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Federal No Surprise Act Readiness

Developed by: Megan Smith
Executive Director of Quality and Training
msmith@hrgpros.com

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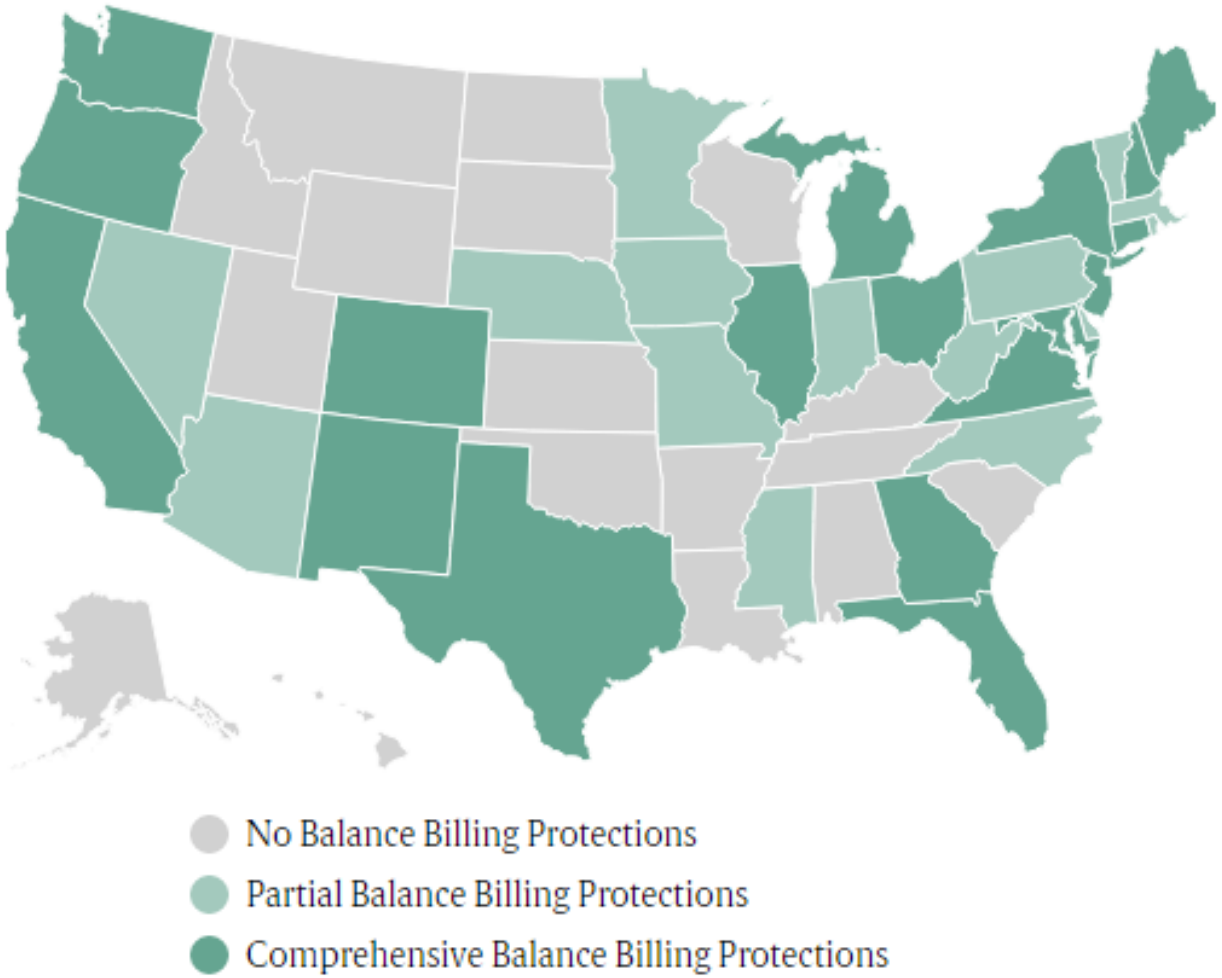
Current Patient Balance Billing Protections



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BALANCE BILLING PROTECTION: STATE vs. FEDERAL

STATE HB2504

- HMO/Mutual Benefit Societies
- Non emergent, emergency (pro & tech)
- Establish dispute resolution process
- Estimates, disclosures, consents
- Provide option for 80% U & C

FEDERAL

- All commercial insurance plans – incl. self funded
- Non emergent/specific emergency and air ambulance services (pro & tech)
- Payment determined as median rate from 2019 reimbursement data
- Consent process
- Formal dispute process for providers & patients
- Good Faith Estimate requirement (uninsured)
- Consumer notification requirement

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What Qualifies as Surprise Billing?

Patient unknowingly receives care by an out of network provider or facility

Includes:

- Services at out of network facility
- Certain ED post stabilization services
- Air ambulance services
- Out of network provider at in-network facility
  Example: anesthesiologist, lab department

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No Surprise Act

- Bans surprise patient billing for emergency, air ambulance and out of network services provided at in-network facilities
- Patient cost sharing cannot be higher than in-network
- Creates a consent process
- Providers required to inform the public
- OON payments based on median in-network rate 2019 – forward
- Dispute process for providers and patients

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Out of Network Definition

- When a hospital, clinic or provider does **not** have a contract with a specific insurance; or
- Hospital has contract, but provider doesn't Example: ED physician, traveling physician, anesthesiologist group, etc.

Why does this matter?

OON claims are processed at much lower benefit level with higher out of pocket for the subscriber

Example: 60/40 instead of 80/20 or 90/10

Payor Provisions

- Nearly all private health plans affected
- All ED and Air Ambulance services automatically processed in-network
- Out of network reimbursed at “qualifying rate” without prior authorization
- Interim payment or notice of denial 30 days receipt of ‘clean claim’. Plan can extend 15 days for additional information
- Routine denials not allowed
- Payment made to provider, not to patient/subscriber

Applicable for in and out of network services

Upon member request with 1 day turn around time

Facility is participating provider (INN) and contract rate for item or service

Description on how to find information on INN providers

Good faith estimates of provider billed charges, insurance allowable, cost-share responsibility, current standing on deductibles and OOP max

Any applicable disclaimers

- Plan years beginning January 1st, 2022
- In-network (INN) deductible
- Out-of-network (OON) deductible
- Out of pocket maximum limit
- Member assistance contact number and website URL
- Where to find INN providers

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Member ID Cards

Provider Responsibilities

Provide Good Faith Estimates for un-insured or self pay patients for scheduled services	Provide notice of rights to consumers: single page notice and website	Develop workflow for consent on non-emergent and certain emergent out of network services	Implement workflow to ensure patients are billed for correct in-network amounts

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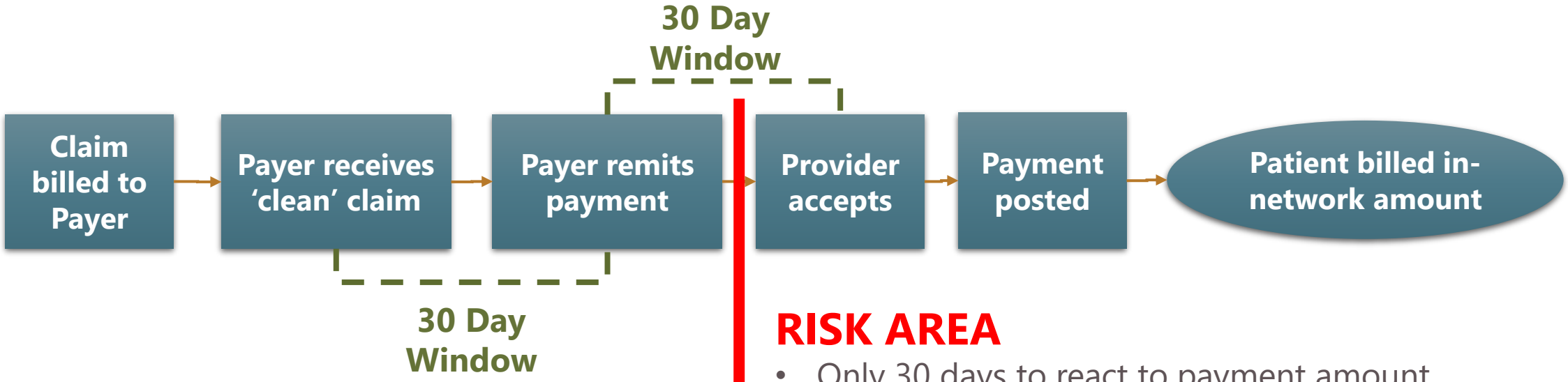
Scenario 1: Agree with Payment Amount



Payment Details Under NSA

- Payer can extend 15 days more for additional information
- Payment is considered "payment in full"
- Payment made to provider, not patient

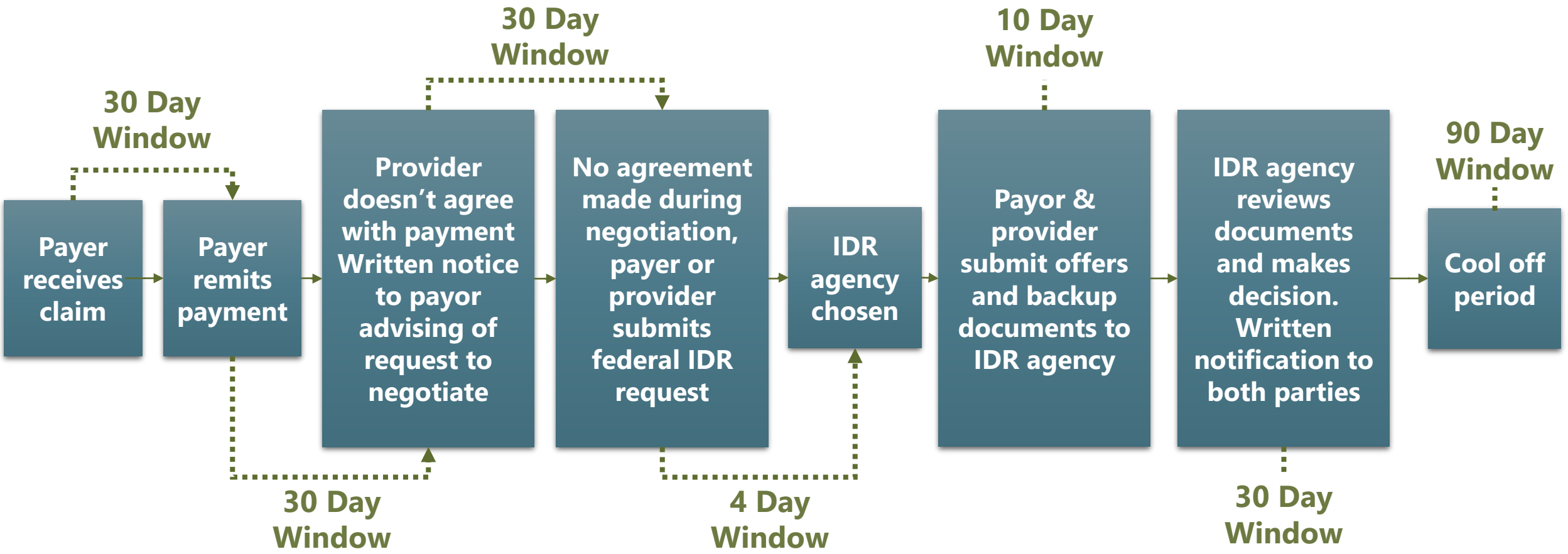
RISK AREA

- Only 30 days to react to payment amount
- Payments posted without further review
- Could be paid under Usual & Customary
- Negotiation sent via fax and misplaced

Remittance Remark Codes

N858	**Alert: State regulations relating to an Out of Network Medical Emergency Care Act were applied to the processing of this claim. Payment amounts are eligible for dispute following the state's documented appeal/ grievance/ arbitration process.** *Start: 11/01/2021*
N859	**Alert: The Federal No Surprise Billing Act was applied to the processing of this claim. Payment amounts are eligible for dispute following the Federal documented appeal/ grievance/ dispute resolution process.** *Start: 11/01/2021*
N860	**Alert: The Federal No Surprise Billing Act Qualified Payment Amount (QPA) was used to calculate the member cost share(s).** *Start: 11/01/2021*

Scenario 2: Disagree with Payment Amount



- **Not a lot of wiggle room.** The NSA adopts “baseball-style” arbitration where each party offers a payment amount, and the IDR entity selects one amount or the other with no ability to split the difference. The decision is binding, although the parties can continue to negotiate or settle during the IDR process
- **There is a cost.** Both parties must pay an administrative fee (estimated $50 each for 2022), and the non-prevailing party is responsible for the certified independent dispute resolution entity fee for the use of this process estimated between $200 - $500
- **The ‘Cool Off’ period.** Once the IDR entity makes a determination, the party that initiated IDR cannot initiate a new round of IDR for the same services with the same party for 90-calendar-days after the determination made

Upon request, providers must provide Good Faith Estimate to all uninsured or self pay patients.

- HHS has delayed requirement for **insured** patients
- GFE includes patient demographic information, description of services, specific codes, itemization of charges, any disclaimers

Patient –Provider Dispute Resolution

- Providers charges are “substantially” higher than GFE
- Substantially defined as $400+ greater
- Patient initiates process via Federal IDR portal with $25 fee
- Must be within initiated within 120 days from receipt of initial bill
- IDR has 30 days to decide patient’s out of pocket

Consent forms allow claim to be processed as OON with higher patient out of pocket. Guidelines include:

- Must be provided 72 hours BEFORE services are rendered in non-emergent situation and within 3 hours in emergent situation
- Allowed for ED AFTER patient stabilized
- Must be a separate document from all other consent paperwork

Guidance still pending for notifying payers when consent is on file

Surprise Billing Protection Form

The purpose of this document is to let you know about your protections from unexpected medical bills. It also asks whether you would like to give up those protections and pay more for out-of-network care.

IMPORTANT: You aren't required to sign this form and shouldn't sign it if you didn't have a choice of health care provider when you received care. You can choose to get care from a provider or facility in your health plan's network, which may cost you less.

If you'd like assistance with this document, ask your provider or a patient advocate. Take a picture and/or keep a copy of this form for your records.

You're getting this notice because this provider or facility isn't in your health plan's network. This means the provider or facility doesn't have an agreement with your plan.

Getting care from this provider or facility could cost you more.

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By signing, I give up my federal consumer protections and agree to pay more for out-of-network care.

With my signature, I am saying that I agree to get the items or services from (select all that apply):

☐ [*doctor's or provider's name*] [*If consent is for multiple doctors or providers, provide a separate check box for each doctor or provider]*

☐ [*facility name*]

With my signature, I acknowledge that I am consenting of my own free will and am not being coerced or pressured. I also understand that:

- I'm giving up some consumer billing protections under federal law.
- I may get a bill for the full charges for these items and services, or have to pay out-of-network cost-sharing under my health plan.
- I was given a written notice on [*enter date of notice*] explaining that my provider or facility isn't in my health plan's network, the estimated cost of services, and what I may owe if I agree to be treated by this provider or facility.
- I got the notice either on paper or electronically, consistent with my choice.
- I fully and completely understand that some or all amounts I pay might not count toward my health plan's deductible or out-of-pocket limit.

More details about your estimate

Patient name: _____

Out-of-network provider(s) or facility name: _____

_____

The amount below is only an estimate; it isn't an offer or contract for services. This estimate shows the full estimated costs of the items or services listed. It doesn't include any information about what your health plan may cover. This means that **the final cost of services may be different than this estimate.**

Contact your health plan to find out how much, if any, your plan will pay and how much you may have to pay.

[*Enter the good faith estimated cost for the items and services that would be furnished by the listed provider or facility plus the cost of any items or services reasonably expected to be provided in conjunction with such items or services. Assume no coverage would be provided for any of the items and services.*].

[*Populate the table below with each item and service, date of service, and estimated cost. Add additional rows if necessary. The total amount on page 2 must be equal to the total of each of the cost estimates included in the table.*]

Date of service	Service code	Description	Estimated amount to be billed

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IMPORTANT: Just because the patient was surprised by a bill doesn't mean it's against the federal law

- We expect a high level of consumer confusion
- EOBs should be carefully reviewed to see how claim processed. Check for known remark codes N858, N859 & N860
- If claim processed OON, is a signed consent on file?
  - If processed OON and no consent, additional review needed
- If claim processed at in-network rate, recommend contacting insurance to discuss their benefit level

Provider Readiness

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Identify Risk Through Research

- Research existing state balance billing protections and compare to federal law (default to more stringent)
- Review 12 months' registration and reimbursement data
  - How many commercial patients were seen?
  - Primary or secondary commercial?
  - Review reimbursement trends; how many claims processed as out of network?

Develop and Document Workflows

Front-end

✓Good Faith Estimates

✓RTE: verification of in/out of network

✓Consents: Scheduling, financial clearance & arrival/admission staff

Back-end

✓Timely response to claims paid under NSA provisions

✓Determine if IDR process will be done. May need to designate staff

✓Validation of patient out of pocket amounts

✓Education and scripting for self pay staff

✓Workflow for additional review of claim/patient balance

Prepare Teams with Training

Front-end Staff

- ❑ No Surprise Act review- what is it and how does it impact the front-end
- ❑ Review RTE responses on out of network payers (be sure to scroll all the way down)
- ❑ Tips for reading insurance cards: define out of network, deductibles, out of pocket, etc.
- ❑ Walk through documented workflows: consent forms, good faith estimates
- ❑ Review resources available to consumers: where to refer in case consumer/patient has questions
- ❑ Role play different scenarios to gain confidence when discussing NSA information with consumers
- ❑ Share monthly denial reports to reinforce importance of getting registration right the first time

Prepare Teams with Training cont.

Back-end Billing Staff

- ❑ No Surprise Act review- what is it and how does it impact billing and reimbursement
- ❑ Walk through documented workflows: account payment review, negotiation, and IDR process
- ❑ Discuss importance of validating the patient balance; review remittance advice codes and if indicator will be used
- ❑ Emphasize the urgency to review and negotiate payments

Prepare Teams with Training cont.

Back-end Self Pay Staff

- ❑ No Surprise Act review- what is it and how does it impact patient out of pocket amounts
- ❑ Instruction on how to determine if balance is subject to NSA requirements or if patient may just be disputing a high out of pocket
- ❑ Workflow for escalating accounts to review patient balance: which hold codes should be used, and specific timeframes for holding accounts, etc.
- ❑ Explanation of Patient and Provider Dispute Resolution process
- ❑ Reviewing materials prepared for the consumer is the best way to prepare for the conversation
- ❑ Role play and practice scripting to ensure phone representatives can respond to caller questions with confidence

Monitor Through Reporting

- ❑ Review 835 reason/remark code mapping, flagging remittance codes associated with NSA payments
- ❑ If system indicator or agency will be utilized, develop reports to track volume of accounts, payer information, reimbursement, and date of claim submission to ensure timely payment of claims
- ❑ If IDR process will be utilized, develop reporting to track all accounts going through IDR process. Be sure to track the date account(s) enter IDR process and outcomes
- ❑ Implement and monitor a weekly denial report to ensure payers aren't blanket denying out of network claims
- ❑ Monitor reimbursement percentages closely for both in and out of network payers to ensure consistent cash flow

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