MASSACHUSETTS MEDICAL PRICE TRANSPARENCY LAW AND COST ESTIMATE WORKSHEET

Massachusetts physicians, hospitals, and insurers are required by law to provide cost information for procedures and services to patients who request it. This includes the amount for any facility fees required, as well as any cost sharing that the patient will be responsible for paying, such as deductibles, co-insurance, or copayments. Out-of-state carriers are not subject to this law.

The Massachusetts Collaborative* has created a standardized *Cost Estimate Worksheet* to help capture the information necessary to obtain cost estimates for services, procedures, and admissions.

Tips for Providers Using this Form:

- Complete the "servicing provider" section of the form, including the Current Procedural Terminology (CPT) codes for all anticipated services and procedures, and the location where the service will be performed.
- For services that will be taking place at a location other than the physician's office (e.g., hospital, MRI facility, ambulatory surgery center), it may be necessary to assist the patient by directing him or her to the appropriate party that can provide the additional information needed to complete the cost estimate.†
- Respond to the health plans' requests for further information in a timely fashion in order to provide the most accurate estimates possible for your patients.
- Keep a copy of the *Cost Estimate Worksheet* in the patient's medical record.

Tips for Health Plan Members Using this Form:

- Work with your health care provider to complete the *Cost Estimate Worksheet*.
- The information from the completed worksheet will be helpful when you contact your health plan to request a cost estimate or when using your health plan's online cost estimator tools (contact your health plan for more information on cost estimator tools that are available).
- Keep a copy of the *Cost Estimate Worksheet* for your records.

Notes: For many types of services, there are typically separate charges from multiple providers. For example, a surgical procedure may include separate charges for anesthesiology or radiology services. You may need to contact the facility at which the service is being performed to gather additional information. You may also provide the facility contact information and a description of service to your health plan. Your health plan can then help you obtain the necessary information.

The information on the form constitutes protected health information and patient privacy considerations should be taken when sending this form (especially electronically). Information should be sent securely if sending via email to a health plan. Confirmation of fax number before submitting to a health plan is advised.

*The Massachusetts Collaborative is a consortium of payers and providers working to streamline and improve administrative processes.
†Certain services may require prior authorization from the health plan in order to be covered.

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Definitions‡

Allowed amount: The allowed amount is the contractually agreed upon dollar amount typically considered payment-in-full for covered services by an insurance company and its associated network of health care providers. If the patient has any cost sharing due to copayments, co-insurance, or deductibles, that amount will be deducted from the allowed amount paid to the provider. For covered benefits received from non-contracted providers, the insurer pays the allowed amount minus any applicable cost sharing and the patient is responsible for the difference between that amount and the provider's charges.

Codes: Obtaining the following codes from the provider will help the insurer give a more precise cost estimate. In some cases, the provider may not know the actual codes until the procedure is performed.

- **Procedure or CPT Code:** These are standardized, uniform codes used by providers, medical coders, and billers to report medical procedures and services to insurers for reimbursement.
- **Diagnosis or ICD-9 Codes:** These codes identify a patient's health condition or diagnosis. For example, 493.0 is the ICD-9 code for asthma.

Co-insurance: This is a percent of the allowed amount that a patient must pay for a covered service. For example, the health insurance plan may pay 80 percent of the allowed amount, leaving the patient responsible for the remaining 20 percent.

Copayment: A copayment is a fixed dollar amount typically collected when a patient presents at a doctor's office (or another medical facility) for a medical appointment.

Deductible: The deductible is a specific dollar amount that the patient must pay for covered benefits before the insurer begins to pay benefits.

Health care provider: A doctor, hospital, health care professional, or health care facility.

NPI Number: The National Provider Identifier (NPI) is a unique identification number that health care providers must use in all administrative and financial transactions.

Out-of-pocket maximum: This is the most a patient will pay each plan year for health care services. Typically this includes copayments, co-insurance, and deductible amounts.

Example

Jane Smith has to have a nasal/sinus endoscopy. She learns that there will be two charges: one from the doctor performing the procedure and the other from the facility where it is being performed. She completes the cost estimate worksheet with help from her doctor's office, and then contacts her health plan. Jane learns that the maximum allowed amount for the physician doing the procedure will be $703, and the maximum allowed amount for the facility where she is having the procedure would be $800, for a total of $1,503.

Jane has a $1,000 deductible, and will be responsible for paying the first $1,000. Her health plan will pay the remaining $503.

‡Everyone's insurance coverage is different. For specific information on your insurance benefits and applicable cost sharing requirements, check with your insurer.

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COST ESTIMATE WORKSHEET

PATIENT INFORMATION *(TO BE COMPLETED BY PATIENT)*	
First Name:	Date:
Last Name:	Health Plan:
Date of Birth:	
Phone Number:	Member ID Number:
Description of Procedure(s) or Service(s) Requested:	

PROVIDER INFORMATION *(TO BE COMPLETED BY PROVIDER)*			
Servicing Provider Information		**Procedure(s) and Diagnosis**	
Servicing Provider's Full Name:		Please provide all procedure codes and diagnosis codes (if known) for all anticipated services for the treatment requested. *For example: arthroscopic knee repair may also include anesthesia, labs, x-rays as well as other procedures.*	
Provider NPI Number:			
Street:		**Procedure Code(s)**	**Diagnosis Code(s)**
City:	State:	1.	
Phone Number:		2.	
Practice Contact Person:		3.	
Email:		4.	
		5.	
		Date of Service *(if known)*:	

FACILITY INFORMATION *(IF SERVICE IS BEING PERFORMED AT A FACILITY, SUCH AS A HOSPITAL OR FREESTANDING MRI OR LAB FACILITY)*			
Servicing Facility Information *(if applicable)*		**Procedure(s) and Diagnosis**	
Facility Name:		Please provide all procedure codes and diagnosis codes (if known) for all anticipated services for the treatment requested. *For example: arthroscopic knee repair may also include anesthesia, labs, x-rays as well as other procedures.*	
Facility NPI Number:			
Street:		**Procedure Code(s)**	**Diagnosis Code(s)**
City:	State:	1.	
Facility Contact Person:		2.	
Email:		3.	
Phone Number:		4.	
Date of Service *(if known)*:		5.	
		Date of Service *(if known)*:	

Cost Estimate: $
Date Estimate Received:

Disclosure Information: The cost estimates shown on this form are good faith estimates based on the information available at the time the request was submitted. This includes, but is not limited to, information provided on this form to identify proposed services; member eligibility and enrollment status; dollar amounts accumulated towards deductibles and out-of-pocket maximums; and contract arrangements in place. If the proposed services shown on this form do not accurately reflect the services that are ultimately billed, or if any other information has changed between the time of the request and the time of service, the cost estimates shown on this form will no longer be valid. The cost estimates only reflect those services listed on the form and assume that the member has obtained any referral or authorization that may be required. The cost estimates also do not take into account any unforeseen services that may arise out of proposed services. A member's financial responsibility may vary from the cost estimates provided should unforeseen services be received and billed. On an estimate for an inpatient service, the health plan will assume the patient will be discharged home. Note that for many types of services, there are typically separate charges from multiple providers. For example, there may be separate charges from facilities, anesthesiologists, or radiologists. Receipt of an estimate from member's health plan does not guarantee coverage of the proposed services. Coverage is based on member meeting all the rules described in member's Evidence of Coverage (e.g., member must be eligible under the health plan at time of service, and the proposed services must be covered services under the member's specific plan).