

Fees and Insurance

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I. General Introduction

The medical payment system is unnecessarily complex and bewildering. I believe that one of the primary problems in healthcare in

this country is a lack of transparency in the system that pays for care. Therefore; in this document, I will attempt to shed some light on this system.

The typical sources for healthcare bills can be from professionals, hospitals, pharmacies, and home health agencies. Professional fees include charges for office visits, x-rays in the office, surgical fees and in-hospital consultation fees. These include your medical doctor, surgeon, radiologist, pathologist and possibly an in-hospital internal medicine consultant. Then there is the hospital bill, which will include numerous items such as the room fees, orthopaedic implants, medicines, physical therapy fees and supplies.

Many insurance companies have contractual discounts with professionals and hospitals. Also, these same insurance companies have complex contractual agreements with patients (co-pay, deductible, in-network and out of network rules, out of pocket maximum). Neither patients nor physicians have much control over these contracts; insurance companies are in the position to pressure us into accepting these arrangements. Therefore, to figure out in advance what your final cost will can be is extremely complicated.

To assist you with this, we can have your speak with our insurance counselor regarding the likely cost for my orthopaedic professional services. We can also connect you with an advisor at the hospital to help you with the hospital cost estimates (By far, the largest cost item).

The services I offer as an orthopaedic surgeon and joint replacement specialist are billed as professional fees in the following categories.

- Office visits
- X-rays in office
- Injections in the office
- Surgical fees

I have entered into contracts with several insurance companies to treat patients covered by these plans for a discounted fee. I bill the insurance company my normal fee, they then disallow a certain percentage as the contractual discount which I am obligated to write off. As demands for my services increase, I will gradually drop these contracts. Generally, specialists with the least demand for their services feel compelled to sign contracts with more insurers at higher discounts.

Later in this document, I will provide detailed figures so you will be well informed about costs before you choose me as a consultant and surgeon. First; however, I will provide a quick reference section to allow you to quickly estimate what your likely costs will be, depending on your

insurance type. If you want to learn more about the whole system and how you fit into it please read the remaining sections.

II. Quick Reference for Insurance Coverage

A. "In network" insurance plans:

If I have a contract to provide my services to an insurance company at a discount, I am "in (their) network", if I do not, I am "out of (their) network".

Currently I am "in network" for the following plans:

1. Blue Cross Blue Shield SC *
2. Blue Cross Blue Shield Federal Employee Plan
3. Blue Cross Blue Shield State Health Plan (SC)
4. Blue Choice
5. Premier
6. Plan Administrators (PAI)
7. United Health Care

*Most standard Blue Cross/ Blue Shield plans from other states have a reciprocal agreement with Blue Cross of SC and are therefore also "in network". We can tell you if this applies to your Blues plan.

Until 1/1/ 08 :

8. Well Path/Coventry
9. South Care
10. First Health
11. Essex
12. Continental General
13. CCN

The hospital is financially independent from my orthopedic practice; even if I am “out of network”, the hospital may still be “in network” for your insurance plan.

If I am in network for your plan, we will request that you pay any unpaid deductible and also the surgical assistant fee (typically \$1200) in advance. Some of our contracted insurance companies don't cover surgical assistant fees. We will then bill your insurance company according to our agreed upon contract with this insurance company. After your insurance company pays me, we will square up the final bill with you.

We have a financial counselor who can assist you with any questions.

We can put you in contact with the financial counselor of the hospital, who can give you approximate charges and answer any questions about insurance coverage of the hospital bill. The hospital charges will amount to the largest portion of your final bill, by far.

There will also be much smaller bills from three other professionals involved in your case. These will all be significantly less than my fee:

- Radiologist
- Pathologist
- Anesthesiologist

When trying to come to a final conclusion about the likely final cost of the procedure, you must also consider the conditions of your contract with your insurance company. What is your copay, your percentage responsibility, your out of pocket maximum for the year? How do all of the above fees apply to the yearly out of pocket maximum? When does the “year” begin and end. Insurance companies have made this process extremely complex.

My fees are fully spelled out in section **IV E**. But if I am “in network” for your plan, as described above, a discounted rate will be applicable to you. We can tell you what this is after we see your insurance card.

B. “Out of network” plans:

I. Explanation:

If I do not have a contract with your insurance plan, I am considered “out of network”. If your insurance company does not appear on the following list, I am **NOT** in your network and this section applies to you.

“In Network” plans:

- a. Blue Cross Blue Shield SC *
- b. Blue Cross Blue Shield Federal Employee Plan
- c. Blue Cross Blue Shield State Health Plan (SC)
- d. Blue Choice
- e. Premier
- f. Plan Administrators (PAI)
- g. United Health Care

*Most standard Blue Cross/ Blue Shield plans from other states have a reciprocal agreement with Blue Cross of SC and are therefore also “in network”. We can tell you if this applies to your Blues plan.

Until 1/1/ 08 :

- h. Well Path/Coventry
- i. South Care
- j. First Health
- k. Essex
- l. Continental General
- m. CCN

If your insurance plan does **not** appear in the above list, I am “out of network” with your insurance company, and the following does apply to you. You have two payment options:

a. **Plan A:** Full prepayment

You pay the discounted surgeon plus assistant fee in advance, we bill your insurance company the full fee and refund to you any amount they pay, up to the amount you paid in advance. Any remainder we keep.

- Your advantage: you probably will pay less
- Your disadvantage: you have to pay more up front and wait until your insurance company pays for reimbursement of some of this.
- My advantage: I don't have to wait on your insurance company.
- My disadvantage: I probably will get paid less.

b. **Plan B:** Partial prepayment

You pay \$2000 in advance. We bill your insurance company the full surgeon plus assistant fee after surgery. After your insurance company pays what they see fit, we apply \$2000 to this and bill any remainder of the full fee to you.

- Your advantage: you pay less in advance, and don't need to wait on your insurance company payment.
- Your disadvantage: You probably will pay more.
- My advantage: I probably will be paid more.
- My disadvantage: I have to wait on your insurance company, and then on you, to pay the remainder.

To make a decision about which plan is best for you, you will need to determine how much of my fee your insurance company will pay. We bill an insurance company for a surgical service with a CPT code. The amount they will pay on this code is what they call an “allowable”. Often the insurance company will not provide this number to us or to you. This can be extremely frustrating. Fortunately, we sometimes have a record of what they have paid on this CPT code for other patients. If we have this number, we will tell you this, but we have no way of holding an insurance company to this number. The best thing to do is to call your company and ask

them how much of my fee they will pay for a certain CPT code. Other details you must know about your insurance contract are:

- Your co-pay for a procedure.
- Your percent responsibility for an “out of network” service.
- Your yearly out of pocket maximum.
- The month when this “year” starts and ends.
- How much of my fee is applied to this out of pocket maximum (usually the portion of the “allowable” that you, rather than your insurance company has paid).

Other than the “allowable”, all of these other numbers are relatively easy for you to obtain from your insurance company.

II. Illustration:

To illustrate the above options, I will provide a simplified sample worksheet for both options for primary hip or knee replacement procedures:

Plan A

- You pay the discounted
Fee in advance: \$6000
- The standard fee is billed
to your insurance carrier: \$8000
- Any payment up to \$6000
from your insurance carrier will
be returned to you ICP*
- Your total payment: \$6000 – ICP*
- My total receipt: \$6000→\$8000

Plan B:

- Your down payment : \$2000
- Standard fee schedule bill to your insurance carrier: \$8000
- Insurance company pays their required amount: ICP*
- Any amount less than the Remaining \$ 6000 that is not paid by the insurance company will be billed to you \$6000 – ICP*
- Any payment over \$6000 from your Insurance company will be returned to you ICP* - \$6000
- Your total payment: \$8000 – ICP*
- My total receipt : \$8000

* Insurance company Payment

III. Sample calculations:

Finally, I will provide you with a set of sample calculations for CPT code 27130 (applies to primary total hip replacement or hip surface replacement) for an “out of network” insurance plan:

- a. your co-pay amount for a procedure.
- b. your percentage responsibility for “out of network” providers.
- c. your insurance company's “allowable” amount for CPT code 27130 (hip replacement)
- d. your yearly out-of-pocket maximum per your insurance contract.

For the above categories (a-d) we will use typical numbers for a set of example calculations. You will need to find out the applicable values for your insurance contract to do your own calculation.

For example, if:

- a. = \$100
- b. = 30%
- c. = \$5500
- d. = \$5000

Then the following calculation could be done:

Plan A:

Advance discounted payment to me:	6000
My bill to your insurance co.:	8000
Your ins. co. payment to me:	$5500 - 100 - (5500 \times 0.30)$ $= 5400 - 1650$ $= 3750$
Refund from me to you:	3750
Net paid by you:	$6000 - 3750$ $= 2250$
Amount that applies to your yearly out-of-pocket maximum:	$1650 + 100$ $= 1750$
Amount that does not apply:	$2250 - 1750$ $= 500$
Your <u>true</u> out-of-pocket maximum for the year:	$5000 + 500$ $= 5500$

Plan B:

Advance partial payment to me:	2000
My bill to your insurance co.:	8000
Your ins. co. payment to me:	$5500-100-(5500 \times 0.30)$ $=5400-1650$ $=3750$
My bill to you:	$8000-2000-3750$ $=2250$
Net paid by you:	$2000+2250$ $=4250$
Amount that applies to your yearly out-of pocket maximum:	$1650+100$ $=1750$
Amount that does not apply:	$4250-1750$ $=2500$
Your <u>true</u> out-of-pocket maximum for the year:	7500

C. Government plans:

I no longer participate with Medicare, Medicaid, Tri care, or workers compensation government plans. This means that if you wish to purchase my services, we must enter into a private contract. The discounted fee schedule (see section **IV E**) applies. All fees for surgical services must be paid in advance. Office based services can be paid at the time of service. Most supplemental Medicare won't pay anything to a provider who is opted out of Medicare.

Hospital payments and other services that are not provided directly by my office will still be handled in the usual fashion by Medicare. These costs are typically the largest portion of any surgical procedure.

Example:

My fee for primary hip or knee replacement including the assistant fee:	\$6000
Hospital fees 20% of approximately \$9000:	\$1800*
Anesthesiologist, radiologist and pathologist fees:	\$1250*
Supplemental Medicare policy covers some Percentage of the \$3050 (depends on your policy):	?

*these are not under my direct control and are therefore estimates.

D. Cash paying patients:

The global prepayment option has been created to allow patients who do not have insurance, or whose insurance does not cover hip resurfacing, to purchase this service at a reasonable rate. It is a steeply discounted rate that does require payment in full of all charges prior to surgery. Only if there are unusual problems or complications requiring a significant increase in the standard care, will there be any additional charges. (This happens in less than 1% of cases).

1. Providence NE Hospital - \$16,500 (includes implant)
 2. Surgeon \$4800
 3. My assistant \$1200
 4. Anesthesiologist \$1000
 5. Pathologist \$110
 6. Radiologist \$24
- Total - \$23,634**

For your convenience, separate checks to each provider can be given to my office and we will be happy to distribute them to the various providers. The checks should be addressed to:

1. Providence Hospital
2. Midlands Orthopaedics
3. Midlands Orthopaedics
4. Critical Health Systems
5. Providence Pathology Associates PA
6. Pitts Radiological Associates

III. Types of plans

There are a wide variety of types of insurance plans. I will outline some of the more common in very general terms.

- A.** HMO - Typically the lowest cost plans. They pay doctors and hospitals the least and try to restrict your access as a patient only to doctors and hospitals who agree to very steep fee discounts. I do not contract with any of these. Often the only way to go outside of their narrow list of doctors and hospitals is to prove you need something that your list of doctors cannot provide. (e.g. hip surface replacement, a service that I provide). Frequently this requires an appeal to their review board. In my experience, this has been successful in approximately 50% of cases. If the insurance company agrees to pay, my standard fee schedule company, if you would like to take this approach. If you company denies approval, your options include changing companies (e.g. at yearly open enrollment opportunities at some employers) or take advantage of our discounted global prepayment program.
- B.** PPO – Higher cost plans that give you a lower cost when seeing doctors in their network, but for a higher cost (higher co-pay and percentage) they allow you to see doctors outside their network. I have contracts with some of these companies. Our insurance counselor can tell you what our contracted price is, if I have a contract with the company. If I do not have a contract with your PPO, I would be considered “out of network”. You would apply your deductible and out of network percent patient responsibility from your plan to my standard fee schedule. Also, most plans have an out of pocket maximum for each year. If your calculated portion of all total fees (hospital, anesthesiologist, radiologist, pathologist and surgeon) is higher than the out of pocket maximum, you should only be responsible for the “out of pocket” max. Typically, for major surgery, you will

hit your yearly out of pocket maximum. Therefore, this is most likely going to be your cost for the procedure regardless of what is charged. You may be able to use this as your bottom-line of the procedure. I am sorry this is so complicated. I did not create this system, I just struggle to work within it.

- C. Indemnity plans - Cadillac care, the most expensive. They let you go to any doctor. They usually require you to pay a co-pay and a fixed percentage of all fees up to an out of pocket maximum.
- D. Healthcare savings accounts – Coupled with a high deductible insurance plan. You pay everything up to a certain deductible, and then the insurance pays everything thereafter.
- E. Government plans (Medicare, Tricare, Worker's Comp, Medicaid) – The government dictates a very reduced fee schedule to the doctor and hospital, which is now significantly below the cost of overhead. The government then ties them up with endless bureaucratic rules and regulations. I have opted out of all these. If you are under one of these plans and still wish to purchase my services, we can enter into a private contract and you can prepay for my services personally under my discounted prepayment fee schedule. If you wish to take this option, the hospital, anesthesiology, radiology and pathology fee will still be handled in the usual fashion through the Medicare system. At this point in time, it is virtually impossible to purchase private insurance and stay out of the Medicare system, when you have turned 65. (One exception is, if you are working for a company that offers a group health plan). Many companies do offer supplemental policies to Medicare or Medicare HMO replacement policies. These still use the same physician payment schedule as standard Medicare and are therefore not acceptable to me.

IV. Explanation of Fees:

- A. “In network” vs. “out of network”
I do accept payments on your behalf from any insurance company. I will be happy to precertify the surgery and bill your insurance company. If I have a contract to provide my services to an insurance company at a discount, I am “in network”, if I do

not, I am “out of (their) network”. If I am considered “in network” for your health insurance company, please see section (b.), if I am “out of network for your health insurance plan, please see section (c.) below.

B. Standard fee schedule

- Insurance discounts may be applicable.
- This applies to all patients who are covered by insurance companies with which I have a contract. I am “in network” for these plans.
- You pay only what is required by your plan. I receive the a portion of the rest of my standard fee schedule from your insurance plan. I have agreed to provide my services to them at a discount.
- If I do not have a contract with your insurance company (I am “out of network” with your plan), you can choose to have me bill your insurance company the standard fee schedule and you agree to pay the difference later. Or you may opt for prepayment according to a reduced prepayment fee schedule. (see section III d.)

C. Discounted prepayment fee schedule

- Applies to Medicare, Medicaid, Tricare, Workers Comp. With these insurers, you are responsible for my bill and cannot submit it to your government insurance plan or to most Medicare supplemental policies.
- Any patient who has a private non-government insurance company for which I am “out of network” can choose to pay in advance according to this schedule and have us submit a bill to their insurance company for reimbursement. We will be happy to assist you with this paperwork. Any amount the insurance company reimburses us (up to the discounted prepaid rate) will be returned to you (see section III d.).

D. Payment options for patients when I am “out of network” with your insurance carrier (primary hip or knee replacement procedures):

Plan A

- You pay the discounted Fee in advance: \$6000
- The standard fee is billed to your insurance carrier: \$8000

- Any payment up to \$6000 from your insurance carrier will be returned to you
- Your total payment: \$6000 – Insurance payment
- My total receipt: \$6000 – 8000

Plan B:

- Your down payment : \$2000
- Standard fee schedule bill to your insurance carrier: \$8000
- Insurance company pays their required amount: ?
- Any amount less than the remaining \$ 6000 that is not paid by the insurance company will be billed to you
- Any payment over \$6000 from your Insurance company will be returned to you
- Your total payment: \$8000 - insurance payment
- My total receipt : \$8000

Explanation:

As you can see from the above calculations, I am willing to accept a potentially lower total payment if I am paid in advance and don't have to wait on payment from your insurance company.

You will probably pay less under plan A and will know that your payment to me for the operation will be \$6000 or less.

E. Full Fee Schedule:

(The reduced schedule is approximately a 25 % discount and applies if you choose to pay in advance)

	REDUCED	STANDARD
1. OFFICE VISIT:		
A. New problem		
1. Usual	\$150	\$188
2. Complex	200	\$250
B. Follow up visit		
1. Usual	\$50	\$63
2. Post-op (within 3 months)	\$00	\$0
3. Complex	\$100	\$125
4. Follow up with Lee Webb	\$25	\$31
C. Injections		
1. Injection or aspiration any joint	\$50	\$63
2. X-RAY		
(50 per film / \$63 per film)		
Depending on the nature of the evaluation		

and whether right and/or left sides are being checked, 3-13 films may be required (total equals number of films x \$50 per film).

Typical examples are given:

A. Hip

1. New evaluation (#3)	\$150	\$188
2. Follow up (one side #2)	\$100	\$125
3. Follow up (two sides #3)	\$150	\$188

B. Knee

1. New evaluation (one side #4)	\$200	\$250
2. New evaluation (two sides #7)	\$350	\$438
3. Long alignment (view 1 side #3)	\$150	\$188
4. Follow up (one side #3)	\$150	\$188
5. Follow up (two sides #6)	\$300	\$375

C. Others

Most of the areas evaluated require

two to three films	\$100 -150	\$125-188
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D. Retakes due to poor film quality	\$0.	\$0
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3. SURGICAL FEES

These fees will be quoted to you in advance of surgery and are firm quotes. If the operation becomes more complicated than I anticipated, no extra charges will apply. The operation types are grouped in only a few categories to keep it simple.

A. Straight-forward surgery	\$6000	\$8000
1. First time total hip replacement, total knee replacement, partial knee replacement or hip surface replacement in most cases.		
2. Simple revision surgery		
3. Hip impingement surgery		
B. Difficult surgery	\$8000	\$10,000
1. Any of the above in severely obese (BMI greater than or equal to 35%) patients or patients with underlying difficult deformities		
2. Usual revision surgery		
C. Complex surgery	\$10,000	\$12,500
1. Custom implants		
2. Extensive revisions		
D. Minor surgery		
1. Hickman catheter removal	\$1000	\$1250

2. Knee arthroscopy	\$3000	\$3750
E. Miscellaneous	\$-Variable	

F. Assistant fee – a 25% First assistant fee has already been included in the above fees

G. Complications may require repeat surgery which will be billed separately. Revision surgery is more prone to complication.

H. Treatment for an infection will often require two or more difficult and/or complex procedures.

* Some portion of surgical fees must be paid in advance. The amount depends on your insurance type and your choice of payment option. Office visits, injection, x-rays are payable at the time of service.

A. Credit card or Capital One financing accepted.

B. Late payment will result in a 20% surcharge.

V. Global Prepayment.

The global prepayment option has been created to allow patients who do not have insurance, or whose insurance does not cover hip resurfacing, to purchase this service at a reasonable rate. It is a steeply discounted rate that does require payment in full of all charges prior to surgery. Only if there are unusual problems or complications requiring a significant increase in the standard care, will there be any additional charges. (This happens in less than 1% of cases).

- Providence NE Hospital - \$16,500 (includes implant)
- Surgeon \$4800
- My assistant \$1200

- Pathologist \$110
- Anesthesiologist \$1000
- Radiologist \$150
- **Total - \$23,760**

VI. Cost of joint replacement and cost shifting by our government.

In this country the medical payment system is hopelessly complicated. No one fully understands it. We spend incredible amounts of money trying to run it and control it. If you were to enter a hospital and pay for a hip replacement privately, it would cost you \$40,000 to \$50,000. The government (Medicare and Medicaid) pays hospitals about \$8000 and surgeons \$1200 for this operation. I have determined that hospitals (using the best joint implants that cost \$6000 each) can probably provide the service at a cost of \$12,000. I would estimate \$16,500 to allow a reasonable profit. 70% of joint replacement patients are covered under Medicare or Medicaid. To make up for tremendous losses from government plans, you can see why hospitals charge so much for the insured population. I estimate my office overhead cost for providing these services is approximately \$1500. (That is if my time is given for free). From this exercise, it becomes obvious what tremendous damage the government does as it distorts the payment system. Meanwhile, if you believe the politicians, they have created a great system that does an excellent job of controlling costs. Shifting costs of government provided care to the private sector, a devious, non-transparent scheme would be a more accurate description of their system. I have had to opt out because I can no longer justify paying the government \$300 every time I treat a patient on Medicare. You might ask yourself why does any doctor or hospital still participate?

The global prepayment contract was developed to offer joint replacement to anyone who does not have insurance coverage at a reasonable cost. We can offer this because we know we will receive the full payment and we will not have to expend a large amount of resources trying to deal with insurance companies in an attempt to track down late payments. If your insurance company does not have a contract with us

or our hospital, they certainly can choose this option as well. However, they must prepay the entire amount. This offer is not valid after the fact.

VII: Contracted Insurance carriers

This is a list of health insurance companies with whom I have a contract for reduced fee schedules as of 07/28/07:

“In Network”

1. Blue Cross Blue Shield SC *
1. Blue Cross Blue Shield Federal Employee Plan
2. Blue Cross Blue Shield State Health Plan (SC)
3. Blue Choice
4. Premier
5. Plan Administrators (PAI)
6. United Health Care

Until 1/1/ 08 :

7. Well Path/Coventry
8. South Care
9. First Health
10. Essex
11. Continental General
12. CCN

*Most standard Blue Cross/ Blue Shield plans from other states have a reciprocal agreement with Blue Cross of SC and are therefore also “ in network”. We can tell you if this applies to your Blues plan.

