Good Faith Estimates Webinar Follow-up Questions Submitted via Chat | February 3, 2022
Answers prepared by AnnMargaret McCraw

Q: Am I understanding that GFEs must be given to every patient, even those scheduled as elective cases who have insurance?
Q: What about insured patients who want to self-pay?

A: Good Faith Estimates are required for the following patients:
Patients who do not have benefits for an item or service under a group health plan, group or individual health insurance coverage offered by a health insurance issuer, a federal health care program, or a group insurance policy or contract, medical or hospital service agreement, membership or subscription contract, or similar group arrangements provided by a carrier for the purpose of providing, paying for, or reimbursing expenses for health services.

Patients who do have health benefits as described above but who ask you not to bill their insurance. You must honor a privately insured patient's request not to file insurance and provide a GFE for any services scheduled at least 3 days out. You must also provide a GFE if they ask about cost without scheduling.

Exception: patients covered by a Federal Health Care program cannot elect to self-pay for covered services. Patients insured by a Federal Health Care program who are seeking non-covered services should receive an ABN, not a GFE.

Patients who have health insurance that covers the items/services they will receive and who intend to use that health insurance do not need a GFE.

GFEs are only required for services scheduled at least 3 days in advance regardless of insurance coverage.

Q: Is this required for non-covered services, such as visco into the shoulder that is never covered?
A: Yes. Self-pay patients for GFE purposes include those who have private health benefits that do not include coverage for the item or service being offered. Patients covered by a federal healthcare program should receive an ABN for non-covered services, not a GFE.

Q: What if we don't take self-pay patients?
A: GFEs are still required for patients covered by non-government sponsored health plans if they choose to self-pay for services or if the service you are providing is not covered by their health plans.

Unrelated to GFE, increasingly more patients can self-pay for care and do not buy insurance. We encourage you to consider how incorporating these patients into your practice strategy may provide a competitive advantage.

Q: Can a Medicare / secondary insurance, choose to be a self-pay and not file their insurance?
A: Patients insured by any Federal Health Care Program (primary or secondary) may not choose to self-pay for covered services. If they are seeking services not covered by the Federal health Care Program, they should receive an ABN, not a GFE.

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Q: Scenario: A physician sees an uninsured patient with a hip fracture over the weekend while covering call. Surgery is delayed awaiting medical clearance. Clearance is received the next day and surgery is done that day.

A: No GFE required because the surgery was performed within 3 days. Only services scheduled 3 or more days out require a GFE.

Q: Do we have to estimate costs for outside facility like ASC/anesthesia?

A: In 2022, the convening provider (surgeon in this example) does NOT have to provide estimates for the co-providers/facilities: ASC, hospital, or anesthesia. The GFE for the surgeon's services should indicate which ASC, hospital and/or anesthesia practice will be billing the patient for additional services and include contact information so the patient can request GFEs directly from those co-providers.

Note: while not required, if your physicians own the ASC and your practice bills for it, it would be very customer friendly to include those charges on your GFE.

Based on current CMS guidance, convening providers will have to include estimates for co-provider/facilities as of 1/1/2023.

Q: How is the GFE supposed to be provided in writing prior to the visit? Is an email acceptable, and must the e-mail be sent securely?

A: The GFE must be provided in written form either on paper or electronically based on the patient's requested method of delivery. Email or patient portal are acceptable. Electronic delivery must allow save/print options. Estimates given orally over the phone or in person at the patient's request must be followed-up with a written copy.

The HIPAA Security Rule requires that all electronic communication of PHI be secure. That being said, the Right of Access Rule allows an individual to "request transmission by unsecure medium". The patient would have to request (and practice should document) that the GFE be emailed without security.

Q: Scenario: Patients who have been seen in the ER after-hours when our physicians are on-call report to our office the next morning at 7am to be seen. We often don't know they are coming until they arrive, and many are serious injuries. Do GFE requirements apply?

No GFE is required for the office visit evaluation that occurs within 24 hours or for any treatment rendered within the first 3 days. However, if the physician evaluates the patient in the office on Monday morning and schedules surgery for the following Friday, a GFE will be required for the surgery because it is scheduled at least 3 days in advance.

Q: What if a service does not typically cost $400? For example, a therapy visit may only be $50. Would we still need to provide this for them every time?

Q: Do we have to have a new GFE signed for each office visit/service when a patient is having ongoing care?

A: A GFE is required even if the charge is expected to be $0 (charity care).
You are permitted to use 1 GFE for recurring services like therapy. You could list a series of therapy visits on one GFE and simply list the price per visit. Clearly identify the cost of each visit as well as the total expected charge if the patient completes all visits.

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Q: If a self-pay patient calls for an appointment and we schedule an appointment for the following day, is a GFE required?
A: No. GFEs are only required for services scheduled at least 3 days in advance.

Q: Are pre-operative clearances and labs part of the estimate? Can we put "patient choice" meaning it is up to the patient where he or she wants to go?
A: Pre-operative clearances and labs should be included as "separately scheduled" services. List what services are required and who will perform them (if you know), but you do not have include charge information. You may indicate that patient will select the provider of his/her choice, if applicable. See the GFE template examples for sample language.

Q: Do they sign that they have received the item?
A: The Regulation does not require the patient to sign the GFE or to acknowledge with signature that the service/item was received. The practice can certainly add a signature line if desired.

Q: Regarding the implant example: if the hospital bills for the implant, the practice/surgeon doesn't need to worry about it in 2022, correct?
A: Correct. If a practice owns the ASC where the surgery will be performed and bills for those services also, it would be customer-friendly to include the implant cost, but the practice does not have to include estimates for the co-facilities (even physician-owned ASCs) until 2023.

Q: For new self-pay patients, we don't know exactly what will be billed. Would you recommend using the highest E&M, x-rays, injections, casting/splinting to cover ourselves? Do we only need to provide on testing, injections, surgeries? We typically give a range of cost since we don't know exactly what will occur, especially if they haven't been seen.
A: A few thoughts on this one.
The Regulation requires an estimated charge (not a range) for each service. You will fulfill the GFE requirement if you put the high end of your range for each anticipated service. There's certainly no penalty if the actual bill is lower than the estimate.

You might take this opportunity to set standard self-pay prices for your most basic office services and post them online. Price transparency is a competitive advantage, and it simplifies completion of the GFE. We may offer a future webinar on that topic.

Q: If we refer a self-pay patient for a MRI at an independent imaging facility, who provides the GFE?
A: The imaging center provides the GFE. Because it is a distinct service that is not an integral part of a procedure you are scheduling, you are not required to provide the GFE even though you ordered the MRI.

In contrast, a patient can't have surgery without a facility and anesthesia. In this example, the convening provider is the surgeon, and the facility/anesthesia group are co-providers. In 2023, those co-provider charges will need to be added to the GFE. This year, they just need to be listed without charge information.

Q: What if a new patient is coming in and you do not know what level visit or if x-rays are needed; how can you give a GFE?
A: You must include a charge amount, not a range, for the GFE so I recommend practices set a rate for a routine office visit and x-rays that is satisfactory for any level of visit. Set a rate for a new patient and a rate for established patients. Set it high enough to cover the most complex visit.

Bills will not be subject to dispute if they are lower than the GFE. Also, the bill must be at least $400 higher than the GFE to trigger dispute rights. It's unlikely that the difference between a level 3 and 4 E/M or an extra set of x-rays would exceed $400.

Q: If a new patient is price shopping and calls for a price on a service, how can we provide a GFE when we don't have the patient's demographics? They are unlikely to give us this information if they are just price shopping. Do we have to ask every person that calls for their address or email before we even give them a cost amount?

A: Official Requirement: "The No Surprises Act includes provisions that require providers and facilities to furnish good faith estimates to uninsured (or self-pay) individuals upon their request and at the time of scheduling the item or service."

The Act does not specifically consider a scenario in which uninsured or self-pay individuals are calling around for pricing with no commitment to seek care at your practice.

Suggestion given the lack of guidance:

- An individual calls to request the price of a service.
- Verbally give the price.
- Ask the caller if s/he intends to file health insurance for the service.
- If yes, no further action needed related to GFE.
- If no, ask if the caller would like to receive a written Good Faith Estimate for the service.
- Explain that you will need to collect demographic information to do so.
- If caller wants the GFE, proceed to collect necessary information and provide the GFE.
- If the caller declines, no further action needed.

Q: Do we have to allow patients the choice to file their insurance or not? Example: the patient presents with insurance and wants to file the initial visit, but they want to pay cash for the next visit. Once they elect self-pay status, we have required them to be self-pay until that course of treatment is complete. Is there guidance in the policy or is this a practice decision on how to handle?

A: This scenario is not specifically considered by the Act. Other than the provision in the Hi-Tech Act that allows patients to request that their insurance not be billed, no prior law has inferred insured patients can choose to self-pay.

By specifically stating that insured patients who ask to self-pay must receive a GFE, the Act implies that practices must allow them to do so. The Act does not address if the practice must also allow them to switch back to filing insurance upon request. I anticipate insurance plans weighing in on that point, but for now, there's only guidance allowing patients to self-pay – no guidance on allowing them to switch back to filing insurance.

Q: Do DME Items have to be on the GFE sheets also if you think they might require some sort of brace?

A: All services/items "reasonably expected to be furnished for the primary item or service" need to be included on the GFE.

Example: If a surgeon usually orders and dispenses a knee brace after ACL surgery, include the brace on the GFE for the ACL surgery.

If the surgeon writes the order for the brace, but it is dispensed by another entity (hospital or independent DME provider), include it on the ACL GFE in the co-provider/facility section. In 2022, co-provider services should be listed, but no charge information is needed.

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Q: We see many patients from the Amish community, who often do not have access to email, etc. If we provide a verbal GFE for anticipated services before the patient comes to the office (if they are scheduled only a few days out), and have them pick up a paper copy of the GFE on the DOS, would this be sufficient to meet the timing requirements?

A: If the patient's appointment is within 3 days of his/her call to schedule, no GFE is needed. For appointments scheduled 3 days in advance, notice is due 1 day after scheduling.

I recommend providing the verbal GFE at the time the appointment is scheduled and asking the patient how s/he would like to receive the written copy: email, postal mail, or pick-up in person. Prepare the written GFE immediately and initiate delivery as requested. If s/he requests postal mail or personal pick-up, you are complying with the Act's requirement "to deliver the notice according to the individual's requested method of delivery" even if s/he doesn't receive it the next day.

Q: We were told in previous webinars that worker's comp patients are considered uninsured and must receive a GFE. Is this correct?

Q: Scenario: patient is seen for an auto accident injury. We are billing auto insurance as primary; but will not be billing their health insurance. Do we need to issue a GFE when health insurance is considered the secondary payer?

A: The Act does not specifically address workers' compensation or other third-party liability scenarios. *Since we do not have specific guidance on this issue, the following considerations are based on our interpretation of the Act's intent and other provisions. Each practice will need to decide how to respond until HHS provides clarification.*

If a patient being treated also has health insurance that will be filed if the third-party claim is denied, no GFE should be needed.

The stated goal of the GFE requirement is "to ensure that uninsured (or self-pay) individuals are also afforded protections against *surprise health care costs*…" Therefore, if a third-party is accepting responsibility for the services and the patient will have no financial responsibility for them, one could argue no GFE is needed. The problem arises if the third party ultimately denies the claim. If the patient has health insurance and the claims will be refiled with that carrier, no GFE is needed. If the patient does not have health insurance, the GFE requirement would apply but the services were already rendered.

The Act requires GFEs for "patients who do not have benefits for an item or service under *a group health plan, group or individual health insurance coverage offered by a health insurance issuer, a Federal health care program, or a group insurance policy or contract, medical or hospital service agreement, membership or subscription contract**, or similar group arrangements provided by a carrier for the purpose of providing, paying for, or reimbursing expenses for health services***."

While not specifically addressed, one could make the argument that workers' compensation provided by a carrier meets the bolded definition above.

If you do issue a GFE with self-pay rates to a person whose care should be paid by a third party, be aware that you are likely limiting yourself to the rates on the GFE even if the third party may have paid more had the GFE not been issued.

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OON – No Surprises Act (NSA) Questions
Disclaimer: These questions go beyond the scope of the GFE webinar. Basic answers are provided, but nuances exist that require a deeper dive. We will provide additional resources soon.

Q: Can you please make the distinction between OON patients receiving services in a par hospital vs OON patients coming to the office?
Q: It the patient is insured but the physician is not in network, is the patient considered uninsured?

A: CMS Training Materials indicate the No Surprises Act prohibits OON providers and facilities from balance billing in these scenarios:

- A person gets covered emergency services from an out-of-network provider or out-of-network emergency facility.
- A person gets covered non-emergency services from an out-of-network provider delivered as part of a visit to an in-network health care facility.

CMS Training materials indicate the No Surprises Act does not regulate provider billing practices for non-emergency services in these scenarios:

- Non-emergency covered items or services are provided in an OON hospital, HOPD, ASC or other facility type.
- Items or services that are not covered by the patient's insurance plan regardless of the provider's network status.

Scenario A: A surgeon provides care for an emergency medical condition to a patient in a hospital ER or Operating Room while on-call. The surgeon is OON with the patient's insurance, but the hospital is in-network.
The OON surgeon may not send a balance bill to the patient for emergency services covered by the patient's insurance.

Scenario B: A surgeon is asked to provide an orthopedic consult on a patient who has been admitted to a hospital for non-emergency care. The surgeon is OON with the patient's insurance, but the hospital is in-network.
The OON surgeon may not send a balance bill to the patient for the inpatient consult.

Scenario C: A patient calls to make an appointment with Dr. Amazing to evaluate her knee pain. The practice and Dr. Amazing are OON with the patient's insurance. The patient is advised of OON status when she calls. She wants to see Dr. Amazing anyway.
Elective, office-based services like the consultation described above are not governed by the No Surprises Act. However, I recommend asking the patient to sign an acknowledgement of the physician's OON status and provide a cost-estimate.

Scenario D: Following the evaluation described in Scenario C, surgery is ordered for the patient at a hospital or ASC that is in-network with the patient's insurance. Dr. Amazing remains OON with the patient's insurance.
Notice and consent requirements apply to the scenario and must be provided at least 3 days prior to the service being rendered to avoid balance billing limits. If the surgery setting (hospital or ASC) is also OON with the patient's insurance, the Balance Billing rules do not apply.

In all cases, offering patients estimates of their out-of-pocket responsibility is a best practice even if the law does not require it.

We will provide additional resources on the Balance Billing and Notice/Consent requirements of the No Surprises Act soon.