Idaho Patient Act FAQ

Q1: I understand the CSS needs to be provided to patients for goods or services received in the clinic. What about orders for future dates? Example, provider completes an order for the patient to have labs drawn in 30 days, the patient does not get the labs draws in the office, but goes to an independent lab and has the labs drawn there. Do we have to add that to our CSS we provide to the patient at the time of their visit where the doctor ordered the test?

Goods and services that will be provided to the patient in the future do not need to be included on the CSS. Additionally, where a provider orders goods or services to be provided to a patient at a separate health care facility that the patient will visit, the provider is not required to include that other facility/provider on the CSS.

Q2: Our office does not do any extraordinary collection activities. We bill a flat fee each month that covers everything the physician does in the office. If a patient is not current on their monthly payments we simply discontinue providing care, or give them free care. We do not bill for each service. Can we conclusively say we do not need to perform any activities outlined in the act?

Correct – if you do not utilize ECA, and there are no downstream entities that rely upon your issuance of a CSS to pursue an ECA, then you do not need to perform the activities in the Idaho Patient Act.

Q3: Would an ASC be a single billing facility?

It depends. If the patient will not receive a bill from any other provider than the facility the service was performed at, then yes it would qualify as a single billing entity. That means the CSS would not be required but the rest of the requirements apply (as long as you satisfy the other requirements of I.C. 48-309). However, if the patient will receive a bill from the ASC as well as from any other provider (laboratory, radiology, individual providers, etc.) who performed a service at or on behalf of the ASC, then no it is not a single billing facility and full compliance with the Idaho Patient Act is required.

Q4: If the primary payer or secondary payer does not process within 45 days can we send a CSS to the patient letting them know we are still waiting for insurance to process?

First, the requirement to submit charges to insurance companies within 45 days is independent from the requirement to provide a CSS within 60 days. There is nothing in the

Act that requires waiting for insurance to process a claim before sending the CSS. However, the final statement is intended to reflect the final amount that is owed by the patient – thus, waiting until the claims have been processed would be required before sending the final statement. Because the final statement can be sent at any time after goods and services are provided, there is no rush to get this out to the patient.

Q5: If the statement is returned as undeliverable and we can't locate the patient, does that mean we can't send them to collections?

The problem is that the Act requires the patient to *receive* the CSS and Final Statement. It's hard to predict how a court will treat failed attempts at delivery. Another option may be to engage a third-party to collect in the name of the provider (not sell, transfer, or otherwise assign the debt).

Q6: We are a small private practice and we've been giving the CSS when patients check out from their appointment to save time, etc. This is ok, correct?

Yes. You may also want to consider how you are documenting receipt by the appropriate person (e.g., patient signature).

Q7: If we do not draw the lab in the clinic that day, and the patient leaves with an order but we do not know which lab they would go to do we have to generate a CSS?

Similar to FAQ 1, you would only need to provide a CSS for the services that were delivered that day, i.e. the patient visit. A CSS is not required for referrals or orders that are for services that will occur in the future and have not yet taken place.

Q8: What if your practice management system doesn't allow you to bill multiple payers at one time? We are out of luck?

This is an area where IMA and other health care organizations will try to push for changes to the law. The practice may not be able to comply with IPACT if it cannot bill the secondary payer within the 45-day initial window, or within the additional 45-day grace period.

Q9: We are a dental office and have run into a situation where a surgical procedure was performed, claim was sent to dental insurance and they are making us deal with the medical insurance which we aren't set up to do. Therefore the primary claim is past the 60 or even 90 days with secondary still needing to be billed. What are our obligations for a situation where insurance is past their 30 day pay or deny period?

The Idaho Patient Act requires the submission of charges to payors identified by the patient. It does not require submission of charges to those payors otherwise unknown to you. Here, if the medical insurer was not identified by the patient, but you otherwise billed the dental insurer identified by the patient within the requisite period, this should still be compliant with the Act.

Q10: Can you explain again what allows the additional 90 days in submitting a patient a CSS?

Health care facilities have an extra 90 days in addition to the original 60-day deadline to ensure the patient receives an accurate CSS (150 days total) following provision of goods or services. This was contemplated by the bill sponsors as a "grace period" to address situations in which the CSS is incorrect (i.e., a provider's name was omitted). However, providers who must utilize the 90-day grace period will be precluded from recovering costs, expenses, and fees (including attorney fees) in pursuing extraordinary collection action.

Q11: Is interest charged by a collection agency considered a fee or cost?

Likely, yes.

Q12: Has anyone figured out a way for us, a medical group, to report patients to a credit reporting agency (versus a collection agency)? This is the only teeth we have once a patient has refused to pay. If we could do this it would eliminate some of the roadblocks.

This is an area where IMA and other health care organizations will try to push for changes to the law. Credit reporting is a lower level of ECA that is quite effective for practices and minimally harmful to patients. One alternative option would be to engage a third-party to collect in the name of the provider (not sell, transfer, or otherwise assign the debt).

Q13: What happens if the patient does not provide us with the insurance information until after the 45 days and we were not aware they had insurance?

If the patient does not provide insurance information at the time of service, sending the charges directly to the patient within the 45-day window would meet the first timeline requirement.

Q14: What happens if we were unable to reach the patient to get the CSS? Whether it be they gave us the wrong address/phone number and we have tried every method to try to contact them and are unsuccessful?

Same answer as Q5.

Q15: Our office uses multiple labs. Are we required to be specific or can we list all potential labs on the CSS?

In this case it is recommended you list all the labs (or providers) on the CSS and check the box of the lab the patient has seen for the service.

Q16: We have some questions on the insurance company primary and secondary not processing the claim in 45 days. Can we send a CSS and a statement letting them know the charges are still pending and preserve the right to seek ECA?

Same answer as Q4.

Q17: How do we go about getting specific permission to send the CSS on the portal? Can it just be built into our paperwork signed yearly or do we have to get permission every time?

The Act specifically contemplates that patients can agree "in writing to receive consolidated summaries of services or final statement via email or other electronic means." I.C. 48-308. There is no specific requirement related to the frequency of obtaining such an agreement. I would recommend getting updated consent at least annually.

Q18: Regarding return mail: I understand from the webinar that the burden of statement proof is on the provider. If after sending a statement to the patient we receive return mail, what constitutes that burden before sending to collections? What attempts and how many attempts need to be made to obtain the address? Typically, for our practice, we use Accurint, the patient's insurance website, and contacting the hospitals our provider service to obtain the correct address. If all of those attempts fail (and they have in the past), what is our recourse? In the past, we have sent the patient to collections as our efforts were exhausted. It seems this leaves a rather large loophole for the patient to jump through if they try to dodge our good-faith attempts to bill.

Same answer as Q5.