SURPRISE BILLING
CROSSWALK OF FEDERAL AND GEORGIA LAW

Georgia patients are protected from surprise medical bills under both the state ***Surprise Billing and Consumer Protection Act***, which became effective Jan. 1, 2021, and the federal ***No Surprises Act***, which became effective Jan. 1, 2022. Many provisions of these laws overlap. This Crosswalk contains summaries of the state and federal law and is meant to help identify the differences between the two laws. It is for informational purposes only and is not legal advice. GHA recommends hospitals review the complete **state** and **federal** regulations as well as **additional guidance and sample forms** from the Centers for Medicare and Medicaid Services (CMS). Please consult with your legal counsel for any specific questions about the information contained herein.

	GEORGIA LAW	FEDERAL LAW	NOTES
EMERGENCY SERVICES			
Definitions	**Prudent Layperson Standard** **Emergency Medical Services** – medical services rendered *after the recent onset* of a medical or traumatic condition, sickness, or injury exhibiting acute symptoms of sufficient severity, including, but not limited to, severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that his or her condition, sickness, or injury is of such a nature that failure to obtain immediate medical care could result in: (a) placing the patient's health in serious jeopardy; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part. (Ga. Comp. R. & Reg. 120-2-106-.03(5))	**Prudent Layperson Standard** **Emergency Medical Condition** – a medical condition, *including a mental health or substance use disorder*, manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition that places the health of the individual *(or in the case of a pregnant woman, the health of the woman or her unborn child)* in serious jeopardy, causes serious impairment to bodily functions, or causes serious dysfunction of any bodily organ or part. (29 CFR 2590.716-4(c)(1))[1] *Plans cannot limit what constitutes an emergency medical condition solely on the basis of diagnosis codes*. (29 CFR 2590.716-4(b)(4))	Both laws use the prudent layperson standard, but the federal definition is broader. The Georgia definition requires the condition to be of recent onset. The federal definition specifically includes mental health or substance use disorders, not just medical conditions, and injuries to an unborn child. The federal definition also includes post-stabilization care. The differences in definitions make it unclear when the state or federal law applies.

[1] The federal surprise billing regulations are spread out across multiple sections of the Code of Federal Regulations, including 5 CFR 890, 26 CFR 54, 29 CFR 2590, 45 CFR 144, 45 CFR 147, 45 CFR 149, and 45 CFR 156. Many of these sections contain the same, or nearly identical requirements, but apply the regulations to different types of health insurers. For ease of reference, this Crosswalk only cites to one version of the applicable regulations.

	GEORGIA LAW	FEDERAL LAW	NOTES
Definitions (cont.)		**Emergency Services** – (i) an appropriate medical screening exam as required under EMTALA, (ii) such other medical treatment within the capabilities of the staff and facilities available at the hospital as required under EMTALA to stabilize the patient regardless of the department of the hospital in which such further examination or treatment is furnished, and (iii) *items and services covered by the patient's health plan furnished (regardless of the department of the hospital in which such items or services are furnished) after the patient is stabilized and as part of outpatient observation or an inpatient or outpatient stay with respect to the initial emergency visit*. (29 CFR 2590.716-4(c)(2))	
Prior Authorization	Insurers shall pay for covered emergency medical services for covered persons without prior authorization and *without retrospective denial for emergency medical services deemed to be medically necessary*. (Ga. Comp. R. & Reg. 120-2-106-.05(1))	Coverage for emergency services must be provided without the need for any prior authorization determination, even if the services are provided on an out-of-network basis. (29 CFR 2590.716-4(c)(2))	Both federal and state law prohibit prior authorization requirements for out-of-network emergency services. Georgia law also prohibits retrospective denials for medically necessary services, which means that there cannot be technical denials for billing errors.

Patient Cost-Sharing for Out-of-Network Services	If a covered person receives emergency medical services from a non-participating provider, such person shall not be liable to the non-participating provider or facility for any amount exceeding the person's deductible, coinsurance, copayment, or other cost-sharing amount as determined by such person's policy. (Ga. Comp. R. & Reg. 120-2-106-.05(2)) Emergency medical services received from non-participating providers and/or facilities shall count toward the deductible and any maximum out of pocket policy provisions as if the services were obtained from a participating provider. (Ga. Comp. R. & Reg. 120-2-106-.05(4)) In cases of emergency medical services received from a non-participating facility, the facility shall bill the covered person no more than deductible, coinsurance, copayment, or other cost-sharing as determined by such person's policy. (Ga. Comp. R. & Reg. 120-2-106-.05(5))	If emergency services are provided by a nonparticipating provider or nonparticipating facility, coverage for such services must be provided: -without imposing cost-sharing requirements that are greater than the requirements that would apply if the services were provided by a participating provider or a participating emergency facility. (29 CFR 2590.716-4(b)(3)(ii)) -by counting any cost-sharing payments made by the participant or beneficiary with respect to the emergency services toward any in-network deductible or in-network out-of-pocket maximums in the same manner as if the cost-sharing payments were made with respect to emergency services furnished by participating provider or a participating emergency facility. (29 CFR 2590.716-4(b)(3)(v)) *Patient cost-sharing calculating using the "recognized amount."* (29 CFR 2590.716-4(b)(iii)). The recognized amount is defined as (i) the state law (where applicable) or (ii) the lesser of the qualifying payment amount (QPA) or the amount billed by the nonparticipating provider or facility. (29 CFR 2590.716-3)	Federal law (the QPA) will apply to any self-funded Employee Retirement Income Security Act (ERISA) plans that do not opt-in to Georgia's law. For all other health plans, the federal law defers to state law to define the "recognized amount." For nonparticipating providers, the recognized amount under Georgia law is the greater of: (a) the verifiable median contracted amount paid by all eligible insurers for similar services calculated by a vendor utilized and chosen by the Commissioner of the Georgia Office of the Insurance and Safety Fire Commissioner (OCI Commissioner); (b) the most recent verifiable amount agreed to by the insurer and the non-participating emergency medical provider for the same services during which time the provider was in-network with the insurer (if applicable); or (c) a higher amount as the insurer may deem appropriate given the complexity and circumstances of the services provided. The recognized amount for nonparticipating providers may also be the amount established under Georgia's arbitration process if the provider is not satisfied with the payment received. For nonparticipating emergency facilities, the recognized amount is the amount received from the insurer or the amount established under Georgia's arbitration process if the provider is not satisfied with the payment received. There is not a formula under Georgia law to establish the cost-sharing amount while the facility and the insurer are negotiating payment or participating in the arbitration process.

Out-of-Network Provider Reimbursement Rates	*The amount payable by an insurer for emergency medical services paid directly to the provider shall be the greater of:* *(a) The verifiable median contracted amount paid by all eligible insurers for similar services calculated by a vendor utilized and chosen by the OCI Commissioner;* *(b) The most recent verifiable amount agreed to by the insurer and the nonparticipating emergency medical provider for the same services during which time the provider was in-network with the insurer; (if applicable)* *(c) A higher amount as the insurer may deem appropriate given the complexity and circumstances of the services provided*. (Ga. Comp. R. & Reg. 120-2-106-.05(2)) No defined amount of initial payment for hospitals. Payments are subject to arbitration. (Ga. Comp. R. & Reg. 120-2-106-.10(1))	No defined amount of initial payment for individual providers or emergency facilities. (Federal Independent Dispute Resolution (IDR) regulations not yet promulgated.) If the recognized amount is calculated using state law, then the state law also applies for purposes of initial payment. (29 CFR 2590.716-4(b)(3)(iv))	Payments are subject to either the Georgia or federal IDR process depending on the services provided, the type of health plan, and whether the plan has opted-in to the Georgia law.
Balance Billing	Covered persons are not liable to non-participating providers or non-participating facilities for any amount exceeding such person's cost-sharing requirement. (Ga. Comp. R. & Reg. 120-2-106-.05(2))	Nonparticipating providers and nonparticipating emergency facilities are prohibited from balance billing for a payment amount for emergency services that exceeds the cost-sharing requirement for such services. (45 CFR 149.410(a))	Both federal and state law prohibit balance billing for emergency services provided by nonparticipating providers and facilities.
NON-EMERGENCY SERVICES			
Applicable Services	Non-emergency services provided by an out-of-network provider at an in-network facility *(hospital, ASC, birthing center, diagnostic and treatment center, hospice, or other similar institution*). (Ga. Comp. R. & Reg. 120-2-106-.06)	Non-emergency services provided by a nonparticipating provider at a participating hospital or ASC. (29 CFR 2590.716-5(b))	The Georgia law applies to a broader list of facilities.
Patient Choice – Notice and Consent	Patient choice exception for services scheduled in advance that will be provided by an out-of-network healthcare provider(s) in an in-network facility if:	Patient choice exception for nonemergency services provided by a nonparticipating provider at a	The notice and consent requirements in the federal law are much more prescriptive than Georgia law. CMS published a model notice and consent

Patient Choice – Notice and Consent (cont.)	(a) provide an estimate of potential charges, and (b) the covered person must give oral and written consent in advance of the provision of such services. (Ga. Comp. R. & Reg. 120-2-106-.08) If during the provision of non-emergency medical services, a patient requests the provider refer the patient to another provider for the immediate provision of additional non-emergency medical services, an estimate of potential charges is not required as long as: (a) The referring provider advises the patient that the referred provider may be a non-participating provider and may charge higher fees than a participating provider; (b) The patient orally and in writing acknowledges that he or she is aware that the referred provider may be a non-participating provider and may charger higher fees than a participating provider; (c) The written acknowledgement shall be on a document separate from other documents provided by the referring provider and shall include language to be determined by the OCI Commissioner; and (d) The referring provider records the satisfaction of the requirements in the patient's medical file. (Ga. Comp. R. & Reg. 120-2-106-.08(3))	participating facility if the provider (or a participating facility on behalf of a nonparticipating provider): (a) provides written notice in accordance with the regulations *within 72 hours of the time service is scheduled* (or at the time the appointment is made if less than 72 hours, but *can't be less than 3 hours before the services are provided*) -statement that the healthcare provider is nonparticipating -good faith estimate of charges -*statement that prior authorization or other care management may be required in advance* -*consent is optional and the patient may seek care from a participating provider in which case cost-sharing would not exceed plan limits* (b) obtains consent from the patient *in the form required by the regulations*. (45 CFR 149.420 (c) – (e)). *This exception does not apply to "ancillary services":* *(a) Items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a physician or non-physician practitioner;* *(b) Items and services provided by assistant surgeons, hospitalists, and intensivists;* *(c) Diagnostic services, including radiology and lab services; and* *(d) Items and services provided by a nonparticipating provider if there is no participating provider who can furnish such item or service at such facility*. (45 CFR 149.420(b))	document. The Georgia Office of the Insurance and Safety Fire Commissioner (OCI) is supposed to publish a notice and consent document also but has not done so yet. Hospitals could use the federal document for both. The federal law provides a much narrower patient choice exception from the prohibition on balance billing and it is unclear how the federal law and the state law interact here (*i.e.*, it is unclear whether federal law preempts Georgia law because the federal law is more restrictive).

Patient Cost-Sharing for Out-of-Network Services	In the event a patient receives non-emergency medical services from a non-participating provider in a participating facility, the non-participating provider shall collect or bill the patient no more than such patient's deductible, coinsurance, copayment, or other cost-sharing amount as determined by such patient's policy. (Ga. Comp. R. & Reg. 120-2-106-.06(2)) Non-emergency medical services received from non-participating providers in a participating facility shall count toward the deductible and any maximum out-of-pocket policy provisions as if the services were obtained from a participating provider. (Ga. Comp. R. & Reg. 120-2-106-.06(3))	For nonemergency services provided by a nonparticipating provider in a participating facility, a plan: -must not impose a cost-sharing requirement greater than the cost-sharing requirement that would apply if the items and services had been furnished by a participating provider. (29 CFR 2590.716-5(c)(1)) -*must calculate the cost-sharing requirements as if the total amount that would have been charged for the items and services were equal to the recognized amount*. (29 CFR 2590.716-5(c)(2)). -must count any cost-sharing payments made by the patient toward any in-network deductible and in-network out-of-pocket maximums in the same manner as if such cost-sharing payments were made with respect to items and services furnished by a participating provider. (29 CFR 2590.716-5(c)(5)) The recognized amount is defined as (i) the state law (where applicable) or (ii) the lesser of the qualifying payment amount (QPA) or the amount billed by the nonparticipating provider or facility. (29 CFR 2590.716-3)	Federal law (the QPA) will apply to any self-funded ERISA plans that do not opt-in to Georgia's law. For all other health plans, the federal law defers to state law to calculate the "recognized amount." For nonparticipating providers the recognized amount under Georgia law is the greater of: (a) the verifiable median contracted amount paid by all eligible insurers for similar services calculated by a vendor utilized and chosen by the OCI Commissioner; (b) the most recent verifiable amount agreed to by the insurer and the non-participating emergency medical provider for the same services during which time the provider was in-network with the insurer (if applicable); or (c) a higher amount as the insurer may deem appropriate given the complexity and circumstances of the services provided. Ga. Comp. R. & Reg. 120-2-106-.06(2). The recognized amount for nonparticipating providers may also be the amount established under Georgia's arbitration process if the provider is not happy with the payment received.
Out-of-Network Provider Reimbursement Rates	*For non-emergency medical services furnished by a non-participating provider in a participating facility, the insurer shall directly pay the non-participating provider the greater of:* *(a) The verifiable median contracted amount paid by all eligible insurers for similar services calculated by a vendor utilized and chosen by the OCI Commissioner;* *(b) The most recent verifiable amount agreed to by the insurer and the nonparticipating emergency*	No defined amount of initial payment. (Federal IDR regulations not yet promulgated.)	Payments will be subject to either the Georgia or federal IDR process depending on the type of plan and whether the plan has opted-in to Georgia law.

Out-of-Network Provider Reimbursement Rates (cont.)	*medical provider for the same services during which time the provider was in-network with the insurer; (if applicable)* *(c) A higher amount as the insurer may deem appropriate given the complexity and circumstances of the services provided*. (Ga. Comp. R. & Reg. 120-2-106-.06(2))		
PROMPT PAYMENT	Insurer payments for emergency services made to non-participating providers and non-participating facilities and for non-emergency services furnished by non-participating providers in participating facilities shall be in accord with prompt payment requirements under O.C.G.A. § 33-24-59.14. Notification should reflect whether coverage is subject to the exclusive jurisdiction of ERISA. (Ga. Comp. R. & Reg. 120-2-106-.05(6) and .06(5)) O.C.G.A. § 33-24-59.14 requires payment in *15 working days for electronic claims* or 30 calendar days for paper claims.	For emergency services provided by a nonparticipating provider or a nonparticipating facility or for nonemergency services provided by a nonparticipating provider in a participating facility, a plan must send an initial payment or denial notice to the nonparticipating provider or facility not later than 30 calendar days after the bill for services is transmitted by the provider or facility. (29 CFR 2590.716-4(b)(3)(iv) and .716-5(c)(3))	Federal law defers to state law for prompt payment requirements if the recognized amount is also determined by state law. Georgia's shorter 15-day prompt pay requirement will apply except in cases where self-funded ERISA plans have not opted-in to the state law.

STATE LAW OPT-IN			
Plan Option	Self-funded health plans may elect to participate in and be bound by Georgia's *Surprise Billing Consumer Protection Act* beginning Jan. 1 or the first day of the plan's plan year. A plan must indicate whether it will auto renew its participation with an option to terminate upon 30-days' notice prior to the end of the year or plan year. (O.C.G.A. § 33-20F-2)	A group health plan that opts into a specified state law must do so for all items and services to which the specified state law applies and in a manner determined by applicable state authority. (29 CFR 2590.716-3)	Under Georgia law, plans may have to make a decision about whether to opt-in for plan year 2022 before the federal IDR regulations are published.
Notification	OCI will *post a list of plans that have opted-in to state law*. (O.C.G.A. § 33-20F-3)	A group health plan that opts into a specified state law *must prominently display in its plan materials describing the coverage of out-of-network services a statement that the plan has opted into the specified state law, identify the relevant state (or states), and include a general description of the items or services provided by nonparticipating facilities and providers that are covered by the specified state law*. (29 CFR 2590.716-3)	
DISCLOSURE REQUIREMENTS			
Information to be Disclosed	**N/A**	Providers and facilities must disclose: (a) A statement that explains the requirements of and prohibitions applicable to the provider or facility; (b) A statement that explains any state law requirements regarding amounts such provider or facility may, with respect to an item or service, charge an out-of-network patient, after receiving payment, if any, from the health plan and any cost-sharing payment from the patient; and (c) A statement providing contact information for the appropriate state and federal agencies that an individual may contact if the individual believes the provider or facility has violated a requirement described in the notice. (45 CFR 149.430(b))	Since there are no corresponding disclosure requirements under Georgia law, federal law will apply.

Methods and Timing	**N/A**	The required information or a link to the required information must be posted on a public website, must appear on a searchable homepage of the provider's or facility's website. A sign with the required information must be posted prominently at the location of the provider or facility. (A provider that does not have a location does not have to meet this requirement.) Providers and facilities must provide a one-page (double-sided) notice to insured patients, using print no smaller than 12-point font. The notice must be provided in-person or through mail or email, as selected by the patient. The notice must be provided no later than the date and time the provider or facility requests payment from the patient or if the provider or facility does not request payment from the patient, the date and time when a claim is submitted to the patient's health plan. (45 CFR 149.430(c) and (d))	Since there are no corresponding disclosure requirements under Georgia law, federal law will apply.
GOOD FAITH ESTIMATES			
Identification of Uninsured/ Self-Pay Patients	**N/A**	A provider or facility who is primarily responsible for scheduling a health care service must determine if a patient is an uninsured or self-pay patient. (45 CFR 149.610(b)(1))	Since there are no corresponding requirements under Georgia law, federal law will apply.
Good Faith Estimate	**N/A**	The good faith estimate must include: (a) Patient name and date of birth; (b) Description of the primary item or service in clear and understandable language; (c) Itemized list of items or services, grouped by each provider or facility, reasonably expected to be furnished for the primary item or service, and items or services reasonably expected to be furnished in conjunction with the primary item or service;	Since there are no corresponding requirements to provide good faith estimates under Georgia law, federal law will apply. The U.S. Department of Health and Human Services (HHS) plans to exercise enforcement discretion through Dec. 31, 2022, as it relates to incorporating the good faith estimates from outside providers or facilities and encourages states to do the same.

Good Faith Estimate (cont.)		(d) Applicable diagnosis codes, expected service codes, and expected charges associated with each listed item or service; (e) Nam, NPI, and Tax ID Number of each provider or facility represented in the good faith estimate, and the State(s) and office or facility location(s) where the items or services are expected to be furnished; (f) List of items or services that the primary provider or facility anticipates will require separate scheduling and that are expected to occur before or following the expected period of care for the primary item or service; (g) A disclaimer that informs the patient that there may be additional items or services the primary provider or facility recommends as part of the course of care that must be scheduled or requested separately and are not reflected in the good faith estimate; (h) A disclaimer that informs the patient the information provided in the good faith estimate is only an estimate and actual items, services, or charges may differ from the good faith estimate; and (i) A disclaimer that informs the patient of his or her right to initiate the patient-provider dispute resolution process if the actual billed charges are substantially in excess of the expected charges included in the good faith estimate; and (j) A disclaimer that the good faith estimate is not a contract and does not require the patient to obtain the items or services from any of the providers or facilities identified in the good faith estimate.	

Deadlines	**N/A**	A provider or facility who is primarily responsible for scheduling a health care service and who receives a request for a good faith estimate from an uninsured or self-pay patient must contact, no later than 1 business day, all co-providers and co-facilities who are reasonably expected to provide items or services to the patient and request the other providers and facilities submit good faith estimate information to the primary provider or facility. (45 CFR 149.610(b)(1)) Co-providers and co-facilities must provide the good faith estimate information no later than 1 business day after the request is received from the primary provider or facility. (45 CFR 149.610(1)(c)) When a primary item or service is scheduled at least 3 business days before the date the item or service is scheduled to be furnished, the good faith estimate must be provided not later than 1 business day after the date of the scheduling. When a primary item or service is scheduled at least 10 business days before the date the item or service is scheduled to be furnished, the good faith estimate must be provided not later than 3 business days after the date of scheduling. When a good faith estimate is requested by an uninsured or self-pay patient, the good faith estimate must be provided not later than 3 business days after the date of the request.	Since there are no corresponding requirements to provide good faith estimates under Georgia law, federal law will apply.

Deadlines (cont.)		If a provider or facility anticipates or is notified of any changes to the good faith estimate previously furnished to an uninsured or self-pay patient at the time of scheduling, the provider or facility must provide a new good faith estimate to the patient no later than 1 business day before the items or services are scheduled to be furnished. If any changes in expected providers or facilities represented in a good faith estimate occur less than 1 business day before the item or service is scheduled, the replacement provider or facility must accept as its good faith estimate of expected charges the good faith estimate for the relevant items or services included in the original good faith estimate. For good faith estimates provided to an uninsured or self-pay patient upon request, the provider or facility must provide the patient with a new good faith estimate when the item or service is scheduled within the deadlines above for scheduled items or services. (45 CFR 149.610(b)(1))	
Recurring Items or Services	N/A	The scope of the good faith estimate for recurring primary items or services must not exceed 12 months. If items or services are expected to extend beyond 12 months, the primary provider or facility must provide an uninsured or self-pay patient a new good faith estimate, and communicate any changes. (45 CFR 149.610(b)(1)(x))	Since there are no corresponding requirements to provide good faith estimates under Georgia law, federal law will apply.

ENFORCEMENT/COMPLAINT PROCESS			
Enforcement/Complaints Against Providers and Facilities	Following the resolution of an arbitration, the OCI Commissioner is permitted to refer the decision of the arbitrator to the appropriate state agency or the governing entity with governing authority over such provider or facility if the OCI Commissioner concludes that a provider or facility has either displayed a pattern of acting in violation of the surprise billing requirements or has failed to comply with a lawful order of the OCI Commissioner or the arbitrator. However, if the provider or facility's violations or actions fall under the OCI Commissioner's jurisdiction, the OCI Commissioner may investigate and proceed under his or her own authority. (Ga. Comp. R. & Reg. 120-2-106-.10(11))	HHS receives and resolves complaints regarding information that a health care provider or facility may be failing to meet the surprise billing requirements. Based on the nature of the complaint, HHS may: (a) Refer the complainant to another appropriate federal or state resolution process; (b) Notify the complainant and make reasonable efforts to refer the complainant to the appropriate state or federal regulatory authority if HHS receives a complaint where another entity has enforcement jurisdiction over the health care provider or facility; (c) Refer the health care provider or facility to CMS for an investigation under its enforcement authority for group and individual insurance markets; or (d) Provide the complainant with an explanation of resolution and any corrective action taken. (45 CFR 149.450)	If a complaint is made to HHS and Georgia law applies, HHS will refer the complaint to the Georgia OCI. OCI has not published information on how it will handle complaints if federal law applies.
Enforcement/Complaints Against Insurers and Health Plans	Failure to comply with any insurer requirement in the Surprise Billing Consumer Protection Act, including failure to pay a resolution organization as required is considered an unfair claims settlement practice. (O.C.G.A. § 33-6-34(15)) Following the resolution of arbitration, the OCI Commissioner may refer the decision of the arbitrator to the appropriate state agency or governing entity with governing authority over such provider or facility if the OCI Commissioner concludes that a provider or facility has displayed a pattern of acting in violation of the surprise billing law or has failed to comply with a lawful order of the OCI or the arbitrator. Such a referral shall include a description of such violations and the OCI Commissioner's recommendation for	The U.S. Department of Labor (DOL)/HHS receives and resolves complaints regarding information that a health plan or insurer may be failing to meet the surprise billing requirements. Based on the nature of the complaint, DOL/HHS may: (a) Refer the complainant to another appropriate federal or state resolution process; (b) Notify the complainant and make reasonable efforts to refer the complainant to the appropriate state or federal regulatory authority if HHS receives a complaint where another entity has enforcement jurisdiction over the health plan or insurer; (c) Refer the health plan or insurer for investigation; or	If a complaint is made to DOL/HHS and Georgia law applies, HHS will refer the complaint to the Georgia OCI. OCI has not published information on how it will handle complaints if federal law applies.

Enforcement/Complaints Against Insurers and Health Plans (cont.)	enforcement action. The applicable state agency or governing entity shall initiate an investigation regarding such referral within 30 days of receiving such referral and conclude the investigation withing 90 days of receiving such referral. If the provider's or facility's violations or actions fall under the OCI Commissioner's jurisdiction, the OCI Commissioner may investigate and proceed under its statutory authority. (O.C.G.A. § 33-20E-17 and Ga. Comp. R. & Reg. 120-2-106-.10(11))	(d) Provide the complainant with an explanation of resolution and any corrective action taken. (29 CFR 2590.716-7)	
INDEPENDENT DISPUTE RESOLUTION			
Open Negotiation Period	After a request for arbitration has been made, the parties will be permitted 30 days from the date the request was received to negotiate a settlement. The parties must notify the Administrative Procedure Division of OCI of the result of such negotiations. If the Administrative Procedure Division of OCI has not been notified within 30 days of the settlement negotiation's result, the claim will be sent to arbitration. The parties may still reach a negotiated settlement after the claim is referred to the arbiter but before arbitration begins. (Ga. Comp. R. & Reg. 120-2-106-.10(5))	Open Negotiation is a prerequisite to IDR. A provider or health plan must send a notice within 30-business days after an initial payment or notice of denial is received. Notice must be provided using the standard form and include information sufficient to identify the items and services, an offer of an out-of-network rate, and contact information for the party sending the notice. The Open Negotiation Period lasts 30-business days from the date the notice is sent. (29 CFR 2590.716-8(b)(1))	
Initial IDR Request	If a provider or facility concludes that payment received is not sufficient given the complexity and circumstances of the services provided, they may file a request for arbitration with the OCI Commissioner. A request for arbitration must be submitted within 30 days of receipt of payment for the claim and concurrently provide the insurer with a copy of the request. (Ga. Comp. R. & Reg. 120-2-106-.10(1))	Either party may initiate the IDR process by submitting a written notice of IDR initiation to the other party and to HHS during the 4-business day period beginning on the 31st day after the state of the open negotiation period. The notice of IDR initiation must include: (a) Information sufficient to identify the items or services in dispute, including the date(s) and location(s) the item or service was furnished, the type of items or service, corresponding service codes,	The Georgia law does not apply to uninsured or self-pay patients. Therefore, the federal IDR process will apply in instances where an uninsured or self-pay patient requests disputes resolution. Both state and federal regulations are unclear as to how the various IDR deadlines will apply in situations

Initial IDR Request (cont.)		place of service code, the amount of cost sharing allowed, and the amount of the initial payment made; (b) Names of the parties involved and contact information; (c) State where the item or service was furnished; (d) Commencement date of the open negotiation period; (e) Preferred certified IDR entity; (f) An attestation that the items and services under dispute are subject to the IDR process; (g) Qualifying Payment Amount; (h) Information about the QPA; and (i) General information describing the IDR process. (29 CFR 2590.716-8(b)(2))	where the initial IDR request is made to the state when federal law applies vice versa.
Selection of Arbiter/IDR Entity	A list of approved independent resolution organizations will be kept by the Administrative Procedure Division of OCI and available for review upon request. Upon the OCI Commissioner's referral of a dispute to a resolution organization, the parties will have 5 days to select an arbitrator by mutual agreement. If the parties have not notified the resolution organization of their mutual selection before the 5th day, the resolution organization shall select an arbitrator from among its members. Should the parties not agree to the resolution organization's choice of arbitrator, the OCI Commissioner will select one for the parties, and this decision will be final. (Ga. Comp. R. & Reg. 120-2-106-.10(8))	Party receiving the IDR initiation notice has 3 business days to object to the preferred IDR entity. If the receiving party objects to the preferred IDR entity, it must propose an alternative IDR entity. The initiating party must notify HHS of the selection of an IDR entity as soon as reasonably practicable, but no later than 1 business day after the selection. If the receiving party believes the IDR process is not applicable, it must notify HHS by the same date the notice of IDR selection must be submitted. If the parties do not jointly agree on an IDR entity within 3-business days of the initiation of the IDR process, HHS shall select an IDR entity. The initiating entity must notify HHS no later than 1-business day after the failure to select an IDR entity (4-business days after the IDR initiation). HHS will select an IDR entity through a random selection no later than 6 business days after the initiation of the IDR process. (29 CFR 2590.716-8(c)(1))	

Selection of Arbiter/IDR Entity (cont.)		An uninsured or self-pay patient may initiate the IDR process if the total billed charges by a primary or co-provider or facility are at least $400 more than the total expected charges for that particular provider or facility in the good faith estimate. (45 CFR 149.620)	
IDR Process	Within 30 days of the insurer's receipt of a provider's request for arbitration, the insurer must submit to the Administrative Procedure Division of OCI all data necessary to determine whether the insurer's payment complied with the surprise billing regulations. (Ga. Comp. R. & Reg. 120-2-106-.10(3)) The OCI Commissioner will dismiss specific arbitration requests if the disputed claim is: (a) Related to a health plan that is not regulated by the state; (b) The basis for an action pending in state or federal court at the time of the request for arbitration; (c) Subject to a binding claims resolution process entered into prior to July 1, 2021; (d) Made against a health plan subject to the exclusive jurisdiction of ERISA; or (e) The claim is not considered a surprise bill under the law. If an insurer believes one of the criteria is present that would cause the claim to be dismissed, it should submit the appropriate data to support its contention. Should the OCI Commissioner dismiss a claim as not eligible for arbitration, the provider or facility may request a hearing under the OCI hearing procedures contained in Rule 120-2-2. (Ga. Comp. R. & Reg. 120-2-106-.10(4))	Not later than 10 business days after the selection of the IDR entity, the health plan and the provider must each submit: (a) An offer of an out-of-network rate expressed as both a dollar amount and the corresponding percentage of the QPA represented by the dollar amount; and (b) Information requested by the IDR entity relating to the offer. Providers and facilities must also submit the following, as applicable: (a) Information on the size of the provider's practice or facility; and (b) Information on the practice specialty or type. Health plans must also submit the following, as applicable: (a) Information on the coverage area of the plan or issuer, the relevant geographic region for purposes of the qualifying payment amount, whether the coverage is fully-insured or partially or fully self-insured; and (b) The QPA for the applicable year for the same or similar item or service. Either party may submit any additional information relating to the offers that were submitted by the parties.	

IDR Process (cont.)	The parties shall have 10 days after the selection of the arbitrator to submit in writing to the resolution organization each party's final offer and each party's argument in support of such offer. The parties' initial arguments shall be limited to written form and shall consist of no more than 20 pages per party. The parties may submit documents in support of their arguments. The arbitrator may require the parties to submit such additional written arguments and documentation as the arbitrator determines necessary, but the arbitrator may require such additional filing no more than once. Such additional written argument shall be limited to no more than 10 pages per party. The arbitrator may set filing times and extend such times as appropriate. Failure of either party to submit the supportive documentation described herein may result in a default against such party. (O.C.G.A. § 33-20E-14)	Not later than 30 business days after the selection of the IDR entity, the IDR entity must: (a) Select as the out-of-network rate for the item or service on of the offers submitted. The IDR entity must select the offer closest to the QPA unless the IDR entity determines that credible information submitted by either party clearly demonstrates that the QPA is materially different from the appropriate out-of-network rate, or if the offers are equally distant from the QPA. In these cases, the IDR entity must select the offer that best represents the value of the item or service. (b) Notify the health plan and the provider of the selection of the offer and provide the written decision. (29 CFR 2590.716-8(c)(4)(i) and (ii)) Parties may continue to negotiate during the IDR process. If a settlement agreement is reached prior to the IDR payment determination. The initiating party must notify HHS and the IDR entity as soon as possible, but no later than 3 business days after the date of the agreement. (29 CFR 2590.716-8(c)(2))	
Batching	A request for arbitration may involve a single patient and a single type of healthcare service, a single patient and multiple types of healthcare services, multiple patients and a single type of healthcare service, or multiple substantially similar healthcare services in the same specialty on multiple patients. (O.C.G.A. § 33-20E-9(b))	Batched items and services may be submitted and considered jointly as part of one payment determination by an IDR entity if: (a) The items and services are billed by the same provider or group of providers or the same facility; (b) Payment for the items and services would be made by the same health plan; (c) The items and services are the same or similar items and services, meaning they are billed under the same service code, or a comparable code under a different procedural code system;	

Batching (cont.)		(d) All items and services were furnished within the same 30-business day period or the same 90-calendar day period, as applicable. Items and services billed as part of a bundled payment arrangement or where a health plan denies an initial payment as a bundled payment may be submitted as part of one payment determination. (29 CFR 2590.716-8(c)(3))	
Factors Used in Payment Determination	In deciding a claim, arbitrators shall consider the following factors: (a) The complexity and circumstances of each case, including, but not limited to, the level of training, education and experience of the relevant physicians or other individuals at the facility who are licensed or otherwise authorized in this state to furnish healthcare services; (b) Whether there is a gross disparity between the fee charged by the provider and (i) fees paid to the provider for the same services provided to other patients in health plans in which the provider is non-participating, and (ii) the fees paid by the health plan to reimburse similarly qualified out-of-network providers for the same services in the same region; (c) The provider's training, education, experience, and the usual charge for comparable services when the provider does not participate with the patient's health plan; (d) In the case of a hospital, the teaching status, scope of services, and case-mix; (e) Patient characteristics; and (f) For physician services, the usual and customary cost of the service. (O.C.G.A. § 33-20E-15 and Ga. Comp. R. & Reg. 120-2-106-.10(10))	In determining which offer to select, the IDR entity must consider: (a) The QPA for the applicable year for the same or similar item or service; (b) Information requested by the IDR entity; (c) Additional information submitted by a party that clearly demonstrates the QPA is materially different from the appropriate out-of-network rate, provided the information is credible and relates to: (i) The level of training, experience, and quality and outcomes measurements of the provider that furnished the item or service. (ii) The market share held by the provider or the health plan in the geographic region in which the item or service was provided. (iii) The acuity of the patient receiving the item or service or the complexity of furnishing the item or service to the patient. (iv) The teaching status, case mix and scope of services of the facility that furnished the item or service. (v) Demonstration of good faith efforts (or lack thereof) made by the provider or the health plan to entire into network agreements with each other, and, if applicable, contracted rates between the provider	

Factors Used in Payment Determination (cont.)	The arbitrator's final decision shall be in writing, describing the basis for such decision, and shall be made within 30 days of the referral from the OCI Commissioner. (O.C.G.A. § 33-20E-15)	and the health plan during the previous 4 plan years. (29 CFR 2590.716-8(c)(4)(iii)) In determining which offer to select, the IDR entity must NOT consider: (a) Usual and customary charges, including payment or reimbursement rates expressed as a proportion of usual and customary charges; (b) The amount that would have been billed by the provider if the surprise billing rules did not apply; or (c) The payment or reimbursement rate for items and services furnished by a provider by a public payer, including Medicare, Medicaid, CHIP, and TRICARE. (29 CFR 2590.716-8(c)(4)(v))	
Payment	The party whose final offer amount is not selected shall pay the amount of the verdict…directly to the resolution organization. Moneys due shall be paid in full to the resolution organization within 15 days of the arbitrator's final decision. Within 3 days of the resolution organization's receipt of moneys due to the party whose final offer was selected, such moneys shall be distributed to such party. (O.C.G.A. § 33-20E-16)	The amount of the offer selected by the IDR entity (less the sum of the initial payment and any cost-sharing paid or owed by the patient) must be paid directly to the provider not later than 30 calendar days after the determination. If the offer selected by the IDR entity is less than sum of the initial payment and any cost-sharing paid by the patient, the provider is liable to the health plan for the difference and must pay the difference directly to the health plan not later than 30 calendar days after the determination. (29 CFR 2590.716-8(c)(4)(ix))	
Effects of a Payment Determination	Any default or final decision issued by the arbitrator shall be binding upon the parties and is not appealable through the court system. (O.C.G.A. § 33-20E-15)	A determination made by an IDR entity is: (a) Binding upon the parties, in the absence of fraud or evidence of intentional misrepresentation of material facts presented to the IDR entity; and (b) Not subjects to judicial review, except where: (i) the payment determination was procured by corruption, fraud, or undue means; (ii) there was evident partiality or corruption in the IDR entity;	

Effects of a Payment Determination (cont.)		(iii) the IDR entity was guilty of misconduct in refusing to postpone the hearing, upon sufficient cause shown, or in refusing to hear evidence pertinent and material to the controversy; or of any other misbehavior by which the rights of any party have been prejudiced; or (iv) the IDR entity exceeded its powers, or so imperfectly executed them that a mutual, final, and definite award upon the subject matter submitted was not made. (29 CFR 2590.716-8(c)(4)(iv))	
Costs	The party whose final offer amount is not selected shall pay the arbitrator's expenses and fees and any other fees assessed by the resolution organization. In the event of default, the defaulting party shall also pay such moneys. In the event both parties' default, the parties shall each be responsible for paying one-half of all moneys due. Moneys due shall be paid in full to the resolution organization within 15 days of the arbitrator's final decision. (O.C.G.A. § 33-20E-16) If the parties reach a settlement after the OCI Commissioner has referred a claim to arbitration, the parties will be responsible for splitting any costs incurred by the resolution organization due to the referral. (Ga. Comp. R. & Reg. 120-2-106-.10(5))	The party whose submitted offer is not selected is responsible for the payment to the IDR entity of the predetermined fee. Both parties are required to pay the fee when the offers are submitted, and the party whose offer was selected will be refunded the amount of the fee. Both parties must pay a non-refundable administrative fee at the time the IDR entity is selected in an amount established by HHS. (29 CFR 2590.716-8(d)) If the parties came to a settlement agreement prior to the IDR entity making a payment determination, the IDR entity will refund half of each party's pre-paid fee. (29 CFR 2590.716-8(c)(2)(ii)	Under both Georgia and federal law, the party whose offer was not selected is responsible for the cost of the dispute resolution. However, federal regulations require that both parties pay an administration fee.