APTA Practice Advisory: Good Faith Estimate for Uninsured or Self-Pay Patients

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The Issue: The No Surprises Act was passed in 2020 to protect consumers from surprise medical bills, often called "balance billing," that arise most often when the patient couldn't choose their provider, such as in an emergency. As such, most of the No Surprises Act and its corresponding regulations apply only to emergency services, air ambulance services, and certain out-of-network providers, such as anesthesiologists, surgeons, and radiologists, at in-network facilities.

What you need to know: A provision within the regulations that applies to all licensed health care providers regardless of setting or situation requires providers to offer a good faith estimate of the cost of services to uninsured patients or those who pay cash. This would apply to outpatient private practices. Compliance is required as of Jan. 1, 2022.

Suggested Next Steps: Physical therapists should review the regulations and use the provided samples and templates to prepare their clinics to offer the required good faith estimates by Jan. 1, 2022.

Who Does This Impact?

CMS is requiring providers to offer a good faith estimate of the cost of services or items to uninsured patients or those who pay cash.

Under this rule, CMS defines a provider as a physician or other health care provider who is acting within the scope of practice of their license or certification under applicable state law. This means physical therapists and physical therapist assistants are subject to the good faith estimate provision.

However, only the provider scheduling the service is required to provide the good faith estimate. CMS refers to these as "convening health care providers" or "convening health care facilities" — those that receive an initial request for a good faith estimate from an uninsured or self-pay individual and would be responsible for scheduling the primary service or item.

About APTA Practice Advisories

APTA issues practice advisories to assist the physical therapy community in providing quality care that follows best available evidence and practice management principles. Practice advisories are not formal association guidelines, policies, positions, procedures, or standards. They are not clinical practice guidelines and do not establish a standard of care.

Physical therapists, physical therapist assistants, and students of physical therapy are responsible for clinical practice that is consistent with their scope of practice, and for complying with licensure laws and other regulations, all of which vary by state. The information provided is not meant as a substitute for legal or professional advice on any subject matter.

Practice advisories may be updated after their original publication. Use of practice advisories is voluntary.

Requirements for Providers

If you are subject to this rule, you must do the following:

1. Post a Notice of Availability of Good Faith Estimates on your website and in your office where scheduling or questions about the cost of health care occur. CMS provides a sample notice you can use as a template.

2. When a patient requests a service, determine if they are uninsured or choosing to self-pay instead of using insurance coverage.

3. Tell the uninsured or self-pay patient that a good faith estimate of expected charges is available upon scheduling a service or item or upon request. (Note: Consider any discussion or inquiry regarding the potential costs of services or items as a request for a good faith estimate.) You must provide this notice orally and make it available in accessible formats, including in the language(s) spoken by the patients.

4. Provide the good faith estimate as required. This also can be done orally, but you also must provide a written copy. You can deliver it via mail, email, mobile app, or other electronic means, but it must be in a format that allows the patient to save and print it. See "Components of the Good Faith Estimate" below to learn what it must include.

5. Provide the requested good faith estimate within the following timeframes:

    - When an appointment is made three business days or more in advance of the service, provide the estimate not later than one business day after the appointment is scheduled.
    - When an appointment is made 10 business days or more in advance of the service, provide the estimate not later than three business days after the appointment is scheduled.
    - When an uninsured or self-pay patient asks for a good faith estimate without making an appointment, provide the estimate not later than three business days after the request.

6. If you anticipate any changes to a good faith estimate you've provided, provide a new good faith estimate no later than one business day before the scheduled appointment. Anticipated changes include those related to the expected charges, services, items, frequency, recurrences, duration, providers, or facilities.

Components of the Good Faith Estimate

CMS has created a standard template for providers and facilities to use to provide a good faith estimate. You must include the following components:

1. The patient's name.

2. The patient's date of birth.

3. A description of the primary service or item — what's being furnished based on the patient's initial reason for the visit. Use clear and understandable language, and, if applicable, include the scheduled date it's being provided.

4. An itemized list of any additional services or items, grouped by each provider or facility, that you reasonably expect to be furnished along with the primary service or item.

5. The applicable diagnosis codes, expected service codes, and expected charges associated with each listed service or item.

6. The name, national provider identifier, and tax identification number of each provider or facility named in the good faith estimate, and where you expect those services or items to be furnished.

7. A list of services or items that you anticipate will require separate scheduling before or after the expected period of care for the primary service or item. You must include a disclaimer directly above this list notifying the patient that:

    a. Separate good faith estimates will be issued to them upon scheduling or upon request.

    b. For services or items on this list, you have not included information such as diagnosis codes, service codes, expected charges, and provider or facility identifiers, as you will provide that information in separate good faith estimates upon scheduling or upon request.

    c. Included are instructions for obtaining good faith estimates for the services or items on the list.

8. A disclaimer that informs the patient that you may recommend additional services or items as part of the course of care that must be scheduled or requested separately and are not reflected in this good faith estimate.

9. A disclaimer that informs the patient that the information is only an estimate of what is reasonably expected to be furnished at the time the good faith estimate is issued, and that actual services, items, or charges may differ.

10. A disclaimer that informs the patient of their right to initiate a patient-provider dispute if the actual billed charges are substantially higher than the expected charges included in the good faith estimate. You must tell the patient how to find information about initiating the dispute resolution process and state that initiation of the process will not adversely affect the quality of the health care services they receive. Learn more about the process under “Patient-Provider Dispute Resolution Process” below.

11. A disclaimer that the good faith estimate is not a contract and does not require the patient to obtain the services or items from any of the providers or facilities identified in it.

Note: The good faith estimate is considered part of the patient’s medical record and must be maintained in the same manner. Upon request, patients are entitled to copies of previously issued good faith estimates furnished within the last six years.

Patient-Provider Dispute Resolution Process

CMS makes clear that good faith estimates may differ from actual services, items, or charges. If the actual billed charges are more than $400 higher than the good faith estimate, the patient may initiate the patient-provider dispute resolution process. The patient initiates this process by submitting a notification to HHS within 120 calendar days of receiving the initial bill containing the excessive charges.

Upon receipt of the notification, HHS will assign a Selected Dispute Resolution entity to review the dispute and any documentation submitted by the patient and provider. The SDR entity then will make a separate determination for each service or item as to whether the provider or facility has demonstrated that the difference between the billed charge and the estimated charge reflects the costs of a medically necessary

service or item, 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.

Effective Date and Impact of Noncompliance

The rule is effective for requests for good faith estimates made beginning Jan. 1, 2022. If you're subject to the ruling and fail to provide a good faith estimate, or in providing an estimate you intentionally include expected charges that are incomplete or inaccurate, you could face enforcement actions, including civil monetary penalties.

APTA Resources

Members can reach out to advocacy@apta.org with questions.

In addition, check out these resources on providing cash-based services:

- Outpatient Therapy Medicare Physician Fee Schedule Calculator
- Cash-Based Practice
- Cash-Based Practice: It's Complicated
- Compliance Issues in Cash Practice

Last Updated: 12/20/2021
Contact: advocacy@apta.org