

Adventures In (Health-Insurance-Claim) Wonderland

A medical student interpreting her own ER bill figures out insurance claim codes and errors—but then what?

BY AMANDA J. REDIG

I HAVE THE NUMBERS MEMORIZED: first the phone number for a claims adjuster, then the policy number for the person who takes my call. The truth is I'm a medical student who can't escape health insurance claims. Yet it wasn't until I waded through a deluge of paperwork following an accident that something became abundantly clear: too many of America's health care dollars disappear down the rabbit hole into health-insurance-claim wonderland.

Breaking The Fall

ON 8 NOVEMBER 2007, WHILE I WAS OUT FOR A RUN along the lake, my left ankle rolled, and I went tumbling to the ground, arms outstretched to break my fall. The only problem? Both of my arms broke as well.

Several x-rays later, I found myself scowling in the emergency room waiting for an orthopedic evaluation of my double fractures. Overall, it wasn't complicated. Such injuries are usually treated by realigning the bones and then deciding whether surgery is required. And that's exactly what happened. The orthopedic resident set and casted the fractures in the ER and sent me home; the following day, the attending orthopedic surgeon reviewed the postalignment x-rays taken the night before in the ER. He called me to say that surgery wasn't necessary.

Like most insurance policies, my medical school's student plan evaluates ER claims differently than those from scheduled office visits. For an ER visit, I pay 10 percent of a claim. With the appropriate referral, an office visit to a specialist is a \$20 copay per visit. Without the referral, that copay increases to a hefty "non-referral penalty."

On my first scheduled follow-up appointment in the orthopedic clinic—the first visit that didn't involve a direct visit to the ER—despite casts on both arms, I produced my referral paperwork with a flourish worthy of a treasured Smithsonian original. I knew the rules, and I'd played by them. All was in order, and I

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breathed a sigh of relief that there wouldn't be any billing problems.

Six weeks (and many *sotto voce* complaints) later, my casts came off, and I assumed that the entire unpleasant episode was over. Unfortunately, my visit to wonderland was about to begin.

This Can't Be Right

SEVERAL WEEKS LATER—AND BLISSFULLY CAST-FREE—I found an EOB (explanation of benefits) statement from the insurance company in my mailbox in the foyer of my apartment building. Its contents left me half-shrieking and half-wailing in outrage. As I shook the envelope with its rustling plastic window in one hand, holding the horror of the EOB in the other, all thoughts of anyone being nearby vanished. I ignored the sidelong stares and raised eyebrows of my neighbors to focus on the neatly itemized bill for my fractures: nearly \$6,000. My estimated share? Almost all of it.

As the world began to spin, I couldn't help but wonder, "If I swoon in the lobby and hit my head, will insurance cover that ER visit?" Then my eyes drifted to the actual description of charges. *Surgery*? Why was I being billed for a nearly \$2,000 "surgical procedure," not once (and at a nonreferral penalty amount), but twice (denied the second time)?

Then I spotted the date of these supposed surgeries—9 November—and now the world was really spinning. My accident was on 8 November, not 9 November. True, I'd talked with the attending orthopedic surgeon on the 9th, but the x-rays taken in the ER had allowed me to *avoid* surgery, albeit by the slightest of margins: a single millimeter of bone alignment.

My heart was still pounding but now with indignation, not shock. Having reached my apartment, with narrowed eyes I grabbed my phone. There was only one number to call, and I had it memorized.

Down The Rabbit Hole

AFTER REACHING AN INSURANCE REPRESENTATIVE, I tried to explain the problem. I was met with silence. "Soooo, I'm trying to figure this out," I finally said. "Can you help?"

"No, sorry, we can't relate medical details of claims," the representative said.

"But you've verified my identity and this 'surgery' supposedly happened to me!"

"Sorry, you'll have to talk to the billing physician," she replied in the sing-song tone of one who has repeated herself a thousand times before.

"Well, can you tell me who that is? Can you tell me *anything*?" My frustration was growing.

"Sorry," the representative said again, sounding like a badly broken record. "I'm not authorized for that. You'll have to talk to the billing physicians' group."

“Right.” The group she named was the umbrella practice for hundreds of specialists—hardly helpful information. I tried again, hoping she’d agree the situation was absurd. “So you can’t tell me the physician’s name or the billed procedure, just how much I’m supposed to pay for the unknown procedure?”

“Sorry,” she said, without sounding it. “I just show charges of \$5,862.14 on that date.”

“Right,” I said again, failing to keep the sarcasm out of my voice as I hung up. Clearly, this had to be health-insurance-claim wonderland.

Wonderland Questions

AFTER TAKING SEVERAL DEEP BREATHS that kept me from hurling my phone against the wall, I dialed the billing department for the physicians’ group. The charges were indeed coming from an orthopedic surgeon in the group, but the billing office only had the financial paperwork, not a description of my imaginary surgery.

“Sorry,” the woman on the phone told me in an uncanny echo of her counterpart at the insurance company. “All I can tell you is the name of the billing physician. You must have had surgery on that day because that’s what it says.”

Oh, really?

I was tired of trying to explain that I hadn’t had surgery. I’d stumbled through the looking glass only to find Tweedledum and Tweedledee answering the phones.

But sitting at my dining room table and rereading the statement, I noticed something else: duplicate \$50 charges for “supplies.” In my mind’s eye I was back in the ER on the day of the accident, watching the resident unwrap roll after roll of fiberglass that hardens into the layers of a cast when it’s dipped into warm water and wrapped around an arm (or two). What if reducing—the highly unpleasant process of realigning pieces of bone—and casting a fracture is classified by the insurance industry as a surgical procedure? “That’s got to be it!” I thought...before growing confused once more. If this was the “surgery,” why were the charges coming from the attending orthopedic surgeon? He wasn’t the one who’d reduced the fractures in the ER—that was done by the orthopedic resident. In fact, I didn’t even meet the surgeon until the office visits.

So why were the charges listed on the day *after* my ER admission even though all of the other hospital bills were listed on the correct date? It was getting “curiouser and curiouser,” to quote Alice herself. Then there was the referral penalty for treatment in the ER, although emergency care is the lone exception to the referral-penalty rules. And it made no sense that one procedure was denied when both arms were clearly broken.

By now, I needed an insider’s opinion. Luckily, as a medical student I was able to do an end run around both the insurance company and the medical billing office to head straight to an expert source: an actual surgical resident. When I finally cor-

nered one, I discovered that procedures performed by residents are billed under the name of their supervising attending physician.

Aha! That meant that the “surgery” charges were for the fractures set by the resident in the ER on 8 November—but billed by the office of the attending physician on 9 November. The insurance company had seen surgical codes on a date without a documented ER admission and, absent a referral, billed accordingly.

After yet another phone call and protracted discussion with the insurance company representative—explaining that a procedure done in the ER hadn’t been billed until the next day—the claim was sent back to the adjustors for reevaluation. A part of my billing problem, at least, seemed taken care of.

A Physician Approach

IN THE MIDST OF THIS PUZZLE I REALIZED THAT my Alice in Wonderland analogy was apt for only the patient side of the experience. Unlike other recipient-provider relationships, in which one party offers a service and another pays for it, my health care involved three entities with overlapping threads of assistance and financial responsibility: patient, doctor, and a health insurance company. When the Queen screams, “Off with her head!” in this land, it’s the most vulnerable member of the triangle—the patient—who’s most at risk.

Sadly, my claims error story isn’t atypical. The only unusual part is that as a medical student, I was able to question a surgical resident about billing procedures. In doing so, I discovered what many patients already know. Far too many mistakes in health insurance claims processing are predictable because of the ponderous inefficiency of a health care system dominated by a paperwork-driven bureaucracy. The reality of twenty-first-century American medicine is that it now requires maintaining—and paying—a village to manage medical paperwork.

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The dilemma of paying for health care is multifaceted and will continue to inspire vigorous debate at the national level. At my individual level, however, when looking at the spiraling costs of medical care driven by these kinds of inefficiencies and an increasingly unsustainable reimbursement system, I’m able to decide what I’ll do when I become a physician. I know that my own occasional experiences navigating (and getting lost) amidst the health insurance system will influence my future interactions with patients.

I never want to become so removed that my patients are left to manage the nightmares of insurance billings on top of their health concerns. I and other physicians can ensure that each patient has access to someone within the office who can answer billing questions. If standing policy prevents these staff members from

providing clear information to patients, then we need to advocate for those policies to change. We can see that our office staff learns how to document patient care in ways that minimize the likelihood of problems with claims and the need for claim readjustments. We can also take an active role in reminding patients to obtain their specialist referrals, as this, too, is part of continuity of care. All of these actions are far removed from the stethoscope-wielding, prescription-writing image of the physician, but if the outcome augments the more traditional role and is a manageable effort, shouldn't we try?

Furthermore, the medical profession can leverage the strength of our combined voices to lobby for change. To succeed, we need to be clear not just what we're lobbying against, but what we're lobbying *for*. Medical records are increasingly entering the electronic age—why not the physician referral system? If an individual physician refers a patient to a specialist, why can't the documenting information be electronically entered and submitted directly to the specialist and the insurance company instead of having it circuitously navigating through an entire office of insurance representatives? Why can't follow-up care for chronic conditions be tagged electronically so that claims reflect the complexity of longitudinal medicine instead of being processed piece by piece, out of context, and inevitably destined for costly revisions? Federal and state insurance regulatory policies often create dramatically different environments for managing medical care, in turn contributing to escalating administrative costs. Why can't we—at a minimum—lobby for consistency?

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As a group, physicians are ideally positioned to pinpoint inefficiencies in the system of which they are a part and to take an active role in suggesting solutions to streamline a bloated, inefficient bureaucracy. If more physicians experienced—as patients—the firsthand frustrations of billing, insurance coding, and specialist referral madness, perhaps helping correct the process would become an important secondary component of our professional energies—precisely because it affects our primary responsibility so greatly.

After all, the voices of physicians were crucial in focusing attention on frivolous medical malpractice lawsuits, and I can't help but wonder if insurance companies shouldn't be held to the same standard. What would happen if there were a financial penalty for frivolous denial of claims?

And yet...there's an undeniable catch to advocating for this degree of physician involvement. Where is the line at which such activities are no longer a “manageable effort” amid the day-to-day, and often day-to-night, challenges of our main responsibility: taking care of patients? Becoming deeply engaged with health insurance billings and claims on top of our other responsibilities could drain both our time and our energy even while serving as merely an inefficient stopgap effort.

This is a complex problem for which there are no easy answers. But when we know that the problem lies in the roots of an untenable system, don't we have to start digging somewhere?

Escape From Wonderland

MEANWHILE, MY BILLING PROBLEMS WEREN'T OVER YET. The "denied procedure" issue was still on the table. "Well," the insurance representative said when I called again about my claim denial, "your doctor is double-billing. If the doctor has to repeat something because he didn't do it right the first time, that's not something we cover."

"Repeat something?" Did she think the doctor had set the same arm twice?

"Well," I said, looking down at arms that still resembled ghostly toothpicks, "I had bilateral fractures. Right arm. Left arm. They both needed to be set and casted. And," I said, for once knowing I held the upper hand, "I have the bill right here, and it was coded correctly, right and left. There was no duplication."

This was followed by a long silence.

"Oh," she said. "Oh, right. I guess so." Another pause. "Yes, I see that here, right and left." More silence. "I'll, ummm, send that back to be corrected."

She did send it "back." But now, almost two years later, as this essay goes to press, the 2007 billing adjustments dealing with my broken arms remain incomplete. (Why? I don't know. You'll have to ask my insurance company and its billing office—and good luck with that.)

At one point I'd have been content to know that I wasn't personally responsible for paying an almost \$6,000 hospital bill. But as a physician-in-training—occasionally moonlighting as the patient—I realize that my experience is part of a pattern. How many people will eventually handle this extended series of claims for my broken arms by the time this is finally settled? Why was it so difficult? Why is it still taking so long to straighten it out? Even more important is the overall cost of such insurance incidents. When a patient presents with a life-threatening bleed, the medical team springs into immediate, instinctive action. Yet we stand by wringing our hands as our health care system is hemorrhaging funds at the rate of 16 percent of our GDP (according to *OECD Health Data 2009*).

Yet if stories like mine can become part of a collective physician and patient voice calling for reform on this issue, then perhaps falling down the rabbit hole might lead to more than just a series of individual disasters and frustrating back-and-forth conversations. In the meantime, I can't help but point out how very, very fortunate Alice was that when falling, she kept her arms at her sides.