

Recover More™

The Cost of Complexity.

How complex claims drain cash, strain teams, and increase risk—and **what leaders can do about it.**



Complexity is constant, **but its cost is rising.**

Auto accident, workers' compensation, and Veteran Affairs (VA) claims have always behaved differently from traditional commercial health insurance. They require more investigation, more parties, and more persistence to resolve. What has changed in recent years is the environment around them: margins are thinner, labor is more expensive, payer scrutiny is higher, and revenue cycle teams have less capacity to absorb slow-moving, labor-intensive work.

Recent benchmarking from Kaufman Hall shows median hospital operating margins hovering just under 5% in 2024, even as total expenses per day climbed roughly 6% year over year and labor and purchased services costs continued to rise.¹

In that environment, even "small" categories of leakage—like complex claims, which typically account for 3-5% of claim volume—can materially affect a health system's already thin margin.

Thin Margins, **Rising Costs**

Median hospital operating margin in 2024: **just under 5%.¹**

Total expenses per calendar day: **up about 6% year over year.**

Labor and purchased services costs: **still climbing faster than revenue.**

Shifting priorities are **resurfacing old challenges.**

"In the last few years, many health systems have understandably diverted attention away from complex claims to focus on cyber events and security, operational disruptions, and broader uncertainty," said Michael Ford, Chief Revenue Officer of Revecore.

"As those acute risks are beginning to recede, **complex claims are re-emerging as a priority.** Leaders are recognizing that while auto accident, workers' compensation, and VA claims may represent a small share of overall volume, they consume outsized time, create disproportionate AR aging, and carry meaningful litigation and compliance risk."

On the payer side, complexity is becoming more structural. In auto and workers' compensation, payers increasingly rely on bill repricing and payment review firms that sit between the provider and the carrier. These third parties run claims through multiple review layers, apply opaque payment methodologies, leverage PPO networks the provider may not belong to, and resist explaining how reductions were determined.



At the same time, Revecore operational data shows that workers' compensation payers in many markets are taking longer to pay than they did several years ago, often due to invalid denials or outsourced bill review processes.

For VA claims, reimbursement delays remain a chronic issue—especially with manual submissions or appeals—and providers must work within a defined set of rules that govern how, when, and if the VA pays for care. Taken together, these practices systematically delay payment, obscure accountability, and increase the financial risk providers must absorb to secure reimbursement.

Industry analyses estimate that administrative complexity—including billing, coding, and payment friction between providers and payers—adds billions of dollars in excess costs to the U.S. healthcare system each year. Within that broader “complexity tax,” hospitals face structurally high denial rates, with initial denials on private-payer claims approaching 15% in some studies, even when services were preapproved.²

The net effect is a systemic complexity problem across workflows, stakeholders, and time. Denials, underpayments, and complex claims together represent some of the most significant, and often hidden, threats to a hospital's revenue cycle performance. Collectively, they can erode meaningful points of net revenue, siphon scarce staff capacity, and introduce compliance and litigation exposure that goes well beyond “just” delayed cash.

Manual work, unclear COB, and avoidable leakage create a margin problem.

Revenue cycle leaders do not experience the cost of complexity as a single line item. They feel it as a recurring drain: staff hours spent chasing information after discharge, complex claims that sit in aging while teams wait for someone to respond, and balances that are written off or under-recovered because the right payer path was not established early.

Three pain themes show up consistently across complex claims management:

Pain #1: Post-discharge, the work is manual and labor-intensive.

Unlike typical commercial insurance, where coverage is usually confirmed before or at the point of service, auto and workers' compensation claims are often not fully established until after discharge. That is when the real work begins: teams must contact patients, employers, insurers, and sometimes attorneys to identify the correct claim information, open claims, and confirm benefits. On average, it can take multiple calls and letters before a patient responds. Every cycle adds labor cost and opportunity cost, especially when complex claims staff are small teams pulled away from core revenue cycle work.

At the same time, hospitals are absorbing sustained increases in labor and contract staffing costs, with total expenses and non-labor costs growing faster than reimbursement in the post-pandemic period.³ In recent revenue cycle surveys, finance leaders frequently cite staffing shortages, manual follow-up, and high cost to collect as top operational concerns — pressures that are amplified when complex claims depend on repeated, post-discharge outreach.^{6 7}

Pain #2: Workflows vary widely, while inconsistency leaves room for error and risk.

Because complex claims represent a small fraction of total volume, many organizations have not designed standardized workflows or clear coordination-of-benefits (COB) rules for them. The result is manual, duplicative work; inconsistent performance; and increased risk.

Common patterns include:

Billing a patient's health insurance or the patient directly without thorough investigation.

Dropping accounts to self-pay and offering discounts that reduce reimbursement well below what first-party coverage might have paid.

Billing Medicare or Medicaid before pursuing auto or workers' compensation dollars, which can preclude pursuing those primary payers later.

Writing off balances as uncollectible because the perceived effort outweighs expected recovery.

Coordinating benefits incompletely or incorrectly, which can violate state and federal COB requirements and expose the organization to litigation.

These issues are not theoretical. Nationally, denial rates on some commercial claims now approach 15 percent, even when services were preapproved.² Each misstep—especially in claims that already require investigation—can translate directly into delayed or lost dollars.

Mishandling complex claims is also not just a financial issue. Even a single improperly billed accident claim can create the basis for a class action, turning what appeared to be a small operational lapse into a significant legal and reputational risk.

Pain #3: Opaque rules are causing payer friction to rise.

Hospitals are seeing more aggressive behavior from carriers: additional documentation demands, higher denial rates tied to missing third-party information, and more disputes over medical necessity and causality. Interactions around complex claims have become more contentious. In auto and workers' compensation, outsourced bill review firms can introduce additional layers of negotiation and "methodologies" that providers struggle to validate or challenge.

HFMA's 2024 hospital financial and revenue cycle benchmarks show that "true" accounts receivable days were more than 5% higher for many hospitals than in the prior year, driven in part by increased request-for-information activity and higher initial denial rates.⁴ The net effect is that AR pressure is still intensifying even as leaders work to stabilize performance, with complex claims sitting at the intersection of payer friction, documentation demands, and delayed cash.⁴

The cost of complexity compounds when internal teams are overextended, and external partners are siloed.

For many providers, fragmented vendor strategies add to the burden. A multi-vendor approach—meant to avoid putting "all the eggs in one basket"—often increases data breach risk, multiplies implementation and vendor-management work, and limits any single vendor's line of sight across the complex-claims spectrum. The cost of complexity compounds when internal teams are overextended, and external partners are siloed.

Imagine a world where complex claims are identified early, routed correctly, billed compliantly, and resolved faster—**without draining staff resources.**

In a "mastered" state, complex claims do not disappear, but they stop creating challenges for teams and distorting cash flow. Complexity is anticipated, not reacted to. The organization understands the nuances of auto, workers' comp, and VA coverage, treats COB sequencing as a discipline, and builds workflows that reflect that reality—often with specialized partners who focus exclusively on these categories.

In that world:

COB complexity is understood earlier in the process, which reduces downstream rework and prevents improper billing.

Insurance verification starts sooner—often before or immediately after discharge—and claims reach the right carriers faster, with fewer touches.

Complex-claims AR is managed deliberately, with a clear expectation that the vast majority of accounts resolve before aging past 120-180 days.

Timely filing write-offs, especially on health insurance following complex claims, **are reduced** because workflows protect filing windows rather than react to missed deadlines.

Leaders who “win” in complexity are decisive about how they run this work. **They:**

Outsource intentionally and consolidate to a single, accountable partner rather than spreading small volumes across multiple vendors.

Provide accurate, reliable data during discovery so potential partners can model realistic lift and pricing instead of generic promises.

Pressure test their current in-house and vendor performance, asking not just about fee rates but about total dollars recovered, AR impact, compliance safeguards, and staff efficiency.

Vet vendor promises using references tied to those exact commitments, and avoid decisions based on pricing or relationship alone.

Mastering complexity transforms this claim set from a reactive queue into a managed, measurable capability that supports enterprise cash and reduces risk.

What leaders are trying to protect: **cash, time, and risk.**

Against a backdrop where median margins remain thin and expenses—particularly labor, drugs, and supplies—are rising faster than revenue, leaders increasingly view every recoverable dollar as essential to sustaining operations and strategic investment.

When CFOs and revenue cycle leaders talk about complex claims, they tend to start with outcomes, not workflows. The same objectives surface repeatedly:

1. **Accelerate cash** and stabilize cash flow.
2. **Reduce aging**, especially over 120-180 days, and prevent timely filing write-offs.
3. **Increase cash collections** in line with placement dollars and estimated opportunity.
4. **Reduce operational drag** by lowering manual rework and follow-up gaps.
5. **Protect patient experience**, often prioritized even above formal compliance risk.
6. **Mitigate exposure to audits**, recoupments, and litigation tied to improper billing and weak COB discipline.

There is also a strategic, opportunity-cost dimension. If providers can outsource complex claims and achieve a clear return on that investment, they no longer need to absorb the production drag that comes from asking small, overstretched internal teams to manage this work in-house. Every hour previously spent manually identifying auto or workers' comp payers, correcting COB errors, or repairing aged accounts is an hour given back to core priorities.

“For many health systems, complex claims may be small in count, but they’re meaningful in dollars—and they carry real downside risk,” Ford said. “With labor costs up, payers pushing back harder, and margins still tight, letting these claims sit or get worked inconsistently means leaving money on the table and taking on risk that’s increasingly difficult to justify as ‘just the cost of doing business.’”

Complexity Breakdown: **Auto Accident Claims**

Auto accident claims stall after discharge, when discovery and education matter most.

These claims often begin with an information and education gap. Many patients assume that their health insurance is primary, even when an accident is involved. Registration teams may not capture full accident details or explain coordination of benefits clearly, and patients frequently leave without opening a claim or understanding what information the hospital will need later.

Once the patient is discharged, the hospital must rely on patient responsiveness to open a claim, obtain the carrier and claim number, and gather documentation. It can take multiple outreach attempts before a patient acts, and if the hospital bills health insurance or self-pay too soon, the opportunity to recover from first-party coverage (such as PIP or MedPay) may be reduced or lost. In many organizations, only a small fraction of accounts arrive with an identified auto lead, which means the majority of opportunity depends on downstream discovery rather than early capture.

A second layer of complexity is COB sequencing. Some providers treat auto accident cases solely as third-party liability matters. In reality, there may be payers ahead of liability—first-party auto coverage, other accident benefits, and the patient’s health insurance. Misunderstanding this sequence can lead to noncompliant billing, delayed payment, suboptimal reimbursement, or all three.

What “mastery” looks like in auto accident claims:

Registration and front-end teams consistently identify potential accident-related visits and explain to patients what information will be needed and why.

The organization applies disciplined-and ideally automated-rules to determine payer order, including first-party benefits and health insurance, rather than defaulting to liability or self-pay.

Discovery workflows—often supported by technology—reduce repeated outreach cycles and help prevent accounts from slipping into avoidable aging.

Teams avoid billing health insurance or dropping to self-pay without a thorough, documented investigation of accident coverage, reducing leakage and compliance risk.

IN PRACTICE:

Advancing auto accident recovery through technology-enabled execution

SITUATION:

A large regional health system recognized that strengthening auto accident recovery required more advanced automation, stronger payer identification, and tighter workflow controls.

SOLUTION:

After upgrading to Revecore’s advanced technology platform for accident claims, the organization enhanced its ability to quickly identify correct payers, apply disciplined work queue rules, and consistently sequence claims in alignment with coordination-of-benefits requirements.

RESULTS:

Auto performance improved measurably. Annualized cash pickup from the claims set reached **\$3.39 million**, with an estimated **\$1.89 million in net MVA lift** after adjusting for medical insurance impact. Overall, the technology upgrade contributed to an estimated **\$3.3 million in total annual ROI** across accident claims—demonstrating how advanced automation and focused execution can translate into meaningful financial lift.

\$3.39M

Annualized MVA
cash pickup

\$1.89M

in net MVA lift

\$3.3M

Total annual ROI



Complexity Breakdown: **Workers' Compensation Claims**

Workers' comp reimbursement slows down when employer and injury details aren't captured up front.

Workers' compensation claims are highly sensitive to what happens at registration. If intake fails to capture key employer and injury information—such as employer name, location, and how the injury occurred—the downstream team has no solid starting point once the patient leaves. Patients often assume their employer's workers' compensation insurer will “take care of it” and may feel no urgency to respond to follow-up requests, especially if they are not personally responsible for the bill.

In many organizations, complex workers' compensation accounts receive limited dedicated attention because they represent a small share of overall volume. As a result, claims are sometimes billed incorrectly to the patient's commercial health plan, written off prematurely, or dropped to self-pay with discounts that far exceed what workers' comp would have paid. Operational friction compounds the problem: many providers either cannot submit workers' comp claims electronically or cannot reliably attach required medical records, even though documentation is mandatory in many jurisdictions.

Field experience suggests that workers' compensation payers are taking longer to pay than they did several years ago, with average payment timelines stretching from roughly one to two months and often extended further by invalid denials or outsourced bill review processes. When claims start with incomplete data and then encounter slower, more contested processing, AR aging and cost to collect rise rapidly.

What “mastery” looks like in workers' compensation claims:

Registration consistently captures required employer and injury context, giving downstream teams a reliable starting point.

Payer identification is automated, and verification begins promptly, without waiting through multiple unanswered patient outreach attempts.

Claims are submitted with the appropriate medical records and documentation from the outset, aligned with workers' compensation rules.

Workflows are built for reality: they assume the need for employer coordination, persistent follow-up, and structured tracking of aging and next steps, rather than treating workers' comp like standard commercial billing.

Automation is applied to workflows to streamline staff tasks and documentation.

IN PRACTICE:

Applying a Day 1, tech-driven approach to workers' compensation claims

SITUATION:

A large academic health system took a proactive approach to managing workers' compensation claims by transitioning Day 1 work from an in-house, manual model to a technology-enabled, partner-supported approach.

SOLUTION:

By automating employer-to-payer identification, standardizing documentation and billing workflows, and applying disciplined payment verification and appeals processes, the organization improved both efficiency and recovery.

RESULTS:

After reaching stabilized performance, the health system generated \$6.9 million in incremental workers' compensation collections over a 12-month period, with 265 additional paid accounts compared to historical performance. Payments were received in an average of 62 days from placement, while 100% fee schedule compliance was maintained—allowing internal teams to reallocate time toward core revenue cycle priorities without sacrificing accuracy or oversight.

\$6.9M

**WC collections in
12 month period**

265

**Additional
paid accounts**

62

**Average
days to pay**

100%

**Fee schedule
compliant**

Complexity Breakdown: VA Claims

VA claims become costly when authorizations and fee schedule factors aren't captured cleanly.

VA claims bring their own set of challenges, typically in three places: authorization, fee schedules, and filing requirements. Missed authorizations—or authorizations that are obtained but not accurately recorded in the EHR—are frequent pain points that can result in denials, rework, or delayed payment. At payment review, VA reimbursement often depends on multiple fee schedule factors, requiring careful validation to ensure that payments align with allowable amounts.

From a broader perspective, the VA continues to shift more care to community providers, and the veteran population is aging and living longer. This combination increases both the volume and complexity of VA-related work for hospitals. As demand grows, organizations that treat VA claims as an afterthought, rather than a specialized workflow, are more likely to experience AR aging, underpayments, and frustration on all sides.



What “mastery” looks like in VA claims:

Authorization capture is disciplined, standardized, and reliably documented in the EHR so that billing teams have clear visibility.

Documentation and billing are aligned with the VA’s defined set of rules and fee schedules, enabling accurate and efficient payment validation.

Payment review processes identify variances quickly and route them into defined follow-up workflows, rather than leaving issues to surface only through aging or write-offs.

IN PRACTICE:

Improving VA recoveries through a specialized model

SITUATION:

A large health system managing a high volume of VA community care claims recognized that the complexity of VA reimbursement—particularly fee schedules, documentation requirements, and payment validation—required a more specialized approach than traditional health insurance billing.

SOLUTION:

Rather than dispersing this work across general billing teams, the organization partnered with Revecore to apply a dedicated VA-focused model designed to consistently navigate VA rules and validate payments accurately.

RESULTS:

The health system achieved \$66.3 million in recoveries, generating a \$15 million lift above historical performance. By ensuring VA claims were worked by specialists focused exclusively on this complexity, the organization improved recovery predictability and reduced underpayments while allowing internal teams to stay focused on core reimbursement priorities.

\$66.3M

VA recoveries

\$15M

**Lift above
historical performance**



What It Takes to Master Complexity

Specialized workflows, consistent data, and the discipline to coordinate benefits correctly.

Managing complex claims is not just “more follow-up.” It is a different category of work—one that combines specialized billing, documentation management, legal and regulatory awareness, and persistent, multi-party coordination. Many providers and generalist revenue cycle management firms do not have the staff capacity, tools, or the specialized expertise required to handle this work consistently, especially when billing systems and standard processes are built around commercial claims rather than auto, workers’ comp, or VA. Technology is an important part of the answer.

Current and emerging tools can:

Use predictive models to triage accident claims by recovery potential and likely time to pay.

Apply natural language processing to extract accident, employer/carrier, and state rules automatically.

Analyze denial patterns to identify which carriers, adjusters, or review firms generate frequent errors.

Model expected reimbursements and likely denials with greater precision to inform strategy and staffing.

Use voice and workflow automation to streamline staff tasks and documentation.

Even in a mature technology environment, there will always be substantial need for hands-on work in clinical, legal, and client-support functions. Mastery in complex claims comes from combining specialized expertise with enabling technology and disciplined process design.

A practical “mastery” framework includes:

Standardizing intake and discovery for auto accident and workers’ comp claims so investigations are not rebuilt account by account.

Treating COB sequencing as a core competency, with rules and training that prevent improper billing and missed first-party coverage.

Building documentation flows that support workers' comp and authorization discipline for VA, including consistent capture and transmission of required records.

Designing follow-up cadence and tasking that reduce aging, protect timely filing windows, and ensure no long gaps between touches and next steps.

Using data not just to report on performance, but to manage work allocation, identify bottlenecks, and challenge assumptions about in-house and vendor results.

How to Evaluate a Revenue Cycle Partner

Choose proof over promises, and one firm over multiple.

In response to complexity, providers may choose to spread auto, workers' comp, and VA claims management across multiple vendors. The rationale is understandable—avoiding concentration risk—but the outcome is often counterproductive. Multiple vendors mean more interfaces, more data security exposure, more performance meetings, more contract cycles, and less holistic visibility across complex claim types. Each vendor manages a smaller slice of revenue and has less incentive and capability to see cross-cutting trends.

A growing number of health systems are recognizing that complexity is better managed through consolidation and deeper partnership. **When evaluating approaches and partners, leaders can benefit from a few guiding principles:**

Proof over promises. If a pricing proposal or performance promise seems too good to be true, ask for references tied to that exact claim and validate whether the vendor has delivered similar results elsewhere.

Data discipline early. Providing reliable data during discovery enables credible forecasting of lift and pricing. Without this, decisions are prone to focus on fee rates alone, rather than total financial and operational impact.

Pressure testing current state. Use standardized data pulls to compare internal and incumbent vendor performance against realistic alternatives, including recovery differences, aging impact, and cost to collect—not just headline percentages.

Transparency and partnership. A strong partner will help unpack your data, answer detailed questions about setup and deliverables, and be candid about constraints. Both sides should aim for a relationship where issues can be surfaced and addressed quickly, rather than hidden.

When complex claims are treated as a managed capability, supported by the right combination of internal governance and external expertise, they stop being a reactive work queue. Instead, they become a defined, measurable way to protect margin at the edges, stabilize pockets of cash flow, and reduce enterprise risk that would otherwise go unmanaged.

Mastering Complexity Starts with Seeing it Clearly.

Complex claims are often a small share of total encounters, but they generate outsized operational burden, financial drag, and risk exposure when workflows are not designed for their reality. Manual investigation and follow-up consume scarce staff time. Inconsistent processes and fragmented vendor strategies create avoidable leakage and delays. Payer scrutiny and documentation demands add friction at every step. Weak COB discipline and improper billing open the door to litigation that can far exceed the original claim value.

There is no single “silver bullet,” but there is a clear path. Health systems that standardize what can be standardized, design workflows for how auto, workers’ comp, and VA actually function, use data early and often, and pressure test their own assumptions and vendor relationships are best positioned to protect every available dollar—and the teams responsible for recovering it.

In an era of rising costs and thin margins, the cost of complexity is simply too high to leave unmanaged.

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