



American College of Radiology (ACR) Detailed Summary of Requirements Related to Surprise Billing: Final Rules

On Friday, August 19, the Departments of Labor, Health and Human Services (HHS), and the Treasury (“the Departments”) issued the [Requirements Related to Surprise Billing: Final Rules](#). This set of rules is narrow in scope and only addresses the payment determination standards under the Federal independent dispute resolution (IDR) process.

These final rules make changes as a result of decisions made in Texas in February of this year. In late October 2021, the Texas Medical Association and a Texas physician filed a lawsuit against the Departments and the Office of Personnel Management (OPM) claiming that provisions of the October 2021 interim final rules that directed IDR entities to presume that the qualifying payment amount (QPA) is the appropriate out-of-network rate for the service under consideration violated the intent of the NSA. The plaintiffs argued that the interim final rules ignored Congress’s intent that certified IDR entities weigh the QPA and other factors equally, and as a result, the rules would skew IDR results in favor of plans and issuers. On February 23, 2022, the United States District Court for the Eastern District of Texas (District Court) issued a memorandum opinion and order that vacated portions of the October 2021 interim final rules governing aspects of the Federal IDR process.

Background

The Consolidated Appropriations Act, 2021 (CAA), including the No Surprises Act (NSA), was enacted on December 27, 2020. The NSA provides Federal protections against surprise billing and limits out-of-network cost sharing under many of the circumstances in which unexpected bills arise most frequently. “Surprise billing” occurs when an individual receives an unexpected medical bill from a health care provider or facility after receiving medical services from a provider or facility that, usually unknown to the participant, beneficiary, or enrollee, is a nonparticipating provider or facility with respect to the individual’s coverage.

The Departments issued interim final rules in [July](#) detailing the QPA calculation methodology and additional interim final rules in [October](#) to lay out the IDR process. The ACR submitted comments on both the [July](#) and [October](#) rules.

The Departments note that they received many comments related to the payment determination standards under the Federal IDR process, including the provisions that govern the certified IDR entity’s consideration of the enumerated factors. These final rules address only the provisions related to these comments, and they make changes in light of the decisions in Texas Medical Association and LifeNet. The Departments intend to address comments related to other provisions of the July 2021 and October 2021 interim final rules, including comments received in response to the July 2021 interim final rules related to the disclosure requirements that are not specifically related to downcoded service codes, at a later date.



Downcoding

The Departments received many comments from stakeholders concerned about plan or issuers “downcoding” service codes without explanation. In these final rules, the Departments conclude that additional disclosure of information about the QPA when services are downcoded is appropriate.

These final rules define the term “downcode,” as described in the preamble to the October 2021 interim final rules, to mean “the alteration by a plan or issuer of a service code to another service code, or the alteration, addition, or removal by a plan or issuer of a modifier, if the changed code or modifier is associated with a lower QPA than the service code or modifier billed by the provider, facility, or provider of air ambulance services”.

The Departments believe that additional information would be helpful in cases in which the plan or issuer has downcoded the billed claim to ensure that providers, facilities, and providers of air ambulance services receive the relevant information from a plan or issuer needed to engage in a productive open negotiation period. Without information on what the QPA would have been if the claim not been downcoded, the provider may be at a disadvantage compared to the plan or issuer. In cases in which the plan or issuer has downcoded the billed claim and asserts that the QPA that corresponds with the downcoded claim is the correct total payment amount, it is of particular importance that the provider, facility, or provider of air ambulance services knows that the item or service in question has been downcoded and has information regarding both the QPA for the downcoded claim and the amount that would have been the QPA had the service code or modifier not been downcoded.

These final rules state that, if a QPA is based on a downcoded service code or modifier, in addition to the information already required to be provided with an initial payment or notice of denial of payment, a plan or issuer must provide a statement that the service code or modifier billed by the provider, facility, or provider of air ambulance services was downcoded; an explanation of why the claim was downcoded, including a description of which service codes were altered, if any, and which modifiers were altered, added, or removed, if any; and the amount that would have been the QPA had the service code or modifier not been downcoded.

The Departments are continuing to consider whether additional disclosures requirements related to the QPA calculation methodology should be provided with an initial payment or notice of denial of payment, or upon request. The Departments note that the statute places the responsibility for monitoring the accuracy of plans’ and issuers’ QPA calculation methodologies with the Departments (and applicable state authorities) by requiring audits of plans’ and issuers’ QPA calculation methodologies. The Departments also stress that payment determinations in the Federal IDR process should center on a determination of a total payment amount for a particular item or service based on the facts and circumstances of the dispute at issue, rather than an examination of a plan’s or issuer’s QPA methodology.



Independent Dispute Resolution

These final rules remove the language from the October interim final rules stating that the IDR entities must begin with the presumption that the QPA is the appropriate out-of-network rate for the item or service under consideration. Rather, the final rules now state, “**The certified IDR entity must select the offer that the certified IDR entity determines best represents the value of the qualified IDR item or service as the out-of-network rate.**”. The rules then go on to state that the IDR entity must first consider the QPA for the same or similar item or service and then must consider additional “credible” information submitted. Credible information is defined as “information that upon critical analysis is worthy of belief and is trustworthy”.

The additional information may include:

1. The level of training, experience, and quality and outcomes measurements of the provider or facility that furnished the service(s).
2. The market share held by the provider or facility or that of the plan or issuer in the geographic region in which the service was provided.
3. The acuity of the participant, beneficiary, or enrollee receiving the item or service, or the complexity of the furnishing the item or service to the beneficiary.
4. The teaching status, case mix, and scope of services of the furnishing facility.
5. Demonstration of good faith efforts (or lack thereof) made by the provider or facility or the plan or issuer to enter into network agreements with each other, and, if applicable, contracted rates between the provider or facility, as applicable, and the plan or issuer, as applicable, during the previous 4 plan years.

In weighing the above considerations, the certified IDR entity should evaluate whether the information is credible and relates to the offer submitted by either party for the payment amount for the qualified IDR item or service that is the subject of the payment determination. The Departments state that the certified IDR entity should not give weight to information to the extent it is not credible, it does not relate to either party’s offer for the payment amount for the qualified IDR item or service, or it is already accounted for by the qualifying payment amount.

The October interim final rule requires the IDR entity to provide a detailed explanation of its decision only if the QPA is not selected as the appropriate out-of-network rate. **In these final rules, the Departments states that in all cases, a written decision with a comprehensive discussion of the rationale for the decision must be included to ensure that the parties understand the outcome of the payment determination. The certified IDR entity’s written decision must include an explanation of its determination, including what information the certified IDR entity determined demonstrated that the offer selected as the out-of-network rate is the offer that best represents the value of the qualified IDR item or service, including the weight given to the QPA and any additional credible information submitted. These final rules also require that, if the certified IDR entity relies on additional information or additional circumstances in selecting an offer, its written decision must include an explanation of why the certified IDR entity concluded that this information was not already reflected in the QPA.**



Effective Date

These final rules are applicable with respect to items or services provided or furnished on or after October 25, 2022, for plan years or in the individual market policy years beginning on or after January 1, 2022.

Frequently Asked Questions

In addition to the final rules, the Departments published a supporting [Frequently Asked Questions](#) (FAQ) document to address questions and issues raised by stakeholders, including concerns raised by medical specialty societies, including the ACR.

Methodology for Calculating Qualifying Payment Amounts

The QPA is the median of the contracted rates recognized by the plan or issuer on January 31, 2019, for the same or similar item or service that is provided by a provider in the same or similar specialty and provided in a geographic region in which the item or service is furnished, increased for inflation.

The ACR and other medical specialty societies are concerned that the QPA calculation methodology does not consider market share and weighs all contract rates equally. A recent [study](#) by Avalere Health showed that primary care practices often have contracted rates for services they rarely or never provide. The study found that 68% of respondents surveyed had services that they rarely provide (fewer than twice a year) included in their contracts, and 57% of respondents had services that they never provide included in their contract. Such rates may artificially lower the QPA.

The FAQ document recognizes this issue and clarifies that plans and issuers are required to calculate a QPA separately for each provider specialty. The document urges providers, facilities, and providers of air ambulance services with concerns about a plan's or issuer's compliance with the QPA calculation methodology may contact the No Surprises Help Desk at 1-800-985-3059, submit a complaint at <https://www.cms.gov/nosurprises/policies-andresources/providers-submit-a-billing-complaint>, or contact the applicable state authority.

Plan or Issuer Online Portals

Several plans or issuers have developed their own online portals for providers to submit the information necessary to initiate the open negotiation period. The Departments clarified that plans or issuers are not prohibited from encouraging the use of an online portal, however, plans or issuers must accept standard open negotiation forms sent by the initiating party to the contact information provided by the non-initiating party.

The Departments will continue to monitor whether and how the parties to a payment dispute interact during the open negotiation period and will consider whether additional guidance is needed.



For questions about the No Surprises Act final rules, please contact [Katie Keysor](#), ACR Senior Director of Economic Policy.