Federal Rule to Prevent Surprise Health Care Billing: Application to Clinical Social Workers

January 5, 2022
(updated from December 21, 2021)

This blog post updates information from our post of December 21, 2021. It provides updated clarifying information that was not available until now regarding Part II of a federal rule that pertains to the provision of Good Faith Estimates (GFEs). And it provides new information on Part I of this regulation. If you reviewed our December 21 post, you may also find it helpful to review this one. We are continuing to closely monitor this dynamic policy area so we can continue to provide updates to our members. We are also advocating on behalf of clinical social workers with key federal regulatory agencies and other stakeholders.

Background on Federal Rule

New federal regulations implementing the No Surprises Act (enacted by Congress in 2020) went into effect on January 1, 2022. The aim of the law is to protect consumers from unanticipated medical bills. There are three (3) parts to the regulations that were developed by multiple federal agencies including the US Department of Health and Human Services (HHS):

Part I protects consumers/patients with health plan coverage from surprise bills from *out-of-network* (OON) providers (including but not limited to clinical social workers, or CSWs) who provide emergency and non-emergency services at *in-network* facilities. This portion of the regulations only impacts CSWs who work in these types of arrangements.

Part II requires *all* health care providers (including CSWs) and health care facilities licensed, certified or approved by the state to provide good faith estimates (GFEs) of expected charges for services and items offered to uninsured (e.g., not enrolled in any health plan) and self-pay (e.g., not planning to file a claim with their plan) consumers. Effective January 1, 2022, any health care provider or health care facility subject to state licensure must provide a GFE of expected charges for services and items within specific timeframes to current/established and future patients. These new regulations set forth specific requirements for how providers need to inform patients of their right to a GFE, what these good faith estimates must contain and how records are to be maintained. Part II of the regulations also establishes a process for consumers to dispute provider charges that "substantially exceed" a good faith estimate. ("Substantial" is defined as $400 or more). GFEs do not need to be provided to patients who are enrolled in federal health insurance plans (e.g., Medicare, Medicaid, TRICARE, Indian Health Service or the Veterans Affairs health system).

Providing a GFE to patients is not new to CSWs who, as part of best clinical and ethical practice, routinely discuss services and fees before or during the initial interview with new patients and provide informed consent forms. However, the new federal rule formalizes this process and it is now a matter of federal regulatory compliance.

Part III ("Prescription Drug and Health Care Spending" rule) implements new requirements for group health plans and issuers to submit certain information about prescription drug and health care spending. This includes, among other things, information on the most frequently dispensed and costliest drugs, and enrollment and premium information, including average monthly premiums paid by employees versus employers. This part does not directly impact CSWs.

Below, we provide more information on Parts I and II and how CSWs can comply with these new policies. NASW is awaiting clarification from the relevant federal agencies (including HHS) on the regulations and will provide updates as new information is provided. We are also continuing to advocate on behalf our members regarding implementation of the new law.

Part I: Balance Billing Rules for Out of Network Providers Furnishing Services in In-Network Facilities

This part of the new regulations applies to CSWs in specific arrangements. If these do not apply to you, please go to Part II on Good Faith Estimates, which applies to all CSWs. If these do apply to you, further information is provided below. We also encourage you to confer with the compliance officers at the facilities for whom you provide services for specific guidance.

- CSWs who work at ***emergency*** in-network facilities but are out of network (OON) providers for the patient's health plan.
- CSWs who work in in-network facilities providing ***non-emergent*** care and are OON with the patient's health plan.

Emergency Providers at In-Network Facilities

CSWs who work in settings that provide emergency care (such as hospital emergency departments) where the facility is in-network, but the CSW is OON, are not permitted to balance bill patients beyond in-network cost-sharing amounts.

For example, if a CSW provided emergency care to a patient and is OON with the patient's health plan, the CSW cannot bill patients for charges above and beyond what the patient's portion is under their plan.

The OON provider is required to determine the patient's health insurance status and the applicable in-network cost-sharing amount.

Non-Emergency Providers at In-Network Facilities

CSWs who are OON but provide non-emergent care to patients at in-network facilities cannot balance bill patients above the cost-sharing amount permitted by the patient's

insurance. However, there is an exception if they take steps to allow patients the opportunity to receive notice and provide consent before rendering care. CSWs can meet the notice and consent requirements by providing the patient with:

- Written notice and consent 72 hours in advance of their appointment; and
- A list of in-network providers at the facility and information regarding medical care management, such as prior authorization.

The notice must:

- Alert the patient that the provider does not participate in-network;
- Provide an estimate of the OON charges; and
- List in-network providers at the facility.

The penalty for billing a patient more than the cost-sharing amount is up to $10,000. The HHS Secretary may permit a hardship exemption or waiver if the provider did not knowingly violate the law and takes appropriate corrective action with interest paid to the patient within 30 days of the violation.

Patient Continuity of Care

Health plans will be required to notify patients of any changes to in-network status of current treating providers and ensure continuity of care. If a provider contract is terminated, a patient can elect to continue with that provider for either 90 days after the contract is terminated or the date when no longer a continuing patient, whichever is earliest. The provider is required to continue the provision of services under the same terms and conditions as the in-network contract unless the provider is terminated for cause (such as failing to meet quality standards). This provision allows patients time to transition their care to an in-network provider so there is not an abrupt termination of services.

For CSWs, this provision applies to treatment for serious or complex conditions and institutional or inpatient care. A serious and complex condition is defined as a condition "serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm" or a chronic condition that "is life-threatening, degenerative, potentially disabling, or congenital; and requires specialized medical care over a prolonged period of time.

Updating Provider Directories

The No Surprises Act requires that by 2022, plans verify and update their provider directories at least every 90 days. In-network providers must submit to plans the following information:

- When the provider begins a network agreement with a plan;
- When the provider terminates an agreement;
- Any material changes to the content of the provider directory information; and
- Any other time determined appropriate by the Secretary of HHS

Part II: Good Faith Estimates

On October 7, 2021, Part II of the interim final rule was issued. It applies any health care provider who is acting within the scope of the provider's license or certification under applicable state law. This rule therefore applies to all CSWs who meet that broad definition.

Definitions

Below are definitions of a several key terms in the rule as they apply to CSWs:

"Convening provider" or facility: That who receives the initial request for a good faith estimate and who is responsible for scheduling the primary item/service in question.

"Expected charge" for an item or service:

- the cash pay rate or rate established by a provider for an uninsured (or self-pay) patient, reflecting any discounts for such individuals; or
- the amount the provider would expect to charge if the provider intended to bill a health care plan directly for such item or service.

"Items and services": All encounters, procedures, medical tests provided or assessed in connection with the provision of health care. Services related to mental health substance use disorders are specifically included.

Compliance Steps

To comply with the new federal rule, CSWs should take the following steps. ***As stated earlier, we are awaiting clarification from HHS on several of these provisions, including the use of diagnoses codes for new patients who have not yet been evaluated. As soon as we receive policy clarifications, we will provide them to members.***

1) **Ask *both* current/established and new patients if they have any health insurance coverage and ascertain if they are uninsured or self-pay.** If a patient is insured, make a copy of the insurance card for your files and ask the patient if they plan to submit a claim for the services they will receive.

2) **Inform all uninsured and self-pay patients of their right to a GFE**. Written notice must be provided in clear language that the individual can understand in an accessible format, prominently displayed in the office and on the provider/facility's website and must be easily searchable from a public search engine. Written notices should account for any vision, hearing or language limitations, including individuals with limited English proficiency or other literacy needs. It may be provided on paper or electronically, depending on the individual's preference. The written notice should also state that information will be orally provided when the service is scheduled or when the patient asks about costs, and available in accessible formats, in the language(s) spoken by the patient.

3) **Provide all uninsured or self-pay patients with a GFE**. This must include:

- Patient name and date of birth
- a clear description of each item/service
- applicable diagnosis codes, expected service codes and expected charges associated with each listed item or service (and date of service if scheduled) (e.g., 50-minute individual psychotherapy session, weekly until otherwise indicated). *Note: Providers may have diagnoses for existing patients but not for prospective/new patients who have not yet been evaluated. The provider should reasonably attempt to include expected service codes and expected charges associated with the service.*
- the name, National Provider Identification (NPI) number, and Tax Identification Number (TIN) of each provider/facility where the items or services are expected to be furnished. Note: Note*: Some providers do not have an NPI or TIN and instead use their social security number (SSN) as their business tax ID. NASW recommends providers obtain a TIN/EIN to avoid publicly disclosing their SSN.*
- a disclaimer that the GFE is only an estimate of items/services reasonably expected to be furnished at the time and final items, services or charges may differ. (For recurring services, see "GFEs for Recurring Services", below).
- a disclaimer that additional recommended items or services may be part of the course of care but are not reflected in the GFE along with a separate list of items/services that require separate scheduling and for which separate GFEs would need to be requested. *Note: This may not apply to CSWs, particularly in private practice.*
- a disclaimer informing the patient of their right to initiate the patient-provider dispute resolution (PPDR) process if the actual billed charges are substantially greater than the estimated charges along with instructions of where to find more information and written assurance that initiating such process will not adversely affect the quality of services rendered. (See "Dispute Resolution", below).
- a disclaimer that the estimate is not a contract and does not require the individual to obtain the items or services from any of the providers or facilities identified.

4) **Explain the GFE to the patient over the phone or in-person** if the patient requests it, and follow-up with a paper or electronic GFE.

5) **Document the GFE** in the clinical record.

CSWs who are employed by group practices and other types of health care facilities should contact their compliance officers for guidance.

Timeframes

Information regarding scheduled items and services must be furnished within:

- one (1) business day of scheduling an item or service to be provided in three (3) business days;
- within three (3) business days of scheduling an item or service to be provided in at least 10 business days.

A new GFE must be provided, within the specified timeframes if the patient reschedules the requested item or service. If any information provided in the estimate changes, a new GFE must be provided no later than one (1) business day before the scheduled care. Also, if there is a change in the expected provider less than one business day before the scheduled care, the replacement provider must accept the original GFE as their expected charges.

GFEs for Recurring Services

If you expect to provide a recurring service to the uninsured or self-pay patient, you may submit a single GFE to that patient for those services, so long as the GFE 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 GFE can only include recurring services that are expected to be provided within the next 12 months. For additional recurrences beyond 12 months, the provider must provide a new GFE and communicate any changes between the initial and the new estimates.

For example, if you have a patient whom you expect will need continuing services throughout the year, the GFE could say: "I expect that my care of you will require weekly psychotherapy sessions of 50 minutes through the end of the year, at $X per session for a total of 50 weeks, accounting for vacations, holidays, emergencies and sick time or an estimated total of AMOUNT per session x (number of weeks).

If the future course of treatment is less certain, the GFE could say: "Depending on the progress we make this year (or insert applicable factors), I expect that you will need 10–20 more sessions this year. At $X per session the estimated total cost would be 10 x (rate per session) and 20 x (rate per session)."

GFE and Notice Templates and Resources

Here is a link to resources including templates by the Centers for Medicare and Medicaid Services (CMS) that can be used to prepare good faith estimates and model language for informing patients of their rights to GFE.

We will be providing a customized template that CSWs can use as a model for their GFE.

Record Keeping

GFEs are considered part of a patient's medical record and must be maintained in the same manner. Accordingly, convening providers/facilities must be able to provide a copy of any estimates within the last six (6) years. Providers will not be considered noncompliant if they act in good faith and with reasonable due diligence and correct any inaccuracies as soon as practicable. HHS will exercise enforcement discretion in scenarios where convening providers and facilities are relying on the accuracy of expected charges for items or services for which they do not bill from co-providers or co-facilities, provided that they did not know or reasonably should have known, that the information was incomplete or inaccurate, and that they attempt to correct any inaccuracies as soon as possible. Providers/facilities who experience others' failures to comply with these requirements may file a complaint for enforcement investigation.

Dispute Resolution

Although the information provided in the GFE is only an estimate, and the actual items, services, or charges may differ from what is included in it, uninsured or self-pay individuals may challenge a bill from a provider through a new patient-provider dispute resolution (PPDR) process if the billed charges substantially exceed the expected charges in the GFE. "Substantially exceeds" means an amount that is at least $400 more than the expected charges listed on the GFE.

Through this process, consumers will also be able to request a third-party arbitrator to review the GFE, their bill, and information submitted by their provider or facility to determine if the additional charges are allowed or if the provider or facility can only charge less than the billed charge. HHS intends to establish an online portal and offer documents for hard-copy submissions for patients initiating a dispute resolution process.

Future Action: Providing GFEs to Insurers

The federal government will also soon issue regulations requiring CSWs and other health providers to provide GFEs to commercial or government insurers when the patient has insurance and plans to use it.

NASW will continue to advocate for CSWs around these new regulations and update members as new policy information is made available.

Disclaimer: Legal and regulatory issues are complex and highly fact-specific and state-specific. They require legal expertise that cannot be provided in this article. The information in this alert does not constitute and should not be relied upon as legal advice and should not be used as a substitute for obtaining personal legal advice and consultation prior to making decisions.