





This decision tree provides a series of questions to help consumer advocates assess whether the No Surprises Act surprise billing protections apply in a particular situation. It can be used during virtual or in-person consultations and is intended to be used with the <u>Decision Tree</u>: <u>Notice and Consent</u>. For more information on these protections, see <u>No Surprises Act</u>: <u>Overview of Key Consumer Protections</u> and <u>The No Surprises Act's Prohibitions on Balancing Billing</u>.

This decision tree begins with a set of general screening questions. Depending on the type of item or service that is involved, there are three separate decision tree sections:

- 1. Emergency services,
- 2. Non-emergency services provided by a non-participating provider at a participating facility, and
- 3. Air ambulance services provided by a non-participating provider of air ambulance services.

When using this decision tree, please note:

- For plan years or policy years beginning on or after January 1, 2022, the No Surprises Act provides new protections against surprise billing for people who have certain types of health coverage. The law provides different protections for uninsured and self-pay patients. Protections for uninsured or self-pay individuals are not addressed in this document.
- While the No Surprises Act provides new federal protections for consumers, state laws also may have similar provisions for either insured individuals, uninsured individuals, or both. The No Surprises Act supplements state surprise billing laws; it does not take the place of state law. For example, the No Surprises Act applies in instances where there is no applicable state law or a state law does not apply to a specific circumstance that is covered under federal law.
- Consumer advocates should research the existence of any state laws that may be relevant to a client's situation, as state laws may have additional or stronger protections than the No Surprises Act. See the State Laws for more information. This decision tree assumes that no state laws apply.

Where can I go for help?

Contact the No Surprises Help Desk at 1-800-985-3059 or you can submit a complaint online at: https://www.cms.gov/medical-bill-rights/help/submit-a-complaint. For more information on contacting the No Surprises Help Desk, see No Surprises Help Desk, see No Surprises Act: How to Get Help and File a Complaint.

State Consumer Assistance Programs (CAPs) may also help with surprise billing questions. To see if your state has a CAP, please visit this <u>state listing</u>.



This document is intended to provide clarity to the public about requirements related to surprise billing. It does not have the force and effect of law.

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Revision Date: 9/2023

Documents Needed for a Consultation

When a consumer makes an appointment to discuss a surprise bill, ask them to bring the following documents if they have them available:

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☐ Health insurance card(s) if the consumer is insured.	
☐ Information on whether the consumer's plan is a self-insured plan (the consumer can call their employer's benefits office or the health insurance company to find out).	
☐ Information about any gaps in health coverage, especially if they overlap with the date(s) of service in dispute.	
☐ Medical bills.	
□ Explanation of Benefits statements.	
Other Helpful Information	
☐ Consent forms the consumer or their representative may have signed waiving their balance billing protections.	
☐ Good faith estimates received from health care providers, if any.	
☐ Correspondence the consumer or their authorized representative has had with their health care provider, facility, air ambulance service provider, insurance company, health plan, or state or federal agency concerning billing disputes. All correspondence should include dates if possible.	
☐ Notes from any phone calls with the health care provider, facility, air ambulance provider insurance company, health plan, or state or federal agency.	r,
☐ Records of any related medical bills the consumer has already paid, including co-pays, coinsurance, and deductibles.	
☐ Communications concerning late fees or collection attempts for medical bills.	
lacktriangle Medical records related to the item(s) or service(s), such as discharge summaries.	
☐ Documentation authorizing a representative to communicate on the consumer's behalf (if available, not required).	
☐ Information posted on the provider or facility's website outlining surprise billing protections, including state and federal agency contact information.	
☐ Summary plan description or certificate of coverage.	

START

1

For information on insurance coverage that is **not** subject to federal surprise billing protections, see No Surprises Act:

Overview of Key Consumer Protections.

STEP 1: Determine if the consumer is covered by a plan type subject to the No Surprises Act.

Is the consumer insured or enrolled in a health benefit plan through:

- an employer (including self-funded and fully insured plans);
- a plan purchased on or outside the federal or statebased Marketplaces;
- a non-federal governmental plan that is sponsored by a state or local government employer (for example, a health plan through a school district);
- · certain church plans;
- a Federal Employee Health Benefit (FEHB) health plan; or
- student health insurance plans offered by a college or university?

Yes

No

Federal surprise billing protections **do not apply**. However, uninsured and self-pay patients may have protection against bills that are substantially higher than a good faith estimate provided to them. See the <u>Decision Tree: Requirements for Good Faith Estimates for Uninsured (or Self-Pay) Individuals.</u>

END

2

See page 10 for tips for reviewing Explanation of Benefits statements and medical bills. STEP 2: Determine if the claim(s) and bill(s) were

Consumers and consumer advocates should carefully review all Explanation of Benefits statements and medical bills. The Explanation of Benefits statements and the bill should match. Contact the health plan or insurance company and the health care provider, facility, or provider of air ambulance services if they do not match.

properly processed.

3

protections are different from No Surprises Act surprise billing protections. Continuity of care protections might apply instead of or in addition to surprise billing protections. After exploring whether continuity of care protections apply, go to Step 4 to continue evaluating whether surprise billing protections might also apply.

STEP 3: Determine if continuity of care protections apply.

Is the consumer receiving health care benefits from a provider or facility that has lost their in-network status with the health plan?

Yes

The consumer might be allowed to have up to 90 days of continued health care benefits with that provider or facility if they are a continuing care patient with respect to that provider or facility.

STEP 4: Determine the type of item or service received.

What type of item or service did the consumer receive? Note that the consumer may have received items and services in more than one category. Consult all relevant sections.

If enrolled only in Medicare (including a **Medicare Advantage** plan), Medicaid (including a Medicaid managed care plan), or TRICARE, or receiving services only through the **Indian Health Service or** the Veterans Health **Administration:** No Surprises Act protections do not apply but other surprise billing protections may apply. Refer the consumer to their respective program(s) for further assistance.

For more information about continuity of care protections and similar transitional care protections under the FEHB program, see No Surprises Act: Overview of Key Consumer Protections.

If the consumer received emergency items and services, go to Section A.

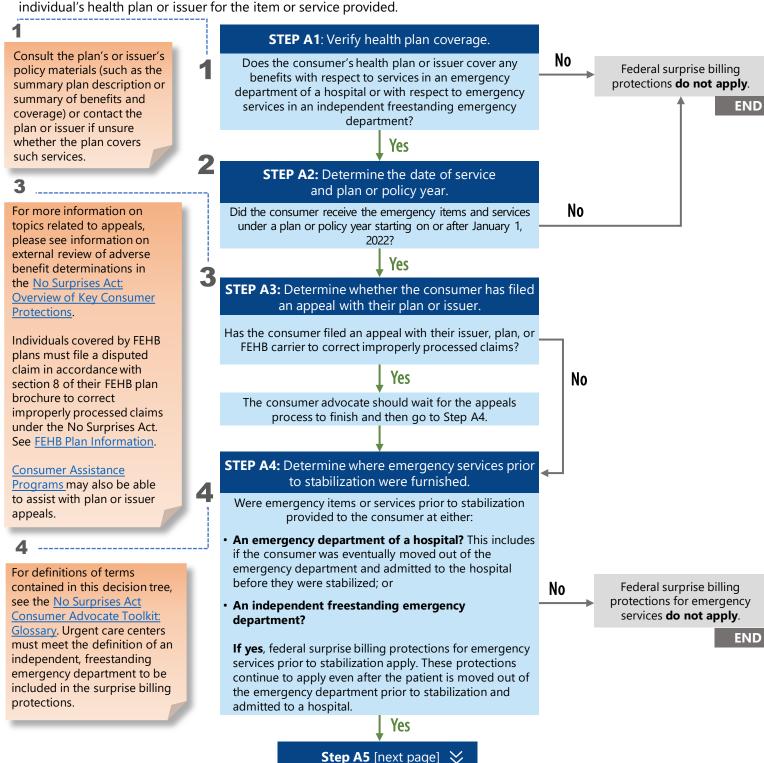
If the consumer received non-emergency items and services, go to Section B.

If the consumer received air ambulance services, go to Section C.

No

Section A: Emergency Items and Services

Under the No Surprises Act, **out-of-network providers** and **out-of-network emergency facilities** must not send surprise medical bills to consumers who receive an **emergency service** for an **emergency medical condition** at an **emergency facility**. In addition, when the No Surprises Act applies, the consumer's cost-sharing requirement for out-of-network items or services cannot be greater than the requirement that would apply if the items or services were provided in-network. For example, a consumer's costs for the out-of-network service would be determined using in-network copay amounts or coinsurance percentages. Out-of-network means that a provider or facility doesn't have a contractual relationship with an individual's health plan or issuer for the item or service provided.



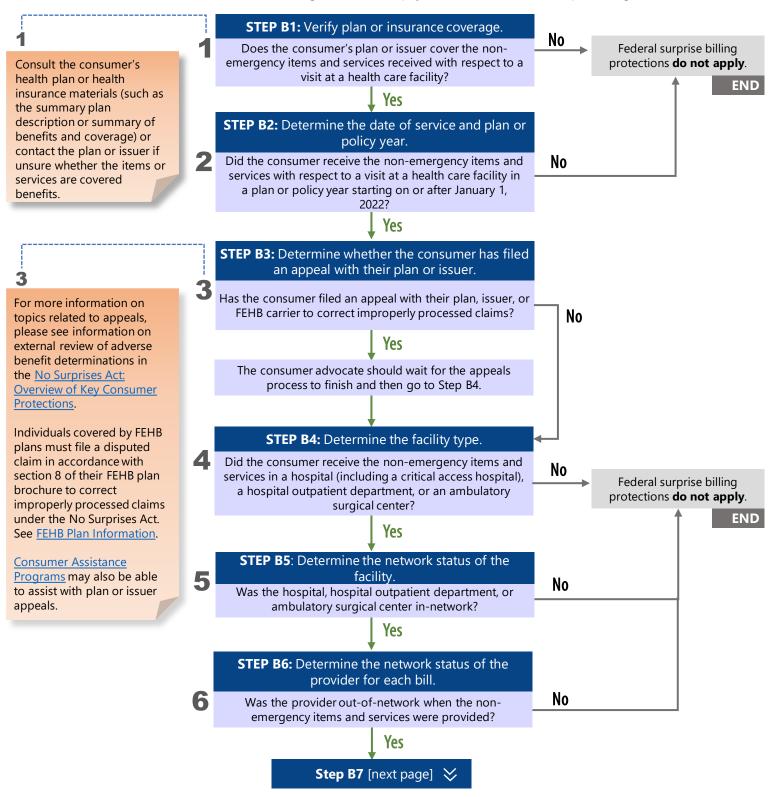
Section A: Emergency Items and Services

STEP A5: Determine if the facility or provider asked the consumer to waive billing protections for emergency services prior to stabilization. Did the facility or provider ask the consumer to provide No consent to waive their surprise billing protections for emergency services prior to stabilization and then bill more than permitted under the surprise billing protections? For more information, see the <u>Decision Tree: Notice</u> Yes and Consent or the CMS webpage for information The provisions of the No Surprises Act were violated. The on how signing a notice consumer may contact the facility or provider, or plan or and consent form may issuer, to request the bill be adjusted. The consumer increase your costs. should also contact the No Surprises Help Desk to report the violation. Notice and consent to waive surprise billing protections is **NEVER** allowed when providing emergency services before a patient is stabilized. **STEP A6:** Determine if the consumer received post-stabilization emergency services. After the consumer was stabilized, did the consumer No receive any items or services (related to the emergency services prior to stabilization) as part of outpatient observation or an inpatient or outpatient stay? The definition of emergency services under the No Surprises Act includes certain poststabilization services. Federal surprise billing protections for post-stabilization emergency services apply regardless of the department of the hospital in which such items or services were furnished. **STEP A7:** Determine if the consumer waived surprise The No Surprises Act surprise billing protections likely apply. billing protections for post-stabilization services. No If there is concern that these protections were violated, Was the bill for out-of-network post-stabilization services AND did the consumer provide consent to waive their contact the health care surprise billing protections? provider or health care facility and the health plan or issuer For more information, with general questions about consult the Decision Tree: Yes the bill and how cost sharing Notice and Consent. was calculated, and to ask if the If the provider or facility was permitted to seek notice and bill can be adjusted. You may consent to waive surprise billing protections, federal also contact the No Surprises surprise billing protections do not apply. However, before Help Desk to report a potential a consumer waives their surprise billing protections, the violation. provider or emergency facility must provide the consumer **END** with a good faith estimate for the post-stabilization services using the standard notice and consent document.

END

Section B: Non-Emergency Items and Services

Generally, under the No Surprises Act, **out-of-network providers** are prohibited from balance billing an individual who gets certain covered, non-emergency services that are **part of a visit to a participating health care facility**. When the No Surprises Act applies, the consumer's cost-sharing requirement for out-of-network items or services cannot be greater than the requirement that would apply if the items or services were provided in-network. For example, a consumer's costs for the out-of-network service would be determined using in-network copay amounts or coinsurance percentages.



Section B: Non-Emergency Items and Services

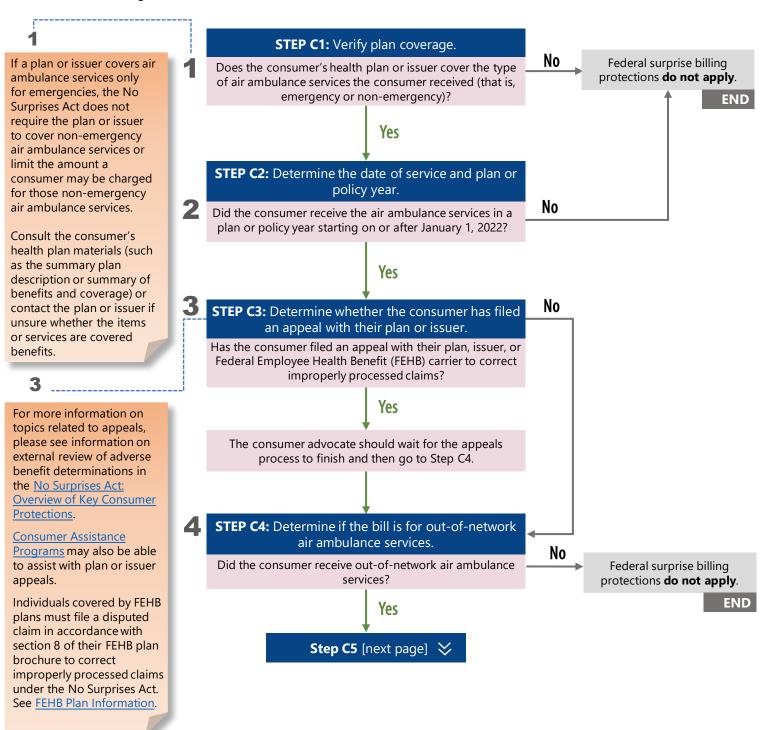
Yes 7 **STEP B7:** Determine whether ancillary services were Non-emergency ancillary provided. services provided by out-ofnetwork providers at Were the non-emergency items and services considered participating health care ancillary services? facilities are always subject The No Surprises Act surprise to surprise billing billing protections likely protections. **apply**. If there is concern that No these protections were For more information about violated, contact the health ancillary services, see care provider or health care **Frequently Asked Questions** facility and the health plan or For Providers About The No issuer with general questions Surprises Act. about the bill and how cost sharing was calculated, and **STEP B8:** Determine if consumer waived surprise to ask if the bill can be adjusted. You should billing protections. 8 contact the No Surprises No For more information, Did the consumer receive notice and provide consent to Help Desk to report a waive their surprise billing protections? potential violation. consult the **Decision Tree**: Notice and Consent or Also see the Helping the CMS webpage for Consumers Protect Their Rights Under the No information on how Surprises Act. signing a notice and Federal surprises billing protections do not apply in consent form may situations where notice and consent is permitted. **END** increase your costs. However, before a consumer waives their surprise billing protections, they must be provided a good faith estimate for the non-emergency services using the standard notice and consent document. **END**



Section C: Air Ambulance Services

Under the No Surprises Act, **out-of-network air ambulance providers** are prohibited from balance billing an individual who receives covered air ambulance services. When the No Surprises Act applies, the consumer's cost-sharing requirement for out-of-network items or services cannot be greater than the requirement that would apply if the items or services were provided in-network. For example, a consumer's costs for the out-of-network service would be determined using in-network copay amounts or coinsurance percentages.

Note that ground ambulance services are not addressed under federal law. There may be other state or municipal laws limiting what emergency medical services providers can charge consumers. See if your state has a <u>Consumer Assistance Program</u> for more information on ground ambulance services.



Section C: Air Ambulance Services

For more information, consult the <u>Decision Tree</u>: <u>Notice and Consent</u> or the <u>CMS webpage</u> for information on how signing a notice and consent form may increase your costs.

STEP C5: Determine if the consumer waived surprise billing protections.

Did the consumer receive notice and provide consent to waive their surprise billing protections?

Yes

The provisions of the No Surprises Act were violated.

Air ambulance service providers may never seek an individual's consent to waive No Surprises Act protections for out-of-network air ambulance services.

The consumer may contact the air ambulance provider or plan or issuer to request the bill be adjusted. Contact the No Surprises Help Desk to report the violation.

END

No

The No Surprises Act surprise billing protections likely apply. If there is concern that these protections were violated, contact the air ambulance provider and the health plan or issuer with general questions about the bill and how cost sharing was calculated, and to ask if the bill can be adjusted. You should also contact the No Surprises Help Desk to report a potential violation.

END



Tips for Reviewing Explanation of Benefits Statements and Medical Bills

- Providers, facilities, and providers of air ambulance services may submit a claim directly to the consumer's health plan or insurance, even if they are not an innetwork provider.
- If a consumer has multiple sources of coverage, the providers, facilities, and providers of air ambulance services should submit claims to all of the sources.
- The health plan or insurance company must process claims promptly and alert the provider, facility, or provider of air ambulance services and consumer of the amount of cost sharing the consumer is liable to pay for the service.
- The cost-sharing amount should appear on the insurance statement, also called the Explanation of Benefits.
- The Explanation of Benefits must include a standard notice indicating that No Surprises Act protections apply for items and services subject to the No Surprises Act.
- Before paying any bills, the consumer should compare the bill to the Explanation of Benefits to make sure they match.
- If they do not match, call both the health plan or insurance company and the provider, facility, or provider of air ambulance services to find out why.

