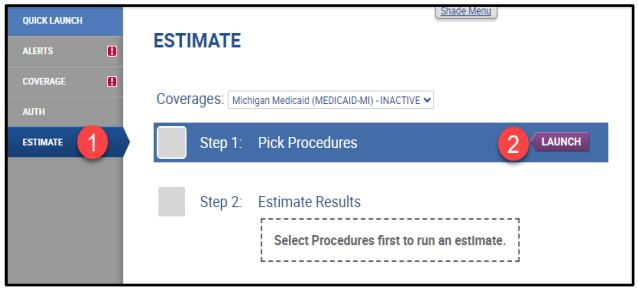
eCare NEXT Patient Estimates Workflows for Clerical Staff

Before creating a patient estimate, eligibility must be submitted. If a Historical Result alert is received, resubmit the eligibility from the coverage chevron to obtain a fresh result. If updates need to be made, make the changes in Cerner Revenue Cycle, then submit eligibility to ensure an accurate response. **For more eligibility information, see [eCare NEXT Response.pdf (munsonhealthcare.org)](#).**

Launching Procedure Selection

From the patient's eCare NEXT response:

1. Click the Estimate chevron
2. Click Launch to the access Select Procedure(s) window



There are four ways to select procedure(s) to include in the estimate:

1. **Claims Search** – used for an enhanced historical claim database search – variable pricing (IP stays, surgery, etc.)
2. **Easy Search** – used for services that are in the charge master – fixed pricing – most commonly used search function
3. **Generic Procedures** – used to add a procedure code not found in the Charge Description Master (CDM) or historical claims search – the price must be known, and manager approval is needed
4. **Series/Therapy Visit** – used for multiple/recurring visits

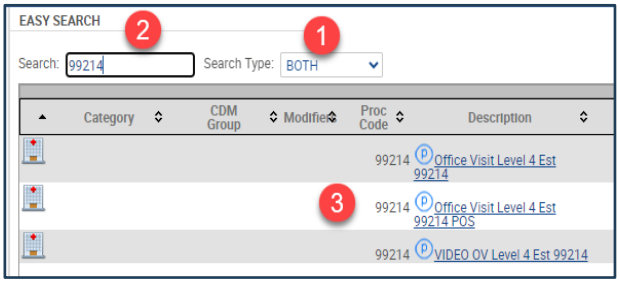
After selecting a procedure code search option, additional fields need completion. Fields with a red asterisk are required.

Easy Search

Easy Search is the most common and easiest way to search for procedure codes.

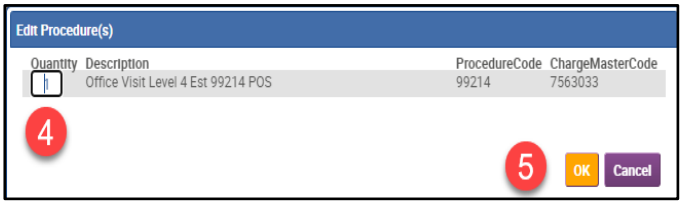
Easy Search:

1. Select CDM or BOTH from the drop-down menu
2. Search for a procedure by code or description
3. Click the hyperlinked Description to edit



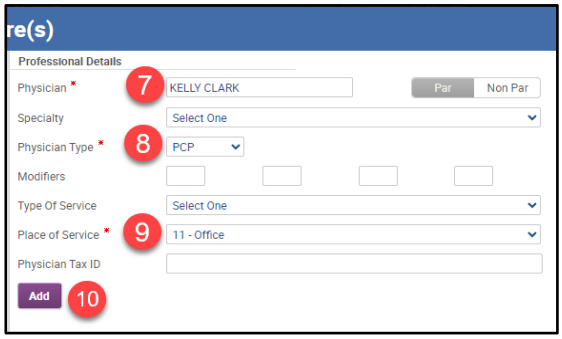
Edit Procedure(s):

4. Change the quantity if desired
5. Click OK



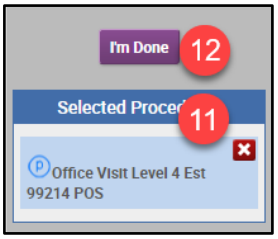
Professional Details:

7. Select Physician
8. Select Physician Type
9. Select Place of Service
10. Click Add



The procedure will be added to the Selected Procedures List:

11. Click the X to remove procedures entered in error
12. Click I'm Done after all procedures have been selected

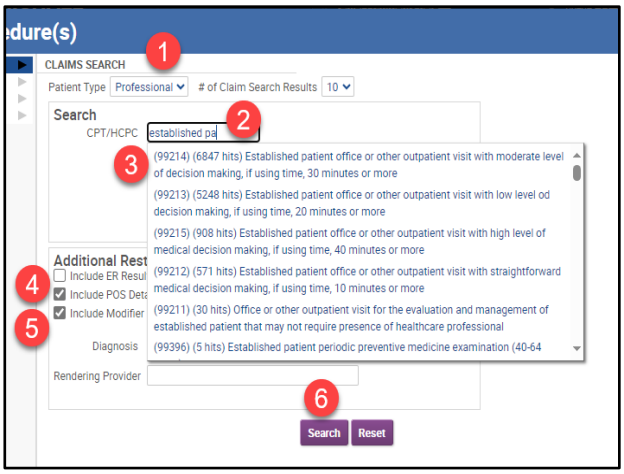


Claims Search

Claims Search is used for procedures with variable pricing and applies existing claims data to provide a historical claim price when a procedure or diagnosis is searched.

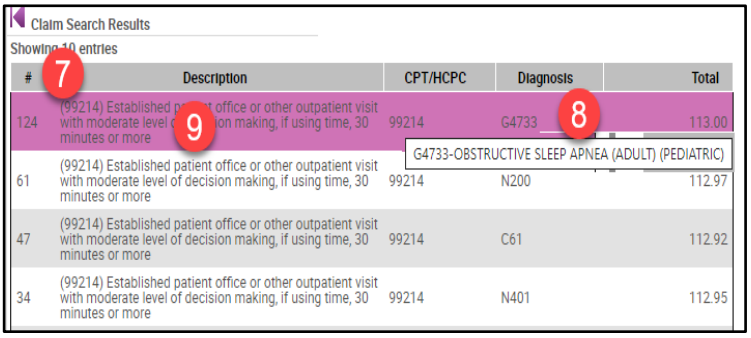
Claims Search:

1. Search for the CPT by description or code
2. Results will display codes with the number of claims or "hits" for each code
3. Select a code
4. Check Include POS Details
5. Check Include Modifier
6. Click Search



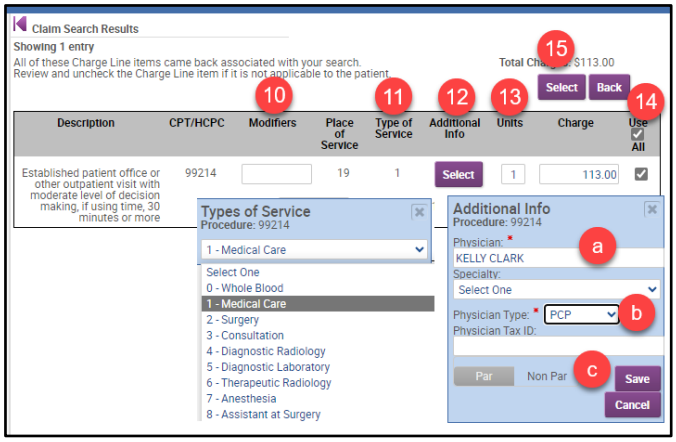
Claim Search Results breaks down the claims by diagnosis and revenue codes that were found within historical claims data:

7. Hovering over a diagnosis will display a description
8. Select a procedure code to continue – If a user does not know the diagnosis code, best practice is to pick the top result



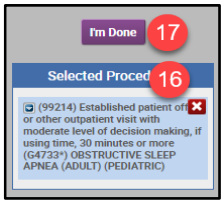
Breakdown of charge line items:

10. Enter Modifiers if needed
11. Select the Type of Service
12. Select Additional Info
    a. Choose the Physician
    b. Choose the Physician Type
    c. Click Save
13. Adjust the number of units, if applicable
14. If multiple procedures are displayed, uncheck those that are not applicable
15. Click Select



The procedure will be added to the Selected Procedures List:

16. Click the X to remove procedures entered in error
17. Click I'm Done after all procedures have been selected

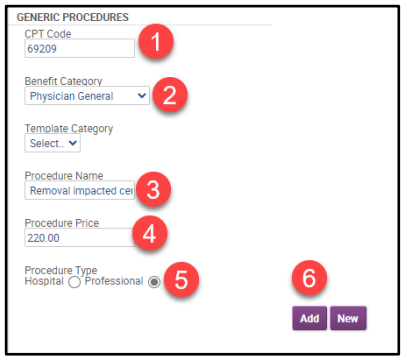


Generic Procedures

Generic Procedures is used to add a procedure not found in the charge master (CDM) or historical claims search. The price must be known, and approval must be received from the Practice Manager and CBO, before utilizing this code search function.

Generic Procedures:

1. Enter the CPT Code
2. Select the Benefit Category
3. Enter the Procedure Name
4. Enter the Procedure Price
5. Procedure Type: click Professional
6. Click Add

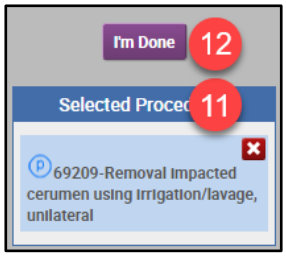


Professional Details:

7. Select the Physician
8. Select the Physician Type
9. Select Place of Service
10. Click Add

The procedure will be added to the Selected Procedures List:

11. Click the X to remove procedures entered in error
12. Click I'm Done after all procedures have been selected

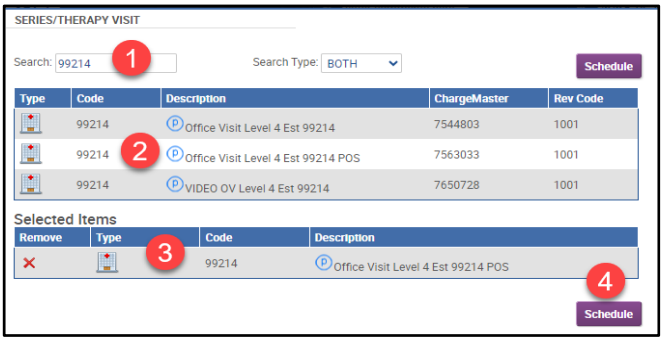


Series/Therapy Visit

Series/Therapy Visit is used for multiple/recurring visits.

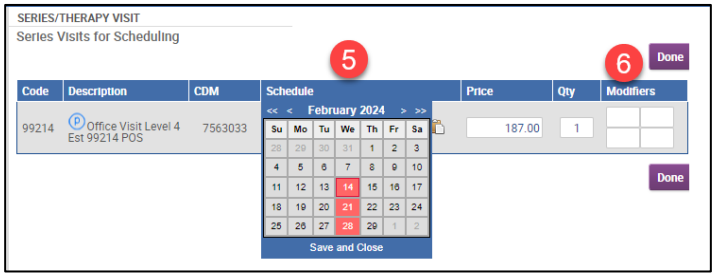
Select the procedure:

1. Search for the Procedure
2. Select the appropriate procedure from the list
3. The procedure will move below to Selected Items
4. Click Schedule



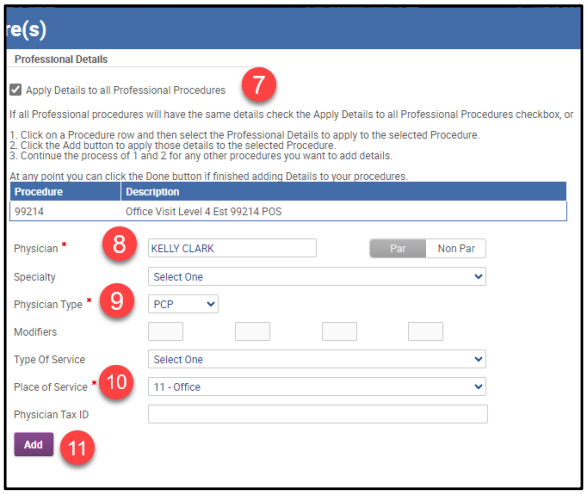
Series Visits for Scheduling:

5. Select the visit dates on the calendar, then click Save and Close
6. Click Done



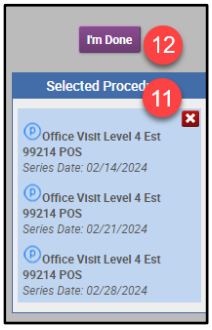
Professional Details:

7. Check Apply Details to all Professional Procedures (or uncheck to enter details separately)
8. Select the Physician
9. Select the Physician Type
10. Select the Place of Service
11. Click Add



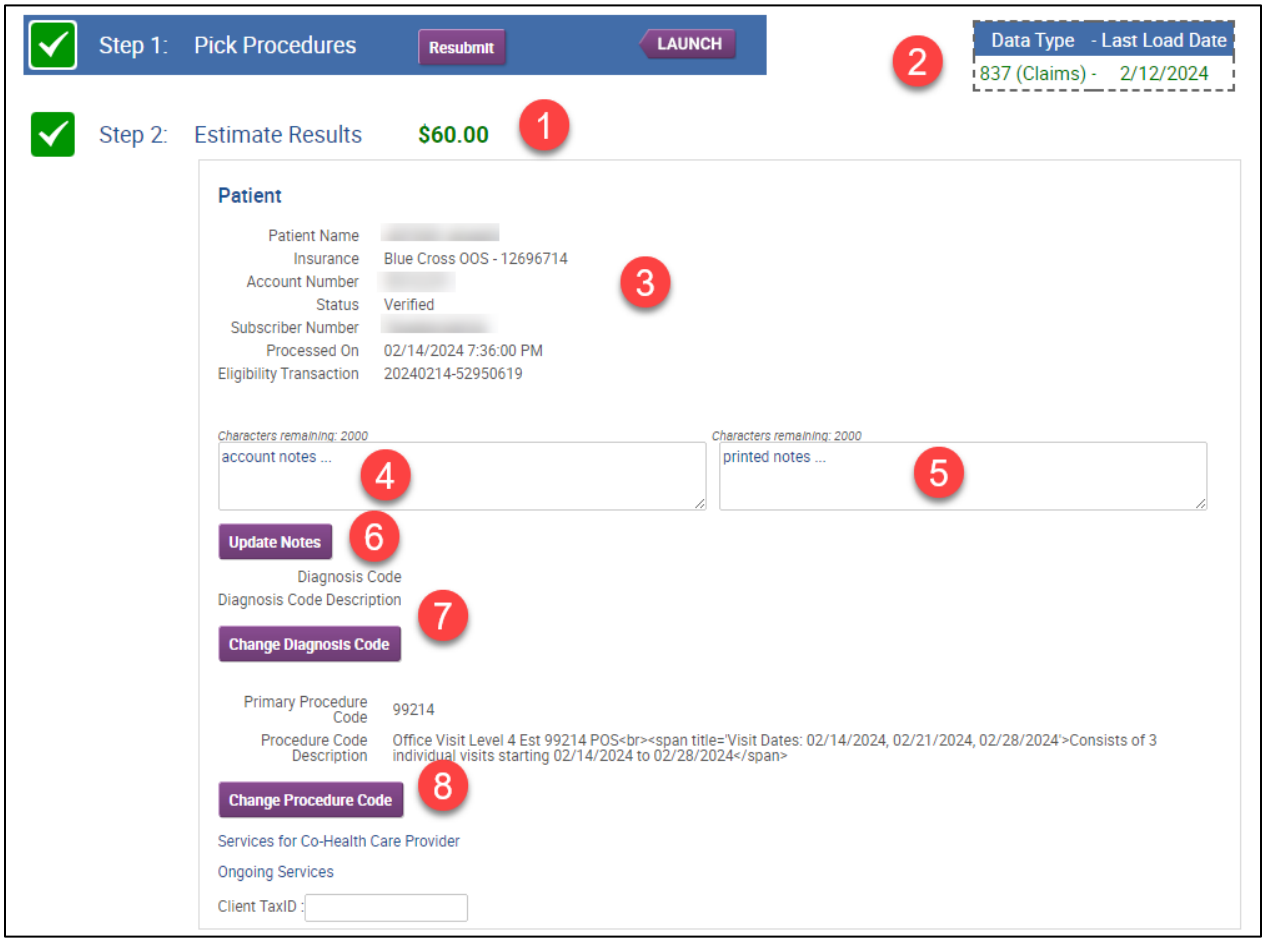
The procedure will be added to the Selected Procedures List:

11. Click the X to remove procedures entered in error
12. Click I'm Done after all procedures have been selected



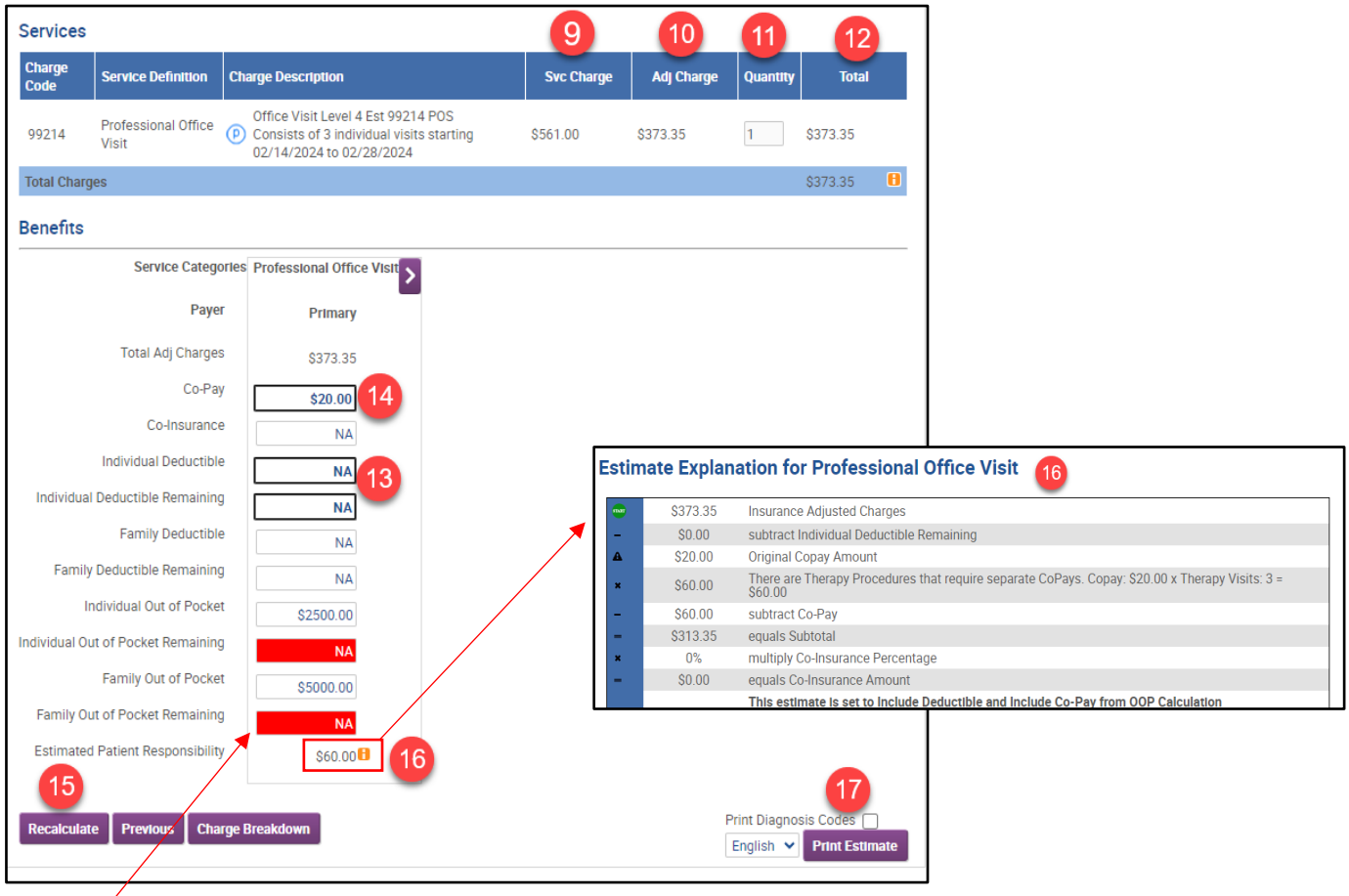
Patient Estimate Result

1. Estimated Patient Responsibility (EPR) is the **Green Dollar Amount** at the top of the estimate
2. Data Type indicates the date the last 837 Claims File was uploaded to Experian
3. Overview of the patient and insurance information used to value the estimate
4. Account notes can be entered, and are for internal use only - they do NOT print on the estimate
5. Printed notes will print on the estimate given to the patient
6. Click Update Notes to save account and printed notes
7. Change Diagnosis Code must be selected for Self-Pay patients
8. Change Procedure Code can be used to update procedure codes, but the estimate must be recalculated



Services and Benefits:

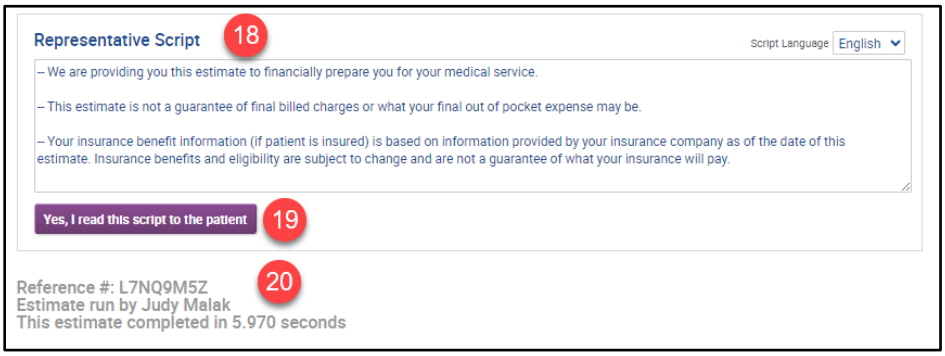
9. The Svc Charge is the full price of the procedure in the Charge Description Master (CDM)
10. The Adj Charge is the insurance contracted rate
    a. Click the orange i icon to view additional details
11. Quantity may be adjusted as needed
12. Total is the Adj Charge multiplied by the Quantity
13. Fields containing NA, a ?, or are blank indicate that the eligibility response did not contain information for that benefit category
14. Fields with a bold black box around them indicate that those benefits are being applied to the estimate; gray boxes are not used to calculate the estimate
15. Click the Recalculate button if changes have been made to the estimate information
16. Click the information icon to display the Estimate Explanation
17. Click Print Estimate to generate a PDF of the estimate



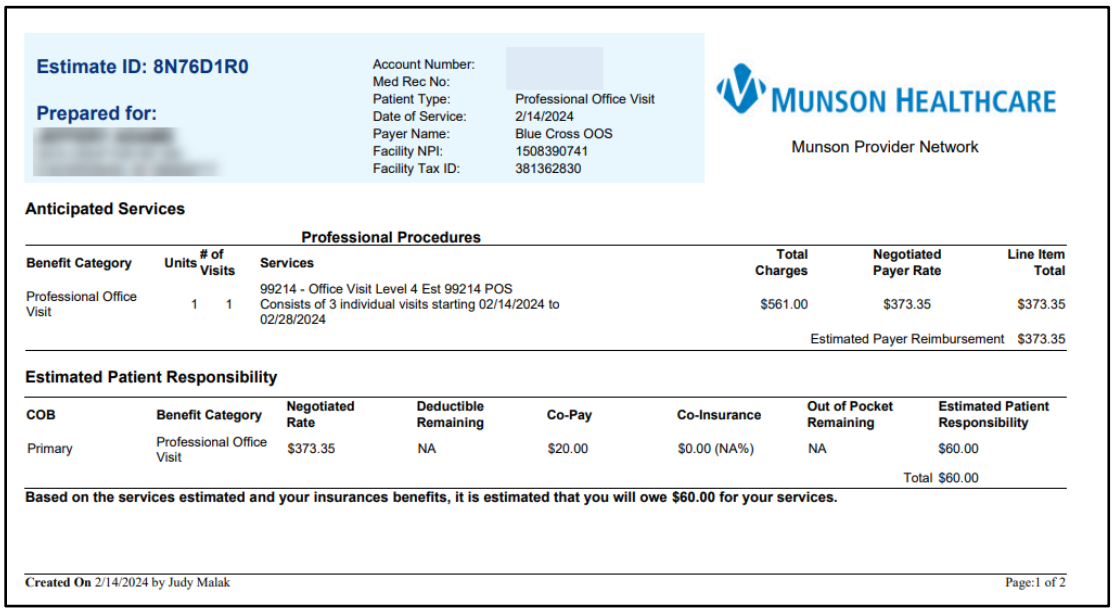
If a field has no data but is being used to calculate the estimate, it will appear in red.

Representative Script includes a reminder that the patient is being provided with an estimate NOT a guarantee of final billed charges:

18. Read the Script to the patient
19. Click Yes, I read the script to the patient
20. The reference number is located at the bottom of every estimate
    a. The Reference # helps identify estimates and locate them in the eCare NEXT Shade Menu for 60 days from the encounter date of service. Historical estimates can also be found in Revenue Cycle at the encounter level.



Printed Estimate - Page 1 (of 2) for Insured Patient



Estimate ID: 8N76D1R0

Prepared for:

[redacted]

Account Number:	
Med Rec No:	
Patient Type:	Professional Office Visit
Date of Service:	2/14/2024
Payer Name:	Blue Cross OOS
Facility NPI:	1508390741
Facility Tax ID:	381362830

MUNSON HEALTHCARE
Munson Provider Network

Anticipated Services

Professional Procedures

Benefit Category	Units	# of Visits	Services	Total Charges	Negotiated Payer Rate	Line Item Total
Professional Office Visit	1	1	99214 - Office Visit Level 4 Est 99214 POS Consists of 3 individual visits starting 02/14/2024 to 02/28/2024	$561.00	$373.35	$373.35
					Estimated Payer Reimbursement	$373.35

Estimated Patient Responsibility

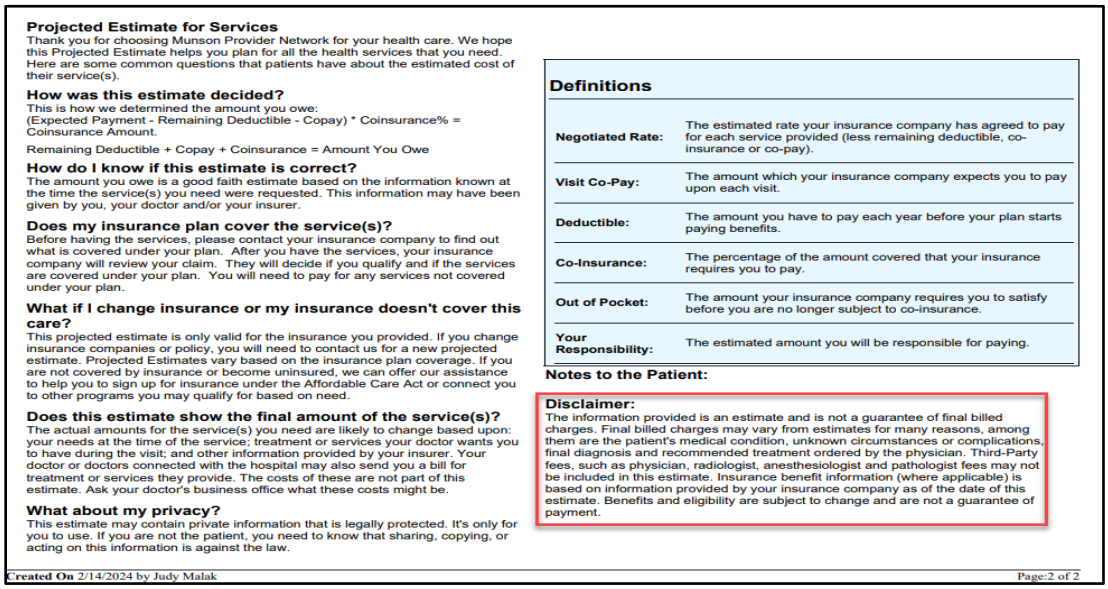
COB	Benefit Category	Negotiated Rate	Deductible Remaining	Co-Pay	Co-Insurance	Out of Pocket Remaining	Estimated Patient Responsibility
Primary	Professional Office Visit	$373.35	NA	$20.00	$0.00 (NA%)	NA	$60.00
						Total	$60.00

Based on the services estimated and your insurances benefits, it is estimated that you will owe $60.00 for your services.

Created On 2/14/2024 by Judy Malak

Page:1 of 2

Printed Estimate – Page 2 (of 2) for Insured Patient



Projected Estimate for Services

Thank you for choosing Munson Provider Network for your health care. We hope this Projected Estimate helps you plan for all the health services that you need. Here are some common questions that patients have about the estimated cost of their service(s).

How was this estimate decided?

This is how we determined the amount you owe:
(Expected Payment - Remaining Deductible - Copay) * Coinsurance% = Coinsurance Amount.

Remaining Deductible + Copay + Coinsurance = Amount You Owe

How do I know if this estimate is correct?

The amount you owe is a good faith estimate based on the information known at the time the service(s) you need were requested. This information may have been given by you, your doctor and/or your insurer.

Does my insurance plan cover the service(s)?

Before having the services, please contact your insurance company to find out what is covered under your plan. After you have the services, your insurance company will review your claim. They will decide if you qualify and if the services are covered under your plan. You will need to pay for any services not covered under your plan.

What if I change insurance or my insurance doesn't cover this care?

This projected estimate is only valid for the insurance you provided. If you change insurance companies or policy, you will need to contact us for a new projected estimate. Projected Estimates vary based on the insurance plan coverage. If you are not covered by insurance or become uninsured, we can offer our assistance to help you to sign up for insurance under the Affordable Care Act or connect you to other programs you may qualify for based on need.

Does this estimate show the final amount of the service(s)?

The actual amounts for the service(s) you need are likely to change based upon: your needs at the time of the service; treatment or services your doctor wants you to have during the visit; and other information provided by your insurer. Your doctor or doctors connected with the hospital may also send you a bill for treatment or services they provide. The costs of these are not part of this estimate. Ask your doctor's business office what these costs might be.

What about my privacy?

This estimate may contain private information that is legally protected. It's only for you to use. If you are not the patient, you need to know that sharing, copying, or acting on this information is against the law.

Definitions

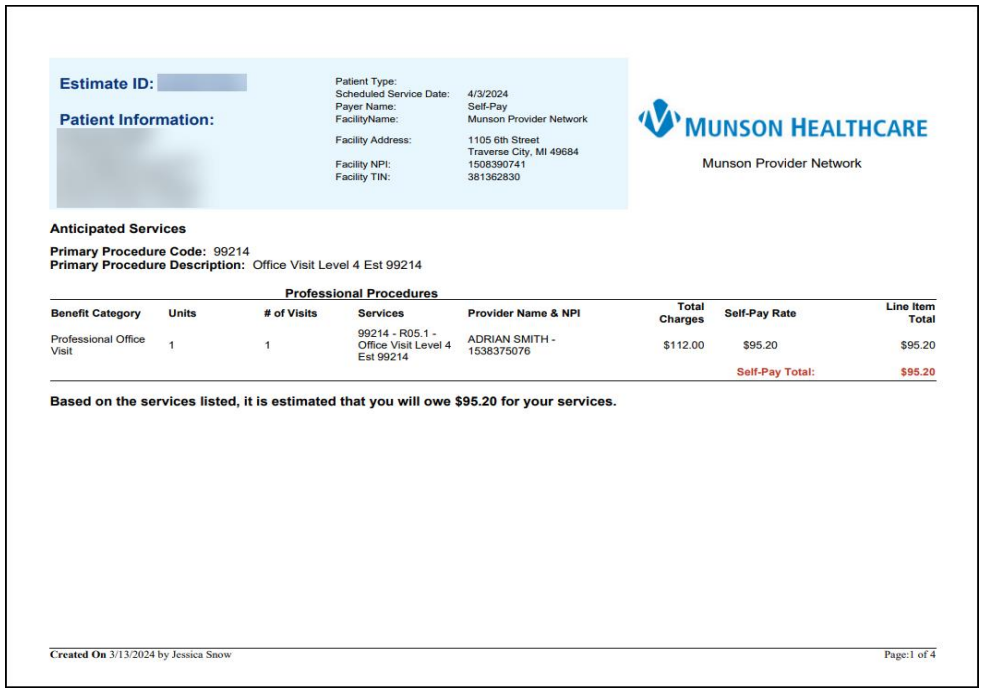
Negotiated Rate:	The estimated rate your insurance company has agreed to pay for each service provided (less remaining deductible, co-insurance or co-pay).
Visit Co-Pay:	The amount which your insurance company expects you to pay upon each visit.
Deductible:	The amount you have to pay each year before your plan starts paying benefits.
Co-Insurance:	The percentage of the amount covered that your insurance requires you to pay.
Out of Pocket:	The amount your insurance company requires you to satisfy before you are no longer subject to co-insurance.
Your Responsibility:	The estimated amount you will be responsible for paying.

Notes to the Patient:

Disclaimer:
The information provided is an estimate and is not a guarantee of final billed charges. Final billed charges may vary from estimates for many reasons, among them are the patient's medical condition, unknown circumstances or complications, final diagnosis and recommended treatment ordered by the physician. Third-Party fees, such as physician, radiologist, anesthesiologist and pathologist fees may not be included in this estimate. Insurance benefit information (where applicable) is based on information provided by your insurance company as of the date of this estimate. Benefits and eligibility are subject to change and are not a guarantee of payment.

Created On 2/14/2024 by Judy Malak Page:2 of 2

Printed Estimate PDF - Page 1 (of 4) for Self-Pay Patient



Estimate ID: [redacted]

Patient Information: [redacted]

Patient Type:
Scheduled Service Date: 4/3/2024
Payer Name: Self-Pay
FacilityName: Munson Provider Network
Facility Address: 1105 6th Street Traverse City, MI 49684
Facility NPI: 1508390741
Facility TIN: 381362830

MUNSON HEALTHCARE
Munson Provider Network

Anticipated Services

Primary Procedure Code: 99214
Primary Procedure Description: Office Visit Level 4 Est 99214

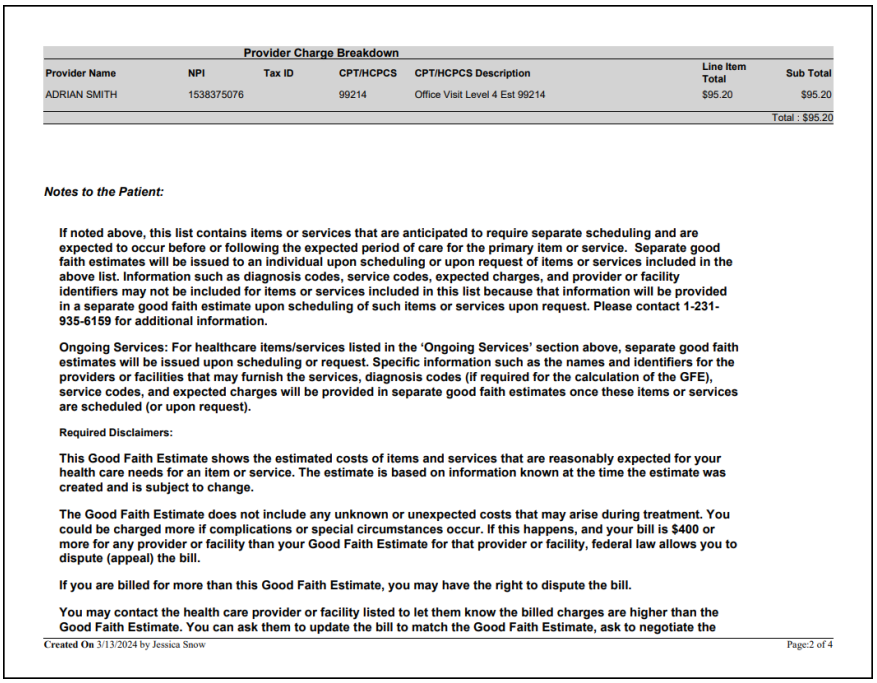
Professional Procedures

Benefit Category	Units	# of Visits	Services	Provider Name & NPI	Total Charges	Self-Pay Rate	Line Item Total
Professional Office Visit	1	1	99214 - R05.1 - Office Visit Level 4 Est 99214	ADRIAN SMITH - 1538375076	$112.00	$95.20	$95.20
						Self-Pay Total:	**$95.20**

Based on the services listed, it is estimated that you will owe $95.20 for your services.

Created On 3/13/2024 by Jessica Snow Page:1 of 4

Printed Estimate PDF - Page 2 (of 4) for Self-Pay Patient



Provider Charge Breakdown

Provider Name	NPI	Tax ID	CPT/HCPCS	CPT/HCPCS Description	Line Item Total	Sub Total
ADRIAN SMITH	1538375076		99214	Office Visit Level 4 Est 99214	$95.20	$95.20
						Total : $95.20

Notes to the Patient:

If noted above, this list contains items or services that are anticipated to require separate scheduling and are expected to occur before or following the expected period of care for the primary item or service. Separate good faith estimates will be issued to an individual upon scheduling or upon request of items or services included in the above list. Information such as diagnosis codes, service codes, expected charges, and provider or facility identifiers may not be included for items or services included in this list because that information will be provided in a separate good faith estimate upon scheduling of such items or services upon request. Please contact 1-231-935-6159 for additional information.

Ongoing Services: For healthcare items/services listed in the 'Ongoing Services' section above, separate good faith estimates will be issued upon scheduling or request. Specific information such as the names and identifiers for the providers or facilities that may furnish the services, diagnosis codes (if required for the calculation of the GFE), service codes, and expected charges will be provided in separate good faith estimates once these items or services are scheduled (or upon request).

Required Disclaimers:

This Good Faith Estimate shows the estimated costs of items and services that are reasonably expected for your health care needs for an item or service. The estimate is based on information known at the time the estimate was created and is subject to change.

The Good Faith Estimate does not include any unknown or unexpected costs that may arise during treatment. You could be charged more if complications or special circumstances occur. If this happens, and your bill is $400 or more for any provider or facility than your Good Faith Estimate for that provider or facility, federal law allows you to dispute (appeal) the bill.

If you are billed for more than this Good Faith Estimate, you may have the right to dispute the bill.

You may contact the health care provider or facility listed to let them know the billed charges are higher than the Good Faith Estimate. You can ask them to update the bill to match the Good Faith Estimate, ask to negotiate the

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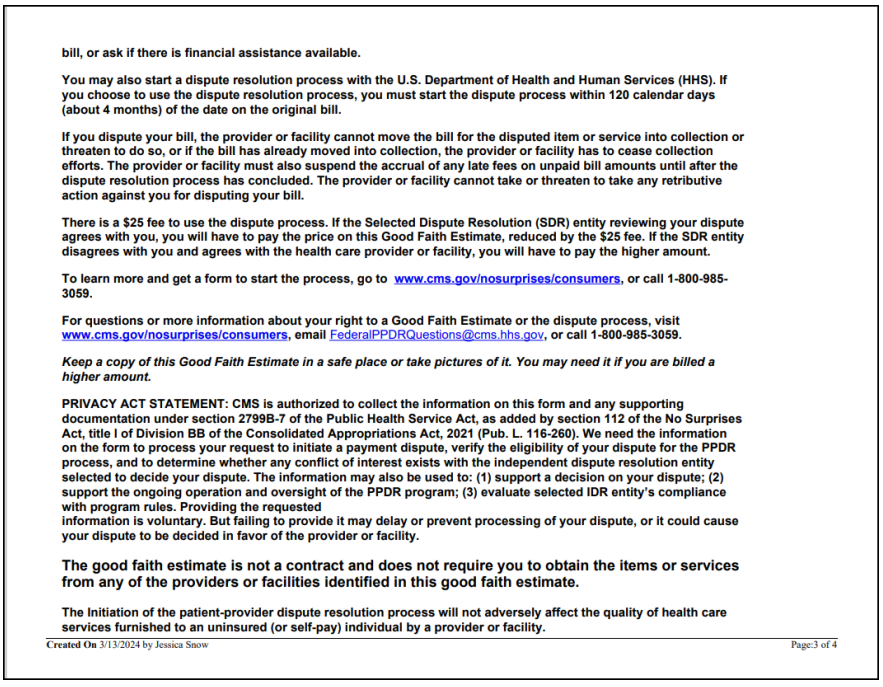
Printed Estimate PDF - Page 3 (of 4) for Self-Pay Patient



bill, or ask if there is financial assistance available.

You may also start a dispute resolution process with the U.S. Department of Health and Human Services (HHS). If you choose to use the dispute resolution process, you must start the dispute process within 120 calendar days (about 4 months) of the date on the original bill.

If you dispute your bill, the provider or facility cannot move the bill for the disputed item or service into collection or threaten to do so, or if the bill has already moved into collection, the provider or facility has to cease collection efforts. The provider or facility must also suspend the accrual of any late fees on unpaid bill amounts until after the dispute resolution process has concluded. The provider or facility cannot take or threaten to take any retributive action against you for disputing your bill.

There is a $25 fee to use the dispute process. If the Selected Dispute Resolution (SDR) entity reviewing your dispute agrees with you, you will have to pay the price on this Good Faith Estimate, reduced by the $25 fee. If the SDR entity disagrees with you and agrees with the health care provider or facility, you will have to pay the higher amount.

To learn more and get a form to start the process, go to www.cms.gov/nosurprises/consumers, or call 1-800-985-3059.

For questions or more information about your right to a Good Faith Estimate or the dispute process, visit www.cms.gov/nosurprises/consumers, email FederalPPDRQuestions@cms.hhs.gov, or call 1-800-985-3059.

Keep a copy of this Good Faith Estimate in a safe place or take pictures of it. You may need it if you are billed a higher amount.

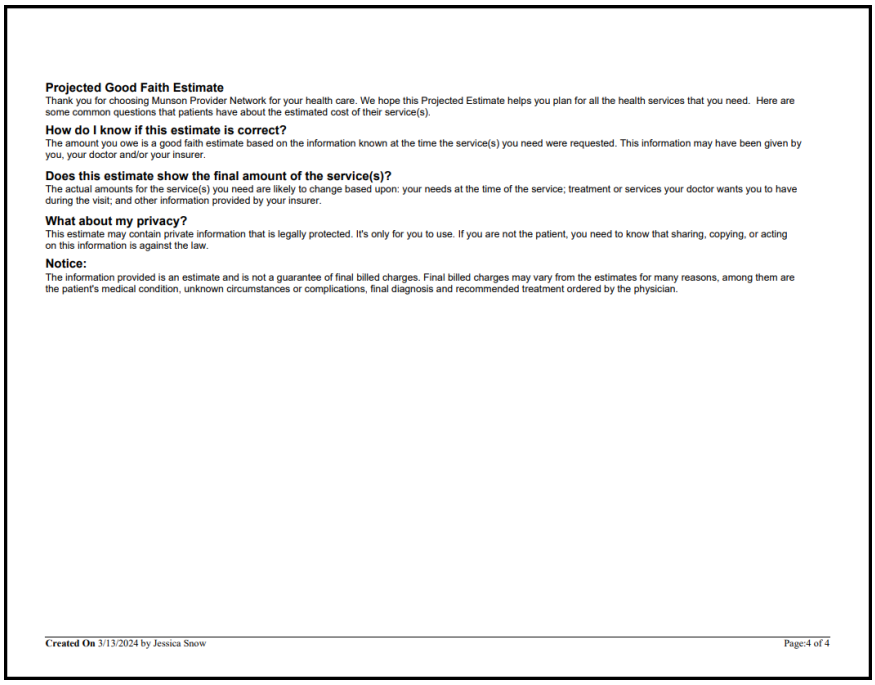
PRIVACY ACT STATEMENT: CMS is authorized to collect the information on this form and any supporting documentation under section 2799B-7 of the Public Health Service Act, as added by section 112 of the No Surprises Act, title I of Division BB of the Consolidated Appropriations Act, 2021 (Pub. L. 116-260). We need the information on the form to process your request to initiate a payment dispute, verify the eligibility of your dispute for the PPDR process, and to determine whether any conflict of interest exists with the independent dispute resolution entity selected to decide your dispute. The information may also be used to: (1) support a decision on your dispute; (2) support the ongoing operation and oversight of the PPDR program; (3) evaluate selected IDR entity's compliance with program rules. Providing the requested information is voluntary. But failing to provide it may delay or prevent processing of your dispute, or it could cause your dispute to be decided in favor of the provider or facility.

The good faith estimate is not a contract and does not require you to obtain the items or services from any of the providers or facilities identified in this good faith estimate.

The Initiation of the patient-provider dispute resolution process will not adversely affect the quality of health care services furnished to an uninsured (or self-pay) individual by a provider or facility.

Created On 3/13/2024 by Jessica Snow Page:3 of 4

Printed Estimate PDF - Page 4 (of 4) for Self-Pay Patient



Projected Good Faith Estimate

Thank you for choosing Munson Provider Network for your health care. We hope this Projected Estimate helps you plan for all the health services that you need. Here are some common questions that patients have about the estimated cost of their service(s).

How do I know if this estimate is correct?

The amount you owe is a good faith estimate based on the information known at the time the service(s) you need were requested. This information may have been given by you, your doctor and/or your insurer.

Does this estimate show the final amount of the service(s)?

The actual amounts for the service(s) you need are likely to change based upon: your needs at the time of the service; treatment or services your doctor wants you to have during the visit; and other information provided by your insurer.

What about my privacy?

This estimate may contain private information that is legally protected. It's only for you to use. If you are not the patient, you need to know that sharing, copying, or acting on this information is against the law.

Notice:

The information provided is an estimate and is not a guarantee of final billed charges. Final billed charges may vary from the estimates for many reasons, among them are the patient's medical condition, unknown circumstances or complications, final diagnosis and recommended treatment ordered by the physician.

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