

Centers for Medicare & Medicaid Services

Questions and Answers from Special Open Door Forum:

Provider Requirements for No Surprises Act

December 8, 2021

1. I have a question regarding how we are going to be required to do a pre-estimate if we don't know the complexity of the service that's going to be provided. We're primary care.
 - a. I think there were discussions in the preamble language about certain, about possible ways to approach developing a good faith estimate. I think we also talked about the development of an updated new good faith estimate once the individual has been in situations where a new good faith estimate may need to be developed once the patient has been evaluated. So, I would recommend if you haven't already, taking a look at some of that discussion in the preamble. That may be helpful.
2. Are these regulations applicable to skilled nursing facilities? We're not emergency and in many cases not urgent.
 - a. The requirements under which services provided by a non-participating provider in a participating facility apply to the following types of facilities, a hospital, a hospital outpatient department a critical access hospital or an ambulatory surgical center.
 - i. Was the question broadly about kind of all of the No Surprises Act requirements or specifically the balance billing provision?
 1. No Surprises Act.
 - a. Specifically, regarding the provisions for the uninsured good faith estimate, underinsured or self-pay good faith estimate, I would refer you to the definitions of health care provider and health care facility that are included in our regulations as well as the discussion on the preamble related to those.
 - i. Okay. So, I think you're saying there are some sections that do, but the specific notice and other requirements by interpretation, is that correct?
 1. I'm unable to speak to the other provisions beyond the good faith estimate for an uninsured.
 3. We are a multi-specialty billing company and deal primarily with hospitalists who treat patients with pulmonary critical care type conditions. Are the payers going to be required to pay automatically in situations where we are non-participating providers and have no knowledge of what the patient's insurance is at the time that we're seeing them? I work for a group of

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hospitalists who work in a closed ICU unit. The hospital has a contract with the critical care doctors in the group to see the patients in the unit. We have to see every patient in the unit. We can't pick and choose based on insurance. If we see a patient who has an insurance that we are non-participating providers for, we submit the claim to the insurance that we're not contracted for, is the insurance going to automatically process and pay the claim under and in-network reimbursement? Because the problem is we don't know when we go into the hospitals who these patients even have insurance with. And are we going to be required to carry these consent documents for them to sign, for the patient to sign? And a lot of times our patients are not even able to communicate with us because they're intubated.

- a. A more specific answer to that question will require additional rulemaking.
 - i. And then the second part of that is the way I interpret this, it says no surprise billing. But there's verbiage in the presentation that would indicate that we can bill in-network charges for non-network services.
 - 1. Surprise billing is kind of a term that's used in the regulations and the statute to indicate situations where an individual sees an out-of-network provider unbeknownst to the patient that the provider or perhaps in some instances a facility is out-of-network. And in instances where that happens, the individual can still be billed. They just can't be surprised billed. What that means is that because they have an expectation that they're seeing a network provider, they can only be billed for cost sharing that approximates their in-network cost sharing and they're prohibited from being balance billed.
 - a. My question then is when you say cost sharing, is that their deductible, coinsurance or co-pay?
 - i. Yes. Cost sharing is something separate and different from balance billing. They could still be responsible for cost sharing, as you say, deductibles, co-insurance, co-payments. But it would only be for what they would pay approximately if they were to have received in-network care and they cannot be balance billed.
 - 1. Let me give you a scenario. Non-par provider, inpatient contracted facility. The non-par provider is not contracted. In a normal environment, the insurance company would reimburse at say \$75. So, can we bill for the \$75 hour, or can we bill for, let's say, a \$10 copay?
 - a. Right. Assuming the individual has coverage, but you are out-of-network for that individual's coverage, you could

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charge the individual or the individual could only be responsible for the copay that they would pay if you were an in-network provider. And in terms of what the insurance company or the plan would pay the provider, that's kind of dictated by a different process.

- i. Where does that process come into play? Because I can honestly see this being an absolute total gravy train for insurance companies because to be totally in this - the patient has totally been taken out of the scenario.
- ii. Answer: In the July 1st rules that we published, it dictates the process for the amount that the provider would get reimbursed by the plan or issuer in these instances. And there's a number of different ways that could be resolved. If there's an all payer model agreement or a specified state law that determines the amount that the plan or issuer would pay the provider, then that method would dictate. If there's not either an all payer model agreement or a specified state law that would determine that amount that the non-participating provider would be get paid, it could be done either by negotiation between the two parties. And after a 30 day open negotiation period if the two parties cannot resolve on

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the amount to be paid, either party could initiate, under the federal process, an independent dispute resolution process under which an independent dispute resolution entity would make a determination as to how much a non-participating provider would get paid by the plan or the issuer, and that whole process is set forth in the July 1 regulation.

iii. Question: So, once we submit the claim to the payer, that 30 day negotiation starts from the date they process the claim or the date of service? Because that's not made clear in the regulation either.

iv. Answer: The 30 day period starts - the 30 open negotiation period starts from the day that the plan or issuer, and this is all set forth in the regulations, either makes an initial payment or sends a denial of payment and that's when either party can initiate the negotiation process.

4. As far as a good faith estimate goes, from what I've been seeing only out-of-network providers have to provide that, except for the uninsured. Am I correct on that?
 - a. The regulations that were included and the provisions included in the regulations that were issued as the interim final rule in October were specifically related to uninsured and self-pay individuals. We are in the process and as part of that rule, we also indicated that additional information will be provided as well as requirements related to good faith estimates where an individual is insured. So, there will be more to come on that.
 - i. So, at this point we're just to give good faith estimates to uninsured self-pay patients until we hear more.

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1. Those are the requirements that have been released. Now those are the requirements under the October regulations. In the regulations that were published in July, which deal more specifically with the No Surprises Act provisions, there is a requirement for notice and consent in instances where an individual or the provider is out-of-network and for example the person went to an in-network facility. And in order to balance bill that individual, the provider would have to gain the individual's consent to do that. And as part of that consent process, the provider has to include a good faith estimate of the cost as well. So that's kind of a good faith estimate in a different context but that applies as of July 1, 2022 and that applies to insured individuals.
 - a. For out-of-network providers. In other words, we mostly see in-network. So, at first, I thought we were going to have to give good faith estimates to all our patients. But if we're in-network with their insurance, we don't have to do that?
 - i. Right. With regard to the provisions in the regulations that were published on July 1, the good faith estimate that's discussed in those regulations, which again kind of kick in when an individual is going to be seen by an out-of-network provider. Those specific regulations apply to individuals who are insured. And those good faith estimates, to the extent a provider is seeking consent to be able to balance bill the individual, those apply to insured individuals and they do apply as of 1/1/22.
5. I'm looking specifically at the estimates piece as it relates to our self-pay patients. We're a medium sized multi-specialty group, and we're reviewing this with our legal counsel. The problem that we're running into and that we're envisioning is when you have a patient that you schedule, at the time of service the patient has insurance. They have coverage, and they schedule their appointment for several months out, possibly a year out if it's their physical. In the interim, between the time you scheduled the appointment and the time the patient physically arrives, they have changed coverage or they've lost coverage, so now they qualify as a self-pay patient. But the problem that we have is we don't know that. And we can't find any provisions in the statutes for an allowance when a patient arrives unexpectedly, now qualifying as self-pay, and from my counsel's point of view and mine as well, it would appear that we're going to have to turn the patients away and reschedule them because we can't find any area where they have the ability to waive their right to receive an estimate. There seems to be a lot of unintended consequences in this. Are we reading this correctly?
 - a. A more specific answer to that question will require additional rulemaking.
 - i. I'll do that. Is there any provision or review being made for some of the cost of doing this? We're looking at this. We've got about 500 providers in our group and see about a million patient visits a year. The cost of having to mail estimates

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via the U.S. Postal Service to patients who don't have - who are not signed up on our patient portal, the man hours to send those out and everything else just dealing with the self-pay patients and the prospect of having to do it for all patients down the road is really starting to send shock waves through the provider community that I've spoken with. And just the sheer cost of trying to comply with the estimate piece of this, it seems very easy when you're doing it for surgeries. But to the point of the caller earlier, when a patient is coming in for a primary care visit, we have no way of knowing until the patient gets here level of service, other procedures the patient might request when they get here, like a mole removal in addition to their original scheduled visit. And it's putting us into a spot of having to schedule more visits down the road and increasing the cost of care trying to comply with the estimate piece. And it just feels like trying to apply this into the physician's office is a square peg in a round hole, and it's causing an enormous amount of problems to try to operationalize this.

6. Which is in private practice chiropractic offices, does any of this Surprise Act, are they governed by it in any way?
 - a. The definition of provider in the regulations is pretty broad so the answer is yes.
 - i. I'll move on to another part of the question then, which is in the regulations it states health care facility, but chiropractic offices are not defined as facilities. So, I'm trying to figure out what piece does chiropractic actually play relative to this act?
 1. For example, if an individual comes in to seek services from a chiropractor, I believe the good faith estimate provisions would apply. Also, the provisions of some of the other notification provisions. To the extent, I think you are correct that a chiropractic office would not be a health care facility. To the extent a chiropractor is practicing in their facility, the whole regime of provisions that occur when individual seeks care from an out-of-network chiropractor at, for example, an in-network chiropractic facility, those specific provisions would apply but some other ones would.
 - a. I would also refer you out to the definitions of health care facility and health care provider in the regulations. The good faith estimates for, let's say, a chiropractor who's out-of-network, but the group is in-network seem to apply. I think related to whether or not, you know, in-network or out, the regulations that we have released as part of IFR - from the interim final rule in October apply to uninsured or self-pay individuals. So, questions regarding whether or not something would apply, whether GFE provisions for those that are uninsured, which would be those where, if they were in-network or out-of-network, in those particular instances we will have - more information will be forthcoming. We have not yet issued rules or regulation specific to those provisions yet.

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7. In reading the regulations and the interpretations, can you clarify, does the good faith estimate need to be provided to all self-pay, or when they're choosing not to use their insurance and have it paid? So, they have coverage, but they're opting not to have a claim filed for all services or only upon the request of the patient?
 - a. And the good faith estimate requirements for uninsured self-pay individuals would apply if an individual schedules an item or service or upon request.
 - i. So, both situations. So, if they schedule something, we have to provide a good faith estimate for what they're scheduled for.
 1. You may also want to take a look at the preamble language. Yes, definitely consider taking a look at the preamble language if you haven't already done so. There is discussion regarding more situations, regarding the provision of estimates, so when the items and services are scheduled as well as when they're requested.
 - a. Okay. And then you keep stating that there'll be more rules that will be forthcoming. Do we have an estimate? Those would not be something we are required to be compliant with by January 1 I would assume.
 - i. I can't speak directly to that question. But again, as we discussed in the proposed rule - I mean in the interim final rule in October, we have stated that additional information will be forthcoming.
8. We work orthopedic so we do a lot of surgeries and we don't always notify the patient on the estimate. It is usually on the physician charge only. But when they do need an assistant for surgery, our financial counselors don't always know there's going to be an assistant. But we are in-network, so I didn't know if we needed to start notifying the patient. There could be a charge for that. And also, sometimes we have physicians that work as co-surgeons for some of our spine surgeries. Do they need to be notified there could be a cost for both of those as well when we are in-network?
 - a. The situations regarding in-network where insurance is involved, additional information will be forthcoming as we discussed in the interim final rule released in October. If your question is actually related to the individuals who are uninsured or self-pay, then I would refer you to their regulatory provisions in the October interim final rule.
9. We are a hospital management group that oversees long-term acute care hospitals. So, from a licensing perspective, I know that we fall under that hospital category. Does this rule apply to all of the physicians that are coming around or see patients while they are inpatient in our hospital? We don't employ these doctors. We don't have contracts with these doctors. These are just doctors that are on our medical staff that are coming in as either pulmonology, internal medicine, infectious disease type doctors, again seeing patients from an inpatient perspective in our setting. Does it apply to all of those physicians, or does it only apply to there's a few select physicians throughout all of our hospital long-term acute care hospitals that we perform Part B billing for? So again, that does not apply to all of our providers and staff, just a selection that we do Part B billing for.

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- a. The information and the requirements that have been released are specific to uninsured for uninsured - good faith estimates for those that are uninsured or self-pay. Additional information will be made available in the future regarding how good faith estimates apply when an individual is insured.
 - i. If an individual is getting services from an out-of-network provider at an in-network facility, then the no surprise provisions apply in that unless that out-of-network provider gives notice and consent to treat the person and the individual, of course, signs that notice and consent in a manner that's consistent with the regulations, then that provider cannot balance bill the patient. So, the NSA provisions in that context would apply not just to patients that do- or, it's not a question of whether or not the facility is handling some part of the issues for them. It's a question of whether the patient has private insurance, and whether they are in a facility seeking care or getting care from an in-network facility from an out-of-network provider.
 - 1. Okay. The in-network facility piece, I understand that out-of-network provider piece because again, we don't employ these providers. They're just on our medical staff and they're rounding. So, the physicians, prior to seeing the patients, they're not asking for their insurance information to denote if their payer plan is in or out-of-network. Well would these providers be independently billing the patient independent of the facility?
 - a. Yes.
 - i. Yet they don't ask the patient whether or not they're insured and who their insurer is?
 - 1. Well they get a copy. They get a copy of the patient's face sheet of their hospital - their long-term acute care face sheet. And they take that to their offsite billing company. What they do with that and how they bill for that physician that has nothing to do with our long-term acute care entity.
 - a. Okay, but yes, just if the provider themselves, if the entity - if the provider wants to be able to the balance bill the patient, whether doing it himself or whether doing it through some billing company that he contracts with, he has to comply with the provisions. If either the provider or the billing company on behalf of the provider wants to balance bill that patient, the consent and the good faith estimate have to be provided.

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10. Post-stabilization, if the patient refuses to sign the consent form, what are we to do? I mean, are we informing the insurance that the patient did not sign the consent form or are we treating it or is this the provider's call? And my second question is we also have a walk-in center. How are we to give a good faith estimate in that scenario?
- a. Let me take the first question first. There's never a requirement, at least under our rules, once the patient is stabilized, for the out-of-network provider to treat the patient. So, in circumstances where the patient is presented with the consent form and doesn't, you know, sign the consent form, then at least under our regulations, there are no requirements or obligations on the provider to treat the patient. Now for your second question, you mentioned a walk-in facility?
 - i. Yes.
 - 1. I would again refer you to the regulations and the definition of facility in the regulations.
 - a. I do remember reading it where it says that urgent care, if it qualifies as an ER then yes, then the ER thing applies, so then obviously you're not giving until the patient is stabilized. But we also see patients who, you know, instead of going to the ER, it's not an emergency situation, but they would walk in. So, there is no emergency situation, but they're walking in on, say, Saturday or Sunday. They don't want to go to the hospital. They just come in for sore throats for example.
 - i. Right. And also, a lot depends, too, on whether the care they're receiving qualifies as emergency care, and it sounds like from what you're describing in a lot of situations, it would not. You know, prudently a person would not think that they are in an emergency situation. So, the emergency care provisions may not apply under those circumstances if it's not emergency care.
 - 1. Do we have to give them GFE (Good Faith Estimate)?
 - a. Regarding the good faith estimate, again, if the individual is uninsured or self-pay then I would refer you to the definitions we included in our regulations for a health care provider and health care facility. Those would be helpful in terms of determining whether or not as a provider facility if these requirements apply. And if your question is regarding individuals, whether insured, where insurance is

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involved, again, information will be forthcoming.

- i. I'm still not clear for non-emergency situation. We understand for emergency situation what provisions apply, but for non-emergency situations we are - it's our call? It's a provider's call how to treat the patient? Or do we have to have that three hour window and say, wait, here's a good faith estimate? Please sign this and then three hours later, we treat the patient?
- ii. ANSWER: In terms of the time frames, again, our interim final rule discusses requirements for when a good faith estimate must be provided and the time frames in which they're required. Take a look at the time frames of exactly of when that information needs to be provided to the consumer, again, in the context of an uninsured.
- iii. QUESTION: So, it is three hours. So, it is three hours before unless it's a scheduled appointment. So, the provision is three hours before the service if the patient does not make an appointment or is walking in or non-emergency situation. So that would be a pickle for all of us. I mean, you're going to give them the estimate and have them wait for three hours.
- iv. FOLLOW-UP: Again, I would refer you to the provisions in

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the regulation for additional information.

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