December 2022

No Surprises Act
Claims & Billing
Frequently Asked Questions for Providers

The No Surprises Act establishes member protections from balance billing, starting January 1, 2022. More details and resources are available here.

The following frequently asked questions (FAQs) are for providers and facilities regarding the No Surprises Act regulations related to claims and billing information.

1) When is Florida Blue implementing the No Surprises Act for claims processing?

Services rendered on or after January 1, 2022, by non-participating providers may be subject to requirements imposed by the rules. Claims received on and after August 16, 2022, will be subject to the No Surprises Act rules and include appropriate messaging.

2) Does Florida already have state laws that limit balance billing?

Yes. Florida Statutes 627.64194 and 641.513 already contain provisions that limit balance billing in certain scenarios. Per the No Surprises Act rules, if a state law provides balance billing protection, the state law will apply.

3) The No Surprises Act allows patients to consent to waive surprise billing protections in certain circumstances. Is a patient required to sign the notice and consent form to waive their protections?

If an out-of-network provider or facility plans to balance bill a patient, they must provide the patient (or an authorized representative) notice detailing the patient's protections under the No Surprises Act rules. It must also include information about the potential costs if the patient waives their surprise billing protections. **Note**: The notice and consent are only allowed for post-stabilization services, when certain conditions are met, and for certain non-emergency services. Surprise billing protections always apply to ancillary services for non-emergency care (not post-stabilization services) provided by out-of-network providers related to a visit to an in-network facility. These ancillary services include diagnostic services like radiology and laboratory, anesthesiology, pathology, and neonatology - whether provided by a physician or nonphysician. A patient is not permitted to waive surprise billing protections for these services. Thus, in surprise billing situations, providers are not allowed to seek notice and consent for these services.

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4) If a patient waives balance billing protection and signs the consent form, how is this reported on the claim?

Electronic claims: If the patient has waived balance billing protection for an appropriate scenario, report the CK indicator in the PWK segment. This is a segment within the 837 Professional and Institutional electronic transactions. The PWK segment provides *linkage* between electronic claims and other documentation needed for claims adjudication. The indicator is applied at the claim level or line level.

Paper claims: The consent form should be sent as an attachment to the paper claim. The title of the consent form must include the suggested title from the Centers for Medicare & Medicaid Services (CMS) Surprise Billing Protection Form. If the title of the consent form reads different from Surprise Billing Protection Form, you will need to submit an appeal including the claim and signed consent form.

5) How will a provider know the No Surprises Act claim processing rules have been applied to a claim?

Remittance messages will indicate when No Surprises Act rules have been applied to a claim. The following reason codes and messages along with linked remittance advice remark code (RARC) messages will apply as follows:

A. when the scenario was processed based on Federal Law and the allowed amount is the Qualifying Payment Amount (QPA).

- LIASB – No balance billing permitted by Federal Law
- N860 – The Federal No Surprises Billing Act Qualified Payment Amount (QPA) was used to calculate the member cost share(s).
- N877 – Alert: This initial payment is provided in accordance with the No Surprises Act. The provider or facility may initiate open negotiation if they desire to negotiate a higher out-of-network rate.
- N862 – Alert: Member cost share complies with the No Surprises Act and is calculated using the lesser of the QPA or billed charge.

B. when the scenario was processed based on State Law.

- LBSBN – Allowed based on State Law in keeping with the Federal Law.
- N860 – Alert: The charge[s] for this service was processed in accordance with Federal/State, Balance Billing/No Surprises Act billing regulations. Any amount identified with OA, CO, or PI cannot be collected from the member and may be considered a provider liability or be billable to a subsequent payer. Any amount the provider collected over the identified PR amount must be refunded to the member within applicable Federal/State timeframes. Payment amounts are eligible for dispute pursuant to any Federal/State documented appeal/grievance process(es).
- N867 – Alert: Cost sharing was calculated based on a specified state law, in accordance with the No Surprises Act.
- N871 – Alert: This initial payment was calculated based on a specified state law, in accordance with the No Surprises Act.

6) Are there other claim scenarios with dedicated messaging for the No Surprises Act?

Yes, there are additional claim scenarios that will include dedicated messaging for the No Surprises Act:

A. The following reason code and messaging will apply when the scenario is processed based on an indication the patient's consent was received, therefore, the rules of the Federal Law do not apply. This message is an allowed reason and is not linked to specific RARC messages created for the No Surprises Act:

- PSBCK - Patient consent given, amount represents maximum allowable.

B. The following reason code and messaging will apply when the claim is for non-participating physician or professional ancillary providers performing services in a non-participating inpatient hospital. The No Surprises Act applies to this claim scenario when the patient is converted from the emergency room (ER) to inpatient. There is currently no indicator available for the 837P or CMS 1500 claim form/format to specify the inpatient services were due to conversion from the ER. Also, there is no guarantee the hospital claim will be on file when the professional claim is submitted for reimbursement. Therefore, some claims will receive the following message and may need to be appealed or disputed. This process is specific to Florida Blue, Health Options, Inc., and Guidewell Inc. products. Claims for Federal Employee Program and BlueCard members may not follow this process. This message is an allowed reason with no linked RARC codes and messaging.

- PRPSB - Amount is maximum allowed, cannot conclude Federal Law applies.

C. The following reason code and messaging along with linked RARC messaging will apply when the claim is for air ambulance services and consent is indicated on the electronic claim or the consent form is attached to the paper claim. Consent does not apply to this claim scenario, and it will be processed based on the rules of the No Surprises Act.

- PRCNK – Amount represents BCBSFL's Qualified Payment Amount.
- LBCNK – Consent requested in error; Federal Law applied.
- N869 – Alert: Cost sharing was calculated based on the qualifying payment amount, in accordance with the No Surprises Act.
- N859 – Alert: The Federal No Surprises Billing Act was applied to the processing of this claim. Payment amounts are eligible for dispute pursuant to any Federal documented appeal/ grievance/dispute resolution process(es).

D. Additional emergency claim scenarios* where consent should not be requested from the member include:

- The hospital claims for emergency room services.
- Non-par physician and professional ancillary services performed in the ER regardless of the physician's specialty or the type of professional ancillary provider.

E. Non-emergency claim scenarios* where consent should not be requested of the member include:

- Non-par physicians that represent emergency medicine, anesthesiology, pathology, radiology, and neonatology along with assistant surgeons, hospitalists, and intensivists.
- Non-physician practitioners, when there is no information on the claim to indicate the specialty of the physician the practitioner is working under to be able to identify these claims.

***Note:** Florida Blue continues to analyze the No Surprises Act to update our processing rules to ensure these scenarios are not processed based on provided consent.

F. Finally, those items or services provided by a third party as part of the primary service/claim that qualifies as a No Surprises Act claim scenario cannot systematically be identified by Florida Blue. This is specific to the No Surprises Act reference indicating these third-party services are subject to the provisions of the No Surprises Act. This includes "off-site nonparticipating providers who furnish items or services that an individual receives as part of a visit to such health care facility."

   For example: A laboratory specimen referred to an outside non-participating independent clinical laboratory for a surgical procedure performed at an ambulatory surgical center (i.e., a colonoscopy).

7) Are there billing rules for emergency hospital claim scenarios, ER, and ER to inpatient conversion?

Yes. When a portion of the institutional claim is subject to the No Surprises Act processing rules, the claim must be split billed for the services subject to the No Surprises Act from those that are not, due to patient consent. The patient will have separate liabilities applicable to the two claims. This should be considered when the estimated patient liability is determined as part of the process for gaining their consent. This could apply if a patient is stabilized before or during conversion from the outpatient setting to an inpatient setting.

8) Are there billing rules for institutional air ambulance claim scenarios?

Yes. For Florida Blue to differentiate ground ambulance from air ambulance claims, air ambulance must be submitted with the proper revenue code (545 for air ambulance). The general revenue code for ambulance services, revenue code 540, has been linked to ground ambulance now that there is a dedicated revenue code to identify air ambulance. If air ambulance claims are not submitted with revenue code 545, the claim will not be identified as applicable to the No Surprises Act.

In addition, ground and air ambulance should not be submitted on the same claim. If billed on the same claim because they were performed by the same provider, the entire claim will be processed under the No Surprises Act including balance billing protection. To avoid this, ground and air ambulance services should be billed on separate claims.

9) Are there billing rules for physician and professional ancillary provider claim scenarios about patient consent once stabilization is achieved?

Yes. When stabilization occurs, prior to or during conversion to an observation setting, the claim should be submitted with an outpatient hospital place of service, not the ER place of

service. Consent will not be honored for non-participating physician or professional ancillary claims with an ER place of service.

10) Are there billing rules for physician and professional ancillary provider claim scenarios when services are performed in the hospital or ambulatory surgical center setting?

Yes. For Florida Blue to properly identify physician and professional claims that qualify under the No Surprises Act, the Service Facility name and address must be provided.

- It is preferred the hospital or ambulatory surgical center's NPI is also reported. The CMS 1500 claim form, field 32 (name & address), 32a (NPI number), 32b (qualifier/taxonomy code) should be submitted on the paper claim.
- Florida Blue requires the following information on the electronic professional claim format, 837P, SERVICE FACILITY LOCATION NAME in loop 2310C.
- Professional claims submitted for services performed in a hospital or ambulatory surgical center settings must include the Service Facility information for correct processing. Claims will be denied if the Service Facility information is missing or incorrect.

11) How do I initiate an Open Negotiation Request?

Non-participating providers have 30 business days to dispute a paid or denied claim that meets criteria for the IDR process as defined by cms.gov.

To begin the 30-Day Open Negotiation Period:

A. Complete the Open Negotiation Notice form.
B. Email the form to independentdisputeresolution@bcbsfl.com. The form can also be **faxed to 1-904-301-1529.**

12) How do I initiate the IDR process?

If we do not reach an agreement by the end of the 30-Day Open Negotiation Period, you may initiate the IDR process for eligible claims within four business days of the end of the Open Negotiation period.

To initiate the IDR process:

A. Complete the Federal Dispute Resolution Form (PDF).
B. Submit the form to us at: independentdisputeresolution@bcbsfl.com.

For more information, visit cms.gov.