



Required Compliance Components (and updates) of the No Surprises Act

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Disclaimer

The information provided in this training is intended only to be a summary of legal standards. It is not intended to take the place of the statutes, regulations, or formal policy guidance. This tutorial presents current policy and operations as of the date it was presented. We encourage all attendees and/or library members to refer to the applicable statutes, regulations, and appropriate interpretive materials for complete and current information. This resource is to provide clarity but is not to be considered as legal interpretation of the law.

Disclaimer




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The Focus of the No Surprises Act



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A Closer Look

- Hidden Charges
- Excessive Balance Billing
- Medical Debt despite efforts to confirm network status

4




Consumer Empowerment



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What is Surprise Billing?

Surprise billing occurs when an individual receives an **unexpected medical bill** from a health care provider or facility after receiving medical services from a provider or facility that, **usually unknown** to the participant, beneficiary, or enrollee, is a **nonparticipating provider** or facility with respect to the individual's coverage.



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Summary of the Rule

- No balance billing for air ambulance services by nonparticipating air ambulance providers (PHSA 2799B-5; 45 CFR 149.440)
- No balance billing for out-of-network emergency services (PHSA 2799B-1; 45 CFR 149.410)
- No balance billing for **non-emergency services by nonparticipating providers at certain participating health care facilities**, unless notice and consent was given in some circumstances (PHSA 2799B-2; 45 CFR 149.420)

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What is a Facility?

Health care facilities include:
hospitals, hospital outpatient departments, critical access hospitals, and ambulatory surgical centers

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Does the Balance Billing Protection Rule Apply to Me in My Chiropractic Office?

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The KMC University No Surprises Act (NSA) Doctor of Chiropractic (DC) Decision Making Matrix®

Non-Emergency Services & Doctors of Chiropractic (DC)

Does the DC have Hospital, Emergency Department or Ambulatory Surgery Center privileges?

- YES** → Is the facility in-network?
 - NO** → The No Surprises Billing rule applies to in-network facilities. You do not need to abide by the NSA if you are rendering services as an out-of-network doctor at an out-of-network facility. Implement a non-covered services notification form when rendering out-of-network or non-covered services.
 - YES** → Is the DC in network with facility?
 - NO** → Is there a Single Case Agreement in place?
 - NO** → Local State Surprise Billing Laws & NSA apply
 - YES** → The Single Case Agreement controls billing procedures for the individual case
- NO** → Surprise Billing rule does not apply to out-of-network doctors who are not rendering services at an in-network facility. Implement a non-covered services notification form when rendering out-of-network or non-covered services.

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Single Case Agreement



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Cost Sharing Amounts- For the 1%

- Amount determined by an applicable **All Payer Model Agreement (PMA)** under the Social Security Act Section 1115A
If no PMA
- Amount determined by **State Law** or
- The lesser of the billed charge or the plan's or issuer's median contracted rate which is referred to as **Qualifying Payment Amount (QPA)**



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Overview

- The qualifying payment amount (QPA) is the **basis for determining individual cost-sharing** for items and services **covered by the balance-billing protections** in the No Surprises Act (NSA), under certain circumstances.
 - Cost-sharing for emergency items and services and non-emergency items and services furnished by an out-of-network provider in an in-network facility must be based on the lesser of billed charges or the QPA, where an All-Payer Model Agreement under section 1115A of the Soc. Sec. Act or a specified state law does not apply.
 - Cost-sharing for air ambulance services must be based on the lesser of billed charges or the QPA.
- Certified Independent Dispute Resolution (IDR) entities are required to consider the QPA when selecting between the offer submitted by a plan or issuer and the offer submitted by a facility or provider or provider of air ambulance services when determining the total out-of-network payment rate for items and services subject to the federal IDR process.

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The Independent Dispute Resolution (IDR)

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David (aka Provider) & Goliath (aka Payer)

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American Medical Association™ Guide for Physicians: Disputing Out-of-Network Payments Using the No Surprises Act Independent Dispute Resolution Process

MARCH 2022
updated April 2022

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CMS IDR Update in August 2022

High Volume of Disputes

Between April 15th and August 11th, disputing parties initiated over **46,000 disputes** through the federal IDR portal, which is substantially more than the Department's initially estimated would be submitted for a full year. Of the disputes initiated between April 15th and August 11th, certified IDR entities rendered a **payment determination in over 1,200 disputes**. Between April 15th and August 11th, non-initiating parties **challenged over 21,000 disputes'** eligibility for the federal IDR process, which constitutes nearly half of all disputes initiated. This does not necessarily mean that these disputes are ineligible, only that a party has challenged the eligibility of a dispute and that additional review by the certified IDR entities is necessary to determine eligibility. As a result of eligibility challenges, preliminary data suggests that certified IDR entities have already **found over 2,000 disputes ineligible** for the federal IDR process. Certified IDR entities have also determined a number of disputes to be eligible for the federal IDR process despite eligibility challenges made by non-initiating parties.

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David's Slingshot!

The AMA and the American Hospital Association (AHA) filed a **complaint** (PDF) and **motion for a stay or for summary judgment** (PDF) on Dec. 9, 2021, in the U.S. District Court for the District of Columbia arguing that the **IDR conflicts with the statute by establishing a presumption in favor of the QPA**. The text, context, purpose and history of the NSA make clear that the statutory IDR procedure Congress created leaves no room for the agencies to require the arbitrator to **put a thumb on the scale in favor of health issuers over providers**. The Physicians Advocacy Institute, **16 national medical specialty societies** and **sixteen state medical associations** filed an **amicus brief** (PDF) in support of the AMA/AHAS lawsuit.

The **Texas Medical Association (TMA)** brought a **similar suit** in the U.S. Federal District Court for the Eastern District of Texas. In February, that court found in favor of **TMA and several other providers in the TMA that weighed the IDR process in favor of health plans**. In April, the administration filed a notice of appeal to the U.S. Court of Appeals for the Fifth Circuit challenging the ruling but asked the court to hold its appeal pending the release of Final Rules. The court granted the administration's request and Final Rules were issued on August 19.

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Texas Medical Association

On July 26, 2022, the U.S. District Court for the Eastern District of Texas issued a judgment and order in LifeNet, Inc v. United States Department of Health and Human Services (LifeNet), vacating the final sentences of 45 CFR 149.520(b)(2), 26 CFR 54.9817-2(b)(2), and 29 CFR 2590.717-2(b)(2), which are parallel provisions governing the Federal Independent Dispute Resolution (IDR) process applicable to air ambulance payment disputes. **The sentence the court vacated states: "This [additional] information must also clearly demonstrate that the qualifying payment amount is materially different from the appropriate out-of-network rate."**

As a result of the LifeNet decision, effective July 26, 2022, certified IDR entities may not apply the vacated standard in reaching a payment determination in any payment dispute related to air ambulance services. The Departments are in the process of identifying revisions and updates to Federal IDR program guidance and related documents that are necessary to make them consistent with the LifeNet decision, and will issue these updates in the near future.

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.** To learn more about these protections, visit www.cms.gov/nosurprises.

The Departments are reviewing the court's decision and considering next steps. This announcement serves as a notification to health care providers, emergency facilities, providers of air ambulance services, group health plans, health insurance issuers, Federal Employees Health Benefits (FEHB) Carriers ("Disputing Parties"), and certified IDR entities of steps the Departments are taking to conform to the court's order.

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Recent Updates for IDR

On **Thursday, October 19, 2022**, the Department of Health and Human Services (HHS), the Department of Labor (DOL), and the Department of the Treasury (collectively, the Departments), in partnership with the Office of Personnel Management (OPM) launched an updated **Notice of Offer web form for providers, facilities, providers of air ambulance services, plans and issuers (disputing parties)**. The new Notice of Offer web form in the **Federal Independent Dispute Resolution (IDR) portal** will replace all existing methods for submitting a Notice of Offer to certified IDR entities.

Click [here](#) to view a demo of the Notice of Offer web form

This updated Notice of Offer web form is intended to make submitting final offers for payments and other required information easier and less burdensome for disputing parties and certified IDR entities. With this improvement, disputing parties will now have access to a semi-customized Notice of Offer web form within the Federal IDR portal. **Beginning October 19, 2022**, all disputes that are not currently within the 10-business day notice of offer phase of the Federal IDR process and that have not already received Notice of Offer forms from their certified IDR entity will receive a web link from their selected certified IDR entity to submit the Notice of Offer form through the Federal IDR portal once the certified IDR entity confirms eligibility for the Federal IDR process. Parties who received a Notice of Offer form in another format, such as an Excel form, before October 19, 2022 and are currently within the 10-business day deadline to submit an offer should submit your Notice of Offer directly to the selected certified IDR entity in the form and manner specified by your selected certified IDR entity by the Notice of Offer deadline.

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Interesting but Not Applicable

- IDR is for out of network providers who are rendering services in a in-network facility.
- IDR updates will apply to only a small percentage of DCs.
- DCs who are part of the 1% should work closely with their state associations on any movements towards 'defining' the Qualified Payment Amount for out of network services.



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Disclosure Requirements- Misinformation

OMB Control Number: 0938-1403
Expiration Date: 02/01/2025

Model Disclosure Notice Regarding Patient Protections Against Surprise Billing

Instructions for Providers and Facilities
(For use beginning January 1, 2022)

Section 2799b-3 of the Public Health Service Act (PHS Act) requires health care providers and facilities to make publicly available, post on a public website of the provider or facility (if applicable), and provide a one-page notice that includes information in clear and understandable language on:

- (1) the restrictions on providers and facilities regarding balance billing in certain circumstances;
- (2) any applicable state law protections against balance billing; and
- (3) information on contacting appropriate state and federal agencies in the case that an individual believes that a provider or facility has violated the restrictions against balance billing.

Health care providers and facilities may, but aren't required to, use this model notice to meet these disclosure requirements. To use this document properly, the provider or facility should review and complete it in a manner consistent with applicable state and federal law. HHS considers use of this model notice in accordance with these instructions to be good faith compliance with the disclosure requirements of section 2799b-3 of the PHS Act and 45 CFR 149.438, if all other applicable PHS Act requirements are met.



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Do You Need a Billing Protection Disclosure?

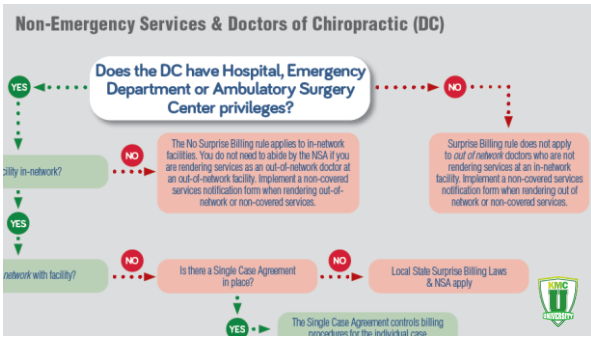
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Who Must Comply

- Hospitals (including critical access hospitals)
- Hospital outpatient departments
- Ambulatory surgical centers
- Emergency departments of hospitals
- Independent freestanding emergency departments



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1% of Providers To Do List

- Locate the Balance Billing Protection Resources
- Obtain a Balance Billing Protection Form from CMS or from KMC University
- Obtain a Model Disclosure Notice from CMS or KMC University
- Review the AMA Resources (available online)



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Billing Protection Form for the 1%

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Surprise Billing Protection Form

Surprise Billing Protection Form

IMPORTANT: You are not required to sign this form and should not sign if you do not have a choice of health care provider when you need care. You do choose to sign if you have a genuine choice of health care provider, which may be you. If you are not satisfied with the decision, ask your provider or patient advocate how to file a complaint with the regulator. Ask your provider or patient advocate how to file a complaint with the regulator.

When you sign this form, you agree to:

- Allow your doctor or provider to render services at an in-network facility, if available.
- Allow your doctor or provider to render services at an out-of-network facility, if available, if you do not have a genuine choice of health care provider.
- Allow your doctor or provider to render services at an out-of-network facility, if available, if you do not have a genuine choice of health care provider.

When you sign this form, you agree to:

- Allow your doctor or provider to render services at an in-network facility, if available.
- Allow your doctor or provider to render services at an out-of-network facility, if available, if you do not have a genuine choice of health care provider.
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- Allow your doctor or provider to render services at an out-of-network facility, if available, if you do not have a genuine choice of health care provider.



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The Model Disclosure for the 1%

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 incur 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:

Medicare Already Has Rules

- The rules do not apply to people with coverage through programs such as Medicare, Medicaid, Indian Health Services, Veterans Affairs Health Care, or TRICARE. Each of these programs already has other protections against high medical bills.

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Summary of the Balance Billing Protection NSA Rule

- No balance billing for air ambulance services by nonparticipating air ambulance providers (PHSA 2799B-5; 45 CFR 149.440)
- No balance billing for out-of-network emergency services (PHSA 2799B-1; 45 CFR 149.410)
- No balance billing for non-emergency services by nonparticipating providers at certain participating health care facilities, unless notice and consent was given in some circumstances (PHSA 2799B-2; 45 CFR 149.420)
- Disclose patient protections against balance billing (PHSA 2799B-3; 45 CFR 149.430)

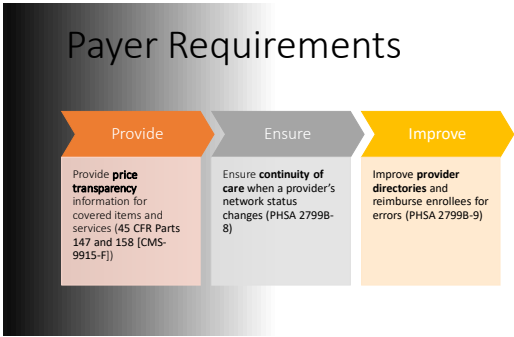
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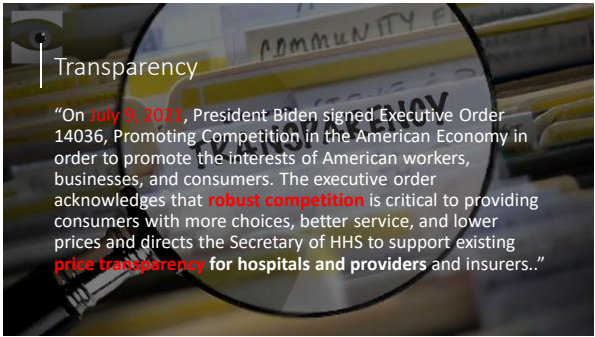
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Payer Requirements for Transparency



- Permit members to search based on billing code or description
- Allow members to compare costs **across both in-network and out-of-network providers**
- Inform members of any accumulated deductible or other out-of-pocket expenditures to date
- Provide cost estimates in paper format at the member's request

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Continuity of Care-90 Day Rule

Health plan members are **continuing care patients** if they meet one or more of these conditions with respect to a terminated provider or facility:

- Undergoing a course of treatment for a **serious and complex condition** [defined as "serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm"]
- Undergoing a course of institutional or inpatient care
- Are scheduled for a non-elective surgery, including receipt of postoperative care
- Are pregnant and undergoing a course of treatment for the pregnancy
- Are receiving treatment for a terminal illness (see section 1861(dd)(3)(A) of the Social Security Act)

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Disclosures

Appendix 1
Standard Notice: "Right to Receive a Good Faith Estimate of Expected Charges" Under the Law
(For use by health care providers and health care facilities)
(Effective January 1, 2022)

Under Section 2799B-2 of the Public Health Service Act, health care providers and health care facilities are required to inform individuals who are self-paying for care or coverage at a Federal health care program, or are seeking care at a clinic with a self-paying patient, of their **right to receive a good faith estimate** of expected charges before receiving care or services, or to receive a "Good Faith Estimate" of expected charges.

This notice may be used by the health care providers or health care facilities only when care is provided to a self-paying patient or a Federal health care program (including individuals, or individuals who are enrolled but not seeking to file a claim with their plan or coverage (e.g., individuals of their right to "Good Faith Estimate") to help them estimate the expected charges they may be liable for receiving certain health care items and services. Information regarding the availability of a "Good Faith Estimate" notice is prominently displayed on the receiving provider's and/or facility's website and is updated and revised when scheduling or questions about the cost of health care occur.

Model Discharge Notice Regarding Patient Protections Against Surprise Billing
Instructions for Providers and Facilities
(For use by Section 2799B-2)

Section 2799B-2 of the Public Health Service Act requires health care providers and facilities to make publicly available notices of patient protections against surprise billing in clear and understandable language on:

- (1) the restrictions on participating in surprise billing in certain circumstances;
- (2) any applicable state law provisions on surprise billing; and
- (3) information on contacting appropriate state and federal agencies in the case that an individual believes that a provider or facility has violated the restrictions against surprise billing.

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What Does Apply To Majority of DCs?

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Provider Impact

Improve

- Improve provider directories (PHSA 2799B-9)

Provide

- Provide good faith estimate in advance of scheduled services, or upon request (PHSA 2799B-6; 45 CFR 149.610 (for uninsured or self-pay individuals))

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Provider Directories

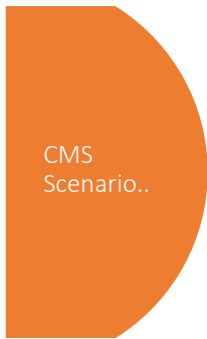
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Provider Requirements

Must submit provider directory information to a plan or issuer:

- at the beginning of a network agreement with a plan or issuer
- if the provider terminates a network agreement with a plan or issuer
- when there are material changes to the content of provider directory information of the provider
- at any other time (including upon the request of plan or issuer) determined appropriate by the provider, health care facility, or the Secretary of Health and Human Services (HHS)

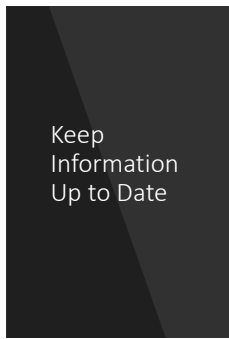
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- A doctor of chiropractic recently began a network agreement with a new health plan. **Is the DC required to submit provider directory information to the plan?**

Yes, under the No Surprises Act, the DC is required to submit provider directory information (i.e. the provider's name, address(es), specialty, telephone number(s), and digital contact information) to a plan or issuer when they begin a network agreement with a plan or issuer with respect to certain coverage.

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- Names, addresses, specialty, telephone numbers, and digital contact information of **individual health care providers**; and
- Names, addresses, telephone numbers, and digital contact information of each medical group, **clinic**, or health care facility contracted to participate in any of the networks of the group health plan or health insurance coverage involved.

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Providers Urged to Update Information

Hi Jill,

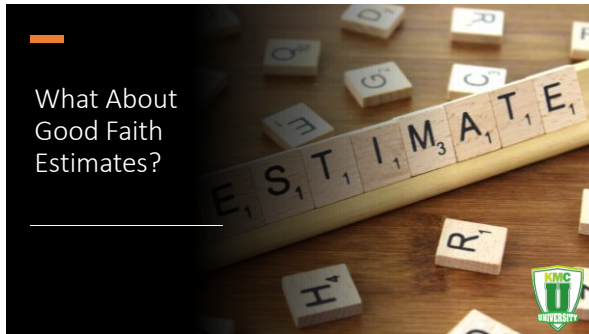
Your patients (and people who want to be your patients) rely on insurance companies' provider directories to find physicians that are right for them.

Under the No Surprises Act, your payers are **required** to have processes in place to remove providers who have not verified their directory information. Our records show that as of **September 16**, at least one of your **providers' information has not been verified** in more than 90 days.

It's essential that you complete this critical task today. Log in to the Availity Portal (now known as Availity Essentials) and check your providers' information.

Remember, even if nothing has changed, **the No Surprises Act requires verification of your directory information every 90 days.**

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What About Good Faith Estimates?

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The No Surprises Act Complexity

Independent Dispute Resolution (IDR) Process

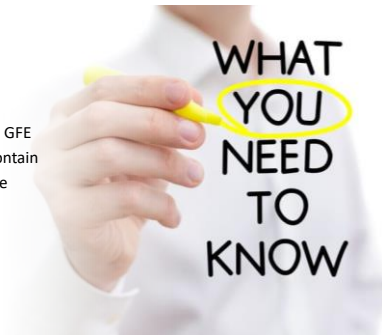
Requires Good Faith Estimates

Advance Explanation of Benefits

Patient Provider Dispute Resolution

Transparency & Balance Billing Protections

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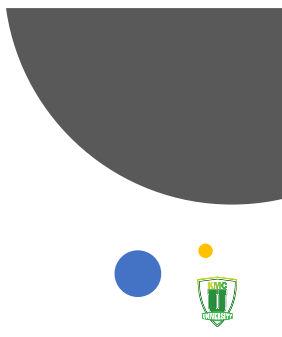


- **Who** should receive a GFE
- **What** a GFE should contain
- **When** should a GFE be provided
- **How** can a clinic be compliant

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“Health care providers and health care facilities are required under PHS Act section 2799B-6 to furnish a **notification of the good faith estimate of expected charges to an uninsured (or self-pay) individual** who schedules an item or service...”

Good Faith Estimate



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" physicians or other health care providers acting within the scope of their state licenses"

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Self-Pay Patients

- Uninsured
- Does not plan to use their insurance benefits to pay for the services provided by the physician—OON!

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Who Also Gets One?

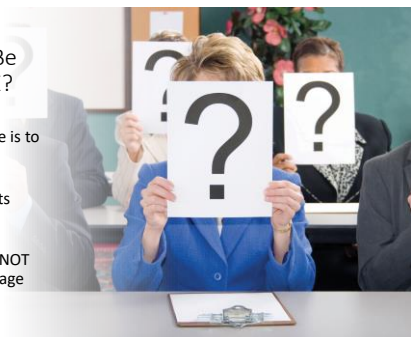
“...to an individual **who has not yet scheduled an item or service**, but **requests** a good faith estimate”



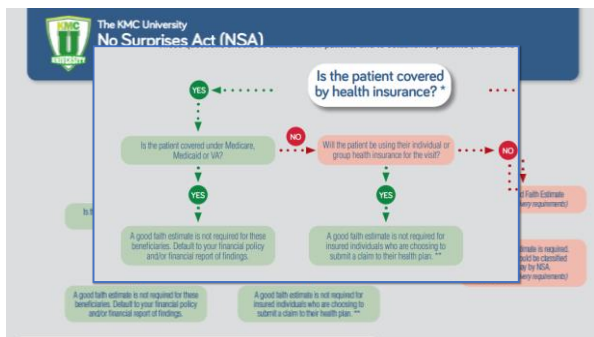
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Who Should Be Offered a GFE?

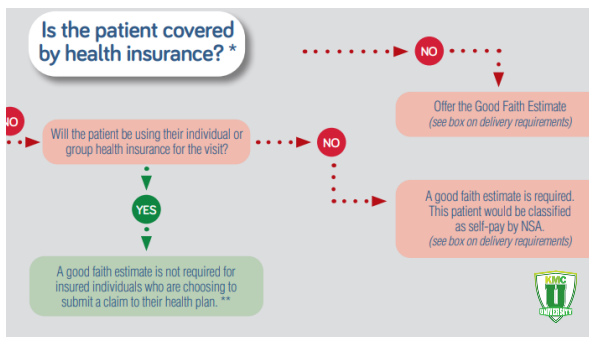
- Good Faith Estimate is to be offered to the following:
- Uninsured patients (self-pay)
 - Patients who are insured but elect NOT to use their coverage



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Timeline for Good Faith Estimate

“PHS Act section 2799B-6 requires providers and facilities to furnish a good faith estimate to an uninsured (or self-pay) individual who schedules an item or service at least **3 business days before the date such item or service is to be so furnished...**”



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Delivery Times

- 10 business days in advance, the GFE must be provided within three business days
 - 3-9 business days in advance, the GFE must be provided within one business day
 - less than 3 days in advance you ARE NOT required to provide a GFE in writing. Notify orally upon scheduling, provide estimate of initial evaluation
- HEADS UP!**
If patients request a GFE on their own, you need to provide one within three days of the date requested

GFE Delivery Requirements

If appointment is made:
10 business days in advance, the GFE must be provided within three business days
3-9 business days in advance, the GFE must be provided within one business day
less than 3 days in advance you ARE NOT required to provide a GFE in writing.
Notify orally upon scheduling (provide estimate of initial evaluation).

NOTE: If the patient requests a GFE on their own, while at the clinic or just shopping for care, then you need to provide one within three days of date of request. Keep all copies of GFEs as part of the medical record and provide a hard copy or electronic to the patient or prospective patient.



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Delivery



In Writing



If electronic, in a format the patient can save and print



Can be verbal if followed up with written estimate

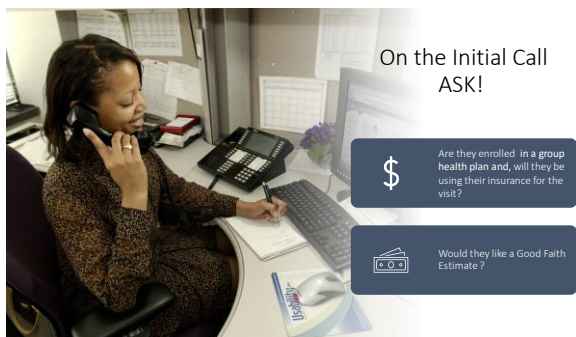


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Must Contain

- Patient name
- Patient date of birth
- Description of the services that will be provided, in understandable language
- Itemized list of goods or services reasonably expected to be provided in connection with the scheduled services
- Diagnostic codes, service codes, and expected charges associated with each of those goods or services
- Provider name, NPI and/or tax ID number
- Office location where services will be provided

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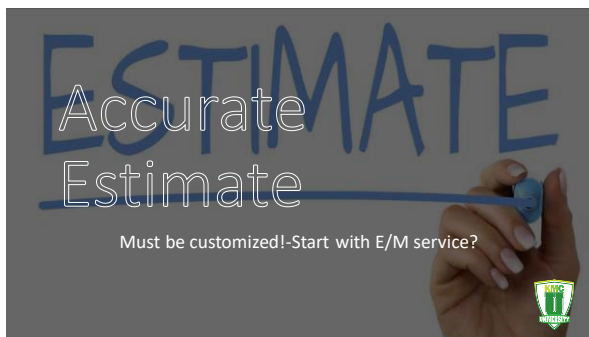


On the Initial Call
ASK!

Are they enrolled in a group health plan and, will they be using their insurance for the visit?

Would they like a Good Faith Estimate?

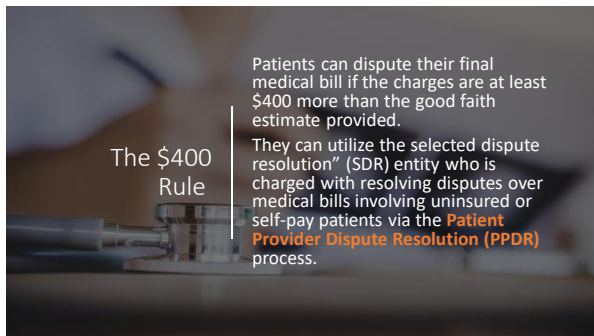
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Accurate
Estimate

Must be customized!-Start with E/M service?

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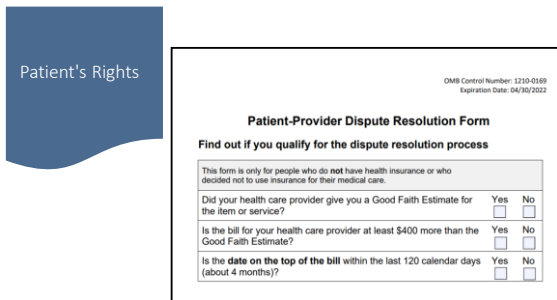


The \$400 Rule

Patients can dispute their final medical bill if the charges are at least \$400 more than the good faith estimate provided.

They can utilize the selected dispute resolution" (SDR) entity who is charged with resolving disputes over medical bills involving uninsured or self-pay patients via the **Patient Provider Dispute Resolution (PPDR)** process.

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Patient's Rights

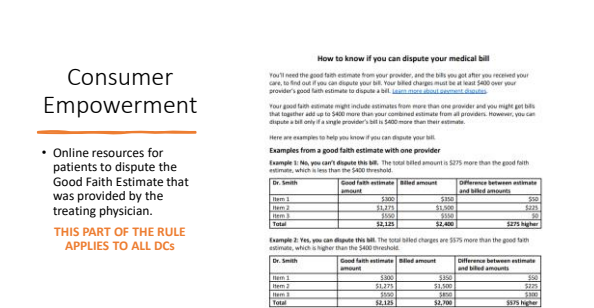
OMB Control Number: 1210-0169
Expiration Date: 04/30/2022

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

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Consumer Empowerment

- Online resources for patients to dispute the Good Faith Estimate that was provided by the treating physician.

THIS PART OF THE RULE APPLIES TO ALL DCs

How to know if you can dispute your medical bill

You'll need the good faith estimate from your provider, and the bills you get after you received your care. To find out if you can dispute your bill, your billed charges must be at least \$400 over your provider's good faith estimate to dispute a bill.

Your good faith estimate might include estimates from more than one provider and you might get bills that together add up to \$400 more than your combined estimate from all providers. However, you can dispute a bill only if a single provider's bill is \$400 more than their estimate.

Here are examples to help you know if you can dispute your bill.

Examples from a good faith estimate with one provider

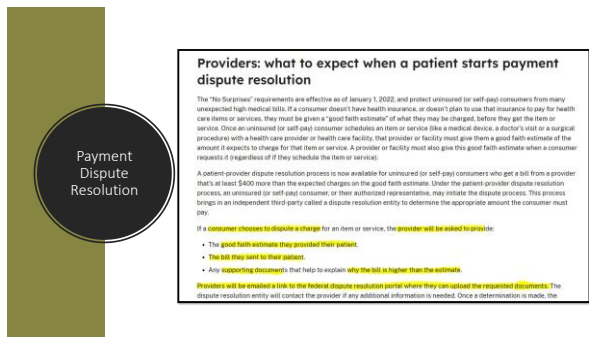
Example 1: No, you can't dispute this bill. The total billed amount is \$275 more than the good faith estimate, which is less than the \$400 threshold.

Dr. Smith	Good faith estimate amount	Billed amount	Difference between estimate and billed amount
Item 1	\$500	\$500	\$0
Item 2	\$175	\$175	\$0
Item 3	\$500	\$675	\$175
Total	\$1,175	\$1,450	\$275 higher

Example 2: Yes, you can dispute this bill. The total billed charges are \$575 more than the good faith estimate, which is higher than the \$400 threshold.

Dr. Smith	Good faith estimate amount	Billed amount	Difference between estimate and billed amount
Item 1	\$500	\$500	\$0
Item 2	\$175	\$175	\$0
Item 3	\$500	\$1,075	\$575
Total	\$1,175	\$1,750	\$575 higher

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Payment Dispute Resolution

Providers: what to expect when a patient starts payment dispute resolution

The "No Surprises" requirements are effective as of January 1, 2022, and protect uninsured (or self-pay) consumers from many unexpected high medical bills. If a consumer doesn't have health insurance, or doesn't plan to use their insurance to pay for health care items or services, they must be given a "good faith estimate" of what they may be charged, before they get the item or service. Once an uninsured (or self-pay) consumer schedules an item or service (like a medical device, a doctor's visit or a surgical procedure) with a health care provider or health care facility, that provider or facility must give them a good faith estimate of the amount it expects to charge for that item or service. A provider or facility must also give the good faith estimate when a consumer requests it regardless of if they schedule the item or service.

A patient provider dispute resolution process is now available for uninsured (or self-pay) consumers who get a bill from a provider that's at least \$400 more than the expected charges on the good faith estimate. Under the patient provider dispute resolution process, an uninsured (or self-pay) consumer, or their authorized representative, may initiate the dispute process. This process brings in an independent third party called a dispute resolution entity to determine the appropriate amount the consumer must pay.

If a consumer chooses to **dispute a charge** for an item or service, the **provider will be asked to provide:**

- The good faith estimate they provided their patient.
- The bill they sent to their patient.
- Any supporting documents that help to explain why the bill is higher than the estimate.

Providers will be **provided a link to the federal dispute resolution portal** where they can upload the requested documents. The dispute resolution entity will contact the provider if any additional information is needed. Once a determination is made, the

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Stop the Payment
Dispute Resolution

- Patient and Provider come to an agreement
- Provider notifies the SDR
- Settlement agreement finalized

Health Care Provider or Facility Notice of Payment Settlement to Selected Dispute Resolution Entity

A health care provider or facility must complete this form when they, in partnership with the uninsured (or self-pay) individual or the individual's authorized representative have resolved a payment dispute outside of the dispute resolution process.

Federal standards require health care providers and facilities notify the Selected Dispute Resolution (SDR) entity, no later than 3 business days after the date of the settlement.

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Government Form vs. KMC University



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Initial Visit
GFE
Customization

Good Faith Estimate John Doe Chiropractic & Wellness Center
123 Main Street
Springfield, KY 40383

Patient Information
Name: Jody Jones Date of Birth: 04-02-1997
Address: 1 Paradise Lane Apt 100
City: Springfield State: KY Zip: 41000

SERVICE/ITEM	CONDITION	DIAGNOSIS CODE	NUMBER OF UNITS	UNIT COST	TOTAL
Exam (Evaluation)	low back, chronic neck, radicular		1	145.00	145.00
Imaging	diagnostic		1-2	105.00	210.00
Electrical Stimulation	muscle spasm		1	36.00	36.00

Total Expected Charges \$ 521.00

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New Patient Visit Customization

Estimate

SERVICE/ITEM	CONDITION	DIAGNOSIS CODE	NUMBER OF UNITS	UNIT COST	TOTAL
Exam (Evaluation)	Pain		1	145-230.00	230.00
Imaging	diagnostic		1-2	65-105	215.00
Electrical Stimulation	muscle spasm		1	36.00	36.00

Total Expected Charges \$ 481.00



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Must Notify
Patient of
Availability
of GFE

OMB Control Number (2600-0002)
Expiration Date (MM/DD/YYYY)

Appendix 1

Standard Notice: "Right to Receive a Good Faith Estimate of Expected Charges" Under the No Surprises Act
(For use by health care providers on or after January 1, 2022)

Instructions:

Under Section 2799D-4 of the Public Health Service Act, health care providers and health care facilities are required to inform individuals who are not enrolled in a plan or coverage or a Federal health care program, or not seeking to file a claim with their plan or coverage both orally and in writing of their ability upon request or at the time of scheduling health care items and services, to receive a "Good Faith Estimate" of expected charges.

This form may be used by the health care provider to inform 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 their right to receive a "Good Faith Estimate" to help them estimate the expected charges they may be billed for receiving certain health care items and services. Information regarding the availability of a "Good Faith Estimate" must be prominently displayed on the covering provider's and covering facility's website and in brochures and signage where scheduling or questions about the cost of health care occur.

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Second Step
of the
GFE Process

Financial Report of Findings John Doe Chiropractic & Wellness Center
Good Faith Estimate Dr. John Doe TN 26-00000002

Patient Information
Name: Jody Jones Date of Birth: 04-02-1997
Address: 1 Paradise Lane Apt 100
City: Springfield State: KY Zip: 41000
Phone: 555-555-1111 Email: contactme@gmail.com

The following is a list of items and services which the provider/clinic anticipates you will need once your initial visit or treatment has been completed. The recommended treatment is based on the patient's condition, and is provided in accordance with the patient's condition.

SERVICE/ITEM	CONDITION	DIAGNOSIS CODE	NUMBER OF UNITS	UNIT COST	TOTAL
Spinal Manipulation 3 areas		M9000.M9002.S27064	15	65.00	975.00
Manual Therapy	Shoulder pain	M7541	12	45.00	540.00
Exercise Therapy		M9000.M9003	20	65.00	1300.00
Re-Exam	spine & shoulder	N/A	2	85.00	210.00



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Review Your Process
 Educate Staff
 Build a Compliant Process
 Train Staff

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The Established Patient- Data Collection

- Confirm on each call the insurance status of the patient
- Blame federal law for the reason you must ask the question AGAIN
- Create an outgoing hold message

Thank you for calling. We appreciate your patience as our office is implementing new regulations required for healthcare providers. Please be ready with your insurance information when making your appointment. If you do not have insurance, you can request a Good Faith Estimate for the services recommended by the treating physician.

- Say it with a smile :)

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Need to Know
 Data Collection
 Process

 First Name Last Name

 Type of Problem (area)

 Insurance or Self-Pay

 DOB

 Address

 Email & Phone

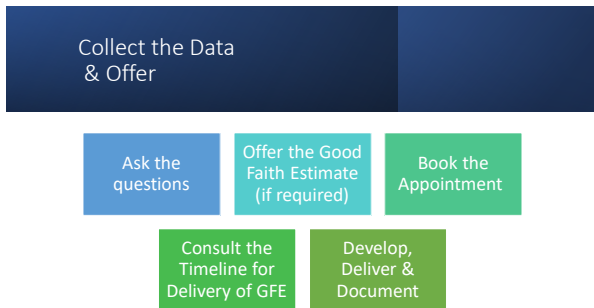
Insurance Details [injury claim, Medicare, Medicaid, VA, individual health, group health, Medicare Part C (MA)]

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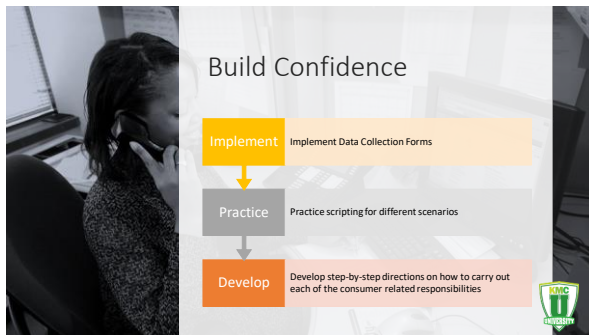
Data Equals Action

- If self-pay or uninsured, need to develop a GFE
- If insured but service or technique is not covered need to inform patient and offer alternatives or provide estimate
- If insured and wants to know cost, need to offer and provide GFE
- If it is an injury claim need to confirm status of claim and whether doctor can take the case (WC or Auto)
- If Medicare or Medicaid or Medicare Advantage –need to consider network status of provider and inform patient accordingly

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Non-Compliance Penalty



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What's Next?



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Changes on the Horizon

- Current** - a GFE is required for uninsured/self-pay patients or insured patients who are not using their insurance and includes only the expected charges from the provider who is actually providing the estimate
- Future** - the departments are going to enforce a requirement that it includes the **expected charges of other providers** and other facilities that **may be involved in the service** other than the one that's scheduling the service
- Future** - GFE will be required for **all patients- insured**, uninsured, and those opting not to use their insurance

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Interim: Do Your Best! Good Faith!

"Plans, issuers, providers and facilities are expected to implement the requirements using a **good faith, reasonable interpretation** of the statute prior to **issuance of rulemaking**"

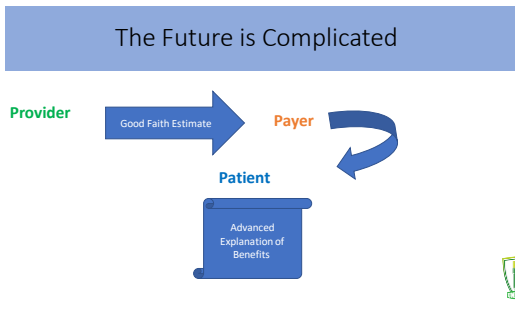
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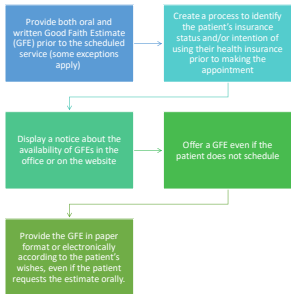
93

Provider 'Future' Responsibility

- Ask patients whether they are enrolled in a group health plan and, if so, provide an estimate of the expected charges to the patient's insurer.
- After receiving the estimate, the payer must provide an advanced EOB to the patient.

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Implementation Steps

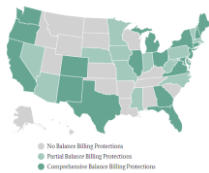


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- Focus on Payer Relationships
- Register Online Portals and Availability
- Medical Review Policies
- Identify Non-Covered Services
- Create a list of network payers on your website
- Provide a list of non-covered services and their fee (proactive step)

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State Laws



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Centers for Medicare & Medicaid Services

Medicare | Medicaid/CHIP | Medicare/Medicaid Coordination | Private Insurance | Innovation Center | Regulations & Guidance | Research, Statistics, Data & Systems | Outreach & Education

Home > No Surprises Act

Home | Policies & Resources | Consumer Protections | Help resolve payment disputes

Ending Surprise Medical Bills

See what's coming to help to protect people from surprise medical bills and removing consumers from payment disputes between a provider or health facility and their health plan.

Resources

Learn More

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Recommendations

- Stay Alert to Educational Opportunities
- Know Your Fees & Compliance Obligations
- Build a Financial Report of Findings Process
- Include a Good Faith Estimate in the Intake Process
- Patient Rights Posted in the Clinic
- Patient Rights on Surprises Act Posted on Your Website

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For Nerds Like Us

FAQS ABOUT AFFORDABLE CARE ACT AND CONSOLIDATED APPROPRIATIONS ACT, 2021 IMPLEMENTATION PART 55

August 19, 2022

Set out below are Frequently Asked Questions (FAQs) regarding implementation of certain provisions of the Affordable Care Act and title I (the No Surprises Act) of Division B of the Consolidated Appropriations Act, 2021. These FAQs have been prepared jointly by the Departments of Labor, Health and Human Services (HHS), and the Treasury collectively, the Departments' Jointly Issued FAQs (available at <https://www.dhs.gov/ease-of-care-act/faq>), and the Departments' Jointly Issued FAQs (available at <https://www.dhs.gov/ease-of-care-act/faq>), these FAQs answer questions from stakeholders to help people understand the law and promote compliance.

Full FAQ of how the ACA blends with the NSA

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