Reminder: Most Federal Surprise Billing Requirements Begin January 1

As health care organizations are generally aware, most regulatory requirements related to the federal No Surprises Act apply beginning January 1, 2022. These surprise billing regulations implement a number of new patient billing and cost-sharing limitations in the emergency services context, as well as in situations involving non-emergency services rendered by out-of-network providers at in-network facilities (as further discussed in our client update from earlier this year).

As 2021 draws to a close, we want to remind clients of two aspects of these new regulations that have not received as much attention, to ensure they are not overlooked:

Patient Notice Requirement

In addition to complying with other surprise billing requirements, health care facilities and facility-based providers are required to give insured patients general written notices regarding federal and state protections against balance billing (see, for example, CMS' Model Form). CMS requires that the applicable providers and facilities must:

- make such notices available on their public websites (if applicable);
- post such notices on a sign at any publicly accessible location of the facility or provider; and
- make the notice available on a one-page form (can be double-sided) given in-person, via postal mail, or via e-mail, as selected by the individual.

The providers and facilities must give such notices to insured patients prior to billing the patients or their health plans.

Please note that facility-based providers can avoid the sign and one-page notice requirements (but not the website notice requirement) by entering into an agreement with their facilities to have the facilities provide the applicable notices in the required form and manner. If the provider has entered into an agreement with the facility and the facility fails to provide the notices, CMS will not view that failure as a violation of the regulations by the provider. We expect that many facilities will be willing to enter into such agreements in the interest of avoiding duplicate patient notices. Accordingly, we recommend that our facility-based provider clients discuss this with their facilities if they have not already.

Good Faith Estimates for Uninsured or Self-Pay Patients

The regulations also require health care facilities and providers to give uninsured or self-pay patients a good faith estimate of the expected charges (GFE) for health care items or services (a) upon request or (b) upon scheduling of health care items and services. The regulations also allow such patients to initiate a dispute resolution process if they are billed for charges substantially in excess (at least $400 more than total expected charges) of a good faith estimate.

Important things to bear in mind regarding this requirement include:

- This requirement applies to a wide range of state-licensed providers and facilities (i.e., not just to those covered by the surprise billing restrictions and requirements)
- A "convening provider" that receives a GFE request or is responsible for scheduling the primary health care item or service (i.e., the item or service that is the initial reason for the visit) with the patient must determine at the time of the request or at the time of scheduling whether a patient is uninsured or self-pay
- Determining whether a patient is self-pay will require asking the patient if the patient is seeking to have a claim submitted to health insurance for a particular item or service
- "Convening providers" must verbally inform uninsured and self-pay patients of the availability of GFEs when scheduling and when cost questions arise
- Providers must generally display a notice about the availability of GFEs on their websites and on-site (different from the patient notice discussed above, and CMS has provided a model notice)
- GFEs must be provided on specific timeframes (i.e., within three business days after the date of a patient request, within one business day after scheduling for items/services scheduled at least three business days in advance of the date the item or service is scheduled to be furnished, and within three business days after scheduling for items/services scheduled at least 10 business days in advance)
- The regulations include requirements for co-providers or co-facilities from which convening providers must gather information for purposes of providing GFEs
- Providers must update GFEs to reflect any changes they anticipate or become aware of
- Any discussion or inquiry from a patient about costs should be viewed as a GFE request
- CMS has published information and a standard form covering what must be included in GFEs
- GFEs should be considered part of the patient medical record and maintained as such

We recommend that clients consider these requirements, if they have not already, and incorporate them into their patient intake processes. Additionally, they should plan for coordination with other providers and facilities when third-party information is necessary for purposes of preparing GFEs.

Our Chambliss team continues to monitor health care developments, including issues related to the No Surprises Act. Please contact Cal Marshall or your relationship attorney if you have any questions or need additional information.