No Surprises Act
Good Faith Estimate Requirements

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NARA Webinar
February 4, 2022

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
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

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
No Surprises Act and Good Faith Estimate

January 1, 2022

Payment Cuts  Assistant Modifier  Telehealth  No Surprises Act  CMS Mandates

No Surprises Act – Where the GFE Fits

- Title 45  Public Welfare
- Subtitle A  Department of Health and Human Services
- Subchapter B  Requirements Relating to Health Care Access
- Part 149  Surprise Billing and Transparency Requirements
- Subpart G  Protection of Uninsured or Self-Pay Individuals

- § 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.

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 estimates 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.
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)

CMS: The Source for Providers

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

Comparison

Balance Billing (Part I)

- Balance billing prohibition is somewhat limited in scope
- 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.
- 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 consent process is not available for OON providers providing “ancillary services” at an in-network facility or to emergency services.

Good Faith Estimate (Part II)

- GFE requirement applies broadly to all health care providers.
- Law requires health care providers to give all uninsured & self-pay patients a GFE upon scheduling item/service or to all patients upon request.
- This GFE relates to the scheduled item/service and must identify the cost of all items & services relating to that item/service.
- 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
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)

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”
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

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.

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

Definitions

Important Consideration in Application of the No Surprises Act
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.


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.

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.

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.
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.**


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.

Implementation
Sample Checklist, Stakeholders, Policies, Processes

Suggested Implementation

- **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)).
Suggested Implementation

☑ 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.

Suggested Implementation

☑ 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.
Suggested Implementation

✓ 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)).

Suggested Implementation

✓ 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)).
Suggested Implementation

- **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.
Link: End Point for GFE Notice

You have the right to receive a "good faith estimate" explaining how much your medical care will cost. Under this law, health care providers need to give patients who don’t have insurance or who are not using insurance an estimate of the bill for medical items and services.

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

For questions or more information about your right to a Good Faith Estimate, visit:

www.cms.gov/nursinghome

Develop a Call Script Flow Sheet

<table>
<thead>
<tr>
<th>IF PROCESS</th>
<th>THEN</th>
<th>IF</th>
<th>THEN WHAT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are you calling to schedule therapy? (a service)?</td>
<td>yes/no</td>
<td>if yes, go to #3, if no, go to #2</td>
<td></td>
</tr>
<tr>
<td>Are you calling for pricing needs (prior to scheduling a service)?</td>
<td>yes/no</td>
<td>if yes, go to #6, if no, go to #5</td>
<td></td>
</tr>
<tr>
<td>Do you have info from your referring MD/Referral for Therapy services?</td>
<td>yes/no</td>
<td>if yes, go to #9, if no, go to #8</td>
<td></td>
</tr>
<tr>
<td>Are you requesting therapy services via &quot;direct access&quot; (without referral)?</td>
<td>yes/no</td>
<td>if yes, go to #9, if no, go to #8</td>
<td></td>
</tr>
<tr>
<td>Are you enrolled in a group health plan, group or individual health insurance coverage offered by a health insurer, or HMO Plan, that is a federal health care program beneficiary (Medicare, Medicaid, or Tricare)?</td>
<td>yes/no</td>
<td>if yes, go to #11, if no, go to #10</td>
<td></td>
</tr>
<tr>
<td>Are you a Self-Pay Patient?</td>
<td>yes/no</td>
<td>if yes, go to #12, if no, go to #11</td>
<td></td>
</tr>
<tr>
<td>Are you seeking to have your claim for services submitted to your health benefit plan/insurer?</td>
<td>yes/no</td>
<td>if yes, go to #12, if no, go to #11</td>
<td></td>
</tr>
<tr>
<td>Are you ready to schedule and have your claim submitted to your insurance for payment?</td>
<td>yes/no</td>
<td>if yes, go to #12, if no, go to #11</td>
<td></td>
</tr>
<tr>
<td>Schedule Evaluation/Sessions</td>
<td>yes/no</td>
<td>if yes, submit claim to insurance, if no, go to #11</td>
<td></td>
</tr>
</tbody>
</table>
Good Faith Disclaimers

- 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.

Good Faith Disclaimers

- 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 or 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.
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

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
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)

For Further Information & Discussion

<table>
<thead>
<tr>
<th>Item</th>
<th>Comment</th>
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<tbody>
<tr>
<td>Dispute Resolution</td>
<td>&quot;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.&quot;</td>
</tr>
<tr>
<td>Convening Provider</td>
<td>It is not likely that a Therapy Practice, RA or CORF is a convening provider or co-provider in vast majority of circumstances.</td>
</tr>
<tr>
<td>Further Info?</td>
<td>When available from CMS in the Final Rule</td>
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For Reference: Dispute Resolution

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
**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
## Contact Information

<table>
<thead>
<tr>
<th>Panelist</th>
<th>Contact Information</th>
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<tbody>
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<td>Christie Sheets</td>
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