

n05711
Balance Billing Policy

Values

Accountability • Integrity • Service Excellence • Innovation • Collaboration

Abstract Purpose:

This reimbursement policy outlines 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 for any service not listed as an exclusion in the member/participant's coverage document.
 - A. The provider may collect from the member/participant for:
 1. Applicable deductible, coinsurance, or co-payments as indicated in the member/participant's coverage document; except for a Medicare Advantage member who has been designated as a Qualified Medicare Beneficiary by the Centers for Medicare and Medicaid Services.
 2. Services determined to be not medically necessary by Network Health's Utilization Management department or its designee through prior authorization before services are rendered.
 3. Services specifically excluded in the member/participant's coverage document.
 - B. The Provider may not collect from any member enrolled in both the Medicare and Medicaid program for eligible expenses for which the state Medicaid agency would be responsible; but shall bill the applicable state Medicaid agency for such covered expenses.
 - C. 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.
 - D. 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.

- E. If the provider collects payment for services that are not listed as an exclusion in the coverage document, or for any service determined to be medically necessary by Network Health's Utilization Management department or its designee, the provider must issue the member a full refund.
 - 1. The Provider may submit a request for prior-authorization or pre-determination to Network Health's Utilization Management department before services are rendered to determine medical necessity.
 - 2. In accordance with the Claim Submission Policy and the terms of the provider's contract, the provider should submit the claim for benefit review and payment determination.
- 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 between 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:

[n05659 Claim Submission Policy](#)

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