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Compliance Today - November 2021
Compliance requirements for providers under surprise billing regulations: Part 1

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Editor's note: At press time for the November issue of Compliance Today, *the federal agencies issued Part 2 of the surprise billing regulations. This article outlines compliance obligations for healthcare providers under Part 1 of the regulations and references that Part 2 of the regulations are expected later this year.*

On July 13, the Departments of Health & Human Services (HHS), Labor, and the Treasury (the departments), along with the Office of Personnel Management, published an interim final rule with comment period (IFC) implementing portions of the federal ban on surprise medical bills enacted by Congress in December 2020.[1] The No Surprises Act (the act), part of the Consolidated Appropriations Act, 2021, included a ban on "balance billing," also referred to as "surprise medical bills," when a payer does not cover the entire cost of a patient's treatment by a nonparticipating (i.e., out-of-network, or OON) provider, and the patient receives a "surprise" bill to make up the difference.[2]

The departments are issuing regulations in phases to implement the act and refer to the IFC as "Part I" of requirements related to surprise billing. The IFC codifies a number of new compliance obligations, including requirements that will be applicable to healthcare providers as of January 1, 2022.[3] Although the departments issued the regulations as an interim final rule, and the effective date of the regulations is September 13, 2021, the departments are soliciting feedback from the public on the new requirements. Comments were due September 7, 2021.

Meanwhile, the HHS has published sample documents and instructions[4] to assist providers and facilities with meeting new disclosure obligations. Providers and facilities should review the IFC and accompanying guidance to prepare for meeting the new requirements by January 1, 2022.

Below is an outline of key compliance rules in the IFC applicable to providers and facilities.

Ban on balance billing and cost-sharing limitations

The IFC codifies in regulations a ban on balance billing at 45 C.F.R. § 149.410–420. The ban applies to emergency services, nonemergency services furnished by an OON provider at an in-network healthcare facility, and OON air ambulance services. The IFC also places limits on cost-sharing amounts that providers and facilities may charge for such services.

In general, the IFC requires OON providers or facilities furnishing emergency care and OON providers furnishing

certain nonemergency services at in-network facilities to charge patients no more than the amount that would apply for in-network care. Providers and facilities must calculate cost-sharing amounts based on:[5]

1. An amount determined by an all-payer model agreement in place in a given state (if applicable);
2. An amount determined under state law (if no all-payer model agreement is in place); or
3. The lesser amount of either the billed charge or the qualifying payment amount, which is generally the payer's median contracted rate (if no applicable state law).

The IFC requires OON air ambulance providers to calculate cost-sharing amounts based on the lesser of the billed charge or the payer's qualifying payment amount and the cost-sharing requirement that would apply if the services were rendered by an in-network provider.[6]