FAQS

Answering all of your questions on the

No Surprise Act

ICANotes
Behavioral Health EHR

Q: Does this law apply to existing self-pay clients or new ones coming in?

A: The law applies to both existing and new self-pay clients.

Q: Do we need the Good Faith Estimate for clients who have insurance or only for self-pay clients?

A: Good Faith Estimates are for clients that are self-pay, uninsured, or do not plan on using insurance.

Q: What if you have a group practice with independent clinicians where they each have their own rates?

A: In this case, you would only send the estimate for the clinician who was assigned to or will see the client. In ICANotes forms, it is possible to pull in billing rates from specific clinicians.

Q: How does this apply if you only see insurance clients?

A: The federal ruling still applies if you see insured clients out of network.

Q: If our client is seeing their Primary Care Physician for psychiatric meds would this need to be covered in our estimate?

A: According to the mandate, co-providers and co-facilities are required to provide GFE information to the requesting convening provider or facility. This information must include, among other things, the expected charges for items or services provided in conjunction with the primary item or service. It must be sent to the convening provider or facility no later than one business day after receiving the request.

Q: What about individuals who receive Medicare/Medicaid? As my LPC isn't recognized by Medicare...can I only receive what Medicaid reimburses?

A: According to The Trust Insurance, estimates are not required to be provided to clients enrolled in federal health insurance plans (e.g., Medicare, Medicaid, TRICARE, Indian Health Service, or Veterans Affairs), as these plans already prohibit balance billing.

Q: If a client's therapy is being paid for by a scholarship or grant but they have a small copay do we still need to give them a Good Faith Estimate?

A: To make sure you are completely covered in all aspects, you should provide a Good Faith Estimate because there is no specific language that addresses this in the law.

Q: Will ICANotes have the CMS 10791 boilerplate form available for filling in via portal?

A: The ICANotes form is very similar to the CMS 10791 form. Our form will be available in the forms and assessments section in every client/patient's chart.

Q: What if someone is indigent and cannot afford the fee -- are there hardship waivers?

A: You can provide hardship waivers to any individuals that you deem necessary. But the GFE must include the expected charges, including discounts or other adjustments expected to be applied to an uninsured individual's actual billed charges. For example, some tax-exempt organizations need to meet certain Financial Assistance Policy (FAP) requirements and as such, any adjustments under the FAP would be taken into consideration and reflected in the GFE amount.

Q: Is there anywhere that we can find examples of forms for clients to waive the out-of-network or the easy-to-understand notice of explanation for patients?

A: ICANotes will have forms available to our users. The Department of Health and Human Services has a form available at this link: https://www.cms.gov/files/document/standard-notice-consent-forms-nonparticipating-providers-emergency-facilities-regarding-consumer.pdf

Q: Will ICANotes provide us with a Good Faith Estimate template?

A: Yes.

Q: What if the insurance company doesn't give us 90 days' notice that a member is no longer covered?

A: For each visit or encounter, it is very important to inquire about the client's/patient's insurance coverage. Insurance eligibility checks done with ICANotes can also help confirm the client's insurance status.

Q: The continuity of care requirement - if I drop an insurance company, do I have to offer my clients a fee that would be paid by the insurance company?

A: The continuing care patient may choose to continue to receive the same benefits under the same terms and conditions that would have applied under the plan or coverage had the termination not occurred in relation to the treatment provided by the provider. For 90 days the clinician should accept payment from the plan or issuer for services as payment in full.

Q: How will this affect acute inpatient care?

A: The No Surprises Act applies to inpatient care.

Q: So if a clinical psychologist terminates an insurance contract would existing clients still be seen and would the insurance co-pay?

A: In the continuing care context, for 90 days the patient may choose to continue to receive the same benefits under the same terms and conditions that would have applied had the termination not occurred in relation to the treatment provided by the provider.

Q: If you are giving an estimate before the client starts your program, how can you put the diagnosis code on the estimate? Is this required?

A: In the event that the client has a diagnosis code, this must be included in the estimate.

Q: If the service is free do we need to provide the GFE (we are grant-based)?

A: Yes, the Good Faith Estimate must be provided to every uninsured individual who schedules services or requests an estimate even if they have zero financial responsibility. A GFE is required even if the uninsured (or self-pay) individual has no estimated financial responsibility because the actual billed charges for the items or services are not guaranteed to be $0 and a GFE is required to initiate the patient-provider dispute resolution process if actual billed charges are at least $400 greater than the estimate.

Q: We work as a collaborative clinic and clients see multiple med providers and possibly a therapist. Do all potential providers need to be included in the notice?

A: In ICANotes you have the ability to list up to three providers/clinicians on the Good Faith Estimate. It depends on if the client/patient is going to see all three providers or are they going

Q: Our patients pre-pay and submit to their insurance for reimbursement to them. We do not accept insurance and they sign a consent with all of the fees clearly stated on the agreement. We are always out of network. And there are never surprise charges, How would this work in this situation? Our patients sign a treatment agreement that shows the fees. They are 100% aware of the charges and know they pay upfront and they submit to their insurance for reimbursement to them, not to us.

A: In this situation, provided you are transparent with all of your fees, you are only required to offer Good Faith Estimates to self-pay clients and patients who do not have insurance or for whom insurance reimbursement is not a consideration.

Q: The Good Faith Estimate is only required for self-pay patients, correct?

A: Correct.

Q: Should we document that we discussed the GFE with the client in the client's "actual chart?"

A: Yes, documenting your verbal discussion is strongly recommended. With ICANotes, you can create custom buttons that make it easy to insert that type of documentation into your note in a way that is specific to the client/patient.

Q: How do we allow for fluctuation in psychiatry visits from a visit to visit - coding changes based on medical necessity?

A: This is a great question! I would list all of your billing CPT codes and discuss with the patient that the complexity of their visit determines which codes are used.

Q: Is publishing rates on our website an alternative to a good faith estimate?

A: It is best practice to publish your rates on your website for transparency, however, it does not replace a Good Faith Estimate.

Q: If you have to give the estimate 72 hours prior to treatment, how do you provide a diagnosis? Use symptoms/chief complaint?

A: If you have never seen the patient before it is impossible to give a diagnosis. Symptoms and a chief complaint are not required on a Good Faith Estimate.

Q: Do you have to give a good faith estimate every 10 sessions for example?

A: Good Faith Estimates last for one year or until your rates change.

Q: Does the provider's name need to be on the Good Faith Estimate? Can it be the company name? Our clients see more than one provider in the company. They see an individual therapist and go to group sessions.

A: Best practice is that the clinician that is rendering the service and their NPI number should be included on the Good Faith Estimate.

Q: The biggest challenge we have with forms is keeping up on clients signing things and getting them back. Will ICANotes create a fail-safe on portal forms?

A: A Good Faith Estimate does not require a signature on the form. Currently, you can build your own forms in the ICANotes portal and put a signature capture on a form. As of now, we do not have the capability to mandate specific forms or areas on the forms in the patient portal, however this is on our development roadmap.

Q: So this means that facilities need to know from the patient's insurance ahead of time what will be an out-of-network charge for a service? They often don't.

A: Unfortunately, the onus is on the provider or clinician to determine whether the service is in or out of network with the client's insurance. If the service is out of network and not covered by a federal plan you are permitted to bill the difference, however, you should get a signed statement from the client indicating that they understand the balance will be their responsibility.

Q: So, if you aren't sure how many counseling sessions, some may want weekly, bi-weekly... so aside from sticker shock, wouldn't it be easier to say for a year, estimate weekly appointments, so that would be 52 sessions, $150 per hour, etc?

A: It is up to the individual clinician to decide whether to show an estimate for 6 sessions or 10 sessions or 52 sessions. It is important that the Good Faith Estimate considers all charges that can reasonably be expected to be incurred for services rendered.

Q: If a client's therapy is being paid for by a scholarship or grant but they have a small copay do we still need to give them a GFE?

A: An estimate should be provided to anyone with a charge. Let's use an example: perhaps their co-pays exceed $400. The client could say they were not aware of any charges, including copays. If you gave them an estimate verbally or on paper and documented this, then you would be in compliance with the legislation. Your actions may be perceived as excessive, however, you would be protecting yourself.

Q: Usually, the client will determine when they are done with counseling and therapy so... can the estimate be the rate until the client terminates for the end date?

A: Yes, the estimate is good until the client terminates services or a year after the date of the estimate.

Q: Medicaid patients often drop off insurance for failure to complete annual forms, financial coverage. Should we all just do a GFE for them as well just to cover if they drop off and have to self-pay?

A: This is a great question! It really depends on the client/patient population that you deal with as a mental health professional. This is also considered a gray area because there are no specific instructions or mandates in these situations. If your clients are frequently losing their coverage and then become self-pay, a Good Faith Estimate should be provided as best practice.

Q: Am I understanding that a provider will need to contact a client's insurance and verify in-network/out-of-network status to determine whether or not this applies?

A: Yes, it is important that you inquire about the insurance coverage of clients and then if possible verify that information.

Q: If a diagnosis is required, I am going to assume that the clinician after their first meeting with the client will fill that in and then have the client sign. Is that correct?

A: You are correct in that if you have not met the client yet you cannot provide a diagnosis. In that case, a Good Faith Estimate without diagnosis is not a problem. The client is not required to sign a Good Faith Estimate.

Q: Is the estimate of how many visits a necessary component or just a nice add-on?

A: The clinician may offer an estimate based on the needs of the client. The terminology you use is up to you but it could indicate how many sessions you feel the client needs at the time to treat them effectively. To ensure compliance with the regulations, ICANotes has generalized terminology that will meet a variety of customer needs.

Q: If a patient hasn't even been seen yet, how could we ethically provide how many visits might be necessary?

A: The healthcare professional will provide an estimate depending on the client's needs. The client's choice of language or situation, however, may reflect the number of sessions you believe the client will need at that moment in order to get appropriate treatment from you.

Q: What if you have a group practice with independent clinicians where they each have their own rates?

A: You should only send the estimate of the clinician who has been assigned to see or will see the client. The ICANotes form has the capability to pull billing rates from specific clinicians if multiple clinicians will be assigned to the care of the client. We created our form to be versatile to work for single or multiple clinicians and services.

Q: So what's the best way to handle if the service charge fee needs to be more than the visit estimate initially provided.

A: This is an excellent question! You can always resend another Good Faith Estimate if you feel the client/patient requires more intensive treatment or more sessions.

Q: If you don't accept insurance would it be better just to do the form with everyone?

A: If all your clients/patients are self-pay then they will require a Good Faith Estimate.

Q: If we have documented consent to self-pay rates and they are collected on the date of service, do we really need to do a good faith estimate? It is based on how long they see a provider so it is a fee-for-service situation.

A: Good Faith Estimates must be created in written form and provided to the client on paper or electronically. Ideally, you would want to have this form separate from other forms in your practice.

Q: We left an insurance network last year and notified our patients in a timely manner. The issue we ran into was for patients who had an out-of-network deductible that they wouldn't have had in-network so they found themselves paying out of pocket. Not sure if that situation is relevant to surprise billing or not?

A: This situation is pertinent to the No Surprises Act. A 90-day transitional care period protects patients when their physician or hospital plan network status changes, as part of the No Surprises Act. During this time period, health plans and issuers are required to restrict cost-sharing to in-network providers.

Q: What if you have a client that wants to be seen weekly and then change to every other week. Do they need a new Good Faith Estimate form?

A: Not necessarily, on the Good Faith Estimate form, you could schedule a specific number of sessions or appointments and this would prevent you from having to toggle between weekly and biweekly visits. If you went over the specified amount of sessions then you would want to re-issue another Good Faith Estimate. It may seem strange right now that a healthcare provider is giving a patient an estimate like they are at an auto body shop trying to get their car fixed, but this will become standard practice in health care.

Q: What if the insurance company doesn't give us 90 days notice that a member is no longer covered?

A: This is a complex situation. The continuity of care protections apply to individuals who meet the definition of a continuing care patient and receive services from an out-of-network provider. For the purpose of defining continuing care patients, individuals must meet at least one of the following requirements. Undergoing treatment from the provider or facility for a serious and complex condition, defined as in the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm. In the case of a chronic illness or condition, a condition that is life-threatening, degenerative, potentially disabling, or congenital; and that requires specialized medical care over a prolonged period of time. **The law places the onus on clinicians to give timely notification to the patient.**

Q: If we schedule a current patient for an appointment tomorrow, check the benefits and find out his/her insurance is terminated...do we charge in-network rates in those cases?

A: While there is no definite answer in the mandate laws regarding this question, we have to analyze the continuity of care requirements. The requirement states that the patient must be undergoing treatment. If you have not treated them yet, then continuity of care would not apply. If an individual is not insured then you would be required to give them a Good Faith Estimate.

Q: Since we are almost 6 weeks into the year and it seems many providers have not started to provide these good faith estimates yet, are they enforcing this at this time?

A: This is a valid question. The ruling could be enforced, however, it is at the discretion of the Department of Health and Human Services at this time.

Q: How do we allow for fluctuation in psychiatry visits from a visit to a visit - coding changes based on medical necessity?

A: In this situation, you would want to show all of your billing rates on the Good Faith Estimate. The interim final rules do not require that a Good Faith Estimate include unanticipated items or services that could arise due to unforeseen events.

Q: We are a multi specialty group - can patients be provided separate GFEs?

A: Yes, you can provide separate Good Faith Estimates.

Q: Do you get an alert a few days before the GFE expires?

A: In ICANotes you can set alerts to notify clinicians, front office staff, administration etc.

Q: Do we give the good faith form to insurance patients as well as non-insurance patients?

A: Only self-pay, non-insured, and those not wanting to use insurance should receive the form.

Q: If I only see insurance clients for whom I am in-network, am I still required to present a GFE?

A: Valid question, the answer is no. While technically not required by the mandate a Good Faith Estimate for any charges that the client is expected to pay out of pocket is the best practice. There is a strong possibility that the law will be updated to include in-network insurance. Right now Good Faith Estimates are required for self-pay, uninsured, and those not utilizing their insurance.

Q: If I refer a client to a psychiatrist, do I have to provide a Good Faith Estimate regarding those anticipated charges?

A: ***This is a complicated question*** because in a perfect world you are only responsible for the billing rates and fee schedules of the services you provide to the patient. If you are a therapist and you are working with a psychiatrist to whom you directly refer your clients and you work as a team the terminology that the mandate uses states verbatim: In instances where multiple providers might be responsible for furnishing care in conjunction with a primary item or service, the "convening provider or facility" must provide a Good Faith Estimate to the uninsured (or self-pay) individual, which includes items or services reasonably expected to be furnished by the convening provider or facility, and items or services reasonably expected to be furnished by co-providers or co-facilities.

It then goes on to state: The convening provider or facility is the provider or facility that is responsible for scheduling the primary items or services. Other providers or facilities that furnish items or services in conjunction with the primary item or service furnished by the convening provider or facility are considered "co-providers" and "co-facilities."

As if the above is not confusing in itself, the timeline is shortened to provide a quote: No later than one business day after scheduling the primary item or service or receiving a request for a Good Faith Estimate, the convening provider or facility must contact all co-providers and/or co-facilities that will provide items or services in conjunction with the primary items or services and request GFE information including the expected charges for these items or services expected to be provided by the co-provider or co-facility.

Now because this is a short period of time and this is a new mandate it is stated: We understand that it may take time for providers and facilities to develop systems and processes for receiving and providing the required information from co-providers and co-facilities. Therefore, for GFEs provided to uninsured (or self-pay) individuals from January 1, 2022 through December 31, 2022, HHS will exercise its enforcement discretion in situations where a GFE provided to an uninsured (or self-pay) individual does not include expected charges from co-providers or co-facilities.

Then they go on to state: We note that nothing prohibits a co-provider or co-facility from furnishing the GFE information to the convening provider or facility before December 31, 2022, and nothing would prevent the uninsured (or self-pay) individual from separately requesting a GFE directly 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 items or services. Otherwise, during this period (January 1, 2022 through December 31, 2022), we encourage convening providers and facilities to include a range of expected changes for items or services expected to be provided and billed by co-providers and co-facilities.

The short answer is yes. If you are co-providing services with a psychiatrist and the client is self-pay, non-insured, or does not plan on using their insurance you should provide GFE's for your co-provider as well. However, for the entire year of 2022, the Department of Health and Human Services will have the power to choose whether or not they want to require that GFEs are provided to individuals who are not insured (or self-pay) and do not include the expected charges from co-providers.

Ideally, if you work closely with a co-provider, make a plan for how you will provide good faith estimates to patients who require them.

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