PDA Pennsylvania Dental Association

Understanding the No Surprises Act of 2021

Guidance for Private Dental Practices

Are there circumstances in which the No Surprises Act applies to private dental offices?

Yes. According to the ADA and the Pennsylvania Insurance Department (PID), the separate requirements of the law related to **transparency and patient-provider dispute resolution** do apply to uninsured (or self-pay) patients who are treated in a private dental office. Dentists must provide a good faith estimate within three days of a patient's request or when a service is scheduled.

Uninsured (self-pay) patients must be given the good faith estimate in writing or electronically (so long as it can be printed). The patient has the right to initiate the dispute resolution process if the billed charges exceed the good faith estimate by a minimum of $400.

The Centers for Medicare and Medicaid Services (CMS) provides guidance on what the good faith estimate must include and the dispute resolution process. Dentists who must provide good faith estimates to uninsured (self-pay) patients should include the following in their written notice:

- A list of items and services that you expect to provide for a defined period.
- Applicable diagnostic and service codes.
- Expected charges for each item and service.
- Notice that if the actual charges are higher than the good faith estimate that the patient can request that the bill match the good faith estimate, attempt to negotiate, or ask if financial aid is available.
- Information on how patients can dispute a bill that is at least $400 more than the good faith estimate.

Guidance for Dentists Who Provide Services in Other Applicable Settings

Which facilities and services must follow the No Surprises Act?

- Emergency air ambulance services
- Emergency ground ambulance services (enforcement deferred for further study)
- **Emergency facility/provider services**
- **Non-emergency services provided in an in-network facility (includes hospitals, hospital outpatient department, ambulatory surgical centers)**

Which insurance plans apply?

- Employer-based coverage
- Pennie (state-based marketplace)
- Direct coverage through a market insurance company

The ADA believes that it is possible that dental services could be affected in cases of major medical coverage. Learn more here.

Which insurance plans do NOT apply?

- Indemnity or excepted benefit plan enrollees
- A plan that is not an "individual market" coverage plan
- A plan that does not typically have a network
- Short-term limited duration plan enrollees
- Healthcare sharing ministry or Amish participants
- Individuals with no health care coverage
- Medicare*
- Medicaid*
- Indian Health Services*
- Veterans Affairs Health Care and TRICARE*

*These plans offer other balance bill protections

Which providers in these facilities may not balance bill?

According to the PID, the patients may not be balance billed when they have been treated by the following providers or services:

- Emergency room providers
- Anesthesiologists
- Pathologists
- Neonatologists
- Assistant surgeons
- Hospitalists
- Intensivists
- Diagnostic services (including radiology and laboratory)
- **Any service provided by an out-of-network provider if an in-network provider was unavailable.**
- **Urgent services that arise during a service for which notice, and consent, was provided.**
- Other specialty items identified by the U.S. Department of Health and Human Services.

What are the disclosure requirements for the Act itself?

- Patients must be given written notice about the balance billing requirements (under the No Surprises Act and any applicable state laws) for providers and facilities. CMS provides a model disclosure notice for providers and facilities who must disclose.
- Contact information for appropriate state and federal agencies if the patient believes the provider or facility were non-compliant.

How does billing work for out-of-network providers who cannot balance bill patients who are covered under the No Surprises Act?

- Providers may collect cost-sharing amounts at in-network level.
- Providers must bill patient's plan for all remaining charges. The plan is required to pay the provider directly.

What are the disclosure requirements in the No Surprises Act for out-of-network providers who CAN balance bill when providing services to certain patients in in-network facilities?

- Must first give written notice and get written consent from patient (Notice of Consent).
- Providers should use the CMS's standard notice and consent form.
- Written notice must be given patient at least 72 hours (three days) before service is rendered; or, if service is scheduled within three days, the notice must be given at least three hours ahead of time.
- Signed patient consent must be retained for at least seven years and a copy given to patients.

Must out-of-network providers provide good faith estimates/notice of patient-provide dispute process to both insured and uninsured/self-pay patients?

Under section 2799B-6 (42 U.S.C. 300gg-136) of the No Surprises Act, the good faith estimate requirement applies to all patients, whether insured or uninsured/self-pay.

However, in interim final regulations issued on October 7, 2021, the federal government acknowledged the challenges providers and facilities face with developing the infrastructure to meet this requirement for insured patients, and *deferred enforcement* of the requirement that providers and facilities provide good faith estimates for insured patients covered in the act. Currently, both the federal government and PID are enforcing the transparency requirement (good faith estimate and notice of patient-provider dispute process) for uninsured (self-pay) patients *only*.

Because enforcement of all provisions in the act will likely begin in 2023, PDA encourages members who are impacted by this requirement to begin working with the facilities in which they practice in preparing for enforcement of the provision that providers give good faith estimates and information about the patient-provider dispute process to insured patients.

What must the Notice of Consent include?

- Disclosure that the provider does not participate with the patient's health plan.
- A good faith estimate that the provider may charge the patient. The good faith estimate should include:
  - A list of items and services that the scheduling provider or facility reasonably expects to provide during a timeframe.
  - A list of items and services and their associated costs, that can reasonably be expected to be given by another provider or facility involved in the patient's care (a co-provider or co-facility). This specific requirement takes effect in 2023 (see question above for more information).
  - Applicable diagnostic and service codes.
  - Expected charges or costs associated with each item or service from each provider and facility.
  - Notification that if the billed charges are higher than the good faith estimate, a patient can ask the provider or facility to update the bill to match the good faith estimate, **attempt to** negotiate the bill, or ask if there is financial assistance available.
  - Information on how a patient may dispute a bill if it is at least $400 higher than the good faith estimates for any provider or facility.
- Notice that the plan may have to authorize the service.
- Disclosure that the Notice of Consent is optional and that a patient does not have to consent.
- Must include notice that the patient has the option to select an in-network provider (*Note: If the facility cannot provide the option of an in-network provider to the patient, the non-participating dentist providing services cannot balance bill*).

Who should providers contact with complaints against health plans and/or patients?

Providers should contact the PID, which has a process in place to quicky expedite complaints. You can also call (877) 881-6388.

Providers are able to file No Surprises Bill Review Request Forms to resolve disputes.