Priority Health	BILLING POLICY No. 089
BALANCE BILLING	
Date of origin: Apr. 15, 2025	**Review dates: None yet recorded**

APPLIES TO

- Commercial
- Medicare follows CMS unless otherwise specified
- Medicaid follows MDHHS unless otherwise specified

DEFINITION

Balance billing is the practice of billing the patient for the difference between what Priority Health pays for a covered service and the charge price for that service.

FOR MEDICARE

For indications that don't meet criteria of NCD, local LCD or specific medical policy a Pre-Service Organization Determination (PSOD) will need to be completed. Get more information on PSOD in our Provider Manual.

POLICY SPECIFIC INFORMATION

Participating providers may not balance bill patients for covered services, per contract.

Out-of-network providers must disclose the potential of balance billing before providing non-emergent services. Balance billing is not allowed in emergency scenarios. By law, if the provider fails to disclose this and obtain a patient signature, the patient may not be balance billed.

Disclosure must include:

- Statement that insurer may not cover all services
- A "good-faith" estimate for the to be provided
- Statement that care can be requested from an in-network provider
- Acknowledgement of understanding signed by patient or representative

Reimbursement for PARE providers

Out-of-network PARE providers (pathologists, anesthesiologists, radiologists and emergency room physicians) will be paid 150% of the Medicare payment OR the plan median contracted rate, whichever is greater.

Payment disputes

An out-of-network provider has the right to initiate a 30-day open negotiation period if they disagree with the reimbursement received related to surprise billing. To initiate this contact Multiplan at provider.multiplan.com, *NSAService@multiplan.com* or 888.593.7427. Please also notify us this process has been started at *NSA@priorityhealth.com*.

Documentation requirements

Complete and thorough documentation to substantiate the procedure performed is the responsibility of the provider. In addition, the provider should consult any specific documentation requirements that are necessary of any applicable defined guidelines.

Resources

- State of Michigan Bill No 4459
- State of Michigan Bill No 4460

DISCLAIMER

Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements appropriate to procedure, diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS) and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standard, compliant codes defined by CPT, HCPCS and revenue codes for all claim submissions. CPT, HCPCPS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document for services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align to these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

CHANGE / REVIEW HISTORY

Date	Revisions made