



January 21, 2022

CMS, Office of Strategic Operations and Regulatory Affairs,
Division of Regulations Development,
Attention: Document Identifier/OMB Control Number: CMS-10791
Room C4-26-05,
7500 Security Boulevard,
Baltimore, Maryland 21244-1850

Submitted online via www.regulations.gov

Re: CMS-10791 Requirements Related to Surprise Billing; Part II Proposed Collection with
Request for Comments (OMB control number: 0938- NEW)

Dear Sir/Madam:

On behalf of the American Association of Oral and Maxillofacial Surgeons (AAOMS), which represents more than 9,000 oral and maxillofacial surgeons (OMSs) in the United States, thank you for the opportunity to comment on the Proposed Collection of Information related to "Requirements Related to Surprise Billing; Part II," as published in the *Federal Register* on January 5, 2022.

OMSs – many of whom are part of small practices – are also an integral part of hospital systems, providing emergency department coverage, serving as essential members of trauma teams throughout the country and performing complex procedures at hospitals. AAOMS supports efforts to prevent patients from being unfairly surprised by an out-of-network bill, while ensuring that providers have the opportunity to be reimbursed at a fair and reasonable rate.

AAOMS remains committed to consumer protection and education, ensuring patients have the tools and resources available to understand the costs of care. We understand that the provision of Good Faith Estimates (GFE) for scheduled or requested services is an integral component of the patient protections against surprise medical bills set forth under the No Surprises Act (NSA); however, AAOMS is concerned that certain requirements outlined in the Interim Final Rule (IFR), specific to the provision of GFEs, the interpretation of a "health care facility," and the patient-provider dispute resolution process for uninsured (or self-pay) individuals, pose great challenges for and represent undue administrative burden to providers, especially those in small group practices.

The provision of GFEs for uninsured (or self-pay) patients presents unique challenges for office-based providers.

First, we would like to thank CMS for delaying the implementation of the provision of GFEs for insured patients beyond January 1, 2022, recognizing the significant administrative and logistical challenges this poses for both providers and insurers. Clearly, it will take time for all relevant stakeholders to come together to create meaningful pathways and protocols to allow for seamless integration of patient care and insurance reimbursement.

Arguably, for those providers who routinely provide services in ambulatory surgical centers (ASCs), hospital outpatient facilities or inpatient hospitals, processes may already exist to generate and communicate treatment costs to uninsured (or self-pay) patients. On the other hand, most OMSs are primarily office-based, functioning within the constraints of smaller practices. These OMSs face unique challenges in providing a GFE for patients being treated outside of the office setting, particularly with respect to the requirement that providers include items and services of co-providers/co-facilities involved in the patient's care.

In the case of nonemergency surgical services, the OMS is often subject to the scheduling constraints and the limited availability of specialty-specific equipment and supplies in facilities in which they have privileges. As such, it is uncommon for ancillary providers (e.g., anesthesiologists, radiologists or hospitalists) associated with an OMS procedure to have their respective procedures predetermined at the time of scheduling.

Similarly, the insurance and network information for ancillary providers are often not communicated to the OMS in advance of the procedure nor are the procedures predetermined. As a result, procedures are often performed prior to predetermination of insurance coverage.

In addition to questions surrounding the accuracy of GFEs in such instances, office-based practices also are not likely staffed to adequately accommodate the increased communication that will be required between facilities and co-providers for the provision of GFEs to uninsured (or self-pay) patients within the restrictive timeframes being implemented.

Also, it is our understanding that GFEs must be provided for scheduled as well as requested services. While AAOMS appreciates the importance of transparency in the cost of health care services, the provision of a GFE in cases in which the provider does not already have an established relationship with the individual requesting it - presumably for purposes of price comparison - places additional burden on the OMS practice and once again calls into question the accuracy with which such an estimate is able to be provided.

AAOMS recognizes the fact that the Department of Health and Human Services (HHS) is cognizant of these considerable challenges and supports the decision to exercise enforcement discretion through December 31, 2022.

A "health care facility" must not include the office-based setting

AAOMS also seeks clarification as to the scope of the requirements for the provision of GFEs, specifically with respect to the "providers" and "facilities" to which the provision pertains. It

has been the general understanding - and a point that AAOMS has previously requested clarification on - that the definition of “health care facility,” as outlined in the IFR, does not include physician and/or dental office-based settings.

Yet, in December 2021, CMS released a set of [Frequently Asked Questions](#) regarding GFEs for uninsured (or self-pay) individuals, prepared by HHS, which maintains that the requirement to provide a GFE for scheduled or requested services pertains to providers of all specialties, facility types and sites of service. The implications are that office-based providers are responsible for providing GFEs to uninsured (or self-pay) patients not only for those procedures performed in ASCs, hospital outpatient facilities or inpatient hospitals, but also for those performed in an office setting, allowing for somewhat ambiguous interpretation of the GFE requirements.

A large percentage of OMS procedures are safely and routinely performed in the office setting. However, site of service differentials between large health care organizations and small group practices includes both economies of scale and staffing limitations. With such constraints as high-volume demand, staff size and quick turnaround times, the provision of GFEs for uninsured (or self-pay) patients for office-based services will be difficult at best.

In summary, small office-based practices generally lack the robust administrative framework necessary to comply with the requirements already in effect regarding the provision of GFEs for uninsured (or self-pay) patients. For physician and dental offices still attempting to navigate the continually evolving health care landscape, such provisions place additional administrative burden on an already strained system. OMS offices battling staffing shortages, physician burnout and steadily decreasing resources are ill-equipped to design and implement novel workflows while striving to maintain clinical best practices and optimal patient outcomes.

The definition of “substantially in excess” will be problematic.

An integral part of the Patient-Provider Dispute Resolution Process, the IFR states that both providers and facilities are required to submit information to select dispute resolution (SDR) entities to allow for informed payment determinations to be made in the event billed charges are deemed “substantially in excess” of the corresponding GFE.

Although the process has implications of furthering the administrative burdens already inherent to the implementation of the NSA, AAOMS supports a standardized and consistent dispute resolution process and agrees that such a process is necessary to ensure increased transparency and prevent surprise medical bills.

From a clinical standpoint, even a straightforward procedure may exceed the base threshold of \$400. Thus, absent a more appropriate threshold amount at which the dispute process may be initiated, this could lead to the routine over-estimation of charges as a way of avoiding the patient-provider dispute resolution process in its entirety. Such practices could have the reverse effect on the perceived cost of care, limiting accessibility and ultimately delaying patient care.

As such, AAOMS strongly encourages HHS to reconsider what is defined as “substantially in excess” of the good faith estimate.

Thank you for your consideration of these comments. Please contact Patricia Serpico, AAOMS Director of Health Policy, Quality & Reimbursement, with any questions at 800-822-6637, ext. 4394 or pserpico@aaoms.org.

Sincerely,

A handwritten signature in black ink that reads "J. David Johnson Jr. DDS". The signature is written in a cursive, flowing style with a large initial 'J' and a distinct 'DDS' at the end.

J. David Johnson Jr., DDS
AAOMS President