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January 2, 2024

The Honorable Xavier Becerra
Secretary
U.S. Department of Health and Human Services
200 Independent Avenue, SW
Washington, DC 20201

The Honorable Julie A. Su
Acting Secretary
U.S. Department of Labor
200 Constitution Avenue, NW
Washington, DC 20210

The Honorable Janet Yellen
Secretary
U.S. Department of the Treasury
1500 Pennsylvania Avenue, NW
Washington, DC 20220

RE: Federal Independent Dispute Resolution Operations, CMS-9897-P

Dear Sectaries Becerra and Yellen and Acting Secretary Su:

On behalf of the physician and student members of the American Medical Association (AMA), I appreciate the opportunity to offer our comments to the Departments of Health and Human Services, Labor, and Treasury ("the Departments") on the proposed rules related the Federal Independent Dispute Resolution (IDR) operations under the No Surprises Act (NSA).

The AMA continues to support the goal of the NSA—to protect patients from surprise medical bills, and in order to protect patients from surprise medical bills while ensuring patient's continued access to care, a fair, balanced, and accessible process for determining out-of-network payments to physicians is needed. From the AMA's perspective, implementation of the NSA and specifically the dispute resolution process has, at a minimum, been a difficult and often disheartening process, during which time we have advocated to the Departments for policies that, among other things, would improve efficiencies and transparencies in the dispute resolution process. While we cannot support everything proposed in these rules, we recognize many of the proposals reflect policies for which we have been advocating and appreciate the Departments' consideration of our input. If finalized, these proposed rules will be an important step in the right direction towards improving the dispute resolution process for physicians and all interested parties. We also wish to signal our appreciation for the recent re-opening of the IDR portal for all claims, including batched claims, and hope that the policies proposed in this rule help to avoid future similar disruptions to the portal's ability to process new claims.

I. Communication between parties

Mandated use of CARCs and RARCs

The AMA continues to hear from physicians who are struggling to determine whether an out-of-network claim is eligible for the federal process, or whether the specified state law applies in those states with

existing surprise billing laws. While there are many nuances to determining the correct process beyond whether the health plan is state or federally regulated, including whether the federal law fills gaps in a specified state law, providing this type of important information earlier in the process could help to reduce resource waste and consequential delays.

As such, **the AMA strongly supports the Departments' proposal to require plans to use Claim Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARCs)**, when providing the initial payment or notice of denial. The AMA agrees with the Departments that requiring the use of CARCs and RARCs to convey information related to the NSA on both electronic and paper remittance advice will improve the flow of information between plans and physicians and increase efficiencies in the processing of claims subject to the NSA, as well as in the processing of claims that are not subject to the NSA's requirements. The AMA also agrees with the Departments that the use of CARCs and RARCs has the potential to reduce inefficiencies in other steps of the payment resolution process for all parties, including IDR entities (IDREs). Therefore, the AMA urges the Departments to finalize this proposed requirement as quickly as possible.

The Departments also seek comment on whether the development of RARCs to convey additional eligibility information would be useful. The AMA is of the opinion that the more information communicated to the physician during the claims processing period the better and believes that additional information such as whether a plan has opted into a state specified law, whether the plan is self-insured, or simply whether the NSA surprise billing protection does not apply to a claim would be extremely useful in reducing eligibility confusion. Therefore, the AMA supports the development of RARCs that would convey such information.

Information to be shared with the QPA

The AMA supports the disclosure of additional information along with the QPA to physicians that would help physician practices identify key information related to NSA eligibility. Additionally, information such as the legal business name of the plan, the legal business name of the plan sponsor, and if the plan is registered with the IDR registry, will help physician practices access the payment dispute process under the NSA, including the open negotiation process, more easily.

II. Changes to the open negotiations process

Congress required the open negotiations process as an important component of the dispute resolution process under the NSA and consistent and good faith use of this process should lead to fewer IDR claims. Unfortunately, we understand that health plans are frequently dismissing outreach from physicians to participate in the open negotiations process and refusing to respond with offers for payment. The AMA appreciates the Departments' acknowledgment of the ongoing lack of participation by non-initiating parties in the open negotiation process and the need for new requirements to formalize this process and create accountability.

Use of federal IDR portal for open negotiation

The AMA supports the proposed requirement that the initiating party provide the open negotiation initiation notice to the non-initiating party via the Federal IDR portal. Benefits to such an approach include increased clarity on initiation and completion of the open negotiation period, which would reduce

related eligibility issues. This transition could also reduce confusion about to whom or where initiating parties should send the open negotiation initiation form, including through individual plan portals that may require separate logins and passwords, creating administrative burdens and confusion for practices. Additionally, moving the open negotiation process to the federal portal could provide an opportunity to eventually make a preliminary eligibility determination regarding federal or state authority on a claim prior to IDR initiation. The IDR portal could efficiently be used for all communication during the open negotiation process, beyond just the initiation notice, and the AMA encourages the Departments to pursue this requirement.

Should the Departments choose to finalize this proposed provision and use the IDR portal for the purposes of the open negotiation process, which the AMA supports, **we urge the Departments to refrain from collecting any associated administrative fee for use of the portal**. Good faith negotiations during this stage of the dispute resolution process must be encouraged and assessing a fee at this time would do just the opposite.

Changes to open negotiations initiating notice

The AMA recognizes that more information may be required on the open negotiations notice to help streamline the process. However, **we urge the Departments to mitigate the impact of placing new administrative burdens on physician practices when finalizing changes wherever possible.** For example, we encourage the Department to consider how the portal could be used to create "check the box" acknowledgements of requirements rather than submission of separate disclosure forms or how physicians' information could be auto-populated into the system.

Additionally, the AMA has concerns with the proposed requirement that initiating parties include the QPA on the open negotiations notice. While the Departments state that the reason for this proposed requirement is to facilitate better communication between parties in identifying whether there may be a mistake in the QPA, we are concerned that including the QPA along with the initiating party's offer erroneously suggests that the QPA is the most relevant factor in the open negotiations process and that the two amounts should be compared in order to determine the out-of-network rate. Moreover, providing this information back to the plan in the open negotiation notice is administratively duplicative.

Changes to open negotiations response notice

The AMA supports the Departments proposal to require a response and counteroffer to the open negotiation initiation notice. This counteroffer will help confirm receipt of the initiation notice and establish a line of communication between the appropriate representatives of each party. The AMA believes an improved open negotiations process will likely lead to more disputes being settled prior to IDR initiation and therefore are glad to see that the response notice content proposed by the Departments anticipates possible acceptance of the initiating party's offer.

Additionally, the AMA appreciates the Departments' attention to the fact that plans may choose to question eligibility or accuracy of information much later in the process, after time, resources, and other opportunities for dispute resolution have been spent. As such, we agree that information such as an explanation of why the non-initiating may believe the item or service at issue is not subject to the Federal IDR process is most useful during the exchange of the open negotiation notice and response and will ultimately have the impact of reducing later eligibility disputes.

Finally, the AMA suggests, as we have in the past, that the health plans be responsible for submitting the data used to calculate the QPA as early in the process as possible. If the physician has not received that information prior to the open negotiation response notice, the notice should contain that information.

III. Changes to IDR initiation notice and response

IDR initiation notice

The AMA encourages the Departments to streamline the IDR initiation process by requiring use of the portal for the initiation notice, response notice, and all other related communications. This would reduce some administrative burden associated with the use of multiple channels of communication between parties, as well as allow for pre-population of notices with available information, including information obtained through the open negotiation process via the portal. Additionally, this will promote consistency between open negotiation and IDR processes and help ensure that required timelines are being met.

The AMA has concerns with the Departments' proposal to require the provider's Tax Identification Number (TIN) in the IDR initiation notice for the purported purposes of facilitating automatic administrative fee collection and debt collection. Unlike health plans, physician practices frequently operate without a financial cushion. Should a physician not pay an IDR-related debt on time, it is very likely because they are financially unable to do so. Given the unique and important role of physician services, the **AMA urges the Departments to balance any policies aimed at debt collection against physicians with the need for physician practices to remain financially stable and able to provide care to patients, particularly practices serving rural and underserved communities**.

The AMA appreciates the Departments clarifying that the QPA must only be included in the IDR initiation notice if it was included with the initial payment or denial notice since, otherwise, it is not information that the physician practice would have readily available. However, the AMA urges the Departments to remove this requirement altogether for physicians and other health care providers, and instead place the requirement on health plans to submit the QPA and their calculation methodology.

Notice of IDR initiation response

The AMA generally supports the proposed requirements that the non-initiating party respond to the IDR initiation notice with additional and more comprehensive information than what is currently being required, such as the detailed contact information for the party as well as for any third-party representatives, in order to streamline the process. The Departments also proposed to require service-related information that will improve eligibility determinations and potentially address some QPA inaccuracies. Additionally, the AMA supports using the response notice to support or object to the initiating party's IDRE selection. Finally, the AMA agrees with the Department's clarification that delays in a response should not impact the IDR timeline or delay initiation of the process.

IV. Collection of IDRE fees

The AMA supports the Departments' proposal that IDRE fees be returned to the parties in full if a settlement between the parties is reached prior to an eligibility determination by the IDRE. We believe this provision will encourage parties to continue to negotiate a fair out-of-network rate after the

open negotiation process has concluded but before IDRE resources are spent on eligibility determinations and evaluation of offers. Significant resources can be saved if such continued communication and negotiation between the parties is incented.

Additionally, we support greater enforcement of a non-initiating party's failure to pay their IDRE fees, including by not considering a party's offer unless they have paid the fees. The AMA often hears from physicians about delays in the process due to late fee payment, and the AMA is glad to see greater proposed enforcement of these time requirements.

V. Batching provisions

The AMA appreciates the Departments' proposals to expand the ability of parties to batch claims for IDR and the recognition that broader batching rules will generally increase efficiencies in the IDR process. We have suggestions for improvements to these proposals below.

Changes to the "related to the treatment of a similar condition" requirement

The Departments propose to expand how claims can be batched under the statutory requirement that such claims relate to the treatment of a similar condition. Under the proposed rule, this requirement can be met using three new mechanisms:

1. Services furnished to a single patient during the same encounter, defined as one or more consecutive days during which the items or services were furnished to the same patient and billed on the same claim form;
2. Items and services billed under the same service code or a comparable code under a different procedural code system; or
3. Anesthesiology, radiology, pathology, and laboratory items and services billed under service codes belonging to subcategories under the same Category I CPT code ranges, specified in guidance.

First, the AMA supports the Departments' proposal to permit services furnished to a single patient during the same encounter to be batched together. We agree that this allowance would create efficiencies by preventing physicians from having to file multiple separate disputes, and pay separate fees, to resolve a single episode of care. Additionally, we agree IDREs would not be burdened by this proposal given that much of the information related to each service is similar or identical—e.g., the health plan, location, date of services—are located on a single claim form.

Second, the AMA agrees that it is important for physicians to be able to batch claims under the same service code or a comparable code under a different coding system. We encourage the Departments to work with the AMA, national medical specialty societies and other coding experts in implementation of this proposal.

Third, the AMA broadly supports the Departments' proposal to move toward allowing subcategories of CPT codes in the same Category I CPT code range to be batched together. However, the Departments should ensure that the appropriate clinical expertise is obtained from the national medical specialty societies as to how feasible the proposed subcategories would be and/or if there are alternative categories that may be more practical and efficient for radiologists, pathologists, and

anesthesiologists than those proposed in this rule. For example, permitting radiology services to be batched using the categories of diagnostic radiology, interventional radiology, radiation oncology and nuclear medicine, would make batch eligibility determinations less burdensome and reduce the number of IDR claims for radiology services.

The AMA also urges the Departments to continue to consider how the use of Category I CPT codes could be used for batching of emergency medical services under this requirement. We continue to see efficiencies in the batching of all emergency department (ED) evaluation and management (E/M) services together to gain greater efficiencies. However, to address concerns about variability in the severity of cases, the Departments could consider subcategories based on ED E/M levels, perhaps allowing ED levels 1-3 to be batched together and ED levels 4-5 or levels 4-5 *and* critical care codes to be another batching group.

Finally, we urge the Departments to consider that in addition to permitting batching by these subcategories, it is important to consider allowances for batching by conversion factor for anesthesiology services. Such an expansion would create the most efficiencies in terms of batching for these services. To summarize, should the Departments move forward with the subcategories as laid out in the proposed rule, the AMA urges the Departments to work with the national medical specialty societies and CPT experts in the development of guidance. The AMA would welcome the opportunity to assist the Departments in this effort.

Same group health plan or health insurance issuer requirement

The Departments seek to retain the requirement that claims cannot be batched across self-insured plans when the third-party administrator (TPA) is the same. The AMA urges the Departments to reconsider this limitation. From the physician's perspective and even with changes proposed in these rules, it is difficult to initially determine separate payers behind a single TPA making it administratively complicated and time consuming to differentiate claims for batching purposes. Conversely, there are significant efficiencies applicable to all parties that could be gained by allowing claims across self-insured payers to be batched and taken to IDR as a single batched claim.

Problems with the 90-calendar-day cooling off period

The AMA appreciates that the Departments recognize that issues may arise with expanded batching rules and the 90-calendar-day cooling offer period, including operational challenges, barriers to submission of subsequent IDR disputes, and resource waste by both the initiating party and the IDRE. Like the Departments, the AMA can imagine scenarios where significant time is spent by physician practices removing single services from batched submissions to meet the "cooling off" requirements and IDREs spending significant time determining what services in large, batched submission are or are not eligible due to this 90-day requirement. Moreover, with broader batching requirements, it is very possible that there could be a stacking of cooling off periods that could last years.

As such, the **AMA encourages the Departments to use their statutory waiver authority to limit the 90-day cooling off period to as short a timeframe as possible—one day**. We suggest this waiver apply when the service(s) subject to the cooling off period is initially submitted as part of a batched claim, as well as when the service is initially submitted as a single claim but subsequently submitted as part of a batched claim.

Line items limits for batched items and services

The AMA is concerned that limiting the line items to be batched together to 25 items may negate some of the efficiencies and costs savings associated with the proposed batching expansions. The AMA believes that rules such as those that limit batching to claims within a 30-business-day period and to those paid by the same insurer or self-insured group health plan will naturally limit the line items. Additionally, the AMA believes that improvements to the ease and timeliness of eligibility determinations proposed elsewhere in this rule will help ensure that IDREs are less burdened with complicated eligibility determination for batched claims.

If the Departments proceed with line-item limitations, the AMA suggests the following:

- Increasing the proposed line-item limitation of 25 to at least 50, including for services provided to the same patient billed on the same claim.
- Reevaluate the line-item limitation after a year in light of other changes in these proposed rules that would improve efficacies in eligibility determinations and the open negotiations process.

Additionally, the **AMA urges the Departments to maintain the flexibility for resubmitting inappropriately batched claims** at least until the impact of proposed changes in this rule can be fully evaluated. Foreclosure of this flexibility could have a significant financial impact on physicians who continue to struggle to navigate the changing batching rules.

V. Administrative fee

Administrative fee manner of payment

In terms of the manner of payment of the administrative fee, as well as for the IDRE fees, the Departments seek comment on restricting the payment through electronic payments, including electronic funds transferred from bank accounts. The AMA accepts that time and efficiency can be gained in limiting payment in this manner and generally supports such a requirement. However, it will be important for the Departments to allow for exceptions for physician practices and other health care providers who may be limited to using checks for payment, as well as ensure that practices can use an electronic payments system that they are currently using in order to prevent administrative burdens associated with enrolling in new systems. Finally, we urge the Departments to ensure that no additional fees are associated with the use of electronic payment methods when paying the administrative or IDRE fees.

Reduced fee for non-initiating parities in cases of ineligible disputes

The Departments are proposing to require payment of the nonrefundable administrative fee by the initiating party within two business days of the preliminary selection of the IDRE and within two business days of an eligibility determination for the non-initiating party. If a claim is determined ineligible, the non-initiating party is only required to pay 20 percent of the administrative fee, while the initiating party must pay the entire amount.

The AMA has concerns about only providing this reduced administrative fee to the non-initiating party upon a negative eligibility determination, and not the initiating party as well. We suggest that both parties should receive reduced administrative fees upon a determination of ineligibility because their use of the

IDR process is limited when compared with parties that proceed through the entire IDR process to a decision. For example, administrative fees are said to fund, among other things, IDR decision audits and technical assistance to IDREs to streamline payment determinations. But to the AMA it seems that if parties only use the process to the point of an eligibility determination, their fees should be limited.

Moreover, we urge the Departments to recognize that even with the proposals in this rule to reduce the number of ineligible claims, the complexity of the IDR process and changing requirements will continue to lead to good faith mistakes related to eligibility. As such **we ask that the Departments refrain from penalizing physicians and, instead, offer initiating parties the same discounts for ineligible claims as non-initiating parties**.

Reduced fee for low-dollar amount disputes

The proposed rule would essentially permit a reduced administrative fee of 50 percent when the highest offer is less than the amount of the standard administrative fee. **The AMA appreciates and supports the Department's efforts to make the IDR process more financially accessible for physicians by reducing the administrative fee for lower-dollar amount disputes**. The AMA has long been concerned that increases in the administrative fee continue to create higher thresholds to participation in the IDR process and that smaller, independent practices and those serving rural or marginalized communities are most impacted.

We suggest that there may be opportunities for greater flexibilities that the Departments could implement to further increase the accessibility of the IDR process for many physicians, including setting the threshold for the discounted rate at slightly higher than the administrative fee—perhaps 10 percent higher. We think that such a buffer furthers the spirit of the proposal by maintaining value of the dispute resolution process to the initiating party even with low-dollar amount offers. Alternatively, and perhaps more effective, the AMA suggests that the Departments should look at the difference between the initiating party's offer and the non-initiating party's offer (i.e., the amount being disputed) and use that amount as the basis for the discount threshold. If the difference is less than the administrative fee, the discount is meaningful to both parties.

Additionally, we urge the Departments to consider how even the discounted administrative fee will impact those with smaller claim amounts, including independent or rural practices and those specialists who regularly have claims below 50 percent of the current administrative fee amount. We ask the Departments to continue to work to lower the administrative fee amount so that the IDR process works for all physicians.

VI. Registration of health plans with IDR portal

The Departments propose to require that all health plans subject to the IDR process register with a centralized IDR registry to be made available through the IDR portal. The plans would be required to submit important, delineated information including their legal business name; the legal business name of the group health plan sponsor; whether the plan or coverage is a self- or fully-insured group health plan subject to ERISA, individual health insurance coverage, a plan offered by a FEHB carrier, a self- or fully-insured non-Federal governmental plan, or a self- or fully-insured church plan; the State(s) in which the plan is subject to a specified State law for any items or services to which the protections against balance billing apply or a self-insured group health plans not otherwise subject to State law; any State(s) where

plan opted into a specified State law; contact information for the appropriate person or office to initiate open negotiations and more. **The AMA strongly supports the establishment of such a registry and appreciates the Departments' proposal to make this information readily accessible to physicians via the portal.**

As we have stated in previous letters, too often dispute resolution efforts are delayed or disrupted because the physician cannot get in contact with the correct person at the plan, creating both administrative burdens on the practice and barriers to use of the dispute resolution process. Moreover, physician practices face difficulty in determining whether a plan is fully or self-insured and subject to state or federal surprise billing requirements. Despite a physician's best intentions and efforts, such confusion may lead to the filing of ineligible claims and contribute to the backlog of disputes. The AMA agrees with the Departments that this registry would contribute to a reduction in the backlog of claims, increase the use and timeliness of the open negotiations process, and reduce administrative burdens on many physician practices. We encourage the Departments to operationalize such a registry as quickly as possible and we support the Departments proposal to require registration by plans within 30-business days of the registry becoming available and continuous updates as information changes but no later than 30-buriness days following the change.

VII. Expansion of Departments' authorities for extenuating circumstances

Extension of time periods

The Departments propose an extension of time periods when they determine that such extension is necessary due to extenuating circumstances that contribute to systematic delays in processing disputes under the federal IDR process, such as a high volume of disputes or federal IDR portal system failures. The AMA supports limited extensions for limited periods of time but is concerned that by allowing a broadly applicable exemption for "extenuating circumstances" that would expressly include a "high volume of disputes," the Departments are casting too wide of a net. The AMA urges the Departments to consider that while plans largely benefit from process delays ultimately resulting in delayed payments, physicians face negative financial implications because of these delays**. The AMA suggests that a "high volume of disputes" should not alone be considered an extenuating circumstance and open the door for the Departments to extend time periods.**

If the Departments advance policies related to the extension of time periods, we urge them to clearly define specific criteria that would warrant timeline extensions and to work with interested parties to establish reasonable guardrails for such extensions. It is important that protections are put in place to ensure that timeline extensions are temporary and reserved for extenuating circumstances.

Departmental final eligibility determinations

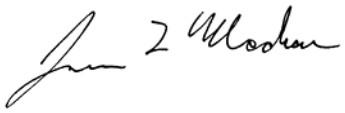
The Departments propose to grant themselves the authority to make final eligibility determinations in certain circumstances. The Departments already make eligibility determination recommendations, and this change would just relieve the IDREs in these circumstances from making a final determination. The AMA agrees that this proposal would likely increase efficiency in the IDR process by reducing burden on the IDREs. Furthermore, data has shown that a sizeable portion of submitted claims have been deemed ineligible for a handful of core reasons. Should the Administration just screen claims for the most common causes of ineligibility, we believe that in itself would help to reduce the current claims backlog

moving forward. As such, **the AMA supports this proposed change to allow Departmental final eligibility review of claims.**

VIII. Next Steps

The AMA supports many of the changes in these proposed rules to improve the entire dispute resolution process for physicians and all stakeholders, and we appreciate that the Departments have incorporated policies for which the AMA and many other medical societies have long championed. As the Departments move toward a final rule, the AMA stands ready to offer assistance in the refinement of any of these policies, and particularly the batching provisions, as well as with the development of guidance to further implement these changes. If you have any questions, please contact Margaret Garikes, Vice President for Federal Affairs, at 202-789-7409 or margaret.garikes@ama-assn.org.

Sincerely,



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