Medicaid Member Balance Billing

Provider Guide

What is balance billing?

Balance billing is when a provider bills a Medicaid beneficiary for:

- The difference between the provider's charge and the Medicaid payment
- Services denied due to provider errors (e.g. no authorization, non-timely billing)
- Services not covered by Medicaid (unless specific conditions are met)
- Missed appointment
- Copying of medical records to send to another provider

Process and Guidelines Regarding Balance Billing

- Follow all MDHHS rules protecting Medicaid recipients from balance billing, available for your reference in the Medicaid Provider Manual (page 32)
- Validate patient insurance before rendering (non-emergent) services
- Work directly with Meridian for payment of services being rendered to patients you have confirmed to be enrolled with Meridian for their Medicaid benefits.
- If the Member is seeking medical care for non-covered services, submit a request for prior authorization of those services. This ensures that
    - Meridian makes a coverage determination based on the member's specific medical needs, based on medical documentation provided in the request
    - Meridian can inform the member of the coverage determination and member appeal rights if they disagree with our coverage decision
- If you are seeing patients with Meridian and are not in Meridian's network of providers, prior authorization is required.

Can a beneficiary choose to pay privately?

After Meridian has had the chance to review the authorization request and make a plan coverage determination, if the plan denies the coverage being requested, the provider can work with the Meridian Medicaid member to sign an attestation form for liability of the services, in accordance with MDHHS regulations.