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Overview of the Independent Dispute Resolution Process under the No Surprises Act

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Introduction

The federal No Surprises Act has drastically altered payor-provider payment disputes. In addition to the numerous patient protections aimed at preventing balance billing for emergency services and surprise bills for non-emergency services, the Act established an Independent Dispute Resolution process to resolve payment disputes. This means that a substantial number of payment disputes will no longer see a courtroom.

Under the new framework, payors must pay providers the “out of network rate” The act defines "out-of-network rate" as:

- In states where a state law “provides for a method for determining the total amount payable,” “the amount determined in accordance with such law.”
- In states without such laws, the payment as agreed by the plan and provider or the amount determined by the independent dispute resolution program established by the act.
- In states with all-payer models, the state-approved amount.

In short, where no state law provides a method to determine payment and the parties cannot agree, the Federal IDR process is likely the only option. Below, I distill the necessary stages of the IDR process set forth in the recently passed regulations. I also discuss the criteria for providers to obtain informed consent to avoid IDR and be able to balance bill the patients. At the end of this paper, you will find a deadlines cheat sheet and a list of the certified IDR entities.

I. The process begins when the payor either pays or denies the provider's claim. From the day of payment or denial, a party has 30 days to initiate the 30-day open negotiations period.

A. The open negotiation notice must identify the service(s) (including the date(s) the item(s) or service(s) were furnished, the service code, and initial payment amount, if applicable), an offer of an out-of-network rate, and contact information for the party sending the open negotiation notice. The notice must be in writing and can be provided electronically.

II. If negotiations fail, a party has 4 business days to initiate IDR after the open negotiation period ends (initiation date is the date of receipt by CMS).

A. The Notice of IDR must include:

1. Information sufficient to identify the services in dispute, including the date, location, and type of service, amount of cost sharing allowed, amount of initial payment, if applicable;

2. Names and contact information of the parties involved;

3. Commencement date of the open negotiation period;

4. Preferred IDR entity;

5. An attestation that the items and services under dispute are qualified IDR items or services;

6. Qualifying Payment Amount.

B. The initiating party must also submit the Notice of IDR Initiation to CMS by using the Federal IDR portal, available at https://www.nsa-idr.cms.gov.

III. After Notice of IDR provided, the parties have 3 business days to mutually agree on an IDR entity.

A. Initiating Party indicates its preferred IDR entity in the IDR initiation notice.

B. If the other party fails to object within 3 business days, the preferred IDR entity identified in the notice of IDR initiation will be selected, so long as the IDR entity does not have a conflict of interest.

C. If parties cannot agree, CMS will randomly select and IDR entity within 6 business days.

D. Within 4 business days of initiation, parties must notify CMS of selection or failure to select.

E. If the parties have failed to select an IDR entity, the notice should so state.

F. If the parties have selected an IDR entity, the notice of selection must include:

1. the name of the IDR entity;

2. the IDR entity number (a unique identification number assigned to each certified IDR entity); and

3. an attestation by the parties (or by the initiating party if the other party did not respond) that the selected IDR entity does not have a disqualifying conflict of interest.

G. If a party believes that the Federal IDR process does not apply (for instance, because the service at issue is not within the auspices of the Act, a "specified state law" applies, or the patient has signed the appropriate consent forms), that party must explain why within the same timeframe that the notice of selection (or failure to select) is required.

H. Once the IDR entity is selected, the Initiating Party must notify CMS of the selection no later than 1 business day after selection.

I. If the selected IDR entity has a conflict of interest, the entity must notify CMS through the Federal IDR portal within 3 business days, and CMS will notify the parties. The parties will then have 3 business days to select another IDR entity or notify CMS of a failure to select so that CMS may randomly select another IDR entity.

J. If the parties reach an agreement after initiating IDR, the parties must notify CMS as soon as possible, but no later than 3 business days after the agreement. This notice must include:

1. The agreed-upon out-of-network rate (the total payment amount, including both cost sharing and the total plan or coverage payment).

2. Allocation of how parties agree to pay IDR entity fee.

IV. No later than 10 days after the selection of an IDR entity, parties must provide their offer. The offer must include:

A. Final offer of payment expressed both as a dollar amount and as a percentage of the Qualifying Payment Amount (QPA). Regulations set forth a detailed methodology for calculating the QPA. In essence, the QPA is the median contracted rate for similar services in the relevant geographic area.

B. QPA for the applicable year for the same or similar services. Where batched services have different QPAs, the parties should provide these different QPAs and may provide different offers for these items and services, provided that the same offer should apply for all items and services with the same QPA.

C. Any information requested by the IDR entity.

D. For providers and facilities,

1. information on the size of the practice.

2. The practice specialty, such as anesthesiologist, plastic surgeon, etc.

E. For payors, information on the coverage area of the plan or issuer, the relevant geographic region for purposes of the QPA, and, for group health plans, whether the coverage is fully insured or self-insured (or a FEHB carrier).

F. Parties may provide additional information related to the offer, as long as it does not relate to usual and customary charges, the billed amount, or government payment rates.

G. Parties may provide additional credible information related to the offer that the IDR entity must consider in making a payment determination if this information clearly demonstrates that the QPA is materially different from the appropriate out-of-network rate is submitted by a party. This may include:

1. Credible information about the level of training, experience, and quality and outcome measurements of the provider or facility.

2. Credible information about the market share held by the nonparticipating provider, or facility or the plan (including, for self-insured plans, the market share of their third-party administrator (TPA) in instances where the self-insured plan relies on the TPA's networks) or issuer in the relevant geographic region.

3. Credible information about patient acuity or the complexity of the service.

4. Credible information about the teaching status, case mix, and scope of services of the nonparticipating facility.

5. Credible information about good faith efforts (or lack thereof) made by the nonparticipating 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 and the plan or issuer, as applicable during the previous 4 plan years.

6. For air ambulance services,

a) credible information about the quality and outcomes measurements of the provider of air ambulance services that furnished the services.

b) credible information about the acuity of the condition of the participant, beneficiary, or enrollee receiving the services, or the complexity of providing the services.

c) credible information about the level of training, experience, and quality of medical personnel that furnished the air ambulance services.

d) credible information about the ambulance vehicle type, including the clinical capability level of the vehicle.

e) credible information about the population density of the point of pick-up for the air ambulance (such as urban, suburban, rural, or frontier).

V. No later than 30 days after selection (20 days after the offer), IDR entity must select one of the submitted offers, notify the parties, and provide a written decision.

A. The IDR entity does not have discretion to select an amount that is other than the two offers.

B. According to CMS guidance, the IDR entities must begin with the presumption that the QPA is the appropriate OON amount. If a party submits additional information (see above), then the IDR entity must consider this information if it is credible. To deviate from the offer closest to the QPA, the information must clearly demonstrate that the value of the item or service is materially different from the QPA.

VI. Once the IDR entity has made a payment determination, it must provide the underlying rationale for its determination in a written decision submitted to the parties and CMS.

A. If the IDR entity does not choose the offer closest to the QPA, the written decision must include an explanation of the credible information that the IDR entity determined demonstrated that the QPA was materially different from the appropriate out-of-network rate.

B. The amount of the offer selected by the IDR entity (less the sum of the initial payment and any cost sharing paid or owed by the participant or beneficiary) must be paid directly to the provider or facility not later than 30 calendar days after the determination.

C. 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, the amount of the difference must be paid to the plan or issuer not later than 30 calendar days after the determination.

VII. Both parties must pay an administrative fee ($50 each for 2022), and the non-prevailing party is responsible for the IDR entity fee ($200-$670).

VIII. A party may request to extend the time periods (excluding the timing of payment) in the case of extenuating circumstances on a case-by-case basis if the extension is necessary to address delays due to matters beyond the control of the parties or for good cause.

Overview of the Criteria to Obtain Patient Informed Consent

Informed consent allows providers to both avoid the IDR process and to balance bill the patient. The IDR process does not apply if the patient has signed the proper documents consenting to be treated and billed by a non-participating provider. Indeed, no party may start the IDR process if the party knows (or reasonably should have known) that the provider received consent. In this section, I discuss the requirements for providers to obtain valid informed consent from the patient.

First, the treating physician must determine that the patient can travel via non-emergency transport to a participating facility.

This makes sense because the key point of patient's consent is a waiver of the right to be treated by a participating provider. If the patient is not stable enough to be transferred, the consent to be treated by an out of network provider becomes meaningless.

Second, the treating physician must determine, using appropriate medical judgment, that the patient is in a condition to receive the notice and consent document and to provide informed consent (the patient's authorized representative may provide informed consent as well).

This is another common-sense provision to protect patients from being forced to sign documents when they may not understand their significance.

Third, if the above conditions are met, the provider must satisfy the notice and consent criteria:

1. Notice must be in a written document, separate from all others;
2. Notice must be given 72 hours before treatment if appointment set 72 hours in advance OR on the date of the treatment if appointment set less than 72 hours in advance but no later than 3 hours before treatment.
3. Notice must include:
    a. Statement that the provider is non-participating;
    b. The good faith estimated amount that the non-participating provider may charge;
    c. Statement that the patient's consent is not a contract that binds the patient to be treated by that provider or to pay the estimated charge;
    d. Statement that prior authorization may be required before treatment;
    e. Statement that the consent to be treated by a non-participating provider is optional and that the patient may instead seek care from an available participating provider, and that the patient's the cost-sharing would be lower if treated by a participating provider.

f. Statement that the payment by the patient might not accrue toward meeting any limitation that the plan places on cost sharing, including an explanation that such payment might not apply to an in-network deductible or out-of-pocket maximum applied under the plan;

g. In case of emergency services, give a list of participating providers to whom the patient may be referred;

h. Statement that by signing the consent, the individual agrees to be treated by the non-participating provider and understands the individual may be balance billed by that provider.

4. Consent must be voluntarily given.

5. Time and date of the notice and of the consent must be documented.

6. Signed copy must be provided to the patient.

If the provider can met the above requirements, it may balance bill the patient and need not engage in the IDR process to obtain additional payment from the plan.

But, non-participating providers cannot balance bill, regardless of whether the provider obtained informed consent, for "unforeseen, urgent medical needs that arise at the time an item or service is furnished." And, in cases of surprise billing only, the provider cannot bill, even with informed consent, for so called "ancillary services." These include, among others, diagnostics, labs, anesthesiology, and radiology. Ancillary services also include "services provided by a nonparticipating provider if there is no participating provider who can furnish such item or service at such facility." It is important to understand that even if the non-participating provider obtains informed consent, it still may not bill the patient where there are no participating providers at the participating facility who could treat the patient.

Illustrations of IDR Outcomes Provided in the Regulations

Example 1—

(1) Facts. A nonparticipating provider and an issuer are parties to a payment determination in the Federal IDR process. The nonparticipating provider submits an offer and additional written information asserting that the provider has made good faith efforts to enter into network agreements with the issuer. The nonparticipating provider fails to provide any documentation of these efforts, such as correspondence or records of conversations with representatives of the issuer.

(2) Conclusion. In this Example 1, the nonparticipating provider has submitted additional information. However, this information is not credible, as the nonparticipating provider has failed to provide any documentation in support of the provider's assertions of good faith efforts to enter into network agreements with the issuer. Therefore, the certified IDR entity cannot consider the information.

Example 2—

(1) Facts. A nonparticipating provider and an issuer are parties to a payment determination in the Federal IDR process. The nonparticipating provider submits credible information relating to the provider's level of training, experience, and quality and outcome measurements from 2019. The provider also submits credible information that clearly demonstrates that the provider's level of training and expertise was necessary for providing the service that is the subject of the payment determination to the particular patient. Further, the provider submits credible information that clearly demonstrates that the qualifying payment amount generally presumes the service would be delivered by a provider with a lower level of training, experience, and quality and outcome measurements. This information, taken together, demonstrates that the qualifying payment amount is not an appropriate payment amount and the provider submits an offer that is higher than the qualifying payment amount and commensurate with the provider's level of training, experience, and quality and outcome measurements with respect to the service provided. The issuer submits the qualifying payment amount as its offer with no additional information.

(2) Conclusion. In this Example 2, the nonparticipating provider has submitted information that is credible. Moreover, the credible information clearly demonstrates that the qualifying payment amount does not adequately take into account the provider's level of training, experience, and quality and outcome measurements with respect to the service provided, and that the appropriate out-of-network rate should therefore be higher than the qualifying payment amount. Accordingly, the certified IDR entity must select the provider's offer, as that offer best represents the value of the service that is the subject of the payment determination.

Example 3—

(1) Facts. A nonparticipating provider and an issuer are parties to a payment determination in the Federal IDR process. The nonparticipating provider submits credible information to the certified IDR entity relating to the acuity of the patient that received the service, and the complexity of furnishing the service to the patient, by providing details of the service at issue and the training required to furnish the complex service. The provider contends that this information demonstrates that the qualifying payment amount is not an appropriate payment amount, and the provider submits an offer that is higher than the qualifying payment amount and equal to what the provider believes is commensurate with the acuity of the patient and the complexity of the service that is the subject of the payment determination. However, the evidence submitted by the provider does not clearly demonstrate that the qualifying payment amount fails to encompass the acuity and complexity of the service. The issuer submits the qualifying payment amount as its offer, along with credible information that demonstrates how the qualifying payment amount was calculated for this particular service, taking into consideration the acuity of the patient and the complexity of the service.

(2) Conclusion. The information submitted by the provider to the certified IDR entity is credible with respect to the acuity of the patient and complexity of the service. However, in this example, the provider has not clearly demonstrated that the qualifying payment amount is materially different from the appropriate out-of-network rate, based on the acuity of the patient and the complexity of the service that is the subject of the payment determination. Accordingly, the certified IDR entity must select the offer closest to the qualifying payment amount, which is the issuer's offer.

Example 4—

(1) Facts. A nonparticipating provider and an issuer are parties to a payment determination in the Federal IDR process. The issuer submits credible information demonstrating that the patent for the item that is the subject of the payment determination has expired, including written documentation that demonstrates how much the cost of the item was at the time the provider rendered service and how the qualifying payment amount exceeds that cost. The issuer submits an offer that is lower than the qualifying payment amount and commensurate with the cost of the item at the time service was rendered. The nonparticipating provider submits the qualifying payment amount as its offer and also submits credible information demonstrating the provider's level of training, experience, and quality and outcome measurements from 2019, but the provider does not explain how this additional information is relevant to the cost of the item.

(2) Conclusion. In this Example 4, both the nonparticipating provider and issuer submitted information that is credible and that may be considered by the certified IDR entity. However, only the issuer provided credible information that was relevant to the service that is the subject of the payment determination. Moreover, the issuer has clearly demonstrated that the qualifying payment amount does not adequately take into account the complexity of the item furnished—in

this case that the item is no longer patent protected. While the provider submitted credible information, the provider failed to show how the information was relevant to the item that is the subject of the payment determination. Accordingly, the certified IDR entity must select the offer that best represents the value of the item, which is the issuer's offer in this example.

IDR Deadlines Cheat Sheet

Independent Dispute Resolution Action	Timeline
Initiate 30-business-day open negotiation period	30 business days, starting on the day of initial payment or notice of denial of payment
Initiate independent dispute resolution process following failed open negotiation	4 business days, starting the business day after the open negotiation period ends
Mutual agreement on certified independent dispute resolution entity selection	3 business days after the independent dispute resolution initiation date
Departments select certified independent dispute resolution entity in the case of no conflict-free selection by parties	6 business days after the independent dispute resolution initiation date
Submit payment offers and additional information to certified independent dispute resolution entity	10 business days after the date of certified independent dispute resolution entity selection
Payment determination made	30 business days after the date of certified independent dispute resolution entity selection
Payment submitted to the applicable party	30 business days after the payment determination

Certified IDR Entities

Legal Business Name	Website	Flat Fee (single determinations)	Batched Fee (batched determinations)
C2C Innovative Solutions, Inc.	https://www.c2cinc.com	$299	$670
Island Peer Review Organization	https://ipro.org	$500	$670
Maximus Federal Services, Inc.	https://maximus.com/federal	$375	$475
National Medical Reviews	https://nationalmedicalreviews.com	$285	$570
Network Medical Review Company	https://www.nmrco.com	$397	$655