

The Essential Claims Backlog Recovery Blueprint

A 30–60–90 day framework to stabilize performance, manage complexity, and regain control of claims operations.



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Claims Operations Are Fundamentally Changing

As Complexity Rises and Automation Removes Routine Work, Backlog Recovery Requires a Different Operating Approach

Claims backlogs have become one of the most visible and disruptive challenges facing healthcare payers today.

But backlog is rarely driven by volume alone. Drawing on hands-on experience supporting healthcare payers through backlog recovery, Imagenet has found that most backlog issues stem from breakdowns in visibility, segmentation, and operational discipline as claim complexity increases.

In practice, backlog rarely builds evenly. It concentrates in specific queues, often involving high-dollar claims, pended claims awaiting documentation, or more complex scenarios. These queues begin to age faster than the rest of the inventory, creating bottlenecks that standard throughput models cannot resolve.

This blueprint presents a practical 30-60-90 framework to help healthcare payers stabilize claims backlog, improve performance consistency, and reduce the risk of recurrence over time.

As automation continues to absorb routine, low-complexity claims, what remains in manual workflows is disproportionately more difficult to process. These claims require deeper expertise, more nuanced decision-making, and tighter coordination across systems, policies, and stakeholders.

What once appeared to be a throughput challenge is now a structural one. Operating models designed for predictable, high-volume processing are struggling to keep pace with variability and risk. When those models begin to break down, the symptoms are familiar: inventory accumulates, turnaround times slip, rework increases, and compliance exposure expands.

Backlog is not the root problem. It is the operational signal that the model is no longer keeping pace with the complexity of modern claims.

The Cost of Inaction



Financial leakage from inaccurate payments



Missed regulatory timelines and penalties



Increased provider disputes and abrasion



Member dissatisfaction due to delays, inaccurate EOPs, or denials



Expanded audit and compliance risk

Left unaddressed, operational instability compounds quickly.

A Phased Framework for Backlog Recovery

First 30 days

Triage backlog, segment risk, and establish performance visibility.

Days 31-60

Build consistency through workforce alignment, workflow discipline, and quality controls.

Days 61-90

Optimize performance, reduce rework, and strengthen prevention efforts.

Why Now Is a Pivotal Time to Shift to Proactive Control

Successful backlog recovery is not defined by how quickly inventory is cleared—it's defined by how well performance is stabilized.

High-performing claims organizations don't just reduce backlog. They build the visibility, control, and operating discipline required to manage complexity and reduce the risk of recurrence over time.

Traditionally, claims operations could rely on volume-based scaling and standardized workflows. But that model is no longer sufficient. **As claim complexity rises and variability increases, organizations must shift from reactive recovery to proactive control.**

This shift requires more than incremental improvements. It requires a fundamentally different approach to how claims operations are structured, monitored, and governed.

Without this shift, organizations remain trapped in a reactive cycle—continuously working to reduce backlog, only to see it return.

This blueprint is designed to help healthcare payers move beyond short-term recovery and toward a more controlled, sustainable operating model for claims performance.

What Stabilization Delivers



Stabilized
inventory levels



Higher first-pass
accuracy



Improved
turnaround times



Reduced rework and
escalation volume

Why Claims Are Getting Harder—Not Easier

To understand why backlog continues to build—and why recovery efforts stall—payer organizations must look at how the claims landscape has changed. At the center of backlog growth is one key driver: the increasing concentration of complex claims.

As automation continues to absorb routine, low-complexity claims, what remains in manual workflows is disproportionately more difficult to process. This shift is not always immediately visible—but it fundamentally changes how claims operations function.

Where teams once worked through high volumes of relatively straightforward claims, they are now increasingly faced with cases that require deeper expertise, more investigation, and more nuanced decision-making.

At the same time, broader industry trends are compounding this complexity.

An [aging population is driving higher utilization](#) and more [clinically complex cases](#). Meanwhile, reimbursement structures—particularly in areas like durable medical equipment (DME), specialty services, and multi-layered benefit designs—are becoming more difficult to interpret and adjudicate consistently.

For claims teams, this translates directly into operational strain. Processing times increase, more claims require multiple touches, and resolution becomes more dependent on individual expertise rather than standardized workflows. Workforce challenges further accelerate the issue, as the gradual training pathways that once supported skill development become less viable in a complexity-driven environment.

Organizations are now asking less experienced staff to handle a vast array of more complex claims—often without the structure or support required to do so consistently. As complexity increases, processing time becomes less predictable. Two claims of the same type may require significantly different handling depending on documentation quality, benefit structure, or coordination across payers—making it harder for operations and expertise to keep pace consistently.

When operating models designed for predictable, high-volume processing are applied to this new reality, backlog becomes increasingly difficult to control.

What's Evolving in Claims

- Fewer simple claims
- More complex inventory
- Less training runway
- Greater reliance on experienced staff
- Higher financial and compliance risk per claim

“With areas like DME, you’re not just processing a claim—you’re interpreting coverage, documentation, and multiple variables at once.”

— Shawna Kamper,
Chief Operating Officer
Imagenet

What Makes a Claim Complex—and Why It Matters

Not all claims are weighted equally. Within any claims inventory, a relatively small portion of claims can account for a disproportionate share of processing time, financial exposure, and operational risk. These are complex claims—and in an evolving landscape, they are becoming the most critical segment to manage effectively.

Understanding what makes a claim complex is the first step toward stabilizing performance.

Defining Complex Claims

Complex claims are not defined by one attribute, but a matrix of variables. Each requires deep expertise, insightful investigation, and more precise decision-making.

Examples of complex claims include:

 <p>Coordination of benefits (COB) across multiple payers</p>	 <p>Manual pricing or out-of-network reimbursement scenarios</p>	 <p>Authorization or eligibility discrepancies that require validation</p>	 <p>High-dollar facility or specialty claims</p>	 <p>Institutional claims involving case-rate or bundled reimbursement arrangements</p>
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While these claims may differ in structure, they share a common characteristic: they cannot be processed through standard workflows alone. They require judgment, experience, and careful interpretation of policies, contracts, and documentation.

Why Complexity Changes Everything

Complex claims take longer to process. They are more likely to require multiple touches. And when handled inconsistently, they create downstream rework that compounds quickly.

Even claims that are similar to each other can require significantly different handling depending on documentation quality, benefit structure, or coordination across payers—making consistency more difficult to maintain at scale. More importantly, while complex claims introduce variability into the system, the margin for error is significantly smaller. A single misjudgment on a complex claim can result in:

- Financial inaccuracies
- Provider disputes or escalation
- Compliance exposure during audits

In this environment, treating all claims the same is no longer viable. These claims not only take longer—they introduce variability that disrupts forecasting, strains staffing models, and reduces throughput predictability.

A small portion of claims often carries the majority of operational and financial risk.

Common Characteristics of Complex Claims

- Multi-line or multi-service claims
- Multi-payer involvement
- Documentation gaps or inconsistencies
- Manual intervention required
- Higher financial exposure

These characteristics increase processing time, variability, and risk.

Why Complex Claims Are Reshaping Claims Operations

At the center of backlog growth is one key driver: the increasing concentration of complex claims.

As automation continues to absorb routine, low-complexity claims, what remains in manual workflows is disproportionately more difficult to process. The overall volume of claims may not change significantly, but the composition of that volume has fundamentally shifted.

But the impact of this shift is not just about what types of claims are being processed—it is about how claims operations must function differently as a result.

Work that was once predictable becomes variable. Processing times become less consistent, and performance becomes more dependent on individual expertise rather than standardized workflows. As complexity increases, traditional operating models begin to break down.

This shift has significant implications for workforce models.

Organizations are increasingly reliant on experienced examiners to handle complex claims, while at the same time facing workforce attrition and limited training pathways for newer staff. As a result, less experienced examiners are often asked to manage more complex work—without the structure or support required to do so consistently.

Training models that once relied on gradual progression—from simple to complex claims—are becoming less effective as simpler claims disappear from the workflow.

At the same time, consistency becomes more difficult to maintain.

When similar claims require different levels of investigation, documentation review, or coordination, variability increases across teams. This can lead to uneven decision-making, higher error rates, and increased rework—particularly in high-risk or financially sensitive claims.

Over time, these pressures make backlog more difficult to forecast, staffing models harder to sustain, and throughput less predictable. The result is a widening gap between the demands of the work and the structure of the operation.

Drawing on hands-on experience supporting healthcare payers through backlog recovery, this is where organizations often begin to see performance break down—when complexity outpaces the structure, visibility, and discipline of the operation.

When that gap is not addressed, backlog becomes increasingly difficult to control.

A Shifting Claims Landscape	
Then	Now
High volume, low complexity	Lower volume, higher complexity
Traditional, gradual training and matriculation pathways	Immediate complexity exposure
Throughput-driven	Accuracy + judgment-driven

“It’s not just about volume anymore—it’s what’s inside each claim. They’re more complex, and they require more expertise to get right.”

— Angie Lanasa,
Senior Vice President of Operations,
Imagenet

Understanding this shift is critical—because it explains why many recovery efforts fail.

Why Traditional Backlog Recovery Approaches Fall Short

Most backlog recovery efforts fail for a simple reason: they attempt to solve a complexity problem with a volume-based approach. What appears to be a capacity issue is actually a mismatch between the work being done and how most payer operations are structured to handle it.

In practice, this shows up quickly—through inconsistent output, growing rework queues, and increasing pressure on experienced staff to step in.

1. The Headcount Assumption: More Isn't Always More

When backlog builds, the instinct is to add more people. But additional headcount doesn't immediately improve performance. New examiners take time to ramp—often weeks or months when handling complex claims. Without strong training, structure, and quality alignment, scaling introduces variability.

In many cases, organizations believe they are reducing backlog—only to see the same claims re-enter the system within days due to quality issues, missing documentation, or inconsistent adjudication decisions.

2. Treating All Claims the Same: The Cost of Uniform Workflows

When pushed through standard workflows, complex claims are often rushed or misinterpreted. At the same time, standardized workflows mean lower-risk claims may receive unnecessary attention, which slows throughput.

The result is uneven performance, with errors concentrated where they matter most:

- High-dollar claims
- Complex reimbursement scenarios
- Compliance-sensitive cases

Without segmentation, backlog becomes harder to control.

3. Volume Over Discipline: Speed-First Mindset Creates Downstream Failure

To reduce backlog quickly, many organizations prioritize speed over consistency. Their teams focus on clearing inventory, just without the controls needed to ensure accuracy.

In the short term, this creates the appearance of progress. But in practice, it leads to:

- Increased errors
- Higher rework volume
- More escalations and disputes

Claims processed quickly—but incorrectly—return to the system, adding to the backlog.

Effective backlog recovery requires an evolved approach—one grounded in segmentation, visibility, and resilience.



A Practical 30-60-90 Framework for Backlog Recovery

No two backlog situations look exactly the same, but effective recovery efforts tend to follow a common path. This 30-60-90 framework outlines practical priorities to help healthcare payers stabilize backlog, improve performance consistency, and reduce the risk of recurrence over time.

Phase 1: First 30 Days

Triage, Control, and Visibility

Recovery begins with control, not acceleration.
The first step in stabilization is to break down the backlog into meaningful segments.



1. Segment the backlog to prioritize risk

- Claim complexity (e.g., routine vs. complex)
- Financial exposure (e.g., high-dollar claims, leakage, duplicate claims)
 - Aging and timeliness risk (e.g., aged inventory, approaching TAT thresholds, timely filing risk)
 - Regulatory or compliance sensitivity (e.g., audit exposure, mandated handling requirements)

Prioritize work not by volume—but by impact.



2. Establish performance visibility

Use dashboards to gain a clear view of the following:

- Backlog volume and aging
- Throughput percentage relative to incoming claims
- Claim pending rates
- Early indicators of quality drift

Without real-time visibility, organizations are forced into reactive decision-making—often after issues have already escalated.



3. Build a rhythm

High-performing organizations review daily or frequently:

- Claims backlog (including both volume and age)
- Volumes in cross-departmental queues
- Productivity by claim type and departmental standards
- Exceptions, escalations, and bottlenecks
- Quality signals

Segmenting Claims by Complexity and Risk to Drive Handling Strategy

Not all claims should be handled the same way. Segmenting by complexity and risk ensures the right level of expertise, speed, and control is applied to each claim.

	Low Risk	High Risk
Low Complexity	Streamlined processing	Elevated review
High Complexity	Specialized handling	Immediate prioritization

Early warning signs of backlog instability

- Throughput begins to fall behind intake
- Inventory aging increases
- More claims require multiple touches
- Pend rates trend upward
- QA errors begin to increase
- Increased call center volumes

Build Consistent Performance at Scale

Once the backlog is stabilized, the focus shifts to scaling performance—without reintroducing variability.



1. Scale Through Workforce Alignment—Not Just Headcount

At this stage, the goal is not simply to increase capacity—it's to equip examiners with the right level of expertise. Without this alignment, less experienced staff are often assigned complex claims—leading to higher error rates, increased rework, and added pressure on backlog.

Effective scaling depends on:

- Assigning complex claims to experienced examiners
- Aligning skill levels to claim types and risk profiles
- Building specialization within the workforce

Sustainable scaling requires a workforce model that flexes with both volume and complexity.



2. Standardize Workflows to Reduce Variability

Variability in how claims are processed—across examiners, teams, or locations—can quickly lead to increased error rates and rework.

Standardized workflows mean:

- Claims are routed consistently
- Escalations have defined pathways
- Policies and reimbursement rules are interpreted uniformly



3. Reinforce Quality as a Control Mechanism

Quality can no longer be a downstream check. Ongoing calibration and feedback loops help ensure consistency—especially as claim complexity increases.

Healthcare payers must ensure that:

- Performance is measured not just by output, but by first-pass resolution
- Accuracy expectations are clearly defined and consistently applied
- Feedback loops enable teams to identify and correct errors quickly

Phase 3: 61-90 days

Focus on Optimization & Prevention

Sustainable backlog recovery requires preventing the conditions that caused it in the first place.

1. Reduce Rework Through Root Cause Analysis and Preventive Action

Sustainable performance depends on addressing the underlying drivers of backlog—not just clearing inventory.

Organizations must identify why claims are:

- Delayed
- Pended unnecessarily
- Require multiple touches
- Require manual intervention

By addressing issues like inconsistent policy interpretation, unclear documentation, workflow breakdowns, and training gaps, payers can reduce rework and improve first-pass resolution.

2. Embed Compliance into Daily Workflows

In high-performing claims operations, compliance is built into workflows and includes:

- Consistent documentation of claim decisions
- Clear alignment with regulatory/payer guidelines
- Visibility into audit readiness

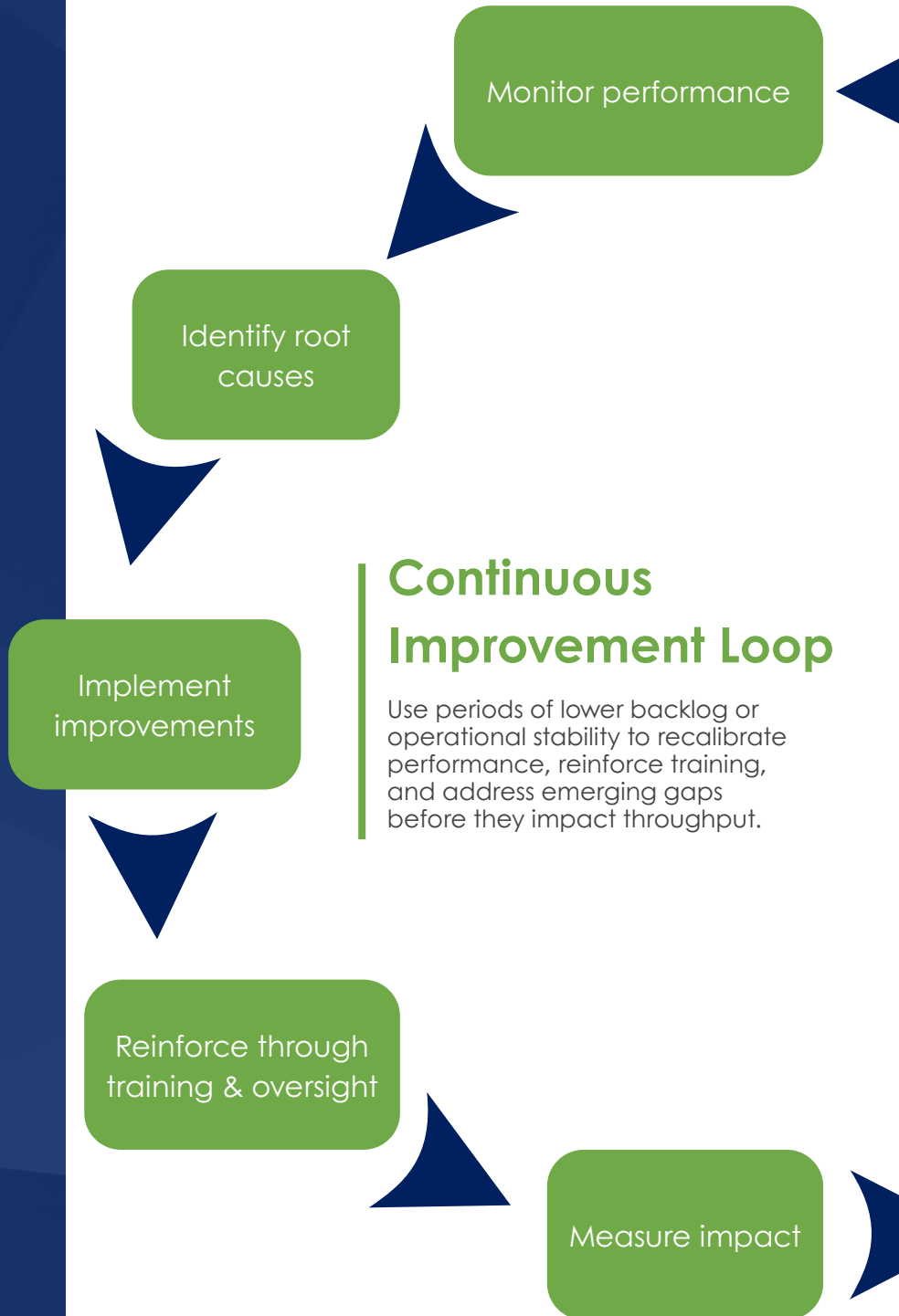
3. Strengthen Payment Integrity and Financial Control

During backlog cycles, financial accuracy is often at risk.

Errors in complex claims can result in:

- Overpayments or underpayments
- Increased provider disputes
- Higher administrative costs
- Increased customer service calls

All of these consequences can lead to provider and member abrasion, and can in turn drive provider terminations within a payer's network.



Continuous Improvement Loop

Use periods of lower backlog or operational stability to recalibrate performance, reinforce training, and address emerging gaps before they impact throughput.

Operational Control Requires Discipline

Sustainable claims performance is not achieved through one-time recovery efforts. It is the result of visibility, governance, and a connected operating model. When these elements are in place, organizations move beyond backlog recovery—and toward proactive, resilient operations.

Establishing Performance Visibility Through KPIs

Leaders need to maintain a clear, consistent view of performance across key indicators, including:

- Turnaround time (TAT) by claim type and days receipt on hand (DROH)
- Inventory levels and aging trends
- Pend rates and root causes
- Rework and first-pass accuracy
- Examiner productivity and throughput
- Escalations, disputes, and provider abrasion

These KPIs provide early visibility into where backlog is forming, where performance is drifting, and where corrective action is needed before instability escalates.

Governance Drives Accountability

Metrics alone are not enough—performance must be actively managed. High-performing organizations have a model that includes:

- Frequent (often daily) operational oversight of backlog and throughput
- Weekly performance reviews aligned to KPIs
- Cross-functional alignment across intake, adjudication, and QA

Connect the Claims Lifecycle End-to-End

Claims performance does not begin at adjudication—it begins upstream. A connected lifecycle means:

- Documentation is complete and accurate at intake
- Claims are routed appropriately based on complexity and priority
- Downstream teams can process claims efficiently and consistently

What operational resilience looks like:

- Stable, predictable inventory levels
- Consistent turnaround times
- High first-pass accuracy
- Low dispute and escalation rates
- Strong audit readiness and compliance performance

From Recovery to Action

Backlog recovery is not defined by how quickly claims are processed, but by how consistently performance is stabilized over time. As claim complexity increases, sustainable recovery depends on stronger visibility, better operational discipline, and a model designed to support accuracy, consistency, and control.

For healthcare payers, the goal is not simply to work down inventory, but to build a more controlled claims operation that can manage complexity without sacrificing quality, compliance, or financial performance. Informed by real-world experience supporting payer operations, this blueprint outlines a practical framework for moving from reactive recovery to more stable, sustainable performance.

Take the Next Step Toward Claims Backlog Stabilization

A conversation with Imagenet's claims experts can help clarify where backlog is building, where performance may be breaking down, and where targeted operational support can help improve control, consistency, and recovery.

In that discussion, we can help you:

- 

Identify likely drivers behind backlog growth
- 

Surface high-risk or high-impact claim areas
- 

Uncover workflow, quality, or escalation breakdowns
- 

Explore practical ways to support stabilization and sustained performance

Connect with Imagenet to discuss your claims backlog recovery priorities.

Scan to Start the Conversation



Supporting Healthcare Payers Across Critical Operational Areas

Claims recovery is just one part of the broader operational picture. For more than two decades, Imagenet has helped healthcare payers improve performance across complex operational areas through a combination of technology, domain expertise, and scalable support.

From intake and processing to claims adjudication, member communications, and contact center services, we help organizations bring greater structure, visibility, efficiency, and control to the functions that shape operational performance.

Our core solutions include:

[Digital Mailroom](#)

[Claims Adjudication](#)

[Contact Center](#)

[Member Communications & Reconciliation](#)

Discover how Imagenet helps healthcare payers strengthen performance across critical operational areas.



Scan to
Explore
Solutions