



AMA Summary of No Surprises Act Final Rule and supporting documents

On Friday, August 19, the Departments of Labor, Health and Human Services (HHS), and the Treasury (“the Departments”) issued [Final Rules](#) addressing several provisions of the physician and provider payment process for out-of-network care under the No Surprises Act (NSA).

The Final Rules and supporting [FAQs](#) address downcoding of out-of-network services by health insurance plans, clarification on plan requirements to initiate open negotiations, the use of certain contracted rates in the calculation of the Qualifying Payment Amount (QPA), and use of the QPA and other factors in the Independent Dispute Resolution entity’s (IDRE’s) determination of the out-of-network rate.

The Final Rules and FAQ respond to several concerns raised by the AMA and other physician and provider organizations, including:

- Clarifying that the initiating party to an open negotiation is always permitted to send the standard Federal initiation notice (i.e., a plan cannot require physicians/providers to use the plan’s proprietary portal).
- Requiring plans to provide additional information on why a claim was downcoded if the QPA is based on a downcoded service or modifier.
- Clarifying that plans must calculate a median contracted rate separately for each physician specialty.
- Removing the requirement that IDREs must presume that the QPA is the appropriate out-of-network rate.

Below is a summary of the Final Rules and accompanying documents from the Departments.

Initiation of the open negotiations

Under the NSA, if a physician wants to dispute the initial payment or denial from a plan for out-of-network care, the physician must initiate a 30-day open negotiations process. After receiving feedback from physicians and other providers that health plans were requiring parties to initiate the open negotiations process via a proprietary portal rather than allowing physicians to use the CMS-created form to start the process, **the Departments clarified that the initiating parties are *always* permitted to send the standard Federal initiation notice. The rule clarifies that a plan cannot require a physician to use their proprietary portals to initiate open negotiations.**

Downcoding

The Final Rules respond to concerns brought by the AMA and many other physician organizations over the lack of transparency when a plan downcodes a service and calculates a QPA based on the downcoded service code. The Final Rules define downcode to mean “the alteration by a plan or issuer of a service code to another service code, or the alteration, addition, or removal by a plan or issuer of a modifier, if the changed code or modifier is associated with a lower QPA than the service code or modifier billed by the provider, facility, or provider of air ambulance services.”

The Final Rules state that if a QPA is based on a downcoded service code or modifier, in addition to the information already required to be provided with an initial payment or notice of denial of payment, a plan must provide:

- a statement that the service code or modifier billed by the provider was downcoded;
- an explanation of why the claim was downcoded, including a description of which service codes were altered, if any, and which modifiers were altered, added, or removed, if any; and
- the amount that would have been the QPA had the service code or modifier not been downcoded.

This information must be provided in writing, either on paper or electronically, to a nonparticipating physician or provider.

The Departments recognize that this additional information will benefit physicians and other providers, as well as IDREs, in that:

- It will help ensure that physicians and other provider receive the relevant information from the plan that they need for the open negotiation process and, potentially, the IDR process.
- Without information on what the QPA would have been had the claim not been downcoded, the physician may be at a disadvantage compared to the plan in disputing the payment, especially when the plan has downcoded the billed claim and asserts that the QPA that corresponds with the downcoded claim is the correct total payment amount.
- It will aid in the open negotiation process by helping physicians understand how the plan arrived at the relevant QPA in relation to the billed claim.
- It may be critical to the physicians in developing an informed offer and submitting information to the IDRE if it believes that the QPA calculated by the plan does not best represent the value of the service provided.
- If submitted for the IDRE's consideration, it will aid the IDRE in selecting the offer that best represents the value of the service.

Calculation of the QPA by specialty

In response to concerns expressed by the AMA and other physician organizations that non-negotiated contracted rates (e.g., "ghost rates") were being included in QPA calculations and contributing to artificially low QPAs, **the Departments clarify in the FAQ document that plans must calculate a median contracted rate separately for each provider specialty, if the plan's contracted rates for service codes vary based on provider specialty.** Plans are required to calculate separate median contracted rates by provider specialty both in instances where their contracting process purposefully sets different rates for different specialties and when the contracting process otherwise results in different rates for different specialties.

The Departments state that for the purpose of identifying specialties for which QPAs must be separately calculated, a plan's contracted rates for a service are considered to vary based on provider specialty if there is a *material difference* in the median contracted rates for a service code between providers of different specialties, after accounting for variables other than provider specialty. Whether a material difference exists depends on all the relevant facts and circumstances.

The Departments will not require plans to calculate QPAs for 90 days and are encouraging states to take a similar approach to enforcement.

Independent Dispute Resolution

Background:

In October 2021, the Departments issued interim final rules (IFR) requiring IDREs to presume that the QPA is the correct out-of-network rate and to select the offer closest to the QPA, unless the IDRE determined that credible information submitted by the parties established that the QPA was materially different from the appropriate out-of-network rate. The AMA [expressed significant concern](#) with this rebuttable presumption in favor of the QPA and the impact it would have on physicians' ability to negotiate fair contracts with health plans.

The AMA and the American Hospital Association (AHA) filed a lawsuit on December 9, 2021, in the U.S. District Court for the District of Columbia, arguing that the IFR conflicts with the NSA by establishing a presumption in favor of the QPA. The text, context, purpose, and history of the NSA make clear that the statutory IDR procedure Congress created leaves no room for the agencies to require the arbitrator to put a thumb on the scale in favor of health insurers over providers.

Also, on October 28, 2021, the Texas Medical Association (TMA) filed a lawsuit in the U.S. Federal District Court for the Eastern District of Texas arguing the same. In February 2022, that court found in favor of TMA and vacated the provisions in the IFR that created the rebuttable presumption in favor of the QPA in the IDR process. **These Final Rules remove the vacated provisions and the requirements on the IDRE to presume that the QPA is the appropriate out-of-network rate.**

Removing the rebuttable presumption in favor of the QPA:

The Final Rules do not include the provisions that the District Court in Texas determined to have the effect of imposing a rebuttable presumption in favor of the QPA in the IDR process and specify that IDREs should select the offer that best represents that value of the service after considering the QPA and all permissible information submitted by the parties.

Continued reliance on the QPA in the IDR process:

While removing the language directing IDREs to assume the QPA is the appropriate out-of-network payment rate is a substantial improvement, the Departments state they are of the view that it will often be the case that the QPA represents an appropriate out-of-network rate, as the QPA is largely informed by similar information as to what would be provided by disputing parties to support their offers. The Departments clearly still expect a level of reliance on the QPA in payment determinations to "promote consistency and predictability in the process."

"Double counting":

The Departments aim to prevent "double counting" of information submitted to the IDRE that may be accounted for in the QPA calculation. They state that the IDREs should consider whether the additional information included in the parties' offers is already accounted for in the QPA or in other information

submitted and then avoid weighting the same information twice. To the extent a factor is not already reflected in the QPA, the IDRE should give that factor appropriate weight based on related information submitted by the parties.

To illustrate what is meant by “double counting,” the Departments suggest, for example, a plan may submit an offer equal to its QPA for CPT code 99285 along with credible information showing that this CPT code accounts for the acuity of the patient’s condition. The IDRE may then determine that the QPA accounts for the acuity of the patient’s condition and therefore would not give weight to information submitted by the physician or provider that addresses patient acuity.

Written decision by IDRE:

The October 2021 IFR required that IDREs provide written decisions to the Departments at the end of each IDR process and if the IDRE did not choose the offer closest to the QPA, it must include a detailed explanation of additional considerations relied upon, whether the information submitted by the parties was credible, and the basis upon which the IDRE determined that the credible information demonstrated that the QPA is materially different from the appropriate out-of-network rate.

The AMA expressed concerned about the emphasis on the QPA in the written report and the requirement that the IDRE justify the reasons for deviation from the QPA in their decision making, if applicable. The AMA also thought this requirement provided an additional incentive to IDREs to pick the party’s offer that is closest to the QPA to avoid the administrative hassle of creating such a detailed report justifying a decision in favor of the other party.

The District Court in Texas invalidated this requirement to provide an explanation of the information relied upon by the IDRE if it determined the out-of-network rate was materially difference from the QPA. However, the Departments, in the Final Rules, determine that is necessary for IDREs to submit written explanations of their decisions in all cases (not only when the QPA is determined to best represent the out-of-network rate) in order for the Departments to monitor and report on how often, and why, an offer is selected that exceeds the QPA and to inform future policy making related to the QPA methodology.

As such, the Departments are finalizing standards for written decisions that will require IDREs to provide a written explanation of their decision, including:

- The information the IDRE determined demonstrated that the offer selected is the offer that best represents the value of the services;
- The weight given to the QPA and any additional information submitted by the parties; and
- If the IDRE relied on additional information/circumstances in selecting an offer, an explanation of why the IDRE concluded this information was not already reflected in the QPA.

IDR Status update

In addition to the Final Rules and supporting FAQs, the Departments also released a [status update](#) on the IDR process, showing that the volume of IDR disputes has been higher than anticipated by the Departments.

- Between April 15 and August 11, disputing parties initiated over 46,000 disputes through the federal IDR portal.
- Of the disputes initiated between April 15 and August 11, IDREs made payment determinations in over 1,200 disputes.
- Non-initiating parties challenged over 21,000 disputes' eligibility for the IDR process. (This does not indicate ineligibility, but only that a party has challenged the eligibility of a dispute and that additional review by the IDRE is necessary to determine eligibility.)
- Preliminary data suggests that IDRE have already found over 7,000 disputes ineligible for the IDR process and the primary cause of delays in the processing of disputes is the complexity of determining whether disputes are eligible for the IDR process.