

Surprise Billing and External Arbitration

What types of claims are eligible for the negotiation and arbitration process outlined in section 376.690, RSMo?

Claims for *unanticipated out-of-network care* arising out of a situation involving *emergency care* are eligible for the negotiation and arbitration process outlined in section 376.690. *Unanticipated out-of-network care* is health care services a patient receives at a facility that is in-network, from a health care professional who is out of network. This definition applies to all services performed from the time the patient presents with an emergency medical condition until the time the patient is discharged.

Does the patient have to participate in the negotiation and arbitration process?

No, the patient can't be required to participate in the process. Furthermore, if the health care professional takes part in the negotiation and arbitration process, he or she cannot balance bill the patient. "Balance billing" is a practice where an out-of-network provider sends a bill to the patient for the difference between the reimbursement rate paid by the health carrier and the health care professional's billed charges.

As a health care professional, how do I get my claim for services to the health carrier?

Health care professionals are required to send claims for charges incurred for unanticipated out-of-network services to the patient's health carrier within 180 days of the date of service.

What is the negotiation period?

A health carrier must offer to pay the health care professional a reasonable reimbursement amount, based on the health care professional's services. Once the health carrier makes an offer of reimbursement and the health care professional declines the initial offer of reimbursement, the parties have 60 days from the date of the initial offer to negotiate in good faith.

What if the health care professional and health carrier don't reach an agreement?

If the health care professional and health carrier don't reach an agreement during the 60 day negotiation period, the dispute must be resolved through arbitration.

How do the health care professional and health carrier start arbitration proceedings?

Either the health carrier or the health care professional can start the arbitration proceedings by notifying the Director and the other party in writing within 120 days of

the end of the negotiation period. They must provide information to the Director about the billed amount and the date and amount of the last offer for each party.

Is the outcome of the arbitration binding?

Yes, the arbitrator's decision is binding on all parties.

How does the arbitrator decide on the amount of reimbursement?

The arbitrator must take several factors into consideration, including the health care professional's training, education, and experience; the nature of the service provided; the usual and customary charge for comparable services; the circumstances and complexity of the particular case; and the average contracted rate for the service in the area. The dollar amount the arbitrator determines is due for the service provided must be between 120% of the Medicare allowed amount and the 70th percentile of the usual and customary rate for the care, as determined by benchmarks from independent nonprofit organizations not affiliated with health carriers or health care professionals.