What is the No Surprises Act?

The No Surprises Act was designed to protect consumers from receiving unexpected medical bills. These bills have been a problem particularly in the emergency and outpatient healthcare settings. Consumers may go to a facility that is in-network with their insurance company but receive services at that facility from an out-of-network provider; the consumer is then surprised by medical bills that their insurance doesn't cover, in some cases totaling thousands of dollars. A few studies estimated that "surprise medical bills" happen about 1 in every 5 emergency room visits, in addition to 9-16% of in-network hospitalizations for non-emergency care.

The most significant change for naturopathic doctors and integrative healthcare providers in private practice is a new requirement to provide a good faith estimate (GFE). Beginning in 2022, health care providers are required to give new and established patients who are uninsured, or self-pay, a good faith estimate of costs for services that they provide.

The Good Faith Estimate provision of the No Surprises Act is designed to give consumers predictability in how much they will be charged for the healthcare services they will be receiving, prior to their appointment.

What do I need to know about Good Faith Estimates as a licensed healthcare provider?

As of January 1, 2022, state-licensed or certified health care providers need to give a Good Faith Estimate of healthcare charges to every new and continuing patient who is either uninsured or is self-pay (insured but not planning to submit a claim to their insurance for the healthcare services they seek, or their insurance doesn't cover your services). Therefore, most all Naturopathic Doctors, functional medicine doctors and other licensed healthcare providers will need to provide Good Faith Estimates to all patients or the majority of their patients.

There are specific rules for what information has to be in that Good Faith Estimate and when it has to be provided. You can find templates of the Good Faith Estimate I have prepared below that you can customize for your practice or find other examples from the Centers for Medicare and Medicaid Services.

You also need to inform every uninsured or self-pay patient of their right to receive a Good Faith Estimate and post this notice at your office if you have a physical office location as well as on your website. A standard notice is provided below for your use.

In other words, you need to ask each patient whether they have insurance and whether they intend to use it to cover your services. If the answer to either question is no, they need to receive a Good Faith Estimate.

**Because most naturopathic doctors in California do not accept insurance, most all patients will need to receive a Good Faith Estimate.*

© 2022 Stephanie Berg Law PC

The good part is that you are most likely already very clear about the cost of your services with your patients. So, with the templates, it just adds one additional step. Once you're familiar with the requirements and templates, compliance is fully achievable, and will likely become as routine as the other disclosure paperwork in your practice, such as the Notice of Privacy Practices required for covered entities under HIPAA.

Do I need to abide by the No Surprises Act and the Good Faith Estimate provisions?

The Act applies to all healthcare providers and facilities operating under the scope of a state-issued license or certification. So, if you are a licensed or registered provider in your state, you likely need to abide by the Act. No specific specialties, types of service, or facilities are exempt.

Which patients need to be given a Good Faith Estimate?

Any patient who is uninsured or who is insured but does not plan to or cannot use their insurance benefits to pay for the health care services you provide should be provided a Good Faith Estimate. A Good Faith Estimate is not necessary at this time for a patient or patient who is planning to use their insurance benefits to cover your services. ("At this time" is a key phrase there, as HHS has said that future rulemaking will address Good Faith Estimate obligations to this group.)

The Good Faith Estimate provisions do not apply if the patient is a participant in Medicare, Medicaid, or other federal healthcare programs and you are a Medicare provider (again, unfortunately NDs cannot accept Medicare or Medicaid at this time, so a GFE will need to be provided). Good Faith Estimates are also not generally required for emergency services, which by their nature cannot be scheduled in advance.

At the present time, the requirement for a good faith estimate applies to these categories of patients:

1. Patients who do NOT have health insurance of any kind, (i.e., commercial insurance, HMOs, union health plans or government health plans.)

2. Patients who DO have health insurance that would pay for all or part of your treatment, but who DECLINE to use their insurance for the cost of your treatment. *It's not always clear if insurance will pay for naturopathic care.

3. Patients who DO have health insurance, but it doesn't cover your care and so they are paying out of pocket.

What information needs to be included in a Good Faith Estimate?

- Must be specific to each patient; a generic list of fees is not acceptable although you can certainly attach your fee schedule and still provide all your same financial and cancellation policies in your patient forms.

- Must include the cost of expected items and services.

- Must be given in writing.
- Should include estimates for all providers from your office who may be involved in their care.
- Must include the expected scope of any recurring primary items or services (such as timeframes, frequency, and total number of recurring items/services).
- May not exceed 12 months for recurring items/services.

The Good Faith Estimate must include all of the following:

- 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
    - General cost of the **office visit**s.
    - List of services you know you will be providing based on information known at the time the estimate was created, with the **health care codes** (including E&M, ICD-10, CPT) assigned to it and the expected costs of each.
    - Any **lab tests** that you know you will order and their **costs**. You will need to be familiar with the fee schedules of the labs you normally use. However, you may also provide them an updated estimate after you know which labs you will order if they are cash-pay labs.
    - Estimated **supplement cost(s)** that may be most likely indicated – or let them know that they don't have to order supplements.
    - Any **other fees** that apply.
- Diagnostic codes, service codes, and expected charges associated with each of those goods or services
- Name, National Provider Identifier (NPI), and Tax Identification Number (TIN) of each provider/facility represented in the good faith estimate as well as the states and offices/facility locations where the items or services are expected to be furnished (**Note: I highly recommend that providers who don't have an EIN, obtain an EIN to avoid publicly disclosing their SSN.)**

© 2022 Stephanie Berg Law PC

Some disclaimers to note on the Good Faith Estimate:

- The provider may recommend additional items or services as part of the treatment that are not reflected in the estimate. These would need to be scheduled separately.
- The information provided in the Good Faith Estimate is only an estimate, as actual items, services, or charges may differ.
- The patient has the right to engage in a dispute resolution process if the actual costs of services significantly exceed those listed in the Good Faith Estimate by $400 or more.
- The Good Faith Estimate does not obligate or require the patient to obtain any of the listed services from the provider.

The list of services to be provided should differentiate between those services that the provider will be offering, and those offered through what the law defines as co-providers and co-facilities: Others who will be providing services related to the treatment being sought.

In addition to the estimate itself, patients who are not using their insurance benefits to pay for services must also be given notice of their right to receive a Good Faith Estimate upon request. The Department of Health and Human Services has a sample notice you can customize and include in your practice, and I have also attached it below.

When do patients need to be given the Good Faith Estimate?

The law puts forth specific guidelines for when a patient must be given a Good Faith Estimate.

- If a service is scheduled at least 10 business days in advance, the Good Faith Estimate must be provided within 3 business days of scheduling. (This is within 3 business days of the *scheduling*, not of the appointment itself.)
- If a service is scheduled at least 3 business days in advance, the Good Faith Estimate must be provided within 1 business day of scheduling.
- If a service is scheduled less than 3 business days in advance, a Good Faith Estimate should be provided as soon as possible – I would just recommend 1 business day if you can.
- If an individual requests a Good Faith Estimate at any time, it must be provided within 3 business days.

The Good Faith Estimate must be provided in writing, and if delivered electronically, must be provided in a format that the patient can save and print if they wish. The estimate should also be provided verbally if the patient asks about costs, but verbal delivery must

© 2022 Stephanie Berg Law PC

be followed up with a written Good Faith Estimate. Providing the information only in verbal form would not be considered compliant.

These timing provisions do not appear to be either-or. A Good Faith Estimate should be provided in connection with the scheduling of a service as described above, and also upon request. For patients receiving long-term or ongoing services, a good rule of thumb is that a Good Faith Estimate should be completed every 12 months, to cover the next 12 months of planned or potential services.

Note: If any information provided in the estimate changes (e.g., a provider raises fees or the agreement for the frequency or type of services changes), a new Good Faith Estimate should be provided as soon as possible but no later than one business day before the scheduled care. Also, if there is a change in the expected provider less than one business day before the scheduled care, the replacement provider must accept the good faith estimate as the expected charges. Generally, if you are changing your fees, I recommend giving patients 30 days' advance notice before the effective date of your fee increase.

Can patients waive their right to a Good Faith Estimate?

While some patients will either be unaware of their right to a Good Faith Estimate or feel comfortable not receiving such an estimate, there are no provisions in the federal regulation allowing patients waiving their right to a Good Faith Estimate. The regulation allows patients to waive some of the protections related to balance billing but does not allow providers to bypass the Good Faith Estimate through a patient waiver.

How specific does a patient request for a Good Faith Estimate need to be?

The regulation stipulates that any discussion or inquiry about the costs of treatment should be considered a request for a Good Faith Estimate. Patients do not need to use the exact phrase.

Can I include the Good Faith Estimate with my usual patient intake paperwork?

Yes. Depending on the nature and scope of the services you provide, it may make sense to include the Good Faith Estimate as part of your standard intake paperwork. If you do so, bear in mind that the estimate must relate to the specific services to be provided to that patient, and the estimate must be made available to new patients in a specific time frame once services are scheduled, as listed above.

Specifically including the Good Faith Estimate in a *treatment contract* may confuse patients though, as the Good Faith Estimate requires a disclaimer specifically telling consumers that the estimate is *not* a contract and does not create an obligation to receive services from that provider. So, the Good Faith Estimate may make more sense to patients when put into a separate document.

I have created two versions of the Good Faith Estimate. Once for new patients to provide before their initial appointment and one to provide to current patients and new patients after their initial visit when you know more about their case.

© 2022 Stephanie Berg Law PC

When estimating costs, particularly for new patients, can I use a range?

In many cases—including naturopathic medical care and functional medicine—it can be difficult for a provider to know how much treatment will be needed when a new patient schedules services for the first time. In these instances, it may make sense to offer a range of potential costs. For example, you may provide a potential range of appointments with you that may be needed, estimated costs at each end of the range, and the factors that may influence whether costs ultimately land toward the lower or higher end of the range.

Even though the Good Faith Estimate is supposed to be individualized, you can still also attach your fee schedule to the Good Faith Estimate.

Depending on your case*, you may need between [insert number] and [insert number] of appointments with Dr. __________. Generally, after the initial new patient appointment, labs are ordered and there are several follow-up appointments including a [__ minute] follow-up appointment to review labs, and 2 or 3 more [__-minute] follow appointments every 4-6 weeks thereafter.*

At our current rates (which may increase in the future), this would be:

- Initial new patient appointment $____
- Follow-Up appointment to review labs $___
- Follow-Up 6 weeks after $___
- Follow-up 6 weeks after $__
- Follow-up 6 weeks after $___
    - Total Cost: $__________
    - *Note the cost of labs varies depending on lab ordered and whether insurance covers it depending on your individual plan.
    - The cost of supplements that may be recommended and any medications prescribed also varies. You are not required to purchase supplements in order to receive care.

How can I estimate costs or services for patients I haven't met?

The Good Faith Estimate is just that: An estimate. You may revise the estimate based on information gathered from the patient at an initial appointment. For example, prior to meeting a patient, you may not have enough information to include diagnostic codes on the Good Faith Estimate, or to provide anything more than a broad range of potential costs or simply the cost for the new visit. Once you have met with the patient and have a

better sense of their symptoms, likely diagnoses, and severity, you may be able to offer more specific guidance.

The spirit of the law is to provide patients with transparency in pricing. Revising a Good Faith Estimate, especially when you can make it more specific on the basis of newly gathered information, would appear to be in keeping with that spirit.

Therefore, I have created two different templates for you to use and modify for your practice. One for new patients that only covers the cost of the new patient visit and one for existing patients and for patients after their initial visit.

What if my estimate turns out to be wrong?

As noted in the rulemaking itself, the Good Faith Estimate rules "do not require the good faith estimate to include charges for unanticipated items or services that are not reasonably expected and that could occur due to unforeseen events." If a patients' needs are ultimately different from what was expected, a provider can update the Good Faith Estimate to address the new information or events.

Is the Good Faith Estimate binding?

The information provided in the good faith estimate is only an estimate, and the actual items, services, or charges may differ from what is included in the good faith estimate. However, uninsured or self-pay individuals may challenge a bill from a provider through a new patient-provider dispute resolution process if the billed charges substantially exceed the expected charges in the good faith estimate. Substantially exceeds means an amount that is at least $400 more than the expected charges listed on the good faith estimate for a specific provider.

There is no penalty if you overestimate the costs. If in doubt, it seems that it would be best to overestimate expected charges.

Additionally, you can provide them as many updated Good Faith Estimates as you like – if you wanted, you could provide a new one after each visit. Or you can provide one that covers up to 12 months of care.

Additionally, if you are charging at the time of service, they shouldn't be surprised by any bills.

How should I document delivery of the Good Faith Estimate?

Good faith estimates are considered part of the patient's medical record and must be maintained in the same manner. A copy of the estimate must be available to the patient up to six years after it was provided. Since California law requires healthcare providers to keep patient records for a minimum of seven years from the date services were terminated (or if the patient is a minor, seven years from termination of services or until the minor reaches the age of 25, whichever is greater), I recommend keeping the good faith estimates for the same period of time.

© 2022 Stephanie Berg Law PC

The rules don't require that it is signed, but you can have a policy to have patients sign their estimates if you want to.

Process for Resolving Charge Disputes Between Consumers (Patients) and Providers

Starting in January 2022, if an uninsured or self-pay consumer is billed for an amount that exceeds the good faith estimate they were provided by $400 or more, they can use a new patient-provider dispute resolution process to determine a payment amount. Consumers are eligible to use this process if they have a good faith estimate, they have a bill within the previous 120 calendar days, and the difference between the good faith estimate and the bill is at least $400.

Through this process, consumers can request a third-party arbitrator to review the good faith estimate, the bill, and the information submitted by the provider or facility to determine whether the additional charges are allowed. HHS intends to establish an online portal and offer documents that patients who are initiating a dispute resolution process can submit as hard copy.

Other than the Good Faith Estimate rules, what else is included in the No Surprises Act?

The No Surprises Act also includes new restrictions on balance billing, which most commonly apply to services provided by out-of-network healthcare providers at in-network facilities. The Act prohibits balance billing (that is, billing consumers for the difference between the insurance payment and the out-of-network provider's rate) for emergency care. For non-emergency care, balance billing is only allowed if the consumer has been given notice and provided specific consent.

These provisions typically will not be relevant to outpatient, private-practice care providers, but it will be for those who work in group practice, hospital, clinic, or other institutional settings. If you fall into this situation, you may want to consult with your employer as to whether the balance billing provisions are relevant to your specific setting.

One less-discussed provision has to do with provider directories that are maintained by insurance companies. These directories have often been criticized for including outdated and inaccurate information, making it harder for consumers to find a provider who is actually in-network. Under the No Surprises Act, as of 2022 insurers must update their directories every 90 days. Providers must inform any insurances that they are in-network with, of any meaningful changes to their directory listing, and any time the provider terminates an agreement. HHS can also set forth other notification requirements.

Along similar lines, insurers are required to notify patients when the in-network status of a treating provider changes. The patient will have the option to continue with that treating provider for up to 90 days under the same payment terms that existed under the provider's in-network contract, with some exceptions.

© 2022 Stephanie Berg Law PC

What's the risk if I don't follow this new requirement?

HHS has said it is deferring enforcement and doing some additional rulemaking for in-network services, but that it is *not* deferring enforcement of the requirement to provide Good Faith Estimates for uninsured or cash-pay patients. As with HIPAA, providers found to be violating the regulations can be fined.

Is there a chance the law will be blocked or suspended?

While many provider groups have expressed dissatisfaction with both the law and its implementation, it does not appear likely at this time that either the broader law or its Good Faith Estimate provisions specifically will be blocked or suspended. Providers should plan to abide by the law's requirements.

Summary of How to Comply with the No Surprises Act

Even prior to the No Surprises Act, healthcare providers should discuss fees with patients ahead of time and most provide this information in their Informed Consent and/or in separate financial policies. Under the new rules, healthcare providers must also do the following for current and future patients:

1. Ask if the patient has any kind of health insurance coverage, and whether the patient intends to submit a claim for the service. ***Note: It is not yet clear if the patient intends to submit a superbill on their own if they still require a GFE. At this time, if you are a cash-based practice, assume you need to provide a Good Faith Estimate to all patients.***

2. Create a written document for all uninsured and self-pay patients stating that a good faith estimate of expected charges is available OR use the template notice I have provided. (*Note:* This notice regarding the availability of a good faith estimate must be prominently displayed on the provider's website or the facility's website as well as in the office or on the site where scheduling and questions about the cost of health care occur. The notice must be made available in either paper or electronic format. The CMS model Notice for providers and facilities to use called Standard Notice: "Right to Receive a Good Faith Estimate of Expected Charges" Under the No Surprises Act is attached. The provider or facility must fill in the blanks with the appropriate information. While use of the HHS model notice is not required, HHS considers its use good faith compliance with the good faith estimate requirements.

3. Orally provide the notice regarding the availability of the good faith estimates when scheduling services or when patients have questions about cost.

4. Offer in written form the Good Faith Estimate of expected charges for a scheduled or requested service, either on paper or electronically according to the individual's requested method of delivery and within the time frames discussed below. If provided electronically, the format must be one that would allow the patient to save and print. I have created two sample Good Faith Estimate templates that you can

use – one for new patients prior to the first visit and one for existing patients and new patients after the first visit. HHS has made a sample template available called Standard Form: “Good Faith Estimate for Health Care Items and Services” Under the No Surprises Act which is also attached and that you can use.

Where can I find additional information, sample language, and Good Faith Estimate templates?

Again, I have provided Good Faith Estimate templates that you can use to customize for your practice.

The federal Centers for Medicare and Medicaid Services (CMS) has a detailed fact sheet and list of frequently asked questions on the law, as well as a whole website focused on No Surprises Act implementation.

© 2022 Stephanie Berg Law PC