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Navigating Regulations Compliantly and Effectively

Federal Implications to Healthcare

September 25, 2023

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Key policy rules in healthcare RCM market

RULE	PRICE TRANSPARENCY	SURPRISE MEDICAL BILLING	PAYER PRICE TRANSPARENCY
EFFECTIVE DATE	January 1, 2021	January 1, 2022	January 1, 2022 (phased through 2024)
PROVISION SUMMARY	Providers must make available their negotiated prices, and in machine readable format	Providers are prohibited from balance billing patients for out of network (OON) claims, must follow arbitration if cannot agree, and must meet notice requirements for OON patients	Payers must make available their negotiated rates, in machine readable format, and also must provide an advanced evidence of coverage (AEOB) to members
APPLICABLE PENALTIES	$300/day <30 beds; $10/day >30 beds, up to a daily dollar amount of $5,500 (Annual fine max ~$2M/facility)	$10,000 per violation	Enforcement under ERISA; currently $1625 per day for DOL violations - varies)
MARKET IMPACT	CMS has issued warning letters. HHS delaying enforcement; ~70% of market is in compliance – Providers are reticent on the MRF portion (re: proprietary rates)	Loss in reimbursement outweighs fines, most large providers feel are in compliance with their homegrown process today.	CMS is delaying enforcement into 2023. AHIP provided guidance to payers for compliance

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Price Transparency

Best practices for providers

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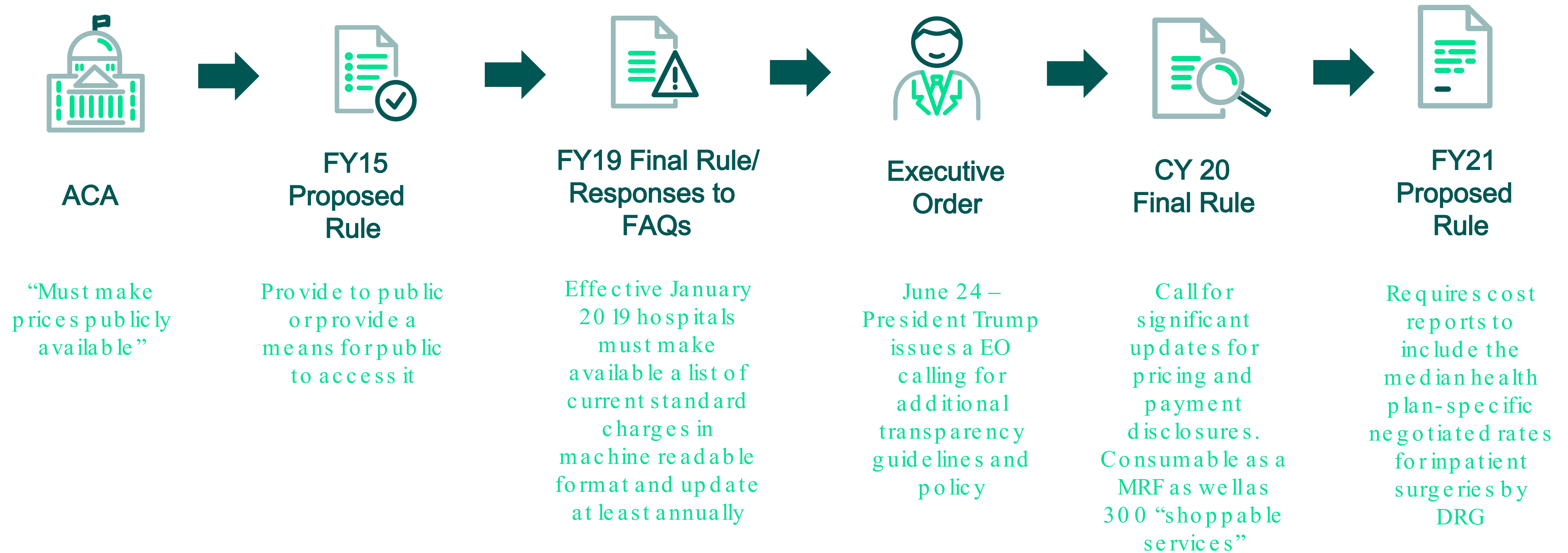
Transparency is NOT new…



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https://www.cleverleyassociates.com/price-transparency/

Nearly two-thirds of hospitals are not complying with price transparency requirements

FGA's independent review of more than 6,400 hospitals reveals widespread non-compliance with federal transparency requirements.[24] **Altogether, more than 63 percent of hospitals are not complying with the transparency rule.[25]** Some of these hospitals have refused to disclose cash prices, negotiated rates with private insurance plans, prices for some services, or even any prices at all.[26]

Nearly two-thirds of hospitals are not complying with price transparency requirements.

37% complying

63% not complying

Source: Authors' Calculations

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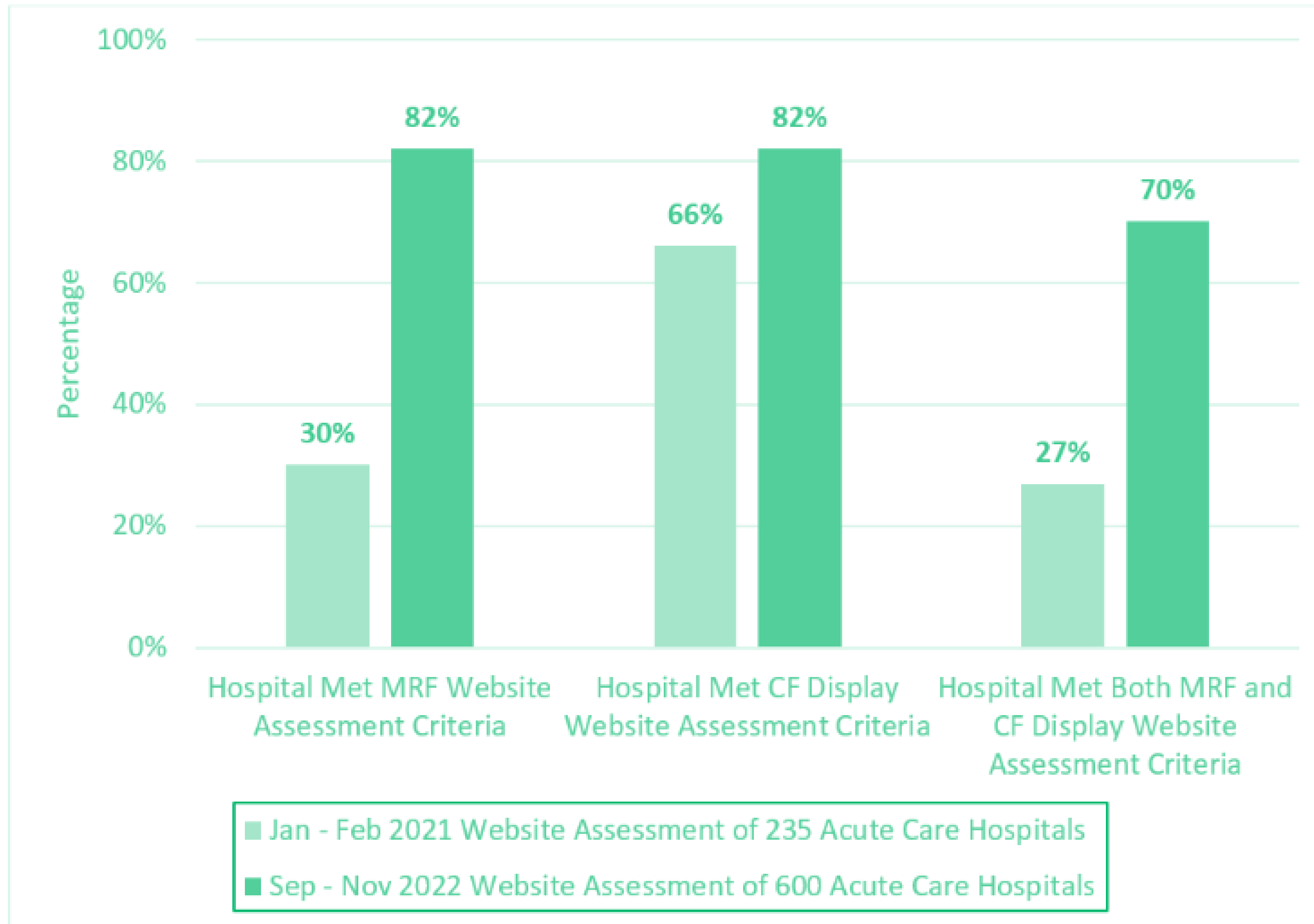
https://thefga.org/research/americas-hospitals-are-hiding-the-cost-of-health-care/

Compliance is growing…



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https://www.healthaffairs.org/content/forefront/hospital-price-transparency-progress-and-commitment-achieving-its-potential

Compliance is growing…

"As of January 2023, CMS had issued nearly 500 warning notices and over 230 requests for corrective action plans since the initial implementing regulation went into effect in 2021. Nearly 300 hospitals have addressed problems and have become compliant with the regulations, leading to closure of their cases. While it was necessary to issue penalties to two hospitals in 2022 for noncompliance (posted on the CMS website), every other hospital that was reviewed has corrected its deficiencies."

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https://www.healthaffairs.org/content/forefront/hospital-price-transparency-progress-and-commitment-achieving-its-potential

"CMS has assisted hospitals by choosing not to enforce the rule robustly. It has issued financial penalties on only two hospitals out of the thousands nationwide that are noncompliant…

The two fined hospitals quickly became compliant and posted exemplary price files …"

THE HILL

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Garland reaffirms US commitment to holding Russia accountable in surprise Ukraine visit
ADMINISTRATION - 4M 27S AGO

Republicans notch key win with Biden's DC crime bill move
SENATE - 14M 56S AGO

Liberals fume over Biden's turn against home rule in decision on DC crime bill
HOUSE - 16M 4S AGO

America must stop China's lethal fentanyl engine
CONGRESS BLOG - 21M 59S AGO

Seattle councilmember launches movement toward new workers

THE VIEWS EXPRESSED BY CONTRIBUTORS ARE THEIR OWN AND NOT THE VIEW OF THE HILL

Making the hospital price transparency rule a reality on its two-year anniversary

BY CYNTHIA A. FISHER, OPINION CONTRIBUTOR - 12/31/22 2:00 PM ET

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Most Popular

1 Judiciary Democrats go

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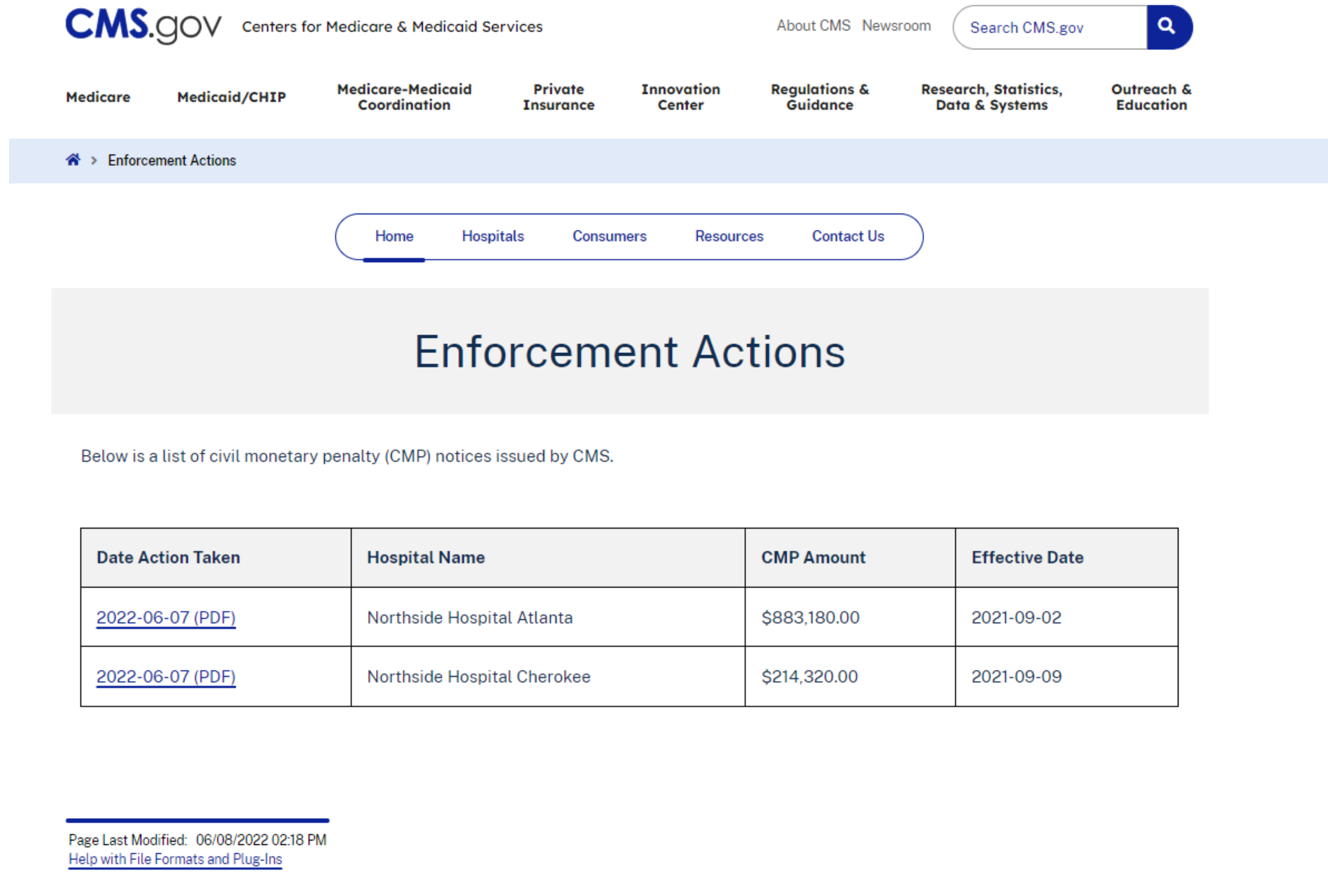
https://thehill.com/opinion/healthcare/3794376-making-the-hospital-price-transparency-rule-a-reality-on-its-two-year-anniversary/

Do YOU want to be on this list?



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https://www.cms.gov/hospital-price-transparency/enforcement-actions

Getting the patients engaged..the basics

63% of healthcare providers are having trouble providing sufficient price transparency for patients facing a growing financial responsibility

Three steps:

1	Assess **eligibility** to determine coverage and benefits
2	Educate the patient about the financial policy, payment options and financial assistance programs
3	Offer cost estimates and push for full price transparency - increasing price transparency can improve patient satisfaction and generate more payments from patients

"By ensuring patients fully ***understand their financial responsibility****, they can better equip them to make decisions about care access. Ultimately, this may help more patients get access to care that they can afford"*

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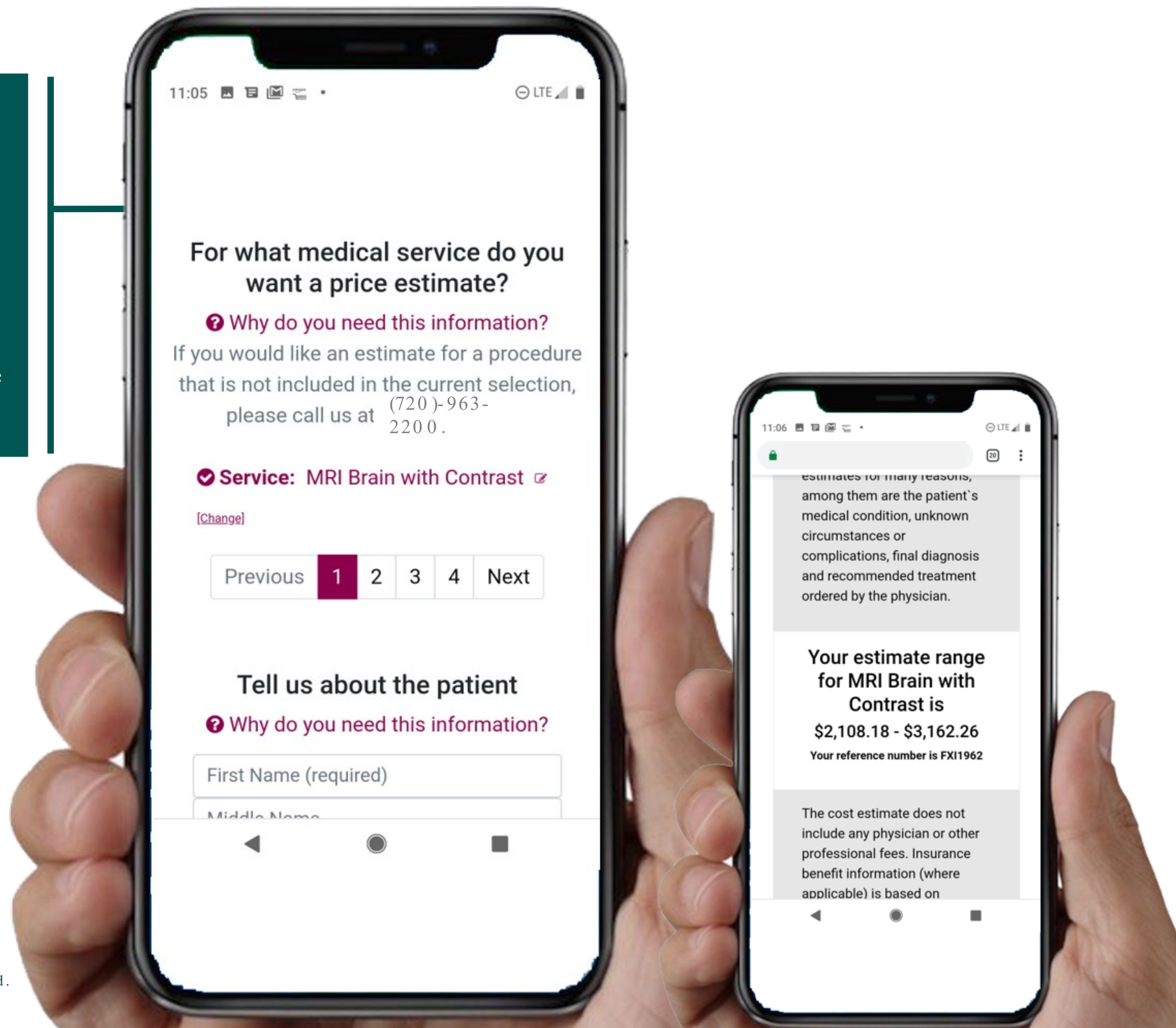
Source: https://patientengagementhit.com/news/providers-struggle-with-patient-price-transparency-responsibility

Patients can create estimates via their mobile devices

Android and iOS compatible with a responsive user interface design to fit various screen sizes, allowing patients to create estimates via mobile devices



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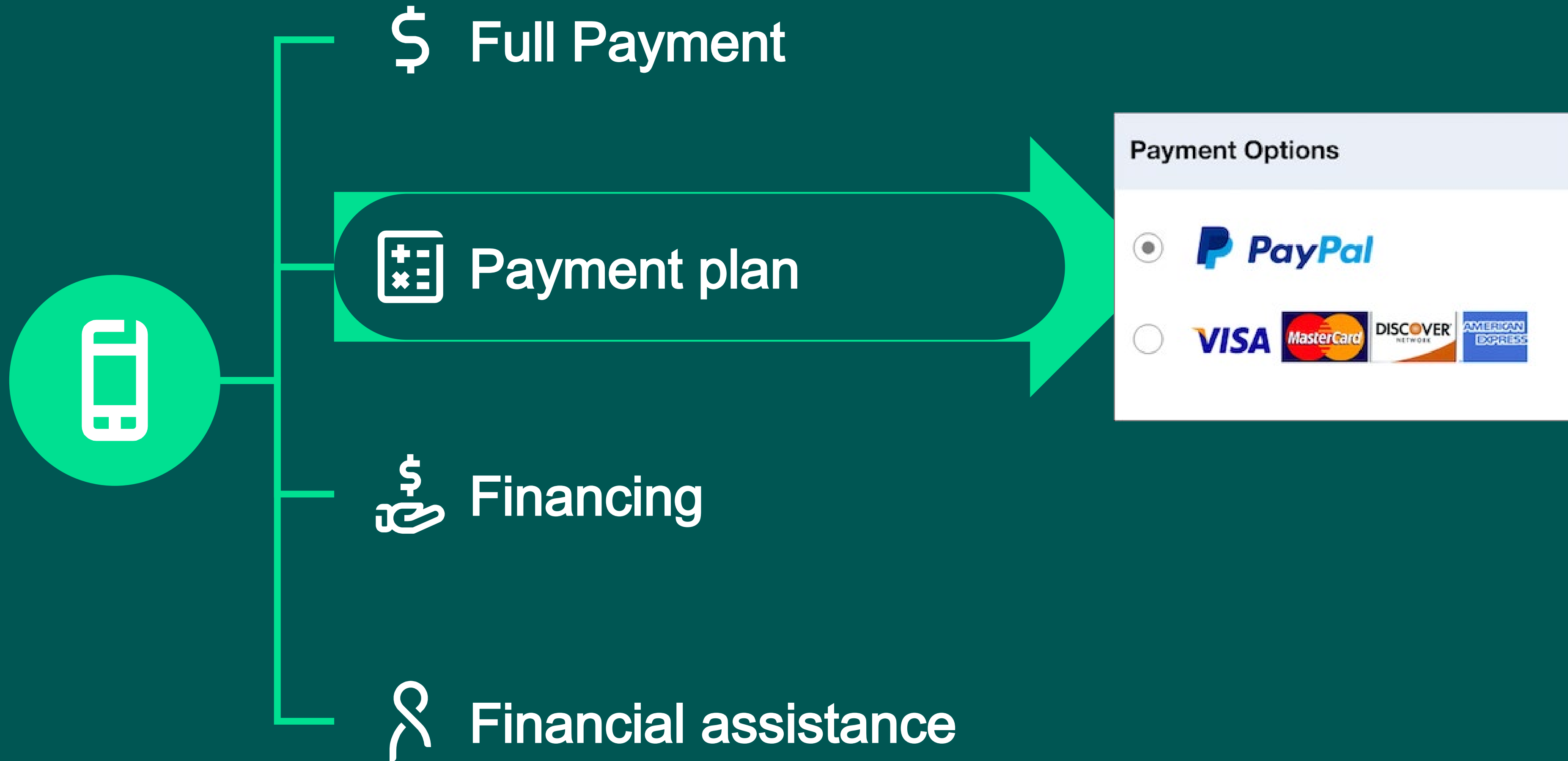
Flexible payment options tailored to patient behavior



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Frictionless payment

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No Surprises Act

Best practices for providers

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"No patient should forgo care for fear of surprise billing…

Health insurance should offer patients peace of mind that they won't be saddled with unexpected costs…

The Biden-Harris Administration remains committed to ensuring transparency and affordable care, and with this rule, Americans will get the assurance of no surprises."

Xavier Becerra, Secretary HHS

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Why does the No Surprises Act exist?

- 41% of insured adults were surprised by a medical bill in 2020
- 18% of emergency visits and 16% of hospital in-patient stays result in a surprise bill
- 21% of surgeries have a surprise bill
- 16.5% of anesthesiology services are out of network

Unexpected Medical Bills Top List Of Public's Worries

How worried, if at all, are you about being able to afford each of the following for you and your family?

	Very worried	Somewhat worried	Not too worried	Not at all worried
Unexpected medical bills	35%	30%	17%	17%
Your health insurance deductible*	22%	26%	22%	28%
Your prescription drug costs	22%	23%	23%	30%
Your rent or mortgage	18%	24%	20%	36%
Gasoline or other transportation costs	15%	26%	26%	32%
Your monthly health insurance premium*	18%	22%	24%	34%
Your monthly utilities like electricity or heat	16%	22%	26%	34%
Food	17%	18%	24%	41%

NOTE: *Asked of those who are insured.
SOURCE: KFF Health Tracking Poll (conducted February 13-18, 2020). See topline for full question wording and response options.

KFF HENRY J KAISER FAMILY FOUNDATION

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https://aspe.hhs.gov/sites/default/files/migrated_legacy_files//196341/Surprise-Medical-Billing.pdf
https://www.kff.org/health-costs/poll-finding/data-note-public-worries-about-and-experience-with-surprise-medical-bills/

Why does the No Surprises Act exist?

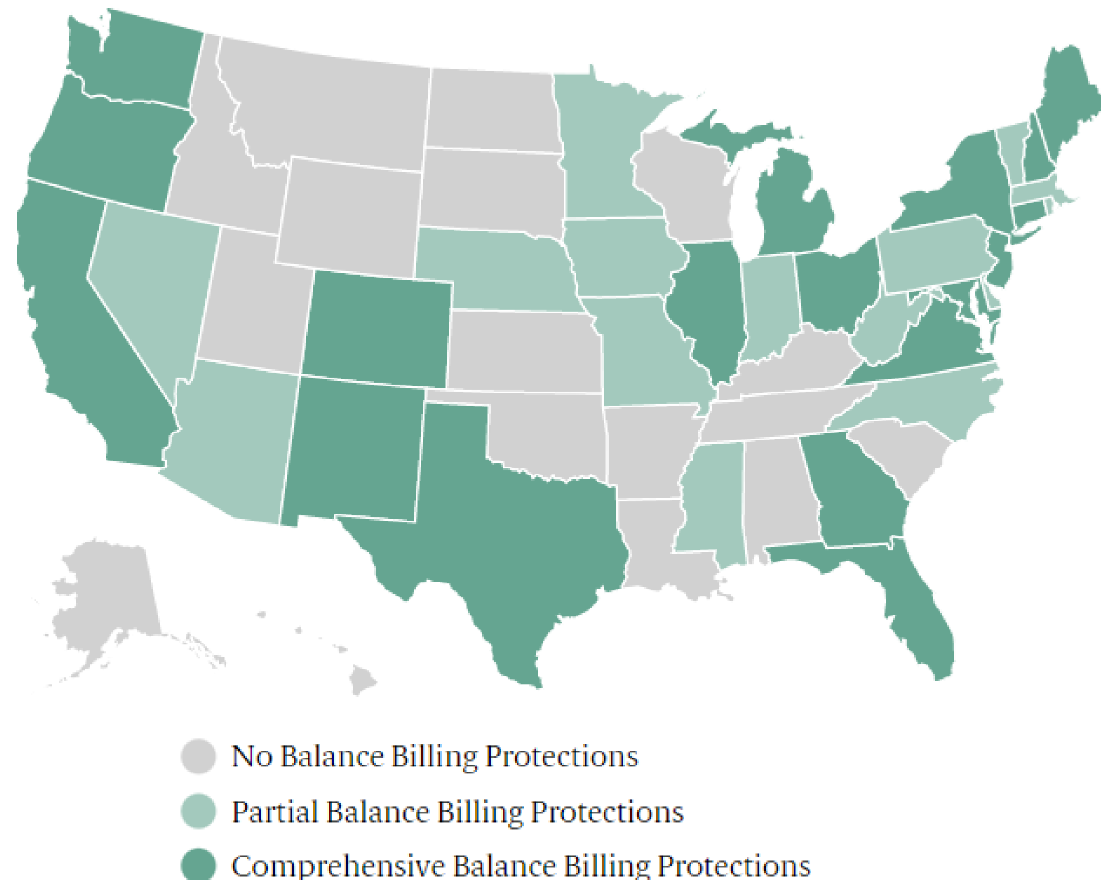
33 states have enacted laws to protect enrollees from balance billing

Commonwealth – Balance billing protection based on:

1) a requirement that the consumer has received and acknowledged a disclosure statement about the risk of balance bills when using out-of-network providers or;

2) a minimum claim amount, unless that minimum does not limit the protection for the consumer

ERISA exemption: Federal law enacted to govern plans that are exempt from state law under ERISA



https://www.commonwealthfund.org/publications/maps-and-interactives/2021/feb/state-balance-billing-protections

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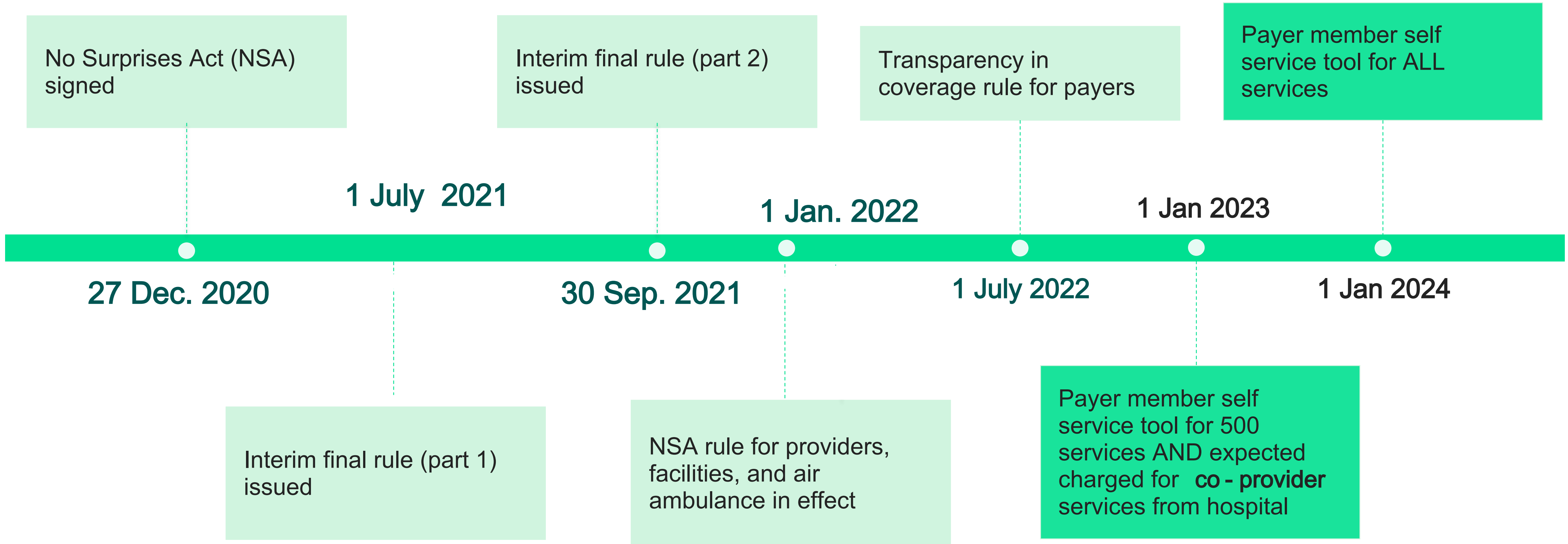
No Surprises Act (NSA) Timeline



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“Big Four” of the No Surprises Act

1 Prohibits Out-of-Network (OON) ED balance billing

2 Insurer Benefit Reciprocity for patient liability (copay, coinsurance, deductible) Same as IN NETWORK

3 No OON billing on other (non-ED) services unless Notice and Consent provided

4 Good Faith Estimates (GFE) for self pay or uninsured

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Think of NSA as two separate laws

1. Protections Against Medical bills

- Balance billing
- Commercial health insurance
- Must meet certain requirements
- Notice/Display/Posting

2. Good Faith Estimate (GFE)

- Uninsured and self pay
- Price Transparency
- Larger scope/locations
- Notice/Display/Posting

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Convening Provider and Co-Provider

NOTE: Effective 1/1/23, GFE MUST include ANY item or service that is REASONABLY expected to be provided in conjunction with scheduled or requested item or service BY ANOTHER PROVIDER or FACILITY(ies) (i.e "co-provider)

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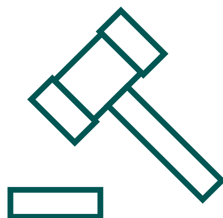
No Surprises Act



12/2/22:

Enforcement of co-providers co-facilities has been "extend[ed] into 2023 for enforcement discretion"

FAQS ABOUT CONSOLIDATED APPROPRIATIONS ACT, 2021 IMPLEMENTATION - GOOD FAITH ESTIMATES (GFES) FOR UNINSURED (OR SELF-PAY) INDIVIDUALS – PART 3

December 2, 2022

Set out below are Frequently Asked Questions (FAQs) regarding implementation of Section 112 of Title I (the No Surprises Act (NSA)) of Division BB of the Consolidated Appropriations Act, 2021, and implementing regulations published in the Federal Register on October 7, 2021 as part of interim final rules with comment period, titled *Requirements Related to Surprise Billing; Part II*. These FAQs have been prepared by the Department of Health and Human Services (HHS) to address the provision of GFEs for uninsured (or self-pay) individuals, as described in Public Health Service Act (PHS Act) section 2799B-6 and implementing regulations at 45 CFR 149.610.

Additional FAQs related to GFEs for uninsured (or self-pay) individuals are available at https://www.cms.gov/cciio/resources/regulations-and-guidance#Good_Faith_Estimates.

Q1: Will CMS enforce the requirement that GFEs for uninsured (or self-pay) individuals include cost estimates from co-providers and co-facilities beginning on January 1, 2023?

A1: No. HHS is extending enforcement discretion, pending future rulemaking, for situations where GFEs for uninsured (or self-pay) individuals do not include expected charges from co-providers or co-facilities.

PHS Act section 2799B–6 and implementing regulations at 45 CFR 149.610(b)(1)(v) and (2)(i) require a GFE to include expected charges for any item or service that is reasonably expected to be provided in conjunction with the scheduled or requested item or service, including those provided by co-providers or co-facilities. In the *Requirements Related to Surprise Billing; Part II* interim final rules (IFR),[1] HHS indicated that it will exercise its enforcement discretion in situations where a GFE provided to an uninsured (or self-pay) individual from January 1, 2022 through December 31, 2022 does not include expected charges from co-providers or co-facilities. We explained that this exercise of enforcement discretion was necessary to allow time for providers and facilities to develop mechanisms for convening providers and facilities to request, and co-providers and co-facilities to provide, complete and accurate pricing information for the convening provider or facility to incorporate into the GFE for uninsured (or self-pay) individuals.

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

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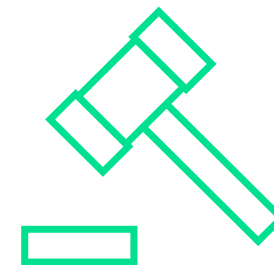
No Surprises Act



Enforcement

Providers and payers that violate the No Surprises Act are subject to civil monetary penalties of up to **$10,000** - can be enforced by federal or state agencies

Most providers (and their associations – AMA, AHA, MGMA, etc) have indicated they are NOT ready

But...

*"Accordingly, until rulemaking to fully implement this requirement …. **HHS will defer enforcement** …"*

And…

"[As it relates to the NSA] Consumer Financial Protection Bureau (CFPB) …will closely review the practices of those engaged in the collection or reporting of medical debt, will hold debt collectors accountable for failing to comply with the Fair Debt Collection Practices Act (FDCPA) and Regulation F, and will hold consumer reporting agencies (CRAs) and furnishers accountable for failing to comply with the Fair Credit Reporting Act (FCRA) and Regulation V…"

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Texas lawsuit (won), HHS is appealing

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Consumer Information and Insurance Oversight
200 Independence Avenue SW
Washington, DC 20201

Memorandum Regarding Continuing Surprise Billing Protections for Consumers

Date: February 28, 2022

On February 23, 2022, the United States District Court for the Eastern District of Texas, in the case of *Texas Medical Ass'n, et al. v. United States Department of Health and Human Services, et al.*, Case No. 6:21-cv-425 (E.D. Tex.), invalidated portions of an interim final rule, Requirements Related to Surprise Billing; Part II, 86 Fed. Reg. 55,980 (Oct. 7, 2021) (the "Rule"), issued by the Departments of Health and Human Services, Labor, and the Treasury (the "Departments") governing aspects of the federal independent dispute resolution (IDR) process under the No Surprises Act.

This court's order *did not* affect any of the Departments' other rulemaking under the No Surprises Act. **Thus, consumers continue to be protected from surprise bills for out-of-network emergency services, out-of-network air ambulance services, and certain out-of-network services received at in-network facilities.** The patient-provider dispute resolution process for uninsured and self-pay consumers to dispute bills that exceed a provider's or facility's good faith estimate by $400 or more also remains available and unchanged by the court's order. To learn more about these protections, visit www.cms.gov/nosurprises.

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Texas won "again"...

- Aug. 7, 2023, the HHS lost another lawsuit ruling in favor of the Texas Medical Association
- TMA has challenged the rule 4x, and this time argued it was illegal and unfairly favored health insurers
- The ruling also vacated an increase in administrative fees from $50 to $350 and placed restrictions on batching related claims
- The judgment removes barriers for providers to file dispute resolution claims, and will likely increase the volume of claims
- CMS has again halted the IDR process again for the second time this year, with the first coming in February

DIVE BRIEF

Texas judge rules in favor of doctors in latest suit over surprise billing process

The decision is expected to increase the number of provider claims, especially for smaller amounts.

Published Aug. 7, 2023

Rebecca Pifer
Senior Reporter

The U.S. Department of Health and Human Services building is shown August 16, 2006 in Washington, DC. *Mark Wilson via Getty Images*

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https://www.healthcaredive.com/news/texas-decision-no-surprises-idr-lawsuit-fee-batching/690032/#:~:text=It's%20the%20TMA's%20fourth%20lawsuit,particular%20metrics%20used%20in%20IDR.

CMS put IDRs on pause…

Unplanned Outage

On August 3, 2023, the U.S. District Court for the Eastern District of Texas issued a judgment and order in Texas Medical Association, et al. v. United States Department of Health and Human Services, Case No. 6:23-cv-59-JDK (TMA IV), vacating certain portions of 45 C.F.R. § 149.510, 26 C.F.R. § 54.9816-8T, and 29 C.F.R. § 2590-716-8. As a result of the TMA IV decision, effective immediately, the Departments have temporarily suspended the Federal IDR process, including the ability to initiate new disputes until the Departments can provide additional instructions.

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https://nsa-idr.cms.gov/paymentdisputes/s/

Current approaches for compliance

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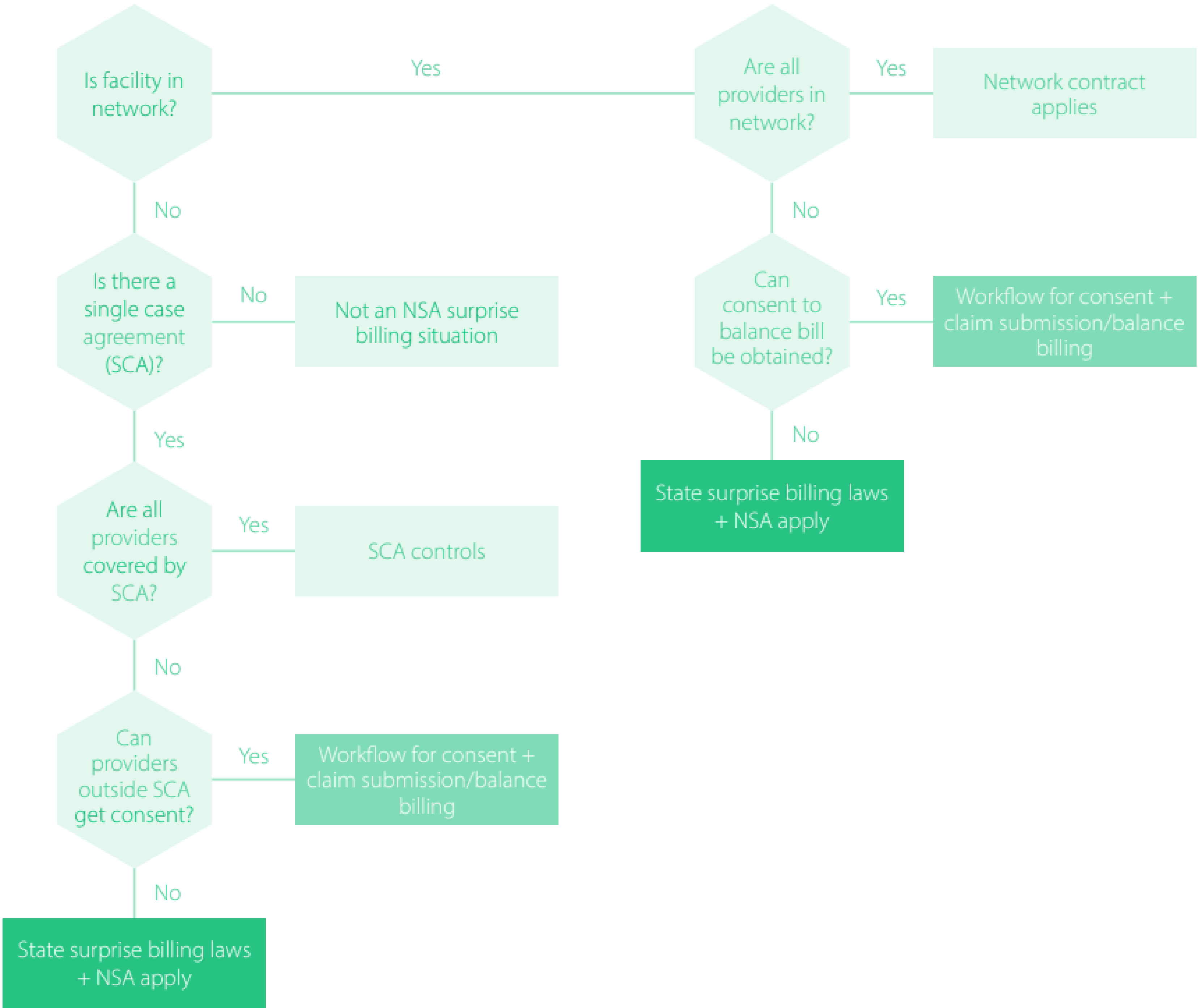
NSA non-emergency services decision tree



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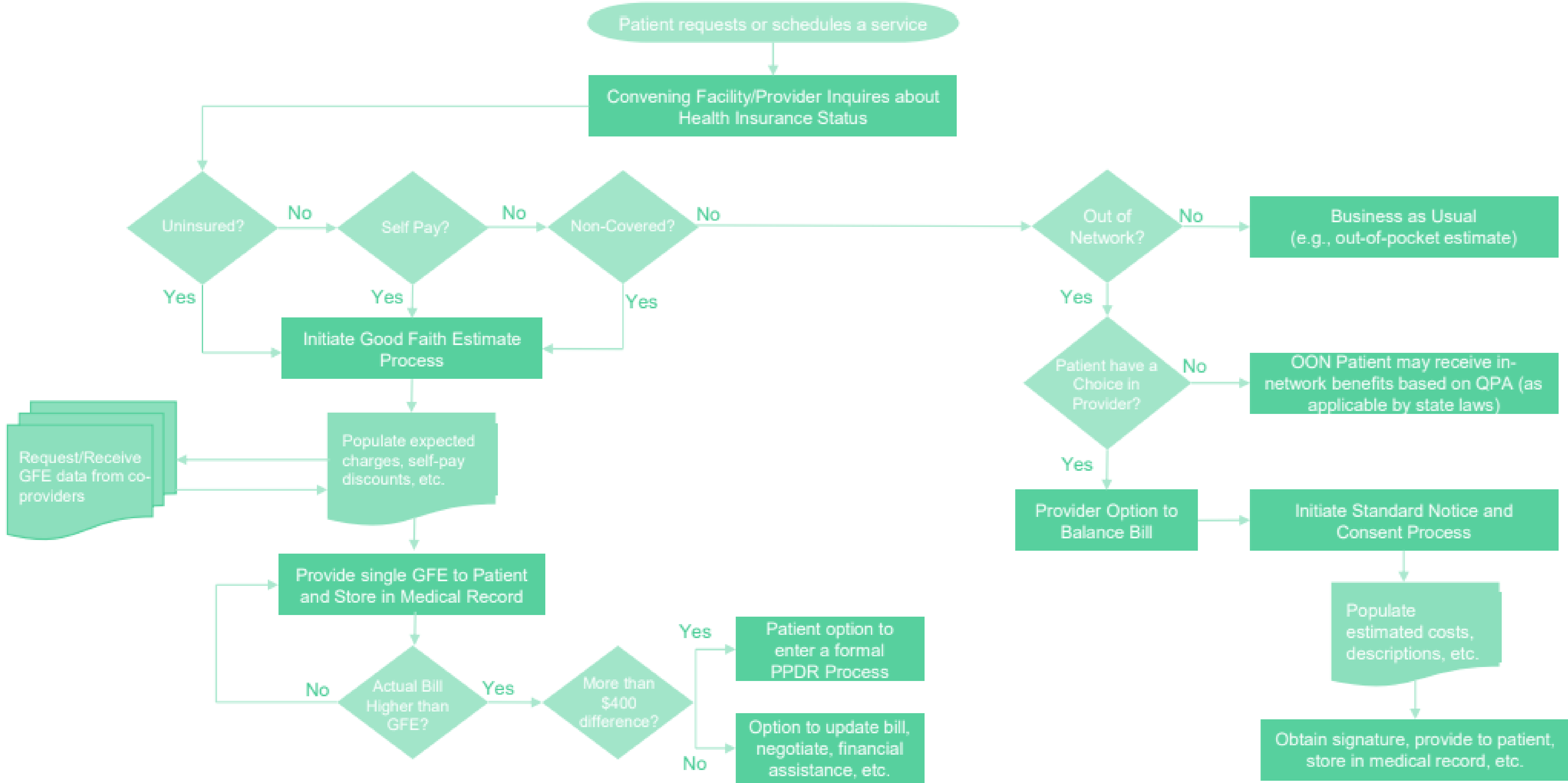

Source: Panacea

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GFE GRID/ TIMING – 10 :3 : 1 rule

Date of scheduling / request	GFE should be sent within:
10+ business days in advance	Three (3) business days
Non-Scheduled	Three (3) business days from request
3-9 business days in advance	One (1) business day
<3 Days	Not required

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GFE CHECKLIST - 45 CFR 149.610 (b)

- ❑ Insured or self pay
- ❑ Written in clear and understandable manner
- ❑ Made available in accessible formats (paper, electronic, oral, language, convening, co-provider)
- ❑ Lists ALL necessary elements (see right and next slide)
- ❑ Includes potential cost to include:
  - ❑ ANY item or service that is REASONABLY expected to be provided,
  - ❑ In conjunction with scheduled or requested item or
  - ❑ Service BY ANOTHER PROVIDER or FACILITY
- ❑ Appropriate timeframe (10 / 3 / 1 rule – see grid)
- ❑ Includes any changes (1 business day)
- ❑ Includes recurring items or services
- ❑ Expires in 12 months from each NEW GFE (date)

GFE REQUIREMENTS

- ❑ Patient name and date of birth,
- ❑ Clear description of service and date scheduled (if applicable),
- ❑ List of all items and services (including those to be provided by co-providers),
- ❑ Current Procedural Terminology (CPT) code, diagnosis code, and charge per item of service,
- ❑ Name, National Provider Identifier, and Taxpayer Identification Number of all service providers and the state where the services will be rendered,
- ❑ List of items from other providers that will require separate scheduling,
- ❑ Disclaimer that separate GFEs will be issued upon request for services that require separate scheduling and that CPT codes, diagnosis codes, and charges per item of service will be provided in those separate GFEs,
- ❑ Disclaimer that there may be other services required that must be scheduled separately during treatment and are not included in the GFE,
- ❑ Disclaimer that this is only an estimate, and that actual services and charges may differ,
- ❑ Disclaimer informing the patient of their rights to a patient-provider dispute resolution process if actual billed charges are substantially above the estimate, as well as where to find information on how to start the dispute process,
- ❑ Disclaimer that the GFE is not a contract, and the patient is not required to obtain services from the provider.

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GFE "Gotchas"

- Not clear and understandable
- Provided routinely for emergency services
- Only in English and Spanish
- Only primary and facility charges
- Is static (never updates)
- Not sent or sent late
- Expired
- Price increases
- $0 charges/visits
- Non-traditional services (Dental, Physical Therapy, Chiro, etc)
- Changes in coverage (Scheduling versus Reception)
- Failure to document uninsured/self-pay

[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: [ ] Check this box if this service or item is not yet scheduled		

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

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CMS: Model Documents

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.

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

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.

Estimate of what you could pay

Patient name: ______________________________

Out-of-network provider(s) or facility name: ______________________________

____

Total cost estimate of what you may be asked to pay:	

▶ **Review your detailed estimate.** See Page 4 for a cost estimate for each item or service you'll get.

▶ **Call your health plan.** Your plan may have better information about how much you will be asked to pay. You also can ask about what's covered under your plan and your provider options.

▶ **Questions about this notice and estimate?** Call *[Enter contact information for a representative of the provider or facility to explain the documents and estimates to the individual, and answer any questions, as necessary.]*

▶ **Questions about your rights?** Contact *[contact information for appropriate federal or state agency]*

Prior authorization or other care management limitations

[Enter either (1) specific information about prior authorization or other care management limitations that are or may be required by the individual's health plan or coverage, and the implications of those limitations for the individual's ability to receive coverage for those items or services, or (2) include the following general statement:

Except in an emergency, your health plan may require prior authorization (or other limitations) for certain items and services. This means you may need your plan's approval that it will cover an item or service before you get them. If prior authorization is required, ask your health plan about what information is necessary to get coverage.]

[In the case where this notice is being provided for post-stabilization services by a nonparticipating provider within a participating emergency facility, include the language immediately below and enter a list of any participating providers at the facility that are able to furnish the items or services described in this notice]

Understanding your options

You can also get the items or services described in this notice from these providers who are in-network with your health plan:

More information about your rights and protections

Visit *[website]* for more information about your rights under federal law.

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https://www.cms.gov/httpswwwcmsgovregulations-and-guidancelegislationpaperworkreductionactof1995pra-listing/cms-10780

Balance Billing Consent form

Balance Billing Consent form includes:

List of services, service date, description and estimated amount to be billed out-of-network

Patient acknowledgement and signature line

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.

Estimate of what you could pay

Patient name:____________________

Out-of-network provider(s) or facility name:____________________

Total cost estimate of what you may be asked to pay:	

► **Review your detailed estimate.** See Page 4 for a cost estimate for each item or service you'll get.

► **Call your health plan.** Your plan may have better information about how much you will be asked to pay. You also can ask about what's covered under your plan and your provider options.

► **Questions about this notice and estimate?** Call [*Enter contact information for a representative of the provider or facility to explain the documents and estimates to the individual, and answer any questions, as necessary.*]

► **Questions about your rights?** Contact [*contact information for appropriate federal or state agency*]

Prior authorization or other care management limitations

[*Enter either (1) specific information about prior authorization or other care management limitations that are or may be required by the individual's health plan or coverage, and the implications of those limitations for the individual's ability to receive coverage for those items or services, or (2) include the following general statement:*

Except in an emergency, your health plan may require prior authorization (or other limitations) for certain items and services. This means you may need your plan's approval that it will cover an item or service before you get them. If prior authorization is required, ask your health plan about what information is necessary to get coverage.]

[*In the case where this notice is being provided for post-stabilization services by a nonparticipating provider within a participating emergency facility, include the language immediately below and enter a list of any participating providers at the facility that are able to furnish the items or services described in this notice*]

Understanding your options

You can also get the items or services described in this notice from these providers who are in-network with your health plan:

More information about your rights and protections

Visit [*website*] for more information about your rights under federal law.

More details about your estimate

Patient name: ____________________

Out-of-network provider(s) or facility name: ____________________

The amount below is only an estimate; it isn't an offer or contract for services. This estimate shows the full estimated costs of the items or services listed. It doesn't include any information about what your health plan may cover. This means that **the final cost of services may be different than this estimate**.

Contact your health plan to find out how much, if any, your plan will pay and how much you may have to pay.

[*Enter the good faith estimated cost for the items and services that would be furnished by the listed provider or facility plus the cost of any items or services reasonably expected to be provided in conjunction with such items or services. Assume no coverage would be provided for any of the items and services.*].

[*Populate the table below with each item and service, date of service, and estimated cost. Add additional rows if necessary. The total amount on page 2 must be equal to the total of each of the cost estimates included in the table.*]

Date of service	Service code	Description	Estimated amount to be billed
		Total estimate of what you may owe:	

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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CMS.gov
Centers for Medicare & Medicaid Services

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Home > No Surprises Act > Consumers > Complaints about medical billing

Home | Policies & Resources | Consumers | Resolving out-of-network payment disputes

Complaints about medical billing

Starting in 2022, insurance companies and plans, providers, and health care facilities must follow new rules that protect consumers from surprise medical bills. If you have a question about these rules or believe the rules aren't being followed, contact the No Surprises Help Desk at 1-800-985-3059 from 8 am to 8 pm EST, 7 days a week, to submit your question or a complaint. Or, you can submit a complaint online, below. We may ask you to provide supporting documentation like medical bills and your Explanation of Benefits. We'll send a confirmation email when we receive your complaint to notify you of next steps and let you know if we need any additional information. To check on the status of a complaint, or to see what documentation is needed, contact the No Surprises Help Desk.

What we can do:

- Review your complaint to make sure your insurance company, medical provider, or health care facility followed surprise billing rules.
- Investigate and enforce federal laws and policies under our jurisdiction.
- Try to find patterns of problems that may need further review.
- Help you understand what documentation you need to submit or what next steps you should take.
- Help answer your questions or direct you to someone who can.

What we can't do:

- Require medical providers or health care facilities to adjust their charges.
- Act as your lawyer or give you legal advice.
- Make medical judgments or determine if further treatment is necessary.
- Determine the value of a claim, or the amount owed to you.
- Address issues we can't legally enforce.

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Five considerations for NSA

1	2	3	4	5
Ensure RCM process is solid	**Work with your payers**	**Provider Directories**	**Review contracts**	**Overcommunicate to patients**
• Regulations make a bad process "worse" • Ensure financial clearance and estimation process is known and followed • Add as little to the process as needed to be compliant ("good faith effort")	• AEOB requirement • GFE sharing • Network status across plans (look for "hot spots")	• Work with medical staff/credentialing • Ask for contract reciprocity (if you can't get it, identify where and communicate that)	• Ensure arbitration risks can be mitigated/ and/or funded • Review any OON provisions and ensure clear PAR language as well	• Regulations have requirements – expand on them with signage, FAQ, what to do • A happy and informed patient is less likely to escalate the issues

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Questions?

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Thank you!

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Appendix

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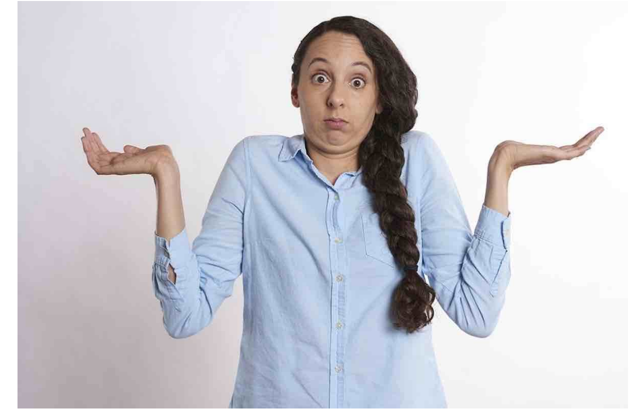
In plain English…

NSA part ONE outlines:



- Protection provisions for **insured** individuals from surprise medical bills
- **Public disclosure** requirements (signage, documentation, notice, consent)
- **Emergency services** (incl. Air Ambulance) can **never (ever) balance bill** patients for out-of-network (OON)
- **Non-emergency services** (scheduled, walk in, outpatient ambulatory) can be billed as OON with **NOTICE AND CONSENT**
- Defines which **facilities** applies to:
  - Hospital (STACH)
  - Hospital outpatient (HOPPS)
  - Critical Access Hospital (CAH)
  - Ambulatory Surgery Center (ASC)

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In plain English…

NSA part TWO outlines:

- GFE for Self pay / Uninsured
- Patient-Provider Dispute Resolution
- Applicability to Health plans – AEOB
- Process for QPA

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FAQs

- How can you give an accurate Good Faith Estimate **without a diagnosis**?
  - No. A provider or facility is required to provide a diagnosis code only where one is required for the calculation of the GFE. For example, in situations in which a provider or facility has not determined a diagnosis, such as for initial screening visits or evaluation and management visits; or if there is not a relevant diagnosis code for an item or service, such as for certain dental screenings or procedures, providers and facilities are not required to include diagnosis codes on a GFE. However, the provider or facility must include the expected charges and service codes for the items and services to be furnished during that visit, even when no diagnosis code is available.
- Are your estimates required to include **possible financial assistance** options?
  - Yes. The GFE must reflect the expected charges, including any expected discounts or other relevant adjustments that the provider or facility expects to apply to an uninsured (or self-pay) individual's actual billed charges. For example, certain tax-exempt hospital organizations are required to meet certain Financial Assistance Policy (FAP) requirements; for purposes of this example, any adjustments expected to be applied under the FAP would be factored in and reflected in the amount reported in the GFE
- What should you include when calculating a **QPA (Qualifying Payment Amount)**?
  - https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/no-surprises-act/surprise-billing-part-ii-information-collection-documents-attachment-6.pdf

https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Guidance-Good-Faith-Estimates-FAQ.pdf
https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Guidance-Good-Faith-Estimates-FAQ-Part-2.pdf

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FAQs

- What charges should you **include or exclude** on an estimate?

  - Include: Co-providers and co-facilities are required to submit GFE information to the requesting convening provider or facility, which must include, among other things, the expected charges for items or services that are reasonably expected to be provided in conjunction with the primary item or service.

  - Exclude: "..rules do not require the good faith estimate to include charges for unanticipated items or services that are not reasonably expected and that could occur due to unforeseen events

- What **disclaimers must you include on** Good Faith Estimates to comply with the law?

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

- Does the type of service you provide **dictate the format** of your estimate?

  - NO. The GFE must be provided in written form either on paper or electronically (for example, electronic transmission of the GFE through the convening provider's patient portal or electronic mail), pursuant to the uninsured (or self-pay) individual's requested method of delivery. GFEs provided to uninsured (or self-pay) individuals that are transmitted electronically must be provided in a manner that the uninsured (or self-pay) individual can both save and print, and must be provided and written using clear and understandable language and in a manner calculated to be understood by the average uninsured (or self-pay) individual. If a patient requests that the GFE information is provided in a format that is not paper or electronic delivery, like orally over the phone or in person, the provider/facility may provide the GFE information orally but must follow-up with a written paper or electronic copy in order to meet the regulatory requirements.

https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Guidance-Good-Faith-Estimates-FAQ.pdf
https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Guidance-Good-Faith-Estimates-FAQ-Part-2.pdf

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FAQs

- If a **patient has insurance but chooses to self-pay**, is a Good Faith Estimate required?

  - HHS has not yet issued rulemaking related to the provision of GFEs for individuals who are enrolled in a plan or coverage and are seeking to have a claim submitted to their plan or4 coverage. Until rulemaking to fully implement this requirement to provide such GFE to a plan or coverage is adopted and applicable, HHS will defer enforcement of the requirement that providers and facilities provide GFE information for individuals enrolled in a plan or coverage and who are seeking to submit a claim for scheduled items or services to their plan or coverage.

- What format must your Good Faith Estimate be in - **hard copy or electronic**?

  - The GFE must be provided in written form either on paper or electronically (for example, electronic transmission of the GFE through the convening provider's patient portal or electronic mail), pursuant to the uninsured (or self-pay) individual's requested method of delivery. GFEs provided to uninsured (or self-pay) individuals that are transmitted electronically must be provided in a manner that the uninsured (or self-pay) individual can both save and print, and must be provided and written using clear and understandable language and in a manner calculated to be understood by the average uninsured (or self-pay) individual. If a patient requests that the GFE information is provided in a format that is not paper or electronic delivery, like orally over the phone or in person, the provider/facility may provide the GFE information orally but must follow-up with a written paper or electronic copy in order to meet the regulatory requirements.

https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Guidance-Good-Faith-Estimates-FAQ.pdf

https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Guidance-Good-Faith-Estimates-FAQ-Part-2.pdf

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FAQs

- If your **practice posts its prices**, are you still required to provide a Good Faith Estimate?
  - Yes. A GFE must be provided to all uninsured (or self-pay) individuals who schedule items or services or request a GFE. A GFE is required even if there is a set price for the service because the actual billed charges may not reflect the anticipated set price for the service at the time of estimate.
- What if you need to change your initial Good Faith Estimate?
  - HHS notes that the convening provider or facility is required to provide an uninsured (or self-pay) individual a new GFE if the convening provider or facility or co-provider or co facility anticipates or is notified of any changes to the scope of a GFE (such as anticipated changes to the expected charges, items, services, frequency, recurrences, duration, providers, or facilities) previously furnished at the time of scheduling; a new GFE must be issued to the uninsured (or self-pay) individual no later than 1 business day before the items or services are scheduled to be furnished. In addition, co-providers and co-facilities must notify and provide new GFE information to a convening provider or convening facility if the co-provider or co facility anticipates any changes to the scope of GFE information previously submitted to a convening provider or convening facility (such as anticipated changes to the expected charges, items, services, frequency, recurrences, duration, providers, or facilities).
- How **detailed must your Good Faith Estimate be** (i.e., supplies, etc.)?
- Does **providing your estimate over your patient portal** comply with requirements?

https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Guidance-Good-Faith-Estimates-FAQ.pdf

https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Guidance-Good-Faith-Estimates-FAQ-Part-2.pdf

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FAQs

- How **detailed must your Good Faith Estimate be** (i.e., supplies, etc.)?

  - Include: Co-providers and co-facilities are required to submit GFE information to the requesting convening provider or facility, which must include, among other things, the expected charges for items or services that are reasonably expected to be provided in conjunction with the primary item or service.
  - https://www.cms.gov/regulations-and-guidancelegislationpaperworkreductionactof1995pra-listing/cms-10791

- Does **providing your estimate over your patient portal** comply with requirements?

  - The GFE must be provided in written form either on paper or electronically (for example, electronic transmission of the GFE through the convening provider's patient portal or electronic mail), pursuant to the uninsured (or self-pay) individual's requested method of delivery. GFEs provided to uninsured (or self-pay) individuals that are transmitted electronically must be provided in a manner that the uninsured (or self-pay) individual can both save and print, and must be provided and written using clear and understandable language and in a manner calculated to be understood by the average uninsured (or self-pay) individual. If a patient requests that the GFE information is provided in a format that is not paper or electronic delivery, like orally over the phone or in person, the provider/facility may provide the GFE information orally but must follow-up with a written paper or electronic copy in order to meet the regulatory requirements.

https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Guidance-Good-Faith-Estimates-FAQ.pdf

https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Guidance-Good-Faith-Estimates-FAQ-Part-2.pdf

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Do providers or facilities need to provide GFEs to all individuals, for instance, patients with Medicare or Medicaid?

Effective January 1, 2022, providers and facilities are required to provide GFEs to uninsured (or self-pay) individuals who schedule items or services or request an estimate. An uninsured individual is one who is not enrolled in a group health plan, or group or individual health insurance coverage, or a Federal health care program, or a Federal Employees Health Benefits (FEHB) program health benefits plan. A self-pay individual is one who is enrolled in but is not seeking to have a claim submitted to their group health plan, health insurance coverage, or FEHB program health benefits plan for the item or service being scheduled or for which a GFE is requested. Under the No Surprises Act statute, providers and facilities are generally not required to provide GFEs to individuals insured under Medicare, Medicaid, or other federal health care programs.

[from HHS FAQs for GFEs Part 1]

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How can providers or facilities provide a GFE to an uninsured (or self-pay) individual when the underlying complexity of an individual's condition is not yet known?

GFE must include items or services reasonably expected to be furnished for the primary item or service, and items or services reasonably expected to be furnished in conjunction with the primary item or service [. . .]. " . . . the interim final rules do not require the good faith estimate to include charges for unanticipated items or services that are not reasonably expected and that could occur due to unforeseen events.

[from HHS FAQs for GFEs Part 1]

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Do providers or facilities need to factor in financial assistance an uninsured (or self-pay) individual may receive when calculating the expected charges for items or services included in the GFE?

Yes. The GFE must reflect the expected charges, including any expected discounts or other relevant adjustments that the provider or facility expects to apply to an uninsured (or self-pay) individual’s actual billed charges. For example, certain tax-exempt hospital organizations are required to meet certain Financial Assistance Policy (FAP) requirements; for purposes of this example, any adjustments expected to be applied under the FAP would be factored in and reflected in the amount reported in the GFE. [from HHS FAQs for GFEs Part 1]

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Is a provider or facility required to provide a GFE to uninsured (or self-pay) individuals upon scheduling same-day (or walk-in) items or services?

No. The requirement to provide a GFE to an uninsured (or self-pay) individual . . . is not triggered upon scheduling an item or service if the item or service is being scheduled fewer than 3 business days before the date the item or service is expected to be furnished.

For example, if an uninsured (or self-pay) individual arrives to schedule same-day laboratory testing services, the laboratory testing provider or facility is not required to provide the individual with a GFE [from HHS FAQs for GFEs Part 2]

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Scope of facilities that must comply with NSA requirements pertaining to protections for uninsured (or self-pay) individuals

All health care institutions licensed under applicable state or local law are treated as **health care facilities** that must comply with the NSA's good faith estimate and PPDR requirements including, for example:

- Hospitals;
- Hospital outpatient departments;
- Critical access hospitals;
- Ambulatory surgical centers;
- Rural health centers;
- Federally qualified health centers;
- Laboratory centers; and
- Imaging centers.

ts-slides.pdf

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Part 1 Key Provisions

- Applies to providers, air ambulance providers, group health plans, health insurance issuers and Federal Employees Health Benefits Program carriers
- No higher out-of-pocket costs for emergency services delivered by an out-of-network provider
- Must count beneficiaries' cost-sharing for those emergency services toward their in-network deductible and out-of-pocket maximums
- Health plans cannot use prior authorization for those services and must pay for them regardless of whether the clinician is an in-network provider or emergency facility
- Plans will have to calculate consumers' out-of-pocket expenses based on a state's all-payer model agreement or other applicable state law in most cases (QPA)
- If state laws don't specify that an insurer must pay a specific price for a given service, providers and insurers will have to agree to an amount or go through an independent dispute resolution process

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Part 2 Key Provisions

Outlines the federal **independent dispute resolution (IDR) process**

IDR **Submittal timeframes, requirements**, etc. (30 day open negotiation, if that fails, then IDR. IDR decides in 30 days on amount to be paid, "baseball"

Sets the "**good faith estimate**" requirements for self pay, timing and provisions, including a $400 accuracy threshold

Qualifying Payment Amount (QPA) [defined as] "the lesser of the billed charge or the plan's or issuer's median contracted rate, the latter referred to as the qualifying payment amount (QPA)."

QPA will be set by geographic area and represent median reimbursement across all payers

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Cost Sharing Requirements

Benefit amounts (paid by the plan) must be at least equal to the greatest of the following:

- Median amount negotiated with in-network providers for the same service on that plan
- The amount for the emergency service calculated using the standard methodology for out-of-network rates by the plan
- The amount paid under Medicare Part A or Part B for the emergency service
- If this amount cannot be agreed upon by the provider and payor, it is directed to an Independent Dispute Resolution Entity

Cost sharing amounts (paid by the patient) cannot exceed in-network levels, and must count towards in-network deductibles and out-of-pocket maximums

- An amount determined by an applicable All-Payer Model Agreement
- An amount determined by specific state law (if one applies)
- The Qualifying Payment Amount (the lesser of the billed charge or the plan's or issuer's median contracted rate)

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Claim Submission & Dispute Resolution

- For each item or service furnished by a nonparticipating provider or nonparticipating emergency facility, the provider must notify the plan or issuer as to whether No Surprises Act protections apply to an item or service, and provide a signed copy of consent documents

- Plans and Issuers must submit initial payment or denial within 30 days of bill submission from a nonparticipating provider or facility, and include the below if not using previously negotiated or standard All Payer model amounts
  - The Qualifying Payment Amount used
  - A statement certifying that the Qualifying Payment Amount is applies for the recognized benefit amount, and was determined in compliance with the No Surprises Act methodology
  - Contact information if the provider wishes to open a 30-day "open negotiation period" to determine the total amount of payment or request additional information on the QPA methodology

- Disputes not resolved in the 30-day window can be turned over to an Independent Dispute Resolution entity within 4 days of the expiration of the window.

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Convening Provider Responsibilities

A **convening health care provider** or facility is the provider or facility that is responsible for scheduling the primary items or services or that receives an initial request for a GFE. They must inquire whether a patient is covered under commercial health coverage, Medicare, Medicaid or FEHBP and, if so, whether he or she intends to use that coverage. The convening provider is then required to inform uninsured and self-pay patients of the availability of the GFE.

The written GFE requires the following components:

- Patient name and date of birth,
- Clear description of service and date scheduled (if applicable),
- List of all items and services (including those to be provided by co-providers),
- Current Procedural Terminology (CPT) code, diagnosis code, and charge per item of service,
- Name, National Provider Identifier, and Taxpayer Identification Number of all service providers and the state where the services will be rendered,
- List of items from other providers that will require separate scheduling,
- Disclaimer that separate GFEs will be issued upon request for services that require separate scheduling and that CPT codes, diagnosis codes, and charges per item of service will be provided in those separate GFEs,
- Disclaimer that there may be other services required that must be scheduled separately during the course of treatment and are not included in the GFE,
- Disclaimer that this is only an estimate, and that actual services and charges may differ,
- Disclaimer informing the patient of their rights to a patient-provider dispute resolution process if actual billed charges are substantially above the estimate, as well as where to find information on how to start the dispute process,
- Disclaimer that the GFE is not a contract, and the patient is not required to obtain services from the provider.

Co-Provider Responsibilities

Other providers or facilities that furnish items or services in conjunction with the primary item or service furnished by the convening provider or facility are considered **co-providers and co-facilities.**

Co-providers (and co-facilities) must provide the GFE information within one business day of a request from a convening provider or facility. Co-providers and co-facilities must update their estimate if they anticipate any changes to the scope of services after they submit their update (e.g., anticipated changes to the expected charges, items, services, frequency, recurrences, duration, providers, or facilities).

Each co-provider or co-facility is required to provide to the convening provider or facility:

- The patient's name and date of birth,
- An itemized list of items and services to be provided by co-provider or co-facility, with diagnosis and procedure codes as well as expected charges,
- The name of and identifying information for each provider or facility,
- A disclaimer that the estimate is not a contract.

NOTE: Effective 1/1/23, GFE MUST include ANY item or service that is REASONABLY expected to be provided in conjunction with scheduled or requested item or service BY ANOTHER PROVIDER or FACILITY(ies) (i.e “co-provider)

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Resources

- https://www.cms.gov/nosurprises/policies-and-resources/overview-of-rules-fact-sheets
- https://www.cms.gov/nosurprises
- https://www.cms.gov/files/document/faq-providers-no-surprises-rules-april-2022.pdf
- https://www.hfma.org/topics/landing-no-surprises-act.html
- https://www.ama-assn.org/system/files/ama-nsa-toolkit.pdf
- https://www.aha.org/advisory/2021-01-14-detailed-summary-no-surprises-act
- https://www.kff.org/private-insurance/fact-sheet/surprise-medical-bills-new-protections-for-consumers-take-effect-in-2022/
- https://www.jdsupra.com/legalnews/no-surprise-billing-rules-checklist-for-7120253
- https://www.natlawreview.com/article/no-surprises-act-final-checklist-2022

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All Providers: Good Faith Estimate to Self-Pay Patients. Virtually all providers and facilities must do the following for any self-pay patients:

Providing the Good Faith Estimate.

- Post the HHS Notice, "Right to Receive a Good Faith Estimate of Expected Charges," on the provider's or facility's website, in the office, and onsite where scheduling or questions about the cost of items or service occur. (45 CFR 149.610(b)(1)(iii)(A)). The information must be prominently displayed and published in accessible formats and presumably available in languages spoken by the patient. (Id. at 149.610(b)(1)(iii)(C)).
- Ask patients if they are self-pay. (45 CFR 149.610(b)(1)(i)-(ii)).
- Inform self-pay patients orally that they have a right to obtain a good faith estimate upon request or upon scheduling an appointment. (45 CFR 149.610(b)(1)(iii)). The oral notice should presumably be given in the language spoken by the patient. (See id. at 149.610(b)(1)(ii)(C)).

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https://www.jdsupra.com/legalnews/no-surprise-billing-rules-checklist-for-7120253/

Providing the Good Faith Estimate (CONT)

- For self-pay patients, prepare and give the good faith estimate to the patient if (1) the patient asks about the cost of services,7 (2) the patient requests the estimate, or (3) services are scheduled. (45 CFR 149.610(b)(1)(iv) - (v)). The good faith estimate is not required in the case of emergency services.

- Ensure the good faith estimate includes the elements and disclaimers required by the regulation. (45 CFR 149.610(c)). HHS has published a sample form, "Good Faith Estimate for Health Care Items and Services," along with a chart of required data elements. Ensure the estimate is complete and accurate. Providing an incomplete or inaccurate good faith estimate may limit your ability to collect from the self - pay patient if the patient initiates the SDR process. To facilitate timely, complete estimates, consider preparing standard template estimates for common items or services in advance.

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Providing the Good Faith Estimate (CONT)

- Provide the good faith estimate to the self-pay patient in written form either on paper or electronically as requested by the patient. (45 CFR 149.610(e)(1)). The estimate must be provided within the following time frames:
    - If the item or service is scheduled at least 3 business days before the date the item or service is scheduled to be furnished: not later than 1 business day after the date of scheduling;
    - If the item or service is scheduled at least 10 business days before such item or service is scheduled to be furnished: not later than 3 business days after the date of scheduling; or
    - If a good faith estimate is requested by a self-pay patient: not later than three 3 business days after the date of the request. (45 CFR 149.610(b)(1)(vi))
- If you anticipate changes that will affect the estimate (e.g., changes to the charges, items, services, providers or facilities, etc.), issue a new good faith estimate no later than 1 business day before the items or services are scheduled to be provided. (45 CFR 149.610(b)(1)(vii)).

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Providing the Good Faith Estimate (CONT)

- If there are any changes in the providers or facilities less than 1 business day before the item or service is scheduled to be furnished, the replacement provider or facility must accept as its good faith estimate of expected charges the good faith estimate that was previously provided. (45 CFR 149.610(b)(1)(vii)). Accordingly, consider checking the prior good faith estimate before assuming care.
- Consider issuing a recurring estimate. A provider or facility may issue a single good faith estimate for recurring items or services for up to 12 months if certain conditions are satisfied.10 (45 CFR 149.610(b)(1)(x)).
- Maintain a copy of the good faith estimate as part of the self-pay patient's medical record. (45 CFR 149.610(f)(1)). To ensure compliance with your obligation to provide copies of a good faith estimate, maintain the estimate for at least 6 years.

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Providing the Good Faith Estimate (CONT)

- If requested by a self - pay patient, provide the patient with a copy of any good faith estimate previously issued within the prior 6 years. (45 CFR 149.610(f)(1)).
- Beginning in 2023, the good faith estimate must include estimates from co - providers11 (45 CFR 149.610(b)(1)(v) and (b)(2); HHS has exercised its discretion not to enforce co - provider rules during calendar year 2022. (86 FR 56023). Update your policies and process as appropriate

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Patient provider resolution (Self pay dispute resolution; SDR)

- If the actual charges are $400 or more than the charges listed in the good faith estimate, the self-pay patient may initiate the SDR process. (45 CFR 149.620)
  - A self-pay patient must initiate the SDR process by submitting notice and an administrative fee within 120 days after receiving the disputed bill. (45 CFR 149.620(c)(1)).
  - If the SDR entity believes the matter is appropriate for SDR, the SDR entity will notify you and request that you submit required information within 10 days. (45 CFR 149.620(c)(4)
  - Upon receipt of the SDR notice and while the SDR process is pending, (1) do not move the self-pay patient's bill for the disputed item or service into collection or threaten to do so; (2) if the bill has already moved into collection, cease collection efforts; (3) suspend the accrual of any late fees on unpaid bill amounts; and (4) do not take or threaten to take any retributive action against the self-pay patient. (45 CFR 149.620(c)(5)-(6)).

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Patient provider resolution (Self pay dispute resolution; SDR) (CONT)

- Within 10 days of receiving the notice from the SDR entity, submit the required information, including (1) a copy of the good faith estimate provided to the self-pay patient; (2) a copy of the billed charges; and (3) if available, documentation demonstrating that the difference between the billed charge and the good faith estimate (a) reflects the cost of a medically necessary item or service and (b) is based on unforeseen circumstances that could not have reasonably been anticipated by the provider or facility when the good faith estimate was provided. (45 CFR149.620(f)(2)(i)). This is the standard that will govern the SDR entity's determination and how much you may recover from the self-pay patient.

- Within 30 days of receipt of your information, the SDR entity will make her/his determination consistent with the parameters of the regulation. (45 CFR 149.620(f)(2)(ii), (3)). The losing party is responsible for paying the SDR entity's fee. (Id. at 149.620(g)). HHS has published a sample decision notice, which is helpful in evaluating the standards used for SDR determinations.

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Patient provider resolution (Self pay dispute resolution; SDR) (CONT)

- If you settle the dispute with the patient while the SDR process is pending, notify the SDR entity within 3 business days. (45 CFR 149.620(f)(1)). HHS has published a form for the notice.
- The SDR determination is generally binding on the parties absent fraud. (45 CFR 149.620(f)(4)). Of course, you still must collect any amount due directly from the self-pay patient

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Limits on OON Charges: Importantly, the limits on OON billing only apply if you are (1) an emergency facility (i.e., a hospital emergency department, hospital outpatient department providing emergency services, or a freestanding emergency department); (2) a health care facility (i.e., a hospital, critical access hospital, hospital outpatient department or ambulatory surgery center); or (3) a provider who furnishes items or services at such facilities. If you fit within these descriptions, comply with the following:

1. Limits on Balance Billing Insured Patients

- Post a public notice of patients' rights concerning the limits on balance billing. (45 CFR 149.430(a), (c), (e)). HHS has published a form notice, "Your Rights and Protections Against Surprise Medical Bills," that you may use.14 The public notice must be posted on your website and in a prominent sign in your facility or publicly accessible location. (Id. at 149.430(a), (c)(1) - (2)).

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1. Limits on Balance Billing Insured Patients (CONT)

- Provide a written notice to insured patients either in-person or through mail or e-mail as selected by the patient. (45 CFR 149.430 (c)(3), (e)). The written notice must be given (1) no later than the date and time when the provider or facility requests payment from the patient, or (2) if the provider or facility does not request payment from the patient, no later than the date on which the provider or facility submits a claim to the payer. (Id. at 149.430 (d)). An OON provider may agree with a facility that the facility will provide the required notice. (Id. At 149.430 (f)).

- Do not balance bill the patient more than the cost-sharing amount established by the regulations unless you obtain the patient's prior notice and consent as required by the regulations. (45 CFR 149.410 (a) and 149.420 (a)). The cost-sharing amount is usually the in network cost-sharing amount as applied to the qualified payment amount (QPA). 15

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1. Limits on Balance Billing Insured Patients (CONT)

- If you seek to obtain the written notice and consent from the patient to balance bill above the regulatory cost-sharing amount:
  - Confirm that the items or services are subject to the patient consent exception. The consent exception only applies to (1) certain post-stabilization emergency services (45 CFR 149.410 (b)); and (2) certain non-emergency services provided by an OON provider at an in-network facility. (Id. at 149.420 (c)). The consent exception never applies to (1) items or services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished (id. at 149.410 (c) and 149.420 (b)(2)); and (2) certain non-emergency ancillary services provided by OON providers at an in-network facility. (Id. at 149.420 (b)(1)).
  - Provide written notice to the patient that contains the information and statements required by 45 CFR 149.410 (b)(2)(i)-(ii) and 420 (d), including a good faith estimate of the anticipated charges. HHS has published a form, "Surprise Billing Protection Form." The written notice must be provided in written or electronic form as selected by the patient. (Id. at 149.420 (c)(1)). The notice must be provided: (1) at least 72 hours before the date of service if possible; or (2) on the date of the appointment but at least 3 hours before the service if the appointment was scheduled within 72 hours of the date of service. (Id. at 149.420 (c)(1)(iii)).

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1. Limits on Balance Billing Insured Patients (CONT)

- Obtain the patient's signed written consent for balance billing using the HHS form before the items or services are provided.18 (45 CFR 149.410 (b)(2) and .420 (c)(2), (e)). The consent must contain the information in 45 CFR 149.420 (e).
- Give the patient the choice to obtain the notice and consent document in any of the 15 most common languages in the relevant state or geographic region serviced by the facility or obtain a qualified interpreter to explain the notice and consent document to the patient. (45 CFR 149.420 (f)).
- Provide a copy of the signed written notice and consent to the patient through mail or e-mail as determined by the patient. (45 CFR 149.420 (c)(3)).
- Maintain the executed notice and consent for seven (7) years. (45 CFR 149.410 (d) and .620 (h)).
- Notify the payer of the patient's consent and provide a copy of the executed notice and consent. (45 CFR 149.410 (e) and .420 (i)).

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2. Participating in the IDR Process

If you dispute the OON rate paid by a payer, you may initiate the IDR process:

- Decide whether IDR is worth it considering the likelihood of success, the non-refundable administrative fee, and the IDR entity predetermined fee. As currently established, the IDR will be selected.
- Within 30 business days after receiving the partial payment or denial from the payer, initiate the 30-day open negotiation by submitting the "Open Negotiation Notice" form 20 to the payer via mail or e-mail. (45 CFR 149.510(b)(1)).
- If you and the payer cannot agree during the 30-day open negotiation period, request IDR within 4 business days after the 30-day open negotiation period ends by submitting the "Notice of IDR Initiation" form 21 to HHS via the Federal IDR portal and to the payer via mail or e-mail. (45 CFR 149.510(b)(2)). A party may not initiate the IDR process if the party obtained notice and consent from the patient to balance bill above the regulatory cost-sharing amount. (Id. at 149.510(b)(2)(iii)).

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2. Participating in the IDR Process (CONT)

- Within 4 days after IDR is initiated, attempt to agree on an IDR entity. (45 CFR 149.510(c)(1)). If the parties cannot agree, HHS will appoint the IDR entity, which may result in higher costs. The IDR entity will notify the parties of its selection. (Id. at 149.510(c)(1)(iii)).
- Submit the IDR non-refundable administrative fee at the time the IDR entity is selected. (45 CFR 149.510(d)(2)). Note: this is different than the IDR entity predetermined fee described below.
- Within 10 days after the IDR entity's selection, submit (1) the OON rate offer (as both a dollar amount and percentage of QPA) and any supporting documentation used to support the offer, and (2) the IDR entity's predetermined fee. (45 CFR 164.510(c)(4) and (d)(1)). Relevant information may include items such as the provider's training, experience, quality, outcomes, and market share; the acuity of patient or complexity of item or service; the facility's teaching status; case mix scope of services; and prior network agreements between the parties. (Id. at 149.510(c)(4)(i)(A), (iii)). Prohibited information includes the provider's usual and customary charges; amounts the provider would have charged but for the limit on balance billing; and/or amounts or reimbursement rates payable by a public payer. (Id. at 149.510(c)(4)(v)). The DOL has published a helpful list of data elements to include in the offer.
- Within 30 days after the IDR entity's selection, the IDR issues its written decision. (45 CFR 149.510(c)(4)(ii), (vi)). The IDR entity must select the offer closest to the QPA unless credible information submitted by the parties clearly demonstrates that the QPA is materially different from the appropriate OON rate. (Id. at 149.510(c)(4)(ii)(A)).

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2. Participating in the IDR Process (CONT)

- Within 30 days after the IDR entity's selection, the IDR issues its written decision. (45 CFR 149.510 (c)(4)(ii), (vi)). The IDR entity must select the offer closest to the QPA unless credible information submitted by the parties clearly demonstrates that the QPA is materially different from the appropriate OON rate. (Id. at 149.510 (c)(4)(ii)(A)).

- If the parties settle the dispute while the IDR is pending, notify the IDR entity through the Federal IDR portal within 3 business days. (45 CFR 149.510 (c)(2)).

- The losing party must pay any amount due within 30 days after the determination by the IDR entity. (45 CFR 149.510 (c)(4)(ix)). The prevailing party will have its IDR fee returned. (Id. At 149.510 (d)(1)).

- If you are the party initiating IDR, do not submit additional IDR notifications involving the same parties and similar items or services for 90 calendar days after the IDR entity determination. (45 CFR 149.510 (c)(4)(vii)).

NOTE: The NSA is still under review for interpretation. The checklist above is based on the latest information at the time of this publication and are subject to change

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Qualifying Payment Amount (QPA) Considerations

- Qualifying payment amount is calculated by taking the [January 31, 2019] median contracted rate for the same or a similar item/service under such plan or coverage, and increasing said rate by the combined percentage increase reflecting the change in consumer price index (CPI-U) [as published by IRS and Treasury] over 2019, 2020, and 2021

- For items/services provided in 2022, the combined percentage increase is 1.0648523983

- If the group plan or individual plan issuer does not have sufficient information to calculate the 2019 median contracted rate – for example, if the item/service was not offered in 2019 – the following process is used to calculate the qualifying payment amount (QPA):

  - Identify the rate equal to the [2021] median of in-network allowed amounts for the same or a similar item/service provided in your geographic region. The plan/issuer can use any eligible database as the source of this information

  - Increase the above rate by the percentage increase in consumer price index (CPI-U) over 2021. The CPI-U percentage increase over 2021 = the average monthly CPI-U for 2021 divided by the average monthly CPI-U for 2020. For items/services provided in 2022, this percentage increase is 1.0299772040.

https://www.cbiz.com/insights/articles/article-details/no-surprises-act-calculating-the-qualified-payment-amount
https://www.irs.gov/pub/irs-drop/n-22-11.pdf

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Qualifying Payment Amount (QPA) Considerations

Table 1. Circumstances/Factors for Qualified Non-Air Ambulance Items and Services – Additional Circumstances
1. **The level of training, experience, and quality and outcomes measurements** of the provider or facility that furnished the qualified IDR item or service(such as those endorsed by the consensus-based entity authorized in Section 1890 of the Social Security Act) of the provider or facility that furnished the qualified IDR item or service. • Information should demonstrate the experience or level of training of a provider was necessary for providing the qualified IDR item or service to the patient, or that their experience or training made an impact on the care that was provided.
2. **The market share** held by the provider or facility or that of the plan in the geographic region in which the qualified IDR item or service was provided. • Information should demonstrate how the market share affects the appropriate OON rate.
3. **The acuity of the participant, beneficiary, or enrollee** receiving the qualified IDR item or service, **or the complexity of furnishing** the qualified IDR item or service to the participant, beneficiary, or enrollee. • Information should demonstrate how patient acuity or the complexity of furnishing the qualified IDR item or service to the participant, beneficiary, or enrollee affects the appropriate OON rate for the qualified IDR item or service.
4. **The teaching status, case mix, and scope of services** of the facility that furnished the qualified IDR item or service, if applicable. • Information should demonstrate the teaching status, case mix, or scope of services of the OON facility in some way affects the appropriate OON rate.
5. **Demonstrations of good faith efforts (or lack thereof) made by the provider or facility or the plan to enter into network agreements** with each other, and, if applicable, **contracted rates** between the provider or facility, as applicable, and the plan during the previous 4 plan years. • For example, a certified IDR entity should consider what the contracted rate might have been had the good faith negotiations resulted in the OON provider or facility being in-network, if a party is able to provide related credible information of good faith efforts or the lack thereof.

Table 2. Additional Circumstances/Factors for Qualified Air Ambulance Items or Services
1. **The quality and outcomes measurements** of the provider of air ambulance services that furnished the services.
2. **The acuity of the condition of the participant, beneficiary, or enrollee** receiving the services, or **the complexity of providing services** to the participant, beneficiary, or enrollee.
3. **The level of training, experience, and quality of medical personnel** that furnished the air ambulance services.
4. **The air ambulance vehicle type, including the clinical capability level of such vehicle**. • Certified IDR entities should consider information on the air ambulance vehicle type and the vehicle's level of clinical capability only to the extent not already taken into account by the QPA.
5. **The population density of the point of pick-up** for the air ambulance of the participant, beneficiary, or enrollee (such as urban, suburban, rural, or frontier). • The QPA for the geographic regions used to calculate the QPA may already reflect the population density of the pick-up location. Nevertheless, in certain circumstances, the QPA for air ambulance services may not adequately capture the population density, due to additional distinctions, such as between metropolitan areas within a state, or between rural and frontier areas.
6. **Demonstrations of good faith efforts (or lack of thereof) made by the provider of air ambulance services or the plan to enter into network agreements, as well as contracted rates** between the provider and the plan during the previous 4 plan years.

https://www.cms.gov/files/document/rev-102822-idr-guidance-disputing-parties.pdf

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