Idaho Medical Association
Idaho Hospital Association
Idaho Medical Group Management Association

IDAHO PATIENT ACT ("IPACT")

FREQUENTLY ASKED QUESTIONS

By Kim C. Stanger and Ally Kjellander, Holland & Hart LLP

Q1. If a patient has a service in the office during the course of their visit (e.g., a biopsy, blood draw, etc.) must we notify the patient of the cost of the service if the patient is billed directly from the lab? We provide their name and contact information, but I thought I read we have to provide the cost and we don't always know how much a service from another office is going to be.

A1. IPACT differs from the federal No Surprise Billing Rules. Under IPACT, a consolidated summary of services ("CSS") should be sent if a patient will receive bills from different entities for services rendered at the facility, but the CSS need only contain a general description of the items provided and the contact information for the billing entities; there is no requirement to include costs. (See IC 48-303(1), -304(b), and -309). Also, under IPACT, the final notice before extraordinary collection action ("FN") need only include the charges from the entity seeking to collect on the bill; it need not contain charges from other billing entities. (See IC 48-303(4) and -304(c)). In contrast, beginning CY2023, the federal No Surprise Billing Rules relating to uninsured (self-pay) patients may require a good faith estimate of charges from co-providers in limited circumstances, but those rules are subject to change.

Q2. In order to add interest to outstanding patient accounts, is a final notice required to be sent?

A2. A health care provider may not charge or cause to accrue any interest, fees, or other ancillary charges until at least sixty (60) days have passed from the date of receipt of the FN or the receipt of the CSS, whichever is received later by the patient. (IC 48-304(d)).

Q3. If we give patients a slip of paper at their visit with only the outside lab information at time of service, do we still have to send the CSS?

A3. A healthcare facility should ensure that a patient receives a CSS within the statutory deadlines if an outside lab will bill the patient for services provided during the patient's visit to the facility. A facility may provide the CSS at the time of service or later, but the CSS must contain the items required by the statute, which include but are not limited to the contact information for labs and other entities that will bill for services performed at the facility. (IC 48-303(1), -304, and -309). Simply providing

the lab's contact information will not satisfy the requirements for a CSS if other required information is omitted. See the answer to Q9, below.

Q4. Can you clarify regarding including the names of other providers who will bill for service on the CSS or FN?

A4. If a CSS is required, the CSS must contain (among other things) "a general description of goods and services provided to the patient during the visit to the healthcare facility, including the name, address, and telephone number of each billing entity whose health care providers provided the services and goods to the patient." (IC 48-303(1)). A healthcare facility is <u>not</u> required to provide a CSS if: (i) the patient will receive a FN from a single billing entity for all goods and services provided to the patient at that healthcare facility; (ii) the patient was clearly informed in writing of the name, phone number, and address of the billing entity; and (iii) the health care facility otherwise complies with all other provisions of IC 48-304. (IC 48-309).

In contrast, a FN does <u>not</u> need to include the names of other providers who will bill for services. Instead, the FN need only include (among other things) the name and contact information of the healthcare facility where the healthcare provider provided goods and services to the patient, and a list of the goods and services that the healthcare provider provided to the patient during the patient's visit to the healthcare facility. (IC 48-303(4)).

Q5. Since the law is specific about a patient "receiving" verses facility sending CSS, if patient provided incorrect address and the CSS is returned to facility, patient fails to reply to phone requests for updated address and therefore we are not able to confirm patient received CSS within 60 days, are we still able to take any extraordinary collection actions?

A5. It is not entirely clear how a court would resolve this situation. IPACT states:

> *<u>REBUTTABLE</u> PRESUMPTION OF RECEIPT. A patient <u>shall be presumed to have received</u> a [CSS] or [FN] three (3) days after the document has been sent by first class mail to the patient's address confirmed by the patient during the patient's last visit to the health care provider or as updated by the patient in subsequent written or electronic communications. Nothing in this section shall be interpreted as precluding the patient from agreeing in writing to receive consolidated summaries of services or final statements via email or other electronic means.*

(IC 48-308, emphasis added). The statutory language itself suggests that a patient is deemed to have received a CSS or FN that was sent to the address confirmed or updated by the patient regardless of whether the patient actually received it. However, the title to this section characterizes it as a "rebuttable" presumption,

suggesting that the patient may be able to rebut the presumption of receipt, although it is not clear what inference may be rebutted: actual receipt or that the CSS or FN was sent to the right address. It would be unfair to prohibit a healthcare provider from pursuing collection actions in situations in which a patient gave false contact information or otherwise attempted to dodge delivery of the CSS or FN. Accordingly, I think a court would likely conclude that a provider who in good faith properly sent the CSS and/or FN to the addresses confirmed by the patient as described in the statute would be allowed to pursue extraordinary collection actions ("ECA") even if the patient did not actually receive the CSS or FN.

Q6. Does patient's phone number need to be added to FN before ECA?

A6. Yes. The FN must include, among other things, "[t]he name and contact information, including telephone number, of the patient." IC 48-303(4). Of course, in the unlikely event that a patient does not have a phone number, it cannot be included and its absence should not preclude an ECA.

Q7. In private practice, if a provider orders labs, collects the specimen, performing lab picks up the specimen, and the lab company bills the patient for the labs they perform at their facility, is a CSS required?

A7. It will depend on which entity bills for the services performed at the practice. A CSS is generally required unless, among other things, "the patient will receive a [FN] from a single billing entity for all goods and services provided to the patient at the facility." If the practice is billing for all services provided at its facility (including specimen collection), a CSS may not be required. On the other hand, if the lab is billing for any services provided at the facility (including specimen collection and/or picking up the specimen), then a CSS would likely be required. (IC 48-309).

Q8. In private practice, is a CSS required if a provider orders imaging during the visit, sends the imaging order to the imaging facility to schedule the patient, and the imaging center bills for services they provide at their facility?

A8. A CSS is generally required unless, among other things, "the patient will receive a [FN] from a single billing entity for all goods and services provided to the patient at the facility." If none of the imaging services are provided at the practice, then a CSS may not be required. On the other hand, if the imaging facility is billing for any services provided at the practice, then a CSS would likely be required. (IC 48-309).

Q9. May you provide a CSS at the intake with the names and contact information of the most commonly used providers for labs, imaging, etc.? Further, can the CSS, like a GFE, be a standing CSS, provided once per year or when significant changes are made?

A9. See answer to Q3. A facility may provide a CSS at intake, but the CSS would need to contain the information required by the statute, i.e., (i) the name and contact

information, including telephone number, of the patient; (ii) the name and contact information, including telephone number, of the health care facility that the patient visited to receive goods or services; (iii) the date and duration of the visit to the health care facility by the patient; (iv) a general description of goods and services provided to the patient during the visit to the health care facility, including the name, address, and telephone number of each billing entity whose health care providers provided the services and goods to the patient; and (v) the notice language required by the statute. (IC 48-303(1)). Simply providing a list of commonly used providers without the additional information required by the statute would not suffice.

It is unlikely that a single standard annual CSS will satisfy IPACT requirements. First, the CSS would still need to contain the information described above, many of which are specific to the patient's particular episode of care. Second, if a CSS is required, the CSS must be received by the patient within sixty (60) days from the latest of: (i) the date of the provision of goods or delivery of services to the patient; (ii) the date of discharge of the patient from the healthcare facility; or (iii) the first date permitted by the applicable billing code or codes and the applicable policies and procedures in connection with the patient's care in each case as published by the relevant national association. (IC 48-304(b)). It may be difficult to satisfy these requirements with a single, standard, annual CSS.

Q10. Can you clarify the question section regarding undeliverable mail? Can these accounts be sent to collection agencies?

A10. See answer to Q5.

Q11. Do we have any recourse if a facility doesn't include us in a CSS when we provided services?

A11. As amended, IPACT allows a provider to send an updated or corrected CSS. To be able to recover collection fees, costs and expenses, the updated CSS must be provided within 60 days from the date the services were provided, the patient was discharged, or the date that billing was first permitted by national billing standards. The national billing standards and guidelines are drafted by associations such as the American Medical Association via CPT codes. IPACT provides an additional 180 days (i.e., 240 days total) to send the CSS, but the provider would not be able to recover collection fees, costs and expenses.

There are good arguments that a provider should not be penalized because another facility failed to include the provider in the facility's CSS; however, we do not know how a court would rule given the language in the statute. It would be safer for the provider to send or arrange for the facility to send an amended or updated CSS.

Q12. Can you clarify the "first date permitted by applicable national standards" in determining the deadline for filing claims or receiving the CSS?

A12. As a result of recent advocacy by the IMA and others, IPACT was amended so that the time limit for submitting claims and for patient's receipt of the CSS runs from the later of (i) the date of the provision of goods or the delivery of services to the patient; (ii) the date of discharge of the patient from a health care facility; or (iii) the first date permitted by the applicable billing code or codes and the applicable policies and procedures in connection with the patient's care in each case as published by the relevant national association. (IC 48-304(a), (b)). For example, in cases such as maternity care where bills are submitted in a bundled or global payment plan, the deadline will not run until the time for submitting the claims consistent with billing standards from national associations.

Q13. Patients may not always provide accurate contact information intentionally. Or we can make a mistake in entry of the information. Does the presumption still apply?

A13. For situations in which the patient provides inaccurate contact information, see responses to Q5 and Q10. For situations in which the provider makes a mistake, the presumption of receipt will not apply if the document was not sent to the patient's address confirmed by the patient during the patient's last visit, an updated address provided by the patient in a subsequent written or electronic communication, or as otherwise agreed by the patient. (IC 48-308).

Q14. For the CSS exception (only supply FN), how do you recommend the patient receives/provider provides the writing with the billing entity information?

A14. The relevant portion of IPACT only requires that "the patient was clearly informed in writing of the name, phone number, and address of the billing entity." (IC 48-309(2)). This requirement should be satisfied by the FN. It may also be satisfied through other written communications between the provider and the patient, including but not limited to scheduling communications, registration materials, consent documents, etc. The provider will want to retain a copy of such written communications to prove that the required information was provided.

Q15. Are there any lobbying efforts to get an exception for non-profit hospitals that already have to comply with IRS 501r ACA regs that have overlapping ECA requirements?

A15. I understand that such lobbying efforts were attempted but unsuccessful.

Q16. Are dental practices covered by IPACT?

A16. Yes. If the dental practice provides healthcare services to a patient, the dental practice must comply. "Healthcare services" are defined as "the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease."

(IC 48-303(7)). IPACT applies to “health care providers” and “health care facilities,” which are defined as follows:

> *(5) "Health care facility" means any person, entity, or institution operating a physical or virtual location that holds itself out to the public as providing health care services through itself, through its employees, or through third-party health care providers. Health care facilities include but are not limited to hospitals and other licensed inpatient centers; ambulatory surgical or treatment centers; skilled nursing centers; residential treatment centers; urgent care centers; diagnostic, laboratory, and imaging centers; and rehabilitation and other therapeutic health settings, as well as medical transportation providers.*
>
> *(6) "Health care provider" means:*
> *(a) A physician or other health care practitioner licensed, accredited, or certified to perform health care services consistent with state law, or any agent or third-party representative thereof; or*
> *(b) A health care facility or its agent.*

(IC 48-303(5), (6)).

18927403_v4