

Decision Tree: No Surprises Act Federal Surprise Billing Protections



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 [Decision Tree: Notice and Consent](#). For more information on these protections, see [No Surprises Act: Overview of Key Consumer Protections](#) and [The No Surprises Act's Prohibitions on Balancing Billing](#).

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 Surprise Billing Laws and the No Surprises Act](#) and [Questions and Answers on the No Surprises Act and 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 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 [state listing](#).



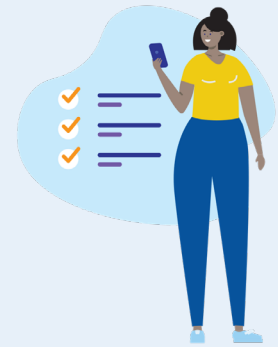
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Documents Needed for a Consultation

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

Key Documents

- 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.

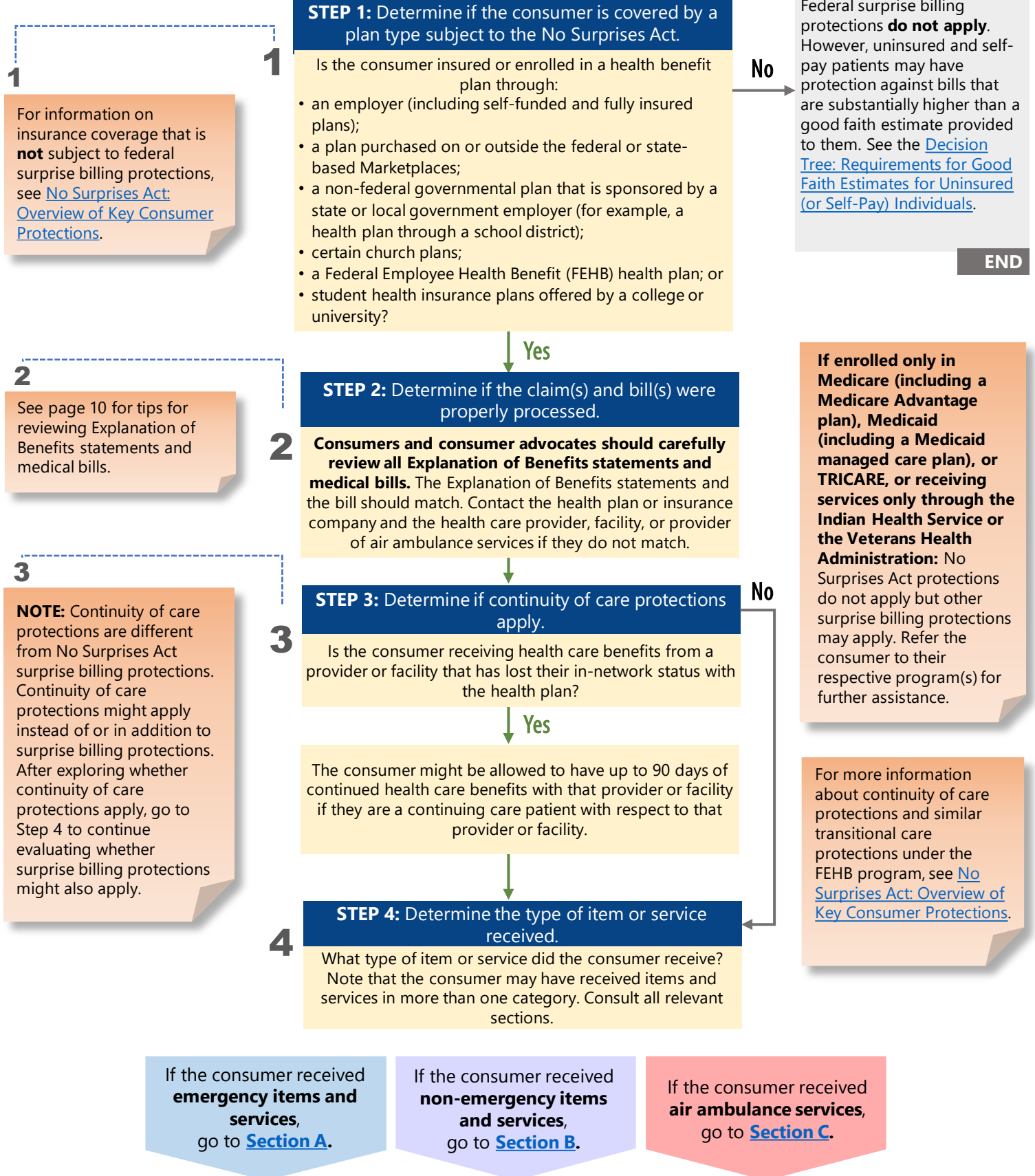


Other Helpful Information

- 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.
- 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.
- 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.

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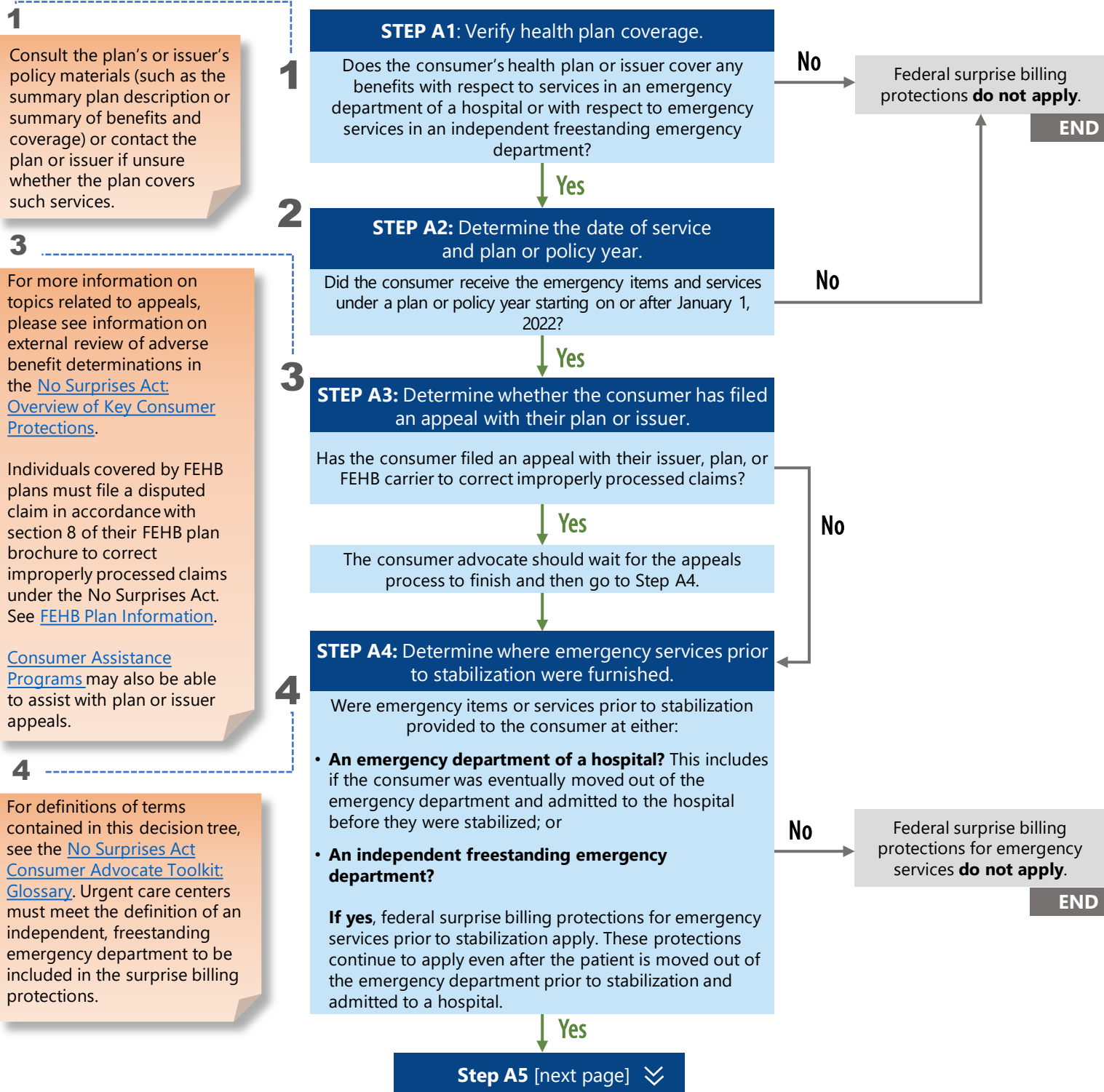
START



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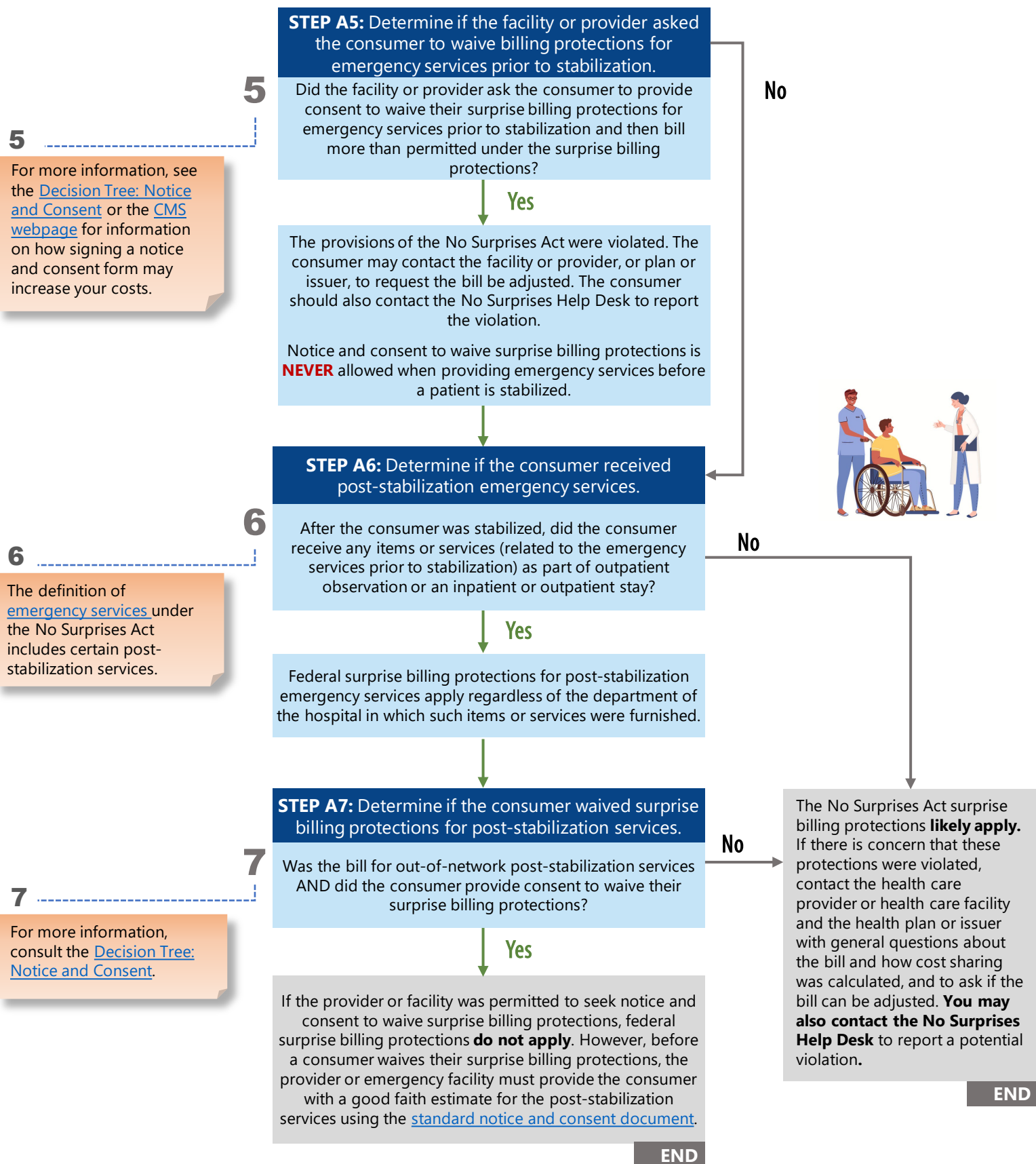
Section A: Emergency Items and Services

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.



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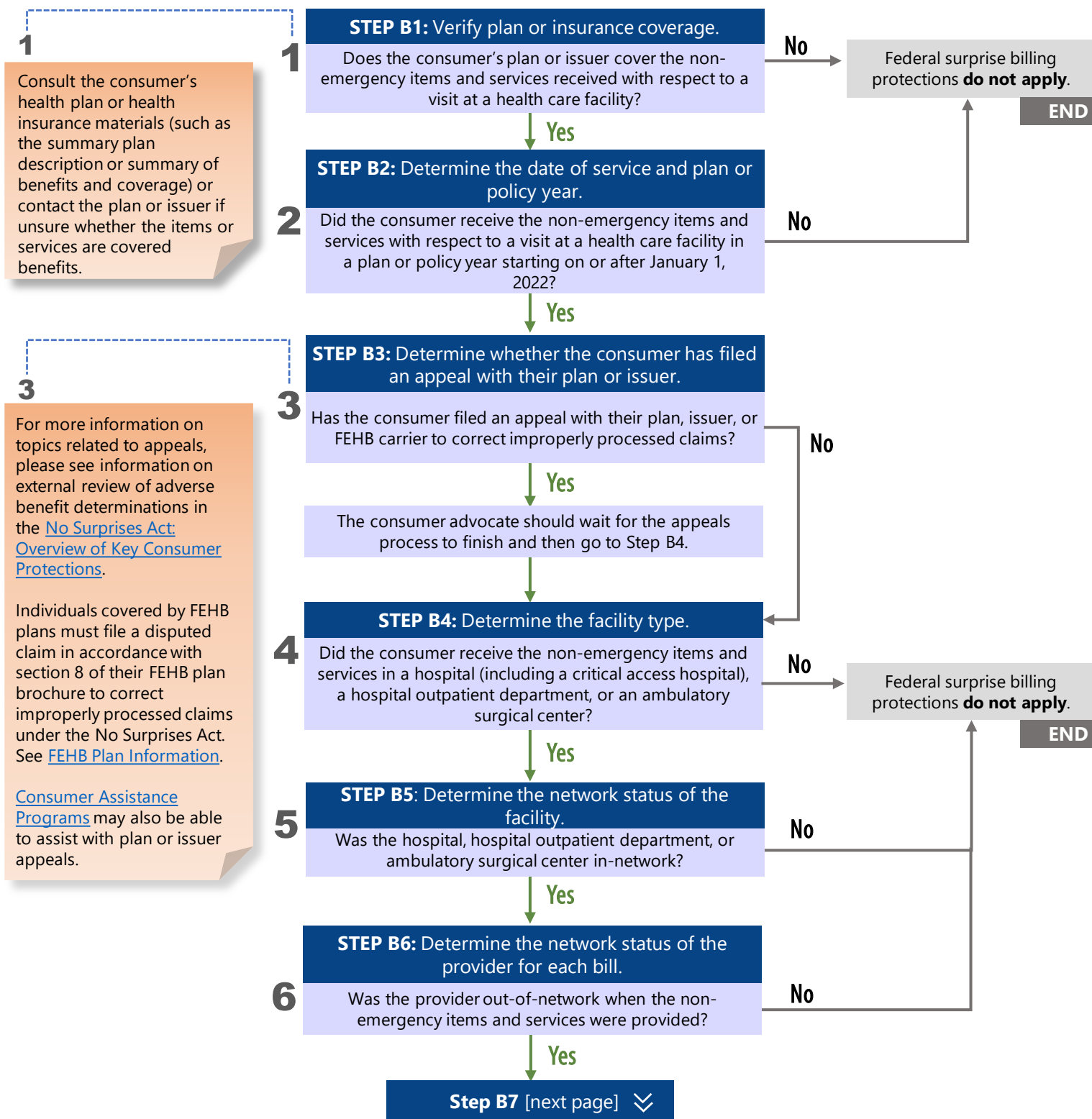
Section A: Emergency Items and Services



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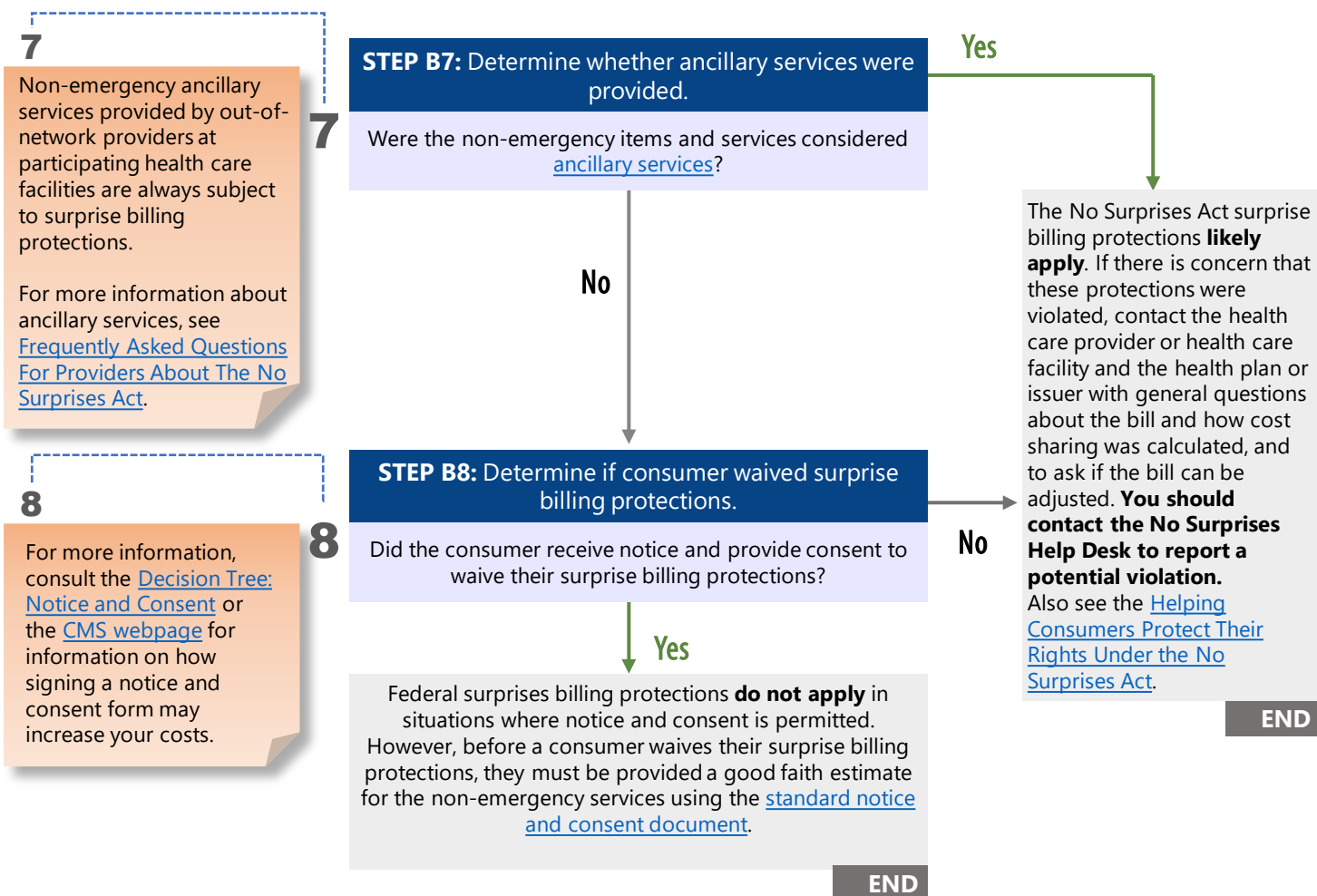
Section B: Non-Emergency Items and Services

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.



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Section B: Non-Emergency Items and Services

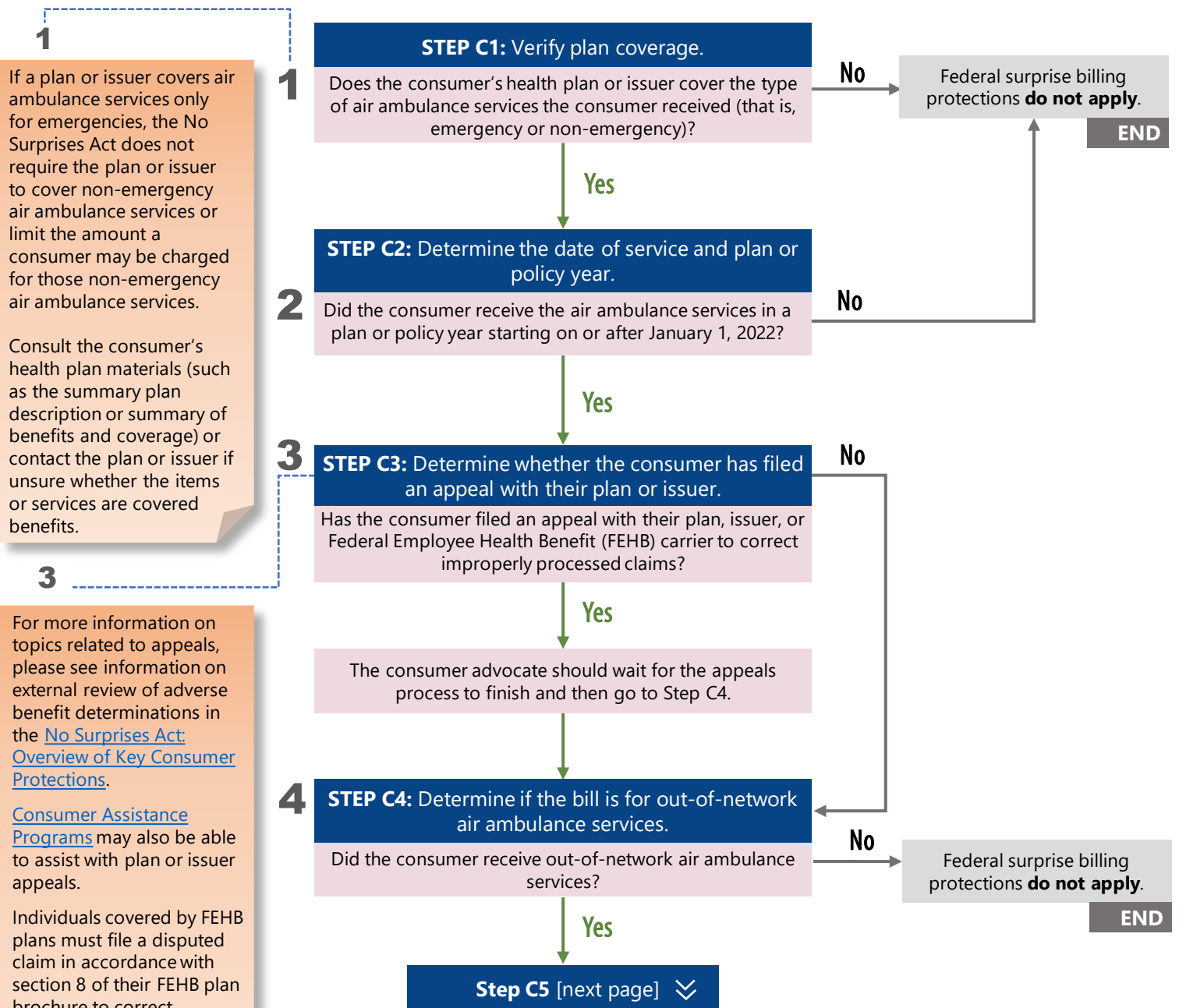


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Section C: Air Ambulance Services

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 [Consumer Assistance Program](#) for more information on ground ambulance services.



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Section C: Air Ambulance Services

For more information, consult the [Decision Tree: Notice and Consent](#) or the [CMS webpage](#) for information on how signing a notice and consent form may increase your costs.

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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



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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 in-network 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.

