No Surprises Act & Ohio House Bill 388

FAQ Sheet

Disclosure Forms

No Surprise Billing Disclosure

Disclosure forms need to be acknowledged by **all patients** receiving care at ESSC. They need to receive the disclosure at each encounter.

In general, providers and facilities must give the disclosure notice to individuals who are:

- Participants, beneficiaries, or enrollees of a group health plan or group or individual health insurance coverage offered by a health insurance issuer, including covered individuals in a health benefits plan under the Federal Employees Health Benefits Program, and
- To whom the provider or facility furnishes items or services, but only if such items or services are furnished at a health care facility, or in connection with a visit at a health care facility.

Providers and facilities shouldn't give these documents to an individual who has Medicare, Medicaid, or any form of coverage other than previously described, or to an individual who is uninsured.

Providing this notice
Providers and facilities must provide the notice in-person, by mail, or by email, as selected by the individual. The disclosure notice must be limited to one, double-sided page and must use a 12-point font size or larger.

Providers and facilities must issue the disclosure notice no later than the date and time they request payment from the individual (including requests for copayment or coinsurance made at the time of a visit to the provider or facility). If the provider or facility doesn't request payment from the individual, they must provide the notice no later than the date they submit a claim for payment to the plan or issuer.

Good Faith Estimate

Under Section 2799B-6 of the Public Health Service Act, health care providers and health care facilities are required to inform individuals who are not enrolled in a plan or coverage or a Federal health care program, or not seeking to file a claim with their plan or coverage both orally and in writing of their ability, upon request or at the time of scheduling health care items and services, to receive a "Good Faith Estimate" of expected charges.

What Qualifies as Emergent on Facility-to-Facility Transports for EMS

If a patient requires either ground (Ohio Bill 388) or Air (Federal No Surprises Act) transportation due to an emergent issue then the patient cannot be balance billed, this includes appropriate transfers undertaken prior to an emergency medical condition being stabilized. A patient is not considered to be in post-stabilization until discharged (can leave with their own transportation).

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Good Faith Estimates – When do they Apply

We are interpreting this to be all patients receiving care at ESSC that are self-pay or un-insured or an individual that asks for one.

PHS Act section 2799B-6(2) and the September 2021 interim final rules specify that a provider or facility must provide a notification (in clear and understandable language) of the good faith estimate of the expected charges for furnishing such items or services (including any items or services that are reasonably expected to be provided in conjunction with such scheduled items or services and such items or services reasonably expected to be so provided by another health care provider or health care facility), with the expected billing and diagnostic codes (i.e., ICD, CPT, HCPCS, DRG, and/or NDC codes) for any such items or services. The definitions related to good faith estimates of expected charges for uninsured (or self-pay) individuals for scheduled items and services and upon request, requirements for the providers and facilities, timing, and good faith estimate content requirements are set forth in PHS Act section 2799B-6 and implementing regulation at 45 CFR 149.610, established under the September 2021 interim final rules.

HHS is adding new 45 CFR 149.620 to implement the patient-provider dispute resolution process including specific definitions related to the patient-provider dispute resolution process. HHS is also codifying provisions related to: eligibility for the federal patient-provider dispute resolution process; selection of an SDR entity; fees associated with this section; certification of SDR entities; and deferral to state patient-provider dispute resolution processes.

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