NO SURPRISE BILLING RULE PART 2: WHAT PROVIDERS NEED TO KNOW

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(11-21)

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WRITTEN MATERIALS

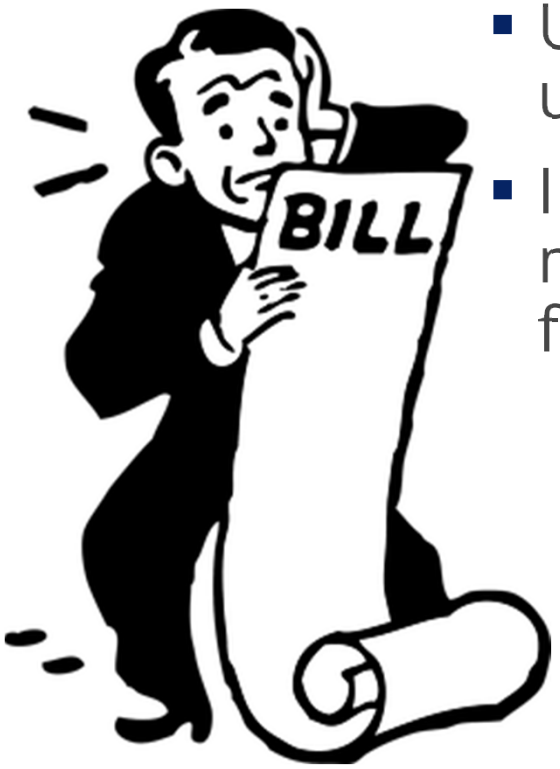
- Part 1
  - No Surprise Billing Rule Part 1, 86 FR 36872 (7/13/21), https://www.govinfo.gov/content/pkg/FR-2021-07-13/pdf/2021-14379.pdf
  - Fact Sheet, *Requirements Related to Surprise Billing; Part I Interim Final Rule with Comment Period*, https://www.cms.gov/newsroom/fact-sheets/requirements-related-surprise-billing-part-i-interim-final-rule-comment-period
- Part 2
  - No Surprise Billing Rule Part 2, 86 FR 55980 (10/7/21), https://www.cms.gov/regulations-and-guidancelegislationpaperworkreductionactof1995pra-listing/cms-10791
  - Fact Sheet, Requirements Related to Surprise Billing; Part II Interim Final Rule with Comment Period, https://www.cms.gov/newsroom/fact-sheets/requirements-related-surprise-billing-part-ii-interim-final-rule-comment-period

WRITTEN MATERIALS

- Part 1 Forms, available at https://www.cms.gov/httpswwwcmsgovregulations-and-guidancelegislationpaperworkreductionactof1995pra-listing/cms-10780
  - Model Notice re Patient Protections against Surprise Billing
  - Model Notice and Consent to Balance Billing
- Part 2 Forms, available at https://www.cms.gov/regulations-and-guidancelegislationpaperworkreductionactof1995pra-listing/cms-10791
  - Model Notice re Right to Receive Good Faith Estimate of Expected Charges
  - Good Faith Estimate Template
  - Good Faith Estimate Data Elements
  - SDR Determination Notice to Parties
  - Payment Settlement Form

HTTPS://WWW.CMS.GOV/NOSURPRISES/POLICIES-AND-RESOURCES/OVERVIEW-OF-RULES-FACT-SHEETS

PROBLEM: SURPRISE MEDICAL BILLS



- Uninsured or self-pay patient receives unexpected medical bill.
- Insured patient receives unexpected medical bill from out-of-network ("OON") facility or provider:
  - Emergency services rendered by OON facility or provider.
    - E.g., payer limits coverage for emergency services, requires preauthorization, etc.
  - OON providers at in-network facility bill separately from facility.
    - E.g., surgeons, anesthesiology, radiology, pathology, surgical assists, labs, etc.

NO SURPRISE BILLING RULES: EFFECTIVE **JANUARY 1, 2022**

Insured Patients

- Limits amount OON provider/facility may bill patient and payer for
  - Emergency services at emergency facility, or
  - Non-emergency services by OON provider at in-network facility, or
  - Air ambulance services.
- Notice of rights to patient.

(Part 1, 86 FR 36872 (7/13/21)

- Independent dispute resolution process ("IDR") for OON providers/facilities and payers

(Part 2, 86 FR 55980 (9/30/21))

Self-Pay Patients

- Providers/facilities must give patient a good faith estimate of charges.
- Selected dispute resolution process ("SDR") if actual bill is substantially in excess of good faith estimate.
- Notice of rights to patient.

(Part 2, 86 FR 55980 (9/30/21))

➢ Penalties

- $10,000 civil penalty (see No Surprise Act § 2799D; 45 CFR 150.513; 86 FR 51730)
- Limited or denied payment (see regulations)

NO SURPRISE BILLING RULES: EFFECTIVE **JANUARY 1, 2022**

Insured Patients

- Limits amount OON provider/facility may bill patient or payer for
  - Emergency services at emergency facility, or
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(Part 1, 86 FR 36872 (7/13/21)

- Independent dispute resolution process ("IDR") for OON providers/facilities and payers

(Part 2, 86 FR 55980 (9/30/21))

Self-Pay Patients

- Pr ers/facilities must
- No of rights to patient.

(Part 2, 86 FR 55980 (9/30/21))

We covered this in Webinar on August 19, 2021

➢ Penalties
- $10,000 civil penalty (see No Surprise Act § 2799D)
- Limited or denied payment (see regulations)

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NO SURPRISE BILLING RULE PART 1

No Surprise Billing Rule: What Providers Need to Know
(August 19, 2021)

available at
https://www.hollandhart.com/no-surprise-billing-rule-what-providers-need-to-know

NO SURPRISE BILLING RULES: EFFECTIVE **JANUARY 1, 2022**

Insured Patients

- Limits amount OON provider[illegible] patient [illegible]
  - Eme[illegible] eme[illegible]
  - Non-[illegible]ency services by O[illegible]vider at in-netw[illegible]ility, or
  - Air a[illegible]nce services.
- Notice o[illegible]s to patient.

(Part 1, 86 FR [illegible]872 (7/13/21)

- Independent dispute resolution process ("IDR") for OON providers/facilities and payers

(Part 2, 86 FR 55980 (9/30/21))

Today

Self-Pay Patients

- Providers/facilities must give patient a good faith estimate of charges.
- Selected dispute resolution process ("SDR") if actual bill is substantially in excess of good faith estimate.
- Notice of rights to patient.

(Part 2, 86 FR 55980 (9/30/21))

➢ Penalties
- $10,000 civil penalty (see No Surprise Act § 2799D)
- Limited or denied payment (see regulations)

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DISCUSSION TODAY

- Insured patients
  - IDR process for disputes between OON providers/facilities and payers re:
    - Emergency services by OON provider/facility
    - Non-emergency services by OON provider at in-network facility
- Self-pay patients
  - Good faith estimate to self-pay patients
    - Notice to patients
    - Confirmation of self-pay status
    - Good faith estimate
  - SDR process if actual charges are substantially in excess (>$400) of good faith estimate
- Action items to comply by **January 1, 2022.**

PAYMENT BY PAYER TO OON PROVIDER/FACILITY

OON RATE PAID TO OON PROVIDER/FACILITY

- Applies to:
  - Emergency service furnished by OON provider or OON facility at an emergency facility.
    - Facility = emergency dept of hospital or independent freestanding emergency dept as licensed by state (may include urgent care center) (86 FR 36879)
  - Non-emergency item or service furnished by an OON provider at an in-network facility.
    - Facility = hospital, hospital outpatient dept, CAH, or ASC that has a contract with a health plan covering the services provided, including single case agreements. (86 FR 36882).

(45 CFR 149.510(b)(1))

OON RATE PAID TO OON PROVIDER/FACILITY

- Total amount paid to OON provider/facility, including any patient cost-sharing amount =
  - Amount determined by applicable All-Payer Model Agreement under the SSA; or
  - If there is no applicable All-Payer Model Agreement, amount determined by state law; or
  - If neither of the foregoing apply, an amount agreed upon by the payer and provider/facility during 30-day "open negotiation" period; or
  - If plan and provider/facility cannot agree, amount determined through independent dispute resolution ("IDR") process.

(*CMS, Requirements Related to Surprise Billing; Part I Interim Final Rule with Comment Period*, https://www.cms.gov/newsroom/fact-sheets/requirements-related-surprise-billing-part-i-interim-final-rule-comment-period)

30-DAY OPEN NEGOTIATION PERIOD

- To initiate 30-day open negotiation period:
  - Within 30 days after the OON provider/facility receives either the initial payment or notice of denial, send notice to other party using HHS form.
    - Paper, or
    - E-mail, if good faith belief other party will receive it.
  - Notice must include:
    - Items and services furnished;
    - Date items or services furnished;
    - Service code;
    - Initial payment amount (if applicable);
    - Offer of OON rate; and
    - Contact info of person sending the open negotiation notice.
- 30-day open negotiation period begins the day the notice is sent.

(45 CFR 149.510(b)(1))

OPEN NEGOTIATION PERIOD: NOTICE OF INITIATION

OMB Control No. 1210-0169
Expiration Date: 4/30/2022

Open Negotiation Notice

[Enter date of this notice]

You are receiving this notice because [*Enter name of party initiating negotiations*], a(n) [group health plan, health insurance issuer, Federal employee health benefits (FEHB) carrier, health care provider, health care facility, or provider of air ambulance services] is disputing the out-of-network rate for [*insert appropriate descriptor of the item(s) or service(s)*] provided. More information regarding these items or services is provided below. The No Surprises Act provides a Federal independent dispute resolution (Federal IDR) process that group health plans, health insurance issuers of group and individual health insurance coverage, and FEHB carriers and out-of-network or nonparticipating health care providers, facilities, and providers of air ambulance services may utilize to determine the out-of-network rate for certain services following the end of an open negotiation period. The Federal IDR process is available only for certain services, such as out-of-network emergency services, certain services provided by out-of-network providers at an in-network facility, or air ambulance services. The Federal IDR process is also only available if a state All-Payer Model Agreement or specified state law does not apply.

What is an open negotiation period?

The open negotiation period is a period of up to 30 business days to determine an agreed-upon amount for the total out-of-network rate (including any cost sharing) for an item or service furnished by a nonparticipating provider, nonparticipating facility, or a nonparticipating provider of air ambulance services to a participant, beneficiary, or enrollee in a group health plan, group or individual health insurance policy, or FEHB carrier and for which a payment is required to be made by the plan or coverage.

What happens at the end of the open negotiation period?

If we have not agreed upon a payment amount by the end of the open negotiation period [*insert date 30 business days after the date on the open negotiation notice*], either of us may initiate the Federal IDR process by [*insert date 4 business days after the open negotiation period*], under which a certified IDR entity will select the payment amount for the item(s) and/or service(s) at issue.

Initiating the Federal IDR process does not prohibit us from agreeing on a payment amount after the open negotiation period has ended and before the certified IDR entity determines the payment amount.

For more information on the Federal IDR process and to obtain the notice to initiate the Federal IDR process, visit https://www.nsa-idr.cms.gov.

- Agency Form at https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/no-surprises-act/surprise-billing-part-ii-information-collection-documents-attachment-2.pdf

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IDR PROCESS: INITIATION

- If parties cannot agree on OON rate during the 30-day open negation period, either party may request IDR.
- To initiate IDR:
  - Within 4 business days after 30-day open negotiation period ends,
  - Submit written notice of IDR using HHS form,
  - To other party and HHS.
    - Other party: by paper or e-mail.
    - HHS: using federal IDR portal.
- Cannot initiate IDR if OON provider obtained consent to balance bill patent per 45 CFR 149.410(b) or .420(c).

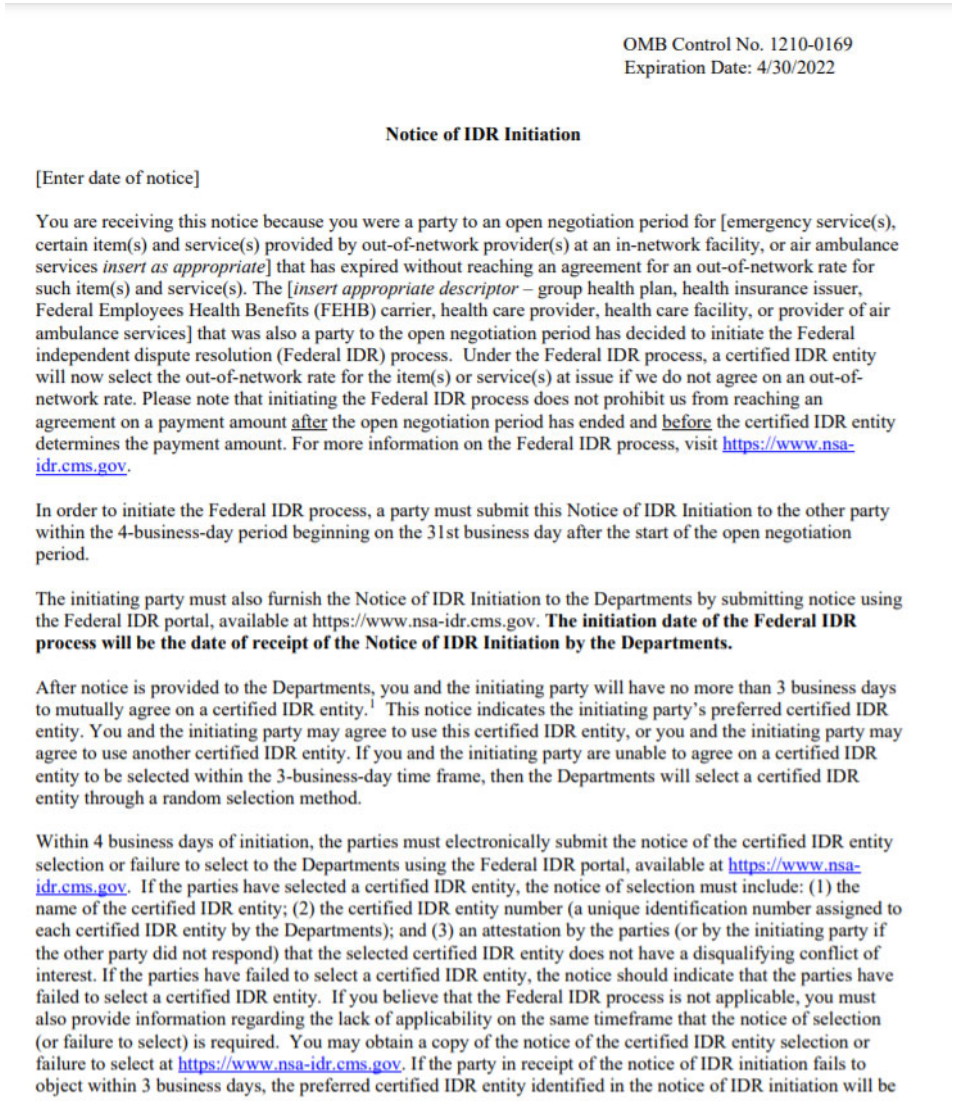
(45 CFR 149.510(b)(2))

IDR PROCESS: NOTICE

- Notice of initiation must include:
  - Specific items/services under dispute, i.e.,
    - Emergency services, or
    - Services by OON provider at in-network facility.
  - Names and contact info of parties.
  - State where item/service furnished.
  - Date open negotiation period began.
  - Preferred certified IDR entity.
  - Attest that items/service are qualified for IDR.
  - Qualifying payment amount ("QPA") and related info.
    - *QPA = the plan's median contracted rate in 2019 for the same or similar items or services provided by a similar provider in the same geographic region adjusted by CPI.*
  - General info about IDR process as specified by HHS.

(45 CFR 149.510(b)(2))

IDR PROCESS: NOTICE OF IDR INITIATION



OMB Control No. 1210-0169
Expiration Date: 4/30/2022

Notice of IDR Initiation

[Enter date of notice]

You are receiving this notice because you were a party to an open negotiation period for [emergency service(s), certain item(s) and service(s) provided by out-of-network provider(s) at an in-network facility, or air ambulance services *insert as appropriate*] that has expired without reaching an agreement for an out-of-network rate for such item(s) and service(s). The [*insert appropriate descriptor* – group health plan, health insurance issuer, Federal Employees Health Benefits (FEHB) carrier, health care provider, health care facility, or provider of air ambulance services] that was also a party to the open negotiation period has decided to initiate the Federal independent dispute resolution (Federal IDR) process. Under the Federal IDR process, a certified IDR entity will now select the out-of-network rate for the item(s) or service(s) at issue if we do not agree on an out-of-network rate. Please note that initiating the Federal IDR process does not prohibit us from reaching an agreement on a payment amount after the open negotiation period has ended and before the certified IDR entity determines the payment amount. For more information on the Federal IDR process, visit https://www.nsa-idr.cms.gov.

In order to initiate the Federal IDR process, a party must submit this Notice of IDR Initiation to the other party within the 4-business-day period beginning on the 31st business day after the start of the open negotiation period.

The initiating party must also furnish the Notice of IDR Initiation to the Departments by submitting notice using the Federal IDR portal, available at https://www.nsa-idr.cms.gov. **The initiation date of the Federal IDR process will be the date of receipt of the Notice of IDR Initiation by the Departments.**

After notice is provided to the Departments, you and the initiating party will have no more than 3 business days to mutually agree on a certified IDR entity.[1] This notice indicates the initiating party's preferred certified IDR entity. You and the initiating party may agree to use this certified IDR entity, or you and the initiating party may agree to use another certified IDR entity. If you and the initiating party are unable to agree on a certified IDR entity to be selected within the 3-business-day time frame, then the Departments will select a certified IDR entity through a random selection method.

Within 4 business days of initiation, the parties must electronically submit the notice of the certified IDR entity selection or failure to select to the Departments using the Federal IDR portal, available at https://www.nsa-idr.cms.gov. If the parties have selected a certified IDR entity, the notice of selection must include: (1) the name of the certified IDR entity; (2) the certified IDR entity number (a unique identification number assigned to each certified IDR entity by the Departments); and (3) an attestation by the parties (or by the initiating party if the other party did not respond) that the selected certified IDR entity does not have a disqualifying conflict of interest. If the parties have failed to select a certified IDR entity, the notice should indicate that the parties have failed to select a certified IDR entity. If you believe that the Federal IDR process is not applicable, you must also provide information regarding the lack of applicability on the same timeframe that the notice of selection (or failure to select) is required. You may obtain a copy of the notice of the certified IDR entity selection or failure to select at https://www.nsa-idr.cms.gov. If the party in receipt of the notice of IDR initiation fails to object within 3 business days, the preferred certified IDR entity identified in the notice of IDR initiation will be

- Agency Form at https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/no-surprises-act/surprise-billing-part-ii-information-collection-documents-attachment-3.pdf

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IDR PROCESS

- Within 3 business days after IDR initiated, the parties may agree or object to the IDR entity.
  - E.g., conflict of interest.
- Within 4 days after IDR initiated, initiating party must notify HHS of IDR entity if parties agreed.
- Within 4 days after IDR initiated, receiving party must submit any objections to IDR process.
- Within 6 days after IDR initiated, if parties fail to agree to IDR entity, HHS will appoint the IDR entity.
  - IDR entity's fees may be greater than if selected by parties.
- Parties must pay IDR administrative fee set by HHS.
- If parties agree on OON rate while IDR is pending, they most notify HHS within 3 days after agreement.
- IDR amounts may be submitted in batches or bundled payment arrangements.

(45 CFR 149.510(c))

IDR PROCESS: RATE OFFERS

- Within 10 days after IDR entity selected, each party submits OON rate offer.
  - Both in dollar amount and % of QPA.
  - Info requested by IDR entity.
  - Additional info as appropriate:
    - Size of practice or facility (i.e., number of employees)
    - Practice specialty
    - QPA for the applicable year for the same or similar item or service.
  - Additional info the party believes is appropriate.
    - Not prohibited factors (see below).
- Both parties submit IDR entity's fee.
  - Winner receives a refund.

(45 CFR 149.510(c)(4))

IDR PROCESS: DECISION

- Within 30 days after IDR entity selected, IDR issues written decision selecting one of the offers based on:
  - QPA for applicable year for same or similar item/service.
  - Info requested by IDR entity.
  - Additional info submitted by parties relating to:
    - Provider's training, experience, quality, outcomes.
    - Market share.
    - Acuity of patient or complexity of item/service.
    - Facility's teaching status, case mix scope of services.
    - Prior network agreements between the parties.
  - Additional info submitted by parties.
    - Not prohibited info.
  - Info must be credible.

(45 CFR 149.510(c))

IDR PROCESS: FACTORS TO CONSIDER

- *IDR is skewed heavily in favor of QPA.*
  - "IDR entity must select the offer closest to the QPA, unless the credible info submitted by the parties clearly demonstrates that the QPA is materially different from the appropriate OON rate…"

  (86 FR 55995)
  - Additional info must clearly demonstrate that the QPA is materially different from the appropriate OON rate.
  - If IDR entity does not choose the offer closest to the QPA, the IDR entity's written decision must explain how the credible info demonstrates that the appropriate OON is materially different from the QPA.

  (45 CFR 149.510(c)(4)(vi)(B))

IDR PROCESS: FACTORS NOT TO CONSIDER

- IDR entity may not consider:
  - Usual and customary charges.
  - Amounts the OON provider/facility would have charged but for the limit on balance billing.
  - Amounts or reimbursement rates payable by a public payer.

(45 CFR 149.510(c)(4)(v))

IDR PROCESS: EFFECT OF DECISION

- Effect of decision:
  - Binding on parties absent fraud or intentional misrepresentation of a material fact.
  - Not subject to judicial review.
  - Party who initiated IDR may not initiate another IDR involving same party and same or similar claims for 90 days.
- Within 30 days of decision:
  - Loser pays balance due other party.
  - Loser remains responsible for IDR entity fee.
  - Winner's prepaid fee is refunded.

(45 CFR 149.510(c)(4)(vii)-(ix))

IDR ENTITY: DISSATISFACTION

- Provider, facility or payer may petition for the denial or revocation of an IDR entity's certification for failure to meet a requirement of the regulations.

(45 CFR 149.510(e)(5))

SELF-PAY PATIENT PROTECTIONS

SELF-PAY PATIENT PROTECTIONS: APPLY TO…

Healthcare Facilities and Providers

- Healthcare facilities, i.e., institutions licensed under state law (e.g., hospitals, CAH, ASC, RHC, FQHC, lab, or imaging center).
- Healthcare providers, i.e., physicians and other providers acting within the scope of their license or certification.

(45 CFR 149.610(a))

Uninsured (Self-Pay) Patients

- Person does not have benefits under a group health plan, group or individual health insurance coverage, or federal healthcare program.
- Person has such benefits but does not seek to have a claim submitted to the payer.

(45 CFR 149.610(a))

GOOD FAITH ESTIMATE TO SELF-PAY PATIENTS

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PROVIDERS

Convening Provider/Facility

- Provider or facility that is responsible for scheduling the "primary item or service", i.e., the item or service that is the reason for the initial visit.

➢ *Primarily responsible for compliance*

(45 CFR 149.610(a)

Co-Provider/Facility

- Provider or facility other than the convening provider/facility that furnishes items or services that are customarily provided in conjunction with a primary item or service.

INQUIRE IF PATIENT IS SELF-PAY

- Convening provider/facility must:
  - Determine if an individual is a self-pay individual:
    - Ask if the patient is covered by a plan, insurance or a federal healthcare program.
    - If patient has coverage, ask if patient wants to have the claim submitted to the payer for the primary item or service.
  - If patient is self-pay, inform the patient that they may obtain a good faith estimate expected charges upon:
    - Scheduling the item or service, or
    - Upon request.

(45 CFR 149.610(b)(1))

INFORM PATIENT OF RIGHT TO GOOD FAITH ESTIMATE

- Convening provider/facility must inform self-pay patients about right to good faith estimate by:
  - Written notice prominently displayed
    - On provider/facility's website;
    - In its office; and
    - Onsite where scheduling or questions about cost of items or services occur.
  - Orally inform patient when scheduling item or service or when patient asks about cost of items or services.
- Notice must be made available in accessible formats and the language spoken by the patient.

(45 CFR 149.610(b)(1))

NOTICE OF RIGHT TO GOOD FAITH ESTIMATE

OMB Control Number [XXXX-XXXX]
Expiration Date [MM/DD/YYYY]

You have the right to receive a "Good Faith Estimate" explaining how much your medical care will cost

Under the law, health care providers need to give **patients who don't have insurance or who are not using insurance** an estimate of the bill for medical items and services.

- You have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency items or services. This includes related costs like medical tests, prescription drugs, equipment, and hospital fees.
- Make sure your health care provider gives you a Good Faith Estimate in writing at least 1 business day before your medical service or item. You can also ask your health care provider, and any other provider you choose, for a Good Faith Estimate before you schedule an item or service.
- If you receive a bill that is at least $400 more than your Good Faith Estimate, you can dispute the bill.
- Make sure to save a copy or picture of your Good Faith Estimate.

For questions or more information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises or call [INSERT PHONE NUMBER].

- CMS Form at https://www.cms.gov/regulations-and-guidancelegislationpaperworkreductionactof1995pra-listing/cms-10791

PROVIDE GOOD FAITH ESTIMATE

- If self-pay person
  - Requests a good faith estimate (including inquiry or discussion about costs), or
  - Upon scheduling a primary item or service,

  convening facility must:
  - Within 1 business day, ask co-providers/facilities to submit good faith estimate to the convening provider/facility by due date.*
  - Timely provide written good faith estimate to the patient.

(45 CFR 149.610(b)(1))

PROVIDE GOOD FAITH ESTIMATE: CO-PROVIDERS

- For CY 2022, HHS will exercise enforcement discretion in cases where good faith estimate does not include expected charges from co-providers/facilities.

(86 FR 56023)

➢ *As a practical matter,*

- *Convening providers probably don't need to worry about co-providers until January 1, 2023.*
- *Co-providers likely don't need to worry about responding to requests*

Until January 1, 2023.

GOOD FAITH ESTIMATE: TIMING

- If item/service scheduled at least 3 days in advance, provide good faith estimate not later than 1 business day after the date of scheduling.
- If item/service scheduled at least 10 days in advance, provide good faith estimate not later than 3 business days after the date of scheduling.
- If patient requests good faith estimate, provide good faith estimate not later than 3 business days after the date of the request.
- If patient requested good faith estimate and then schedules services, must provide new good faith estimate within time frames described above.
- If any change to anticipated charges, must provide updated good faith estimate no later than 1 business day before the items/services are scheduled to be rendered.

(45 CFR 149.610(b)(1))

GOOD FAITH ESTIMATE: RECURRING SERVICES

- Convening facility may issue a single good faith estimate for recurring primary items/services if:
  - Such good faith estimate includes in clear manner the scope of the recurring items/services (e.g., timeframes, frequency, total number, etc.)
  - Scope of good faith estimate may not exceed 12 months.
  - If good recurring items/service extend beyond 12 months, must provide new good faith estimate.

(45 CFR 149.610(b)(1))

GOOD FAITH ESTIMATE BY CO-PROVIDERS

- Upon request by convening provider/facility, co-provider/facility must provide its good faith estimate to convening provider/facility within 1 business day of request.
- If there are changes to scope of estimate, co-provider must provide new good faith estimate to convening provider/facility.

➢ *As practical matter, probably don't have to worry about this until 1/1/23.*

(45 CFR 149.610(b)(2)(i)-(ii))

- If self-pay patient separately schedules or requests a good faith estimate from a co-provider/facility, the co-provider/facility becomes a convening provider/facility.

(45 CFR 149.610(b)(2)(iv))

GOOD FAITH ESTIMATE: REPLACEMENT PROVIDERS

- If convening providers/facilities or co-providers/facilities listed in good faith estimate change less than 1 business day before the item/service is scheduled to be provided:
  - Replacement provider/facility must accept the existing good faith estimate as its good faith estimate.
  - Replacement providers/facilities are bound by the existing good faith estimate.

(45 CFR 149.610(b)(1)(viii)-(2)(iii))

➢ *Replacement providers should review good faith estimate and provide new good faith estimate if there is time.*

GOOD FAITH ESTIMATE BY CONVENING PROVIDER

- Good faith estimate by convening provider/facility must include:
  - Patient name and birthdate;
  - Itemized list of anticipated items/services provided by co-provider/facility in conjunction with primary item/service;
  - Applicable diagnosis and service codes with charges;
    - Apply discounts or adjustments. e.g., cash pay, charity care, etc.
  - Name, NPI, TIN of co-provider/facility, and states and offices where they are expected to be provided;
  - Location where each item/service is provided;
  - List of items/services that will require separate scheduling + disclaimer re obtaining separate estimate.

(45 CFR 149.610(c)(1))

GOOD FAITH ESTIMATE BY CONVENING PROVIDER

- Good faith estimate by convening provider/facility must include disclaimers:
  - If separate services anticipated, note that separate good faith estimates will be provided.
  - There may be additional items/services recommended as part of course or care that must be scheduled or requested and are not included in good faith estimate.
  - Info in good faith estimate is an estimate only; actual items, services and charges may differ.
  - Patient has right to initiate the SDR process if actual charges are substantially in excess of estimate.
  - Instructions for finding info about SDR process.
  - SDR process will not adversely affect quality of care.
  - Good faith estimate is not a contract and does not require the patient to obtain items/services from such providers.

(45 CFR 149.610(c)(1)(vi)-(xi))

GOOD FAITH ESTIMATE

OMB Control Number [XXXX-XXXX]
ExpirationDate [MM/DD/YYYY]

[NAME OF CONVENING PROVIDER OR CONVENING FACILITY]

Good Faith Estimate for Health Care Items and Services

Patient		
Patient First Name	Middle Name	Last Name
Patient Date of Birth: _____/_____/_____		
Patient Identification Number:		
Patient Mailing Address, Phone Number, and Email Address		
Street or PO Box		Apartment
City	State	ZIP Code
Phone		
Email Address		
Patient's Contact Preference:	[ ] By mail	[ ] By email
Patient Diagnosis		
Primary Service or Item Requested/Scheduled		
Patient Primary Diagnosis		Primary Diagnosis Code
Patient Secondary Diagnosis		Secondary Diagnosis Code

- HHS Form at https://www.cms.gov/regulations-and-guidancelegislationpaperworkreductionactof1995pra-listing/cms-10791

➢ ***Make sure good faith estimate is:***
  - ***Accurate, and***
  - ***Complete***

Because you are likely going to be bound by it…

GOOD FAITH ESTIMATE BY CO-PROVIDER

- Good faith estimate by co-provider/facility must include:
  - Patient name and birthdate;
  - Description of primary item/service and date scheduled;
  - Itemized list of anticipated items or services grouped by convening and co-provider/facility;
  - Applicable diagnosis and service codes with charges;
  - Name, NPI, TIN of each provider/facility, and states and offices where they are expected to be provided;

(45 CFR 149.610(c)(1))

➢ *Probably don't need to worry about this until 1/1/23.*

PROVIDING GOOD FAITH ESTIMATE

- Must be in writing and given in manner requested by patient:
  - Paper;
  - Electronically in form so patient may save and print;
  - Orally if requested, but still must provide in writing.

(45 CFR 149.610(e))

- Must provide in a manner understandable to the patient, considering:
  - Vision and hearing;
  - Language limitations, including limited English proficiency;
  - Communication needs of underserved populations;
  - Health literacy.

(86 FR 56021)

➢ *May need interpreters, translators, auxiliary aids.*

MAINTAINING GOOD FAITH ESTIMATE

- Good faith estimate is part of the patient's medical record and must be maintained in same manner as medical record.
- Must keep for 6 years and provide to patient if requested.

(45 CFR 149.610(f)(1)-(2))

➢ *Need to have good faith estimate available if there is claim:*

- *SDR*
- *Dispute over collections*

GOOD FAITH ESTIMATE ERRORS

- Errors ≠ noncompliance so long as:
  - Acted in good faith with reasonable due diligence; and
  - Correct info as soon as practicable
- Good faith reliance on other providers ≠ noncompliance so long as:
  - Did not know and should not know of error; and
  - Correct info as soon as practicable.
- But still bound by SDR if actual charges are substantially in excess of good faith estimate.

(45 CFR 149.610(f)(3)-(4))

SDR PROCESS FOR SELF-PAY PATIENTS

CHARGES SUBSTANTIALLY IN EXCESS OF GOOD FAITH ESTIMATE

- If total billed charges for the listed provider/facility are "substantially in excess" of the total charges on the good faith estimate (i.e., at least $400 more than expected charges), patient may initiate selected dispute resolution ("SDR") process.

(45 CFR 149.620(b))

- Total billed charges = total billed charges for:
  - All primary items or services, and
  - All other items or services furnished in conjunction with the primary items or services to a self-pay patient

  regardless of whether such items or services were included in the good faith estimate.

(45 CFR 149.620(a)(2)(iii))

CHARGES SUBSTANTIALLY IN EXCESS OF GOOD FAITH ESTIMATE

- "Substantially in excess" is determined by the provider, e.g.:
  - Provider A provides services X and Y.
  - Provider B provides services Z.
  - Self-pay patient may initiate SDR if the total charges for X and Y exceed A's good faith estimate for such services by $400.
- "Substantially in excess" calculation includes items/services that were not included in the good faith estimate.
  - Provider Z includes item C in estimate.
  - Provider Z bills for items C, D, and E.
  - Patient may initiate SDR if total charges for C,D, and E exceed $400.

(86 FR 56028)

SDR PROCESS: INITIATION

- To initiate SDR process:
  - Within 120 days of receiving bill containing disputed charges, patient or authorized representative must submit:
    - Notification to HHS; and
    - $25 administrative fee.
  - Notice must contain:
    - Info sufficient to identify disputed item/service;
    - Copy of the disputed bill;
    - Copy of the good faith estimate;
    - Contact info for provider/facility; and
    - State where the items/services were provided.
  - Submit through portal, electronically, or on paper.

(45 CFR 149.620(c)(1)-(2))

SDR PROCESS

- HHS will select SDR entity.
- SDR entity will notify patient and provider/facility.
- SDR will review submission and may give patient time to provide additional info to satisfy SDR rules.
- If SDR entity concludes the matter is appropriate for SDR, SDR will request info from provider/facility.

(45 CFR 149.620(c)(1)-(2))

- If parties settle the dispute while the SDR process is pending, they must notify the SDR entity within 3 business days.
  - Must split administrative fee.

(45 CFR 149.620(f)(2), (g))

SDR PROCESS: STAY OF COLLECTION ACTIONS

- While the SDR process is pending, provider/facility must not:
  - Move the disputed bill to collections or threaten to do so;
  - If bill moved to collections, cease collection efforts;
  - Suspend accrual of late fees on unpaid bill amounts;
  - Take or threaten any retribution against patient to obtain resolution of dispute.

(45 CFR 149.620(c)(5)-(6))

➢ *Upon receipt of notice of SDR, immediately suspend collection actions.*

SDR PROCESS: PROVIDER'S RESPONSE

- Within 10 days of notice to provider, provider must submit to SDR entity:
  - Copy of the good faith estimate relevant to dispute.
  - Copy of the billed charges that are subject to dispute.
  - If available, documentation showing that the difference between billed charge and good faith estimate reflects:
    - Cost of medically necessary item/services; and
    - There were unforeseen circumstances that could not have reasonably been anticipated by provider/facility when the good faith estimate was provided.

Relevant Standard

(45 CFR 149.620(c)(1)-(2))

SDR PROCESS: DETERMINATION

- Within 30 days after receiving provider/facility info, SDR entity makes determination of amount owed by patient.
- Basis for decision:
  - Has provider/facility produced credible info demonstrating that difference between billed charge and good faith estimate reflects
    - Cost of medically necessary item/service, and
    - Difference is based on unforeseen circumstances that could not have reasonably been anticipated by the provider/facility when the good faith estimate was provided.

Relevant Standard

(45 CFR 149.620(f)(2)-(3))

SDR PROCESS: BILLED CHARGE ON ESTIMATE

If billed charge is listed on the good faith estimate:

- If billed charge ≤ expected charge:
  - Patient pays the billed charge
- If billed charge > expected charge and provider failed to prove medical necessity and unforeseeability:
  - Patient pays the expected charge from estimate.
- If billed charge > expected charge and provider proves medical necessity and unforeseeability:
  - Patient pays the lesser of the:
    - Billed charge, or
    - Expected charge if expected charge > median rate paid by a payer for same/similar service by same/similar provider in the geographic area as listed in independent database, or
    - Median rate if expected charge < median rate.

(45 CFR 149.620(f)(3)(iii)(A))

SDR PROCESS: BILLED CHARGE NOT ON ESTIMATE

If billed charge is not listed on good faith estimate:

- If provider failed to prove medical necessity and unforeseeability:
  - Patient pays $0 for the item/service.
- If provider proves medical necessity and unforeseeability:
  - Patient pays the lesser of the:
    - Billed charge, or
    - Median rate paid by a payer for same/similar service by same/similar provider in the geographic area as listed in independent database.

(45 CFR 149.620(f)(3)(iii)(B))

SDR DECISION

- Depending on decision, patient must pay one of the following:
  - The total expected charges from the good faith estimate minus the $25 administration fee; or
  - The billed charge; or
  - The median amount for the same or similar services by a same or similar provider in the geographic area.

(See SDRE Determination Letter, available at https://www.cms.gov/regulations-and-guidancelegislationpaperworkreductionactof1995pra-listing/cms-10791)

SDR PROCESS: FINAL DETERMINATION

- To calculate final payment amount:
  - SDR entity adds together the amounts to be paid for all items services as determined by the SDR entity.
  - If SDR amount < billed charges, SDR entity subtracts the administrative fee from the amount to be paid.
    - Provider/facility effectively pays the administrative fee.
- SDR entity informs parties through the federal IDR portal, e-mail, or paper mail.

(45 CFR 149.620(f)(3)(iii)(C))

- SDR determination is binding absent fraud.
- *But still have to collect the money from patient….*
  - May negotiate lower amount, financial assistance, payment plan, etc. with patient.

(45 CFR 149.620(f)(4))

HTTPS://WWW.CMS.GOV/NOSURPRISES

COORDINATION WITH STATE LAWS

- May need to coordinate the No Surprise Billing Rules with state laws, e.g.,
  - Notice concerning fees.
  - Fees that may be charged.
  - Dispute resolution process.
  - Other?
- If and to the extent state laws provide less protection to patients than the No Surprise Billing Rules, apply the No Surprise Billing Rules.
- If and to the extent state laws provide more protection to patients than the No Surprise Billing Rules, defer to state law.

(45 CFR 149.620(h))

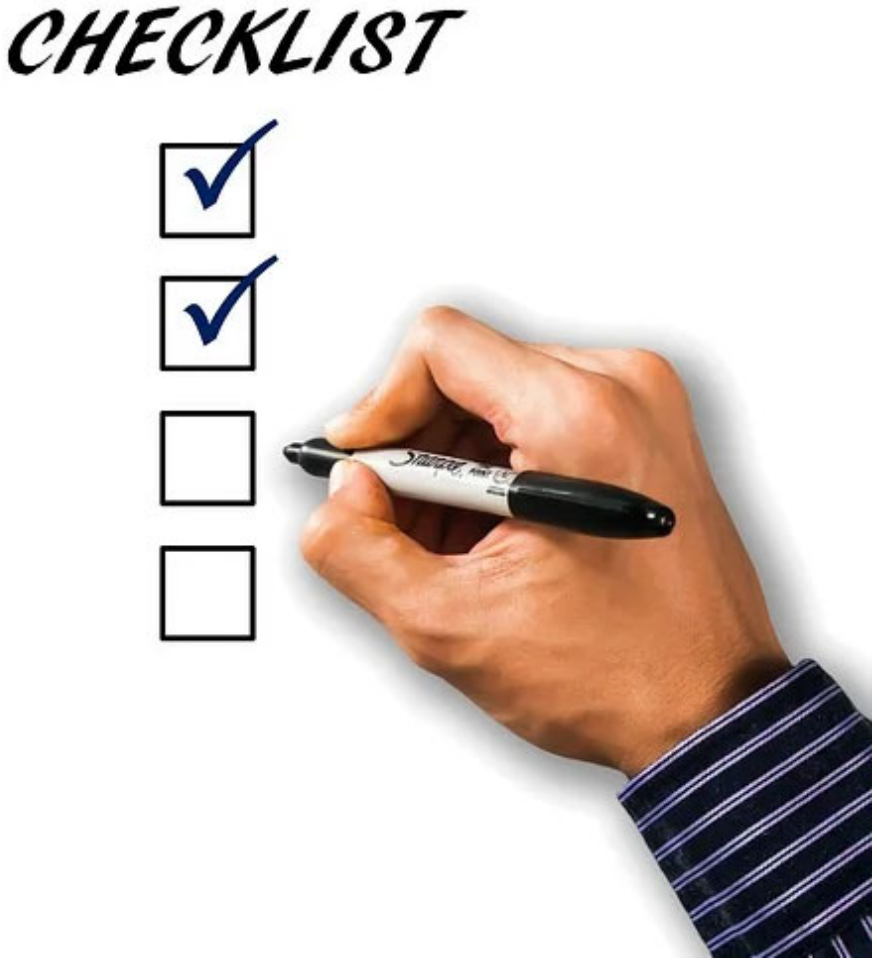
COMMENT DEADLINE

- To submit comments:

  Centers for Medicare & Medicaid Services
  Dept. of Health and Human Services
  Attn: CMS-9908-IFC
  P.O. Box 8010
  Baltimore, MD 2144-8010
  Attn: RIN0938-AU62

- Deadline: December 6, 2022

ACTION ITEMS



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BEFORE 1/1/22: DETERMINE POLICIES

- ✓Confirm and coordinate state law requirements.
- ✓Determine if OON providers/facilities render:
  - ✓Emergency services, or
  - ✓Non-emergency services at in-network facility
  - ➢*Generally, determines Part 1 relevance.*
- ✓Determine if you are going to attempt to obtain advance notice + consent from patients for OON services.
- ✓Determine if and when you are going to initiate IDR for disputes with payers.
- ✓Determine if and when you are going to respond to SDR for disputes with patients.

BEFORE 1/1/22: FORMS

- Obtain or create required forms or documents
  - Billing for OON services
    - Notice and consent
    - Agreement with facility to provide patient rights notice
  - IDR for disputes with payers
    - Notice to initiate 30-day open negotiation period
    - Notice to initiate IDR
    - Rate offer
    - Additional supporting criteria
  - Good faith estimate
    - Establish estimate for standard procedures.
  - SDR for disputes with self-pay patients
    - Response to SDR including criteria.

BEFORE 1/1/22: NOTICES

- ✓Obtain or prepare required notices.
  - ✓Notice of Right re Balance Billing
  - ✓Notice of Right to Good Faith Estimate
- ✓Publish required notices
  - Website
  - Sign in prominent location in office or facility
  - Location where billing questions are discussed
  - Comply with language and accessibility requirements.
    - Easily understandable
    - Translation in relevant languages
    - Interpreters
    - Auxiliary aids

BEFORE 1/1/22: PROCESS TO CALENDAR IDR DEADLINES

Timing	Action
w/in 30 days after payment or denial	Initiate 30-day open negotiation period
30 days after notice initiating IDR	Open negotiation period
w/in 4 days after open negotiation period ends	Initiate IDR by submitting request
3 days after IDR initiated	Parties object or agree on the IDR entity
1 day (4 days from initiation)	Initiating party notifies HHS of selected IDR entity; Receiving party objects to applicability of IDR process
6 days after IDR initiated	HHS appoints IDR entity if not selected by parties
10 days after IDR entity selected	Submit OON rate offer and additional permitted info
30 days after IDR selected	IDR's written decision
30 days after IDR decision	Loser pays any balance due

BEFORE 1/1/22: DEVELOP AND TRAIN RE PROCESSES

- ✓Develop and train staff re internal self-pay patient process
  - Determine if self-pay patient.
  - Advise patient of right to good faith estimate.
  - Generate good faith estimate.
    - Develop templates or database with expenses
  - Obtain estimate from co-providers/facilities.
    - After 1/1/23.
  - Provide estimates to patients in timely manner.
  - Update estimates as appropriate.
  - If you are a replacement provider, review and update estimate.
  - Maintain good faith estimate.

BEFORE 1/1/22: PROCESS TO CALENDAR SDR DEADLINES

Timing	Action
w/120 days of bill	Self-pay patient initiates SDR and pays fee.
Upon receipt of patient's initiation	HHS selects SDR entity; SDR entity reviews info submitted by patient; may give patient 21 days to submit more info
	SDR entity notifies provider/facility and patient.
Upon notice of SDR	Provider/facility suspends collection activity.
w/10 days of notice	Provider/facility submits good faith estimate, billed charges, and additional supporting info.
w/3 days of settlement	Notify SDR entity of settlement, if any.
w/30 days after provider/facility submits info	SDR entity issues determination and notifies parties.

BEFORE 1/1/22: EDUCATE STAFF

- ✓Educate staff
  - Limits on charges to patient and balance billing rules.
  - Confirming self-pay status.
  - Notice to re good faith estimate.
  - Obtain and timely provide good faith estimate.
  - IDR process.
  - SDR process.
  - Record retention.

Training should include following personnel:

- Payer contracting
- Medical staff office
- Patient intake and scheduling
- Billing and collections
- Compliance
- Website design
- Others?

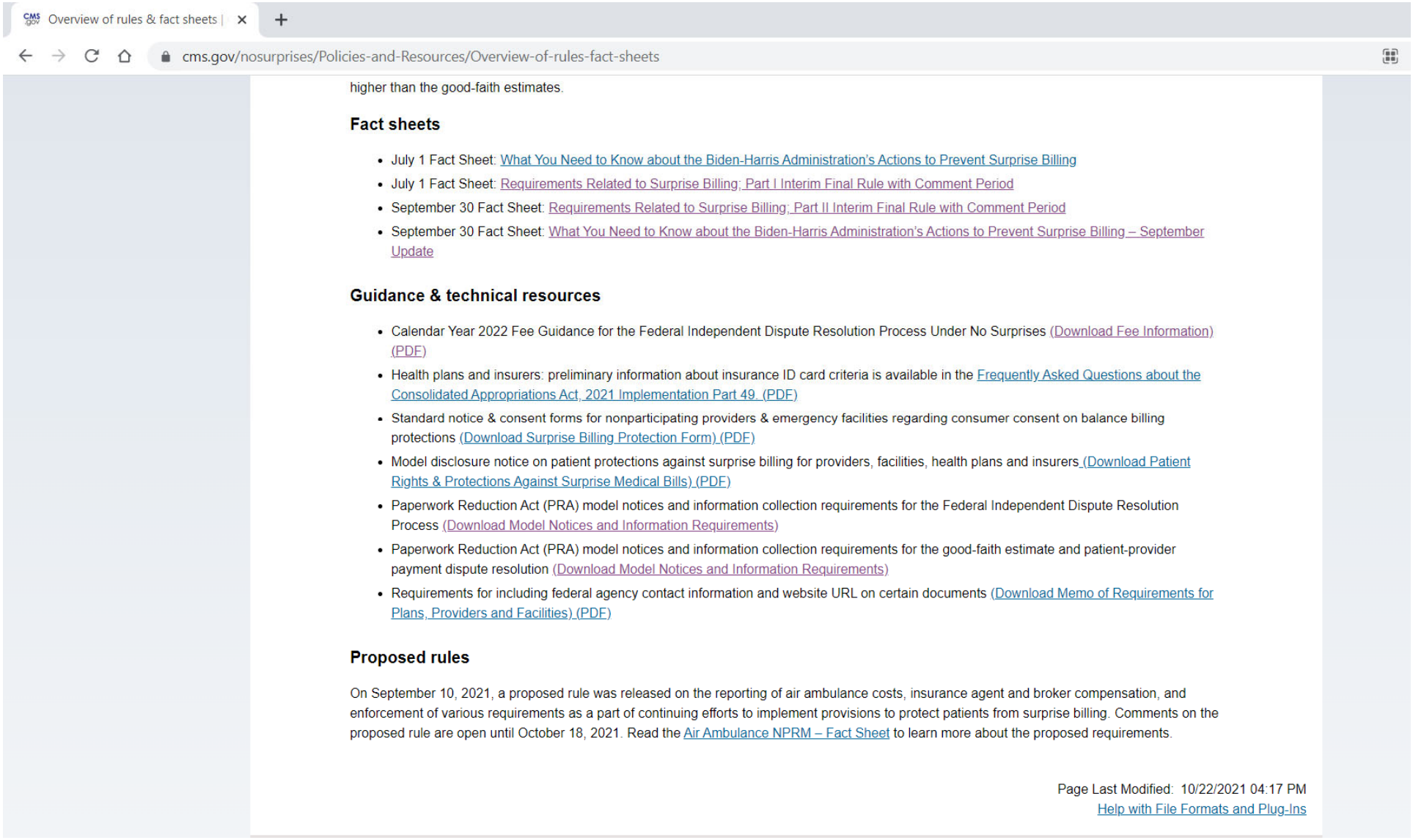
AFTER 1/1/22

- Stay tuned…
  - Additional guidance from HHS.
  - HHS forms.
  - Final rules following comments.
    - Perhaps changes?
  - Regulations implementing other portions of the No Surprise Act, e.g.,
    - Good faith estimate to insured patients and payers.
    - Others?

ADDITIONAL RESOURCES

HTTPS://WWW.CMS.GOV/NOSURPRISES/POLICIES-AND-RESOURCES/OVERVIEW-OF-RULES-FACT-SHEETS

HTTPS://WWW.CMS.GOV/NOSURPRISES/POLICIES-AND-RESOURCES/OVERVIEW-OF-RULES-FACT-SHEETS



higher than the good-faith estimates.

Fact sheets

- July 1 Fact Sheet: What You Need to Know about the Biden-Harris Administration's Actions to Prevent Surprise Billing
- July 1 Fact Sheet: Requirements Related to Surprise Billing; Part I Interim Final Rule with Comment Period
- September 30 Fact Sheet: Requirements Related to Surprise Billing; Part II Interim Final Rule with Comment Period
- September 30 Fact Sheet: What You Need to Know about the Biden-Harris Administration's Actions to Prevent Surprise Billing – September Update

Guidance & technical resources

- Calendar Year 2022 Fee Guidance for the Federal Independent Dispute Resolution Process Under No Surprises (Download Fee Information) (PDF)
- Health plans and insurers: preliminary information about insurance ID card criteria is available in the Frequently Asked Questions about the Consolidated Appropriations Act, 2021 Implementation Part 49. (PDF)
- Standard notice & consent forms for nonparticipating providers & emergency facilities regarding consumer consent on balance billing protections (Download Surprise Billing Protection Form) (PDF)
- Model disclosure notice on patient protections against surprise billing for providers, facilities, health plans and insurers (Download Patient Rights & Protections Against Surprise Medical Bills) (PDF)
- Paperwork Reduction Act (PRA) model notices and information collection requirements for the Federal Independent Dispute Resolution Process (Download Model Notices and Information Requirements)
- Paperwork Reduction Act (PRA) model notices and information collection requirements for the good-faith estimate and patient-provider payment dispute resolution (Download Model Notices and Information Requirements)
- Requirements for including federal agency contact information and website URL on certain documents (Download Memo of Requirements for Plans, Providers and Facilities) (PDF)

Proposed rules

On September 10, 2021, a proposed rule was released on the reporting of air ambulance costs, insurance agent and broker compensation, and enforcement of various requirements as a part of continuing efforts to implement provisions to protect patients from surprise billing. Comments on the proposed rule are open until October 18, 2021. Read the Air Ambulance NPRM – Fact Sheet to learn more about the proposed requirements.

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Help with File Formats and Plug-Ins

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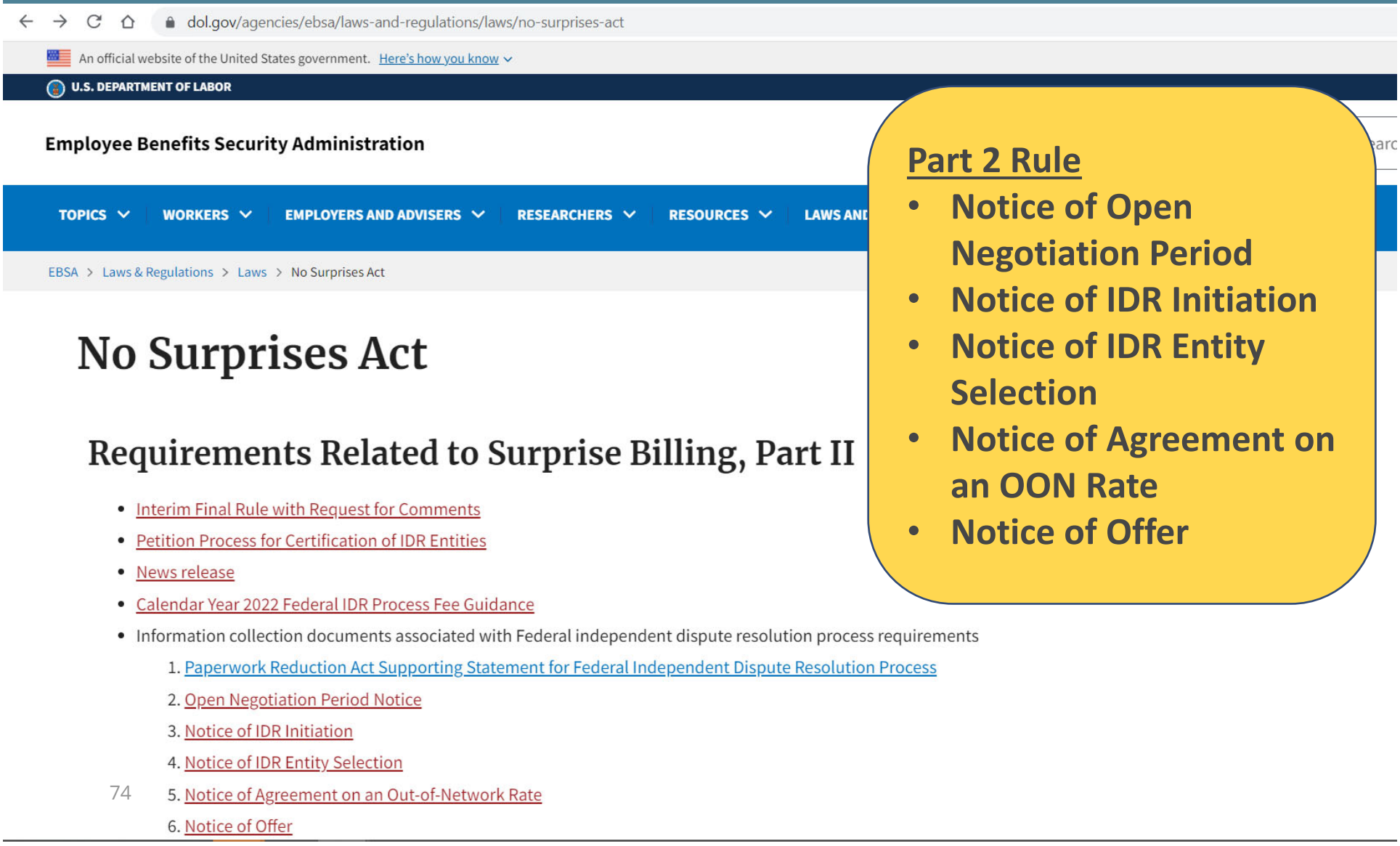

Part 2 Rule

- **Notice of Open Negotiation Period**
- **Notice of IDR Initiation**
- **Notice of IDR Entity Selection**
- **Notice of Agreement on an OON Rate**
- **Notice of Offer**

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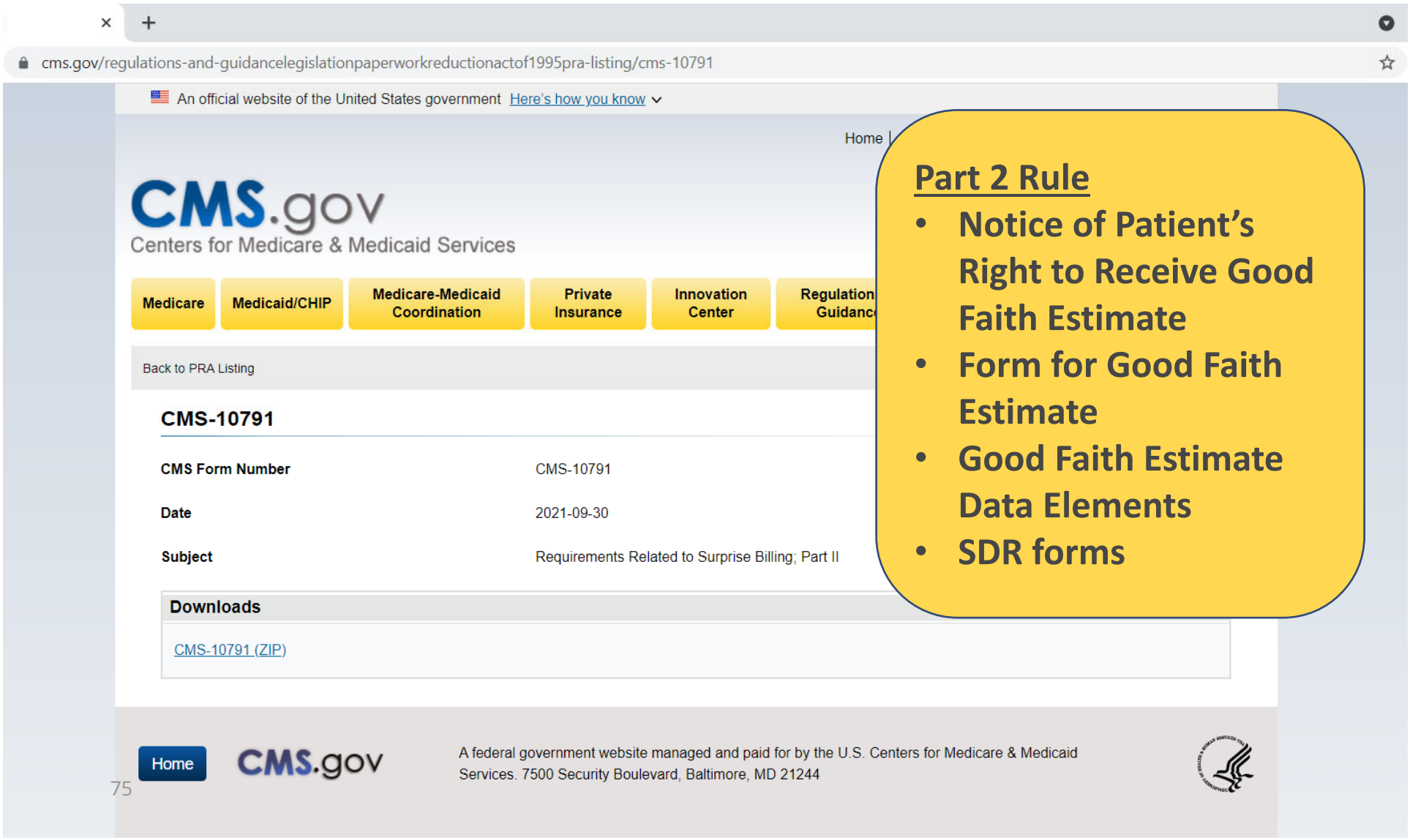

Part 2 Rule

- **Notice of Patient's Right to Receive Good Faith Estimate**
- **Form for Good Faith Estimate**
- **Good Faith Estimate Data Elements**
- **SDR forms**

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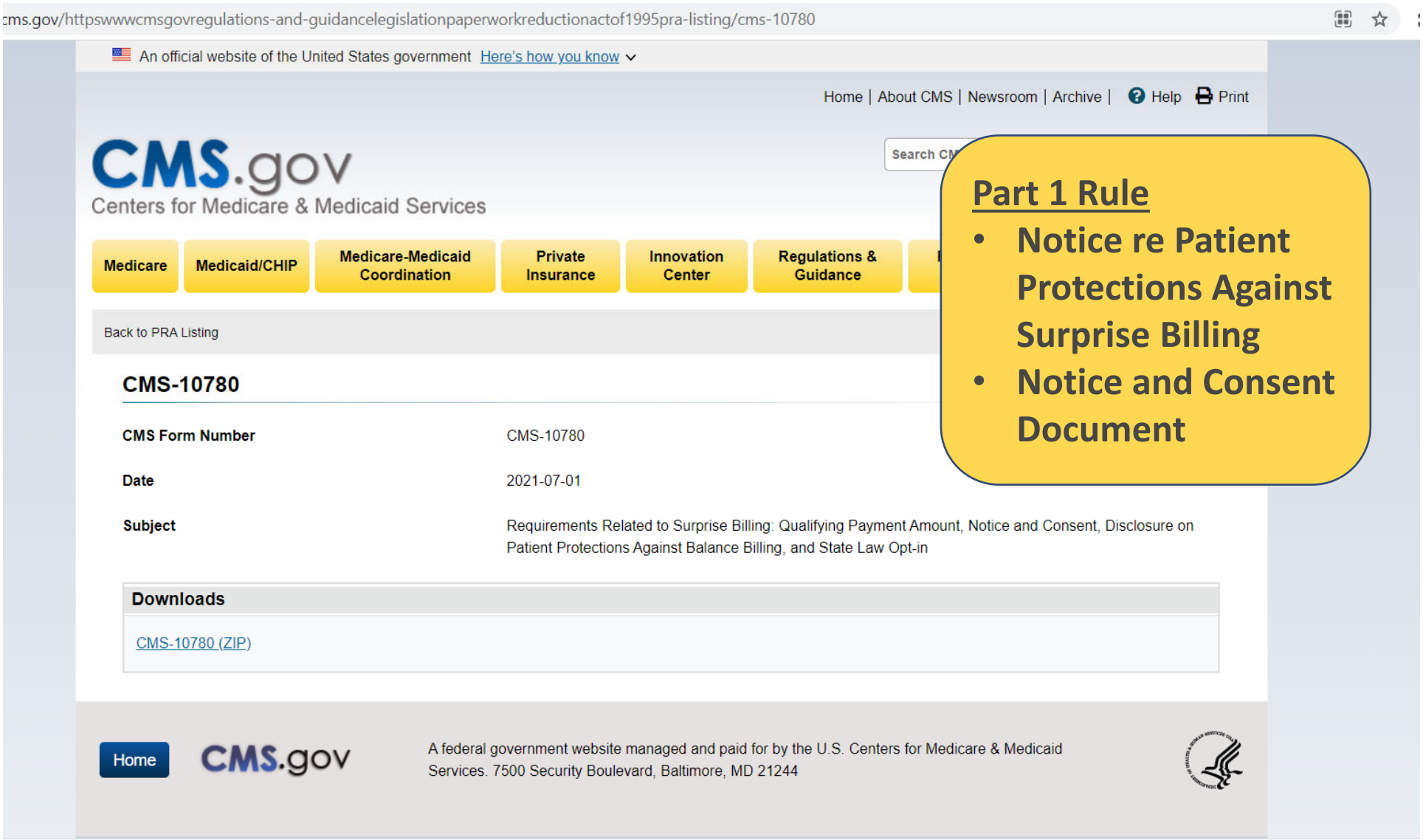

Part 1 Rule

- **Notice re Patient Protections Against Surprise Billing**
- **Notice and Consent Document**

NOTICE OF PATIENT RIGHTS RE BALANCE BILLING

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services
If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

[*Insert plain language summary of any applicable state balance billing laws or requirements OR state-developed model language as appropriate*]

Certain services at an in-network hospital or ambulatory surgical center
When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

[*Insert plain language summary of any applicable state balance billing laws or requirements OR state-developed model language regarding applicable state law requirements as appropriate*]

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
    - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
    - Cover emergency services by out-of-network providers.
    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
    - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact [*applicable contact information for entity responsible for enforcing the federal and/or state balance or surprise billing protection laws*].

Visit [*website*] for more information about your rights under federal law.
[*If applicable, insert:* Visit [*website*] for more information about your rights under [state laws].]

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NOTICE AND CONSENT TO BALANCE BILL

Surprise Billing Protection Form

The purpose of this document is to let you know about your protections from unexpected medical bills. It also asks whether you would like to give up those protections and pay more for out-of-network care.

IMPORTANT: You aren't required to sign this form and shouldn't sign it if you didn't have a choice of health care provider when you received care. You can choose to get care from a provider or facility in your health plan's network, which may cost you less.

If you'd like assistance with this document, ask your provider or a patient advocate. Take a picture and/or keep a copy of this form for your records.

You're getting this notice because this provider or facility isn't in your health plan's network. This means the provider or facility doesn't have an agreement with your plan.

Getting care from this provider or facility could cost you more.

If your plan covers the item or service you're getting, federal law protects you from higher bills:

- When you get emergency care from out-of-network providers and facilities, or
- When an out-of-network provider treats you at an in-network hospital or ambulatory surgical center without your knowledge or consent.

Ask your health care provider or patient advocate if you need help knowing if these protections apply to you.

If you sign this form, you may pay more because:

- You are giving up your protections under the law.
- You may owe the full costs billed for items and services received.
- Your health plan might not count any of the amount you pay towards your deductible and out-of-pocket limit. Contact your health plan for more information.

You **shouldn't** sign this form if you **didn't** have a choice of providers when receiving care. For example, if a doctor was assigned to you with no opportunity to make a change.

Before deciding whether to sign this form, you can contact your health plan to find an in-network provider or facility. If there isn't one, your health plan might work out an agreement with this provider or facility, or another one.

See the next page for your cost estimate.

By signing, I give up my federal consumer protections and agree to pay more for out-of-network care.

With my signature, I am saying that I agree to get the items or services from (select all that apply):

☐ [*doctor's or provider's name*] [*If consent is for multiple doctors or providers, provide a separate check box for each doctor or provider]*

☐ [*facility name*]

With my signature, I acknowledge that I am consenting of my own free will and am not being coerced or pressured. I also understand that:

- I'm giving up some consumer billing protections under federal law.
- I may get a bill for the full charges for these items and services, or have to pay out-of-network cost-sharing under my health plan.
- I was given a written notice on [*enter date of notice*] explaining that my provider or facility isn't in my health plan's network, the estimated cost of services, and what I may owe if I agree to be treated by this provider or facility.
- I got the notice either on paper or electronically, consistent with my choice.
- I fully and completely understand that some or all amounts I pay might not count toward my health plan's deductible or out-of-pocket limit.
- I can end this agreement by notifying the provider or facility in writing before getting services.

IMPORTANT: You **don't** have to sign this form. But if you don't sign, this provider or facility might not treat you. You can choose to get care from a provider or facility in your health plan's network.

_____	or	_____
Patient's signature		Guardian/authorized representative's signature
_____		_____
Print name of patient		Print name of guardian/authorized representative
_____		_____
Date and time of signature		Date and time of signature

Take a picture and/or keep a copy of this form.

It contains important information about your rights and protections.

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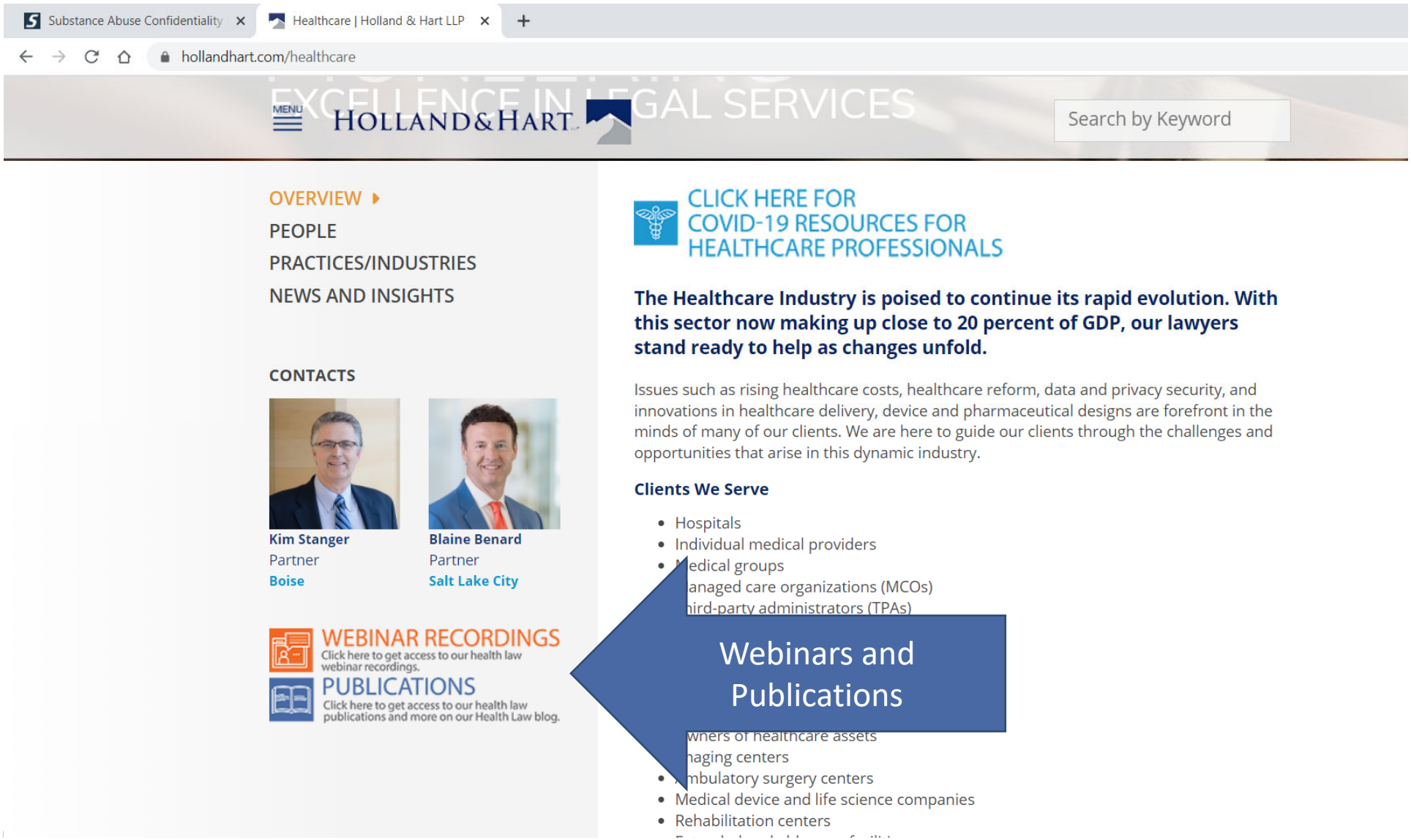

QUESTIONS?

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