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January 19, 2023

The Honorable Xavier Becerra
Secretary
U.S. Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue SW
Washington, DC 20201

The Honorable Martin J. Walsh
Secretary
U.S. Department of Labor
200 Constitution Avenue NW
Washington, DC 20210

The Honorable Janet Yellen
Secretary
U.S. Department of the Treasury
1500 Pennsylvania Avenue NW
Washington, DC 20220

Dear Secretaries Becerra, Walsh, and Yellen:

The American College of Radiology (ACR®), representing more than 41,000 diagnostic radiologists, interventional radiologists, radiation oncologists, nuclear medicine physicians and medical physicists, appreciated the opportunity to attend the January 5 meeting hosted by the Center for Consumer Information and Insurance Oversight (CCIIO) regarding issues surrounding implementation of the No Surprises Act ("NSA").

ACR supports the goals of the NSA, including removing patients from the middle of reimbursement disputes for out-of-network healthcare services and an efficient independent dispute resolution ("IDR") process. However, we write to raise our concern over the barriers being erected which prevent many clinicians, and nearly all of radiology, from accessing IDR. This is due to unnecessarily narrow restrictions on how clinicians are permitted to batch qualified IDR items and services during the IDR process[1] and the 600% increase in the IDR administrative fee. The batching restrictions have created unnecessary

[1] 45 C.F.R. § 149.510(c)(3)(i).

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inefficiencies, are contrary to the NSA's text and intent, and are driving the high volume of IDR disputes in an overburdened system.[2]

We urge the Departments of Health and Human Services ("HHS"), Labor and the Treasury (collectively, "the Departments"), to work with CCIIO to enhance the IDR process for all stakeholders by modifying the process to permit more robust batching, including allowing for batching by similar service codes, and for services paid *within the previous 90-day period*. Notably, these proposed changes will help resolve the Federal IDR backlog, including clinician submissions that currently have no action, will help alleviate the IDR delays of more than 75-plus days, and will ultimately reduce the financial hardships for IDR participants.

Concerns About 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.*"[3] However, the rules setting forth batching parameters published in the Interim Final Rule, *Requirements Related to Surprise Billing; Part II*[4] ("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 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).[5]

Despite the Departments' objective to leverage batching, which "decreases the number of IDR proceedings, avoids unnecessary complications from single disputes…and streamlines certified IDR entity decision-making,"[6] the October 2021 Rule defines batching parameters so narrowly that it creates a financial hardship for clinicians 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 radiology clinicians. For example, one radiology clinician 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

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[2] As reported in the August 19, 2022, Federal Independent Dispute Resolution Process Status Update, disputing parties initiated over 46,000 disputes between April 15th and August 11th, a figure exponentially larger than expected. *See* https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/federal-independent-dispute-resolution-process-status-update.pdf. The batching rules have contributed to this backlog, which flies in the face of the orderly, timely process that Congress set out in great detail in the NSA. Your office's recent announcement of a blanket, open-ended extension to all IDR entities ("IDREs") for all payment determinations highlights the broken status of the IDR process. *See* http://www.cms.gov/nosurprises/help-resolve-payment-disputes/payment-disputes-between-providers-and-health-plans.

[3] 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.

[4] 86 Fed. Reg. 55,980 (Oct. 7, 2021).

[5] 45 C.F.R. § 149.510(c)(3)(i).

[6] *Federal Independent Dispute Resolution (IDR) Process Guidance for Certified IDR Entities* at 16 (Apr. 2022), https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/Revised-IDR-Process-Guidance-Disputing-Parties.pdf

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 Departments aim to achieve.

Furthermore, by permitting clinicians 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. 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."[7]

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, radiology clinicians 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.[8] Clinicians thus lose the time value of the money they pay, compounding the financial expense of participating in IDR. Moreover, even when a clinician 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 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.

With an IDR administrative fee of $50 and IDRE fees up to $670, accessing IDR with radiology claims in a cost-efficient manner was 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, radiology clinicians 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 radiology clinicians, and by these

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

8 86 Fed. Reg. 55,980, 56,005 (Oct. 7, 2021).

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

narrowly defined batching requirements, it's cost prohibitive to participate in the Federal IDR process, resulting in massive underpayments.

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. Wait times for preventive screening, such as mammograms, are anecdotally on the rise. We believe that the effects are most predominant in rural communities and underserved urban centers, which are less well-resourced and harder to staff.

In addition to establishing a more reasonable IDR administrative fee, there are actions the Departments can take to improve the IDR process by revising the batching requirements. This will reduce the backlog of cases, limit the number of future submissions and help provide stability to medical practices.

Recommendations
ACR recommends that CCIIO, along with the Departments, inject greater flexibility into the batching requirements through the following proposals:

1. The Departments 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, radiology clinicians 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,"[10] and has been proven to be effective and efficient in Texas' IDR process under SB 1264.[11]

2. The Departments 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.[12]

3. The Departments should immediately rescind the significant increases in both the administrative fee and the fees that certified IDR entities can charge. These changes were issued without proper notice and comment and the fees create a financial barrier that prevents many radiology clinicians from participating in the IDR process.

The Departments must take steps to ensure the operation of an IDR process that generates timely and reasonable payment determinations. ACR thanks you for your time and commitment to ensure successful implementation of the NSA.

[10] 42 U.S.C. § 300gg-111(c)(3)(A)(iii).
[11] *See, e.g.*, Senate Bill 1264: Six-month preliminary report, https://www.tdi.texas.gov/reports/documents/SB1264-preliminary-report.pdf.
[12] 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).

If you have any questions or comments, please do not hesitate to contact me at wthorwarth@acr.org.

Sincerely,

William T. Thorwarth Jr., MD, FACR
Chief Executive Officer
American College of Radiology

cc: Deborah Bryant
Colin Goldfinch
Camille Kirsch

Appendix A

45 C.F.R. § 149.510(c)(3)(i)

(3) Treatment of batched items and services –

(i) In general. Batched items and services may be submitted and considered jointly as part of one payment determination by a certified IDR entity only if the batched items and services meet the requirements of this paragraph (c)(3)(i). Batched items and services submitted and considered jointly as part of one payment determination under this paragraph (c)(3)(i) are treated as a batched determination and subject to the fee for batched determinations under this section.

(A) The qualified IDR items and services are billed by the same provider or group of providers, the same facility, or the same provider of air ambulance services. Items and services are billed by the same provider or group of providers, the same facility, or the same provider of air ambulance services if the items or services are billed with the same National Provider Identifier or Tax Identification Number;

(B) Payment for the qualified IDR items and services would be made by the same plan or issuer;

(C) The qualified IDR items and services are the same or similar items and services. The qualified IDR items and services are considered to be the same or similar items or services if each is billed under the same category of service codes, or comparable codes under a different procedural code system, such as Current Procedural Terminology (CPT) codes with modifiers, if applicable, Healthcare Common Procedure Coding System (HCPCS) with modifiers, if applicable, or Diagnosis-Related Group (DRG) codes with modifiers, if applicable; and

(D) All the qualified IDR items and services were furnished within the same 90 days of payment.