Surprise billing regulations establish procedures to determine out-of-network rates

Rick L. Hindmand | Monday, October 11, 2021

The second interim final rule implementing the No Surprises Act establishes procedures and timeframes for determining out-of-network payment rates, requires healthcare providers and facilities to inquire about an individual's health coverage status and provide good faith cost estimates to uninsured and self-pay patients upon request, and establishes a patient-provider dispute resolution process for uninsured and self-pay patients.

No Surprises Act and Interim Final Rules

The No Surprises Act was enacted in December 2020 on a bipartisan basis to protect patients from surprise medical bills for non-emergency services furnished by out-of-network providers at in-network healthcare facilities, emergency services, and out-of-network air ambulance services. The No Surprises Act also sets the framework for determining payment amounts by the patient and health plan or insurer for out-of-network services, and will require disclosures by nonparticipating providers and their healthcare facilities.

The No Surprises Act will apply to plan and policy years that begin on or after January 1, 2022. Healthcare providers and facilities will be required to comply with the Act starting January 1, 2022.

The Department of Health and Human Services (HHS), the Department of Labor, the Department of the Treasury and the Office of Personnel Management are implementing the No Surprises Act in multiple phases. The first interim final rule, Requirements Related to Surprise Billing; Part I, was issued in July and

sets forth patient surprise billing protections and related obligations of health plans, insurers, healthcare providers and healthcare facilities. The second interim final rule, Requirements Related to Surprise Billing; Part II, was published in the Federal Register on October 7.

This article updates our July blog post to reflect these new regulations.

Providers and facilities subject to surprise billing restrictions and procedures

- Healthcare facilities: hospitals, hospital outpatient departments, critical access hospitals and ambulatory surgical centers
- Independent freestanding emergency departments
- Providers of air ambulance services
- Nonparticipating providers: physicians and other healthcare providers who do not have a direct or indirect contractual relationship with the health plan or insurance carrier with respect to the items or services, and furnish services with respect to a visit at a participating healthcare facility or provide emergency services at a hospital or independent freestanding emergency department.

July 2021 Regulations

The Part I interim final rule (issued in July) sets forth regulations addressing:

- Health plan and insurer obligations to cover emergency and related post-stabilization services, as well as items and services furnished by nonparticipating providers with respect to a visit[1] at a participating healthcare facility.
- Patient protections from balance billing[2] and from cost sharing obligations (e.g., copayments, coinsurance and deductibles) that exceed the in-network cost sharing amounts unless notice and patient consent requirements are satisfied.
- Standards for providing notice and obtaining patient consent to allow balance billing, along with categories of ancillary services for which balance billing will not be permitted even with consent.
- Healthcare provider and facility public and individual disclosure requirements.
- Processes for the filing of complaints of No Surprises Act violations.

Negotiation and Independent Dispute Resolution (IDR) Procedures

An initial issue is whether out-of-network rates will be determined under state law (or All-Payer Model Agreement) or under the No Surprises Act and related regulations. If state law or an applicable All Payer Model Agreement provides a method for determining the out-of-network rate that rate will apply. Otherwise, the out-of-network rates will be determined under the interim final rules, which establish the following timeframes for negotiating and determining out-of-network rates:

Process	Deadline/Timeframe
Initial payment or notice of denial of payment	30 days after submission of clean claim
Either party may initiate 30 business day open negotiation period by written notice	30 business days commencing upon initial payment or notice of denial
Minimum period (suspension	

period) between submission of IDR notices for the same or similar items or services involving the same parties	90 calendar days
Either party may initiate IDR process by written notice	4 business days commencing on the 31st business day after the start of the open negotiation period
Propose, agree or object to proposed IDR entity	3 business days after the IDR initiation
Initiating party notify Secretary of IDR entity selection	1 business day after selection
Initiating party notify Secretary of failure to agree upon selection of IDR entity	4 business days after initiation of IDR process
Department select IDR entity through random selection process (if the parties fail to agree, or if selected IDR entity has a conflict of interest)	6 business days after IDR initiation
Submit payment offer and information to IDR entity	10 business days after selection of IDR entity
Parties can negotiate during IDR process	Until payment determination by IDR entity
IDR entity selection of one of the offers (without modification)	30 business days after the IDR entity is selected
Payment: (out-of-network rate) – (patient cost sharing amount) – (initial payment)	30 business days after IDR entity determines payment amount

Once the IDR process is initiated, the IDR entity must select one of the offers (without modification) within 30 business days after the IDR entity has been selected. The parties are allowed to continue negotiating during the IDR process, and may agree on the out-of-network rate until the IDR entity determines the payment.

In a blow to providers, the regulations establish a presumption in favor of the health plan or insurer's median contracted rate as the out-of-network rate under the IDR process, and so appear likely to subject providers to contracted rates of the health plan or insurer.

The regulations require the IDR entity to select the offer closest to the qualifying payment amount (the health plan or issuer's median contracted rate) unless the IDR entity determines that credible information submitted by one of the parties clearly demonstrates that the qualifying payment amount is materially different from the appropriate out-of-network rate. Moreover, the IDR entity is prohibited from considering usual and customary or billed charges, the amount the provider would have billed in the absence of the No Surprises Act limitations, or the payment rates by public payors, including Medicare, Medicaid, CHIP, and Tricare, for the provider's items or services.

A party initiating the IDR process will be allowed to batch similar items and services into a single IDR proceeding if all of the items or services:

- Are billed by a provider, group of providers or facility with the same National Provider Identification (NPI) or Tax Identification Number (TIN)
- Are payable by the same health plan or issuer
- Are billed under the same service code (e.g., CPT, HCPCS or DRG)
- Are furnished within the same 30 business day period (or, if applicable, within the 90 calendar day suspension period between permitted IDR notices for the same or similar items or services between the parties).

Uninsured patient cost estimates and dispute resolution process

The regulations will protect uninsured and self-pay individuals by requiring "convening"[3] providers and facilities to (i) inquire about an individual's health coverage status in order to determine whether the individual is uninsured or self-pay, (ii) inform all uninsured or self-pay individuals of the availability of a good faith estimate of expected charges, and (iii) provide good faith cost estimates to uninsured and self-pay individuals upon request. In responding to a request the convening provider or facility will be required to contact other providers and facilities who are expected to provide items or services in connection with the primary item or service (referred to as "co-providers" or "co-facilities"), and each co-provider or co-facility will be required to submit good faith estimate information as requested by a convening provider or facility in connection with an individual's request for a cost estimate.

The regulations also establish a patient-provider dispute resolution process for uninsured or self-pay patients who are charged substantially in excess of the estimated amount, and prohibit collection of disputed charges while this process is in place.

Implications and action plans for healthcare providers

With the No Surprises Act taking effect in less than three months (January 1, 2022), healthcare providers who furnish services at healthcare facilities and bill on an out-of-network basis should start preparing to navigate these changes as well as related state law restrictions. Important action steps include:

1. Analyze the likely impact of the No Surprises Act and related regulations on the provider's business model and professional practice, and plan for appropriate adjustments to relationships as well as participation and negotiation strategies.
2. With an eye on compliance, implement policies and procedures to determine when the No Surprises Act is implicated, satisfy disclosure requirements, submit appropriate billing and related information to third party payors, determine appropriate cost sharing amounts, avoid billing the patient for more than the permitted amount, and identify and promptly refund any overpayments.

3. Develop strategies, policies and procedures to identify whether out-of-network rates will be determined under state law or under the No Surprises Act, determine when and how to challenge payment amounts and file for IDR, and manage the tight timeframes for contesting and negotiating payment amounts and for the IDR process.
    - Keep in mind that the initial payment amount could become the de facto out-of-network rate if the provider fails to request negotiation on a timely basis, or if the parties fail to agree upon the payment amount and neither party invokes the IDR process. The interim final rules and the No Surprises Act do not establish any minimum amount for the initial payment, but the regularions express the expectation that the initial payment should be reasonably intended as payment in full based on the relevant facts and the terms of the plan or coverage. The July 2021 interim final rule asked for comment on whether a minimum payment amount should be required and, if so, the payment rate or methodology.
4. Prepare to provide disclosures that will be required commencing January 1, 2022 for all healthcare providers who furnish items or services at healthcare facilities or in connection with visits at healthcare facilities. The July 2021 interim final rule invites healthcare providers and facilities to use model disclosures provided by the agencies in order to satisfy disclosure obligations. In order to lighten overlapping administrative burdens and potential confusion, providers can enter into written agreements with their healthcare facilities so that the facilities can furnish the required disclosures to patients and on signage.
5. Determine whether their services are eligible for balance billing under the notice and patient consent provisions and, if so, the feasibility and desirability of obtaining consent. Keep in mind that a broad range of items and services that fall within the following categories will not be eligible for the consent exception and therefore will not be subject to balance billing:
    - Emergency medicine, anesthesia, pathology, radiology or neonatology
    - Assistant surgeon, hospitalist and intensivist items and services
    - Diagnostic services, including radiology and laboratory services
    - Items or services provided by a nonparticipating provider if there are no participating providers who can furnish the item or services at the facility
    - Items or services that result from unforeseen, urgent medical needs that arise when the item or service is furnished.
6. If a provider intends to balance bill with patient consent, the provider should implement policies and procedures to ensure that the items or services are eligible for the patient consent exception and that No Surprises Act requirements are satisfied, including notice, patient consent, timely notification to the plan or issuer, and retention of the written notice and consent for at least 7 years.
7. Establish policies and procedures to inquire about health coverage status, inform uninsured or self-pay patients of the availability of a good faith estimate of expected charges, and provide cost estimates, and to determine when these obligations apply.
8. If interested in commenting on the second interim final rule, please do so during the comment period that runs through 5 p.m. EST on December 6, 2021.
9. Watch for upcoming regulations implementing more provisions of the No Surprises Act, including price comparison tools and enforcement, or modifying the regulations.

For more information on these regulations, the No Surprises Act or related matters, please contact the attorney below.

[1] The July regulations define "visit" to include items and services furnished at the facility, as well as equipment, devices and telemedicine, imaging, laboratory and preoperative and postoperative services, furnished to an individual at a health care facility, whether or not provided at the facility. The July interim final rule solicited comments regarding other items and services that would be appropriate to include within the scope of a "visit."

[2] "Balance billing" involves out-of-network providers billing patients for the amount by which the provider's billed charges exceed the amounts collected by the provider from the third party payor (e.g, the health plan or insurer) and from patient copayments, coinsurances and deductibles.

[3] The regulations define a "convening" provider or facility as a provider or facility who receives the uninsured or self-pay patient's request for a good faith estimate and is responsible for scheduling the primary item or service.

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