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REVENUE CYCLE RESOURCES

Denials to Dollars: Real Strategies that Work!

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HFMA Fall Conference 2025

So Much Info, So Little Time

Who We Are

Why We Are Here

Goal:
Leave with one idea or nugget you can use tomorrow

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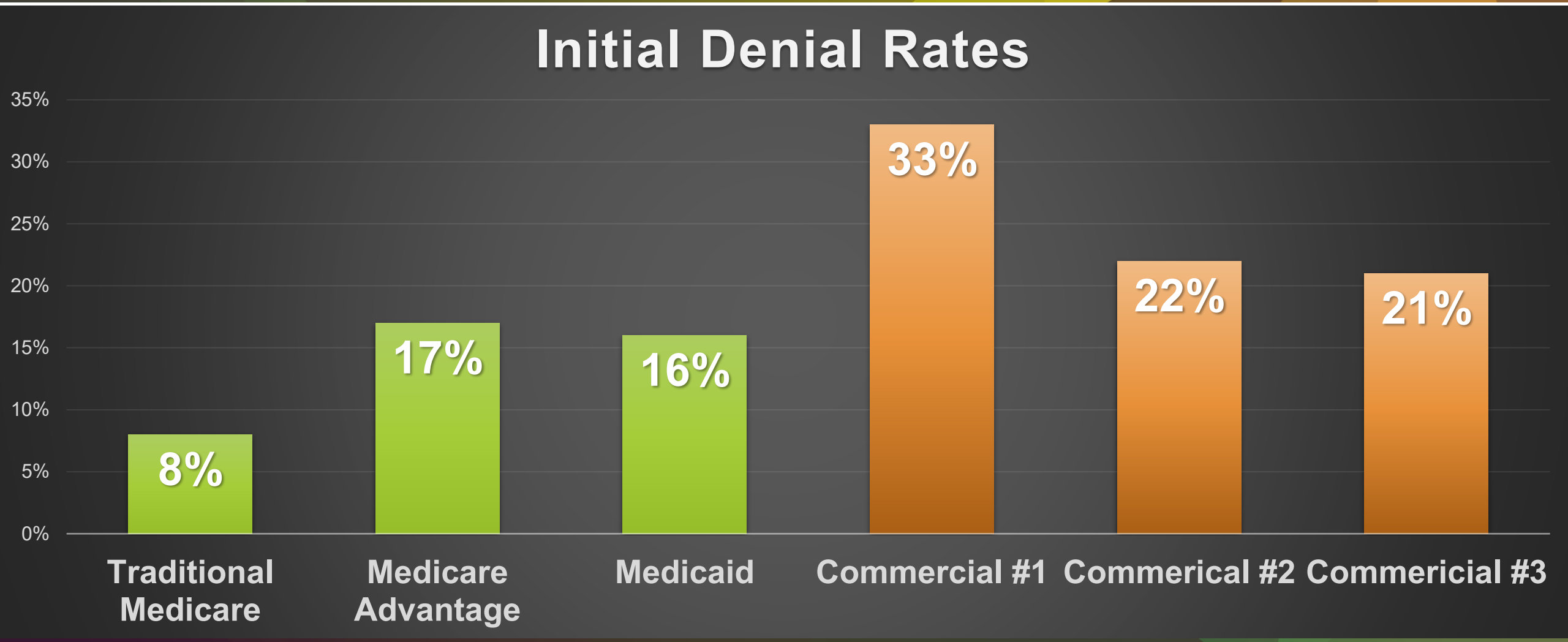
Current Denial Landscape

Not one problem- a thousand papercuts

Denial Rates- Quick Pulse Check



Source: KFF, *ACA Marketplace Claim Denials (2023 data, published Jan 2025)*

Where Are Denials Coming From?

- **In Plain Sight on EOBs** – Clearly listed denial codes and reasons
- **Hidden on EOBs** – Presented as contractual adjustments or unexplained payment reductions
- **Payor Post-Payment Reviews** – Recoupment months after services are paid
- **Payor Policy-Driven Denials** – Medical and Reimbursement payor rules that restrict coverage
- **Third Party Partnerships –** Vendors incentivized or commissioned to find denials
  - Examples: Evicore, Cotiviti, Conduent, Carelon
  - “AI-driven payment integrity solutions”
  - Boasts a 15% increase in denials

AI is Changing the Game!

84% of payors use AI or ML within the claims adjudication/review process

- UHC, Humana, and Cigna are facing class-action lawsuits alleging reliance upon algorithms to deny care
  - UHC AI, *nH Predict*, **had a 90% error rate,** with 9 of 10 appealed denials ultimately reversed
  - Cigna AI, *PXDX*, denied **300,000** claims in a 2 month period, resulting in **1.2 seconds** for each physician-reviewed claim

Source- The Guardian-New AI tool counters health insurance denials decided by automated algorithms

Political Intervention-Federal

2024 Medicare Advantage Final Rule (CMS-4201-F)

- Must align with Medicare NCDs/LCDs
- Enforcement of the Two Midnight Rule
- Determinations must be made by a physician with appropriate expertise
- Retro review of prior authorized services not allowable
- No site of service restrictions

CMS Interoperability and Prior Authorization Final Rule

- Effective: Jan 2027 (some 2026 provisions)
- Implementation of *Application Performing Interfaces* (APIs) to improve info exchange
- Streamlined prior auth
- Applies to MA, Medicaid, Marketplace

Political Intervention-State

LB 77-Ensuring Transparency in Prior Authorization Act

- **Effective Date:** January 1st, 2026 for Majority of Provisions
- **Applicability:** Fully Insured Commercial Plans/ Some Medicaid Provisions
- **Key Provisions**:
  - Prohibits use of AI as the sole basis for denials
  - Review entities cannot be paid based on volume of denials
  - Denials must be made by a physician in the same specialty
  - Denials must cite clinical criteria
  - Peer-to-peer review must occur within 3 business days
  - Response Timeframes: Urgent : 72 hours, Non-urgent: 7 days
  - Standardized PA Form: Providers to utilize January 1st 2026

Strategies

Our Strategy:
Act Fast, Act Smart

1. **Identify:** Pinpoint Denial Trends Early with Data and reporting

2. **Resolve:** Act quickly and effectively

3. **Prevent:** Address root causes

Identify

Identify: Denial Type

Remit-Coded Denials

Denial Coded on EOB

- Routes Appropriately for Review
  - Prior Authorization
  - Frequency/MUE
  - Medically Necessity/Experimental
  - NDC/UOM
  - Coordination of Benefits

Silent Denials

Contractual on EOB

- Adjustment in Full or Underpayment
  - Misapplication of NCCI Edits, MPPR, or Claim Payor Edits
  - Downcoding
  - Incorrect Contract Load
  - Inappropriate Bundling

Identify: Pinpoint Trends

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Initial Denials

- **Real Time or Monthly Reports**
  - High Level Trend Identification
- **Biller Identification**
  - Verify With Reporting

Final Denials

- **Detailed Adjustment Categories**
- **Monthly Reporting Review**
  - In Depth Root Cause Analysis

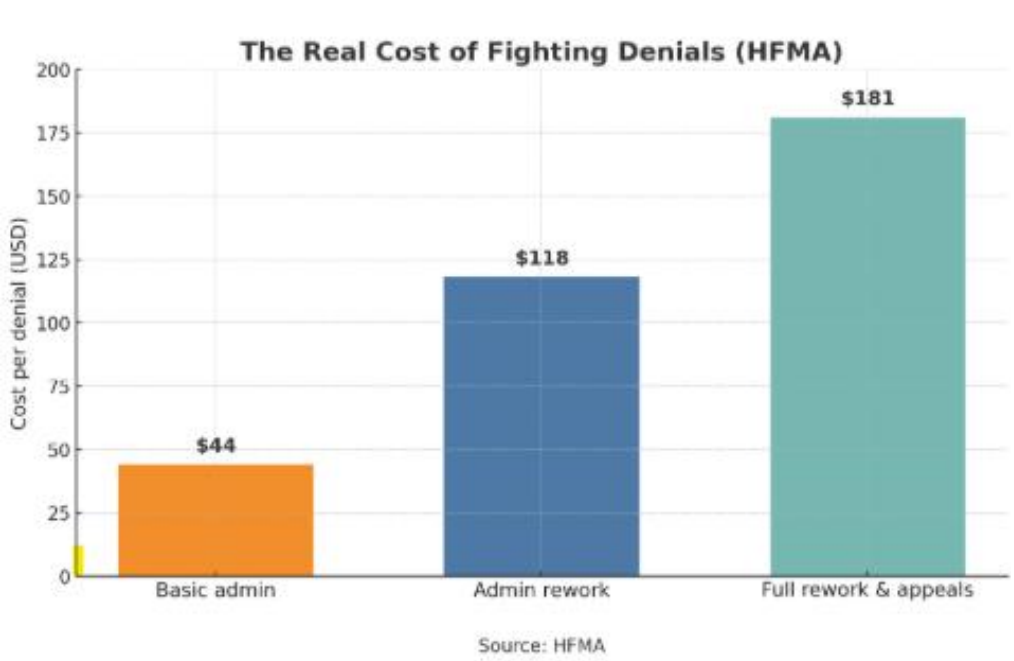
Resolve

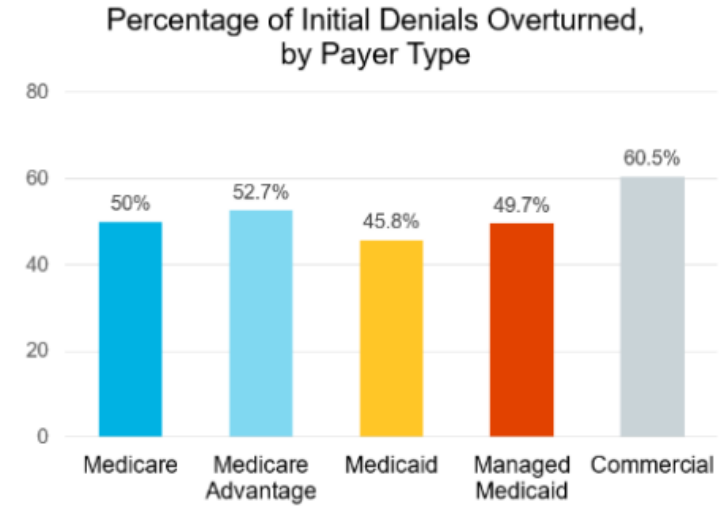
Resolve-Considerations

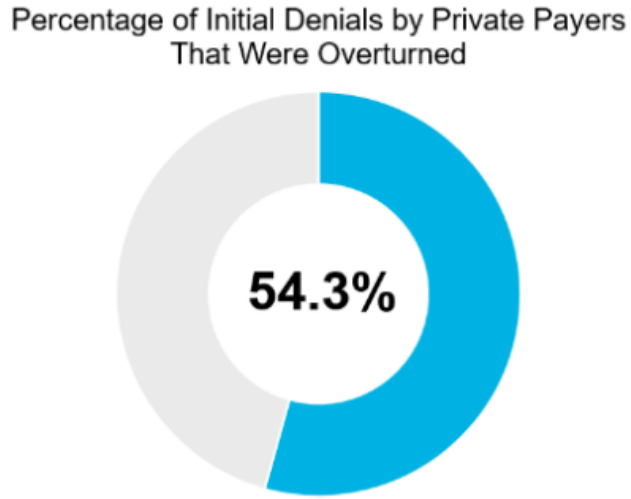
Is it Appealable?	• Verify against your contractual terms and payor policy
Frequency:	• Ask if this denial is a one-off or part of a trend
Documentation:	• Appeals are worthwhile when records strongly support the case
Cost vs. Value:	• Fighting denials requires staff time, resources, and effort
Threshold:	• Create a sensible threshold for when to pursue denials

Resolve-Decide Where to Spend Effort

Balance Recovery Value vs. Cost of Appeal







Source: Premier National Survey on Payment Delays and Denials, October-December 31, 2023

Prevent

Prevention: Food for Thought
A Mindset Shift

Let's Stop Normalizing Denials

- When did denials become "normal" work?
- Small task forces: not bigger chase teams
- Fix the cause in the workflow, not just the claim

Scale Up Offense

- Defense is reactive; offense designs out flaws

Treat Every Denial as a Process Defect

- Ask "What could we have done better"
- Changes: embrace simple- don't fear bold

Denial KPIs

HFMA Denial Map Keys

- Remittance (Initial) Denial Rate
- Denial W/O as Percentage of Net Revenue

Other Recommended KPIs

- Overturn/Appeal Success Percentage
- Top 5 Denial Reasons
- Open Denials AR Days

KPI Detail

Initial Denial Rate	• Number of Denials/Number of Claims
Denial W/O as % of Net Revenue	• Net dollars written off as denials/Average monthly net patient revenue
Overturn/Appeal Success Percentage	• Initial denials overturned and paid/total initial denials (dollars)
Top 5 Denial Reasons	• By volume: claims with reason X ÷ total initial denials • By dollars: gross charges of reason X ÷ total initial-denial dollars
Open Denial AR Days	• Open denial balance/ADR

Tactical Tips!

Building Your Denial Review Loop

- **Name an Owner –** One accountable person and a small cross-team group
- **Define Reporting –** What feeds we use (EOB denials + hidden reductions)
- **Build Infrastructure –** Analytics, policy library, dashboards, templates, and smart tools (AI)
- **Set Cadence for Review** – Standing meeting to review and plan
- **Review Denial Data Trends –** Top issues by dollars and payer; discuss new denial trends
- **Set Goals –** Pick 1–2 targets for the next XX days
- **Take Action –** Assign owners, a plan of action
- **Check Results –** Was progress made?
- **Keep Going –** Lock in what worked, pick the next 1-2 targets, repeat

Pre & Post Payment Reviews

Expect More Reviews

- AI is making it easy!

Proactive ROI Processes and Education

- Prevent Initial Denial- Analyze Records Prior to Sending
- Clear Checklist
  - Coder/Clinical Review on High-Dollar Claims
  - Medication Administration Record
    - Often separate infusion billing record
  - Outside Records

Medical Policy Increase

Good News- LESS Prior Authorizations Required

Bad News- MORE Medical Policies

One Stop- Financial Clearance Team

- Eligibility & Benefits
- Medical Necessity Clearance (Prior Auth, Med Policy Review, etc)
- Propensity to Pay
- Pre-Payment
- Good Faith Estimate
- Scheduling Once Cleared

Payor Contracts Utilization Targeted Tool- Big Impact

Visibility Matters

- Teams needs contract access
- Keep a simple matrix with key contract terms

Use it When it Fits

- Check the Matrix, confirm in the contract
- Cite the exact clause and ask for a specific remedy

Bring in You Contracting Rep

- Involve them early to interpret terms or escalate
- Framing as a potential contract violation gets traction

Fight smart

- Know when NOT to appeal if the denial align with your contract terms

Downcoding

ER Facility/Professional & Office Visit Downcoding

- Level 4 & 5 Reduced to a Level 2 or 3
- Majority are Silent Denials
- Prevention:
  - **Facility ER Levels**
    - Revise ER Matrix-Separately Bill Procedures
    - Often Incorrect Payment for Lower Level- Appeal!
  - **Professional ER Level & Office Visits**
    - Appeal Utilizing Professional Coding Guidelines
    - Often Won!
  - **Frequent Monitoring**
    - Required to appeal timely

Effective Appeals

- **Utilize AI as a Starting Point**
  - Start with the Payor Policy
- **Input From an Expert in that Area**
  - Expert Utilizes AI Template
- **Always Address Payor Medical and/or Reimbursement Policies**
- **Points to Specific Points in Record**
- **Expected TAT and Consequences**

Silent Denials

Underpayment Hiding as Contractual

- Reimbursement Validation:
  - Contract variance module, analytics tools, reimbursement audits
- EHR 835 Crosswalk Optimization
  - CARC/RARC Code Classification
- Act Promptly
  - Most payors limit underpayment reviews to 12 months
- Ongoing Audits are Essential!

Escalation Avenues

Escalation Avenues:

- Medicare Advantage: Review by Part C Independent Review Entity (IRE) (Non-Contracted)
- Medicare Advantage: CMS Regional Office- CMS ROkcmORA ROkcmORA@cms.hhs.gov
- Medicaid: Department of Health and Human Services
- Fully Insured Plans: Nebraska Department of Insurance
- Policies Purchased in Another State: Map to States & Jurisdictions
- Federal Employee Health Benefits Program: Healthcare & Insurance, Office of Personnel Management
- Workers' Compensation: Nebraska Workers' Compensation Court
- Self-funded Benefit Plans: Employee Benefits Security Administration, US Department of Labor
- Tricare: Tricare File a Complaint

Contact Information

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Questions?