SIPA Summary of No Surprises Act & Supplemental Medical Review Audits

No Surprises Act (NSA) Effective 1-1-2022

Part I

Part I of the Act deals with balance billing and out-of-network provider rates. While BCMS believes that this could apply to outpatient therapy services (OPTS), we have put it on the back burner as we await legal interpretation. The implications of this aspect of the Act could be draconian if applied to OPTS.

Part II

Part II of the Act requires that all licensed healthcare providers and facilities offer a 'Good Faith Estimate" (GFE) of expected charges for services provided to all uninsured or self-paying patients. It also creates a Patient-Provider Dispute Resolution (PPDR) for patients to use when they want to dispute amounts over the GFE or out-of-network rates. The PPDR will be presented in a subsequent issue of SIPA as there are multiple unanswered questions as well as lawsuit challenges that could significantly impact the directives.

We can only provide guidance to Part II and only in areas that we feel should not have a negative consequence and that should, at a minimum, demonstrate your intent to comply to your fullest ability. The Act and its Rules are very complex, so we have purposefully carved out sections that we believe are not relevant to the majority of our clients. A list of resources is provided at the end of this article for your personal researching.

At this time, fines and/or penalties for non-compliance with the GFE have not been released.

Definitions:

Expected Charge means, for an item or service, the cash pay rate or rate established by a provider or facility for an uninsured (or self-pay) individual, reflecting any discounts for such individuals, where the good faith estimate is being provided to an uninsured (or self-pay) individual; or the amount the provider or facility would expect to charge if the provider or facility intended to bill a plan or issuer directly for such item or service when the good faith estimate is being furnished to a plan or issuer.

Good Faith Estimate means a notification of expected charges for a scheduled or requested item or service, including items or services that are reasonably expected to be provided in conjunction with such scheduled or requested item or service, provided by a provider and/or facility.

Period of Care means the day or multiple days during which the good faith estimate for a scheduled or requested item or service (or set of scheduled or requested items or services) are furnished or are anticipated to be furnished, including the period of time during which any facility equipment and devices, telemedicine services, imaging services, laboratory services, and preoperative and postoperative services that would not be scheduled separately by the individual, are furnished.

Primary Item or Service means the item or service to be furnished by the provider or facility that is the initial reason for the visit.

Uninsured or Self-pay Individual means:

- Uninsured---An individual who 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 (as defined in section 1128B(f) of the Social Security Act), or a health benefits plan under chapter 89 of title 5, United States Code; or

- Self-pay---An individual who has benefits for an item or service under a group health plan, or individual or group health insurance coverage offered by a health insurance issuer, or a health benefits plan under chapter 89 of title 5, United States Code but who does not seek to have a claim for such item or service submitted to such plan or coverage.

GFE Requirements (as we understand them 1-10-22)

- Post GFE Notice per Patient Rights noted in the NSA
- Prominently in the clinic and where scheduling occurs
- On the clinic's website
- Determine if the patient is enrolled with any of the payers noted above
- Determine if the enrolled patient wants to an insurance claim filed
- Inform all uninsured/self-pay patients of the availability of a GFE

- Recurring Circumstances for Primary Items or Services: Provide the uninsured or self-pay patient with a GFE that is:
  - Written in plain language and in accessible formats and languages per the ACA Section 1557 Rule. Click here for 2020 Summary: https://www.hhs.gov/sites/default/files/1557-final-rule-factsheet.pdf;
  - Presented verbally when scheduling an item/service or when questions posed about the cost of items/services (if the individual requests an oral or phone GFE, the provider/facility is still required to issue the GFE in written

form);
- Written in such a manner as to include the scope of the primary items or services (such as timeframes, frequency, and total number of recurring items or services).
- Composed to include the entire episode of care with a one (1) year expiration

- Non-recurring Circumstances for Primary Items or Services: Provide the uninsured or self-pay patient with a GFE that is:
  - Written in plain language and in accessible formats and languages per the ACA Section 1557 Rule. Click here for 2020 Summary: https://www.hhs.gov/sites/default/files/1557-final-rule-factsheet.pdf
  - Presented verbally when scheduling an item/service or when questions posed about the cost of items/services (if the individual requests an oral or phone GFE, the provider/facility is still required to issue the GFE in written form);
  - Provided within timeframes:
    - When a primary item or service is scheduled at least 3 business days before the date the item or service is scheduled to be furnished: Not later than 1 business day after the date of scheduling;
    - When a primary item or service is scheduled at least 10 business days before such item or service is scheduled to be furnished: Not later than 3 business days after the date of scheduling; or
    - When a good faith estimate is requested by an uninsured or self-pay individual; not later than 3 business days after the date of request.
  - Updated if circumstances change and warrant a GFE modification
    - No later than 1 business day before items or services are scheduled or furnished.

Resources:

CMS-Good Faith Estimate Standard Form:
- https://omb.report/icr/202109-0938-015/doc/115259501

CMS-Good Faith Estimate Data Elements
- https://www.hhhealthlawblog.com/wp-content/uploads/2021/11/CMS-10791-HHS-Appendix-Good-Faith-Estimate-Data.pdf

CMS-Good Faith Estimate FAQ:
- https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Guidance-Good-Faith-Estimates-FAQ.pdf

CMS-No Surprises Act website:
- https://www.cms.gov/nosurprises/policies-and-resources/provider-requirements-and-resources

No Surprises Act Part II Good Faith Estimate CFR
- https://www.ecfr.gov/current/title-45/subtitle-A/subchapter-B/part-149/subpart-G/section-149.610

No Surprises Act Part II Provider-Patient Dispute Resolution Process CFR
- https://www.ecfr.gov/current/title-45/subtitle-A/subchapter-B/part-149/subpart-G/section-149.620

BCMS Concerns about the GFE

- The NSA rules state that they do not, typically, apply to Federal payers such as Medicare, Medicaid, etc. According to the *Mandatory Claims Submission* regulation, a Medicare patient may decline to provide payer information and become self-pay. However, this option is to be self-initiated and not provoked by the provider. The same holds true under HIPAA for non-Medicare patients exercising their patient right to restrict payer information required for claims filing. As a result, they become self-paying individuals. Additionally, most commercial payer contracts require providers to utilize their subscriber's benefits, so will this become a contractual issue for providers and or a HIPAA and Medicare regulatory violation?

- For years we have fought payers who have attempted to pigeonhole us by approving specific CPT codes and the number of units as part of their authorization process. The NSA takes this issue a step further by requiring a 'prognostication' of what we will do with/to the patient to comply with the GFE. It further magnifies the situation by requiring quantification of services and costs.

- The potential for a price war with our patients is inevitable under the GFE mandate because we have many interventions with varying rates. This will be an administrative burden and could also create an unfavorable operational environment.

- The rules do not address:
    - If a patient is prohibited from retro-filing their claims once they reach their deductible;
    - Whether the GFE is required when a patient is involved in a liability or disability claim.
    - Whether the GFE applies to 'suppliers' as there is no mention of the term which, per CMS' Medicare Benefit Policy & Program Integrity Manuals, represent those billing Part B on the 1500 claim form (e.g., PT/OT/SLP, etc.), we recognize that physicians are suppliers. Still, they are mentioned explicitly in the rule. Of additional interest is that Rehab Agencies are facilities, but they, too, are not identified in the list of types of facilities.

BCMS Tips and Options

- Create a consistent billing system to use for uninsured and self-pay patients.
    - Separate Rates for Evaluations and Reports
    - Flat Per Visit Rates
    - Time Increment Visit Rates: Example 30, 45, 60, etc. minutes
    - Flat rates for all 1:1 procedures
    - Flat rates for all modalities and group therapy

- Include all 'intended' interventions in the Plan of Care to qualify as "recurring" services.

- Estimate the frequency and duration to the outer limits for the condition being treated to avoid exceeding the GFE. Remember the GFE for the episode will probably need to be modified if the Plan of Care is revised. Be certain to set up monitors for these circumstances.

- Prepare a script for your office/billing staff to answer Good Faith Estimate questions. The NSA has opened the door for consumer price shopping and, unfortunately, if a question is asked by a 'potential' patient/representative clinic must provide a GFE for the services in question.

Supplemental Medical Review Contractor (SMRC) Audits

Hundreds of practices have been notified by Noridian, the Supplemental Medical Review Contractor, that they are conducting a review of medical records for selected claims from January 1, 2019, through December 31, 2019. It further states that it has new and material evidence that justifies reopening the claim. This notification is called an Additional Documentation Request (ADR).

What we have learned is that the date of service being requested, in the large majority situations, is the initial visit, i.e., the initial evaluation date of service and most cases had not reached the $3,000 threshold. This audit is very perplexing because under the Bipartisan Budget Act of 2018 the Supplemental Medical Review Contractor was charged with reviewing therapy claims over the $3,000 threshold that had aberrant billing or other irregularities as compared to other therapy providers. The $3,000 threshold was not, by itself, a trigger.

The Center for Program Integrity is the oversite body for the SMRC; it does not address a change in the target nor does the SMRC website list a new project. We are unable to

ascertain the purpose of the audit or why the documentation requested is not in accordance with the required documentation for therapy providers/suppliers.

Regardless of the situation you must, if being audited, respond to the ADR within the specified time noted in the letter. You may, according to the letter, request an extension of the due date. We, highly, recommend that you take advantage of that opportunity and contact the SMRC at 833-860-4144 (7:30 am to 5:00 pm CT Monday-Friday) and follow up with an email to: SMRCMail@Noridian.com restating the request for the extension and the phone call response, if one was obtained. Include the following in the email:

- Project ID
- National Provider Identifier (NPI)
- Provider Transaction Access Number (PTAN)
- State
- Question: Request for due date extension for SMRC ADR
- Company/Organization
- Contact Phone Number

BCMS has a SMRC Audit Packet (contact mahoneya@bcmscomp.com) . We have footnoted the questionable line items for your review and utilization. Footnotes 1, 2, 3, 4, and 9 are clips from Medicare regulations to justify not including these items, if not available. The other footnotes are our best guess as to what they are actually asking for. We have been working with the Private Practice Section and the APTA on this matter and hope that we will have clarification and corrective guidance in the need future.

Once the SMRC review is completed, provider/suppliers will be notified through a Review Results Letter containing claim(s)and the detailed review findings associated with those claim(s). If a provider/supplier agrees with the SMRC findings, the standard overpayment recovery process should be followed. If a provider/supplier disagrees with the SMRC findings, a voluntary Discussion & Education (D&E) session with Noridian may be available upon request.

Provider/suppliers requesting a D&E session should reference the Review Results Letter for specific instructions on how to proceed. The final Review Results Letter will also notify the provider/supplier that they may elect to submit missing documentation but decline a D&E session.

The D&E period is intended to allow for the communication of the payment recommendations, discussion of the rationale for the medical review findings, education about coverage, coding, and payment policies for the subject claim to avoid future denials and provide another opportunity to submit missing documentation.

A Re-Review is intended for providers/suppliers who upon receipt of the final review results understand the rationale for the medical review findings and realize they did not submit all documentation to support the services rendered. Requesting a re-review allows providers/suppliers the opportunity to submit additional documentation for review. Once the re-review is completed, a new final review results letter will be sent. Providers/suppliers are not required to request any further action if they agree with the findings.

It is paramount that the owner and any one designated to fulfill the ADR assignment review the links provided and utilize the ADR packet prepared by BCMS for your guidance. We are not in a position to review individual charts for accuracy but, again, recommend that you follow the 'How to Respond to a Payer's Request for Records", precisely.

We also suggest that you purchase our Billing & Coding ($99 for Compliance Program clients), and Documentation Part I & II ($99 for Compliance Program clients) Webinars. These may be found at https://bcms-clientportal.wildapricot.org/BCMS_Products_Services these will be fully compliant for the SMRC audit period. Updates are being finalized to include the new CPT codes and the Assistant Differential; these updates will be automatic. Please note these are online and available 24/7 to you and your authorized staff.

Most Frequently Asked Questions about submitting a successful ADR

Q: How do we handle a situation where we sent the POC to the doctor a couple of times but never received it back? What do we need to send as proof? Can we just send fax transmission confirmation that we sent the Plans?

A. If you do not have a signed Plan of Care, it is subject to a technical denial. The Plan of Care interval is not payable by Medicare. You should pursue the certification to the greatest extent possible. When you get it signed it will be deemed a "Delayed Plan of Care", but this is permitted by Medicare. You do, however, need to document (on the signed Plan of Care or as an addendum) the reason for the delay. Click here for more information.

Q: What do the following terms or requests mean?

- Medical Record?
  A: This would be all of our relevant clinical documentation.
- NCD, LCD, Policy Article?
- A: These are determinations made by the MAC or CMS regarding the coverage status of an item or services. MACs LDC's may not contradict or supersede CMS regulations but can provided greater specificity. LCD's have clarifying articles that address payment matters https://www.cms.gov/Medicare/Coverage/DeterminationProcess/LCDs
- Attendance and Treatment Records?

A: This would be your daily treatment and encounter notes (TEN) which could include a flowsheet, etc. It does not include a copy of your schedule

- Therapy logs, dates, and times?
  A: This would be your dated TEN with 1:1 total minutes and total visit minutes

Q: What is support documentation?
A: This would be signature attestations, if applicable, ABN's abbreviation lists, explanations of unquantified standardized tests i.e., provide norms, ranges, values, amount of impairment or dysfunction, etc.
Q: How to we assure medical necessity?
A: Medical necessity is initially established with a solid evaluation that includes all of the required elements per Medicare's Benefit Policy Manual Chapter 15. It is further justified with each compliant Progress Report. TEN do not have to justify medical necessity but rather prove that skilled services were delivered and that the documentation can be directly correlated to the codes billed.
Q: Should we include all records? Even those documents after the date of service requested.
A: NO
Q: Does a Plan of Care have to be signed by the same doctor that sent a referral?
A: No, as long as the patient is under the care of physician's and non-physician practitioners (e.g., NP, PA, etc.) and those providers have the authority to sign. Please note that these individuals must be permitted to authorize services under each state practice act.
Q: What should a cover sheet include?
A: It should serve as an introduction and contact resource. Additionally, it should include information that you want to highlight or that could be unique to this chart and/or date of service. Example 1: If Plans of Care are part of the evaluation but the required elements are not clustered together you can state: "The Plan of Care is included in the initial evaluation and the required elements are located on pages xyz. Example 2: Our EMR entitles our 10th visit Progress Reports as Re-evaluations. These documents meet all of the Progress Report timing and content requirements and are not billed as a re-evaluation. Please note the manually corrected title.