99TH NHA ANNUAL Convention

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Delays, Denials & Appeals: Nebraska Revenue Cycle Update

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NEBRASKA REVENUE CYCLE UPDATE

Delays, Denials & Appeals

Reducing avoidable revenue loss in Hospitals

PRESENTED BY

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Delays



Denials



Appeals

LEARNING OBJECTIVES

By the end of this session, you will be able to...

1

Identify

common causes of claim delays and denials affecting Nebraska hospitals, and distinguish preventable denials from issues requiring payer intervention.

2

Analyze

denial trends by root cause, payer, service area, and revenue cycle function to prioritize opportunities for improvement.

3

Apply

practical strategies to strengthen front-end, clinical, coding, and billing processes that reduce avoidable claim delays and denials.

AGENDA

Our roadmap for the next 45 minutes

1. **The 2026 landscape**
   National trends, Nebraska changes, and why rural feels it more
2. **Where revenue leaks**
   Delays vs. denials; preventable vs. payer-driven
3. **Reading your denial data**
   Four lenses, key metrics, and prioritization
4. **Prevention across the cycle**
   Front-end, clinical, coding, billing, accountability
5. **Appeals & payer communication**
   What to appeal, how to win, when to escalate



Our goal today

Move denials from a back-office billing problem to an organization-wide performance measure—owned, tracked, and improved like quality or safety.

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PART 1

The 2026 Landscape

Denials are rising, payer rules are changing, and hospitals have the least margin for error.

NATIONAL PICTURE

Denials remain high and are costing more to recover

11.6%

median initial denial rate for hospitals in 2025, up from 11.4% in 2024

Kodiak Solutions (Mar. 2026)

2.7%

median final denial rate in 2025 and revenue ultimately written off

Kodiak Solutions (Mar. 2026)

41%

of providers say at least 1 in 10 claims is denied (30% in 2022)

Experian Health, State of Claims 2025

$18B

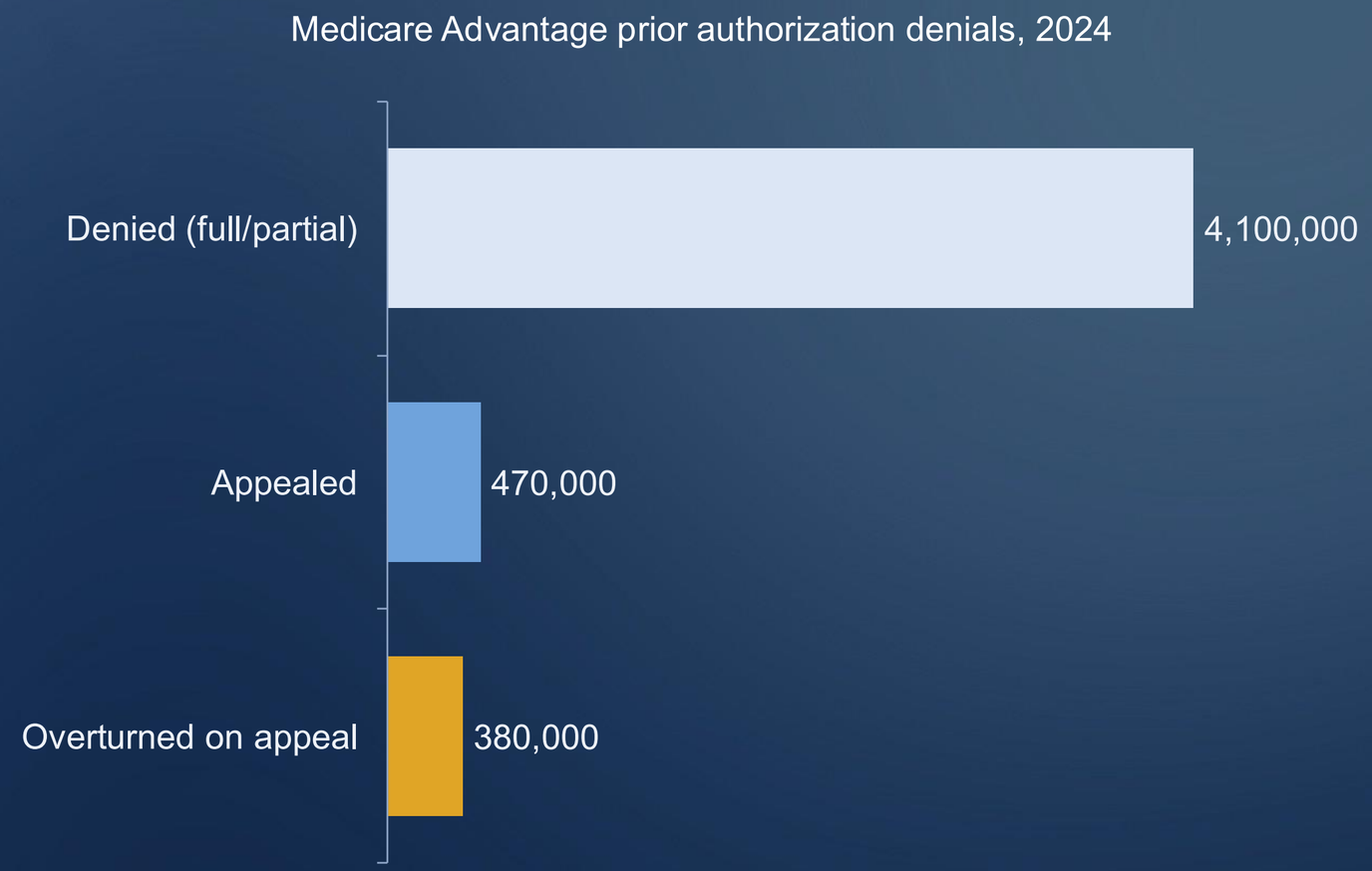
hospitals spent in 2025 just working to overturn denials

AHA, Costs of Caring (2026)

2026 UPDATE

Kodiak's mid-year data: initial denials fell to 10.63% in H1 2026 (from 12.00% in H1 2025) but final denials rose 9.1% and commercial takebacks rose 12%. Payers are denying less up front and clawing back more later.

Most denials are never challenged and most challenges win



7.7% of 53M MA prior auth requests fully or partially denied

11.5% of those denials were appealed

80.7% of appealed denials were fully or partially overturned

Source: KFF analysis of CMS data (Jan. 2026); KFF analysis of 2025 insurer-posted prior authorization metrics (Aug. 2026).

WHY IT HITS HARDER HERE

Rural hospitals absorb denials with the least margin for error

Critical Access Hospitals

- Traditional Medicare pays on cost, but Medicare Advantage, Medicaid MCOs, and commercial plans typically pay on contract terms—so denials hit harder as payer mix shifts
- High-scrutiny services are rural staples: swing bed, observation vs. inpatient, therapy, behavioral health
- Low days cash on hand turns payment delays into operating risk

Rural Emergency Hospitals

- Outpatient-only billing (TOB 013x/014x, no inpatient claims) under a new provider type adds configuration and edit risk
- The monthly facility payment is not claim-based but nearly every other dollar is
- Transfers and referrals out create authorization and coordination handoffs

PPS Hospitals

- Paid prospectively by DRG/APC with no cost-report settlement. Each denial is a direct, unrecovered loss
- Inpatient status (Two-Midnight Rule), DRG downgrades, and clinical validation drive high-dollar denials
- Higher claim volume and payer mix mean small edit gaps scale into large revenue leaks

SHARED REALITY

- One or two people often own the entire back end and vacation or turnover stalls cash
- Limited leverage with national payers
- Vendor/EHR edits not tuned to local payer behavior

IF YOU OUTSOURCE

- **Scope:** which functions the vendor owns: coding, billing, A/R, denials, appeals
- **Reconciliation:** monthly tie-out of claims sent, worked, and paid
- **Performance:** contract KPIs: denial rate, A/R days, appeal turnaround

You can outsource the work, but not the responsibility. Your hospital still must hold vendors accountable for results.

New prior authorization rules at the federal and state level

Federal: CMS Interoperability & Prior Authorization Rule (CMS-0057-F)

Medicare Advantage, Medicaid & CHIP (FFS and managed care), and ACA Marketplace plans

- Since Jan. 2026: decisions within 72 hours (expedited) and 7 calendar days (standard)
- Specific reason required for every denial
- Payers must publicly post prior auth metrics to include approval, denial, and appeal rates
- Payers must offer electronic authorization API's by January 2027

Nebraska: Ensuring Transparency in Prior Authorization Act (LB 77)

Approved June 2025; most provisions operative Jan. 1, 2026. Applies to state-regulated plans—not self-funded ERISA plans or Medicare.

- Prior auth requirements and clinical criteria must be published
- Advance notice before new prior auth requirements take effect
- Physician review of adverse determinations; AI cannot be the sole basis for a denial
- Limits on retroactively denying services performed under an approved authorization
- Enforced by the Nebraska Department of Insurance

Eligibility is becoming a moving target

MAY 1, 2026

Nebraska became the first state to implement Medicaid work requirements for expansion adults—eight months ahead of the federal deadline.

Expansion adults move to eligibility renewals every six months instead of every 12, phased in through mid-2027.

What this means at registration

- Coverage verified last month may not be valid today—eligibility denials are the most likely early impact
- Three Heritage Health MCOs—Nebraska Total Care, UnitedHealthcare Community Plan, and Molina—mean three sets of auth and billing rules
- Patients losing coverage shift balances to self-pay; financial counseling and re-enrollment help protect both patient and hospital

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PART 2

Where Your Revenue Leaks

Delays and denials are different problems—and not every denial is yours to fix.

Cash can stall at every step of the claim lifecycle

Scheduling & Registration	Authorization	Documentation	Coding & Charge Review	Billing	Payer Adjudication
Missing or wrong insurance; unverified eligibility	Auth pending or not obtained	Unsigned orders; incomplete notes, Downcoding	Coding backlog; missed charges (DNFB), Downcoding	Claim edits and holds not worked	Pended for records or info requests

Delay: the claim is held before billing or pended by the payer. Cash is late, not lost—yet. Timely filing turns delays into denials.

Denial: the payer refuses payment. Soft denials can be corrected and resubmitted; hard denials require an appeal or are written off.

OBJECTIVE 1

Common causes of delays and denials we see in Nebraska

Eligibility & registration

Terminated coverage, wrong payer or plan, MA patients registered as traditional Medicare, COB not updated

Authorization & referral

No auth, expired auth, wrong CPT/site on auth, inpatient auth not converted from observation

Medical necessity & level of care

Inpatient downgraded to observation, swing bed and therapy necessity, behavioral health treatment plans

Coding & billing edits

ER level downcoding, critical care in emergency room, trauma activation criteria not being met

Missing information & timely filing

Records requests not answered, incomplete claim data, claims aging past filing limits

Payer-side issues

Contract/fee schedule loading errors, policy changes applied inconsistently, credentialing gaps

OBJECTIVE 1

Preventable denials vs. issues requiring payer intervention

Within our control: fix the process

- Eligibility not verified or re-verified
- Authorization not obtained or not updated
- Documentation doesn't support the service or level of care
- Coding, modifier, and chargemaster errors
- Missing claim data; timely filing missed
- Records requests not answered on time
- Enforcing vendor accountability

Payer-driven: escalate the pattern

- Contract rates or fee schedules loaded incorrectly
- Payer system or configuration errors
- Criteria applied that conflict with contract, CMS rules, or LB 77
- MA plans not following Medicare coverage criteria (e.g., two-midnight rule)
- Credentialing/enrollment processing delays
- Repeated "lost" records or unexplained denials

Industry studies have long found most initial denials are potentially avoidable—start with what you control, but don't absorb what you don't.

A SIMPLE TRIAGE

Four questions to route every denial to the right owner

1	Did we have accurate coverage and authorization at the time of service?	→	No → Patient Access / Scheduling
2	Did the documentation support the service and level of care?	→	No → Providers, Nursing, UM / CDI
3	Did the code, charge, and claim meet payer edits?	→	No → Coding / HIM / Charge Master / Billing
4	Did the payer apply the contract and rules correctly?	→	No → Payer escalation (Managed Care / Finance)

If the answer to all four is "yes," the denial is appealable—appeal it.

WHEN THE PAYER IS THE PROBLEM

Escalate patterns, not individual claims

Bring data, not anecdotes: claim numbers, dates of service, dollars, denial codes, and the outcome you expected.

1

Provider representative

Send a claim-level issue log with dollars, dates, and examples

2

Claims project / reprocessing

Request a bulk reprocess once root cause is confirmed

3

Joint operating meeting

Escalate to contract leadership; ask for the policy in writing

4

Create a peer forum

Convene peer revenue cycle leaders to benchmark payer trends, share proven solutions, and advance issues with one collective voice

5

Regulators

NE Dept. of Insurance (state-regulated plans), NE DHHS (Heritage Health MCOs), CMS (Medicare Advantage)

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PART 3

Reading Your Denial Data

You can't prioritize what you can't see. Four lenses turn a pile of denials into a plan.

OBJECTIVE 2

Look at denials through four lenses—at the same time

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Root cause

Why was it denied? Group CARC/RARC codes into categories you can act on.

Which three root causes drive 60–80% of denied dollars?



Payer

Who is denying? Compare denial rates and overturn rates across payers.

Is one payer denying at twice the rate of the others?



Service area

Where is it happening? ED, swing bed, therapy, imaging, behavioral health, clinics.

Which service lines carry the most denied dollars?



Revenue cycle function

Who owns the fix? Access, UM/clinical, coding/HIM, billing, payer.

Which department caused it—and does it know?

Translate payer codes into root causes and owners

Example CARC	What the payer is saying	Likely root cause	Owner
27	Expenses incurred after coverage terminated	Eligibility not verified	Patient Access
197	Precertification / authorization absent	Auth not obtained or not updated	Scheduling / UM
50	Not deemed a medical necessity by the payer	Documentation or level of care	Providers / UM / CDI
16	Claim lacks information needed for adjudication	Incomplete claim data	Billing
97	Payment included in another service (bundled)	Coding or modifier error	Coding / HIM
29	Time limit for filing has expired	Delay not worked in time	Billing / A/R follow-up
18	Exact duplicate claim/service	Resubmission vs. corrected claim	Billing

Tip: codes are a starting point, not the answer. Many payers use generic codes (like CO-16 or CO-50) for very different problems—read the remark codes and denial text, and validate your categories against a sample of actual claims.

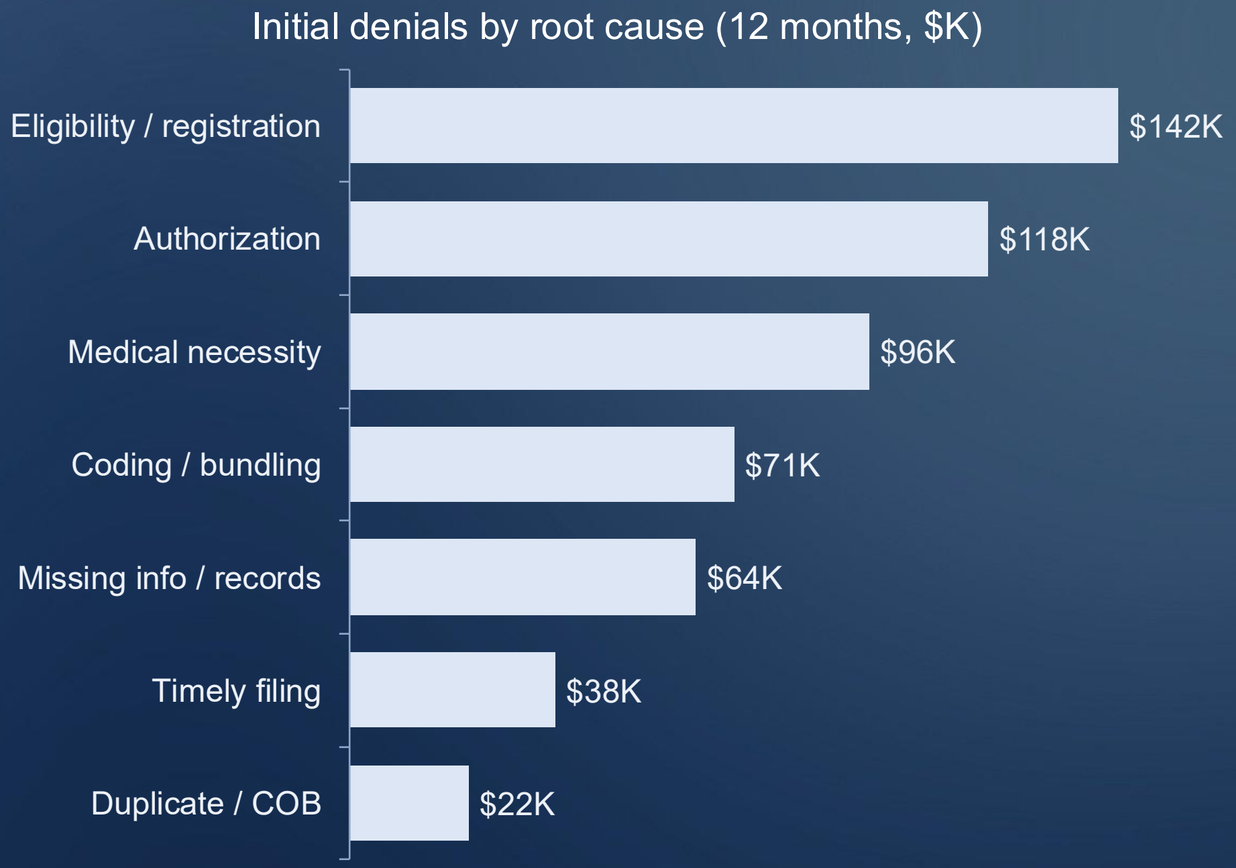
WHY CARC & RARC CODES MATTER

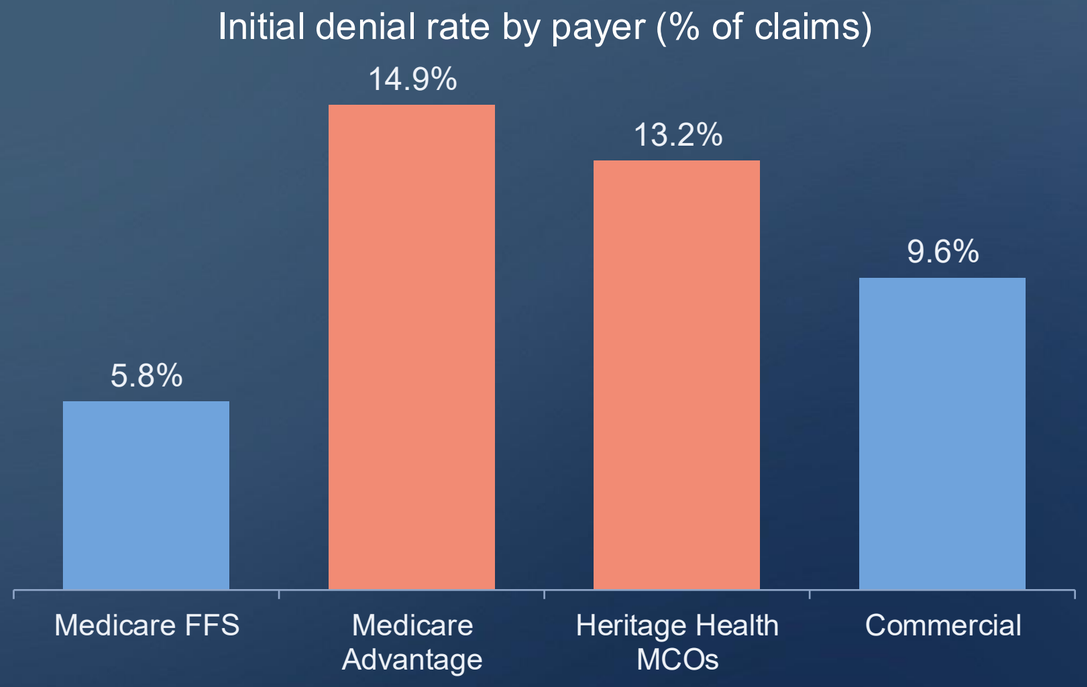
- **CARCs tell you why** the claim paid differently than billed; RARCs add the detail on what to fix
- **Group codes (CO, PR, OA)** show who owns the balance—a write-off or the patient
- **One standard language** on every 835 remit lets you compare payers side by side
- **Captured consistently,** codes turn one-off denials into trends you can fix, report, and escalate

WHAT GOOD REPORTING LOOKS LIKE

An example denial dashboard

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Reading it: the top three root causes drive nearly two-thirds of denied dollars. Start there—with the payers denying most.

Illustrative data for a hypothetical 25-bed CAH—not actual Nebraska hospital results.

EXECUTIVE SCORECARD

Six metrics leaders should see monthly

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Initial denial rate

Denied claims (or $) ÷ submitted

Trend down; compare to ~11.6% national median

Final denial write-off

Denial write-offs ÷ net patient revenue

The revenue actually lost

Clean claim rate

Claims passing edits with no touch

Many target 90–95%+

DNFB days

Discharged-not-final-billed $ ÷ average daily revenue

Measures pre-bill delay

A/R > 90 days

% of A/R older than 90 days, by payer

Where delays become write-offs

Appeal overturn rate

Appeals won ÷ appeals decided, by payer

Low volume + high win rate = under-appealing

Use consistent definitions (e.g., HFMA MAP Keys) so trends are meaningful and comparable.

PRIORITIZE

Rank opportunities by dollars at stake and ease of fixing

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	EASIER TO FIX	HARDER TO FIX
HIGH $	**Quick wins** Real-time eligibility on every visit; MA plan identification; auth checklist for top scheduled services	**Strategic projects** Physician advisor/UM for level of care; CDI for high-denial services; EHR denial reporting build
LOW $	**Easy fixes** Scrubber edit tweaks; duplicate-claim controls; payer-specific billing tips	**Reconsider** Low-dollar, low-frequency issues that need major system change

A simple scoring rule

Annual denied $
× how often it repeats
× how fixable it is

Pick no more than three priorities per quarter. Assign each an owner, a baseline, and a target.

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PART 4

Prevention Across the Cycle

The cheapest denial to work is the one that never happens.

OBJECTIVE 3 · FRONT END

Get it right before the patient is seen

Verify every encounter, every time

Real-time eligibility (270/271) for each visit—including recurring outpatient series. With six-month Medicaid renewals, last month's check isn't enough.

Catch Medicare Advantage at the door

Check eligibility even when a patient presents a traditional Medicare card; confirm plan, network status, and auth requirements.

Financially clear scheduled services

Auth obtained and matched to CPT, site, and dates 3–5 days before service; payer-specific auth lists maintained centrally.

Close the loop on status changes

Observation-to-inpatient, added procedures, and extended stays trigger an auth update the same day.

MEASURE IT

- Registration accuracy rate (QA sample)
- % of scheduled services cleared 3+ days ahead
- Eligibility and auth denials as % of total
- Point-of-service collections

Documentation is the evidence the payer reviews

Level of care

- Apply admission criteria at the time of the order, not after discharge
- Know the rules: MA plans must follow Medicare coverage criteria, including the two-midnight rule
- Use a physician advisor (internal or contracted) for status questions and peer-to-peers

Standalone documentation

- Orders signed, dated, and consistent with services billed
- Swing bed: skilled need documented daily
- Behavioral health: treatment plans, time, and medical necessity for each service

Clinical ownership

- Share denial data with providers—by service, not by name at first
- Queries answered promptly and tracked
- Clinical leaders sit on the denial committee

Clean codes and a current chargemaster prevent silent losses

Chargemaster hygiene

Annual CDM review with quarterly HCPCS/CPT updates; payer and facility-type rules built in.

Edit compliance

NCCI bundling and MUE edits loaded and current; modifier education (25, 59/X{EPSU}); REH-specific billing set up per MAC guidance.

Charge reconciliation

Daily reconciliation by department so missed charges are caught before billing—not by an audit a year later.

Coding turnaround

Set a DNFB target; monitor coding backlog weekly; use outsourced coding support to cover gaps.

Remember: under-coding and missed charges don't show up as denials. They're revenue that never gets billed.

Work the right claims first—never miss a zero-pay

1	**Tune the scrubber**	Add payer-specific edits based on your own denial history, not just vendor defaults
2	**Post every denial**	Capture CARC/RARC on every zero-pay and partial-pay line from the 835 so denials are visible
3	**Prioritize work queues**	By dollars, timely filing deadline, and appeal deadline—not oldest first
4	**Answer records requests fast**	Track payer requests for information (ADRs/RFIs) with owners and due dates
5	**Create a payer matrix**	Create and maintain timely filing rules, corrected-claim rules, appeal limits, and portal contacts for every payer



Common blind spot

If denials aren't posted from the remittance, your denial report undercounts the problem—and adjustments may be attributed to contractual allowance instead of denial write-off.

ACCOUNTABILITY

A denial prevention committee closes the loop



Who's at the table

- Executive sponsor (CFO or CEO)
- Patient access & scheduling
- UM / nursing and a provider champion
- HIM / coding and chargemaster owner
- Business office / billing
- Managed care or contracting lead

Rule of the room: every denial category has a named owner, a baseline, a target, and a date. The business office reports—it doesn't own everything.

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PART 5

Appeals & Payer Communication

When you do it right, you should get paid. Appeal like you expect to win.

Appeal the wrong denials. Fix the process for the rest.

Appeal

- We met coverage, auth, documentation, and coding requirements
- The payer misapplied the contract, CMS rules, or LB 77
- Clinical criteria were met and documentation shows it

Correct & resubmit

- Soft denials: missing data, wrong ID, modifier, or code
- Use the payer's corrected-claim process not a new claim (avoids duplicate denials)

Write off & fix upstream

- Our error, and the payer's rules don't allow recovery
- Record the reason and route it to the owner so it doesn't repeat

Don't set a dollar floor too high. With most appealed Medicare Advantage prior auth denials overturned, small-dollar denials that repeat are worth appealing and templated appeals keep the cost low.

Make it easy for the reviewer to say yes

1

Right level, right deadline

Identify the payer's appeal level and deadline the day the denial posts.

2

Name the denial precisely

Quote the denial reason and code; state exactly what you're asking the payer to do.

3

Cite the rule

Contract language, payer policy, CMS regulation, NCD/LCD, or Nebraska statute—specific sections.

4

Tell the clinical story

A short narrative tying the patient's condition to the criteria, in plain language.

5

Point to the evidence

Attach the relevant records and reference page numbers. Do not send 400 unmarked pages.

6

Track to resolution

Log the submission, follow up before the payer's deadline, and escalate if missed.

Build templates for your top 10 denial types. Consistency wins appeals and cuts cost per appeal.

KNOW THE PATHWAY

Appeal routes differ by payer type

Payer type	Where appeals go	Key points
Traditional Medicare	MAC redetermination → QIC reconsideration → ALJ → Medicare Appeals Council → federal court	Redetermination within 120 days; reconsideration within 180 days. Watch for RAC/TPE audits.
Medicare Advantage	Contracted: dispute process in your contract. Non-contracted: plan reconsideration (65 days), then independent review	MA must follow Medicare coverage criteria (CMS-4201-F). Know your contract's timelines.
Heritage Health MCOs	MCO provider appeal process, then state review options through Nebraska DHHS	Each MCO has its own provider manual and deadlines. Make sure to verify annually.
Commercial / BCBS	Payer internal appeal per contract and provider manual	Fully insured plans: LB 77 and Dept. of Insurance. Self-funded plans follow federal ERISA rules.

Deadlines and processes change—confirm current requirements in your contracts, payer manuals, and CMS/DHHS guidance.

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Treat payers as a managed relationship, not a phone queue

Document every contact	Call reference numbers, names, dates, and what was promised—in the account, not on a sticky note.
Get it in writing	Ask for the policy or criteria behind a denial pattern; LB 77 and CMS rules require publication and specific denial reasons.
Meet regularly	Quarterly joint operating meetings with top payers, with a shared issue log and agreed resolution dates.
Use their own data	Compare payer-posted prior authorization metrics to your experience; bring the gap to the table.
Negotiate prevention	At renewal, seek clearer auth lists, reasonable timely-filing and appeal windows, and payment for denied-then-overturned delays.

PUTTING IT TO WORK

A 30-60-90 day plan for your hospital

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30 DAYS

See the problem

- Confirm denials post from every remittance
- Pull 12 months of denials by root cause, payer, service, and function
- Stand up a monthly denial committee with an executive sponsor

60 DAYS

Pick your targets

- Choose three priorities using the dollars × effort matrix
- Assign owners, baselines, and targets
- Launch front-end quick wins: eligibility every visit, MA identification

90 DAYS

Close the loop

- Build appeal templates for top denial types
- Open payer escalations with issue logs
- Report the six-metric scorecard to leadership and the board

Five questions to ask your revenue cycle team

- What are our top three denial root causes in dollars and who owns each one?
- How much did we write off to denials last year, and how much of it was preventable?
- What percentage of denials do we appeal, and what's our overturn rate by payer?
- Which payer issues should we be escalating right now?
- What is working in our appeal process?

Interested in a Peer Group in 2027?

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Questions & discussion

Prevent what you can. Escalate what you can't. Appeal what's wrong.

PRESENTED BY

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Nebraska Hospital Association

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