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How Does the No Surprises Act Impact RHCs Webinar Transcript

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SPEAKERS

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MODERATOR

Nathan Baugh, Director of Government Affairs @ NARHC

Nathan Baugh 00:05

Good afternoon everyone. My name is Nathan bond. I'm the director of government affairs for the National Association rural health clinics, and the moderator for today's call. Today's topic is the no surprises act. in good faith estimate, how does the no surprises act impact RH C's? This webinar series is sponsored by hearses Federal Office of Rural Health Policy, and is done in conjunction with the National Association of rural health clinics are supported by cooperative agreement as you can see on your screen through the Federal Office of Rural Health Policy, and that allows us to bring you these webinars for free. The purpose of the series is to provide our IT staff with valuable technical assistance and RHC specific information. And we would ask that you please help us spread the word about these free webinars by by encouraging anyone who may benefit from this information to sign up to receive announcements regarding dates, topics, and speakers at the NAR HC website. When we get to the q&a portion of today's presentation, we will open up the q&a box and ask folks to ask their questions through that q&a feature. As with all webinars, we're at the mercy of good bandwidth for all parties. And we all know that the conductivity can go up and down. So if you have any audio or visual freezes usually fixes the issue. If you continue to have issues do not worry because a recording of today's presentation will be posted on our website and ar hc.org. And that will also include links to the slides and transcript. So with that said, I have the privilege of introducing our two speakers for today. Bill Fenner frock, as many of you know, is the founder of national association of rural health clinics, as well as the executive director. And it's been a while since we've had Bill speaking directly on these calls. So I know many of you already know who Bill is. So we were happy to have him back to go over this. But also joining him is Matt writer, who is a colleague of ours, here at Capitol associates, who has been involved for years now on no surprise act, policy, both sort of following it at the legislative stage, as well as into the the regulatory states which we are currently in. So Matt Ryder, the Vice President of capital associates will also be weighing in as as he sees fit. So with that, I'm going to turn it over to you, Bill. The floor is yours.

Bill Finerfrock 03:00

Thanks, Nathan. And thanks, everyone for joining us today. For this presentation. There's prizes, Zach, what does it mean for RFCs. And thanks to our colleague Matt, for for joining me here. Most of us are familiar with the no surprises act and a lot of the public attention that has been garnered by the NSA, because of the what is referred to as the balance billing requirements, a lot of the

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media attention, where patients have been hit with excessive bills for a visit to an emergency room or they got unexpectedly hit with an out of network charge, even though they went to an in network hospital, got surgery from an in network surgeon, only to find out that perhaps somebody else involved in their medical treatment was an out of network provider unbeknownst to them. And so, as a consequence of all that Congress passed, what was referred to is called the no surprises act. And that was passed in late 2020. and established a series of policies and guidelines with regard to balance billing, when you got care from an out of network or O N provider. And it predominantly as I said applies to an out of network emergency department. So you're in a car accident or out of your network, you're taken to the nearest emergency room. And you find out as a patient that the emergency room that you were taken to was not part of your network and you get hit or you get care from an index added in network facility, but from an individual practitioner who happens to be out of network and again, you didn't know that you weren't aware of it. And that's where as I said, a lot of the attention has been focused. And with regard to the balance billing. There's been discussion of what constitutes a facility it has to be care provided in a facility and that the law describes a facility as a hospital, hospital outpatient department a critical access hospital for an ambulatory surgical center. And you'll notice that rural health clinics are not classified as a facility for purposes of the balance billing provisions of the no surprises act. But there's also another aspect of the no surprises act that has not garnered as much attention. And where rural health clinics are mentioned, and frankly, has caused some what of confusion. And we're hoping to clarify some of that and point out some of the things of where you are going to be applicable, some of the provisions of the no surprises act will be applicable to you in your RHC. So there's there's this one section that is referred to as a good faith effort or under the price transparency provision of the no surprises act. And this section does apply to certain patients receiving care at a certain federally certified rural health clinics, the price transparency provisions are going to take effect as of January 120 22. And here's an important component it applies the price transparency provisions apply to what the law describes as providers and facilities and here's where it's going to begin to get gets a little bit confusing for our agencies. So who is defined as a provider for NSE NSA price transparency purposes, the law says a provider is a healthcare provider means a physician or other health care provider who is acting within the scope of practice of that providers license or certification under applicable state law. So you not only have physicians, but you've got physician assistants, nurse practitioners, nurse midwives, psychologists, social workers, all the providers who work in rural health clinics are covered under this definition of provider. It also defines what is it facility, it says a healthcare facility means an institution such as a hospital or hospital outpatient department, critical access hospital, ambulatory surgical center, all those ones that we saw previously, but then it adds Rural Health Center, which I'll talk about in a moment, federally qualified health centers, laboratories, or imaging center. And then it goes on to specify in any state in which state or applicable local law provides the licensing of such an institution that is licensed as such an institution pursuant to such law, or is approved by the agency of such state or locality responsible for licensing such institutions as meeting the standards established for such licensing. But that's a lot of legal technical language. Essentially, when you cut through it all, it means for the purposes of this law, Rural Health Center, which we believe is actually just a typo and meets rural health clinic, but it also has to be state licensed. And so that that is a it's a different way they've never, we've never come across them using this kind of an approach to to clarify or classify rural health clinics FQHCs, or, frankly, labs or imaging centers. And to the best of our knowledge. There are, there are only we said here three, but then when we checked, there was actually only two. As far as we can tell, there are only two states that actually licensed our ACS as our MCs, Louisiana and Nevada. So for purposes of the no surprises act price transparency section, Louisiana and Nevada are the only places where the term rural health center would be applicable. Now. As our as we look at it, it may not even matter, because remember, there was a definition of provider, which would pick up

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the docs, Pa MPs, nurse midwives, everybody who works in the RNC. So even though this facility definition has very limited applicability, the provider definition that we referenced earlier, applies to everybody in the right seat. So the good faith estimate language does apply to the physicians PA, NPs or other health care providers who work in the RHC. And the good faith estimate is for uninsured or self pay patients. So what does that mean? Well, it means that frankly, your RNC definition, as you know is only applicable with regards to your Medicare Advantage. decayed patients. So even though it previously says that it's only in those states where the facility designation, the fact of the matter is that when it comes to uninsured, or self pay patients, your RHC definition or designation is irrelevant. The fact that you are an RHC means nothing with regard to your uninsured or yourself pay patients. It's a designation that is only applicable to your Medicare or Medicaid patients. So what do we conclude, we conclude that the good faith estimate provisions of the no surprises Act apply to every RHC that sees a patient who is uninsured or self pay. And I'm going to elaborate on that self pay or uninsured in terms of what that means here in just a moment. So beginning January, one of 2022, just a couple of weeks from now, all our eight C's must provide a good faith estimate of expected charges for items and services to an uninsured or self pay individual seeking care, or price information from that RHC. And these individuals, these self pay or uninsured individuals are defined as an individual, that one does not have health insurance coverage for an item or service for which they seek care, which would be a traditional term for an uninsured, or an individual that has health insurance coverage for such items or services, but does not wish to have a claim submitted to their health plan for the item or service. So in this case, you have an individual, maybe it's an individual who has, you know, come to your RHC previously, but for whatever reason, has decided that for this particular visit, they don't want to submit the claim to their insurance company. They want to pay for it out of pocket as a cash paying patient, which is there. Is there Right? So how do you how do you deal with this? How do you know who these individuals are? Well, when you're scheduling a patient for an item or service, or if requested by an individual, let's say somebody just calls up and says Hi, my name is Bill Finnur frock. I was not feeling too well. I want to know what you would charge for an office this under this transparency provision, alrighty, along with every other practices is not unique to RIT sees every other provider in America is going to have to comply with this. RTS are required to inquire about the individual's health insurance status, or whether the individual is seeking to have a claim submitted to their health insurance coverage for the care that they are seeking. So let's dig down on this. What what does this mean? So as an example, an individual contacts your RFC to request an appointment, the scheduler the person to get on the phone inquires about the insurance status of the individual, are you insured or are you uninsured? If the individual indicates that he or she has insurance, then the person must inquire as to whether or not the patient intends to submit the claim to his or her insurance, or whether the patient would like to pay cash for the visit. This all occurs during the initial inquiry to the practice. For the individual who will be doing the scheduling they have to collect this information. Let me repeat that. If the individual indicates that he or she has insurance, the scheduler still must inquire as to whether or not the patient intends to submit the claim to his or her insurance, or whether the patient would like to pay cash, that the patient says I'm going to submit it to my insurance. You move on and you schedule. If the patient says I'd like to pay cash or I'm not sure, you know, I'm not sure let me know. Then, if the patient indicates that they do not intend to submit the claim to their insurance, the scheduler then must ask if the individual would like a good faith estimate for the cost of the care they are going to receive. So these are our enquiries that have to occur at the initial point of contact when the patient calls up to schedule an appointment. Another example the individual is uninsured individual contacts the RFC to request an appointment. And again, the insurer the scheduler must verify the insurance status of the patient. But in this case, the individual indicates that he or she has no insurance. Then the page they the scheduler also then must acquire as to whether or not the patient would like a good faith estimate of the cost of the visit. If the patient

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says no, I don't want a good faith estimate, you move on and you schedule. If however, the patient says, Yes, I would like a good faith estimate. This is where the various requirements of the new law will kick in. At this point, the patient says, Yes, I would like a good faith estimate, then you are required, you are obligated to provide what is referred to as a timely response to a request for a good faith estimate. And the timing of that response, how quickly you have to turn around that response is based upon the amount of time between the request of the appointment and the date of the appointment. The following chart shows what constitutes a timely response for the good faith estimate. So if the individual has said they're uninsured, or they're insured, but they want to pay cash, then here are the schedules. If the appointment you're scheduling is 10 days, or more, or if the request is 10 days or more business days in advance of when the appointment will occur. So they call on Monday, and the soonest appointment you can have is two weeks from there. So it's outside the 10 business days requirement, you would have three business days from that point of which the inquiry was made to, to get them the the within I'm sorry, within three business days of scheduling, to get them to good faith estimates. If the appointment is going to be between three days to nine days, in advance of the appointment, you have to do that within one business day of scheduling. And if it is, if the appointment is less than three days in advance, or this call is less than three days in advance of the appointment, so they call on Monday, and the patient, you say oh, we can get you in on Wednesday, then it's less than three days, you do not have to do the good faith estimate, because you don't have enough time to turn that around. So let me go over that, again, scheduling appointment is going to be 10 or more business days, in advance of the appointment, you have to do the GMP. And you have to do it within three business days of scheduling. If it's between three and nine days in advance the scheduling they're doing, then you have to get it within one day of scheduling. And if it's less than three days, you don't have to do a good faith estimate. So the patient requests a good faith estimate because that scheduling appointment at this time, they just call up, they're aware that you have to provide them and they just say I I'm interested in potentially coming in, I'm not sure if I do I don't want to necessarily schedule an appointment, I just want you to tell me what the estimated cost of the service will be if I do schedule an appointment. And in that case, you have three business days of the request to send the good faith estimate to the patient. So in this case, they're not scheduling an appointment. So you don't have that timeframe. This is just I'd like to know what it costs, you have to turn that around within three business days. If the patient is this is a recurring visit visit for the same service. So for example, patients coming in for some type of therapy, or they're coming in for allergy injections, or some type of a a visit that occurs for the same service on a recurring basis. Do you have to do a good faith estimate on for each one of those? And the answer to that is no. If you know that this is a service that is going to be on a recurring basis, then you simply provide them with a single good faith estimate. And you can do that for up to a maximum of 12 months. So if you know the patient is going to come in for once a month over the next 12 months, you can give them the good faith estimate for the first visit. And presumably that will carry you up through 12 months. Okay. Yeah. What do you have to have in that good faith estimate? And your good faith estimates and we're going to provide you with some, some cheat sheets, if you will, on how to capture and report this information. You have to identify the primary service that the clinic expects to provide to the patient during the period of care. So the patient says, I have I'm having headaches, and so you're going to schedule Then let's say for an office visit, and you're expecting that that's going to be a level three in M visit. So the first thing you want to do is you're going to need to provide them with an estimate a good faith estimate of what it would cost them for an office is. The estimate must also include items or services that are reasonably expected to be provided in conjunction with the primary service for which the clinic or an outside provider has a separate charge. So in this example, the patient calls up. In this case, I said a strep throat. And the good faith estimate would include an office visit. And you might reasonably expect that you're going to do a lab test, in conjunction with that patient says, you

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know, I have a sore throat, you can presume, okay, we're probably going to do a lab test. So your good faith estimate would include not only an estimate for the office visit, as I said, presume a level three nm, as well as the cost for the lab test. Now remember, these are not Medicare or Medicaid patients, so they don't fall into your all inclusive rate system, these are going to pay based on whatever your if it's a contracted provider, or fee schedule is going to be for these visits. But what would be the good faith estimate, if a patient comes into your clinic who's cash paying patient or uninsured, for a lab test, or, you know, and then it may be that you're going to say it is possible that if it's a strep throat, we're going to have a prescription. So the good faith estimate would say, visit a lab test and a medication to treat the strep throat. And this is our good faith estimate of what we think it would cost. Now, keep in mind, this is a good faith estimate. This is not an exact science, this is not exactly what it's going to cost. And you have some wiggle room here. In terms of what the patient recourses, if the if the estimate that you provide the patient is wildly in air. And quite frankly, as we go through this, you'll see it's going to be pretty hard for you to be wildly and error on your estimates. But the the estimate that you're going to provide to the patient is based on the information that you have, at the time that the good faith estimate is requested. You are not to account for unanticipated care that is not reasonably expected, or results from unforeseen events. And patient says, I have a strep throat, or I have a sore throat, it's reasonable to presume that it's a strep throat, but it wouldn't be necessarily reasonable to presume that the patient has throat cancer. So if it comes out and you you determine that there's something there that causes the physician or the pH MP to say, gee, you know, I'm not liking what I see, when I look in your throat, we're gonna send you for something that we didn't reasonably anticipate. You're you're not on the hook, if it's not reasonable. And so I realized that the word reasonable is somewhat subjective. But and because this is a new law, we don't know how some of these things are going to be interpreted as we go forward. But I think a reasonable expected, then the example I gave of, you know, it's reasonable to presume that if it's a sore throat, it could be strap, it's not reasonable to presume if it's a sore throat, that it's, it's going to be cancer something more serious. So what is it that you're going to want to collect this is the data that you'll be required to collect, first and foremost, a patient's name and date of birth. So it'll be first name, last name, date of birth, or this uninsured or self pay individual. Next, you're you're gonna want to collect a description of the primary items or services in clear and understandable language. The date the primary item or service is scheduled. So an office visit, potentially a lab is potentially a prescription, and then you will describe the item or service to be purchased by the convening provider, you as the RNC will be considered the convening provider, you're the the initial reason you're the first point of contact that this person has. And so you're the convening provider. And then you're going to want identify items or services reasonably expected to be furnished for the period of care. Are there any other answers? ciliary services item dies list, a grouped by each provider facility reasonably expected to be provided to these individuals with the primary item or service. And you can read further and it says those items and services expected to be furnished by the convening provider or, and here's where it becomes a little trickier. Those items and services expected to be furnished by CO providers or CO facilities for the period of care. So those would be we're going to send you we're going to need to send you out for an x ray, or we think we're going to patient says, I was playing football, and I, you know, twisted my knee. And, you know, I'm really concerned and they come limping in, and they have difficulty. And you suspect that maybe they tore their ACL or they did some significant damage to where you may have to refer them to an orthopedic surgeon. And then you're going to that's going to be a co provider. Again, what is it that you reasonably might expect to have happen? You're going to list the service codes and description using the CPT codes hickspicks codes, if it's a hospital, the DRG, or if it's a prescription, the National Drug Code, the NDC. For prescriptions, the diagnosis codes, what is the anticipated ICD code, this is again, it gets a little bit trickier here. And then what are the expected charges for each of the listed items or services? What is the name of the

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provider who you expect, who will be providing this care, the tax ID number for the for the facility, and the NPI for the individual provider practitioner who's going to be providing the care to the patient. Now, as I mentioned, this law takes effect on January one. And CMS has acknowledged that providers are going to have difficulty getting charged information from those outside providers that it's expected to be included in the good faith estimate. So you're going to send a patient out for an x ray, you're going to send a patient refer he or she to an orthopedic surgeon. In all likelihood, especially since the loss is going to take effect in two weeks, you don't have the time to be able to put together that information. And so what CMS has says that, even though the requirement to include information from the outside provider also takes effect on January one of 2022. They're not going to enforce that requirement until January one of 2023. So you have reasonable amount of time to begin putting together your referral network, collecting information from those refer those entities to whom you anticipate you'll be referring patients and collecting charge information. So that beginning in 2023, you will be able to provide that information to your patients. Now, let me take a second here and note that this, the language and the requirements for this provision, only were released a couple months ago as part of the no surprises act final rules. And as I mentioned at the outset, this is a provision that has really not gotten a lot of attention. There is really very little in the statute, if you go back and read the law that was passed last year, this particular section is a very, very small part of a very large bill, and quite honestly had not gotten a whole lot of attention. I would not be surprised if there are delays in enforcement of this simply because this is a lot for folks to have to take on. There's a lot for folks to have to do. And quite honestly not a whole lot of time for them to put all this together. So I think it is possible that CMS will either delay or announced that they will be a lot of flexibility, particularly in the early going in terms of enforcement of this provision, simply because they don't you know, it's going to take a while. For folks, there's going to be a lot of questions about what some of these provisions mean, what will constitute or qualify as good information, etc. So I think you should do everything your you've heard here in terms of being ready to go, being ready to start on January one if you get a request from a patient for a good faith effort to make a good faith effort to have that to be in compliance with the law. And we will continue to have conversations with CMS to look at this to see if there's an opportunity to give some more flexibility This is something this is from CMS. And if you go into if you download the slides, you'll be able to get this is a link here, in terms of this is a document or signage that you may want to put at your front desk so that people can see it. This is from CMS. And it is proposed language. Now you'll see that at the bottom there, it says Insert phone number. And we don't have that phone number, yet it hasn't been released. But they do have a website that you can refer patients to if they have questions. But this is targeted at the patients. So they know what their rights are. With regard to these good faith estimates. CMS is also provided a template that you could use to collect the information that I mentioned before. And you can again, you can go and you can download this template, just say circled at the top note, it says Name of convening provider or competing facilities. So this is a generic template, you'll want to perhaps use this but but put your name, the name of your clinic or the name of your clinicians at the at the top of the document there. So it is apparent that this came from your practice, but it lists all the information that you're going to want to have their in how the patient contacted you what the patient's contact information is, what was the primary item or service the diagnosis codes, secondary, primary and secondary. In addition, you want to identify the date the primary service will be provided. And then the date of the good faith estimate this is so they can identify if someone has a question. They can identify when the estimate was provided relative to when the request was made. And then the provider name and what the total cost for the care would be based on MO You can obviously add if there are other providers who would be listed there.

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Nathan Baugh 32:18

Hey, Bill real quick. Yeah, yep. For for the for the thing that's patient facing explaining their rights. Does that have? Is that a requirement to post somewhere like in the lobby?

Bill Finerfrock 32:31

No, I not. I met you can correct me, I don't believe I've seen where it is you are required to but it is suggested.

Matt Reiter 32:40

I think I think it is supposed to be posted. I forget the exact details of how and where but I think it is supposed to be made public, both in person and on the website.

Bill Finerfrock 32:53

Okay. All right. So you'll want to post that. And then the disclaimer of what the purpose of the good faith estimate is. And then what you can do. It says if you are billed for more than this Good Faith Estimate, you have the right to dispute the bill. And it goes through what the patient's rights are. Now, what it does not say is that in order for a patient to dispute the bill, the bill has to be more than \$400 above what the estimate was that you received from the provider. So as an RHC, that's a pretty huge cushion. If a patient's coming in, you know, think about the patients, and they come into your office. And what are the most typical examples? And what is the total cost of that typically, would it be on a fee schedule basis, and you have a \$400 above that. So there's no there's no penalty, if the estimate you get it ends up being less than the estimate you provided. So you want to keep that in mind. And you have a cushion of \$400 above the estimate before the patient has the ability to pursue this in terms of some type of resolution through through the dispute resolution process. So the hope is that because that \$400 And you know, whether or not you might want to think about, you know, thinking, you know, what is your estimate going to be but knowing that you have 100 \$400 above that, I think is an important component. Again, this particular document is also downloadable. So I wanted to leave you and then Matt, you can come in and add this, but there's still a lot out there It needs to be resolved by CMS in terms of guidance and information, we're going to continue to put stuff out, we're frankly, still learning. As I mentioned, there's stuff that we have not there, the section of the law is probably about four or five paragraphs. And this has translated into, you know, significant pages in the Federal Register of compliance, and then additional guidance and documents. So it's gonna take a little while for this all to work its way through. But you know, this is a significant, quite honestly a significant burden that will be placed on all medical practices to have a better sense of what are your charges? What are what information can you? Or do you need to share with patients as part of this process? Matt, do you want to elaborate or anything you want to add to this before we go to questions, and you can help out there?

Matt Reiter 35:59

Yeah, just from skimming through the questions here. And I can see, it's a lot and I haven't been able to keep up with all of them. But just a few. I think just points to emphasize as highlights, I think it's important to understand that for providing the good faith estimate, it's for uninsured, or self pay patients, either upon request by the patient, or when the patient schedules the care. So

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even if the patient says, oh, yeah, I don't need one, but they still schedule the care according to the regulation, you're still supposed to provide them with a good faith estimate. And, you know, it says that patients, even if they have insurance, you know, like, it's like Bill was saying before, they can say, Well, I'm not planning to submit the bill, to my insurance, I want to know what the price would be, if I don't, you know, and so that's intended to allow the patient to basically comparison shop, what they would cost to go through insurance versus out of pocket. And so if it doesn't matter what type of insurance they have, it could be Medicare, could be Medicaid, it could be, it could be commercial insurance. So if they decide that, you know, it doesn't matter what type of insurance they have, they say they're not going to submit it to their health plan, then it has to be treated as a, as a self paid for this. And I just think that it's, it's still a little, you know, we're looking for more like Bill said, it's still kind of murky at what, you know, how to really define what is a kind of reasonable, connected care, you know, and they're not going to enforce that for a year, so that it's in, they're going to provide more information they say about, you know, what that process will be for reaching out to the coordinating with the other facilities and the other providers for that, but, you know, it's it's gonna be, you know, we're still waiting for a little bit more details on kind of exactly, you know, from CMS, what they're expecting in terms of, you know, the level of of what they mean by reasonable connect amount of connected care. But I think, you know, if you kind of go by, you know, your best judgment is what you think is reasonable at the time of scheduling this service, you know, I think they're going to kind of, you know, defer to your judgment, if I, if I had to guess. And lastly, when it comes to this dispute resolution process, I think it's important to really try to take these good faith estimates seriously for these patients. Because if it does go to this patient provider dispute resolution process, you know, there's a few different outcomes, you know, the arbiter basically has to, you know, it's kind of is limited to what they can really decide, you know, they can either say, you know, what the good fate, you know, the provider was was right, and, and the patient has to pay, even though the, the bill was much higher than what was, you know, in the estimate, you know, it's a reasonable circumstances that caused the actual price to be more than \$400. Above the with estimate was, so yeah, the patient has to pay that. That's one option. But the other is, you know, well, now the, you know, the provider should have provided a more accurate estimate, and they fail to comply with the process your provide the more accurate estimate. And so, the patient does not need to pay this higher bill, in which case, you know, the arbiter has to select either that build amount, what's the lower amount of either that providers charge or the median in network rate so similar to these, you know, more traditional surprise bill protections that people are really talking about for the hospital facility stuff, you know, and how that those are that arbitration process really leans on the median in network rate, this patient provider arbitration process for these self self pay and uninsured patients, kind of applies the same way. So really cut it inserts this meeting in network right into the conversation for what uninsured or self pay patients would potentially have to pay depending on on how this process goes. So I see we have the questions Adding up as we go, yeah, let's make sure we save enough time for those. So I'll stop there after those highlights.

Nathan Baugh 40:05

So I think I think we can categorize the a lot of the top questions here. And Joe, Joe Husky captures it, Becky Baker captures it, which is basically what the scheduler doesn't know what the service is going to be. So how is the scheduler supposed to estimate based on you know, just the patient calling in what they're going to do? So that's the broad category of the top questions here. And the way Joe puts it is, she says that, you know, they offered the same cash discount to cash patients, but again, she doesn't know that e&m code, the scheduler isn't going to know the e&m code. So how do they provide this information?

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Bill Finerfrock 40:55

So first, it's, again, this is your good faith estimates. So we know that in all while there's going to be a right so the question is, as you've suggested, is okay, is this going to be a what level e&m visit is going to be, you know, the, the, what's the differential between the charge for Level Three versus a level four, you could uniformly say our estimate is that every visit is going to be a level four, even if it ends up being less than that, the patient obviously is not going to be disappointed, because it was less than what you estimated. So you are going to have to pick what level e&m is going to be. But the presumption is going to be that everything is going to center around the visit. Now, beyond that, their receptionist or whoever is taking the inquiry, may not, there may be additional questions. So you may have to go to someone else in the office and say, you know, what would be reasonable to presume Now, also, keep in mind that over time, you're going to have a certain level of experience, once you know, patient goes up, I have a headache, I have a, you know, abdominal pain, you know, you're going to come up with with scenarios that you're going to hear on repetitive basis, think about your practices, and how common there are certain visits that are pretty common and typical, within the RHC. As far as you know, what the patients are coming in for, you know, how long are your visits? What is your typical visit? Well, most of our business, our level three and four, you're going to learn that and and so you can do it based on on history as you're collecting information. But you're absolutely right. There may be circumstances where you're not going to know everything that may be a part of that process. And if you don't know, you don't know. And that's where you can say, Look, we had no reasonable expectation for this. And keep in mind, again, you have that \$400 cushion, how much of what you might do in your clinic, certainly in the near term, is going to result in a bill being \$400 more than what you might reasonably estimate for the typical patient coming into your practice,

Nathan Baugh 43:17

Bill, is it an option for practices and rural health clinics to have a sheet of the most common services provided, you know, all the e&m codes, the top procedures, so on and so forth? And sort of provide a bunch of different price estimates. This is and

Bill Finerfrock 43:38

this is something that that we've talked about, and I've talked to different people about, because that was kind of my view was, well, couldn't you come up with a cheat sheet that would have, you know, these four are different office visits, you know, and you have 54321, and then you have a charge, and then you would have a little box, so you could check off, okay, we estimate that this is going to be a level for you check that box up, we estimate that there's going to be a lab or something. And much as for those of you who are old enough back, you know, when I was young, and you'd go to the doctor, and you would get you had to submit the claim to the insurance company, right? You didn't the practices didn't submit it for you. And so I would get a sheet that would be pre populated with information from the office about the things that they did and and it would be like office visits and different services, and then they would just simply check off on that box what they did, and then there would be an other and they would write in any additional services and then I would turn around and submit that the insurance company. It seems to me that you could do the same thing here that that as I mentioned, a lot of the stuff is going to fall into a typical patient's typical services. You may have an outlier but a lot of it is going to center around You know, very common services, common procedures, common complaints. There's, I've asked this question some people say, yes, you could some people have said, No, it has to be

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customized. I mean, it seems to me why you couldn't fill out the the template that I mentioned, and then attach this form that I'm talking about where you would have a pre populated, and you would just check off the box as to which particular service you estimated, and then it would total it up and give you the total. Now, so but we don't know, I believe that that is or something that should be permissible. We don't know for sure. But I believe that it should.

Nathan Baugh 45:38

Okay, let's move on to Australia get to some of these questions. Next question is from Becky Baker. She wants you to confirm that the medication that you're have to give an estimate on medication, and she knows that they don't have a retail pharmacy on site. So this would probably fall into what the the outside provider.

Bill Finerfrock 46:00

Right. Right. And this is, yeah, this is where you're going to have to perhaps reach out to you have a pharmacy in town, you know, pharmacy where patients will typically go in your community, and you're going to want to get with them. And, again, perhaps identify the most commonly prescribed medications and asset pharmacy, what is the cash price for these medications? Okay,

Nathan Baugh 46:23

great. And next question is from Jared, you mentioned, Bill, that the diagnosis code is one of the things that you have to provide. So the question is just quite simply, how could you even? Yeah, it's

Bill Finerfrock 46:37

that's exactly I mean, until the visit occurs? We've asked that same question, Jared. And I don't have an answer for you. Because the patient, as I said, is typically going to call up and they have, you know, perhaps a nondescript, I have head pain, you know, I'm having headaches, I have abdominal pain, I hurt my knee, but you don't know what the diagnosis is going to be. Is it? You know, is it just headaches is it whatever it may be. So it's not clear how you're going to, you know, free prior to the visit, put in what the ICD code, the diagnosis code would be. And I would, I would say, I would leave that blank at the outset, for scheduling purposes, and just say, we don't know.

Matt Reiter 47:21

And so it's interesting to, you know, really, if you think about it, you know, the concept of health insurance is really a financial product to protect you from these costs, it adds some level of predictability to, you know, what your costs are going to be. And so, you know, by by purchasing insurance, you're kind of, you know, providing yourself with that kind of financial security, but by being, you know, uninsured or self pay, it's almost like you're kind of making the decision to kind of, you know, live in the wild a little bit more when it comes to the prices. So I understand, and I sympathize with kind of the direction, you know, that policymakers and Congress are trying to go to protect patients from, you know, high bills, but you know, I think it is interesting, where really this, they're, you know, this policy essentially tries to add some level of certainty for these uninsured patients that didn't previously exist. But if they had insurance or chose to use their insurance that they would have that that certainty.

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Nathan Baugh 48:19

Sure. So Patti points out that the scheduler if the scheduler is going to be estimating, one the diagnosis and then to the CPT code. Isn't that quasi practicing medicine?

Bill Finerfrock 48:34

It's a good question. I mean, I save the scheduler, it doesn't necessarily have to be the scheduler, but that's, you know, typically, the person is the first point of contact, they're going to at least need to capture the information, one, ask the question about the insurance status of the individual and whether or not they they're interested in, you know, they want the cash, and then take down the information on the primary purpose or reason for the visit. Whether or not the practice provides or empowers that individual to provide certain information, or they have someone else in the office who does it, you know, is going to be up to the practice and what the law stipulates in terms of the practice of medicine, this is for a financial transaction, not, you know, the actual diagnosis. Given that that is a you know, it is a prince of primary complaint is what you're capturing, and then you're trying to make an estimate, financial estimate based on that primary complaint.

Nathan Baugh 49:33

So Bill, could you say that, like the scheduler would collect that information from the patient? Yes. But then you would turn it over to a clinician who would then look at that information and say, Okay, this is probably the diagnosis and this is probably the CPT code.

Bill Finerfrock 49:48

Yeah, I mean, whether or not again, it's this issue of I mean, I think paddy raises an interesting question as to what constitutes the practice of medicine, but you're not providing a diagnosis here. Your clinic information, in the same way that the practice would collect a lot of information on the front end. And you're trying to use that for purposes of a financial transaction, not for an actual diagnosis. And so, but yes, you could, I could envision a scenario where the receptionist would capture the information and then share it with someone else who would actually construct a good faith estimate to transmit back to the patient.

Nathan Baugh 50:27

Just quick note, it's we're coming up eight minutes to three o'clock, as most of you know, we do go over, particularly when we have a lot of questions, and I know everyone here can stay on. So we're gonna be asking questions, and answering questions for you know, maybe another 20 or even 30 minutes. Try to help as many folks as we can. All right, up and down. This is a slightly different category. So we're happy here. Mary Moriarty asks, Does the good faith estimate have to be in writing?

Bill Finerfrock 51:00

Yes, Matt. Yes, yeah. Yes. Okay. All right, the regular you

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Nathan Baugh 51:05

couldn't be virtual, like what a digital digital account,

Bill Finerfrock 51:09

it can be electronic. Yes, it can be electronic, but something that the patient can actually have to be able to compare what the actual cost was to what the estimate was. Okay.

Nathan Baugh 51:23

Cheryl, is has concerns about the diagnosis code? Does it have to be a diagnosis code? Or is it just more like a general categorization of diagnosis?

Bill Finerfrock 51:36

I'm not sure if I understand what the differential there is. Well, I added, I'm not I'm not a clinician. But I think this is one of the areas where it's really challenging. And I don't know why CMS included this as part of the of the information, because you just simply don't have a diagnosis at this stage in the process. So how can you put that on to the good faith estimate, even if you have a clinician who has looked at it looked at the primary complaint, because not going to, to put down a diagnosis, simply because they don't have enough information? They haven't actually checked the patient taking the vitals lifting, done the investigation to determine what the diagnosis his for the problem? So this is an area where it's very confusing, and I don't know why CMS included this.

Matt Reiter 52:33

Yeah, I think I see the key phrase, you know, in the regulations are, you know, you know, it's reasonably expected. So, you know, again, I think it's, you know, use your judgment, I think there was a question there about, you know, asking, should we document all this? I think that's a good idea. You know, it's not, you know, necessarily required here, the regulation, but I think it's, it would definitely be wise to document, you know, kind of what the patient said, and why you're, you know, kind of making this, this, you know, kind of what you think is reasonably expected to be furnished at this visit, or the Connected Care eventually, you know, when the patient says, you know, hey, I want to come in, I got a burn, or I have a cut, you know, I want you to look at, you know, what type of questions you typically asked, and, you know, how big is the cut, you know, how bad is the burn? And kind of based on what the patient says, you know, kind of, again, use a REIT, what do you reasonably expect, you know, to be providing, and then you know, you,

Bill Finerfrock 53:23

but in those situations where there's a cut or burn, I would also point out, it's in all likelihood, it's going to be something you're going to want to deal with immediately. So you're going to say I, you know, come in right away? Well, again, remember, if it's something that is occurring within one day of the call, then you don't have to do this good faith estimates. So you might also think about your scheduling, how far out or how close, you schedule appointments, in terms of what your obligations are, as far as the good faith estimate. So do you typically schedule appointments, two weeks out? Where do you have appointments that you can schedule for one day out? And and

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how can your scheduling help ease some of the burden as to what your requirements are? So anything that is in that kind of immediate care is necessary? The good faith estimate is not going to apply because of the timeframe between when they call when the patient comes in.

Nathan Baugh 54:25

Okay, hey, just a suggestion. Do you want to maybe move the slides back to a slide that has like a good summary of things just just to have that up? Sure. If I couldn't figure out how to do do you just press press left on the keyboards here Alright, so yeah, so yeah, just so maybe scroll around as you're referencing things as you answer. Um, so Tanya, she it's it's a bit of a comment and less of a question, but she's noting how How much time this is going to add to the scheduling process? Because we're talking about every single patient Nathan, by if I call my doctor, they better offer me the option for cash pay. Right? So like,

Bill Finerfrock 55:14

no, no, no, no. Okay, so it's not patient when the patient calls up. And they say, you know, this is Bill Federer frock? You know, I'd like to schedule an appointment. Okay, Mr. Fender Brock, you know, are you insured? And do you intend to use your insurance to pay for this? I suspect it is still the vast majority of patients are going to say, Yes, I'm covered by insurance. I want to have my insurance covered this no conversation, you move ahead with scheduling Righto vacations for good faith test?

Nathan Baugh 55:47

Okay, I got that. So but do they? So? If, but they have to offer every patient every single time? The question, do you want a good faith estimate?

Bill Finerfrock 55:58

No, they have to say, Do you want to pay this with your insurance? Or do you want to pay cash? Are you going to buy her insurance? Right? If I want to pay cash, then they go into the good faith estimate. But if the patient says, Yes, I have insurance, I'm going to use my insurance to pay for the visit and have conversation.

Nathan Baugh 56:17

Got it? Okay. So any thoughts on the scheduling process time that that will add and ways to make perhaps minimize the impact there?

Bill Finerfrock 56:28

Again, I think it will add, for those patients who want the good faith estimate your years from a scheduling from the front person, you're going to need to capture the information that's on this page here that's on your screen name. And you know, and you may already have it, if it's a patient who has been there, you may already have that in your system, in which case, you're going to you know, what is the primary service or item that is being requested or scheduled? And so you're going to write that in at that point of primary patient primary diagnosis, you're not going to have that. So you could say, unknown, or, you know, some something to indicate you don't know the answer to that question. And you're simply at this point, taking primary service or item requested

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or scheduled. So, you know, if it's, if it's pre populated, you're really only answering one question at this point in the process now, because for me, I would not expect you to that person to do a lot more than that, and then pass it on to someone else or that person if they're going to do it would do it on time when they're not on the phone with a patient.

Nathan Baugh 57:44

Okay, man, I saw you started typing the answer to this question. Do you think it's possible for the patient to refuse a good faith estimate? I'm not sure exactly what that would look like. But but the question from the knees is do you document the patient refused the good faith estimate?

Matt Reiter 58:02

Yeah, you can't. If the patient schedules the care, you still have to provide to them. It's not it doesn't matter if they if they refuse it. You mean

Bill Finerfrock 58:13

just by that? They mean that patient says I don't want it. Right. Yeah. They're saying no, because they don't

Matt Reiter 58:19

end up scheduling the care, then that's fine. But if they are and uninsured or self pay patient, when they schedule the care that the good faith estimate requirement kicks in?

Nathan Baugh 58:30

What if What if when the when you ask them, if you want a good faith estimate? You're like they say, oh, no, no, that's fine.

Bill Finerfrock 58:37

They say they don't want one at the outset. I think that's fine. They have to they do have to it doesn't self enforcing automatically recur? Yeah. If the patient says I'm paying cash, you can say would you like in good faith estimates are what you will be paying if you're paying cash, and they can say at that point? No, I don't need that. I don't want that. And that can be the end of the conversation as well. I don't believe I'm I'm Do you disagreement? Yeah.

Matt Reiter 59:12

Okay, I look, I'd want to confirm that. All right. Because, you know, it's the way they regulate, at least the way the regulations are worded. It's either upon request, or when scheduling the care. I'll have to double check to see if there's anything in the regulations about the patient still declining the estimate. But, you know, I think it's, you know, that upon scheduling care kind of makes it clear to me that it's still need to be provided. And, again, it's to avoid situations here where the patient, you know, even if they, you know, either in the past where there was no such requirement and they just kind of schedule the care or here if they decline, then they get this bill is higher than they thought, you know, again, that's the kind of the sentiment that they're, you know, that they're

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trying to address here, you know, these patients being surprised by bills or higher bills than they expected. So, right, but I will confirm that in the regulation. But yeah.

Nathan Baugh 1:00:11

Okay, quick one from Ashley here. Does this apply to ca outpatient services?

Bill Finerfrock 1:00:19

Yes, cars are trouble. Okay, perfect.

Nathan Baugh 1:00:26

Next one is from Penny, she says, do the good faith estimates need to be tracked on when they were sent out? And what method needs to be used to track this?

Matt Reiter 1:00:39

Can I back up to that last question? Again, real quick? Sure. At the cars, so the cars, you know, again, they might be that connected care facility where they might have to be coordinating with the RHC, you know, about, you know, care that, that they're going to be providing in conjunction with the initial, you know, visit if our HC, so

Bill Finerfrock 1:00:59

the outpatient department would it would be a covered entity in its own right.

Matt Reiter 1:01:04

Yeah, that's true, it could work. In which case, if the care originated there at that outpatient department, you know, they would have to provide this good faith estimate to but you know, the outpatient department of the HCA also might be where the patient was referred. And so they might have to be on this on the other side of it as well. So it could be both. Sorry, you're sorry, Nathan, I mean, to interrupt.

Nathan Baugh 1:01:25

It's just about sending out the gfps and tracking them, and what method do you use to track the good faith estimates? And perhaps, I mean, what is the purpose of tracking them? Is there a purpose? I mean, you want to show that you send it in a timely manner? Right,

Bill Finerfrock 1:01:46

right. Yes, that's the key issue is did you send it in a timely manner? So when did the request occur? And did you meet the timely response timeframe of how many days after was the good faith estimate provided to the to the patient? I mean, that I'm not sure if that warrants or constitutes tracking, as much as just a date. This was a data commit, this is a date to respond.

Nathan Baugh 1:02:19

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Yeah, I'm just trying to identify another question. We have a lot of people who are pointing out the problem about not knowing what other facilities charge, right, whether it's for medication, or for imaging, or

Bill Finerfrock 1:02:33

anything. And that's why as we mentioned, that particular provision is not going to be enforced for a year, they've already announced that they won't. I suspect that in many cases, there are providers with whom you would typically refer a patient. You know, and you may, I know, when I go to my doctor's office, for example, and they want to refer me, they will provide me with a list of providers. And I obviously live in an urban area, and I have a lot of options in terms of if I'm going to fall on a river. But it's if you're a rural health clinic, the options for your patients for imaging services for prescription might be relatively limited. In which case, you know, you just would simply over the course of the next 12 months, reach out to those entities that you would typically refer patients to and say, Could you provide me with a good faith estimate of what you would charge for an x ray, what you would charge for a CT, what you would charge for an MRI, different types? Again, what are the typical examples and so that when you have a patient and you suspect, you're going to have to make a referral? You know, here's what we have concluded are the estimated costs for those services.

Matt Reiter 1:03:48

Right? All you can say, in the moment, reasonably is the, you know, looking at this next question here from Bethany, that, you know, for orthopedic, you know, example, patient calls and says, you know, that, you know, they're there, you know, they ankle, you know, they twisted it, and it hurts, and they can't put any pressure on it, or whatever they want to come in. Now, you might reasonably at that point, say, well, I'll take a look. But I'm also going to probably know, reasonably going to need to refer you to an x ray. And so that, you know, you know, it again, it's not totally clear in the regulations. But you know, you might say, well, reasonably, I'm going to refer you to get an x ray. And that X Ray would count as kind of connected care that would eventually need to be included on the good faith estimate. Once that piece of it starts to be enforced, but, you know, you there's no way to reasonably know what the X ray is gonna find or how bad that the fracture, sprained ankle is. So, you know, at that point, you know, that they go to the X ray, then they go to their orthopedist and the orthopedist looks at the X ray and says, Oh, I see you're uninsured or self pay. And well, you know, here's the here's a new good faith estimate based on what we found in X ray and then the Connected Care again, so you know, kind of, there might be certain you know, life cycles of these good faith. estimates depending on what the patient has, but you know, you know, looking at it from yourself, you know, what are you can you reasonably expect to be included in this care? You know, in that case, it's, you know, you'll examine them, and you might send them to an x ray. But beyond that, there's no way, you know, for you to reasonably know what's going to be on that X ray. So you will have to consider include all of that information, start to end of the entire care episode and that estimate,

Bill Finerfrock 1:05:25

and if it's an insured individual at that point, they may say, You know what, I think I want my insurance to cover this because it's getting expensive. Yeah.

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Nathan Baugh 1:05:33

Well, I guess what I'm struggling with guys, is that, okay, that? Why is the hospital not obligated to provide a good faith estimate of the X ray, or the place that I'm getting the X ray? Because their facility? Right, like, so they would? Yo, so why is the initial provider projecting out like several steps down the road, because you're what

Bill Finerfrock 1:05:57

they classify as the convening provider, you're the you're the person that they the portal of entry into the healthcare delivery system, you're going to make certain referrals, you're going to make certain, you know, requests for additional information that may have cost ramifications. And the idea is to give the patient as much of a reasonable estimate as you can at that point as to what the costs are going to be. It may result, as we've said, you're going to have to go for surgery, you're gonna have to go and whatever that finds out which case it's out of your control. But when that person enters the portal of entry, that primary care system, that primary care provider, can you provide them with a reasonable estimate of what they're looking at as far as the cost is concerned?

Nathan Baugh 1:06:42

Okay. Next question is from Jackie. She notes that patients are not always forthcoming about why they're being seen, and particularly will be hesitant to talk to the scheduler about Yep. So any any insight here on how to handle that?

Bill Finerfrock 1:07:00

No, I don't I think it's a great question. And I think it is absolutely the reality of the situation. I remember, years ago, I was visiting a rural clinic and asked for the opportunity to kind of watch the patient engagement process and they got the patient's permission. It was actually pretty HIPAA, which will tell you how long ago it was. But there was a situation where a young woman had called up and she said that she had a ringing in her ears, and she wanted it to be checked out. And so she came into the office and into the exam room. In this case, it was a PA who was seeing the patient, he looked in her ears, your ears seemed fine. At which point, this woman said, well, actually, I don't have ringing in my ears, I had a problem with binging and purging. And I just wanted to come in. But I didn't want to say that to the person who's scheduled the appointment. It's exactly the situation you described. So here, you would have gone through the potential to say, okay, bringing in yours, we're gonna do a brief office visit, we're gonna do an exam and boom, you're done. Next thing, you know, this visit turns into something completely different than what you had estimated. And now would be, you know, potentially more, because now you're saying I got to do a referral to a mental health provider, all this stuff. So you're absolutely right, that that this is one of the problems we're going to have with how is this new law going to work in the real world, where patients are not often forthcoming, at that point of scheduling with what are the actual problems? Yeah, hope that, you know,

Matt Reiter 1:08:35

if that sort of situation were to occur under, you know, under this on January 2, you know, under this new framework, that if the patient did say, you know, hey, well, I just got this bill that's higher

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than what I thought, and they take it to this arbitration process that the provider could say, Well, hey, this is, you know, based on the time when we scheduled the care, this is what you know, I was told, and this is why I gave them this estimate. And then, you know, things changed in the exam room, and I had no control over that. And you would write that that would be you know, that they would be given, you know, kind of that that level of understanding in that arbitration process.

Nathan Baugh 1:09:10

Okay. Yeah. So I think a pretty straightforward one from Patty is next, do you base the GFP on your charges, the self pay discount or the expected payment from an insurance company?

Matt Reiter 1:09:24

The what you're going to try and Bill the patient.

Bill Finerfrock 1:09:27

Yeah. And so if you do have a sliding fee scale, and the patient qualifies for your Sliding Fee Scale, you would factor that into what the patient's expected payment would be. So the idea is you're trying to give the patient information on what they can expect to pay cash. So if you do have a discounting process, you would need to see if they qualify, whatever your discount is and factor that into your estimate.

Nathan Baugh 1:09:52

Okay. Teresa asks, Can the estimate be a range Like a price range?

Bill Finerfrock 1:10:03

I don't believe so I think you have to, you know, the, you obviously don't know and e&m is a good example, is it at level three or level four? And you could potentially provide both and level three, and here's what the charge up or the cost would be, or level four, here's what the cost would be, but I don't believe you can provide him with the range.

Matt Reiter 1:10:22

Okay. And I think one thing to think about, you know, the, the patient has the ability to go to this arbitration process, if what they're billed is more than \$400, than what was provided to them, and the good faith estimate total. And so if you're not sure, if it's a level three, or level four, you know, maybe you say level four, and that way, you kind of give yourself a little added cushion, even, you know, towards that kind of \$400 threshold, but it's nothing to say it's an estimate, there's nothing to say, Oh, well, we told you, it's gonna cost \$100. But actually, you know, after exam, you know, examining you it's only 75. Here you go. And, you know, there's nothing to say you can do that.

Nathan Baugh 1:11:04

So, just to confirm, for the diagnosis code that goes in the good faith, estimate it does that have to be an ICD 10 code. Yeah, it does. Okay. So yes, confirmed calling. Cara Jo Carson asked, do we have to post the disclaimer? And she says, 15? Or do you? Is there some sort of require language

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Bill Finerfrock 1:11:27

requirement? Yeah, there are. Okay.

Nathan Baugh 1:11:31

So what is it that

Matt Reiter 1:11:33

I'm gonna, I'm gonna put if it's easier about I mean, we can they tell you, it's easier, but their regulations for this basically, you know, list, you know, certain disclaimers on there, you know, basically say, you know, like, this is an estimate, you know, kind of, you know, basic stuff like that. And that, you know, you're it's a you know, so it's I don't think it's anything that's to be too difficult to provide. But you know, the regulations do kind of require you to include certain disclaimer information on there. And it's outlined pretty clearly in the regulation. So

Bill Finerfrock 1:12:05

I, but I thought the question was the languages, right? Number of languages, right? Because you have to provide information based on the I forget

Matt Reiter 1:12:15

what, Okay, number languages, it's the patient's preferred language, I'm pretty sure I don't think there's requirements that it has to be in the 12 most commonly spoken language or something like that. I think it's just, you know, I think it's in the patient's preferred language, but I'd have to double check that. Okay. Yeah, it's the language is, I'm pretty sure, just by quick Ctrl F search for the regulation here, I think it says made available. And, you know, language is spoken by the individual. Okay, that would

Bill Finerfrock 1:12:43

be upon request, right, we wouldn't have to put 10 versions of it on your counter for the 10 most common languages, you could write it there in English, with a sign that says, you know, in the languages, if you would like this in your language, they could obtain a copy,

Matt Reiter 1:13:01

right, ultimately needs to be provided according to this and the language that the individual speaks, you know, so you don't need to necessarily be putting out bitten all 12 languages every time, you know, but, you know, just if the patient comes in speaking Spanish instead, you know, that's, you know, the language, you would you would provide it in?

Nathan Baugh 1:13:20

Mm hmm. So, I'm trying to identify some newer questions here. I mean, we have a lot of questions about difference. And, you know, what you were expecting versus what actually was done. And that, obviously, we've covered that, but certainly, that is concerning, considering that surgeries

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can change a lot. And additional tests can be added. And it's very unknown. So I don't know if you guys want to speak to that sort of general concept, why try to identify another question here.

Bill Finerfrock 1:13:58

This is one of those areas where it's going to take some time to kind of have some cases where there are challenges here as to what constitutes reasonable, what constitutes some of the other subjective terms? And what is, you know, is it good faith? You know, totally time will tell. And then as, as the some of these challenges, you know, either court or CMS will provide additional guidance that will help to elaborate what is meant by these and what is acceptable, what the parameters are.

Matt Reiter 1:14:34

Yeah, the regulations acknowledge all of these challenges. And they're, and they're saying we're doing the best we can to implement this in a way that we think is reasonable to implement it, you know, starting in January one so some of this, you know, information about, you know, connected care again, is not going to be enforced. So, you'll at least have a little bit more control over you know, what, the services that you yourself are going to provide least compared to other people Type providers. But again, I think the key word, the key phrase, and in the in the regulation is, you know, what do you reasonably expect? No. So if you have a way to kind of document, you know, why you're determining, in that estimate why you reasonably expect this is the service to provide, you know, that way, if, for whatever reason, this case ends up before this, you know, arbitration process, you know, they're they're gonna ask you to kind of justify, you know, why you made that estimate and stuff. And so there are some some things in the regulation about, you know, if you know, some things are going to change, you know, that, that you provide updated estimates to the patient. And that's applies also to, you know, changes in the the connected provider who's going to be providing care and stuff like that. But again, it's this this focus on this term reasonably expect. So I think what, Bill, can

Nathan Baugh 1:15:54

you go back? Sorry, did, Matt, can you go back to the slide that has the timing of how quickly you have to turn around the good faith estimate? Yeah. So Morgan asks, if you're if you scheduled less than three days in advance, she says, We do not have to provide the good faith estimate. Correct. And the good faith estimate must be provided upon. So scheduling per requirements or upon request, what if patient is scheduled same day. So per scheduling requirements, it's not required. By

Bill Finerfrock 1:16:31

facing calls up at, you know, eight in the morning and says, you know, my, my daughter, has been up all night with an earache, and I need to come in, and it's a walk in clinic. And so yes, come on in, we're available, we're open. You there is no good faith estimate required? Because it's same day, it's less than three business days in advance.

Nathan Baugh 1:16:56

Any idea how this is going to be built into the EHRs?

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Bill Finerfrock 1:17:02

Uh, no, although, I mean, I think if you have an EHR, it may be helpful, because I mean, what I would be thinking is, what I would do is, at least begin to identify, and I would think with your EHR, you could do this the top 10 most commonly billed office codes? Well, first, what are your charges for, you know, 12345 new and established patients. So those are going to cover your office visit? In which case, it's then just deciding which do I want to identify this? Is a new patient level four, or an existing patient? Level three or level four, then what are the most 10? Most commonly prescribed medications? What are the 10 most commonly ordered labs? And what are the 10 most commonly ordered imaging procedures and begin collecting that data? And that, I would think that that would cover a significant percentage of the patients who may want to request in good faith estimate. So you will at least have that collected and that you could do internally based on the information you have now.

Nathan Baugh 1:18:18

Oh, can you clarify, Brenda says Do you believe the entire roll will be delayed or just the provision of outside providers?

Bill Finerfrock 1:18:27

Well, definitely the outside providers has been delayed. CMS has already opined in terms of the rest of the rule, I think a they're a CMS will be very flexible on its enforcement, or they will provide a delay. And that's like, I mean, this is just Bilfinger frock speculating. And some people are like, you know, you shouldn't even do that. But I mean, I think that there are a lot of issues. And I think CMS has acknowledged and recognized that there are a lot of issues that are unclear to folks. And so I don't believe that, that if they say we're going to move ahead with this, I don't believe they're going to be particularly aggressive in their enforcement, certainly in the near term. And we've seen this with some other rules. Nathan and I have worked on some of the what are called the appropriate use requirements is that was a law that was supposed to take effect, but four or five years ago, and they continue to delay its enforcement because of of issues. So I let me just I'll say it this way. I would not be surprised if they delayed it. But I do believe that there will be flexibility in terms of enforcement.

Nathan Baugh 1:19:36

Getting a fair number of questions about patients that are insured but are out of network. How do they fall into the workflow here? So it there they have insurance, but it's not, you know, you don't have as a provider a contract with that insurance company?

Bill Finerfrock 1:19:55

Again, I mean, it depends, you know, the question to the patient is, you know, It's essentially are you going to pay past their insurance status? So the relationship with the insurance company is is really not not relevant? If if they say, Yes, I have insurance, even if I'm out of network or whatever, they have insurance, I intend to submit it to my insurance company, then the good faith estimate doesn't apply. The question is, Do you have insurance? Do you? Will you be submitting this to insurance for coverage? At which point they say yes? No good faith estimate is necessary.

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It would only be if they say, I am paying self pay for this visit? I don't want it submitted to my insurance company.

Nathan Baugh 1:20:41

Okay, got it. Okay, can you list a diagnosis of unknown when the patient isn't being forthcoming?

Bill Finerfrock 1:20:51

To me that again, yeah, like, I'm not the one who's going to be sitting in judgment. But to me, that would be reasonable. That's what I would do. In a situation where I didn't have sufficient information from the patient, I made a good faith effort to collect, I made a good faith effort to try and get that information. The MP, either the patient didn't give it forthcoming, which, which, you know, prevented me from providing them with what I was supposed to do. But you know, you want documentation for that. That will be just as you know, your medical record, if it's not in the medical record, it didn't happen, you know, you want to document I asked the patient for this information the patient didn't forth come, therefore, I was not able to provide a good faith estimate, because I didn't have sufficient information upon which to base that estimate.

Nathan Baugh 1:21:37

Okay, so next question from Steven is about these cycles, right? So if, like, the \$400. Estimate, if, if you think, Okay, this patient sounds like they are headed towards an ACL surgery, I mean, everyone was at the football game, we saw Johnny go down, it looks like an ACL. And they're starting at your RHC. Obviously, you're you're going to be projecting out in this particular scenario, ACL surgery. Right? And that and at that moment, you could you could definitely be \$400, off whatever the orthopedic surgeon charges. So but as that patient goes through the process, I mean, do they get new good faith estimates? How do they handle that? So the way Stephen puts it is that if a patient will need a surgery that costs five to \$50,000, they estimate \$45,000. And the surgeon ends up building \$100,000 Is the IMC on the hook for being so far off.

Bill Finerfrock 1:22:52

Yeah, Matt, this is where I struggle as well is your ability to provide a reasonable accurate information on a situation exactly like this, it's one thing to say, well, you know, is a headache that they're going to need an X ray or was abdominal, I thought they might need a sonogram or something like that, and providing an estimate. But then once that sonogram, or that X ray or that CT occurs, and you find out it is a torn ACL, or it is, you know, something going on in the abdomen that requires surgery, suddenly, how's I suppose provided reasonable estimate? It met? How in your reading? What are they going to do in those situations? Does that responsibility recur, then to the to the surgeon to the to elsewhere? What liability or responsibility would have with the RNC have? If, you know, it's determined that there was something much more serious than anybody had anticipated when they walked into the arts?

Matt Reiter 1:23:52

Yeah, so this is my professional interpretation, although this is, you know, be appreciate having more clarity, you know, from CMS on that on this question, but my reading of this is, it is not the convening provider. So in this case, you know, the Archie's responsibility to provide a good faith estimate for like, an entire episode of care if there's gonna be multiple providers involved with

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ACL, you talking about surgery and rehab and, you know, physical therapy, you know, like, you're not, it's not this kind of, you know, exam plus 90 days out, you know, that's not what the good faith estimate for is it's the patient calls you up and says, Hey, you know, I'm happy, you know, I hurt my knee playing football yesterday, you know, I need you to take a look, you know, you reasonably can say, well, I'm going to have to refer this out for an x ray or a CT or an MRI or whatever. And, you know, that's reasonably what you in that moment know you're going to do. So that's what you would include in the estimate. You don't know what it's going to be. You have no reasonable way I know what's going to be on the MRI you have no idea have a way to know what an orthopedic provider you send them to, it's going to it's going to do so I think, you know, just, you know, take a deep breath, think about it in terms of, you know, in that moment, what do you reasonably think is going to be, you know, happen, what's going to be connected to that care, and then you're going to have to collaborate with those that appear the imaging facility, you know, to get their, you know, cost data to include on the estimate. But, and that's not easy. But I think, you know, you don't need to think you know, more anything beyond what you in that moment reasonably expect will be involved.

Nathan Baugh 1:25:34

And what's the term officially bill? Is it related care? Or what, what is it? Is it just reasonably expected related care? Or what is the terminology that they use? Let's see here. I'm blanking. I feel like it was in the slides, but sorry to throw you on the loop. Let's do one more. Go ahead. Matt. You got it.

Matt Reiter 1:26:00

I'm looking it up still. Go to the next question to come back to me Atari find it. Okay.

Nathan Baugh 1:26:08

We're gonna just do one last one. I know we had a lot

Bill Finerfrock 1:26:11

a lot here. Here's where decides is the items or services that are reasonably expected to be provided in conjunction with the primary service in which the clinic or an outside provider has a separate charge?

Nathan Baugh 1:26:25

Okay. So diving down on what is in conjunction with the primary service? Could could be a long, or deep rabbit hole, if you will. Yeah. But

Bill Finerfrock 1:26:39

I think that's right. I mean, if you What is it reasonably in conjunction with that, well, you came in, you had knee pain, alright, we're gonna, we're gonna, we might give you something in anti inflammatory to help you do swelling. And we're going to schedule you for an x ray. Beyond that, we have no idea what's going to happen because that X ray, so I'll give you a reasonable estimate for the office visit, I'll give you the reasonable estimate for the cost of the medication to reduce

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swelling, I can give you a reasonable estimate for the imaging services. Beyond that, it's anybody's guess. That's my, so that's where my responsibility begins, and I believe pants.

Nathan Baugh 1:27:20

Okay, so the last question I have is, regarding Medicaid are in. I lost who said it, because I moved my thing around, but she was asking, Are we even allowed to charge Medicaid pay patient she's questioning if that's even an option for Medicaid patients to opt to self pay? I don't know if you guys want to weigh in on this is I've never heard of this, like being a rule before that a Medicaid patient couldn't self pay.

Matt Reiter 1:27:59

Yeah, nice. The regulation says, you know, that, you know, government payers, you know, so if you have a government payer, you know, plant, you know, insurance that with by government payer and you are choosing not to use it and go in as self pay that, you know, this applies. Now, like you said, I don't know why a Medicaid patient would want to be self pay. But you know, technically, if they do, you know, then they would have they would get a good faith estimate. Right? How do we do they

Nathan Baugh 1:28:26

had a sliding fee scale, they would almost certainly qualify for the max discount, right?

Bill Finerfrock 1:28:31

Probably pretty good chance. I mean, I'm, how would you know, unless you had, that the patient was on Medicaid? And let's say they said, I'm on Medicare. Yeah. which case you you wouldn't you wouldn't say, Oh, do you want to pay for this by cash, your presumption is going to be that it's going to be covered by Medicaid?

Nathan Baugh 1:28:48

Well, I thought, don't you have to ask that basic question?

Bill Finerfrock 1:28:52

Well, if they, if it's yes, how are you paying for this visit? If they say I'm paying for it via Medicaid? Or I'm, I'm paying for this as cash? Me if they say I'm gonna pay cash, you don't even ask them? Is it like, that's beginning, middle and end of that conversation? I'm gonna pay for cash. Good Faith Estimate applies. If they say I have insurance, then you would say Who do you have for insurance? covered by Medicaid? I'm covered by Medicaid, Medicare, HMO, whatever it may be, and then and then it would be okay. Are you intending to submit this? Your Medicaid HMO? And they say no. If they say no, now they're back to being a cash patient. But in my mind, I'm wondering why I might maybe somebody can say here's why, but I'm hard pressed to understand why a patient would choose to pay cash for something that would have otherwise been covered by Medicaid.

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Matt Reiter 1:29:44

Regardless of what type of health insurance the patient has, if they say they're going to submit the bill to their insurance, you don't have to say well, do you know about your right to instead of submitting to your insurance to self pay and receive this Good Faith Estimate? No, you don't need to go out of your way to disclose it, you know if they say that, that that process if they say they're going to submit the bill to their insurance, if they write, they'll say before they say I'm going to send to my insurance, okay, yep. Then you're again. Yep.

Nathan Baugh 1:30:11

Okay. Okay. But you do have to have those notices posted. So then people might be like, Oh, I have this option. All right. Well, we are 332. There. 479 brave souls still with us. Thank you all for attending. I'm going to go ahead and close this out. Thank you so much to everyone for joining us. And especially of course, our speakers, they'll fender frock and Matt Ryder for the presentation today, as well as of course, the Federal Office of Rural Health Policy for sponsoring the webinar series. Again, we encourage others who may be interested bill, if you could put the slide for the CEU code back up real quick. If others are going to be interested, please have them sign up at narhc.org. And in addition, we welcome any sort of subject suggestions at NathanDaBaNeic.org. The CU code and Bill's going to get it up. But I'm going to read it out the CEU code for today's call is ag I don't think I have it. So you Okay, sorry. So type it out. Bill. AG, ex GF FAGXGF. Ag actually, I will put this in the in the slides on our website as well. When we schedule the next webinar, which will probably be in the new year. We'll send an email to everyone that's on our list. Thank you all for your participation. And that concludes today's call. Thank you, everybody. Thank you. Thank you