DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Consumer Information and Insurance Oversight
200 Independence Avenue SW
Washington, DC 20201

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From: Centers for Medicare & Medicaid Services (CMS), Center for Consumer Information and Insurance Oversight (CCIIO)
Subject: Guidance on Good Faith Estimates and the Patient-Provider Dispute Resolution (PPDR) Process for Providers and Facilities as Established in Surprise Billing, Part II; Interim Final Rule with Comment Period (CMS 9908-IFC)

Summary
Effective January 1, 2022, the No Surprises Act[1] (NSA) protects uninsured (or self-pay) individuals from many unexpectedly high medical bills. If an individual does not have certain types of health insurance, or does not plan to use that insurance to pay for health care items or services, they are eligible to receive a "good faith estimate" of what they may be charged, before they receive the item or service. Once an uninsured (or self-pay) individual schedules an item or service (such as a medical device, a doctor's visit, or a surgical procedure)[2] with a health care provider[3] or health care facility,[4] that provider or facility must give them a good faith estimate of the amount it expects to charge for that item or service. A provider or facility must also give this good faith estimate when an individual requests it (regardless of whether they have scheduled the item or service). Throughout this document the term "providers" also includes providers of air ambulance services.

Additionally, a new patient-provider dispute resolution (PPDR) process will be available for uninsured (or self-pay) individuals who get a bill from a provider that is substantially in excess of the expected charges on the good faith estimate. Under the PPDR process, an uninsured (or self-pay) individual, or their authorized representative, may initiate the PPDR process to seek a determination from an independent third-party certified by HHS (a Selected Dispute Resolution (SDR) entity) for the amount the individual has to pay. This process can provide the uninsured

[1] Enacted as part of the Consolidated Appropriations Act, 2021 (Pub. L. 116-260).
[2] Items or services are any encounters, procedures, medical tests, supplies, prescription drugs, durable medical equipment, and fees (including facility fees), provided or assessed in connection with the provision of health care.
[3] For purposes of the good faith estimate, a health care provider means a physician or other health care provider who is acting within the scope of practice of that provider's license or certification under applicable State law, including a provider of air ambulance services.
[4] For purposes of the good faith estimate, a health care facility (facility) means an institution (such as a hospital or hospital outpatient department, critical access hospital, ambulatory surgical center, rural health center, federally qualified health center, laboratory, or imaging center) in any State in which State or applicable local law provides for the licensing of such an institution, that is licensed as such an institution pursuant to such law or is approved by the agency of such State or locality responsible for licensing such institution as meeting the standards established for such licensing.

(or self-pay) individual important consumer protections from paying billed charges that are significantly more than the expected charges in the good faith estimate.

On October 7, 2021, HHS published interim final rules (IFR) titled *Requirements Related to Surprise Billing; Part II*,[5] implementing various provisions of the NSA, including good faith estimates and the PPDR process for payment determinations.

This guidance is intended to help providers and facilities better understand what information they must include in the good faith estimate and the PPDR process. More specifically, this guidance includes information on:

(1) Good Faith Estimates for Uninsured (or Self-Pay) Individuals
(2) Patient-Provider Dispute Resolution (PPDR) Process
(3) Summary of the PPDR Process

Good Faith Estimates for Uninsured (or Self-Pay) Individuals

The good faith estimate (or GFE) is a notification that outlines an uninsured (or self-pay) individual's expected charges for a scheduled or requested item or service. Providers and facilities must give this estimate to an uninsured (or self-pay) individual (or their authorized representative)[6] who requests it or who schedules an item or service. The good faith estimate will also include items or services reasonably expected to be provided along with the primary item(s) or service(s),[7] even if the individual will receive the items and services from another provider or another facility.

These requirements are applicable for good faith estimates requested on or after January 1, 2022 or for good faith estimates required to be provided in connection with items or services scheduled on or after January 1, 2022.

Convening provider or facility and co-provider or co-facility

A convening provider or convening facility is the provider or facility who schedules an item or service or who receives the initial request for a good faith estimate from an uninsured (or self-pay) individual. A convening provider must provide a good faith estimate to the uninsured individuals, including any item or service that is reasonably expected to be provided in conjunction with a scheduled or requested item or service by another provider or facility.

A co-provider or co-facility is a provider or facility other than a convening provider or a convening facility that furnishes items or services that are customarily provided in conjunction with a primary item or service. For instance, if a patient schedules a surgery, the convening

[5] Requirements Related to Surprise Billing; Part II, 86 Fed. Reg. 55980 (October 7, 2021) codified at 45 CFR 149.610 & 149.620.

[6] Authorized representative means an individual authorized under State law to provide consent on behalf of the uninsured (or self-pay) individual, provided that the individual is not a provider affiliated with a facility or an employee of a provider or facility represented in the good faith estimate, unless such provider or employee is a family member of the uninsured (or self-pay) individual.

[7] Primary item or service means the item or service to be furnished by the convening provider or convening facility that is the initial reason for the visit.

provider or facility might include in the good faith estimate the cost of the surgery, and the co-provider or co-facility might include the costs of any labs, tests, or anesthesia that might be used during the operation.

The good faith estimate will provide an itemized list of items and services, grouped by each provider or facility, that is reasonably expected to be provided as part of the primary item or service, and items and services reasonably expected to be furnished in conjunction with the primary item or service, for that period of care.[8] As a result, the good faith estimate could contain expected charges from multiple providers: the convening provider, and co-providers or co-facilities that furnish items and services that are customarily provided in conjunction with a primary item or service.

Informing uninsured (or self-pay) individuals
A convening provider or facility must inform all uninsured (or self-pay) individuals of the availability of a good faith estimate of expected charges upon scheduling an item or service or upon request. To determine if an individual is an uninsured (or self-pay) individual, the provider or facility must ask if the individual is enrolled in:

- A group health plan;
- Group or individual health insurance coverage offered by a health insurance issuer;
- A Federal health care program, or
- A health benefits plan under a Federal Employees Health Benefits (FEHB) Program.

Note: Enrollees in Federal health care programs are not eligible to receive a good faith estimate as there are other surprise billing protections under these programs.

If not enrolled in any of the above, the individual is considered uninsured for the purposes of the good faith estimate. If the individual is enrolled in a group health plan, group or individual health insurance coverage offered by a health insurance issuer, or a FEHB health benefits plan, the convening provider or facility must ask if the individual is seeking to have a claim submitted for the items or services with such plan or coverage. If not, the individual is considered self-pay for the purposes of the good faith estimate.

Distribution and display of the good faith estimate to individuals
Information regarding the availability of good faith estimates for uninsured (or self-pay) individuals must be written in a clear and understandable manner (model notices can be found here), **prominently displayed (and easily searchable from a public search engine) on the convening provider's or convening facility's website, in the office, and on-site where scheduling or questions about the cost of items or services occur.**

[8] Period of care means the day or multiple days during which the good faith estimate for a scheduled or requested item or service (or set of scheduled or requested items or services) are furnished or are anticipated to be furnished, regardless of whether the convening provider, convening facility, co-providers, or co-facilities are furnishing such items or services, including the period of time during which any facility equipment and devices, telemedicine services, imaging services, laboratory services, and preoperative and postoperative services that would not be scheduled separately by the individual, are furnished.

Convening providers and facilities must also give information about the good faith estimate for uninsured (or self-pay) individuals when scheduling an item or service or when questions about the cost of items or services occur. Convening providers and convening facilities must consider any discussion or inquiry regarding the potential costs of items or services under consideration as a request for a good faith estimate.

Convening providers and facilities must also make information regarding the availability of good faith estimates for uninsured (or self-pay) individuals available in accessible formats, and in the language(s) spoken by individual(s) considering or scheduling items or services.

Timeframes

Upon receiving a request for a good faith estimate from an uninsured (or self-pay) individual or upon scheduling a primary item or service for an uninsured (or self-pay) individual, the convening provider or convening facility must contact all co-providers and co-facilities who are reasonably expected to provide items or services in conjunction with, and in support of, the primary item or service no later than 1 business day after scheduling or receiving the request. The convening provider or convening facility must request that the co-providers or co-facilities submit good faith estimate information to the convening provider or facility. The request must also include the date that good faith estimate information must be received by the convening provider or facility.

Convening providers and facilities must provide a good faith estimate to uninsured (or self-pay) individuals within the following timeframes:

- When a primary item or service is scheduled at least 3 business days before the date the item or service is scheduled to be furnished, the good faith estimate must be provided no later than 1 business day after the date of scheduling.
- When a primary item or service is scheduled at least 10 business days before such item or service is scheduled to be furnished, the good faith estimate must be provided no later than 3 business days after the date of scheduling.
- When a good faith estimate is requested by an uninsured (or self-pay) individual, the good faith estimate must be provided no later than 3 business days after the date of the request.

HHS recognizes that some providers or facilities may need to establish efficient and secure communication channels for transmission of good faith estimate information between convening providers or facilities and co-providers and co-facilities. It is also understood that it may take time for providers and facilities to develop systems and processes for receiving and providing the required information from co-providers and co-facilities. Therefore, for good faith estimates provided to uninsured (or self-pay) individuals from January 1, 2022 through December 31, 2022, HHS will exercise its enforcement discretion in situations where a good faith estimate provided to an uninsured (or self-pay) individual does not include expected charges from co-providers or co-facilities.

A co-provider or co-facility is not prohibited from furnishing the information before December 31, 2022, and nothing would prevent the uninsured (or self-pay) individual from separately requesting a good faith estimate directly from the co-provider or co-facility, in which case the co-provider and co-facility would be required to provide the good faith estimate for such items or services. Otherwise, during this period, HHS encourages convening providers and convening facilities to include a range of expected charges for items or services reasonably expected to be provided and billed by co-providers and co-facilities. To the extent states are the primary enforcers of these requirements, HHS encourages states to take a similar approach, and will not consider a state to be failing to substantially enforce these requirements if it takes such an approach from January 1, 2022 through December 31, 2022.

Changes to the scope of the good faith estimate

If a convening provider, convening facility, co-provider, or co-facility anticipates or is notified of any changes to the scope of a good faith estimate (such as anticipated changes to the expected charges, items, services, frequency, recurrences, duration, providers, or facilities) previously furnished at the time of scheduling, the convening provider or convening facility must provide the individual with a new good faith estimate no later than 1 business day before the items or services are scheduled to be furnished.

If any changes in expected providers or facilities represented in a good faith estimate occur less than 1 business day before the item or service is scheduled to be furnished, the replacement provider or facility must accept the good faith estimate for the relevant items or services being furnished that was provided by the replaced provider or facility.

For good faith estimates provided upon request of an uninsured (or self-pay) individual, upon scheduling of the requested item or service, the convening provider or convening facility must provide the individual with a new good faith estimate for the scheduled item or service within the standard timeframes specified in the **Timeframes** section of this guidance.

Good faith estimate for recurring primary items or services

A convening provider or convening facility may issue a single good faith estimate for recurring primary items or services if both of the following requirements are met:

- The good faith estimate for recurring items or services 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);
- The scope of a good faith estimate for recurring primary items or services does not exceed 12 months. If additional recurrences of furnishing such items or services are expected beyond 12 months, a convening provider or convening facility must provide an uninsured (or self-pay) individual with a new good faith estimate, and communicate such changes (such as timeframes, frequency, and total number of recurring items or services) upon delivery of the new good faith estimate to help patients understand what has changed between the initial good faith estimate and the new good faith estimate.

Requirements for co-providers and co-facilities
Co-providers and co-facilities must submit good faith estimate information upon the request of the convening provider or convening facility. The co-provider or co-facility must provide, and the convening provider or convening facility must receive, the good faith estimate information no later than 1 business day after the co-provider or co-facility receives the request from the convening provider or convening facility.

Co-providers and co-facilities must notify and provide new good faith estimate information to a convening provider or convening facility if the co-provider or co-facility anticipates any changes to the scope of good faith estimate information previously submitted to a convening provider or convening facility (such as anticipated changes to the expected charges, items, services, frequency, recurrences, duration, providers, or facilities).

If any changes to the co-providers or co-facilities listed in the good faith estimate occur less than 1 business day before the item or service is scheduled to be furnished, the replacement co-provider or co-facility must accept as its good faith estimate of expected charges the good faith estimate for the relevant items or services included in the good faith estimate provided by the replaced provider or facility.

In the event that an uninsured (or self-pay) individual separately schedules or requests a good faith estimate from a provider or facility that would otherwise be a co-provider or co-facility, that provider or facility must meet all requirements that apply to convening providers and convening facilities for issuing a good faith estimate to the individual.

Content requirements of a good faith estimate issued to an uninsured (or self-pay) individual
A good faith estimate issued to an uninsured (or self-pay) individual must include:

- Patient name and date of birth;
- Description of the primary item or service in clear and understandable language (and if applicable, the date the primary item or service is scheduled);
- Itemized list of items or services, grouped by each provider or facility, reasonably expected to be furnished for the primary item or service, and items or services reasonably expected to be furnished in conjunction with the primary item or service, for that period of care including both:
    - Items or services reasonably expected to be furnished by the convening provider or convening facility for the period of care;
    - Items or services reasonably expected to be furnished by co-providers or co-facilities.

- Applicable diagnosis codes,[9] expected service codes,[10] and expected charges[11] associated with each listed item or service;
- Name, National Provider Identifier, and Tax Identification Number 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 by such provider or facility;
- List of items or services that the convening provider or convening facility 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. The good faith estimate must include a disclaimer directly above this list that includes all of the following information:
    - Separate good faith estimates will be issued to an uninsured (or self-pay) individual upon scheduling or upon request of the listed items or services;
    - Notification that 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 of such items or services;
    - Instructions for how an uninsured (or self-pay) individual can obtain good faith estimates for such items or services.
- A disclaimer that informs the uninsured (or self-pay) individual 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 informs the uninsured (or self-pay) individual that the information provided in the good faith estimate is only an estimate regarding items or services reasonably expected to be furnished at the time the good faith estimate is issued to the uninsured (or self-pay) individual and that actual items, services, or charges may differ from the good faith estimate;
- A disclaimer that informs the uninsured (or self-pay) individual of that individual's right to initiate the PPDR process if the actual billed charges are substantially in excess of the expected charges included in the good faith estimate. This disclaimer must include instructions for where the individual can find information about how to initiate the PPDR process and state that the initiation of the PPDR process will not adversely affect the quality of health care services furnished to the individual by a provider or facility;
- 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

[9] A diagnosis code is a code that describes an individual's disease, disorder, injury, or other related health conditions using the International Classification of Diseases (ICD) code set.

[10] A service code is the code that identifies and describes an item or service using the Current Procedural Terminology (CPT), Healthcare Common Procedure Coding System (HCPCS), Diagnosis-Related Group (DRG) or National Drug Codes (NDC) code sets.

[11] An expected charge means, for an item or service, the cash pay rate or rate established by a provider or facility for an uninsured (or self-pay) individual, reflecting any discounts for such individuals, where the good faith estimate is being provided to an uninsured (or self-pay) individual; or the amount the provider or facility would expect to charge if the provider or facility intended to bill a plan or issuer directly for such item or service when the good faith estimate is being furnished to a plan or issuer.

providers or facilities identified in the good faith estimate (example disclaimer notice can be found here).

Content requirements for good faith estimate information submitted by co-providers or co-facilities to convening providers or convening facilities

Good faith estimate information submitted to convening providers or convening facilities by co-providers or co-facilities for inclusion in the good faith estimate must include:

- Patient name and date of birth;
- A list of items or services expected to be provided by the co-provider or co-facility that are reasonably expected to be furnished in conjunction with the primary item or service as part of the period of care;
- Applicable diagnosis codes, expected service codes, and expected charges associated with each listed item or service;
- Name, National Provider Identifiers, and Tax Identification Numbers of the co-provider or co-facility, and the state(s) and office or facility location(s) where the items or services are expected to be furnished by the co-provider or co-facility;
- 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 co-providers or co-facilities identified in the good faith estimate.

Required methods for providing good faith estimates for uninsured (or self-pay) individuals

A good faith estimate must be provided in written form either on paper or electronically, pursuant to the uninsured (or self-pay) individual's requested method of delivery, and within the timeframes described above. Good faith estimates provided electronically must be provided in a manner that the uninsured (or self-pay) individual can both save and print. Good faith estimates provided to uninsured (or self-pay) individuals by paper mail must be postmarked by the timelines specified in the **Timeframes** section above.

A good faith estimate must be provided and written using clear and understandable language.

To the extent that an uninsured (or self-pay) individual requests a good faith estimate in a method other than paper or electronically (for example, by phone or orally in person), the convening provider may orally inform the individual of information contained in the good faith estimate using the method requested. However, in order for a convening provider or convening facility to meet the requirements of this section, the convening provider or convening facility must also issue the good faith estimate to the uninsured (or self-pay) individual in written form.

Additional requirements

A good faith estimate issued to an uninsured (or self-pay) individual under this section is considered part of the patient's medical record and must be maintained in the same manner as a patient's medical record. Convening providers and convening facilities must provide a copy of

any previously issued good faith estimate furnished within the last 6 years to an uninsured (or self-pay) individual upon the request of the individual.

For all providers or facilities that issue good faith estimates following their state's processes and rules, if those state processes and rules do not meet federal good faith estimate requirements, those provides and facilities have failed to comply with federal good faith estimate requirements.

A provider or facility will not fail to comply with federal good faith estimate requirements solely because, despite acting in good faith and with reasonable due diligence, the provider or facility makes an error or omission in a required good faith estimate, provided that the provider or facility corrects the information as soon as practicable. If items or services are furnished before an error in a good faith estimate is addressed, the provider or facility may be subject to PPDR if the actual billed charges are substantially in excess of the good faith estimate (as described later in this guidance).

To the extent compliance with federal good faith estimate requirements requires a provider or facility to obtain information from any other entity or individual, the provider or facility will not fail to comply with this section if it relied in good faith on the information from the other entity, unless the provider or facility knows, or reasonably should have known, that the information is incomplete or inaccurate. If the provider or facility learns that the information is incomplete or inaccurate, the provider or facility must provide corrected information to the uninsured (or self-pay) individual as soon as practicable. If items or services are furnished before an error in a good faith estimate is addressed, the provider or facility may be subject to PPDR if the actual billed charges are substantially in excess of the good faith estimate.

Example of how itemized lists of expected items or services could be displayed in a good faith estimate for uninsured (or self-pay) individuals

Details of Services and Items for [Provider/Facility 1]

Service/Item	Address where service/item will be provided	Diagnosis Code	Service Code	Quantity	Expected Cost
	[Street, City, State, ZIP]	[ICD code]	[Service Code Type: Service Code Number]		
Total Expected Charges from [Provider/Facility 1]				$	
Additional Health Care Provider/Facility Notes					

Details of Services and Items for [Provider/Facility 2]

These additional Provider/Facility costs may not be included until 2023

Service/Item	Address where service/item will be provided	Diagnosis Code		Service Code	Quantity	Expected Cost
	[Street, City, State, ZIP]	[ICD code]		[Service Code Type: Service Code Number]		
Total Expected Charges from [Provider/Facility 2]					$	
	Additional Health Care Provider/Facility Notes					

Disclaimer (example)

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.

To learn more and get a form to start the process, go to https://www.cms.gov/nosurprises/consumers or call 1-800-985-3059.

For questions or more information about your right to a Good Faith Estimate or the dispute process, visit https://www.cms.gov/nosurprises/consumers or call 1-800-985-3059.

Keep a copy of this Good Faith Estimate in a safe place or take pictures of it. You may need it if you are billed a higher amount.

Patient-Provider Dispute Resolution (PPDR) Process
Beginning January 1, 2022, a PPDR process will be available for uninsured (or self-pay) individuals who get a bill for an item or service that is substantially in excess of the expected charges on the good faith estimate. Under the PPDR process, the uninsured (or self-pay) individual may seek a determination from a Selected Dispute Resolution (SDR) entity for the amount the individual has to pay. This process can provide the uninsured (or self-pay) individual important consumer protections from billed charges that are substantially in excess of the expected charges in the good faith estimate.

Items or services eligible for PPDR
The PPDR process can apply to any item or service furnished by a convening provider, convening facility, co-provider, or co-facility to an uninsured (or self-pay) individual where the total billed charges are substantially in excess of the total expected charges in the good faith estimate. HHS regulations establish that **when the billed charges for any provider or facility are in excess of the good faith estimate for that provider or facility by $400 or more, the item or service may be eligible for payment determination by a SDR entity through the PPDR process.** As each good faith estimate could potentially contain expected charges from multiple providers and facilities, the substantially in excess determination is made separately for each specific provider or facility listed on the good faith estimate.

If a co-provider or co-facility that provided an estimate of the expected charge for an item or service in the good faith estimate is replaced by a different co-provider or co-facility less than 1 business day before that item or service is scheduled to be furnished, an item or service billed by the replacement co-provider or co-facility is eligible for dispute resolution if the billed charge is $400 or more than the total expected charges included in the good faith estimate for the original co-provider or co-facility. If the replacement provider or facility provides the uninsured (or self-pay) individual with a new good faith estimate, in a timely manner, then the determination of whether an item or service billed by the replacement co-provider or co-facility is eligible for dispute resolution is based on whether the total billed charge for the replacement co-provider or co-facility is $400 or more than the total expected charges included in the good faith estimate provided by the replacement co-provider or co-facility.

Enforcement discretion in 2022 for expected charges for items and services from a co-provider or co-facility
For good faith estimates provided to uninsured (or self-pay) individuals on or after January 1, 2022 through December 31, 2022, HHS will exercise its enforcement discretion in situations where the good faith estimate does not include expected charges for items and services from a co-provider or co-facility. During the period of enforcement discretion, items or services to be provided by a co-provider or co-facility that appear on the good faith estimate that do not include an estimate of expected charges or that appear as a range of expected charges would not be eligible for the PPDR process for the item or service provided by the co-provider or co-facility. If expected charges for a co-provider and co-facility do appear on the good faith estimate, those items or services will be eligible for the PPDR process as normal. This particular application for PPDR eligibility would only apply in 2022.

Would a provider or facility be subject to requirements for the PPDR process but not requirements for the good faith estimate?
The good faith estimate requirements work together with the PPDR requirements to establish important consumer protections for uninsured (or self-pay) individuals who receive billed charges that are substantially in excess of the good faith estimates they received prior to scheduling (or upon request of) items or services. As a result, the requirements for the PPDR process apply to all providers or facilities subject to the good faith estimate requirements.

How is PPDR eligibility determined when there are different providers or facilities listed on the same good faith estimate?
Eligibility for PPDR is determined separately for each unique provider or facility listed on the good faith estimate. For each provider or facility, the total expected charges for each item or service should be added up. This total amount is then compared with the total of all billed charges for the provider or facility, including billed charges for items and services that were furnished but not included in the good faith estimate, to determine eligibility for PPDR.

Example 1

Provider	**Item or Service**	**Expected charge**
Provider A	Item 1	$300
	Item 2	$1275
	Item 3	$550
Total Expected Charges from Provider A		**$2125**
Provider B	Item 1	$500
Total Expected Charges from Provider B		**$500**

In example 1, the good faith estimate contains two providers, A and B. The total expected charges for both providers A and B equal $2625, however for purposes of PPDR the total of expected charges are separated by provider. In this case, the total expected charges for provider A are $2125 and the total expected charges for provider B are $500. The billed charges for providers A and B respectively are compared with their total expected charges to determine whether the billed charges are eligible for PPDR as shown in example 2.

Example 2

Provider A	**Expected charge**	**Billed charge**
Item 1	$300	$350
Item 2	$1275	$1500
Item 3	$550	$550
Total	**$2125**	**$2400**

In example 2, even though the total of all billed charges for provider A ($2400) is greater than the total of expected charges ($2125), the difference between the billed charges and expected charges are less than $400. As a result, items provided by provider A are not eligible for PPDR.

Example 3

Provider A	**Expected charge**	**Billed charge**
Item 1	$300	$350
Item 2	$1275	$1500
Item 3	$550	$850
Total	**$2125**	**$2700**

In example 3, the total of all billed charges for provider A ($2700) is greater than the total of expected charges ($2125), and the difference between the billed charges and expected charges are greater than $400. As a result, items provided by provider A are eligible for PPDR.

Example 4

Provider A	**Expected charge**	**Billed charge**
Item 1	$300	$350
Item 2	$1275	$1500
Item 3	$550	$550
Item 4	NA	$200
Total	**$2125**	**$2600**

In example 4, the uninsured individual was billed by provider A for an item that did not appear on the good faith estimate, item 4. Even though item 4 is not included in the total expected charges as it did not appear on the good faith estimate, the billed charge for item 4 is included in the total billed charges. As the total billed charges exceed the total expected charges by $400 or more, items provided by provider A are eligible for PPDR.

Initiating the PPDR process

An uninsured (or self-pay) individual, or their authorized representative, can initiate the PPDR process by submitting an initiation notice to HHS through the online federal IDR portal, submitting an initiation notice electronically, or submitting through the mail if postmarked within 120 calendar days of receiving the initial bill containing charges for the item or service that is substantially in excess of the expected charges in the good faith estimate. **HHS strongly recommends that the initiation notice be submitted through the federal IDR portal to help ensure the request can be processed quickly and securely**.

Additionally, as part of the initiation process, **the SDR entity will collect an administrative fee totaling $25**. If the PPDR process results in the SDR entity determining a payment amount less

than the billed amount, an amount equal to the administrative fee paid will be subtracted from the final payment determination amount.

The initiation notice

When an uninsured (or self-pay) individual is billed for items or services where the total billed charges for a provider or facility are $400 or more above the total expected charges for the provider or facility in the good faith estimate, the uninsured (or self-pay) individual or their authorized representative[12], may submit a notification (initiation notice) to HHS to initiate the PPDR process. The initiation notice must include all of the following:

- Information sufficient to identify the items or services under dispute, including:
    a. The date of service or date the item was provided
    b. A description of the item or service
- A copy of the bill for the items and services under dispute (the copy can be a photocopy or an electronic image so long as the document is readable);
- A copy of the good faith estimate for the items and services under dispute (the copy can be a photocopy or an electronic image so long as the document is readable);
- The contact information of the parties involved, including:
    a. Name
    b. Email address
    c. Phone number, and
    d. Mailing address
- The state where the items or services in dispute were furnished; and
- The uninsured (or self-pay) individual's contact information including:
    a. Name
    b. Email address
    c. Phone number
    d. Mailing address, and
    e. Communication preference: email, paper mail, or phone

What is the administrative fee and how does it work?

HHS has established a $25 administrative fee to participate in the PPDR process in 2022. The fee amount is meant to ensure there is no barrier to an uninsured (or self-pay) individual's ability to access this process. The administrative fee is an amount paid by the individual to use the PPDR process to settle payment disputes with providers and facilities. HHS will assess the $25 administrative fee in 2022 on the non-prevailing party (providers, facilities, and uninsured (or self-pay) individuals) to the PPDR process.

The uninsured (or self-pay) individual will pay the administrative fee at the beginning of the process to the SDR entity. Providers and facilities are not required to pay the $25 administrative

[12] Authorized representative means an individual authorized under State law to provide consent on behalf of the uninsured (or self-pay) individual, provided that the individual is not a provider affiliated with a facility or an employee of a provider or facility represented in the good faith estimate, unless such provider or employee is a family member of the uninsured (or self-pay) individual.

fee upfront. If the SDR entity determines the payment amount to be lower than the billed charges, the SDR entity will apply an adjustment to the final payment determination amount to allow for the individual to recover the $25 paid.

The amount of the administrative fee may change in future years, but any such change will be promulgated in advance by additional guidance. For more information on the PPDR administrative fee see PPDR fee guidance.

Prohibition on collections and retributive action

While the PPDR process is pending, the provider or facility must not move the bill for the disputed item or service into collection or threaten to do so, or if the bill has already moved into collection, the provider or facility should cease collection efforts. The provider or facility must also suspend the accrual of any late fees on unpaid bill amounts until after the PPDR process has concluded. Finally, the provider or facility must not take or threaten to take any retributive action against an uninsured (or self-pay) individual for utilizing the PPDR process to seek resolution for a disputed item or service.

The online federal IDR portal

When practicable, providers and facilities should use the online federal IDR portal to submit documentation for the PPDR process. The federal IDR portal is the same portal used for the federal IDR process (i.e. payer-provider and payer-air ambulance provider processes). Providers and facilities may also receive notices from HHS and the SDR entity, submit additional supporting documents, and receive the SDR entity's determination via email. More information on the federal IDR portal can be found on the portal webpage.

PPDR process following SDR receipt of initiation notice

The SDR entity will review the initiation notice submitted by the uninsured (or self-pay) individual to ensure that the items or services in dispute meet the eligibility criteria for the PPDR process and that the initiation notice contains all the required information. Once the SDR entity has determined that an item or service is eligible for dispute resolution and that the initiation notice contains all the required information, the SDR entity will notify the uninsured (or self-pay) individual and the provider or facility through the federal IDR portal, or electronic or paper mail, or phone, that a PPDR initiation request has been received and is under review. The SDR entity will also include information identifying the item or service under dispute, and the date the initiation notice was received. Additionally, the SDR entity will notify the provider or facility that they must provide certain information within 10 business days. HHS strongly recommends that this information be submitted using the federal IDR portal. This information must include all of the following:

- A copy of the good faith estimate provided to the uninsured (or self-pay) individual for the items or services under dispute (the copy can be a photocopy or an electronic image so long as the document is readable);

- A copy of the billed charges provided to the uninsured (or self-pay) individual for items or services under dispute (the copy can be a photocopy or an electronic image so long as the document is readable); and
- If available, documentation providing evidence to demonstrate that the difference between the billed charges and the expected charges in the good faith estimate reflects the costs of a medically necessary item or service and is based on unforeseen circumstances that could not have reasonably been anticipated by the provider or facility when the good faith estimate was provided.

No later than 30 business days after receiving this information, the SDR entity must make a determination regarding the amount to be paid by the uninsured (or self-pay) individual.

The SDR entity will also notify the uninsured (or self-pay) individual in cases where the initiation notice is determined to be incomplete or the item or service is determined ineligible for dispute resolution, in which case the uninsured (or self-pay) individual would be provided 21 calendar days to submit any missing information or provide supplemental information to demonstrate the item or service is eligible for the PPDR process.

See the above examples of calculating eligibility provided earlier in this guidance.

How does the SDR entity make the determination?

The SDR entity will review the billed charges to see if the items and services were included on the good faith estimate, as well as review all documentation timely submitted by the parties, including the uninsured (or self-pay) individual or their authorized representative and the provider or facility. The SDR entity will determine how much the uninsured (or self-pay) individual must pay based on documentation submitted by the provider or facility; whether the provider or facility has provided credible information to demonstrate that the difference between the billed charge and the expected charge for the item or service in the good faith estimate reflects the costs of a medically necessary item or service and is based on unforeseen circumstances that could not have reasonably been anticipated by the provider or facility when the good faith estimate was provided. For this purpose, information is credible if, upon critical analysis, the information is worthy of belief and trustworthy. The SDR entity will make this assessment separately for each unique billed item or service.

Examples of determining the payment amount

1) For any item or service where the billed charge is equal to or less than the expected charge in the good faith estimate, the SDR entity would determine that the billed amount is not substantially in excess of the good faith estimate and this case is not eligible for the PPDR process. The SDR entity would inform the patient or their authorized representative that they are ineligible for this dispute resolution process.

Example: billed charge $500; expected charge $975. The SDR entity would inform the patient or their authorized representative that this case is ineligible for resolution via the PPDR process.

2) For a billed item or service that was included on the good faith estimate, if the billed charge for an item or service is substantially in excess of the expected charge in the good faith estimate, and the SDR entity determines the provider or facility has not provided credible information that the difference between the billed charge and the good faith estimate reflects the costs of a medically necessary item or service and is based on unforeseen circumstances that could not have reasonably been anticipated by the provider or facility when the good faith estimate was provided, the SDR entity must determine the amount to be paid by the uninsured (or self-pay) individual for the item or service to be equal to the good faith estimate amount.

Example: billed charge $875; expected charge $450. The payment amount will be $450.

3) If the SDR entity determines that the provider or facility has provided credible information that the difference between the billed charge and the expected charge in the good faith estimate reflects the cost of a medically necessary item or service and is based on unforeseen circumstances, the SDR entity must select as the amount to be paid by the uninsured (or self-pay) individual the lesser of: (1) the billed charge; or (2) the median payment amount paid by a plan or issuer for the same or similar service, by a same or similar provider in the geographic area as defined in § 149.140(a)(7) where the services were provided, that is reflected in an independent database as defined in § 149.140(a)(3) using the methodology described in § 149.140(c)(3), except that in cases where the amount determined by an independent database is determined to be less than the expected charge for the item or service listed on the good faith estimate, the amount to be paid will equal to the expected charge for the item or service listed on the good faith estimate. When comparing the billed charge with the amounts contained in an independent database, the SDR entity should account for any discounts offered by the provider or facility.

Example: billed charge $900; expected charge $450

If the SDR entity determines that the provider **did provide** credible information justifying the higher charge, the payment amount for the item will be the lower of: $900; or the median payment amount described above, or if lower than the good faith estimate, the good faith estimate ($450).

What about items not originally on the good faith estimate?

For billed items or services not listed on the good faith estimate, if the SDR entity determines the provider or facility did not provide credible information that demonstrates that the difference between the billed charge for the new item or service and the good faith estimate reflects the costs of a medically necessary item or service and is based on unforeseen circumstances that could not have reasonably been anticipated by the provider or facility when the good faith estimate was provided, then the SDR entity must determine that amount to be paid for the new item or service to be equal to $0.

If the SDR entity determines that a provider or facility has provided credible information that the billed charge for new items or services that did not appear on the good faith estimate does reflect the costs of a medically necessary item or service and is based on unforeseen circumstances that could not have reasonably been anticipated by the provider or facility when the good faith estimate was provided, then the SDR entity must determine the charge to be paid by the uninsured (or self-pay) individual for the new item or service as the lesser of:

(1) The billed charge, or
(2) The median payment amount paid by a plan or issuer for the same or similar service, by a same or similar provider in the geographic area as defined in § 149.140(a)(7) where the services were provided, that is reflected in an independent database as defined in § 149.140(a)(3) using the methodology described in § 149.140(c)(3). When comparing the billed charge with the amounts contained in an independent database, the SDR entity should account for any discounts offered by the provider or facility.

After making a determination about each item and service subject to the PPDR, the SDR entity will add together the amounts to be paid for all items and services subject to the determination. In cases where the final amount determined by the SDR entity is lower than the billed charge, the SDR entity will reduce the final amount by the administrative fee amount paid by the individual.

Can providers and facilities settle their payment dispute with uninsured (or self-pay) individuals during the PPDR process?
Yes. HHS recognizes that the two parties to the PPDR process (the uninsured (or self-pay) individual and the provider or facility) may agree to resolve the dispute by settling on a payment amount.

At any point after the PPDR process has been initiated but before the date on which a determination is made by the SDR entity, the parties can settle the payment amount through either an offer of financial assistance or an offer to accept a lower amount, or an agreement by the uninsured (or self-pay) individual to pay the billed charges in full.

In the event that the parties agree to settle on a payment amount, the provider or facility should notify the SDR entity through the federal IDR Portal, electronically, or in paper form, as soon as possible, but no later than 3 business days after the date of the agreement. The settlement notification must contain at a minimum, the settlement amount, the date upon which settlement was reached, and documentation demonstrating that the provider or facility and uninsured (or self-pay) individual have agreed to the settlement. The settlement notice must also document that the provider or facility has applied a reduction to the uninsured (or self-pay) individual's settlement amount that is equal to at least half the amount of the administrative fee ($12.50). Once the SDR entity receives the notification of the settlement, the SDR entity must close the dispute resolution case as settled and the agreed upon payment amount will apply.

Treatment of payments made prior to determination
Payment of the billed charges (or a portion of the billed charges) by the uninsured (or self-pay) individual (or by another party on behalf of the uninsured (or self-pay) individual) prior to a determination does not demonstrate agreement by the individual to settle at that amount or any other amount.

Deferral to state PPDR processes
If HHS determines that a state law provides a process to determine the amount to be paid by an uninsured (or self-pay) individual to a provider or facility, and that such process meets or exceeds minimum federal requirements, HHS shall defer to the state process and direct any PPDR requests received from uninsured (or self-pay) individuals in such state to the state process to adjudicate the dispute resolution initiation request.

Extension of time periods for extenuating circumstances
The time periods specified throughout the PPDR (other than the timing of all payments, including payment of the administrative fees) may be extended in extenuating circumstances at HHS's discretion if:

- An extension is necessary to address delays due to matters beyond the control of the parties or for good cause; and
- The parties attest that prompt action will be taken to ensure that the determination under this section is made as soon as administratively practicable under the circumstances.

Any party may request an extension by submitting a request for extension due to extenuating circumstances through the federal IDR portal or electronic or paper mail if the extension is necessary to address delays due to matters beyond the control of the party or for good cause.

Summary of the PPDR Process

(Areas of particular applicability to providers and facilities have been underlined for emphasis)

TIMELINE	PROCESS STEP Before the PPDR Process:
Within 120 calendar days	**1. Initiation Notice and Administrative Fee:** the uninsured (or self-pay) individual submits the initiation notice and other relevant information to the Secretary of the Department of Health and Human Services (HHS). The initiation notice must be sent within *120 calendar days* from when the uninsured or (self-pay) individual received their initial bill for items and services from their provider or facility. HHS will choose and notify the Selected Dispute Resolution Entity (SDR entity). Once HHS has chosen the SDR entity, the uninsured (or self-pay) individual must pay an administrative fee to the SDR entity.
Within 3 business days	**2. SDR Entity Conflict of Interest Identification:** Should a conflict of interest exist, HHS will select a new SDR entity to conduct the PPDR Process. If no SDR entities are available to resolve the dispute, the initially-selected SDR entity will be required to initiate their entity-level conflict of interest mitigation plan, (which may include identifying a sub-contractor whom they have verified does not have a conflict of interest) and submit notice to HHS related to the implementation of the mitigation plan, no later than *3 business days* following selection by HHS. HHS will then assign the case to the identified alternative SDR entity to conduct the PPDR process.
Within 21 calendar days	**3. Eligibility Determination and Additional Information:** After the SDR entity receives information submitted by the uninsured or (self-pay) individual, it will notify them regarding: - Whether or not they are eligible for PPDR - If additional information is needed to determine eligibility or if the patient can proceed to dispute resolution If additional information is required, the patient has *21 calendar days* to furnish it after being notified of the information deficiency.
PPDR Process:	

TIMELINE	PROCESS STEP Before the PPDR Process:
	4. PPDR Initiation: If the SDR entity determines that the item or service meets the eligibility criteria, and the initiation notice contains the required information, the SDR entity will notify the uninsured (or self-pay) individual and the provider or facility that the item or service has been determined eligible for dispute resolution.
Within 3 business days	**5. Parties' Conflict of Interest Identification:** The uninsured (or self-pay) individual and provider or facility may attest to having a conflict of interest with the SDR entity. Should a conflict of interest exist, the SDR entity must notify HHS within *3 business days* of receiving the attestation. HHS will select a different entity to conduct the PPDR process.
Within 10 business days	**6. Provider or Facility Submits Information:** The provider or facility should submit any required information to the SDR entity within *10 business days* of receipt of the selection notice. This information includes: - A copy of the good faith estimate provided to the uninsured (or self-pay) individual for the item or service under dispute - A copy of the billed charges provided to the uninsured (or self-pay) individual for the item or service under dispute - If available, documentation demonstrating that the difference between the billed charge and the expected charges in the good faith estimate reflects the cost of a medically necessary item or service and is based on unforeseen circumstances.

TIMELINE	PROCESS STEP Before the PPDR Process:
Within 3 business days	**7. Patient-Provider Negotiation:** If the parties to a PPDR process agree on a payment amount (through either an offer of financial assistance or an offer of a lower amount, or an agreement by the uninsured (or self-pay) individual to pay the billed charges in full) after the PPDR process has been initiated but before the date on which a determination is made, the provider or facility will notify the SDR entity through the federal IDR portal, electronically, or in paper form as soon as possible, but no later than *3 business days* after the date of the agreement. The settlement notification must contain at a minimum, the settlement amount, the date of such settlement, and documentation demonstrating that the provider or facility and uninsured (or self-pay) individual have agreed to the settlement. The settlement notice must also document that the provider or facility has applied a reduction to the uninsured (or self-pay) individual's settlement amount equal to at least half the amount of the administrative fee paid.
Within 30 business days	**8. Payment Determination for PPDR by the SDR Entity:** No later than *30 business days* after receiving the required information from the provider or facility, the SDR entity must make a determination regarding the amount to be paid by the uninsured (or self-pay) individual, taking into account the requirements of the PPDR payment determination process. The SDR entity should inform both parties of this determination as soon as practicable after reaching a payment determination. The determination made by the SDR entity will be binding upon the parties involved, in the absence of fraud or evidence of misrepresentation of facts presented to the selected SDR entity regarding the claim, except that the provider or facility may provide financial assistance or agree to an offer for a lower payment amount than the SDR entity's determination, the uninsured (or self-pay) individual may agree to pay the billed charges in full, or the uninsured (or self-pay) individual and the provider or facility may agree to a different payment amount.
Time Period Extensions	**Extenuating Circumstances:** The parties may request extensions to most of the time periods above in cases of extenuating circumstances.

For additional resources to help with the PPDR process, please see https://www.cms.gov/nosurprises/consumers

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