New Federal "No Surprise Billing" Provisions Your Office NEEDS to Know!

Introduction

The No Surprises Act was passed at the end of 2020 as a part of the Consolidated Appropriations Act of 2021. Initially most experts believed that the No Surprises Act applied only to facility-based (such as hospital) providers; however, on the recent finalization of Part II of the rules, it became clear that a specific portion applies to all health care providers.

One of the new No Surprises Act's major goals is to ensure that patients do not receive health care bills that far exceed their awareness or expectations. Although the most heralded portions of the law (usually pertaining to hospital services) do not apply to the vast majority of chiropractors, another key provision pertaining to "good faith estimates" **will apply to nearly all chiropractic offices beginning on January 1, 2022**. Health and Human Services (HHS) issued rules, FAQs, and other information pertaining to the No Surprises Act throughout late 2021.

The Washington State Chiropractic Association has worked with our counterparts in Illinois and Michigan to provide you with resources for compliance with this law. We will continue to monitor and review any new information as the requirements evolve.

The No Surprises is comprised of two major parts. Part I is entitled: "Requirements Related to Air Ambulance Services, Agent and Broker Disclosures, and Provider Enforcement; Part I," and the second is "Requirements Related to Surprise Billing; Part II."

Part I applies specifically to certain Medicare defined "facilities," so it does not pertain to chiropractic physicians working in an office setting. "Facilities" include a hospital setting, a Federally Qualified Health Center, or another type of defined facility. At this time, chiropractic offices that treat Medicare patients are not included in the definition of "facility". Part I puts restrictions on air ambulance services and surprise billings from non-participating provider services in participating facilities (for example, an out-of-network anesthesiologist who provides services during surgery as part of a team of providers) and emergency service billings. For obvious reasons only Part II will apply to most chiropractic offices.

Part II, however, has a much broader application that does include chiropractic physicians. Its primary purpose is to better inform patients regarding the cost of care and require a "Good Faith Estimate." Fortunately, the law limited the scope of this requirement to particular situations; however, it will still require ***all chiropractic physicians, whether insurance based, in-network, out of network, or cash, to make an initial determination for all patients whether a good faith estimate is required***.

Although the No Surprises Act requires Good Faith Estimates (GFE) for both self-pay and insurance-based patients, HHS only issued rules for the patients who are uninsured or self-pay patients (see more information below). However, HHS is specifically excluding insured patients from current requirements (and enforcement) because the infrastructure is not available to provide meaningful information to the patient. This article will focus on the GFE requirements for uninsured or self-pay patients (Important: see below for definitions of "uninsured" and "self-pay.").

Important Note: This regulation will impact your office in some way, since the **minimum requirements** will include required questions of patients, posters in your office, additions to your website, and paperwork for Medicare patients.

The information in this article is based on the Interim Final Rule that was active on October 7, 2021 but is subject to change because it is still in the comment period. Additionally, these interpretations are based on the best information currently available. Some of these requirements MAY change from future updates to the rule or based on court rulings. Nonetheless, these requirements are in place and active beginning January 1, 2022. Patients will be fully aware of these rights since the requirements will be in place for all healthcare providers. As the WSCA receives more information, we will update this article and inform our members of the changes.

What are Good Faith Estimates (GFEs)?

One of the key concepts of the No Surprises Act is to ensure that patients do not receive medical bills that are greater than they anticipate. Although the vast majority of the law focuses on large surprises from air ambulance and non-participating physicians at participating hospitals, ***they also want patients to know in advance the cost of services being rendered in non-emergency settings.***

The law goes a step further than simply requiring a price list of services offered in the practice. Instead, ***providers must provide during scheduling (or before scheduling, if the patient requests) a clear list of services (with prices) anticipated for the specific patient.***

Good Faith Estimates (or GFEs) have required elements:

- A list of all reasonably expected services for the scheduled visit with all prices
- CPT codes and ICD-10 codes
- Patient and provider identifying information
- Appointment date (if scheduled), and
- Several disclaimers

A full listing of required elements and an editable template have been provided to all chiropractors through the weekly e-newsletter and you can find the links on our website in "member updates" and in the Government Relations tab under "advocacy/legislation."

Providers must present the Good Faith Estimate in writing, but they can also present it orally. HHS has clarified that providers can satisfy the written requirement through electronic means, such as email (if requested) or a patient portal. ***However, they clarify that the patient MUST have the ability to "both save and print" the GFE.***

GFE Required Elements and Downloadable Form

The law and rules require that the Good Faith Estimate form include very specific information. As a result, the WSCA has developed an editable template for our members. On our FAQ located on our website, you will find the full list of required elements.

When is the Good Faith Estimate Given to the Patient?

The deadline for giving a patient the Good Faith Estimate (GFE) is based on ***when the patient makes a request, or when an appointment is scheduled.*** Use this list that is based on the date an appointment is scheduled (in business days):

- 10 Days in Advance – Provide GFE **3 business days** after the date of scheduling, or
- 3 – 9 Days in Advance – Provide GFE **1 business day** after the date of scheduling, or
- Under 3 Days in Advance* – **GFE is required if requested**, or
- No appointment scheduled – Provide GFE **3 business days** after the date the patient requests the GFE.

** Note: Currently, experts are divided on interpreting whether or not a GFE is required at all if the appointment is scheduled less than 3 business days before the appointment time. However, because no court or agency has specifically ruled on this issue, prudent practice points toward providing a GFE when requested in these situations.*

The WSCA has developed a one-page form that includes the elements required (except the separate scheduling portion also not included in the HHS form). Members can access that form on our website.

Please remember that providers must present the Good Faith Estimate in writing, but they can also present it orally. HHS has clarified that providers can satisfy the written requirement through electronic means, such as email (if requested) or a patient portal. However, they clarify that the patient MUST have the ability to "both save and print" the GFE.

Conclusion

As indicated above, these requirements are in place as of ***January 1, 2022***, ***and should not be ignored or postponed.*** Additionally, the information in this article is based on the Interim Final Rule that was active on October 7, 2021 but could change after the

comment period. Additionally, these interpretations are based on the best information currently available. Some of these requirements MAY change from future updates to the rule or based on court rulings. However, providers should implement now.

Additional resources, including a FAQ document with additional detail and examples, are available at chirohealth.org. As the WSCA receives more information and clarification, we will update this article and inform our members of the changes.

Special appreciation to the Illinois Chiropractic Society (ICS) and the Michigan Association of Chiropractic (MAC) for their support with detail and documents for WSCA use.