0 (0s):
Hi, it's Dr. Weitz. Thanks so much for joining me for this episode of the private medical practice academy as practice owners. We're always trying to figure out whether we should be in network or out of network with insurance companies, physicians who remain out of network. Haven't been subject to the same rules and reimbursement as their colleagues who remain in network. The overwhelming advantage to being out of network was the ability to balance bill for the difference between what you charged and what the insurance paid. Now, if you noticed that I'm referring to this in the past tense, you're right. And that's because the rules are changing at the end of 2020, Congress passed the no surprises act to provide new federal consumer protection against surprise medical bills.

0 (49s):
The law goes into effect on January 1st, 2022, not surprisingly pun intended. It comes with a host of new regulations for providers to understand why this is important to you and how it's going to impact you. You first need to understand that surprise billing and balance billing are the same thing. Now, if you don't know a whole lot about surprise billing, you may be under the false impression that it only applies to a few people and a few circumstances, the no surprises act actually extends to most out of network providers and a violation of the no surprises act may result in a state enforcement action or a federal civil monetary penalty of up to $10,000 per violation.

0 (1m 39s):
So you're going to want to understand these rules. The no surprises act is meant to protect consumers from the cost of unanticipated out of network medical bills. If you are an out of network provider, this new law prohibits you from billing patients more than in network cost sharing amounts, which is based on the recognized amount. Okay? So now you're wondering what is the recognized amount? The recognized amount is defined as either the amount that's specified by state law, which applies to plans regulated by state law or a qualifying amount or an amount approved by the state. For those who

1 (2m 17s):
Have an all pair model agreement,

0 (2m 19s):
While the no surprises act only holds a patient liable for their in-network cost sharing amount, you will have the opportunity to negotiate reimbursement with insurers. I bet you're wondering how that's going to work first. The insurance company has to make the initial payment, which is determined by the plan or send you a denial. And this has to happen within 30 days from the time that the bill is submitted. Then if you, the provider aren't satisfied with the payment, from the insurer, you can begin a 30 day open negotiation period. During that 30 day period, you and the insurer can engage in private voluntary negotiations to try and resolve the payment dispute.

0 (3m 2s):

If agreement cannot be reached during that open negotiation period, the plan or the provider has four days to notify the other party and the secretary of HHS that they want to have an independent dispute resolution process. Otherwise known as an IDR. Once the IDR is initiated, then both the provider and or the plan submits a notification to the other party and the secretary of HHS within three business days, following the date of that initiation, you and the insurance company jointly select a certified IDR entity.

0 (3m 44s):
Basically, whoever's going to do the arbitration, both parties, you and the insurance company can continue to negotiate during the 30 day IDR process. And maybe you can agree on an amount of payment before the end of the process. If that happens, then both you and the insurance companies share the cost to compensate the IDR entity. Now, the next step is that within 10 days of the IDR being selected, both parties must submit their final offers, including any information that's requested by the IDR entity and any information that the parties would like related to their offers.

0 (4m 30s):
Within 30 days, the IDR entity think arbiter selects. One of the offers submitted and in figuring out which offer they're going to select, they must consider the offer of both parties, the qualifying payment amount, meaning basically how much has paid for the same service in the same geographic area. They also need to consider additional circumstances like training, experience, quality and outcome measures. I want to pause here to point out to you the importance of developing a niche so that you can differentiate yourself from other physicians. It's also the reason that you want to make sure that you are doing everything possible to earn the best possible MIPS score.

0 (5m 16s):
These are going to be the keys to your negotiating power. The other thing I want you to realize is that while this law allows providers and insurance to access this independent dispute resolution process, it doesn't set a benchmark reimbursement amount with the no surprises act, arbitration rules. Each party offers a payment amount and then the arbiter selects one amount or the other with no ability to split the difference. The decision is then binding to both parties. The loser in this case, the one whose payments is not chosen is then responsible for the cost of arbitration.

0 (5m 57s):
Presumably there's no settlement and no request for arbitration. You are accepting the amount that the insurance company is paying you. In other words, if you decide that the amount that the insurer is offering is inadequate. You're going to want to have a compelling reason complete with data to justify why you're asking for more money. Also, you're not going to want to ask for some greatly inflated pie in the sky number that's unrealistic your usual and customary or your billed charges or the rates paid by federal healthcare programs like Medicare. Aren't considered here as benchmarks. I expect that there's going to be a significant learning curve with this. I would start to keep track either by running reports, using your practice management

software, or just keeping a spreadsheet.

0 (6m 42s):
You're going to want to know how much are the payments that are being made. And then if you go to arbitration, what the insurers offered and then ultimately what gets accepted, this is going to help you in the future. If you decide to remain out of network to figure out what your offers should be in the case of you're worried that you're going to have to do this on a claim by claim basis. That's not necessarily true. Multiple cases can be grouped together in a single arbitration proceeding to encourage efficiency. But those group cases must involve the same provider, the same insurer, the same treatment and the same medical condition, or at least something that's very similar.

0 (7m 23s):
And they also have to have occurred within a single 30 day period. In other words, there must be enough similarity between these cases so that they can be grouped together. One of the goals of the no surprises act is to increase transparency so that patients better understand their cost sharing liability ahead of time, basically, unless emergency services are being performed consumers, I E the patients must receive an advanced explanation of benefits before the services rendered. If you will providing out of network services, you need to do this as a provider, you're going to have to give them a good faith estimate of costs and cost sharing.

0 (8m 6s):
Identify the fact that you are out of network. And if you're out of network, you're going to have to give them a list of potential in network providers for them to go see the insurance companies are going to have to offer price, comparison information by phone. They also need to develop a web price comparison tool, and they have to maintain up-to-date provider directories. I'm sure you're wondering what this really means to you. Basically, if you're out of network, you can no longer send patients bills for excess charges. The law specifically states that providers shall not bill and shall not hold patients liable for any amount that is more than the in network cost sharing amount for such services.

0 (8m 57s):
What this does is put the burden on you, the out of network provider, because you're going to have to determine a patient's insurance status, and then the applicable in network cost sharing for that surprise medical bill. This means that you and your staff and your billing folks are going to have to do more work to potentially get no more than if you are in network. You're going to want to carefully monitor changes in reimbursement and changes in the expense that it's costing. You collect the reimbursement. Now maybe you're wondering if you can still be at a network and get around this. The answer is yes, but you will need to provide the patient with written notice that you're out of network.

0 (9m 39s):

You're going to have to disclose the charges and obtain consent for the patient to provide the services that are out in network at least 72 hours in advance of the appointment. Now, let's talk about what you need to do to make sure that you are set up to deal with the no surprises. His act first and foremost, you were going to one review your approach process for eligibility insurance verification, 40% of denials originate from registration errors. Before you ever see the patient. I cannot stress enough. The importance of ensuring that your pre-service processes don't derail you. This is going to be especially important as the no surprises act is implemented.

0 (10m 23s):
Next, you are required to provide a timely advanced EOB notification to the patient. This has to be written in plain and simple language, and it has to include the following one, whether you're in network, if you're out of network, you must tell the patient how they can find information on participating physicians to a good faith estimate of the cost. Based on the codes you expect to use three, a good faith estimate of what the insurance company is responsible for paying for a good faith estimate of cost sharing. Basically what you expect, the patient's responsibility to be five, a good faith estimate of the amount the patient has met towards their out-of-pocket maximum and their deductible six, a disclaimer, that the coverage is subject to medical management requirements.

0 (11m 18s):
Meaning if the insurance company comes back and tells you, it's not medically necessary, that this may be an issue. And then last a disclaimer, that the information is only an estimate and is subject to change. So, as you're listening to this now may be a good time for me to bring to your attention that not only do you have to do all of this stuff, but if you remain at a network and choose to go, the arbitration route you'll have new, additional administrative costs from the fees associated with each arbitration case, not to mention the additional staff time, and that are going to need to be devoted to managing this process. If you are listening to this and thinking, well, this is going to be a nosebleed you're right.

0 (12m 3s):
This is why it's the time for you to review your contracts. Yes, you will want to consider whether or not you want to remain at a network. If you do, you will want to make sure that you have a process for clearly communicating that you're out of network with the patient and obtain their consent to pay for certain out of network services for more than the cost sharing amount. Before you see them. On the other hand, after evaluating your options, you may actually choose to go in network reaching in network participation agreements with the insurance companies, with the largest presence in your area is ultimately going to help you reduce your financial risk from the arbitration negotiations.

0 (12m 47s):
And it's also going to help you retain your patients. Thanks for joining me, please be sure to sign up for my newsletter below, I'll be sending you tips on how to start a practice, grow a practice, and then add multiple

services so that you can maximize your revenue.