Questions and Answers (Q&A)

No Surprises Act Tasks for Providers: New Requirements for Giving Patients Advance Treatment Costs Webinar

Q. Does this apply to specialist providers who only provide emergency care when on call? Would we have to post in our office or rely on hospitals to post notices?

A. The notice for no surprise billing must be posted in all facilities that provide emergency care, inpatient hospitals, and in the office of any provider that would provide services in an inpatient hospital or emergency room.

Q. How does the lawsuit in Texas effect the NSB regulations?

A. The lawsuit was about the resolution of disputes between the provider and the health plan. CMS is revising those instructions. The rest of the NSA regulations are not impacted.

Q. Does this apply to cosmetic surgery practices?

A. Yes. GFE's must be provided to patients per the regulations.

Q. If a patient is an emergency (or potential emergency), does this apply? Is a facility (ED) required to give an estimate?

A. Not usually, estimates are only required if services are scheduled at least three days in advance.

Q. What if the patient is insured but want to pay as self-pay? Do we need to provide a GFE?

A. Yes, this requires a GFE that follows all of the requirements.

Q. If these patients have no insurance, who is policing this?

A. Enforcement will be done either by the State or HHS, depending on State law.

Q. Does this also apply to personal injury payors (attorney)?

A. This only applies to non-governmental commercial health plans.

Q. Do we have to provide good faith estimates over the phone without ever seeing the patient?

A. Yes, if requested by the patient. Note that any discussion of cost of services is considered a request for a GFE. The GFE must be provided in writing, either on paper or electronically via email.

Q. If we already provide Pre-Treatment Estimates to our patients with our own format, do we still have to complete the GFE with that specific form?

A. The form is not required, however specific content is.

Specifically, the good faith estimate issued by the convening provider or convening facility to the uninsured (or self-pay) individual must include:

- Patient name and date of birth;
- Description of the primary item or service in clear and understandable language (and if applicable, the date the primary item or service is scheduled);
- Itemized list of items or services, grouped by each provider or facility, reasonably expected to be provided for the primary item or service, and items or services reasonably expected to be furnished in conjunction with the primary item or service, for that period of care including: (1) Those items or services reasonably expected to be furnished by the convening provider or convening facility, and (2) those items or services expected to be furnished by co-providers or co-facilities;
- Applicable diagnosis codes, expected service codes, and expected charges associated with each listed item or service;
- Name, NPI, and TIN of each provider or facility represented in the good faith estimate, and the state(s) and office or facility location(s) where the items or services are expected to be furnished by such provider or facility;
- List of items or services that the convening provider or convening facility anticipates will require separate scheduling and that are expected to occur before or following the expected period of care for the primary item or service. The good faith estimate must include a disclaimer directly above this list that states that 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 and 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;

Q. If we already provide Pre-Treatment Estimates to our patients with our own format, do we still have to complete the GFE with that specific form? (Continued from previous page)

A.

- A disclaimer that informs the uninsured (or self-pay) individual that there may be additional items or services the convening provider or convening facility recommends as part of the course of care that must be scheduled or requested separately and are not reflected in the good faith estimate;

- A disclaimer that informs the uninsured (or self-pay) individual that the information provided in the good faith estimate is only an estimate of items or services reasonably expected to be furnished at the time the good faith estimate is issued to the uninsured (or self-pay) individual and that actual items, services, or charges may differ from the good faith estimate;

- A disclaimer that informs the uninsured (or self-pay) individual of their right to initiate the patient-provider dispute resolution process if the actual billed charges are substantially in excess of the expected charges included in the good faith estimate, as specified in 45 CFR 149.620; this disclaimer must include instructions for where an uninsured (or self-pay) individual can find information about how to initiate the patient-provider dispute resolution process and state that the initiation of the patient-provider dispute resolution process will not adversely affect the quality of health care services furnished to an uninsured (or self-pay) individual by a provider or facility; and

- A disclaimer that the good faith estimate is not a contract and does not require the uninsured (or self-pay) individual to obtain the items or services from any of the providers or facilities identified in the good faith estimate.

Q. Does this include non-covered cosmetic services?

A. Yes, any service performed by a licensed provider operating within the scope of their license.

Q. **Does this rule apply for an office-based solo clinician? non-institutional, not affiliated to hospital?**

A. Yes.

Q. **Can you please clarify if it is required to provide the good faith estimate for non-emergency services? And must it be provided to self-pay as well as commercial pay patients directly, even though we do not send it to the health plan?**

A. Yes, the GFE is for all services. As of now, it must only be provided to uninsured/self-pay patients. Requirements for commercial pay patients have not been set.

Q. **EXAMPLE: Result of annual well visit, sent patient for mammogram and bone density; commercial insurance didn't pay bone density at 100% screening because patient wasn't age 65 (said they pay screening only age 65 and older). Ordering provider didn't know this limitation, patient surprised it wasn't paid. Is this No Surprises Act relevant? Relevant today or not till 2023? What happens? Do they still owe or only if >$400?**

A. The ordering provider is responsible for knowing patient's insurance coverage and should understand the services that are covered. If the ordering provider got information from the health plan and acted on that with patient agreement, then no GFE was necessary. If provider knew that health plan would not cover and patient had to pay out of pocket, then patient should have been provided with a GFE according to the requirements.

Q. **Does this apply to Medicare Advantage Plans?**

A. No.

Q. **Regarding the directory - What do we do if we have notified an insurance carrier multiple times of a directory update and it has not been done on their end in a timely manner? Several carriers are still behind in credentialing/updates due to covid.**

A. Best suggestion is to keep records of your communications with the health plan and make sure you notify them timely of any changes.

Q. **The GFE is to be provided to the patient. We are an addiction treatment facility & often deal with families regarding finances rather than the patient. How would you recommend we handle this?**

A. If a family is designated as the patient's representative, then they can receive the GFE. There may be State laws that provide guidance on what information can be released to families.

Q. **Is the GFE required even if the patient does not ask for one?**

A. Yes. Per the regulations, providers must:

Provide a good faith estimate (as specified in paragraph (c)(1) of this section) to uninsured (or self-pay) individuals within the following timeframes:

(A) When a primary 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;

(B) When a primary 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

(C) When a good faith estimate is requested by an uninsured (or self-pay) individual: Not later than 3 business days after the date of the request.

Q. What if an insurance company directory is out-of-date and they make a mistake and tell a patient we're in network when we're not? Do we still have to refund + interest?

A. If a provider gives, or fails to correct, incorrect information about their in-network/out-of-network status, and a patient mistakenly relies, as a result, on this mistaken information, the provider must refund all monies paid by the patient in excess of the in-network amount. If the provider has met all of their directory update requirements to the plan, the provider would not be liable for the mistake.

An in-network provider must submit correct provider directory information to the health insurance company, at a minimum of the following times:

At the beginning of the in-network agreement with the health insurance company;

At the time of termination of an in-network agreement with a health insurance company;

When there are material changes to the content of the provider's directory information;

Upon request by the plan or issuer, and

At any other time determined appropriate by the provider or HHS.

Q. Is this only for out of network plans?

A. The GFE requirements are currently for uninsured/self-pay patients. The prohibitions against balance billing apply to all commercial health plans.

Q. **With dermatology when a patient comes in for a full skin exam, I do not know what icd-10 will be used or what in office procedures they may need at that time. So how would I do a Good Faith Estimate without this information? There is no way to really know in advance… Other than the office visits.**

A. The GFE is only required to include the information on the scheduled service (the full skin exam). If a diagnosis is not necessary to provide the cost estimate, it is not required.

Q. **How will plastic surgery offices be affected by this as we only have emergent cases when one of our doctors is on call at the hospital? Should we post the Rights and Protections notice somewhere in our office regardless of this? Is a good faith estimate required for all patients that we see that we are out of network with even if the patient has out of network benefits?**

A. Plastic surgery offices are required to fulfill all of the requirements, just as any other provider. If your doctors handle emergency services or in-hospital services, the notices should be posted. GFEs are, as of now, only required for uninsured/self-pay patients.

Q. **During the webinar, it was mentioned that we should post a couple of items on our website and in our office. Can you specify which of those forms are required? The one that we post in the office: Where do you recommend that be posted for patients?**

A. The required postings are the one that specifies the availability of GFEs (for all providers) and the one that discusses the provisions about balance billing (for emergency facilities, hospitals, and providers that practice in those). These should be posted at the registration desk or similar area so that they are clearly visible to patients.

Q. Regarding Trizetto's Patient Responsibility Estimation, is this an additional service you have to pay for?

A. Trizetto's Patient Responsibility Estimation and Pricer are both available to any practice regardless of the current relationship with another claims clearinghouse provider. Each solution can be utilized on a standalone basis.

Q. Regarding Trizetto's Patient Responsibility Estimation, would this replace our current claim submission software?

A. No. Trizetto does not require a change in clearinghouse or software to utilize Patient Responsibility Estimation or Pricer solutions.

Q. Is the Patient Responsibility Estimation feature an additional charge or is that part of our Trizetto benefits?

A. Patient Responsibility Estimation solution is currently offered in the Smart Package under the MicroMD partnership although it can also be added to other packages or utilized as a standalone solution.