MICHIGAN MEDICINE
UNIVERSITY OF MICHIGAN

Questions About Healthcare Costs

Why is my healthcare so expensive?

Our method for determining our charges considers all of our costs. We compare charges using a database from comparable academic health systems.

Why do I still have to pay when Medicare already paid?

Medicare determines the payments for outpatient services. These are called APC (Ambulatory Payment Classifications). Sometimes their allowed amount is more than our charges. When this happens, we are required to bill you Medicare's specified cost share amount, even though the Medicare payment and adjustment may be equal to or greater than the charges.

Why am I being charged for more than just an HME?

A Health Maintenance Exam (HME) is for preventative care. Oftentimes, it is easier and more convenient to take care of all of your issues at that time. If you and your doctor discuss medical concerns outside of the limits of an HME, you will have an office visit charge in addition to the charge for the HME.

Why are there multiple administration charges on my statement?

The CDC (Center for Disease Control) guidelines requires Michigan Medicine to bill an administration charge for each part (called components) in the vaccine. For example, TDaP has 3 components (Tetanus, Diphtheria and Pertussis). Therefore, TDaP is billed with 3 administration charges.

I was told I am being admitted as inpatient, shouldn't the stay be covered?

Before billing, we review all charges for accuracy. The decision regarding inpatient or observation stay is based on your medical condition, your treatment needs, and guidelines determined by your insurance company. **Observation** services are processed under the outpatient portion of your health care benefits. All outpatient out of pocket expenses specific to your plan will apply.

Why do I have a balance- my insurance should cover?

This claim was submitted to your insurance company. The balance owed represents your copayment/coinsurance/deductible as determined by your plan benefits. Therefore, it is suggested that you contact your insurance plan directly if you have any additional questions. Unfortunately, we are not able to offer additional discounts or settlements of these items as this would violate our contract with your insurance plan.

Questions about specific procedures:

Why am I receiving a bill for the second time Mammogram?

According to our records, your provider ordered a **diagnostic** mammogram, which is different from a **scheduled screening** mammogram. A diagnostic mammogram uses x-ray films to examine for breast cancer after your provider found a sign or symptom of disease.

Most often, your provider will order a screening mammogram first. The Radiologist may then require additional films based on findings of the screening. This is a diagnostic procedure. When this happens the additional films are no longer considered a part of the screening and additional charges are added for diagnostic films. A non-preventive medical diagnosis is

used. Diagnostic mammograms are usually covered, but co-pays and deductibles do apply.

Why is there an extra charge on my statement if colonoscopy is covered by my insurance?

According to our records, your provider ordered a **diagnostic** colonoscopy, which is different from a **scheduled screening** colonoscopy (preventive colonoscopy). A diagnostic colonoscopy is usually ordered either as a follow-up from findings on a screening colonoscopy, or from specific symptoms you report to your provider. Unlike screening colonoscopies, diagnostic colonoscopies are subject to deductible, co-payment and/or coinsurance.

Why is there an additional charge for a pathologist (colonoscopy)?

During the colonoscopy procedure if your provider performs a biopsy, it is reviewed by a pathologist. This may add an out of pocket cost.