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# The No Surprises Act's Good Faith Estimates – What Every Provider Needs to Know

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The No Surprises Act ("NSA") became effective January 1, 2022 and protects consumers against surprise medical bills. However, a lesser known part of the NSA, called the Good Faith Estimate provisions, requires essentially all health care providers make available a good faith estimate ("GFE") of charges for items and services provided to an uninsured patient and to an insured patient who elects not to submit a claim to his or her health insurance for coverage (a self-pay patient). If an uninsured or self-pay patient receives a bill from a provider that is $400 or more above the GFE, the patient may dispute the bill with the U.S. Department of Health and Human Services ("HHS").

## Which Providers Must Offer a GFE?

Providers covered by the GFE requirements include physicians, behavioral and mental health providers, other State licensed professionals and air ambulance providers, as well as any health care facility licensed to operate under laws of the State in which it is located, including hospitals, hospital outpatient departments, critical access hospitals, ambulatory surgery centers, rural health clinics, federally qualified health centers, clinical laboratories and imaging centers. Under the GFE rules, the provider or facility scheduling the primary service or item or who receives an initial request for a GFE from an uninsured or self-pay patient is referred to as the "convening provider or facility."


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## Which Patients are Entitled to Receive a GFE?

At the time of scheduling an item or service, a convening provider or facility must ask the patient whether the patient has insurance. If the patient is uninsured, or if insured and the patient asks that the item or service not be billed to his or her insurer (i.e., self-pay), then the patient is automatically entitled to a GFE of expected charges, but only if the item or service is scheduled at least three business days in advance. An uninsured or self-pay patient is also entitled to a GFE upon request, but again only if the item or service is scheduled at least three business days in advance. Any discussions or inquiry by an uninsured or self-pay patient regarding potential costs of items and services to be provided should be considered a request for a GFE.

If the convening provider or facility is out-of-network with the patient's insurer, the patient will only be considered self-pay if the patient requests to pay the claim directly without insurance billing. Most urgent care or walk-in clinics will not be required to provide a GFE since these types of provides rarely schedule appointments three or more business days in advance. However, if an urgent care or walk-in clinic schedules a follow-up visit with an uninsured or self-pay patient more than three business days in advance, a GFE would be required.

## Notice of GFE Rights

Each covered provider and facility must prominently display in a clear and understandable manner information regarding the availability of a GFE on its website, in its office or facility and on-site where scheduling or questions about the cost of items or services may occur. A GFE informational notice developed by HHS may be found here. Providers and facilities must also provide information about the availability of a GFE to uninsured and self-pay patients when scheduling an item or service or when questions about the cost of items or services occur. A GFE must be available in accessible formats and in the language(s) spoken by individual(s) considering or scheduling items or services.

## What is Included in a Good Faith Estimate?

A GFE is a written (either on paper or electronic) notification from the convening provider or facility that outlines for an uninsured or self-pay patient (or their authorized representative) the reasonably expected charges for a scheduled or requested item or service. After January 1, 2023, the GFE from the convening provider or facility must also include information from co-providers or facilities so that the patient receives only one GFE covering all items and services to be offered to the patient. Under the GFE rules, a "co-provider or facility" is a provider or facility that provides items or services in connection with the primary service offered by the convening provider or facility. For example, if after January 1, 2023 an uninsured or self-pay patient schedules knee surgery with a physician's office at least three business days in advance (the physician office in this example would be the convening provider), the GFE will need to include all items or services that are reasonably expected to be provided from the date of admission for surgery through discharge, including fees associated with the surgeon, hospital or ambulatory surgery

center, anesthesiologist, prescription drugs and durable medical equipment. A separate GFE would be provided for any pre- or post-op items or services, including, for example, pre-operative laboratory testing or post-discharge physical therapy. Any GFE issued to an uninsured or self-pay patient must be included as part of the patient's medical record.

A GFE includes pertinent information about the item or service to be provided and the anticipated cost, including the following information:

- Patient name and date of birth;
- Description of the primary item or service to be provided in clear and understandable language (and if applicable, the date the primary item or service is scheduled);
- Applicable diagnosis codes, expected service codes, and expected charges associated with each listed item or service;
- Name, National Provider Identifier, and Tax Identification Number of each provider or facility represented in the GFE;
- List of items or services that the convening provider or 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 that informs the uninsured or self-pay patient that there may be additional items or services the convening provider or facility recommends as part of the course of care that must be scheduled or requested separately and are not reflected in the GFE;
- A disclaimer that informs the uninsured or self-pay patient that the information provided in the GFE is only an estimate and that actual items, services or charges may differ from the GFE;
- A disclaimer that informs the uninsured or self-pay patient of that individual's right to initiate a dispute resolution process if the actual billed charges are substantially in excess of the expected charges included in the GFE. This disclaimer must include instructions about how to initiate the dispute resolution process and state that the initiation of the process will not adversely affect the quality of health care services furnished to the individual by a provider or facility; and
- A disclaimer that the GFE is not a contract and does not require the uninsured or self-pay patient to obtain the items or services from any provider or facility identified in the GFE.

A GFE template developed by HHS may be found here.

## When does a GFE need to be provided?

If an uninsured or self-pay patient is entitled to a GFE, the convening provider or facility must comply with the following timeframes:

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- When a primary item or service is scheduled at least three business days before the date the item or service is scheduled to be furnished, the GFE must be provided no later than one business day after the date of scheduling.
- When a primary item or service is scheduled at least ten business days before the date the item or service is scheduled to be furnished, the GFE must be provided no later than three business days after the date of scheduling.
- When a GFE is requested by an uninsured or self-pay patient, the GFE must be provided no later than three business days after the date of the request. If, however, the GFE request is for an item or service to be provided within less than three business days, no GFE is required.

Any anticipated change in a GFE (such as changes to the expected charges, items, services, frequency, recurrences, duration, providers or facilities) must be provided to the patient no later than one business day before the item or service is scheduled to be furnished. If any change in expected providers or facilities represented in a GFE occurs less than one business day before the item or service is scheduled to be furnished, the replacement provider or facility must accept the GFE for the relevant item or service being furnished that was provided by the replaced provider or facility.

## Dispute Resolution Process

When billed charges for any provider or facility are in excess of the GFE provided to an uninsured or self-pay patient by $400 or more, the patient has the right within 120 days after receiving the disputed bill to file a challenge through a dispute resolution process called a Patient-Provider Dispute Resolution ("PPDR") process. While the PPDR process is pending, the provider or facility must not pursue collection efforts against the patient. An HHS selected dispute resolution ("SDR") entity will evaluate the claim and obtain information from the patient and the applicable provider or facility. Within 30 business days after receiving all necessary information, the SDR entity will determine the amount owed by the patient and whether the provider or facility has provided credible information to demonstrate that the difference between the billed charges and the expected charges in the GFE reflect the costs of a medically necessary item or service and is based on unforeseen circumstances that could not have reasonably been anticipated by the provider or facility when the GFE was provided to the patient.

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