No Surprises Act – Good Faith Estimate - Part III

Standard Notice – Right to Receive a Good Faith Estimate of Expected Charges

Effective Date: January 1, 2022 What to Know:

Health care providers and health care facilities are required to inform individuals who are not enrolled in a plan or coverage or a Federal health care program (Uninsured), or not seeking to file a claim with their plan or coverage (Self-Pay/Cosmetic) both orally and in writing of their ability, upon request or at the time of scheduling health care items and services, to receive a "Good Faith Estimate" of expected charges. Until 1/1/2023, only the Center's estimate is necessary, this may change with the start of next year.

Center Leadership immediate actions:

- Update the Good Faith Estimate for Health Care Items and Services Form per the instructions below. Complete all bracketed areas and save a copy for continued use.
- Establish an internal process for the completion and distribution of the notice within the required timelines outlined below.
- Print and Post in your facility the "You have the right to receive a "Good Faith Estimate" explaining how much your medical care will cost"
- Confirm the "Good Faith Estimate" notice has been posted to your facility website on 2/28/2022.

Good Faith Estimate Form requirements:

This form should be used by health care providers to inform individuals who are not enrolled in a plan or coverage or a Federal health care program (uninsured individual), or individuals who are enrolled but not seeking to file a claim with their plan or coverage (self-pay/cosmetic individuals) of their right to a "Good Faith Estimate" to help them estimate the expected charges they may be billed for receiving certain health care items or services.

Data elements the facility is required to include in the good faith estimate:

DATA ELEMENT	DESCRIPTION
Patient name and date of birth	First name, Last name, and date of birth for the uninsured (or self-pay) individual receiving items or services
Description of the primary procedure in clear and understandable language, and DOS if applicable	Description of the procedure and DOS
Items and services reasonably expected to be furnished for the period of care	An itemized list of services reasonably expected to be furnished by the facility, and items or services expected to be furnished in conjunction with and in support of the primary service.

Service Codes	Description of the procedure using the CPT, HCPCS, DRG or NDC codes
Diagnosis Codes	Primary ICD-10 code
Expected Charges	Expected charges associated with each listed item or service
Name of Facility	Facilities Legal Name as written on their business license
Tax ID Number	Facilities Taxpayer ID Number
National Provider Identifier (NPI)	Facilities National Provider Identifier (NPI)
List of items and services requiring separate scheduling	List of items or services that the facility anticipates will require separate scheduling and with either occur prior to or following the expected care.
Facility Location	Physical address of the facility, including street name and number, city, state, and zip code
Disclaimer Information:	
Good Faith Estimate is an estimate and subject to change	Provided on the last page of the Good Faith Estimate
There may additional items or services not contained in the good faith estimate	Provided on the last page of the Good Faith Estimate
Right to initiate the patient-provider dispute resolution process	Provided on the last page of the Good Faith Estimate
Good Faith Estimate is not a contract	Provided on the last page of the Good Faith Estimate

A sample form is provided, but you may create your own Good Faith Estimate form if it includes the required data elements.

Good Faith Estimate Timeline requirements:

- Must be provided within 3 business days upon request.
- If scheduled within 3 business days of DOS, estimate must be provided within 1 business day.
- If scheduled within 10 business days of DOS, estimate must be provided within 3 business days.

Availability of a Good Faith Estimate:

To ensure the public is aware of the information regarding the availability of a "Good Faith Estimate", The "You have the right to receive a "Good Faith Estimate" explaining how much your medical care will cost" signage must be prominently displayed (attached on the next page):

- Center website homepage will include the disclosure notice or a link to access it
- Please work with your website administrator to have this added by 2/28/2022

Your Rights and Protections Against Surprise Medical Bills

When you get treated by an out-of-network provider ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in- network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Certain services at an in-network ambulatory surgical center

When you get services from an in-network ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to anesthesia, pathology, laboratory, assistant surgeon, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.

- Your health plan generally must:

  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.

  - Count any amount you pay for out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact 1-800-985-3059

Visit https://www.cms.gov/nosurprises for more information about your rights under federal law.