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Final No Surprises Act Rule: Payers Must Say More About Downcoding

By Nina Youngstrom

An Aug. 19 final rule on the No Surprises Act requires health plans and issuers to be more forthcoming about changes to codes and modifiers on claims from out-of-network providers that reduce the "qualified payment amount" (QPA).[1] The rule also tweaks the payment determination process for independent dispute resolution (IDR), although attorneys aren't sure it will do providers much good. The QPA for an out-of-network service may continue to be a sore spot.

"There's good and bad" for providers in the final rule, said attorney Jamie Gelfman, with McDermott Will & Emery LLP in Miami, Florida. More transparency about downcoding that affects payments for out-of-network services is helpful, particularly if providers seek open negotiation and the federal IDR process. But the rule, which comes from HHS and the departments of Labor and the Treasury, "still strongly favors the QPA," something many providers don't like, said another attorney, who prefers not to be identified. "What the departments gave providers on the IDR is marginally better than it was in the interim final rules, but not great."

The No Surprises Act protects patients from large or unexpected bills from out-of-network providers when they're treated at hospitals, ambulatory surgery facilities and other facilities, depending on the circumstances. The law limits patient liability for out-of-network services to no more than in-network cost-sharing amounts, which means balance billing isn't allowed when patients receive emergency services (including poststabilization) from out-of-network hospitals or nonemergency services from out-of-network providers at certain in-network hospitals and other facilities.