

What's Eating Your Bottom Line?

HFMA GREATER HEARTLAND SPRING CONFERENCE
APRIL 8TH-10TH, 2026

OS
Inc.

Learning Objectives

- Identify the primary causes of healthcare claim denials and prevention opportunities
- Analyze the financial impact of denials on cash flow and accounts receivable
- Develop strategies to reduce denials using revenue cycle technology and process improvement

Agenda

- 1** | **Welcome & Introduction**
- 2** What are Denials Costing your Organization?
- 3** How to Design Meaningful Denial Reports
- 4** Improving First Pass Payment Rate
- 5** Preventing our Most Common Denials
- 6** Leveraging Analytics for Denial Prioritization

Who Really Bills Claims?

- Green Patient Access

- Blue HIM/Coding

- Orange Charge Master

- Yellow System Generated

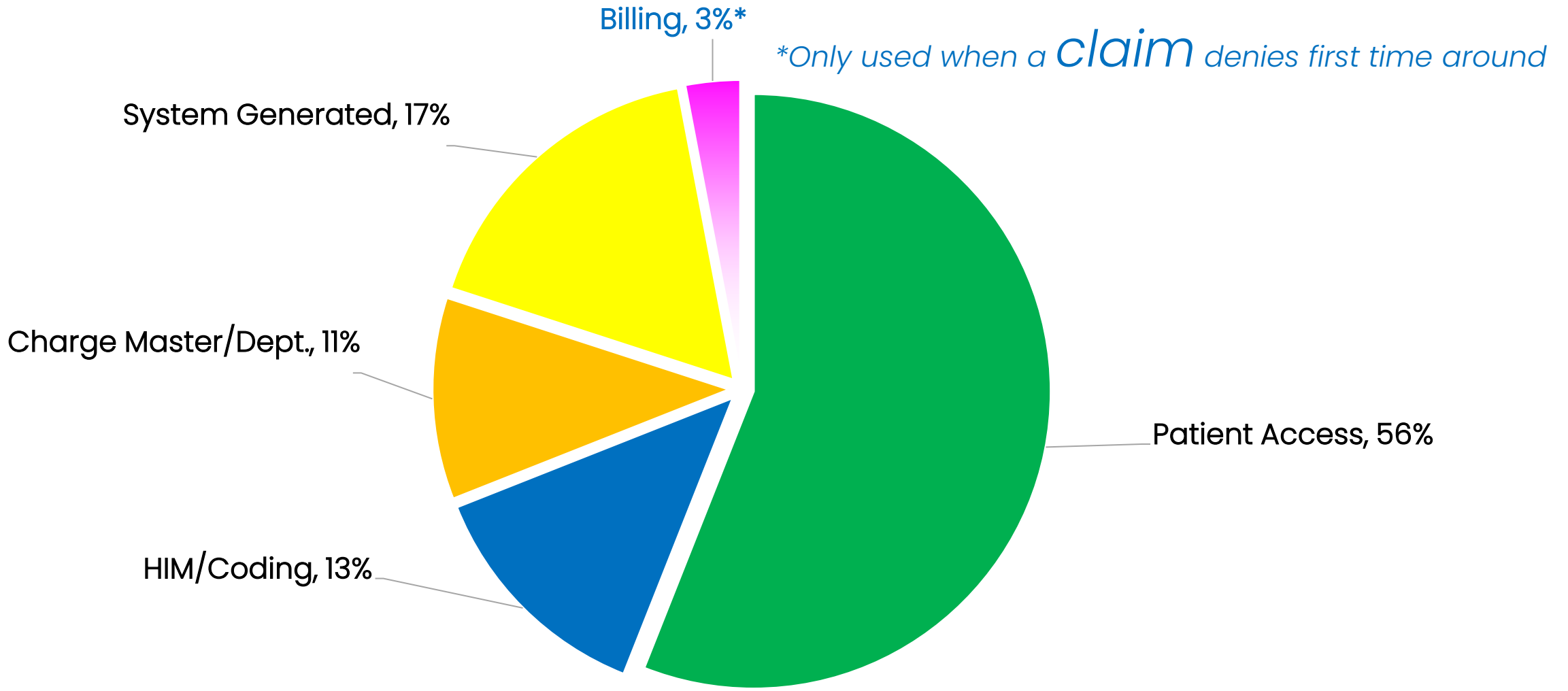
- Pink Billing

The image shows a complex medical claim form with multiple sections. The form is color-coded to match the categories in the legend:

- Yellow:** Patient information (1-10), occurrence dates (31-37), value codes (39-41), and remarks (80).
- Blue:** Procedure codes (74-79).
- Orange:** Description of services (42-43), HCPCS codes (44), and charges (45-49).
- Pink:** Insurance information (50-52), treatment authorization (63-65), and other administrative fields (66-73).

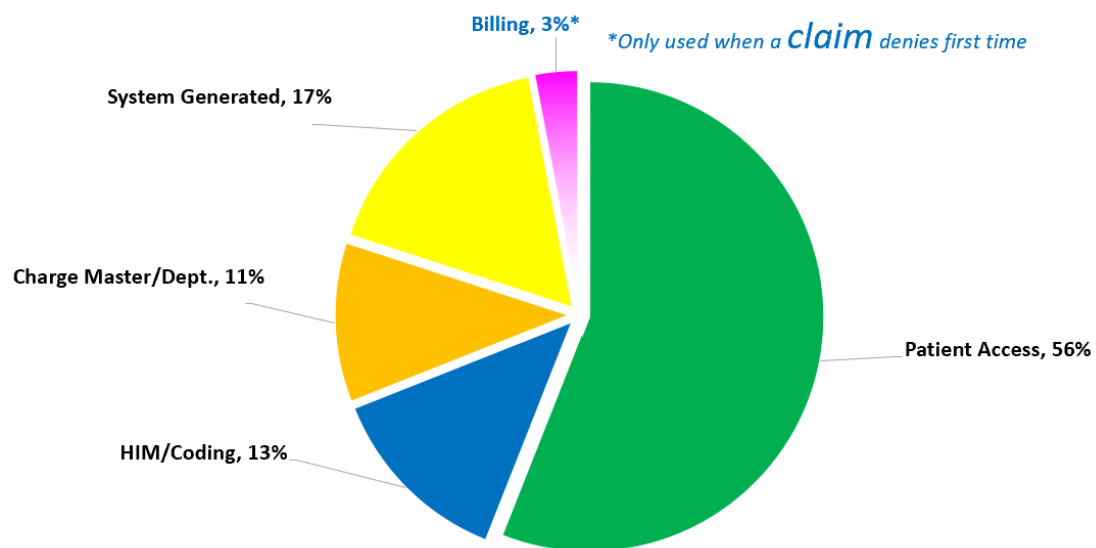
 The form includes fields for patient name, address, birth date, sex, admission date, condition codes, occurrence dates, procedure codes, charges, and insurance details. It also has a 'TOTALS' section and a 'REMARKS' section at the bottom. The footer contains the form ID 'UB-64 CMS-1450' and the NUBC logo.

Not the Billing Department

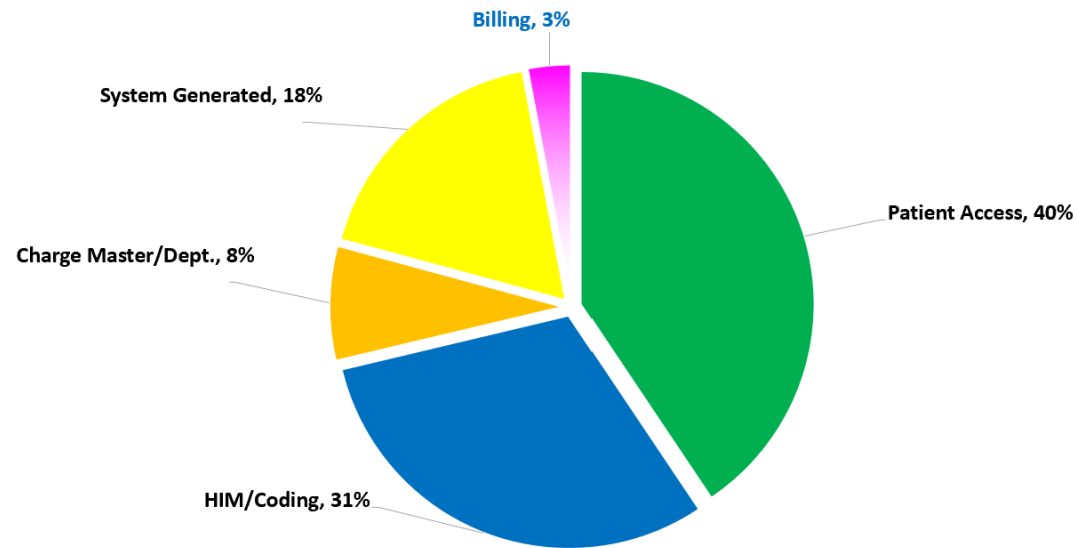


Comparison – Billing requirements to denials by department

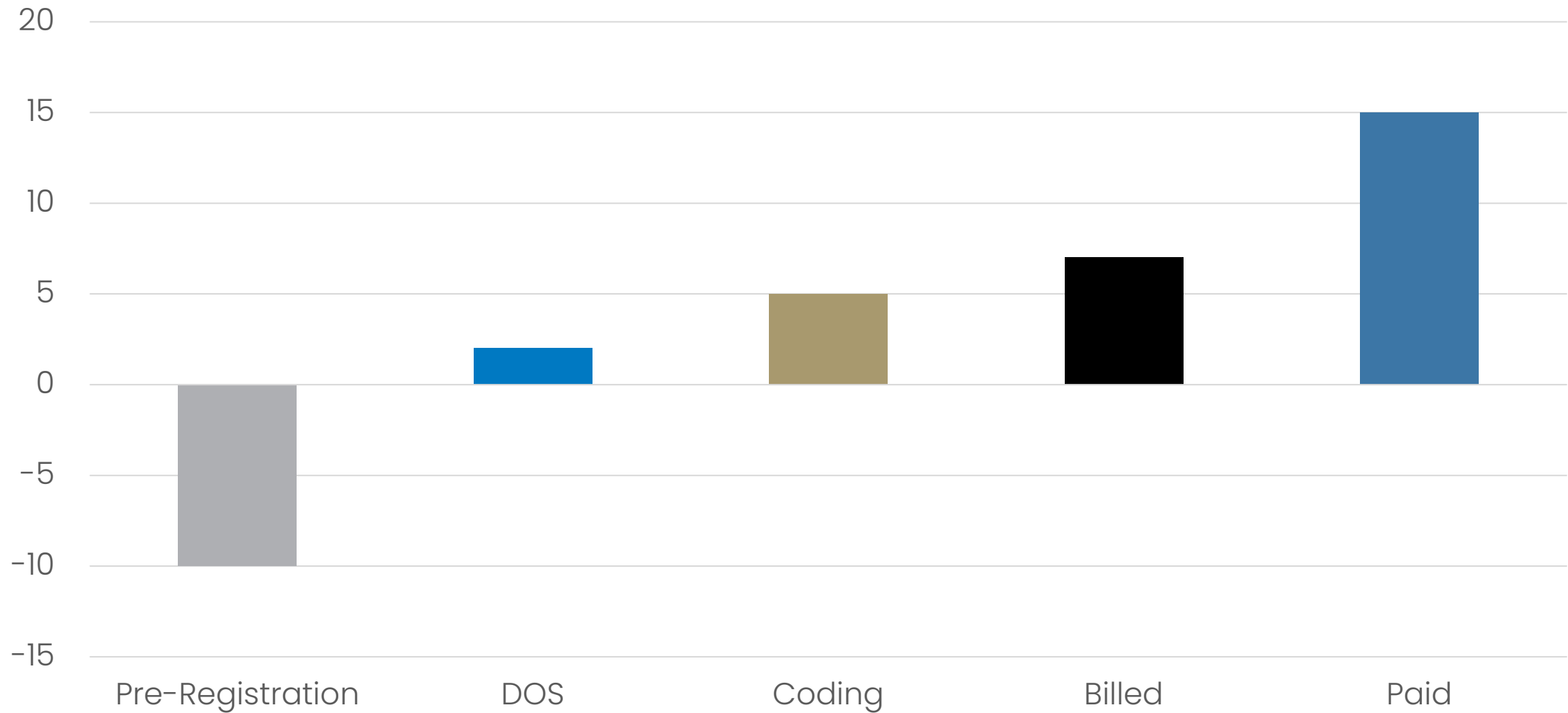
UB fields by department



Denials by department



Timeline of a Paid Claim



Payment Turnaround Times

Benchmarking - Overall Health

First Pass Yield (i)

My Average

91.69%

Community Average

85.31%

Days from Service to Create (i)

My Average

20.44

Community Average

39.77

Days from Service to Payment (i)

My Average

24.86

Community Average

34.90

Days from Create to Billed (i)

My Average

1.72

Community Average

2.06

Benchmarking - Payer

Reimbursement Rate (i)

My Average

46.01%

Community Average

39.97%

First Pass No Response Rate (i)

My Average

18.30%

Community Average

41.88%

Days from Billed to Payment (i)

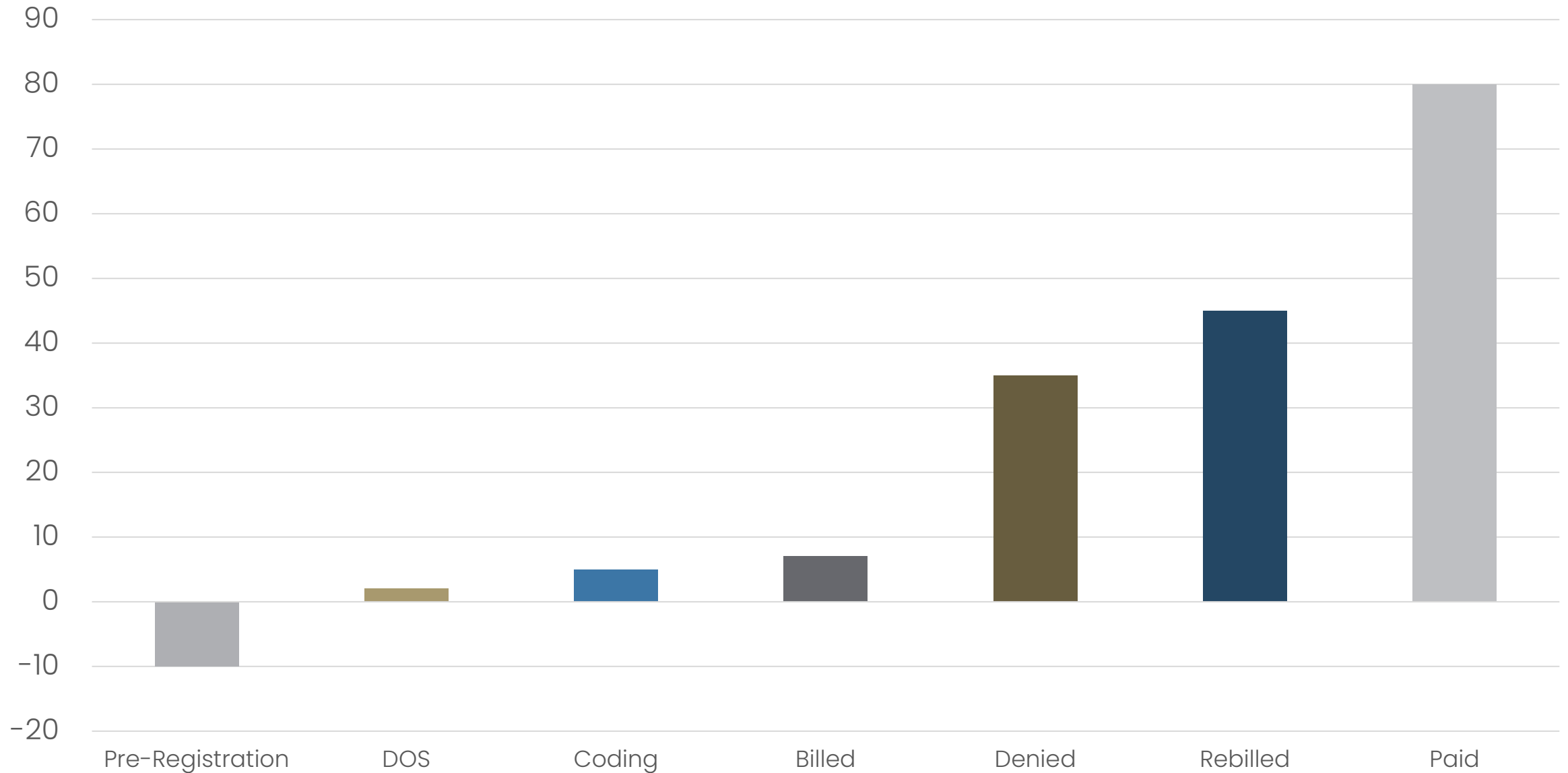
My Average

11.10

Community Average

12.31

Timeline of a Denied Claim



Payment Turnaround Time

If you bill correctly, they will pay

If you bill correctly, they will pay
most claims in 15 days

If you bill most of your claims correctly and keep your
unbilled < 7 days, **GDRO in the 30s is easy!**

Cost of Unnecessary Denials

Cost to rework a claim due to denial = \$118

- Denial rates average 10-40% of claims
- Almost 60% of claims rebilled after a denial – DENY AGAIN!

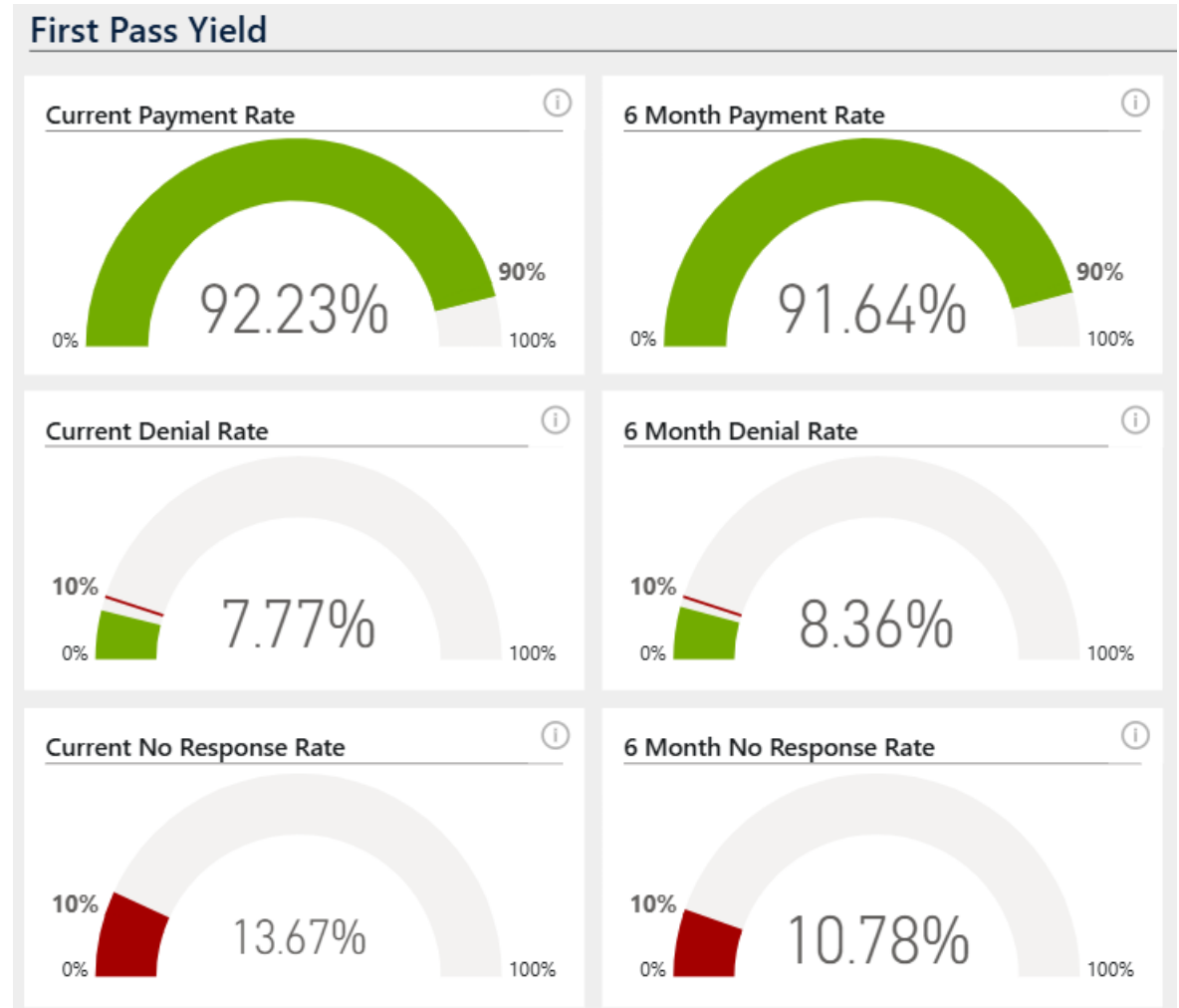
10,000 claims x 20% FPDR = 2,000 denials

2,000 x \$118 per denial = \$236,000 per month

1,500 denials worked per FTE per month

First Pass Yield

- Measure claims being paid on first submission – Goal 90-95%
- Track initial denials separately to identify root cause issues
- Less emphasis on clean claim rate – focus on payment rates
- No response rates – improve 835 response rates



Benchmarking - Denials

Denial Percentage - # of Claims

My Rate

10.30%

Community Rate

19.53%

Denial Percentage - Dollars

My Rate

16.00%

Community Rate

20.26%

Medicare Return to Provider (RTP)

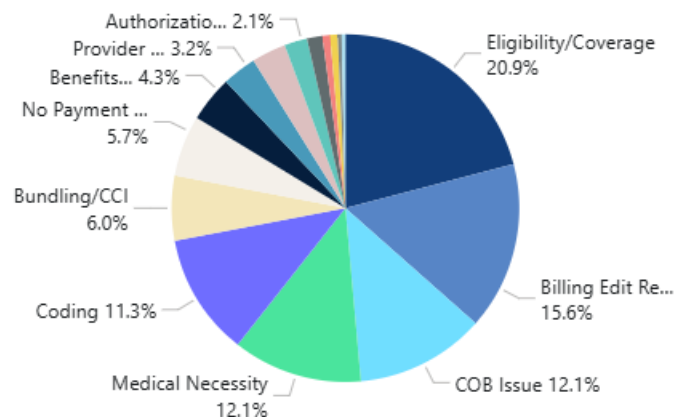
My Rate

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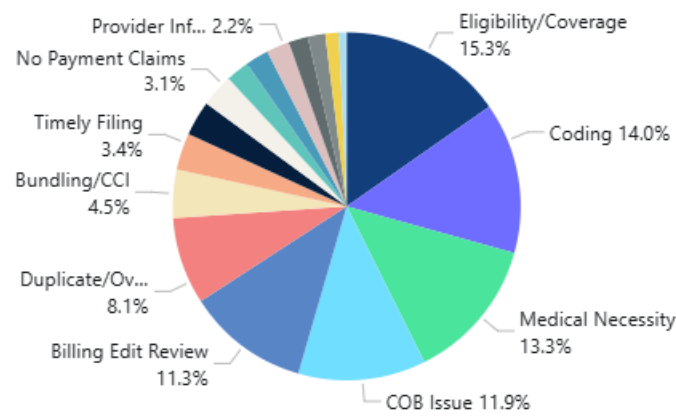
Community Rate

1.73%

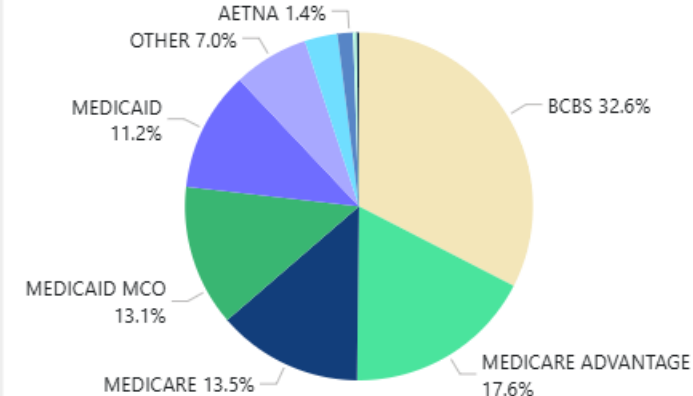
My First Pass Denials by Category



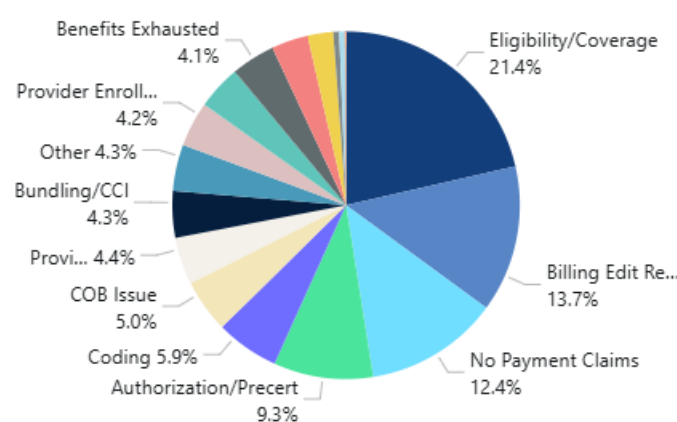
My Denials by Category



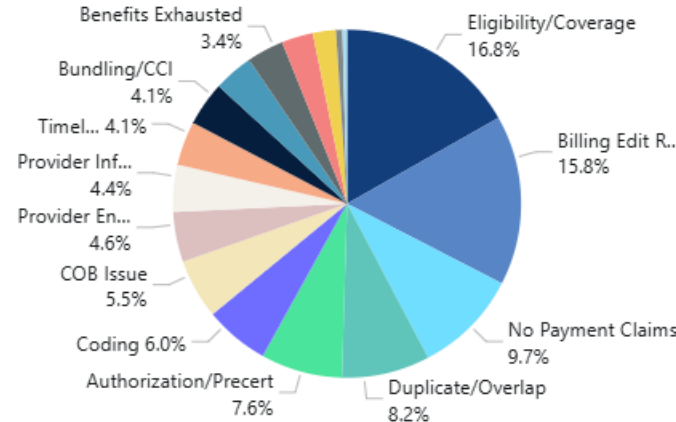
My Denials by Payer



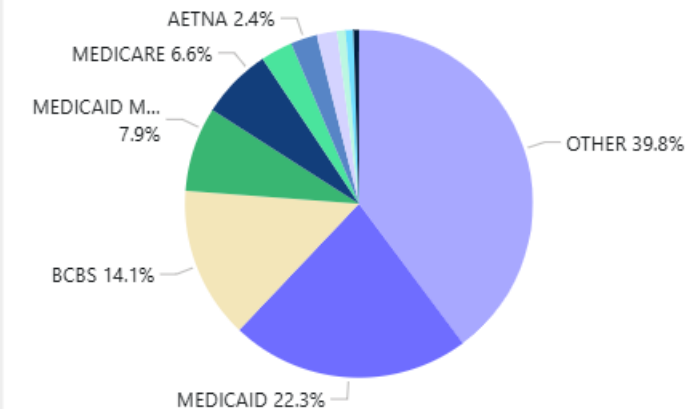
Community First Pass Denials by Category



Community Denials by Category

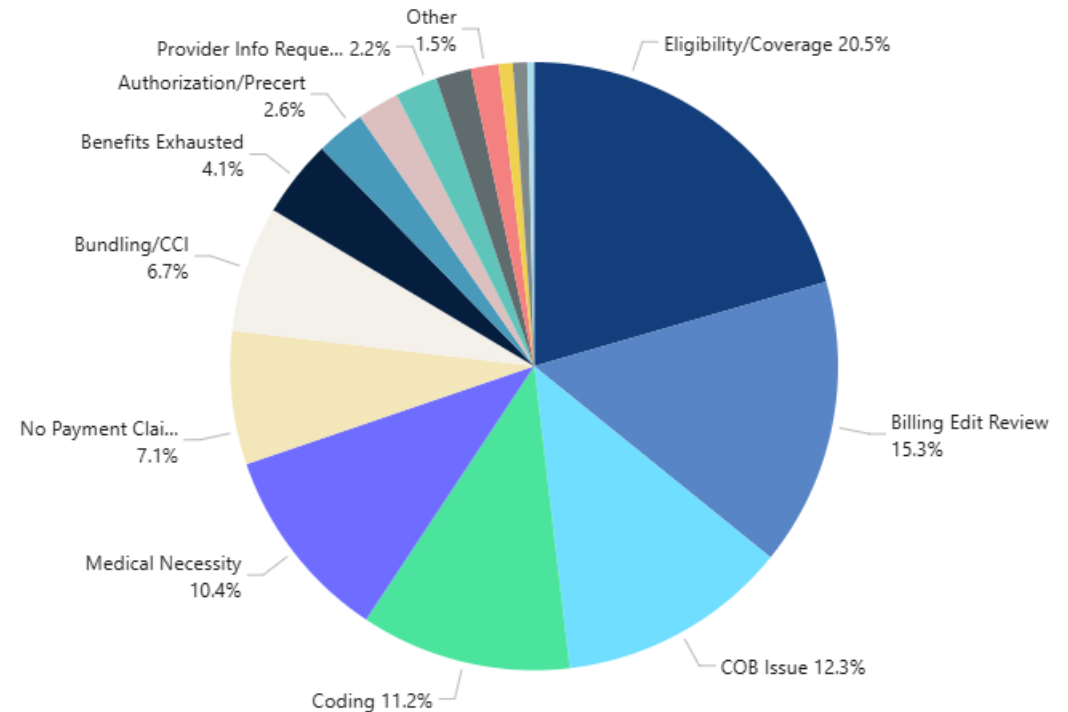


Community Denials by Payer



First Pass Denials by Category

- Track all denial sources
- Any claim/service charge not paid on first submission
- Edits are first line of defense to prevent denials
- Engage all departments in improving first pass payment rates
- Monitor “no-payment” claims

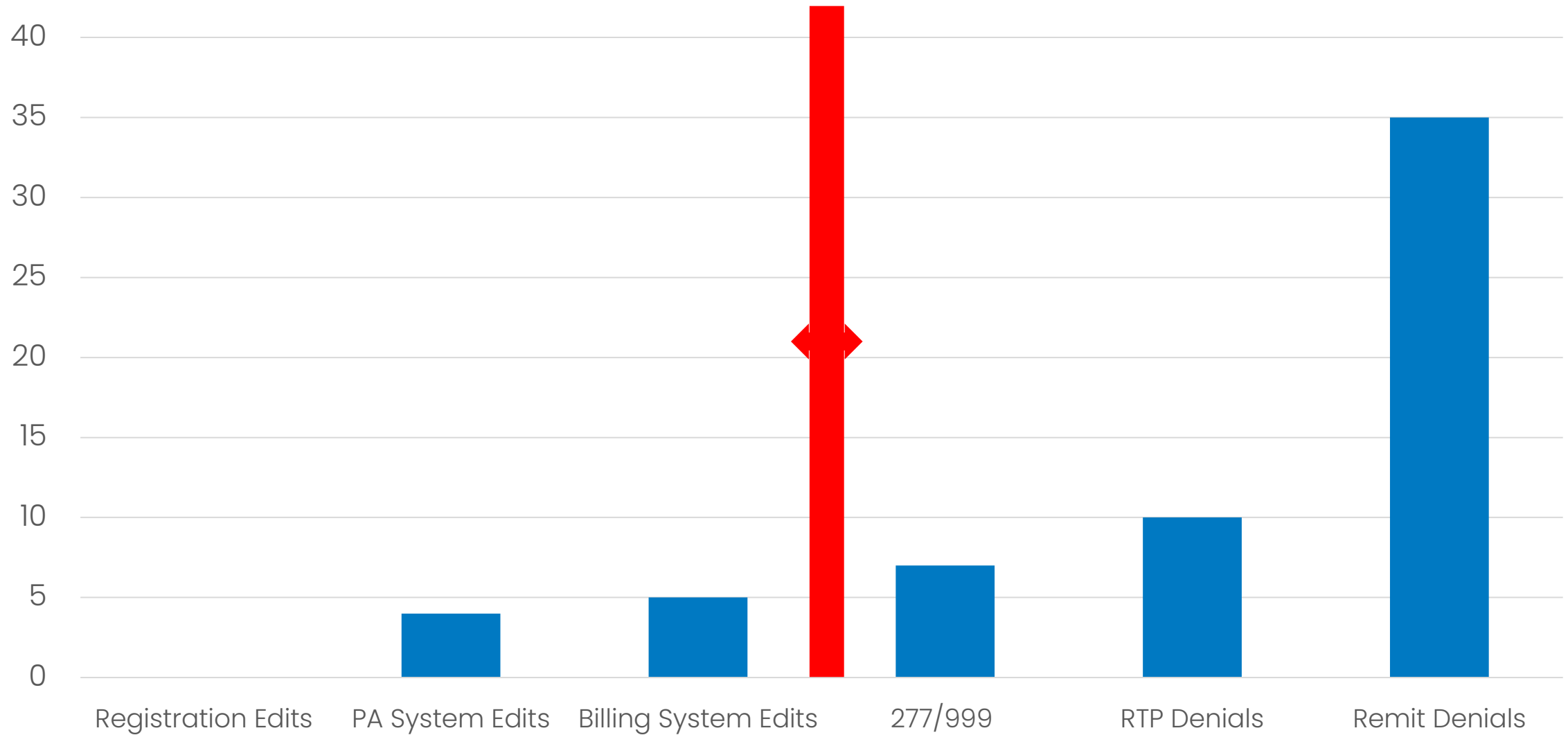


Putting Data to Work

- Where do I start?
- What are the easy fixes?
- What can be fixed in our EMR versus the Clearinghouse?
- Set goals each week to meet a reduction in denials
- Accountability from start to finish



Timeline of Critical Denial/Edit Points



Case Study Reducing Denials - Resubmissions

Calculations			
Rate	MTD	6 Months	Clients
Resubmission	12.02%	8.62%	4.01%
Denied Dollar	9.97%	10.71%	6.61%
Denial Claim	13.86%	15.75%	5.62%
Clean Claims	64.32%	78.19%	77.01%

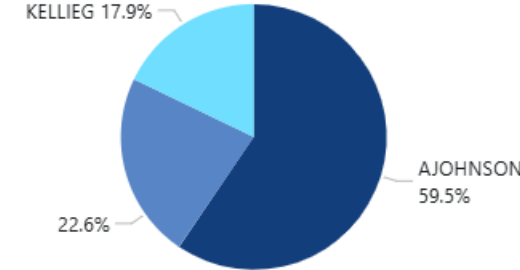
Calculations			
Rate	MTD	6 Months	Clients
Resubmission	5.00%	12.44%	5.68%
Denied Dollar	7.15%	6.87%	7.01%
Denial Claim	8.49%	8.79%	6.31%
Clean Claims	52.47%	61.10%	79.79%

Denials by User

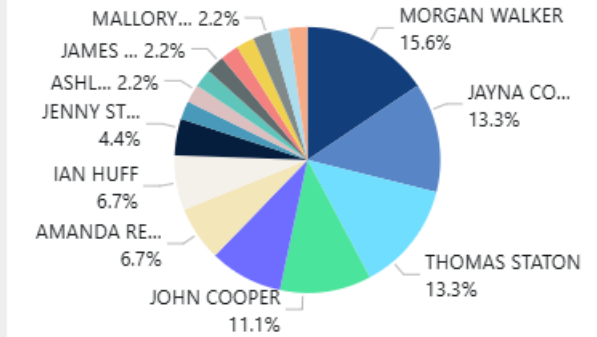
- Coding related denials by Coder
- Eligibility denials by Registrar
- Medical Necessity by Physician
- Billing related and duplicate by Biller
- Appeals Denied by Biller

Denials by User

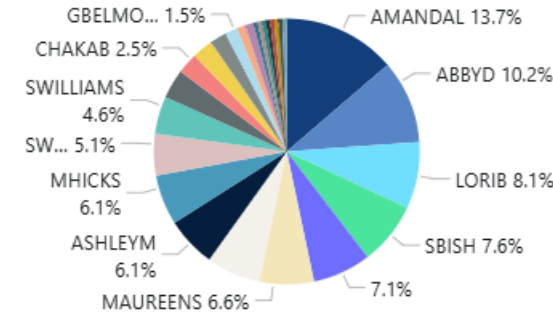
Denials By Coder



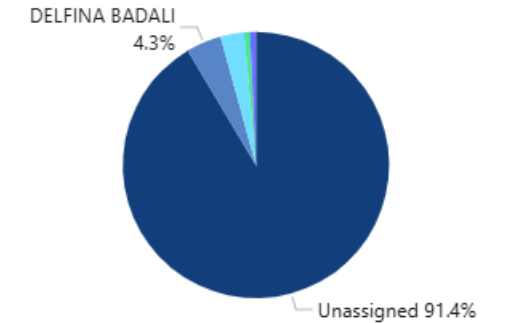
Medical Necessity by Provider



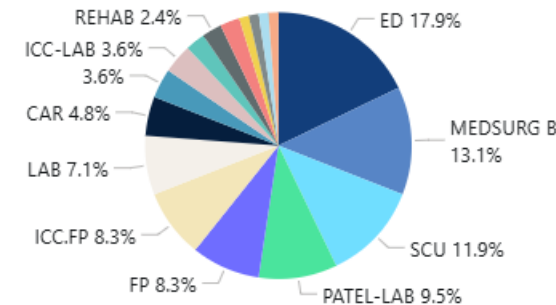
Denials by Registrar



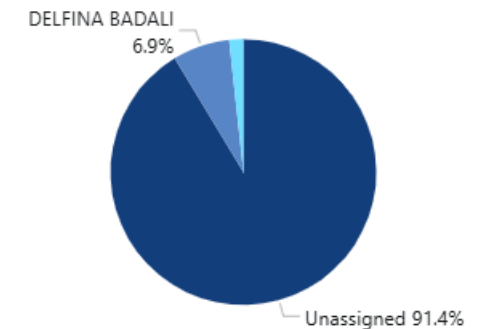
Denials by Assigned User



Denials by Department



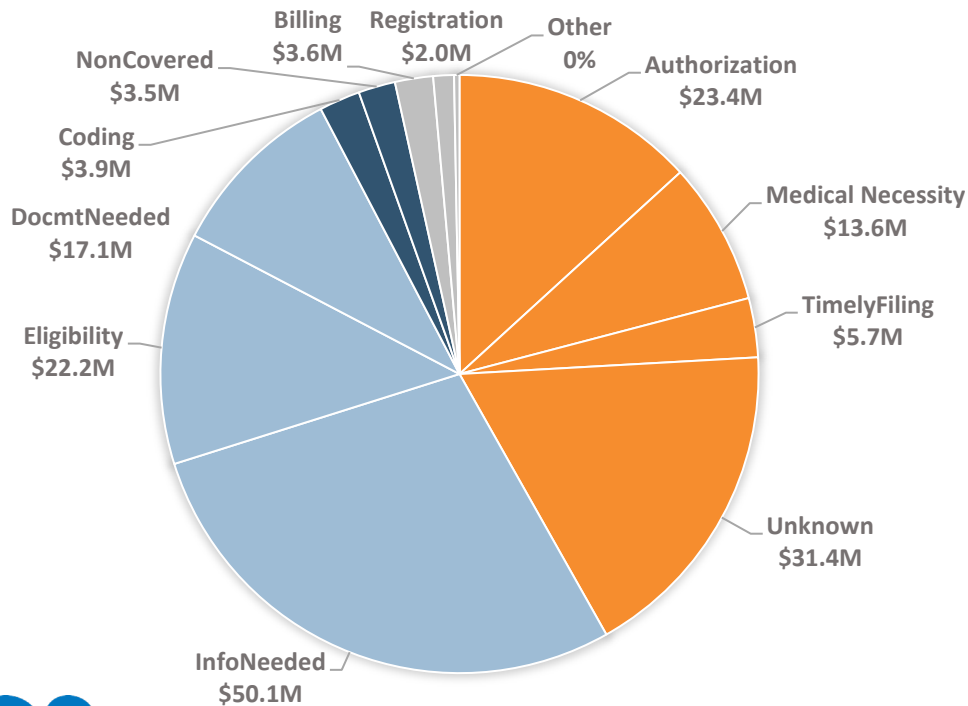
Duplicate Claim Denials by Assigned User



Case Study – Denial Impact

To address net revenue potential and rework opportunities within your gross denials, it's important to understand the category characteristics, and then to review avoidable write-off data (next slide) to understand true losses.

Distribution of Top 10 Denial Categories



Initial Gross Denials (\$)	Category Characteristics	Improvement effort
Avoidable Loss Denials (\$74M)	<ul style="list-style-type: none"> Hard to recover after service billed Avoidable reasons: No Authorization, Medical Necessity, and Untimely Main driver for improved net revenue 	High
High recovery Denials (\$89.4M)	<ul style="list-style-type: none"> Often recoverable after billing Avoidable reason includes providing additional info, chart requests, COB/Eligibility, etc. High opportunity to accelerate cash, improve efficiency and eliminate unnecessary write-offs 	Medium
Low recovery Denials (\$7.4M)	<ul style="list-style-type: none"> Hard to recover after service billed and often not highly avoidable Denial reason includes Non-Covered, Coding Specific 'bundling' prevention opportunity for avoidable write-offs and efficiencies 	Med/High
Soft Denials / System (\$6.1M)	<ul style="list-style-type: none"> High efficiency opportunity through system updates and review of workflow 	Low

HIM/PFS Joint Project

- DNFB – was at about 10 days
- Denial Rate – Exceeds 5%
- Coding Related Denials = 23% of the total
- Claim edits/ touches – 15% needed Rework
- HIM and PFS were not communicating



Claim Touches – August

Biosimilar HCPCS reported without biosimilar modifier.	6	\$ 57,768.57
CCI edit	232	\$ 1,437,658.89
Diagnosis cannot be primary and should be paired with another diagnosis.	6	\$ 1,726.33
Diagnosis code reported is invalid for the statement date	173	\$ 107,559.77
Diagnosis is not valid for patient age	1	\$ 2,233.24
DX code is exempt from reporting POA according to the Code Table.	2	\$ 148,847.60
DX V707 or Z006 being reported on claim. Condition Code 30 required for non-research services	2	\$ 497.84
EKG or Chest X-ray billed with pre-op DX code as principal DX is not covered	25	\$ 22,146.59
External Cause of Injury codes cannot be listed as primary.	15	\$ 5,543.77
Functional G codes require appropriate pairing	9	\$ 9,784.66
If vaccine charges are only services being billed, DX Z23 must be principal DX	6	\$ 1,630.04
Medical Necessity	256	\$ 821,143.47
Medical visit on the same day as a type T or S procedure without modifier 25	139	\$ 422,103.73
Modifier 25 invalid with CPT being billed when no other charges are on claim	6	\$ 917.16
Modifier 25 should not be billed for this CPT code	7	\$ 15,079.71
Modifier 27 invalid on a professional claim.	1	\$ 92.00
Modifier 50 not allowed with CPT being reported	2	\$ 618.50
Modifier 50 should not be reported on the same line as RT/LT	2	\$ 6,860.54
Modifier GO only allowed with Revenue Code 43x	3	\$ 4,028.57
Modifier GZ and GY should not be reported on the same service line charge	4	\$ 19,841.97
Multiple medical visits are present on the same day with the same revenue code without condition code G0	118	\$ 133,338.45
Non-specific codes (NOC) require procedure description.	10	\$ 55,656.40
Principal DX is not covered by Medicare and charges are not reflected in non-covered	3	\$ 6,694.70
PT/OT evals to Medicare require functional G Code	13	\$ 50,075.89
Screening DX primary; Possible coverage issue	89	\$ 69,070.86
Screening pap charge requires screening DX code	4	\$ 2,839.71
Speech therapy evals to Medicare require functional G Code	2	\$ 1,700.78

Total Touches per month 1281

Claim Edit Improvement

Biosimilar HCPCS reported without biosimilar modifier.	0	\$	-
CCI edit	100	\$	685,256.00
Diagnosis cannot be primary and should be paired with another diagnosis.	1	\$	250.25
Diagnosis code reported is invalid for the statement date	3	\$	1,025.65
Diagnosis is not valid for patient age	0	\$	-
DX code is exempt from reporting POA according to the Code Table.	0	\$	-
DX V707 or Z006 being reported on claim. Condition Code 30 required for non-research services	3	\$	2,056.00
EKG or Chest X-ray billed with pre-op DX code as principal DX is not covered	24	\$	21,256.00
External Cause of Injury codes cannot be listed as primary.	0	\$	-
Functional G codes require appropriate pairing	8	\$	8,784.86
If vaccine charges are only services being billed, DX Z23 must be principal DX	6	\$	1,630.04
Medical Necessity	200	\$	733,000.00
Medical visit on the same day as a type T or S procedure without modifier 25	101	\$	324,136.25
Modifier 25 invalid with CPT being billed when no other charges are on claim	0	\$	-
Modifier 25 should not be billed for this CPT code	0	\$	-
Modifier 27 invalid on a professional claim.	0	\$	-
Modifier 50 not allowed with CPT being reported	0	\$	-
Modifier 50 should not be reported on the same line as RT/LT	0	\$	-
Modifier GO only allowed with Revenue Code 43x	0	\$	-
Modifier GZ and GY should not be reported on the same service line charge	1	\$	17,562.00
Multiple medical visits are present on the same day with the same revenue code without condition code G0	50	\$	48,012.00
Non-specific codes (NOC) require procedure description.	5	\$	45,121.00
Principal DX is not covered by Medicare and charges are not reflected in non-covered	1	\$	5,694.00
PT/OT evals to Medicare require functional G Code	12	\$	49,125.00
Screening DX primary; Possible coverage issue	90	\$	70,012.00
Screening pap charge requires screening DX code	5	\$	2,939.21
Speech therapy evals to Medicare require functional G Code	2	\$	1,645.00

Total Touches = 697

Denials by category

Category	Count of Category	Sum of Total Denied Charge	% of #	% of \$
Additional info requested - Patient	18	\$4,924.00	1.70%	0.80%
Additional info requested - Provider	4	\$7,517.20	0.38%	1.20%
Authorization/Pre-Cert	6	\$13,562.00	0.57%	2.20%
Benefits Exhausted	35	\$6,502.90	3.31%	1.10%
Billing Related - Edit Review needed	35	\$74,041.96	3.31%	12.10%
Bundling/CCI Edit	92	\$66,348.00	8.71%	10.83%
COB Issue	81	\$30,295.42	7.67%	4.90%
Coding	90	\$4,999.42	8.52%	0.80%
Duplicate/Overlap	70	\$51,911.81	6.63%	8.50%
Eligibility/Coverage	133	\$126,515.50	12.59%	20.60%
Exceeds Frequency	23	\$34,725.19	2.18%	5.70%
Medical Necessity	72	\$49,278.50	6.82%	8.00%
Other	11	\$21,495.91	1.04%	3.50%
Other Facility Overlap	20	\$18,331.62	1.89%	3.00%
Provider Enrollment	360	\$100,994.49	34.09%	16.48%
Timely Filing	6	\$ 1,453.00	0.57%	0.20%
Grand Total	1,056	\$612,896.96		

Results - December

Category	Count of Category	Sum of Total Denied Charge	% of #	% of \$
Additional info requested - Patient	6	\$ 5,336.00	0.89%	1.33%
Additional info requested - Provider	11	\$ 10,371.00	1.62%	1.20%
Authorization/Pre-Cert	5	\$ 12,005.80	0.74%	2.20%
Benefits Exhausted	20	\$ 4,440.00	2.95%	1.10%
Billing Related - Edit Review needed	28	\$ 13,018.62	4.14%	12.10%
Bundling/CCI Edit	0	\$ 0.00	0.00%	0.00%
COB Issue	67	\$ 18,947.59	9.90%	4.90%
Coding	23	\$ 24,502.51	3.40%	0.80%
Duplicate/Overlap	50	\$ 42,359.94	7.39%	8.50%
Eligibility/Coverage	240	\$ 184,373.74	35.45%	20.60%
Exceeds Frequency	5	\$ 4,950.00	0.74%	5.70%
Medical Necessity	26	\$ 11,247.20	3.84%	8.00%
Other	10	\$ 5,361.74	1.48%	3.50%
Other Facility Overlap	18	\$ 4,717.00	2.66%	3.00%
Provider Enrollment	166	\$ 53,824.10	24.52%	13.46%
Timely Filing	2	\$ 4,475.69	0.30%	0.20%
Grand Total	677	\$ 399,930.93		

Results

- Communication and Cooperation

Claims touches
Reduced by 45%
Savings per year = \$16,000



Denial Reduction
Reduced by 66%
Savings per year = \$ 315,768



Total = \$331,768

Summary

- Monitor First Pass Yield – Goal to get 95% paid on first submission
- Improved First Pass Payment Rates lead to:
 - Increased cash flow
 - Decreased uncollectible write off
 - Improved A/R performance
- Engage all departments in denial prevention
- Look for ways to turn denials into edits to get the claim right the first time
- Prioritize how denials are worked based on historical overturn data

Questions



Thank you for joining us today!

Don't hesitate to reach out to our presenter with follow up questions or if you'd like to learn more about OS inc.'s services.

Lori Zindl
President

lzindl@os-healthcare.com

