

No Surprises Act

FAQs

*for Professional
Counselors in
Private Practice*

This FAQ below is geared towards counselors working in a solo private practice setting. Counselors employed in group practices and larger organizational settings, or who work in facilities (including outpatient departments) are advised to consult with their compliance department or lawyers regarding any changes to processes with regards to the “No Surprises Act”. Graduate counseling professors and clinical site supervisors should consult with their local state laws and regulations regarding the billing and payment practices of services provided by counseling students while in practicum, internship, and/or residency.

What is the “No Surprises Act?”

The “No Surprises Act”, hereafter referred to as “the Act,” which became effective on January 1, 2022, aims to increase price transparency, and reduce the likelihood that clients receive a “surprise” medical bill. Specifically, the Act requires healthcare providers to inform clients or their insurer of a “good faith estimate” (“GFE”) of the costs for a scheduled service or upon request before the service is provided.

Additionally, the Act aims to reduce “surprise” medical bills from out-of-network providers providing services related to an in-network facility visit by: (i) requiring that such providers charge patients no more than the in-network cost sharing amount and prohibiting balance billing, absent advanced notice, and consent from the client. Balance billing is when a healthcare provider bills a patient for the difference between the total cost of services charged and the amount the insurance pays. For such “surprise” medical bills, the Act creates a new baseball-style independent dispute resolution process when providers and insurers are unable to agree on the out-of-network rate for a particular claim (or group of claims for the same service).

The Act also has introduced new notice requirements for healthcare providers.

What is the definition of providers, and are counselors subject to this law?

The Act defines “provider” broadly to encompass all healthcare providers practicing within the scope of a state-issued license. Professional counselors working in a clinical setting with a state-issued practitioner license meet this definition and are subject to this law.

Are counseling services subject to this law?

Yes. Services related to mental health, and substance use disorders are specifically included in the Act. Services are defined broadly to include, “all encounters, procedures, medical tests... provided or assessed in connection with the provision of health care.”

Good Faith Estimate

What is a Good Faith Estimate?

The “Good Faith Estimate”, hereafter referred to as “GFE”, is a notification of expected charges for a scheduled or requested item or service, including items or services that are reasonably expected to be provided in conjunction with such scheduled or requested item or service (whether provided by the provider or another provider or facility). *Note that CMS is deferring the requirement to include items and services provided by other providers or facilities in the GFE for 2022 but encourages providers to do so when feasible.*

The expected charges should take into account any discounts or financial assistance. GFEs are not required for emergency services, which cannot be scheduled in advance, unless specifically requested by the client.

The GFE provisions are meant to give consumers predictability of how much they will be charged for services provided prior to keeping an appointment or receiving any billable services. The GFE must be communicated in written form, either on paper or electronically.

To what category of clients do I need to provide a Good Faith Estimate?

The Act requires providers to provide a GFE directly to clients who are uninsured or self-pay. Self-pay clients are those who are enrolled in commercial insurance (including a Federal Employees Health Benefits (“FEHB”) program health benefits plan) but is not seeking to have a claim submitted to that plan.

The Act also requires providers to provide a GFE to a client’s insurer if the client is enrolled in a commercial plan and seeking to have a claim submitted to that plan. However, the Center for Medicare and Medicaid Services (“CMS”) has not issued regulations on these requirements for insured patients and is deferring enforcement of this requirement until such rules are issued and final. Therefore, the information below focuses on requirements for providing a GFE to uninsured or self-pay clients.

Under the Act, providers are generally not required to provide GFEs to individuals insured under Medicare, Medicaid, or other federal health care programs.

Do I have to ask if the client has health care insurance?

Yes. Ask the client if they have any kind of health care insurance and whether they intend to file a claim to pay for your counseling services. If the client is uninsured or will not seek to file a claim with their health care insurance to pay for your services, you must provide them with a GFE.

Do I have to provide a good faith estimate to new or current clients?

Yes. You must provide a GFE to all new and current uninsured or self-pay clients. The Act makes no distinction between current or future

patients. Provider may provide clients with a single GFE for recurring services (e.g., multiple counseling visits). It must be noted that particular GFE is good only for one year (12 months).

When do I need to provide a good faith estimate?

The good faith estimate needs to be provided within the following time frames:

- If the service is scheduled at least three business days before the appointment date, no later than one business day after the date of scheduling.
- If the service is scheduled at least 10 business days before the appointment date, no later than three business days after scheduling.
- If the uninsured or self-pay client requests a good faith estimate (without scheduling the service), no later than three business days after the date of the request. A new good faith estimate must be provided, within the specified time frames if the client schedules the requested service.

If the information included in the GFE changes, the provider must issue a new GFE no later than one business day before the item or service is scheduled to be furnished.

What is the good faith estimate based on?

The GFE is an estimation of the expected charge(s) to an uninsured or self-pay client for a scheduled or requested service. This expected charge is the rate established by the counselor to an uninsured or self-pay client (or the amount the counselor intended to bill a healthcare plan for insured patients) and inclusive of any discounts or financial assistance.

What information should be included in a good faith estimate?

Per the Centers for Medicare and Medicaid Services (CMS), the following information should be included in a good faith estimate:

- Client's name and date of birth.
- A description of the primary service or item in clear and understandable language, and if it applies, the date that the service or primary item is scheduled for.
- The "reasonably expected" items and services that will be provided for that primary item or service, and any other items or services reasonably expected to be provided in conjunction with the primary item or service. This list should be itemized and grouped by provider and facility.
Note that CMS is deferring the requirement to include items and services provided by other providers or facilities in the GFE for 2022 but encourages providers to do so when feasible.
- The diagnostic codes, expected service codes, and expected charges associated with each listed service.
- Provider and facility information for each person represented in the GFE, including the provider's name, NPI (National Provider Identifier), TIN (Tax Identification Number), state and office or facility location where the items or services are expected to be furnished by the provider or facility.
- A list of the items or services that the provider or facility anticipates will require separate scheduling and that are expected to occur before or after the expected period of care for the primary item or service.

- Include the following disclaimers that are required components of the GFE:
 - There may be additional services or items the provider or facility recommends that many need to be scheduled or requested separately.
 - The information provided in the GFE is only an estimate of items or services, and that because of this, additional items or services that are not reflected on that GFE may be recommended during the course of care and that actual charges may differ.
 - The client has the right to initiate a client-provider dispute resolution process if the charges that are billed substantially exceed the charges that were expected and reflected in the GFE. This disclaimer must include information about how to initiate the dispute resolution process and that initiating the dispute resolution process will not adversely affect the client's quality of care.
 - The good faith estimate is not a contract, and it does not require the self-pay or uninsured individual to obtain the items or services from the providers or facilities identified in the good faith estimate.

An example template of a Good Faith Estimate form has been provided by CMS and can be found here: [Good Faith Estimate for Health Care Items and Services](#)

The CMS requires counselors include “applicable diagnosis” codes in good faith estimates. What diagnostic codes can counselors identify for uninsured or self-pay clients they have not seen yet?

We recommend reviewing the [ACA Code of Ethics](#) about counselor responsibilities and client rights regarding diagnosis. We offer the suggestion of completing one general GFE form (using for example, a code such as Z03.89 “no diagnosis”) to provide individuals (potential clients) prior to the first session (intake assessment) occurring. Subsequent to the first appointment, the counselor can include in the good faith estimate, more accurate diagnostic codes and the CPT (Current Procedural Terminology) codes for recommended services. This updated form should be provided to the client, per the timeline(s) and guidelines specified above.

Do providers need to retain copies of good faith estimates?

Yes. GFEs are considered part of the client's medical record and must be maintained in the same manner. Providers must provide a copy of any previously issued GFEs furnished within the last 6 years to an uninsured or self-pay client upon request.

Is the good faith estimate binding?

No. The good faith estimate is just that, an estimate. The actual amount charged may differ from the estimate. However, if the actual amount charged is substantially higher-defined as being \$400 or more than the good faith estimate- the client has the right to dispute the charges through a new federal patient-provider dispute resolution process.

What documentation do I need to provide if a client disputes a charge?

Upon notice from a selected dispute resolution (“SDR”) that a client has initiated the dispute resolution process, a provider has 10 business days to provide:

- A copy of the good faith estimate provided to the client
- A copy of the bill sent to the client
- Any supporting documentation demonstrating that the difference between the billed charges and the expected charges in the GFE reflects (i) the costs of a medically necessary item or service and (ii) is based on unforeseen circumstances that could not have reasonably been anticipated by the provider or facility when the good faith estimate was provided.

What if my state has a surprise billing law?

Per CMS, the Act supplements state surprise billing laws and does not supplant them. As long as a state's surprise billing law provides the same level of protection as the Act, the state's surprise billing law will apply. Providers will need to comply with any state requirements that are incremental to the federal requirements under the Act. Contact your state for more information and for related questions.

Do I need to inform clients of the availability of a good faith estimate?

Yes. Providers must inform uninsured (or self-pay) individuals, both in writing and orally, that good faith estimates of expected charges are available to uninsured (or self-pay) individuals upon scheduling an item or service, or upon request. Providers must provide written notice in a clear and understandable manner prominently displayed (and easily searchable from a public, digital search engine) on the provider's website, in the office, and on-site where scheduling or questions about the cost of items or services occur. In addition, the provider must orally inform uninsured (or self-pay) individuals of the availability of a good faith estimate when

questions about the cost of items or services occur. Information regarding the availability of a good faith estimate must be made available in accessible formats and languages spoken by individuals considering or scheduling items or services with such provider. CMS has provided a model notice that providers may use for these purposes here: [Good Faith Estimate for Health Care Items and Services.](#)

Do I need to update my informed consent?

Not necessary. The 2014 *ACA Code of Ethics* states counselors are to include fees and billing arrangements in their informed consent (A.2.b.). As described above, providers must provide the GFE within specific time frames, in advance of a scheduled appointment (or services of scheduled appointments for the same service). If patients are provided with informed consent documents at their first visit, that timing is too late to satisfy the GFE requirements.

Additionally, as described in the question immediately above, providers must in certain places and in certain circumstances inform the uninsured or self-paid client, both orally and in writing, about their right to receive a GFE. Counselors could consider including this information in their informed consent; however, that will not alleviate their obligation to provide that notice as otherwise required (e.g., on a website, in the office, etc.).

Remember to communicate this information in ways that are both developmentally and culturally appropriate (A.2.c., *ACA*, 2014). Counselors have the ethical imperative to ensure their clients understand the cost of services, fees for no-shows and cancellations, and any and all other billing and financial practices and policies. This is a required

part of the informed consent process that doesn't begin and end at intake. Counselors must ensure clients truly understand their personal financial cost of receiving services throughout the entire treatment process.

Can clients waive their right to a good faith estimate?

There are no provisions in the Act which allows clients to waive this estimate. The regulation allows clients to waive some of the protections related to balance billing but does not allow providers to bypass the GFE through a client waiver.

Is this all I need to know?

No. We recommend all counselors review the pages below to learn more about the Act and its requirements. There you will find more information about its various nuances and requirements.

- [Ending Surprise Medical Bills](#) -CMS's main page about this legislation
- [Provider requirements and resources: CMS guidance regarding provider requirements](#)
- [The No Surprises Act's Continuity of Care, Provider Directory, and Public Disclosure](#)

[Requirements](#) - CMS presentation outlining provider requirements under the Act

- [The No Surprises Act's Prohibitions on Balancing Billing: CMS presentation No Surprises Act](#) - Employee Benefits Security Administration; U.S. Department of Labor resources on the No Surprises Act including guidance, fact sheets, and model documents
- [§ 149.610 Requirements for provision of good faith estimates of expected charges for uninsured \(or self-pay\) individuals](#) - Link to access regulations implementing the Act
- [Federal Register :: Requirements Related to Surprise Billing; Part I](#): First Interim Final Rule published in the Federal Register
- [Requirements Related to Surprise Billing; Part II](#) –Second Interim Final Rule published in the Federal Register
- [Tele-behavioral health insurance and billing](#) -ACA Resource
- [Evidence on Surprise Billing: Protecting Consumers with the No Surprise Act](#)

Disclaimer: *The contents of this publication are for informational and educational purposes only. Healthcare law is complex, specific, and requirements vary by state. To adhere to any healthcare law or regulation, including the "No Surprises Act" referenced in this article, requires expertise and information that is outside the scope of this article. This article is not a substitute for seeking out personal legal advice and/or consultation. The ACA does not and cannot provide legal advice or direction to our members or state associations. We encourage all professional counselors to consult with their state licensure board and a healthcare attorney to ensure compliance with state and federal laws.*

Source: Center for Medicare & Medicaid Services