February 26, 2024

The Honorable Xavier Becerra
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

The Honorable Julie A. Su
Acting Secretary
U.S. Department of Labor
200 Constitution Avenue NW
Washington, DC 20210

The Honorable Janet Yellen
Secretary
U.S. Department of the Treasury
1500 Pennsylvania Avenue NW
Washington, DC 20220

RE: Health Plans Violating the *No Surprises Act*: Changes to Patient Cost-Sharing Amounts Post-IDRE Payment Determination

Dear Secretaries Becerra and Yellen and Acting Secretary Su:

On behalf of the American College of Emergency Physicians (ACEP) and the Emergency Department Practice Management Association (EDPMA), we write to request immediate action by the Departments of Health and Human Services, Labor, and Treasury (the Departments) to address the numerous instances in which health plans are altering patient cost-sharing amounts after an independent dispute resolution (IDR) payment determination. This is a direct violation of the *No Surprises Act*. ACEP and EDPMA strongly support the patient protections in the *No Surprises Act* and our members have strived to ensure that patients are kept out of the middle of billing disputes as the law envisions. This pattern of behavior on the part of health plans strikes directly at those patient protections. Further, we have witnessed health plans engage in this practice as an apparent means to avoid amounts due to providers after the ruling of a certified IDR entity. While our organizations have raised this issue with several officials in the Departments and we are aware of ACEP and EDPMA members that have submitted complaints on this issue via the *No Surprises Act* complaint portal, we have grown concerned about the apparent lack of enforcement or Department communications emphasizing the need for compliance with this patient protection.

We request immediate action to (1) ensure that patients are not subjected to health plans' overt disregard of the *No Surprises Act* cost-sharing protections through "after the fact" changes to their cost-sharing liabilities; (2) protect providers from making inadvertent requests for patient payment based on faulty health plan information that is setting or changing patient cost-sharing liabilities in violation of the protections guaranteed by the *No Surprises Act*; (3) compel health plans to transfer to providers the correct out-of-network rate amounts due as

explicitly laid out in the *No Surprises Act;* and (4) responsibly administer the implementation of the *No Surprises Act* by taking enforcement action against health plans for this overt disregard of Federal statute.

We emphasize to the Departments that the information herein is based on what health plans have sent to providers; in these situations, it is unclear what correspondence the health plans are furnishing to patients. However, we are concerned that patients may believe they have been subjected to a change in their financial responsibility incongruent with the protections in the *No Surprises Act* given inexplicable changes in patient cost-sharing calculations that health plans are furnishing to providers.

The *No Surprises Act* Firewall between the "Recognized Amount" and the "Out-of-Network Rate"

While health insurance policies can differ regarding the terms of coverage, payment rates for providers, and levels of patient cost-sharing, policies typically are structured in such a way that patient cost-sharing amounts for certain items and services are predicated on the underlying payment rates to the providers. For instance, if a patient has a 20% co-insurance responsibility for a hospitalization and the contract between the payer and the provider would otherwise set a payment rate of $1,000 for that given hospitalization, the payer would pay the provider $800 and the patient would be responsible for $200 under the policy terms for co-insurance.

The *No Surprises Act* acknowledges that in situations where care is delivered by an out-of-network provider, there is no underlying agreement on a payment rate, since there is no contract between the provider and the health plan. In order to establish patient cost-sharing protections for emergency services that ensure that cost-sharing is closely aligned with what the patient cost-sharing would have been had the care been delivered in-network, the *No Surprises Act* created a concept referred to as the "Recognized Amount" for purposes of calculating patient cost-sharing. The "Recognized Amount" is by-and-large unrelated to what the out-of-network provider is ultimately paid for the item or service furnished to the patient.

As articulated by the *No Surprises Act*,[1]

> * * *
>
> (ii) *the cost-sharing requirement is not greater than the requirement that would apply if such services were provided by a participating provider or a participating emergency facility*;
>
> (iii) *such cost-sharing requirement is calculated as if the total amount that would have been charged for such services by such participating provider or participating emergency facility were equal to the recognized amount . . . for such services, plan or coverage, and year[.]*

The statute defines the term "Recognized Amount" as:[2]

> *The term "recognized amount" means, with respect to an item or service furnished by a nonparticipating provider or nonparticipating emergency facility during a year and a group health plan or group or individual health insurance coverage offered by a health insurance issuer-*
>
> (i) *subject to clause (iii), in the case of such item or service furnished in a State that has in effect a* ***specified State law*** *with respect to such plan, coverage, or issuer, respectively; such a nonparticipating provider or nonparticipating emergency facility; and such an item or service, the amount determined in accordance with such law*;
>
> (ii) *subject to clause (iii), in the case of such item or service furnished in a State that does not have in effect a specified State law, with respect to such plan, coverage, or issuer, respectively; such a nonparticipating provider or nonparticipating emergency facility;*

[1] 42 USC 300gg–111(a)(1)(C); 29 USC 1185e(a)(1)(C); 26 USC 9816(a)(1)(C).
[2] 42 USC 300gg–111(a)(3)(H); 29 USC 1185e(a)(3)(H); 26 USC 9816(a)(3)(H) (emphasis added).

*and such an item or service, the amount that is **the qualifying payment amount** … for such year . . . for such item or service; or*

(iii) *in the case of such item or service furnished in a **State with an All-Payer Model Agreement** under section 1115A of the Social Security Act, the amount that the State approves under such system for such item or service so furnished*.

That is, in states without a State law addressing balance billing and reimbursement for emergency services furnished by non-participating providers or a State all-payer model, the *No Surprises Act* anchors the patient cost-sharing to the "qualifying payment amount" or QPA, which the law generally defines as the median contracted rate for that item or service as represented by 2019 contracts and updated for inflation. However, **the No Surprises Act does not establish the QPA as the payment rate for the provider. Rather, the QPA is simply an anchor for determining a basis upon which patient cost-sharing amounts can be established** since there is no underlying contract between the health plan and the out-of network provider.

The "Recognized Amount" is an altogether different concept under law from the "Out-of-Network Rate," which is the amount ultimately determined as the responsibility of the health plan to reimburse the provider for furnishing the item or service to the patient insured by that health plan. For emergency services, the *No Surprises Act* obligates that a covered health plan "*pays a total plan or coverage payment directly to such provider or facility . . . equal to the amount by which the out-of-network rate . . . for such services exceeds the cost-sharing amount for such services . . . and year*."[3]

The *No Surprises Act* defines the "Out-of-Network Rate" as follows:[4]

The term "out-of-network rate" means, with respect to an item or service furnished in a State during a year to a participant, beneficiary, or enrollee of a group health plan or group or individual health insurance coverage offered by a health insurance issuer receiving such item or service from a nonparticipating provider or nonparticipating emergency facility-

(i) *subject to clause (iii), in the case of such item or service furnished in a State that has in effect a **specified State law** with respect to such plan, coverage, or issuer, respectively; such a nonparticipating provider or nonparticipating emergency facility; and such an item or service, the amount determined in accordance with such law*;

(ii) *subject to clause (iii), in the case such State does not have in effect such a law with respect to such item or service, plan, and provider or facility-*

(I) *subject to subclause (II), **if the provider or facility (as applicable) and such plan or coverage agree on an amount of payment** (including if such agreed on amount is the initial payment sent by the plan under subsection (a)(1)(C)(iv)(I), subsection (b)(1)(C), or section 300gg–112(a)(3)(A) of this title, as applicable, or is agreed on through open negotiations under subsection (c)(1)) with respect to such item or service, such agreed on amount; or*

(II) *if such provider or facility (as applicable) and such plan or coverage enter the independent dispute resolution process under subsection (c) and do not so agree before the date on which **a certified IDR entity . . . makes a determination** with respect to such item or service under such subsection, the amount of such determination; or*

(iii) *in the case such **State has an All-Payer Model Agreement** under section 1115A of the Social Security Act [42 U.S.C. 1315a], the amount that the State approves under such system for such item or service so furnished*.

That is, when there is no State law (or State all-payer model) governing how much a health plan should reimburse

[3] 42 USC 300gg–111(a)(1)(C); 29 USC 1185e(a)(1)(C); 26 USC 9816(a)(1)(C).

[4] 42 USC 300gg–111(a)(3)(K); 29 USC 1185e(a)(3)(K); 26 USC 9816(a)(3)(K) (emphasis added).

for out-of-network emergency services, the "Out-of-Network" rate is either what the health plan and the provider agree to or the amount of the payment determination decided by the certified IDR entity. However, this does not affect patient cost-sharing (or the "Recognized Amount"). In fact, a primary intent of the law was to make patient cost-sharing a known amount that does not fluctuate over time as the health plan and the provider work through the process of determining the payment amount for the service delivered to the patient outside of the health plan's provider network (thus removing patients from the middle of these disputes).

We appreciate the Departments' delineation of these concepts in the first *No Surprises Act* interim final rule discussion:

> ***Because the cost-sharing amount is calculated using the recognized amount . . . that is calculated separately from the determination of the out-of-network rate****, these requirements may result in circumstances where a plan or issuer must make payment prior to an individual meeting their deductible. Specifically,* ***where the surprise billing protections apply, and the out-of-network rate exceeds the amount upon which cost sharing is based, a plan or issuer must pay the provider or facility the difference between the out-of-network rate and the cost sharing amount (the latter of which in this case would equal the recognized amount, or the lesser of the QPA or the billed amount****), even in cases where an individual has not satisfied their deductible, as illustrated in the following example.*
>
> ***Example****. An individual is enrolled in a high deductible health plan with a $1,500 deductible and has not yet accumulated any costs towards the deductible at the time the individual receives emergency services at an out-of-network facility. The plan determines that the recognized amount for the services is $1,000. Because the individual has not satisfied the deductible, the individual's cost-sharing amount is $1,000, which accumulates towards the deductible. The out-of-network rate is subsequently determined to be $1,500.* ***Under the requirements of the statute and these interim final rules, the plan is required to pay the difference between the out-of-network rate and the cost-sharing amount****. Therefore, the plan pays $500 for the emergency services, even though the individual has not satisfied the deductible.* ***The individual's out-of-pocket costs are limited to the amount of cost-sharing originally calculated using the recognized amount (that is, $1,000)*** (emphasis added).[5]

Despite this clear and unequivocal direction from the Departments, our members have repeatedly seen instances of health plans altering the patient cost-sharing amount based on the ultimate payment rate (i.e., "Out-of-Network Rate") differing from the establishment of the "Recognized Amount" (i.e., the patient's cost-sharing calculation), most commonly after a payment determination is made by a certified IDR entity. We write to request immediate enforcement action to stop this behavior.

Health Plans Are Ignoring the *No Surprises Act* and Changing Patient Cost-Sharing Based on Changes to the Out-of-Network Rate

In instances too numerous to count, ACEP and EDPMA members have received correspondence from health plans changing patient cost-sharing amounts after the Recognized Amount has been established. (*See,* three examples in attachments 1 through 6). This most commonly appears to happen after a payment determination is made by a certified IDR entity but in some instances has happened after an agreement has been reached during the Open Negotiation period. In these scenarios, the pattern exhibited by the health plans typically involves:

1. The health plan issues an initial remittance advice (RA) or explanation of benefits (EOB) document that sets the "Allowed Amount" at what the health plan purports to be the QPA with the patient cost-sharing amount calculated based on the amount of that QPA.
2. A dispute proceeds to the IDR process, where a payment determination is ultimately rendered that results in the health plan owing the provider funds (either because the provider's offer was selected or because the health plan's offer was selected but that health plan offer was higher than the initial payment plus the

[5] 86 *Fed. Reg.* 36884 (July 13, 2021).

initially calculated patient-cost sharing amount).

3. The health plan issues a revised RA or EOB document that changes the "Allowed Amount" to the amount of the payment determination by the certified IDR entity and recalculates the patient cost-sharing amount based on that number (i.e., the "Out of Network Rate") rather than the "Recognized Amount" as required by law.

The recalculated cost-sharing amounts result in several problematic distortions of the *No Surprises Act*:

- If the patient is responsible for co-insurance, the health plans have forwarded information to the providers falsely suggesting that the patient has additional co-insurance amounts due.
- If the increased patient cost-sharing amount is attributed to a patient that has not yet exhausted their deductible, the health plans have forwarded information to the provider falsely suggesting that the patient owes additional funds to the provider.
- The health plan fails to pay the provider the balance of the out-of-network rate that the health plan is obligated to pay under statute (because it has shifted that cost to the patient either via an increased co-insurance amount or an increased deductible liability).

The Departments Must Hold Health Plans Accountable for Violating the Patient Protections in the *No Surprises Act*

To ensure compliance with the *No Surprises Act*, it is imperative that the Departments immediately address the issue of health plans altering patient cost-sharing outside of the rules for calculating the "Recognized Amount."

First, this disregard of the law by health plans strikes directly at the heart of the patient cost-sharing protections in the *No Surprises Act.* Patient cost-sharing for a furnished item or service should not change over time, nor should it depend on the payment determinations made in IDR. A lack of enforcement action against plans engaging in this practice will invite more and more scenarios in which patients receive bills that they should never receive.

Second, this disregard of the law by health plans places our members at risk of inadvertent noncompliance by forwarding information that falsely states the amount of federally-protected patient cost-sharing calculations. While we have worked to educate our members on the patient cost-sharing protections and believe that most providers are fully aware that they cannot bill patients beyond the "Recognized Amount" for emergency services under the *No Surprises Act*, health plan proliferation of incorrect cost-sharing calculations will surely result in requests for reimbursement slipping through the cracks. Any enforcement action taken against physicians because of false information or incorrectly calculated cost-sharing amounts provided to physicians by health plans would be a severe maladministration of the *No Surprises Act.* Because it is the health plan that holds all of the information necessary to determine the correct patient cost-sharing amounts, it is near impossible for providers to police inaccuracies with any confidence. The Departments and the health plans are best-positioned to correct this problem, not providers who are being flooded by health plans with inaccurately calculated patient cost-sharing amounts.

Finally, in addition to the patient cost-sharing protections put at risk by this health plan behavior, the *No Surprises Act* provides a mechanism for resolving payment disputes that health plans are now circumventing by shifting onto the patient the amount the health plan owes the provider under statute. As providers follow the law and fail to bill the patient this incorrectly increased cost-sharing amount communicated by the health plan, the provider continues to be denied the amount determined to be a fair reimbursement by a certified IDR entity, while allowing the health plans to retain funds to which they have no right.

In sum, we urge the Departments to immediately address the issue of health plan re-calculation of patient cost-sharing liabilities outside the statutory and regulatory provisions for setting the "Recognized Amount." The extent to which this health plan behavior is undermining key pillars of the *No Surprises Act* cannot

be overemphasized. As the Departments engage on this issue, ACEP and EDPMA would remind the Departments that it is impossible for providers to investigate or police this issue when the providers do not have the source information and are not the primary actor that is resulting in documentation of increased patient cost-sharing out of compliance with the patient protections in the *No Surprises Act.*

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We appreciate the opportunity to provide feedback. If you have any questions, please do not hesitate to contact EDPMA's Executive Director, Cathey Wise, at cathey.wise@edpma.org or Laura Wooster, ACEP's Senior Vice President of Advocacy and Practice Affairs at lwooster@acep.org.

Sincerely,

Andrea Brault

Andrea Brault, MD, MMM, FACEP
Chair
Emergency Department Practice Management Association

Aisha T. Terry, MD, MPH, FACEP
President
American College of Emergency Physicians

ATTACHMENT 1

EXAMPLE 1: Original EOB & Post-IDR Revised EOB

ANTHEM HEALTH PLANS OF VIRGINIA
PO BOX 7368 / GA081E
COLUMBUS, GA 31908
TE:8004709630

Check Date: 04/22/22
Check/EFT #: [redacted]
Group Provider #: [redacted]

Remittance Notice

[redacted]

PERF PROV	SERV DATE	POS	NOS	PROC MOD	BILLED	ALLOWED	DEDUCT	COINS	GRP/RC-AMT	PROV PD
[redacted]									ASG Y	
[redacted]	0206 020622	1		99284 SA	1416.00	180.43	0.00	36.09	CO-45 1235.57	144.34
REM: N830										
PT RESP 36.09				CLAIM TOTALS	1416.00	180.43	0.00	36.09	1235.57	144.34
CLM STATUS: 1										144.34 NET
TaxID [redacted] PayerID 00423										

GLOSSARY: Group, Reason, MOA, Remark and Adjustment Codes
CO Contractual Obligations
45 Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arran
N830 The charge[s] for this service was processed in accordance with Federal/ State Balance/ Surprise Billing

ANTHEM HEALTH PLANS OF VIRGINIA
PO BOX 7368 / GA081W
COLUMBUS, GA 31908
TE:8002824548

Check Date: 08/31/23
Check/EFT #: [redacted]
Group Provider #: [redacted]

Remittance Notice

[redacted]

PERF PROV	SERV DATE	POS	NOS	PROC MOD	BILLED	ALLOWED	DEDUCT	COINS	GRP/RC-AMT	PROV PD
NAME [redacted]									ASG Y	
[redacted]	0206 020622	1		99284 SA	1416.00	704.00	0.00	140.80	CO-45 712.00	563.20
REM: N830										
PT RESP 140.80				CLAIM TOTALS	1416.00	704.00 ***	0.00	140.80	712.00	563.20
CLM STATUS: 1										563.20 NET
TaxID [redacted] PayerID 00423										

GLOSSARY: Group, Reason, MOA, Remark and Adjustment Codes
CO Contractual Obligations
45 Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arran
N830 The charge[s] for this service was processed in accordance with Federal/ State Balance/ Surprise Billing

*** Altered Allowed Amount Reflecting IDRE Payment Determination Amount, Resulting in Increased Patient Cost-Sharing

(See Attachment 2)

Attachment 2
Example 1 Certified IDR Entity Payment Determination

IDR dispute status: Payment Determination Made - Fees and Offer from One Party Only
IDR reference number: DISP-23152

National Medical Reviews, Inc. has reviewed your Federal Independent Dispute Resolution (IDR) dispute with reference number **DISP-23152** and has determined that [redacted] is the prevailing party in this dispute. [redacted] prevailed in all dispute line items.

Because only one party, [redacted] , submitted an offer and paid the corresponding fees, National Medical Reviews, Inc. has determined that the out-of-network payment amount for the items and/or services is as outlined in the table below for this dispute.

Claim Number	Service Code	Prevailing Party Offer Amount
	99284	$704.00
	99284	$704.00
	99284	$704.00
	99284	$704.00
	99284	$704.00
	99284	$704.00
	99284	$704.00
	99284	$704.00
	99284	$704.00
	99284	$704.00
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	99284	$704.00
	99284	$704.00
	99284	$704.00

	99284	$704.00
	99284	$704.00
	99284	$704.00
	99284	$704.00

Determination Rationale for all Line Items Associated with this Dispute
The certified IDR entity requested fees and offers from both parties, however, the certified IDR entity did not receive an offer and/or fees from one party. As a result, the certified IDR entity has found in favor of the party that submitted an offer and fees. National Medical Reviews, Inc. did not receive an offer and/or fees from Anthem Virginia . As a result, the certified IDR entity has found in favor of [redacted], the only party to submit an offer and fees.

Next Step:

If any amount is due to either party, it must be paid **not later than 30 calendar days** after the date of this notification, as follows:

- **A plan, issuer, or Federal Employees Health Benefits (FEHB) Program carrier owes a payment to a non-participating provider or facility** when the total amount of the offers selected by the certified IDR entity exceeds the sum of 1) any initial payment the plan, issuer, or FEHB carrier has paid to the non-participating provider or facility and 2) any cost sharing paid or owed by the participant, beneficiary, or enrollee.

- **A non-participating provider or facility owes a refund to a plan, issuer or FEHB carrier** when the total amount of the offers selected by the certified IDR entity is less than the sum of 1) any initial payment the plan, issuer, or FHHB carrier has paid to the non-participating provider or facility and 2) any cost sharing paid or owed by the participant, beneficiary, or enrollee.

NOTE: The non-prevailing party is ultimately responsible for the certified IDR entity fee, which is retained by the certified IDR entity for the services performed. National Medical Reviews, Inc. has not received an offer and/or fees from Anthem Virginia and is therefore the non-prevailing party in DISP-23152 and is responsible for paying the certified IDR entity fee. The certified IDR entity fee that was paid by the prevailing party will be returned to [redacted] by the certified IDR entity within 30 business days of the date of this notification.

Pursuant to the Federal Employees Health Benefits Act at 5 U.S.C. 8902(p), Internal Revenue Code sections 9816(c)(5)(E) and 9817(b)(5)(D), Employee Retirement Income Security Act sections 716(c)(5)(E) and 717(b)(5)(D), and Public Health Service Act sections 2799A-1(c)(5)(E) and 2799A-2(b)(5)(D), and their implementing regulations at 5 CFR 890.114, 26 CFR 54.9816–8T (c)(4)(vii), 29 CFR 2590.716-8(c)(4)(vii) and 45 CFR 149.510(c)(4)(vii), this determination is legally binding unless there is fraud or evidence of intentional misrepresentation of material facts to the certified IDR entity by any party regarding the dispute.

The party that initiated the Federal IDR Process may not submit a subsequent Notice of IDR Initiation involving the same other party with respect to a claim for the same or similar item or service that was the subject of this dispute during the 90-calendar-day suspension period following the date of this email, also referred to as the “cooling off” period.

If the initiating party was a provider, the provider is identified by the National Provider Identifier (NPI) or Taxpayer Identification Number (TIN). During the cooling off period, the provider may not submit a

subsequent Notice of IDR Initiation involving the same non-initiating party with respect to a claim billed under the same NPI or TIN for the same or similar item or service.

The initiating party with respect to dispute number DISP-23152 was [redacted]. The initiating party's . The non-initiating party was Anthem Virginia. The 90-calendar day cooling off period begins on July 26, 2023 . Please retain this information for your records.

If the end of the open negotiation period for such an item or service falls during the cooling off period, either party may submit a Notice of IDR Initiation within 30 business days following the end of the cooling off period, as opposed to the standard 4-business-day period following the end of the open negotiation period. This 30-business-day period begins on the day after the last day of the cooling off period.

Resources
Visit the No Surprises website for additional IDR resources.

Contact information
For questions, contact National Medical Reviews, Inc.. Include your IDR Reference number referenced above.

Thank you,

National Medical Reviews, Inc.

Attachment 3
Example 2: Original EOB & Post-IDR Revised EOB

UHC
9900 BREN ROAD
MINNETONKA, MN 553439664
TE:8778423210

Check Date: 02/10/23
Check/EFT #: [redacted]
Group Provider #: [redacted]

Remittance Notice

[redacted]

PERF PROV	SERV DATE	POS	NOS	PROC MOD	BILLED	ALLOWED	DEDUCT	COINS	GRP/RC-AMT	PROV PD
NAME [redacted] HIC [redacted]										
[redacted]	1213 121322	1		99284 SA	1517.00	188.31	0.00	56.49 PI-242	1328.69	131.82
REM: N830										
PT RESP 56.49				CLAIM TOTALS	1517.00	188.31	0.00	56.49	1328.69	131.82
CLM STATUS: 1										131.82 NET
TaxID [redacted]										

GLOSSARY: Group, Reason, MOA, Remark and Adjustment Codes
PI Payor Initiated Reductions
242 Services not provided by network/primary care providers.
N830 The charge[s] for this service was processed in accordance with Federal/ State Balance/ Surprise Billing

UHC
9900 BREN ROAD
MINNETONKA, MN 553439664
TE:8778423210

Check Date: 06/22/23
Check/EFT #: [redacted]
Group Provider #: [redacted]

Remittance Notice

[redacted]

PERF PROV	SERV DATE	POS	NOS	PROC MOD	BILLED	ALLOWED	DEDUCT	COINS	GRP/RC-AMT	PROV PD
NAME [redacted] HIC [redacted]										
[redacted]	1213 121322	1		99284 SA	1517.00	648.00	0.00	194.40 PI-242	869.00	453.60
REM: N875										
PT RESP 194.40				CLAIM TOTALS	1517.00	648.00***	0.00	194.40	869.00	453.60
CLM STATUS: 1										453.60 NET
TaxID [redacted]										

GLOSSARY: Group, Reason, MOA, Remark and Adjustment Codes
PI Payor Initiated Reductions
242 Services not provided by network/primary care providers.
N875 N875- ALERT - THIS FINAL PAYMENT EQUALS THE AMOUNT SELECTED AS THE OUT-OF-NETWORK RATE BY A FEDERAL INDEP

*** Altered Allowed Amount Reflecting IDRE Payment Determination Amount, Resulting in Increased Patient Cost-Sharing

(See Attachment 4)

Attachment 4
Example 2: Certified IDR Entity Payment Determination

FHAS has reviewed DISP-399731 on June 12, 2023 and has found that [redacted] offer of $648.00 best represents the value of service code(s) 99284.

[redacted], submitted an offer of $648.00 per code.

United Healthcare submitted an offer of $188.31 per code.

After a complete and careful consideration of the totality of the evidence as promulgated in 45 CFR 149.510(c)(4) which does not include information on the prohibited factors described in 45 CFR 149.510(c)(4)(v), and after applying the No Surprises Act statutory provisions, [redacted] offer best represents the value of the services that are the subject of this unique payment determination.

Both the Prevailing Party and the Non-Prevailing Party submitted an offer and credible information representing their valuation of the services provided. FHAS found that the Prevailing Party's offer best represents the value of the out-of-network service(s) due to the submitted, credible information for the following factors:

- Additional information submitted by a party (ex: information on down coding or additional information requested by the certified IDR entity)
- The acuity of the participant, beneficiary, or enrollee, receiving the qualified IDR item or service, or the complexity of furnishing the qualified IDR item or service to the participant, beneficiary, or enrollee
- The level of training/experience/quality/outcomes measurements of the provider or facility that furnished the qualified IDR item or service

Please note that while all factors are reviewed as required under 45 CFR 149.510(c)(4), the submitted evidence and information associated with the aforementioned factors demonstrated the prevailing party's offer best represents the value of the out-of-network service(s) in this particular case.

The Non-Prevailing party objected to not receiving the Open Negotiation Notice for the dispute. Supporting documentation was submitted showing the date when the open negotiation period was completed; and documentation that confirms the open negotiation start date. After reviewing the supporting documentation for the objection, FHAS has determined that the Open Negotiation period was within CMS timeframes. Therefore, the objection was overruled.

Next Step:
If any amount is due to either party, it must be paid **not later than 30 calendar days** after the date of this notification, as follows:

- **A plan, issuer, or Federal Employees Health Benefits (FEHB) Program carrier owes a payment to a non-participating provider or facility** when the amount of the offer selected by the certified IDR entity exceeds the sum of 1) any initial payment the plan, issuer, or FEHB carrier has paid to the non-participating provider or facility, and 2) any cost sharing

paid or owed by the participant, beneficiary, or enrollee.

- **A non-participating provider or facility owes a refund to a plan, issuer or FEHB carrier** when the offer selected by the certified IDR entity is less than the sum of 1) any initial payment the plan, issuer, or FHHB carrier has paid to the non-participating provider or facility and 2) any cost sharing paid by the participant, beneficiary, or enrollee.

NOTE: The non-prevailing party is ultimately responsible for the certified IDR entity fee, which is retained by the certified IDR entity for the services performed. FHAS has determined that United Healthcare is the non-prevailing party in DISP-399731 and is responsible for paying the certified IDR entity fee. The certified IDR entity fee that was paid by the prevailing party will be returned to [redacted] by the certified IDR entity within 30 business days of the date of this notification.

Pursuant to the Federal Employees Health Benefits Act at 5 U.S.C. 8902(p), Internal Revenue Code sections 9816(c)(5)(E) and 9817(b)(5)(D), Employee Retirement Income Security Act sections 716(c)(5)(E) and 717(b)(5)(D), and Public Health Service Act sections 2799A-1(c)(5)(E) and 2799A-2(b)(5)(D), and their implementing regulations at 5 CFR 890.114, 26 CFR 54.9816–8T (c)(4)(vii), 29 CFR 2590.716-8(c)(4)(vii) and 45 CFR 149.510(c)(4)(vii), this determination is legally binding unless there is fraud or evidence of intentional misrepresentation of material facts to the certified IDR entity by any party regarding the dispute.

The party that initiated the Federal IDR Process may not submit a subsequent Notice of IDR Initiation involving the same other party with respect to a claim for the same or similar item or service that was the subject of this dispute during the 90-calendar-day suspension period following the date of this email, also referred to as the “cooling off” period.

If the initiating party was a provider, the provider is identified by the National Provider Identifier (NPI) or Taxpayer Identification Number (TIN). During the cooling off period, the provider may not submit a subsequent Notice of IDR Initiation involving the same non-initiating party with respect to a claim billed under the same NPI or TIN for the same or similar item or service.

The initiating party with respect to dispute number DISP-399731 was [redacted]. The initiating party’s NPI is 1942467113. The non-initiating party was United Healthcare. The 90-calendar day cooling off period begins on June 12, 2023. Please retain this information for your records.

If the end of the open negotiation period for such an item or service falls during the cooling off period, either party may submit a Notice of IDR Initiation within 30 business days following the end of the cooling off period, as opposed to the standard 4-business-day period following the end of the open negotiation period. This 30-business-day period begins on the day after the last day of the cooling off period.

Resources
Visit the No Surprises website for additional IDR resources.

Contact information
For questions, contact FHAS at IDRE@fhas.com**.** Include your IDR Reference number referenced above.

Thank you,

FHAS
IDRE ID: IDREApp-107

Attachment 5
Example 3: Original EOB & Post-IDR Revised EOB

FLORIDA BLUE
4800 DEERWOOD CAMPUS
JACKSONVILLE, FL 32246
TE:8007272227

Check Date: 01/23/23
Check/EFT #: [redacted]
Group Provider #: [redacted]

Remittance Notice

[redacted]

PERF PROV	SERV DATE	POS	NOS	PROC	MOD	BILLED	ALLOWED	DEDUCT	COINS	GRP/RC-AMT	PROV PD
NAME [redacted] HIC [redacted]											ASG Y
[redacted]	1121 112122		1	99285		2461.00	236.92	0.00	47.38	CO-45 2224.08	189.54
REM: N381											
PT RESP 47.38				CLAIM TOTALS		2461.00	236.92	0.00	47.38	2224.08	189.54
CLM STATUS: 1											189.54 NET

TaxID [redacted] PayerId 592015694

GLOSSARY: Group, Reason, MOA, Remark and Adjustment Codes
CO Contractual Obligations
45 Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arran
N381 Consult our contractual agreement for restrictions/billing/payment information related to these charges.

FLORIDA BLUE
4800 DEERWOOD CAMPUS
JACKSONVILLE, FL 32246
TE:8007272227

Check Date: 09/05/23
Check/EFT #: [redacted]
Group Provider #: [redacted]

Remittance Notice

[redacted]

PERF PROV	SERV DATE	POS	NOS	PROC	MOD	BILLED	ALLOWED	DEDUCT	COINS	GRP/RC-AMT	PROV PD
NAME [redacted] HIC [redacted]											ASG Y
[redacted]	1121 112122		1	99285		2461.00	725.00	0.00	145.00	CO-45 1736.00	580.00
REM: N381											
PT RESP 145.00				CLAIM TOTALS		2461.00	725.00***	0.00	145.00	1736.00	580.00
CLM STATUS: 1											580.00 NET

TaxID [redacted] PayerId 00590

GLOSSARY: Group, Reason, MOA, Remark and Adjustment Codes
CO Contractual Obligations
45 Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arran
N381 Consult our contractual agreement for restrictions/billing/payment information related to these charges.

*** Altered Allowed Amount Reflecting IDRE Payment Determination Amount, Resulting in Increased Patient Cost-Sharing

(See Attachment 6)

Attachment 6
Example 3: Certified IDR Entity Payment Determination

IDR dispute status: Payment Determination Made
IDR reference number: DISP-366898

Federal Hearings and Appeals Services, Inc. has reviewed your Federal Independent Dispute Resolution (IDR) dispute with reference number **DISP-366898** and has determined that [redacted] is the prevailing party in this dispute.

After considering all permissible information submitted by both parties, Federal Hearings and Appeals Services, Inc. has determined that the out-of-network payment amount of **$725.00** offered by [redacted] is the appropriate out-of-network rate for the item or service 99285 on claim number [redacted] under this dispute.

Federal Hearings and Appeals Services, Inc. based this determination on a review of the following:

[redacted] submitted an offer of $725.00

Florida Blue submitted an offer of

For each of the following determination factors, an "x" in the Initiating Party and/or Non-Initiating Party column means the party provided supporting information.

	Additional Circumstances	Initiating Party	Non-Initiating Party
1	The level of training, experience, and quality and outcomes measurements of the provider or facility that furnished such item or service (such as those endorsed by the consensus-based entity authorized in section 1890 of the Social Security Act)		
2	The market share held by the nonparticipating provider or facility or that of the plan or issuer in the geographic region in which the item or service was provided		
3	The acuity of the individual receiving such item or service or the complexity of furnishing such item or service to such individual		
4	The teaching status, case mix, and scope of services of the nonparticipating facility that furnished such item or service		
5	Demonstrations of good faith efforts (or lack of good faith efforts) made by the disputing parties to enter into network agreements and, if applicable, contracted rates between the disputing parties during the previous 4 plan years		
6	Additional information submitted by a party		

Final Determination Rationale

After a complete and careful consideration of the totality of the evidence as promulgated in 45 CFR 149.510(c)(4) which does not include information on the prohibited factors described in 45 CFR

149.510(c)(4)(v), and after applying the No Surprises Act statutory provisions, Melbourne Emergency Group, LLC's offer best represents the value of the services that are the subject of this unique payment determination.

Both the Prevailing Party and the Non-Prevailing Party submitted an offer and credible information representing their valuation of the services provided. FHAS found that the Prevailing Party's offer best represents the value of the out-of-network service(s) due to the submitted, credible information for the following factors:

· Single offer and single fee received

Please note that while all factors are reviewed as required under 45 CFR 149.510(c)(4), the submitted evidence and information associated with the aforementioned factors demonstrated the prevailing party's offer best represents the value of the out-of-network service(s) in this particular case.

Next Step:

If any amount is due to either party, it must be paid **not later than 30 calendar days** after the date of this notification, as follows:

• **A plan, issuer, or Federal Employees Health Benefits (FEHB) Program carrier owes a payment to a non-participating provider or facility** when the amount of the offers selected by the certified IDR entity exceeds the sum of 1) any initial payment the plan, issuer, or FEHB carrier has paid to the non-participating provider or facility and 2) any cost sharing paid or owed by the participant, beneficiary, or enrollee.

• **A non-participating provider or facility owes a refund to a plan, issuer or FEHB carrier** when the offer selected by the certified IDR entity is less than the sum of 1) any initial payment the plan, issuer, or FHHB carrier has paid to the non-participating provider or facility and 2) any cost sharing paid by the participant, beneficiary, or enrollee.

NOTE: The non-prevailing party is ultimately responsible for the certified IDR entity fee, which is retained by the certified IDR entity for the services performed. Federal Hearings and Appeals Services, Inc. has determined that Florida Blue is the non-prevailing party in DISP-366898 and is responsible for paying the certified IDR entity fee. The certified IDR entity fee that was paid by the prevailing party will be returned to [redacted] by the certified IDR entity within 30 business days of the date of this notification.

Pursuant to the Federal Employees Health Benefits Act at 5 U.S.C. 8902(p), Internal Revenue Code sections 9816(c)(5)(E) and 9817(b)(5)(D), Employee Retirement Income Security Act sections 716(c)(5)(E) and 717(b)(5)(D), and Public Health Service Act sections 2799A-1(c)(5)(E) and 2799A-2(b)(5)(D), and their

implementing regulations at 5 CFR 890.114, 26 CFR 54.9816–8T (c)(4)(vii), 29 CFR 2590.716-8(c)(4)(vii) and 45 CFR 149.510(c)(4)(vii), this determination is legally binding unless there is fraud or evidence of intentional misrepresentation of material facts to the certified IDR entity by any party regarding the dispute.

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If the initiating party was a provider, the provider is identified by the National Provider Identifier (NPI) or Taxpayer Identification Number (TIN). During the cooling off period, the provider may not submit a subsequent Notice of IDR Initiation involving the same non-initiating party with respect to a claim billed under the same NPI or TIN for the same or similar item or service.

The initiating party with respect to dispute number DISP-366898 was [redacted]. The initiating party's NPI is 1932562915 and TIN is 811929801. The non-initiating party was Florida Blue. The 90-calendar day cooling off period begins on July 9, 2023 . Please retain this information for your records.

If the end of the open negotiation period for such an item or service falls during the cooling off period, either party may submit a Notice of IDR Initiation within 30 business days following the end of the cooling off period, as opposed to the standard 4-business-day period following the end of the open negotiation period. This 30-business-day period begins on the day after the last day of the cooling off period.

Resources
Visit the No Surprises website for additional IDR resources.

Contact information
For questions, contact Federal Hearings and Appeals Services, Inc.. Include your IDR Reference number referenced above.

Thank you,

Federal Hearings and Appeals Services, Inc.