ConsumerReports® Health

The real cost of care

How to save on medical bills, without compromising quality

Contents

ConsumerReports® Health

2

OUCH. AGAIN. Rachel Collier, of San Jose, Calif., visited an emergency room for abdominal pain that went away without treatment. The bill: $14,638, including $9,038 for a CT scan that would have cost $318 at a nearby imaging center in her health plan's network.

That CT scan costs how much?

Health-care prices are all over the map, even within your plan's network

IF GAS STATIONS worked like health care, you wouldn't find out until the pump switched off whether you paid $3 or $30 a gallon. If clothes shopping worked like health care, you might pay $80 for a pair of jeans at your local boutique and $400 for the identical pair at the nearest department store—and the clothes wouldn't have price tags on them.

"Why can't you or I as a consumer ask what it's going to cost and be met with something other than a blank stare?" asks Will Fox, a principal with Milliman, a national health actuarial consulting firm. The answer, he says, is that neither providers nor health insurers really want consumers to have that information.

Here's why: The contracted prices that health plans negotiate with providers in their networks have little or nothing to do with the actual quality of services provided and everything to do with the relative bargaining power of the providers.

Here's what this system means for consumers:

- Not even staying within your plan's network will guarantee you low prices. Providers who have a lot of market clout, such as a prestigious university hospital, may command prices several times higher than providers who don't.
- It may be difficult, if not impossible, to find out the price of health care ahead of time, especially for complex services such as elective surgery. That's a special problem for people with high-deductible

DID YOU KNOW?

Medical costs can vary substantially

In one Midwestern city the in-network price of a colonoscopy ranged from $840 at a freestanding medical practice to more than five times that amount at the local academic medical center. Big variations in the facility fee (dark purple) account for most of the difference. The light purple represents professional fees for the gastroenterologist.

Source: Healthcare Blue Book

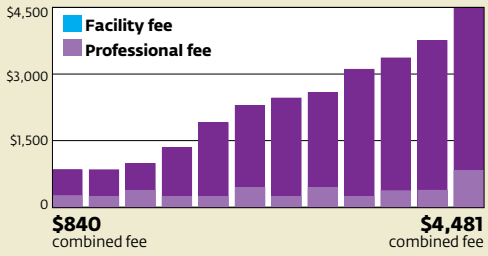

PHOTO: ROBERT HOUSER

plans, who may be responsible for the first $5,000 or even $10,000 of their health expenses every year.

• If you go out of network, whether on purpose or involuntarily, you may be hit with a five-figure bill that your insurance company isn't obligated to pay.

• There are ways to protect yourself against being blindsided by a huge bill. But they're often not easy and don't always work.

The $4,400 colonoscopy

Consumers often have no clue that prices can vary so much within a network, says Jeffrey Rice, M.D., chief executive officer of Healthcare Blue Book, a Nashville-based company that collects prices paid by large group health plans. "It's as if some employees went out to fill up the company cars and half came back with receipts for $4-a-gallon gas, the rest for $20 a gallon, and no one asked why," he says.

In one Midwestern city, Healthcare Blue Book found that prices paid by members in managed-care networks for a colonoscopy ranged from $840 at a freestanding office run by a gastroenterology group to $4,481 at the local academic medical center. (See chart on the facing page.)

In Hartford, Conn., an Aetna PPO negotiated a network price of $5,249 for an uncomplicated vaginal delivery at one hospital and $8,941 at another just a few miles away. A member with a typical coinsurance of 20 percent would save $738 in out-of-pocket expenses by choosing the cheaper hospital.

Rachel Collier, 41, a sales executive from San Jose, Calif., got a harsh education in medical pricing in August 2011, when she was stricken with pain in her back, which then moved to her abdomen. Her employer had recently switched its health plan to a Cigna PPO with a $5,000 deductible, and Collier had not yet selected a doctor or hospital to replace the providers at her former plan, a Kaiser HMO.

She went to the emergency room of a hospital in the Cigna network and was given blood tests, a CT scan, and an IV. She went home with a couple of medications, and the pain let up after a few hours.

"A few days later, I got a call from the hospital billing office," she recalls. "They said, 'Your total bill is $14,600, including $9,000 for the CT scan, and with your insurance you'll owe $6,500. But if you want to pay the uninsured rate in cash right now, you can have a discount and it will be a little more than $3,000.' So I gave them

How to avoid unwelcome surprises

1 Understand your health insurance. OK, it's not a fun read, but it pays to familiarize yourself with the rules and cost-sharing features of your health plan. How much is the deductible? What out-of-pocket costs apply toward it? Is there an extra copay for the emergency room? Do you need advance approval for tests, elective procedures, or specialist visits? Does the plan allow you to go out of network at all? Many HMOs don't, except for emergencies when you are outside the plan's service area or for hard-to-find treatments for rare conditions.

2 Stay in network if you can. Network providers have agreed to accept the negotiated health-plan price as payment in full. Even if you haven't met your annual deductible, you'll still pay the in-network price, and if you have met it, you'll only be on the hook for your copay or coinsurance.

3 Compare network prices. Many health plans now post some price information online. Take advantage if you can. If you can't, call your health-plan customer-service number. If that fails, call providers directly, but be aware that some of them truly might not know your network's price. Jeffrey Rice, M.D., chief executive officer of Healthcare Blue Book, used this tactic a few years ago to save big when his son needed outpatient foot surgery. The hospital quoted a price of $15,000 to $25,000. But having the procedure in an outpatient center, with the same surgeon, cost just $1,515.

4 Don't pay until all bills are in. You may receive a hospital bill with scary-looking high "charges" on it. Don't panic, and don't write a check. They're list prices, typically much higher than the network price you'll actually owe. Save all provider bills and compare them with the explanation of benefit (EOB) forms that you'll eventually get from your health plan. You will generally owe only the "patient responsibility" amount indicated on those forms for in-network care.

5 Fight back against stealth out-of-network bills. If you get blindsided by a bill from a non-network doctor after surgery or an emergency-room visit in a network hospital, you might be able to get it reduced if you make enough noise. First, ask the doctor to discount the fee. If that fails, complain to the hospital, your insurer, your employer (especially if you work for a large company), and your state insurance department or state health insurance consumer advocate.

6 For elective out-of-network care, find out about your plan's reimbursement policy. That information should be in your health-plan documents, but if not, call the plan and ask. Some set their own "allowed amount," some use the Fair Health pricing database, and some pay a set percentage of Medicare's fee schedule. Typically a plan will pay a portion, such as 60 percent, of that agreed-upon price. You'll be obligated to pay the rest plus the balance of whatever your out-of-network provider decides to charge. So if a non-network doctor charges $2,000 for a treatment and the insurance company says the allowed price is $1,000, it will reimburse you $600 and you'll owe the doctor $1,400.

7 Negotiate prices with the out-of-network provider in advance. Start by looking up the "fair" prices in your geographical area for your test, procedure, or operation on FairHealthConsumer.org, HealthcareBlueBook.com, or both. Fair Health also has a sliding tool that shows what your reimbursement will be if your plan pays a percentage of Medicare's fee schedule for out-of-network services. Use those results as a basis for negotiating a price agreement with the out-of-network provider, and get it in writing. Healthcare Blue Book has a printable standard contract you can use for that purpose. Failure to agree on a price in advance could leave you liable for a very, very large balance bill.

8 For complex out-of-network procedures, prepare for lots of homework. If your procedure or surgery isn't included on either HealthCareBlueBook.com or FairHealthConsumer.org, ask the out-of-network provider for the CPT codes (standard medical billing codes) for each service to be performed. Also get the provider's tax identification number and the ZIP code of the location where the service will be performed. "Call the insurance company with this information, and they are absolutely obligated to tell you what they will pay," says Jennifer Jaff, executive director of the nonprofit group Advocacy for Patients with Chronic Illness. "This is not information they're going to have at their fingertips. Chances are it's going to take days." Once you have that information, negotiate with your provider as above.

my bank account number and they pulled out the money right away. All I could think was, 'What the heck just happened?'"

What the heck happened remains unclear; as we went to press, Cigna was still investigating why the hospital didn't charge Collier the lower network price or submit a claim to the health plan.

What's not in doubt is that Collier paid much more for that CT scan than she needed to. Cigna allows plan members to look up some cost information online, and it turns out that an in-network freestanding imaging center near her home offers the same type of CT scan that she had in the hospital, but for a mere $318.

Dialing for dollars

If the price for a treatment or test you need is not on your health plan's website, getting a price quote from a network provider may be difficult if not impossible.

Stephen Griffing, 58, a manufacturer's representative from Danbury, Conn., ran into the problem when he signed up for an individual Aetna health plan with a $5,000 in-network annual deductible. He needs two common blood tests every six months to monitor the safety of a cholesterol-lowering medication that he takes.

None of the three local network labs he called was able to supply his in-network price for the tests. They weren't available on Aetna's member price lookup site and an Aetna customer service representative didn't have the information, either. "Surely I am not the first person to want to know exactly what something will cost, out of my pocket, before purchase," Griffing says.

Jerry Diffley, who was then director of billing compliance for Quest Diagnostics, one of the labs involved, says that it had contracts with 75 Aetna plans. "There may be a specific fee schedule for his plan," he says. "Insurance companies may only pay for the tests for certain conditions, or so many times a year, and without knowing those details, we don't know what he may pay out of pocket."

Out-of-network price traps

Few consumers understand the severe limitations on the out-of-network benefit that PPOs and similar plans tout as an advantage over HMOs (which typically don't pay for any out-of-network care except in rare emergency situations).

"The PPO says it will pay 60 or 70 percent of the allowable amount for out-of-network providers," says Jennifer Jaff, executive director of Advocacy for Patients with Chronic Illness, a nonprofit consumer group in Farmington, Conn. "People think that means 60 or 70 percent of whatever the out-of-network provider charges. That's not what happens. It's a fixed percentage of whatever the insurer decides is the right amount."

And that amount, what's often called the UCR ("usual, customary, and reasonable") price, is often much less than the bills that come from the non-network providers. That can leave patients on the hook for the balance—the amount not reimbursed by their plan.

Julie Lindgren, 47, a nuclear-medicine technologist from Seattle, chose an out-of-network doctor and hospital in 2005 when she was facing a risky surgery to treat kidney cancer.

The surgery was a success, but the bills that came afterward were a shock. Lindgren recalls that the total came to some $28,000, of which insurance paid about $5,000. Ultimately, the hospital wrote off a portion of its bill, but the surgeon and the anesthesiologist demanded their full fee of $9,000, which she paid in part by borrowing from family.

SURGERY SHOPPING Jeffrey Rice, M.D., used his own service, Healthcare Blue Book, to save 90 percent on foot surgery for his son, Jack.

What's a reasonable price?

Traditionally, insurers have based UCR prices on what providers charge. Some rely on proprietary internal numbers, and some use national data collected and analyzed by Fair Health, a nonprofit organization based in New York City.

But that's changing, as more insurers have begun setting their out-of-network price as a percentage of what Medicare pays for the service. A March 2012 investigation by the New York State Department of Financial Services found that most plans that use this method pay between 110 percent and 150 percent of what Medicare pays. "It sounds like a lot but it's extraordinarily low," says Robin Gelburd, Fair Health's president.

Because of Medicare's size—it pays a bigger portion of the nation's health-care bill than any other single entity—and ability to set prices without negotiating with doctors, its fee schedule "does not come close to reimbursing what providers actually charge" non-Medicare patients, says Connecticut State Healthcare Advocate Victoria Veltri.

PHOTO: BOB SCHATZ

DID YOU KNOW?

Don't let this happen to you

A patient in a Northeastern state hired an out-of-network back surgeon to correct severe scoliosis, expecting her PPO to pay 80 percent of his bill. But the insurer, like most, paid only 80 percent of what it considered an appropriate fee for the service, leaving her legally liable to pay the balance—a heart-stopping $480,000. The patient is working with her state's consumer advocate in hopes of negotiating a settlement.

We used an online calculator at *fairhealthconsumer.org* to determine that the "fair," or typical, price for a laparoscopic gallbladder removal in Consumer Reports' Yonkers, N.Y., ZIP code is $6,700. A plan that reimbursed 60 percent of the fair price would leave patients owing a balance of $2,680. But Medicare pays only $855 for the procedure in our neck of the woods. So a plan that based its 60 percent reimbursement on 140 percent of Medicare would leave patients with a balance bill more than twice as high: $5,981.

Of course, the financial damage can be even worse when, as frequently happens, the out-of-network hospital or doctor charges more than the fair price—sometimes a lot more.

We spoke with a man in a Northeastern state whose wife chose an out-of-network neurosurgeon for a complex procedure to correct a severe case of scoliosis. The insurer said the UCR was $111,875, but the surgeon charged $591,875, leaving the patient with a bill of $480,000. She asked not to be identified because she is working with a state consumer advocate to negotiate a settlement.

What price an MRI: $504 or $2,520?

These are actual prices paid by large employers nationwide, as collected by the Healthcare Blue Book. The low prices represent the 10th percentile, and the high prices the 90th percentile. The "fair" price is based on Healthcare Blue Book's own evaluation.

Test or treatment	Low	Fair	High
Brain MRI	$ 504	$ 560	$ 2,520
Chest X-ray	40	44	255
Colonoscopy	800	1,110	3,160
Complete blood count	15	23	105
Hip replacement	19,500	21,148	43,875
Hysterectomy	8,000	8,546	16,480
Knee replacement	17,800	19,791	42,750
Knee arthroscopy	3,000	3,675	7,350
Laminectomy (spine surgery)	8,150	11,744	25,760
Laparoscopic gallbladder removal	5,000	6,459	12,480
Tubal ligation	2,865	3,183	5,729
Transurethral prostate removal	4,000	4,409	8,875
Ultrasound, fetal	120	169	480
Vasectomy	700	1,003	2,100

Bills out of the blue

An obvious way to avoid getting hit with stratospheric out-of-network bills is not to use out-of-network providers.

But that's not always possible: Sometimes, especially in the hospital, you can be seen by an out-of-network provider without even knowing it. Annmarie Bragdon, 41, from Farmington Hills, Mich., used a network hospital and doctor when her infant needed surgery for a congenital kidney problem. "But we got a bill of about $10,000 for the anesthesiologist, who was out of network," she says.

The company Bragdon worked for intervened and arranged for her to pay the same rates as for an in-network anesthesiologist. But not everyone is so lucky, as documented in the report by the New York State Department of Financial Services.

It cited some jaw-dropping bills that patients received from out-of-network doctors who treated them in emergencies: $31,700 for surgery for a brain hemorrhage, $83,000 for reattaching a finger severed in a table-saw accident. "These hospital-based specialists have insurers completely over a barrel," Will Fox of Milliman says. "They say, 'If you don't pay us our full billed charges, we won't play.'"

Why don't hospitals force doctors to participate in networks? "An individual hospital could have 50 different plans," says Caroline Steinberg, a vice president of the American Hospital Association. The hospital might not know "which plan a physician has negotiated a contract with."

Or as patient advocate Jennifer Jaff puts it: "Nobody in this drama has an interest in helping you. The provider knows you're on the hook, no matter what. And the insurance company knows they're going to pay what they're going to pay."

PHOTO: INTI ST.CLAIR

COSTLY CANCER CARE Julie Lindgren, of Seattle, was hit with more than $20,000 in balance bills after going out of network for risky cancer surgery.

ConsumerReports® Health

What's fair?

Fair healthcare pricing from Healthcare Blue Book

Healthcare Blue Book is a free consumer guide to help you determine fair prices in your area for healthcare services

Total Hip Replacement

Alternate name: Hip replacement surgery (CPT code 27130)

Fair price:

Includes: Physician fee, facility fee, anesthesia fee

National fair price: $21,148

National range: ..... $19,500 – 43,875

Local fair prices:

Boston, Massachusetts 02102 ..... $24,182

Milwaukee, Wisconsin 53202 ..... $19,946

Minneapolis, Minnesota 55402 ..... $19,975

Jacksonville, Florida 32202 ..... $20,096

Los Angeles, California 90006 ..... $20,421

Houston, Texas 77010 ..... $20,251

New York, NY 10003 ..... $20,820

Check the fair price in your region at healthcarebluebook.com

Details:

How were these prices calculated and what are they based on?

This is Healthcare Blue Book's recommended price for a total hip replacement.

The fair price recommendation is based on the typical negotiated payment amount that providers accept from insurance companies.

If you have insurance, you should be able to find in-network providers that accept prices at or below the Blue Book fair price, although many providers may charge more.

How should consumers use this information?

You can use the Blue Book fair price as a guide to help you compare prices when you shop for care and to make sure that you receive treatment at a fair price.

If you have health insurance, you should use your provider directory to identify in-network providers in your area. Total hip replacement is an orthopedic procedure and is typically performed by an orthopedic surgeon.

You can call the providers or your health insurance company to get a cost estimate. You will need to know the name of the procedure and possibly the Current Procedural Terminology (CPT) code for the service you need. It is also useful to have your insurance card available.

Prices for total hip replacement may range from $19,500 to over $40,000 in many areas. We recommend that you call several providers to find one that charges a fair price.

If you do not have insurance, make sure to let the office know that you are a self-paying patient. Self-pay patients are frequently quoted the billed charges amount (like the sticker price for a new car) for the service, which can be 2 to 3 times what the provider would accept from an insurance company. Many providers will offer a discount to self pay patients – but you must remember to ask for the discount.

Key points to consider when shopping for total hip replacement.

- Total hip replacement pricing can vary by over 200% in some locations. It is not uncommon to find total hip replacement pricing from $19,500 to more than $40,000. You should call several providers to ask about the price of your total hip replacement before you have your procedure.
- The fair price does not include the cost of the hip implant. The implanted device can cost anywhere from $6,000 to over $10,000. You should talk to your doctor about the device that is right for your needs.

- Make sure that the price estimate includes the physician fee, the facility fee and the anesthesia fee. You may need to call your physician, the facility and the anesthesia practice to get prices.
- Be sure to also ask about other costs you may have to pay that are related to the surgery. These costs may include laboratory tests before and after the procedure, imaging tests (x-ray, CT, MRI), post surgery rehabilitation and medications.
- If your Primary Care Physician has already referred you to a specialist, make sure to ask for their price and compare it to the Blue Book fair price before receiving treatment.
- If you get a price estimate that is significantly higher than the fair price, you may want to talk to your doctor about other facilities where you could have your procedure performed.
- If you have a Health Savings Account (HSA) or Health Reimbursement Account (HRA) you can apply those funds to any deductible, co-insurance or other out of pocket costs.

Is total hip replacement typically covered by health insurance plans?

Yes, total hip replacement is usually covered by health insurance. Always check with your insurer to make sure a procedure is covered before seeking treatment.

Your insurer may require pre-certification prior to agreeing to cover your total hip replacement. You should always ask and then confirm that your provider is going to obtain pre-certification for your total hip replacement before you receive treatment.

If your provider does not obtain pre-certification prior to your total hip replacement, you will need to call the health plan and request pre-certification yourself. Insurers may deny payment of the claim if you have not obtained pre-certification.

Is total hip replacement typically covered by Medicare or Medicaid plans?

Yes, total hip replacement is covered under Medicare and Medicaid. Your provider may need to establish medical necessity or pre-certification before you receive treatment.

What kind of out-of-pocket costs should I expect to pay?

Your out of pocket costs will depend on the type of insurance that you have. You may be responsible for copays, deductibles or coinsurance amounts. In order to determine your out of pocket costs, always review your co-pay amounts, current deductible balance and current co-insurance obligation before seeking treatment. If you have questions about your benefit plan or out of pocket costs, talk to your insurance company.

Remember, if you have a Health Savings Account (HSA) or Health Reimbursement Account (HRA) you can apply those funds to any deductible, co-insurance or other out of pocket costs.

Do the costs for this service vary depending on which provider I use?

The price variation in some locations can vary by almost 200%. Make sure to ask about the price of this service before you get your care to make sure that you will be charged a fair price. If you are not satisfied with a provider's price, you can consider other providers that may offer you a more reasonable price.

What other trends or variations in cost should I be aware of?

There are a few things to consider when evaluating the need for a total hip replacement.

First, do you need the surgery? Artificial hip joints have a finite useable life before they wear out and have to be replaced. Most physicians encourage patients to delay having a joint replaced for as long as possible. However, patients should bear in mind the need to revise or replace a joint at some point in the future.

What other tips can help me ensure I get the best price?

The choice of hospital for your total hip replacement will usually have the biggest impact on your total price.

Many surgeons only operate at certain hospitals. You may want to find out what hospitals have the best pricing and then find surgeons who can do your surgery at those hospitals.

Qualifications

Hospitals should be accredited by the Joint Commission on Accreditation for Healthcare Organizations (JCAHO).

Orthopedic surgeons should be board certified by the American Board of Orthopedic Surgeons.

The pricing and benefits information reflected in this report is based upon the common pricing and practices found in most markets and may not reflect the specific pricing or health benefits available to you. Some providers charge amounts well in excess of the Blue Book fair price. Some insurance plans cover services differently. If possible, you should check with your medical provider and health insurance company to confirm pricing and benefit coverage for services before you get care. In addition, you will want to check on your providers' quality information.

Consumer Reports Health "What's Fair?" reports should not be viewed as a substitute for a consultation with a medical or health professional.

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Hysterectomy

(CPT code 58150)

Fair price:

Includes: Physician fee, facility fee, anesthesia fee

National fair price:	**$8,546**
National range:	**$8,000 – 16,480**

Local fair prices:

Boston, Massachusetts 02102	**$10,130**
Milwaukee, Wisconsin 53202	**$8,380**
Minneapolis, Minnesota 55402	**$8,404**
Jacksonville, Florida 32202	**$8,503**
Los Angeles, California 90006	**$8,771**
Houston, Texas 77010	**$8,632**
New York, NY 10003	**$9,100**

Check the fair price in your region at healthcarebluebook.com

Details:

How were these prices calculated and what are they based on?

This is Healthcare Blue Book's recommended price for a hysterectomy.

The fair price recommendation is based on the typical negotiated payment amount that providers accept from insurance companies.

If you have insurance, you should be able to find in-network providers that accept prices at or below the Blue Book fair price, although many providers may charge more.

How should consumers use this information?

You can use the Blue Book fair price as a guide to help you compare prices when you shop for care and to make sure that you receive treatment at a fair price.

If you have health insurance, you should use your provider directory to identify in-network providers in your area. Hysterectomy is an obstetrical/gynecological (OBGYN) procedure and is typically performed by an OBGYN specialist.

You can call the providers or your health insurance company to get a cost estimate. You will need to know the name of the procedure and possibly the Current Procedural Terminology (CPT) code for the service you need. It is also useful to have your insurance card available.

Prices for hysterectomy may range from $8,000 to over $14,000 in many areas. We recommend that you call several providers to find one that charges a fair price.

If you do not have insurance, make sure to let the office know that you are a self-paying patient. Self-pay patients are frequently quoted the billed charges amount (like the sticker price for a new car) for the service, which can be 2 to 3 times what the provider would accept from an insurance company. Many providers will offer a discount to self pay patients – but you must remember to ask for the discount.

Key points to consider when shopping for a hysterectomy.

- Hysterectomy pricing can vary by almost 200% in some locations. It is not uncommon to find hysterectomy pricing below $8,000 or above $14,000. You should call several providers to ask about the price of your hysterectomy before you have your procedure.
- Make sure that the price estimate includes the physician fee, the facility fee and the anesthesia fee. You may need to call your physician, the facility and the anesthesia practice to get prices.
- If your Primary Care Physician has already referred you to a specialist, make sure to ask for their price and compare it to the Blue Book fair price before receiving treatment.
- If you get a price estimate that is significantly higher than the fair price, you may want

to talk to your doctor about other facilities where you could have your procedure performed.

- If you have a Health Savings Account (HSA) or Health Reimbursement Account (HRA) you can apply those funds to any deductible, co-insurance or other out of pocket costs

Is a hysterectomy typically covered by health insurance plans?

Yes, hysterectomy is usually covered by health insurance. Always check with your insurer to make sure a procedure is covered before seeking treatment.

Your insurer may require pre-certification prior to agreeing to cover your hysterectomy. You should always ask and then confirm that your provider is going to obtain pre-certification for your hysterectomy before you receive treatment.

If your provider does not obtain pre-certification prior to your hysterectomy, you will need to call the health plan and request pre-certification yourself. Insurers may deny payment of the claim if you have not obtained pre-certification.

Is hysterectomy typically covered by Medicare or Medicaid plans?

Yes, hysterectomy is covered under Medicare and Medicaid. Your provider may need to establish medical necessity or pre-certification before you receive treatment.

What kind of out-of-pocket costs should I expect to pay?

Your out of pocket costs will depend on the type of insurance that you have. You may be responsible for copays, deductibles or coinsurance amounts. In order to determine your out of pocket costs, always review your co-pay amounts, current deductible balance and current co-insurance obligation before seeking treatment. If you have questions about your benefit plan or out of pocket costs, talk to your insurance company.

Remember, if you have a Health Savings Account (HSA) or Health Reimbursement Account (HRA) you can apply those funds to any deductible, co-insurance or other out of pocket costs.

Do the costs for this service vary depending on which provider I use?

The price variation in some locations can vary by almost 200%. Make sure to ask about the price of this service before you get your care to make sure that you will be charged a fair price. If you are not satisfied with a provider's price, you can consider other providers that may offer you a more reasonable price.

What other trends or variations in cost should I be aware of?

There are two things to consider when evaluating the need for a hysterectomy.

- First, do you need the surgery? About 10% of hysterectomies are performed for cancer. The other 90% are often performed for symptoms such as excessive bleeding or

painful fibroids. If you don't have cancer, make sure to discuss with your doctor the indications for the surgery, alternative treatment options and the advisability of having the surgery now versus trying more conservative treatments first.

- Second, if you are being treated for excessive bleeding (menorrhagia), you may want to consider thermal endometrial ablation. This therapy is often effective with 90% of women reporting excellent results. Endometrial ablation usually costs about one half as much as hysterectomy. While surgeon fees are a little higher, the fees for the surgical facility are lower. In addition, the recovery time and time away from work may also be shorter.

What other tips can help me ensure I get the best price?

The choice of hospital for your hysterectomy will usually have the biggest impact on your total price.

Many surgeons only operate at certain hospitals. You may want to find out what hospitals have the best pricing and then find surgeons who can do your surgery at those hospitals..

Qualifications

Hospitals should be accredited by The Joint Commission on Accreditation for Healthcare Organizations (JCAHO).

Obstetricians and gynecologists should be board certified by the American Board of Obstetrics and Gynecology.

Alternatives

If you are being treated for excessive bleeding (menorrhagia), you may want to consider thermal endometrial ablation. This therapy is often effective with 90% of women reporting excellent results. Endometrial ablation usually costs about one half as much as hysterectomy. While surgeon fees are a little higher, the fees for the surgical facility are lower. In addition, the recovery time and time away from work may also be shorter.

Overuse

About 10% of hysterectomies are performed for cancer. The other 90% are often performed for symptoms such as excessive bleeding or painful fibroids.

In some cases there may be conservative treatment options that can spare a patient from a hysterectomy.

The pricing and benefits information reflected in this report is based upon the common pricing and practices found in most markets and may not reflect the specific pricing or health benefits available to you. Some providers charge amounts well in excess of the Blue Book fair price. Some insurance plans cover services differently. If possible, you should check with your medical provider and health insurance company to confirm pricing and benefit coverage for services before you get care. In addition, you will want to check on your providers' quality information.

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Knee replacement

Alternate name: Knee arthroplasty (CPT code 27447)

Fair price:

Includes: Physician fee, facility fee, anesthesia fee

National fair price:	**$19,791**
National range:	**$17,800 – 42,750**

Local fair prices:

Boston, Massachusetts 02102	**$23,780**
Milwaukee, Wisconsin 53202	**$19,610**
Minneapolis, Minnesota 55402	**$19,636**
Jacksonville, Florida 32202	**$19,744**
Los Angeles, California 90006	**$20,038**
Houston, Texas 77010	**$19,885**
New York, NY 10003	**$20,399**

Check the fair price in your region at healthcarebluebook.com

Details:

How were these prices calculated and what are they based on?

This is Healthcare Blue Book's recommended price for a total knee replacement.

The fair price recommendation is based on the typical negotiated payment amount that providers accept from insurance companies.

If you have insurance, you should be able to find in-network providers that accept prices at or below the Blue Book fair price, although many providers may charge more.

How should consumers use this information?

You can use the Blue Book fair price as a guide to help you compare prices when you shop for care and to make sure that you receive treatment at a fair price.

If you have health insurance, you should use your provider directory to identify in-network providers in your area. Total knee replacement is an orthopedic procedure and is typically performed by an orthopedic surgeon.

You can call the providers or your health insurance company to get a cost estimate. You will need to know the name of the procedure and possibly the Current Procedural Terminology (CPT) code for the service you need. It is also useful to have your insurance card available.

Prices for total knee replacement may range from $19,000 to over $40,000 in many areas. We recommend that you call several providers to find one that charges a fair price.

If you do not have insurance, make sure to let the office know that you are a self-paying patient. Self-pay patients are frequently quoted the billed charges amount (like the sticker price for a new car) for the service, which can be 2 to 3 times what the provider would accept from an insurance company. Many providers will offer a discount to self pay patients – but you must remember to ask for the discount.

Key points to consider when shopping for knee replacement.

- Total knee replacement pricing can vary by over 200% in some locations. It is not uncommon to find total knee replacement pricing from $19,000 to more than $40,000. You should call several providers to ask about the price of your total knee replacement before you have your procedure.
- The fair price does not include the cost of the knee implant. The implanted device can cost anywhere from $6,000 to over $10,000. You should talk to your doctor about the device that is right for your needs.

- Make sure that the price estimate includes the physician fee, the facility fee and the anesthesia fee. You may need to call your physician, the facility and the anesthesia practice to get prices.
- Be sure to also ask about other costs you may have to pay that are related to the surgery. These costs may include laboratory tests before and after the procedure, imaging tests (x-ray, CT, MRI), post surgery rehabilitation and medications.
- If your Primary Care Physician has already referred you to a specialist, make sure to ask for their price and compare it to the Blue Book fair price before receiving treatment.
- If you get a price estimate that is significantly higher than the fair price, you may want to talk to your doctor about other facilities where you could have your procedure performed.
- If you have a Health Savings Account (HSA) or Health Reimbursement Account (HRA) you can apply those funds to any deductible, co-insurance or other out of pocket costs.

Is a total knee replacement typically covered by health insurance plans?

Yes, total knee replacement is usually covered by health insurance. Always check with your insurer to make sure a procedure is covered before seeking treatment.

Your insurer may require pre-certification prior to agreeing to cover your total knee replacement. You should always ask and then confirm that your provider is going to obtain pre-certification for your total knee replacement before you receive treatment.

If your provider does not obtain pre-certification prior to your total knee replacement, you will need to call the health plan and request pre-certification yourself. Insurers may deny payment of the claim if you have not obtained pre-certification.

Is a total knee replacement typically covered by Medicare or Medicaid plans?

Yes, total knee replacement is covered under Medicare and Medicaid. Your provider may need to establish medical necessity or pre-certification before you receive treatment.

What kind of out-of-pocket costs should I expect to pay?

Your out of pocket costs will depend on the type of insurance that you have. You may be responsible for copays, deductibles or coinsurance amounts. In order to determine your out of pocket costs, always review your co-pay amounts, current deductible balance and current co-insurance obligation before seeking treatment. If you have questions about your benefit plan or out of pocket costs, talk to your insurance company.

Remember, if you have a Health Savings Account (HSA) or Health Reimbursement Account (HRA) you can apply those funds to any deductible, co-insurance or other out of pocket costs.

Do the costs for this service vary depending on which provider I use?

The price variation in some locations can vary by over 200%. Make sure to ask about the price of this service before you get your care to make sure that you will be charged a fair price. If you are not satisfied with a provider's price, you can consider other providers that may offer you a more reasonable price.

What other trends or variations in cost should I be aware of?

There are a few things to consider when evaluating the need for a total knee replacement.

First, do you need the surgery? Artificial knee joints have a finite useable life before they wear out and have to be replaced. Most physicians encourage patients to delay having a joint replaced for as long as possible. However, patients should bear in mind the need to revise or replace a joint at some poin in the future.

What other tips can help me ensure I get the best price?

The choice of hospital for your total knee replacement will usually have the biggest impact on your total price.

Many surgeons only operate at certain hospitals. You may want to find out what hospitals have the best pricing and then find surgeons who can do your surgery at those hospitals.

Qualifications

Hospitals should be accredited by The Joint Commission on Accreditation for Healthcare Organizations (JCAHO).

Orthopedic surgeons should be board certified by the American Board of Orthopedic Surgeons.

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Knee Arthroscopy

(CPT code 29881)

Fair price:

Includes: Physician fee, facility fee, anesthesia fee

National fair price:	**$3,675**
National range:	**$3,000 - 7,350**

Local fair prices:

Boston, Massachusetts 02102	**$3,882**
Milwaukee, Wisconsin 53202	**$3,587**
Minneapolis, Minnesota 55402	**$3,600**
Jacksonville, Florida 32202	**$3,652**
Los Angeles, California 90006	**$3,794**
Houston, Texas 77010	**$3,720**
New York, NY 10003	**$3,969**

Check the fair price in your region at healthcarebluebook.com

Details:

How were these prices calculated and what are they based on?

This is Healthcare Blue Book's recommended price for a knee arthroscopy.

The fair price recommendation is based on the typical negotiated payment amount that providers accept from insurance companies.

If you have insurance, you should be able to find in-network providers that accept prices at or below the Blue Book fair price, although many providers may charge more.

How should consumers use this information?

You can use the Blue Book fair price as a guide to help you compare prices when you shop for care and to make sure that you receive treatment at a fair price.

If you have health insurance, you should use your provider directory to identify in-network providers in your area. Knee arthroscopy is an orthopedic procedure and is typically performed by an orthopedic surgeon.

You can call the providers or your health insurance company to get a cost estimate. You will need to know the name of the procedure and possibly the Current Procedural Terminology (CPT) code for the service you need. It is also useful to have your insurance card available.

Different in-network providers often charge different prices. Prices for knee arthroscopy may range from $3,000 to over $7,000 in many areas. We recommend that you call several providers to find one that charges a fair price.

If you do not have insurance, make sure to let the office know that you are a self-paying patient. Self-pay patients are frequently quoted the billed charges amount (like the sticker price for a new car) for the service, which can be 2 to 3 times what the provider would accept from an insurance company. Many providers will offer a discount to self pay patients – but you must remember to ask for the discount.

Key points to consider when shopping for knee arthroscopy.

- Knee arthroscopy pricing frequently varies by over 200% in many locations. It is not uncommon to find knee arthroscopy pricing below $3,000 or above $7,000. You should call several providers to ask about the price of your knee arthroscopy before you have your procedure.
- Sometimes knee arthroscopy is performed in conjunction with other procedures. Make sure you ask your provider if other procedures are going to be performed, and whether additional procedures will impact the cost.

- Make sure that the price estimate includes the physician fee, the facility fee and the anesthesia fee. You may need to call your physician, the facility and the anesthesia practice to get prices.
- If your Primary Care Physician has already referred you to a specialist, make sure to ask for their price and compare it to the Blue Book fair price before receiving treatment.
- If you get a price estimate that is significantly higher than the fair price, you may want to talk to your doctor about other facilities where you could have your procedure performed. Some doctors can perform the procedure at a free standing Ambulatory Surgery Center (ASC). Receiving treatment at an independent ASC is typically less expensive than having the procedure at a hospital's outpatient facility.
- If you have a Health Savings Account (HSA) or Health Reimbursement Account (HRA) you can apply those funds to any deductible, co-insurance or other out of pocket costs.

Is knee arthroscopy typically covered by health insurance plans?

Yes, knee arthroscopy is usually covered by health insurance. Always check with your insurer to make sure a procedure is covered before seeking treatment.

Your insurer may require pre-certification prior to agreeing to cover your knee arthroscopy. You should always ask and then confirm that your provider is going to obtain pre-certification for your knee arthroscopy before you receive treatment.

If your provider does not obtain pre-certification prior to your knee arthroscopy, you will need to call the health plan and request pre-certification yourself. Insurers may deny payment of the claim if you have not obtained pre-certification.

Is knee arthroscopy typically covered by Medicare or Medicaid plans?

Yes, knee arthroscopy is covered under Medicare and Medicaid. Your provider may need to establish medical necessity or pre-certification before you receive treatment.

What kind of out-of-pocket costs should I expect to pay?

Your out of pocket costs will depend on the type of insurance that you have. You may be responsible for copays, deductibles or coinsurance amounts. In order to determine your out of pocket costs, always review your co-pay amounts, current deductible balance and current co-insurance obligation before seeking treatment. If you have questions about your benefit plan or out of pocket costs, talk to your insurance company.

Remember, if you have a Health Savings Account (HSA) or Health Reimbursement Account (HRA) you can apply those funds to any deductible, co-insurance or other out of pocket costs.

Do the costs for this service vary depending on which provider I use?

The price variation in most locations varies by 200% or more depending on where you get your care. Make sure to ask about the price of this service before you get your care to make sure that you will be charged a fair price. If you are not satisfied with a provider's price, you can consider other providers that may offer you a more reasonable price.

What other trends or variations in cost should I be aware of?

Sometimes knee arthroscopy is performed in conjunction with other related procedures (arthroscopic treatment for several parts of the knee). Patients should always ask if they need multiple related procedures in the recommended course of treatment. Additional procedures will increase the cost of care, and should be discussed with your provider prior to treatment.

What other tips can help me ensure I get the best price?

The choice of facility for your knee arthroscopy will usually have the biggest impact on your total price. When seeking a surgeon, patients will want to make sure to ask if the surgeon can perform the procedure at an independent ambulatory surgery center (ASC). Independent ASCs are not affiliated with major hospitals, and generally charge less than hospital based outpatient facilities for equivalent or better quality care.

Qualifications

Hospitals should be accredited by The Joint Commission on Accreditation for Healthcare Organizations (JCAHO).

ASCs should be accredited by one of the major agencies, including the Accreditation Association for Ambulatory Health Care (AAAHC), American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF) or the Joint Commission on Accreditation for Healthcare Organizations (JCAHO).

Orthopedic surgeons should be board certified by the American Board of Orthopedic Surgeons.

The pricing and benefits information reflected in this report is based upon the common pricing and practices found in most markets and may not reflect the specific pricing or health benefits available to you. Some providers charge amounts well in excess of the Blue Book fair price. Some insurance plans cover services differently. If possible, you should check with your medical provider and health insurance company to confirm pricing and benefit coverage for services before you get care. In addition, you will want to check on your providers' quality information.

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Laminectomy

Alternate name:
Surgical removal of the lamina

(CPT code 63047)

Fair price:

Includes: Physician fee, facility fee, anesthesia fee

National fair price:	**$11,744**
National range:	**$8,150 – 25,760**

Local fair prices:

Boston, Massachusetts 02102	**$13,993**
Milwaukee, Wisconsin 53202	**$11,558**
Minneapolis, Minnesota 55402	**$11,582**
Jacksonville, Florida 32202	**$11,683**
Los Angeles, California 90006	**$11,957**
Houston, Texas 77010	**$11,814**
New York, NY 10003	**$12,293**

Check the fair price in your region at healthcarebluebook.com

Details:

How were these prices calculated and what are they based on?

This is Healthcare Blue Book's recommended price for a laminectomy.

The fair price recommendation is based on the typical negotiated payment amount that providers accept from insurance companies.

If you have insurance, you should be able to find in-network providers that accept prices at or below the Blue Book fair price, although many providers may charge more.

How should consumers use this information?

You can use the Blue Book fair price as a guide to help you compare prices when you shop for care and to make sure that you receive treatment at a fair price.

If you have health insurance, you should use your provider directory to identify in-network providers in your area. Laminectomy is an orthopedic procedure and is typically performed by an orthopedic surgeon or a neurosurgeon.

You can call the providers or your health insurance company to get a cost estimate. You will need to know the name of the procedure and possibly the Current Procedural Terminology (CPT) code for the service you need. It is also useful to have your insurance card available.

Prices for laminectomy may range from $10,000 to over $25,000 in many areas. We recommend that you call several providers to find one that charges a fair price.

If you do not have insurance, make sure to let the office know that you are a self-paying patient. Self-pay patients are frequently quoted the billed charges amount (like the sticker price for a new car) for the service, which can be 2 to 3 times what the provider would accept from an insurance company. Many providers will offer a discount to self pay patients – but you must remember to ask for the discount.

Key points to consider when shopping for a laminectomy.

- Laminectomy pricing can vary by over 200% in some locations. It is not uncommon to find laminectomy pricing below $10,000 or above $25,000. You should call several providers to ask about the price of your laminectomy before you have your procedure.
- Make sure that the price estimate includes the physician fee, the facility fee and the anesthesia fee. You may need to call your physician, the facility and the anesthesia practice to get prices.
- Sometimes laminectomy is performed in conjunction with other procedures, such as the removal of a spinal disk. Make sure you ask your provider if other procedures are going to be performed, and whether additional procedures will impact the cost.

- Be sure to also ask about other costs you may have to pay that are related to the surgery. These costs may include laboratory tests before and after the procedure, imaging tests (CT or MRI) and medications.
- If your Primary Care Physician has already referred you to a specialist, make sure to ask for their price and compare it to the Blue Book fair price before receiving treatment.
- If you get a price estimate that is significantly higher than the fair price, you may want to talk to your doctor about other facilities where you could have your procedure performed.

If you have a Health Savings Account (HSA) or Health Reimbursement Account (HRA) you can apply those funds to any deductible, co-insurance or other out of pocket costs.

Is a laminectomy typically covered by health insurance plans?

Yes, laminectomy is usually covered by health insurance. Always check with your insurer to make sure a procedure is covered before seeking treatment.

Your insurer may require pre-certification prior to agreeing to cover your laminectomy. You should always ask and then confirm that your provider is going to obtain pre-certification for your laminectomy before you receive treatment.

If your provider does not obtain pre-certification prior to your laminectomy, you will need to call the health plan and request pre-certification yourself. Insurers may deny payment of the claim if you have not obtained pre-certification.

Is a laminectomy typically covered by Medicare or Medicaid plans?

Yes, laminectomy is covered under Medicare and Medicaid. Your provider may need to establish medical necessity or pre-certification before you receive treatment.

What kind of out-of-pocket costs should I expect to pay?

Your out of pocket costs will depend on the type of insurance that you have. You may be responsible for copays, deductibles or coinsurance amounts. In order to determine your out of pocket costs, always review your co-pay amounts, current deductible balance and current co-insurance obligation before seeking treatment. If you have questions about your benefit plan or out of pocket costs, talk to your insurance company.

Remember, if you have a Health Savings Account (HSA) or Health Reimbursement Account (HRA) you can apply those funds to any deductible, co-insurance or other out of pocket costs.

Do the costs for this service vary depending on which provider I use?

The price variation in some locations can vary by more than 200%. Make sure to ask about the price of this service before you get your care to make sure that you will be charged a fair price. If you are not satisfied with a provider's price, you can consider other providers that may offer you a more reasonable price.

What other trends or variations in cost should I be aware of?

Some patients may be able to have this surgery performed on an outpatient basis. Outpatient surgery is often less expensive than the inpatient surgery.

What other tips can help me ensure I get the best price?

The choice of hospital for your laminectomy will usually have the biggest impact on your total price.

Many surgeons only operate at certain hospitals. You may want to find out what hospitals have the best pricing and then find surgeons who can do your surgery at those hospitals.

Qualifications

Hospitals should be accredited by The Joint Commission on Accreditation for Healthcare Organizations (JCAHO).

Orthopedic surgeons should be board certified by the American Board of Orthopedic Surgeons.

The pricing and benefits information reflected in this report is based upon the common pricing and practices found in most markets and may not reflect the specific pricing or health benefits available to you. Some providers charge amounts well in excess of the Blue Book fair price. Some insurance plans cover services differently. If possible, you should check with your medical provider and health insurance company to confirm pricing and benefit coverage for services before you get care. In addition, you will want to check on your providers' quality information.

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Lap-Band

Alternate name:
Laparoscopic placement of a gastric band

(CPT code 43770)

Fair price:

Includes: Physician fee, facility fee, anesthesia fee

National fair price:	**$12,980**
National range:	**$8,900 – 22,000**

Local fair prices:

Boston, Massachusetts 02102	**$14,640**
Milwaukee, Wisconsin 53202	**$14,640**
Minneapolis, Minnesota 55402	**$12,370**
Jacksonville, Florida 32202	**$12,790**
Los Angeles, California 90006	**$13,930**
Houston, Texas 77010	**$13,350**
New York, NY 10003	**$15,340**

Check the fair price in your region at healthcarebluebook.com

Details:

How were these prices calculated and what are they based on?

This is Healthcare Blue Book's recommended price for a Lap-Band surgery.

The fair price recommendation is based on the typical negotiated payment amount that providers accept from insurance companies.

If you have insurance, you should be able to find in-network providers that accept prices at or below the Blue Book fair price, although many providers may charge more.

How should consumers use this information?

You can use the Blue Book fair price as a guide to help you compare prices when you shop for care and to make sure that you receive treatment at a fair price.

If you have health insurance, you should use your provider directory to identify in-network providers in your area. The Lap-Band procedure is typically performed by a bariatric surgeon (a surgeon that specializes in weight loss related surgeries) or a general surgeon trained in weight loss surgical techniques.

You can call the providers or your health insurance company to get a cost estimate. You will need to know the name of the procedure and possibly the Current Procedural Terminology (CPT) code for the service you need. It is also useful to have your insurance card available.

Different in-network providers often charge different prices. Prices for Lap-Band surgery may range from $9,000 to over $20,000 in many areas. We recommend that you call several providers to find one that charges a fair price.

If you do not have insurance, make sure to let the office know that you are a self-paying patient. Self-pay patients are frequently quoted the billed charges amount (retail price) for the service, which can be 2 to 3 times what the provider would accept from an insurance company. Many providers will offer a discount to self pay patients – but you must remember to ask for the discount.

Key points to consider when shopping for breast reduction surgery.

- Lap-Band surgery pricing frequently varies by over 200% in many locations. It is not uncommon to find Lap-Band surgery pricing below $10,000 or more than $20,000. You should call several providers to ask about the price of your Lap-Band surgery before you have your procedure.
- Make sure that the price estimate includes the physician fee, the facility fee and the anesthesia fee. You may need to call your physician, the facility and the anesthesia practice to get prices.
- Be sure to ask whether the price includes follow up visits for adjustments to the Lap-Band for a period of time, such as the first year.
- Be sure to also ask about other costs you may have to pay that are related to the surgery. These costs may include laboratory tests before and after the procedure, imaging tests and medications.

- If your Primary Care Physician has already referred you to a specialist, make sure to ask for their price and compare it to the Blue Book fair price before receiving treatment.
- If you get a price estimate that is significantly higher than the fair price, you may want to talk to your doctor about other options for where you will have your procedure performed. Some doctors can perform the procedure at a free standing Ambulatory Surgery Center (ASC). Receiving treatment at an independent ASC is typically less expensive than having the procedure at a hospital's outpatient facility.

If you have a Health Savings Account (HSA) or Health Reimbursement Account (HRA) you can apply those funds to any deductible, co-insurance or other out of pocket costs.

Is Lap-Band surgery typically covered by health insurance plans?

Lap-Band surgery may be covered by your insurance company. Most insurers have patient clinical criteria that must be met before approving the treatment. The most common criteria is that the patient must have a Body Mass Index (BMI) in excess of 40.

Your insurer may also have other criteria that must be met before granting approval, such as requiring the patient to participate in a 3 month weight-loss program supervised by a nutritionist. Patients may also be required to use certain certified providers and facilities for their surgery.

Lap-Band may be approved for patients with a BMI below 40 when accompanied by other clinical conditions such as:

- Weight related disabling joint disease; or
- Pulmonary hypertension from obesity; or
- Coronary artery disease; or
- Insulin-resistant type II diabetes

Patients should talk to their doctor about whether or not they meet the criteria. Always check with your insurer to make sure a procedure is covered before seeking treatment.

Your insurer may require pre-certification prior to agreeing to cover your Lap-Band surgery. You should always ask and then confirm that your provider is going to obtain pre-certification for your Lap-Band surgery before you receive treatment.

If your provider does not obtain pre-certification prior to your Lap-Band surgery, you will need to call the health plan and request pre-certification yourself. Always make sure that your Lap-Band surgery is pre-certified before receiving treatment. Insurers may deny payment of the claim if you have not obtained pre-certification.

Is Lap-Band surgery typically covered by Medicare or Medicaid plans?

Medicare will pay all or part of Lap-Band surgery if the procedure is considered a medical necessity. Cases are evaluated on an individual basis and patients must meet sev-

eral criteria. These criteria include a BMI in excess of 35 and one or more clinical complications related to obesity. If approved, Medicare also requires the patient to receive treatment at a Medicare approved bariatric surgery center.

Medicaid coverage for Lap-Band surgery is covered on a state-by state basis. Patients should check their state Medicaid website for more information.

What kind of out-of-pocket costs should I expect to pay?

Your out of pocket costs will depend on the type of insurance that you have. You may be responsible for copays, deductibles or coinsurance amounts. In order to determine your out of pocket costs, always review your co-pay amounts, current deductible balance and current co-insurance obligation before seeking treatment. If you have questions about your benefit plan or out of pocket costs, talk to your insurance company.

Remember, if you have a Health Savings Account (HSA) or Health Reimbursement Account (HRA) you can apply those funds to any deductible, co-insurance or other out of pocket costs.

Do the costs for this service vary depending on which provider I use?

The price variation in most locations varies by 200% or more depending on where you get your care. Make sure to ask about the price of this service before you get your care to make sure that you will be charged a fair price. If you are not satisfied with a provider's price, you can consider other providers that may offer you a more reasonable price.

What other trends or variations in cost should I be aware of?

- Lap-Band surgery is an outpatient procedure. Patients should talk to their doctor to see if they can have the surgery performed at a qualified independent bariatric surgery center. Many times the independent facilities offer better prices with equal or better care quality.
- Patients should also ask about other costs you may have to pay that are related to the surgery. These costs may include laboratory tests before and after the procedure, im aging tests and medications.
- Lap-Band patients will have on-going costs related to periodic adjustment of the band. Be sure to discuss follow up and ongoing costs related to band adjustment or other diagnostic tests.

What other tips can help me ensure I get the best price?

The choice of facility for your Lap-Band surgery will usually have the biggest impact on your total price. When seeking a surgeon, patients will want to make sure to ask if the surgeon can perform the procedure at an independent ambulatory surgery center (ASC). Independent ASCs are not affiliated with major hospitals, and generally charge less than hospital based outpatient facilities for equivalent or better quality care.

Qualifications

Patients should choose a facility that has been certified as a Bariatric Surgery Center of Excellence. Several organizations accredit Bariatric surgery centers, including American Society for Metabolic and Bariatric Surgery and the American College of Surgeons.

Hospitals should also be accredited by The Joint Commission on Accreditation for Healthcare Organizations (JCAHO). ASCs should also be accredited by one of the major agencies, including the Accreditation Association for Ambulatory Health Care (AAAHC), American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF) or the Joint Commission on Accreditation for Healthcare Organizations (JCAHO).

Surgeons should be board certified by the American College of Surgeons. You can also ask if your surgeon is a member of the American Society for Metabolic and Bariatric Surgery.

Alternatives

Patients should talk to their doctor about alternatives to surgical procedures for weight loss. Patients should always try to achieve weight loss through non-invasive surgical techniques such as diet and exercise. Patients may want to ask their doctor about working with a nutritionist or finding an exercise therapist.

There are other surgical techniques for addressing weight loss, including gastrointestinal bypass surgery. Gastric bypass surgery is a more invasive inpatient procedure that involves surgery of the stomach. Gastric bypass generally has higher complication rates and requires a longer recovery period following surgery.

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Brain MRI

(CPT code 70551)

Fair price:

Includes: Physician fee, facility fee

National fair price: $560

National range: $504-2520

Local fair prices:

Boston, Massachusetts 02102 ..... $632

Milwaukee, Wisconsin 53202 ..... $529

Minneapolis, Minnesota 55402 ..... $534

Jacksonville, Florida 32202 ..... $552

Los Angeles, California 90006 ..... $601

Houston, Texas 77010 ..... $576

New York, NY 10003 ..... $662

Check the fair price in your region at healthcarebluebook.com

Details:

How were these prices calculated and what are they based on?

This is Healthcare Blue Book's recommended price for a brain MRI without contrast.

The fair price recommendation is based on the typical negotiated payment amount that providers accept from insurance companies.

If you have insurance, you should be able to find in-network providers that accept prices at or below the Blue Book fair price, although many providers may charge more.

How should consumers use this information?

You can use the Blue Book fair price as a guide to help you compare prices when you shop for care and to make sure that you receive treatment at a fair price.

If you have health insurance, you should use your provider directory to identify in-network providers in your area. You can call the providers or your health insurance company to get a cost estimate. You will need to know the name of the procedure and possibly the Current Procedural Terminology (CPT) code for the service you need. It is also useful to have your insurance card available.

Different in-network providers often charge different prices. Prices for brain MRI without contrast may range from $400 to over $2,500 in many areas. We recommend that patients call several providers to find one that charges a fair price.

Key points to consider when shopping for brain MRI

- MRI pricing frequently varies by over 500% in many locations. It is not uncommon to find MRI pricing below $400 or above $2,500. Patients should call several providers to ask about the price of your MRI before you have your procedure.
- Make sure that the price estimate includes both the physician fee and the facility fee.
- If your Primary Care Physician has already referred you to an imaging facility, make sure to ask for their price and compare it to the Blue Book fair price before receiving treatment.
- If you get a price estimate that is significantly higher than the fair price, you may want to talk to your doctor about other facility options. You may want to ask your doctor about free-standing or independent imaging facilities (those that are unaffiliated with a hospital). Treatment at an independent imaging facility is typically less expensive than at the hospital's outpatient imaging facility.

If you have a Health Savings Account (HSA) or Health Reimbursement Account (HRA) you can apply those funds to any deductible, co-insurance or other out-of-pocket costs.

Is brain MRI typically covered by health insurance plans?

Yes, MRIs are usually covered by health insurance as long as they are medically necessary. Your insurer may require pre-certification prior to agreeing to cover your MRI. You should always ask and then confirm that your provider is going to obtain pre-certification for your MRI before you receive treatment.

If your provider does not obtain pre-certification prior to your MRI, you will need to call the health plan and request pre-certification yourself. Always make sure that your MRI is pre-certified before receiving treatment. Insurers may deny payment of the claim if you have not obtained pre-certification.

Always check with your insurer to make sure a procedure is covered before seeking treatment.

Is brain MRI typically covered by Medicare or Medicaid plans?

Yes, MRIs are covered under Medicare and Medicaid. Your provider may need to establish medical necessity or pre-certification before you receive treatment.

What kind of out-of-pocket costs should I expect to pay?

Your out-of-pocket costs will depend on the type of insurance that you have. You may be responsible for copays, deductibles or coinsurance amounts. In order to determine your out-of-pocket costs, always review your copay amounts, current deductible balance and current co-insurance obligation before seeking treatment. If you have questions about your benefit plan or out-of-pocket costs, talk to your insurance company.

Remember, if you have a Health Savings Account (HSA) or Health Reimbursement Account (HRA) you can apply those funds to any deductible, co-insurance or other out-of-pocket costs.

Do the costs for this service vary depending on which provider I use?

The price variation in most locations varies by 500% or more depending on where you get your care. Make sure to ask about the price of this service before you get your care to make sure that you will be charged a fair price. If you are not satisfied with a provider's price, you can consider other providers that may offer you a more reasonable price.

What other trends or variations in cost should I be aware of?

If you require contrast with your MRI, then the fee for the procedure will be higher.

What other tips can help me ensure I get the best price?

The facility where you receive your MRI will most often have the biggest impact on your total price. When seeking an imaging facility, patients should consider free-standing or independent imaging facilities.

Qualifications

Imaging facilities should be accredited. Accrediting organizations for facilities include the American College of Radiology (ACR) and The Joint Commission on Accreditation for Healthcare Organizations (JCAHO).

Your MRI will be interpreted by a physician. In most cases you will want to have your images reviewed by a board certified radiologist. If you have a complex problem, you may want to seek a subspecialist who is trained in neuroradiology.

Alternatives

A common alternative for brain MRI is the CT scan. Your clinical situation will determine whether an MRI or CT scan is most appropriate.

Overuse

Imaging studies can be overused.

You may want to discuss with your doctor what specific information the study will provide that will impact your care, if you could safely wait before having the study, or if there is a less expensive alternative that would provide the same information.

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Rhinoplasty

Alternate name:
Cosmetic surgery of the nose

(CPT code 30410)

Fair price:

Includes: Physician fee, facility fee, anesthesia fee

National fair price: $5,860

National range: ..... $4,000 - $10,550

Local fair prices:

Boston, Massachusetts 02102 ..... $6,441

Milwaukee, Wisconsin 53202 ..... $5,613

Minneapolis, Minnesota 55402 ..... $5,648

Jacksonville, Florida 32202 ..... $5,796

Los Angeles, California 90006 ..... $6,194

Houston, Texas 77010 ..... $5,987

New York, NY 10003 ..... $6,683

Check the fair price in your region at healthcarebluebook.com

Details:

How were these prices calculated and what are they based on?

This is Healthcare Blue Book's recommended price for rhinoplasty.

Rhinoplasty is an elective cosmetic surgery and is therefore not covered by most health insurance. The Blue Book fair price recommendation is based on the typical payment amount that providers accept from cash paying patients.

Patients should be able to find providers in their area that accept prices at or below the Blue Book fair price, although many providers may charge more.

How should consumers use this information?

You can use the Blue Book fair price as a guide to help you compare prices when you shop for care and to make sure that you receive treatment at a fair price.

Because rhinoplasty is typically paid for by the patient, patients should call several cosmetic surgery practices and ask about price. Patients can search for cosmetic surgeons at the American Medical Association website (www.ama-assn.org) or the American Association of Plastic Surgeons (www.plasticsurgery.org)

Different providers often charge different prices. Prices for rhinoplasty may range from $4,000 to over $9,000 in many areas. We recommend that patients call several providers to find one that charges a fair price.

Alternatively, patients may ask if a provider accepts the Blue Book fair price. The provider may accept the fair price amount or offer some discount from the original price.

Key points to consider when shopping for rhinoplasty.

- Prices for this service frequently vary by over 200% in many locations. Patients should call several providers to ask about the price before you have your procedure.
- Make sure to ask what is included in the price. Specifically, ask if the price estimate includes the physician fee, facility fee, anesthesia and one or more follow-up visits.
- Ask about other typical costs you may have to pay, such as pre-operative lab tests, imaging or post-operative medications.

Unless the procedure is to correct a structural defect in the nose, rhinoplasty does not qualify as a reimbursable expense for your Health Savings Account (HSA) or Health Reimbursement Account (HRA).

Is rhinoplasty typically covered by health insurance plans?

Rhinoplasty is considered an elective cosmetic procedure and is typically not covered by most health insurance policies.

However, if you require rhinoplasty to correct a structural defect of the nose or as part of treatment for another serious medical condition, your insurance company may pay part or all of the cost. Patients who need rhinoplasty to correct a medical problem will be required to provide evidence of medical need and receive pre-approval from their insurance company before having the procedure.

Is rhinoplasty typically covered by Medicare or Medicaid plans?

Rhinoplasty is considered an elective cosmetic procedure and is typically not covered by Medicare or Medicaid, except in instances of medical need.

What kind of out-of-pocket costs should I expect to pay?

Patients should expect to pay 100% of the cost out of pocket.

Patients may want to ask their provider if they can have an additional discount for paying the full bill at the time of treatment. If you cannot pay the full cost of the procedure at the time of treatment, some cosmetic surgery practices offer financing and payment plans.

Do the costs for this service vary depending on which provider I use?

The price variation in most locations varies by 200% or more depending on where you get your care.

Since this procedure is paid directly by the patient, most provider practices can be flexible in terms of offering discounts. If you are not satisfied with a provider's price, you can consider other providers that may offer you a more reasonable price.

What other trends or variations in cost should I be aware of?

There may be additional costs, such as pre-operative lab tests, imaging and post-operative medications (antibiotics, ointment or pain medications) that the patient may have to pay out of pocket.

What other tips can help me ensure I get the best price?

- If the quoted price is not initially in the range of the fair price, don't be afraid to ask for a discount.
- Always be courteous and respectful when asking about price or when interacting with office staff.
- If you are offered a discount based on payment at the time of treatment, make sure to pay your bill promptly.

Qualifications

Cosmetic surgeons should be board certified by the American Board of Plastic Surgeons.

Other concerns

Like any invasive surgery, rhinoplasty has its own risks, including infection, complication and scarring. Patients may also feel dissatisfied with the aesthetic results, which may lead to additional surgery.

Patients should discuss their expectations, the surgical risks and the long term clinical and financial implications with their doctor before electing to have this procedure.

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Colonoscopy

Alternate name:
Endoscopic evaluation of the colon

Fair price:

Includes: Physician fee, facility fee

National fair price:	**$1,110**
National range:	**$800 – 3,160**

Local fair prices:

Boston, Massachusetts 02102	**$1,272**
Milwaukee, Wisconsin 53202	**$1,210**
Minneapolis, Minnesota 55402	**$1,188**
Jacksonville, Florida 32202	**$1,204**
Los Angeles, California 90006	**$1,246**
Houston, Texas 77010	**$1,224**
New York, NY 10003	**$1,224**

Check the fair price in your region at healthcarebluebook.com

Details:

How were these prices calculated and what are they based on?

This is Healthcare Blue Book's recommended price for a Colonoscopy (without biopsy).

The fair price recommendation is based on the typical negotiated payment amount that providers accept from insurance companies.

If you have insurance, you should be able to find in-network providers that accept prices at or below the Blue Book fair price, although many providers may charge more.

How should consumers use this information?

You can use the Blue Book fair price as a guide to help you compare prices when you shop for care and to make sure that you receive treatment at a fair price.

If you have health insurance, you should use your provider directory to identify in-network providers in your area. You can call the providers or your health insurance company to get a cost estimate. You will need to know the name of the procedure and possibly the Current Procedural Terminology (CPT) code for the service you need. It is also useful to have your insurance card available.

Different in-network providers often charge different prices. Prices for Colonoscopy (without biopsy) may range from $800 to over $3,000 in many areas. We recommend that patients call several providers to find one that charges a fair price.

Key points to consider when shopping for colonoscopy.

- Colonoscopy pricing frequently varies by over 300% in many locations. It is not uncommon to find colonoscopy pricing below $1,000 or above $3,000. Patients should call several providers to ask about the price of your colonoscopy before you have your procedure.
- Make sure that the price estimate includes both the physician fee and the facility fee. You may need to call both your physician and the facility to get prices.
- If your Primary Care Physician has already referred you to a specialist, make sure to ask for their price and compare it to the Blue Book fair price before receiving treatment.
- If you get a price estimate that is significantly higher than the fair price, you may want to talk to your doctor about other options for where you will have your procedure performed. Some doctors can perform the procedure in their office or at a free standing Ambulatory Surgery Center (ASC). Care in the office setting or at an ASC is typically less expensive.
- Not all patients require anesthesia for their colonoscopy. You may want to ask your physician if they use anesthesia and if there are other options like mild sedation.

If you have a Health Savings Account (HSA) or Health Reimbursement Account (HRA) you can apply those funds to any deductible, co-insurance or other out of pocket costs.

Is colonoscopy typically covered by health insurance plans?

Yes, colonoscopies are usually covered by health insurance for members over the age of 50, or those under the age of 50 who may be at-risk for colon cancer or other types of cancer. Your insurer may also have limits on how frequently a colonoscopy can be performed. For example, most insurers will pay for a colonoscopy every 4 years, unless there is a medical reason for more frequent screenings.

Always check with your insurer to make sure a procedure is covered before seeking treatment.

Is colonoscopy typically covered by Medicare or Medicaid plans?

Yes, colonoscopies are covered under Medicare Part D. Patients may be screened once every ten years, or more frequently depending on medical need (such as risk of cancer). Patients may be required to pay a portion of the Medicare schedule amount.

What kind of out-of-pocket costs should I expect to pay?

Beginning in 2011 many employers (but not all) are required to make preventive procedures like colonoscopies and mammograms exempt from co-pays and the deductible. Colonoscopy (without biopsy) is typically considered a preventive procedure, so you should check with your insurance benefits to find out whether or not this procedure is exempt from deductible or copayment.

Your out of pocket costs will depend on the type of insurance that you have. You may be responsible for copays, deductibles or coinsurance amounts. In order to determine your out of pocket costs, always review your co-pay amounts, current deductible balance and current co-insurance obligation before seeking treatment. If you have questions about your benefit plan or out of pocket costs, talk to your insurance company.

Remember, if you have a Health Savings Account (HSA) or Health Reimbursement Account (HRA) you can apply those funds to any deductible, co-insurance or other out of pocket costs.

Do the costs for this service vary depending on which provider I use?

The price variation in most locations varies by 300% or more depending on where you get your care. Make sure to ask about the price of this service before you get your care to make sure that you will be charged a fair price. If you are not satisfied with a provider's price, you can consider other providers that may offer you a more reasonable price.

What other trends or variations in cost should I be aware of?

If you require anesthesia for this procedure, the anesthesia charge may be an additional $150-$200.

If your doctor performs a biopsy during the procedure, then the cost of the procedure will be higher. In addition, there would be a pathology fee.

What other tips can help me ensure I get the best price?

The facility you use for your colonoscopy will most often have the biggest impact on your total price. When seeking a provider, patients will want to make sure to ask if the provider can perform the procedure in office or at an ambulatory surgery center.

If you are searching for a provider in your provider directory, you may want to check for facilities called Endoscopy Centers. Endoscopy Centers are a type of ambulatory surgery center that specialize in procedures such as colonoscopies and endoscopies. In many instances Endoscopy Centers offer the best value.

Qualifications

ASCs should be accredited by one of the major agencies, including the Accreditation Association for Ambulatory Health Care (AAAHC), American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF) or the Joint Commission on Accreditation for Healthcare Organizations (JCAHO).

Gastroenterologists should be board certified by the American Board of Gastroenterology.

Alternatives

There are radiologic imaging studies that can be used to image the colon. You can discuss these alternatives with your doctor.

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