5 COMMON PAYER STRATEGIES

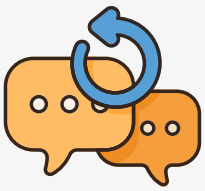
Impacting Your Insurance A/R & How to Overcome Them

REVCO SOLUTIONS

ADMINISTRATIVE FRICTION AND PAYMENT DELAYS

The claim isn't stuck.
The system is designed that way.

Unlike a denial, which creates a visible reimbursement barrier, administrative friction often manifests as repeated requests, additional reviews, and procedural requirements that delay payment and incur substaintially higher cost to collect without necessarily changing the final reimbursement outcome.



Repeated or Excessive Medical Record Requests

When records are requested multiple times despite prior submission, resolution timelines are extended while staff spend additional time gathering and resubmitting information rather than working new inventory, increasing labor costs and delaying reimbursement.

Manual Review Queues

A claim meets all submission requirements and is accepted by the payer but is routed to a manual review queue due to claim value, diagnosis complexity, utilization concerns, or payer-specific review criteria. Payment delays occur even when no additional provider action is required.

Multiple Appeal Layers

Providers must navigate several levels of appeal before resolution. Even highly defensible claims can remain unresolved for extended periods, increasing administrative costs and delaying reimbursement.

Claim Reprocessing Cycles

A provider may correct a denial and resubmit the claim, only for the payer to issue a different denial reason or request additional information. The claim then enters another correction, submission, and review cycle. These reprocessing loops may occur multiple times before final resolution.

YOUR NEXT STEPS

Warning Signs

Claims remain in the same payer status for 30+ days with no clear path to resolution

The same claims are being touched three or more times before payment

Corrected claims continue cycling back with new denial reasons

The same payer repeatedly requests information already submitted

What to Monitor

DAYS IN A/R BY PAYER
Investigate when a payer consistently exceeds your average by 15–20 days

APPEAL TURNAROUND TIME
Compare against payer contract requirements or your own historical baseline

CLAIM TOUCH RATE
Claims should not exceed 3+ touches per claim

Action Checklist

- [ ] **Automate follow-up workflows**
  Establish automated work queues, reminders, and escalation triggers to ensure claims receive timely follow-up throughout the reimbursement lifecycle.
- [ ] **Track payer-specific cycle times**
  Not all payers create the same level of administrative burden. Delays can appear to be general A/R challenges, so measure how long individual payers take to process claims, review documentation, and submit appeals/reimbursements for better visibility.
- [ ] **Create escalation pathways for aged claims**
  Develop predefined workflows that route unresolved claims to specialized resources once they exceed established aging thresholds.
- [ ] **Standardize documentation requirements**
  Create payer-specific documentation templates and submission protocols for common denial and appeal scenarios that are shared with all necessary departments.
- [ ] **Monitor repeat administrative barriers**
  Track recurring payer behaviors such as duplicate record requests, excessive documentation requirements, repeated claim reprocessing, or prolonged manual reviews.
- [ ] **Automate medical record submission**
  For payers that permit it, submitting medical records with the initial claim can help prevent downstream documentation-related denials.

UNDERPAYMENTS

Denials get reviewed.
Underpayments get missed.

Payers are increasingly shifting away from claim-by-claim review toward standardized payment algorithms designed for scale. These payment methodologies systematically reduce reimbursement, often without generating a formal denial.

Medicare-Based Reimbursement Formulas

Payers reimburse using a percentage of Medicare rates rather than billed charges or market reimbursement levels. Medicare rates often do not reflect specialty complexity, regional labor costs, staffing expenses, or commercial market dynamics.

Fee Schedule Discrepancies

Claims are systematically routed to fee schedules or reimbursement tables that may not align with current contract terms, resulting in automated underpayments that occur at scale with limited visibility.

Bundled Claim Repricing

Multiple services are grouped together and reimbursed as a single payment rather than reimbursing each component individually. Bundling can suppress reimbursement for high-cost services, specialty care, or resource-intensive encounters.

Interpretation Variances

The payer applies contract language, policies, coding guidelines, and reimbursement rules differently than expected, resulting in inconsistent and lower reimbursements.

Geographic Adjustments

Reimbursement logic is based on geographic assumptions that may not align with actual operating costs.

Hospitals

Hospitals may face additional underpayment issues, including contract reimbursement errors, incorrect DRG payments, missed carve-outs (high-cost implants, drugs, or devices), outlier/stop-loss payment errors, and authorization or medical necessity reductions.

YOUR NEXT STEPS

Warning Signs

Average reimbursement declines over 2–3 consecutive months with no contract changes

The same payer begins paying identical claims differently across facilities or service dates

Payment variances repeatedly fall just below escalation thresholds (e.g., 5–10%)

Specialties such as surgery, emergency medicine, cardiology, or behavioral health begin receiving lower reimbursement despite stable utilization

What to Monitor

CONTRACT VARIANCE RATE
Target <3% variance from modeled reimbursement

AVERAGE PAYMENT PER HIGH-VOLUME CPT
Track the top 20 CPTs by volume

REIMBURSEMENT YIELD BY PAYER
Yield dropping below ~90–92% for a single payer should be flagged and reviewed

UNDERPAYMENT RATE
Sustained movement above ~5–7% suggests systemic underpayment behavior rather than isolated variance

Action Checklist

- [ ] **Benchmark Reimbursement Vs. Expected Contract Rate**
  Compare current reimbursement performance against historical payment patterns to identify where payer behavior has shifted.
- [ ] **Track payment variance trends**
  Monitor reimbursement variation across payers, service lines, locations, and claim types to identify patterns of underpayment. Variation often reveals systematic reimbursement suppression that claim-level reviews miss.
- [ ] **Build payer methodology libraries**
  Create centralized documentation of how each payer calculates, negotiates, and processes reimbursement. Organizations frequently lose efficiency when reimbursement knowledge sits with individual employees instead of systems.
- [ ] **Establish escalation thresholds for dnderpayments**
  Define rules that determine when claims move beyond standard workflows into higher-priority review or dispute pathways. Without thresholds, organizations often spend equal effort on low-value and high-value recovery opportunities.

DENIALS

A denial is obvious.
The root cause usually isn't.

Payers apply coverage policies, medical necessity criteria, utilization management rules, and denial processes that limit reimbursement eligibility. These denials can be particularly difficult to manage because they often involve clinical judgment, evolving payer policies, and varying interpretations of medical necessity criteria.

Site-of-Service Restrictions

A payer denies or reduces reimbursement because the service was performed in a higher-cost setting than the payer considers appropriate, even when the care setting was clinically justified.

Observation vs. Inpatient Disputes

A payer challenges a patient's admission status, arguing that observation services were more appropriate than inpatient admission. These disputes commonly occur when the payer applies utilization review criteria that support a lower level of care.

Experimental or Investigational Determinations

A payer classifies a treatment, procedure, device, or therapy as experimental, investigational, or not yet supported by sufficient clinical evidence under its coverage policies - even if payer policies may lag behind evolving standards of care.

Coverage, Medical Necessity & Administrative Denials

Payers deny or reduce reimbursement when services do not align with coverage policies, medical necessity criteria, utilization management rules, or administrative requirements established by their own internal guidelines. Resolution for denials such as medical necessity, authorization, eligibility, timely filing, and technical claims typically requires clinical documentation, policy interpretation, and multi-level appeals.

It's time to rethink denials.
Doownload the white paper.

YOUR NEXT STEPS

Warning Signs

Denial rates remain stable, but appeal volume continues to rise

The same service line repeatedly receives the same denial reason

Physicians and clinical staff spend more time supporting appeals

Clusters of clinically-based denials may signal changes in payer utilization management or coverage policies

What to Monitor

DENIAL RATE BY PAYER
Typical overall denial rates often range 5–10%; sustained rates above 10–12% require investigation

DENIAL RATE BY SERVICE LINE
Watch for >15–20% increase in denial rate within a single service line over a 1–2 quarter period

APPEAL OVERTURN RATE
Healthy overturn rates often fall in the 40–60% range

REPEAT DENIAL RATE
Claims receiving the same or related denial *more than once* should be flagged for root cause analysis rather than repeated rework

Action Checklist

- [ ] **Maintain payer policy libraries**
  Develop and maintain a centralized repository of payer medical necessity guidelines, utilization management criteria, coverage policies, and authorization requirements. Include information such as payers with frequent policy changes, services commonly subject to medical necessity reviews, and variations in payer criteria for similar services.
- [ ] **Strengthen clinical documentation programs**
  Ensure clinical documentation clearly supports the medical necessity, severity of illness, treatment rationale, and care setting decisions associated with each encounter. Proactively identify missing clinical justification, incomplete physician documentation or admission status challenges.
- [ ] **Perform root cause analysis on recurring denials**
  Analyze denial trends to identify common drivers including repeat denial reasons, services lines with elevated denial rates, frequently challenged procedures, and payer-specific denial patterns.
- [ ] **Monitor policy updates**
  Establish a process or designate staff for regularly reviewing payer policy changes, utilization management updates, and coverage revisions. This should include new prior authorization requirements and changes in medical necessity criteria.
- [ ] **Develop specialty-specific appeal templates**
  Tailor to high-volume specialties and common denial scenarios including service lines with high appeal volumes, frequently denied procedures, and repetitive denial reasons.

POST-PAYMENT AUDITS

Settlement isn't the finish line.
It's a checkpoint.

Even after claims are paid, payers may conduct retrospective audits to identify perceived billing, coding, documentation, or reimbursement issues that can result in payment reductions or recoupments. Without effective reconciliation processes, providers risk increased administrative costs, disrupted cash flow, and hidden revenue leakage.

Recovery Audits

Payers or contracted recovery audit vendors retrospectively review previously paid claims to identify perceived overpayments or reimbursement errors. These reviews often target large populations of claims using data analytics and may occur months or even years after the original payment.

Clinical & Coding Validation Reviews

Payers perform post-payment reviews to determine whether the submitted documentation supports the diagnoses, procedures, DRG assignment, or level of service that was reimbursed. These reviews can lead to payment reductions or recoupments long after payment has been received, often requiring significant physician, coding, and revenue cycle resources to appeal.

Payment Recoupments & Offsets

After identifying a perceived overpayment, payers recover funds through direct repayment requests, claim adjustments, or by offsetting future reimbursements rather than issuing separate invoices. Offsets and recoupments can create unexpected cash flow disruptions, complicate payment reconciliation, and make it more difficult to accurately track reimbursement performance.

YOUR NEXT STEPS

Warning Signs

Net reimbursement declines after payment has already been posted

Audit requests become concentrated around specific DRGs, service lines, or diagnoses

A payer represents >30–40% of total annual recoupments despite not being proportional in claim volume

Future remittances include unexplained payment offsets

What to Monitor

RECOUPMENT RATE
Typical environments often see ~5–15% recoupment on reviewed claims; sustained rates above 15–20% should be flagged

POST-PAYMENT AUDIT VOLUME
Investigate when audit volume increases 20–30% over a 2–3 month baseline

NET FINANCIAL IMPACT
Watch for >2–5% erosion of gross reimbursement from post-payment adjustments

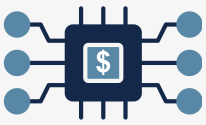
Action Checklist

- [ ] **Establish post-payment reconciliation processes**
  Compare remittance advice, audit findings, and recovery requests against contractual terms and prior payment history to validate that payer adjustments are accurate before accepting reductions.
- [ ] **Track audit activity by payer**
  Monitor which payers conduct the highest volume of post-payment reviews, the issues they commonly target, and the financial impact of those reviews to identify recurring patterns.
- [ ] **Build standardized audit response workflows**
  Develop consistent processes for routing audit requests, gathering documentation, engaging clinical and coding experts, and managing appeal deadlines.
- [ ] **Analyze recurring audit findings**
  Identify trends in coding, documentation, or reimbursement issues that repeatedly trigger post-payment reviews and use those insights to strengthen front-end processes.
- [ ] **Monitor recoupments and payment offsets**
  Reconcile repayment requests and offsets to ensure they align with audit determinations and contractual obligations, and promptly investigate unexplained reductions in future remittances.

OUT-OF-NETWORK TACTICS

No Contract. No Problem.
You Just Need a Strategy.

Out-of-network (OON) reimbursement presents a distinct set of financial and operational challenges beyond those affecting the broader insurance A/R landscape. While many common payer strategies from the categories above still apply, the absence of negotiated contract rates gives payers greater discretion in determining (and limiting) reimbursement.



Proprietary Reimbursement Algorithms

Payers or third-party vendors use internal methodologies that calculate payment amounts using nontransparent formulas. Providers often cannot validate how payment calculations were derived or challenge assumptions used in the methodology.

Implementing the Qualifying Payment Amount

Payers use the QPA as a negotiation anchor during OON reimbursement discussions. When negotiations become anchored around one benchmark, other reimbursement factors like acuity, training, case complexity, and market conditions may receive less weight.

Third-Party Repricers

External repricing vendors apply proprietary methodologies and benchmarks to determine reimbursement, with limited visibility into how payment amounts are calculated.

Silent PPO (Leased Network) Arrangements

Payers apply discounted reimbursement rates through leased or rented PPO networks, even when the provider is unaware the agreement exists, or may not have anticipated the network would be used for that claim.

Settlement Pressure Tactics

Providers are “encouraged” to accept reduced reimbursement in exchange for faster payment.

YOUR NEXT STEPS

Warning Signs

Reimbursement explanations become less transparent or harder to validate over time

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QPA becomes the dominant reference point in nearly all negotiations

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Longer negotiation cycles with no improvement in yield

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Reimbursement declines without corresponding changes in contract terms, coding, or patient acuity

What to Monitor

SETTLEMENT ACCEPTANCE RATE

Establish internal minimum reimbursement thresholds before settlement approval (e.g. settlements below 80–85% of your modeled reimbursement)

ALGORITHMIC REPRICING

Sustained payment variance greater than 10–15% or consistent reductions across similar claims may indicate algorithmic repricing rather than claim-specific adjudication.

Action Checklist

- [ ] **Build OON reimbursement benchmarks**
  Establish baseline reimbursement expectations by payer, service line, and claim type to identify underperformance, quantify variance, and strengthen negotiation leverage during disputes and settlements.
- [ ] **Maintain payer-specific negotiation playbooks**
  Develop structured guidance by payer that documents historical settlement behavior, reimbursement patterns, escalation pathways, and successful dispute strategies to improve consistency and recovery outcomes.
- [ ] **Monitor third-party repricer involvement**
  Many reimbursement decisions now involve vendor ecosystems that create additional complexity and opacity. Track where third-party repricers, cost containment vendors, or payment integrity firms influence reimbursement outcomes. Develop standardized rebuttal workflows for each vendor or methodology.
- [ ] **Track arbitration and dispute outcomes**
  Analyze IDR and arbitration results by payer, service type, and dollar impact to identify trends, strengthen future negotiation positioning, and improve success rates in formal dispute resolution processes.
- [ ] **Establish escalation criteria for significant reimbursement variances**
  Define thresholds for when reimbursement deviations trigger escalation, ensuring high-value or high-variance claims receive specialized review, faster intervention, and appropriate recovery strategy alignment.

Turn Payer Intelligence into Revenue Recovery

Every payer strategy leaves a measurable pattern. The organizations that recognize those patterns are best positioned to preserve reimbursement, reduce unnecessary administrative burden, and recover revenue that would otherwise remain hidden.

The final step is evaluating how your own organization compares. Consider the following questions to assess whether your current processes are effectively identifying payer behavior, protecting reimbursement, and minimizing revenue leakage before it becomes a recurring financial challenge"

Questions Every Revenue Cycle Leader Should Be Asking

- Where are administrative requirements increasing our cost to collect?
- Are we identifying underpayments as effectively as denials?
- Are audits eroding reimbursement after claims are considered resolved?
- Do we have the visibility needed to recognize reimbursement shifts before they become recurring revenue leakage?
- Which payer behaviors are creating the greatest financial impact?

READY TO RECOVER WHAT'S ALREADY YOURS?

Revco Solutions helps healthcare organizations identify payer trends, optimize insurance A/R performance, and recover revenue across the entire reimbursement lifecycle. Schedule a complimentary Insurance A/R Assessment to move beyond reactive claim management with a more intelligent, data-driven approach to revenue recovery.

Scan the QR code to get started.