Supplemental FAQs on the No Surprises Act and Good Faith Estimates

These FAQs are based on some of the most common questions APA has received concerning the No Surprises Act and its new requirement for providers to furnish a "good faith estimate" of expected costs to patients. This requirement takes effect January 1, 2022.

Federal agencies will likely issue additional guidance in response to questions that arise as a wide range of providers and health care entities try to implement the new requirements.

Unlike some laws, the estimate requirement does not currently appear to carry any direct monetary penalties or fines for non-compliance. However, a potential consequence of failing to provide an accurate estimate is becoming subject to a billing dispute resolution process (see Q2 for more information on this process).

Q1: I have an appointment with a new patient who I haven't treated before. How do I fill in the information requesting "applicable diagnosis codes"?

A: Applicable diagnosis codes are one of the required elements for an estimate. We believe that a reasonable interpretation of the requirement is that until you have given a patient an initial evaluation and formulated a diagnosis, there is no applicable diagnosis code (unless, for example, the patient has been referred by another mental health professional who provided a diagnosis.) Thus, for most new patients you can indicate "TBD" under the "diagnosis code" section. If you later assign a diagnosis to that patient, you can update this information in future estimates provided to the patient.

Q2: What happens if I make a mistake or omit information in the good faith estimate?

A: If the services have not yet been provided to the patient, you should provide a corrected estimate to the patient as soon as practicable.

If the services have already been provided, you should provide the patient with an updated estimate as soon as practicable, at least prior to their next appointment. A patient may still initiate the dispute resolution process in the No Surprises Act if the total amount you charge the patient (per provider) is at least $400 more than the charges listed in the estimate.

We recommend that you develop a system for tracking your estimates against actual patient billing to reduce issues with patients complaining that you exceeded your estimate. You will want to avoid reaching the $400 threshold, which the rule defines as fees "substantially in excess" of the estimate.

Q3: Is it enough to just provide your rates per session or do you have to give your best estimate of the number of sessions or frequency in writing as well?

A: It is not enough to just provide your rates per session to a new or established patient. The estimate should include the rates per session of the service(s) you anticipate providing to the patient, as well as the projected number and frequency of sessions. If you anticipate providing the same services to the patient at the same frequency over a period of time, you may provide a single estimate to that patient for all those services, so long as: (1) the estimate 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)"; and (2) the estimate can only include recurring services that are expected to be provided within the next 12 months.

Q4: What do I do if a patient later requires more or less intensive treatment or services?

A: You should update the information in the estimate previously provided to that patient to reflect any significant changes to the expected cost of services to the patient. For example, you would need to update the estimate if the patient originally came in with a mild diagnosis that you expected would merit 8-10 sessions, but subsequent trauma or discovery of a more serious diagnosis causes you to shift to a much longer expected course of treatment.

It is especially important to update your estimate if it goes up and creates the risk of exceeding your original Estimate.

Q5: **The postal service in my area is slow. How do I ensure that patients receive their good faith estimates within the required timeframes?**

A: The rule does not specify how the estimate should be transmitted. For example, an updated estimate can be provided in-person to the patient at the end of their appointment if it is available. The general presumption in federal laws is that the U.S. Mail is an acceptable form of delivery. If you are sending this information by U.S. Mail, make sure the notice is postmarked within the timeframes specified above.

If the patient consents to communications via email, you may send the estimate to their preferred email address. However, remember that the estimates include sensitive information such as applicable diagnosis and the type of treatment. We recognize that the rule's effort to create greater cost transparency for patients also increases the risk that their sensitive information regarding mental health (or other private health matters) may be intercepted. While email is much faster and more efficient, it is a less secure communication method unless the email is encrypted.

Q6: My state also requires me to disclose costs of treatment to the patient. Which rules do I follow?

A: If your state laws are less stringent than the federal rule, follow the rules and processes outlined in federal law. Otherwise, follow the laws in your state.

Q7: What recordkeeping requirements apply to these estimates?

A: The new rules consider these estimates to be part of the patient's medical record, so estimates must be maintained in the same manner as the patient's medical record. Providers and facilities should also retain any good faith estimates provided to current and former patients since January 1, 2022, for at least six years, as the rule requires these estimates to be provided to the patient upon their request.