The colonoscopies were free but the 'surgical trays' came with $600 price tags

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Chantal Panozzo and her husband followed their primary care doctors' orders last year after they both turned 45, now the recommended age to start screening for colorectal cancer. They scheduled their first routine

colonoscopies a few months apart.

Panozzo said she was excited to get a colonoscopy, of all things, because it meant free care. The couple run a business out of their suburban home near Chicago and purchase coverage costing more than $1,400 each month for their family of four on the exchange, which was created by the Affordable Care Act.

By law, preventive services—including routine colonoscopies—are available at zero cost to patients. So Panozzo said she expected their screenings would be fully covered.

"This was our chance to get our free preventative care," she said.

Their results came back normal, she said.

Then the bills came.

The Patients: Chantal Panozzo, who uses her maiden name professionally, now 46, and Brian Opyd, 45, are covered by Blue Cross and Blue Shield of Illinois.

Medical Services: Two routine colonoscopies (one for him, one for her), as recommended by the U.S. Preventive Services Task Force for patients beginning at age 45.

Service Provider: Illinois Gastroenterology Group in Hinsdale. The practice is part of the private equity-backed GI Alliance, which has more than 800 gastroenterologists working in 15 states, including Florida, Missouri, and Texas.

Total Bill: For each colonoscopy, the gastroenterology group charged $2,034 before any insurance discounts or reductions. After discounts,

Blue Cross and Blue Shield of Illinois said it was responsible for paying $395.18 for Brian's screening and $389.24 for Chantal's.

But apart from the screening costs, the total included a $600 charge for each patient—though insurance documents did not identify what the charge was for. This left Chantal and Brian each with a $250 bill, the amount allowed by BCBS of Illinois, which was applied to their deductibles.

What Gives: Panozzo and her husband's experience exposes a loophole in the law meant to guarantee zero-cost preventive services: Health care providers may bill how they choose as long as they abide by their contracts with insurance—including for whatever goods or services they choose to list, and in ways that could leave patients with unexpected bills for "free" care.

After their screenings, Panozzo said she and her husband each saw the same strange $600 charge from the Illinois Gastroenterology Group on their insurance explanation of benefits statements. Bills from the gastroenterology group explained these charges were for "surgical supplies." Her insurer eventually told her the codes were for "surgical trays."

At first, she was confused, Panozzo said, Why were they receiving any bills at all?

The Affordable Care Act requires preventive care services to be fully covered without any cost sharing imposed on patients—procedures such as colonoscopies, mammograms, and cervical cancer checks.

Policymakers included this hallmark protection because, for many patients, cost can deter them from seeking care. A KFF poll in 2022 found that roughly four in 10 adults skipped or postponed care they

needed due to cost concerns.

Under the law, though, it is the insurer's responsibility to make preventive care available at zero-cost to patients. Providers may exploit this loophole, said Sabrina Corlette, a research professor and co-director of the Center on Health Insurance Reforms at Georgetown University.

"The insurance company is supposed to pay the full claim, but there is no requirement on the provider to code the claim correctly," Corlette said.

In this case, BCBS of Illinois covered the full cost of the screenings the couple received, according to its own documents. But those documents also showed that each patient was on the hook for a portion of their separate, $600 charges.

Panozzo thought a phone call with her insurer, BCBS of Illinois, would quickly fix the mistake. But she said she spent most of her time on hold and could not get an answer as to why the colonoscopy came with a separate charge for supplies. She said she learned in later communications with her insurer that the $600 was specifically for "surgical trays."

BCBS of Illinois declined to comment despite receiving a waiver authorizing the insurer to discuss the case.

Panozzo said that she called the gastroenterology practice and was told by a billing representative that the extra charge was part of an arrangement the practice has with BCBS: She recalled being told that the practice was accustomed to keying in a billing code for "surgical trays" in lieu of a separate fee, which was described to Panozzo as a "use cost" for the doctor's office.

"I was getting a different story from any person I talked to," Panozzo

said.

She said she was stuck in "no man's land," with each side telling her the other was responsible for removing the charge.

The Resolution: Panozzo went wide with her objections, contesting the total $500 they owed by filing appeals with her insurer; lodging a complaint with the Illinois Department of Insurance; and writing to her elected officials, warning that Illinois consumers were being "taken advantage of" and "ripped off."

Ultimately, BCBS approved both appeals, saying neither Panozzo nor her husband was expected to pay the charges.

An administrative employee reached by phone at the Illinois Gastroenterology Group location where the couple was treated said they could not comment and directed KFF Health News to contact an executive with GI Alliance, the national group that manages the practice. Neither the executive nor media relations representatives responded to multiple requests for comment.

Panozzo said that, in the past, she would have paid the bill to avoid wasting time haggling with the doctor, insurer, or both. But getting hit with the same bill twice? That was too much for her to accept, she said.

"If change is ever going to happen, I need to stop accepting some of these bills that I knew were potentially incorrect," Panozzo said.

The Takeaway: Medical providers have broad leeway to determine how they bill for care, including by deciding how to identify what goods or services are provided. This means patients may get stuck with charges for unfamiliar or downright bizarre things.

And because the law doesn't address how providers bill patients for preventive services, odd charges can crop up even for care that should be fully covered.

Research also shows private equity ownership, which has been increasing in specialties like gastroenterology, can lead to higher costs for patients, as well as lower quality care.

For patients, "under federal law, there is no recourse," Corlette said. State regulatory bodies may go after these providers for billing patients for covered services, but that can be a mixed bag, Corlette said.

Insurers should crack down on this kind of practice with the providers participating in their networks, Corlette said. Otherwise, patients are stuck in the middle, left to contest what should be "free" care—and at the mercy of the insurance appeals process.

Health plans may not catch billing oddities—after all, for a major insurer, a charge of $600 may not be worth investigating. That leaves patients ultimately responsible for keeping track of what they're being asked to pay—and speaking up if something seems suspicious.

Panozzo said the experience left her feeling defeated, exhausted, and distrustful of America's health care system.

Having lived abroad with her family for almost 10 years, she said, "I could function in a health care system in German better than I could here in English."

https://medicalxpress.com/news/2024-01-colonoscopies-free-surgical-trays-price.html