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WHITEPAPER

Surprise, No Surprise Act Is Here!

How can providers prepare themselves for the No Surprises Act?

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Introduction

From patients' point of view, rising medical debt, presently a staggering $140 billion, is the largest source of debt for families living in the United States. An enormous part of this is a quick outcome of the immediate aftereffect of surprise billing, with a third of insured grown-ups saying they've received an unexpected bill in the last two years.

What's not much, then, is that two-thirds of US grown-ups stress over having the option to manage the cost of these unanticipated medical bills. It's an issue that concerns such countless patients that it presently has the attention and action of both state and federal governments. To assist with taking care of this issue, Congress signed the No Surprises Act into law.

Learn about No Surprise Act

The No Surprises Act, effective January 1st, 2022, is known to safeguard consumers from no less than one contributor to the issue: unexpected bills for out-of-network care in emergency and non-emergency settings.

Around a fifth of emergency claims and a sixth of in-network hospital stays consolidate an out-of-network bill, routinely in light of emergency or ancillary care. Since patients need significant decisions with regards to picking these unexpected services, they have no option but to pay up or face negative marks on their credit reports. Typically, while health plans cover some of the bills, patients will in any case be responsible for the remaining balances.

That is the reason, this rule is poised to transform the payment environment in healthcare. It incorporates patient protections and disclosure requirements, alongside a dispute resolution procedure for health plans and providers. The execution of the rule, in any case, strays from the statutory language and is probably going to challenge physicians.

How does the law impact the providers/practices?

Provider directories

To work on the accuracy of provider directory information, providers should submit regular updates to health plans to help insurers maintain up-to-date, accurate directories of their in-network doctors. Health plans will be needed to verify provider contract status on a regular basis, update this information in some measure once at least once every 90 days, and build up a procedure for removing providers unable to verify.

In the event a patient relies upon imprecise provider directory information, the health plan can't force a cost-sharing amount more than in-network rates. On the off chance that a provider submits a bill to a patient greater than the in-network cost-sharing and the patient takes care of the bill, then, at that point, the provider must refund the cost difference that too with interest.

Provider price transparency

To choose provider payments for scheduled out-of-network services, out-of-network providers should give a "good faith estimate" of all the billing and service codes for the care the patient is dependent on to get to the health plan. These estimates should be submitted something like three days prior to providing the scheduled services and obtaining the patient's consent.

Providers should post a concise explanation of state regulations related to balance billing on their site and incorporate contact information for the proper enforcement agency with which the patient can file a complaint.

What does a provider/practice need to do to be compliant with this law?

Starting Jan. 1, 2022, providers/practices must:

- Have a procedure in the proper place to deliver provider directory information to health plans on time. For instance, providers must notify health plans when the provider begins a network agreement with a plan concerning certain coverage and also notify the plan when the provider ends an agreement.
- Submit to the plan any material changes to the content of medical provider directory information.
- Be ready to submit information to the plan at any other time determined appropriate by the Secretary of the Health and Human Services Department.
- The No Surprises Act offers significant assurances for patients just as expanded straightforwardness on the cost of healthcare. Yet, steadily changing guidelines can 100% add to a practice's administrative burden.

A few steps to take now

- Be well-aware on the new law, stay current on subsequent guidelines, know your state(s) law
- Review current contracts concerning emergency and ancillary providers to determine potential areas of concern or exposure
- Start thoroughly considering revenue cycle and workflow processes (e.g., necessary notification, consent form, good faith estimate, balance billing)
- Consider or review price transparency tools in view of this law
- Set up an internal work team to manage planning and execution
- Watch state legislatures for surprise billing activities
- Get credentialed with more and more insurance companies to deal with in-network patients going forward

How can Capline Healthcare Management help?

- **Prior Eligibility Verification:**

  We can provide a prior eligibility check of the services to the clients so that there will be no surprise for them after receiving the bill. Prior verification of services will help clients in getting clearance regarding their bills and services. Authenticity will be maintained.

- **Credentialing:**

  To cover the out-network loss we suggest more and more providers get credentialed, which not only covers the loss but is also helpful in getting more in-network patients in the offices.

We help in getting providers' enrolled on various health plans and most importantly assist them in getting paid right. At Capline Healthcare Management, we have hands-on assisting providers to get the fees they deserve for their services. Besides being acquainted with government norms and fee regulations, our seamless negotiation skills further help us achieve the goal.

Furthermore, we assist practices dramatically reduce their accounts receivable cycle and increase revenue, by remarkably lessening the impact of ineligibility, and increasing the number of "clean" claims that are sent to insurance.

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