BLACKROCK ORTHOPEDICS | Knee Surgery

PATIENT RIGHTS AND PROTECTION REGARDING SURPRISE MEDICAL BILLS

Balance billing, also known as surprise billing, occurs when medical providers and facilities have not signed a contract with a patient's health insurance plan. Out-of-network providers are permitted to bill patients for the difference between their full charged amount and the amount that the patient's health insurance plan agreed to pay. This amount may likely be more than in-network costs for the same service and may not count towards patient's annual out-of-pocket limit; also known as stop loss.

Surprise billing is an unexpected charge that is billed to patients. This may happen when a patient does not have control over who is involved in their care – such as when they receive care at an emergency department or an in-network facility but are unexpectedly treated by an out-of-network provider. Patients are protected from balance billing in cases such as:

Emergency Services – In the event a patient receives treatment for an emergency condition from an out-of-network provider or facility, that maximum that provider or facility can bill a patient is their plan's in-network cost sharing amount(s), such as copayments, coinsurance, and deductibles. Patients CANNOT be balance billed for these emergency services. This also includes services a patient may receive once their condition is stabilized unless the patient has provided written consent and given up their protections to not be balanced billed for stabilization treatment.

Services received a in-network facilities including hospitals and ambulatory surgical centers – If a patient receives treatment from an in-network facility, certain providers that treat patients at these facilities may be out-of-network with the patient's health insurance plan. In this scenario, out-of-network providers may bill patients their insurance plan's in-network cost sharing amounts. Examples would include charges for emergency medicine providers, pathology, radiology, assistant surgeons, and anesthesia. These providers CANNOT balance bill patients and CANNOT ask them to give up their protections not to be balance billed.

Patients are only responsible for paying their cost shares, such as deductibles, copayments, and coinsurance, that they would be required to pay if they received services from in-network providers and facilities. Patient's health plan will pay out-of-network providers and facilities directly. Health insurance plans generally must (1) cover emergency services without requiring their member to get approval for services in advance (such as prior authorizations), (2) cover emergency services by out-of-network providers, (3) determine patient balances based on would the health insurance plan would pay an in-network provider or facility and reflect such in their explanation of benefits (EOB), (4) apply any amount the patient pays for emergency or out-of-network services towards your deductible and out-of-pocket limits.

Patients are never required to give up their protections from balance billing. Patients are also never required to receive care from out-of-network providers or facilities – they may choose to utilize a provider or facility that is in-network with their health insurance plan.

If a patient believes they have been incorrectly billed, they may contact the Federal Government's NO SURPRISES HELPDESK at 800-985-3059.