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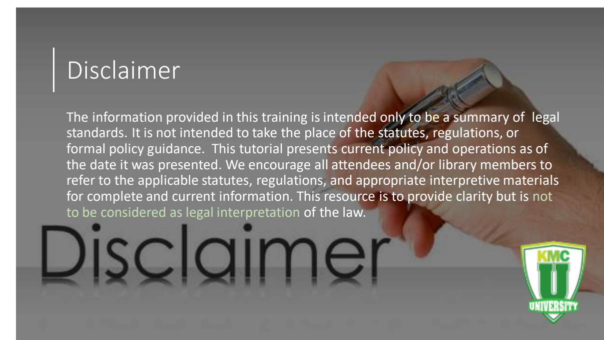

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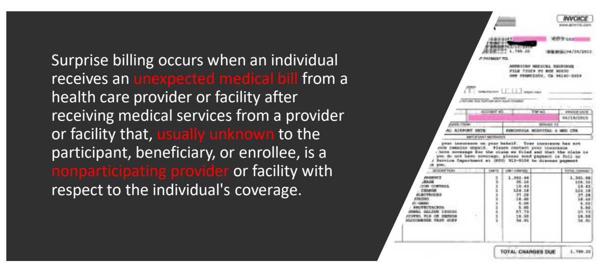
What is Surprise Billing?



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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?

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

American Medical Association™ Guide for Physicians:
Disputing Out-of-Network Payments Using the No Surprises Act Independent Dispute Resolution Process

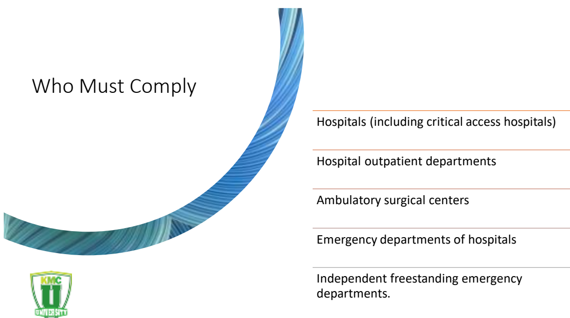
MARCH 2022
updated April 2022

13

Do You Need a Billing Protection Disclosure?

14

Who Must Comply



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

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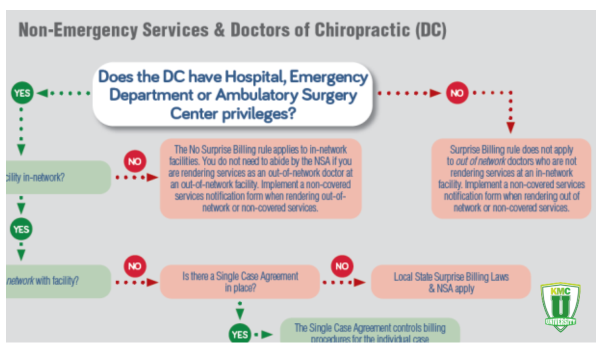

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1% of Providers
To Do List

- 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)

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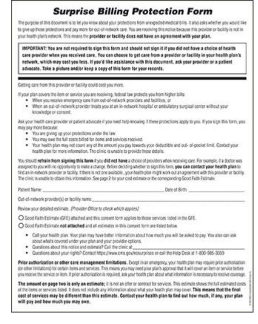
Billing Protection Form for the 1%



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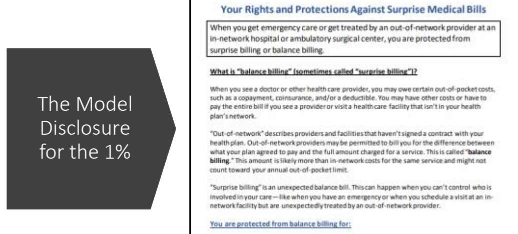

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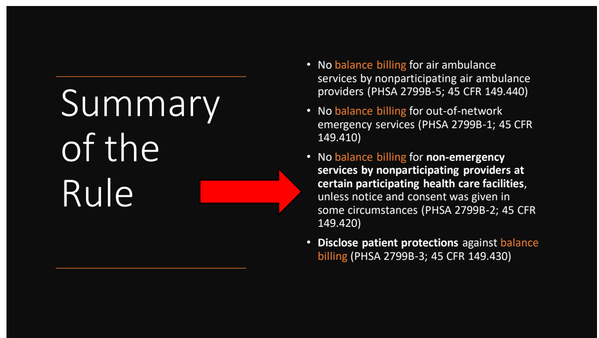

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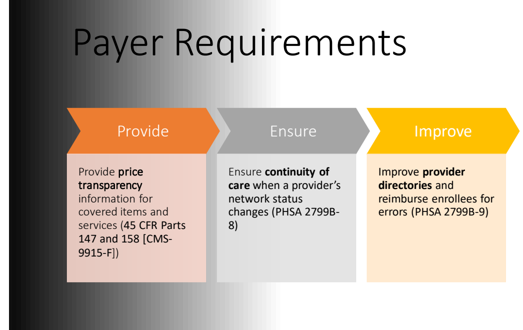

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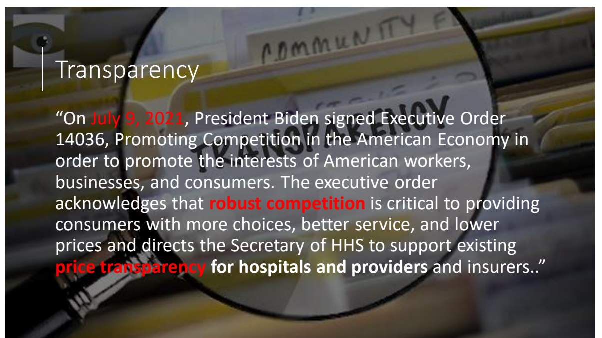

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Continuity of Care-90 Day Rule

Health plan members are **continuing care patient**s 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 1861(dd)(3)(A) of the Social Security Act)

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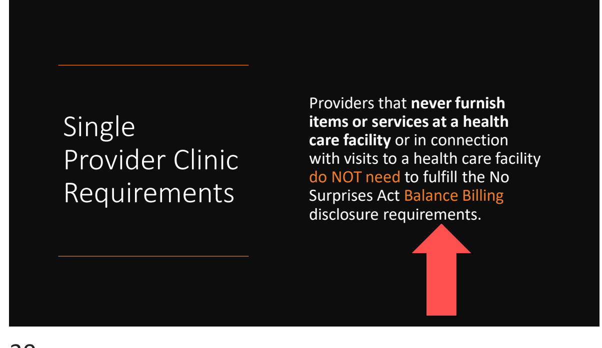

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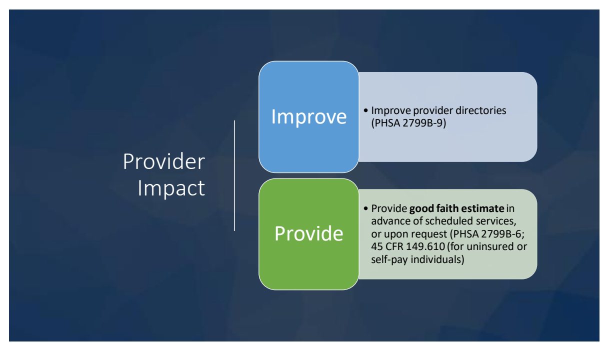

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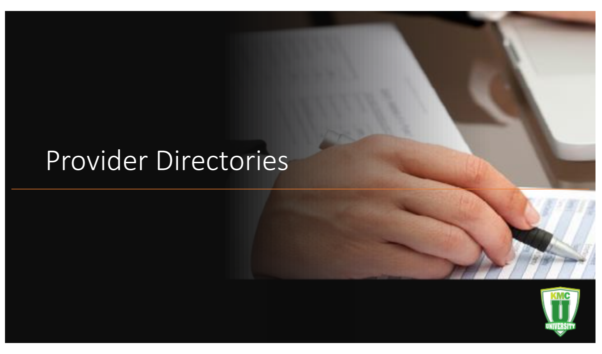

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Provider Requirements

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)

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- 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.

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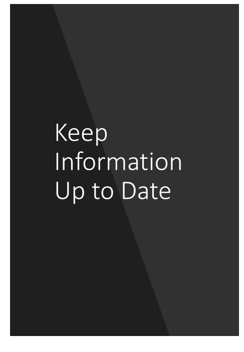

- Names, addresses, specialty, telephone numbers, and digital contact information of individual health care providers; and
- Names, addresses, telephone numbers, and digital contact information of each medical group, clinic, or health care facility contracted to participate in any of the networks of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

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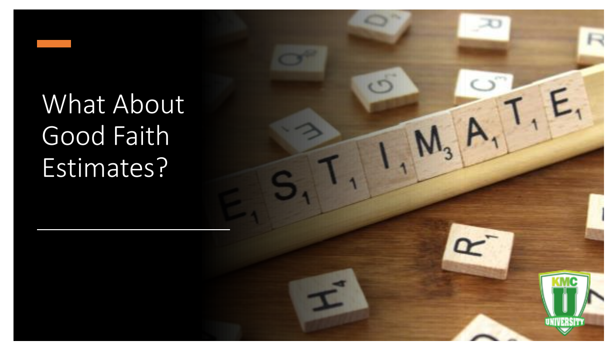

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The No Surprises Act Complexity

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

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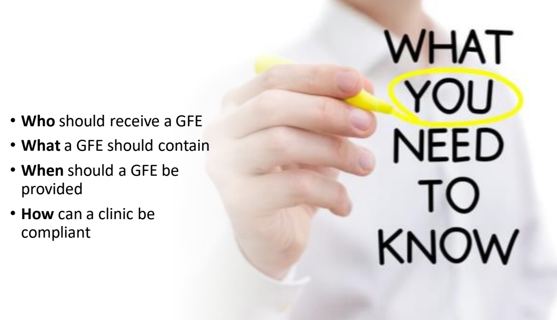

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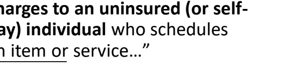
"Health care providers and health care facilities are required under PHS Act section 2799B-6 to furnish a **notification of the good faith estimate of expected charges to an uninsured (or self-pay) individual** who schedules an item or service..."



Good Faith Estimate

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

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WHO Gets One?

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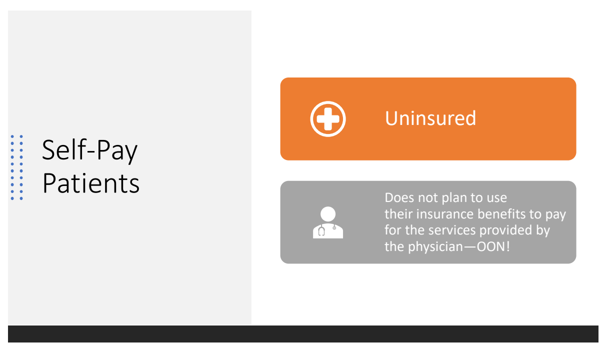

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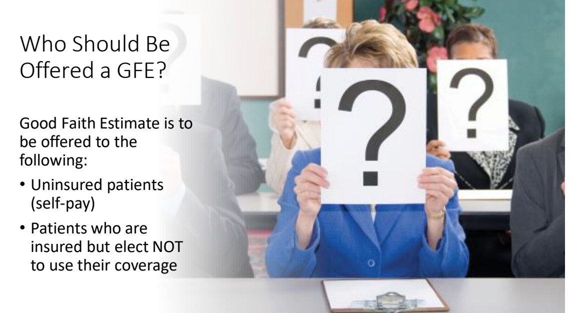

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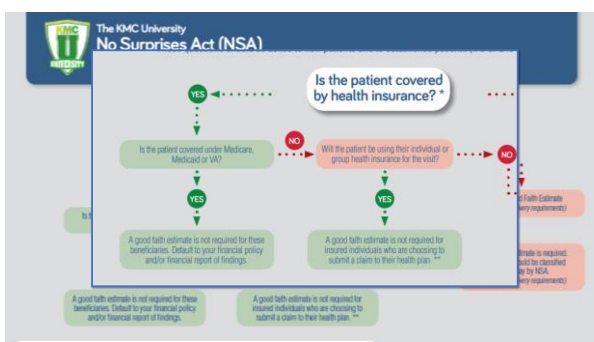

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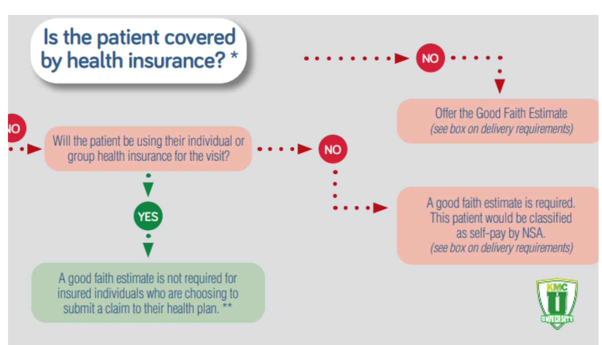

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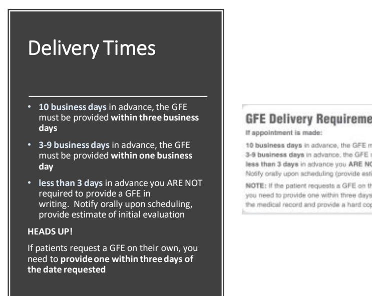
Delivery Times

- **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 shopping 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.

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Delivery

- In Writing
- If electronic, in a format the patient can save and print
- Can be verbal if followed up with written estimate

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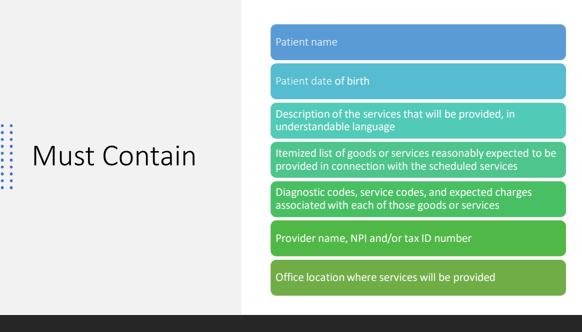

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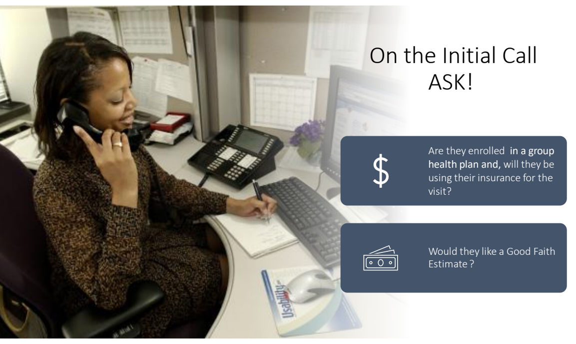

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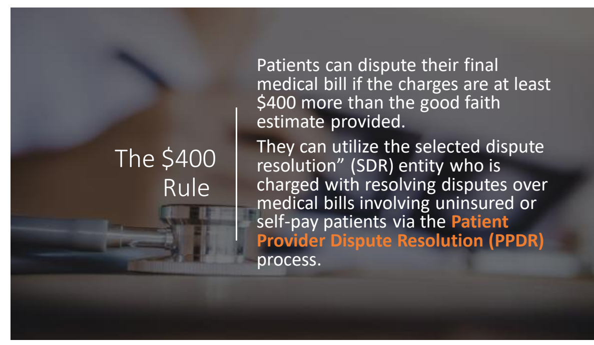

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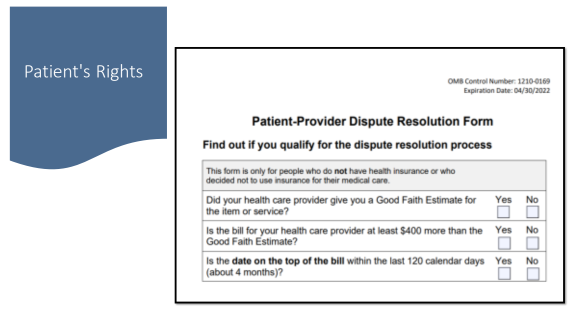

OMB Control Number: 1210-0169
Expiration Date: 04/30/2022

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.

	Yes	No
Did your health care provider give you a Good Faith Estimate for the item or service?	☐	☐
Is the bill for your health care provider at least $400 more than the Good Faith Estimate?	☐	☐
Is the **date on the top of the bill** within the last 120 calendar days (about 4 months)?	☐	☐

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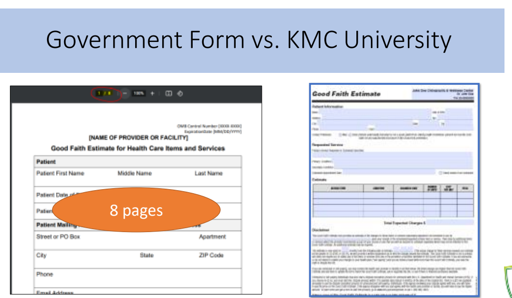

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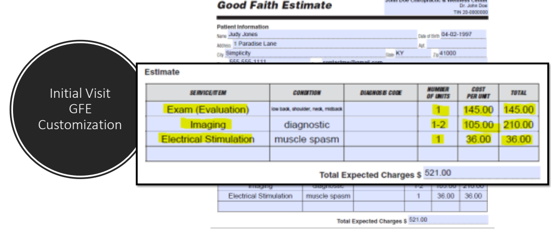

Good Faith Estimate

John Doe Chiropractic & Wellness Center
Dr. John Doe

Patient Information

Name Judy Jones — Date of Birth 04-02-1997
Address 1 Paradise Lane
City Simplicity — State KY — Zip 41000

Estimate

SERVICE/ITEM	CONDITION	DIAGNOSIS CODE	NUMBER OF UNITS	COST PER UNIT	TOTAL
Exam (Evaluation)	low back, shoulder, neck, midback		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

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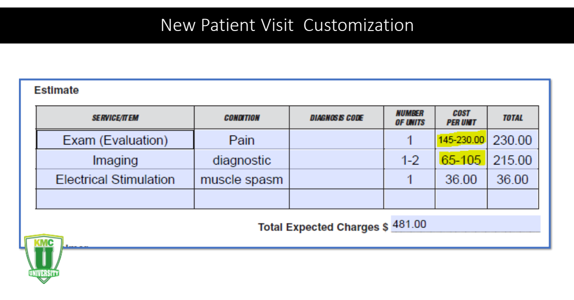

Estimate

SERVICE/ITEM	CONDITION	DIAGNOSIS CODE	NUMBER OF UNITS	COST PER UNIT	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

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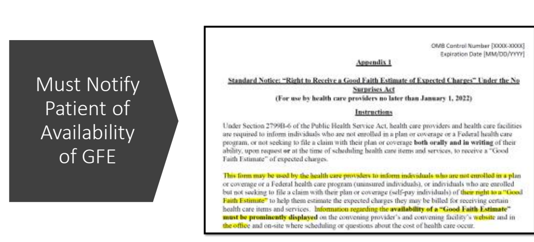

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Expiration Date [MM/DD/YYYY]

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 no later than January 1, 2022)

Instructions

Under Section 2799B-6 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 providers 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 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 convening provider's and convening facility's website and in the office and on-site where scheduling or questions about the cost of health care occur.

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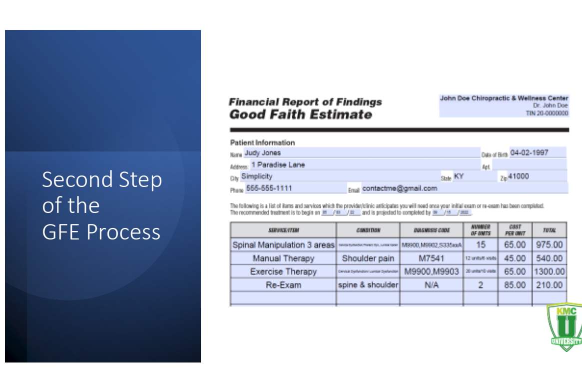

Financial Report of Findings
Good Faith Estimate

John Doe Chiropractic & Wellness Center
Dr. John Doe
TIN 20-0000000

Patient Information

Name Judy Jones — Date of Birth 04-02-1997
Address: 1 Paradise Lane — Apt.
City Simplicity — State KY — Zip 41000
Phone 555-555-1111 — Email contactme@gmail.com

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 __/__/__ and is projected to completed by __/15/2022.

SERVICE/ITEM	CONDITION	DIAGNOSIS CODE	NUMBER OF UNITS	COST PER UNIT	TOTAL
Spinal Manipulation 3 areas	[illegible]	M9900,M9902,S335xxA	15	65.00	975.00
Manual Therapy	Shoulder pain	M7541	12 units/6 visits	45.00	540.00
Exercise Therapy	Cervical Dysfunction/ Lumbar Dysfunction	M9900,M9903	20 units/10 visits	65.00	1300.00
Re-Exam	spine & shoulder	N/A	2	85.00	210.00

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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 05 / 03 / 22 and is projected to completed by 08 / 15 / 2022.

SERVICE/ITEM	CONDITION	DIAGNOSIS CODE	NUMBER OF UNITS	COST PER UNIT	TOTAL
Spinal Manipulation 3 areas	Cervical Dysfunction Thoracic Dys.. Lumbar Sprain	M9900,M9902,S335xxA	15	65.00	975.00
Manual Therapy	Shoulder pain	M7541	12 units/6 visits	45.00	540.00
Exercise Therapy	Cervical Dysfunction/ Lumbar Dysfunction	M9900,M9903	20 units/10 visits	65.00	1300.00
Re-Exam	spine & shoulder	N/A	2	85.00	210.00

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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 04 / 19 / 2022 and is projected to completed by 06 / 19 / 2022.

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		

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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 06 / 19 / 2022 and is projected to completed by 06 / 18 / 2023.

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

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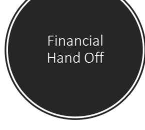

The following is a list of items and services which the provider/clinic anticipates you will need once your initial exam or re-exam has been completed.

SERVICE/ITEM	CONDITION	DIAGNOSIS CODE	NUMBER OF UNITS	COST PER UNIT	TOTAL
Spinal Manipulation 3 areas		M9900,M9902,S335xxA	15	65.00	975.00
Manual Therapy	Shoulder pain	M7541	12 units/6 visits	45.00	540.00
Exercise Therapy		M9900,M9903	20 units/10 visits	65.00	1300.00
Re-Exam	spine & shoulder	N/A	2	85.00	210.00

Total Expected Charges $ 3025.00

Disclaimer

This Good Faith Estimate only provides an estimate of the charges for those items or services reasonably expected to be furnished to you by ______ upon your receipt of the scheduled/requested primary item or service. There may be additional items or services which the provider recommends as part of your course of care that you will be required to schedule separately which may not be reflected in this Good Faith Estimate. An additional estimate may be required.

The estimate is only valid for 6 months from the following date of estimate 5 / 03 / 22. If the actual charge for these services exceeds our estimate

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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.

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Document Delivery
It is part of the medical record

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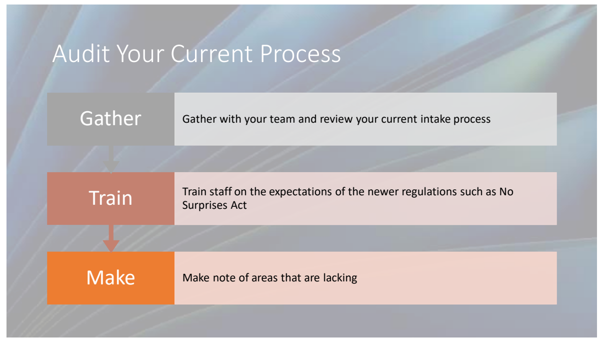

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The Established Patient- Data Collection

- 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 :)

KMC UNIVERSITY

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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)]

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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

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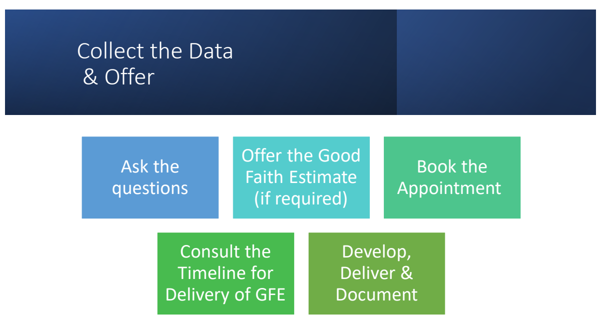

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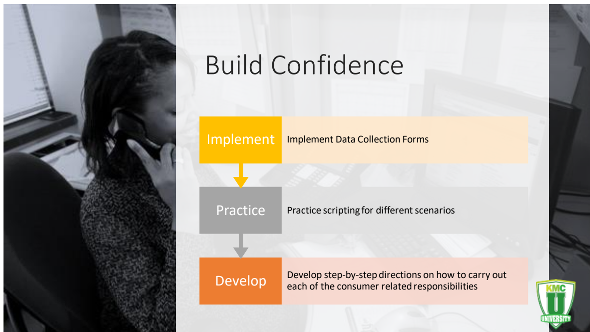

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Changes on the Horizon

- **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

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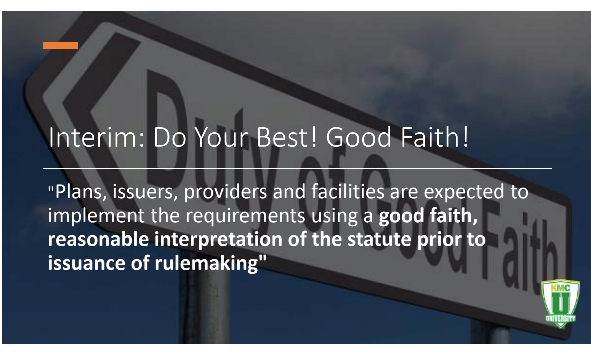

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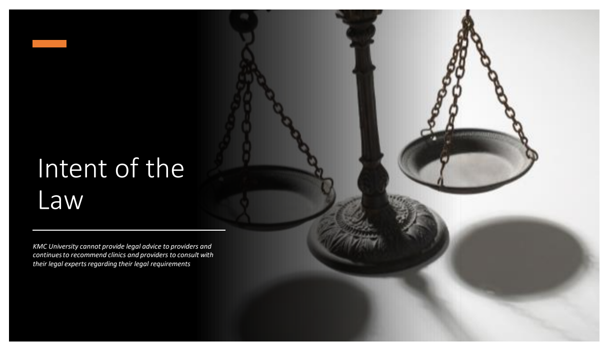

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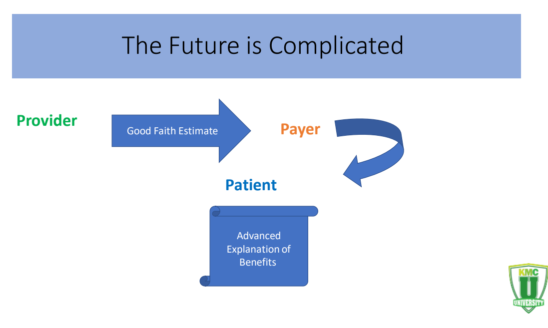

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Provider 'Future' Responsibility

- $ 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.

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Implementation Steps

- Provide both oral and written Good Faith Estimate (GFE) prior to the scheduled service (some exceptions apply)
- Create a process to identify the patient's insurance status and/or intention of using their health insurance prior to making the appointment
- Display a notice about the availability of GFEs in the office or on the website
- Offer a GFE even if the patient does not schedule
- Provide the GFE in paper format or electronically according to the patient's wishes, even if the patient requests the estimate orally.

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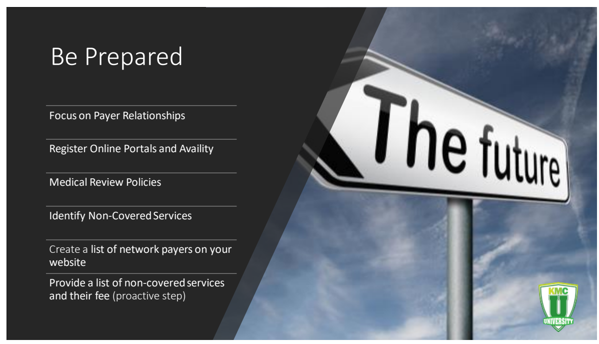

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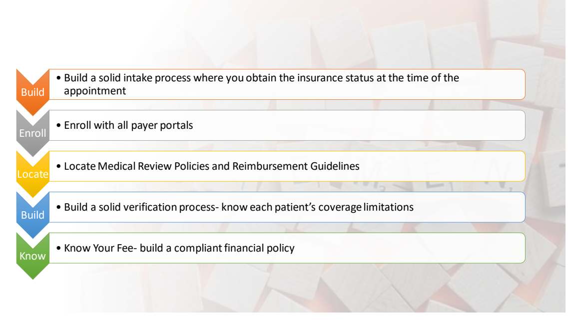

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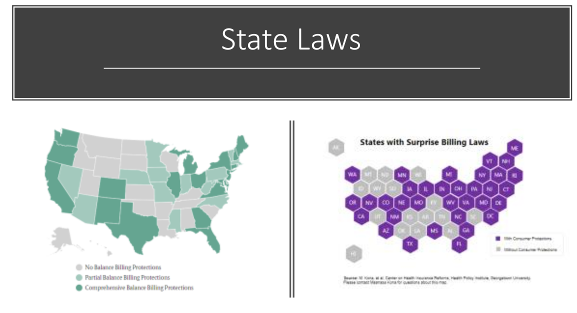

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