AMERICAN PSYCHOLOGICAL ASSOCIATION
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New billing disclosure requirements take effect in 2022

Psychologists will need to provide estimated costs of services before starting treatment.

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Beginning January 1, 2022, psychologists and other health care providers will be required by law to give uninsured and self-pay patients a good faith estimate of costs for services that they offer, when scheduling care or when the patient requests an estimate.

This new requirement was finalized in regulations issued October 7, 2021. The regulations implement part of the “No Surprises Act,” enacted in December 2020 as part of a broad package of COVID- and spending-related legislation. The act aims to

reduce the likelihood that patients may receive a “surprise” medical bill by requiring that providers inform patients of an expected charge for a service before the service is provided. The government will also soon issue regulations requiring psychologists to give good faith estimates to commercial or government insurers, when the patient has insurance and plans to use it.

Psychologists working in group practices or larger organizational settings and facilities will likely receive direction from their compliance department or lawyers on how to satisfy this new requirement.

Read on for answers to FAQs that apply to practicing psychologists who treat uninsured or self-pay patients.

What providers and what services are subject to this rule?

“Provider” is defined broadly to include any health care provider who is acting within the scope of the provider’s license or certification under applicable state law. Psychologists meet that definition.

The definition of “items and services” for which the good faith estimate must be provided is also broadly defined to encompass “all encounters, procedures, medical tests, … provided or assessed in connection with the provision of health care.” Services related to mental health substance use disorders are specifically included.

What steps do I need to take and when?

Psychologists are ethically obligated to discuss fees with patients upfront. This new requirement builds on that by adding more structure and specific timeframes for action.

Under the new rule, psychologists and other providers must take the following steps for their uninsured or self-pay patients:

1. Ask if the patient has any kind of health insurance coverage (including government insurance programs like Medicare, Medicaid, or Tricare), and if so, whether the patient intends to submit a claim to that insurance for the service.
2. Inform all uninsured and self-pay patients that a good faith estimate of expected charges is
   a. available in a written document that is clear, understandable, and prominently displayed;
   b. orally provided when the service is scheduled or when the patient asks about costs; and
   c. available in accessible formats, and in the language(s) spoken by the patient.
3. Provide a good faith estimate of expected charges for a scheduled or requested service, including items or services that are reasonably expected to be provided in conjunction with such scheduled or requested item or service." That estimate must be provided within specified timeframes:
   a. If the service is scheduled at least three business days before the appointment date, no later than one business day after the date of scheduling;
   b. If the service is scheduled at least 10 business days before the appointment date, no later than three business days after the date of scheduling; or
   c. If the uninsured or self-pay patient requests a good faith estimate (without scheduling the service), no later than three business days after the date of the request. A new good faith estimate must be provided, within the specified timeframes if the patient reschedules the requested item or service.

If any information provided in the estimate changes, a new good faith estimate must be provided no later than 1 business day before the scheduled care. Also, if there is a change in the expected provider less than one business day before the scheduled care, the replacement provider must accept the original good faith estimate as their expected charges.

What is the good faith estimate based on?

The good faith estimate is a notification of expected charges for a scheduled or requested service (or item). The "expected charge" for an item or service is either:

- the cash pay rate or rate established by a provider for an uninsured (or self-pay) patient, reflecting any discounts for such individuals; or
- the amount the provider would expect to charge if the provider intended to bill a health care plan directly for such item or service.

Is the good faith estimate binding?

The information provided in the good faith estimate is only an estimate, and the actual items, services, or charges may differ from what is included in the good faith estimate. However, uninsured or self-pay individuals may challenge a bill from a provider through a new patient-provider dispute resolution process if the billed charges substantially exceed the expected charges in the good faith estimate. Substantially exceeds means an amount that is at least $400 more than the expected charges listed on the good faith estimate for a specific provider.

What information should the good faith estimate contain?

The Centers for Medicare and Medicaid Services (CMS) have provided instructions and a sample good faith estimate template (PDF, 163KB) (/practice/legal/managed/good-faith-estimate-template.pdf) . A good faith estimate (PDF, 130KB) (/practice/legal/managed/good-faith-estimate-notice.pdf) must contain the following information in clear and understandable language:

- The patient's name and date of birth;
- A description of the primary item or service being furnished to the patient (and if applicable, the date the primary item or service is scheduled);

- An itemized list of items or services that are "reasonably expected" to be furnished;
- Applicable diagnosis codes, expected service codes, and expected charges associated with each listed item or service;
- The name, National Provider Identifier, and Tax Identification Number (TIN) of each provider or facility represented in the good faith estimate, and the state(s) and office or facility location(s) where the items or services are expected to be furnished. (APA recommends using a business TIN (/practice/business/finances/employer-identification-numbers) rather than your SSN*)*;
- A list of items or services that the provider or convening facility (the provider or facility that handles the scheduling of the service) anticipates will require separate scheduling and that are expected to occur before or following the expected period of care for the primary item or service; [1] (#service)
- A disclaimer that there may be additional items or services the convening provider or convening facility recommends as part of the course of care that must be scheduled or requested separately and are not reflected in the good faith estimate;
- A disclaimer that the information provided in the good faith estimate is only an estimate and that actual items, services, or charges may differ from the good faith estimate; and
- A disclaimer that informs the patient of their right to initiate a patient-provider dispute resolution process if the actual billed charges substantially exceed the expected charges included in the good faith estimate. This should include instructions for where the patient can find information about how to initiate the dispute resolution process, as well as a statement that the initiation of a patient-provider dispute resolution process will not adversely affect the quality of health care services furnished to the patient; and
- A disclaimer that 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.

The required disclaimers are included in the CMS template cited above.

[1] If there are such separately scheduled services, the estimate should also include a disclaimer that (a) separate good faith estimates will be issued upon scheduling or upon request of the listed items or services, (b) for items or services included in this list, information such as diagnosis codes, service codes, expected charges and provider or facility identifiers do not need to be included, as that information will be provided in separate good faith estimates upon scheduling or upon request; and (c) instructions for how an uninsured (or self-pay) individual can obtain good faith estimates for such items or services.

Do these requirements apply to existing/ongoing patients?

The rule makes no distinction between current and future patients. These new disclosure requirements would presumably apply to continued services furnished to existing patients as well as to new patients.

Special scenarios

Can I provide a single good faith estimate to a patient who I anticipate treating throughout the year?

Yes. If you expect to provide a recurring service to the uninsured/self-pay patient, you are allowed to submit a single good faith estimate to that patient for those services, so long as: (1) the good faith estimate includes, in a clear and understandable manner, the “expected scope of the recurring primary items or services (such as timeframes, frequency, and total number of recurring items or services)”; and (2) the good faith estimate can only include recurring services that are expected to be provided within the next 12 months. For additional recurrences beyond 12 months, the provider must provide a new good faith estimate and communicate any changes between the initial and the new estimates.

For example, if you have a psychotherapy patient that you expect will need continuing therapy throughout the year, the good faith estimate might say the following:

> I expect that my care of you will require continued weekly therapy sessions continuing through the end of the year, at $X per session for a total of 50

> weeks, accounting for vacations and holidays for an estimated total of [$X x 50].

Or if the future course of treatment is less certain, an estimate might look like this:

> 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].

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 item or service.

Depending on how appointment requests are received and scheduled in your setting, psychologists 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.

My patient is insured and intends to use their insurance to pay for my services. How do I send this information to the patient’s insurance plan?

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.

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