7 STEP INSURANCE A/R RECOVERY PLAYBOOK

A Unified Framework for Unlocking Hidden Revenue

REVCO SOLUTIONS

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1

IDENTIFY THE INVENTORY

Make hidden work visible

Before you can improve performance, you need a clear picture of what actually exists. Hidden revenue is often buried across multiple systems, work queues, and reporting gaps. Without a defined inventory, teams become reactionary.

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KEY AREAS OF FOCUS

AGING CLAIMS

MIDDLE A/R BLIND SPOTS

Claims sit untouched because teams are focused on high-dollar accounts and low-dollar automation rules. These accounts aren't denied, but are quietly approaching timely filing limits. **Watch claims between $2,500 - 15,000!**

AGING WITHOUT OWNERSHIP

Accounts move between teams (billing, follow-up, denials) with no clear accountability. The work exists, but no one owns the outcome.

WORKQUEUE RECYCLING WITHOUT RESOLUTION

Claims are repeatedly touched for status checks but never escalated or resolved. Productivity looks high, but recoverability is steadily declining.

UNRESOLVED EDITS

DNFB/PE EDITS

Unworked registration, service access, and provider edits upstream can cause significant delays. By the time they drop, valuable follow-up time has been lost and the claims are at higher risk for denial or timely filing loss. In fact, these edits can delay a claim **as many as 20-40 days before billing.**

KEY AREAS OF FOCUS

UNDERPAYMENT VARIANCES

CONTRACT UPDATES NOT LOADED TIMELY

If new payer rates go into effect but the system is still calculating old rates, under-collects can occur for months before discovery, and even longer for recovery.

MODIFIER-BASED UNDERPAYMENTS

Missing or misapplied modifiers can lead to consistent partial reimbursement. In these cases, each claim can look small, but over time this can lead to significant leakage. **Watch for modifiers 25 and 59!**

MISSED APPEAL WINDOWS

Underpayments are often identified too late because there are no workflows in place to track appeal deadlines, which leads to recoverable dollars becoming unrecoverable.

SYSTEM ACCEPTS PAYMENTS AS COMPLETE

The payment posts and the account closes, but reimbursement is below contracted rates. If expected reimbursement logic is not created or maintained, contract variances can't be flagged and underpayments are quietly accepted.

KEY AREAS OF FOCUS

OUT-OF-NETWORK CLAIM FLAGS & COMPLEX PAYER TYPES

WRITTEN OFF TOO EARLY

When OON claims are not flagged at registration or in early billing stages, they are often identified too late to leverage negotiation timelines. Similarly, low initial payments are accepted without negotiation or IDR evaluation.

NO STANDARD INTAKE

Out-of-network claims are often treated as one-offs and are handled differently depending on who picks it up.

LACK EARLY IDENTIFICATION

The payment posts and the account closes, but reimbursement is below contract rates. If expected reimbursement logic is not created or maintained, contract variances can't be flagged and underpayments are quietly accepted.

APPEAL FATIGUE

Complex claims require multiple levels of appeal, but are frequently dropped after the first or second attempt. Often times, **MVA and WC claims sit idle** because of this. These appeals are not unwinnable, just unfinished!

YOUR NEXT STEPS

QUICK ACTIONS

1

Categorize A/R segmented by:

- Age buckets (0-30, 31-60, 61-90, 91-120, 120+)
- Financial class
- Payer

2

Run variance reports vs. expected reimbursement:

- Flag claims with no activity in 14-21 days, claims missing documentation

3

Build a “recoverable inventory dashboard:

- Total dollars
- Claim counts
- Average balance

COMMON PITFALLS

Relying on surface-level A/R visibility instead of identifying specific recovery opportunities. **Only looking at total A/R balance can create blind spots!**

SEGMENT BY RISK AND RECOVERABILITY

Sort by Urgency and Likelihood of Success

Not all A/R is created equal. Some claims are at immediate risk of write-off, while others have a longer runway but lower probability of recovery. Segmentation introduces discipline into decision-making by balancing time sensitivity with likelihood of reimbursement.

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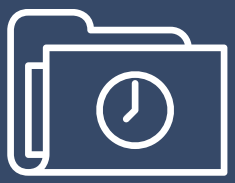
BEST PRACTICE SEGMENTS

TIMELY FILING RISK



- **Claims at day 80 with a 90 day filing limit**
  ***Example*:** The claim is still in edits due to a missing modifier. If not resolved in the next 10 days it becomes a 100% write-off risk.
- **Late charges holding up billing**
  ***Example*:** Inpatient account waiting on final charges for 25 days, but payer filing limit = 30 days from discharge.
- **Secondary claims not triggered timely**
  ***Example*:** Primary paid, but supplement coverage never verfied.
- **Provider enrollment delay**
  ***Example*:** Claim held due to provider enrollment issues. **These are going to be bulk in volume, not one-off claims!**

APPEAL DEADLINES

- Denied claim at day 25 of 30 day appeal window.
- Multiple level appeal opportunity: claim denied, first level appeal missed, but second level still open.

BEST PRACTICE SEGMENTS

IDR ELIGIBILITY WINDOWS

IDENTIFIED AS OON AFTER PAYMENT POSTED

OON claims worked as standard A/R and by the time it is recognized, IDR window has closed.

PARTIAL PAYMENT RECEIVED

On high dollar cases, there may be strong recovery potential within IDR window, but limited appeal leverage outside of it.

CLAIMS ELIGIBLE FOR IDR

Under No Surprises Act, the IDR process must be initiated within 30 business days.

DOCUMENTATION COMPLETENESS

DENIALS THAT REQUIRE CLINICAL DOCUMENTATION

Establish a process to submit medical records with the initial claim filing for those payers that accept it, even just for certain claim types.

PAYER BEHAVIOR PATTERNS

PRIORITIZING PATTERNS IN ADDITION TO VALUE OR AGE

A few common payer trends to watch include:

1. Medical necessity denials frequently overturned
2. Low response/slow payment
3. Consistent underpayments on specific CPT codes
4. Low appeal success rates
5. Frequent requests for additional documentation

YOUR NEXT STEPS

QUICK ACTIONS

1

Tag claims by:

- Sensitivity (days to deadline)
- Documentation status (complete/missing/needs clinical support)
- Payer difficulty score

2

Create and segment by risk tiers:

🔴 High risk / urgent
🟠 Moderate risk
🟢 Low risk / stable

3

Build simple rules like:

- <15 days to filing = auto priority
- Missing op report = hold + route

⚠ COMMON PITFALLS

Segmenting only by balance. Staff is spending limited time focusing on the highest balances, but those can be more difficult to recover or offer a lower ROI.

PRIORITIZE BY ROI, NOT BALANCE

Put Limited Resources Where Return Is Highest

An ROI-driven approach ensures teams focus on accounts that maximize financial impact without over-investing in low-yield efforts.

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PRIORITIZATION MATRIX

DECISION FRAMEWORK

1 **How likely are we to get paid?**

2 **How much effort will it take?**

APPLICATION:

- HIGH LIKELIHOOD + LOW EFFORT = WORK FIRST
- HIGH LIKELIHOOD + HIGH EFFORT = STRATEGIC FOCUS
- LOW LIKELIHOOD + LOW EFFORT = AUTOMATE
- LOW LIKELIHOOD + HIGH EFFORT = STOP WORKING

CLAIM TYPE / SCENARIO	EFFORT	LIKELIHOOD OF RECOVERY	ROI PRIORITY	RECOMMENDED ACTION
Denial-modifier/coding fix	Low	High	High	Work immediately
Repeated failed appeals	High	Low	Low	Do not pursue
Workers' Comp / MVA	High	Medium	Medium	Strategic focus
Small balance / low variance	Low	Low	Low	Automate

YOUR NEXT STEPS

QUICK ACTIONS

1

Build a simple ROI scoring model:

- Score = (Balance size x likelihood of success / effort)

2

Define Thresholds:

🔴 Immediate Action
🟠 Standard Workflow
🟢 Low Touch/Automation

3

Identify:

- Quick wins (fast cash)
- Strategic recoveries (larger and more recoverable balances)

⚠ COMMON PITFALLS

Treating all claims equally. They are not equal assets.

4 OPERATIONALIZE EXECUTION

Build Repeatable Workflows

Even the best prioritization strategy fails without consistent execution. Organizations that outperform in complex A/R build standardized workflows that scale across teams.

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STANDARD WORKQUEUES

TIMELY FILING RISK

CRITERIA:

- Claims within 10-15 days of filing deadline

INCLUDE:

- All payers + all balances

PRIORITY:

- Highest

HIGH ROI UNDERPAYMENT

CRITERIA:

- Variance >$500 and payer with known recovery success

FILTER BY:

- Top underpayment drivers: modifiers, DRG mismatch, etc

MIDDLE A/R OPPORTUNITY

CRITERIA:

- Balances between $2,500-$15,000 aged 30-60 days

EXCLUDES:

- High-dollar accounts already being worked

OON/IDR-ELIGIBLE

CRITERIA:

- Out-of-network claims within IDR eligibility window

INCLUDES:

- Flag for days remaining to initiate dispute

PAYER-SPECIFIC RULES

HIGH DENIAL, HIGH OVERTURN

STRATEGY:

- Appeal aggressively within 7 days

INCLUDE:

- Full clinical documentation upfront

HELPFUL TIP:

- Escalate after first denial

SLOW RESPONSE, LOW DENIAL

STRATEGY:

- Follow up at 25-30 days

HELPFUL TIP:

- Use call escalation early

FREQUENT UNDERPAYMENTS

STRATEGY:

- Route to underpayment specialists

HELPFUL TIP:

- Use contract comparison tools

LOW APPEAL SUCCESS

STRATEGY:

- Limit to first-level appeal

HELPFUL TIP:

- Only pursue high-dollar cases

DOCUMENTATION CHECKLISTS

MEDICAL NECESSITY APPEAL

- Physician notes
- Operative reports
- Clinical indicators tied to payer policy

OON/IDR SUBMISSION

- Itemized bill
- Explanation of Benefits
- Proof of good faith estimate
- Timeline validation

AUTHORIZATION DENIAL

- Auth number verified
- Dates of service aligned
- Documentation of prior approval

YOUR NEXT STEPS

QUICK ACTIONS

1

Create Workqueues:

- Aligned to priority tiers
- Additional flags for higher-risk segments

2

Build Payer-Specific Playbooks:

- Contact methods
- Required documentation
- Appeal language

3

Define:

- Who owns each claim type
- Expected touch frequency
- Escalation policy

4

Implement Checklists:

- Prevent work
- Ensure clean submissions

COMMON PITFALLS

Relying on individual effort instead of repeatable processes. When follow-up depends on individual knowledge or inconsistent habits, performance becomes difficult to scale and even harder to sustain.

ESCALATE INTELLIGENTLY

Match the Claim to the Right Expertise

High-value and complex claims often require specialized knowledge—whether that's contract interpretation, clinical validation, or negotiation strategy. Escalation should be intentional, not reactive.

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ESCALATION TRACKS

PERSISTENCE-DRIVEN FOLLOW-UP

Keep claims moving with consistent, structured outreach. Repeated payer contact, status checks, and timely resubmissions help prevent high-value accounts from stalling or aging out.

CONTRACT EXPERTISE + REIMBURSEMENT MODELING

Validate whether payment aligns with payer contracts and expected reimbursement. Use contract language and underpayment analysis to identify variance and support stronger recovery efforts.

CLINICAL APPEALS + CODING SUPPORT

Strengthen denials with medical necessity documentation, coding validation, and detailed clinical rationale. Complex denials often require defensible evidence, which are more than your standard appeal.

NEGOTIATION + IDR READINESS

For disputed or underpaid claims, prepare for formal negotiation efforts with the folloiwng: complete documentation, payment history, and reimbursement benchmarks.

ESCALATION TRACKS

TRIGGER	CRITERIA EXAMPLE	INITIAL OWNER	ESCALATION TIMEFRAME	ESCALATE TO	REQUIRED ACTION
Timely Filing Risk	<30 days remaining	Collector/ Biller	Same Day	Supervisor	Immedicate claim validation and submission
High-Dollar Aging	>$25k Hospital balance and >45 days	Collector	2 days unresolved	Manager	Executive payer outreach review
Repeat Denials	Same denial >2 occurrences	Denials Analyst or Collector	72 hours	Denials Manager	Root cause analysis initiated
Authorization Missing	No auth on scheduled service	Access/Auth team	Prior to date of service	Director	Clinical escalation
Medical Records Pending	Records not sent > 7 days	HIM	24 hours	HIM Manager	Expedite documentation
Appeal Deadline Risk	<10 days remaining	Appeals team	Immediate	Director	Priority appeal processing
No Payer Response	No payer action >30 days	Collector	5 business days	Payer Relations	Formal payer escalation: also trend by payer to escalate report of all accounts applicable
Recurring Payer Issues	Trend/analysis of same issue/same payer	Denials Manager	Weekly review	Executive Leadership	Strategic payer intervention/meeting demand

YOUR NEXT STEPS

QUICK ACTIONS

1

Define escalation triggers:

- # of touches exceeded
- Denial upheld
- High-dollar threshold

2

Build a tiered expertise model:

- Collectors
- Analysts
- Specialists (clinical, legal, contracting)

3

Pre-Build:

- Appeal templates
- Clinical justification libraries

COMMON PITFALLS

Escalating too late or not at all. Don't wait until a claim is severely aged, repeatedly denied, or nearing timely filing limits before taking action.

TREND ROOT CAUSES

Measure What Your Billing System Can’t See

Critical insights around why revenue is delayed, reduced, or lost often live outside standard reporting. Without intentional tracking, these patterns remain hidden, even as teams work to resolve them. Trending root causes creates a feedback loop between recovery and performance improvement.

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KEY REPORTS & FORMULAS

UNDERPAYMENT RATES BY PAYER/ SERVICE LINE

Expected vs Actual Reimbursement
- Identifies payment variances

Contract Variance Report
- Detects payer underpayments

(Expected Reimbursement – Actual Payment) / Expected Reimbursement x 100

TIMELY FILING LOSS RATE

Timely Filing Adjustment
- Quantifies preventable write-offs

Filing Deadline Aging
- Claims nearing expiration

Unbilled Aging Inventory
- Revenue sitting pre-claim

Timely filing write-offs / total claims billed x 100

OVERTURN VELOCITY + SUCCESS RATE

Appeal Aging
- Measures delay impact

Payer Appeal Performance
- Payer responsiveness

Successful appeals / Total appeals submitted x 100

REPEAT VARIANCE DRIVERS

Variance Recurring
- Repeat underpayment patterns

Root cause frequency
- Process failure identification

Edit failure trends
- System logic gaps

Recurring variance cases/Total Variance Cases x 100

TOUCH RATE (COST TO COLLECT)

Workqueue Activity
- Collector productivity

Cost-to-collect Financial Analysis
- Operational efficiency

Account touch tracking
- Manual effort measurement

Touch Rate:
Total Manual account touches / Total accounts worked

Cost to Collect:
Total Revenue Cycle Operating Cost / Total Cash Collected x 100

YOUR NEXT STEPS

QUICK ACTIONS

1

Build recurring reporting cadence:

- Executive Leadership Dashboards with daily focused review of:
  - Gross AR / Net AR Trends
  - AR >90 Days and >180 Days (from date of service)
  - Cash Collections vs Goal
  - Candidate for Bill
  - Claim Edits
  - Charge Lag Trends

2

Identify:

- Top 5 denial categories
- Top 3 payer issues

3

Layer in:

- Service line insights
- Facility-level trends

COMMON PITFALLS

Focusing on resolution without addressing why issues keep happening. Without identifying root cause, organizations spend more to collect the same dollars instead of preventing leakage upstream.

PREVENT RECURRENCE

Fix the Upstream Leakage

If the same issues continue to reappear in A/R, the problem isn't in follow-up, it's in the process. Prevention requires closing the loop between back-end recovery and front-end operations. Leveraging payer bulletins is essential to maintaining and optimizing your denial avoidance strategy.

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KEY AREAS OF FOCUS

CENTRALIZED BULLETIN INTAKE

SOURCES TO MONITOR

- Commercial payer portals
- CMS/Medicare updates/bulletins
- Medicaid bulletins
- Managed Medicaid notices
- Clearinghouse notifications
- Authorization/vendor updates
- Medical policy bulletins
- Coding updates

RECOMMENDED OWNERSHIP

- Centralized payer governance coordinator or reimbursement analyst

RISKS WITHOUT CENTRALIZED INTAKE

- Bulletins get buried in email
- Operational teams assume someone else reviewed it
- Critical changes never reach Epic/System/IT build teams

BULLETIN TRIAGE + DOCUMENTATION

Bulletin triage creates a structured process for reviewing updates, identifying operational impact, and documenting what changes need to happen across the revenue cycle. By categorizing updates, teams can quickly assign ownership, prevent avoidable denials, and reduce downstream revenue leakage before it reaches A/R. **See the chart** ⟶

BULLETIN WORKFLOW

CATEGORY	EXAMPLE
Authorization changes	New prior authorization requirements
Medical necessity	Added/removed covered diagnoses
Coding/Billing rules	Modifier requirement changes
Filing requirements	New attachments/form requirements
Reimbursement methodology	DRG/payment logic changes
Portal submission changes	Corrected claims routing changes
Coordination of benefits	New COB edits
Timely filing	Updated reconsideration deadlines
Documentation requirements	Operative note requirements
Government mandates	NSA/price transparency updates

BULLETIN WORKFLOW

CROSS FUNCTIONAL REVIEW

ALIGNING TEAMS AROUND SHARED REVENUE RISKS

TEAM	IMPACT
Patient Access	Authorization/precertification
HIM/Coding	Coding documentation
Billing	Claim submission
Denials	Appeal/rework
Contracting	Payer interpretation validation
Epic/System/IT	System logic build updates
Compliance	Regulatory risk review
Clinical	Workflow/documentation changes

PRIORITIZE BASED ON RISK LEVELS

CRITICAL

- Payer policy change affecting high volume claims
- Government mandates: risk of audits/fines

HIGH

- New auth requirements

MEDIUM

- Portal workflow update

LOW

- Minor language clarification

BULLETIN WORKFLOW

ASSIGN OPERATIONAL OWNERSHIP

Schedule regular, recurring meetings to discuss bulletin action items

REQUIRED	EXAMPLE
Executive owner	Director of PFS
Operational lead	Denials manager
System owner	Epic/IT analyst
Due date	Prior to effective date
Testing requirements	Claim validations
Training plan	Staff communication/education
Monitoring	Pre and post Go-Live review

SYSTEM/LOGIC WORKFLOW UPDATES

SOURCES TO MONITOR

- Claim edit creation
- WQ routing logic
- Auth edits
- Modifier hard stops
- Med Nec edits
- Eligibility logic changes
- Denial routing rules

YOUR NEXT STEPS

BEST PRACTICES

1

Establish monthly routine root cause reviews:

- Review repeat denial drivers
- Track payer trends + timely filing losses
- Identify recurring operational breakdowns

2

Strengthen cross-functional accountability:

- Align coding, patient access, managed care, enrollment, and contracting
- Assign ownership for recurring issues
- Prevent siloed problem-solving

3

Implement proactive monitoring + escalation:

- Set payer escalation thresholds
- Monitor contract variance alerts
- Address reimbursement issues early

4

Close the loop upstream:

- Create feedback loops to front-end teams
- Implement pre-bill audits + authorization checkpoints
- Regularly update contracts + charge master

COMMON PITFALLS

Treating prevention as a reporting exercise instead of enforcing operational change. Data is only as good as the processes built as a result.

Turn Recovery Into Long-Term Performance

This playbook delivers a unified framework for identifying, prioritizing, and recovering hidden revenue across insurance A/R. By implementing these 7 steps, your healthcare organization can move beyond fragmented, reactive processes.

Want to see how this framework applies to your organization?

Revco Solutions works with healthcare providers to uncover and recover hidden revenue across complex A/R while building more sustainable, scalable processes for long-term performance.

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