



November 28, 2022

The Honorable Xavier Becerra
Secretary
U.S. Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue SW
Washington, DC 20201

The Honorable Martin J. Walsh
Secretary
U.S. Department of Labor
200 Constitution Avenue NW
Washington, DC 20210

The Honorable Janet Yellen
Secretary
U.S. Department of the Treasury
1500 Pennsylvania Avenue NW
Washington, DC 20220

RE: Request to Require the Use of Remittance Advice Remark Codes (RARCs)

Dear Secretaries Becerra, Walsh, and Yellen:

On behalf of our members, the American College of Emergency Physicians (ACEP) and the Emergency Department Practice Management Association (EDPMA) reiterate our previous request for the Departments to **require** health plan and issuer use of the [Remittance Advice Remark Codes \(RARCs\)](#) when providing the disclosures that are required along with the initial payment or notice of denial for out-of-network services under the *No Surprises Act*.¹

¹ ACEP and EDPMA have previously requested that the Departments make the RARCs mandatory in a [letter dated April 25, 2022](#), and [another one dated June 21, 2022](#).

As background, ACEP is the national medical society representing emergency medicine. Through continuing education, research, public education, and advocacy, ACEP advances emergency care on behalf of its 40,000 emergency physician members and the nearly 150 million Americans we treat on an annual basis. EDPMA is the nation’s largest professional physician trade association focused on the sustainable delivery of high-quality, cost-effective care in the emergency department (ED), and its members handle over half of the visits to U.S. emergency departments each year. Together, ACEP and EDPMA members provide a large majority of emergency care in our country, including rural and urban settings.

The Departments and our organizations maintain a shared goal of an efficient federal independent dispute resolution (IDR) process that should be relied upon as a resolution of last resort. In order to achieve this goal, it is necessary for all parties involved to have clear, accurate information about the regulatory body that maintains jurisdiction over disputes. **To that end, ACEP and EDPMA strongly believe that the Departments must require health plans and issuers to use the RARCs in order for providers to have the information they need to know for certain whether state or federal rules apply to an out-of-network dispute. Ensuring the use of the RARC codes for all claims will also give providers the necessary information to assess patient responsibility amounts, keep patients out of the middle of the process, and reduce the need to initiate payment disputes for out-of-network services. Further, the RARC codes will provide certified IDR entities with dispositive information about whether a particular claim is eligible for the Federal IDR process. As already articulated by the Departments, this eligibility determination has been a major factor in the delayed adjudication and increased costs for of tens of thousands of out-of-network claims, and unfortunately, now has driven the Departments to announce a significant increase in the calendar year (CY) 2023 certified IDR entity fees.** We believe that requiring these RARC codes upfront will provide a critical, proactive measure that promotes efficiency; reduce the number of ineligible claims in the federal IDR queue; and mitigate the administrative burden and cost for all stakeholders.

Inability to Determine IDR Eligibility

The Departments recently released [new IDR fees](#) that go into effect starting on January 1, 2023. Although most claims are currently “on hold” and have not been adjudicated, the Departments announced a 40 percent increase to the maximum amounts that certified IDR entity fees could charge:

	2022	2023	Percent Increase
IDR Entity Fee Single Claim	\$200-\$500	\$200-\$700	40 percent

The increase in the fees is mainly due to 1) the high administrative burden on certified IDR entities to determine whether the claims are subject to the Federal IDR process; and 2) the fact that certified IDR entities are only receiving fees on a fraction of claims they are reviewing because they are

ultimately determining that many claims are ineligible for the Federal IDR process.² With this increase, the financial burden of entering the IDR process will become even more cost-prohibitive for emergency physicians, who are often part of small organizations with limited infrastructure or resources.

Solution: Require the Use of the RARCs

This significant issue of determining IDR eligibility, which is both contributing to the backlog of claims and causing the Departments to increase IDR fees, can be solved if the RARCs are required at the time of the initial payment or notice of denial.

As background, earlier this year, the Centers for Medicare & Medicaid Services (CMS) released *No Surprises Act* [RARCs](#). The codes are broken out into the following buckets:

- The *No Surprises Act* Provisions that Apply to the Claim
- How Cost Sharing Was Calculated under the No Surprises Act
- Initial Payment Amount
- Final Payment Amount
- Denial of Payment
- Notice of Consent
- Miscellaneous

The use of these RARCs is currently optional, and our members have reported that health plans and issuers are inconsistently using them. Universal usage of the codes ***would help streamline each step of the Federal dispute resolution process***. Mandatory use of these codes would clearly delineate whether every claim is eligible for the Federal IDR process and enable providers to

² The Departments state in the [Calendar Year 2023 Fee Guidance for the Federal Independent Dispute Resolution Process Under the No Surprises Act](#) that between the launch of the Federal IDR portal on April 15, 2022, and September 30, 2022, disputing parties initiated more than 90,000 disputes through the Federal IDR portal and non-initiating parties challenged over 41,000 disputes' eligibility for the Federal IDR process. The Departments go on to state that "These contested eligibility disputes involved complex eligibility determinations that have required certified IDR entities to expend considerable time and resources to review. As a result of eligibility challenges, as of September 30, 2022, certified IDR entities have found over 22,000 disputes ineligible for the Federal IDR process. While the process for eligibility determination informs the overall rate that certified IDR entities are permitted to charge, certified IDR entities may not collect fees for those cases that they ultimately determine are ineligible for the Federal IDR process. Further, only about 3,500 payment determinations were made by certified IDR entities. Because so many disputes have been found ineligible, certified IDR entities are only receiving payment for a small percentage of the disputes to which they are devoting significant time and resources[...]. In setting the certified IDR entity fee ranges for calendar year 2023, the Departments considered the anticipated time and resources needed for certified IDR entities to meet the requirements of the Federal IDR process, such as the time and resources needed for IDR entity certifications, making payment determinations (including determining whether the dispute belongs in the Federal IDR process), data reporting, and responding to audits. During calendar year 2022, certified IDR entities incurred more administrative burden than originally anticipated by the Departments."

accurately bill their patients since they would know that the cost-sharing was calculated in accordance with the *No Surprises Act*.

Furthermore, since these codes are not being used regularly, it is often impossible to verify the type of health plan and whether it is subject to a state or federal law. Not only would requiring the RARCs enable certified IDR entities to IMMEDIATELY identify whether a claim is eligible for the Federal IDR process, but it would also prevent many claims from being submitted in the first place. **In all, requiring the use of the RARCs would solve the most fundamental problem that is disrupting the flow of the Federal IDR process and undermining the successful implementation of the *No Surprises Act*.**

ACEP and EDPMA also do not believe that requiring the use of the RARCs would necessitate any changes to the templates that health plans and issuers typically use to relay information about a claim to a provider. When health plans and issuers adjudicate claims and communicate information to the health care provider, they do so in a standardized format called an ANSI 835 (835) remittance. Health Insurance Portability and Accountability Act (HIPAA) transaction and code set (TCS) standards already require that health plans and users use ANSI Claims Adjustment Reason Code (CARC) and RARC for their 835 electronic healthcare transactions. There are enough fields on the standard 835 remittance to accommodate the *No Surprises Act* RARCs. The Departments should also begin the process of requesting a modification to the standard 835 remittance form so that all the information, including the qualifying payment amount (QPA), is disclosed in a uniform way.

Thank you again for the opportunity to reiterate our previous request that health plans and issuers be required to use the RARCs at the time of the initial payment and notice of denial. We do note that the RARCs will be even more valuable given the Departments' recent announcement that as of today, disputing parties will be required to provide the QPA and the additional information that health plans are required to disclose at the time of the initial payment or notice of denial when initiating the IDR process. If health plans and issuers do not provide this information in a consistent way, disputing parties may be confused about what exactly they should upload into the IDR portal. This confusion in turn could result in disputing parties uploading incorrect information about the claim, which could delay the resolution of claim even further. Lastly, we wish to point out that without proper enforcement of all these requirements, health plans and issuers will continue to have an incentive to circumvent different aspects of the federal dispute resolution process. A sound oversight and enforcement strategy is therefore absolutely necessary to avoid both the appearance and reality of there being a clear advantage to health plans during negotiations—despite the fair and balanced dispute resolution process that the *No Surprises Act* intended to provide.³ **To that**

³ Proper enforcement and oversight have proven to be critical to ensure health plan accountability in other CMS programs. For example, as noted in a November 21, 2022 NPR article, [Hidden audits reveal millions in overcharges by Medicare Advantage plans](#), “Newly released federal audits reveal widespread overcharges and other errors in payments to Medicare Advantage health plans, with some plans overbilling the government more than \$1,000 per patient a year on average.”

end, the Departments should instruct the certified IDR entities to *automatically rule in favor of the disputing party* if health plans or issuers do not use the RARCs or provide the information, including the QPA, that is required to be disclosed at the time of the initial payment or notice of denial.

If you have any questions, please contact Laura Wooster, ACEP's Senior Vice President of Advocacy and Practice Affairs at lwooster@acep.org, or Cathey Wise, EDPMA's Executive Director at cathey.wise@edpma.org.

Sincerely,



Christopher S. Kang, MD, FACEP
ACEP President



Don Powell, DO
Chair of the Board, EDPMA