

IMPORTANT PROVISIONS AND DATES PHYSICIANS SHOULD BE AWARE OF UNDER THE SURPRISE BILL LAW:

- August 30, 2018 is the new law's effective date – so practice should be prepared to follow new law by that date
- No regulations in place yet to address how law actually works; could take another year or longer (also amendments to statute possible)
- Disclosures (see below)
- UCR proofs to be used for negotiations and arbitrations (see below)
- Do physicians want to challenge the law in Court because questionable whether it applies to fully-insured ERISA plans and I believe it should not apply to self-funded ERISA plans that attempt to opt-in (though it is unlikely any self-funded ERISA plans would even want to opt-in)

NEW PHYSICIAN DISCLOSURES FOR PURPOSE OF “TRANSPARENCY”

(You may want to address with the practice's corporate/compliance attorney)

A. Website Disclosures (Generally) and Disclosures at Time of “Non-Emergent” Appointment at Office (Specifically)

- Website or in writing prior to scheduling “non-emergent” services – identify all plans you participate with and all hospital affiliations (Suggest- publish all of this on the practice website)
- Orally or in writing at time of the “non-emergent” services – identify all plans you participate with and all hospital affiliations (Suggest- have this in writing to be given to the patient when he/she comes to the office for appointment)

B. Disclosures to Patients in Office Prior to Providing In-Office Services When Out-of-Network

- If non-par with the plan, then prior to scheduling “non-emergent” services – advise patient you are OON and inform patient that info about estimated amount you intend to bill is available upon request
- If patient then makes the request for estimated bill – advise patient in writing the estimated amount that will be billed by CPT code, inform patient he/she shall have financial obligation in excess of co-payment, deductible or co-

insurance, and advise patient to contact his/her insurance company for info about that obligation

- Provide complete contact info to the patient, to extent possible, of all other providers involved in the “non-emergent” services to be rendered, and tell patient to contract those respective other providers for info about the plans they are in, their estimated bills, etc.

C. Disclosures to Patients Prior to Performing Scheduled “Non-Emergent” Services at Inpatient and Outpatient Facilities When Out-of-Network

- Essentially same as last bullet of B, above – provide complete contact info to patient for any surgeons, other providers etc. that are going to be arranged by the physician and tell patient to contact those respective other surgeons/providers for info about the plans they are in, their estimated bills, etc.

NEGOTIATION & ARBITRATION OF “EMERGENCY” and “INADVERTENT” SERVICES RENDERED BY OUT-OF- NETWORK PROVIDER

- Applies only when patient had no choice of providers
- Only applies with certainty to non-ERISA fully-insured plans; if also applies to ERISA fully-insured plans, then new law applies to around 30% of covered lives in NJ
- When it applies, patients cannot be balance billed
- Three phases – (1) Submission of Bill/Insurer Response; (2) Negotiations; and (3) Arbitration
- If all three phases are needed, all OON bills under this law will be fully resolved within 100 days of date of receipt of bill by insurer

Phase 1 - Submission of Bill/Insurer Response

- Insurer must respond within 20 days of receipt of OON bill (Question- what constitutes receipt date? Easier to determine for electronic claims)
- Insurer can either pay billed charges (unlikely), dispute the bill as “excessive” (most likely), or not respond (also likely)
- If billed charges are paid, the matter is over.
- If response is charges are “excessive,” move onto Phase 2. Nothing will be paid at this juncture.

- If no response, interesting question! I would argue insurer forfeited right to contest and therefore go to Phase 3 and demand full payment or perhaps file a lawsuit to collect full payment.
- Another interesting question – what about appeals? Do you still need to do them for claims under this law?

Phase 2 – Negotiation

- Parties have up to 30 days to negotiate resolution of disputed bill
- Unknown at this time who you are actually negotiating with (presumably info would be provided by the insurer when sending “excessive” notice).
- Whatever the insurer’s “final offer” is, this amount must be paid to doctor within 30 days.

Phase 3 – Arbitration

- Physician must file for arbitraiton within 30 days of insurer’s “final offer,” provided the difference between what the physician demands and the insurer’s “final offer” is greater than \$1000.
- Insurer is bound by its “final offer” for purposes of arbitration.
- Physician can demand in arbitration whatever he/she believes she can support with evidence and proofs.
- “Baseball style” arbitration, which means arbitrator will choose either the doctor’s demand or insurer’s “final offer.” No middle ground.
- Arbitration decisions within 30 days of arbitration initiation.
- Any arbitration award in excess of insurer’s “final offer” must be paid to doctor within 20 days thereafter.
- Costs of arbitration split equally between parties unless carrier acted in bad faith
- Attorneys’ fees unknown.

Other Related issues:

(a) If self-funded ERISA plan opts into law (unlikely), arbitrator awards what is “reasonable”

(b) If patient covered by self-funded ERISA plan that does not opt in chooses to arbitrate (possible, but likely preempted under the law), arbitrator makes a “non-binding recommendation” of payment to the self-funded ERISA plan

VERY CRITICAL – EVIDENCE AND PROOFS TO BE SUBMITTED TO THE ARBITRATOR BY PHYSICIAN TO SUPPORT BILLED CHARGES

- Physician needs to establish what it gets paid for the CPT codes in dispute
- IMMEDIATELY- COLLECT ALL “COMPARABLE” or “EXEMPLAR” EOBs BY INSURER FOR ALL CPT CODES (Go back a few years if necessary)
- IMMEDIATELY- RUN REPORTS BY INSURER SHOWING PAYMENT FOR ALL CPT CODES
- Health insurance EOBs are best, but by no means limited to that- PIP, Workers Comp, etc. also helpful
- Do not rely on Fee Analyzer, as that only establishes billed amounts, not paid amounts.
- Do rely on Fair Health 90 (utilized by Maximus in PIP arbs and also the SHBP).

WAIVER OF COST-SHARING

- Physician must collect co-pays, deductibles and co-insurances.
- Penalty- up to \$1000 per occurrence for max of \$25,000 per claim.
- Question- what if patient refuses to pay, do you have to sue? (Put in collections at a minimum)