Federal Surprise Bill – Balance Billing - Authored

Published Date **9/30/22**
Expiration Date **Does not expire**

LOB ALL
State ALL

1. System(s) – Solution Central
2. Functional Area(s) – Member Experience; Provider Experience; Broker Experience
3. Description – Starting January 1, 2022, consumers will have new billing protections when getting emergency care, non-emergency care from out-of-network providers at in-network facilities, and air ambulance services from out-of-network providers.

Federal Surprise Bill Act

In Scope	Out of Scope
• All States • Individual • Small Group • Local FI & ASO (ERISA & Non-ERISA) • National ASO • National FI • Home/Host	• Commercial Retiree's • Local FI covered under State Mandate • Patient who have signed consent form (72-hr prior to date of service) • COB/Medicare Primary Claims

Starting January 1, 2022, consumers will have new billing protections when getting emergency care, non-emergency care from **out-of-network providers at in-network facilities**, and **air ambulance services from out-of-network providers.** Through new rules aimed to protect consumers, excessive out-of-pocket costs will be restricted, and emergency services must continue to be covered without any prior authorization, and regardless of whether a provider or facility is in-network.

A surprise bill is when a member receives a balance bill from an Out of Network provider and the member thought the service(s) would be paid In-Network.

Examples include:
Out of Network Emergency Services (including Air Ambulance) – impacts both Facility and Professional claims in either the inpatient or outpatient setting.

Professional Office Settings are not covered under this bill. (Out of Scope)

Out of Network Non-Emergency Services if performed in a participating facility as indicated below:

- Anesthesiologists
- Radiologists
- Pathologists
- Assistant Surgeons
- Surgeons (where a prior patient consent form Advanced Patient Notification/Patient Consent was not obtained).

Revision History

Date	What was changed?
09/30/22	Updated Language around QPA, consent forms, and added EOB screenshot
07/27/22	Updated Chart and other things throughout per Governance Review
06/10/22	Added In and Out of Scope, Professional Office setting out of scope, removed Fed3 from the chart under NY, added how to find QPA under View Claims Details.
05/18/22	FAQs updated question "What if the provider is not satisfied with the QPA/Allowable?"
02/07/22	Original Post

Terms and Definitions

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Terms and Definitions

Terms and Definitions

Term	Definition
Federal Surprise Bill (FSB)	When a member receives a balance bill from an Out of Network provider and the member thought the service(s) would be paid In-Network.
Patient Consent Form	The mandate allows in certain situations the out of network provider the option to have a member sign a consent form acknowledging the service is out of network, the benefits are out of network and balance billing apply. **Note:** If the member signs one of these consent forms, the federal mandate no longer applies.
Qualifying Payment Amount - QPA	Average In-network rate used solely for the purpose of calculating any in-network cost share. Member cost-shares on Surprise Bill claims are limited to the lower of billed charges or the

	QPA.
Maximum Allowed Amount (MAA)	Out of Network rate used to pay the provider.

Surprise Bill Types and Scenarios

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Surprise Bill Types and Scenarios

Surprise Bill Types and Scenarios

When a member receives a balance bill from an out-of-network provider/facility and the member thought the service(s) would be paid at the in-network rate.			
Under the Federal Surprise Bill: • Providers cannot balance bill a member. • Impacts both facility and professional claims. • Includes Inpatient and Outpatient settings.			
Type	**Facility**	**Provider**	**Does the Surprise Bill mandate apply?**
Emergency Services	Out of Network (Non-PAR) ER Facility	Out of Network (Non-PAR) Provider **Example:** Surgeons (no waiver signed by the patient) **Note:** The below providers are not allowed to request member consent forms. • Anesthesiologists • Radiologists • Pathologists • Assistant Surgeons	**Yes – law applies.** They must not bill patients more than the in-network cost share or copay. **Some providers can ask the member to waive their rights by signing a consent form. By signing the patient gives up there billing protection under the surprise bill and may be billed for all charges. Patients are NOT required to sign this form, but the patient can choose an in-network provider(s) elsewhere to lower their cost.
Non- Emergency Services	In-network (PAR) Facility	Out of Network (Non-PAR) Provider **Example:** Surgeons (no waiver signed by the patient) **Note:** The below providers are not allowed to request member consent forms. • Anesthesiologists • Radiologists • Pathologists • Assistant Surgeons	**Yes - law applies.** They must not bill patients more than the in-network cost share or copay. **Some providers can ask the member to waive their rights by signing a consent form. By signing the patient is giving up there billing protection under the surprise bill and maybe billed for all charges. Patients are NOT required to sign this form, but the patient can choose an in-network provider(s) elsewhere to lower their cost.
	Out of Network (Non-PAR) Facility	Out of Network (Non-PAR) Provider	**No – Law does not apply**
Air Ambulance	N/A	Out of Network	**Yes – Law applies.** They must not bill patients more than the in-network cost share or copay. **Ground Ambulances **are not** covered under the Federal mandate, check the state mandates chart. Surprise Bill Mandate

			Guide - Selection by state

State vs Federal Chart with Different LOBs and All Anthem States

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State vs Federal Chart with Different LOBs and All Anthem States

State vs Federal Chart with Different LOBs and All Anthem States

The Federal Surprise Bill mandate is not to be confused with state specific surprise bill mandates. The Federal mandate covers emergency care, non-emergency care from out-of-network providers at in-network facilities, and air ambulance services from out-of-network providers. However, if a state has a surprise bill mandate, the state law supersedes the federal mandate. Only if a claim does not meet the criteria for the state mandate would the claim be considered under the Federal mandate. Please refer to the below chart for more details or visit the Surprise Bill Mandate Guide.

MARKET	Fully Insured (including MEWA - multiple employer welfare arrangement)		ERISA-ASO	Non-ERISA ASO (Self-funded plans sponsored by gov't entity or a church)	Self funded MEWA (multiple employer welfare arrangement)	Air Ambulance All Funding
CA	DMHC: STATE	CDI: STATE/FED[9]	FEDERAL[7]	FEDERAL	STATE/FED[9]	FEDERAL[4]
CO	STATE		FEDERAL	FEDERAL	FEDERAL	FEDERAL
NV	STATE/FED[6]		FEDERAL[7]	STATE	N/A	FEDERAL
MO	STATE/FED[5]		FEDERAL	STATE	STATE	FEDERAL
IN	STATE/FED[11]		FEDERAL	FEDERAL	FEDERAL	FEDERAL
OH	STATE		FEDERAL	STATE/FED[8]	STATE	FEDERAL
KY	FEDERAL		FEDERAL	FEDERAL	FEDERAL	FEDERAL
WI	FEDERAL		FEDERAL	FEDERAL	FEDERAL	FEDERAL
GA	STATE		FEDERAL[1]	FEDERAL[1]	FEDERAL[1]	FEDERAL
VA	STATE		FEDERAL[7]	STATE	N/A	FEDERAL
CT	STATE		FEDERAL	FEDERAL	N/A	FEDERAL
ME	STATE/FED[10]		FEDERAL[7]	STATE/FED[10]	STATE/FED[10]	FEDERAL
NH	STATE/FED[2]		FEDERAL	FEDERAL	N/A	FEDERAL
NY	STATE/FED[3]		FEDERAL	FEDERAL[3]	N/A	FEDERAL

Notes

1	GA state law specifically calls out SHBP and USG as covered by state; All other ERISA ASO, Non ERISA ASO or Self Funded MEWAs have the option to OPT IN.	6	NY - State mandate only covers emergency services
2	NH -Only Pathology, Radiology, Anesthesiology, and Emergency Medicine will apply STATE rules.	7	ERISA-ASO plans are allowed to OPT IN to the State Mandate
3	NY Law excludes non-physician providers which are typically: Physician's Assistant (including Registered Physician Asst, Surgical Asst), Nurse Prac, RN, CRNA, DME supplier. NYSHIP- State Mandate.	8	OH NON ERISA ASO - ASO Non-Erisa Public follows STATE and ASO non-Erisa Private follows FEDERAL
4	CA - DMHC regs regarding air ambulance reimbursement will no longer apply beginning January 1, 2022. The federal law will apply. Anthem may reimburse air ambulance services per EOC, but federal process applies.	9	CA -FI CDI and Self Funded MEWA -State (AB72) applies for non emergency, Federal applies for emergency
5	MO - Emergency Facility ONLY follows State for Fully Insured and Non ERISA ASO/MEWAs, if professional the emergency has to be at an in network facility to qualify for the state law. Non Emergency, with Authorization - State Mandate for FI/Non ERISA ASO/MEWAs, Non Emergency, without authorization – ALL	10	ME statute (§4303-C.) provides the reimbursement rate for emergency (prof & facility) and OON professionals at an INN facility setting. ME statue will not apply to OON professionals proving emergency services at an OON facility.
11	IN - State law applies to non-emergency professional health services provided by OON practitioner at in-network facility. Emergency is not covered by the statute. Requirement allows plan to reimburse "the rate established by the member's network plan". The provider cannot balance bill. Federal rules apply for purposes of cost share limitation using QPA, emergency services and independent Dispute Resolution.		

Note: NY State Employees Health Insurance Plan (NYSHIP) which is a non-ERISA ASO but because of State law it must follow the NY Surprise Bill law for any services rendered inside NYS, so it is an exception to what is shown for NY in the chart above.

Claims and EOB Examples – Supporting Member Inquiries

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Claims and EOB Examples – Supporting Member Inquiries

Claims and EOB Examples – Supporting Member Inquiries

Claims processed with a date of service on or after 1/1/2022 that are subject to the federal surprise bill, will include specific reason codes/explanations indicating that the claim is subject to surprise billing laws.

Note:

- Associate Empowerment Guidelines (AEG) - does not apply to the federal mandate.
- Out of Network Labs are not included in the Federal Mandate.
- KM – Surprise Billing Mandates – State Level State Mandates take precedent over Federal Mandate
- Or see **State Vs Federal Chart with Different LOBs and All Anthem** States dropdown above.

Supporting Member Inquires:

- **Member is being balance bill claim processed correctly.** Verify that the members claim has processed, and the EOB has the Federal Surprise Bill explanation code (see EOB screen shot below). If the member is being balanced billed CSR should contact the provider and advise the claim falls under the Federal Mandate. If the provider disputes the payment portion, advise the provider to contact Provider Services to receive information on the Independent Dispute Process (IDR).
- **Member is being balance billed due to a signed consent form.** Verify that the provider submitted a signed patient consent form. The Consent form should be attached with the submitted claim. If not attached to the claim contact the provider to verify the form was signed by the member to accept balanced billing. Advise the member that the claim processed correctly, and that the member has the right to file an appeal. Follow normal process.

Note: Non-emergency OON providers can submit a signed patient consent form with the claim if the member **knowingly accepts** the

liability of seeing an OON provider and can be balanced billed for these claims.

The following providers are not allowed to request patient consent forms:

- Anesthesiology
- Lab/Pathology
- Radiology
- Neonatology
- Assistant Surgeons

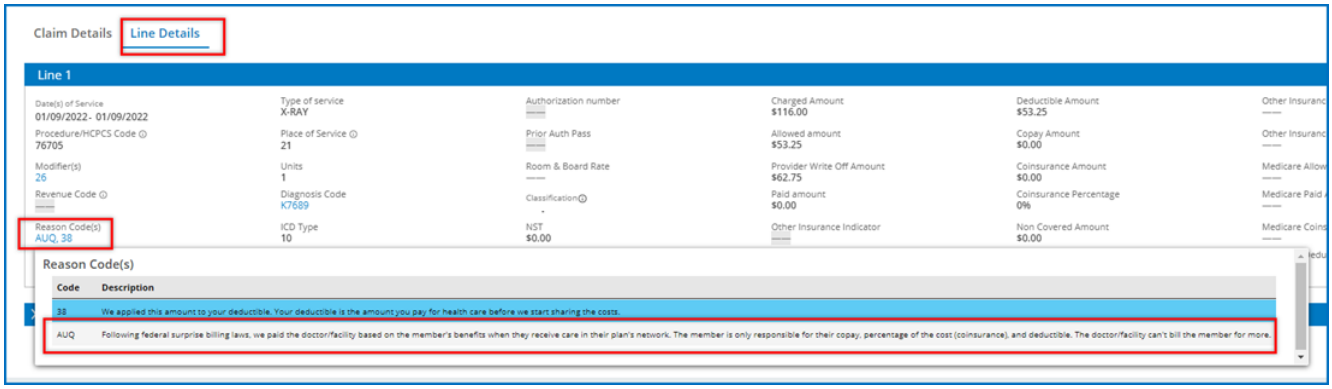
Claims research:

- Look in Content Framework (WCF) to see if any consent forms were submitted with the claim.
- Ask the member if they signed a consent form to accept balanced billing.
- Reach out to provider – remember you are representing Anthem / Empire be professional and get the name of the person you are speaking to for your notes.
- Out of State claims must be handled in BlueSquare or by calling the Plan-to-Plan phone number. **Do not contact Out - of - State Providers.**

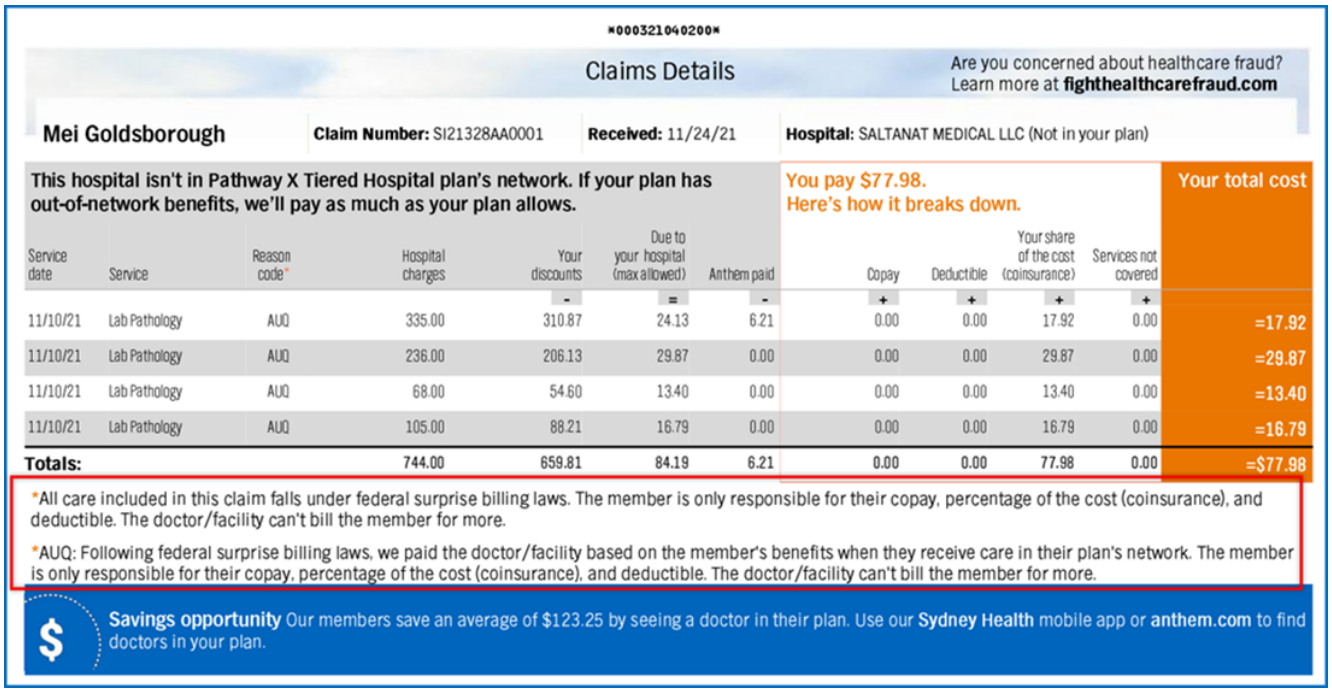
Manage Claims – Line Details – Reason Code(s)

AUQ represents the reason code.
The description will be the same as on the EOB.

**AUQ: Following federal surprise billing laws, we paid the doctor/facility based on the member's benefits when they receive care in their plan's network. The member is only responsible for their copay, percentage of the cost (coinsurance), and deductible. The doctor/facility can't bill the member for more.*



Sample EOB – Notes for Claims Processed Correctly applying the Federal Surprise Bill.



Note on EOBs and Provider Remits processed under the federal surprise bill act:

**All care included in this claim falls under the federal surprise billing laws. The member is only responsible for their copay, percentage of the cost (coinsurance), and deductible. The doctor/facility can't bill the member for more.*

**AUQ: Following federal surprise billing laws, we paid the doctor/facility based on the member's benefits when they receive care in their plan's network. The member is only responsible for their copay, percentage of the cost (coinsurance), and deductible. The doctor/facility can't bill the member for more.*

View QPA in Solution Central - Qualifying Payment Amount (QPA)

View QPA in Solution Central - Qualifying Payment Amount (QPA)

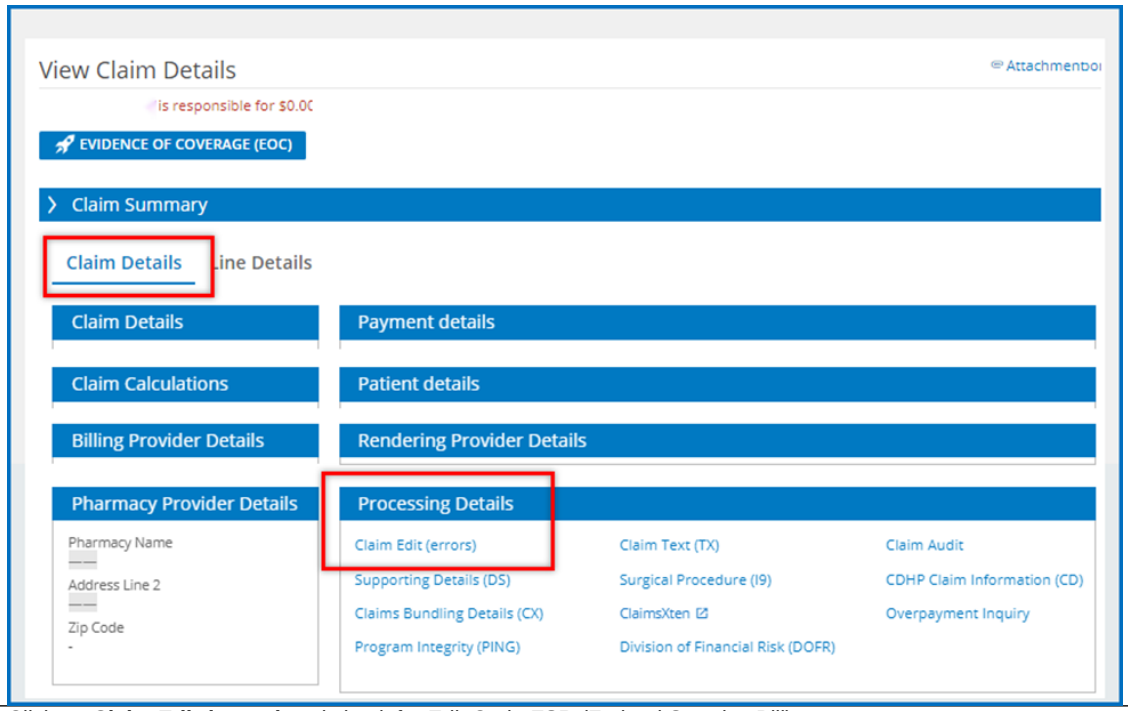
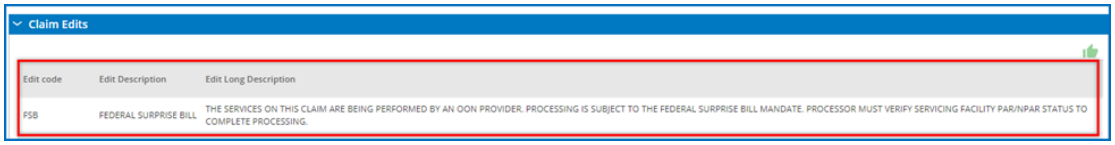
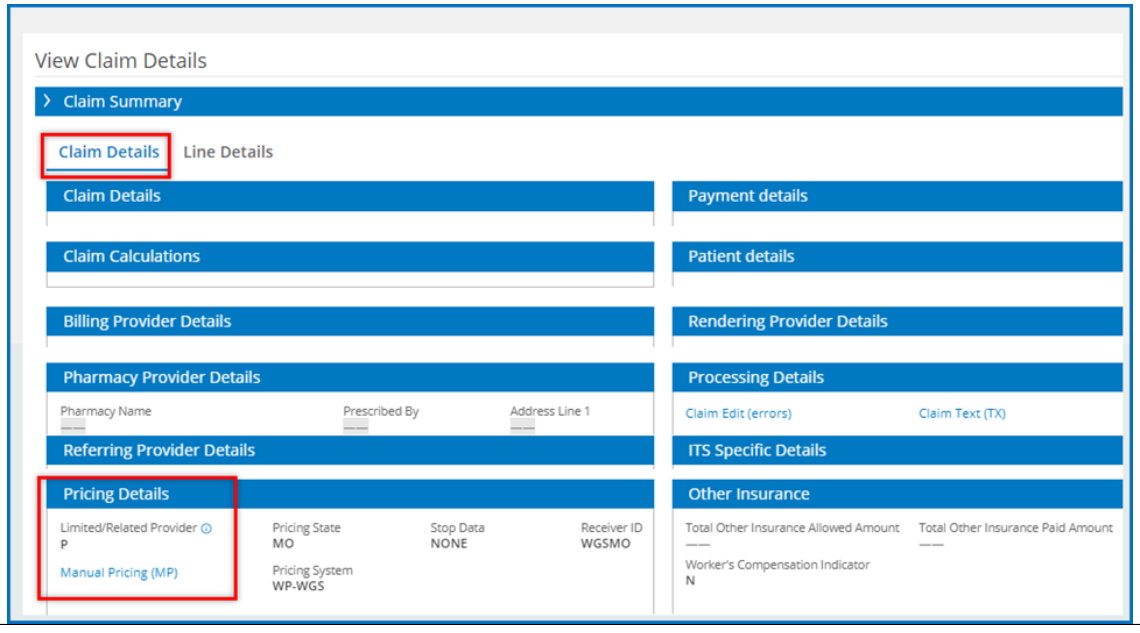
View QPA in Solution Central - Qualifying Payment Amount (QPA)

Qualifying Payment Amount (QPA)

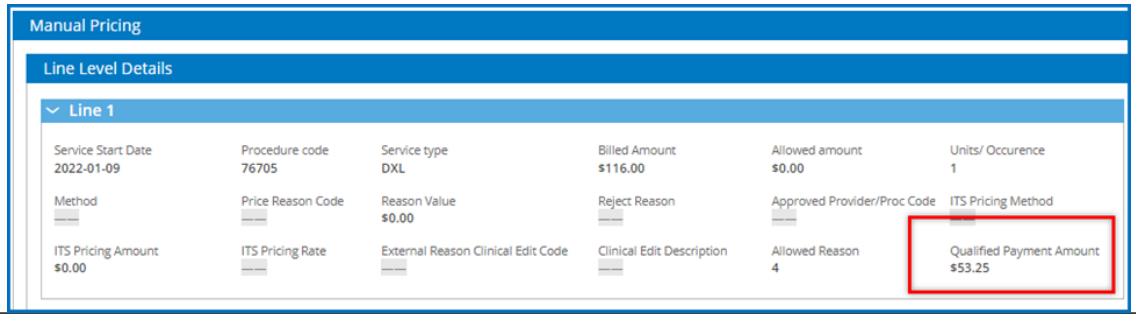
The QPA is the average In-Network rate used solely for the purpose of calculating any in-network cost share.

Member cost-shares on Surprise Bill claims are limited to the lower of billed charges or the QPA. In some instances, the QPA will be slightly higher than the MAX allowed amount. Please refer to the examples below to identify the QPA (is the QPA higher, lower, or equal to the MAX allowed amount).

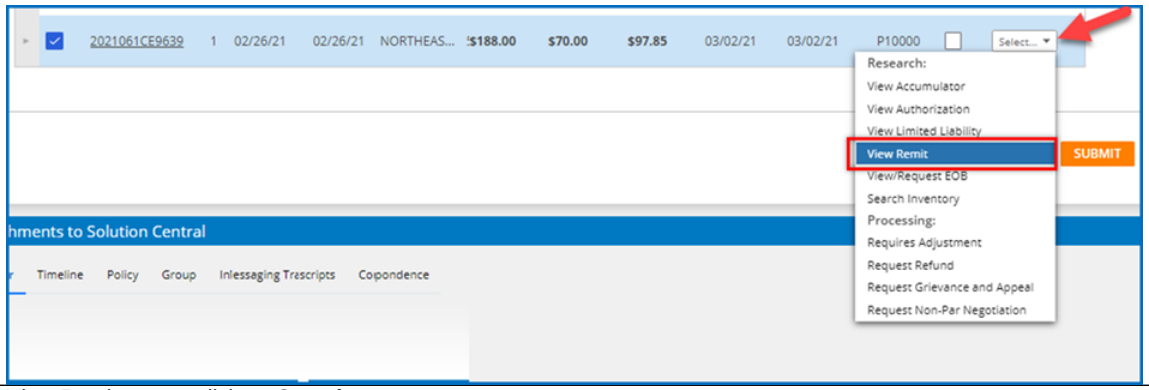
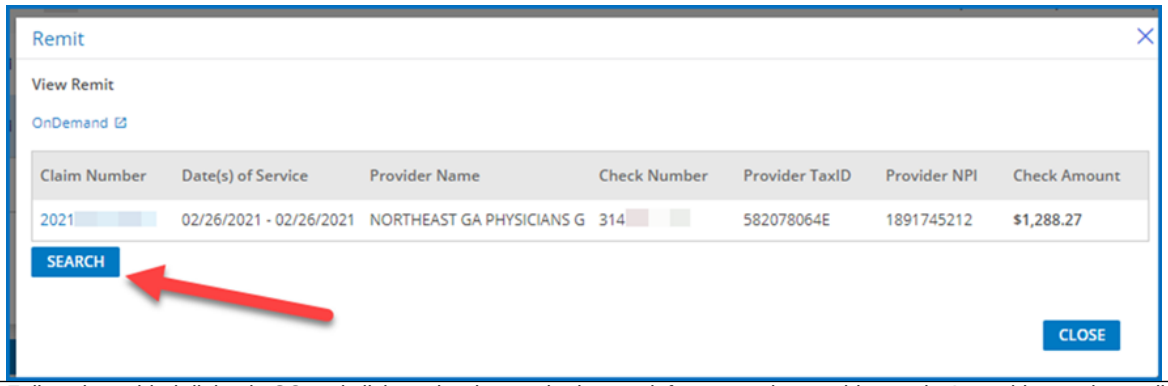
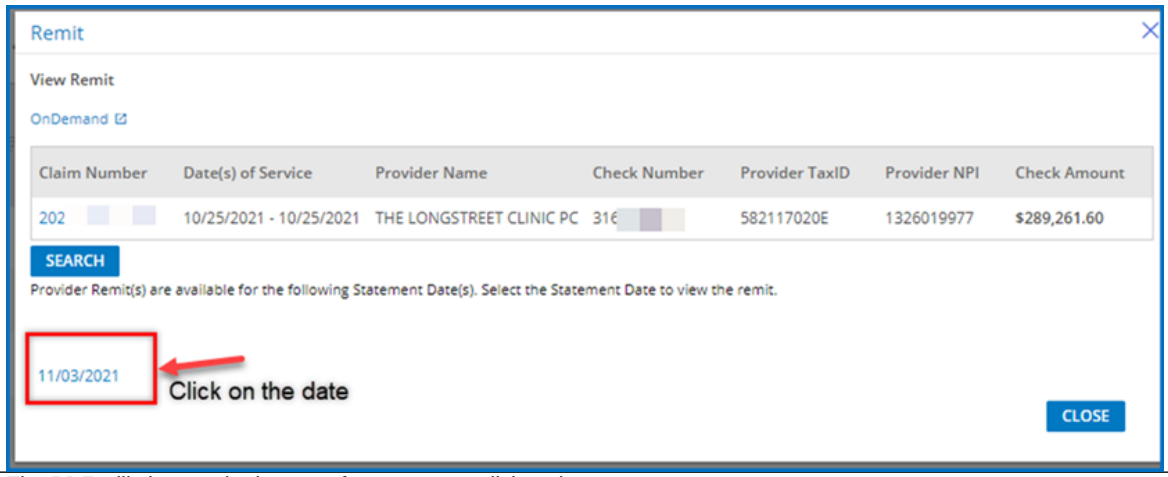
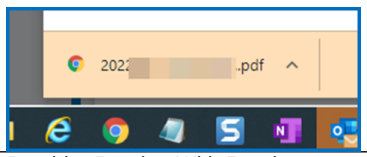
The QPA is visible on **the Manage Claims - Claims Detail** and the **Provider Remit,** see **Step, Action** tables below for both processes.

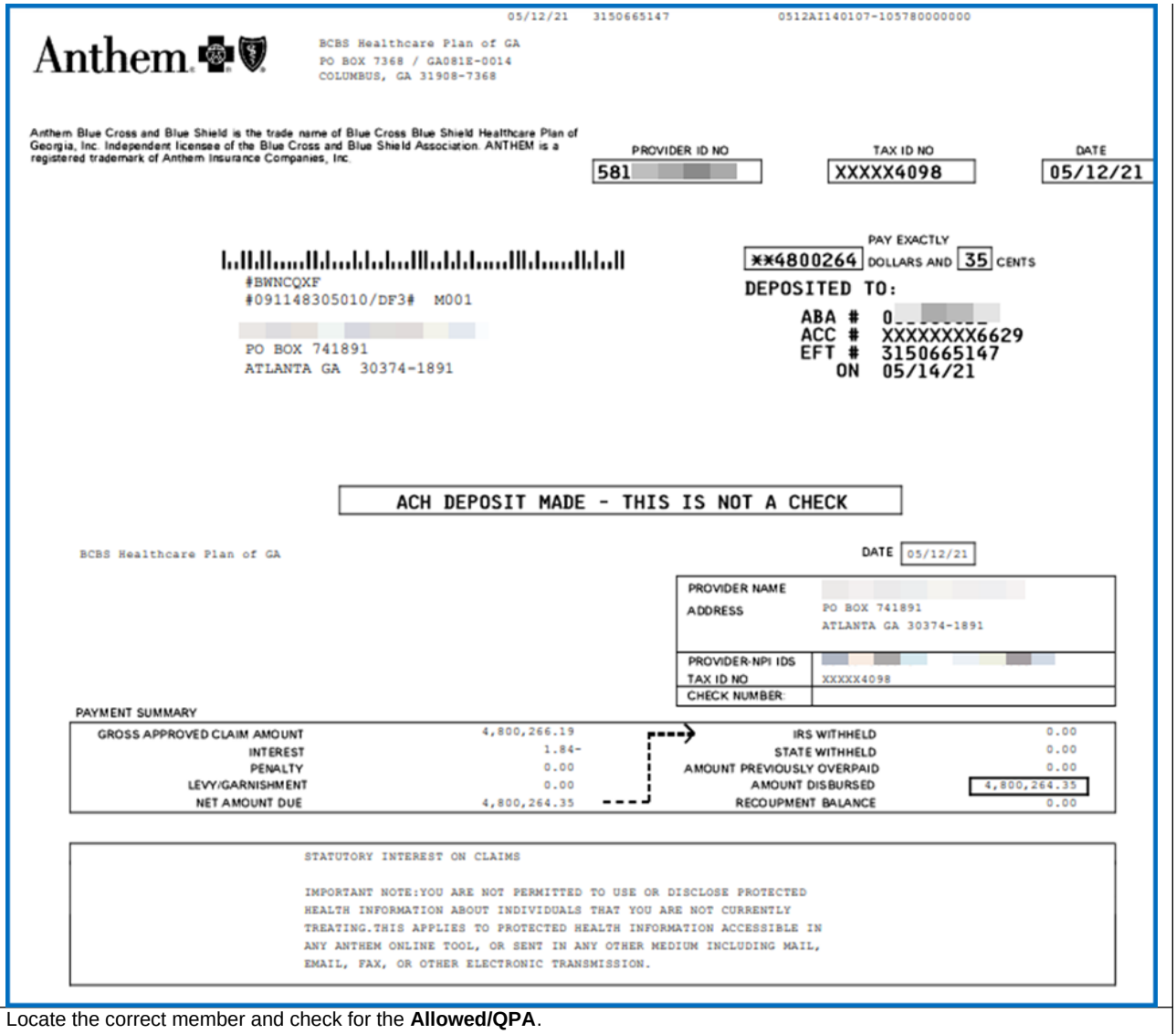
Step	Action QPA on Claim
1.	From **Manage Claims** task > Claim in focus
2.	Click on the **Claim Number** hyperlink to **View Claim Details** popup
3.	Verify this is a Surprise Bill by going to Claim - **Processing Details** 
4.	Click on **Claim Edit (errors)** and check for Edit Code **FSB** (Federal Surprise Bill)  "The services on this claim are being performed by an OON provider. Processing is subject to the Federal Surprise Bill Mandate. Processor must verify servicing PAR/NPAR status to complete processing"
5.	If this is a Federal Surprise Bill claim proceed to **Pricing Details** under **Claims Details** and **Manual Pricing (MP)** click hyperlink for the popup. 

6. **Manual Pricing (MP) –** Check here for QPA for this claim.



Provider Remit

Step	Action
1.	With a tagged claim in focus click on **Select** and **View Remit** under the Research dropdowns. 
2.	View Remit popup, click on **Search.** 
3.	Follow the guided dialog in SC and click on the date at the bottom left to open the provider remit. A provider remit may list many patients, these are internal documents that **MAY NOT** be shared with the member. 
4.	The PDF will show at the bottom of your screen, click on it to open. 
5.	Provider Remit – With Remit open use **CTRL +F** to search for the claim number or member name.



05/12/21 3150665147 0512AI140107-105780000000

Anthem

BCBS Healthcare Plan of GA
PO BOX 7368 / GA081E-0014
COLUMBUS, GA 31908-7368

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PROVIDER ID NO	TAX ID NO	DATE
581	XXXXX4098	05/12/21

#BWNCQXF
#091148305010/DF3# M001

PO BOX 741891
ATLANTA GA 30374-1891

PAY EXACTLY
**4800264 DOLLARS AND 35 CENTS

DEPOSITED TO:
ABA # 0
ACC # XXXXXXXX6629
EFT # 3150665147
ON 05/14/21

ACH DEPOSIT MADE - THIS IS NOT A CHECK

BCBS Healthcare Plan of GA

DATE 05/12/21

PROVIDER NAME
ADDRESS PO BOX 741891 ATLANTA GA 30374-1891
PROVIDER NPI IDS
TAX ID NO XXXXX4098
CHECK NUMBER

PAYMENT SUMMARY

GROSS APPROVED CLAIM AMOUNT	4,800,266.19	IRS WITHHELD	0.00
INTEREST	1.84-	STATE WITHHELD	0.00
PENALTY	0.00	AMOUNT PREVIOUSLY OVERPAID	0.00
LEVY/GARNISHMENT	0.00	AMOUNT DISBURSED	4,800,264.35
NET AMOUNT DUE	4,800,264.35	RECOUPMENT BALANCE	0.00

STATUTORY INTEREST ON CLAIMS

IMPORTANT NOTE:YOU ARE NOT PERMITTED TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION ABOUT INDIVIDUALS THAT YOU ARE NOT CURRENTLY TREATING.THIS APPLIES TO PROTECTED HEALTH INFORMATION ACCESSIBLE IN ANY ANTHEM ONLINE TOOL, OR SENT IN ANY OTHER MEDIUM INCLUDING MAIL, EMAIL, FAX, OR OTHER ELECTRONIC TRANSMISSION.

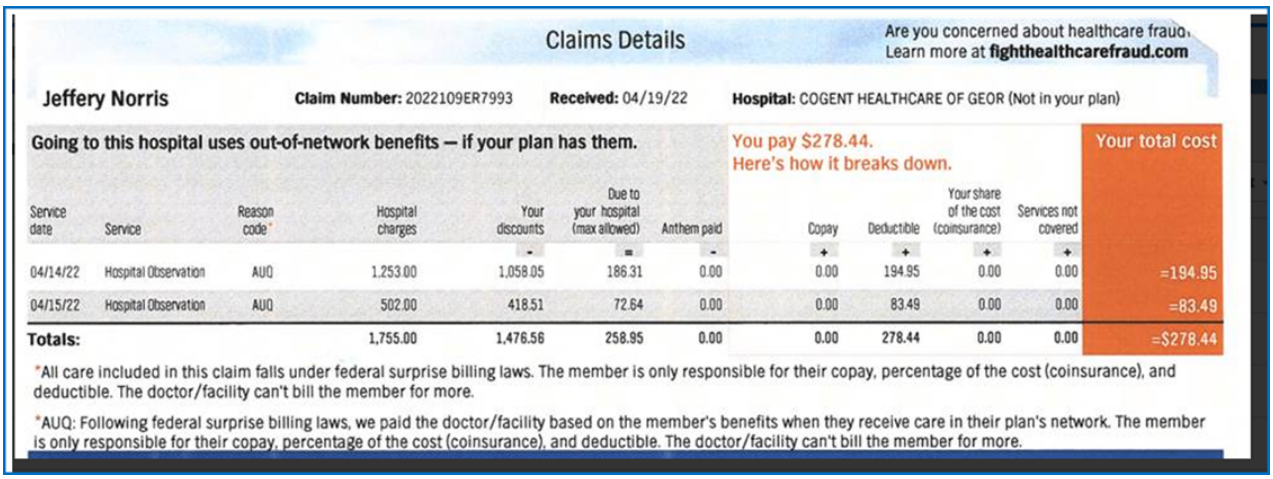
6. Locate the correct member and check for the **Allowed/QPA**.

Example Higher QPA

***Note the Max Allowed Amount will be the same amount as the QPA

Except when the QPA is greater than the MAA and the member has not met there out of pocket, the EOB will not reflect the correct QPA amount in the column “due to your hospital”. The cost share amount (deductible and coinsurance) is correct and based on the QPA amount

EOB Example when cost share is not met.



Claims Details

Are you concerned about healthcare fraud? Learn more at **fighthealthcarefraud.com**

Jeffery Norris **Claim Number:** 2022109ER7993 **Received:** 04/19/22 **Hospital:** COGENT HEALTHCARE OF GEOR (Not in your plan)

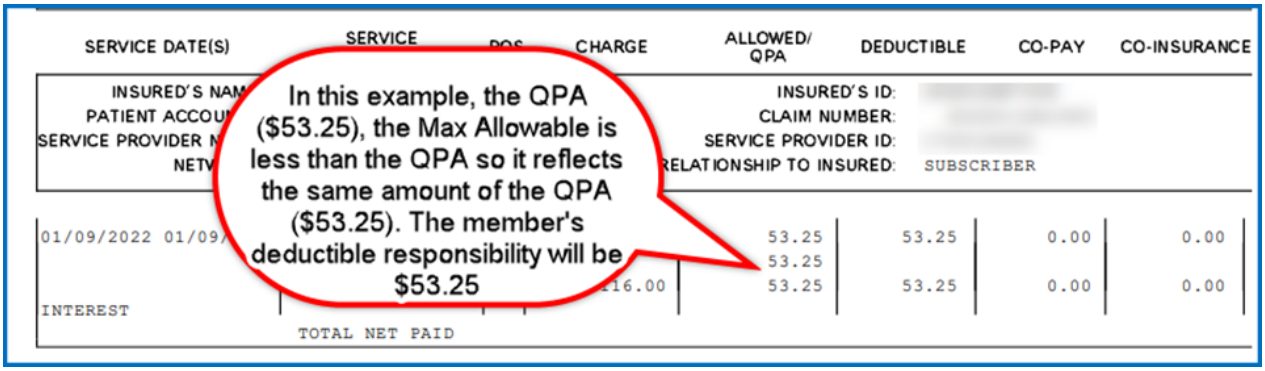
Going to this hospital uses out-of-network benefits — if your plan has them.

You pay $278.44. Here's how it breaks down.

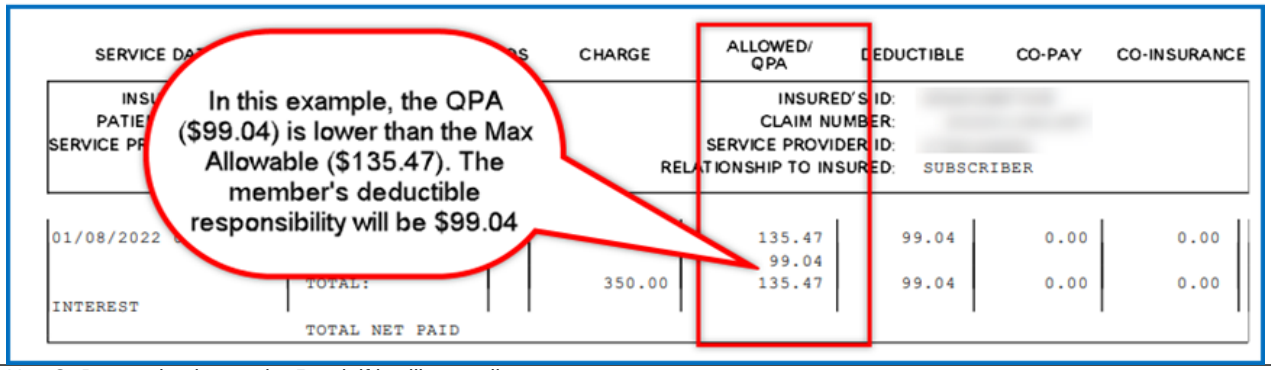
Service date	Service	Reason code*	Hospital charges	Your discounts	Due to your hospital (max allowed)	Anthem paid	Copay	Deductible	Your share of the cost (coinsurance)	Services not covered	Your total cost
				-	=	-	+	+	+	+	
04/14/22	Hospital Observation	AUQ	1,253.00	1,058.05	186.31	0.00	0.00	194.95	0.00	0.00	=194.95
04/15/22	Hospital Observation	AUQ	502.00	418.51	72.64	0.00	0.00	83.49	0.00	0.00	=83.49
Totals:			1,755.00	1,476.56	258.95	0.00	0.00	278.44	0.00	0.00	=$278.44

*All care included in this claim falls under federal surprise billing laws. The member is only responsible for their copay, percentage of the cost (coinsurance), and deductible. The doctor/facility can't bill the member for more.

*AUQ: Following federal surprise billing laws, we paid the doctor/facility based on the member's benefits when they receive care in their plan's network. The member is only responsible for their copay, percentage of the cost (coinsurance), and deductible. The doctor/facility can't bill the member for more.



Example of Lower QPA



7.	Use OnDemand to locate the Remit if it will not pull.

Patient Consent Forms

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Patient Consent Forms

Patient Consent Forms

The patient gives up their Federal consumer protections and agrees to pay more for out-of-network care when signing a patient consent form.

If a member is calling in about a bill you think might be covered under the Federal Surprise Bill act, ask them if they signed any documents waiving their rights when they went to the provider. If in doubt check the claim to verify that the consent was attached or contact the provider for the member and kindly ask if the patient signed one. **Members must sign them within 72 hours prior to their provider/facility visit**.

Copies should have been given to the member/patient or ask the provider to send a copy to the patient.

Providers and Facilities may use either the initial version of the standard notice and consent form (Appendix II) Initial version of the Standard Notice and Consent Documents Under the No Surprise Act or the revised version (Appendix IV) Revised version of the Standard Notice and Consent Documents Under the No Surprise Act for items/services furnished during calendar year 2022 and beyond.

Providers must submit the Consent Form with the claim.

The following providers are not allowed to request member consent forms:

- Anesthesiology
- Lab/Pathology
- Radiology
- Neonatology
- Assistant Surgeons

Sample language on the form might read like this:

Surprise Billing Protection Form

The purpose of this document is to let you know about your protections from unexpected medical bills. It also asks whether you would like to give up those protections and pay more for out-of-network care.

IMPORTANT: You aren't required to sign this form and shouldn't sign it if you didn't have a choice of health care provider when you received care. You can choose to get care from a provider or facility in your health plan's network, which may cost you less.

If you'd like assistance with this document, ask your provider or a patient advocate. Take a picture and/or keep a copy of this form for your records.

You're getting this notice because this provider or facility isn't in your health plan's network. This means the provider or facility doesn't have an agreement with your plan.

Getting care from this provider or facility could cost you more.

If your plan covers the item or service you're getting, federal law protects you from higher bills:

- When you get emergency care from out-of-network providers and facilities, or
- When an out-of-network provider treats you at an in-network hospital or ambulatory surgical center without your knowledge or consent.

Ask your health care provider or patient advocate if you need help knowing if these protections apply to you.

If you sign this form, you may pay more because:

- You are giving up your protections under the law.
- You may owe the full costs billed for items and services received.
- Your health plan might not count any of the amount you pay towards your deductible and out-of-pocket limit. Contact your health plan for more information.

Estimate of what you could pay

Patient name:_____

Out-of-network provider(s) or facility name:_____

_____

Total cost estimate of what you may be asked to pay:	

► **Review your detailed estimate.** See Page 4 for a cost estimate for each item or service you'll get.

► **Call your health plan.** Your plan may have better information about how much you will be asked to pay. You also can ask about what's covered under your plan and your provider options.

► **Questions about this notice and estimate?** Call [*Enter contact information for a representative of the provider or facility to explain the documents and estimates to the individual, and answer any questions, as necessary.]*

► **Questions about your rights?** Contact [*contact information for appropriate federal or state agency]*

Prior authorization or other care management limitations

[*Enter either (1) specific information about prior authorization or other care management limitations that are or may be required by the individual's health plan or coverage, and the implications of those limitations for the individual's ability to receive coverage for those items or services, or (2) include the*

limitations for the individual's ability to receive coverage for those items or services, or [2] include the following general statement:

Except in an emergency, your health plan may require prior authorization (or other limitations) for certain items and services. This means you may need your plan's approval that it will cover an item or service before you get them. If prior authorization is required, ask your health plan about what information is necessary to get coverage.]

[*In the case where this notice is being provided for post-stabilization services by a nonparticipating provider within a participating emergency facility, include the language immediately below and enter a list of any participating providers at the facility that are able to furnish the items or services described in this notice]*

Understanding your options

You can also get the items or services described in this notice from these providers who are in-network with your health plan:

More information about your rights and protections

Visit [*website*] for more information about your rights under federal law.

By signing, I give up my federal consumer protections and agree to pay more for out-of-network care.

With my signature, I am saying that I agree to get the items or services from (select all that apply):

☐ [*doctor's or provider's name*] [*If consent is for multiple doctors or providers, provide a separate check box for each doctor or provider]*

☐ [*facility name*]

With my signature, I acknowledge that I am consenting of my own free will and am not being coerced or pressured. I also understand that:

- I'm giving up some consumer billing protections under federal law.
- I may get a bill for the full charges for these items and services, or have to pay out-of-network cost-sharing under my health plan.
- I was given a written notice on [*enter date of notice*] explaining that my provider or facility isn't in my health plan's network, the estimated cost of services, and what I may owe if I agree to be treated by this provider or facility.
- I got the notice either on paper or electronically, consistent with my choice.
- I fully and completely understand that some or all amounts I pay might not count toward my health plan's deductible or out-of-pocket limit.
- I can end this agreement by notifying the provider or facility in writing before getting services.

IMPORTANT: You **don't** have to sign this form. But if you don't sign, this provider or facility might not treat you. You can choose to get care from a provider or facility in your health plan's network.

_____ or	_____
Patient's signature	Guardian/authorized representative's signature
_____	_____
Print name of patient	Print name of guardian/authorized representative
_____	_____
Date and time of signature	Date and time of signature

Take a picture and/or keep a copy of this form

Take a picture and/or keep a copy of this form.

It contains important information about your rights and protections.

Frequently Asked Questions

Create Child Content

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What is Surprise Billing?
When a member receives a balance bill from an Out of Network provider and the member thought the service(s) would be paid In Network.

When is the CAA Surprise Billing Federal mandate effective?
On December 27, 2020, the President signed legislation called Consolidated Appropriations Act (CAA) which includes numerous provisions, and the majority will become effective on January 1, 2022.

What is the No Surprises Act (NSA)?
The No Surprises Act (NSA) applies to all types of employer plans, including self-funded employers as well as health insurance issuers in the individual and group markets. Specifically, the NSA:

- Provides for patients to be responsible for only in-network cost sharing amounts, including deductibles, in emergency situations, non-emergency situations where patients receive services by an out-of-network provider at an in-network facility and air ambulance services.
- Prohibits providers from balance billing except in limited circumstances with patient notice and consent obtained by certain types of providers.
- Provides access to an independent dispute resolution (IDR) process for providers and plans who cannot reach an agreement on payment after a 30-day negotiation period.
- Includes Provisions in the bill that provide exceptions to OB/GYN Services as well as child beneficiaries to an in-network pediatrician.

What are some types of Surprise Bills under the Federal mandate?
Out of Network Emergency Services (including Air Ambulance) - impacts both Facility and Professional claims in either the inpatient or outpatient setting.

Out of Network Non-Emergency Services if performed in a participating facility as indicated below:

- Anesthesiologists
- Radiologists
- Pathologists
- Assistant Surgeons
- Surgeons (where a prior patient consent form Advanced Patient Notification/Patient Consent was not obtained)

What plans are in scope for this Mandate?
For most scenarios Fully Insured will be covered under the state mandates whereas ASO will be covered under the Federal laws.

Does this apply AEG (Associate Empowerment Guidelines)?
No, this mandate does not apply to AEG.

How do I determine if state and Federal mandates apply?
The claim, member EOB and provider remit will indicate if it falls under the Federal Surprise Billing mandate.

Here is an example of an EOB with the **AUQ** reason code and explanation "*Following federal surprise billing laws, we paid the doctor/facility based on the member's benefits when they receive care in their plan's network. The member is only responsible for their copay, percentage of the cost (coinsurance), and deductible. The doctor/facility can't bill the member for more´*

×000321040200×

Claims Details

Are you concerned about healthcare fraud? Learn more at **fighthealthcarefraud.com**

Mei Goldsborough **Claim Number:** SI21328AA0001 **Received:** 11/24/21 **Hospital:** SALTANAT MEDICAL LLC (Not in your plan)

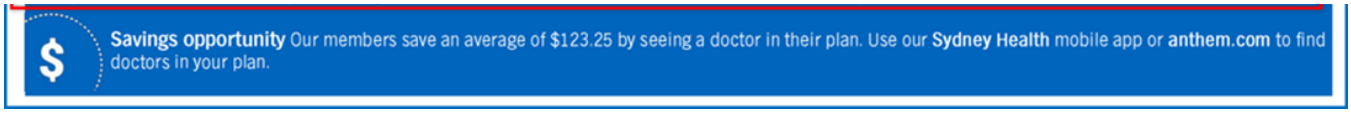
This hospital isn't in Pathway X Tiered Hospital plan's network. If your plan has out-of-network benefits, we'll pay as much as your plan allows.

You pay $77.98. Here's how it breaks down.

Service date	Service	Reason code*	Hospital charges	- Your discounts	= Due to your hospital (max allowed)	- Anthem paid	+ Copay	+ Deductible	+ Your share of the cost (coinsurance)	+ Services not covered	Your total cost
11/10/21	Lab Pathology	AUQ	335.00	310.87	24.13	6.21	0.00	0.00	17.92	0.00	=17.92
11/10/21	Lab Pathology	AUQ	236.00	206.13	29.87	0.00	0.00	0.00	29.87	0.00	=29.87
11/10/21	Lab Pathology	AUQ	68.00	54.60	13.40	0.00	0.00	0.00	13.40	0.00	=13.40
11/10/21	Lab Pathology	AUQ	105.00	88.21	16.79	0.00	0.00	0.00	16.79	0.00	=16.79
Totals:			744.00	659.81	84.19	6.21	0.00	0.00	77.98	0.00	=$77.98

*All care included in this claim falls under federal surprise billing laws. The member is only responsible for their copay, percentage of the cost (coinsurance), and deductible. The doctor/facility can't bill the member for more.

*AUQ: Following federal surprise billing laws, we paid the doctor/facility based on the member's benefits when they receive care in their plan's network. The member is only responsible for their copay, percentage of the cost (coinsurance), and deductible. The doctor/facility can't bill the member for more.



What if the provider is not satisfied with the QPA/Allowable?
If it is under the Federal mandate the provider may dispute that with Anthem.

There are 3 options:

- They can Dispute through Availity
- They can mail a Dispute Form or Request for Negotiation to the Anthem Independent Dispute Resolution team in the Anthem state where they file claims or to the PO Box 105187, Atlanta GA, 30348 address; or
- They can email a Dispute Form or Request for Negotiation to the Anthem Independent Dispute Resolution team at FederalIDRIntake@anthem.com. If it falls under the state mandate, see the related article" Surprise Bill Mandate Guide – QST Selection by state.

Why was my claim adjusted?
If it is determined that provider should receive additional payment, then the claim will be adjusted to reflect the new allowable rate.

What should you do if the member was balance billed or were charged more than the member's responsibility per the EOB?
Review the claim to determine if it meets the Federal or State Balance Billing guidelines. If the claim meets guidelines, ask the member if they signed a Patient Consent form. If the member doesn't know or did not, contact the provider's office. If the member did not sign a patient consent form, inform the provider that this claim falls under the Federal mandate and you will be sending the claim for adjustment to remove the member balance billed amount.

How can I tell if a member is protected from being balance billed?
If the claim indicates that it falls under the Mandate and the patient has not signed a patient consent form. The member will receive an explanation of benefits (EOB) that gives a reason code **AUQ** advising that the claim falls under the Federal surprise billing laws. The EOB will also have the amount the member is responsible to pay the provider.

**All care included in this claim falls under the Federal surprise billing laws. The member is only responsible for their copay, percentage of the cost (coinsurance), and deductible. The doctor/facility can't bill the member for more.*

**AUQ: Following Federal surprise billing laws, we paid the doctor/facility based on the member's benefits when they receive care in their plan's network. The member is only responsible for their copay, percentage of the cost (coinsurance), and deductible. The doctor/facility can't bill the member for more.*

Related Links

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Related Links

Related Links

CMS.gov no surprises

CAA Surprise Bill – Federal Mandate

Surprise Bill Mandate Guide - Selection by state.

CAA Surprise Billing Federal Mandate – FAQs