CHOOSEWELL

Estimating Costs and Reviewing EOB's for a hospital inpatient stay or procedure, or for an outpatient surgical center

For more details, see http://chooselivewell.com/estimating-costs/ .

Note: In the steps below, we're encouraging you to ask some of the same questions to both your lead physician AND the facility or hospital where they are performing the procedure. Some avoidable costs come from (incorrectly) assuming that the hospital, the physicians, and all supporting staff are one team operating under one set of paperwork. That is not necessarily the case. Contracted physicians are often involved, and they will have their own paperwork and they may or may not accept the same insurance plans as your lead physician or the facility. And all involved parties may not know about an Advance Directive that you gave to your lead physician.

Step 1: Choose your Providers carefully (lead doctor/surgeon, hospital, outpatient surgery center, specific surgeon, etc).

Step 2: Contact your Insurance Company to confirm …

_____ Are my planned Providers in network?

_____ Explain the procedure(s) your anticipating, and confirm that they are included benefits.

_____ Do they require pre-authorization? If so, make sure you understand the process.

_____ Ask what the insurer's experience has been with your selected providers in terms of unanticipated use of facility fees, excluded benefits, and/or out of network providers. They may not provide this information; if they use patient confidentiality/HIPAA as a reason (which is bogus), clarify that you're NOT asking for

any personally identifiable data. You don't want to know anything about their identity or who they are – just what they were billed for their similar procedures. Did they get a lot of unexpected line item charges from the hospital? If they decline to answer stating that it's in violation with the confidentiality clause in their contract with the hospital/provider, you're out of luck.

Step 3: Prior to your pre-procedure consult, ask the hospital or surgical center for all applicable Informed Consent forms and anything else you'll be expected to sign.

_____ Be sure to specifically ask for forms from any provider that may be a contractor as opposed to an employee (such as an anesthesiologist). If at all possible, review all of them prior to your face to face meeting with your lead doctor.

Step 4: During your pre-procedure consult, address any questions you have (in general or from the informed consent documents).

Questions for my Doctor regarding my upcoming procedure:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____ Have past patients with similar Reasons for Visit had any common unpredicted procedures? For example, if 20% of them get a certain reflexive procedure as the result of some finding in the primary procedure, you want to know about this. Are these included benefits? Are they done under the primary providers tax ID? If not, is the new service provider in my plan's network? A good example of this is the pre-emptive removal of non-cancerous polyps found during a screening colonoscopy. The screening colonoscopy may be paid for by your insurance plan, but the polyps removal may not.

_____ Make your lead doctor aware of who your Proxy will be during your procedure (and provide them with the appropriate limited healthcare Power of Attorney), and discuss with them the conditions under which you might either require an additional consult or an unplanned additional procedure, and when those options can be discussed with your Proxy for their input or decision prior to action. Give them copies of your Living Will/Advance Directive/POLST, and discuss to the point where you're sure they understand your intent.

Make sure your lead doctor knows that even though you may be signing their Informed Consent document, that you're cost conscious, since you'll be paying a substantial amount of your bill out of pocket. Ask if she can help you be a good consumer, and be particularly conscious of;

_____ Will your procedure likely require blood product transfusions? If so, can you have your own blood drawn in advance and given back to you (or donated if unused)? This is both safer, and can save considerable expense.

_____ Diagnostic tests on admission; can the be done in advance at an outpatient service center? This may also help you delay your admission and spend less time in the hospital, as some procedures schedule you for early check in just for early diagnostic tests.

_____ Diagnostic tests after admission; avoid redundancy and order only what's necessary. If the hospital has patterns of 'standing orders' or 'morning orders' of standard battery's of lab tests, for example, can she forgo those and only order what's necessary? Your insurance plan may not cover such tests, unless they're specifically ordered by your doctor for your condition/procedure. Can she be conscious of not re-ordering tests if previous tests can be used?

_____ Use of unanticipated excluded benefits; can she work with your Proxy to first consider procedures that are included benefits, and discuss the need for excluded benefits prior to use.

_____ Use of unanticipated out of network providers; can she work with your Proxy to first consider in network providers.

_____ Recovery; How much of your recuperation or post procedure monitoring can be done at home?

Step 5: Call hospital the to schedule your appointment, let them know your Reason for Visit, and also confirm that Provider is still In Network.

_____ Presuming their in network status is confirmed, schedule your appointment and provide all of your insurance plan information.

Step 6: In the same call, ask if all anticipated services, including diagnostic tests (based on your Reason for Visit) are included benefits under your plan, are administered by the hospital or another provider within your network, and what your insurance company's Allowed Charges are.

_____ Ask if they charge facility or consumables fees beyond the allowed benefits already cleared by your insurance company. Note that you need the amounts they anticipate your insurance plan will pay ('Allowed Amount'); NOT what the provider will bill ('Provider Charges'), since the Provider Charges are meaningless to you. This will almost certainly require a billing person or a specialized admissions person. Since there is generally much more money involved than with outpatient procedures, it's far more common for hospitals and surgical centers to make the effort to anticipate total charges.

Step 7: Ask the hospital if past patients with similar Reasons for Visit had any common unpredicted procedures.

_____ For example, if 20% of them get a certain reflexive procedure as the result of some finding in the primary procedure, you want to know about this. Are these included benefits? Are they done under the primary providers tax ID? If not, is the new service provider in my plan's network? A good example of this is the pre-emptive removal of non-cancerous polyps found during a screening colonoscopy. The screening colonoscopy may be paid for by your insurance plan, but the polyps removal may not.

Step 8: Ask who you should provide copies of your Living Will/Advanced Directive, limited healthcare Power of Attorney, and (if you have one) your POLST to.

_____

_____

_____

Step 9: Ask for all applicable Informed Consent or any other forms (privacy statements, etc) from all parties.

_____ Use open ended questions like 'if you or anyone else expects me to sign something, I'm asking for it in advance' and 'who will be involved in my care that is not an employee of the hospital?'. Be aware that their first response might be to say something like 'we'll give you those when you're admitted'. Persist, and ask for them in advance. Some of your doctors, such as surgeons or anesthesiologists, may not be employees of the hospital, and so the admissions people might not have consent or other forms from them – but they should be able to tell you where to go to get them. It's important that you have these forms in advance so you have an opportunity to read and really understand what you're signing. Once you're admitted and well down the path to your procedure, you're virtually powerless if you question any of the terms.

Step 10: Call your insurance plan.

Tell them which provider you're seeing and what procedure you're anticipating; confirm that;

_____ The hospital/facility and all known physicians are in network.
_____ The procedure is an included benefit; and
_____ Ask if they have a history with unpredicted excluded benefits or out of network providers from past patients going through the same procedure.

Be aware that you might be the first patient who has ever asked this question, but don't back down. It's worth being very friendly and cultivating a relationship with someone at your insurance company – send cookies if you have to – who can check into this,

because the hospital is far less likely to tell you, and the insurance company is really the only one who could see a pattern of this type of behavior.

Step 11: Check in, and prepare to pay up.

You will almost certainly be asked for some money. The most sophisticated hospitals will have applied your insurance information, address, SSN, and DOB prior to your check in and compared that to your anticipated bill to do a complete 'ability to pay' analysis on you. This includes a credit check, collecting info on your annual income, and other intimate financial details. Based on this, they have already have a pretty well informed idea of what you are capable of paying, and they'll ask for as much of it in advance as they feel they can get away with. If you feel you're in this situation, be certain that they're collecting from you based on the Allowed Amounts they anticipate from the insurance plan – NOT their Provider Charges. If your ability to pay is more limited, they probably won't lower the total amount – at least initially – but they will put together a payment plan and ask you to agree to it in writing prior to check in. Less sophisticated hospitals will submit their bill to your insurance plan, let them adjudicate it, wait for their EOB, then bill you for your portion later.

Step 12: Hop in the wheel chair and roll up to pre-op.

Get prepped. High five your surgeon. Snarf the happy gas. Faaaddddeee aaaawwwwaaaayyy.

Step 13: Go home and enjoy life.

Step 14: When your EOB comes later (10 – 60+ days) from your insurance company, review it carefully, and specifically look for the following;

_____ Are the dates of service correct?

_____ Do you understand the service descriptions, and did you actually receive all the services represented? Does anything look silly? Is there a line item for 'Mucus Capture Devices', quantity 2, for $179.45 each? That's a box of Kleenex. 'Oral Admin Fee' for $6.25 per instance, for a total of $87.50 over the stay? This was for the nurse to hand you a pill that you took by mouth[1]. How about 'Headlight' for $93.50? This was for the cost of using the overhead light in the operating room. Or 'Cup, Medicine', 44 units at $10 each for a total of $440. This was for the little plastic cup – not the medicine inside, the cup – that the nurse used to hand you the meds you took orally. If you find any of these, get indignant.

_____ Did you get an unexpected or unreasonable Facility Fee?

_____ Are there any apparent duplicates or other billing errors (which neither you nor the insurance company should pay for)?

_____ Is there any evidence of un-bundling? Insurance companies generally pay for a procedure or a day's stay in a normal, ICU, or ER hospital bed, but that should include most normal disposables and consumables needed. Was there a charge for a surgical tray, then another charge for the individual components? If you start seeing itemized consumables that you suspect represent double billing, highlight them. Are there any surprises regarding included vs excluded benefits?

_____ If you made a payment when you received the services, does that payment reconcile with the amount you're responsible for on the EOB?

If you find any problems, your next best step is usually to call your insurance company, since the EOB you received is generated by the insurance company, and only they can compare it to the actual bill they've received from your provider. If you can't work out the problem with the insurance company representative, then ask if the two of you can call the hospital or surgical center together and resolve the issue.

The hospital will likely want to start this conversation by trying to negotiate a discount off the whole bill if you pay cash. DO NOT go down that road. At least not at first. Get them to completely remove anything found under the bullets above. Did you receive excluded benefits that you didn't agree to in advance? Request to get them removed

completely, but bear in mind that if you signed an Informed Consent, they'll likely refer to that as your pre-approval for anything they decided to do. Still, give it a shot.

Step 15: Do you need a professional Advocate?

If you detected problems and the insurance company couldn't help you resolve them with the hospital or surgical center, or you couldn't get satisfactory resolution dealing directly with the hospital, you might be in over your head – especially if we're talking about thousands of dollars. Professional Advocates are generally experienced medical billers who have worked for hospitals, doctor's offices, insurance companies, or all of the above, and understand the intricacies of medical billing. They often know, by Reason for Visit or hospital procedure, what some of the signs are of being overbilled. And they are more likely than you are to know exactly what to ask or how to negotiate with the hospital to whittle your bill down as far as possible.

Step 16: If you didn't make a payment up front, or only made a partial payment, then you will soon be getting a bill from the hospital or surgical center.

It should reflect the exact amount your EOB states is your responsibility (or the difference if you made a partial payment up front). If you can't pay the outstanding balance in one payment, contact your hospital or surgical center's billing office and work out a payment plan.

Step 17: Share your experience. By sharing your experiences, insights or stories, we improve other's chances and of making well informed choices. Start by sharing your experience with the ChooseWell community at http://chooselivewell.com/share-an-experience/ .

There are several other groups who are already sharing experiences that we wanted to make sure you know about:

If you have a condition, symptoms, or are receiving a treatment, take a look at Patients Like Me (https://www.patientslikeme.com/). They provide connections with others like you for education and social support.

Smart Patients (https://www.smartpatients.com/) is an online community where patients and caregivers can learn from others like them. This includes information on research, clinical trials, and personal stories.

If you're interested in consumer feedback specific to medications, Iodine (http://www.iodine.com/) is a 'Community of over 100,000 people sharing their medication experience and advice.'

Yelp (http://www.yelp.com/). That's right, the same app you used to find a good Greek restaurant when you were visiting a new town. It's not a typo. You can either enter 'Doctors' in the main search window, or navigate to 'More Categories', then 'All Categories', then 'Health & Medical', then 'Doctors' followed by their specialty (or another category if something other than a doctor).

CAHPS surveys (http://www.ahrq.gov/cahps/surveys-guidance/index.html) ask patients to report on their experiences with a range of health care services delivered in ambulatory, hospital, dialysis, nursing home and other settings.

Step 18: Go back to enjoying life.

Be sure you understand our Disclaimer –

We coach, support, educate, and empower. We illuminate options you may not have known you had. But we don't decide what's right for you in your unique circumstances; only you can do that. And we don't provide medical, financial, or legal advice; nor do we replace the valuable counsel of those who do.

The ChooseWell website, blog, and any other branded communication contains general wellness, medical, health insurance, legal and financial information that is meant to inform and educate the reader, and to prepare them for conversations with appropriate professional advisors. The applicability of the information contained varies based on

each person's unique circumstances including, but not limited to, their personal health, medical conditions, insurance coverage, and the state or geographic region in which they live. Readers should consult with their doctors, employers, insurance brokers, lawyers, accountants, and financial advisors about their specific situations, as this content does not replace their counsel. It is provided with the understanding that the publisher and author shall have neither the liability nor responsibility to anyone who feels that information provided caused, directly or indirectly, any loss or damage.