

REQUIREMENTS RELATED TO SURPRISE BILLING (CMS-9909-F AND CMS-9908-F)

On Aug. 19, the Departments of Health and Human Services (HHS), Labor, and the Treasury (Departments) issued [final rules](#) related to the No Surprises Act. These rules finalize requirements related to information that group health plans and health insurance issuers offering group or individual health insurance coverage (payers) must disclose. These disclosures apply to:

1. The qualifying payment amount (QPA);
2. How arbiters must consider various factors in making payment determinations through the federal independent dispute resolution (IDR) process; and
3. Information arbiters or IDR entities must include in their written payment determination explanation.

Updated Disclosure Requirements

These final rules address certain disclosure requirements outlined for payers under the July 2021 No Surprises Act interim final rule (see IHA's [summary](#)). Currently, payers must make certain information available to out-of-network providers on how the QPA is calculated, such as the QPA value for each furnished item or service and a statement indicating each QPA was determined in compliance with methodologies specified in regulation. Payers are also required to disclose additional information on how the QPA is calculated upon provider request.

In these final rules, the Departments acknowledge that providers are disadvantaged in negotiations and the IDR process if they do not have information on whether the payer downcoded a claim in calculating the QPA. Therefore, upon initial payment or notice of denial, payers must now communicate:

1. If the claim was downcoded;
2. The rationale for downcoding the claim; and
3. The QPA(s) for the items and services both as originally billed by the provider and as downcoded by the payer.

The Departments define “downcode” as the alteration by a plan or issuer of a service code to another service code, or the alteration, addition, or removal by a plan or issuer of a modifier, if the changed code or modifier is associated with a lower QPA than the service code or modifier billed by the provider, facility, or provider of air ambulance services.

The Departments also note that they, or the applicable state authorities, will be responsible for monitoring the accuracy of payer QPA methodologies via audits.

Payers must report relevant downcoding information for items or services furnished on or after Oct. 25, 2022, for plan years beginning on or after Jan. 1, 2022.

Federal IDR Payment Determinations

By statute, the IDR entity must consider the QPA as well as any additional information or circumstances submitted by either the payer or out-of-network provider. In the Oct. 2021 interim final rule (see IHA's

[summary](#)), IDR entities were instructed to select the submitted offer closest to the QPA unless the certified IDR entity determined that credible information submitted by either party demonstrated that the QPA amount is materially different from the appropriate out-of-network rate.

In this final rule, the Departments revised the IDR payment determination process, instructing IDR entities to select the submitted offer that best represents the value of the item or service under dispute.

In order to determine the best offer, the IDR entity is instructed to consider the QPA and all additional information submitted by either the payer or provider, provided that additional information relates to the party's offer and does not include information that the IDR entity is prohibited from considering (e.g. Medicare reimbursement rates). The Departments also specify that the IDR entity should evaluate whether additional information is credible, and not give weight to any information deemed not credible. The Departments define "credible" as information that upon critical analysis is worthy of belief and is trustworthy.

Additional information to be considered includes information related to the following factors:

1. The level of training, experience, and quality and outcomes measurements of the provider/facility that furnished the qualified IDR item or service;
2. The market share held by the provider/facility or that of the payer in the geographic region in which the qualified IDR item or service was provided;
3. The acuity of the individual receiving the qualified IDR item or service, or the complexity of furnishing the qualified IDR item or service to the individual;
4. The teaching status, case mix, and scope of services of the facility that furnished the qualified IDR item or service, if applicable; and
5. The demonstration of good faith efforts (or lack thereof) made by the provider/facility or the payer to enter into network agreements with each other, and, if applicable, contracted rates between the provider/facility and the payer during the previous four plan years.

The IDR entity must also consider any information it requests from the parties.

IDR entities must follow this process for items or services provided on or after Oct. 25, 2022 for plan years beginning on or after Jan. 1, 2022.

Double-Counting

In addition to the process outlined above, the Departments state that IDR entities should not give weight to additional information that is already accounted for by the QPA in making payment determinations.

For example, the Departments explain that because payers must calculate the QPA using median contracted rates for service codes and applicable modifier, and because service codes and modifiers often reflect patient acuity and service complexity, these factors will often already be reflected in the QPA. In such cases, the IDR entity should not give weight to any additional information submitted by a party on patient acuity or service complexity in determining the appropriate out-of-network payment. Several additional examples of how information might be double-counted are given in the final rules beginning on *Federal Register* page [52629](#).

IDR entities must follow this process for items or services provided on or after Oct. 25, 2022 for plan years beginning on or after Jan. 1, 2022.

Requirements for IDR Written Explanations

Under the Oct. 2021 interim final rule (see IHA's [summary](#)), IDR entities were required to provide a written explanation of their payment determination to the payer, provider, and the Departments. As part

of this written explanation, an IDR entity was to explain what credible information was relied on if it did not select the offer closest to the QPA. The District Court for the Eastern District of Texas vacated this requirement in its Feb. 23, 2022 ruling on *Texas Medical Association, et al. v. United States Department of Health and Human Services, et al.*

In these final rules, the Departments reiterate that they believe it is important for IDR entities to provide a written explanation on all arbitrated cases to the payer, provider, and the Departments. This explanation must include the IDR entity's rationale for its decision, describing the information the IDR entity relied upon in making its determination, including the weight given to the QPA and any additional credible information submitted by the parties. The IDR entity must also explain why it believes any additional information was not already accounted for in the QPA.

IDR entities must provide these written explanations for items or services provided on or after Oct. 25, 2022 for plan years beginning on or after Jan. 1, 2022.

Contact:

Cassie Yarbrough, Senior Director, Medicare Policy
630-276-5516 | cyarbrough@team-iha.org

Sources:

Internal Revenue Service, Dept. of the Treasury; Employee Benefits Security Administration, Dept. of Labor; Centers for Medicare & Medicaid Services, Dept. of Health and Human Services. Requirements Related to Surprise Billing. Aug. 26, 2022. Available from: <https://www.federalregister.gov/documents/2022/08/26/2022-18202/requirements-related-to-surprise-billing>. Accessed Aug. 29, 2022.