New Actions to Prevent Surprise Billing

Chronic Care Fact Sheets

What You Need to Know about New Actions to Prevent Surprise Billing

Related to Chronic Care Management Remote Patient Monitoring Billing & Payment - On July 1, 2021, through the U.S. Departments of Health and Human Services (HHS), Labor, and the Treasury, as well as the Office of Personnel Management, issued "Requirements Related to Surprise Billing; Part I," an interim final rule with comment period that will restrict surprise billing for patients in job-based and individual health plans and who get emergency care, non-emergency care from out-of-network providers at in-network facilities, and air ambulance services from out-of-network providers.

Source: CMS.com

https://www.cms.gov/newsroom/fact-sheets/what-you-need-know-about-biden-harris-administrations-actions-prevent-surprise-billing

... This first rule implements several important requirements for group health plans, group and individual health insurance issuers, carriers under the Federal Employees Health Benefits (FEHB) Program, health care providers and facilities, and providers of air ambulance services.

What is a Surprise Medical Bill?

When a person with a group health plan or health insurance coverage gets care from an out-of-network provider, their health plan or issuer usually does not cover the entire out-of-network cost, leaving them with higher costs than if they had been seen by an in-network provider. In many cases, the out-of-network provider can bill the person for the difference between the billed charge and the amount paid by their plan or insurance, unless prohibited by state law. This is known as “balance billing.” An unexpected balance bill is called a surprise bill.

This rule protects patients from surprise bills under certain circumstances.

Who will Benefit from this Rule?

These surprise billing protections apply to you if you get your coverage through your employer (including a federal, state, or local government), or through the federal Marketplaces, state-based Marketplaces, or directly through an individual market health insurance issuer.

The rule does not apply to people with coverage through programs such as Medicare, Medicaid, Indian Health Services, Veterans Affairs Health Care, or TRICARE. These programs already prohibit balance billing.

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Who is Affected by Surprise Bills?

Surprise medical bills and balance bills affect many Americans, particularly when people with health insurance unknowingly get medical care from a provider or facility outside their health plan's network. This can be very common in emergency situations, where people usually go (or are taken) to the nearest emergency department without considering their health plan's network.

An in-network hospital still might have out-of-network providers, and patients in emergency situations may have little or no choice when it comes to who provides their care.

For non-emergency care, an individual might choose an in-network facility or an in-network provider, but not know that a provider involved in their care (for example, an anesthesiologist or radiologist) is an out-of-network provider.

How Does this Rule Help?

If your health plan provides or covers any benefits for emergency services, this rule requires emergency services to be covered:

- Without any prior authorization (meaning you do not need to get approval beforehand).
- Regardless of whether a provider or facility is in-network.

This rule also protects people from excessive out-of-pocket costs by limiting cost sharing for out-of-network services to in-network levels, requiring cost sharing for these services to count toward any in-network deductibles and out-of-pocket maximums, and prohibiting balance billing under certain circumstances. Cost sharing is what you pay out of your own pocket when you have insurance, such as deductibles, coinsurance, and copayments when you get medical care.

The protections in this rule apply to most emergency services, air ambulance services from out-of-network providers, and non-emergency care from out-of-network providers at certain in-network facilities, including in-network hospitals and ambulatory surgical centers.

Additionally, this rule requires certain health care providers and facilities to furnish patients with a one-page notice on:

- The requirements and prohibitions applicable to the provider or facility regarding balance billing.
- Any applicable state balance billing prohibitions or limitations.

How to contact appropriate state and federal agencies if the patient believes the provider or facility has violated the requirements described in the notice.

This information must be publicly available from the provider or facility, too.

When Does the Rule Take Effect?

Consumer protections in the rule will take effect beginning on January 1, 2022.

The regulations are generally applicable to group health plans and health insurance issuers for plan years beginning on or after January 1, 2022, and to FEHB program carriers for contract years beginning on or after January 1, 2022. They are applicable to providers and facilities beginning on January 1, 2022.

Where Can I Comment on this Interim Final Rule?

Written comments must be received by 5 p.m. 60 days after display in the Federal Register to be considered.

Visit https://www.cms.gov/files/document/cms-9909-ifc-surprise-billing-disclaimer-50.pdf to read more about the interim final rule.

https://www.cms.gov/newsroom/fact-sheets/what-you-need-know-about-biden-harris-administrations-actions-prevent-surprise-billing

Are You Getting Full Benefits of RPM & CCM?

Schedule a personal webinar with updates and Q & A about Chronic Care Management and Remote Patient Monitoring: Click here, email care@vitalhealthlinks.com, or call 1-888-515-8490

- Providing CCM since 2016 (Inception of non-face-to-face reimbursement)
- Clinical focused Care Coordinator program is led and overseen by physicians
- Care Coordinator methodology enhances revenue growth through CCM & RPM reimbursements
- Founder/CEO Saurin Patel holds an MBA from Indiana University Kelley Business School
- Coordinated care platforms integrate with practice workflows and care standards
- CCM and RPM platforms are turn-key and require virtually no up-front investment such as in personnel, technology, or additional infrastructure

CCM/RPM Billing & Qualifications

With the expansion of the CCM program, including Remote Patient Monitoring, CMS now offers more opportunities to help patients achieve optimum health while putting physicians and practices in the best possible position to receive reimbursement for their care coordination efforts. The following describes CCM program fees and details.

CPT Code	Description	Requirements	Reimbursements
99453	Initial setup: of remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate	Patient education on use of equipment.	$19 *One-time reimbursement
99091	Collection and interpretation of physiologic data (eg, ECG, blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified healthca e professional, qualified by education, training, licensu e/regulation (when applicable)	Requiured minimum of 30 minutes of time, each 30 days	$57
99454	Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate), initial; device(s) supply with dailyb recording(s) or programmed alert(s) transmission	Every 30 days	$63
99457	Remote physiologic monitoring treatment management services by clinical staff/physician/other qualified healthca e professional	20 minutes or more time in a calendar month Interactive communication with the patient or a caregiver during the month	$51
99458	Remote physiologic monitoring treatment management services by a clinical staff/physician/other qualified health care professional.	Additional 20 minutes interactive communication with the patient/caregiver during the month;	$41

CPT Code	Description	Requirements	Reimbursements
99490	Chronic care management services, directed by a physician or other qualified healthca e professional	• 20 minutes or more time in a calendar month, multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient; • Chronic conditions place the patient at significant risk of death acute exacerbation/ decompensation, or functional decline; • Compreensive care plan established, implemented, revised, or monitored.	$42
99457	Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate), initial; device(s) supply with daily recording(s) or programmed alert(s) transmission	Every 30 days	$63
99458	Remote physiologic monitoring treatment management services by a clinical staff/physician/other qualified health care professional.	Each additional 20 minutes of clinical staff time directed by a physician or other qualified healthca e professional, per calendar month	$63

NOTE: INFORMATION IN THIS PUBLICATION APPLIES ONLY TO THE MEDICARE FEE FOR-SERVICE PROGRAM/ MEDICARE

REQUIREMENTS AND PAYMENT FOR RHCS AND FQHCS

CCM, GENERAL BHI, PSYCHIATRIC COCM

Requirements	CCM	General BHI	Psychiatric CoCM
Initiating Visit	An E/M, AWV, or IPPE visit occurring no more than one-year priorto commencing care coordination services. Furnished by a primary care physician,NP, PA, or CNM. Separately billable RHC/FQHC visit.	Same Same Same	Same Same Same
Beneficiar Consent	Obtained during or after initiating visit and before provision of care coordination services by RHC or FQHC practitioner or clinical staff. Written or verbal, documented in the medical record. Includes information: • On the availability of carcoordination services and applicable cost-sharing; • That only one practitioner can furnish and be paid for care coordination services during a calendar month; • That the patient has right to stop care coordination services at any time (effective at the end of the calendar month); and • That the patient has given permission to consult with relevant specialists.	Same Same Same	Same Same Same
Billing Requirements	At least 20 minutes of care coordination services per calendar month that is: • Furnished under the direction of the RHC or FQHC primary care physician, NP, PA, or CNM; and • Furnished by an RHC or FQHC practitioner, or by clinical personnel under general supervision.	Same	At least 70 minutes in the first calenda month, and at least 60 minutes in subsequent calendar months of psychiatric CoCM services that is: • Furnished under the direction of the RHC or FQHC primary care practitioner. • Furnished by an RHC or FQHC practitioner or behavioral health care manager under generalsupervision.

Requirements	CCM	General BHI	Psychiatric CoCM
Patient Eligibility	Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, and place the patient at significant risk of death, acute exacerbation/ decompensation, or functional decline.	Any behavioral health or psychiatric condition being treated by the RHC or FQHC primary care practitioner, including substance use disorders, that, in the clinical judgment of the RHC or FQHC practitioner, warrants BHI services	Same As General BHI
Requirement Service Elements	Includes: • Structured recording of patient health information using Certified EH Technology and includes demographics, problems, medications, and medication allergies that inform the careplan, care coordination, and ongoing clinical care; 2 of resources and supports; a comprehensive care plan for all health issues with particular focus on the chronic conditions being managed; • Care plan information made available electronically (including fax) in a timely manner withinand outside the RHC or FQHC as appropriate and a copy of the plan resources and supports; a comprehensive care plan for all health issues with particular focus on the chronic conditions being managed;	Includes: • Initial assessment or follow-up monitoring, including the use of applicable validated rating scales;...	Includes: • Initial assessment or follow-up monitoring, including the use of applicable validated rating scales;...

Requirements	CCM	General BHI	Psychiatric CoCM
Requirement Service Elements (Cont'd)	• Care plan information made available electronically (including fax) in a timely manner withinand outside the RHC or FQHC as appropriate and a copy of the plan of care given to the patient and/or caregiver; • Management of care transitions between and among health care providers and settings, including referrals to other clinicians; follow-up after an emergency department visit; and follow-up after discharges from hospitals, skilled nursing facilities, or other health care facilities; timely creation and exchange/transmit continuity of care document(s) with other practitioners and providers; • Coordination with home- and community-based clinical service providers, and documentation of communication to and fromhomeand community-based providers regarding the patient's psychosocial needs and functional deficits in th patient's medical record; and • Enhanced opportunities for the patient and any caregiver to communicate with the practitioner regarding the patient's care through not only telephone access, but also through the use of secure messaging, Internet, or other asynchronous non-face-to-face consultation methods.		...relationship with the rest of the care team; and Psychiatric Consultant: • Participate in regular reviews of the clinical status of patients receiving CoCM services; • Advise the RHC or FQHC practitioner regarding diagnosis, options for resolving issues with beneficiar adherence and tolerance of behavioral health treatment; making adjustments to behavioral health treatment for beneficiaries who a e not progressing; managing any negative interactions between beneficiaries behavioral health and medical treatments; and • Facilitate referral for direct provision of psychiatric care when clinically indicated

Where we go from here

CCM, RPM, and other extended patient care services help practices generate revenue beyond what CPT codes provide. When done correctly, remote patient care provides contextual engagement with patients, collects important between-visit data, and can help spot potential concerns early.

"It is critical to the success of achieving the "Triple Aim" of providing better care, lower costs, and improved health."

This relationship-based, proactive approach to care helps encourage preventive care making your patients' next visit more encouraging than the last.

Additionally, with the industry's latest reimbursement models, there is tremendous value in how CCM & RPM can improve patient satisfaction and health, leading to better quality and performance scores.

CCM and RPM are two significant pieces of coordinated care. However, there are still others, including Annual Wellness Visits and Transitional Care Management.

Additionally, having success with MACRA (MIPS or Advanced APM path) and CPC+ are part of a larger goal—the proactive management of chronic conditions before they become a more significant threat to patient and population health and its additional costly impact on the U.S. economy.

It is a complete care coordination strategy that Medicare has been advancing year after year. It is critical to achieving the "Triple Aim" of providing better care, lower costs, and improved health.

10,000 baby boomers will turn 65 every day for the next 8 years, a growing patient base that is prone to developing multiple chronic conditions.

Know your CCM/RPM options before you have to. Speak with one of our physicians:
1-888-515-8450 | care@vitalhealthlinks.com

Hello! We are Vital Health Links, a doctor-led provider of dedicated coordinated care. We partner with practices across the country, but credit out midwestern diligence and care to our home-base, among the shores of 10,000 lakes, in Minnesota. In other words, we are friendly and would love to connect with you.

To say 'hello'

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