Today’s speaker

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EXPERT SESSION:

Upstream Accuracy, Downstream Impact: Stop Denials Before They Start

Walk away knowing how to:

- The top causes of denials in today's market
- What tactics aren't solving the problem
- Proven ways to leverage people, processes, and technology to block more denials
- How to build a denial prevention strategy

Register to win a pair of Nike Sneakers!

Learning Objectives

- Recognize the operational + financial impact of preventable denials
- Identify methods to determine root causes for denials across eligibility, authorization, medical necessity, documentation, coding, and billing workflows
- Adopt methodologies that can effectively prevent denials and reduce staff burnout
- Apply practical strategies to reduce rework, improve clean claims, and protect revenue
- Evaluate how analytics, AI + automation can prioritize workflow and strengthen denial prevention
- Pressure test denial prevention strategies with KPIs and robust analytics

State of the industry

A PROBLEM WORTH SOLVING

Denials aren't a new problem – but they are becoming a more expensive one

THE PROBLEM

~15%
of all claims are denied[1]

450M
annually denied claims[1]

$62B
revenue recouped from denials[2,3]

THE OPPORTUNITY

63%
of claims are recoverable[2]

2/3
of denials are never worked[2]

~$44
Spent per appeal to overturn[1]

1: Premier Provider Survey | 2: Waystar and HFMA Research |
3: Analysis from Definitive Healthcare data

A PROBLEM WORTH SOLVING

The increasing denials crisis

As payment complexity increases, cost to collect is rising faster than revenue itself

The scope of denials

20%+
Rise in denials

65%
Never appealed

$25-30
Cost to rework

3x
Payer investments in AI expected to triple by 2033

$450M
claims are denied annually

$20B
Spent annually by providers to overturn denials

Market trends

OPERATIONAL GAP

Preventable denials:
Caused by **front-end errors** that persist due to lack of visibility

OPERATIONAL GAP

Timing-consuming denials:
Caused by **complex payer requirements** + manual workflows

REVENUE LEAKAGE

Hidden, silent denials:
Payers **recouping past payments** via PLB adjustments

[1]Premier Inc [2]AHA [3]Beckers
Source: Grand View Research, 2025

CURRENT STATE OF DENIALS

What's not working

- Additional resources
- More data
- Misallocated investments

Where does your organization today invest the most resources to combat the growing denial problem?

A. Denial root cause analysis to prevent future denials

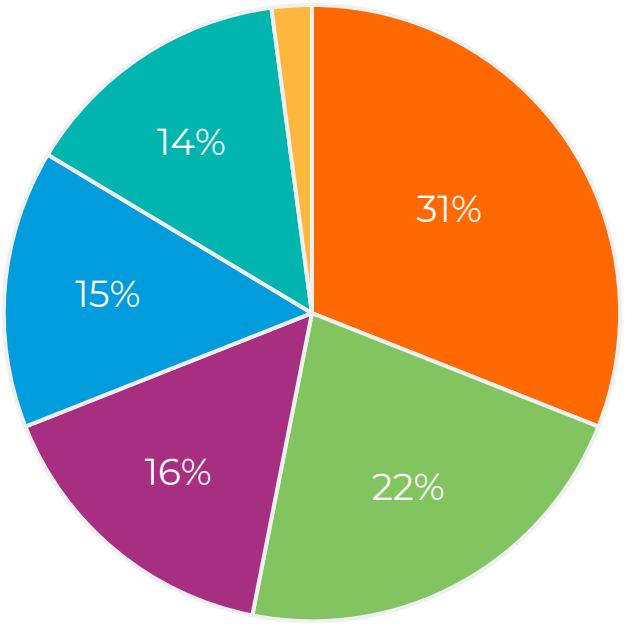
B. Denial review and appeal submission workflow

C. Denial prevention processes related to patient access workflow

D. Denial trend reporting by CARC Code and payer

E. Denial prevention education and denial risk-detection

Denial prevention tops the priority list



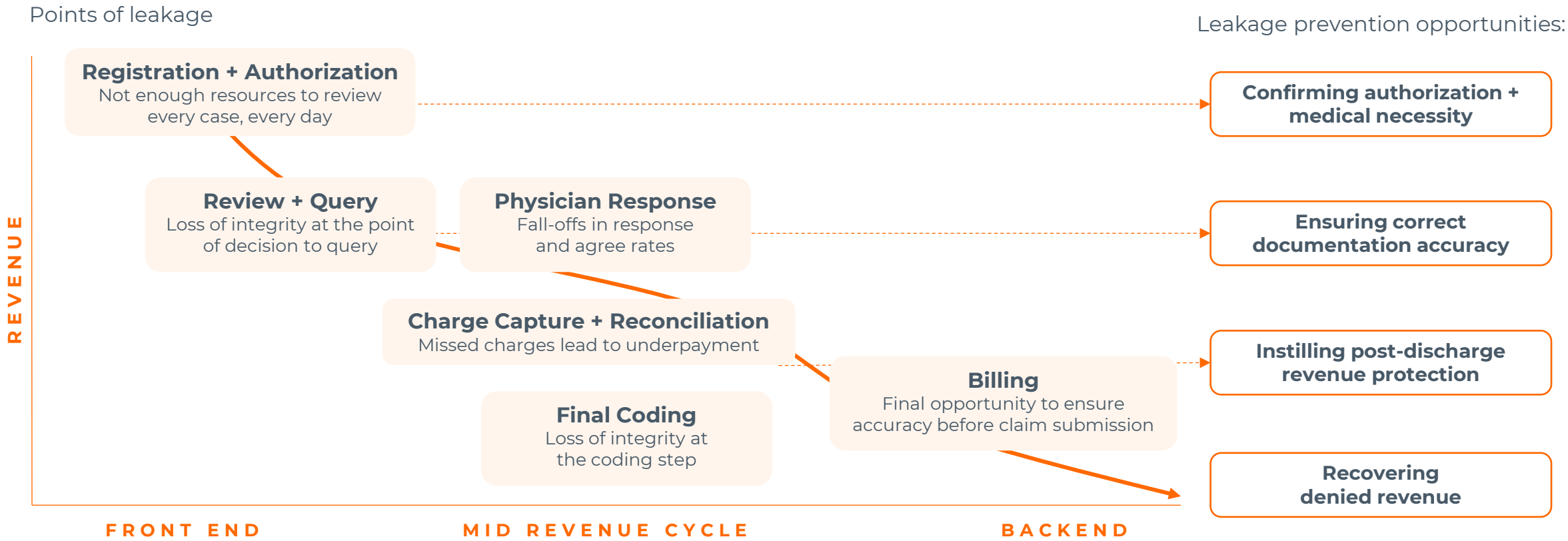
- **Denial Prevention**
- Denial root cause analysis
- Denial reduction
- Denial work and appeal submission
- Denial prioritization and work queue routing
- Other

Denial rates are up 20% with the trend expected to continue[2]

[1] *HFMA Denials Study 2023*
[2] *Journal of the American Health Information Management Association, Claim Denials: A step-by-step approach to resolution (2022)*

A problem worth solving

Revenue leakage often caused by silos in the revenue cycle



A PROBLEM WORTH SOLVING

Disconnected workflows + data silos

Financial + Clinical workflow gaps create denials

Data integration gaps create blindspots

- Accessing data is manual, costly, and inconsistent
- Complete and accurate clinical data not available at claim submission
- Data normalization and integration is not supported by current systems
- Workflow is inefficient and requires insight into payer behavior

Lack of visibility into the financial outcomes of clinical actions

Reasons for denial prevention failures

DENIAL PREVENTION

Three areas of denial management that make denial prevention a challenge

1 Data problem

+ Inability to track trends
+ No clear likelihood to pay
+ Denial reason codes that are misaligned and confusing

2 Workflow problem

+ Lack of technology-enabled workflow optimization
+ Routing to the wrong team
+ Process inefficiencies leading to rework

3 Scale problem

+ Unmanageable volume
+ Unproductive touches
+ Alert fatigue and work queue overload

WAYSTAR | SIMPLIFY HEALTHCARE PAYMENTS

Reasons denial prevention fails

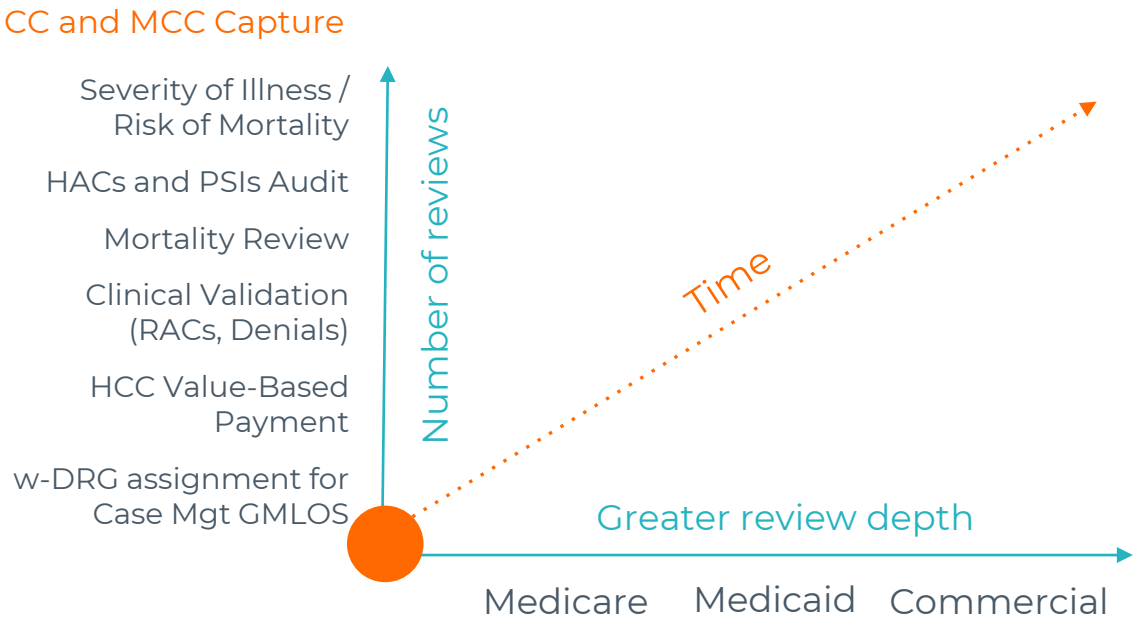
- Admission errors + coverage-related issues
- Shifting, confusing payer requirements
- Repeated documentation gaps and errors
- Staffing challenges + process inefficiencies
- Underutilization of technology + lack of shareable data insights

REASONS DENIAL PREVENTION FAILS

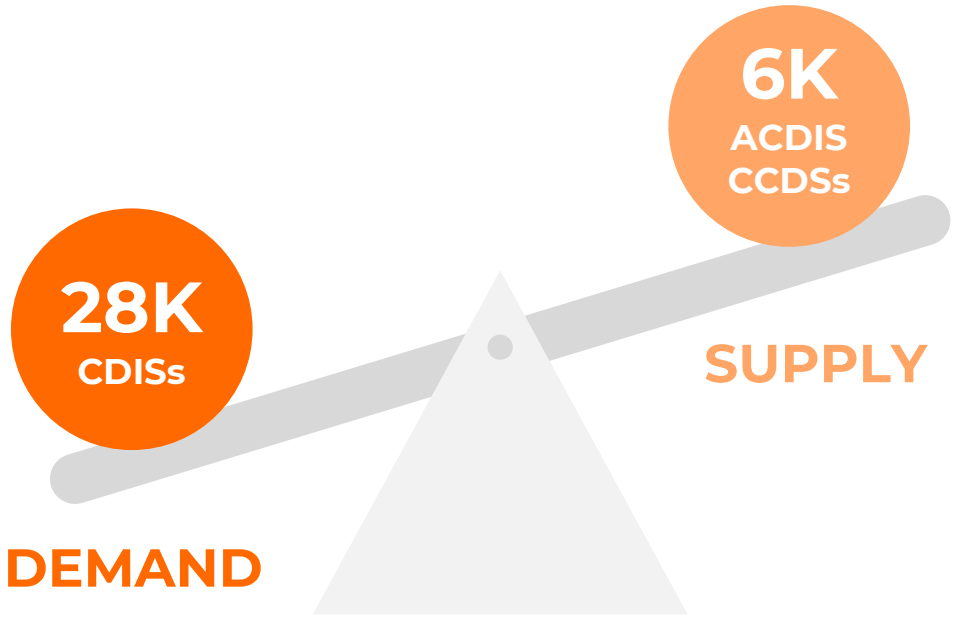
Hiring is not a sustainable long-term strategy

As payer scrutiny intensifies and documentation requirements deepen,
CDI teams are under increasing pressure

More payers and greater depth of review strain CDI capacity…



…but supply of CDI specialists can't meet demand & need



ACDIS recommended CDI staffing ratio: 1:1,250 – 1:1,500 admissions

Critical documentation errors are costly

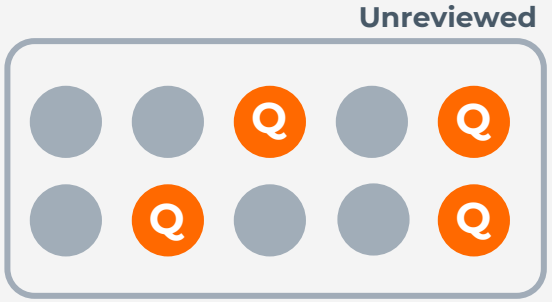
Traditional tech lacks precision, causing 70%+ of CDI time to be unproductive —leading to missed opportunities, unnecessary reviews, and lost revenue

Concurrent + retrospective reviews

Inability to discern the right cases at the right time

10 Cases reviewed
3 Queries generated
7 Unnecessary reviews

70%+ of CDIS's time is unproductive, simply 'ruling out' cases without opportunity



10 Cases Unreviewed
4 Missed Queries

Creating a denial prevention strategy

DENIAL PREVENTION STRATEGY

4 steps to denial prevention

Build + retain the right team

+ The right team, focused on the right tasks, leveraging tools to make them efficient

Get it right from the start

+ Accurate data, the first time, prevents denials before they happen
+ Continuous denial investigation across staff & technologies

Ensure every claim is clean

+ Efficient + accurate submission of claims reduces the likelihood of a denial
+ Continuous review of claim edits that reduce downstream denial risk

Respond with data-driven intelligence

+ Addressing static data + manual processes allows staff to operate at peak efficiency
+ Ensure reporting provides actionable insights and response-enable metrics

IDENTIFY OPPORTUNITIES BY LEVERAGING AI + AUTOMATION

DENIAL PREVENTION STRATEGY

Build + retain the right team

The right resources, focused on the right tasks

+ Identify your biggest gaps + prioritize recruiting efforts
+ Review onboarding, training, + employee policies to identify needed updates
+ Review processes to use AI + automation where possible
+ Find people with experience or the appetite to learn
+ Be open to new ways of working

DENIAL PREVENTION STRATEGY

Leverage AI + automation across the rev cycle

1 Patient Access

Return richer, more accurate benefit information, identify potentially missing insurance coverage, + identify authorization requirements and follow-up on requests

2 Patient Financial Care

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

3 Revenue Capture

Identify accounts with a high probability of **missing charges and DRG anomalies** to maximize revenue opportunities

4 Claim + Payer Payments

Generate custom claim rules, optimize when to status claims, retrieve updated, normalized responses, match claims to remits, post + reconcile payer and patient payments

6 Denial + Appeal Management

Identify those denials most likely to be successfully appealed to guide workflow + generate appeal letters based on specific denial scenarios

7 Analytics + Reporting

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

DENIAL PREVENTION STRATEGY

Organizations are steadily looking to AI

And gaining confidence based on real-proved results

AI is meeting or exceeding expectations across the revenue cycle

78% Financial Clearance

83% Patient Financial Care

84% Revenue Capture

83% Claim + Payer Payments

76% Denial + Appeal Management

89% Analytics + Reporting

81% Security + Accuracy

60%

MORE ACCURATE

Find AI's outputs more accurate than manual intervention

58%

GAINED TRUST THROUGH USE

Have less concern about the integrity of AI outputs after using it

Real-proven results: enable denial prevention in minutes

1 Minute to create[2]

1 Minute to test

1 Minute to deploy

+ **Stop preventable denials** within minutes
+ Reduce clicks and **improve claim correction efficiency**
+ Leverage AI to automatically generate custom rules – enhancing accuracy + speed rule creation resulting in **improved First Pass Payment rates**

1: Based on client feedback

DENIAL PREVENTION STRATEGY

Get it right from the start

The right data, the first time

+ Streamlined admissions with efficient staff support
+ Fast + complete electronic eligibility responses
+ Accurate, detailed benefit information that won't require follow up
+ Process to identify hidden coverage
+ Automate authorizations

WAYSTAR | SIMPLIFY HEALTHCARE PAYMENTS

Real-proven results: Automated authorizations

A healthcare organization's journey to **automate authorizations**

+ Largest healthcare organization in SC
+ 1,500,000 unique patients treated annually

The need: Understand and apply payer policies to every encounter by procedure level correctly. Manage volume early to not impact scheduling/patient access. Correctly source for prior authorization routing. Increase productivity as volumes and complexities increase.

The solution: Adopting software to help automate and accelerate the process of authorizations, ensuring the proper payer rules are applied to the encounter and routing along with automation to increase productivity.

The results:

>2 minutes

spent per authorization

70%

reduction in time

85%

auto-approval rate without submitting clinical documentation

DENIAL PREVENTION STRATEGY

Ensure every claim is clean

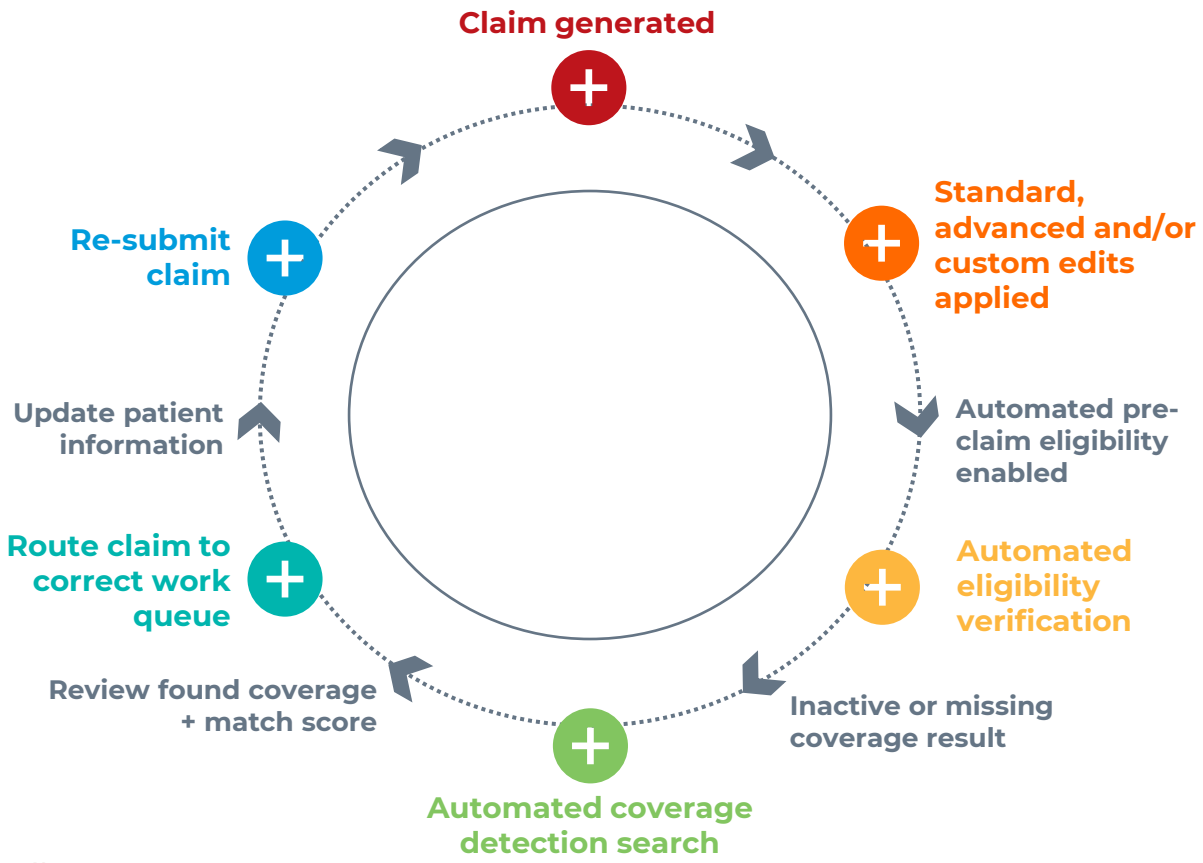
Efficient, accurate submission

- Simple, seamless enrollment process
- AI-generated custom claim rules
- Ability to identify under coded claims
- Flexible, customizable claim edits
- Electronic claim attachment submission options
- Implement a fail-safe process to identify errors after claim creation but prior to submission

DENIAL PREVENTION STRATEGY

Reduce the burden of verifying, finding and using coverage

Pre-Claim Eligibility + Coverage Detection



The Results:

- Prevent eligibility related denials
- Automatically locate updated coverage
- Improve staff efficiency + save time
- Eliminate manual coverage searches + phone calls

DENIAL PREVENTION STRATEGY

What good prevention looks like

Pre-service + point-of-service

Eligibility verification conducted at or before time of service

↓

Coverage detection triggered automatically when inactive or unknown response

↓

Proactive, automated authorization requests

The result:
Increased revenue and efficiency + reduced manual work

During the patient stay

All cases analyzed for documentation vs evidence gaps

↓

Opportune cases prioritized for review and action

↓

Gaps are closed and the record is updated

The result:
Record accuracy is improved, reducing denials and underpayment

Prior to claim submission

Proper claim edits applied prior to submission

↓

Eligibility verified + coverage found prior to claim submission

↓

Corrections are made and **clean claim** submitted to payer

The result:
Reduction in coverage-related denials

Real-proven results: taking control of RCM management

An outpatient imaging network's journey to **find a superior revenue cycle partner for all needs**

The problem: Disconnected front- and back-end processes leading to preventable denials

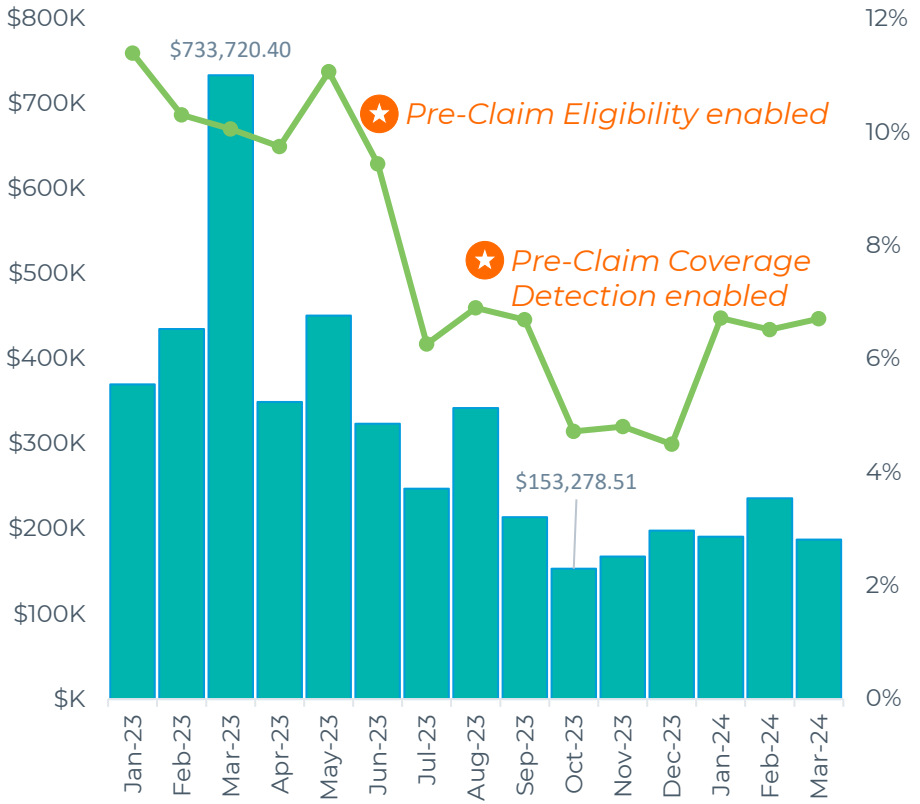
The solution: Adopting an automated solution to verify eligibility + identify updated coverage in a single platform

The results:

37%
Reduction in eligibility denial rate in Q1 YoY

60%
Reduction in total dollars denied for eligibility-related reasons in Q1 YoY

58%
Of coverage searches automated



DENIAL PREVENTION STRATEGY

Respond with data-driven intelligence

Operate at peak efficiency

+ Statusing the right claims at the right time
+ Ability to prioritize denial work based on predictive analytics
+ Automated appeal generation + submission process
+ Remove print + mail processes
+ Ability to easily update + resubmit coverage-related denials

Confirming your denial prevention strategy

DENIAL PREVENTION STRATEGY

How to pressure test your prevention strategy

- ✓ Can you confidently identify all active coverage?
- ✓ Do you know which cases to prioritize for documentation gap correction?
- ✓ Do staff know exactly when action is required?
- ✓ Are auth requirements verified before care?
- ✓ Are you tracking front-end denial drivers?

COMPEHENSIVE DENIALS PREVENTION

Key levers to prevent avoidable denials

Front-end denial prevention & coordination

Insurance eligibility verification, Prior authorization management, Registration & demographic accuracy, & Coverage validation + benefits checks

Dedicated denial management & appeals teams

Dedicated denial analysts, Appeals specialists, Revenue integrity staff, & Payer contract management professionals

Clinical documentation improvement (CDI) and coding

CDI specialists, Medical coders, Physician documentation education & Utilization review teams

Technology, analytics, & automation

Denial analytics platforms, Predictive denial models, AI-assisted prior authorization, & Automated claim scrubbing + workflow tool

Relentless commitment to review of key KPIs and trends

Dashboards, Analytics, Communications, Teamwork & Commitment from leadership + Stakeholders

IDENTIFY OPPORTUNITIES TO LEVERAGE AI + AUTOMATION

AI-POWERED DENIALS PREVENTION

Connect the data ecosystem

Must-have inputs

The power of data…

Financial, registration, clinical documentation and payer information represents the patients being served

- *Registration, labs, vitals, medications, orders, documentation (H&P, ED notes, progress notes), orders…*

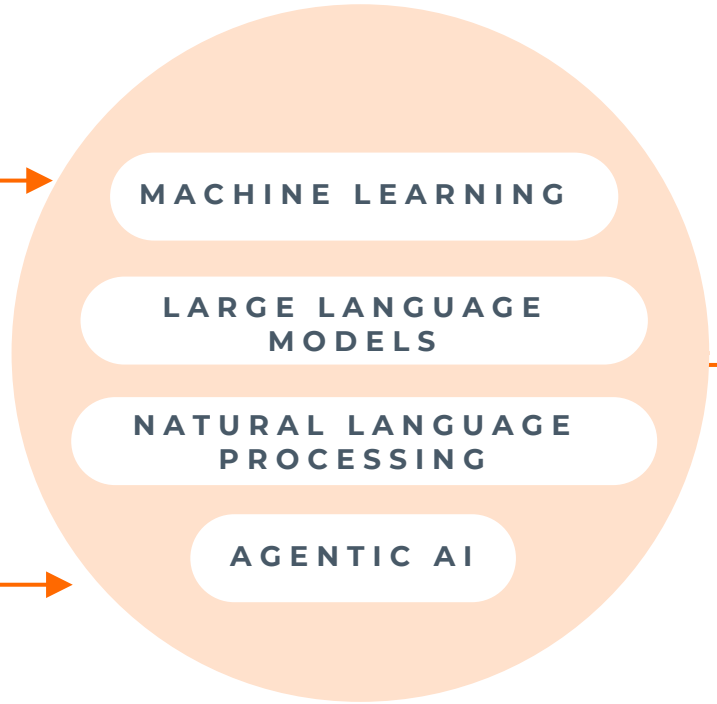
Garbage in, garbage out → poor data leads to poor outcomes → data quality and volume matters

…paired with expertise

Experienced data scientists that understand the healthcare landscape and the strengths/limitations of AI types

Iterative training → models improve over time, doesn't happen overnight

Use the right AI in the right situation



Outputs must amplify staff expertise

Data-driven predictions + insights

Predictions and recommendations to support more effective and efficient case reviews

- Examples:
  - Case prioritization
  - Patient status predictions
  - Possible conditions
  - DRG
  - GMLOS / LOS
  - Chart summaries
  - Appeal letters

Realized impact + final thoughts

DENIAL PREVENTION STRATEGY

Potential realized impacts

Delivering 15+ years of measurable denial prevention.

FRONT-END IMPACTS

23%

Reduction in PB Eligibility denials

21%

Reduction in HB Eligibility denials

46%

Reduction in auth-related denials

38%

Reduction in payer error rates

MID-REVENUE + CLAIMS

>2%

Medical Necessity denial rate achievement

40%

higher denial overturn rate with AltitudeAI™

$15.5B

Denials prevented in 2025 across platform

DENIAL PREVENTION STRATEGY

Denial prevention strategies must invest in...

- ✓ **Preventing Denials**
  - (Patient Access / Authorization teams)
- ✓ **Recovering Revenue**
  - (Denial Management & Appeals teams)
- ✓ **Eliminating Medical Necessity and Coding Denials**
  - (Clinical documentation & coding programs)

Preventing denials in healthcare

1 Know common denial points

- Watch registration data + coverage detection.
- Validate medical necessity, pre-auth, and timely filing.
- Flag duplicate claims, extra-info requests, and payer-specific coding rules.
- Expect payer rules to keep changing.

2 Reduce denials up front

- Know payer payment policies to avoid medical-necessity denials.
- Build rules into the EHR where appropriate.
- Address likely denials in real time with the patient.
- Shift care plans when a covered alternative avoids the denial.

3 Automate the denials process

- Auto-route routine denials to task management.
- Sweep multiple sources for insurance coverage.
- Use smart queues to prioritize high-value or deadline-sensitive denials.
- Populate appeal letters with patient/account details within 48 business hours.

4 Track + report denials

- Capture denial reasons from all sources, including payer letters.
- Catalog by type, frequency, value, and payer.
- Create a workgroup to report trends and root causes.
- Use insights to smooth the revenue cycle.

Key takeaways + next steps

KEY TAKEAWAYS

+ Pre-claim reviews catch issues early and protect clean claim rates
+ AI-driven automation and case prioritization scales prevention without adding staff
+ Strong prevention strategies, tools and processes result in less time and money spent chasing denials

NEXT STEPS

+ Automate eligibility verifications and prior authorizations
+ Identify and close gaps between clinical documentation and evidence
+ Ensure claims are accurate and clean before submitting

Q + A