Federal Independent Dispute Resolution (IDR) Guidance for Certified IDR Entities and Disputing Parties
October 29 2026
Topic: Treatment of Batched and Bundled Qualified IDR Items and Services as Required by the Federal IDR Operations Final Rule

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Background

On June 4, 2026, the Department of the Treasury, Department of Labor and the Department of Health and Human Services (the Departments), along with the Office of Personnel Management (OPM) published the Federal IDR Operations Final Rules (final rules) to improve the functioning of the Federal Independent Dispute Resolution (IDR) process established under the No Surprises Act (NSA).[1]

The NSA and its implementing regulations give parties initiating the Federal IDR process the ability to include multiple items or services in a single payment determination (referred to as "batched qualified IDR items or services" or "batched dispute"). The final rules, in relevant part,

[1] 91 FR 33900 (June 4, 2026).

amended requirements regarding how qualified IDR items and services can be batched. Specifically, the final rules include four criteria that must be met for qualified IDR items or services to be batched as part of a single payment determination.[2]

First, the qualified IDR items and services must be billed by the same provider or group of providers, the same facility, or same provider of air ambulance services.

Second, the payment for the qualified IDR items and services must be made by the same group health plan or same issuer of individual or group health insurance coverage.

Third, all qualified IDR items and services must be related to the treatment of a similar condition. The final rules specify three ways in which a batch can be related to the treatment of a similar condition:

1. Items or services are furnished to a single patient during a single patient encounter, defined as items and/or services furnished to a single patient on one or more consecutive dates of services and billed on the same claim;
2. Items or services are furnished to one or more patients and billed under the same service code or comparable service code under a different procedural coding system; or
3. Anesthesiology, Radiology, Pathology, and Laboratory items or services are furnished to one or more patients and billed under service codes included in the same code range, as specified by the Departments in guidance.

Fourth, batched qualified IDR items and services must have been furnished within the same 30-business-day period following the date on which the first item or service included in the batched determination was furnished, except if the cooling off period applies.

In all instances, the batched qualified IDR items and services must also have been subject to a 30-business day open negotiation period that ended within 4 business days of IDR initiation, except if the cooling off period applies. If the cooling off period applies, the batched qualified IDR items and services must have an open negotiation period that ended within the same cooling off period or overlapping cooling off periods. Overlapping cooling off periods occur when a dispute for an item or service receives a payment determination after the date another dispute involving the same item or service with the same non-initiating party is initiated, but before that dispute receives a payment determination.

The cooling off period for batched disputes is 30 business days. Furthermore, under the final rules, a batched dispute cannot include more than 50 line items.

Moreover, in the case of items and services which are included as part of a bundled payment arrangement, the applicable regulations provide that such items and services may be part of a single determination ("bundled dispute").[3] In the final rules, the Departments finalized the

[2] 26 CFR 54.9816-8(c)(4)(i), 29 CFR 2590.716-8(c)(4)(i), and 45 CFR 149.510(c)(4)(i).
[3] 26 CFR 54.9816-8(c)(4)(ii), 29 CFR 2590.716-8(c)(4)(ii), and 45 CFR 149.510(c)(4)(ii).

definition of bundled payment arrangement at 26 CFR 54.9816-3, 29 CFR 2590.716-3, and 45 CFR 149.30.

This guidance explains how the finalized batching requirements will be operationalized; specifies the permissible CPT code ranges for anesthesiology, radiology, pathology and laboratory items and services that are considered to relate to the treatment of a similar condition; explains the definition of a bundled payment arrangement; and provides examples to guide how disputing parties and certified IDR entities should apply the finalized batching and bundled payment provisions.

Applicability of Batching and Bundling Provisions

Under the final rules, the ***definition of batched qualified IDR items and services*** is applicable to disputes with open negotiation periods beginning on or after November 1, 2026. The final rules also include an applicability date for the ***treatment of batched qualified IDR items and services***, which applies to disputes with open negotiation periods beginning 90 calendar days after the Departments issue notice that the functionality supporting this requirement has become available. The Departments use the term "treatment of batched qualified IDR items and services" to refer to the criteria required to batch items and services that were finalized in the final rules. The Departments issued notice on August 3, 2026, that the functionality supporting the treatment of batched qualified items and services will be available on November 1, 2026, which is 90 calendar days from the date of the notice.

Therefore, for items and services with open negotiation periods beginning on or after November 1, 2026, a disputing party must initiate batched disputes according to the final rules.

Until then, parties must continue to submit batched qualified IDR items or services in accordance with Internal Revenue Code section 9816(c)(3)(A), Employee Retirement Income Security Act section 716(c)(3)(A), and Public Health Service Act section 2799A–1(c)(3)(A)(iii), in conjunction with regulations set forth in the Requirements Related to Surprise Billing; Part II final rules and sub-regulatory guidance that were not vacated by the United States District Court for the Eastern District of Texas. *See Tex. Med. Ass'n v. U.S. Dep't of Health & Hum. Servs.* ("*TMA IV*"), No. 6:23-cv-59-JDK, 2023 WL 4977746 (E.D. Tex. Aug. 3, 2023); *Tex. Med. Ass'n v. U.S. Dep't of Health & Hum. Servs.* ("*TMA III*"), No. 6:22-cv-450-JDK, 2023 WL 5489028 (E.D. Tex. Aug. 24, 2023).[4]

The bundling provisions of the final rules, including the definition of a bundled payment arrangement, are applicable on the effective date of the final rules, August 3, 2026.

[4] *See* 86 FR 55980 (Oct. 7, 2021) and FAQs about Affordable Care Act and Consolidated Appropriations Act, 2021 Implementation Part 63, Q2 (Nov. 28, 2023), available at https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-63 and https://www.cms.gov/files/document/faqs-part-63.pdf.

Batched Items and Services Must be Billed by the Same Provider, Facility, or Provider of Air Ambulance Services

The final rules state that items and services can only be batched if they were billed by the same provider or group of providers, the same facility, or the same provider of air ambulance services. Specifically, all qualified IDR items and services included in a batch must be billed under the same National Provider Identifier (NPI) or Tax Identification Number (TIN).

Batched Items and Services Must be Paid by the Same Group Health Plan or Health Insurance Issuer

The final rules state that items and services can be batched if payment for the items or services is required to be made by the same group health plan or health insurance issuer. Additionally, the final rules specify how claims must be batched for self-insured plans as opposed to fully-insured plans.

For self-insured group health plans, qualified IDR items and services can be batched only if the same self-insured group health plan is required to make a payment for the qualified IDR items and services. Claims for qualified IDR items and services payable by different self-insured group health plans cannot be batched, regardless of whether the plans are administered by the same third-party administrator (TPA). Prior to the applicability of the health plan registry provisions[5], a self-insured group health plan can be identified by the plan's TIN or, if the plan does not have a TIN, by the plan sponsor's Employer Identification Number (EIN) or TIN; and the three-digit plan number as reported on IRS form 5500 or, if the plan does not have a plan number, by the plan's name. After the applicability date of the health plan registry, the same self-insured group health plan can be identified by its unique health plan registry number.

For fully-insured group health plans, qualified IDR items and services can be batched if payment is required to be made by the same health insurance issuer, even if the qualified IDR items and services relate to claims from different fully-insured group or individual health insurance coverage offered by the issuer. The same issuer is defined as the issuer at the state level and is identified by the issuer's five-digit Health Insurance Oversight System (HIOS) issuer ID prior to the applicability of the health plan registry provisions. After the applicability date of the health plan registry, the same issuer can be identified by its unique health plan registry number.

Batched Items and Services Must be Related to the Treatment of a Similar Condition

Qualified items and services that satisfy any of the three criteria below are considered to relate to the treatment of a similar condition

Items and Services Are Considered to Relate to the Treatment of a Similar Condition If They Are Furnished to a Single Patient During a Single Patient Encounter

Qualified IDR items and services are considered to relate to the treatment of a similar condition when they were furnished to a single patient during a single patient encounter. A single patient encounter is treatment which occurs on one or more consecutive days during which the qualified IDR items or services were furnished to the same patient and billed on the same claim form. A

[5] *See* 26 CFR 54.9816-9, 29 CFR 2590.716-9, and 45 CFR 149.530 (88 FR 75803).

disputing party may batch together items or services that were furnished to a single patient during a single patient encounter.

Example 1: Emergency Department Single Patient Encounter

An out-of-network emergency department physician furnished multiple emergency items and services to patient Tillie starting on June 3 and continuing into June 4, when Tillie is discharged. The physician bills all items and services for the initial emergency visit (June 3-4) on the same claim form under his or her NPI and submits the claim form to Tillie's insurer. Tillie's insurer sends an initial payment to the physician, which the physician believes to be insufficient for the items and services provided, and the physician initiates open negotiation within the required timeframes. The parties do not reach an agreement on payment during open negotiation. Within the required timeframes, the physician initiates the Federal IDR process. The physician **would be permitted to batch 50 or fewer qualified IDR items and services provided to Tillie during her initial emergency room visit on June 3-4 because they were billed on the same claim form and all other batching criteria were met.**

Items and Services Are Considered to Relate to the Treatment of a Similar Condition If They Are Furnished to One or More Patients and Were Billed Under the Same or Comparable Service Code

Under the final rules, qualified IDR items and services are considered to relate to the treatment of a similar condition when they are furnished to one or more patients and were billed under the same service code or a comparable code under a different procedural code system, such as Current Procedural Terminology (CPT) codes with modifiers, Healthcare Common Procedure Coding System (HCPCS) codes with modifiers, or Diagnosis-Related Group (DRG) codes with modifiers. Qualified IDR items or services billed under the same code or under comparable codes of different coding systems are considered to relate to treatment of a similar condition because they are the same item or service. For example, CPT code 93000 and HCPCS code G0403 both correspond to a routine electrocardiogram (with 12 leads). The Departments clarify that only the primary service codes must be the same or comparable; this standard does not apply to modifiers of such primary service codes or to anesthesia qualifying circumstances add-on codes, which function as modifiers.

The table below outlines examples of comparable codes across HCPCS and CPT coding systems.[6,7]

[6] American Medical Association. CPT 2026 Professional Edition. American Medical Association; 2026.
[7] American Medical Association. HCPCS Level II Professional Edition. American Medical Association; 2026.

TABLE 1: Comparable Codes across HCPCS and CPT Coding Systems

HCPCS	**CPT Equivalent**
B1. **G0403** – A routine electrocardiogram (with 12 leads)	**93000** – A routine 12-lead electrocardiogram (ECG/EKG) that includes the tracing, interpretation, and a written report
B2. **G0017** – Psychotherapy for crisis furnished in an applicable site of service (any place of service at which the non-facility rate for psychotherapy for crisis services applies, other than the office setting); first 60 minutes	**90839** – Psychotherapy for crisis; first 60 minutes
B3. **G0105** – Colorectal cancer screening; colonoscopy on individual at high risk	**44404** – Colonoscopy through stoma: with directed submucosal injection(s), any substance **44408** – Colonoscopy through stoma: with decompression (for pathologic distention) (e.g., volvulus, megacolon), including placement of decompression tube, when performed **45378** – Colonoscopy, flexible; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)

Example 2: Emergency Department Psychotherapy Treatment for Multiple Patients

Patient Susie presents to a freestanding out-of-network emergency department in an apparent psychotic state. The on-call psychiatrist provides crisis psychotherapy to Susie. After the psychiatrist attends to Susie, she provides crisis psychotherapy to another patient, Natalie. Susie and Natalie have coverage from the same health insurance issuer, under which the psychiatrist is out-of-network. The psychiatrist submits separate claim forms for Susie and Natalie under her NPI. Susie's and Natalie's insurer sends initial payments to the psychiatrist, which the psychiatrist believes to be insufficient, and the psychiatrist initiates open negotiation within the required timeframes. The parties do not reach an agreement on payment during open negotiation. Within the required timeframes, the psychiatrist initiates the Federal IDR process.

Two Patients Billed Under Same Service Code

The psychiatrist bills separately for Susie's and Natalie's care under CPT code 90839 (Psychotherapy for crisis; first 60 minutes). The psychiatrist **would be permitted to batch qualifying services for these two claims,** because the services were furnished to one or more patients (Susie and Natalie), the services were billed under the same service code (CPT code 90839), and all other batching criteria were met.

Two Patients Billed Under Comparable Service Codes

Instead, the psychiatrist bills for Susie's care under CPT code 90839 and Natalie's care under HCPCS code G0017 **(**Psychotherapy for crisis furnished in an applicable site of service (any place of service at which the non-facility rate for psychotherapy for crisis services applies, other than the office setting); first 60 minutes). The psychiatrist **would be permitted to batch these qualifying services furnished to Susie and Natalie,** because the services were furnished to one or more patients (Susie and Natalie), the services were billed under comparable service codes (CPT code 90839 and HCPCS code G0017), and all other batching criteria were met.

Items and Services Are Considered to Relate to the Treatment of a Similar Condition if they are Anesthesiology, Radiology, Pathology, and Laboratory Items and Services, Were Furnished to One or More Patients, and Were Billed Under Service Codes Belonging to the Same Category I CPT Code Range

The final rules specify that qualified items and services are considered to relate to the treatment of a similar condition if the qualified IDR items or services are billed under the same Category I CPT code range for anesthesiology, radiology, pathology, and laboratory items and services, as specified in guidance (see Tables 2-4 below). The initiating party may batch together items and services within one of the code ranges below (e.g., CPT 75557 – 75989 for Diagnostic Radiology (Imaging): Heart, Vascular), but may not batch together items and services *across* different code ranges (e.g., CPT 77011 – 77014 for Radiologic Guidance: CT Guidance and CPT 77046 – 77067 for Breast Mammography: Mammography).[8] Comparable codes under different procedural coding systems (i.e., HCPCS) cannot be batched together within Category I CPT code ranges for their comparable codes.

TABLE 2: Radiology CPT Code Ranges for Permissible Batched Determinations

Radiology	CPT Code Range	Description
Diagnostic Radiology (Imaging)	70010 - 71555	Head and Neck, Chest
	72020 - 72295	Spine and Pelvis
	73000 - 73725	Upper Extremities, Lower Extremities
	74018 - 74363	Abdomen, Gastrointestinal Tract
	74400 - 74775	Urinary Tract, Gynecological and Obstetrical
	75557 - 75989	Heart, Vascular
	76000 - 76499	Other Procedures
	R0070 - R0076	Transportation, Portable Radiology Equipment

[8] If these items or services are provided to a single patient during a single patient encounter, the initiating party may batch them together as a single patient encounter under 26 CFR 54.9816-8(c)(4)(i)(C)(*1*), 29 CFR 2590.716-8(c)(4)(i)(C)(*1*), and 45 CFR 149.510(c)(4)(i)(C)(*1*), if all other batching criteria are met.

Radiology	CPT Code Range	Description
Diagnostic Ultrasound	76506 - 76642	Head and Neck, Chest
	76700 - 76776	Abdomen and Retroperitoneum
	76800 - 76873	Spinal Canal, Pelvis, Genitalia
	76881 - 76886	Extremities
	76932 - 76965	Ultrasonic Guidance Procedures
	76975 - 76999	Other Procedures
Radiologic Guidance	77001 - 77003	Fluoroscopic Guidance
	77011 - 77014	CT Guidance
	77021 - 77022	MRI Guidance
Breast Mammography	77046 - 77067	Mammography
Bone/Joint Studies	77071 - 77092	Bone/Joint Studies
Radiation Oncology	77261 - 77370	Clinical Treatment Planning, Medical Radiation Physics
	77371 - 77425	Stereotactic Radiation Treatment Delivery, Other, Radiation Treatment Delivery, Neutron Beam Radiation Delivery
	77427 - 77499	Radiation Treatment Management
	77520 - 77525	Proton Beam Treatment Delivery
	77600 - 77620	Hyperthermia, Clinical Intracavitary Hyperthermia
	77750 - 77799	Clinical Brachytherapy
Nuclear Medicine	78012 - 78999	Diagnostic Nuclear Medicine
	79005 - 79999	Therapeutic Nuclear Medicine

TABLE 3: Pathology and Laboratory CPT Code Ranges for Permissible Batched Determinations

CPT Code Range	Description
80047 – 80081	Organ or Disease Oriented Panels
80143 – 80299, 80305 - 80377	Drug Assay, Therapeutic Drug Assay
80400 – 80439	Evocative Suppression Testing
80503 – 80506	Pathology Clinical Consultations, Molecular Pathology
81105 – 81383	Molecular Pathology Tier I
81400 - 81408, 81479	Molecular Pathology Tier II

CPT Code Range	Description
81410 - 81471, 81490 – 81599	Genomic Sequencing and Other Molecular Multianalyte Assays, Multianalyte Assays with Algorithmic Analysis
81000 – 81099	Urinalysis
82009 – 84999	Chemistry
85002 – 85999	Hematology and Coagulation
86000 - 86849, 86850 – 86999	Immunology, Transfusion Medicine
87003 – 87999	Microbiology
88104 - 88199, 88230 – 88299	Cytopathology and cytogenetic studies
88000 – 88099	Anatomic Pathology
88300 – 88399	Surgical Pathology
88720 - 88749, 89049 – 89240	In Vivo, Other Procedures
89250 – 89398	Reproductive Medicine Procedures
0001U - 0520U	Proprietary Laboratory Analysis
P2028 - P2038, P3000 - P3001, P7001, P9603 - P9604, P9612 - P9615	Laboratory Tests of Blood and Hair, Pap Smears, Urine Bacterial Culture and Sensitivity Studies, Specimen Collection Travel Allowance, Specimen Collection, Catheterization
P9010 - P9100	Blood and Blood Products

TABLE 4: Anesthesiology CPT Code Ranges for Permissible Batched Determinations

CPT Code Range	Description
00100 – 00222	Head
00300 – 00352	Neck
00400 – 00474	Thorax (Chest Wall and Shoulder Girdle)
00500 – 00580	Intrathoracic
00600 – 00670	Spine and Spinal Cord
00700 – 00797	Upper Abdomen
00800 – 00882	Lower Abdomen
00902 – 00952	Perineum
01112 – 01173	Pelvis (Except Hip)
01200 – 01274	Upper Leg (Except Knee)
01320 – 01444	Knee and Popliteal Area
01462 – 01522	Lower Leg (Below Knee, Includes Ankle and Foot)
01610 – 01680	Shoulder and Axilla
01710 – 01782	Upper Arm and Elbow
01810 – 01860	Forearm, Wrist and Hand

CPT Code Range	Description
01916 – 01942	Radiological Procedures
01951 – 01953	Burn Excisions or Debridement
01958 – 01969	Obstetric
01990 – 01999	Other Procedures

The Departments will review annual updates to the American Medical Association's CPT Code Manual and update this guidance document as needed. However, it is the Departments' understanding that these code ranges typically do not undergo substantial changes year over year, so frequent updates to this guidance are not anticipated.

Example 3: Four Patients Involved in Separate Motor Vehicle Accidents Receive Radiology Services at the Same Hospital

Each patient arrives at the emergency room of an in-network hospital following their respective accidents. Patients Anne, Fabio, Trisha, and Bill receive a computed tomography (CT) of the head, a CT of the lumbar spine, x-ray of the right wrist, and x-ray of the sternum, respectively. All four have coverage from the same health insurance issuer. The same radiologist who is out-of-network for all four people interprets their radiology studies. The radiologist bills the issuer as follows:

- For Anne under CPT code 70450 (Computed tomography head or brain without contrast material)
- For Fabio under CPT code 72131 (Computed tomography of the lumbar spine without contrast material)
- For Trisha under CPT code 73110 (Radiologic examination, wrist complete, minimum of 3 views)
- For Bill under CPT code 71120 (Radiologic examination, sternum, minimum of 2 views)

The radiologist submits separate claim forms for each patient under her NPI. Their issuer sends an initial payment for each claim to the radiologist, which the radiologist believes to be insufficient for the services provided, and the radiologist initiates open negotiation for each claim within the required timeframes. The parties do not reach an agreement on payment during open negotiation. Within the required timeframes, the radiologist initiates the Federal IDR process.

Radiology Items and Services

The radiologist **could batch the items and services for Anne and Bill** because the items and services were for radiology, were furnished to one or more patients, and were billed under service codes belonging to the same Category I CPT code range (70010 - 71555), and all other batching criteria were met. However, the radiologist could not include the items and services for either Fabio (72131) or Trisha (73110) in the batch with Anne and Bill because the service codes for Fabio and Trisha are in different Category I CPT code ranges than the codes for Anne (70450) and Bill (71120).

The radiologist also could not batch the items and services for Fabio with Trisha because their codes are in different Category I CPT code ranges (72020 - 72295, 73000 - 73725, respectively).

Computed Topography (CT) for Spine and Pelvis Diagnostic Radiology

Anne also receives a CT of the cervical spine, which is billed under CPT code 72125 (CT, cervical spine, without contrast material) by the same out-of-network radiologist. Here, the radiologist **could batch Anne's CT of the cervical spine (72125) with Fabio's CT of the lumbar spine (72131)** because the items and services were for radiology, were furnished to one or more patients (Anne and Fabio), and were billed under services codes belonging to the same Category 1 CPT code range (72020 - 72295); and all other batching criteria were met.

Alternatively, the radiologist could batch Anne's items and services together as a single patient encounter batch if the items and services were provided on the same claim form on the same or consecutive days, despite the fact that they are in different Category I CPT code ranges (see example 1). If the radiologist chose to batch Anne's items and services together under the single patient encounter, the radiologist could not include services for any other patient in the batch.

Example 4: Pathology and Laboratory Services

Patients John and Sarah are both treated at an in-network emergency department for chest pain on the same day and have coverage from the same health insurance issuer. A cardiac workup is performed along with six cardiac laboratory studies for both John and Sarah, and for which the out-of-network laboratory bills the following identical CPT codes for both patients:

- 82550 (Creatine kinase (CK), (CPK), total)
- 82553 (CK, MB fraction only)
- 84484 (Troponin, quantitative)
- 83880 (Natriuretic peptide)
- 85610 (Prothrombin time)
- 85730 (Thromboplastin time, partial (PTT); plasma or whole blood)

The laboratory submits separate claim forms for each patient under its NPI to their health insurance issuer. Their issuer sends a notice of denial of payment for each claim to the laboratory, and the laboratory initiates open negotiation within the required timeframes for each claim. The parties do not reach an agreement on payment for either claim during open negotiation. Within the required timeframes, the laboratory initiates the Federal IDR process.

The laboratory **could batch the items and services related to CPT codes 82550, 82553, 84484, and 83880 for both John and Sarah and separately batch CPT codes 85610 and 85730 for both patients,** because these laboratory items and services were furnished to one or more patients, and were billed under the service codes belonging to the same Category I CPT code ranges (82009 – 84999 and 85002 - 85999, respectively), and all other batching criteria were met. Alternatively, the laboratory could submit separate batches for John's single patient encounter and Sarah's single patient encounter.

Service Code Modifiers

A service code modifier provides a more specific description of the furnished item or service and may adjust the payment rate or affect the processing or payment of the code billed. Service code modifiers are appended to the service code and are submitted on the same line as the service code on a claim. Currently in the Federal IDR process, service code modifiers are not treated as line items for which disputing parties can submit an offer and receive a payment determination; instead, they are treated as codes with additional information that may alter the payment of a primary service code. Service code modifiers can be included in single, bundled, or batched disputes.

Service code modifiers do not count toward the 50-line-item limit, as they are not considered line items in the Federal IDR process.

Anesthesia Qualifying Circumstances Add-on Codes

Some anesthesia services are provided under difficult circumstances and, to document such circumstances, providers often use one or more of the following four qualifying circumstances add-on codes, as appropriate:

99100 - Anesthesia for patient of extreme age, younger than 1 year and older than 70

99116 - Anesthesia complicated by utilization of total body hypothermia

99135 - Anesthesia complicated by utilization of controlled hypotension

99140 - Anesthesia complicated by emergency conditions (specify)

These qualifying circumstances add-on codes function like service code modifiers in that they provide additional information about the circumstances of the anesthesia service and may alter the payment of the primary service code. Therefore, these anesthesia qualifying circumstances add-on codes should not be reported alone but should be reported as additional codes qualifying an anesthesia procedure or service.

Like service code modifiers, the anesthesia qualifying circumstances add-on codes are always associated with a primary anesthesia CPT service code on the claim, but unlike service code modifiers, the qualifying circumstances add-on codes are not billed on the same line as the anesthesia service code. Payers vary in whether they bundle these qualifying circumstances add-on codes together under the primary anesthesia code for one payment or provide separate payment for these qualifying circumstances add-on codes.

Initiating parties may submit a batched or bundled dispute that includes qualified IDR items and services that are billed with any of the four anesthesia qualifying circumstances add-on codes, provided they are submitted together with the primary anesthesia service code for the qualified item or service on the same date of service. These anesthesia qualifying circumstances add-on

codes cannot be initiated as a single, non-bundled line-item dispute. A batch cannot include solely qualifying circumstances add-on codes without the primary anesthesia service code(s).

When payment for an anesthesia qualifying circumstances add-on code is bundled with the primary anesthesia code, the initiating party should:

- Initiate the dispute as a bundle, with the primary anesthesia code as the bundled service code and the appended anesthesia qualifying circumstances add-on code as a component service code.

When payment for an anesthesia qualifying circumstances add-on code is made separate from the reimbursement for the primary anesthesia code, the initiating party should:

- Create a batched dispute with one or more line items for the primary anesthesia service code(s). The initiating party should not create dispute line items for the appended anesthesia qualifying circumstances add-on code(s). The information about the anesthesia qualifying circumstances add-on code would be collected separately in the Federal IDR process (e.g., in the supporting documents submitted with the offer).
- Submit an offer for the primary anesthesia code that accounts for the difficult circumstance conveyed by the qualifying circumstances add-on code(s). The initiating party should not submit a separate offer for the anesthesia qualifying circumstances add-on code(s) since this amount should already be included in the offer for the primary anesthesia service code. The anesthesia qualifying circumstances add-on codes(s) would not be separate line items in the dispute.
- Include in their offer supporting documents information about the anesthesia qualifying add-on codes associated with the primary anesthesia circumstances service codes included in the batch.

The anesthesia qualifying circumstances add-on codes would not affect the ability to batch according to anesthesia CPT Category I code ranges (e.g., not all primary anesthesia service codes in the batch need to have the same anesthesia qualifying circumstance add-on code(s)).

Similarly to service code modifiers, anesthesia qualifying circumstances add-on codes do not count toward the 50-line-item limit, as they are not treated as line items in the Federal IDR process.

Example 5: Four Patients are Admitted to the Hospital and Receive Anesthesia Services

Isabella is admitted to the hospital for a vaginal delivery with anesthesia, Calliope is admitted for an emergency cesarean delivery, Abigail (age 11 months) is admitted for an appendectomy, and Mac (age 9 months) is admitted for spinal surgery. These four patients have coverage from the same health insurance issuer under which the anesthesiologist is out-of-network. The anesthesiologist bills for anesthesia as follows:

- For Isabella under CPT code 01960 (Anesthesia for vaginal delivery only).

- For Calliope under CPT code 01961 (Anesthesia for cesarean delivery only) and 99140 (Anesthesia complicated by emergency conditions) to indicate anesthesia complicated by emergency conditions.
- For Abigail under CPT code 00840 (Anesthesia for intraperitoneal procedures in lower abdomen including laparoscopy, not otherwise specified) and 99100 (Anesthesia for patient of extreme age, younger than 1 year or older than 70) to indicate anesthesia complicated by age younger than 1 year.
- For Mac under CPT code 00670 (Anesthesia for extensive spine and spinal cord procedures (e.g., spinal instrumentation or vascular procedures)) and 99100 (Anesthesia for patient of extreme age, younger than 1 year or older than 70) to indicate anesthesia complicated by age younger than 1 year.

The anesthesiologist submits separate claim forms for each patient under her NPI. The issuer sends an initial payment for each claim to the anesthesiologist, and the anesthesiologist initiates open negotiation for each claim within the required timeframes. The parties do not reach an agreement on payment during open negotiation. Within the required timeframes, the anesthesiologist initiates the Federal IDR process.

Anesthesia for Obstetrics

The anesthesiologist **would only be permitted to batch the items and services furnished to Isabella (01960) and Calliope (01961)** because they were billed under service codes belonging to the same Category I CPT code range for obstetric anesthesia codes (01958 - 01969), and all other batching criteria were met.

Calliope's claim also contains the qualifying circumstances add-on code of 99140 (Anesthesia complicated by emergency conditions). Batching is based on the primary anesthesia service code and not the qualifying circumstances add-on code for anesthesia. Therefore, Isabella and Calliope's claims could still be batched.

Anesthesia Billed with Qualifying Condition Codes

The anesthesia **items and services for Abigail and Mac could not be batched together** because their primary anesthesia service codes (00840 and 00670, respectively) are not in the same Category I CPT code range (00800 - 00882 and 00600 - 00670, respectively). Although both claims include the same qualifying circumstances add-on code, batching is based on the primary anesthesia service code and not the qualifying circumstances add-on code.

In summary, the anesthesiologist would have to submit three separate disputes for these four patients:

- The claims for Isabella (01960) and Calliope (01961, with information about qualifying circumstance add-on code 99140) can be submitted as a batched dispute because these primary anesthesia codes belong to the same Category I CPT code range, obstetric anesthesia codes (01958 – 01969),

- Single dispute for Abigail (00840), and
- Single dispute for Mac (00670).

Traditional Add-on Codes

Traditional CPT add-on codes are 5-digit CPT codes that must be billed with a specific primary CPT code.[9] This contrasts with service code modifiers and anesthesia qualifying circumstances add-on codes which can be billed with any primary CPT code. For example, traditional CPT add-on code +01968 (Anesthesia for cesarean delivery following neuraxial labor analgesia/anesthesia) may only be billed with the code for primary procedure 01967 (Neuraxial labor analgesia/anesthesia for planned vaginal delivery).

Traditional CPT add-on codes also differ from service code modifiers and anesthesia qualifying circumstances add-on codes because they are codes for separate procedures. Further, unlike service code modifiers, they may be paid separately and a plan or issuer may not require them to be exclusively bundled with their primary service code. Additionally, anesthesiology, radiology, laboratory, and pathology traditional add-on codes are already included in the Category I CPT code ranges described in Tables 1, 2, and 3.

Disputes including qualified IDR items and services that were billed using a traditional CPT add-on code can be initiated as a single (non-bundled) dispute or a batched dispute solely containing the traditional add-on codes. The traditional add-on codes can also be initiated as a batch with their associated primary service code, if they meet all other batching requirements. The traditional add-on code can be included in a bundled dispute as a component line item with the associated primary service code if it meets the definition of a bundled payment arrangement. Traditional add-on codes are submitted as separate dispute line items and count toward the 50-line-item limit in a batched dispute.

Batched Items and Services Must Have Been Furnished Within the Same Time Period

Under the final rules, batched qualified IDR items and services must have been furnished within the same 30-business-day period following the date on which the first item or service included in the batched dispute was furnished, and must have been the subject of a 30-business-day open negotiation period that ended within 4 business days of IDR initiation, except if the items and services are subject to the cooling off period, as described below.

The Cooling Off Period

Under the final rules, the party that initiated the Federal IDR process may not submit a subsequent Notice of IDR Initiation involving the same other party with respect to a claim for the same item or service that was the subject of a prior payment determination during the 90-calendar-day cooling off period if the prior determination was for a single line item dispute, and

[9] Some traditional CPT add-on codes must be reported with one specific primary CPT code. Other traditional CPT add-on codes must be reported with one of a few options of specific primary CPT codes, as appropriate for the services furnished.

during the 30-business-day cooling off period if the prior determination was for a batched dispute. The date of the payment determination is day one of the cooling off period.

The Departments interpret the phrase "same item or service" to mean a health care item or service billed under the same service code (including traditional add-on code(s)), regardless of any service code modifier(s) or anesthesia qualifying circumstances add-on code(s).

For a party that is a health plan or health insurance issuer or Federal Employees Health Benefits (FEHB) carrier, the Departments define "same other party" in the same way it defines "same group health plan or health insurance issuer" for batching purposes (see page 5). As a result:

- For fully-insured group and individual health plans, qualified IDR items or services are subject to the cooling off period only if a payment determination was rendered for qualified IDR items and services paid for by the same issuer, even if the qualified IDR items and services relate to claims from different fully-insured group or individual health plan coverage insured by the issuer. The same issuer is defined as the issuer at the state level and is identified by the issuer's 5-digit HIOS prior to the applicability of the health plan registry provisions. After the applicability date of the health plan registry, the same issuer can also be identified by its unique health plan registry number.
- For self-insured group health plans, qualified IDR items or services are subject to the cooling off period only if a payment determination was rendered for qualified IDR items and services paid for by the same plan. Qualified IDR items or services are not subject to the cooling off period if they were paid for by different self-insured group health plans, even if those plans are administered by the same third-party administrator (TPA). The self-insured group health plan can be identified by the plan's TIN or, if the plan does not have a TIN, by the plan sponsor's EIN or TIN; and the three-digit plan number from IRS form 5500 or, if the plan does not have a plan number, by the plan's name. After the applicability date of the health plan registry provisions, a self-insured group health plan can also be identified by its unique health plan registry number.

For a party that is a provider, facility, or provider of air ambulance services, the Departments define "same other party" in the same way it defines "same provider, facility, or provider of air ambulance services" for batching purposes (see page 5). As a result, the qualified IDR items and services are subject to the cooling off period if a payment determination was rendered regarding items and services billed by the same provider or group of providers, the same facility, or same provider of air ambulance services, identified by NPI or TIN.

Cooling Off Period for Batched vs. Single Disputes

The Departments reduced the cooling off period from 90 calendar days to 30 business days for batched disputes. This shorter cooling off period for batched disputes mitigates concerns regarding the complexity of applying the cooling off period to payment determinations for batched disputes, given the new batching provisions in the final rules.

If a dispute is initiated as a batched dispute and a certified IDR entity renders a payment determination, the 30-business-day batched cooling off period would apply. This means a disputing party would not be able to initiate a single or batched dispute with the same other party which includes any of the same items or services during the 30-business-day period that begins on the day the payment determination is issued.

If a dispute is initiated as a single dispute and a certified IDR entity renders a payment determination, the 90-calendar-day single dispute cooling off period would apply. This means a disputing party would not be able to initiate a single or batched dispute with the same other party which includes the same item or service during the 90-calendar-day period that begins on the day the payment determination is issued.

Overlapping Cooling Off Periods

If a dispute for an item or service receives a payment determination after the date another dispute involving the same item or service and with the same non-initiating party is initiated, but before that dispute receives a payment determination, this may result in overlapping cooling off periods. Each payment determination triggers a cooling off period, during which the initiating party cannot initiate a new dispute for any of the same items or services involving the same non-initiating party. Each cooling off period begins on the day the payment determination is issued. It is not necessary to wait for one cooling off period to end for a second to begin; the cooling off periods may overlap. The certified IDR entity must find items and services subject to a cooling off period to be ineligible for the Federal IDR process and should list the ineligible reason as "cooling off period not completed."

Process of Submitting Disputes Subject to a Cooling Off Period

Qualified IDR items and services with open negotiation periods that ended during a cooling off period or during overlapping cooling off periods can be submitted during the applicable submission window (described below) following the last day of the final cooling off period. Additionally, qualified IDR items and services with open negotiation periods that ended during the 30 business days *prior* to the cooling off period for a *batched* dispute only can also be submitted during the applicable submission window following the last day of the final cooling off period.

In either circumstance, if a batched dispute submitted after the end of a cooling off period includes items and services with multiple open negotiation periods, the initiating party should indicate the open negotiation period start date for the first claim in the batch on the Notice of IDR Initiation web form and should also submit evidence of all the open negotiation periods relevant to the batch in the supporting documentation part of the Notice of IDR Initiation web form. The certified IDR entity should confirm that all items and services in the batch had open negotiation periods that ended within the same cooling off period or during overlapping cooling off periods, or, if applicable, within 30 business days prior to the batched cooling off period.

Submission Window for Batched vs. Single Disputes Subject to the Cooling Off Period

The length of the submission window for submitting the dispute varies depending on whether the cooling off period was for a single dispute or a batched dispute:

- After a 90-calendar-day cooling off period for a single dispute, either party may submit a subsequent Notice of IDR Initiation within 30-business-days following the end of the cooling off-period. The 30-business day period begins on the day after the last day of the cooling off period.
- After a 30-business-day cooling off period for batched disputes, either party may submit a subsequent Notice of IDR Initiation within 4 business days following the end of the cooling-off period. The 4-business-day time period begins on the business day after the last day of the cooling off period.

In the case of overlapping cooling off periods, the submission window is determined by the last cooling off period. If the last cooling off period was for a batched determination, the submission window is 4-business-days following the end of the cooling off period. If the last cooling off period was for a single determination, the submission window is 30-business-days following the end of the cooling off period.

Example 6: Single Dispute's Cooling Off Period

A certified IDR entity issues a payment determination for a single dispute involving CPT code 99284 (Emergency department visit for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making) on February 4, 2027 (Dispute A). Because this is a single dispute, the cooling off period is 90 calendar days, running from February 4, 2027, through May 4, 2027. Neither party may initiate a single or batched dispute for CPT code 99284 against the same disputing party during this time.

The open negotiation period for another dispute involving the same parties and the same CPT code (Dispute B) ends on February 15, 2027, which is during the cooling off period for Dispute A. Either party may initiate Dispute B during the 30-business-day period following the end of the cooling off period for Dispute A (May 5, 2027 through June 16, 2027), as long as another cooling off period does not apply.

Example 7: Batched Dispute's Cooling Off Period

A certified IDR entity issues a payment determination on February 12, 2027, for a batched dispute that includes CPT codes 93000 (Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report) and 86701 (Antibody; HIV-1) during a single patient encounter (Dispute A). Because this is a batched dispute, the cooling off period is 30 business days, running from February 12, 2027, through March 26, 2027. Neither party may initiate a single or batched dispute for CPT codes 93000 or 86701 against the same disputing party during this time.

Example 7.1: Initiating a Dispute with an Open Negotiation Period Ending ***During a Batched Dispute's Cooling Off Period***

The open negotiation period for another dispute involving the same parties and CPT code 93000 (Dispute B) ends on February 15, 2027, which is during the cooling off period for Dispute A. Either party may initiate Dispute B during the 4-business-day period following the end of the cooling off period for Dispute A (March 29, 2027, through April 1, 2027), as long as another cooling off period does not apply.

Example 7.2: Initiating a Dispute with an Open Negotiation Period Ending ***During the 30 Business Days Prior to a Batched Dispute's Cooling Off Period***

Assume instead, the open negotiation period for another dispute involving the same parties and the same CPT code 93000 (Dispute B) ends on February 5, 2027, which is during the 30-business-day period *prior to* the cooling off period for Dispute A.

Either party may initiate Dispute B during the 4-business-day period after the end of the open negotiation period for Dispute B (February 8, 2027, through February 11, 2027), as generally permitted, because the cooling off period for Dispute A has not begun, as long as another cooling off period does not apply.

Alternatively, a party may wait until the end of the cooling off period for Dispute A to initiate Dispute B. Specifically, either party may initiate Dispute B during the 4-business-day period following the end of the cooling off period for Dispute A (March 29, 2027, through April 1, 2027), as long as another cooling off period does not apply.

Example 8: Overlapping Cooling Off Periods

Dispute A

A provider initiates a single dispute involving CPT code 96372 (Therapeutic, prophylactic, or diagnostic injections or infusion (excludes chemotherapy and other highly complex drug or highly complex biologic agent administration)) against an issuer (Dispute A). The certified IDR entity issues a payment determination on March 4, 2027. The cooling off period for Dispute A runs from March 4, 2027, through June 1, 2027 (90 calendar days). Neither party may initiate a single or batched dispute for CPT code 96372 against the same disputing party during this time.

Dispute B

The same provider wants to initiate a second single dispute against the same issuer involving CPT code 96372 (Dispute B). Dispute B has an open negotiation period that ends on January 13, 2027. The provider initiates the IDR process for Dispute B on January 14, 2027. Dispute B was

not initiated during the cooling off period for Dispute A, because it was initiated before the payment determination for Dispute A was made on March 4, 2027.

The certified IDR entity issues a payment determination for Dispute B on March 5, 2027. The cooling off period for Dispute B runs from March 5, 2027, through June 2, 2027 (90 calendar days). This results in overlapping cooling off periods for Disputes A and B, from March 4, 2027 through June 2, 2027.[10] Neither party may initiate a single or batched dispute for CPT code 96372 against the same disputing party during this time.

Dispute C

The same provider wants to initiate a third single dispute against the same issuer involving CPT code 96372 (Dispute C). Dispute C has an open negotiation period that ends on March 12, 2027, which is during the overlapping cooling off periods for Disputes A and B.

Either party may initiate Dispute C beginning on the first business day after the end of the last cooling off period (June 3, 2027), and has 30 business days to do so (from June 3, 2027, to July 16, 2027)[11]

Example 9: Batched and Single Disputes' Cooling Off Periods

Dispute A – Batched Dispute

A certified IDR entity issues a payment determination on February 9, 2027, for a batched dispute involving the following four service codes for a single patient episode of care:

- CPT codes 99285 (Emergency department visit for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making),
- CPT 85025 (Blood count, complete (CBC), automated (Hgb, Hct, RBC, WBC, and platelet count) and automated differential WBC count),
- CPT 96374 (Therapeutic, prophylactic or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug), and
- CPT 96360 (Intravenous infusion, hydration; initial, 31 minutes to 1 hour).

This batched dispute (Dispute A) results in a 30-business-day cooling off period from February 9, 2027, through March 23, 2027. Neither party may initiate a single or batched dispute for CPT codes 99285, 85025, 96374, or 96360 during this time.

Dispute B – Batched Dispute

[10] The first cooling off period (Dispute A) starts on March 4, 2027, and the last cooling off period (Dispute B) ends on June 2, 2027).

[11] The last cooling off period (Dispute B) ends on June 2, 2027.

The same provider wants to initiate a second batched dispute against the same issuer involving CPT codes 99285 and 85025 (Dispute B). Dispute B has an open negotiation period that ends on March 8, 2027, which is during the cooling off period for Dispute A. Either party may initiate Dispute B beginning on the first business day after the end of the cooling off period for Dispute A (March 24, 2027), and has 4 business days to do so (from March 24, 2027, to March 29, 2027), as long as another cooling off period does not apply.

The provider initiates Dispute B on March 25, 2027. The certified IDR entity issues a payment determination on May 13, 2027. The cooling off period for Dispute B runs from May 13, 2027, through June 25, 2027. Neither party may initiate a single or batched dispute for CPT codes 99285 or 85025 during this time.

Dispute C – Single Dispute
The same provider wants to initiate a third single dispute against the same issuer involving CPT code 99285 (Dispute C). Dispute C has an open negotiation period that ends on June 3, 2027, which is during the cooling off period for Dispute B.

Either party may initiate the Federal IDR process for Dispute C beginning on the first business day after the end of the cooling off period for Dispute B (June 28, 2027), and has 4 business days to do so (from June 28, 2027, to July 1, 2027), as long as another cooling off period does not apply.

The provider initiates the IDR process for Dispute C on July 1, 2027. The certified IDR entity issues a payment determination on August 18, 2027. The cooling off period for Dispute C runs from August 18, 2027, through November 15, 2027 (90 calendar days).

Removing Flexibility to Resubmit Incorrectly Batched Disputes

The ability to resubmit incorrectly batched disputes will no longer be available 120 days following the applicability of the IDR registry provisions. The IDR registry provisions are applicable 90 business days after the Departments issue guidance announcing that the functionality supporting the registry has become available. Certified IDR entities who determine a dispute to be inappropriately batched are directed to proceed with rendering payment determinations for the items or services that are found to be properly batched.

Line-item Limit

The final rules include a 50-line-item limit for batched disputes. This guidance clarifies that service code modifiers and anesthesia qualifying circumstances add-on codes that function as modifiers do not count toward this 50-line-item limit.

Definition of a Bundled Payment Arrangement

The final rules define a bundled payment arrangement as an arrangement under which:

1. A provider, facility, or provider of air ambulance services bills for multiple items or services furnished to a single patient under a single service code that represents multiple items or services (for example, a DRG code); or
2. A plan or issuer makes an initial payment or notice of denial of payment to a provider, facility, or provider of air ambulance services under a single service code that represents multiple items or services furnished to a single patient (for example, a DRG code).

Example 10: Bundled Payment Arrangement for Breast Mammography

A provider performed multiple items and services that were billed under CPT code 77066 (Diagnostic mammography . . . bilateral).[12] Because the items and services are billed under one service code (CPT 77066), they may be considered a bundled payment arrangement and treated as part of a single determination for purposes of the Federal IDR process.

[12] The National Correct Coding Initiative (NCCI) Policy Manual states that a physician who performs bilateral mammography shall report CPT code 77066 (Diagnostic mammography... bilateral). It further states that the provider shall not report CPT code 77065 (Diagnostic mammography... unilateral) with 2 UOS or 77065 LT (unilateral left breast mammography) plus 77065 RT (unilateral right breast mammography).

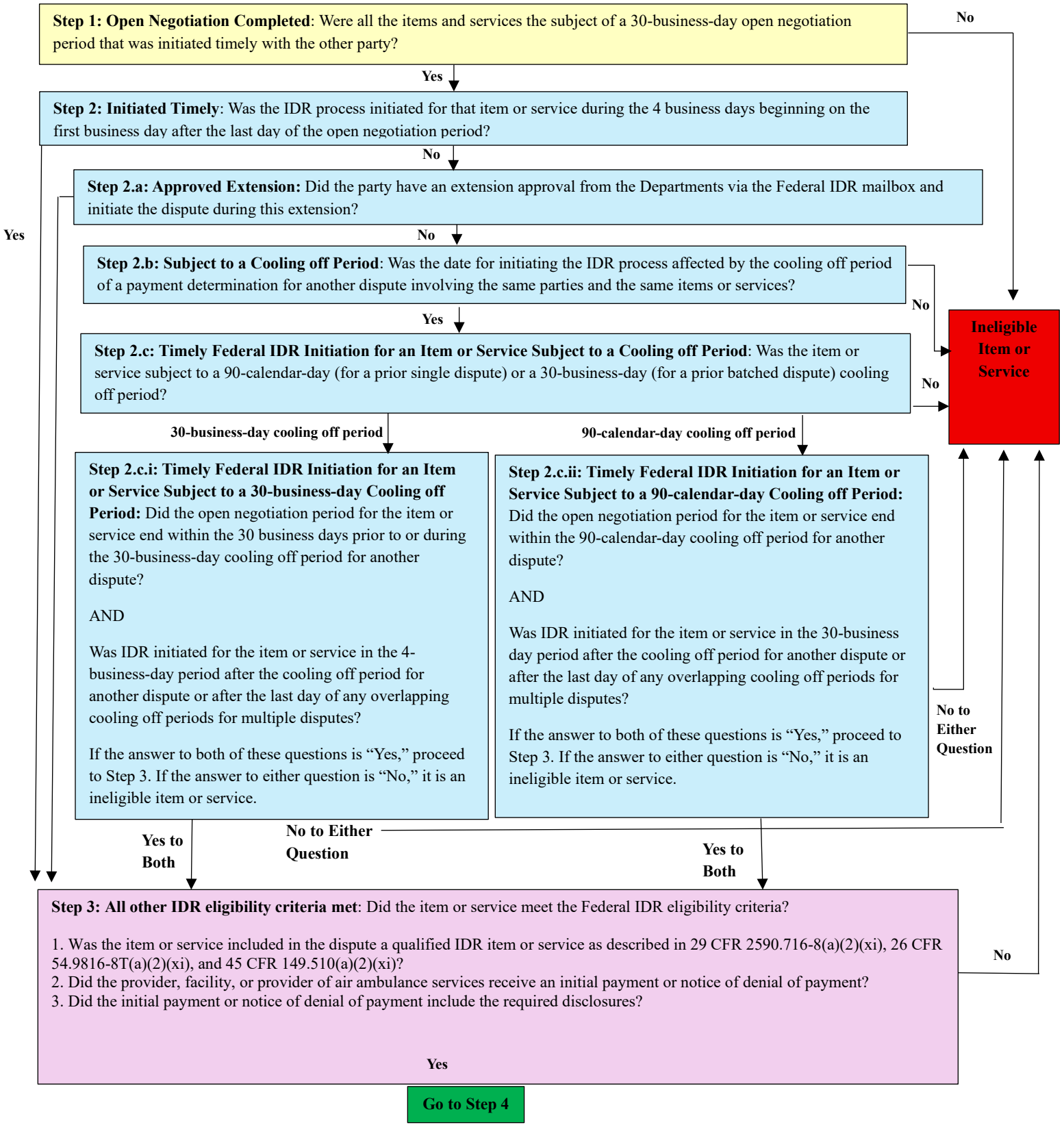
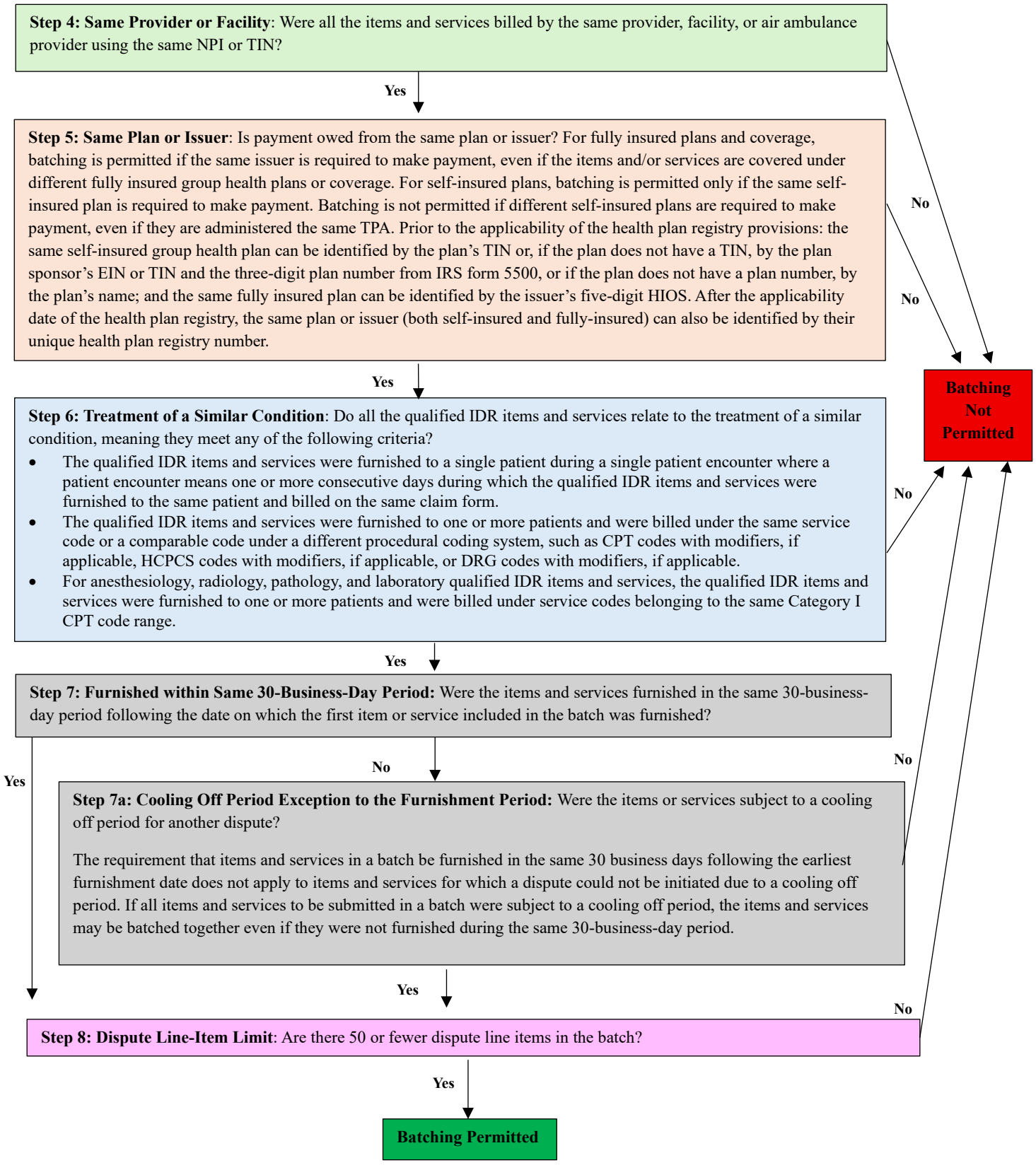
Appendix

Summary of Batching Requirements Based on Ways in Which a Batch May Be Related to the Treatment of a Similar Condition

Requirement	Ways in Which a Batch May Be Related to the Treatment of a Similar Condition		
	Single Patient Encounter Pathway	**Same or Comparable Service Code Pathway**	**Certain Anesthesiology, Radiology, Pathology and Laboratory CPT Code Range Pathway**
Line-item cap	50 or fewer	50 or fewer	50 or fewer
Same provider entity	Yes	Yes	Yes
Same payer requirement	Yes	Yes	Yes
Treatment of a similar condition test	Met by same patient, same encounter, one or more consecutive days, same claim form	Met if items/services were furnished to one or more patients and billed under the same service code or a comparable code under a different procedural code system	Met for certain anesthesiology, radiology, pathology, and laboratory items/services if billed under service codes in the same Category I CPT code range specified in guidance
Single claim form required	Yes	No	No
Same patient required	Yes	No	No
Consecutive days required	Yes	No	No
Same or comparable code requirement	No	Yes	No; codes must fall within the same permitted Category I CPT code range
Limited to certain specialties	No	No	Yes: anesthesiology, radiology, pathology, and laboratory

Federal IDR Process Batching Decision Tree

I. Ensure the Item or Service is Eligible for the Federal IDR Process



II. Ensure the Item or Service Meets the Criteria for Batching