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# NO SURPRISE BILLING RULES: CHECKLIST FOR PROVIDERS

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Many providers make the No Surprise Billing Rules[1] more complicated and expansive than they are. This short guide is intended to help providers understand, implement, and monitor compliance with the new rules.

**UNDERSTANDING THE RULES.** The rules were designed to protect patients in two situations: (1) a self-pay patient who receives a bill for substantially more than they expected; and (2) an insured patient who receives an unexpected bill from an out-of-network (OON) provider or facility for certain emergency or non-emergency services. To that end, the rules require the following:

**All Providers and Facilities: Good Faith Estimate to Self-Pay Patients.** Effective January 1, 2022, virtually all healthcare facilities and providers[2] from whom a self-pay patient seeks care[3] must (1) notify self-pay patients[4] of their right to obtain a good faith estimate of anticipated charges; and (2) provide a

[1] The No Surprise Billing Rules implement the No Surprises Act and issued in two parts: Part I covers limits on balance billing and out-of-network provider rates (45 CFR 149.410-.450, 86 FR 36872 (7/13/21)); Part II applies to the good faith estimate for self-pay patients (45 CFR 149.610), the SDR process for disputes about the estimate (*id.* at 164.620), and the IDR process for disputes over the out-of-network rates (id. at 149.510). (86 FR 55980 (10/7/21)).

[2] The self-pay rules apply to health care "facilities" and "providers." For purposes of this rule, "facility" is defined as "an institution (such as a hospital or hospital outpatient department, critical access hospital, ambulatory surgical center, rural health center, federally qualified health center, laboratory, or imaging center) in any State in which State or applicable local law provides for the licensing of such an institution …." (45 CFR 149.610(a)(2)(vii)). "Provider" means "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, including a provider of air ambulance services." (*Id*. at 149.610(a)(2)(viii)).

[3] The regulations refer to such providers as the "convening provider" or "convening facility", *i.e*., "the provider or facility who receives the initial request for a good faith estimate from an uninsured (or self-pay) individual and who is or, in the case of a request, would be responsible for scheduling the primary item or service." (45 CFR 149.610(a)(2)(ii)).

[4] The rules define an "uninsured (or self-pay)" patient as "(A) An individual who does not have benefits for an item or service under a group health plan, group or individual health insurance coverage offered by a health insurance issuer, Federal health care program …, or a health benefits plan …; or (B) An individual who has benefits for such item or service … but who does not seek to have a claim for such item or service submitted to such plan or coverage." (45 CFR 149.610(a)(2)(xiii)).

good faith estimate of charges to the self-pay patient before the services are rendered. (45 CFR 149.610). If the actual charges are $400 or more than the charges listed in the good faith estimate, the self-pay patient may initiate a selected dispute resolution (SDR) process to determine how much the patient must pay. (45 CFR 149.620). Significantly, the good faith estimate rule only applies to self-pay patients, which is usually a small percentage of a provider's or facility's patient population. It does not (currently) apply or require a good faith estimate to insured patients or government program beneficiaries.[5]

**Certain OON Providers and Facilities: Limits on OON Payments**. Effective January 1, 2022, the rules cap the amount that certain OON facilities and providers may collect from patients and payers. (45 CFR 149.410-.420). Significantly, the OON rules and limits only apply to (1) "emergency facilities" (*i.e.*, hospital emergency departments, hospital outpatient departments providing emergency services, and freestanding emergency departments); (2) "health care facilities" (*i.e.*, hospitals, hospital outpatient departments, CAHs, and ASCs); and (3) OON providers who render services at such facilities. (*Id*. at 149.30, .410(a) and .420(b)). If the rules apply, (1) the OON facility or provider may not balance bill the patient beyond the regulatory cap unless they obtain the patient's prior written consent; and (2) the OON facility or provider must post a public notice of the limits on balance billing. (*Id*. at 149.430(a), (e)). If the OON facility or provider and payer disagree on the OON rate, the rules establish an independent dispute resolution (IDR) process to determine the amount the OON provider must pay. (*Id*. at 149.510).

**IMPLEMENTING THE RULES.**

**All Providers: Good Faith Estimate to Self-Pay Patients.** Virtually all providers and facilities must do the following for any self-pay patients:

**1. Providing the Good Faith Estimate.**

- ☐ Post the HHS Notice, "Right to Receive a Good Faith Estimate of Expected Charges,"[6] on the provider's or facility's website, in the office, and onsite where scheduling or questions about the cost of items or service occur. (45 CFR 149.610(b)(1)(iii)(A)). The information must be prominently displayed and published in accessible formats and presumably available in languages spoken by the patient. (*Id*. at 149.610(b)(1)(iii)(C)).

- ☐ Ask patients if they are self-pay. (45 CFR 149.610(b)(1)(i)-(ii)).

[5] The No Surprises Act will require such estimates in the future, but HHS postponed implementing that portion of the Act.

[6] Available at https://www.cms.gov/regulations-and-guidancelegislationpaperworkreductionactof1995pra-listing/cms-10791. Providers and facilities are not required to use the HHS form, but if not, the alternative notice must contain the elements required by the regulations.

- ☐ Inform self-pay patients orally that they have a right to obtain a good faith estimate upon request or upon scheduling an appointment. (45 CFR 149.610(b)(1)(iii)). The oral notice should presumably be given in the language spoken by the patient. (*See id.* at 149.610(b)(1)(ii)(C)).

- ☐ For self-pay patients, prepare and give the good faith estimate to the patient if (1) the patient asks about the cost of services,[7] (2) the patient requests the estimate, or (3) services are scheduled. (45 CFR 149.610(b)(1)(iv)-(v)). The good faith estimate is not required in the case of emergency services.[8]

- ☐ Ensure the good faith estimate includes the elements and disclaimers required by the regulation. (45 CFR 149.610(c)). HHS has published a sample form, "Good Faith Estimate for Health Care Items and Services," along with a chart of required data elements.[9] Ensure the estimate is complete and accurate. Providing an incomplete or inaccurate good faith estimate may limit your ability to collect from the self-pay patient if the patient initiates the SDR process. To facilitate timely, complete estimates, consider preparing standard template estimates for common items or services in advance.

- ☐ Provide the good faith estimate to the self-pay patient in written form either on paper or electronically as requested by the patient. (45 CFR 149.610(e)(1)). The estimate must be provided within the following time frames:

    - ☐ If the item or service is scheduled at least 3 business days before the date the item or service is scheduled to be furnished: not later than 1 business day after the date of scheduling;

    - ☐ If the item or service is scheduled at least 10 business days before such item or service is scheduled to be furnished: not later than 3 business days after the date of scheduling; or

    - ☐ If a good faith estimate is requested by a self-pay patient: not later than three 3 business days after the date of the request.
    (45 CFR 149.610(b)(1)(vi)).

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[7] Per the regulations, "convening facilities shall consider any discussion or inquiry regarding the potential costs of items or services under consideration as a request for a good faith estimate." (45 CFR 149.610(b)(1)(iv)).
[8] According to HHS, "some items or services may not be included in a good faith estimate because they are not typically scheduled in advance and are not typically the subject of a requested good faith estimate, such as urgent, emergent trauma, or emergency items or services…" (86 FR 56015).
[9] Available at https://www.cms.gov/regulations-and-guidancelegislationpaperworkreductionactof1995pra-listing/cms-10791. Providers and facilities are not required to use the HHS form but, if not, their estimate must contain the required elements listed at 45 CFR 149.610(c).

- ☐ If you anticipate changes that will affect the estimate (*e.g.*, changes to the charges, items, services, providers or facilities, *etc.*), issue a new good faith estimate no later than 1 business day before the items or services are scheduled to be provided. (45 CFR 149.610(b)(1)(vii)).

- ☐ If there are any changes in the providers or facilities less than 1 business day before the item or service is scheduled to be furnished, the replacement provider or facility must accept as its good faith estimate of expected charges the good faith estimate that was previously provided. (45 CFR 149.610(b)(1)(vii)). Accordingly, consider checking the prior good faith estimate before assuming care.

- ☐ Consider issuing a recurring estimate. A provider or facility may issue a single good faith estimate for recurring items or services for up to 12 months if certain conditions are satisfied.[10] (45 CFR 149.610(b)(1)(x)).

- ☐ Maintain a copy of the good faith estimate as part of the self-pay patient's medical record. (45 CFR 149.610(f)(1)). To ensure compliance with your obligation to provide copies of a good faith estimate, maintain the estimate for at least 6 years.

- ☐ If requested by a self-pay patient, provide the patient with a copy of any good faith estimate previously issued within the prior 6 years. (45 CFR 149.610(f)(1)).

- ☐ Beginning in 2023, the good faith estimate must include estimates from co-providers[11] (45 CFR 149.610(b)(1)(v) and (b)(2); HHS has exercised its discretion not to enforce co-provider rules during calendar year 2022. (86 FR 56023). Update your policies and process as appropriate.

2. **Participating in the SDR Process.** If the actual charges are $400 or more than the charges listed in the good faith estimate, the self-pay patient may initiate the SDR process. (45 CFR 149.620).

   - ☐ A self-pay patient must initiate the SDR process by submitting notice and an administrative fee within 120 days after receiving the disputed bill. (45 CFR 149.620(c)(1)).

   - ☐ If the SDR entity believes the matter is appropriate for SDR, the SDR entity will notify you and request that you submit required information within 10 days. (45 CFR 149.620(c)(4)).

[10] A good faith estimate may be issued for recurring items or services if: (1) the good faith estimate specifies the expected scope of the recurring items or services (*e.g.*, timeframes, frequency, and total number of items or services); and (2) the scope of a good faith estimate may not exceed 12 months. (45 CFR 149.610(b)(1)(x)).
[11] A "co-provider" or "co-facility" means "a provider or facility other than a convening provider or a convening facility that furnishes items or services that are customarily provided in conjunction with a primary item or service." (45 CFR 149.610(a)(2)(iii)).

- ☐ Upon receipt of the SDR notice and while the SDR process is pending, (1) do not move the self-pay patient's bill for the disputed item or service into collection or threaten to do so; (2) if the bill has already moved into collection, cease collection efforts; (3) suspend the accrual of any late fees on unpaid bill amounts; and (4) do not take or threaten to take any retributive action against the self-pay patient. (45 CFR 149.620(c)(5)-(6)).

- ☐ Within 10 days of receiving the notice from the SDR entity, submit the required information, including (1) a copy of the good faith estimate provided to the self-pay patient; (2) a copy of the billed charges; and (3) if available, documentation demonstrating that the difference between the billed charge and the good faith estimate (a) reflects the cost of a medically necessary item or service and (b) is based on unforeseen circumstances that could not have reasonably been anticipated by the provider or facility when the good faith estimate was provided. (45 CFR 149.620(f)(2)(i)). This is the standard that will govern the SDR entity's determination and how much you may recover from the self-pay patient.

- ☐ Within 30 days of receipt of your information, the SDR entity will make her/his determination consistent with the parameters of the regulation. (45 CFR 149.620(f)(2)(ii), (3)). The losing party is responsible for paying the SDR entity's fee. (*Id.* at 149.620(g)). HHS has published a sample decision notice, which is helpful in evaluating the standards used for SDR determinations.[12]

- ☐ If you settle the dispute with the patient while the SDR process is pending, notify the SDR entity within 3 business days. (45 CFR 149.620(f)(1)). HHS has published a form for the notice.[13]

- ☐ The SDR determination is generally binding on the parties absent fraud. (45 CFR 149.620(f)(4)). Of course, you still have to collect any amount due directly from the self-pay patient.

**Certain Facilities and Providers: Limits on OON Charges.** Importantly, the limits on OON billing only apply if you are (1) an emergency facility (*i.e.*, a hospital emergency department, hospital outpatient department providing emergency services, or a freestanding emergency department); (2) a health care facility (*i.e.*, a hospital, critical access hospital, hospital outpatient department or ambulatory surgery center); or (3) a provider who furnishes items or services at such facilities. If you fit within these descriptions, comply with the following:

[12] Available at https://www.cms.gov/regulations-and-guidancelegislationpaperworkreductionactof1995pra-listing/cms-10791.
[13] Available at https://www.cms.gov/regulations-and-guidancelegislationpaperworkreductionactof1995pra-listing/cms-10791.

**1. Limits on Balance Billing Insured Patients.**

☐ Post a public notice of patients' rights concerning the limits on balance billing. (45 CFR 149.430(a), (c), (e)). HHS has published a form notice, "Your Rights and Protections Against Surprise Medical Bills," that you may use.[14] The public notice must be posted on your website and in a prominent sign in your facility or publicly accessible location. (*Id.* at 149.430(a), (c)(1)-(2)).

☐ Provide a written notice to insured patients either in-person or through mail or e-mail as selected by the patient. (45 CFR 149.430(c)(3), (e)). The written notice must be given (1) no later than the date and time when the provider or facility requests payment from the patient, or (2) if the provider or facility does not request payment from the patient, no later than the date on which the provider or facility submits a claim to the payer. (*Id.* at 149.430(d)). An OON provider may agree with a facility that the facility will provide the required notice. (*Id*. at 149.430(f)).

☐ Do not balance bill the patient more than the cost-sharing amount established by the regulations unless you obtain the patient's prior notice and consent as required by the regulations. (45 CFR 149.410(a) and 149.420(a)). The cost-sharing amount is usually the in-network cost-sharing amount as applied to the qualified payment amount (QPA).[15]

☐ If you seek to obtain the written notice and consent from the patient to balance bill above the regulatory cost-sharing amount:

  ☐ Confirm that the items or services are subject to the patient consent exception. The consent exception only applies to (1) certain post-stabilization emergency services (45 CFR 149.410(b)); and (2) certain non-emergency services provided by an OON provider at an in-network facility. (*Id*. at 149.420(c)). The consent exception never applies to (1) items or services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished (*id*. at 149.410(c) and 149.420(b)(2)); and (2)

[14] Available at https://www.cms.gov/httpswwwcmsgovregulations-and-guidancelegislationpaperworkreductionactof1995pra-listing/cms-10780. Providers and facilities are not required to use the HHS form but, if not, their notice must contain the elements required by the regulations. (45 CFR 149.430).

[15] The QPA is generally the payer's median contracted rate for the same or similar item or service provided by a provider in the same or similar specialty or facility of the same or similar type and provided in the geographic region in which the item or service is furnished. (*See* 45 CFR 149.140).

certain non-emergency ancillary services provided by OON providers at an in-network facility. (*Id*. at 149.420(b)(1)).[16]

☐ Provide written notice to the patient that contains the information and statements required by 45 CFR 149.410(b)(2)(i)-(ii) and 420(d), including a good faith estimate of the anticipated charges. HHS has published a form, "Surprise Billing Protection Form."[17] The written notice must be provided in written or electronic form as selected by the patient. (*Id.* at 149.420(c)(1)). The notice must be provided: (1) at least 72 hours before the date of service if possible; or (2) on the date of the appointment but at least 3 hours before the service if the appointment was scheduled within 72 hours of the date of service. (*Id*. at 149.420(c)(1)(iii)).

☐ Obtain the patient's signed written consent for balance billing using the HHS form before the items or services are provided.[18] (45 CFR 149.410(b)(2) and .420(c)(2), (e)). The consent must contain the information in 45 CFR 149.420(e).

☐ Give the patient the choice to obtain the notice and consent document in any of the 15 most common languages in the relevant state or geographic region serviced by the facility or obtain a qualified interpreter to explain the notice and consent document to the patient. (45 CFR 149.420(f)).

☐ Provide a copy of the signed written notice and consent to the patient through mail or e-mail as determined by the patient. (45 CFR 149.420(c)(3)).

☐ Maintain the executed notice and consent for seven (7) years. (45 CFR 149.410(d) and .620(h)).

☐ Notify the payer of the patient's consent and provide a copy of the executed notice and consent. (45 CFR 149.410(e) and .420(i)).

[16] Such ancillary services include: (i) items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology; (ii) items and services provided by assistant surgeons, hospitalists, and intensivists; (iii) diagnostic services, including radiology and laboratory services; and (iv) items and services provided by a nonparticipating provider if there is no participating provider who can furnish such item or service at such facility. (45 CFR 149.420(c)).

[17] Available at https://www.cms.gov/httpswwwcmsgovregulations-and-guidancelegislationpaperworkreductionactof1995pra-listing/cms-10780. Providers and facilities may use their own form so long as it contains the elements required by 45 CFR 149.420(b)(2)(i)-(ii) and 420(d).

[18] Available at https://www.cms.gov/httpswwwcmsgovregulations-and-guidancelegislationpaperworkreductionactof1995pra-listing/cms-10780.

2. **Participating in the IDR Process.** If you dispute the OON rate paid by a payer, you may initiate the IDR process.

   ☐ Decide whether IDR is worth it considering the likelihood of success, the non-refundable administrative fee, and the IDR entity predetermined fee. As currently established, the IDR process is skewed heavily in favor of the QPA and chances are that the offer closest to the QPA will be selected.[19]

   ☐ Within 30 business days after receiving the partial payment or denial from the payer, initiate the 30-day open negotiation by submitting the "Open Negotiation Notice" form[20] to the payer via mail or e-mail. (45 CFR 149.510(b)(1)).

   ☐ If you and the payer cannot agree during the 30-day open negotiation period, request IDR within 4 business days after the 30-day open negotiation period ends by submitting the "Notice of IDR Initiation" form[21] to HHS via the Federal IDR portal and to the payer via mail or e-mail. (45 CFR 149.510(b)(2)). A party may not initiate the IDR process if the party obtained notice and consent from the patient to balance bill above the regulatory cost-sharing amount. (*Id*. at 149.510(b)(2)(iii)).

   ☐ Within 4 days after IDR is initiated, attempt to agree on an IDR entity. (45 CFR 149.510(c)(1)). If the parties cannot agree, HHS will appoint the IDR entity, which may result in higher costs. The IDR entity will notify the parties of its selection. (*Id*. at 149.510(c)(1)(iii)).

   ☐ Submit the IDR non-refundable administrative fee at the time the IDR entity is selected. (45 CFR 149.510(d)(2)). Note: this is different than the IDR entity predetermined fee described below.

   ☐ Within 10 days after the IDR entity's selection, submit (1) the OON rate offer (as both a dollar amount and percentage of QPA) and any supporting documentation used to support the offer, and (2) the IDR entity's predetermined fee. (45 CFR 164.510(c)(4) and (d)(1)). Relevant information may include items such as the provider's training, experience, quality, outcomes, and market share; the acuity of patient or complexity of item or service; the facility's teaching status; case mix scope of services; and prior network agreements between the parties. (*Id*. at 149.510(c)(4)(i)(A), (iii)). Prohibited information includes the provider's usual and customary charges; amounts the provider would have charged but for the limit on balance billing; and/or

[19] Providers and industry groups have sued HHS challenging the weight that is placed on the QPA.
[20] Available at https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/no-surprises-act.
[21] Available at https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/no-surprises-act.

amounts or reimbursement rates payable by a public payer. (*Id*. at 149.510(c)(4)(v)). The DOL has published a helpful list of data elements to include in the offer.[22]

☐ Within 30 days after the IDR entity's selection, the IDR issues its written decision. (45 CFR 149.510(c)(4)(ii), (vi)). The IDR entity must select the offer closest to the QPA unless credible information submitted by the parties clearly demonstrates that the QPA is materially different from the appropriate OON rate. (*Id*. at 149.510(c)(4)(ii)(A)).

☐ Within 30 days after the IDR entity's decision, the losing party must pay any balance due the other party. The losing party remains liable for the IDR entity's fee; the prevailing party's fee is refunded. (45 CFR 149.510(c)(4)(vii)-(ix))

☐ If the parties settle the dispute while the IDR is pending, notify the IDR entity through the Federal IDR portal within 3 business days. (45 CFR 149.510(c)(2)).

☐ The losing party must pay any amount due within 30 days after the determination by the IDR entity. (45 CFR 149.510(c)(4)(ix)). The prevailing party will have its IDR fee returned. (*Id.* at 149.510(d)(1)).

☐ If you are the party initiating IDR, do not submit additional IDR notifications involving the same parties and similar items or services for 90 calendar days after the IDR entity determination. (45 CFR 149.510(c)(4)(vii)).

**FUTURE DEVELOPMENTS.** The No Surprise Billing Rules were issued as interim final rules. The rules may change based on comments, experience, or pending litigation. In addition, expect more regulations in the future implementing the No Surprises Act. Stay tuned…

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[22] Available at https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/no-surprises-act.