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Balance Billing Policy

Values

Accountability ● Integrity ● Service Excellence ● Innovation ● Collaboration

Abstract Purpose:

This reimbursement policy Network Health's process, for all lines of business, for balance billing Network Health members/participants for services rendered.

Policy Detail:

I. Network Health does not allow providers to bill for health care costs for which the member/participant is not liable, or is not listed as an exclusion in the member/participant's coverage document.

A. The provider can collect from the member/participant:

1. Applicable deductible, coinsurance, or co-payments as indicated in the member/participant's coverage document; with the exception of a Medicare Advantage member who has been designated as a Qualified Medicare Beneficiary by the Centers for Medicare and Medicaid Services; a provider can not collect from the Medicare Advantage Dual Eligible member costs.

2. Services determined to be not medically necessary by Network Health's Utilization Management department or its designee through a prior authorization before services are rendered.

3. Services specifically excluded in the member/participant's coverage document.

B. Network Health does not allow providers to bill the member/participant the difference between the provider's billed charges and Network Health's allowed amount.

C. Network Health will require a provider to issue a refund if the member/participant paid the provider any dollar amount greater than what is indicated in the coverage document.

D. Network Health will require a provider to issue a refund and submit a claim on the members/participants behalf for any service that is not listed as an exclusion in the coverage document, or any service determined to be medically necessary

by Network Health's Utilization Management department or its designee.

1. Provider can submit a request for prior-authorization or pre-determination to Network Health's Utilization Management department before services are rendered to determine medical necessity.

II. The Consolidated Appropriations Act (CAA) of 2021, which includes the No Surprises Act, imposes requirements effective 1/1/2022, on plans offering group or individual health insurance coverage.

A. No Surprises Act prevents balance billing of members/participants for non-participating emergency room providers/facility's services, non-participating ancillary services performed at a participating hospital, facility, or clinic, and non-participating air ambulance provider's services. Providers may not balance bill members/participants the difference of the plan payment and member/participant cost share.

III. Commercial Lines of Business

A. Hold Harmless Provision: A provider who is subject to the statutory hold-harmless provision may not bill, charge, collect a deposit from, seek remuneration or compensation from, file, or threaten to file with a credit reporting agency, or have any recourse against a Network Health member/participant for health care costs for which the member/participant is not liable. Network Health holds participating providers liable to Sections 609.91 to 609.935, and 609.97 (1) of the Wisconsin State Statutes. https://docs.legis.wisconsin.gov/statutes/statutes/609/91.

IV. Medicare Advantage Lines of Business

A. Providers may not balance bill members per the Medicare Managed Care Manual, Chapter 4, Section 170.2.

Regulatory Citations:

H.R. 133 - Consolidated Appropriations Act, 2021, Division BB, Title I
Medicare Managed Care Manual, Chapter 4, 170.2
Wisconsin State Statute 609.91

Related Policies:

Claim Submission Policy

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