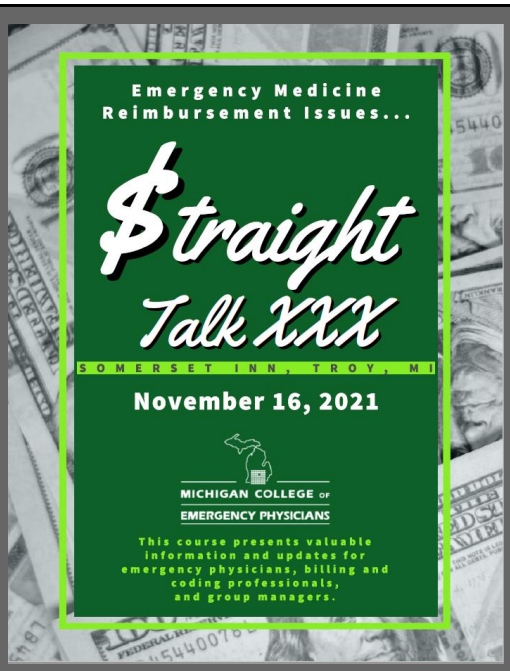
The federal No Surprises Act (NSA) & State of MI Out of Network (OON) Law—What You Need to Know.

Ed Gaines, JD, CCP, VP, Zotec Partners, Joint ACEP/EDPMA NSA Implementation Task Force, co lead for work group B (state & federal issues)

&

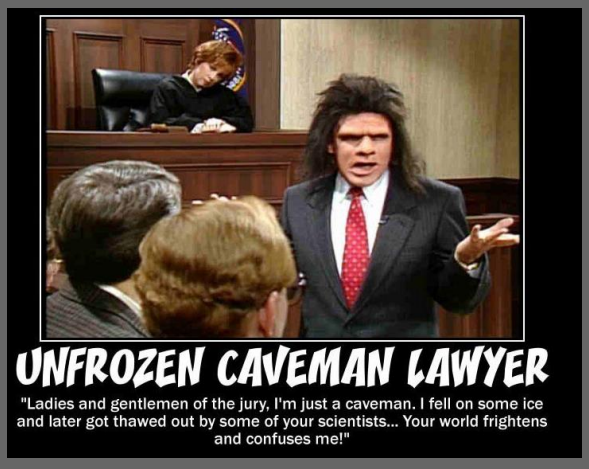
Don Powell, DO, VP, ECS Grand Rapids, & Chair Emergency Dept. Practice Management Association (EDPMA)



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Conflicts Disclosures & Caveats—and a word from my role model:

- I am an officer of Zotec Partners, LLC, a revenue cycle management company for emergency medicine & other hospital and clinic-based clinicians.
- The opinions expressed herein are my own and are not those of my employer, physician specialties or trade associations where I am in positions of leadership.
- This presentation is offered as general information and is not legal advice; experienced and qualified healthcare counsel should be consulted regarding the new federal out of network/balance billing law or existing state laws.



2

2

Learning Goals—to:

- Achieve understanding of provisions of the NSA & rule making (July Interim Final Rule [IFR] & Sept. IFR) regarding Pt. protections & independent dispute resolution (IDR);
- Gain knowledge of existing state-based IDR processes, learn how those may inform the federal IDR and understand what legislative changes may be necessary to enhance the MI laws;
- Outline the Pt. disclosure protections for Pts including the requirements of the good faith estimate and selected dispute resolution (SDR) for these Pts.

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Part 1: The federal No Surprises Act (NSA), effective 1/1/22



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NSA—Why it matters even if your group is nearly 100% in network

- 1st time ERISA plans (~120+M covered lives) will be subject to federal comprehensive out of network/balance billing (OON/BB).
- 1st time broad application of federal law patient protections for patients in group, individual & ACA exchange plans.
- The "Par/Non-Par" issue is now different
- vis-à-vis your hospital partners.
- Impact to practices 95+% in network and have never engaged in OON/BB.



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The issues is whether the physician community & stakeholders won the battle but lost the war?

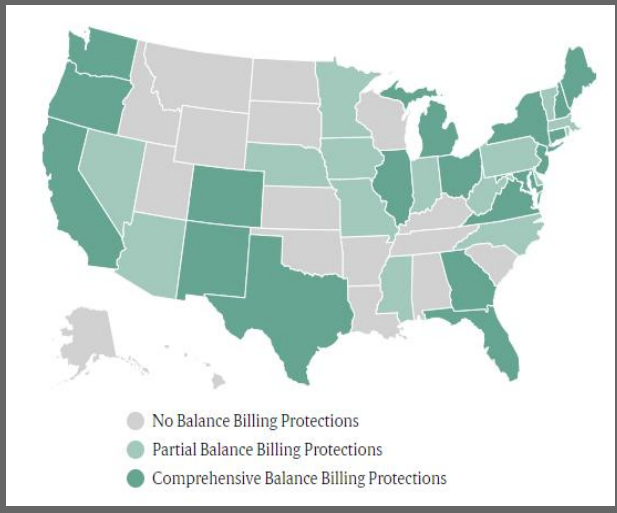
- The physician stakeholders defeated the statutory efforts by the health plans to establish federal "benchmarking" or rate setting in the NSA statute.
- The Departments of Health & Human Services (HHS) and Labor (DOL), Treasury ("Tri-Departments"), and the Office of Personnel Management (OPM), released a two interim final rules (July IFR and Sept IFR) with comment periods implementing provisions of the No Surprises Act (NSA).
- Sept. IFR implements provisions related to the independent dispute resolution (IDR) (Federal IDR) process.
- The Sept. IFR was much different from what Congress passed in the NSA statute & from the advocacy positions of physician & trade association stakeholders.

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NSA—years in the making & with a "federalist" orientation

- **Federal Activity:**
  - SMB proposals
  - 2019 House E&C commerce bills & "Pallone/Alexander Compromise" bill~ "benchmarking" bills were defeated .
- **State Activity**
  - 17 states with no BB protections (32%)
  - 15 states with partial BB protections (30%)
  - 18 states with comprehensive BB protections (36%)

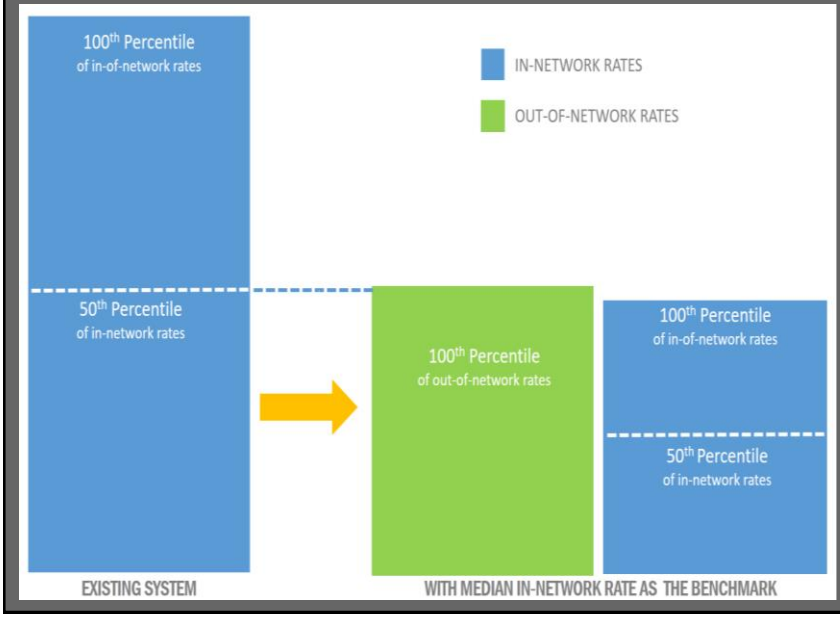


*Source: Common Wealth Funder | www.commonwealthfund.com

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What is "benchmarking" or rate setting & why is it an issue--From Heller, Gaines et al in RSNA's publication *RADIOLOGY (July 2021)*



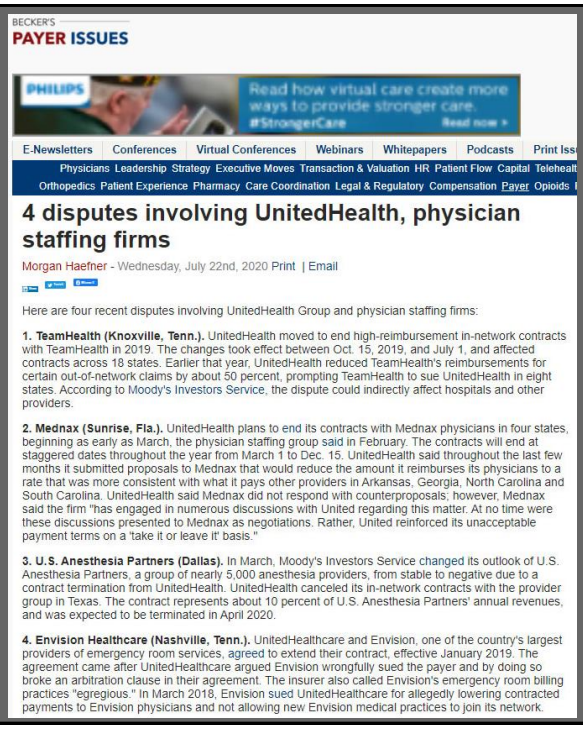
- **FIGURE 2: With a benchmark system that bans balance billing and uses the median in-network rate as the payment standard, the previous 50th percentile of in-network rates would become the new ceiling for out-of-network payments.**
- **Assuming a discount to be in-network, the new maximum (100th percentile) in-network rate would be below the previous 50th percentile.**

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Health plans began in 2019 to "manage the median downward" in anticipation of "benchmarking"

- Physician group contracts were term'd by plans unilaterally mid-term, w/ no discussion or negotiation.
- Threshold was whether the group was "above the median in network" allowed amount.



BECKER'S
PAYER ISSUES

PHILIPS
Read how virtual care create more ways to provide stronger care.
#StrongerCare
Read now ›

4 disputes involving UnitedHealth, physician staffing firms

Morgan Haefner - Wednesday, July 22nd, 2020 Print | Email

Here are four recent disputes involving UnitedHealth Group and physician staffing firms:

1. TeamHealth (Knoxville, Tenn.). UnitedHealth moved to end high-reimbursement in-network contracts with TeamHealth in 2019. The changes took effect between Oct. 15, 2019, and July 1, and affected contracts across 18 states. Earlier that year, UnitedHealth reduced TeamHealth's reimbursements for certain out-of-network claims by about 50 percent, prompting TeamHealth to sue UnitedHealth in eight states. According to Moody's Investors Service, the dispute could indirectly affect hospitals and other providers.

2. Mednax (Sunrise, Fla.). UnitedHealth plans to end its contracts with Mednax physicians in four states, beginning as early as March, the physician staffing group said in February. The contracts will end at staggered dates throughout the year from March 1 to Dec. 15. UnitedHealth said throughout the last few months it submitted proposals to Mednax that would reduce the amount it reimburses its physicians to a rate that was more consistent with what it pays other providers in Arkansas, Georgia, North Carolina and South Carolina. UnitedHealth said Mednax did not respond with counterproposals; however, Mednax said the firm "has engaged in numerous discussions with United regarding this matter. At no time were these discussions presented to Mednax as negotiations. Rather, United reinforced its unacceptable payment terms on a 'take it or leave it' basis."

3. U.S. Anesthesia Partners (Dallas). In March, Moody's Investors Service changed its outlook of U.S. Anesthesia Partners, a group of nearly 5,000 anesthesia providers, from stable to negative due to a contract termination from UnitedHealth. UnitedHealth canceled its in-network contracts with the provider group in Texas. The contract represents about 10 percent of U.S. Anesthesia Partners' annual revenues, and was expected to be terminated in April 2020.

4. Envision Healthcare (Nashville, Tenn.). UnitedHealthcare and Envision, one of the country's largest providers of emergency room services, agreed to extend their contract, effective January 2019. The agreement came after UnitedHealthcare argued Envision wrongfully sued the payer and by doing so broke an arbitration clause in their agreement. The insurer also called Envision's emergency room billing practices "egregious." In March 2018, Envision sued UnitedHealthcare for allegedly lowering contracted payments to Envision physicians and not allowing new Envision medical practices to join its network.

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Why it Matters Right Now—whether your group is nearly ~100% in network or not!



- Congressional Budget Office (CBO) & "Pay As You Go" (PAYGO) Rules.
- CBO "scored" HR 2328 (2019 E&C bill) – no IDR as originally proposed: +$20 billion in "savings."
- Most health care is delivered inside a in-network, and more than 80% of the estimated budgetary effects of Title IV [SMB provisions] arise from in-network payment rate changes.
- "CBO and the JCT [Joint Committee on Taxation] estimate that by creating a method for reimbursing OON care at median in network rates, payments to providers—inside and outside of networks—would converge around those median rates."

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No Surprises Act & July IFR Summary

Key Features + Implications

Feature:	Purpose:	Function:	Meaning:	Significance:	Implications:
Protects patients from out-of-network (OON) + balance bills (BB).	Protects patients who don't knowingly consent in writing to OON/BB 72 hours in advance.	OON/BB is barred by OON physicians at in-network facilities, for emergency care & air ambulances	Patients pay in-network cost sharing and are removed from reimbursement disputes.	NSA protects large and self-insured employer ERISA members for the first time from OON/BB.	Violations can be subject to civil monetary penalties of $10K per violation.
Mandated negotiation period for reimbursement disputes.	Encourages the parties to compromise before formalized independent dispute resolution (IDR).	Clinicians initiate the negotiation from the date of the initial payment or denial, 30 days from claim filing.	Both sides are incented to compromise as the adjudicator picks the winner in IDR, and the loser pays IDR costs.	Clinicians cannot initiate the IDR process before the 30-day negotiation period expires.	Failure to resolve disputes could extend reimbursement weeks into the future.

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No Surprises Act & July IFR Summary

Key Features + Implications

Feature:	Purpose:	Function:	Meaning:	Significance:	Implications:
Initial payment is decided by the health plan; patient cost sharing is determined (most cases) by the "qualifying payment amount." (QPA)	Establishes criteria for patient cost sharing on the "recognized amount"—either per "specified state law" or the QPA determined by the health plan.	The QPA is the median in-network rate as of 1/31/19 for same/similar service & specialty in a geographic region (MSA), adjusted for inflation (CPI-U) to '22.	CY 2022 QPA is set by law but subsequent years may be subject to manipulation; QPA will also be used a factor in IDR.	Multiple QPAs for a single CMS 1500/837-P claim & not a weighted average per CPT code in a geographic region.	Rule making definitions for the subsequent years will be critical in setting the QPA and initial payments. Health plans contend that the QPA should be the predominant factor used in IDR.
IDR may be initiated after the 30-day negotiation period expires.	Removes patients from reimbursement dispute; Pts. pay in-network cost sharing or QPA. Subjects uninsured patients to IDR for non-emergent services when cost is "substantially excess" of estimate.	Clinicians and health plans have 4 days to provide notice to the other party and 3 days to select the IDR adjudicator.	Within 10 days of IDR adjudicator's selection, parties must submit final offers and supporting info.	If settled before final decision, the parties split IDR costs, if not then the loser pays the IDR costs. "Baseball IDR"—1 or the other offer is selected by the adjudicator.	Adjudicator has 30 days to select an offer. Clinician may "batch" no more than 30 days of same/similar payor claims. The party initiating IDR can't bring another IDR for 90 days after the decision.

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No Surprises Act & July IFR Summary

Key Features + Implications

Feature:	Purpose:	Function:	Meaning:	Significance:	Implications:
Specified factors and allowance for other factors in the IDR adjudicator's decision.	Provides clinicians the opportunity to show how the initial reimbursement is insufficient.	The QPA, final offers by both parties, other factors and enumerated factors are to be equally considered in IDR.	Enumerated factors are training, quality, outcomes, party market share, case complexity, good faith of the parties to contract for the past 4 years.	Quality metrics along with parties' prior rates offer clinicians evidence to support final payments greater than initial market-based reimbursements.	The statute bars consideration of the clinician's charges, Medicare, Medicaid, CHIP and Tricare reimbursements by the adjudicator.
The interaction of federal law with existing state laws on OON/BB is partially addressed but many issues remain.	States with "specified laws" for determining payment standards are permitted under the NSA under our federalism principles.	State payment standards (including Pt cost sharing) may be honored in place of federal QPA for individual and group health plans and states with ERISA opt-in.	States that have adopted the FAIR Health database may be permitted to do so for individual and group health plans if clarified in rule making.	The definition of "specified state law" does not clarify if state law procedural and IDR standards will be permitted under federal law.	18 states have comprehensive state OON/BB laws so there may be a dual process in these states for individual and group plans.

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Part 2: The Sept. IFR + TMA & Dr. Adam Corley file lawsuit challenging the Sept. IFR + MI & other state experiences.



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No Surprises Act Part II – Sept. IFR—2 Critical Takeaway Messages:

1. Understand the new federal No Surprises Act (NSA) independent dispute resolution (IDR) process for out of network claims beginning 1/1/22—you may be 90+% in network but that could change in 2022;

2. For physicians in hospital or ambulatory surgical center (ASC) based settings, determine if the hospital or ASC will facilitate the provider and facility NSA disclosure requirements regarding the NSA's Patient protections & obtain that hospital agreement in writing for your group;



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Key Definitions/Concepts in IFR Part 2 (cont.)

- "Qualified IDR Services" (ED services & services by an out of network (OON) clinician at an in-network facility)—not services per an all-payor model agreement + services per specified state law & those subject to the 90-day cooling off period.
- "Certified IDR Entity" (CIE): entity certified by the Depts. to adjudicate reimbursement disputes.
- "Days" means business days unless otherwise stated.
- "Open Negotiation Period": it may start on the 31st date after the payment or denial but does not officially begin until the notice is sent (electronic or paper if requested).
- Official "open negotiation notice" on the Dept. of Labor website—runs for 30 days from date the notice is sent.

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Key Definitions/Concepts in IFR Part 2 (cont.)

- "Notice of IDR" & Federal IDR Portal—deadline is the 4th biz day after the Open Negotiation Period ends—the date is "the Initiation Date".
- Parties have 10 business days from Initiation Date to submit offers & supporting information/data.
- Initiating party has 4 business days to notify the Depts. via the portal that either the parties agree on the Certified IDR Entity (CIE) or they don't.
- Questions re: who makes the state vs. federal law applicability decisions remain but CIE will notify the parties w/in 3 days which law applies.

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Key Definitions/Concepts in IFR Part 2 (cont.)

- Settlements during IDR Initiation mean both sides split the IDR costs; otherwise, it is loser pays in "baseball styled" IDR—1 or the other offer must be selected:
  - Admin. fee is $50 for '22
  - "Batched claims" fees run $268-$670 total.
  - Non-batched claims $200-500 total.
- "Batching": same/similar services and CPTs billed under same TIN during a 30-day period OR during the 90-day cooling off period AFTER an adjudication by a CIE (and after the suspension period has ended).
- "Final offers" ($s & as a percentage of the QPA + maybe multiple QPAs to submit offers)

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The rebuttable presumption that the QPA should be the final appropriate amount.

- "Payment Determinations": The CIE "must presume" that the QPA is the appropriate amount but "must also consider other factors….only if the information is submitted by the parties." (Additional Factors)
- Additional factors for IDR consideration in addition to the QPA:
  1. Clinician's training and experience
  2. Teaching status of the facility
  3. Quality & outcome measurements;
  4. Acuity and complexity of care;
  5. Prior K rates for prior 4 yrs.
  6. Good faith or lack thereof of plan or clinician to K;
  7. Market share by clinician or plan in a geographic area.
- Additional factors must be "credible" & must demonstrate that the QPA is materially different from the appropriate OON rate.

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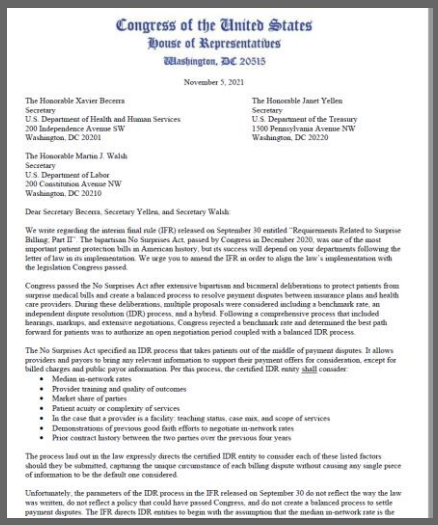
The rebuttable presumption that the QPA should be the final appropriate amount (cont.)

- The CIE's role is to NOT decide if the QPA is correct, medical necessity of svs. or issues of denials of coverage.
  - "Downcoding" may be challenged by the clinician that the QPA provided did not "properly encompass" the Pt. acuity.
  - Plans must issue QPAs that "reasonably reflect" the furnished services.
- Recall the "prohibited factors"—includes when health plans state market rates as a % of CMS, e.g. 150% of Medicare.
- 90 day cooling off period—90 calendar days, same or similar services—but those 90 days of services may be included in a subsequent IDR.
- Determination of a final OON rate that would be higher than the plans' QPA does NOT change the Pt. cost sharing.

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152 bi-partisan members of Congress express their unhappiness with the Sept. IFR on 11/5/21.



Congress of the United States
House of Representatives
Washington, DC 20515

November 5, 2021

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

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

The Honorable Martin J. Walsh
Secretary
U.S. Department of Labor
200 Constitution Avenue NW
Washington, DC 20210

Dear Secretary Becerra, Secretary Yellen, and Secretary Walsh:

We write regarding the interim final rule (IFR) released on September 30 entitled "Requirements Related to Surprise Billing; Part II". The bipartisan No Surprises Act, passed by Congress in December 2020, was one of the most important patient protection bills in American history, but its success will depend on your departments following the letter of law as its implementation. We urge you to amend the IFR in order to align the law's implementation with the legislation Congress passed.

Congress passed the No Surprises Act after extensive bipartisan and bicameral deliberations to protect patients from surprise medical bills and create a balanced process to resolve payment disputes between insurance plans and health care providers. During these deliberations, multiple proposals were considered including a benchmark rate, an independent dispute resolution (IDR) process, and a hybrid. Following a comprehensive process that included hearings, markups, and extensive negotiations, Congress rejected a benchmark rate and determined the best path forward for patients was to authorize an open negotiation period coupled with a balanced IDR process.

The No Surprises Act specified an IDR process that takes patients out of the middle of payment disputes. It allows providers and payors to bring any relevant information to support their payment offers for consideration, except for billed charges and public payor information. Per this process, the certified IDR entity shall consider:

- Median in-network rates
- Provider training and quality of outcomes
- Market share of parties
- Patient acuity or complexity of services
- In the case that a provider is a facility: teaching status, case mix, and scope of services
- Demonstrations of previous good faith efforts to negotiate in-network rates
- Prior contract history between the two parties over the previous four years

The process laid out in the law expressly directs the certified IDR entity to consider each of these listed factors should they be submitted, capturing the unique circumstance of each billing dispute without causing any single piece of information to be the default one considered.

Unfortunately, the parameters of the IDR process in the IFR released on September 30 do not reflect the way the law was written, do not reflect a policy that could have passed Congress, and do not create a balanced process to settle payment disputes. The IFR directs IDR entities to begin with the assumption that the median in-network rate is the appropriate payment amount prior to considering other factors. This directive establishes a de-facto benchmark rate, making the median in-network rate the default factor considered in the IDR process. This approach is contrary to statute and could incentivize insurance companies to set artificially low payment rates, which would narrow provider networks and jeopardize patient access to care – the exact opposite of the goal of the law. It could also have a broad impact on reimbursement for in-network services, which could exacerbate existing health disparities and patient access issues in rural and urban underserved communities.

We appreciate the complex nature of the patient protections that must be established and look forward to a final rule that accurately reflects Congress's multi-year bipartisan and bicameral work to pass this landmark legislation. Therefore, we urge you to revise the IFR to align with the law as written by specifying that the certified IDR entity should not default to the median in-network rate and should instead consider all of the factors outlined in the statute without disproportionately weighting one factor.

Thank you for your continued efforts on this important matter. We look forward to working with you to ensure the best outcomes for our patients and the health of our communities.

Sincerely,

Thomas R. Suozzi
Member of Congress

Brad R. Wenstrup, D.P.M.
Member of Congress

Raul Ruiz, M.D.
Member of Congress

Larry Bucshon, M.D.
Member of Congress

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Lawsuit filed 10/28/21 by the TX Medical Association (TMA) and Dr. Adam Corley in USDC Eastern Dst. Of TX challenging the Sept. '21 IFR.

- Lawsuit seeks a court order vacating the Sept. IFR –not the Pt protections of the NSA statute or July IFR—on the grounds that the "Tri-Depts" created a legal rebuttable presumption that the QPA should be the appropriate final payment when the NSA text does not support such a presumption;
- Plaintiffs contend that the NSA text supports that all IDR factors be equal and that this contention is supported in the text & Congressional intent.
- Complaint also challenges the procedural process of the issuance of "Interim Final Rule" instead of a "Notice of Proposed Rule Making" (NPRM) as mandated by the Administrative Procedures Act (APA).
- Ct. does not have to reach the APA procedural issue if it finds on textual contentions.



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NSA mandated Pt disclosure—CMS forms do not indicate that disclosure is only OON Pts.

NSA requires clinicians & facilities subject to the future rule making "to make publicly available, post on a website of the provider or facility (if applicable), and to provide to participants, beneficiaries, and enrollees a one-page notice about the balance billing requirements and prohibitions that apply to the provider or facility".

- **The notice must include information about applicable state requirements. If a state develops model notice language for providers/facilities to post, the provider/facility would be deemed to be compliant with the requirement if used.**
- **The notice must include information about how to contact appropriate state/federal agencies if the patient believes there is a violation of the balance billing rules.**
- **The law also requires facilities and physicians to publish a notice on balance billing protections on their website (if they have one) that may be available for patients. CMS also provided a template disclosure that facilities can use.**
- **Providers/facilities must comply with language access standards.**

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Strategy: approach the hospital to facilitate the Pt. disclosure requirements (links in the appendix).

One-Page Notice to Patients.

- **The statute requires that providers/facilities provide a one page-notice to individuals who are participants, beneficiaries, or enrollees of a group health plan or individual health insurance coverage offered by a health insurance issuer.**
- **In order to prevent duplication in the one-page notice distribution, HHS provides that "to the extent a provider furnishes an item or service covered under the plan or coverage at a health care facility (including an emergency department of a hospital or independent free standing emergency department), the provider satisfies the disclosure requirements if the facility agrees to provide the information, in the required form and manner, pursuant to a written agreement".**

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Key Takeaways: Protections for Non-emergent Uninsured and Self-pay (S/P) Pts.

- Providers and facilities must provide a good faith estimate (GFE) of "reasonably expected" charges for services to an uninsured or S/P Pt (self-pay Pts. might have insurance but due to "sensitive diagnosis" or other issues do not want claims filed).
- Consumers may request a good faith estimate without actually scheduling items or services to compare costs and make a decision about from which provider or facility they will seek care.
- The insured Pt rule enforcement has been deferred until future rule making.
- Convening provider or convening facility: the provider or facility who receives the initial request for a good faith estimate from an uninsured or S/P Pt. and who is or, in the case of a request, would be responsible for scheduling the primary item or service.
  - Enforcement will begin 1/1/22 for convening providers and facilities
- Co-provider or co-facility: A provider or facility other than a convening provider or a convening facility that furnishes items or services that are customarily provided in conjunction with a primary item or service.
  - Enforcement will be discretionary until 7/1/22 for co-providers and co-facilities responsible for providing good faith estimates to uninsured or S/P Pts.

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Key Takeaways: Protections for Non-emergent Uninsured and Self-pay Patients

- Written notice on the convening provider website, in the office and at the location where scheduling occurs—model notice and listing of required elements is available.
- Convening providers must request the GFE no later than 1 business day after the scheduling or request and the co-providers have 1 business day to produce the GFE.
- Providers and facilities must provide the GFE to the Pt. w/in 1 business day of the request if the service will occur w/in 3 business days of scheduling. They will have 3 business days to provide the GFE if the service is occurring at least 10 business days after scheduling.
- While this requirement will still take effect on January 1, 2022, the agencies will exercise some enforcement discretion in situations where a good faith estimate does not include expected charges from co-providers and facilities that are involved in the individual's care.

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Part 2: MI Surprise Medical Billing (SMB) law



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Michigan – State Law



- State Law trumps Federal Law if the health plan is not an ERISA plan;
- ERISA plan disputes would be adjudicated under federal NSA IDR.
  - HB 4459 and 4460
  - Enacted 10/22/2020
  - Effective date 1/1/2021 "Sanctions for Violations"
  - IDR process available 7/1/2021
    - Limited use to date
    - Concerns for lack of engagement

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Michigan- State Law

- Law prohibits OON providers from billing enrollees for any amount beyond in-network level of cost sharing
  - HMO and PPO enrollees
  - For emergency services by OON professionals and facilities and non-emergency services provided by OON professionals at in-network facilities
  - Provided by all or most classes of OON health care professionals
  - State provides the payment standard
  - State provides a dispute resolution process

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Michigan- State Law

- Protections do NOT apply to
  - Ground ambulance services
  - Enrollees who consent to non-emergency OON services
  - Enrollees of self-funded plans (ERISA)

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Michigan- State Law

For OON visits, the provider is limited to the greater of:

The median amount negotiated by the carrier for the region and provider specialty, excluding any in-network coinsurance, copayments or deductibles; or

150% of the Medicare fee schedule for the service provided, excluding any in-network coinsurance, copayments, or deductible

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Michigan- State Law

- "Complicating Factor"
  - In cases where an enrollee has received emergency services, a non-participating provider can request an additional 25% of the payment standard amount if a complicating factor is identified. If the carrier rejects the request, a non-participating provider can initiate binding arbitration specific to whether there was a complicating factor
  - The term "complicating factor" means a factor that is not normally incident to a health care service, including, but not limited to, the following: (a) increased intensity, time, or technical difficulty of the health care service, (b) the severity of the patient's condition, or (c) the physical or mental effort required in providing the health care service. The request must be supported with clinical documentation demonstrating the complicating factor and the emergency patient's medical record (highlighted to show the complicating factor).

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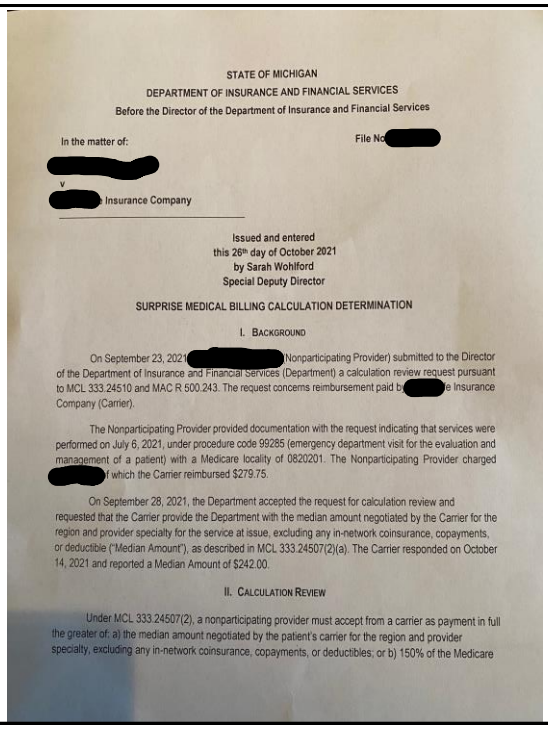
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Michigan- State Law

- Independent Dispute Resolution (IDR)
- Claim cost
- Claim submission and resolution via State of Michigan-
  - Department of Insurance and Financial Services (DIFS)
- Limited use to date
  - Experiences?
  - Concerns for lack of engagement "Good Law"

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STATE OF MICHIGAN
DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES
Before the Director of the Department of Insurance and Financial Services

In the matter of: File No.

v

Insurance Company

Issued and entered
this 26th day of October 2021
by Sarah Wohlford
Special Deputy Director

SURPRISE MEDICAL BILLING CALCULATION DETERMINATION

I. BACKGROUND

On September 23, 2021 Nonparticipating Provider) submitted to the Director of the Department of Insurance and Financial Services (Department) a calculation review request pursuant to MCL 333.24510 and MAC R 500.243. The request concerns reimbursement paid b e Insurance Company (Carrier).

The Nonparticipating Provider provided documentation with the request indicating that services were performed on July 6, 2021, under procedure code 99285 (emergency department visit for the evaluation and management of a patient) with a Medicare locality of 0820201. The Nonparticipating Provider charged f which the Carrier reimbursed $279.75.

On September 28, 2021, the Department accepted the request for calculation review and requested that the Carrier provide the Department with the median amount negotiated by the Carrier for the region and provider specialty for the service at issue, excluding any in-network coinsurance, copayments, or deductible ("Median Amount"), as described in MCL 333.24507(2)(a). The Carrier responded on October 14, 2021 and reported a Median Amount of $242.00.

II. CALCULATION REVIEW

Under MCL 333.24507(2), a nonparticipating provider must accept from a carrier as payment in full the greater of: a) the median amount negotiated by the patient's carrier for the region and provider specialty, excluding any in-network coinsurance, copayments, or deductibles; or b) 150% of the Medicare

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File [redacted]
Page 2

fee for service schedule for the health care service provided, excluding any in-network coinsurance, copayments, or deductibles.

Upon receipt of the information supplied by the Carrier, the Department conducted a calculation review as required under MCL 333.24510(2) by comparing the Median Amount to the Medicare amount and the actual amount paid to the Nonparticipating Provider. The Department determined that the amount was incorrectly calculated, as set forth in the table below.

CPT/HCPCS	Amount Paid	Median Amount	Medicare Amount	Amount Owed
99285	$ 279.75	$ 242.00	$ 190.00 x 150%= $285.00	$ 5.25

III. DETERMINATION

The Department determines that the Carrier incorrectly calculated the reimbursement and that the correct calculated amount is $285.00.

The Nonparticipating Provider is entitled to an additional reimbursement of $5.25 plus simple interest of 12% per annum, *see* MCL 500.2006(8), accruing from the date on which the amount specified should have been paid (i.e., 60 days after the Carrier received the claim; *see* MCL 333.24507(4)).

This order applies only to the Nonparticipating Provider, Carrier, Median Amount, and dates of services discussed herein and may not be relied upon by either party to determine reimbursement in other circumstances not addressed in this order.

Anita G. Fox
Director
For the Director:

X Sarah Wohlford

Sarah Wohlford
Special Deputy Director
Signed by: Sarah Wohlford

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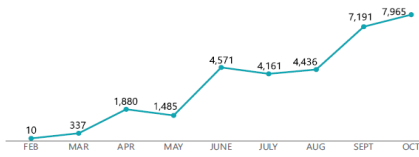
NSA: TX TDI Data Then and Now

Texas TDI—1st 10 months of 2020*

Arbitration

SB 1264 outlines an arbitration process for billing disputes between out-of-network health care providers (not facilities) and health plans. From January 1 through October 31, 2020, TDI received 32,036 requests for arbitration.

Arbitration requests



Arbitration requests by provider type

Provider type	Requests
Emergency department physician	27,492
Anesthesiologist	2,138
Certified Registered Nurse Anesthetist	609
Assistant surgeon	425
Hospitalist	339
Neurologist	18
Neuromonitor	55
Nurse practitioner	22
Pathologist	130
Physician assistant	96
Surgeon	189
Surgical assistant	437
Other	86
Total	32,036

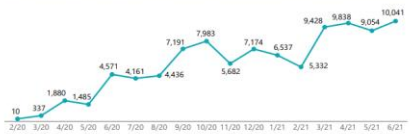
- **Settlements: when IDR is settled, clinicians receiving 4.43X of initial payment.***
- **Adjudicated IDRs: clinicians receiving 4.74X of the initial payment.***

Texas TDI—July 2021*

Arbitration

SB 1264 outlines an arbitration process for billing disputes between out-of-network health care providers (not facilities) and health plans. In 2020, TDI received 44,910 requests for arbitration. In the first half of 2021, TDI received 50,230 requests.

Arbitration requests by month



Arbitration requests by provider type

Provider type	Jan-June 2021
Emergency department physician	35,172
Anesthesiologist	8,238
Certified registered nurse anesthetist	1,993
Radiologist	1,749
Surgical assistant	759
Physician assistant	741
Assistant surgeon	686
Neuromonitor	321
Surgeon	169
Hospitalist	117
Nurse practitioner	96
Pathologist	72
Neonatologist	29
Neurologist	10
Other	78
Total	50,230

- **IDRs settled during the discussion period have increased from 4.43X of the initial payment in '20 to 4.6X of the initial payment in '21.***
- **IDRs adjudicated have seen a decrease from 4.74X of the initial payment to 3.4X of the initial payment but the initial payment increased $53 in that 1-year period.***

Source: Texas Department of Information | tdi.Texas.gov

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Additional Resources:

- Press release
- Fact sheet
- "What you need to know"
- CY 2022 Fee Guidance for the Federal IDR Process
- New Surprise Billing Resource Webpage
- CMS zip file of standard forms, worksheets & notices can be found here:
  - **https://www.cms.gov/regulations-and-guidancelegislationpaperworkreductionactof1995pra-listing/cms-10791**

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Thank you and Questions!

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Vice President of RCM and Advocacy, Emergency Care Specialists, Grand Rapids, MI, and
Chair of Emergency Dept. Practice Management Association.

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Appendix: MCEP Straight Talk

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Patient-Provider Dispute Resolution:

- In a situation where an uninsured or S/P Pt. receives a good faith estimate and then is billed for an amount "substantially in excess" of the good faith estimate, the regulation establishes an arbitration process similar to the IDR called "select dispute resolution (SDR)."
- For purposes of SDR eligibility, "substantially in excess" means at least $400 more for any provider or facility listed on the good faith estimate.
- Eligibility is NOT based on the charges in the GFE—it's on the total billed charges—"anti-sandbagging" provision.
- The GFE is the presumed appropriate final amount unless "unforeseen circumstances" are shown that could not have been anticipated that increased the final bill beyond the GFE.

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Patient-Provider Dispute Resolution: Impact on collection efforts, late fees & retaliation

- Once the SDR entity is selected, the SDR notice is sent to the uninsured or S/P Pt. and the provider/facility per a standard notice on the CMS website (Appendix 9 in the zip file).
- The provider/facility cannot transfer the Pt's account to collections AND must cease all collection activity on that account until the dispute is resolved.
- Provider must also suspend accrual of late fees on unpaid bills and not engage in conduct that would be considered retaliation for the Pt filing the SDR.

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