Texas No Surprises Act
Out-of-Network Provider Frequently Asked Questions

1. What is Texas No Surprises Act and who does this apply to?
   Since Jan. 1, 2020 Texans with state-regulated (fully insured) health insurance have new protections against some surprise medical bills, also called balance bills.
   a. This law does not apply to all Texans. The law applies to members who meet one of the following:
      i. Their member ID card has a "TDI" printed on it.
      ii. They are covered by the Employee Retirement System (ERS).
      iii. They are covered by the Teachers Retirement System (TRS).
   b. This law does **not** apply to:
      i. Self-funded employer-sponsored health plans, unless the employee has opted into the Texas No Surprises Act, in which their member ID card has "TXI"printed on it.
      ii. Medicare
      iii. The Federal Employee Plan
      iv. Plans issued by health plans outside Texas
   c. Note: members who are not protected by the Texas No Surprises Act may have protections under the federal No Surprises Act. You can refer Surprise Billing Provisions of the No Surprises Act for more details on the federal law.

If you are not sure what type of plan the member has, please contact the customer service number on the back of the member ID card.

2. What type of services are subject to the Texas No Surprises Act?
   a. Services provided by out-of-network (OON) providers who practice at in-network hospitals, birthing centers, ambulatory surgical centers and free-standing emergency medical care facilities.
   b. Emergency services and supplies provided by OON physicians and facilities, including hospitals, free-standing emergency medical care facilities and ground ambulance companies.
   c. OON diagnostic imaging services and laboratories that provide services in connection with a service from an in-network provider.

The new law bans providers from sending balance bills to members in those cases. Instead, providers can work directly with the health plans to agree on payment for those bills.

3. What payment standards apply?
   a. For covered services described above that are provided on or after January 1, 2020, the health benefit plan issuer shall pay the usual and customary rate or agreed rate.

4. What happens if I disagree with the reimbursement of the service(s) on a claim?
   a. If a provider disagrees with the amount of payment on the claim:
      i. The regular internal claim reconsideration and appeal processes apply to these claims. If an additional amount is paid because of the internal appeals process, patient share (coinsurance/deductible) may be adjusted to account for the internal appeal adjustment.
      ii. in addition to the appeals process, an OON provider who disagrees with the level of payment may initiate a dispute resolution process described below.

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4. What happens if I disagree with the reimbursement of the service(s) on a claim? (cont.)

    b. An OON facility may initiate mediation to resolve a dispute about the level of payment.
        i. The mediation process does not have a set time frame from initial payment of the claim in which the OON facility must request mediation.
        ii. The goal of the mediation process is for the health plan and the facility to agree to the amount to be paid, but if the parties do not reach an agreement, the balance bill prohibition remains.
    c. A non-facility OON provider may initiate arbitration to resolve a dispute about the level of payment.
        i. The arbitration process must be initiated by the provider within 90 days from the date the provider receives payment on the claim, but not before 20 days from the date the provider receives initial payment.
    d. If a waiver was signed pre-service, the provider may not request arbitration – see FAQ 6 below.

5. How do I initiate arbitration/mitigation/negotiation?
    a. Visit the Texas Department of Insurance (TDI) website to begin the process via the TDI Portal.
    b. In addition to requesting dispute resolution thought the TDI Portal, you must also email Blue Cross and Blue Shield of Texas Provider Arbitration at tx.provider.arbitration@bcbstx.com.

6. When does a waiver allow balance billing?
    a. If a member sees an out-of-network provider at a network facility or the member visits an out-of-network lab or imaging center, the provider may ask the member to sign a Balance Billing Waiver form. If the member signs this form, the member is giving up their protections against balance billing and the provider can bill the member over the amount of their deductible, copayments and coinsurance.
    b. The member must sign the Balance Billing Waiver at least ten business days before getting services for it to be effective. If a member signs a waiver, ten business days or more before getting the service and then changes their mind, the member can:
        - Cancel a waiver within five business days of signing.
        - Tell the provider that they are canceling the services. The provider cannot charge the member a cancellation fee, or any other type of fee for canceling the service.

    Note: The waiver cannot be used in an emergency or when an out-of-network provider was assigned to a case, such as when an anesthesiologist is assigned to a surgery.