

## Questions from APA members regarding the Good Faith Estimate

As of December 29, 2021

The following are questions received through the APA's Practice Management Helpline ([practicemanagement@psych.org](mailto:practicemanagement@psych.org)). These pertain specifically to those in solo/small group practices. If you are employed in a larger group, system/facility, please begin by seeking guidance from your compliance office. We will continue to update this list of questions.

- 1. I am a psychiatrist working in a private practice in an outpatient office setting. I do not take any particular insurance, but my clients usually submit a claim through their insurance. My understanding of the No Surprises Act applied to providers who worked in facilities that provided emergency services whether or not they provided emergency care or not. **Am I responsible in providing good faith estimates for those who are considered self-pay** (those who do not plan to submit their claims through insurance)?* Yes. While much of the No Surprises Act focuses on emergency and inpatient care, patient protections have been put into place for care provided in outpatient settings as well. You will need to provide a Good Faith Estimate (GFE) for any patient that does not submit claims to their insurance company - patients who are uninsured or choose to self-pay and not seek any reimbursement. This also applies to patients who are shopping for services.
- 2. Does this requirement apply to new patients or is it also for existing patients?* It is for both.
- 3. In my office agreement, I say that I don't accept insurance. Does this suffice to cover the law or do I need a separate document?* You need an individualized document for each patient. There is no requirement that the patient sign the form.
- 4. I am a private practice, cash-pay (no insurance) psychiatrist. I have a consent form where patients acknowledge that I do not accept any insurances and they have my fee schedule (price per appointment) outlined in my intake paperwork. It seems that the No Surprises Act is meant for large facilities and hospitals. Am I correct in concluding that this is not applicable in my solo fee-for-service outpatient practice where my patients already know they are paying out of pocket, since I am not contracted with insurance?* No, you are not correct. The GFE portion of the rule does apply to you. It is likely that you just need to modify your existing forms to capture some additional information. Once in place this is something that can be done annually and timed with any future changes in rates.
- 5. If patients have insurance, is any of this required?* Only if they choose not to submit to their insurer. If they are insured and send in a claim then this does not apply for now (will be required for all in 2023)
- 6. Regarding the No Surprises Act, how does this pertain for a private practice patient who has entered into a Medicare private contract with a provider who has opted out of Medicare (neither the provider nor the patient will seek reimbursement)?* Until we have further clarification, we suggest treating these individuals as you would any self-pay patient who does not submit a claim.
- 7. Does this apply if I have a contract with a patient as a non-par Medicare provider?* You would not be required to provide a GFE if you are a non-par Medicare provider. In those instances, the

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patient would be submitting their claim to Medicare to recoup money paid to you for their care.

8. *I provide services in a setting offering multiple kinds of services to the same patient (i.e., a federally qualified health center, rural health clinic, hospital), and I do not separately schedule appointments or bill for my services. Does this rule apply to me?* The regulation describes slightly different obligations for a “convening provider or convening facility,” which is a provider or facility who receives the patient’s request for a good faith estimate of costs and is responsible for scheduling the primary service.

Depending on how appointment requests are received and scheduled in your setting, psychiatrists who work at these types of facilities might not be responsible for compiling or providing the good faith estimate, but they are expected to contribute any information that may be relevant to the estimate. If you are in such a setting, you should consult with your facility or clinic’s compliance officer or attorney about your personal obligations under this new regulation.

9. *My patient is insured and intends to use their insurance to pay for my services. Do I have to do this for those patients as well? If so, how do I send this information to the patient’s insurance plan?* This requirement is not yet in place for patients who pay for services through their insurance. Federal agencies will soon issue rules specifying the form, timing, and manner by which good faith estimates must be transmitted to insurers. APA will provide further updates when these rules are issued. The information in this FAQ is only meant to apply to communication with patients who are self-pay or uninsured.
10. *If a patient loses insurance and does not inform us are we at risk?* If you can show a good faith effort was made, you shouldn’t be. We recommend confirming insurance coverage (and whether or not they plan to use the coverage) annually in January or if there has been a change in employment status.
11. *For new patients the form asks you to customize per patient primary diagnosis which I would not have prior to the initial appointment?* In those instances where a diagnosis has not been established, we recommend coming up with some standard language (i.e., TBD pending evaluation for MH/SUD.)
12. *If I am seeing someone weekly, do I put the cost for each session or the total for the year?* We suggest listing the cost per session, an estimated number of sessions and then calculating what that would be for the defined period (full or partial year).
13. *For established patients it asks you the date of visit but I do not know all their future appointment dates for the year. How do you suggest customizing and completing the form for existing patients?* You can use terms such as weekly, semi-monthly, monthly, every six months rather than specific dates of service. You will still need to calculate out an estimated cost or range of costs.

*For example: I anticipate your treatment will require [weekly/semi-monthly/monthly/quarterly] XX-minute psychotherapy sessions in addition to [weekly/semi-monthly/monthly/quarterly]*

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*evaluation and management services throughout the next 12 months at [X dollars] per session for a total of [x weeks] taking into consideration availability (reduce as appropriate for things like vacations, holidays, emergencies, sick time) for an estimated total of [fee per session] x [number of weeks].*

*Or*

*Depending on [insert applicable factors], you may need between X to Y more visits this year. At [\$ per visit] the estimated total costs are between X and Y [fee per visit times the number of visits].*

14. *Are we permitted to provide a range of cpt services (types of cpt services and possible frequency of meeting) and fees? Yes.*
15. *Is the \$400 difference based on a single date of service (single invoice/superbill) or the 12 month estimate we can provide for ongoing services? We believe is on the entire estimate.*
16. *Is there a risk if overestimating in good faith estimate? There does not appear to be a penalty for overestimating.*
17. *Do you have an example of a good faith estimate? Yes, we suggest you begin with your existing paperwork related to your fees. The good faith estimate needs to include the following information:*

Patient Name: Jane Doe

DOB: 10/1/2000

Patient contact information (email, address, phone number): [jane.doe@gmail.com](mailto:jane.doe@gmail.com), 100 King Street, Anytown, VA, 703-111-2222

**Primary** service requested/scheduled, **primary** diagnosis and dx code [in clear and understandable language]:

[For new patients]: Initial Psychiatric Evaluation (90792) to access for mental health/substance use disorders

[For established patients] Evaluation and management services/office visit in conjunction with psychotherapy services; Adjustment Disorder with Mixed Anxiety and Depressed Mood; F43.23

List of Fees including applicable CPT codes [Pull this from your standard fee schedule; We've listed a range of services, yours may be smaller in scope; remove/add as appropriate]:

90792 [or list 99202-99205 series], Psychiatric Diagnostic Evaluation with Medical Services: \$200

99212 Office evaluation and management service [Straightforward]: \$100

99213 Office evaluation and management service [Low]: \$120

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99214 Office evaluation and management service [Moderate]: \$140

99215 Office evaluation and management service [High]: \$160

90833 Psychotherapy, 30 minutes: \$100

90836 Psychotherapy 45 minutes: \$120

90838 Psychotherapy 60 minutes: \$140

Date of Service(s): January 22, 2022 [if recurring – [Weekly/Semi-Monthly/Monthly/Quarterly] for 12 months]

Date of Good Faith Estimate (GFE): January 11, 2022

Estimated cost: \$12,000 within next 12 months [(\$120 + \$120) x (50 visits)] [see [GFE](#) below for more information]

Provider name and National Provider Identifier (NPI) and Tax Identification Number (TIN) [Do not use your Social Security Number]

List of services that will require separate scheduling and that are expected to occur before or after the expected period of care for the primary service: [This may not apply but could include unusual services not covered above.]

### Disclaimers:

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, federal law allows you to dispute (appeal) the bill.

If you are billed for more than this Good Faith Estimate, you have the right to dispute the bill. You may contact the health care provider or facility listed to let them know the billed charges are higher than the Good Faith Estimate. You can ask them to update the bill to match the Good Faith Estimate, ask to negotiate the bill, or ask if there is financial assistance available. You may also start a dispute resolution process with the U.S. Department of Health and Human Services (HHS). If you choose to use the dispute resolution process, you must start the dispute process within 120 calendar days (about 4 months) of the date on the original bill. There is a \$25 fee to use the dispute process. If the agency reviewing your dispute agrees with you, you will have to pay the price on this Good Faith Estimate. If the agency disagrees with you and agrees with the health care provider or facility, you will have to pay the higher amount.

### **Additional information re Good Faith Estimate (GFE)**

For regular/recurring services such as E/M and psychotherapy you can provide a single good-faith estimate for the entire year as long as the estimate includes the expected scope of primary

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services including frequency, fee per visit and anticipated timeframe. There is no penalty to overestimate the charges. The good faith estimate can only include recurring services that are expected to be provided within 12 months. The clinician must offer a new estimate for additional services beyond 12 months and discuss any changes between the initial and new estimate.

Examples:

*I anticipate your treatment will require [weekly/semi-monthly/monthly/quarterly] XX-minute psychotherapy sessions in addition to [weekly/semi-monthly/monthly/quarterly] evaluation and management services throughout the next 12 months at [X dollars] per session for a total of [x weeks] taking into consideration availability (reduce as appropriate for things like vacations, holidays, emergencies, sick time) for an estimated total of [fee per session] x [number of weeks].*

For psychiatrists, the level of E/M services and length of time spent providing psychotherapy could vary so it may be appropriate to provide a range of potential costs or to overestimate the charges to accommodate for some variability. This also applies to those situations where it is harder to determine the course of treatment. Another option is to provide an initial estimate and revise as needed. IF the future course of treatment is less certain, an estimate might look like this:

*Depending on [insert applicable factors], you may need between X to Y more visits this year. At [\$ per visit] the estimated total costs are between X and Y [fee per visit times the number of visits].*

*or*

*Depending on the progress we make this year, I expect that you will need 10–20 more sessions this year. At \$X per session the estimated total cost would be [10X–20X].*