AAOS
AMERICAN ASSOCIATION OF ORTHOPAEDIC SURGEONS

Surprise Billing Final Rule: August 2022

On August 19, 2022, the Departments of Health and Human Services, Labor, and Treasury (the Departments) released a final rule building on the policies set forth in the July 2021 and October 2021 interim final rules on the Requirements Related to Surprise Billing regulation, which was initiated as a result of the passage of the No Surprises Act in December 2020. This rule updates the process for payment determination under the Federal Independent Dispute Resolution (IDR) process, as well as clarifies information about the Qualifying Payment Amount (QPA).

What is new?

Following the filing of several lawsuits (including one supported by the AAOS) challenging the Departments' interpretation of looking first and primarily at the QPA when determining payment during the IDR process, a federal judge issued a decision and final judgment to set aside key parts of the rule for implementing the No Surprises Act which took effect Jan. 1. He agreed with the Texas Medical Association that parts of the Independent Dispute Resolution (IDR) process for resolving out-of-network bills are inconsistent with congressional intent and should be invalidated on a nationwide basis. In response to the ruling, the Departments withdrew all guidance that referenced or relied on the sections of the rule which were invalidated by the judicial ruling. In this final rule, they have updated the regulation text to align with the ruling, as it states that "the certified IDR entity must consider the QPA for the applicable year for the same or similar item or service ***and then*** must consider all additional information submitted by a party to determine which offer best reflects the appropriate out-of-network rate, provided that the information relates to the party's offer for the payment amount for the qualified IDR item or service that is the subject of the payment determination (and does not include information that the certified IDR entity is prohibited from considering in making the payment determination under the statute)."

The factors that the IDR entity must consider are:

- "The level of training, experience, and quality and outcomes measurements of the provider or facility that furnished the qualified IDR item or service"
- "The market share held by the provider or facility or that of the plan or issuer in the geographic region in which the qualified IDR item or service was provided"
- "The acuity of the participant, beneficiary, or enrollee receiving the qualified IDR item or service, or the complexity of furnishing the qualified IDR item or service to the participant, beneficiary, or enrollee"
- "The teaching status, case mix, and scope of services of the facility that furnished the qualified IDR item or service, if applicable"
- "The demonstration of good faith efforts (or lack thereof) made by the provider or facility or the plan or issuer to enter into network agreements with each other, and, if applicable, contracted rates between the provider or facility, as applicable, and the plan or issuer, as applicable, during the previous 4 plan years"

While this acknowledges the original intent of the legislation and accounts for the portion of the rule vacated by the court, it unfortunately does not go far enough to ensure that *all* factors are considered equally in the IDR process. This is made evident in the rule, where it states that the QPA should remain the first factor to be looked at. The rule goes on to state that "the certified IDR entity should consider whether the additional information is already accounted for in the QPA and should not give weight to information related to a factor if the certified IDR entity determines the information was already accounted for in the calculation of the QPA, to avoid weighting the same information twice." The purpose of this language is to ensure that factors are not double counted in the IDR process. However, we are concerned that this may serve as yet another loophole for insurers to avoid presenting a fair offer to physicians during the IDR process.

In addition to the changes to the language surrounding the QPA and IDR process, the final rule also responds to concerns raised by physician groups during the comment process. In particular, the rule adds language to address the issue of insurers "down coding" billed claims.

What is down coding?

The rule defines "down code" as "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." When a claim that has been down coded is provided for the QPA, the "plan or issuer must provide a statement that the claim was down coded; an explanation of why the claim was down coded, including a description of which service codes were altered, if applicable, and a description of which modifiers were altered, added, or removed, if applicable; and the amount that would have been the QPA had the service code or modifier not been down coded." This addition to the rule is a positive step towards a fair and transparent payment system under the parameters of the Surprise Billing law.

What happens next?

This final rule applies to provisions from the July 2021 and October 2021 interim final rules and will be effective in October 2022, for plan years that began on or after January 1, 2022.

AAOS will continue to monitor the implementation of the Requirements Related to Surprise Billing regulations to ensure that orthopaedic surgeons and their patients have access to a fair and independent process for addressing unexpected medical bills. All guidance from the Departments on the implementation of the rule can be found at https://www.cms.gov/nosurprises/policies-and-resources/overview-of-rules-fact-sheets.

All AAOS resources on the issue of Surprise Medical Billing can be found at the AAOS Advocacy Action Center.