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MID AMERICA SUMMER INSTITUTE 2026

Fields of Opportunity

Growing Healthcare Finance Together

August 3rd–5th, 2026 · Des Moines, Iowa

2026 Recovery Trends & Best Practices

PMMC®

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What impact are denials and contractual underpayments having on your net revenue?

Revenue Challenges

2 in 5 Hospitals

Negative Operating Margins in 2024

$25+ Billion Loss

Annually to Denials

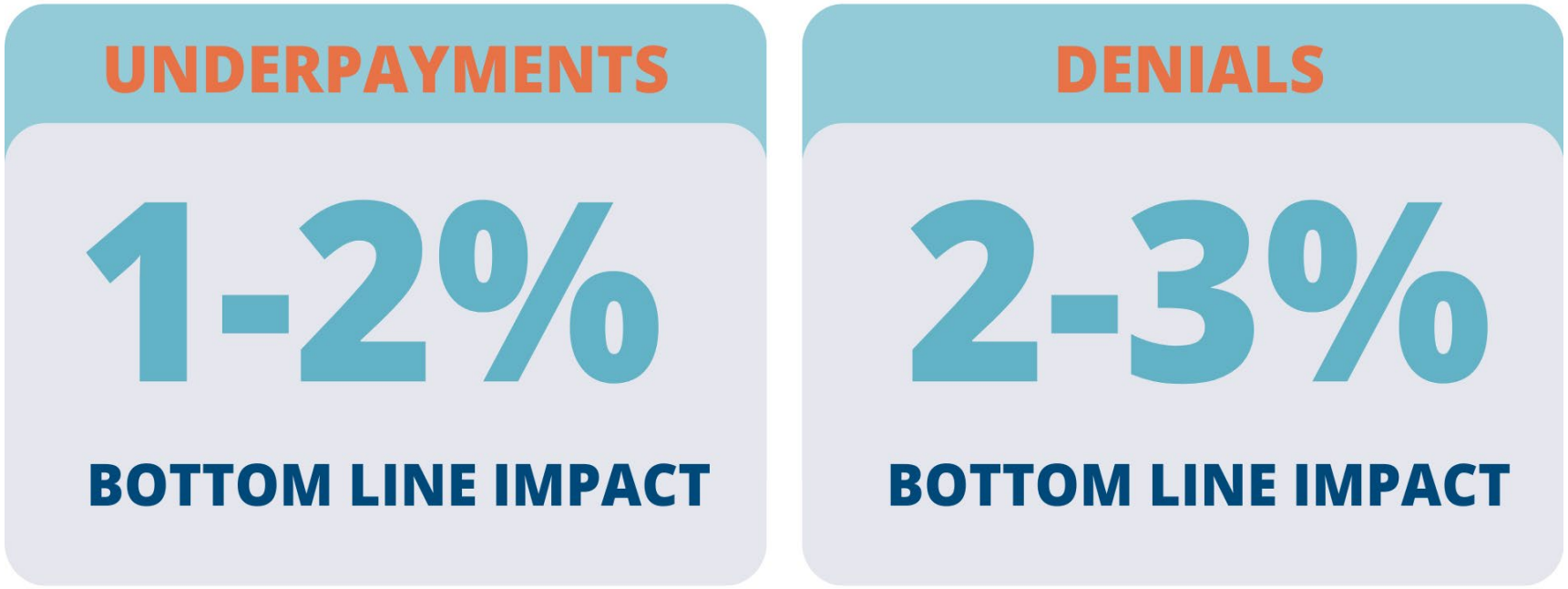
~50% Decline

Margins Compared to Pre-Pandemic

"We lose money on 60% of what we do… hopefully at the end of the year we can break even or have a 1-2% margin."

- CEO of Partners Healthcare
Becker's Hospital Review

All Variances Impact Your Bottom Line

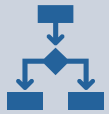



I think I see the problem here.....
You are in a constant
state of denial.
THERAPIST
HOSPITAL CLAIM

Baseline Definition

Denial Management & Contractual Underpayment Recovery is:

The evaluation and understanding of why a medical claim is being denied and/or underpaid.



Determining and implementing best practices for reducing denials and underpayments from occurring.

Creating processes, procedures and review strategies to ensure the organization collects its full reimbursement on the services that have been provided.

Causes of Reimbursement Variances

Variances happen due to breakdowns across the revenue cycle, such as:




PEOPLE	PROCESS	TECHNOLOGY	DATA
• Staffing issues • Front-end denial causes not understood	• Organizations take a reactive-only approach to denials	• Systems not in place for analyzing denial reasons and categories	• No method for deriving meaningful info from data

Top Contractual Underpayment Issues

TREND	SOLUTION
Incorrect contractual bundling (bundling implants, surgeries, etc.. incorrectly)	**Confirm what should and should not be bundled.**
Revenue code issues	**At times, the revenue code can dictate the payment and some services are billable on more than one revenue code. Verifying which codes to use could increase payment amount.**
MCR Advantage policy updates not being applied timely (usually in the first month or two of a new quarter)	**Verify the timeframe for underpaid claims based on updates not being applied.**

COMMON VARIANCES

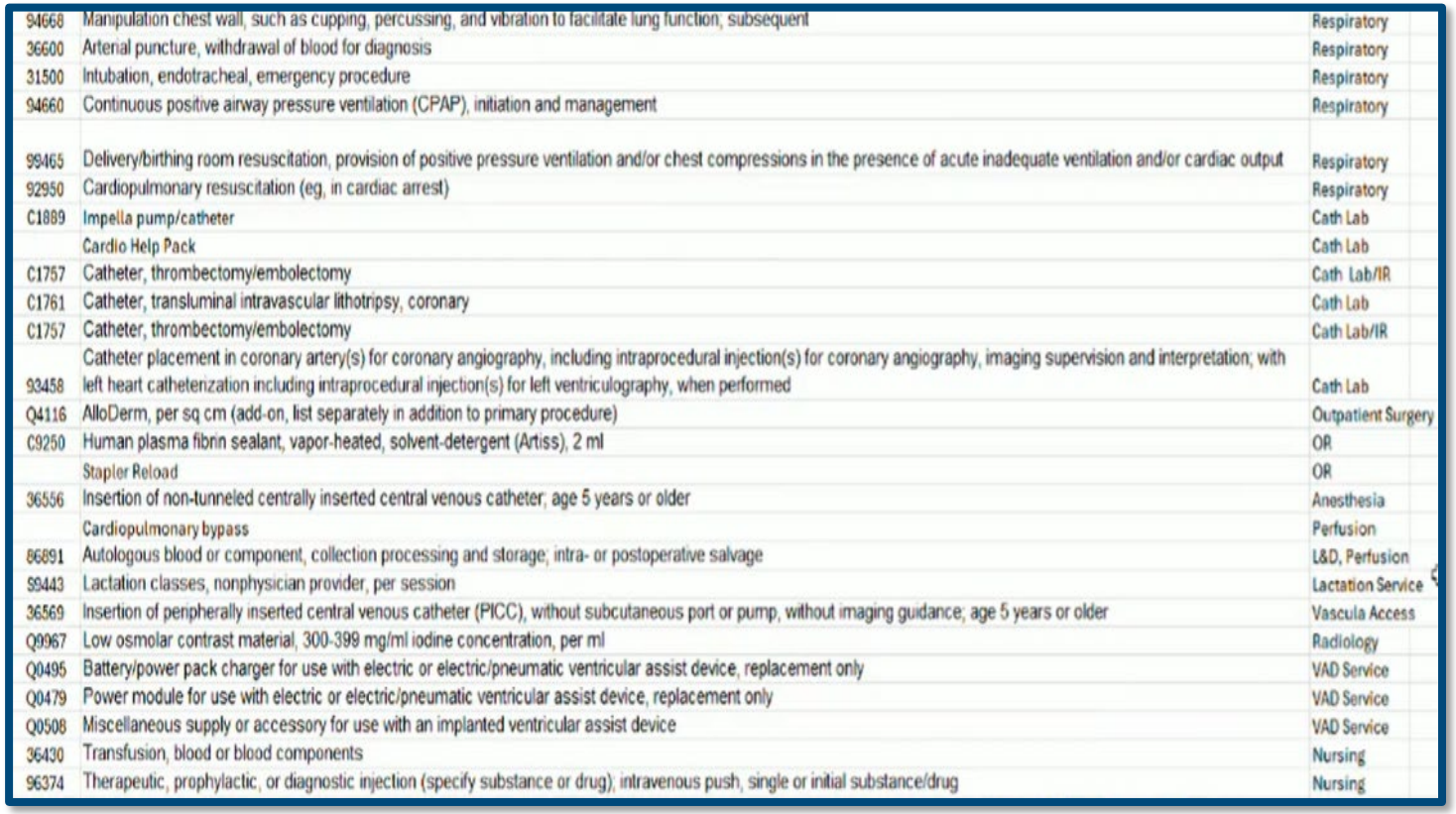
- CO-97 & CO-45
- Stop/Loss Outliers
- Add-on items
- Prior rate schedules
- DRG Downgrade & ER Downgrade
- Multi-Proc Discount / Incorrect surgery rate
- Per visit reimbursement issue
- % of Charge Paid Incorrectly
- Codes billed by Rev Code that are not separately reimbursed (636 Rx)
- Unknown rate paid

CONTRACTUAL VARIANCES:
Accounts where the payer does not pay the negotiated contractual rate and/or terms

PMMC Business Intelligence Trend

Payers Bundling to Lower Outlier Hits via Recoupment

- Payers are using third-party vendors such a Optum
- Bundling commonly involves respiratory services, procedural areas (Cath lab, IR, OR), high-dollar supplies, anesthesia, perfusion, lactation, vascular access, VAD services, and certain labs
- Widespread problem that impacts accounts that are hitting outlier terms
- Challenge is balancing what to fight and what should be considered ‘norma/routine ’ Room & Board’

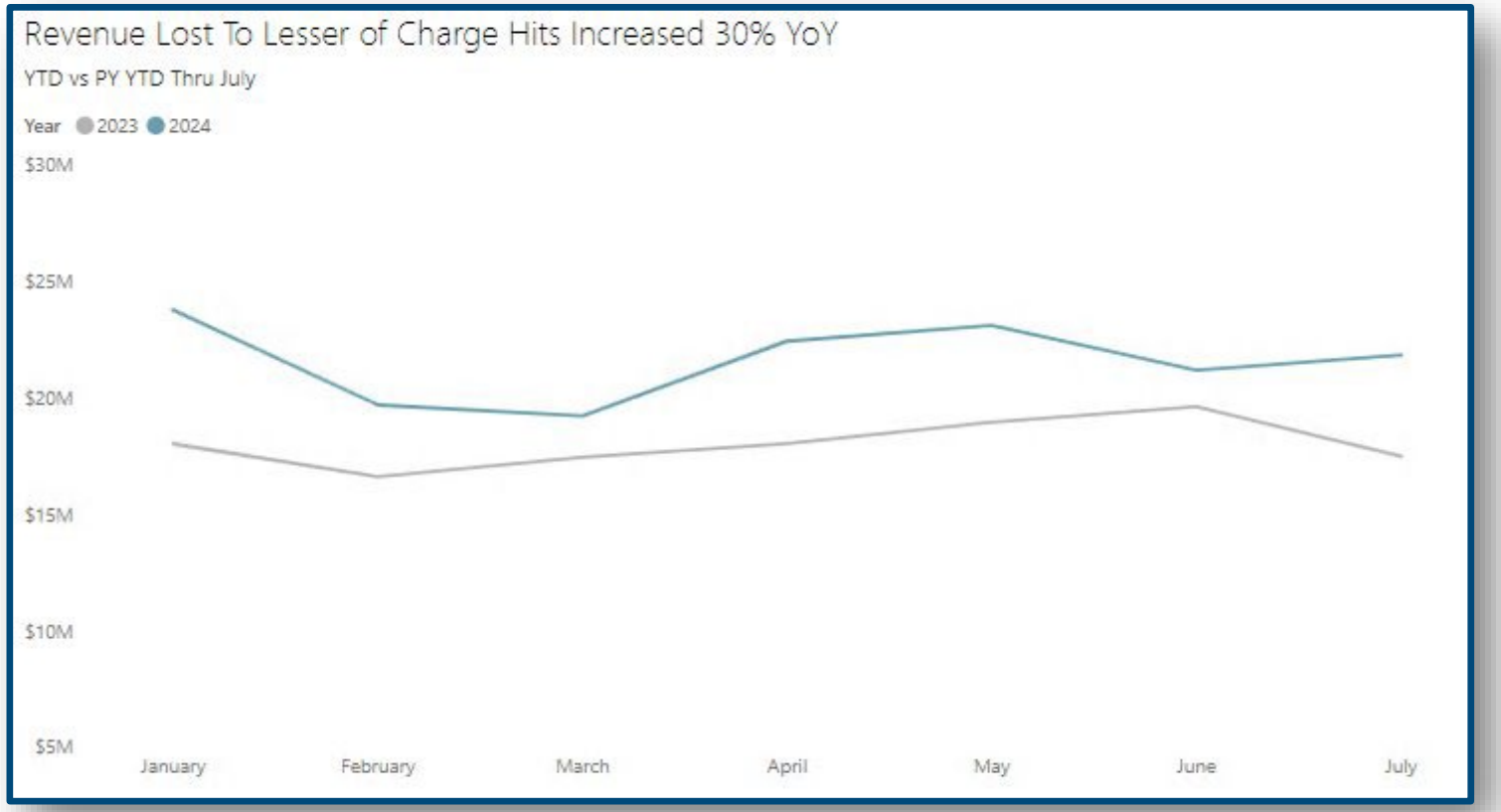


94668	Manipulation chest wall, such as cupping, percussing, and vibration to facilitate lung function, subsequent	Respiratory
36600	Arterial puncture, withdrawal of blood for diagnosis	Respiratory
31500	Intubation, endotracheal, emergency procedure	Respiratory
94660	Continuous positive airway pressure ventilation (CPAP), initiation and management	Respiratory
99465	Delivery/birthing room resuscitation, provision of positive pressure ventilation and/or chest compressions in the presence of acute inadequate ventilation and/or cardiac output	Respiratory
92950	Cardiopulmonary resuscitation (eg, in cardiac arrest)	Respiratory
C1889	Impella pump/catheter	Cath Lab
	Cardio Help Pack	Cath Lab
C1757	Catheter, thrombectomy/embolectomy	Cath Lab/IR
C1761	Catheter, transluminal intravascular lithotripsy, coronary	Cath Lab
C1757	Catheter, thrombectomy/embolectomy	Cath Lab/IR
93458	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed	Cath Lab
Q4116	AlloDerm, per sq cm (add-on, list separately in addition to primary procedure)	Outpatient Surgery
C9250	Human plasma fibrin sealant, vapor-heated, solvent-detergent (Artiss), 2 ml	OR
	Stapler Reload	OR
36556	Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older	Anesthesia
	Cardiopulmonary bypass	Perfusion
86891	Autologous blood or component, collection processing and storage; intra- or postoperative salvage	L&D, Perfusion
S9443	Lactation classes, nonphysician provider, per session	Lactation Service
36569	Insertion of peripherally inserted central venous catheter (PICC), without subcutaneous port or pump, without imaging guidance; age 5 years or older	Vascula Access
Q9967	Low osmolar contrast material, 300-399 mg/ml iodine concentration, per ml	Radiology
Q0495	Battery/power pack charger for use with electric or electric/pneumatic ventricular assist device, replacement only	VAD Service
Q0479	Power module for use with electric or electric/pneumatic ventricular assist device, replacement only	VAD Service
Q0508	Miscellaneous supply or accessory for use with an implanted ventricular assist device	VAD Service
36430	Transfusion, blood or blood components	Nursing
96374	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug	Nursing

PMMC Business Intelligence Trend

Lesser-of Charge Reductions Increasingly Eating Into Hospital Revenue

- Post-Covid & Price Transparency, Hospitals have been less aggressive with their annual charge adjustments
- Rate of net revenue lost to lesser-of charges hits increased ~30% across the data set
- 43% of PMMC clients saw an increase in lost revenue YoY
- Of hospitals that lost revenue to lesser-of hits, the average loss is -0.6% of net revenue



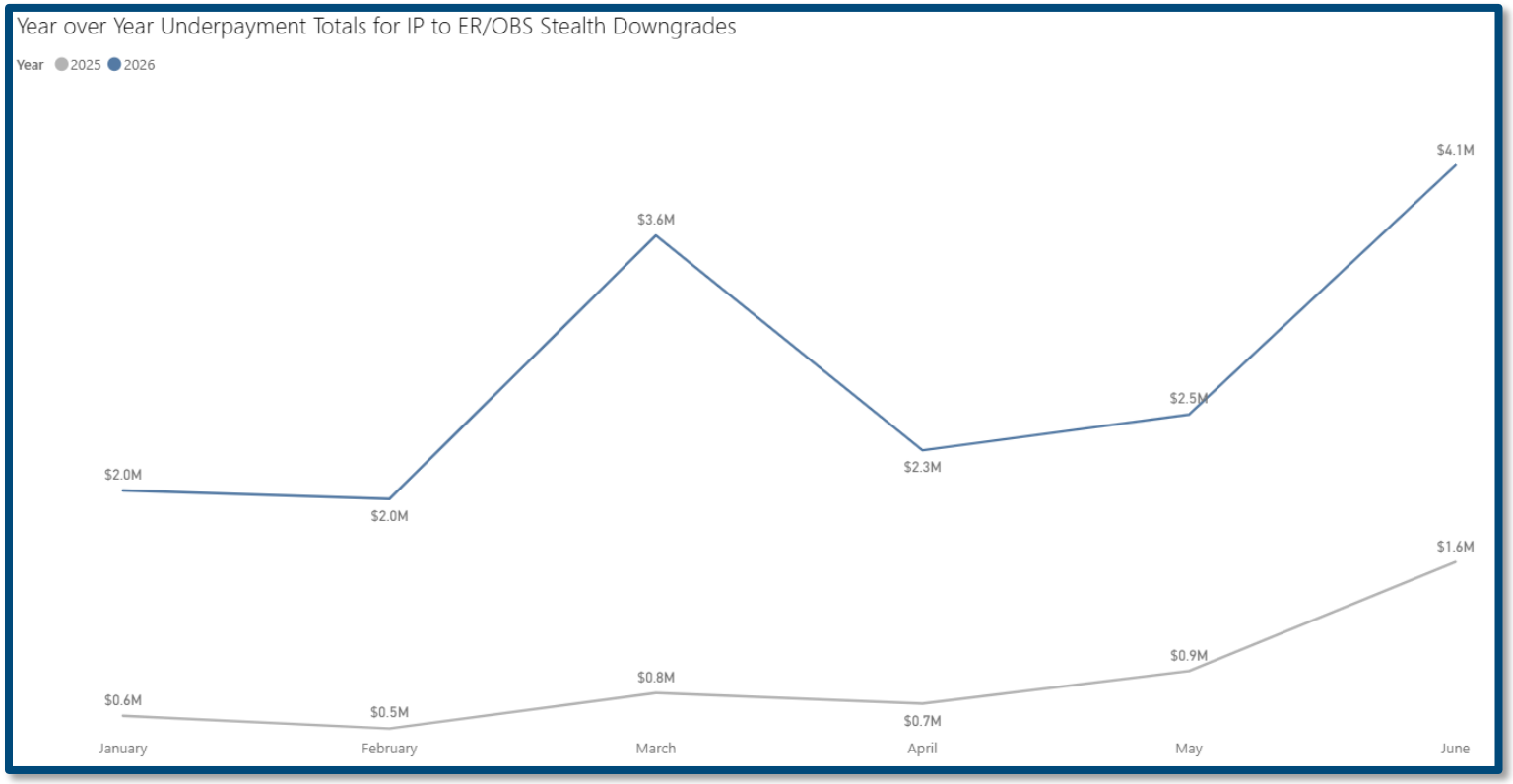
PMMC Business Intelligence Trend

‘IP Stealth’ Underpayments Up 210% YTD on Initial Payments: Payers Quietly Lowering Reimbursement

- This analysis isolates inpatient stays where the payer quietly reimbursed at ER/observation levels instead of the inpatient rate, with no denial or status-change notice
- IP stealth downgrades grew 210% year over year, with June alone up to $4.1M from $1.6M

Things to know

- UHC and Aetna are driving the surge, together accounting for more than half of identified 2026 stealth downgrade volume
- Pattern aligns with Aetna's new level-of-severity payment policy (effective January 2026) and UHC's expanded use of medical necessity line-item denials, so most of these downgrades never surface as a traditional denial



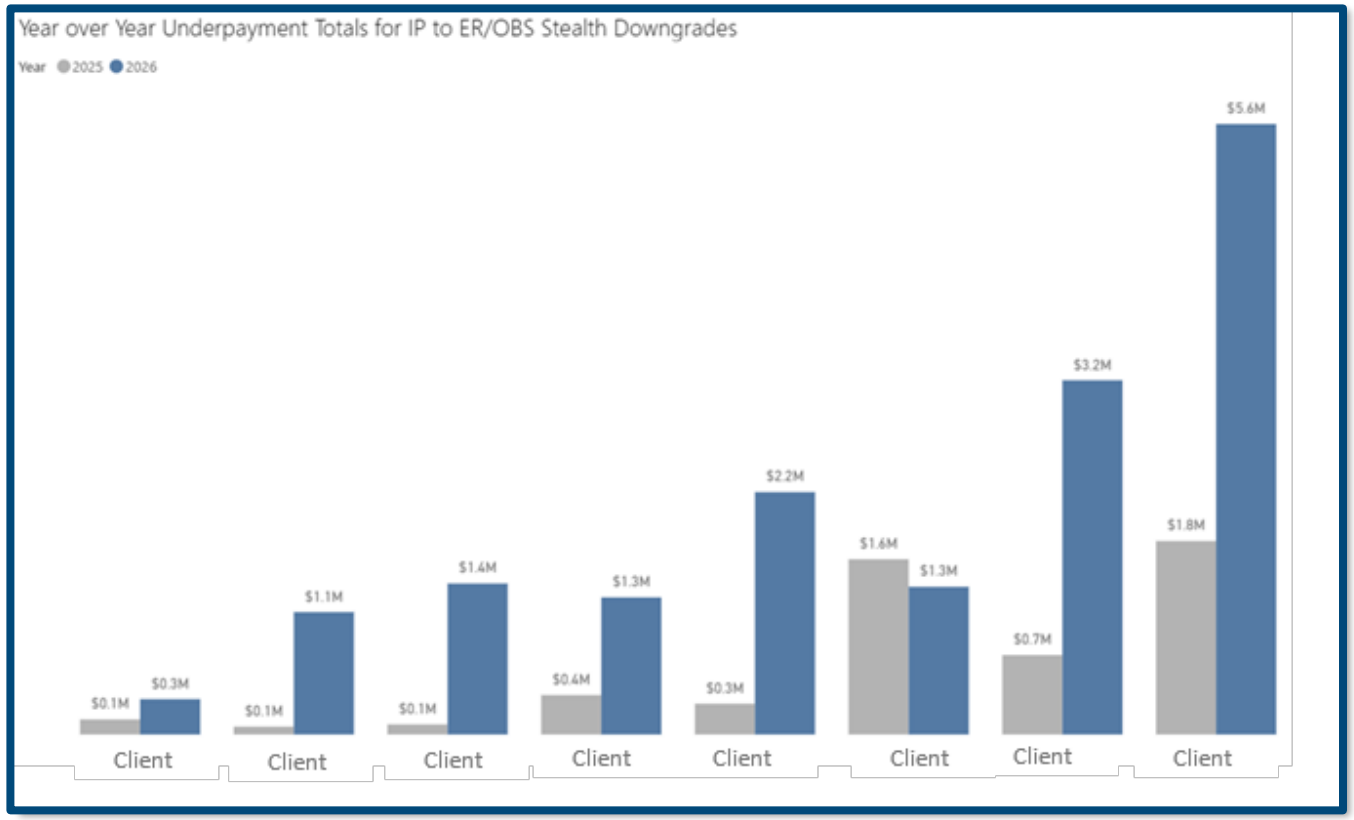
PMMC Business Intelligence Trend

‘IP Stealth’ Underpayments Up 210% YTD on Initial Payments: Payers Quietly Lowering Reimbursement

- Several clients had steep increases of (+211%), (+357%), and (+633%) carry the steepest growth.

Things to know

- Watch for claims where the room and board or pharmacy charges get paid at $0 but the ER charge still gets paid. This is the pattern behind a stealth downgrade, and it's easy to miss because it looks like a normal payment
- The best defense is strong documentation at the time of admission that clearly explains why the patient needed inpatient care. Payers are checking whether the doctor's reasoning at admission supports an inpatient stay, not just how long the patient actually stayed

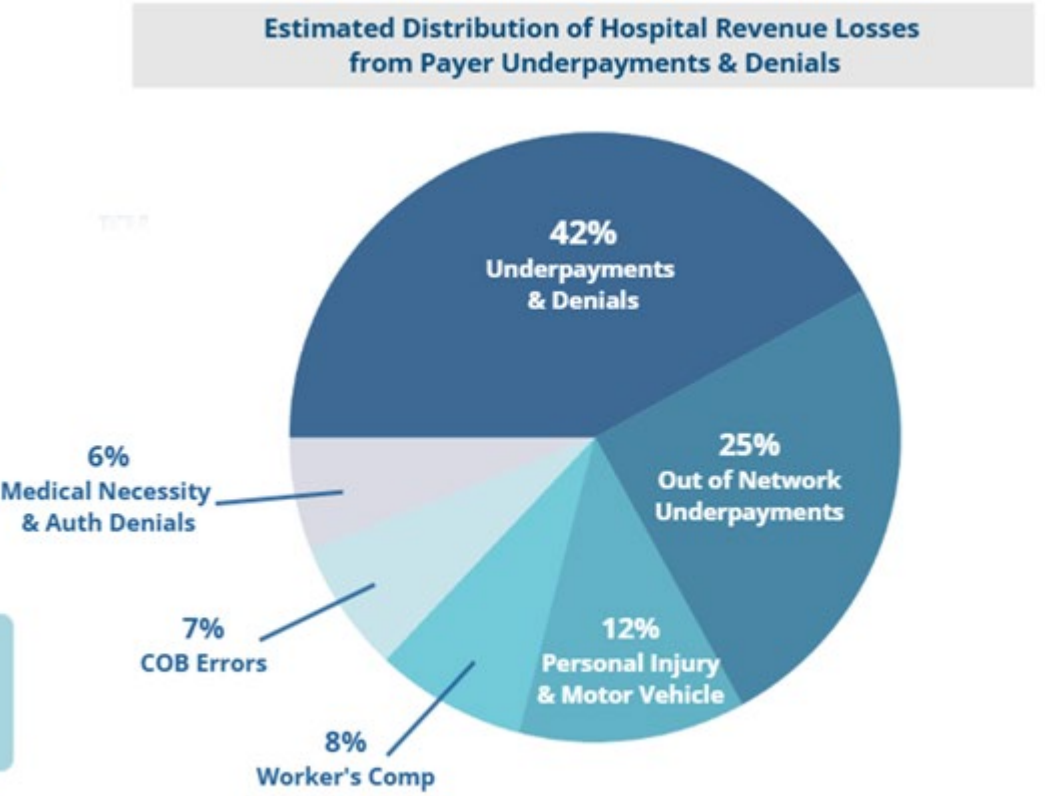


PMMC Business Intelligence Trends

Projected NSA Arbitration Financial Impact (technical & professional)

- **Most Eligible Claims are never arbitrated**
  - 80%+ of IDR-eligible claims go untouched
  - Nearly $10B in lost revenue (conservatively)
- **Why its not happening:**
  - Confusing process
  - Limited internal expertise
  - Resource constraints
  - Tight timelines & poor data access

Are you capturing your share of the $10B opportunity?



PMMC Business Intelligence Trends

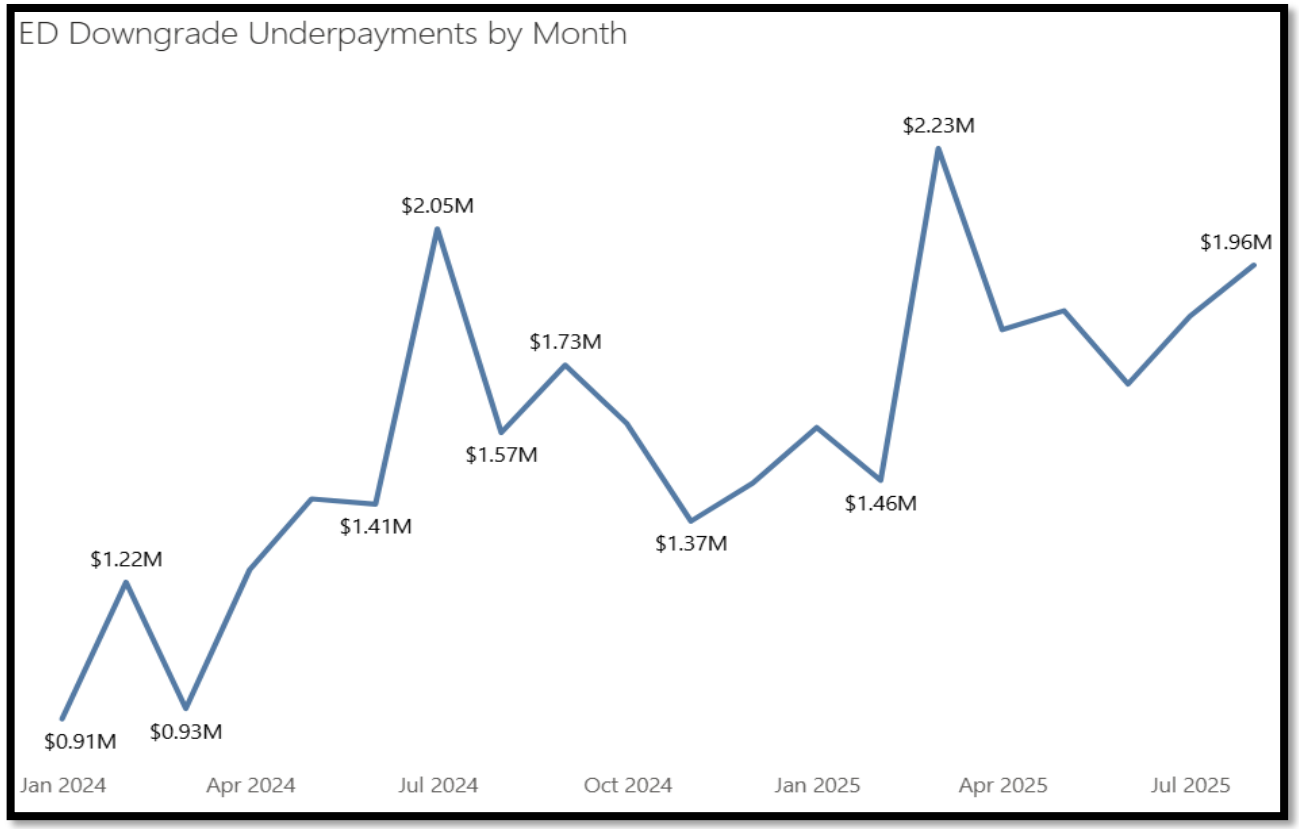
NSA Arbitration Example Results

ANESTHESIA	SPINAL SURGERY	NEUROSURGEON
Anesthesia during spin/spinal cord cervical discectomy (00600)	Open Reduction of L1 burst fracture with fusion	C4-C5 Discectomy and C5-C7 fusion with instrumentation
Initial Insurance Offer: **$1,481**	Initial Insurance Offer: **$6,342**	Initial Insurance Offer: **$5,706**
Final Arbitration Award **$43,302**	Final Arbitration Award **$210,675**	Final Arbitration Award **$224,293**

PMMC Business Intelligence Trend

ED Downcoding Underpayments

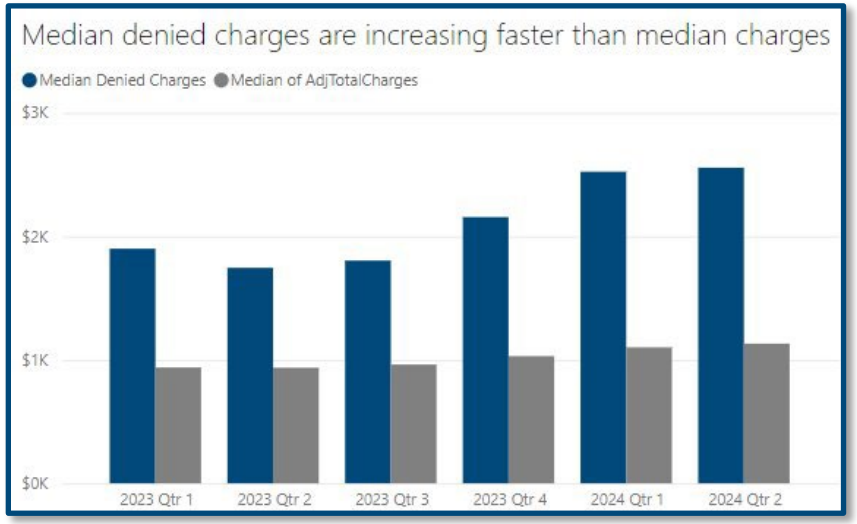
- Payers are often not denying or technically underpaying from one ED Level to another.
- ED Downgrades increased 115% from Jan ‘24 to Aug ’25
- There are similar results with DRG downcoding.

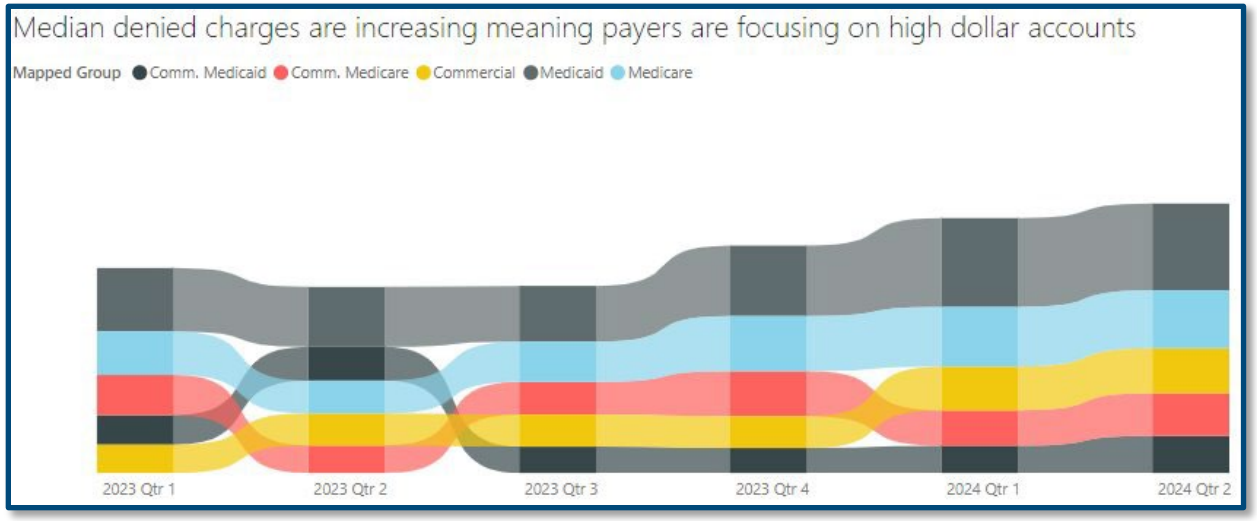


PMMC Business Intelligence Trend

Payers Are Denying High Dollar Accounts At A Greater Rate

- Median denied charges have increased 54% year over year while the median charges for all accounts has only increased 18%
- Higher charge accounts (>$25,000)make up 66% of denied revenue in the first quarter of 2024 so as this trend continues a greater portion of clients' highest revenue accounts will be at risk due to denials
- Documentation, Authorization, Coding, Credentialing and Non-Covered have the highest increases in Median denied charges
    - Hospitals should ensure authorization, coding and documentation processes are followed on high dollar accounts to prevent denials

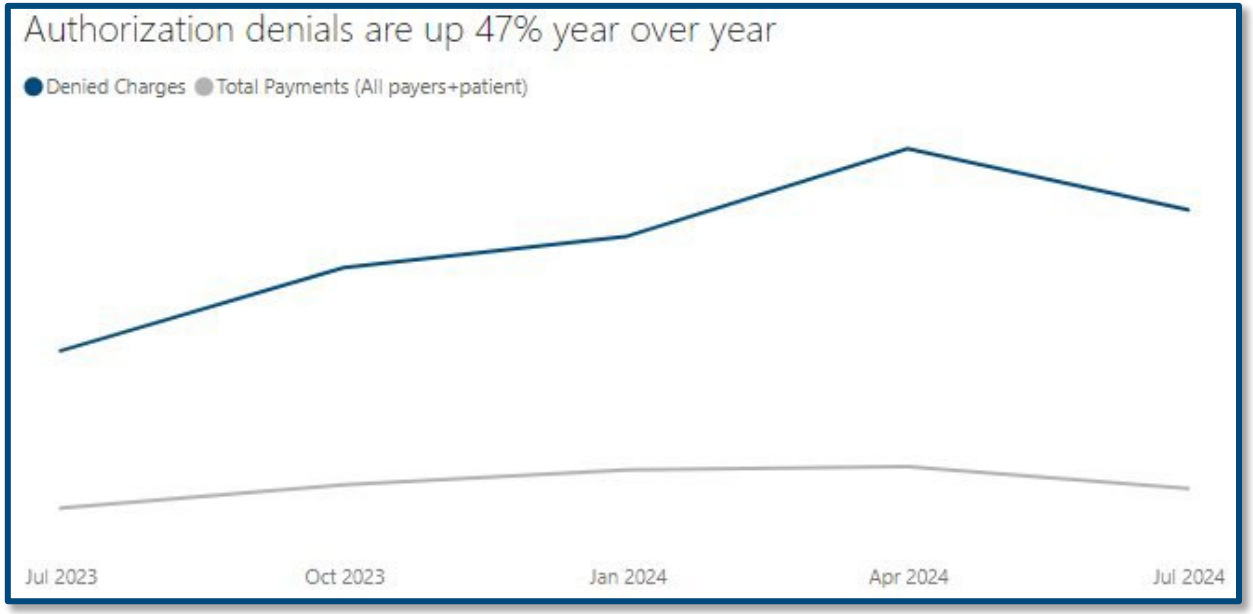




PMMC Business Intelligence Trend

Authorization Denials Increasingly Eating Into Hospital Revenue

- HFMA survey of 134 CFOs found 51.5% ranked 'Prior Authorization' Denials as one of their top-3 areas of revenue cycle department stress
- Auth denials have some of the lowest initial payment rates at 7.4% of charges compared to the 22% average and the total payment rate is 11% lower than average
- BCBS appears to have the greatest YoY increase



No Authorization

Common CARC Codes:
197, 198, 210, 39

Check to see if an authorization was originally requested

- If Yes, attempt to send the claim back with the available authorization number(occasionally an authorization code is valid, but the payer does not process the authorization with the claim.
- If No Authorization as requested or the auth was not valid for the billed services, recommend appealing with medical records and extenuating circumstantial documentation that the provide service was medically necessary.

Medical Necessity

Common CARC Codes: 50

When a claim is denied for medical necessity, start with the Medical Record.

- Submit your appeal based on the medical record.
- Build your case for why the services were medically necessary for treatment.

Missing Documentation

Common CARC Codes: 252, 226

Occurs with full or partial claim denials and often can be avoided with correct support documentation submitte d on the front end.

Determine from the payer exactly what documentation is needed and submit that material for review.

Missing Device Code

Common CARC Codes: 4

Commonly see device dependent procedures billed without the applicable device code. In these scenarios, a device was used or implanted but was left off the billed claim.

Rebill with the applicable device code. Example 27447 is a code commonly used for a total knee arthroplasty (replacing knee joint with prosthetic implants). The implant (device code) must be billed for the code to pay.

Missing/Invalid Modifier

Common CARC Codes: 4

Certain codes require a modifier that is applicable to the treatment to be billed so the claim is processed appropriately.

- Research to determine the appropriate modifier.
- Rebill to add or change to the appropriate modifier.
- Common issues:
  - Missing modifier on E/M codes that need modifier 25 to indicate a significant separately identifiable service
  - Missing modifier 59 to indicate distinct service
  - Missing LT?RT modifier to indicate which side was treated

Eligibility

Common CARC Codes:
24, 26, 27, 31, 32, 200

Check to determine if the member did have active coverage during the date of service.

- Research the payers' online portals and review past or future claims to determine if the patient had another plan that may have been active during the DOS.
- Often, an incorrect subscriber ID is used, the patient's name was misspelled, the policy holder name was used instead of the patient's name or the patient had other active coverage that was not added or used.
- Once verified, then rebill to correct the information or rebill to the active plan.

Incorrect Discharge Status Billed

Common CARC Codes: 193,18

Occasionally, a provider will bill a discharge status that is inconsistent with the information the payer has.

- For example, discharge status 01 (discharged home) may be billed but the payer has information that the patient was transferred to home health (06).
- Once this denial is received, contact the payer to retrieve the information they have and rebill to change to the correct discharge status code.

Coordination of Benefits

Common CARC Codes:
22, 227

Providers are seeing a large increase in claims that deny requesting a COB update or additional information from the member.

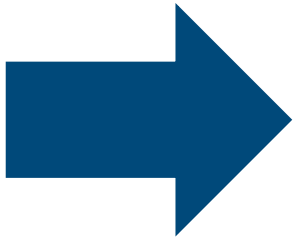
Recommend consistently checking with the payer to verify if the member has updated the needed information.

- If yes, the claim should be sent for reprocessing or request a rebill if needed for that payer (sometimes this step is not automatically done).
- If no, follow up with the member by phone call or letter to inform them that their insurance company is requesting additional information.
- Often the provider will coordinate with the patient but never follow up with the payer.

Bilateral Procedures with Mod 5 Incorrectly Billed

Common CARC Codes:
16, 18, 4

When billing a bilateral procedure, one (1) unit should be billed on one line with modifier 50 appended

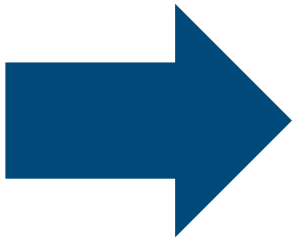


- Commonly see bilateral procedures billed incorrectly with two (2) units, LT/RT modifiers used instead of modifier 50.
- Also commonly see modifier 50 left off entirely.
- Action item is to rebill to change the billing for correct compliance with bilateral procedures.

Covid Test

Common Contractual Codes: CO97, CO45

Commonly see Payer not denying it but they just are not paying it separately and that code should be paid separately.



Appeal with the Medicare APC Pricer

Self-Administered Drugs (Rev Code 0637)

Common CARC Codes: 16, 216

Commonly see Self-Administered drugs billed on outpatient claims using the revenue code 0637 with no CPT.

Some payers (most common with UHC and Cigna) will deny the 0637 charge for billing errors and the rest of the claim as contractual, paying $0. In these cases, rebill to remove the 0637 charge entirely.

No JZ/JW Modifier Used to Indicate Drug Waste

Common CARC Codes: 16, 4

Drugs billed from single-dose containers require the use of JZ or JW modifier to indicate waste.

This is needed with Medicare and MCR Adv plans but will sometimes apply to commercial payers as well.

- Commonly see hospitals billing high-cost drugs from single-dose containers but leaving off JZ/JW modifier entirely, resulting in a denial.
- Rebill to add the applicable modifier (JZ if the entire drug amount was administered or splitting to 2 lines and appending modifier JW to one line if a portion of the drug was discarded and not given to the patient).

Updated CMS Inpatient Only Surgical Codes

Common CARC Codes: 171

Medicare removed 285 primarily complex ortho/spine and musculoskeletal surgical procedure codes for the list

- Many payers have been slow to update their list and systems. Many were denying earlier this year.
- Appeal with Medicare guidelines.

Medicare IP/OP 72-hour Rule

Common CARC Codes: 18,193

Medicare requires hospitals to bundle all outpatient diagnostic and related non-diagnostic services provided within 72 hours before an inpatient admission to the inpatient claim. Many claims billed separately or billed without the appropriate condition codes.

- If this happens, rebill to cancel the outpatient claim and combine with the inpatient claim if services were related.
- If services were unrelated, rebill to append the correct condition code indicating services were unrelated.

Observation Charges Billed Incorrectly

Common CARC Codes: 16, 216

Per CMA guidelines, observation charges should generally be billed on a single line for the entire duration of the stay, including all hours up to 72, with the DOS reflecting the say observation began.

- Often, we will see observation charges separated on multiple lines by calendar day, instead of combining to one line, resulting in a denial.
- In this case, rebill to combine observation charges to one line with the appropriate units.

Units Exceeding the MUE

Common CARC Codes:
151, 119, 16

If a claim is billed with more units than the "Medically Unlikely Edit" for a specific code this will result in a denial.

- Often, this denial appears to be related to a benefits issue based on the CARC codes applied to the EOB and is incorrectly attributed to patient responsibility.
- Commonly see this with surgical procedures. For example, 27130 has an MUE of one (1), billing with two (2) units will result in a denial.
- Rebill to correct the units billed to comply with the MUE.

Readmission

Common CARC Codes:
249, 272, 96

Each payer has a readmission rule outlined in their policy (commonly 30 days)

- If a patient is discharged and then readmitted during that time frame for a related condition, the claim is denied.
- Review the claim that is denied as well as the surrounding claims billed to determine if the denied claim qualifies as a readmission. If the claim denied was billed outside of the readmission window, then appeal due to the incorrect denial or send the claim back for correct processing.
- If the claim denied was unrelated to the previous admission or was an unavoidable circumstance, appeal with medical records for medical necessity stating the two admissions were unrelated or unavoidable.

Timely Filing

Common CARC Codes: 20

Determine if there were extenuating circumstances that prevented the claim from being billed within the payer's time frame parameters.

- Examples would be the patient providing incorrect insurance or personal/demographic information at the time of service
- Build the appeal process with timeline notes outlining how the claim would have been submitted within the deadline had the extenuating circumstance not occurred.

Example A9595 Claims: Same Billing, Different Outcomes

SCENARIO 1

Paid Then Retracted

- 9 units billed
- Initially Paid
- CO-97 retraction (appeals unsuccessful)

SCENARIO 2

Paid as Billed

- 9 units billed
- Paid as billed
- No retraction to date

Inconsistent payer behavior for identical billing

$90k retracted in 2025
$100k at risk for retraction

A9595 is included on the fee schedule, yet identical billing produces different outcomes, suggesting inconsistent policy application.

Requires standardization and payer alignment to ensure consistent reimbursement

Recommended Approach: Example A9595 Reimbursement Alignment

Based on observed reimbursement inconsistency, we recommend the following approach:

VALIDATE AND QUANTIFY

- Analyze paid vs retracted claim patterns
- Identify variance in reimbursement for identical billing
- Quantify financial impact and consistency gaps

ENGAGE THE PAYER

- Present findings and claim examples
- Seek methodology clarification
- Align on consistent reimbursement approach

Payer alignment = Predictable reimbursement

Analytical Reporting Best Practices

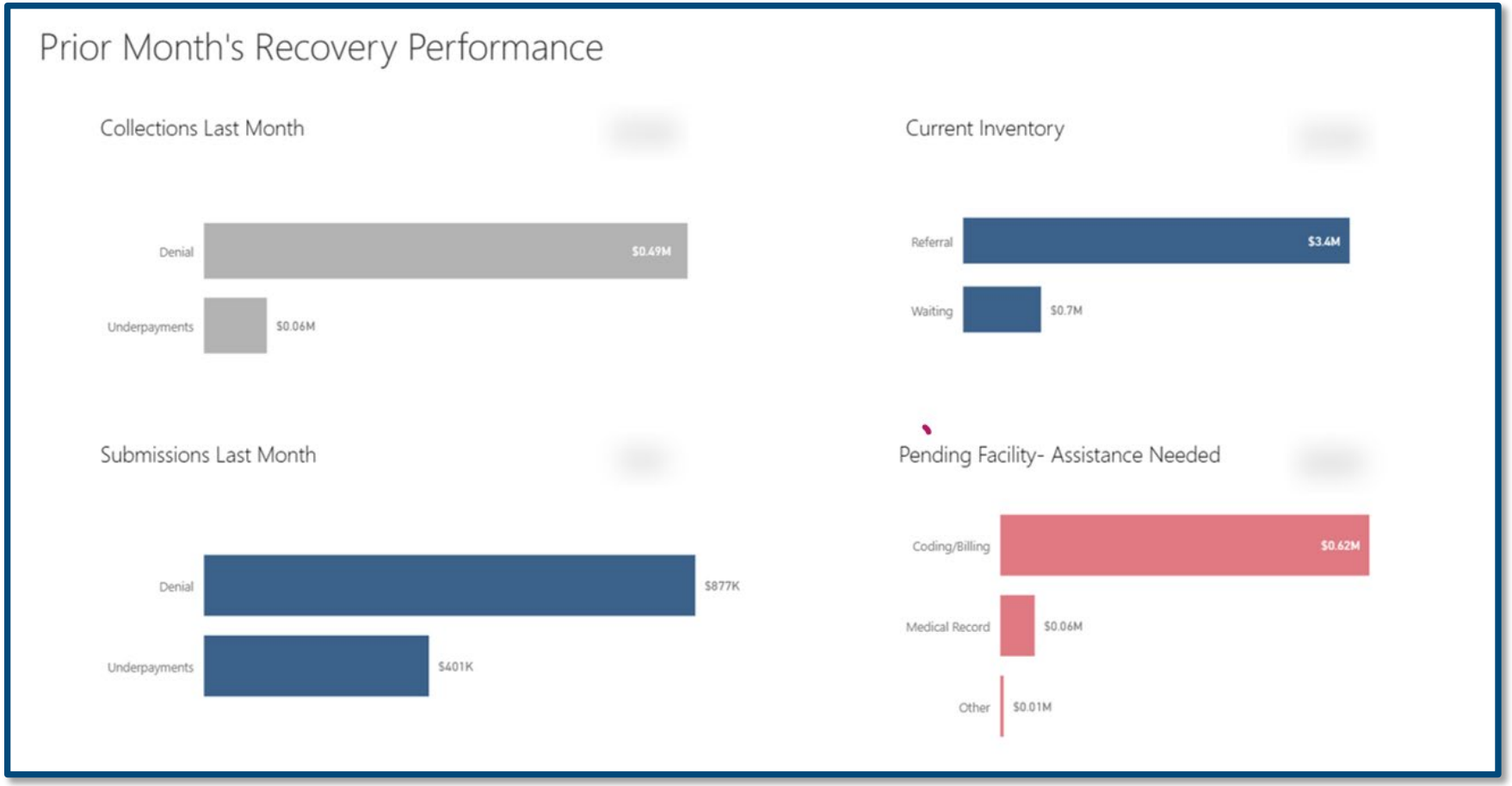
Reporting dashboards should be designed to provide visibility into recovery performance, opportunity, and workflow.

- **Transparency**
  Comprehensive insight into submissions, collections, inventory, and closures - providing a full view of total performance
- **Accountability**
  Clear visibility into productivity, follow-up activity, and recovery performance to ensure consistent execution and results
- **Collaboration**
  Actionable insights that align your teams to identify trends, address root causes, and drive continuous improvement

Prior Month Recovery Performance

Monitor recovery activity for the prior month, including collections, new opportunity identified and current inventory status.

- **Collections**
  Broken down between denials and underpayments, reflecting cash recovered during the previous month
- **Submissions**
  Represent new opportunities and what has been added to inventory for potential recovery
- **Current Inventory**
  Reflect accounts actively being pursued, with a breakdown of:
  - *Referral: Accounts currently with the payer for review*
  - *Waiting: Accounts pending additional information or action from client*



Collections and Submissions Analysis

Compares what has been submitted to payers against what has been collected, providing visibility into overall recovery performance

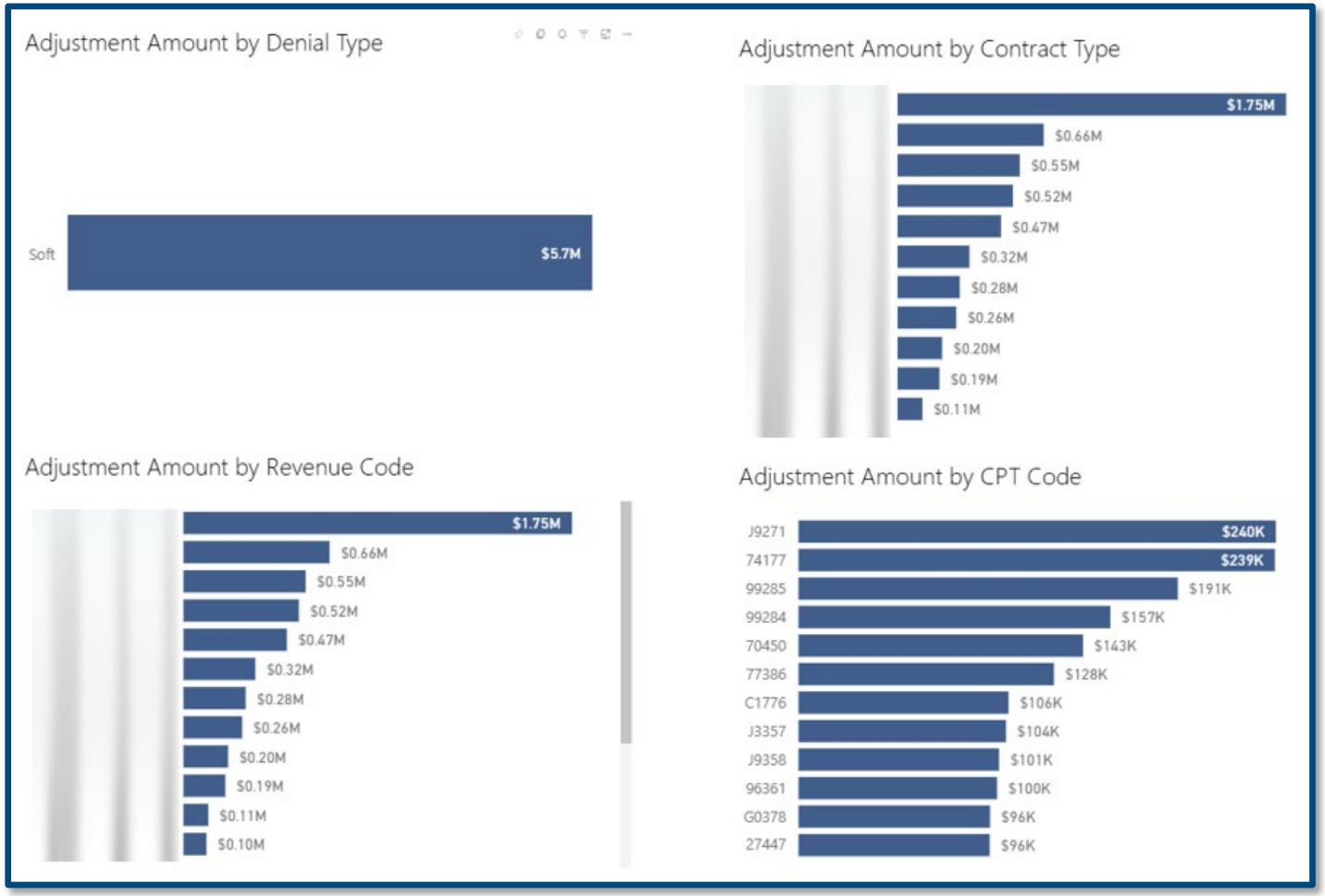
- Measure success rates by payer, highlighting where recovery efforts are most effective
- Track month-over-month performance based on when accounts were submitted
- Breakdown by review category to identify trends in denials vs. underpayments
- Includes a cash projection based on prior submissions, outlining expected collections in subsequent months

Line Level Denials

Provides detailed insight into denial at the line level, supporting a more strategic approach to revenue optimization.

- Identify trends by denial type, contract, revenue code, and CPT code
- Highlight specific areas where denials and underpayments are occurring most frequently
- Incorporate drill-down to pinpoint root causes and patterns

This allows your team to proactively address issues related to billing, coding, authorization, and registration that may be impacting reimbursement.

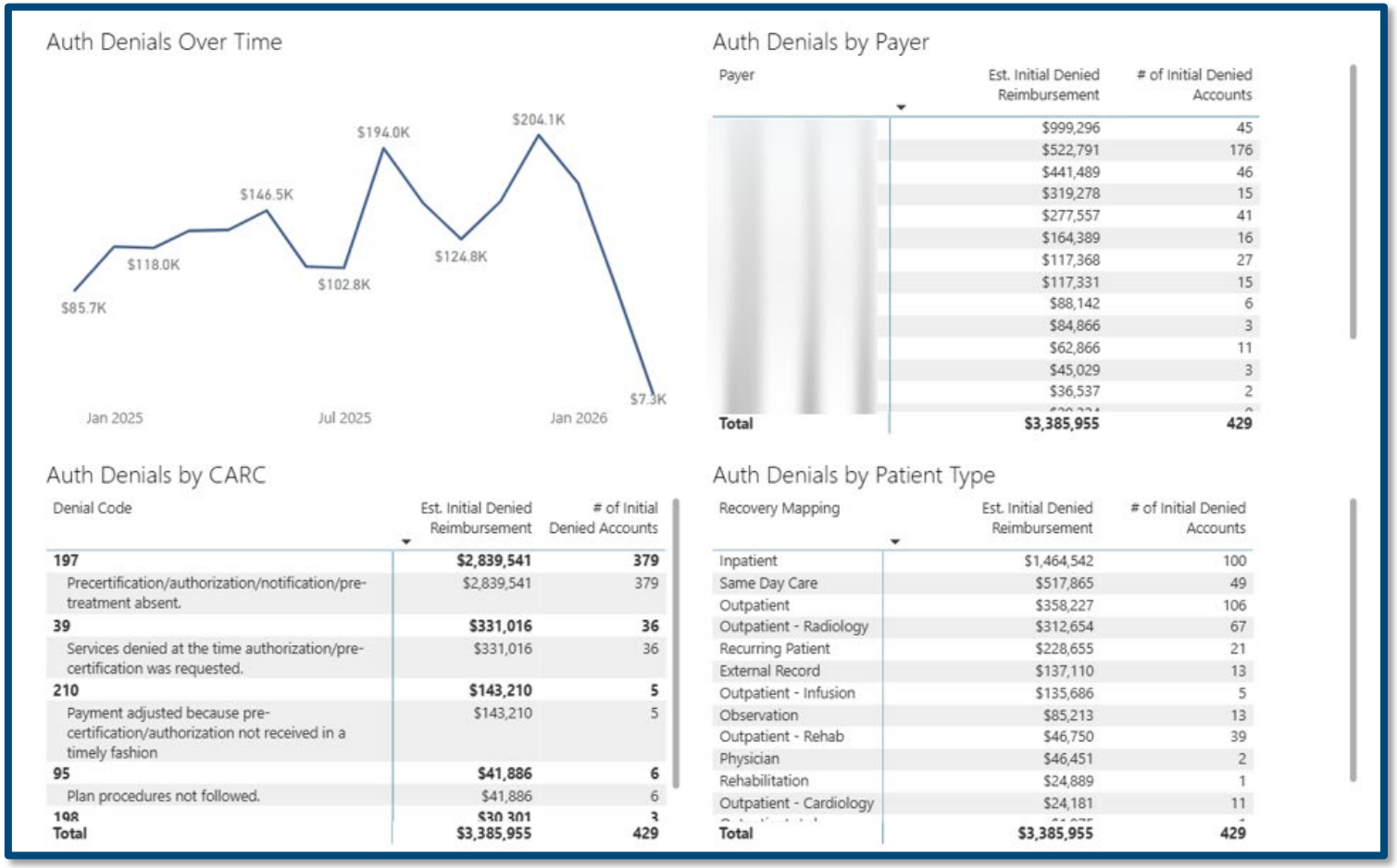


No Auth Denial Analysis

- Pinpoint trends by payer, CARC, and patient type
- Expose gaps in authorization, registration, intake workflows, etc.
- Quantify the financial impact of preventable denials

By addressing these drivers upstream, organizations can reduce denials, improve efficiency, and drive more consistent reimbursement.

Authorization related denials represent avoidable revenue loss and unnecessary rework.

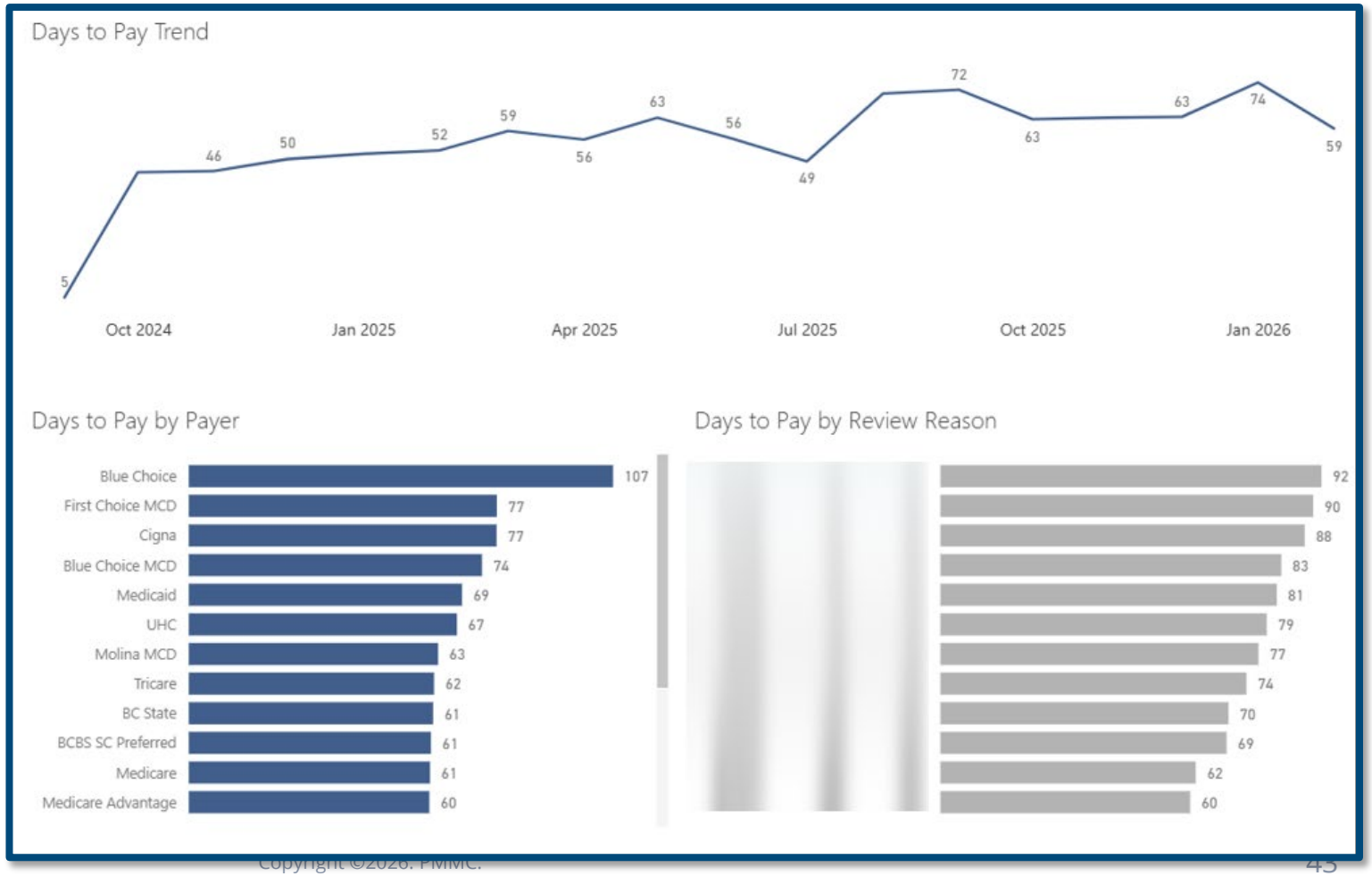


Days to Pay Summary

- Display days-to-pay by payer, highlighting payer-specific patterns
- Breakdown by review reason to identify drivers of delays
- Trend analysis over time to monitor changes in payer behavior

Understanding these trends helps optimize follow-up strategies and improve recovery timelines

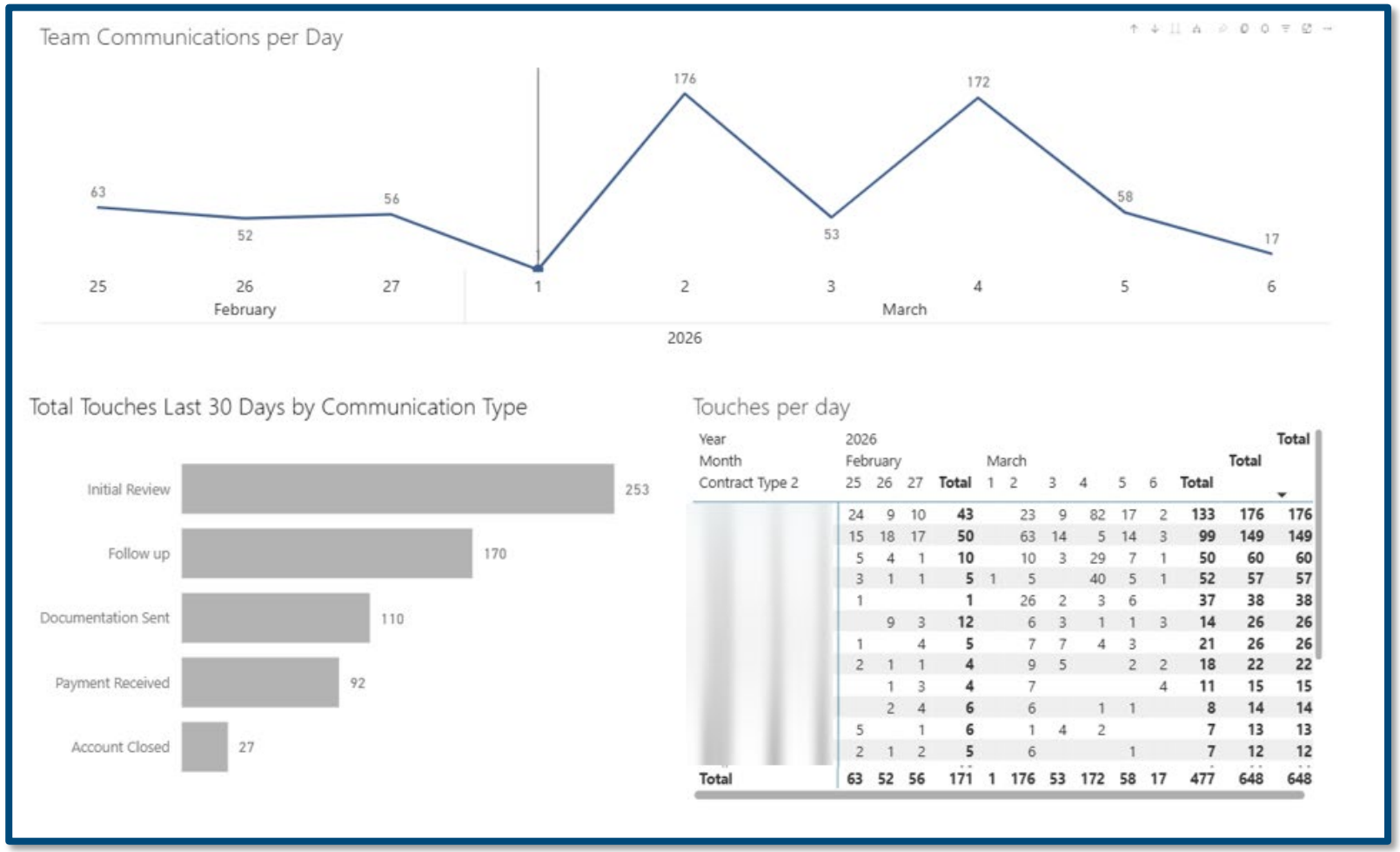
Tracks trends in payer response times, measured from when accounts are worked to when payment is received



Daily Productivity

- Track daily touch activity across accounts being worked
- Provides visibility into team engagement and consistency

This ensures consistent activity across accounts and reinforces accountability in driving recovery outcomes.



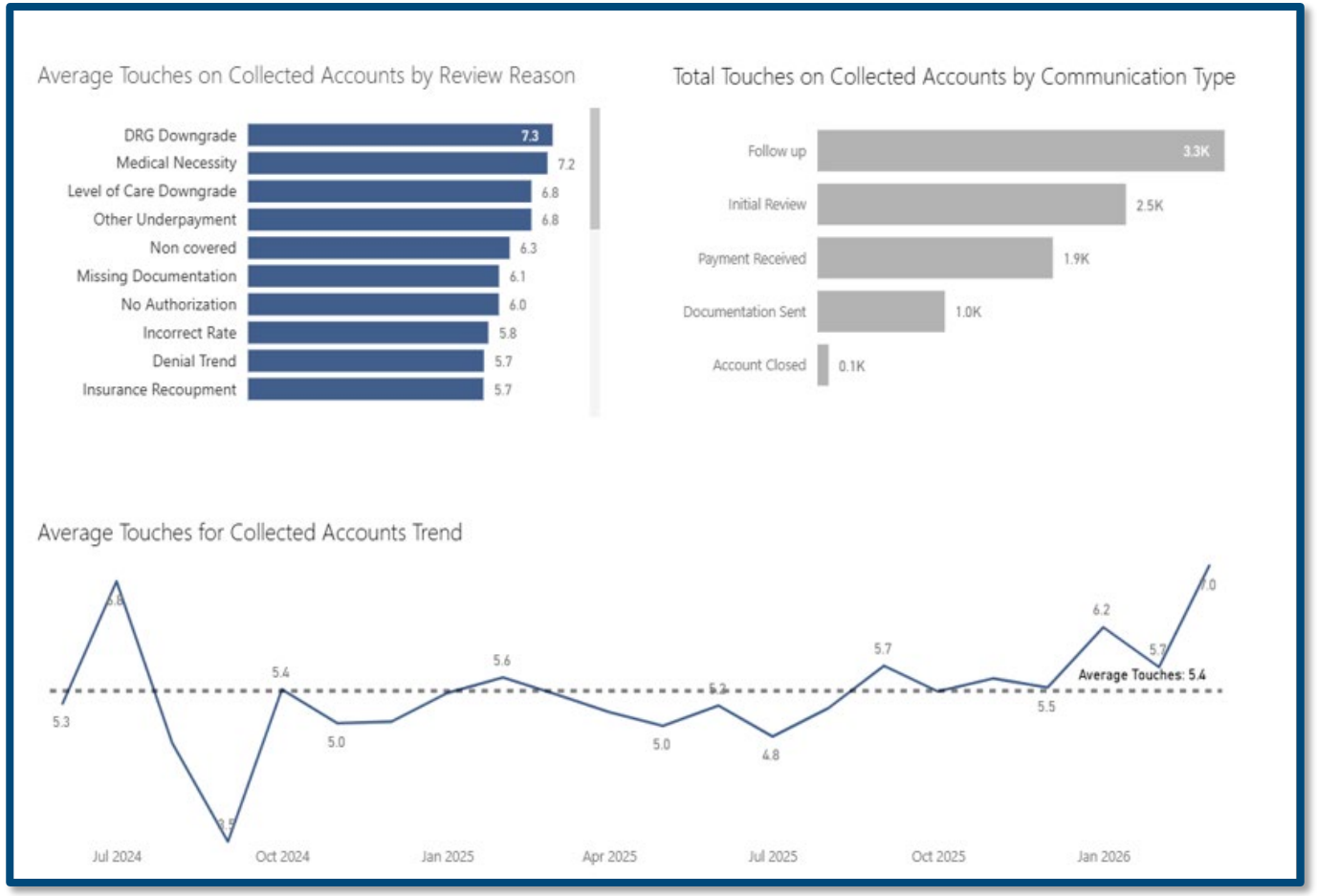
Year	2026												
Month	February			Total	March						Total	Total	
Contract Type 2	25	26	27		1	2	3	4	5	6			
	24	9	10	43		23	9	82	17	2	133	176	176
	15	18	17	50		63	14	5	14	3	99	149	149
	5	4	1	10		10	3	29	7	1	50	60	60
	3	1	1	5	1	5		40	5	1	52	57	57
	1			1		26	2	3	6		37	38	38
		9	3	12		6	3	1	1	3	14	26	26
	1		4	5		7	7	4	3		21	26	26
	2	1	1	4		9	5		2	2	18	22	22
		1	3	4		7				4	11	15	15
		2	4	6		6		1	1		8	14	14
	5		1	6		1	4	2			7	13	13
	2	1	2	5		6			1		7	12	12
Total	63	52	56	171	1	176	53	172	58	17	477	648	648

Recovery Touches Summary

Insight into the level of effort and engagement applied to accounts throughout the recovery process

- Track the number of touches required to achieve successful recovery
- Displays total touch activity by communication type, including follow-up, review, and documentation efforts
- Tracks trends in average touches over time, providing visibility into workflow efficiency and consistency

Often accounts follow up can for 120–180 days post-ZB date, with follow-up occurring every 15–30 days to maintain consistent payer engagement.

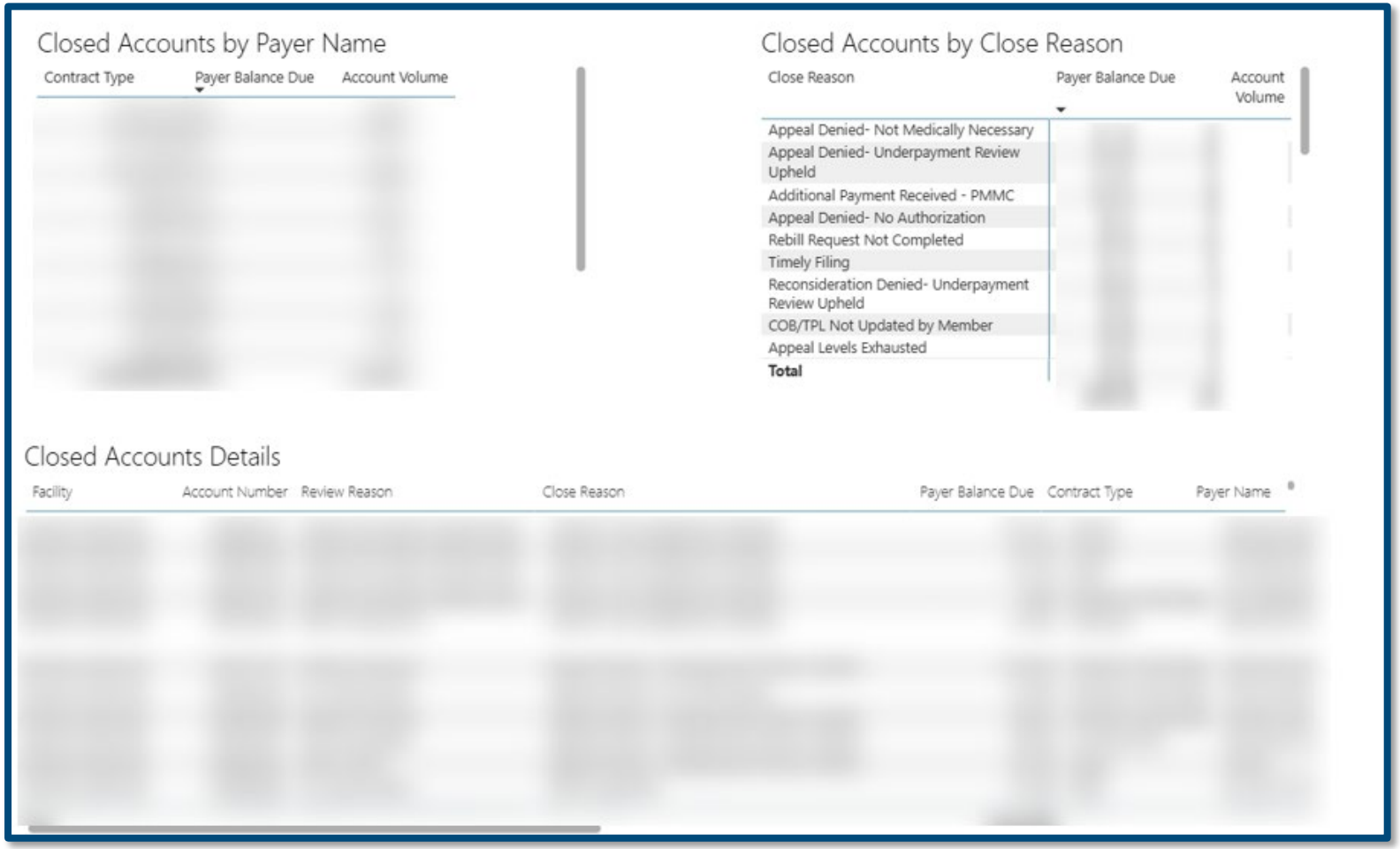


Closed

Insight into accounts closed from inventory and the reasons behind closure.

While the goal is always to recover additional dollars, this report provides transparency into both successful recoveries and accounts closed after all efforts have been exhausted.

- Breakdown of closed accounts by payer and close reason
- Visibility into outcomes, including successful recoveries and exhausted efforts
- Allows for deeper analysis of closure trends and helps identify patterns impacting recovery performance.



How effectively are you using analytics today to manage your underpayments and denials?

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THANK YOU FOR YOUR TIME

If you have questions or would like additional resources, please contact Greg Kay or Carter Loesch.

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