

No Surprise Billing Act

Riverside's journey and things that were learned
along the way



Presenters

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How did we get here? And where are we going?

- Background- understanding of laws and regulations
- Early work- committees, reading and interpreting
- Building rules in patient accounting system
- What did we actually see once we got claims?
- What do we know and where do we think this is going?

No Surprises Act: High Level

Emergency services must be covered at an in-network rate, even if they are provided out-of-network, including post-stabilization services. They cannot require a prior authorization.

Prohibits out-of-network charges for items and services **provided by out-of-network providers at an in-network facility,** except in certain instances if the patient grants consent.

Notice of patient protections against balance billing must be provided to each patient who is enrolled in commercial health coverage prior to collections or billing.

Requires providers and hospitals to provide **a good faith estimate,** within established timeframes to uninsured, non-covered or self-pay patients. A patient's bill is eligible for a dispute resolution process if the patient is billed "substantially in excess" of the good faith estimate, which CMS defines as billed charges being at least \$400 more than the estimate.

Establishes an **independent dispute resolution (IDR) process)** when payers and facilities cannot come to agreement on payment. Portal for payment arbitration cases opened in mid-April, delayed by the outcome of a February court ruling challenging the IDR process. HHS will be issuing new regulations for the arbitration criteria.

System Building- Meetings and LOTS of reading... and then some more meetings

- Fall of 2021, worked with Epic on their interpretations of law
- Attended many calls with other hospitals, CMS, IHA, and Epic
 - Everyone seemed to be “mostly” on par with each other, but several interpretations of the law were circulating
- Read the federal register, then had to read it again once the “final” law was placed
 - This didn’t happen until mid December, 2021

After Jan 1, what did we see?

- 99% of the emphasis was on the provider, not the payor
- Rules were overbuilt, but we comfortable as we felt it was doing the right thing
 - Estimates
 - OON for provider offices
- Consultations with others
 - Everyone needed to do what was best for their organization
 - Large scale variations on how it was handled and rolled out per organization

Actual Operating within the Law

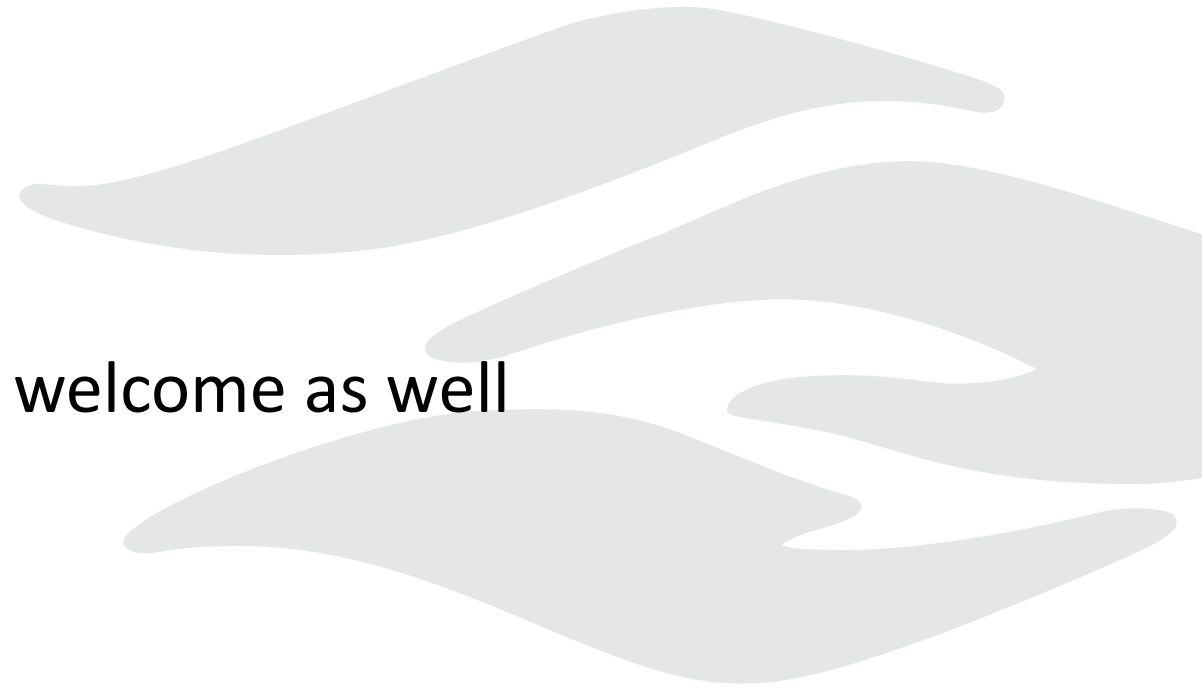
- Payor EOBs looked the same
 - A few used the new remark codes for NSBA, but not many
- No phone numbers or email addresses at insurance companies that would specialize in NSBA
- Required to call same 1-800 number on back of card
 - Most reps we spoke with had no real idea what we were asking about
- How do we go about asking to enter the negotiating period? And who do we ask?
- Providers penalized for processing the EOBs the way payors sent them

Going Forward... (and questions)

- Ambulance charges
 - Oversight not being covered?
 - Included in 2023?
- Co-provider regulations
 - Managing fee schedules/chargemasters for numerous outside providers
- Secondary payor OON, primary is INN, or vice versa
- Hopeful better utilization of payor remark codes
- How do ensure that someone was given the estimate, even if we know it was run?

Questions??

- Comments, opinions or concerns are welcome as well



Thank You



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