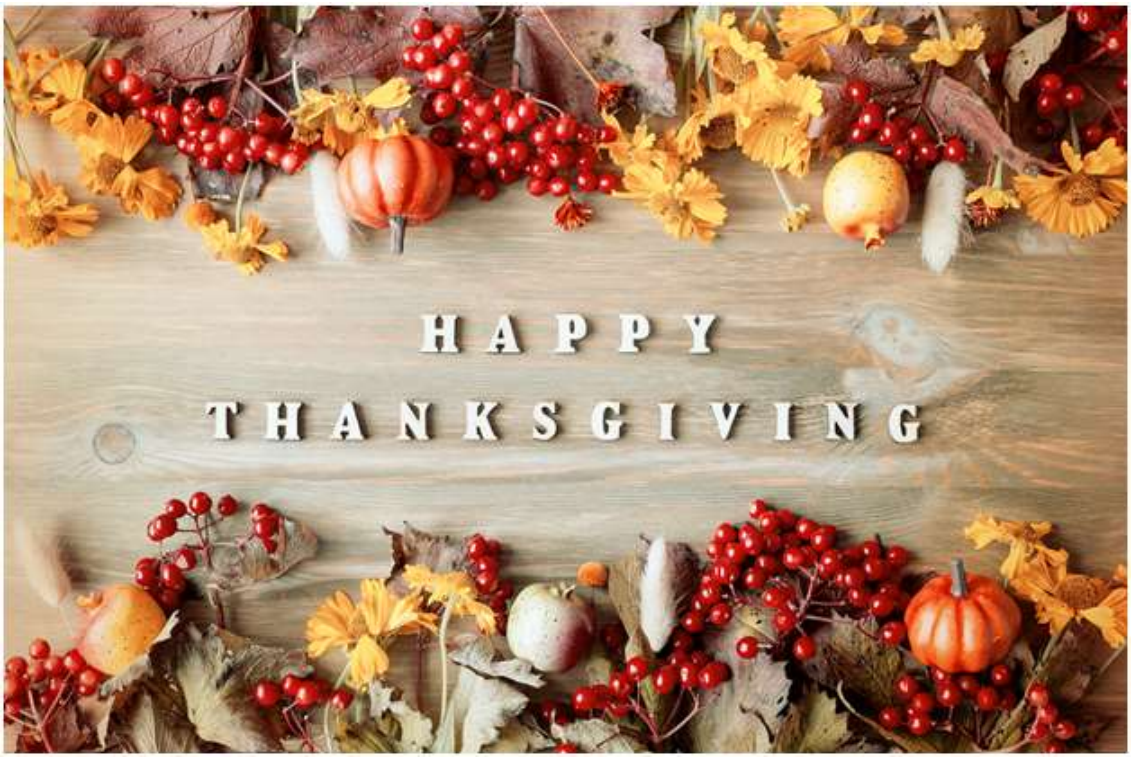
ADVANCED PACIFIC MEDICAL, LLC

November 2021

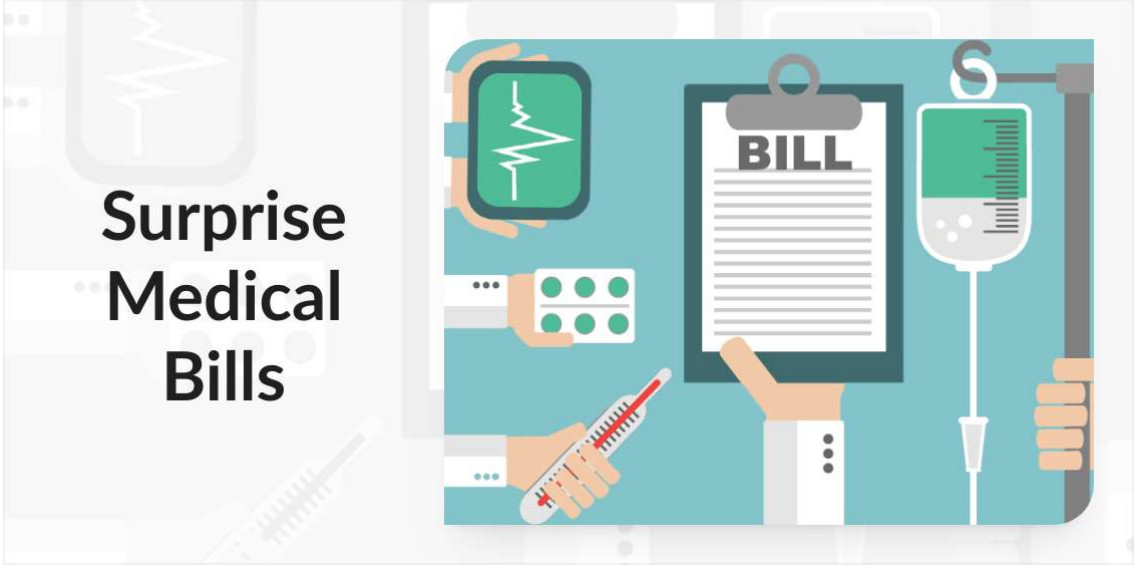
# ADVANCED NEWS




We want to say "Thank You" to all of our providers and their staff, that we have the honor of working with everyday. We appreciate your business very much!

We will be closed November 25th and 26th to spend time with our families.

Roxanne, Keith, Kristen, Jessie, Janet, Charlie, Cheryl, Jean, Veronica, Timna, Katie and Monica.




By now you have probably heard about the No Surprise Medical act that was passed in December 2020 and takes effect January 1, 2022. It is intended to protect patients from receiving bills from Out of Network providers while seen at in-network facilities. It would limit the patients out of pocket charge to the in network median rate.

The health plan has 30-days from receiving the claim to negotiate a payment rate. The provider then has 4 days from the time of receiving the payment to file an independent dispute resolution process to determine a different payment amount. This will then go to arbitration and the arbiter will look at several different factors - the providers expertise, the median in-network rate and complexity of the service provided.

There are separate rules if the patients health plan is a Federal plan, is in a different state than the provider is or if they have paid the payment to the patients already? It is very confusing. The exact policies are still being defined:

- Requiring the arbiter to consider a rate based on the providers charge e.g. 80% of FAIR health
- Require health plans to list information about the patients plan type ERISA, ACA, etc. on the insurance card.
- Account for delays in the credentialing process

We met an attorney at the HBMA conference in September and he specializes in fighting the insurance companies for the low payments that are sometimes made. We will keep you posted if we see any out-of-network payments made for patients seen at in-network facilities.


Advanced has had a written compliance manual for many years now. It was created from the regulations set up by the OIG for Third Party Medical Billing Companies (us) to make sure that we are following the guidelines set in place. Our clients receive a copy of our manual at the beginning of our services so the roles are clear and everyone knows what is expected of them.

Some of the highlights are :

- Our modifier policy - we are not able to add modifiers to billing codes sent to us just to get them "paid". Those have to come from the client as they have to match the documentation in the chart. For us to unbundle the codes by adding a modifier is making a statement that they are distinctly different and separate.
- Changing CPT codes - we are not able to change codes to payable codes as the code billed has to match what is documented in the patients note. There are meanings in the codes that are very detailed.
- We are not able to release clinical information/medical records on a client's behalf. It is up to the client to ensure that any required release of records is obtained.
- Overpayments - Under the ACA any person who receives an overpayment must return the payment within 60-days after the payment is identified. For this reason, we run credit balance reports at the 60-day mark and send a refund request to the provider to return the funds.

For all of these policies, there are Civil and Criminal penalties that can be imposed to both a provider and the billing service and they are BIG! Per claim fines, prison times and legal fees we don't even want to talk about. So not worth it!

Compliance is not exciting or fun but needed in the healthcare industry to follow the rules that have been set up to follow. It's like the Monopoly game, you can win if you read the rules on the back of the box.

**Thank you,**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*Member of HBMA Board of Directors*