American College of Radiology™

July 10, 2023

The Honorable Bill Cassidy, M.D.
Ranking Member
Senate HELP Committee
Washington, D.C. 20510

Re: Input on No Surprises Act (NSA) Regulatory Challenges

Dear Dr. Cassidy:

The American College of Radiology (ACR®) thanks you and your staff, as well as the Committee on Health, Education, Labor, and Pensions (HELP), for continuing to ensure that the No Surprises Act (NSA) is implemented as Congress intended when passed in 2020. While regulatory challenges have plagued physician practices attempting to utilize the Independent Dispute Resolution (IDR) process created through passage of the NSA, we appreciate the opportunity to provide additional feedback as you work with federal agencies to rectify these issues. ACR was honored to send a member to the HELP Committee surprise billing roundtable, Ashutosh Rao, MD, held on May 17, and attend the subsequent Republican staff roundtable on June 29. Below, ACR highlights NSA challenges for radiologists and potential solutions.

ACR supports the goal of the NSA to protect patients from surprise medical bills for care received by out of network providers. For radiologists, the main concerns regarding NSA implementation are access to the IDR process and batching, as well as reasonable and timely payment.

Batching Restrictions

The NSA permits multiple qualified IDR services to be "batched" in a single IDR process "*for purposes of encouraging efficiency (including minimizing costs) of the IDR process.*"[1] However, the rules setting forth batching parameters published in the Interim Final Rule, *Requirements Related to Surprise Billing; Part II*[2] ("October 2021 Rule"), do not achieve this objective—they do the opposite. The October 2021 Rule imposes the following restrictions on batching: (1) the services must be billed by a clinician with the same National Provider Identifier or Taxpayer Identification Number; (2) payment for the services must be made by the same plan or issuer; (3) the services are billed under the same service code (or a comparable code under a different

[1] 42 U.S.C. § 300gg–111(c)(3) (emphasis added). The NSA amended three statutes with identical provisions: the Publish Health Service Act ("PHSA"), the Employee Retirement Income Security Act ("ERISA"), and the Internal Revenue Code ("IRC"). For ease of reference, this letter cites to the PHSA provisions.

[2] 86 Fed. Reg. 55,980 (Oct. 7, 2021).

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procedural code system); and (4) the services must be furnished within the same 30-business-day period (or the same 90-calendar-day cooling off period, if applicable).[3]

The October 2021 Rule defines batching parameters so narrowly that it creates a financial hardship for physicians and operational dysfunction for the IDR process. Participating in the IDR process for each under-reimbursed claim is administratively burdensome and cost prohibitive.

First, the current regulations are so restrictive that "batching" is almost non-existent for radiologists. For example, one radiologist recently determined that for 18,123 IDR-qualified charges (for one Tax Identification Number, one payor, and one 30-business-day service period), they must initiate **9,238** separate IDR disputes. In other words, a batch on average is only two charges. Smaller batch sizes necessitate submission of a larger number of disputes, which impose significant administrative costs and greater IDR fees. This is not the robust batching process that Congress intended, and we do not believe it reflects the type of batching process the Department of Health and Human Services (HHS) aims to achieve.

Furthermore, by permitting health care providers to submit only small batches (if any), the October 2021 Rule has resulted in an IDR process that is overwhelmed and unsustainable, as evidenced by the now-common practice of placing claims "on hold" for an indeterminant length of time. IDR entities (IDREs) are disregarding the deadlines set forth in the NSA as they have been flooded with disputes. The Departments acknowledged this flood in their recent report, noting that, "from April 15 – September 30, 2022, disputing parties initiated 90,078 disputes through the Federal IDR portal, significantly more than the number of disputes the Departments initially estimated would be submitted for a full year."[4]

In what has become a vicious cycle, these delays further exacerbate the financial hardship imposed by participation in Federal IDR. The delays mean that clinicians often must wait nearly 220 days for payment, which does not include the additional mandatory 90-day cooling-off period following a ruling. The IDR fees are held for months in escrow while IDR proceedings remain in limbo. In 2022, radiologists in two practices we spoke with paid more than $290,300 and $193,100, respectively, in IDRE fees for cases that are past the deadline for a payment determination. Making matters worse, IDREs are allowed to accrue interest on the funds they hold in trust or escrow for parties participating in IDR, with no requirement to include accrued interest with the returned fees.[5] Providers lose the time value of the money they pay, compounding the financial expense of participating in IDR. Moreover, even when a provider prevails in IDR, payors are not paying when required and are sometimes paying only a fraction of what the IDRE awarded. And because IDRE payment determinations have no precedential effect, plans typically persist in underpaying even after they lose in IDR. As a result, as soon as

[3] 45 C.F.R. § 149.510(c)(3)(i).

[4] https://www.cms.gov/files/document/initial-report-idr-april-15-september-30-2022.pdf

[5] 86 Fed. Reg. 55,980, 56,005 (Oct. 7, 2021).

the cooling-off period is complete, practices are forced back into the IDR process to request reasonable reimbursement for claims substantially similar to those on which they previously prevailed.

Recommendations: Modify batching rules

- HHS should allow clinicians to batch qualified IDR items and services under the same category of service codes rather than restricting batches to only those claims with the same service code. Under this approach, for example, radiologists would be able to batch similar diagnostic radiology services that fall under the 70000 CPT code series. This approach to batching is consistent with the language of the NSA, which permits batching of claims for services "related to the treatment of a similar condition,"[6] and has been proven to be effective and efficient in Texas' IDR process under SB 1264.[7]

- HHS should allow clinicians to batch qualified IDR items and services paid within the same 90 days of payments, rather than limiting the time window to 30 business days of service.[8]

Increased Fees and Impact on Patient Care

With an IDR administrative fee of $50 and IDRE fees up to $670, accessing IDR with radiology claims in a cost-efficient manner has been challenging. The recent increase in the IDR administrative from $50 to $350[9], along with an increase in the IDRE fees (which can now be more than $1200), has made accessing IDR nearly impossible for radiology. Most radiology claims are for less than $50, with the vast majority below $100. Almost none are $350 or more. Thus, without batching, radiology cannot access IDR in a cost-efficient manner.

Even before the increase in IDR fees, batching requirements were so narrow that clinicians would often need to pay more to participate than the dispute was worth. For example, for CPT 71045 (X-ray exam chest 1 view) Medicare pays an average of $9. With the current batching requirements, radiologists would be able to batch only two charges for CPT 71045 for one Employer Group Health Plan furnished within the same 30-business-day service period. The total batch value per Medicare payment would be $18. This is one of the most frequently billed CPT codes by radiologists, and by these narrowly defined batching requirements, it is cost prohibitive to participate in the Federal IDR process, resulting in massive underpayments.

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[6] 42 U.S.C. § 300gg-111(c)(3)(A)(iii).

[7] *See, e.g.*, Senate Bill 1264: Six-month preliminary report, https://www.tdi.texas.gov/reports/documents/SB1264-preliminary-report.pdf.

[8] The NSA permits the Departments to craft a rule with an "alternative period" to "encourage procedural efficiency and minimize health plan and provider administrative costs." 42 U.S.C. § 300gg-111(c)(3)(A)(iv).

[9] https://www.cms.gov/cciio/resources/regulations-and-guidance/downloads/amended-cy2023-fee-guidance-federal-independent-dispute-resolution-process-nsa.pdf

These underpayments have material impacts on patient care. Radiology is suffering from a national labor force shortage, which has been compounded by ongoing Medicare reimbursement cuts, stresses from the pandemic and macroeconomic factors such as inflation. As a result, medical groups are struggling to provide care and in many cases are reducing their services. ACR is aware of radiology practices terminating relationships with hospitals that they are no longer able to serve, leaving the hospital scrambling to provide patch coverage.

Recommendation: Reduce the IDR fees

- HHS should immediately rescind the significant increases in both the administrative fee and the fees that certified IDR entities can charge.

Lack of Transparency and Disclosure of Information

Federal vs. State IDR Process

Another issue with batching is determining whether an IDR claim falls under state or federal jurisdiction. Ideally, a patient's insurance card should include sufficient information needed for determining jurisdiction. Without this information, it is unclear if a claim is one that is covered under the federal or state process. Since the insurers have failed to provide this information, physicians often have difficulty availing themselves of the IDR process. As a result, if a batch of claims contains even one claim that falls under the jurisdiction of the other system, federal or state, the entire batch is rejected. This causes delays and adds to the administrative burden.

Qualified Payment Amount (QPA)

In many instances, the initial payment or notice of denial sent to the provider by the insurer does not include all the required information. In some cases, the qualifying payment amount (QPA) for the item or service billed is not being clearly identified, and a certifying statement is missing that affirms that the QPA was calculated properly and that it serves as the recognized amount for the purposes of calculating patient cost-sharing. This lack of information makes it difficult for providers, and eventually for certified IDREs, to determine whether a claim is eligible for the federal IDR process.

Recommendations:

- HHS should require that the plan type be disclosed at the time of the initial payment or notice of denial, as this information is not available on a patient's insurance ID card. Without knowing the type of plan early in the dispute resolution process, it is

extremely difficult for the provider to determine whether the plan is a fully insured or self-insured plan, and which dispute resolution process applies.

- HHS should require insurers to use the Remittance Advice Remark Codes (RARCs) when providing the required disclosures that accompany the initial payment or notice of denial. This will give providers the necessary information to assess patient responsibility amounts and reduce the need to initiate payment disputes. Further, the RARC codes will provide IDREs with dispositive information about whether a particular claim is eligible for the federal IDR process.

Lack of Timely Payment

Many physicians have reported the extremely troubling trend of insurers' failure to pay what they owe if an IDRE finds in favor of the provider. Insurers are simply not paying the amount owed within the required 30-day period, if at all, despite numerous attempts by providers to collect the payment they are entitled to under the terms of the arbitration.

Recommendations: Enforce required payments and uniform process

- HHS should enforce required timely payments. Insurers who are not paying what they owe to a provider after the IDR process is completed must be penalized and forced to compensate the provider for the total amount owed plus interest.

- A uniform electronic payment process should be in place. Certified IDREs should have a uniform process established to collect all the IDR fees and refund the winning party the certified IDR entity fee.

Other Issues

QPA Methodology

The QPA methodology finalized by the agencies is leading to artificially low QPAs that do not reflect market-rates. It was designed to limit cost-sharing liabilities and is not a market-based indicator of appropriate payment for an item or service. There are also reports of insurers miscalculating the QPA, leading to QPAs even lower than what proper adherence to the methodology would dictate.

Recommendations

- Increase transparency around calculation of the QPA. HHS should require insurers to disclose the methodology used to calculate the QPA for an out-of-network claim, so that providers are confident it is calculated correctly and in line with the regulatory requirements. Currently, there is little minimal recourse for providers who believe that the QPA is miscalculated. Providers are restricted from requesting from insurers specific information on how the QPA was calculated (i.e., to "check their math"), so requiring more transparency is the ONLY way to ensure that health insurers actually adhere to the methodology.

- Require public reporting on the results of these audits. Accordingly, insurers will be able to better understand the common mistakes that are being made when calculating the QPA and, hopefully, the number of miscalculations will decrease.

Lack of Open Negotiation

Providers have reported a lack of active negotiations during the open negotiations phase of the dispute resolution process. Insurers do not always acknowledge receipt of the notice to initiate open negotiations and/or are not actively engaging in negotiations at any point during the 30-day period. This is a significant contributing factor toward the number of disputes advancing to IDR process.

Communication During IDR Process

If a provider does not reach resolution with the insurer during the 30-day open negotiation period, a claim is submitted through IDR portal. However, once the dispute is submitted, there is no way to check the status of that dispute in the portal. This results in an extremely high number of email communications from insurers to providers. The emails cover a range of topics including IDRE selection, requests for additional information, fee requests, offer links, and determinations from IDREs. This is entirely too many separate communications regarding one dispute and created additional administrative burden on practices.

Recommendation: Include the open negotiations process in the IDR portal

- HHS should consider incorporating the open negotiations process into the IDR portal. Doing so could help both insurers and providers better track what claims are entering the dispute resolution process and when the 30-day open negotiations process begins. The updated portal should clearly include the contact information for all the key

contacts involved in the dispute. Finally, it should formalize the process and provide additional data to HHS about compliance or non-compliance.

Auditing

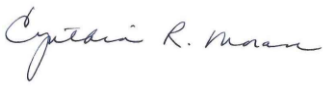
Auditing is critical to ensuring that insurers have an incentive to comply with the statutory and regulatory requirements.

Recommendation: HHS should publicly report auditing results

- Enforcement and auditing should be more transparent. HHS should release information about the complaints they receive—broken out by state.

Thank you for your time and commitment to ensuring the NSA is implemented as Congress intended. We appreciate the opportunity to outline radiology's concerns related to the NSA and provide potential solutions to help improve the IDR process. If you have any question, please contact ACR Director of Government Affairs, Ashley Walton.

Sincerely,



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