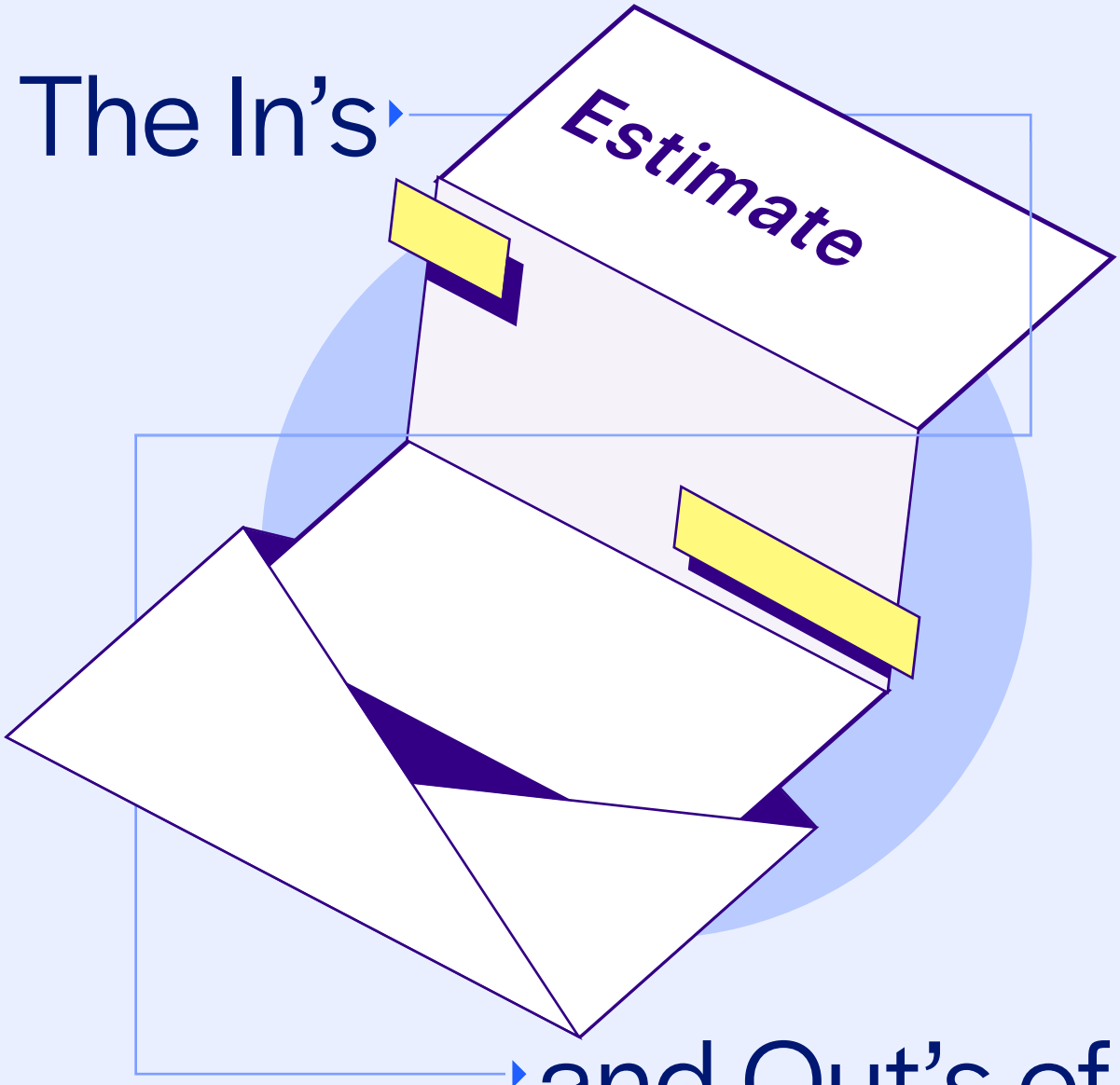
A riveting ebook by rivet

The In's and Out's of the Good Faith Estimate



What is a Good Faith Estimate (GFE)?

To understand the Good Faith Estimate (GFE), let's first dive into the No Surprises Act; the legislation in which the GFE is found. Effective January 1, 2022, the No Surprises Act (NSA) is a collection of federal rules designed by the Department of Health and Human Services (HHS) with other federal departments to protect patients from surprises in medical costs. Specifically, the NSA protects self-pay [1] patients from receiving bills that are substantially more than expected, and protects insured patients from receiving unexpected bills from out-of-network (OON) facilities or providers for certain emergency or non-emergency services.

To protect self-pay patients from receiving bills for substantially more than expected, the NSA requires virtually all healthcare facilities and providers to 1) notify self-pay patients of their right to obtain a GFE of anticipated charges; and 2) provide a GFE of charges to the self-pay patient before items or services are rendered.

Something to keep in mind: If the actual charges billed are $400 or more than the GFE, the self-pay patient may initiate what's called the selected dispute resolution (SDR) process [2] to determine what the patient must pay.

Healthcare providers and facilities are currently only federally required to offer GFEs to self-pay patients in 2022; however, some states may require GFEs for insured patients (e.g., Indiana and Ohio). Check your local laws to be sure you are providing estimates compliant with your state legislation.

The basic 2022 GFE to-do list[3]

- [ ] Post the notice "Right to Receive a Good Faith Estimate of Expected Charges" from the Centers for Medicaid and Medicare Services (CMS) in languages spoken by your patients.
  Where to post: On the provider's or facility's website, in the office, and wherever scheduling or questions about healthcare cost occurs.
- [ ] Ask patients if they are not covered by a group plan, individual or group insurance, or federal health care program. If insured, ask if the patient does not want to submit the claim to the group plan or insurer.
- [ ] Tell the self-pay patient (in the language they speak) that they have the right to a GFE upon scheduling or request.
- [ ] Provide a GFE to the self-pay patient who asks about costs, requests a GFE, or schedules services. [4]
- [ ] Ensure the GFE is complete and accurate and includes all of the required elements and disclaimers.
  The patient may be eligible to initiate the SDR process for incomplete or inaccurate GFEs, so it is imperative to provide new, more accurate GFEs if changes are made to planned care before services are rendered.
- [ ] Provide the GFE on paper or electronically, depending on the patient's preference, within the set time frames established in the NSA.

[1] Self-pay in this context refers to patients without insurance coverage or who do not seek to use their plan or coverage.

[2] For GFEs, the SDR process is also known as the patient-provider dispute resolution (PPDR) process. For OON balance billing, the SDR process is known as the independent dispute resolution (IDR) process.

[3] Adapted from Kim Stanger's "No Surprises Billing Rules: Checklist for Providers"

[4] GFEs are not necessary for care or services that aren't typically planned (i.e., emergency urgent care or emergency trauma services).

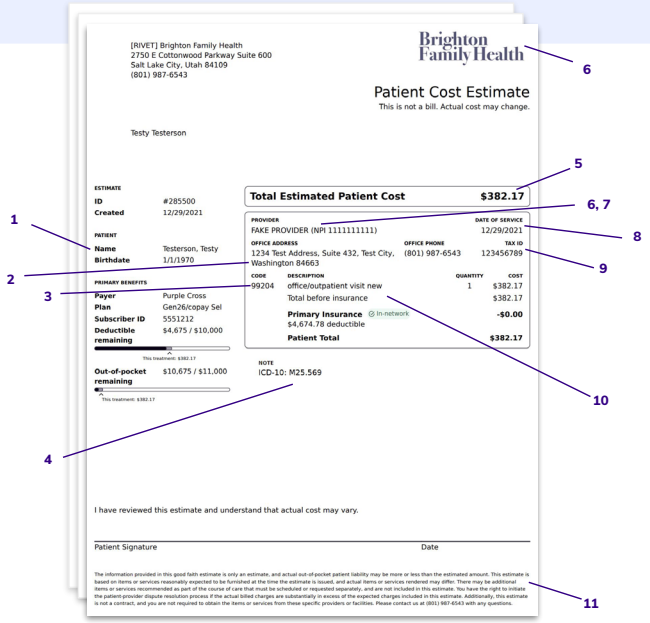
GFE requirements

Every GFE needs to have the patient's name and date of birth, the office or facility location(s), service codes, diagnosis codes, expected charges, names of providers and facilities, national provider identifier (NPI), date(s) of service(s), tax ID number, disclaimers, description of primary item or service; and an itemized list of items and services, grouped by each provider or facility.

CMS has a free downloadable template that can be utilized to stay compliant; however, Rivet's software not only allows providers to offer clean good faith estimates for insured and self-pay patients, providers can also check eligibility, manage their payer contracts, and collect up-front payment from patients.

Below are descriptions of each data element needed and how Rivet's software is compliant with these requirements.

How Rivet's Good Faith Estimates (GEFs) Comply with the No Surpises Act



Good Faith Estimates Must Include		
1	Patient name & birthdate	First name, last name and date of birth for the patient receiving items or services.
2	Office or facility location(s)	Physical address, including street name and number, city, state and zip code for all providers and facilities involved.
3	Service codes	Description of an item or service using CPT, HCPCS, DRG or NDC codes.
4	Diagnosis codes	The code that describes the patient's disease, disorder, injury and other related health conditions using the current ICD code set.
5	Expected charges	Expected charges associated with each listed item or service.
6	Names of providers & facilities	First Name, last name, title of provider(s) and legal name of facility(ies) as written on their business license.
7	National Provider Identifier (NPI)	Number associated with the provider or facility.
8	Date(s) of Service(s) (if applicable)	When service(s) will be offered to the patient.
9	Tax Identification Number (TIN)	Provider or facility's TIN, employer ID number (EIN) or federal TIN (FTIN) issued by the IRS.
10	Description of primary item or service and an itemized list of items and services, grouped by each provider or facility	A clear, understandable description of primary item or service to be furnished by the convening provider(s) or facility(ies) (as defined for purposes of 45 CFR 149.610).
11	Disclaimer information	Disclaimer that states the following information: a) The GFE is an estimate and subject to change. b) There may be additional items or services not contained in this GFE. c) The patient has the right to initiate the patient-provider dispute resolution process. d) The GFE is not a contract.

*Good Faith Estimates (GFEs) are oly federally required for uninsured (self-pay) individuals, but we recommend that you consult your state's legislation to determine whether GFEs are required for all patients in your area.

The NSA requires national drug codes (NDCs) and Rivet is currently making updates to accommodate this requirement. Currently, Rivet's notes section can be utilized to put in NDCs.

How fast do providers need to provide a GFE?

Situation	Provide the GFE:
An item or service is scheduled 3–9 business days before the date of the item or service is rendered.	No later than 1 business day after the date of scheduling.
An item or service is scheduled at least 10 business days before the date of the item or service is rendered.	No later than 3 business days after the date of scheduling.
A self-pay patient requests a GFE.	No later than 3 business days after the date of the request.
Changes to the original GFE are anticipated (e.g., changes to the charges, items, services, providers or facilities, etc.).	No later than 1 business day before the items or services are scheduled to be rendered.

Note: If changes to providers or facilities are made less than 1 business day before the scheduled item or service, the replacement provider or facility must accept the previous GFE as their GFE. Always be sure to check for any prior GFE before assuming care less than 1 business day before the scheduled item or service.

When should providers consider providing a recurring estimate?

A provider or facility may issue a single GFE for recurring items or services if the following conditions are met:

- The GFE specifies the expected scope of recurring items or services such as timeframes, frequency, and total number of items or services.
- The scope of a GFE does not exceed 12 months of expected care.

How long do providers need to maintain GFEs?

A copy of the GFE should be maintained as part of the self-pay patient's medical record for at least 6 years. Self-pay patients may request a copy of any GFE issued within the prior 6 years.

What is a convening provider or facility GFE?

The "convening provider or facility" is essentially the provider or facility responsible for the primary item or service. Under the NSA, they are the one that is ultimately responsible for providing a comprehensive estimate that includes all charges from "co-providers" and/or "co-facilities" that furnish items or services that are provided in conjunction with a primary item or service.

For example, a hospital may furnish a surgery, but as part of that surgery the self-pay patient may need anesthesia from a co-provider. The hospital (the convening facility in this case) needs to provide a GFE with charges pertaining to the surgery and anesthesia (the co-provider charge in this case).

The HHS has determined that enforcement of the convening provider part of the legislation will start beginning 2023. That means the entirety of 2022 is a time to explore how to alter processes and policies to accommodate for convening provider/facility estimates.

Do separately scheduled services need to be on the convening provider/facility GFE?

Short answer: Yes.

Better answer: Providers should offer a GFE that has everything they should know is in their future. Like with knee surgery, the patient will likely need physical therapy. However, physical therapy may be scheduled separately from the surgery itself, and may be offered through a co-provider or facility. In this type of situation, the provider need only offer a list of services that the patient will need to schedule separately from the primary service. Diagnosis codes, service codes and expected charges do not need to be part of this estimate.

Above the separately scheduled items/services, the convening provider/facility should insert a disclaimer like this one from CMS that is compliant with the NSA:

> Separate Good Faith Estimates will be issued by designated provider(s) or facility(ies) for the following items and/or services upon scheduling or request.

What is the SDR process?

If the actual charges are $400 or more than the expected charges on the GFE, the patient may initiate the selected dispute resolution (SDR) process, or the process by which a patient may utilize a third party to dispute their claim and possibly reduce or eliminate charges. The patient must initiate the SDR process within 120 days after receiving the disputed bill. Remember: 120 days does NOT start on the date of service but the date upon receiving the bill.

To initiate the process, the patient must submit notice and administrative fee to the SDR entity. If the SDR entity believes the disputed claim is appropriate for SDR, the SDR entity will notify the provider and request required information from the provider. Providers have 10 days to submit the required information.

Once the provider receives notice of SDR process initiation, providers may NOT move the self-pay patient's bill for disputed item or service into collection or threaten the patient to do so. If the patient's bill has already gone into collection, collection efforts must stop. Any accrual of late fees on unpaid bills must also stop. Retributive action must not be taken or threatened to be taken against the patient.

Providers will need to gather the following required information upon receiving notice from the SDR entity of the instigation of the SDR process:

- A copy of the GFE provided to the self-pay patient
- A copy of the billed charges
- If available, documentation that demonstrates the difference between the billed charge and the GFE:
  - reflects the cost of a medically necessary item or service
  - and is based on unforeseen circumstances that could not have reasonably been anticipated by the provider or facility at the time the GFE was provided

Within 30 days (after providers send required documentation) the SDR entity will determine who is responsible for payment. The losing party is responsible for paying the SDR entity's fee. See the HHS sample decision notice for more information.

At any point while the SDR process is pending, the provider and the patient may settle the dispute on their own. If settlement occurs outside of the SDR process, the provider must notify the SDR entity within 3 business days of settlement. The HHS published a form to provide notice to the SDR entity.

The SDR determination is binding (unless in cases of fraud). The provider will still have to collect any amount due directly from the patient and regular collection efforts may resume in these instances.

What else do providers need to know? ASCs?

The NSA also has limits on out-of-network (OON) charges for insured patients. This part of the bill affects emergency facilities, health care facilities (i.e., an ambulatory surgical center (ASC), hospital, critical access hospital, or hospital outpatient department), or a provider who furnishes items or services at such facilities.

To-do list[5]:

- ☐ Post a public notice on the provider's website and in the provider's facility of patients' rights concerning limits on balance billing. Use HHS's published form notice "Your Rights and Protections Against Surprise Medical Bills."
- ☐ Provide a written notice to insured patients either on paper in person or via mail or email, depending on patient preference. An OON provider may have an agreement with a facility that the facility will provide such notice.
  "Written notice must be given (1) no later than the date and time 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." [6]
- ☐ Do not balance bill the patient more than the cost-sharing amount unless you obtain the patient's prior notice and consent as required by the NSA. The cost-sharing amount is typically the in-network cost-sharing amount as applied to the qualified payment amount (QPA).

How do providers obtain written notice and consent from a patient?

If you'd like to obtain written notice and consent from the patient to balance bill above the aforementioned cost-sharing amount, you should confirm that the items or services are, in fact, part of the patient consent exception.

Notice and consent to balance bill applies to:

- Certain post-stabilization emergency services and certain non-emergency services provided by an OON provider at an in-network facility.

The consent exception does NOT apply to:

- Items or services rendered as a result of unforeseen, urgent medical needs that arise at the time an item and/or service is furnished.
- Certain non-emergency ancillary services provided by OON providers at in-network facilities.[7]

If you are eligible to obtain written notice and consent from the patient to balance bill, you must provide written notice to the patient that contains the information and statements required by the NSA[8], including a GFE of anticipated charges. HHS published a sample form, "Surprise Billing Protection Form" that you can use.

[5]Adapted from Kim Stanger's "No Surprises Billing Rules: Checklist for Providers." [6]Quoted from Kim Stanger's "No Surprises Billing Rules: Checklist for Providers."

[7]Certain 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.

[8]See the NSA legislation: 45 CFR 149.410(b)(2)(i)-(ii) and 420(d).

Written notice must be provided in paper or electronic form, depending on patient preference. You must obtain the patient's signed written consent for balance billing before proceeding with care. The notice must be provided at least 72 hours before the date of service. If the appointment is made within 72 hours of the date of service, notice must be given at least 3 hours before the appointment.

The notice and consent document must be available in the 15 most common languages in your state or geographic region or you must provide a qualified interpreter to explain the notice and consent document to the patient.

After all of the previous work is done, you'll need to:

- Provide a copy of the signed written notice and consent to the patient via mail or email, depending on patient preference.
- Keep record of the notice and consent for 7 years.
- Notify the payer of the patient's consent with a copy of the notice and consent.

Much like the SDR process, OON balance billing has their own dispute resolution process called the independent dispute resolution (IDR) process. To learn more about the IDR process, visit dol.gov.

Resources

Need-to-know

CMS fact sheet on surprise medical bills

CMS main information page

CMS PDF templates

CMS regulations and guidance

CMS start a dispute website (for self-pay patients)

No Surprises Act part 1 (surprise billing requirements)

No Surprises Act part 2 (GFE requirements)

No Surprise Billing Rules: Checklist for Providers by Kim Stanger

U.S. Department of Labor NSA resource page

State surprise billing laws

Commonwealth Fund article "Have Surprise Billing Laws Lowered Healthcare Prices?"

Federal Trade Commission will study the NSA

HHS press release about the NSA

Indiana good faith estimate legislation

Maine No Surprises bill

National Conference of State Legislatures state actions on transparency of health costs

National Conference of State Legislatures surprise and balance billing state policy options

Notice of IDR initiation

Ohio No Surprises legislation

PEW Trusts "Surprise Medical Billing: Some States Ahead of Feds"

rivet

Shameless Plug

Rivet's Estimates software offers accurate good faith estimates that you can send to patients via HIPAA-compliant text and/or email, or print out the estimate right in your office. Patients will see their deductible/out-of-pocket maximum met, diagnostic codes, their financial responsibility and their plan's financial responsibility, prior authorization flags, customized disclaimers and more.

See how you might use Rivet Estimates at your practice:

Rivet Estimates

Visit Rivethealth.com for more information.

Estimates

Rivet Estimates is an eligibility and cost estimate tool that offers you:

Eligibility Checks
Verify eligibility before upcoming appointments.

Cost Estimates
Provide accurate patient cost estimates, even for multiple payers, treatments, facilities or providers.

Up-front Patient Payments
Collect payment from patients before service is rendered via SMS text message or email, reducing A/R days.

Payer Contract Management
Model and manage payer contracts, rates and fee schedules.

When would I use Estimates?

Day-to-day issues you encounter	How Rivet Intelligence **helps**
I have a full schedule of patient appointments that need eligibility checks.	→ **Pull in your upcoming appointments** and automate eligibility days before your patients come to the office.
I have patients with complicated circumstances such as multiple payers, treatments, providers and facilities, so I can't provide a good estimate for them.	→ **Estimate patient responsibility for patients** with multiple levels of coverage, taking into account what earlier payers will pay. **Create a single comprehensive estimate for patients** who will see multiple providers; have multiple visits; or receive care comprising facility, non-facility, and/or ASC services.
I want to collect up-front payment, but estimates take so long and are often inaccurate.	→ **Offer patients accurate estimates** and provide full or partial payment options through PHI compliant text messages or email.
I juggle a lot of contracts and fee schedules.	→ **Rivet will set you up to boost your revenue** this year: you'll know the status of your contracts quickly and prepare for an upcoming meeting easily.

"With changing coverages, deductibles, and eligibility, it can be hard to produce truly accurate estimates at scale. However, with Rivet, **running eligibility and estimates is a quick, one-stop shop."**

— Kellie Ickowski, Practice Administrator, Audubon Women's Medical Associates

Interested to see more of Rivet's modern revenue cycle product suite? **Find out more at rivethealth.com.**