
Update to Administrative Fee for Independent Dispute resolution (page 17).

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INTRODUCTION

Congress passed the No Surprises Act (NSA) in December 2020 as part of the [Consolidated Appropriations Act](#) (page 1577). It is effective as of January 1, 2022 and applies to all health insurance plans and ERISA plans, but not Medicare, Medicaid, and TRICARE. These three plans already outright prohibit balance billing of patients by a healthcare provider. It also does not apply to workers' compensation claims.

The two major parts of the NSA of direct importance to physicians are the balance billing provision and the good faith estimate provision.

Rules providing details on the implementation of the NSA were [published in the Federal Register](#) on July 13, 2021. These rules have been codified in the Code of Federal Regulations at 45 C.F.R. § 149.10 to § 149.450. However, on February 23, 2022, a federal court gutted several pro-insurance industry provisions of the No Surprises Act rules only related to the balance billing arbitration provision. In a lawsuit brought by the Texas Medical Association, the court decided that several rules promulgated by the Biden administration conflicted with the Act. The rules as promulgated gave health insurance plans a considerable advantage in arbitration when an out-of-network provider challenges a low payment by a health plan.

The court's ruling helps level the playing field. The arbitrator now has to consider five different factors instead of just one when deciding what the proper reimbursement should be. Providers will be able to argue to the arbitrator that their reimbursement should be higher than the in-network rate. The ruling is the best scenario outcome for this litigation, which TMA supported financially and by filing an amicus brief through the Physicians Advocacy Institute (which TMA helped create). In August, a second set of rules were [published in the Federal Register](#) addressing the arbitration process.

Regarding balance billing, basically, the NSA prohibits balance billing for the following services unless certain notice and consent requirements are met:

Emergency Services at an Out-Of-Network Facility;
Non-Emergency Services from a Non-Participating Provider at a Participating Facility; and
Air Ambulance Services.

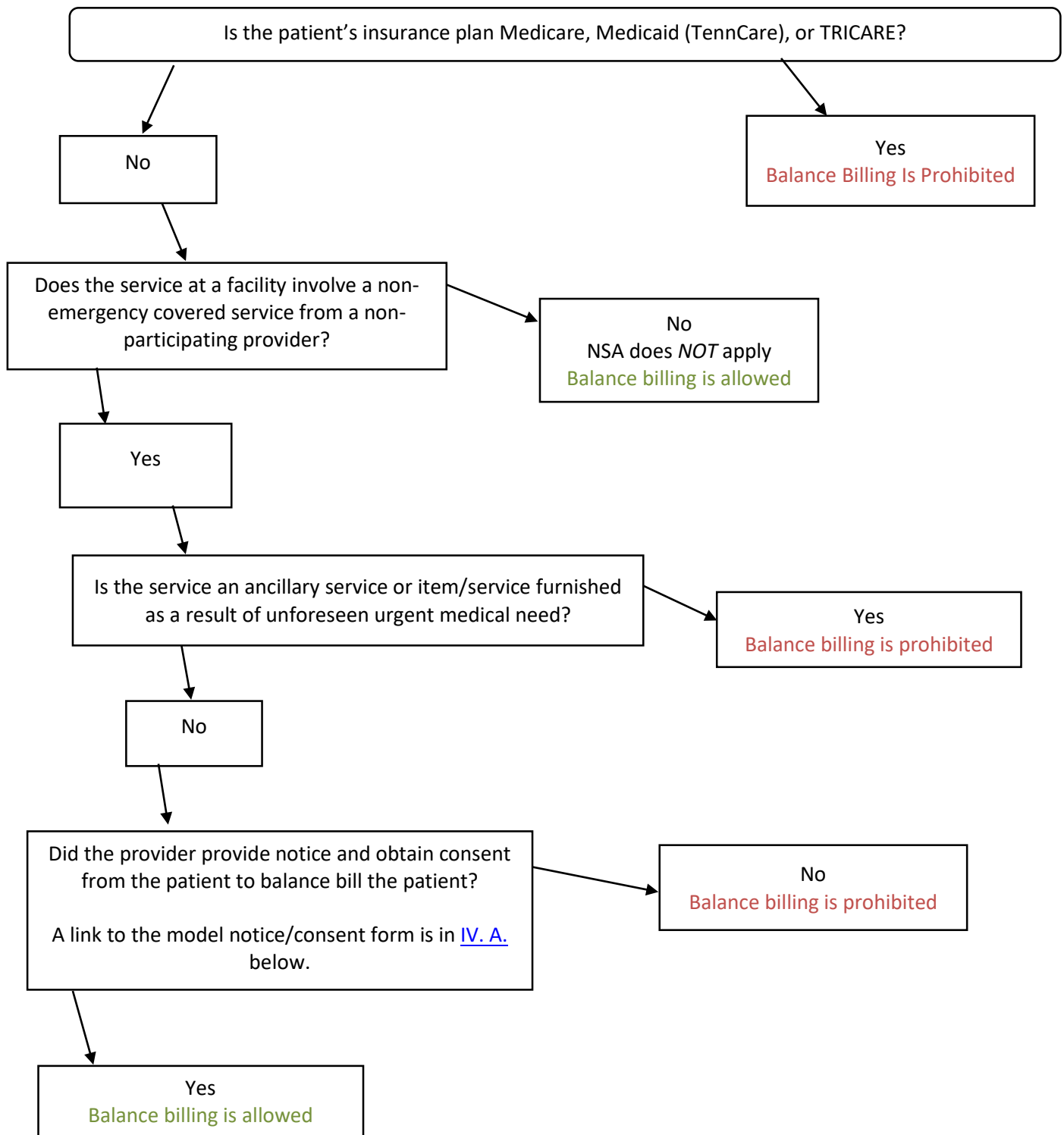
There is currently no Tennessee state law applicable to balance billing. Therefore, Tennessee defers to the NSA regarding balance billing. Until litigation concludes and legislative action, if any, is finalized, this Law Guide topic outlines the major provisions of the NSA currently applicable to physicians. Finally, this topic takes a deeper dive into the first two listed services, but does not address air ambulances.

Regarding the good faith estimate provision, this requires health care providers to furnish most patients with a good faith estimate of the cost of the patient's expected health care services before an appointment or upon request. This Law Guide topic provides some guidance to members as to how they must comply with its provider requirements.



- I. Applicability of the Balance Billing Provisions of the NSA
 - A. The NSA provisions on balance billing apply to services *performed* within a health care facility, such as a hospital. This includes emergency services and ancillary services like anesthesia, imaging, lab work, etc. They do **not** apply to services *performed* in a doctor's office.
 1. Providers are not allowed to balance bill commercially insured patients for emergency services furnished at out-of-network facilities or non-emergency services provided by out-of-network providers at in-network facilities. There are exceptions, which we will explain.
 2. If the provider is dissatisfied with the health plan's reimbursement, the provider may use the independent dispute resolution (IDR) process to try to get a higher payment on a claim from the patient's health plan.
 3. The exception to the balance billing prohibition is if the patient has received notice of their protections against balance billing and has provided consent to be balance billed by the provider. The notice and consent exception does not apply to either:
 - a. Pre-stabilization emergency care; or
 - b. Ancillary services provided in an in-network facility by an out-of-network provider.
 - B. Out-of-network providers can balance bill for services provided in a medical practice office as permitted in their provider agreements with health insurance plans without having to comply with the NSA notice and consent provisions.
 - C. TMA has developed a decision tree flow chart to assist TMA members in determining whether the NSA balance billing provisions apply to emergency services provided at an out-of-network facility, non-emergency services from a non-participating provider at a participating facility, and air ambulance services. See the chart on the next page.
 - D. CMS has [FAQs](#) on the promulgated rules for the No Surprises Act.





II. Balance Billing for Emergency Services Furnished at an Out-of-Network Facility

- A. NSA surprise billing protections apply if the patient’s health insurance plan covers services provided at an emergency department and the patient goes to an out-of-network (OON) emergency room.¹ A prior authorization is not required.²
- B. This section addresses the NSA’s applicability to covered emergency services provided at an out-of-network emergency department as well as post-stabilization services.
- C. Balance Billing for Emergency Services Performed at an Out of Network Facility
 - 1. The NSA balance billing requirements for emergency services apply to services provided in a hospital emergency department but also to emergency services provided in other settings such as a labor and delivery unit, critical access hospital, freestanding emergency department, and ambulatory surgery center. See also the section on Post Stabilization Services in II.B below.
 - 2. A health insurance plan cannot require a health care provider to obtain a prior authorization for covered emergency services delivered in an emergency facility.
 - 3. The cost-sharing for a patient receiving covered emergency services at an out-of-network facility must not be greater than if the service was provided by a participating (PAR or in-network) provider or facility.
 - 4. Any cost-sharing payment by the patient must be counted toward any in-network deductible or out-of-pocket maximums.³
 - 5. The emergency services provision of the NSA ends after post-stabilization.
- D. Post Stabilization Services
 - 1. Post-stabilization services are considered emergency services and subject to the protections of the NSA unless all of the following conditions are met:
 - a. The emergency or treating provider determines that the patient may travel via nonmedical or nonemergency medical means to an available participating provider/facility.
 - b. The provider/facility must be within a reasonable distance, considering the patient’s medical condition.

¹ [45 CFR § 149.410](#)

² [45 CFR § 149.410 \(b\)\(1\)](#)

³ [45 CFR § 149.410](#) & [45 CFR § 149.110](#)



- c. The treating provider is a physician or health care provider who has evaluated the patient.
 - d. The provider's decision on travel is binding on the facility. The provider must inform the patient who can travel on their own if there is an in-network facility available that can take care of them that would not balance bill them. If the patient chooses to stay, they can sign a waiver and be balance billed.
 - e. The provider should consider patient's transportation options when making the decision.
 - i. Can patient pay for their own transportation?
 - ii. Does patient have a car or someone to drive him/her?
 - iii. If public transit is available, does the patient's medical condition make this travel type acceptable?
 - f. The provider/facility furnishing post-stabilization services must satisfy the notice and consent requirements discussed in Section IV of this Law Guide below.
 - g. The patient or his/her representative must be in a condition to receive the notice and provide informed consent.
 - h. Conditions/requirements of state law must be met.
 - i. Tennessee does have laws and regulations regarding the transfer of hospital inpatients.
 - ii. There is also an interplay with EMTALA to consider in situations, for example, as to when to inquire about the patient's insurance.
 - iii. Consult with the hospital where the patient is located regarding any transfer requirements that must be met to comply with Tennessee law and rules.⁴
- E. CMS has [FAQs](#) on the promulgated rules for the No Surprises Act.
- F. Patient Notice to Balance Bill for Emergency (and post-stabilization) services are discussed in Section IV below.
- III. Balance Billing for Non-Emergency Services from a Non-Participating Provider at a Participating Facility
- A. If a health insurance plan covers a non-emergency item/service and the covered item/service is provided in a participating facility by a nonparticipating provider, the surprise billing prohibition applies unless the provider or facility satisfy certain notice and consent requirements.⁵

⁴ T.C.A. § 68-11-702, Rule 1200-08-01-.05, 1200-08-30-.04

⁵ [45 C.F.R. § 149.420](#)



B. The following services are always subject to the balance billing prohibitions:

1. Ancillary services:

- a. Items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a physician or non-physician practitioner;
- b. Items and services provided by assistant surgeons, hospitalists, and intensivists;
- c. Diagnostic services, including radiology and laboratory services; and
- d. Items and services provided by a nonparticipating provider if there is no participating provider who can furnish such item or service at such facility.

2. Items or services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished, regardless of whether the nonparticipating provider satisfied the notice and consent criteria.⁶

C. To waive the balance billing protections (and be able to legally balance bill the patient), the non-participating provider must provide the patient a written notice in paper or electronic form (as selected by the patient).

1. CMS has created a model notice and consent form that may be accessed by clicking [here](#).
2. More on the notice and consent requirements is provided in IV. immediately below.

IV. Notice and Consent Requirements for Services at an Out of Network Emergency Department and Non-Emergency Services from a Non-Participating Provider at a Participating Facility

A. A federal rule details the information that must be included in the notice and consent and a standard notice and consent document has been developed. [Click here](#) to access the form on CMS' website and in the Downloads section click on CMS-10780. This downloads a zip file of pdfs and the consent form is titled *CMS-10780 – Standard Notice and Consent.pdf*.

B. The notice must explain that the patient can be billed for out-of-network services. Notice is due to the patient before the provider seeks payment from the patient.

C. The hospital or facility can provide notice to the patient if it has an agreement to do so with the provider of out-of-network services in a facility.

D. If the out of network provider does *not* have an agreement with the facility for the facility to provide the notice to the patient, the work-around is for the provider to mail the notice *before*

⁶ [45 C.F.R. § 149.420](#) (b)



submitting a bill for out-of-network services.

E. Notice and Consent Requirements

1. Services at an out of network emergency facility and non-emergency services from a non-participating provider at a participating facility may only be balance billed for any amount exceeding the patient's cost-sharing requirement for an item/service when the non-participating provider has provided notice and obtained the consent of the patient/patient's representative.

2. The following notice and consent requirements must be met:

a. The notice and consent are provided per HHS guidance. A federal rule details the information that must be included in the notice and consent and a model standard notice and consent document has been developed.

i. [Click here](#) to access the form on CMS' website and in the *Downloads* section click on CMS-10780. This downloads a zip file of pdfs and the consent form is titled *CMS-10780 – Standard Notice and Consent.pdf*.

TMA note: TMA strongly recommends that providers use the CMS model form because notice and consent are presumed to be compliant if the properly completed form is used.

b. The notice and consent are physically separate from other documents and not attached to or in any other document; and

c. In non-emergency situations, the notice and consent are given to the patient/authorized representative:

i. At least 72 hours before the appointment if scheduled at least 72 hours before the provision of the item/service; or

ii. On the date of appointment when it is scheduled less than 72 hours before the provision of the item/service. The notice/consent must be provided at least three hours before the item/service is delivered to the patient.⁷

TMA note: TMA realizes this provision is an operational nightmare for practices and patients. If you encounter any requirements that impede or delay patient care, TMA encourages you and your patients to share these concerns with your federal legislators.

d. A facility is allowed to provide notice and obtain consent on behalf of the provider. Providers must make formal arrangements with their hospitals to do so.

⁷ [45 C.F.R. § 149.420](#) (c)



- e. The non-participating provider (or participating facility on behalf of the provider) must provide the patient with the choice to receive the written notice and consent document in any of the 15 most common languages in the State in which the facility is located, except that the notice and consent document may instead be available in any of the 15 most common languages in a geographic region that reasonably reflects the geographic region served by the applicable facility.
 - i. If the patient's preferred language is not among the 15 most common languages and the patient cannot understand the language in which the notice and consent document are provided, the notice and consent criteria are not met unless the non-participating provider (or the participating facility on behalf of the provider) has obtained the services of a qualified interpreter to assist the individual with understanding the information contained in the notice and consent document.
3. An executed notice and consent must be retained for seven years after the date on which the item/service is furnished.
4. For each item/service furnished by a nonparticipating provider, the patient's health insurer must receive timely notification that it was provided during a visit to a participating facility and provide a copy of the consent document, when applicable.⁸ When the nonparticipating provider bills the patient directly, the timely notification requirement may be satisfied by sending the consent with the bill to the patient.

V. Balance Billing Protections Notice to Patients

A. Display of Notice

1. The rules require the NSA Notice to be "on a sign posted prominently at the location of the provider or facility." A provider that does not have a publicly accessible location [e.g., clinical laboratory] is not required to post any signage.⁹
2. The rules also require that the NSA Notice must be linked on the searchable home page of their websites, if they have a website.

B. Delivery of the Notice to Patients¹⁰

1. The NSA Notice must be delivered in person or through mail or e-mail (as selected by the patient) no later than the date on which the provider or facility requests payment from the individual or, if the facility or provider does not request payment from the patient, the date on which the facility or provider submits a claim to the patient's health insurance.

⁸ [45 C.F.R. § 149.420](#) (i)

⁹ [45 C.F.R. § 149.430](#) (c)

¹⁰ [45 C.F.R. § 149.430](#)



2. Again, if the out-of-network provider has an agreement with a facility to provide notice to the patient, the provider does not need to duplicate delivery of the notice.

C. Format of Notice

1. Provide a one-page (double-sided) notice in no smaller than a 12-point font.¹¹
2. It must be available in the 15 most common languages in Tennessee or in the geographic region served by the provider.
 - a. If the patient's preferred language is not one of the 15, the provider or facility must obtain the services of a qualified interpreter to assist the patient.
3. A model form is available from CMS and the Department of Labor. While it only mentions insurance plans in the introduction, it complies with the requirement for a provider regarding this notification. [Click here](#) to access and scroll down to *Model Notice under Requirements Related to Surprise Billing, Part I*.

VI. Out-of-Network Reimbursement Rate and Coverage

- A. The NSA places limits on the coverage of out-of-network service by health insurance plans, the patient's responsibility for an out-of-network bill, and initial provider reimbursement. The [chart below](#) after subsection D.5. goes through the allowances by the NSA and discusses each element of payment.
- B. Tennessee law does not address payment issues for balance billing. Thus, those issues defer to the NSA.
- C. Patient's Responsibility
 1. The patient's cost-sharing amount is based on the qualifying payment amount (QPA). QPA is defined as the median of the contracted rates for an item or service recognized by the health insurance plan or issuer on January 31, 2019, for the same or similar item or service furnished by a provider in the same or similar specialty in a specific geographic region, adjusted annually for inflation.
 - a. For dates of service in calendar year 2022, increase adjustment to the 2019 median contracted rate is 1.0648523983.
 - b. Basically, the median contracted rate is calculated by arranging in order from least to greatest the contracted rates of all plans of the plan sponsor or all coverage offered by the issuer in the same insurance market.

¹¹ [45 C.F.R. § 149.430](#) (c)



D. Provider’s Reimbursement and Balance Billing

1. It is up to the patient’s insurer to give the billing provider the QPA so the provider can calculate the patient’s cost-sharing amount.
TMA note: Unfortunately, the law does not provide for an independent mechanism by which to verify that the health plan’s representation of the QPA is accurate. Providers must essentially take the plan’s word for it. The only verification tool included in the rules is audits. The rules do not address whether the audits will be random and/or based on complaints.
2. Once a claim is filed, the health plan must furnish the provider with an initial payment or notice of denial within 30 business days of a claim being submitted.
3. The health plan’s initial payment to the provider does not have to be based on the QPA; the plan has sole discretion regarding the amount of the initial payment.
4. If the provider is not satisfied with the amount of the health plan’s initial payment, the provider can notify the plan within 30 business days of receipt of the payment that the provider wants to initiate a 30-business-day open negotiation period in order to attempt to negotiate a higher payment.
5. If the health plan and provider do not arrive at an agreed payment, the provider can take the dispute to an independent dispute resolution (IDR) process described below in [Section VII](#) of this Law Guide.

	Patient Receives Services From:	
	Emergency Services at a Non-Par¹² Emergency Room and/or Non-Par Provider¹³	Non-Emergency Services from a Non-Par Provider at a Par¹⁴ Facility¹⁵
Coverage by Health Insurer & Coverage Limitations	<p>May <i>not</i> be more restrictive than those for a participating ER or ER provider.</p> <p>May not limit what constitutes an emergency medical condition solely on the basis of diagnosis codes.</p>	<p>Insurer must cover the services unless the provider gives notice to the patient & receives consent from the patient.</p>

¹² Non-Par: Non-Participating

¹³ [45 C.F.R. § 149.110](#)

¹⁴ Par: Participating

¹⁵ [45 C.F.R. § 149.120](#)



	Patient Receives Services From:	
	Emergency Services at a Non-Par ¹² Emergency Room and/or Non-Par Provider ¹³	Non-Emergency Services from a Non-Par Provider at a Par ¹⁴ Facility ¹⁵
Item/Service Coverage Determination by Health Insurer	<p>Not later than 30 calendar days after the claim is submitted by the provider or facility, the health insurer must determine whether the items/services are:</p> <ul style="list-style-type: none"> - Covered by the plan; and - If covered, send the provider/facility an initial payment or denial. <p>The 30-day count begins the date the necessary information is received by the insurer.</p>	
Payment to Non-Par Provider by Health Insurer	<p>Health insurer must pay the non-par provider/facility the amount by which the out-of-network rate exceeds the patient's cost-sharing amount less the initial payment mentioned directly above.</p> <p>Out-of-Network Rate Determined by Insurer <u>Less Patient Cost-Sharing</u> <i>Equals</i> Payment to Non-Par Provider</p> <p>(If a non-par provider disagrees, then negotiation with insurer takes place, and if non-par provider still disagrees then independent dispute resolution is the option)</p>	
Prior Authorization	Insurer must cover ER services without a prior authorization.	Prior authorization is allowed.
Patient Cost-Sharing Calculation	May <i>not</i> be greater than the amount the patient would be responsible for to a par facility/provider.	Must calculate cost-sharing as if the total amount that would have been



	Patient Receives Services From:	
	Emergency Services at a Non-Par ¹² Emergency Room and/or Non-Par Provider ¹³	Non-Emergency Services from a Non-Par Provider at a Par ¹⁴ Facility ¹⁵
		charged by a par provider were equal to the recognized amount (RA) ¹⁶ .
	Must be calculated based on one of the following amounts: <ul style="list-style-type: none"> • An amount determined by an All-Payer Model Agreement (Tennessee does not have one); • An amount determined under a specified state law (Tennessee does not have any); or • The lesser of either the billed charge or the qualifying payment amount, which is generally the insurer’s median contracted rate.¹⁷ 	
Patient Deductible and Out-of-Pocket Maximum	Any cost-sharing payment made by a patient must count toward any deductible or out-of-pocket maximum.	

VII. Denial of Payment by Insurer and Initiation of Independent Dispute Resolution Process

A. Notice of Denial or Payment by Insurance Plan

1. When a plan receives the information necessary to process the claim from a healthcare provider, it has 30 calendar days to¹⁸ determine if the item/service is covered or not covered.
2. If covered, the insurance plan makes an initial payment to the provider.
3. If not covered, the insurance plan issues a notice of denial to the healthcare provider that includes the reason for the denial.¹⁹
4. If the dispute is over a downcoded claim, the health insurance plan must provide:

¹⁶ Recognized Amount: When there is no applicable All-Payer Model Agreement (APMA) or specified state law (Tennessee does not have either one), this is the *lesser* of the amount billed by the provider/facility or the Qualifying Payment Amount (QPA).

The QPA is the *lesser* of the billed charge or the insurer’s median contracted rate.

¹⁷ CMS Fact Sheet: [Requirements Related to Surprise Billing; Part I Interim Final Rule with Comment Period](#)

¹⁸ [45 CFR § 149.120 \(c\)](#) & [45 CFR § 149.110 \(b\)\(iv\)](#)

¹⁹ [45 CFR § 149.30](#) (Definition of Notice of Denial of Payment)



- a. Information on what the QPA would have been had the claim not been downcoded as well as what it determines the QPA for the amount that would have been the QPA had the service code or modifier not been downcoded. This information should be furnished with the plan's initial payment or notice of denial of payment.
 - b. A statement that the service code or modifier billed by the provider, facility, or provider of air ambulance services was downcoded;
 - c. 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.
 - i. "Downcode," is defined 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.
- B. Open Negotiation Period²⁰
1. A health care provider may initiate a 30-day open negotiation period when he/she believes a payment is too low or the claim should not have been denied. The 30-day period begins on the day of receipt of notification of a payment/denial.
 2. The initiating party must send a notice containing specific information on a [standard form created by the HHS Secretary](#). The notice may be sent electronically (i.e., e-mail) if the party sending it has a good faith belief that the method is readily accessible by the other party and the notice is provided in paper form free of charge upon request.
 3. The rules published in August 2022 note that some health plans require nonparticipating providers to use the health plan's web system portal to initiate the open negotiation period. However, the rules require the health insurance company to provide a telephone number and email address for providers to use to initiate the open negotiation period. If the provider sends the notice of initiation of the open negotiation period to the email address identified by the plan in the notice of denial of payment or initial payment, that transmission would satisfy the regulatory requirement. *[TMA note: TMA advises that providers wishing to initiate the open negotiation period do so by utilizing either the phone number or email address designated by the insurance company. If the insurance company does not provide either a phone number or email address, use the portal but lodge a complaint with the company for not complying with the rules. TMA does not want its members tripped up by allowing the insurance company to claim an open negotiation period was improperly requested by the provider.]*

²⁰ [45 CFR § 149.510 \(b\)](#)

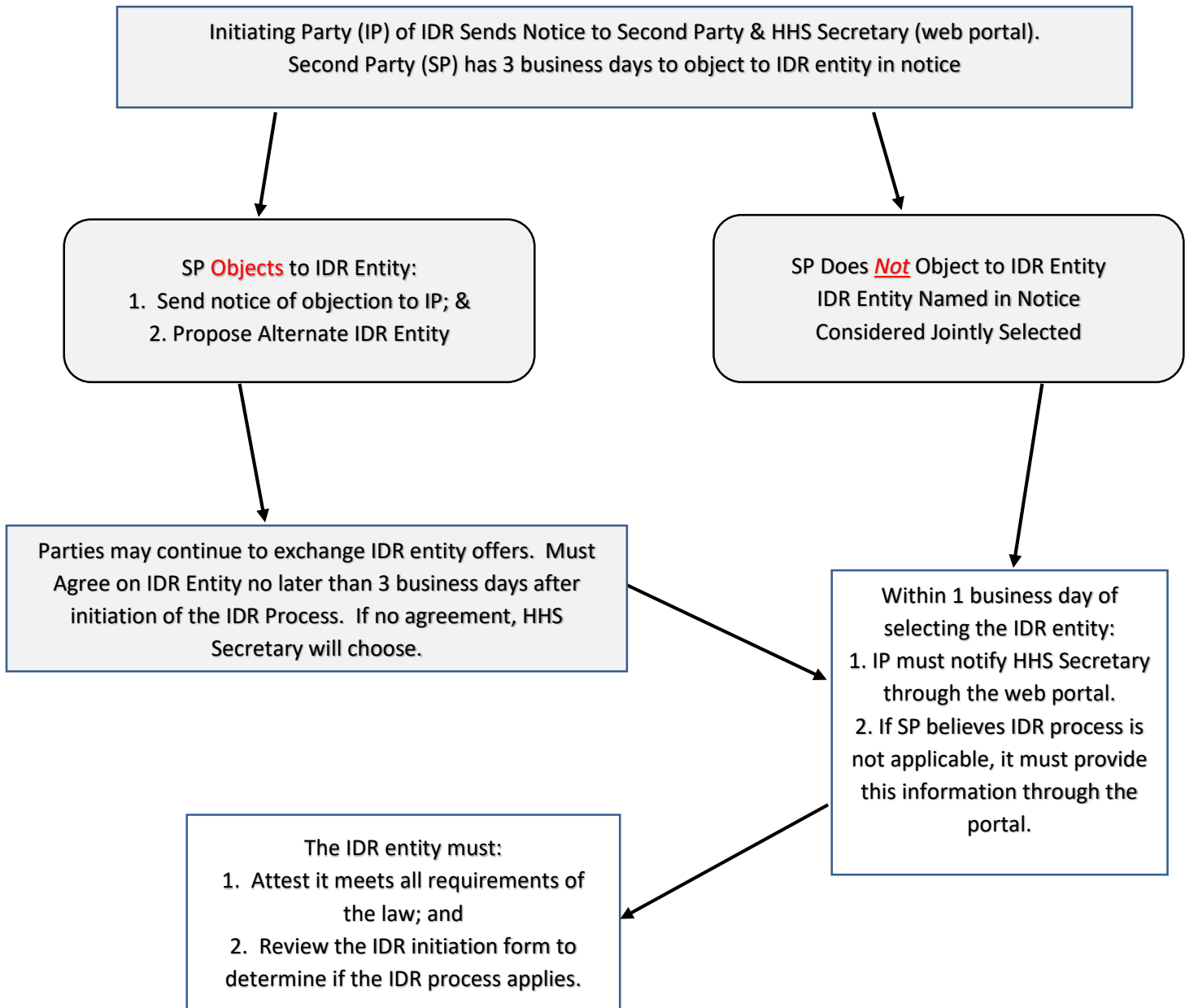


4. If the health care provider and the health insurance company agree on a payment amount during the 30-day open negotiating period, that is the end of the process.
 5. If the parties do *not* agree on a payment by the last day of this negotiation period, either party may initiate the Independent Dispute Resolution (IDR) process.
- C. Independent Dispute Resolution (IDR) Process Initiation²¹
1. Either party to the open negotiation may initiate the IDR process by submitting a written notice on the [standard form developed by the HHS Secretary](#). The form must be sent by the Initiating Party (IP) to the Second Party (SP) *and* to the HHS Secretary. The notice to the HHS Secretary must be submitted through the [Federal IDR portal](#).
 2. The form **must be sent during the four-business days after the 30-day negotiation period ends**. The initiation date of IDR will be the date of receipt by the HHS Secretary.
 3. The notice to the SP of the IDR may be sent electronically (i.e., e-mail) if the party sending it has a good faith belief that the method is readily accessible by the other party and the notice is provided in paper form free of charge, upon request.
- D. The federal government provides and IDR guidance that disputing parties may consult. The guidance provides information on how the disputing parties engage in open negotiation prior to the Federal IDR Process, initiate the Federal IDR Process, select a certified IDR entity, and meet the requirements of the Federal IDR Process.
1. [IDR Process Guidance for Disputing Parties](#) - services provided before 10/25/2022
 2. [IDR Guidance for Disputing Parties](#) – services provided on and after 10/25/2022
- E. Selection of the IDR Entity²²
1. The process followed is shown in the flow chart beginning on the next page.

²¹ [45 CFR § 149.510](#)

²² [45 C.F.R. § 149.510 \(c\)](#)





F. IDR Entity Selected

1. Once the Independent Dispute Resolution (IDR) entity is selected it must review the information in the notice of the IDR Initiation and determine if the Federal IDR process applies. If it does not apply, the IDR entity must notify the Secretary, the physician, and the insurance plan within 3 business days of making that determination.
2. IDR may also occur between a patient and a physician. Additional information may be found by [clicking here](#) and choosing *Providers: payment resolution with patients* on the left side of the page under *Policies & Resources*. This Law Guide topic discusses IDR between a physician and an insurance plan only.
3. After selection of the IDR entity, the physician and the insurance plan may continue to negotiate on the out-of-network rate until the IDR entity makes a determination.
 - a. If both agree on the rate, the Initiating Party (IP) of the IDR must notify the Secretary of Health and Human Services and the IDR entity through the IDR portal within 3 business days of the agreement.²³
 - b. If the agreed upon rate exceeds the initial payment amount or any cost sharing paid, payment must be made by the health plan to the physician no later than 30 business days after the agreement is reached.²⁴
 - c. The IDR entity must return half of each parties' fee, but not the administrative fee.²⁵

G. IDR Fees

1. **TMA Comment: The fee in 2. below is only effective until 1/19/2024. Beginning on 1/20/2024, the fee in 3. will be effective.**
2. A court decision²⁶ on August 3, 2023 vacated the 2023 \$350 administrative fee discussed in 2. below.
 - a. The court decision reverts the administrative fee to \$50 for any dispute initiated beginning August 3, 2023.
 - b. [Click here](#) to access an FAQ document discussing the administrative fee change from the U.S. Department of Health and Human Services.

²³ [45 CFR § 149.510 \(c\)\(1\)\(v\)](#)

²⁴ [45 CFR § 149.510 \(c\)\(2\)\(i\)](#)

²⁵ [45 CFR § 149.510 \(c\)\(2\)\(ii\)](#)

²⁶ [Texas Medical Association v. United States Department of Health and Human Services](#), Case No. 6:23-cv-59-JDK (TMA IV).



3. In a [December 2023 rule](#), CMS updated the administrative and IDR fees for 2024.
 - a. The administrative fee that each party must pay is \$115.
 - b. The estimate for a single IDR determination will be within the range of \$200-\$840. For a batched IDR, the fee will be within \$268-\$1,173.

H. IDR Process

1. The health insurance plan and the physician must submit information to the IDR entity within 10 business days of the selection of the IDR entity. Click [here](#) and scroll down to (c)(4)(i) to review the list of items that must be submitted.²⁷
 - a. CMS updated the Notice of Offer web form in the Federal IDR Portal on 10/18/22. This form should make submitting final offers for payments and other required information easier to submit.²⁸
 - b. Beginning 10/19/22 all new disputes will receive a web link from the selected IDR entity to submit the Notice of Offer form through the portal after confirmation of eligibility for the IDR process.
2. The IDR entity must select either the offer submitted by the health plan or the offer submitted by the physician within 30 business days after selection of the IDR entity.²⁹ There are many considerations the IDR entity must review before choosing from the submitted offers.
 - a. The federal IDR rule required the IDR entity to select the offer **closest** to the qualifying payment amount (QPA) *unless* it was determined that credible information submitted by either party clearly demonstrates that the QPA is materially different from the appropriate out-of-network rate.³⁰ However, based on a recent federal court decision, QPA is only one of a number of factors that the dispute entity must consider. The “material difference” was struck. The final rules did away with this requirement. *TMA strategy note: In IDR, do not let the health plan get away with claiming that the IDR entity must choose the offer closest to the QPA. The courts and now the final rules struck that requirement. 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.*

²⁷ [45 CFR § 149.510 \(c\)\(4\)](#)

²⁸ [Independent Dispute Resolution \(IDR\) Notice of Initiation Web Form Job Aid \(Updated October 19, 2022\)](#), CMS website

²⁹ [45 CFR § 149.510 \(c\)\(4\)\(ii\)](#)

³⁰ [45 CFR § 149.510 \(c\)\(4\)\(ii\)\(A\)](#)



- b. The QPA is generally the median of a plan’s contracted rates for the service/item and is calculated by the plan.
- c. Besides the QPA, the rules specify the IDR entity is required to consider:
 - i. 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);
 - ii. 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;
 - iii. 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. *TMA strategy note: It might be beneficial to note any patient specific comorbidities that had to be taken into consideration when treating the patient, thereby making the encounter more complex.*
 - iv. The teaching status, case mix, and scope of services of the facility that furnished the qualified IDR item or service, if applicable; and
 - v. 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.
 - vi. Information related to the offer provided in response to a request from the certified IDR entity.
 - vii. *TMA strategy note: Your best arguments are those based on factors not already accounted for in the calculation of the QPA. Be prepared for arguments made by the plan that the QPA takes into account one or more of these factors. Make the plan present evidence to that effect; don’t allow the IDR entity to just take the payer’s word for it.*
 - viii. *TMA note: In preparation for your IDR, the section addressing “Examples Provided” starting on page 106/146 of the rules is a good read. It provides examples that give insight as to how to present a winning IDR.*



- d. The IDR entity cannot consider:
 - i. The usual and customary charges (including payment or reimbursement rates expressed as a proportion of usual and customary charges);
 - ii. The amount that would have been billed by the provider with respect to the qualified IDR item or service had the balance billing provisions of 45 CFR 149.410, 149.420, and 149.440 (as applicable) not applied; or
 - iii. The payment or reimbursement rate for items and services furnished by the provider payable by a public payor (like TennCare or Medicare).
 - (A) Footnote 39 of the rules specifies that it is permissible to submit information based on a percentage of Medicare if that is what a provider's contracted rates are based on.
3. Batched claims/services may be submitted and considered jointly as one payment by the IDR entity if they meet the requirements listed in the rule. To review these requirements, click [here](#) and scroll down to (c)(3)(i).³¹
4. *TMA note on IDR strategy for downcoded claims: in a dispute that concerns a qualified IDR service for which the plan or issuer downcoded the billed service code, the provider, should consider presenting information showing that the billed service code was more appropriate than the downcoded service code. Argue that the IDR entity can determine that the downcode does not sufficiently encompass the complexity of furnishing the service because it was based on a service code for a different service from the one actually provided. If the IDR entity makes such a determination, then the amount that would have been the QPA had the service code or modifier not been downcoded may be relevant to the certified IDR entity in determining which offer best represents the value of the qualified IDR item or service.*
5. *In any IDR, note to the IDR entity that the rules require that payment determinations in the Federal IDR process should center on a determination of a total payment amount for a particular item or service based on the facts and circumstances of the dispute at issue, rather than an examination of a plan's or issuer's QPA methodology. Emphasize the complexity of the service.*
6. In section VII.H., we provide more information as to how to batch appeals for an IDR entity.

³¹ [45 CFR § 149.510 \(c\)\(3\)\(i\)](#)



I. IDR and Batched Claims

1. When initiating the IDR process by submitting a written notice on the [standard form developed by the HHS Secretary](#), the initiating party must indicate if the items/services are batched.³²
 2. Batched items/services³³ may be considered part of one payment determination by an IDR entity if they meet the requirements below.³⁴
 - a. The items/services are billed by the same provider or group of providers. They are considered billed by the same provider/group if they are billed with the same National Provider Identifier (NPI) or Tax Identification Number;
 - b. The same insurance plan would have paid for the items/services;
 - c. The items/services are the same or similar items/services. They are considered same or similar if each is billed under the same service code or a comparable code under a different procedural code system (i.e., CPT, HCPCS with modifiers); and
 - d. All of the items/services were furnished within the same 30-day business period.
 3. Another IDR request may not be submitted with the same insurance plan for 90 calendar days.
 - a. Once the 90-days have passed, IDR may be initiated for claims that occurred during the 90-day suspension period that meet the requirement of IDR.³⁵
 4. Bundled payment arrangements are subject to the rules for batched determinations and the certified IDR fee for single determinations.³⁶
 5. In a [December 2022 memo](#), CMS updated the administrative and IDR fees for 2023
- J. In its determination letter, the IDR entity should provide a written rationale for the rate it chooses.
- K. If you believe that a health plan is not complying with the IDR process or you have a question about the process, you may contact the No Surprises Help Desk at 1-800-935-3059 daily between 7 am to 7 pm CT to submit a question of complaint. A complaint may also be

³² [45 CFR § 149.510 \(b\)\(2\)\(iii\)\(A\)\(1\)](#)

³³ Batched items and services mean multiple qualified IDR items or services that are considered jointly as part of one payment determination by a certified IDR entity for purposes of the Federal IDR process. In order for a qualified IDR item or service to be included in a batched item or service, the qualified IDR item or service must meet the criteria set forth in paragraph (c)(3) of this section. [\[45 CFR § 149.510 \(a\)\(2\)\(i\)\]](#)

³⁴ [45 CFR § 149.510 \(c\)\(3\)\(i\)](#)

³⁵ Requirements Related to Surprise Billing; Part II, [Federal Register Vol. 86, No. 192, page 55994](#), 10/7/2021

³⁶ [45 CFR § 149.510 \(c\)\(3\)\(ii\)](#)



submitted online by [clicking here](#). Additional information may be requested by the Help Desk to process the complaint.

VIII. Good Faith Estimate for Self-Pay Patients

A. Good Faith Estimate (GFE) Requirement

1. The GFE requirement applies to *any* health care provider or facility that schedules services at least three days in advance *and* the patient is self-pay, a service is not covered, or the patient does not wish to pay with any insurance. Additionally, if an insured patient *requests* a GFE, one must be provided in advance with information as to how much the patient would pay if they were self-pay.
 - a. The GFE does apply to doctors' offices.
 - b. It does not apply to Medicare or Medicaid because the patient has insurance.
2. FAQs on GFE from CMS may be accessed by [clicking here](#).

B. A physician practice must display in a prominent place in the office and on its website (if the practice has a website) the availability of a Good Faith Estimate (GFE) ³⁷ & ³⁸.

1. A model notice has been developed and you may access it by [clicking here](#) and opening the *Right to Receive a Good Faith Estimate of Expected Charges Notice* document. It includes all of the requirements and required disclaimers of a compliant GFE notice.

TMA note: TMA recommends the use of this model notice since a properly completed notice is presumed to demonstrate compliance.

C. Convening Provider and Co-Provider

1. The GFE must include the costs by co-providers of services. It is the responsibility of the convening provider (the one scheduling the service) to provide the GFE to the patient and obtain the costs associated with the service from co-providers.
2. As an example, if a provider's office is scheduling a procedure that will reasonably include services performed by outside providers such as imaging or labs, then the convening provider must obtain cost information from the imaging center and lab and include them in the GFE before delivering the GFE to the patient.
3. Co-providers must be contacted within one day of scheduling or receiving a request.

³⁷ Good faith estimate means a notification of expected charges for a scheduled or requested item or service, including items or services that are reasonably expected to be provided in conjunction with such scheduled or requested item or service, provided by a convening provider, convening facility, co-provider, or co-facility. [\[45 C.F.R. § 149.610\]](#)

³⁸ [45 CFR § 149.610\(b\)\(1\)\(iii\)](#)



4. If a provider is a co-provider of services:
 - a. The co-provider will receive a request for information necessary for the convening provider to complete the GFE. The request will include the date by which the information must be received by the convening provider.
 - b. The regulations require a co-provider to deliver the GFE information requested to the convening provider no later than **one** business day following receipt of the request.
 - c. A co-provider is required to provide updated information to a convening provider if the co-provider anticipates any changes to the information previously submitted to the convening provider.
 - d. If there is any change in the expected co-providers listed in the GFE less than **one** business day before the item or service is scheduled to be furnished (for example, a substitute anesthesiologist from a different practice is scheduled to participate), the replacement co-provider must accept the expected charges furnished by the original co-provider.
 5. Enforcement discretion of the requirement to obtain the charges of a co-provider has been delayed by the US Department of Health and Human Services beyond January 1, 2023.³⁹ However, it is a good idea to include in their GFEs a range of expected charges for co-provider services now.
- D. The GFE has to include any patient discounts or reductions for the patient based on the patient's financial needs. If the reduction gets to a \$0 cost, the provider still has to fill out the notice. If the service is for a flat-rate fee, a GFE must still be provided.
 - E. If a patient declines a GFE, it still must be prepared and maintained in the practice's records.
 - F. The GFE is PHI under HIPAA so all HIPAA precautions must be taken in delivery of it to the patient, maintenance of it, etc. The GFE must be part of the patient's medical record.
 - G. Providers should include a disclaimer on the GFE as to how long it is good for; some time frame.
 - H. Convening Provider's GFE Process/Policy
 1. When a patient calls the provider's office to schedule an appointment, the scheduler needs to ask if the patient has health insurance and if it will be used to pay for the service(s) provided during the appointment.
 - a. If the patient is uninsured or does not want a claim submitted to his/her insurance plan (self-pay), the office must provide a GFE detailing the charges for the service(s) before

³⁹ [CMS FAQs on Good Faith Estimates Part 3](#), pg. 1, 12/2/2022



the appointment.

- b. The NSA also requires a GFE for patients with insurance, but enforcement has been delayed until rules are published and a technical infrastructure to transmit the GFE data to the insurance plan is developed.⁴⁰
 2. If the convening provider or a co-provider updates any information, it must be relayed to the patient.
 3. Under the NSA, the office receiving the request for the appointment is considered the convening provider (CP) and any provider/facility furnishing item(s)/service(s) that are usually provided in conjunction with the primary item/service is a co-provider.⁴¹
 4. A model form is available for physicians to use when creating a GFE for a patient. The form may be accessed by [clicking here and opening the *Good Faith Estimate Template Notice* document](#). The GFE rules require that certain information must be included and using this template will help ensure that you are in compliance with the rule.⁴² The GFE must be provided:
 - a. No later than one business day if the appointment is scheduled at least three business days before the appointment; or
 - b. No later than three business days if the appointment is scheduled at least 10 business days before the appointment.⁴³
 - c. No later than three business days after the date the patient requests a GFE.
TMA Note: If the patient schedules the appointment one or two days in advance, makes a same-day appointment, or walks in without an appointment, we do not believe that a GFE is required unless the patient requests it. This is confirmed in [CMS FAQs Q5 on page 3](#).
 5. There is no enforcement discretion in place as it relates to the convening provider who schedules uninsured and self-pay patients. Facilities and providers should provide uninsured and self-pay patients a GFE that includes expected charges for services furnished by the convening facility/provider, even if the GFE does not include expected charges for co-provider services.
- I. On the next page is a flow chart that summarizes the GFE process as required by the NSA.

⁴⁰ FAQ from US Department of Labor, <https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-49.pdf>, page 5, question Q5.

⁴¹ [45 CFR § 149.610\(b\)\(1\)\(v\)](#)

⁴² [45 CFR § 149.610 \(c\)](#)

⁴³ [45 CFR § 149.610\(b\)\(1\)\(iii\)](#)



A patient calls the office to schedule an appointment with the provider. The provider is now considered the convening provider. Does a GFE of expected charges need to be provided to the patient?

Ask the patient:
1. Does he/she have insurance?
2. If insured, will a claim be submitted to the insurance plan?

Patient is *uninsured*

Patient is *insured* – Claim will *NOT* be submitted

Patient is *insured* – Claim *WILL BE* submitted

Provide a GFE.
Beginning 1/1/2023 it must include estimates from all co-providers

GFE not currently required. Waiting on rules & development of technical infrastructure

Timeframes to Provide GFE:
Appointment scheduled 3+ days in advance = GFE in 1 business day
Appointment scheduled 10+ days in advance = GFE in 3 business days
Appointment scheduled 0-2 days in advance = GFE not required unless patient requests



- J. CMS has developed an excellent guidance on GFEs that should be read as you plan your process for implementing these requirements. [Click here](#) to access this document. It provides additional detail on what to do when there are changes to the scope of a GFE the practice provided to a patient, how it may be provided to the patient, retention of the GFE in the medical record, and a GFE for recurring primary items or services.
- K. If the variance between the patient's final bill and the GFE is more than \$400, the patient can dispute it through IDR.
- L. Proposed rules set penalties at \$10,000 per violation.
- M. GFE Problems that Delay Patient Care
 - 1. The provision of GFEs to patients is a daunting task and nightmarish unfunded operational mandate. Your practice may encounter many problems not anticipated when the rules were written.
 - 2. If you encounter any requirements that impede or delay care, TMA encourages you and your patients to share these situations with your federal legislator:
 - a. Find your U.S. Representative by [clicking here](#) and then entering your zip code.
 - b. Find your U.S. Senators by [clicking here](#) and then clicking the dropdown *Find Your Senators* at the top of the page.

IX. Additional Resources

- A. [Click here](#) to access the PYA Implementation Guide.
- B. [Click here](#) to access the AMA Toolkit for Physicians: *Preparing for Implementation of the No Surprises Act*.
- C. [Click here](#) to access CMS resources on the Good Faith Estimate:

