Federal Independent Dispute Resolution Process

Checklist of requirements for group health plans and group and individual health insurance issuers

November 2, 2022

The Departments of the Treasury, Labor, and Health and Human Services (collectively, the Departments), have received a number of complaints regarding group health plan and health insurance issuer compliance with the requirements for making initial payments or sending notices of denial of payment to nonparticipating providers, facilities, and providers of air ambulance services for items and services for which the No Surprises Act balance billing protections apply. Most complaints received to date by the No Surprises Help Desk allege violations of the requirements to:

- Send an initial payment or notice of denial of payment within 30 calendar days after the provider or facility submits a bill or a claim;
- Provide the disclosures required with these initial payments or denials (such as the Qualifying Payment Amount (QPA), a contact telephone number, and email address); and
- Provide information about the 30-business-day open negotiation period.

For example, the Departments have also received complaints that some plans and issuers are requiring providers and facilities to initiate the open negotiation period through a private issuer hosted web-portal which may not allow for the submission of the standard open negotiation initiation notice to initiate open negotiation as described under federal regulations[1] and are creating significant barriers to providers and facilities accessing the Federal Independent Dispute Resolution (IDR) process. These complaints point to potential systemic problems with plan and issuer compliance with No Surprises Act requirements. The Departments are committed to ensuring compliance with the requirements of the NSA and it's implementing regulations.

This checklist is intended to help plans and issuers understand their obligations and comply with key requirements of the No Surprises Act when processing claims for items and services that fall within the scope[2] of the new surprise billing protections for emergency services, non-emergency services performed by nonparticipating providers at participating health care facilities, and air ambulance services furnished by nonparticipating providers of air ambulance services ("qualified IDR item(s) or service(s)").[3] *Please note this is not an exhaustive list of No Surprises Act requirements.* See below for a list of additional resources, including the No Surprises Help Desk.

Requirement to process claims within 30-calendar-day timeframe

- ☐ Within 30 calendar days after a nonparticipating provider, facility, or provider of air ambulance services submits a bill for a qualified IDR item(s) or service(s), plans and issuers must make an initial payment or send a notice of denial of payment. The 30-caledar-day period begins on the date the plan or issuer receives the information necessary to decide a claim for payment for the item or service.

[1] 26 CFR 54.9816-8T(b)(1)(ii), 29 CFR 2590.716-8(b)(1)(ii), and 45 CFR 149.510(b)(1)(ii).

[2] In general, an item or service falls within the scope if it is an emergency service, nonemergency service furnished by nonparticipating providers at participating facilities, or air ambulance service furnished by nonparticipating providers of air ambulance services where an All-Payer Model Agreement or specified state law does not apply.

[3] See sections 9816(a)(1)(C)(iv)(I) and 9817(a)(3)(A) of the Code, sections 716(a)(1)(C)(iv)(I) and 717(a)(3)(A) of ERISA, sections 2799A-1(a)(1)(C)(iv)(I) and 2799A-2(a)(3)(A) of the PHS Act, and 86 FR 36872.

- The initial payment should be an amount that the plan or issuer reasonably intends to be payment in full based on the relevant facts and circumstances and as required under the terms of the plan or coverage, prior to the beginning of any open negotiation period or initiation of the Federal IDR process.
- The notice of denial of payment must:
    - Be in writing.
    - State that payment for the item or service will not be made by the plan or issuer.
    - Explain the reason for the denial of payment.

Note: A notice of denial of payment is appropriate when the item or service is a covered benefit under the plan or coverage. A notice of denial of payment could be provided, for example, if an item or service is covered but is subject to a deductible greater than the recognized amount. The term "notice of denial of payment" does not include a notice of benefit denial due to an adverse benefit determination as defined in 29 CFR 2560.503-1.

Requirement to provide certain information in writing with each initial payment or notice of denial of payment

- Plans and issuers must provide the following information regarding the QPA to nonparticipating providers, nonparticipating emergency facilities, and nonparticipating providers of air ambulance services, where the recognized amount (or in the case of air ambulance services, the amount upon which cost sharing is based) with respect to an item or service furnished by the provider or facility is the QPA.[4]
    - The QPA for each item or service involved.
    - A statement certifying that the plan or issuer has determined that the QPA applies for the purposes of the recognized amount (or, in the case of air ambulance services, for calculating the participant's, beneficiary's, or enrollee's cost sharing), and each QPA was determined in compliance with the methodology established in Requirements Related to Surprise Billing; Part I[5].
    - A statement that if the provider or facility, as applicable, wishes to initiate a 30-day open negotiation period for purposes of determining the amount of total payment, the provider or facility may contact the appropriate person or office of the plan or issuer to initiate open negotiation, and that if the 30-day negotiation period does not result in a determination, generally, the provider or facility may initiate the Federal IDR process within 4 days after the end of the open negotiation period.
    - Contact information, including a telephone number **and** email address, for the appropriate person or office of the plan or issuer to initiate open negotiations for purposes of determining an amount of total payment (including cost sharing) for the item or service.
- Upon request of the provider or facility, the plan or issuer must provide, in a timely manner, the following information:
    - Whether the QPA for items and services involved included contracted rates that were not on a fee-for-service basis for those specific items and services and whether the QPA for those items and services was determined using underlying fee schedule rates or a derived amount.

[4] 26 CFR 54.9816-6T(d), 29 CFR 2590.716-6(d), and 45 CFR 149.140(d).
[5] 86 FR 36872

- If a related service code was used to determine the QPA for a new service code, information to identify the related service code.
- If the plan or issuer used an eligible database to determine the QPA, information to identify which database was used.
- If applicable, a statement that the plan's or issuer's contracted rates include risk-sharing, bonus, or other incentive-based or retrospective payments or payment adjustments for covered items and services that were excluded for purposes of calculating the QPA.

Open Negotiation Period

Before accessing the Federal IDR process to determine the out-of-network rate for a qualified IDR item(s) or service(s), the disputing parties must engage in a 30-business-day open negotiation period to attempt to reach an agreement regarding the total out-of-network rate (including any cost sharing).

- Either party can initiate the 30-business-day open negotiation period within 30 business days after the provider, facility or provider of air ambulance services receives the initial payment or denial of payment.
- To initiate the open negotiation period, the initiating party must provide the standard open negotiation notice (found here) to the other party. Note that, if the initiating party submits the standard open negotiation notice to the non-initiating party, the open negotiation period begins on the day that the initiating party sends the open negotiation notice regardless of whether the non-initiating party "accepts" the notice or not. For example, if the non-initiating party directs the initiating party to use a web portal, the portal declines to "accept" the open negotiation notice, but the initiating party emails the standard open negotiation notice to the proper email address for the non-initiating party, the open negotiation period has begun.
- If either party has a concern that the open negotiation process did not occur or that the party was not notified of the open negotiation period, the party may request an extension due to extenuating circumstances by emailing the Federal IDR box at FederalIDRQuestions@cms.hhs.gov. While a request for an extension due to extenuating circumstances is under review by the Departments, the Federal IDR Process and all of its timelines continue to apply, so the parties should continue to meet deadlines to the extent possible.

Federal IDR Initiation

Within 4 business days after the close of the open negotiation period, either party can initiate the Federal IDR Process by submitting a Notice of IDR Initiation to the other party and to the Departments. Information submitted in the Notice of IDR Initiation must include the following:

- Initiating party type (i.e., provider, facility, provider of air ambulance services, issuer, plan, or FEHB Carrier).
- The names and contact information of both parties involved, including:
  - Email addresses;
  - Phone numbers; and
  - Mailing addresses.
- Information sufficient to identify the qualified IDR items or services under dispute, including:
  - A description of the qualified item(s) or service(s);
  - Whether the item(s) and/or service(s) are batched;
  - The date(s) the item(s) was/were provided or the date(s) of the service(s);
  - The location where the item(s) or service(s) was/were furnished (including the state or territory);

- Any corresponding service and place-of-service codes;
- The type of qualified IDR item or service (e.g., emergency, post-stabilization, professional);
- The amount of cost sharing allowed; and
- The amount of initial payment made by the plan, where payment was made on the claim(s), if applicable.

- The QPA for each of the services or items involved.
- The following information from the plan or issuer about the QPA(s) that was provided to the provider, facility, or provider of air ambulance services with the initial payment or notice of denial of payment:
  - The statement that the QPA applies for purposes of the recognized amount for the item(s) or service(s) in question (or, in the case of air ambulance services, for calculating the participant's, beneficiary's, or enrollee's cost sharing);
  - Any related service codes used to determine the QPA for new services; and
  - Where requested by the provider, facility, or provider of air ambulance services, any information given by the plan or issuer about:
    - Whether the QPA was calculated using non-fee-for-service rates and/or underlying fee schedules;
    - Any eligible databases used by the plan or issuer to determine the QPA; and
    - Any statements noting that the plan's or issuer's contracted rates include risk-sharing, bonus, penalty, or other incentive-based or retrospective payments or payment adjustments;
  - The start date of the open negotiation period;
  - The initiating party's preferred certified IDR entity;
  - An attestation that the item(s) or service(s) under dispute is/are qualified IDR item(s) or service(s) within the scope of the Federal IDR Process; and
  - General information describing the Federal IDR Process as specified by the Departments.

Additional Resources

- Federal IDR Process Guidance for Disputing Parties:
  - Guidance effective as of July 26, 2022, and applicable to all items and services furnished before October 25, 2022, for plan years (in the individual market, policy years) beginning on or after January 1, 2022, by an out-of-network provider subject to the Requirements Related to Surprise Billing; Part II, 86 FR 55980. https://www.cms.gov/files/document/federal-independent-dispute-resolution-guidance-disputing-parties.pdf
  - Guidance applicable to all items and services that are furnished on or after October 25, 2022, for plan years (in the individual market, policy years) beginning on or after January 1, 2022, by an out-of-network provider subject to the Requirements Related to Surprise Billing; Part II Interim Final Rules, 86 FR 55980 and Requirements Related to Surprise Billing Final Rules; 87 FR 52618. https://www.cms.gov/files/document/rev-102822-idr-guidance-disputing-parties.pdf

- Requirements Related to Surprise Billing; Part I (86 FR 36872): https://www.federalregister.gov/documents/2021/07/13/2021-14379/requirements-related-to-surprise-billing-part-i
- Requirements Related to Surprise Billing; Part II (86 FR 55980): https://www.federalregister.gov/documents/2021/10/07/2021-21441/requirements-related-to-surprise-billing-part-ii
- More information about the No Surprises Help Desk and to submit a complaint: https://www.cms.gov/nosurprises/consumers/complaints-about-medical-billing