April 25, 2022

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

RE: ***Feedback on the Independent Dispute Resolution (IDR) Portal***

Dear Secretaries Becerra, Walsh, and Yellen:

On behalf of our members, the American College of Emergency Physicians (ACEP) and the Emergency Department Practice Management Association (EDPMA) would like to lay out some issues emergency physicians have had obtaining the required information from plans and issuers as articulated under the *Requirements Related to Surprise Billing; Part I Interim Final Rule* (First IFR).[1] All of the information listed in the regulation is absolutely necessary for providers in order to accurately assess the patient responsibility amounts, keep patients out of the middle of easily

[1] Requirements Related to Surprise Billing; Part I. 86 FR. 36898-36899 (July 13, 2021).

addressable issues, sustain clinical practices, and eventually resolve any payment disputes for out-of-network services with efficiency for all parties involved.

As background, ACEP is the national medical society representing emergency medicine. Through continuing education, research, public education and advocacy, ACEP advances emergency care on behalf of its 40,000 emergency physician members, and the nearly 150 million Americans we treat on an annual basis. EDPMA is the nation's largest professional physician trade association focused on the sustainable delivery of high-quality, cost-effective care in the emergency department (ED), and its members handle over half of the visits to U.S. emergency departments each year. Together, ACEP and EDPMA members provide a large majority of emergency care in our country, including rural and urban settings, in all fifty states and the District of Columbia.

Overview of Regulatory Requirement

In the First IFR implementing the *No Surprises Act*, the Departments require that "plans and issuers make certain disclosures with each initial payment or notice of denial of payment, and that plans and issuers must provide additional information upon request of the provider or facility. This information must be provided in writing, either on paper or electronically, to a nonparticipating provider, emergency facility, or provider of air ambulance services, as applicable, when the QPA serves as the recognized amount."[2]

These required disclosures, which are specifically found in the First IFR[3], include the following:

- First, a plan or issuer must provide the Qualifying Payment Amount (QPA) for each item or service involved.

- Second, a plan or issuer must provide a statement certifying that, based on the determination of the plan or issuer: (1) the QPA applies for purposes of the recognized amount (or, in the case of air ambulance services, for calculating the participant's, beneficiary's, or enrollee's cost sharing), and (2) each QPA shared with the provider or facility was determined in compliance with the methodology outlined in these interim final rules.
    - The First IFR also requires a statement from the plan or issuer that the QPA applies for purposes of the recognized amount so that providers and facilities will understand that the plan or issuer has determined that neither an All-Payer Model Agreement nor a specified state law applies for purposes of calculating a participant's, beneficiary's, or enrollee's cost-sharing liability, but rather that cost sharing liability has been calculated using the QPA. The Departments expect that in most if not all cases where the QPA serves as the basis for determining the recognized amount, the federal IDR process will govern any dispute over payment instead of a specified state law or process. Therefore, this notice will also serve to

[2] 86 FR. 36898 (July 13, 2021).
[3] 86 FR. 36898-36899 (July 13, 2021).

direct providers or facilities to the federal IDR process if the parties cannot agree on an out-of-network rate.

- Third, a plan or issuer must provide a statement that if the provider or facility, as applicable, wishes to initiate a 30-day open negotiation period for purposes of determining the amount of total payment, the provider or facility may contact the appropriate person or office to initiate open negotiation, and that if the 30-day open negotiation period does not result in a determination, generally, the provider or facility may initiate the IDR process within 4 days after the end of the open negotiation period. The plan or issuer must also provide contact information, including a telephone number and email address, for the appropriate office or person to initiate open negotiations for purposes of determining an amount of payment (including cost sharing) for such item or service.

- In addition, upon request of the provider or facility, a plan or issuer must provide, in a timely manner, information about whether the QPA includes contracted rates that were not set on a fee-for-service basis for the specific items and services at issue and whether the QPA for those items and services was determined using underlying fee schedule rates or a derived amount. If a related service code was used to determine the QPA for a new service code, a plan or issuer must provide information to identify which related service code was used. Similarly, if an eligible database was used to determine the QPA, a plan or issuer must provide information to identify which database was used to determine the QPA.

- Finally, if applicable upon request, a plan or issuer must provide a statement that the plan's or issuer's contracted rates include risk-sharing, bonus, penalty, or other incentive-based or retrospective payments or payment adjustments for the items and services involved that were excluded for purposes of calculating the QPA. Having information about whether the median contracted rate excludes these types of payment adjustments will better inform the open negotiation and IDR process.

Examples of Incomplete information

ACEP and EDPMA are extremely concerned that although these requirements have been very clearly spelled out for months in the First IFR, they are already not being met and therefore threaten the objectives of the *No Surprises Act.* As seen in the examples provided in Appendix 1, some issuers are not providing all the required information directly to providers with each initial payment or notice of denial of payment. Here are some overall issues our members are experiencing:

- **Issuers do not indicate that the QPA applies for purposes of the recognized amount**: As required by the *No Surprises Act*, when a state law or all-payer model does not apply, the cost-sharing amount for out-of-network services (called the "recognized amount"), should be based on the QPA. However, as seen from the Appendix 1 examples labelled "Unclear if patient responsibility tied to QPA," there is no statement or any other notification from the issuer that the QPA applies for purposes of the recognized amount. Since it is unclear whether the cost-sharing amount included in the remittance notice *is* the

recognized amount, our members are unable to verify whether that amount is accurate. **This lack of information can cause confusion for both providers and patients and can easily result in patients being billed the incorrect amount—which consequentially puts patients back in the middle of billing disputes.**

While the Centers for Medicare & Medicaid Services (CMS) recently released guidance for *No Surprises Act* Remittance Advice Remark Codes (RARCs) that would note that the cost-sharing amounts are calculated in concordance with the *No Surprises Act* requirements, the RARC codes are not mandatory and are not always being used. There are also RARC codes that identify whether the claim is subject to the federal process, but these also are not being included on remittance notices. The omission of the RARC codes is reflected in the Appendix 1 examples that are labelled "No Code (RARC) to notify claim is subject to the federal process**." Thus, without the RARC codes, and without a statement that the QPA applies for purposes of the recognized amount, it is also impossible to know whether the federal dispute resolution process applies to the claim instead of a specified state law or process.**

- **The QPA is NOT provided along with each initial payment or notice of denial.** The initial payment or denial, along with other information about the claim, are usually provided on an electronic remittance advice (ERA) or paper-based remittance notice. However, many issuers are not including the QPA on the ERA or paper-based remittance notice. We include such examples in Appendix 1 (labelled "No QPA"). Omission of the QPA from these remittance notices violates the regulatory requirement for the issuer to provide the QPA to the provider with each initial payment or notice of denial.

- **Most issuers are not providing contact information, including an email address, for the appropriate office or person with which to initiate open negotiations.** This information in many cases is not located on ERAs or paper-based remittance notices, and often cannot even be provided by issuers when our members contact them and specifically request it. Examples of missing contact information are included in Appendix 1 (labelled "No Email Contact for Initiation of Open Negotiation"). On the occasions that a phone number is at least included, without an email address, initiating open negotiation becomes administratively inefficient for all parties, adding costs to the system. Unlike a phone number, an email address also ensures a documented paper trail that will provide all parties with appropriate protection to demonstrate that the *No Surprises Act*'s many required timelines for open negotiation and the IDR process were adhered to.

Specific Requests

ACEP and EDPMA believe that the Departments should take the following actions to ensure that issuers are complying with the regulatory requirements around information sharing.

1. **Require Issuers to Include All Information in One Place: The Departments should require issuers to include all the required information listed in the First IFR in one place at the time of the initial payment or notice of denial—specifically in the ERAs or paper-based remittance notices.** Currently, there is no requirement for issuers to provide the information in a specific format or in a specific document. Creating and enforcing such a requirement may help address some of the issues we are experiencing and reduce administrative complexity.

2. **Require Information to Be Displayed in a Standardized Format:** In addition to requiring issuers to display all the information in one place**, the Departments should require the use of a standardized template in which to relay the information. The Departments could create such a standard template which includes all the required information in a clear and easily understood format.** Issuers then could then incorporate the standardized template into their ERAs or paper-based remittance notices to ensure that all required information is accurately transmitted to providers at the time of the initial payment or notice of denial.

3. **Require the use of the *No Surprises Act* RARCs**: As referenced above, CMS recently finalized new RARCs that are now optional for issuers to use to communicate information about claims to providers and facilities, subject to state law. **As part of the standardized template, the Departments should require the use of the RARCs.**

ACEP and EDPMA strongly believe that adopting these recommendations would help achieve many noteworthy goals that we both share: ensuring that patients are billed accurately and kept out of the middle of payment disputes; reducing administrative complexity and burden; and eliminating unnecessary costs in the health care system as both issuers and providers reduce the number of billing errors and the overall time it takes to properly review and adjudicate claims. Finally, having all the required information could help improve negotiations between the disputing parties, which potentially could help avoid having to rely on the IDR process to resolve disputes. We therefore respectfully request that the Departments duly and carefully consider our requests.

Lastly, ACEP and EDPMA would like to reiterate our previous request that the following information be made available in addition to the information already required to be disclosed by the First IFR:

- The type of plan that covers each claim and the dates that each plan has opted into and out of any state laws;
- The resolution pathway that each item or service lives under (i.e., "Specified State Law" or federal IDR process);
- The QPA(s) for the items and services *as billed by the provider* in cases where the initial payment or recognized amount is based off of a different service or level of service that the provider initially billed;

- The patient's copay, deductible, and coinsurance for each claim;
- Additional information that helps with the valuation of payment amounts should be routinely supplied in an easily accessible, machine-readable, downloadable format, including how the QPA(s) was calculated. Specific information includes:
    - The number of contracts used to calculate the QPA;
    - Whether the QPA was calculated using contracts with clinicians in the same or similar specialty;
    - The geography used to calculate the QPA (i.e., Single MSA, all MSAs in a state, Census Division);
    - Percentage of total claims covered by contracts used to calculate QPA (in-network percentage);
    - Percentage of in-network claims attributable to each contract;
    - Whether the plan or issuer's QPA calculations have had an audit result of anything other than "clean" within the last 3 years;
    - If the plan or issuer uses a standard fee schedule, the amount for the service as it appears on the fee schedule for the specific market; and,
    - If the plan or issuer uses contracts from a plan year other than January 31, 2019 to calculate the QPA.

By requiring issuers to provide this information in the initial response to the providers' claim—in addition to all the disclosures that the First IFR required—the Departments will facilitate clearer insight into how the QPA was calculated and reduce the potential for billing errors even further.

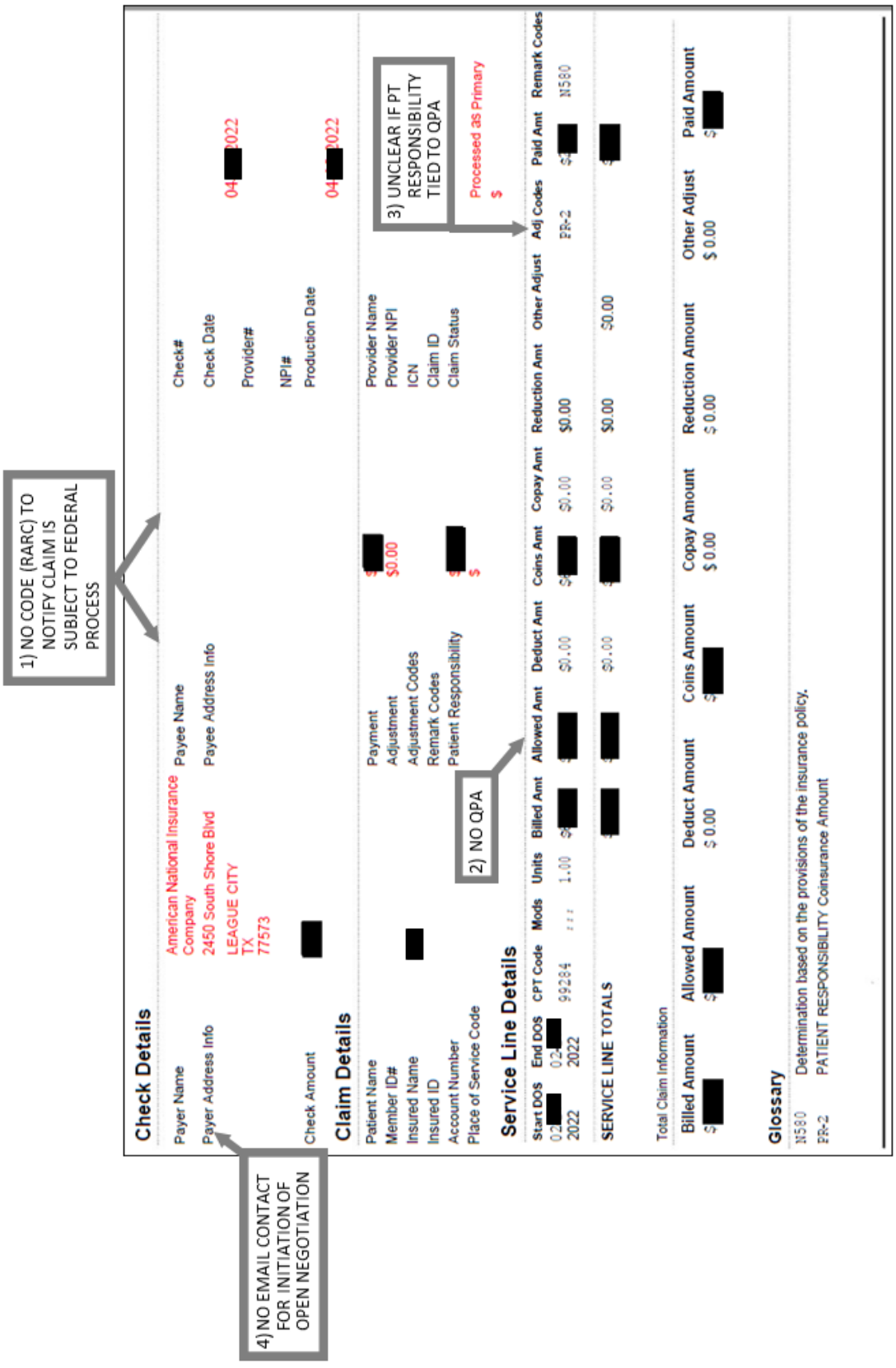
Thank you for the opportunity to provide our input on some of the issues our members are experiencing when it comes to receiving all the required information related to the QPA. If you have any questions, please contact Laura Wooster, ACEP's Senior Vice President of Advocacy and Practice Affairs at lwooster@acep.org, or Cathey Wise, EDPMA's Executive Director at cathey.wise@edpma.org.

Sincerely,

Gillian R. Schmitz, MD, FACEP
ACEP President

Don Powell, DO
Chair of the Board, EDPMA

Appendix 1


1) NO CODE (RARC) TO NOTIFY CLAIM IS SUBJECT TO FEDERAL PROCESS
4) NO EMAIL CONTACT FOR INITIATION OF OPEN NEGOTIATION
2) NO QPA
3) UNCLEAR IF PT RESPONSIBILITY TIED TO QPA
Check Details
Payer Name
American National Insurance Company
Payee Name
Check#
Payer Address Info
2450 South Shore Blvd
LEAGUE CITY
TX
77573
Payee Address Info
Check Date
Provider#
NPI#
Production Date
Check Amount
Claim Details
Patient Name
Member ID#
Insured Name
Insured ID
Account Number
Place of Service Code
Payment
Adjustment
Adjustment Codes
Remark Codes
Patient Responsibility
$0.00
Provider Name
Provider NPI
ICN
Claim ID
Claim Status
Processed as Primary
Service Line Details
Start DOS
End DOS
CPT Code
Mods
Units
Billed Amt
Allowed Amt
Deduct Amt
Coins Amt
Copay Amt
Reduction Amt
Other Adjust
Adj Codes
Paid Amt
Remark Codes
99284
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$0.00
$0.00
$0.00
$0.00
PR-2
N580
SERVICE LINE TOTALS
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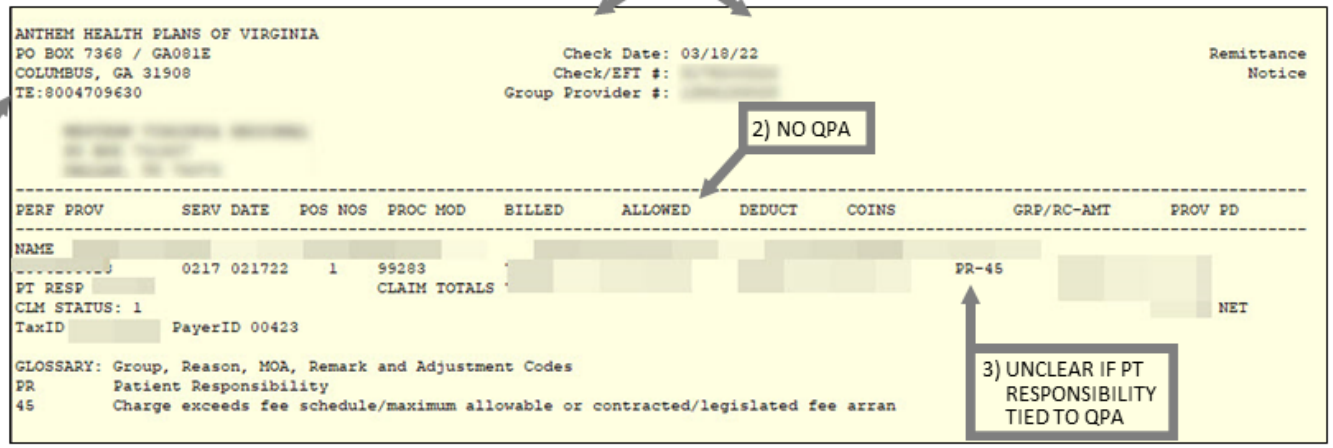
$0.00
$0.00
$0.00
Total Claim Information
Billed Amount
Allowed Amount
Deduct Amount
$ 0.00
Coins Amount
Copay Amount
$ 0.00
Reduction Amount
$ 0.00
Other Adjust
$ 0.00
Paid Amount
Glossary
N580 Determination based on the provisions of the insurance policy.
PR-2 PATIENT RESPONSIBILITY Coinsurance Amount

1) NO CODE (RARC) TO NOTIFY CLAIM IS SUBJECT TO FEDERAL PROCESS

4) NO EMAIL CONTACT FOR INITIATION OF OPEN NEGOTIATION

2) NO QPA

3) UNCLEAR IF PT RESPONSIBILITY TIED TO QPA



ANTHEM HEALTH PLANS OF VIRGINIA
PO BOX 7368 / GA081E
COLUMBUS, GA 31908
TE:8004709630

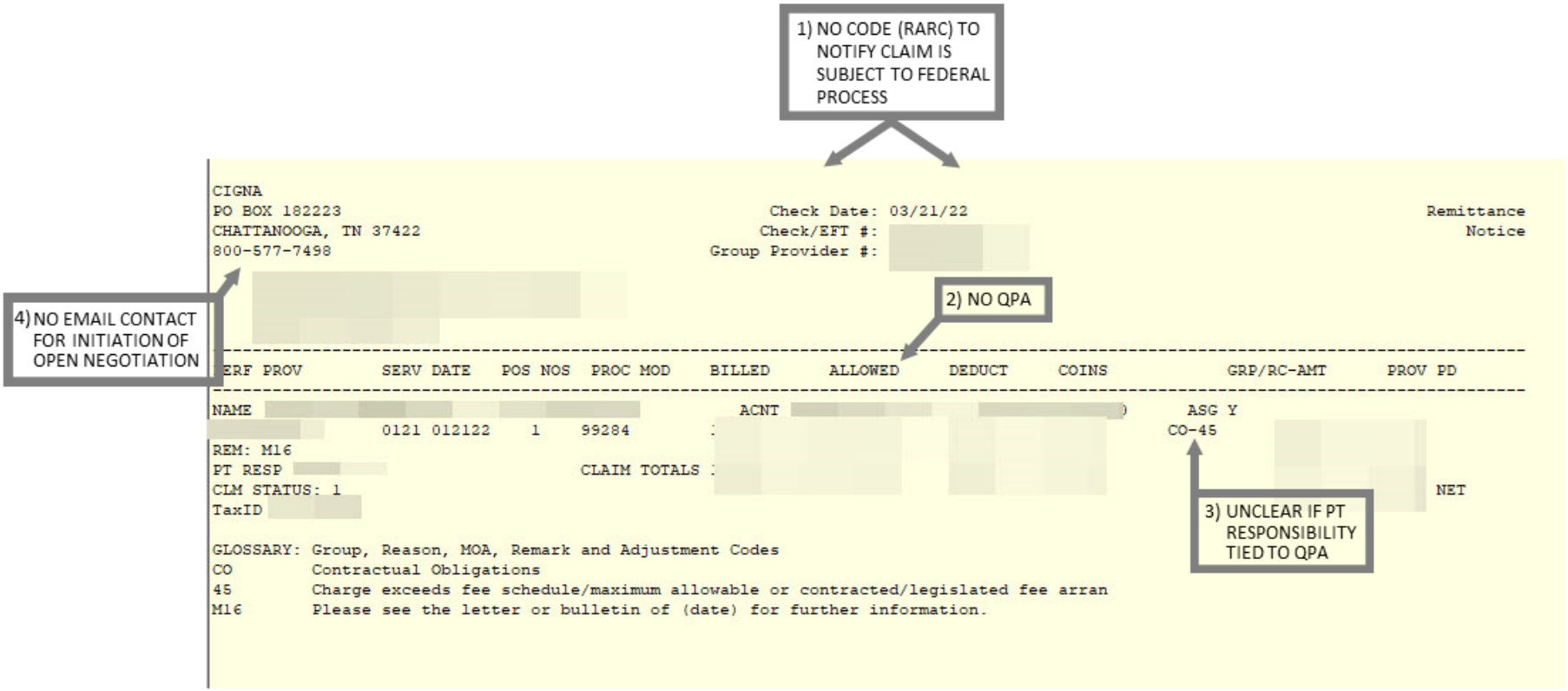
Check Date: 03/10/22
Check/EFT #:
Group Provider #:

Remittance Notice

PERF PROV	SERV DATE	POS	NOS	PROC MOD	BILLED	ALLOWED	DEDUCT	COINS	GRP/RC-AMT	PROV PD
NAME										
	0217	021722	1	99283					PR-45	
PT RESP				CLAIM TOTALS						NET

CLM STATUS: 1
TaxID PayerID 00423

GLOSSARY: Group, Reason, MOA, Remark and Adjustment Codes
PR Patient Responsibility
45 Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arran


1) NO CODE (RARC) TO NOTIFY CLAIM IS SUBJECT TO FEDERAL PROCESS
4) NO EMAIL CONTACT FOR INITIATION OF OPEN NEGOTIATION
2) NO QPA
3) UNCLEAR IF PT RESPONSIBILITY TIED TO QPA
CIGNA
PO BOX 182223
CHATTANOOGA, TN 37422
800-577-7498
Check Date: 03/21/22
Check/EFT #:
Group Provider #:
Remittance Notice
ERF PROV SERV DATE POS NOS PROC MOD BILLED ALLOWED DEDUCT COINS GRP/RC-AMT PROV PD
NAME ACNT ASG Y
0121 012122 1 99284
CO-45
REM: M16
PT RESP
CLAIM TOTALS
CLM STATUS: 1
NET
TaxID
GLOSSARY: Group, Reason, MOA, Remark and Adjustment Codes
CO Contractual Obligations
45 Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arran
M16 Please see the letter or bulletin of (date) for further information.