Updated as of: December 9th, 2021

No Surprises Act

Hospital FAQs

For the most recent NSA Hospital FAQs Document, go here:
https://www.ruralmed.net/nsa-frequently-asked-questions-guide/

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REVENUE CYCLE RESOURCES

Table of Contents

Balance Billing

1. In what circumstances do balance billing protections apply?

Balance Billing Protections Will ALWAYS apply:

- Emergency services provided by ANY OON provider/facility, includes:
  - Pre-stabilization services
  - Post stabilization services (unless conditions are met regarding notice and consent)
  - Ancillary services defined in the IFR:
    - Anesthesiology, Pathology, Radiology, Laboratory, Neonatology, Assistant Surgeons, Hospitalists, Intensivists
    - Ancillary services provided by an OON provider when there is ***NO*** in-network provider who can furnish such a service at the in-network facility
  - Services due to unforeseen, urgent medical needs (even if Notice and Consent is received)
  - OON Air Ambulance

Balance Billing Protections will apply, UNLESS Notice & Consent Is Obtained:

- Limited Post-stabilization services
  - Specific provider documentation required
  - Patient can travel using nonmedical or nonemergency medical transportation to a PPO facility within a reasonable distance and is documented in medical record
    - Only applied in limited circumstances
- Non-Emergent services provided by OON provider at an in-network facility

Balance Billing Protections DO NOT Apply:

- Non-emergent services provided by:
  - OON provider at OON facility
  - OON facility
- Patients are subject to their OON insurance benefits/patient responsibility and have no protections under the NSA.

2. What is balance billing?

Under the NSA, Balance billing is when the OON provider or facility bills the patient for any amount above the allowed amount, such as the assigned contractual adjustment.

3. Even if I don't intend to balance bill patients, do I need still need to provide a disclosure?

Yes, regardless of if you intend to balance bill, you must still provide the disclosure to every patient with a group or individual health plan. The disclosure must also be posted in your ER, other public areas (such as financial services), and on your website.

4. Do our specialty clinic providers need to provide the disclosure, even if they don't intend to balance bill?

Yes, ALL health care providers must provide the disclosure to any patient with a group or individual health plan who they provide services to at a facility or in connection with visits at a facility. Providers also must post the disclosure at their office and on their website. This can be done by a facility on the provider's behalf with a written agreement in place.

5. Does Nebraska have model language to insert in the CMS model disclosure?

Nebraska has not released any model language. Consult with legal counsel regarding State specific language.

6. Can the disclosure be provided to the patient when they arrive at the facility?

The disclosure must be provided prior to any patient payment request, including time or service payment requests. If no time-of-service payment request, then you must provide to the patient prior to the claim submission date.

7. Do Ancillary providers need to provide the disclosure?

Yes. The statute reads Each Health Care Provider…health Care provider is defined as a physician or other health care provider who is acting within the scope of practice of that provider's license or certification under applicable state law.

8. Can I provide the disclosure on behalf of our specialty clinic or other providers?

Yes, facilities and providers can enter into a written agreement or amend a current written agreement. If such an agreement is in place, then the facility takes complete ownership for compliance of this disclosure. If the facility fails to provide the notice with an agreement in place, they are responsible for the compliance violation.

The provider cannot delegate the responsibility for the website posting. All providers that provide services at facility and have a website, must post the disclosure.

9. If I do not intend to balance bill, is there ever a situation where I would need to obtain notice and consent?

No, if you do not intend to balance bill, you will never need to obtain notice and consent. Your duty to ***disclose*** remains.

10. Is it our responsibility to get notice and consent if our specialty clinic providers want to balance bill?

No, if the provider would like to balance bill it is their responsibility to get notice and consent.

However, if you would like to coordinate to assist your specialty clinic providers in obtaining notice and consent you can.

11. Do I have to use the CMS model documents for disclosure, notice, estimate, and consent, or can I create my own?

You must use the CMS Notice document, exactly how it is (*See CMS-10780-Standard Notice and Consent)*.

The Disclosure, Estimate, and Consent you can modify the CMS templates, or you can create your own, as long as all the required elements and disclaimers are included. Using the templates provide does provide a presumption of compliance.

12. If I did get notice and consent, how do I provide that on the claim form?

That is not known right now, HHS is seeking comment on how to modify electronic claim submissions to accommodate notice and consent information.

13. As an OON provider/facility what will I get paid if I do not obtain Notice & Consent?

You will receive the "OON Rate" from the payor, which will be determined by state law, and if no applicable state law exists, then you will receive the amount agreed upon with the payor. If you are unable to agree upon an amount with the payor, then the IDR process will be initiated

14. Will the patient responsibility be based on the "OON Rate"?

No, the patient responsibility for OON services ("Recognized Amount) is determined by state law, and if no applicable state law exists, then it is set by the lesser of either the amount billed by the facility/provider or the qualifying payment amount (QPA).

15. What is the Qualifying Payment Amount (QPA)?

The QPA is the "Median of the contracted rates recognized by the plan or issuer on January 31, 2019, for the same or similar item or service that is provided by a provider in the same or similar specialty and provided in a geographic region in which the item or service is furnished, increased for inflation. The median contracted rate is determined with respect to all group health plans of the plan sponsor or all group or individual health insurance coverage offered by the health insurance issuer that are offered in the same insurance market, consistent with the methodology established by the Departments."

16. Why is the "OON Rate" different from the "Recognized Rate"

The "Recognized Amount" **cannot** be disputed, but the "OON Rate" can be disputed. Therefore, having two different methodologies protects patients from surprise bills while still allowing the provider and payor to settle on a fair rate.

17. Why is the "OON Rate" not based on QPA?

The "OON Rate" is not really a rate. Laws impose a minimum OON payment requirement on payors by either directly specifying a "benchmark" payment or indirectly by creating an arbitration process. The NSA uses the indirect method, the arbitration process (IDR).

Good Faith Estimate

1. What entities must comply with GFE requirements?

All licensed providers and facilities must comply, including hospitals, ASCs, RHCs, FQHCs, imaging centers, independent physician clinics, behavioral health providers, etc.

2. If a patient is not scheduled, but is requesting a GFE do I still have to provide?

Yes, if a patient requests a GFE, or if there is ANY discussion about charge a GFE must be provided within 3 business days from date of request. It does not matter if patient is scheduled or has insurance.

3. Do I have to provide a GFE to commercial insured patients?

If a patient requests a GFE, even if they are a known insured patient, a GFE must be provided. The GFE will be based on an uninsured/self-pay rate.

The GFE requirement factoring in insurance is postponed until July 2022 or later.

4. If an uninsured or self-pay patient does not request a GFE, do I still have to provide one?

If they schedule a service 3 days out or farther, yes. If provided orally, it still must be provided in writing too.

- Scheduled 3-9 days – must be provided 1 day after scheduled
- Scheduled 10+ days out – no later than 3 days after scheduled

5. Do patients have the option to waive their right for a good faith estimate?

The Departments do not address this question, therefore at the moment, we would assume no.

6. Do I have to use the CMS model documents the GFE or can I create my own?

The use of the CMS provided templates provides a presumption of compliance with respect to those forms. You can modify the CMS templates, or you can create your own, as long as all the required elements and disclaimers are included.

7. If an appointment is scheduled less than 3 days in advance, do I have to provide a GFE?

HHS states “Some items or services may not be included in a GFE because they are not typically scheduled in advance and are not typically the subject of a requested GFE, such as urgent, emergent trauma, or emergency items or services…. However, to the extent an urgent care appointment is scheduled at least 3 days in advance, these interim final rules require a provider or facility to provide a GFE”. However, this leaves room for interpretation around non urgent appointments scheduled less than 3 days in advance.

8. Do I have to include the price of separately scheduled subsequent services on the GFE? For example, physical therapy following knee replacement surgery.

No, you only need to list the subsequent services. Right above the list of subsequent services, there should be a disclaimer that states separate GFEs will be issued upon scheduling and include the process for requesting such GFE.

Example:

> *"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:*
> *(25) Physical Therapy Sessions following knee replacement*
>
> *To request a GFE regarding physical therapy services please contact _____.*

9. Are all the required disclaimers in the CMS model notice?

No, there are a couple of disclaimers that are required in 45 CFR §149.430 that are not in the CMS model GFE template. Insure you refer to the statute to include all requisite disclaimer statements.

10. Do I have to notify the uninsured or self-pay patient of the availability of GFE in writing?

You must post in locations where patients schedule/check-in, etc. and on your website, and orally inform them. You are not required to hand patients a disclosure regarding GFE.

11. Can I just provide the GFE orally?

The GFE must be provided in written format, regardless of if you provided it orally or not.

12. Can I provide a single GFE for recurring care?

Yes, you can issue a single GFE for up to a 12-month time period. Ensure that all the required elements are included.

13. If the patient requested a GFE prior to scheduling, do I need to provide them another one upon scheduling?

Yes, a new GFE must be issued within the required timeframes, as per HHS "the individual may not have been evaluated for underlying conditions that could impact the accuracy of the GFE".

14. If the service has been performed, and final billed charges are more than $400 of the GFE, do I need to provide a corrected GFE?

The statue does not state you need to provide a corrected GFE if the service has already been performed, however we would recommend that you do so, as that would potentially assist in the resolving the claim with the patient and assist in the event the dispute process is utilized by the patient.

15. What if a patient comes in for an office visit and then needs lab work, do I have to provide a GFE for the lab work?

The IFR states "The GFE does not have to include charges for unanticipated items/services that were not reasonably expected for that item/service and that could occur due to unforeseen circumstances". Based on this statement, if the lab work is expected based on the reason for visit, then you would want to include the lab work in the initial GFE with the office visit. However, if lab work was not reasonably expected, then a new GFE would not need to be issued. For example, if a patient scheduled a wellness visit, then lab work would be reasonably expected and should be included in the initial GFE with the office visit. However, if the patient scheduled a visit for a cough, then lab work would not be reasonably expected, and therefore does not require a separate GFE. If there is opportunity to issue a new GFE once provider/facility is aware of the need, that would be a best-case scenario, but recognize that this may not be practical. Documentation of the provider will be important. There will need to be clarity that the lab work could not have been reasonably expected.

Independent Dispute Resolution

1. When would we use the IDR process?

The IDR process is used to dispute payment from commercial payors. You would use this process if you are unable to reach a settlement with the payor and you believe that you should be paid an amount closer to the QPA than what the insurance company is offering.

2. What are the statutory timelines associated with the IDR process?

Independent Dispute Resolution Action	Timeline
Initiate 30-business-day open negotiation period	30 business days, starting on the day of initial payment or notice of denial of payment
Initiate independent dispute resolution process following failed open negotiation	4 business days, starting the business day after the open negotiation period ends
Mutual agreement on certified independent dispute resolution entity selection	3 business days after the independent dispute resolution initiation date
Departments select certified independent dispute resolution entity in the case of no conflict-free selection by parties	6 business days after the independent dispute resolution initiation date
Submit payment offers and additional information to certified independent dispute resolution entity	10 business days after the date of certified independent dispute resolution entity selection
Payment determination made	30 business days after the date of certified independent dispute resolution entity selection
Payment submitted to the applicable party	30 business days after the payment determination

3. What if we have a similar claim against the same payor right after an IDR determination?

The IDR process does mandate a 90 day “cooling off period.” You will need to hold this claim and can combine/batch it with other similar claims against the same payor to be filed after the 90 days has passed.

Selected Dispute Resolution (SDR)

1. When would we be subject to the SDR process?

The SDR is the process to resolve complaints of patients against payors. The patient has three criteria that must be met to be eligible for the SDR process:

- Patient received a GFE,
- Patient received the services (or additional services) reflected on the GFE, and
- Patient received an invoice for actual charges $400 over the GFE expected charges.

2. What do we have to do when we receive a SDR Notice of Initiation?

When you receive a Notice of Initiation of and SDR you will need to:

- Cease all efforts to collect for the claims and patient involved;
- Must not move or threaten to move the patient to collections;
- Suspend the accrual of any late fees; and
- Not threaten any retributive action.

3. Once a patient has filed an SDR am I forbidden to talk to the patient regarding financial assistance or otherwise?

No, you are free to continue to try and reach a settlement regarding payment, so long as you do not do any of the actions in #20.