



Required Compliance Components of the No Surprises Act

Presented by:
Kathy (KMC) Weidner, MCS-P, CCPC, CCA



1

Disclaimer

The information provided in this training is intended only to be a summary of legal standards. It is not intended to take the place of the statutes, regulations, or formal policy guidance. This tutorial presents current policy and operations as of the date it was presented. We encourage all attendees and/or library members to refer to the applicable statutes, regulations, and appropriate interpretive materials for complete and current information. This resource is to provide clarity but is not to be considered as legal interpretation of the law.

Disclaimer



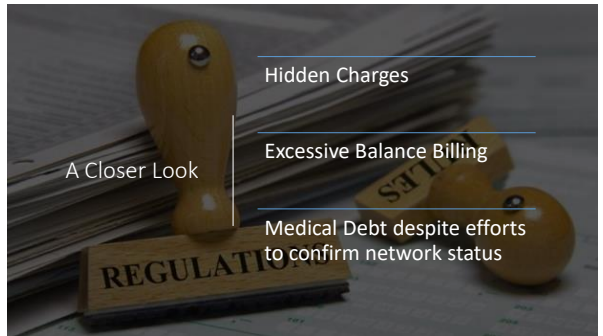
2



The Focus of the No Surprises Act



3



A Closer Look

- Hidden Charges
- Excessive Balance Billing
- Medical Debt despite efforts to confirm network status

4




Consumer Empowerment



5

What is Surprise Billing?

Surprise billing occurs when an individual receives an **unexpected medical bill** from a health care provider or facility after receiving medical services from a provider or facility that, **usually unknown** to the participant, beneficiary, or enrollee, is a **nonparticipating provider** or facility with respect to the individual's coverage.



6

Summary of the Rule

- No balance billing for air ambulance services by nonparticipating air ambulance providers (PHSA 2799B-5; 45 CFR 149.440)
- No balance billing for out-of-network emergency services (PHSA 2799B-1; 45 CFR 149.410)
- No balance billing for **non-emergency services by nonparticipating providers at certain participating health care facilities**, unless notice and consent was given in some circumstances (PHSA 2799B-2; 45 CFR 149.420)

7

What is a Facility?

Health care facilities include:
hospitals, hospital outpatient departments, critical access hospitals, and ambulatory surgical centers

8

Does the Balance Billing Protection Rule Apply to Me in My Chiropractic Office?

9

The KMC University No Surprises Act (NSA) Doctor of Chiropractic (DC) Decision Making Matrix®

Non-Emergency Services & Doctors of Chiropractic (DC)

Does the DC have Hospital, Emergency Department or Ambulatory Surgery Center privileges?

- YES** → Is the facility in-network?
 - NO** → The No Surprises Billing rule applies to in-network facilities. You do not need to abide by the NSA if you are rendering services as an out-of-network doctor at an out-of-network facility. Implement a non-covered services notification form when rendering out-of-network or non-covered services.
 - YES** → Is the DC in network with facility?
 - NO** → Is there a Single Case Agreement in place?
 - NO** → Local State Surprise Billing Laws & NSA apply
 - YES** → The Single Case Agreement controls billing procedures for the individual case
- NO** → Surprise Billing rule does not apply to out-of-network doctors who are not rendering services at an in-network facility. Implement a non-covered services notification form when rendering out-of-network or non-covered services.

10

Single Case Agreement

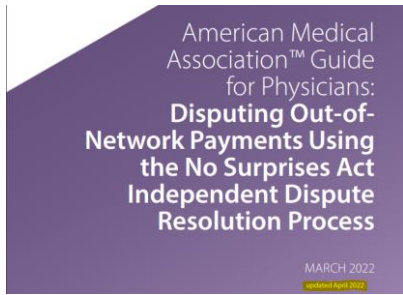
11

Cost Sharing Amounts- For the 1%

- Amount determined by an applicable **All Payer Model Agreement (PMA)** under the Social Security Act Section 1115A
If no PMA
- Amount determined by **State Law** or
- The lesser of the billed charge or the plan's or issuer's median contracted rate which is referred to as **Qualifying Payment Amount (QPA)**



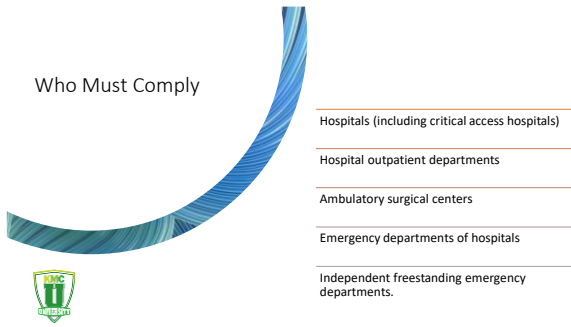
12



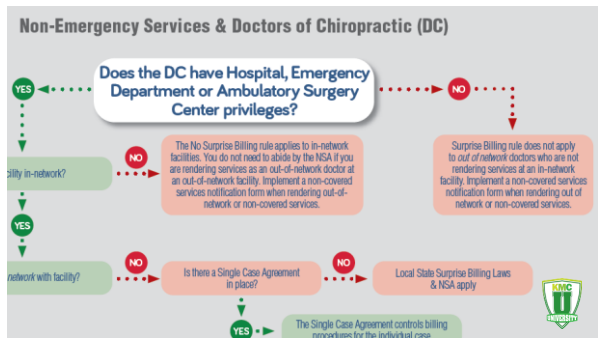
13



14



15



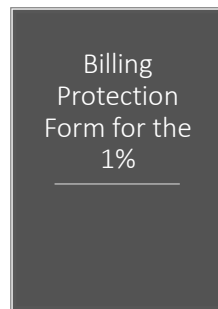
16

1% of Providers To Do List

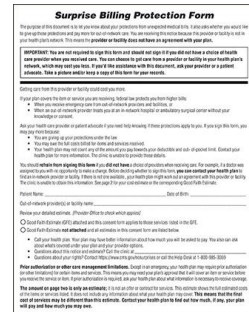
- Locate the Balance Billing Protection Resources
- Obtain a Balance Billing Protection Form from CMS or from KMC University
- Obtain a Model Disclosure Notice from CMS or KMC University
- Review the AMA Resources (available online)



17



18



The Model Disclosure for the 1%

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

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, such as a copayment, coinsurance, and/or a deductible. You may have other 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" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay 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 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.

You are protected from balance billing for:

19



Medicare Already Has Rules

The rules do not apply to people with coverage through programs such as Medicare, Medicaid, Indian Health Services, Veterans Affairs Health Care, or TRICARE. Each of these programs already has other protections against high medical bills.

20

Summary of the Rule →

- No balance billing for air ambulance services by nonparticipating air ambulance providers (PHSA 2799B-5; 45 CFR 149.440)
- No balance billing for out-of-network emergency services (PHSA 2799B-1; 45 CFR 149.410)
- No balance billing for non-emergency services by nonparticipating providers at certain participating health care facilities, unless notice and consent was given in some circumstances (PHSA 2799B-2; 45 CFR 149.420)
- Disclose patient protections against balance billing (PHSA 2799B-3; 45 CFR 149.430)

21



Payer & Provider Relationship

22

On the Horizon

- Price Transparency
- Continuity of Care
- Disclosures
- Provider Directory
- Advance Explanation of Benefits

23

Payer Requirements

Provide	Ensure	Improve
Provide price transparency information for covered items and services (45 CFR Parts 147 and 158 [CMS-9915-F])	Ensure continuity of care when a provider's network status changes (PHSA 2799B-8)	Improve provider directories and reimburse enrollees for errors (PHSA 2799B-9)

24

Transparency

"On July 9, 2021, President Biden signed Executive Order 14036, Promoting Competition in the American Economy in order to promote the interests of American workers, businesses, and consumers. The executive order acknowledges that **robust competition** is critical to providing consumers with more choices, better service, and lower prices and directs the Secretary of HHS to support existing **price transparency for hospitals and providers and insurers.**"

25


The Benefits of the Transparency Rule

- Pricing Information Prior to Seeking Care
- Ability to Shop for Care
- Increase Competition in the Health Market



26

Payer Requirements for Transparency



- Permit members to search based on billing code or description
- Allow members to compare costs **across both in-network and out-of-network providers**
- Inform members of any accumulated deductible or other out-of-pocket expenditures to date
- Provide cost estimates in paper format at the member's request

27

Continuity of Care-90 Day Rule


Health plan members are **continuing care patients** if they meet one or more of these conditions with respect to a terminated provider or facility:

- **Undergoing a course of treatment for a serious and complex condition** [defined as "serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm"]
- Undergoing a course of institutional or inpatient care
- Are scheduled for a non-elective surgery, including receipt of postoperative care
- Are pregnant and undergoing a course of treatment for the pregnancy
- Are receiving treatment for a terminal illness (see section 1361(d)(3)(A) of the Social Security Act)

28

Who Must Comply-1%


- Hospitals (including critical access hospitals);
- Hospital outpatient departments;
- Ambulatory surgical centers;
- Emergency departments of hospitals; and
- Independent freestanding emergency departments.



29

Single Provider Clinic Requirements

Providers that **never furnish items or services at a health care facility** or in connection with visits to a health care facility **do NOT need to fulfill the No Surprises Act Balance Billing disclosure requirements.**



30

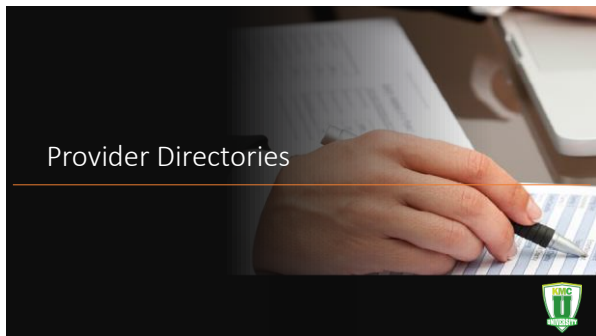


31

Provider Impact

- Improve**
 - Improve provider directories (PHSA 2799B-9)
- Provide**
 - Provide **good faith estimate** in advance of scheduled services, or upon request (PHSA 2799B-6; 45 CFR 149.610 (for uninsured or self-pay individuals))

32



33

Provider Requirements

Must submit provider directory information to a plan or issuer:

- at the beginning of a network agreement with a plan or issuer
- if the provider terminates a network agreement with a plan or issuer
- when there are material changes to the content of provider directory information of the provider
- at any other time (including upon the request of plan or issuer) determined appropriate by the provider, health care facility, or the Secretary of Health and Human Services (HHS)

34

CMS Scenario..

- A doctor of chiropractic recently began a network agreement with a new health plan. **Is the DC required to submit provider directory information to the plan?**

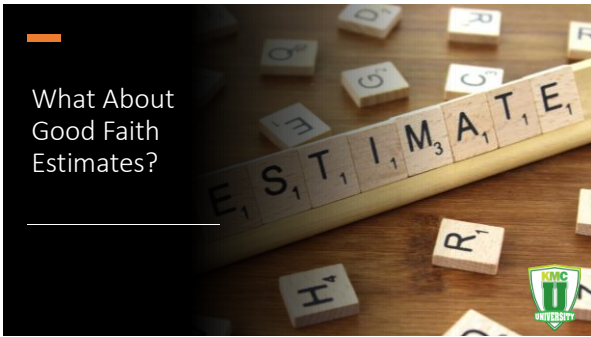
Yes, under the No Surprises Act, the DC is required to submit provider directory information (i.e. the provider's name, address(es), specialty, telephone number(s), and digital contact information) to a plan or issuer when they begin a network agreement with a plan or issuer with respect to certain coverage.

35

Keep Information Up to Date

- Names, addresses, specialty, telephone numbers, and digital contact information of **individual health care providers**; and
- Names, addresses, telephone numbers, and digital contact information of each medical group, **clinic**, or health care facility contracted to participate in any of the networks of the group health plan or health insurance coverage involved.

36



What About Good Faith Estimates?



37

The No Surprises Act Complexity

- Independent Dispute Resolution (IDR) Process
- Requires Good Faith Estimates**
- Advance Explanation of Benefits
- Patient Provider Dispute Resolution
- Transparency & Balance Billing Protections

38

- **Who** should receive a GFE
- **What** a GFE should contain
- **When** should a GFE be provided
- **How** can a clinic be compliant



39

"Health care providers and health care facilities are required under PHS Act section 2799B-6 to furnish a **notification of the good faith estimate of expected charges to an uninsured (or self-pay) individual** who schedules an item or service..."

Good Faith Estimate



40



Providers are defined as...

"physicians or other health care providers acting within the scope of their state licenses"

41



WHO Gets One?



42

Self-Pay Patients

Uninsured

Does not plan to use their insurance benefits to pay for the services provided by the physician—OON!

43

Who Also Gets One?

"...to an individual who has not yet scheduled an item or service, but requests a good faith estimate"

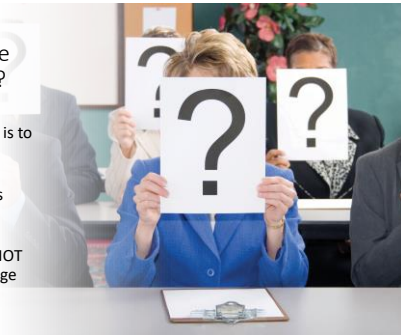


44

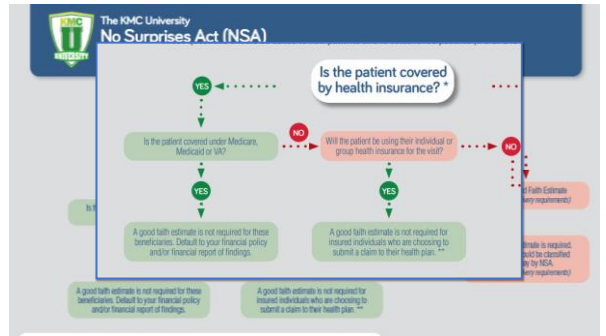
Who Should Be Offered a GFE?

Good Faith Estimate is to be offered to the following:

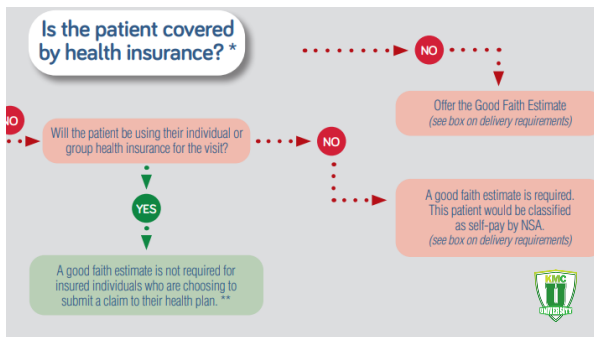
- Uninsured patients (self-pay)
- Patients who are insured but elect NOT to use their coverage



45



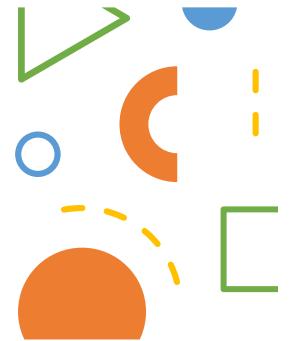
46



47

Timeline for Good Faith Estimate

"PHS Act section 2799B-6 requires providers and facilities to furnish a good faith estimate to an uninsured (or self-pay) individual who schedules an item or service at **least 3 business days before the date such item or service is to be so furnished...**"



48

Delivery Times

- 10 business days in advance, the GFE must be provided within three business days
- 3-9 business days in advance, the GFE must be provided within one business day
- less than 3 days in advance you ARE NOT required to provide a GFE in writing. Notify orally upon scheduling, provide estimate of initial evaluation

HEADS UP!
If patients request a GFE on their own, you need to provide one within three days of the date requested

GFE Delivery Requirements


If appointment is made:
10 business days in advance, the GFE must be provided within three business days
3-9 business days in advance, the GFE must be provided within one business day
less than 3 days in advance you ARE NOT required to provide a GFE in writing. Notify orally upon scheduling, provide estimate of initial evaluation.

NOTE: If the patient requests a GFE on their own, while at the clinic or just stopping for care, then you need to provide one within three days of date of request. Keep all copies of GFEs as part of the medical record and provide a hard copy or electronic to the patient or prospective patient.




49


Delivery




In Writing



If electronic, in a format the patient can save and print



Can be verbal if followed up with written estimate




50

Must Contain

- Patient name
- Patient date of birth
- Description of the services that will be provided, in understandable language
- Itemized list of goods or services reasonably expected to be provided in connection with the scheduled services
- Diagnostic codes, service codes, and expected charges associated with each of those goods or services
- Provider name, NPI and/or tax ID number
- Office location where services will be provided

51

On the Initial Call ASK!





- Are they enrolled in a group health plan and, will they be using their insurance for the visit?
- Would they like a Good Faith Estimate?

52

ESTIMATE

Accurate Estimate

Must be customized!-Start with E/M service?

53

The \$400 Rule

Patients can dispute their final medical bill if the charges are at least \$400 more than the good faith estimate provided.

They can utilize the selected dispute resolution" (SDR) entity who is charged with resolving disputes over medical bills involving uninsured or self-pay patients via the **Patient Provider Dispute Resolution (PPDR)** process.

54

Patient's Rights

OMB Control Number: 1210-0169
Expiration Date: 04/30/2022

Patient-Provider Dispute Resolution Form

Find out if you qualify for the dispute resolution process

This form is only for people who do not have health insurance or who decided not to use insurance for their medical care.

Did your health care provider give you a Good Faith Estimate for the item or service? Yes No

Is the bill for your health care provider at least \$400 more than the Good Faith Estimate? Yes No

Is the date on the top of the bill within the last 120 calendar days (about 4 months)? Yes No

55

Government Form vs. KMC University

OMB Control Number (2008-0085)
Expiration Date (04/30/2022)

Good Faith Estimate for Health Care Items and Services

Patient Information

Patient First Name Middle Name Last Name

Patient Date of Birth

Patient ID#

Street or PO Box Apartment

City State ZIP Code

Phone

Facility Address

Good Faith Estimate

John Doe Chiropractic & Wellness Center

1234 Main Street
Anytown, KY 40300

Phone: 555-555-1111

Website: www.johndoechiro.com

Insurance Information

Insurance Name

Insurance ID#

Insurance Group

Insurance Type

Insurance Start Date

Insurance End Date

Insurance Status

Insurance Network

Insurance Plan

Insurance Policy

Insurance Coverage

Insurance Benefits

Insurance Deductible

Insurance Copay

Insurance Coinsurance

Insurance Out-of-Pocket

Insurance Maximum

Insurance Renewal

Insurance Termination

Insurance Cancellation

Insurance Appeal

Insurance Grievance

Insurance Arbitration

Insurance Mediation

Insurance Conciliation

Insurance Reconciliation

Insurance Reinstatement

Insurance Renewal

Insurance Termination

Insurance Cancellation

Insurance Appeal

Insurance Grievance

Insurance Arbitration

Insurance Mediation

Insurance Conciliation

Insurance Reconciliation

Insurance Reinstatement

56

Initial Visit
GFE
Customization

Good Faith Estimate

John Doe Chiropractic & Wellness Center
1234 Main Street
Anytown, KY 40300

Phone: 555-555-1111

Website: www.johndoechiro.com

Insurance Information

Insurance Name

Insurance ID#

Insurance Group

Insurance Type

Insurance Start Date

Insurance End Date

Insurance Status

Insurance Network

Insurance Plan

Insurance Policy

Insurance Coverage

Insurance Benefits

Insurance Deductible

Insurance Copay

Insurance Coinsurance

Insurance Out-of-Pocket

Insurance Maximum

Insurance Renewal

Insurance Termination

Insurance Cancellation

Insurance Appeal

Insurance Grievance

Insurance Arbitration

Insurance Mediation

Insurance Conciliation

Insurance Reconciliation

Insurance Reinstatement

SERVICE/ITEM	CONDITION	DIGANOS CODE	NUMBER OF UNITS	UNIT PRICE	TOTAL
Exam (Evaluation)	no back, shoulder, neck, or hand		1	145.00	145.00
Imaging	diagnostic		1-2	105.00	210.00
Electrical Stimulation	muscle spasm		1	36.00	36.00

Total Expected Charges \$ 521.00

SERVICE/ITEM	CONDITION	DIGANOS CODE	NUMBER OF UNITS	UNIT PRICE	TOTAL
Electrical Stimulation	muscle spasm		1	36.00	36.00

Total Expected Charges \$ 521.00

57

New Patient Visit Customization

Estimate

SERVICE/ITEM	CONDITION	DIGANOS CODE	NUMBER OF UNITS	UNIT PRICE	TOTAL
Exam (Evaluation)	Pain		1	145-230.00	230.00
Imaging	diagnostic		1-2	65-105	215.00
Electrical Stimulation	muscle spasm		1	36.00	36.00

Total Expected Charges \$ 481.00

58

Must Notify
Patient of
Availability
of GFE

OMB Control Number (2008-0085)
Expiration Date (04/30/2022)

Appendix 1

Standard Notice—"Right to Receive a Good Faith Estimate of Expected Charges" Under the No Surprises Act

(For use by health care providers on or after January 1, 2022)

Instructions:

Under Section 2796(d) of the Public Health Service Act, health care providers and health care facilities are required to inform individuals who are not enrolled in a plan or coverage or a Federal health care program, or not seeking to file a claim with their plan or coverage both orally and in writing of their ability upon request or at the time of scheduling health care items and services, to receive a "Good Faith Estimate" of expected charges.

This form may be used by the health care provider to inform individuals who are not enrolled in a plan or coverage or a Federal health care program (uninsured individuals), or individuals who are enrolled but not seeking to file a claim with their plan or coverage (self-pay individuals) of their right to receive a "Good Faith Estimate" to help them estimate the expected charges they may be billed for receiving certain health care items and services. Information regarding the availability of a Good Faith Estimate must be prominently displayed on the covering provider's and covering facility's website and in brochures and signage where scheduling or questions about the cost of health care occur.

59

Second Step
of the
GFE Process

Financial Report of Findings

Good Faith Estimate

John Doe Chiropractic & Wellness Center
1234 Main Street
Anytown, KY 40300

Phone: 555-555-1111

Website: www.johndoechiro.com

Insurance Information

Insurance Name

Insurance ID#

Insurance Group

Insurance Type

Insurance Start Date

Insurance End Date

Insurance Status

Insurance Network

Insurance Plan

Insurance Policy

Insurance Coverage

Insurance Benefits

Insurance Deductible

Insurance Copay

Insurance Coinsurance

Insurance Out-of-Pocket

Insurance Maximum

Insurance Renewal

Insurance Termination

Insurance Cancellation

Insurance Appeal

Insurance Grievance

Insurance Arbitration

Insurance Mediation

Insurance Conciliation

Insurance Reconciliation

Insurance Reinstatement

SERVICE/ITEM	CONDITION	DIGANOS CODE	NUMBER OF UNITS	UNIT PRICE	TOTAL
Spinal Manipulation 3 areas		M9000.M9002.S27004	15	65.00	975.00
Manual Therapy	Shoulder pain	M7541	12	45.00	540.00
Exercise Therapy	M9000.M9003	M9000.M9003	20	65.00	1300.00
Re-Exam	spine & shoulder	N/A	2	85.00	210.00

60

Treatment Plan from the DC

The following is a list of items and services which the provider/clinic anticipates you will need once your initial exam or re-exam has been completed. The recommended treatment is to begin on **08/27/2020** and is projected to be completed by **09/14/2020**.

SERVICE/ITEM	CONDITION	DIAGNOSIS CODE	NUMBER OF UNITS	COST PER UNIT	TOTAL
Spinal Manipulation 3 areas	Neck/Shoulder/Thoracic/Lower Back	M9900,M9902,S335xxA	15	65.00	975.00
Manual Therapy	Shoulder pain	M7541	12	45.00	540.00
Exercise Therapy	Shoulder/Neck/Upper Limbs/Thoracic	M9900,M9903	20	65.00	1300.00
Re-Exam	spine & shoulder	N/A	2	85.00	210.00



61

Treatment Plan

The following is a list of items and services which the provider/clinic anticipates you will need once your initial exam or re-exam has been completed. The recommended treatment is to begin on **08/27/2020** and is projected to be completed by **09/14/2020**.

SERVICE/ITEM	CONDITION	DIAGNOSIS CODE	NUMBER OF UNITS	COST PER UNIT	TOTAL
Adjustment 2 Regions	Neck		20		
Re-Evaluation 99213	Neck		2		
Muscle Stim 97014	Neck		12		
Laser	Neck		12		
Exercises	Neck		4		

62

Maintenance Plan

The following is a list of items and services which the provider/clinic anticipates you will need once your initial exam or re-exam has been completed. The recommended treatment is to begin on **08/27/2020** and is projected to be completed by **09/14/2020**.

SERVICE/ITEM	CONDITION	DIAGNOSIS CODE	NUMBER OF UNITS	COST PER UNIT	TOTAL
Adjustment S8990	Maintenance		24		



63



The following is a list of items and services which the provider/clinic anticipates you will need once your initial exam or re-exam has been completed. The recommended treatment is to begin on **08/27/2020** and is projected to be completed by **09/14/2020**.

SERVICE/ITEM	CONDITION	DIAGNOSIS CODE	NUMBER OF UNITS	COST PER UNIT	TOTAL
Spinal Manipulation 3 areas	Neck/Shoulder/Thoracic/Lower Back	M9900,M9902,S335xxA	15	65.00	975.00
Manual Therapy	Shoulder pain	M7541	12	45.00	540.00
Exercise Therapy	Shoulder/Neck/Upper Limbs/Thoracic	M9900,M9903	20	65.00	1300.00
Re-Exam	spine & shoulder	N/A	2	85.00	210.00

Total Expected Charges \$ **3025.00**

Disclaimer:
 The following table provides only a general estimate of the charges for these items or services. Actual charges may vary due to individual circumstances. These charges are subject to change without notice. The actual charges for these services are available upon request. An additional estimate may be required. The actual charges for these services are available upon request. An additional estimate may be required.



64

What About Hardship Arrangements?

Q: Do providers or facilities need to factor in financial assistance an uninsured (or self-pay) individual may receive when calculating the expected charges for items or services included in the GFE?
A: Yes. The GFE must reflect the expected charges, including any expected discounts or other relevant adjustments that the provider or facility expects to apply to an uninsured (or self-pay) individual's actual billed charges. For example, certain tax-exempt hospital organizations are required to meet certain Financial Assistance Policy (FAP) requirements; for purposes of this example, any adjustments expected to be applied under the FAP would be factored in and reflected in the amount reported in the GFE.

65



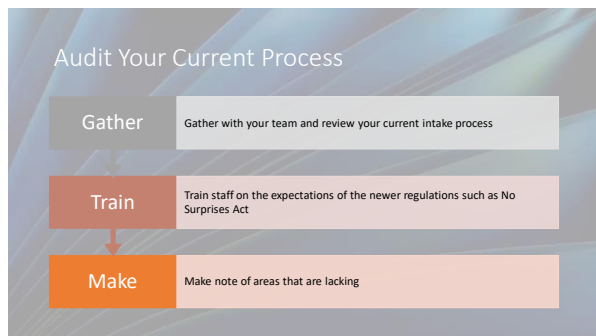
66



67



68



69

The Established Patient- Data Collection

- Confirm on each call the insurance status of the patient
- Blame federal law for the reason you must ask the question AGAIN
- Create an outgoing hold message
Thank you for calling. We appreciate your patience as our office is implementing new regulations required for healthcare providers. Please be ready with your insurance information when making your appointment. If you do not have insurance, you can request a Good Faith Estimate for the services recommended by the treating physician.
- Say it with a smile :)



70

Need to Know

First Name Last Name

Type of Problem (area)

Insurance or Self-Pay

DOB

Address

Email & Phone

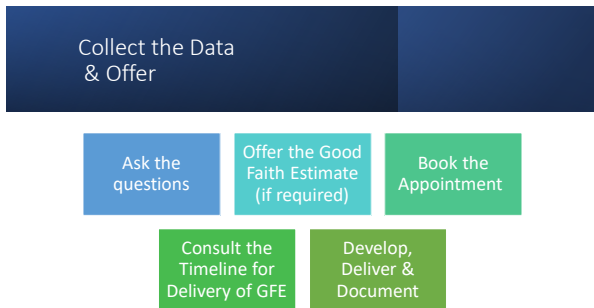
Insurance Details [injury claim, Medicare, Medicaid, VA, individual health, group health, Medicare Part C (MA)]

71

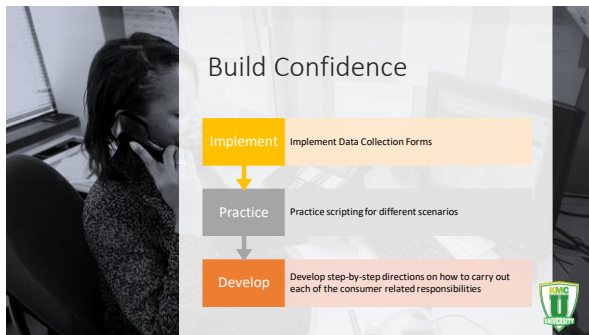
Data Equals Action

- _____
If self-pay or uninsured, need to develop a GFE
- _____
If insured but service or technique is not covered need to inform patient and offer alternatives or provide estimate
- _____
If insured and wants to know cost, need to offer and provide GFE
- _____
If it is an injury claim need to confirm status of claim and whether doctor can take the case (WC or Auto)
- _____
If Medicare or Medicaid or Medicare Advantage –need to consider network status of provider and inform patient accordingly

72



73



74

Non-Compliance Penalty



75

Changes on the Horizon

- Current** - a GFE is required for uninsured/self-pay patients or insured patients who are not using their insurance and includes only the expected charges from the provider who is actually providing the estimate
- Future** - the departments are going to enforce a requirement that it includes the **expected charges of other providers** and other facilities that **may be involved in the service** other than the one that's scheduling the service
- Future** - GFE will be required for **all patients - insured, uninsured, and those opting not to use their insurance**

76

Interim: Do Your Best! Good Faith!

"Plans, issuers, providers and facilities are expected to implement the requirements using a **good faith, reasonable interpretation of the statute prior to issuance of rulemaking**"

77

Intent of the Law

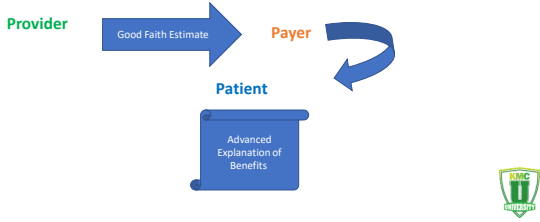
KMC University cannot provide legal advice to providers and affiliates to recommend ethics and providers to consult with their legal experts regarding their legal requirements.

78



79

The Future is Complicated



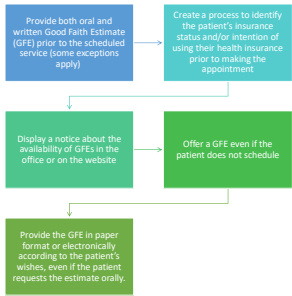
80

Provider 'Future' Responsibility

- Ask patients whether they are enrolled in a group health plan and, if so, provide an estimate of the expected charges to the patient's insurer.
- After receiving the estimate, the payer must provide an advanced EOB to the patient.

81

Implementation Steps



82

Be Prepared

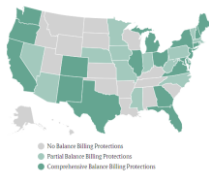
- Focus on Payer Relationships
- Register Online Portals and Availability
- Medical Review Policies
- Identify Non-Covered Services
- Create a list of network payers on your website
- Provide a list of non-covered services and their fee (proactive step)

83

- Build** • Build a solid intake process where you obtain the insurance status at the time of the appointment
- Enroll** • Enroll with all payer portals
- Locate** • Locate Medical Review Policies and Reimbursement Guidelines
- Build** • Build a solid verification process- know each patient's coverage limitations
- Know** • Know Your Fee- build a compliant financial policy

84

State Laws



85

Centers for Medicare & Medicaid Services

Medicare | Medicaid/CHIP | Medicare/Medicaid Coordination | Private Insurance | Innovation Center | Regulations & Guidance | Research, Statistics, Data & Systems | Outreach & Education

Home > No Surprise Act

Home | Policies & Resources | Consumer Protections | Help resolve payment disputes

Ending Surprise Medical Bills

See what's coming to help to protect people from surprise medical bills and removing consumers from payment disputes between a provider or health facility and their health plan.

Resources

Learn More

86

Recommendations

- Stay Alert to Educational Opportunities
- Know Your Fees & Compliance Obligations
- Build a Financial Report of Findings Process
- Include a Good Faith Estimate in the Intake Process
- Patient Rights Posted in the Clinic
- Patient Rights on Surprises Act Posted on Your Website



87



Need More Information?

info@kmcuniversity.com

88