No Surprises Act

Reimbursment Methodology & Dispute Processes

Who We Are

- Experienced Team of Revenue Cycle Professionals
- Committed to Helping Healthcare Organizations Thrive
- Passionate About Solving Even The Most Difficult of Revenue Cycle Challenges!

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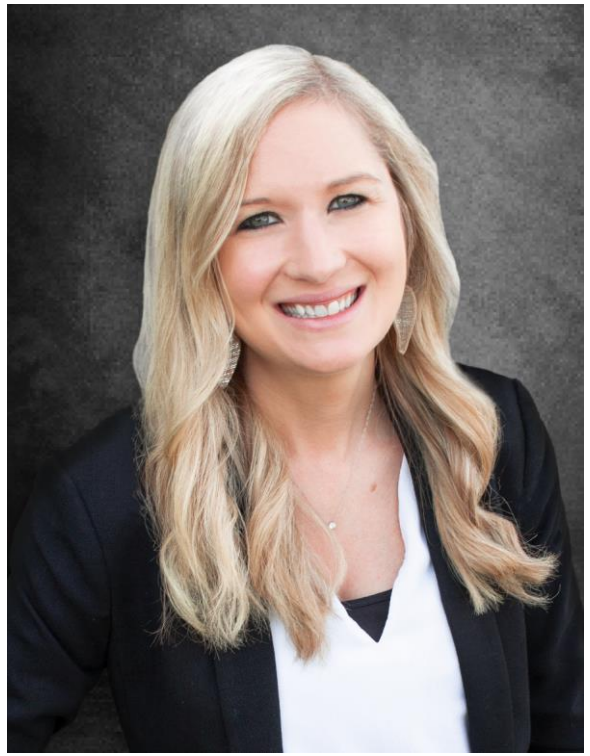
Introductions



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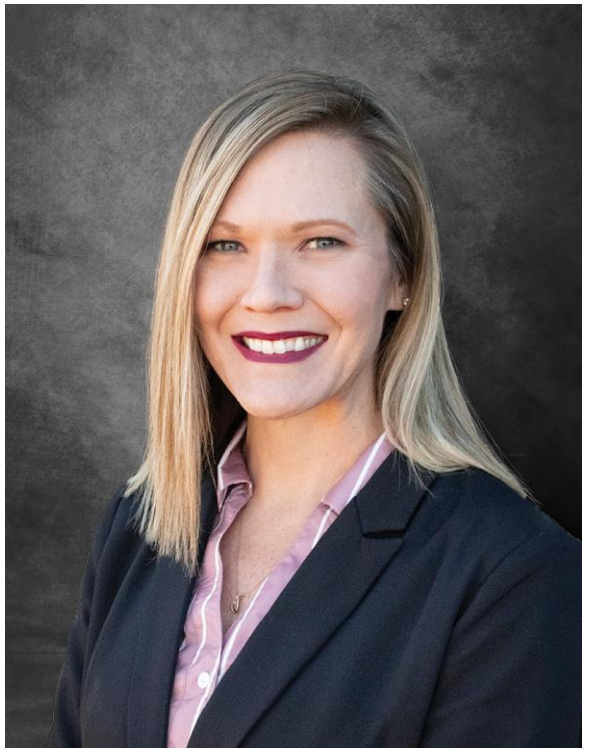

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Acronyms

- DOS=Date of Service
- GFE=Good Faith Estimate
- HHS= Department of Health and Human Services
- IDR=Independent Dispute Resolution
- IFR=Interim Final Rule
- NSA=No Surprises Act
- OON=Out-of-Network
- QPA=Qualifying Payment Amount
- TOS=Time of Service
- TPA=Third Party Administrator
- SDR=Selected Dispute Resolution

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Disclaimer

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Agenda

- Reimbursment Methodology
- Independent Dispute Resolution
- Selected Dispute Resolution
- Questions

Reimbursment Methodology

When Will an OON Provider/Facility Receive an OON Rate?

Balance Billing Protections Will ALWAYS Apply and receive OON Rate:

- Emergency services provided by ANY OON provider/facility, includes:
  - Pre-stabilization services
  - Post stabilization services (unless conditions are met to provider notice and consent)
  - Ancillary services defined in the IFR:
    - Anesthesiology, Pathology, Radiology, Laboratory, Neonatology, Assistant Surgeons, Hospitalists, Intensivists
    - Ancillary services provided by an OON provider when there is **NO** in-network provider who can furnish such a service at the in-network facility
  - Services due to unforeseen, urgent medical needs (even if Notice and Consent is received)
  - OON Air Ambulance

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When Will an OON Provider/Facility Receive an OON Rate?

Balance Billing Protections will Apply and receive OON Rate, UNLESS Notice & Consent Is Obtained:

- Post-stabilization services
  - Specific provider documentation required
    - Patient can travel using nonmedical or nonemergency medical transportation to a PPO facility within a reasonable distance and is documented in medical record
      - Only applied in limited circumstances
- Non-Emergent services provided by OON provider at an in-network facility

Balance Billing Protections will NEVER Apply:

- Non-emergent services provided by:
  - OON provider at OON facility
  - OON facility
- Patients are subject to their OON insurance benefits/patient responsibility and have no protections under the NSA.

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Insurance Companies Responsibilities

- Must pay provider/facility an OON rate
- Must ensure the patient responsiblity does not exceed the in-network rate

Provider/Facility Payment Vs. Patient Responsibility Calculation

"Recognized Amount"

"**Recognized Amount":** The amount used to determine the patient's responsibility

Determined by the following hierarchy:

- An applicable All-Payer Model Agreement;
- If not applicable, then an amount determined by state law;
- If not applicable, then the lesser of the amount billed by the facility/provider or the qualifying payment amount (QPA)

"OON Rate"

"OON Rate": The total payment made to the OON facility/provider

Determined by the following hierarchy:

- An All-Payer Model Agreement;
- If not applicable, then an amount determined by a specified state law;
- If not applicable, then the plan and facility/provider agreed upon amount;
- If not applicable, then the parties enter into dispute (IDR) process

What Hierarchy Applies to Nebraska Hospitals & Providers?

"OON Rate"

1. ~~All-Payer Model Agreement~~
2. **State Law:**
   - CAHs: Not Applicable
   - PPS: Emergency Services
   - Providers: Emergency Services
3. **Federal Law: Plan and facility/provider agreed upon amount or IDR Process**
   - CAHs: All OON situations
   - PPS: Post-Stabilization
   - Providers: Post-Stabilization & Non-Emergent services performed in in-network facility

"Recognized Amount"

1. ~~All-Payer Model Agreement~~
2. **State Law:**
   - CAHs: Not Applicable
   - PPS: Emergency Services
   - Providers: Emergency Services
3. **Federal Law: Lower of Qualifying payment amount (QPA) or billed charges:**
   - CAHs: All OON situations
   - PPS: Post-Stabilization
   - Providers: Post-Stabilization & Non-Emergent & Non-Emergent services performed in in-network facility

What is the Qualifying Payment Amount (QPA)

- Definition:
  - "**Median of the contracted rates** recognized by the plan or issuer on January 31, 2019, for the **same or similar item** or service that is provided by a provider in the **same or similar specialty** and provided in a **geographic region** in which the item or service is furnished, increased for inflation. The median contracted rate is determined with respect to all group health plans of the plan sponsor or all group or individual health insurance coverage offered by the health insurance issuer that are offered in the **same insurance market**, consistent with the methodology established by the Departments."

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QPA “Median Contract Rate”

- Contract rates are ordered from least to greatest, then the median is selected
  - The contract rates are made up of plans/coverage offered, within the same insurance market, for the same/similar item/service, that is provided by a provider in the same/similar specialty or facility, in the same/similar geographic region
- Each *unique* rate in a group/facility contract is counted as a single contracted rate contracted rate constitutes a single contracted rate:
- A plan is considered to have sufficient information to calculate the median of contracted rates if it has at least three contracted rates on January 31st, 2019
  - If plan does not have sufficient information to calculate the median contracted rate, then an eligible database must be used

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QPA “Same or Similar”

“Same or Similar Service”: An item/service billed under the same service code, or a comparable code under a different procedural code system (HCPCS vs. CPT)

- If plan’s contracted rates vary based on modifier, the plan must calculate a separate median contracted rate for each code-modifier combination
- New code calculated on related code

“Same or Similar Specialty”: The specialty of a provider, as identified by the plan

- Plans only need to calculate median contracted rates separately by provider specialty when the plan varies its contracted rates based on provider specialty

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QPA Additional Definitions

“Geographic Region””: The IFR established geographic regions based on whether care was provided in urban or rural areas

- One region for each metropolitan statistical area (MSA) in a state and one region consisting of all other portions of the state

“Insurance Market”:

- Fully insured plans grouped with other fully insured plans
- Self-Insured plans grouped with plans from that sponsor or other plans utilizing that TPA
- Medicare Advantage and Medicaid Managed Care Organizations are not included

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Why Are There Two Different Methodologies?

Two Issues:

- Protect the patient from OON “surprise” bills
  - Payors cannot impose a higher patient responsibility than what would have been imposed in-network, so the “Recognized Amount” is based on the “in-network” rate
  - Protections to the patient, or the “Recognized Amount” cannot be disputed
- Still account for facility/provider payment when OON
  - These rates are open for negotiation and provider is protected by the dispute (IDR) process

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Implications of the Two Different Methodology?

If the “OON rate” exceeds the “recognized amount”, a payor must pay the difference

- Example:
  - A patient receives emergency services at an OON facility and has a $1,500 deductible (not yet met).
  - Payor determines the “Recognized Amount” as $1,000.
  - Payor and provider/facility negotiate “OON rate” as $1,500
  - The “Recognized Amount” cannot be disputed, and so patient owes $1,000
  - Plan must pay the $500 additional that was negotiated above the “Recognized Amount”

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Why Isn't The QPA the "OON Rate"?

- The "OON Rate" isn't really a rate….
- Laws impose a minimum OON payment requirement on payors by either **directly** specifying a "benchmark" payment or **indirectly** by creating an arbitration process
  - The NSA uses the indirect method, the arbitration process (IDR)

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What Will Payors Pay Providers/Facilities?

- Most likely payors will base their payment off the QPA because:
  - The arbitration process (IDR) will favor the offer closest to QPA, unless there is very credible evidence otherwise

What Information About QPA Does The Payor Have to Share?

Disclosures from Insurance Company to Facility/Provider:

- Required with Initial Payment or Denial:
  - The QPA for each item or service
  - Statement certifying QPA applies for purposes of recognized amount and each QPA is in compliance w/ the IFR
  - Statement about open negotiation and IDR process
  - Contact information to initiate negotiation
- Upon Request:
  - Information about whether the QPA includes contracted rates that were NOT set on a fee-for-service basis
  - Whether QPA was determined using underlying fee schedule rates or a derived amount
  - If applicable:
    - Related code used to determine new code QPA
    - Database used to determine QPA
    - Plan's exclusions from QPA calculation, such as (incentive payments, retrospective payments, or payment adjustments)

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Problems With QPA Calculation?

- Its COMPLEX, with a lot of room interpretation
- QPA is meant to represent median in-network rate, but method to calculate could result in lower amounts than the median:
  - Small and large contracts weighted equally
  - Bonuses/incentive based/non fee for service payments are not considered
  - Plans actions, such as down-coding & denials can skew QPA
- More difficult for physicians to receive fair payment for OON services and successfully negotiate fair contracted rates
- Ultimately reducing in-network rates for facilities and providers
- IFR states “anchoring” OON rates will help reduce prices that “may have been inflated due to the practice of surprise billing”

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Nebraska State Law

Who Does State Law Apply To?

- State law payment and dispute methodology will apply ONLY to :
  - Emergency services (narrow definition of “emergency”)
  - General Acute Hospitals, Satellite ERs, ASCs, and providers (CAHs excluded)
  - Fully insured and self-insured plans (not preempted by federal law)
- Narrower definition of “emergency” than in the NSA

What is the Law?

- Protect patients from being billed over in-network allowable for emergency services
  - Payors must process claims as such, and providers must accept the payment

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Nebraska Payment & Dispute

Payment For OON Services:

- Considered reasonable if based on the higher of:
  a) The contracted rate under any then-existing in-network contractual relationship between the insurer and the out-of-network health care provider for the same or similar services
  b) 175% of the payment rate for Medicare services received from CMS for the same or similar services in the same geographic area.

Dispute Resolution:

- Parties have 30 days, from date notification to the plan, to negotiate a settlement
- If a settlement cannot be reached, engage in mediation (cost is split)
- Plan can negotiate a payment amount which differs from the “reasonable payment” in the law.

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Key Takeaways

Federal Law:

- "OON Rate" is the payment made to the provider/facility
  - Indirectly sets a minimum OON payment through arbitration (IDR process)
  - Payors initial payment will most likely be based on QPA, but could pay above or below QPA, as there is no "benchmark" rate
- "Recognized Amount" is the patient responsibility amount
  - Directly sets a patient responsibility amount based on the lesser of QPA or billed charges
  - Provider/facility **cannot** dispute this amount in the IDR process
- Implications of Two Different Methodologies:
  - Reduces disputes
  - If "OON Rate" was negotiated higher than QPA, payor would have to pay the difference between the "Recognized Amount" and "OON Rate", even when the patient has met their deductible

State Law:

- Applicable only to:
  - Emergency services (narrow definition of "emergency")
  - General Acute Hospitals, Satellite ERs, ASCs, and providers (CAHs excluded)
  - Fully insured and self-insured plans (not preempted by federal law)
- Payment and patient responsibility are set by a benchmark rate

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Independent Dispute Resolution (IDR)

What is IDR and why?

- What:
  - Federal Independent Dispute Resolution
- Who:
  - Providers/Facilities and Payors
  - **NOT patients vs provider or plan**
- When:
  - Dispute only relates to payment amount to the provider from payors
  - Cannot affect patient responsibility
- Why:
  - Establish process for disputes
  - Create efficiencies
  - Report data

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Step #1-Initial Payment/Notice of Denial

- Plan must send payment/denial within 30 days of clean claim receipt.
- Initial payment should be the amount the plan intends to pay in full
- “Notice of Denial of Payment”
- Must have disclosures referenced in prior slide
  - The qualifying payment amount applies for purposes of the recognized amount (or, in the case of air ambulance services, for calculating the participant's, beneficiary's, or enrollee's cost sharing); and
  - Each qualifying payment amount shared with the provider or facility was determined in compliance with this section;
  - A statement that if the provider or facility, as applicable, wishes to initiate a 30-day open negotiation period for purposes of determining the amount of total payment, the provider or facility may contact the appropriate person or office to initiate open negotiation, and that if the 30-day negotiation period does not result in a determination, generally, the provider or facility may initiate the independent dispute resolution process within 4 days after the end of the open negotiation period; and
  - Contact information, including a telephone number and email address, for the appropriate person or office to initiate open negotiations for purposes of determining an amount of payment (including cost sharing) for such item or service.
- Additional information can be requested

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Step #2-Open Negotiation

- Provider to send written notice to the plan within 30 **business** days of payment/denial
  - Standard notice is available for use Open Negotiation Notice (dol.gov)
- Open negotiation (30 **business** days) begins on day notice is sent
  - Can be via email if:
    - Electronic method is readily available
    - Provide in paper form free of charge if requested
    - Have to make efforts to ensure they received it (use read receipts!)
- Exhaust period before initiating IDR

Step #3-IDR Initiation

- Either party may Initiate IDR process
  - Beginning one day after Open Negotiation ends
  - Not more than 4 days after Open negotiation ends
- Submit IDR notice to other party and initiate on Federal IDR portal on the same day
- Utilize standard “Notice of IDR Initiation” form

  Notice of IDR Initiation (dol.gov)

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Step #3 – Selection of Certified IDR Entity

- Parties jointly select an IDR entity within 3 business days of initiation
  - Initiating party will state their preference
  - Non-initiating party can agree or object (can also use this time to state IDR does not apply)
  - Initiating party then notifies if agreed or failed to agree
- If agree, they file a Notice of Certified Entity
  - APPENDIX 1: Federal Independent Dispute Resolution (IDR) Process: Selection of Certified IDR Entity Data Elements (dol.gov)
- Failed to agree, Departments will randomly select a Certified IDR Entity
- 6 business days after Notice of Initiation - Certified IDR Entity will be assigned
- Each Pay Administrative Fee ($50.00)

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Step #4-IDR Submission Material

- Submission of Offers
  - Each party submits an offer for payment & additional information
  - 10 business days of the selection of the IDR entity
  - Pay Entity Fee at same time ($200-$500)
  - Appendix 3: Federal Independent Dispute Resolution (IDR) Process Notice of Offer (dol.gov)
- Information includes:
  - Offer as a dollar amount and % of QPA
  - **Providers/Facilities**-
    - size of practices/facilities
    - Number of employees (< 20, 20-50, 51-100, 101-500, >500)
    - Practice specialty or type
  - **Plans**-Coverage and geographic regions
  - Credible and relevant information
    - CANNOT include any reference to usual and customary charges, billed amounts and/or public payor rates

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Authority to Continue Negotiations

- Just because you are “in” does not mean you cannot still reach a deal
- If reach an agreed upon amount, that amount will be treated as the OON Rate and will be treated as having resolved the dispute
- Initiating Party must notify Departments through the portal within 3 business days of reaching an agreement
- Plan or issuer must pay directly to provider or facility the total balance amount of the agreed upon OON within 30 business days
- Each party pays ½ of the Certified Entity Fee
- NO circumstance that allows for either party to seek additional payment from participant
- Appendix 2: Federal Independent Dispute Resolution (IDR) Process: Notice of Agreement Data Elements (dol.gov)

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Step #5-IDR Determination

- IDR entity **must** select offer closest to QPA, unless information clearly demonstrates that is QPA is materially different from appropriate out of network rate

Step #5-IDR Determination – Credible Information used to Rebut the QPA Presumption

- **Factors that could consider:**
  - Market Share of Provider/Plan
  - Previous Provider/Payor Contract Negotiations
    - IDR considers good faith efforts, or lack thereof, of previous contract negotiations within the previous 4 years
    - Reviews what contracted rate might have been if negotiations were successful
  - Quality Measures
  - Teaching Status, Case Mix, Scope of Service
    - Must be critical to delivery of care
    - Example: Level I trauma center was required to perform services
  - Level of Provider Training/Experience (not likely)
  - Patient Acuity or Complexity (not likely)
    - Service codes and modifiers reflecting patient acuity factored into QPA

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Example #1

- Nonparticipating provider submits statement that they have tried to enter into network agreements with plan/issuer.
  - Fails to provide written documentation in support
- Issuer provides offer at QPA amount

  - **Conclusion**: Provider did not offer “credible information”

Example #2

- Nonparticipating provider submits credible information relating to the provider's level of training, experience, and quality and outcome measurements from 2019.
- The provider also submits credible information that clearly demonstrates that the provider's level of training and expertise was necessary for providing the service that is the subject of the payment determination to the particular patient.
- Provider submits credible information that clearly demonstrates that the qualifying payment amount generally presumes the service would be delivered by a provider with a lower level of training, experience, and quality and outcome measurements.
- **Conclusion**: Provider’s offer is accepted

Example #3

- Nonparticipating provider submits credible information to the certified IDR entity relating to the acuity of the patient that received the service, and the complexity of furnishing the service to the patient, by providing details of the service at issue and the training required to furnish the complex service.
- Evidence submitted by the provider does not clearly demonstrate that the qualifying payment amount fails to encompass the acuity and complexity of the service.
- Issuer submits the qualifying payment amount as its offer, along with credible information that demonstrates how the qualifying payment amount was calculated for this particular service, taking into consideration the acuity of the patient and the complexity of the service.
- **Conclusion:** The information submitted by the provider to the certified IDR entity is credible with respect to the acuity of the patient and complexity of the service. However, in this example, the provider has not clearly demonstrated that the qualifying payment amount is materially different from the appropriate out-of-network rate, based on the acuity of the patient and the complexity of the service that is the subject of the payment determination. Accordingly, the certified IDR entity must select the offer closest to the qualifying payment amount, which is the issuer's offer.

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Example #4

- Issuer submits credible information demonstrating that the patent for the item that is the subject of the payment determination has expired, including written documentation that demonstrates how much the cost of the item was at the time the provider rendered service and how the qualifying payment amount exceeds that cost.
- The issuer submits an offer that is lower than the qualifying payment amount and commensurate with the cost of the item at the time service was rendered. The nonparticipating
- Provider submits the qualifying payment amount as its offer and also submits credible information demonstrating the provider's level of training, experience, and quality and outcome measurements from 2019
- Provider does not explain how this additional information is relevant to the cost of the item.
- **Conclusion**: Only the issuer provided credible information that was relevant to the service that is the subject of the payment determination. Moreover, the issuer has clearly demonstrated that the qualifying payment amount does not adequately take into account the complexity of the item furnished - in this case that the item is no longer patent protected. While the provider submitted credible information, the provider failed to show how the information was relevant to the item that is the subject of the payment determination. Accordingly, the certified IDR entity must select the offer that best represents the value of the item, which is the issuer's offer in this example

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Step #5-IDR Determination Cont.

- **Factors IDR Cannot Consider**:
  - Usual and customary rates
  - Billed charges
  - Payment rates by public payors (Medicare, Medicaid, Tricare, etc.)

Step #5-IDR Determination Final

- Written IDR determination provided within 30 days of IDR entity selection date
  - Appendix 6: Certified IDR Entity's Written Decision of Payment Determination Data Elements (dol.gov)
- Prevailing Party receives Entity Fee back
  - Non-prevailing pays
- Non-prevailing party has 30 calendar days to make payment directly to prevailing party
  - Batched Claims:
    - Party with fewest determinations in its favor is responsible for paying the IDRE fee.
- No "appeals" process unless believe fraud or evidence of intentional misrepresentation

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Step #6-IDR 90 Day Period & Fees

- Cooling Off Period:
  - Provider cannot bring another claim for same item/service with that plan to IDR for 90 calendar days.
  - Once period is up, the party may submit batched claims from that 90-day period to IDR.
- Fees:
  - Administrative Fee: $50-Paid by each party

    AND
  - IDR Entity Fee: Estimate-$400-Paid by non-prevailing party

IDR Timeline Overview

Independent Dispute Resolution Action	Timeline
Initiate 30-business-day open negotiation period	30 business days, starting on the day of initial payment or notice of denial of payment
Initiate independent dispute resolution process following failed open negotiation	4 business days, starting the business day after the open negotiation period ends
Mutual agreement on certified independent dispute resolution entity selection	3 business days after the independent dispute resolution initiation date
Departments select certified independent dispute resolution entity in the case of no conflict-free selection by parties	6 business days after the independent dispute resolution initiation date
Submit payment offers and additional information to certified independent dispute resolution entity	10 business days after the date of certified independent dispute resolution entity selection
Payment determination made	30 business days after the date of certified independent dispute resolution entity selection
Payment submitted to the applicable party	30 business days after the payment determination

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Key Takeaways

- Unlikely to be used often … we think
- IDR portal will somewhat ease process
- Closest to QPA will prevail unless creditable and significant information proving otherwise

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ACA External Review

What will the ACA Extended Review cover?

- No Surprises Act ensures ACA external review processes apply to Adverse Benefit Determinations, such as:
  - Whether item/services were covered under NSA protections
    - Was it an emergency service?
    - Was it OON provider at an in-network facility?
  - Whether an individual was in a condition to receive notice and consent
  - **Whether a claim was coded correctly**
  - Whether cost sharing was appropriately calculated

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What if patient wants to dispute an ABD?

- The NSA only protects individuals from surprise bills if the providers and plans agree that a given item/service is subject to the NSA
- So extended review to item/service that are not covered by the NSA under ACA
  - ACA's review covered only grandfathered plans
- NSA extends to both grandfathered and non-grandfathered plans

Selected Dispute Resolution

Selected Dispute Resolution (SDR) - What, Why, When, Who, and How?

- What:
  - Patient-Provider Dispute Resolution process
  - Even if the charges were not listed on the estimate
  - Can be subject if patient feels provider or facility not complying with GFE requirement

- Why:
  - Protect uninsured/self-pay patients from unexpected charges

- When:
  - Actual charges "*substantially in excess"* of expected charges listed in the Good Faith Estimate (GFE)
  - Substantially in Excess equals $400.00
  - 120 days after initial billed charges

Selected Dispute Resolution (SDR) - What, Why, When, Who, and How? *Continued*

- Who:
  - Uninsured/self-pay individual or their representative who:
    - 1 – received a GFE, AND
    - 2 – Received the items and services, AND
    - 3 – The actual charges substantially exceeded expected
    - Looking at individual provider and their services; individual facility and its charges

- How:
  - Patient or Representative submits a Notice of Initiation to the Secretary of HHS

Step #1: SDR – Initiation

- Patient or Authorized Rep
  - Provider or facility contained on GFE cannot do this for the patient
- Federal Portal or Paper
  - Form Specified by HHS
- Administrative Fee - $25.00
- Date of Initiation = Date of Receipt of the Notice by HHS

Step #2: SDR – Selection of SDR Entity

- Strict Conflict of Interest Requirements
- Round-Robin Selection
- All Certified SDR Entities are required to be able to operate in all states
- Once SDR Entity Selected Notice to the Patient and to the Provider/Facility:
  - Information regarding receipt of Notification
  - Item or service in dispute
  - Date of Initiation

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Step #2: SDR – Selection of SDR Entity *continued*

- Obligation of Provider and Facility
  - CANNOT move patient to collection
  - CANNOT threaten to move patient to collection
  - MUST cease ALL efforts to collect
  - MUST suspend the accrual of any late fees
  - MUST NOT threaten any retributive action

Step #4: SDR – Review by SDR Entity

- Eligibility for SDR Process
  - 10 days
  - Can provide patient 21 days to fix errors (availability of additional 14 day extension)
  - Payment by Patient does not exclude them from eligibility
- ALWAYS CAN SETTLE WITH THE PATIENT
  - Provider/Facility required to provide notice if settlement is reached
    - Within 3 days
  - Required to reduce settlement amount by the administrative fee paid by the patient

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Step #5: SDR – Provider/Facility Information Submission

- 10 days after Selection of SDR Entity
  - Copy of the GFE provided to the uninsured/self-pay
  - Copy of Billed Charges provided to the uninsured/self-pay
  - Documentation demonstrating the difference between the above
    - Medically necessary item/service
    - Could not have reasonably been anticipated by provider/facility

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Step #6: SDR – Determination

- 30 business days after Receipt of Information
- Presumed appropriate amount = GFE
  - UNLESS – credible information provided justifying difference
    - Credible information – information is credible if upon critical analysis the information is worthy of belief and consists of trustworthy information
  - Medically Necessary
  - Could not have been anticipated

Step #6: SDR – Determination *continued*

- Billed Charge equal to or less than Expected = Billed Charge
- Billed Charge greater than Expected Charge and no credible information = Expected Charge
- Billed Charge greater than Expected Charge and credible information then equals the **lesser of**:
  - Billed Charge; or
  - Median Payment Amount for same or similar service in the geographic area as reflected in independent database
    - Or if independent database is higher that the expected charge in the GFE, then the GFE amount

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Effect of SDR Determination

- Binding … unless its not
  - Evidence of misrepresentation or fraud, or
  - Provider/Facility provide financial assistance or agree to lesser amount, or
  - Patient agrees to pay the billed charges in full, or
  - Patient and Provider/Facility agree to a different amount

- HHS seeks comment on this approach and on judicial review opportunity

Assessment of Fees

- Non-prevailing Party will be assessed fees
  - **Provider/Facility** when SDR entity determines the total amount to be paid to be less than the totaled billed charges
    - Will result in reduction of amount payable
  - **Uninsured/Self-pay** when SDR entity determines the total amount to be paid to be equal to the total billed charges
    - Will result in no reduction to provider/facility
    - Uninsured/Self-pay individual will make payment directly to SDR Entity

- When settlement is reached fee will be assessed ½ the amount of the Administrative Fee

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State Patient-Provider Dispute Resolution Process

- Some states have own dispute resolution process (NE does not only for plan/provider disputes)
- Allowed to continue under state process IF it provides same or greater protections to the uninsured/self-pay individual
- HHS will make the determination of whether a state patient-provider dispute resolution process provides same or greater protections

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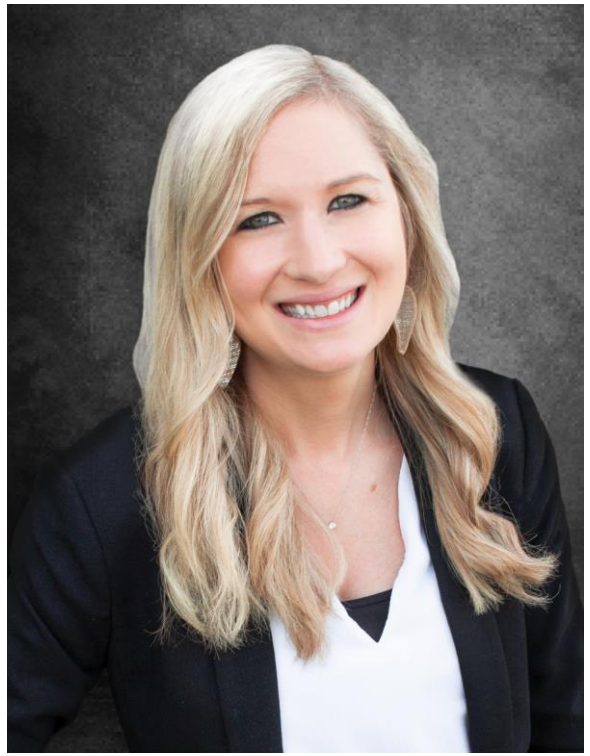
Contact Us



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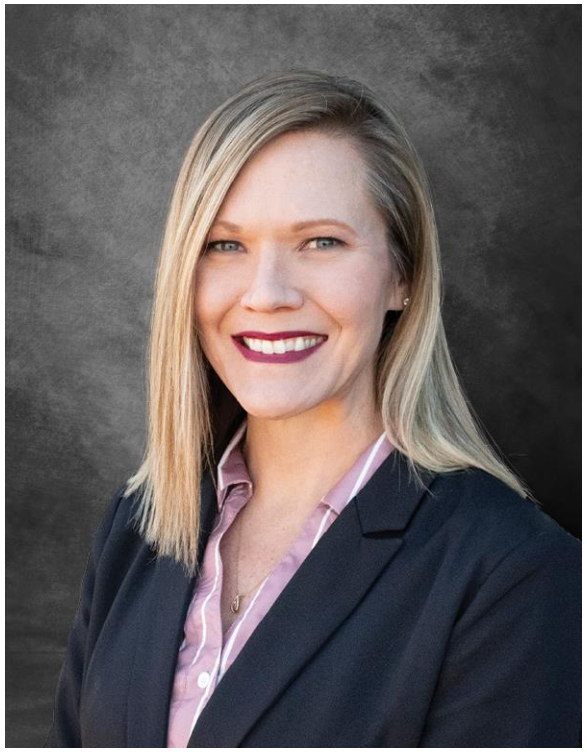

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Questions