Federal Authorities Clarify Independent Dispute Resolution Process under No Surprises Act

Insights
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A collection of federal agencies recently released final rules regarding the No Surprises Act – the new federal law establishing consumer protections against surprise medical bills. The rules issued by the U.S. Departments of Health and Human Services, Labor, and the Treasury specifically address the required independent dispute resolution (IDR) process of certain claims and expenses. They also finalize prior interim final rules relating to information that group health plans must disclose about the qualifying payment amount (QPA) a plan uses to resolve disputed out-of-network expenses. What are the most significant rules you should be aware of?

Federal IDR Process

The No Surprises Act requires regulators to develop an IDR process to resolve conflicts over out-of-network expenses. If payers and providers cannot resolve their dispute within 30 days, either side may elect binding arbitration. The IDR entity is to consider the QPA, as well as other relevant submitted information, and then select one side's suggested payment amount.

Under interim final rules issued in October 2021, certified IDR entities were to select the offer closest to the QPA unless the certified IDR entity decided that additional credible information submitted by the parties showed the QPA to be materially different from the appropriate out-of-network rate. A federal court vacated this requirement in 2022, so the final rules remove the offending provisions.

The final rules specify that certified IDR entities should select the offer that best represents the value of the item or service under dispute after considering the QPA and all permissible information submitted by the parties. So, certified IDR entities must consider the QPA and then must consider all additional permissible information submitted by each party to determine which offer best reflects the appropriate out-of-network rate. The additional information may not include information prohibited by the statute.

Certified IDR entities should consider whether the information relates to the payment amount offer submitted by either party and whether it is credible. The certified IDR entity also must decide if the information duplicates any information already factored into the QPA. Certified IDR entities then should select the offer best reflecting the value of the item or service under dispute.

The interim final rules require plans and issuers to disclose the QPA for each item or service to providers and facilities with each initial claim payment or notice of denial of payment in any case where the QPA set the relevant cost-sharing amount. Additionally, when a plan or issuer changes a provider or facility's service code to one of lesser value, the plan or issuer must now provide additional information for this "downcode" process.

The final rules state that if a QPA is based on a downcode, the plan or issuer must provide the following with its initial payment or notice of denial:

- a statement that the payer downcoded the service code or modifier billed by the provider, facility, or provider of air ambulance services;
- an explanation of the downcoding, including which, if any, service codes or modifiers were altered, added, or removed; and
- the QPA had the service code or modifier not been downcoded.

The federal agencies believe the foregoing required information is critical to the IDR process and will ensure that providers can develop more appropriate offers during IDR.

Certified IDR Entity Written Determinations

The interim final rules also required certified IDR entities to explain their payment determinations and underlying rationale in writing submitted to the parties and the federal agencies. The final rule provides that the written decision must explain the information the certified IDR used to demonstrate that its selected offer is the out-of-network rate that best represents the value of the item or service. This includes the weight given to the QPA and any other credible information. If the certified IDR entity relies on additional information when selecting an offer, it must explain why it felt the information was not already reflected in the QPA.

Air Ambulance Service Coverage

The FAQs reiterate that the No Surprises Act does not mandate that plans and insurers covering only emergency air ambulance services also cover air ambulance services for non-emergencies like transporting a patient between two facilities. If a plan or insurer covers benefits for air ambulance services, the plan or insurer must cover the services when provided by an out-of-network air ambulance provider.

However, this does not mean that such benefits or services that must be covered. So, if a plan excludes non-emergency air ambulance services, the No Surprises Act does not that requires those services to be covered.

Finally, where the No Surprises Act does apply to air ambulance services, the FAQs state that patients are protected from out-of-network bills from air ambulance companies even with a non-

U.S. pickup point. The federal agencies pledge to provide future guidance as to which geographic region plans should use to determine the QPA in these cases. Until then, plans and insurers must use a reasonable method to determine the geographic region, including by basing the geographic region on the border point of entry to the United States after patient pickup.

Transparency Rules

The No Surprises Act requires plans and issuers to post a notice about patient protections and balance billing requirements on their websites. Plans and insurers must also disclose this information on explanations of benefits for covered items or services. The FAQs confirm group health plan sponsors without their own public health plan website can satisfy this requirement if a TPA or insurer agrees in writing to post the information on its website.

The FAQs also clarify that a group health plan sponsor can satisfy the requirement to post machine-readable files (MRF) if their service provider agrees in writing to post the information on its website on behalf of the plan. If a plan maintains a public website, it must still post a link back to the provider's website.

Plans and insurers must make price comparison information and cost-sharing estimates available through an internet-based self-service tool for 500 specific items and services as of January 1, 2023, and all covered items and services as of January 1, 2024. The federal agencies have stated they will update the list of items and service codes for the already-identified 500 items and services quarterly and provide reasonable time for plans and insurers to update their tools to reflect the current codes.

Conclusion

The final rules intend to further the transparency of how plans and carriers cover out-of-network costs, but it will be a work in progress as to whether and how they achieve the intended results. Federal officials recently reviewed some 45,000 disputes and have based the current guidance in part on this data. The federal agencies announced that they will continue examining payment determinations and will adjust the process through future guidance.

We will continue to monitor the results and related guidance and will provide necessary updates. Make sure you are subscribed to Fisher Phillips' Insight system to get the most up-to-date information. If you have questions, contact your Fisher Phillips attorney, the author of this Insight, or any attorney in our Employee Benefits and Tax Practice Group.

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