

The No Surprises Act: Independent Dispute Resolution for Planned Procedures

June 2026



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Key Takeaways

- Under the No Surprises Act (NSA), out-of-network providers may submit disputes regarding payment for some non-emergency procedures to an independent dispute resolution (IDR) process.
- This analysis found that awards to providers from the IDR process for certain planned procedures (e.g., plastic surgery, spine surgery) are extreme, averaging more than 50 times benchmarks that reflect in-network commercial rates and Medicare rates.
- Policy changes are needed to ensure that the NSA does not contribute to rising healthcare costs, particularly for planned out-of-network care.

Overview

Some surgical procedures, when performed by an out-of-network provider at an in-network facility, may be subject to the No Surprises Act (NSA), a federal law which protects commercially insured patients from surprise medical bills.

Providers may submit disputes over payment for certain out-of-network items and services to a certified Independent Dispute Resolution Entity (IDRE) for resolution through an independent dispute resolution (IDR) process. In this process, the IDRE determines the required payment (the “award”) by choosing either the provider’s or the insurer’s offer. Previous research, which has mainly focused on emergency care, has shown that providers win an overwhelming majority of disputes under the NSA, and their awards are several times in-network rates for the same procedures. Preliminary insurer data suggests that this IDR process is leading to even more expensive care for planned out-of-network procedures.

Providers win most disputes under the NSA and receive awards several times in-network rates.

This paper quantifies the awards from the IDR process under the NSA in 2024 through early 2026 for certain planned procedures (e.g., plastic surgery, spine surgery) compared to several benchmarks that reflect in-network commercial rates and Medicare rates.

Background

The NSA, which went into effect in January 2022, protects patients nationally from surprise medical bills, which are charges for out-of-network care that patients did not anticipate or could not prevent. The NSA covers hospital-based emergency care, non-emergency (planned) care at in-network facilities, and air ambulance services.

Dispute Resolution Under the NSA

When an out-of-network provider does not want to accept the insurer’s payment for care subject to the NSA, the provider must negotiate with the insurer to determine payment. If negotiations fail after 30 days, the provider may initiate a dispute through the NSA’s IDR process. The process is “baseball style,” meaning that the IDRE chooses either the offer of the insurer or that of the provider as the final award to the provider.

IDREs may consider several factors when choosing one of the offers, including the Qualifying Payment Amount (QPA) (i.e., the insurer or plan’s median in-network rate, which is also used in the calculation of patient cost sharing under the NSA); the training, experience, and market share of the provider; and patient acuity and complexity. Usual and customary charges and public payer (e.g., Medicare) rates are prohibited from being considered by the IDRE. The original implementing regulations of the NSA directed IDREs to favor offers close to the QPA, reflecting the law’s intent that out-of-network care be compensated similarly to in-network care. However, the requirement to prioritize the QPA over other factors was struck down in court, and research has shown that providers are consistently receiving awards several times the QPA.¹⁻⁴

The QPA is defined by the NSA as a health plan's median in-network contracted rate for the same service in the same geographic region, based on 2019 rates and adjusted for inflation, and Centers for Medicare & Medicaid Services (CMS) regulations further clarify the definition. However, some provider organizations and associations have argued that the QPA is artificially low, particularly due to the inclusion of contracted rates of providers who rarely or never submit claims for those procedures, known as “ghost rates,” which are likely to be lower than the rates of providers who perform the procedures frequently.⁵

Non-Emergency Care Under the NSA

Planned procedures may fall under the NSA if both the facility and the primary surgeon or physician are in-network, but supporting providers—such as radiologists or anesthesiologists, who were likely not chosen by the patient—are out of network. In this type of case, the primary provider receives payment based on the negotiated in-network rate, but the supporting providers may submit the claim to the IDR process.

While not the primary scenario contemplated under the NSA, planned procedures in which the primary provider is out-of-network, but the facility is in-network, may also result in the IDR process. The NSA anticipated that patients may choose to seek out-of-network care and required that to balance bill the patient (i.e., charge them more than what is covered by insurance), the out-of-network provider must give the patient a notice that explains the waiver of NSA protections and provides a good faith estimate of the expected out-of-pocket cost.

However, if the patient does not consent to be billed for the out-of-network care—or if the provider never notified the patient—the provider may still perform the procedure, and rather than balance bill the patient (which is prohibited by the law absent written consent to waive NSA protections), the provider may initiate the IDR process. Because the original expectation was that providers would receive amounts close to in-network rates through the IDR process, the use of the IDR process instead of requiring patient consent for these scenarios was unanticipated. In theory, this scenario should become more limited due to the Federal IDR Operations final rule released on May 28, 2026, which requires providers and facilities to attest that disputed services do not qualify for the notice-and-consent exception before proceeding through the IDR process,⁶ though it is not yet clear how much this requirement will alter provider behavior in practice.

Objective

The objective of this white paper is to compare the awards from the NSA IDR process from 2024 to early 2026 for certain planned procedures (e.g., plastic surgery, spine surgery) with benchmarks including the QPA, in-network commercial rates, and Medicare rates. The study also looks at how awards have changed over the last two years. This analysis includes surgical and endoscopic procedures performed by primary surgeons or physicians or assistant surgeons, and does not include ancillary services performed during a planned procedure.

Methods

Data and Study Sample

This retrospective study uses NSA IDR data from Elevance Health affiliates' and subsidiaries' (Elevance Health) disputes for planned (non-emergency) surgical and endoscopic procedures that were determined between 1/1/2024 and 2/1/2026. Specifically, this paper focuses on the 25 most common CPT (procedure) codes for planned surgical and endoscopic procedures in Elevance Health's IDR data (Appendix Table A1). Of these 25 codes, 11 are related to spine surgery, 8 are related to plastic surgery, and 6 are for other procedures, including colonoscopy and hysteroscopy.

Disputed claim lines were included if they met the following criteria: the dispute had been resolved, the claim line was from a professional (rather than facility) claim, and the CPT and ZIP code were not missing. Exclusions were made for duplicate claims or disputes, care occurring in an emergency department, claims for Medicare or Medicaid beneficiaries, in-network care, and where data limitations did not allow for the determination of the award at the claim line (rather than dispute) level.

The dispute data contained the CPT code(s) and modifier codes of the care under dispute, the location of care, the provider and insurer offers, the QPA, the winner/decision, and the final amount awarded to the provider, among other information.

The dispute data were linked, based on the CPT code and geography (at the core based statistical area (CBSA)-state level), to three other data sources:

- 1. Payer Transparency in Coverage (TiC) data** (obtained through Turquoise Health) for in-network care—both from Elevance Health and other insurers—to compare IDR awards to industry-wide median in-network contracted rates;
- 2. Elevance Health in-network professional claims** in 2024-2025, to compare IDR awards to median in-network costs for similar procedures (weighted by provider volume); and
- 3. Medicare Fee-for-Service (FFS) pricing data** from CMS, to compare to Medicare prices.

Outcomes and Analysis

The unit of analysis was the claim line. While most disputes (82%) in the study sample only had one claim line, some had multiple; in these cases, the award from the dispute was broken down into the component parts by claim line, and only claim lines with the procedure codes of interest were included.

For each disputed claim line, we compared the final award to: 1) the QPA; 2) the median non-zero in-network contracted rate across the industry (from the TiC data); 3) the median non-zero in-network Elevance Health

allowed amount from in-network claims (with each paid claim line counting as one observation); and 4) FFS Medicare prices (see data sources above), all for the same CPT code in the same CBSA and state.

To create an apples-to-apples comparison for each disputed claim line, the benchmarks were adjusted to account for the quantity (billed units) and for procedure modifiers in the disputed claim line (except for QPA, which already accounts for quantity and modifiers). For example, if a disputed line contained modifier 50 (indicating a bilateral procedure and requiring a 50 percent increase in pay), the benchmarks for that line—which are based on prices/payments for that procedure absent any modifiers—would be increased by 50 percent before calculating the ratio of the award to the benchmark. Another example is modifiers 80, 81, 82, or AS for assistant surgeons or assistants at surgery (hereafter, “assistant surgeons”); the presence of these codes would result in an 84-86 percent decrease in the benchmark. See the Appendix (“Calculation of Benchmarks”) for further explanation of this calculation.

This paper describes disputes for the procedures of interest, including the winner of the dispute, geographic information, and whether the dispute was from an assistant surgeon. The paper then presents means and medians of the ratio of the awards from these disputes to the four benchmarks of interest. Trends over time are presented for some metrics. Additional details are provided for sample procedures in sample markets.

Results

Description of Disputes

7,304 claim lines with CPT codes for the procedures of interest from Elevance Health disputes met the inclusion criteria. These 7,304 claim lines came from 483 unique providers, 3,706 unique surgical/endoscopic episodes, 4,628 unique claims, and 6,594 unique disputes (Figure 1).

Figure 1
Sample Size and Source
of Sample Claim Lines

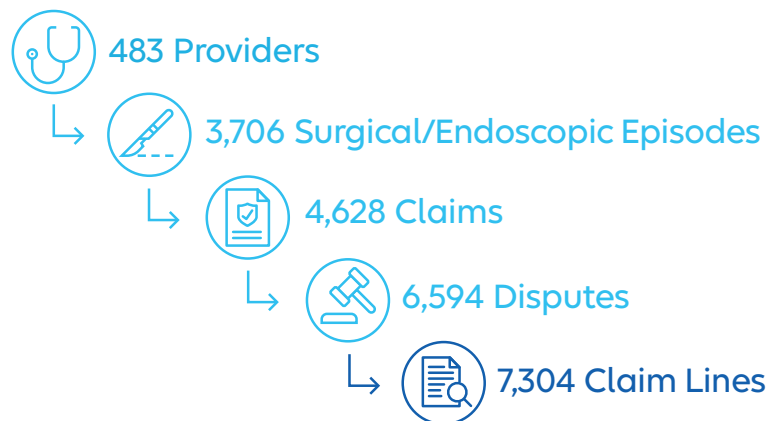


Figure 2 shows that 43 percent of disputed claim lines for planned procedures were for spine surgeries, 34 percent were for plastic surgery, and 24 percent were for other procedures (though a few of these procedures may also be related to spine or plastic surgery). 2,360 (32.3%) of the disputed claim lines were from assistant surgeons. Based on a sub-sample with available data, approximately 30 percent of these were from surgeries where the patient’s primary surgeon was in-network, and the remaining were from surgeries where the primary surgeon was also out-of-network. 578 (7.9%) of the disputed claim lines were from co-surgeons (modifier 62, which results in a 37 percent decrease in payment). More than 90 percent of the disputes came from New York, California, and Connecticut (Figure 3).

Figure 2
Disputed Claim Lines
by Procedure Type

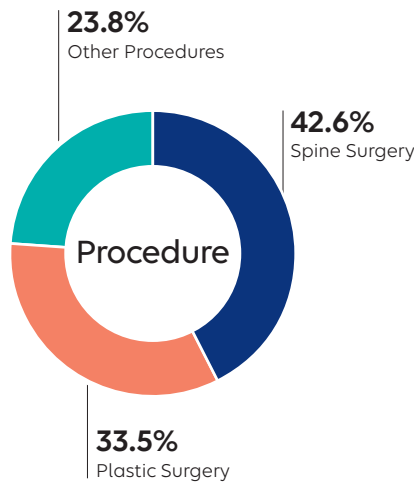
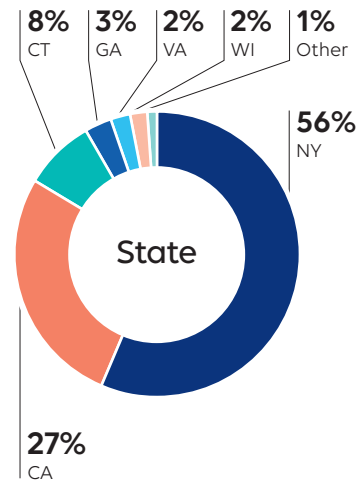


Figure 3
Disputed Claim Lines
by State



Note. See Appendix Table A1 for the list of procedures included in Spine, Plastic, and Other.

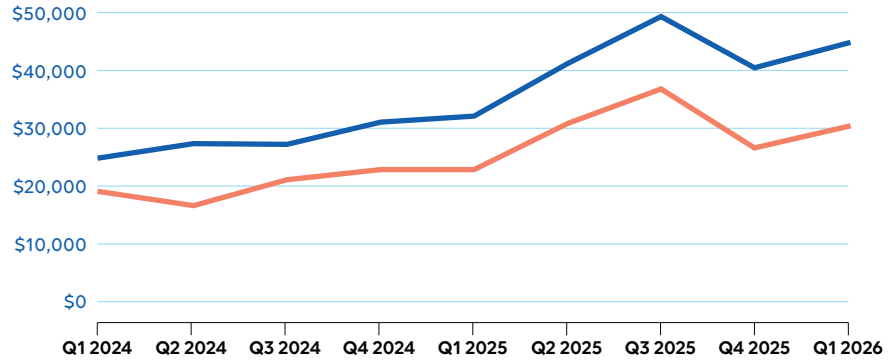
Overall, 89.5 percent of disputed claim lines were won by providers. The mean award for a disputed claim line was \$39,875, while the mean QPA was \$798. Appendix Table A2 shows the mean award and mean QPA (along with other benchmarks) by CPT code. The mean QPA for claim lines from primary surgeons (i.e., when there was no reduction for assistant surgeons or co-surgeons) was \$975. Figure 4 shows the changes in the mean and median award over the study period.

Figure 4

Mean and Median Awards for Disputed Claim Lines, by Quarter

- Mean award
- Median award

Note. Quarter is based on when the IDRE decision was determined.



Comparison to Benchmarks

Figure 5 shows the awards the providers received compared to the four benchmarks of interest (as noted on the horizontal axis). For example, the first column for QPA shows that 8 percent of disputed claim lines received awards of up to 2 times the QPA; 14 percent had awards between 2 and 20 times the QPA; 25 percent had awards between 20 and 50 times the QPA; 23 percent had awards between 50 and 100 times the QPA; 22 percent had awards between 100 and 400 times the QPA; and 7 percent had awards more than 400 times the QPA. Only 0.6 percent of disputed claim lines had an award smaller than QPA (included in the “Up to 2 times” bar).

Figure 5

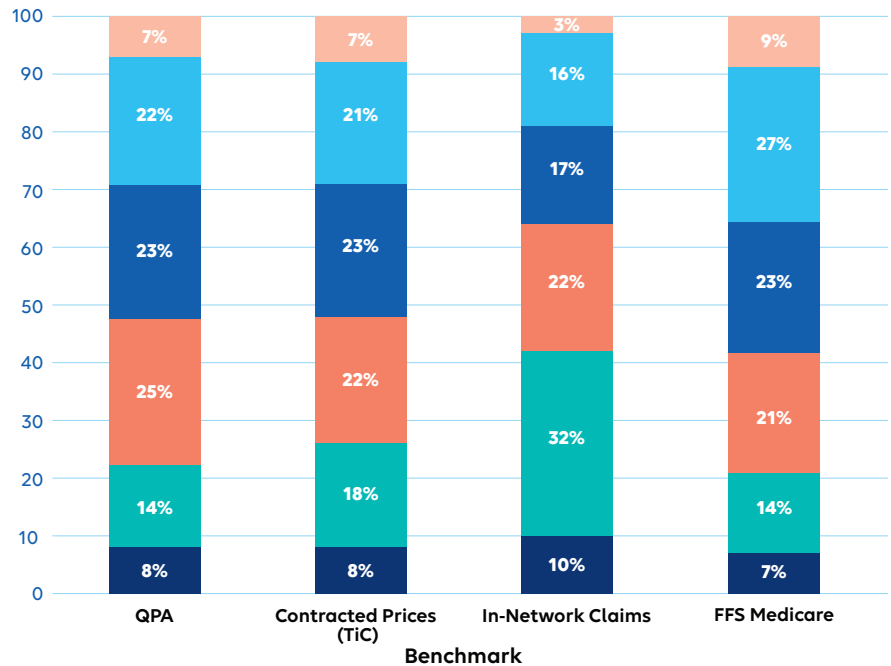
Percent of Provider Awards from Disputed Claims Lines, by Ratio of Award to Benchmark

- Up to 2 times
- 2–20 times
- 20–50 times
- 50–100 times
- 100–400 times
- More than 400 times

Note.

FFS = Fee for Service; QPA = qualifying payment amount; TIC = transparency in coverage.

The contracted prices benchmark represents the median price across the industry from TIC data. The in-network claims benchmark is the median of the allowed amount from Elevance Health in-network professional claims.



The median and mean ratios of the awards to each benchmark are provided in Table 1. Overall, the median award was 52.9 times the QPA, 53.7 times the median contracted rate across payers (TiC), 28.6 times the median of in-network Elevance Health paid claims, and 67.4 times the Medicare FFS price. These ratios were even higher when limiting the analysis to the cases where the provider won. In cases where Elevance Health won, these ratios were close to one; for example, the median (mean) ratio to QPA was 1.0 (2.8).

Table 1
Median and Mean Ratios of Awards to Benchmarks, Total and by Winner

	QPA N=6,356		Contracted Prices (TiC) N=7,231		In-Network Claims N=7,262		FFS Medicare N=7,304	
	Median	Mean	Median	Mean	Median	Mean	Median	Mean
Total	52.9	118.6	53.7	118.8	28.6	73.8	67.4	144.8
Provider Win	62.5	132.8	62.9	132.4	35.1	82.4	76.2	161.5
Insurer Win	1.0	2.8	1.3	2.9	0.7	1.6	1.5	3.6

Note. FFS = Fee for service; QPA=qualifying payment amount; TiC=transparency in coverage.

The medians and means represent the median and mean value of the ratio of awards to their calculated benchmarks, with each disputed claim line counting once.

Sample size: QPA was not available in the dispute data for some of the disputes. Median contracted prices and in-network claims were not calculated when there were no prices/claims in the data for the combination of CPT code, geography, and timeframe of interest. FFS Medicare price benchmarks were available for all disputed lines.

The contracted prices benchmark represents the median price across the industry from TiC data. The in-network claims benchmark is the median of Elevance Health in-network professional claims.

Trends over time in the median and mean ratios of the awards to the four benchmarks are displayed in Figure 6. The awards increased from early 2024 through mid-2025, though awards from disputes for these procedures determined in the last quarter of 2025 appear to have fallen slightly (though they are still extremely high).

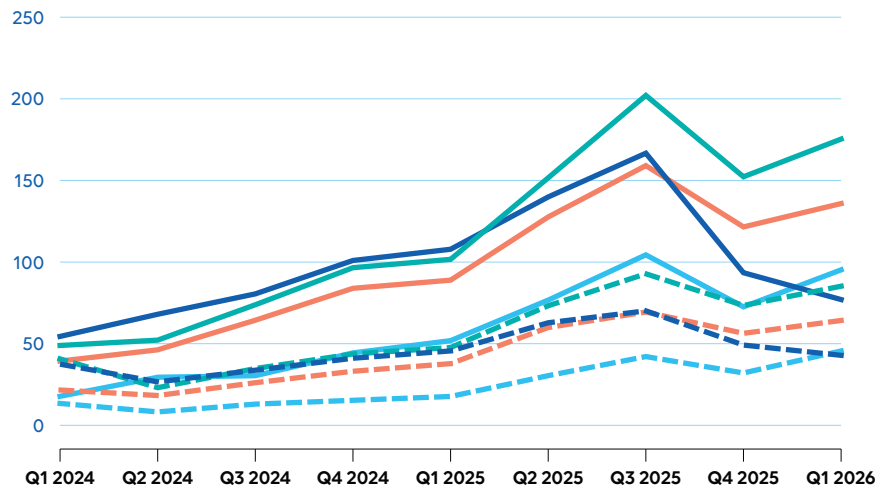
Figure 6
Median and Mean Ratios of Awards to Benchmarks, by Quarter

Mean Ratio to:

- QPA
- Contracted Prices (TiC)
- In-Network Claims
- FFS Medicare

Median Ratio to:

- QPA
- Contracted Prices (TiC)
- In-Network Claims
- FFS Medicare



Note. FFS = Fee for service; QPA=qualifying payment amount; TiC=transparency in coverage.

Quarter is based on when the IDRE decision was determined.

The medians and means represent the median and mean value of the ratio of awards to their calculated benchmarks, with each disputed claim line counting once.

The contracted prices benchmark represents the median price across the industry from TiC data. The in-network claims benchmark is the median of Elevance Health in-network professional claims.

Table 2 presents differences in the ratios of the awards to the four benchmarks by several dispute characteristics, including procedure category, state, and whether the claim was submitted by an assistant surgeon or co-surgeon. While all categories had very high awards compared to the benchmarks, some were higher than others: spine surgeries tended to have awards slightly higher than plastic surgeries relative to benchmarks; California and New York had higher awards than other states; and assistant surgeons had much higher awards compared to their benchmarks (which were adjusted to 14-16% of median prices)—approximately four times higher than primary surgeons/physicians.

Table 2
Median and Mean
Ratios of Awards to
Benchmarks, by
Dispute Characteristics

	Percent Provider Win	QPA		Contracted Prices (TiC)		In-Network Claims		FFS Medicare	
		Median	Mean	Median	Mean	Median	Mean	Median	Mean
Total	89.5%	52.9	118.6	53.7	118.8	28.6	73.8	67.4	144.8
Spine	88.0%	57.7	126.8	67.7	151.6	34.3	87.9	75.0	172.4
Plastic	89.7%	35.1	103.2	28.2	92.6	15.0	51.4	34.8	123.6
Other	91.8%	63.4	124.2	48.9	97.3	48.7	80.6	86.7	125.4
New York	87.7%	52.3	125.3	45.3	108.2	17.4	47.5	51.5	119.8
California	90.7%	63.1	132.7	70.7	159.7	66.4	125.8	100.3	193.9
Other	93.4%	29.4	62.3	32.3	84.0	29.1	76.6	54.7	148.9
Primary Surgeon/Physician	90.6%	38.6	55.7	33.4	44.1	17.5	29.5	45.0	57.1
Assistant Surgeon	88.9%	146.7	246.5	195.3	267.6	108.3	163.7	237.8	321.9
Co-Surgeon	83.6%	62.4	81.1	68.7	80.3	26.5	41.8	74.2	85.3

Note. FFS = Fee for Service; QPA = qualifying payment amount; TiC = transparency in coverage.

See Appendix Table A1 for the list of procedures included in Spine, Plastic, and Other. The state is based on where the care occurred. Assistant surgeon is designated if the disputed claim line included modifiers AS, 80, 81, or 82; co-surgeon is designated if the disputed claim line included modifier 62.

The medians and means represent the median and mean value of the ratio of awards to their calculated benchmarks, with each disputed claim line counting once.

The contracted prices benchmark represents the median price across the industry from TiC data. The in-network claims benchmark is the median of Elevance Health in-network professional claims.

A Closer Look at Two Illustrative CPT Codes

The following examination dives deeper into the costs of two of the most common CPT codes in our analysis in two of the primary CBSA-states the disputes arose from: 19318 (breast reduction) in New York City (NYC), NY (N=446 claim lines from 86 providers) and 22853 (insertion of bio-mechanical device during spinal fusion) in Los Angeles/Long Beach/Anaheim, CA (N=100 claim lines from 22 providers).

Figure 7 shows the distribution of 446 awards compared with the distribution of 1,095 in-network paid professional claim lines (with non-zero values) in 2024-2025 with CPT code 19318 in NYC. Note that the dollar values represent the final awards and actual allowed in-network

payments per claim line. The figure shows that most awards were much higher than what in-network providers received for the same service; while 48 percent of in-network claim lines were paid less than \$5,000 (the first orange-striped bar) and almost all in-network claims were paid less than \$20,000, only 11 percent of awards were less than \$5,000 (the first blue bar). Most of the awards that were in the same range as the in-network claims were from disputes won by the insurer.

The median (mean) in-network professional claim line allowed amount for this procedure was \$5,422 (\$5,196), while the median (mean) award was \$67,000 (\$82,049). When excluding assistant or co-surgeons, the median (mean) in-network claim was paid \$6,184 (\$6,483). While 23 percent of in-network claim lines for this procedure were billed by assistant surgeons, 35 percent of disputed claim lines were billed by assistant surgeons.

Figure 7

Distribution of In-Network Claim Line Payments vs. IDR Awards for CPT Code 19318 in New York City

■ IDR awards
 ▨ In-Network claim line payments

Note. The last blue bar in this figure includes awards greater than \$200,000 (<1% of awards). No in-network professional claim lines were above this amount.

Claims appear as received, including any modifiers (i.e., they were not adjusted to represent the base rate of the CPT code for a primary surgeon with one billed unit).

Blue bars and orange-striped bars each add up to 100%.

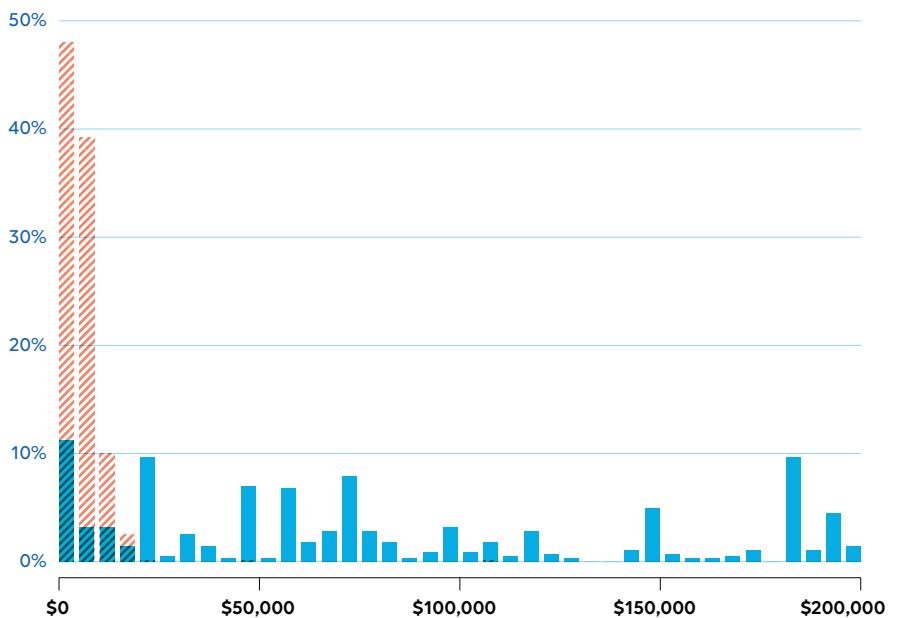


Figure 8 shows a similar story for CPT code 22853 in Los Angeles/Long Beach/Anaheim, with 100 awards and 1,694 in-network paid professional claim lines (with non-zero values). 92 percent of in-network claim lines were less than \$1,250 (first orange-striped bar), compared with 7 percent of IDR awards (first blue bar). The median (mean) in-network professional claim line allowed amount for this procedure was \$411 (\$545), while the median (mean) award was \$43,500 (\$42,314). When excluding assistant or co-surgeons, the median (mean) in-network claim line was paid \$642 (\$807). While 38 percent of in-network claim lines for this procedure were billed by assistant surgeons, 54 percent of disputed claim lines were billed by assistant surgeons.

Figure 8

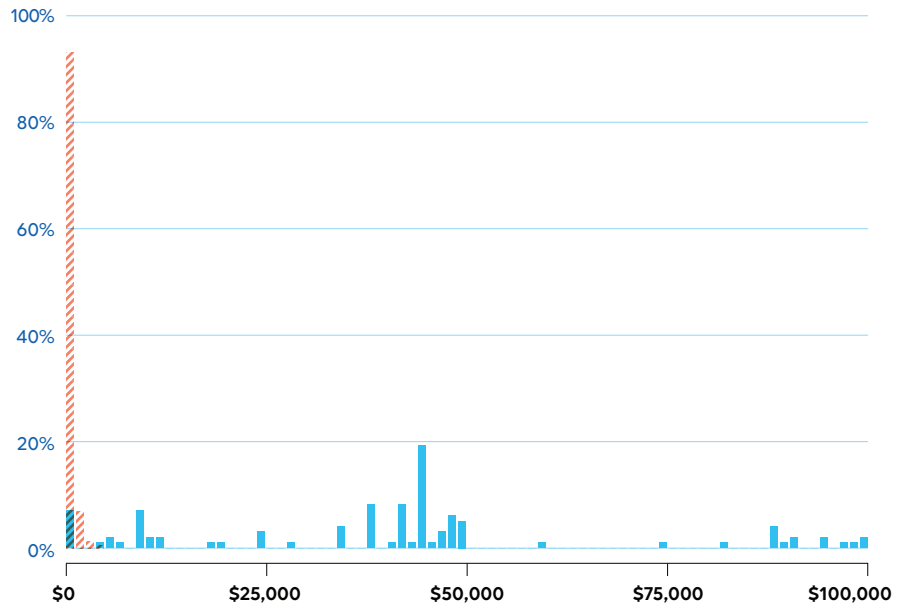
Distribution of In-Network Claim Line Payments vs. IDR Awards for CPT Code 22853 in Los Angeles/ Long Beach/Anaheim

■ IDR awards
▨ In-Network claim line payments

Note. The last blue bar in this figure includes awards greater than \$100,000 (2% of awards). No in-network professional claim lines were above this amount.

Claims appear as received, including any modifiers (i.e., they were not adjusted to represent the base rate of the CPT code for a primary surgeon with one billed unit).

Blue bars and orange-striped bars each add up to 100%.



Discussion

Whereas prior research has shown that awards from the IDR process (including for emergency care, the most common type of dispute) are several times the QPA on average, this analysis shows that in the case of planned procedures, awards are extreme, with the median award 53 times the QPA and the mean award 119 times the QPA.

This study also found that the median award was 29 times the median in-network claim for similar services and the mean award was 74 times the median in-network claim. IDREs are choosing the provider as the winner in 90 percent of disputed claim lines for these procedures, despite that provider offers are much higher than what in-network providers receive. Furthermore, this trend has increased over the last two years, with per-claim line awards 43 percent higher in 2025 than in 2024 for these procedures.

The discrepancy between awards and benchmarks was especially pronounced for assistant surgeons, half of whom were awarded more than 147 times the QPA (in contrast with primary surgeons/physicians, who had a median award of 39 times the QPA), 195 times contracted prices (TiC), and 108 times in-network claims. Claim lines with an assistant surgeon modifier indicate that a primary surgeon also billed for the same procedure; the assistant's payment is a second payment for the procedure of interest, which is why it is typically only paid at 16 percent (for physicians) or 14 percent (for non-physicians) of the regularly contracted rate. The QPA and the calculated benchmarks take this payment reduction into account. However, assistant surgeons have been winning awards with amounts similar to those of primary surgeons for these procedures, which is why their awards show even greater divergence from benchmarks.

Looking across the ratios of awards to the four different benchmarks included in this study, while the ratios of awards to in-networks claims were extremely high, these ratios were still somewhat lower than the ratios to QPA, indicating that the median claim is greater than the QPA. This is due to how the QPA is defined by the NSA, which is the median in-network contracted rate, whereas the median claim can be considered volume-weighted. It also suggests that more claims are submitted by providers whose rates are higher than the median rate, and it is possible that “ghost rates” are at least partially contributing to the lower QPA.

In contrast, the median and mean ratios to the QPA and to the TiC benchmark are extremely close, indicating that industry-wide prices (captured by the TiC data) are similar to those from Elevance Health. This is expected because the QPA is statutorily based on median contracted rates, which are the same rates reported in the TiC data.

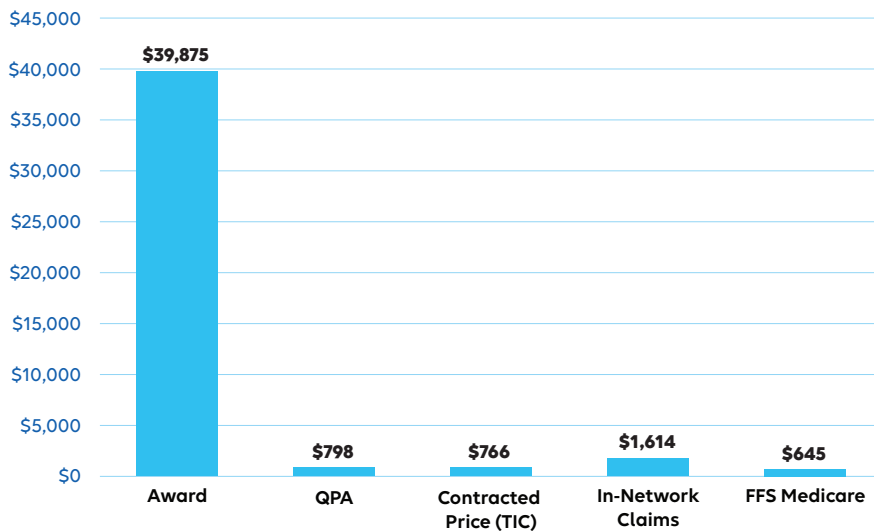
Nevertheless, the difference between the QPA/TiC and paid claims benchmarks still pales in comparison to the difference between any of these benchmarks and the average IDR award (Figure 9). The QPA—often offered by the insurer in the IDR process—was approximately half of the average in-network claim cost for procedures included in this analysis, representing a decrease of several hundred to one thousand dollars for most of these planned procedures. Relative to paid in-network claims, providers are asking for and IDREs are awarding amounts that are tens to hundreds of times higher—adding tens of thousands of, or in some cases even more than one hundred thousand, dollars in excess costs.

Figure 9
Mean Award and Benchmarks

Note.

FFS = Fee for Service;
QPA = qualifying payment amount;
TiC = transparency in coverage.

The contracted prices benchmark represents the median price across the industry from TiC data. The in-network claims benchmark is the median of Elevance Health in-network professional claims.



Furthermore, while the number of disputed claim lines related to surgical procedures and associated neuromonitoring is relatively small (~16%) compared to emergency services, the costs stemming from these disputes amounted to approximately 60 percent of Elevance Health’s costs for NSA awards due to the extreme awards for this type of care. These disputes are driving up costs not only for insurers, but for employers, and ultimately consumers, as the increased costs will likely result in increased premiums.

Policy Recommendations

The NSA requires out-of-network providers to inform the patient in advance about estimated out-of-pocket costs for planned procedures and present the patient with a waiver and obtain the patient's consent. The IDR process is intended as a last resort when this process fails.

The underlying assumption of the NSA was that providers would receive approximately in-network rates for planned procedures if they went through the IDR process, hence there would not be an incentive to skip patient waiver and consent for balance billing and instead bring the case to IDR.

However, our study found that certain providers have repeatedly brought cases to the IDR process and have secured exceptionally high payments for planned services performed at in-network facilities. Because providers have been requesting and winning awards at least an order of magnitude higher than accepted in-network rates, it appears to have become a strategy for obtaining lucrative reimbursement from insurers while keeping patient out-of-pocket costs low, rather than a last stop for dispute resolution.

The following recommendations suggest actions that CMS or Congress may employ to better align the IDR process with the original intent of the NSA:

Limit eligibility of planned services for IDR to cases where waiver and consent could not transpire.

Congress should amend the NSA to restrict the use of IDR for scheduled, non-emergent services. Congress intended that providers would seek a waiver and consent for out-of-network scheduled, non-emergent services, in accordance with section 279BB-2(D) of the Public Health Service Act. Doing so would ensure patient awareness that a provider is out-of-network and allow the patient to decide between paying the balance for out-of-network care or seeking care elsewhere. Congress expected that only in exceptional cases where waiver and consent could not reasonably be provided and obtained would these planned services be eligible for IDR. However, because of the significant award amounts, waiver and consent are not being offered and signed. Congress should clarify that IDR is unavailable where waiver and consent could have been obtained. IDR should be limited to (i) emergency services and (ii) unforeseen ancillary services furnished in connection with a scheduled service for which waiver and consent was not practicable.

Meanwhile, CMS's recently released final rule⁷ begins to address this issue by requiring providers and facilities to attest that disputed services do not qualify for the notice-and-consent exception before proceeding through the federal IDR process. Robust auditing, oversight, and enforcement will be needed to ensure providers are accurately representing eligibility

and not improperly routing notice-and-consent cases into IDR. While this requirement may help identify some ineligible disputes, its focus on provider attestations is unlikely to materially reduce the volume of planned procedure disputes. Congressional engagement remains needed to address the underlying question of whether planned procedures, with providers selected by patients, should be eligible for the IDR process.

Reinforce use of market-based benchmarks.

IDR awards should be tied to an auditable, market-based price reflecting actual resource use, and if an award deviates from a market-based price it must be clearly and transparently justified. As our research shows, in addition to the QPA defined in the NSA, TiC data may serve as a verified and auditable reflection of price and resource use. To the extent policy-makers determine that the QPA does not fully reflect realized market payments, targeted refinements could be considered—such as incorporating utilization-weighted contracted rates—provided such changes preserve the QPA’s role as the central statutory reference point and do not introduce inflationary bias.

Increase transparency and accountability in IDR decision-making.

IDREs should provide written rationales for determinations, particularly when awards materially exceed auditable, market-based prices reflecting resource use. CMS should monitor variation across IDREs to identify outlier decision patterns and require consistent, defensible application of auditable, market-based prices reflecting resource use. Entities that demonstrate persistent deviation should be subject to corrective action, including potential decertification.

Require application of role-based payment standards.

We recommend that CMS establish explicit training requirements for IDREs on modifier-based reimbursement standards, including Medicare’s assistant surgeon reduction. Role-based modifiers may be overlooked, and failure to account for modifiers results in some providers securing payments far above customary rates. IDREs should be required to apply role-based modifier conventions, or explicitly justify departures from them.

Updating the regulations of the NSA—or amending the NSA itself—to reflect the original law’s intent of protecting patients from surprise balance bills, rather than an opportunity to receive extremely large payments from insurers for scheduled, non-emergency care, is important to prevent a very costly abuse of the IDR process.

Conclusion

This analysis shows that in the case of planned procedures, awards from the IDR process under the NSA are extreme, with the median award exceeding 50 times the QPA. Policy changes are needed to ensure that the NSA does not contribute to rising healthcare costs, particularly for planned out-of-network care that should not be a “surprise” for patients.

Endnotes

- ¹ Ukert, B., & Gordon, A.S. (2025, December 10). Arbitration Outcomes for Out-of-Network Medical Bills Under the No Surprises Act. *INQUIRY: The Journal of Health Care Organization, Provision, and Financing* 62. Retrieved April 13, 2026, from <https://doi.org/10.1177/00469580251401475>.
- ² Duffy, E.L., et al. (2024, October 17). No Surprises Act Independent Dispute Resolution Outcomes for Emergency Services. *Health Affairs Scholar* 2(11). Retrieved April 13, 2026, from <https://doi.org/10.1093/hasch/qxae132>.
- ³ Hoadley, J., Watts, K., & Baron, Z. (2025, June 11). Independent Dispute Resolution Process 2024 Data: High Volume, More Provider Wins. *Health Affairs Forefront*. Retrieved April 13, 2026, from <https://doi.org/10.1377/forefront.20250609.318536>.
- ⁴ Hoadley, J., et al. (2026, March 20). The No Surprises Act IDR Process: An Early Look at 2025 Data. *Health Affairs Forefront*. Retrieved April 13, 2026, from <https://doi.org/10.1377/forefront.20260318.548269>.
- ⁵ American College of Emergency Physicians, American College of Radiology, & American Society of Anesthesiologists. (2024, December 5). *Recommendations for TMA III Enforcement Guidance* [Letter]. Retrieved April 22, 2026, from <https://www.asahq.org/-/media/sites/asahq/files/public/advocacy/alerts/washington-alerts/2024-12-5---acep-acr-asa-letter-on-tma-iii-enforcement-ii.pdf>.
- ⁶ Centers for Medicare & Medicaid Services. (2026, May 28). Federal Independent Dispute Resolution Operations Final Rule. Retrieved May 29, 2026, from <https://www.cms.gov/files/document/federal-independent-dispute-resolution-operations-final-rule.pdf>.
- ⁷ Ibid.

Appendix

Table A1

List of CPT Codes, Their Descriptions, Categories, and Counts

CPT Code	Description	Category	Count
19318	Breast reduction	Plastic	662
58662	Laparoscopy, surgical; with fulguration or excision of lesions of the ovary, pelvic viscera, or peritoneal surface by any method	Other	606
22853	Insertion of interbody biomechanical device(s) (e.g., synthetic cage, mesh) with integral anterior instrumentation for device anchoring (e.g., screws, flanges), when performed, to intervertebral disc space in conjunction with interbody arthrodesis, each interspace (List separately in addition to code for primary procedure)	Spine	549
14301	Adjacent tissue transfer or rearrangement, any area; defect 30.1 sq cm to 60.0 sq cm	Plastic	386
63047	Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [e.g., spinal or lateral recess stenosis]), single vertebral segment; lumbar	Spine	381
63048	Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [e.g., spinal or lateral recess stenosis]), single vertebral segment; each additional vertebral segment, cervical, thoracic, or lumbar (List separately in addition to code for primary procedure)	Spine	359
43239	Esophagogastroduodenoscopy, flexible, transoral; with biopsy, single or multiple	Other	351
14302	Adjacent tissue transfer or rearrangement, any area; each additional 30.0 sq cm, or part thereof (List separately in addition to code for primary procedure)	Plastic	306
15734	Muscle, myocutaneous, or fasciocutaneous flap; trunk	Plastic	283
58558	Hysteroscopy, surgical; with sampling (biopsy) of endometrium and/or polypectomy, with or without D & C	Other	260
22842	Posterior segmental instrumentation (e.g., pedicle fixation, dual rods with multiple hooks and sublaminar wires); 3 to 6 vertebral segments (List separately in addition to code for primary procedure)	Spine	253
19380	Revision of reconstructed breast (e.g., significant removal of tissue, re-advancement and/or re-inset of flaps in autologous reconstruction or significant capsular revision combined with soft tissue excision in implant-based reconstruction)	Plastic	252
22614	Arthrodesis, posterior or posterolateral technique, single interspace; each additional interspace (List separately in addition to code for primary procedure)	Spine	246
22612	Arthrodesis, posterior or posterolateral technique, single interspace; lumbar (with lateral transverse technique, when performed)	Spine	241
22845	Anterior instrumentation; 2 to 3 vertebral segments (List separately in addition to code for primary procedure)	Spine	236

CPT Code	Description	Category	Count
22558	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar	Spine	223
22551	Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophyctomy and decompression of spinal cord and/or nerve roots; cervical below C2	Spine	222
45380	Colonoscopy, flexible; with biopsy, single or multiple	Other	212
63030	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, lumbar	Spine	212
15777	Implantation of biologic implant (e.g., acellular dermal matrix) for soft tissue reinforcement (i.e., breast, trunk) (List separately in addition to code for primary procedure)	Plastic	204
15771	Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, and/or legs; 50 cc or less injectate	Plastic	193
22840	Posterior non-segmental instrumentation (e.g., Harrington rod technique, pedicle fixation across 1 interspace, atlantoaxial transarticular screw fixation, sublaminar wiring at C1, facet screw fixation) (List separately in addition to code for primary procedure)	Spine	193
64722	Decompression; unspecified nerve(s) (specify)	Other	178
19357	Tissue expander placement in breast reconstruction, including subsequent expansion(s)	Plastic	164
69990	Microsurgical techniques, requiring use of operating microscope (List separately in addition to code for primary procedure)	Other	132

Table A2**Mean Awards and Benchmarks by CPT Code**

CPT Code	Award	QPA	Contracted Prices (TiC)	In-Network Claims	FFS Medicare
19318	\$ 78,287	\$1,138	\$1,357	\$3,196	\$1,173
58662	\$ 34,537	\$760	\$575	\$744	\$479
22853	\$ 30,759	\$365	\$282	\$603	\$216
14301	\$ 22,618	\$610	\$844	\$1,546	\$716
63047	\$50,828	\$1,145	\$846	\$1,374	\$768
63048	\$28,108	\$316	\$240	\$553	\$186
43239	\$15,408	\$258	\$266	\$265	\$143
14302	\$27,813	\$708	\$752	\$2,076	\$661
15734	\$41,041	\$1,280	\$1,925	\$3,657	\$1,884
58558	\$16,926	\$541	\$633	\$1,005	\$252
22842	\$33,819	\$754	\$653	\$1,678	\$518
19380	\$45,723	\$948	\$1,097	\$2,907	\$1,019
22614	\$40,695	\$1,079	\$678	\$1,876	\$512
22612	\$60,371	\$1,282	\$1,122	\$2,730	\$1,017
22845	\$36,073	\$591	\$521	\$1,468	\$448
22558	\$71,449	\$1,457	\$915	\$1,397	\$910
22551	\$55,679	\$1,383	\$1,319	\$3,964	\$1,195
45380	\$18,125	\$340	\$435	\$321	\$208
63030	\$52,236	\$1,224	\$747	\$1,965	\$659
15777	\$25,543	\$307	\$346	\$699	\$253
15771	\$13,085	\$405	\$636	\$689	\$500
22840	\$34,841	\$764	\$552	\$1,348	\$456
64722	\$57,348	\$647	\$464	\$491	\$476
19357	\$65,217	\$1,524	\$1,614	\$3,106	\$1,081
69990	\$13,322	\$280	\$207	\$890	\$194

Table A3

Modifier Codes and Adjustment Factors

CPT Modifier Code	Factor
50	1.50
52	0.50
54	0.70
55	0.20
56	0.10
62	0.63

CPT Modifier Code	Factor
78	0.70
80, 81, 82	0.16
AS	0.14
QK, QX, QY	0.50
QZ	0.90

Calculation of Benchmarks

Transparency in Coverage (TiC) Data

The median in-network contracted rate (excluding \$0 rates) within CPT code, CBSA, and state was calculated using data across insurers compiled by Turquoise Health. These median rates were then matched to disputed claim lines by CPT code, CBSA, and state. The median rates were then adjusted by up to two CPT modifier codes on the disputed claim lines according to the factors in Table A3. This value was then multiplied by the number of billed units on the dispute to get the final TiC benchmark amount for the disputed claim line.

In-Network Claims Data

The first step was to calculate a “base rate” for the CPT code that represents the allowed amount for one unit if there had been no modifiers on the claim line. To do this, the allowed amount for each claim line was adjusted by dividing by the factors in Table A3 to account for any procedure modifier codes present on each in-network claim line. Then within each year, CPT code, CBSA, and state, the median of the non-zero allowed amounts (base rate) was calculated and matched to each disputed claim line. The median rates were then adjusted by up to two CPT modifier codes on the disputed claim line according to the factors in Table A3. This value was then multiplied by the number of billed units on the disputed claim line to get the final in-network claim benchmark amount for the disputed claim line.

Medicare Data

The physician fee schedule from 2025 for each CPT code (<https://www.cms.gov/medicare/physician-fee-schedule/search>) was matched on Medicare Administrative Contractor (MAC) to the ZIP code on the dispute. The prices were then adjusted by up to two CPT modifier codes on the disputed claim line according to the factors in Table A3. This value was then multiplied by the number of billed units on the disputed claim line to get the final FFS Medicare benchmark amount for the disputed claim line.

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