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MICHIGAN STATE MEDICAL SOCIETY

Michigan State Medical Society

SURPRISE BILLING GUIDE

for Physicians

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Overview

In 2020, the Michigan legislature and United States Congress each enacted laws to regulate unexpected or "surprise" medical bills that a patient receives after receiving health care services from an out of network or nonparticipating provider. Last year, Michigan and federal agencies issued administrative rules and guidance to further implement the legislation, including with respect to fee limitations, transparency, and options for dispute resolution between providers and payors.

Although most physicians and other providers have already modified their policies and protocols to comply with Michigan's surprise medical billing legislation, which has been in effect since October 2020, physicians should further review and modify their policies and protocols where necessary to comply with provisions under the federal No Surprises Act, most of which take effect beginning January 1, 2022. Physicians should also continue to monitor for updates or changes to available guidance and any model forms. This Guide provides an overview of the Michigan and federal surprise medical billing laws and regulations as they apply to physicians and other providers in the form of frequently asked questions. A summary of the Michigan's surprise medical billing laws and regulations is provided in **Appendix I**. A summary of the federal surprise billing laws and regulations is provided in **Appendix II**. Available model forms are also provided in appendices to this Guide.

For purposes of this Guide, physicians should refer to the following key definitions except where otherwise specified in this Guide:

"Health care provider" means any health care professional[1] who is licensed, registered, or authorized to engage in a health profession under Article 15 of the Michigan Public Health Code.

"Participating provider" means any health care provider who has a contractual relationship with the respective health plan or issuer for furnishing an item or service under the plan or insurance.

"Nonparticipating provider" means any health care provider who does not have a contractual relationship with the respective health plan or issuer for furnishing an item or service under the plan or insurance.

"Health care facility" means

(1) a hospital,

(2) a hospital outpatient department,

(3) a critical access hospital, or

(4) an ambulatory surgical center.

[1]Michigan's surprise billing laws exclude dentists from the definition of "provider." Federal surprise billing laws also exclude standalone dental plans. However, this Guide should not be construed to represent the applicability or inapplicability of the Michigan or federal surprise billing laws for dentists.

01 Applicability of Surprise Billing Laws

Do the Michigan or federal surprise billing laws apply to a physician who participates with the patient's health plan?

Michigan's surprise billing laws do not apply to services rendered by participating physicians. Under federal law, participating physicians who furnish services at health care facilities (e.g., hospital, ambulatory surgical center, etc.) must satisfy the federal public disclosure requirement (Chapter 5).

HHS has delayed enforcement of the federal requirement to furnish a good faith estimate to a health plan or insurer (also known as the "Advanced EOB") until further rulemaking is complete. Once enforceable, and unless otherwise specified by such further rulemaking, this requirement will apply to all health care providers, regardless of participation status.

Do the Michigan or federal surprise billing laws apply to physicians who do not accept insurance?

Yes. Both the Michigan and federal laws apply to physicians who do not accept insurance.

Do the Michigan or federal surprise billing laws apply to Medicare or Medicaid patients?

No. The Michigan and federal laws do not apply to patients with coverage through Medicare, Medicaid, Indian Health Services, Veterans Affairs Health Care or TRICARE programs, which already prohibit balance billing.

Are there circumstances for which only Michigan's surprise billing laws or only federal surprise billing laws will apply?

Yes, but this will often depend on a variety of factors, including (1) the type of service rendered to the patient, (2) the type of location at which the services are rendered, and (3) the patient's insurance status/health plan. In addition, when there is a conflict between Michigan and federal law, federal law will apply unless the conflicting Michigan law provides stronger balance billing protections.

From a practical perspective, and for purposes of risk management and consistency, it is advisable for physicians and facilities to comply with both Michigan and federal law to the extent feasible whenever surprise billing protections may be triggered. For example, a nonparticipating physician may wish to comply with Michigan's disclosure and consent requirement in addition to the federal notice and consent requirements when rendering nonemergency services to a patient, even if the patient is ultimately covered by a self-funded health plan regulated by ERISA, which is excluded from Michigan's surprise billing laws. This approach can help avoid potential liability in the event services are rendered to a patient covered by a health plan or insurance which is subject to either or both the Michigan and federal surprise billing laws.

Do the Michigan or federal surprise billing laws apply to services rendered via telemedicine?

Yes. Federal interim final rules clarify that a "visit" to a health care facility includes the furnishing of telemedicine services to a patient at the health care facility, regardless of whether the provider furnishing such services is at the facility. Similarly, Michigan law does not expressly distinguish between services rendered by providers in-person or via telemedicine in connection with a "health facility," which is more broadly defined to include a physician's office or "other outpatient setting" in addition to a hospital, skilled nursing facility, laboratory, etc.

02 Limitations on Balance Billing

How do the federal and Michigan surprise billing laws regulate balance billing?

Michigan and federal surprise billing laws collectively prohibit nonparticipating providers and facilities from balance billing patients beyond the applicable in-network cost sharing amount (e.g. co-insurance, co-payments, and deductibles) for emergency services, nonemergency services rendered at a participating health care facility, and out of network air ambulance services, except under certain circumstances and when certain notice and consent requirements are met, as further discussed in Chapters 3 and 4.

Do the balance billing limitations apply to participating providers of emergency or nonemergency services?

No.

Does a nonparticipating provider have to be physically located in a health care facility to trigger federal balance billing limitations?

No. The federal interim final rules clarify that a "visit" to a participating health care facility includes the furnishing of equipment and devices, telemedicine services, imaging services, laboratory services, and preoperative and postoperative services to a patient at the health care facility, regardless of whether the provider furnishing such items or services is at the facility.

If the balance billing limitations apply, am I required to submit a bill to the patient's health plan or coverage?

Yes. When the balance billing limitations apply, the nonparticipating provider must submit a claim to the patient's plan or issuer for the health care service rendered. Michigan law requires nonparticipating providers to submit a claim within 60 days after the date of the health care service.

If the balance billing limitations apply, what amount is the plan or issuer required to pay a nonparticipating provider?

Federal law requires a plan or issuer to either send a denial of payment or pay the nonparticipating provider one of the following amounts, less any cost sharing from the patient, within 30 calendar days after the plan or issuer receives a "clean claim" from the provider:

- The amount specified by Michigan law, which is the greater of:
  - » The median amount negotiated by the patient's health plan or issuer for the region and provider (as determined by the patient's health plan or issuer), excluding any in-network coinsurance, copayments, or deductibles; or
  - » 50% of the Medicare fee for service schedule, excluding any in-network coinsurance, copayments, or deductibles.

NOTE: See FAQ below regarding additional payments for health care services furnished to an emergency patient involving a "complicating factor."

- In the event the patient's health plan or issuer is exempt from Michigan's surprise billing laws (and thus there is no specified state law), the amount agreed upon by the plan or issuer and the provider; or
- If the parties cannot agree on an amount, and if the parties enter into an informal dispute resolution process (IDR), the amount determined by the IDR entity.

Notably, the amount specified by Michigan law will apply to most claims submitted by nonparticipating providers pursuant to the surprise billings laws. Michigan and federal law also permit nonparticipating providers and health plans/issuers to agree to a payment amount that is greater than the amount specified by Michigan law.

Michigan law allows plans and issuers 60 days after receiving a claim to pay the claim, while federal law requires payment within 30 calendar days after receiving a "clean claim." Which time frame applies?

Until Michigan or federal agencies clarify otherwise, when both Michigan and federal surprise billing laws apply, federal law would likely preempt Michigan law, and the claim should be paid or denied within 30 calendar days after receiving a clean claim. Physicians should look to Michigan's clean claim standards for determining whether a claim is a "clean claim."

Am I still allowed to request an additional payment from the health plan or issuer if the health care service furnished to an emergency patient involves a "complicating factor?"

Yes. Michigan law permits a nonparticipating who provides a health care service involving a "complicating factor" to an emergency patient to submit a claim for an additional payment that is 25% of the amounts allowed as specified in the FAQ above.

A "complicating factor" means a factor that is not normally incident to a health care service, including, but not limited to,

increase intensity, time or technical difficulty of the health care service, the severity of the patient's condition, or the physical or mental effort required in providing the health care service. The claim must meet the requirements specified by Michigan law, as further discussed in Appendix I. A plan or issuer must respond to the claim for an additional payment within 30 days after receiving the claim.

If the balance billing limitations apply, what am I allowed to charge the patient?

When the balance billing limitations apply, nonparticipating providers are prohibited from balance billing a patient except for the applicable cost-sharing amount, which is determined as follows:

- The amount determined by Michigan law, which permits nonparticipating providers to bill patients any applicable in-network coinsurance, copayments, or deductibles.

> **NOTE:** This amount will apply to most claims for health care services rendered by nonparticipating providers to patients pursuant to the surprise billing laws.

- In the event the patient's health plan or issuer is exempt from Michigan's surprise billing laws, a nonparticipating provider who provided may charge the patient the lesser of the billed charge or the "qualifying payment amount" (QPA), which is the plan or issuer's median contracted rate for the health care service in the geographic region.

03 Balance Billing Limitations for Nonemergency Services

What are the notice and consent requirements under Michigan and federal surprise billing laws?

Nonparticipating providers of nonemergency services may balance bill under certain circumstances and when certain notice and consent requirements are met. Importantly, Michigan and federal law each have their own notice and consent requirements.

Michigan's notice and consent requirement applies when a nonparticipating provider furnishes nonemergency services to a patient, regardless of the type of location at which the services are rendered. When applicable, a nonparticipating provider may satisfy Michigan's notice and consent requirement as follows:

(1) Provide the patient with a written disclosure which contains certain language required by Michigan law at the earliest of the following:

- If the health care service was scheduled and is being provided in a hospital, freestanding surgical outpatient facility, skilled nursing facility, laboratory, or radiology or imaging center, at least 14 days before providing the health care service or, if the health care service will be provided within 14 days after scheduling, within 14 days;
- If the health care service is being provided in a physician's office or other outpatient setting, at the time of the nonparticipating provider's first contact with the nonemergency patient regarding the health care service; or
- Regardless of the location that the health care service is provided, during a presurgical consultation, scheduling or intake call, preoperative review or similar contact occurring before the health care service.

(2) Obtain the patient's or the patient's representative's signature on the written disclosure acknowledging that the patient or his or her authorized representative has received, read, and understands the disclosure; and

(3) Provide the patient or the patient's representative with a good faith estimate of the cost of the health care service to be provided to the nonemergency patient.

A sample Michigan disclosure and consent form and good faith estimate form are available at **Appendix Form 1A and Appendix Form 1B.**

The Federal notice and consent requirement applies when nonemergency services are provided by a nonparticipating provider at a participating health care facility. To satisfy the federal notice and consent requirement, a nonparticipating provider must do the following:

(1) Provide the patient with a written notice on a form required by HHS which contains certain information as required by federal law, including, but not limited to, a good faith estimate of expected charges in paper or electronic form (as selected by the patient) within the following timeframes:

- If the appointment for such items or services is scheduled at least 72 hours prior to the date on which the items or services are to be furnished, not later than 72 hours prior to the date on which the individual is furnished items or services; or
- If the appointment for such items or services is scheduled within 72 hours of the date on which items or services are to be furnished, on the date of the appointment, but no later than 3 hours prior to furnishing items or services to which the notice and consent requirements apply.

(2) Obtain the patient's signature on the U.S. Department of Health and Human Services (HHS) form.

A copy of the HHS instructions and federal notice and consent form is available at **Appendix Form 2.**

If I provide nonemergency services as a nonparticipating provider solely at my private office and do not provide nonemergency services at or in connection with a visit at a hospital or ambulatory surgical center, do I only need to comply with Michigan's notice and consent requirement to avoid the balance billing limitations?

Yes. The federal notice and consent requirements do not apply to nonemergency services which are not rendered at a health care facility (i.e., hospital or ambulatory surgical center). Under this circumstance, nonparticipating providers may use the documents set forth in Appendix Form 1A and Appendix Form 1B within the timeframe provided by law to satisfy Michigan's notice and consent requirement.

If I provide nonemergency services at a participating hospital or ambulatory surgical center as a nonparticipating provider and must comply with both Michigan and federal notice and consent requirements to avoid the balance billing limitations, which documents should I provide to the patient?

At this time, until further guidance or clarification is given by Michigan and/or federal agencies, nonparticipating providers

should utilize the following documents within the timeframes set forth by applicable law (discussed above) to satisfy both Michigan and federal notice and consent requirements:

- Michigan notice and consent form (See **Appendix Form 1A**); and
- Federal notice and consent form (See **Appendix Form 2**).

Can I use the federal notice and consent form to satisfy both Michigan and federal notice and consent requirements? Alternatively, can I modify the federal notice form to add the language required by Michigan law in order to satisfy both requirements?

At this time, and until further guidance or clarification is given by Michigan and/or federal agencies, the federal notice form cannot be used to also satisfy Michigan's notice and consent requirement (or vice versa). This is because, although both forms provide similar information notifying patients regarding surprise billing protections, Michigan law requires the notice and consent form to contain certain language as provided by Michigan statute to satisfy its requirement, which the federal notice form does not expressly contain. Likewise, Michigan's notice and consent form language does not meet all of the statutory and regulatory requirements under federal law.

In addition, due to acknowledged concerns regarding the federal notice being embedded within other information or provided with additional consent forms, federal interim final rules expressly require the use of the HHS form which must be physically separate from and not attached to or incorporated into any other documents. HHS instructions for the form further prohibit the modification of the form except as indicated in brackets on the form. Thus, until further clarification is provided, the HHS form cannot be modified to add Michigan's notice and consent language.

Notwithstanding, nonparticipating providers may complete and utilize the good faith estimate information set forth in the HHS form to satisfy the good faith estimate component under both Michigan and federal's notice and consent requirements. Physicians should still ensure that the notices and patient consents (see FAQ immediately above) are obtained within the above timeframes required by each law.

Physicians should continue to monitor for updates or changes to available guidance on this issue.

Under what circumstances do the balance billing limitations still apply, even if the notice and consent requirements are met?

A nonparticipating provider of nonemergency services is subject to the balance billing limitations under the following circumstances, even if the notice and consent requirements are otherwise satisfied:

- If the notice and consent requirements are not satisfied within the time frame(s) required by applicable law;
- If the nonparticipating provider provides a nonemergency service at a participating health care facility and the patient does not have the ability or opportunity to choose a participating provider to furnish the service at the facility.
  - » Under this circumstance, the term "health care facility" includes a hospital, freestanding surgical outpatient facility, skilled nursing facility, physician's office or other outpatient setting, laboratory, or a radiology or imaging center[2].
- If the nonparticipating provider furnishes the following nonemergency services at a participating hospital, hospital outpatient department, critical access hospital or ambulatory surgical center:
  - » Ancillary services, including items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a physician or non-physician practitioner;
  - » Items and services provided by assistant surgeons, hospitalists and intensivists;
  - » Diagnostic services, including radiology and laboratory services;
  - » Items and services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished;
  - » Nonparticipating providers of air ambulance services.

NOTE: Under federal law, a service is considered to be furnished at the participating health care facility regardless of whether the provider furnishing the items or services is at the facility. For example, if a sample is collected during an individual's hospital visit and sent to an off-site laboratory, the laboratory service would be considered part of the patient's visit to the participating health care facility.

[2]Although federal law imposes this limitation solely for nonemergency services furnished by a nonparticipating provider at a participating hospital or ambulatory surgical center, to the extent the health care service is regulated by both Michigan and federal surprise billing laws, Michigan law will likely govern on this issue because it applies broader surprise billing protections.

04 Balance Billing Limitations for Emergency Services

When do the balance billing limitations apply to nonparticipating providers for emergency services?

The balance billing limitations apply to emergency services under the following circumstances:

- Emergency services rendered by nonparticipating providers which are covered by the patient's health plan or coverage, regardless of whether the services are rendered at a participating or nonparticipating health care facility.
- Health care services rendered to an emergency patient admitted within 72 hours after receiving a healthcare service in the hospital's emergency room by a nonparticipating provider at a participating hospital.

> **NOTE:** Under this circumstance, Michigan law requires the billing requirements and limitations apply to any health care service provided by a nonparticipating provider to the emergency patient during his or her hospital stay.

- Post-stabilization services rendered by nonparticipating providers unless the following conditions have been met:
  - » The attending emergency physician or treating provider determines that the patient (1) can travel using non-medical or nonemergency medical transportation to an available participating provider or facility located within a reasonable travel distance, taking into account the individual's medical condition, and (2) the patient (or the patient's authorized representative) is in a condition to receive notice and provide informed consent;
  - » The nonparticipating provider or facility satisfies the Michigan and federal notice and consent requirements; and
  - » The services do not fall within the circumstance immediately above regarding health care services rendered to an admitted emergency patient.

05 Federal Public Disclosure Requirement

What is the federal public disclosure requirement?

Federal law requires health care providers and health care facilities to make certain public disclosures regarding patient protections against balancing billing. The disclosure must be (1) made publicly available via a sign posted prominently at a publicly accessible location, (2) posted on a public website of the provider or facility, and (3) provided to participants, beneficiaries and enrollees of a group health plan or individual health insurance coverage.

Who must comply with the federal public disclosure requirement?

The public disclosure requirement applies to all health care providers and facilities, with two exceptions:

First, health care providers are not required to satisfy the public disclosure requirement if they do not furnish items or services at a health care facility or in connection with visits at health care facilities (e.g., services are rendered solely at a private physician office).

Second, health care providers must furnish the public disclosure only to individuals to whom they furnish items or services at a health care facility or in connection with a visit at a health care facility, and only then if the individuals are participants, beneficiaries and enrollees of a group health plan or individual health insurance coverage (i.e., individuals who are uninsured or are not receiving services from the provider are not required to receive the public disclosure).

If I provide services exclusively within my private office and not at or in connection with a visit at a health care facility, do I have to comply with the federal public disclosure requirement?

No—see first exception in FAQ above.

Am I required to use the federal model public disclosure notice?

No. Interim final rules have confirmed that heath care providers and facilities may, but are not required to, use the model public disclosure notice to satisfy the public disclosure requirement. However, use of the model notice in accordance with the instructions that accompany the model notice will be considered to be good faith compliance with the public disclosure requirement.

Can the federal model public disclosure notice be used to satisfy all three public disclosure requirements?

Yes. The same federal model disclosure notice can be posted on the provider's website, in a publicly accessible location, and provided to patients. The model disclosure notice includes instructions for compliance with these requirements.

The federal model public disclosure notice on CMS's website has instructions to insert "applicable state balance billing law or requirements or state-developed model language regarding applicable state law requirements." If I use the model disclosure notice, can I insert the disclosure language set forth in Michigan's surprise billing laws?

Yes. **Appendix Form 3** to this Guide contains the federal model public disclosure notice with added language regarding Michigan's required disclosure language set forth in Michigan law as well as other Michigan-related information.

When must the public disclosure be provided to the patient?

Federal law requires that the public disclosure be provided to the patient, either in-person or through mail or email, as selected by the patient, no later than the date and time on which the provider or facility requests payment from the patient, or if no payment is requested from the patient, no later than the date on which the provider or facility submits a claim to the patient's group health plan or health insurance issuer.

What if my practice does not have a website?

A health care provider or facility that does not have its own website is not required to make the public disclosure on a website.

What if I do not have a publicly accessible location?

Providers without a publicly accessible location (such as where individuals schedule care, check-in for appointments or pay bills) are not required to make the public disclosure publicly available via this method.

Can a health care facility provide the required public disclosure on my behalf?

Yes. A health care provider can satisfy the federal public disclosure requirements (other than the public website requirement) if the facility at which the provider furnishes services agrees to provide the required information, in the required form and manner, pursuant to a written agreement. In such instance, the public disclosure must include information about the balance billing requirements applicable to both the provider and the health care facility. This option is available regardless of whether the provider

and facility bill jointly or separately.

However, health care providers who have their own public website must still post the public disclosure on their website.

What if the health care facility fails to provide or post the public disclosure pursuant to the written agreement?

Federal interim final rules have clarified that if the health care facility and health care provider have a written agreement under which the facility agrees to provide the public disclosure information and the facility fails to provide full or timely disclosure information, then the facility, but not the provider, would be in violation of the public disclosure requirement.

06 Federal Good Faith Estimate Requirement

What is the federal good faith estimate (GFE) requirement?

This is a requirement imposed by federal law which requires health care providers and facilities to provide a good faith estimate of expected charges for health care services to be rendered. The federal GFE requirement discussed in this chapter is separate and distinct from the good faith estimate information furnished as part of the Michigan and federal notice and consent requirements for purposes of avoiding balance billing limitations.

Who must comply with the federal GFE requirement?

All health care providers and facilities, regardless of their participation status or the location at which services are rendered must comply with the federal GFE requirement upon request by an uninsured or self-pay patient or upon scheduling an item or service to be rendered to an uninsured or self-pay patient. For purposes of the GFE requirement, the term "facility" is more broadly defined to include any state or locally licensed health care institution.

How do I comply with the federal GFE requirement?

The manner of compliance depends on whether the patient has insurance coverage or is uninsured/self-pay.

When scheduling an item or service, the patient should be asked if he or she is covered by a group health plan, or group or individual health insurance and if so, whether the patient intends to have a claim for the service(s) submitted to their plan or insurance coverage.

If the patient is insured and seeking to have a claim for the item or service submitted to such plan or issuer, the provider or facility must furnish the GFE to the patient's plan or issuer of coverage (also known as the "Advanced EOB"). However, HHS has delayed enforcement of this requirement until further rulemaking is complete, due to concerns regarding challenges of developing the technical infrastructure necessary for providers and facilities to transmit the GFE to plans and issuers as required by January 1, 2022.

If the patient is (1) uninsured, or (2) will be self-pay for the item or service, the GFE must be provided directly to the patient[3]. A GFE must also be provided to a patient who requests a GFE for an item or service, even if the item or service has not yet been scheduled. HHS has not delayed enforcement of these requirements.

What information must be provided to satisfy the GFE requirement?

There are two informational requirements. First, the patient must be provided a notice which informs the patient that a GFE is available upon scheduling an item or service or upon request.

The GFE notice must satisfy the following requirements:

- Written in a clear and understandable manner, prominently displayed on the provider or facility's website, in the office and on-site where the scheduling or questions about cost of items or services occur;
- Orally provided when scheduling an item or service or when questions about the cost of items or services occur, and
- Made available in accessible formats, and in the language(s) spoken by individual(s) considering or scheduling items or services with the provider or facility.

Provided that the GFE notice satisfies the above requirements, a copy of the GFE notice is also permitted, but not required, to be furnished with the GFE.

Second, the patient must be provided with the GFE. The GFE must satisfy the criteria specified by federal law, as more fully discussed in Appendix II. To satisfy the notice and GFE criteria, providers and facilities may, but are not required, use the federal model GFE notice and GFE documents. See **Appendix Form 4**.

What if there will be other providers or facilities involved in the health care service?

If there will be other providers or facilities that are reasonably expected to provide items or services in conjunction with and in support of the primary item or service, federal law requires that upon the request for a GFE or the scheduling of the primary item or service, the primary provider or facility must contact such co-provider(s) or co-facility(ies) within 1 business day of the request or scheduling and request that the co-provider(s) or co-facility(ies) submit GFE information to the provider or facility. The GFE information provided by the co-provider(s) or co-facility(ies) must be included in the GFE provided to the patient. This requirement will more typically apply when patients are furnished services at health care facilities.

However, due to the time it may take for providers and facilities to develop systems and processes for receiving and providing the required GFE information from co-providers and co-facilities,

HHS confirmed that for GFEs provided to a patient from January 1, 2022 through December 31, 2022, HHS will exercise its enforcement discretion in situations where a GFE provided to a patient does not include expected charges from co-providers or co-facilities. HHS also noted that nothing prohibits a co-provider or co-facility from furnishing the GFE information before December 31, 2022, and nothing would prevent the patient from separately requesting a GFE from the co-provider or co-facility, in which case the co-provider or co-facility would be required to provide the GFE for such item or service.

After a patient requests the GFE or an item or service is scheduled, how soon must the GFE be provided to the patient?

The GFE must be provided within the following time frames:

- If the item or service is scheduled at least 3 business days before the item or service is scheduled to be furnished, not later than 1 business day after the date of scheduling;
- If the item or service is scheduled at least 10 business days before the item or service is scheduled to be furnished, not later than 3 business days after the date of scheduling; or
- If a GFE is requested by a patient, not later than 3 business days after the date of the request

NOTE: This requirement applies to both scheduled and non-scheduled items and services.

Do I have to provide the GFE for urgent or emergency services?

No, the GFE requirement does not apply to services that are not generally scheduled in advance, including urgent, emergent trauma or emergency services. However, to the extent such services are scheduled at least 3 days in advance, providers and facilities must comply with the GFE requirement.

What if there are changes to the services to be rendered after I provide the GFE?

When the GFE requirement applies, the patient must be provided with a new GFE if the provider or facility anticipates or is notified of any changes to the scope of the GFE previously furnished at the time of scheduling (such as anticipated changes to the expected charges, items, services, frequency, recurrences, duration, providers or facilities) no later than 1 business day before the items or services are scheduled to be furnished.

What if the health care services will be provided on a recurring basis? Can I provide one GFE for all recurring services?

If the provider or facility expects to furnish recurring items or services to a patient (such as multiple physical therapy visits occurring outside the period of care for a surgical procedure), the provider or facility may issue a single GFE for the recurring items or services if the GFE includes, in a clear and understandable manner, the expected scope of the recurring items or services (such as timeframes, frequency, and total number of recurring items or services), and the scope of the GFE for recurring primary items or services does not exceed 12 months.

If additional recurrences of items or services are expected beyond 12 months, a provider or facility must provide the patient with a new GFE and communicate any changes upon delivery of the new GFE to help the patient understand what has changed between the initial GFE and the new GFE.

What if the total amount billed to the patient is different than the amount stated in the GFE?

Federal law permits uninsured or self-pay patients to dispute the bill and seek a determination regarding the amount to be paid by the patient through the patient-provider dispute resolution process (See Chapter 7) if the patient is billed charges that are "substantially in excess" of the total expected charges stated in the GFE.

Federal interim final rules presently define "substantially in excess" to mean total billed charges that exceed the total expected charges in the GFE by $400 or greater.

To reduce the possibility of a patient disputing a bill for health services rendered, physicians should exercise diligence in providing patients with a new GFE whenever the physician reasonably anticipates or is notified of any changes to the scope of the GFE previously furnished to the patient.

[3]HHS has not yet issued rulemaking regarding whether a GFE must be provided to an individual who is insured and seeking to have a claim submitted to their plan or coverage. Accordingly, HHS has deferred enforcement of the requirement that providers and facilities provide GFEs to individuals who are insured and seeking to submit a claim for a scheduled item or service to their plan or coverage.

07 Dispute Resolution Process

What dispute resolution processes exist under the surprise billing laws?

There are four dispute resolutions processes that may apply under various circumstances, including:

- Federal GFE patient-provider dispute resolution process
  - » This process is set forth by federal law and applies when an uninsured or self-pay patient seeks to dispute a bill sent by a health care provider or facility for health care services rendered by the provider which substantially exceeds the total charges set forth in the good faith estimate by $400 or more.
  - » **How it works:** A patient (or his or her authorized representative) may initiate dispute resolution by submitting an initial notice to HHS within 120 calendar days of receiving the initial bill containing charges for the item or service that is substantially in excess of the expected charges in the good faith estimate. HHS will select a dispute resolution (SDR) entity which will review the initiation notice and confirm that the disputed items and services are eligible for the dispute resolution process and that it has received all required information. The SDR entity will then provide notice to the uninsured or self-pay patient and the provider or facility regarding the pending patient-provider dispute resolution matter. The SDR entity may request the provider or facility provide certain information within 10 business days. Within 30 business days after receiving the information from the provider, the SDR will then make a determination regarding the amount to be paid by the patient.
- Federal informal dispute resolution (IDR) process
  - » This is the federal process to address payment or claim disputes between providers, facilities, and health plans/issuers.
  - » **How it works:** If a provider disputes the denial or the initial payment received from the plan or issuer, the provider has 30 business days from the date the provider receives initial payment or denial of payment to initiate an "open negotiation period," which may last up to an additional 30 business days. If the parties cannot agree on an out of network rate, and the open negotiation period is exhausted, either party may initiate the federal IDR process. During the IDR process, an IDR entity is selected, and the parties will submit an offer for a payment amount for the disputed item or service and other information requested by the IDR entity within 10 business days of the selection of the IDR entity. The IDR entity must first presume that the qualified payment amount (QPA) is the appropriate out of network rate. The IDR must then select the offer that is closest to the QPA unless the IDR entity determines that credible information submitted by either party clearly demonstrates that the QPA is materially different from the appropriate out of network rate. The amount determined by the IDR entity at the end of the IDR process will be the amount the provider is entitled to receive.
- Michigan DIFS calculation review
  - » This process applies for health plans and coverage regulated by Michigan's surprise billing laws and allows providers to dispute a health plan or issuer's calculation of payment under Michigan law.
  - » **How it works:** A nonparticipating provider may request the Michigan Department of Insurance and Financial Services (DIFS) to review a health plan or issuer's calculation of payment to the nonparticipating provider by submitting a request to DIFS on Form FIS 2369. Within 14 days, DIFS will notify the health plan or issuer of the calculation review and request data necessary to assist in reviewing the calculation of payment. The health plan or issuer must respond within 14 days of receiving DIFS' request. DIFS will then issue a determination resolving the request for calculation review no later than 14 days after the health plan or issuer submits its response or after the time period to respond has expired.
- Michigan DIFS arbitration process
  - » This process is available for nonparticipating providers to dispute via binding arbitration a plan or issuer's denial of a claim for an additional payment for a health care service to an emergency patient involving a "complicating factor."
  - » **How it works:** A nonparticipating provider may request binding arbitration by submitting a request to DIFS on Form FIS 2368. If the request is accepted, DIFS will notify the health plan or issuer. Within 30 days after receiving the DIFS notification, the health plan or issuer must submit written documentation to DIFS either confirming its denial of the claim or providing an alternative payment offer to be considered in the arbitration process. The parties must then agree to an arbitrator who is approved by DIFS for purposes of providing binding arbitration under this process. The

arbitrator will review written submissions by both parties, including alternative payment offers, and issue a written decision within 45 days after receiving the documentation submitted by the parties. The parties must each pay one-half of the total costs of the arbitration proceeding.

If there are multiple providers identified in the good faith estimate, can the patient initiate the GFE patient-provider dispute resolution process against all of the identified providers?

Yes, but only if the total charges billed exceed the total charges in the good faith estimate for services rendered by each provider. The federal interim final rules provide the following example: A good faith estimate lists 3 services, A, B and C. Services A and B are provided by Provider Y and service C is provided by co-provider Z. The total billed charges for services A and B must exceed the total expected services set forth in the good faith estimate for those services by at least $400 in order to initiate dispute resolution against Provider Y. Likewise, the total billed charge for service C must exceed the total expected charges for service C by $400 to initiate dispute resolution against co-provider Z.

What if the services billed did not appear in the good faith estimate?

The patient may initiate dispute resolution against a provider for all services billed by the provider if the total charges billed exceed the total expected charges in the good faith estimate by $400, even if the total charges billed include charges for services by the provider that were not included in the good faith estimate. In addition, if the SDR entity determines that the service which did not appear in the GFE was not medically necessary and/or based on unforeseen circumstances that could not have been reasonably anticipated by the provider or facility at the time the GFE was provided, the SDR entity may determine that the provider is not entitled to any amount for that service. This is intended to encourage providers and facilities to ensure that the GFEs prepared by the provider or facility are as accurate as reasonably possible.

Can I appeal an SDR Entity's determination?

Presently no. The SDR entity's determination is binding on the parties involved in the absence of a fraudulent claim or evidence of misrepresentation of facts. Federal law prohibits the SDR entity's determination from being subject to judicial review except in very limited circumstances. HHS is currently seeking comments on the issue of judicial review for these matters.

Who pays for the GFE patient-provider dispute resolution process?

Beyond the administrative fee to initiate dispute resolution (which is ultimately borne by the non-prevailing party), the cost for the GFE patient-provider dispute resolution process will be paid by HHS through contracts with SDR entities.

Have there been recent challenges to the federal IDR process? Is the IDR process still enforceable?

As of January 1, 2022, the federal IDR process is still enforceable. Recently, several lawsuits have been filed by various organizations seeking to prevent the implementation of certain interim final rules related to the IDR process due to the rules' interpretation of the IDR process under the No Surprise Act. Specifically, opponent have challenged rules which require the presumption in favor of the Qualified Payment Amount (QPA), which opponents argue unfairly favors insurers and contradicts the No Surprises Act. In addition, 152 members of Congress sent a letter urging the federal agencies to amend interim final rules implementing the IDR process. However, no court order has been issued to delay the effective date of the No Surprises Act, and no other action has been taken to delay or amend the IDR process. Physicians should continue to monitor for updates or changes related to the IDR process.

What is the federal IDR portal? Where can I find the federal IDR portal?

The federal IDR portal was established to assist with the federal IDR process, including IDR initiation, applications to be a certified IDR entity, and for satisfying certain reporting requirements.

The federal IDR portal is available at https://www.nsa-idr.cms.gov.

08 Provider Directory Requirement

What is the provider directory requirement?

Federal law requires health plans to establish a system and process for verifying the accuracy of their provider directory information. Health care providers are required to submit updated provider information to assist health plans with ensuring the accuracy of their provider directory.

When must updated provider information be provided to a plan or issuer?

Updated provider information must be provided during the following times:

- At the beginning or termination of a network agreement with a plan or issuer;
- When there are material changes to the content of the provider director information of the provider or facility;
- Upon request by the plan or issuer; and
- Any other time determined appropriate by the provider, facility, or HHS.

Do I have to provide updated provider directory information to a health plan or issuer with which I do not participate?

No. The provider directory requirement applies only for health care providers who have or had a contractual relationship with the plan or issuer.

09 Enforcement

What happens if I fail to comply with applicable surprise billing laws?

Enforcement of the surprise billing laws, and the consequences for violation of the same, depends on a number of factors, including, but not limited to, the nature and extent of the violation and whether the violation is enforceable by state or federal agencies.

For example, a physician who fails to provide the Michigan disclosure and consent form to a patient or engages in balance billing in violation of Michigan law may be subject to disciplinary action and sanctions against his or her license, including a fine. Likewise, physicians who engage in balance billing in violation of federal surprise billing laws may be subject to federal enforcement action and civil monetary penalties of up to $10,000. However, such penalties may be waived under federal law if the health care provider does not knowingly violate the law, should not have reasonably known his or her act violated the law, withdraws the bill within 30 days and reimburses any payments received plus interest. HHS will also address enforcement of the federal surprise billing laws in future rulemaking.

Appendix I // Summary of Michigan Surprise Medical Billing Laws

Disclaimer: This Appendix provides a general summary of Michigan's surprise medical billing laws only. It does not contemplate the applicability or inapplicability of federal surprise billing laws, which are summarized in Appendix II. Physicians should review the Frequently Asked Questions in Chapters 1-9 of this Guide to determine compliance in situations when both Michigan and federal surprise billing laws apply

Applicability

Michigan's surprise medical billing laws apply whenever "health care services" are furnished by a "nonparticipating provider" to a patient, regardless of the type of facility or office at which the services are rendered (including services rendered via telemedicine). Michigan law broadly defines "health care services" to include any diagnostic procedure, medical or surgical procedure, examination, or other treatment. Similarly, a "nonparticipating provider" includes any health professional (other than a dentist) who is licensed, registered or authorized to engage in a health profession under Article 15 of the Michigan Public Health Code and who does not have a contractual agreement with a carrier to provide health care services to individuals covered by a health benefit plan issued by the carrier and to accept payment in full other than coinsurance, copayments or deductibles.

Disclosure, Good Faith Estimate and Consent Requirements

Michigan law requires nonparticipating providers furnishing nonemergency health care services to a nonemergency patient to complete and provide the patient with a written disclosure at the earliest of the following:

- If the health care service was scheduled and is being provided in a hospital, freestanding surgical outpatient facility, skilled nursing facility, laboratory, or radiology or imaging center, at least 14 days before providing the health care service or, if the health care service will be provided within 14 days after scheduling, within 14 days;
- If the health care service is being provided in a physician's office or other outpatient setting, at the time of the nonparticipating provider's first contact with the nonemergency patient regarding the health care service; or
- Regardless of the location that the health care service is provided, during a presurgical consultation, scheduling or intake call, preoperative review or similar contact occurring before the health care service.

Michigan law prohibits the disclosure from being provided to a nonemergency patient at the time of the nonemergency patient's admittance to a health care facility or at the time of preparing the nonemergency patient for a surgery or another medical procedure.

The disclosure must be in not less than 12-point font and in substantially the following form:

Your health benefit plan may or may not provide coverage for all of the health care services you are scheduled to receive or the providers providing those services. You may be responsible for the costs of the services that are not covered by your health benefit plan.

The nonparticipating provider must provide a good-faith estimate of the cost of the health care services to be provided. A good-faith estimate does not take into account unforeseen circumstances, which may affect the cost of the health care services provided.

You also have a right to request that the health care services be performed by a provider that participates with your health benefit plan, and may contact your carrier to arrange for those services to be provided at a lower cost and to receive information on in-network providers who can perform the health care services that you need.

I have received, read, and understand this disclosure.

_____ _____

(Patient or patient's representative's signature) (Date)

_____

(Type or print name of patient or patient's representative)

The nonparticipating provider must also obtain the signature of the nonemergency patient, or the patient's representative, acknowledging that the patient/representative has received, read, and understands the disclosure. The signed disclosure must be retained for at least 7 years.

In addition to the disclosure, the nonparticipating provider must also provide the patient or the patient's representative with a good faith estimate of the cost of the health care service to be provided to the nonemergency patient. Unlike the disclosure, Michigan law does not impose any formatting or other language requirements for the good faith estimate.

A sample of the Michigan disclosure and good faith estimate form is available at **Appendix Form 1A and Appendix Form 1B.**

Billing Requirements and Limitations

Michigan law imposes certain billing requirements and limitations upon nonparticipating providers under the following four circumstances:

(1) If a nonparticipating provider provides a health care service to a nonemergency patient and fails to provide the nonemergency patient with the above-described disclosure when required;

(2) If a health care service is provided to a nonemergency patient by a nonparticipating provider at a participating healthcare facility, the healthcare service is covered by the nonemergency patient's health benefit plan and either (i) the nonemergency patient does not have the ability or opportunity to choose a participating provider, or (ii) the nonemergency patient has not been provided the above-described disclosure when required;

(3) If a health care service is provided to an emergency patient, the healthcare service is covered by the emergency patient's health benefit plan, and the healthcare service is provided by a nonparticipating provider at a participating or nonparticipating health care facility;

(4) If a healthcare service is provided to an emergency patient admitted within 72 hours after receiving a healthcare service in the hospital's emergency room, by a nonparticipating provider at a participating hospital. Under this circumstance, the billing requirements and limitations apply to any health care service provided by a nonparticipating provided to the emergency patient during his or her hospital stay.

When these circumstances occur, a nonparticipating provider must submit a claim for the health care service to the patient's carrier within 60 days after the date of the health care service and accept from the patient's carrier, as payment in full, the greater of the following:

- The median amount negotiated by the patient's carrier for the region and provider specialty (as determined by the carrier), excluding any in-network coinsurance, copayments, or deductibles; or
- 150% of the Medicare fee for service fee schedule for the health care service provided, excluding any in-network coinsurance, copayments, or deductibles.

A carrier must pay the above amount to the nonparticipating provider within 60 days after receiving the claim from the nonparticipating provider.

If the nonparticipating provider provides a health care service that involves a "complicating factor" to an emergency patient under circumstances (3) or (4) above, Michigan law permits the nonparticipating provider to submit a claim with the carrier for an additional payment that is 25% of the amount allowed as described above. A "complicating factor" means a factor that is not normally incident to a health care service, including, but not limited to, increase intensity, time or technical difficulty of the health care service, the severity of the patient's condition, or the physical or mental effort required in providing the health care service. Claims requesting additional payment due to a complicating factor must be accompanied by clinical documentation demonstrating the complicating factor, along with the emergency patient's medical record for the health care service, with the portions of the record supporting the complicated factor highlighted. Within 30 days of receiving the claim for an additional payment, the carrier must either make the additional payment, or, if the carrier determines that the documentation submitted with the claim does not demonstrate a complicating factor, issue a letter to the nonparticipating provider denying the claim.

Michigan law also permits nonparticipating providers and carriers to agree, through private negotiations or an internal dispute resolution, to a payment amount that is greater than the amount specified under Michigan law. Regardless of the amount paid by the carrier or any agreement between the nonparticipating provider and the carrier, when the billing limitations apply, nonparticipating providers cannot balance bill the patient or collect any amount from the patient other than the applicable in-network coinsurance, copayment, or deductible.

Dispute Resolution Process

Beginning July 1, 2021, if a nonparticipating provider disagrees with a carrier's calculation of payment, the nonparticipating provider is permitted to make a request the Michigan Department of Insurance and Financial Services (DIFS) for a review of the calculation. The request must be submitted on Form FIS 2369, which is available on DIFS' website. Following receipt of the request, DIFS will notify the carrier of the request for a calculation review, and request data on the carrier's median amount or any documents, materials, or other information DIFS believes is necessary to assist in reviewing the calculation. The carrier must respond to DIFS's request within 14 days. The carrier may also provide DIFS with access to a database that contains all of the carrier's median amounts, provided that the database meets certain requirements. DIFS must issue a determination resolving the request for a calculation review no later than 14 days after the carrier submits a timely and complete response or after the expiration of the time period allow has expired.

If a nonparticipating provider disagrees with a carrier's determination regarding a claim for additional payment due to a complicating factor, the nonparticipating provider may file a written request for binding arbitration with DIFS using Form FIS 2368. The filing must include the documentation that the nonparticipating provider submitted to the carrier, the contact information for the emergency patient's health benefit plan and the carrier's denial letter. Following receipt of a complete request for arbitration, DIFS will notify the carrier of the request for arbitration. Within 30 days after receiving notification of the

request, the carrier must submit written documentation to DIFS either confirming its denial or providing an alternative payment offer to be considered in the arbitration process. The parties must then agree on an arbitrator from a list of arbitrators approved by DIFS. The arbitration must include a review of written submissions by both parties, including alternative payment offers. The arbitrator must provide a written decision within 45 days after receiving the documentation submitted by the parties. The nonparticipating provider and the carrier must each pay one-half of the total costs of the arbitration proceeding.

Disciplinary Action for Violation of Michigan Surprise Billing Laws

Beginning January 1, 2021, providers who violate Michigan's surprise billing or disclosure requirements may be subject to a licensing investigation and disciplinary sanctions, including a fine.

Appendix II // Summary of Federal Surprise Billing Laws

Disclaimer: This appendix provides a general summary of federal surprise billing laws only. It does not contemplate the applicability or inapplicability of Michigan's surprise billing laws, which are summarized in Appendix I. Physicians should review the Frequently Asked Questions in Chapters 1-9 of this Guide to determine compliance in situations when both Michigan and federal surprise billing laws apply.

Applicability

The federal No Surprises Act aims to provide patients with new protections against surprise medical bills from health care providers and facilities by prohibiting balance billing under certain circumstances and creating more transparency around the cost of services. It also establishes certain dispute resolution processes, including an independent dispute resolution process for providers and health plans to use to resolve out of network care payment disputes. The No Surprises Act applies broadly to all "items or services," which includes all encounters, procedures, medical tests, supplies, prescription drugs, durable medical equipment, and fees (including facility fees) provided or assessed in connection with the provision of health care.

Limitations on Balance Billing

The federal No Surprises Act prohibits nonparticipating providers from balance billing patients beyond the applicable in-network cost sharing amount (i.e., the amount that would have been charged to a patient by a participating provider or facility) for emergency services, nonemergency services rendered to patients by nonparticipating providers at participating health care facilities, as well as out of network air ambulance services, subject to certain exceptions, as follows:

- For emergency services, nonparticipating providers and facilities are prohibited from balance billing patients beyond the applicable in-network cost sharing amount. There are no applicable exceptions to this requirement.
- Nonparticipating providers and facilities may balance bill for post-stabilization services only if all of the following conditions have been met:
  - » The attending emergency physician or treating provider determines that the patient (1) can travel using non-medical or nonemergency medical transportation to an available participating provider or facility located within a reasonable travel distance, taking into account the individual's medical condition, and (2) the patient (or the patient's authorized representative) is in a condition to receive notice and provide informed consent;
  - » The nonparticipating provider or facility satisfies certain notice and consent requirements discussed below (the "Notice and Consent Requirement"); and
  - » The provider or facility satisfies any additional state law requirements.
- Nonparticipating providers of nonemergency services at a participating health care facility may balance bill patients only if it satisfies the Notice and Consent Requirement. Notwithstanding, the balance billing limitation will apply regardless of a nonparticipating provider's compliance with the Notice and Consent Requirement with respect to the following services:
  - » Ancillary services, including items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a physician or non-physician practitioner;
  - » Items and services provided by assistant surgeons, hospitalists and intensivists;
  - » Diagnostic services, including radiology and laboratory services;
  - » Items and services provided by a nonparticipating provider if there is no participating provider who can furnish the item or service at such facility; and
  - » Items and services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished, regardless of whether the nonparticipating provider satisfied the Notice and Consent Requirement.
  - » Nonparticipating providers of air ambulance services are prohibited from balance billing patients for covered air ambulance services beyond the in-network cost sharing amount.

Where the federal surprise billing protections apply, the nonparticipating provider must submit a claim to the patient's plan or issuer. Within 30 calendar days after the plan or issuer receives a "clean claim" from the provider, the plan or issuer must either send

a denial of payment, or pay the nonparticipating provider one of the following amounts, less any cost sharing from the patient:

- An amount determined by an applicable All-Payer Model Agreement[4];
- If there is no applicable All-Payer Model Agreement, an amount determined by state law;
- If there is no All-Payer Model Agreement or specified state law, the amount agreed upon by the plan or issuer and the provider or facility; or
- If none of the above conditions apply, and if the parties enter into an informal dispute resolution process (IDR) (discussed below) and do not agree on a payment amount before the date when the IDR entity makes a determination, then the amount determined by the IDR entity.

Importantly, in order for a state's surprise medical billing law to determine the amount to be paid by the plan or issuer or the out of network rate, the state law must apply to both (1) the plan or issuer involved, (2) the nonparticipating provider and (3) the item or service involved. If a state law does not satisfy all of these criteria, the state law does not apply to determine the out of network rate. Importantly, Michigan's surprise medical billing laws do not apply to plans and issuers which are not subject to Michigan insurance regulation, such as self-funded plans covered by the federal Employee Retirement Income Security Act of 1974 ("ERISA"). In these circumstances, the balance billing limitations established by Michigan's surprise billing laws will not apply to determine the out of network rate.

The applicable cost-sharing amount that may be charged to the patient is also limited, as follows:

- The amount determined by state law, which permits nonparticipating providers to bill patients any applicable in-network coinsurance, copayments, or deductibles.
  - » Note: This amount will apply to most claims for health care services rendered by nonparticipating providers to patients pursuant to the surprise billing laws.
- In the event state law does not have an amount that applies or is in effect, the lesser of the billed charge or the "qualifying payment amount" (QPA), which is the plan or issuer's median contracted rate for the health care service in the geographic region.

Notice and Consent Requirement

When applicable, a nonparticipating provider or facility can meet the Notice and Consent Requirement as follows:

- The patient is provided with a written notice in paper or, as practicable, electronic form (as selected by the patient) that contains following information:
  - » A statement that the health care provider is a nonparticipating provider with respect to the patient's health plan or coverage;
  - » The good faith estimated amount that the nonparticipating provider may charge the patient for the items and services involved (including any item or service that is reasonably expected to be furnished by the nonparticipating provider in conjunction with such items or services) along with notification that the provision of the good faith estimate or the consent to be treated does not constitute a contract with respect to the charges estimated for such items and services or a contract that binds the patient to be treated by the provider or facility;
  - » A statement that prior authorization or other care management limitations may be required in advance of receiving such items or services at the facility; and
  - » A statement that consent to receive such items and services from such nonparticipating provider is optional and that the patient may instead seek care from an available participating provider, with respect to the plan or coverage, as applicable, and that in such cases the cost-sharing responsibility of the patient would not exceed the responsibility that would apply with respect to such an item or service furnished by a participating provider, as applicable, with respect to such plan.
- The written notice must be provided with the consent document described below and physically separate from other documents and not attached to or incorporated into any other document. The written notice must also be provided to the patient within the following time frames:
  - » If the appointment for such items or services is scheduled at least 72 hours prior to the date on which the items or services are to be furnished, not later than 72 hours prior to the date on which the individual is furnished items or services; or
  - » If the appointment for such items or services is scheduled within 72 hours of the date on which items or services are to be furnished, on the date of the appointment, but no later than 3 hours prior to furnishing items or services to which the notice and consent requirements apply.
- The patient provides written consent which is documented on a notice and consent form required by the HHS Secretary (See Appendix Form 2), including the patient's signature, and the time and date on which the patient received the written notice, and the time and date on which the patient signed the consent to be furnished such items and services by such nonparticipating provider.
  - » The patient must be provided with the choice to receive the notice and consent document in any of the 15 most common

[4]Michigan does not have an applicable All-Payer Model Agreement.

languages in the state in which the facility is located or the geographic region that reasonably reflects the geographic region served by the facility.

  - » If the patient's preferred language is not among the 15 most common languages and the patient cannot understand the language in which the notice and consent document are provided, the Notice and Consent Requirement is not satisfied unless the provider (or the facility on behalf of the provider) has obtained the services of a qualified interpreter to assist the patient with understanding the information contained in the notice and consent.
  - » The patient's authorized representative (e.g., an individual authorized to provide consent) may receive the notice on behalf of the patient and provide consent provided that the representative is not a provider affiliated with the facility or an employee of the facility (unless such provider or employee is a family member of the patient).
  - » The consent must be provided voluntarily without undue influence, fraud, or duress, and must not be revoked by the patient prior to receipt of the items or services to which the consent applies.
  - » A copy of the signed written notice and consent must be given to the patient in-person or through mail or email, as selected by the patient.
- The signed written notice and consent document must be retained for at least 7 years after the date on which the item or service is furnished. A nonparticipating provider may either individually retain the written notice and consent or coordinate with the facility to retain the written notice and consent.
- For each item or service furnished by a nonparticipating provider, the provider (or the participating facility on behalf of the provider) must timely notify the plan or issuer that the item or service was furnished during a visit at a participating health care facility and, if applicable, provide the plan or issuer a copy of the signed written notice and consent document. If the nonparticipating provider bills the patient directly (to the extent permitted), the provider may satisfy this requirement by including the notice with the bill to the patient.

HHS published a standard notice and consent form which may be used beginning January 1, 2022 and is available at **Appendix Form 2.**

Public Disclosure Requirements

The federal No Surprise Act requires health care providers and health care facilities to make certain public disclosures, including:

- A statement that explains the requirements of and prohibitions applicable to the health care provider or health care facility;
- If applicable, a statement that explains any state law requirements regarding the amounts such provider or facility may, with respect to an item or service, charge a patient after receiving payment, if any, from the plan or coverage for such item or service and any applicable cost-sharing payment from the patient, and
- A statement providing contact information for the appropriate state and federal agencies that an individual may contact if the individual believes the provider or facility has violated a requirement described in the notice.

A provider or facility that has its own website must post the required disclosure on a searchable homepage of the website, or a link to such information. The provider or facility must also make the disclosure public on a sign posted prominently at the location of the provider or facility unless the provider does not have a publicly accessible location. The disclosure must further be provided to the patient in a one-page, double sided notice, using print no smaller than 12-point font, either in-person or through mail or email, as selected by the patient, no later than the date and time on which the provider or facility requests payment from the individual, or if no payment is requested from the patient, no later than the date on which the provider or facility submits a claim to the group health plan or health insurance issuer. HHS has published a model disclosure notice (Appendix Form 3) which may be used during 2022. Importantly, physicians should continue to monitor for updates or changes to the model surprise billing documents as may be published by HHS.

The disclosure requirement does not apply if the provider does not furnish items or services at or in connection with visits at certain "health care facilities," which include (1) a hospital, (2) a hospital outpatient department, (3) a critical access hospital, or (4) an ambulatory surgical center. A provider is also not required to provide the disclosure to individuals to whom the provider does not furnish items or services at a health care facility or in connection with a visit at a health care facility.

To avoid patients receiving duplicate notices from both the provider and health care facility, a provider and health care facility may enter into a written agreement under which the facility agrees to make the required disclosure information available. Recent interim final rules have clarified that if a provider and facility enter into such a written agreement and the facility fails to make the disclosure information available as required, only the facility (and not the provider) will be in violation of the disclosure requirement. However, if a provider maintains a website, the provider must still post the public disclosure on the provider's website.

Good Faith Estimate Requirement

Regardless of setting, all physicians, facilities, and other health care providers must provide a good faith estimate (GFE) of expected charges upon request or upon scheduling an item or service. In order to comply with this requirement, patients scheduling a health service will first need to be asked if they are covered by

a group health plan, group or individual health insurance and, if so, whether they intend to have their claim(s) for the service submitted to the plan or coverage.

If the patient is enrolled in a plan or coverage and is seeking to have a claim for the item or service submitted to such plan or coverage, the provider or facility must furnish the GFE to the individual's plan or issuer of coverage (also known as the "Advanced EOB"). Due to concerns regarding challenges of developing the technical infrastructure necessary for providers and facilities to transmit the GFE to plans and issuers as required by January 1, 2022, HHS has confirmed it will not enforce the GFE requirement for insured or non-self-pay patients until further rulemaking is complete.

If the patient is uninsured or will be self-pay for the item or service, the GFE must be provided directly to the patient. A GFE must also be provided to an uninsured or self-pay patient who requests a GFE for an item or service. The GFE requirement for uninsured or self-pay patients and patients who request a GFE (as further discussed below) is enforceable beginning January 1, 2022.

If a provider or facility determines a patient is uninsured or self-pay, the patient must be informed that a GFE is available upon scheduling an item or service or upon request. Information regarding the availability of a GFE must be:

- Written in a clear and understandable manner, prominently displayed on the provider or facility's website, in the office and on-site where the scheduling or questions about cost of items or services occur;
- Orally provided when scheduling an item or service or when questions about the cost of items or services occur; and
- Made available in accessible formats, and in the language(s) spoken by individual(s) considering or scheduling items or services with the provider or facility.

In addition, upon the request for a GFE from an uninsured or self-pay patient or the scheduling of a primary item or service to be furnished to such patient, the provider or facility furnishing the primary item or service must, within 1 business day of such scheduling or request, contact all co-providers and co-facilities who are reasonably expected to provide items or services in conjunction with and in support of the primary item or service and request that the co-providers or co-facilities submit GFE information to the provider or facility. The request must include the date that the GFE information must be received by the provider or facility. Co-providers and co-facilities must provide the GFE information to the provider or facility no later than 1 business day after receiving the request from the provider or facility.

However, due to the time it may take for providers and facilities to develop systems and processes for receiving and providing the required GFE information from co-providers and co-facilities, HHS confirmed that for GFEs provided to a patient from January 1, 2022 through December 31, 2022, HHS will exercise its enforcement discretion in situations where a GFE provided to a patient does not include expected charges from co-providers or co-facilities. HHS also noted that nothing prohibits a co-provider or co-facility from furnishing the GFE information before December 31, 2022, and nothing would prevent the patient from separately requesting a GFE from the co-provider or co-facility, in which case the co-provider or co-facility would be required to provide the GFE for such item or service.

When providing the GFE to an uninsured or self-pay patient, the GFE must include the following information:

- The patient's name and date of birth;
- A description of the primary item or service in clear and understandable language (and if applicable, the date the primary item or service is scheduled);
- An itemized list of items or services, grouped by each provider or facility, reasonably expected to be furnished for the primary item or service, and items or services reasonably expected to be furnished in conjunction with the primary item or service, for that period of care including: (1) items or services reasonably expected to be furnished by the convening provider or convening facility for the period of care; and (2) Items or services reasonably expected to be furnished by co-providers or co-facilities;
- Applicable diagnosis codes, expected service codes, and expected charges associated with each listed item or service. The term "expected charges" means the cash pay rate or rate established for an item or service by a provider or facility for an uninsured/self-pay individual, or the amount the provider or facility would expect to charge if the provider or facility intended to bill a plan or issuer directly for such item or service when the GFE is being furnished to a plan or issuer;
- The name, National Provider Identifier (NPI), and Tax Identification Number of each provider or facility represented in the GFE, and the state(s) and office or facility location(s) where the items or services are expected to be furnished by such provider or facility;
- A list of items or services that the provider or facility anticipates will require separate scheduling and that are expected to occur before or following the expected period of care for the primary item or service. The GFE must include a disclaimer directly above this list that includes the following information:
  - » Separate GFEs will be issued to an uninsured (or self-pay) individual upon scheduling or upon request of the listed items or services;
  - » Notification that for items or services included in this list, information such as diagnosis codes, service codes, expected charges and provider or facility identifiers do not need to be included as that information will be provided in separate good faith estimates upon scheduling or upon request of such items or services; and

» Instructions for how an uninsured (or self-pay) individual can obtain GFEs for such items or services.

- A disclaimer that informs the uninsured or self-pay patient that there may be additional items or services the provider or facility recommends as part of the course of care that must be scheduled or requested separately and are not reflected in the GFE;
- A disclaimer that informs the uninsured or self-pay patient that the information provided in the GFE is only an estimate regarding items or services reasonably expected to be furnished at the time the GFE is issued to the uninsured or self-pay patient and that actual items, services, or charges may differ from the GFE; and
- A disclaimer that informs the uninsured or self-pay patient of the patient's right to initiate the patient-provider dispute resolution process if the actual billed charges are substantially in excess of the expected charges included in the GFE. This disclaimer must include instructions for where the patient can find information about how to initiate the patient-provider dispute resolution process and state that the initiation of the patient-provider dispute resolution process will not adversely affect the quality of health care services furnished to the patient by a provider or facility; and
- A disclaimer that the GFE is not a contract and does not require the patient to obtain the items or services from any of the providers or facilities identified in the GFE.

The GFE must be provided within the following time frames:

- If the item or service is scheduled at least 3 business days before the item or service is scheduled to be furnished, not later than 1 business day after the date of scheduling;
- If the item or service is scheduled at least 10 business days before the item or service is scheduled to be furnished, not later than 3 business days after the date of scheduling;
- If a GFE is requested by an uninsured or self-pay individual, not later than 3 business days after the date of the request (Note: This requirement applies to both scheduled and non-scheduled items and services).

The GFE must be provided in written form either on paper or electronically (pursuant to the individual's requested method of delivery). If the individual requests an electronic GFE, the GFE must be provided in a manner that the individual can both save and print. If the individual requests the GFE in a method other than paper or electronically (such as by phone or orally in person), the provider or facility may orally inform the individual of the information contained in the GFE, provided that the provider or facility also issues the GFE in written form.

HHS has published a model notice for purposes of informing a patient of the availability of a GFE, as well as a model GFE, set forth in Appendix Form 4. Providers and facilities are not required to use the model notice or model GFE.

The uninsured or self-pay patient must be provided with a new GFE if the provider or facility anticipates or is notified of any changes to the scope of the GFE previously furnished at the time of scheduling (such as anticipated changes to the expected charges, items, services, frequency, recurrences, duration, providers or facilities) no later than 1 business day before the items or services are scheduled to be furnished. If the provider or facility expects to furnish recurring items or services to an uninsured or self-pay patient (such as multiple physical therapy visits occurring outside the period of care for a surgical procedure), the provider or facility may issue a single GFE for the recurring items or services if 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) and the scope of the GFE for recurring primary items or services does not exceed 12 months. If additional recurrences of items or services are expected beyond 12 months, a provider or facility must provide the uninsured or self-pay individual with a new GFE and communicate any changes upon delivery of the new GFE to help the patient understand what has changed between the initial GFE and the new GFE.

GFE Patient-Provider Dispute Resolution Process

If the total charges billed to an uninsured or self pay patient, including charges for new items or services, exceed the total expected charges set forth in the good faith estimate by at least $400 (whether or not the services billed appear in the good faith estimate), a patient may dispute the billed charges via the federal provider-patient dispute resolution process. A patient (or his or her authorized representative) may initiate dispute resolution by submitting an initial notice to HHS within 120 calendar days of receiving the initial bill containing charges for the item or service that is substantially in excess of the expected charges in the good faith estimate. The notice must include information sufficient to identify the items or services under dispute, including the date of service of date the item was provided and description of the item or service, a copy of the bill for the items and services under dispute, a copy of the GFE for the items and services under dispute, the contact information of the parties involved, the state where the items or services were furnished, and the uninsured/self-pay patient's communication preference (federal IDR portal discussed below, or electronic or paper mail). The patient must also pay a $25.00 administrative fee (if the patient prevails, the patient will recoup the amount of the administrative fee).

Once the notice is received, HHS will select a dispute resolution (SDR) entity which will review the initiation notice and confirm that the disputed items and services are eligible for the dispute resolution process and that it has received all required information.

The SDR entity will then provide notice to the uninsured or self-pay patient and the provider or facility that a patient-provider dispute resolution initiation request has been received and is under review along with information identifying the item or service under dispute. The SDR entity may request the provider or facility provider certain information within 10 business days, including a copy of the GFE provided to the patient, a copy of the billed charges provided to the patient, and documentation demonstrating that the difference between the billed charges and the expected charges reflects the costs of a medically necessary item or service and is based on unforeseen circumstances that could not have reasonably been anticipated when the GFE was provided.

Within 30 business days after receiving the information from the provider, the SDR will then make a determination regarding the amount to be paid by the patient, as follows:

- If the item or service billed is equal to or less than the expected charge in the GFE, the SDR entity will determine the payment amount to be the billed charge.
- If the billed charge is higher than the expected charge and the provider has not provided credible information that the difference in the charges reflects the costs of a medically necessary item or service and is based on unforeseen circumstances that could not have been reasonably anticipated by the provider or facility at the time the GFE was provided (the "Credible Information"), the SDR entity will determine the payment amount to the be expected charge.
- If the billed charge is higher and the provider or entity provided credible information described above, the SDR entity will determine the amount to be paid as the less of (1) the billed charge or (2) the median payment amount for the same or similar service in the geographic area as reflected in an independent database.
- If the item or service was not listed on the GFE, then unless the SDR entity determines the provider submitted Credible Information, the payment amount will be $0. If provider submits Credible Information, then the payment amount will be the lesser of (1) the billed charge or (2) the median payment amount for the same or similar service in the geographic area as reflected in an independent database.
- If the SDR payment determination is less than the total billed charges, the payment amount will be further reduced by the amount of the administrative fee paid by the patient.

While the dispute resolution process is pending, a health care provider cannot move bills for the disputed items into collection or threaten to do so and must cease any active collection efforts until the dispute has been settled. The provider must also suspend the accrual of late fees and cannot take or threaten to take retributive action against the patient for utilizing the dispute resolution process. Prior to the SDR's payment determination, the parties may agree to resolve the dispute by settling on a payment amount. If the parties reach a settlement, notice of the settlement must be given to the SDR entity within 3 business days after the date of the settlement.

Independent Dispute Resolution (IDR) Process

After a provider has submitted a clean claim to a plan or issuer, the plan or issuer has 30 calendar days to either make a payment or deny the claim. If a provider disputes the denial or the initial payment received from the plan or issuer, the provider has 30 business days from the date the provider receives initial payment or denial of payment to initiate an "open negotiation period." The open negotiation period may continue for up to an additional 30 business days until the parties agree to an out of network rate or the 30-business day period has been exhausted. If the parties cannot agree on an out of network rate, the parties must first exhaust the 30-business day open negotiation period before initiating the federal IDR process.

Either the provider or the insurer may initiate the IDR process. The parties may select a certified IDR entity or if one is not selected by the parties, the federal agencies will do so. During the IDR process, the parties must submit to the IDR entity an offer for a payment amount for the disputed item or service and other information requested by the IDR entity within 10 business days of the selection of the IDR entity. The IDR entity must begin with the presumption that the qualified payment amount (QPA) is the appropriate out of network rate. The IDR must then select the offer that is closest to the QPA unless the IDR entity determines that credible information submitted by either party clearly demonstrates that the QPA is materially different from the appropriate out of network rate. The IDR entity may not consider usual and customary charges or any public payor payment or reimbursement rates. The amount determined by the IDR entity at the end of the IDR process will be the amount the provider is entitled to receive.

To further assist with the administration of the federal IDR process, federal agencies established a federal IDR portal, which will be available at https://www.nsa-idr.cms.gov. The portal may be used to satisfy various requirements for the IDR process, including IDR initiation, applications to be a certified IDR entity, and for satisfying certain reporting requirements.

Recently, several lawsuits have been filed by the American Medical Association, the American Hospital Association, and other provider organizations in federal court seeking to prevent the implementation of certain interim final rules related to the federal No Surprises Act due to the rules' interpretation of the IDR process, which opponents argue unfairly favors insurers and contradicts the No Surprises Act. In addition, 152 members of Congress sent a letter urging the federal agencies to amend interim final rules implementing the IDR process. However, no court order

has been issued to delay the effective date of the No Surprises Act, and no other action has been taken to amend the IDR process. Physicians should continue to monitor for updates or changes related to the IDR process.

Provider Directory Requirement

Any health care provider or facility that has or has had a contractual relationship with a plan or issuer to provide items or services under such plan or insurance coverage is required to submit provider directory information to the plan or issuer, at a minimum, under the following circumstances:

- At the beginning or termination of a network agreement with a plan or issuer;
- When there are material changes to the content of the provider director information of the provider or facility;
- Upon request by the plan or issuer; and
- Any other time determined appropriate by the provider, facility, or HHS.

APPENDIX FORM 1A: MICHIGAN DISCLOSURE AND CONSENT FORM

Michigan Surprise Medical Billing Disclosure Form

Your health benefit plan may or may not provide coverage for all of the health care services you are scheduled to receive or the providers providing those services. You may be responsible for the costs of the services that are not covered by your health benefit plan.

The nonparticipating provider must provide a good-faith estimate of the cost of the health care services to be provided. A good-faith estimate does not take into account unforeseen circumstances, which may affect the cost of the health care services provided.

You also have a right to request that the health care services be performed by a provider that participates with your health benefit plan, and may contact your carrier to arrange for those services to be provided at a lower cost and to receive information on in-network providers who can perform the health care services that you need.

I have received, read, and understand this disclosure.

_____ _____

(Patient or patient's representative's signature) (Date)

_____

(Type or print name of patient or patient's representative)

APPENDIX FORM 1B: MICHIGAN GOOD FAITH ESTIMATE FORM

Good Faith Estimate of Total Costs

Patient name: _____

Out-of-network provider(s) or facility name: _____

_____

The amount below is only an estimate; it isn't an offer or contract for services. This estimate shows the full estimated costs of the items or services listed. It doesn't include any information about what your health plan may cover. This means that the final cost of services may be different than this estimate.

Contact your health plan to find out how much, if any, your plan will pay and how much you may have to pay.

[Enter the good faith estimated cost for the items and services that would be furnished by the listed provider or facility plus the cost of any items or services reasonably expected to be provided in conjunction with such items or services. Assume no coverage would be provided for any of the items and services.].

[Populate the table below with each item and service, date of service, and estimated cost. Add additional rows if necessary. The total amount on page 2 must be equal to the total of each of the cost estimates included in the table.]

Date of service	Service code	Description	Estimated amount to be billed
		Total estimate of what you may owe:	

APPENDIX FORM 2: FEDERAL STANDARD NOTICE AND CONSENT WITH GFE

Standard Notice and Consent Documents Under the No Surprises Act

(For use by nonparticipating providers and nonparticipating emergency facilities beginning January 1, 2022)

Instructions

The Department of Health and Human Services (HHS) developed standard notice and consent documents under section 2799B-2(d) of the Public Health Service Act (PHS Act). These documents are for use when providing items and services to participants, beneficiaries, enrollees, or covered individua ls in group health plans or group or individual health insurance coverage, including Federal Employees Health Benefits (FEHB) plans by either:

- A nonparticipating provider or nonparticipating emergency facility when furnishing certain post-stabilization services, or
- A nonparticipating provider (or facility on behalf of the provider) when furnishing non- emergency services (other than ancillary services) at certain participating health care facilities.

These documents provide the form and manner of the notice and consent documents specified by the Secretary of HHS under 45 CFR 149.410 and 149.420. HHS considers use of these documents in accordance with these instructions to be good faith compliance with the notice and consent requirements of section 2799B-2(d) of the PHS Act, provided that all other requirements are met. To the extent a state develops notice and consent documents that meet the statutory and regulatory requirements under section 2799B-2(d) of the PHS Act and 45 CFR 149.410 and 149.420, the state-developed documents will meet the Secretary's specifications regarding the form and manner of the notice and consent documents.

These documents may not be modified by providers or facilities, except as indicated in brackets or as may be necessary to reflect applicable state law. To use these documents properly, the nonparticipating provider or facility must fill in any blanks that appear in brackets with the appropriate information. Providers and facilities must fill out the notice and consent documents completely and delete the bracketed italicized text before presenting the documents to patients. In particular, providers and facilities must fill in the blanks in the "Estimate of what you may pay" section and the "More details about your estimate" section before presenting the documents to patients.

The standard notice and consent documents must be given physically separate from and not attached to or incorporated into any other documents. The documents must not be hidden or included among other forms, and a representative of the provider or facility must be physically present or available by phone to explain the documents and estimates to the individual, and answer any questions, as necessary. The documents must meet applicable language access requirements, as specified in 45 CFR 149.420. The provider or facility is responsible for translating these documents or providing a qualified interpreter, as applicable, when necessary to meet those requirements. The standard notice must be provided on paper, or, when feasible, electronically, if selected by the individual. The individual must be provided with a copy of the signed consent document in-person, by mail or via email, as selected by the individual.

If an individual makes an appointment for the relevant items or services at least 72 hours before the

date that the items and services are to be furnished, these notice and consent documents must be provided to the individual, or the individual's authorized representative, at least 72 hours before the date that the items and services are to be furnished. If the individual makes an appointment for the relevant items or services within 72 hours of the date the items and services are to be furnished, these notice and consent documents must be provided to the individual, or the individual's authorized representative, on the day the appointment is scheduled. In a situation where an individual is provided the notice and consent documents on the day the items or services are to be furnished, including for post-stabilization services, the documents must be provided no later than 3 hours prior to furnishing the relevant items or services.

NOTE: The information provided in these instructions is intended to be only a general informal summary of technical legal standards. It is not intended to take the place of the statutes, regulations, or formal policy guidance upon which it is based. Refer to the applicable statutes, regulations, and other interpretive materials for complete and current information.

Do not include these instructions with the standard notice and consent documents given to patients.

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid Office of Management and Budget (OMB) control number. The valid OMB control number for this information collection is 0938-1401. The time required to complete this information collection is estimated to average 1.3 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Surprise Billing Protection Form

The purpose of this document is to let you know about your protections from unexpected medical bills. It also asks whether you would like to give up those protections and pay more for out-of-network care.

IMPORTANT: You aren't required to sign this form and shouldn't sign it if you didn't have a choice of health care provider when you received care. You can choose to get care from a provider or facility in your health plan's network, which may cost you less.

If you'd like assistance with this document, ask your provider or a patient advocate. Take a picture and/or keep a copy of this form for your records.

You're getting this notice because this provider or facility isn't in your health plan's network. This means the provider or facility doesn't have an agreement with your plan.

Getting care from this provider or facility could cost you more.

If your plan covers the item or service you're getting, federal law protects you from higher bills:

- When you get emergency care from out-of-network providers and facilities, or
- When an out-of-network provider treats you at an in-network hospital or ambulatory surgical center without your knowledge or consent.

Ask your health care provider or patient advocate if you need help knowing if these protections apply to you.

If you sign this form, you may pay more because:

- You are giving up your protections under the law.
- You may owe the full costs billed for items and services received.
- Your health plan might not count any of the amount you pay towards your deductible and out- of-pocket limit. Contact your health plan for more information.

You **shouldn't** sign this form if you **didn't** have a choice of providers when receiving care. For example, if a doctor was assigned to you with no opportunity to make a change. Before deciding whether to sign this form, you can contact your health plan to find an in-network provider or facility. If there isn't one, your health plan might work out an agreement with this provider or facility, or another one. See the next page for your cost estimate.

Estimate of what you could pay

Patient name: _____

Out-of-network provider(s) or facility name: _____

_____

Total cost estimate of what you may be asked to pay:	

- Review your detailed estimate. See Page 4 for a cost estimate for each item or service you'll get.
- Call your health plan. Your plan may have better information about how much you will be asked to pay. You also can ask about what's covered under your plan and your provider options.
- Questions about this notice and estimate? Call *[Enter contact information for a representative of the provider or facility to explain the documents and estimates to the individual, and answer any questions, as necessary.]*
- Questions about your rights? Contact *[contact information for appropriate federal or state agency]*

Prior authorization or other care management limitations

[Enter either (1) specific information about prior authorization or other care management limitations that are or may be required by the individual's health plan or coverage, and the implications of those limitations for the individual's ability to receive coverage for those items or services, or (2) include the following general statement:

Except in an emergency, your health plan may require prior authorization (or other limitations) for certain items and services. This means you may need your plan's approval that it will cover an item or service before you get them. If prior authorization is required, ask your health plan about what information is necessary to get coverage.]

[In the case where this notice is being provided for post-stabilization services by a nonparticipating provider within a participating emergency facility, include the language immediately below and enter a list of any participating providers at the facility that are able to furnish the items or services described in this notice]

Understanding your options

You can also get the items or services described in this notice from these providers who are in-network with your health plan:

More information about your rights and protections

Visit www.cms.gov/nosurprises/consumers for more information about your rights under federal law.

By signing, I give up my federal consumer protections and agree to pay more for out-of-network care.

With my signature, I am saying that I agree to get the items or services from (select all that apply):

☐ *[doctor's or provider's name] [If consent is for multiple doctors or providers, provide a separate check box for each doctor or provider]*

☐ *[facility name]*

With my signature, I acknowledge that I am consenting of my own free will and am not being coerced or pressured. I also understand that:

- I'm giving up some consumer billing protections under federal law.
- I may get a bill for the full charges for these items and services, or have to pay out-of-network cost-sharing under my health plan.
- I was given a written notice on [enter date of notice] explaining that my provider or facility isn't in my health plan's network, the estimated cost of services, and what I may owe if I agree to be treated by this provider or facility.
- I got the notice either on paper or electronically, consistent with my choice.
- I fully and completely understand that some or all amounts I pay might not count toward my health plan's deductible or out-of-pocket limit.
- I can end this agreement by notifying the provider or facility in writing before getting services.

IMPORTANT: You **don't** have to sign this form. But if you don't sign, this provider or facility might not treat you. You can choose to get care from a provider or facility in your health plan's network.

_____	or	_____
Patient's signature		Guardian/authorized representative's signature
_____		_____
Print name of patient		Print name of guardian/authorized representative
_____		_____
Date and time of signature		Date and time of signature

Take a picture and/or keep a copy of this form.

It contains important information about your rights and protections.

More details about your estimate

Patient name: _____

Out-of-network provider(s) or facility name: _____

_____

The amount below is only an estimate; it isn't an offer or contract for services. This estimate shows the full estimated costs of the items or services listed. It doesn't include any information about what your health plan may cover. This means that the final cost of services may be different than this estimate.

Contact your health plan to find out how much, if any, your plan will pay and how much you may have to pay.

[Enter the good faith estimated cost for the items and services that would be furnished by the listed provider or facility plus the cost of any items or services reasonably expected to be provided in conjunction with such items or services. Assume no coverage would be provided for any of the items and services.].

[Populate the table below with each item and service, date of service, and estimated cost. Add additional rows if necessary. The total amount on page 2 must be equal to the total of each of the cost estimates included in the table.]

Date of service	Service code	Description	Estimated amount to be billed
		Total estimate of what you may owe:	

APPENDIX FORM 3: FEDERAL MODEL PUBLIC DISCLOSURE NOTICE

Model Disclosure Notice Regarding Patient Protections Against Surprise Billing

Instructions for Providers and Facilities

(For use beginning January 1, 2022)

Section 2799B-3 of the Public Health Service Act (PHS Act) requires health care providers and facilities to make publicly available, post on a public website of the provider or facility (if applicable), and provide a one-page notice that includes information in clear and understandable language on:

(1) the restrictions on providers and facilities regarding balance billing in certain circumstances,

(2) any applicable state law protections against balance billing, and

(3) information on contacting appropriate state and federal agencies in the case that an individual believes that a provider or facility has violated the restrictions against balance billing.

Health care providers and facilities may, but aren't required to, use this model notice to meet these disclosure requirements. To use this document properly, the provider or facility should review and complete it in a manner consistent with applicable state and federal law. HHS considers use of this model notice in accordance with these instructions to be good faith compliance with the disclosure requirements of section 2799B-3 of the PHS Act and 45 CFR 149.430, if all other applicable PHS Act requirements are met.

If a state develops model language for its disclosure notice that is consistent with section 2799B-3 of the PHS Act, HHS will consider a provider or facility that makes good faith use of the state-developed model language to be compliant with the federal requirement to include information about state law protections.

Public Disclosure Requirements

The disclosure notice must be publicly available, and (if applicable) posted on a provider's or facility's public website.

- To satisfy the public disclosure requirement, providers and facilities must prominently display a sign with the required disclosure information in a location of the provider or facility, such as, where individuals schedule care, check-in for appointments, or pay bills, unless the provider doesn't have a publicly
  accessible location.
- To satisfy the separate requirement to post the disclosure on a public website, the disclosure or a link to the disclosure must appear on a searchable homepage of the provider's or facility's public website.

The contents of this document do not have the force and effect of law and are not meant to bind the public in any way, unless specifically incorporated into a contract. This document is intended only to provide clarity to the public regarding existing requirements under the law.

Who Should Get This Notice

In general, providers and facilities must give the disclosure notice to individuals who are participants, beneficiaries, or enrollees of a group health plan or group or individual health insurance coverage offered by a health insurance issuer, including covered individuals in a health benefits plan under the Federal Employees Health Benefits Program, and to whom they furnish items or services, and then only if such items or services are furnished at a health care facility, or in connection with a visit at a health care facility.

Provision of the Notice

Providers and facilities must provide the notice in-person, by mail, or via email, as selected by the individual. The disclosure notice must be limited to one-page (double-sided) and must use a font size of 12-points or larger.

Providers and facilities must issue the disclosure notice no later than the date and time on which they request payment from the individual (including requests for copayment or coinsurance made at the time of a visit to the provider or facility). If the provider or facility doesn't request payment from the individual, the notice must be provided no later than the date on which the provider or facility submits a claim for payment to the plan or issuer.

Language Access

Use of Plain Language

Health care providers, facilities, plans, and issuers are encouraged to use plain language in the disclosure notice and test the notice for clarity and usability when possible.

Plain language, accessibility, and language access resources:

- http://www.Plainlanguage.gov/guidelines
- http://www.Section508.gov
- http://www.LEP.gov

Compliance with Federal Civil Rights Laws

Entities that receive federal financial assistance must comply with federal civil rights laws that prohibit discrimination. These laws include section 1557 of the Affordable Care Act, Title VI of the Civil Rights Act of 1964, and section 504 of the Rehabilitation Act of 1973. Section 1557 and title VI require covered entities to take reasonable steps to ensure meaningful access to individuals with limited English proficiency, which may include offering language assistance services such as translation of written content into languages other than English.

Section 1557 and section 504 require covered entities to take appropriate steps to ensure effective communication with individuals with disabilities, including provision of appropriate auxiliary aids and services. Auxiliary aids and services may include interpreters, large print materials, accessible information and communication technology, open and closed captioning, and other aids or services for persons who are blind or have low vision, or who are deaf or hard of hearing. Information provided through information and communication technology also must be accessible to individuals with disabilities, unless certain exceptions apply. Providers and facilities are reminded that the disclosure notice must comply with applicable state or federal language-access standards.

NOTE: The information provided in these instructions is intended to be only a general summary of technical legal standards. It is not intended to take the place of the statutes, regulations, or formal policy guidance on which it is based. Refer to the applicable statutes, regulations, and other interpretive materials for complete and current information.

Do not include these instructions with the disclosure notice provided to patients.

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid Office of Management and Budget (OMB) control number. The valid OMB control number for this information collection is 0938-1401. The time required to complete this information collection is estimated to average 3.5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Your Rights and Protections Against Surprise Medical Bills

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

- Emergency services
  - » If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

- Certain services at an in-network hospital or ambulatory surgical center
  - » When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

When Balance Billing Isn't Allowed, You Also Have the Following Protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
  - » Cover emergency services without requiring you to get approval for services in advance (prior authorization).
  - » Cover emergency services by out-of-network providers.
  - » Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
  - » Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

Michigan Surprise Medical Billing Disclosure Statement (Nonemergency Services):

Your health benefit plan may or may not provide coverage for all of the health care services you are scheduled to receive or the providers providing those services. You may be responsible for the costs of the services that are not covered by your health benefit plan.

The nonparticipating provider must provide a good-faith estimate of the cost of the health care services to be provided. A good-faith estimate does not take into account unforeseen circumstances, which may affect the cost of the health care services provided.

You also have a right to request that the health care services be performed by a provider that participates with your health benefit plan, and may contact your carrier to arrange for those services to be provided at a lower cost and to receive information on in-network providers who can perform the health care services that you need.

If you believe you've been wrongly billed, you may contact:

- Centers for Medicare & Medicaid Services (CMS): 1-800-985-3059
- Michigan Department of Insurance and Financial Services (DIFS): 1-877-999-6442

Visit www.cms.gov/nosurprises/consumers for more information about your rights under federal law.

Visit www.michigan.gov/difs for more information about your rights under Michigan law.

APPENDIX FORM 4: FEDERAL GOOD FAITH ESTIMATE (UNINSURED & SELF-PAY PATIENTS)

Standard Form: "Good Faith Estimate for Health Care Items and Services" Under the No Surprises Act

(For use by health care providers no later than January 1, 2022)

Instructions

Under Section 2799B-6 of the Public Health Service Act, health care providers and health care facilities are required to provide a good faith estimate of expected charges for items and services to individuals who are not enrolled in a plan or coverage or a Federal health care program, or not seeking to file a claim with their plan or coverage both orally and in writing, upon request or at the time of scheduling health care items and services.

This form may be used by the health care providers to inform individuals who are not enrolled in a plan or coverage or a Federal health care program (uninsured individuals), or individuals who are enrolled but not seeking to file a claim with their plan or coverage (self-pay individuals) of the expected charges they may be billed for receiving certain health care items and services. A good faith estimate must be provided within 3 business days upon request. Information regarding scheduled items and services must be furnished within 1 business day of scheduling an item or service to be provided in 3 business days; and within 3 business days of scheduling an item or service to be provided in at least 10 business days.

To use this model notice, the provider or facility must fill in the blanks with the appropriate information. HHS considers use of the model notice to be good faith compliance with the good faith estimate requirements to inform an individual of expected charges. Use of this model notice is not required and is provided as a means of facilitating compliance with the applicable notice requirements. However, some form of notice, including the provision of certain required information, is necessary to begin the patient-provider dispute resolution process.

NOTE: The information provided in these instructions is intended only to be a general informal summary of technical legal standards. It is not intended to take the place of the statutes, regulations, or formal policy guidance upon which it is based. Readers should refer to the applicable statutes, regulations, and other interpretive materials for complete and current information.

Health care providers and facilities should not include these instructions with the documents given to patients.

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid Office of Management and Budget (OMB) control number. The valid OMB control number for this information collection is 0938-XXXX. The time required to complete this information collection is estimated to average 1.3 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

[NAME OF CONVENING PROVIDER OR CONVENING FACILITY]

Good Faith Estimate for Health Care Items and Services

Patient		
Patient First Name	Middle Name	Last Name
Patient Date of Birth: _____ / _____ / _____		
Patient Identification Number:		
Patient Mailing Address, Phone Number, and Email Address		
Street or PO Box	Apartment	
City	State	Zip Code
Phone		
Email Address		
Patient's Contact Preference: [ ] By mail [ ] By email		
Patient Diagnosis		
Primary Service or Item Requested/Scheduled		
Patient Primary Diagnosis	Primary Diagnosis Code	
Patient Secondary Diagnosis	Secondary Diagnosis Code	

If scheduled, list the date(s) the Primary Service or Item will be provided: [ ] 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
Total Estimated Cost: $	

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 reoccurring, "The estimated costs are valid for 12 months from the date of the Good Faith Estimate."]

[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	

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]		

Total Expected Charges from [Provider/Facility 1] $
Additional Health Care Provider/Facility Notes

[Provider/Facility 2] Estimate		
Provider/Facility Name	Provider/Facility Type	
Street Address		
City	State	Zip Code
Contact Person Phone Email		
National Provider Identifier	Taxpayer Identification Number	

[Provider/Facility 2] Estimate [Delete if not needed]

Details of Services and Items for [Provider/Facility 2]

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]		

Total Expected Charges from [Provider/Facility 2] $
Additional Health Care Provider/Facility Notes

[Provider/Facility 3] Estimate		
Provider/Facility Name	Provider/Facility Type	
Street Address		
City	State	Zip Code
Contact Person Phone Email		
National Provider Identifier	Taxpayer Identification Number	

[Provider/Facility 3] Estimate [Delete if not needed]

Details of Services and Items for [Provider/Facility 3]

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]		

Total Expected Charges from [Provider/Facility 3] $
Additional Health Care Provider/Facility Notes

Total Estimated cost for all services and items: $

Disclaimer

This Good Faith Estimate shows the costs of items and services that are reasonably expected for your health care needs for an item or service. The estimate is based on information known at the time the estimate was created.

The Good Faith Estimate does not include any unknown or unexpected costs that may arise during treatment. You could be charged more if complications or special circumstances occur. If this happens, federal law allows you to dispute (appeal) the bill.

If You Are Billed For More Than This Good Faith Estimate, You Have the Right to Dispute the Bill.

You may contact the health care provider or facility listed to let them know the billed charges are higher than the Good Faith Estimate. You can ask them to update the bill to match the Good Faith Estimate, ask to negotiate the bill, or ask if there is financial assistance available.

You may also start a dispute resolution process with the U.S. Department of Health and Human Services (HHS). If you choose to use the dispute resolution process, you must start the dispute process within 120 calendar days (about 4 months) of the date on the original bill.

There is a $25 fee to use the dispute process. If the agency reviewing your dispute agrees with you, you will have to pay the price on this Good Faith Estimate. If the agency disagrees with you and agrees with the health care provider or facility, you will have to pay the higher amount.

To learn more and get a form to start the process,
go to www.cms.gov/nosurprises or call 1-800-985-3059.

For questions or more information about your right to a Good Faith Estimate or the dispute process,
visit www.cms.gov/nosurprises or call 1-800-985-3059.

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