Outpatient Facility Fees – Expanded Notice
(House Bill 1149/Senate Bill 1103)

CONSUMER STORIES

Radiology Services

- I had an MRI of my thoracic spine at the University of Maryland Medical Center hospital on 2/11/22. I'm an employee of the University of Maryland Medical Center and made my appointment at the hospital for this reason. I did not expect a $632.44 charge and at no point was I given an estimate of the charges. My insurance only paid $131.96 from the original balance of $764.40. The insurance plan I was under is called the Bronze plan and comes with a deductible. On 5/1/22, I upgraded my health insurance to the Gold plan, since I became a full time employee. Had I known that I would be paying $632.44 out of pocket, I would have waited until after 5/1, which is what I did for my cervical MRI (I needed both thoracic and cervical). Even though I know that my insurance at the time carried a deductible, I did not expect this high amount and was not provided a facility fee estimate in writing nor through my patient portal. The fee was in addition to and separate from the physician's fee bill for $125.97.

- I had inquired on the cost of the service on the day performed; however, I was not directed toward any resources, nor was I given any physical copy or verbal estimate of the fee (or an alternative that does not charge hospital facility fees). The business office told me that they did not need to provide a fee estimate and referenced Maryland SB 632 on their website. They verbally alluded multiple times that because it was a "Radiology fee" not a "hospital outpatient facility fee" it did not need to be disclosed at all. I have disputed this with them, but they have not provided an explanation or answer as to why my dispute was rejected. I think the bill they sent was unreasonably high at $1,329.63 for a simple outpatient imaging study, and I absolutely would not have gotten this study performed if I knew what the cost was.

Physical Therapy

- Union Memorial Hospital has billed me for two one-hour sessions of outpatient physical therapy for $681.14 and $400.95, adding up to $1,082.09 for two total hours of physical therapy. Compared with any measure I could find of market rates for these services, these charges are unreasonable. I seek any guidance your office may have for options consistent with Maryland law and regulation to reduce these fees to levels consistent with any measure of the market rate for outpatient physical therapy. Our state has spent years grappling with this and other types of surprise billing, in which hospitals saddle outpatient services with costs of numerous unrelated services. Your office has taken a leading role in improving transparency for certain types of these surprise fees, the hospital "facility" charge commonly added to visits with medical professionals (https://www.wmar2news.com/matterformallory/ patients-blindsided-by-hidden-health-care-fee). And it is because of that role that I seek both your office's assistance with this specific disagreement and with this particular type of surprise fee generally, for the benefit of all Maryland consumers…In late March 2021, I had a consultation about knee pain with an orthopedic sports-medicine specialist at a practice in one of the professional buildings on the Union Memorial campus. (No facility fee was charged for this visit.) The doctor recommended physical therapy and recommended the physical therapy clinic in the same professional building. I had an initial physical-therapy session the next day and what was intended to be the first of several follow-up sessions a week later. Soon afterwards, though, I saw preliminary insurance data showing charges for the initial session of nearly $800. The clinic is in-network on my United Healthcare insurance, a high-deductible health plan. We had not fulfilled our deductible for in-network services for the year, so UHC processed the charges as an entirely out-of-pocket payment for my family. I immediately canceled all remaining appointments and set out to

understand the basis for so high an hourly rate. The Facility Fee Right to Know Act is an achievement in transparency for Maryland consumers. If I understand the law correctly, though, the required disclosures do not include advising consumers that outpatient services of the type I received will be billed as hospital services. This is a gap I would encourage your office to seek to fill. Surprise hospital charges harm all Marylanders, whether for making care unaffordable or discouraging individuals from obtaining services in the first place.

Sleep Study

- I received a bill for $787.88 for the hospital/facility fee for my daughter's sleep study. This amount is accurate, given what was charged to insurance ($4,003.45), the amount allowed by our insurance ($3939.39), what our insurance paid (80%) and what was left for us to pay (20%). The problem, however, is that if I had known my daughter's sleep study would cost this much, I may never have chosen to have it done. I learned after the fact that I was supposed to have received a facility fee disclosure at the time of scheduling, or at least prior to the sleep study, but I never received it. After receiving the bill, I spoke with multiple people at the customer service office at the hospital. They assert that I received the facility fee disclosure, pointing to the line "I have been informed of the issues and responsibilities related to payment for service" on the "Outpatient Agreement Form" that I signed. I do not believe this to be a disclosure of the facility fee. It does not list any range of possible fees for the proposed service, nor does it reference the term "facility fee" or anything like it**.**

Out-of-State Hospital

- We have been charged a $2,723.26 facility fee after insurance discounts for not more than 15 minutes with a clinician and a less than one minute procedure. This charge was not disclosed prior to the procedure and appears to be unreasonable and potentially fraudulent.

- In October of last year, we took my son to Children's National at Montgomery County to see a cardiologist. After viewing his normal ECG result, the cardiologist told us to take a TTE as a precautionary measure. Without any further explanation regarding what TTE is and its potential cost, the testing was immediately arranged on site. Had we known in advance that we would be burdened with $2,200 in medical debt for such a precautionary procedure, we would have reconsidered and sought care elsewhere or perhaps even paid the discounted cash price… To obtain a fair price estimate for a TTE procedure at Montgomery County, I searched the websites of patient advocacy groups (e.g. https://www.fairhealthconsumer.org/); I searched Physician Fee Schedule for Medicare; I also called the insurance company for a price quote. For the medical billing code 93306 of TTE with doppler, the quoted price consistently ranges from $250 up to $800 in all my inquiries. In comparison, I was charged $2,896 and am responsible for at least $1,905.57 after the insurance discount.

- My pediatrician referred me to an imaging center, Children's National Montgomery County, where my son had an abdominal ultrasound to check his bladder. I called ahead to make sure they accepted my insurance carrier. In early October we received the bill for said service for $1,349. As it happened my husband had an abdominal ultrasound at Community Radiology around the same time, for which he was billed around one-tenth of that sum. Once Cigna assured me Children's National's bill wasn't a mistake. I called Community Radiology to double-check their billing practices: without insurance, the total sum would have been $170. With it, $140. I called two more radiology centers within a 3-mile radius of my home, asking for a quote for the same exact service for my son, assuming I had no insurance. All providers supplied immediate responses ranging from $170 to $250.