Articles + Publications | August 25, 2022

After Multiple Strikes, Final Rules Issued for the No Surprises Act

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On August 19, the U.S. Departments of Health and Human Services, Labor, and the Treasury (the Departments) issued final rules implementing the No Surprises Act, known as the "Requirements Related to Surprise Billing: Final Rules."[1] Importantly, the final rules include modifications to the independent dispute resolution (IDR) process, governing out-of-network payments established by interim rules that prompted criticism by providers and courts.

IDR Process

The interim final rules provided that, in the event of a dispute between a payor and provider regarding out of network payment amounts, the parties could initiate the IDR process. In resolving the dispute, the IDR entity would begin with a presumption that the qualifying payment amount (QPA) — the payor's median contract rate for the same or similar service in the relevant region — was the appropriate out-of-network rate. This presumption in favor of the QPA was struck down by a federal court on two occasions.

On February 23 and July 26, 2022, the U.S. District Court for Eastern District of Texas in *Texas Medical Association, et al. v. United States Department of Health and Human Services, et al.*, Case No. 6:21-cv-425 (E.D. Tex.) (*Texas Medical Association*), which we reported about in March 2022, and *LifeNet, Inc. v. United States Department of Health and Human Services, et al.*, Case No. 6:22-cv-162 (E.D. Tex.) (*LifeNet*) vacated different portions of the October 2021 interim final rules,[2] holding that establishing the QPA as the default payment amount ran afoul of the No Surprises Act's statutory text.

In light of *Texas Medical Association* and *LifeNet* rulings and the comments received to date, the Departments issued the final rules, which, among other things, remove the presumption in favor of the QPA.[3]

The final rules require that the IDR entities *consider* the QPA for the applicable year for the same or similar item or service, as well as all additional permissible information submitted by each party to determine which offer best reflects the appropriate out-of-network rate, provided that the information relates to the party's offer for the payment amount for the qualified IDR item or service that is the subject of the payment determination.[4] The IDR entities must also evaluate the credibility of the information offered and should not give weight to information that is not credible.[5]

After weighing these considerations, the IDR entities then must select the offer that "best represents the value of the item or service under dispute."[6]

The final rules also impose requirements on IDR entities, requiring them to explain their payment determination and underlying rationale. Although *Texas Medical Association* invalidated the requirements to provide an explanation of the credible information that the IDR entities determined demonstrated that the QPA was materially different from the appropriate out-of-network rate, the final rules require that the IDR entities provide an explanation for their decision in all cases, including the weight given to the QPA and any additional credible information regarding the relevant factors, and not only when the IDR entity does not choose an offer closest to the QPA.

Downcoding Disclosure Requirements

In addition to removing the presumption in favor of the QPA in the IDR process, the final rules require additional disclosures related to the QPA. Specifically, plans and insurers must disclose additional information about the QPA if they downcode a billed claim.[7] The final rules define "downcode" as "the alteration by a plan or issuer of a service code to another service code, or the alteration, addition, or removal by a plan or issuer of a modifier, if the changed code or modifier is associated with a lower QPA than the service code or modifier billed by the provider, facility, or provider of air ambulance services"[8]

If a QPA is based on a "downcoded" service code or modifier, the final rules now require that the plan or issuer provide the following information[9] with its initial payment or notice of denial of payment:

- A statement that the service code or modifier was downcoded and an explanation of the reason for downcoding; and

- The amount that would have been the QPA absent downcoding.

The Departments continue to consider comments on whether further additional disclosures related to the QPA calculation methodology should be required with an initial payment or notice of denial of payment, or upon request.[10]

Troutman Pepper will continue to monitor the No Surprises Act and provide updates when more guidelines are released.

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[1] We reported about the interim final rules in July and October 2021.

[2] 86 FR 55980 (October 7, 2021) (2021 Interim Final Rule Part II).

[3] *See* https://www.cms.gov/nosurprises/policies-and-resources/overview-of-rules-fact-sheets.

[4] Requirements Related to Surprise Billing: Final Rules, at 38.

[5] The final rules define credible information as information that upon critical analysis is worthy of belief and is trustworthy. *See* 26 CFR 54.9816-8T(a)(2)(v), 29 CFR 2590.716-8(a)(2)(v), and 45 CFR 149.510(a)(2)(v).

[6] Requirements Related to Surprise Billing: Final Rules, at 30.

[7] *Id.* at 29.

[8] *Id.* at 32.

[9] Requirements Related to Surprise Billing: Final Rules, at 32.

[10] The interim final rules note that the Departments are responsible for monitoring the accuracy of plans' and issuers' QPA calculation methodologies by requiring audits of plans' and issuers' QPA calculation methodologies. The Departments have committed to conducting audits.

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