Medical-bill errors becoming more common

8 out of 10 hospital statements have multiple mistakes, expert says

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WASHINGTON - Don't assume that your complicated medical bill is correct. Errors on bills for doctors, medical tests or hospitals can result in overcharges that run from a few dollars to **tens of thousands of dollars.** Husband and wife Ron and Marilyn Hess, from Homer, Alaska, were left facing a bill of about $10,000 from a hospital after Marilyn needed an appendectomy. The hospital bill was about $45,000, of which her insurer agreed to pay $35,000. After obtaining an itemized bill and with the help of a medical-billing advocate, the couple **uncovered procedures billed that weren't performed.** And on her appendectomy and the second clean-up surgery, Marilyn was charged separately for each item used rather than a set fee for a surgical packet. "We were outraged when we saw the itemized statement from the hospital," Ron said. Nora Johnson, director of education and hospital billing compliance who advocated for Marilyn Hess, estimates **"eight out of every 10" hospital bills she scrutinizes contain multiple errors.** And while bills from doctors' offices and labs tend to contain fewer mistakes, consumers can still end up paying unnecessarily. Watching for common errors Six out of 10 Americans with health insurance said they are paying more out of pocket for medical expenses, according to a recent survey by the Employee Benefit Research Institute, or EBRI. And the higher costs are hurting their household finances, with one-third reporting difficulty paying for basic necessities. "These results show the impact of rising health care costs is widespread and growing," said EBRI President Dallas Salisbury. Against this backdrop, it is more important than ever to assure you aren't paying more than you owe for medical services. You can take steps to protect your finances, but you need to be mindful of deadlines. It helps to watch for common types of errors. For instance, Johnson says consumers with high-deductible health plans can take a hit if their insurer fails to apply discounted group rates — which insurers negotiate with health-care providers — to charges incurred within the deductible. Deductibles in these plans can run from a thousand dollars to more than $10,000. Other common blunders include **medical-coding errors**, mistakes in how **annual deductibles are applied** and confusion over which providers are **in or out of network**. Fraudulent activity by some unscrupulous health care providers and medical-identity theft are other bugaboos, experts say. Deciphering medical bills isn't always easy. Paula Fryland, manager of the national health care group at PNC Financial Services Group Inc., says **one in three Americans reported having trouble** understanding the explanation of health benefits in a recent study the company conducted. An explanation of benefits, or EOB, is the statement your insurer

sends you after you have received health-care services. One in four consumers polled by PNC said they believe their insurer had denied a legitimate claim, and, of those, one in five paid the claim out of their own pocket (consumer advocates say the fear of getting their credit damaged motivates many). But persistence pays off: More than half of consumers got their insurer to pay all or part of the claim. Reviewing your EOB before you get a bill is the best way to track your medical expenses. If your insurer offers you the ability to review your EOBs online, sign up; if you can receive e-mail alerts, even better. Susan Johnson, a senior consultant at Watson Wyatt Worldwide, advises checking that the name, address, insurance group and identification numbers are correct. If they are inaccurate, it might mean that you have received someone else's EOB by mistake, or, more worryingly, that someone is using your health benefits without your consent. Next, check the claim activity to ensure that the name of the health care provider, services rendered and dates tally with your recollection. **"Sometimes you can get billed for tests you didn't have,"** says Johnson. Often this is due to a clerical error; however, multiple procedures for which you have no memory of receiving and/or surprisingly high **charges can signal insurance fraud.** Mark Rucci, a senior vice president at Apex Management Group, a division of Gallagher Benefit Services Inc., says consumers should also track the contributions they have made toward their annual deductible. Alert your insurer if your EOB erroneously says you haven't met your deductible. Make sure to get credit for using an **in-network health** care provider. HMO plans can hit you with the full cost of out-of-network treatment. PPO plans require higher coinsurance payments out of network. If you notice discrepancies in your EOB, call your insurer's toll-free customer service line, advises Dr. Charles Cutler, Aetna Inc.'s chief medical director. You will find the numbers on your EOB, your insurance ID card or your insurer's Web site. Avoid calling on Mondays, as they are notoriously busy. If all or part of a claim is denied, it is usually because the insurer **didn't receive all the information** required or because it believes the procedure isn't covered or medically necessary. You can appeal such decisions over the phone, but it is best to do so in writing, **with your agent's assistance**, supply supporting evidence and keep copies of correspondence. Generally, your insurer has 30 days to reply (within days if it involves urgent care). Most insurers have a multilevel appeals process, and you may also be entitled to an external review. It is important to find out what your plan's rules — and deadlines — are.

Sincerely,

Joe Jessome

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