No Surprise Billing | Price Transparency FAQs for Staff

Definitions:

- Emergency Services: treatment of a condition that, if not treated, could reasonably be expected to result in placing the patient's health in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part [correlates to the EMTALA definition]
- Health Care Facility: Hospital, Ambulatory Surgery Center, Skilled Nursing Facility, Physician Office, Laboratory, or Radiology/Imaging Center
- Ancillary: anesthesiologist, radiologist, ED physician, hospitalist, pathologist, intensivist, neonatologist, assistant surgeon
- "In Advance" – means:
    - 14 days in advance of a scheduled service except:
    - If the service is scheduled less than 14 days in advance: notice must be provided 3 days in advance
    - If the service is scheduled less than 3 days in advance: notice must be provided on the day appointment is made
    - For same day services: notice must be given 3 hours prior to furnishing the service

What is surprise billing?

Surprise billing occurs when a patient goes to participating facility and is surprised to receive out-of-network bills from an individual healthcare professional that provides services at the in-network facility.

When a patient sees a healthcare provider, they may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. Patients may have additional costs or be required to pay the entire bill if they see a provider or visit a facility that is not in their health plan's network. Out-of-network providers and facilities that haven't signed a contract with the health plan may be permitted to bill for the difference between their charge and what the health plan has agreed to pay. This is called *balance billing*. *Surprise billing* is an unexpected balance bill. Surprise billing may happen when patient is unexpectedly treated by an out-of-network provider.

What is Price Transparency?

Price transparency is a set of federal regulations aimed at helping patients know the cost of a healthcare item or service before receiving it.

Why are we providing this information to patients now?

New state and federal regulations have gone into effect to protect patients from receiving surprise bills and requiring price transparency. The laws prohibit surprise billing under certain circumstances, require healthcare organizations to notify patients of these protections, and, in some cases, to provide an estimate of the cost of care.

What services are covered under these new regulations?

The new Surprise Billing regulations apply to emergency services as well as to non-emergency services provided by an out-of-network individual healthcare professional in 2 settings: at an in-network facility (such as a hospital or ASC) and in an office setting.

The new Price Transparency regulations apply to all patients covered by the Surprise Billing regulations AND Uninsured/Self-Pay Patients.

Do these policies apply to patients with short-term, limited-duration plans, liability insurance/workers compensation plans, or health sharing ministries?

Patients enrolled in these types of coverage, absent enrollment in other forms of comprehensive coverage, are considered uninsured for the purpose of this regulation, as these types of coverage are not recognized as group health insurance. Therefore, these patients should receive uninsured/self-pay good faith estimates prior to scheduled care.

What information must be given to patients?

The regulations apply to 2 types of patients: Uninsured/Self Pay patients and patients covered by an Out of Network insurance plan. The requirements vary depending on the patient type.

The **Notice of Patient Protections Against Surprise Billing (Form #12478)** must be provided to *all patients with private healthcare plans* (does not include government insurance like Medicare, Medicaid, Tricare, or VA or non-traditional insurances like health share ministries, worker's compensation, or liability coverage) and must be posted in the facility and online. This form must be provided at every patient visit, in every setting (ED and ambulatory), even if the patient has received it previously.

The **Notice of Right to Receive a Good Faith Estimate (Form #12479)** must be provided to *all uninsured and self-pay patients, including those with non-traditional health insurance, such as health share ministries, worker's compensation, or liability coverage,* and must be posted in the facility and online. This form must be provided at every patient visit, in every setting (ED and Ambulatory), even if the patient has received it previously.

Uninsured/self-pay patients must be provided a **Detailed Good-Faith Estimate (Form #12480)**. This includes anyone who does not have traditional health insurance, such as health share ministries, worker's compensation, or liability coverage. This form must be provided in advance of the patient receiving services in the Ambulatory setting only (not ED).

Patients with out-of-network insurance will need to sign the **Balance Billing Acknowledgement (Form #12477)** and be provided a **Detailed Good-Faith Estimate (Form #12480)** in the Ambulatory setting only (not ED).

- Only the **Balance Billing Acknowledgement (Form #12477)** needs to be signed.
- Both the **Balance Billing Acknowledgement (Form #12477)** and the **Detailed Good-Faith Estimate (Form #12480)** must be scanned in and saved to the medical record for 6 years.
- Copies must be provided to the patient, in printed or digital form.

Refer to the form grid and process flow on the for more specific information.

How does the scheduling of the procedure affect requirements for providing a GFE?

Rules are slightly different between uninsured/self-pay and out-of-network (OON) patients. OON patients are ALWAYS entitled to a Notice/Acknowledgment/GFE, regardless of whether the service is same-day or scheduled 2 weeks in advance.

Self-Pay/Uninsured Patients (note that this definition includes any patient who is not insured under either a group health plan or a government plan, e.g., Christian med-share program, workers comp, auto-no fault): GFE is required for every service (facility and professional) but only in 2 scenarios:

- A service scheduled at least 3 days in advance OR
- If the patient requests it

Stated otherwise, if a self-pay patient is a walk-in and does not request a GFE, we are not legally obligated to provide a GFE. We did make the organizational decision, however, to provide a GFE to every uninsured patient every time even though it's technically not legally required except in these 2 scenarios.

Out-of-Network Patients: A Balance Billing Acknowledgement + GFE is only required to be provided in 2 scenarios:

- At a facility (hospital, surgery center, imaging center): when the facility is in-network and the individual provider(s) are out of network (e.g., for a radiology test, if there is an insurance company for which MMC is in-network and Grand Traverse Radiologists is out of network). In this situation, the OON Provider (not the In-Network Facility) is responsible for providing the GFE.
- In an office/clinic setting: the OON Provider must provide a Balance Billing Acknowledgement + GFE.

What is considered a good-faith estimate (GFE)?

A good-faith estimate is defined to mean "a notification of expected charges for a scheduled or requested item or service, including items or services that are reasonably expected to be provided in conjunction with such scheduled or requested item or service, provided by a convening provider, convening facility, co-provider or co-facility."

Are Cash Pay – Uninsured – Self-Pay Discount & Financial Assistance (lines 3C and 3D on Good Faith Estimate) included in the GFE?

Estimates will NOT include other financial assistance deductions. The only discount given right away for private pay / self-pay patients is the 15% discount in line 3c.

You don't have to include any discount under the Financial Assistance Policy. The cash discount should only be given to patients who plan to pay out of pocket; if the plan is to bill a third party, then the cash discount should not be calculated.

For patients who qualify for Munson financial assistance, where can we find the approval dates and percentage so we can deduct it from the estimates?

The info is in STAR, Meditech, and Cerner. However, staff would need to locate individual account notes which would not be easy. Munson Healthcare is working on a communication tool for other facilities to

inquire about financial assistance information for the uninsured/self-pay patients. In the meantime, please email the Financial Assistance team at MHC-FinancialAssistance@mhc.net -noting in subject line (For GF Estimate).

Should we notify anyone if we learn that outside grant assistance (the Assistance Fund, for example) is available to the patient, yet they chose not to apply or supply income documents?

Are these patients declining those grants but want to apply for the Munson Healthcare Financial Assistance program? If yes, I would request your team to email the Financial Assistance email at MHC-FinancialAssistance@mhc.net and informing us of this situation.

Are labs included in the GFE?

If a GFE is required, it needs to include all items and services that the provider is billing for.

Patients that come in for walk-in lab draws are sent to the hospital and are registered as PDS lab specimens. How should GFEs be handled in this instance?

Out of Network Patients: No GFE is required because neither Michigan nor federal law applies. Michigan law only requires notice/consent/GFE for individual providers/physicians; the individual physicians billing for lab services are with Grand Traverse Pathology, which is an independent practice. Federal law requires out-of-network labs be billed at the in-network rate; thus, a notice/consent/GFE is not required.

Uninsured/Self-Pay: A GFE is generally required under federal law, but for a patient who walks in or is scheduled less than 3 days out, the GFE requirement does not apply. MHC locations that offer lab draw/specimen collection services should still issue the two Surprise Billing Notices (Forms 12478 and 12479) to these patients. If the patient asks for a GFE, complete the estimate request form, and Financial Counselors will process the request.

When I use an Itemized Statement from STAR to get the charges for the next chemo, I see that pharmacy charges for IV bags, and it can add a significant amount to the bill. Therefore, it would be more accurate to use the charges from the last treatment, as the coders cannot predict how many IV bags will be used. Do I need to subtract the 15% patient discount from the Itemized Statement?

If you're viewing the charges from a previous itemized statement, you'll need to look at the bottom to see if an uninsured 15% discount was given. If you're changing any of the charges, then the 15% uninsured discount would change accordingly as well.

Can we email the GFE?

We must honor the patient's choice of delivery method (paper or electronic).

The GFE can be emailed to those patients who choose this delivery method. Otherwise it can be mailed, hand delivered, discussed on the phone, given in person, etc. A copy of both the signed Acknowledgement and the GFE must be provided to the patient.

Can we use the patient portal to send documents to patients?

Yes, as long as the patient can save and print from the portal. (Not all portals in use at MHC have that capability.)

Where can I direct patients for more information?

More details are on our website under Patients and Visitors | Price Transparency.

The billing department or provider office can provide more information.

Can we guarantee patients their cost will be as estimated?

No, we cannot guarantee a cost. The good faith estimate is just that – an estimate. Sometimes actual costs will vary from the estimate, for example, when the cost of a drug changes, when benefits are not as quoted, when the service must be revised, or when additional tests are needed. The good-faith estimate form includes language noting that the estimate is not a guarantee of cost.

Is there a list of out-of-network plans?

We have compiled a listing of all in-network plans, by hospital. That listing can be accessed here: MHC Contracted Payer List.xlsx

How are estimates handled for non-traditional or uncommon plans?

- Religious Cost Sharing
  - All require GFE, regardless of how information is pulled to account.
- Work Comp / Auto / Liability
  - If a secondary insurance is pulled to the account, commercial or federal, we wouldn't provide a GFE.
  - GFE is only required when no additional insurance is available to pull to account.
  - Same Day / Walk-In Service must be offered GFE. The patient can decline and still have services.
- Tribal
  - Tribal plans are considered federal; therefore, they do not fall under these regulations.
- Amish
  - Munson Healthcare has a contract with this group; they are treated like any other commercial payer.

Are Critical Access Hospitals (for Munson Healthcare, that includes Charlevoix, Kalkaska, and Paul Oliver Memorial Hospital) in-network all payers?

There is nothing about Critical Access Hospital status that automatically makes these locations in-network for all payers. Critical Access Hospitals must follow these new laws.

How can we provide a GFE to an uninsured (or self-pay) individual when the underlying complexity of an individual's condition is not yet known?

A GFE provided to uninsured (or self-pay) individuals must include an itemized list of items or services reasonably expected to be provided in conjunction with the primary item or service during that period of care. The good-faith estimate is not expected to include charges for unanticipated items or services that are not reasonably expected and that could occur due to unforeseen events. If we are notified of any changes to the scope of service, we are required to provide an uninsured (or self-pay) individual a new GFE no later than one business day before the scheduled service. Please communicate these changes to help patients understand the differences between the initial GFE and the new GFE.

Who is responsible for completing this process for surgical patients?

This process is not required for patients who are admitted through the emergency department. They will not be balance billed even if their insurance plan is out-of-network.

Until 1/1/2023, the surgical office who is boarding the case is responsible for (1) providing a GFE for the surgeon's professional fees for the episode of care, (2) explaining to the patient that the GFE is not comprehensive, and the patient will get bills from other providers and (3) informing the patient that they should contact those other providers for a GFE for their services.

Beginning in January 2023, providers are expected to work together to provide the patient with one, comprehensive GFE that covers the entire episode of care (e.g., if the patient is scheduled for knee replacement surgery, the GFE could potentially include fees from the orthopedic surgeon, anesthesiologist, radiologist, and facility).

Cost Estimator may calculate different values for par and non-par payers. How should estimates be handled?

Out-of-network payers will be charged the chargemaster rate - that is the rate that should be on the good faith estimate.

If patient is uninsured/self-pay, the uninsured discount can be applied.

How are estimates handled for private-pay or self-pay patients who have series accounts?

The good faith estimate will include the length of service worth of estimate on it. If treatment changes, a new estimate should be provided.

The GFE is just that, a "good faith estimate." It is considered an estimate based on what is known at the time it is furnished. HOWEVER, a new GFE must be provided if the provider is notified of any changes to the scope of the GFE (such as anticipated changes to the expected charges, items, services, frequency, recurrences, duration, providers or facilities).

Can we give an estimate "per treatment" and mark it recurring?

Yes, HHS does permit one GFE for recurring items/services, but the maximum time frame is 12 months. And, if the treatment plan or estimate of costs changes, then a new GFE is required.

What if the provider is not credentialed with insurance but other providers in the practice are?

Offer the patient the chance to go to another provider that is in network. If they decline, must sign the balance billing acknowledgment and be provided a good-faith estimate.

What if there is a discrepancy between our list of contract payers and what's on the patient's insurance card?

A listed contract payer in our list may not match exactly what's on the card. If staff are unfamiliar with the nuances and unaware the card insurance falls under one of the listed payers, they may have to follow the consent and good faith estimate process, even if it turns out the payer was in network with the provider or office.

How are cosmetic procedures handled?

Cosmetic procedures fall under private pay/uninsured. Patients must be given the **Notice of Right to Receive a Good Faith Estimate (Form #12479)** receive a **Detailed Good-Faith Estimate (Form #12480).**

What if a patient refuses to take the information?

If a patient refuses **Notice Regarding Patient Protections (Form 12478)** or **Notice of Right to Receive a Good Faith Estimate (Form #12479),** let them know we have the information available if they change their mind.

If a patient refuses to sign the **Balance Billing Acknowledgement (Form #12477)**, the service cannot be scheduled. Suggest they contact their health plan to find an in-network facility or provider or to try to come to an agreement on a different facility or provider.

Suggested language is included in the Staff Scripting document.