

A scenic landscape at sunset with mountains and tall grass. The sun is low on the horizon, casting a warm, golden glow over the scene. The mountains in the background are silhouetted against the bright sky, and the foreground is filled with tall, green grass.

OUTSMART DENIALS: **5 strategies for a** **proactive action plan**

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Agenda

1. Welcome
2. Market Challenges + Insights
3. 3 A's to Outsmarting Denials
4. Final Takeaway
5. Q&A



Learning Objectives

3 A's to Outsmarting Denials

In this session, we will cover how to:

1. Automate front-to-back-end processes
2. Allocate denials for smart follow-up
3. Avoid write-offs across all channels



Current State of Denials



Feel like you are fighting a losing game?



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Current State of Denials

The average denial rate has increased 33% since 2016¹

A problem worth solving

3 of 4

Respondents indicated reducing denials as their highest priority¹

41%

of denials are caused by front-end issues²

5-15%

of the time claims are denied, resulting in billions of dollars of delayed or lost revenue¹

55%

Of registration/eligibility denials are avoidable but non-recoverable²



¹The State of Claims Survey 2022
²Denials Index 2022

Eligibility

22%

An improvement from 2021 but still the largest contributor to denials is registration/eligibility¹

Data

16%

of denials are due to missing or invalid claim data¹



Documentation

14%

of denials is due to medical documentation required – an increase from 2021¹

Authorizations

13%

Authorizations/Pre-Certification account for the 4th largest contributor to denials¹





49.5%¹ of leaders allocate most of their denials related resources to working denials + submitting appeals

Leaders who allocate most of their denials related resources to denial prevention experience a **2.7%**¹ lower denial rate than those who do not

53%² of providers say denials are most often manually reviewed and assigned to a work queue while **10%**¹ say they don't even have a way to accurately filter or prioritize denials



The 3 A's to Outsmarting Denials



Automate

Front-to-back-
end processes

Allocate

Denials for smart
follow-up

Avoid

write-offs across
all channels



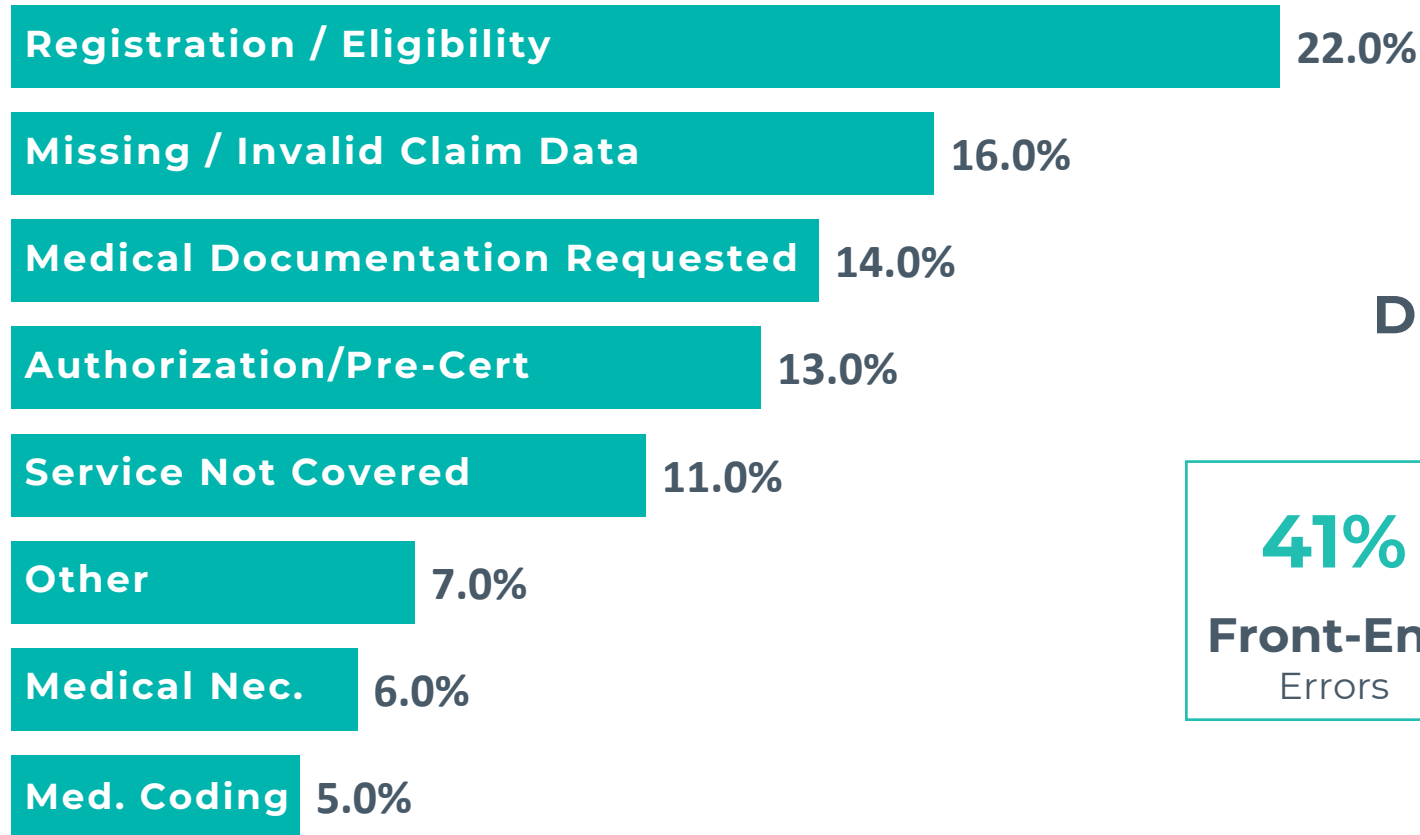
Automate

Front-to-back-end processes

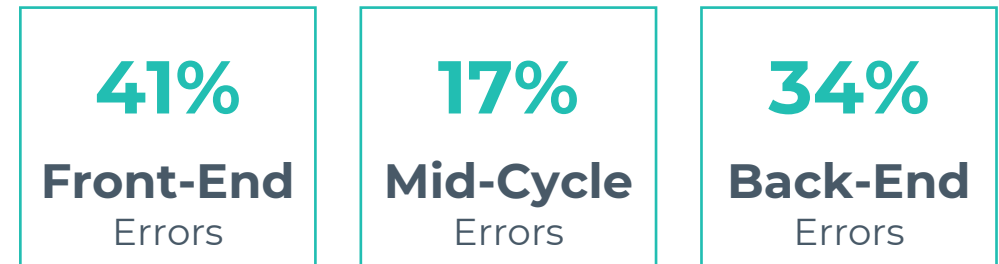


AUTOMATE

More than half of denials are front-end related



Denial Breakdown by RCM Areas*



*Unknown Breakdown = 8%



AUTOMATE

Questions to consider



How much time is spent manually finding/confirming coverage?

Do we have an opportunity to automate + streamline authorizations?

What is our process to identify missing charges and DRG anomalies?

Do we automate claim status checks based on specific payer performance?

How does my staff identify + prioritize their denial work?

Is my team manually creating and submitting appeal packages to payers?

Is our payment posting/reconciliation process completely automated?



AUTOMATE

Automation opportunities across the rev cycle

1 Eligibility Verification

Use of RPA to augment missing data from X12 in order to **return richer, more accurate benefit information** as well as identify potentially missing insurance coverage

2 Estimation of Patient Responsibility

Use of machine learning (AI) to identify payer adjudication rules and RPA to retrieve **real-time updates on patient financial responsibility and deliver truly accurate patient estimates**

3 Prior Authorizations

Use of machine learning to **identify upcoming services requiring authorization + RPA to initiate and follow-up on authorization requests**

4 Patient Payment Optimization

Use of predictive analytics to **provide tailored payment options and automated identification of charity** determination while delivering **personalized communications to drive self-service payments**

5 Revenue Capture

Use of machine learning to identify accounts with a high probability of **missing charges and DRG anomalies** to maximize revenue opportunities

6 Claim Status Checks

Predictive analytics to optimize when to **check status of claims**, use of **RPA to retrieve updated claims status** information, and AI to **normalize each payer's unique remark codes and auto-assign disposition codes**

7 Denial Management

Predictive analytics to **identify those denials most likely to be successfully appealed** in order to guide workflow

8 Payment Posting/Reconciliation

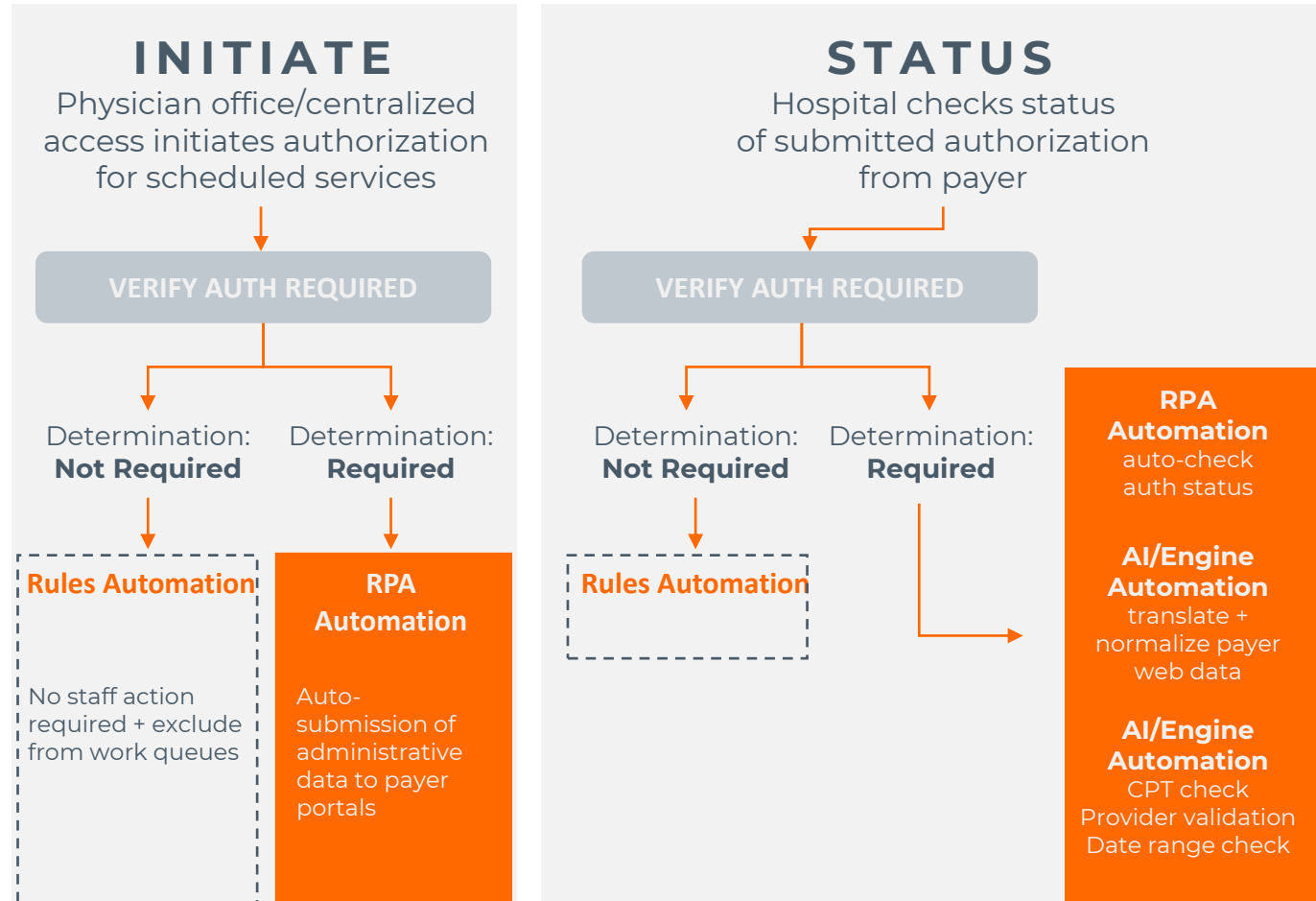
Automated **matching of claims to remits, posting of payer and patient payments**, including remit splitting and identification of missing payments as well as **reconciliation of all payments**



AUTOMATE

Automating prior authorizations at scale

- + Leverage purpose-built automation to navigate payer-specific rules
- + Continuous status monitoring enables staff focus and efficiency
- + Exception-based workflows alert staff to act only if/when needed
- + Reduce auth-related denials by effectively initiating, statusing and logging authorizations across the largest set of service lines and settings
- + Utilize multiple data transfer methods, including RPA, HL7, APIs, EDI 278



AUTOMATE

Intelligently automate status checks

- + Automate status checks + **intelligently route claims to the correct work queues**
- + Leverage multiple connections to retrieve the most **enriched claim data directly from payers**
- + Ensure **responses are normalized** and supports actionable follow-up
- + Leverage technology to provide automated statuses at the right time, **reducing unproductive touches** + shifting focus to cases requiring follow-up
- + Improve overall efficiency, resulting in **time and cost savings**

The Approach

Curate

the most enriched status responses

Control

claim follow-up with proactive work queue routing

Capture

payments faster + forecast your AR

The Results

Accelerate cash flow

Save time + reallocate resources

Increase user productivity

Reduce overall A/R days



AUTOMATE

Accelerate appeals + convert denials to payments

Paperless Appeal Package + Submission Options



Certified mail



Print + mail



e-Fax



Payer portals

Pre-Populated, Payer-Specific Appeal Templates



Commercial payers



Government payers



Pre-filled fields



Attachments

Tracking + Reporting + Control Across All Appeals



Transaction history



HIS/PM integration



Settings options



Workflow tracking

The value

- Maximize your investment
- Decrease write-offs
- Reduce cost to collect
- Eliminate appeal uncertainty
- Improve productivity + streamline workflows
- Increase realized revenue



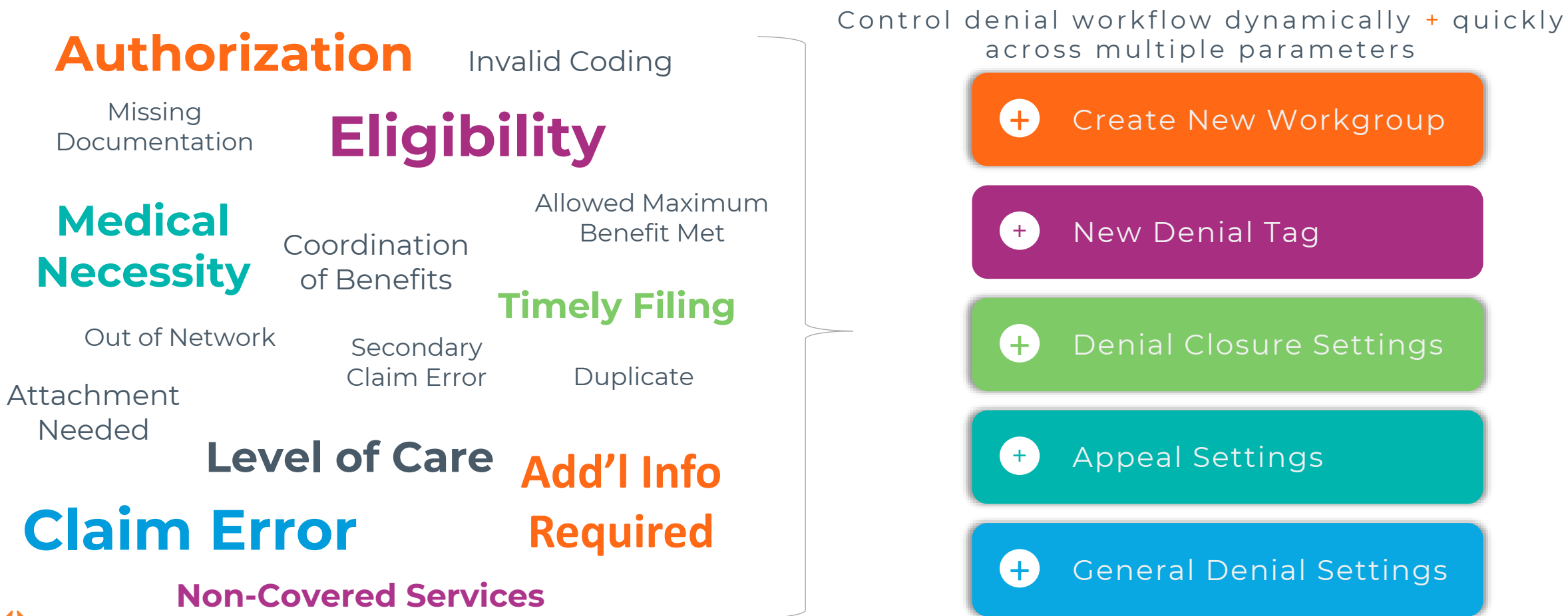
Allocate

Denials for smart follow-up



ALLOCATE

Flexible workflows to meet unique needs



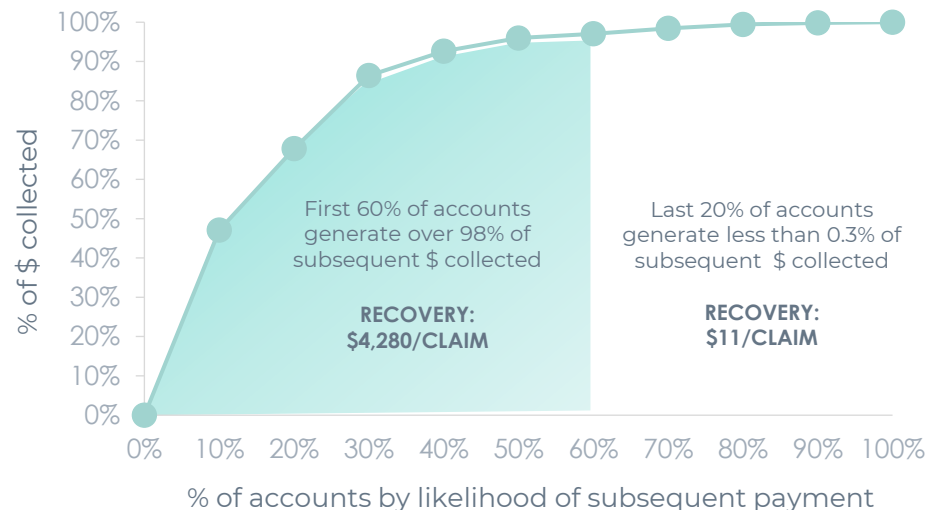
ALLOCATE

Accurately prioritize denials

- + Identify workable denials via **predictive analytics identifying probability of payment**
- + **Automatically route** those denials to appropriate team or work queue
- + Leverage **900+ pre-populated payer-specific forms** to automatically generate the right appeals content on your behalf
- + Provide real-time **one-click eligibility** verification
- + **Automatically submit paperless appeals** packages directly to payer

The value of our predictive analytics:

- + By analyzing massive sets of CARC/RARC patterns, it's possible to **predict the probability of additional payment** on a given denial
- + This enables **prioritization based on payment**, rather than the typical approach of age or balance, saves time and produces better, faster results.



Automatically prioritizing the accounts to work

Automatically focus on only those that will be successful

Automatically complete the appeal form



ALLOCATE

Leverage technology to prioritize denials

Probability of Payment

Identify denials that have highest rate of return



Denial Priority Score

Flag highest priority denials for staff to address



Work Smarter
leverage *innovative technology* to improve staff efficiency while *increasing recovered revenue*



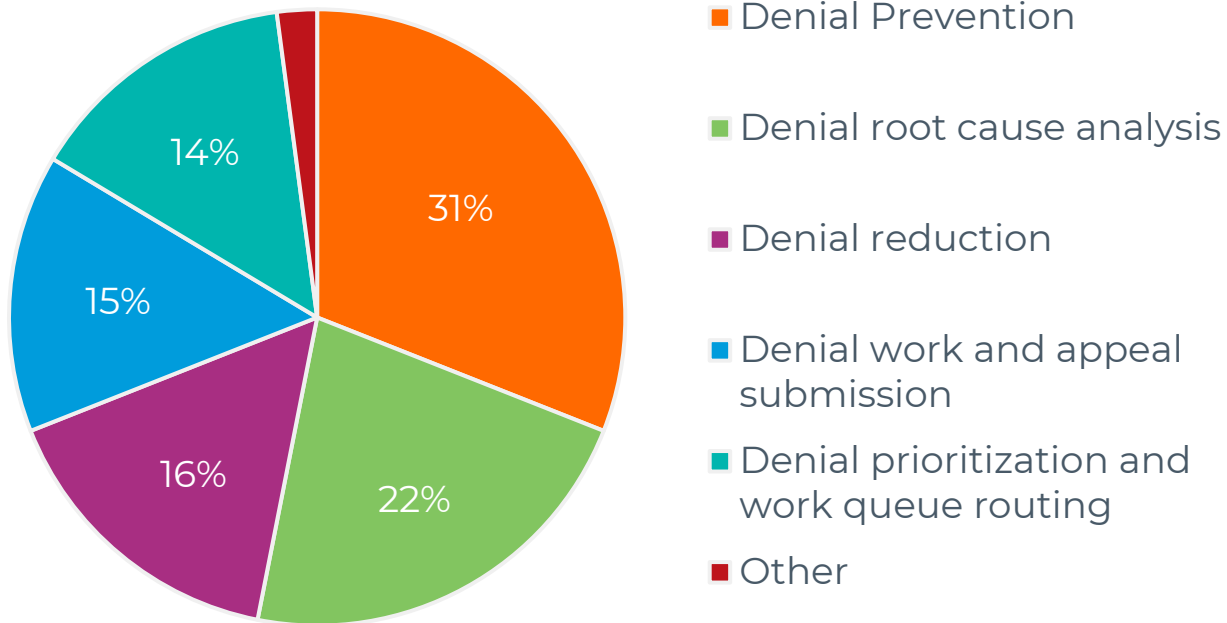
Avoid

Write-offs across all channels



AVOID

Denial prevention tops the priority list



While denial rates continue to rise:

Up **20%** with the trend expected to continue²



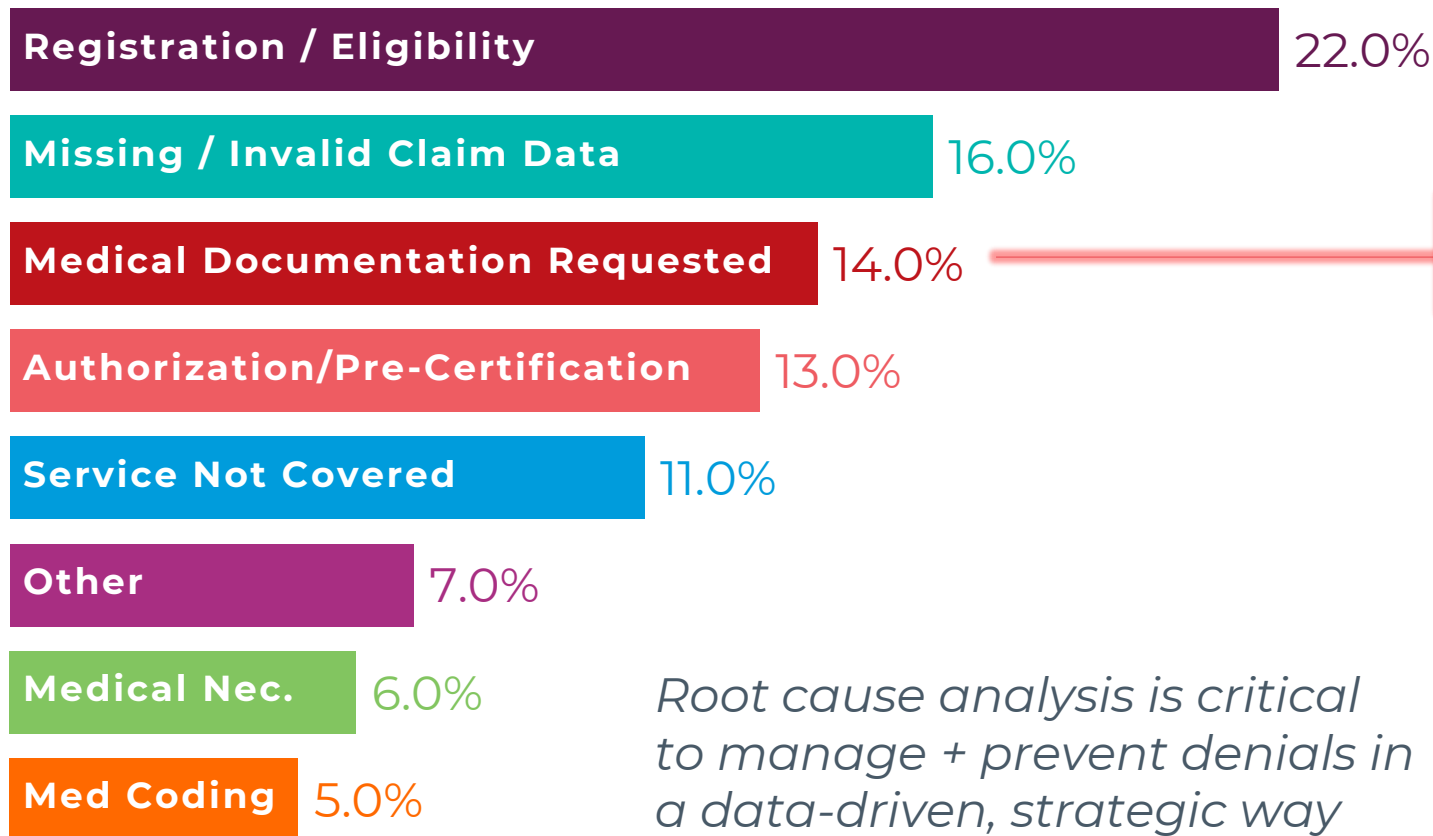
¹ HFMA Denials Study 2023

² Journal of the American Health Information Management Association, Claim Denials: A step-by-step approach to resolution (2022)

AVOID

Denial reason \neq root cause

Sample Root Cause Issues



OON Provider	Registration Error	Allowed Max Benefit Met
Missing Provider Info	Secondary Claim Error	Invalid Coding
Order Change	Add-on Service	Recurring Encounters
ABN Not Signed	Experimental Procedure	Procedure Not Contracted
Payer Needs More Info	Medical Necessity	Missing/Insuff. Documentation
Missing/Insuff. Documentation	Unlisted Dx Code	Length of Stay
New User Training	Process Gap	New Technology
Retro Coverage	Primary Claim Delay	Delayed Appeal

Root cause analysis is critical to manage + prevent denials in a data-driven, strategic way



AVOID

Discover denial patterns through analytics



Root Cause Reason

Claims by Denial Reason

Dollars Denied / Adjusted

Claims Denied + Reworked

Avoidable Denial Write-Off Rate

Denial Overturn Rate

First Pass Clean Claim Rate

Payer Scorecard

Denied Procedures

Sample denial metrics

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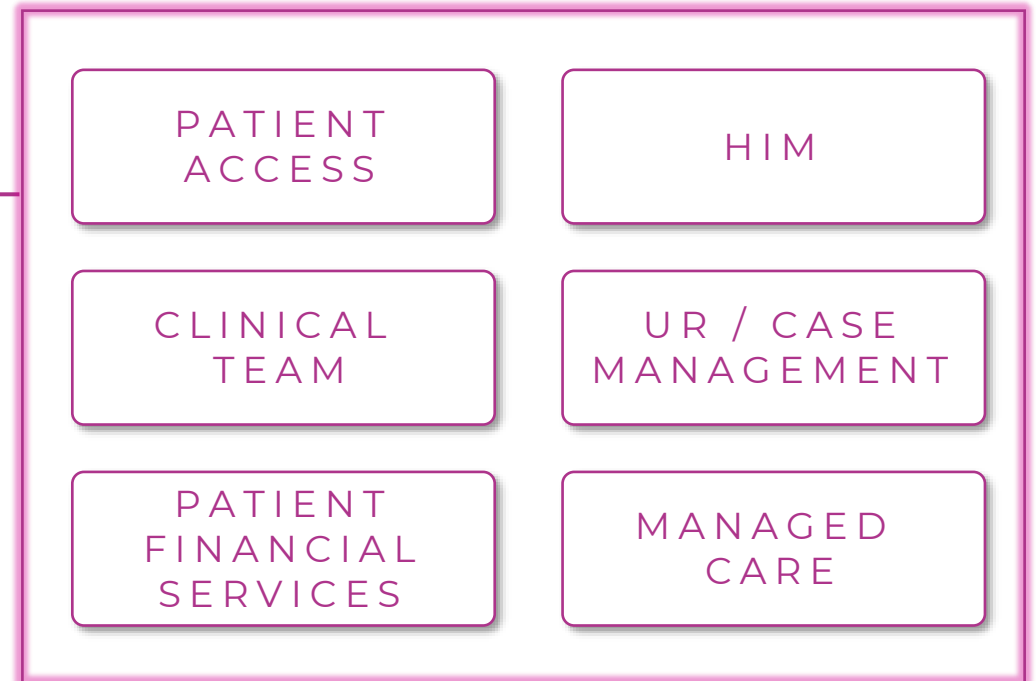


AVOID

Denials is an everyday problem, alignment is key

Key steps to establishing successful denials prevention strategy

1. Executive support + multi-disciplinary alignment
2. Establish expectations, ownership, cadence
3. Perform root cause analysis
4. Define + execute action plan
5. Track + measure improvement
6. Continuous refinement



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Q + A



Thank you

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