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How does the Federal No Surprises Act Impact Telemedicine Providers? Part One

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In this two-part blog series, we dive into the key points for telemedicine providers in the several hundred pages of the No Surprises Act interim regulations (NSA). The good news for the telemedicine industry is that the majority of the several hundred pages of statutes and regulations are inapplicable to many telehealth providers.

In Part One, we discuss i) the good faith estimate requirements for uninsured and self-pay patients and ii) the prohibition on balance billing for emergency services. Part Two will dive into i) notice and consent requirements for out of network providers providing services at participating health care facilities and ii) disclosure obligations.

The NSA defines a **physician or health care provider** as:

“a physician or other health care provider who is acting within the scope of practice of that provider’s license or certification under applicable State law, but does not include a provider of air ambulance services.”

Telemedicine providers within the scope of this definition should confirm their obligations under the NSA.

Please note that the NSA does not apply to individuals insured under Medicare, Medicaid, Tricare or other federal health care programs.

Good Faith Estimate for Uninsured and Self-Pay Patients

All providers subject to the NSA now have a duty to provide a good faith estimate of expected charges (GFE) to any patients who do not have health insurance (uninsured) or who have health insurance but are paying for their health care services out-of-pocket (self-pay). Providers must determine whether the patient is self-pay or uninsured, and, if so, provide them a GFE when

scheduling. A provider must also provide a GFE when requested–and any discussion or inquiry regarding the potential costs of items or services must be construed as a request for a GFE.

The provider must provide the GFE following specific timelines:

- For services scheduled 10+ business days in advance, a GFE must be provided no later than 3 business days after scheduling.
- For services scheduled 3 – 9 business days in advance, a GFE must be provided no later than 1 business day after scheduling.
- When a GFE is requested, the provider must give a GFE to the patient no later than 3 business days after the request.

Note: there is an obligation to provide a follow-up GFE no later than 1 business day before the primary item or service is furnished if: 1) there are any changes to a GFE already provided; or 2) there are any changes to *who* is providing the services represented in the GFE.

CMS has made available a template GFE that can be utilized; however, the following information is required to be provided in each GFE:

- Patient name and date of birth.
- Description of the primary item or service in clear and understandable language.
- If applicable, the date the primary item or service is scheduled.
- Itemized list of items or services reasonably expected to be furnished for the primary item or service or in conjunction with the primary item or service, grouped by each provider or facility—including co-provider and co-facilities, for that period of care.
- Applicable diagnosis codes, expected service codes, and expected charges associated with each listed item or service.
- Name, National Provider Identifier, and Tax Identification Number of each provider or facility included in the GFE and the office or facility location(s) where the items or services are expected to be furnished.
- The list of items or services that are anticipated requiring separate scheduling and that are expected to occur before or following the expected period of care for the primary item or service.
- A number of disclaimers:
    - Directly above the list of separately scheduled items or services, the GFE must indicate that:
        - Separate GFEs will be issued 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 identified do not need to be included as that information will be provided in such separate GFE.

        - Instruction for how the uninsured (or self-pay) individual can obtain GFEs for such items or services.

    - There may be additional items or services the convening provider or convening facility recommends as part of the course of care that must be scheduled or requested separately and are not reflected in the GFE.

    - 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) individual and that actual items, services, or charges may differ from the GFE.

    - The individual has the 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.

    - The initiation of the patient-provider dispute resolution process will not adversely affect the quality of health care services furnished by the provider or facility.

    - The GFE is not a contract and does not require the individual to obtain the items or services from any of the providers or facilities identified in the GFE.

    - The disclaimers must also provide instructions for where the individual can find information about how to initiate the patient-provider dispute resolution process.

In addition to the GFE itself, written information about the availability of a GFE must be readily available on the provider's website and in its office, including on-site where scheduling occurs (if applicable).

Prohibition on Balanced Billing for Emergency Services

The first and headlining requirement of the NSA is its balanced billing prohibition for emergency services in certain situations. Specifically, the prohibition applies to nonparticipating providers providing emergency services at an emergency facility, which are generally the following licensed entities where emergency services are provided:

- Any emergency department of a hospital;

- A hospital, with respect to emergency services; or

- An independent freestanding emergency department, which is a health care facility that:

    - Is geographically separate and distinct and licensed separately from a hospital under applicable State law; and

- Provides any emergency services.

This requirement implicates any telemedicine emergency services provided to an emergency facility. For the purpose of this rule, emergency services are services provided to treat an emergency medical condition and generally include:

- An appropriate medical screening examination as required under the Emergency Medical Treatment & Labor Act (EMTALA) (or as would be required if such section applied to an independent freestanding emergency department) that is within the capability of the emergency department of a hospital or of an independent freestanding emergency department, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and

- Within the capabilities of the staff and facilities available at the hospital or the independent freestanding emergency department, as applicable, such further medical examination and treatment as are required under EMTALA (or as would be required if such section applied to an independent freestanding emergency department) to stabilize the patient (regardless of the department of the hospital in which such further examination or treatment is furnished).

For example, if a hospital emergency department has contracted with a telemedicine provider for emergency services or specialist services that are provided in the context of an emergency, that provider cannot balance bill the patient.

This restriction applies if the patient has insurance that covers certain emergency services but is out of network with this particular provider. In this situation, the telemedicine provider would be required to bill the patient's insurance company directly or through the health care facility (depending on the arrangement between the facility and provider). The patient may only be billed the amounts owed if the provider were in network (e.g., co-pay, deductible, or co-insurance).

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