FEDERAL SURPRISE BILLING FINAL IDR OPERATIONS RULE – THE SIIA ANALYSIS

Helpful Changes, But Fundamental Problems Remain

By Anthony Murrello

Nearly five years after the Surprise Medical Billing Rules took effect, the Federal Independent Dispute Resolution (IDR) Process continues to create headaches and significant operational challenges. Rather than functioning as Congress intended, the Process has been exploited by bad actors, particularly private equity-backed provider groups and IDR dispute middlemen, who have fueled fraud, waste, and abuse within the system.

The result is a Process that is driving up healthcare costs for employers and consumers alike, while moving further away from the original purpose of protecting patients from surprise medical bills. SIIA and our coalition partners have consistently communicated these concerns to members of Congress and the Federal Departments, but fundamental reforms to the Process remain elusive.

Recent data indicates the magnitude of the problem. According to the non-partisan Congressional Budget Office (CBO), the volume of IDR disputes has far exceeded original projections, with arbitration awards often substantially higher than expected. The CBO also found that a relatively small number of organizations account for a disproportionate share of all disputes; for example, just five organizations generated nearly 60 percent of all IDR filings.

Recent reports have also shown IDR awards reaching three to nine times typical in-network reimbursement rates, with some specialties receiving awards many multiples higher than negotiated commercial rates. CMS data further indicates that providers received nearly $15 billion through the Federal IDR Process during 2025 alone, a nearly 275% increase over the previous year. This abusive behavior has transformed the IDR Process into a high-volume business model, and a profitable one for certain providers, including providers backed by private-equity groups.

As discussions surrounding broader structural reforms to the Surprise Billing Rules continue, the Federal Departments (i.e., the Departments of Health and Human Services, Labor, and Treasury) recently finalized regulations that should help improve the operation and administration of the Federal IDR Process. While these regulatory changes largely address procedural inefficiencies on the margins – rather than the underlying issues and perverse incentive structures that continue to drive excessive dispute filings and inflated arbitration awards (as discussed above) – these final regulations represent an important step toward making the IDR Process more transparent and administratively efficient.

WHAT DOES THE FINAL IDR OPERATIONS RULE DO?

The recently released final regulation includes several changes intended to streamline dispute resolution and reduce unnecessary administrative burdens. One of the more significant changes is the creation of standardized communication requirements between self-insured plans and insurance carriers (i.e., healthcare payers) and out-of-network medical providers. Here, payers must now include specified Claim Adjustment Reason Codes (CARCs) and standardized Remittance Advice Remark Codes (RARCs) when issuing remittance advice for applicable out-of-network claims.

This information (which explains why a claim was paid differently than it was billed (through the CARCs) and identifies any adjustment to the billed amounts (through the RARCs)) is intended to tell providers whether the claim is subject to the Federal Surprise Billing rules or not. As such, the Departments believe that this change will reduce the number of ineligible disputes submitted to the Federal IDR Portal.

On the heels of the release of the final rule, the Federal Departments subsequently issued implementing guidance enumerating the required RARCs, explaining when each code must be used, and providing technical instructions for both electronic and paper remittance advice. While plans may continue using the CARCs they deem most appropriate for claim adjustments, plans must include one of the required RARCs for applicable items and services. These requirements take effect August 3, 2026. This guidance (which can be found on CMS's website) also explains that if the failure to provide this required information prevents a medical provider from timely initiating the IDR process, the provider may request an extension to initiate a dispute.

Additional changes in the final rule include:

- Requiring both parties to initiate and manage the Open Negotiation Process through the Federal IDR Portal, creating a documented timeline, and reducing disputes over whether negotiations properly occurred. This also helps both payers and providers (and the Federal government) track the 30-business-day Open Negotiation timeline, instead of payers being surprised when a provider skips Open Negotiation and goes straight to Federal IDR.
- Expanding batching and bundling rules to allow certain related claims to be resolved within a single dispute while establishing reasonable limits on the number of line items included. The final rule also allows disputes to be bundled by a single CPT, DRG, or HCPCS code.
- Extending eligibility determination timelines to provide Certified IDR Entities (CIDREs) additional time to evaluate disputes and obtain necessary information from the parties. CIDREs must now determine whether a claim is eligible (or ineligible) for the Federal IDR Process within 5 business days of the CIDRE being selected to review the dispute.
- Reducing the administrative fee for initiating an IDR dispute from $115 to $15 per party. If the initiating party fails to pay the administrative fee within 2 business days of the selection of the CIDRE, the dispute will be closed, and neither party will be responsible for paying the administrative fee.
- Creating a new Federal IDR Registry requiring payers to register with the Departments and obtain a Federal IDR registration number, making it easier for providers to identify the appropriate payer contact when disputes arise. For self-insured plans that hire a TPA or other plan service provider to help the plan navigate the Federal IDR Process and/or submit offers on behalf of the plan, information for the TPA or service provider must be included in the registration to ensure that the provider knows what plans the TPA/service provider represents.

FEDERAL IDR GATEWAY

In addition to the operational and administrative changes to the Federal IDR Process set forth in the final rule, CMS is also moving forward with the implementation of the Federal IDR Gateway Platform, a centralized technology platform designed to improve the efficiency and administration of the IDR process. More specifically, the IDR Gateway Platform – which is effectively an upgrade of the existing Federal IDR Portal – is intended to modernize the existing IDR infrastructure by streamlining case submissions, improving communication between disputing parties, enhancing data collection, and reducing administrative burdens associated with managing disputes. The IDR Gateway Platform is expected to be introduced by late 2026.

LOOKING AHEAD

The final IDR Operations rule, the release of implementing guidance for the CARCs and RARCs, and the upcoming implementation of the Federal IDR Gateway platform represent progress toward improving the day-to-day administration of the Federal IDR Process. Standardized remittance requirements, clearer operational procedures, and enhanced communication between payers and providers should reduce avoidable disputes and improve administrative efficiency. Additionally, these administrative changes should improve the amount and quality of data the Federal Departments can collect on the IDR Process.

As implementation of the final rule continues, SIIA and our coalition partners will monitor how these operational changes are impacting self-insured plans, while continuing to advocate and fight for broader reforms that preserve the original intent of the Surprise Billing Rules, which is: Protecting patients from surprise medical bills without creating incentives that increase healthcare costs for employer-sponsored health plans and the individuals they cover. ■

Anthony Murrello serves as government relations manager for SIIA. He can be reached at amurrello@siia.org.