NEW(ISH) BILLING RULES FOR LTC FACILITIES, HHA AND HOSPICE

- **Federal No Surprise Billing Rules**
- **Idaho Patient Act**

Kim C. Stanger
Idaho Health Care Ass'n
(7-22)

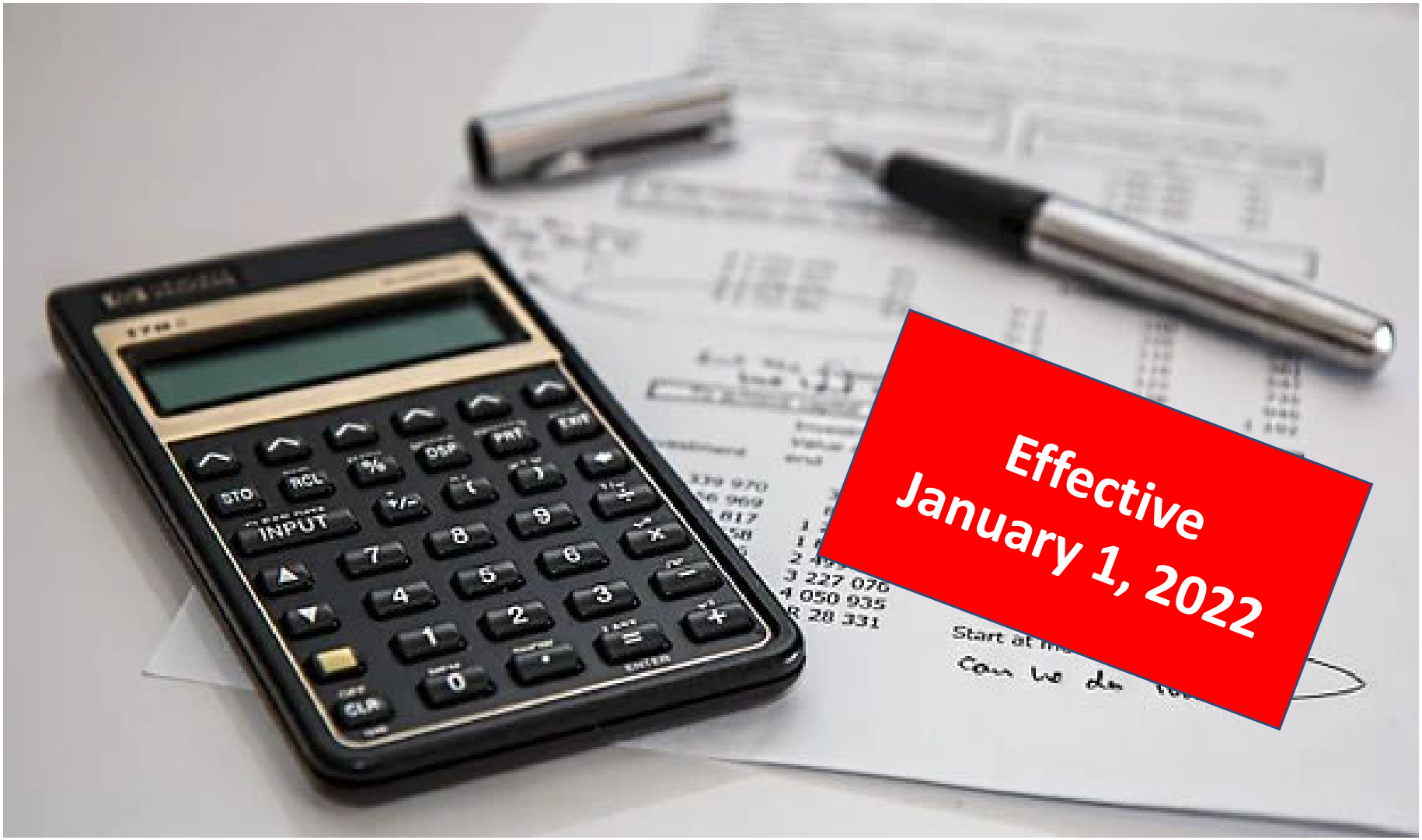
HOLLAND&HART LLP

This presentation is similar to any other legal education materials designed to provide general information on pertinent legal topics. The statements made as part of the presentation are provided for educational purposes only. They do not constitute legal advice nor do they necessarily reflect the views of Holland & Hart LLP or any of its attorneys other than the speaker. This presentation is not intended to create an attorney-client relationship between you and Holland & Hart LLP. If you have specific questions as to the application of law to your activities, you should seek the advice of your legal counsel.

WRITTEN MATERIALS: NO SURPRISE BILLING RULES

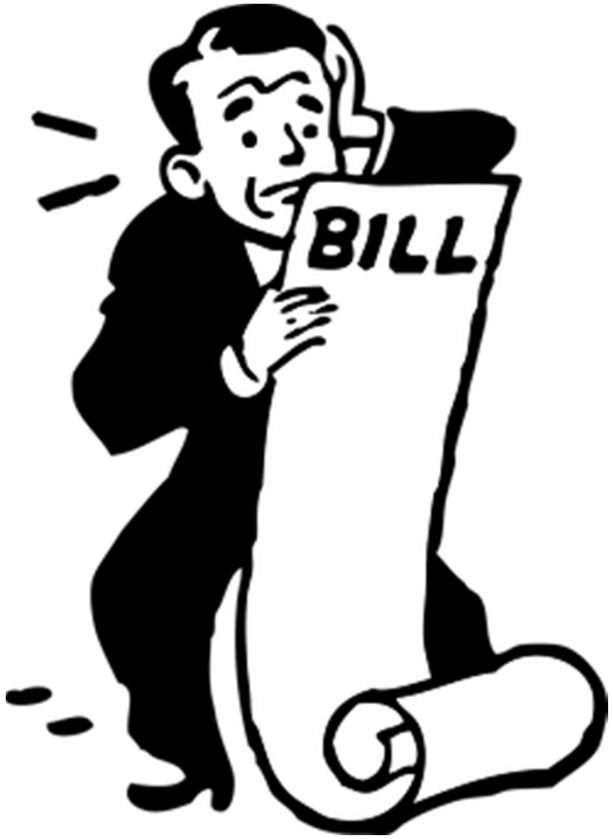
- No Surprise Billing Rule, Protection of Uninsured or Self-Pay patients, 45 CFR 149.610-.620, https://www.ecfr.gov/current/title-45/subtitle-A/subchapter-B/part-149.
- CMS, *Guidance on Good Faith Estimates and PPDR Process* (12-21-21), https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Guidance-Good-Faith-Estimate-patient-Provider-Dispute-Resolution-Process-for-Providers-Facilities-CMS-9908-IFC.pdf
- CMS, *Good Faith Estimate FAQs* (12-21-21), https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Guidance-Good-Faith-Estimates-FAQ.pdf
- Stanger, *No Surprise Billing Rules: Checklist for Providers*, https://www.hollandhart.com/no-surprise-billing-rules-checklist-for-providers

NO SURPRISE BILLING RULES: GOOD FAITH ESTIMATES



HOLLAND&HART LLP

NO SURPRISE BILLING RULES



- Govt concerned about:
  - Uninsured or self-pay patient receives unexpected medical bill.
  - Insured patient receives unexpected medical bill from out-of-network ("OON") facility or provider
- No Surprises Act
  - Title I of Division BB of the Consolidated Appropriations Act ("CAA") for 2021
- No Surprise Billing Rules
  - 45 CFR part 149
  - Effective January 1, 2022

NO SURPRISE BILLING RULES

Insured patients

- Limits amount OON provider/facility may bill patient and payer.
- Only applies to:
  - Hospital or freestanding emergency dept
  - Hospital, hospital outpatient dept, or ASC

(45 CFR part 149)

Self-Pay patients

- Providers/facilities must give patient/resident a good faith estimate of charges.
- Selected dispute resolution ("SDR") *nka* patient-Provider Dispute Resolution ("PPDR") process if actual bill is substantially in excess (i.e., > $400) of good faith estimate.
- Notice of rights to patient.

(45 CFR 149.610-.620)

SELF-PAY RULES: APPLICATION

Applies to:

- **Health care facility** = "an institution (such as a hospital or hospital outpatient dept, critical access hospital, ambulatory surgical center, rural health center, federally qualified health center, laboratory, or imaging center) in any State in which State or applicable local law provides for the licensing of such an institution, that is licensed as such an institution...."
- **Health care provider** = "a physician or other health care provider who is acting within the scope of practice of that provider's license or certification under applicable State law, including a provider of air ambulance services."

(45 CFR 164.610)

SELF-PAY RULES: APPLICATION

Applies to facilities/providers who provide "items or services",

Items or services = "all encounters, procedures, medical tests, supplies, prescription drugs, durable medical equipment, and fees (including facility fees), provided or assessed in connection with the provision of health care."

(45 CFR 147.210(a)(2) and 149.610(a)(2)(x)).

SELF-PAY RULES: APPLICATION

"Q: Which providers and facilities are required to provide GFEs to uninsured (or self-pay) individuals?

"A: Generally, all providers and facilities that schedule items or services for an uninsured (or self-pay) individual or receive a request for a GFE from an uninsured (or self-pay) individual must provide such individual with a GFE. No specific specialties, facility types, or sites of service are exempt from this requirement."

(HHS, FAQs re Good Faith Estimates, available at https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Guidance-Good-Faith-Estimates-FAQ.pdf)

SELF-PAY RULES: APPLICATION

- CMS/CCIIO has indicated SNFs and ALFs are included in Surprise Billing and Good Faith Estimate requirements.
- AHCA is attempting to obtain:
  - Answers to questions unique to LTC.
  - 6- to 9-month grace period because SNF and ALF inclusion was unexpected.

(E-mail from Mike Cheek, AHLA, dated 3/25/22)

SELF-PAY RULES: APPLICATION

Applies to **"uninsured (self-pay) individuals"**

- Does not have benefits for an item or service under a group health plan, group or individual health insurance coverage offered by a health insurance issuer, Federal health care program … or a health benefits plan …, or
- Has such benefits but who does not seek to have a claim for such item or service submitted to such plan or coverage.

(45 CFR 164.610)

Does not apply to federal program beneficiaries:

- "These requirements do not apply to beneficiaries or enrollees in federal programs, e.g., Medicare, Medicaid, Indian Health Services, Veterans Affairs Health Care, or TRICARE.
- "These programs have other protections against high medical bills."

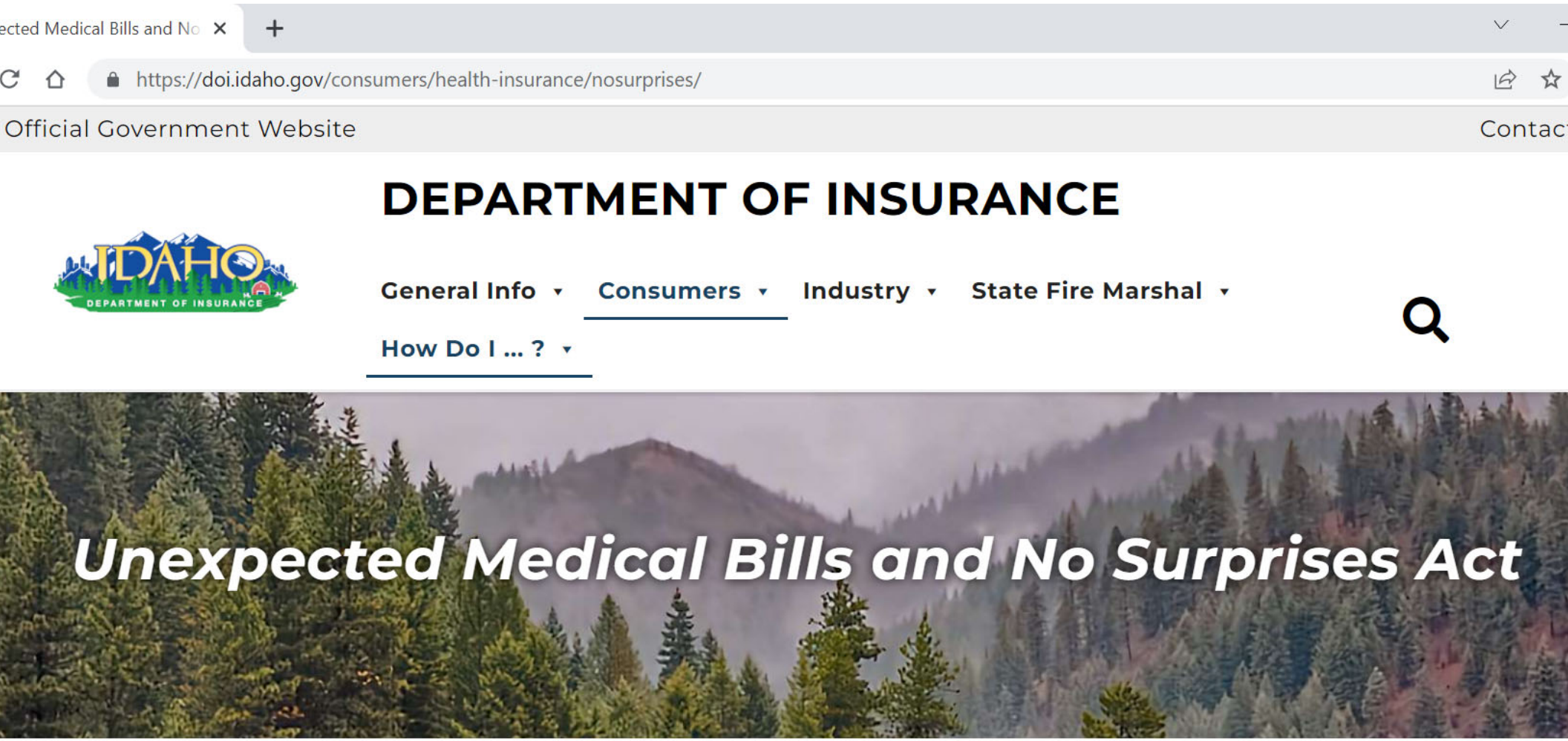
(https://www.cms.gov/files/document/high-level-overview-provider-requirements.pdf)

SELF-PAY RULES: ENFORCEMENT

- Reduced or denied payment if actual bill is substantially in excess of good faith estimate.
- State enforcement.
- If state fails to enforce, HHS may impose:
  - Corrective action plan
  - $10,000 civil penalty

(42 USC 300gg-134(b); 45 CFR 150.101(b)(3), 150.501(a), and 150.513(a))

HTTPS://DOI.IDAHO.GOV/CONSUMERS/HEALTH-INSURANCE/NOSURPRISES/



SELF-PAY RULES: IDAHO ENFORCEMENT

- "[T]he DOI will be investigating complaints related to the NSA and will refer violations of Federal statues to the Centers for Medicare and Medicaid Services (CMS) for any action that may be taken. If during an investigation the DOI finds violations that fall under the jurisdiction of the Department, we will decide at that time how we will proceed with those.
- "Both the DOI and CMS understand that these are new and, in some cases, changing requirements and while this can be a challenge, we do expect all involved parties to act in good faith in complying with the new requirements."

(E-mail from William Coon, Idaho Dept. of Insurance dated 7/13/22)

FACILITIES / PROVIDERS

Convening Provider/Facility

- Facility that is responsible for scheduling the "primary item or service", i.e., the item or service that is the reason for the initial visit.

➢ *Primarily responsible for compliance*

Co-Provider/Facility

- Facility other than the convening provider/facility that furnishes items or services that are customarily provided in conjunction with a primary item or service.

(45 CFR 149.610(a)

INQUIRE IF PATIENT IS SELF-PAY

- Convening facility/provider must:
  - Determine if an individual is uninsured or a self-pay individual:
    - Ask if the patient is covered by a group plan, insurance or a federal healthcare program.
    - If patient has coverage, ask if patient wants to have the claim submitted to the payer for the primary item or service.
  - If patient is self-pay, inform patient that they may obtain a good faith estimate of expected charges upon:
    - Scheduling the item or service, or
    - Upon request.

(45 CFR 149.610(b)(1))

NOTICE OF RIGHT TO GOOD FAITH ESTIMATE

- Convening facility must inform self-pay patients about right to good faith estimate by:
  - Written notice prominently displayed
    - On provider/facility's website;
    - In its office; and
    - Onsite where scheduling or questions about cost of items or services occur.
  - Orally inform patient when:
    - Scheduling item or service, or
    - Patient asks about cost of items or services.
- Notice must be made available in accessible formats and the language spoken by the patient.

(45 CFR 149.610(b)(1))

HTTPS://WWW.CMS.GOV/REGULATIONS-AND-GUIDANCELEGISLATIONPAPERWORKREDUCTIONACTOF1995PRA-LISTING/CMS-10791

OMB Control Number [XXXX-XXXX]
Expiration Date [MM/DD/YYYY]

You have the right to receive a "Good Faith Estimate" explaining how much your medical care will cost

Under the law, health care providers need to give **patients who don't have insurance or who are not using insurance** an estimate of the bill for medical items and services.

- You have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency items or services. This includes related costs like medical tests, prescription drugs, equipment, and hospital fees.
- Make sure your health care provider gives you a Good Faith Estimate in writing at least 1 business day before your medical service or item. You can also ask your health care provider, and any other provider you choose, for a Good Faith Estimate before you schedule an item or service.
- If you receive a bill that is at least $400 more than your Good Faith Estimate, you can dispute the bill.
- Make sure to save a copy or picture of your Good Faith Estimate.

For questions or more information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises or call [INSERT PHONE NUMBER].

- HHS form notice.

PROVIDE GOOD FAITH ESTIMATE

- If self-pay person
  - Requests a good faith estimate,
  - Schedules a primary item or service, or
  - Inquires about cost,

  convening facility must:
  - Within 1 business day, ask co-providers/facilities to submit good faith estimate to the convening provider/facility by due date.*
  - Timely provide written good faith estimate to the patient.

(45 CFR 149.610(b)(1))

** Rules re co-providers not enforced until 1/1/23.*

PROVIDE GOOD FAITH ESTIMATE

- If item/service scheduled at least 3 days in advance, provide good faith estimate not later than 1 business day after the date of scheduling.
- If item/service scheduled at least 10 days in advance, provide good faith estimate not later than 3 business days after the date of scheduling.
- If patient requests good faith estimate, provide good faith estimate not later than 3 business days after the date of the request.
- If patient requested good faith estimate and then schedules services, must provide new good faith estimate within time frames described above.
- If any change to anticipated charges, must provide updated good faith estimate no later than 1 business day before the items/services are scheduled to be rendered.

(45 CFR 149.610(b)(1))

PROVIDE GOOD FAITH ESTIMATE

"There are some items or services that may not be included in a GFE because they are not typically scheduled in advance and not typically the subject of a requested GFE (such as urgent, emergent trauma, or emergency items or services); however, to the extent that such care is scheduled at least 3 days in advance, a provider or facility would be required to provide a GFE.

"For example, individuals will likely not be able to obtain GFEs for emergency air ambulance services, as these are not generally scheduled in advance. However, making these requirements applicable to providers of air ambulance services helps to ensure that individuals can obtain a GFE upon request or at the time of scheduling non-emergency air ambulance services…"

(HHS, FAQs re Good Faith Estimates, available at https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Guidance-Good-Faith-Estimates-FAQ.pdf)

PROVIDE GOOD FAITH ESTIMATE

- Convening facility may issue a single good faith estimate for recurring primary items/services if:
  - Such good faith estimate includes in clear manner the scope of the recurring items/services (e.g., timeframes, frequency, total number, etc.)
  - Scope of good faith estimate may not exceed 12 months.
  - If good recurring items/service extend beyond 12 months, must provide new good faith estimate.

(45 CFR 149.610(b)(1))

PROVIDE GOOD FAITH ESTIMATE

- If convening providers/facilities or co-providers/facilities listed in good faith estimate change less than 1 business day before the item/service is scheduled to be provided:
  - Replacement provider/facility must accept the existing good faith estimate as its good faith estimate.
  - Replacement providers/facilities are bound by the existing good faith estimate.

(45 CFR 149.610(b)(1)(viii)-(2)(iii))

➢ *Replacement providers should review good faith estimate and provide new good faith estimate if there is time.*

HTTPS://WWW.CMS.GOV/REGULATIONS-AND-GUIDANCELEGISLATIONPAPERWORKREDUCTIONACTOF1995PRA-LISTING/CMS-10791

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

[NAME OF CONVENING PROVIDER OR CONVENING FACILITY]

Good Faith Estimate for Health Care Items and Services

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

- GFE must include info:
  - Patient name and birthdate;
  - Items and services by codes and charges.
  - Discounts or adjustments.
  - Name, NPI, TIN of co-provider/facility,
  - Location where each item/service is provided;
  - List of items/services that will require separate scheduling; and
  - Disclaimers

(45 CFR 149.610(c))

GOOD FAITH ESTIMATE

- Must be in writing and given in manner requested by patient:
  - Paper;
  - Electronically in form so patient may save and print;
  - Orally if requested, but still must provide in writing.

(45 CFR 149.610(e))

- Must provide in a manner understandable to the patient, considering:
  - Vision and hearing;
  - Language limitations, including limited English proficiency;
  - Communication needs of underserved populations;
  - Health literacy.

(86 FR 56021)

➢ *May need interpreters, translators, auxiliary aids.*

MAINTAIN GOOD FAITH ESTIMATE

- Good faith estimate is part of the patient's medical record and must be maintained in same manner as medical record.
- Must keep for 6 years and provide to patient if requested.

(45 CFR 149.610(f)(1)-(2))

➢ *Need to have good faith estimate available if there is claim:*

- *PPDR*
- *Dispute over collections*

GOOD FAITH ESTIMATE ERRORS

- Errors ≠ noncompliance so long as:
  - Acted in good faith with reasonable due diligence; and
  - Correct info as soon as practicable.
- Good faith reliance on other providers ≠ noncompliance so long as:
  - Did not know and should not know of error; and
  - Correct info as soon as practicable.
- But still bound by PPDR if actual charges are substantially in excess of good faith estimate.

(45 CFR 149.610(f)(3)-(4))

PPDR PROCESS FOR SELF-PAY PATIENTS

PPDR PROCESS

- If total billed charges for the listed provider/facility are "substantially in excess" of the total charges on the good faith estimate (i.e., at least $400 more than expected charges), patient may initiate the patient-provider dispute resolution ("PPDR") process.

(45 CFR 149.620(b))

- Total billed charges = total billed charges for:
  - All primary items or services, and
  - All other items or services furnished in conjunction with the primary items or services to a self-pay patient

  regardless of whether such items or services were included in the good faith estimate.

(45 CFR 149.620(a)(2)(iii))

PPDR PROCESS

- "Substantially in excess" is determined by the provider, e.g.:
  - Provider A provides services X and Y.
  - Provider B provides services Z.
  - Self-pay patient may initiate PPDR if the total charges for X and Y exceed A's good faith estimate for such services by $400.
- "Substantially in excess" calculation includes items/services that were not included in the good faith estimate.
  - Provider Z includes item C in estimate.
  - Provider Z bills for items C, D, and E.
  - patient may initiate PPDR if total charges for C,D, and E exceed $400.

(86 FR 56028)

PPDR PROCESS

- Within 120 days of receiving bill containing disputed charges, patient must notify HHS of intent to pursue PPDR and pay $25 fee.
- If PPDR entity determines PPDR is appropriate, it will notify provider/facility.
- While PPDR pending, provider/facility may not:
  - Move the disputed bill to collections or threaten to do so;
  - If bill moved to collections, cease collection efforts;
  - Suspend accrual of late fees on unpaid bill amounts;
  - Take or threaten any retribution against patient to obtain resolution of dispute.

(45 CFR 149.620(c)(1)-(2))

HTTPS://WWW.CMS.GOV/NOSURPRISES/CONSUMERS/MEDICAL-BILL-DISAGREEMENTS-IF-YOU-ARE-UNINSURED

PPDR PROCESS

- Within 10 days of notice to provider, provider must submit to PPDR entity:
  - Copy of the good faith estimate relevant to dispute.
  - Copy of the billed charges that are subject to dispute.
  - If available, documentation showing that the difference between billed charge and good faith estimate reflects:
    - Cost of medically necessary item/services; and
    - There were unforeseen circumstances that could not have reasonably been anticipated by provider/facility when the good faith estimate was provided.

- Within 30 days, PPDR entity issues decision.

(45 CFR 149.620(c), (f))

PROCESS TO CALENDAR PPDR DEADLINES

Timing	Action
w/120 days of bill	Self-pay patient initiates PPDR and pays fee.
Upon receipt of patient's initiation	HHS selects SDR entity; PPDR entity reviews info submitted by patient; may give patient 21 days to submit more info
	SDR entity notifies provider/facility and patient.
Upon notice of PPDR	Provider/facility suspends collection activity.
w/10 days of notice	Provider/facility submits good faith estimate, billed charges, and additional supporting info.
w/3 days of settlement	Notify PPDR entity of settlement, if any.
w/30 days after provider/facility submits info	PPDR entity issues determination and notifies parties.

BILLED CHARGE IS ON ESTIMATE

If billed charge is listed on the good faith estimate:

- If billed charge ≤ expected charge:
  - patient pays the billed charge
- If billed charge > expected charge and provider failed to prove medical necessity and unforeseeability:
  - patient pays the expected charge from estimate.
- If billed charge > expected charge and provider proves medical necessity and unforeseeability:
  - patient pays the lesser of the:
    - Billed charge, or
    - Expected charge if expected charge > median rate paid by a payer for same/similar service by same/similar provider in the geographic area as listed in independent database, or
    - Median rate if expected charge < median rate.

(45 CFR 149.620(f)(3)(iii)(A))

BILLED CHARGE NOT ON ESTIMATE

If billed charge is not listed on good faith estimate:

- If provider failed to prove medical necessity and unforeseeability:
  - patient pays $0 for the item/service.
- If provider proves medical necessity and unforeseeability:
  - patient pays the lesser of the:
    - Billed charge, or
    - Median rate paid by a payer for same/similar service by same/similar provider in the geographic area as listed in independent database.

(45 CFR 149.620(f)(3)(iii)(B))

STAY TUNED…

- Additional guidance from HHS.
- HHS forms.
- Final rules following comments.
  - Perhaps changes?
- Regulations implementing other portions of the No Surprise Act, e.g.,
  - Good faith estimate to insured patients and payers.
  - Others?

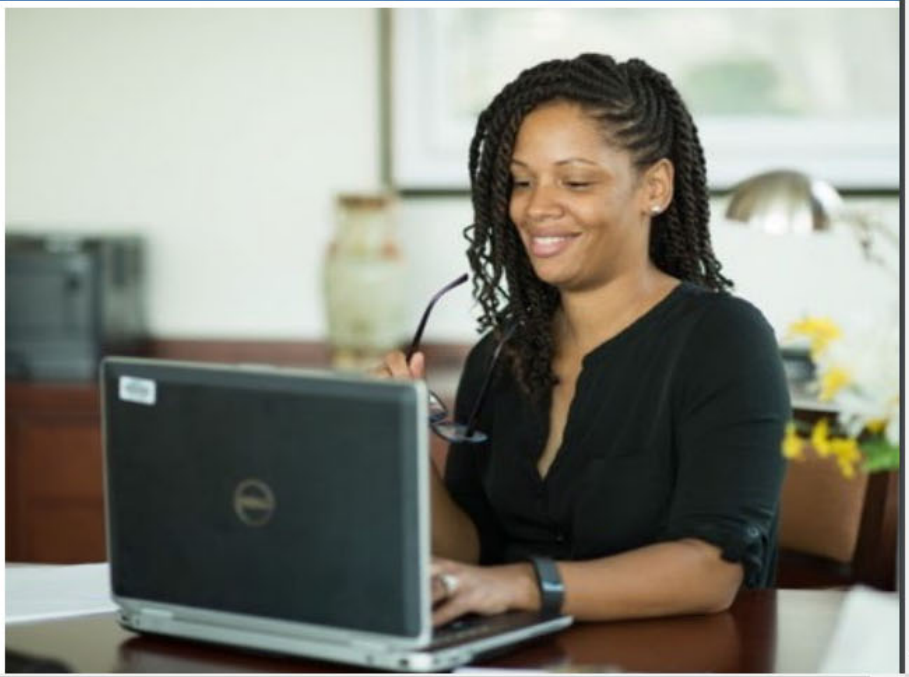
ADDITIONAL RESOURCES

HTTPS://WWW.CMS.GOV/FILES/DOCUMENT/GFE-AND-PPDR-REQUIREMENTS-SLIDES.PDF

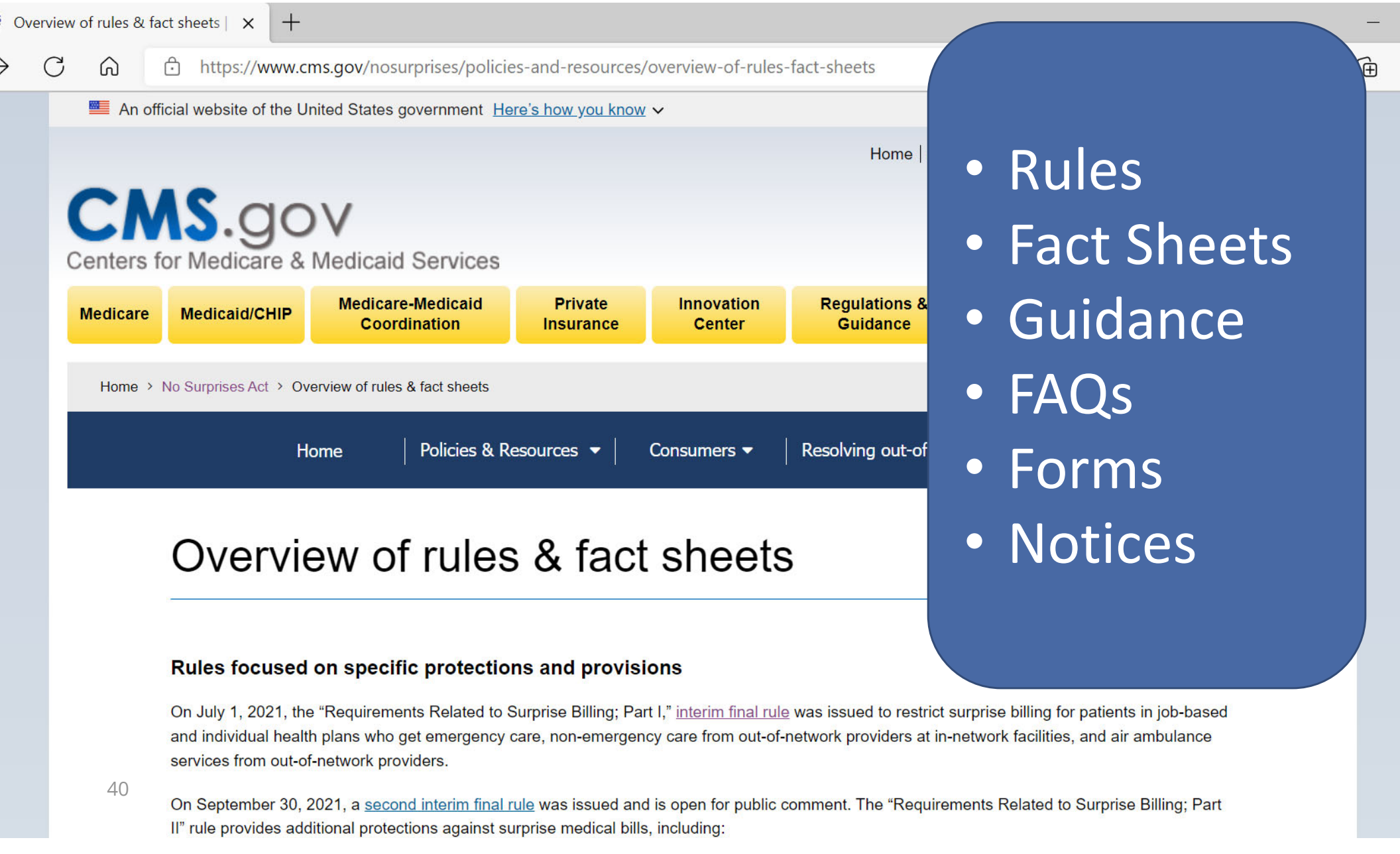
CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

The No Surprises Act's Good Faith Estimates and Patient-Provider Dispute Resolution Requirements

Center for Consumer Information & Insurance Oversight (CCIIO)

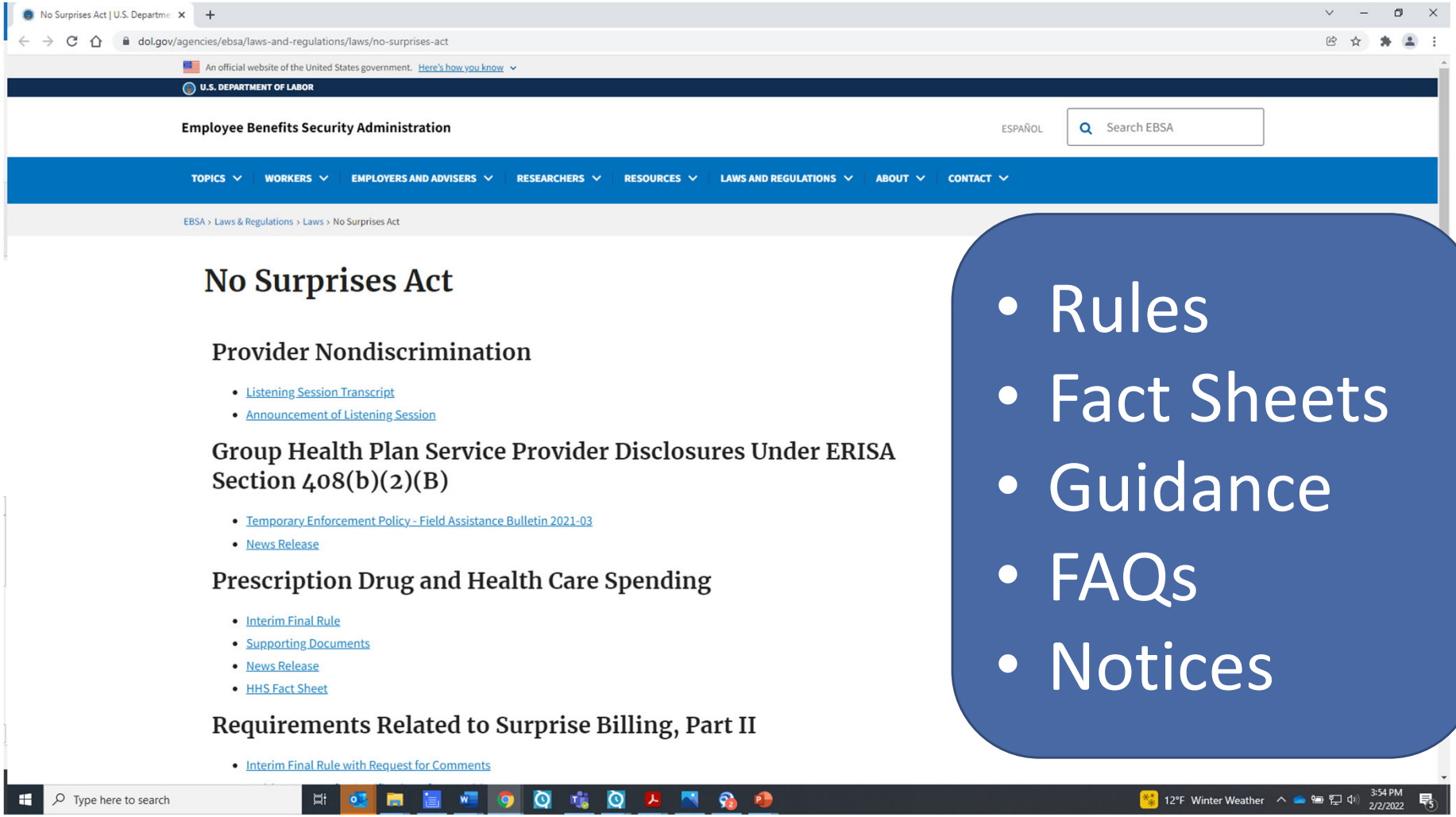


HTTPS://WWW.CMS.GOV/NOSURPRISES/POLICIES-AND-RESOURCES/OVERVIEW-OF-RULES-FACT-SHEETS



- Rules
- Fact Sheets
- Guidance
- FAQs
- Forms
- Notices

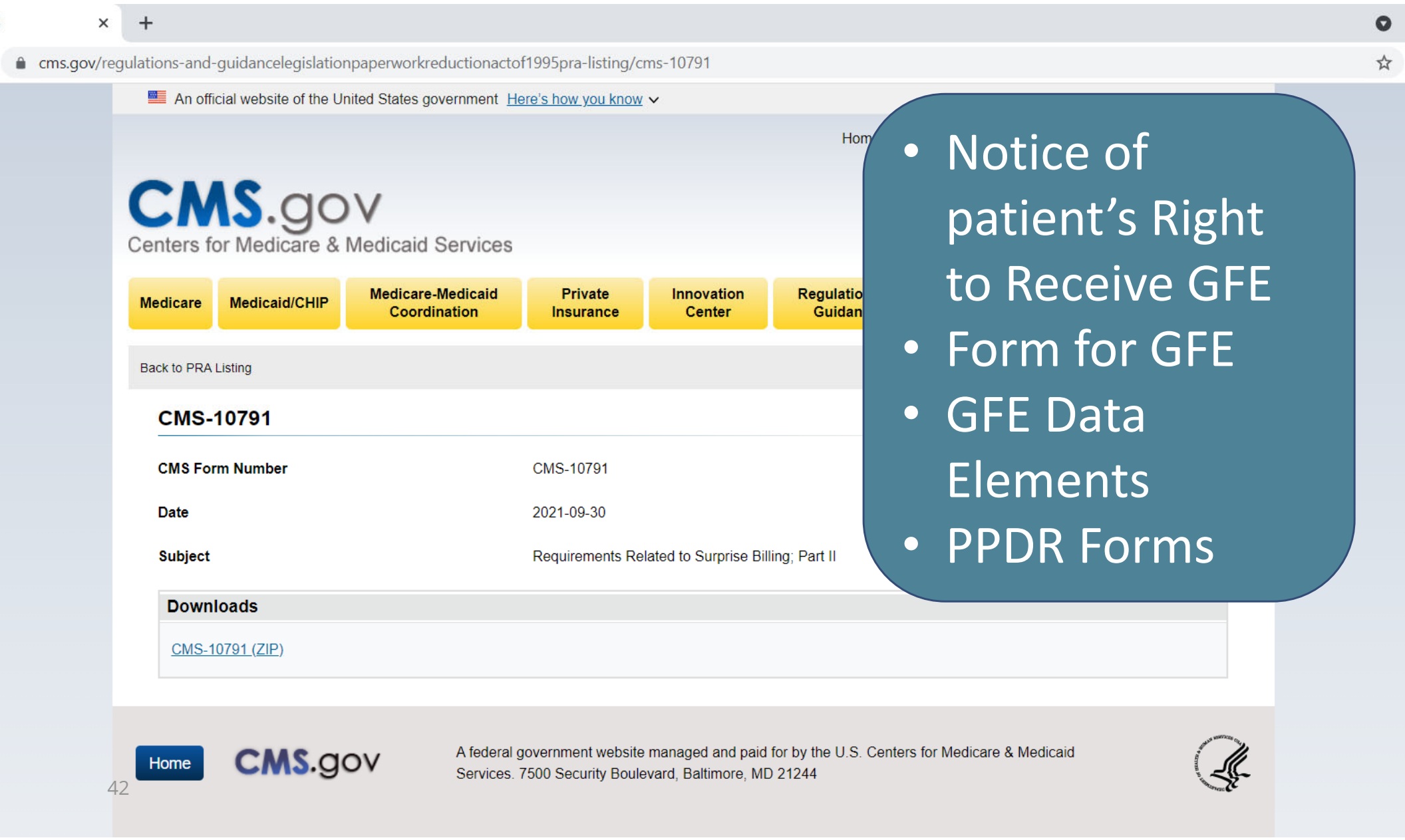
HTTPS://WWW.DOL.GOV/AGENCIES/EBSA/LAWS-AND-REGULATIONS/LAWS/NO-SURPRISES-ACT



- Rules
- Fact Sheets
- Guidance
- FAQs
- Notices

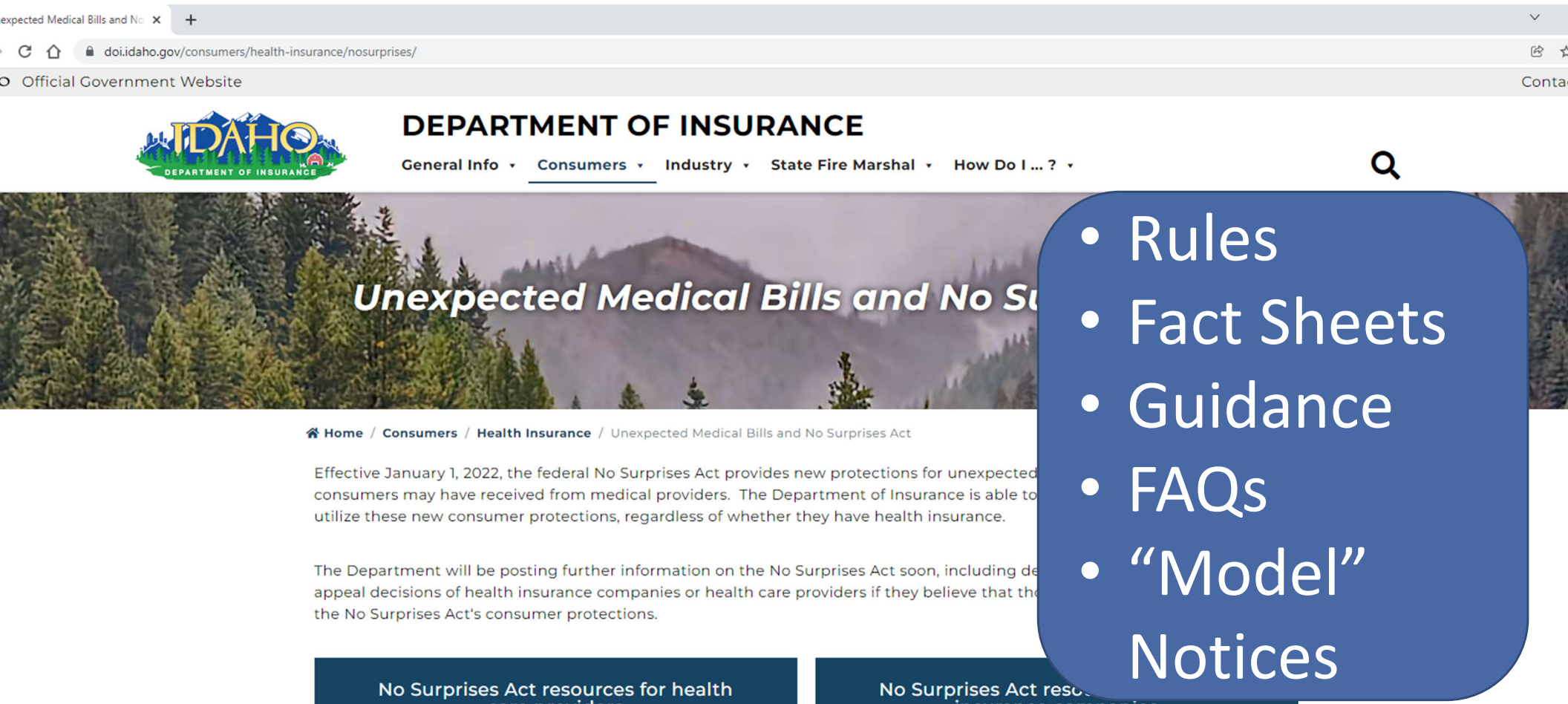
HOLLAND&HART LLP

HTTPS://WWW.CMS.GOV/REGULATIONS-AND-GUIDANCELEGISLATIONPAPERWORKREDUCTIONACTOF1995PRA-LISTING/CMS-10791



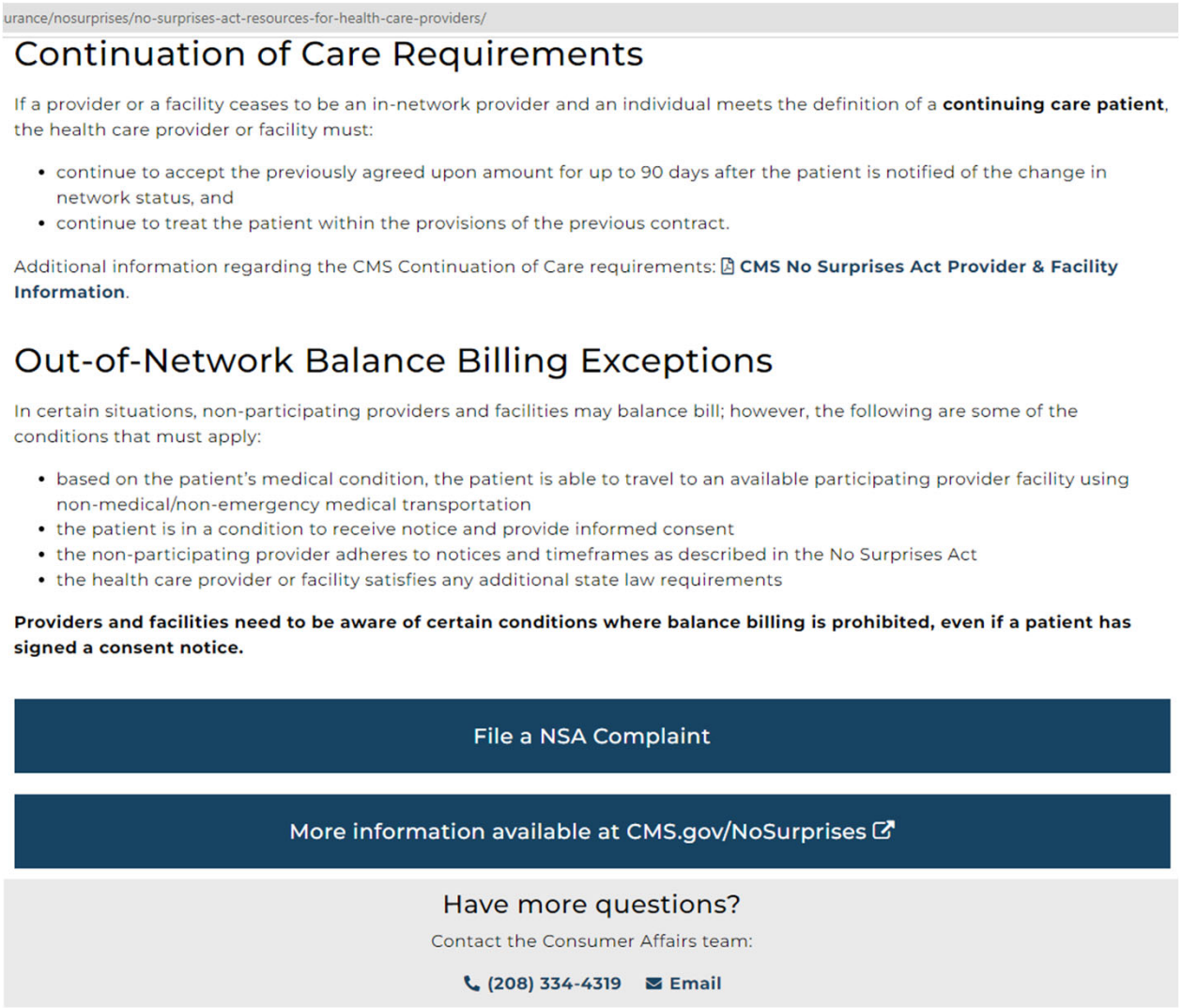
- Notice of patient's Right to Receive GFE
- Form for GFE
- GFE Data Elements
- PPDR Forms

HTTPS://DOI.IDAHO.GOV/CONSUMERS/HEALTH-INSURANCE/NOSURPRISES/



- Rules
- Fact Sheets
- Guidance
- FAQs
- "Model" Notices

CALL THE IDAHO DEPARTMENT OF INSURANCE



urance/nosurprises/no-surprises-act-resources-for-health-care-providers/

Continuation of Care Requirements

If a provider or a facility ceases to be an in-network provider and an individual meets the definition of a **continuing care patient**, the health care provider or facility must:

- continue to accept the previously agreed upon amount for up to 90 days after the patient is notified of the change in network status, and
- continue to treat the patient within the provisions of the previous contract.

Additional information regarding the CMS Continuation of Care requirements: **CMS No Surprises Act Provider & Facility Information**.

Out-of-Network Balance Billing Exceptions

In certain situations, non-participating providers and facilities may balance bill; however, the following are some of the conditions that must apply:

- based on the patient's medical condition, the patient is able to travel to an available participating provider facility using non-medical/non-emergency medical transportation
- the patient is in a condition to receive notice and provide informed consent
- the non-participating provider adheres to notices and timeframes as described in the No Surprises Act
- the health care provider or facility satisfies any additional state law requirements

Providers and facilities need to be aware of certain conditions where balance billing is prohibited, even if a patient has signed a consent notice.

File a NSA Complaint

More information available at CMS.gov/NoSurprises

Have more questions?

Contact the Consumer Affairs team:

(208) 334-4319 Email

Idaho Department of Insurance Consumer Affairs team's phone number is: 208-334-4319

HOLLAND&HART LLP

IDAHO PATIENT ACT

HOLLAND&HART LLP

WRITTEN MATERIALS: IDAHO PATIENT ACT

- Idaho Patient Act, I.C. 48-301 et seq., https://legislature.idaho.gov/wp-content/uploads/statutesrules/idstat/Title48/T48CH3.pdf.
- Stanger, *Idaho Patient Act Changes*, https://www.hollandhart.com/idaho-patient-act-changes#:~:text=A%20health%20care%20provider%20may,48%2D304(d)).
- Stanger, *Idaho Patient Act Timelines.*

IDAHO PATIENT ACT
IDAHO CODE 48-301 et seq.

- Before pursuing *extraordinary collection actions* ("ECA") against patients, providers must:
  - Timely submit claims to patients and payors;
  - Timely send patients a *consolidated summary of services* ("CSS") unless excepted; and
  - Provide a *final notice before extraordinary collection actions* ("FN") and wait 60 days.
- Failure to do so:
  - May limit ability to pursue ECA;
  - Prevents providers from recovering costs, expenses and fees associated with collection; and/or
  - May expose provider to statutory penalties.

(IC 48-301 et seq.)

IPACT AMENDMENTS 2022

Generally effective for ECAs initiated after 3/25/22.

- Extends time and provides flexibility in submitting claims and CSS consistent with national billing standards (global service codes).
- Renames “final statement” to “final notice before extraordinary collection action” (“FN”).
- Allows changes to the CSS and FN but beware effect on deadlines.
- Waiting period for ECA runs from later of a compliant CSS or FN.
- Not required to include patient’s group and member number in FN so long as submitted claim to correct payor.

IPACT AMENDMENTS 2022

Generally effective for ECAs initiated after 3/25/22.

- Extends grace period for patient's receipt of CSS to 180 days (240 days total), but results in waiver of costs, expenses and fees.
- Providers may act immediately on bounced checks if they comply with current statute concerning bounced checks.
- Shortens time to report patient to credit agencies to 45 days if satisfy certain conditions, but forfeit right to file lawsuit, lien, attachment, garnishment, etc.
- ECA complaint must include specified information.

COMPLYING WITH IPACT AS AMENDED

HOLLAND&HART LLP

IPACT APPLIES TO:

- "Healthcare providers", including:
  - A physician or other health care practitioner or any agent or third-party representative thereof; or
  - A health care facility, i.e., any person, entity, or institution operating a physical or virtual location that holds itself out as providing health care services, including but not limited to hospitals, ASCs; skilled nursing facilities; residential treatment centers; urgent care centers; diagnostic, laboratory, and imaging centers; rehabilitation and other therapeutic health settings; and medical transportation providers.

(IC 48-303(5)-(6))

IPACT APPLIES TO:

- Debt of a "patient", which includes the parent of a minor patient, a legal guardian, or any person contractually or otherwise liable for the financial obligations of the person receiving goods or services from the health care provider.

(IC 48-303(8))

  - Applies to persons responsible for debt as well as patient.

- Any "person" seeking to bring an ECA.

(IC 48-304)

  - Includes collection agencies or others who may try to collect on the patient's debt.

EXTRAORDINARY COLLECTION ACTIONS ("ECA")

Any of the following in connection with a patient's debt:

- Prior to sixty (60) days from the patient's receipt of the FN, selling, transferring, or assigning a patient's debt to any third-party, or otherwise authorizing any third-party to collect the debt in a name other than the name of the health care provider.
- Reporting adverse info about the patient to a consumer reporting agency; or
- Commencing any judicial or legal action or filing or recording any document in relation thereto, including but not limited to:
  - Placing a lien on a person's property or assets;
  - Attaching or seizing a person's bank account or any other personal property;
  - Initiating a civil action against any person; or
  - Garnishing an individual's wages.

(IC 48-303(3)(a))

EXTRAORDINARY COLLECTION ACTIONS ("ECA")

- Not action in response to a bad check if comply with requirements in IC 28-22-105, i.e.,
  - If gave prior notice to or have agreement with patient, may collect $20 fee plus costs of collection.
  - If no prior notice or agreement, must:
    - Send notice required by IC 28-22-104 to patient giving 15 days to pay check; and
    - If patient fails to pay, may collect $20 fee plus costs of collection.

(IC 48-303(3)(b); IC 28-22-105)

➢ *May act on bad checks without waiting per IPACT.*

EXTRAORDINARY COLLECTION ACTIONS ("ECA")

- May take any action that is not an ECA. (IC 48-312)
- May engage in self-help.
  - Send bills or letters demanding payment yourself.
  - Discharge patient from your facility or care.
    - *Beware patient abandonment issues.*
  - Contact guarantors or others with responsibility.
    - *Beware HIPAA.*
  - Other?
- May engage third party to help collect debt in provider's own name.
- May send to third party collection agency after 60 days from FN.
  - But collection agency cannot pursue ECA.
- May pursue ECA, but—
  - Cannot recover costs, expenses and fees, and
  - Subject to penalties of $1000 to $3000 or damages.

  (See discussion below)

45 days

CHARGES

To pursue ECA:

- Submit charges to
  - Third-party payors (including multiple payors) identified by the patient; or
  - To patient if patient did not identify third-party payors
- Within 45 days of the later of:
  - Provision of goods or services to patient;
  - Date of discharge from a healthcare facility; or
  - First date permitted by applicable billing codes, policies or procedures as published by the relevant national association.

(IC 48-304(1)(a))

➢ *Amendment accommodates problematic situation, including bundled or global fee situations.*

45-day grace period

CHARGES: GRACE PERIOD

To pursue ECA:

- May take an additional 45 days (90 days total) to submit charges to third-party payors or patients, but…
- If do so, cannot recover costs, expenses, and fees, including attorneys' fees.

(IC 48-306)

➢*At least you can recover the principal debt.*

HOLLAND&HART LLP

IDAHO PATIENT ACT TIMELINES (Idaho Code 48-304 and 306)

TO BRING AN EXTRAORDINARY COLLECTION ACTION ("ECA")[1]

1. Submit claim to payors or patient.
2. Patient receives Consolidated Summary of Services ("CSS"), unless excepted.
3. Patient receives Final Notice Before ECA ("FN"), and either:
   a. Claims were submitted to correct payor; or
   b. FN contains
      i. Payor's name,
      ii. Patient's group number, and
      iii. Last 4 digits of patient's membership number

Time runs from the latest date:
1. Services provided;
2. Discharge; or
3. As permitted by national billing standards

45 Days — Additional 45 days (90 days total)

Cannot recover fees, costs, expenses

60 Days — Additional 180 days (240 days total)

Cannot recover fees, costs, expenses

Time runs from the:
1. Later of FN or CSS, and
2. If ECA is pursued, final resolution of claim reviews, disputes, and appeals

Wait at least 60 days to charge interest or other fees

Wait at least 90 days to pursue ECA[2]

ECA

[2] May report to credit agency after 45 days if satisfy certain conditions, but cannot pursue lawsuit or file documents, liens, garnishment, etc. relating thereto.

[1] The Idaho Patient Act only applies to "Extraordinary Collection Actions", i.e.,

1. Selling, transferring, or assigning a patient's debt to any third-party prior to sixty (60) days from patient's receipt of the FN;
2. Reporting adverse information about the patient to a consumer reporting agency; or
3. Commencing any judicial or legal action or filing or recording any document in relation thereto, including but not limited to (i) placing a lien on a person's property or assets; (ii) attaching or seizing a person's bank account or other property; (iii) initiating a civil action against any person; or (iv) garnishing an individual's wages.

CHARGES

- *Document, calendar, and monitor 45-day deadline to submit claims.*
- *Document third-party payors identified by patients.*
- *Document submissions to payors, including:*
  - ✓ *Payors to whom claim submitted.*
  - ✓ *Date of submissions.*
- *Document relevant national association billing policies.*
- ❖ *Such documentation will be important if there is a dispute or litigation.*

60 days

CONSOLIDATED SUMMARY OF SERVICES ("CSS")

To pursue ECA,

- patient must receive CSS from a healthcare facility (unless excepted as described below)
- Within 60 days of the later of:
  - Provision of goods or services to patient;
  - Date of discharge from a healthcare facility; or
  - First date permitted by applicable billing codes, policies or procedures as published by the relevant national association.

(IC 48-304(b))

180-day grace period

CONSOLIDATED SUMMARY OF SERVICES ("CSS")

To pursue ECA:

- May submit CSS so that plaintiff receives it within an additional 180 days (240 days total), but…
- If do so, cannot recover costs, expenses, and fees, including attorney fees.

(IC 48-306)

HOLLAND&HART LLP

IDAHO PATIENT ACT TIMELINES (Idaho Code 48-304 and 306)

TO BRING AN EXTRAORDINARY COLLECTION ACTION ("ECA")[1]

1. Submit claim to payors or patient.
2. Patient receives Consolidated Summary of Services ("CSS"), unless excepted.
3. Patient receives Final Notice Before ECA ("FN"), and either:
   a. Claims were submitted to correct payor; or
   b. FN contains
      i. Payor's name,
      ii. Patient's group number, and
      iii. Last 4 digits of patient's membership number

Time runs from the latest date:
1. Services provided;
2. Discharge; or
3. As permitted by national billing standards

45 Days — Additional 45 days (90 days total)

Cannot recover fees, costs, expenses

60 Days — Additional 180 days (240 days total)

Cannot recover fees, costs, expenses

Time runs from the:
1. Later of FN or CSS, and
2. If ECA is pursued, final resolution of claim reviews, disputes, and appeals

Wait at least 60 days to charge interest or other fees

Wait at least 90 days to pursue ECA[2]

ECA

[2] May report to credit agency after 45 days if satisfy certain conditions, but cannot pursue lawsuit or file documents, liens, garnishment, etc. relating thereto.

[1] The Idaho Patient Act only applies to "Extraordinary Collection Actions", i.e.,

1. Selling, transferring, or assigning a patient's debt to any third-party prior to sixty (60) days from patient's receipt of the FN;
2. Reporting adverse information about the patient to a consumer reporting agency; or
3. Commencing any judicial or legal action or filing or recording any document in relation thereto, including but not limited to (i) placing a lien on a person's property or assets; (ii) attaching or seizing a person's bank account or other property; (iii) initiating a civil action against any person; or (iv) garnishing an individual's wages.

CONSOLIDATED SUMMARY OF SERVICES ("CSS")

- CSS is not required if:
  - Patient receives a FN from a single billing entity for all goods and services provided to the patient at that health care facility;
  - Patient was clearly informed in writing of the name, phone number, and address of the billing entity; and
  - Health care facility complies with all other provisions of section IC 48-304, e.g.,
    - Submitted charges w/in 45/90 days.
    - Sent FN.
    - Waited to charge interest and fees or pursue action for required time period.

(IC 48-309)

CONSOLIDATED SUMMARY OF SERVICES ("CSS")

CSS must include:

- *"This is Not a Bill. This is a Summary of Medical Services You Received. Retain This Summary for Your Records. Please Contact Your Insurance Company and the Health Care Providers Listed on this Summary to Determine the Final Amount You May Be Obligated to Pay."*
- Patient's name, phone, and contact info
- Facility's name, phone, and contact info
- Date and duration of patient's visit to facility
- General description of items provided to patient, including name, address, phone of each billing entity whose providers rendered items to patient.

(IC 48-303(1)(a))

CONSOLIDATED SUMMARY OF SERVICES ("CSS")

- If there are multiple CSS's due to changes, calculate the 60/240-day deadline using the first CSS that supplied the required info if the info did not change in subsequent CSS.

(IC 48-303(1)(b))

- *May modify CSS.*
- *But make sure modified CSS is received within the 60/240-day deadline.*

RECEIPT OF CSS AND FN

- Deadlines run from when patient receives the CSS and FN, not when sent.

(IC 48-304)

- Patient presumed to receive the CSS and FN three (3) days after they were sent by first class mail to patient's address--
  - As confirmed by patient during last visit or
  - As updated by patient in subsequent written electronic communications.
- Patient may agree in writing to receive CSS or FN via e-mail or other electronic means.

(IC 48-308)

➢ *Factor in mailing/delivery to deadlines.*

➢ *Document delivery and method.*

Wait 60/90 days

FINAL NOTICE BEFORE ECA ("FN")

- Provide *final notice before extraordinary collection action* ("FN").
  - f/k/a "final statement"
- To charge interest or other fees: wait at least 60 days after patient receives the FN or CSS, whichever is later.
- To pursue ECA: wait at least 90 days after:
  - Patient receives the FN or CSS, whichever is later; and
  - Final resolution of internal reviews, disputes, and appeals of charges or payor obligations or payments.
- Exception: may wait only 45 days to report to credit agency if satisfy certain conditions (see next slide).

(IC 48-304(c)-(e))

Wait 45 days

FINAL NOTICE BEFORE ECA ("FN")

- May wait only 45 days to report to consumer reporting agency if:
  - At least 30 days before the report, patient receives written notice that you may make the report.
  - Provider is prohibited from commencing lawsuit or recording any document relating thereto, including but not limited to:
    - Placing a lien on a person's property or assets;
    - Attaching or seizing a person's bank account or any other personal property;
    - Initiating a civil action against any person; or
    - Garnishing an individual's wages.

(IC 48-304(e))

FINAL NOTICE BEFORE ECA ("FN")

- If there are multiple FN's, calculate the deadlines using the first FN that supplied the required info if such info did not change in subsequent FNs.

(IC 48-303(4)(b))

- *May modify FN.*
- *But make sure modified FN is received at least 90 days before pursuing ECA.*

FINAL NOTICE BEFORE ECA ("FN")

FN must include:

- ❑ Patient's name, phone, and contact info.
- ❑ Facility's name, phone and contact info.
- ❑ List of goods and services provided, including initial charges and dates provided, in reasonable detail.
- ❑ Statement that a full itemized list of goods and services provided to the patient is available on patient's request.
- ❑ Name of third-party payors to which charges submitted.
- ❑ Detailed description of reductions, adjustments, offsets, and payments received.
- ❑ Final amount patient is liable to pay taking into account all reductions, adjustments, offsets, payments, etc.

(IC 48-303(4)(a))

- ❑ May want to include patient's group and membership number (see next slide).

FINAL NOTICE BEFORE ECA ("FN")

To pursue ECA:

- Ensure provider either:
  - Submitted all charges to correct third-party payor, or
  - FN includes:
    - ❑ Name of the third-party payor to which charges were submitted,
    - ❑ Patient's group number, and
    - ❑ Last 4 digits of patient's membership number.

(IC 48-304(3))

- FN does not need to include patient's group number and membership number, but if not, must be able to prove you submitted claim to correct third-party payor.

(See IC 48-303(4)(a)(v))

HOLLAND&HART LLP

IDAHO PATIENT ACT TIMELINES (Idaho Code 48-304 and 306)

TO BRING AN EXTRAORDINARY COLLECTION ACTION ("ECA")[1]

1. Submit claim to payors or patient.
2. Patient receives Consolidated Summary of Services ("CSS"), unless excepted.
3. Patient receives Final Notice Before ECA ("FN"), and either:
   a. Claims were submitted to correct payor; or
   b. FN contains
      i. Payor's name,
      ii. Patient's group number, and
      iii. Last 4 digits of patient's membership number

Time runs from the latest date:
1. Services provided;
2. Discharge; or
3. As permitted by national billing standards

45 Days — Additional 45 days (90 days total)

Cannot recover fees, costs, expenses

60 Days — Additional 180 days (240 days total)

Cannot recover fees, costs, expenses

Time runs from the:
1. Later of FN or CSS, and
2. If ECA is pursued, final resolution of claim reviews, disputes, and appeals

Wait at least 60 days to charge interest or other fees

Wait at least 90 days to pursue ECA[2]

ECA

[2] May report to credit agency after 45 days if satisfy certain conditions, but cannot pursue lawsuit or file documents, liens, garnishment, etc. relating thereto.

[1] The Idaho Patient Act only applies to "Extraordinary Collection Actions", i.e.,

1. Selling, transferring, or assigning a patient's debt to any third-party prior to sixty (60) days from patient's receipt of the FN;
2. Reporting adverse information about the patient to a consumer reporting agency; or
3. Commencing any judicial or legal action or filing or recording any document in relation thereto, including but not limited to (i) placing a lien on a person's property or assets; (ii) attaching or seizing a person's bank account or other property; (iii) initiating a civil action against any person; or (iv) garnishing an individual's wages.

IPACT COMPLIANCE

Comply with IPACT

- May recover principal.
- May recover costs, expenses and fees subject to
  - Parties' agreement, and
  - Applicable laws.
- Limits on fees apply.

Violate IPACT

- May be able to recover principal.
- Cannot recover costs, expenses, or fees for ECA.

(IC 48-305(1))

- May be subject to penalties.

(IC 48-305()

BURDEN OF PROOF; COMPLAINT

- Person pursing ECA:
  - Has burden of proving compliance with IPACT, i.e.,
    - Timely submission of claims.
    - Timely receipt of CSS unless excepted.
    - Appropriate FN.
  - Complaint must:
    - ❑ Plead with particularity compliance with each requirement; and
    - ❑ Identify:
      - ❑ Name, group and policy numbers of third-party payors to which claims were submitted, and
      - ❑ Date(s) of each submission.

(IC 48-307)

PROVIDER WINS: COURT MAY AWARD

- Uncontested judgment: principal + up to lesser of $350 or 100% of principal + pre- and post-judgment interest
- Contested judgment: principal + up to lesser of $700 or 100% of principal + pre- and post-judgment interest.
- Post-judgment motions and writs: up to $75/$25 per successful motion or writ + service fees.
- If contested judgment, may petition for more fees if:
  - Costs, expenses and fees are grossly disproportionate to amount set forth above, and
  - Patient willfully attempted to avoid paying bona fide debt.

(IC 48-305(1)-(2))

PATIENT WINS: COURT MAY AWARD

- Patient may recover all costs, expenses and fees incurred by patient, including attorneys' fees.
- Patient has no liability for pre-judgment interest, costs, expenses, or fees, including attorneys' fees.

(IC 48-305(3))

➢ *No cap on amounts that patient may recover.*

PENALTIES

- If bring ECA without complying with IC 48-304 or -306:
  - Patient has no liability for collection costs, expenses and fees.
  - Provider is liable to patient for greater of:
    - $1,000, or
    - Damages suffered by patient due to violation.
  - If provider willfully or knowingly violated the statute, court may award greater of:
    - $3,000, or
    - 3x damages suffered by patient due to violation.

    Patient is entitled to costs + reasonable attorneys fees.

(IC 48-311)

SUMMARY: TO INITIATE ECA W/OUT PENALTY

- w/in 45/90 days after services or discharge, submit charges to patient or payors identified by patient.
- w/in 60/240 days after services or discharge, make sure patient receives CSS unless excepted.
  - Exception: single billing entity that provides final notice and info re billing entity.
- Submit FN to patient.
- Wait at least 60* days after patient receives FN to charge interest or other fees.
- Wait at least 90* days after patient receives FN or CSS, whichever is later, and resolution of claims.
- Ensure claims went to correct payor or that FN includes info about third-party payor and patient's group and membership numbers.

(IC 48-304 and -306)

ADDITIONAL RESOURCES

IDAHO MEDICAL ASSOCIATION

https://www.idmed.org/idaho/Idaho_Public/Resources/Idaho_Patient_Act_Resources/Idaho_Public/Resources/Idaho_Patient_Act_Resources.aspx?hkey=8ff3c150-8bf6-4f87-a492-d51418fdd120

Member Login | Contact Us

IMA | About Us | Membership | Resources | Advocacy | Events | News & Advertising | Physician Finder

Idaho Patient Act Compliance Resources

The Idaho Patient Act (IPACT) went into full effect on July 1, 2021. The Idaho Patient Act is only applicable to physician practices that need to pursue extraordinary collection actions (ECA)*. However, during the 2022 legislative session, Idaho Medical Association joined with other health care organizations to successfully author and pass HB 778 which will help practices comply with the Idaho Patient Act. Although the legislation represents a compromise with Melaleuca and isn't everything the IMA and other health care groups desire, the legislation will ease some of the major burdens on practices as they comply with the Idaho Patient Act. The changes outlined in HB 778 went into effect on March 25, 2022.

Please click the links below for a detailed overview of the changes in HB 778:

- 2022 Changes to the Idaho Patient Act: What physicians need to know
- Holland and Hart: Idaho Patient Act Changes webinar, 5/19/2022

Resources

- Coronavirus Resources
- **Idaho Patient Act Compliance Resources**
- IMA Products and Services
- IMA Education Webinars
- Reimbursement Services
- Legal Resources
- Physicians Recovery Network

HTTPS://IDAHOPATIENTACT.ORG/SOLUTIONS/

https://idahopatientact.org/solutions/

The Idaho Patient Act

ACTION CENTER ISSUE STORIES NEWS SOLUTIONS SUPPORTERS ABOUT

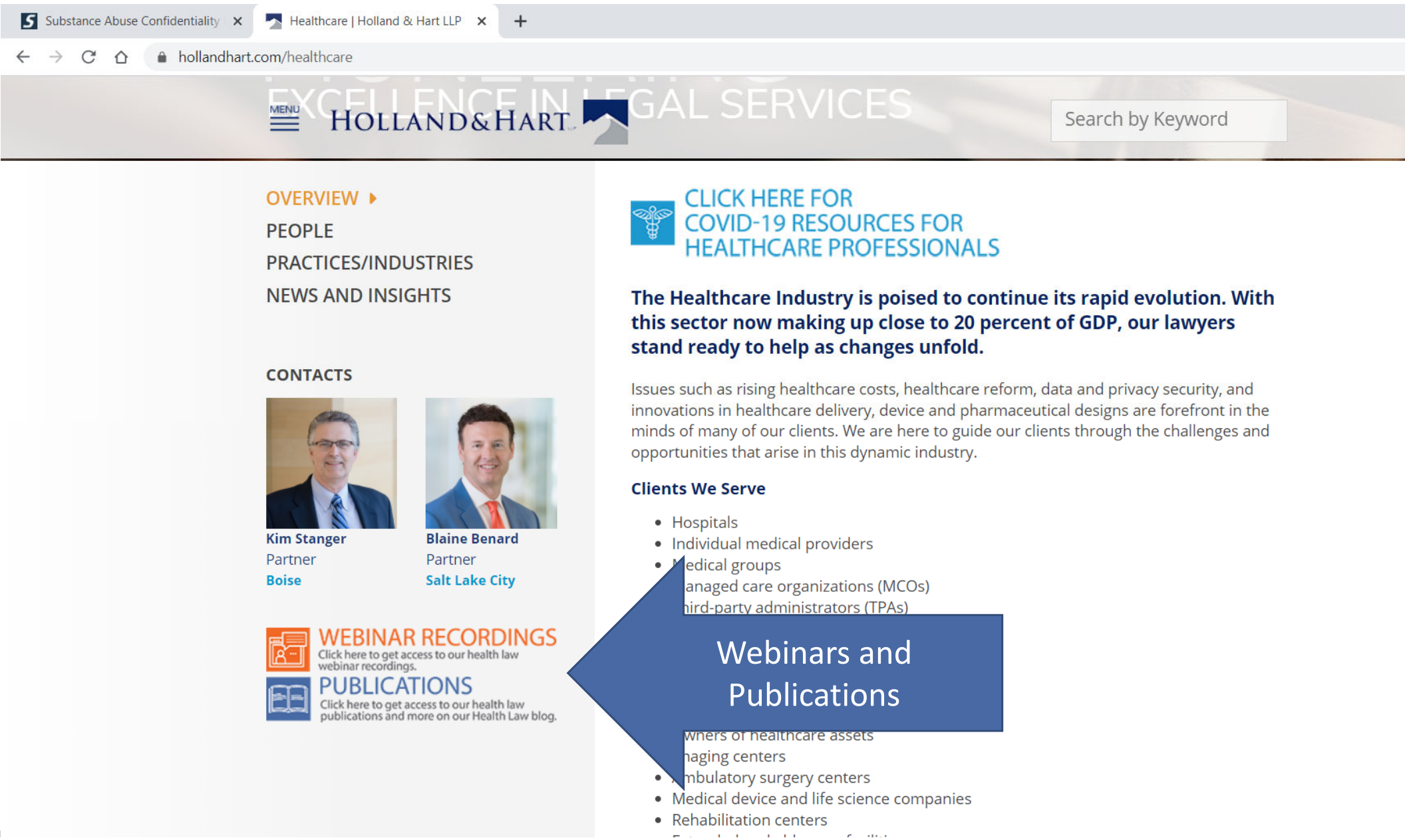
THE IDAHO PATIENT ACT: PROTECTING IDAHOANS

We believe that with a little transparency and better billing practices, patients will be better able to pay their bills in full. Fewer medical debts will end up in collections which will help patients and doctors alike.

UNDER IPACT

- Doctors will submit charges within 45 days of seeing a patient.
- Patients will receive a single list of everyone that's going to bill them.
- Appropriate grace periods allow time to correct errors.
- Attorneys' fees will be limited so patients are protected from outrageous medical debt collection fees.
- Doctors will be paid more timely because patients will understand their bills and can pay with confidence without delay.

WWW.HOLLANDHART.COM/HEALTHCARE



QUESTIONS?

Kim C. Stanger

Office: (208) 383-3913

Cell: (208) 409-7907

kcstanger@hollandhart.com

Ally Kjellander

Office: (208) 383-3930

aakjellander@hollandhart.com

HOLLAND&HART LLP