Surprise Billing Requirements

Updated November 24, 2021 - During July and September of 2021, the Centers for Medicare and Medicaid Services (CMS) introduced a series of three rules (Requirements Related to Surprise Billing; Part I; Reporting Requirements Regarding Air Ambulance Services, Agent and Broker Disclosure Requirements and HHS Enforcement; and Requirements Related to Surprise Billing; Part II) that collectively implement the No Surprises Act. With an effective date of January 1, 2022, the rules prohibit balance billing for emergency and certain non-emergency services, and air ambulance service, provided by out-of-network providers without patient consent, and limit patient cost-sharing.

Overview

In December of 2020, the No Surprises Act was passed as part of the Consolidated Appropriations Act, with the goal of protecting consumers from surprise medical bills. A surprise medical bill is an unexpected "balance bill" in which an out-of-network provider bills a patient for the difference between the bill charged and the amount paid by the patient's health plan. Federal health insurance plans such as Medicare and Medicaid already prohibit balance billing. The rules provide important protections to consumers who do not receive coverage through federal programs, and for those who are uninsured.

Requirements

Beginning January 1, 2022, providers are required to comply with the provisions of the Surprise Billing rules. The regulations impact healthcare facilities with physicians who provide services at in-network facilities but are not themselves in-network for respective health plans. CMS has launched a resource page to assist providers with navigating the regulations, and below is a high-level overview of the key requirements that healthcare organizations and providers should be aware of.

Balance Billing & Consent

The Requirements Related to Surprise Billing; Part I final rule, released July 17, 2021, prohibits out-of-network providers, healthcare facilities, and providers of air ambulance services from balance billing patients in certain situations. Providers and facilities are permitted to balance bill individuals if the following notice requirements are satisfied, and consent from the patient is received. (The notice and consent exception does not apply to out-of-network providers of radiology, pathology, emergency, anesthesiology, diagnostic and neonatal services; assistant surgeons, hospitalists, intensivists, and providers offering services when no other in-network provider is available.)

- For appointments made with an out-of-network provider, notice must be provided prior to the appointment, or on the date the appointment is made if the appointment is scheduled within 72 hours of the date of the appointment. If the appointment is made the same day, the services are furnished, notice must be provided 3 hours prior to the scheduled services.
- Notice must be provided using the standard notice document provided by HHS, and must include information specific to the individual, including a good faith estimate of services.

Note: This information is based on what we know today and is subject to change.

- Notice must also include a list of in-network providers at the facility and information regarding medical care management, such as prior authorization.

CMS has established a federal independent dispute resolution process that may be used to determine the OON rate after an unsuccessful open negotiation.

Disclosures

The rule also requires healthcare facilities and providers to provide disclosures of federal and state patient protections against balance billing, as well as information on contacting appropriate State and Federal agencies in the case of a violation. The notice must be made available using the following methods:

- Publicly available (i.e., if applicable, on a public website that can be accessed via search engines)
- Provided directly to individuals who are "participants, beneficiaries, or enrollees of a group health plan or individual health insurance coverage offered by a health insurance issuer" in person or through mail or email
- Displayed on a sign posted prominently at the location of the healthcare provider or healthcare facility.

Good Faith Estimates

Beginning January 1, 2022, providers and facilities must give uninsured (self-pay) patients "a good faith estimate" when a visit is scheduled or when it is requested. The estimate must include any item or service that is reasonably expected to be provided in conjunction with the requested service, including those from co-providers and co-facilities. Note: CMS will exercise enforcement discretion during 2022 in situations where the estimate does not include outside charges. (Requirements Related to Surprise Billing; Part I and Requirements Related to Surprise Billing; Part II)

There are a number of requirements for providers and facilities providing "good faith estimates":

- The provider or facility scheduling the appointment must contact all applicable co-providers and co-facilities no later than 1 business day after the request for the good faith estimate is received or after the primary item or service is scheduled, and request submission of expected charges for items or services that meet the requirements for co-providers and co-facilities.
- For an appointment/service scheduled at least 3 business days in advance, the good faith estimate shall be provided no later than 1 business day after the date of scheduling.
- In the case of an appointment or service scheduled at least 10 business days in advance, the good faith estimate shall be provided no later than 3 business days after the date of such scheduling or such request.
- If the estimate information changes, the provider or facility must issue a new good faith estimate no later than 1 business day before the item or service is scheduled to be furnished.
- If there are any changes in expected providers or facilities represented in a good faith estimate less than 1 business day before the item or service is scheduled to be furnished, the replacement provider or replacement facility must accept the good faith estimate as their expected charges.
- If a patient requests an estimate and then schedules the appointment, the provider or facility should review the previous estimate and must issue a new estimate and explain any changes.
- For recurring items or services (i.e., therapy after surgery) the provider or facility may issue a single good faith estimate for recurring primary items or services.
    - Must include in a clear and understandable manner the expected scope of the recurring items or services, such as time frames and total number of recurring items or services.

- New estimate to be prepared after 12 months, including an explanation of what has changed.

MEDITECH's Next Steps

At this time, CMS has not provided any standard list of Remittance Codes (CARCs or RARCs) to identify services provided out-of-network, and we are not aware of any standard lists from insurance companies. Without a standard list, we are unable to leverage any of the functionality within remittances or denial management. MEDITECH continues to perform research to identify best practice workflows, and is developing guidance that will outline how organizations can use existing functionality to manually identify out-of-network services. If you have been provided a list of standard codes from insurance companies, MEDITECH Patient Accounting can assist with leveraging existing functionality to use these for identifying out-of-network services.

MEDITECH published KB documents with guidance on existing functionality that can assist with manual identification of out-of-network services (Expanse/6x & C/S, MG). In addition, we continue to research automated identification of accounts. If you are interested in participating in interviews as part of MEDITECH's research, please reach out to your Client Services Patient Accounting specialist.

Resources

- CMS Fact Sheet: Surprise Billing, Part 1
- CMS Fact Sheet: Surprise Billing, Part 2
- CMS No Surprises Resource Page
- AMA Summary of the No Surprises Act

Questions

Please contact the MEDITECH Regulatory Mailbox.