
# NO SURPRISE BILLING RULES FOR PROVIDERS

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(6/25)

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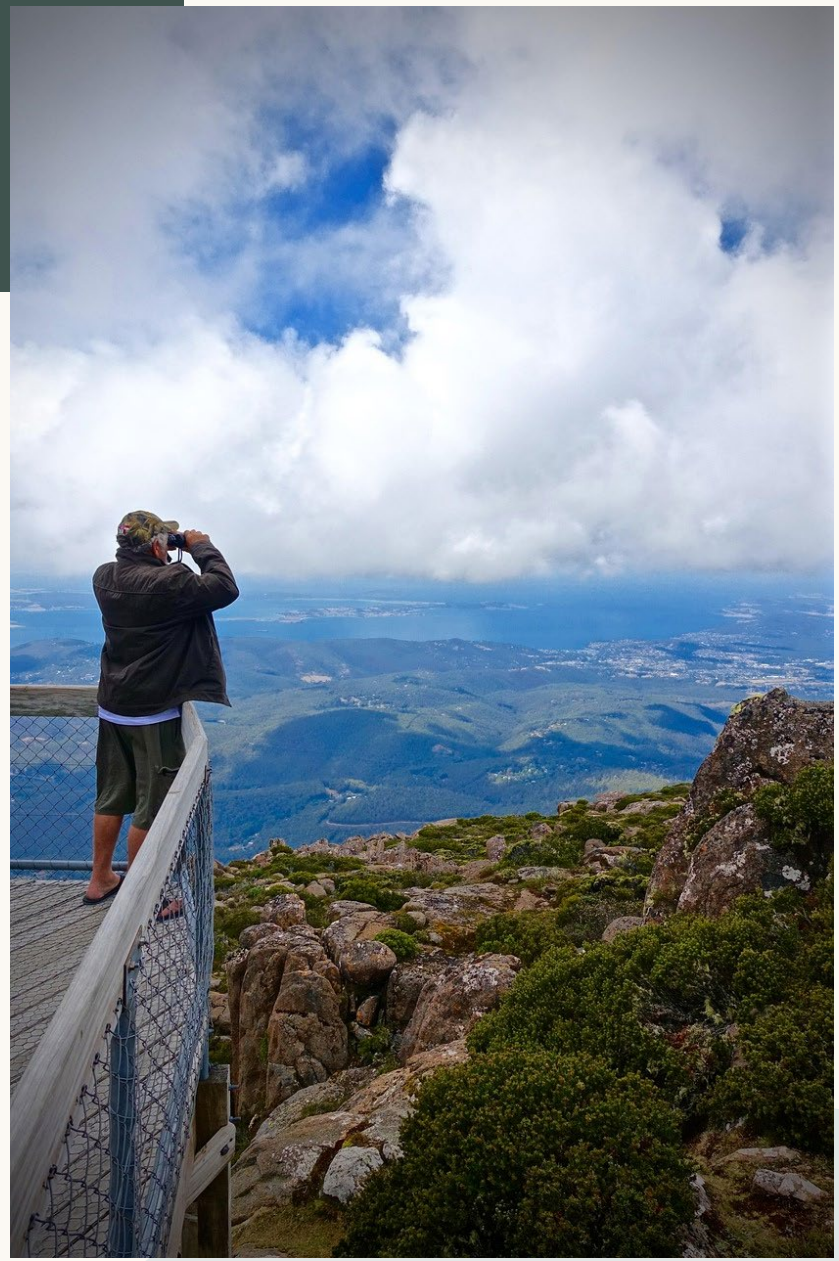
# Preliminaries

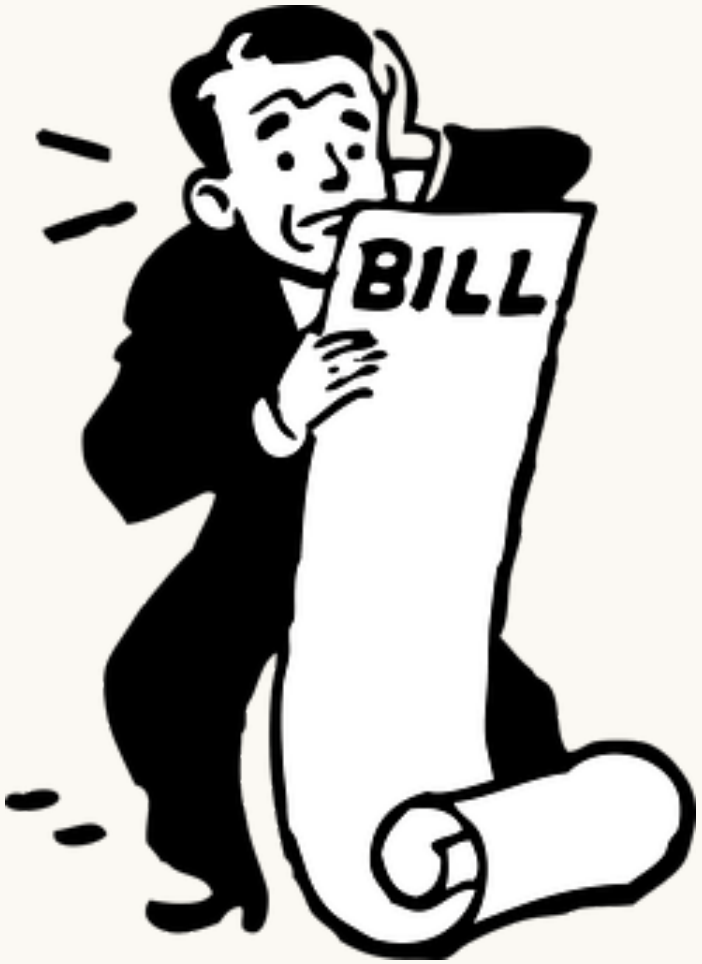
- This is an overview of the regulations.
  - Focusing on provider issues, not those provisions specific to health plans or others.
  - Will not get into the weeds.
  - Check actual regs to apply.
- Some of the rules are in flux due to pending litigation and proposed rules.
  - Check regs and guidance at https://www.cms.gov/nosurprises/policies-and-resources/overview-of-rules-fact-sheets
  - Monitor developments.



# Written Resources

- Stanger, *No Surprise Billing Rules: Checklist for Providers*, https://www.hollandhart.com/no-surprise-billing-rules-checklist-for-providers
- CMS, *Overview of Rules & Fact Sheets*, https://www.cms.gov/nosurprises/policies-and-resources/overview-of-rules-fact-sheets
- If you did not receive link to written materials, contact CECobbins@hollandhart.com.

# No Surprises Act
# No Surprise Billing Rules




- Govt concerned about:
  - Uninsured or self-pay patient receives unexpected medical bill.
  - Insured patient receives unexpected medical bill from out-of-network ("OON") facility or provider.
- Response:
  - No Surprises Act
    - Title I of Division BB of the Consolidated Appropriations Act ("CAA") for 2021
  - No Surprise Billing Rules
    - 45 CFR part 149
    - Effective January 1, 2022

# No Surprise Billing Rules

## INSURED PATIENTS

- Limits amount OON provider/facility may bill patient and payer for
  - Emergency services at an emergency facility, or
  - Non-emergency services by OON provider at in-network facility, or
  - Air ambulance services.
- Notice of rights to patient.
- Independent dispute resolution ("IDR") process for OON providers/facilities and payers*

(45 CFR part 149)

## SELF-PAY PATIENTS

- Providers/facilities must give patient a good faith estimate of charges.
- Notice of rights to patient.
- Patient-Provider Dispute Resolution ("PPDR") process if actual bill is substantially in excess of good faith estimate.

(45 CFR 149.610-.620)

# No Surprise Billing Rules: Penalties


- Reduced or denied payment.
  - Insured Patient: limited or denied payment
    - Unable to balance bill patient
    - Limited OON rate from payers
  - Self-Pay Patient: limited or denied payment under the PPDR process
- State enforcement
  - May vary by state.
- If state fails to enforce, HHS may impose:
  - Corrective action plan
  - $10,000 civil penalty

(42 USC 300gg-134(b); 45 CFR 150.101(b)(3), 150.501(a), and 150.513(a))

# Part I: Insured Patients

- OON providers
- Limits on cost-sharing and balance billing patients
- Notice of patient rights concerning balance billing
- Independent Dispute Resolution ("IDR") process with payers

# Insured Patients: Limits on Billing Patients

- Only applies to certain items or services covered under a health plan or insurance ("health plan") that are provided by OON providers and/or OON facilities to patients.
  - Applies to most health insurance and plans, including individual or group plans whether insured or self-insured, private employment-based group health plans subject to ERISA, non-federal plans, church plans, and traditional indemnity plans.
  - Does not apply to in-network, participating providers.
  - Does not apply to govt programs (e.g., Medicare/Medicaid), health reimbursement arrangements, short-term limited-duration insurance, or retiree plans.

(86 FR 36904)

# Insured Patients: Limits on Billing Patients

- Only applies to OON providers or facilities when:
  - Emergency services are provided by an OON provider or OON 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 services are provided by an OON provider at an in-network health care 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).*
  - Air ambulance services are furnished by an OON provider of air ambulance services.

(45 CFR 149.410-.420; *see also* 86 FR 36904)

# Insured Patients: Limits on Billing Patients

- Patient's cost-sharing for OON services is no higher than in-network level.
  - E.g., if patient's cost-sharing amount for in-network services is 20%, then patient's cost-sharing amount for OON service is 20%.
- The amount to which cost-sharing applies (i.e., the "recognized amount") is determined in descending order of the following:
  - 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, the lesser amount of either the billed charge or the *qualifying payment amount* ("QPA").
    - The QPA is generally the plan's median contracted rate for the same or similar items or services provided by a similar provider in the same geographic region adjusted by factors set forth in the regulations.

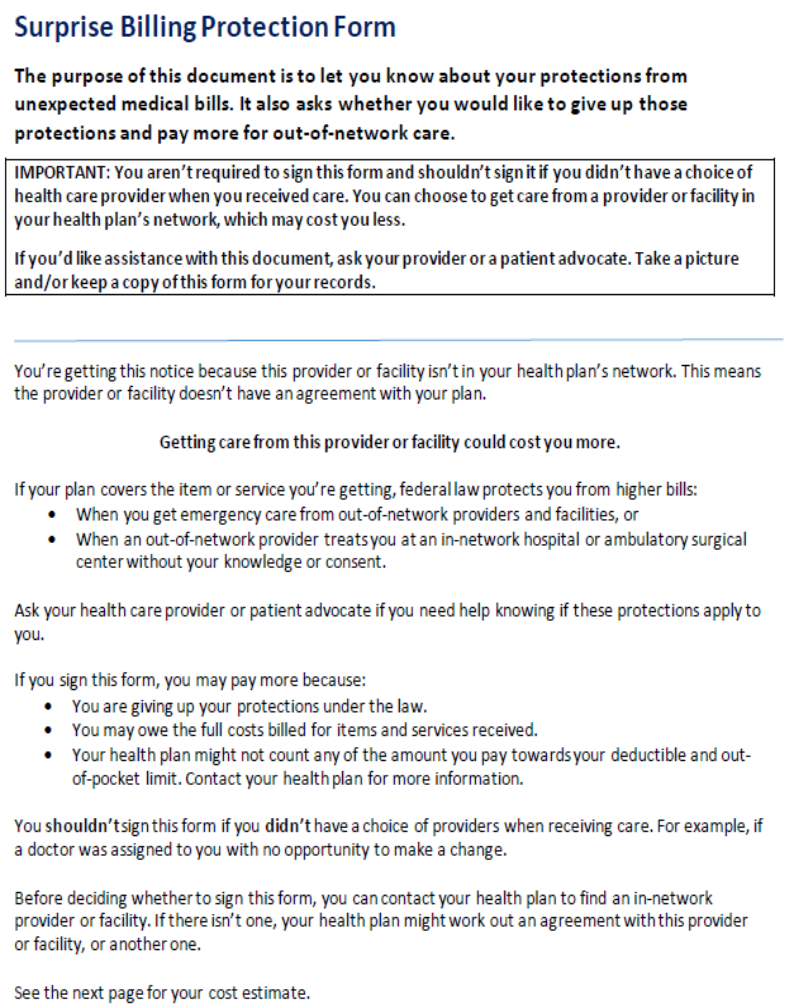
(45 CFR 149.20 and .140(a)(16) and (c))

# Insured Patients: Limits on Billing Patients

- OON provider/facility may avoid limits on balance billing if prior to services:
  - Give required written notice of patient rights to patient; and
  - Obtain patient's written informed consent to bill above limits on cost-sharing.
- Notice and consent exception does not apply to certain services, including:
  - Unforeseen, urgent medical needs that arise at time services rendered.
  - Pre-stabilization emergency services.
  - Certain non-emergency services, e.g., anesthesiology, pathology, radiology, neonatology; assistant surgeons, hospitalists, and intensivists; diagnostic services, including radiology and labs; and items or services provided by OON provider if there is an in-network provider who can furnish them at the facility.
- OON provider/facility must notify insurer if obtain consent to balance bill.

(45 CFR 149.410-.420)

# Insured Patients: Notice and Consent Form



**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.

- Notice and consent must contain certain info.
  - Provider is OON.
  - Good faith estimate of charges.
  - Notice is not a contract.
  - Consent is optional.
  - Patient may receive care from in-network provider.
  - Info about services.

(45 CFR 164.520(c))

➢ See HHS Form at https://www.cms.gov/files/document/notice-and-consent-form-example.pdf

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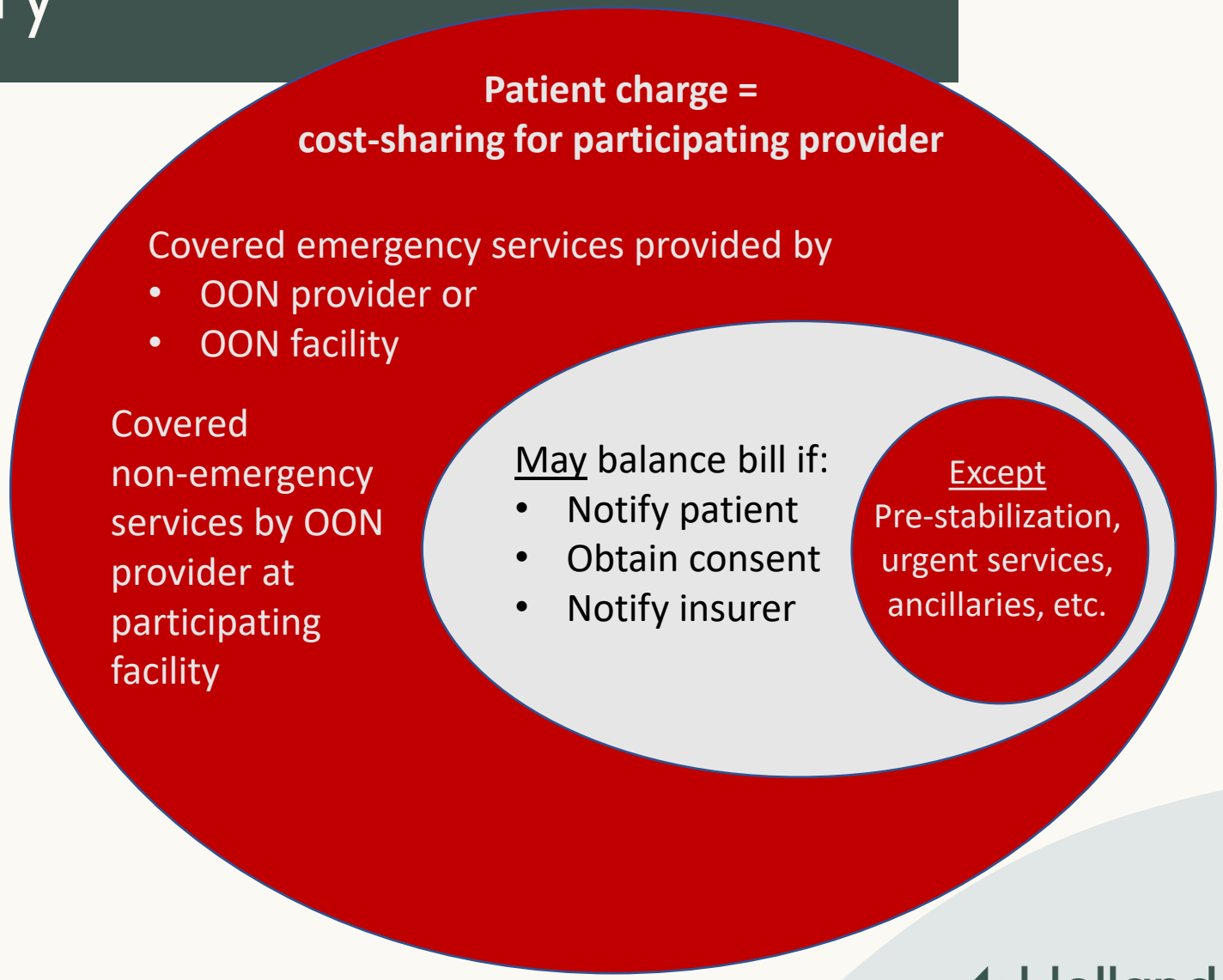
# Insured Patients: NSBR Summary

Limits on surprise bills do not apply to:

- Participating providers/facilities.
- Self-pay patients.
- Govt programs.
- Health reimbursment arrangements, retiree-only plans, short-term limited duration plans.
- Items or services not covered by health plan.
- Items or services that are not provided at or in connection with a visit to a "facility."

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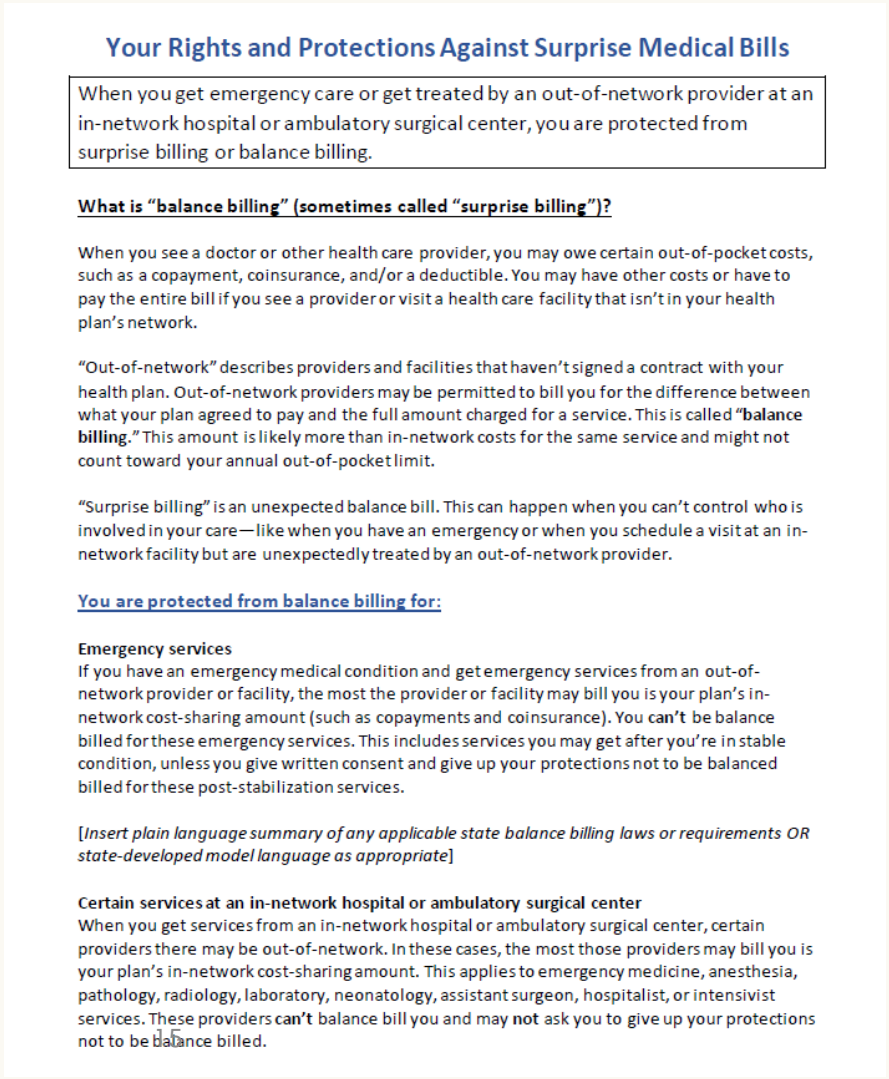
# Insured Patients: Notice of Patient Rights



**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.

- Facilities and providers to which the balance bill rule applies must:
  - Post notice on website.
  - Post notice on sign.
  - Give notice to patients in person, mail, or e-mail as determined by patient.

(45 CFR 149.430)

- See HHS form at https://www.cms.gov/files/document/model-disclosure-notice-patient-protections-against-surprise-billing-providers-facilities-health.pdf

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# Insured Patients:
# IDR Process for Payment by Payers

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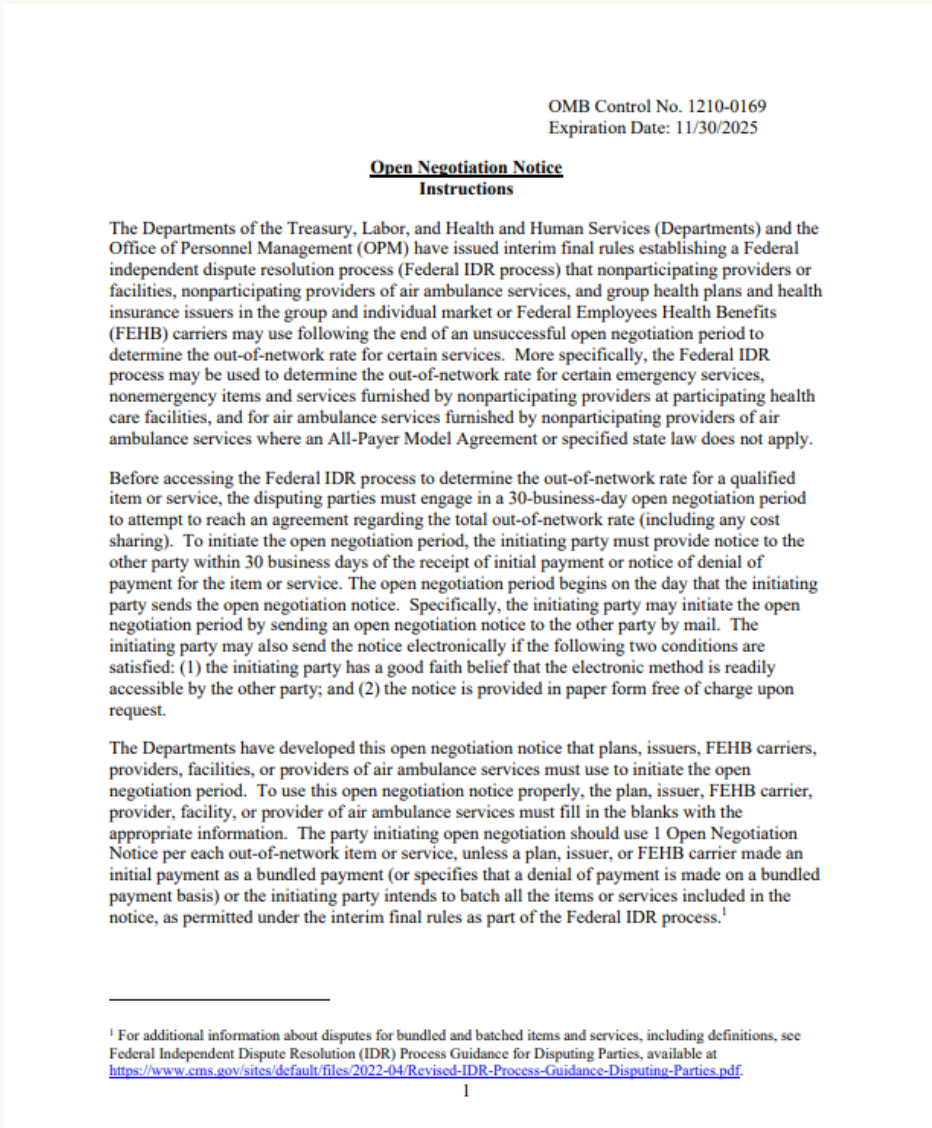
# Insured Patients: OON Payment to Providers

- Total amount paid to OON provider/facility, including 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)

# Insured Patients: IDR Process



OMB Control No. 1210-0169
Expiration Date: 11/30/2025

**Open Negotiation Notice**
**Instructions**

The Departments of the Treasury, Labor, and Health and Human Services (Departments) and the Office of Personnel Management (OPM) have issued interim final rules establishing a Federal independent dispute resolution process (Federal IDR process) that nonparticipating providers or facilities, nonparticipating providers of air ambulance services, and group health plans and health insurance issuers in the group and individual market or Federal Employees Health Benefits (FEHB) carriers may use following the end of an unsuccessful open negotiation period to determine the out-of-network rate for certain services. More specifically, the Federal IDR process may be used to determine the out-of-network rate for certain emergency services, nonemergency items and services furnished by nonparticipating providers at participating health care facilities, and for air ambulance services furnished by nonparticipating providers of air ambulance services where an All-Payer Model Agreement or specified state law does not apply.

Before accessing the Federal IDR process to determine the out-of-network rate for a qualified item or service, the disputing parties must engage in a 30-business-day open negotiation period to attempt to reach an agreement regarding the total out-of-network rate (including any cost sharing). To initiate the open negotiation period, the initiating party must provide notice to the other party within 30 business days of the receipt of initial payment or notice of denial of payment for the item or service. The open negotiation period begins on the day that the initiating party sends the open negotiation notice. Specifically, the initiating party may initiate the open negotiation period by sending an open negotiation notice to the other party by mail. The initiating party may also send the notice electronically if the following two conditions are satisfied: (1) the initiating party has a good faith belief that the electronic method is readily accessible by the other party; and (2) the notice is provided in paper form free of charge upon request.

The Departments have developed this open negotiation notice that plans, issuers, FEHB carriers, providers, facilities, or providers of air ambulance services must use to initiate the open negotiation period. To use this open negotiation notice properly, the plan, issuer, FEHB carrier, provider, facility, or provider of air ambulance services must fill in the blanks with the appropriate information. The party initiating open negotiation should use 1 Open Negotiation Notice per each out-of-network item or service, unless a plan, issuer, or FEHB carrier made an initial payment as a bundled payment (or specifies that a denial of payment is made on a bundled payment basis) or the initiating party intends to batch all the items or services included in the notice, as permitted under the interim final rules as part of the Federal IDR process.[1]

[1] For additional information about disputes for bundled and batched items and services, including definitions, see Federal Independent Dispute Resolution (IDR) Process Guidance for Disputing Parties, available at https://www.cms.gov/sites/default/files/2022-04/Revised-IDR-Process-Guidance-Disputing-Parties.pdf.

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- Within 30 days after receipt of partial payment or denial, send notice starting open negotiating period.
  - Notice must contain required info.
- Attempt to negotiate resolution during 30-day negotiation period.

(45 CFR 149.510(b))

- See DOL form at https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/no-surprises-act/open-negotiation-notice.pdf

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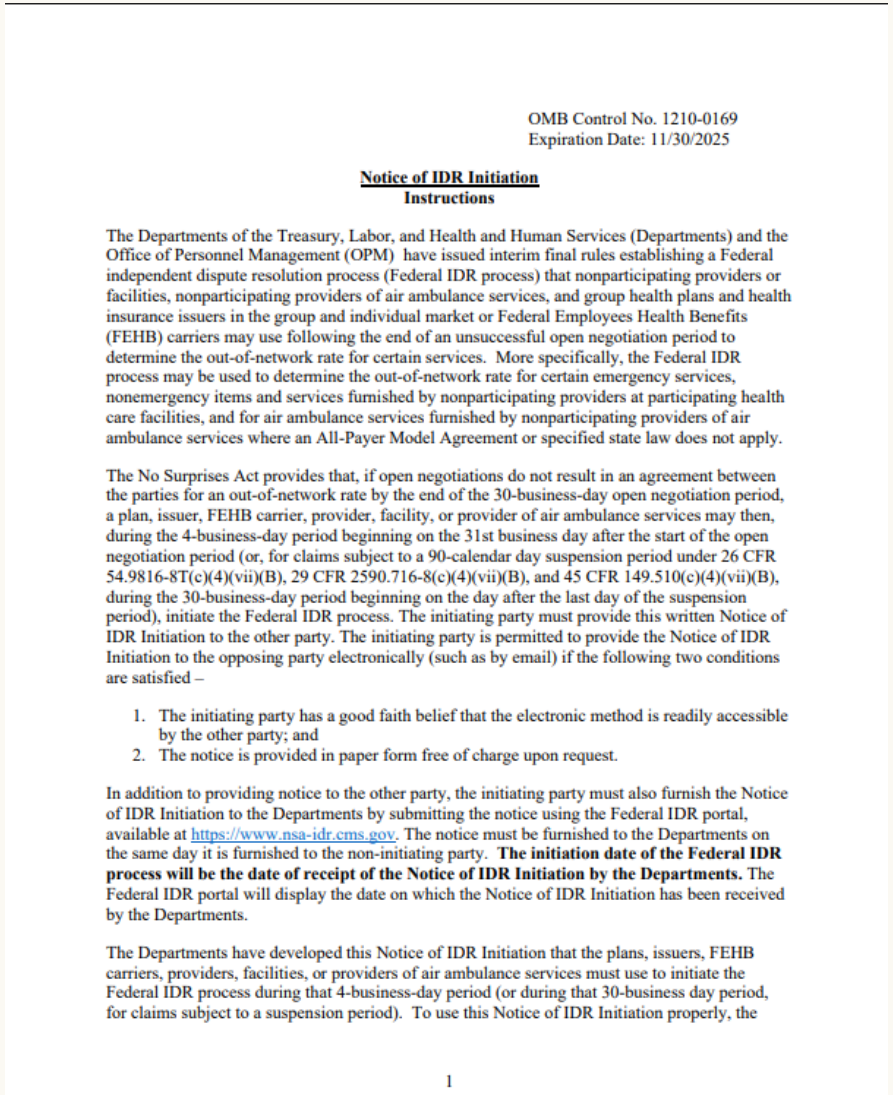
# Insured Patient: IDR Process



OMB Control No. 1210-0169
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The No Surprises Act provides that, if open negotiations do not result in an agreement between the parties for an out-of-network rate by the end of the 30-business-day open negotiation period, a plan, issuer, FEHB carrier, provider, facility, or provider of air ambulance services may then, during the 4-business-day period beginning on the 31st business day after the start of the open negotiation period (or, for claims subject to a 90-calendar day suspension period under 26 CFR 54.9816-8T(c)(4)(vii)(B), 29 CFR 2590.716-8(c)(4)(vii)(B), and 45 CFR 149.510(c)(4)(vii)(B), during the 30-business-day period beginning on the day after the last day of the suspension period), initiate the Federal IDR process. The initiating party must provide this written Notice of IDR Initiation to the other party. The initiating party is permitted to provide the Notice of IDR Initiation to the opposing party electronically (such as by email) if the following two conditions are satisfied –

1. The initiating party has a good faith belief that the electronic method is readily accessible by the other party; and
2. The notice is provided in paper form free of charge upon request.

In addition to providing notice to the other party, the initiating party must also furnish the Notice of IDR Initiation to the Departments by submitting the notice using the Federal IDR portal, available at https://www.nsa-idr.cms.gov. The notice must be furnished to the Departments on the same day it is furnished to the non-initiating party. **The initiation date of the Federal IDR process will be the date of receipt of the Notice of IDR Initiation by the Departments.** The Federal IDR portal will display the date on which the Notice of IDR Initiation has been received by the Departments.

The Departments have developed this Notice of IDR Initiation that the plans, issuers, FEHB carriers, providers, facilities, or providers of air ambulance services must use to initiate the Federal IDR process during that 4-business-day period (or during that 30-business day period, for claims subject to a suspension period). To use this Notice of IDR Initiation properly, the

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- If cannot agree during 30-day open negotiation period, request IDR by filing notice within 4 business days after 30-day open negotiation period ends.
  - Notice must contain required info.

(45 CFR 149.510(b))

- See DOL Form at https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/no-surprises-act/notice-of-idr-initiation.pdf

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# Insured Patient: 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 must notify HHS within 3 days after agreement.
- IDR amounts may be submitted in batches or bundled payment arrangements.*

(45 CFR 149.510(c))

# Insured Patients: IDR Process

- 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.
- Both parties submit IDR entity's fee.
  - Winner receives a refund.

(45 CFR 149.510(c)(4))

# Insured Patients: IDR Process

- 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.
  - Additional info submitted by a party 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.
    - Other info relevant to offer submitted by a party.
  - Additional info submitted by parties in response to IDR entity request.

(45 CFR 149.510(c))

# Insured Patients: IDR Process

- As originally drafted, the IDR process was skewed heavily in favor of the QPA.
- Texas Medical Association ("TMA"), AMA, AHA, and others sued, e.g.,
  - *TMA III:* invalidated QPA methodology and bias; case is still pending.
  - *TMA IV:* invalidated $350 IDR administrative fee; new regs establish fee structure.
- As a result of the litigation:
  - HHS amended regulations re IDR process and proposed others.
  - HHS issued a series of FAQs and other guidance addressing effects of *TMA III*;
  - Depts will exercise enforcement discretion in evaluating parties' methodologies. (See FAQs (1/14/2025) at https://www.cms.gov/files/document/faqs-part-69.pdf).

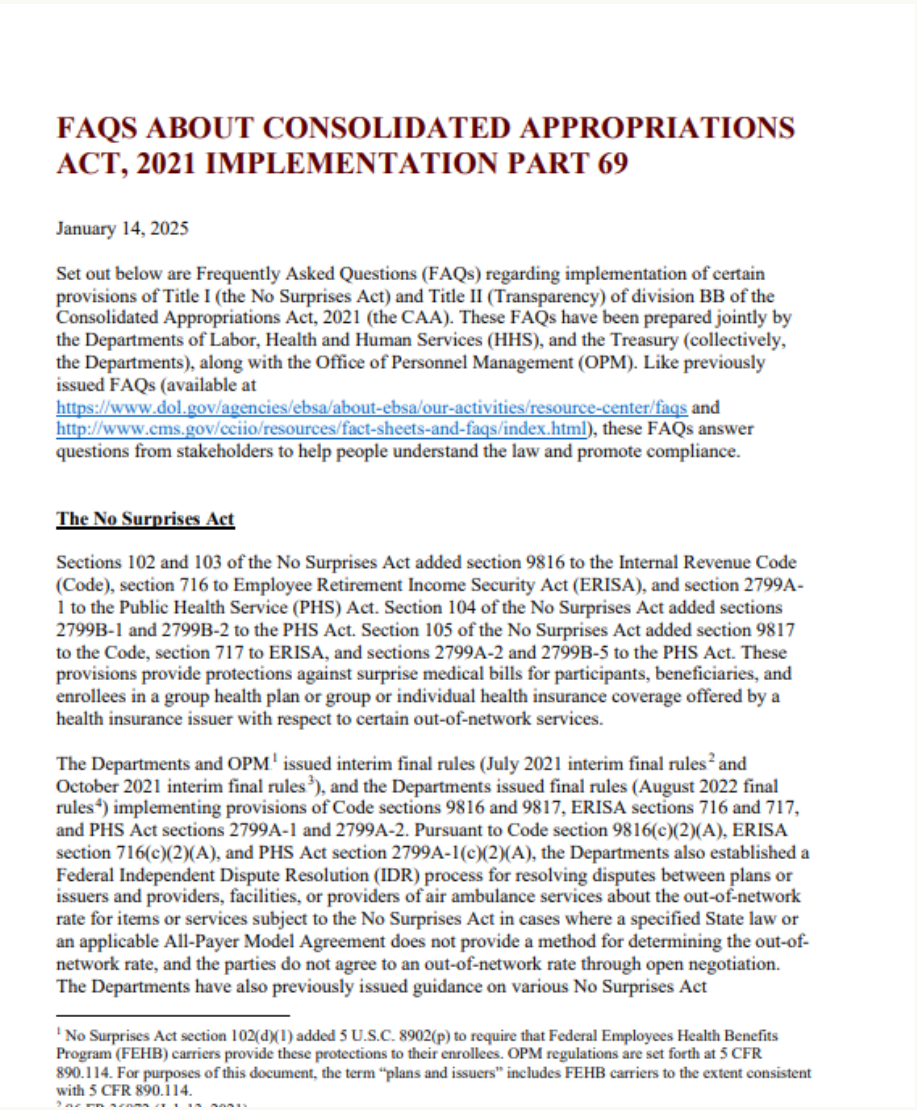
# Insured Patients: IDR Process

- Effect of IDR 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))

- In 6/25, HHS issued guidance on reopening IDR process to address errors identified after dispute closure. (See https://www.cms.gov/files/document/idr-ta-errors-after-dispute-closure.pdf)

# Insured Patients: IDR Process



**FAQS ABOUT CONSOLIDATED APPROPRIATIONS ACT, 2021 IMPLEMENTATION PART 69**

January 14, 2025

Set out below are Frequently Asked Questions (FAQs) regarding implementation of certain provisions of Title I (the No Surprises Act) and Title II (Transparency) of division BB of the Consolidated Appropriations Act, 2021 (the CAA). These FAQs have been prepared jointly by the Departments of Labor, Health and Human Services (HHS), and the Treasury (collectively, the Departments), along with the Office of Personnel Management (OPM). Like previously issued FAQs (available at https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/faqs and http://www.cms.gov/cciio/resources/fact-sheets-and-faqs/index.html), these FAQs answer questions from stakeholders to help people understand the law and promote compliance.

**The No Surprises Act**

Sections 102 and 103 of the No Surprises Act added section 9816 to the Internal Revenue Code (Code), section 716 to Employee Retirement Income Security Act (ERISA), and section 2799A-1 to the Public Health Service (PHS) Act. Section 104 of the No Surprises Act added sections 2799B-1 and 2799B-2 to the PHS Act. Section 105 of the No Surprises Act added section 9817 to the Code, section 717 to ERISA, and sections 2799A-2 and 2799B-5 to the PHS Act. These provisions provide protections against surprise medical bills for participants, beneficiaries, and enrollees in a group health plan or group or individual health insurance coverage offered by a health insurance issuer with respect to certain out-of-network services.

The Departments and OPM[1] issued interim final rules (July 2021 interim final rules[2] and October 2021 interim final rules[3]), and the Departments issued final rules (August 2022 final rules[4]) implementing provisions of Code sections 9816 and 9817, ERISA sections 716 and 717, and PHS Act sections 2799A-1 and 2799A-2. Pursuant to Code section 9816(c)(2)(A), ERISA section 716(c)(2)(A), and PHS Act section 2799A-1(c)(2)(A), the Departments also established a Federal Independent Dispute Resolution (IDR) process for resolving disputes between plans or issuers and providers, facilities, or providers of air ambulance services about the out-of-network rate for items or services subject to the No Surprises Act in cases where a specified State law or an applicable All-Payer Model Agreement does not provide a method for determining the out-of-network rate, and the parties do not agree to an out-of-network rate through open negotiation. The Departments have also previously issued guidance on various No Surprises Act

[1] No Surprises Act section 102(d)(1) added 5 U.S.C. 8902(p) to require that Federal Employees Health Benefits Program (FEHB) carriers provide these protections to their enrollees. OPM regulations are set forth at 5 CFR 890.114. For purposes of this document, the term "plans and issuers" includes FEHB carriers to the extent consistent with 5 CFR 890.114.

- For more info about status of IDR process, see https://www.cms.gov/files/document/faqs-part-69.pdf.
- For info about IDR steps and timelines, see https://www.cms.gov/files/document/independent-dispute-resolution-idr-timeline-claims.pdf

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# Part II: Uninsured or Self-Pay Patients

- Good faith estimate
- Patient-Provider Dispute Resolution ("PPDR") process

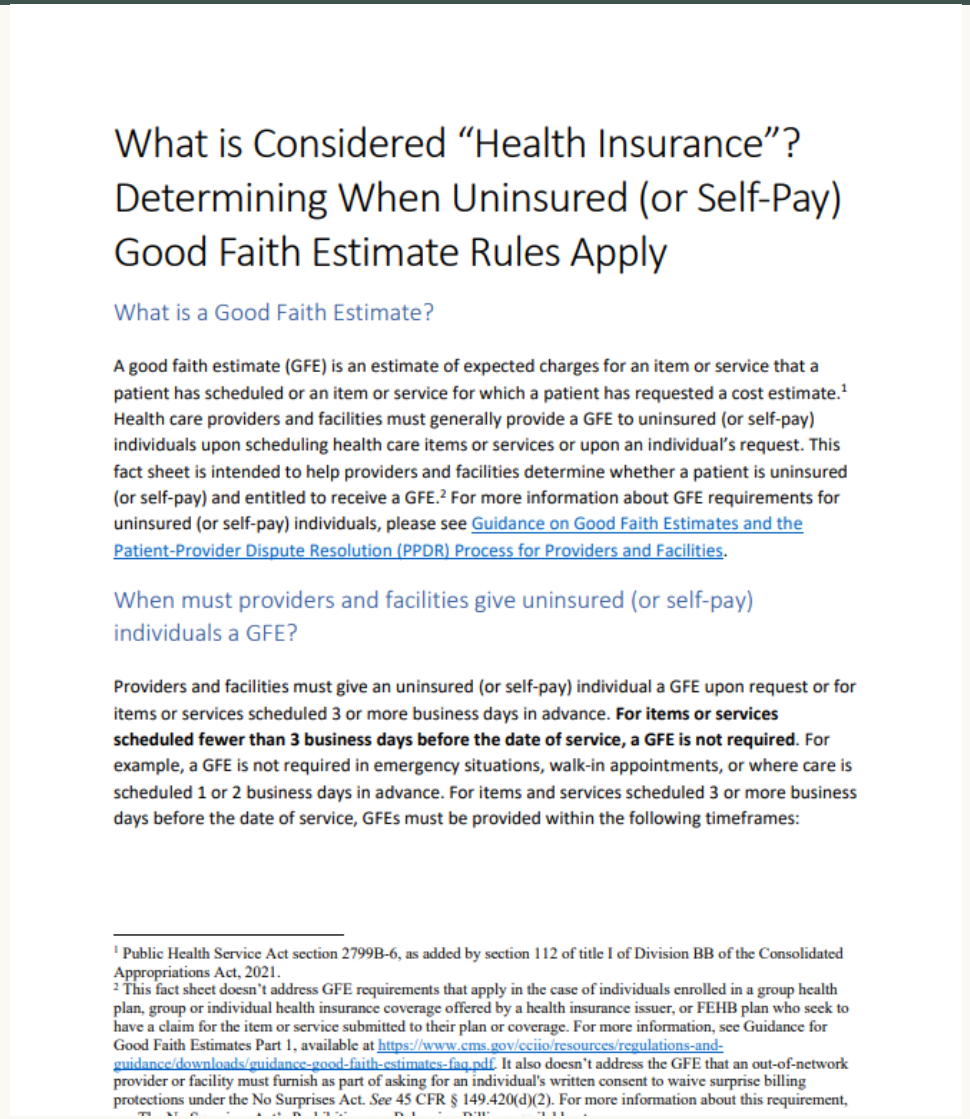
# Self-Pay Patients: Inquire if Patient is Self-Pay

- Convening provider/facility must:
  - Determine if an individual is uninsured or a self-pay (collectively "self-pay") individual:
    - Ask if the patient is covered by a group 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 of expected charges upon:
    - Scheduling the item or service, or
    - Upon request.

(45 CFR 149.610(b)(1))

* Patient enrolled in federal health care program (e.g., Medicare/Medicaid) is not considered a self-pay individual even if the service is not covered or they do not want to submit the claim to the program. (https://www.cms.gov/files/document/fact-sheet-what-is-considered-health-insurance.pdf).

# Self-Pay Patients: Determining "Self-Pay" Status



## What is Considered "Health Insurance"? Determining When Uninsured (or Self-Pay) Good Faith Estimate Rules Apply

### What is a Good Faith Estimate?

A good faith estimate (GFE) is an estimate of expected charges for an item or service that a patient has scheduled or an item or service for which a patient has requested a cost estimate.[1] Health care providers and facilities must generally provide a GFE to uninsured (or self-pay) individuals upon scheduling health care items or services or upon an individual's request. This fact sheet is intended to help providers and facilities determine whether a patient is uninsured (or self-pay) and entitled to receive a GFE.[2] For more information about GFE requirements for uninsured (or self-pay) individuals, please see Guidance on Good Faith Estimates and the Patient-Provider Dispute Resolution (PPDR) Process for Providers and Facilities.

### When must providers and facilities give uninsured (or self-pay) individuals a GFE?

Providers and facilities must give an uninsured (or self-pay) individual a GFE upon request or for items or services scheduled 3 or more business days in advance. **For items or services scheduled fewer than 3 business days before the date of service, a GFE is not required**. For example, a GFE is not required in emergency situations, walk-in appointments, or where care is scheduled 1 or 2 business days in advance. For items and services scheduled 3 or more business days before the date of service, GFEs must be provided within the following timeframes:

[1] Public Health Service Act section 2799B-6, as added by section 112 of title I of Division BB of the Consolidated Appropriations Act, 2021.

[2] This fact sheet doesn't address GFE requirements that apply in the case of individuals enrolled in a group health plan, group or individual health insurance coverage offered by a health insurance issuer, or FEHB plan who seek to have a claim for the item or service submitted to their plan or coverage. For more information, see Guidance for Good Faith Estimates Part 1, available at https://www.cms.gov/cciio/resources/regulations-and-guidance/downloads/guidance-good-faith-estimates-faq.pdf. It also doesn't address the GFE that an out-of-network provider or facility must furnish as part of asking for an individual's written consent to waive surprise billing protections under the No Surprises Act. *See* 45 CFR § 149.420(d)(2). For more information about this requirement,

- For more info, see https://www.cms.gov/files/document/fact-sheet-what-is-considered-health-insurance.pdf

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# Self-Pay Patients: Notice of 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))

# Self-Pay Patients: Notice of Good Faith Estimate

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

Under the law, health care providers need to give **patients who don't have certain types of health care coverage or who are not using certain types of health care coverage** an estimate of their bill for health care items and services before those items or services are provided.

- You have the right to receive a Good Faith Estimate for the total expected cost of any health care items or services upon request or when scheduling such items or services. This includes related costs like medical tests, prescription drugs, equipment, and hospital fees.

- If you schedule a health care item or service at least 3 business days in advance, make sure your health care provider or facility gives you a Good Faith Estimate in writing within 1 business day after scheduling. If you schedule a health care item or service at least 10 business days in advance, make sure your health care provider or facility gives you a Good Faith Estimate in writing within 3 business days after scheduling. You can also ask any health care provider or facility for a Good Faith Estimate before you schedule an item or service. If you do, make sure the health care provider or facility gives you a Good Faith Estimate in writing within 3 business days after you ask.

- If you receive a bill that is at least $400 more for any provider or facility than your Good Faith Estimate from that provider or facility, you can dispute the bill.

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

- See HHS form at https://www.cms.gov/files/document/appendix-1-standard-notice-right-receive-good-faith-estimate-expected-charged-under-no-surprises-act.pdf

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# Self-Pay Patients: 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))

** Rules re co-providers postponed until future rulemaking.*

(*https://www.cms.gov/files/document/good-faith-estimate-uninsured-self-pay-part-3.pdf*)

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# Self-Pay Patients: Provide Good Faith Estimate

- 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))

# Self-Pay Patients: Provide Good Faith Estimate

- "Providers and facilities must give an uninsured (or self-pay) individual a GFE upon request or for items or services scheduled 3 or more business days in advance.
- "**For items or services scheduled fewer than 3 business days before the date of service, a GFE is not required**. For example, a GFE is not required in emergency situations, walk-in appointments, or where care is scheduled 1 or 2 business days in advance."

(https://www.cms.gov/files/document/fact-sheet-what-is-considered-health-insurance.pdf)

# Self-Pay Patients: Provide Good Faith Estimate

- 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))

# Self-Pay Patients: Provide Good Faith Estimate

- 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.*

# Self-Pay Patients: Good Faith Estimate

**[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: | _____/_____/_____ | | |
| Account Number (last four digits) (optional): | | | |
| **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 | [ ] By phone |
| **Patient Diagnosis (if determined)** | | | |
| Primary Service or Item Requested/Scheduled | | | |
| Patient Primary Diagnosis | | Primary Diagnosis Code | |
| Patient Secondary Diagnosis | | Secondary Diagnosis Code | |
| If scheduled, list the date(s) the Primary Service or Item will be provided:<br>[ ] Check this box if this service or item is not yet scheduled | | | |

- Good faith estimate must include required info:
  - Patient name and birthdate;
  - Items and services by codes and charges.
  - Discounts or adjustments.
  - Name, NPI, TIN of co-provider/facility,
  - Location where each item/service is provided;
  - List of items/services that will require separate scheduling; Disclaimers

(45 CFR 149.610(c))

- See HHS form at https://www.cms.gov/files/document/good-faith-estimate-example.pdf

➢ ***Make sure good faith estimate is accurate and complete because you are likely going to be bound by it…***

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# Self-Pay Patients: Good Faith Estimate

## Sample Good Faith Estimate for Uninsured (or Self-Pay) Individuals

Below is an example of a good faith estimate form for uninsured (or self-pay) individuals who are expected to receive a bill for their care. This sample form highlights key information that is required by the No Surprises Act. Providers and facilities do not have to use this specific form, as long as they use a form that includes the required information. For a full list of good faith estimate requirements, see the regulatory requirements at 45 CFR § 149.610(c). To access the form, see the Good Faith Estimate for Health Care Items and Services template.

**[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: _____/_____/_____ | | |
| Account Number (last four digits) (optional): | | |
| **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 [ ] By phone | | |
| **Patient Diagnosis (if determined)** | | |
| Primary Service or Item Requested/Scheduled | | |
| Patient Primary Diagnosis | | Primary Diagnosis Code |
| Patient Secondary Diagnosis | | Secondary Diagnosis Code |
| If scheduled, list the date(s) the Primary Service or Item will be provided:<br>[ ] Check this box if this service or item is not yet scheduled | | |

The form must include information such as the patient's name, date of birth, and the primary item or service (with diagnosis codes).

- For more info re GFE, see https://www.cms.gov/files/document/nsa-sample-good-faith-estimate.pdf

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# Self-Pay Patient: 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.*

# Self-Pay Patients: Maintain 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:*

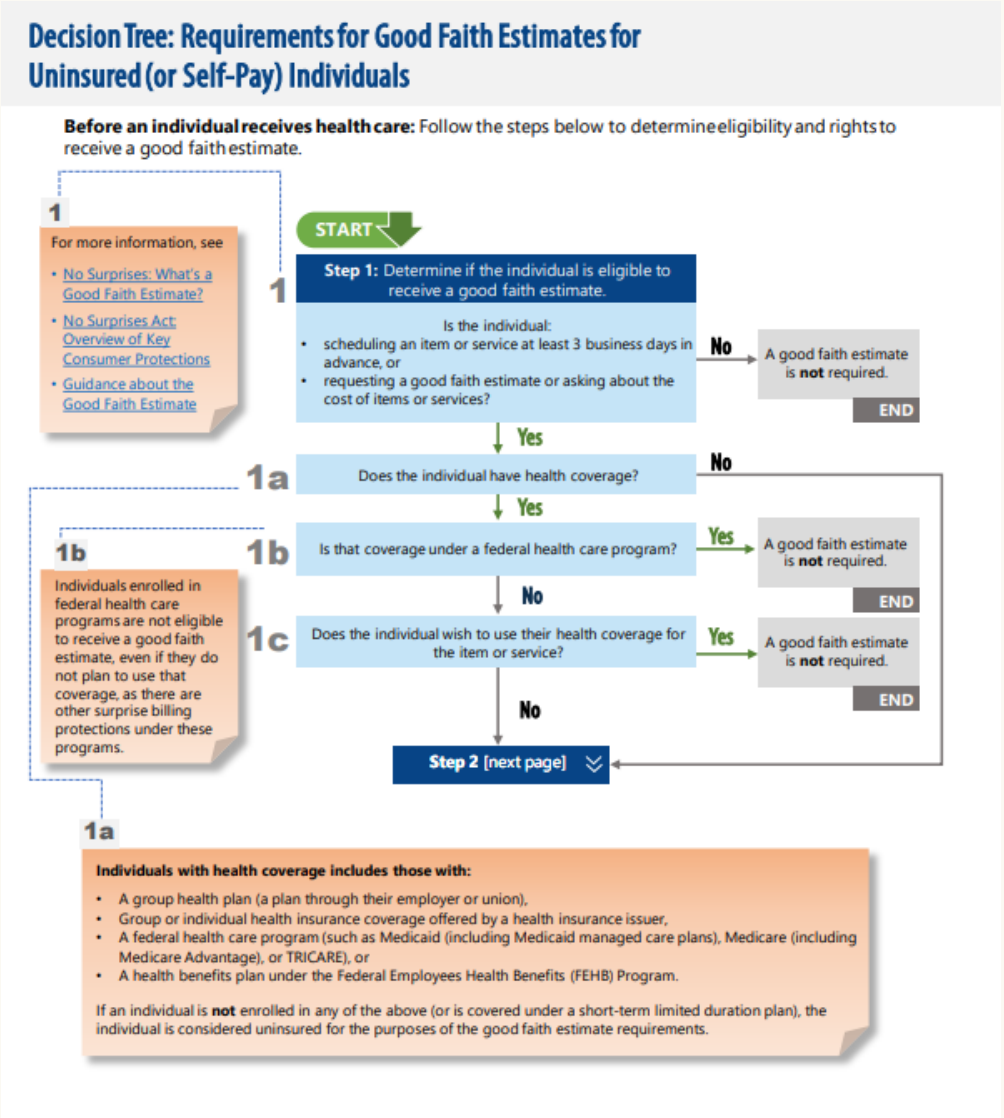
- *PPDR*
- *Dispute over collections*

# 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 PPDR if actual charges are substantially in excess of good faith estimate.

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

# Good Faith Estimate Guidance



**Decision Tree: Requirements for Good Faith Estimates for Uninsured (or Self-Pay) Individuals**

**Before an individual receives health care:** Follow the steps below to determine eligibility and rights to receive a good faith estimate.

1

For more information, see
- No Surprises: What's a Good Faith Estimate?
- No Surprises Act: Overview of Key Consumer Protections
- Guidance about the Good Faith Estimate

START

1 **Step 1:** Determine if the individual is eligible to receive a good faith estimate.

Is the individual:
- scheduling an item or service at least 3 business days in advance, or
- requesting a good faith estimate or asking about the cost of items or services?

No → A good faith estimate is **not** required. END

Yes

1a Does the individual have health coverage?

No

Yes

1b Is that coverage under a federal health care program?

Yes → A good faith estimate is **not** required. END

No

1c Does the individual wish to use their health coverage for the item or service?

Yes → A good faith estimate is **not** required. END

No

**Step 2** [next page]

1b

Individuals enrolled in federal health care programs are not eligible to receive a good faith estimate, even if they do not plan to use that coverage, as there are other surprise billing protections under these programs.

1a

**Individuals with health coverage includes those with:**
- A group health plan (a plan through their employer or union),
- Group or individual health insurance coverage offered by a health insurance issuer,
- A federal health care program (such as Medicaid (including Medicaid managed care plans), Medicare (including Medicare Advantage), or TRICARE), or
- A health benefits plan under the Federal Employees Health Benefits (FEHB) Program.

If an individual is **not** enrolled in any of the above (or is covered under a short-term limited duration plan), the individual is considered uninsured for the purposes of the good faith estimate requirements.

- Decision Tree for GFE, see https://www.cms.gov/files/document/nsa-gfe-decision-tree.pdf

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# PPDR Process for Self-Pay Patients

# Self-Pay Patients: PPDR Process

- 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 the patient-provider dispute resolution ("PPDR") 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))

# Self-Pay Patients: PPDR Process

- "Substantially in excess" is determined by services rendered by provider, e.g.:
  - Provider A provides services X and Y.
  - Provider B provides services Z.
  - Self-pay patient may initiate PPDR 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 PPDR if total charges for C,D, and E exceed $400.

(86 FR 56028)

# Self-Pay Patients: PPDR Process

- Within 120 days of receiving bill containing disputed charges, patient must notify HHS of intent to pursue PPDR and pay $25 fee.
- If PPDR entity determines PPDR is appropriate, it will notify provider/facility.
- While PPDR pending, provider/facility may 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)(1)-(2))

# Self-Pay Patients: PPDR Process

- Within 10 days of notice to provider, provider must submit to PPDR 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

- Within 30 days, PPDR entity issues decision.

(45 CFR 149.620(c), (f))

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# Self-Pay Patients: Billed Charge is 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))

# Self-Pay Patients: 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))

# Air Ambulances




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# Air Ambulances

- OON air ambulance provider renders services to a covered person, provider may not bill patient more than cost-sharing amount that would apply to an in-network provider.
- No exception for notice and consent.

(45 CFR 149.440)

➢*May still bill and recover from plan or insurer for covered services.*

➢*May still bill self-pay patients.*

# Complaints

# Complaint Process

- Complainant may file complaint with HHS for violations of the No Surprises Billing Rule.
- HHS will review the complaint and may request additional information.
- HHS may refer complaints against payers to CMS enforcement process under 45 CFR part 150.
- HHS will make reasonable attempts to notify the complainant of the resolution.

(45 CFR 149.450)

# 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))

# Additional Resources




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# https://www.cms.gov/nosurprises

CMS.gov Centers for Medicare & Medicaid Services

About CMS Newsroom Data & Research

Medicare Medicaid/CHIP Marketplace & Private Insurance Initiatives Training & Education

Initiatives > No Surprise Billing > Overview

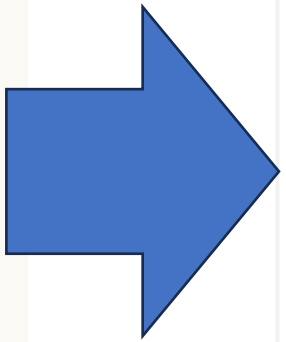
Home Notices Policies & Resources Engaging in IDR Consumers and Advocates Contact Us

Feedback

## Ending Surprise Medical Bills

Learn how providers, facilities, plans and issuers can comply with surprise billing protections and resolve

# https://www.cms.gov/nosurprises



### Policies & resources

Review rules and fact sheets on what No Surprises rules cover, and get additional resources with more information.

Overview of rules & fact sheets

Provider resources

Providers: submit a billing complaint

Providers: payment resolution with patients

Plans and Issuers resources

Independent dispute resolution reports

Privacy policies & notices for this website

### Resolving out-of-network payment disputes

Learn about out-of-network payment disputes between providers and health plans and how to start the independent dispute resolution (IDR) process, apply to become a certified independent dispute resolution entity, or submit a petition on an applicant or to revoke certification of a current IDR entity.

Learn about or start a payment dispute

Tips for disputing parties

Become a dispute resolution organization

List of certified organizations

Submit petition to deny IDRE certification

### Consumers and consumer advocates

Learn about rights and protections for consumers to end surprise bills and remove consumers from payment disagreements between their providers, health care facilities and health plans.

Consumers rights, protections, & resources

Consumer Advocate Toolkit

Feedback

# https://www.cms.gov/nosurprises/policies-and-resources/overview-of-rules-fact-sheets

IDR Resources

## Guidance & technical resources

**Independent dispute resolution process**

- IDR YouTube playlist: Webinars and system demonstrations
- IDR system job aids and user guides:
  - Federal Independent Dispute Resolution (IDR) Notice of Initiation Web Form User Guide (Revised May 2024) (PDF)
  - Certified Independent Dispute Resolution (IDR) Entity Selection Web Form Job Aid (Revised December 2023) (PDF)
  - Federal Independent Dispute Resolution (IDR) Notice of Offer Web Form Job Aid (Revised December 2023) (PDF)
  - Federal Independent Dispute Resolution (IDR) Resubmission Web Form User Guide (April 2024) (PDF)
- February 28, 2022: Memorandum regarding continuing surprise billing protections for consumers (PDF)
- Paperwork Reduction Act (PRA) model notices and information collection requirements for the Federal Independent Dispute Resolution Process
- No Surprises Act (NSA) Independent Dispute Resolution (IDR) Batching and Air Ambulance Policy Frequently Asked Questions (FAQs) (PDF)
- Frequently Asked Questions (FAQs) about Affordable Care Act and Consolidated Appropriations Act, 2021 Implementation (Set 63) (PDF)
- Frequently Asked Questions (FAQs) about Affordable Care Act and Consolidated Appropriations Act, 2021 Implementation (Set 62) (PDF)
- Frequently Asked Questions (FAQs) about Affordable Care Act and Consolidated Appropriations Act, 2021 Implementation (Set 67) (PDF)
- No Surprises Act (NSA) Independent Dispute Resolution (IDR) Partial Reopening of Dispute Initiation Frequently Asked Questions (FAQs) (PDF)
- No Surprises Act (NSA) Independent Dispute Resolution (IDR) Administrative Fee Frequently Asked Questions (FAQs) (PDF)
- Federal Independent Dispute Resolution (IDR) Process Administrative Fee and Certified IDR Entity Fee Ranges

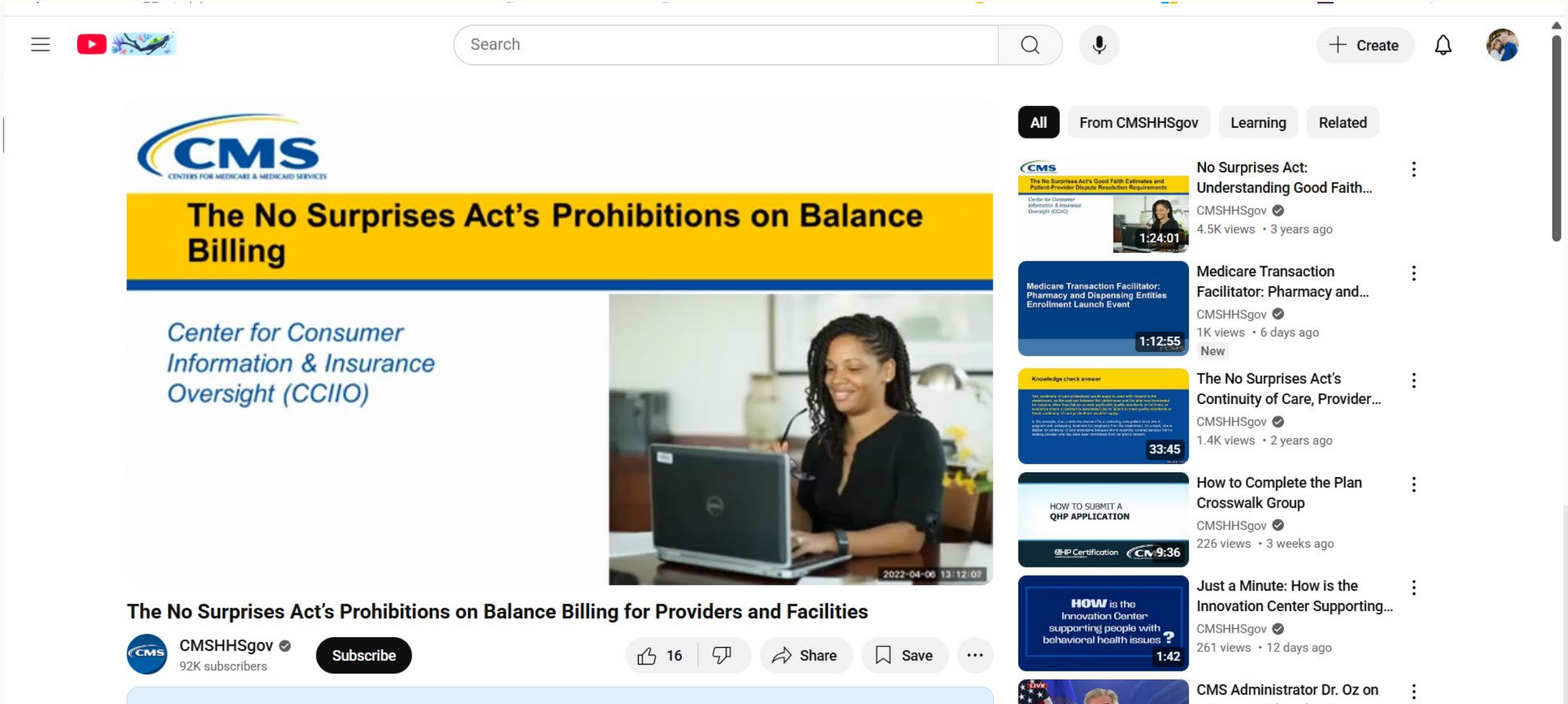
# https://www.cms.gov/nosurprises/policies-and-resources/overview-of-rules-fact-sheets

GFE and PPDR Resources

**Good faith estimates, patient-provider dispute resolution, and advanced explanation of benefits**

- Model Notice: Good Faith Estimate for Health Care Items and Services and Abbreviated GFE for No-Cost Health Care Items or Services (PDF)
- Model Notice: Right to Receive a Good Faith Estimate of Expected Charges (PDF)
- Paperwork Reduction Act (PRA) model notices and information collection requirements for the good-faith estimate and patient-provider payment dispute resolution
- Guidance on good faith estimates and the Patient-Provider Dispute Resolution (PPDR) process for people without insurance or who plan to pay for the costs themselves (PDF)
- Guidance on good faith estimates and the Patient-Provider Dispute Resolution (PPDR) Process for providers and facilities as established in Surprise Billing, Part II; Interim Final Rule with Comment Period (PDF)
- Guidance for Selected Dispute Resolution (SDR) Entities: Required steps to making a payment determination under the Patient-Provider Dispute Resolution (PPDR) process (PDF)
- Calendar Year 2023 fee guidance for the Federal Patient-Provider Dispute Resolution (PPDR) process established in Surprise Billing, Part II; Interim Final Rule with Comment Period (PDF)
- Frequently Asked Questions (FAQs) about Consolidated Appropriations Act, 2021 Implementation – Good Faith Estimates (GFE) for Uninsured (or Self-Pay) Individuals – Part 1 (PDF)
- Frequently Asked Questions (FAQs) about Consolidated Appropriations Act, 2021 Implementation - Good Faith Estimates (GFE) for Uninsured (or Self-Pay) Individuals – Part 2 (PDF)
- Frequently Asked Questions (FAQs) about Consolidated Appropriations Act, 2021 Implementation - Good Faith Estimates (GFE) for Uninsured (or Self-Pay) Individuals – Part 3 (PDF)
- Frequently Asked Questions (FAQs) about Consolidated Appropriations Act, 2021 Implementation - Good Faith Estimates (GFE) for Uninsured (or Self-Pay) Individuals – Part 4 (PDF)

https://www.youtube.com/watch?v=aQ87InetyaA



https://regtap.cms.gov/reg_library_videoe.php?id=3817

# Action Items

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# Establish and/or Review 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 PPDR for disputes with patients.

# Create and Implement Forms

- 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.
- PPDR for disputes with self-pay patients
  - Response to PPDR including criteria.

# Post and Distribute 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

# Develop and Train Staff re Processes

- ✓ Develop and train staff re processes, including those applicable to insured and 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
  - 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.

# 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;<br>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 |

# Process to Calendar PPDR Deadlines

| Timing | Action |
|---|---|
| w/120 days of bill | Self-pay patient initiates PPDR and pays fee. |
| Upon receipt of patient's initiation | HHS selects PPDR entity; PPDR entity reviews info submitted by patient; may give patient 21 days to submit more info |
| | PPDR entity notifies provider/facility and patient. |
| Upon notice of PPDR | 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 PPDR entity of settlement, if any. |
| w/30 days after provider/facility submits info | PPDR entity issues determination and notifies parties. |

# Questions?

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