No Surprises Act Webinar Transcript

Mike Whitmer (00:04):

Hello. My name is Mike Whitmer and I'm Vice President of NCMIC's Chiropractic Insurance Programs. Welcome to our webinar. Before we get started, I have a few notes that I'd like to share with you. We're using the webinars to explore a variety of topics affecting how you practice. Today's webinar is prerecorded to accommodate schedules. So we're not going to have the opportunity to address any questions you have live. But if you do have questions as you're watching this webinar that you would like us to address, please give us a call at 800-247-8043, or you can submit your question through the contact us section of ncmic.com. Once we receive your question, we'll be sure to follow up with you. Our monthly webinar library is posted in the resources section of ncmic.com. We've been doing monthly webinars now for quite a while and there's a great library of past programs out there, all free and on demand. So again, that's at ncmic.com under the resources section.

Mike Whitmer (01:06):

So today's topic is the No Surprises Act. As with many new government regulations, there's a lot of information to absorb about the act and there's confusion within the health care community as to what's required and even who the act applies to. So to help us delve into this topic, we have with us, Kathy Weidner from KMC University. Kathy is an international lecturer, author, columnist and trainer. She advises many in the chiropractic profession and is a speaker on NCMIC Speakers Bureau. Kathy is a Certified Medical Compliance Specialist and a Certified Chiropractic Professional Coder. She and her team also provide insurance support, coding training and reimbursement advice at association events. Kathy's one of the road warriors of the profession. I see her out on the road all the time. So Kathy, thank you for joining us today to unpack this topic. I'm going to go ahead and turn it over to you.

Kathy Weidner (02:09):

Awesome. Thanks so much. Well, this is one of those frustrating entities that has come about that the government kind of put the cart before the horse. So unfortunately, despite the fact that a lot of this information in the final and interim rules came out in 2021, they didn't even get the head of this department advertised for until December and yet we're starting in July or in January of 2022. Just yesterday, it was announced that the Texas Medical Board sued HHS and won over some of the dispute issues in here. So it's very important to know that what we're going to be talking about today is changing as we speak. And so the core pieces of what we'll talk about are not only what you have to be doing now, but what you should be looking to for the future. And I urge you to stay connected to experts in the field who can keep you advised as changes come up.

Kathy Weidner (03:16):

It's meant to be a summary of legal standards. This is a law, which means it's interpreted by lawyers in courts. I am not an attorney, don't claim to be an attorney, but it is important to know that in my company, for example, we insist on accuracy, that's our pledge. So what we know we can back up and that's what I can show you here. But keep in mind that it's constantly moving and constantly changing as we learn a little bit more. So let's start by just understanding generally what the focus of the act really is. And what's most important to understand is this is a consumer protection law. It's meant to help people to not be getting these crazy medical bills, balance billing, surprise billing, of course, as it's named, but also to be able to set some, I guess I'm going to use the term the way the government does, some competition out in the marketplace because part of the rule indicates that you have to be able to give estimates ahead of time.

Kathy Weidner (04:26):

Maybe hopefully allowing the patient to be able to shop a little bit, which we all hate, but we know that can happen. We do know that medical debt is often the number one reason for bankruptcies in this country. It's very difficult for people, especially if you don't have the type of insurance we used to have in those Mercedes '80s. And that is not what people have anymore. So consumer empowerment is the name of the game. Try to keep that in mind as you grumble about all the stuff we have to do in offices because that's just what it is. So surprise billing by definition is actually just getting a bill that you didn't think you were going to get. So I have health insurance. I insure my staff and we have really what is kind of a straight up HMO. So of course, we want to try to stay with doctors who we know are going to be in-network, accepting our fee schedule, et cetera, but occasionally there's a need to go outside of the network.

Kathy Weidner (05:28):

Unfortunately, what happens, and you may have seen this in your own community, these little popup emergency rooms and urgent cares are showing up on corners. And a colleague shared a story with me that their wife had a cut on their hand and went in, and it was a $10,000 bill. And part of the reason was because although the facility might have been in network, she was seen by two out-of-network providers. So we've all been to circumstances where you go to the hospital and you think everything's fine and some random radiologist read your film and you have to pay their full price. That's kind of where this all came from. So in summary, without going into a lot of gory detail here, the idea is, and I want to tell you, one of the culprits was really these air ambulance services. If you are in need of an air ambulance, chances are you don't give a flip, well, how much it costs. It's like: Get me to the hospital.

Kathy Weidner (06:23):

So unfortunately, people took a lot of advantage of that. So nonparticipating air ambulance providers through this bill can no longer balance bill. They have to accept the amount that would've been in network. There's no balance billing for out-of-network emergency services anymore. And in most chiropractic practices, a high percentage of this bill is not going to affect us. And I'm going to focus in for you a little bit later on the things that do affect us. And then what's important to know is that I'm going to be talking throughout here about the 1%. And the 1% are really the doctors that maybe are an out-of-network provider in an in-network facility. We know we have doctors that work in hospitals, for example. It may be in your multidisciplinary practice that you work in a CORF and you are out-of-network.

Kathy Weidner (07:16):

Weird things can happen, but what we know is it's about 1% of our profession. We are going to define essentially what facility means. Facility is a very important word in this law because you can see the facilities are do not necessarily include our chiropractic offices or any standalone practitioner office. That's a good thing because the entire first half of the law will not apply to the 99%. It might apply if you fall into the 1% that we'll talk about. So really the question is, does the balance billing protection rule apply to me? And let's take a step back. There's two parts to the law. There is the first part that are balance billing protections. And then there is good faith estimate. So on part one of the balance billing protections, that's the 99%, 1%. So if you are not a provider who works in some type of a facility, these things will not apply to you.

Kathy Weidner (08:19):

However, 100% of us will have to comply with part two. So this is cost sharing amounts in some of the rules. And again, I'm speaking quickly to the 1% here. If you're in the 99% not working in a facility, you won't have this issue. But essentially what it's telling you is that if you are an out-of-network provider in an in-network facility, they can force you to have to accept the in-network amounts. Now, you notice that in most of the rule, we don't talk about Medicare, VA, Medicaid. It's because balance billing protections are already included there. There really isn't an out-of-network scenario in these types of situations. If you're out-of-network, you're just cash. You're paying out of pocket on your own that has nothing to do with the plan. Right now for the last nine months, my team and I have been doing some very heavy investigation into Medicare Part C advantage plans and connecting with our contacts at CMS and at the various MACs because think about the times that Medicare could be out-of-network.

Kathy Weidner (09:25):

And that's in the advantage side where you may not be a participating provider in that Part C plan. So if you're not, we've always thought: Well, it's just like anything else. I'm choosing to go to this doctor on my own and it's cash. Unfortunately, there may be billing protections built in there. And the No Surprises Act brought a lot of that to the forefront. So we're really working hard to try to get some definitive, very clear communication that we can share. If you fall in the 1% on this part one, you will have to post this disclosure and get it signed. For all intent and purposes, you're saying, "Hey, you have rights here. And in order to be treated in this particular fashion, you may need to give up some of those rights." Now, again, 1%, not the 99%. So this is an example of the form we created for some of that.

Kathy Weidner (10:21):

It's not necessary to read it in detail if you're not in the 1%. But essentially what this does is it allows for on that visit one for you to be able to see that there is in fact, there's some rules in place about what you can and can't receive as far as an additional bill since you are not using your insurance. So under these circumstances, again, 1%, this is the piece that happen. So we talked about kind of air ambulance, out-of-network emergency services, no balance billing for non-emergency services performed by nonparticipating providers at certain participating health care facilities. So it's important to know this is what comprises the 1%. Now those who are enrolled in these plans are protected. So you may recall that a lot of the self-insured plans, the unions, things of that nature have always been exempted from a lot of the rules that come out around insurance.

Kathy Weidner (11:24):

This one captured all of it. So employment-based group plans whether self-insured or not are included. And as you can see, there are quite a number of things here that these protections will protect those people. Once again, patient has to sign that they understand this is the billing protection that's in place. So if you're in the 1%, that will interest you and you do need to do some further investigation. If you're in the 99%, no matter what you hear, because unfortunately right now in our profession, there are a lot of people teaching this what I feel we can prove is incorrect saying, you have to do these things, please note you just need to do a little more research on your own to get the facts for what's best for you in your practice. So these are some things that are coming that we want you to be aware of because what this act did is it formulated a very interesting connection between the payer and the provider.

Kathy Weidner (12:23):

And as you'll see, there's some really crazy stuff coming down the line, but the biggest piece is this price transparency. That's one issue we'll talk about. We're also going to talk about continuity of care. If

you're in a plan and decide to get out of a plan, and the patient's in the middle of some serious health care, some serious heart surgery or something that the patient did and the doctor goes out-of-network, the patient has to be informed in a particular way. There are a number of disclosures that meet with this. And one of the most important things that are going to come up for you now that we are advising folks to do now is to be aware of the plans that you are in-network with so that you can make sure you're properly listed on their provider directories. And there's more to come on that. Same with advance EOBs.

Kathy Weidner (13:18):

So part of what the payers have to do, and I want to be absolutely clear, payers are not up to date on this. They are not doing it. In some cases, they have until 2023 and even 2024 to come into full alignment with these rules. But the idea is to help promote the idea of more of a robust competition, for the lack of a better word. So they're going to have to do something called an advance explanation of benefits in the future, probably in 2023, where a patient can say: I have all of these things that are going to be done. Here's the estimate from my doctor. Look at this and tell me what my benefits will cover versus relying on the provider's office to do that. It is the introductory scenario of the good faith estimate, if you will. So we'll go into that here in just a moment. But the idea is for price transparency, that everyone has an idea of exactly what they're going to have to pay.

Kathy Weidner (14:26):

Anyone who knows me knows that I recently became a grandma. And I am always interested in looking at EOBs and bills. And I was looking through my daughter-in-law's hospital bill. And what I found interesting is that the payer had already given her the estimate of exactly what her co-payments and co-insurance would look like given her deductible. So I believe that certain payers are already thinking in this manner. Continuity of care, when a network status changes is important. We are not going to experience that so much in our profession. And then of course, these provider directories. So this is the idea that when the executive order came out, look at the name of it, Promoting Competition in the American Economy in order to promote the interests of workers, businesses, and consumers. So the idea behind this was to have everyone have to show what their fees are so that people could make informed decisions about whether or not to go there.

Kathy Weidner (15:26):

I mean, on the consumer side, there's great benefit to that. I would like to know. Right now I'm in the middle of planning a quarterly meeting in which I fly all my team in. And I've been to four restaurants to figure out who can accommodate 20 people and for what price. I want to know where I'm going to get the best bang for my buck. I think that's reasonable as a consumer. Now they're bringing that into health care. And obviously emergency care, you can't help it. But that's why these protections went into place, so you can't be dinged because you walked into the wrong place. It allows patients to shop, and it does in theory, increase the idea of competition. So eventually what the payers are going to have to do is make it possible for members to actually search in their portals for billing codes and what's charged.

Kathy Weidner (16:16):

It's going to allow them to compare in and out-of-network. So many chiropractors have found that with declining reimbursement, it's easier to be out-of-network with a plan and instead to actually just find a person and utilize a fee schedule from a discount medical plan instead. So we see a lot of that. That's going to be kind of brought to the forefront. It also will help inform members to accumulated

deductibles and out of pockets. I can tell you, my payer has already been doing that for a number of years. So that when you see any EOB, it explains how just where you are, but I can also search for it online. And then eventually to be able to provide these cost estimates, such as has been mentioned. And part of the issue here, and this is where it's really going to come into play in 2023, that all of these transparencies are going to come about, and that consumers as well as providers need to be able to become aware of the costs and the benefits, et cetera, in a more public way.

Kathy Weidner (17:25):

Continuity of care does not affect us as much. But for example, if a provider wanted to jump out-of-network with someone, they have to have a runway of time to do that. Because if someone is undergoing a course of treatment for something very complex, which of course, as you can see, that means the possibility of death or harm, we're probably not going to experience that in a traditional chiropractic practice as much. This is somebody that needs to have chemotherapy out of place and the facility decides to go out-of-network for whatever reason. It's unlikely they would do that, but they had to put this rule into place. So for the 1%, if you are part of a 1% and you work in any of these areas as an out-of-network provider, it's important to be aware of that. I'm going to tell you the majority of our profession, maybe even 99.5% will not have to deal with this.

Kathy Weidner (18:19):

Now, if you are in, and this is the most important thing to hear for this section, now that you've been kind of overviewed, if you will, providers that never furnish items or services in a facility or in connections with visits to a facility do not need to fulfill the No Surprises Act Balance Billing disclosure requirements. And essentially what that is this extra disclosure and the ability to have to tell someone if they're not using their insurance what they have to do does not apply in the very large majority of single provider clinics. So now tell me what I do need to do. So this is what will absolutely apply to DCs in the 99%. And I feel like it's important because of the misinformation that I'm seeing out there that you understand what I just went through so that when somebody says, "But you're supposed to do that," you can say, "Wait a minute. No, I'm not."

Kathy Weidner (19:23):

So he with the most knowledge wins. And I think it's important that you're aware of that. So you do have to provide good faith estimates, which we abbreviate as GFEs, in advance of scheduled services or upon request. And I'll go into those details. Now, keep in mind, this is only at this time for anyone who is uninsured, so those are your cash paying patients, or somebody that has insurance and is electing not to use their insurance. So I know of a carrier or a company out there, ChiroHealthUSA, for example, who maybe the provider has a fee schedule there that is a much more favorable fee schedule than my $10,000 deductible that I have to meet. So I can formally elect to self-pay and become a cash paying patient. And if I do, then this would absolutely apply to them because I become self-pay. Who it does not impact are your insured patients working within an in-network scenario. So understand that difference.

Kathy Weidner (20:29):

And you will have to immediately start working with the provider directories. So let's talk about that. First, let's hope that for every payer that you deal with, you have already set up some communication through a provider portal, et cetera. Now, a lot of doctors think that just because I credentialed with a plan, they're automatically going to put me in their directory. And that is just simply not true. Now they

are putting the onus back on the physician to make sure they are in the directory and correctly listed, out-of-network or in-network. So typically you have to make sure this happens at the beginning of any network agreement. When you terminate that agreement, you have to triple check to make sure you've been removed and any material changes. You've moved, your phone number changed, anything like that. And then any other time somebody asks you to make that change.

Kathy Weidner (21:29):

For example, DC begins a network agreement with a new health plan. Are they required to submit it? Yes. You have to submit it separately, not just as a part of your credentialing. So you want to make sure you ask when you're doing that process. Have to keep all the information up to date. That includes if you're connected to an office, if there's three doctors in an office, for example, the rules very clearly state, individual health care providers and the clinic. So it's just like Medicare. If you are enrolled in Medicare, you know that your entity has to have its numbers and the physician has to have its numbers. Same idea when you're introducing yourself in these types of ways. So the bulk of your requirement now comes around the good faith estimate conversation. And the good faith estimate essentially is to make sure that patients understand an approximation of what their out of pocket costs are going to look like.

Kathy Weidner (22:33):

And again, I think we were sort of the little sardines that got caught in the net fishing for the bigger fish. That's what happened. And yes, we have to find our way to get out of the net or to accommodate what needs to happen now that we're in the net. So we're going to talk about who should get them, what it has to have on it, when it should be provided, and then how to make sure implementation takes place. One of our very important proven processes is not just to learn it, but what all systems in the practice have to change to make sure this doesn't become a broken cog in our wheel, because that's the last thing you need when these big new things come into play. Now, there are a lot of things that go along with this.

Kathy Weidner (23:23):

We are electing not to talk about the IDR process today because it is literally something down the road. It is happening now. That's what the Texas Medical Association just won a lawsuit on yesterday. But this is a patient who feels you have not followed the law and can go through a proper, almost mediation around their fees. And so if that happens, you need more help than you're going to learn in a webinar here anyway. Now, good faith estimate, absolutely. Advance explanations of benefits are coming, probably 2023, maybe 2024. And then of course, you have your other dispute resolutions and things of that nature. So this is the rule. Health care providers and facilities are required 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. So we'll talk about that from an implementation point of view here. Providers by definition are any physician or other health care provider acting within the scope of their license. And guess what? That's us. That's chiropractors.

Kathy Weidner (24:35):

So let's talk about the who. Very clearly, they say it is an uninsured person, somebody who is uninsured or does not plan to use their benefits. So who is that person? That's someone who's an in-network with your facility person. They've got a $10,000 deductible and they say, "Wait a minute. I want to use this other fee schedule." And they become a cash paying patient. That is also an out-of-network patient. So

there are legitimate out-of-network benefits for this person, but we're not going to use them because again, $10,000 deductible or whatever it will be. Because remember, if you bill, they're out-of-network. They're using insurance and you would not necessarily be required to supply the good faith estimate at this time. In my opinion, it's the one time you should be doing it because it's going to be the most out of pocket.

Kathy Weidner (25:32):

So remember that when we're talking about the law, this is what you must do. And there's also just simply best business practices that frankly you should have been doing all along anyway. Letting people know an estimate of what they think they should be having out of pocket. Now, an individual who has not yet scheduled or item or service, but requests a good faith estimate. If you call my office and I say, part of what I want to do is say, "Yes, Mrs. Jones, we can absolutely get you in this week. Do you plan to use your insurance?" Yes, I have insurance. "Are you in-network with my payer?" Look. "Oh, I see that we're not in-network. We're out-of-network." Oh, well, I heard about that new law and I'd like to know about how much it's going to cost.

Kathy Weidner (26:15):

Now they can request that and you must provide it prior to them even scheduling an appointment. Now we all pray and hope that this is the minuscule amount of people who will actually even try this. But it's important that you know if you get asked, you must comply. Now a good faith estimate again, will be offered, and remember the term is offered, to these people. We had a question come in the help desk just this last week. And the CA had been to some seminar and they were told that for every new patient that called, they had to supply a full price list of every service that they do in the office. And it had to be sent out three days ahead of their appointment. Well, that's completely wrong on five fronts. So it's important that we keep it clean only these people and only at these timeframes.

Kathy Weidner (27:10):

So we encourage you to create a system around asking on that initial new patient call, whether you're using a form or whatever you used to fill out, are they planning to use their insurance and what insurance is it? And would they like a good faith estimate ahead of time? Now that to me feels like a can of worms because people are going to go: What's that? Well, it's a way we can estimate what your cost would be. Now let's backtrack a minute and talk about again, best business practices. Most practices have something in that new patient scripting anyway that talks about the approximate cost of that initial visit. Now, my land says, documentation and medical necessity is one of my specialties. So I try to help doctors understand, don't automatically assume because I have a spine and a pulse, I'm going to get x-rays and I'm going to get all this stuff on visit one.

Kathy Weidner (28:05):

Here's what you do know. They're going to get an evaluation and management service. So our suggestion for making this work in your practice is to simply give them verbally, and perhaps in that advance GFE if they ask for it, what's the range of 99202 through 99205. And maybe it's $100 up to 250. Well, that's okay to give them that range, which can only be determined when they come in and it's determined what their condition is and the complexity of that E&M service. That's the only way you're ever going to know, but you are allowed to do that. Now, if after that, I need these films, I think we're going to do some therapy, again, you would have to go ahead and estimate what that would be. Now

some doctors like to do a formal report of findings right at the end of that first visit. Some like to do it the next visit.

Kathy Weidner (29:00):

Again, this is where we want you to kind of work this into your existing kind of plan and timeline. So it gets very picky. And this is why I think the person who wrote to our help desk had the question about three days because it gets a little bit confusing. And it said that you have to do it at least three business days before the date such item or service is delivered. But look at this timeframe and the way that this becomes more clear. If the appointment is scheduled 10 business days in advance, it has to be provided within three business days. If it's between three and nine business days, it has to be provided within one business day. And less than three days in advance, you are not required to provide it in writing, but you can provide it orally, which is kind of what we're recommending.

Kathy Weidner (29:51):

And this is again, only if they ask for it. You don't have to do it automatically. So keep in mind that most of us are going to be able to get a new patient in, in a day or two. So that actually happens. Now if the patient requests the GFE on their own, you do have to provide one within three days of the request, whatever that looks like. So let's figure out for you how this fits into what your normal practice is. I know some doctors that are scheduling new patients out two weeks. Well, if a good faith estimate is asked for, they have the ability to send that at least three business days ahead. So it can be in writing. If it's electronic, it has to be in a format that the patient can print on their own, such as email or whatever that would be, or download.

Kathy Weidner (30:39):

They can't really download it from the website because it has to be particular. And then it can be verbal, as long as it's followed up with a written estimate. Now these are all the things that the government says has to be on your good faith estimate, including the diagnosis, which is insane because I haven't even met you yet. How do I know your diagnosis? So what we are suggesting is that doctors become very familiar with a small handful of pain codes because really that is what a patient normally complains. If they say that my diagnosis or my condition is neck pain, we know that we can provide the more formal diagnosis of cervicalgia and it means the same thing. So it is not an actual diagnosis. It is literally just the expectation of what we expect to see based on what you've told us.

Kathy Weidner (31:30):

And the idea here is to work with a form that's going to do this very simply and very easily. Now it cannot be a blanket thing because this is what I always do. The reason is because all that other information has to be on it. Now, if you elect to only start with your evaluation and management service, sure, that can be the same every time. But then I have to customize all the additional information. Now, part of that dispute resolution we talked about has to do with the rule that your estimate needs to be around no more than $400 off in either direction. And if it is, then they can go through this dispute process. But who knows where that's going to go based on this lawsuit, we just don't know. There's a form that's been provided. It's all very formal. What we hope is that we don't get that.

Kathy Weidner (32:21):

I'm going to use like the nosy neighbor person who just wants to try these things out. We'll have to wait and see what happens. So in this world, this is where we're going to recommend that you list out the expected items or services. And I kind of want to show you one that we used as an example. So this is the way that this would normally be filled. And you can see here that the only thing we did was talk about a new patient evaluation and management service. And there is a range of 130 to 160 because we don't know what level the person's going to have. And you can easily run a report of your code usage and see what you usually do, et cetera, and get a pretty good idea. But really our suggestion is that you start there.

Kathy Weidner (33:11):

Now, the patient comes in, they get this. You formalize the way they receive it. And now either at the end of that visit or on the next visit, now we can create a list based on the provider's treatment plan, because that is an automatic part of your documentation anyway. So the treatment plan itself will then at least give us an estimated amount of visits. Now, remember there's frequency and there's duration. So some doctors like to do their treatment plan out to the first reevaluation, about 30 days let's say. If you do that, no worries, but then you would have to do another good faith estimate after that reevaluation. Some doctors want to use protocols that they could say, "You know what? Based on your case, it's typically between 15 and 18 visits is what we see. And in your case, we're going to do these services. And here's what the cost could be."

Kathy Weidner (34:11):

Even if they get better quicker, that's a valid reason for why the estimate was over. And nobody's going to complain about something costing less than you suggested. So this is kind of, in our particular form, the back of it. And we suggest that providers use this almost like a financial report of findings, that after the clinical report of findings, we can outline this. In this case, the patient is expected to have 12 visits. On four of them, these additional services. And six on this one with these estimated costs. And that the estimate is valid for this period of time. This is the reason why it really needs to be personalized for your practice and the way you do business. Now, there is a standard notice. Remember how I said there's a notice on the first half with balance billing, there's also a notice here.

Kathy Weidner (35:02):

It needs to be posted in your office and it needs to be posted on your website that essentially says, you have the right to receive a good faith estimate of charges. That's just how it works. Now, when you deliver this document, keep in mind, it becomes a part of the medical record. So if it's a separate standalone document, scan it into your EHR. The patient needs to be given a copy. A lot of patients these days just want to take a picture with their phone. That's totally fine, as long as you can prove that indeed there has been delivery. Now the intent, there's the intent and the spirit of the law. Again, I'm going to reiterate, not a lawyer. Everyone should have a health care attorney available to them. And when you have legal questions, that's the way to go. But what I can tell you from probably the 20 different trainings and meetings that we've attended around this topic, we have learned that there is a do your best kind of a clause. Have good faith.

Kathy Weidner (36:02):

And the idea is that there is what's supposed to happen and your best business practice showing that you're trying, that you're doing your best to meet the requirements of the law. And not that you're sort of doing it halfway, but that you're really operating in good faith. And that really is to us, the spirit of the

law. There are definitely penalties for non-compliance. I will be highly shocked if this actually comes to fruition. Now, what you can do now is focus in on those payer relationships. Make sure you are enrolled in those portals, that you're staying on top of things. One of the biggest things we see as we're working with a practice who's been in an audit, let's say, is that the payer actually sent out updates about a code and its code usage or something and the person never realized it because they agreed ages ago to receive that by email. And it went to sally@soandsochiropractic, and Sally's been gone two years.

Kathy Weidner (37:03):

You have to stay connected to these blue reviews and things of that nature because that's how they're going to keep you informed as a provider. So we always suggest that you have a generic email billing at, or office manager at your URL. And then make sure that whoever is in that seat, the email is routed to them. Every email server can do that. They're called aliases. And then if Sally wins the lottery and moves to Cancun and Mary takes over that those emails automatically, she becomes billing at. That's how you make sure you stay connected. Be in those online portals. Be in connected with your clearinghouses in Availity. Make sure you're reviewing medical review policies because another thing that has to happen here is even if I have an insured person, let's pretend that they're insured with Aetna and I'm in-network with Aetna.

Kathy Weidner (37:54):

Well, we all know that Aetna's medical review policy says they will not pay for Graston, they will not pay for ART, and about 75 other things. So if I'm going to do that, I have to get advance notice from the patient and their agreement to pay for that. So even though they don't qualify in the uninsured, et cetera, they are essentially self-pay for those services that their insurance will not cover. Now, this is different than a bundled service where I can't charge the patient. But if I can charge the patient, I would need to do a good faith estimate for those portions that would be separately identifiable, such as that. And that's your non-covered or experimental, unproven, investigational is usually the terminology that they use.

Kathy Weidner (38:40):

It's also very important, and unfortunately, we see this a lot where we'll ask a provider: Well, what plans are you in? And they'll go: Oh, it's everybody. Well, it's not everybody. You should always at all times have an active list. We have a tool that you can make yourself called a carrier and verification resource, that where you would have the carrier's name, any passcodes to get into the portals, what your status is, where the contract is stored. These are things you need to know about every plan. And then I would add to it plans that you experience that you may be out-of-network with. And don't forget your Medicare advantage plans on this as well. And then always make sure that you know what things may be non-covered with people's health plans. Now the future, and I hope it's the very distant future is this idea of an advance explanation of benefits.

Kathy Weidner (39:35):

So what will likely happen is this GFE will be replaced by having to send it to the payer and have the payer, let them know what their expected charges would be and how much would be out of pocket. And we also expect that it will not just be the patients who are self-pay or uninsured, but it will also be all patients. That is what it's looking like. And again, we're just this little sardine in the big fishnet and it stinks. But it is, we are regulated health care providers and we have to manage that. So good faith estimate goes to the payer and then the patient gets this advance explanation of benefits is how it

would work. And it is complicated. And it is also contrary to everything we do in our practices as chiropractors. It may also be that what you're able to do now is make sure you alter your procedures so that you are asking about insurance and perhaps being able to give that estimated initial visit E&M range at that time.

Kathy Weidner (40:42):

And then once this happens in the future, the payer has to then provide that EOB. So making sure that you do the little pieces. At this point, really it has been in effect since January. If you haven't really done what you should do prior to having watch this webinar, I suggest that you start with your new people. So begin your processes, work the implementation with existing patients. Oh, I'm sorry, with your new patients. And then kind of get exercised in that muscle exactly how you go about doing that. Make sure that your systems work. Then I also suggest that you go back to any patients who are actively treating, figure that out next, anyone who is active. And I would just suggest you pick five or 10 a day out of your schedule and then go back through and figure out where they are to be completely in line with this.

Kathy Weidner (41:47):

And I have been doing this 39 years and I promise you they'll be doctors who will go: I ain't doing that. And I don't blame you, but you decide what's right for you and your practice regarding your existing people. Minimum, put up your notice. Change up your new patient phone call procedure. Offer the GFE even if they don't schedule and have it available in a way that you can also provide it electronically. So whatever form you're using, have it be a writeable form of some kind. You're certainly able to do that. And I believe if you follow these steps and begin getting into this kind of a process, you're going to be kind of ahead of the game, even from some of your colleagues, because this is a big mama jama. It is not easy and there's a lot to it. So starting with some simple steps, which hopefully you could have started in November, December last year.

Kathy Weidner (42:41):

But if you didn't, then it's good to pick up the baton and move now. You also have to make sure that your fee schedules are compliant and that you're working without excessive discounts and inappropriate and non-compliant discounting. So it's a good opportunity to take a solid look at all of it. The other thing that I want you to notice is that besides the fact that we have this law, many states have also had billing protections. Now we all know that NCMIC is in good old Iowa. So let's just take a look. And these are several different locations you can go to. And hopefully the internet works for me. Good. And you can see that on some of these things, we can go straight to find the state. Here we go. And let's just look and see what's happening in Iowa.

Kathy Weidner (43:29):

And you can see, there are already partial balance billing protections. And it will tell you exactly what is already in place that you already should have been following. If the state law is not as protective as this law federally, the federal law will prevail. So it's also possible that if there is something around a state law that is not mentioned in the NSA, which is hard to believe, then the state law would also, that would pull out and also apply. So you see how it says, does not imply to enrollees of self-funded plans. We know that the federal law overrode that. And that they're not emergency services. We know that the federal law overrode that. So we expect that they need to get back on the stick and get that squared away. Of course, there are great resources out there. Medicare has put together, HHS has put together an entire page on it.

Kathy Weidner (44:26):

So last but not least, just stay alert to educational opportunities, know these things in place. Start to think about how you can implement it into your practice and post those patient rights up in your website, as well as in your office. And I know that Mike gave you some information ahead of time as to how to submit questions. If you have questions, just please do that. It's a lot to consume in a short time. So take it a small bite at a time. And as with all regulatory things you have to do in your practice, do the best you can and know that at all times we're here to help. So Mike, I think that takes us to the end of this lovely topic.

Mike Whitmer (45:13):

Well, thank you very much, Kathy. That was super informative. I feel like I've got a much better understanding of the act now than I certainly did when we spoke a few weeks ago out on the road. I do have a few questions I'd like to throw out there-

Kathy Weidner (45:28):

Sure.

Mike Whitmer (45:29):

Just to... What about multidisciplinary practices? Because I'm hearing more and more about that. Doctors of chiropractic working within multidisciplinary environments, do they have to handle this differently from DC-only practices?

Kathy Weidner (45:45):

So not particularly differently, but it will apply to the physicians in the practice. So I had mentioned earlier about a CORF, for example. If the multidisciplinary practice is deemed as a facility and the chiropractor perhaps is out-of-network in that in-network facility that is a multidisciplinary CORF, then it would apply. But my expectation would be most of the time an individual office is not a facility. So it would not the first portion, the billing protection's half does not apply in those cases, but multidisciplinary offices and standalone chiropractic offices do have to comply with the good faith estimate.

Mike Whitmer (46:30):

Okay. And then just real quick, if I'm a doctor of chiropractic, will I need to post my fees on my website?

Kathy Weidner (46:41):

So at this point, you do not have to post your fees. That's perhaps coming down the road. I hope it doesn't, but it's coming down the road. That whole idea of transparency, it may be that when these payer rules come into play, that the payers will actually end up having to do a little bit more of that review of fees by comparative doctors and they may ask you to provide your fees. But at this point, it's not necessary to do that.

Mike Whitmer (47:11):

All right. Kathy, thank you so much for helping us understand this new act. I really appreciate your help. It's complicated. There's a lot to it. And I would also expect too that we need to stay tuned, that there's going to be a lot more on this.

Kathy Weidner (47:26):

There's no doubt about it. It will change by the day.

Mike Whitmer (47:29):

All right. Well, we'll have you back at a future date to give us an update on this. So thank you again. Really appreciate it. Before we go, I do have a few things I'd like to remind our listeners about. First of all, NCMIC's podcast, Chiropractical. We're now into our third year of the podcast and we have some great topics planned for the rest of it coming out this year. So check it out at ncmic.com or wherever you get your podcasts. Our monthly webinars are something else I'd like to remind you about. They typically are live the third Thursday of each month at 2:00 PM Central Time. You can also visit our archive as well under the resources section of ncmic.com for the past webinars that we've had.

Mike Whitmer (48:19):

You can also keep up to date on new resources from NCMIC by following us on Facebook, Twitter, Instagram, and LinkedIn. In closing, I'd like to thank everyone for watching. We hope the information presented has been helpful to you. And also if you have any ideas for future topics, please let us know, reach out to us here at NCMIC. So once again, thank you, Kathy. Really appreciate it. And thanks to everybody for listening.

Kathy Weidner (48:46):

Thanks for having me.

Mike Whitmer (48:55):

And I think that's it.