Issue Brief

FEDERAL ISSUE BRIEF • August 24, 2022

Final Surprise Billing Rule Being Issued

The Departments of Treasury, Labor and Health and Human Services are issuing a final rule regarding Requirements Related to Surprise Billing. The rule is available on the ***Federal Register*** site at: https://public-inspection.federalregister.gov/2022-18202.pdf. The rule is scheduled for publication on August 26.

The document finalizes certain disclosure requirements relating to information that group health plans, and health insurance issuers offering group or individual health insurance coverage, must share about the qualifying payment amount (QPA) under the interim final rules issued in July 2021.

The document also finalizes select provisions under the October 2021 interim final rules to address certain requirements related to consideration of information when a certified independent dispute resolution (IDR) entity makes a payment determination under the Federal IDR process.

These final rules will be effective 60 days after the date of publication in the ***Federal Register***.

The ***No Surprises Act*** provisions that apply to health care providers, facilities, and providers of air ambulance services, such as prohibitions on balance billing for certain items and services and requirements related to disclosures about balance billing protections, were added to title XXVII of the PHS Act in a new part E.

If a provider, facility, or provider of air ambulance services sends the standard notice of initiation of open negotiation to the email address identified by the plan or issuer in the notice of denial of payment or initial payment, that transmission would satisfy the regulatory requirement to provide notice to the opposing party (so long as the provider, facility, or provider of air ambulance services also sends the notice free of charge in paper form upon request).

The Departments are issuing these final rules to add a definition for the term "downcode" to 26 CFR 54.9816-6, 29 CFR 2590.716-6, and 45 CFR 149.140; and final rules under 26 CFR 54.9816-6(d), 29 CFR 2590.716-6(d), and 45 CFR 149.140(d) to require additional information about the QPA that must be provided with an initial payment or notice of denial of payment, without a provider, facility, or provider of air ambulance services having to make a request for this information, in cases in which the plan or issuer has downcoded the billed claim.

These final rules also specify that, if a QPA is based on a downcoded service code or modifier, in addition to the information already required to be provided with an initial payment or notice of denial of payment, a plan or issuer must provide a statement that the service code or modifier billed by the provider, facility, or provider of air ambulance services was downcoded; an explanation of why the claim was downcoded, including a description of which service codes were altered, if any, and which 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.

These final rules do not require the certified IDR entity to select the offer closest to the QPA. Rather, these final rules specify that

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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.

In determining which offer to select during the Federal IDR process under these final rules, the certified IDR entity must consider the QPA for the applicable year for the same or similar item or service and then must consider all additional information submitted by a party to determine which offer best reflects the appropriate out-of-network rate, provided that the information relates to the party's offer for the payment amount for the qualified IDR item or service that is the subject of the payment determination.

For non-air ambulance items and services, the 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 or facility that furnished the qualified IDR item or service (such as those endorsed by the consensus-based entity authorized in section 1890 of the Social Security Act);
2. the market share held by the provider or facility or that of the plan or issuer in the geographic region in which the qualified IDR item or service was provided;
3. the acuity of the participant, beneficiary, or enrollee receiving the qualified IDR item or service, or the complexity of furnishing the qualified IDR item or service to the participant, beneficiary, or enrollee;
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 or facility or the plan or issuer to enter into network agreements with each other, and, if applicable, contracted rates between the provider or facility, as applicable, and the plan or issuer, as applicable, during the previous 4 plan years.

The rule contains 5 examples to illustrate the consideration of factors when making a payment determination, including whether and how to give weight to additional information submitted by a party.

The process for a certified IDR entity to select an offer in a dispute related to qualified IDR services that are air ambulance services is generally the same as the process applicable to disputes related to qualified IDR items or services that are not air ambulance services.

For air ambulance services, this information includes information related to the following factors:

1. quality and outcomes measurements of the provider that furnished the services;
2. the acuity of the condition of the participant, beneficiary, or enrollee receiving the service, or the complexity of furnishing the service to the participant, beneficiary, or enrollee;
3. training, experience, and quality of the medical personnel that furnished the air ambulance service;
4. ambulance vehicle type, including the clinical capability level of the vehicle;
5. population density of the point of pick-up; and
6. demonstrations of good faith efforts (or lack thereof) by the disputing parties to enter into network agreements with each other, as well as, if applicable, contracted rates between the parties during the previous 4 plan years.

COMMENT

While this rule extends 126-pages, the pertinent material is in the rule's sections II and III – pages 25-48 of the display copy.

Over one-third of the rule is actual regulatory changes.