Status **Active** PolicyStat ID **13500541**

Effective	04/2023
Approved	04/2023
Last Revised	04/2023
Expiration	04/2024

Owner	Krista Zabreznik: Business Office Manager
Department	Patient Accounts
Categories	Policy, Procedure

No Surprise Billing Act - Good Faith Estimate

Policy

It is the policy of North Valley Hospital District to adhere to the regulations outlined by Centers of Medicare and Medicaid Services (CMS) Department of Health and Human Services (HHS), the Department of Labor (DOL), along with the Office of Personnel Management (OPM), as it pertains to the "No Surprise Billing Act." State regulations take precedence over federal regulations. This regulation is effective January 1, 2022.

PURPOSE

The "No Surprise Billing" rule restricts excessive out of pocket costs to patients from surprise billing and balance billing, when the provider and/or facility is considered out-of-network (OON). This includes: Emergency services (up to the point of stabilization) at an out-of-network facility Bans high out-of-network cost-sharing for emergency and some non-emergency services. Out-of-network providers performing non-emergency or elective services incidental to an in-network facility service Disallows other out-of-network charges without the patient's advance notice and consent.

DEFINITIONS

Interim Final Rule (IFC): The IFC implements many of the law's requirements for group health plans, health insurance issuers, carriers under the Federal Employees Health benefits program, health care providers, facilities and air ambulance service providers. The IFC protects the patient from surprise medical bills for emergency services, air ambulance services provided by out of network providers, and non-emergency services provided by out-of-network providers at the in-network facilities in certain circumstances.

Select Dispute Resolution (SDR): In a situation where an uninsured or self-pay patient receives a good faith estimate and then is billed for an amount substantially in excess of the good faith

estimate, the dispute is resolved through the SDR process.

Federal Employees Health Benefits (FEHB): Is the largest employer-sponsored group health insurance program in the world covering almost 9 million people including employees, annuitants, and their family members as well as some former spouses and former employees.

PROCEDURE

1. Eligibility/Benefits/Coverage

A. When scheduling an item or service, or if requested by an individual, providers and facilities are required to inquire about the individual's health insurance status or whether an individual is seeking to have a claim submitted to their health insurance for services requested.

B. If the provider is in network, the reference lab, ambulance, radiologist etc., may not be in network. It is important that the patient understand this and be provided an estimate of these charges.

C. If the health plan covers any benefits for emergency services, this IFC requires emergency services to be covered:

1. Without any prior authorization;
2. Regardless of whether the provider is an in-network provider or an in-network emergency facility.
3. Regardless of any other term or condition of the plan or coverage other than the exclusion or coordination of benefits, or permitted affiliation or waiting period.
4. Emergency services include certain services in an emergency department of a hospital or an independent freestanding emergency department, as well as post-stabilization services.

2. Good Faith Estimate

A. The provider or facility must provide a good faith estimate of expected charges for items and services to an out-of-network provider/facility or uninsured/self-pay patients.

B. For scheduled services, the good faith estimate must be delivered to the patient three days prior to receiving care. If care is to be delivered the same day, at least three hours prior to providing services.

C. If the patient has benefits under a group health plan, group or individual insurance group and does not want their insurance billed, a good faith estimate must also be provided.

D. The good faith estimate must include the expected charges for the items or services that are reasonably expected to be provided together with the primary item or service, including items or services that may be provided by other providers and facilities. Examples would be; air ambulance, reference lab, radiology interpretation etc.

3. Patient Disputes

A. In a situation where an out-of-network or self-pay patient receives a good faith estimate and

then is billed for an amount substantially higher than the good faith estimate, the patient-provider dispute resolution will be decided by the SDR department. The patient will receive a handout explaining this process and their rights.

B. If patients have questions about their rights they may contact the Washington State Office of the Insurance Commissioner on-line at https://www.insurance.wa.gov/ or call 800-562-6900 8:00am-5:00pm M-F.

4. No Surprise Billing Consent

A. If non-emergency services are provided, and the provider/facility is out-of-network, the patient needs to sign a consent agreeing to the services and accepting financial responsibility for said services. If the patient refuses to sign the consent but wants the service, two North Valley Hospital employees should sign and witness the patient's refusal.

B. If the consent is not signed or witnessed, the out-of-network provider/facility is prohibited from collecting payment from the patient any amount except as determined by the health plan.

C. Follow the link below to access the "No Surprise Billing Consent/Good Faith Estimate."

D. If the provider/facility fails to provide notice and obtain consent, the provider/facility cannot balance bill the patient for the portion the health plan will not cover.

5. Single Case Agreement (SCA)

A. North Valley Hospital may initiate a SCA with the out-of-network health plan. The amounts generally billed (AGB) will be used to calculate a fair and equitable payment amount.

6. Billing

A. The provider/facility must notify the health plan as to whether the requirements for the notice and consent have been met when transmitting the bill. This can be done by adding a note to the claim or sending a copy of the document.

7. Determination of Out of Network Rates

A. An amount determined by an applicable All-Payer Model Agreement under section 1115A of the Social Security Act.

B. If there is no such applicable All-Payer Model Agreement, an amount determined by a specified state law.

C. If there is no such applicable All-Payer Model Agreement or specified state law, an amount agreed upon by the plan or issuer and the provider or facility.

D. If none of the three conditions above apply, an amount determined by an independent dispute resolution (IDR) entity may be used.

E. Both the payer and provider will submit supporting documentation

8. Notification Displayed

A. The IFC requires health care providers and facilities to make publicly available, post on a public website, and provide individuals a one-page notice about:

1. The requirements and prohibitions applicable to the provider or facility under Public Health Service Act sections 2799B-1 and 2799B-2 and their implementing regulations;
2. Any applicable state balance billing limitations or prohibitions;
3. How to contact appropriate state and Federal agencies if someone believes the provider or facility has violated the requirements described in the notice.

9. Provider Disputes

A. The No Surprises Act provides that, if open negotiations do not result in an agreement between the parties for an out-of-network rate by the end of the 30-business-day period, a plan, issuer, carrier, provider, facility, or provider of air ambulance services may then, during the 4-business-day period beginning on the 31st business day after the start of the open negotiation period, initiate the Federal IDR process. The initiating party must provide this written Notice of IDR initiation to the other party. The initiating party is permitted to provide the notice of IDR initiation to the opposing party electronically (such as by email) if the following two conditions are satisfied:

1. The initiating party has a good faith belief that the electronic method is readily accessible by the other party; and
2. The notice is provided in paper form free of charge upon request. In addition to providing notice to the other party, the initiating party must also furnish the Notice of IDR Initiation to the Departments by submitting the notice using the Federal IDR portal, available at https://nsa-idr.cms.gov/paymentdisputes/s/ . The initiation date of the Federal IDR process will be the date of receipt of the Notice of IDR Initiation by the Departments.

B. If the health plan and provider/facility are unable to negotiate a fair payment amount, the dispute will go through an independent dispute resolution process (IDR). An arbitration is a final, legally binding process. The arbitrator hears both sides at an informal hearing. The losing party to a binding arbitration will also be responsible for paying all legal fees in addition to the services provided to the patient.

C. There are no appeal rights to an arbitration.

REFERENCES

Federal Register: https://www.federalregister.gov/documents/2021/10/07/2021-21441/requirements- related-to-surprise-billing-part-ii

CMS: https://www.cms.gov/newsroom/press-releases/hhs-announces-rule-protect-consumers-surprise- medical-bills

American Hospital Association: https://www.aha.org/special-bulletin/2021-08-23-departments-hhs- labor-and-treasury-release-faqs-transparency-no

CMS-9909-IFC: https://www.cms.gov/files/document/cms-9909-ifc-surprise-billing-disclaimer-50.pdf

All Revision Dates

04/2023

Approval Signatures

Step Description	Approver	Date
	John McReynolds: CEO	04/2023
	Alan Ulrich: CFO	04/2023
	Krista Zabreznik: Business Office Manager	04/2023