AAOS
American Association of Orthopaedic Surgeons

Surprise Billing Regulations Part II: What Physicians Need to Know

What? The second part of the regulations implementing the No Surprises Act, which was signed into law at the end of 2020, have been released by the Departments of Health and Human Services, Labor, and Treasury. The agencies have issued guidance in this rule on the mechanics of the independent dispute resolution (IDR) process, the good faith estimate requirements for self-pay/uninsured patients, and the dispute resolution process for self-pay/uninsured patients. The rule follows more than two years of AAOS advocacy to remove patients from the middle of out-of-network billing disputes and ensure that physicians can access an IDR process for resolving payment issues as opposed to a federal rate-setting benchmark.

When? The rules will take effect on January 1, 2022. Hospitals, providers, and insurers will all be required to meet new standards for the disclosure of information regarding a patient's insurance status and estimated cost-sharing for non-emergent care.

How? This Part II regulation builds on the guidance issued in July for emergency and scheduled care. The Departments will be implementing a Federal portal to manage the dispute resolution processes. Read the AAOS summary of the Part I regulation here. In addition, AAOS will be submitting formal comments to the agencies on this rule in November.

Independent Dispute Resolution (IDR) Process

Prior to entering the IDR process, there will be a 30-business day open negotiation period which can be initiated by any party beginning on the day the nonparticipating provider or facility receives an initial payment or notice of denial of payment for an item or service.

If the provider or facility accepts the initial payment as the total payment, that initial payment combined with the cost-sharing amount for the item or service will be deemed the out-of-network rate.

The party wishing to initiate the open negotiation period must provide written notice to the other party of their intent to negotiate—the notice must include the following details: the date the item or service was furnished, the service code, the initial payment amount or notice of denial of payment, and (as applicable) an offer for the out-of-network rate, and contact information of the party sending the open negotiation notice.

If the parties to the open negotiation have not come to an agreement for the out-of-network rate by the last day of the open negotiation period, *then* either party may begin the IDR process. Parties will

have a 4-business-day period beginning on the 31st business day **after** the start of the open negotiation period.

The Federal IDR process will not be permitted if the initiating party knows or should have reasonably known that the provider or facility provided notice and obtained consent from the patient to waive surprise billing protections.

Initiating the IDR Process

As with the open negotiation process, the initiating party must submit notice to the other party as well as a Notice of IDR to the Departments of Health and Human Services, Labor, and Treasury through the newly created Federal IDR Portal online. The initiation date of the IDR process is the date of receipt of the Notice of IDR by the Departments.

The following content elements must be included in the Notice of Initiation:

- Information sufficient to identify the qualified IDR items or services, including whether they are designated as batched items and services, along with the dates and location of the items or services, the type of qualified IDR items or services (emergency services, post-stabilization services, professional services, hospital-based services), corresponding service and place-of-service codes, the amount of cost sharing allowed and the amount of the initial payment made by the plan or issuer for the qualified IDR items or services
- The name and contact information of the parties involved, including email addresses, phone numbers, and mailing addresses
- The state where the qualified IDR items or services were furnished
- The commencement date of the open negotiation period
- The initiating party's preferred certified IDR entity
- An attestation that the items or services are qualified IDR items and services within the scope of the Federal process
- The Qualifying Payment Amount (QPA)
- Information about the QPA as described by law
- General information describing the Federal IDR process

Selection of the IDR Entity

The party that receives the Notice of IDR Initiation has the right to agree or object to the selection of the preferred certified IDR entity identified in the Notice of IDR Initiation.

If that party fails to object within 3 business days of the date of initiation, the preferred certified IDR entity identified will be the selected entity, so long as there is not a conflict of interest.

The initiating party must either agree to or object to the alternative IDR entity.

Negotiation Process

When the parties to the negotiation do not reach an agreement, the IDR entity will select the amount submitted by one of the parties. The amount by which this agreed-upon out-of-network rate exceeds the cost-sharing amount will be considered the total plan or coverage payment.

The plan must pay this amount to the provider or facility no later than 30 business days following the agreement.

When an agreement is reached, the notification to the Departments must include the following content elements:

- The out-of-network rate (the total payment amount inclusive of cost-sharing and total plan payment)
- Signatures from an authorized signatory for each party

Batching Items and Services

If the following conditions are met, multiple claims for IDR items and services may be submitted and considered jointly as part of a single payment determination:

- The qualified IDR items and services must be billed by the same provider or group of providers or facility—they are considered the same if they are billed with the same NPI or TIN
- The payment for the items and services must be the same or similar services—same or similar is defined as those that are billed under the same service code, or a comparable code under a different procedural code system
- All qualified IDR items and services must have been furnished within the same 30-day business period, or the 90-calendar-day suspension period—if the items or services are furnished within the 90-day-calendar suspension period and meet the other requirements, they may be submitted and considered jointly once the suspension has ended

Bundled items and services will be considered as one payment determination by the IDR entity.

IDR Timeline

No later than 10 business days after the selection of the certified IDR entity: Parties must submit offers to the IDR entity. The offer must be expressed as a dollar amount and as a corresponding percentage of the QPA.

When batching items with different QPAs, the parties should provide these along with different offers, as long as the same offer applies for the items and services with the same QPA.

No later than 30 business days after the selection of the certified IDR entity: The IDR entity must select one of the offers submitted by the plan or issuer and the provider or facility to be the out-of-network rate for the qualified IDR item or service.

In selecting an offer, the certified IDR entity must select the offer closest to the QPA unless credible information submitted by the parties clearly demonstrates that the QPA is materially different from the out-of-network rate.

Note: AAOS strongly advocated in the legislative and rulemaking processes for the QPA to be weighted equally with all other factors considered in the IDR process. We are deeply concerned by the prioritization of the QPA as the primary factor and are exploring options for resolving this.

In scenarios where the two offers are equal distance from the QPA but in opposing directions, the IDR entity must select the offer that best represents the value of the items or services.

When plans do not possess sufficient information to calculate their own median contracted rate, they must utilize an independent database that is free of conflicts of interest.

Plans and issuers must provide detailed information to the provider or facility on how the QPA was calculated.

Additional information which may be considered:

- If the plan's contracted rate includes risk-sharing, bonus, penalty, or other incentive-based or retrospective payments that were excluded for the purposes of calculating the QPA, a party will be eligible to provide evidence explaining why the provider or facility's quality or outcome measures support an out-of-network rate that is different from the QPA.
- Credible information about the market share held by the provider or facility or plan in the geographic region where the service was provided
- Credible information about patient acuity or complexity of furnishing the item or service—including evidence of down-coding by the plan
- Credible information about teaching status, case mix, and scope of services
- Demonstrations of good faith efforts by the provider or facility to enter into network agreements, and if applicable, contracted rates between the provider or facility and plan as applicable in the previous 4 plan years

Additional information which may not be considered:

- Usual and customary charges
- The amount that would have been billed had there not be a prohibition on balance billing
- Payment or reimbursement rates from public payors

90 Calendar Day Cooling Off period: Once the IDR entity makes a determination, the party that submitted the initial Notice of IDR is not allowed to submit a subsequent notice involving the same other party with respect to a same or similar service that was the subject of the initial determination

30 Calendar Days After IDR Payment Determination: Plan must make any additional payment, if applicable, of the amount of the offer selected by the IDR entity directly to the provider or facility. If the offer selected by the IDR entity is less than the sum of the initial payment and any cost sharing paid by the patient, the provider or facility will be liable to the plan for the difference and must be paid directly to them no later than 30 calendar days after the determination.

IDR Fees

When the IDR entity is chosen, both parties must pay a $50 administrative fee to the Departments for participation in the process.

When the parties come to an agreement after an IDR entity was selected but prior to when the entity makes a determination, each party must pay half of the IDR entity fee.

Each party is required to pay the entire IDR entity fee (average of $400) at the time the parties provide their offer. Within 30 business days of making the determination, the IDR entity must refund the prevailing party the amount that party submitted. The non-prevailing party is required to pay the IDR fee.

When considering batched determinations, the IDR entity can make different determinations for each item or service. In these cases, the party with the fewest determinations in its favor is deemed the non-prevailing party.

Good Faith Estimate for Self-Pay Patients

If a patient is uninsured or insured but not seeking to have a claim for a specific item or service submitted to their plan or coverage, providers or facilities must inform patients that good faith estimates of expected charges are available. Written notice of this right must be displayed in the provider or facility's office and online.

The convening provider must also verbally inform the patient of the availability of the good faith estimate.

The good faith estimate must include the following content elements:

- Patient name and date of birth

- Description of the primary item or service in clear and understandable language; if applicable—the date the primary item or service is scheduled
- Itemized list of items or services, grouped by each provider or facility, reasonably expected to be provided for the primary item or service, and items or services reasonably expected to be provided in conjunction with the primary item or service, for the period of care including: (1) the items or services reasonably expected to be furnished by the convening provider or facility and (2) the items and services expected to be furnished by co-providers or co-facilities
- Applicable diagnosis codes, expected service codes, and expected charges associated with each listed item or service
- Name, NPI and TIN of each provider or facility represented in the good faith estimate and the state/s and office or facility locations where the items or services are expected to be furnished by such provider or facility
- List of items or services that the convening provider or facility anticipates will require separate scheduling, and that are expected to occur before or following the expected period of care for the primary item or service
- Several disclaimers including: (1) informing patients that a separate good faith estimate with diagnosis and service codes will be issued upon scheduling an appointment (2) informing patients that there may be additional items or services the convening provider or facility will recommend as part of the course of treatment and not reflected in this good faith estimate (3) informing patients that the information provided is only an estimate and that charges may differ (4) informing patients of their right to initiate the patient-provider dispute resolution process (5) informing the patient that the good faith estimate is not a contract

The good faith estimate is also representative of co-providers and co-facilities. As such, they are required to submit good faith estimates that include the following content elements:

- Patient name and date of birth
- Itemized list of items and services expected to be provided by the co-provider or co-facility that are reasonably expected to be furnished with the primary item or service
- Applicable diagnosis codes, expected service codes, and expected charges associated with each listed item or service
- Name, NPI, and TIN of the co-provider or co-facility, along with the state/s and office or facility locations where the items or services are expected to be furnished
- A disclaimer that the good faith estimate is not a contract

Example: "In the instance of a knee surgery, a good faith estimate could include an itemized list of items or services in conjunction with and including the actual knee surgery (such as physician professional fees, assistant surgeon professional fees, anesthesiologist professional fees, facility fees, prescription drugs, and durable medical equipment fees) that occur during the period of care. An individual would not typically schedule days in the hospital post-procedure separately from

scheduling the primary service of a knee surgery. HHS would therefore expect that all the items or services that are reasonably expected to be provided from admission through discharge as part of that scheduled knee surgery, from all physicians, facilities, or providers be included in the good faith estimate… Additionally, in this illustrative example, a provider or facility would furnish separate good faith estimates upon scheduling or upon request for any items or services that are necessary prior to or following provision of the primary item or service beyond the period of care. Examples could include certain pre-operative or post-operative items or services that are not typically scheduled during the period of care for the knee surgery, such as certain laboratory tests or post-discharge physical therapy as discussed earlier."

Enforcement

For good faith estimates provided to self-pay patients from January 1, 2022 to December 31, 2022, HHS will use discretion in the enforcement of good faith estimates that do not include expected charges from co-providers or facilities.

If a patient requests the good faith estimate directly from the co-provider or co-facility, the provider or facility would be required to provide the good faith estimate.

During this period, HHS asks that convening providers or facilities include a range of expected charges to be billed by co-providers or co-facilities.

Patient-Provider Dispute Resolution Process

If a self-pay patient receives a bill for items and services where the total billed charges is in substantial excess (defined as $400) of the total expected charges in the good faith estimate, the patient or their authorized representative may submit an initiation notice to the HHS Secretary through either the Federal IDR portal, electronically, or in paper. Along with the notice, the patient must submit the $25 administrative fee. The notice must include the following content elements:

- Information to identify the items and services under dispute, including the date of service or date the item was provided along with a description of the item or service
- A copy of the bill for the items or services
- A copy of the good faith estimate
- The contact information for the parties involved—name, email address, phone number and mailing address
- The state where the items or services were furnished
- The patient's communication preference

During the time period when the dispute resolution process is pending, the provider or facility is prohibited from moving bills for the disputed charges to collections or should cease collections until after the dispute has been settled. The provider or facility must also suspend the accrual of any late fees on unpaid bills until after the dispute resolution has ended.

Dispute Resolution Timeline

Patients have 120 calendar days to initiate the process once the initial bill is received. Once the request to initiate the patient-provider dispute resolution process has been received by HHS, they will choose a contracted Select Dispute Resolution (SDR) entity to conduct the process.

If the SDR entity determines the claim is eligible for the process, the patient will have 21 calendar days to submit additional evidence should the SDR entity determine the initiation notice is missing information.

No later than 10 business days after receipt of the notice from the SDR initiating the dispute resolution process: The provider or facility must submit the following information to the SDR entity:

- A copy of the good faith estimate provided to the patient
- A copy of the billed charges under dispute
- Documentation demonstrating that the difference between the billed and expected charges reflects the cost of a medically necessary item or service and is based on unforeseen circumstances

During the time while the SDR entity is making a payment determination, the two parties may resolve the dispute by settling on a payment amount. This can happen in three ways: (1) settle through an offer of financial assistance (2) agree to accept a lower amount (3) agree to pay the billed charges in full.

If the parties agree to settle, the provider or facility must notify the SDR entity no later than 3 business days after the date of the agreement. The settlement notice must contain the below information:

- Settlement amount
- Date settlement was reached
- Documentation demonstrating the provider or facility and patient agreed to the settlement
- Documentation showing that the provider or facility has applied a reduction to the patient's settlement amount equal to at least half the amount of the administrative fee paid to the SDR entity

No later than 30 business days after receipt of information by the SDR entity: The entity will make a payment determination on the amount to be paid by the patient.

If the SDR entity determines that the provider or facility has presented credible evidence, the SDR entity must select as the amount to be paid by the patient to be the lesser of: (1) the billed charge or (2) the median payment amount for the same or similar service in the geographic area that is reflected in an independent database.

If the amount in the database is less than the expected charge in the good faith estimate, then the good faith estimate amount will be selected.

State Law Interaction

For states that already implement their own patient-provider dispute resolution process that HHS determines meets or exceeds the minimum Federal standards, then HHS will defer to the state process.