

In Brief Article
Medical Billing: Tricks of the Trade
Part II of a multi-part series.

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Goliath Isn't Getting Any Smaller or Kinder

Identifying Un-Bundled Charges

Bundling is an industry-accepted standard that groups related services and supplies into a single charge. Unbundling is a method by which related services or supplies are separately billed. When charges are unbundled you pay more for services that were performed as a group. An example is a Chem-7, or a blood test that measures seven blood components. Even though the test automatically performs the seven sub-tests, the hospital may separately bill for each test. Billed separately the cost is much higher than when billed as a bundle. The “*value meal*” at McDonalds is less expensive than buying each item separately. This is also true for medical services when billed separately. Ask the hospital staff what items have been unbundled.

Identifying Excessive or Double-Billed Charges

It is not uncommon for hospitals to charge more than once for a single item. Locate any item identified as a “*package*”, a “*tray*”, or a “*pack*” and ask for a break down of what supplies are in each. Then scan the bill for items contained in the package and billed separated.

Another common practice is to make the patient pay for staff errors. If charges for two surgical packs appear, ask why. Did the staff drop one requiring an additional pack? Why should the patient pay for their mistake? Taking and reading of x-rays is an area where double billing is prevalent. Past practices of radiologists “*over reading*” the X-rays on the following day are no longer being accepted as a reason to make two charges for reading x-rays.

A surgical charge is an area to be carefully scrutinized. If the surgeon had an assistant how much should the assistant be paid? Medicare guidelines dictate that an assistant surgeon can charge only sixteen percent of the primary surgeon's charges. The insurance industry generally allows twenty percent. What percentage does your client's health insurer allow? If the surgeon took on the work knowing the insurers allowable percentage, it can be argued that unless the patient was properly advised prior to the surgery (for an opportunity to shop) then the doctor is bound by the allowable percentage.

Charges identified as “*administrative fees*” are in fact often time's double billings. “*Oral administrative services*” is just more of the same. These terms refer to simple administrative tasks like filling our forms or handing the patient a pill. The patient is already paying for these basic services in the room charge.

Identifying the Medical Device Actually Used

What is a “*cough support device*?” Believe it or not it could be a cough drop or a teddy bear. It shouldn’t cost the patient \$50.00. “*Thermal therapy*, a *gauze collection bag* and a *cotton professional*” are an ice pack, a garbage bag and a Q-tip. The hospital cost of these items is most likely very small. The hospital should not be charging over one hundred times the actual cost. Charges to be reasonable have to reflect a fair markup over the acquisition cost. This is true for all medical supplies.

Identifying the Procedures Performed and the Supplies Actually Provided

It’s not unusual for the hospital-billing department to be out of sync with the treating physicians and it’s own medical staff. Make sure all billing charges are consistent. I’ve personally discovered a bill for two surgeries on two different fingers when only one was performed. A workers’ compensation insurance company actually paid the bill. An audit disclosed this was not an isolated incident.

Identifying The Medical Personnel Involved

If the patient doesn’t recognize a person’s name in the medical record, then ask the provider for an explanation. Seek to prove that the billed service was properly documented and the service was actually performed at the time and place recorded. If there is no record of the service or the service is insufficiently identified, the rule is there can be no charge to the patient. If Doctor X is identified in the records and bills show she performed daily checks on the patient ask the patient if in fact he met or ever saw Doctor X. If not, ask for an explanation of the times and services performed by the doctor. Did the doctor ever see this patient or just stick their head in the room at odd hours? Did they look at the chart, speak to, ask questions and give the patient advice? Don’t assume the patient doesn’t know what they are talking about. Doubt so expressed by the patient is an initial cause for suspicion. It’s not unusual for a “*pop their head into the room visit*” to be the basis for a consultation charge. A head popping into the patient’s room to say hello I did show up is not a reasonable basis for a consultation charge.

Identifying Clerical Errors

Clerical errors can add thousands of dollars onto a bill. From adding a zero, to billing the wrong patient, to miscoding of a procedure to the wrong patient, or using the incorrect code, errors do occur with frequency. As hospitals struggle with reducing staff sizes these types of errors will surely continue to rise. I include in the area of clerical errors miscoding by the nursing staff. Supplies in many hospital settings have yellow tags on each package. It is the responsibility of the nursing staff to remove the tag and place it in

the patient's billing record. It doesn't always happen. Those tags end up stuck to uniforms of busy nurses and find their way into other patient's charts. Know the reason for the hospitalization and what processes and procedures were employed in the healing process.

Identifying Unreasonable or “Unnecessary” Charges

This is the area where knowledge of government regulations is most helpful. Hospitals routinely charge a mark-up over the actual cost of the item. The size of the markup can be enormous. Industry wide over-inflated markups are being used to offset losses in certain hospital departments as well as from losses incurred through contracts with third party payors. Companies that insure many lives get unjustified discounts that private payors are being asked to makeup. Unreasonable mark-ups may be identified by reviewing those charges the patient's health insurance carrier did not pay or paid less than was submitted by the hospital. Often times if the health insurance carrier won't pay for the item or won't pay the full price submitted it has to do with the reasonableness of the charge rather than it not being covered in the policy. The insurance industry knows what charges are reasonable. They also know the rules for reimbursement by governmental agencies. Government regulations setting prices for reasonable medical compensation reimbursement is public record and accessible to anyone. [<http://hcfa.gov/stats/pufiles.htm>] The hospitals know the patient is usually the only party without knowledgeable representation. Why should the patient pay more than the third-party payor accepts as reasonable? Inquire as to why the health insurance carrier denied the charge. Don't accept the answer that “*We don't pay for that.*” If it's not a reasonably priced item or a procedure, ask what price would be reasonable and why. Understand the basis for determining a reasonably priced item. Were less expensive options available? Did the daily charge when totaled for the entire stay exceed the hospital's cost? The health insurance industry is aware of normal costs and markups. They are in a better position than the insured to know where abuses lie. The insured has a right to know the specific reason for denial. Ask for a written explanation that is specific and then use it as leverage against the hospital.

Surgical fees should be examined closely. Government regulations limit the fees charged by surgeons performing more than one procedure during a single surgery. They are not allowed a full fee for second and third procedures. Currently they may bill no more than half of the normal fee for additional procedures.

Look carefully at charges for implanted medical devices that may be new or re-engineered. These devices may be the latest model or a dated model; it's like comparing new Cadillac's with old Volkswagens. For obvious reasons one is more expensive than the other is. To make intelligent comparisons identify the specific device, the make, model, year manufactured and identity of the manufacturer and supplier. Contact the supplier for specific pricing to this hospital. There is no reason the patient should pay the hospital \$14,000 for an older model cardiac device for which they paid less than \$7,000. Once you have this information the hospital will be more inclined to listen and to negotiate the price. They do not like this information being made public. Here's a

question to pose, “Do you think Channel 7 News might be interested in how much the hospital is marking up pacemakers?”

Oxygen therapy is another area for close scrutiny. It can be an example of an “unnecessary charge”. Hospitals routinely charge for oxygen therapy in accordance with the doctor’s orders. If the doctor orders oxygen to be administered “as needed.” the hospital may charge a daily rental fee although the patient never used oxygen. They argue if the oxygen tank is in the room, hooked up and ready to be used a charge is reasonable. Clearly this item is negotiable. Examining charges made for daily supplies can expose similarly hidden over charges. A charge of \$50 per day over a weeks stay for a heating blanket costing \$60 is not reasonable. Of course it’s not likely the blanket will be so easily identified. It’s more likely to be billed as “thermal therapy”. Medicare and most private insurers don’t allow reimbursement in excess of the item’s cost. Ask for the actual cost to the hospital of each item charged.

Inpatients versus outpatient operating room charges vary widely. If you can get involved before the surgery, it helps to ask questions and shop around. A recent case involved a female patient adding an elective cosmetic surgical procedure to a non-elective in-patient surgical one. The cost of doing both surgeries at the same time in the hospitals in-patient surgical suite exceeded the cost of doing the two procedures separately by a whopping \$6,600.00. The difference was operating room time charges that were lower at an outpatient surgical center.

Conclusion

This is not an easy part of the case, but certainly not the hardest either. Conducting a routine audit can and will make a difference in your client’s recovery. As lawyers we should be able to train our support staff to identify uncovered medical expenses and other items that formulate a basis for closely scrutiny. Conducting an audit before paying off a hospital lien could prove well worth the time invested. Good luck in your practices!