BRACEWELL

No Surprises Act Creates Payment Challenges for Providers

Article

August 18, 2023 | *Law360* | 7 minute read

Since April 15, 2022,[1] – the date the US Departments of Health and Human Services, Labor and the Treasury launched the federal Independent Dispute Resolution portal, following the implementation of the No Surprises Act ("NSA") – providers have been forced, to a degree, to navigate the new world of so-called baseball-style arbitration with little practical guidance.[2]

Providers and practitioners are now left with one question: How do we really get paid?

The No Surprises Act's stated purpose is to provide federal protection for patients against surprise bills by allowing providers and insurers a mechanism to dispute certain out-of-network charges via the IDR process.[3]

In a nutshell, IDR was designed to remove the patients from the reimbursement process. It provides an expedited resolution procedure that gives provides and insurers the opportunity to present their out-of-network offers to an independent dispute resolution entity, or IDRE, who then chooses a binding offer.[4]

The advantages of IDR are a provider's relative ease of access to a resolution mechanism, the ability for providers to get reimbursed at the assumed correct out-of-network rate, its theoretically low cost and its expedited nature in resolving disputes.

Despite its stated purpose, the ensuing lawsuits, the departments' ever-changing rules and implementation of said rules by the IDREs have left providers and their counsel scratching their heads in efforts to get consistently reimbursed for out-of-network emergency services.

In this article, we discuss issues that have arisen with the IDR process and provide practical solutions to hopefully ensure success in reimbursements.

Related People

Carrie Douglas
Partner
SAN ANTONIO
+1.210.299.3435
carrie.douglas@bracewell.com

Julia Maeve Kowalsky
Associate
HOUSTON
+1.713.221.1436
julia.kowalsky@bracewell.com

Related Industries

Healthcare

Related Practices

Healthcare & Life Sciences

The first of many issues with the current IDR rules relates to the lack of guidance with respect to NSA applicability and the commencement of an individual's health plan year.

The NSA provides that the IDR process is applicable to plan years beginning on or after January 1, 2022.[5] In interpreting these statutes, one would think that so long as the emergency services occur in a calendar year and are pursued via the NSA during the same calendar year, IDR is applicable to the claim at issue. This has not been the case.

For example, imagine a provider that billed an out-of-network insurer for emergency services and received a remittance from the payor in March 2022. The provider decided to pursue the IDR process but was informed that because the individual's health plan year did not begin until September 2022, the services were therefore ineligible for IDR.

From a practical and equitable standpoint, this reasoning and lack of support for it meant that any services the provider rendered to this patient – or any other patient that did not have a plan start on January 1, 2022, but was still covered during that year – from January 2022 to August 2022 were not NSA-eligible.

The plain text of the statutes simply does not support this conclusion and potentially leaves patients on the hook for services rendered before their plan year began.

The next concern with the current IDR rules is the use of service codes – Current Procedural Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes, and Diagnosis-Related Group (DRG) codes.

Notably lacking from this list, however, are revenue codes. Revenue codes indicate the department in which services were actually rendered, as opposed to a CPT code, for example, which evidences the service or procedure itself.[6]

Revenue codes are important when facility providers bill claims, because certain procedures cost more when performed in certain departments, such as the emergency department.

Because the IDR process does not allow providers to include revenue codes on their submissions via the IDR portal, facility providers are inherently forced to choose pursuing service codes only.

In doing so, facility providers are losing any additional costs that the IDR does not currently account for. This is also true regarding the IDR's former batching rules.[7]

Under the former batching rules, "qualified IDR items or services [were] considered to be the same or similar items or services if each is billed under the same service code, or a comparable code under a different procedural system."[8]

On August 3, 2023, the US District Court for the Eastern District of Texas vacated this rule and opined in *Texas Medical Association v. US Department of Health and Human Services* that batching rule's "'same service code' requirement effectively forces providers out of IDR for some claims, substantially impacting the ability to recover their proposed payment."[9]

Although the inability to include revenue codes when batching services greatly impacts how much a provider can recover in one submission, the cost-prohibitive effects are still present when a facility provider decides against batching and pursues individual CPT codes for a single patient. The result in both instances is multiple and costly submissions.

Another issue with the use of CPT or other service codes is the quantity of units and total amount sought per code. For example, the IDR portal requires that providers include a total amount sought for a particular CPT code.

For a CPT code that includes multiple units, such as mileage for an air ambulance provider or time of case for an anesthesiologist, the code necessarily encompasses a per-unit charge and total aggregate charges.

When an individual CPT code charge is included on the total charges submission box, some IDREs have chosen a single unit amount, as opposed to the provider's total aggregate charges, despite the provider's submission explicitly stating the total charges sought in multiple sections in their submission.

In effect, an IDRE's binding determination can result in the provider receiving a favorable determination that is actually lower than the payor's initial qualified payment amount (QPA) for a certain CPT code when the aggregate reimbursement is not included in the binding determination.

To remedy this situation, providers have contacted the IDRE to explain the per unit versus total amount issue. In doing so, the result is not consistent.

Some IDREs have recognized the inherent bind of this situation and have retroactively rendered the full amount sought by the provider, but some have simply asserted that the provider included the wrong total amount in its submission. In a situation like this, providers only recourse is to file a complaint with CMS, as sending a complaint to the payor for additional payment is simply nonsensical.

Perhaps the greatest pitfall with the current rules is the lack of an enforceability mechanism for payments once the IDRE has rendered a binding determination.

Under the IDR rules, IDRE determinations are binding upon the parties except in the instance of fraud or intentional misrepresentation to the IDRE and are not subject to judicial review.[10] Despite their binding nature, payors have consistently refused to pay providers after a determination has been rendered.

In another example of this, consider an air ambulance provider batched nine identical CPT codes in one submission, and the IDRE chose the provider's offer for each claim.

The payor refused to pay on the purported basis that the codes were incorrectly batched and that the IDRE should not have allowed the provider's submission to get through the IDR process.

Upon learning of the payor's refusal to pay in this example, a demand letter was sent to the payor explaining that IDR determinations are binding and that it did not have discretion to withhold payment on this basis. The demand letter was partially successful, as the payor paid on a few of the claims, but not all.

An additional demand letter was sent to the state's insurance commissioner explaining the payor's behavior as violative of both federal and state insurance law, including the state's Unfair and Deceptive Trade Practices Act and prompt payment laws. After taking these extreme measures, the payor finally remitted all outstanding amounts to the provider.

Alternatively, payors have also been utilizing overpayment notice and/or recoupment demands in an attempt to avoid their IDR obligations. In multiple instances, payors have initially rendered the remaining payment due a provider as a result of a favorable IDR determination, only to seek a refund of the amount later in an attempt to cross-plan offset the amount.

This behavior lends itself to a host of other additional problems, including the need to assess whether the Employee Retirement Income Security Act ("ERISA") notice requirements for adverse benefit determinations are met.

This behavior is an example of payors remorse, which also violates both the letter and spirit of the IDR regulations, as recoupments negate the IDR's binding determination rule.

Ultimately, providers are left with headaches and the decision to continue to pursue payment and incur more costs – potentially more than if they let things stand – or accept defeat.

Situations like this are unfortunately not rare. The IDR's lack of enforcement mechanism and failure to provide for any penalties against noncompliant payors necessarily mean that providers and their counsel are obligated to pursue alternative measures to get reimbursed.

As discussed above, one of these ways is to send demand letters to appropriate individuals in the hopes that they will force the payor's hand. Another tactic is to contact and coax the noncompliant insurer's counsel or their IDR liaison with bated breath to see if the payor will ultimately pay or rescind its refund request.

However, these additional ad hoc measures only impose more costs on providers, both due to the time delay in getting paid and the increased legal fees. This goes against the perceived advantage of the IDR process's cost-

saving nature. The additional painful truth is that these tactics don't always work – and there's no one governing body that is able to slap an insurer's wrist.

Although the Independent Dispute Resolution process under the No Surprises Act has many advantages for providers to quickly get reimbursed for out-of-network emergency services, the process is still in its infancy and the practicalities of its use continue to be hammered out.

If a payor simply refuses to reimburse a provider after a favorable determination, providers are currently left to their own devices in their attempts to be fully reimbursed.

The departments need to issue additional rules that modify and broaden the current batching procedures, create an enforceability framework and establish penalties for noncompliant payors, and expand the amount and type of codes necessary to reduce unnecessary submission costs.

As the IDR process continues to mature, providers are hopeful that the concerns highlighted above – particularly enforceability – will be remedied by the rules. As things stand, a demand letter can only take us so far.

---

[1] *Amendment to the Calendar Year 2023 Fee Guidance for the Federal Independent Dispute Resolution Process Under the No Surprises Act: Change in Administrative Fee*, Centers for Medicare & Medicaid Services (Dec. 23, 2022), at 4, /https://www.cms.gov/cciio/resources/regulations-and-guidance/downloads/amended-cy2023-fee-guidance-federal-independent-dispute-resolution-process-nsa.pdf.

[2] Federal Officials Revise Approach to Arbitration Under No Surprises Act, Health Affairs Forefront (Aug. 22, 2022), https://www.healthaffairs.org/content/forefront/federal-officials-revise-approach-arbitration-under-no-surprises-act.

[3] *Federal Independent Dispute Resolution (IDR) Process for Guiding Disputing Parties*, Centers for Medicare & Medicaid Services (March 2023), https://www.cms.gov/files/document/federal-idr-guidance-disputing-parties-march-2023.pdf.

[4] 49 C.F.R. 149.510(c)(4)(vii)(A)(1)(2).

[5] 26 C.F.R. § 54.9816-5T(d); 29 C.F.R. § 2590.716-4(d).

[6] *Revenue Code*, Law Insider, https://www.lawinsider.com/dictionary/revenue-codes (last accessed Aug. 6, 2023).

[7] As of August 3, 2023, the Eastern District of Texas ordered that the current batching rules related to grouping service codes – CPT, HCPS, and DRG codes – were vacated on the basis that they were not broad enough and were cost-prohibitive to providers with smaller claims. *Texas Med. Assoc., et al., v. U.S. Dept. of Health and Human Services, et al.*, No. 6:23-cv-59-JDK, 2023 WL 3977746, at *11-12, 15 (E.D. Tex. Aug. 3, 2023) (mem. op.). CMS has not yet

indicated whether the batching rules will be broadened, scrapped, or otherwise modified. The CMS IDR portal was set on an unplanned outage schedule as of this date.

[8] 45 C.F.R. § 149.510(c)(3)(i)(C).

[9] *Texas Med. Assoc., et al., v. U.S. Dept. of Health and Human Services, et al.*, No. 6:23-cv-59-JDK, 2023 WL 3977746, at *11 (E.D. Tex. Aug. 3, 2023) (mem. op.).

[10] 45 C.F.R. § 149.510(c)(4)(vii)(A)(1)-(2).

Article originally published on Law360 on August 18, 2023.