



Policy Title: No Surprises Act - Good Faith Estimate & Out - of - Network Insurance Plans	
Policy Type: Clinical, Administrative	Policy Number: 02.01.0021.P
Policy Owners: Deputy Chief Operating Officer	Policy Approver:
Committee/Board Approval(s): Clinician Advisory Board TWCCH Board	Date Policy Originally Established: October 25, 2024 January 21, 2025
Date(s) of Last Approval: October 25, 2024 April 25, 2025	Next Review Date: January 2026

PURPOSE

The Wright Center for Community Health (TWCCH) upholds safety (physical, psychological, social, and moral) as a primary value. In the interest of providing safe, healthy and productive environments for employees and patients, TWCCH has adopted this written policy in order to provide open communication and guidance concerning this policy.

TWCCH utilizes the Entrepreneurial Operating System (EOS) to clarify, simplify and achieve its mission and vision. One of the six key components of the EOS model is Process which embodies the concept of developing policies and procedures that are clearly documented and are required to be followed by all.

The purpose of this policy is to provide clear directives for TWCCH in offering the Good Faith Estimate (GFE) under the “No Surprises Act” for self-pay patients, including patients who elect not to use their insurance and patients whose insurance is not participating with TWCCH (“Out-of-Network”), in accordance with other applicable TWCCH policies.

RESPONSIBLE PARTIES

This policy applies to Clinical Administrative Assistants (CAA), Practice Managers, Billing Department, Medical Directors, Deputy Chief Operating Officer, Community Health Worker and governs self-pay patients, including patients who do not elect to use their insurance and patients whose insurance is not participating with The Wright Center for Community Health (TWCCH) (“Out-of-Network”) and guarantors. It is an essential function of the job



responsibilities of the CAA to provide self-pay patients or patients who elect not to use their insurance a Good Faith Estimate or advance notification to patients whose insurance is not participating with TWCCCH that there may be a balance bill as their insurance is Out-of-Network and does not have a contractual relationship with TWCCCH.

This policy shall be administered by the Deputy Chief Operating Officer.

SCOPE

TWCCCH utilizes the Entrepreneurial Operating System (EOS) to clarify, simplify and achieve its mission and vision. One of the six key components of the EOS model is Process which embodies the concept of developing policies and procedures that are clearly documented and are required to be followed by all. Consistency of application regardless of position or individual adds to the safety of an organization as it ensures the reliability of processes and procedures.

GUIDELINES/DEFINITIONS

Self-Pay Patient - A self-pay patient is someone who pays for their healthcare expenses directly, without using insurance or other third-party payers. This can include patients who do not have insurance, or those patients who have insurance but choose to pay for some services themselves.

TWCCCH offers self-pay patients various payment options, including grace periods, payment plans, financial counseling, information about the Sliding Fee Discount Program (SFDP), and, when applicable, details on the fee waiver process based on policy guidelines.

Good Faith Estimate (GFE) - A GFE is a list of expected charges for health center services or items before a patient receives them. It is not a bill, and it's only provided to patients who don't have insurance or aren't using insurance to pay for their care. GFEs help patients make informed decisions about their health care.

Balance Billing – Balance billing refers to the practice of out-of-network providers billing patients for the difference between: (1) the provider's billed charges, and (2) the amount collected from the plan or issuer plus the amount collected from the patient in the form of cost sharing (such as a copayment, coinsurance, or amounts paid toward a deductible). This occurs when a patient receives care from TWCCCH, but TWCCCH is not part of the patient's insurance network ("Out-of-Network"), meaning no pre-negotiated rates exist between TWCCCH and the insurance provider. When balance billing occurs, the patient is responsible for covering the difference between the amount paid by their insurance company and the total cost charged by the TWCCCH. This amount is likely more than In-Network costs for the same service and might not count toward a patients annual out-of-pocket limit.

Surprise Billing – An unexpected bill from an out-of-network provider. This includes a specific type of balance billing where a patient receives a balance bill for services from a TWCCCH provider not enrolled in an insurance plan.

POLICY

Patients who do not have insurance or choose to pay out-of-pocket for their care (self-pay patients) are entitled to receive a Good Faith Estimate (GFE) of their expected charges for services provided by the health center. TWCCCH is required to provide this GFE prior to the patient receiving care. TWCCCH is also required to inform the patient at the time of service that a balance bill may apply if TWCCCH does not participate in their insurance plan.

Communication to Patient Prior to Visit:

- **Primary Care (Medical) and Behavioral Health**
 - **Communication of GFE to Patient at the Time of Visit:**
 - At time of visit, the CAA will clarify if the patient has insurance or will be self-pay, including electing not to use their insurance.
 - When the patient is checking in, the CAA informs the patient of their options of the Sliding Fee Discount Program, One Time Sliding fee. The CAA/DAA will also print and hand a copy of the GFE letter to the patient.
 - Depending on the patient's eligibility, based on their income and household size, the CAA/DAA will complete the process for the One-Time Sliding Fee program, the Sliding fee Discount program, and also connect them to a Community Health Worker (CHW).
 - When a patient schedules a visit, the patient notes their insurance or self-pay.
 - When the patient is scheduled 3 days in advance or more, the patient will be mailed a copy of the GFE letter by the CAAs no later than 1 business day after the date of scheduling.
 - When the patient is scheduled at least 10 business days before such item or service is scheduled to be furnished, the GFE must be provided no later than 3 business days after the date of scheduling.
 - When a GFE is requested by an uninsured (or self-pay) individual, the GFE must be provided no later than 3 business days after the date of request.
 - During weekdays (Monday through Friday), a member of the CAAs will run the Electronic Health Record (EHR) DM/HM #3844 report daily (this can be run more often if needed). The report captures patients with self-pay listed anywhere in the insurance and patient's with an upcoming appointment along with following the inclusion criteria.
 - Have Insurance #s 79, 409, or 924
 - Appt upcoming within the next 14 days.

- Report looks for patients whose GFE MED or GFE-MEDSP document is older than the date of their last appointment or who do not have a GFE MED document on file.
 - Once the EHR report is generated the CAAs will export the file to excel.
 - The CAAs will either print the report or work from the spreadsheet.
 - The CAA will go into the patient EHR with either the name or account number, verifying the correct patient identity using 2 patient identifiers.
 - Once in the EHR the CAA will go to documents and click on the + to create a new document, type in “good” and select either the English or Spanish version. (the report states if English or Spanish).
 - Then print and close the document and mail to the patient. Verify address prior to addressing mailing envelope.
 - When the CAA is checking in a patient and does not see a GFE in the EHR or if the patient states they do not have insurance the CAA can print and provide a copy to the patient at the time of the visit.
- **Dental**
 - During weekdays (Monday through Friday), the DAA will run the report and send out the required information sheet to any “SELF-PAY” patients.
 - Within the Dental EHR, the DAA will run the pre-programmed report for patients that are scheduled within the next 14 days to create a GFE letter to be sent out.
 - When the patient is scheduled 3 days in advance or more, the patient will be mailed a copy of the GFE letter by the DAAs no later than 1 business day after the date of scheduling.
 - When the patient is scheduled at least 10 business days before such item or service is scheduled to be furnished, the GFE must be provided no later than 3 business days after the date of scheduling.
 - When a GFE is requested by an uninsured (or self-pay) individual, the GFE must be provided no later than 3 business days after the date of request.
 - The DAA will add the GFE letter and their dental intake forms to complete prior to their appointment.
 - The DAA will add the ‘GFE’ code into the patient ledger when they have sent out the GFE letter or hand it to the patient at the time of check in.

The GFE must include a breakdown of services and corresponding healthcare codes, ensuring the information is accessible to the patient.

As part of its policy, TWCCCH sends a form letter detailing frequently billed services and their associated codes to self-pay patients to comply with these requirements. This task is carried out by the CAA under the supervision of the Practice Manager. If requested, TWCCCH staff will also review the GFE with the patient over the phone or in person. At the time of the visit, if the



patient has not received a GFE letter (as confirmed by the CAA through a review of the EHR), the CAA will provide a copy of the form GFE letter during check-in.

Patients or guarantors may dispute any charges that exceed the GFE by more than \$400. Complaints can also be filed with the U.S. Department of Health and Human Services (HHS).

Annually in the first quarter of the calendar year, the VP, Controller Revenue Cycle provides an updated fee schedule which includes the corresponding healthcare codes and charges to the Deputy Chief Operating Officer for GFE letter update. Similarly, the Director of Dental Operations supplies the Deputy Chief Operating Officer with a list of services and dental codes for dental procedures and items based on the Fee Schedule.

Patients and guarantors may challenge any charge, denial of a Sliding Fee Discount application, denial of a fee waiver or referral to collections in accordance with the Patient Grievance Policy.

PROCEDURE

Refer to Good Faith Medical Estimate SOP
Refer to Good Faith Dental Estimate SOP

REFERENCE

Patient Complaint / Grievance Policy
Standard Operating Procedures for Dental and Primary Care/Behavioral Health
EOS Toolbox
[No Surprises Act | CMS](#)
[Federal Register : Requirements Related to Surprise Billing](#)
[No Surprises Act | Insurance Department | Commonwealth of Pennsylvania](#)
[Decision Tree: Requirements for Good Faith Estimates for Uninsured \(or Self-Pay\) Individuals](#)

Helayna Szescila

Deputy Chief Governance Officer & Assistant Secretary