National Association of Independent Review Organizations
230 Washington Ave Ext, Ste 101
Albany, NY 12203
Ph: 518-313-0555
Fx: 518-463-8656
www.nairo.org

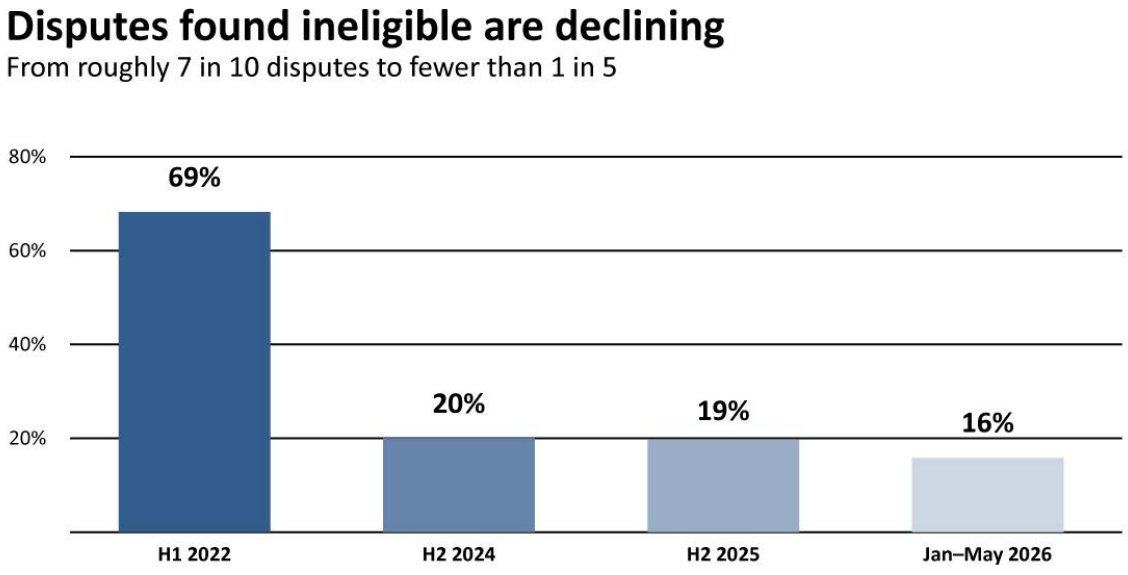
Eligibility in the Federal IDR Process: *A shared responsibility – and a shared opportunity for improvement*

By NAIRO

Four years into the No Surprises Act, the primary participants in the Independent Dispute Resolution process it created – providers, payers and certified independent dispute resolution entities (IDREs) – agree on two things. First, the law has succeeded in protecting patients from many surprise out-of-network bills. Second, the eligibility of disputes submitted to the process is an ongoing challenge.

Eligibility disagreements benefit no one. Providers spend time and money filing disputes that cannot proceed. Payers spend time and money filing objections. IDREs must divert considerable resources from the actual arbitration process to requesting additional information from both parties to resolve eligibility issues, which slows down the adjudication process. **Reducing ineligibility – both by preventing ineligible disputes from being filed and by ensuring that filed disputes contain the information needed to resolve eligibility quickly – is therefore a shared goal. Achieving it requires each participant to do its part.**

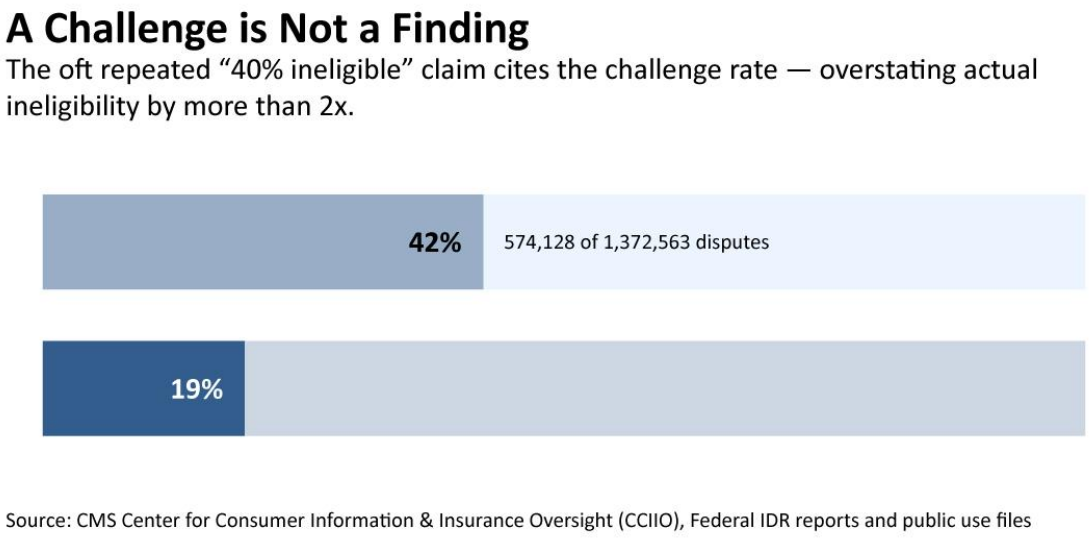
What Does the Data Say? Steady progress with room for improvement.



Source: CMS Center for Consumer Information & Insurance Oversight (CCIIO), Federal IDR reports and public use files

According to the Centers for Medicare & Medicaid Services' (CMS) Center for Consumer Information & Insurance Oversight (CCIIO), approximately 69% of disputes were found ineligible in the first six

months of 2022, which decreased to 20% in the last six months of 2024, and further declined to 19% in the last six months of 2025. Non-initiating parties challenged the eligibility of 42% of initiated disputes in the last six months of 2025 (574,128 of 1,372,563), up 2% from the first half of 2025. The most current CCIIO statistics from January through May 2026 showed ineligibility, declining to 16% of disputes, or 222,599 of 1,354,911.



A widely repeated assertion that 40% of disputes are ineligible is not supported by government data. That figure appears to conflate the rate at which eligibility is challenged (now 42%) with the rate at which disputes are actually found ineligible (19%). A challenge rate is not an ineligibility rate, and presenting the former as the latter overstates actual ineligibility by more than a factor of two. While more challenges to eligibility may appear negative, more challenges demonstrate that health plans are engaging more with the IDR process which is a positive trend; further, successful challenges comes from plans supporting their challenges with evidence such as whether a claim involves Medicare or Medicaid, which is data only a plan has in many cases and is critical to IDREs in determining eligibility.

Why Is Eligibility Review Complex?

Before arbitrating a payment dispute, an IDRE must determine if it belongs in the federal process. An IDRE applies criteria comprising established rules, sub-regulatory guidance, and direction from CCIIO. An IDRE cannot supplement the record or replace those rules with its own view of what is fair.

The questions can be difficult: Is the claim governed by federal law, a specified state law, or an All-Payer Model Agreement? Were filing deadlines met? Were items and services batched correctly? Has the cooling-off period expired? Did the parties provide the information needed to decide those questions?

These are not minor administrative checks. They are fact-specific jurisdictional and procedural determinations. Ambiguous remittance information, incomplete records, and technically demanding

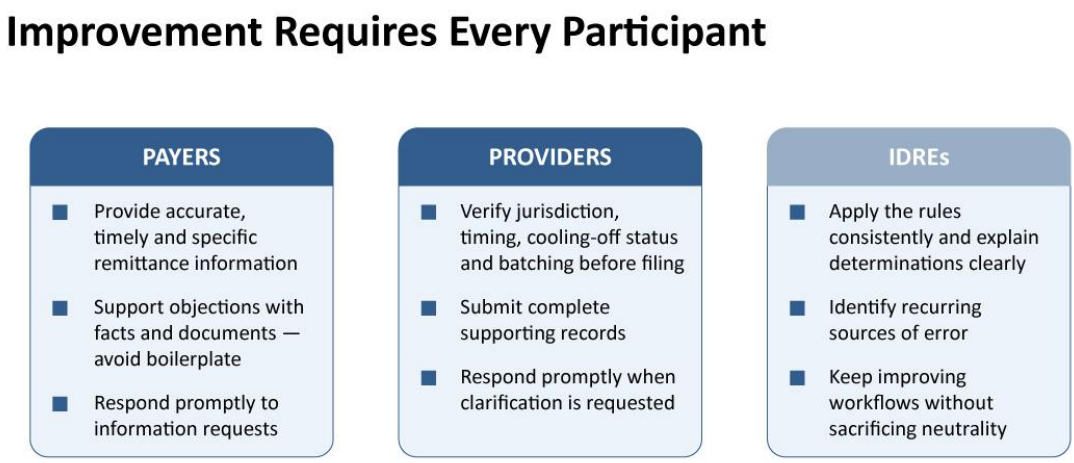
filing rules can create errors by any participant. Unsupported or insufficiently documented objections consume resources, just as incomplete or misdirected filings do.

Why Disputes Are Found Ineligible

Recent ineligibility findings are driven principally by process and jurisdiction: an unexpired cooling-off period, a dispute governed by a specified state law or All-Payer Model Agreement, missed deadlines, improper batching, or information not supplied within the required timeframe.

These outcomes should not automatically be treated as evidence of bad faith. The federal-state boundary can be difficult to navigate, batching rules are technical, and the cooling-off period has created acknowledged complexity. Ineligibility is a determination about venue or procedure – not, by itself, a finding that either party attempted to game the system.

Key Takeaway:



Payers can support process improvement by: providing accurate, timely, and specific remittance information that identifies the correct dispute pathway, supporting eligibility objections with the relevant facts and documents, responding promptly to information requests, and avoiding broad or boilerplate challenges. Notably, payers are responsible for issuing Remittance Advices (RAs) that must contain specific information related to a claim's NSA eligibility. Clearer and more specific information provided with the initial remittance advice would substantially reduce ineligibility.

Providers and their representatives can support process improvement by: verifying jurisdiction, timing, cooling-off status, and batching requirements before filing; submitting complete supporting records; and responding promptly when clarification is requested.

IDREs can support process improvement by: applying the rules consistently, explaining eligibility determinations clearly, identifying recurring sources of error and continuing to improve workflows without sacrificing neutrality or accuracy.

The Departments of Health and Human Services, Labor and the Treasury have acted, taking a pivotal step with publication of the 2026 Federal IDR Operations Rule. The rule requires payers to provide clear and detailed information on the initial payment determination, including specific RA codes that establish whether the federal NSA process applies, the actual plan issuing coverage, and whether state law rather than the federal IDR process should govern the dispute. Further, payers also must register with the Federal Registry, which solves a particularly thorny issue of providers not always knowing the actual plan (for example, a self-insured group using a TPA) involved in coverage.

A System Moving in the Right Direction

The decline in ineligibility shows that clearer guidance, better tools and participant experience are working. With clearer rules from the departments, better information from payers, more careful filings from providers and consistent review by IDREs, the process will be markedly more straightforward. When each participant fulfills its role, fewer disputes will be found ineligible, eligible cases will move faster and the federal IDR process will work better for everyone – above all, for the patients the No Surprises Act was written to protect.

About NAIRO

The National Association of Independent Review Organizations (NAIRO) is an industry trade association formed in 2000. We are comprised of URAC accredited Independent Review Organizations (IROs), Health Utilization Management (HUM), and Workers' Compensation Utilization Management (WCUM) entities. Our mission is to protect the integrity of the medical peer review, utilization review, and independent dispute resolution (IDR) processes.

Please join NAIRO for its 2027 Annual Conference – *Saddle Up! Independent Medical Review Roundup* - March 23-25, 2027 in San Antonio, Texas. For more information about NAIRO, its mission, and our conference, please visit www.nairo.org.