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January 2, 2024

Ms. Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1751-P Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Submitted Electronically: https://www.regulations.gov/document/CMS-2023-0157-0002.

Re: File Code RIN 0938-AV15, Federal Independent Dispute Resolution Operations

Dear Administrator Brooks-LaSure:

On behalf of the Radiology Business Management Association (RBMA), we appreciate the opportunity to submit comments to the Centers for Medicare & Medicaid Services (CMS) regarding the Proposed Rule (88 FR 75744)

These proposed rules would set forth new requirements relating to the disclosure of information that group health plans and health insurance issuers offering group or individual health insurance coverage must include along with the initial payment or notice of denial of payment for certain items and services subject to the surprise billing protections in the No Surprises Act.

Established in 1968, RBMA is a professional association that consists of over 2200 radiology practice business leaders who represent over 800 radiology practices in all 50 states. This includes diagnostic radiology, interventional radiology, nuclear medicine, IDTFs and radiation oncology. RBMA is dedicated to advancing the interests and addressing the challenges of radiology business management. Our members are committed to supporting the sustainability and efficiency of radiology practices in the United States, ensuring high-quality patient care and equitable financial outcomes.

In this letter, we aim to address key concerns and provide insights into the proposed rule's potential impact on radiology practices and, by extension, the patients they serve.

Current State of the Independent Dispute Resolution (IDR) Process:

RBMA members are supportive of the No Surprises Act (NSA) goal of protecting patients from balance billing. It has been helpful to protect patients from being caught in the middle of contract negotiations between providers and health plans.

Some radiology groups have found the Open Negotiation and Independent Dispute Resolution process to be helpful to address out of network payment situations. In the vast majority of such cases radiology groups used the batched dispute method prior to its suspension.

Hospital-based radiology services often involve relatively small payment amounts (x-ray payments are typically on the order of $10 per service, for example), and frequently high volumes of a single CPT code (easily thousands of x-rays for a typical radiology group with a major payor in a 30-business day period, and potentially tens of thousands for very large radiology groups). It is critical to radiologists that the batch method be preserved in a form that is viable for both providers and the Independent Dispute Resolution Entity (IDRE).

The CMS IDR portal as it has existed up to now is extremely cumbersome to use for batch disputes on a scale that is viable for radiology groups. Manual entry of individual claims is generally not practical for radiology groups, due to the large number of services involved in the typical economically viable radiology dispute. Further, the requirement to upload copies of explanation of benefits (EOB) or remittance advices is exceedingly cumbersome, since this requires extracting individual claim data from multiple bulk remittances, or manually downloading data from a health plan or issuer websites when available, and then editing to exclude information about patients and services not involved in the batch dispute.

It is our experience that in too many cases health plans and issuers have not adapted their claim processing policies and systems to comply with the provisions of the NSA. The commentary included with the proposed rule notes many of the issues. In addition, we have seen numerous cases where no initial payment is sent to the provider within 30 days of claim submission, as required by law. In some instances, we see the initial payment being sent to the patient. We have also seen cases where health plans and issuers have refused to process claims for services rendered at in network facilities by out of network providers because the health plan has not received a claim from the facility, which is obviously not a permissible exception under the law.

Use of Claim Adjustment Reason Codes (CARC) and Remittance Advice Remark Codes (RARC)

We support the Department's plans to reinforce and expand the use of CARC's and RARC's to standardize and facilitate electronic communications concerning claims subject to the NSA. We noted with concern comments in the preamble to the effect that plans or issuers would not be required to include CARC's and RARC's on payments for out of network services made to the participant, beneficiary or enrollee. In our view, there would never be a service subject to balance billing protections in which payment could be made to anyone other than the provider, and this should be clearly stated in the final rule to avoid any confusion or misunderstanding.

Proposed Changes to Open Negotiation Process

The Departments propose to require that Open Negotiation Notices (ONN) be submitted via the IDR Portal, including submission of supporting documents relevant to the initial payment. As noted above, extraction of documentation of the initial payment from the bulk remittance advices received by radiology groups, which are typically transmitted in electronic form and often encompassing hundreds or thousands of services, is an exceedingly cumbersome, time consuming and often manual process. In view of the 30-business day window from receipt of the initial payment to submission of the OPN, requiring extraction of such documentation prior to submitting the ONN would significantly hamper the ability of radiology groups to access the dispute resolution process. In the current state, extraction of such documents can happen during the Open Negotiation Period (ONP) and prior to submission to the IDR portal, which is operationally more feasible.

We see no mention of how the Departments intend to use the documentation of the initial payment during the ONP. It's our understanding that Open Negotiation (ON) is strictly between the initiating and non-initiating parties, both of which have the relevant documentation. If the Departments don't intend to make use of the documentation, then it should not be necessary to submit such documentation in order to initiate an ON.

If for some reason the Departments have a need for documentation of the initial payment in order to facilitate ON, then we believe the health plan or issuer should be responsible for submitting it, since they own the relevant data and can more easily extract and submit it based on the claim number, CPT code, date of service and NPI submitted by the initiating party.

Determination of Applicability

Throughout the proposed rule the Departments indicate an expectation that health plans and issuers will make the determination about whether a service is subject to the balance limitations. While this is certainly the normal expectation, we caution the Departments to provide an outlet for providers when health plans or issuers incorrectly process a claim as not being subject to NSA rules. For example, some radiology practices report that plans and issuers have improperly refused to provide initial payment or other applicable information for services rendered by out of network providers at in- network facilities in the absence of a claim from the facility. Others have failed to send initial payment and QPA information to providers within the 30-day time frame required by law, sometimes sending it to the patient instead, leaving providers with no way to access the dispute resolution process. There must be a viable avenue for providers to address such situations.

Open Negotiation Response Notice

It has been our observation that more often than not the non-initiating party never responds to ON notices. Therefore, we support the proposal to require a response within 15 business days. We would also support allowing certified IDRE to consider compliance with this requirement when making payment determinations with respect to good faith negotiation.

Open Negotiations via the Federal IDR Portal

The Departments requested comment on whether disputing parties should be required to use the Federal IDR portal for further communication related to ON, beyond initiation and submission of response notice. There may be cases where resolution can best be achieved by face-to-face meetings, or other means of negotiation, and therefore the Federal IDR portal should not be the only permissible venue for ON. To the extent the disputing parties wish to submit documentation concerning good faith negotiations or lack thereof for consideration by the IDR entity, which can be done along with the proposed payment amount as is currently the case.

New Requirements for Initiating an IDR Dispute

The proposed rule would require the initiating party to provide a statement as to whether the considerations for the Federal IDR process are different than those discussed during the ON period. We don't believe this information should be relevant to the IDRE's decision, nor is consideration of such information mentioned in the statute. ON and IDRE arbitration based on statutorily defined factors are two entirely different processes. To the extent open negotiations have occurred under the auspices of the NSA, the factors to be considered by the IDR entities are rarely discussed. We believe the information required for submission to the IDR entity should be strictly limited to information that is relevant to the IDRE's decision under the statute, which would include evidence of good faith negotiations, or the absence thereof, during the open negotiation period.

Batching

The Departments propose to limit batches to 25 services. This limitation would largely make the dispute resolution process economically off limits to radiologists. One of the most common services provided by radiologists is professional interpretation and report on an x-ray. Reimbursement for this service is typically around $10 each. The volume of such services is often quite large. For a typical radiology group and a major payor in a market, it would not be unusual to have hundreds or thousands of x-rays involving a single code within a 30-business day period, and for the largest radiology groups that could extend to tens of thousands. The difference between the initial payment and a reasonable reimbursement rate might be one or two dollars per service, which is significant on a percentage basis, and would be significant in terms of aggregate compensation if batch size is not unduly limited.

It should be obvious that limiting batches to 25 services where the amount in dispute is one or two dollars per service is not possible. Even if the administrative fee was reduced to zero, a 25-service batch limit would result in a dramatic increase in the volume of disputes, which would clearly be counter productive. For example, a dispute involving a single plan or issuer and a single code could previously be submitted as a single batch, for which all of the relevant information other than claim numbers and dates of service would typically be identical. A 25-service limit would mean that what was previously a single batch of 500 services with identical facts would now have to be split into 20 batches, resulting in an exponential increase in dispute volume and related costs.

The same logic holds true with other radiology services such as mammograms and CT scans, where a significant difference between the initial payment and a reasonable payment amount might still be less than $10 per service. Even if the administrative fee is less than the amount in dispute, the cost of navigating the IDR process, especially when the process is largely manual, would make small batch submission prohibitively expensive.

We fully understand the challenges of handling large complex batches, and we support modifying the rules to expedite the processing of disputes. In order to achieve this end while keeping the process accessible to radiologists, we strongly encourage the Departments to resume permitting batches of unlimited size provided there is a single CPT code or single CPT code sub-category for radiology, and the facts to be considered by the IDR (other than claim number and date of service) are essentially the same for all services in the batch. The IDR entity would accept the proposal from one party or the other with respect to all services in the batch. In this scenario, we don't think batches involving hundreds or thousands of claims would be cumbersome for the IDR entities, since there would be a single set of facts and a single decision to be made with respect to all services in the batch. For example, if there is a batch of 1000 chest x-rays and the same facts apply to all services in the batch, the IDRE would accept the proposal from the initiating party or the non-initiating party with respect to all services in the batch. In the experience of our members, this is functionally the way large batch disputes have worked thus far.

We would also ask that the Departments reconsider the 30-business day limit for dates of service in a batch. We find that it is not unusual for plans and issuers to delay payment on certain claims, or reprocess at a later date, so that such claims cannot be placed into a batch. We recommend that the only service date limitation on a large single code, or sub-category batch be that dates of service occur in the same calendar year, in view of the fact that QPA's are generally fixed per calendar year.

We note the proposal to use CPT code sub-categories for batching radiology services. Unfortunately, the proposed groupings by body part are not a good way to identify similar services for purposes of batch arbitration. Within most of the proposed sub-categories there are x-rays that might involve a $10 payment to the radiologist, MRI's that might involve a $100 payment, and other modalities in between. A more reasonable approach would be to group by imaging modality (for example CT, MRI, Ultrasound, mammography, and x-ray/radiography), where appropriate payment amounts, and other relevant facts are more likely to be similar. We would be happy to work with the Departments to devise a more suitable framework to categorize radiology codes for purposes of batching.

The proposed rule permits batching of services when payment is made by the same group health plan or health insurance issuer, which is reasonable. We ask that the Departments clarify whether there will be one identification number for each group health plan or health insurance issuer, or is it possible that there could be multiple identification numbers? In the latter scenario, it could be difficult to determine whether claims are eligible to be batched, so we would strongly encourage a limit of one identification number per group health plan or health insurance issuer.

Reduced Cooling Off Period

To facilitate prompt dispute resolution, we support the Departments proposals to reduce the cooling off period following a batched dispute determination to as little as one business day. By the time a decision has been reached, it will not be uncommon for a significant new batch to have accumulated, worked its way through the ON process and be ready for submission to the IDR portal.

Administrative Fees

We appreciate the effort the Departments made in the proposed rule to balance the costs of the program to participants and the cost of maintaining a program that operates efficiently and effectively for everyone.

The Departments have proposed a reduced administrative fee of $75 for initiating parties and $30 for non-initiating parties in cases where the sum of the highest offers made during ON is less than the standard administrative fee (currently proposed to be $150), terming these to be "low dollar" disputes. Considering the costs providers incur to navigate the dispute resolution process in its current form, or its proposed form, we believe disputes meeting this definition will be exceedingly rare, and therefore this proposal is not meaningful. In view of the administrative costs involved in navigating the process, it would not be reasonable to pursue a dispute where the total payment is less than $150. Even if the difference between the initial payment and the highest offer is 50%, an exceptionally large gap, paying a $75 administrative fee plus the cost of gathering data and navigating the dispute resolution process for a maximum gain of $75 would not make sense.

We support the concept of reduced fees for "low dollar" disputes, but the threshold should be based on the aggregate difference between the initiating party's offers and the initial payments, since this is the potential amount in dispute.

The Departments requested comment on the possibility of limiting payments to electronic payments, including electronic funds transferred from a bank account, and not allowing payment by check. We would encourage the Departments to allow payment by credit card in addition to EFT.

Registration of Group Health Plans, Health Insurance Issuers and Federal Employee Health Benefits Carriers

We believe the development of a registry of plans, issuers and FEHB carriers has great potential to help facilitate the dispute resolution process. We encourage the Departments to seek to organize the registry so that initiating parties to disputes will be able to appropriately batch claims based on the registration and require that the applicable registration number be provider with initial payments. In order to facilitate this, we believe it's important that plans, issuers and FEHB carriers be required to register prior to issuing initial payment for a service subject to balance billing limitations and list their registration number on the remittance.

We note that the proposed rule contemplates that the registry will include state specific information relative to state balance billing protections. We caution the Departments that state balance billing

protections generally apply based on the state where health care services are rendered, which could be any of the 50 states, not just the state(s) that might be recorded on a registry. Therefore, it is not clear to us why registry information about state balance billing protections would be relevant.

ID Cards

The preamble to the proposed rule includes discussion about including certain information on ID cards. The Departments should recognize that in the vast majority of cases hospital-based physicians such as radiologists never see an insurance card for a patient receiving services in a facility, so this is not a reliable method to communicate to providers.

IDR Portal

In view of the many changes proposed with respect to how disputes are submitted to the Federal IDR portal, we ask the Departments to eliminate the requirement to hand key information with minimal breaks or upload individual documents for each service, and instead make it possible to submit all required data to initiate a dispute via a single file upload per dispute. In view of the transition to plans and issuers providing CARCs and RARCs, in most cases the relevant data should exist in standardized text or similar files. This data can be readily extracted into a file format, such as CSV, which can be generated, uploaded and processed by the departments and IDR entities much more readily. The current requirement to generate individual PDFs or similar snippets from large data files is exceedingly cumbersome and should be unnecessary.

RBMA appreciates the opportunity to submit these comments. We continue to support the NSA through reasonable development of operational processes that will benefit both the patients and radiologists we serve. If your staff have questions regarding any of our comments, please contact me at bob.still@rbma.org.

Sincerely,

Robert T. Still
Executive Director