



The No Surprises Act's Good Faith Estimates and Patient-Provider Dispute Resolution Requirements

*Center for Consumer
Information & Insurance
Oversight (CCIIO)*



Agenda



- Background: No Surprises Act Training Series
- Overview of the No Surprises Act Protections for Uninsured (or Self-Pay) Individuals
- Provision of Good Faith Estimates to Uninsured (or Self-Pay) Individuals
- Patient-Provider Dispute Resolution Process Requirements
- Questions

Legal Disclaimers

The information provided in this presentation is intended only to be 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. This presentation summarizes current policy and operations as of the date it was presented. We encourage readers to refer to the applicable statutes, regulations, and other interpretive materials for complete and current information.

Legal Disclaimers (continued)

The contents of this document do not have the force and effect of law and are not meant to bind the public in any way, unless specifically incorporated into a contract. This document is intended only to provide clarity to the public regarding existing requirements under the law.

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Background: No Surprises Act Training Series



Overview of the No Surprises Act

The No Surprises Act* introduced new requirements for providers, facilities, and providers of air ambulance services to protect individuals from surprise medical bills. These requirements:

- Prohibit providers and facilities from directly billing individuals for the difference between the amount they charge and the amount that the individual's plan or coverage will pay plus the individual's cost-sharing amounts (i.e., balance billing) in certain circumstances;
- Require providers and facilities to provide good faith estimates of charges for care to uninsured (or self-pay) individuals upon scheduling care or on request, and for individuals with certain types of coverage, to submit good faith estimates to the individual's plan or issuer;
- Create a patient-provider dispute resolution process for uninsured (or self-pay) individuals to contest charges that are "substantially in excess" of the good faith estimate;
- Require certain providers and facilities to publicly disclose restrictions on balance billing; and
- Limit billed amounts in situations where a provider's network status changes mid-treatment or individuals act on inaccurate provider directory information.

* Title I (No Surprises Act) of Division BB of the Consolidated Appropriations Act, 2021 (CAA) amended title XXVII of the Public Health Service Act (PHS Act).

Scope of individuals protected under the No Surprises Act

Beginning January 1, 2022, these No Surprises Act requirements will apply to items and services provided to most individuals enrolled in **private or commercial health coverage**, like:

- Employment-based group health plans (both self-insured and fully insured)
- Individual or group health coverage on or outside the Federal or State-based Exchanges
- Federal Employee Health Benefit (FEHB) health plans
- Non-federal governmental plans sponsored by state and local government employers
- Certain church plans within IRS jurisdiction
- Student health insurance coverage [as defined at 45 CFR 147.145]

Scope of individuals protected under the No Surprises Act (continued)

Some requirements also apply to providers and facilities with respect to uninsured (or self-pay) individuals, like requirements that providers and facilities provide good faith estimates for scheduled care, or upon request.

Requirements under the No Surprises Act don't apply to beneficiaries or enrollees in Medicare, Medicaid, Indian Health Services, Veterans Affairs Health Care, or TRICARE. These programs have other protections against high medical bills. The protections also don't apply to short-term limited duration insurance (STLDI), excepted benefits, or retiree-only plans; or account-based group health plans.

No Surprises Act Training Series

The training series is intended to educate providers and facilities on these major provisions of the No Surprises Act.

***Focus of today's presentation**

| Summary of Provision | Statute and Regulatory Citation |
|---|--|
| Prohibition on balance billing for emergency services provided by out-of-network providers or emergency facilities | PHS Act section 2799B-1 45 C.F.R § 149.410 |
| Prohibition on balance billing for non-emergency services by out-of-network providers at certain in-network health care facilities | PHS Act section 2799B-2 45 C.F.R. § 149.420 |
| Prohibition on balance billing for air ambulance services by out-of-network air ambulance service providers | PHS Act section 2799B-5 45 C.F.R. § 149.440 |
| Public disclosure of individual protections against balance billing | PHS Act section 2799B-3 45 C.F.R. § 149.430 |
| Restrictions on how much providers and facilities bill individuals in situations where the provider's or facility's network contract with the individual's plan or issuer is terminated during continuing care | PHS Act section 2799B-8 |
| Restrictions on how much providers and facilities bill individuals in situations where an individual inadvertently receives care from an out-of-network provider or facility based on inaccurate provider directory information | PHS Act section 2799B-9 |
| *Provision of good faith estimates of charges to uninsured or self-pay individuals in advance of scheduled items or services or upon request | PHS Act section 2799B-6 45 C.F.R. § 149.610 |
| *The patient-provider dispute resolution process | PHS Act section 2799B-7 45 C.F.R § 149.620 |
| The independent dispute resolution process | PHS Act section 2799A-1 45 C.F.R § 149.510 |

Overview of the No Surprises Act's Protections for Uninsured (or Self-Pay) Individuals

Effective January 1, 2022, the No Surprises Act* (NSA) protects **uninsured (or self-pay)** individuals from many unexpectedly high medical bills.

- If an individual does not have certain types of health insurance, or does not plan to use that insurance to pay for health care items or services, they are eligible to receive a “**good faith estimate**” of what they may be charged, before they receive the **item or service**.
- A new **patient-provider dispute resolution** (PPDR) process is available for uninsured (or self-pay) individuals who get a bill from a provider that is substantially in excess of the expected charges on the good faith estimate.

Overview of the No Surprises Act's Protections for Uninsured (or Self-Pay) Individuals (continued)

On October 7, 2021, HHS published interim final rules (IFR) titled *Requirements Related to Surprise Billing; Part II*,* implementing various provisions of the NSA, including good faith estimates and the PPDR process for payment determinations.

This presentation will focus on what information must be included in the good faith estimate and the PPDR process.

*Requirements Related to Surprise Billing; Part II, 86 Fed. Reg. 55980 (October 7, 2021) codified at 45 CFR 149.610 & 149.620.

Good Faith Estimates for Uninsured (or Self-Pay) Individuals

The **good faith estimate** (or GFE) is a notification that outlines an uninsured (or self-pay) individual's expected charges for a scheduled or requested item or service.

Providers and facilities must give this estimate to an uninsured (or self-pay) individual (or their **authorized representative**) who requests it or who schedules an item or service.

The good faith estimate will also include items or services reasonably expected to be provided along with the **primary item(s) or service(s)**, even if the individual will receive the items and services from another provider or another facility.

These requirements are applicable for good faith estimates requested on or after January 1, 2022 or for good faith estimates required to be provided in connection with items or services scheduled on or after January 1, 2022.

Scope of providers that must comply with NSA requirements pertaining to protections for uninsured (or self-pay) individuals

For the purposes of the good faith estimate, a **health care provider** means a physician or other health care provider who is acting within the scope of practice of that provider's license or certification under applicable State law, including a provider of air ambulance services.

The following types of health care providers must comply with the NSA's good faith estimate and PPDR requirements:

- Physicians;
- Other health care providers who are acting within their scope of practice under applicable State law;
- Providers of air ambulance services.

Scope of facilities that must comply with NSA requirements pertaining to protections for uninsured (or self-pay) individuals

All health care institutions licensed under applicable state or local law are treated as **health care facilities** that must comply with the NSA's good faith estimate and PPDR requirements including, for example:

- Hospitals;
- Hospital outpatient departments;
- Critical access hospitals;
- Ambulatory surgical centers;
- Rural health centers;
- Federally qualified health centers;
- Laboratory centers; and
- Imaging centers.

Scope of care included in good faith estimates

Under the NSA, uninsured (or self-pay) individuals should receive a single, comprehensive **good faith estimate** that includes expected charges for:

- The **primary item or service** that will be furnished by the convening provider or convening facility and that is the initial reason for the visit.
- All items and services that are reasonably expected to be provided in conjunction with the primary item or service, provided during a defined **period of care**.

These **items or services** can include any of the following:

- Encounters;
- Procedures;
- Medical tests;
- Supplies;
- Prescriptions drugs;
- Durable medical equipment; or
- Fees (including facility fees).

Example: Good faith estimate for knee surgery

If an individual schedules a knee surgery with their orthopedic surgeon, a good faith estimate could include an itemized list of items or services in conjunction with and including the actual knee surgery, such as:

- Physician professional fees;
- Assistant surgeon professional fees;
- Anesthesiologist professional fees;
- Facility fees;
- Prescription drugs; and
- Durable medical equipment fees.

Example: Good faith estimate for knee surgery (continued)

All the items or services that are reasonably expected to be provided **from admission through discharge** are part of that scheduled knee surgery period of care. These services or items should be included in the good faith estimate.

Separate good faith estimates would be provided upon scheduling or upon request for any items or services that are necessary prior to or following provision of the primary item or service **beyond the period of care** (e.g., pre-operative laboratory tests or post-discharge physical therapy).

How expected charges are determined for a good faith estimate

Expected charges included on a good faith estimate should be the cash pay rate or rate that the uninsured (or self-pay) individual would be expected to pay for items or services listed on the good faith estimate.

The expected charges should reflect true anticipated billed charges, including any anticipated discounts or adjustments that a provider or facility would anticipate applying to the uninsured (or self-pay) individual.

For example, the expected charges provided by a federally tax-exempt non-profit hospital should apply any adjustments to billed charges that would be applied to an individual under the hospital's Financial Assistance Policy (FAP).

How expected charges are determined for a good faith estimate (continued)

In determining expected charges, providers and facilities are expected to use the coding that best describes each item or service listed in the good faith estimate.

When a single service code is available that captures reporting and billing for the component parts of an item or service, the single service code and expected charge for that single service code would be reported in the good faith estimate to capture the most comprehensive coding level.

The component parts would not be included in the good faith estimate as they would not be separately reported or billed.

Convening provider or facility and co-provider or co-facility

A **convening provider or facility** must provide a good faith estimate to the uninsured individual, including any item or service that is reasonably expected to be provided in conjunction with a scheduled or requested item or service by another provider or facility (**co-provider or co-facility**).

As a result, the good faith estimate could contain expected charges from multiple providers: the convening provider, and co-providers or co-facilities that furnish items and services that are customarily provided in conjunction with a primary item or service.

For instance, if a patient schedules a surgery, the convening provider or facility might include in the good faith estimate the cost of the surgery, and the co-provider or co-facility might include the costs of any labs, tests, or anesthesia that might be used during the operation.

Knowledge Check

A provider is deciding which CPT codes to use for a laboratory test. The provider is choosing between:

1. CPT code 85027 (complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count)), which represents a laboratory test that measures an individual's hematocrit, hemoglobin, red blood cell count, leukocyte (white blood cell) counts, and platelet count.
2. Individual CPT codes for each of the component parts of the service represented by CPT code 85027 (CPT codes: 85014 (hematocrit (Hct)), 85018 (hemoglobin (Hgb)), 85041 (red blood cell (RBC), automated), 85048 (leukocyte (WBC), automated), and 85049 (platelet, automated)).

In order to remain compliant with the NSA, which option would best describe the item or service for use in the good faith estimate?

Knowledge Check Answer

HHS expects that the good faith estimate would include expected charges for CPT code 85027, not expected charges for each component part since there is a single CPT code available that better captures reporting for all of the component parts of the laboratory service.

When a single service code is available that captures reporting and billing for the component parts of an item or service, the single service code and expected charge for that single service code would be reported in the good faith estimate to capture the most comprehensive coding level.

Informing uninsured (or self-pay) individuals

A **convening provider or facility** must inform all **uninsured (or self-pay) individuals** of the availability of a good faith estimate of expected charges upon scheduling an item or service or upon request. To determine if someone is an uninsured (or self-pay) individual, the provider or facility must ask if the individual is enrolled in:

- A group health plan,
- Group health insurance coverage offered by a health insurance issuer,
- A Federal health care program, or
- A health benefits plan under a Federal Employees Health Benefits (FEHB) Program.

Informing uninsured (or self-pay) individuals (continued)

If not enrolled in any of the above, the individual is considered uninsured for the purposes of the good faith estimate.

If the individual is enrolled in a group health plan, group or individual health insurance coverage offered by a health insurance issuer, or a FEHB health benefits plan, the convening provider or facility must ask if the individual is seeking to have a claim submitted for the items or services with such plan or coverage. If not, the individual is considered self-pay for the purposes of the good faith estimate.

Distribution and display of the good faith estimate to individuals

- Information regarding the availability of good faith estimates for uninsured (or self-pay) individuals must be written in a **clear and understandable manner**, **prominently displayed (and easily searchable from a public search engine) on the convening provider's or convening facility's website, in the office, and on-site where scheduling or questions about the cost of items or services occur.**
- Convening providers and facilities must also give information about the good faith estimate for uninsured (or self-pay) individuals when scheduling an item or service or when questions about the cost of items or services occur.
- Convening providers and convening facilities must consider any discussion or inquiry regarding the potential costs of items or services under consideration as a request for a good faith estimate.

Timeframes

Upon receiving a request for a good faith estimate from an uninsured (or self-pay) individual or **upon scheduling a primary item or service** for an uninsured (or self-pay) individual, the convening provider or convening facility must contact all co-providers and co-facilities who are reasonably expected to provide items or services in conjunction with, and in support of, the primary item or service no later than 1 business day after scheduling or receiving the request. The convening provider or convening facility must request that the co-providers or co-facilities submit good faith estimate information to the convening provider or facility.

Timeframes (continued 1)

Convening providers and facilities must provide a good faith estimate to uninsured (or self-pay) individuals within the following timeframes:

- When a primary item or service is scheduled at least 3 business days before the date the item or service is scheduled to be furnished, the good faith estimate must be provided no later than 1 business day after the date of scheduling.
- When a primary item or service is scheduled at least 10 business days before such item or service is scheduled to be furnished, the good faith estimate must be provided no later than 3 business days after the date of scheduling.
- When a good faith estimate is requested by an uninsured (or self-pay) individual, the good faith estimate must be provided no later than 3 business days after the date of the request.

Timeframes (continued 2)

HHS recognizes that some providers or facilities may need to establish efficient and secure communication channels for transmission of good faith estimate information between convening providers or facilities and co-providers and co-facilities.

It is also understood that it may take time for providers and facilities to develop systems and processes for receiving and providing the required information from co-providers and co-facilities.

Therefore, for good faith estimates provided to uninsured (or self-pay) individuals from January 1, 2022 through December 31, 2022, HHS will exercise its enforcement discretion in situations where a good faith estimate provided to an uninsured (or self-pay) individual does not include expected charges from co-providers or co-facilities.

Timeframes (continued 3)

A co-provider or co-facility is not prohibited from furnishing the information before December 31, 2022, and nothing would prevent the uninsured (or self-pay) individual from separately requesting a good faith estimate directly from the co-provider or co-facility, in which case the co-provider and co-facility would be required to provide the good faith estimate for such items or services.

Otherwise, during this period, HHS encourages convening providers and convening facilities to include a range of expected charges for items or services reasonably expected to be provided and billed by co-providers and co-facilities.

Changes to the scope of the good faith estimate

If a convening provider, convening facility, co-provider, or co-facility anticipates or is notified of any **changes to the scope of a good faith estimate** (such as anticipated changes to the expected charges, items, services, frequency, recurrences, duration, providers, or facilities) previously furnished at the time of scheduling, the convening provider or convening facility must provide the individual with a new good faith estimate no later than 1 business day before the items or services are scheduled to be furnished.

If any changes in expected providers or facilities represented in a good faith estimate occur less than 1 business day before the item or service is scheduled to be furnished, the replacement provider or facility must accept the good faith estimate for the relevant items or services being furnished that was provided by the replaced provider or facility.

Changes to the scope of the good faith estimate (continued)

For good faith estimates provided upon request of an uninsured (or self-pay) individual, upon scheduling of the requested item or service, the convening provider or convening facility must provide the individual with a new good faith estimate for the scheduled item or service within the standard timeframes specified in the **Timeframes** section of this presentation.

Good faith estimate for recurring primary items or services

A convening provider or convening facility may issue a single good faith estimate for **recurring primary items or services** if both of the following requirements are met:

- The good faith estimate for recurring items or services includes, in a clear and understandable manner, the expected scope of the recurring primary items or services (such as timeframes, frequency, and total number of recurring items or services).
- The scope of a good faith estimate for recurring primary items or services does not exceed 12 months.

Requirements for co-providers and co-facilities

Co-providers and **co-facilities** must submit good faith estimate information upon the request of the convening provider or convening facility. The co-provider or co-facility must provide, and the convening provider or convening facility must receive, the good faith estimate information no later than 1 business day after the co-provider or co-facility receives the request from the convening provider or convening facility.

Co-providers and co-facilities must notify and provide new good faith estimate information to a convening provider or convening facility if the co-provider or co-facility anticipates any changes to the scope of good faith estimate information previously submitted to a convening provider or convening facility (such as anticipated changes to the expected charges, items, services, frequency, recurrences, duration, providers, or facilities).

Requirements for co-providers and co-facilities (continued)

If any changes to the co-providers or co-facilities listed in the good faith estimate occur less than 1 business day before the item or service is scheduled to be furnished, the replacement co-provider or co-facility must accept as its good faith estimate of expected charges the good faith estimate for the relevant items or services included in the good faith estimate provided by the replaced provider or facility.

In the event that an uninsured (or self-pay) individual separately schedules or requests a good faith estimate from a provider or facility that would otherwise be a co-provider or co-facility, that provider or facility must meet all requirements that apply to convening providers and convening facilities for issuing a good faith estimate to the individual.

Content requirements of a good faith estimate issued to an uninsured (or self-pay) individual

A **good faith estimate** issued to an uninsured (or self-pay) individual must include:

- **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 both:
 - Items or services reasonably expected to be furnished by the convening provider or convening facility for the period of care
 - Items or services reasonably expected to be furnished by co-providers or co-facilities

Content requirements of a good faith estimate issued to an uninsured (or self-pay) individual (continued 1)

- 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 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

Content requirements of a good faith estimate issued to an uninsured (or self-pay) individual (continued 2)

- **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. The good faith estimate must include a disclaimer directly above this list that includes all of the following information:
 - Separate good faith estimates will be issued to an uninsured (or self-pay) individual upon scheduling or upon request of the listed items or services
 - Notification that for items or services included in this list, information such as diagnosis codes, service codes, expected charges and provider or facility identifiers, do not need to be included as that information will be provided in separate good faith estimates upon scheduling or upon request of such items or services
 - Instructions for how an uninsured (or self-pay) individual can obtain good faith estimates for such items or services

Content requirements of a good faith estimate issued to an uninsured (or self-pay) individual (continued 3)

- A **disclaimer** that informs the uninsured (or self-pay) individual that there may be additional items or services the convening provider or convening facility recommends as part of the course of care that must be scheduled or requested separately and are not reflected in the good faith estimate
- A **disclaimer** that informs the uninsured (or self-pay) individual that the information provided in the good faith estimate is only an estimate regarding items or services reasonably expected to be furnished at the time the good faith estimate is issued to the uninsured (or self-pay) individual and that actual items, services, or charges may differ from the good faith estimate

Content requirements of a good faith estimate issued to an uninsured (or self-pay) individual (continued 4)

- A **disclaimer** that informs the uninsured (or self-pay) individual of that individual's right to initiate the PPDR process if the actual billed charges are substantially in excess of the expected charges included in the good faith estimate. This disclaimer must include instructions for where the individual can find information about how to initiate the PPDR process and state that the initiation of the PPDR process will not adversely affect the quality of health care services furnished to the individual by a provider or 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 providers or facilities identified in the good faith estimate ([example disclaimer notice can be found here](#))

HHS model notice and template

HHS has developed a model template and notice that providers and facilities may use to prepare good faith estimates for uninsured (or self-pay) individuals and to notify uninsured (or self-pay) individuals of the availability of a good faith estimate.

Use of this model notice is not required and is provided as a means of facilitating compliance with the applicable notice requirements.

This model notice and template were published as part of [CMS Form Number 10791](#) and are available for download.

HHS model notice and template (continued)

OMB Control Number [XXXX-XXXX]
ExpirationDate [MM/DD/YYYY]

[NAME OF CONVENING PROVIDER OR CONVENING FACILITY]
Good Faith Estimate for Health Care Items and Services

| Patient | | |
|--|--------------------------|-----------|
| Patient First Name | Middle Name | Last Name |
| Patient Date of Birth: _____/_____/_____ | | |
| Patient Identification Number: | | |
| Patient Mailing Address, Phone Number, and Email Address | | |
| Street or PO Box | | Apartment |
| City | State | ZIP Code |
| Phone | | |
| Email Address | | |
| Patient's Contact Preference: <input type="checkbox"/> By mail <input type="checkbox"/> By email | | |
| Patient Diagnosis | | |
| Primary Service or Item Requested/Scheduled | | |
| Patient Primary Diagnosis | Primary Diagnosis Code | |
| Patient Secondary Diagnosis | Secondary Diagnosis Code | |

2

OMB Control Number [XXXX-XXXX]
Expiration Date [MM/DD/YYYY]

You have the right to receive a "Good Faith Estimate" explaining how much your medical care will cost

Under the law, health care providers need to give **patients who don't have insurance or who are not using insurance** an estimate of the bill for medical items and services.

- You have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency items or services. This includes related costs like medical tests, prescription drugs, equipment, and hospital fees.
- Make sure your health care provider gives you a Good Faith Estimate in writing at least 1 business day before your medical service or item. You can also ask your health care provider, and any other provider you choose, for a Good Faith Estimate before you schedule an item or service.
- If you receive a bill that is at least \$400 more than your Good Faith Estimate, you can dispute the bill.
- Make sure to save a copy or picture of your Good Faith Estimate.

For questions or more information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises or call [INSERT PHONE NUMBER].

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Content requirements for good faith estimate information submitted by co-providers or co-facilities to convening providers or convening facilities

Good faith estimate information submitted to convening providers or convening facilities by co-providers or co-facilities for inclusion in the good faith estimate must include:

- **Patient name** and date of birth
- A **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-provider 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-providers or co-facilities identified in the good faith estimate

Required methods for providing good faith estimates for uninsured (or self-pay) individuals

A **good faith estimate** must be provided in **written form** either on paper or electronically, pursuant to the uninsured (or self-pay) individual's requested method of delivery, and within the timeframes described above. Good faith estimates provided electronically must be provided in a manner that the uninsured (or self-pay) individual can both save and print. Good faith estimates provided to uninsured (or self-pay) individuals by paper mail must be postmarked by the timelines specified in the **Timeframes** section of this presentation.

A good faith estimate must be provided and written using clear and understandable language.

Additional requirements

A good faith estimate issued to an uninsured (or self-pay) individual under this section is considered **part of the patient's medical record** and must be maintained in the same manner as a patient's medical record. Convening providers and convening facilities must provide a copy of any previously issued good faith estimate furnished within the last 6 years to an uninsured (or self-pay) individual upon request by the individual.

For all providers or facilities that issue good faith estimates following their state's processes and rules, if those state processes and rules do not meet federal good faith estimate requirements, those providers and facilities have failed to comply with federal good faith estimate requirements.

Additional requirements (continued 1)

A provider or facility will not fail to comply with federal good faith estimate requirements solely because, despite acting in good faith and with reasonable due diligence, the provider or facility makes an error or omission in a required good faith estimate, provided that the provider or facility corrects the information as soon as practicable. If items or services are furnished before an error in a good faith estimate is addressed, the provider or facility may be subject to PPDR if the actual billed charges are substantially in excess of the good faith estimate (as described later in this presentation).

Additional requirements (continued 2)

To the extent compliance with federal good faith estimate requirements requires a provider or facility to obtain information from any other entity or individual, the provider or facility will not fail to comply with this section if it relied in good faith on the information from the other entity, unless the provider or facility knows, or reasonably should have known, that the information is incomplete or inaccurate. If the provider or facility learns that the information is incomplete or inaccurate, the provider or facility must provide corrected information to the uninsured (or self-pay) individual as soon as practicable. If items or services are furnished before an error in a good faith estimate is addressed, the provider or facility may be subject to PPDR if the actual billed charges are substantially in excess of the good faith estimate.

Example of how itemized lists of expected items or services could be displayed in a good faith estimate for uninsured (or self-pay) individuals

Details of Services and Items for [Provider/Facility 1]

| Service/Item | Address where service/item will be provided | Diagnosis Code | Service Code | Quantity | Expected Cost |
|--|---|----------------|--|----------|---------------|
| - | [Street, City, State, ZIP] | [ICD code] | [Service Code Type: Service Code Number] | - | - |
| - | - | - | - | - | - |
| - | - | - | - | - | - |
| Total Expected Charges from [Provider/Facility 1] | | | | | \$ |
| Additional Health Care Provider/Facility Notes | | | | | |

Example of how itemized lists of expected items or services could be displayed in a good faith estimate for uninsured (or self-pay) individuals (continued)

Details of Services and Items for [Provider/Facility 2]

These additional Provider/Facility costs may not be included until 2023

| Service/Item | Address where service/item will be provided | Diagnosis Code | Service Code | Quantity | Expected Cost |
|--|---|----------------|--|----------|---------------|
| - | [Street, City, State, ZIP] | [ICD code] | [Service Code Type: Service Code Number] | - | - |
| - | - | - | - | - | - |
| - | - | - | - | - | - |
| Total Expected Charges from [Provider/Facility 2] | | | | | \$ |
| Additional Health Care Provider/Facility Notes | | | | | |

Patient-Provider Dispute Resolution (PPDR) Process

Beginning January 1, 2022, a **PPDR** process will be available for uninsured (or self-pay) individuals who get a bill for an item or service that is substantially in excess of the expected charges on the good faith estimate. Under the PPDR process, the uninsured (or self-pay) individual may seek a determination from a Selected Dispute Resolution (SDR) entity for the amount the individual has to pay. This process can provide the uninsured (or self-pay) individual important consumer protections from billed charges that are substantially in excess of the expected charges in the good faith estimate.

Items or services eligible for PPDR

The PPDR process can apply to any item or service furnished by a convening provider, convening facility, co-provider, or co-facility to an uninsured (or self-pay) individual where the total billed charges are substantially in excess of the total expected charges in the good faith estimate.

HHS regulations establish that **when the billed charges for any provider or facility are in excess of the good faith estimate for that provider or facility by \$400 or more, the item or service may be eligible for payment determination by a SDR entity through the PPDR process.**

As each good faith estimate could potentially contain expected charges from multiple providers and facilities, the substantially in excess determination is made separately for each specific provider or facility listed on the good faith estimate.

Items or services eligible for PPDR (continued)

If a co-provider or co-facility that provided an estimate of the expected charge for an item or service in the good faith estimate is replaced by a different co-provider or co-facility less than 1 business day before that item or service is scheduled to be furnished, an item or service billed by the replacement co-provider or co-facility is eligible for dispute resolution if the billed charge is \$400 or more than the total expected charges included in the good faith estimate for the original co-provider or co-facility.

If the replacement provider or facility provides the uninsured (or self-pay) individual with a new good faith estimate, in a timely manner, then the determination of whether an item or service billed by the replacement co-provider or co-facility is eligible for dispute resolution is based on whether the total billed charge for the replacement co-provider or co-facility is \$400 or more than the total expected charges included in the good faith estimate provided by the replacement co-provider or co-facility.

Knowledge Check

Tonya is a 40-year-old female with a long history of right knee pain. She does not have any form of health insurance. Tonya schedules an appointment with her orthopedist to receive a cortisone injection in her knee. Upon scheduling the appointment, her orthopedist sends her a good faith estimate. The good faith estimate lists the total expected charges of \$300 for the procedure. Tonya undergoes the injection and subsequently receives a bill from the orthopedist. The total billed charge is \$850.

Would Tonya be eligible to pursue the PPDR process?

Knowledge Check Answer

Yes, Tonya would be eligible to pursue the PPDR process.

Tonya is uninsured, and the total billed charge is considered substantially in excess of the good faith estimate, since the difference between the total expected and total billed charges is greater than or equal to \$400. Under the NSA, in order to be eligible to pursue the PPDR process, an individual must be considered uninsured or self-pay, the total billed charges by the particular convening provider, convening facility, co-provider, or co-facility, must be substantially in excess (\geq \$400) of the total expected charges for that specific provider or facility listed in the good faith estimate, and the date of the bill must be within 120 days.

Enforcement discretion in 2022 for expected charges for items and services from a co-provider or co-facility

For good faith estimates provided to uninsured (or self-pay) individuals on or after January 1, 2022 through December 31, 2022, HHS will exercise its enforcement discretion in situations where the good faith estimate does not include expected charges for items and services from a co-provider or co-facility.

During the period of enforcement discretion, items or services to be provided by a co-provider or co-facility that appear on the good faith estimate that do not include an estimate of expected charges or that appear as a range of expected charges would not be eligible for the PPDR process for the item or service provided by the co-provider or co-facility.

Would a provider or facility be subject to requirements for the PPDR process but not requirements for the good faith estimate?

The good faith estimate requirements work together with the PPDR requirements to establish important consumer protections for uninsured (or self-pay) individuals who receive billed charges that are **substantially in excess** of the good faith estimates they received prior to scheduling (or upon request of) items or services. As a result, the requirements for the PPDR process apply to all providers or facilities subject to the good faith estimate requirements.

How is PPDR eligibility determined when there are different providers or facilities listed on the same good faith estimate?

Eligibility for PPDR is determined separately for each unique provider or facility listed on the good faith estimate. For each provider or facility, the **total expected charges** for each item or service should be added up. This total amount is then compared with the total of all billed charges for the provider or facility, including billed charges for items and services that were furnished but not included in the good faith estimate, to determine eligibility for PPDR.

How is PPDR eligibility determined when there are different providers or facilities listed on the same good faith estimate? (continued 1)

Example 1

| Provider | Item or Service | Expected charge |
|---|-----------------|-----------------|
| Provider A | Item 1 | \$300 |
| - | Item 2 | \$1275 |
| - | Item 3 | \$550 |
| Total Expected Charges from Provider A | | \$2125 |
| Provider B | Item 1 | \$500 |
| Total Expected Charges from Provider B | | \$500 |

In example 1, the good faith estimate contains two providers, A and B. The total expected charges for both providers A and B equal \$2625, however for purposes of PPDR the total of expected charges are separated by provider. In this case, the total expected charges for provider A are \$2125 and the total expected charges for provider B are \$500. The billed charges for providers A and B respectively are compared with their total expected charges to determine whether the billed charges are eligible for PPDR as shown in example 2.

How is PPDR eligibility determined when there are different providers or facilities listed on the same good faith estimate? (continued 2)

Example 2

| Provider A | Expected charge | Billed charge |
|--------------|-----------------|---------------|
| Item 1 | \$300 | \$350 |
| Item 2 | \$1275 | \$1500 |
| Item 3 | \$550 | \$550 |
| Total | \$2125 | \$2400 |

In example 2, even though the total of all billed charges for provider A (\$2400) is greater than the total of expected charges (\$2125), the difference between the billed charges and expected charges are less than \$400. As a result, items provided by provider A are not eligible for PPDR.

How is PPDR eligibility determined when there are different providers or facilities listed on the same good faith estimate? (continued 3)

Example 3

| Provider A | Expected charge | Billed charge |
|--------------|-----------------|---------------|
| Item 1 | \$300 | \$350 |
| Item 2 | \$1275 | \$1500 |
| Item 3 | \$550 | \$850 |
| Total | \$2125 | \$2700 |

In example 3, the total of all billed charges for provider A (\$2700) is greater than the total of expected charges (\$2125), and the difference between the billed charges and expected charges are greater than \$400. As a result, items provided by provider A are eligible for PPDR.

How is PPDR eligibility determined when there are different providers or facilities listed on the same good faith estimate? (continued 4)

Example 4

| Provider A | Expected charge | Billed charge |
|--------------|-----------------|---------------|
| Item 1 | \$300 | \$350 |
| Item 2 | \$1275 | \$1500 |
| Item 3 | \$550 | \$550 |
| Item 4 | NA | \$200 |
| Total | \$2125 | \$2600 |

In example 4, the uninsured individual was billed by provider A for an item that did not appear on the good faith estimate, item 4. Even though item 4 is not included in the total expected charges as it did not appear on the good faith estimate, the billed charge for item 4 is included in the total billed charges. As the total billed charges exceed the total expected charges by \$400 or more, items provided by provider A are eligible for PPDR.

Initiating the PPDR process

An uninsured (or self-pay) individual, or their authorized representative, can initiate the PPDR process by submitting an initiation notice to HHS through the online federal IDR portal, submitting an initiation notice electronically, or submitting through the mail if postmarked within 120 calendar days of receiving the initial bill containing charges for the item or service that is substantially in excess of the expected charges in the good faith estimate.

HHS strongly recommends that the initiation notice be submitted through the [federal IDR portal](#) to help ensure the request can be processed quickly and securely.

The initiation notice

When an uninsured (or self-pay) individual is billed for items or services where the total billed charges for a provider or facility are **\$400 or more above the total expected charges** for the provider or facility in the good faith estimate, the uninsured (or self-pay) individual or their authorized representative, may submit a notification (**initiation notice**) to HHS to initiate the PPDR process. The initiation notice must include all of the following:

- Information sufficient to identify the items or services under dispute, including:
 - a. The date of service or date the item was provided
 - b. A description of the item or service
- A copy of the bill for the items and services under dispute (the copy can be a photocopy or an electronic image so long as the document is readable)
- Last 4 digits of the account number on the bill
- A copy of the good faith estimate for the items and services under dispute (the copy can be a photocopy or an electronic image so long as the document is readable)

The initiation notice (continued)

- The contact information of the parties involved, including:
 - a. Name,
 - b. Email address,
 - c. Phone number, and
 - d. Mailing address.
- The state where the items or services in dispute were furnished, and
- The uninsured (or self-pay) individual's contact information including:
 - a. Name,
 - b. Email address,
 - c. Phone number,
 - d. Mailing address, and
 - e. Communication preference: email, paper mail, or phone.

What is the administrative fee and how does it work?

HHS has established a \$25 **administrative fee** to participate in the PPDR process in 2022. The fee amount is meant to ensure there is no barrier to an uninsured (or self-pay) individual's ability to access this process. The administrative fee is an amount paid by the individual to use the PPDR process to settle payment disputes with providers and facilities. HHS will assess the \$25 administrative fee in 2022 on the non-prevailing party (providers, facilities, and uninsured (or self-pay) individuals) to the PPDR process.

The uninsured (or self-pay) individual will pay the administrative fee at the beginning of the process to the SDR entity. Providers and facilities are not required to pay the \$25 administrative fee upfront. If the SDR entity determines the payment amount to be lower than the billed charges, the SDR entity will apply an adjustment to the final payment determination amount to allow for the individual to recover the \$25 paid.

What is the administrative fee and how does it work?

(continued)

The amount of the administrative fee may change in future years, but any such change will be promulgated in advance by additional guidance. For more information on the PPDR administrative fee see [PPDR fee guidance](#).

Prohibition on collections and retributive action

While the PPDR process is pending, the provider or facility must not move the bill for the disputed item or service into collection or threaten to do so, or if the bill has already moved into collection, the provider or facility should cease collection efforts. The provider or facility must also suspend the accrual of any late fees on unpaid bill amounts until after the PPDR process has concluded. Finally, the provider or facility must not take or threaten to take any retributive action against an uninsured (or self-pay) individual for utilizing the PPDR process to seek resolution for a disputed item or service.

The online federal IDR portal

When practicable, providers and facilities should use the **online federal IDR portal** to submit documentation for the PPDR process. The federal IDR portal is the same portal used for the federal IDR process (i.e., payer-provider and payer-air ambulance provider processes). Providers and facilities may also receive notices from HHS and the SDR entity, submit additional supporting documents, and receive the SDR entity's determination via email. More information on the federal IDR portal can be found on the [portal webpage](#).

PPDR process following SDR receipt of initiation notice

The **SDR entity** will review the **initiation notice** submitted by the uninsured (or self-pay) individual to ensure that the items or services in dispute meet the eligibility criteria for the PPDR process and that the initiation notice contains all the required information. Once the SDR entity has determined that an item or service is eligible for dispute resolution and that the initiation notice contains all the required information, the SDR entity will notify the uninsured (or self-pay) individual and the provider or facility through the federal IDR portal, or electronic or paper mail, or phone, that a PPDR initiation request has been received and is under review.

PPDR process following SDR receipt of initiation notice (continued 1)

Additionally, the SDR entity will notify the provider or facility that they must provide certain information within 10 business days. HHS strongly recommends that this information be submitted using the federal IDR portal. This information must include all of the following:

- A **copy of the good faith estimate** provided to the uninsured (or self-pay) individual for the items or services under dispute (the copy can be a photocopy or an electronic image so long as the document is readable);
- A **copy of the billed charges** provided to the uninsured (or self-pay) individual for items or services under dispute (the copy can be a photocopy or an electronic image so long as the document is readable); and
- If available, **documentation providing evidence to demonstrate that the difference between the billed charges and the expected charges** in the good faith estimate reflects 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 good faith estimate was provided.

PPDR process following SDR receipt of initiation notice (continued 2)

No later than 30 business days after receiving this information, the SDR entity must make a determination regarding the amount to be paid by the uninsured (or self-pay) individual.

The SDR entity will also notify the uninsured (or self-pay) individual in cases where the initiation notice is determined to be incomplete or the item or service is determined ineligible for dispute resolution, in which case the uninsured (or self-pay) individual would be provided 21 calendar days to submit any missing information or provide supplemental information to demonstrate the item or service is eligible for the PPDR process.

See the previous examples of calculating eligibility provided earlier in this presentation.

Knowledge Check

Tom is a 30-year-old male with a history of a chronic cholecystitis, which has become progressively more symptomatic over time. He does not have health insurance of any kind. Tom is advised to schedule a laparoscopic cholecystectomy with the general surgeon. He schedules the surgery with the general surgeon. The provider sends Tom a good faith estimate for the surgery, which includes good faith estimates from the general surgeon and the anesthesiologist. The total expected charges for the general surgeon are \$2,000. Tom undergoes the surgery. During the surgery, the surgeon determines that the surgery must be converted to an open cholecystectomy, due to multiple adhesions to surrounding tissue. As a result, the surgery takes much longer than anticipated. Tom must stay inpatient for several days. Several weeks later, Tom receives a bill from the surgeon with total billed charges of \$3,600.

Tom submits an initiation notice to HHS to initiate the PPDR process and the assigned SDR entity determines that the total billed charges are eligible for review under the PPDR process.

Under the NSA, what information must the provider furnish to the SDR entity?

Knowledge Check Answer

The provider must submit a copy of the good faith estimate and a copy of the billed charges. They must also submit documentation providing evidence to demonstrate that the difference between the billed charges and the expected charges in the good faith estimate reflects 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 good faith estimate was provided.

How does the SDR entity make the determination?

The **SDR entity** will review the **billed charges** to see if the items and services were included on the good faith estimate, as well as review all documentation timely submitted by the parties, including the uninsured (or self-pay) individual or their authorized representative and the provider or facility.

The SDR entity will determine how much the uninsured (or self-pay) individual must pay based on documentation submitted by the provider or facility; whether the provider or facility has provided credible information to demonstrate that the difference between the billed charge and the expected charge for the item or service in the good faith estimate reflects 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 good faith estimate was provided.

The SDR entity will make this assessment separately for each unique billed item or service.

Examples of determining the payment amount

1. **For any item or service where the billed charge is equal to or less than the expected charge in the good faith estimate**, the SDR entity would determine that the billed amount is not substantially in excess of the good faith estimate and this case is not eligible for the PPDR process. The SDR entity would inform the patient or their authorized representative that they are ineligible for this dispute resolution process.

Example: billed charge \$500; expected charge \$975. The SDR entity would inform the patient or their authorized representative that this case is ineligible for resolution via the PPDR process.

Examples of determining the payment amount (continued 1)

- 2. For a billed item or service that was included on the good faith estimate, if the billed charge for an item or service is substantially in excess of the expected charge in the good faith estimate, and the SDR entity determines the provider or facility has not provided credible information that the difference between the billed charge and the good faith estimate reflects 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 good faith estimate was provided, the SDR entity must determine the amount to be paid by the uninsured (or self-pay) individual for the item or service to be equal to the good faith estimate amount.**

Example: billed charge \$875; expected charge \$450. The payment amount will be \$450.

Examples of determining the payment amount (continued 2)

- 3. If the SDR entity determines that the provider or facility has provided credible information that the difference between the billed charge and the expected charge in the good faith estimate reflects the cost of a medically necessary item or service and is based on unforeseen circumstances,** the SDR entity must select as the amount to be paid by the uninsured (or self-pay) individual the lesser of: (1) the billed charge; or (2) the median payment amount paid by a plan or issuer for the same or similar service, by a same or similar provider in the geographic area as defined in § 149.140(a)(7) where the services were provided, that is reflected in an independent database as defined in § 149.140(a)(3) using the methodology described in § 149.140(c)(3), except that in cases where the amount determined by an independent database is determined to be less than the expected charge for the item or service listed on the good faith estimate, the amount to be paid will equal to the expected charge for the item or service listed on the good faith estimate. When comparing the billed charge with the amounts contained in an independent database, the SDR entity should account for any discounts offered by the provider or facility.

Examples of determining the payment amount (continued 3)

Example: billed charge \$900; expected charge \$450

If the SDR entity determines that the provider **did provide** credible information justifying the higher charge, the payment amount for the item will be the lower of: \$900; or the median payment amount described above, or if lower than the good faith estimate, the good faith estimate (\$450).

PPDR Process: Payment determination

Once the SDR entity determines whether the billed charges are justified, the SDR entity must determine the final payment amount for each item or service billed by the provider or facility, using the following rules.

For any item or service that appears on the good faith estimate:

| Billed Charge for an Item or Service | Credible Information Provided to Justify Charges | Amount to be Paid |
|---------------------------------------|--|--|
| Less than or equal to expected charge | N/A | Billed charge (and not eligible for PPDR process) |
| Greater than expected charge | No | Expected charge |
| Greater than expected charge | Yes | The lesser of: 1. Billed charge or 2. Median payment amount paid by a plan or issuer for the same or similar service, by a same or similar provider in the geographic area where services were provided. |

What about items not originally on the good faith estimate?

For billed items or services not listed on the **good faith estimate**, if the SDR entity determines the provider or facility did not provide **credible information** that demonstrates that the difference between the billed charge for the new item or service and the good faith estimate reflects 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 good faith estimate was provided, then the SDR entity must determine that amount to be paid for the new item or service to be equal to \$0.

What about items not originally on the good faith estimate? (continued 1)

If the SDR entity determines that a provider or facility has provided credible information that the billed charge for new items or services that did not appear on the good faith estimate does 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 good faith estimate was provided, then the SDR entity must determine the charge to be paid by the uninsured (or self-pay) individual for the new item or service as the lesser of:

1. The **billed charge**, or
2. The **median payment amount** paid by a plan or issuer for the same or similar service, by a same or similar provider in the geographic area as defined in § 149.140(a)(7) where the services were provided, that is reflected in an independent database as defined in § 149.140(a)(3) using the methodology described in § 149.140(c)(3). When comparing the billed charge with the amounts contained in an independent database, the SDR entity should account for any discounts offered by the provider or facility.

What about items not originally on the good faith estimate? (continued 2)

After making a determination about each item and service subject to the PPDR, the SDR entity will add together the amounts to be paid for all items and services subject to the determination. In cases where the final amount determined by the SDR entity is lower than the billed charge, the SDR entity will reduce the final amount by the administrative fee amount paid by the individual.

For any item or service that DOES NOT appear on the good faith estimate (e.g., new item or service):

| Credible Information Provided to Justify Charges | Amount to be Paid |
|--|--|
| No | \$0 |
| Yes | The lesser of: 1. Billed charge or 2. Median payment amount. |

Can providers and facilities settle their payment dispute with uninsured (or self-pay) individuals during the PPDR process?

Yes. HHS recognizes that the two parties to the PPDR process (the uninsured (or self-pay) individual and the provider or facility) may agree to resolve the dispute by settling on a payment amount.

At any point after the PPDR process has been initiated but before the date on which a determination is made by the SDR entity, the parties can settle the payment amount through either an offer of financial assistance or an offer to accept a lower amount, or an agreement by the uninsured (or self-pay) individual to pay the billed charges in full.

Can providers and facilities settle their payment dispute with uninsured (or self-pay) individuals during the PPDR process? (continued)

In the event that the parties agree to settle on a payment amount, the provider or facility should notify the SDR entity through the federal IDR Portal, electronically, or in paper form, as soon as possible, but no later than 3 business days after the date of the agreement.

Once the SDR entity receives the notification of the settlement, the SDR entity must close the dispute resolution case as settled and the agreed upon payment amount will apply.

Knowledge Check

Maria is a 25-year-old female self-pay individual. She has an appointment with her gynecologist to discuss long acting reversible contraceptives. Maria decides to schedule a procedure to have an intrauterine device placed. Upon scheduling the appointment, her gynecologist sends her a good faith estimate, which includes a total expected charge of \$400. Maria undergoes the procedure. Several weeks later she receives a bill for \$850. Maria submits an initiation notice to HHS. However, before the SDR entity makes a determination, Maria instead agrees to pay the billed charges in full.

Are parties allowed to settle a dispute outside of the PPDR process?

Knowledge Check Answer

Yes, parties are allowed to settle the payment amount after the PPDR process has been initiated but before a determination is made. The parties can settle the payment amount through:

- An offer of financial assistance;**
- An offer to accept a lower amount; or,**
- An agreement by the uninsured (or self-pay) individual to pay the billed charges in full.**

If the parties agree to settle, the provider or facility must provide a settlement notification to the SDR entity no later than 3 business days after the date of the agreement.

Treatment of payments made prior to determination

Payment of the **billed charges** (or a portion of the billed charges) by the uninsured (or self-pay) individual (or by another party on behalf of the uninsured (or self-pay) individual) prior to a determination does not demonstrate agreement by the individual to settle at that amount or any other amount.

Deferral to state PPDR processes

If HHS determines that a **state law** provides a process to determine the amount to be paid by an uninsured (or self-pay) individual to a provider or facility, and that such process meets or exceeds minimum federal requirements, HHS shall defer to the state process and direct any PPDR requests received from uninsured (or self-pay) individuals in such state to the state process to adjudicate the dispute resolution initiation request.

Extension of time periods for extenuating circumstances

The time periods specified throughout the PPDR process (other than the timing of all payments, including payment of the administrative fees) may be extended in **extenuating circumstances** at HHS's discretion if:

- An extension is necessary to address delays due to matters beyond the control of the parties or for good cause, and
- The parties attest that prompt action will be taken to ensure that the determination under this section is made as soon as administratively practicable under the circumstances.

Any party may request an extension by submitting a request for extension due to extenuating circumstances through the federal IDR portal or electronic or paper mail if the extension is necessary to address delays due to matters beyond the control of the party or for good cause.

HHS model notices

HHS has developed a **model notice** that SDR entities may use to provide the determination notice to providers or facilities, and a model notice that providers or facilities may use to notify the SDR entity and HHS that all parties agree to settle on a payment amount.

These model notices were published as part of [CMS Form Number 10791](#) and are available for download.

HHS model notices (continued 1)

OMB Control Number XXXX-XXXX
Expiration Date MM/DD/YYYY

**Selected Dispute Resolution (SDR) Entity Decision Notice to
Health Care Provider or Facility**

Date

Health Care Provider or Facility Name
Health Care Provider or Facility Address
Health Care Provider or Facility City, State, Zip

RE: Patient-provider dispute process decision re: Reference Number:
XXXXXXXX

[Health Care Provider or Facility],

We have reviewed the information for [Reference Number: XXXXXXXX]. Based on our review, our decision is that you **[select one: have OR have not]** provided enough evidence to demonstrate that the difference between the billed charges and the Good Faith Estimate is medically justified and based on unforeseen circumstances that could not have been reasonably anticipated.

[If have prevailed:]
Based on this decision, [patient name] must pay **[select one: \$XXX,** which is the total expected charges provided in the Good Faith Estimate minus the \$25 administration fee the patient paid for the dispute process **OR \$YYY,** which is the billed charge **OR \$ZZZ,** which is the median amount for the same or similar services by a same or similar provider in your geographic area]. You must arrange for such payment directly with [patient name].

[If have not prevailed:]
Based on this decision, [patient name] must pay **[select one: \$XXX,** which is the total expected charges provided in the Good Faith Estimate minus \$25 that you must credit to the patient for the administration fee they paid for the dispute process **OR \$YYY,** which is the billed charge minus \$25 that you must credit to the patient for the administration fee they paid for the dispute process **OR \$ZZZ,**

OMB Control Number XXXX-XXXX
Expiration Date MM/DD/YYYY

which is the median amount for the same or similar services by a same or similar provider in your geographic area minus \$25 that you must credit to the patient for the administration fee they paid for the dispute process]. You must arrange for such payment directly with [patient name].

This decision is binding, unless there are claims of fraud or a misrepresentation of facts presented to us, in which case you may have the right to other legal remedies. For more information, see www.cms.gov/nosurprises.

Sincerely,
[SDR entity name and contact information]

HHS model notices (continued 2)

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

Health Care Provider Notice of Payment Settlement to Selected Dispute Resolution Entity

A health care provider or facility must complete this form when an uninsured (or self-pay) individual or the individual's authorized representative have resolved a payment dispute outside of the dispute resolution process.

Federal standards require health care providers and facilities to notify the Selected Dispute Resolution (SDR) entity, no later than 3 business days after the date of the settlement.

| |
|--|
| Please complete the information about the payment agreement. |
| Today's date: _____ / _____ / _____ |
| SDR Entity Name: |
| Reference Number: |
| Provider or Facility Name: |
| Agreed Payment Amount |
| Date when the new payment agreement was reached: _____ / _____ / _____ |
| Select one: |
| <input type="checkbox"/> We agreed to a new payment amount. The final payment amount for the patient is: |
| \$ _____ |
| <input type="checkbox"/> We agreed to provide financial assistance. The final payment amount for the patient is: |
| \$ _____ |

1

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

| | | |
|---|-------------|-----------|
| Patient Information | | |
| Patient Name: First Name | Middle Name | Last Name |
| (optional) Authorized Representative Name: | | |
| Health Care Provider Information | | |
| Health Care Provider Name | | |
| Hospital or Group Name | | |
| Street | | |
| City | State | ZIP |
| Email | Phone | |
| I have included with this form (check one): | | |
| <input type="checkbox"/> Documentation signed by the patient and agreeing to the new payment amount | | |
| <input type="checkbox"/> Documentation from the patient agreeing to the new payment in the form of an email, letter, or fax | | |
| <input type="checkbox"/> I acknowledge that I am sending this for this form to the SDR entity, the patient or authorized representative, and the U.S. Department of Health and Human Services (HHS) by uploading it to www.cms.gov/nosurprises | | |

Once you submit this form, the SDR entity will confirm receipt of documentation and notify the health care provider of the reduced SDR entity fee [owed by/ that will be refunded] by [call/email/ www.cms.gov/nosurprises].

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Summary of the PPDR Process

Areas of particular applicability to providers and facilities have been underlined for emphasis.

| Timeline | Process step |
|--|--|
| | Before the PPDR Process: |
| <p>Within 120 calendar days</p> | <p>1. Initiation Notice and Administrative Fee: the uninsured (or self-pay) individual submits the initiation notice and other relevant information to the Secretary of the Department of Health and Human Services (HHS). The initiation notice must be sent within <i>120 calendar days</i> from when the uninsured or (self-pay) individual received their initial bill for items and services from their provider or facility. HHS will choose and notify the Selected Dispute Resolution Entity (SDR entity). Once HHS has chosen the SDR entity, the uninsured (or self-pay) individual must pay an administrative fee to the SDR entity.</p> |
| <p>Within 3 business days</p> | <p>2. SDR Entity Conflict of Interest Identification: Should a conflict of interest exist, HHS will select a new SDR entity to conduct the PPDR Process. If no SDR entities are available to resolve the dispute, the initially-selected SDR entity will be required to initiate their entity-level conflict of interest mitigation plan, (which may include identifying a sub-contractor whom they have verified does not have a conflict of interest) and submit notice to HHS related to the implementation of the mitigation plan, no later than <i>3 business days</i> following selection by HHS. HHS will then assign the case to the identified alternative SDR entity to conduct the PPDR process.</p> |

Summary of the PPDR Process (continued 1)

Areas of particular applicability to providers and facilities have been underlined for emphasis (continued).

| Timeline | Process step |
|--------------------------------|---|
| | Before the PPDR Process: |
| Within 21 calendar days | <p>3. Eligibility Determination and Additional Information: After the SDR entity receives information submitted by the uninsured or (self-pay) individual, it will notify them regarding:</p> <ul style="list-style-type: none"> - Whether or not they are eligible for PPDR - If additional information is needed to determine eligibility or if the patient can proceed to dispute resolution <p>If additional information is required, the patient has <i>21 calendar days</i> to furnish it after being notified of the information deficiency.</p> |
| | PPDR Process: |
| | <p>4. PPDR Initiation: If the SDR entity determines that the item or service meets the eligibility criteria, and the initiation notice contains the required information, the SDR entity will notify the uninsured (or self-pay) individual and the provider or facility that the item or service has been determined eligible for dispute resolution.</p> |

Summary of the PPDR Process (continued 2)

Areas of particular applicability to providers and facilities have been underlined for emphasis (continued).

| Timeline | Process step |
|-------------------------|--|
| Within 3 business days | <p>5. Parties' Conflict of Interest Identification: The uninsured (or self-pay) individual and provider or facility may attest to having a conflict of interest with the SDR entity. Should a conflict of interest exist, the SDR entity must notify HHS within <i>3 business days</i> of receiving the attestation. HHS will select a different entity to conduct the PPDR process.</p> |
| Within 10 business days | <p>6. Provider or Facility Submits Information: The provider or facility should submit any required information to the SDR entity within <i>10 business days</i> of receipt of the selection notice. This information includes:</p> <ul style="list-style-type: none"> - A copy of the good faith estimate provided to the uninsured (or self-pay) individual for the item or service under dispute, - A copy of the billed charges provided to the uninsured (or self-pay) individual for the item or service under dispute, - If available, documentation demonstrating that the difference between the billed charge and the expected charges in the good faith estimate reflects the cost of a medically necessary item or service and is based on unforeseen circumstances. |

Summary of the PPDR Process (continued 3)

Areas of particular applicability to providers and facilities have been underlined for emphasis (continued).

| Timeline | Process step |
|------------------------|---|
| Within 3 business days | <p>7. Patient-Provider Negotiation: If the parties to a PPDR process agree on a payment amount (through either an offer of financial assistance or an offer of a lower amount, or an agreement by the uninsured (or self-pay) individual to pay the billed charges in full) after the PPDR process has been initiated but before the date on which a determination is made, the provider or facility will notify the SDR entity through the federal IDR portal, electronically, or in paper form as soon as possible, but no later than <i>3 business days</i> after the date of the agreement.</p> <p>The settlement notification must contain at a minimum, the settlement amount, the date of such settlement, and documentation demonstrating that the provider or facility and uninsured (or self-pay) individual have agreed to the settlement. The settlement notice must also document that the provider or facility has applied a reduction to the uninsured (or self-pay) individual's settlement amount equal to at least half the amount of the administrative fee paid.</p> |

Summary of the PPDR Process (continued 4)

Areas of particular applicability to providers and facilities have been underlined for emphasis (continued).

| Timeline | Process step |
|---------------------------------------|--|
| <p>Within 30 business days</p> | <p>8. Payment Determination for PPDR by the SDR Entity: No later than <i>30 business days</i> after receiving the required information from the provider or facility, the SDR entity must make a determination regarding the amount to be paid by the uninsured (or self-pay) individual, taking into account the requirements of the PPDR payment determination process. The SDR entity should inform both parties of this determination as soon as practicable after reaching a payment determination.</p> <p><u>The determination made by the SDR entity will be binding upon the parties involved</u>, in the absence of fraud or evidence of misrepresentation of facts presented to the selected SDR entity regarding the claim, <u>except that the provider or facility may provide financial assistance or agree to an offer for a lower payment amount than the SDR entity's determination</u>, the uninsured (or self-pay) individual may agree to pay the billed charges in full, or the uninsured (or self-pay) individual <u>and the provider or facility may agree to a different payment amount</u>.</p> |
| <p>Time Period Extensions</p> | <p>Extenuating Circumstances: The parties may request extensions to most of the time periods above in cases of extenuating circumstances.</p> |

Main Takeaways

The No Surprises Act protects **uninsured (or self-pay)** individuals from unexpectedly high medical bills in two ways:

- If an individual does not have certain types of health insurance, or does not plan to use that insurance to pay for health care items or services, they are eligible to receive a “good faith estimate” of what they may be charged, before they receive the item or service.
- When the billed charges for any provider or facility are in excess of the good faith estimate for that provider or facility by \$400 or more, the item or service may be eligible for payment determination by a SDR entity through the PPDR process.

A convening provider must provide a good faith estimate to the uninsured individual, including any item or service that is reasonably expected to be provided in conjunction with a scheduled or requested item or service by another provider or facility. A co-provider or co-facility is a provider or facility other than a convening provider or a convening facility that furnishes items or services that are customarily provided in conjunction with a primary item or service.

Main Takeaways (continued)

Providers' and facilities' main responsibilities in the PPDR process include:

- The provider or facility should submit any required information to the SDR entity within 10 business days of receipt of the selection notice.
- While the PPDR process is pending, the provider or facility must not move the bill for the disputed item or service into collection or threaten to do so, or if the bill has already moved into collection, the provider or facility should cease collection efforts. The provider or facility must also suspend the accrual of any late fees on unpaid bill amounts until after the PPDR process has concluded.
- In the event that the parties agree to settle on a payment amount, the provider or facility should notify the SDR entity through the federal IDR Portal, electronically, or in paper form, as soon as possible, but no later than 3 business days after the date of the agreement.
- The determination made by the SDR entity will be binding upon the parties involved.

Resources

- [Requirements Related to Surprise Billing; Part II](#)
- Patient-Provider Dispute Resolution Guidance: <https://www.cms.gov/ccio/resources/regulations-and-guidance#Patient-Provider%20Dispute%20Resolution>
- Sample Disclaimer and Model Notice: <https://www.cms.gov/regulations-and-guidance/legislation/paperworkreductionactof1995pra-listing/cms-10791>
- For more information about the No Surprises Act and the PPDR process, please see www.cms.gov/nosurprises
- For additional assistance, contact the No Surprises Help Desk at 1-800-985-3059, 8:00 am to 8:00 pm ET, 7 days a week

Questions



Send any questions about the provider requirements and provider enforcement to provider_enforcement@cms.hhs.gov.

Appendix: Glossary



Glossary

| Term | Definition | Citation in the CFR | Originating No Surprises Act Rule |
|--|--|---------------------------|--|
| Authorized Representative | An individual authorized under State law to provide consent on behalf of the uninsured (or self-pay) individual, provided that the individual is not a provider affiliated with a facility or an employee of a provider or facility represented in the good faith estimate, unless such provider or employee is a family member of the uninsured (or self-pay) individual. | 45 CFR 149.610(a)(2)(i) | <u>Requirements Related to Surprise Billing; Part II IFC</u> |
| Billed charge | The amount billed by a provider or facility for an item or service. | 45 CFR 149.620(a)(2)(i) | <u>Requirements Related to Surprise Billing; Part II IFC</u> |
| Convening health care provider or convening health care facility (convening provider or convening facility) | The provider or facility who receives the initial request for a good faith estimate from an uninsured (or self-pay) individual and who is or, in the case of a request, would be responsible for scheduling the primary item or service. | 45 CFR 149.610(a)(2)(ii) | <u>Requirements Related to Surprise Billing; Part II IFC</u> |
| Co-health care provider or co-health care facility (co-provider or co-facility) | A provider or facility other than a convening provider or a convening facility that furnishes items or services that are customarily provided in conjunction with a primary item or service. | 45 CFR 149.610(a)(2)(iii) | <u>Requirements Related to Surprise Billing; Part II IFC</u> |

Glossary (continued 1)

| Term | Definition | Citation in the CFR | Originating No Surprises Act Rule |
|--|---|---------------------------|--|
| Credible information | Information that upon critical analysis is worthy of belief and is trustworthy. | 45 CFR 149.620(f)(3)(ii) | <u>Requirements Related to Surprise Billing; Part II IFC</u> |
| Diagnosis code | The code that describes an individual's disease, disorder, injury, or other related health conditions using the International Classification of Diseases (ICD) code set. | 45 CFR 149.610(a)(2)(iv) | <u>Requirements Related to Surprise Billing; Part II IFC</u> |
| Expected charge | 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. | 45 CFR 149.610(a)(2)(v) | <u>Requirements Related to Surprise Billing; Part II IFC</u> |
| Good faith estimate | 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. | 45 CFR 149.610(a)(2)(vi) | <u>Requirements Related to Surprise Billing; Part II IFC</u> |
| Health care facility (facility) | An institution (such as a hospital or hospital outpatient department, critical access hospital, ambulatory surgical center, rural health center, federally qualified health center, laboratory, or imaging center) in any State in which State or applicable local law provides for the licensing of such an institution, that is licensed as such an institution pursuant to such law or is approved by the agency of such State or locality responsible for licensing such institution as meeting the standards established for such licensing. | 45 CFR 149.610(a)(2)(vii) | <u>Requirements Related to Surprise Billing; Part II IFC</u> |

Glossary (continued 2)

| Term | Definition | Citation in the CFR | Originating No Surprises Act Rule |
|--|--|----------------------------|--|
| Health care provider (provider) | A physician or other health care provider who is acting within the scope of practice of that provider's license or certification under applicable State law, including a provider of air ambulance services. | 45 CFR 149.610(a)(2)(viii) | <u>Requirements Related to Surprise Billing; Part II IFC</u> |
| Items or services | All encounters, procedures, medical tests, supplies, prescription drugs, durable medical equipment, and fees (including facility fees), provided or assessed in connection with the provision of health care. | 45 CFR 147.210(a)(2)(xiii) | N/A |
| Period of care | The day or multiple days during which the good faith estimate for a scheduled or requested item or service (or set of scheduled or requested items or services) are furnished or are anticipated to be furnished, regardless of whether the convening provider, convening facility, co-providers, or co-facilities are furnishing such items or services, including the period of time during which any facility equipment and devices, telemedicine services, imaging services, laboratory services, and preoperative and postoperative services that would not be scheduled separately by the individual, are furnished. | 45 CFR 149.610(a)(2)(x) | <u>Requirements Related to Surprise Billing; Part II IFC</u> |
| Primary item or service | The item or service to be furnished by the convening provider or convening facility that is the initial reason for the visit. | 45 CFR 149.610(a)(2)(xi) | <u>Requirements Related to Surprise Billing; Part II IFC</u> |
| Service code | The code that identifies and describes an item or service using the Current Procedural Terminology (CPT), Healthcare Common Procedure Coding System (HCPCS), Diagnosis-Related Group (DRG) or National Drug Codes (NDC) code sets. | 45 CFR 149.610(a)(2)(xii) | <u>Requirements Related to Surprise Billing; Part II IFC</u> |
| Substantially in excess | With respect to the total billed charges by a provider or facility, an amount that is at least \$400 more than the total amount of expected charges listed on the good faith estimate for the provider or facility. | 45 CFR 149.620(a)(2)(ii) | <u>Requirements Related to Surprise Billing; Part II IFC</u> |

Glossary (continued 3)

| Term | Definition | Citation in the CFR | Originating No Surprises Act Rule |
|---|---|----------------------------|--|
| Total billed charge(s) | The total of billed charges, by a provider or facility, for all primary items or services and all other items or services furnished in conjunction with the primary items or services to an uninsured (or self-pay) individual, regardless of whether such items or services were included in the good faith estimate. | 45 CFR 149.620(a)(2)(iii) | <u>Requirements Related to Surprise Billing; Part II IFC</u> |
| Uninsured (or self-pay) individual | (A) An individual who does 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, Federal health care program (as defined in section 1128B(f) of the Social Security Act), or a health benefits plan under chapter 89 of title 5, United States Code; or (B) An individual who has benefits for such item or service under a group health plan, or individual or group health insurance coverage offered by a health insurance issuer, or a health benefits plan under chapter 89 of title 5, United States Code but who does not seek to have a claim for such item or service submitted to such plan or coverage. | 45 CFR 149.610(a)(2)(xiii) | <u>Requirements Related to Surprise Billing; Part II IFC</u> |