Purpose:

This Patient Billing Guide includes important information about our patient billing practices. We encourage you to call us at any time, if you have questions about the statements you receive from one of our offices.

Our goal in the billing department of the Foot and Ankle Center of Nebraska is to process your medical bill correctly and in a timely manner. To ensure that we have the most current information when we bill your insurer, we will need a copy of your identification card for all your insurance contracts. You will also be asked to assign benefits from your insurance company to our practice, so that we might bill the insurance company on your behalf.

Other Bills You May Receive

We will send you a bill for medical services. If you had certain tests or procedures, you may also receive a separate bill from the hospital, surgical center or professional organizations providing the service such as a radiologist, pathologist or another physician. If you required anesthesia, you will receive a separate bill from the professional organization providing the anesthesia service. The hospital and/or surgical center is also responsible for billing fees.

Please Contact Us Directly with your Questions and/or Concern…

We strive to provide positive, effective and cutting edge medical services. Please feel free to contact a billing specialist with questions on costs and/or coverage of your services. We are happy to provide estimates on the cost of your care. After your care has been billed, you may also request an itemized bill to be mailed to your home. Our billing team can be contacted by mail, telephone or via email:

Billing Department, Foot and Ankle Center of Nebraska
8027 S 83rd Ave, La Vista, NE 68128
Phone: 402-932-6519
Fax: 402-934-5181
Email: billing.facnne@gmail.com

PATIENT BILLING GUIDE

Mission Statement

The Foot & Ankle Center of Nebraska shall be the CENTER OF EXCELLENCE in providing TOTAL care of the foot and ankle in Omaha and its surrounding area.

Providing complete foot and ankle care

Billing Process

The process starts at your doctor's visit. The physician evaluates your condition and renders treatment. Three primary types of service can be provided: an office visit, a procedure and/or durable medical equipment. Each new patient will have a new patient office charge. This is universal in healthcare as a patient is established in an office. This charge cannot used again unless the patient has had a three year gap in services. Follow office visits maybe charged. Procedures are codes for any physical treatment provided. This can include removing ingrown toenails, trimming callouses or performing a major surgery. The final charge is durable medical equipment or DME. These charges are for medical supplies such as a brace, bandage or crutches.

After the visit, the charges are processed by billing and sent to your insurance company. They process the claim and will do one of three things: pay the claim, deny the claim stating that the payment is your responsibility (uncovered service) or deny the claim and request more information. This part of the process can take months or even years. This is also where many patients can get confused or frustrated due to the excessive delays in the system.

After the claim is processed, our billing team then sends out statements for any balance due. Mailings from our billing department will follow the following flow:

0-30 days past due	Statement issued
31-60 days past due	Statement issued
61-90 days past due	Statement issued
91+ days past due	Demand letter sent
121+ days past due	Balance is transferred to Collection Agency

Our Third Party Collection Agency, unless otherwise prohibited by law, is authorized to contact patients 1) by telephone at the telephone number(s) provided to our office and registered to the patient's account including via wireless telephone numbers, 2) by sending text messages or emails, 3) using pre-recorded/artificial voice message or automatic daily services. Message, phone and/or data charges may apply.

This brochure is intended to serve as an educational resource for our patients. It in no way supersedes any local, state or federal laws.

The Foot and Ankle Center of Nebraska and its subsidiaries such as F.A.S.T. Physical Therapy complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Foot and Ankle Center of Nebraska also:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you believe that the Foot and Ankle Center of Nebraska has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our office:

Pam Joekel
7337 Dodge Street Omaha, NE 68114
Phone: 402-391-7575
Fax: 402-391-1508

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Pam Joekel is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW Room 509F, HHH Building
Washington, D.C. 20201
Phone1-800-368-1019, 800-537-7697 (TDD)
https://ocrportal.hhs.gov/ocr/portal/lobby.jsf,

account balance, make payment arrangements account specialists or submit application for financial assistance within 30 days of services rendered to avoid negative events as being sent to our Third Party Collection Agency.

Who determines the amount paid on office and procedural charges?

Health care payments are determined by contracts with insurance carriers. Government plans such as Medicare and Medicaid have set fee schedules for services and medical goods that we provide. These fee schedules are not negotiable and are determined on a state and national scale. Commercial carriers have negotiated contractual rates. These rates can vary even within the same commercial carrier based on your plan. The value of a procedure or service is based on three factors: physician work (54%), practice expense (41%), and malpractice expense (5%).

Can I negotiate my bill or do you provided discounts for prompt payment?

While many physician offices and hospitals may reduce the amount you owe, we do not. The amount that you owe is based on your insurance benefits. Reducing that amount by waiving co-pays and reducing deductibles collections, is illegal and is considered insurance fraud. If this occurs and you have government plan such as Medicare or Medicaid, reducing payment violates both the Stark law and Anti-Kick Back statues. If you are under an employer benefit plan, this violates the ERISA act. The only exception to these laws is if we can prove financial hardship. Please refer to the section “Financial Hardship Program” to further details.

Can I set up a payment plan on my balance?

Under certain circumstances, we will allow payment plans for outstanding balances. We attempt to arrange manageable payment plans for our patients who need further financial assistance but do not qualify for “Financial Hardship Program.” We require a credit card on file to arrange a payment plan. Payment will be charged to the card your payment has not been received through other means prior to your due date. You may also qualify for **Care Credit**, a specialized medical credit card which has various repayment options. We are proud to offer alternative payment methods to ensure our patients have access to the care that is needed. Interest and fees may apply if you choose to use our Care Credit plans.

Frequently Asked Questions

Medicare is the only insurance I have. How will you bill Medicare, and how will I know what I owe?

If you are covered by Medicare, we will help you identify any deductible and coinsurance amounts that you may owe. Once your total charges have been submitted to Medicare, you will receive from Medicare a summary statement that confirms when payment has been made. Once the Medicare payment has been applied to your account, we will then send you a bill for any amount that remains outstanding. Payment will be due within 30 days.

I have Medicare and Commercial Insurance. How will you bill my insurances and how will I know if I owe after my insurances have paid?

If you have commercial insurance secondary to Medicare, we will submit any charges to both carriers. Once your total charges have been submitted to Medicare, you will receive from Medicare a summary statement that confirms when payment has been made. The summary will also show the balance which we will forward to your secondary insurance for payment. If your secondary insurance does not pay within 60 days, we will send you a statement requesting that you contact your insurance company to determine why they have not paid. If our records do not indicate any reason to allow additional time for payment based on information you have supplied to us, any remaining balance will be your responsibility and is due within 30 days.

I have Medicare and Medicaid. How will you bill my insurances and how will I know if I owe after my insurances have paid?

If you have Medicare and Medicaid insurance, we will submit any charges to both carriers. If Medicaid requires you to make copayments for the services you received, we will notify you of your amount due based upon Nebraska Medicaid coverage guidelines. Once your total charges have been submitted to Medicare, you will receive from Medicare a summary statement that confirms when payment has been made. After we have applied the Medicare payment to your account, we will then send a bill to Medicaid for payment.

Medicare with Non-Covered Services (ABN). How are my bills processed?

Medicare will only pay for services that it determines to be "reasonable and necessary" as stated in Section 1862 (a) (1) of the Medicare law. If Medicare determines that a particular service, although it would be otherwise covered, is "not reasonable and necessary" under the Medicare program standards, Medicare will deny payment for that service. At the time the service is to be rendered, you will be asked to sign an Advance Beneficiary Notice (ABN), which identifies the services that may not be covered and for which you may be personally and fully responsible for payment.

I have Commercial Insurance. How will you bill my carriers and how will I know if I owe after my carriers have paid?

If you are covered by a commercial insurance carrier, we will help you identify any deductible and coinsurance amounts that you are required to pay. This information may be listed on your insurance card. If I is not, we will attempt to identify and collect these fees the day of your office visit. We will bill your commercial insurance following your date of service. Your commercial insurance will send you an explanation of benefits summarizing the payment and your account balance. After applying the commercial insurance payment, we will send a claim to any applicable secondary insurance or will send you a bill for any amount your commercial insurance states you owe. Payment is due within 30 days.

I am uninsured (have no insurance). How does billing work?

If you are uninsured, we will attempt to provide a free estimate of expected charges based on the anticipated services. We require all uninsured patients to provide a $300 deposit prior to receiving services. This can be paid in cash, debit card or credit card. Final charges will be determined by your provider at the completion of your visit. If the charges are less than the deposit, you will receive an immediate refund. If the charges exceed $300, payment is required at that time.

I went to F.A.S.T. Physical Therapy not the Foot and Ankle Center of Nebraska, why did I get a bill?

F.A.S.T. Physical therapy is a subsidiary company to the Foot and Ankle Center of Nebraska. All billing is processed by the Foot and Ankle Center of Nebraska.

Why was I asked for a down payment?

Many of new insurance plans have high out of pocket limits. If you have one of these plans and are having a procedure performed or ordering a custom medical device, we may request a down payment prior to scheduling the procedure or ordering the device. The down payment can and will be used towards any current outstanding or future balance. If excess funds are collect or the procedure is cancelled, these funds will be refunded promptly. We have the right to retain any down payment if an outstanding balance is present at the time of requested refund. All funds paid by an HSA account must be refunded to the HSA account to prevent triggering a tax penalty.

Why was I asked to file my credit or debit card?

If you have arranged a payment plan or have a down payment for a surgical procedure, we may request a credit or debit card on file. If you fail to pay your balance or payment as scheduled, your credit or debit card will be charged. This will continue until your balance is paid in full

Financial Hardship Program

Patients with balances due resulting from limited or no insurance coverage may qualify for our Financial Hardship Program. This application is appropriate for patients who meet the financial eligibility rules and have no insurance a remaining balances due follow the payment by the insurance carrier. We use the current poverty income guidelines issued by the US Department of Health and Human Services to determine a person's eligibility for indigent care. Full or partial eligibility is determined by documented family income and family size. The patient is responsible for providing information requested during the qualification process. A determination letter will be mailed to you after receipt of the fully completed application and requested supporting documentation. If you have been approved, you should contact one of our Billing Specialist Manager. Once approved, a billing specialist will work to create a repayment option which may include a payment plan and/or balanced adjustments. This will occur to all current charges and future charges up to 30 days from the application date. If further care is necessary outside of 30days from approval, a second application will be necessary.