No Surprises Act Updates – New Final Rule, CMS Resources and New FAQs

Related Professionals

Chandler Martin
803.540.2161
cmartin@maynardnexsen.com

Practices

Health Care

Article
09.23.2022

On August 19, 2022, the United States Department of Health and Human Services, Department of Labor, and Department of the Treasury (the Departments) published a new final rule (Final Rule) under the federal No Surprises Act, a consumer protection law enacted to help curb surprise billing for medical care. The Final Rule is available here: Final Rule – Requirements Related to Surprise Billing. The provisions of the Final Rule will be effective October 25, 2022.

As a reminder of the broader regulatory context, the new Final Rule follows two interim final rules under the No Surprises Act from July 2021 and October 2021. As outlined in the Centers for Medicare and Medicaid Services "Overview of Rules & Fact Sheets" for the No Surprises Act, the July 2021 interim final rule introduced initial requirements under the No Surprises Act to restrict surprise billing for patients in health plans who get emergency care, non-emergency care from out-of-network providers at in-network facilities, and air ambulance services from out-of-network providers. Specifically, among other things, the patients' cost-sharing amounts for emergency services furnished by nonparticipating facilities or providers, and nonemergency services furnished by nonparticipating providers at certain participating facilities, must be calculated based on the "recognized amount." That amount in many circumstances is determined based on the lesser of the provider's or facility's billed charge or the qualifying payment amount (QPA). The QPA in most cases is the applicable payer's median contracted rate for that item or service, and the payer is required under the No Surprises Act to make certain disclosures and provide certain information about the QPA upon each payment or denial of payment when the QPA is used to determine payment.

The October 2021 interim final rule subsequently provided additional protections against surprise medical bills, including: Establishing an independent dispute resolution (IDR) process to determine out-of-

network payment amounts between providers or facilities and health plans; Requiring good faith estimates of medical items or services for uninsured or self-pay individuals; Providing a defined way to appeal certain health plan decisions; and establishing a patient-provider dispute resolution process for uninsured or self-pay individuals to determine payment amounts due to a provider or facility under certain circumstances.

As an aside, we recommend visiting CMS' above-mentioned Overview of Rules & Fact Sheets for those interested in additional guidance on and help staying up-to-date with the No Surprises Act.

A. August 2022 Final Rule

Following those interim final rules, the recent Final Rule was issued as part of the Departments' continued work to implement and put into effect the No Surprises Act. The Final Rule, according to the Departments, will clarify the process for providers and health insurance companies to resolve their disputes. Toward that end, the Final Rule addresses, among other things, the following under the No Surprises Act:

1. Information To Be Shared About the Qualifying Payment Amount

The July 2021 interim final rule requires insurance plans and issuers to make certain disclosures with each initial payment or notice of denial of payment for items and services covered by the No Surprises Act. When the QPA serves as the recognized amount upon which patient cost-sharing amounts are based, insurance plans and issuers must disclose the QPA and certain information related to the QPA for the item or service involved, as well as certain additional information, upon request of the applicable provider or facility for each item or service involved.

As part of the Final Rule, the Departments require that insurance plans and issuers disclose additional information if they "downcode" a billed claim from a provider or facility. The Final Rule provides a definition for the term "downcode" consistent with the common understanding of the term in healthcare billing and coding. It also requires that if the QPA is based on a downcoded service code or modifier, the insurance plan or issuer must provide the following with its initial payment:

- → a statement that the service code or modifier billed by the provider or facility was downcoded;
- → an explanation of why the claim was downcoded, including a description of which service codes or modifiers were altered, added, or removed, if any; and
- → the amount that would have been the QPA had the service code or modifier not been downcoded.

2. Payment Determinations Under the Federal IDR Process

The October 2021 interim final rule originally required that certified IDR entities, in resolving payment related disputes under the No Surprises Act, must select the offer closest to the QPA, unless the IDR entity determined that any additional credible information submitted by the parties demonstrated that the QPA was materially different from the appropriate out-of-network rate. This requirement was invalidated by federal District Courts prior to the issuance of the Final Rule and, as a result, was removed under the Final Rule.

The Final Rule now provides that IDR entities must consider the QPA and all additional permissible information submitted by each party and must determine which offer best reflects the value of the item or service under dispute to determine the appropriate out-of-network rate. Such additional information may not include information expressly prohibited by No Surprises Act (e.g., reimbursement rates expressed as a proportion of usual and customary charges, amounts that would have been balance billed in the absence of a prohibition on balance billing, and reimbursement rates payable by a government healthcare program). To be considered by the IDR entity, the additional information must also relate to the payment amount offer submitted by either party and must be credible. Additionally, the Final Rule makes clear that the IDR entity should evaluate additional information to avoid double counting information that is already accounted for by the QPA or by any of the other information submitted by the parties. After weighing these considerations, the IDR entities should select the offer that best represents the value of the item or service under dispute.

3. The Certified IDR Entity's Written Payment Decision

The Final Rule also finalizes provisions of the October 2021 interim final rule requiring IDR entities to explain their payment determinations and underlying rationale in a written decision submitted to the parties and the Departments. Specifically, the Final Rule requires that an IDR entity's written decision in a payment dispute include an explanation of the information related to the chosen offer that made the IDR entity determine that such chosen out-of-network rate best represented the value of the item or service. This includes the weight given to the QPA and any additional credible information regarding the relevant factors. If the IDR entity relies on additional information when selecting an offer, the Final Rule requires that the IDR entity's written decision must include an explanation of why it concluded the information was not already reflected in the QPA.

B. Other Updates Under No Surprises Act

In addition to the Final Rule, the Departments also issued on August 19, 2022 new Frequently Asked Questions regarding the No Surprises Act (FAQs). These new FAQs are available here: August 19, 2022 FAQs for the No Surprises Act. These FAQs were jointly developed by the Departments, along with previously issued FAQs, to "answer questions from stakeholders to help people understand the law and promote compliance."

The Departments also issued a "Federal Independent Dispute Resolution Process Status Update" on August 19, 2022 that highlighted the significance of the IDR process under the No Surprises Act. The status update disclosed that between April 15, 2022 (the date the federal IDR portal was launched) and August 11, 2022 disputing parties initiated over 46,000 disputes through the federal IDR portal. With such a staggering number of disputes in such a short period of time, the Departments indicated that the number of disputes during that period "is substantially more than the Departments initially estimated would be submitted for a *full year*." It remains to be seen whether these disputes are all eligible for the IDR process or what factors may be driving such significant volume, but it's clear for now that the IDR process is already very active.