Should you trust (and pay) statements from your medical providers?

In my professional career, I have observed that patients tend to fall into two opposite categories. The "trusting" types always pay whatever amount is indicated, while the "questioning" ones rarely do so until a final or collection notice is sent to them.

The common excuses of the latter types are their lack of trust in the amount billed or their waiting for explanations (they usually do not request). The former trusts the billing staff as they do their doctor.

Here are some guidelines to help you determine when to pay and when to wait.

1. Check your insurance policy

Each January, find out what amounts you can expect to ultimately be responsible for in the coming year. What is your yearly deductible (the sum you pay first before your insurer starts issuing payment)? What is your yearly out of pocket (your percentage of the cost before your insurer pays 100%). Do you have an office co-pay (set fee)?

Contact your insurance if the terms of your policy are unclear or confusing.

2. Verify and compare

Every amount listed on your provider's statement (doctor, facility, imaging center, lab etc) should match your insurance Explanation of Benefit (EOB). You can also go online to check whether a claim has been paid, and what is your total liability. If the statement's balance matches the EOB's: you owe this amount.

A spreadsheet at the time of matching statements and EOBs is a great visual help for you, and for your tax person during tax season.

3. If you have not received an EOB

Further research may be required.

Has the claim not been sent? More medical offices no longer handle claims, leaving it to patients to mail them. If you have been handed a claim form or an itemized bill, make sure to forward it to your insurance for processing.

A first statement may just be a notification or description of services rendered. Confirm a claim has been processed before paying such a "notice".

Does the provider have your correct information? If you received a new card, forward a copy to the office: an identifying number or claim address may have changed. Charges may have been denied for the incorrect info.

4. If your EOB does not match

Is the claim pending by your insurance for additional information? The EOB will indicate what is needed. It could be required from you (info regarding another possible primary coverage, verification of a dependent status, or return of a health questionnaire or from your medical provider (address update, medical records). In this case, forward a copy of your EOB to the billing department and demand prompt handling.

Consider calling the billing person, to verify contractual adjustments were correctly applied, or ask for justification. After all, mistakes happen. You may also contact your insurance for explanations.

Is the provider "out of network", meaning not within the contractual network your policy covers? If this is the case, you will need to negotiate a settlement as you are liable for whatever amount is billed to you.
However, if services were rendered to you by an out-of-network provider at an in network facility or setting, especially if you had no choice, an appeal to your insurance should be fruitful. Your insurer, once informed you are being billed for the full amount, would likely propose a financial settlement or issue additional benefits to reduce, or cancel, your balance.

5. What are your rights?

In case of any conflicting or unclear paperwork, you are entitled, as a patient, to receive concrete explanations from your insurance carrier. You may also file an appeal, and ask for a review or reprocessing of any charge. Detailed steps and specific forms are available in your policy booklet or online.

As your creditor, the medical office has the burden to detail and explain any liability billed to you. Although many do not, by choice or lack of understanding or training on the part of their staff, do not give up. A call placed to an office manager or doctor will usually resolve such issues.
Filing complaint to the insurance company, a grievance to your state commissioner's office or medical board is next.

In conclusion:

While ignoring a bill from your medical provider is never a good idea, paying up without checking the amount billed to you is not recommendable either.

Your insurance should be your primary guide when determining if a bill is owed, and how much. Discussing charges with the billing department is a right to exercise whenever appropriate.