

# Consumer Guide to the 20 Most Common Ways Hospitals Overcharge Patients

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## Look Before You Pay

Hospitals are an essential public service. Every day hundreds of thousands of Americans go to hospitals for everything from life-sustaining minor surgeries, to life-changing child births, to life-saving emergency treatment. We need hospitals. We are the grateful recipients of their services. We are also, eventually, recipients of bills for their services.

Those bills are the topic of this article. Americans spend more on health care than any other people in the world. Ten percent of our gross national product goes into health care, the fastest growing industry in the nation. And every year we spend more; for the past 20 years health care costs have risen at twice the inflation rate. Dramatic increases in hospital charges are a major contributor to those rising costs.

Hospital bills are extremely problematic—and not just because they are high and can be very difficult to understand. They are problematic because they are, most of the time, wrong. The U.S. General Accounting Office estimates that 99 percent of bills from hospitals have overcharges. (New York Times, Jan. 27, 1993). The insurance industry, which hires private audit companies to review bills for accuracy, has also found a high level of hospital billing errors. The largest audit company used by insurers, Intracorp, estimates that 80-90% of hospital bills contain errors. When these audits are done, they generally result in striking reductions of the hospital bills.

This article explains how hospitals overcharge. While most of the information presented here has been used by the Legal Assistance Foundation to argue against illegitimate hospital charges against uninsured patients, all patients have grounds to fight these charges. All health care consumers should be aware of this information.

This article was adapted from a much longer manual designed for attorneys who are representing clients who have been sued by hospitals. If you are being sued by a hospital for unpaid medical bills, you should consult with an attorney. In almost every case where patients fight back in the courts, charges are reduced or eliminated. Of the 184 hospital debt cases handled by the Legal Assistance Foundation between 1983 and 2001, for example, 128 (or 70 percent) had their debts completely eliminated. Of the remainder, all but one had their charges dramatically reduced.

But even if you, or your insurance company, can pay the bill, you shouldn't be paying for services that the hospital has no business billing you for. Nor should you be paying for services that are overpriced.

The burden is on the hospital to prove that services are reasonably priced. Most hospitals provide services without a written contract or even verbal agreement. Illinois law makes it clear that under these circumstances, there is an agreement to pay a "reasonable price" for the services delivered. Specifically, the hospital must establish the following:

- The delivery of each good and service
- The method of pricing each good and service
- The reasonable value of each good and service

This is a tough task for hospitals because when held up to scrutiny, nearly all hospital bills contain errors. And the mistakes usually favor the hospital and overcharge you, the patient.

To check for the errors listed in this article, you need more information than just the hospital bill. As is aptly observed in *Take This Book to the Hospital With You*, "Translating the cuneiform carvings on the Rosetta stone was a lot easier than deciphering a hospital bill". Besides that, your bill doesn't tell the whole story.

You need to obtain the following from the hospital, which you absolutely have a legal right to do:

- An itemized bill
  - Your medical record
  - Your pharmacy ledger or record (an itemized list of all of the drugs you were provided)
- With these documents, you can check for some of the discrepancies listed in this article. Health care is a service that you purchase, whether directly with cash or through your insurance. Those who provide that service must be accountable to you, the consumer. This article is designed to help you achieve that accountability.

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## **The Top 20 Ways Hospitals Overcharge Patients:**

### **1. Billing for Services not Rendered**

You can be billed for many procedures that are never actually performed. This is where it is important to have all the medical and pharmaceutical records and itemized bills from the hospital. For example, the medical records may show results of six blood tests while you are being charged for nine.

Any billed procedure that is not reflected in the medical records can be challenged. Examine the bill for charges that make no sense, such as a charge for circumcision of a newborn baby girl. Look over the procedures listed and make sure they were all actually performed. For example, if you are charged \$300 for a blood transfusion, did you actually receive this treatment?

### **2. Duplicate Billings**

A frequent error is a duplicated billing in which you are billed twice for a service rendered but once. A slip of a finger on the computer keyboard can cause this problem.

### **3. Shoddy Testing**

You shouldn't have to pay for an X-ray that was botched. If two chest X-rays were administered in two days, find out if the second X-ray was needed because the hospital erred in the first test.

### **4. Phantom Charges**

Some hospitals automatically bill for certain items ordinarily associated with particular services. Their computer program may automatically impose a wide variety of charges for a particular procedure. So if you are charged for a childbirth, for example, there should be no charges for sedation unless you actually received the sedative drugs.

### **5. Quantity Errors**

Have you been charged for 200 facemasks rather than two? Again, a slip of a finger on a keyboard could cause such an error. A frequent error of hospitals occurs with respect to intravenous solutions that are administered on the day of admission. The hospital computer will bill you for a full day's worth of IV solutions—for example, \$189 for an IV ampicillin antibiotic solution. That is the daily rate. But if you are admitted late in the day, you may only receive four hours worth of solution and

you should not have to pay for a full day's rate. There may be several hundred dollars worth of IV solutions that the hospital did not actually provide.

Hospitals often charge patients for the use of operating rooms on an hourly basis. If there is a billing for eight hours in the operating room, verify this in the medical records.

## **6. "Unbundling" Related Charges**

Proper billing procedures (and Medicare law) require the hospital to "bundle" related charges for a particular medical procedure. For example, the charge for removing an appendix will include the operating room, the operating utensils, and all other goods and services normally related to this operation. "Unbundling" occurs where the hospital separates some of the charges that should be included in the "global" charge for the appendectomy, thus duplicating some of the charges. For example, a bill for an appendectomy may wrongly include separate charges for the pre-operative physical, such as drawing blood, cardiogram, and interpretation of the cardiogram.

## **7. Excessive Mark-ups**

When reviewing your itemized bill, look for specific charges that seem vague or too high, such as \$75 for a laxative, \$30 for a "thermal therapy kit" (plastic bag of ice cubes), \$10 for a "urinal" (plastic cup) or \$8 for a Coca Cola. Outrageous mark-ups are frequent and have been well documented. A December 1994 article in Money Magazine, for example, offered this illustration: "Dr. James is busy replacing a 64-year-old knee. He traces a line on her leg with a disposable skin-marking pen that costs the hospital less than \$1, then tosses it aside for my sake with a flippant '28 bucks'. That's what the insurer will be billed for it. The plastic sheet on her leg: 59 bucks. Cost: \$8. It's a racket".

Drug charges, in particular, are the target of excessive mark-ups. Modern Maturity, in its May/June 2001 issue, reported that "markups of 200 to 400 percent are common, but some drugs and small items are marked up as much as 5000 percent. A hospital can buy a Cepacol throat lozenge wholesale for 4.5 cents, then turn around and bill you \$2.25 or more per lozenge". In the same article it is reported that a hospital charged a patient nearly \$14,000 for a used pacemaker which the hospital purchased for \$6,700.

One useful technique to gauge the reasonableness of drug charges by the hospital is to compare their prices to those paid by Medicaid and Medicare. Medicaid and Medicare reimbursement rates for drugs are based on the "AWP" (average wholesale price). The AWP is the average price that wholesalers give to retailers for a given medication. Each year an "AWP Red Book" is published that lists AWP's for thousands of drugs. If the AWP for a Tensilon tablet (10mg) is \$1.09, the hospital shouldn't be charging \$56 for it.

## **8. Exceeding "Comparable Charges"**

Some hospitals charge much more for the same services than other hospitals in the same market. The 1999 "Illinois Hospital Price Survey Report," published by the Illinois Health Care Cost Containment Council, stated that Provident Hospital in Chicago charged \$630 for a semi-private room while Illinois Masonic Hospital charged \$1,053 for a semi-private room. Chest x-ray charges varied from \$79 at Bethany Hospital to \$226 at the Illinois Masonic Hospital. If you have been charged \$220 for a chest x-ray, you should be able to use the information in this report to argue that the price was unreasonably high. Also, you can get a range of information on comparable hospital charges by filing a Freedom of Information Act request with the Illinois Department of Public Health.

## **9. Mis-coding the "DRG"**

Mis-coding or inappropriate coding occurs when a hospital uses the wrong DRG (diagnostic related grouping) code to label—and therefore bill—for a procedure. For example, a patient who is coded as having a urinary tract infection has a much shorter authorized length of stay than the patient whose

illness is coded urinary sepsis. Coding these procedures differently could result in a higher bill. Some hospitals hire specialists who are "talented" in selecting codes that maximize hospital reimbursement. Many hospitals have faced criminal or civil penalties for wrongfully "upgrading" the coding of procedures and illnesses. You will need to inquire into the DRG coding of your bill to investigate this possibility.

## **10. Unnecessary Staffing**

Hospitals sometimes pad bills by unnecessarily overstaffing a surgical procedure. Find out if the surgical assistant—for whom you were billed \$1,400—was necessary in the particular surgery performed. Medicare regulations, for example, will not allow costs related to assistant surgeons in many procedures.

## **11. Delays That Lead to Longer Stays**

This is a delay that causes your hospital bill to increase as a result of some error or mistake of the hospital staff.

The most dramatic example of this is in the number of days you spent in the hospital—particularly where some of these days resulted from a hospital blunder. A study of about 1,000 hospital patients in the Boston area was reported in *Medical Care*, February 1989. A full 30 percent of the patients studied experienced delays averaging almost three days in their hospital stays. These delays amounted to a whopping 17 percent of all hospital days in the study. (See numbers 12 through 15).

## **12. Test Re-scheduling Delays**

The main reason patients spent unnecessary days in the hospital is because the hospital erred in its test scheduling. Typically, a patient would be admitted on a Monday, for example, with a pre-surgery test scheduled for the afternoon and the surgery scheduled for Tuesday. But the hospital may have overbooked the particular test for Monday, resulting in re-scheduling the test for Tuesday. This means the surgery is pushed back to Wednesday—if possible—and you spent a needless and anxious extra day in the hospital. Then the hospital bills you for that day as if no mistake had been made.

## **13. Test Result Delays**

Test result delays are a similar problem. The hospital may have a typical eight-hour lag to get the results of a particular lab test from the pathology department. But if pathology is running late or if they lose the results of the test and it has to be done over, you are going to have to pay for the hospital's mistakes that lengthen the hospital stay. They will even have the nerve to bill you for two tests when they lost the results of the first test.

## **14. Surgery Delays**

Another common foul-up is surgery delay caused when the hospital sets too many elective surgeries for one day. You may get bumped to the next day and have to pay for this even though the hospital was negligent in its scheduling.

Surgery may be delayed because a scheduled consultation visit by a consulting doctor does not occur when the hospital forgets to notify the consulting doctor. You can often find these problems described in the medical charts; you should not have to pay for the extra day caused by the hospital's mistake.

## **15. Teaching Hospital Delay**

One of the worst abuses regarding delays in discharge is where you are a patient in a teaching hospital and happen to have a rare disease or an unusual predicament. The medical staff of the

teaching hospital may want a large number of the residents to have an opportunity to review your case; it may be their only chance to see this particular affliction during their residency. The hospital stay may drag on needlessly long to give every resident an educational benefit.

## **16. Late Checkout Effect**

Some hospitals charge a late charge or even a whole day's charge if the patient is discharged after noon. If you were discharged at 2 p.m. due to some hospital screw-up, you should not have to pay the extra charge.

## **17. Paying for Wasteful Hospital Practices**

In December 1994, Money magazine published "Undercover in a Hospital". The author exposes how most hospitals are extremely wasteful in that they use disposable, as opposed to reusable, supplies and instruments. The article notes that some operations call for the use of more than \$1,000 worth of disposable materials and makes the point that many hospitals are now using re-usable goods and instruments to cut costs. Patients should not have to pay for expensive, disposable items when that is a result of wasteful hospital practices. These charges can be challenged.

## **18. Hospital-caused Infections**

Another type of overlooked hospital negligence is hospital-caused infections. These are infections acquired during a hospitalization and produced by microorganisms that dwell in the hospital. It is not an infection that was present in the patient at the time of admission.

Between 5 and 10 percent of all hospital patients contract an infection during their hospital stay. A recent Chicago Tribune investigation by reporter Michael Berens found that, nationwide, roughly 103,000 deaths in 2000 were linked to hospital-caused infections. While most patients survive these infections, they pay handsomely for this "gift" from the hospital.

The average hospital-caused infection adds four extra days to a hospital visit at an average cost of \$800 a day. Hospital-caused infections account for 15 percent of all hospital charges and end up adding between \$2.5 and \$4 billion to the annual American health care bill. In the November 1986 issue of American Journal of Surgery, it was estimated that surgical wound infections alone add an average of seven days to some patients' hospital stays and \$10 billion annually in direct and indirect costs. Hospital-caused infection rates have been found to be higher in large teaching hospitals than in non-teaching institutions, because the teaching institutions have more people floating around the hospital thus increasing the chances for the spread of infection.

Pneumonia is the most common hospital-acquired infection. Sometimes pneumonia is introduced into the lungs by contaminated respiratory therapy equipment, or by medical personnel coughing in close quarters like intensive care units. Other hospital-caused infections can be spread by improper preparation of hospital equipment or the failure of hospital personnel to engage in simple sanitary precautions such as frequent washing of the hands.

Find out whether your hospital stay was extended by reason of a hospital-caused infection. If so, you should take the position that you should not be asked to pay for costs that were probably generated as the result of the hospital not taking adequate sanitary precautions. Inquire whether the hospital has an active Infection Control Committee. If it does not, you will be able to argue that the hospital has not taken all possible steps to prevent the infection you contracted.

## **19. Padding Hospital Surplus**

If you are interested in going beyond the particulars of your bill to make a more systemic critique of hospital charges, you may want to find out how much "surplus" (otherwise known as profit) your hospital generates. Get a copy of the hospital's Statement of Patient Revenue and Operating Expenses or "revenue and expense statement." Determine whether the hospital had "surplus

revenue" for the fiscal year in which you were billed. For example, the non-profit Evanston Hospital had a \$9 million "profit" in 1985 on total revenue of \$147 million. This information could be used to argue for a percentage reduction of your bill. Non-profit hospitals are required by the Internal Revenue Service to file a Form 990 Report that lists sources of support, expenses, revenues and executive compensation. Federal law requires that the 990 be available for public inspection. You can probably access the hospital's reported revenue statement at the [American Hospital Directory](#) under "free services".

## 20. Discriminatory Billing

If you do not have health insurance, you could be a victim of discriminatory billing. This is also known as cost shifting or variable pricing. These terms refer to the policy of shifting hospital costs away from third-party payers (such as Blue Cross and Medicare/Medicaid) and onto the shoulders of self-payers. Whatever this policy is called, it amounts to this: different payers pay different prices for identical services. "So-called cost shifting then results in higher charges to individuals who personally pay for all or a portion of their hospital confinement," says a report of the Illinois Health Care Cost Containment Council. Thus the poor, who do not have insurance, pay more for the same medical treatment than more economically advantaged patients do.

Here is how the New York Times reported this situation in an April 2, 2001 article: *"It's horribly ironic," said Paul Menzel, a professor of philosophy at Pacific Lutheran University in Tacoma, Washington. The care of the poor was once supported by the wealthy and the insured, but now the opposite is happening, he said. "It is the people who are most provided for, not the people who are least provided for, who get the benefit of cost-shifting," he said.*

Most patients paying the full fare have no idea that their bill may be many times that of the people next to them in the doctor's waiting room.

For example, in an August 1979 report, Illinois Masonic Medical Center listed a three-tier charge system, whereby Medicare/Medicaid paid an average \$279 daily patient fee, Blue Cross patients averaged \$389 daily, and self-payers (the uninsured), averaged \$463 daily. Discriminatory billing is the consequence of the practice of all hospitals of entering into reimbursement agreements (or "provider discount agreements") with different third-party payers that call for differing reimbursement amounts to be paid for the same services. The more powerful the third-party payer—such as the government or Blue Cross— the greater the discounted prices they are able to negotiate with the hospital. All hospitals enter into these agreements with payers.

And don't let semantics misguide you: many hospitals try to claim that they charge every payer the same amount. While they may "charge" the same amounts to all payers, the hospitals will accept as full payment from third-party payers amounts less, often far less, than the full charges.