ACUPUNCTURE Today

BILLING 101

Don't Be Surprised by the "No Surprises Act"

HOW THE NEWLY ENACTED LEGISLATION APPLIES TO ACUPUNCTURISTS.

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Question: Does the No Surprises billing act apply to acupuncture providers and offices?

The No Surprises Act, which took effect earlier this year, is designed to prevent patients from getting large medical and hospital bills as a "surprise" when they assumed the provider was in-network and later turned out to be out of network. It also protects patients by stipulating that they must be made aware of the costs for services and any out-of-pocket estimates that will be due. While this law is intended for large medical costs, it does affect an acupuncture practice.

Out-of-Pocket Costs

For acupuncture providers who see self-pay and uninsured patients, as well as patients who have insurance, patients should be made aware of their out-of-pocket costs before receiving care. Standard financial agreements used in acupuncture offices likely are already using some language that will aid in compliance with this element of the new law. A typical financial agreement often will have language such as the following:

"*Many insurance policies do cover acupuncture care, but this office makes no representation that yours does. Insurance policies may vary greatly in terms of deductible and percentage of coverage for acupuncture care. Because of the variance from one insurance policy to another, we require that you, the patient, be personally responsible for the payment of your deductibles, as well as any unpaid balances in this office.*"

This statement places the patient on notice that they are liable for any amounts not paid by the plan. But this alone is not enough to satisfy what the new rule requires.

The Good-Faith Estimate

There is also a requirement now to include a "good-faith estimate" for out-of-pocket or non-covered fees. For *in-network s*ervices, this is not complicated, as these plans have a set co-pay or coinsurance amount that is easily identified in the patient's plan and should be part of your financial agreement.

For example, if a provider is part of American Specialty Health (ASH), the patient will have a specific co-pay per visit of $10-$25 and that would be disclosed to the patient. However, even ASH has exclusions for some services, such as massage or manual therapy. These services may be billed to the patient, but not without prior notice to the patient that those services are excluded and are payable only from the patient. ASH does use a "billing acknowledgment form" so the patient is made aware of the costs prior and essentially are not surprised.

Always makes sure that if a service you are recommending is not a covered service or payable by the patient's insurance, the patient is made aware of their costs for the service, as it will be completely out of pocket with no reimbursement by the insurance company.

On the other hand, *out-of-network* providers will need clear disclosure that they are out of network with the patient's plan and ensure the patient is aware of the cost of each service. While the plan

may make some payment, there is no guarantee by the provider, so the patient should be notified of the cost of each service and their potential liability or estimate thereof.

Keep in mind that there is no guarantee the patient's insurance will pay; the patient could be liable for the entire billed amount. An estimate can be made, but still is no guarantee based on deductibles and policy provisions of which you were not made aware.

In simplest terms, an office must disclose the cost of their services and provide a good-faith estimate of what the patient may or will be liable to pay.

Practical Tips

- Be specific to each patient; a generic list of fees is not acceptable.
- Include the cost of expected items and services.
- Provide this information orally and in writing.
- Always have the patient sign the written estimate.
- Make sure it is in an accessible format for the patient (e.g., may need to be in a different language).
- Include estimates from any and all other providers who may be involved in care (e.g., massage, imaging), and note whether the provider for each service is in-network or out of network).
- Include the expected scope of any recurring primary items or services (such as time frames, frequency and the total number of recurring items / services).
- Cannot exceed 12 months for recurring items / services.

This may seem daunting at first glance, but if you break it down to basic elements, it is likely something most providers are already doing with their financial agreements. For most, it should mean some fine-tuning to be sure a patient is fully aware of costs.

Insurance Company Requirements That Will Benefit You & Your Patients

Allowed Rates: Part of the law also emphasizes that insurance companies must be more transparent as to the amount they would allow; as well as give providers information on their allowed rates. For example, Blue Cross Blue Shield of Illinois is making its fee schedule accessible through the "Availity" portal. There should be more carriers providing this type of accessibility soon, as a provider of services cannot provide information to which they do not have access.

Note that it is reasonable also to ascertain allowed rates from past payments from others within the same plan. But keep it simple; it is what the patient will likely owe. When a provider is willing to bill for a service, they must also collect for such and not be afraid to make the patient aware of the cost. In a scenario in which the deductible is not met, the patient may owe the full amount billed or allowed. If you are willing to bill $300 a visit, you must disclose it and make patients aware of the amount for which they can be liable.

Provider Lists: The new law also requires insurance carriers to keep their list of providers up to date so patients who choose a provider based on such a list are not later liable for amounts when the provider was out of network. Insurance plans have a duty to verify who is or is not "in-network" every 90 days. Their provider directories must be updated within two business days when a provider updates their information; the same is true for providers who no longer participate.

This is to provide patients with a clear list of providers who are in-network at any facility and not get a surprise of a provider in an "in-network" facility who is actually out of network. This means an office with multiple providers who do not participate in all the plans must be clear to their patients

as to which plans providers are or are not part of. If the provider fails to provide this information, the patient would not be liable for that "surprise bill" from an out-of-network provider.

Payment / Denial Notices: Insurance plans have to provide an initial payment or notice of denial to the physician / provider within 30 days of a bill being submitted. It also creates laws to protect providers from erroneous timelines to submit claims.

Disputes: There is also a dispute resolution that may be used by the patient to dispute a bill; or by the provider to dispute fee allowance by the insurance payer. While this does place onus on a provider to disclose fees and costs of services, insurance payers must provide transparency of their allowance or payment as well.

Take-Home Points

So yes, the No Surprises Act does apply to acupuncture offices. The law intends to protect the consumer, but being that the provider is, in essence, a consumer of the insurance system, it should also increase a provider's ability to have clear access to and information about allowed rates and payments. This should provide patients with accurate out-of-pocket costs.

Patients are no different from any consumer of goods and services, and often make the primary decision based on costs. The No Surprises Act should give patients and providers a clear path to provide the information so the consumer can choose care without the worry of a "surprise bill."

Editor's Note: This CMS webpage has information for providers and consumers, as well as links to sample forms for compliance. Some of the forms are lengthy and detailed, but can be edited to fit the simpler protocol of an individual

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