A Patient's Guide to Making Healthcare a Fair Fight



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EMPOWERING YOU TO NAVIGATE COSTS, CARE, AND YOUR RIGHTS

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Part 1: Why Healthcare Isn't Like Buying Peas

Chapter 1: No Price Tag on the Shelf

The Can of Peas

Walk into any grocery store and you get something healthcare almost never gives you: a choice.

One can of peas is $0.69. The fancy brand next to it is $1.39. You compare, you pick, you pay, you go home. Don't like either price? Try the store down the street.

Now think about your doctor. Not *a* doctor, *your* doctor: the one who knows your history, the specialist they sent you to, the hospital where your surgeon operates. You don't choose them off a shelf by price. Even when a price is posted somewhere, you rarely get to say "no thanks, I'll take the cheaper one." You need the care, you need that provider, and the price is whatever it is.

And on top of having no real choice, healthcare is the only thing most of us buy backwards: **you get the service first, and you find out what it costs later.** Sometimes much later. And the number you finally see depends on a pile of things you never chose and were never shown.

This chapter explains why the price is so hard to see, what the law now requires providers and insurers to show you, and what you can do before you ever walk in the door.

The Price Nobody Pays

Every doctor's office keeps a price list called a fee schedule, and every hospital keeps a master version called a **chargemaster**. It holds a "charge" for every service, supply, test, and room they offer. That's the number you see at the top of your statement.

Here's the dirty little secret: **almost nobody actually pays the chargemaster price.**

Insurance companies negotiate their own rates with providers. Medicare and Medicaid set their own rates by law. Those negotiated or set amounts are called the **allowed amount**, and they're often a fraction of the charge. The difference between the charge and the allowed amount is written off by the provider as a **contractual adjustment**.

So your doctor's office might charge $320 for a routine office visit, your plan might allow $145, and the other $175 simply disappears from the books. What you owe is based on the allowed amount, not the charge.

That's why the first number you see on a statement can be wildly misleading. It's a list price for a product that is almost never sold at list price.

The one group who sometimes gets stuck with something close to the full charge? People without insurance. Which is exactly backwards, and exactly why it pays to ask about self-pay discounts and financial assistance, something we'll cover later in this book.

Same Service, Different Price

At the grocery store, a can of peas costs the same no matter who buys it. In healthcare, the exact same MRI can cost two neighbors very different amounts. Here's why:

- **Your plan.** An HMO, a PPO, a high-deductible plan, Medicare, Medicare Advantage, and Medicaid all pay differently, and each has its own deductible, copay, and coinsurance rules.
- **Your network.** In-network providers have agreed to the plan's allowed amounts. Out-of-network providers haven't, and you can end up paying far more.
- **The contract.** Every insurer negotiates separately with every hospital and practice. Two big insurers can pay the same hospital very different amounts for the same thing.
- **Where it happens.** The same test can cost more in a hospital outpatient department than in an independent imaging center or doctor's office, partly because hospitals can add a facility fee on top of the professional fee.
- **Where you are in your year.** Early in the year, before your deductible is met, you may pay the whole allowed amount. Later, you might only owe a copay or a percentage. Same service, same plan, different month, different price.
- **How it gets coded.** The codes on the claim decide what gets paid. A screening that gets coded as diagnostic, or an office visit coded at a higher level, changes what you owe, even though the care itself didn't change.

None of these show up on a shelf tag. Most of them aren't visible to you until after the fact, and some of them aren't even known to the person scheduling your appointment.

What the Law Now Gives You

The good news: you have more right to see prices than you did a few years ago. Most people just don't know these tools exist.

Hospital price lists. Since 2021, federal rules have required hospitals to post their prices online, including the rates they've negotiated with insurers, plus a consumer-friendly list or estimator for common "shoppable" services you can schedule ahead of time.

Your insurance company's cost estimator. Most private health plans are now required to offer an online tool that shows your estimated out-of-pocket cost for a service with a specific in-network provider. Log in to your plan's website or app and look for "cost estimator" or "find care and costs."

The Good Faith Estimate (if you're uninsured or paying yourself). Under the No Surprises Act, if you don't have insurance, or you choose not to use it, providers must give you a written Good Faith Estimate of expected charges. You get it when you schedule a service at least three business days ahead, or any time you ask.

The right to dispute. If your final bill from any provider or facility comes in at least $400 more than their Good Faith Estimate, you can challenge it through the federal Patient-Provider Dispute Resolution process. You have 120 calendar days from the date of the bill to start, and there's a $25 fee, which comes off what you owe if you win. If the bill is already in collections, the provider has to stop pursuing it while the dispute is underway. Chapter 19 covers the No Surprises Act and this dispute process in full.

Where the Rules Still Fall Short

Those rules are real progress. But don't mistake them for a price tag on a shelf.

- **Estimates are just estimates.** Your doctor finds something unexpected, orders another test, or a different specialist gets involved, and the number changes. Nobody is lying; that's just how care works.
- **Emergencies don't wait for price shopping.** Nobody compares MRI prices from the back of an ambulance.
- **Hospital price files are built for computers, not people.** Some are huge spreadsheets full of codes that are nearly impossible for a regular person to use.
- **Insured patients still don't get a Good Faith Estimate.** The law also called for insured patients to get an "Advanced Explanation of Benefits" before scheduled care, but as this is written, that piece still hasn't been put into effect.

- **Not everyone follows the rules.** Compliance with price transparency has been uneven, and the burden of noticing usually falls on you.
- **The estimate is only as good as the codes.** If the claim gets coded differently from what was estimated, the price changes with it. That's a whole chapter of its own.

The takeaway isn't that these tools are useless. It's that **you have to ask, and you have to keep the paperwork**, because the estimate is your evidence if the bill doesn't match.

Before You Walk In the Door

You can't turn healthcare into a grocery aisle. But for anything you can schedule ahead, you can get a lot closer. Before your next planned visit, test, or procedure:

- [ ] **Confirm every provider is in your network.** Not just the doctor, but the facility, the lab, the radiologist, and the anesthesiologist if there is one. Ask your insurance company, not just the front desk.
- [ ] **Ask for the codes.** Ask the office which procedure codes (CPT) they expect to bill. With those codes, your insurer's cost estimator and the hospital's price list become far more useful.
- [ ] **Run your plan's cost estimator** and save a screenshot or printout with the date.
- [ ] **Ask where your deductible stands.** How much have you met this year? It changes your share more than almost anything else.
- [ ] **Check whether prior authorization is needed,** and get the authorization number in writing before the service.
- [ ] **Uninsured or paying yourself? Ask for a Good Faith Estimate in writing,** and ask about self-pay discounts and financial assistance.
- [ ] **Compare settings.** Ask whether the same test can be done at an independent imaging center or office instead of a hospital department.
- [ ] **Keep everything.** Estimates, authorization numbers, the names of the people you talked to, and the dates. If the bill doesn't match later, this is your proof.

Notice a theme? Your doctor's office, the hospital, and your insurance company each keep a complete file on you: every visit, every code, every dollar, every phone call. **Do you have as complete a file on them?**

Your best defense is a good offense, or at least matching their resources.

From Doug's Case Files

[Doug: a real story goes here, fully disguised. Ideal for this chapter: a time someone got a price, or no price at all, and the final bill came in very different. Two or three short paragraphs, told in your voice, ending with what the person could have done differently.]

The Bottom Line

- Healthcare is bought backwards: service first, price later.
- The big number on a statement is usually a list price almost nobody pays. What matters is the allowed amount.
- The same service can cost different people very different amounts, depending on plan, network, contracts, setting, timing, and coding.
- You have real tools now: hospital price lists, your plan's cost estimator, and, if you're uninsured or self-pay, a Good Faith Estimate and the right to dispute.
- None of it works unless you ask, and keep the paperwork.

Next chapter: that envelope in your mailbox that looks like a bill. It isn't one.

Chapter 2: That's Not a Bill

The Envelope in Your Mailbox

It shows up a few weeks after your visit. Your doctor's office logo in the corner. A big number in a box. "Amount Due." Maybe a due date, maybe a friendly reminder that you can pay online.

It looks like a bill. It feels like a bill. Most people pay it like a bill.

It's not a bill. It's a statement.

A statement is the provider's summary of your account: what they charged, what they've received so far, and what they say is left. It's their side of the story, and only their side.

And often it doesn't even give you enough information to check it. Many statements show a date, a vague description like "office visit" or "lab services," and a dollar amount. No procedure codes, no diagnosis codes, none of the details that actually went to your insurance company. You're being asked to make sense of something built from information you've never seen.

Why leave the codes off? Partly habit, partly space. But there's another reason that should make you shake your head: the procedure codes used to bill almost every doctor's visit in America, called CPT codes, are copyrighted. The American Medical Association owns them and charges licensing fees for their use. So some providers hesitate to print them on what they send you.

Think about that. The language the entire billing system runs on is privately owned, and everyone in the chain pays to use it, a cost that eventually lands back on patients. It's one of many quiet, wasteful costs built into healthcare.

The good news: you have every right to ask for an itemized statement, and the codes that were billed for your care.

Here's what most people never realize: **your insurance company never sees that statement.** Not once. The insurer isn't checking it, approving it, or comparing it to anything. It goes from the provider straight to you.

What your insurer sees is something completely different, called a claim. And the gap between the claim and the statement is exactly where mistakes, and money, go missing.

What Your Insurer Actually Sees: The Claim

A **claim** is the provider's formal request for payment, sent to your insurance company. It's built from your medical record and translated into codes: what was wrong with you, what was done, where, by whom, and what they're charging for it.

There are two standard claim forms, and which one gets used depends on who's billing:

	CMS-1500	UB-04 (also called CMS-1450)
Used by	Doctors, physical therapists, independent labs, ambulance services, and other "professional" providers	Hospitals, surgery centers, skilled nursing facilities, home health, hospice, and other "institutional" providers
Services described with	CPT and HCPCS procedure codes, plus modifiers	Revenue codes for departments (room, pharmacy, lab, OR), plus CPT/HCPCS for outpatient services and ICD-10-PCS procedure codes for inpatient stays
Diagnoses listed with	ICD-10-CM codes, each service "pointed" to the diagnosis that justifies it	ICD-10-CM codes, led by the principal diagnosis that explains the stay
Example	Your doctor's office visit, the radiologist reading your X-ray	Your hospital stay, the facility side of your outpatient surgery

That's why one trip to the hospital often produces several separate claims, and several separate statements: one from the hospital itself on a UB-04, and others from the doctors who treated you there on CMS-1500s. The surgeon, the anesthesiologist, the radiologist, and the pathologist may all bill separately, and each one can be in or out of your network.

Every one of those claims is only as accurate as the codes on it. One wrong diagnosis code, one wrong procedure code, or one missing modifier changes what gets paid, and what you're told you owe.

Paper Is Mostly Gone

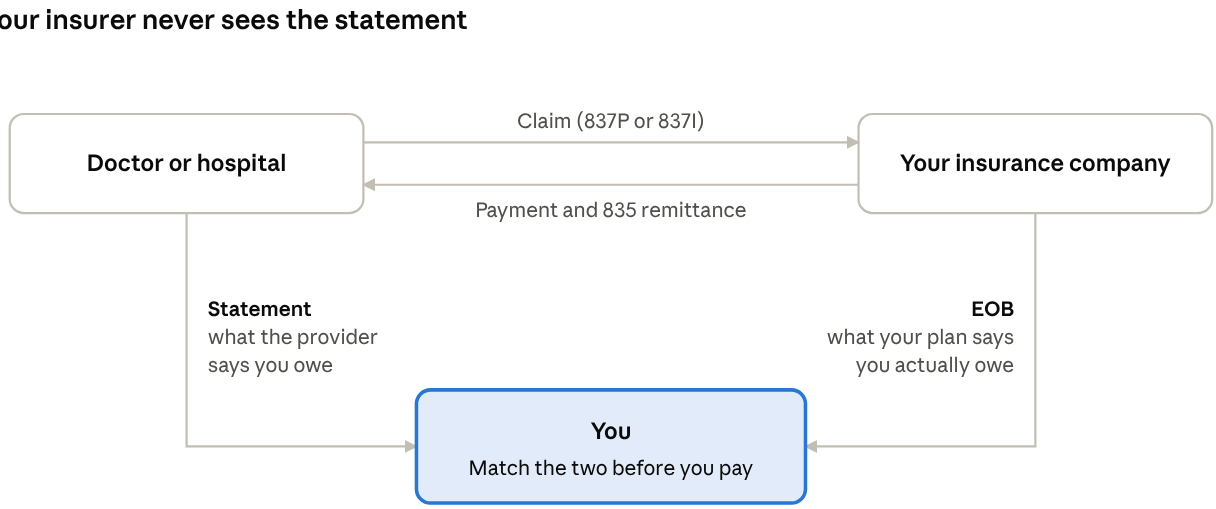
If you picture someone filling out a CMS-1500 by hand and mailing it, that's mostly history. Today the vast majority of claims travel electronically, in a standard format that HIPAA requires every insurer and provider to use. The paper forms still matter, because the electronic versions carry the same information in the same structure, but almost nobody prints them.

These electronic transactions are known by numbers. You'll never need to send one, but knowing they exist explains a lot about why things take as long as they do:

Transaction	What it does	Why it matters to you
270 / 271	Eligibility check and response	The office asks your insurer if you're covered. Wrong info here leads to denials later.
278	Prior authorization request and response	The approval, or denial, for services that need it before they happen.
837P	Professional claim (the electronic CMS-1500)	Your doctor's claim.
837I	Institutional claim (the electronic UB-04)	The hospital's or facility's claim.
276 / 277	Claim status inquiry and response	How the office checks where a claim stands.
835	Payment and remittance advice	The insurer's detailed explanation to the provider of what it paid, adjusted, and denied, line by line. Your EOB is the patient's version of the same decision.

The important part: the provider gets the 835 with the full payment breakdown. You get the EOB. And the statement in your mailbox is supposed to match both. Often it doesn't.

How It All Flows



how a claim, payment, EOB, and statement flow

The claim and payment travel between your provider and your insurer. You get two separate documents: the EOB from your insurer and the statement from your provider. Nobody but you ever compares them.

The EOB: The Insurer's Side of the Story

After your insurer processes a claim, it sends you an **Explanation of Benefits**, or EOB. It usually says right on it: "This is not a bill." And it isn't. But it's the single most important piece of paper in this whole process, because it tells you what you actually owe.

For each service, an EOB typically shows:

- **What the provider charged.** The chargemaster price.
- **The allowed amount.** What your plan says the service is worth under its contract.
- **What the plan paid.**
- **Your share,** broken down into deductible, copay, and coinsurance.
- **Any amount not covered,** with a reason code explaining why.
- **Your total responsibility.** This is the number your statement should match.

If you're in network, the provider generally can't bill you more than the "your responsibility" amount on the EOB. Anything above it is usually a contractual adjustment the provider agreed to write off.

So the EOB is your answer key. The statement is the provider's homework. Your job is to grade it.

Before You Pay Any Statement

- [ ] **Wait for the EOB.** Statements often arrive before insurance has finished processing. If the statement doesn't show an insurance payment yet, don't pay it. When every statement and EOB is logged by date of service in one place, you can see at a glance which ones are still waiting.
- [ ] **Match them up.** Same patient, same date of service, same provider, same claim. One visit can produce several statements from different providers, so each one has to be matched to its own EOB. With everything filed under the visit it belongs to, the match is already made for you, instead of being a scavenger hunt through a kitchen drawer.
- [ ] **Compare the bottom lines.** Your amount due on the statement should equal "your responsibility" on the EOB, minus anything you've already paid. If it's higher, stop and ask why. Side by side, a difference jumps out; buried in two separate envelopes weeks apart, it rarely does.
- [ ] **Look for the adjustment.** The statement should show the contractual adjustment. If the charge minus the insurance payment equals your "balance," the adjustment is probably missing. A ledger that tracks charge, allowed amount, insurance paid, and your share for every visit makes a missing adjustment obvious.
- [ ] **Ask for an itemized bill.** A summary statement hides the details. The itemized version shows every line, code, and charge. Keep it attached to the visit it belongs to, so it's there when you need it, not lost in a pile.
- [ ] **Watch for duplicates.** The same service billed twice, or billed by two providers. Duplicates are nearly impossible to spot from memory, and easy to spot when every service you've received is in one searchable record.
- [ ] **Write it down.** When you call, get the name of the person you spoke with, the date, and a reference number. Keeping those records for all your medical services in one central place that's searchable, retrievable, printable, and easy to send lets you match the resources the system uses against you, and makes it far easier to audit for errors and waste.

None of this is hard on its own. What makes it hard is the volume: dozens of statements, EOBs, phone calls, and letters across every provider and every member of your family. Having a structured system built for this many moving parts is like having a strong army to defend against attack.

From Doug's Case Files

[Doug: a real story goes here, fully disguised. Ideal for this chapter: a statement that didn't match the EOB, such as a missing contractual adjustment, a patient balance and adjustment posted backwards, or a balance billed before insurance had paid. Two or three short paragraphs in your voice, ending with how it got caught or fixed.]

The Bottom Line

- The "bill" in your mailbox is a statement: the provider's version of your account, and nobody else checks it.
- Your insurer only sees the claim, sent on a CMS-1500 for professionals or a UB-04 for facilities, almost always electronically.
- The EOB is your answer key. Never pay a statement until it matches.

Next chapter: the language all of this is written in. More than 100,000 codes, and nobody ever handed you the dictionary.

Chapter 3: The Language Barrier

Two Versions of the Same Visit

You went to the doctor with a sore throat. You waited, got your throat swabbed, talked with the doctor for ten minutes, and left with a prescription.

Here's how your insurance company saw that same visit:

99213 · 87880 · J02.0

That's it. An office visit, a rapid strep test, and a diagnosis of strep throat, written in a language you were never taught. Every dollar that changed hands was decided by those few characters, not by what happened in the exam room.

Healthcare doesn't run on words. It runs on codes. More than 100,000 of them, spread across several separate code sets, each with its own structure, its own rulebook, and its own annual updates. The people billing you and the people paying for your care speak this language fluently. You were never handed the dictionary.

This chapter is that dictionary, at least the first few pages of it.

The Code Sets

There isn't one healthcare language. There are several, and a single doctor's visit can use three or four of them at once.

Code set	What it describes	Roughly how many	Everyday example
ICD-10-CM	Diagnoses: what's wrong with you, and why you were seen	More than 70,000	J02.0 — strep throat · I10 — high blood pressure
CPT	Procedures and services by doctors and other professionals	About 11,000	99213 — office visit, established patient · 87880 — rapid strep test

Code set	What it describes	Roughly how many	Everyday example
HCPCS Level II	Supplies, equipment, drugs given in the office, ambulance rides, and some Medicare services	Thousands	E0114 — crutches · J1100 — a steroid injection
Modifiers	Two-character add-ons that change a procedure code's meaning	Hundreds	25 — a separate problem handled at the same visit · RT/LT — right or left side
ICD-10-PCS	Procedures done during an inpatient hospital stay	More than 70,000	Used only for hospital admissions
Revenue codes	The hospital department or type of charge on a facility claim	Hundreds	0450 — emergency room · 0300 — laboratory
Denial and adjustment codes	Why a claim was paid, reduced, or denied	Hundreds	The short codes and notes on your EOB

Add them up and you're well past 100,000 codes. And knowing what a code *means* is only half of it. The other half is knowing the rules for when it can be used.

Dewey Decimal Meets the Phonebook

Diagnosis codes aren't random. They're built like a library call number: each character narrows things down, from a broad chapter to a specific body part, a side of the body, and even which visit this is. Here's the code for an everyday sprained ankle:

One sprained ankle, five pieces of information: S93.401A

S	93	.40	1	A
Chapter Injury, sorted by body region	**Category** Ankle, foot, and toe joints	**Details** Sprain, ligament not specified	**Side** Right (2 means left)	**Encounter** First treatment (D means follow-up)

how one diagnosis code breaks into five parts

Seven characters, five facts. Change one character and you've described a different injury, a different side of the body, or a different visit, and the claim changes with it.

And the detail can get absurd. There's a code for being struck by a duck (W61.62XA, first visit). There are codes for injuries in an opera house and for walking into a lamppost. Coders love to joke about them, but they make the point: this system is enormous, precise, and unforgiving.

Every Code Comes With a Rulebook

If the codes were just a dictionary, you could look one up and be done. But every code set comes with its own rules, and those rules decide what gets paid.

And it runs deeper than the code sets. **Every single code has its own unique descriptor, the exact wording of what it means, and its own rules attached to it.** Those words are precise, and every one of them matters.

Take an MRI of your lower back. Without contrast dye is one code. With contrast is a different code. Without, then with, in the same session is a third code. Same body part, same machine, three codes, three prices, and the descriptor is the only thing telling them apart.

Other codes are defined by time ("each 15 minutes"), by side of the body, by age, by number of areas treated, or by what *must* or *must not* be billed alongside them. Diagnosis codes carry their own notes too: conditions that can't be coded together, codes that must be listed first, and codes that require a second code to tell the whole story.

So a code isn't just a label. It's a contract, and the fine print decides what gets paid. On top of each code's own rules sit the rules for the whole system:

- **Official coding guidelines.** ICD-10-CM alone comes with a thick set of official guidelines on which diagnosis goes first, when a symptom can be coded, and when it can't.
- **The diagnosis has to justify the service.** Insurers check that the diagnosis supports what was done. A test billed without a diagnosis that explains why it was needed is a classic reason for a denial, and that denial can land on your statement.
- **Some codes can't be billed together.** Medicare's National Correct Coding Initiative, followed by many private insurers too, lists pairs of codes that shouldn't be billed on the same day, because one already includes the other.
- **Office visit levels.** A routine office visit can be billed at several levels, from a quick check-in to a complex visit. The level depends on how complex the doctor's decision-making was, or how much time was spent, and the difference between one level and the next can be meaningful money.
  IF YOU WENT TO A DOCTOR'S OFFICE, WEREN'T AT RISK OF DYING, AND WENT HOME INSTEAD OF TO THE HOSPITAL, AND YOUR OFFICE VISIT CODE ENDS IN A 5 (99205 OR 99215), IT WAS ALMOST CERTAINLY NOT CODED CORRECTLY.
  The top level is meant for situations like drug therapy that needs intensive monitoring for toxicity, a decision about elective major surgery when you have identified risk factors, a decision about emergency major surgery, a decision to hospitalize you, or starting palliative care because of a poor prognosis. The one legitimate exception: the top level can also be billed based on the doctor's total time with your case that day, so a genuinely long visit can qualify. If yours didn't, ask.
- **Modifiers change everything.** The right modifier can make a legitimate second service payable. The wrong one, or a missing one, can get it denied, or overpaid.

The people who apply these rules for a living train for them, get certified in them, and still argue about them. It's not reasonable to expect a patient to master them. But it is reasonable to know they exist, because they're behind almost every surprise on a bill.

A Language That Changes Every Year

Imagine learning a language that rewrites part of its dictionary every year. That's medical coding.

ICD-10-CM diagnosis codes are updated every October 1. CPT procedure codes change every January 1. HCPCS codes are updated throughout the year. Codes get added, deleted, and redefined, and the rules that go with them shift too.

A code that was correct on your visit last spring might not exist this fall. A billing office that misses an update, or software that wasn't updated in time, can send a claim with an outdated code. That claim gets denied, delayed, or paid wrong, and the fallout often lands on your statement before anyone figures out why.

What the Codes Mean for You

Those few characters decide more than your bill:

- **What you pay.** A higher visit level, an extra procedure code, or a screening coded as diagnostic can change your share by a lot.
- **Whether it's covered at all.** A diagnosis that doesn't support the service can turn a covered visit into a denied one.
- **What follows you.** Every diagnosis code billed under your name becomes part of your record, and it can show up again in future care, insurance applications, and more. See what happened to one woman below, and we'll dig deeper in a later chapter.

You don't need to become a coder. But a little fluency goes a long way:

- [ ] **Ask for the codes.** Request an itemized statement, and ask what diagnosis and procedure codes were billed. They're on the claim; you're entitled to know them.
- [ ] **Look them up.** The CDC offers a free online ICD-10-CM lookup for diagnosis codes, and Medicare's physician fee schedule lookup shows short descriptions of many procedure codes.
- [ ] **Ask whether each diagnosis is right.** If your EOB shows a condition you've never been told you have, ask the provider why.
- [ ] **Keep the translation with the visit.** A code you've looked up once is a code you never have to look up again. Store each code with its plain-English meaning, right alongside the visit it came from, and over time you build your own personal dictionary of your family's care.

From Doug's Case Files

The 100-Pound Weekend

One of my favorite teaching cases comes from the record of a woman I know very well. She's a medical coder herself, which makes this even better.

She stands 4 feet 10 inches tall. At a routine checkup on a Monday, the office weighed her at 97 pounds. Her body mass index was a perfectly healthy 20, and it was coded that way.

She went back two days later for a follow-up. This time her chart says she weighed 198 pounds. The system did the math on its own and calculated a body mass index of nearly 41. A week after that, "morbid obesity" was sitting on her active problem list.

Nobody gains 101 pounds in two days, even if they're decorated with cinder blocks like Christmas tree ornaments. Look closely at the numbers and there are two likely culprits. My personal suspicion: someone hit an extra 1 in front of 98. Or, since 198 pounds is exactly 90 kilograms, a number went into the wrong box or the wrong unit. Either way, the software took it from there. No one ever looked at her.

And she wasn't just underweight that week. That same visit diagnosed her with an overactive thyroid, a condition that typically makes people *lose* weight.

Here's why it matters: morbid obesity is one of the diagnoses that raises a patient's risk score and what gets paid. Once it lands on a problem list, it tends to get carried forward visit after visit. It can show up when you apply for life insurance and get you rated up or turned down. And she'd never have known it was there if she didn't read medical records for a living.

It got caught because she looked. Most people never look.

The Bottom Line

- Your insurer doesn't see your visit. It sees codes: more than 100,000 of them across several code sets.
- Every code comes with rules that decide what's covered, what's paid, and what you owe.
- The language changes every year, and mistakes in it land on you.
- You don't have to be a coder. Ask for the codes, look them up, question what doesn't fit, and keep the translations.

Next chapter: why no two claims are alike, even for the exact same visit.

Part 2: How the Money Actually Moves

Chapter 4: No Two Claims Are Alike

Same Visit, Different Price

Five neighbors on the same street catch the same cold. Each one goes to their own primary care doctor for a quick 15-minute visit, and every one of those visits is billed with the exact same code.

They don't pay anywhere near the same amount.

One pays a $30 copay and forgets about it. One gets a bill for the whole visit. One owes a few dollars. One gets hit with a bill that's bigger than the visit should have cost. And one has never been asked for anything at all.

Same cold, same kind of visit, same code. The difference is everything that happens after the visit: the plan, the network, the contract, the time of year, and the fine print. That's why no two claims are alike, and why comparing your bill to a friend's almost never tells you anything.

One Office Visit, Five Patients

Here's how those five visits could play out. To keep it simple, say each doctor charges $320. The amounts are examples, but the patterns are real.

Neighbor's coverage	Allowed amount	Plan pays	Patient pays	Why
PPO, in network	$145	$115	**$30**	A flat office-visit copay; the plan pays the rest of the allowed amount
High-deductible plan, in network, in January	$132	$0	**$132**	A different contract with a different allowed amount, and the deductible hasn't been met yet, so the patient pays it all

Neighbor's coverage	Allowed amount	Plan pays	Patient pays	Why
Original Medicare, deductible already met	$92	$73.60	**$18.40**	Medicare sets its own rates by law; the patient owes 20% coinsurance, or less with a supplement plan
PPO, but the doctor is out of network	$145	$87	**$233**	The plan pays a smaller share, and the doctor can bill the patient for the rest of the $320 charge
Medicaid	Set by the state	Nearly all	**$0**	Medicaid rates are set by the state, and most visits cost the patient nothing or a very small copay

From $0 to $233 for the exact same 15 minutes. Nobody did anything wrong. That's just how the system is built.

The Plan Types

The letters on your insurance card tell you a lot about how your claims will be paid. Here are the most common:

Plan type	How it works	Watch out for
HMO	You pick a primary care doctor who coordinates your care. Specialists usually need a referral.	Out-of-network care generally isn't covered at all, except emergencies
PPO	You can see any doctor, but in-network costs much less. No referrals needed.	Out-of-network doctors can bill you for the difference between their charge and what the plan pays
EPO	Like a PPO with no out-of-network coverage. Usually no referrals.	Seeing an out-of-network doctor can mean paying the entire bill

Plan type	How it works	Watch out for
POS	A blend: a primary doctor and referrals like an HMO, with some out-of-network coverage like a PPO	The rules change depending on whether you got a referral
High-deductible plan (often with an HSA)	Lower premiums, but you pay the full allowed amount for most care until the deductible is met. Preventive care is usually covered from day one.	The first months of the year can be expensive
Original Medicare	Part A covers hospital stays; Part B covers doctors and outpatient care. You usually owe 20% after the Part B deductible, with no yearly cap.	No out-of-pocket maximum unless you add a supplement
Medicare Advantage	A private plan that replaces Original Medicare, often run as an HMO or PPO, with a yearly out-of-pocket maximum	Networks, referrals, and prior authorizations, like commercial plans
Medicare Supplement (Medigap)	Works alongside Original Medicare to pay some or all of the 20% and deductibles	It doesn't work with Medicare Advantage
Medicaid	State-run coverage for people with limited income; rules vary by state	Providers must accept Medicaid, and not all do

Two plans with the same letters can still work very differently. The details live in your plan documents, which we'll get to in a later chapter.

Networks and Contracts

The single biggest factor in what a claim pays isn't the care. It's the contract.

Every insurer negotiates its own deal with every provider. Your doctor might accept one rate from one insurance company and a very different rate from another, for the identical code. Many commercial contracts are built as a percentage of what Medicare pays. Medicare and Medicaid don't negotiate at all; they set their rates by law and regulation.

In network means a deal was signed. An in-network doctor has agreed to accept the plan's allowed amount as payment in full. Whatever's left after the plan pays and you pay your share gets written off. You can't be billed for the difference.

Out of network means no deal. Without a contract, the doctor isn't bound by the plan's allowed amount. In many cases they can bill you for the difference between their full charge and what the plan paid. That's called **balance billing**, and it's how the fourth neighbor ended up owing $233.

The No Surprises Act closed some of the worst traps. Since 2022, federal law protects you from balance billing for most emergency care, for many out-of-network providers who treat you at an in-network hospital or surgery center (think anesthesiologists and radiologists you never chose), and for air ambulances. In those cases, you pay only your normal in-network share. But it doesn't cover everything, including ground ambulances in many states, or an out-of-network doctor's office you chose to visit. Chapter 19 covers these protections in full.

Networks change. Doctors join and leave plans, sometimes mid-year. The doctor who was in network last spring may not be now. Check every time, especially before anything you can schedule ahead.

Same Plan, Different Month, Different Price

Even with the exact same plan and the exact same doctor, your claim can pay very differently depending on *when* it happens and *what kind* of visit it is.

- **Deductibles reset.** Most plans start your deductible over every January 1. The same visit that cost you $132 in January might cost you just a fraction of that in October, once the deductible's been met.
- **The out-of-pocket maximum.** Once you hit your plan's yearly cap, covered in-network care is paid at 100% for the rest of the year. A family that's had a rough year might owe nothing for a December visit that would have cost hundreds in February.
- **Preventive vs. problem visits.** A yearly physical with routine screenings is often covered at no cost. But mention your bad knee during that physical, and part of the visit can be billed as a problem visit, with a copay or deductible attached. Same

appointment, two kinds of care, two different prices.

- **Copay services vs. deductible services.** Many plans charge a flat copay for office visits but apply the deductible to labs, imaging, and procedures. The visit itself costs $30; the blood work drawn during it can cost much more.

We'll work through the actual math of deductibles, copays, coinsurance, and out-of-pocket maximums in the next chapter.

What You Can Do

- [ ] **Know your plan type, and what it means.** Look at your card, then look up your plan's rules for referrals, networks, and out-of-network coverage. Having your plan's key details recorded in one spot, right next to your claims (just like your doctor's office and insurance company have it), saves you from digging through a drawer every time a question comes up.
- [ ] **Check network status every time.** Ask your insurer, not just the doctor's office, and note who you talked to and when. If a bill later says "out of network," that note is your proof.
- [ ] **Know where you stand for the year.** Track how much of your deductible and out-of-pocket maximum you've used, for every family member and every plan. Most people have no idea how close they are, and it changes what every visit will cost.
- [ ] **Separate preventive from problem care.** At a checkup, ask whether bringing up a new issue will be billed separately, so a free visit doesn't become a surprise.
- [ ] **Never compare your bill to someone else's.** Compare it to your own EOB. Your claim is only alike to itself, and keeping every claim, EOB, and payment tied together by visit is what lets you see whether yours was handled right.

From Doug's Case Files

[Doug: a real story goes here, fully disguised. Ideal for this chapter: two people with the same service and very different bills, a surprise out-of-network bill from a provider the patient never chose, or a network change nobody told the patient about. Two or three short paragraphs in your voice.]

The Bottom Line

- The same kind of visit, billed with the same code, can cost five people five different amounts.
- Your plan type sets the rules; your network and the contract behind it set the price.
- In network, you can't be billed beyond your share. Out of network, you often can, though the No Surprises Act now protects you in many emergency and hospital situations.
- Timing matters: deductibles reset, out-of-pocket maximums cap your year, and preventive care follows different rules than problem care.
- The only fair comparison for your claim is your own EOB.

Next chapter: the math behind your share. Deductibles, copays, coinsurance, and the out-of-pocket maximum, worked out step by step.

Chapter 5: Deductibles, Copays, Coinsurance, and the Out-of-Pocket Max

Four Words That Decide Your Share

Deductible. Copay. Coinsurance. Out-of-pocket maximum.

You've seen these words on every insurance card, enrollment form, and EOB you've ever received. Most people can give a rough definition of each one. Almost nobody can tell you how they work *together*, in what order, on a real claim.

That's not a knock on anyone. The order of operations isn't printed on your card, and it isn't explained on your EOB. But it's the math that decides every dollar you owe.

By the end of this chapter, you'll be able to take any EOB, look at the allowed amount, and work out for yourself whether your share is right.

The Terms in Plain English

Term	What it means	Example
Allowed amount	The price your plan has agreed to for a service. Everything else is figured from this number, not from the doctor's charge.	Doctor charges $320; plan allows $145
Deductible	What you pay out of your own pocket each year before your plan starts sharing costs for most services	$500 per year
Copay	A flat fee for certain services, usually office visits and prescriptions	$30 per office visit
Coinsurance	Your percentage share of the allowed amount after the deductible is met	You pay 20%, the plan pays 80%
Out-of-pocket maximum	The most you'll pay in a year for covered, in-network care. Once you hit it, the plan pays 100% for the rest of the year.	$3,000 per year

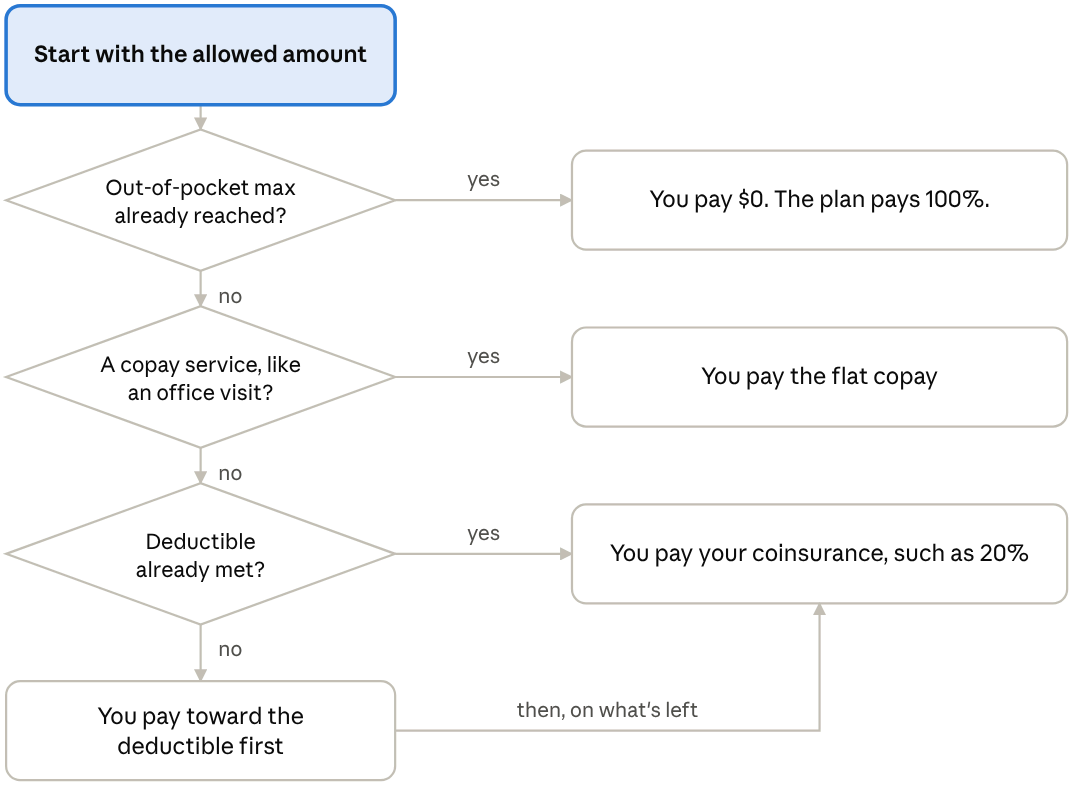
Term	What it means	Example
Premium	What you pay just to have the insurance, usually monthly. It does **not** count toward your deductible or out-of-pocket maximum.	$450 per month

The examples above are the plan we'll use for the rest of this chapter: a $500 deductible, a $30 office-visit copay, 20% coinsurance, and a $3,000 out-of-pocket maximum.

The Order It All Happens In

Every claim runs through the same steps, in the same order. Once you see it, the math stops being a mystery.

Your share is figured in the same order every time



Whatever you pay is capped: no claim can take you past your out-of-pocket maximum.

the order your share is figured in

One wrinkle: in some plans, a copay service still goes toward the deductible first. Your plan documents spell out which services work which way.

Example: One Office Visit With Lab Work

In February, you see your primary care doctor about fatigue. The doctor examines you and orders blood work, drawn right there in the office. It's your first care of the year, so you haven't paid anything toward your deductible yet.

Two services, two different rules:

Service	Allowed amount	Which rule applies	You pay	Plan pays
Office visit	$145	Office visits have a flat copay	$30	$115
Blood work	$120	Labs go toward the deductible, and none of it's been met	$120	$0
Total	**$265**		**$150**	**$115**

Most people expect to pay $30 for that visit. They're shocked when a $120 lab bill shows up weeks later. Nothing went wrong. The visit and the lab simply followed different rules, and only one of them was printed on the insurance card.

Where you stand afterward: $120 of your $500 deductible is met, and you've paid $150 toward your $3,000 out-of-pocket maximum. (In most plans, copays count toward the out-of-pocket maximum even when they don't count toward the deductible.)

Example: One Person's Whole Year

Now follow that same person through a rough year. Same plan: $500 deductible, $30 office copay, 20% coinsurance, $3,000 out-of-pocket maximum.

When	Care	Allowed amount	How your share was figured	You pay	Deductible met	Out-of-pocket so far
February	Office visit and blood work	$265	$30 copay for the visit, plus $120 lab toward the deductible	$150	$120	$150
April	MRI of the knee	$640	The last $380 of the deductible, plus 20% of the remaining $260	$432	$500	$582
June	Outpatient knee surgery	$9,000	Deductible met, so 20% coinsurance	$1,800	$500	$2,382
August	10 physical therapy visits	$1,200	20% coinsurance	$240	$500	$2,622
October	Follow-up office visit	$145	$30 copay	$30	$500	$2,652
November	Second procedure	$4,000	20% would be $800, but only $348 remains before the cap	$348	$500	**$3,000**
December	Office visit	$145	Out-of-pocket maximum reached; the plan pays 100%	**$0**	$500	$3,000

Across the whole year, nearly $15,400 in allowed charges, and this person paid exactly $3,000. Every row only makes sense if you know where they stood on the row before it.

That's the part almost nobody tracks. Your insurance company tracks it to the penny, for every member of your family. Its running totals decide what you're charged on every claim, and the only way to know they're right is to keep your own running totals alongside them.

What Trips People Up

- **Premiums don't count.** Paying $450 a month for insurance doesn't move you one penny closer to your deductible or out-of-pocket maximum.
- **Copays may not count toward the deductible.** In many plans, office copays count toward the out-of-pocket maximum but not the deductible. Some plans count them toward both. Your plan documents say which.

- **Family plans have two kinds of limits.** Most family plans have an individual deductible for each person and a family deductible for everyone combined. Some plans make the whole family meet the full family deductible before anyone's coinsurance kicks in. That difference can be worth thousands.
- **In network and out of network are tracked separately.** Many plans have a separate, higher deductible and out-of-pocket maximum for out-of-network care, and some have no out-of-pocket maximum at all out of network.
- **Not everything counts.** Services the plan doesn't cover, and anything an out-of-network provider balance-bills you, usually don't count toward your limits.
- **The clock may not start in January.** Many plans run on the calendar year, but some employer plans run on a plan year that starts in another month.
- **Original Medicare has no out-of-pocket maximum.** That 20% keeps going all year unless you have a supplement or another plan.
- **Preventive care is often free, before any deductible.** Covered screenings and checkups at an in-network provider usually cost you nothing, which is why a checkup that turns into a problem visit can surprise you.

What You Can Do

- [ ] **Write down your plan's four numbers.** Deductible, copays, coinsurance, and out-of-pocket maximum, for individuals and for the family, in network and out. Keep them where you'll actually see them when a bill arrives, not buried in a 90-page plan booklet.
- [ ] **Check the math on every EOB.** Start from the allowed amount, apply the rules in order, and see if you land on the same number the EOB did. Once you've done it a few times, it takes a minute.
- [ ] **Keep your own running totals.** Your insurer keeps a year-to-date tally of your deductible and out-of-pocket spending for every person on the plan. Keep one too, visit by visit, so you can spot it when theirs drifts. A mistake early in the year quietly inflates every claim that follows.
- [ ] **Watch the cap.** Once you're close to your out-of-pocket maximum, any claim that charges you more than what's left is wrong. Without your own totals, you'd never know.
- [ ] **Plan around the reset.** If you've already hit your deductible or out-of-pocket maximum, care you can schedule before the year resets may cost far less now than in January.

From Doug's Case Files

[Doug: a real story goes here, fully disguised. Ideal for this chapter: an insurer's deductible or out-of-pocket tally that was wrong, a family charged after already hitting their maximum, or a copay and deductible applied to the same service. Two or three short paragraphs in your voice.]

The Bottom Line

- Everything starts from the allowed amount, not the doctor's charge.
- Copay services, deductible services, and coinsurance follow different rules, even within the same visit.
- The order matters: copay or deductible first, then coinsurance, all capped by the out-of-pocket maximum.
- Premiums never count toward your limits.
- Your insurer keeps running totals for every family member. Keep your own, so you can tell when theirs are wrong.

Next chapter: what happens when you have more than one insurance plan, and who pays first.

Chapter 6: When You Have More Than One Plan

Two Cards, Twice the Confusion

Having two insurance plans sounds like a good problem to have. Your employer's plan and your spouse's. Medicare and a retiree plan. Your child's coverage through you and through their other parent.

More coverage should mean less out of pocket, and often it does. But two plans also means two sets of rules, two networks, two deductibles, and one very important question nobody explains to you: **which one pays first?**

Get that wrong, and claims get denied, delayed, or paid twice and taken back months later. The provider's office gets confused, the insurers point at each other, and the statement lands in your mailbox while everyone sorts it out.

The process of deciding who pays first, and how much each plan pays, is called **coordination of benefits**. The rules are mostly standard. Most people have just never seen them.

Primary and Secondary

When you have two plans, one is **primary** and pays first, as if it were your only coverage. Then the claim goes to the **secondary** plan, which looks at what's left and may pay some or all of it.

Take the office visit with blood work from the last chapter. Your primary plan is your own, through work. You're also covered as a dependent on your spouse's plan, which is secondary.

Service	Allowed amount	Primary pays	Left after primary	Secondary pays	You owe
Office visit	$145	$115	$30 copay	$30	**$0**
Blood work	$120	$0 (applied to your deductible)	$120	$96	**$24**

In this example, the secondary plan pays what it would have paid if it were primary, up to whatever you still owe. Assuming you'd already met the spouse plan's deductible, your share drops from $150 to $24.

But not every secondary plan is that generous. Some use a method that only pays the difference between what the primary paid and what the secondary would have paid on its own, which can mean little or nothing. And together, the two plans almost never pay more than the allowed amount. Two plans means less out of pocket, not a profit.

Who Pays First

Most plans follow the same standard rules to decide the order. The most common situations:

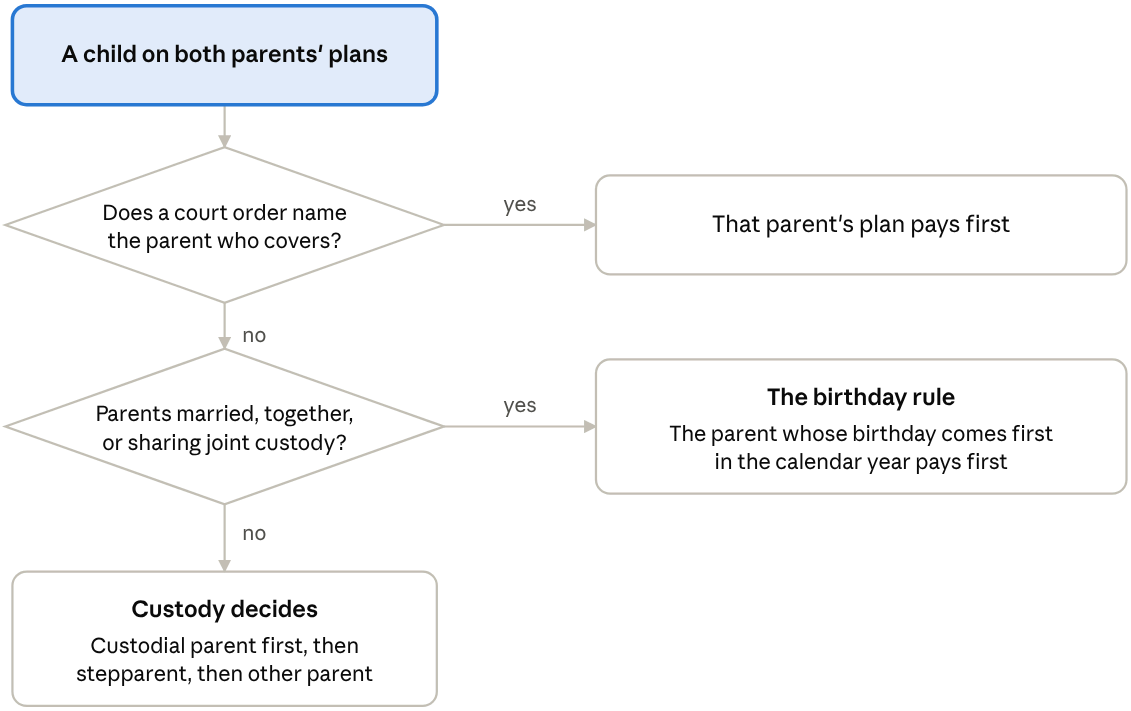
Your situation	Who pays first
Covered on your own job's plan and as a dependent on your spouse's	Your own plan. The plan that covers you as the employee always comes before the one that covers you as a dependent.
An active job's plan and a COBRA or retiree plan	The plan from the job you have now
65 or older, still working, with Medicare and your employer's plan	Your employer's plan pays first if the employer has 20 or more employees. With fewer than 20, Medicare pays first.
Under 65, on Medicare because of a disability, with an employer plan	The employer plan pays first if the employer has 100 or more employees; otherwise Medicare does
Medicare and Medicaid	Medicare pays first. Medicaid always pays last.
Original Medicare and a Medicare Supplement (Medigap)	Medicare pays first; the supplement picks up some or all of what's left
An injury at work, or in a car accident	Workers' compensation or auto insurance usually pays first for that injury, before your health plan
Children covered by both parents	It depends on the household. See the next section.

These are the general rules. Your plan documents have the exact wording, and there are exceptions, but this table covers the situations most families run into.

Kids, Split Households, and the Parent Who Isn't There

When a child is covered by both parents' plans, the order follows its own set of rules:

For kids with two plans, a court order beats every other rule



who pays first for a child covered by both parents

The birthday rule surprises everyone. It's not about who's older. Only the month and day count. If Mom was born on March 3 and Dad on January 15, Dad's plan pays first for the kids, no matter which parent is older or earns more.

Divorced and separated families get complicated fast. A child may be covered through a parent who doesn't live in the house at all. The parent who takes the child to the doctor may not have the member ID, may not know the other parent's employer or date of birth, and often never sees the EOB, because EOBs usually go to the policyholder, not the parent in the waiting room.

That's why the policyholder's details matter so much: their full name, date of birth, employer, member ID, and their relationship to the child. Billing offices need every one of them, and a single wrong digit can send a child's claims bouncing between two plans for months.

When Coordination Goes Wrong

Two plans means twice as many places for a claim to go sideways:

- **The "other coverage" letter.** Insurers regularly send a questionnaire asking whether you have any other insurance. Ignore it, and many will hold or deny every claim until you answer. It looks like junk mail. It isn't.
- **The claim goes to the wrong plan first.** The office bills the secondary plan as primary, or the other way around. The claim gets denied, or paid and then taken back months later, and the balance lands on you in the meantime.
- **The secondary plan is never billed.** The primary pays, and the office sends you a statement for the rest instead of sending the claim to your second plan. You pay money a second plan should have paid.
- **Old coverage is still on file.** A plan you dropped two years ago is still listed in the office's system, so claims bounce.
- **Each office has a different picture.** Your doctor has one set of insurance information, the lab has another, and the hospital has a third. All three are supposed to match.

Almost all of these come down to one thing: someone, somewhere, has incomplete or outdated information about your coverage.

What You Can Do

- [ ] **Know the order for every person in your family.** Who's primary and who's secondary, for each family member, and why. Write it down along with the policyholder's name, date of birth, and employer for each plan, since those are exactly what billing offices ask for.
- [ ] **Answer the "other coverage" letter right away.** Keep a copy of what you sent and the date you sent it.
- [ ] **Give every office the same, complete information.** Both plans, in the right order, every time your coverage changes. One accurate record of your family's coverage, kept current and easy to hand over, beats trying to remember it at every front desk.
- [ ] **Look for two EOBs.** For every claim, you should get one from the primary and, if it was billed, one from the secondary. If the second one never comes, ask the office whether they billed it.
- [ ] **Keep the court order handy.** If a divorce decree says which parent covers the kids, keep a copy with your insurance records. Plans may ask to see it.
- [ ] **Update after every life change.** Marriage, divorce, a new job, retirement, turning 65. Each one can change the order.

From Doug's Case Files

[Doug: a real story goes here, fully disguised. Ideal for this chapter: a family billed in full because a second plan was never billed, a child's claims bouncing between two parents' plans, or a claim held for months over an unanswered "other coverage" letter. Two or three short paragraphs in your voice.]

The Bottom Line

- With two plans, one pays first and the other looks at what's left.
- The order follows standard rules: your own plan before a dependent plan, an active job before COBRA or retiree coverage, and Medicaid always last.
- For kids, a court order comes first, then the birthday rule or custody decides.
- Most coordination problems come from incomplete or outdated coverage information. Keep yours complete, current, and the same everywhere.

Next chapter: where claims are born, and where many of them go wrong. If it isn't documented, it didn't happen.

Chapter 7: Claim Creation: If It Isn't Documented, It Didn't Happen

Rule Number One

Every coder in America learns the same rule on day one: **if it isn't documented, it didn't happen.**

The claim your insurer receives is supposed to be a faithful translation of what's written in your medical record. Not what the doctor remembers. Not what usually happens at a visit like yours. What's actually written down.

That rule is supposed to protect everyone. But there's a flip side most patients never think about: **if it's documented wrong, it happened wrong.** A diagnosis typed into the wrong field, a template that fills in an exam that never took place, a note copied forward from last year's visit. Once it's in the record, it becomes the truth as far as the billing system is concerned.

And rules were made to be broken, as the saying goes. Some providers treat this one that way, by accident or on purpose. Errors at this stage are common, and they flow straight through to the claim, the EOB, and your statement.

This chapter follows a claim from the exam room to the moment it's sent, and shows you where it goes wrong.

From the Exam Room to the Claim

Here's the path your doctor's visit takes before it ever reaches your insurer:

1. **Check-in.** The front desk confirms who you are and what insurance you have. A wrong date of birth, an old insurance card, or the wrong plan order starts the whole claim off on the wrong foot.
2. **The visit.** You and the doctor talk, the doctor examines you, orders tests, and makes decisions.
3. **Documentation.** The doctor writes or dictates the visit note, usually in an electronic health record, often using templates and pick lists. This note is the only thing that counts later.

4. **Code selection.** The visit is turned into codes: a visit level, any procedures or tests, and the diagnoses that explain why. Depending on the office, the doctor picks them, a coder assigns them, or the software suggests them.
5. **Charge entry.** The codes are attached to the office's prices from its fee schedule.
6. **The scrubber.** Billing software checks the claim for obvious errors, like a missing modifier or a code pair that can't be billed together, before it goes out.
7. **Submission.** The claim is sent electronically to your insurer.

Every one of those seven steps is done by a person, a program, or both. And every one is a place where something can slip.

Who Actually Picks the Codes

Most patients assume a trained expert carefully reads every note and assigns every code. Sometimes that's true. Often, it isn't.

- **The doctor clicks.** In many offices, the doctor picks the visit level and diagnoses from a list on the screen at the end of the visit, between patients, in a hurry. Doctors go to school for medicine, not coding, and most get very little coding training.
- **The coder reviews, sometimes.** Larger practices and hospitals employ certified coders. But many review only some claims, or only the ones the software flags.
- **The software decides more than you'd think.** Electronic health records turn plain-English choices into codes behind the scenes. The doctor clicks "protein malnutrition" or "diabetes" on a menu; a table hidden in the system decides which code actually goes on the claim. If that table is wrong, every claim using it is wrong, and the doctor may never know.
- **Templates fill in the blanks.** Many notes are built from templates that pre-fill a normal exam, a review of symptoms, or a history. Unless the doctor edits them, the note can describe an exam that never happened, and that note supports a higher level of service.
- **Copy and paste.** Notes copied forward from a previous visit carry old diagnoses, old findings, and old problems into a new visit, as if they were addressed again.

None of this is necessarily dishonest. But it means the claim can say something your doctor never meant, about care you never received.

How It Goes Wrong

Error	What it means	What it can look like for you
Upcoding	Billing a higher level or more complex service than what was documented or done	A quick follow-up billed as a complex visit, and a bigger share for you
Unbundling	Billing separately for parts of a service that's supposed to be billed as one package	Several line items where there should be one, each with its own cost
Wrong or missing modifier	The two-character add-on is missing, wrong, or used to slip a service past the edits	A legitimate service denied, or a service paid twice
Diagnoses that shouldn't be there	A condition carried forward, suggested by software, or coded as confirmed when the doctor was only ruling it out	A diagnosis on your EOB you've never been told you have
Template and copy-paste notes	The note describes exams, history, or problems that weren't addressed at this visit	A visit level or diagnosis that doesn't match your memory of the appointment
Services not provided	A test, supply, or procedure billed that never happened	A charge for something you never received
Wrong patient, date, or provider	The claim lands on the wrong person, day, or doctor	A bill for a visit you didn't have, or one billed twice under two dates
Wrong insurance information	Old coverage, the wrong plan order, or a typo in a member ID	Denials, delays, and statements for the full amount

One important point: most of these are honest mistakes, made by busy people using complicated systems. Some aren't. Either way, the claim that goes out is the one you pay for.

Copy, Paste, and a Cold Leg at 3 a.m.

Dr. Davis is a practicing interventional radiologist in Las Vegas. One of the emergencies she handles is a "cold leg," a blocked blood vessel that can cost a patient their leg by morning if it isn't opened up.

One night she was called in at 3 a.m. for exactly that. But when her team checked the records, they found that the emergency room doctor had copied and pasted another patient's ultrasound results into this patient's chart. The vascular surgeon who sent the case on had never even seen the patient; he'd copied and pasted the ER doctor's report. Nurses and others passed it along. When Dr. Davis finally sat down to explain the procedure, the patient said, "My leg's not cold."

The wrong information had traveled through three doctors and everyone in between, and should have been stopped at four separate points before it reached her. She was about to perform an invasive procedure on a patient who didn't need it. In her words, it all comes back to the basics: documentation and communication.

If copy and paste can nearly put a patient on the procedure table, imagine what it does to a claim.

Watch Dr. Davis tell the story in 3 minutes: Copy, Paste, and a Cold Leg

What You Can Do

- [ ] **Keep your own visit notes.** Right after each appointment, jot down who you saw, roughly how long, what was examined, what tests were done, and what you talked about. It takes two minutes, and it's your side of the record. Months later, when a claim doesn't match, your notes made the same day carry real weight.
- [ ] **Get the doctor's note.** You have the right to a copy of your visit notes, and most patient portals now show them. Read them. Does the note describe the visit you actually had?
- [ ] **Compare the note to the claim.** Line up the visit note, the codes on your EOB or itemized statement, and your own notes. A test you never had, an exam that never happened, or a diagnosis nobody mentioned should jump out.
- [ ] **Check your insurance information at every check-in.** The claim starts at the front desk. Make sure they have your current plan, the right member ID, and the right order if you have two plans.

- [ ] **Ask, politely, when something doesn't fit.** "Can you help me understand why this visit was billed at this level?" or "I don't recognize this diagnosis; can you show me where it came from?" are fair questions. A good billing office will answer them.

The practice keeps every note, every code, and every charge for your visit, organized and searchable. When you keep your own notes, their notes, and their claims together, visit by visit, you're finally holding the same set of facts they are.

From Doug's Case Files

What the Doctors Never Saw

Years ago, I was a senior consultant for a large public hospital system. While reviewing their coding, something caught my eye that didn't add up.

The doctors were selecting one diagnosis on their screens: a perfectly reasonable, ordinary choice. But deep in the system's data files, that selection had been programmed to a different, far more serious code. That was the code that went out on the claims. The doctors had no idea. They never saw it. Every patient whose doctor picked that option walked out with a diagnosis on their record that their doctor never gave them.

I walked into the CFO's office, sat down, and said, "You've got a problem. I suggest you fix it. Today." They did, and corrected the code files before it ever became the kind of headline that other hospitals ended up in for exactly this kind of mapping error.

It was years before I fully appreciated what we'd dodged. But the lesson for patients has stayed with me: **if the doctors didn't know what was being billed under their own names, the patients certainly didn't.** The only place the truth showed up was in the claims themselves.

Other hospitals didn't catch it in time. Their stories made headlines:

- Hospital faces $8.1M suit for inflated malnutrition rates — a Baltimore hospital whose system reportedly translated "protein malnutrition" into kwashiorkor, a famine disease, on Medicare claims (Fierce Healthcare)
- Prime hospital suddenly changes billing practices of kwashiorkor — a California hospital reported to bill kwashiorkor at roughly 70 times the state average, which then stopped (Fierce Healthcare)
- Billing practices questioned at local hospitals — including a Medicare patient billed for kwashiorkor who said she never knew she'd been diagnosed with it (NBC San Diego)

These were allegations, and Prime maintained its billing was legal and accurate. But notice the pattern: in every case, the patients were the last to know.

The Bottom Line

- The claim is supposed to be a faithful translation of your medical record. If the record is wrong, the claim is wrong.
- Codes are picked by doctors in a hurry, by coders, and by software tables nobody sees, and templates and copy-paste can put things in your record that never happened.
- Upcoding, unbundling, bad modifiers, and diagnoses that don't belong are the most common problems. Most are honest mistakes. Some aren't.
- Your best defense: your own notes from every visit, the doctor's notes, and the claim, side by side.

Next chapter: the other side of the counter. Insurance companies make mistakes too.

Chapter 8: Claims Processing: The Other Side Screws Up Too

Into the Machine

Last chapter, we followed your claim out of the doctor's office. Now it lands at the insurance company.

Most people picture someone at a desk reading the claim, checking your policy, and deciding what to pay. For most routine claims, that's not what happens. The claim goes into software that checks it, prices it, applies your benefits, and pays it, often within days and often without a human being ever looking at it. The industry calls it **auto-adjudication**.

That's efficient, and most of the time it works. But software only knows what it's been told. If the doctor's contract was loaded wrong, if your coverage dates are off, if your deductible tally is wrong, or if a rule was set up incorrectly, the machine applies that mistake perfectly, claim after claim, to everyone it touches.

The provider's office makes mistakes. So does the insurer. And then the provider's office has to read the insurer's answer correctly too. This chapter covers the other side of the counter.

Inside the Insurance Company

Here's roughly what happens to your doctor's claim once the insurer receives it:

1. **Front-end checks.** Is the claim complete? Is the member ID valid? Are the codes real codes? Claims that fail are rejected before they're ever processed.
2. **Eligibility.** Were you covered on the date of service, under this plan, at this level?
3. **Edits.** The claim is run against coding rules: codes that can't be billed together, too many units, a diagnosis that doesn't support the service, a missing authorization.
4. **Pricing.** The software looks up the contract with your doctor and calculates the allowed amount for each code.
5. **Benefits.** Your plan's rules are applied: copay, deductible, coinsurance, and where you stand on your yearly limits.
6. **Coordination.** If you have other coverage on file, the insurer decides whether it's primary or secondary.

7. **Payment and explanation.** The insurer pays the provider, sends the provider the electronic 835 explaining every line, and sends you the EOB.

Seven steps, and every one runs on data someone entered: your coverage, your doctor's contract, your plan's rules, your running totals. Bad data in means a bad claim out.

How the Insurer Gets It Wrong

Error	What happened	What it can look like for you
Coverage error	Your coverage dates, plan, or dependents are wrong in the insurer's system	"Not covered on date of service" when you were
Wrong contract or network status	The doctor's contract wasn't loaded, or loaded wrong	An in-network doctor processed as out of network, or the wrong allowed amount
Wrong running totals	Your deductible or out-of-pocket tally is off	Being charged a deductible you already met, or charged after you hit your maximum
Wrong benefit applied	The claim is processed under the wrong part of your plan	A covered preventive visit charged a copay or deductible
Authorization not linked	The approval exists but isn't connected to the claim	A denial for "no authorization" when you had one
Duplicate denial	A legitimate second service or corrected claim is flagged as a repeat	A service denied as "already paid"
Coordination mix-up	Old or wrong information about your other coverage	Claims held, denied, or paid as the wrong plan
Take-backs	The insurer pays, then reverses the payment months later after an audit or correction	A balance suddenly reappearing on your statement long after you thought it was settled

Many of these get fixed when someone calls and asks. The trouble is, most people don't know anything's wrong, so nobody calls.

Then the Doctor's Office Has to Post It

When the insurer's payment comes back, someone in the doctor's billing office has to record it on your account: the payment, the contractual adjustment, and what's left for you. That step is called **payment posting**, and it's one of the most overlooked sources of bad statements.

Take the office visit from earlier chapters: the doctor charged $320, the plan allowed $145, paid $115, and your copay was $30. Here's what your account should look like, and what it looks like when one line gets missed:

	Posted correctly	Adjustment missed
Charge	$320.00	$320.00
Insurance payment	−$115.00	−$115.00
Contractual adjustment	−$175.00	not posted
Balance on your statement	**$30.00**	**$205.00**

Same visit, same EOB, and a statement for nearly seven times what you actually owe. Nothing about it looks wrong at a glance. It just says "Amount Due: $205.00."

Other posting mistakes are just as common: a payment applied to the wrong visit or the wrong family member, an adjustment and a patient balance swapped, or a payment never posted at all. You'd only catch any of them by putting the statement next to the EOB.

Decoding the Denial Codes

Every adjustment and denial on a claim comes with a standard reason code. Your EOB usually translates them into a short note at the bottom; the provider's 835 carries the raw codes. A few you'll see often:

Code	What it means
1	Applied to your deductible
2	Your coinsurance
3	Your copay

Code	What it means
45	The charge is more than the allowed amount (the contractual adjustment)
97	Already included in another service that was paid (bundled)
197	Required authorization was missing
27	Coverage had ended before the date of service
29	The claim was filed too late

The two letters that matter most. Every one of those codes travels with a two-letter group code that says *who* is responsible for that amount:

- **PR — Patient Responsibility.** This part is yours.
- **CO — Contractual Obligation.** This part belongs to the provider under their contract. **If you're seeing an in-network provider, they generally can't bill you for a CO amount.**

That second one is worth its weight in gold. If an in-network doctor's office files your claim too late and it's denied as CO-29, that's their mistake to absorb, not your bill to pay. Same for a missing authorization that was their job to get. If an amount marked CO shows up on your statement, ask the office to take it off.

What You Can Do

- [ ] **Read every EOB, especially the denials.** Look at the reason note at the bottom. "Not covered on date of service," "out of network," or "no authorization" are all worth a phone call if you know they're wrong.
- [ ] **Check the running totals on your EOB.** Most EOBs show your deductible and out-of-pocket progress. Compare them to your own tally. If theirs is lower than yours, claims are being processed against you.
- [ ] **Know who owns each dollar.** If your EOB or the office can tell you an amount is a contractual adjustment, that amount isn't yours to pay at an in-network office.
- [ ] **Line up the statement with the EOB, visit by visit.** That's the only way to catch a missed adjustment or a payment posted to the wrong account. When each EOB, each statement, and each payment sits together under the visit it belongs to, the mismatch shows itself.

- [ ] **Keep the paper trail long after you've paid.** Take-backs can happen months later. If a balance suddenly reappears, the EOB and payment record from the first time around are what settle it.

From Doug's Case Files

The Yes or No Guy

For a number of years, I contracted with a major health plan to review and make determinations on member grievances and appeals. (Yes, I was the Yes or No guy!)

There was a two-month stretch where I was busier than a raccoon attacking a garbage can, all because of a single setting in the claims system. It had processed copays for certain provider types incorrectly. Mostly, primary care visits were getting the higher specialist copay applied, though there were several other oddities mixed in. Patients who had dutifully paid the correct copay at the front desk started receiving bills from their doctors for the difference.

One setting, wrong on every claim it touched. And because the claims process is so highly automated, it was the patients who ultimately took the brunt of the error.

Why not just hit a button and reprocess all the claims? Well, welcome to the world of trying to unscramble an egg. Explaining why would be a novel all its own, so let the egg analogy stand on its own.

The Bottom Line

- Most claims are processed by software, not people, and software repeats whatever mistakes were built into it.
- Insurers get coverage, contracts, running totals, benefits, and authorizations wrong, and they sometimes take payments back months later.
- Then the doctor's office has to post the payment correctly. A single missed adjustment can turn a $30 copay into a $205 statement.
- Learn the two letters: PR is yours; CO, at an in-network office, generally isn't.

That wraps up how the money moves. Next, Part 3: reading your paperwork like a pro, starting with the EOB, line by line.

Part 3: Reading Your Paperwork Like a Pro

Chapter 9: How to Read an EOB, Line by Line

The Paper Everyone Throws Away

It arrives in a plain envelope from your insurance company. Across the top, in bold: **THIS IS NOT A BILL.** So most people do the logical thing. They toss it.

That's a mistake. The Explanation of Benefits is the single most important piece of paper in this entire process. It's the insurer's official record of what was billed in your name, what it decided, what it paid, and exactly what it says you owe. It's the answer key you'll check every statement against. And it's often the only place a wrong diagnosis, a wrong network status, or a wrong deductible tally will ever show up.

EOBs look intimidating, but they're built the same way almost everywhere. Once you know where to look, reading one takes a couple of minutes.

The Top: Who, What, When, and Where

Before you look at a single dollar, check the basics at the top of the EOB:

- **Patient.** Is it you, or the right family member? If you're the policyholder, EOBs for your spouse and kids usually come to you.
- **Member ID and plan.** Is it the plan you thought this claim went to? If you have two plans, is this the primary or the secondary?
- **Provider.** Is this the doctor or office you actually saw? Watch for names you don't recognize, like a lab or a radiologist who read your X-ray.
- **Date of service.** Were you there that day?
- **Claim number.** Write this down. It's how the insurer, the provider, and you all refer to this exact claim.
- **Network status.** Was the provider processed as in network or out of network? This one line can change everything below it.

If any of these are wrong, stop there. A claim processed for the wrong person, the wrong date, or the wrong network status is wrong all the way down.

A Sample EOB, Column by Column

Here's what the EOB for the February office visit with blood work from Chapter 5 might look like. One important warning first: there's no universal EOB. Every insurer designs its own, and the column names, their order, and even what gets lumped together vary from plan to plan.

Some of those differences cause real confusion. One EOB says "Plan Discount," another says "Not Allowed," another says "Amount Not Covered," and they can mean very different things. On some EOBs, "Not Covered" mixes the doctor's contractual write-off (which isn't yours) together with services the plan actually denied (which may be). "What You Owe" on one EOB might be called "Patient Responsibility" or "Amount You May Owe the Provider" on another. When a column's meaning isn't clear, the explanation at the bottom of the EOB, or a call to the insurer, should settle it. Never guess.

The example below uses common labels to show the information that's almost always there, somewhere.

Service	Amount billed	Plan discount	Allowed amount	Plan paid	Deductible	Copay	Coinsurance	Not covered	Your share	Remark
Office visit (99213)	$320.00	$175.00	$145.00	$115.00	$0.00	$30.00	$0.00	$0.00	$30.00	3, 45
Blood draw (36415)	$25.00	$15.00	$10.00	$0.00	$10.00	$0.00	$0.00	$0.00	$10.00	1, 45
Metabolic panel (80053)	$185.00	$75.00	$110.00	$0.00	$110.00	$0.00	$0.00	$0.00	$110.00	1, 45
Total	**$530.00**	**$265.00**	**$265.00**	**$115.00**	**$120.00**	**$30.00**	**$0.00**	**$0.00**	**$150.00**	

What each column tells you:

- **Amount billed.** The doctor's full charge, straight off their fee schedule. Mostly irrelevant to you.
- **Plan discount.** Also called "not allowed," "provider savings," or "contractual adjustment." This is the amount the in-network doctor agreed to write off. It should never end up on your statement.
- **Allowed amount.** The amount your plan's terms allow for the service, usually based on the plan's contract with the doctor. It isn't set by any law, and it's not a universal "fair price." It's simply what this plan has agreed to pay for this service, and everything below is figured from it. If the doctor is out of network, the doctor never agreed to that number, which is why balance billing happens. Medicare is the exception: its amounts

are set by federal rules. And even there, a doctor who doesn't "participate" with Medicare can charge more than Medicare's amount, up to a cap called the limiting charge.

- **Plan paid.** What the insurance company sent the doctor.
- **Deductible, copay, coinsurance.** Your share, broken into the three ways you pay it.
- **Not covered.** Anything the plan refused to pay at all. If there's a number here, the remark code explains why, and it's worth a closer look.
- **Your share.** The bottom line: what you owe this provider for this claim. This is the number your statement should match.
- **Remark.** The reason codes. Here, 3 is your copay, 1 is your deductible, and 45 is the contractual write-off.

A quick math check: allowed amount minus plan paid, plus anything not covered, should equal your share. Here, $265 − $115 = $150. If it doesn't add up, something's wrong.

The Running Totals and the Fine Print

Below the service lines, most EOBs have three more things worth your attention.

Your running totals. Usually a small box or bar showing how much of your deductible and out-of-pocket maximum you've met so far this year, for you and for the family. After the claim above, it should show $120 of the $500 deductible and $150 of the $3,000 out-of-pocket maximum. Compare it to your own totals every time. A mistake here quietly affects every claim that comes after it.

The remark code explanations. Each code in the remark column is explained at the bottom of the EOB, usually in a sentence or two. Read them, especially for anything denied or not covered. "Not covered on date of service," "provider out of network," or "authorization required" tell you exactly where to start if you think the decision is wrong.

Your appeal rights. Every EOB with a denial has to explain how to appeal it, and the deadline. For most private plans, you generally have 180 days from the denial to file an internal appeal. Don't let that clock run out while you're waiting on hold. Appeals get their own chapter later in this book.

Six Questions for Every EOB

- [ ] **Did this happen?** Right person, right provider, right date, and services you actually received.

- [ ] **Is the network status right?** If your in-network doctor was processed as out of network, call the insurer before you do anything else.
- [ ] **Do the diagnoses make sense?** If the EOB lists diagnoses, do they match what you were told? A condition you've never heard of deserves a question.
- [ ] **Does your share follow your plan's rules?** Run it through the order from Chapter 5: copay, deductible, coinsurance, capped by the out-of-pocket maximum.
- [ ] **Are the running totals right?** Compare the deductible and out-of-pocket numbers to your own.
- [ ] **Anything denied or not covered?** Read the reason, decide whether it's right, and note the appeal deadline.

Answering those six questions is fast when last month's EOBs, this month's statements, and your own running totals are all in one place. It's nearly impossible when they're scattered across envelopes, inboxes, and patient portals.

From Doug's Case Files

[Doug: a real story goes here, fully disguised. Ideal for this chapter: someone who caught an error only because they read the EOB, such as a provider they'd never seen, a wrong network status, or a deductible applied twice. Two or three short paragraphs in your voice.]

The Bottom Line

- The EOB isn't a bill, but it's the most important paper you'll get. Never throw it away.
- Check the top first: right patient, provider, date, plan, and network status.
- The allowed amount is the number that counts. The plan discount should never land on your statement.
- "Your share" is the number every statement should match.
- Check the running totals, read the remark codes, and note any appeal deadline.

Next chapter: the provider's side of the story, line by line. Why you should always ask for an itemized bill.

Chapter 10: How to Read an Itemized Bill

The Tip of the Iceberg

The statement you get in the mail is a summary. A date, a provider, a total, maybe one line that says "Professional Services." It tells you what they want from you. It doesn't tell you what you're paying for.

Behind every summary statement is an **itemized bill**: every service, every test, every supply, each on its own line, with its code, its date, its quantity, and its charge. It's the provider's version of the details, the counterpart to the EOB you learned to read in the last chapter.

Most people never see one, because most people never ask. That's a shame, because the itemized bill is where duplicate charges, services you never received, and charges that should have been included in something else stop hiding.

Rule of thumb: **never pay a balance you can't see the details of.** Ask for the itemized bill first.

A Doctor's Office Itemized Bill

Here's the itemized version of the same February office visit with blood work. The summary statement just said "Balance Due: $150.00." Here's what's behind it:

Date	Code	Description	Units	Charge	Insurance paid	Adjustment	You owe
Feb 12	99213	Office visit, established patient	1	$320.00	−$115.00	−$175.00	$30.00
Feb 12	36415	Blood draw	1	$25.00	$0.00	−$15.00	$10.00
Feb 12	80053	Comprehensive metabolic panel	1	$185.00	$0.00	−$75.00	$110.00
		Totals		**$530.00**	**−$115.00**	**−$265.00**	**$150.00**

Notice that the "blood work" is really two services: drawing the blood and running the test. That's normal. But it's exactly the kind of detail worth checking line by line. Was blood actually drawn in the office, or at an outside lab that will bill you separately? Was it

drawn once, or billed twice? Is there a line for a test you never had? On a summary statement, you'd never know.

And here's the kicker: **in some cases, the blood draw isn't allowed to be billed separately at all.** Depending on the payer's rules and what else was billed that day, it may be considered part of another service. This is exactly the kind of scenario that even trained, certified professionals get wrong, because it all comes down to the rules.

So how are you supposed to make sense of it if you've never read those rules, or don't even have access to them? How would you know what to question and what to let go? You're not expected to memorize the rulebook. But you do need to know that it exists, keep every detail organized so the right questions are easy to spot, and know when to bring in someone who reads those rules for a living.

The totals tie out: charges of $530, minus the insurance payment and the contractual adjustment, leaves $150, the same as "your share" on the EOB. When an itemized bill and an EOB agree like this, you can pay with confidence. When they don't, now you know exactly which line to ask about.

Hospital and Facility Itemized Bills

If you've had an outpatient procedure, an emergency room visit, or a hospital stay, the itemized bill from the facility looks very different. Instead of a handful of lines, it can run for pages. It's built from the hospital's chargemaster, and it often includes:

- **Revenue codes,** grouping charges by department: pharmacy, lab, radiology, operating room, recovery, emergency room, room and board.
- **Descriptions written for computers, not people,** like "SUPPLY MISC," "IV SOLN 1000ML," or "OR TIME EA 15MIN."
- **Quantities,** for every pill, every bag of IV fluid, and every 15 minutes of operating room time.
- **Supply and pharmacy charges** that can look shocking line by line, like a single tablet you could buy at the drugstore for pennies.

Don't let the length scare you off. You don't need to understand every line. You're looking for things that don't fit: something you didn't receive, something billed more than once, or a quantity that can't be right.

Red Flags to Look For

- **Duplicates.** The same code, same date, same quantity, twice. Sometimes legitimate, often not.
- **Services you never received.** A test you were told was canceled, a medication you refused, a procedure that didn't happen.
- **Wrong dates.** Charges dated before you arrived or after you left.
- **Quantities that can't be right.** Ten units of something you received once, or hours of time for a 20-minute visit.
- **Charges that should be included in something else.** Basic supplies, routine nursing care, or a blood draw that's part of a larger procedure, billed separately on top of it.
- **Room charges for the day you went home.** For a hospital stay, the day of discharge generally isn't billed as a room day.
- **Vague "miscellaneous" lines.** Anything you can't identify, ask about.
- **A total that doesn't match the EOB.** If the itemized charges match the claim but your balance doesn't match "your share," the problem is in the posting, not the services.

How to Ask for One

You're entitled to see the details of what you're being billed for. Your billing records are part of the medical record HIPAA gives you the right to access, and many states have their own laws requiring providers to give you an itemized bill when you ask.

Call the billing office, or send a written request through the patient portal or by mail. Keep it simple:

> "Please send me a fully itemized statement for account number [your account number], for services on [date]. Please include the date, the CPT or HCPCS code, the revenue code if applicable, the description, the units, and the charge for every line, along with all payments and adjustments posted to the account."

Two more things worth asking for while you're on the phone:

- **A hold on the account** while you review it, so it isn't sent to collections in the meantime. Not every office will agree, but many will.
- **The name of the person you spoke with,** the date, and a reference number if they give one.

If you asked in writing, keep a copy. If the itemized bill never arrives, that copy is your proof that you asked.

What You Can Do

- [ ] **Ask for an itemized bill for anything over a small copay.** Especially for anything involving a procedure, an ER visit, or a hospital.
- [ ] **Check each line against your own visit notes.** If you wrote down what happened at the visit, you'll know quickly whether a line belongs.
- [ ] **Match the codes to the EOB.** The codes and charges on the itemized bill should match the services on the EOB. If a line appears on one but not the other, ask why.
- [ ] **Circle what you don't recognize,** then ask about just those lines. You don't have to challenge the whole bill.
- [ ] **Save it with the visit.** An itemized bill tucked into a drawer is hard to find when a collection letter shows up six months later. Kept alongside the EOB, the statement, and your notes for that same visit, it's ready the moment you need it.

From Doug's Case Files

The $10,000 Surprise

A family had an 11-year-old boy with an eye condition that required surgery. Their insurance wouldn't cover it, because the plan only approved that surgery for children 12 and older. So they did the responsible thing: they agreed on a price with the hospital and paid it out of their own pocket before the surgery.

Several months later, they received a bill for $10,000. They lost their minds!

Two things had happened. First, a medication line totaling more than $9,000 had been billed at a quantity of 4 when it should have been 2. Double what was actually given. On a bill, and especially a hospital bill, there can be hundreds of lines or more, and many of them legitimately have a quantity greater than 1. Spotting that one wrong number is extremely hard. Only someone who has read hundreds of thousands of medical records, like a medical coder, would be likely to catch it without going insane or spending grueling hours doing so.

Second, in the time between their payment and the bill, the hospital had raised its chargemaster rate for operating room time, typically billed in quarter-hour units, and applied the new rate to their surgery. Wrongly, since they'd already agreed on a price.

These aren't rare, isolated incidents. Industry estimates have put the share of medical bills containing errors as high as 80 percent. It took someone who knew how to read every line to find both.

And then, sit down for this one: it took **two years** of fighting with the hospital to get it corrected, all while a collection agency kept calling.

The Bottom Line

- A summary statement tells you what they want. The itemized bill tells you what you're paying for.
- Doctors' itemized bills are short and readable; hospital bills are long and cryptic, but you only need to look for what doesn't fit.
- Duplicates, services never received, wrong dates, impossible quantities, and charges that should be bundled are the most common red flags.
- You have a right to the details. Ask in writing, ask for a hold while you review, and keep a copy.

Next chapter: putting it all together. The EOB and the statement, side by side, where the errors jump out.

Chapter 11: The EOB and the Statement, Side by Side

Two Documents, One Truth

You now know how to read an EOB, and how to read an itemized bill. On their own, each one tells half the story. The EOB is the insurer's version. The statement is the provider's version. They're about the same visit, and they're supposed to agree.

The magic happens when you put them side by side. That's where a missing adjustment, a payment that was never credited, or a balance billed before insurance paid stops hiding and starts jumping off the page.

This is the single most valuable skill in this entire book. Most errors that cost patients money can be caught right here, by comparing two pieces of paper you already have.

The Three-Way Match

In the billing world, checking that everything lines up is called a reconciliation. For you, it means three things side by side: the **EOB**, the **statement** (or better, the itemized bill), and **your own payment records**, like the receipt from the copay you paid at the front desk.

1. **Match the visit.** Same patient, same provider, same date of service, and if it's shown, the same claim number.
2. **Match the services.** The codes and services on the statement should be the ones on the EOB. Nothing extra, nothing missing.
3. **Match the charges.** The amount billed on each line should be the same on both.
4. **Match the insurance payment.** What the EOB says the plan paid should be credited on the statement.
5. **Match the adjustment.** The plan discount on the EOB should appear as an adjustment on the statement. If it's missing or smaller, your balance will be too high.
6. **Match your payments.** Every copay or payment you made should be credited.
7. **Match the bottom line.** The statement's balance should equal "your share" on the EOB, minus what you've already paid.

If all seven line up, pay with confidence. If any one doesn't, you've just found exactly what to ask about.

A Side-by-Side Example

You see a dermatologist about a spot on your arm. The doctor examines it and does a quick biopsy in the office. You pay the $50 specialist copay at the front desk on the way out. Your deductible was met earlier in the year, so the biopsy is covered at 80%.

A few weeks later, the statement arrives: **Balance Due: $130.00.** Here's what you see when you put it next to the EOB and your receipt:

	EOB says	Statement says	Match?
Total charges	$630.00	$630.00	✓
Plan paid	$200.00	$200.00	✓
Plan discount / adjustment	$350.00	$300.00	✗ $50 short
Your share	$80.00 ($50 copay + $30 coinsurance)		
Your payments	$50.00 copay (your receipt)	$0.00	✗ never credited
What you should owe	**$30.00**	**$130.00**	✗ $100 too high

Two separate mistakes, $50 each. The office posted only part of the contractual adjustment, and the copay you paid at the front desk never made it onto your account. Neither one is obvious from the statement alone. It just says $130. But side by side, they're impossible to miss.

This is also why your own payment records matter. The EOB can't tell you what you paid at the front desk. Only your receipt can.

Common Mismatches, and What They Usually Mean

What you see	What it usually means	What to ask
Statement balance equals the full charge	Insurance hasn't paid yet, or the claim was never sent	"Has this claim been sent to my insurance, and when?"

What you see	What it usually means	What to ask
No EOB at all for a statement you received	The claim was never filed, or was filed under the wrong plan or member ID	Call your insurer first: "Do you have a claim from this provider for this date?"
Statement balance is higher than "your share" on the EOB	A missing or partial adjustment, or a payment not credited	"Can you show me how my balance was calculated?"
A payment you made isn't shown	It was posted to the wrong visit, the wrong family member, or not at all	"I paid $__ on __; where was it applied?" Have your receipt ready.
Your share on the EOB was later changed	The claim was reprocessed or adjusted after the first EOB	Ask the insurer for the latest EOB and compare again
The EOB shows a denial marked as the provider's responsibility	The doctor's office missed something, like timely filing or an authorization	"The EOB shows this as a contractual write-off; please remove it from my balance."
A service is on the statement but not the EOB	It was never billed to insurance, or billed separately	"Was this service billed to my insurance?"
A second plan never paid	The secondary plan was never billed	"Did you send this to my secondary insurance?"

When They Don't Match

Start with the right office. If the EOB looks right but the statement doesn't, the problem is usually at the provider's billing office: posting, payments, or adjustments. If the EOB itself looks wrong, the problem is at the insurance company: network status, benefits, or running totals. Calling the wrong one first can cost you a week.

Lead with the numbers. Billing offices respond to specifics. Something like:

> "I'm calling about account [number], date of service [date]. My EOB shows my share as $80, and I paid a $50 copay at the visit. Your statement shows a balance of $130. Can you walk me through how that was calculated?"

Ask for three things before you hang up: a corrected statement, a hold on the account while it's fixed, and the name of the person you spoke with, the date, and a reference number.

Don't pay the disputed part. You can pay what you agree you owe, $30 in the example above, and note on your payment that it's for that specific visit. Hold the rest until it's corrected.

Follow up. If the corrected statement doesn't come, call again with your notes from the first call. That record is what turns "I called last month" into "I spoke with Maria on March 3, reference number 44721, and she said it would be corrected."

None of this works without the paperwork in hand. Having every EOB, statement, receipt, and call note for a visit gathered in one spot, instead of spread across a kitchen drawer, an email inbox, and three patient portals, is what makes a five-minute phone call possible.

From Doug's Case Files

Following the Trail

Remember the family with the $10,000 surprise from the last chapter? Finding the errors on that bill was only half the battle. Proving them was the other half.

In a hospital, charges don't come from one place. They're entered at different points, by different people, in different departments: the pharmacy, the operating room, the lab, the nursing floor. Each one feeds the bill. So when that medication showed up at a quantity of 4 instead of 2, the trail had to go all the way back to the pharmacy's records of what was actually dispensed, because somewhere along the way, someone at the charge entry step made a keying error.

That kind of detective work is challenging even for highly experienced professionals who know exactly where to look. The odds are stacked heavily against a patient who simply sought treatment and trusted that the bill would be right.

The Bottom Line

- The EOB is the insurer's version; the statement is the provider's. They're supposed to agree.
- Match seven things: the visit, the services, the charges, the insurance payment, the adjustment, your payments, and the bottom line.
- Your own receipts fill the one gap the EOB can't: what you paid at the front desk.

- When they don't match, call the right office, lead with the numbers, pay only what you agree you owe, and write everything down.

That wraps up Part 3. Next, Part 4: what to know before the care happens, starting with prior authorizations and referrals.

Part 4: Before the Care Happens

Chapter 12: Prior Authorizations and Referrals

Approved Doesn't Mean Paid

Your doctor wants you to get an MRI. The office says, "We need to get it authorized by your insurance first." A week later, you get a letter: **APPROVED.** You breathe a sigh of relief, get the MRI, and forget about it.

Then the EOB arrives. Denied.

How? The approval letter almost certainly said it, in small print: an authorization is not a guarantee of payment. It approves a specific service, by a specific provider, within specific dates, for a specific number of visits, assuming you're still covered and the claim matches. Change any one of those details, and the approval may not apply to what was actually done.

This chapter covers the two gatekeepers that stand between you and a lot of care, referrals and prior authorizations, and the small details that decide whether they actually protect you.

Referrals vs. Prior Authorizations

People use these words interchangeably. They're not the same thing.

	Referral	Prior authorization
What it is	Your primary care doctor's OK to see a specialist	Your insurance company's OK for a specific service before it happens
Who gives it	Your primary care doctor	Your insurance company, after reviewing the request

	Referral	Prior authorization
Common with	HMO and POS plans, and many Medicare Advantage plans	Most plans, for imaging like MRIs and CT scans, surgeries, specialty drugs, durable medical equipment, therapy, and hospital stays
What it usually specifies	The specialist, how many visits, and for how long	The exact service and codes, the provider and facility, how many units or visits, and the date range
What happens without it	The specialist visit may not be covered at all	The claim may be denied, even if the care was medically necessary

You can need both: a referral to see the orthopedist, and a prior authorization for the MRI the orthopedist orders.

What an Authorization Actually Covers

An authorization is precise, and the claim has to match it. Here's how an approved MRI can still end up denied:

The authorization says	What actually happened	Result
MRI of the lower back **without** contrast	The radiologist decided to do it **without, then with** contrast	A different code than the one approved, possibly denied
Valid **March 1 through March 31**	The first available appointment was **April 3**	Outside the approved dates, possibly denied
At **the imaging center named in the approval**	You switched to a closer imaging center	A different provider than the one approved, possibly denied
6 physical therapy visits	You needed **9**	Visits 7, 8, and 9 not covered unless the authorization is extended
For a member covered on the date of service	Your coverage changed before the appointment	Denied for eligibility, no matter what the authorization says

Remember the MRI from Chapter 3? Without contrast, with contrast, and without-then-with are three different codes. An authorization for one isn't an authorization for the others.

Each of these is fixable, often before the claim is ever sent, if someone notices. The doctor's office can usually update or extend an authorization when plans change. The trouble is that patients rarely know the details of the authorization in the first place, so nobody notices until the denial arrives.

Whose Job Is It?

Usually, the provider's. When you see in-network doctors, getting the referral or authorization is generally the ordering doctor's or the performing provider's responsibility. Their contracts with your plan typically say so.

And when they drop the ball, it's usually theirs to absorb. If an in-network provider fails to get a required authorization, the denial often comes back as a contractual obligation, the CO code from Chapter 8. That generally means they can't bill you for it. If it lands on your statement anyway, ask them to take it off.

Out of network, it may be yours. When you see an out-of-network provider, or you're on a plan that puts the responsibility on the member, you may be the one who has to get the approval. Your plan documents will say which.

Either way, it's your care. Even when it's not your job, it's your claim, your EOB, and possibly your bill. A two-minute call to confirm that an authorization exists, and what it covers, can save you months of headaches.

When the Answer Is No

A denied authorization isn't the end of the road. It's the start of a process.

- **Ask why, in writing.** The denial should state a specific reason. "Not medically necessary" usually means the plan wants more information, a trial of something cheaper first, or a different diagnosis on the request.
- **Ask your doctor for a peer-to-peer.** Many plans let your doctor talk directly with the plan's reviewing doctor. A five-minute conversation between two physicians can reverse a denial that months of paperwork wouldn't.

- **Appeal.** You have the right to appeal a denied authorization, and if your health is at serious risk, to ask for an expedited (urgent) appeal. Appeals get their own chapter later.

New rules on how long they can take. Starting in 2026, federal rules require Medicare Advantage plans, Medicaid, CHIP, and plans sold on the federal marketplace to decide most prior authorization requests within 7 calendar days, and urgent ones within 72 hours, and to give a specific reason for any denial. Employer plans aren't covered by that rule, but many states have their own timelines.

If you're waiting on an approval and the clock is running out, call the plan, ask where it stands, and write down what they tell you.

What You Can Do

- [ ] **Ask, before anything you can schedule:** "Does this need a referral or a prior authorization, and has it been approved?"
- [ ] **Get the details.** The authorization number, the approved service, the provider and location, the number of visits or units, and the start and end dates. Write them down or ask for the approval letter.
- [ ] **Check the details against your appointment.** Right place, right date range, right service. If anything changed, ask the office to update the authorization before the visit, not after.
- [ ] **Count your visits.** For physical therapy, specialist visits, and other series of appointments, keep track of how many you've used against how many were approved, and ask for an extension before you run out. Nobody else is counting on your behalf.
- [ ] **Watch the expiration date.** Authorizations expire. If your appointment gets pushed back, check that the approval still covers the new date.
- [ ] **Keep the approval with the claim.** When an EOB says "no authorization" and you can pull up the approval number, the dates, and who gave it to you in seconds, a denial like that usually gets reversed with one phone call.

From Doug's Case Files

Approved, Then Denied

I once worked for a surgeon who planned a sympathectomy, a surgery that interrupts the nerves that trigger sweating, for a patient with hyperhidrosis, or severe excessive sweating. I called the health plan for authorization, and it was not approved.

I had sent everything they asked for: the diagnosis, the patient's treatment history, and all the relevant clinical information, including proof that the first-line treatment had already been tried. (The plan required a course of Botox to fail before it would approve surgery, and it had.) After several losing battles with the nurses at the insurance plan, I had to go two rounds with a medical doctor at the health plan, and I lost the first round. Finally, we got the approval.

And yes, if you think you know what's coming, you're right. The claim submitted after the surgery was denied as "not approved." On to the appeal we went.

The time, labor, and wasted resources on all sides were simply mind-boggling. Worse yet, someone with a checklist and an attitude, who had never seen the patient, often had more say in their care than the treating physician. That's why every single step along the way is so critical to watch closely, document meticulously, and preserve.

The Bottom Line

- A referral is your doctor's OK to see a specialist; a prior authorization is your insurer's OK for a specific service.
- Approval is not a guarantee of payment. The claim has to match the authorization's service, codes, provider, dates, and visit count.
- With in-network providers, getting the approval is usually their job, and a denial for their mistake usually isn't yours to pay.
- A denial is the start of a process: ask why, ask for a peer-to-peer, and appeal if needed.
- Keep the details and count your visits. Nobody else will.

Next chapter: covered vs. not covered. How to find the real answers in your plan documents, and what "medical necessity" actually means.

Chapter 13: Covered vs. Not Covered

"Is It Covered?"

If only we each had a crystal ball!

It really doesn't matter whether you get insurance through an employer that offers a choice of several plans, or you buy it on your own. Aside from conditions you already have, the ability to predict what treatment you'll need in the future is, well... exceptional and rare.

So this really starts *before* you need care: reviewing what is and isn't covered while a condition doesn't even exist yet. Remember the 11-year-old with the eye surgery? At 12, it would have been covered. One year, and one line of fine print, made all the difference. That's why this chapter matters.

It's the most common question anyone asks about their insurance, and the answer is almost never a simple yes or no.

"Covered" doesn't mean free. A covered service can still come with a copay, a deductible, and coinsurance. "Covered" doesn't mean covered everywhere, either. It may only apply in network, with a referral, with a prior authorization, for certain diagnoses, at certain ages, or after something cheaper has been tried first.

And when someone at the insurance company tells you over the phone that something's covered, that's not a promise. The real answer lives in your plan documents, in the plan's medical policies, and in what gets decided when the claim comes in.

This chapter shows you where those answers are written down, and how to find them before the bill arrives.

Your Plan Documents

Your insurance card is a key, not a rulebook. The rules are in a stack of documents most people never open:

Document	What it tells you	Where to get it
Summary of Benefits and Coverage (SBC)	A short, standardized overview: deductibles, copays, coinsurance, out-of-pocket maximum, and examples of common costs	Your plan's website, your employer's HR or benefits office, or by calling the plan
Summary Plan Description (SPD)	The full rulebook for most employer plans: what's covered, what's excluded, how claims and appeals work	Your employer's HR office; for most employer plans, you have a legal right to a copy
Evidence of Coverage (EOC) or Certificate of Coverage	The full rulebook for Medicare Advantage and many individual plans	Your plan's website or member services
Formulary (drug list)	Which prescriptions are covered, at what tier, and with what restrictions	Your plan's website or pharmacy benefit manager
Medical or coverage policies	The plan's detailed criteria for specific services, like when an MRI, a surgery, or a therapy is considered medically necessary	Often posted publicly on the plan's website; ask member services for the policy that applies
Provider directory	Who's in network	Your plan's website, but always confirm by phone
Amendments and riders	Changes and add-ons to your plan during the year	Usually mailed or posted; easy to miss

Plan documents change, often every year. The rules that applied to your care are the ones in effect on your date of service, not today's version. That's why it pays to keep each year's documents, not just the current ones.

What "Medical Necessity" Really Means

Your doctor says you need it. Your plan says it's "not medically necessary." How can both be true?

Because "medically necessary" isn't a medical opinion. It's a contract term, and your plan defines it. Most definitions say a service has to be appropriate for your diagnosis, consistent with generally accepted standards of care, not mainly for convenience, and not more costly than an equally effective alternative.

To decide whether your care meets that definition, plans use written criteria: their own medical policies, and often commercial criteria sets that spell out exactly which symptoms, test results, and prior treatments have to be documented before a service qualifies. Medicare uses its own national and local coverage rules.

That's why the hyperhidrosis surgery in the last chapter hinged on proving that Botox had already been tried and had failed. The surgeon knew the patient needed it. The plan's criteria demanded proof, in a specific order, and even with that proof in hand, it took a fight.

Two things follow from that:

- **The documentation is everything.** A service can be truly necessary and still be denied if the record doesn't show what the criteria require. It's Chapter 7's rule again: if it isn't documented, it didn't happen.
- **The criteria can be found.** Many plans post their medical policies online. When a service is denied as not medically necessary, you can ask which policy was used, and compare it to what your doctor documented.

The Fine Print That Trips People Up

- **Exclusions.** Services the plan simply doesn't cover, no matter what: often cosmetic procedures, many weight-loss treatments, some fertility services, hearing aids, or adult dental and vision care. They're listed in the plan documents, usually in a section people skip.
- **Experimental or investigational.** Treatments the plan considers unproven, even if your doctor recommends them. This is one of the most common reasons for denials of newer treatments.
- **Age, frequency, and quantity limits.** Remember the 11-year-old in Chapter 10 whose surgery wasn't covered because the plan only approved it for ages 12 and up? Limits like that are written into plans and policies everywhere: one eye exam a year, so many therapy visits, so many pills a month.
- **Step therapy.** "Try this first." The plan requires a cheaper drug or treatment to fail before it will cover the one your doctor prescribed.

- **Preventive vs. diagnostic.** Many preventive services, like recommended screenings and vaccines, are covered with no cost to you at an in-network provider. But the same test done because of a symptom or a finding can be billed as diagnostic, with full cost sharing. Same test, different reason, different price.
- **Site of care.** Some plans cover a service at an outpatient center or in the office, but not in a more expensive hospital setting, or they pay less there.

None of this is hidden, exactly. It's just buried.

How to Find the Real Answer

Before anything you can schedule, especially anything expensive:

1. **Start with the SBC** for the big picture: is this kind of service covered at all, and what will your share look like?
2. **Check the full plan document** (the SPD or EOC) for the exact wording, especially the exclusions and limits sections.
3. **Find the medical policy** for that specific service. Search your plan's website for the service name and "medical policy" or "coverage policy," or ask member services for it.
4. **Compare the policy to your situation.** What has to be documented? What has to be tried first? Share it with your doctor's office so they know exactly what the plan will look for.
5. **Call the plan and ask specific questions,** with the service code if you have it: "Is CPT code ___ covered for diagnosis ___ under my plan, in network, and is prior authorization required?"
6. **Get it in writing, or get a reference number.** A verbal "yes, that's covered" without a name, date, and reference number is worth very little when the claim is denied.

What You Can Do

- [ ] **Get your plan documents now,** not when something goes wrong. The SBC, the full plan document, and the formulary, for every plan in your family.
- [ ] **Keep every year's version.** When a claim from last spring is denied this fall, the rules from last spring are the ones that count. Filed by plan and by year, the right version is there when you need it; tossed out each January, it's gone.
- [ ] **Read the exclusions section once.** It's usually only a few pages, and it answers more "is it covered?" questions than any phone call.

- [ ] **Ask for the medical policy behind any denial.** Then compare what it requires to what your doctor documented.
- [ ] **Never rely on "it's covered" over the phone alone.** Write down who said it, when, and the reference number.

Your insurer has your plan, every policy behind it, and every version of both at its fingertips. Having your own copies, organized and easy to search, is how you read from the same rulebook they're using.

From Doug's Case Files

[Doug: a real story goes here, fully disguised. Ideal for this chapter: a patient told "it's covered" who was denied anyway, a denial overturned because the plan's own medical policy supported the care, or a service denied under an exclusion buried in the plan documents. Two or three short paragraphs in your voice.]

The Bottom Line

- "Covered" doesn't mean free, and it doesn't mean covered everywhere, for everyone, every time.
- The real rules live in your plan documents and the plan's medical policies, not on your card or in a phone call.
- "Medically necessary" is a contract term, judged against written criteria. The documentation has to show what the criteria require.
- Exclusions, limits, step therapy, and preventive-vs-diagnostic rules cause most coverage surprises.
- Keep every year's documents, and get any "yes" in writing or with a reference number.

That wraps up Part 4. Next, Part 5: your medical record is your business, starting with what's actually in your chart.

Part 5: Your Medical Record Is Your Business

Chapter 14: What's Actually in Your Chart

Your Chart Outlives the Visit

A bill gets paid, and it's over. Your medical record never is.

Every visit adds to it. Every diagnosis, every medication, every test result, every note, and every code billed under your name. And unlike a bill, nothing in your chart quietly expires. A diagnosis entered by mistake in 2019 can still be sitting on your problem list today, read by every new doctor you see, shared with other providers, and pulled up by insurance companies deciding whether to sell you a policy.

Most people have never read their own chart. Most have no idea what's in it. And as we've seen throughout this book, what's in it isn't always true.

This part of the book is about your medical record: what's in it, how it goes wrong, why that matters long after the bill is paid, and what rights you have to see it and fix it.

What's in Your Chart

Part of the chart	What it is	Why it matters
Problem list	A running list of your diagnoses and conditions, active and resolved	The first thing most doctors look at. Anything "active" here is treated as true until someone removes it.
Past medical history	Conditions, surgeries, and hospital stays from your past	Often filled in from what you said years ago, or copied from another record
Medication list	What you're taking now, and sometimes what you used to take	Out-of-date lists cause dangerous mix-ups, and the medications themselves hint at diagnoses

Part of the chart	What it is	Why it matters
Allergies	Drugs, foods, and other things you react to	A wrong allergy can keep you from the right treatment; a missing one can hurt you
Vital signs and measurements	Height, weight, blood pressure, BMI, and other numbers	Software often calculates and flags things from these automatically
Visit notes	The doctor's written record of each visit	The basis for every code billed, and the story the next doctor reads
Test results and reports	Labs, imaging, pathology	Usually accurate, but sometimes filed to the wrong patient
After-visit summaries	The printout or portal summary you get after a visit	Often the easiest place to see the diagnoses that were recorded that day

The problem list deserves special attention. It's where a diagnosis goes to live forever unless someone deliberately takes it off. And in a busy practice, almost nobody takes anything off.

How Errors Get In

Remember the 100-pound weekend from Chapter 3? A woman weighed at 97 pounds on Monday, recorded at 198 pounds two days later, and labeled with morbid obesity on her active problem list a week after that. That one story shows almost every way a chart goes wrong:

- **A keying error.** An extra digit, a number in the wrong box, or the wrong unit.
- **Software that takes it from there.** The system calculated a body mass index from the bad number, and the diagnosis followed. No person ever made that decision.
- **The problem list that never forgets.** Once "morbid obesity" was active, it was positioned to be carried forward visit after visit.
- **Nobody looked at the patient.** A 97-pound woman, labeled morbidly obese, and no one noticed.

And there are plenty of other ways:

- **Copy-forward notes** that repeat last year's problems as if they were addressed again today.
- **"Rule out" diagnoses recorded as confirmed.** A doctor considers a condition, orders a test that comes back normal, and the condition stays on the record anyway.
- **Misheard history.** "My father had heart disease" becomes "heart disease" on your own list.
- **The wrong patient's results** filed in your chart, like the copied ultrasound in Dr. Davis's story from Chapter 7.
- **Diagnoses added for billing,** sometimes from chart reviews or home visits you barely remember, which we'll dig into in the next chapter.

None of these require anyone to do anything dishonest. They just require nobody to check.

Why It Follows You

A wrong entry in your chart doesn't stay in one place:

- **Into your future care.** Every new doctor reads the problem list and medication list first. A diagnosis you don't have can steer tests, prescriptions, and treatment decisions. An allergy that's wrong can keep you from the medication you need.
- **Into other doctors' records.** Many health systems share records electronically. An error made in one office can travel to the hospital, the specialist, and the urgent care across town.
- **Into insurance applications.** Life, disability, and long-term care insurers commonly review your medical records and prescription history before they'll sell you a policy, with your authorization. A diagnosis you never had can mean a higher premium or a flat denial, and you may never be told exactly why.
- **Into your career.** Pilots report diagnoses to the FAA for their medical certificates. Commercial truck and bus drivers need a DOT medical card. Police officers, firefighters, and military members face fitness-for-duty reviews, and security clearances can involve medical history. One wrong code can put a career on hold while you prove it's wrong.
- **Into your peace of mind.** Reading that you have a serious condition nobody ever told you about is frightening, even when it turns out to be a mistake.

That's the real cost of a chart error. Not the bill, but everything that comes after it.

How to Check Yours

1. **Log in to each patient portal** you have, one for every doctor's office and health system. Yes, all of them.
2. **Find the problem list.** It may be called "Health Summary," "Conditions," "Health Issues," or "Medical History."
3. **Read every item.** For each one, ask yourself: Do I have this? Was I ever told I have this? Is it still active, or was it resolved years ago?
4. **Check the medication and allergy lists.** Are they current? Is anything listed that you never took, or never reacted to?
5. **Skim your recent visit notes.** Federal rules now require most providers to give you electronic access to your notes, usually through the portal. Do they describe the visits you actually had?
6. **Look at your measurements.** Height, weight, blood pressure. Anything that couldn't possibly be right?
7. **Write down what's wrong,** with the date, the portal, and exactly how it appears. You'll need it to get it fixed, which is the subject of Chapter 16.

What You Can Do

- [ ] **Review your problem list once a year,** and after any hospital stay, new diagnosis, or major visit. Do the same for each family member you manage.
- [ ] **Compare diagnoses across sources.** The diagnoses on your EOBs, your after-visit summaries, and your problem list should tell the same story. A condition that shows up on a claim but that no doctor ever mentioned deserves a question.
- [ ] **Read your after-visit summary before you leave.** It's the easiest moment to catch a wrong diagnosis, while the doctor is still down the hall.
- [ ] **Keep your own health history.** Your conditions, surgeries, medications, and allergies, in your own words, kept current. When a chart doesn't match what you know, your own record is the starting point for setting it straight.
- [ ] **Save the evidence.** Screenshots or printouts of anything wrong, with the date. Portals change, and entries can quietly disappear or reappear.

Across a family, that's a lot of charts in a lot of portals. Having every diagnosis, every visit, and every claim gathered together in one place is what turns "I think something's wrong in my record" into "here's exactly what's wrong, where it came from, and when."

From Doug's Case Files

Remember the little lady who gained 100 pounds in two days? Her bills weren't the problem. Her record was.

Billing isn't the only thing you should be keeping an eye on. Be sure to read your medical records, too, so an error like hers doesn't become an unwanted surprise when you can least afford one.

The Bottom Line

- Your chart outlives every bill. Errors in it don't expire on their own.
- The problem list is where wrong diagnoses go to live forever, unless someone takes them off.
- Keying errors, software, copy-forward notes, and "rule out" diagnoses are the usual culprits.
- Chart errors can follow you into future care, other doctors' records, insurance applications, and your career.
- Read your problem list, medications, allergies, and notes at least once a year, and keep your own health history to compare against.

Next chapter: diagnoses you don't have. Risk adjustment, HCCs, and why some errors aren't accidents.

Chapter 15: Diagnoses You Don't Have

Some Errors Aren't Accidents

The last chapter was about honest mistakes: a wrong number, a copied note, a list nobody cleaned up. This chapter is about something else.

In parts of our healthcare system, **the diagnoses on your record are worth money,** sometimes a lot of it, to someone other than your doctor. The sicker you look on paper, the more certain organizations get paid. That creates a powerful incentive to find every possible diagnosis, and sometimes to find diagnoses that aren't really there.

This isn't a conspiracy theory. It's a well-documented pattern that federal auditors, the Department of Justice, and investigative journalists have spent years exposing. And the people it affects most, the patients carrying those diagnoses on their records, are usually the last to know.

How Risk Adjustment Works

Medicare Advantage plans, the private plans that replace Original Medicare for millions of people, are paid a monthly amount by the government for each member. That amount isn't the same for everyone. It's **risk adjusted**: a member who appears sicker earns the plan a bigger payment, because they're expected to cost more to care for. ACA marketplace plans and many Medicaid plans use their own versions of the same idea.

Here's how "sicker" gets measured:

1. **Diagnosis codes are collected** from your claims and records over the year.
2. **Certain diagnoses are grouped into Hierarchical Condition Categories,** or HCCs. Diabetes with complications, congestive heart failure, morbid obesity, major depression, and many other chronic conditions have them. A sore throat doesn't.
3. **Each HCC adds to a risk score,** along with your age and other factors.
4. **The higher the score, the bigger the payment** to the plan for the following year.
5. **Diagnoses have to be documented again every year.** A condition counts only if it's documented and supported in a face-to-face visit that year, which creates a yearly push to "capture" every condition again.

On its own, risk adjustment makes sense. Plans that take on sicker patients should be paid more. But it also means every HCC diagnosis on your record has a dollar value attached, and that's where the trouble starts.

Where Questionable Diagnoses Come From

- **In-home health assessments.** Many Medicare Advantage plans send a nurse practitioner or doctor to members' homes for a "wellness" or "health risk" visit. These visits can be genuinely helpful. They're also a known source of diagnoses that never show up again in any treating doctor's records, and federal auditors have flagged them repeatedly.
- **Chart reviews.** Plans hire coders to comb through members' medical records looking for diagnoses that weren't billed. Finding real, documented conditions is legitimate. Adding diagnoses the record doesn't truly support, and ignoring the ones that should be deleted, isn't.
- **The never-cleaned problem list.** A condition that resolved years ago, still sitting on the list as "active," can be picked up and counted year after year.
- **Software suggestions.** Some record systems prompt doctors with possible diagnoses to "capture." Click yes too quickly, and a suggestion becomes a diagnosis.
- **Mapping errors.** As Chapter 7 showed, a doctor can select one thing on the screen while a more serious code goes out on the claim.

The common thread: in each case, a diagnosis can end up on your record without your doctor ever actually treating you for it, and often without you ever hearing about it.

The Government Has Noticed

Over the past decade, several of the largest Medicare Advantage companies in the country have faced Department of Justice lawsuits or paid settlements over risk adjustment diagnoses. A few examples:

- In 2020, the Justice Department sued Anthem, alleging it failed to correct inaccurate diagnosis codes in its Medicare Advantage business and kept millions of dollars in improper payments as a result. (Healthcare Dive)
- In 2023, Cigna agreed to pay $172 million to resolve allegations that it submitted inaccurate diagnoses for Medicare Advantage members, many of them from in-home assessments.

- Other major plans have faced similar allegations, and federal auditors continue to flag diagnoses that appear only in home visits or chart reviews.

And it isn't only the plans. Hospitals get paid more for inpatient stays when certain serious secondary diagnoses are on the claim. That's how the kwashiorkor era happened: hospitals billing Medicare for a famine disease mostly seen in toddlers in developing countries, on elderly patients who'd never been near a famine. You read about some of those headlines at the end of Chapter 7.

The companies involved have generally denied wrongdoing. But the pattern is the same every time: the money moved, the diagnoses stayed on the records, and the patients were the last to know.

Why It Matters to You

You might think, "If the plan gets paid more, that's the government's problem, not mine." It's both.

- **It's on your record.** A diagnosis added to boost a risk score is still a diagnosis on your record, with every consequence Chapter 14 described: future care, other doctors, life and disability insurance, and careers.
- **It can shape your care.** A doctor who sees "congestive heart failure" or "major depression" on your problem list may treat you differently, prescribe differently, or order different tests.
- **You never see the money.** The extra payment goes to the plan. You get nothing but the diagnosis.
- **It costs everyone.** Improper payments drain Medicare, which is funded by taxpayers and premiums. That's your money too.

And here's the thing that should make you sit up: **you are the one person who can most easily tell whether a diagnosis is true.** A coder can't always tell from a chart. An auditor reviews a tiny sample. But you know whether anyone ever told you that you have heart failure.

How to Review Every Diagnosis Billed Under Your Name

Get the list. Federal rules require Medicare Advantage plans, Medicaid, CHIP, and plans on the federal marketplace to let you access your own claims data, usually through the plan's member website or an app you connect to it. If you have Original Medicare, your

claims are available through your online Medicare account. Your EOBs and your patient portal problem lists are other sources.

Ask one question about each diagnosis: "Do I have this?" Yes, no, or not sure. You don't need to understand the code rules. You just need to know whether anyone ever told you that you have it, or treated you for it.

Pay special attention to the serious ones: heart failure, diabetes with complications, major depression or other psychiatric conditions, morbid obesity, vascular disease, kidney disease, and malnutrition. These are the diagnoses most often tied to higher payments.

If one is wrong:

- **Ask the provider who recorded it** where it came from. Sometimes there's a real explanation you weren't told about. If there isn't, you can ask them to correct your record. Chapter 16 walks you through that request.
- **Tell your health plan in writing** that the diagnosis is inaccurate, and keep a copy.
- **If you suspect it was added deliberately,** you can report it to the HHS Office of Inspector General at 1-800-HHS-TIPS, or contact your state's Senior Medicare Patrol, which helps Medicare beneficiaries spot and report billing problems.

Frame it as a question, not an accusation. Some diagnoses that surprise you will turn out to be legitimate things nobody explained clearly. But many won't. And you'll never know which is which unless you look.

A complete list of every diagnosis billed for each family member, kept in one place and reviewed once a year, is the simplest defense there is. It's also the one thing almost nobody has.

From Doug's Case Files

It's not even a secret: there's waste and abuse in every area of healthcare, and it drives up costs, primarily for patients and the people paying premiums. All it takes is a look at the government's own measures, like the Medicare Part C (Medicare Advantage) payment error rates, and the steady stream of Justice Department actions against those responsible for the errors:

- CMS: Medicare Part C improper payment measurement
- U.S. Department of Justice: Independence Blue Cross to resolve False Claims Act allegations
- Healthcare Dive: UnitedHealth and the Senate's Medicare Advantage investigation

- Healthcare Dive: DOJ sues Anthem for millions in overpayments related to MA plan members

The Bottom Line

- In risk-adjusted plans like Medicare Advantage, diagnoses on your record are worth money to the plan.
- That creates pressure to capture every diagnosis, and sometimes diagnoses that aren't really there, through home visits, chart reviews, stale problem lists, and software prompts.
- Major plans and hospitals have faced federal lawsuits and settlements over it.
- The diagnosis stays on your record, with real consequences for you. The money never reaches you.
- You're the best judge of whether a diagnosis is true. Get your list, ask "Do I have this?", and act on the ones that are wrong.

Next chapter: your rights. The HIPAA right to see your records, and the right to ask that they be corrected.

Chapter 16: Your Rights

You Have More Power Than You Think

By now you've seen how errors get into your bills and your records. Here's the good news: federal law gives you real, enforceable rights to see what's in your records and to ask that mistakes be fixed. Most people never use them, mostly because nobody ever told them they exist.

These rights come from HIPAA, the federal privacy law. They apply to your doctors, hospitals, and other providers, and to your health plan too.

The Right to See Your Records

You have the right to see and get a copy of your **designated record set**. That's a mouthful, but it covers almost everything that matters: your medical records, **and your billing records**.

- **What you can get:** visit notes, test results, problem lists, medication lists, imaging reports, itemized bills, and payment records.
- **How fast:** a provider generally has to act on your request within 30 calendar days, with one 30-day extension allowed if they tell you why in writing.
- **In what form:** if the records are electronic and you ask for an electronic copy, they generally have to give you one.
- **What it costs:** providers can charge only a reasonable, cost-based fee for copies. They can't charge you for searching for or retrieving your records.
- **To someone else:** you can direct a provider to send a copy straight to someone you choose, like a patient advocate or another doctor.

On top of that, federal rules now require most providers to make your electronic health information, including visit notes and test results, available to you without unnecessary delay. That's why so many results show up in your patient portal before your doctor has even called you.

The Right to Ask for a Correction

If something in your record is wrong or incomplete, you have the right to ask the provider to **amend** it. That includes a wrong diagnosis, a wrong weight, a medication you never took, or an allergy you don't have.

- **Put it in writing.** Many providers require it, and you want the paper trail anyway.
- **They have 60 days to respond,** with one 30-day extension allowed if they tell you why in writing.
- **If they agree,** they have to correct the record and make reasonable efforts to let others who received the wrong information know about the change, including people you name.
- **If they say no,** they have to explain why in writing. They can refuse if they believe the record is already accurate and complete, or if they didn't create it, in which case you'll need to ask the provider who did.
- **If they refuse, you still get a say.** You can submit a written **statement of disagreement**, and the provider has to attach it to the disputed information and include it whenever that information is shared in the future.

That last right is a big one. Even when a provider won't change the record, your side of the story travels with it.

A Simple Amendment Request

> To the Health Information Management Department:
>
> I am requesting an amendment to my medical record under my rights under HIPAA.
>
> Patient name: [your name] · Date of birth: [date] · Date of service: [date]
>
> My record lists [the incorrect entry, exactly as it appears]. This is not accurate because [brief reason, such as: I have never been diagnosed with or treated for this condition / my weight on that date was 98 pounds, as recorded two days earlier].
>
> Please correct my record and notify anyone who received the incorrect information, including [names of any doctors, plans, or others]. Please respond in writing.
>
> Signed, [your name and date]

Keep a copy, and note the date you sent it. The clock starts when they receive it.

Other Rights Worth Knowing

- **An accounting of disclosures.** You can ask for a list of certain disclosures of your information made to others in the past six years.
- **Paying privately.** If you pay for a service in full out of your own pocket, you can ask the provider not to share information about that service with your health plan, and they generally have to agree.
- **Your family.** Parents and legal guardians, and others with legal authority like a healthcare power of attorney, generally have the same rights on behalf of the person they represent, with some limits for teens' sensitive care under state law.
- **Filing a complaint.** If a provider or plan won't honor these rights, you can file a complaint with the HHS Office for Civil Rights, generally within 180 days of when you knew about the problem.

What You Can Do

- [ ] **Request your full records** from any provider whose bills or records you're questioning, including billing records.
- [ ] **Ask for corrections in writing,** using the sample letter above, and calendar the 60-day deadline.
- [ ] **If you're turned down, file a statement of disagreement.** It costs nothing and it follows the record.
- [ ] **Keep every request, response, and date together.** A records request sent in March is only useful in June if you can find proof you sent it. Kept with the visit and the record it concerns, it's evidence; scattered, it's a memory.

From Doug's Case Files

[Doug: a real story goes here, fully disguised. Ideal for this chapter: a patient who got a wrong diagnosis removed through an amendment request, a provider who dragged their feet on a records request, or a statement of disagreement that made a difference. Two or three short paragraphs in your voice.]

The Bottom Line

- HIPAA gives you the right to see your medical and billing records, generally within 30 days, at a reasonable cost.

- You have the right to ask for corrections. Providers generally have 60 days to respond, and must explain any refusal in writing.
- If they refuse, your statement of disagreement must travel with the record.
- Put every request in writing, and keep copies and dates.

That wraps up Part 5. Next, Part 6: fighting back, starting with how to call your insurance company without losing your mind.

Part 6: Fighting Back

Chapter 17: Calling the Insurance Company Without Losing Your Mind

The Call Everyone Dreads

The hold music. The phone tree that doesn't have an option for your problem. The representative who reads you the same sentence three times. The promise that it'll be fixed, followed by nothing.

Most people make these calls unprepared, take no notes, and hang up with nothing but a vague memory of a conversation. Then, when the problem isn't fixed, they have to start all over again.

It doesn't have to go that way. A call to your insurance company is a business transaction, and the person who shows up prepared, asks for specific things, and writes everything down usually wins.

Before You Dial

Have these in front of you:

- Your member ID and the patient's name and date of birth
- The EOB, with the **claim number**, date of service, and provider
- The statement or itemized bill, if the problem involves one
- Your own notes on what's wrong, in one or two sentences
- Any earlier reference numbers from calls about the same problem
- Something to write with, and a quiet half hour

Know exactly what you want before you call: a claim reprocessed, a network status corrected, an authorization linked, a running total fixed, or an explanation in writing. "I want this fixed" isn't specific enough. "I want claim number ___ reprocessed as in network" is.

During the Call

- **Get their name right away,** and write it down, along with the date and time.
- **Lead with the claim number and one sentence** about what's wrong: "Claim ___ for my visit on ___ was processed as out of network, but Dr. ___ is in network."
- **Ask what they see.** Let them read you the claim. You'll often learn exactly where the error is.
- **Ask for a specific action and a timeline:** "Can you send this back for reprocessing? When should I expect a corrected EOB?"
- **Ask for a reference number** for the call before you hang up. Every time. It's the single most important thing you'll get.
- **If you're getting nowhere, ask for a supervisor,** or ask to file a formal grievance or appeal. Calmly. Polite persistence works far better than anger.
- **Repeat back what they promised,** and write it down word for word.

After the Call

- **Write a short summary right away,** while it's fresh: date, time, name, reference number, what you asked for, and what they promised, by when.
- **Put the follow-up date on your calendar.** If they said ten business days, check on day eleven.
- **When you call back, lead with your notes.** "I spoke with Chris on September 18 at 2:14 p.m., reference number ___, and was told a corrected EOB would be issued within ten business days" gets a very different response than "I called a few weeks ago."
- **If a phone call isn't working, put it in writing.** Many plans have an online message center or a mailing address for written complaints. Written requests create a record that's hard to ignore.

What You Can Do

- [ ] **Never make a call without the claim number in hand.**
- [ ] **Always get a name and a reference number,** and write down what was promised and by when.
- [ ] **Keep a running call log** for every claim: every call, every name, every reference number, and every promise, in order.

- [ ] **Escalate politely** when the first answer doesn't solve it: a supervisor, a grievance, or an appeal.

Your insurer keeps a log of every call you make, every note its representative typed, and every promise made. When your own call log sits right next to the claim it's about, you're both working from a record, instead of one side working from memory.

From Doug's Case Files

[Doug: a real story goes here, fully disguised. Ideal for this chapter: a call log or reference number that turned a dead end into a fix, or a representative's promise that was kept only because the patient wrote it down. Two or three short paragraphs in your voice.]

The Bottom Line

- Prepare before you call: claim number, EOB, and exactly what you want.
- Get a name and a reference number every time, and write down what was promised and by when.
- Follow up on the promised date, and lead with your notes.
- When the phone fails, put it in writing, and escalate politely.

Next chapter: when the answer is still no. Appeals, and how to write a letter that gets read.

Chapter 18: Appeals

"No" Is Often Just the First Answer

A denial feels final. It isn't. When your insurance company denies a claim or a service, you have the legal right to challenge that decision, and many people who appeal win. The ones who lose most often are the ones who never appeal at all.

This chapter walks you through the two levels of appeal most people have, and how to write a letter that gets taken seriously.

Level One: The Internal Appeal

An **internal appeal** asks your insurance company to take a second look at its own decision.

- **Deadline:** for most private plans, you generally have 180 days from the date of the denial notice to file. Medicare and Medicaid have their own deadlines, which will be listed on your notice.
- **How:** follow the instructions on your EOB or denial letter. Most plans accept appeals in writing, and many have an online form. Use whatever creates a record.
- **Urgent cases:** if waiting could seriously harm your health, you can ask for an **expedited** appeal, which has to be decided much faster, often within 72 hours.
- **What you can ask for:** a copy of your claim file, including the policy or criteria the plan used to deny you. Ask for it. You can't argue against a rule you haven't seen.

Level Two: External Review

If your internal appeal is denied, you can usually ask for an **external review**, where an **independent review organization**, not your insurance company, makes the decision.

- External review is generally available for denials based on medical necessity, appropriateness of care, or a treatment being called experimental, and for certain surprise billing disputes.
- The independent reviewer's decision is generally binding on the plan.
- Your denial letter has to explain how to request it, and the deadline, often four months after the final internal denial.

- Medicare has its own multi-level appeal process, and your Medicare notices explain each step.

How to Write a Letter That Gets Read

Appeal reviewers read a lot of letters. The ones that win are short, specific, and backed by evidence.

1. **Identify the claim:** patient name, member ID, claim number, date of service, and provider.
2. **Say exactly what you're appealing:** "I am appealing the denial of ___ on ___."
3. **Say why the decision is wrong,** in plain language, in a few sentences.
4. **Point to the rules:** quote your plan document or the plan's own medical policy where it supports you.
5. **Attach the evidence:** the EOB, the doctor's notes, a **letter of medical necessity from your doctor**, test results, authorization numbers, call log notes.
6. **Say exactly what you want:** "Please reprocess this claim and issue a corrected EOB."
7. **Keep a copy of everything,** and send it in a way you can prove, like certified mail or the plan's online portal with a confirmation.

The most powerful attachment is usually the letter from your doctor. A clear explanation of why this care was necessary for you, tied to the plan's own criteria, wins more appeals than anything you can write yourself.

What You Can Do

- [ ] **Note the appeal deadline the day the denial arrives,** and put it on your calendar.
- [ ] **Request your claim file and the criteria used** to deny it.
- [ ] **Ask your doctor for a letter of medical necessity,** and share the plan's criteria with them.
- [ ] **Send everything in a way you can prove,** and keep copies.
- [ ] **Don't stop at the first no.** If the internal appeal fails, ask about external review.

An appeal is only as strong as the paper behind it. The authorization number, the call log, the doctor's notes, the plan document from that year, and the EOB, gathered for that one visit and ready to attach, are what turn a frustrated letter into a winning one.

From Doug's Case Files

[Doug: a real story goes here, fully disguised. Ideal for this chapter: something from your years deciding grievances and appeals, such as what made an appeal impossible to deny, or the evidence most people forget to include. Two or three short paragraphs in your voice.]

The Bottom Line

- A denial is not the end. You have the right to an internal appeal, usually within 180 days for private plans.
- If that fails, an independent external review can overturn your plan's decision.
- Ask for your claim file and the criteria used, then answer them directly.
- Short, specific letters with strong evidence, especially a doctor's letter of medical necessity, win.

Next chapter: the No Surprises Act, and what to do when a bill comes in far above what you were told.

Chapter 19: The No Surprises Act and Dispute Resolution

A Law Built for the Bills Nobody Saw Coming

We've touched on it in earlier chapters. Here's the whole picture.

For years, one of the cruelest things in American healthcare was the surprise bill. You did everything right: you went to an in-network hospital, used an in-network surgeon, and then got a bill for thousands from an out-of-network anesthesiologist you never chose and never met. Or you were rushed by ambulance to the nearest emergency room, which happened to be out of network.

The **No Surprises Act**, in effect since 2022, put federal limits on many of those bills. It also gave uninsured and self-pay patients new tools. Here's what it does, and what it doesn't.

If You Have Insurance: Protection From Surprise Bills

In these situations, you generally can't be billed more than your normal in-network share, no matter who treated you:

- **Emergency care,** at any emergency room, in or out of network, including care to stabilize you afterward.
- **Out-of-network providers at an in-network hospital or surgery center,** like anesthesiologists, radiologists, pathologists, and assistant surgeons you didn't choose.
- **Air ambulance** services.

In those cases, your deductible and coinsurance are figured as if the provider were in network, and those payments count toward your in-network limits. The out-of-network provider and your insurer settle the rest between themselves, through a federal process called **independent dispute resolution**. You're out of the middle.

A few exceptions to know: in some non-emergency situations, an out-of-network provider can ask you to sign a form giving up these protections ahead of time. Read anything you're asked to sign, and you can refuse. And ground ambulances aren't covered by the federal law, though some states protect you.

If You're Uninsured or Paying Yourself: The Good Faith Estimate

If you don't have insurance, or you choose not to use it, providers have to give you a written **Good Faith Estimate** of expected charges. You get it when you schedule a service at least three business days in advance, or any time you ask for one.

The Right to Dispute a Bill That's Too High

If your final bill from a provider is **at least $400 more** than their Good Faith Estimate, you can challenge it through the federal **Patient-Provider Dispute Resolution** process:

- You have **120 calendar days** from the date of the bill to start.
- There's a **$25 fee**, which is credited back against the bill if you win.
- An independent dispute resolution entity reviews the estimate, the bill, and the provider's explanation, and decides what you owe.
- While the dispute is underway, the provider can't send the bill to collections, and has to pause collection activity that's already started.

Keep that Good Faith Estimate. Without it, you have nothing to compare the bill against.

Where to Get Help

If you think a bill violates these protections, contact the federal No Surprises Help Desk at 1-800-985-3059, or start at the federal medical bill rights website listed in the resources at the end of this book. Your state insurance department may also have its own protections and complaint process.

What You Can Do

- [ ] **After any emergency or hospital visit, check the network status of every provider** on your EOBs. If an out-of-network provider charged you more than your in-network share in a protected situation, push back and cite the No Surprises Act.
- [ ] **Read before you sign.** If you're asked to waive your surprise billing protections, you can say no.
- [ ] **Uninsured or self-pay? Always ask for a Good Faith Estimate,** and keep it with the visit.
- [ ] **Compare the final bill to the estimate.** At $400 or more over, calendar the 120-day deadline and start a dispute.

The estimate, the bill, the dates, and the deadline are all you need to win a dispute, as long as you can lay your hands on all four at once.

From Doug's Case Files

[Doug: a real story goes here, fully disguised. Ideal for this chapter: a surprise bill from a provider the patient never chose, or a self-pay bill that came in far above the estimate. Two or three short paragraphs in your voice.]

The Bottom Line

- The No Surprises Act generally limits you to your in-network share for emergency care, for out-of-network providers at in-network facilities, and for air ambulances.
- Uninsured and self-pay patients are entitled to a Good Faith Estimate.
- If the bill is $400 or more over the estimate, you have 120 days to dispute it, for a $25 fee.
- Read anything that asks you to give up these protections, and keep every estimate.

Next chapter: financial assistance and charity care, the help most people never ask for.

Chapter 20: Financial Assistance and Charity Care

The Help Most People Never Ask For

Here's something hospitals don't advertise nearly as loudly as they could: many of them are **required** to offer financial assistance, and many patients who qualify never apply.

If you're facing a bill you can't pay, from a hospital especially, this chapter may be worth more than every other chapter in this book combined.

Nonprofit Hospitals Have Rules to Follow

Most hospitals in the United States are nonprofits. In exchange for not paying most taxes, federal tax rules require them to:

- **Have a written financial assistance policy** that explains who qualifies for free or discounted care and how to apply.
- **Make it widely available,** on their website, in the hospital, and in plain-language summaries.
- **Limit what they charge** people who qualify to no more than the amounts generally billed to insured patients for emergency and other medically necessary care.
- **Make reasonable efforts to see whether you qualify** before taking serious collection actions, like reporting you to credit bureaus, selling your debt, or suing you. Generally, that means notifying you about the policy and giving you time to apply, typically at least 120 days from the first post-discharge bill before those actions can start.

Eligibility is usually based on household income compared to the federal poverty level, and some hospitals help people with incomes well into the middle class, especially for large bills.

It's Not Just Nonprofits

- **For-profit hospitals and doctors' offices** often have their own discount programs or will set up a payment plan, even when they aren't required to. You just have to ask.
- **Many states have their own charity care laws,** some stronger than the federal rules.

- **Medicaid can sometimes reach back.** If you might have qualified for Medicaid when you received care, many states can cover bills from up to three months before you applied.
- **Self-pay discounts** are common. If you're uninsured, ask for the self-pay rate before you pay anything else.

How to Apply

1. **Ask for the financial assistance policy and application,** by name, from the hospital's billing office or website.
2. **Ask them to put the account on hold** while your application is reviewed.
3. **Gather what they ask for,** usually proof of income and household size.
4. **Apply even if you think you won't qualify.** Thresholds are often higher than people expect, and many policies consider large bills relative to income.
5. **Apply even after the bill has gone to collections.** In many cases, you still can, and approval can reverse collection actions.
6. **Get the decision in writing.**

What You Can Do

- [ ] **Ask about financial assistance before you pay a large hospital bill,** not after you've drained your savings.
- [ ] **Ask about self-pay discounts and payment plans** at every provider, including doctors' offices.
- [ ] **Check whether you might have qualified for Medicaid** at the time of care.
- [ ] **Keep copies of everything you send,** and the date you sent it. Those dates matter if collection actions start anyway.

An application needs your bills, your income documents, and proof of what you've already paid. When all of that's already organized, applying takes an evening instead of a month.

From Doug's Case Files

[Doug: a real story goes here, fully disguised. Ideal for this chapter: a family who had a large bill reduced or forgiven through financial assistance, often after it had already gone to collections. Two or three short paragraphs in your voice.]

The Bottom Line

- Nonprofit hospitals must have a financial assistance policy, publicize it, limit charges for people who qualify, and make reasonable efforts before serious collection actions.
- Other providers often have discounts and payment plans too. You have to ask.
- Apply even if you think you won't qualify, and even if the bill is already in collections.
- Medicaid can sometimes cover bills from up to three months before you applied.

Next chapter: collections and lawsuits, what collectors can and can't do, and why you must never ignore a court summons.

Chapter 21: Collections and Lawsuits

When the Bill Goes Somewhere Else

Sometimes, despite everything, a medical bill ends up with a collection agency. Sometimes it's a bill you owe. Sometimes it's one of the errors this book has been warning you about, and a collector is calling about money you don't actually owe while you're still fighting to get it corrected. Remember the family with the $10,000 surprise, fielding collection calls for two years?

You have rights in collections, and in court. Knowing them changes the conversation.

What Collectors Can and Can't Do

The federal Fair Debt Collection Practices Act applies to third-party debt collectors, the agencies that collect on behalf of a hospital or doctor or that buy the debt.

- **They have to tell you about the debt in writing,** generally within five days of first contacting you, including the amount, who it's owed to, and how to dispute it.
- **You can dispute it.** If you dispute the debt in writing within the validation period, generally about 30 days, the collector has to stop collecting until it sends you verification.
- **They can't harass you.** No threats, no abusive language, no lying about who they are or what will happen, no threatening arrest.
- **There are limits on calls.** Generally not before 8 a.m. or after 9 p.m. your time, not at work if you tell them your employer doesn't allow it, and federal rules presume it's harassment if they call more than seven times in seven days about the same debt.
- **You can tell them to stop contacting you,** in writing. They have to stop, except to tell you about specific actions like a lawsuit. The debt doesn't go away, though.

Always dispute in writing, and keep a copy. A phone call isn't enough to trigger your rights.

Medical Debt and Your Credit

The three major credit bureaus have voluntarily changed how they handle medical collections: paid medical collections are removed, unpaid ones generally aren't reported until they're a year old, and medical collections under $500 aren't reported at all. A federal rule that would have removed most medical debt from credit reports was struck down in court in 2025, but a growing number of states have passed their own limits. Check your credit reports, which you can get for free, and dispute any medical debt that's wrong.

If You're Sued: Never Ignore It

If a hospital, doctor, or collector sues you, you'll be served with a **summons** and a **complaint**. This is the most important rule in this chapter: **never ignore a court summons.**

- **There's a deadline to respond,** often only a few weeks, and it varies by state and court. It's on the paperwork.
- **If you don't respond, you'll almost certainly lose by default,** even if you don't owe the money. A default judgment can let them garnish your wages, freeze your bank account, or put a lien on your property.
- **Respond and show up.** File your answer by the deadline and go to every court date.
- **Ask them to prove it.** Make the other side show what you owe and how they calculated it. Bring your EOBs, itemized bills, and any proof of errors, disputes, or financial assistance applications.
- **Get help.** Legal aid organizations often handle medical debt cases for free or at low cost. Many courts also offer self-help centers.
- **Be careful with old debts.** Debts have a time limit for being sued on, set by state law. In some states, even a small payment can restart that clock, so get advice before paying an old debt.

What You Can Do

- [ ] **Dispute any debt you don't recognize or don't owe in writing,** within the validation period.
- [ ] **Keep a log of every collection call:** date, time, company, and what was said.
- [ ] **Check your credit reports** and dispute medical debts that are wrong.
- [ ] **If you're sued, respond by the deadline,** and call legal aid right away.

In a dispute or a courtroom, the side with the paperwork wins. The EOBs, the itemized bill, the call log, the financial assistance application, and the dates, kept together for every visit, are your whole case.

From Doug's Case Files

[Doug: a real story goes here, fully disguised. Ideal for this chapter: a patient pursued by a collector for a bill that turned out to be wrong, or a lawsuit that was won, or lost, because of the paperwork. Two or three short paragraphs in your voice.]

The Bottom Line

- Collectors must tell you about the debt in writing, and you can dispute it in writing within about 30 days.
- They can't harass, threaten, or lie to you, and federal rules limit how often they can call.
- Paid medical collections and those under $500 shouldn't be on your credit report.
- Never ignore a court summons. Respond by the deadline, show up, make them prove it, and get help.

That wraps up Part 6. Next, Part 7: getting organized for good, starting with building your family's health financial file.

Part 7: Getting Organized for Good

Chapter 22: Building Your Family's Health Financial File

Matching Their Resources

Every chapter in this book has ended in the same place: the side with the organized paperwork wins. Your doctor's office, the hospital, and your insurance company each keep a complete, searchable file on you: every visit, every code, every dollar, every phone call, every letter. They've had decades and billions of dollars to build those systems.

This chapter is about building yours.

Everything Hangs on the Date of Service

The secret to organizing it all is the same one the professionals use: **tie everything to the visit.** Every medical event has a patient, a provider, and a date of service. Every document that follows, the claim, the EOB, the statement, the itemized bill, your payment, the call log, the appeal, connects back to that one visit.

Organize by **person, then by date of service,** and almost everything falls into place. When a question comes up about "that MRI last spring," you go straight to it, and every piece of paper about it is right there.

What to Keep

For each person	For each visit	For each plan
Insurance cards, front and back, for every plan	Your own visit notes	The Summary of Benefits and Coverage
The policyholder's details for each plan	The EOB from each plan	The full plan document
A health history in your own words: conditions, surgeries, medications, allergies	The statement and the itemized bill	The formulary

For each person	For each visit	For each plan
Legal documents: healthcare power of attorney, HIPAA authorizations, guardianship	Your receipts and payment confirmations	Each year's version, not just the current one
A yearly copy of the problem list	Authorizations and referrals	Your running deductible and out-of-pocket totals
	Call logs, letters, and appeals	
	Good Faith Estimates, if you're self-pay	

How Long to Keep It

- **Until it's fully resolved,** at a minimum: paid, matched to the EOB, and no disputes or appeals pending.
- **Anything you use for taxes:** generally at least three years after you file that year's return, and longer in some situations. Ask your tax professional.
- **Plan documents:** keep every year's version for as long as you have claims from that year.
- **Your health history and legal documents:** keep them current, permanently.

When in doubt, keep it. Paper is cheap; a missing EOB in a dispute is expensive.

A Simple Routine

- **After every visit:** jot down your notes the same day.
- **When mail arrives:** file every EOB and statement with the visit it belongs to, the day it arrives.
- **Once a month:** match statements to EOBs, check your running totals, and follow up on anything open.
- **Once a year:** review problem lists for everyone, pull together your tax records, and save the new year's plan documents.

Ten minutes after a visit and half an hour a month is all it takes to never again be the least-informed person in your own healthcare.

Paper, Folders, or Something Better

You can do all of this with folders and a filing cabinet, and many people do. The challenge is scale: several family members, several providers each, two plans, a dozen documents per visit, and years of history. Folders don't add up your deductible, flag a statement that doesn't match its EOB, remind you that an appeal deadline is coming, or find "that MRI last spring" in seconds.

That's exactly what a structured system built for this many moving parts is for. Whatever you use, the principle is the same: one place, organized by person and date of service, kept up as you go.

What You Can Do

- [ ] **Pick one place** for everything, for every family member.
- [ ] **Organize by person, then by date of service.**
- [ ] **Gather what you already have,** starting with this year.
- [ ] **Set the routine:** same-day notes, file on arrival, a monthly check, and a yearly review.

From Doug's Case Files

[Doug: a real story goes here, fully disguised. Ideal for this chapter: a family whose organized records won a dispute in minutes, or one whose missing paperwork cost them. Two or three short paragraphs in your voice.]

The Bottom Line

- The professionals keep a complete file on you. Build your own.
- Organize by person, then by date of service, and tie every document to its visit.
- Keep everything until it's resolved, tax records for at least three years, and every year's plan documents.
- A few minutes after each visit and a monthly check is all it takes.

Next chapter: medical expenses at tax time.

Chapter 23: Medical Expenses at Tax Time

Money You May Be Leaving on the Table

After a year of medical bills, there's one more place your organized records can pay off: your tax return. Depending on your situation, some of what you spent on medical care may be deductible. Many people who could benefit never find out, because pulling a year of receipts together in April feels impossible.

Tax rules are detailed and change over time, so treat this chapter as a starting point and check with a tax professional for your situation.

How the Medical Expense Deduction Works

- **You have to itemize.** Medical expenses are deducted on the itemized deductions schedule, so they only help if your total itemized deductions are more than the standard deduction.
- **Only the amount over 7.5% of your adjusted gross income counts.** If your adjusted gross income is $60,000, the first $4,500 of qualifying medical expenses don't count. Spend $6,000, and you can deduct $1,500.
- **Only what you actually paid, and weren't reimbursed for.** Anything paid by insurance, or from a tax-free HSA or FSA, doesn't count.
- **It's the year you paid that matters,** not the year you got the care. A bill for December care that you paid in January counts in January's tax year. A payment by credit card generally counts when it's charged.
- **You can include your spouse and dependents,** and in some cases others you support.

For most families, that 7.5% threshold is a high bar. But in a year with a big medical event, a long illness, or ongoing care for an aging parent, many families clear it without realizing it.

What Generally Qualifies

IRS Publication 502 is the official list. Common qualifying expenses include:

- Payments to doctors, dentists, hospitals, therapists, and other medical providers: copays, deductibles, and coinsurance you paid

- Prescription drugs and insulin
- Health insurance premiums you paid with after-tax dollars, including Medicare premiums (but not premiums your employer deducted from your pay before taxes)
- Eyeglasses, contact lenses, hearing aids, crutches, and other medical equipment and supplies
- Dental and vision care
- Transportation to and from medical care, at the IRS standard medical mileage rate for that year, plus parking and tolls
- Lodging while away from home for medical care, within limits
- Qualified long-term care services, and long-term care insurance premiums within age-based limits
- Programs to stop smoking, and weight-loss programs to treat a specific disease diagnosed by a doctor

Generally **not** deductible: cosmetic procedures, nonprescription medicines other than insulin, gym memberships for general health, and anything reimbursed by insurance or paid from an HSA or FSA.

What Your Tax Preparer Needs From You

- A list of every qualifying payment, by date, payee, amount, and family member
- Proof of payment: receipts, statements showing payments, and EOBs showing what insurance paid
- Premiums you paid yourself, and what was deducted pre-tax at work
- Mileage to and from medical appointments, with dates and destinations
- Any HSA or FSA distributions and reimbursements, so nothing is counted twice

What You Can Do

- [ ] **Track qualifying expenses as you pay them,** not in April.
- [ ] **Log medical mileage** with the date and destination of every trip.
- [ ] **Mark which payments came from an HSA or FSA** so they aren't counted twice.
- [ ] **Run the 7.5% math** before deciding it isn't worth it.
- [ ] **Hand your preparer a clean package:** totals by category and family member, with the receipts behind them.

When every payment is already recorded with its visit, the year-end package practically builds itself. That's a very different April than a shoebox full of receipts.

From Doug's Case Files

[Doug: a real story goes here, fully disguised. Ideal for this chapter: a family that discovered they qualified for the medical expense deduction after a hard year, or one that missed out because they hadn't kept records. Two or three short paragraphs in your voice.]

The Bottom Line

- Medical expenses you paid out of pocket may be deductible if you itemize, for the amount above 7.5% of your adjusted gross income.
- IRS Publication 502 lists what qualifies, including copays, prescriptions, after-tax premiums, equipment, and medical mileage.
- Nothing paid by insurance or from an HSA or FSA counts.
- Track it all year, and ask a tax professional about your situation.

Next, the final chapter: when to call in a pro.

Chapter 24: When to Call in a Pro

You Don't Have to Do This Alone

This book has given you the tools to handle a lot on your own: reading EOBs, matching statements, checking your records, making the call, and writing the appeal. Most problems can be solved that way.

But some can't. Remember the family with the $10,000 surprise? Finding a quantity error buried among hundreds of hospital charge lines, and tracing it back to the pharmacy's records, took someone who has read hundreds of thousands of medical records. That's not a failure on your part. It's what professionals are for.

Signs It's Time

- The amount is large enough that a mistake would really hurt.
- You've been denied, appealed, and been denied again.
- You're being sued, or a collector won't stop.
- The rules are beyond what you can reasonably learn: coding edits, coordination between several plans, or a hospital bill hundreds of lines long.
- A deadline is close and you're not sure what to file.
- You're simply overwhelmed, or the patient is too sick to fight.

Who Can Help

Professional	What they do	Cost
Patient advocates and medical billing advocates	Review bills and records, find errors, negotiate with providers, and handle appeals on your behalf	Usually hourly, a flat fee, or a percentage of what they save you
Certified medical coders and auditors	Read the record and the codes line by line to find what doesn't belong	Varies

Professional	What they do	Cost
Attorneys	Handle lawsuits, large disputes, and cases involving serious harm or bad faith by an insurer	Varies; some work on contingency
Legal aid organizations	Help with medical debt, collections, and lawsuits	Free or low-cost for those who qualify
Tax professionals	Sort out medical expense deductions, HSAs, and FSAs	Varies
State Health Insurance Assistance Programs (SHIP)	Unbiased counseling on Medicare choices, claims, and appeals	Free
Your state insurance department	Takes complaints about insurers and can help with some disputes	Free
Hospital financial counselors	Help you apply for financial assistance and set up payment plans	Free

How to Choose an Advocate

- **Ask about credentials and experience,** especially with coding, billing, and appeals. Look for recognized certifications.
- **Ask exactly how they charge,** and get it in writing before work starts.
- **Ask for references,** and check them.
- **Make sure they work for you,** not for a provider or insurer, and that they'll protect your privacy.
- **Sign the right authorization.** Your insurer and providers will need your written permission to talk with them about your care.

Make Their Time Count

A professional's time is what you're paying for. Hand them a shoebox, and you'll pay for hours of sorting before the real work starts. Hand them an organized file, every visit with its EOB, statement, itemized bill, payments, call log, and authorizations, and they can go straight to finding the problem. Everything you've learned in this book makes any professional you hire faster, cheaper, and more effective.

From Doug's Case Files

[Doug: a real story goes here, fully disguised. Ideal for this chapter: a case only a trained professional could have untangled, or a family who waited too long to ask for help. Two or three short paragraphs in your voice.]

The Bottom Line

- Handle what you can, and call in a pro for large amounts, repeated denials, lawsuits, complex rules, tight deadlines, or when you're simply overwhelmed.
- Patient and billing advocates, coders, attorneys, legal aid, SHIP counselors, and your state insurance department can all help.
- Ask about credentials and fees up front, and get the agreement in writing.
- An organized file makes every professional faster, cheaper, and better.

A Last Word: Make It a Fair Fight

When you started this book, the people billing you, coding your care, and deciding what gets paid had the files, the rules, the codes, and the systems. You had a stack of envelopes and a lot of questions.

Now you know that the envelope isn't a bill. You know the language, how the money moves, how to read the paperwork, where the errors hide, what your rights are, and how to fight back. You know that the side with the organized record wins.

The system isn't going to get simpler on its own. But you don't have to walk into it blind anymore.

It's time to make healthcare a fair fight.

Resources

Free tools and official sources mentioned throughout this book, grouped by what you're trying to do.

Look Up Codes and Prices

- CDC ICD-10-CM Browser Tool — free lookup for diagnosis codes
- CMS Physician Fee Schedule Look-Up Tool — Medicare rates and short descriptions for many procedure codes

Surprise Bills, Good Faith Estimates, and Billing Disputes

- CMS: Your medical bill rights — the federal No Surprises Act site
- CMS: Dispute a medical bill — the Patient-Provider Dispute Resolution process
- CMS: Understanding the Good Faith Estimate and dispute resolution process
- No Surprises Help Desk: **1-800-985-3059**

Your Records and Your Rights

- HHS: Your right to access your health information
- HHS Office for Civil Rights: File a HIPAA complaint

Appeals

- HealthCare.gov: Appealing a health plan decision — internal appeals and external review

Medicare

- Medicare.gov — your Medicare account, claims, and appeals
- State Health Insurance Assistance Programs (SHIP) — free, unbiased Medicare counseling
- Senior Medicare Patrol — help spotting and reporting Medicare billing problems

Reporting Fraud

- HHS Office of Inspector General: Report fraud — or call **1-800-HHS-TIPS**

Debt, Credit, and Legal Help

- AnnualCreditReport.com — your free credit reports
- LawHelp.org — find free legal aid in your state

Taxes

- IRS Publication 502: Medical and Dental Expenses

Further Reading

- CMS: Medicare Part C improper payment measurement
- Congressional Research Service: The Federal Patient-Provider Dispute Resolution Process