American Society of Anesthesiologists®

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February 14, 2023

Jeff Wu, JD, MBA
Deputy Director for Policy
Center for Consumer Information and Insurance Oversight
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Baltimore, MD 21244

Re: Improving the Batching of Anesthesia Claims

Dear Deputy Director Wu,

I am writing in follow-up to our call of January 13 regarding our recommendations for the implementation of the provisions of the No Surprises Act (NSA) governing the batching of claims for the federal Independent Dispute Resolution (IDR) process. Our members believe that adjustments can – and should – be made to the IDR process to increase the speed and reduce the cost of the process for all stakeholders. I have summarized our members' concerns below, and I urge CCIIO to adopt our members' recommendations for achieving more timely and efficient resolutions of out-of-network payment disputes.

Existing policies on batching are restrictive and increase IDR costs for all stakeholders

The NSA authorizes the Secretary to specify the criteria under which multiple qualified IDR items and services may be considered jointly as part of a single determination. Such items and services may be "batched" only if (i) they are furnished by the same provider or facility, (ii) payment is made by the same group health plan or health insurance issuer, (iii) the items and services are related to the treatment of a similar condition, and (iv) the items and services were furnished during the 30-day period following the date on which the first item or service included was furnished *or* "an alternative period as determined by the Secretary . . . to encourage procedural efficiency and minimize health plan and provider administrative costs."[1]

By regulation, batched services must be billed by providers with the same National Provider Identifier or Tax Identification Number, and "paid by the same plan or issuer." Batched claims must also be for the same or similar items and services, meaning they must be billed under the same service code, or a comparable code under a different procedural code system, such as Current Procedural Terminology (CPT), Healthcare Common Procedure Coding System (HCPCS), or Diagnosis-Related Group (DRG) codes. In addition, they must be furnished within the same 30-business-day period, or the same 90-calendar-day cooling off period, if applicable.[2]

The agency has implemented its regulation in a way that limits batching to the same anesthesia CPT code "paid by the same plan or issuer" in the narrowest possible sense. If, for example, an issuer offers multiple insurance plans, then the provider must batch the claims at the level of the specific anesthesia CPT code and the insurance plan through which the issuer would pay. The provider may not batch claims across all plans offered by the issuer.

[1] Public Health Service Act (PHSA) § 2799A-1(c)(3)(A)(i)-(iv).
[2] 45 C.F.R. §§ 149.510(c)(3)(i)(B), (C), (D).

The narrow implementation of the regulation often limits IDR submissions to batches that are so small that the transaction cost of IDR exceeds the potential recovery. When that occurs, ASA members with meritorious claims lose access to IDR and, ultimately, fair payment.

The problem has only worsened since the agency implemented additional pre-eligibility review procedures and increased the administrative fee due from *each party* from $50 to $350 per dispute.[3] The IDR entity fee already ranges from $268 to $938 for batched determinations,[4] and combines with the increased administrative fee to deter our members from invoking the IDR process and obtaining fair payment. Sadly, our members in small to medium-sized community practices suffer the greatest impact because they are the ones hurt the most when plans and issuers pay unreasonably low qualifying payment amounts (QPAs).

Even when the pursuit of IDR makes economic sense for our members, the limits on batching increase the overall volume and current backlog of unresolved IDR filings.[5] The current backlog has reduced our members' access to IDR and prevented them from obtaining timely and fair payment. We imagine that the backlog has also taxed the resources of CCIIO and the IDR entities. Our members believe that all stakeholders in the NSA ecosystem would benefit from increased batching and the reduction in IDR filings that would result from it.

CCIIO should encourage the batching of all anesthesia claims paid by the same issuer

The agency should permit the batching of anesthesia claims without regard to CPT code because payment for anesthesia turns on a single conversion factor for all anesthesia services. The conversion factor is the same regardless of the procedure which the patient undergoes, and payers typically negotiate a single conversion factor amount with an anesthesia provider for all of their plans. The batching of anesthesia claims with different CPT codes, but with the same conversion factor serves the purpose of the NSA by driving the process towards payment for the same or similar services (anesthesia) at rates grounded in the market. Anesthesiologists should be permitted, but not required, to batch a larger volume of claims. If, for example, an anesthesiologist still seeks to resolve payment disputes by individual CPTS codes as permitted in current guidance they should have the flexibility to do so.

The agency should also clarify its interpretation of the phrase "same plan or issuer" to promote expanded batching. Neither the NSA nor the regulatory text defines the phrase "same group health plan" or "same health insurance issuer." The same health insurance issuer may offer multiple insurance plans in the same geographic market. The plain language of the statute and the regulation support batching at the issuer level, not the plan level.

Group health plans operate differently but the analysis is the same. Employers sponsor group health plans and contract with third-party administrators (TPAs) to administer the plans. The TPAs generally provide the same administrative services under the same template contracts with employers, so that the TPA may achieve uniform administration and economies of scale across all of the employers they serve. The group health plans administered by a single TPA are the "same" functionally. Moreover, the TPA presents those plans to providers as the "same" by negotiating uniform in-network rates with providers and issuing uniform provider manuals and guidance. The plain language of the statute and regulation support batching at the level of the TPA because the TPA presents all of its contracted employers to

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[3] *See* Amendment to the Calendar Year 2023 Fee Guidance for the Federal Independent Dispute Resolution Process Under the No Surprises Act: Change in Administrative Fee (Dec. 2022) at p. 6; available at: https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Amended-CY2023-Fee-Guidance-Federal-Independent-Dispute-Resolution-Process-NSA.pdf.

[4] *Id.* at p. 6-7.

[5] *See* Initial Report on the Independent Dispute Resolution Process, April 15 – September 30, 2022 (Dec. 2022) at p. 7 ("[f]rom April 15 – September 30, 2022, disputing parties initiated 90,078 disputes through the Federal IDR portal, significantly more than the number of disputes the Departments initially estimated would be submitted for a full year"); available at: https://www.cms.gov/files/document/initial-report-idr-april-15-september-30-2022.pdf.

providers as the "*same* group health plan" functionally, and asks providers to treat those employers as the "*same* group health plan."

The policy rationales for this textual, common-sense approach are compelling, particularly in the anesthesia context. First, it aligns with how the healthcare industry actually works. A TPA or health insurance issuer will typically seek to negotiate the same in-network conversion factor with anesthesia providers in the same market. In some instances, the same payer (e.g., UnitedHealthcare) operates as both a TPA and a health insurance issuer in the same market and offers a uniform conversion factor to all anesthesia providers on a take-it-or-leave basis. Even when there are meaningful negotiations and conversion factors vary across anesthesia providers in the market, a single anesthesia provider will typically receive the same conversion factor across the payer's entire book of business. A payer operating as both a TPA and a health insurance issuer will pay the same rate to the anesthesia provider regardless of whether the provider serves patients employed by the same companies or enrolled in the same insurance plans. In the real world, there are not material differences in payment linked to CPT codes, or employers or insurance plans.

Second, the approach will promote more efficiency by reducing the number of IDR filings by anesthesia providers while simultaneously expanding their access to the IDR process and fair payment. Increased efficiency vindicates the purposes of the NSA and helps not only anesthesia providers but also CCIIO and the IDR entities.

CCIIO should authorize batching for anesthesia in 90-day periods

The NSA establishes that items and services may be batched only if the items and services were furnished during the 30-business day period following the date on which the first item or service included was furnished *or* "an alternative period as determined by the Secretary . . . to encourage procedural efficiency and minimize health plan and provider administrative costs."[6]

To promote these outcomes, the agency should permit a longer period of time – 90 days instead of 30 days – for which furnished services may be batched. Congress expressly granted the agency the authority to define an alternative period in this way. Allowing services furnished within the same 90-day period to be batched would alleviate administrative burdens on providers, reduce the administrative fees paid by *both* the initiating and non-initiating parties, and decrease the Federal IDR backlog.

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We thank you for your consideration of these recommendations. We believe that, if acted upon, these recommendations will advance implementation of the NSA, create efficiencies in the IDR process, and allow our members to focus on what they do best – providing exceptional patient care. If it would be helpful to discuss some of these concerns or explore solutions further, we would be happy to connect with you to share more about our experience with the NSA to date.

If you have any questions, please contact Manuel Bonilla, ASA's Washington, D.C. representative, at M.Bonilla@asahq.org at 202-289-7045.

Sincerely,

Michael W. Champeau, M.D., FASA
President, American Society of Anesthesiologists

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[6] Pub. Law No. 116-260.