

AVOID SURPRISES OF THE NO SURPRISES ACT

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The federal No Surprises Act went into effect Jan. 1, 2022.¹ The law gives consumers billing protections when getting emergency care, non-emergency care from out-of-network providers at in-network facilities, and air ambulance services from out-of-network providers. The American Dental Association (ADA) has provided clarifications for the dental community, which are summarized in this column.²

Balance Billing Provisions Largely Inapplicable to Dental Services

The law's protections against balance billing largely do not affect private dental offices because dental benefits are excepted benefits, according to the Centers for Medicare and Medicaid Services (**CMS**). The requirements on balance billing generally apply to items and services provided to consumers enrolled in group health plans, group or individual health insurance coverage, as well as federal employees' health benefits plans, but not excepted dental benefit plans.

In the case of major medical coverage, the ADA believes dental components could be affected. The question would come down to whether the dental coverage is classified as one of the categories of services that these protections apply to. The ADA believes if the dental component is an excepted benefit, most dentists will not have to worry about making that determination initially. The exception would be in rare instances where the dispute resolution and arbitration requirements apply to dental because they are site specific to hospitals and ambulatory surgical centers.

Dentists Must Provide Good Faith Estimates for Uninsured (or Self-pay) Patients

The separate requirements of the law for transparency of health care costs and the requirements related to the patient-provider dispute resolution process do apply to uninsured (or self-pay) consumers who visit a private dental office. On Feb. 22, 2023, CMS sent an email to ADA confirming that dental providers are required to provide uninsured (or self-pay) individuals with a good faith estimate of expected charges, under federal regulation 45 CFR 149.610.

CMS did note that providers and facilities are "generally not required to provide a good faith estimate to an individual enrolled in an excepted benefit plan or coverage such as a limited-scope dental plan, even if the individual is not enrolled in other coverage." CMS stated: "This is because such an individual is considered to be enrolled in a group health plan or health insurance coverage under the Public Health Service Act, and therefore is generally not considered uninsured."

However, CMS indicated there are two exceptions to the above interpretation:

"If the excepted benefit plan or coverage does not cover a scheduled or requested item or service (for example, because the excepted benefit plan is a limited-scope vision plan and the individual is scheduling dental services), and the individual has no other coverage for the item or service, that individual is considered uninsured with respect to that item or service, and the provider or facility must give them an uninsured or self-pay good faith estimate."

"Similarly, if the individual does not seek to have a claim for the item or service submitted to their excepted benefit plan or coverage, and the individual has no other coverage for that item or service, that individual is considered self-pay with respect to that item or service, and the provider or facility must give them an uninsured (or self-pay) good faith estimate."

"In both of these cases, the individual with the uninsured or self-pay good faith estimate would be eligible to initiate the Patient-Provider Dispute Resolution process if the provider or facility's bill is at least \$400 more than the estimate in the good faith estimate."

CMS also noted that in making the determination as to whether the individual is uninsured or self-pay, "there is no requirement in [the regulation] that providers or facilities verify coverage for each item or service with the individual's plan or issuer. Providers and facilities may make this determination based on its inquiries of the individual under [the regulation.]"

Regarding unexpected situations where a patient is already undergoing treatment and there is no time to create a new good faith estimate, CMS acknowledged that unexpected circumstances may arise during a visit. The good faith estimate “must include a disclaimer that informs the uninsured (or self-pay) individual that the information provided in the good faith estimate is only an estimate regarding the items or services reasonably expected to be furnished at the time the good faith estimate was issued and that the actual items, services, or charges may differ from the good faith estimate.”

Good faith estimate sample disclaimer language is provided below, as part of a larger model form provided by CMS.³

“Disclaimer: This Good Faith Estimate shows the costs of items and services that are reasonably expected for your health care needs for an item or service. The estimate is based on information known at the time the estimate was created. The Good Faith Estimate does not include any unknown or unexpected costs that may arise during treatment. You could be charged more if

complications or special circumstances occur. If this happens, and your bill is \$400 or more for any provider or facility than your Good Faith Estimate for that provider or facility, federal law allows you to dispute the bill. The Good Faith Estimate is not a contract and does not require the uninsured (or self-pay) individual to obtain the items or services from any of the providers or facilities identified in the Good Faith Estimate.”

There is a plethora of additional CMS guidance on the No Surprises Act, including the Patient-Provider Dispute Resolution process, on the agency website.⁴

For further information contact Chief Operating Officer and General Counsel C. Scott Litch at (773) 938-4759 or slitch@aapd.org.

This column presents a general informational overview of legal issues. It is intended as general guidance rather than legal advice. It is not a substitute for consultation with your own attorney concerning specific circumstances in your dental practice. Mr. Litch does not provide legal representation to individual AAPD members.

¹ As part of the Consolidated Appropriations Act of 2021 enacted on December 27, 2020, P.L. 116-260.

² <https://adanews.ada.org/ada-news/2022/march/ada-shares-update-on-how-no-surprises-act-could-affect-dentists/>
https://adanews.ada.org/ada-news/2023/february/ada-receives-clarification-on-no-surprises-act?_ga=2.7873905.252216339.1689341320-767022005.1687795704

³ <https://www.cms.gov/files/document/good-faith-estimate-example.pdf>

⁴ [CMS.gov/NoSurprises](https://www.cms.gov/NoSurprises)

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