



December 22, 2023

The Honorable Chiquita Brooks-LaSure  
Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-9897-P  
Mail Stop C4-26-05  
7500 Security Boulevard  
Baltimore, MD 21244-1850

**Re: File code RIN 0938-AV15, Federal Independent Dispute Resolution Operations**

Dear Administrator Brooks-LaSure:

The American College of Radiology (ACR), representing more than 41,000 diagnostic radiologists, interventional radiologists, radiation oncologists, nuclear medicine physicians and medical physicists, appreciates the opportunity to comment on the proposed rule issued by the Office of Personnel Management; Internal Revenue Service, Department of the Treasury; Employee Benefits Security Administration, Department of Labor; and the Centers for Medicare & Medicaid Services, Department of Health and Human Services on the Federal Independent Dispute Resolution (IDR) process operations. The IDR process is mandated by the No Surprises Act (NSA), included in the Consolidated Appropriations Act of 2021. The ACR shares the Administration's patient-centered goal of ending "surprise medical billing" (SMB), while also addressing payer network adequacy issues that often lead to such problems.

***General Comments***

The ACR strongly supports the NSA "hold harmless" provisions, removing patients from reimbursement disputes between insurers and providers. In addition, the ACR appreciates the NSA's intended balanced approach with respect to insurance companies and medical practices. The law was designed to end the problem of surprise medical billing while preserving access to care by protecting good-faith negotiations between insurance companies and provider groups, giving neither side unbalanced leverage in network contract negotiations.

To promote a sustainable healthcare system, it is imperative that fair payment mechanisms exist to ensure adequate reimbursement for out-of-network services. The NSA represents a reasonable solution to this issue. The ACR is particularly supportive of the open negotiation between payers and providers, with use of IDR to resolve lingering disputes.

The ACR appreciates the Departments' acknowledgement of many concerns that providers have been communicating with regard to payer behavior and the IDR process and attempts to mitigate these issues in these proposed rules. Specifically, these proposed rules address the failure of payers to communicate IDR eligibility information with payment remittance, financial accessibility of IDR for radiology practices, open negotiation communication issues, cooling off

period concerns and IDR entity selection issues. The ACR appreciates these proposals and the opportunity to provide input.

### ***IDR Dispute Submission Volume***

In the proposed rules, the Departments note that in the first year of IDR operations, disputing parties submitted fourteen times the number of disputes the Departments anticipated. This has led to a significant burden on IDR entities and a backlog of disputes. There is a self-perpetuating cycle of events driving this volume which is based on unintended incentives for insurers to under-reimburse providers. When an insurer under-reimburses a provider, the insurer benefits from the interest off their investment. The greater the under-payment and the longer insurers can delay final payment, the greater their reward. Further, due to tight submission deadlines and financial and logical barriers, not all underpayments will result in IDR submission, which is also beneficial for the insurer. Thus, insurers are incentivized to systematically under-reimburse providers. This drives providers to use the IDR process, which floods the system, slowing down the IDR process. Since insurers benefit financially from a slow IDR process, the worse the backlog of cases (and slower the IDR process), the greater the incentive for insurers to under-reimburse providers.

The ACR believes in patients' access to high-quality, in-network medical imaging care and is concerned about the rise in out of network billing. Dysfunction in the IDR process has empowered insurers to demand that providers accept a substantial reduction in reimbursement or be pushed out of network and fight through IDR to be paid. The initial report from the Assistant Secretary for Planning and Evaluation (ASPE) noted that radiology was 97 percent in network prior to the NSA. We expect that future reports will demonstrate an increase in out-of-network billing in radiology. Practices would prefer to be in-network at sustainable rates. Those practices that are out-of-network would prefer to be paid reasonably upfront rather than having to pursue open negotiations and IDR. Providers have offered proof of qualifying payment amount (QPA) and initial payments that are frequently below Medicare rates and evidence of insurers demanding that in-network practices accept Medicare rates for commercially insured patients in order to remain in-network (Attachment A).

If payers offered reasonable reimbursement rates at the outset, the number of IDR disputes would dramatically decrease. Incentivizing this behavior is how we believe the Departments could break the negative cycle of IDR submissions.

### ***Updated Initial Payment/Denial of Payment Disclosure Requirements***

#### **Proposals**

The Departments propose to require plans and issuers to use claim adjustment reason codes (CARCs) and remittance advice remark codes (RARC). Plans and issuers would have to follow guidance issued by the Departments to communicate information related to whether a claim for an item or service furnished by an entity that does not have a direct or indirect contractual relationship with the plan or issuer with respect to the furnishing of such item or service under the plan or coverage is subject to the provisions of the No Surprises Act. Specifically, the Departments propose to require plans and issuers to use CARCs and RARCs to convey specific

information about the No Surprises Act when a plan or issuer provides a paper or electronic remittance advice to any entity with which it does not have a direct or indirect contractual relationship with respect to the furnishing of an item or service under the plan or coverage. These proposed requirements would also apply to plans and issuers when sending remittance advice to entities with which they do not have a direct or indirect contractual relationship with respect to items and services to which the No Surprises Act surprise billing requirements do not apply, in order to convey that the No Surprises Act does not apply.

#### ACR Perspective and Comments

**The ACR requested this requirement of payers in previous comment letters and thanks the Departments for this proposal.** We believe the inclusion of this information with payment remittance or notice of denial will give providers a better understanding of what claims are eligible for IDR and will reduce the volume of ineligible claim submissions. **We encourage the Departments to consider enforcement mechanisms for payers who do not provide the required information.**

#### *Information to be Shared about the QPA*

##### Proposals

The Departments propose to require plans and issuers to disclose the legal business name of the plan or issuer, the legal business name of the plan or sponsor (if applicable), and the registration number assigned if the plan or issuer is registered with the Federal IDR registry. The Departments also propose to require plans or issuers to provide the QPA for each item or service involved in a claim, as well as a statement certifying that based on the determination of the plan or issuer, the QPA applies for purposes of the recognized amount and each QPA shared with the provider was determined in compliance with the methodology outlined in the July 2021 interim final rules. The plan or issuer must provide contact information for the appropriate office or person for the provider to contact to initiate open negotiations if deemed necessary.

##### ACR Perspective and Comments

**The ACR supports these proposals for additional information to be provided at the time of initial payment or notice of denial of payment and for the Federal IDR registry.** Providers have reported that contact information is often not provided by payers, making it extremely difficult to initiate open negotiations within the required timeframe.

#### *Open Negotiation and Initiation of the Federal IDR Process*

##### Proposals

The Departments propose to amend the open negotiation provisions to establish additional requirements for initiating open negotiation via the Federal IDR portal and to revise the open negotiation period start date. The Departments also propose to add a requirement for the party in receipt of the open negotiation notice to provide a written response to the initiating party through the Federal IDR portal no later than the 15<sup>th</sup> business day after initiation of open negotiation.

In addition to already required claim information, the Departments propose to require the following:

- information to identify the location where the item or service was furnished,
- type of item or service,
- the State where the item or service was furnished,
- the claim number,
- whether the item or service is an emergency service or a non-emergency service,
- whether the item or service is an air ambulance service,
- the QPA for the item or service if it has been provided on the initial payment or denial of payment, and
- whether the item or service is a professional service or facility-based service.

#### ACR Perspective and Comments

**The ACR appreciates and supports the proposal to use the Federal IDR portal for open negotiation notices and the proposal to require the non-initiating party to respond within 15 business days after initiation of open negotiation.** The proposed 15 business-day response deadline is appropriate and should not be extended further. **The ACR believes that compliance with this requirement and meaningful engagement (or lack thereof) should be considered by IDR entities in making payment determinations. In addition, the Departments should consider implementing enforcement measures for lack of engagement in open negotiations.**

The Departments requested comment on whether the party submitting the open negotiation notice should be required to provide a statement describing why the party is initiating the open negotiation period. The ACR believes that such a requirement is unnecessary and would be burdensome to providers as any such questions would be answered during the negotiation process.

#### *IDR Entity Selection Process*

##### Proposals

The Departments propose that if the non-initiating party submits a response identifying an alternative preferred IDR entity on or before the second business day after IDR initiation and the initiating party agrees or fails to object by the end of the third business day after IDR initiation, the non-initiating party's alternative preferred IDR entity would have been jointly selected. When the non-initiating party responds and objects on the third business day and the initiating party fails to either agree or object to the alternative preferred IDR entity, the parties will be considered to have not jointly selected the IDR entity. Rather, the initiating party will receive an additional two business days to agree or object. If the party agrees or fails to respond, the Departments will choose the alternative preferred IDR entity. If the party objects, the Departments will select an IDR entity.

The Departments also propose that objections to selected IDR entities must include the name of another alternative preferred IDR entity and an explanation of any conflict of interest with the other party's preferred IDR entity.

The Departments propose that an IDR entity is considered to be only preliminarily selected until it can attest that it meets the required conflict-of-interest standards. The preliminarily selected IDR entity has three days to attest that it meets those standards.

### ACR Perspective and Comments

Under the current rules, when non-initiating parties wait until the last minute to object and select an alternative preferred IDR entity, the initiating party does not have time to object and the alternative preferred IDR entity is “jointly” selected by default. **The ACR supports the proposals to revise the IDR selection process to avoid these scenarios.**

### *Federal IDR Process Eligibility Review*

#### Proposals

The Departments report that certified IDR entities report spending 50-80 percent of their time working on eligibility determinations. Providers and facilities have raised concerns that the existing disclosure rules do not require plans and issuers to provide information necessary for determining whether the item or service is subject to a specified State law, an All-Payer Model Agreement, or the Federal IDR process.

In addition to proposals requiring payers to provide additional information with initial payment or notice of denial of payment, the Departments propose to extend the timeline for certified IDR entities to assess a claim’s eligibility for the Federal IDR process from three to five business days after the selection of the IDR entity. The Departments also propose to establish an eligibility review process whereby, when certain conditions are met, the Departments would conduct the eligibility review and make the eligibility determination on behalf of the certified IDR entity. The intention of this proposal is that the departmental eligibility review would be temporary and would involve advance public notification of the effective date and the reasons for invoking the departmental eligibility review process, as well as public notification of the end date. Any increased expenditures related to conducting eligibility determinations would be reflected in the IDR administrative fee.

The Departments also seek comment on whether patient insurer ID cards should display the plan or coverage type and a symbol or code indicating regulatory authority of the plan (i.e., State, Federal, or both).

### ACR Perspective and Comments

**The ACR strongly supports the proposals in this rule to simplify the process of determining claim eligibility.** Delays in processing IDR submissions harm providers and their patients by holding up payments and benefits payers. The communication requirements proposed in these rules, if followed, would reduce the number of ineligible claim submissions to the Federal IDR portal and improve efficiency. **The ACR strongly recommends that the Departments establish consequences for failure to accurately comply with communication requirements.**

The ACR supports the inclusion of plan and coverage type information on patient insurance ID cards.

## ***Batching Guidelines***

### Proposals

The Departments have received many stakeholder comments on batching rules in order to ensure that all providers have access to the IDR process. The Departments specifically recognize that some radiologists assert that the vacated batching rules prohibited them from batching radiology items and services provided to a single patient because these items and services are billed under different service codes. The Departments acknowledge the concern that absent the ability to batch, radiologists are effectively denied access to the Federal IDR process because the reimbursements for most individual radiology codes are low-dollar and therefore are not cost-effective to dispute individually.

On the other hand, certified IDR entities have indicated that disputes involving batched items and services under the current and now-vacated rules are more administratively burdensome than non-batched disputes, due to the extra time and resources they must expend in verifying that the items and services are properly batched and eligible for the Federal IDR process.

The Departments propose to expand opportunities for batching by allowing batching services provided to a single patient during the same patient encounter and billed on the same claim form. In addition, the Departments propose to specify in guidance ranges of Current Procedural Terminology® (CPT) codes that may be batched in order to promote efficiency in the IDR process. The rule includes 27 proposed CPT code ranges for radiology. The Departments solicit comment on these categories.

The Departments propose to limit batched determinations to 25-line items in a single dispute. The Departments seek comment on the proposed limit and whether an alternative line-item limit that is higher or lower than 25-line items would be more appropriate to promote efficiencies and cost savings in the Federal IDR process.

The Departments propose to remove the flexibility that allows resubmission of claims in a batched dispute that contained ineligible claims.

The Departments propose to use statutory waiver authority to shorten the 90-day cooling off time period with respect to qualified IDR items and services for which a certified IDR entity makes a payment determination as part of a batched dispute. The Departments seek comment on this exception and alternative time periods the Departments should consider for the cooling off period.

### ACR Perspective and Comments

The ACR appreciates the Departments' recognition of our concerns regarding accessibility of the Federal IDR process for radiology services and the proposals to address these concerns. The College also understands the challenges that massive and varied dispute submissions produce for IDR entities.

**The ACR supports the proposal to allow batching of services for single patients. The College recommends that the requirement for these services to be “on consecutive days”**

**and “on the same claim form” be removed since a patient may receive many imaging services within a 30-day period that are related to the same condition and may or may not be on consecutive days or on the same claim form.**

**The ACR also supports the proposal to allow batching by CPT code groups to be specified and updated regularly in guidance.** With regards to the 27 proposed groups of radiology-related CPT codes, we understand the Departments’ position that batching by full CPT division would create too much variability. However, the College feels that batching by 27 sub-categories of the radiology division would add complexity for providers and IDR entities in identifying claim eligibility and appropriateness of batching. Further, the sub-categories do not align with standard clinical practice since all diagnostic exams may be used in reference to one another. As an example, ultrasounds are frequently used in conjunction with radiographs, CT and MRI. **The ACR suggests a compromise approach, simplifying the process by allowing batching in 4 categories of CPT codes, diagnostic radiology, interventional radiology, nuclear medicine and radiation oncology.** This approach addresses the Departments concerns about batch variability and aligns with both statutory language on batching (“related to the treatment of a similar condition”) as well as Medicare’s existing specialty classification system. This would make batch eligibility determinations less burdensome and reduce the number of IDR claims for radiology services. However, should the Departments move forward with an approach based on sub-categories, similar to that laid out in the proposed rule, the ACR stands ready to assist the Departments in development of groupings that make clinical sense.

**The ACR understands the need to reduce the burden of extremely large batches on IDR entities, however, we feel that limiting batches to 25-line items is too restrictive and request that the limit be increased to at least 50-line items or removed entirely.** The now-finalized IDR fee rule includes the option of additional IDR entity fees for batches over 25-line items to account for the additional time and effort involved in processing larger batches, so a size limit is redundant. It is also worth noting that given the restriction to the same 30-day period, same health plan and same provider/TIN and other batching restrictions, to date many radiology batches have been around 2 claims per batch.

**The ACR urges the Departments not to finalize the proposal to remove the allowance for resubmission of batches that contain ineligible claims.** While we appreciate the proposals to improve transparency of claim eligibility, we are concerned that as providers and insurers adjust to the new communication and batching guidelines, inclusion of a single ineligible claim would invalidate an entire batch. Further, if a single ineligible claim invalidates the entire batch without the potential for resubmission, there would be a strong incentive for insurers to be less transparent with claim eligibility.

The ACR appreciates the Departments’ proposal to reduce the length of the cooling off period to encourage efficiency and continue to allow access to the IDR process. **The ACR strongly supports changing the cooling off period to one business day.** Providers have raised concerns that lengthy cooling off periods provide incentive for payers to underpay.

## *Administrative Fee Proposals*

### Proposals

The Departments propose to revise the administrative fee calculation methodology by using the total volume of initiated disputes rather than the total volume of closed disputes due to the collection of administrative fees earlier in the process.

The Departments recognize provider concerns regarding access to the IDR process for providers whose claims are largely less than the amount of the administrative fee. The Departments propose a reduced administrative fee for both parties in low-dollar disputes where the highest offer made during open negotiations is lower than the standard administrative fee. The reduced fee would be 50% of the full administrative fee (or \$57.50 under the recently finalized fees) per party per dispute. The Departments also propose a reduced administrative fee of 20% of the full administrative fee for non-initiating parties in ineligible disputes.

The Departments propose to require the initiating party to pay the administrative fee within 2 business days of the date of preliminary selection of the certified IDR entity. The Departments further propose that the non-initiating party must pay the administrative fee within 2 business days of the date of notice that an eligibility determination has been reached.

### ACR Perspective and Comments

The ACR appreciates the Departments' recognition of our continued concern about access to the IDR process for providers whose claims are largely less than the amount of the administrative fee. We recognize that the administrative fee can be a tool to encourage good faith behavior and compliance with the Departments' regulations and helps to recoup the costs of maintaining the IDR portal and processes, but it should not be a barrier to enter the IDR process.

**The ACR believes that the proposed reduced administrative fee for low dollar claims of 50% of the full administrative fee is too high and recommends a reduced administrative fee of no more than \$50.** Under the recently finalized fee regulations, the proposed reduced administrative fee would be \$57.50, which would still be a barrier to IDR for many imaging services. Further, the sites most likely to be impacted by reduced access are those with limited resources, including both urban and rural populations. The pressure from insurers is also helping drive vertical consolidation as practices consider joining hospital systems, or consolidate with other provider groups or national practices.

Analysis by the Neiman Health Policy Institute shows that, if radiologists were to recover the difference between charges and the allowed amount, entering the IDR process (with the recently finalized \$115 administrative fee for 2024) would be financially viable for only 32% to 52% of claims when batched according to current IDR rules. However, recovering this amount is unrealistic. Assuming a more realistic recovery of one-quarter of the difference between charges and allowed amount, entering the IDR process would be financially viable for 11% to 24% of radiologists for radiology claims. If the administrative fee were to \$75, financial viability improves minimally - 11% to 29% of claims.



**The ACR disagrees with the proposal to charge a reduced administrative fee to a non-initiating party when a dispute is determined to be ineligible.** Offering a reduced fee in these circumstances disincentivizes insurers from complying with the requirements to include claim eligibility information with initial payments or notice of denial of payment. Further, there is no evidence that providers are intentionally submitting ineligible claims to IDR, since such submissions are costly and delay the process of final payment.

The College agrees with the proposal to collect the administrative fee directly through the Federal IDR portal. This should help increase collection of the fees and remove inefficiencies.

The ACR believes that both parties should be required to pay the administrative fee at the same time as differing deadlines for initiating and non-initiating parties creates an unnecessary complexity.

With regard to the administrative fee calculation methodology, as stated in our previous comments on this issue, the ACR believes that it is most appropriate to use the number of disputes where parties submitted their offers since that is an accurate reflection of the number of administrative fees paid. In addition, the College believes that some of the costs included in the estimates are not exclusive to the IDR process. The QPA serves two functions, patient cost sharing calculations and IDR consideration. The cost of QPA audits should not be borne solely by IDR fees.

### *Summary*

In summary, the ACR appreciates the Departments' acknowledgment of many concerns we have raised in previous comment letters and the proposals to address these concerns. While these are a step in the right direction, if there is not meaningful enforcement of these regulations, there is limited efficiency of rulemaking. We strongly urge the Departments to establish and enforce penalties for non-compliance with these NSA regulations. We also urge the Departments to work to end the cycle of IDR submissions by correcting the incentives for insurers to under-reimburse providers.

The College fully supports the intent of the NSA to eliminate "surprise" medical bills for patients. However, it is imperative that fair payment mechanisms, including provider access to IDR, ensure adequate reimbursement for out-of-network services to promote a sustainable healthcare system. The NSA was crafted in a balanced manner, avoiding favoring insurers or providers, to preserve patients' access to care.

Thank you for the opportunity to provide feedback on this proposed rule. The ACR looks forward to continuing to engage and offer comments during the continued rulemaking process. If you have any questions, please contact Kathryn Keysor, ACR Senior Director, Economics and Health Policy at [kkeysor@acr.org](mailto:kkeysor@acr.org).

Sincerely,

A handwritten signature in black ink, reading "William T. Thorwarth, Jr., MD, FACR". The signature is written in a cursive style with a large, stylized initial "W".

William T. Thorwarth, Jr., MD, FACR  
Chief Executive Officer

Enclosure: Attachment A

Attachment A



[REDACTED]  
[REDACTED] TN [REDACTED]

July 26, 2023

[REDACTED]  
[REDACTED] TN [REDACTED]

Re: Participation Agreement for UnitedHealthcare Commercial and Medicare Advantage Benefit Plans

To whom it may concern:

[REDACTED] is currently contracted under a Medical Group Participation Agreement effective 08/01/2005. United requires the contract to be updated to compliant paper to remain contracted as a participating clinic. The Commercial Fee Schedule is [REDACTED] 100% CMS and the Medicare Advantage is [REDACTED] 100% CMS. Please review and sign the attached agreement.

If you have any questions, feel free to contact myself, Erin Domzalski, at 630-324-9749 and/or email me at [erin\\_domzalski@uhc.com](mailto:erin_domzalski@uhc.com).

Thank you.

A handwritten signature in black ink that reads 'Erin Domzalski'.

Erin Domzalski  
Senior Network Contract Manager | East & Middle TN