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Our Plan Today

- Have fun!
- Review of key issues with Medicare causing denials and cash-flow interruption.
- Differences between Medicare Part B and Part C.
- Did you master No Surprises Act in 2022? If not, you get another chance with new changes.

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### Types of Medicare Coverage

- Basic Medicare Part B coverage is what most of the senior population have but that is quickly changing
- Medicare Part B is usually the primary coverage

THE FOUR PARTS OF MEDICARE

**PART A**  
HOSPITAL INSURANCE

**PART B**  
MEDICAL INSURANCE

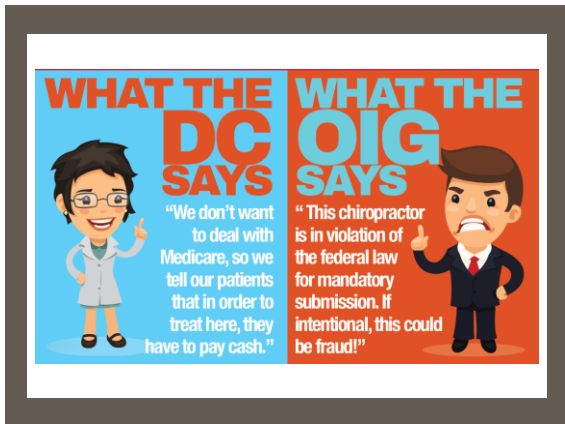
Chargable benefits are included in traditional Medicare Part A.

**PART C**  
MEDICARE ADVANTAGE PLANS (MA/PO) Includes Part A, Part B and sometimes Part D coverage

**PART D**  
MEDICARE PRESCRIPTION DRUG COVERAGE

Medicare

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### PARTICIPATING (PAR) VS. NON-PARTICIPATING (NON-PAR) MEDICARE PROVIDER

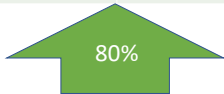
Participating Provider (Par)	Non-Participating Provider (Non-Par)
Collects the participating allowable fee schedule amount for EMT services	Collects no more than the Limiting Fee set by Medicare at the time-of-service
Must submit claims to Medicare	Must submit claims to Medicare
Always accepts assignment in Item 27 of 1500 Claim Form	Usually does not accept assignment in Item 27 of 1500 Claim Form but may elect to accept assignment on a case-by-case basis
Submits to secondary/Medigap carriers	No obligation to submit to secondary/Medigap carriers
Reduces out-of-pocket expense for patient	Increases out-of-pocket expense for patient

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\*\*Dollar amounts for educational purposes only

### Calculations for Spinal CMT in Part B

Procedure Code	Par Allowable	Non-Par Allowable	Limiting Fee
98940	\$28.93	\$27.48	\$31.60
98941	\$41.55	\$39.47	\$45.39
98942	\$49.18	\$41.47	\$53.19



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Must Know  
The  
Difference

|

Chiropractic is Different  
In Medicare

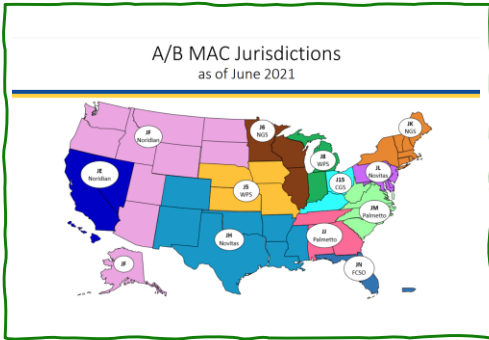
#### CHIROPRACTIC MEDICARE BENEFITS AND LIMITATIONS

Recognize the Fundamentals of Medicare Coverage for Chiropractic Services

<p><b>Covered and Payable</b></p> <p><b>Covered but Not Payable</b></p> <p><b>Statutorily Excluded from Medicare Chiropractic Benefit</b></p>	<p><b>Active Treatment (AT) Spinal Chiropractic Manipulative TX (CMT)</b> CPT Codes 98940, 98941, 98942</p> <p>Spinal CMT codes are deemed Covered but Not Payable when performed for:</p> <ul style="list-style-type: none"> <li>• Chiropractic maintenance treatment</li> <li>• More than one spinal manipulation per day</li> </ul> <p>All services/supplies ordered or provided by a chiropractor, other than those defined above, are excluded from the Medicare benefit, and therefore the patient is responsible for payment. This includes but is not limited to:</p> <ul style="list-style-type: none"> <li>• Extremity CMT 98943</li> <li>• X-rays</li> <li>• Products/Supplies</li> <li>• Therapies</li> <li>• Exams</li> <li>• Alternative treatment protocols</li> </ul>
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\*ABN form must be provided to the patient prior to rendering Covered but Not Payable services.  
\*ABN is not required for these services. Office Financial Policy is recommended to communicate these limitations of Medicare coverage.

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### Part B MAC Provider Portal

national government
HOME

What would you like to do in NGSConnect?

Eligibility Lookup

Claim Status Lookup

Part B Claim Submissions

Appeals

ADR

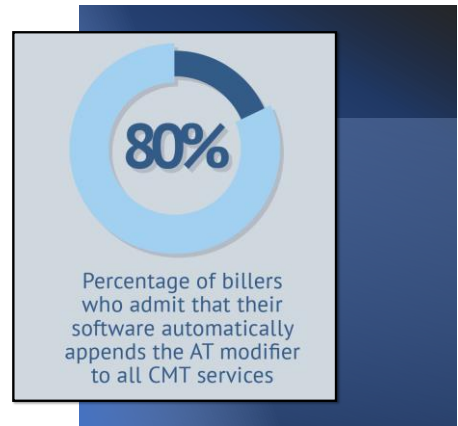
Inquiries

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Who Determines Active vs. Maintenance?



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**Notifier(Practice) Spelling** → Kathy's Chiropractic Health  
1234 Main Street Honolulu, HI 99998 999-888-7777

Patient Name: \_\_\_\_\_ Identification Number: \_\_\_\_\_

### Advance Beneficiary Notice of Noncoverage (ABN)

**NOTE:** If Medicare doesn't pay for everything, **Chiropractic maintenance care below**, you may have to pay. Medicare does not pay for everything, **Chiropractic maintenance care below**, you may have to pay. Medicare does not pay for everything, **Chiropractic maintenance care below**, you may have to pay. Medicare does not pay for everything, **Chiropractic maintenance care below**, you may have to pay.

Chiropractic Maintenance Care	Reason Medicare May Not Pay	Estimated Cost
98940	Medicare does not pay for Chiropractic maintenance care	\$24.71
98941		\$32.46
98942		\$41.97

**Covered Services Codes** → 98940, 98941, 98942

**Reason is clear** → Medicare does not pay for Chiropractic maintenance care

**Fee Choice Here** → Estimated Cost

**WHAT YOU NEED TO DO NOW:**

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive **Chiropractic maintenance care** listed above.

**Options:** Check only one box. We cannot choose a box for you.

**OPTION 1.** I want the **Chiropractic maintenance care** listed above. You may ask to be paid now, but I also want Medicare billed for my payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less savings or deductibles.

**OPTION 2.** I want the **Chiropractic maintenance care** listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment, and I cannot appeal if Medicare is not billed.

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**OPTIONS:** Check only one box. We cannot choose a box for you.

**OPTION 1.** I want the **Chiropractic maintenance care** listed above. You may ask to be paid now, but I also want Medicare billed for my payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less savings or deductibles.

**OPTION 2.** I want the **Chiropractic maintenance care** listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment, and I cannot appeal if Medicare is not billed.

**OPTION 3.** I don't want the **Chiropractic maintenance care** listed above. I understand with this choice I am not responsible for payment, and I cannot appeal to see if Medicare would pay.

**Additional Information:**

This notice gives you the right to make a choice on your Medicare questions on this notice or Medicare billing call 1-800-MEDICARE (800-633-4277/TTY: 877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: [AltFormatRequest@cms.hhs.gov](mailto:AltFormatRequest@cms.hhs.gov).**

According to the Paperwork Reduction Act of 1995, no person is required to provide information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0046. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Baltimore, Maryland 21244-1850.

**Form CMS-R-131 (Exp. 06/30/2025)**

Form Approved OMB No. 0938-0566

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### Common Billing Errors

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MEDICARE MODIFIERS		
Modifiers Used Only With 98940, 98941, 98942		
Code	Description/Instruction	Effect on Medicare Payment
AT	Requiring Active/Controlled Treatment Indicates service rendered not medically necessary per Medicare guidelines.	Medicare will consider for payment.
GA	Waiver of Liability (ABL) on file for necessity only. Indicates maintenance care or visit exceed cancer screen.	If patient selects ABL Option 1, you must bill Medicare. Medicare will deny an appeal if necessary. Patient will be financially responsible.
GZ	Indicates you failed to collect ABL for maintenance care as required.	Claims will be denied. Patient will not be deemed responsible for payment.
Modifiers Used with All Statutorily Excluded Services		
Code	Description/Instruction	Effect on Medicare Payment
GY	Indicates statutorily non-covered item/service is reviewed by a BC.	Billing of these services is not required unless the patient requests. Patient is financially liable.
GX	ABL on file for voluntary use.	Claims will be denied/patient financially liable. Use with CY modifier on certain therapy services to receive support code.
GP	Used for certain therapy services as part of supervised treatment plan.	Claims will be denied/patient financially liable. Use with CY modifier on certain therapy services to receive support code.

**MANDATORY SUBMISSION** → AT, GA, GZ

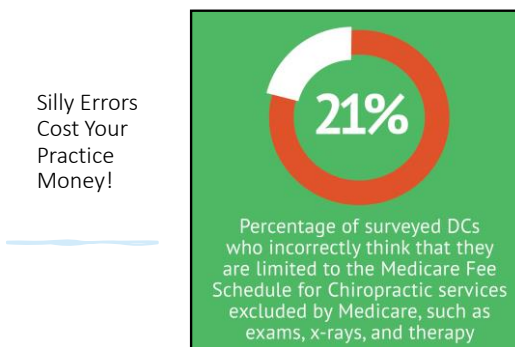
**VOLUNTARY SUBMISSION** → GY, GX, GP

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### You Must Understand

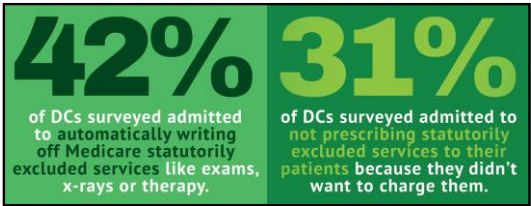


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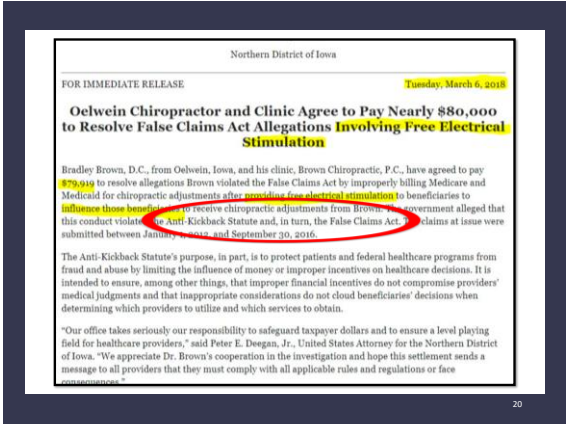


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## Bad News Either Way!



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### Four Possible Fee Structures For Excluded Services

- Charge your actual fee
- Charge a reasonable time of service discounted fee (5-15%)
- Use a network-based, legally discounted fee of choice
- Allow for a legal hardship/indigence fee the patient qualifies for

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Not for QMB Patients!!!

- Medicare IVR/portals can let you know if deductible is met for the year
- Always based on allowable amount if participating

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## Qualified Medicare Beneficiaries (QMB)

### DUALY ELIGIBLE BENEFICIARIES

"Dually eligible beneficiaries" generally describes beneficiaries enrolled in Medicare and Medicaid. The term includes beneficiaries enrolled in Medicare Part A and/or Part B and getting full Medicaid benefits and/or assistance with Medicare premiums or cost sharing through the Medicare Savings Program (MSP):

- **Qualified Medicare Beneficiary (QMB) Program:** Helps pay Part A, Part B, or both Program premiums, deductibles, coinsurance, and copayments
- **Specified Low-Income Medicare Beneficiary (SLMB) Program:** Helps pay Part B premiums
- **Qualifying Individual (QI) Program:** Helps pay Part B premiums but is limited to a first-come, first-served basis
- **Qualified Disabled Working Individual (QDWI) Program:** Pays Part A premiums for certain disabled and working beneficiaries under 65 not getting Medicaid and who meet certain income and resource limits set by their State

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## Verify QMB Status

**OPTION 1:** Since July 2018, original Medicare providers and suppliers have been able to readily identify the QMB status of patients and billing prohibitions from the Medicare Provider Remittance Advice which contains new notifications and information about a patient's QMB status.

**OPTION 2:** Providers can verify beneficiaries' QMB status online through his/her state of residence's Medicaid eligibility system.

**OPTION 3:** Ask beneficiaries for other proof such as their Medicaid identification card (look for the QMB) or some other documentation—issued by the State—that proves the patient is enrolled in the QMB program.

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Your Obligation is to Know the Rules

**MEDICARE VOCABULARY LESSON**

**Inducement**  
The provision of free goods or services to patients that may influence them to select a particular provider.

**Remuneration**  
'Anything of value' which includes waivers of coinsurance, cost deductible amounts, etc.

**FREE**

**You may not give any item or service to a Medicare patient that exceeds a value of \$15, or with a \$75 annual limit per Medicare patient.**

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**FACTS**

- Chiropractors are one of three service providers that are not permitted to opt-out of Medicare along with independent PTs and OTs.
- DCs must submit bills on behalf of all Medicare patients for all CMT codes, unless otherwise directed by Option Two on the Mandatory ABN.
- Medicare's mandatory submission rule states that all covered services (spinal CMT) MUST be billed to Medicare by the provider.
- Participation in the Medicare program has nothing to do with Medicare Enrollment. DCs must be enrolled to treat Medicare patients, even for excluded services.

Know the Facts!

- Not allowed to Opt-Out
- Mandatory Submission rule applies to all covered services (CMT)
- Participation in Medicare is not the same as enrollment
- Claim submission required unless directed otherwise by the patient via the Advance Beneficiary Notice (ABN)

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**Steps to Minimize Risk with Medicare**

- Recognize the risks of not being enrolled and properly billing Medicare according to mandatory submission rules
- Distinguish active, billable treatment from not-medically necessary maintenance care
- Complete Medicare's documentation requirements flawlessly
- Prepare patients to be aware of the difference between covered and excluded services
- Apply proper Medicare rules to financial transactions with Medicare patients

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**Types of Medicare Coverage: Part C**

- Also known as Medicare Advantage Plans or Replacement Plans— "Managed Care Medicare"
- Redirects benefits to a private carrier
- No Part A or B

**THE FOUR PARTS OF MEDICARE**

- PART A** HOSPITAL INSURANCE
- PART B** MEDICAL INSURANCE
- PART C** MEDICARE ADVANTAGE PLANS (HMO/PPO) Includes Part A, Part B, and contains Part C coverage
- PART D** MEDICARE PRESCRIPTION DRUG COVERAGE

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Different Plan Types

2022 Humana Medicare Advantage Health Maintenance Organization (HMO) plan

The following documents contain information about HMO and HMO point-of-service (HMO-POS) plans and HMO Special Needs Plans (SNPs).

HMO electronic claims flyer

HMO FAQs

2022 Humana Medicare Advantage Preferred Provider Organization (PPO) Plan

PPO electronic claims flyer

PPO FAQs

2022 Humana Medicare Advantage full and partial networks private-fee-for-service (PFFS) plans

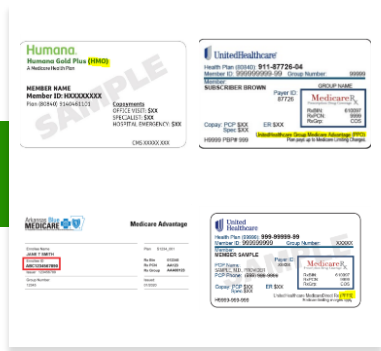
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Find the Specific Provider Manual or Medical Review Policies

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- Resources available online
- Simple Google Search "Medicare Advantage Provider Manual"

Identify the Plan Type & Your Network Status



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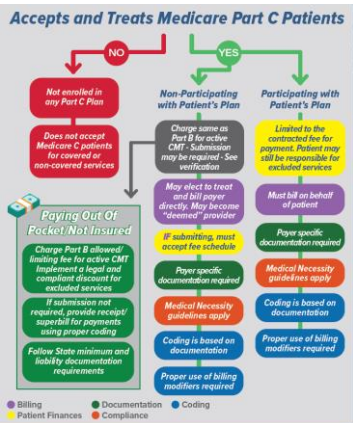
## Mandatory Submission

A provider is not required to agree to accept a PFFS plan's terms and conditions of payment or agree to treat a PFFS plan member. If a provider does not agree to accept the plan's terms and conditions of payment or refuses to treat the member, then the member will need to find another provider that will accept the plan's terms and conditions of payment. PFFS plans should assist members to locate another provider in the member's area who will accept the plan's terms and conditions of payment. For example, if there are providers in the area that the PFFS plan knows have accepted its terms and conditions of payment it should identify those providers to its members who are seeking a provider willing to be deemed as possible sources of care.

A provider that decides not to accept the plan's terms and conditions of payment should not provide services to a member, except in emergencies. If the provider nonetheless

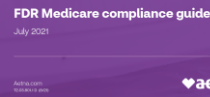
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Obligations of DCs When Agreeing to Accept and Treat Medicare Part C Patients



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## FDR Compliance- AMA Requirement



**Review compliance program requirements**

This guide summarizes Medicare compliance program requirements. Be sure to review it and comply with these requirements each calendar year. Here are some of the actions you must take:

- Distribute a code of conduct or a compliance policy
- Distribute general compliance and FWA education and training
- Complete exclusion list screenings
- Make employees aware of reporting mechanisms
- Report FWA and compliance concerns to us
- Report and request to use offshore operations
- Fulfill specific federal and state compliance obligations
- Monitor and audit first tier, downstream and related entities

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## Watch For Open Enrollment for Medicare

- Approximately 65% of Medicare enrollees choose Part C over Part B
- Sometimes, they don't even know what they have
- New deductibles
- Different plans
- Must verify all insurance again in the new year...not on policy year



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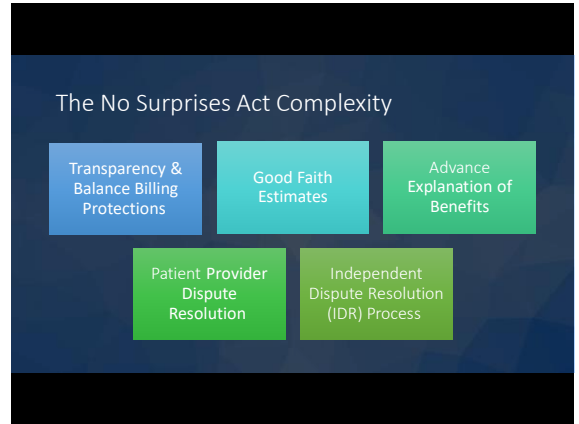
## Summary

- Confirm your Medicare participation status
- Identify your network status with all Medicare Advantage Plans
- Locate Payer Policies & Agreements
- Make a list of network plans and plan types
- Locate the FDR Requirements for each plan
- Establish a Notification & Consent Process for out-of-network services

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### Summary of the Balance Billing Protection NSA 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)

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

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- 1% of Providers To Do List
- Locate the Balance Billing Protection Resources
  - Obtain a Balance Billing Protection Form
  - Obtain a Model Disclosure Notice
  - Review the AMA Resources (available online)

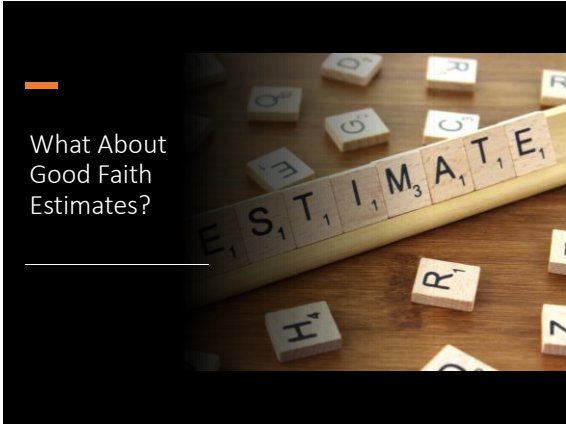


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**Medicare Already Has Rules**

- 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.

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What About Good Faith Estimates?

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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...”

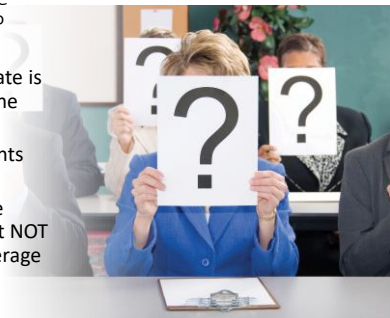
Good Faith Estimate

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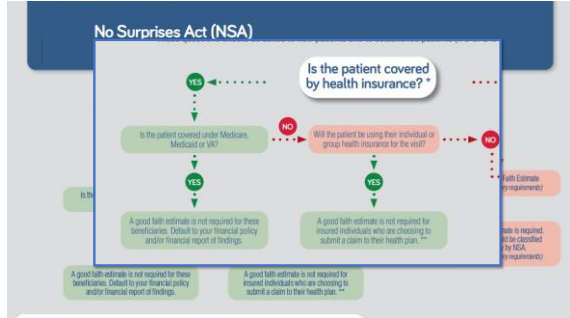
Who Should Be Offered a GFE?

Good Faith Estimate is to be offered to the following:

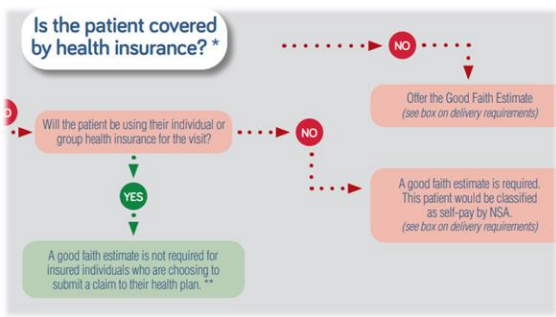
- Uninsured patients (self-pay)
- Patients who are insured but elect NOT to use their coverage



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**New Patient Data Collection Form**

(This portion of the call will measure the patients that they have called the right place)

Name: \_\_\_\_\_

Who may we thank for referring you? \_\_\_\_\_

What type of problem are you having? \_\_\_\_\_

How long has this been going on? \_\_\_\_\_ "Result of accident?"  Yes  No

Insurance:

Do you have some kind of insurance that you'd like us to assist in filing for you?  Yes  No\*

\*If answer is No, "Would you like a Good Faith Estimate for your out of pocket cost?"

Would you please get your insurance/Medicare Card/accident information so we can review it? \_\_\_\_\_

Appointment Date/Time: \_\_\_\_\_

Now I'm going to ask you some questions that will save you time when you are in the office...

Address: \_\_\_\_\_ DOB: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_ Phone: \_\_\_\_\_  Cell  Home

Email Address: \_\_\_\_\_

Do you have some kind of insurance that you'd like us to assist in filing for you?  Yes  No\*

\*If answer is No, "Would you like a Good Faith Estimate for your out of pocket cost?"

Would you please get your insurance/Medicare Card/accident information so we can review it? \_\_\_\_\_

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### GFE Delivery Requirements

- **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 at initial evaluation if requested.

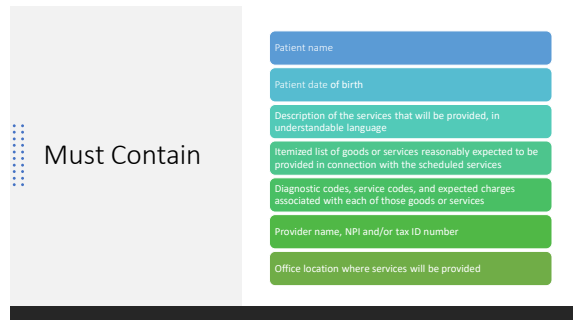
**HEADS UP!**

If patients request a GFE on their own, you need to provide one within three days of the date requested. **Keep all copies of GFE's as part of the medical record and provide a hard copy or electronic to the patient or prospective patient.**

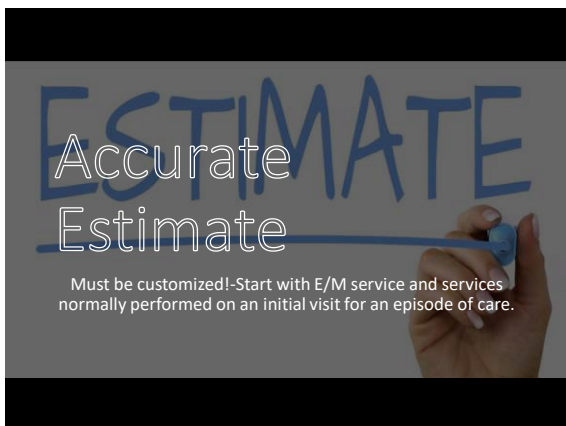
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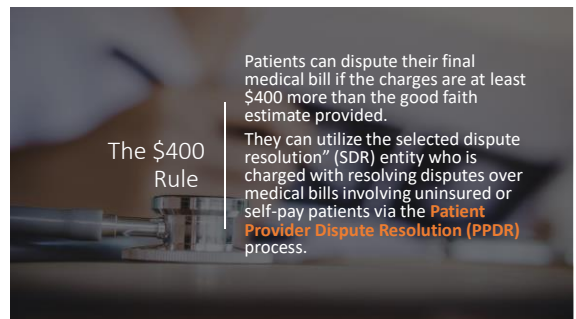
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## Patient's Rights

### 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 <input type="checkbox"/>	No <input type="checkbox"/>
Is the bill for your health care provider at least \$400 more than the Good Faith Estimate?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Is the date on the top of the bill within the last 120 calendar days (about 4 months)?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

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## Payment Dispute Resolution

### Providers: what to expect when a patient starts payment dispute resolution

The "No Surprises" requirements are effective as of January 1, 2022, and protect uninsured (or self-pay) consumers from many unexpected high medical bills. If a consumer doesn't have health insurance, or doesn't plan to use that insurance to pay for health care items or services, they must be given a "good faith estimate" of what they may be charged, before they get the item or service. Once an uninsured (or self-pay) consumer schedules an item or service (like a medical device, a doctor's visit or a surgical procedure) with a health care provider or health care facility, that provider or facility must give them a good faith estimate of the amount it expects to charge for that item or service. A provider or facility must also give this good faith estimate when a consumer requests it (regardless of if they schedule the item or service).

A patient-provider dispute resolution process is now available for uninsured (or self-pay) consumers who get a bill from a provider that's at least \$400 more than the expected charges on the good faith estimate. Under the patient-provider dispute resolution process, an uninsured (or self-pay) consumer, or their authorized representative, may initiate the dispute process. This process brings in an independent third-party called a dispute resolution entity to determine the appropriate amount the consumer must pay.

If a consumer chooses to dispute a charge for an item or service, the provider will be asked to provide:

- The good faith estimate they provided their patient.
- The bill they sent to their patient.
- Any supporting documents that help to explain why the bill is higher than the estimate.

Providers will be emailed a link to the federal dispute resolution portal where they can upload the requested documents. The dispute resolution entity will contact the provider if any additional information is needed. Once a determination is made, the

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Initial Visit  
GFE  
Customization

### 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. 41000  
City: Simplicity State: KY Zip: 41000  
Phone: 555-555-1111 Email: contactme@gmail.com

**Requested Service**  
Primary Service Requested or Scheduled (describe):  
Examination (evaluation)  
Secondary Condition: Shoulder impingement syndrome (cervical and mid-back pain)  
Scheduled Appointment Date: May 3, 2022  Check bubble if not scheduled

SERVICE/ITEM	CONDITION	DIAGNOSIS CODE	NUMBER OF UNITS	COST PER UNIT	TOTAL
Exam (Evaluation)	no back, no neck, no related	M54.5	1	145.00	145.00
Imaging diagnostic		M54.5	1-2	105.00	210.00
Electrical Stimulation	muscle spasm	M54.5	1	36.00	36.00

Total Expected Charges \$ 521.00

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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. 41000  
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 05/03/2022, and is projected to be completed by 05/10/2022.

SERVICE/ITEM	CONDITION	DIAGNOSIS CODE	NUMBER OF UNITS	COST PER UNIT	TOTAL
Spinal Manipulation 3 areas	Neck/Shoulder/Thoracic/low lumbar pain	M9900.M9902.S335xxA	15	65.00	975.00
Manual Therapy	Shoulder pain	M7541	12 units/60 weeks	45.00	540.00
Exercise Therapy	Neck/Shoulder/Thoracic/low lumbar pain	M9900.M9903	20 units/10 weeks	65.00	1300.00
Re-Exam	spine & shoulder	N/A	2	85.00	210.00

### Second Step of the GFE Process

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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 05/03/2022, and is projected to be completed by 05/10/2022.

SERVICE/ITEM	CONDITION	DIAGNOSIS CODE	NUMBER OF UNITS	COST PER UNIT	TOTAL
Spinal Manipulation 3 areas	Neck/Shoulder/Thoracic/low lumbar pain	M9900.M9902.S335xxA	15	65.00	975.00
Manual Therapy	Shoulder pain	M7541	12 units/60 weeks	45.00	540.00
Exercise Therapy	Neck/Shoulder/Thoracic/low lumbar pain	M9900.M9903	20 units/10 weeks	65.00	1300.00
Re-Exam	spine & shoulder	N/A	2	85.00	210.00

**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 your provider. It does not include any charges for 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 60 months from the following date of estimate: 05-03-22. If the actual charges for these services exceeds our estimate by the amount of 20% or more, we will promptly re-evaluate and update the estimate to reflect the current estimated cost and charges.

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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 05/10/2022, and is projected to be completed by 05/10/2022.

SERVICE/ITEM	CONDITION	DIAGNOSIS CODE	NUMBER OF UNITS	COST PER UNIT	TOTAL
Adjustment S8990	Maintenance	Z00.00	24		

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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.



**Document Delivery**  
It is part of the medical record

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### Audit Your Current Process

**Gather**

Gather with your team and review your current intake process

**Train**

Train staff on the expectations of the newer regulations such as No Surprises Act

**Make**

Make note of areas that are lacking

**Non-Compliance Penalty**



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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

### Be Prepared

Focus on Payer Relationships

Register Online Portals and Avallity

Medical Review Policies

Identify Non-Covered Services

Create a list of network payers on your website



**The future**

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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

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