HEALTH LAW ALERT
September 6, 2022

No Surprises Act Rule Imposes New Disclosure Requirements for "Downcoded" Claims

FAQs Seek to Clarify QPA Payment Process

The Departments of Health and Human Services, Labor, and the Treasury (the **Agencies**) published final Rules adopting changes to regulatory requirements implementing the No Surprises Act provisions prohibiting surprise medical bills for emergency services, certain non-emergency services, and services from air ambulance service providers (in each case) furnished by out-of-network providers (**No Surprises Act Covered Services**). The revised Rules require a health plan to provide additional information to an out-of-network provider when the plan pays a claim for No Surprises Act Covered Services after "downcoding" the claim. The revised Rules also make changes to reflect two Federal court decisions regarding the Rules.

The revised Rules are published at 87 *Federal Register* 52618 (click here). Click here for my compilation of the Department of Health and Human Services' version of Selected Federal Health Insurance Provisions incorporating these changes into previously-published rules (or see the "Resources" page at tbixbylaw.com) and see Volume I of "Federal Insurance Rules," under "Compiled Rules." The No Surprises Act provisions applicable to health plans are in Part 149, Subparts A, B, D, and F.

In addition, the Agencies published more than 20 FAQs addressing various aspects of the No Surprises Act prohibition on surprise medical bills. See the last section of this Alert below for some highlights of the FAQs. Click here for the FAQs.

Disclosures for Downcoded Claims

In most States, health insurers, self-funded group health plans, and the Federal Employees Health Benefits Program (FEHBP) (as well as providers) must comply with a Federal Independent Dispute Resolution process to determine payment amounts for No Surprises Act Covered Services furnished by out-of-network providers (the **NSA Payment Process**). Health insurers in States with an All Payer Model Agreement (under Federal law) or a State law addressing balance billing are generally not required to comply with the NSA

Payment Process. Similarly, self-funded group health plans and FEHBP contractors that have opted into these State programs (where permitted to do so) are not generally required to comply with the NSA Payment Process. Click here for the Centers for Medicare and Medicaid Services' table listing applicability of the NSA Payment Process. For "Bifurcated States" (*i.e.*, States for which a State process applies to some items and services and the NSA Payment Process applies to others), click here. The requirements described below apply only to the claims for services subject to the NSA Payment Process.

Health plans subject to the NSA Payment Process must calculate a "Qualified Payment Amount" for No Surprises Act Covered Services furnished by an out-of-network provider based on the plan's contracts with participating providers (the **QPA**). Health plans must make an "initial payment" to these out-of-network providers (or provide a notice of denial of payment) within 30 days of receiving a clean claim. When a health plan makes an initial payment of the QPA or issues a denial of payment, it is required to send the out-of-network provider a written notice concerning the payment (or denial of payment).

Under the revised Rule, a health plan that "downcodes" a claim must include additional information in this notice. The Agencies define "downcoding" to mean "the alteration . . . of a service code to another service code, or the alteration, addition, or removal . . . of a modifier, if the changed code or modifier is associated with a lower qualifying payment amount." When a plan downcodes a claim for No Surprises Act Covered Services, its notice to the out-of-network provider, in addition to the other required information, must include:

- A statement indicating the claim was downcoded;
- An explanation of the downcoding, including the reason for downcoding and a description of the codes (or modifiers) that were altered or removed; and
- The QPA applicable to the unaltered code(s) (or code(s) with unaltered modifier(s)) (as well as the QPA for the altered code(s) (or modifier(s)).

The requirement to provide this additional information with downcoded claims subject to the NSA Payment Process goes into effect on October 25, 2022 (except for health plans with plan (or policy) years that begin after October 25, in which case the requirement goes into effect at the beginning of the next plan (policy) year).

Changes to Reflect Court Rulings

Two Federal courts vacated provisions of the original version of these Rules that dictated the process for determining amounts providers should be paid for furnishing No Surprises Act Covered Services when a dispute arises between a health plan and an out-of-network provider. In each case, the vacated provisions were viewed as requiring the Federal Independent Dispute Resolution entities to rely too heavily on the QPA, to the detriment of other factors that the parties might raise. The revised Rules replace the vacated language and direct the IDR entities to select the rate proposed by a party that the IDR entity "determines best represents the value of [the applicable] item or service as the out-of-network rate." The

Rule spells out the factors the IDR entity may (and may not) take into account in making its determination but continues to emphasize the importance of the QPA.

No Surprises Act FAQs

The Agencies published FAQs concerning the NSA Payment Process in conjunction with the revised Rules. The FAQs addressed a variety of subjects related to the No Surprises Act prohibition on surprise medical bills from out-of-network providers for No Surprises Act Covered Services. Among other things, the FAQs seek to clarify:

- Application of the Rules to emergency services furnished by a behavioral health crisis facility (see FAQ 10);
- Application of State laws on surprise billing to self-funded plans and out-of-state insurers (see FAQ 12);
- The methodology for calculating the QPA, including (i) when a separate QPA must be calculated for different provider specialties and (ii) explaining that contracts with a $0 rate for a No Surprises Act Covered Service should not be included in the calculation of the QPA for that Service (see FAQ 14 and footnote 29);
- The effect of a health plan's failure to provide the required notice to an out-of-network provider (see FAQ 20);
- The use of Remittance Advice and Remark Codes (RARCs) in standard electronic transactions to facilitate (and automate) communication concerning the NSA Payment Process (see FAQ document at page 22).

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