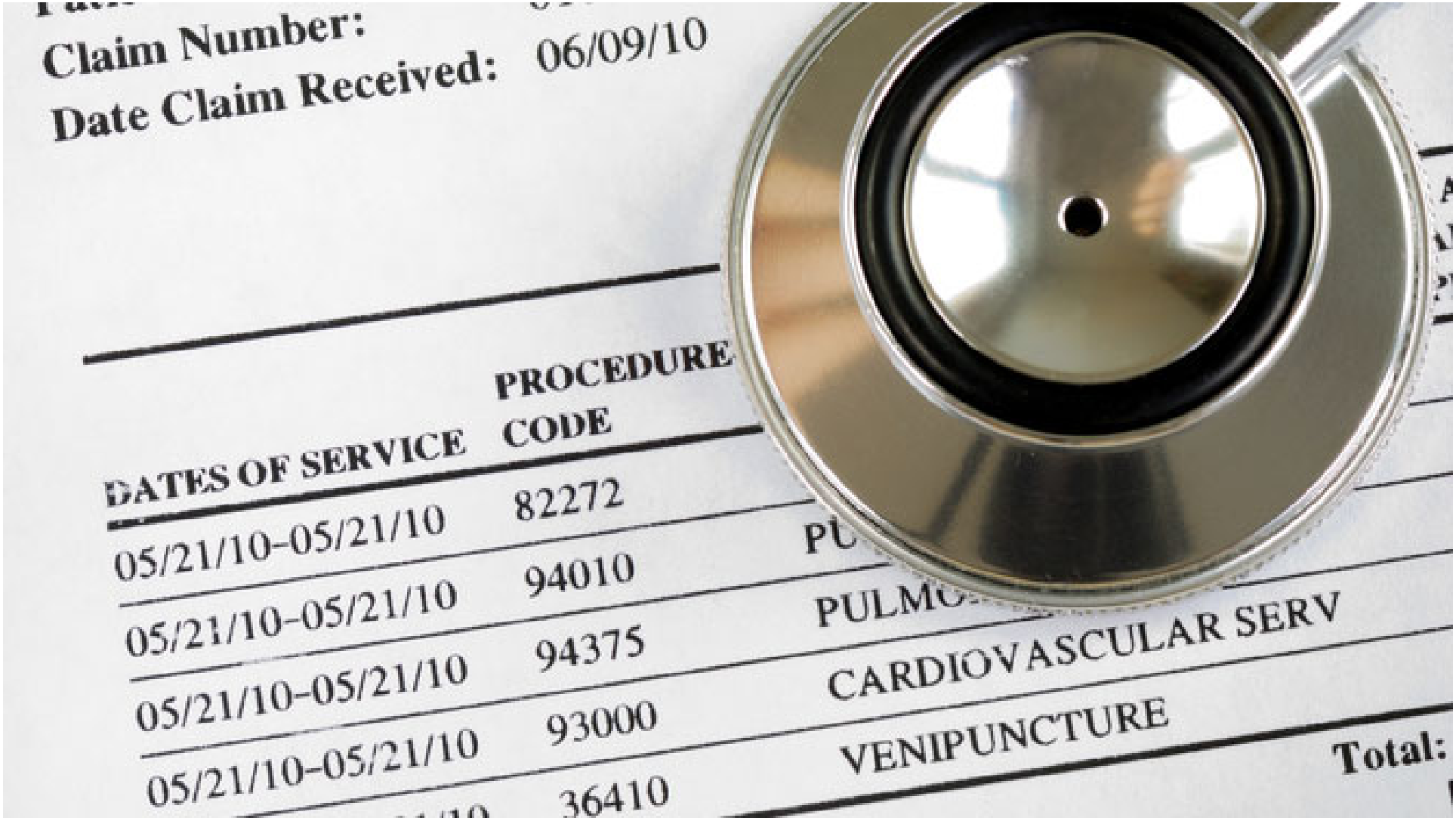


# IDAHO PATIENT ACT

JULY 28, 2021

HOLLAND&HART LLP

# DISCLAIMER

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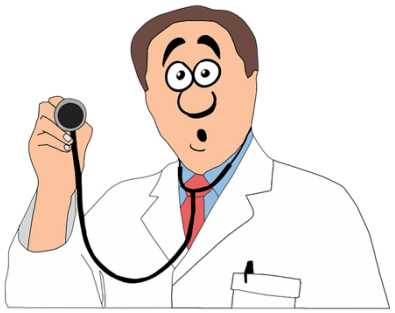
# WHO MUST COMPLY

- Any **health care provider** that wants to engage, directly or indirectly, in any **extraordinary collection action**.



  - **Health Care Provider**:
    - 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
    - A **health care facility** or its agent.
  - **Health Care Facility**:
    - 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 Services**:
    - Services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease.

# WHO MUST COMPLY

**Extraordinary Collection Actions**:

1. Prior to sixty (60) days from the patient's receipt of the **final statement**, selling, transferring, or assigning any amount of a patient's debt to any third-party, or otherwise authorizing any third-party to collect the debt in a name other than the name of the health care provider.
2. Reporting adverse information about the patient to a consumer reporting agency.
3. Commencing any judicial or legal action or filing or recording any document in relation thereto, including but not limited to:
   i. Placing a lien on a person's property or assets;
   ii. Attaching or seizing a person's bank account or any other personal property;
   iii. Initiating a civil action against any person;
   iv. Garnishing an individual's wages.

Idaho Code § 48-303

# STEP 1
## SUBMIT CHARGES

Patient receives goods or services from a Health Care Facility


Within **45 days** of the provision of goods/services or discharge:

- Health Care Provider must submit charges to **Third-Party Payors** identified by Patient
- If none identified, submit charges to Patient



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# STEP 1: FAQS
## SUBMIT CHARGES

**When does the 45-days start for patients receiving series of medical treatments billed together?**

As written, the Act requires submission of charges 45 days after the date of service (or discharge). Thus, although this may not be consistent with third-party payor processes or claim submission requirements for services billed globally, strict compliance with the Act requires the submission.

**Does the Act require the submission of "charges" or "claims"?**

Technically, the Act requires submission of charges. The Act makes no reference to a "claim" and similarly does not expressly require submission of a "complete claim" or "clean claim."

**What if the charges were submitted incorrectly (our error), but the error was noticed after expiration of the 45-day period?**

It's likely that submissions can be corrected or modified beyond the 45-day window where the initial submission was made within 45 days.

**What if we learn only after submitting charges (or providing the patient with the charges) within the 45-day period that the patient provided incorrect information (i.e., stated no coverage or provided wrong policy)?**

You can rely on information provided by patient, even if incorrect or no payor information is provided.

# STEP 1: FAQS
## SUBMIT CHARGES

**How does the 45-day grace period work?**

Health care facilities have an extra 45 days to submit charges (90 total) following provision of goods or services but will be precluded from recovering costs and attorney fees in pursuing extraordinary collection action.

**What is the penalty for not submitting charges within either 45 or 90 days?**

May not pursue extraordinary collection action without being subject to fines and damages.

**Are charges expected to be submitted within 45 days even when policy is not yet active (e.g., newborns)?**

The plain letter of the law requires strict compliance with the established timelines following a date of service, regardless of whether submission of a claim will be accepted or rejected by the third-party payor. Therefore, multiple claim submissions may be required to accomplish reimbursement.

# STEP 1: FAQS
## SUBMIT CHARGES

**Are we required to submit charges to medical sharing entities?**

The Act requires only the submission of charges to third-party payors identified by patient, or to the patient where no payor is identified. “Third party payor” is a defined term and includes a health carrier, as defined in IC 41-5903, or a self-funded plan, as defined in IC 41-4002 or 41-4102. Medical sharing entities are not a “third party payor.”

**Are we required to submit charges to secondary and tertiary third-party payors within the 45-day period?**

Yes, the Act expressly contemplates submission of charges to the third-party payor or *payors* of the patient. Thus, if there are multiple payors identified by the patient, charges must be submitted to each.

**Are we permitted to set up payment plans with patients prior to providing a CSS or Final Statement?**

Yes, as long s that the debt remains in the name of the health care provider. Transferring, selling, or assigning any amount of det to a third party will constitute an ECA and must first comply with requirements of the Act.

# STEP 2
## SEND CONSOLIDATED SUMMARY OF SERVICES


Within **60 days** of the provision of goods/services or discharge:

- Patient must *receive* a **Consolidated Summary of Services** from the Health Care Facility visited.

**Exception**: A Health Care Facility is not required to provide a Consolidated Summary of Services where

- The Patient receives a final statement from a single billing entity for all goods and services provided to the Patient at that Health Care Facility;
- The patient was informed in writing of the name, phone number, and address of the billing entity; **and**
- The health care facility complies with the other statutory provisions.



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# STEP 2
## SEND CONSOLIDATED SUMMARY OF SERVICES

**Consolidated Summary of Services**: Idaho Code § 48-303

1. Name and contact information, including telephone number, of the patient.
2. Name and contact information, including telephone number, of the health care facility that the patient visited to receive goods or services.
3. Date and duration of the visit to the health care facility by the patient.
4. 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.
5. A clear and conspicuous notification at the top of the notice that states:

> ***This is not a bill. This is a summary of medical services you received. Retain this summary for your records. Please contact your insurance company and the Health Care Providers listed on this summary to determine the final amount you may be obligated to pay.***

# STEP 2: FAQS
## SEND CONSOLIDATED SUMMARY OF SERVICES

**How must the CSS be provided to patients?**

There is no specific requirement on delivery method. The CSS can be provided to a patient in-person, via email (w/appropriate consents), via patient portal, mailed.

**How does the 3-day mailing presumption factor into the 60-day timeline?**

If mailing by first class mail, must be sent within 57 days after date of goods/services/discharge to ensure patient "receives" the CSS within 60 days.

**How does the 90-day grace period work?**

Health care facilities have an extra 90 days to ensure the patient receives a CSS (150 days total) following provision of goods or services but will be precluded from recovering costs and attorney fees in pursuing extraordinary collection action.

**What if the CSS sent to the patient is incorrect?**

The issuing health care facility should correct any errors/omissions within the statutory timeframes to ensure all affected facilities'/providers' ability to pursue ECA.

# STEP 2: FAQS
## SEND CONSOLIDATED SUMMARY OF SERVICES

**What can a downstream provider/entity do if the health care facility where the patient visited does not issue a CSS or leaves the downstream provider/entity off the CSS?**

If providers are left off the facility/hospital's consolidated summary, the provider should work with the facility to correct and reissue the CSS within the statutory periods to preserve right to pursue ECA.

**As a medical clinic or solo provider, when am I required to send CSS?**

The facility that the patient visits is obligated to provide a CSS where the patient will also receive a bill from another billing entity for goods or services provided to the patient by other health care providers. For example, where a patient visits only one facility, but has blood drawn and sent to the laboratory, which bills separately. In that situation, the facility should include information about the laboratory on a CSS provided to the patient.

**What if a CSS is returned to the provider/facility as undelivered?**

The Act only establishes a presumption of receipt 3 days after mailing via USPS. If the mail is returned, this eliminates the presumption and the burden shifts to the provider to provide CSS within statutory periods.

# STEP 2: FAQS
## SEND CONSOLIDATED SUMMARY OF SERVICES

**What constitutes a "general description"?**

There is no definition or context within the Act to infer an interpretation. Therefore, the words should be given their ordinary meaning.

**What is "duration" and how does it apply to an outpatient clinic?**

Again, give this word its ordinary meaning, which would be the length of the visit, even in an outpatient setting.

**If a practice does not have to provide a CSS due to there being no outside billing, how must the practice satisfy the requirement of 48-309 that the patient be "clearly informed in writing of the name, phone number, and address of the billing entity"?**

The phone number requirement would be satisfied via the Final Statement, but otherwise there is no specific methodology required for how to provide this information.

# STEP 2: FAQS
## SEND CONSOLIDATED SUMMARY OF SERVICES

**Can providers use a standard statement in their financial policy or registration form alerting patients that if they receive labs, they may be billed separately by XYZ Lab?**

No. The CSS must include information that will be specific to each visit, including the date and duration of the visit, and the general description of goods and services provided to the patient during the visit, etc. See I.C. 48-303(1)(c) and (d).

**If the patient receives their final statement within 60 days of the date of service, must the facility still provide a CSS?**

Unless the health care facility is exempt from having to provide the CSS under I.C. 48-309, the health care facility must provide both the CSS and final statement. Many providers are providing the CSS as an after-visit summary to save postage.

# STEP 3
## SEND FINAL STATEMENT


Patient must receive a **final statement** from the health care provider.


Health care provider may not charge interest until at least 60 days have passed since patient *received* the final statement (63 days after mailed).


Health care provider may not pursue extraordinary collection action until at least 90 days have passed since patient *received* the final statement (93 days after mailed).



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# STEP 3
## SEND FINAL STATEMENT

**Final Statement**

1. *The name and contact information, including telephone number, of the patient.*
2. *The name and contact information, including telephone number, of the health care facility where the health care provider provided goods and services to the patient.*
3. A list of the goods and services that the health care provider provided to the patient during the patient's visit to the health care facility, including the initial charges for the goods and services and the date the goods and services were provided, in reasonable detail.
4. A statement that a full itemized list of goods and services provided to the patient is available upon the patient's request.
5. The name of the third-party payors to which the charges for health care services were submitted by the health care provider and the patient's group and membership numbers.
6. A detailed description of all reductions, adjustments, offsets, third-party payor payments, including payments already received from the patient, that adjust the initial charges for the goods and services provided to the patient during the visit.
7. The final amount that the patient is liable to pay after taking into account all applicable reductions, including but not limited to the items identified in [#6 above].

# STEP 3: FAQS
## SEND FINAL STATEMENT

**When must this final statement be sent to patient?**

There is no correlation between the date goods/services were provided and date final statement must be sent. This is a prerequisite to charging interest and pursuing an ECA.

**What if a patient disputes or is appealing the amount owed?**

You must wait either 60/90 days required by Act, or until the resolution of any appeal, review, or good-faith dispute, whichever is later.

**What if the amount owed is adjusted following submission of final statement to patient?**

There is no obligation to send an updated final statement before pursuing ECA.

**What is the difference between a "final statement" and any other statement sent to a patient?**

The final statement requires very specific elements and starts countdown for when interest can be charged or an ECA can be pursued. There is no prohibition against sending any other notices or statements to the patient prior to or after sending the initial final statement.

# STEP 3: FAQS
## SEND FINAL STATEMENT

**How many statements for a final balance must be sent before an account can be sent to collections?**

One fully compliant final statement must be received by the patient at least 60 days before sending to collections.

**Can the final statement be emailed to patients (assuming we have appropriate consent)?**

Yes. There is no requirement on how the final statement is sent, only that it be *received* by the patient – consider how to ensure receipt by the patient.

**What if EMR does not have capability to include required information?**

Because the final statement is a prerequisite to charging interest or pursuing ECA (i.e., is not time-barred after a certain period), one approach is to manually issue final statements only for those patients where an ECA is desired.

# STEP 3: FAQS
## SEND FINAL STATEMENT

**What if a Final Statement is returned to the provider/facility as undelivered?**

The Act only establishes a presumption of receipt 3 days after mailing via USPS. If the mail is returned, this eliminates the presumption and the burden shifts to the provider to ensure receipt of final statement prior to pursuing ECA.

**What is "reasonable detail"?**

This is not defined, so a court would consider the ordinary meaning of those words in evaluating compliance with the Act.

**Must the final statement be labeled in any particular way?**

No. Unlike the CSS, there is no requirement that the final statement be identified with any specificity. It must merely contain the information contemplated in the statute.

# FEES & COSTS

| Case Type | Provider Wins | Patient Wins |
|---|---|---|
| Non-Contested Judgment | Principal + Prejudgment interest + $350* | n/a |
| Contested Judgment | Principal + Prejudgment interest + $750** | All costs, expenses, fees incurred in contesting the action. |
| Contested Against "Willful" Debtor | If costs/fees grossly disproportionate to award amount, can petition court for supplemental award. | n/a |
| Non-Compliant Action | n/a | Actual damages, including costs and attorney fees or $1,000, whichever is greater.*** |

* $350 or 100% of Principal, whichever is less; only available where strict compliance with statute.
** $750 or 100% of Principal, whichever is less; only available where strict compliance with statute.
*** If willfully or knowingly violates Act, court can award up to 3x actual damages or $3,000, whichever is greater.

# ECA FAQS

**What if we have no intention of pursuing an ECA?**

Health care facilities and providers can still utilize internal collection efforts or non-ECA methods to collect outstanding debt without complying with the Act.

**What is the consequence of pursuing an ECA without strict compliance?**

Penalties for pursuing an ECA without complying with the Act include a civil fine of $1,000 (or $3,000 if willful noncompliance) and damages incurred by patient (or 3x damages if willful).

**What if we don't use a collection agency?**

As long as you don't engage in any ECA (assign/sell/transfer debt to third-party, report to credit agency, pursue legal action), you don't need to comply with Steps 1 and 3 of the Act. However, consider whether there are downstream providers relying on your provision of a CSS to patients to preserve their right to pursue an ECA.

# OTHER FAQS

**How does the time extension in I.C. 48-313 impact compliance requirements?**

As a result of the extension, provided that rendered goods or services to a patient prior to July 1, 2021, can pursue an ECA for amounts owed for those services without strict compliance with the statutory timelines. This means that for all goods and services provided before July 1, 2021 (i.e., October 1, 2018), a provider must first comply with all applicable elements of the Act prior to pursuing an ECA.

**Are DME suppliers required to comply with the Act?**

A DME supplier is neither a health care facility nor a health care provider, as those terms are defined under the Act, and are generally not an agent of either.

**What if a patient disputes or is appealing the amount owed?**

You must wait either 60/90 days required by Act, or until the resolution of any appeal, review, or good-faith dispute, whichever is later.

# FINAL CONSIDERATIONS

- Consider:
  - Documentation requirements to demonstrate compliance with every step as prerequisite to pursuing extraordinary collection action.
  - Cost of filing fees and service fees take up large portion of cap.
  - Consider renegotiating contracts with collection agencies to allocate risk of non-compliance.
  - Consider renegotiating contracts with collection agencies so the debt remains in the name of the provider / facility.
  - Risk of damage award to patients for provider's non-compliance.
  - Providers can still engage in internal collection efforts.

# CONTINUED LOBBYING EFFORTS

IMA and other stakeholders are currently engaged in discussions with Melaleuca on opportunities to improve the Idaho Patient Act. Below are common concerns IMA and others have raised with Melaleuca regarding compliance with the Act.

- Global Fees
  - How can practices meet the timelines of IPACT in these unique circumstances.
- CSS
  - Allow an opportunity correct a CSS when a provider is inadvertently left off the CSS by the facility in charge of sending the CSS to the patient.
- Final Statement
  - The information needed to be added to Final Statement has shown to be complicated for EMR vendors and has added cost. IMA has proposed simplifying the information needed on a Final Statement. This would also address identity theft concerns by removing the patient's insurance member number from the FS.

# CONTINUED LOBBYING EFFORTS

- Definition of ECA
  - Not all ECA's are the same. Reporting to a credit bureau is an effective tool used to prompt payments from patients and avoid need for further legal proceedings.

- Bounced Check
  - When a patient passes a bad check at the time of service or any point thereafter, practices should not need to be held to the requirements of the Idaho Patient Act so they can recoup the costs of the services they rendered.

- Exempt clinical outpatient services from the requirement of the Idaho Patient Act
  - The law already recognizes that single billing providers do not need to send a CSS. However, the burdens of the Final Statement have shown to be much more complicated and thus should not need to be subject to the Idaho Patient Act.

# QUESTIONS?

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