Policy Update

Departments Propose Broader Batching and IDR Process Changes for Surprise Billing Claims

Overview

On October 27, 2023, the US Departments of Health and Humans Services, Labor and the Treasury (the Departments), along with the Office of Personnel Management, issued a proposed rule titled Independent Dispute Resolution Operations (CMS-9897). The rule would permit the broader batching of claims under the No Surprises Act (NSA) and make other changes to the Federal Independent Dispute Resolution (IDR) process.

The rule results from recent federal district court litigation challenging batching rules, among other aspects of the Departments' implementation of the law. The rule is open for comment until **January 2, 2024.**

Much of the rule is in response to technical limitations that stakeholders have highlighted since the IDR process began, which have led to backlogs, challenges in correctly identifying the right venue for initiating disputes, and problems processing similar claims together. Below, we highlight the proposed changes related to batching of claims, new information to exchange prior to initiating IDR, and additional direction on IDR fees.

The proposed modifications to the batching and IDR processes would apply to disputes with open negotiation periods beginning on or after the later of **August 15, 2024, or 90 days after the effective date of the final rules**. However, the requirement for health plans to register on the IDR portal would take effect immediately upon publication of the final rule, and the changes to IDR fees would apply to disputes initiated on or after January 1, 2025. The Departments are also seeking comment on whether the new disclosure requirements would be effective six months or a year after additional sub-regulatory guidance is provided.

- A press release on the rule is available here.
- A fact sheet on the rule is available here.

BACKGROUND ON BATCHING CLAIMS

The NSA sought to create efficiencies by allowing for multiple qualified IDR items or services to be submitted as a batched dispute, and by allowing IDR entities to consider similar items or services jointly as part of a single payment determination. Under the statute, a batched item or service must be:

- Billed by the same provider or group of providers
- Paid by the same payer
- Of the same service code, or of a similar service code under a different procedural coding system

- Provided within the same 30-business-day period (or following open negotiation periods ending within a 90-calendar-day cooling-off period), with the discretion for the Departments to broaden this time period (per Public Health Service Act (PHSA) § 2799A-1(c)(3)(A)(i)-(iv))

If a dispute is incorrectly batched, the certified IDR is directed to select one service code to continue through the IDR process. The certified IDR then asks the moving party to resubmit the other service codes as separate disputes, resulting in stakeholders having to file individual claims or resubmit and revise other batches. In addition to undermining efficiencies for claimants and resolvers, separating claims is costly and discourages participation, because parties are responsible for fees related to each dispute brought through the IDR process.

The Departments previously issued regulations that further defined how to appropriately batch claims. (See 26 CFR 54.9816-8T(c)(3), 29 CFR 2590.716-8(c)(3) and 45 CFR 149.510(c)(3).) Two sticking points limiting batching involved how the Departments defined "the same or similar items or services" and "the same group health plan or health insurance issuer." In additional sub-regulatory guidance, the Departments defined "the same or similar items or services" as the same Current Procedural Terminology (CPT), Healthcare Common Procedure Coding System (HCPCS) or Diagnosis-Related Group (DRG) code that describes a qualified IDR item or service. The earlier guidance also defined what it meant to be the same payer, stating that with respect to self-insured claims, "items or services paid for by different self-insured group health plans are not allowed to be batched."

Providers and other stakeholders argued that this guidance ignored how certain providers, especially subspecialists, bill and are paid for services. They also argued that language identifying the "same payer" was overly restrictive, preventing batching across different plans offered by the same issuer, and that the timeframe should more closely align with patient stays or episodes of care, as well as other limitations on submitting similar claims. In addition, some argued that the self-insured claim batching policy effectively means that providers must know the employer of a product to batch self-insured claims. This information may not be readily available to out-of-network clinicians.

Reports issued by the Departments since finalizing the original batching requirements (see also Initial Report on the IDR Process) highlighted problems with the requirements. Facing inefficient, expensive and backlogged disputes, and resistance by the Departments to revisit this batching guidance, providers sought redress through litigation.

On August 3, 2023, a federal court in *Texas Medical Association, et al. v. United States Department of Health and Human Services*, Case No. 6:23-cv-59-JDK (*TMA IV*) vacated the batching regulation, including the definition of "same or similar service." The court found that the Departments failed to consider "broader batching criteria that would give providers increased opportunity to bring their claims to arbitration." The IDR portal then halted operations and, although it has partially been opened, it has since not allowed entities to submit batched claims.

It is also important to note that this proposed rule does not address issues related to the calculation of the qualifying payment amount (QPA) that was the subject of the *Texas Medical Association et al. v. U.S. Department of Health and Human Services et al.* (*TMA III*) court decision. On October 6, 2023, the Departments issued frequently asked questions explicitly clarifying that they disagree with the TMA III decision and that the US Department of Justice will appeal the decision. With respect to the calculation of the QPA, the Departments state that they "do not intend to issue interim guidance . . . [and that] plans and issuers are expected to calculate QPAs using a good faith, reasonable interpretation of the applicable statutes and regulations that remain in effect after the TMA III decision." HHS states that it will exercise enforcement discretion from now until May 1, 2024, and may consider extending the enforcement discretion until November 1, 2024.

EFFORTS TO ADDRESS KEY BATCHING CONCERNS

Overall, how are the Departments proposing to change the batching rules?

The Departments would revise how to define "same service code or a similar service code." While still allowing batching by the same CPT, HCPCS or DRG code, the Departments also propose three additional ways to batch:

- Services that are billed under a comparable code within a different procedural code system (the Departments use the example of CPT code 93000 and HCPCS code G0403, which both correspond to a routine electrocardiogram)
- Buckets of CPT codes that different specialties typically provide (see answer to next question for more details)
- All the services that were provided to a patient during a single encounter that are found on the same claim

The rule, however, places an overall limitation on the number of batches to 25 qualified items or services (line items). This proposal intends to prevent extremely large batches and highlights concerns from the Departments that IDR entities may not be able to process larger groupings of claims and meet required deadlines.

Do the proposed batching changes address how different specialties bill and provide care?

Yes, the Departments propose to allow batching of anesthesiology, radiology, pathology and laboratory items and services billed under service codes that belong to the same Category I CPT code sections. These CPT code sections would focus on a particular body part. For example, radiology would use buckets of CPT codes for imaging services such as 70010 – 71555: Head and Neck, Chest.

This change comes in response to providers who found that current batching guidance prevented them from combining similar claims. While some specialties asked for even broader batching—*e.g.*, batching by the specialty conversion factor without a tie back to a CPT code— the Departments solicit alternative approaches.

The Departments, however, do not allow this flexibility for emergency care providers, who had asked for the ability to batch across the five levels of evaluation and management codes that are typically billed as emergency department services (*i.e.,* CPT codes 99281 – 99285). The Departments believe that there is too much variability among the conditions across these codes—thereby increasing the likelihood for "dissimilar conditions and patient acuities" to permit effective batching. If extremely different conditions were batched together (*e.g.,* an insect bite and a heart attack), the Departments argue that it would be untenable for IDR entities to resolve the batches. The Departments seek comment on whether there are ways to provide additional batching flexibility for emergency department services in a way that mitigates the Departments' concerns.

Again, the rule also places limitations on the new batching flexibility by restricting batched determinations to 25 line items.

Can providers batch claims based on an episode of care?

Generally, the rule does not propose to change the timeframe used to batch claims—relying on the statutory wording of services provided within the same 30-business-day period, and declining to use discretionary authority provided by the law. Despite providers asserting that permitting batching across longer time periods could improve efficiency and align better with certain care episodes, the rule continues to rely on specific-day cut-off periods.

The rule will allow a narrower type of batching, when the items and services are provided to a single patient on one or more consecutive dates of service and are billed on the same claim form (a single patient encounter), but this flexibility may not be as broad as many providers had sought to cover more complex care episodes.

Can batches be done at the issuer level, rather than at the plan level?

Stakeholders pressed the Department to change its interpretation of the phrase "same plan or issuer" to promote expanded batching at the issuer level, rather than at the plan level. They argued that the same health insurance issuer may offer multiple insurance plans in the same geographic market, and that grouping them could result in efficiencies. The Departments now propose to allow batching if the same issuer is required to pay for the qualified IDR items and services, even if the qualified IDR items and services relate to claims from different group health plans or individual market policies.

However, for self-insured group health plans, this requirement would only be satisfied if the same self-insured group health plan is required to pay for the qualified IDR items and services, including when the plan makes payments through a third-party administrator (TPA). The requirement would not be satisfied if multiple self-insured group health plans are required to make payments for the qualified IDR items and services, even if those group health plans make payments through the same TPA. While a given TPA may administer multiple self-insured plans, the self-insured group health plan generally is the responsible party for payment or reimbursement of the qualified IDR items and services.

In all, this policy is effectively the same as the one currently in place: Batching for self-insured plans must be by the plan and not the TPA. However, as discussed below, health plans are required to make additional disclosures at the time of the initial payment and notice of denial, and they must register in the IDR portal. This additional information may help providers identify individual self-insured health plans.

PROPOSALS TO IMPROVE TRANSPARENCY PRIOR TO IDR

The Departments also propose to create an IDR registry, in which all self-insured and fully insured health plans would provide specific information that would help providers identify and contact the plans. Plans would be required to register and provide additional information, including relating to state laws, within 30 business days after the rule is finalized. Once registered, the plan or issuer would receive an IDR registration number.

Additionally, the Departments propose that more information be shared between providers and payers. Specifically, the Departments would require payers to communicate information to all providers that do not have contractual relationships with the payer by using specific claim adjustment reason codes (CARCs) and remittance advice remark codes (RARCs). These codes could help identify whether the claim is subject to the federal dispute resolution process, a specified state law or an all-payer model. Further, health plans must provide information clarifying whether the "recognized amount" that represents the cost-sharing that patients owe is the QPA, and they must provide additional information that helps identify the plan, including:

- The legal business name of the plan (if any) or issuer
- The legal business name of the plan sponsor (if applicable)
- The registration number if the plan or issuer is registered with the IDR registry

The Departments are also proposing improvements to help facilitate negotiations before the IDR process. As proposed, the initiating party must send an Open Negotiations notice to both the Departments and the non-initiating party (currently the notice must go only to the non-initiating party), thereby helping to alleviate any confusion about when an Open Negotiations process begins. The non-initiating party would then send a notice back to the initiating party within 15 business days.

Notably, the non-initiating parties must provide the cost-sharing amount and the plan type to avoid confusion about what a patient owes and to help identify whether the plan is a fully insured plan or self-insured plan for the IDR process.

Further, the Departments are proposing to integrate the Open Negotiations process into the IDR portal, so much of the information that the certified IDR entity would require to resolve disputes would be in the system before the IDR process even started.

ADMINISTRATIVE FEE CHANGES

The Departments recently issued a separate IDR fee proposed rule (Federal Independent Dispute Resolution (IDR) Process Administrative Fee and Certified IDR Entity Fee Ranges, 88 Fed. Reg. 65,888), with comments due on October 26 (one day before the release of this rule). However, the Departments' proposed changes to fee structure and collection in this rule may affect many of previous rule's proposals. While the Departments continue to base the fee on the number of expenditures for process operation (the numerator) divided by an estimated number of fees to be collected (the denominator), the Departments propose to estimate the number of administrative fees to be collected based on the total volume of disputes that may be *initiated* rather than the volume of disputes projected to be *closed*. Although the Departments had estimated their expenditures to be $70 million in the initial IDR fee proposed rule, they would estimate their expenditures to be $100.2 million if this new rule is finalized.

Additionally, the Departments propose to collect the administrative fee two business days after the certified IDR entity is selected. Thus, the initiating party would have to pay the full fee regardless of whether a claim is determined to be eligible or ineligible. If a dispute is determined to be ineligible, the non-initiating party would be required to pay 20% of the fee two business days after the determination is made. The non-initiating party would still pay the full administrative fee for eligible disputes.

Finally, the Departments propose a low-volume threshold (set at the level of the fee itself) for disputes, starting in 2025. If a dispute is below that low-volume threshold, the administrative fee would only be 50%. Taking this all into account, the Departments still propose a new administrative fee of $150, the same as the fee amount proposed in the IDR fee proposed rule.

For more information, please contact Kristen O'Brien or Jeffrey Davis.