No Surprises Act Readiness Guide

SECTION 1: Summary of Final Ruling

Effective for service dates on or after January 1, 2022, the Act bans surprise billing for emergency and out of network services. It also proposes that patient cost-sharing cannot be higher than services would be by an in-network physician.

- The rule bans surprise billing ancillary services, always prohibiting out-of-network charges in in-network facilities
- It creates a consent process to allow patients to waive their balance billing protections and agree to out-of-network charges
- Similar price transparency, providers must publicly inform patients about their surprise billing protections
- CMS has defined the qualifying payment amount for out of network claims as the issuer's median in-network rate for 2019 trended forward
- Outlines independent dispute provisions for both patients and providers

SECTION 2: What Qualifies as Surprise Billing?

Surprise billing is defined as when a patient **unknowingly** receives care by an out of network provider or facility, including:

- ED visits at out of network facility, or
- services from an out of network provider at in-network facility, or
- air ambulance services provided by out of network provider

How do we know if the provider or facility is considered out of network? If there is no contract in place between the insurance company and provider and/or facility, then it is considered out of network.

SECTION 3: Payer Provisions

The final ruling has outlined requirements for payers to ensure compliance with the Act. These changes are significant, and with nearly all private health plans affected, we anticipate delays in adjudication systems getting updated in time for the January go-live.

- ED and Air Ambulance services must be processed at in-network rates
- Out of network reimbursed at “qualifying rate” without prior authorization requirements
- Interim payment or notice of denial within 30 days receipt of ‘clean claim’. Plan can extend 15 days for additional information
- Routine denials not allowed
- Payment made to provider, not to patient/subscriber

Additionally, payers will be required to provide more information on insurance cards with plan years beginning January 1st, 2022. These changes include adding both In-network and out of network deductibles and out of pocket maximums. Payers must also include a toll-free phone number and website to assist subscribers in finding an in-network provider.

SECTION 3: Payer Provisions continued

Advanced EOB: a requirement for payers under the NSA, advanced EOBs must be provided within 24 hours of request by the subscriber. Advanced EOBs are applicable for both in and out of network providers and is trigged by the provider notification and Good Faith Estimate (see below). Each advanced EOB must contain the following information:

- Good faith estimates of provider billed charges, allowables, cost-share and current standing on any deductibles and out of pocket maximums, and
- Notification if provider/facility is in-network, and
- Information on how to find in-network providers, and
- Any applicable disclaimers

Due to delays in the Good Faith Estimate provision for insured patients, the Advanced EOB requirement has been delayed with the go-live date yet to be determined.

SECTION 4: Provider Provisions

Similar to payer requirements, the final ruling outlines steps providers must take to be in compliance with the Act. These provisions are lower in volume, but will require just as much, if not more preparation due to the need to develop new front-end and back-end workflows, staff training and development of reporting.

- **Providers must make available a notice to consumers** outlining the surprise billing protections, and contact information for federal agencies should the consumer have any questions or concerns. This information must be separate from all other financial and/or clinical documents and should be available in paper copy as well as quickly accessible on website
- **Informed consent**. The consent can be utilized for out of network non-emergent and specific services in an emergency setting **prior to** the services being provided to the patient. Although optional, this consent must be on file to balance bill the patient if claim is processed under NSA provisions
- **Good Faith Estimates.** When an individual schedules health care services or requests information prior to scheduling, providers and facilities must notify the patient and their plan or insurer of an estimate of expected charges for those services with expected billing and diagnostic codes

Effective January 1st, 2022 the requirement for Good Faith Estimates goes into effect for **uninsured patients only** with the requirement extending to insured consumers later in CY2022.

SECTION 5: Provider Go-live Readiness

RESEARCH

Since this Act impacts both front end and back-end staff, it's important that revenue cycle workflows are developed, and staff is trained prior to go-live. Before getting started, it's important to check your specific risk level. To help, try asking yourself the following questions:

- **Are there out of network protections already in place at the state level?** As of 2021, 33 of the 50 states have enacted laws covering out of network balance billing. The following website is an excellent resource to search balance billing laws: Balance Billing Protections by State [1]
- **How many out of network patients were seen in the last 12 months?** This can be determined by looking into reimbursement and registration data. Most out of network plans are registered under a commercial financial class and when claims are reimbursed at out of network rates, payers may use ANSI standard remark code N830 to indicate charges were processed in accordance with Federal/ State Balance/ Surprise Billing regulations

DEVELOP WORKFLOWS

Once you've determined the volume of claims and potential risk, workflow development is next. When developing workflows, you will need to include front-end and back-end staff. Documentation of policies and procedures is important to ensure consistency and will also increase accountability.

Front-end workflows include providing good faith estimates upon request for uninsured consumers as of January 1st 2022. Build in a plan for notification to payers once requirement extends to insured consumers.

- Scheduling, financial clearance, and arrival/admission staff will need to add completing the consent forms into their workflow. This also includes emergency department registration staff
- Another item to consider for front end staff is purchasing real time eligibility tools for verification whether in/out of network

Back-end billing workflows include timely responses to underpaid out of network claims. Due to the short window for the Independent Dispute Resolution (IDR) process, it's important that out of network claims are reviewed as soon as they are remitted. To designate claims paid under the NSA provisions, three ANSI standard 835 remittance remark codes have been developed [2].

N858	**Alert: State regulations relating to an Out of Network Medical Emergency Care Act were applied to the processing of this claim. Payment amounts are eligible for dispute following the state's documented appeal/ grievance/ arbitration process.** *Start: 11/01/2021*
N859	**Alert: The Federal No Surprise Billing Act was applied to the processing of this claim. Payment amounts are eligible for dispute following the Federal documented appeal/ grievance/ dispute resolution process.** *Start: 11/01/2021*
N860	**Alert: The Federal No Surprise Billing Act Qualified Payment Amount (QPA) was used to calculate the member cost share(s).** *Start: 11/01/2021*

[1] Source: Commonwealth Fund, *State Balance Billing Protections*; February 2021 https://www.commonwealthfund.org/publications/maps-and-interactives/2021/feb/state-balance-billing-protections

[2] Source: X12 External Code Lists; *Remittance Advice Remark Codes*, https://x12.org/codes/remittance-advice-remark-codes

Deciding whether to handle negotiation and the IDR process in-house or outsourcing is the next step. If handling in-house, a solid workflow is critical to ensure timely follow-up.

Independent Dispute Resolution Workflow [3]

1. Before initiating the federal independent dispute resolution process, disputing parties must initiate a 30-day "open negotiation" period to determine a payment rate. If a provider wants to initiate the open negotiation period, they must inform the plan or insurer and send written notice within 30 business days of an initial payment or denial of payment. The open negotiation period then extends for 30 business days from the date of the notice. The parties must exhaust this open negotiation period before initiating the federal IDR process.
2. If no agreement is reached on the out-of-network rate, either party can initiate the federal IDR process within 4 business days. This 4-business-day period begins on the 31st business day after the start of the open negotiation period and is triggered by a separate notice of IDR initiation from one party to the other.
    a. This notice must include, among other information, the relevant Qualifying Payment Amount (QPA), the initiating party's preferred certified IDR entity, and the qualified IDR items or services at issue. This notice must also be submitted to federal officials (through the federal IDR portal) on the same day it is sent to the other party. This triggers the federal IDR process.
3. The parties can agree upon a certified IDR entity within 3 business days of IDR initiation. If no party objects to the initiating party's preferred IDR entity (and there are no conflicts of interest), that entity will serve as the IDR entity. If a party objects to the other's preferred IDR entity, it must explain its objection and propose an alternative IDR entity. The other party then has the option to agree or object to the proposed alternative. This process can continue for up to 3 business days.
4. After an entity is selected, both parties will have 10 days to submit their offers for payment along with supporting documentation. The offer must be listed as both a dollar amount and a percentage of the QPA.
    a. Providers and facilities must disclose the size or their practice or facility (based on the number of employees) and the practice specialty or type.
    b. Plans and insurers must disclose their coverage area, relevant geographic area, and whether their coverage is fully insured or self-insured. This, and any other information provided by the parties or requested by the IDR entity, must be submitted through the IDR portal.
5. Over the next 30 days the certified independent dispute resolution entity will review then issue a binding determination selecting one of the parties' offers as the payment amount. The IDR entity will provide notice to the parties in writing and the written decision must include the entity's underlying rationale including a detailed explanation of additional considerations relied upon if the IDR entity did not choose the offer closest to the QPA

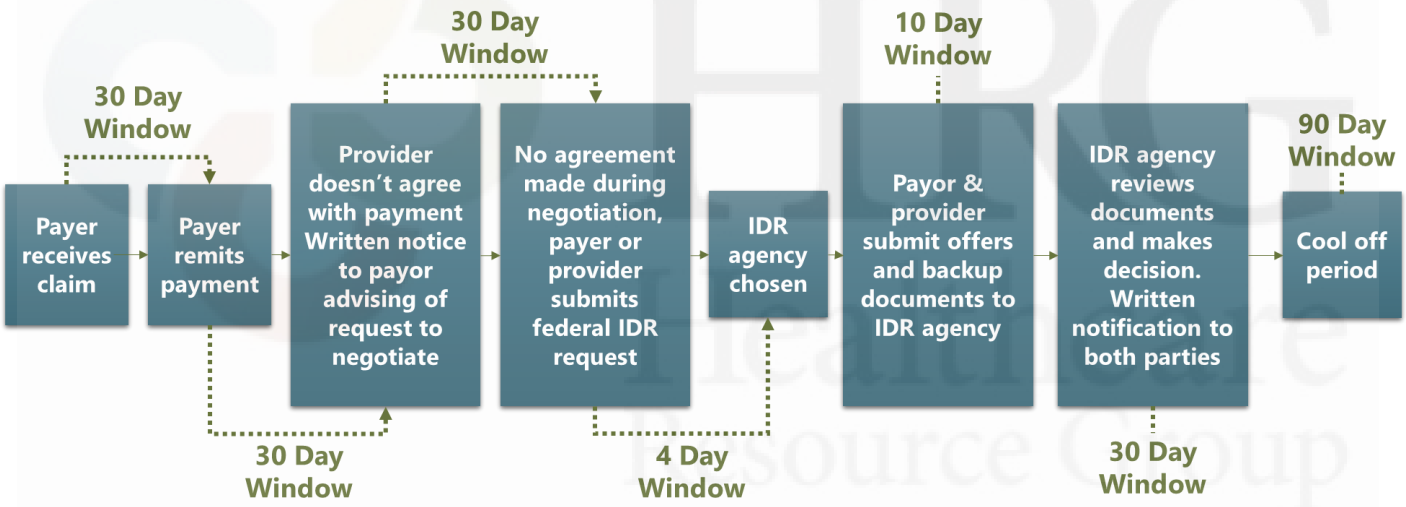
[3] CMS Newsroom: *Requirements Related to Surprise Billing Part II Interim Final Rule with Comment Period*, September 30, 2021

Before engaging in the IDR process, here are a few things to keep in mind:

- **Not a lot of wiggle room.** The NSA adopts "baseball-style" arbitration where each party offers a payment amount, and the IDR entity selects one amount or the other with no ability to split the difference. The decision is binding, although the parties can continue to negotiate or settle during the IDR process
- **There is a cost.** Both parties must pay an administrative fee (estimated $50 each for 2022), and the non-prevailing party is responsible for the certified independent dispute resolution entity fee for the use of this process estimated between $200 - $500
- **The 'Cool Off' period.** Once the IDR entity makes a determination, the party that initiated IDR cannot initiate a new round of IDR for the same services with the same party for 90-calendar-days after the determination was made

On the plus side, multiple cases can be batched together in a single proceeding, but batched cases must involve the same provider or facility, the same insurer, the same or similar medical condition, and must occur within a single 30-day period.

Independent Dispute Resolution Timeline



Double check patient balances. It's always important to validate all patient out of pocket amounts prior to transferring the balance to self pay. Being extra diligent with out of network claims is going to save time in the long run.

- If your informatics system allows, utilize an indicator to ensure special handling. This indicator can also help isolate these accounts for reporting purposes.

Back-end self-pay workflows should include clear guidance and scripting for call representatives in the likely event a patient calls to dispute their 'surprise bill'. Keep in mind most consumers won't be fully aware of the regulatory details and may use this as a reason to question their bill and request another review of the balance thereby delaying having to pay the balance.

Back-end self-pay workflows cont.

- Workflow for placing collection efforts on hold and referring the account back to billing to do a patient balance review
- Familiarize team with the Patient and Provider Dispute Resolution Process
- Develop reason/remark code crosswalk for cash posters

Patient and Provider Dispute Resolution Process [4]

Starting in January 2022, if an uninsured (or self-pay) consumer is billed for an amount that exceeds the good faith estimate they were provided, the consumer can use a new patient and provider dispute resolution process to determine a payment amount. Consumers will be eligible to use this process if they have a good-faith estimate, a bill within the last 120 calendar days, and the difference between the good-faith estimate and the bill is at least $400.

Through this process, consumers will also be able to request a third-party arbitrator to review the good-faith estimate, their bill, and information submitted by their provider or facility to determine if the additional charges are allowed or if the provider or facility can only charge less than the billed charge.

PREPARE TEAMS WITH TRAINING

Once workflows have been documented, the next step is to roll out training. This doesn't require a formal classroom setting but should be done as an instructional training rather than self-study only. Since people tend to learn with different techniques, if may be a good idea to try a mixture of both.

Whatever type of training you choose, be sure to include poll questions during training and a short quiz at the end of each session. This helps keep engagement high and reinforces the lesson.

Front-end Training Checklist

- ☐ No Surprises Act review- what is it and how does it impact the front-end
- ☐ Review RTE responses on out of network payers (be sure to scroll all the way down)
- ☐ Tips for reading insurance cards: define out of network, deductibles, out of pocket, etc.
- ☐ Walk through documented workflows: consent forms, good faith estimates
- ☐ Review resources available to consumers: where to refer in case consumer/patient has questions
- ☐ Role play different scenarios to gain confidence when discussing NSA information with consumers
- ☐ Share monthly denial reports to reinforce importance of getting registration right the first time

Back-end Training Checklist

- ☐ No Surprises Act review- what is it and how does it impact billing and reimbursement
- ☐ Walk through documented workflows: account payment review, negotiation, and IDR process
- ☐ Discuss importance of validating the patient balance; review remittance advice codes and if indicator will be used

[4] Source: Centers for Medicare & Medicaid Services; *Ending Surprise Medical Bills; https://www.cms.gov/nosurprises*

Self Pay Training Checklist

- ☐ No Surprises Act review- what is it and how does it impact patient out of pocket amounts
- ☐ Instruction on how to determine if balance is subject to NSA requirements or if patient may just be disputing a high out of pocket
- ☐ Workflow for escalating accounts to review patient balance: which hold codes should be used, and specific timeframes for holding accounts, etc.
- ☐ Explanation of Patient and Provider Dispute Resolution process
- ☐ It's important to understand what the public has been told. Reviewing materials prepared for the consumer is the best way to prepare for the conversation. CMS.gov has put together a consumer and provider toolkit and can be found by visiting https://www.cms.gov/nosurprises
- ☐ Role play and practice scripting to ensure phone representatives can respond to caller questions with confidence

REPORTING CHECKLIST

Since the Federal No Surprises Act provisions are new, and payer readiness is a valid concern, it's crucial to monitor your receivables to ensure reimbursement amounts are valid and opportunities aren't missed. The following are suggestions for reports that may be useful in monitoring AR:

- ☐ Review 835 reason/remark code mapping, flagging remittance codes associated with NSA payments
- ☐ If system indicator or agency will be utilized, develop reports to track volume of accounts, payer information, reimbursement, and date of claim submission to ensure timely payment of claims. Remember, payors have 30 days to issue payment, which can only be extended 15 days if additional information is requested
- ☐ If IDR process will be utilized, develop reporting to track all accounts going through IDR process. Be sure to track the date account(s) enter IDR process and outcomes
- ☐ Implement and monitor a weekly denial report to ensure payers aren't blanket denying out of network claims
- ☐ Monitor reimbursement percentages closely for both in and out of network payers to ensure consistent cash flow

ADDITIONAL RESOURCES

CMS IDR Fee Guidance for CY 2022: https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Technical-Guidance-CY2022-Fee-Guidance-Federal-Independent-Dispute-Resolution-Process-NSA.pdf

No Surprises Act Public Notices and Consent Form No. CMS -10780: https://www.cms.gov/httpswwwcmsgovregulations-and-guidancelegislationpaperworkreductionactof1995pra-listing/cms-10780

CMS' NSA Overview of Rules and Fact Sheets: https://www.cms.gov/nosurprises/Policies-and-Resources/Overview-of-rules-fact-sheets