



American Medical
Association™ Toolkit
for Physicians:
**Preparing for
Implementation of
the No Surprises Act**

JANUARY 2022



AMERICAN MEDICAL ASSOCIATION™ TOOLKIT FOR PHYSICIANS: PREPARING FOR IMPLEMENTATION OF THE NO SURPRISES ACT

THIS AMA® TOOLKIT FOR PHYSICIANS:

PREPARING FOR IMPLEMENTATION OF THE NO SURPRISES ACT

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Introduction to the No Surprises Act and this toolkit

The federal No Surprises Act (NSA)¹ prohibits out-of-network health care providers² and facilities from balance billing commercially insured patients, in certain circumstances. The NSA and its implementing regulations set a method for determining the patient cost-sharing for these out-of-network situations, and when state law does not establish a provider payment methodology, the NSA establishes an independent dispute resolution (IDR) arbitration system to establish provider payment.³

This toolkit focuses on three operational challenges that physicians will need to address immediately in order to be compliant with the new requirements. Each is addressed in a separate part of this toolkit.

- **Part I: Non-emergency services at in-network facilities** — notice and consent requirements that allow out-of-network physicians to balance bill when seeing patients at in-network facilities, as well as situations in which such patient consent is not or cannot be obtained.
- **Part II: Emergency services and post-stabilization care at hospitals or freestanding emergency departments** — rules applicable to emergency care, especially circumstances in which out-of-network providers can balance bill for care after an out-of-network emergency.
- **Part III: Good faith estimates (GFEs) for self-pay and uninsured patients** — obligations to provide a GFE of provider charges for scheduled self-pay and uninsured patients, including dispute resolution for bills substantially in excess of the GFE.

WHEN DO THE NSA RULES ON SURPRISE MEDICAL BILLING APPLY?

The NSA rules apply to:

1. Out-of-network emergency services provided at a hospital emergency department or independent freestanding emergency department or by air ambulance (but not ground ambulance)
2. Nonemergency care rendered by out-of-network providers at an in-network hospital or ASC unless the patient has consented to be treated by an out-of-network provider and agrees to be balance billed

WHEN ARE THE NSA RULES EFFECTIVE?

The NSA prohibition on balance billing as well as its principal implementing regulations apply beginning **January 1, 2022**.

WHAT DO PHYSICIANS NEED TO KNOW NOW ABOUT THE FEDERAL INDEPENDENT DISPUTE RESOLUTION (IDR) PROCESS FOR CERTAIN OUT-OF-NETWORK BILLS?

The IDR process for provider payment by health plans of out-of-network bills is established in regulation at 45 C.F.R. § 149.510. In general, health plans have 30 days to make an initial payment after receiving a claim. If the provider is unhappy with the initial payment amount, the provider has 30 days to initiate an open negotiation period, which is itself 30 days long. The IDR process may then be triggered during the four business days after the end of the negotiation period. The federal IDR process does not apply to provider charges to which a state methodology applies for determining out-of-network payment. This toolkit does not focus on the IDR process in detail, because physicians do not need to take immediate action with respect to it, but physicians who receive payment for out-of-network care should be aware of these deadlines to initiate negotiation and the IDR process. The IDR process will be addressed in future AMA™ resources.

WHAT OTHER REQUIREMENTS APPLY TO PHYSICIANS UNDER THE NSA, BEYOND THOSE ADDRESSED IN LATER SECTIONS OF THIS TOOLKIT?

The NSA and its implementing regulations set certain additional requirements that physicians should be aware of:

- **Provider and facility disclosure requirements** — each provider, hospital and ASC is required to make publicly available, including on its website and to each patient who is enrolled in commercial health coverage, a disclosure regarding the patient protections against balance billing. The U.S. Department of Health and Human Services (HHS) has created a model notice that providers and facilities should use. The notice must be provided individually to commercially insured patients, including those in the Federal Employees Health Benefits Program (FEHBP), no later than the time a bill is sent to the patient or a claim for payment is submitted to a health plan. Model notice and instructions are available here: www.cms.gov/files/document/model-disclosure-notice-patient-protections-against-surprise-billing-providers-facilities-health.pdf.
 - Providers only need to provide notice if they provide care in a hospital or an ASC, or in connection with a visit to a hospital or an ASC. Providers do not need to post the notice at their location or furnish it to patients if the hospital or ASC does so. Providers should enter written agreements for the facilities to provide these notices.
 - Providers still need to post the notice on their website, if they have one.
- **GFEs for insured patients** — the federal government has delayed implementation of the requirement that health care providers generate a GFE of charges for scheduled services for *insured* patients, until the government issues regulations on this topic.⁴ The requirement to provide a GFE to uninsured and self-pay patients **is** applicable beginning Jan. 1, 2022, and is discussed in the third part of this toolkit.
- **Health plan directory updates** — under the NSA, health plans will be required to establish a system to verify the accuracy of their provider directory information every 90 days. Providers are required to ensure timely provision of this information to health plans, when there are material changes.⁵ Additional information on new provider directory requirements will be addressed in future AMA™ resources.
- **Continuity of care** — for up to 90 days after a contract termination, each provider is required to adhere to the former contract's payment rates and other policies, for continuing care patients.⁶

Part I: Nonemergency services at in-network facilities

For nonemergency services, the No Surprises Act (NSA) balance billing rules apply when an out-of-network provider treats a patient at certain in-network facilities.

WHAT TYPES OF NONEMERGENCY CARE CAN BE SUBJECT TO THE PROHIBITION ON BALANCE BILLING?

Care provided in hospitals, hospital outpatient departments, critical access hospitals and ambulatory surgery centers (ASCs) is subject to the prohibition on balance billing.⁷

WHAT RULES APPLY TO THESE SETTINGS?

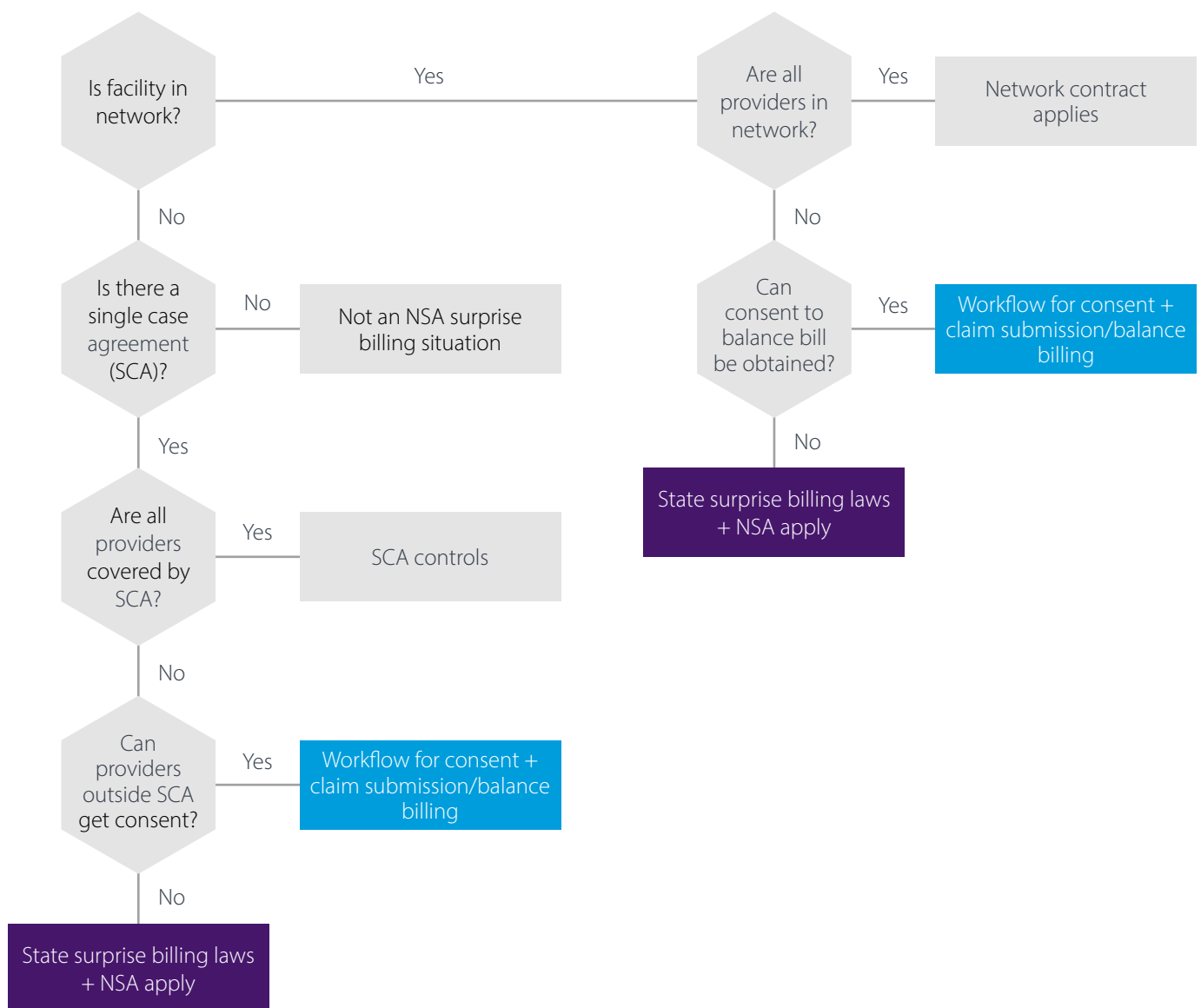
The basic rule is that when an *out-of-network* provider treats a patient covered by commercial health coverage at one of these in-network facilities, the provider may collect only the in-network cost-sharing from the patient and may not balance bill, unless the provider has furnished advance notice to the patient and obtained the patient's written consent to balance bill (for those providers and services where the rules permit the patient to give consent to be balance billed).⁸

HOW DOES AN OUT-OF-NETWORK PROVIDER RECEIVE PAYMENT IN A NONEMERGENCY SURPRISE BILLING SITUATION?

The amount of out-of-network payment by the health plan is governed by the state's surprise billing law, or if there is no state law or the state law does not apply to the patient's plan or service, the federal independent dispute resolution (IDR) process can be used to determine payment.

Figure 1 is a decision tree to illustrate, in general terms, which rules apply to various nonemergency situations.

FIGURE 1. NONEMERGENCY SERVICES NSA DECISION TREE



Notice and consent to balance bill

Facilities and providers should understand when and how they can obtain a patient's consent to bill for out-of-network care at an in-network facility.

IN WHICH NONEMERGENCY SITUATIONS DOES THE PROHIBITION ON BALANCE BILLING ALWAYS APPLY AND THE PROVIDER IS NOT PERMITTED TO SEEK CONSENT TO BALANCE BILL AT ITS OUT-OF-NETWORK RATE?

The NSA rules on nonemergency services apply only to services performed at an in-network hospital or ASC. A provider is **not permitted** to obtain the patient's consent for the following services.⁹ If an out-of-network provider performs these services at an in-network hospital or ASC, the provider will always be limited to collecting the in-network cost-sharing and may not balance bill:

- Items and services related to emergency medicine, anesthesiology, pathology, radiology and neonatology, whether provided by a physician or non-physician practitioner
- Items and services provided by assistant surgeons, hospitalists and intensivists
- Diagnostic services, including radiology and laboratory services
- Items and services provided by a nonparticipating provider if there is no participating provider who can furnish such item or service at such facility
- Items or services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished, regardless of whether the provider previously obtained consent to balance bill

WHEN AN OUT-OF-NETWORK PROVIDER AT AN IN-NETWORK FACILITY IS PERMITTED TO SEEK PATIENT CONSENT TO PROVIDE CARE AT AN OUT-OF-NETWORK RATE, HOW DOES THE PROVIDER DO SO?

HHS has developed a standard notice and consent form that nonparticipating providers must use to obtain consent to balance bill, unless a state has developed its own form that satisfies the federal requirements.¹⁰ The current version of the federal standard notice and its instructions for use are available here: www.cms.gov/files/document/standard-notice-consent-forms-nonparticipating-providers-emergency-facilities-regarding-consumer.pdf.

- If an appointment is made at least 72 hours in advance, the notice and consent must be furnished to the patient at least 72 hours in advance.
- If the appointment is made less than 72 hours in advance, the notice and consent must be furnished the day the appointment is made but at least three hours before the appointment.
- To complete the notice, the provider must include an estimate of charges.
- The patient may revoke in writing his or her consent to balance bill prior to the provision of care.
- The provider must furnish the notice and consent in any of the 15 most commonly spoken languages in the provider's region and must provide an interpreter if the patient speaks a different language.

WHAT DOCUMENT RETENTION REQUIREMENTS APPLY WHEN A PROVIDER OBTAINS CONSENT TO BALANCE BILL?

If the in-network facility assists in obtaining the consent, it must retain the consent for seven years. If the out-of-network provider directly obtains the consent, the out-of-network provider must retain the consent for seven years or arrange for the facility to do so.

HOW DOES THE PROVIDER NOTIFY THE HEALTH PLAN THAT IT OBTAINED CONSENT TO BALANCE BILL?

When submitting a claim to a health plan, the out-of-network provider must indicate that the service was rendered during a visit to an in-network facility and, if applicable, provide a copy of the signed consent to bill at their out-of-network rate. When the provider bills the patient directly, the provider may satisfy this requirement by including a copy of the signed consent with the bill.

Part II: Emergency services and post-stabilization care at hospitals or freestanding emergency departments

When out-of-network emergency services are provided to a commercially covered patient at a hospital emergency department or an independent freestanding emergency department, the No Surprises Act (NSA) prohibition on balance billing applies to services necessary to evaluate and stabilize the patient. The facility and providers may charge the patient only the applicable in-network cost-sharing.¹¹ The NSA also largely applies to post-stabilization care as part of the same visit in which emergency treatment occurred, although patients and providers have some options to navigate in determining whether the balance billing prohibition applies for post-stabilization care.

WHAT IS “POST-STABILIZATION” CARE?

Post-stabilization care is observation, inpatient or outpatient care that is part of the emergency visit after the patient is stabilized; it can be in any department of the hospital that provided the evaluation and stabilization of the emergency medical condition.¹³

WHAT RULES APPLY WHEN THE PATIENT HAS NOT CONSENTED TO OUT-OF-NETWORK POST-STABILIZATION CARE?

If the patient has not been given the opportunity to consent to treatment by an out-of-network provider or facility for post-stabilization care, the provider and facility are limited to charging the patient the in-network cost-sharing (and out-of-network payment by the health plan is subject to state law or the federal independent dispute resolution process).

HOW IS “EMERGENCY MEDICAL CONDITION” DEFINED FOR THE PURPOSE OF THESE RULES?

For the purpose of these rules, an emergency medical condition means acute symptoms of sufficient severity “that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in” serious jeopardy to the individual’s (or unborn child’s) health, serious impairment to bodily function or serious dysfunction of an organ.¹²

WHEN MAY AN OUT-OF-NETWORK PROVIDER OR FACILITY SEEK PATIENT CONSENT TO PROVIDE POST-STABILIZATION CARE AT OUT-OF-NETWORK RATES?

An out-of-network provider or facility is permitted to balance bill the patient if the following conditions are met:

1. The treating provider determines the patient would be able to travel to a network provider using nonemergency medical transportation or nonmedical transportation in light of the patient's condition. The provider's determination is binding on the facility.
2. The out-of-network provider or facility provides the patient written notice and the patient consents to out-of-network post-stabilization care, using the form prescribed by HHS, unless a state has established a form that satisfies federal standards. The current version of the federal standard notice and its instructions for use are available here: www.cms.gov/files/document/standard-notice-consent-forms-nonparticipating-providers-emergency-facilities-regarding-consumer.pdf.
 - a. The notice must include any network providers at the facility who could provide the service and notify the patient of the option to be referred to such a provider.
 - b. The notice is required to be provided at least three hours before the post-stabilization care is furnished.
 - c. To complete the notice, the out-of-network provider or facility must include an estimate of charges.
 - d. The patient may revoke in writing his or her consent to balance bill prior to the post-stabilization services being rendered.
 - e. The provider must furnish the notice and consent in any of the 15 most commonly spoken languages in the provider's region and must provide an interpreter if the patient speaks a different language.
3. The patient or his or her authorized representative is in a condition to receive the notice as determined by the treating provider using medical judgment, and to provide informed consent under state law.
4. The provider or facility satisfies any additional requirements under state law.

Even if the out-of-network provider or facility complies with the requirements to obtain consent for post-stabilization services, the provider or facility still may not balance bill for unforeseen, urgent medical needs (at least in connection with a visit arising from an emergency medical condition).

WHAT DOCUMENT RETENTION REQUIREMENTS APPLY WHEN A PROVIDER OBTAINS CONSENT TO BALANCE BILL?

The out-of-network facility must retain the consent for seven years. If the out-of-network provider directly obtains the consent, the out-of-network provider must retain the consent for seven years or arrange for the facility to do so.

HOW DOES THE PROVIDER NOTIFY THE HEALTH PLAN THAT IT OBTAINED CONSENT TO PROVIDE CARE AT OUT-OF-NETWORK RATES?

When submitting a claim to a health plan for post-stabilization services, the out-of-network provider or facility must notify the plan whether the notice and consent requirements were satisfied and, if applicable, provide the plan with a copy of the signed written notice and consent document.

The possibility of balance billing for out-of-network post-stabilization services in connection with an emergency visit appears to be quite limited. The treating provider needs to determine that additional outpatient, inpatient or observation services are necessary but the patient is healthy enough to be transported by a nonemergency or nonmedical vehicle to a different facility.



Part III: Good faith estimates for uninsured or self-pay patients

Under the No Surprises Act (NSA), uninsured patients and commercially insured patients who choose not to use their benefits are entitled to a good faith estimate (GFE) of charges from providers before scheduled services. If the actual charges by a particular provider or facility exceed the GFE amount by more than \$400, the patient is entitled to dispute the charges under an arbitration process.¹⁴ Physicians' responsibilities for the GFE differ depending on whether they serve as a "convening provider" or a "co-healthcare provider." A convening health care provider (or facility) is one that receives an initial request for a GFE or that is responsible for scheduling the primary service. A co-health care provider (or facility) is one, other than the convening provider or facility, that furnishes items or services in conjunction with the primary service.¹⁵ The NSA also requires that GFEs be available for insured patients, but that requirement is not being enforced until the government resolves further issues regarding its implementation.¹⁶

Convening provider responsibilities

TO WHICH PATIENTS MUST A GFE BE PROVIDED?

A convening provider or facility is required to inquire whether a patient is covered under commercial health coverage, Medicare, Medicaid or the Federal Employees Health Benefits Program (FEHBP) and, if the patient is covered under commercial coverage or FEHBP, whether he or she intends to use that coverage. An individual covered only by short-term limited-duration insurance is considered uninsured for this purpose and is entitled to receive a GFE.

The convening provider or facility is then required to inform uninsured and self-pay patients of the availability of the GFE. Notice of the availability of the GFE must be posted on the provider's or facility's website, at the office, and on-site where scheduling or cost questions arise. The notice must be clear, understandable, prominently displayed and easily searchable. The current version of HHS's model notice is available here: <https://www.cms.gov/regulations-and-guidance/legislation/paperworkreductionactof1995pra-listing/cms-10791>.

WHAT TRIGGERS THE OBLIGATION TO PROVIDE A GFE?

A patient may request a GFE prior to scheduling care. Further, convening providers are required to treat any discussion with or inquiry from an uninsured patient regarding costs to be a request for a GFE. Further, the convening provider or facility is required to provide a GFE when a service is scheduled.

HOW QUICKLY MUST THE GFE BE PROVIDED?

Within one business day of a service being scheduled or a GFE requested, the convening provider or facility is required to request estimates from each co-provider or co-facility expected to provide services in connection with the convening provider's or facility's services.

When a service has been scheduled, the GFE is to be provided not later than one business day after the date of scheduling if the service is scheduled at least three business days before the service, and within three business days of scheduling if the service is scheduled at least 10 business days in advance. If a GFE is requested before the service is scheduled, the GFE is due within three business days. Once the service is scheduled, a new GFE must be provided.

For the 2022 calendar year, HHS will not enforce the requirement that the convening provider's or facility's GFE incorporate estimates from the co-providers or co-facilities. Patients would be free to request estimates directly from co-providers and co-facilities, and those providers and facilities would be required to provide a GFE directly to the patient.

WHAT HAPPENS WHEN ELEMENTS OF THE GFE CHANGE BEFORE THE SERVICE IS FURNISHED?

The convening provider or facility must update the GFE at least one business day before the service if it learns of or anticipates any changes to the scope of the prior GFE. If any providers represented in the GFE change within one business day prior to the scheduled service, the replacement providers must accept the GFE as their own GFE.

CAN THE PROVIDER FURNISH A SINGLE GFE FOR RECURRING SERVICES?

The convening provider or facility may provide a single GFE for recurring services, as long as the GFE is updated at least every 12 months.

WHAT IS THE REQUIRED CONTENT OF A GFE?

HHS is publishing a template GFE,¹⁷ although providers and facilities are not required to use that template. The GFE is required¹⁸ to include:

1. The patient's name and date of birth
2. A description of the primary item or service in "clear and understandable language" and, if applicable, the date of scheduled service
3. The items or services expected to be provided in conjunction with primary service, grouped by provider or facility, with their diagnosis code, procedure code and expected charge
4. The name of and identifying information for each provider or facility
5. The items or services that require separate scheduling and that will be estimated in a separate GFE
6. Various required disclaimers

HOW MUST THE GFE BE FURNISHED TO A PATIENT?

The GFE must be provided either in writing or electronically, as requested by the patient. An electronic GFE must be provided in a manner such that the patient can both save and print it.¹⁹

Co-provider responsibilities

WHAT MUST CO-PROVIDERS DO WHEN THEY RECEIVE A REQUEST FROM A CONVENING PROVIDER OR FACILITY?

Co-providers (and co-facilities) are required to provide the GFE information within one business day of a request from a convening provider or facility. Co-providers and co-facilities must update their estimate if they anticipate any changes to the scope of services after they submit their update. If the co-provider or co-facility changes less than one business day before the service is scheduled to be furnished, the replacement co-provider or co-facility must accept the estimate of expected charges that had been previously provided.

- If an uninsured or self-pay patient directly contacts a provider to schedule a service or request an estimate and that provider would otherwise have been considered a co-provider, the provider is treated as a convening provider for the purpose of these rules.

WHAT INFORMATION MUST CO-PROVIDERS FURNISH TO THE CONVENING PROVIDER OR FACILITY?

Each co-provider or co-facility is required²⁰ to provide to the convening provider or facility:

1. The patient's name and date of birth
2. An itemized list of items and services to be provided by co-provider or co-facility, with diagnosis and procedure codes as well as expected charges
3. The name of and identifying information for each provider or facility
4. A disclaimer that the estimate is not a contract

WHAT DOCUMENT RETENTION REQUIREMENTS APPLY?

The GFE must be preserved as part of the patient's medical record for at least six years, and a copy must be provided to the patient upon request during that period.

MUST PROVIDERS UPDATE GFES IF THEY DISCOVER ERRORS BEFORE THE SERVICE IS RENDERED?

Yes, providers or facilities must correct errors in GFEs as soon as practicable after discovery.

Dispute resolution of patient charges

WHEN MAY A SELF-PAY OR UNINSURED PATIENT DISPUTE A BILL UNDER THESE RULES?

An uninsured or self-pay patient may dispute any bill that exceeds by more than \$400 the amount listed for the provider or facility in the GFE.²¹

HOW WILL A PROVIDER LEARN OF A PATIENT DISPUTE?

A patient may initiate the dispute resolution process by submitting an "initiation notice" to HHS. HHS refers the notice to the state, if the state has adopted its own patient-provider dispute resolution process. The dispute resolution entity will notify the provider or facility if it determines the dispute is eligible for dispute resolution (for example, the difference between the GFE amount and the billed amount exceeds \$400).

WHAT MUST A PROVIDER DO WHEN IT LEARNS A BILL IS BEING DISPUTED?

Once notified that the dispute resolution process has been initiated, the provider or facility has 10 business days to provide a copy of the disputed GFE and bill, and any documentation showing that the difference was based on a medically necessary item or service that could not have been reasonably anticipated when the GFE was provided.

Providers and facilities must suspend collections and accrual of late fees on unpaid amounts while the dispute resolution process is pending and must not take or threaten any retributive action for a patient's use of the dispute resolution process.

The patient and provider may agree to settle the dispute at any point prior to the resolution of the dispute. The provider is required to notify the dispute resolution entity of the resolution within three business days of the settlement.

- 1 Consolidated Appropriations Act, 2021, Pub. L. No. 116-260 div. BB tit. I, 134 Stat. 1182, 2758 (2020).
- 2 “Providers” include physicians and other healthcare providers. See 45 C.F.R. § 149.30.
- 3 In surprise medical billing situations covered by the NSA, a state law that determines the patient cost-sharing or the provider payment continues to apply—if the law is effective for the provider, plan and service at issue. If a state law does not determine cost-sharing or provider payment, the NSA methodologies apply. See 45 C.F.R. § 149.39 (definition of “recognized amount” and “out-of-network rate”). The NSA prohibition on balance billing and other patient protections serves as a federal floor—more protective state laws may continue to apply that do not prevent the application of the NSA provisions. Private-employer self-insured group health plans (“ERISA” plans) have not been subject to state surprise billing laws but are subject to the NSA rules. Further, under the NSA, a state may elect to give ERISA plans the option to opt in to the state surprising billing law. See *id.* (definition of “specified state law”).
- 4 FAQs About Affordable Care Act and Consolidated Appropriations Act, 2021 Implementation Part 49. U.S. Department of Labor. August 20, 2021: 5. www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-49.pdf. Accessed December 21, 2021.
- 5 Public Health Service Act § 2799B-9 (42 U.S.C. 300gg-139).
- 6 Public Health Service Act § 2799B-8 (42 U.S.C. 300gg-138).
- 7 45 C.F.R. § 149.30 (definitions of “health care facility” and “participating health care facility”).
- 8 45 C.F.R. § 149.420(a).
- 9 45 C.F.R. § 149.420(b).
- 10 45 C.F.R. § 149.420(c), (d), (e).
- 11 45 C.F.R. § 149.110(c).
- 12 45 C.F.R. § 149.410(a).
- 13 45 C.F.R. § 149.110(c)(2)(ii).
- 14 45 C.F.R. § 149.620.
- 15 45 C.F.R. § 149.610(a)(2)(ii), (iii).
- 16 FAQs About Affordable Care Act and Consolidated Appropriations Act, 2021 Implementation Part 49. U.S. Department of Labor. August 20, 2021: 5. www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-49.pdf. Accessed December 21, 2021.
- 17 CMS-10791. CMS. September 30, 2021. www.cms.gov/regulations-and-guidance/legislation/paperworkreductionactof1995pra-listing/cms-10791. Accessed December 21, 2021.
- 18 45 C.F.R. § 149.610(c).
- 19 The requirement for the notice and consent form for out-of-network billing to be translated into 15 languages does not apply to the GFE.
- 20 45 C.F.R. § 149.610(d).
- 21 45 C.F.R. § 149.620.

