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HEALTH CARE NEWS

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QUEST DIAGNOSTICS AGREES TO STOP IMPROPERLY BILLING NEW YORKERS

Mr. C was puzzled by the $377.06 bill sent by his health plan's participating provider - Quest Diagnostics, Inc. - for laboratory services covered by his plan. Mr. C contacted the Health Care Bureau and a mediator discovered that Mr. C's health plan had already paid Quest. But Quest was attempting to recover from Mr. C the difference between its charges and the amount paid by the health plan, a practice called balance billing.

Complaints like this led the Health Care Bureau to investigate Quest Diagnostics, Inc., the nation's largest provider of laboratory and other diagnostic testing services. Under the terms of a settlement agreement with Attorney General Eliot Spitzer ending the investigation, Quest will stop balance billing or double billing New Yorkers for services covered by their health plans. Quest will also reimburse New Yorkers who were improperly billed and stop any current collection efforts against them.

"Consumers' out-of-pocket health care costs are high enough without being subjected to bills for procedures that are covered by their health plans," Spitzer said. "Health care providers should not put consumers in the middle of their disputes with health plans or force consumers to pay for their bureaucratic mistakes."

Under New York law and contracts that health plans have with most health care providers, a provider cannot bill a consumer who is properly enrolled in a health plan if the provider is a "participating provider" and the services received from the provider are covered under the plan. Exceptions to this prohibition are bills for deductibles, coinsurance and amounts designated by the health plan as the consumer's responsibility.

In some instances, Quest billed consumers for the entire balance when it received no response from the consumer's health plan after submitting a claim.

"With this investigation and agreement, Attorney General Spitzer has sent a strong message that health plan members will be afforded the protection guaranteed by state law and their own insurance contracts," said Elizabeth Benjamin, Supervising Attorney of the Legal Aid Society's Health Law Unit.

HEALTH CARE HELPLINE AT 1-800-771-7755 option 3

Ms. T, a Rennselaer County resident, was trying to refinance her home mortgage when she discovered $7,503.09 posted on her credit record as a bad hospital debt. Several months before, Ms. T had surgery that her HMO authorized and agreed to fully cover at its *participating* hospital. So, Ms. T was astonished when she found out that her hospital bill was left unpaid and the hospital's collection agency had obtained a judgement against her. Ms. T called the Health Care Bureau. She told a mediator that her HMO had initially denied the claim because the plan had "questions about the procedure code" the hospital had used on its claim form. The hospital then resubmitted the claim. The Helpline mediator contacted both the hospital and the HMO and found that Ms. T's HMO had failed to process the claim and the hospital had inappropriately billed Ms. T instead of pursuing the HMO. The mediator called the hospital and informed a representative that New York law prohibits it, as an HMO's *participating* provider, from billing an HMO member for a covered service. The hospital acknowledged its mistakes, agreed to remove the bad debt from Ms. T's credit record and asked the court to vacate judgment against her. When the mediator contacted Ms. T's HMO, it agreed to pay the claim in full. Since New York's Prompt Pay Law requires a health insurer to pay an undisputed claim within 45 days of receipt and include interest at the rate of 12% if the claim is paid after 45 days, the HMO added the late pay interest automatically.

Q. How can I avoid health care billing surprises?

A. Here are some tips that can help you keep track of your health insurance claims:

Check records. Make sure that your provider has all the correct billing information, including the identification or group number of your insurance plan.

Stay in contact. After receiving a bill, check with your health insurer and the provider to be sure that the claim is being processed. Write down the names of people with whom you speak, the dates and the confirmation numbers, if available.

Learn the codes. Diagnostic or procedure codes are used by providers and health plans to process claims. Always verify that the medical procedure being charged is the one that was performed.

Follow your money. Check with your plan if you think you are being billed twice or being charged more than the contracted rate between the plan and the provider.

Attorney General Eliot Spitzer's Health Care Bureau protects - and advocates for - the rights of all health care consumers statewide. The Bureau operates a Health Care Helpline that assists thousands of New Yorkers with individual problems; investigates and takes law enforcement actions to address systemic problems in the operation of the health care system; and proposes legislation to enhance health care quality and availability in New York State. **To share your views contact the Editor: Rashmi.Vasisht@oag.state.ny.us**