Health Providers Signal Support for No Surprises Dispute Rules

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- Proposal could cut ineligible claim filings, provider group says
- Payer lawyer warns more burden on insurers could result

By Sara Hansard

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The Biden administration's proposed rule for operating No Surprises Act arbitration cases could significantly reduce the number of ineligible claims clogging the system and give medical providers more transparency into how insurers are treating their claims, provider groups say.

The 443-page proposed rule (RIN 0938-AV15) from the Departments of Health and Human Services, Labor, the Treasury, and the Office of Personnel Management released Oct. 27 is intended to make the system to resolve billing disputes between insurers and providers set up under the No Surprises Act more efficient, which should reduce the backlog of cases.

The No Surprises Act (H.R. 133), enacted as part of the Consolidated Appropriations Act of 2021, protects patients from being billed out-of-network rates in emergencies and when they are treated by out-of-network providers at in-network facilities. But payers have brought and won four suits challenging the administration's implementation of the arbitration systems under the surprise billing law in the US District Court for the Eastern District of Texas.

The new proposal the administration issued following its court losses would require employer health plan and health insurance payers to submit claim adjustment reason codes (CARCs) and remittance advice remark codes (RARCs) to medical providers, an idea many providers support. The codes explain how payers adjudicate claims and whether the claims are eligible to go through the independent dispute resolution process. Payers would have to send them when they make payments to non-network providers under the proposed rule.

"If this is used correctly, it should significantly reduce the number of claims that are later determined to be ineligible" for the federal arbitration system, said Andrea Brault, CEO and president of Brault Practice Solutions in San Dimas, Calif., and chair of the Emergency Department Practice Management Association (EDPMA).

Brault also applauded the departments' proposal to cut administrative fees that must be paid by both providers and insurers in arbitration cases from $150 to $75 if the disputed claim is less than $150.

An April report from HHS's Centers for Medicare & Medicaid Services said that more than 330,000 payment disputes over out-of-network health-care claims were initiated in the first year the process was started under the No Surprises Act, nearly 14 times what agencies had estimated would be filed. The first year of operations of the federal independent dispute resolution process "was characterized by a large volume of disputes, substantial complexity in determining whether disputes were eligible for the federal process, and ongoing technical and operational improvements to the federal IDR process," the report said.

The independent dispute resolution system remains closed to groups of "batched" claims as the government works to comply with the district court rulings.

Requiring payers to provide the remittance advice remark codes "will give some important transparency to providers in the process," said Ronald Harter, professor of anesthesiology at Ohio State University and president of the American Society of Anesthesiologists. "It's challenging at best for them with limited information from the payers" to know whether to submit claims to the federal arbitration process, or to arbitration systems used in some states.

However, Lisa Campbell, a principal with Groom Law Group who represents employer plans and health insurers, said requiring payers to submit the codes could put more burden on them. "It would be up to the plans or issuers to provide all this information and to make indications as to whether or not a claim is subject to the NSA," she said.

Batching at Issue

The proposal would also establish standards for what types of claims can be "batched," or combined through the arbitration system, and the departments asked for comments on batching.

Currently, only services with the same current procedural terminology (CPT) codes can be batched together. CPT codes are used by insurers when paying claims based on specific services provided.

The EDPMA favors allowing a range of CPT codes to be combined in arbitration cases, Brault said.

Anesthesiologists would like to see the batching proposal go farther, Harter said. "Anesthesia billing is somewhat unique," and is based on "unit value," he said.

"We ought to be able to batch pretty much every anesthesia claim with a given payer in one large batch," for efficiency, Harter said.

Accuracy will be important in the way claims are batched, Campbell said.

In some cases, many different kinds of claims have been submitted."Who's going to be policing this to

make sure that it's done the way it should be?" she said.

The agencies' proposal would set more rules for the 30-day negotiating period required by the No Surprises Act as well.

Confusion exists about whether the parties are actually in the open negotiation period, and often negotiations are not taking place, said Campbell. Under the new proposal, parties that want to initiate the open negotiation period would have to submit a notice with information including the services in dispute and the initial payment or reason for denying the claim to the other party.

"That is a good thing," because it could lead to negotiating settlements without having to use the independent dispute resolution system, Campbell said.

Employer groups that sponsor health plans want to see the arbitration system improved, Melissa Bartlett, senior vice president of health policy for the ERISA Industry Committee (ERIC), said. The group representing large companies that sponsor employee benefit plans supports the No Surprises Act, but "the implementation has been a pretty big mess due to litigious providers," she said.

"To the extent that these proposals will help avoid a logjam or sort of move things along, then that could be a good thing," she said.

But employers are concerned "with the continued worsening of the IDR process," Bartlett said. "Patient costs are going up," she said. "This is not the way that the No Surprises Act was intended to be implemented."

To contact the reporter on this story: Sara Hansard in Washington at shansard@bloomberglaw.com

To contact the editors responsible for this story: Rebekah Mintzer at rmintzer@bloombergindustry.com; Genevieve Douglas at gdouglas@bloomberglaw.com