



SURPRISE BILLING FAQs

UPDATED: DECEMBER 14, 2021

PATIENT BALANCE BILLING PROTECTIONS

Q: What care is protected under the federal regulation of surprise billing?

A: All emergency services are covered under No Surprises Act and all out-of-network care furnished at an in-network facility is covered under the patient balance billing protections. The patient balance billing protections generally only apply in the facility setting and not to care furnished in a physician's office.

Q: When does the federal regulation of balance billing take effect?

A: The patient protections against balance billing take effect on Jan. 1, 2022.

Q: Where can I find the qualifying payment amount (QPA) for services?

A: The QPA is the median in-network rate of a particular insurer of a given service in a particular geographic region. Typically, a provider will only have access to the calculated QPA when they receive an initial payment or notice of denial for out-of-network care that is protected by the federal regulation of balance billing.

UNINSURED AND SELF-PAY GOOD FAITH ESTIMATE (GFE)

Q: What clinicians must provide the GFE for services to uninsured or self-pay patients?

A: All providers, regardless of setting, must provide uninsured or self-pay patients with a GFE for services upon request or upon scheduling care at least 3 days in advance. The uninsured or self-pay GFE is a separate requirement from the balance billing patient protections and applies to any clinician that is providing patient care under their license, including physician office visits.

Q: When does the uninsured or self-pay GFE requirements take effect?

A: Beginning Jan. 1, 2022, all providers, regardless of clinical setting, must provide a GFE to uninsured or self-pay patients.

Q: What flexibilities exist for convening and co-providers/co-facilities in CY 2022?

A: In CY 2022, convening providers, or the primary provider that scheduled care with the patient and is furnishing the primary service within the period of care, are not required to include cost estimates from co-providers or co-facilities on the uninsured or self-pay GFE. However, if the patient separately schedules or requests a GFE from a co-provider or co-facility, the co-provider or co-facility would have to furnish a GFE.

Q: Is there a requirement to provide insured patients with an advanced explanation of benefits (AEOB)?

A: The No Surprises Act established AEOB requirements for insured patients. However, the Departments of Health and Human Services, Labor, and Treasury, have delayed the implementation of this requirement. On Jan. 1, 2022, providers are not required to furnish an AEOB to insured patients. The Departments intend to undergo notice and comment rulemaking in CY 2022 to implement this provision.

An insured patient can however, state that they do not intend to bill their insurer for care and under this circumstance, the patient would qualify as a self-pay patient and the provider would be required to furnish an uninsured or self-pay GFE for care if certain timing requirements are met.

[1] [FAQS ABOUT AFFORDABLE CARE ACT AND CONSOLIDATED APPROPRIATIONS ACT, 2021 IMPLEMENTATION PART 49](#)