Centers for Medicare & Medicaid Services

Open Door Forum: Physicians, Nurses and Allied Health Professionals

Moderator: Jill Darling

September 28, 2022

2:00 pm ET

Coordinator: Thank you for standing by. At this time all participants are in listen only mode until the question and answer session of today's conference. At that time, you may press star 1 on your phone to ask a question. I'd like to inform all parties today's conference is being recorded. If you have any objections you may disconnect at this time.

I'd now like to turn the conference over to Jill Darling. Thank you. You may begin.

Jill Darling: Thank you, (Dustin). Good morning and good afternoon, everyone. I'm Jill Darling in the CMS Office of Communications. And welcome to today's Physicians, Nurses, and Allied Health Professionals Open Door Forum. Before we get into the agenda today, I have one brief announcement. This open door forum is open to everyone. But if you are a member of the press you may listen in, but please refrain from asking questions during the Q&A portion of the call. If you do have any inquiries please contact CMS at Press@CMS.HHS.gov.

And to begin, we will start with (Alper Ozinal), who has an update on the independent dispute resolution under the No Surprises Act.

(Alper Ozinal:) Great. Thanks very much, Jill. And thanks to the Office of Communications for hosting this, and everyone for dialing in. I'm (Alper Ozinal). I'm part of (CCIIO) and the Consumer Support Group. And as Jill mentioned, so I'm going to go over five or six items dealing with independent dispute resolution under the No Surprises Act. The first one is specifically, the requirements related to surprise billing final rules, which were published on August 26th, so just over a month ago.

So, the Departments of Health and Human Services, Labor and Treasury, collectively known as the Departments, released final rules titled Requirements Related to Surprise Billing Final Rules. As I mentioned, they did publish in the Federal Register on August 26th. The rules finalized certain requirements under the July 2021 interim final rules related to information that group health plans and health insurance issuers offer in group or individual health insurance coverage from must share about the qualifying payment amounts, which is well known as the QPA.

In light of the court rulings from earlier this year and comments received on the October 2021 interim final rule, the rules also finalized select provisions of the October 2021 interim final rules related to information that a certified IDR entity must consider when making a payment determination under the federal IDR process. First, we'll turn a little bit to information about the QPA that plans and issuers must share. So, in order to ensure that providers, facilities, and providers of air ambulance services have the information they need to engage in meaningful open negotiations. And in response to comments we've received from stakeholders, the Departments are finalizing a

definition of the term “down code”, and requiring that plans and issuers disclose additional information if they down code a billed claim.

The rules defined the term down code to mean the alteration by a plan or issuer of the service code, to another service code, where 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, then the service code or modifier billed by the provider, facility or provider of air ambulance services. If a QPA is based on a down coded service code or modifier, the plan or issuer must provide the following with its initial payment or notice of denial of payment. So, these are three things that they must provide that I'm about to mention, in a situation where it's based on the down coded service or modifier.

First, a statement that the service code or modifier billed by the provider facility or provider of air ambulance services, was down coded. Next, an explanation of why the claim was down coded, including a description of which service codes or modifiers were altered, added, or removed, if any. And also, the amount that would have been the QPA, had the service code or modifier not been down coded. So that takes care of the portion about the QPA the plans and issuers must share. Now I'm going to turn to payment determinations under the federal IDR process that are QPA-specific.

So initially, the October 2021 interim final rules required that certified IDR entities select the offer closest to the QPA, unless a certified IDR entity determined that any additional credible information submitted by the parties, demonstrated that the QPA was materially different from the appropriate out of network rate. However, the district court vacated this requirement in rulings

that occurred both this past February and July. So, both of them earlier this year in 2022. Therefore, these final rules remove the provisions that the district court vacated.

The rules specify that the certified IDR entities should select the offer that best represents the value of the item or service under dispute, after considering the QPA and all permissible information submitted by the parties. Additionally, certified IDR entities must consider the QPA and then must consider all additional permissible information submitted by each party, to determine which offer best reflects the appropriate out of network rate.

The certified IDR entity should evaluate the information to avoid double counting information that is already accounted for by the QPA, or by any of the other information submitted by the parties. After weighing these considerations, certified IDR entities should then select the offer that best represents the value of the item or service under dispute. Next, I'm going to talk a little bit about payment determinations and the underlying rationale that guides those payment determinations.

So, the final rules also finalize provisions of the October 2021 interim final rules requiring certified IDR entities, to explain their payment determinations and underlying rationale, in a written decision submitted to the parties in the departments. The rules require that the written decision include an explanation of information the certified IDR entity determined demonstrated that the selected offer is the out of network rate that best represents the value of the item or service.

This includes the weight given to the QPA and any additional credible information regarding the relevant factors. If the certified IDR entity relies on additional information or circumstances, when selecting an offer, the final rules state that its written decision must include an explanation of why the certified IDR entity concluded the information was not already reflected in the QPA.

I also want to note that we have published a checklist of requirements for group health plans and group and individual health insurance issuers, and it's on the CMS Website. And the point of the checklist is to help plans and issuers and others, make sure that they provide the information needed, to make sure that the IDR process can go as smoothly as possible. Also, we'd like to mention that we are planning on having a webinar on next Thursday, October 6th, from 2:00 to 3:00 Eastern time, where we will discuss the final rule or regulation in more detail than we just went over. So again, that'll be next Thursday, October 6th, from 2:00 to 3:00 Eastern time.

A few other things I just wanted to mention quickly - along with the final rules that were published in August, we also published some FAQs. And those FAQs again, which are on the CMS Website, they do cover areas such as applicability to no network and closed network plans, applicability to air ambulance services, applicability to emergency services furnished in behavioral health crisis facility, and general disclosure for protections against balance billing.

Standard notice and consent form, and model disclosure notice regarding patient protections against balance billing; methodology for qualifying

payment amounts; requirements for initial payments or notices of the dial of payment related disclosures, and initiation of open negotiation periods and federal IDR process; and transparency in coverage, machine-readable files. All that information is on FAQs that are on the Website and I can provide that to OC if anyone has any questions about - if they're having any difficulty with finding them, I can certainly pass those forward so that you can access them easily, after the call.

We also released additional technical assistance in August, specifically regarding the - we released federal IDR process guidance for certified IDR entities. However, the guidance is also relevant for any other parties that are trying to participate in the IDR process. That guidance went over topics such as whether multiple qualified IDR items or services can be submitted together for separate payment determinations, you know, which we refer to as a batch dispute, as part of the federal IDR process.

You know, what is the appropriate way to batch anesthesia services? Are revenue codes considered service codes for the purpose of batch disputes? And we also discussed things such as bundled arrangements for the purposes of the federal IDR process. That guidance document also does have examples that have - that illustrate questions and answers. Again, it's another one that I can make sure to pass forward.

Also, on September 20, so I think a week ago yesterday, CMS sent out an email that basically had updates of the technical cache issue, specifically it was called browser recommendations for IDR dispute initiation and Web form repeat submitters. So, this email was sent out to initiating parties, and we

reached out to multiple audiences to explain the cache issue and offer them recommendations on how they can see the updated Web forms. Recently, the IDR Web form was updated to accommodate guidance related and system feature enhancements to improve users' experience.

We have a few recommendations that were in that email, specifically that highlight best performance. So, if you have initiated an IDR case through the portal in the past, please clear your computer's cache or open the form in a private or incognito window, to access the updated IDR initiation form. We recommend doing this at least once a week to ensure you are seeing the most up to date version of the initiation form. And I just want to also note that failure to clear your cache or open the form in a private or incognito window, could result in additional follow up with the certified entities, or could lead to some system errors.

Lastly, I'm going to go over some portal functionality updates. The first thing was - the first thing that the portal functionality updates, one of the updates is to screen out disputes where the open negotiation period is less than 30 business days. So initiating parties will be required to indicate that the open negotiation period was opened at least 30 business days ago. If a date is reported that is too recent, as in less than 31 business days ago, then the dispute will be blocked from submission. Another functionality update is to screen out disputes where more than four business days have passed since the end of the open negotiation period.

So initiating parties will be required to indicate that the open negotiation period was opened between 31 to 34 business days ago, to meet the 30-day

requirement, for the open negotiation period and the four business day submission deadline after the open negotiation period ends. So, if a date is reported that's too late, so more than 34 business days, the dispute will be blocked from submission, unless the initiating party attests to an allowable reason for the delayed submission. There are three allowable reasons for a delayed submission.

If an initiating party attests to one of these reasons, the reason will be indicated in the portal. So, one reason would be the party received an extension approval from the federal IDR mailbox and will upload evidence of this extension in a supporting documentation section of the Web form. Another would be that the party is correcting a previous dispute submission that required corrections to how dispute line items were batched or bundled. And then the third, the items are services under dispute were subject to a 90-day cooling off period which ended no more than 30 business days from today.

So, if an initiating party attests to resubmitting due to a batching or bundling here, the prior dispute number will be a required field and will display in the IDR portal. So that's another thing to keep in mind. Another portal functionality update and I'm getting to the end of this soon, but I wanted to say that the portal will now require an attestation when the item or service was provided in certain states where there are both state and federal processes for IDR. So initiating parties who indicate that a dispute line item or service took place in a state where both state and federal IDR processes apply, will be prompted to review state-specific IDR eligibility rules.

And then will be required to attest that they have reviewed the rules and believe the dispute to be eligible for the federal IDR process. The complex state attestation in this situation, what is called the complex state attestation, will appear in the IDR portal on the dispute line item page, and will be checked only when an attestation was provided. And then lastly, there have been also portal updates in terms of the ability to upload supporting documents when initiating IDR. There is a new upload button that can be used to upload additional supporting documentation that may help expedite review and avoid delays.

Examples of potential documents include copies of the initial payment or notice of denial of payment, and associated documents. An example of that would be remittance advice or an explanation of benefits. The notice of open negotiation, emails from a certified IDR entity requesting a previous or submitted dispute be resubmitted with corrections to batching errors, or also an extension email which can serve as evidence of an extension being granted.

So that's it for my formal portion here. I'll turn it back to Jill, and then I will be on for questions later. Thank you, all.

Jill Darling: Great. Thank you, (Alper). Last, we have (Darlene Fleischmann), who will talk about the Make Your Voice Heard request for information on promoting efficiency, reducing burden, and advancing equity within CMS programs.

(Darlene Fleischmann): Thank you, Jill. I just want to take this opportunity to make sure that everyone is aware of our release of request for information titled Make Your Voice Heard. It's open for comment now. It closes on November 4th. It's

a 60-day RFI, request for information. It includes focused areas, four specific areas, about which we're seeking input. Those four are accessing healthcare and related challenges, understanding provider experiences, advancing health equity, and impact of PHE waivers and flexibilities. And each of the four focus areas include suggested or example sub topics, which are in no way intended to limit input, or comment. They're just a few suggested subject matters based on input we've received.

One of the topics I just want to mention or highlight today, based on particular relevance perhaps in this meeting, is understanding provider experiences, and again, there are suggested sub topics under each of the topics. So, under provider experiences some of those include factors that impact provider well-being and attrition, compliance with payment rules and quality programs, including challenges with suggested improvements. Participation challenges in underserved populations, and willingness or ability to service certain populations.

And again, I just want to emphasize that these are just suggested topics or sub topics rather, that you'll see. Really each of the four topics that are included in this RFI, are intended to focus on the specific practice setting and personal experiences of those who are responding. So hopefully, one or all may resonate with the experience of commenters. The request for information in this particular case that's being released, has been released as a Web form. The actual publication date was the 6th.

It's intended to be completed as a Web form in one session. There's no save option for continued work later, nor is there opportunity for attachments. It's

intended to be more easily navigated, such as through a handheld device. And also, to navigate and identify topics of interest or applicability. If there are any issues accessing the RFI just try another browser. We haven't heard too much in this space, but just please keep in mind that the comment period closes November 4th.

I believe the Web site; the link was attached to the information about this meeting. But in any event, just by typing in CMS, visiting the homepage for CMS, or CMS request for information, Make Your Voice Heard again, is the title; it will pop up; it'll bring you right to the form. And there's also an easy link or click if there are any technical issues with completing the form. And again, I'm available for any questions or additional information that's needed. Thanks, Jill.

Jill Darling: Thank you, (Darlene). And thank you, (Alper). (Dustin), will you please open the lines for Q&A?

Coordinator: Thank you. Now I'll begin the question and answer session. If you'd like to ask a question, please press star 1, unmute your phone, and record your name clearly. Your name is required to introduce your question. If you need to withdraw your question, press star 2. Again, to ask a question, please press star 1. It'll take a few moments for the questions to come through. Our first question is from (Michael). Go ahead. Your line is open.

Dr. (Michael Duffy): Hi. (Michael Duffy) here. I'm a family physician and Chief Health Officer of a healthcare technology company that primarily provides chronic care management and chronic disease management. So not surprisingly, my

question has to do with chronic care management. And so, I hope it's not anticipated that questions in the forum specifically relate to the topics just presented. Is it okay that I ask a question of unrelated material? If so, the question has to do with specifically chronic care management provisions as they might change at the end of the public health emergency, and what changes might occur.

Specifically, I'm having a problem with initiating visits being allowed to be provided virtually, via tele-health. Is it anticipated that at the end of the public health emergency initiating visits for chronic care management will no longer be allowed to be furnished virtually, and they will be returned to being - need to be provided in person? Or will that provision be extended beyond the public health emergency? Thanks.

Gift Tee: Hey, Dr. (Duffy), this is Gift Tee. Thanks for that question. I believe we're working through provider response via email behind the scenes. But just to throw out some information that may be helpful for others that maybe have the same question, and maybe you can actually give us more context. The idea of the initiating visit, right, being let's say an office visit in advance of that care management service. To the extent that that is already on the tele-health list or is a permanent tele-health service, then you'd be allowed to furnish that service via tele-health.

But indulge me. What sort of visit or initiating encounter are you considering or thinking about?

Dr. (Michael Duffy): Great. I appreciate that. So, what our service does is we team up with primary care providers to provide chronic care management and chronic disease management. So, the patients that we're seeing with our service are not patients that we've seen before, but we work alongside of the PCP, to provide this as an additional service integrated into their current processes. So, when we go to provide an initiating visit it's really a - it's an introduction to our provider team, to that patient, on the tech side. And then we integrate that into the work done already by the PCP. So, there is no real preceding visit on our behalf, that we can rely on to fulfill that obligation.

Gift Tee: Okay. No. Thank you for the context. So, like I said, we're working on a response, but go ahead and shoot me an email with that additional context you provided just to lay out the scenario a little bit more for us. That would be Gift...

Dr. (Michael Duffy): Okay.

Gift Tee: G-I-F-T dot T-E-E at CMS dot HHS dot gov.

Dr. (Michael Duffy): Would you repeat that one last time?

Gift Tee: Gift, G-I-F-T dot T-E-E at CMS dot HHS dot gov.

Dr. (Michael Duffy): T-I-F-T?

Gift Tee: Gift as in Christmas gift, Christmas present.

Dr. (Michael Duffy): Oh, sorry. Okay.

Gift Tee: And Gift Tee as in golf tee. Yes.

Dr. (Michael Duffy): Got it. Dot - Gift dot is it E-E-E?

Gift Tee: Dot T-E-E. T-E-E as in golf tee.

Dr. (Michael Duffy): Dot, I got it. Okay. Sorry about that. And I really appreciate the information. And I'll shoot you an email. Thank you.

Coordinator: Our next question is from (Richard Heller). Go ahead. Your line is open.

(Richard Heller): Thank you very much for this. This is very helpful. I have a - my name is (Richard Heller) and I'm a radiologist here in Chicago. I have a two-part question about IDR. The first is what are the departments doing to clear the backlog of IDRs? It's been reported the vast majority of IDRs have yet to be determined, and are still in a backlog. And the second question has to do with so-called phantom rates. In the FAQ document the Departments acknowledge the existence of phantom rates and specified that such rates forward, should not be included in the QPA determination.

I just want to clarify that the FAQ document is - will - that that clarifies what the ruling is, or will the QPA methodology be specified in future rule making, to again specify such so-called phantom rates will not be included in the QPA calculation methodology?

(Alper Ozinal): Okay. Thanks for that. And I appreciate both parts of the question. First, on the backlog one, thanks for bringing that up, and we are working as expeditiously as possible to minimize the backlog and get through those cases as fast as possible. I know we've been working all year long, many months now, trying to make operational system improvements and issuing clarifying guidance and things like that, to really reduce the number of cases. And so that's probably the best I can say on the backlog for the moment, unless - I don't know if anyone else on our team who's on, wants to say anything else.

The only other thing I would say is that we've had many more cases than were initially anticipated being in the - if you look at our rule making that went out, we didn't - the volume of cases was projected to be lower than this. We tried to take that into account and then make operational systems improvements and staff up in the right areas. And we are working through them as fast as possible.

The phantom rates question is one I wasn't sure if anyone on our team that might be able to - I'm aware of what you're talking about, but I was wondering if there was someone else that wanted to shed more light on that, and that might be one we'll have to get back to you on, if no one else is on.

(Elizabeth): Hey, (Alper), it's (Elizabeth). I think on the FAQs in general, I would like to note that, you know, that that is interpretive guidance from the Departments. And it is additional clarification that address questions that have come up from state rules that we have issued. And so, you know, we interpret those FAQs to be requirements that are in place now in interpretation of how our existing regulations should be complied with.

Now with that said, obviously we always want to make sure that all of our interpretations and guidance are included in some sort of final rule. And the rules are currently in interim final regulation state, and we in the Departments, will continue to evaluate comments and take feedback, and intend to issue additional guidance of final rule making in the future.

(Richard Heller): Thank you very much.

(Alper Ozinal): And thank you for the questions.

Coordinator: I show no further questions at this time. Again, as a reminder, please press star 1 on your phone and record your name if you have a question. One moment, please. And I show no further questions at this time.

Jill Darling: All right. Well, great. Thank you everyone, for joining us today. If you do have any follow up questions, please feel free to email us at Partnership@CMS.HHS.gov. That email is listed on the agenda. Again, Partnership@CMS.HHS.gov. Thanks, everyone. Have a wonderful day. And that concludes today's call.

Coordinator: That concludes today's conference. Participants, you may disconnect at this time. Speakers, please allow a moment of silence and standby for your post conference.

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