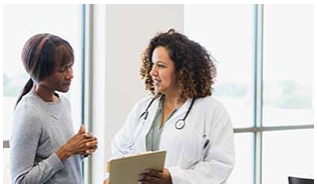

At last minute, CMS gives clarity on No Surprises estimates, convening terms

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As parts of the new No Surprises rules go into effect, CMS has responded to appeals from providers to clarify some points that had been left unclear. These include how to handle good faith estimate (GFE) notification times in the case of urgent care and the requirement that "convening" providers must provide estimates of other providers' care costs in the case of procedures with multiple touch points.

In the Q&A section of a No Surprises-themed CMS provider call on Dec. 8, a listener asked the moderators about the notification period for the provision of GFEs. These estimates, a key part of the plan to make sure patients know what they'll be charged for services ahead of time, are currently only required for self-pay and uninsured patients but are expected to apply to other patients before the end of 2022.

A caller from a facility with a walk-in clinic asked if the three-hour-notice stipulation in the Part I rule from July — "providers and facilities are required to provide the notice no later than three hours prior to furnishing items or services to which the notice and consent requirements apply," as the rule states — applied to urgent care patients. Notice and consent forms are to be offered to patients who receive services for which they may later be billed (*PBN 12/6/21*).

While most notice and consent is required by three days before treatment, the three-hour rule is meant "to address situations where an individual might be asked to provide consent immediately before a provider furnishes the item or service, which may prevent their consent from being truly voluntary," according to the rule.

The caller wondered whether the notice had to be produced at least three hours before the urgent care service, even if the scenario made that nearly impossible — for example, if the provider wished to perform a simple procedure, would the patient have to wait three hours to receive it?

The moderators said they'd deal with the query offline, but a frequently asked question (FAQ) document released by CMS on Dec. 27 clarifies that "there are some items or services that may not be included in a GFE because they are not typically scheduled in advance and not typically the subject of a requested GFE (such as urgent, emergent trauma, or emergency items or services)" (*see resources, below*).

Note: These requirements and clarifications apply to health care facilities as defined by the rules, and do not apply to independent practices as such — at least not yet — but do apply to outpatient departments, ambulatory surgery centers (ASC) and other settings .

Find clarity on 'convening'

The FAQ also addresses the GFE requirement for a "convening provider or facility" in the event that a procedure or service requires the involvement of multiple providers — for example, a scenario involving an ACL repair performed by a surgeon that results in follow-up physical therapy.

Recognizing 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," HHS will "exercise its enforcement discretion" in such cases through the end of the year, according to the FAQ document.

However, HHS notes that self-pay and uninsured patients may request a GFE "directly from the co-provider or co-facility," in which case those providers would be obliged to produce it.

CMS further cautions that when the convening provider or facility or co-provider "anticipates or is notified of any changes to the scope of a GFE" — that is, when they learn of a new requirement for outside care for the treatment or service they convene — they must supply an amended GFE to the patient "no later than one business day before the items or services are scheduled to be furnished."

You will find some additional guidance in the FAQ that will help you adjust to the new rules:

- **Oral GFE**. "If a patient requests that the GFE information is provided in a format that is not paper or electronic delivery, like orally over the phone or in person, the provider/facility may provide the GFE information orally but

must follow up with a written paper or electronic copy in order to meet the regulatory requirements," the FAQ states.

- **Discounts and GFEs**. If a provider anticipates discounts on a service to GFE-eligible patients, through financial aid or other means, you must figure that into the GFE. In fact, "even if the uninsured (or self-pay) individual has no estimated financial responsibility" due to such discounts, a GFE is required.

"Clearly, the complex nature of these regulations leave unanswered questions for medical groups," says Claire Ernst, director of government affairs with the Medical Group Management Association (MGMA) in Washington, D.C. "We are hopeful that HHS provides both additional guidance and flexibility for certain requirements as to not punish practices that are making good faith efforts to comply with a deluge of new requirements."

Resources

- CMS, "Frequently Asked Questions (FAQs) about Consolidated Appropriations Act, 2021 Implementation - Good Faith Estimates," Dec. 27, 2021: *www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Guidance-Good-Faith-Estimates-FAQ.pdf*

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