and are billed for an out-of-network service that you had no control over, this is called "surprise billing." Common examples of this are if you are charged for seeing an out-of-network emergency room doctor despite going to an in-network hospital for emergency services, or if you are billed for an out-of-network anesthesiologist despite selecting an in-network surgeon and hospital.

This surprise billing practice may sound illegal, but unfortunately there are no explicit federal protections against it yet. As of July 2018, there are 21 states that provide some protections from surprise billing, with only 6 states (California, Connecticut, Florida, Illinois, Maryland, and New York) providing comprehensive protection. In those 21 states, the law extends some version of a "hold harmless" provision, which means that in these states, a provider can still send you a

“surprise” bill, but you do not have to pay it. Providers in these states may still send these bills because they know that consumers might be unaware of their rights and pay the bill anyway. Surprise billing has gained a lot of national attention in recent years, and as a result, there is movement in Congress to make the practice illegal at the federal level, and many other states have introduced legislation to address the issue. For the most up to date information about federal and state surprise billing laws, please contact the CLRC directly.

### **Negotiating a Medical Bill**

Once you have resolved any billing mistakes and determine what you truly owe the provider, you may find it is still more than you can afford. However, it is important to make sure you either pay the amount owed or work on reducing or eliminating the amount you owe so that you do not face unwanted consequences such as the bill being sent to collections and negatively impacting your credit score. Even a small unpaid bill can have disastrous consequences.

There are tools and resources online to see whether the prices you were charged were fair. These websites are:

- Clear Health Costs: <https://clearhealthcosts.com/>
- FAIR Health: <https://www.fairhealthconsumer.org/>
- Health Care Bluebook: <https://www.healthcarebluebook.com/>

#### **You can negotiate a payment plan**

If your bill is unaffordable, many providers are willing to negotiate. Providers are often willing to reduce the amount you owe or accept a smaller lump sum as payment in full. Providers are often willing to negotiate because they would rather receive a partial payment than none at all, and it also prevents the provider from having to hire a debt collection agency to collect what you owe.

Setting up a payment plan may also be a good option. If your provider agrees, you can write out or agree to a payment plan over the phone. Be sure both parties agree to a specific monthly payment or lump sum settlement that includes not reporting to credit bureaus. Once your debt is paid off, ask the provider to send you a new statement to reflect your zero balance. You may want to consult an attorney or credit counseling service for advice before negotiating a payment plan. Hospitals and other providers are not required to accept payment plans, so even if you set one up, they may be able to terminate the payment plan at any time and demand payment in full.

#### **Medical Dispute Letter**

If you have looked at your medical bill, contacted the billing department, and still want to dispute a charge for a service or treatment by the healthcare provider, you can write a *medical dispute letter* that can either be mailed, faxed, or emailed to the billing department. It is important to have it in writing and to do it as soon as possible. The letter should include:

- account information (the account number assigned to you by the provider);
- details of the charges that you are disputing (such as date, time, facilities, physician name, and code number);
- a statement as to why you are disputing certain charges; and

- attachments of any supporting documentation.

### **File a Complaint**

If necessary, you can file a grievance with your insurance company or a complaint with the Department of Insurance in your state if you find that you are getting nowhere with your healthcare provider about resolving your medical billing disputes.

## **Medical Billing Resources**

### **American Medical Association**

<https://www.ama-assn.org/practice-management/cpt/finding-coding-resources>

(Users may log in to perform up to five daily CPT code searches)

### **Federal Trade Commission**

(877) FTC-HELP

[www.ftccomplaintassistant.gov](http://www.ftccomplaintassistant.gov)

(Helps with consumer complaints, FDCPA complaints, and identity theft.)

### **Alliance of Claims Assistance Professionals**

(888) 394-5163

[www.claims.org](http://www.claims.org)

(Claims assistance professionals advocate for you with your insurance company and providers.)

### **MedClaims Liaison**

855-625-4968

[www.medclaimsliaison.com](http://www.medclaimsliaison.com)

(Manages healthcare reimbursement process from start to finish, maximizing benefits.)

### **Medical Billing Advocates of America**

(855) 203-7058

[www.billadvocates.com](http://www.billadvocates.com)

(Helps with true and accurate charges and fair and reasonable prices / overcharge audits.)

### **Consumer Action**

San Francisco: (415) 777-9635

Los Angeles: (213) 624-8327

Washington D.C.: (202) 544-2088

[www.consumer-action.org](http://www.consumer-action.org)

(Provides free educational materials about credit and financial planning.)

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