AMA summary of the No Surprises Act (NSA) Interim Final Rule (IFR) Requirements Related to Surprise Billing: Part II

The IFR issued by the Departments of Health and Human Services (HHS), Treasury, Labor, and the Office of Personnel Management ("the Departments") on September 30, 2021, implements the following parts of the NSA:

- The open negotiations and independent dispute resolution (IDR) processes between providers (physicians, hospitals, etc.) and health plans;
- Section 110 of the NSA expanding the scope of the federal external review process to cover adverse benefit determinations under the NSA;
- The good faith estimate (GFE) requirements for uninsured patients and patients who are not planning to use their coverage (i.e., self-pay); and
- The dispute resolution process for uninsured or self-pay patients when the GFE significantly exceeds the costs of care.

Key takeaways:

- By establishing the qualifying payment amount (QPA) as a presumptively reasonable out-of-network payment, the Departments are underscoring their objective to reduce the frequency with which the IDR is used and ultimately bringing down the in-network rates of facilities and facility-based providers.
- Although the QPA is meant to represent the median in-network rate, the method used to calculate it (as outlined in the Part I IFR), will often result in much lower amounts. Together, the Part I and Part II IFRs will make it more difficult for physicians to receive fair payment for out-of-network services and to enter into meaningful contract negotiations with health plans which now have little incentive to offer fair contracted rates (especially since most insurance markets are highly concentrated).
- Improvements made in the IFR to the ability of physician groups to batch all claims during the 90-day "cooling off" period will create greater efficiencies for many physicians.
- While advancing greater price transparency, the provisions implementing the GFE requirements could place a significant burden on physician practices, especially those physicians who are responsible for collecting the estimates of other ancillary providers and as patients use the GFE to shop for services.
- The patient-provider dispute resolution process could result in some confusion for patients and providers, especially in situations where last minutes changes are made to ancillary providers and when unanticipated care is needed during a service or procedure.
- Expanding the scope of the external review process may provide greater clarity in the way in which denials are handled under the NSA and increase opportunities for patients to challenge adverse benefit determinations.

Summary

The first IFR implementing the NSA established the process for determining the cost-sharing responsibility of patients in a surprise billing situation by outlining a method to calculate the QPA. For the federal process, the QPA is meant to represent the median in-network rates for the same or similar services in that geographic area. However, the AMA remains very concerned that the method the Departments direct plans to use to calculate the QPA will often result in rates well below the true median of in-network commercial rates.

In the most recent IFR, the Departments outline the processes for payers and health plans to settle disputes over out-of-network payments, beginning with an open negotiation period followed by the formal IDR process. However, before any dispute can begin, the IFR clarifies that an initial payment or notice of denial must be sent to the provider and any **initial payment** should be an amount that the plan or issuer reasonably intends to be payment in full based on the relevant facts and circumstances.

Additionally, the Departments are establishing a Federal IDR portal (https://www.nsa-idr.cms.gov) to be used for IDR entity (IDRE) certification, the initiation of the IDR process, the selection of an IDRE by parties, the submission of supporting documentation to IDREs, and the submission of IDRE reporting metrics.

Open negotiations
The party initiating the open negotiations must provide written notice to the other party of its intent to negotiate (open negotiation notice). The Departments are providing a standard notice form that must be used to satisfy this requirement.

The notice must be sent within 30 business days of the initial payment or notice of denial and must be in writing. (It can be sent electronically if the party sending the notice has a good faith belief that the electronic method is readily accessible to the other party, and the notice is provided in paper form free of charge upon request.) The 30-business-day open negotiation period begins on day the open negotiation notice is sent by a party.

The notice must include:

- the date the service was furnished,
- the service code,
- the initial payment amount or notice of denial of payment,
- an offer for the out-of-network rate, and
- contact info of the party sending the notice.

If the parties cannot agree on an out-of-network rate, they must exhaust the 30-business-day open negotiation period before initiating the Federal IDR process. Of note, a party may not initiate the IDR process if it knows or reasonably should have known that the provider provided notice and obtained consent from a patient to waive surprise billing protections.

Initiating the Federal IDR Process
If a payment amount cannot be determined through open negotiations, either party may initiate the IDR process during the 4-business-day period after the end of the open negotiations period. The party initiating the process submits a Notice of IDR Initiation to the other party and to the Departments through the IDR portal on the same day. The initiation date of the IDR process is the date of receipt of the Notice of IDR Initiation by the Departments and the Departments will confirm the initiation date upon receipt of the notice.

The Notice of IDR initiation must include:

- Information sufficient to identify the services (and whether services are designated as batched services), including the dates and location of services, type of services (e.g., emergency services, post-stabilization services, etc.); and corresponding service and place-of-service codes.
- The amount of cost sharing allowed and the amount of the initial payment made by the plan;
- Names and contact info of the parties;

- State where services were furnished;
- Date the open negotiation period started;
- Initiating party's preferred IDRE;
- Attestation that services are within the scope of the IDR process;
- The QPA;
- Additional information about the QPA as described in regulation; and
- General information describing the IDR process. (The Departments have developed a form that the parties must use for this.)

Selecting an IDRE
Parties should jointly select an IDRE no later than 3 business days following the date of the IDR initiation. But if they fail to agree, the initiating party must provide notification in one business day through the IDR portal and the Departments will randomly select an IDRE within 6 days.

If the non-initiating party believes the IDR process is not applicable and/or state laws apply, they can provide notice via the IDR portal. Based on information and any additional info requested by the selected IDRE, it will determine whether the process is applicable within 3 business days.

Batching claims
The IFR allows multiple claims for services to be considered jointly by an IDRE entity if:
- Claims are billed by the same provider or group of providers or facility and billed with the same National Provider Identifier (NPI) or Taxpayer Identification Number (TIN);
- Payment would be made by the same group health plan or health insurance issuer;
- Claims include the same or similar items or services; and
- Services are furnished within the same 30-business-day period, or the 90-calendar-day suspension period (services delivered during the 90-calendar-day suspension period are eligible for the IDR process and may be included in the same batch).

Additionally, where services are billed as part of a bundled arrangement, or where a plan makes an initial payment as a bundled payment, services may be submitted and considered as part of one payment determination by the IDRE (and subject to the fee for single determinations).

IDR process and payment determination
If the parties reach an agreement prior to IDRE's decision but after selection of the IDRE, each party pays half the fees of the IDRE. When an agreement is reached either before or after IDRE is selected, notification to the Departments must include the out-of-network rate and signatures for each party.

Each party must submit an offer for a payment amount and other information related to the offer as requested by the IDRE within 10 business days of selection of the IDRE and may submit additional information for the IDRE consider. Not later than 30 days after selection of IDRE, the IDRE must select an offer. Information to be submitted to the IDRE includes:
- The party's offer expressed as both a dollar amount and percentage of the QPA;
- Information requested by IDRE;
- Providers must provide the size of their practices and facilities and plans must submit coverage areas, geographic regions, etc. for purposes of QPA; and
- Any additional information (minus prohibited information) to support an offer.

In making a determination of which offer to select, the IDRE must begin with the presumption that the QPA is the appropriate out-of-network rate for the or service under consideration. The IDRE must select the offer closest to the QPA, unless the credible information submitted by the parties clearly demonstrates that the QPA is materially different from the appropriate out-of-network rate, based on the additional circumstances allowed.

Information submitted by the parties must be credible and relate to the offer submitted by either party. Information is considered credible if "upon critical analysis the info is worthy of belief and is trustworthy."

If the IDRE determines that credible information about additional circumstances clearly demonstrates that the QPA is materially different from the appropriate out-of-network rate, the IDRE must select the offer that best represents the appropriate out-of-network rate. A material difference exists where there is substantial likelihood that a reasonable person with the training and qualifications of an IDRE would consider the information important in determining the out-of-network rate and view the information as showing that the QPA is not the appropriate out-of-network rate under the additional circumstances.

Standards for IDR for treatment of factors to dispute QPA/support offer
The NSA states that with some exceptions, a party may provide additional information to an IDRE to support their offer for an out-of-network rate and delineates several factors that may be relevant. The Departments attempt to create standards for how an IDRE should consider these factors in order to select an offer that is not closest to the QPA in an effort to ensure "consistency" in how different IDR entities evaluate offers – suggesting that such a process yields predictable outcomes and reduces administrative costs:

- Level of training, experience, and quality and outcome measurements: According to the Departments, services should not necessitate an out-of-network rate higher than the offer closest to the QPA simply based on the level of experience or training of a provider, as this would lead to an increase in prices without a valid reason. A party may provide evidence as to why the provider's or facility's quality or outcome measures support an out-of-network rate that is different from the QPA and the IDRE should consider whether this requires selecting an OON rate that is higher (in the case of a bonus) or lower (in the case of a penalty) than the offer closest to the QPA.
- Market share: The Departments state that the market dominance of a provider or a plan can drive reimbursement rates up or down in a given region.
- Patient acuity or complexity of furnishing item or service: The Departments state that because service codes and modifiers reflect patient acuity and the complexity of the service, these factors will already be factored into the QPA, so only in rare instances would the QPA not adequately account for the acuity of the patient or complexity of the service. If a plan has changed the service code or modifier for a claim and applies a QPA that uses a different service code or modifier than those submitted by the provider, the provider could submit credible information to the IDRE showing that the QPA applied by the plan is based on a service code or modifier that did not encompass patient acuity or the complexity of furnishing the service.
- Teaching status, case mix, and scope of services of the nonparticipating facility: To deviate from the QPA, the Departments require that credible info that the teaching status, case mix, or scope of services of the facility was in some way critical to the delivery of the care. For example, the IDRE could consider the trauma level of a hospital when the dispute involves trauma care that could not be performed at a lower-level hospital, but only to the extent the QPA does not otherwise reflect this factor.

- Demonstrations of good faith efforts (or lack thereof) to enter into network agreements and contracted rates between the provider and the plan during the previous 4 plan years: According to the Departments, the IDRE must consider what the contracted rate might have been had the good faith negotiations resulted in the provider's services being in-network, if a party is able to provide related credible information of good faith efforts or the lack thereof.

A written decision of the IDRE must be submitted the Departments, and if the IDRE does not choose the offer closest to the QPA, the report must include a detailed explanation of the additional considerations relied upon, whether the information submitted by the parties was credible, and the basis upon which the IDRE determined that the credible information demonstrated that the QPA is materially different from the appropriate out-of-network rate.

Departments' reasoning for defaulting to the QPA as a reasonable out-of-network rate
Statutory interpretation
In the IFR, the Departments state that their best interpretation of the statute is that an IDRE must look first to the QPA and then to other considerations. The presumption that the QPA is the appropriate out-of-network rate can then be rebutted by credible information about additional circumstances that clearly demonstrate that the QPA is materially different from the appropriate out-of-network rate.

In creating this presumption, the Departments point to the fact that the statute lists the QPA as the first factor that the IDRE must consider in determining which offer to select. They also consider that the statute provides relatively limited guidance on how to consider the additional circumstances, but sets out detailed rules for calculating the QPA, suggesting that an accurate and clear calculation of the QPA is integral to the application of consumer cost-sharing and to determination of the out-of-network rate.

The Departments highlight additional statutory elements they believe show the importance of the QPA in the IDR process and suggest that the QPA will frequently be a reasonable out-of-network rate:
- Plans must provide information on how the QPA is calculated to out-of-network providers, ensuring they are aware of how this amount is calculated;
- Plans are subject to audit requirements on calculating the QPA;
- Cost-sharing for enrollees is based on the recognized amount, which will generally be the QPA; and
- Departments must report how payment determinations compare to the corresponding QPA.

Perceived benefits by the Departments of their interpretation
The Departments believe the QPA should reflect "standard market rates" arrived at through typical contract negotiations and should therefore be a reasonable out-of-network rate under most circumstances. They state that the QPA is generally based on the median of contracted rates, and these contracted rates are established through arms-length negotiations between providers and plans.

By anchoring the out-of-network rates to the QPA, the Departments state that IDR outcomes will be more predictable, and parties may be encouraged to reach an agreement outside of the IDR process to avoid the administrative costs. Additionally, they suggest that this "anchoring" will help reduce prices that "may have been inflated due to the practice of surprise billing" before the NSA and will help limit the indirect impact on enrollees that would occur from higher out-of-network rates if plans were to pass higher costs through increases in premiums.

The AMA strongly disagrees with the Departments interpretation of the Statute as it relates to the use of the QPA in the IDR process and believes that the negative, long-term impact of this "anchoring" of out-of-network rates to the QPA on independent practices, fair contracting, and eventually access to care will overwhelm any perceived benefits of this statutory interpretation.

"Cooling off period"
Under the NSA, following a decision by an IDRE, a provider may not bring another claim for such item or service with that plan to IDR for "90 days." The IFR clarifies that the 90 days refers to 90 calendar days and "such item or service" in this context refers to "same or similar item or service" as defined in the July IFR. It also provides that services provided during this 90-day period are eligible for IDR and may be included in the same batch following the end of that period. After the end of the 90-day period, either party can initiate the IDR process for claims affected by the suspension and the initiating party must submit the Notice of IDR Initiation within 30 business days following the end of cooling off period (as opposed to the standard 4-business-day period following the end of the open negotiation period). The 30-business-day period begins on the day after the last day of the 90-calendar-day period.

IDR Fees
At the time that an IDRE is selected each party must pay an *administrative fee* due to the Departments for participating in the IDR process ($50 for 2022). Additionally, at the time of submission of the offer by each party, an *IDR fee* must be paid to the IDRE by each party - the Departments estimate that on average the IDRE fees will be $400.

Each party will be able to view the IDRE fees and administrative fees in the IDR portal when engaging in the IDRE selection process and there will be annual guidance from Departments on range of allowed fees. IDREs will hold funds in a trust or escrow account until an offer is selected or when parties agree on an out-of-network rate. If the parties negotiate an out-of-network rate before the IDRE makes a determination, the IDRE will return half of each party's payment for the IDRE fee.

In case of batched claims, the party with fewest determinations in its favor is considered the non-prevailing party and is responsible for paying the IDRE fee. If each party prevails in an equal number of determinations, the fee will be split evenly between the parties.

IDRE Certification
Organizations interested in becoming IDRE must submit applications by November 1, 2021, to be certified by January 1, 2022. The Departments estimate that 50 entities will apply, including some entities currently providing external review or state IDR services.

The IFR clarifies that IDREs must be free of conflicts of interest by requiring that they are free from relationships, conditions, or statuses that impact their ability to make an unbiased and impartial decision. For example, their staff cannot be or be associated with an entity regulated by the NSA and no assigned personnel can have a material relationship with a party in IDR. The IDRE must also demonstrate that it has procedures in place to ensure that the specific personnel assigned to a payment determination do not have conflicts of interest regarding any party to the dispute within the 1 year immediately preceding an assignment.

The IFR lays out several additional IDRE certification requirements including:

- Sufficient expertise and staffing to conduct determinations on a timely basis,

- Accreditation by a nationally recognized and relevant accrediting body (such as URAC) or otherwise ensuring that IDRE personnel possess the requisite training to conduct payment determinations (for example, provide documentation that personnel employed by the IDRE have completed arbitration training by the American Arbitration Association, the American Health Law Association, or a similar organization);
- Procedures in place to retain certified IDRE fees and retain/remit administrative fees;
- Meet appropriate indicators of fiscal integrity and stability;
- Possess directly or through contracts or other arrangements, sufficient arbitration and claims administration of health care services, managed care, billing, coding, medical, and legal expertise, including available medical expertise with the appropriate training and experience as it relates to the claim; and
- The ability to collect and transmit the information required to be reported to the Departments.

In terms of data privacy, the IDREs will have standards to maintain the confidentiality of Individually identifiable health information (IIHI) obtained while conducting the IDR process. IDRE must have procedures in place to protect consumers from improper storage, use, handling, or transmission of this information. The confidentiality standards are informed by the privacy, security, and breach notification regulations issued under HIPAA and the HITECH Act.
IDRE certification is good for five years. Any stakeholder may petition for the denial of a certification of an IDRE or a revocation of a certification through the Federal IDR portal.

IDR Data Reporting
The IFR requires that within 30 business days of the close of each month, each IDRE must report certain data and information to the Departments for IDR claims subject to payment determinations including:

- Number of Notices of IDR Initiation for which a final determination was made by the IDRE;
- The types of items or services;
- The practice specialty or type of each provider;
- Each party's name and address;
- The relevant geographic region for purposes of the QPA;
- The offers submitted by each party as both a dollar amount and percentage of the QPA;
- Whether the offer selected by the IDRE was submitted by the plan or the provider;
- The rationale for the decision, including if the IDRE relied on criteria other than the QPA;
- The number of times the out-of-network rate determined exceeded the QPA;
- The number of business days taken between the selection of the certified IDRE and the selection of the payment amount by the IDRE; and
- The total amount of IDRE fees paid to the IDRE, including amounts refunded by IDRE to the prevailing party and the administrative fees that are collected on behalf of the Departments.

Additionally, IDREs must report on the practice or facility size in terms of employees. The Departments state that this information will allow them to assess whether smaller providers and facilities have the needed resources to use the IDR process and will assist them in determining whether larger organizations may have an unfair advantage in the process. According to the Departments, this data will also assist in determining the effect of the IDR process on horizontal and vertical integration of providers and facilities, and in reporting on this effect to Congress, as required by the statute.

External review changes under Section 110 of NSA

The Affordable Care Act (ACA) requires health plans to comply with federal or state external review processes which are available for adverse benefit determinations based on medical necessity, appropriateness, setting, level of care, or effectiveness of a covered benefit. The NSA directed the Departments to ensure that ACA external review processes apply to adverse benefit determinations by a plan under the NSA. Therefore, the IFR broadens the scope of external review requirements to explicitly state that any adverse benefit determination that involves consideration of whether a plan is complying with the NSA is eligible for external review.

Also, because the NSA applies to grandfathered health plans, the scope of external review for NSA claims is expanded to grandfathered plans. Patients in such plans can access external review after exhausting all internal and state appeal processes, or if none exists, immediately following the denial.

The IFR provides examples of adverse benefit determinations that would be eligible for external review related to NSA protections:

- Whether a claim is for treatment for emergency services that involves medical judgment or consideration of compliance with the cost-sharing and surprise billing protections.
- Whether a claim from nonparticipating provider at an in-network facility is subject to the protections under the NSA, as adjudication of the claim requires consideration of health care setting and level of care or compliance with cost-sharing and surprise billing protections.
- Whether an individual was in a condition to receive a notice about the availability of the NSA protections and give informed consent to waive those protections, as adjudication of the claim involves consideration of compliance with the cost-sharing and surprise billing protections and medical judgment.
- Whether a claim is coded correctly, consistent with the treatment an individual actually received, as adjudication involves medical judgment.
- Whether cost-sharing was appropriately calculated for claims for ancillary services provided by an out-of-network provider at an in-network facility, as adjudication involves consideration of compliance with the cost-sharing and surprise billing protections.

Good Faith Estimate

Definition and scope

Under the IFR, a patient considering care or scheduling it is entitled to a GFE of potential charges. A GFE means a notification of expected charges for a scheduled or requested service including those that are reasonably expected to be provided in conjunction with the care. A GFE is considered part of a patient's medical record.

When a patient is scheduling care, or upon request, a provider must determine if a patient has health care coverage and is planning to use it. If they have health care coverage, the provider will send a GFE to the health plan which will provide the patient with an advanced EOB. Regulations on this process are forthcoming but, generally, have been delayed beyond January 1, 2022. However, if the patient is uninsured or planning to pay for their own care (self-pay), the provider will provide the GFE directly to the patient. (This includes patients enrolled in products not considered health insurance such as short-term limited duration insurance.) The latter situation is addressed in this IFR.

Of note, a patient may request a GFE to compare costs and make a decision about from where they will seek care, or whether they will submit a claim to insurance or self-pay. These individuals would be considered self-pay for purposes of the requirement on the provider or facility to provide a GFE.

Importantly, under this section of the IFR, health care facility is defined more broadly as an institution (such as a hospital or hospital outpatient department, critical access hospital, ambulatory surgical center, rural health center, federally qualified health center, laboratory, or imaging center) in any state in which state or applicable local law provides for the licensing of such an institution.
Under the IFR, the GFE must contain:

- Patient's name and date of birth;
- Description of service and date primary services are scheduled;
- Itemized list of services, grouped by provider or facility, reasonably expected to be provided including those in conjunction with the primary services for that period of care;
- Applicable diagnosis codes, service codes, and charges associated with each service;
- Name, NPI, and TIN of each provider and states and facility location where care will be provided;
- List of services that convening provider/facility anticipates will require separate scheduling (must include a disclaimer saying that separate GFE will be issued upon scheduling or request of listed item or services);
- Disclaimer that there may be additional services that convening provider/facility recommends as part of the course of care that must be scheduled separately and not reflected;
- Disclaimer that information is only an estimate;
- Disclaimer that informs patient about the right to initiate dispute resolution process; and
- Disclaimer that GFE is not a contract.

The GFE can be provided electronically if a patient requests but must be in way that the patient can save and print, and it must be provided in clear and understandable language.

Convening provider/facility and co-provider responsibilities

A convening health care provider or facility is the provider or facility who receives the initial request for a GFE from a patient and would be responsible for scheduling the primary item or service (i.e., the initial reason for the visit). The convening provider must inform the patient (orally and in writing) that a GFE is available upon scheduling or upon request. The IFR clarifies that **any discussion or inquiry regarding the potential cost of items or services under consideration as a request for a GFE.**
The convening provider/facility must provide a GFE to an uninsured (or self-pay) patient within 3 business days upon request. Information regarding scheduled care must be furnished within 1 business day of scheduling care to be provided in 3 business days; and within 3 business days of scheduling care to be provided in at least 10 business days. The IFR states that the convening provider or facility must contact all applicable co-providers and co-facilities no later than 1 business day after the request for the GFE is received or the primary service is scheduled. A single GFE can be issued for recurring primary services if certain requirements are met (not to exceed a scope of 12 months).

The information for the GFE submitted by co-providers/facilities must be received by the convening provider no later than 1 business day after the co-provider or co-facility receives the request. If one of the co-providers is no longer able to participate, the convening provider must issue a new GFE within 1 business day of when care is scheduled to be provided. If any changes in co-providers/facilities represented in GFE occur less than 1 business day before care is scheduled, the replacement provider must accept the GFE as their expected charges.

Importantly, through December 2022, regulators will exercise enforcement discretion in situations where the GFE does not include co-providers and co-facilities. Moreover, a provider will not fail to comply with these requirements just because, despite acting in good faith and with reasonable due diligence, the provider makes an error in a GFE, provided that they correct the information as soon as practicable.

However, if the services are furnished before the error in the GFE is addressed, the provider may be subject to patient-provider dispute resolution if the billed charges are substantially in excess of the GFE. Finally, a provider will not fail to comply with this section because it relied in good faith on the information from another entity, unless the provider knows, or reasonably should have known, that the information is inaccurate.

Interaction with good faith estimate included in notice and consent documents
A GFE is also required as part of the notice and consent requirements under the NSA and as described in the July IFR implementing the NSA. Despite different requirements (i.e., the GFE to be included as part of notice only includes estimates from out-of-network provider), the IFR states that the requirements in each of the two rules generally take into account the same process and considerations for calculating the good faith estimate. Therefore, HHS encourages providers to use similar considerations for both GFEs whenever possible to avoid confusion for patients.

Patient-provider dispute resolution process
The IFR implements a patient-provider dispute resolution process when the charges from an out-of-network provider to an uninsured or self-pay patients are substantially in excess of the GFE. Substantially in excess means, with respect to the total billed charges, an amount that is at least $400 more than the total amount of expected charges listed on the GFE.

For this selected dispute resolution (SDR) process, SDR entities (SDRE) will generally have to meet the same requirements as an IDRE with some exceptions. For this process, HHS anticipates that up to three SDREs will be selected in 2022, nationwide to resolve an estimated 27,000 claims per year.

To initiate the process, a patient submits notification (initiation notice) and an administrative fee (currently $25) via the Federal IDR portal, electronically, or on paper, postmarked within 120 calendar days of receiving the initial bill containing charges substantially in excess of expected charges in GFE.

The initiation notice must include:

- Information sufficient to identify service under dispute, including the date the service was provided, and a description of the service;
- A copy of the provider or facility bill for the service under dispute;
- A copy of the GFE for the service under dispute;
- Contact information of the provider or facility involved, including, if available, name, email address, phone number, and mailing address;
- The State where the services were furnished; and
- The patient's communication preference.

HHS will select an SDRE upon receipt of the initiation notice and SDRE will, through the federal portal, electronically or by paper mail, notify the patient and the provider that the SDRE request has been received and is under review.

First, the SDRE makes a determination on the claim's SDR eligibility and gives the patient 21 calendar days to submit more information if the SDRE determines the initiation notice is incomplete. If complete, the SDRE will notify parities that they have 10 business day to provide a copy of the GFE; a copy of the billed charges; and, if available, documentation demonstrating that the difference between the billed charges and the expected charges reflect the costs of medically necessary care and are based on unforeseen circumstances that would not have been anticipated when the GFE was provided.

While the process is pending, the provider may not move the disputed bill into collection or threaten to do so, and the provider must stop any current collection efforts. The provider must also suspend the accrual of any late fees until after the SDR process has concluded.

Not later than 30 business days after receipt of information, the SDRE will make a determination on the amount to be paid by patient. During the process, the SDR entity must review any documentation submitted by the patient or provider and must make a determination as to whether the provider has provided credible information to show that the difference between the billed charge and the expected charge reflects the costs of medically necessary care and is based on unforeseen circumstances that could not have reasonably been anticipated when the GFE was provided. The SDRE must make a separate determination for each service charged.

Some states, including Maine and New York, have similar patient-provider dispute processes in place and can continue to operate their dispute resolution process, but must meet minimum requirements.

Next steps
Comments on this IFR will be accepted by the Departments until the end of November.