Decision Tree: Patient-Provider Dispute Resolution Process

Introduction

Beginning January 1, 2022, the No Surprises Act requires health care providers[1] and facilities to provide an estimate of expected charges to:

- Consumers who do not have health coverage or those who lack coverage for a particular item or service; and
- Consumers who have certain types of health coverage[2] but do not intend to use it (also known as "self-pay" individuals).

This estimate of charges is known as a "good faith estimate" and must be provided when such consumers schedule a service at least 3 business days in advance or request an estimate. If the actual billed charges from a provider or facility for a health care item or service are $400 or more above the good faith estimate from that provider or facility, the consumer may challenge the bill using the patient-provider dispute resolution process. Learn more about the dispute resolution process, including who may use it and what information or documents are needed to start a dispute. Consumers in any state can use the federal patient-provider dispute resolution process.

Once an individual without health insurance or a "self-pay" individual receives a good faith estimate, this decision tree lays out how to determine if the individual is eligible to use the patient-provider dispute resolution process and what steps to take in the process.

This decision tree is meant to be paired with the Decision Tree: Requirements for Good Faith Estimates for Uninsured (or Self-Pay) Individuals.

Please refer to the No Surprises Act Consumer Advocate Toolkit: Glossary for definitions of terms.

Where can I go for help?

Contact the No Surprises Help Desk at 1-800-985-3059 or email FederalPPDRQuestions@cms.hhs.gov. 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 questions on the patient-provider dispute resolution process. To see if your state has a CAP, please visit this state listing.

[1] Throughout this document, the term "providers" also includes providers of air ambulance services.
[2] Generally, this includes health coverage subject to the No Surprises Act protections.

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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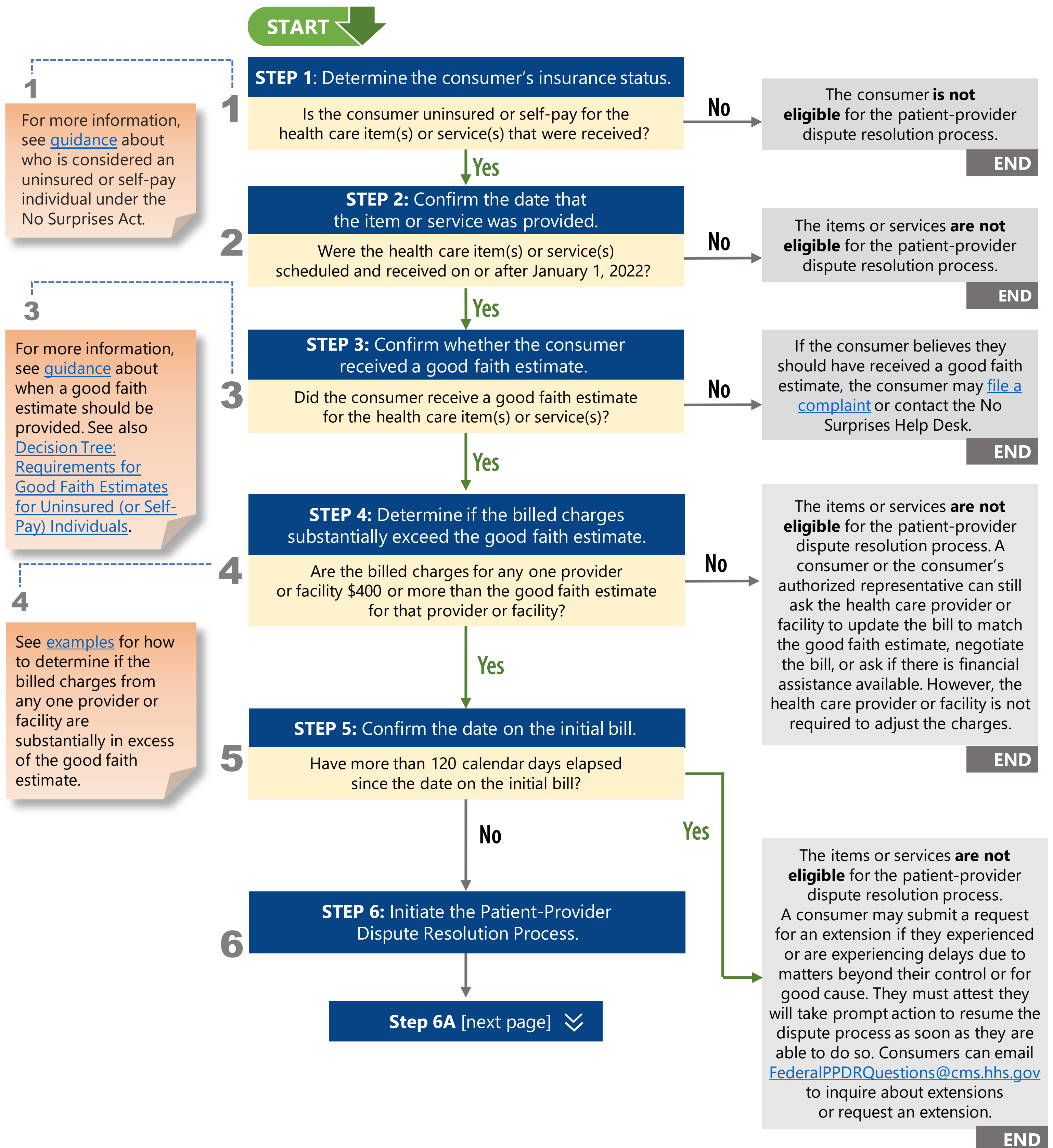
Determine if the Consumer is Eligible for the Patient-Provider Dispute Resolution Process



Decision Tree: Patient-Provider Dispute Resolution Process

The Steps of the Patient-Provider Dispute Resolution Process

6a

STEP 6a: Initiate the patient-provider dispute resolution process.

The consumer or their authorized representative can start the dispute resolution process by submitting a Patient-Provider Dispute Resolution Initiation Form and other relevant information to the Department of Health and Human Services (HHS). The notice can be submitted through the online federal Independent Dispute Resolution portal or by mail. **HHS strongly recommends that the initiation notice be submitted through the online portal to help ensure efficient processing**.

The Patient-Provider Dispute Resolution Initiation Form must be submitted electronically or postmarked within 120 calendar days of the date on the initial bill. If the form cannot be submitted via the online portal, download a copy of the Patient-Provider Dispute Resolution Initiation Form and mail it to:

C2C Innovative Solutions Inc., Patient-Provider Dispute Resolution

P.O. Box 45105 | Jacksonville, FL 32232-5105

6b

STEP 6b: Pay the administrative fee to the selected dispute resolution entity.

HHS will select a dispute resolution entity to handle the dispute. The consumer must pay a $25 administrative fee to the selected dispute resolution entity. The administrative fee can be submitted electronically or via mail to the selected dispute resolution entity. The consumer can submit payment in the form of a money order, cashier's check, or electronic third-party payment as specified by the selected dispute resolution entity (such as credit card, debit card, or payment apps). Cash and personal checks are not acceptable forms of payment.

6b

If the selected dispute resolution entity decides that the consumer should pay anything less than the billed charge, the $25 administrative fee will be subtracted from the final amount the dispute resolution entity determines is due to the provider or facility.

6c

STEP 6c: If necessary, provide additional information to the selected dispute resolution entity.

The selected dispute resolution entity will review the dispute resolution initiation form to see if the consumer is eligible to use the patient-provider dispute resolution process. The dispute resolution entity will reach out to the consumer if more information is needed. The consumer or their authorized representative must respond to a request for additional information with the requested information **within 21 calendar days**.

6d

STEP 6d: Determine if the consumer has a conflict of interest with the selected dispute resolution entity.

Once the selected dispute resolution entity determines the consumer is eligible to use the dispute resolution process, it will notify the consumer and the health care provider or facility. If the consumer has a conflict of interest with the selected dispute resolution entity, they can give notice of the conflict when the dispute resolution entity first contacts them. For example, the consumer may be a family member of an employee who works for the entity, and that relationship could prevent the entity from reviewing the case fairly.

If any party (the consumer or the provider or facility) has a conflict of interest with the selected dispute resolution entity, HHS will step in. HHS will select a different dispute resolution entity or otherwise resolve the conflict of interest.

6d

For more information about conflicts of interest, see the regulations: Requirements Related to Surprise Billing: Part II.

6e

STEP 6e: If applicable, pay any balance due to the provider or facility.

Within **30 business days** of receiving information requested from the provider or facility, the selected dispute resolution entity will decide the final payment amount. The dispute resolution entity will notify the consumer and the provider or facility of its decision and whether the consumer owes a balance.

END

Frequently Asked Questions

1. What documents are required to initiate the patient-provider dispute resolution process?

There is a $25 fee to start the dispute process.

The following information is requested to complete the Patient-Provider Dispute Resolution Initiation Form:

- Consumer information
- Details of the dispute
- Provider or facility information (if not included in the good faith estimate): name, email address, phone number, and mailing address
- State where the service was provided
- A copy of the good faith estimate for the item or service to be disputed
- A copy of the bill from the health care provider or facility that is to be disputed
- The last 4 digits of the account number on the bill
- If filing the dispute by mail or fax, the completed Patient-Provider Dispute Resolution Initiation Form (en español).

Most of the information required to complete the form can be found on bills from the provider or facility. If the consumer needs this information, they should contact their provider or facility.

2. What can the consumer expect once they initiate the dispute resolution process?

Generally:

- HHS will select an independent party, called a selected dispute resolution entity, to handle the dispute.
- The selected dispute resolution entity must notify HHS if it has a conflict of interest within 3 business days following selection. Either party may also attest that it has a conflict of interest with the selected dispute resolution entity. If so, the selected dispute resolution entity must notify HHS within 3 business days of receiving the attestation.
- The selected dispute resolution entity will follow up with the consumer if the Patient-Provider Dispute Resolution Initiation Form is incomplete, if the entity needs more information, or if the item or service is not eligible for dispute resolution. The consumer will have 21 calendar days to submit any requested information.
- The selected dispute resolution entity requests information from the provider or facility. A provider or facility must submit required information to the selected dispute resolution entity within *10 business days* of receiving the entity's selection notice.
- Once the dispute resolution entity receives this information, they have 30 business days to decide the amount that the consumer must pay.

3. What are the consumer protections during the dispute resolution process?

While the dispute resolution process is pending, the provider or facility cannot threaten to take any action against the consumer. The provider or facility cannot move the bill for the disputed item or service into collections nor threaten to do so. If the bill is already in collections, the provider or facility must pause this action. The provider or facility cannot collect any late fees on unpaid bills until the dispute process has ended. If the consumer is having an issue with debt collection, they can submit a complaint with the Consumer Financial Protection Bureau by calling (855) 411-CFPB (2372).

Frequently Asked Questions

4. What decision can the selected dispute resolution entity make regarding the dispute?

The selected dispute resolution entity must decide the final payment amount for each item or service. The following rules apply:

For any item or service that appears on the good faith estimate:

- If the billed charge for an item or service is less than or equal to the expected charge, the amount to be paid is the billed charge.
- If the billed charge for an item or service is greater than the expected charge and the provider or facility did not provide credible information to justify[3] the charges, the amount to be paid is the expected charge.
- If the billed charge for an item or service is greater than the expected charge and credible information is provided to justify the charges, the amount to be paid is the lesser of:
    - The billed charge, or
    - The median payment amount paid by a plan, issuer, or Federal Employee Health Benefits carrier for the same or similar service by a same or similar provider in the geographic area where services were provided that is reflected in an independent database. If the amount in the database is less than the expected charge reflected on the good faith estimate for the item or service, the amount to be paid is the expected charge.

For an item or service that does not appear on the good faith estimate:

- If the provider or facility does not provide credible information to justify the charges, the amount to be paid will be equal to $0.
- If the provider or facility does provide credible information to justify the charges, the amount to be paid will be the lesser of:
    - The billed charge, or
    - The median payment amount paid by a plan, issuer, or Federal Employee Health Benefits carrier for the same or similar service, by a same or similar provider in the geographic area that is reflected in an independent database.

Note: Some consumers may receive abbreviated good faith estimates, which do not list any items and services. These estimates can be furnished in instances where providers and facilities expect to provide care at no cost to a consumer. HHS guidance strongly encourages selected dispute resolution entities to take into account that the provider indicated they did not intend to bill the consumer for any items or services.

The selected dispute resolution entity will inform both parties of the decision as soon as feasible.

5. What happens if the consumer and the provider come to a payment agreement before the dispute process ends?

The consumer and the provider or facility can settle the dispute and agree on a payment amount any time before the dispute resolution entity notifies the parties of a final determination. For example, the provider or facility can offer financial assistance or let the consumer pay a lower amount. The consumer can also agree to pay the billed charges in full.

If the consumer and the provider or facility agree on a payment amount, the bill must be reduced by at least $12.50 (half of the administrative fee). The provider also must notify the dispute resolution entity that a settlement has been reached.

[3] In this context, a charge is justified if the provider or facility provides credible information that the difference between the billed charge and the expected charge for the item or service in the good faith estimate reflects the costs of a medically necessary item or service and is based on unforeseen circumstances that could not have reasonably been anticipated by the provider or facility when the good faith estimate was provided.

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