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.

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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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

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 state-based 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?

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 Decision Tree: Requirements for Good Faith Estimates for Uninsured (or Self-Pay) Individuals.

END

Yes ↓

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 2: Determine if the claim(s) and bill(s) were properly processed.

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.

2 See page 10 for tips for reviewing Explanation of Benefits statements and medical bills.

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?

No →

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.

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.

3 **NOTE:** Continuity of care 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.

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.

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 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**.

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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.

1

Consult the plan's or issuer's policy materials (such as the summary plan description or summary of benefits and coverage) or contact the plan or issuer if unsure whether the plan covers such services.

3

For more information on topics related to appeals, please see information on external review of adverse benefit determinations in the No Surprises Act: Overview of Key Consumer Protections.

Individuals covered by FEHB plans must file a disputed claim in accordance with section 8 of their FEHB plan brochure to correct improperly processed claims under the No Surprises Act. See FEHB Plan Information.

Consumer Assistance Programs may also be able to assist with plan or issuer appeals.

4

For definitions of terms contained in this decision tree, see the No Surprises Act Consumer Advocate Toolkit: Glossary. Urgent care centers must meet the definition of an independent, freestanding emergency department to be included in the surprise billing protections.

1

STEP A1: Verify health plan coverage.

Does the consumer's health plan or issuer cover any benefits with respect to services in an emergency department of a hospital or with respect to emergency services in an independent freestanding emergency department?

No → Federal surprise billing protections **do not apply**. **END**

Yes ↓

2

STEP A2: Determine the date of service and plan or policy year.

Did the consumer receive the emergency items and services under a plan or policy year starting on or after January 1, 2022?

No → Federal surprise billing protections **do not apply**. **END**

Yes ↓

3

STEP A3: Determine whether the consumer has filed an appeal with their plan or issuer.

Has the consumer filed an appeal with their issuer, plan, or FEHB carrier to correct improperly processed claims?

No → **STEP A4**

Yes ↓

The consumer advocate should wait for the appeals process to finish and then go to Step A4.

4

STEP A4: Determine where emergency services prior to stabilization were furnished.

Were emergency items or services prior to stabilization provided to the consumer at either:

- **An emergency department of a hospital?** This includes if the consumer was eventually moved out of the emergency department and admitted to the hospital before they were stabilized; or
- **An independent freestanding emergency department?**

If yes, federal surprise billing protections for emergency services prior to stabilization apply. These protections continue to apply even after the patient is moved out of the emergency department prior to stabilization and admitted to a hospital.

No → Federal surprise billing protections for emergency services **do not apply**. **END**

Yes ↓

Step A5 [next page]

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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.

5

Did the facility or provider ask the consumer to provide consent to waive their surprise billing protections for emergency services prior to stabilization and then bill more than permitted under the surprise billing protections?

No

Yes

The provisions of the No Surprises Act were violated. The consumer may contact the facility or provider, or plan or issuer, to request the bill be adjusted. The consumer 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.

5

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

STEP A6: Determine if the consumer received post-stabilization emergency services.

6

After the consumer was stabilized, did the consumer receive any items or services (related to the emergency services prior to stabilization) as part of outpatient observation or an inpatient or outpatient stay?

No

Yes

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.

6

The definition of emergency services under the No Surprises Act includes certain post-stabilization services.

STEP A7: Determine if the consumer waived surprise billing protections for post-stabilization services.

7

Was the bill for out-of-network post-stabilization services AND did the consumer provide consent to waive their surprise billing protections?

No

The No Surprises Act surprise billing protections **likely apply.** If there is concern that these protections were violated, contact the health care provider or health care facility 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 may also contact the No Surprises Help Desk** to report a potential violation.

END

Yes

If the provider or facility was permitted to seek notice and consent to waive surprise billing protections, federal surprise billing protections **do not apply**. However, before a consumer waives their surprise billing protections, the provider or emergency facility must provide the consumer with a good faith estimate for the post-stabilization services using the standard notice and consent document.

END

7

For more information, consult the Decision Tree: Notice and Consent.

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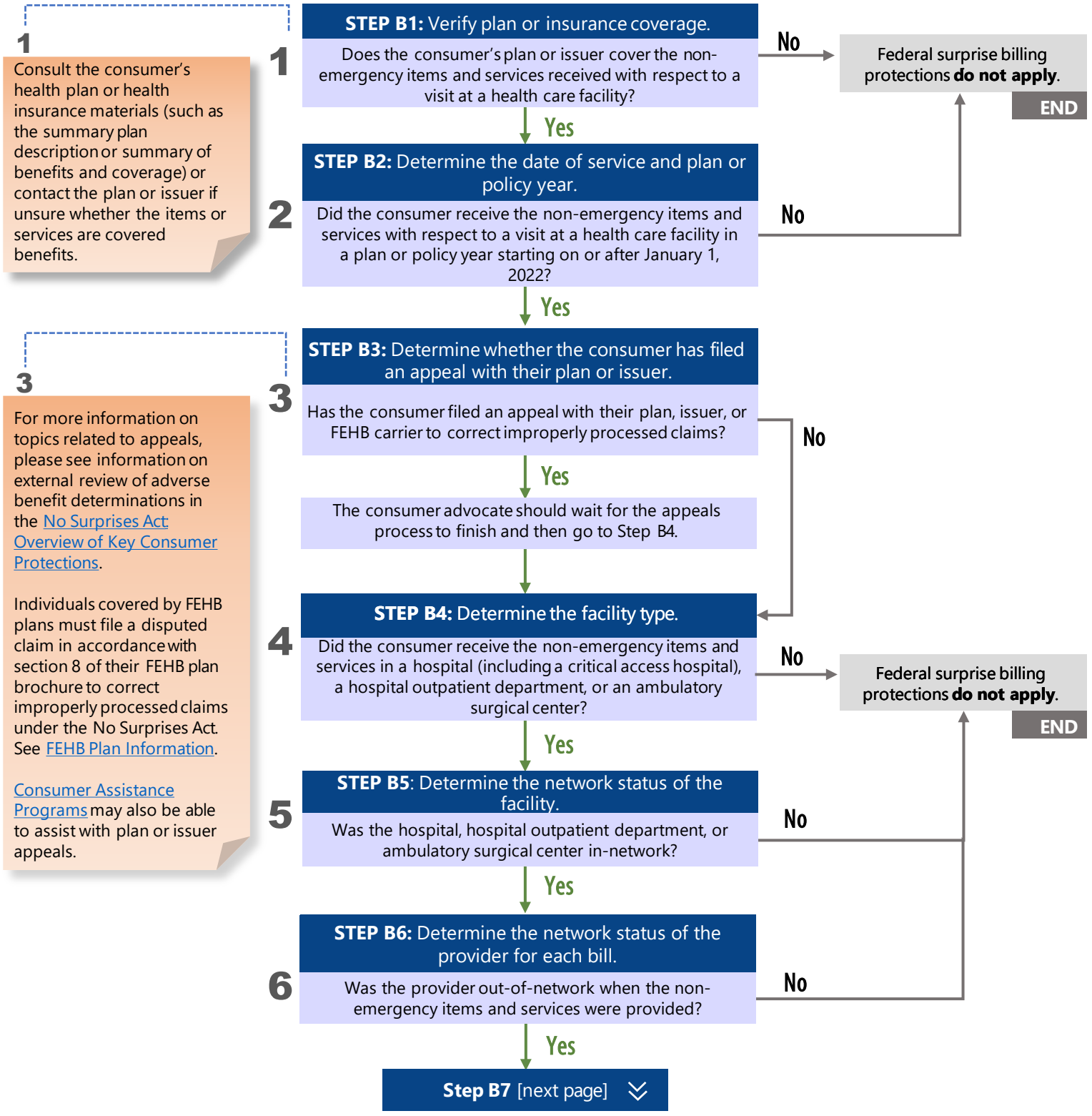
Section B: Non-Emergency Items and Services

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

7

Non-emergency ancillary services provided by out-of-network providers at participating health care facilities are always subject to surprise billing protections.

For more information about ancillary services, see Frequently Asked Questions For Providers About The No Surprises Act.

8

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.

STEP B7: Determine whether ancillary services were provided.

Were the non-emergency items and services considered ancillary services?

Yes

The No Surprises Act surprise billing protections **likely apply**. If there is concern that these protections were violated, contact the health care provider or health care facility 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 contact the No Surprises Help Desk to report a potential violation.** Also see the Helping Consumers Protect Their Rights Under the No Surprises Act.

END

No

STEP B8: Determine if consumer waived surprise billing protections.

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

No

Yes

Federal surprises billing protections **do not apply** in situations where notice and consent is permitted. 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

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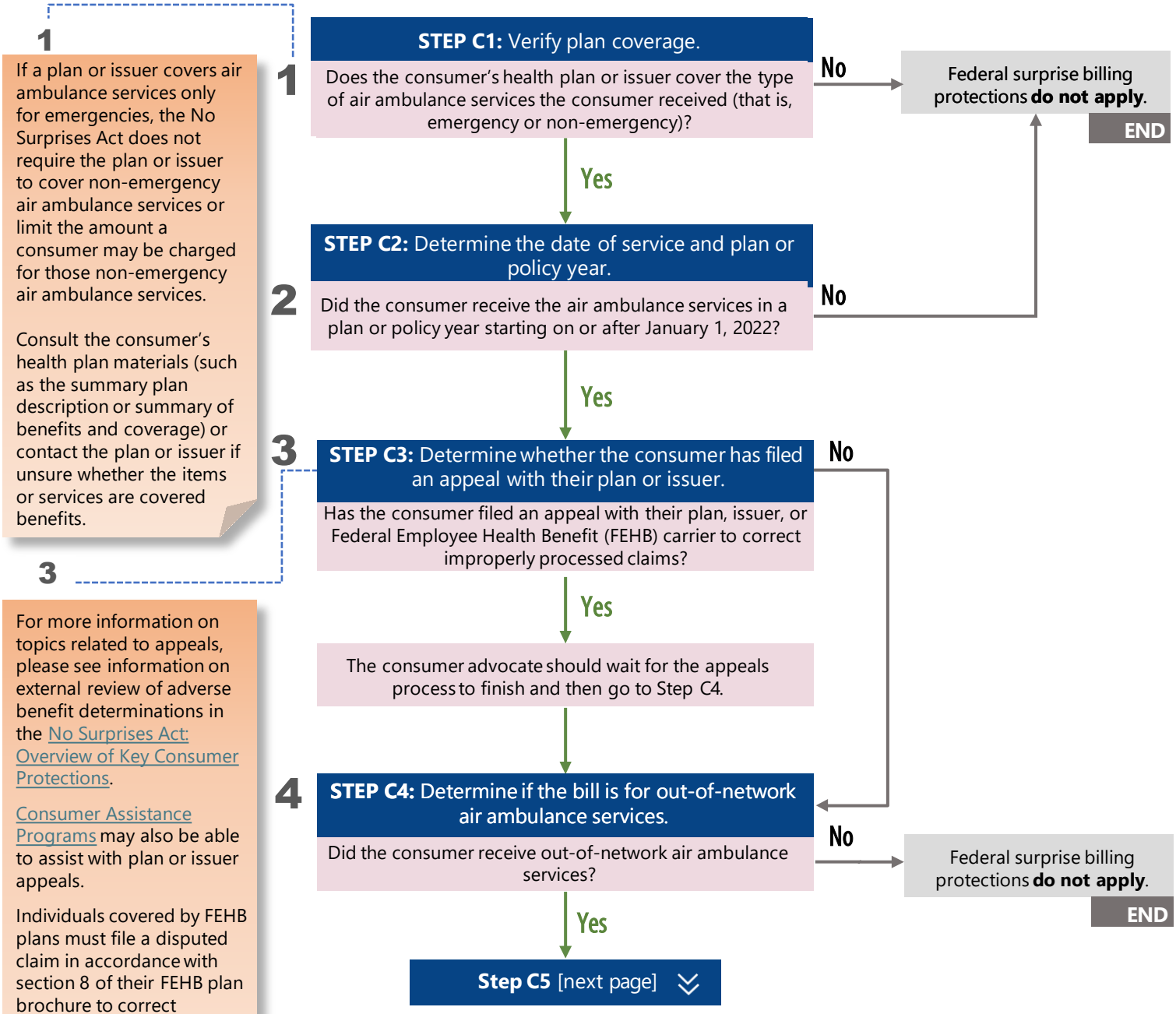
Section C: Air Ambulance Services

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.

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

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

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

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

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.

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