Out-of-network payment disputes: Understanding

Effective January 2022, the No Surprises Act (NSA) limited out-of-network providers from balance billing commercially insured patients in certain circumstances. Federal rules issued throughout 2021 and 2022 outlined important provisions of the NSA, including a method for determining out-of-network reimbursement for services that fall under the scope of the law. The rules also established a process for providers to negotiate and, when applicable, dispute out-of-network payment rates believed to be unfair or inaccurate.

The federal Independent Dispute Resolution (IDR) process may be initiated following unsuccessful payment negotiations between an out-of-network provider and a health plan or payer. The IDR process employs an independent arbitrator to review the facts of the case and make a final determination of payment. However, it's important to note the IDR process does not apply equally to payment disputes in all states when covered out-of-network services are rendered.

Applicability

In many cases, the qualifying payment amount (QPA), or a payer's median contracted rate for a given service, constitutes the out-of-network rate under the NSA. When the QPA applies, so does the IDR process. However, there are other mechanisms for determining out-of-network payment rates. If a state has an all-payer model agreement in place, for instance, it will supersede NSA rate setting methodology. Such agreements set across-the-board payment rates for the same service regardless of who pays for it, although Maryland is currently the only state in which this applies.

Some states have existing laws that dictate the total amount payable for certain services when rendered by an out-of-network provider. These laws also outline state-specific dispute resolution processes. Under the NSA, these are referred to as "specified state laws." When such a law exists, the federal IDR process does not apply. However, not all states may have laws that govern out-of-network rates and disputes under all circumstances. Therefore, each claim scenario must be analyzed individually to determine whether state surprise billing laws or NSA rules apply.

In general, the NSA rules – including the IDR process – apply to ERISA or self-insured plans unless a plan opts into a state's surprise billing laws, which the NSA allows. It is important to note that the NSA does permit a patient to consent to be balance billed by an out-of-network provider under limited circumstances. When a patient agrees to pay out-of-network rates, the IDR process will not apply.

To aid providers in determining whether the federal IDR process applies and under what circumstances, CMS has developed the several resources that may be found at CMS.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/CAA. OMSs are encouraged to consult with a practice attorney to determine how federal and state surprise billing laws impact their practice.

IDR at-a-glance

The following summarizes key points of the IDR process:

- Federal agencies have set strict timeframes for each phase in the process.
- Open negotiation between the provider and health plan is the mandatory first step.
- Following the open negotiation period, either party can initiate arbitration via the IDR portal: CMS.gov/NoSurprises/Help-Resolve-Payment-Disputes/Payment-Disputes-Between-Providers-and-Health-Plans
- Each party pays a non-refundable administrative fee – increased to $350 in 2023 – to participate in the process.
- IDR is baseball-style arbitration: Each party submits an offer with the arbitrator required to choose one or the other.
- Payment determination via arbitration is binding.

federal IDR process

- The party that loses the dispute is held responsible for the arbitration entity's fee. This can range between $200 to $700 for single determinations that began Jan. 1.
- Any amount due from one party to another must be paid within 30 calendar days of the final determination.
- The party that initiated the IDR process cannot initiate new arbitration with the same party and for the same services for 90 days.

Payment determinations

Since its implementation, the federal IDR process has remained the focus of intense scrutiny and litigation. The surprise billing final rules issued in August 2022 revamped the standards for payment determinations under the IDR process, in accordance with a district court ruling issued earlier that year.

The updated requirements instruct arbitrators to select the offer that "best represents the value of the item or service under dispute" and to consider the QPA in addition to all relevant and permissible evidence submitted by the disputing parties. In other words, factors such as the provider's level of training and experience, patient acuity and overall complexity of the service must be weighted alongside the median in-network rate. When making a payment determination, certain factors may not be considered, including the provider's usual and customary or billed charges and public payer (i.e., Medicare, Medicaid or TRICARE) rates.

CMS has worked with individual states to determine how certain provisions of the NSA are implemented, including the enforcement of the outcome of the IDR process. Enforcement arrangements by state are available at CMS.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/CAA.

Additional information on the IDR process, as well as other NSA provider resources, may be found at AAOMS.org/CodingReimbursement. ■