REDUCE YOUR OUT OF NETWORK BILLS *

Scenario: You recently had surgery, or ended up in the ER. One (or more) physician evaluated you. Not all are part of your insurance network, and you are now receiving outrageous fees. You did not choose them or directly request their services. How can you get out of paying these bills?

This is routinely happening in our times of restricted insurance coverage, smaller networks, reduced choice of in-network providers and growing trend among physicians of opting out of all contracts.

Appeals made by patients are often rejected. Reasons range from "it is the patient's responsibility to use in network providers" to "the policy has a strict exclusion for all out of network services".

Understand that you may have to pay something for the services rendered to you. But know that you do have options, and rights, at your disposal before taking out your credit card.

1. Get the insurance to pay

If the hospital is "in network", but the insurance paid a provider at the out of network rate, file an appeal and demand they pay the higher contracted rate based on the preferred contracted status of the facility. Other arguments should include: You had no choice in the matter, you went to the correct facility, services were medically necessary, this was the only specialist available, or none of the specialists on call were providers (often the case with anesthesiologists).

Ask that the insurance attempt to sign a one-time agreement with the physician. Inform the office: such deals are routinely (and gratefully) accepted.

2. Invoke your rights

Your patient's rights include the rights to receive timely, appropriate, adequate, qualified care. If the in-network or preferred provider could not render the service soon enough, lacked the necessary qualifications, expertise or training, was too far away from your location, or if you could not trust him for specific reasons, your insurer must cover the out-of-network cost of the provider you chose.

If a service was rendered under emergency conditions, specific policy guidelines and regulations kick in. **Public Health Service Act (PHS Act) section 2719A** and the **ACA** ("Obamacare") impose on health insurances to fully cover emergency services in an emergency department of a hospital without regard if the provider is out of network, and requires insurers to apply the same financial liability to the patient as would have been if in network.

3. Call your State's Insurance Commissioner

If your appeal is still denied despite using these arguments, consult your State's Insurance Commissioner's website for information on how to submit a grievance against the health plan. Include a copy of all relevant documents when filing. Some states offer free phone consultations to determine whether you have a case.

4. Deal with the provider directly

A provider may refuse an insurance agreement or to write off your balance after an "in network" payment. Request to meet the office manager to negotiate. Meanwhile, send small monthly payments to avoid collection action.
Your insurance representative may be able to help you determine an acceptable settlement, as would a billing advocate. Remember that a one-time "paid in full" remittance is more attractive than monthly payments.

5. Ask the referring physician

If all fails, contact your surgeon, explain the situation and ask for assistance. A non-contracted provider, counting on more referrals and work from his colleagues, may have to learn to be more flexible and less greedy. Another physician is the best placed to explain this delicate situation.

The referring physician, or his office manager, may be able to use his contacts with the facility's officers to get a bill reduced or an application for financial assistance pushed through.

If the provider belongs to a medical group, as anesthesiologists and ER physicians often do, file a request for a review of your case and ask for a fee reduction directly with the managing director. They often are more sensitive to negative comments and potential backlash, especially if you indicate a copy is being forwarded to the referring physician and to the administrator of the facility.

In conclusion:

A negative response to an insurance appeal or the initial refusal of a reduced fee should not deter patients from seeking other avenues to get a better outcome. Patient satisfaction and the threat of public exposure are growing factors forcing medical providers to "play nice". Knowing your rights and demanding they are respected are powerful incentives, as are hiring a patient advocate or going up the corporate ladder.

* A seen on NerdWallet