Surprise Billing: Summary of QPA and IDR Provisions in the Final Rules

August 22, 2022

This memorandum provides more detail on the latest iteration of the Surprise Billing regulations that focus on the type of information the independent dispute resolution entity may consider when determining reimbursement. Click here for the final rules which become effective 60 days after publication in the Federal Register and here for the 4-page Fact Sheet.

These rules finalize certain provisions of the July 2021 and October 2021 interim final rules and address the decisions in *Texas Medical Association, et al. v. United States Department of Health and Human Services, et al.*, Case No. 6:21-cv-425 (E.D. Tex.) (click here) and *LifeNet, Inc. v. United States Department of Health and Human Services, et al.*, Case No. 6:22-cv-162 (E.D. Tex.) (air ambulance case). The Administration filed an appeal in *Texas Medical Association* which has been stayed pending the release of these final rules; the Administration still has time to file an appeal in *LifeNet, Inc.*

Key Changes for Providers: (Air Ambulance provisions are not addressed in this memo)

- **Expressly defines and permits the use of "downcoding" by issuers in determining reimbursement**

Defines "downcoding" 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. When a claim is downcoded, the plan or issuer must provide additional information about the QPA with an initial payment or notice of denial of payment, without the provider having to request this information. Additionally, a plan or issuer 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 and which modifiers were altered, added, or removed; and the amount that would have been the QPA had the service code or modifier not been downcoded.

- **Allows the Use of Factors other than the QPA in IDR**

The final rule suggests that it is adhering to the requirements of the order in *Texas Medical Association* in that the IDR entity is no longer limited to choosing the QPA or the offer closest to the QPA when determining reimbursement.

The final rules specify that the IDR entity 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.

For non-air ambulance items and services, the additional information to be considered includes:

1. the level of training, experience, and quality and outcomes measurements of the provider or facility that furnished the qualified IDR item or service;
2. 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;
3. 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;
4. the teaching status, case mix, and scope of services of the facility that furnished the qualified IDR item or service, if applicable; and
5. 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.

- **IDR Must Provide Written Decision**

The IDR entity is required to determine if the additional factors to be considered are credible and must also ensure that these factors are not already accounted for in the QPA. *See examples provided on pages 42-46.* The IDR entity must provide a written decision explaining why it included these factors and why it believes these factors are not already reflected in the QPA. The District Court in *Texas Medical Association* invalidated the requirement to provide an explanation of this specific information (but not the general requirement that a certified IDR entity issue a written decision).

As noted in our earlier memo, the Departments intend to address comments related to other provisions of the July 2021 and October 2021 interim final rules at a later date and we are waiting for a proposed rule that we believe will address good faith estimates and advanced explanation of benefits for insured patients. We will keep you updated.

For additional information, please contact our General Counsel Diane Turpin at diane.turpin@shcare.net or 202-578-5444. This information is offered for the general education and knowledge of our clients. It is not offered as legal advice.