SAMPLE PRACTICE / ILLUSTRATIVE REPORT

Know where to negotiate next.

A review of example fees, procedure volume and local reimbursement rates. All financial figures and payer identities are fictional.

POTENTIAL ANNUAL REIMBURSEMENT INCREASE - BASE CASE

$61,488

Estimated using fictional fees and procedure volume.

+3.4%

OF EXAMPLE ANNUAL PRODUCTION - ESTIMATED

TOP 3 OPPORTUNITIES BY FEE SCHEDULE

Schedule A PPO Payer A, Payer B / Commercial review	**$27,919**
Schedule B PPO Payer C / Network strategy	**$10,937**
Schedule C Network Payer D / Commercial review	**$10,697**

ESTIMATED ANNUAL INCREASE - POSSIBLE OUTCOMES

Conservative	Base case	Upside
$27,328	**$61,488**	**$102,479**



These estimates are not guaranteed. Some opportunities require a network change rather than a fee increase.

NEXT STEP

Validate the highest-priority fee schedules and plan mappings before preparing rate requests.

Read the limitations on the next page before making contracting decisions.

READ BEFORE USING THIS REPORT

Important limitations and terms.

This report supports reimbursement analysis and negotiation planning. It is not a promise of results.

NO GUARANTEE OF REIMBURSEMENT OR CASH IMPROVEMENT

PayorMap does not guarantee that an insurer will approve higher fees or that a report will increase collections, cash receipts, patient volume or profit. Modeled dollar gaps are not actual recoveries or forecasts of financial results.

1. Estimates depend on assumptions.

Results depend on rate source quality, payer and plan identification, current fees, geography, procedure counts, service mix and submitted data accuracy.

2. Published rates are not guaranteed payments.

Market comparisons can differ from contracted, allowed, adjudicated or collected amounts. Network participation, fee loading, contract terms and claims processing affect actual results.

3. Verify before taking action.

Confirm current contract terms, plan identities, fees and utilization before relying on a target. This report is not legal, accounting, tax or financial advice.

4. Terms of use.

Client deliverables are subject to the applicable agreement and PayorMap terms. Signed agreements take precedence where applicable.

5. Confidential and limited use.

The actual client report is intended for authorized recipients and advisers. This public sample contains only fictional payer labels, rates and financial inputs.

01 / EXECUTIVE PRIORITIES

Where to start.

Start with the fee schedule offering the largest estimated increase. Confirm applicable plans and paid claims before requesting new rates.

01 Start with Schedule A PPO - $27,919

Why first: it offers the largest modeled increase. Payer A and Payer B use this schedule. One contract review may benefit several plans.

02 Confirm the rates and volume behind the opportunity

Provide the active contract, renewal and notice dates, and paid claims. Confirm network mappings, fees and procedure counts before setting targets.

03 Prepare one focused fee-review packet

Build a current-versus-market table, proposed fees, annual financial impact and supporting evidence. The practice approves targets before any request is sent.

Example: how one CDT code becomes annual upside

Payer A / D1110 Adult cleaning / Illustrative comparison

CURRENT FEE	MARKET REFERENCE	DIFFERENCE	ANNUAL PROCEDURES
$55.00	$74.00	$19.00	210

Annual fee gap: $19.00 x 210 = $3,990. Base case: $3,990 x 50% capture x 90% retained volume = $1,796.

AFTER THAT

Review the next highest-value commercial schedules. For network participation decisions, validate product routing and contract constraints before requesting individual fee changes.

HOW PAYORMAP CAN HELP

Prepare the first fee-review packet and agree on specific CDT requests during a working session. Optional negotiation support is separately scoped.

02 / FEE SCHEDULES COMPARED TO PAYORMAP

How your uploaded fees compare with the market.

Example fee schedules compared with same-insurer rates where available, or broader market evidence. Counts do not include procedure volume.

MORE THAN 5% BELOW	WITHIN 5%	MORE THAN 5% ABOVE
661	303	931

UPLOADED FEE SCHEDULE / NETWORK	COMPARED CODES	BELOW	NEAR	ABOVE	REFERENCE TYPE
Schedule A PPO	240	100	46	94	Same payer + market
Schedule B PPO	210	145	24	41	Market comparison
Schedule C Network	235	65	52	118	Market comparison
Schedule D PPO	225	75	31	119	Market comparison
Schedule E Network	215	45	36	134	Market comparison
Schedule B Premier	190	22	20	148	Market comparison
Schedule F Standard	205	128	32	45	Market comparison
Schedule G Specialty	180	43	30	107	Market comparison
Schedule H Alternate	195	38	32	125	Market comparison

Below and above mean more than 5% lower or higher than the comparison. Near means within 5%. Counts refer to procedure codes, not annual volume or dollars. Alternative fee lists are not combined.

WHAT TO DO NEXT

Use the payer action sheets to compare frequently performed CDT procedures with market rates and prepare targeted requests.

03 / CONTRACT PRIORITIES

Which fee schedules should be reviewed first?

Insurers using the same fee schedule are grouped together. Confirm who controls the fee list and whether direct negotiation or a network strategy is appropriate.

SELECTED FEE LIST	BILLED PAYERS USING IT	BASE-CASE DIFFERENCE	CLASSIFICATION
Schedule A PPO	Payer A, Payer B	**$27,919**	Commercial review
Schedule B PPO	Payer C	**$10,937**	Network strategy
Schedule C Network	Payer D	**$10,697**	Commercial review
Schedule D PPO	Payer E	**$6,652**	Commercial review
Schedule E Network	Payer F	**$5,283**	Commercial review
All selected fee lists	Six modeled billed payers	**$61,488**	Illustrative combined model

HOW TO USE THE RANKING

Start with the largest commercial opportunities. Confirm the contracting party and participating plans. Review network participation separately. The payer action sheets show the supporting codes and estimated volumes.

04 / REVENUE UPSIDE SCENARIOS

What could a successful negotiation add?

These scenarios show how reimbursement could increase if a practice secures higher fees and retains procedure volume. Results are not guaranteed.

CONSERVATIVE	BASE CASE	UPSIDE
$27,328	**$61,488**	**$102,479**
25% capture / 80% volume	50% capture / 90% volume	75% capture / 100% volume

How rates and patient volume affect the result

PROCEDURES KEPT	25% OF GAP GAINED	50% OF GAP GAINED	75% OF GAP GAINED
80.0%	$27,328	**$54,656**	$81,983
90.0%	$30,744	**$61,488**	$92,231
100.0%	$34,160	**$68,320**	$102,479

BASE CASE - SAME-INSURER RATES	BASE CASE - BROADER MARKET RATES
$10,278	**$51,210**

What each billed payer could contribute - base case

PAYER / WHAT TO CONFIRM	POSSIBLE ANNUAL INCREASE
Payer A / confirm plan and fee list	**$10,278**
Payer B / confirm plan and fee list	**$17,641**
Payer C / confirm plan and fee list	**$10,937**
Payer D / confirm plan and fee list	**$10,697**
Payer E / confirm plan and fee list	**$6,652**
Payer F / confirm plan and fee list	**$5,283**
All modeled payers	**$61,488**

PAYER ACTION SHEET / 01

Payer A - billed payer

Estimated annual increase using fictional procedure volume and base-case assumptions.

VALID CDT PROCEDURES	BASE-CASE ANNUAL LIFT	LISTED FEES BELOW MARKET
896	$10,278	42%

Rate source: Schedule A PPO

WHY THIS DIFFERS FROM THE COVER

$10,278 is for this billed payer alone. The $27,919 schedule total includes both billed payers using the selected fee list.

Codes that matter most

Base case = fee difference x annual procedures x 50% capture x 90% retained volume.

CDT / PROCEDURE	EST. ANNUAL PROCEDURES	CURRENT FEE	MARKET REFERENCE	DIFFERENCE / VISIT	BASE-CASE LIFT
D2740 / Ceramic crown	38	$680.00	$870.00	$190.00	**$3,249**
D1110 / Adult cleaning	210	$55.00	$74.00	$19.00	**$1,796**
D2392 / Posterior composite, two surfaces	96	$105.00	$142.00	$37.00	**$1,598**
D0120 / Periodic oral evaluation	295	$29.00	$40.00	$11.00	**$1,460**
D4341 / Scaling and root planing, 4+ teeth	36	$130.00	$180.00	$50.00	**$810**
D2950 / Core buildup	33	$125.00	$177.00	$52.00	**$772**
D0220 / Periapical image, first image	188	$13.00	$20.00	$7.00	**$592**
Base-case annual increase, all modeled codes for Payer A					**$10,278**

ABOUT THESE NUMBERS

Annual procedure volumes are estimates in this fictional example. Market references are comparison targets, not approved fees. Confirm contract applicability and paid claims.

YOUR NEXT STEP

Match the billed plan to the governing fee schedule. Use the high-value code gaps to build an evidence-based fee request.

PAYER ACTION SHEET / 02

Payer B - billed payer

Estimated annual increase using fictional procedure volume and base-case assumptions.

VALID CDT PROCEDURES	BASE-CASE ANNUAL LIFT	LISTED FEES BELOW MARKET
1,366	$17,641	42%

Rate source: Schedule A PPO

WHY THIS DIFFERS FROM THE COVER

$17,641 is for this billed payer alone. The $27,919 schedule total includes both billed payers using the selected fee list.

Codes that matter most

Base case = fee difference x annual procedures x 50% capture x 90% retained volume.

CDT / PROCEDURE	EST. ANNUAL PROCEDURES	CURRENT FEE	MARKET REFERENCE	DIFFERENCE / VISIT	BASE-CASE LIFT
D2740 / Ceramic crown	65	$680.00	$874.00	$194.00	**$5,675**
D1110 / Adult cleaning	360	$55.00	$75.00	$20.00	**$3,240**
D2392 / Posterior composite, two surfaces	152	$105.00	$143.00	$38.00	**$2,599**
D0120 / Periodic oral evaluation	410	$29.00	$41.00	$12.00	**$2,214**
D4341 / Scaling and root planing, 4+ teeth	70	$130.00	$181.00	$51.00	**$1,607**
D2950 / Core buildup	59	$125.00	$178.00	$53.00	**$1,407**
D0220 / Periapical image, first image	250	$13.00	$21.00	$8.00	**$900**
Base-case annual increase, all modeled codes for Payer B					**$17,641**

ABOUT THESE NUMBERS

Annual procedure volumes are estimates in this fictional example. Market references are comparison targets, not approved fees. Confirm contract applicability and paid claims.

YOUR NEXT STEP

Match the billed plan to the governing fee schedule. Use the high-value code gaps to build an evidence-based fee request.

PAYER ACTION SHEET / 03

Payer C - billed payer

Estimated annual increase using fictional procedure volume and base-case assumptions.

VALID CDT PROCEDURES	BASE-CASE ANNUAL LIFT	LISTED FEES BELOW MARKET
910	$10,937	69%

Rate source: Schedule B PPO

Codes that matter most

Base case = fee difference x annual procedures x 50% capture x 90% retained volume.

CDT / PROCEDURE	EST. ANNUAL PROCEDURES	CURRENT FEE	MARKET REFERENCE	DIFFERENCE / VISIT	BASE-CASE LIFT
D2740 / Ceramic crown	47	$692.00	$878.00	$186.00	**$3,934**
D1110 / Adult cleaning	195	$57.00	$76.00	$19.00	**$1,667**
D0120 / Periodic oral evaluation	305	$31.00	$42.00	$11.00	**$1,510**
D2392 / Posterior composite, two surfaces	80	$107.00	$144.00	$37.00	**$1,332**
D4341 / Scaling and root planing, 4+ teeth	42	$132.00	$182.00	$50.00	**$945**
D2950 / Core buildup	39	$127.00	$179.00	$52.00	**$913**
D0220 / Periapical image, first image	202	$15.00	$22.00	$7.00	**$636**
Base-case annual increase, all modeled codes for Payer C					**$10,937**

ABOUT THESE NUMBERS

Annual procedure volumes are estimates in this fictional example. Market references are comparison targets, not approved fees. Confirm contract applicability and paid claims.

YOUR NEXT STEP

Evaluate participation and product routing before assuming an individual rate increase is negotiable.

PAYER ACTION SHEET / 04

Payer C - alternate fee schedule

Fee comparison only. Annual impact requires a confirmed plan match.

VALID CDT PROCEDURES	BASE-CASE ANNUAL LIFT	LISTED FEES BELOW MARKET
Not matched	Not modeled	12%

Rate source: Schedule B Premier

Rates to check before assigning dollars

Annual dollar estimates are unavailable for this alternate schedule.

CDT / PROCEDURE	EST. ANNUAL PROCEDURES	CURRENT FEE	MARKET REFERENCE	DIFFERENCE / VISIT	BASE-CASE LIFT
D2740 / Ceramic crown	Not matched	$700.00	$878.00	$178.00	**Not modeled**
D1110 / Adult cleaning	Not matched	$65.00	$76.00	$11.00	**Not modeled**
D0120 / Periodic oral evaluation	Not matched	$39.00	$42.00	$3.00	**Not modeled**
D2392 / Posterior composite, two surfaces	Not matched	$115.00	$144.00	$29.00	**Not modeled**
D4341 / Scaling and root planing, 4+ teeth	Not matched	$140.00	$182.00	$42.00	**Not modeled**
D2950 / Core buildup	Not matched	$135.00	$179.00	$44.00	**Not modeled**
D0220 / Periapical image, first image	Not matched	$23.00	$22.00	$-1.00	**Not modeled**

ABOUT THESE NUMBERS

No annual volume is assigned to this alternate fee list. Confirm the product, participation and claims before including it in any financial model.

YOUR NEXT STEP

Match actual claims to the alternate network first. Do not treat its fee differences as automatic revenue lift.

PAYER ACTION SHEET / 05

Payer D - billed payer

Estimated annual increase using fictional procedure volume and base-case assumptions.

VALID CDT PROCEDURES	BASE-CASE ANNUAL LIFT	LISTED FEES BELOW MARKET
987	$10,697	28%

Rate source: Schedule C Network

Codes that matter most

Base case = fee difference x annual procedures x 50% capture x 90% retained volume.

CDT / PROCEDURE	EST. ANNUAL PROCEDURES	CURRENT FEE	MARKET REFERENCE	DIFFERENCE / VISIT	BASE-CASE LIFT
D2740 / Ceramic crown	43	$704.00	$882.00	$178.00	**$3,444**
D1110 / Adult cleaning	220	$59.00	$77.00	$18.00	**$1,782**
D2392 / Posterior composite, two surfaces	98	$109.00	$145.00	$36.00	**$1,588**
D0120 / Periodic oral evaluation	330	$33.00	$43.00	$10.00	**$1,485**
D4341 / Scaling and root planing, 4+ teeth	46	$134.00	$183.00	$49.00	**$1,014**
D2950 / Core buildup	35	$129.00	$180.00	$51.00	**$803**
D0220 / Periapical image, first image	215	$17.00	$23.00	$6.00	**$581**
Base-case annual increase, all modeled codes for Payer D					**$10,697**

ABOUT THESE NUMBERS

Annual procedure volumes are estimates in this fictional example. Market references are comparison targets, not approved fees. Confirm contract applicability and paid claims.

YOUR NEXT STEP

Match the billed plan to the governing fee schedule. Use the high-value code gaps to build an evidence-based fee request.

PAYER ACTION SHEET / 06

Payer E - billed payer

Estimated annual increase using fictional procedure volume and base-case assumptions.

VALID CDT PROCEDURES	BASE-CASE ANNUAL LIFT	LISTED FEES BELOW MARKET
635	$6,652	33%

Rate source: Schedule D PPO

Codes that matter most

Base case = fee difference x annual procedures x 50% capture x 90% retained volume.

CDT / PROCEDURE	EST. ANNUAL PROCEDURES	CURRENT FEE	MARKET REFERENCE	DIFFERENCE / VISIT	BASE-CASE LIFT
D2740 / Ceramic crown	30	$716.00	$886.00	$170.00	**$2,295**
D1110 / Adult cleaning	145	$61.00	$78.00	$17.00	**$1,109**
D2392 / Posterior composite, two surfaces	62	$111.00	$146.00	$35.00	**$977**
D0120 / Periodic oral evaluation	215	$35.00	$44.00	$9.00	**$871**
D4341 / Scaling and root planing, 4+ teeth	26	$136.00	$184.00	$48.00	**$562**
D2950 / Core buildup	24	$131.00	$181.00	$50.00	**$540**
D0220 / Periapical image, first image	133	$19.00	$24.00	$5.00	**$299**
Base-case annual increase, all modeled codes for Payer E					**$6,652**

ABOUT THESE NUMBERS

Annual procedure volumes are estimates in this fictional example. Market references are comparison targets, not approved fees. Confirm contract applicability and paid claims.

YOUR NEXT STEP

Match the billed plan to the governing fee schedule. Use the high-value code gaps to build an evidence-based fee request.

PAYER ACTION SHEET / 07

Payer F - billed payer

Estimated annual increase using fictional procedure volume and base-case assumptions.

VALID CDT PROCEDURES	BASE-CASE ANNUAL LIFT	LISTED FEES BELOW MARKET
525	$5,283	21%

Rate source: Schedule E Network

Codes that matter most

Base case = fee difference x annual procedures x 50% capture x 90% retained volume.

CDT / PROCEDURE	EST. ANNUAL PROCEDURES	CURRENT FEE	MARKET REFERENCE	DIFFERENCE / VISIT	BASE-CASE LIFT
D2740 / Ceramic crown	24	$728.00	$890.00	$162.00	**$1,750**
D1110 / Adult cleaning	125	$63.00	$79.00	$16.00	**$900**
D2392 / Posterior composite, two surfaces	58	$113.00	$147.00	$34.00	**$887**
D0120 / Periodic oral evaluation	180	$37.00	$45.00	$8.00	**$648**
D4341 / Scaling and root planing, 4+ teeth	24	$138.00	$185.00	$47.00	**$508**
D2950 / Core buildup	19	$133.00	$182.00	$49.00	**$419**
D0220 / Periapical image, first image	95	$21.00	$25.00	$4.00	**$171**
Base-case annual increase, all modeled codes for Payer F					**$5,283**

ABOUT THESE NUMBERS

Annual procedure volumes are estimates in this fictional example. Market references are comparison targets, not approved fees. Confirm contract applicability and paid claims.

YOUR NEXT STEP

Match the billed plan to the governing fee schedule. Use the high-value code gaps to build an evidence-based fee request.

SERVICE MIX / BY FEE LIST

Which types of care have the most rate differences?

100% means the listed fee matches the comparison; 80% means it is 20% lower. This compares rates, not procedure volume.

INTERPRETATION

A low percentage matters most for frequently performed procedures. Only distinct selected fee schedules with qualified category benchmarks should be compared.

FEE SCHEDULE	DIAG	PREV	REST	ENDO	PERIO	PROSTH	SURG	ORTHO	ADJ
Schedule A PPO	87%	92%	89%	102%	95%	107%	100%	90%	111%
Schedule B PPO	79%	85%	81%	92%	88%	84%	90%	75%	91%
Schedule C Network	95%	104%	98%	109%	97%	108%	105%	102%	96%
Schedule D PPO	109%	102%	104%	97%	103%	110%	101%	117%	108%
Schedule E Network	91%	116%	113%	111%	126%	119%	121%	83%	105%

WHERE TO FOCUS

Use the payer action sheets to combine fee comparisons with yearly usage. Rows without benchmarks need plan-specific rate matching before they can be prioritized.

RECOMMENDED ACTION PLAN

From findings to a payer action plan.

Work with PayorMap to confirm rates, prepare requests and track results. Keep each payer's fees and volume separate.

DAYS 1-30 / PRIORITIZE

Confirm renewal dates, notice windows, fee lists, plan mappings and priority CDT counts. Start with the strongest supported commercial opportunity.

DAYS 31-60 / PREPARE REQUESTS

Prepare contract-specific targets, benchmark evidence and negotiation packets before applicable deadlines. Obtain approval before outreach.

DAYS 61-90 / EVALUATE RESPONSES

Review proposals, model counteroffers and compare actual effective rates with agreed fees. Track implementation and verify paid claims.

Four items needed for the negotiation packet

1. Active payer contract

Renewal, notice terms and participating products.

2. Current rate list

Actual contracted fees for priority CDT codes.

3. Last 12 months of utilization

Payer, plan, procedure and volume.

4. Paid claim examples

Confirm the fees were loaded correctly.

HOW PAYORMAP CAN GUIDE THIS PROCESS

Review each payer's fees, identify credible targets, prepare negotiation materials, evaluate responses and track results. Optional managed negotiations are separately engaged.

COVERAGE / WHAT IS MISSING

What is still missing from the numbers?

Some example payers need a confirmed plan or usable fee schedule. Unpriced opportunities and alternate networks are excluded from the modeled total.

PLAN NEEDS CONFIRMATION

1,737

Unpriced procedures

OUT OF NETWORK

490

Excluded procedures

PARTICIPATION DECISION

Compare joining a network with staying out of network using actual allowed amounts, patient retention, contract terms and expected volume. No automatic revenue lift is included.

EVIDENCE AND CONTRACTING DATES TO COLLECT

Collect billing NPI, relevant plan and network details, paid claims, current contracts, renewal dates and notice deadlines. Verify missing schedules and overlapping fee lists before rerunning the analysis.

WHAT IS INCLUDED IN THE MODEL

5,319 modeled annual procedure entries across six billed payers. Unmatched and out-of-network volumes are not included in the $61,488 example base case.

SUPPORTING INPUT / ESTIMATED PAYER MIX / 1 OF 4

How annual procedures were allocated.

Network mapping uses example selected fee schedules. Volumes and shares are illustrative, not actual annual paid claims.

ANNUAL PROCEDURES	BILLED PAYER LABELS	BASIS OF VOLUMES
7,546	40	Estimated mix

BILLED PAYER / SELECTED FEE SCHEDULE	EST. ANNUAL PROCEDURES	EST. SHARE	MAPPING STATUS
Payer A / Schedule A PPO	896	11.9%	Selected fee schedule - validate claims
Payer B / Schedule A PPO	1,366	18.1%	Selected fee schedule - validate claims
Payer C / Schedule B PPO	910	12.1%	Selected fee schedule - validate claims
Payer D / Schedule C Network	987	13.1%	Selected fee schedule - validate claims
Payer E / Schedule D PPO	635	8.4%	Selected fee schedule - validate claims
Payer F / Schedule E Network	525	7.0%	Selected fee schedule - validate claims
Other payer 01 / Out of network	115	1.5%	Evaluate participation
Other payer 02 / Not mapped	112	1.5%	Not priced - confirm plan
Other payer 03 / Not mapped	109	1.4%	Not priced - confirm plan
Other payer 04 / Not mapped	106	1.4%	Not priced - confirm plan

SUPPORTING INPUT / ESTIMATED PAYER MIX / 2 OF 4

Payer allocation assumptions (continued).

Network mapping uses example selected fee schedules. Volumes and shares are illustrative, not actual annual paid claims.

BILLED PAYER / SELECTED FEE SCHEDULE	EST. ANNUAL PROCEDURES	EST. SHARE	MAPPING STATUS
Other payer 05 / Not mapped	103	1.4%	Not priced - confirm plan
Other payer 06 / Out of network	100	1.3%	Evaluate participation
Other payer 07 / Not mapped	97	1.3%	Not priced - confirm plan
Other payer 08 / Not mapped	94	1.2%	Not priced - confirm plan
Other payer 09 / Not mapped	91	1.2%	Not priced - confirm plan
Other payer 10 / Not mapped	88	1.2%	Not priced - confirm plan
Other payer 11 / Out of network	85	1.1%	Evaluate participation
Other payer 12 / Not mapped	82	1.1%	Not priced - confirm plan
Other payer 13 / Not mapped	79	1.0%	Not priced - confirm plan
Other payer 14 / Not mapped	76	1.0%	Not priced - confirm plan

SUPPORTING INPUT / ESTIMATED PAYER MIX / 3 OF 4

Payer allocation assumptions (continued).

Network mapping uses example selected fee schedules. Volumes and shares are illustrative, not actual annual paid claims.

BILLED PAYER / SELECTED FEE SCHEDULE	EST. ANNUAL PROCEDURES	EST. SHARE	MAPPING STATUS
Other payer 15 / Not mapped	73	1.0%	Not priced - confirm plan
Other payer 16 / Out of network	70	0.9%	Evaluate participation
Other payer 17 / Not mapped	67	0.9%	Not priced - confirm plan
Other payer 18 / Not mapped	64	0.8%	Not priced - confirm plan
Other payer 19 / Not mapped	61	0.8%	Not priced - confirm plan
Other payer 20 / Not mapped	58	0.8%	Not priced - confirm plan
Other payer 21 / Out of network	55	0.7%	Evaluate participation
Other payer 22 / Not mapped	52	0.7%	Not priced - confirm plan
Other payer 23 / Not mapped	49	0.6%	Not priced - confirm plan
Other payer 24 / Not mapped	46	0.6%	Not priced - confirm plan

SUPPORTING INPUT / ESTIMATED PAYER MIX / 4 OF 4

Payer allocation assumptions (continued).

Network mapping uses example selected fee schedules. Volumes and shares are illustrative, not actual annual paid claims.

BILLED PAYER / SELECTED FEE SCHEDULE	EST. ANNUAL PROCEDURES	EST. SHARE	MAPPING STATUS
Other payer 25 / Not mapped	43	0.6%	Not priced - confirm plan
Other payer 26 / Out of network	40	0.5%	Evaluate participation
Other payer 27 / Not mapped	37	0.5%	Not priced - confirm plan
Other payer 28 / Not mapped	34	0.5%	Not priced - confirm plan
Other payer 29 / Not mapped	31	0.4%	Not priced - confirm plan
Other payer 30 / Not mapped	28	0.4%	Not priced - confirm plan
Other payer 31 / Out of network	25	0.3%	Evaluate participation
Other payer 32 / Not mapped	22	0.3%	Not priced - confirm plan
Other payer 33 / Not mapped	19	0.3%	Not priced - confirm plan
Other payer 34 / Not mapped	16	0.2%	Not priced - confirm plan

ALL REPORTED PROCEDURE ENTRIES

7,546 fictional entries. Allocation shares are estimated. Only the selected primary fee schedules are used; alternate schedules are not double-counted and paid-plan rates remain unverified.

HOW TO USE THESE INPUTS

Validate payer-to-network mapping with current contracts and paid claims before treating an insurer’s modeled contribution as an actionable rate request.

APPENDIX / METHODS AND LIMITS

How the numbers were calculated.

Sources, assumptions and calculations. Every practice input and result in this public example is fictional.

PRACTICE IDENTIFIER

Not included in the public sample.

1. INPUTS

Fictional selected fee schedules, local comparison rates, 7,546 reported procedure entries, 5,319 modeled entries and example annual production of $1,800,000.

2. FEE-GAP METHOD

The theoretical annual fee gap is $136,639: (reference minus listed fee) x allocated yearly procedures. Only qualifying below-reference fees are included. Higher fees do not offset the gaps.

BASE CASE

$136,639 x 50% capture x 90% retained volume = $61,488. Conservative: $27,328; upside: $102,479. Not guaranteed.

3. BENCHMARK SOURCES

Same-insurer reference component: $22,839. Broader market component: $113,800. These are components of the theoretical gap, not additional upside.

4. PROCEDURE COUNTS AND SCHEDULE ASSUMPTIONS

Confirm paid claims, plan mapping and relevant utilization. Alternative schedules are not combined. Missing or unusable fees and uncertain procedure mappings are excluded until validated.

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