Medical pricing in the US is similar to airline or hotel pricing in that there are different prices for different consumers. For medical services, the price your are charged depends primarily on who is paying for your services. Many people have insurance but also have substantial co-pays, deductibles and other limits. Others are "self-pay" with full responsibility. Either way, it will pay to get the best price for your services.

Here is some background information which will help you understand medical pricing.

The basic pricing structure is based on relative value studies. These assign a unit value to each medical service. For instance, a common medical office visit is one unit. Each medical service has a relative value assigned. An appendectomy, for example has a relative value of 17 units. These relative values are maintained by the American Medical Association (AMA) and by the US Government Center for Medicare and Medicaid Services (CMS). The relative values are reviewed periodically and adjusted for changes in medical care. Each medical procedure is assigned a five place alphanumeric code. The AMA codes are numeric and the CMS has added additional codes which usually have an alpha character in the first position. There are also a few two digit modifier codes which are added to the end of the five digit codes in special circumstances.

Medical pricing uses these relative values to calculate a price. The relative value is multiplied by a dollar amount to arrive at a price for the service. Currently, Medicaid uses a multiplier of about $36.00 for each unit (there are adjustments to this amount for regions). The amount is set by CMS to provide a "fair" compensation for an efficiently run practice but is the subject of Congressional action. Once you know the relative value, you can calculate the price for a service. Prices for private health insurance are also based on these same relative values and typically, they will negotiate a price with doctors and hospitals that is 20% to 30% higher than the Medicaid multiplier. The multiplier is usually the same for all services. For example, a private insurance company may use a multiplier of $45.00 for its fee schedule. However, private insurance companies do not usually publish their fee schedules or the multipliers. The Medicare program usually pays an amount that is less than the Medicare program. Each state has its own Medicare fee schedule which is usually published on the state Medicaid web site.

You can view all of the codes and the Medicaid fee schedule prices on the web site www.cms.gov (look for the "Physician Fee Schedule" or PFSRVSF). The CMS web site lists current and historical Medicaid pricing.

The most common medical billing codes you will encounter will be for physician office visits. If you are a new patient to the doctor (within the last three years), you will be billed with a code in the range of 99201 to 99205. If you are an established patient, the range is 99211 to 99215.

The last digit of the code indicates the "Level" of the exam which is determined by the severity of the problem and the difficulty of the decision making. Level 1 will be a simple problem with straight-forward decision making typically requiring no more than 10 minutes of physician time for a new patient or 5 minutes for an established patient. On the other hand, Level 5 is a problem requiring a comprehensive history and exam and complex decision making for a severe problem and typically requiring 60 minutes physician time for a new patient or 40 minutes for an established patient. The relative values assigned to these codes reflect the difficulty of the work and vary for new patients from about 1 unit to about 5 units and for established patients from about 0.5 units to about 3.5 units. Special codes apply to visits to medical consultants, emergency visits, hospital visits, and home visits.

The two digit modifier codes that I mentioned above are used for special cases. One of the most common of these is in the case of radiology exams where there is a technical component and a physician service component. When you have an MRI or a CAT scan or even a plain X-ray, this consists of a technical component which is a technician operating the machinery and creating the image and also of professional component provided by the doctor interpreting the image. There is only one 5 digit code for the procedure and that refers to both the technical and professional component. However, you may get separate bills from the people who operate the machinery for the technical component using the modifier code -TC and from the physician who interprets the image using the code -26. The relative value units of these two sub-codes add up to the RVS for the combined procedure.

Hospital billing is either "a la carte" or bundled using a "Diagnosis Related Group" (DRG) indicator. Medicare (and some private insurance) use the DRG which assigns a value for each diagnosis and places these into a relatively small number of groups. The hospital then is reimbursed a lump sum based on the DRG for all services and supplies related to that hospitalization. The alternative is to bill for each and every service and supply used in the hospital which leads to very detailed bills including a detailed itemization of each pill, dressing, nursing intervention, etc.