

ED Operations Summit 2026
North Carolina College of Emergency Physicians
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Disclosures/goals/objectives:

- **ACEP Reimbursement Committee Work Group 2 chair, 15+ yrs. charged w/ fed/state out of network (OON), balance billing issues & “bad payor” issues + chair of the EDPMA No Surprises Act (NSA) Task Force.**
- **I am an officer of Zotec Partners, LLC, a revenue cycle management company for independent group practices, hospital employed and clinic-based clinicians.**
- **The opinions expressed herein are my own and are not those of my employer, physician specialties or trade associations where I am in positions of leadership.**
- **This presentation is offered as general information and is not legal advice; experienced and qualified healthcare counsel should be consulted regarding the new federal out of network/balance billing law or existing state laws.**

Issues & discussion:

1. **Why the lack of an inflationary adjustment in the Medicare physician fee schedule (MPFS) is so important.**
2. **The Conversion Factor (CF)—the slight increase in '26 ED reimbursement is due largely to a +2.5% increase that expires 12/31/26.**
3. **Use the “Transparency in Coverage” (TiC) data as a substitute.**
4. **“Doc vs. Bot”—or “the Doc Bot vs. the Health Plan Bot”.**
5. **The No Surprises Act (NSA): important new data + what does the future portend?**
6. **Q&A**

Issue 1: The issue w/ the Medicare physician fee schedule (MPFS) is NOT the AMA RUC--think of the RVU “pie” as \$1.00 & then a zero-sum game.


➤ **The RBRVS Formula: Work RVUs (W-RVU) X W GPCI + Practice Expense (PE) RVU X the PE GPCI + Prof. Liability (PLI RVU) X PLI GPCI=Total RVU.**

➤ **Total RVU X the conversion factor (CF)=the Medicare allowable reimbursement.**

➤ **Example: CPT 99285, total RVUs 5.13 X \$33.4009=\$171.35**

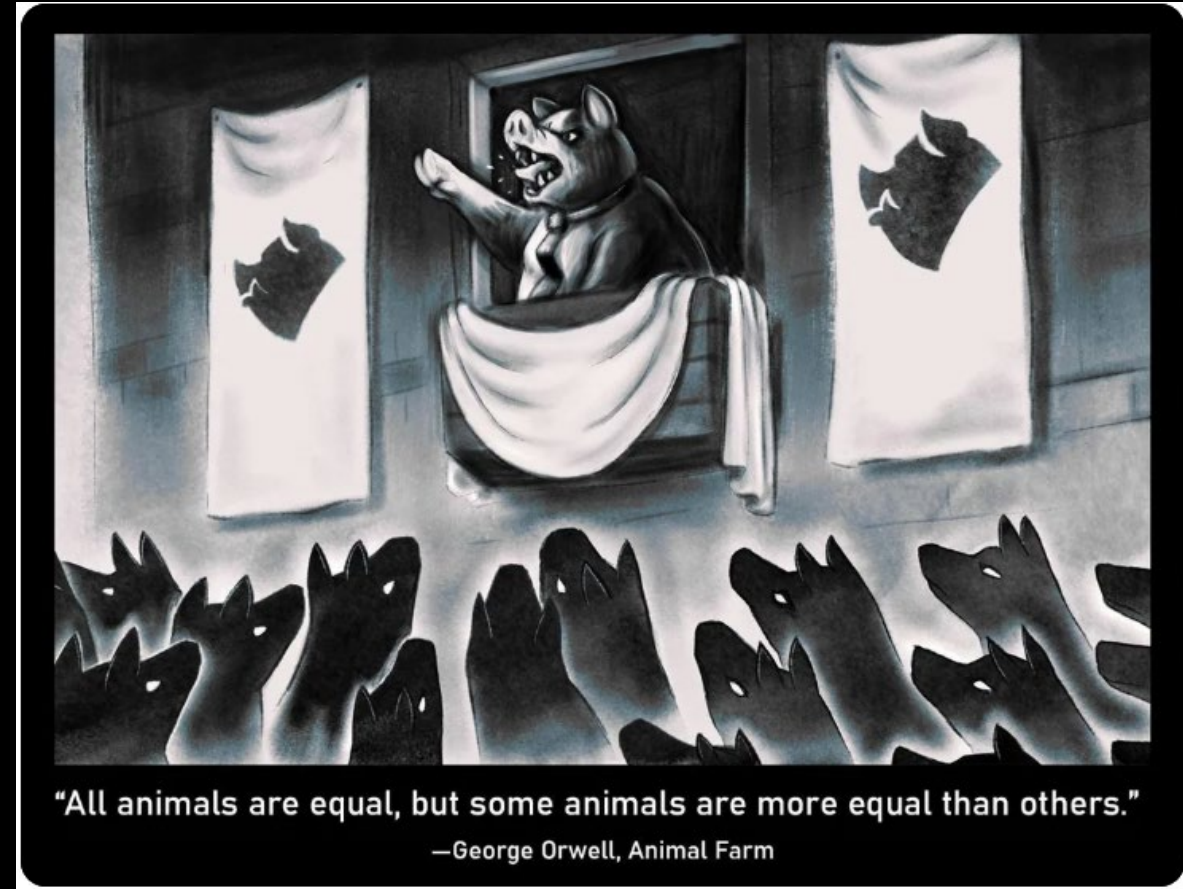
TABLE D-B4: CALCULATION OF THE CY 2026 PFS NON-QUALIFYING APM CONVERSION FACTOR

PFS Non-Qualifying APM Conversion Factor	Percentage	Actual Adjustment	Conversion Factor
Conversion Factor in effect in CY 2025			32.3465
CY 2026 Non-Qualifying APM Update Factor	0.25 percent	1.0025	
CY 2026 RVU Budget Neutrality Adjustment	0.49 percent	1.0049	
CY 2026 2.50 Percent Increase	2.50 percent	1.0250	
CY 2026 Conversion Factor			33.4009



The CF is different if you are part of an “Advanced Alternative Payment Model” (AAPM or APM)

- Check to see if you are in an APM.
- QPP Participation Status Tool: The most direct method is to visit the QPP Participation Status Tool and enter your 10-digit National Provider Identifier (NPI). This tool provides real-time information on your individual status for the current and previous performance years.
<https://qpp.cms.gov/eligibility-participation/eligibility/determination>
- Email: QPP@CMS.HHS.GOV or call 866-288-8292.
- If you are in an APM, your CF is \$33.5675 vs. the non-APM CF at \$33.4009.
- For CPT 99285, you would receive \$.85 more than a non-APM.



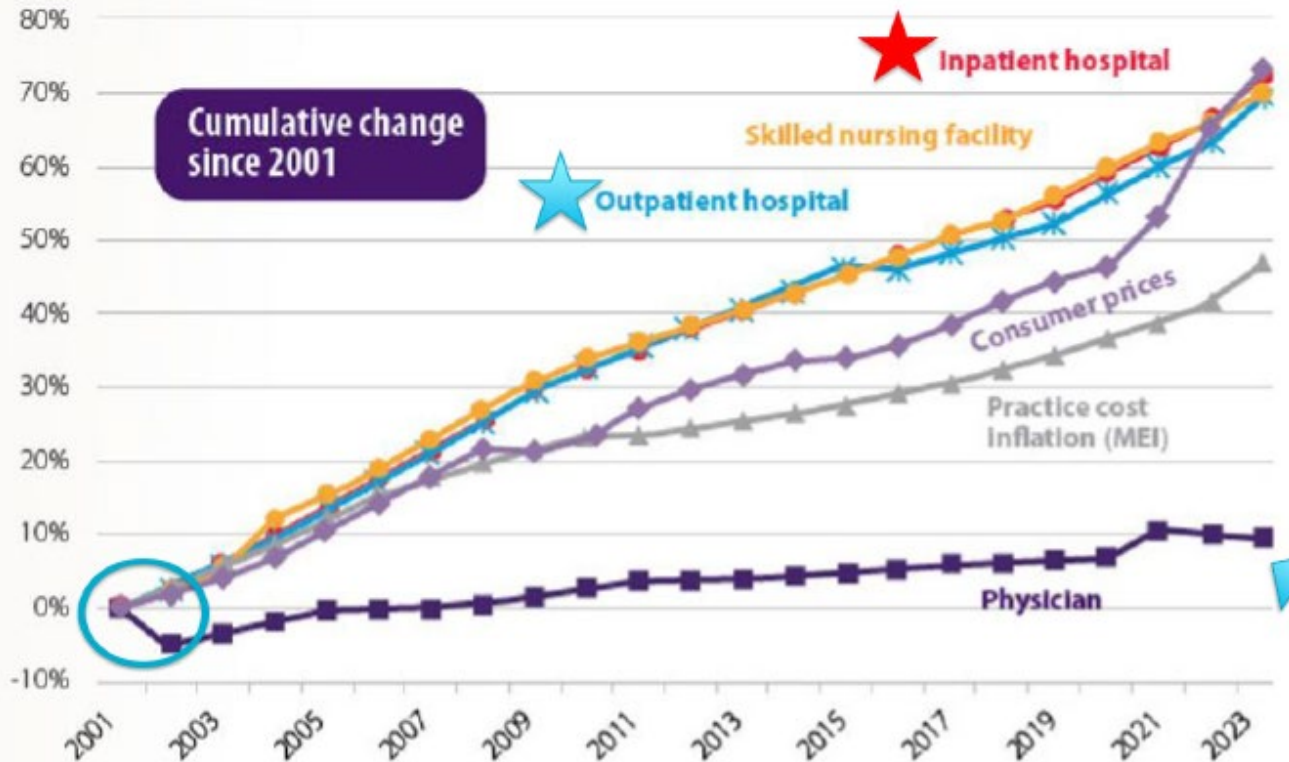
➤ The issue for the MPFS is the lack of an inflationary adjustment (CPI-U).

And here's Exhibit A on not using a % of Medicare as the standard for your health plan contracts.

2025 OPFS Update +2.9%

2025 Physician Update -2.8%

Professional vs Facility Not Keeping Up

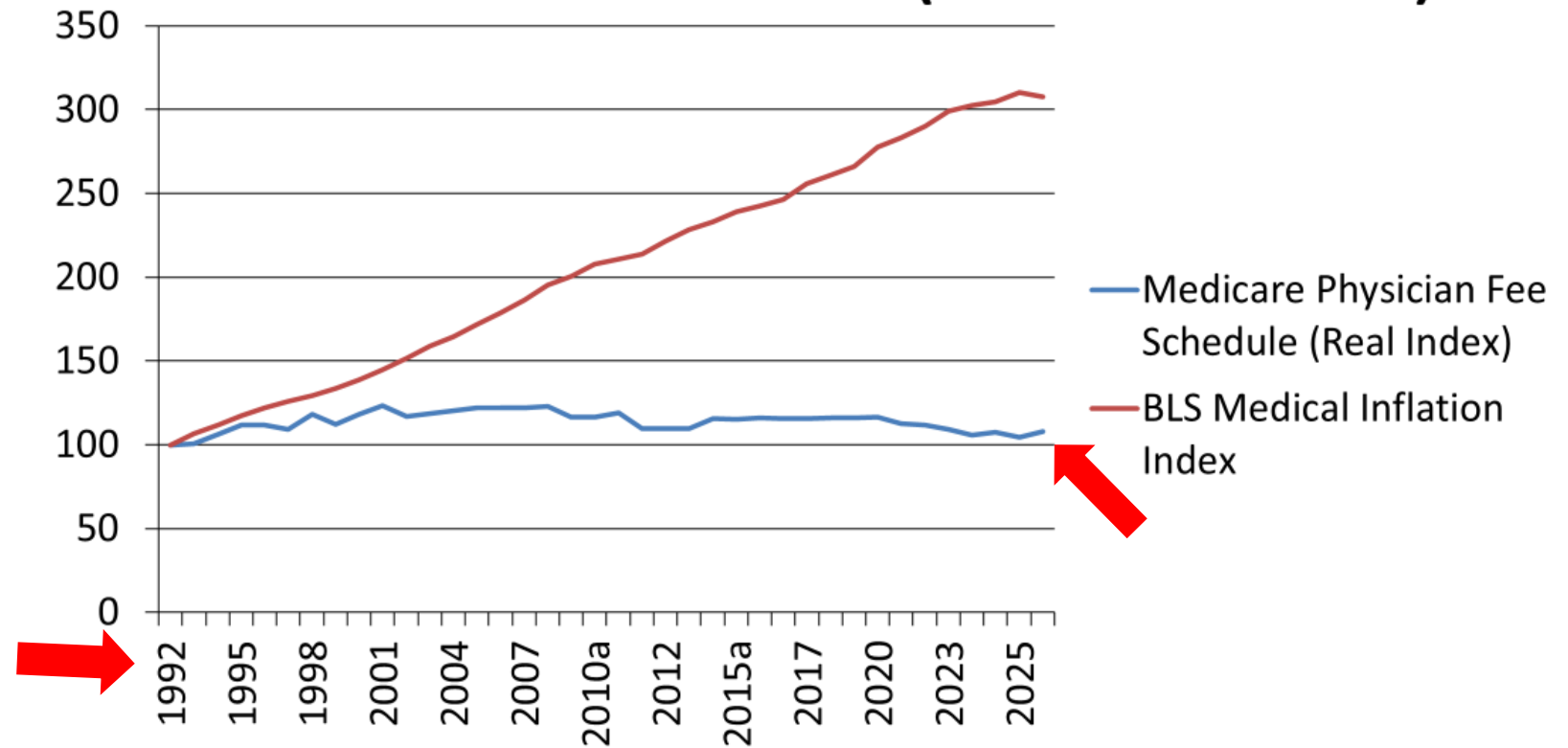


Sources: Federal Register, Medicare Trustees' Reports, Bureau of Labor Statistics, Congressional Budget Office.

➤ The Medicare physician fee schedule is down over ~65% in real dollar terms since '92.

The Medicare adjusted payment index would be ~\$108 since '92 & the US BLS inflation index would be \$308.00

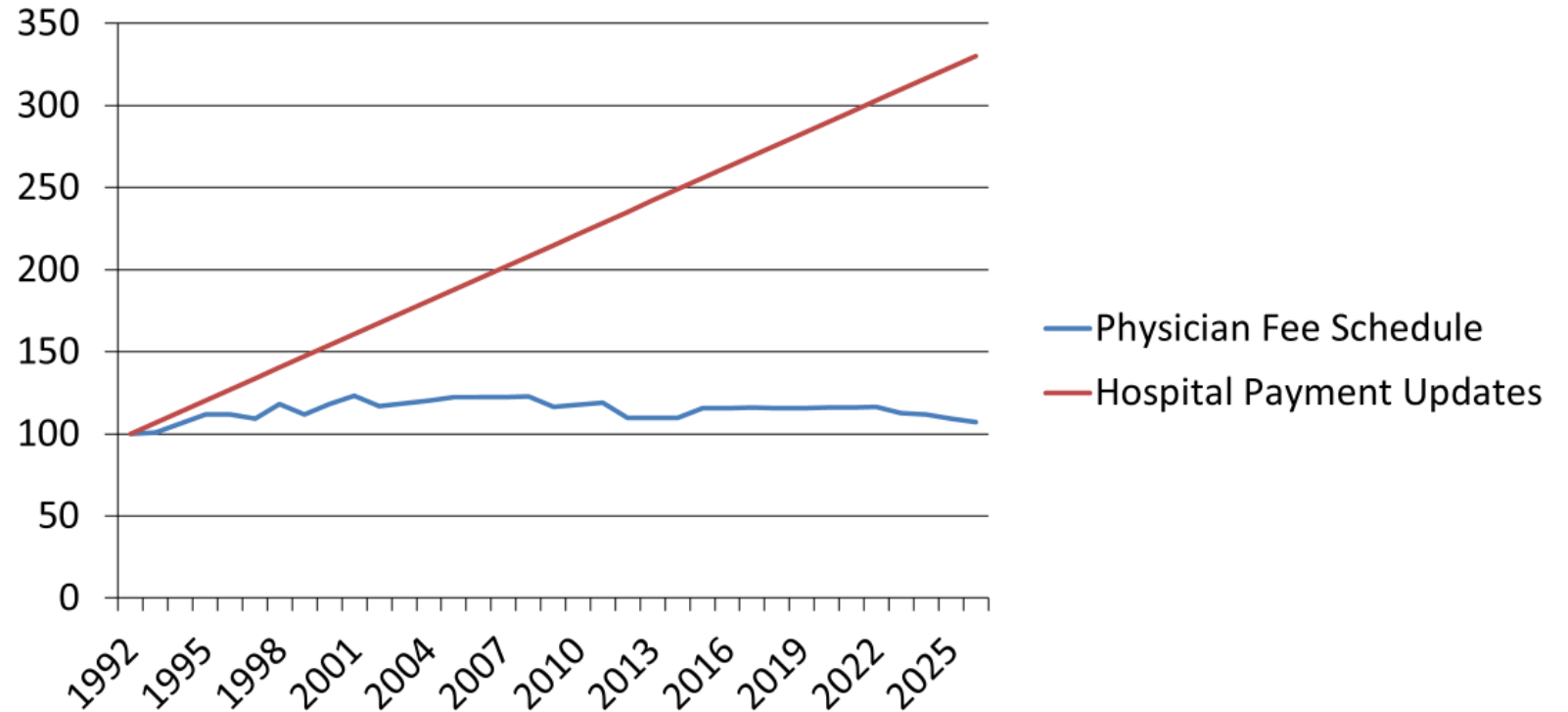
Medicare Physician Payment vs Medical Inflation (1992–2026)



Hospitals receive a “market basket” update each yr., which may not be full CPI but is usually in the +2.5-4% range.

In ‘26 it was +2.6%.

Medicare Payment Policy: Physicians vs Hospitals (1992–2026)



Policy Gap

- Physician payments ~+8% since 1992
- Hospital payments ~+230%
- Hospitals increased ~25× faster
- Major imbalance in Medicare policy

Near-Term Relief Bills: “Stop the Bleeding”

House bill

House: H.R. 879 — Medicare Patient Access and Practice Stabilization Act of 2025

- • Introduced Jan. 31, 2025, by Reps. Greg Murphy, MD (R-NC) and Jimmy Panetta (D-CA).
- • Would prospectively cancel the 2.83% cut that took effect Jan. 1, 2025.
- • Would also provide a 2.0% payment update effective April 1, 2025.

- This wasn't a fringe bill—H.R. 879 had over 100 bipartisan co-sponsors.

Senate bill

Senate: S. 1640 — Medicare Patient Access and Practice Stabilization Act of 2025

- • Introduced May 7, 2025 by Sen. Roger Marshall, MD (R-KS).
- • Bill text would increase PFS payments by 8.51% for services furnished June 1–Dec. 31, 2025.
- • The Senate version shows there is appetite for a stronger temporary bridge.
- • That tells you Congress understands there's a problem—even if they haven't solved it yet.

Good news: Congress has already written bills aimed at reversing recent cuts, not merely studying them.

Purposes behind bipartisan H.R. 6160 & what are the potential sources of funds?

- **Ties payment updates to inflation (MEI) long term**
- **Stabilizes the conversion factor long-term**
- **Applies across the Physician Fee Schedule**
- **Reduces need for annual 'doc fix'.**
- **Kaiser Permanente affiliates to pay \$556 million DOJ said Kaiser pressured physicians to add diagnoses not supported by the medical record, driving higher MA reimbursement.**
- **Aetna to pay \$117.7 million Aetna resolved allegations that it submitted or failed to withdraw inaccurate diagnosis codes, including chart-review and morbid-obesity coding issues.**
- **WSJ: DOJ Investigates Medicare Billing Practices at UnitedHealth--reported in 2025 that UnitedHealth Group was facing both civil and criminal scrutiny over its Medicare Advantage billing practices, including allegations that diagnoses were being documented in ways that increased government payments. The reporting said federal prosecutors were examining whether the company used physicians and nurses to collect diagnoses that boosted reimbursement.**

Issue 2: ACEP & the “House of Medicine” Advocacy achieved a +2.5% increase in the CF for ‘26.

- **According to the Centers for Medicare & Medicaid Services (CMS), the One Big Beautiful Bill Act (HR1) was a key component of the overall 2026 CF updates.**
- **Temporary 2.5% Increase: Mandated by Section 71202 of the One Big Beautiful Bill Act to account for exceptional circumstances, applying to services between January 1, 2026, and January 1, 2027.**
- **Context of Previous Cuts: This increase followed a significant 2.83% decrease in the 2025 conversion factor, which had been set at \$32.35.**

2026 ED RVU Components and RUC Increases

- **Emergency Medicine Total RVUS**
- **Work RVUs 77% (RUC)**
- **Practice Expense 16%**
- **Non physician clinical labor, supplies, and overhead**
- **Doesn't apply much to the ED**

ED RUC Work RVU History

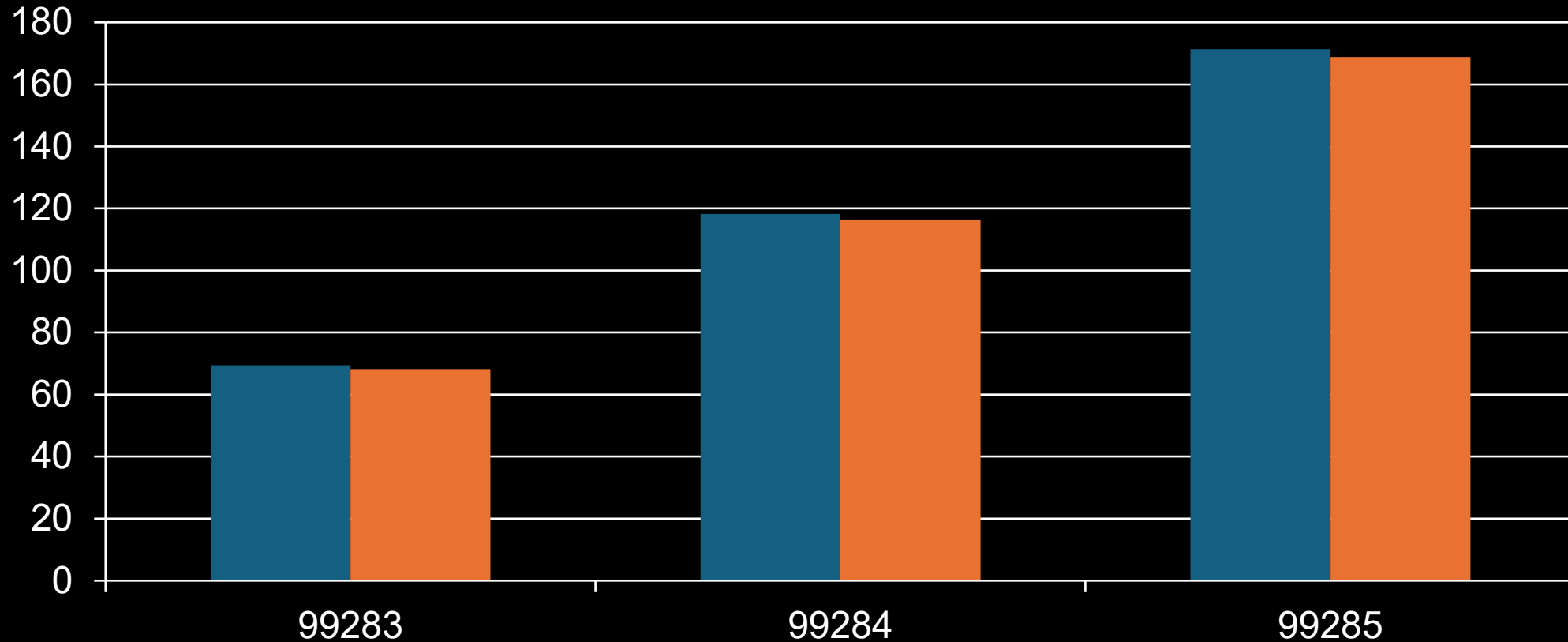
- **2007 big increases~mid teens to >20%+ in E&Ms.**
- **2020 5% increase**
 - **(99283 W-RVU 1.34 - 1.42)**
- **2021 5% increase**
 - **(99284 W-RVU 2.60 - 2.74)**
- **2023 new Work RVU valuations**
 - **RUC recommended 99284 W-RVU 2.60 & ACEP fought back to 2.74**
 - **CMS declined to accept the RUC recommendation and kept 2.74 W-RVU—RUC recommendations have a 90% acceptance rate by CMS.**

The RBRVS Formula & Importance of the W-RVU to EM—W-RVUs stable again for EM in '24, '25 & '26.

- **Formula: Work RVUs (W-RVU) X W GPCI + Practice Expense (PE) RVU X the PE GPCI + Prof. Liability (PLI RVU) X PLI GPCI=Total RVU.**
- **Total RVU X the conversion factor (CF)=the Medicare allowable reimbursement.**

Code	2024 W-RVU	2025 W-RVU	2026 W-RVU
99283	1.60	1.60	1.60
99284	2.74	2.74	2.74
99285	4.00	4.00	4.00

Medicare Reimbursement: Key ED Codes (2026 vs 2025)



Key Takeaways—Blue is 2026 & Orange is 2025.

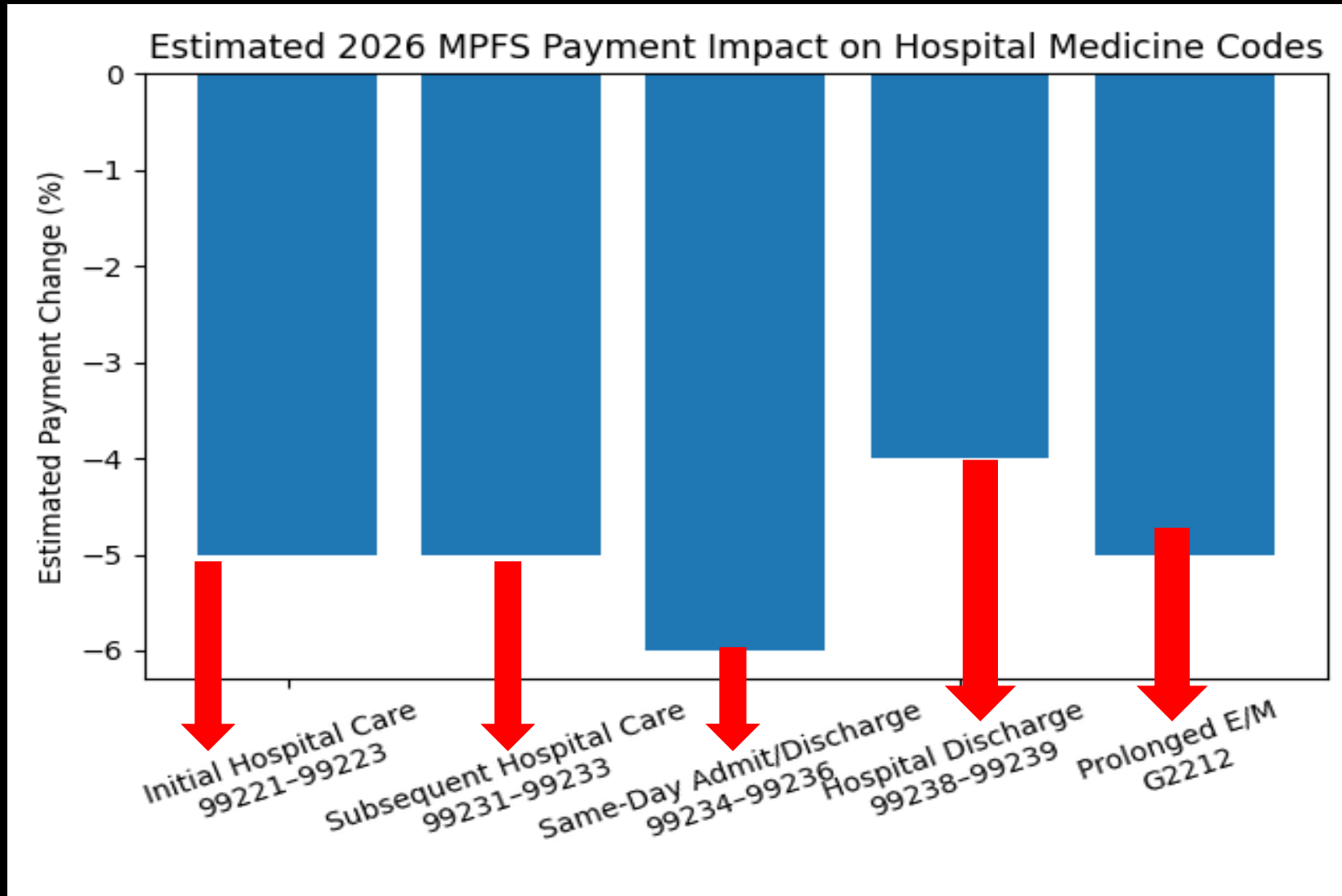
- 99283: \$69.47 vs \$68.25
- 99284: \$118.24 vs \$116.45
- 99285: \$171.35 vs \$168.85

≈ 1.5–1.8% payment increase in E&Ms, w/ offsetting cuts in procedures.

Why Hospital Medicine Codes Are Being Reduced.

- **Two major policy changes in the 2026 MPFS impact facility-based physician services:**
 - **Efficiency adjustment reducing work RVUs by approximately 2.5% for most non-time based services, due to the agency's belief that physician services become more efficient over time due to technology and workflow improvements.**
 - **Indirect practice expense methodology change for facility settings.**
- **Hospital medicine relies heavily on inpatient E/M codes, concentrating the impact of these cuts.**

Estimated Payment Impact on Major Hospital Medicine CPT Codes (Modeled)



Policy Implication for Hospital-Based Specialties

- Hospital medicine and emergency medicine rely on a small number of high-volume E/M CPT codes.
- Even modest RVU reductions create significant revenue impact due to billing concentration.
- Analysts estimate hospital medicine payment reductions of approximately 5–7% under the 2026 MPFS, depending on their mix of services.

Issue 3: The potential “game changer”—the Transparency in Coverage (TiC) regulations:

- **Mandate: Plans and issuers must publicly post distinct Machine-Readable Files (MRFs) on their websites on a monthly basis.**
- **In-Network Rate File: Discloses negotiated rates for all covered items and services with in-network providers.**
- **Out-of-Network Allowed Amount File: Discloses historical out-of-network allowed amounts and billed charges for covered items and services.**
- **Compliance Date: Enforcement for the in-network and out-of-network files began July 1, 2022.**

TiC regulations (cont.)

- **Data Granularity – Allowed amounts by Tax Identification Number (TIN) and CPT codes.**
- **Provider Identification: In-network rates must be identified by the National Provider Identifier (NPI) and Tax Identification Number (TIN) for every in-network & out of network (OON) clinician.**
- **Service Classification: All pricing data must be cross-referenced with Current Procedural Terminology (CPT) codes or other billing codes.**
- **Accessibility: Files must be publicly accessible without a password, account, or any personally identifiable information.**
- **26 CFR 54.9815-2715A3; 29 CFR 2590.715-2715A3; and 45 CFR 147.212**

Pro tip: Use the Transparency in Coverage (TiC) data instead of Medicare for contracting & the NSA: BCBSNC in network allowed amounts, CLT MSA.

Payor	CPT	50 th percentile	75 th percentile	90 th percentile	Max	vs. 2026 Medicare	So what?
BCBSNC	99284	\$232	\$261	\$261	\$264	\$118.23	Max is <2.3X of Medicare
BCBSNC	99285	\$346	\$390	\$390	\$390	\$171.35	Max is <2.3X of Medicare.

Greater CLT Metropolitan Statistical Area (MSA), TiC data for CIGNA:

Payor	CPT	50 th percentile	75 th percentile	90 th percentile	Max	vs. 2026 Medicare	So what?
CIGNA	99284	\$247	\$290	\$352	\$352	\$118.23	Max is <3X of Medicare
CIGNA	99285	\$364	\$426	\$518	\$518	\$171.35	Max is ~3X of Medicare.

Greater CLT Metropolitan Statistical Area (MSA)

Payor	CPT	50 th percentile	75 th percentile	90 th percentile	Max	vs. 2026 Medicare	So what?
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Issue 4--Doc vs. Bot”: In addition to Aetna, non-profit Kaiser Permanente settled an MA “upcoding” fraud case for over \$550M in the past few months.



Ron Howrigan • 1st
Owner, Fulcrum Strategies
3d •



I have been working in Health Care for almost 40 years. Even now the payers still surprise me. Aetna just settled with the Federal Government for \$117M. They settled because they got caught upcoming in order to increase their Medicare Reimbursement.

What makes this surprising is that Aetna is the same company that is unilaterally down coding doctors without a chart audit so they can reduce expenses. They are doing this down coding on Medicare claims as well as commercial claims.

That's right, Aetna is up coding Medicare to increase revenue while also down coding doctors to reduce expenses. If nothing else you have to give them credit for creativity and the moral flexibility that it takes to over charge tax payers while at the same time under paying doctors.

<https://lnkd.in/e5V7wVpt>



Aetna Agrees to Pay \$117.7 Million to Resolve False Claims Act Allegations
justice.gov

- **Ron perfectly captures the irony of Aetna’s MA upcoding fraud settlement while they unilaterally downcode physicians.**
- **He gives Aetna credit for “creativity” & “moral flexibility” to defraud taxpayers while underpaying doctors.**

Health plans have significantly “upped the pressure on hospital-based groups on denials, downcoding prepayment reviews (PPRs) & generative AI based audits.

- **Algorithmic Denial Stack – Overview: Automated payer tools influencing EM reimbursement:**
 - **Claim Editing Engines: ClaimsXten, Cotiviti**
 - **ED Facility Re-Leveling: Optum EDC Analyzer**
 - **Automated Denials: Cigna PXDX, MA AI tools**
 - **Repricing Engines: MultiPlan/Claritiv for OON/NSA**

- **“BUCA” (BCBS, UHC, Cigna & Aetna) have weaponized the No Surprises Act (NSA) over the past several yrs.**
- **Anthem BCBS systemic PPRs—lawsuits resulting.**
- **Cigna terminating long standing health plan agreements.**
- **UHC—systemic PPRs, delays & denials.**
- **WSJ 2/21/25: Major DOJ & OIG investigation of UHC re: MA Plans.**

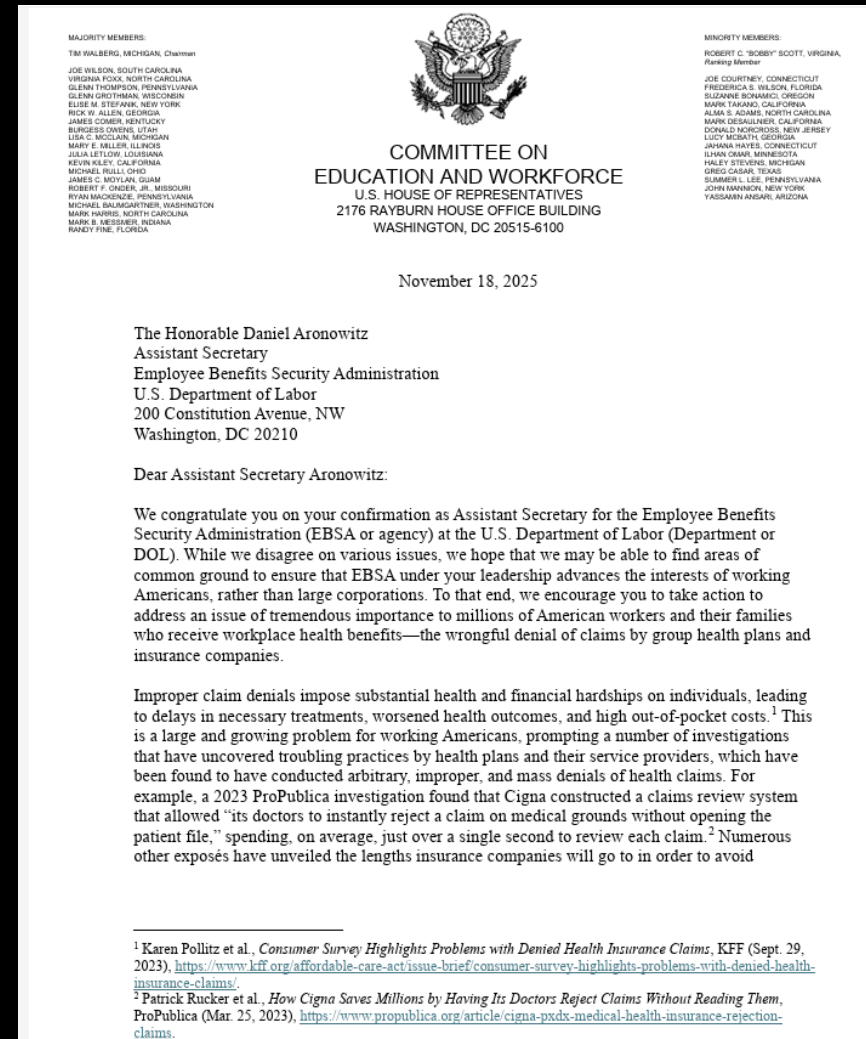
Sources and methods: Cigna, Aetna, Cotivity & Optum (UHC)

- ProPublica published 2X articles on Cigna's "procedure to diagnosis" (PXDX) software in '23 & '24-- <https://www.propublica.org/article/cigna-pxdx-medical-health-insurance-rejection-claims>
- PXDX ("procedure-to-diagnosis") uses rules to auto-review claims.
- ProPublica: ~300,000 claims denied in two months; denials processed in ~1.2 seconds.
- Workflow: medical directors rapidly click through batches of claims, citing pressure for rapid throughput and minimal review.
- Internal documents cite 'billions saved' through reduced claim payments.
- Cigna's PXDX is the subject of an approved class action in CA.
 - <https://benefitslink.com/src/ctop/kisting-leung-v-cigna-edcalif-03312025.pdf>

The ProPublica Investigative Article was cited in a recent group of House Democrats on the Education & Workforce Committee.

➤ “Improper claim denials impose substantial health and financial hardships on individuals....[and is] a large and growing problem...”

➤ Calls for mandatory data collection & reporting on health denials.



Aetna: it does not cite to use of a vendor software.

- **Website on “Disputes and Appeals Process” seems to emphasize peer-to-peer review. https://www.aetna.com/health-care-professionals/disputes-appeals/disputes-appeals-overview.html?utm_source=chatgpt.com**
- **Dr. Elizabeth Potter’s many posts on X regarding the UHC peer-to-peer process suggests that true “peer review” is not legit. (see appendix)**
- **Aetna’s “Evaluation & Management (E&M) Program — Claim and Code Review” document explains that the program reviews levels 4 and 5 E/M codes (for new and established patients across settings including ER/outpatient) to assess whether the service billed matches the intensity of service, severity of illness, history/physical/MDM/time components.**
- **Uses internal algorithms and structured workflows for rapid claims triage and denial.**

Overview of Cotiviti:

- **Cotiviti: Payment-integrity platform for prepay edits, DRG validation & coding audits, & sold to health plans.**
- **Both Aetna & Cotivity represent a shift toward analytics-driven claim automation.**
- **Cotiviti tools: claim pattern reviews, coordination of benefits, & retrospective chart audits.**
- **Clinician impacts: increased documentation scrutiny, higher prepay edit rates, & short appeal deadlines.**
- **Examples: Medical record requests & prepay downcoding triggers.**

Optum/UHC: Optum is a separate division and may sell its software into the health plan space generally.

- **The Optum Emergency Department Claim (EDC) Analyzer™ is an automated tool used by plans (UHC, Medicaid/Medicare Advantage, exchange plans, etc.) to “right-size” outpatient ED facility E/M codes (99281–99285).**
- **Optum for Business #1 Goal: “fair and consistent E/M coding and reimbursement of facility outpatient ED claims” by tying the billed level to resource intensity as defined by CMS guidelines.**
- ***Applies to pro fee ED E&M as well, despite that the “facility coding standards” are apples to oranges to the pro fee stds.***
- **Optum emphasizes Level IV and V “outliers”.**

State Legislative Action on AI Insurance Denials.

State	Status	Key Features	Effective Date
Texas	Enacted	SB 815 (2025) bans use of an “automated decision system” to make or assist in any part of an adverse determination in utilization review (UR).	Effective 9/1/2025; applies to plans delivered/ renewed on or after 1/1/2026
California	Enacted	SB 1120 requires that denials/modifications based on medical necessity be made by a licensed physician or qualified health professional and sets guardrails when AI/algorithms are used in UR/Utilization Management (UM).	1/1/26
Maryland	Enacted	HB 820 (2025), Ch. 747, requires carriers/PBMs/private review agents to ensure any AI/algorithmic tools used in UR meet specific safeguards and do not replace a clinician’s role.	Effective 10/1/2025

Issue 5: The No Surprises Act (NSA): Why should you care?

➤ RAND Report, “Strategies for Sustaining Emergency Care in the US” (April 2025): https://www.rand.org/pubs/research_reports/RRA2937-1.html (study included >50M pro fee claims).

➤ Figure 4.5 shows that OON commercial reimbursement declined 47.7% in 5 years pre & post the NSA (effective 1/1/22)

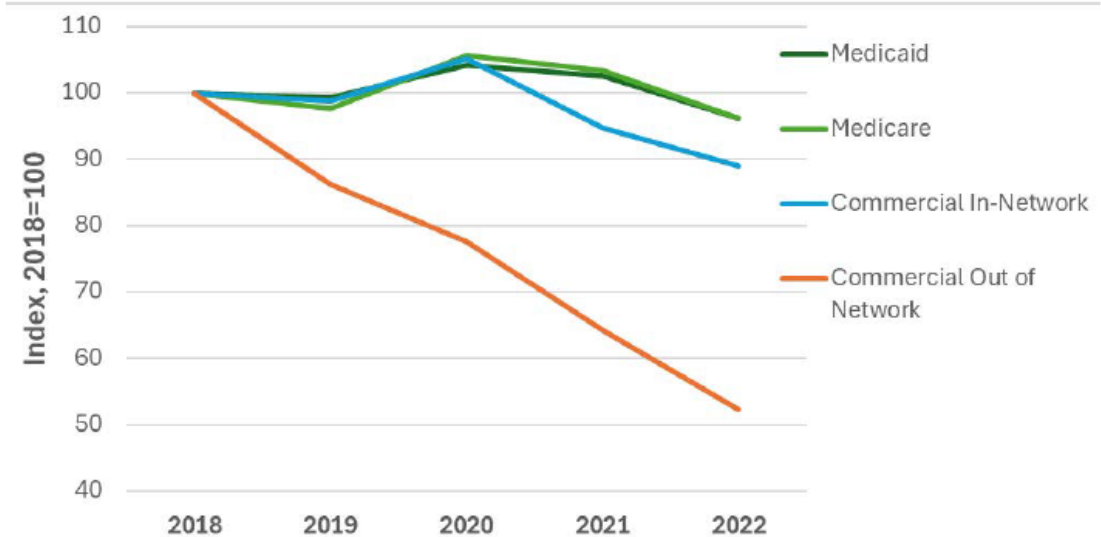
➤ Commercial in network (INN) declined nearly -11% for the same period.

➤ 20% of expected reimbursement from health plans + Pts were unpaid, ~\$5.9B per year.

Financial Implications for ED Professionals, Including Physicians

Figures 4.1 and 4.2–4.4 illustrate two separate challenges facing ED physicians: Average inflation-adjusted allowed amounts are falling (Figure 4.1 and the tables in Appendix F illustrate this trend for the commercially insured populations), and not all of those amounts actually get paid (Figure 4.2). Figure 4.5 illustrates both of these challenges, plus inflation, in a single chart, capturing the reductions in payment caused by inflation, nonpayment or partial payment, and reductions in average allowed amounts across both public and private payers.

Figure 4.5. Index of Inflation-Adjusted Dollars Paid to ED Professionals per Visit, 2018–2022



To this day, Congress is not happy with the way in which either administration has implemented the NSA.

Key words are “bipartisan concern”, “bungled implementation + “bureaucratic nightmare” & “medical providers waiting months to be reimbursed by insurance companies”.

<https://gop-waysandmeans.house.gov/gao-report-biden-administrations-bungled-implementation-of-no-surprises-act-surprises-providers-with-a-bureaucratic-nightmare/>

NSA patient protections--since NC as no state law the NSA is the law for all NC claims.

ED & Facility Services Covered:

- OON ED services cannot be balance billed.
- Applies to ED, FSEDs, ASCs, hospital-owned outpatient settings.



Payment Structure:

- Patient cost-share = in-network levels
 - Based on QPA (initial payment)
- Patient removed entirely from dispute



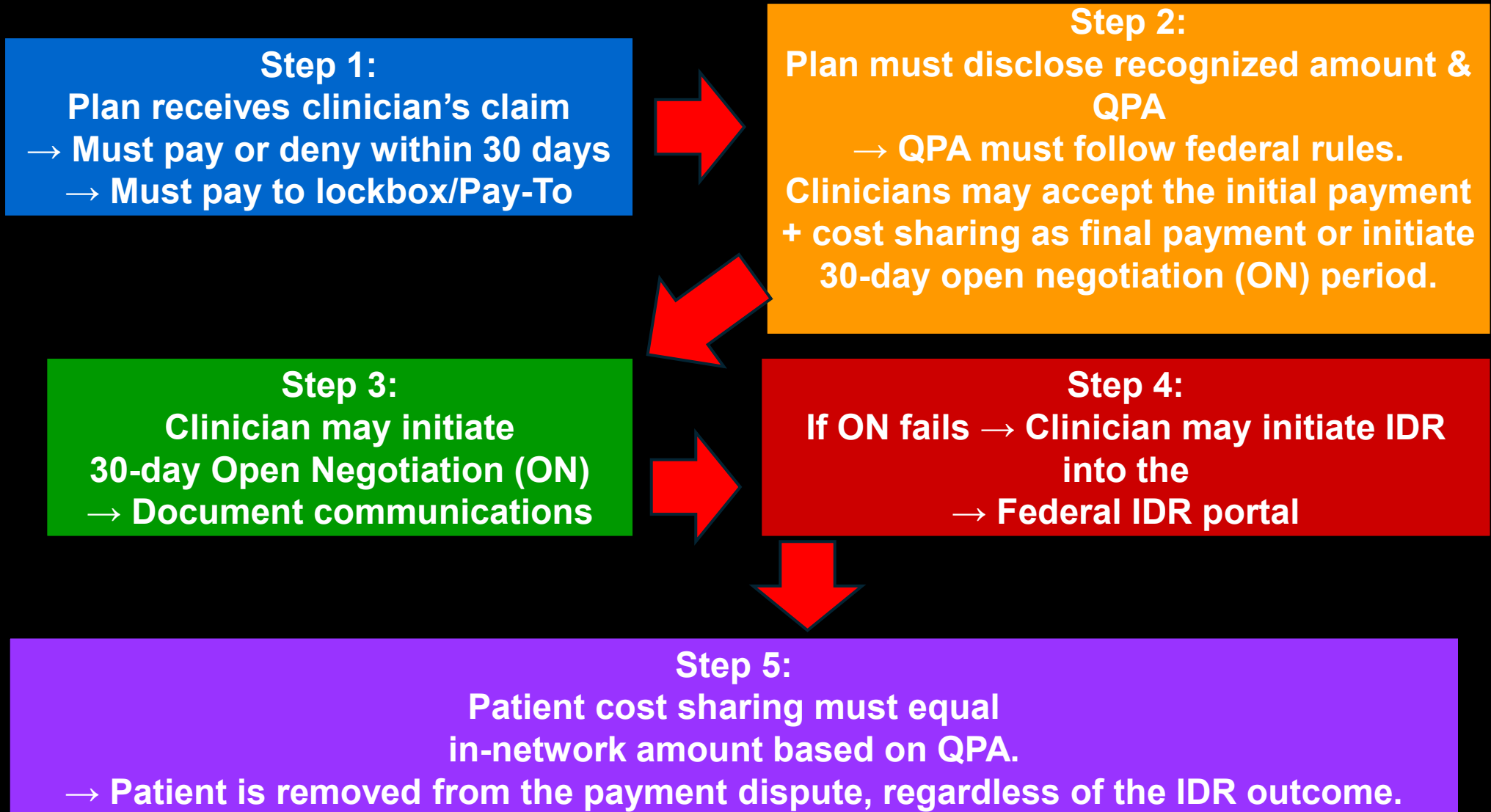
Outcome:

Patients pay only in-network amounts
No balance billing
Dispute is provider ↔ plan only

Hospital-Based Specialties Covered:
radiology, anesthesia, pathology, neonatology, intensivists, hospitalists, asst. surgeons where the hospital is in network.

Example:
CPT 99285 → Charge \$1200, QPA \$600
Patient cost share \$100, remaining \$500 written off.

Health plan obligations under the NSA (assuming NSA IDR is applicable):



Health plans argue that the initial payment (QPA) should “anchor” the decision on final payment & that is wrong on several counts.

- ndp analytics compared the Q4 2024 QPAs reported in CMS’ Public Use Files (PUFs) to median in-network rates disclosed under the Transparency in Coverage (TiC) data.
- This research found that 60% of QPAs were below the actual corresponding median in-network rates.
- On average, the median in-network rate in the TiC data, which reflects the actual contracts in effect for a given insurer, was nearly 300% higher than the reported QPA.

The screenshot shows the Radiology Business website. At the top, the logo for InnovateHealthcare is visible, followed by the title "RADIOLOGY BUSINESS" and the tagline "FOR IMAGING LEADERS IMPROVING ECONOMICS, OPERATIONS & OUTCOMES". A navigation bar includes links for MANAGEMENT, IMAGING, TECHNOLOGY, VIDEOS, CONFERENCES, CUSTOM CONTENT, SUBSCRIBE, and FORTY UNDER 40 AWARD. Social media icons for Twitter, Facebook, LinkedIn, and YouTube are also present.

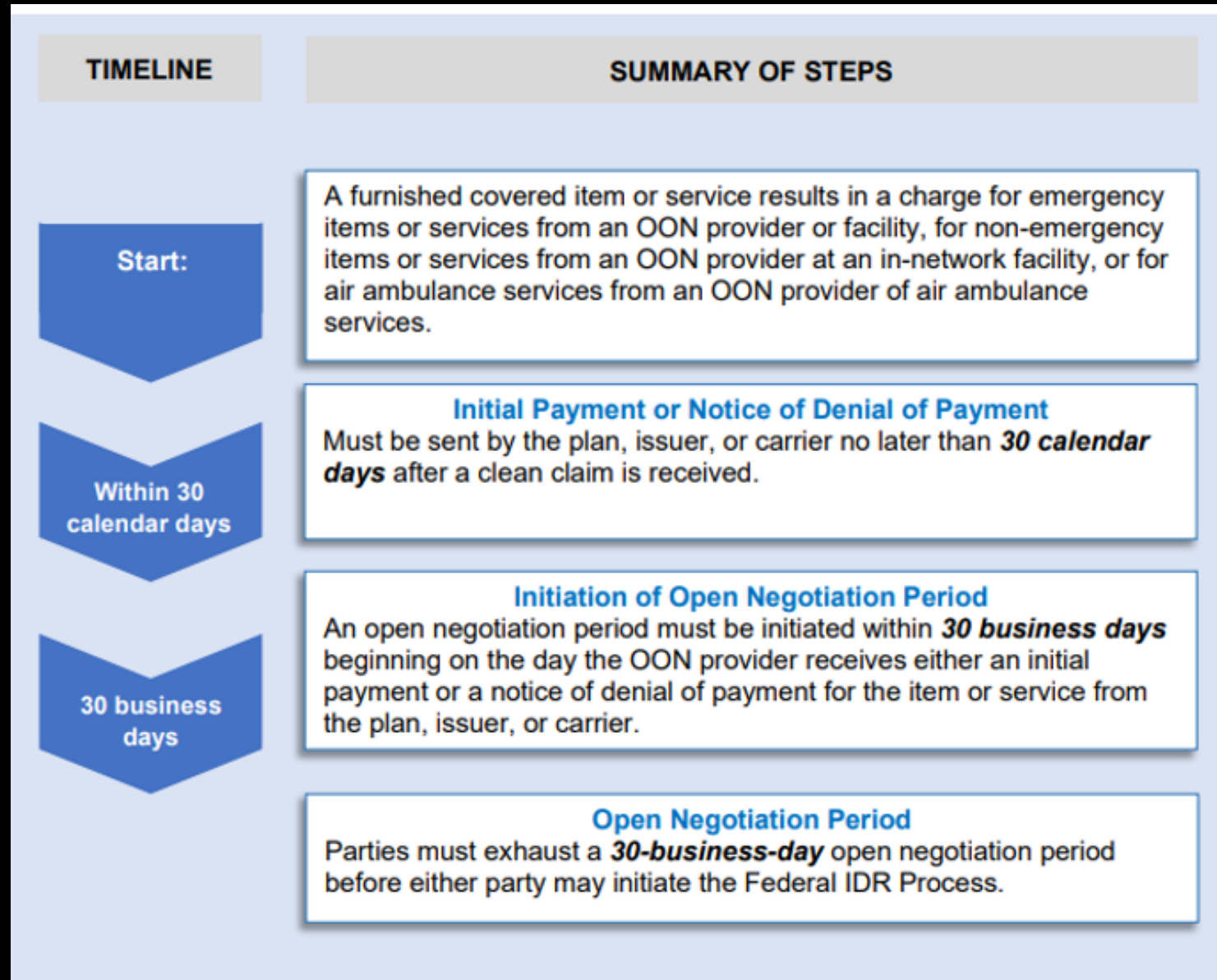
The main content area features a webinar announcement: "RADIOLOGY BUSINESS WEBINAR w/ LIVE Q&A" with the headline "Your Front Office Is Drowning. AI Can Help. Here's What We've Learned So Far." The event is scheduled for Tuesday, April 7th at 1pm ET. A "Register Now" button is provided. The webinar is in cooperation with AbbaDox, and the speakers are Tim Malley, CTO of Capitol Imaging, and Isaac Aronov, CTO of AbbaDox.

Below the webinar announcement is a news article titled "Insurers fudging payment estimates for radiology services under No Surprises Act" by Marty Stempniak, dated December 23, 2025. The article is categorized under "Policy & Regulations" and includes social media sharing icons. The article text states: "New research claims commercial insurers are fudging payment estimates for radiology and other services under the No Surprises Act. The landmark law first took effect in 2022, establishing a process for physicians and insurers to settle disputes over out-of-network care. A key point for starting negotiations is the 'qualifying payment amount,' essentially the median contracted rate for similar such services in a geographic area. However, a new analysis claims the 'benchmark' QPA payers calculate often 'dramatically' understates the actual median in-network rates insurers are paying for in-network care."

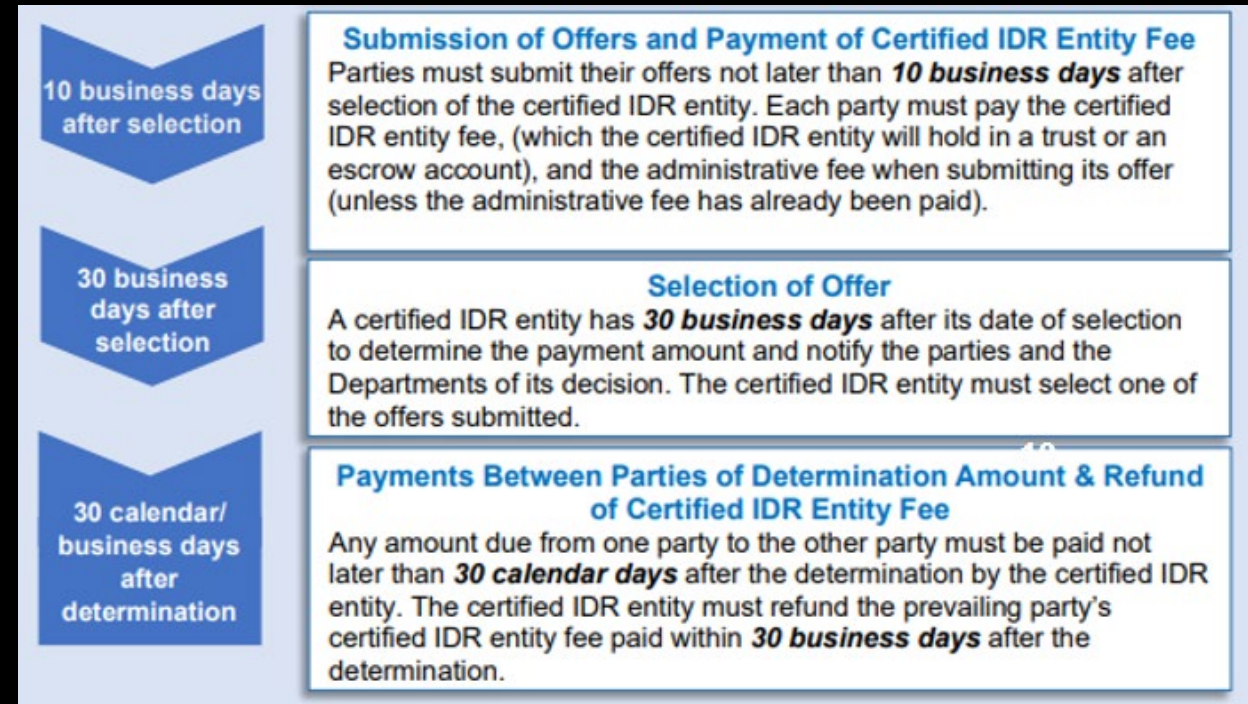
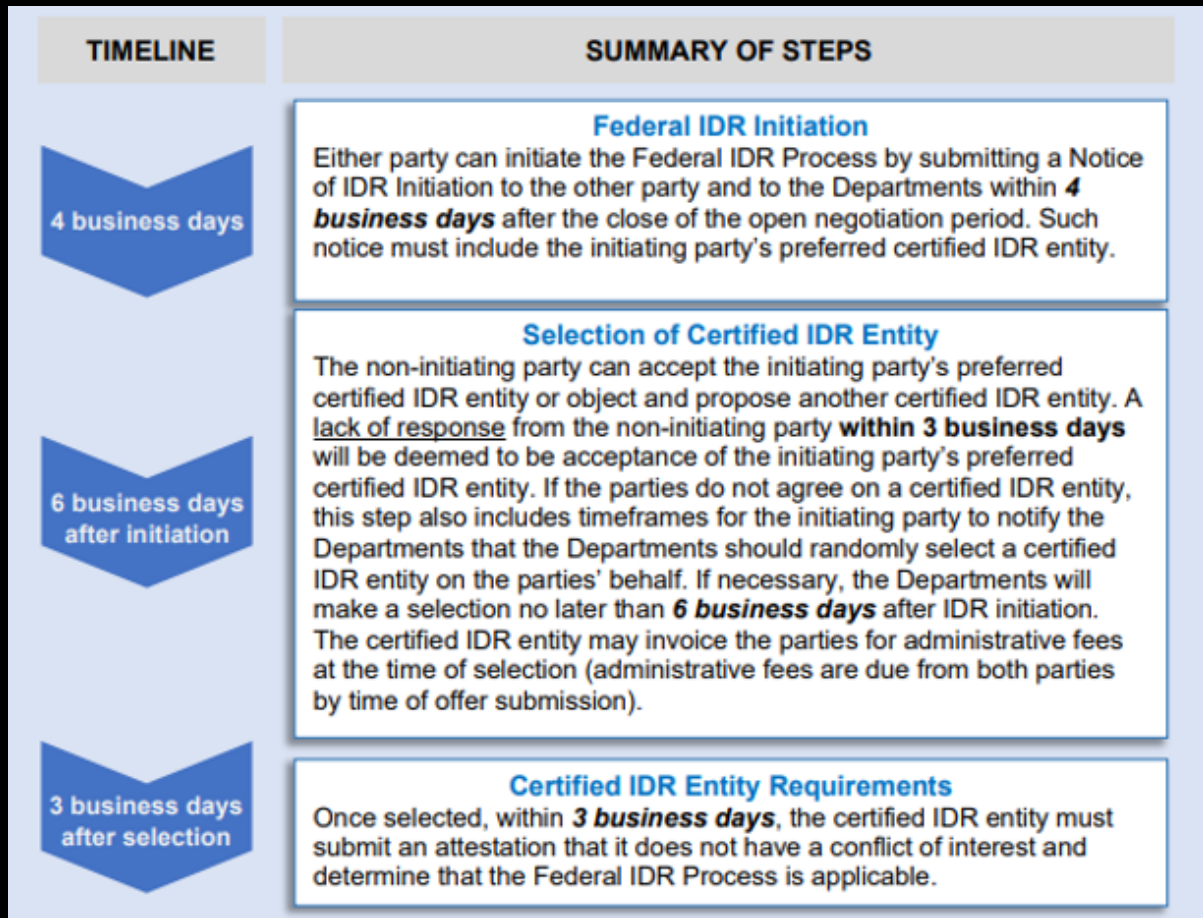
To the right of the article is a section titled "Around the web" with a sub-heading "CARDIOVASCULAR BUSINESS". It features a link to "AI-powered CCTA assessments show 'close agreement' with IVUS" and a brief description: "Advanced AI software developed by Cleerly consistently produced plaque assessments comparable to intravascular ultrasound."

<https://radiologybusiness.com/topics/healthcare-management/healthcare-policy/insurers-fudging-payment-estimates-radiology-services-under-no-surprises-act>

Key steps in the NSA IDR process: CMS



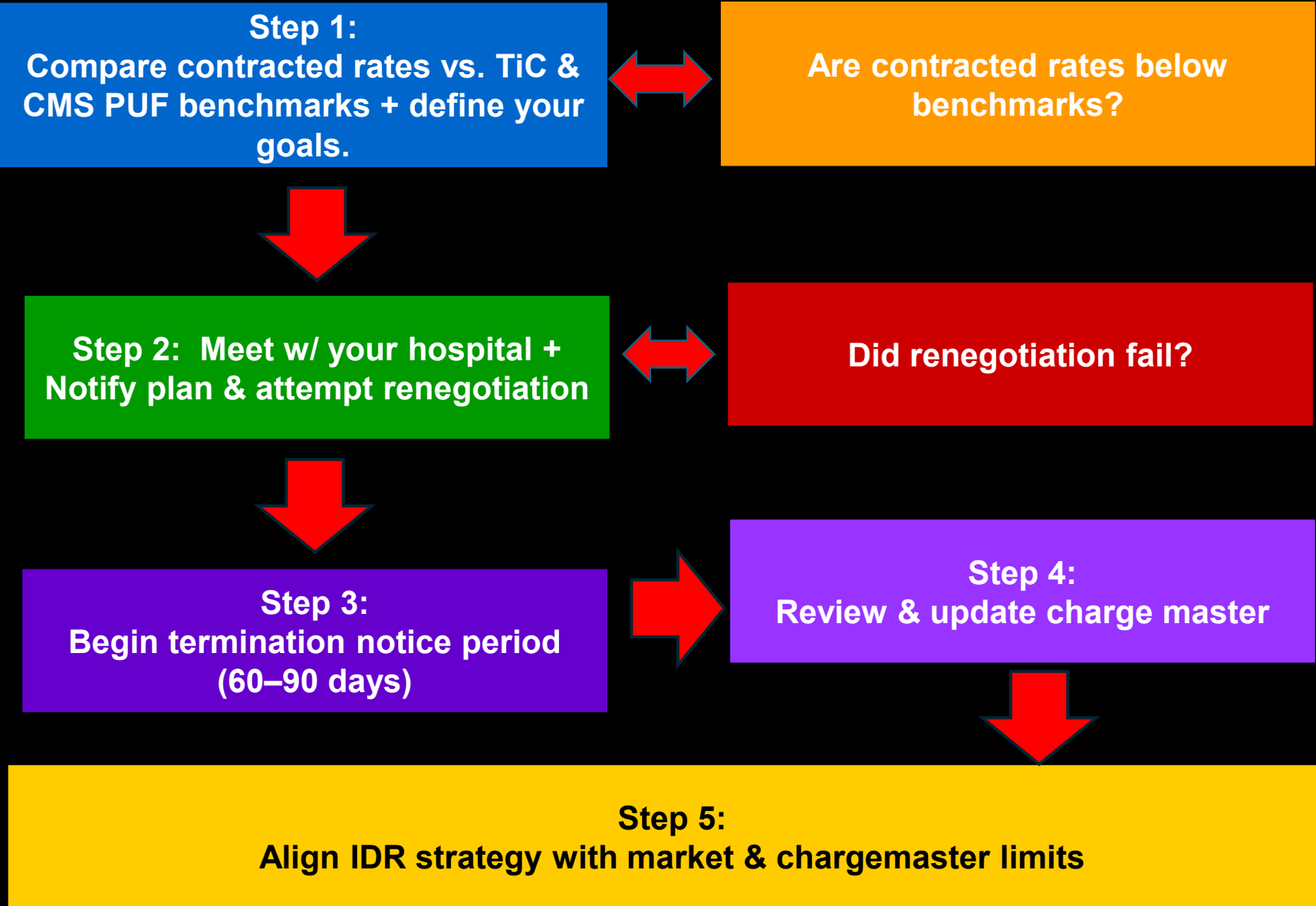
Key steps in the NSA IDR process: CMS



Macro Summary Metrics (Emergency & Non-Emergency): Q1 & Q2 '25 CMS Public Use Files (PUF).

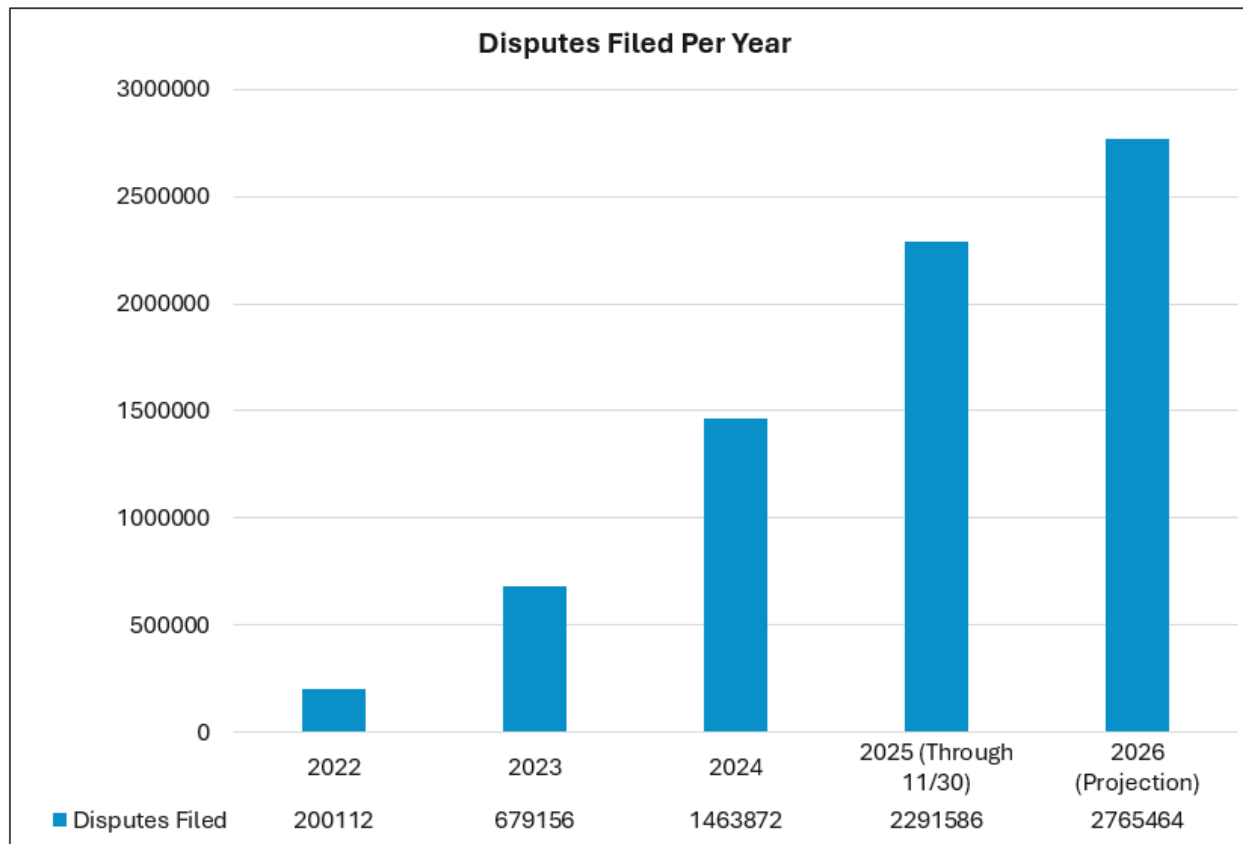
- **Clinician and hospital Win Rate: 88% (up over 300 bps from '24).**
- **40% increase year over year (YOY) in IDRs filed.**
- **1.1M payment determinations in Q1 and Q2 of 2025, 48% increase YOY.**
- **Ineligible disputes declined 300 basis points (BPs) to 17%.**
- **UHC is ~30% of the IDR volume.**
- **For Q1 '25, emergency medicine (the most prolific specialty filing IDRs) received on average 314% of the QPA, and 312% of the QPA in Q2.**
- **For radiology, Q1 results were 469% of the QPA and 512% of the QPA in Q2.**
- **For anesthesia, Q1 saw 309% of the QPA and 312% of the QPA in Q2.**

Part 4: What are the key initial steps in the process to Determining if an ED group should go OON & into the NSA IDR and/or state OON Process?



New data from Federal Hearings & Appeals Services (FHAS): —90% of the claims are eligible for IDR.

IDRE Market: Growing IDR Utilization



Disputes Filed	
2022	200,112
2023	679,156
2024	1,463,872
2025 (Thru 11/30)	2,291,586
2026 Proj.	2,750,000

Keys to winning in IDR: The importance of the actual text of the NSA statute—it says the IDRE “shall consider” such factors.

NSA text does not support ranking 1 factor over another factor and each “shall be” considered (objective or quantitative factors) are in red:

- 1. QPA**
- 2. Clinician’s training and experience**
- 3. Teaching status of the facility**
- 4. Quality & outcome measurements**
- 5. Acuity and complexity of care**
- 6. Contract (K) rates for prior 4 yrs**
- 7. Good faith or lack thereof of plan or clinician to contract**
- 8. Market share by clinician or plan in a geographic area**
- 9. Any other factor that may be deemed relevant.**



RAND--Payment Declines Across Payers:

**Commercial Physician OON
Payments**

↓ -47.7% (2018–2022)

**Commercial In-Network
Physician Payments**

↓ -10.9%



Key Insight:

OON payments declined ~5× faster than INN payments.

**Professional Payments:
Significant downward pressure
Major OON deterioration**

**Reflects payer pressure; highlights importance of IDR
protections: tip—attach the RAND Report to your best and
final offer.**

Why are the health plans so “dern” upset about the NSA? Hypothetical examples.

Medicare (MCA) 2026	Assume the QPA/initial payment is 125% of MCA.	Q1 & Q2 2025 PUF Results for EM.	CIGNA's TiC Data	BCBSNC TiC Data
CPT 99284=\$118	\$148	313% of the QPA=\$<u>463</u>	\$352	\$264
CPT 99285=\$171	\$214	313% of the QPA=\$<u>670</u>	\$518	\$390

Health plans are punching back—excerpts from key messages in the Media

No Surprises Act Arbitration Drags Patients Into Billing Disputes

Modern Healthcare | Alex Kacik, Nona Tepper

February 23, 2026

Infographic: 3 Takeaways From GAO Data On The No Surprises Act

Health Leaders Media | Luke Gale

March 11, 2026

Changes Possible For The “No Surprises” IDR Payment Dispute Process

MedCentral | Kerry Dooley Young

February 20, 2026

Legislature Rejects Hochul's Surprise Billing Reforms, Siding With Doctors And Hospitals

Crains New York | Amanda D'Ambrosio

March 12, 2026

Elevance To Expand 10% Out-Of-Network Penalty Policy Into California

Becker's Hospital Review | Jakob Emerson

March 10, 2026

As Arbitration Drive Up Healthcare Costs, Diverse Stakeholders Call for Stronger Federal Oversight

Shaping benefit policies before they shape you.

February 24, 2026

How Insurers Are Using The Courts To Rewrite The No Surprises Act

Health Care Un-Covered | Wendell Potter

March 11, 2026



ASPE
ASSISTANT SECRETARY FOR
PLANNING AND EVALUATION

OFFICE OF
HEALTH POLICY

REPORT

House Ways & Means Committee NSA oversight Hearing 9/19/23.

- **Clinician witnesses:** Dr. Seth Bleier, VP, Wake Emergency Physicians PA + Mr. Jim Budzinski, EVP & CFO Wellstar Health in Sept. 2023.
- **Bleier:** 2 of WEPPAs “BUCA” payors cut existing par agreements -30% & -40% respectively after the NSA was passed.
- **Budzinski:**
 - Health plans cut hospital reimbursements - 20% & -50% post NSA.
 - Wellstar has >7K in IDR & have been paid in ~1/3 of the cases that they have won. \$40M in A/R tied up in IDRs.

ACEP Members @ACEPNow

Today, ACEP member Dr. Seth Bleier shared the EM physician experience with the flawed implementation of the No Surprises Act. He told Congress that flagrant insurer abuses of the process threaten EM physician practices, our patients & communities. #ACEP4U acep.org/home-page-redi...

HOLDING INSURERS ACCOUNTABLE

“If these challenges are not resolved, practice models like ours may not be viable in the near future, and access to lifesaving emergency care may be severely affected, especially for rural and underserved patients.”

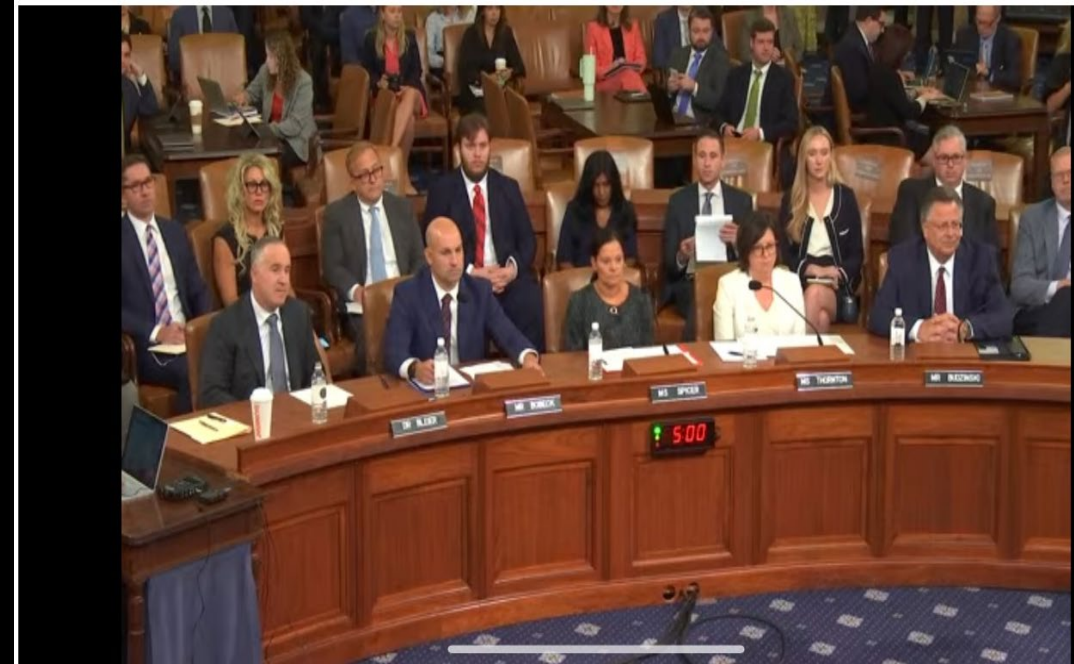
- SETH BLEIER, MD

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

EMERGENCY PHYSICIANS.ORG
#ACEPAdvocacy

House Ways & Means Committee Hearing Sept. 2023 on the implementation of the NSA by the Biden Administration:

- During the hearing, Rep. Panetta (D-CA) cited the EDPMA survey data July 2023 showing that health plans have not paid per the IDRE determination in 87% of over 300K IDRs filed by members.
- Subsequent EDPMA 2025 survey showed payment non-compliance rates of ~60% of hundreds of thousands of IDRE determinations.
- Rep. (and Dr.) Greg Murphy (R-NC) announced that he would address the health plan non-compliance issues w/ a new bill.
- The No Surprises Act Enforcement Act (HR 4710) w/ Rep. Murphy as the key sponsor but w/ bi-partisan co-sponsors from the committees of jurisdiction.



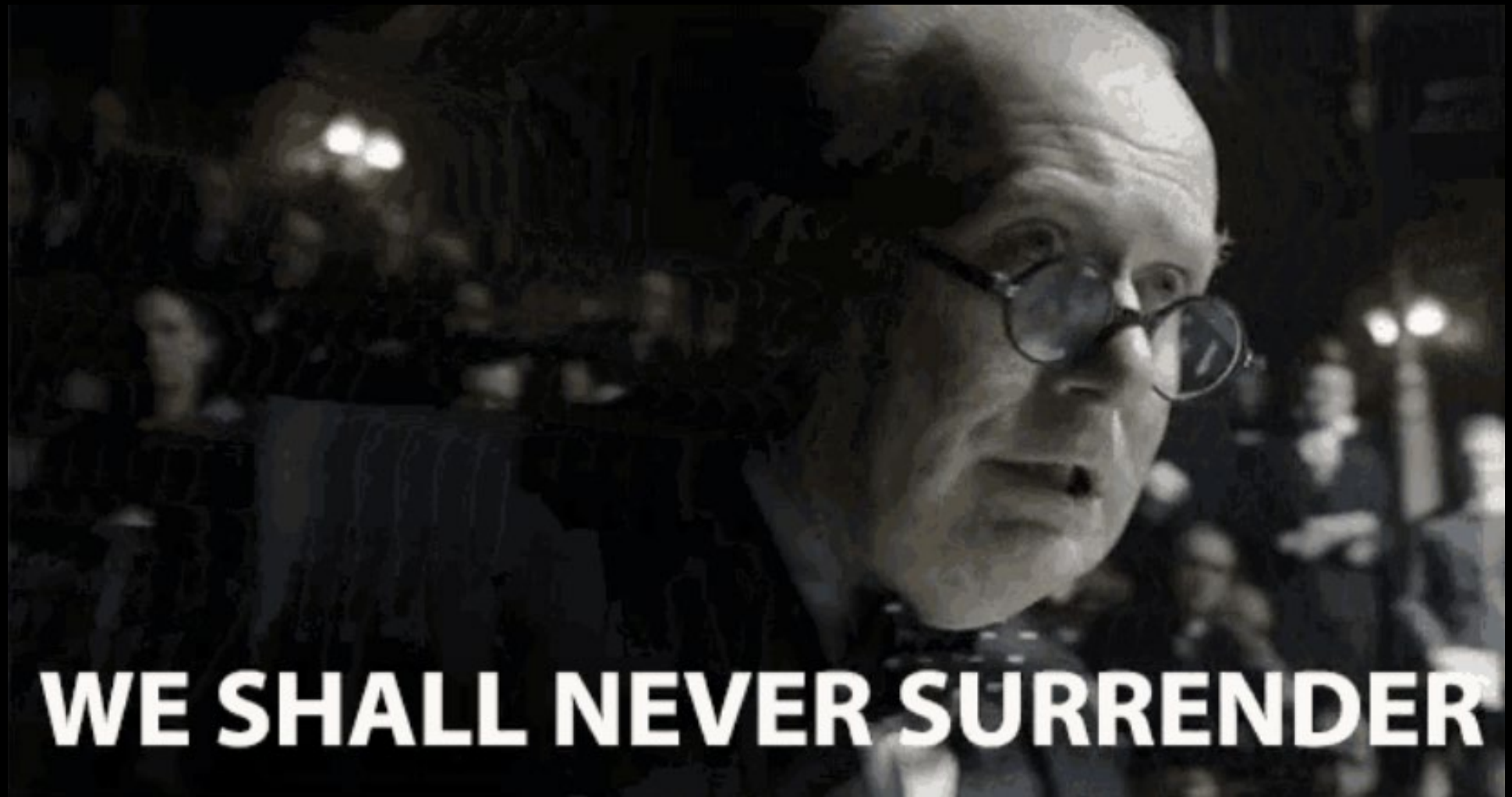
HR 4710: it is solving for health plan non-compliance.

➤ Bill does 3 things:

- Levels the playing field for CMS Civil Monetary Penalties (CMPs) to be assessed for payment non-compliance at up to \$10K per violation.**
- If the plans do not pay w/in 30 days of the IDRE determination, the clinicians receive “treble damages” + interest.**
- Congress requires the Depts. to issue regular reports on enforcement actions, including details on the # of complaints, enforcement actions, penalties issued and types of violations.**

Conclusions—Lightening Rounds...

1. **TiC data is a potential game changer: market rates & basis to argue in the IDR process.**
2. **Gov't payors will continue to be challenged, but Medicare reforms—site neutral payments + MA plan reforms could be a source of funds.**
3. **Advocacy is paying dividends but individual physicians must “get in the game”.**
4. **“Doc vs. Bot” is real & state law reforms may be one effective tool to address it.**
5. **The NSA is under attack from the health plans (see #3 above) & we have to keep fighting.**



Conclusions and contact information.

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Follow me: @EdGainesIII 

The No Surprises Act (NSA) basics + important acronyms & glossary (in the appendix):

- In-network
- Patient cost sharing
- State specified laws
- Individual & group health plans
- State employee & teacher plans
- ERISA
- ERISA plans
- “Baseball” Dispute Resolution
- Batched claim filing
- IDR administrative fees
- IDRE fees
- Out of network (OON).
- Surprise billing vs. surprise insurance gaps
- Benchmarking
- NSA
- IDR
- IDRE
- QPA
- Tri Depts. or The Depts.
- CMS & CCIIO
- Guarantor



Glossary & Acronyms

- **Out of network (OON)—EM services where there is no participation agreement between the physicians & health plan.**
- **Surprise billing vs. surprise insurance gaps—surprise billing was created by health plans as a way to capture the legislators & regulator’s attention to billing Pts for OON services vs. surprise insurance gaps are the concept that most patients are in high deductible health plans (HDHPs) & do not realize that they are first dollar responsible for many services until they reach their deductible.**
- **Benchmarking—health plans attempted for years to set OON reimbursements to a “benchmark”, usually Medicare, as a way to cap their expense. The CBO found that benchmarking would also significantly decrease in-network rates.**
- **NSA—The No Surprises Act (not the other NSA—ha ha).**
- **FHAS—Federal Hearings and Appeal Services.**
- **IDR—Independent Dispute Resolution is the process by which physicians & hospitals resolve OON reimbursement issues with health plans in a resolution process that is “loser pays” & “baseball style” where the physicians or health plans best and final offer is accepted.**

Glossary & Acronyms

- **IDRE**—the independent dispute resolution entity is the 3d party organization charged with managing the IDR dispute & ultimately deciding between the physicians or health plans best & final offer.
- **IP**—initiating party, 80+% it is a hospital or physician group.
- **NIP**—non-initiating party, usually the health plan.
- **QPA**—qualifying payment amount defined in statute & regulation as the median allowed amount as of 1/31/19 adjusted annually for inflation; used to determine Pt cost sharing & as a factor in IDR.
- **Tri Depts.**—HHS and the Depts. of Labor and Treasury.
- **Batched claim filing** refers to filing an IDR dispute w/ for example 30-days of “batched CPT claims” gathered together and filed as one dispute w/ same health plan.
- **CMS & CCIIO**—Centers for Medicare & Medicaid Services, The Center for Consumer Information and Insurance Oversight—both have practical implementation of the Tri Depts. regulations.
- **Guarantor**—The party financially responsible for the services, e.g. an adult patient is also the guarantor but a minor patient has a parent or guardian who is their guarantor.

Glossary & Acronyms

- **In-network**—services that are provided where the patient's health plan & the physicians/hospital are under contract w/ the plan.
- **Patient cost sharing:** the patient's deductible & co-insurance. Under the NSA, the OON services cost sharing is calculated to be what the Pt would have paid in network.
- **State specified laws**—the 22 states that have a state OON law that must be applied to ACA individual & group health plans + state employees and teachers.
- **Individual & group health plans**—governed by the 22 states who have specified laws; for the other states, governed by the NSA.
- **State employee & teacher plans**—same as above.

Glossary & Acronyms

- **ERISA & ERISA plans**—Employee Retirement Income Security Act largely governs medium & large employer self insured plans. These plans use health plans to do third party administration of claims but are largely regulated by federal and not state law.
- **“Baseball” Dispute Resolution**—the term refers to the concept that the IDRE must select either the physician’s or health plan’s best and final offer, and then the loser pays the IDRE fees.
- **IDR administrative fees**—the non-refundable administrative fees set by CMS at \$50 in 2022 & increased to \$115 in '23
- **IDRE fees**—the adjudication fees set by CMS and paid to the IDRE by the losing party to the IDR. The IDRE fees are currently set at \$115 by each party, paid to CMS and are non-refundable.

No Surprises Act

2024 Independent Dispute
Resolution Data

August 2024

The **Emergency Department Practice Management Association (EDPMA)** is the trade association for emergency medicine focused on the sustainable delivery of high-quality, cost-effective patient care in emergency departments. Our members see or support approximately 60% of all emergency department patient care in the US.

The Study

In August 2024 EDPMA captured data from a member survey related to the Independent Dispute Resolution (IDR) process of the No Surprises Act (NSA). The survey period included January 1 through June 30, 2024. EDPMA has previously published extensive data from 2022 and 2023. This is the first survey with 2024 data; it focuses specifically on member experiences related to the IDR process.

Patient Protections and Access to Care

EDPMA fully supports the No Surprises Act (NSA) as enacted by Congress, including the goal of protecting patients from unanticipated out-of-network medical expenses. However, regulations have substantially altered the NSA's intended impact, forcing providers to utilize the expensive and cumbersome IDR process far more than anticipated. Further, health plans are frequently noncompliant with both the law and its regulations. These realities threaten the sustainability of physician groups providing emergency care. If left unaddressed, this presents a significant risk for the nation's emergency healthcare system.

The Findings

EDPMA member respondents answered five (5) survey questions in this focused survey, which addressed key IDR outcomes for the first 6 months of 2024. Here are the outcomes and findings as compiled from survey participants:

1. IDR Disputes Won

Total IDR disputes won by ED physician practices from January 1—June 30, 2024:

43,058

2. Non-payment

Of the total disputes won, how many were NOT paid with 30 days of the IDRE determination as required by No Surprises Act itself?

69.2% (29,816 were not paid within 30 days)

Note:

This is a significant deterioration since the "Deep Dive Survey of 2023" which reported only 24% of awards were not paid within 30 days

EDPMA survey data key points:

- **Over 43K disputes won in Q1 & Q2 '24 by members who participated in survey.**
- **Over 69% were not paid w/in 30 days as required by law.**
- **8.3% were paid incorrectly.**
- **2.5% of the cases the health plans changed/increased the Pt cost sharing after the plan lost the IDRE determination.**

Protecting Emergency Care: The ACCESS

Act: Why Congress Must Fix the 2026 Medicare Physician Fee Schedule Practice Expense Cuts:

The Problem:

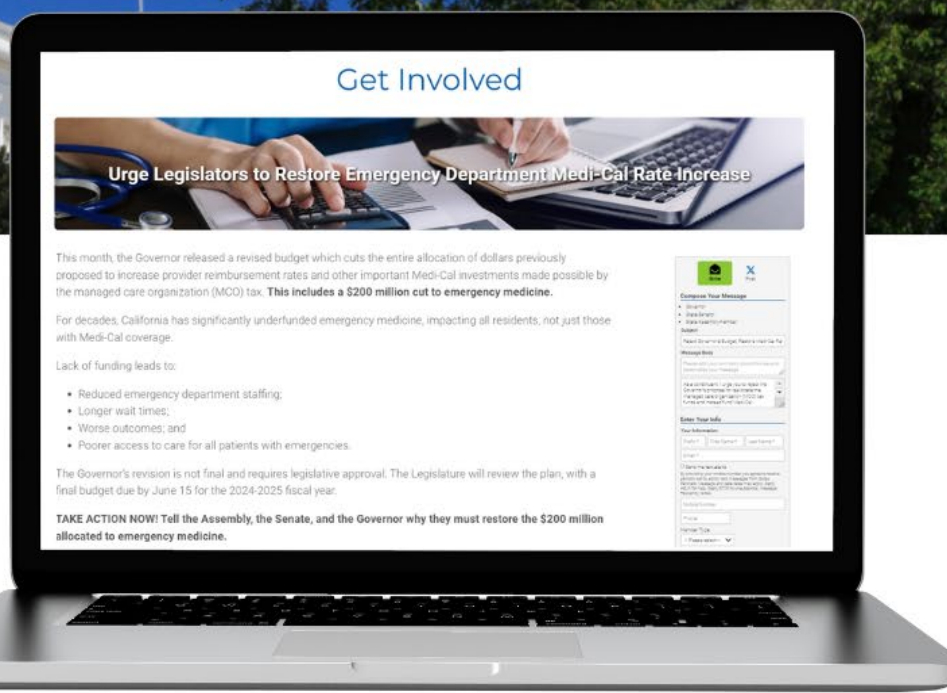
- **CMS reduced indirect practice expense RVUs for physicians practicing in hospital settings.**
- **Policy assumes hospitals bear physician practice expenses.**
- **Approximately 75% of emergency physician groups are independent.**
- **Independent groups must pay for recruiting, IT, billing, compliance, and training.**
- **Impact on EM Care: Emergency physicians must treat all patients under EMTALA regardless of ability to pay.**
 - ❑ **Emergency departments face high levels of uncompensated care.**
 - ❑ **Cuts threaten access to emergency care across the U.S.**

The ACCESS Act: A Targeted Legislative Fix

The ACCESS Act would exclude certain evaluation and management services from the 2026 MPFS practice expense reductions.

- ✓ Emergency department evaluation and management services**
- ✓ Hospital inpatient or observation E/M services**
- ✓ Critical care services**
- ✓ Nursing facility E/M services**
- ✓ Other E/M services determined appropriate by HHS**

- ✓ Goal: Protect access to essential emergency and safety-net care while preserving CMS policy objectives.**



Advocacy

Every day, legislation is introduced at the local, state, and federal levels that can directly impact how you get paid, and healthcare businesses at large. With the Zotec Political Action Committee (ZPAC), we've given clinicians intuitive tools they can use to make a difference in their local businesses and on state and federal levels.

Text ZOTEC to 50457 to become an Advocate.



Here's how it works:

Our internal committee consistently tracks legislation that impacts the business of healthcare.



We communicate the status of each piece of legislation to our clients.



Clinicians can easily take action on legislation using our interactive ZPAC platform.

Take Action Today!



**Tell Representatives to Cosponsor
H.R. 879 & Reverse Medicare Cuts!**