No Surprises Act

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Requirements Related to Surprise Billing; Part I & II January 1, 2022

https://www.cms.gov/nosurprises/Policies-and-Resources/Overview-of-rules-fact-sheets

Requirements Related to Surprise Billing; Part I:

https://www.federalregister.gov/documents/2021/07/13/2021-14379/requirements-related-to-surprise-billing-part-i

Requirements Related to Surprise Billing; Part II:

https://www.federalregister.gov/documents/2021/10/07/2021-21441/requirements-related-to-surprise-billing-part-ii

Title I (the No Surprises Act) of Division BB of the Consolidated Appropriations Act, 2021

Establishes new protections from surprise billing and excessive cost sharing for consumers receiving health care items/services.

It implements additional protections against surprise medical bills under the No Surprises Act, including provisions related to the independent dispute resolution process, **good faith estimates** for uninsured (or self-pay) individuals, the patient-provider dispute resolution process, and expanded rights to external review.

What is a “Surprise Bill”?

An unexpected balance bill from a provider or healthcare facility.

Essentially, this new rule applies to…

Providers practicing in a healthcare facility (Part I)

Health Care Facility

- Part I: For this purpose, a health care facility described in the statute is each of the following, in the context of nonemergency services: (1) A **hospital** (as defined in 1861(e) of the Social Security Act); (2) a **hospital outpatient department**; (3) a **critical access hospital** (as defined in section 1861(mm)(1) of the Social Security Act); or (4) an **ambulatory surgical center** described in section 1833(i)(1)(A) of the Social Security Act.

- Part II: "Health care facility (facility)" is defined more broadly than the definition in 45 CFR 149.30, which applies in the context of balance billing protections for non-emergency services. For purposes of 45 CFR 149.610, "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.

Essentially, this new rule applies to…

Providers who treat Uninsured (Self-Pay) patients (Part II)

Key Definition
Convening health care provider or convening health care facility

Defined as “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.”

Providers who treat Uninsured (Self-Pay) Patients

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)

Who is defined as an Uninsured or "Self-Pay" individual?

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[7],[8];

or

Has benefits for such items/services under a group health plan, group or individual health insurance coverage offered by a health insurance issuer, or a health benefits plan under chapter 89 of title 5, United States Code, but does not seek to have a claim submitted to their plan, issuer, or carrier for the item or service.

Medicare

Since Medicare is a Federal Health Care Program (as defined in section 1128B(f) of the Social Security Act), a Good Faith Estimate will need to be provided to Medicare patients for exams, modalities, and therapies (non-covered services) – OR – if the patient elects to not submit a claim to Medicare for non-payable, covered services (Option #2 ABN form).

What is a “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.

Consists of expected items and services which will allow uninsured (or self-pay) individuals to have access to information about health care pricing before receiving care.

Provided either by paper or electronically.

Uninsured (Self-Pay)
45 CFR 149.610(b)(1)(iii)

Must make available good faith estimates of expected charges upon scheduling an item or service or upon request.

Good faith estimates for uninsured (or self-pay) individuals must be provided in writing and orally.

Must provide written notice in a clear and understandable manner prominently displayed (and easily searchable from a public search engine) on the website, in the office, and on-site where scheduling or questions about the cost of items or services occur.

Must orally inform uninsured (or self-pay) individuals of the availability of a good faith estimate when questions about the cost of items or services occur.

Good faith estimate must be made available in accessible formats and languages spoken by individuals considering or scheduling items or services.

Other Services Provided by Outside Entities

Co-provider amounts are required to be included in the Good Faith Estimate statement to the patient.

Single
Good Faith Estimate
(for recurring primary items or services)

1. The good faith estimate for recurring items or services must include, in a clear and understandable manner, the expected scope of the recurring primary items or services (such as timeframes, frequency, and total number of recurring items or services); and
2. The scope of a good faith estimate for recurring primary items or services must not exceed 12 months.

Required Methods for Providing Good Faith Estimates for Uninsured (or Self-Pay) Individuals.

Written form (paper or electronically – patient request)

Electronic form must be able to save and print

When do we provide the good faith estimate to the patient?

Good Faith Estimate Scenarios

New Patients

New Episodes (Established Patients)

Maintenance Therapy

PRN Basis Care

Timeframe
"Legislative Intent"

"Therefore, HHS is using its general rulemaking authority to establish in 45 CFR 149.610(b)(1)(iii) that the convening provider or facility must inform uninsured (or self-pay) individuals that good faith estimates of expected charges are available to uninsured (or self-pay) individuals **upon scheduling an item or service or upon request**."

When a patient makes an appointment…

1. Is this a New patient or Established patient?

2. If established patient, is this a:
   - ❑ New episode
   - ❑ PRN Visit
   - ❑ Maintenance/Wellness Visit

Good Faith Estimate Timeframes

These timeframes are not typically common in the chiropractic practice…

Good Faith Estimate Timeframes

Provide a good faith estimate to uninsured (or self-pay) individuals within the following timeframes:

1. 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: Must provide Good Faith Estimate **no later than 1 business day after the date of scheduling**;

Good Faith Estimate Timeframes

Provide a good faith estimate to uninsured (or self-pay) individuals within the following timeframes:

2. When a primary item or service is **scheduled at least 10 business days before** such item or service is scheduled to be furnished: Must provide Good Faith Estimate **no later than 3 business days after the date of scheduling**; or

Good Faith Estimate Timeframes

Provide a good faith estimate to uninsured (or self-pay) individuals within the following timeframes:

3. When a good faith estimate is requested by an uninsured (or self-pay) individual: Must provide Good Faith Estimate **no later than 3 business days after the date of the request**.

Dispute Resolution Process

The good faith estimate requirement and the requirements related to the patient-provider dispute resolution process also apply to the uninsured.

What would spark a dispute with a patient?

“Substantially in Excess”

If the patient receives a bill which is $400 or more above the good faith estimate provided to them at the beginning of care, then the patient is eligible to proceed into a dispute resolution process with the provider (if initiated within 120 days of receiving the bill).

What procedures do I need to put into place in my practice to comply with this rule overall?

Summary:

1. Give notice.
2. Provide Good Faith Estimate.
3. Obtain consent.
4. Understand the dispute resolution process.

Notice Requirements

Drafting the specific good faith notice of expected charges for each qualified patient.

Display the notice on clinic website.

Display in two prominent locations – where scheduling and payment occur.

Make publicly available, post on a public website, and provide a one-page notice to individuals regarding:

(1) The requirements and prohibitions applicable to the provider or facility under sections 2799B–1 and 2799B–2 of the PHS Act and their implementing regulations;

(2) Any applicable state balance billing requirements; and

(3) How to contact appropriate state and federal agencies if the individual believes the provider or facility has violated the requirements described in the notice.

Model notices and information collection requirements for the good-faith estimate and patient-provider payment dispute resolution

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

Update your Compliance Policy:

Practice Procedure

Dispute Resolution Process

Group Practices

Update your Provider Agreements

Amend provider agreements (associates, employees) to provide notice of the availability of good faith estimates of expected charges to uninsured (or self-pay) individuals on your behalf

Resources

- CMS-9909-IFC: Requirements Related to Surprise Billing; Part I
- CMS-9909-IFC Fact Sheet: What You Need to Know about the Biden-Harris Administration's Actions to Prevent Surprise Billing
- Model Notice & Consent Templates
- FAQ for CAA implementation, August 20, 2021
- Requirements Related to Air Ambulance Services, Agent and Broker Disclosures, and Provider Enforcement NPRM
- Air Ambulance NPRM – Fact Sheet
- CMS-9908-IFC: Requirements Related to Surprise Billing; Part II
- CMS-9908-IFC Fact Sheet: What You Need to Know about the Biden-Harris Administration's Actions to Prevent Surprise Billing (September 2021)
- Additional trainings will be forthcoming on a variety of provider enforcement topics, including deeper dives into the notice and consent rules, provider disclosure requirements, and other provisions discussed in these slides.

Future rulemaking…

These requirements are in place as of January 1, 2022. The information in this presentation and policy procedures is based on the Interim Final Rule that was active on October 7, 2021, but could change after the comment period.

Some of these requirements MAY change from future updates to the rule or based on court rulings.

Questions about this legislation:

Send any questions about the provider requirements and provider enforcement to provider_enforcement@cms.hhs.gov.

Questions or Comments?

For more information:

info@ChiroArmor.com

www.ChiroArmor.com

Thank you!