PedsOne
Pediatric Business Specialists

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The Dreaded Frequent Parent Complaints in Pediatric Billing

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Section 1

Understanding patient responsibility

The Dreaded Frequent Parent Complaints in Pediatric Billing

Misconception of Insurance Coverage

Patients often assume that having insurance means all medical expenses are fully covered, without understanding deductibles, copays, and coverage limitations.

Lack of Understanding of Insurance Plans

Many patients struggle to comprehend the intricacies of their insurance plans, including what services are covered, in-network vs. out-of-network providers, and pre-authorization requirements.

Unexpected Out-of-Pocket Costs

Patients may be caught off guard by unexpected out-of-pocket expenses, such as high deductibles or non-covered services, leading to frustration and dissatisfaction.

To address these concerns, it's crucial to educate patients on the specifics of their insurance plans, coverage details, and potential out-of-pocket costs during the initial consultation, fostering transparency and managing expectations.

Potential Out-of-Pocket Expenses in Pediatric Billing

Copay

Coinsurance

Deductible

Understand these potential costs to avoid surprise medical bills during routine check-ups.

Understanding Cost-Sharing Concepts

Copay

A fixed amount you pay for a covered healthcare service, such as a doctor's visit or prescription medication. For example, you might have a $20 copay for a visit to your child's pediatrician.

Co-Insurance

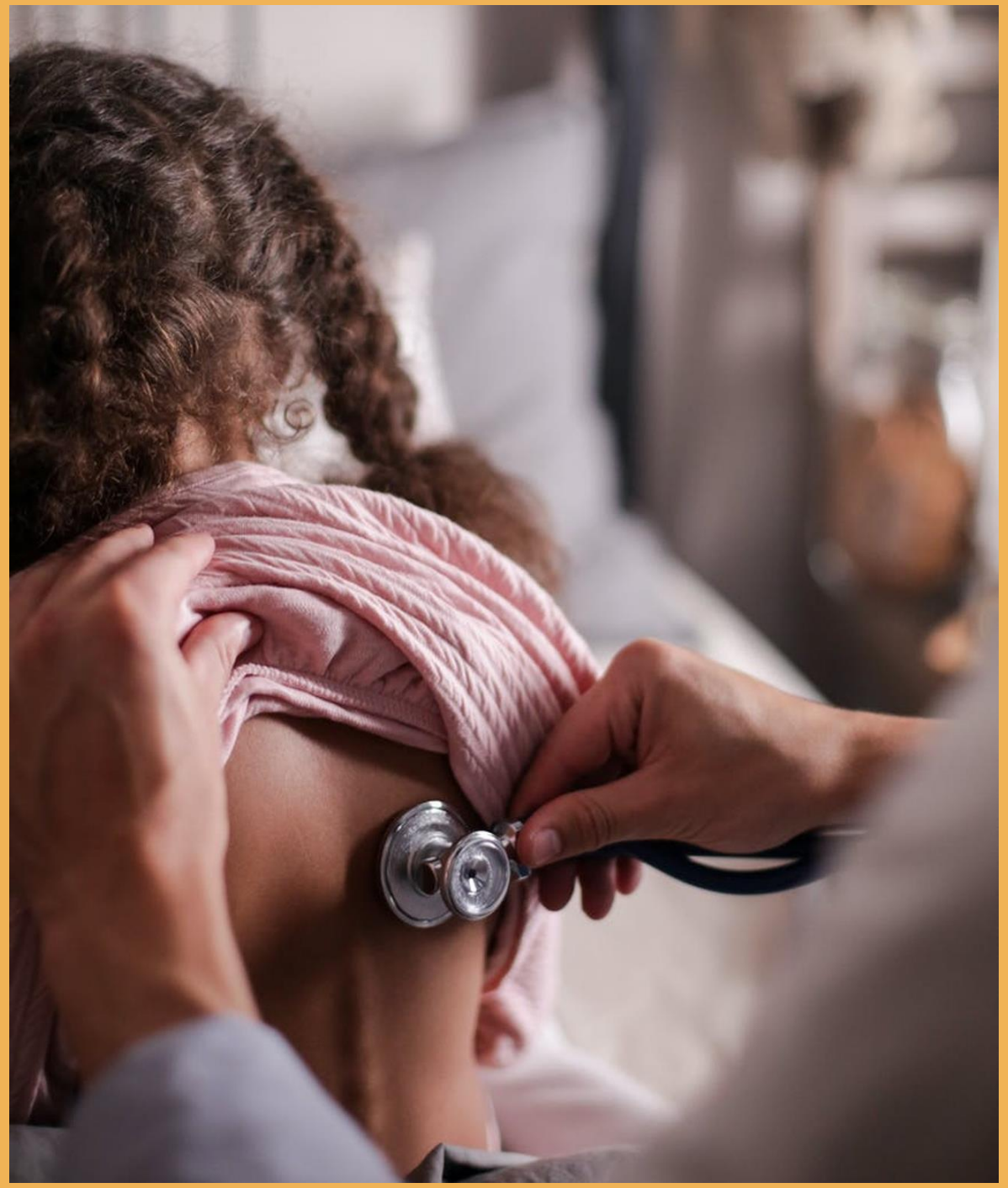
The percentage of costs you pay for a covered healthcare service after meeting your deductible. For instance, with a 20% co-insurance, you would pay 20% of the allowed amount for a procedure, and your insurance would cover the remaining 80%.

Deductible

The amount you pay out-of-pocket for covered healthcare services before your insurance plan starts to pay. For example, if your deductible is $1,000, you would need to pay the first $1,000 of covered services before your insurance kicks in.

Annual Out-of-Pocket Maximum

The most you'll have to pay in a year for covered services. Once you reach this limit, your insurance plan will cover 100% of the allowed amount for covered services for the rest of the plan year.



Section 2

Acute During a Well

The Dreaded Frequent Parent Complaints in Pediatric Billing: Balances for Annual Check-ups

Confusion over insurance coverage

Parents often misunderstand what services are covered under their insurance plan, leading to frustration when copays are required.

Perception of unnecessary costs

Some parents view annual check-ups as routine and may question the need for copays, seeing them as an unnecessary expense.

Lack of financial preparedness

Unexpected copays can strain household budgets, especially for families living paycheck to paycheck.

Addressing these concerns through clear communication and flexible payment options can help mitigate frustrations and improve patient satisfaction.

Balances During Well Checks

Patient responsibility charged for well visits

Parents may be upset to find copays, co-insurances or deductibles charged for routine well child exams they expected to be fully covered.

Insurance plan details

Well visit copays may be allowed by the patient's insurance plan contract.

Coding differences

Billing codes used for sick vs well checks may result in different copays.

While unexpected copays are frustrating, verifying coding and insurance details can explain charges.

Attention Patients and Families:

If during a routine preventative visit, you and/or your provider include management of your existing and/or any new medical problems your insurance will be billed for a separate office visit. The additional office visit charge may not be considered part of the annual check-up. Depending on your insurance benefits you may be subject to a copay, co-insurance, or a deductible for this service.

Section 3

Patient responsibility for screenings

The Dreaded Frequent Parent Complaints in Pediatric Billing: Misunderstanding of Annual Check-up Coverage

Assumed vs Actual Coverage

Patients often expect vision and hearing screenings to be covered under annual check-ups, leading to frustration when they are not.

Lack of Communication

Miscommunication or inadequate explanation about covered services during annual check-ups can contribute to patient frustration.

Limited Understanding

Some patients may have a limited understanding of insurance coverage and what constitutes an annual check-up, leading to unrealistic expectations.

Clear communication about covered services and managing patient expectations can mitigate frustration and enhance overall patient satisfaction.

Common codes that result in patient balances

Hearing Screenings

Vision Screenings

Oral Health & Flouride Treatment

Health Risk Assessments And Screenings

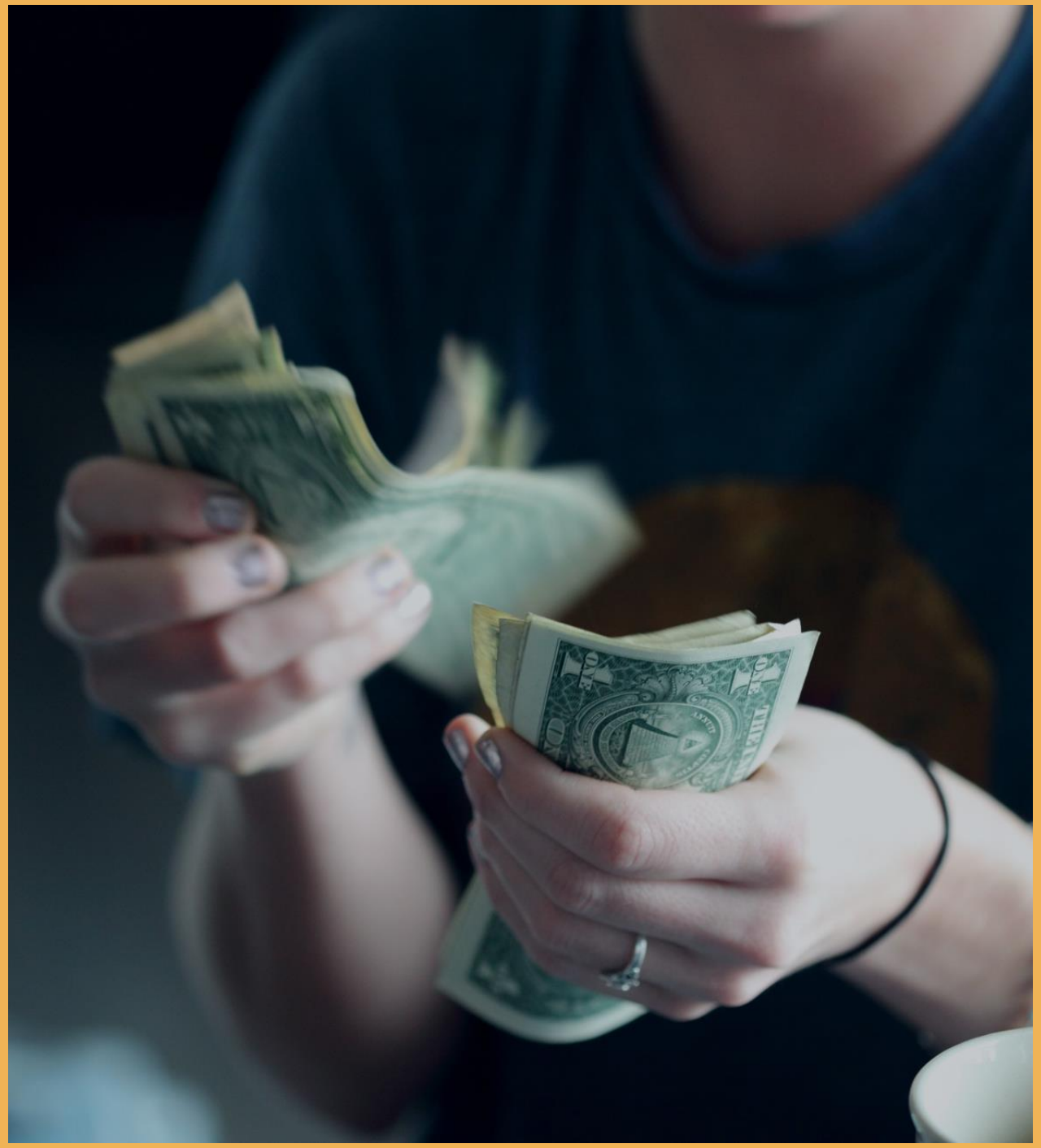
Clear communication, accurate coding, and proper verification can help mitigate patient balances during routine pediatric visits.

Well Child Acknowledgment

Thank you for bringing your child in for a well visit today. Our office **requires** regular well visits (also known as preventive exams or physicals) per the AAP guidelines. We are providing this document to help you understand the difference between what is covered within a well visit and what is not. This form is simply a way to be as transparent as possible about what services we provide during each well check. We follow evidence based medicine using Bright Futures Guidelines.

Screening – During well visits, we perform recommended screenings appropriate to age and seek to uncover any conditions that may lead to sub-optimal health in years to come. ***In our experience, some insurance plans cover these screenings and cover the costs, some recommend the screenings but push costs to patient deductible/co-insurance, and some completely ignore the screening and not cover at all. We do not know in advance what will and will not be covered.*** 90% of the time, these screening tools are covered. It is your responsibility to understand what screening services are covered by your individualized insurance plan.

Screening	CPT Code
Edinburgh PostPartum Screening (every well check through 6 months)*	96161
Ages & Stages Questionnaire (Development screening) *	96110
MCHAT (Modified Checklist for Autism in Toddlers) (18mos, 2 years)*	96110
GoCheckKids vision test * ***(May not covered by Insurance)*** (WCC at 6 months until they can use the chart)	99174
Lead & TB Exposure Questionnaire (6mos, 9mos, 12mos, 18 mos, yearly from 2 years)	96160
Dental Evaluation & Fluoride Protection(until dentist is established) (6mos and 9mos even with no teeth)	99429, 99188
Hearing and Vision Screening (yearly starting at 4 years)*	92551, 99173
PHQ-9 Depression Screen (yearly starting at 11 years)*	96127
CRAFFT Substance Abuse Questionnaire (yearly starting at 11 years)*	96160



Section 4

Self Pay balances

The Dreaded Frequent Parent Complaints in Pediatric Billing: Unexpected Charges After Self-Pay

Inadequate Explanation of Charges

Patients often feel misled when additional charges appear on a bill after being told they paid in full, leading to frustration and mistrust.

Lack of Transparency

Failing to clearly communicate all potential costs upfront can make patients feel blindsided by unexpected charges, eroding trust in the healthcare provider.

Billing Inaccuracies

Errors or discrepancies in billing can result in additional charges that patients were not prepared for, leading to confusion and dissatisfaction.

Ensuring clear communication, transparency, and accuracy in billing practices is crucial to maintaining patient trust and satisfaction.

Comprehensive Check-Out and Documentation for Self-Pay Patients

Verify payment at check-out

Ensure all self-pay patients settle their outstanding balances before leaving the facility.

Thorough documentation

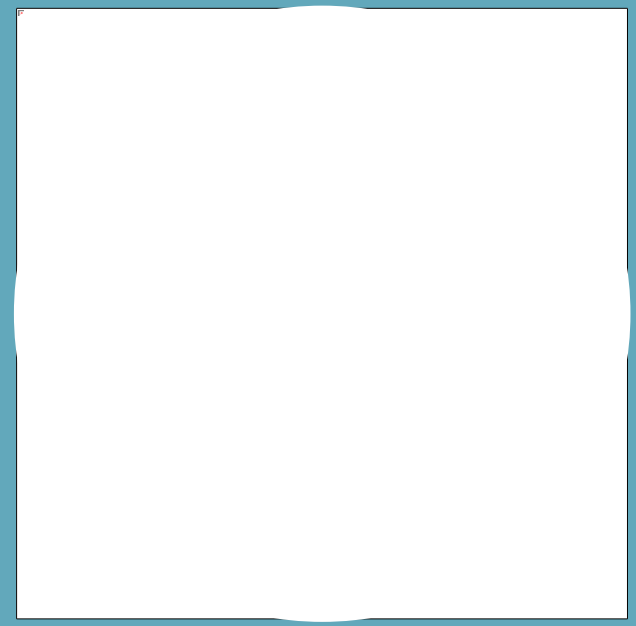
Meticulously record all services rendered, procedures performed, and materials used during the visit.

Prevent revenue leakage

Diligently capture and bill for all chargeable components of the visit to avoid financial losses.

Implementing these measures will help minimize billing issues, improve revenue capture, and mitigate frequent parent complaints related to pediatric billing.

Self Pay Policy



* Everyone should be charged the same
* You can discount after the fact
* Make sure you're in compliance with your medicaid guidelines
* Do not charge more for a vaccine admin that what your state medicaid allows
* Have a clear, formal written policy
* Decide if you're only going to allow a self pay discount if it's paid at time of service

Section 5

Out of network

The Dreaded Frequent Parent Complaints in Pediatric Billing: Unexpected Out-of-Network Charges

Unexpected Out-of-Network Charges

Patients are surprised when billed for higher costs due to receiving care from a provider not covered by their insurance plan.

Lack of Transparency

Insufficient communication about in-network vs. out-of-network status leads to confusion and frustration for families.

Financial Strain

Unanticipated medical expenses can cause significant financial hardship for families with limited resources.

Ensuring clear communication about provider networks and costs upfront can help alleviate frustration and improve patient satisfaction.

Avoiding Out-of-Network Bills for Families

Provide the NPI (National Provider Identifier)

Give parents the office or provider's NPI so they can proactively check if it's in-network with their insurance plan.

Encourage insurance verification

Advise parents to call their insurance company and verify if the provider or office is in-network to avoid out-of-network bills.

Explain out-of-network costs

Inform parents about potential higher out-of-pocket costs if the provider or office is out-of-network with their insurance plan.

By following these steps, parents can take proactive measures to avoid unexpected out-of-network bills and make informed decisions regarding their healthcare provider choices.

Next steps

1. Offer a payment plan
2. Decide if you are willing to do discount
3. Let the family know that they will have to find a provider in-network or come back as self pay
4. Assist with the appeals process if family believes the visit should be covered

Section 6

"The doctor only saw me for 5 minutes"

The Dreaded Frequent Parent Complaints in Pediatric Billing: Perception of High Costs vs. Time Spent

Patients feel undervalued

The patients may feel that the doctor did not spend enough time addressing their concerns, leading to a perception that the medical bill is too high for the service received.

Lack of communication

Inadequate communication between the doctor and the patient can contribute to misunderstandings about the scope of the medical visit, leading to a disconnect between expectations and the actual services provided.

Unclear billing practices

Patients may not fully understand the billing process and the various components that contribute to the overall medical bill, making it challenging to reconcile the perceived value with the cost.

Addressing these concerns through better communication, setting realistic expectations, and providing transparent billing explanations can help mitigate this common complaint.

Perceived Short Visit Time

Visit Duration	Average Perceived Cost
<10 minutes	$75
10-15 minutes	$115
15-20 minutes	$150

*Numbers are fictional and meant to illustrate the perception of low value for short visit times.

Understanding the Scope of an Office Visit

Explain that the office visit encompasses more than just the face-to-face time with the doctor, including preparation, review of records, and follow-up documentation.

Use visuals or diagrams to depict the various steps and activities involved in a typical office visit, highlighting the time and effort dedicated to each stage.

Explain that the billing reflects the overall service provided, not just the time spent in the examination room. Share industry standards or guidelines that support this practice.

Acknowledge and address common misunderstandings or complaints from parents regarding the perceived discrepancy between the time spent with the doctor and the charges.

Emphasize the practice's commitment to transparency and open communication about billing practices, encouraging patients to ask questions or seek clarification if needed.

Section 7

After Hours/Weekend Codes

The Dreaded Frequent Parent Complaints in Pediatric Billing: After-Hours Charges

Extra Charges for After-Hours Services

Parents are frustrated about being charged an additional fee (code 99051) for medical services provided outside of regular business hours or on weekends.

Lack of Clear Communication

Inadequate explanation from healthcare providers about the necessity and purpose of these additional charges can lead to confusion and dissatisfaction among parents.

Financial Burden

For families with limited financial resources, these unexpected fees can pose a significant burden and create frustration with the healthcare system.

Addressing these concerns through transparent communication, providing clear explanations, and considering financial assistance options can improve patient satisfaction and build trust with parents.

Understanding the After-Hours Code

After-hours code for reduced fees

The after-hours code notifies the insurance company that the child was seen outside regular office hours, resulting in lower fees compared to an urgent care or emergency department visit.

Cost-effective healthcare option

By utilizing the after-hours code, parents can receive timely medical attention for their child at a reduced cost, avoiding the higher fees associated with urgent care or emergency facilities.

Convenient and accessible care

The after-hours service provides families with a convenient and accessible option for medical care during non-traditional hours, without compromising quality or incurring excessive costs.

The after-hours code is a valuable resource for parents, offering cost-effective and accessible healthcare for their children outside regular office hours, while minimizing the financial burden of urgent care or emergency department visits.

Explaining After-Hours Visit Fees

Explain extra fees for after-hours visits

Clarify that 99051 or 99050 CPT codes will be billed to insurance for visits on holidays, weekends, or after regular office hours.

Justify the additional charges

These fees cover the added costs for staffing and keeping the office open during non-business hours for patient convenience.

Provide cost transparency

Disclose potential out-of-pocket expenses for these after-hours visits, depending on individual insurance coverage.

Being upfront about after-hours billing policies helps manage parent expectations and minimizes complaints.

Section 8

General Complaints

Typical Parent Complaints

Billing takes too long

Parents often complain about delayed billing and slow turnaround times for claims processing

Errors and mistakes

Incorrect patient information, wrong dates of service, and billing the wrong insurance plan are common errors parents see on bills

Lack of price transparency

Parents want clear upfront estimates of costs and are frustrated by surprise bills or unclear pricing

Difficulty understanding bills

Medical billing terminology, codes, and paperwork are confusing for parents trying to reconcile bills

Addressing these common complaints can improve patient satisfaction and speed up payments.

Strategies for Improving Patient Experience

- **Simplify Bills**
  Break down charges into easy to understand line items with clear descriptions of each service.
- **Offer Payment Plans**
  Allow flexible payment options to ease financial burden.
- **Provide Billing Education**
  Explain common charges and insurance processes so patients know what to expect.
- **Improve Price Transparency**
  Clearly communicate fees upfront so there are no surprises.
- **Address Questions Quickly**
  Have fast response times and staff dedicated to handling billing inquiries.
- **Survey Patient Feedback**
  Regularly collect input on billing experience to identify areas for improvement.

Have more questions?

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