

September 3, 2021

Secretary Xavier Becerra
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, D.C. 20201

RE: Requirements Related to Surprise Billing; Part I [CMS-9909-IFC]

Dear Secretary Becerra:

On behalf of the American Health Information Management Association (AHIMA), I am responding to the US Department of Health and Human Services' (HHS) interim final rule on Requirements Related to Surprise Billing, as published in the July 13, 2021, issue of the *Federal Register* (CMS-9909-IFC).

AHIMA is a global nonprofit association of health information (HI) professionals. AHIMA represents professionals who work with health data for more than one billion patient visits each year. AHIMA's mission of empowering people to impact health drives our members and credentialed HI professionals to ensure that health information is accurate, complete, and available to patients and providers. Our leaders work at the intersection of healthcare, technology, and business, and are found in data integrity and information privacy job functions worldwide.

AHIMA believes that affordability is a critical element that impacts patient access to care. Ensuring patients have access to timely and accurate information about the cost of healthcare services, including information about their expected out-of-pocket costs, is necessary for making informed care decisions. AHIMA supports the use of public policy to ensure that individuals have all the information they need to make informed choices about their healthcare, including efforts to find equitable solutions to prevent "surprise billing" for consumers. As such, AHIMA supports the patient protections contained in this interim final rule and appreciates the administration's efforts to ensure that patients are protected from surprise medical bills for emergency services, air ambulance services provided by out-of-network providers, and non-emergency services provided by out-of-network providers at in-network facilities in certain circumstances. Significant progress has been made in recent years to empower patients to access their data and make more informed health decisions. AHIMA believes that it is important that HHS and other departments and agencies encourage collaboration to ensure that transparency requirements are harmonized to account for developments relating to technological innovation, increasing patient access to health data, and interoperability.

Following are our comments and recommendations on selected sections of the rule.

A. Preventing Surprise Medical Bills

In General

The interim final rule with comment states that in instances when a provider or facility bills in violation of the statute and relevant regulation, “the Secretary of HHS (the Secretary) may impose civil monetary penalties in states where HHS is directly enforcing the balance billing provisions with respect to health care providers, facilities, and providers of air ambulance services.”¹ AHIMA supports that this rule allows for flexibility in cases in which a provider or facility does “not knowingly violate, and should not have reasonably known it violated, the provisions... if such provider or facility, within 30 days of the violation, withdraws the bill that was in violation of such provision and reimburses the health plan or individual.”² AHIMA supports providing flexibility and believes it is necessary to allow for expedient corrective action in cases in which non-compliance is inadvertent. AHIMA believes providers and facilities may need time to implement policies and safeguards in response to the new requirements and patient protections. Considering the short timeline for implementation and the high likelihood for inadvertent violations as providers and facilities adjust to the new requirements, AHIMA urges that sufficient flexibility be allowed. AHIMA recommends that corrective action should be allowed within 30 days of the provider or facility becoming aware of the violation, rather than 30 days of the violation itself. It is possible that a provider or facility may not become aware of the violation during the initial 30-day timeframe and can only act once it is made aware of the violation.

Health Care Facilities

The rule notes HHS is interested in comments regarding “other facilities that would be appropriate to designate as health care facilities” for the purposes of surprise billing protections. Skilled nursing facilities are not currently within the purview of the definition of participating health care facility, but non-emergency services may be provided by non-participating providers at an in-network participating skilled nursing facility. Skilled nursing facilities often contract with therapy service providers, physician groups, pharmacists, hospice providers, and other providers and suppliers to render care to SNF residents. These third-party providers under contract with the SNF may not participate in all the same health plans as the facility, and as a result a SNF resident may incur surprise out of network bills from affiliated providers and suppliers.

Notice and Consent Exception to Prohibition on Balance Billing

The rule allows patients to voluntarily waive cost-sharing and balance billing protections provided that the patient is given a detailed notice and consent form prior to waiving protections. Specifically, a patient may waive protections “only after receiving a written notice that includes detailed information designed to ensure that individuals knowingly accept out-of-pocket charges (including charges associated with balance bills) for care received from a nonparticipating

¹ 86 Fed. Reg. at 36905

² Id.

provider or nonparticipating emergency facility.”³ AHIMA supports this policy and believes it is necessary to ensure that patients maintain access to out-of-network care and understand the financial implications associated with receiving this care.

The rule states that providers and facilities satisfy the requirement for advance notice if the notice is provided to the patient no later than “72 hours prior to the date on which the individual is furnished such items or services, in the case where the appointment to be furnished such items or services is scheduled at least 72 hours prior to the date on which the individual is to be furnished such items and services.”⁴ AHIMA supports this provision and believes it is necessary to ensure that patients do not feel undue pressure to consent to waive cost-sharing and balance billing protections to receive care. AHIMA notes it may be necessary to consider offering these timeframes as presumptive of sufficient advance notice, but not determinative. As written, a patient who makes an appointment 73 hours in advance only affords the non-participating provider or facility one hour to deliver notice and consent documents. As such, non-participating providers and facilities would likely need to design automated mechanisms to identify when a scheduled service may be out of network with their plan participation and transmit notice and consent documents to the patient almost immediately. Even if an entirely automated system were available, many systems may not process transactions immediately in real-time, but instead may run search criteria and communication outreaches every few hours, which may not occur on the same date as an appointment is made.

In cases in which an appointment is made with fewer than 72 hours’ notice, the rule states that the notice may be provided on the same day the items and services are provided if the notice is provided at least three hours prior to furnishing items or services to which the notice and consent requirements apply. AHIMA believes this requirement may need to be reconsidered and instead of a bright-line timeframe, it may be necessary to use a reasonableness standard similar to those outlined in the Medicare Advance Beneficiary Notice criteria that providers are already familiar with. Requiring non-participating providers and facilities to deliver notice and consent three hours prior to a scheduled appointment likely creates unnecessary burden that may not fulfill the intended purpose. During the work week, a patient receiving notice and consent documents during work hours may not have any greater opportunity to review and consider those documents prior to an appointment that is scheduled immediately after work than he or she may have if reviewing them immediately prior to the time of service. Additionally, if a patient is planning to receive services from a non-participating provider while located in a participating facility, electronic delivery to the individual three hours prior to the service may result in situations in which patients receive the notice while they are receiving other care or treatment.

Additionally, AHIMA has concerns related to the operational feasibility of the requirement that the notice must include “the good faith estimated amount that such nonparticipating provider or nonparticipating emergency facility may charge the individual for the items and services involved, including any item or service that the nonparticipating provider reasonably expects to provide in conjunction with such items and services.”⁵ HHS notes it will solicit comments “regarding the method by which this good faith estimated amount should be calculated, and

³ 86 Fed. Reg. at 36906

⁴ 86 Fed. Reg. at 36907

⁵ Id.

anticipates addressing this requirement in future rulemaking.”⁶ AHIMA strongly supports the need for patients to be well-informed prior to agreeing to out-of-network costs. Absent clarification in future rulemaking, AHIMA is concerned that the ambiguity of what would constitute a good faith estimate will pose significant challenges for providers and facilities. AHIMA urges the agency to expeditiously include clarification in forthcoming rulemaking that will be issued prior to the January 1, 2022 implementation date. AHIMA believes the agency should consider aligning guidance regarding the “good faith estimated amount” with Medicare Beneficiary Notice Initiative Advance Beneficiary Notice of Noncoverage cost estimate standards, that also require advance good faith cost estimates. Under this standard, for estimates to be valid, they are generally “within \$100 or 25% of the actual costs, whichever is greater; however, an estimate that exceeds the actual cost substantially would generally still be acceptable, since the beneficiary would not be harmed if the actual costs were less than predicted.”⁷

AHIMA also has similar concerns regarding the requirement that “the notice must provide information about whether prior authorization or other care management limitations may be required in advance of receiving such items or services at the facility or from the provider.”⁸ Acknowledging that it is likely to be difficult for non-participating providers to have access to accurate information related to specific utilization management policies for plans with which they do not participate, the rule notes that providers and facilities “may provide general information in order to satisfy this requirement.”⁹ AHIMA requests clarification on what would constitute “general information” and notes there may be cases in which patients find this element to be misleading.

Health care facilities, providers and health plans must also post a disclosure in a prominent location within the facility and on a public website and provide certain information to patients. This notice must include requirements and prohibitions under the No Surprises Act and implementing regulations, applicable state balance billing requirements, and instructions on how to contact appropriate state and federal agencies if the individual believes the provider or facility has violated any of these requirements. AHIMA appreciates that in implementing this requirement, a federal model disclosure notice is provided that can be used to satisfy these requirements.

B. Preventing Surprise Medical Bills

Same or Similar Item or Service

To determine the qualifying payment amount for the purposes of cost sharing, “a plan or issuer must calculate the median contracted rate for an item or service using contracted rates for the same or similar item or service.”¹⁰ The interim final rule defines the term “same or similar item

⁶ 86 Fed. Reg. at 36908

⁷ Advance Beneficiary Notice of Non-Coverage (ABN) , OMB Approval Number: 0938-0566 .
www.cms.gov/Medicare/Medicare-General-Information/BNI/Downloads/ABN-Form-Instructions.pdf.

⁸ 86 Fed. Reg. at 36908

⁹ Id.

¹⁰ 86 Fed. Reg. at 36890

or service” to be “a health care item or service billed under the same service code, or a comparable code under a different procedural code system. Service code means the code that describes an item or service, including a Current Procedural Terminology (CPT), Healthcare Common Procedure Coding System (HCPCS), or Diagnosis-Related Group (DRG) code.”¹¹

AHIMA notes that a DRG code is not a unique identifier that identifies an item or service with specificity. ICD-10-PCS is the procedure coding system used in the hospital inpatient setting. DRGs are a patient classification structure that provide a means of categorizing hospital inpatients according to resource use. A DRG is defined by a particular set of patient attributes which include principal diagnosis, specific secondary diagnoses, procedures, sex, and discharge status. Instead of a DRG code, AHIMA believes that an ICD-10 procedure coding system (ICD-10-PCS) code should be listed as a type of service code that describes an item or service. ICD-10-PCS codes are used to describe procedural services provided in the hospital inpatient setting.

Emergency Services

The rule defines an emergency medical condition as “a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition... including (1) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (2) serious impairment to bodily functions, or (3) serious dysfunction of any bodily organ or part.”¹²

AHIMA supports not basing the definition of an emergency medical condition solely on the basis of diagnosis codes. The ICD-10-CM Official Guidelines for Coding and Reporting (“official coding guidelines”) stipulate that signs and symptoms that are associated routinely with a disease process should not be assigned as additional codes. Additionally, the official coding guidelines for outpatient encounters (such as emergency department visits), state that codes that describe symptoms and signs, as opposed to diagnoses, are acceptable for reporting purposes when a diagnosis has not been established (confirmed) by the provider. This means that if a patient presents with a symptom that would generally be considered an emergency medical condition, such as chest pain, but the provider confirms a definitive diagnosis that is not generally considered to be an emergency medical condition, such as gastroesophageal reflux disease as the cause of a presenting symptom of chest pain, only the code for the definitive diagnosis is reported on the claim and the code for the presenting symptom would not be reported.

Post-Stabilization Services

The rule states that post-stabilization services are defined as emergency services unless certain conditions are met. Since patients cannot waive surprise billing protections for emergency services, a patient cannot waive the surprise billing protections for post-stabilization services unless the prescribed conditions are met. One of the conditions is that “the attending emergency physician or treating provider must determine that the participant, beneficiary, or enrollee is able

¹¹ Id.

¹² 86 Fed. Reg. at 36879

to travel using nonmedical transportation or nonemergency medical transportation to an available participating provider or facility located within a reasonable travel distance, taking into consideration the individual's medical condition."¹³ HHS is soliciting comments regarding the definition of "reasonable travel distance" for the purpose of waiving surprise billing protections. The agency asks whether in determining a standard for reasonable travel distance if it should "take into account only mileage, or also other factors, such as traffic or other route conditions that might make traveling difficult, time consuming, or hazardous?"¹⁴ AHIMA notes that what constitutes a reasonable distance may vary based on a patient's health status and geography. The burden of traveling a specific fixed distance can be highly variable depending on whether the patient would be traveling in an urban or rural setting, based on local topography, traffic conditions, and the existence of any hazardous conditions. AHIMA also notes that a patient's condition may dictate the length of time and travel conditions that can be tolerated by the patient. AHIMA does not support a fixed mileage standard for travel distance and believes that reasonable travel distance should be determined according to the treating provider's judgement and that the patient should be involved in the decision-making process.

Thank you for the opportunity to provide comments in response to the Requirements Related to Surprise Billing, Part I. Should you or your staff have any additional questions or comments, please contact Lauren Riplinger, AHIMA's Vice President, Policy & Government Affairs, at lauren.riplinger@ahima.org and (202)-839-1218 or Matt Kerschner, AHIMA's Director of Regulatory Affairs at matthew.kerschner@ahima.org and (312)-233-1122.

Sincerely,



Wylecia Wiggs Harris, PhD, CAE
Chief Executive Officer

¹³ 86 Fed. Reg. at 36880

¹⁴ 86 Fed. Reg. at 36881