



American Medical
Association™ Guide
for Physicians:
**Disputing Out-of-
Network Payments Using
the No Surprises Act
Independent Dispute
Resolution Process**

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AMERICAN MEDICAL ASSOCIATION™ GUIDE FOR PHYSICIANS: DISPUTING OUT-OF-NETWORK PAYMENTS USING THE NO SURPRISES ACT INDEPENDENT DISPUTE RESOLUTION PROCESS

THIS AMA® GUIDE FOR PHYSICIANS: DISPUTING OUT-OF-NETWORK PAYMENTS USING THE NO SURPRISES ACT INDEPENDENT DISPUTE RESOLUTION PROCESS

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Effective January 1, 2022, the federal No Surprises Act (NSA) prohibits out-of-network health care providers and facilities from balance billing commercially insured patients, in certain circumstances.¹ The NSA and its implementing regulations set a method for determining the patient cost-sharing for these out-of-network situations, and when state law does not establish a provider payment methodology and the plan and provider disagree on the rate, the NSA establishes an independent dispute resolution (IDR) system to determine provider payment.

A [January 2022 AMA toolkit](#) focused on initial NSA implementation steps for physicians. This new guide focuses on steps for physicians and office administrators and/or billing departments related to the IDR process established by the NSA and outlined in recent regulation.² This toolkit also addresses the implications of ongoing litigation related to the IDR regulation, current as of March 11, 2022.

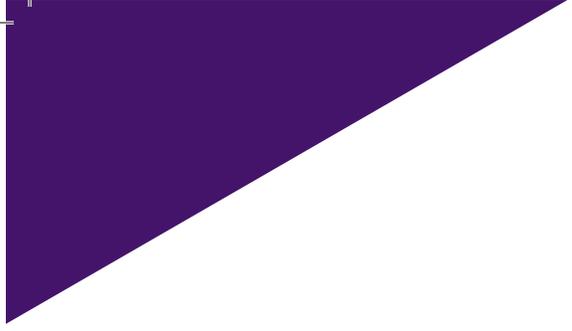
Applicability of Federal IDR Process

WHAT CONSTITUTES A SURPRISE MEDICAL BILL FOR WHICH BALANCE BILLING IS PROHIBITED?

The NSA applies to three types of surprise medical bills:

1. Out-of-network emergency services at a hospital emergency department or independent freestanding emergency department
2. Nonemergency services by out-of-network providers who practice at an in-network hospital, critical access hospital, hospital outpatient department or ambulatory surgery center
3. Air ambulances (but not ground ambulances)³

Even for those types of bills, there are certain circumstances under the rules where a patient is permitted to consent to receive treatment by an out-of-network provider and agree to pay the full out-of-network balance. The details of when and how a provider may seek such consent are described in the [January 2022 AMA publication](#).



DOES THE BALANCE BILLING PROHIBITION APPLY TO CERTAIN HEALTH MARKETS AND NOT OTHERS?

The IDR process described here is available only to those situations in which balance billing is prohibited and the patient has not consented to pay out-of-network rates. Further, these rules apply only to patients covered under employment-based group health plans or individual market health insurance. It does not apply to uninsured patients or patients covered under government health programs. (This IDR process generally applies to individuals covered by qualified health plans through the Affordable Care Act state or federal health insurance exchanges.)

WHEN DOES THE FEDERAL IDR PROCESS APPLY, INSTEAD OF A STATE PAYMENT METHODOLOGY?

The federal IDR process applies only when a state all-payer model agreement or a “specified” state law does not set the out-of-network rate, and the payer and provider have not agreed on a rate. Only Maryland has an all-payer model agreement. A specified state law is one that sets a method for determining the total amount payable that applies to the particular payer, provider, and item or service that is at issue in the out-of-network claim.⁴ If a specified state law exists, the out-of-network rate is determined under that law. Many states have laws that could be considered specified state laws; they may use a benchmark or other methods to set prices. In order to determine whether a state law or the federal IDR process applies, consult guidance from state or federal regulators, or legal counsel. The Centers for Medicare & Medicaid Services (CMS) is publishing and frequently updating information at the following address on whether particular state laws may constitute specified state laws:

www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/CAA

WHAT HAPPENS WHEN STATE LAWS ARE NARROWER THAN THE FEDERAL LAW?

Because state laws often do not have the same scope as the NSA, there may be situations where a specified state law will apply to some claims and the federal IDR process will apply to other claims. Particular claims scenarios will need to be analyzed under particular state laws, focusing on whether the state law sets the payment methodology with respect to the provider, payer, and item or service at issue in the claim.

WHAT ARE SOME EXAMPLES OF HOW THE STATE ROLE VARIES WITH RESPECT TO IDR?

The federal IDR process applies to some disputes about out-of-network rates in every state. For example, the Employee Retirement Income Security Act of 1974 (ERISA) has prevented states from enacting laws that govern disputes for private-employer self-insured health plans (although the NSA now permits states to allow private-employer self-insured plans to opt into a state law⁵). The Airline Deregulation Act of 1978 broadly preempts state laws that relate to air ambulance providers, so surprise bills will generally be subject only to federal law.⁶ But most states have laws that will affect at least some out-of-network payment disputes, and many states have entered into cooperative enforcement agreements (CEAs) through which the state agrees to pursue voluntary enforcement of the **outcome** of the federal IDR process.

Examples of state roles include the following:

- **Pennsylvania** has no authority to resolve disputes about out-of-network rates, but the Pennsylvania Insurance Department (PID) is coordinating enforcement in the commonwealth under a CEA that includes consumer assistance and enforcement of NSA requirements against insurers under their jurisdiction, including the outcome of federal IDR cases. The PID has a website that explains the rights and responsibilities of all parties and offers hands-on assistance to consumers in navigating NSA disputes, including coordination across multiple state agencies that have varying authority over providers and insurers.
- **Texas** has broad authority to resolve disputes about out-of-network rates based on a 2019 law that established an arbitration process for provider-related disputes and a mediation process for facility-related disputes. The Texas IDR process involves multiple state agencies and covers most NSA-governed disputes in emergency departments and in-network facilities other than disputes involving self-insured plans and air ambulances. Texas has not entered into a CEA to pursue voluntary enforcement for federal IDR cases.
- **California** has authority to resolve certain disputes about out-of-network rates based on a 2017 law that established a process for determining the out-of-network rate with respect to nonemergency services in certain cases. The California Department of Insurance (CDI) and the Department of Managed Health Care (DMHC) also had some authority over emergency services cases, but that authority was determined not to be a specified state law since it was based in case law rather than statute. CDI and DMHC have signed a CEA agreeing to pursue voluntary enforcement of the outcomes in federal IDR cases.

The CMS letters memorializing current federal-state enforcement plans always recognize that the states can take on more authority through new specified laws and/or CEAs. A number of states are examining how to better harmonize their laws with the NSA, so it is important to check for updates.

Steps in Federal IDR Process

FEDERAL IDR PROCESS AT A GLANCE

- Commercial payer makes initial payment or issues a notice of denial of payment within 30 calendar days of claim.
- Provider invokes open negotiation process within 30 business days of initial payment or denial.
- Open negotiation period lasts 30 business days.
- IDR process must be initiated within four business days of end of open negotiation period.
- Plan has three business days to object to provider's proposed IDR entity.
- Within four business days of initiating IDR, provider submits notice of selection of IDR entity or failure to agree.
- Provider and plan submit offers to IDR entity within ten business days of IDR initiation.
- Within 30 business days of IDR initiation, IDR entity notifies parties of its determination.
- Any additional payment owed due to IDR must be made within 30 calendar days of decision.

WHAT DOES A PROVIDER DO WHEN IT DISAGREES WITH AN OUT-OF-NETWORK PAYMENT FROM A HEALTH PLAN?

The first step in disputing an out-of-network payment is initiating "open negotiation," which must occur prior to invoking the IDR process. The provider may invoke the open negotiation process during the 30-business-day period beginning on the day the provider receives an initial payment or denial of payment from a plan.⁷

HOW DOES A PROVIDER INITIATE OPEN NEGOTIATION?

The provider must complete the Open Negotiation Notice available here:

www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/no-surprises-act/surprise-billing-part-ii-information-collection-documents-attachment-2.pdf

The provider must send this notice to the health plan by mail, unless the provider sends the notice electronically and meets two additional conditions: It has a good faith belief that the electronic method is readily accessible by the health plan, and it provides the notice in paper form free of charge upon request.

WHEN MAY A PROVIDER INITIATE THE IDR PROCESS?

If the plan and provider do not agree on an out-of-network rate, the negotiation period ends 30 business days after the date of the Open Negotiation Notice, and the provider may initiate the IDR process within four business days after the end of the open negotiation period.

HOW DOES THE PROVIDER INITIATE THE IDR PROCESS?

The provider completes the Notice of IDR Initiation here:

www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/no-surprises-act/surprise-billing-part-ii-information-collection-documents-attachment-3.pdf

The provider must send this notice to the health plan by mail, unless the provider sends the notice electronically and meets two additional conditions: It has a good faith belief that the electronic method is readily accessible by the health plan, and it provides the notice in paper form free of charge upon request.

The provider must also submit the notice to the federal IDR portal here:

www.nsa-idr.cms.gov/

The IDR process is considered initiated on the date the notice is submitted to that portal. The federal IDR portal is not yet operational. Once the portal is operational, providers will have 15 business days to submit notices with respect to any disputes for which the negotiation period has already expired.⁸

CAN THE PARTIES SETTLE A DISPUTE DURING THE ARBITRATION PROCESS?

Yes, the parties may still settle the dispute after the IDR is initiated and before the arbitration is decided. The provider must notify the federal IDR portal within three business days of such a settlement.⁹ In that case, costs will apply; each party must pay half the IDR entity's fee.

HOW IS AN IDR ENTITY SELECTED?

The government will make available a list of certified IDR entities here:

www.cms.gov/nosurprises/Help-resolve-payment-disputes/certified-IDRE-list

The provider will propose an IDR entity in the Notice of IDR Initiation, and the other party may object to it within three business days. The objecting party must propose an alternate entity. If the parties do not agree within three business days of initiation of the IDR process, the Departments of Health and Human Services (HHS), Labor, and the Treasury (the "Departments") will randomly select from among certified IDR entities, with a preference for IDR entities that charge arbitration fees within an acceptable range set by the Departments.¹⁰

Within four business days of initiation of the IDR process, the provider must submit notice via the federal IDR portal regarding the parties' selected IDR entity, or indicate that the parties have not been able to come to an agreement. The parties must attest that the selected IDR entity does not have a conflict of interest, including a conflict of interest based on a relationship between the selected IDR entity or its personnel and one of the parties to the dispute.

HOW DOES THE ARBITRATION PROCEED ONCE AN IDR ENTITY IS SELECTED?

Within ten business days of selection of the IDR entity, the provider and plan must each submit their proposed payment amount, along with the percentage of the qualifying payment amount (QPA) represented by the amount. (The QPA is generally based on the health plan's median in-network rate for the same service in the same geographic area, and it is the basis for calculating the patient cost-sharing for the out-of-network service.)

Providers must submit information on the size of the provider's practice and specialty. Plans must submit information on their coverage

area, relevant geographic region for calculating the QPA, whether coverage is insured or self-insured, and the QPA. The government has provided detailed specifications on

what information **may** be provided as part of an offer.¹¹ The parties may submit any other information they choose, or as requested by the IDR entity, but **may not** submit

information regarding the provider's usual and customary charge, the billed amount, or government program reimbursement rates.

HOW DOES THE IDR ENTITY DETERMINE THE OUT-OF-NETWORK PAYMENT?

The NSA requires "baseball style" arbitration: The IDR entity must select one of the offers submitted; it cannot make up its own payment rate. Within 30 business days of selection of the IDR entity, the IDR entity must select the out-of-network rate from among one of the offers submitted and notify the parties in a written decision via the federal IDR portal.

The IDR entity must consider:

- The QPA for the applicable year for the same or similar item or service
- Credible information submitted by a party at the request of the IDR entity
- Credible information submitted by a party on these topics:
 - Provider's level of training, experience, quality and outcome measures
 - Market share of party
 - Patient acuity or complexity of care
 - Teaching status, case mix and scope of services of nonparticipating facility
 - History of contracting between plan and provider (including the history of or lack of good faith efforts to contract, and any contracts the provider and plan have had in the prior four plan years)

The IDR entity must not consider usual and customary charges, billed charges, or government program reimbursement rates (such as Medicare and Medicaid rates).

HOW HAS LITIGATION CHANGED THE STANDARDS USED BY IDR ENTITIES TO DETERMINE THE OUT-OF-NETWORK RATE?

The interim final rule establishing the IDR process differed from the process described above in that it specified that the “IDR entity must begin with the presumption that the QPA is the appropriate out-of-network rate” and “must select the offer closest to the QPA unless the certified IDR entity determines that credible information submitted by either party clearly demonstrates the QPA is materially different from the appropriate out-of-network rate.”¹² Several parties, including the AMA, filed litigation challenging this aspect of the interim final rules. On February 23, 2022, the first judge to rule on these cases held that this aspect of the rules (1) conflicts with the unambiguous terms of the NSA and (2) was improperly promulgated without prior notice and an opportunity to comment. The district court vacated those aspects of the rules that required the IDR entities to select the offer closest to the QPA unless presented with credible information that clearly demonstrates the QPA is materially different from the appropriate rate.¹³ On February 28, CMS and the Department of Labor said they would withdraw guidance documents that are based on or refer to the invalidated portions of the rules, repost the guidance documents, and provide training to IDR entities on the revised guidance.¹⁴

It remains possible that the government will choose to appeal the court case; the government has until April 25, 2022, to decide whether to appeal. Appeals could still alter the standards that will apply to IDR determinations. This implementation guide describes the standards that apply as of the date of publication, in light of the most recent court decisions and federal guidance.

CAN IDR REQUESTS BE BATCHED TO SIMPLIFY THE PROCESS?

IDR requests may be submitted to the IDR entity in batches—with all the disputes between the same plan and provider (or facility or group of providers) for the same item or service (i.e., the same procedure code) submitted together. The services must have been furnished within the same 30-business-day period. When services are billed by a provider as a bundle (a single fee for an entire episode of care) or paid or denied based on the plan’s bundling, the IDR entity may consider the appropriate payment for the bundle instead of the component services.

For batched items and services, each party may submit different offers for items that have different QPAs (and the IDR entity may select different amounts for each offer).

There is also a 90-calendar-day “cooling off” period after each decision, during which the same provider and same plan cannot submit a new IDR request for the same or a similar item or service; but at the end of the cooling-off period, the parties can submit IDR requests for claims for which negotiation failed during that period (and may batch them at that point).

HOW IS THE FINAL OUT-OF-NETWORK PAYMENT MADE?

If the out-of-network payment selected by the IDR entity exceeds the amounts already paid to the provider, the plan must pay the provider the balance not later than 30 calendar days after the IDR entity makes its determination. If the IDR entity selects an amount lower than the payments already made, the provider must refund the difference to the plan within 30 calendar days.

WHO PAYS THE IDR ENTITY'S FEES?

If the parties settle the reimbursement dispute after the IDR is initiated and before the arbitration is decided, each party must pay half the IDR entity's fee.

The party that loses the arbitration is liable for the IDR entity's fee (which will generally be between \$200 and \$500 for a single determination or between \$268 and \$670 for a batched determination); each party is responsible for paying a \$50 administrative fee to the Departments.¹⁵ The fees are paid at the time each party submits its offer to the IDR entity, and the prevailing party's IDR entity fee is refunded at the end of the process.

The rules do not provide for shifting attorney fees to the losing party.

MAY A PROVIDER REQUEST AN EXTENSION OF ANY DEADLINE UNDER THE IDR PROCESS?

Most deadlines may be extended in extenuating circumstances if necessary to address delays beyond the control of the parties or for good cause. An extension may be requested via the federal IDR portal.¹⁶

- 1 Consolidated Appropriations Act, 2021, Pub. L. No. 116-260 div. BB tit. I, 134 Stat. 1182, 2758 (2020).
- 2 Requirements Related to Surprise Billing; Part II, 86 Fed. Reg. 55980 (Oct. 7, 2021), available at www.federalregister.gov/documents/2021/10/07/2021-21441/requirements-related-to-surprise-billing-part-ii. Accessed March 18, 2022.
- 3 While similar rules apply to air ambulance bills, the focus of this guide is the first two categories of services.
- 4 45 C.F.R. § 149.30.
- 5 45 C.F.R. § 149.30.
- 6 Requirements Related to Surprise Billing; Part I, 86 Fed. Reg. 36872, 36884 (July 13, 2021).
- 7 45 C.F.R. § 149.510(b)(1)(i).
- 8 CMS, Memorandum Concerning Continuing Surprise Billing Protections for Consumers, www.cms.gov/files/document/memorandum-regarding-continuing-surprise-billing-protections-consumers.pdf (2022). Accessed March 18, 2022.
- 9 Notice of Agreement Data Elements, www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/no-surprises-act/surprise-billing-part-ii-information-collection-documents-attachment-5.pdf. Accessed March 18, 2022.
- 10 For calendar year 2022, the range decided on by the Departments for a single determination is \$200–\$500 and for batched determinations is \$268–\$670. www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Technical-Guidance-CY2022-Fee-Guidance-Federal-Independent-Dispute-Resolution-Process-NSA.pdf. Accessed March 18, 2022.
- 11 IDR Process Notice of Offer Data Elements, www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/no-surprises-act/surprise-billing-part-ii-information-collection-documents-attachment-6.pdf. Accessed March 18, 2022.
- 12 Requirements Related to Surprise Billing; Part II, 86 Fed. Reg. 55980, 55984 (Oct. 7, 2021).
- 13 *Texas Med. Ass’n v. U.S. Dep’t of Health & Human Services*, No. 6:21-cv-425 (E.D. Tex. Feb. 23, 2022).
- 14 CMS, Memorandum Concerning Continuing Surprise Billing Protections for Consumers, www.cms.gov/files/document/memorandum-regarding-continuing-surprise-billing-protections-consumers.pdf (2022). Accessed March 18, 2022.
- 15 CMS, Technical Guidance No. 2021-01, Calendar Year 2022 Fee Guidance for the Federal Independent Dispute Resolution Process under the No Surprises Act, www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Technical-Guidance-CY2022-Fee-Guidance-Federal-Independent-Dispute-Resolution-Process-NSA.pdf. Accessed March 18, 2022.
- 16 45 C.F.R. § 149.510(g); see Request for Extension of Federal IDR Process Time Period Due to Extenuating Circumstances, www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/no-surprises-act/surprise-billing-part-ii-information-collection-documents-attachment-10.pdf. Accessed March 18, 2022.

