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Look What You Made Me Bill

Two Sessions on Out-of-Network IDR & Workers' Compensation Billing

EnableComp
Complex Revenue Intelligence

Winning the IDR Game

Effective Strategies for Out-of-Network Disputes Under the No Surprises Act

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Workers' Compensation

Billing Complexity, Wisconsin's 2027 Fee Schedule, and Industry Headwinds

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PART 1

Winning the IDR Game

Effective Strategies for Out-of-Network Disputes Under the No Surprises Act

AGENDA

What we'll cover today

01

The IDR landscape in 2026

Volume, win rates, and what the data tells us

02

Seven strategies that move the needle

From open negotiation through evidence portfolios

03

Wisconsin and the upper Midwest

How state law shapes your dispute path

04

Pitfalls, watch-list, and takeaways

What to operationalize Monday morning

THE QUESTION I GET ASKED MOST

What is the QPA?

The Qualifying Payment Amount is the insurer's median in-network contracted rate for a given service in a geographic region — adjusted annually for inflation. It is the IDRE's reference point in every payment determination.

HOW IT'S CALCULATED

- Median in-network contracted rate
- Same service code (or comparable)
- Same geographic region
- Same plan / market type
- Baseline: contracted rates as of Jan 31, 2019
- Annual CPI-U inflation adjustment

WHY PROVIDERS CHALLENGE IT

- Insurers calculate it themselves — providers don't see the math.
- Pre-TMA III rules let insurers include:
  - "Ghost rates" — providers who never furnish the service
  - Out-of-specialty rates
  - Plans administered by an unrelated TPA
- **Net effect: QPAs run below true market value.**

PRACTICAL IMPLICATION: Post-TMA III, the QPA is the IDRE's starting reference but no longer presumed correct. You can demand QPA disclosure information and challenge the inputs.

BY THE NUMBERS

The IDR landscape in 2026

After four years of operation, the federal IDR process is no longer an exception workflow — it's a core revenue cycle function for many providers.

1.2M+

Disputes initiated

First half of 2025 — up 39% over 2H 2024

88%

Provider win rate

When a payment determination is made (H1 2025)

20%

Found ineligible

Most often: state law applies, batching, or timing

70%

Concentrated at top 10

HaloMD, Team Health, SCP Health alone = ~44%

Sources: CMS Federal IDR Public Use Files (H1 2025); Centers for Medicare & Medicaid Services Supplemental Background; Health Affairs Forefront analysis (March 2026).

THE BOTTOM LINE

IDR rewards operational discipline. Providers who treat it as a governed workflow — with disciplined intake, deadline tracking, and documentation standards — pull far ahead of those who treat it as exception handling.

THE PROCESS

How federal IDR works — briefly

Five phases. Strict deadlines. Most providers leak money in the first two.

1

Initial Payment / Notice of Denial

Payer issues initial OON payment or denial. The clock starts here.

30 days from clean claim

2

Open Negotiation

Either party initiates via formal notice. Document everything. Most disputes settle here.

30 business days

3

IDR Initiation

If negotiation fails, file via federal IDR portal. Eligibility documentation required up front.

4 business days

4

IDRE Selection & Offers

Both parties submit final offers and evidence. Pay the IDRE fee and admin fee.

10 business days

5

Determination

IDRE selects one offer (baseball-style). Loser pays IDRE fee. Payment due in 30 days.

30 business days

PART TWO

Seven Strategies That Move the Needle

From open negotiation through evidence portfolios — the practical playbook

Strategy 1 · Master open negotiation

Most disputes — and most dollars — are won or lost before IDR even begins.

DO

- Send a structured open negotiation notice with claim details, billed charges, and your supporting rationale.
- Anchor your opening offer to defensible benchmarks: prior contracted rates, market rates, FAIR Health, geographic adjustments.
- Track the 30-business-day clock religiously — it's calendared, not assumed.
- Document every counter, every silence, every payer touch.
- Settle when the math works — IDR fees and uncertainty have real cost.

DON'T

- Send a one-line email asking for "more money" — that's not a negotiation notice.
- Skip negotiation and jump to IDR. The dispute will be found ineligible.
- Let the 30-day window expire by accident — re-starting means another 30 days.
- Treat negotiation as a formality. Payers track who actually engages and adjust offers accordingly.
- Forget that the open negotiation start and end dates must be documented in the federal portal.

Strategy 2 · Get eligibility right the first time

In H1 2025, 40% of disputes were eligibility-challenged by the non-initiating party. ~20% were ultimately found ineligible.

TRAP 1

State law applies

If a "specified state law" governs (e.g., Illinois IDOI arbitration), the federal IDR will reject the claim. Always run the state-vs-federal analysis first.

TRAP 2

Open negotiation incomplete

Did you actually file the negotiation notice? Did 30 business days actually pass? The portal now requires documentation of start and end dates.

TRAP 3

Improper batching or bundling

Federal rules limit batching to similar codes (CPT/HCPCS). The 2023 proposed rule would expand this to single-patient encounters and same-Category I sections — but isn't final yet.

WHAT CHANGED IN OCTOBER 2025

Service Code Modifier(s) field is now an optional element on the Notice of IDR Initiation web form.
Use it. Modifier-bearing claims with no modifier captured can be flagged as duplicates and closed.

Eligibility documentation must be attached at initiation — payer challenges to eligibility have dropped from 43% to 40% as a result. Get this right and you skip a 30–60 day eligibility review.

Strategy 3 · Batch strategically

Batching collapses fixed costs across multiple claims — but the rules are tight and getting them wrong sinks the whole batch.

CURRENT RULES (effective today)

- **Same insurer / plan**
- **Same or comparable service codes**
- **Same 90-day period**

Mismatched codes? Whole batch can be ruled ineligible.

IDRE fee is tiered by batch size — batching of 50 claims at $1 each is not the same economics as 5 at $10 each.

PROPOSED RULE (Nov 2023, awaiting finalization)

- **Single-patient encounter (one claim form, consecutive dates)**
- **Same or comparable codes (broader interpretation)**
- **Anesthesiology, radiology, pathology, lab — bundled by Category I CPT section**
- **25 line-item cap per dispute**

Watch this rule closely. If finalized in 2026, it materially shifts the batching calculus for hospital-based specialties.

Strategy 4 · Build a defensible QPA challenge

After TMA III, the QPA is no longer presumed correct — but you have to give the IDRE specific reasons to look past it.

THE TMA TIMELINE

Feb 2022 — **TMA I**

Court vacates QPA rebuttable presumption.

Feb 2023 — **TMA II**

Court rejects "thumb on the scale" for QPA.

Aug 2023 — **TMA III**

Court strikes QPA calculation methodology — bars ghost rates, out-of-specialty rates, and TPA-administered rates.

Aug 2023 — **TMA IV**

Court vacates 600% admin fee hike and tight batching restrictions.

May 2025 — **Fifth Circuit en banc**

Rehearing granted on TMA III. Mandate not yet issued — district court ruling stands for now.

WHAT THIS MEANS FOR YOUR FILINGS

Question the QPA inputs. Was it built on ghost rates? Out-of-specialty rates? Plans administered by an unrelated TPA?

Demand disclosure. Federal regs entitle you to specific QPA disclosure information. Submit a written request.

Tell the IDRE explicitly: the QPA is one of six statutory factors — not the starting point. Reference TMA II and III in your written submission.

Track FAQ Part 69. Until the en banc mandate issues, payers can rely on "good faith" interpretations of the 2023 methodology.

DON'T DEFAULT

Strategy 5 · Choose your IDRE deliberately

There are now 16 certified IDR entities. They are not interchangeable. Track records, decision-writing styles, and turnaround times differ materially.

1

Track decision history

Use the publicly available CMS Federal IDR Public Use Files to analyze each IDRE's decision patterns — by specialty, by service type, by award-as-%-of-QPA.

2

Watch for conflict of interest

IDREs are barred from conflicts, but staffing, parent-company affiliations, and prior payer relationships matter. The non-initiating party can challenge selection.

3

Optimize for your service mix

An IDRE with deep emergency medicine experience may be a poor fit for a complex IR or surgical case. Match expertise to claim type.

Strategy 6 · Build the full evidence portfolio

The NSA gives the IDRE six factors to consider. Most provider submissions only cite the QPA and prior contracted rates. The other four are largely untouched ground.

1 Qualifying Payment Amount

The starting reference — but contestable per TMA III.

2 Provider training & experience

Board certification, sub-specialty fellowships, years in practice. Document them.

3 Patient acuity & complexity

Risk scores, comorbidities, time-on-case, intensity of service.

4 Market share of the parties

Dominant payer in a region? Limited specialty supply? Both cut both ways.

5 Teaching status, case mix, services

AMC? Trauma center? Burn unit? Higher fixed costs justify higher rates.

6 Prior contracted rates (4-year lookback)

Last in-network rate for the same services. Often the most powerful single data point.

Strategy 7 · Set rational filing thresholds

Not every claim deserves IDR. Build a decision rule that factors in fees, expected award lift, and operational cost.

THE COST STACK PER DISPUTE

Federal admin fee (per party)	**$115**
Single-claim IDRE fee	**$200 – $500**
Batched-claim IDRE fee	**$268 – $670**
Internal handling (analyst, evidence prep)	**$150 – $400**
Total cost if you LOSE (single)	**$465 – $1,015**

Total cost if you LOSE on a batched dispute can exceed $1,200.

RULES OF THUMB

Single-claim minimum threshold:
$500 – $750 in expected lift over the QPA. Below that, the math rarely works.

Batched-claim minimum threshold:
$250 – $400 per line item, with 10+ claims in the batch.

Adjust for win probability.
Provider win rate is 88% — but specialty, IDRE, and evidence quality move that number.

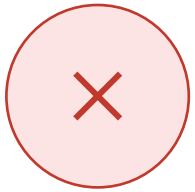
Don't forget the 90-day cooling off.
After a determination, you can't refile against the same payer for the same code for 90 days.

LESSONS LEARNED

Six pitfalls that sink otherwise winnable disputes

Filing federally when state law applies

Illinois fully insured plans go through IDOI arbitration, not federal IDR. Auto-rejection.

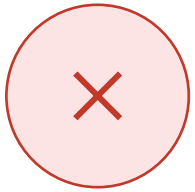


Missed deadlines

30-day open negotiation, 4-day initiation, 10-day offer windows. One slip = ineligible.

Improper batching

Mixing payers, mismatched codes, or services across more than 90 days kills the batch.



Duplicate disputes

Same claim, same date, same code (and now modifier) = duplicate. Closed without determination.

Thin evidence submissions

Submitting only the QPA and a billed charge gives the IDRE nothing to work with on factors 2–6.

Ignoring payer non-response

Default-judgment wins exist (91% provider win when payer doesn't respond), but only if you file.

PART THREE

Wisconsin and the Upper Midwest

Five states. Five different paths. Always check state law first.

FEDERAL-ONLY

Wisconsin

Wisconsin has no state balance billing law.

Federal No Surprises Act protections and federal IDR apply for all eligible disputes. CMS directly enforces.

APPLICATION SUMMARY

Governing law	**Federal NSA / CAA only**
Dispute path	**Federal IDR via CMS portal**
Enforcement	**CMS direct enforcement**
State agency role	**OCI consumer complaints**

PLAN-TYPE COVERAGE

Air ambulance	**Federal NSA covers**
Self-funded ERISA plans	**Federal NSA**
Fully insured plans	**Federal NSA**
State Medicaid	**Not subject to NSA**

Source: Wisconsin Office of the Commissioner of Insurance (oci.wi.gov/pages/consumers/nosurprisesact.aspx); CMS Centers for Consumer Information & Insurance Oversight.

QUICK REFERENCE

Five-state comparison - briefly

State	State Balance Billing Law	State IDR / Arbitration	Payment Methodology	Federal IDR Applies To
Wisconsin	None	None	Federal QPA	All eligible disputes
Illinois	PA 102-0901 / 215 ILCS 5/356z.3a	Yes — IDOI binding arbitration (45 days)	Arbitrator decides; QPA not primary	ERISA/self-funded; air ambulance
Minnesota	Minn. Stat. § 62K.11; § 62Q.55; § 62Q.556	No — federal IDR by reference	Federal QPA	All eligible disputes after MN open negotiation
Michigan	PA 234, 235, 236, 237 of 2020	No state IDR — DIFS recalculation review only	Greater of: median rate OR 150% Medicare	ERISA/self-funded; air ambulance
Iowa	Iowa Code § 514C.16 (emergency only)	None	Federal QPA	All eligible disputes

PRACTICAL TAKEAWAY: Your first decision on every OON dispute is a routing decision. Plan type (ERISA vs. fully insured) + state of issue + service type (emergency vs. ancillary) determine the path. Get this wrong and you lose before you start.

KEY TAKEAWAYS

What to operationalize Monday morning

1. **Treat IDR as a governed workflow, not exception handling**

   Operational discipline drives outcomes more than legal arguments.

2. **Front-load eligibility documentation**

   Every dispute should arrive at the IDRE complete. The October 2025 portal rewards this and penalizes the rest.

3. **Always run the state-vs-federal routing analysis first**

   Wisconsin and Iowa are federal. Illinois is state. Minnesota is hybrid. Michigan is its own thing.

4. **Build evidence portfolios that go beyond the QPA**

   Six factors. Use them all. Cite TMA II and III in your written submissions.

5. **Set thresholds before you file, not after**

   Below $500–$750 expected lift on a single claim, the math doesn't work. Batch when you can.

WHAT'S COMING

2026 watch list

Five regulatory and litigation developments that will reshape how you operate this year.

LITIGATION

TMA III Fifth Circuit en banc rehearing

Granted May 2025; mandate not yet issued. Could meaningfully shift QPA methodology mid-year.

RULEMAKING

Final IDR Operations Rule

Proposed Nov 2023. Expected to be finalized in 2026 — broader batching, standardized codes, mandatory portal registration for payers.

PLATFORM

IDR Gateway launches late 2026

Replaces current single-use web forms with centralized dashboard, identity verification, US-only access protocols.

ENFORCEMENT

Enforcement discretion sunsets

Departments extended discretion through Feb 1, 2026 with possible final extension to Aug 1, 2026. Audit activity expected to ramp.

TRANSPARENCY

Advanced EOB proposed rule

Expected March 2026. Will require plans to provide pre-service cost and coverage information.

QUICK REFERENCE

Acronyms and abbreviations

The terms you'll hear most often today — flip back here any time.

FEDERAL FRAMEWORK

NSA	No Surprises Act
CAA	Consolidated Appropriations Act, 2021
HHS	U.S. Dept. of Health & Human Services
DOL	U.S. Department of Labor
CMS	Centers for Medicare & Medicaid Services
ERISA	Employee Retirement Income Security Act

DISPUTE PROCESS

IDR	Independent Dispute Resolution
IDRE	IDR Entity (the arbitrator)
QPA	Qualifying Payment Amount
OON	Out-of-Network
PUF	Public Use File (CMS data)
TMA	Texas Medical Association (litigant)

STATE BODIES

IDOI	Illinois Dept. of Insurance
DIFS	Michigan Dept. of Insurance & Financial Services
OCI	Wisconsin Office of the Commissioner of Insurance
AAA	American Arbitration Association
AHLA	American Health Law Association

OTHER TERMS

EOB	Explanation of Benefits
AEOB	Advanced Explanation of Benefits
GFE	Good Faith Estimate
TPA	Third-Party Administrator
ASC	Ambulatory Surgical Center
FFS	Fee-for-Service (Medicare)

THANK YOU

Questions, war stories, and disagreements all welcome.

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PART 2

Workers' Compensation

Billing Complexity, Wisconsin's 2027 Fee Schedule, and Industry Headwinds

A G E N D A

What we'll cover today

01

The complexity of WC billing

Ten sources of friction, registration challenges, and why the math is hard

02

Fee schedules and U&C strategy

Methodologies, structural pitfalls, and how to recover what you're owed

03

Wisconsin 2027 and the national landscape

A new hospital fee schedule by July 1 — and where WI fits nationally

04

Industry headwinds shaping 2026+

AI-driven denials and the carrier profitability paradox

OVERVIEW

Why is billing workers' comp complex?

Ten compounding sources of friction — most provider workflows aren't built to handle them.

1. **Complicated and complex billing rules and regulations**
2. **Validation, registration, and verification of coverage**
3. **Document requirements**
4. **Complicated fee schedule math**
5. **Pre-auth and utilization review**
6. **Timely filing requirements**
7. **Compensability and presumption**
8. **Higher denial rate**
9. **Complicated appeal process**
10. **Complicated contracting considerations**

CHALLENGE ONE

WC pain point: validation and registration

Most injured workers don't know who their employer used for workers' comp insurance — and a claim isn't a WC claim until the first report of injury is filed.

CHALLENGES

- Most injured workers do not know who their employer used for workers' compensation insurance.
- Numerous phone calls can be required to determine claim destination — to patient, employer, and payer.
- Company must file first report of injury.
- No matter what the situation, it is not a work comp claim until this happens.

SOLUTIONS

- **Ask the right questions at registration.**
  - Do you know who your employer uses for work comp? (just in case — they probably won't know)
  - Who is my point of contact at your employer (risk management, HR, etc.)?
- **Catalogue everything!**
  - Keeping a database of all insurance/employer relationships can save you time (example: Enforcer360).
- **Always verify — but in one phone call instead of five.**

CHALLENGE TWO

Complicated fee schedule math

Math problems are rarely simple — and require information from multiple sources.

WHY THE MATH IS HARD

- Inputs come from multiple sources — DRG weights, hospital cost-to-charge information, locality, and more.
- Not only do states have different fee schedules — they have different methodologies.
- A lot of hospital systems are not able to quantify some of the complicated fee schedule math and nuance.
  - *Example: Florida outpatient fee schedule contains clinical nuances that can't be built in.*
- Knowing the expected reimbursement before billing a claim can help with planning and appeals.

THE BOTTOM LINE

Provider revenue cycle teams that can model expected reimbursement BEFORE the claim drops:

Catch underpayments faster

Build stronger appeal positions

Forecast WC revenue more accurately

Reduce administrative cycles

REFERENCE

Work comp fee schedule types

Four common methodologies — each with its own profile of margin, complexity, and appeal opportunity.

MOST COMMON

Medicare-based

- Lower margins
- Lower average reimbursement
- May also be Medicaid-based

STREAMLINED

State-specific

- Usually easier to navigate
- Higher reimbursement averages
- More predictable

WI CURRENT

Usual & Customary

- No formal WC rules / fee schedule in place
- Claims must not pay more than other providers in area
- Difficult to work — contracts a plus

MANAGED CARE

State-run (e.g., Ohio)

- Work comp division processes and pays claims
- Typically, through approved managed care groups
- Consistent reimbursement, low appeal opportunity

DEEP DIVE

U&C fee schedule: key issues

Six structural problems baked into Usual & Customary reimbursement.

ISSUE 1

Lack of transparency

U&C rates often based on proprietary databases (e.g., FAIR Health) that aren't publicly available. Providers frequently don't know how the final allowed amount was determined.

ISSUE 2

Underpayment disputes

Carriers may reimburse significantly below the provider's billed charge by citing U&C limits — leading to repeated disputes and appeals.

ISSUE 3

Geographic variability

U&C rates are based on regional averages that may not reflect true local market costs. Rural and high-cost areas often receive lower-than-needed reimbursements.

ISSUE 4

Reimbursement delays

Disagreements over U&C amounts can significantly delay payments — negatively impacting revenue cycle and cash flow, especially for smaller practices.

ISSUE 5

Heavy appeal burden

Providers often need to submit multiple appeals with supporting data to challenge U&C denials — creating administrative burden and dedicated billing-resource demand.

ISSUE 6

Inconsistent payer practices

Different carriers use different benchmarks (e.g., 70th vs. 80th percentile), resulting in inconsistent reimbursement for identical services across payers.

U&C strategy

Five strategies to harden your position and recover what you're owed.

1

Research and understand U&C benchmarks

Regularly research current U&C data for your region using reliable sources like FAIR Health. Understand that U&C rates must be derived from workers' comp claims, not MVA or other types of insurance claims.

2

Ensure detailed and accurate documentation

Provide comprehensive medical necessity notes, patient history, and treatment justification. Ensure proper coding (CPT, ICD-10) matches the service provided to reduce risk of denials or delays.

3

Train billing teams on U&C policies

Educate billing staff on how to interpret U&C rate schedules and payer-specific practices. Provide ongoing training on handling common disputes and appeals based on U&C reimbursement issues.

4

Use analytics to monitor payment trends

Track underpayment patterns to identify consistent issues with specific payers or services. Use data analytics tools to proactively detect discrepancies between billed and reimbursed amounts.

5

Focus on responsible contracting and managed care negotiation

Negotiate contracts with payers that ensure fair reimbursement, taking into account local U&C data. Establish clear terms in agreements to minimize disputes and ensure timely, accurate payment.

MAJOR CHANGE

Wisconsin 2027: historic shift to a hospital fee schedule

Wisconsin was 1 of only 5 states with NO formal WC medical fee schedule. That ends July 1, 2027.

WHY THIS MATTERS

- Wisconsin was 1 of only 5 states with NO formal WC medical fee schedule — an outlier with some of the highest procedure costs in the nation.
- July 3, 2025: Gov. Evers signed biennial budget establishing Wis. Stat. 102.423 — directing DWD to create a hospital fee schedule by July 1, 2027.
- Debate had percolated in the Capitol since 2014. WHA and business groups (WMC) finally reached compromise this budget cycle.

HOW THE RATE IS CALCULATED

- Wisconsin divided into 5 geographic / economic regions.
- Per region: DWD calculates the 75th percentile of in-network commercial rates (Medicare/Medicaid excluded by law).
- Maximum WC payment = 120% of the 75th percentile in-network commercial rate for that region and service.

SCOPE AND LIMITATIONS

- Applies to eligible hospitals under Wis. Stat. 50.33(2) accepting Medicaid; excludes psychiatric/mental health facilities.
- Does NOT cover PT, chiropractic, pain management, or ancillary providers — U&C remains for those.
- Balance billing prohibited; payment under FS does NOT constitute admission of compensability or liability.

OPERATIONAL READINESS

WI 2027 fee schedule: timely payment rules and what providers must do now

The payment deadlines are the law's primary enforcement tool — and your leverage.

CRITICAL PAYMENT DEADLINES

Key enforcement mechanism

- Bills under $65,000: insurer must pay within 60 days of receiving bill or supporting records.
- Bills $65,000+: insurer must pay within 90 days.
- Insurers may request 30-day extensions while reviewing compensability (DWD approval required).
- If extension denied, payment due within 14 days. If insurer misses deadlines, FS voids — hospital may revert to full billed charges.

HOSPITAL DOCUMENTATION

Supporting records

- Hospitals must provide supporting medical records within 10 days of insurer request — to the extent practicable.

OTHER 2025 WI LEGISLATIVE CHANGES

Effective sooner

- Jan. 1, 2026: WC dispute resolution consolidates back to DWD (Division of Hearings & Appeals merges in) — one agency, start to finish.
- Aug. 1, 2025 rule change (Sec. 80.72): Standard deviation for fee reasonableness reduced from 1.4 to 1.2 — tightens the band, making underpayment disputes harder to win.

ACTION STEPS FOR PROVIDERS NOW

Operational checklist

- Categorize your providers — which qualify as eligible hospitals vs. non-hospital (different rules apply).
- Monitor DWD rulemaking and Wisconsin Administrative Register for FS publication — it will only apply to services after publication date.
- Update billing procedures for new payment deadlines; track insurer compliance closely — the payment deadline is your leverage.

National WC fee schedule landscape: where does WI fit?

Fee schedules add predictability, reduce dispute volume, and simplify billing math — Wisconsin is finally joining the rest of the country.

NATIONAL CONTEXT — WHY FEE SCHEDULES MATTER

- NCCI data: states WITH a physician fee schedule saw 2.3% lower annual physician cost growth vs. states without one (2012–2022).
- Fee schedules add predictability, reduce dispute volume, and make billing math far simpler for providers and payers alike.

WI VS. NEIGHBORING STATES AT A GLANCE

- Illinois: Medicare-based FS for most services. | Minnesota: Resource-based relative value scale (RBRVS). | Michigan: Medicare-based FS.
- Wisconsin (pre-2027): U&C only — no formal cap, highest in the region for major procedures like rotator cuff repair and knee replacement.

WHAT THE WI FS CHANGE MEANS FOR HOSPITAL REVENUE

- High-charge hospital claims will face new payment caps — expect downward pressure on reimbursement for surgical and inpatient WC cases.
- Non-hospital providers (PT, chiro, pain mgmt) retain U&C exposure — existing underpayment disputes remain unchanged.
- Revenue cycle teams must model expected impact by region before July 2027 — reserving and budgeting for WC revenue will change.
- Potential silver lining: more predictable rates may reduce appeal volume and administrative overhead once fully implemented.

EMERGING TREND

The real cost of AI-driven denials in work comp

Denial rates rose 20% in five years — and denied claims cost 55% more. AI is accelerating a broken cycle.

7–13%

Initial denial rate

WCRI, 2022–2025 median states

67–70%

Denied claims eventually paid

Lockton Analytics benchmarking study

55% more

Cost of a converted denial

$15,694 vs. $10,153 avg — Lockton

388%

Cost of litigated claims

Median +739%; 195% longer to close

HOW AI ENTERS THE DENIAL PIPELINE

- NLP triage flags injury type, job duties, and red flags from First Report of Injury — before any adjuster review
- Utilization review automation, fraud scoring, and predictive reserve-setting applied in under 2 seconds
- Severity classification and payment decisions made algorithmically — often with limited human override

Denial rates rose ~20% from 2013–2017 as data-driven tools expanded — WCRI tracking further increases through 2025

WHY THIS MATTERS FOR PROVIDERS

- AI cannot account for clinical nuance, state-specific WC rules, or individual injury circumstances
- 70.6% of denied claims are litigated vs. 27.5% of accepted claims — a 2.5x jump (Lockton)
- Denied litigated claims average $36,991 vs. $7,489 for non-litigated accepted claims
- Total WC claim costs rose ~6%/yr 2022–2025 — administrative friction is a primary driver (WCRI)

Sources: WCRI (2025), Lockton Analytics, HealtheSystems 2025 Annual WC Industry Insights Survey, Risk & Insurance, KevinMD (May 2026) | Workers' Compensation

The profitable paradox: premiums down, denials up

Carrier profitability is structural. Denials and utilization review are how it's protected.

$41.6B

2024 net written premium

Down 3% YoY — only P&C line to decrease

86%

2024 combined ratio

11th consecutive year of underwriting gains

7

Straight years <90% combined

Industry redundant reserves: ~$16–18B

−5%

2024 claim frequency

Decades-long decline, yet denials are rising

HOW CARRIERS STAY PROFITABLE WHILE CUTTING RATES

- Profitability = lower premiums collected + aggressive cost containment (denials, delays, utilization review, AI-powered claim decisions).
- 2024 accident year combined ratio estimated at 99% — without prior-year reserve releases, carriers barely break even. Continued denial pressure is structural.
- **Fewer claims, more scrutiny per claim.**

THE TIDE MAY BE TURNING

Rate increases emerging — CA's first hike in 10+ years (+8.7%); WA up Jan. 2025; FL smallest reduction in years.

Medical severity rising 6% in 2024; indemnity severity up 6% — as carrier profitability compresses, denial and delay tactics intensify.

Your denial rates are a lagging indicator of carrier profitability pressure.

THANK YOU

Connect with me — happy to keep the conversation going.

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