FREQUENTLY ASKED QUESTIONS FOR PROVIDERS ABOUT THE NO SURPRISES RULES

April 6, 2022

The Consolidated Appropriations Act of 2021 established several new requirements to protect consumers from surprise medical bills. These requirements are collectively referred to as "No Surprises" rules. These requirements generally apply to items and services provided to consumers enrolled in group health plans, group or individual health insurance coverage, and Federal Employees Health Benefits plans. This document contains information on frequently asked questions from providers and facilities regarding No Surprises rules, independent dispute resolution, and exceptions to the new rules and requirements.

1. What are the new requirements and prohibitions of the No Surprises Act?

Patients now have new billing protections when getting emergency care, certain non-emergency care from out-of-network providers during visits to certain in-network facilities, and air ambulance services from out-of-network providers.

New Surprise Billing Requirements and Prohibitions

- No balance billing for out-of-network emergency services
- No balance billing for non-emergency services by out-of-network providers during patient visits to certain in-network health care facilities, **unless notice and consent requirements are met** for certain items and services.
- Providers and health care facilities must publicly disclose patient protections against balance billing
- No balance billing for covered air ambulance services by out-of-network air ambulance providers
- In instances where balance billing is prohibited, cost sharing for insured patients is limited to in-network levels or amounts
- Providers must give a good faith estimate of expected charges to uninsured and self-pay patients at least 3 business days before a scheduled service, or upon request
- Plans and issuers and providers and facilities must ensure continuity of care when a provider's network status changes in certain circumstances
- Plans and issuers and providers and facilities must implement certain measures to improve the accuracy of provider directory information

2. I want more information on provider and facility requirements. Are there any exceptions?

Requirement: No balance billing for out-of-network emergency services

Requirement Details	Exceptions to Requirement
• Out-of-network providers and out-of-network emergency facilities cannot bill or hold liable participants, beneficiaries, or enrollees who received emergency services for a payment amount greater than the in-network cost-sharing requirement. • For these protections to apply, emergency services must be received at a hospital or an independent freestanding emergency department. • The patient must be enrolled in a group health plan or group or individual health insurance coverage. For this purpose, a Federal Employees Health Benefits plan is included as a group health plan. • Cost-sharing is generally based on the median of contracted rates payable to in-network providers or in-network facilities. • Certain post-stabilization services are considered emergency services, and are therefore subject to this prohibition, unless notice and consent and certain other requirements are met (see next column).	Out-of-network providers and out-of-network emergency facilities may balance bill for post-stabilization services **only if all of the following conditions** have been met: The attending emergency physician or treating provider determines that the participant, beneficiary, or enrollee: • Can travel using non-medical or non-emergency medical transportation to an available in-network provider or facility located within a reasonable travel distance, taking into account the individual's medical condition; and • Is in a condition to receive notice and provide informed consent; • The out-of-network provider or out-of-network emergency facility provides the participant, beneficiary, or enrollee with a written notice including certain information during a specific timeframe (as provided in regulations and guidance) and obtains consent to waive surprise billing protections; and • The provider or facility satisfies any additional state law requirements.

Requirement: No balance billing for certain non-emergency services by out-of-network providers during patient visits to in-network health care facilities, unless notice and consent requirements are met. Review and download Standard Notice and Consent Documents.

Requirement Details	Exceptions to Requirement
• Out-of-network providers cannot bill or hold liable participants, beneficiaries, or enrollees in group health plans or group or individual health insurance coverage who received covered non-emergency services at an in-network health care facility for an amount greater than the in-network cost-sharing requirement for those services, unless notice and consent requirements are met. • Cost-sharing is generally based on the median of amounts that would have been charged by in-network providers or in-network facilities. For purposes of these protections, health care facilities include: hospitals, hospital outpatient departments, critical access hospitals, and ambulatory surgical centers. These protections do not apply to other types of health care facilities, such as urgent care centers.	The notice and consent exception does not apply to the following list of ancillary services, meaning a provider is always prohibited from balance billing for these services: • Items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology • Items and services provided by assistant surgeons, hospitalists, and intensivists • Diagnostic services, including radiology and laboratory services • Items and services provided by an out-of-network provider if there is no in-network provider who can provide the item or service at the facility.

Requirement: Disclosure of patient protections against balance billing. Review and download the Model Disclosure Notice.

Requirement Details	Exceptions to Requirement
• A provider or facility must disclose to any participant, beneficiary, or enrollee in a group health plan or group or individual health insurance coverage to whom the provider or facility furnishes items and services information regarding federal and state (if applicable) balance billing protections and how to report violations. • Providers or facilities must post this information prominently at the location of the facility if the location is publicly accessible, post it on a public website (if applicable), and provide it to the participant, beneficiary or enrollee no later than the date and time on which the provider or facility requests payment from the individual or, with respect to an individual from whom the provider or facility does not request payment, no later than the date on which the provider or facility submits a claim to the group health plan or health insurance issuer.	A provider isn't required to make disclosures if the provider doesn't furnish items or services at a health care facility at which the balance billing protections apply, or in connection with a visit to such a health care facility. A provider is not required to make the disclosure to individuals to whom the provider furnishes items or services, if such items and services are not furnished in connection with a visit at a health care facility. A provider isn't required to make the disclosure to individuals if there is a written agreement where the facility agrees to make the disclosure instead of the provider.

Requirement: No balance billing for air ambulance services by out-of-network providers of air ambulance services

Requirement Details	Exceptions to Requirement
• Out-of-network providers of air ambulance services cannot bill or hold liable participants, beneficiaries, or enrollees in group health plans or group or individual health insurance coverage who received covered air ambulance services for an amount greater than the in-network cost-sharing requirement for those services. • The cost-sharing requirement is generally based on the lesser of the median of contracted rates payable to in-network providers of air ambulance services or the billed amount for the services.	None.

Requirement: Providing a good faith estimate in advance of scheduled services, or upon request, to an uninsured or self-pay individual.

Requirement Details	Exceptions to Requirement
• When a health care provider or facility schedules an item or service, it must inquire if the individual who schedules an item or service is enrolled in a group health plan, group or individual health insurance coverage offered by a health insurance issuer, a federal health care program, or a Federal Employees Health Benefits plan. If so, the provider or facility must inquire if the individual is seeking to have their claims for the item or service submitted to the individual's plan or coverage. • If the patient has no such plan or coverage, or doesn't intend to submit a claim to the plan or coverage, the provider or facility must provide notification to the patient (in clear and understandable language) of the good faith estimate of the expected charges, expected service, and diagnostic codes of scheduled services. • The good faith estimate must include expected charges for the items or services that are reasonably expected to be provided in conjunction with the primary item or service, including items or services that may be provided by other providers and facilities. • For more information regarding the good faith estimate for uninsured (or self-pay) individuals, see Guidance on Good Faith Estimates and the Patient-Provider Dispute Resolution (PPDR) Process for Providers and Facilities • If the patient is enrolled in such plan or coverage, and intends to have a claim submitted for the scheduled items or service, the provider or facility must submit a good faith estimate to the plan or issuer, which in turn must send an advance explanation of benefits to the patient.	• From January 1, 2022 through December 31, 2022, the Department of Health & Human Services (HHS) will exercise its enforcement discretion in situations where a good faith estimate provided to an uninsured (or self-pay) individual doesn't include expected charges from other providers and facilities that are involved in the individual's care. • Until rulemaking is issued regarding the requirement to provide a good faith estimate to an individual's plan or coverage, HHS will defer enforcement of the requirement that providers and facilities provide good faith estimate information for individuals enrolled in a plan or coverage and seeking to submit a claim for scheduled items or services to their plan or coverage.

Requirement: Continuity of care when a provider's network status changes

Requirement Details	Exceptions to Requirement

• When the contractual relationship between a plan or issuer and a provider or facility ends and results in a change in the provider or facility's network status, if the health care provider or facility has a continuing care patient, they must:
 	
  • Accept payment from the plan or issuer (and cost-sharing payments from the individual) for the course of treatment of a continuing care patient at the previously agreed-upon payment amount for up to 90 days after the date the patient was notified of the change in the provider's network status.
 	
  • Continue to adhere to all policies, procedures, and quality standards imposed by the plan or issuer for such items or services as if the contract were still in place.
	None.

Requirement: Implement measures to improve the accuracy of provider directories

Requirement Details	Exceptions to Requirement

• Any health care provider or health care facility that has or has had a contractual relationship with a plan or issuer to provide items or services under the coverage must submit provider directory information to the plan or issuer, at a minimum:
  • At the beginning of the network agreement with the plan or issuer,
  • At the time of termination of the network agreement with the plan or issuer,
  • When there are material changes to the content of the provider directory information of the provider or facility,
  • Upon request by the plan or issuer, and
  • At any other time determined appropriate by the provider, facility, or HHS
  • Any health care provider or health care facility that has or has had a contractual relationship with a plan or issuer to provide items or services under the plan or insurance coverage must:
  • Reimburse participants, beneficiaries, or enrollees who in reliance on an incorrect provider directory, paid a provider bill in excess of the in-network cost-sharing amount. Reimbursement must be for the full amount paid in excess of the in-network cost-sharing amount, plus interest.
	None.

3. **Do No Surprises protections apply to patients in all types of insurance?**

   - Generally, the No Surprises protections apply to individuals enrolled in a health care plan, through an employer (whether self-funded or insured, including coverage offered by federal, state, or local governments, or a multiemployer plan), or through the federal Marketplaces, state-based Marketplaces, or directly through an individual market health insurance issuer.

   - The rules don't apply to people with coverage through programs like Medicare, Medicaid, Indian Health Services, Veterans Affairs Health Care, or TRICARE. Each of these programs already has other protections against surprise medical bills. The protections also don't apply to individuals enrolled in short-term limited duration insurance, excepted benefits (such as stand-alone dental or vision-only coverage), or retiree-only plans.

   - Uninsured and self-pay individuals are also entitled to a good faith estimate, upon request or scheduling of an item or service, through the No Surprises billing protections.

4. **Where can I send questions I have about these new provider and facility requirements?**

   You can send any questions about the provider requirements to provider_enforcement@cms.hhs.gov.

5. **What types of providers do the No Surprises requirements apply to?**

   When assessing whether a No Surprises requirement applies to a particular provider, it is important to look at how the provider practices, rather than the provider's specialty type, license, or certification. The rules apply broadly to any physician or other health care provider who is acting within the scope of practice of that provider's license or certification under applicable state law. However, some providers may not practice in a setting or manner that triggers certain requirements. For example, a provider who never furnishes services in connection with a visit to a health care facility or emergency facility wouldn't furnish items or services that fall within the balance billing protections. However, that same provider would, for example, need to provide a good faith estimate of expected charges to uninsured or self-pay individuals, when applicable, and comply with the continuity of care and provider directory requirements.

6. **Providers and facilities are generally required to provide participants, beneficiaries, and enrollees with a written disclosure about their balance billing protections. Does the patient need to sign an acknowledgement that the patient has received the new disclosure notice regarding patient protections against surprise billing disclosure?**

   No. Under the No Surprises Act, health care providers and facilities must make publicly available, post on a public website of the provider or facility (if applicable), and provide a one-page notice that includes information in clear and understandable language regarding patient protections against surprise billing. Patients don't need to sign to acknowledge that they have received the disclosure notice regarding patient protections against surprise billing. Review and download the model disclosure notice for patient protections against surprise billing, which providers and facilities may use.

   Note, providers and facilities may also provide patients with a notice and consent form if they are asking the patient to waive their balance billing protections. This is a different notice, and different requirements apply to the use of this notice.

7. **The No Surprises rules allow patients to give consent to waive surprise billing protections in certain circumstances. Is a patient required to sign the notice and consent form in order to waive their protections?**

   Under the No Surprises Act, if a provider or facility plans to balance bill a patient in circumstances in which that would otherwise be prohibited, the out-of-network provider or an out-of-network emergency facility must provide the patient (or an authorized representative) with a notice detailing the patient's protections and providing information about the potential costs if the patient waives their surprise billing protections.

   A patient (or an authorized representative) isn't required to, nor should the patient (or their authorized representative), sign the consent form unless the patient is willing to waive these protections and understands or agrees they will be paying out of pocket for balance bills on out-of-network services. However, the patient's (or an authorized representative's) signature (physically or digitally) on the consent form is necessary for a waiver of the balance billing protections to be effective. The standard notice and consent forms, which providers and facilities must use in instances where the provider or facility seeks to balance bill the patient, must be provided in accordance with the regulations and guidance issued by HHS. Providers and facilities must retain signed documents for at least 7 years.

   Note that notice and consent is only allowed for post-stabilization services, if certain conditions are met, and for certain non-emergency services. For non-emergency care (not post-stabilization services) provided by out-of-network providers related to a visit to an in-network facility, surprise billing prohibitions always apply to ancillary services including diagnostic services like radiology and laboratory services, anesthesiology, pathology, and neonatology, regardless of whether provided by a physician or nonphysician practitioner, and a patient is not permitted to waive surprise billing protections for these services. Thus, in surprise billing situations, providers are not allowed to seek notice and consent for these services.

8. **When using the standard notice and consent Documents, can a provider or facility complete the form by listing a physician or provider group instead of an individual physician or provider's name? For example, could the form list XYZ Physician Group if the individual scheduling the visit doesn't know who will see the patient on the day of the visit?**

   The notice and consent form must explicitly identify the individual provider who is expected to provide a given service; listing a provider group is not permitted.

9. **If a patient is having elective services (that is, non-emergency services) and the facility is out-of-network, may the facility, or the provider balance bill the patient?**

   The federal balance billing prohibitions don't apply to non-emergency services provided by out-of-network providers during patient visits to out-of-network facilities. In this setting, the provider does not need to obtain the patient's consent to bill them directly, or balance bill them.

10. **How many types of fees are there for the Federal Independent Dispute Resolution (IDR) process?**

    There are 2 fees for independent dispute resolution:
    1. The administrative fee for use of the process

    2. The certified IDR entity fee, which is payment for review

What is the IDR administrative fee? How much is it?

- Each party is required to pay an administrative fee per single or batched determination. The administrative fee is intended to cover the cost to the Federal government of the Federal IDR Process. For calendar year 2022, the administrative fee due from each party (i.e., the provider or facility, and the insurance company or plan) for participating in the Federal IDR process **is $50.**

11. What is the certified IDR entity fee?

Each party (i.e., the provider or facility and the insurance company or plan) must pay the entire certified IDR entity fee. The certified IDR entity fees are due when each party submits their offer. Following the payment determination, generally, the certified IDR entity fee paid by the prevailing party will be refunded to that party; in some cases, the refund of the fee may be split. For more information, see https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Technical-Guidance-CY2022-Fee-Guidance-Federal-Independent-Dispute-Resolution-Process-NSA.pdf.

12. How much is the certified IDR entity fee?

Single Determination

For calendar year 2022, certified IDR entities must charge a fixed certified IDR entity fee for single determinations within the range of $200-$500, unless the certified IDR entity has received approval from the Departments to charge a fee outside that range.

Batched Determination

A batched determination involves multiple qualified IDR items or services that are considered jointly as part of one payment determination by a certified IDR entity for purposes of the Federal IDR process. The administrative fees will not be refunded, even if the parties reach an agreement before the certified IDR entity makes a determination. If a certified IDR entity chooses to charge a different fixed certified IDR entity fee for batched determinations, for calendar year 2022, that fee must be within the range of $268-$670, unless the certified IDR entity has received approval from the Departments to charge a fee outside that range.

13. I am a provider or facility and have questions about the IDR Administrative Fee and/or the Certified IDR Entity Fees that will be charged.

For further questions about the Federal IDR process or fee guidance, please contact us at FederalIDRQuestions@cms.hhs.gov.