



September 27, 2023

The Honorable Jason Smith
Chairman
House Ways & Means Committee
1100 Longworth House Office Building
Washington, D.C. 20515

The Honorable Richard Neal
Ranking Member
House Ways & Means Committee
1100 Longworth House Office Building
Washington, D.C. 20515

Re: Hearing on Reduced Care for Patients: Fallout From Flawed Implementation of Surprise Medical Billing Protections

Dear Chairman Smith and Ranking Member Neal:

The American College of Radiology (ACR®) appreciates the opportunity to provide written comments in response to the Committee's September 19, 2023, hearing on *Reduced Care for Patients: Fallout From Flawed Implementation of Surprise Medical Billing Protections*. We thank the committee for continuing to ensure that the No Surprises Act (NSA) is implemented as Congress intended when passed in 2020.

ACR supports the goal of the NSA to protect patients from surprise medical bills for care received by out of network providers. However, regulatory challenges have plagued physician practices attempting to utilize the Independent Dispute Resolution (IDR) process created through passage of the NSA. These comments highlight key challenges for radiologists— access to the IDR process, batching, and reasonable and timely payment, and we offer potential solutions.

Batching Restrictions and Financial Challenges

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 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. Further, the current regulations are so restrictive that “batching” is almost non-existent for radiologists. On average, a batch is only two charges. Smaller batch sizes necessitate submission of a larger number of disputes, which impose

¹ 42 U.S.C. § 300gg-111(c)(3) (emphasis added). The NSA amended three statutes with identical provisions: the Public 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).

³ 45 C.F.R. § 149.510(c)(3)(i).

significant administrative costs and greater IDR fees. This is not the robust batching process that Congress intended, and it has created a system that is overwhelmed and unsustainable— claims “on hold” for an indeterminant length of time and independent dispute resolution entities (IDREs) unable to meet the deadlines set forth in the NSA.

In what has become a vicious cycle, these delays further exacerbate the financial hardship imposed by participation in the IDR process. 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 decision. 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.⁴ 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 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.

Fees

Along with the restrictions placed on batching, the IDR fees have been especially frustrating for radiologists trying to participate in the IDR process. Under initial guidance, the administrative fee was set to \$50 and the IDRE fees up to \$670. Then, the IDR administrative increased from \$50 to \$350⁵, along with an increase in the IDRE fees (up to more than \$1200), with less than a two-week warning to physician practices. Most radiology claims are for less than \$50, with the vast majority below \$100. Almost none are \$350 or more. Thus, without broader batching rules, radiology cannot access IDR in a cost-efficient manner.

The Centers for Medicare and Medicaid Services (CMS) announced on August 11 the repeal of a 600% increase to its fee to file a dispute under the NSA. This action is in response to the latest ruling by the U.S. District Court for the Eastern District of Texas in a suit brought against the federal government by the Texas Medical Association, Texas Radiological Society, Houston Radiology Associated and others, that charged the government’s fee increase and batching rule violated federal law. ACR, along with the American College of Emergency Physicians (ACEP) and the American Society of Anesthesiologists (ASA), filed an amicus brief in support of the lawsuit (known as “TMA IV”). ACR was pleased to learn of this result but to make matters even more complicated, new guidance has been issued regarding the IDR fees.

On September 20, 2023, the U.S. Departments of the Treasury, Labor, and Health and Human Services issued a new proposed rule, outlining a new fee structure for the IDR process. The proposed new

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

⁵ <https://www.cms.gov/ccio/resources/regulations-and-guidance/downloads/amended-cv2023-fee-guidance-federal-independent-dispute-resolution-process-nsa.pdf>

administrative fee, which is required to be paid by both providers and payers entering the IDR process, is \$150 beginning January 1, 2024. This triples the \$50 fee which CMS reverted to following the TMA IV court decision and is still not workable for radiologists. The proposed fees for batches have also increased and the larger the batch, the higher the fee. In the proposed rule, the departments also indicate that the final administrative fee may differ from the proposed \$150, if additional data becomes available between the publication of the proposed and final rules. They also propose to allow the fee to be updated more or less frequently than annually using the rulemaking process. This makes financial planning for physician practices nearly impossible and further exemplifies why IDR is still not accessible for radiologists under this new proposal. The chart below illustrates the evolution of the fees for the IDR process.

| | 2022 | 2023 (January 1- August 2) | 2023 (August 3- December 31) | 2024 (Proposed) |
|-------------------------------|-----------|---|---|--|
| Administrative Fee | \$50.00 | \$350.00 | \$50.00 | \$150.00 |
| IDR Entity Fee Range - Single | \$200-500 | \$200-700 | \$200-700 | \$200-840 |
| IDR Entity Fee Range - Batch | \$268-670 | \$268-938 | \$268-938 | \$268-1,173 |
| Large Batch Add-On Fee | N/A | 21-50 items: 110% of batch fee 51-80 items: 120% of batch fee 81 or more: 130% of batch fee | 21-50 items: 110% of batch fee 51-80 items: 120% of batch fee 81 or more: 130% of batch fee | Fixed fee between \$75-250 for every additional 25 line items. |

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 the narrowly defined batching requirements, it is cost prohibitive to participate in the IDR process, resulting in massive underpayments. The newly proposed guidance on fees also deters physicians from batching based on the higher fees for larger batches. While ACR understands new guidance will be issued by the departments about batching, we recommend Congress provide strict oversight to ensure the rules do not disincentivize physicians from accessing the IDR process.

The financial impact on radiology practices is just one challenge resulting from implementation of the NSA. Patient care is also suffering. Radiology is facing a national labor force shortage, which has been compounded by ongoing Medicare reimbursement cuts, stresses from the pandemic and macroeconomic factors such as inflation. In turn, 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.

Recommendations:

- 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. 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.⁶
- Any future rulemaking involving IDR fees should take into consideration the average amount of an actual claim to ensure that the fees are not cost prohibitive for practices attempting to utilize the IDR process.
- The IDR fees should remain a standard amount and only be updated through the rulemaking process. Fees should not deter batching.

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.

Additionally, 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.

Last month, in a separate court ruling, the U.S. District Court for the Eastern District of Texas agreed with the plaintiffs, the Texas Medical Association, that the government was incorrectly permitting insurers to use a faulty methodology when calculating their median in-network rate, also known as the qualifying payment amount (QPA). ACR, along with ACEP and ASA, also filed an amicus brief in support of this

⁶ 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).

litigation (known as “TMA III”). The court agreed that the methodology the insurers employed in calculating the QPA was tilting the arbitration process in the insurers’ favor. The court overturned several regulatory provisions related to the QPA calculation, including those that enabled insurers to include in the calculation of QPAs contracted rates for services that physicians do not provide, known as “ghost rates.” Although the government may still appeal, if the decision stands, this ruling will bring the law back in line with what Congress intended for the NSA.

Unfortunately, because of the court ruling, HHS put a hold on the IDR process, putting physician practices in limbo. However, the hold was partially lifted with an announcement by CMS on September 21, 2023, instructing IDR entities to resume processing disputes submitted on or before the Aug. 3 court ruling. The frequent disruptions in the IDR process have also added to physicians’ frustration and the backlog in claims that await IDR decisions. However, ACR enthusiastically awaits new guidance around the QPA.

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. This will help providers determine 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, as well as provide IDREs with dispositive information about whether a particular claim is eligible for the federal IDR process.
- 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.
- Require public reporting/audits of IDR process, including QPAs.
- Reopen the IDR process and instruct arbitrators to disregard qualified payment amount calculations until a rule that complies with the court’s decision is published.

Lack of Timely Payment and Communication

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.

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 creates additional administrative burden on practices.

Recommendations

- HHS should enforce required timely payments. Insurers who are not paying what they owe to a provider after the IDR process is complete 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.
- 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.

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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Cynthia R. Moran
Executive Vice President
American College of Radiology