Centers for Medicare & Medicaid Services

Questions and Answers:

Special Open Door Forum: NSA Deeper Dive into Other Surprise Billing Protections-

February 23, 2022

1. Question about the prohibitions that apply to items or services that are non-covered benefits. If a patient wants to receive a non-covered item such as cosmetic Botox in the physician's office, are we required to notice and consent those services since they're non-covered?
    a. Yes. Are you saying at a network service or non-covered service?
        i. Covered service.
            1. No, the provisions do not apply on non-covered services.
                a. There is also a part of the rule that I'm not 100% comfortable with regarding non-emergency ancillary services. As a physician's office with diagnostic services available on site is this applicable to us that we may never can see a patient for non-emergency ancillary services?
                    i. The prohibition on notice and consent for non-ancillary services comes into play when a patient is visiting a participating facility and those ancillary services would be provided by a non-participating provider and they're non-emergency services. In a situation like that, the balance billing prohibitions always apply and the exception that might otherwise apply for notice and consent would not apply, meaning that notice - and notice cannot be sought and consent cannot be given for ancillary services in the context that I just mentioned.
2. Are there any provisions to resolve the provider and insurance company disputes for the insurance company underpayments for out of network providers?
    a. Our regulations already published in that regard and in situations where the prohibitions on balance billing apply, the planner issuer has to pay the out-of-network rate to the provider. And the out-of-network rate under the law, and the regulations is determined in one of four different ways. If the state has an

all-payer model agreement that's in effect in that state and that all-payer model agreement applies to the provider or - and the planner issuer and the particular service, then the all-payer model agreement would dictate the amount of the out-of-network rate. Now, most states don't have all-payer model agreements. So, if the state does not have an all-payer model agreement and it does have a specified state law that would dictate that out-of-network rate, then the specified state law would dictate that rate. And the specified state law again, to apply in any specific situation has to apply to be the provider or facility in question, the service in question and the planner issuer in question. Now, if there's no all-payer model agreement and there's no applicable specified state law, then a period of open negotiation can take place under the federal regulations. And it's a 30-day period under which the two parties can negotiate to try to come up with an amount of payment. Also, under the statute and the regulations, if the 30-day open negotiation - and either of the two parties can initiate the open negotiation period. So, if one of the two parties do initiate an open negotiation period, it's a 30-day period and ifs at the end of that 30-day period the two parties still haven't agreed on a rate then, either the two parties can initiate what's known as an independent dispute resolution process. And the way that process works is the term that's commonly used is baseball style arbitration. And what that means is each of the two parties submits to the independent dispute resolution entity, an offer of payment, an amount. And the arbitrator or the dispute - the independent dispute resolution entity has to choose one of those two rounds. It cannot choose like an amount in the middle or some other amount. It has to choose one of those two offers that was submitted by one of the parties. And in those regulations, it specifies the types of considerations that the independent dispute resolution entity may and may not consider in making its decision. So, the answer to your question is yes, there is a scheme in the statute and the regulations to determine what that out-of-network payment would be in instances where the No Surprises Act applies and the two parties just can't come to a resolution on what the payment should be.

i. I already know all that. But the issue is that, the insurance companies are in control of the rates, and we're getting underpaid.
    1. The independent dispute resolution entity would resolve that. So, you're probably familiar with how it works in that the independent dispute resolution entity under the regulations is required to start with the QPA, Qualifying Payment Amount. However, the provider is permitted to present evidence that the

qualifying payment amount, which is the median and contracted rate is just not sufficient. And then the independent dispute resolution entity would take that evidence into consideration in making its determination as to which of the two offers to select.

a. Because I thought there would be an additional rule-making on this because it's still a lot of ambiguities and involved with it. And I understand there's an AMA lawsuit going on still too, and that's hanging out there. So that's why I wasn't sure if there was any additional rule-making promulgated since then.
    i. There has not. That rule that I'm referring to as an interim final rule. The rule will be finalized, but I don't have any sort of a timetable for when that would occur.