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Heads up: New No Surprises rule may block some IDR claims

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A new final rule pertaining to the No Surprises Act (NSA) makes filing independent dispute resolution (IDR) requests easier for providers in some ways. But certain tweaks also make it easier for payers to thwart provider claims, so practices should take extra care to bullet-proof their claims ahead of time.

The NSA was passed as part of the Consolidated Appropriations Act of 2021 to address prices for health care services that patients found unexpectedly high due to facility or out-of-network billing that they had little or no reason to expect. The law ushered in a series of rules, and rewrites of those rules required by legal judgments, between 2021 and 2024 (PBN 7/19/21, 9/16/24).

IDRs are the process by which complaints are filed against payers by providers, who find themselves stiffed when the patients are exempted from paying fees inappropriately charged under the law. IDR entities hired by the federal government then judge the claims and make final decisions.

The new rule, published by HHS and several other federal agencies on June 6, made some changes to the process that seem to make filing easier for providers, including:

- A charge of filing a dispute from $115 to $15 per dispute.
- A requirement that payers use specific claim adjustment reason codes (CARC) and remittance advice remark codes (RARC), which explain the basis for payer decisions in payment determinations, when communicating about disputes, and electronic remittance advice (ERA) when communicating with entities not in their networks.
- Raising the number of IDRs that can be sent in a batch from 25 to 50 line items.
- A requirement that parties use the federal IDR portal to submit the open negotiation notice and open negotiation response notice that must be exchanged before the IDR entities can begin the adjudication process.

More rules, more attention?

Some of these changes give extra work to the payers. But they also require more information be put in front of the IDR entities, which can have pluses and minuses for providers.

Sirisha Bommireddipalli, CEO and founder of MedConverge LLC in Chicago, thinks both providers and payers will benefit from the CARC/RARC requirement.

“On one side, it lets a practice screen eligibility up front and stop wasting time and fees on filings which do not qualify,” Bommireddipalli says. “On the other, that same standardized coding gives payers a clear, documented basis to contest eligibility — and since the payer is the one generating the codes, the value of the transparency depends entirely on how accurately and honestly they apply them.”

But one expected result is that IDR entities will see more about the claims and their potential flaws before they start to examine their merits — and may kick more of them out early.

For example, the rule requires that complainants “provide a written open negotiation notice to the other party and to the Departments through the Federal IDR portal to initiate the open negotiation period.”

CMS suggests this “will improve communication and transparency between parties while enabling certified IDR entities to determine whether a dispute has completed the required open negotiation period” — a hint that they’ll lead to more disqualifications.

Similarly, under the rule, if submissions are batched incorrectly — that is, if they do not meet existing rules for how multiples may be submitted together (for example, that they be “related to the treatment of a similar condition”) — they no longer get an automatic do-over; they just get kicked out. Note: This will be effective 120 days after plans and issuers are required to register in the IDR registry, rather than the 90 business days in the proposed rule.

The rule says that while it made sense to allow resubmission of those spoiled batches in the early days of IDR, when there was some confusion over the process, “now both disputing parties and certified IDR entities are much better equipped to engage in the process, greatly limiting the need for this additional flexibility.”

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Christopher J. Kutner, a partner in the health services practice group at Rivkin Radler LLP in Uniondale, N.Y., hopes this will have a winnowing effect on claims. “In cases thus far filed through the IDR process, roughly 40% turn out to be ineligible,” he says. “So they shouldn’t have gone through the IDR process in the first place. There needs to be a better screening mechanism.”

Mikel Daniels, president and chief medical officer of the We Treat Feet podiatric practice in Maryland, thinks your claims may get closer examination than before.

“If your dispute is sloppily batched, borderline on eligibility, or thinly documented, you are much more likely to see it kicked back or dismissed at the IDR entity level,” Daniels says.

More aggressive payers?

Payers certainly hope this rule winds up reducing the number of negative findings against them, as they’ve been on the losing side of the overwhelming majority of these IDRs from the beginning.

According to a call for new research by the Congressional Budget Office on the effect of the No Surprises rules, though CMS originally expected about 22,000 disputes per year, “from 2022 to mid-2025, 3.4 million disputes were filed.” That led to providers “prevailing more than 80% of the time.”

James Gelfand, president and CEO of the ERISA Industry Committee (ERIC), wrote in a March op-ed in STAT News that the IDR process, “originally intended as a limited, last-resort mechanism,” had failed and now threatened to “bankrupt patients and employers” with high costs.

United HealthCare (UHC) put out a webinar in May suggesting that “private equity-backed groups” were “driving the majority of the volume” of IDRs, and that the payer would more aggressively challenge IDRs in future.

UHC said it was “creating an innovative AI-enabled model specific to the NSA that’s helping us understand why we’re winning and losing,” and would work with in-network providers on “efficiency payment models” that would reward those that “demonstrate elimination of the usage of out-of-network physicians.”

But UHC also said it was prepared to use more punitive approaches, such as “assessing terminations of select ambulatory surgery centers where surgeon behavior shows clear and repeated abuse of the NSA process.”

Presenters pointed to UHC’s previous “targeted litigation strategy against providers where we believe there are clear evidence of abuse of the NSA IDR process” and warned that “we are being pretty strategic about where we’re going to use litigation” in the future. Ominously, they added that UHC was “also assessing the feasibility of applying prior authorization to elective surgeries that are most frequently exploited in the NSA.”

Sweat the details

Bommireddipalli notes that the rule doesn’t touch the Qualified Payment Amount (QPA). QPAs are a sort of benchmark used by IDR entities to adjudicate payable amounts, and the way they’re used has been a bone of legal contention for CMS (PBN 3/27/23).

Kutner thinks the government should set firmer guidelines for the value of services at issue.

“Providers likely do not understand the nuances of what claims are eligible based on the coverage involved and will just file all of their claims and see what claims get adjudicated, and in some cases the awards are quite substantial,” Kutner says. “Providers may be faulted for the amounts being billed for services including complicated surgeries performed on an emergent basis, but they’re reacting to payers that offer them insulting low amounts.”

But however many claims you file, Bommireddipalli says, make sure each and every one is as clean as you can get it: “Treat the rule as a discipline test. If your documentation and deadlines are tight, it helps you. If they are not, it exposes you.”

Resources

- Personnel Management Office, the Internal Revenue Service, the Employee Benefits Security Administration, and HHS, “Federal Independent Dispute Resolution Operations,” final rule, June 6, 2026: www.federalregister.gov/documents/2026/06/04/2026-11140/federal-independent-dispute-resolution-operations
- CBO, “A Call for New Research on the No Surprises Act,” June 15, 2026: www.cbo.gov/publication/62491
- Op-ed, STAT news, “Congress must fix the No Surprises Act before it bankrupts patients and employers,” March 20, 2026: www.statnews.com/2026/03/20/no-surprises-act-independent-dispute-resolution-process
- UHC briefing webinar, “The Unintended Consequences of the No Surprises Act,” May 2026: https://cas-external.video.uhc.com/media/UHC+Briefing+The+Unintended+Consequences+of+the+No+Surprises+Act+NSA/1_uilph1r4

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