NARA
The National Association of Rehabilitation Providers and Agencies

No Surprises Act

Good Faith Estimate Requirements

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NARA Webinar

February 4, 2022

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Housekeeping Reminders

- All attendees are on mute
- **Handout:** link in your reminder email 1 hour ago; available in follow up email and on Member portal
- **Questions for Speaker:** submit them using the ***Q&A button*** on the attendee control panel
- **Technical Questions:** submit them using the ***Chat button*** on the attendee control panel
- **Recording:** will be emailed to all registered attendees 48 hours after concluded; will be available for NARA Members on the portal in 24 hours

NARA
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What We Will Cover Today

- The No Surprises Act caught the Therapy community by "surprise". The Interim Final Rule with Comment (IFC) included a definition of "health care provider" and "health care facility" *implicating* compliance for practitioners, practices, and facilities.
- Are you Ready to Be Compliant?
- This webinar will review:
  - Background and Regulatory Oversight of the No Surprises Act & Implementing Rules
  - Purpose & Requirements of the Good Faith Estimate (GFE)
  - Exceptions to Compliance with the GFE
  - Unanswered Questions & Scenarios Unique to Therapy (Waiting for CMS)
  - Overview of Complaints, Enforcement, and Penalties
  - Examples of Processes & Tools

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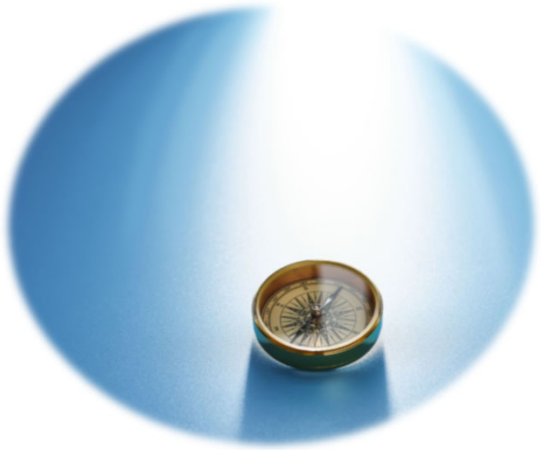
Presentation Navigation



- Format and Timeline
  - NARA Housekeeping: 1 minute
  - No Surprises Act: 20 minutes
  - Provider Implementation: 20 minutes
  - Q & A: 10-12 minutes
  - NARA Wrap Up 2 minutes
- Thank you to:
  - Mountain Land Rehab
  - PPS Special Task Force
  - Kim Stanger Holland & Hart

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No Surprises Act – Where the GFE Fits

	Part / Section
▼ **Title 45** Public Welfare	
▼ **Subtitle A** Department of Health and Human Services	1 – 199
▼ **Subchapter B** Requirements Relating to Health Care Access	140 – 159
▼ **Part 149** Surprise Billing and Transparency Requirements	149.10 – 149.740
▼ **Subpart G** Protection of Uninsured or Self-Pay Individuals	149.610 – 149.620
§ 149.610 Requirements for provision of good faith estimates of expected charges for uninsured (or self-pay) individuals.	
§ 149.620 Requirements for the patient-provider dispute resolution process.	

eCFR :: 45 CFR Part 149 Subpart G -- Protection of Uninsured or Self-Pay Individuals

In addition to the interim final rules issued jointly by the Departments and OPM, this document includes **interim final rules issued by HHS** that address **good faith estimate**s of health care items and services for uninsured or self-pay individuals and the associated patient-provider dispute resolution process. The HHS-only interim final rules apply to selected dispute resolution (SDR) entities, providers, facilities, and providers of air ambulance services.

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Legislation – The Big Picture

- Office of Personnel Management Office
- Internal Revenue Service
- Department of the Treasury
- Employee Benefits Security Administration
- Department of Labor
- Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (HHS)

ENHANCED CONTENT - TABLE OF CONTENTS

Part 149 Surprise Billing and Transparency Requirements	149.10 – 149.740
Subpart A General Provisions	149.10 – 149.30
§ 149.10 Basis and scope.	
§ 149.20 Applicability.	
§ 149.30 Definitions.	
Subpart B Protections Against Balance Billing for the Group and Individual Health Insurance Markets	149.110 – 149.150
§ 149.110 Preventing surprise medical bills for emergency services.	
§ 149.120 Preventing surprise medical bills for non-emergency services performed by nonparticipating providers at certain participating facilities.	
§ 149.130 Preventing surprise medical bills for air ambulance services.	
§ 149.140 Methodology for calculating qualifying payment amount.	
§ 149.150 Complaints process for surprise medical bills regarding group health plans and group and individual health insurance coverage.	
Subpart C [Reserved]	
Subpart D Additional Patient Protections	149.310
§ 149.310 Choice of health care professional.	
Subpart E Health Care Provider, Health Care Facility, and Air Ambulance Service Provider Requirements	149.410 – 149.450
§ 149.410 Balance billing in cases of emergency services.	
§ 149.420 Balance billing in cases of non-emergency services performed by nonparticipating providers at certain participating health care facilities.	

eCFR :: 45 CFR Part 149 -- Surprise Billing and Transparency Requirements

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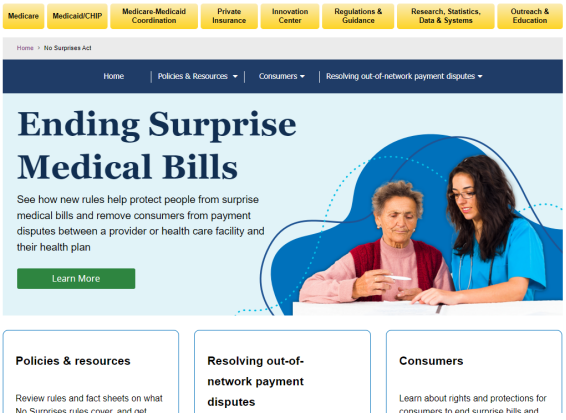
CMS: The Source for Providers



https://www.cms.gov/nosurprises/Policies-and-Resources/Provider-requirements-and-resources

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Disclaimer

This presentation is informational only and is not designed to provide legal and/or consulting advice

Title 45, Subtitle A, Subchapter B, Part 149, Subpart G, §149.610, §149.620

Content information is current as of 2/4/2022

Seek competent legal counsel for specific guidance and applicability to your practice and/or facility

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No Surprises Act Part 1, Key Takeaways*

- Prohibit out-of-network providers from billing patients more than their in-network cost-sharing amount for emergency services and many ancillary services when provided during scheduled care at in-network facilities.
- Establish a formula to calculate the **"qualifying payment amount,"** which is used to determine patient cost-sharing and will be a factor for consideration in the independent dispute resolution process.
- Establish a process for certain out-of-network providers to obtain patient consent to balance bill.
- Establish a complaint process for potential violations of any of these provisions.
- Clarify the interaction between state and federal laws.
- Do not address all provisions in the No Surprises Act, such as the independent dispute resolution process.

*DG_AHAAdvisorySurpriseBillingPart1Reg-.pdf (hthu.net)

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No Surprises Act, Part II

Title I (No Surprises Act) of Division BB of the Consolidated Appropriations Act, 2021 (CAA) amended title XXVII of the Public Health Service Act (PHS Act) to **add a new Part E.**

- Generally, **providers, facilities**, and providers of air ambulance services must comply with these new requirements starting January 1, 2022.
- These provider, facility, and provider of air ambulance services requirements generally apply to items and services provided to individuals enrolled in group health plans or group or individual health insurance coverage, and Federal Employees Health Benefit plans.
- The good faith estimate requirement and the requirements related to the patient-provider dispute resolution process also apply to the uninsured.
- These requirements **do not apply** to beneficiaries or enrollees in federal programs such as **Medicare, Medicaid, Indian Health Services, Veterans Affairs Health Care, or TRICARE.** These programs have other protections against high medical bills.
- Provide good faith estimate in **advance of scheduled services**, or **upon request** 45 CFR 149.610 (for uninsured or self-pay individuals)

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Comparison

Balance Billing (Part 1)	Good Faith Estimate (Part II)
Balance billing prohibition is **somewhat limited** in scope	GFE requirement **applies broadly** to all health care providers.
Generally, applies to **insured patients** who receive services at an **in-network facility** (i.e., hospital, ASC, or CAH) and to emergency services received at these facilities.	Law requires health care providers to give **all uninsured & self-pay patients** a GFE upon scheduling item/service or to all patients **upon request.**
In such cases, an OON provider **cannot bill** a patient for costs **above that patient's in-network rate w/o** giving advance notice and obtaining the patient's consent.	This GFE relates to the scheduled item/service and must identify the **cost of all items & services** relating to that item/service.
This consent process is **not available for OON providers providing "ancillary services"** at an in-network facility or to emergency services.	Providers may need to **coordinate** w/ other health care providers to gather this information and to provide it within timeframe.
	GFE are **not binding**, patients may challenge before an **independent appeals panel** if actual costs **exceed the GFE by more than $400**.

It's Time to Come to Terms with New Surprise Billing Laws - Krieg DeVault LLP

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APTA Practice Advisory

APTA: "Good Faith Estimate for Uninsured or Self-Pay Patients"

- Members Only Document (12-20-2021)
- PPS: State of Affairs: No Surprises Act

AOTA: (1-4-2022)

- No Surprises Act Good Faith Estimates for the Uninsured or Self Pay Applies to Occupational Therapy Practitioners - AOTA

ASHA: (1-21-2022)

- No Surprises Act Goes Into Effect 2022 (asha.org)
- Good Faith Estimate Templates for Audiologists and Speech-Language Pathologists (asha.org)

https://www.apta.org/your-practice/payment/cash-practice/practice-advisory-good-faith-estimate-self-pay-patients

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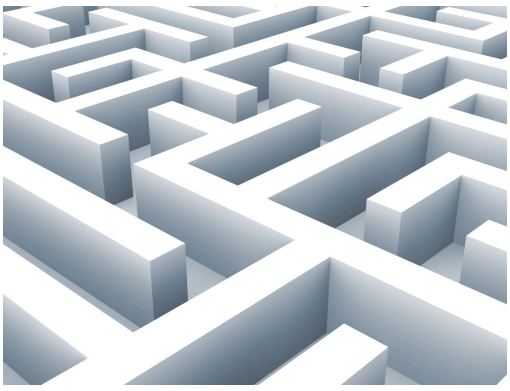
Confusion – Finding A Way Out?

- Provider v. Supplier v. Facility (Medicare v. "This")
- Self-Pay v. Uninsured
- POC v. POC
- "Cash" v. Cash Practice Model
- Uninsured v. Charity Care v. Hardship
- Not Using Insurance? (What?)
- Patient "Choice" to Not Bill? (Own Free Will)
- Mandatory Claims Submission
- Contractual Obligation for Claims Submission
- What is "Wellness"



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Does it Apply? PT

The No Surprises Act applies to all healthcare providers and facilities operating under the scope of a state-issued license or certification.

If you are a licensed provider in your state, the Act applies.

No specific specialties, types of service, or facilities are exempt.

https://www.fsbpt.org/Free-Resources/Licensing-Authorities-Contact-Information

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Does it Apply? SLP

The No Surprises Act applies to all healthcare providers and facilities operating under the scope of a state-issued license or certification.

If you are a licensed provider in your state, the Act applies.

No specific specialties, types of service, or facilities are exempt.

ASHA State-by-State

State Requirements and Contact Information

About state contacts and licensure information.

Alabama	Indiana	Nevada	Tennessee
Alaska	Iowa	New Hampshire	Texas
Arizona	Kansas	New Jersey	Utah
Arkansas	Kentucky	New Mexico	Vermont
California	Louisiana	New York	Virginia
Colorado	Maine	North Carolina	Washington
Connecticut	Maryland	North Dakota	West Virginia
Delaware	Massachusetts	Ohio	Wisconsin
District of Columbia	Michigan	Oklahoma	Wyoming
Florida	Minnesota	Oregon	U.S. Territories
Georgia	Mississippi	Pennsylvania	Overseas
Hawaii	Missouri	Rhode Island	Association of
Idaho	Montana	South Carolina	Communication
Illinois	Nebraska	South Dakota	Sciences

https://www.asha.org/advocacy/state/

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Does it Apply? OT

The No Surprises Act applies to all healthcare providers and facilities operating under the scope of a state-issued license or certification.

If you are a licensed provider in your state, the Act applies.

No specific specialties, types of service, or facilities are exempt.

No Surprises Act Good Faith Estimates for the Uninsured or Self Pay Applies to Occupationa Therapy Practitioners

1/4/2022

Effective January 1, 2022, the No Surprises Act includes a provision that requires that a good faith estimate be provided to any patient presenting either with no insurance or choosing not to bill insurance for the visit. In an FAQ, the Centers for Medicare & Medicaid Services (CMS) clarified that this provision applies to all providers in all settings.

The Requirement

The good faith estimate (GFE) must be given to all insured patients and patients who have insurance but are electing not to use it for these services. The estimate must also be provided for all other providers that may provide co-treatment. So, if the therapy service is generally rendered as part of post-op recovery from a surgery, the hospital or surgeon may ask you to provide an estimate to them so they may provide the patient with a complete estimate prior to surgery. This request should include a required response date.

Applicability

While this policy applies to all uninsured patients and patients intending to be self-pay and not bill insurance, we recommend reviewing any insurance contracts in place to see if self-pay requests can be honored. CMS states if at any time insurance is billed, the GFE requirements do not apply. Additionally, because occupational therapy practitioners cannot opt out of Medicare, this requirement would not apply to Medicare patients. The ABN process would continue to apply in instances where services may not be payable by the Medicare program.

https://www.aota.org/Advocacy-Policy/Federal-Reg-Affairs/News/2021/No-Surprises-Act.aspx

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Definitions

Important Consideration in Application of the No Surprises Act

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Convening or Co-Health Provider

- **Convening** health care provider or convening health care facility (convening provider or convening facility) means the **provider or facility who receives the initial request for a good faith estimate** from an uninsured (or self-pay) individual and who is or, in the case of a request, would be **responsible for scheduling the primary item or service.**
- **Co-health** care provider or co-health care facility (co-provider or co-facility) means a provider or facility other than a convening provider or a convening facility that **furnishes items or services that are customarily provided in conjunction with a primary item or service.**

https://www.ecfr.gov/current/title-45/subtitle-A/subchapter-B/part-149/subpart-G/section-149.610

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Expected Charge

- **Expected charge** means, for an item or service, the **cash pay rate** or **rate established** by a provider or facility for an uninsured (or self-pay) individual, **reflecting any discounts** for such individuals, where the good faith estimate is being provided to an uninsured (or self-pay) individual; *or*
- The amount the provider or facility would expect to charge if the provider or facility intended to bill a plan or issuer directly for such item or service when the good faith estimate is being furnished to a plan or issuer.

https://www.ecfr.gov/current/title-45/subtitle-A/subchapter-B/part-149/subpart-G/section-149.610

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Good Faith Estimate

- Good faith estimate means a **notification of expected charges** for a **scheduled or requested** item or service, including items or services that are reasonably expected to be provided in conjunction with such scheduled or requested item or service, provided by a convening provider, convening facility, co-provider, or co-facility.

https://www.ecfr.gov/current/title-45/subtitle-A/subchapter-B/part-149/subpart-G/section-149.610

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Provider or Facility

- **Health care facility (facility)** means an institution (such as a hospital or hospital outpatient department, critical access hospital, ambulatory surgical center, rural health center, federally qualified health center, laboratory, or imaging center) in any State in which State or applicable local law provides for the licensing of such an institution, that is licensed as such an institution pursuant to such law or is approved by the agency of such State or locality responsible for licensing such institution as meeting the standards established for such licensing. (viii)
- **Health care provider (provider)** means a physician or other health care provider who is acting **within the scope of practice of that provider's license or certification under applicable State law**, including a provider of air ambulance services.

https://www.ecfr.gov/current/title-45/subtitle-A/subchapter-B/part-149/subpart-G/section-149.610

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Uninsured or Self-Pay Individual

- (A) An individual who **does not have benefits for an item or service** under a group health plan, group or individual health insurance coverage offered by a health insurance issuer, Federal health care program (as defined in section 1128B(f) of the Social Security Act), or a health benefits plan under chapter 89 of title 5, United States Code *or*
- (B) An individual who has benefits for such item or service under a group health plan, or individual or group health insurance coverage offered by a health insurance issuer, or a health benefits plan under chapter 89 of title 5, United States Code **but who does not seek to have a claim for such item or service submitted to such plan or coverage.**

https://www.ecfr.gov/current/title-45/subtitle-A/subchapter-B/part-149/subpart-G/section-149.610

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Period of Care (POC)

- Period of care **means the day or multiple days** during which the **good faith estimate** for a **scheduled or requested item or service (or set of scheduled or requested items or services) are furnished** or are **anticipated to be furnished**, regardless of whether the convening provider, convening facility, co-providers, or co-facilities are furnishing such items or services, including the period of time during which any facility equipment and devices, telemedicine services, imaging services, laboratory services, and preoperative and postoperative services that would not be scheduled separately by the individual, are furnished.

https://www.ecfr.gov/current/title-45/subtitle-A/subchapter-B/part-149/subpart-G/section-149.610

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Implementation

Sample Checklist, Stakeholders, Policies, Processes

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Suggested Implementation[1]

- ✓**Post** the HHS **Notice**, "Right to Receive a Good Faith Estimate of Expected Charges,"6 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)).

Sample Steps Source: Kim Stanger - No Surprise Billing Rule – **Adapted with expressed permission** to Laura Riddell

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Suggested Implementation$_2$

- ✓**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)).
- ✓For self-pay patients, prepare and give the good faith estimate to the patient if
  - (1) the patient **asks about the cost** of services,
  - (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.

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Suggested Implementation$_3$

- ✓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.

Of note:

- Providing an incomplete or inaccurate good faith estimate may **limit your ability to collect** from the self-pay patient if the patient initiates the Dispute Resolution process.
- **To facilitate timely complete estimates, consider a standard template for common items or services in advance.**

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Suggested Implementation$_4$

- ✓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)).)

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Suggested Implementation$_5$

- ✓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)).
- ✓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 (45 CFR 149.610(b)(1)(x)).

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Suggested Implementation$_6$

- ✓**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**.
- ✓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-providers (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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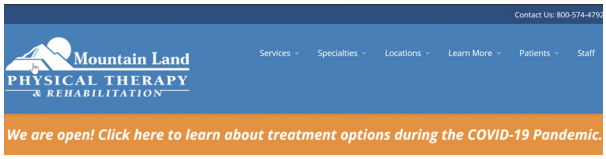
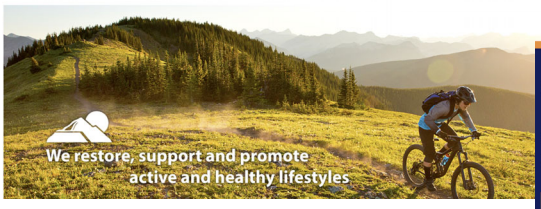
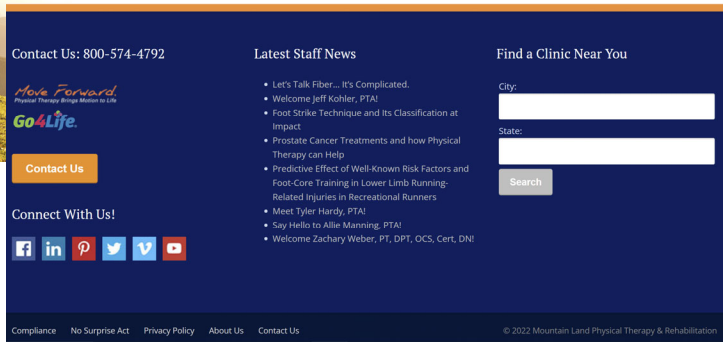
Website Notice

Mountain Land Rehabilitation – Used w/Permission



Home Page
Where Appointments are Scheduled





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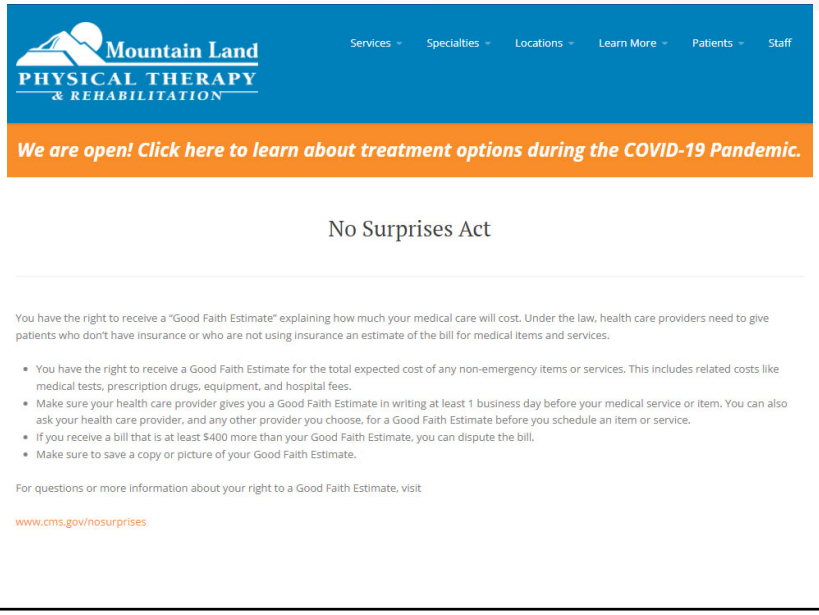
Link: End Point for GFE Notice



- End Point is in Patient Portal
- Starts the process
- Contains the GFE Form

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Develop a Call Script Flow Sheet

STEP #	PROCESS STEPS	INSURANCE	IF.... THEN WHAT
2	Are you calling to schedule therapy? (a service)?	yes/no	If "yes", go to #4 If "no", go to #3
3	Are you calling for pricing today (prior to scheduling a service)?	yes/no	If "yes", go to #8, and Task A If "no" assess reason and respond according to company practices
4	Do you have Rx from your referring MD/NPP for Therapy services?	yes/no	If "yes", go to #6 If "no", go to #5
5	Are you requesting therapy services via "direct access" (without MD/NPP referral)?	yes/no	If "yes", go to #6 If "no", go to #6
6	Are you enrolled in a group health plan, group or individual health insurance coverage offered by a health issuer, or FEHB Plan, that is not a Federal Health Care Program?	yes/no	If "yes", go to #9 If "no", go to #8
7	Are you a federal health care program beneficiary (Medicare, Medicaid, or Tricare)?	yes	If "yes", go to #12; If "no", go to #9
8	Are you a Self-Pay Patient?	yes/no	If "yes", go to #11 If "no", go to #10
9	Are you seeking to have your claims for services submitted to your health benefit plan/insurer? (For individual enrolled in group health plan, group or individual health insurance coverage offered by a health insurance issuer, or a FEHB Plan)	yes	If "yes", go to #10 If "no", go to #11
10	Are you ready to schedule and have your claim submitted to your insurance for payment?	yes/no	If "yes", with go to #12; If "no", go to #11
11	Are you ready to schedule and self-pay?	yes/no	If "yes", go to #12; If "no", assess reason and respond according to company standard practices.
12	Schedule Evaluation/Services	yes/no	If yes and billing insurance, schedule and proceed with intake process If yes and self pay - Complete Task #B and Task #C prior to proceeding with intake

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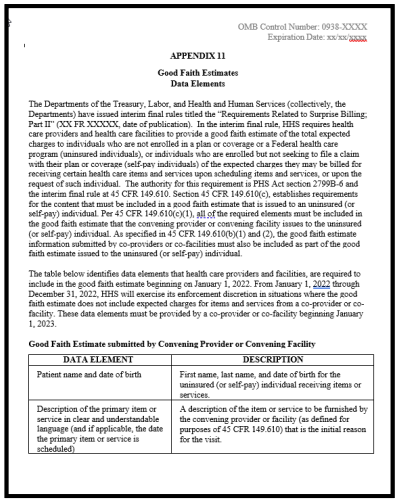
CMS GFE – Sample & Elements



OMB Control Number: 0938-XXXX
Expiration Date: xx/xx/xxxx

APPENDIX 11

Good Faith Estimates
Data Elements

The Departments of the Treasury, Labor, and Health and Human Services (collectively, the Departments) have issued interim final rules titled the "Requirements Related to Surprise Billing; Part II" (XX FR XXXXX, date of publication). In the interim final rule, HHS requires health care providers and health care facilities to provide a good faith estimate of the total expected charges to individuals who are not enrolled in a plan or coverage or a Federal health care program (uninsured individuals), or individuals who are enrolled but not seeking to file a claim with their plan or coverage (self-pay individuals) of the expected charges they may be billed for receiving certain health care items and services upon scheduling items and services, or upon the request of such individual. The authority for this requirement is PHS Act section 2799B-6 and the interim final rule at 45 CFR 149.610. Section 45 CFR 149.610(c), establishes requirements for the content that must be included in a good faith estimate that is issued to an uninsured (or self-pay) individual. Per 45 CFR 149.610(c)(1), all of the required elements must be included in the good faith estimate that the convening provider or convening facility issues to the uninsured (or self-pay) individual. As specified in 45 CFR 149.610(b)(1) and (2), the good faith estimate information submitted by co-providers or co-facilities must also be included as part of the good faith estimate issued to the uninsured (or self-pay) individual.

The table below identifies data elements that health care providers and facilities, are required to include in the good faith estimate beginning on January 1, 2022. From January 1, 2022 through December 31, 2022, HHS will exercise its enforcement discretion in situations where the good faith estimate does not include expected charges for items and services from a co-provider or co-facility. These data elements must be provided by a co-provider or co-facility beginning January 1, 2023.

Good Faith Estimate submitted by Convening Provider or Convening Facility

DATA ELEMENT	DESCRIPTION
Patient name and date of birth	First name, last name, and date of birth for the uninsured (or self-pay) individual receiving items or services.
Description of the primary item or service in clear and understandable language (and if applicable, the date the primary item or service is scheduled)	A description of the item or service to be furnished by the convening provider or facility (as defined for purposes of 45 CFR 149.610) that is the initial reason for the visit.

OMB Control Number [0938-XXXX]
Expiration Date [MM/DD/YYYY]

[NAME OF CONVENING PROVIDER OR CONVENING FACILITY]

Good Faith Estimate for Health Care Items and Services

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

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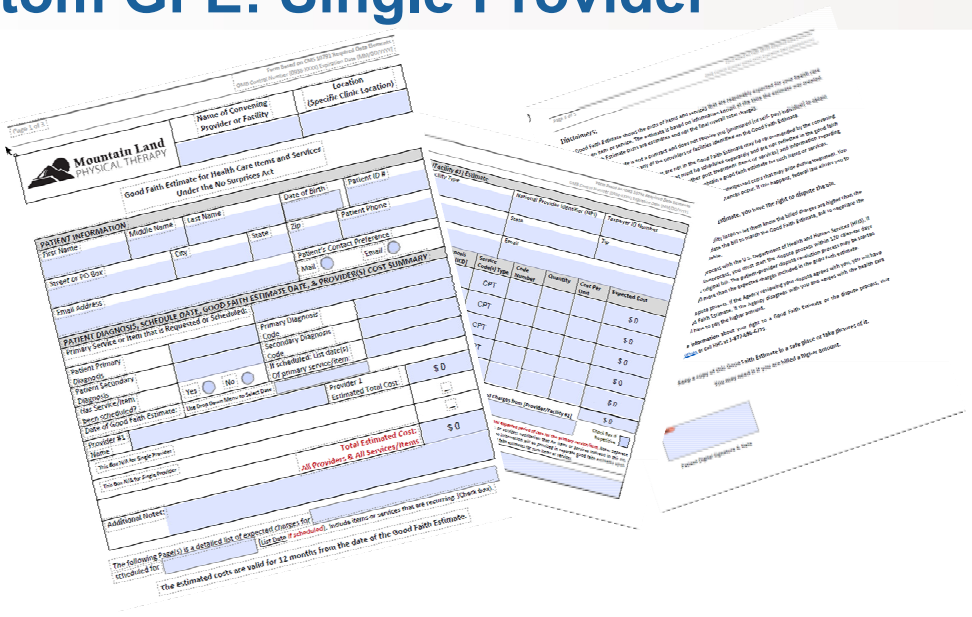
Custom GFE: Single Provider



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Good Faith Disclaimers$_1$

- This Good Faith Estimate shows the costs of items and services that are reasonably expected for your health care needs for an item or service. The estimate is based on **information known at the time the estimate was created.** The Good Faith Estimate costs are estimates and not the final overall total charges.
- The Good Faith Estimate is **not a contract** and does not require you [uninsured (or self-pay) individual] to obtain the items and services from any of the providers or facilities identified on the Good Faith Estimate.
- **Additional items and/or services** that are not in the Good Faith Estimate **may be recommended** by the convening provider as part of the course of care, that must be scheduled separately and are not reflected in the good faith estimate (such as rehabilitation therapies or other post treatment items or services) and information regarding how an you [uninsured (or self-pay) individual] can obtain a good faith estimate for such items or services.
- The Good Faith Estimate **does not include any unknown or unexpected costs** that may arise during treatment. You could be charged more if complications or special circumstances occur. If this happens, federal law allows you to dispute (appeal) the bill.

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Good Faith Disclaimers$_2$

- If you are billed for more than this Good Faith Estimate, you have the **right to dispute the bill**. You may contact the health care provider or facility listed to let them know the billed charges are higher than the Good Faith Estimate. You can **ask** them to **update the bill** to match the Good Faith Estimate, ask to **negotiate the bill**, or ask if there is **financial assistance available**.
- You may also start a **dispute resolution process** with the U.S. Department of Health and Human Services (HHS). If you choose to use the dispute resolution process, you must start the dispute process **within 120 calendar days** (about 4 months) of the date on the original bill. The patient-provider dispute resolution process may be started if the **actual billed charges are $400** more than the expected charges included in the good faith estimate.
- There is **a $25 fee to use the dispute process.** If the Agency reviewing your dispute **agrees** with you, you will have to **pay the price on this Good Faith Estimate**. If the Agency **disagrees** with you and agrees with the health care provider or facility, you will have to **pay the higher amount**.
- To learn more and get a form to start the process, go to www.cms.gov/nosurprises or call the Department of Health & Human Services (HHS) at 1-877-696-6775. For questions or more information about your right to a Good Faith Estimate or the dispute process, visit www.cms.gov/nosurprises or call HHS at 1-877-696-6775.
- Keep a copy of this Good Faith Estimate in a **safe place or take pictures of it**. You may need it if you are billed a higher amount.

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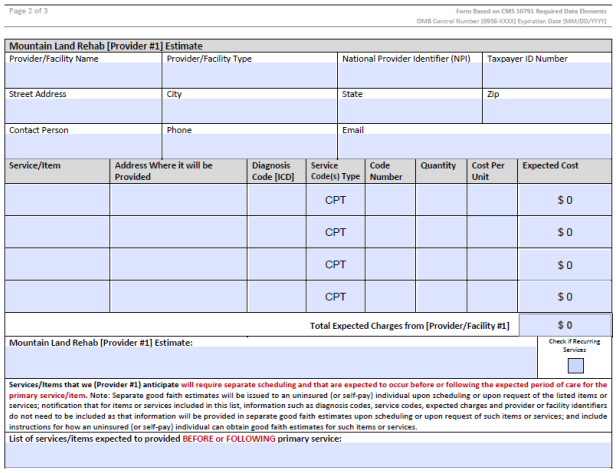
Custom Form: Provider Estimate Details



Page 2 of 3

Form Based on CMS 10791 Required Data Elements
OMB Control Number (0938-XXXX) Expiration Date (MM/DD/YYYY)

Mountain Land Rehab [Provider #1] Estimate

Provider/Facility Name	Provider/Facility Type	National Provider Identifier (NPI)	Taxpayer ID Number
Street Address	**City**	**State**	**Zip**
Contact Person	**Phone**	**Email**	

Service/Item	Address Where it will be Provided	Diagnosis Code [ICD]	Service Code(s) Type	Code Number	Quantity	Cost Per Unit	Expected Cost
			CPT				$ 0
			CPT				$ 0
			CPT				$ 0
			CPT				$ 0
						Total Expected Charges from [Provider/Facility #1]	$ 0

Mountain Land Rehab [Provider #1] Estimate: Check if Recurring Services ☐

Services/Items that we [Provider #1] anticipate will require separate scheduling and that are expected to occur before or following the expected period of care for the primary service/item. Note: Separate good faith estimates will be issued to an uninsured (or self-pay) individual upon scheduling or upon request of the listed items or services; notification that for items or services included in this list, information such as diagnosis codes, service codes, expected charges and provider or facility identifiers do not need to be included as that information will be provided in separate good faith estimates upon scheduling or upon request of such items or services; and include instructions for how an uninsured (or self-pay) individual can obtain good faith estimates for such items or services.

List of services/items expected to provided BEFORE or FOLLOWING primary service:

- Many providers have "form tools"
- Posted to web for ease electronic submission
- Getting all items on forms, and directing info to parties (back office):
- May look easy, but technically may be complicated process

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Develop Tasks & Processes

What is your process?

- Document steps you are taking
- Identify accountability and train staff (Job description)
- Develop a call script
- Must maintain in EMR as part of clinical record
- "Listen to staff" – is it working?
- Understand HIPAA implications (Privacy)
- Understand Section 1557 obligations – language AND accessibility

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For Reference: Enforcement

- Under the statute, CMS **will only enforce a provision** with respect to the applicable regulated parties **if CMS determines that a state is not substantially enforcing** that provision.
- This can occur, for example, when a state lacks authority to enforce, or requests that CMS enforce, one or more provisions.
- "CMS will publish a list, by state, of provisions CMS will enforce."
  - List has not been published as of 2-4-2022, best bet to check your State Insurance Website
- State Enforcement Example:
  - Utah No Surprises Act | Utah Insurance Department
  - Wisconsin OCI No Surprises Act (wi.gov)

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For Further Information & Discussion

Item	Comment
Dispute Resolution	"Starting in January 2022, if an uninsured (or self-pay) consumer is billed for an amount that exceeds the good-faith estimate they were provided, the consumer can use a new patient and provider dispute resolution process to determine a payment amount. Consumers will be eligible to use this process if they have a good-faith estimate, a bill within the last 120 calendar days, and the difference between the good-faith estimate and the bill is at least $400."
Convening Provider	It is not likely that a Therapy Practice, RA or CORF is a **convening provider or co-provider** in vast majority of circumstances.
Further Info?	When available from CMS in the Final Rule

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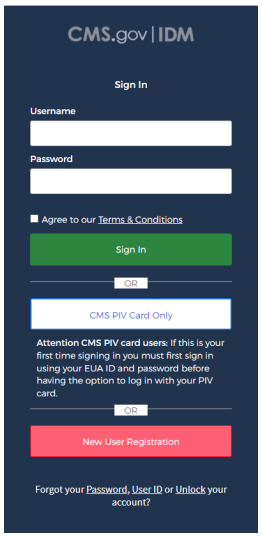
For Reference: Dispute Resolution



CMS Identity Management

OMB Control Number: 1210-0169
Expiration Date: 04/30/2022

Patient-Provider Dispute Resolution Form

Find out if you qualify for the dispute resolution process

This form is only for people who do **not** have health insurance or who decided not to use insurance for their medical care.		
Did your health care provider give you a Good Faith Estimate for the item or service?	Yes ☐	No ☐
Is the bill for your health care provider at least $400 more than the Good Faith Estimate?	Yes ☐	No ☐
Is the **date on the top of the bill** within the last 120 calendar days (about 4 months)?	Yes ☐	No ☐

If you answered **NO** to any of these questions:

- You do not qualify for the dispute resolution process. Please contact your health care provider to negotiate your bill and ask for financial assistance.
- If you think you should have been given a Good Faith Estimate or have other questions, please visit https://www.cms.gov/nosurprises/consumers or call 1-800-985-3059.

If you answered **YES** to **ALL** of these questions:
You qualify for the dispute resolution process. Please complete the rest of this form.

Note: While the dispute resolution process is happening, you can still ask your health care provider for a lower bill.

Patient Provider Dispute Resolution Initiation Form (cms.gov)

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Examples

- Walk Over Splint
- Dry Needling or Cupping – **not covered service**
- Medicare more visits – **not medically necessary**
- WC or Auto, that is denied….
- Medicare Adv – No OON
- SNF

"Any discussion or inquiry about "cost" = a request for a Good Faith Estimate

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Unknowns Still Remain

- Medicare ABN – do we have to do both?
- How to provide DX where not allowed by Practice Act?
- Is there a potential violation of insurance contract?
- Patient decides to reverse course and switch from using “insurance” to “cash”, because “cash” rate is cheaper
- Required time frames if visit not in the “framework” established in the Rule
- Questions to CMS –Waiting for answers

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Contact Information

Panelist	Contact Information
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Rehab Compliance Resources

Thank You

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