Health Law Webinar

The “No Surprise Billing” Act: As Clear as We Can Make It

November 10, 2021

Fredrikson & BYRON, P.A.

The Problem

- Patient goes to an in-network hospital for a surgery by an in-network surgeon. Unbeknownst to the patient, the anesthesiologist is out of network.
- The anesthesiologist bills more than the plan allows, leaving the patient on the hook.

The Solution

- The No Surprises Act public law 116-260 passed December 27, 2020.
- A variety of state laws.
- Like HIPAA, more restrictive state laws generally control.

The Regulatory Framework

- Requirements Related to Surprise Billing; Part I, 86 Fed. Reg. 36872 (July 13, 2021).
- Requirements Related to Air Ambulance Services, Agent and Broker Disclosures, and Provider Enforcement, 86 FR 51730 (September 16, 2021).
- Requirements Related to Surprise Billing; Part II, 86 FR 55980 (October 7, 2021) with comments due December 6, 2021.

Lingo

- ABD: Adverse Benefit Determination.
- Facility: Hospital/ASC/Freestanding ED.
- IDR: Independent Dispute Resolution.
- OON: Out-of-Network.
- Provider: Physician.
- QPA: Qualified Payment Amount.

Lingo

- ABD: Adverse Benefit Determination.
- Facility: Hospital/ASC/Freestanding ED.
- IDR: Independent Dispute Resolution.
- OON: Out-of-Network
- Provider: Physician.
- QPA: Qualified Payment Amount.
- $#%@#: NSA-associated expletives.

Overview

- Applies to services provided by air ambulance, hospital (including CAH) ambulatory surgical center, or freestanding emergency room.
- Applies to both the facility's bill and the bills by medical professionals for services to patients at the facility.
- Does NOT apply to services at a free-standing clinic.*

*Estimate exception is huge.

Overview

- Some provisions apply to health plans, others apply to facilities and professionals.
- Unfortunately, the law uses the term “provider” to refer to “professionals.”


FLY
SUX

Overview

- Some provisions apply to health plans, others apply to facilities and professionals.
- Unfortunately, the law uses the term “provider” to refer to “professionals.”

Overview

- Emergency Services: applies to services at out-of-network hospitals and the professionals providing services there.
- Non-emergency Services: applies to services by professionals at a participating hospital.

Leap of Faith

- Health plans are required to do many calculations.
- Professionals and facilities are largely at their mercy.

Emergency Services

- For EMTALA services, the patient should be treated as if in-network. Co-pays/deductibles are the same as if it was an in-network service.
- Co-pay calculated at the lower of median rate/billed charge.
- Can’t use diagnosis code to determine coverage.

Emergency Services

- The “emergency” continues post-stabilization until the patient can reasonably transfer considering distance, patient’s condition, etc.
- The treating physician is the sole arbiter of when/how far the patient may go/when “emergency” ends.

Emergency Services

- Limited impact on plan payment to facility/professional.
  - If there is a state All-Payer Model agreement, it controls. (MD/VT.)
  - If state law, it controls.
  - Otherwise, parties negotiate. Absent agreement, use dispute resolution.
- Plan must make “initial” payment on clean claim within 30 days.

Non-Emergency Services

- For some non-emergency services, the facility/professional can condition treatment on the patient agreeing to permit balance billing.
- Patient consent is required.
- There is a HUGE exception. Can't seek consent for "ancillary services."

“Ancillary Services”

- Items and services “related to” emergency medicine, anesthesiology, pathology, radiology and neonatology. (Mentions physicians and non-physician practitioners)
- Items and services “provided by” assistants at surgery, hospitalists and intensivists.
- “Diagnostic services” such as radiology and laboratory.
- Any item or service provided by a non-participating professional if there is no participating professional who could provide the service.

Independent Dispute Resolution (IDR)

- Determines payment rate for items and services when the facility or professional and plan can’t agree.
- Baseball-arbitration.
- Presumption that QPA is the appropriate amount.

IDR Action	Timeline
Initiate open negotiation period (one party)	30 business days, starting on the day of initial payment or notice of denial of payment
Initiate IDR process (either party)	4 business days, starting the business day after the open negotiation period ends
Mutually pick IDR entity *NOTE: Departments select certified independent dispute resolution entity in the case of no conflict-free selection by parties	3 business days after the independent dispute resolution initiation date
Submit payment offers and additional information to certified independent dispute resolution entity	10 business days after the date of certified independent dispute resolution entity selection
Payment determination made	30 business days after the date of certified independent dispute resolution entity selection
Payment submitted to the applicable party	30 business days after the payment determination

4 Patient “Disclosures/Notices/Consents”

- The Act creates 4 distinct patient facing “forms” professionals and facilities must provide:
  1. Standard Disclosure (42 CFR § 149.430).
  2. “Universal” Good Faith Estimate (42 CFR § 149.610).
  3. OON Non-Emergency Services Notice & Consent (42 CFR 149.20).
  4. OON Post Stabilization Emergency Services Notice & Consent (42 CFR § 149.10).

No. 1 – Standard Disclosure

Model Disclosure: CMS Form No. CMS 10780

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services
If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

[Insert plain language summary of any applicable state balance billing laws or requirements OR state-developed model language as appropriate]

Certain services at an in-network hospital or ambulatory surgical center
When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

[Insert plain language summary of any applicable state balance billing laws or requirements OR state-developed model language regarding applicable state law requirements as appropriate]

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
  - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact [*applicable contact information for entity responsible for enforcing the federal and/or state balance or surprise billing protection laws*].

Visit [*website*] for more information about your rights under federal law.
[*If applicable, insert:* Visit [*website*] for more information about your rights under [state laws].]

No. 2 – Universal Good Faith Estimate

- This is UNIVERSAL! Applies beyond services in “facilities.”
- Must provide in “clear and understandable language” the “good faith estimate” of the “expect charges for providing scheduled services and items”.
- CMS Form No. 10791
  - Appendix 1: Right to Receive a Good Faith Estimate of Expected Charges Notice
  - Appendix 2: Good Faith Estimate Template
  - Appendix 11: Good Faith Estimate Data Elements

Who Gets the Estimate?

- January 1: if patient is uninsured, the estimate goes to the patient.
- Future: If patient is insured, the estimate will go to the insurance company to inform the advanced EOB that the company must provide the insured patient.

Who Gives the Estimate?

1 estimate, but many responsible parties:

1. “Convening health care provider” or “convening health care facility”: Whoever schedules).
2. “Co-health care provider” or “co-health care facility”: Everyone else.

*Note: “Facility” is defined more broadly for this good faith estimate requirement than non-emergency services in the Act.

Responsibilities of Convening Professional or Facility

1. Ask the patient if they have insurance.
2. If they do, ask if they are seeking to have a claim submitted for the primary item or service with such plan or coverage.
3. If they don't have insurance (or will self-pay), inform them orally and in writing of the availability of a good faith estimate of expected charges.
4. Provide an estimate if patient requests appointment, asks for estimate, or inquiries about costs.
5. If there is a co-professional or co-facility, contact within 1 business day of scheduling the appointment OR a request for an estimate.
6. Generally, make information about the availability of requesting an estimate readily available online and in accessible formats, including language of patient.

Responsibilities of Co-Professional or Facility

- Not enforced until **2023**
- Provide good faith estimate to convening professional/facility no later than 1 business day after request received from convening professional/facility.
- Estimate must include:
  - Patient name and date of birth.
  - Itemized list of items or services expected to be provided by the co-provider or co-facility that are reasonably expected to be furnished in conjunction with the primary item or service as part of the period of care.
  - Applicable diagnosis codes, expected service codes, and expected charges associated with each listed item or service.
  - Name, National Provider Identifiers, and Tax Identification Numbers of the co-provider or co-facility, and the State(s) and office or facility location(s) where the items or services are expected to be furnished by the co-professional or co-facility.
  - A disclaimer that the good faith estimate is not a contract and does not require the uninsured (or self-pay) individual to obtain the items or services from any of the co-professional or co-facilities identified in the good faith estimate.

What Does the Patient's Good Faith Estimate Need to Include?

Top 3:

- Diagnosis codes (ICD).
- Expected service codes (CPT, HCPCS, DRG, NDC).
- "Expected charges" associated with each listed item or service.

  "Expected charge" means, for an item or service, "the cash pay rate or rate established by a provider or facility for an uninsured (or self-pay) individual, reflecting any discounts for such individuals, where the good faith estimate is being provided to an uninsured (or self-pay) individual; or the amount the provider or facility would expect to charge if the provider or facility intended to bill a plan or issuer directly for such item or service when the good faith estimate is being furnished to a plan or issuer."

Contents of Good Faith Estimate

- Patient name and date of birth
- Description of the primary item or service in clear and understandable language (and if applicable, the date the primary item or service is scheduled)
- Itemized list of items or services, grouped by each provider or facility, “reasonably expected” to be furnished for the primary item or service, and items or services reasonably expected to be furnished in conjunction with the primary item or service, for that period of care including by convening and co-professionals/facilities
- Name, National Provider Identifier, and Tax Identification Number of each provider or facility represented in the good faith estimate, and the State(s) and office or facility location(s) where the items or services are expected to be furnished by such provider or facility

Contents of Good Faith Estimate

- List of items or services that the convening provider or convening facility anticipates will require separate scheduling and that are expected to occur before or following the expected period of care for the primary item or service.
- A disclaimer must go above this list with certain estimate information about such items and services.

When is the Estimate Required?

- Estimate is required if appointment is scheduled for 3 or more business days in advance:
  - When the appointment is scheduled 3-9 business days out, the notice must be provided within 1 business day of the date the appointment was scheduled.
  - If scheduled for 10 or more business days out, the estimate must be provided within 3 business days of the date the appointment was scheduled.
- Patient can also request an estimate *without* scheduling an appointment, in which case the estimate must be provided within 3 business days.

What if the Estimate Changes?

- IF professional/facility is notified of any changes to scope of estimate → provide uninsured (self-pay) patient new estimate no later than 1 business day before the appointment.

- IF change in expected professional or facility listed in the estimate happens less than 1 business day before appointment is scheduled → replacement professional or facility must use the good faith estimate of expected charges.

What if a Mistake is Made?

- Still in compliance IF:
  - (i) professional/facility acted in good faith and with reasonable due diligence, AND
  - (ii) the information was corrected as soon as practicable.
- Patient can challenge the bill:
  - Step 1: Open negotiation period (30 business days).
  - Step 2: Patient-provider dispute resolution.

Patient-Provider Dispute Resolution

- Patient can use this process IF:
  - The bill is within the last 120 calendar days.
  - The difference between the good-faith estimate and the bill is at least $400.
- “Select dispute resolution” (SDR) entity makes payment determinations.
- CMS Form No. 10791
  - Appendixes 3-10: Dispute Forms

Important Notes

- Estimates are considered part of medical record.
- Meeting a similar state requirement does NOT meet federal requirement.
- Reminder: Future rulemaking for insured patients.

No. 3 – OON Non-Emergency Services Notice & Consent

Recap:

Generally, a nonparticipating provider that provides items or services for which benefits *are* covered by insurance by a participating provider ***cannot*** bill the patient or hold patient liable for an item or service that exceeds the "cost-sharing requirement" for the covered item or service.

When Can Balancing Billing Protections Be Waived?

- Non-emergency care.
- Non-ancillary services.
- Not prohibited by state law.
- Timing:
  - If appointment is scheduled at least 72 hours or more out, provide Notice & Consent *at least 72 hours* before the appointment.
  - If appointment is scheduled within the next 72 hours, provide Notice & Consent the same day appointment is made and *at least 3 hours* prior to rendering the services or items.
  - If treatment will occur within 3 hours, patient *cannot consent* to be balance billed.

What Must the OON Notice & Consent Include?

- HHS has created a MANDATORY document - “Surprise Billing Protection Form” (CMS Form No. CMS-10780).
  - This specific document MUST be used.
  - It CANNOT be modified (except filling in bracketed sections).
  - It CANNOT be attached or incorporated with other documents.
  - Patient MUST be able to choose to receive electronically or in paper.
  - Make available in 15 languages most commonly used in region.
  - Must include date notice provided to patient and the date AND time patient signs.

Pages 1-2 Provider/ facility Instructions

OMB Control Number: 0938-XXXX
Expiration Date: xx/xx/xxxx

Standard Notice and Consent Documents Under the No Surprises Act

(For use by nonparticipating providers and nonparticipating emergency facilities beginning January 1, 2022)

Instructions

The Department of Health and Human Services (HHS) developed standard notice and consent documents under section 2799B-2(d) of the Public Health Service Act (PHS Act). These documents are for use when providing items and services to participants, beneficiaries, enrollees, or covered individuals in group health plans or group or individual health insurance coverage, including Federal Employees Health Benefits (FEHB) plans by either:

- A nonparticipating provider or nonparticipating emergency facility when furnishing certain post-stabilization services, or
- A nonparticipating provider (or facility on behalf of the provider) when furnishing non-emergency services (other than ancillary services) at certain participating health care facilities.

These documents provide the form and manner of the notice and consent documents specified by the Secretary of HHS under 45 CFR 149.410 and 149.420. HHS considers use of these documents in accordance with these instructions to be good faith compliance with the notice and consent requirements of section 2799B-2(d) of the PHS Act, provided that all other requirements are met. To the extent a state develops notice and consent documents that meet the statutory and regulatory requirements under section 2799B-2(d) of the PHS Act and 45 CFR 149.410 and 149.420, the state-developed documents will meet the Secretary's specifications regarding the form and manner of the notice and consent documents.

These documents may not be modified by providers or facilities, except as indicated in brackets or as may be necessary to reflect applicable state law. To use these documents properly, the nonparticipating provider or facility must fill in any blanks that appear in brackets with the appropriate information. Providers and facilities must fill out the notice and consent documents completely and delete the bracketed italicized text before presenting the documents to patients. In particular, providers and facilities must fill in the blanks in the "Estimate of what you may pay" section and the "More details about your estimate" section before presenting the documents to patients.

The standard notice and consent documents must be given physically separate from and not attached to or incorporated into any other documents. The documents must not be hidden or included among other forms, and a representative of the provider or facility must be physically present or available by phone to explain the documents and estimates to the individual, and answer any questions, as necessary. The documents must meet applicable language access requirements, as specified in 45 CFR 149.420. The provider or facility is responsible for translating these documents or providing a qualified interpreter, as applicable, when necessary to meet those requirements. The standard notice must be provided on paper, or, when feasible, electronically, if selected by the individual. The individual must be provided with a copy of the signed consent document in-person, by mail or via email, as selected by the individual.

If an individual makes an appointment for the relevant items or services at least 72 hours before the date that the items and services are to be furnished, these notice and consent documents must be provided to the individual, or the individual's authorized representative, at least 72 hours before the date that the items and services are to be furnished. If the individual makes an appointment for the relevant items or services within 72 hours of the date the items and services are to be furnished, these notice and consent documents must be provided to the individual, or the individual's authorized representative, on the day the appointment is scheduled. In a situation where an individual is provided the notice and consent documents on the day the items or services are to be furnished, including for post-stabilization services, the documents must be provided no later than 3 hours prior to furnishing the relevant items or services.

NOTE: The information provided in these instructions is intended to be only a general informal summary of technical legal standards. It is not intended to take the place of the statutes, regulations, or formal policy guidance upon which it is based. Refer to the applicable statutes, regulations, and other interpretive materials for complete and current information.

Do not include these instructions with the standard notice and consent documents given to patients.

Paperwork Reduction Act Statement

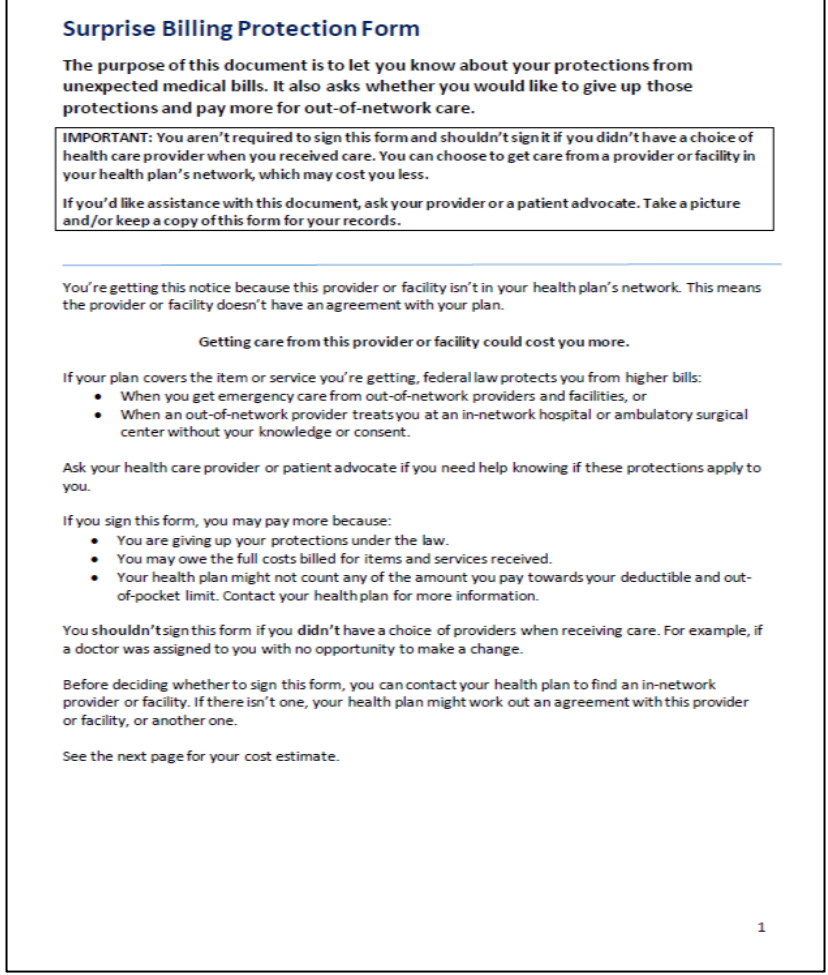
According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid Office of Management and Budget (OMB) control number. The valid OMB control number for this information collection is 0938-XXXX. The time required to complete this information collection is estimated to average 1.3 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

2

Page 1 – Notice

Notice must:

(1) State out of network.
(2) Provide a “good faith estimate” (*see next slide*).
(3) State prior authorization or other care management limitations *may* be required.
(4) State consent is *optional.*



Surprise Billing Protection Form

The purpose of this document is to let you know about your protections from unexpected medical bills. It also asks whether you would like to give up those protections and pay more for out-of-network care.

IMPORTANT: You aren't required to sign this form and shouldn't sign it if you didn't have a choice of health care provider when you received care. You can choose to get care from a provider or facility in your health plan's network, which may cost you less.

If you'd like assistance with this document, ask your provider or a patient advocate. Take a picture and/or keep a copy of this form for your records.

You're getting this notice because this provider or facility isn't in your health plan's network. This means the provider or facility doesn't have an agreement with your plan.

Getting care from this provider or facility could cost you more.

If your plan covers the item or service you're getting, federal law protects you from higher bills:

- When you get emergency care from out-of-network providers and facilities, or
- When an out-of-network provider treats you at an in-network hospital or ambulatory surgical center without your knowledge or consent.

Ask your health care provider or patient advocate if you need help knowing if these protections apply to you.

If you sign this form, you may pay more because:

- You are giving up your protections under the law.
- You may owe the full costs billed for items and services received.
- Your health plan might not count any of the amount you pay towards your deductible and out-of-pocket limit. Contact your health plan for more information.

You **shouldn't** sign this form if you **didn't** have a choice of providers when receiving care. For example, if a doctor was assigned to you with no opportunity to make a change.

Before deciding whether to sign this form, you can contact your health plan to find an in-network provider or facility. If there isn't one, your health plan might work out an agreement with this provider or facility, or another one.

See the next page for your cost estimate.

1

Pages 2 & 4 – Estimate

Estimate of what you could pay

Patient name: _____

Out-of-network provider(s) or facility name: _____

_____

Total cost estimate of what you may be asked to pay:	

► **Review your detailed estimate.** See Page 4 for a cost estimate for each item or service you'll get.

► **Call your health plan.** Your plan may have better information about how much you will be asked to pay. You also can ask about what's covered under your plan and your provider options.

► **Questions about this notice and estimate?** Call [*Enter contact information for a representative of the provider or facility to explain the documents and estimates to the individual, and answer any questions, as necessary.*]

► **Questions about your rights?** Contact [*contact information for appropriate federal or state agency*]

Prior authorization or other care management limitations

[*Enter either (1) specific information about prior authorization or other care management limitations that are or may be required by the individual's health plan or coverage, and the implications of those limitations for the individual's ability to receive coverage for those items or services, or (2) include the following general statement:*

Except in an emergency, your health plan may require prior authorization (or other limitations) for certain items and services. This means you may need your plan's approval that it will cover an item or service before you get them. If prior authorization is required, ask your health plan about what information is necessary to get coverage.]

[*In the case where this notice is being provided for post-stabilization services by a nonparticipating provider within a participating emergency facility, include the language immediately below and enter a list of any participating providers at the facility that are able to furnish the items or services described in this notice*]

Understanding your options

You can also get the items or services described in this notice from these providers who are in-network with your health plan:

More information about your rights and protections

Visit [*website*] for more information about your rights under federal law.

More details about your estimate

Patient name: _____

Out-of-network provider(s) or facility name: _____

_____

The amount below is only an estimate; it isn't an offer or contract for services. This estimate shows the full estimated costs of the items or services listed. It doesn't include any information about what your health plan may cover. This means that **the final cost of services may be different than this estimate.**

Contact your health plan to find out how much, if any, your plan will pay and how much you may have to pay.

[*Enter the good faith estimated cost for the items and services that would be furnished by the listed provider or facility plus the cost of any items or services reasonably expected to be provided in conjunction with such items or services. Assume no coverage would be provided for any of the items and services.*].

[*Populate the table below with each item and service, date of service, and estimated cost. Add additional rows if necessary. The total amount on page 2 must be equal to the total of each of the cost estimates included in the table.*]

Date of service	Service code	Description	Estimated amount to be billed
		Total estimate of what you may owe:	

Fredrikson & BYRON, P.A.

How to Calculate Estimate?

- Use definition of the “expected charge” that would apply when the good faith estimate is provided to a plan or issuer.
- **PROBLEM**: We don’t have this guidance yet from HHS and the non-enforcement position does not extend to the requirement to provide a good faith estimate.
  - HHS is seeking comment.

Page 3 – Consent

By signing, I give up my federal consumer protections and agree to pay more for out-of-network care.

With my signature, I am saying that I agree to get the items or services from (select all that apply):

☐ [*doctor's or provider's name*] [*If consent is for multiple doctors or providers, provide a separate check box for each doctor or provider]*

☐ [*facility name*]

With my signature, I acknowledge that I am consenting of my own free will and am not being coerced or pressured. I also understand that:

- I'm giving up some consumer billing protections under federal law.
- I may get a bill for the full charges for these items and services, or have to pay out-of-network cost-sharing under my health plan.
- I was given a written notice on [*enter date of notice*] explaining that my provider or facility isn't in my health plan's network, the estimated cost of services, and what I may owe if I agree to be treated by this provider or facility.
- I got the notice either on paper or electronically, consistent with my choice.
- I fully and completely understand that some or all amounts I pay might not count toward my health plan's deductible or out-of-pocket limit.
- I can end this agreement by notifying the provider or facility in writing before getting services.

IMPORTANT: You **don't** have to sign this form. But if you don't sign, this provider or facility might not treat you. You can choose to get care from a provider or facility in your health plan's network.

_____	or	_____
Patient's signature		Guardian/authorized representative's signature
_____		_____
Print name of patient		Print name of guardian/authorized representative
_____		_____
Date and time of signature		Date and time of signature

Take a picture and/or keep a copy of this form.

It contains important information about your rights and protections.

3

Steps to Provide OON Non-emergency Services Notice & Consent

1. Determine if you plan to balance bill.
2. If yes, determine if waiver of protections is allowed here.
3. Provide the notice & consent during applicable timing.
4. Mail or email copy of the signed written notice and consent to the patient (patient preference).
5. A participating health care facility (with respect to non-participating provider) must retain copy of the consent & notice for at least 7-year period after date care provided. IF the nonparticipating provider obtains the notice & consent (as opposed to the facility obtaining on behalf of the provider), the provider may either (1) coordinate with facility to retain it OR (2) the provider can retain it.
6. Notify the plan or issuer that care was provided during a visit.

No. 4 – OON Post Stabilization Emergency Care Notice & Consent

Generally, a nonparticipating emergency facility and nonparticipating professional cannot bill or hold liable patients for a payment amount of emergency services that exceed the cost-sharing requirements for such services.

BUT, this requirement does NOT apply with respect to certain services and items and are NOT included as "emergency services" IF 4 conditions are met.

What Items & Services Apply?

Items and services:

1. Benefits are provided or covered under the plan; and
2. Are provided by a nonparticipating professional or emergency facility (regardless of the department of the hospital in which such items or services are provided) **after** the patient 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.

NOTE: Can't consent to unforeseen, urgent medical needs that arise at the time an item or service is furnished.

Condition #1

- Attending emergency physician or treating provider determines (taking into account the individual's medical condition):
  - Patient can travel using nonmedical transportation or nonemergency medical transportation.
  - Available participating provider or facility located within a reasonable travel distance.

Condition #2

- Meet OON notice and consent criteria for non-emergency services (42 CFR § 149.420(c) through (g)).
- PLUS
  - If a *participating* emergency facility and a *nonparticipating* professional, notice and consent must include list of any participating professionals at the facility able to provide the items and services involved and notification that the patient may be referred, at their option, to such a participating provider.
  - If a *nonparticipating* emergency facility, notice must include good faith estimated amount that the patient may be charged for items or services provided by the nonparticipating emergency facility or nonparticipating professionals with respect to the visit at such facility.

Condition #3

- Attending emergency physician or treating provider, using appropriate medical judgment, determines patient can:
  - Receive the notice & consent and
  - Provide informed consent.

Condition #4

Any additional requirements or prohibitions as may be imposed under state law.

Steps to Provide OON Post Stabilization Emergency Care Services Notice & Consent

1. Determine if you plan to balance bill.
2. If yes, determine if waiver of protections is allowed here (can you meet the 4 conditions?).
3. Provide the notice & consent within timing requirements.
4. Mail or email copy of the signed written notice and consent to the patient (patient preference).
5. A participating health care facility (with respect to non-participating professional) must retain copy of the consent & notice for at least 7-year period after date care provided. IF the nonparticipating professional obtains the notice & consent (as opposed to the facility obtaining on behalf of the professional), the professional may either (1) coordinate with facility to retain it OR (2) the professional can retain it.
6. Notify the plan or issuer that care was provided during a visit.

Bottom Line

- Patient facing “forms”:
  - Standard Disclosure
  - Universal Good Faith Estimate Notice
  - OON Non-emergency Services Notice & Consent
  - OON Post Stabilization Emergency Care Notice & Consent
- Put processes in place:
  - Update website and physical space with Standard Disclosure
  - When/how to provide Universal Good Faith Estimate.
  - When/how to provide OON Notices & Consents.
  - How handle IDR open negotiation period.
  - How handle patient-provider dispute resolution open negotiation period.

Resources

- DOL Website
  - https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/no-surprises-act
- CMS Website
  - https://www.cms.gov/nosurprises/Policies-and-Resources/Overview-of-rules-fact-sheets

Presenters

David Glaser
612.492.7143
dglaser@fredlaw.com

Mary E. Heath
612.492.7272
mheath@fredlaw.com