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No Surprise Act

The No Surprises Act was passed by Congress in 2020 to help reduce the problem of consumers receiving an unexpected bill in an emergency or when they are out-of-network. On January 1, 2022, new provisions of the Act go into effect.

What is Surprise Billing?

When a person with a group health plan or health insurance coverage gets care from an out-of-network provider, their health plan or issuer usually does not cover the entire out-of-network cost, leaving them with higher costs than if they had been seen by an in-network provider. In many cases, the out-of-network provider can bill the person for the difference between the billed charge and the amount paid by their plan or insurance, unless prohibited by state law. This is known as "balance billing." An unexpected balance bill is called a surprise bill.

How does that impact me?

The new provisions of the No Surprises Act forbid balance billing in certain situations involving out-of-network care or emergency care and require that self-pay patients receive an estimate for certain scheduled services at or near the time of scheduling.

How does CCMHC Behavioral Health Care handle out-of-network situations?

It is the responsibility of the consumer to verify with their insurance who is in network prior to services. To help ensure consumers are seen by in-network provider(s), CCMHC is proactive in verifying prior to the service and will notify the consumer or the provider if not in network.

Why did I get an estimate for future services?

The Act requires that self-pay patients (patients without insurance, patients with medical sharing ministry plans or patients not planning on filing their charges to their insurance company). Estimates will be given to the consumer at Intake. We call this a Client Fee Agreement, it list(s) services provided and what your Sliding Fee is (your cost).

What if I don't plan on having my charges filed to my insurance company for my upcoming visit?

If you don't plan on having your charges filed to your insurance carrier at your visit, please indicate that at scheduling.

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What happens if I am a self-pay patient and no estimate was given to me?

The Act requires that we generate an estimate for you and if no estimate is sent, we are required to reschedule your visit. Our staff attempt to make sure that any self-pay patient is sent an estimate once their appointment is scheduled. However, if a patient's insurance status changes from the time of scheduling, and prior to the visit itself, we may be unaware of the change in your insurance status. If your insurance status has recently changed to self-pay, please contact our Billing department at 620-231-5130 Ext 808 prior to your visit to discuss the estimated fee.

I am curious about what my visit will cost. Can I get an estimate?

Yes. Please contact our Billing department at 620-231-5130 Ext 808 request an estimate for your upcoming service(s).

What if my final billed charges are more than my estimate?

This estimated cost of anticipated care takes into consideration insurance coverage, co-payments, deductibles, coinsurance and other factors that may affect your out-of-pocket costs based on information provided by you and your insurer(s). Expected charges are estimates. Final billed charges on the bill may vary from the estimate because of a patient's medical conditions; circumstances or complications. Or additional services that need to be scheduled separately.

If the variance between the estimate and the final bill is greater than $400 per provider, and the patient is unable to resolve their concern with CCMHC, the patient may initiate a Dispute Resolution Process by completing a request to Health and Human Services within 120 days of receiving billing. HHS PPDR (Patient-Provider Dispute Resolution Entities

Estimates for patients with insurance coverage can change frequently as the patient's remaining deductible and co-insurance change over their plan year. For that reason, for non-self-pay patients, an estimate is only valid for 30 days from the Creation Date shown on the estimate. If you have any questions regarding your estimate or when you receive your billing statement, please contact us at 620-231-5130 Ext 808.

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Good Faith Estimate

Under the Federal Law, health care providers need to give patients who do not have insurance or who are not using insurance and estimate of the bill for services.

- With proof of income CCMHC consumers are given a Sliding Fee, based off the TOTAL HOUSEHOLD INCOME, MINUS DEPENDENTS LIVING IN THE HOUSEHOLD. This is given at Intake and annually thereafter. If you have any questions, please feel free to contact the CCMHC billing department at 620-231-5130 Ext 808.

- If you receive a bill that is at least $400 more than your Good Faith Estimate, you can dispute the bill. If this happens, federal law allows you to dispute (appeal) the bill. To learn more, you can call 1-800-982-3059 or see http://www.cms.gov/nosurprises/consumers

The Good Faith Estimate does not include any unknown or unexpected costs that may arise during treatment. You could be charged more if complications or special circumstances occur.

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Your Rights and Protections Against Surprise Medical Bills

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You're protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out of network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed.

If you get other types of services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also are not required to get out-of-network care. You can choose a provider or facility in your plan's network.

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When balance billing isn't allowed, you also have these protections:

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.
- Generally, your health plan must:
    - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
    - Cover emergency services by out-of-network providers.
    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
    - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you believe you've been wrongly billed:

Contact us at 620-231-5130 Ext 808

For more information about your rights under federal law, visit www.cms.gov/nosurprises