BALANCE BILLING PROHIBITION: WHAT YOU NEED TO KNOW

Professional Practice Toolkit

The Maryland Psychological Association

Document Objective

This document provides information about the law in MD that prohibits balance billing and impacts all practitioners. This law is not often known by providers, and thus it is possible to be caught off guard by scenarios described below.

Background & Ethical Considerations

Maryland Law prohibits all providers (contracted and non-contracted) from engaging in balance billing. See Health General Article, § 190710 (i) and (p). Balance billing is defined as the practice of a health care provider billing an HMO member for an amount of the provider's charges not covered by the insurer, except co-pays or coinsurance sums or any amounts up to the Medicare approved amount if the HMO is supplemental to Medicare. While this is not an issue for "non-covered services", it is possible that your services could be deemed "covered" without your knowledge and you would then be liable to uphold this law and possibly even reimburse clients who have already paid your fees.

What you need to know

- Basically, we have "covered services" (covered by the subscriber's HMO plan and therefore all applicable rules for fees apply) and "non-covered services" (a treatment service that is rendered, but not covered under the person's HMO plan). You cannot charge higher than the allowed fees (balance bill) for covered services – services authorized by the HMO.
- You are allowed to charge your usual fee with no restriction when you see someone for a "non-covered service" – that is, a service not authorized by the HMO.
- The problem is, that under certain circumstances, *a non-covered service can become a covered service* and under those circumstances, our fees are restricted to the allowed amount.
- So, the question then is: under what circumstances does a non-covered service become a covered service.
- Typically, HMO patients are required to see in-network participating practitioners and have no out-of-network benefits. Therefore, under the usual circumstance, if an HMO patient sees a non-participating practitioner then the service is considered a "non-covered services" and the out-of-network practitioner can charge the patient their usual rate.
- There are several circumstances, however, when a non-covered service can shift and become a covered service and, therefore, the billing limitations apply:
  - In Emergency circumstances (such as an Emergency Room);

- If the patient is referred to the non-participating practitioner by an HMO participating primary care physician with referral authority. In these circumstances, if the referral comes from the primary care doc, then the service may be considered to be a covered service;
- If the HMO pays for the service. (This is the interesting one: sometimes patients submit a bill to the HMO when they are seeing someone out of the network and know it will not be paid but they submit it just to see what happens. ***If the HMO pays for the service, then by virtue of the fact that they have paid for the service, the service now becomes a covered service and all fees must adhere to the HMO fee schedule).*** See Health General Article, §19-710.1.

- If the patient submits the bill to their HMO, and the HMO pays an "out of network" fee, you are then prohibited from billing the "balance" and are obligated to refund the difference, if any, to the patient. It creates an unexpected situation where the patient agrees to not bill the HMO, but does, and the provider is bound by the law.

Possible Scenarios:

- There have been situations where someone who participates with an HMO sees a psychologist who does not participate with the HMO, charges their usual fee, the patient decides to submit the bills to the HMO, the HMO pays, and the psychologist has had to reimburse the patient for the difference between the billed amount and the allowed amount.

- The more usual situation that presents problems is when someone is referred by their HMO primary care doctor with referral authority and all services then become defined as covered services (but the psychologist is not aware of this provision and charges their usual fee).

These scenarios refer to a contracting provider. However, the law also provides for reimbursement rates (generally 125% of the HMO fee based on certain criteria) for a *non-contracting provider, who is also prohibited from balance billing*. The limit for non-contracting provider who is reimbursed by the HMO is 125% of the fee (although emergency room docs may be 140%). But non-contracting providers who provide non-covered service have an unrestricted fee.

What can we do:

- If someone has an HMO policy and you have no contract with the HMO, make sure the patient was not referred by their primary care doc.
- If there was no referral, consider taking the extra step of having the patient call their HMO, confirm that the service is a non-covered service and then document in your chart that the patient called the HMO, the name of the person they spoke with, and the date of the call. This does not happen very often, but can be an expensive mess when it does happen.
- If you are out of network, have the patient agree in writing that they will not submit the bill to their HMO as documentation of your agreement.

Relevant Resources

Read further in this legislative study:

a. Legislative Study Balance Billing- HMO.pdf