The No Surprises Act, Part II. What Providers Need to Know, Practical Takeaways for Implementation

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OVERVIEW OF THE NSA AND INTERPLAY WITH NEW JERSEY LAW

OVERVIEW AND INTERPLAY BETWEEN FEDERAL AND NJ LAW

Both the Federal No Surprises Act ("NSA") and the NJ Out-of-Network ("OON") Law cover the same 4 essential elements.

1. Disclosure requirements: who must disclose what, to whom, and when.
2. Balance billing restrictions: when is balance billing prohibited.
3. Dispute resolution: which dispute resolution process governs.
4. Required consents: who must obtain consents, from whom and when.

FEDERAL vs. NJ LAW

The Federal NSA is in addition to the NJ OON Law. It does not preempt State law in all respects. The Federal NSA creates a "floor" of protections against surprise bills from OON providers. However, where the NJ OON Law provides at least the same level of consumer protections against surprise bills, the NJ OON Law will apply.

Limitations on the NJ OON Law: The NJ OON Law applies only when the carrier is a NJ licensed carrier or a self-funded (ERISA) plan that has opted into participation in the NJ law. The NJ OON Law does not apply to the following: the Federal Employees Health Benefit Program, ERISA plans that do not opt into participation in the NJ Law, Medicaid, Medicare, Medicare Advantage, and TRICARE.

Where NJ OON Law applies, the Federal NSA and the NJ OON Law coexist.

DISCLOSURE REQUIREMENTS

1. Federal NSA requires:
    - Model Disclosure forms (Model Form #1 and Model Form #3)

2. NJ OON Law requires:
    - No standard disclosure form
    - Facilities must post Network Status
    - Facilities must make standard charges available

Conclusion: Both Federal NSA and State OON Law disclosures are required. Comply with both Federal NSA and State OON Law.

BALANCE BILLING RESTRICTIONS

1. Federal NSA covers:
    - Emergency services
    - Non-emergency services by an OON provider at an in-network facility where there is no consent
    - OON air ambulance services
2. NJ OON Law covers:
    - Emergency and urgent care services
    - Inadvertent OON services

Conclusion: Both Federal and NJ balance billing requirements apply, but they are substantially similar – exceptions include urgent care services (covered by NJ law) and air ambulance (covered by Federal law). Also, under Federal law, the balance billing restrictions can never be waived for the following ancillary services, when provided at an in-network facility: anesthesiology, pathology, radiology, and neonatology.

DISPUTE RESOLUTION

So long as a state dispute resolution process meets or exceeds the minimum requirements under the Federal Independent Dispute Resolution ("IDR") process, then the HHS will defer to the state process and will not accept such disputes into the Federal IDR.

Conclusion: NJ OON Law dispute resolution process will apply where it is applicable. NJ OON Law dispute resolution process is preempted by the Federal IDR process when the carrier is the Federal Employees Health Benefits Program or an ERISA plan that has not opted to participate in the NJ OON Law dispute resolution process.

REQUIRED NOTICES AND CONSENTS

Both the Federal NSA and the NJ OON Law require providers to obtain consents from patients prior to the rendering of non-emergent, elective OON services.

1. Federal NSA requires:
    - Standard Notice and Consent (Model Form #2 and Model Form #4)
    - Must contain a GFE, including others who will be involved in the procedure
    - Timing: 72 hours; or when appointment made; but at least 3 hours prior to providing the service
2. NJ OON Law requires:
    - Notify of network status
    - Notify of potential financial responsibility
    - Estimates available, if requested
    - Provide contact information for others that will be involved in the procedure
    - Advise to contact carrier
    - DOH has published forms for facilities

Conclusion: Federal NSA requirements are more stringent than NJ OON Law and generally preempt NJ OON Law. Use the Federal standard Notice and Consent documents, with a NJ supplemental disclosure document, as applicable. Use NJ disclosure where federal law not applicable.

FEDERAL NSA FORMS

1. Insured patients:
   - **Disclosure, Model Form#1:** See Appendix III at https://www.cms.gov/httpswwwcmsgovregulations-and-guidancelegislationpaperworkreductionactof1995pra-listing/cms-10780
   - **Notice and Consent, Mandatory Form#2:** See Appendix IV at https://www.cms.gov/httpswwwcmsgovregulations-and-guidancelegislationpaperworkreductionactof1995pra-listing/cms-10780

2. Uninsured and self-pay patients:
   - **Disclosure, Model Form#3:** See Right to Receive GFE of Expected Charges Notice at https://www.cms.gov/regulations-and-guidancelegislationpaperworkreductionactof1995pra-listing/cms-10791
   - **Good Faith Estimate, Model Form #4:** See GFE Template Notice at https://www.cms.gov/regulations-and-guidancelegislationpaperworkreductionactof1995pra-listing/cms-10791

FEDERAL NO SURPRISES ACT – PRACTICAL IMPLEMENTATION

EVERYONE – ALL PROVIDERS AND FACILITIES

- "Rule #1"
- Implement use of Model Disclosure Form #3 for uninsured and self-pay patients.
  - Screen at time of scheduling in accordance with the rules.
  - Post at location and website.
  - Give in print, signed acknowledgment not required.
  - Document/integrate in medical records.
  - Periodic updates.
- Implement use of Model GFE Notice Form #4 for uninsured and self-pay patients.
  - Who? You if Convening Provider, and Co-Providers.
  - Expected services.
  - GFE of expected charges.
  - Diagnostic codes.

GOOD FAITH ESTIMATE, UNINSURED & SELF-PAY PATIENTS

- GFE must include:
  - Expected charges for primary item or service; and
  - Expected charges for items or services reasonably expected to be provided in conjunction with primary item or service.
  - Includes items or services that may be provided by other providers and facilities (Co-Providers) in conjunction with the primary item or service.
- Calculation of GFE: Amount expected to be paid after discounts and adjustments.
- GFE is not a contract.
- 2022 – HHS enforcement discretion.
- Timing:
  - Convening Provider: Within 3 business days of request
  - Convening Provider must contact all anticipated Co-Providers within 1 business day of request
  - Co-Providers: Within 1 business day of Convening Provider's request
  - Co-Providers: Anticipated changes to GFE within 1 business day before service

EMERGENCY SERVICES – OON PROVIDERS AND OON FACILITIES

- What's an "OON Facility"? OON hospital, Critical Access Hospital or independent freestanding emergency department.
- No balance billing for OON patients.
- Cannot waive requirement with patient consent.

WHAT'S CONSIDERED AN EMERGENCY SERVICE?

- Definition of Emergency Services in NSA (See Appendix):
  - Emergency medical condition.
  - Medical screening examination, treatment and ancillary services.
  - To evaluate and stabilize emergency medical condition.
  - Regardless of the department of the hospital or freestanding emergency department.
- CMS: "Prudent Layperson" definition of Emergency Medical Condition.
- Stabilization: Not defined in NSA.
  - Certain post-stabilization services are considered emergency services and subject to NSA.
  - Definition of post-stabilization services: Covered services provided after patient is stabilized, as part of an outpatient observation, or an inpatient or outpatient stay related to the emergency visit (regardless of the department of the hospital)
  - See EMTALA definition in Appendix.
  - "Notice and Consent Test:" See slide #16.

EMERGENCY MEDICAL CONDITION, "PRUDENT LAYPERSON" DEFINITION

- Balance billing is not permitted for emergency services when an individual gets care for an **emergency medical condition**, using a "prudent layperson definition.

- A person, who has average knowledge of health and medicine, experiences a medical condition (including a mental health condition or substance use disorder) that is so severe he or she believes:
  - They need immediate medical care; and
  - Failing to get immediate medical care could:
    - Result in their health or the health of their unborn child being in serious jeopardy; or
    - Result in serious impairment to bodily functions; or
    - Lead to serious dysfunction of any bodily organ or part.

POST-STABILIZATION SERVICES – OON PROVIDER AT INN EMERGENCY FACILITY, "NOTICE AND CONSENT TEST"

- May balance bill for post-stabilization services after attending emergency physician or treating provider determines (and documents) that the patient:
  - Can travel using non-medical or non-emergency medical transportation to an available participating provider or facility located within a reasonable travel distance, considering the individual's medical condition;
  - Patient or authorized representative is in a condition to receive notice and provide informed consent;
  - Receives written notice and provides written consent within prescribed timeframe (**Notice and Consent Form #2**); and
  - OON provider/facility satisfies any additional state law requirements.
- Attending or treating physician's determination is binding on facility.
- Authorized representative cannot be a provider affiliated with facility or an employee of facility, unless provider or employee is family member.
- CMS intends the Notice and Consent to be a limited exception.

ANCILLARY SERVICES – NO BALANCE BILLING FOR ALMOST ALL

- Broad definition: Anesthesiology, Diagnostic services, including radiology and lab services, Emergency medicine, Neonatology, Pathology, Radiology, items/services provided by assistant surgeons, hospitalists, and intensivists.
- General rule: No balance billing permitted.
- Covered ancillary services at OON facility emergency services: No balance billing, no patient waiver permitted (Form #2).
- Covered ancillary services at OON facility post-stabilization services: No balance billing, no patient waiver permitted (Form #2).
- Covered ancillary services by OON provider at INN facility: No balance billing, no patient waiver permitted (Form #2).
- Covered ancillary services by OON provider at OON facility: Balance billing permitted. Form #2 not required.
- Non-covered ancillary services can be balanced bill because NSA not applicable – When: Emergency, post-stabilization, and non-emergency. However, state law may prohibit. Form #2 not required.

NON-EMERGENCY SERVICES – OON PROVIDER AT INN FACILITY

- OON Provider at INN Facility: NSA applicable.
- OON Provider at OON Facility: NSA not applicable (except Rule #1).
- INN Provider at OON Facility: NSO not applicable (except Rule #1).
- INN Provider at INN Facility: NSA not applicable (except Rule #1).
- What's a "Facility?" Hospital, Critical Access Hospital, Outpatient Department of Hospital, and ASC.
  - Does not include private offices.
- May balance bill if:
  - Not an ancillary service;
  - Another INN provider can deliver item or service at INN facility;
  - Meet all the requirements of the "Notice and Consent Test;" and
  - Written Notice and Consent Form #2 obtained.

NOTICE AND CONSENT FORM #2

- Mandatory – May need to have 2 separate forms if state law requires a specific form or the NSA Form #2 does not meet the requirements of state law.
- Never for emergency services prior to post-stabilization.
- Never for unforeseen urgent medical needs in the course of care delivery.
- Never for "ancillary services" as defined on slide #17.
- Never for items, services or situations banned by state laws.
- Must include:
  - Patient name.
  - OON Provider/Facility name.
  - Statement regarding OON status.
  - GFE for services provided by OON Provider/Facility.
  - Statement regarding prior authorization or other care management limitations.
  - Post-Stabilization services by OON provider at INN emergency facility: List of INN providers at INN facility able to deliver needed item or services.
  - Time and date: When received notice and when signed consent.

NOTICE AND CONSENT FORM #2 (CONT'D)

- Timing of delivery:
  - Appointment scheduled at least 72 hours before appointment date – Give Notice and Consent no later than 72 hours before appointment date.
  - Appointment scheduled within 72 hours of appointment date – Give Notice and Consent on day of appointment, but at least 3 hours before time item or service provided.
  - If cannot meet requirements or patient won't wait: Cannot get patient waiver. No balance billing permitted.
- Method of delivery:
  - Notice and Consent: Together.
  - One page two-sided, size 12 font.
  - Physically separate from other forms: not attached, incorporated, or hidden.
  - Paper or electronic form, as preferred by patient.
  - Representative of OON provider/facility must be physically present or available by phone to answer questions.
  - LEP persons: Translation.

NOTICE AND CONSENT FORM #2 (CONT'D)

- Copy: Must give copy of signed Notice and Consent in person or by mail/email.
- Who can obtain Notice and Consent?
  - OON provider.
  - OON emergency facility.
  - INN Facility on behalf of OON Provider (not an obligation of INN Facility)
- Multiple OON providers: Can use single set of Notice and Consent if:
  - Each provider is identified;
  - Each items/services provided by each provider are identified;
  - GFE for each item/service; and
  - Patient can waive each provider separately.
- Insurance: Must timely notify about waiver and provide copy of signed Notice and Consent Form, preferably with claim.
- Revocation can occur before delivery of item/service.
- Document retention: 7 years.
- Can refuse to treat individual who refuses to waive balance billing, if permitted by law (federal and state).
- Cannot impose any fees for cancellation of service.

FEDERAL NO SURPRISES ACT – INDEPENDENT DISPUTE RESOLUTION PROCESS

TEXAS MEDICAL ASSOC VS. UNITED STATES DHHS

Summary of Court Opinion

- Overview of the IDR process
  - Disputed payment & circumstances.
  - All payer model agreement & state law.
  - The initiation of process.
  - 30-day negotiation.
  - Baseball style arbitration.

FACTORS TO CONSIDER

- Proofs permitted and not permitted.
- Binding decision.
- Decision not subject to review.
- The QPA?

HOW THE QPA FUNCTIONS

- Challenges to final interim rule and QPA implementation.
- Standing & financial harm.
- The rebuttable presumption.

COURT OPINION IN RE: QPA & DHSS RULE

- Rule language vs. statutory language.
- Arbitrator guidance and weight of evidence.
- QPA presumption of correction vs. the language in the law.
- How the text of the rule reads?
- Setting aside [vacatur] the rule, and the impact of the Court's decision.

UNINSURED AND SELF-PAY PATIENTS – PATIENT-PROVIDER DISPUTE RESOLUTION

- A patient-provider dispute resolution process is available for uninsured or self-pay patients who receive a bill from a provider of at least $400 more than the expected charges on the good faith estimate.
- The patient or their authorized representative may initiate the dispute process.
- An independent dispute resolution entity is brought in to determine the appropriate amount the patient must pay.

HOW IS FEE DETERMINED FOR OON PROVIDER WHO CANNOT BALANCE BILL?

- Patient cost-sharing amounts for emergency services furnished by OON providers, and for non-emergency services furnished by OON providers at certain in-network facilities, must be calculated based on one of the following amounts:
  - An amount determined by an applicable All-Payer Model Agreement;
  - If no All-Payer Model Agreement, an amount determined by a specified state law; or
  - If no All-Payer Model Agreement or specified state law, the lesser of the billed charge or the plan's or issuer's median contracted rate, referred to as the qualifying payment amount (QPA).

HOW IS FEE DETERMINED FOR OON PROVIDER WHO CANNOT BALANCE BILL? (CONT'D)

- The balance owed is determined through open negotiations between the provider and the plan for 30 days after the initial payment by the plan to the provider.

- If the provider and plan cannot agree on a rate, either the provider or the plan may initiate the federal Independent Dispute Resolution (IDR) process.

INDEPENDENT DISPUTE RESOLUTION (IDR) PROCESS

- OON providers, facilities, providers of air ambulance services, plans, and issuers may use the IDR process to determine the OON rate for applicable items or services after unsuccessful open negotiations.

- The IDR process is only available for services for which balance billing is prohibited, i.e., emergency services, OON non-emergency ancillary services at an in-network facility, including anesthesia, pathology, radiology, lab, and neonatology; and OON services at an in-network facility if proper notice and consent is not obtained (notice and consent can never be used for the above ancillary services).

INDEPENDENT DISPUTE RESOLUTION (IDR) PROCESS (CONT'D)

- The IDR is prohibited from considering the provider's UCR rate or Medicare rates.
  - May consider the provider's level of training, case complexity, the provider's prior quality and outcome metrics, the provider's market share, etc.
- The IDR determination is binding.
- Judicial review of IDR is only available if fraudulent information was presented or if the arbitrator engaged in fraud, corruption, misconduct or exceeded powers.
- Losing party is responsible for the IDR entity's fee.

ARBITRATION TIMELINE

- Within 20 days after receiving claims (Emergency/Urgent and Inadvertent OON bills) – Carrier must pay or inform provider that the claim is excessive, or partially pay bill.
- Within next 30 days – parties negotiate bill.
- Within the next 30 days, the Carrier, Physician, or Patient may initiate binding arbitration.
- Self-funded plans may elect to adopt Act provisions.

ARBITRATION PROCEDURE

- Party requesting arbitration must notify other party of final offer prior to arbitration.
  - Carrier's offer must be the paid amount.
- Parties' final offers must be at least $1,000 apart.
- Binding arbitration is initiated by request to Department of Banking and Insurance (DOBI).
  - DOBI will contract with an entity that has experience in healthcare pricing arbitration.
  - Health Claims Authorization, Processing and Payment Act (HCAPPA) applies in interim (MAXIMUS).

ARBITRATION PROCESS AND AWARDS

- Parties will make written submissions to arbitrator.
- Within 30 days of request, arbitrator must issue a "baseball-style" award.
  - Arbitrator selects one of the party's final offers.
- Arbitrator fees and costs – split by parties.
  - Exception where arbitrator finds the carrier's final offer was not made in good faith.
- Parties responsible for their own costs including legal fees.
- Excess payment by carrier, if any, to be made within 20 days, without interest, until 20 days post award.

QUESTIONS?

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APPENDIX, ADDITIONAL RESOURCES

WHAT'S CONSIDERED AN EMERGENCY SERVICE?

- Definition of Emergency Service: "With respect to an emergency medical condition, an appropriate medical screening examination within an emergency department of a hospital or a freestanding emergency department, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition, and such further medical examination and treatment to stabilize the patient, regardless of the department of the hospital where the treatment is provided."

HOW IS POST-STABILIZATION DEFINED?

- Definition of Post-Stabilization: Not defined, but widely used in NSA as:
- "[I]tems and services for which benefits are provided or covered under the plan and are furnished by a nonparticipating provider or nonparticipating emergency facility (regardless of the department of the hospital in which such items or services are furnished) after the participant or beneficiary is stabilized and as part of outpatient observation or an inpatient or outpatient stay with respect to the visit in which the [emergency] services are furnished, are not included as emergency services if all of the conditions in 45 CFR 149.410(b) are met." [26 CFR 54.9816-4T(c)(2)(ii)]
- "To stabilize, with respect to an emergency medical condition, has the meaning given such term in section 1867(e)(3) of the Social Security Act [EMTALA] (42 U.S.C. 1395dd(e)(3))" [26 CFR 54.9816-4T(c)(3)]
- "The term 'to stabilize' means, with respect to an emergency medical condition …to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or, with respect to an emergency medical condition [regarding pregnancy], to deliver (including the placenta)." [42 U.S.C. 1395dd(e)(3)]

Summary Comparison
Federal "No Surprises Act"
versus
New Jersey "Out-of-Network Consumer Protection, Transparency, Cost Containment, and Accountability Act"

Federal NSA and NJ Law Comparison

	Federal - NSA	NJ – Surprise Bill Act
Covered Services	• Emergency services by an OON provider or OON emergency facility. • Non-emergency services, by OON providers at in-network facilities and for which patients do not consent. • OON air ambulance services.	• Inadvertent OON services. • Emergency/Urgent services. o Urgent medical condition is a non-life-threatening condition that requires care by a provider within 24 hours.
Services Not Covered	• Non-emergency services at an OON facility. • Non-covered items and services under patient's health plan. • Non-emergency or post-stabilization services by an OON provider at an in-network facility for which the patient consents to be balance billed, when permitted (can never consent to certain ancillary services).	• Knowing, voluntary, and specific selection of OON provider by patient where patient could have chosen in-network services.
Disclosure Requirement	Model Disclosure Notice • Disclosure of balance billing protections must be made by all licensed providers. • For uninsured or self-pay individuals, notice and good faith estimate must be provided. • Exceptions: If the provider never furnishes services at a healthcare facility or if the individual patient will not be receiving services at a facility.	• No specific Disclosure Form available. • Before scheduling a non-emergency or elective procedures with a covered person, facility is now required to disclose whether the facility is in-network for non-emergency services. • Also advise the covered person to (i) ask his or her physician whether the physician is in-network or OON and (ii) contact his or her carrier for further consultation on costs. • Must make available to the public a list of their standard charges, consistent with federal law. • Must post on its website a list of health benefit plans in which the facility is a participating provider and a statement that individual physicians' services are not included in the facility's charges, along with a disclaimer that some physicians may not participate with the same health benefit plans as the facility. • Individual healthcare professionals must (i) disclose the health benefit plans with which they participate; (ii) disclose to a particular covered person if they are OON with the person's plan; (iii) provide the covered person with a billing estimate and with affiliated CPT codes, if requested; (iv) advise the covered person that he or she has the financial responsibility to pay for any OON services; and (v) promptly notify the covered person if their network status changes during the course of treatment.

Federal NSA and NJ Law Comparison

	Federal - NSA	NJ – Surprise Bill Act
Notice and Consent Requirement	Standard Notice and Consent Documents • This form cannot be modified. • Given to obtain a patient's consent to be balance billed for OON non-emergency or post-stabilization services at an in-network facility, except for ancillary services. • Must include a good faith estimate for furnishing such items or services. • Must be provided at least 72 hours before the date the items and services are to be furnished. • If the appointment is made within 72 hours of the date of the items or services are to furnished, the Notice and Consent must be provided on the date the appointment is made. • For same-day appointments, Notice and Consent must be provided at least 3 hours prior to furnishing the services.	• There is no inadvertent OON service where a covered person "knowingly, voluntarily, and specifically" selects an OON provider for services with full knowledge that the provider is OON with respect to the covered person's health benefits plan, under circumstances that indicate that the covered person had the opportunity to be serviced by an in-network provider, but instead selected the OON provider.
Good Faith Estimates for Uninsured and Self-pay	Notice to Uninsured/Self-Pay and Good Faith Estimate Template • Good faith estimate must include expected charges for the items or services that are reasonably expected to be provided, in conjunction with the primary item or services, including items or services that may be provided by co-providers and co-facilities, after discounts.	• A facility must make available to the public a list of the facility's standard charges for all items and services provided by the facility. • Silent on the disclosure requirements to uninsured and self-pay. Professionals must provide a covered person with both a billing estimate and the associated CPT codes, if requested.
Independent Dispute Resolution (IDR) Timeline **(OON Provider v. Plans)**	• Within 30 days – Parties negotiate. • Parties may submit dispute to IDR process within 4 business days of the end of the negotiation period. • Parties choose IDR entity; Secretary chooses if parties cannot agree. • Parties submit their offers and materials to arbitrator within 10 days of the date of selection of the IDR entity. • IDR chooses one of the parties' offers within 30 days of selection of the IDR entity. • Payment to the OON provider no later than 30 days after IDR decision. **NOTE:** If a state has its own payment standard and/or IDR process in place, that process can continue to apply for services covered by state-regulated health plans if meets or exceeds the federal standards.	• Within 20 days – Carrier must pay or notify the provider that it considers the bill to be excessive. • Within next 30 days – Parties negotiate. • If negotiation fails, the carrier will make a payment for the amount of its final offer. • Within next 30 days – Initiate arbitration. • Within 30 days – Arbitrator must issue award. • Excess payment by carrier, if any, to be made within 20 days.

Federal NSA and NJ Law Comparison

	Federal - NSA	NJ – Surprise Bill Act
IDR Decision Factors	• "Baseball-style" arbitration process. • Qualifying payment amount (QPA) will be used as the presumptive reimbursement amount. • Other factors may be considered if a party submits information demonstrating the service is materially different from the QPA.	• "Baseball-style" arbitration process. • Review of written submissions by both parties.
IDR Procedure	• Parties select a certified IDR entity. • Each party submits its offer for payment with documentation. • IDR entity select one of the offers. • Losing party is responsible for the IDR entity's fee.	• Party requesting arbitration must notify of final offer prior to arbitration. • DOBI chooses the arbitrator. • Final offers must be at least $1,000 apart. • Parties split the cost of arbitration, and each party pays their own attorney's fees.
Uninsured/Self-Pay Patient – Provider Dispute Resolution (Uninsured or Self Pay Patient v. Provider)	• Available when patient gets a bill from a provider at least $400 more than good faith estimate. • Patient or their authorized representative may initiate the dispute process. • Patient must file for dispute claim within 120 days of the date on the bill.	• In NJ, there is no arbitration procedure between an uninsured/self-pay patient against the provider.
Self-Funded Plan That Opted In v. OON Provider	N/A	• Self-funded plan (that has elected to be subject to the Law) and an OON provider are unable to resolve a payment dispute. • DOBI will select experienced arbitrators. • Arbitrator must take both positions into account and must ultimately produce written findings.
Covered Person With Self-Funded Plan That Does Not Opt In v. OON Provider	N/A	• The member of the self-funded plan that does not elect to opt-in or the OON provider may request binding arbitration after no resolution within 30 days. • DOBI will select experienced arbitrators. • Arbitration decision must be issued within 30 days after the request for arbitration is filed with the DOBI.
Penalties	• The NSA allows HHS to impose penalties of up to $10,000 per violation.	• Up to $100 per violation for healthcare professionals. • Up to $1,000 per violation for carriers and healthcare facilities (every day qualifies as a separate violation, but no provider will be liable for more than $25,000 per occurrence).

FAQs

MISCELLANEOUS FAQs

- What about non-covered items or services?:
  - Example: Cosmetic procedure or special item within covered procedure (specialty lenses, surgical scaffolding).
  - Not subject to NSA.
- What about Medicare/Medicaid/Tricare patients?
  - Fee-for-service and Part D commercial plans.
  - Not subject to NSA.
- What about self-funded plans: They are subject to the NSA.
- What about unforeseen urgent medical needs post-stabilization or during non-emergency services:
  - Subject to NSA.
  - No balance billing

MISCELLANEOUS FAQs (Cont'd)

- I am an OON provider that never provides services at a Facility under any circumstances. I don't have to do anything, correct? Wrong.
  - Form#1 and Form#2 for insured patients: N/A.
  - Form #3 and Form#4 for uninsured and self-pay patients: Applicable.

- Does the NSA apply to physician's independent offices? Yes, in part.
  - Form#1 and Form#2 for insured patients: N/A.
  - Form #3 and Form#4 for uninsured and self-pay patients: Applicable.

- I heard that the NSA does not apply to Medicare patients, so I am assuming it also does not apply to patients in Federal Employee Health Benefit Health Plans (FEHB), correct? Wrong.
  - The NSA applies to FEHB health plans, Federal and State-based Exchanges, non-federal governmental plans sponsored by state and local government employers, certain church plans within IRS jurisdiction, and student health insurance coverage.

MISCELLANEOUS FAQs (Cont'd)

- The NSA only applies to Physicians so my Nurse Practitioner can continue to balance bill OON patients. Wrong.
  - The NSA applies to Physicians and NPPs.

- Our Practice Group is independent, but we provide pathology services at several hospitals and ASCs under some PSAs. In addition, we process outreach work from several dermatology practices. Since pathology services are "ancillary services," we don't have to do anything under the NSA, correct? Wrong.
  - If you have a website, you must post Form #1 and Form #3.
  - You must work with hospitals, ASCs, and dermatology practices to respond to uninsured/self-pay patients' requests for GFE within 1 business day and advise them of any change to GFE within 1 business day of service/procedure.
  - No balance billing for OON patients at hospitals and ASCs.
  - Balance billing permitted for dermatology practices.

MISCELLANEOUS FAQs (Cont'd)

- This stuff is way too complicated, and I don't think any of this applies to my practice, so I am all good. My patients love me, and I already make them sign a Financial Responsibility Form. What are they going to do? I have it in writing! Wrong.
  - Violations of the NSA may subject providers to civil fines and corrective actions.

- I work for plastic surgeons who take emergency call at the hospital. Some patients can be treated by the ER physician/PA but request a plastic surgeon. In that case, does it become elective and can the doctors have the patient sign release forms so they essentially Opt-Out of the protections afforded by the Act? Maybe…
  - If no longer in the emergency phase, post-stabilization or non-emergency;
  - If post-stabilization, "Notice and Consent Test" requirements are met (slide #16);
  - ER Physician/PA is capable and INN; and
  - Requirements for use of Notice and Consent Form #2 are met.

MISCELLANEOUS FAQS (CONT'D)

- Are all services performed in a physician's office including posting of notices exempt for the NSA? No.
  - If the physician is OON and never performs services at an INN facility, disclosure to insured patients (Form #1) is not required and there is no use for the Notice and Consent (Form #2).
  - Disclosure to uninsured and self-pay patients is required (Form #3).
  - GFE to uninsured and self-pay patients is required upon request (Form #4).

- If a patient requests not to use their insurance, do you have to give the patient the NSA notices? Yes.
  - Disclosure to uninsured and self-pay patients is required (Form #3).
  - GFE to uninsured and self-pay patients is required upon request (Form #4).
  - Some insurances may not permit patients to elect to pay out-of-pocket. In this case, if the provider is OON and provides services at an INN Facility, Form #1 must be used and Form #2 must be used if the provider is seeking and is permitted to balance bill.

CMS CASE STUDIES

CMS CASE STUDY #1

Carol is a 58-year-old female with Marketplace coverage. Over 2 days, she develops worsening abdominal pain, nausea, and constipation, which prompts her to call 911 for medical assistance. She is driven by ground ambulance transport to her local in-network emergency department for exam and treatment.

How much can the ambulance provider bill Carol under the rules of the No Surprises Act?

The ambulance provider isn't banned from balance billing under the No Surprises Act because it is a ground ambulance provider.

Note: Air ambulance service providers, but not ground ambulance service providers, are banned from balance billing under the No Surprises Act. As such, no restrictions are placed on the amount the ambulance provider can bill an individual under the No Surprises Act.

CMS CASE STUDY #2

Zoe is a 26-year-old female with Marketplace coverage. She works as a teacher and has an average knowledge of health and medicine. She has severe pain, swelling and redness of her right calf, and becomes concerned that this may be dangerous. So, she travels to the local hospital emergency department that is in her health plan's network. She has a venous ultrasound. The radiologist, who is out-of-network, reads the ultrasound, which shows a deep vein thrombosis. Zoe is started on medication and discharged from the emergency department.

Do the No Surprises Act's balance billing protections related to emergency services apply to the radiologist?

Yes, it would.

Zoe sought care for a medical condition that, using reasonable layperson judgment, she thought was an emergency medical condition that needed immediate medical attention to avoid serious jeopardy, impairment, or dysfunction. Per the No Surprises Act, out-of-network providers are banned from balance billing for emergency services provided for emergency medical conditions. Emergency services include ancillary services available to the emergency department to evaluate whether an emergency medical condition exists, such as services of a radiologist who reads an imaging study.

CMS CASE STUDY #3

Carlos is a 62-year-old male with employer-sponsored health coverage. He is involved in a motor vehicle accident and sustains multiple injuries. He is taken to the closest hospital, which is out-of-network. He undergoes surgery to repair multiple leg fractures. Once he is stable and out of surgery, he is counseled on the option to transfer care to another local in-network hospital for the duration of his recovery. His treating physician determines the safest form of transport, given his medical state, would be via ambulance. Carlos knows that the hospital he is in has an excellent reputation and wishes to stay there for his recovery. The hospital provides a written notice and gets his written consent to waive his balance billing protections under the No Surprises Act. He remains inpatient for two additional days and is ultimately discharged to home.

Does the No Surprises Act's prohibition on balance billing for emergency services apply to all days of care Carlos received from this hospital?

Yes.

The hospital is banned from balance billing Carlos for items and services provided prior to his being stabilized. The hospital is also banned from balance billing him for post-stabilization services provided after surgery, despite obtaining written consent from Carlos to waive his balance billing protections under the No Surprises Act. Because he could only safely be transferred via ambulance, the hospital can't seek consent from him to waive his balance billing protections under the No Surprises Act specific to post-stabilization services.

CMS CASE STUDY #4

Rhonda is a 50-year-old female with employer-sponsored health insurance who discovers a lump in her breast. Her primary care provider orders a mammogram, which shows a suspicious mass. She is referred to the local in-network hospital's outpatient department for a biopsy. The biopsy is reviewed and found to be negative for malignant cells by a pathologist who happens to be out-of-network.

How much can the pathologist bill Rhonda under the rules of the No Surprises Act?

Under the No Surprises Act, the pathologist is banned from billing Rhonda more than the in-network cost-sharing amounts, as determined by her health plan. The pathologist, as an ancillary service provider, is banned from obtaining consent from the individual to waive these balance billing protections.

CMS CASE STUDY #5

Shawn is a 35-year-old male who has insurance through the Marketplace. He is playing soccer and sustains a knee injury, which is later diagnosed as a torn ACL. He is advised by his friends to go to a specific orthopedist who has an excellent reputation. His surgery is scheduled at an in-network ambulatory surgical center a week in advance. One day before his surgery, he gets an email with the written notice and consent documents, informing him that the orthopedist is out of-of-network and requesting that he consent to waive his balance billing protections under the No Surprises Act in order to be treated by the orthopedist. Shawn signs the consent to waive balance billing protections, as he would like to see this specific provider for his knee surgery. Several weeks after his surgery, Shawn gets a balance bill from his orthopedist.

Did the orthopedist comply with requirements of the No Surprises Act?

No, the provider violated No Surprises Act requirements related to when notice and consent documents must be provided to individuals.

Since Shawn scheduled his surgery more than 72 hours in advance, written notice and consent must be provided to the individual no later than 72 hours before the date of the appointment. In this case, the provider sent notice and consent documents one day before the appointment.

Because all requirements related to using notice-and-consent exceptions were not met, the orthopedic surgeon is banned from balance billing Shawn for services provided as part of the surgery even though he signed the consent form.