Out of Network – Surprise Bill

Physician Guidelines

As you may be aware, New York State Public Health Law (PHL) §24, effective March 31, 2015, requires physicians and other health care professionals to make certain disclosures to patients and prospective patients regarding out-of-network providers. The intent of this law is to enable health-care consumers to make informed decisions regarding their use of providers, and to avoid receiving “surprise bills” from providers who are not participants in patients’ health insurance plans. It is important for physicians and other health care professionals to comply with the patient disclosure requirements of PHL §24. Willful or grossly negligent failure to do so may be considered misconduct, as defined in New York State Education Law (SED) §6530.

Emergency Services
When a physician provides emergency services in a hospital emergency room or to an inpatient directly admitted from the Emergency Department the physician is subject to the Out of Network-Surprise Bill regulations. In most cases this means that even if the physician does not participate with the patient’s insurance, the physician can only bill the patient the “out of pocket” costs he or she would have had to pay if the physician was in-network. Balanced billing in these situations is not permitted. The physician however, may bill his usual and customary charges to the insurance carrier and the insurance carrier is obligated to pay at least the greater of: (1) the amount the health plan has negotiated with participating providers for emergency services (and if more than one amount is negotiated, the median of the amounts); (2) 100% of the allowed amount for services provided by a non-participating provider (i.e. the amount the health plan would pay in the absence of any cost sharing that would otherwise apply for services of non-participating providers); (3) the amount that would be paid under Medicare. The State has set up a dispute mechanism if the parties can’t agree on the amount the health plan should pay for the service.

Non-Emergency Services – Surprise Bills
A “surprise bill” is a bill for health care services, other than emergency services, received by: (1) an insured for services rendered by a non-participating physician at a participating hospital or ambulatory surgical center, where a participating physician is unavailable, or a non-participating physician renders services without the insured’s knowledge, or unforeseen medical services arise at the time the health care services are rendered; provided, however, that a surprise bill shall not mean a bill received for health care services when a participating physician is available and the insured has elected to obtain services from a non-participating physician; or (2) an bill for services rendered by a non-participating provider where the services were referred by a participating physician to a non-participating provider without explicit written consent of the insured acknowledging that the participating physician is referring the insured to a non-participating provider and that the referral may result in costs not covered by the health plan.

A surprise bill includes services referred by a participating physician to a non-participating provider without the explicit written consent of the insured acknowledging that the participating physician is referring the insured to a non-participating provider and that the referral may result in costs not covered by the health plan. A referral to a non-participating provider occurs when (1) the health care
services are performed by a non-participating health care provider in the participating physician’s office or practice during the course of the same visit; (2) the participating physician sends a specimen taken from the patient in the physician’s office to a non-participating laboratory or pathologist; or (3) for any other health care services when referrals are required under the insured’s contract (i.e. a gatekeeper). Physicians when arranging for care of the patient must advise the patient if they are referring the patient to an out of network provider.

**What Must a Physician do to Comply**

The information detailed below must to be provided to a patient or prospective patient at the time physician refers or coordinates services with another provider:

- Name, practice name, mailing address, and telephone number of any health care provider scheduled to perform
  - anesthesiology;
  - laboratory;
  - pathology;
  - radiology or;
  - assistant surgeon services

- in connection with care to be provided:
  - in the physician's office;
  - as coordinated by the physician; or
  - as referred by the physician

The Information detailed below must be provided to a patient and to the hospital for scheduled hospital admissions or scheduled outpatient hospital services, at the time non-emergency services are scheduled:

  - The name, mailing address and telephone number of the facility the physician plans to refer the patient to for the service;
  - The name, practice name, mailing address and telephone number of any other physician whose services will be arranged by the physician and are scheduled at the time of pre-admission testing, registration or; and
  - Information as to how to determine the healthcare plans in which the physician participates,

In order to facilitate this communication, Maimonides has drafted the attached letter which should be given to the patient at the time a referral is being made. In addition to giving the letter to the patient, you should either document in the record that you provided the required information or have the patient sign a copy of the letter and maintain it in your files.

For more information on the Out of Network – Surprise Billing regulations please follow the link below:

[http://www.dfs.ny.gov/insurance/ihealth.htm](http://www.dfs.ny.gov/insurance/ihealth.htm)