ACEP and EDPMA Follow-up on Claim Dispute Adjudication Processes

The American College of Emergency Physicians (ACEP) and the Emergency Department Practice Management Association (EDPMA) would like to thank the Office of Management and Budget's (OMB's) Office of Information and Regulatory Affairs (OIRA) for convening a meeting on June 15, 2021 to discuss the implementation of the *No Surprises Act*. During the meeting, there was a request to share two diagrams that ACEP and EDPMA have previously shared with the Center for Consumer Information and Insurance Oversight (CCIIO). These two diagrams are attached.

Here we provide an overview of the two diagrams to help OMB OIRA and the other individuals on the June 15th call understand the intricacies of the current processes for adjudicating claim disputes and why it is so critical to adhere to the processes and timelines included in the *No Surprises Act*.

The first diagram, entitled "Emergency Department – Pre-NSA Revenue Cycle Process" lays out most of the actions that health plans can currently take when they process a claim. While the *No Surprises Act* only references two possible actions, payment or denial, as one can see from this diagram, there are a number of different ways plans attempt to determine the accuracy of the Current Procedural Terminology codes (CPTs) on the claims and the medical necessity for those services. The brown boxes in the diagram attempt to capture these different scenarios—or "swim lanes," as were referenced on the call. Many of these cases can lead to an internal or even external appeals process and potentially litigation.

One major takeaway from this diagram is that it is not until the very end of the claims adjudication process—the last green box on the right— that the patient's cost-sharing amount is known. It is not uncommon for this entire process to take six months or more—and the patient is kept in the middle of provider and payor billing disputes the whole time.

The second diagram, entitled "ACEP and EDPMA Diagram of No Surprises Act Processes and Timelines" lays out our interpretation of the statutory processes and timelines in the *No Surprises Act*. Here, one can see that patients are billed for their cost-sharing obligation early on in the process and, as the statute intended, are kept out of billing disputes between providers and payors. We anticipate the only "denial" would be that the patients did not actually have that insurance on the date-of-service. Otherwise, all out-of-network claims can be either paid by the health plan, the patient cost sharing is known based on the CPT code(s) on the claim, and then, if necessary, the plan or the provider can access the independent dispute resolution processes.

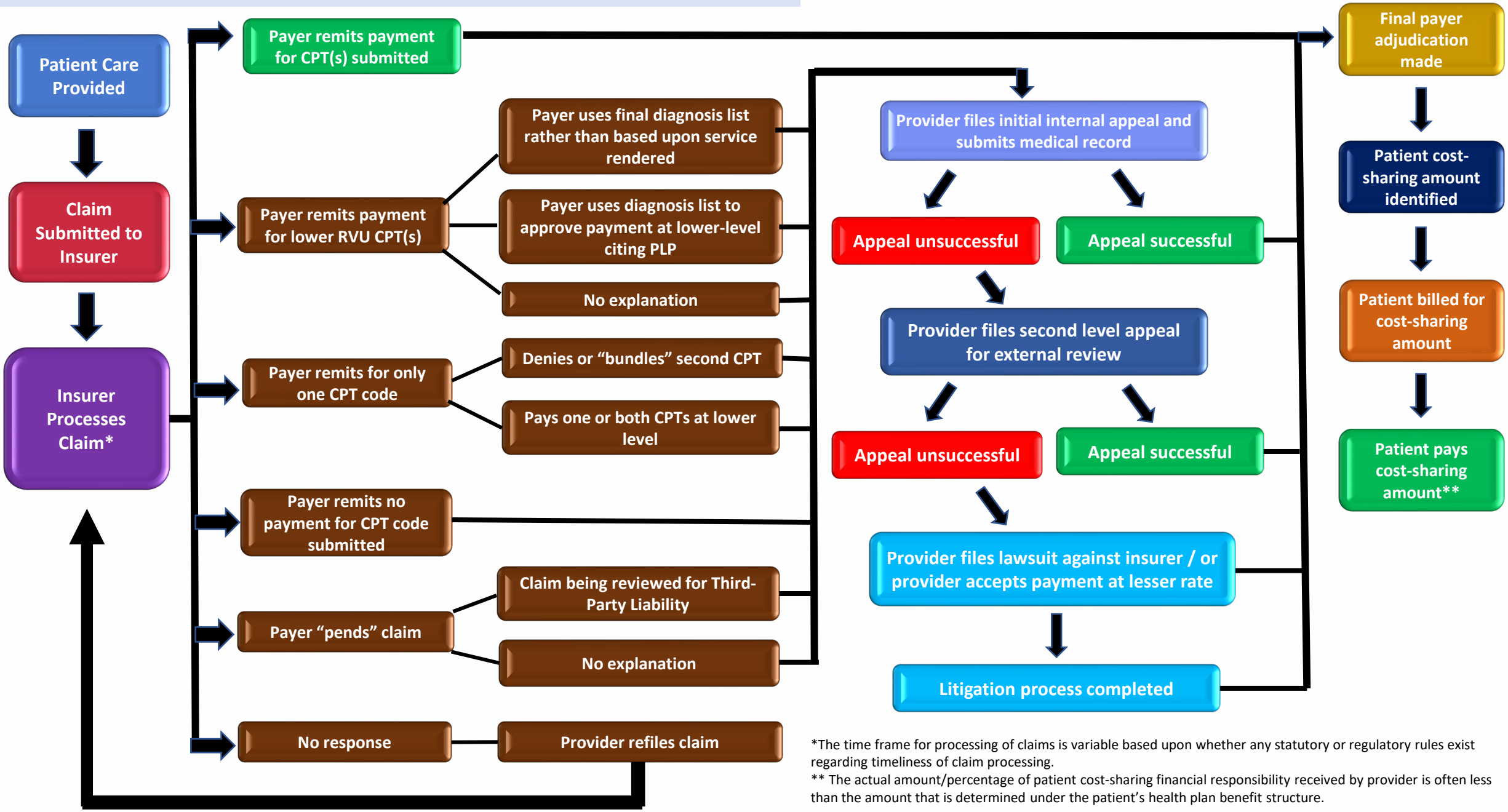
To truly take patients out of the middle, it is imperative that the qualifying payment amount (QPA) be based on the CPT code(s) that was on the claim. If the QPA is not based on this amount, the patient would not know what their cost-sharing obligation is for months (as the first

diagram demonstrates). Health plans can attempt to verify the accuracy of CPT codes on the claim form and/or the medical necessity of the service rendered (or dispute each), but the patient must NOT be pulled back into that conversation. Plans and providers could continue trying to resolve these billing disputes without further involving the patient, guided by the various rules, regulations, and processes already in place today. If, through these concurrent swim lanes, the type of and/or level of service on a claim is ultimately changed and the patient's cost-sharing amount needs to be modified, any differential would be made up by the appropriate party (either the provider or health plan).

Juxtaposing these two diagrams, one can truly appreciate how important it is to adhere to the processes and timelines in the *No Surprises Act.* Further, it is important to ensure that health plans do not take any actions that could keep patients in the middle of billing disputes for months, which could result in patients receiving unexpected health care bills— antithetical to the intention of the *No Surprises Act*.

Attachment 1

Emergency Department – Pre-NSA Revenue Cycle Process

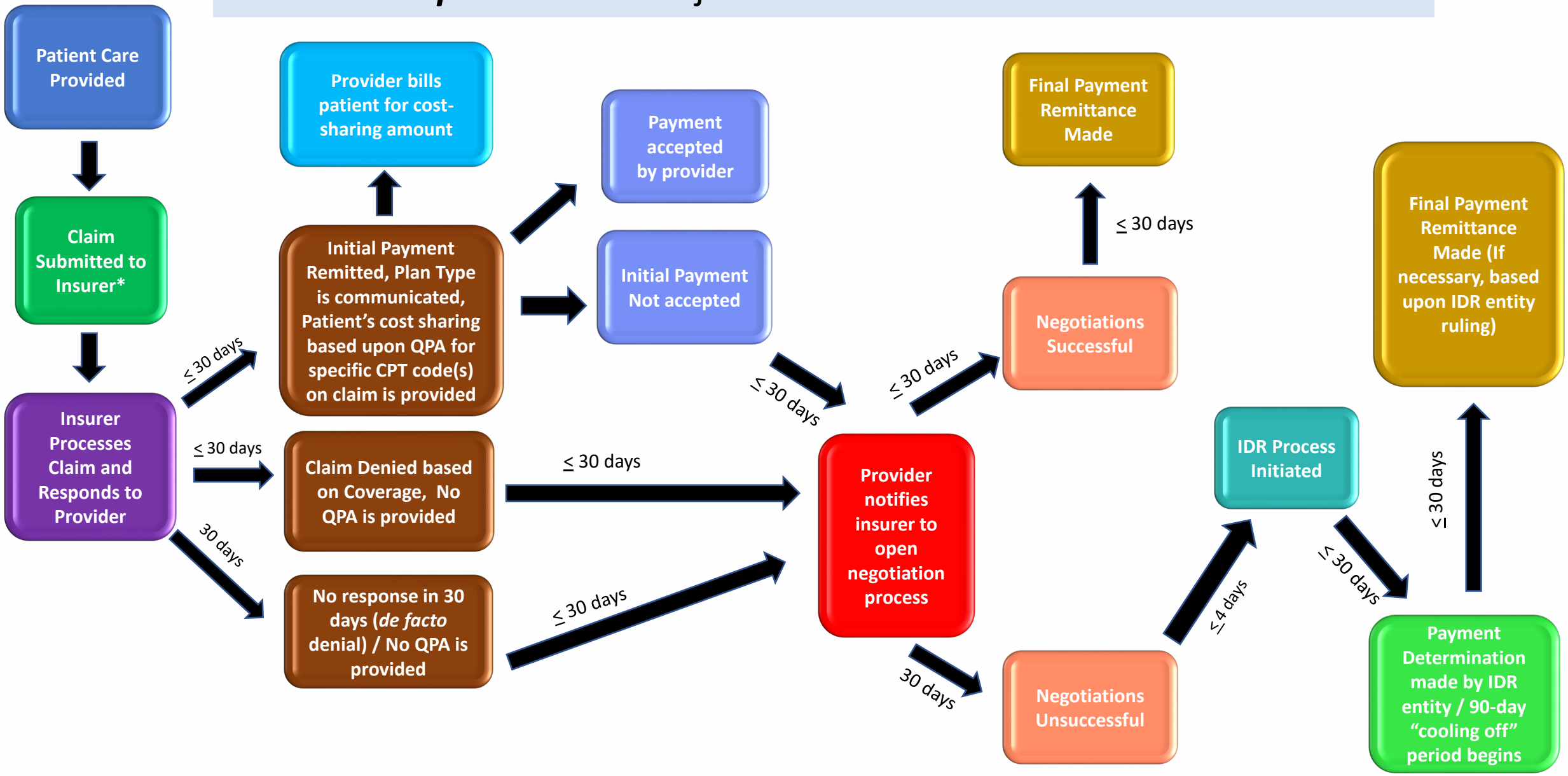


*The time frame for processing of claims is variable based upon whether any statutory or regulatory rules exist regarding timeliness of claim processing.

** The actual amount/percentage of patient cost-sharing financial responsibility received by provider is often less than the amount that is determined under the patient's health plan benefit structure.

Attachment 2

No Surprises Act – Projected Administrative & RCM Timeline



*Disputes regarding CPT code(s) submitted are to be adjudicated through existing administrative processes. However, no administrative process may, in any manner, interfere with the processes and timelines established in the *No Surprises Act* and the patient shall be protected from any financial effect of these processes.