HENRY SCHEIN® MicroMD® Webinar Series: **INDUSTRY INSIGHTS**

sponsored by TriZetto Provider Solutions® A Cognizant Company

No Surprises Act Tasks for Providers: **New Requirements for Giving Patients Advance Treatment Costs**

STANLEY NACHIMSON

Principal, Nachimson Advisors

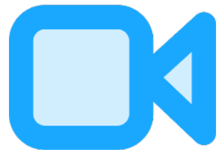
WEBINAR TIPS FOR ATTENDEES

Questions

You can submit a question anytime by using the “Question” area of your control panel. We will reserve time for Q&A at the end of the session.

Audio

Your audio will be streaming through your computer speakers.



Recording

After the webinar ends, registrants will receive a notification through email with a URL link of the recording for on-demand viewing.

OUR PRESENTERS

STANLEY NACHIMSON
Principal, Nachimson Advisors

Stanley has served for over 30 years in the US Department of Health and Human Services in a variety of statistical, management and health technology positions, and brings a wealth of experience and information regarding the use of data, standards, and technology in the health care industry.

ERIC COHOON
Sr. Account Executive, Channel Partnerships, Trizetto Provider Solutions

Eric has spent over 18 years in the revenue cycle/clearinghouse industry working directly with health care providers & health systems, PM/EHR partners, and industry associations.

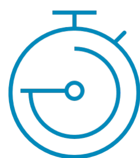
LEGISLATION & PURPOSE

No Surprises Act

Signed into law as part of the Consolidated Appropriations Act of 2021 in response to increasing bankruptcies due to medical costs.

Protects

Protects insured patients against out-of-network charges for emergency services and out-of- network charges in in-network facilities



Implementation Date

Required January 1, 2022

Purpose

Provides further price transparency for patients & several other provider requirements

WHICH PATIENTS ARE IMPACTED

Applies to patients with:

- Comprehensive individual and group health plans including:
  - Fully insured plans sold through the individual and groups markets
  - Self-fund plans (“ERISA” plans)
- Uninsured/self-pay

Does not apply to patients with:

- Medicare
- Medicaid
- Other government plans; as there is no surprise billing

Protects patients but puts certain responsibilities on plans and providers

TODAY'S FOCUS

- Balance Billing Prohibitions
- Advance estimates of patient costs
- Provider Directory requirements
- Extension of treatment when leaving a network

Balance Billing Prohibitions

SPECIFIC PROHIBITIONS

Against Balance Billing

- Health insurers must cover emergency services without any prior authorization and regardless of whether the provider is in or out of the health plan’s network
- The plan must reimburse the provider directly and cannot instead route payment through the patient.
- Any patient cost-sharing must count toward the patient’s deductible and/or out-of-pocket cost sharing maximum as though the services were provided in-network.
- The patient’s cost-sharing obligation is calculated from a new concept called the recognized amount.

“PRUDENT LAYMAN’S” DEFINITION

Emergency Services

a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson could reasonably expect the absence of immediate medical attention to result in:

- (1) placing the health of the individual in serious jeopardy,
- (2) serious impairment to bodily functions, or
- (3) serious dysfunction of any bodily organ or part.

RECOGNIZED AMOUNT

The **recognized amount** is one of the following:

The amount required by state law that applies to that patient situation and service (i.e.. State surprise medical billing law);

The amount established through an all-payer rate setting model (i.e, as in Maryland) or;

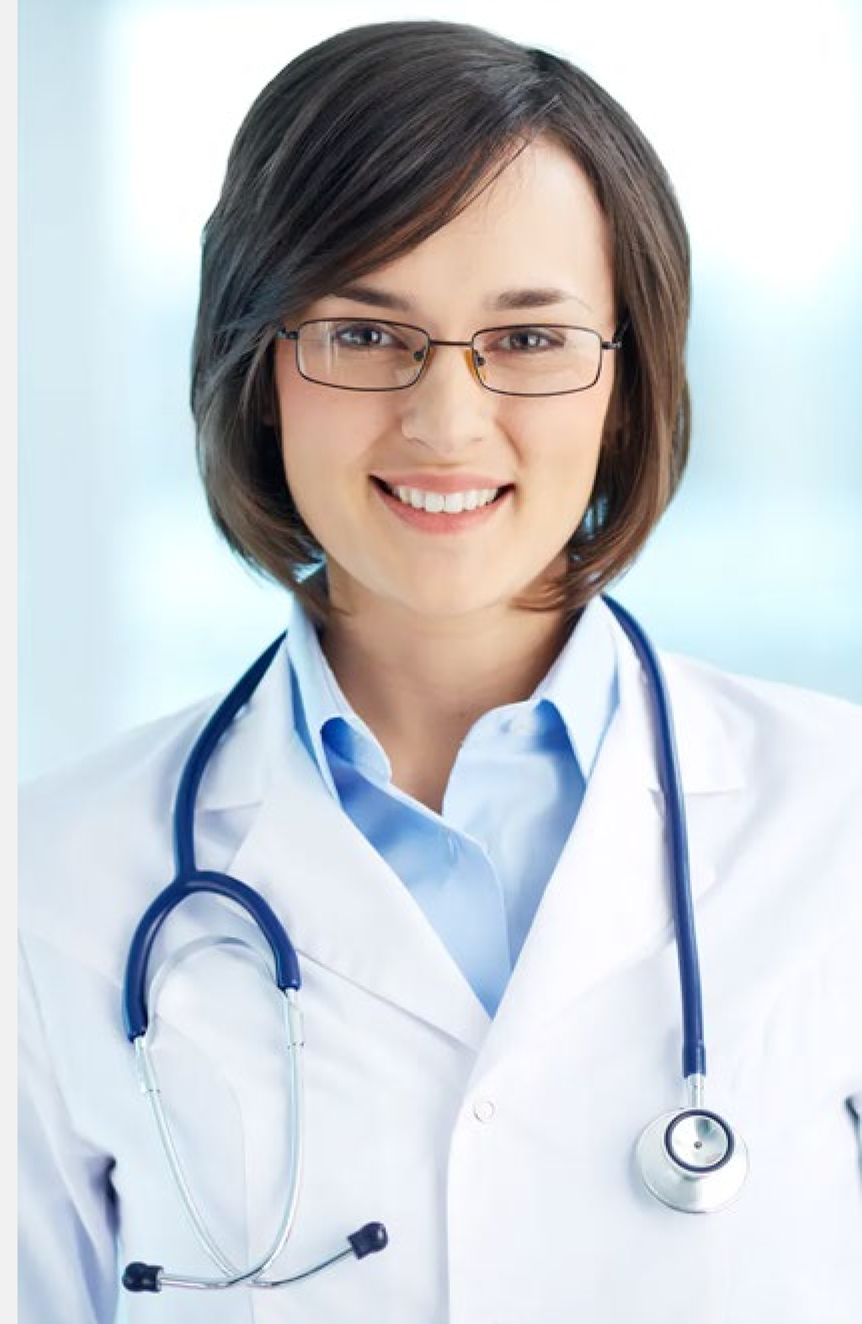
The qualifying payment amount which is based on historical payment rates for in-network services.

IN NETWORK FACILITY PROHIBITIONS

- Patients are also protected against surprise (balance) billing if they at an in-network facility and are treated by out-of-network providers like anesthesiologists or radiologists.
- Patient cost-sharing for these services must be calculated as if they were in-network
- Plans must compensate the provider as described previously for emergency services.
- Exception – patients may choose to get (and pay for) services from certain OON providers.
  - If the provider has obtained consent from the patient consistent with the notice and consent requirements described in the law.

INDEPENDENT DISPUTE RESOLUTION (IDR)

CMS has established an IDR for providers and plans if amount is questioned by the provider and cannot reach agreement with the plan.



Advance Estimates for Patient Costs

NEW REQUIRED TRANSACTIONS

Provider "Good Faith Estimate" (GFE)

In Place Now

If the patient has no health plan or coverage for a specific service or doesn't intend to submit a claim to the plan or coverage, the provider or facility must provide notification to the patient (in clear and understandable language) of the good faith estimate of the expected charges, expected service, and diagnostic codes of scheduled services.

Apply whenever items or services are **scheduled at least three days in advance** or when **requested by a patient** without scheduling the service.

Provider will need to **determine the patient's health coverage status** and develop the "**good faith estimate**" at least **three business days before the service** is furnished and no later than one business day after scheduling, unless the service is scheduled for more than 10 business days later.

If **more than 10 days**, the provider will need to furnish the **information within three business days of a patient requesting an estimate** or scheduling a service.

So "walk-ins" or others scheduled less than 3 days in advance are not subject to this requirement.

Can be emailed or mailed to patient

CMS SUGGESTED FORM FOR GFE

CMS -10791

Good Faith Estimate Template Notice

[Download Form >]

OMB Control Number [XXXX-XXXX]
ExpirationDate [MM/DD/YYYY]

[NAME OF PROVIDER OR FACILITY]

Good Faith Estimate for Health Care Items and Services

Patient		
Patient First Name	Middle Name	Last Name
Patient Date of Birth: ____________/________/___________		
Patient Identification Number:		
Patient Mailing Address, Phone Number, and Email Address		
Street or PO Box		Apartment
City	State	ZIP Code
Phone		
Email Address		
Patient's Contact Preference: [ ] By mail [ ] By email		
Patient Diagnosis		
Primary Service or Item Requested/Scheduled		
Patient Primary Diagnosis	Primary Diagnosis Code	
Patient Secondary Diagnosis	Secondary Diagnosis Code	

NOTE THE DISCLAIMERS

1

The Good Faith Estimate shows the costs of items and services that are reasonably expected for health care needs for an item or service.

2

The estimate is based on information **known at the time the estimate was created.**

3

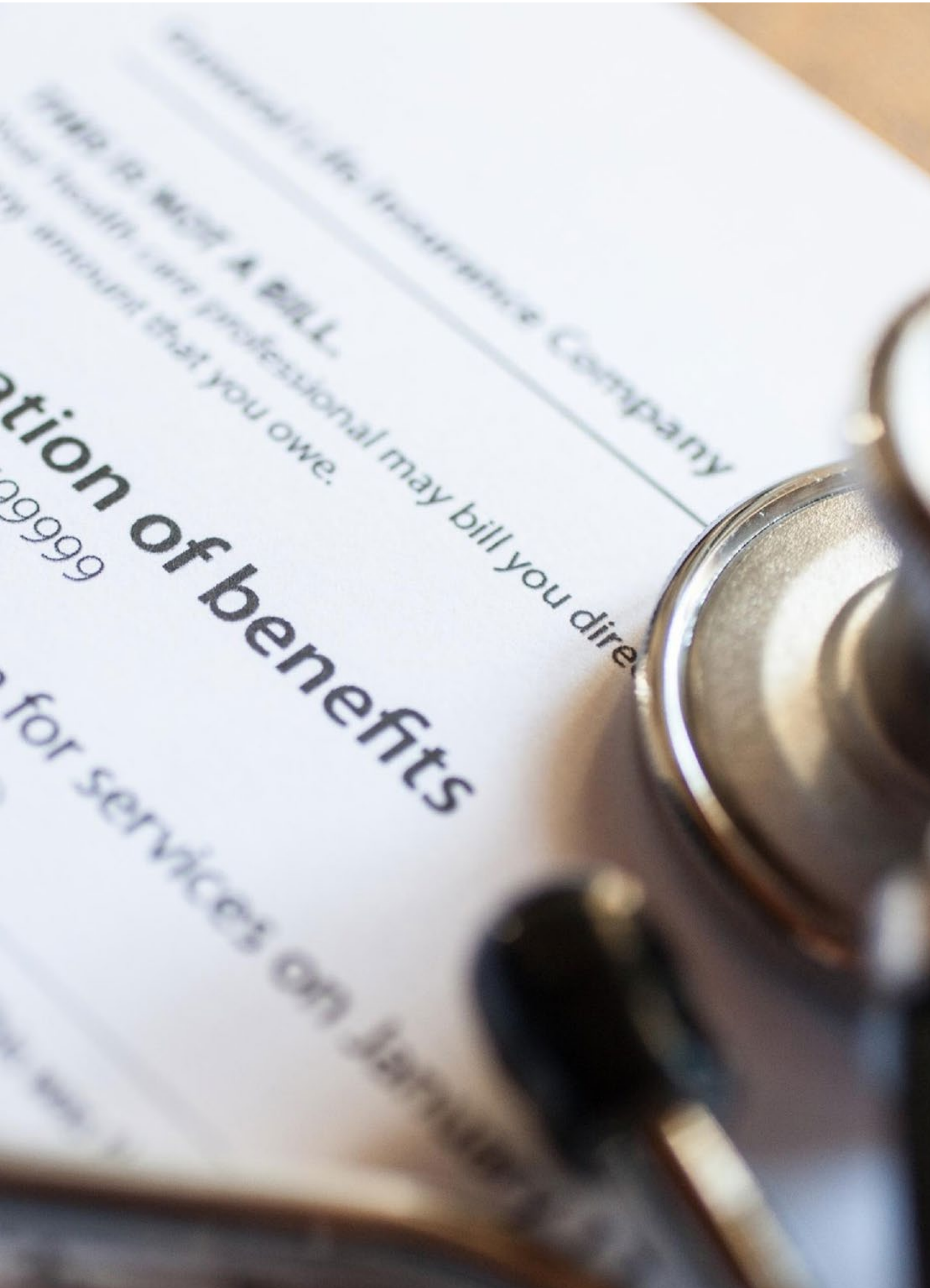
The Good Faith Estimate **does not include any unknown or unexpected costs that may arise during treatment.**

FURTHER GFE REQUIREMENTS

- Law requires a "convening provider" to collect estimates from all involved providers in an episode of care.
- Law required implementation of this by Jan 1, 2022 but CMS has used "enforcement discretion"
- Required GFE for uninsured/self pay; but postponed including providers besides the "convening" in the estimate until Jan 1, 2023
- If GFE for a provider differs by more than $400 patient can dispute bill
- CMS has developed a dispute resolution process.

RECENT GUIDANCE FROM CMS

- GFE provided to an uninsured (or self-pay) individual is considered part of the patient's medical record and must be maintained in the same manner as a patient's medical record, that is subject to HIPAA privacy and security rules.
- A provider or facility is required to provide a diagnosis code only where one is required for the calculation of the GFE. For example, in situations in which a provider or facility has not determined a diagnosis, such as for initial screening visits or evaluation and management visits; or if there is not a relevant diagnosis code for an item or service, such as for certain dental screenings or procedures.
- In circumstances where a provider or facility expects to furnish recurring items and services, such as periodic counseling services or physical therapy services, a provider or facility may issue a single GFE for those recurring items or services, rather than a GFE for each instance, up to 12 months of services.



NEW REQUIRED TRANSACTION - AEOB

Health plans to send patients “Advanced Explanations of Benefits” (EOB) prior to scheduled care or upon request by patients seeking more information prior to scheduling.

- Triggered by provider sending GFE
- Patient may request from health plan

GFE/AEOB Future Requirements for Insured Patients

GFE REQUIREMENTS FOR INSURED PATIENTS

- Law required this by Jan 1, 2022, but CMS has postponed this due to lack of standardized industry processes.
- Provider to determine insurance coverage for patients
- Commercially insured patients will have GFE prepared for them – includes necessary information for health plans to provide an estimate of payments
  - **Diagnosis and procedure codes**
  - **Provider identification**
  - **Provider charges**
- Same timing to provide the GFE to the health plan
- Generally, not applicable if services covered by Medicare, Medicaid, and most other Federal health plans

AEOB REQUIREMENTS ON HEALTH PLANS

The Advanced EOB must contain:

- Information on whether the provider or facility delivering the item or service are in-network for that particular item or service, based on the patient's health plan.
- If the provider or facility is in-network, the contracted rate for the item or service, based on the billing and diagnostic codes sent by the provider.
- If the provider or facility is out-of-network, the health plan will need to include a description of how the patient could obtain information on in-network providers delivering that item or service.
- The "good faith estimate" of expected charges, including likely billing and diagnostic codes, sent by the provider or facility.

AEOB REQUIREMENTS

- A “good faith estimate” of the patient’s expected cost-sharing amount (based on the notification date and not the date of service).
- A “good faith estimate” of the amount the patient has incurred toward meeting their financial responsibility limits, such as their deductible and out-of-pocket maximums.
- A disclaimer that coverage for the item or service is subject to a certain medical management technique (e.g., prior authorization), as appropriate.
- A disclaimer that all information included in the notice is an estimate based on the information known at the time of scheduling or requesting the information and is subject to change.
- Any other information or disclaimers the health plans determine is appropriate for this notice.

AEOB REQUIREMENTS

- Information must be shared (by mail or electronically based on patient preference) within three business days of receiving a request or notice that a service had been scheduled, as long as the service is scheduled for at least 10 business days after the notice.

- If the services is scheduled for less than 10 days after the notice, the health plan will need to provide this information within one business day.

- The HHS Secretary will have the authority to modify the timing requirements for services deemed to have low utilization or significant variations in costs. This requirement is effective for plan years beginning on or after Jan. 1, 2022.

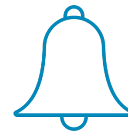
- **CMS has already indicated that this requirement will be postponed until standards are chosen, and infrastructure is in place for providers and health plans**

New Notice & Form Requirements

REQUIRED NOTICES

Providers (facilities dealing with emergency services and those that practice in such facilities) must post notices about no surprise billing:

In their office



Must be a separate notice

On their web site

Must post GFE availability forms

Model Disclosure Notice Regarding Patient Protections Against Surprise Billing Instructions for Providers and Facilities (cms.gov)

CMS -10791 -Right to Receive a Good Faith Estimate of Expected Charges Notice

QUESTIONS FOR DISCUSSION

- No standards named – how will they be developed?
- AEOB Only required to be sent to patients; should it also go to providers?
- Is this necessary for common services (e.g., office visit)
- How to handle secondary and tertiary payers?
- How to group services from different providers?

PROVIDER DIRECTORY REQUIREMENTS

Any health care provider or health care facility that has or has had a contractual relationship with a plan or issuer to provide items or services under the coverage must submit provider directory information to the plan or issuer, at a minimum:

- At the beginning of the network agreement with the plan or issuer,
- At the time of termination of the network agreement with the plan or issuer,
- When there are material changes to the content of the provider directory information of the provider or facility,
- Upon request by the plan or issuer, and
- At any other time determined appropriate by the provider, facility, or HHS

DIRECTORY REQUIREMENTS

Any health care provider or health care facility that has or has had a contractual relationship with a plan or issuer to provide items or services under the plan or insurance coverage must:

Reimburse participants, beneficiaries, or enrollees who in reliance on an incorrect provider directory, paid a provider bill in excess of the in-network cost sharing amount.

Reimbursement must be for the full amount paid in excess of the in-network cost sharing amount, plus interest

CONTINUITY OF CARE WHEN PROVIDER'S NETWORK STATUS CHANGES

When the contractual relationship between a plan or issuer and a provider or facility ends and results in a change in the provider or facility's network status, if the health care provider or facility has a continuing care patient, they must:

- Accept payment from the plan or issuer (and cost-sharing payments from the individual) for the course of treatment of a continuing care patient at the previously agreed-upon payment amount for up to 90 days after the date the patient was notified of the change in the provider's network status.
- Continue to adhere to all policies, procedures, and quality standards imposed by the plan or issuer for such items or services as if the contract were still in place

IMPLICATIONS

- Decisions on network participation for plans and providers
- Estimating revenue and costs for OON providers
- Patient responses and cancellations due to cost
- Standards and infrastructure for communications

QUESTION AND ANSWER

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Patient Responsibility Estimation

Tools to Meet Industry Requirements

Presented by:

Eric Cohoon– TriZetto Provider Solutions

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TPS Product Suite – From Patient to Payment

- **Increase revenue**
- **Decrease costs**
- **Automate tasks**
- **Make faster informed decisions**
- **Negotiate better contracts**
- **Collect funds at point of service**
- **Reduce A/R days**
- **Reduce errors**

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TPS and the No Surprises Act

Our clients are looking to us for guidance and solutions….

1. We are monitoring all legislation to assess the impact on providers
   - Publications from CMS
   - Participation in Industry Organizations

2. This is an evolving project, with new information being provided almost weekly

   www.trizettoprovider.com/resource-library/no-surprises-act

3. There are steps that can be taken today to prepare for the NSA
   - Review your price estimation processes
   - Understand how technology can enhance workflows

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TPS Patient Engagement Solutions

Eligibility

TPS customers connect to more than 800 direct eligibility payers to get the most up-to-date information on patient coverage, co-pays, deductibles and more.

25% of claims are delayed, denied or rejected due to issues related to eligibility verification.

Patient Responsibility Estimation

Quickly obtain patient financial estimates at the point of service to help increase patient revenue, decrease billing costs and improve patient satisfaction through price transparency.

23% of all claims submitted receive no payer-based payment at all. The number one reason is due to patient deductibles not being met.

Insurance Eligibility Discovery

Mitigate financial risk by using an automated process to identify a patient's insurance carrier in a matter of seconds. Submit a real-time eligibility request using minimal patient data to multiple payers at once. Maintain groups of your common payers and easily locate active patients and full eligibility benefits on our website.

On average, finding coverage at the time of visit increases the provider's chance of getting paid 3x over and reduces their days in A/R by 50 days.

Patient Responsibility Estimation

Patient Responsibility Estimation

Quickly obtain patient financial estimates at the point of service to help increase patient revenue, decrease billing costs and improve patient satisfaction through price transparency.

- Reduce collections costs by an average of $1.12/claim
- Increased opportunity to collect an additional 30% of revenue, upfront, by having an accurate estimation tool
- Research shows 52% of patients are willing to pay something at the time of service if estimates are provided

23% of all claims submitted receive **no payer-based payment** at all. The number one reason is due to patient deductibles not being met.

UnitedHealthcare

Chris Gates
Family Medicine
795 Horsham Road
Atlanta, GA 30326

June 16, 2016 - Patient Responsibility Estimation For:

Holly Abernathy
1200 Elm St
Atlanta, GA 10125

Insurance ID: 12345
Group Name: Union Tool & Supply
Group ID: 104589

Estimated Claim Totals

Charges:	$3,203.00
Allowed:	$1,701.83
Contracted Adjustments:	$1,501.17
Provider Paid:	$1,361.46
Deductible:	$0.00
Co-Insurance:	$340.37

Explanation of Estimate

This is an estimate of the amount you will owe for the medical service. It is based on current information as of the time this estimate was generated. Your provider might collect the amount estimated to be your responsibility at the time of

Total Estimated Patient Responsibility: $340.37

Please note this is an estimate only and details may change before the final claim is submitted.

Claim Detail

Service Date From Service Date To	Procedure Code	Modifiers	Submitted Units	Allowed Units	Charge	Allowed	Contracted Adjustment	Deductible	Co-Insurance	Co-Pay	Patient Adjustments	Adjust/ Remark Codes	Provider Paid	Patient Responsibility
06/15/2016 06/15/2016	57425		1 Units	1 Units	$1,703.00	$1,245.88	$457.12	$0.00	$249.18	$0.00	$0.00		$996.70	$249.18
06/15/2016 06/15/2016	57288		1 Units	1 Units	$1,500.00	$455.95	$1,044.05	$0.00	$91.19	$0.00	$0.00		$364.76	$91.19
Service Line Totals					$3,203.00	$1,701.83	$1,501.17	$0.00	$340.37	$0.00	$0.00		$1,361.46	$340.37

Service Details

Line #	Type	Amount	Source	Rule	Description
1	Fee Schedule	$457.12			Adjusted according to contract.
2	Fee Schedule	$1,044.05			Adjusted according to contract.

DISCLAIMER: Patient Responsibility Estimation is to be used for informational purposes only. The information displayed is made available through one of the following ways: a real time payer connection, historical remit data combined with payer specific rules, or payer fee schedules combined with payer specific rules (collectively, “Payer Information”) provided to TriZetto Provider Solutions, LLC (“TriZetto.”)

Patient Responsibility Estimation

Patient Responsibility Estimation

- Ability to estimate patient responsibility in real-time at any point in the revenue cycle
- No need to upload fee schedules or complex payer contracts – sophisticated logic can be used to derive fee schedules from historical remit data
- Simple printout to attach to patient chart or to give to the patient at checkout
- Custom templates available for frequently performed services
- Incorporates over 250 unique claim edits including CCL, NCD, LCD and CPT as well as each state's Medicaid rules. Unique commercial payer rules are also considered.
- Automated access to latest government fee schedules, all managed by TPS
- Utilize Service Type specific 271 eligibility/benefit information to determine copay, coinsurance, patient family deductible balances, and stop loss balance

QUESTION AND ANSWER

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TriZetto RESOURCES

Please visit the Resources section to download a copy of our partner slick. Learn about our unique packages and solutions to help set up your practice for success with the evolving regulations under the No Surprises Act.

CMS Resources

Good Faith Estimate for Health Care Items and Services

Model Disclosure Notice Regarding Patient Protections Against Surprise Billing

Right to Receive a Good Faith Estimate of Expected Charges Notice

No Surprise Act Resource Page

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THANK YOU
FOR ATTENDING

Have more questions?

Reach out to one of our MicroMD Account Representatives.

Disclaimer: All facts and figures are subject to change due to time of webinar and release of new guidelines. Please reference the CMS No Surprise Act Resource Page for the most up-to-date information.