

# NEW GOOD FAITH ESTIMATE REQUIREMENT

## How to prepare your practice

### BACKGROUND

The No Surprises Act, which was signed into law on December 27, 2020, amends the Public Health Service (PHS) Act by establishing requirements for health care providers and facilities to protect patients from surprise medical bills and to provide good faith estimates (GFE) to potential patients. On September 30, 2021, the Departments of Health and Human Services, Labor, and Treasury issued an [interim final rule with comment period](#) outlining the details of the GFE and other provisions of the statute.

### REQUIREMENTS FOR PROVIDERS AND FACILITIES

Beginning January 1, 2022, health care providers and facilities must provide a GFE of expected charges to uninsured consumers and self-pay individuals (insured consumers who do not plan to have their health plan cover the costs of the service) when scheduling a service or when requested by the potential patient. Providers will be required to do the following:

- 1. Inquire if the potential patient is enrolled in a group health plan, group or individual health insurance coverage offered by a health insurance issuer, a Federal health care program or a Federal Employees Health Benefit plan;**
- 2. Inform individuals who are not enrolled in a health plan or coverage, or not seeking to file a claim with their health plan or coverage, both orally and in writing of the opportunity to receive a GFE of expected charges; and**
  - Information regarding the availability of a GFE must be prominently displayed on the provider's and facility's website and in the office where on-site scheduling or questions about the cost of health care occur. The Centers for Medicare & Medicaid Services (CMS) has provided an example of the information that should be communicated in these notices. Please see below for how to access this template document.
- 3. Deliver the GFE to uninsured and self-pay patients in writing before the scheduled service or item.**
  - More specifically, providers must provide a GFE within one business day of scheduling an item or service to be provided in three business days, and within three business days of scheduling an item or service to be provided in 10 business days.
  - Convening providers and facilities may provide a single GFE for recurring services, only if the GFE is updated at least every 12 months.

## CONTENTS OF THE GOOD FAITH ESTIMATE

The GFE must include all expected charges, service codes, and diagnostic codes for the scheduled service as well as any related costs. Additionally, the GFE must also include an estimate for items and services that may be provided by “co-providers or co-facilities,” such as laboratory or imaging services. CMS will exercise enforcement discretion from January 1, 2022 to December 31, 2022 for GFE’s that do not include expected charges from co-providers or co-facilities.

- Example: If a patient is seeing an endocrinologist as a new patient, the estimate would include the items and services required for the patient visit and evaluation, and any labs or tests ordered by the physician in conjunction with that new patient visit. GFEs should include all services except those that are scheduled separately.

Please note that if contents of the GFE change before the scheduled service is furnished, the convening provider or facility must update the GFE at least one business day before the scheduled service occurs. Additionally, if any providers (convening or co-providers) represented in the GFE change within one business day prior to the scheduled service, the replacement providers must honor the GFE as their own GFE.

### Specifically, the GFE must include the following:

- Patient and provider(s) identification;
- Description of the primary service;
- Applicable diagnosis codes, expected service codes, and expected charges;
- An itemized list of items and services reasonably expected to be furnished as part of the primary service or in conjunction with that service, including their expected charges;
  - This includes procedures, medical tests, supplies, prescription drugs, durable medical equipment, and any facility fees.
- A list of items and services that the convening provider or convening facility anticipates will require separate scheduling; and
- Disclaimers\* for the benefit of the patient:
  - Informs the patient that there may be additional items or services recommended as part of the course of care that must be scheduled separately;
  - States the GFE is only an estimate;
  - States the GFE is not a contract between the provider and patient; and
  - The patient has the right to initiate the patient-provider dispute resolution process if the actual billed charges are substantially in excess of the those included in the GFE.

*\*Please note that more details on the content of these disclaimers can be found beginning on Page 129 of the [rule](#). Additional details regarding the content of a GFE begin on Page 126.*

Furthermore, CMS has issued guidance documents for patients and providers located in this [ZIP folder](#). Providers can find the following resources related to GFEs:

- **CMS-10791 – 1. Right to Receive a Good Faith Estimate of Expected Charges Notice**
  - On Page 3 of this document (located in the ZIP folder) providers can find an example of a notice for patients informing them of their right to receive a GFE.
- **CMS-10791 – 2. Good Faith Estimate Template**
  - Beginning on Page 3 of this document (located in the ZIP folder) and provided below, providers can find an example of what a GFE should look like.

[NAME OF CONVENING PROVIDER OR CONVENING FACILITY]		
Good Faith Estimate for Health Care Items and Services		
<small>OMB Control Number (XXXX-XXXX) Expiration Date (MM/DD/YYYY)</small>		
<b>Patient</b>		
Patient First Name	Middle Name	Last Name
Patient Date of Birth: ____/____/____		
Patient Identification Number:		
<b>Patient Mailing Address, Phone Number, and Email Address</b>		
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		
<b>Patient Diagnosis</b>		
Primary Service or Item Requested/Scheduled		
Patient Primary Diagnosis	Primary Diagnosis Code	
Patient Secondary Diagnosis	Secondary Diagnosis Code	

  

[Provider/Facility 1] Estimate	
<small>OMB Control Number (XXXX-XXXX) Expiration Date (MM/DD/YYYY)</small>	
<small>OMB Control Number (XXXX-XXXX) Expiration Date (MM/DD/YYYY)</small>	
If scheduled, list the date(s) the Primary Service or Item will be provided: <input type="checkbox"/> Check this box if this service or item is not yet scheduled	
Date of Good Faith Estimate: ____/____/____	
Provider Name	Estimated Total Cost
Provider Name	Estimated Total Cost
Provider Name	Estimated Total Cost
<b>Total Estimated Cost: \$</b>	

  

[Provider/Facility 1] Estimate					
Provider/Facility Name		Provider/Facility Type			
Street Address					
City	State	ZIP Code			
Contact Person		Phone	Email		
National Provider Identifier		Taxpayer Identification Number			
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)		
<b>Total Expected Charges from [Provider/Facility 1] \$</b>					
Additional Health Care Provider/Facility Notes					

The following is a detailed list of expected charges for [LIST PRIMARY SERVICE OR ITEM], scheduled for [LIST DATE OF SERVICE, IF SCHEDULED]. [Include if items or services are recurring. \*The estimated costs are valid for 12 months from the date of the Good Faith Estimate.\*]

## PATIENT-PROVIDER DISPUTE RESOLUTION PROCESS

Patients may invoke this arbitration process if the cost of the service and related treatments are at least \$400 more than what the provider quoted in the GFE. Patients have 120 calendar days from the day they receive the bill to start the dispute resolution process by submitting an initiation notice to the Secretary of the Department of Health and Human Services (HHS) and pay an administration fee of \$25 to initiate the process. HHS will select a selected dispute resolution (SDR) entity who will make payment determinations about the dispute. The SDR will send a notice to the health care provider or facility initiating the dispute resolution process.

The health care provider or facility must submit information to the SDR entity no later than 10 business days after receiving the notice. The required information must include:

1. A copy of the GFE provided to the uninsured or self-pay individual for the items or services under dispute;
2. A copy of the bill provided to the uninsured or self-pay individual for items or services under dispute; and
3. If necessary, documentation providing evidence to demonstrate the difference between the billed charges and expected charges in the GFE reflects 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 make a payment determination no later than 30 business days after receiving the necessary information from all parties.

### **ADDITIONAL RESOURCES**

[FAQ for CAA implementation, August 20, 2021](#)

[CMS-9908-IFC: Requirements Related to Surprise Billing; Part II](#)

CMS-9908-IFC Fact Sheet: [What You Need to Know about the Biden-Harris Administration's Actions to Prevent Surprise Billing](#) (September 2021)

[Frequently Asked Questions \(FAQs\) about Consolidated Appropriations Act, 2021 Implementation - Good Faith Estimates](#) (December 2021)