



UNDERSTANDING DENIAL TRENDS

Turning Data Into Dollars (With Half the Staff)



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About Your Presenter



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Today's Agenda

Today's Conversation

Denial Trends

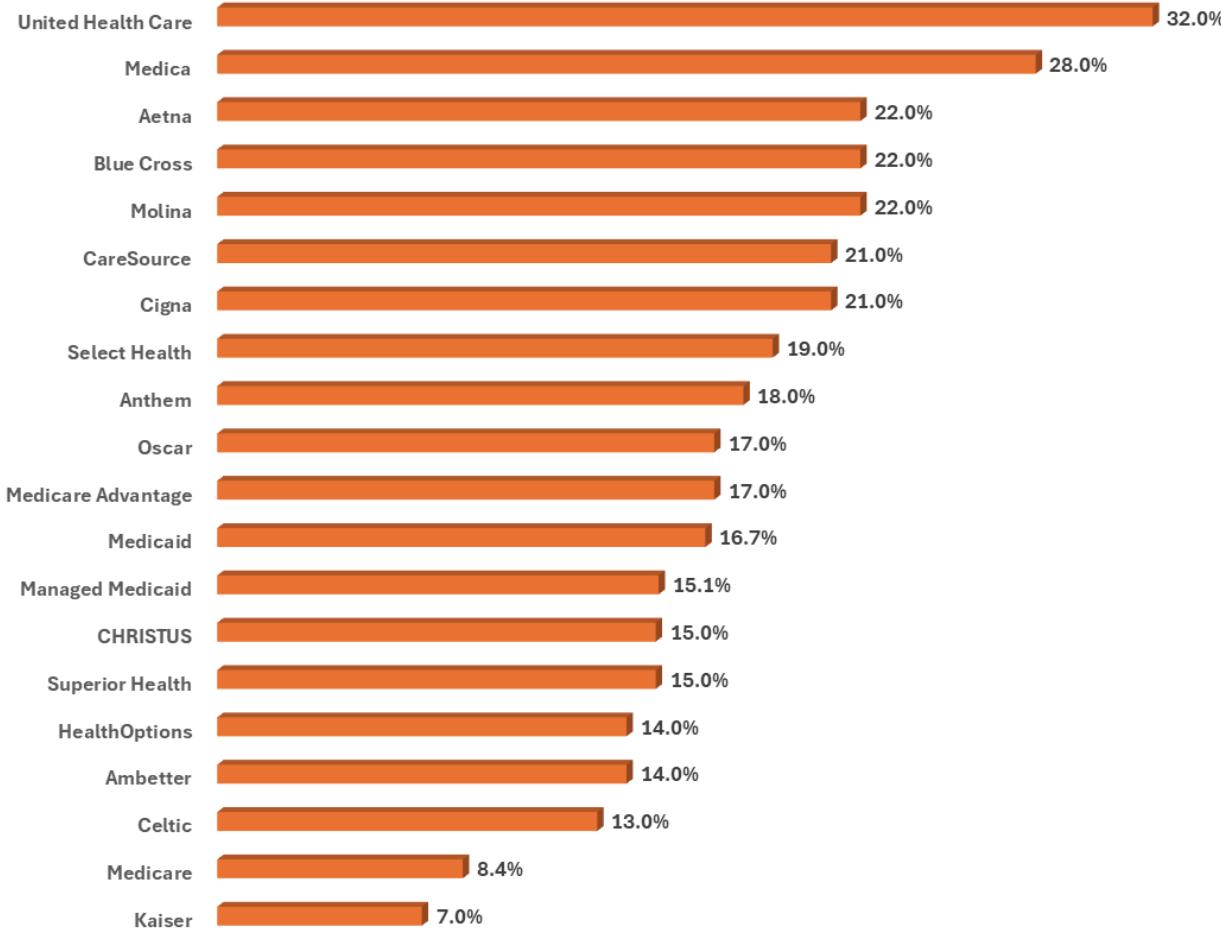


- Denial Trends
- Session Goal
- Education – Remark Codes & Reason Codes
- Skill Building – Measuring Denial KPIs
- How to Manage Denials With Less Staff
- People, Process, Technology
- Conclusion

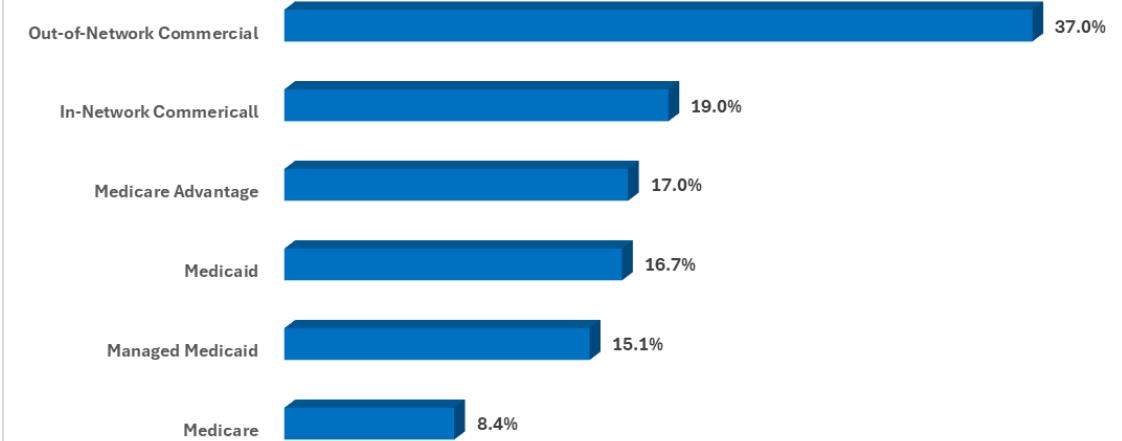
Denial Trends



Denial Rate by Payer



Denial Rate by Payer Category



Across all payers

Nearly 1 in 5 claims is denied

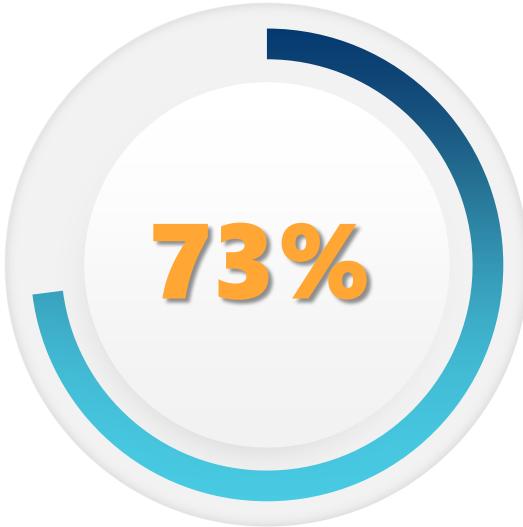
Average Denial Rate Across All Payers



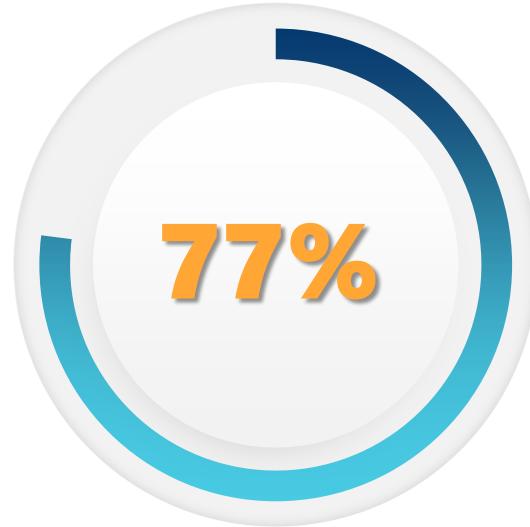
Average Initial Denial Rate Across All Payers is:

16-20%

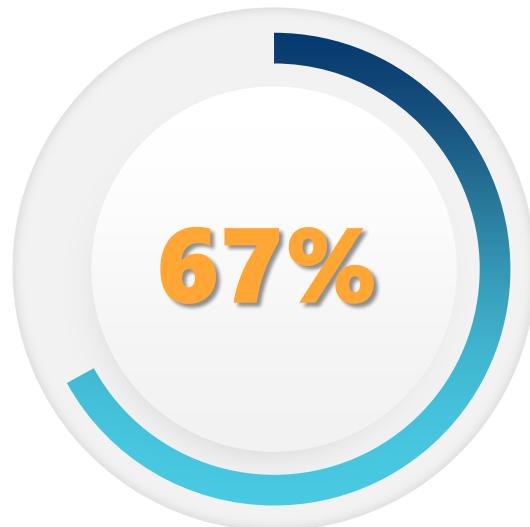
Denial Trends



Denials Are Increasing



Policy Changes Occur With
More Frequency



Reimbursement Times Are
Increasing



Errors in Claim Adjudication
Are Increasing

- All categories up 25.2% on average

In what areas in denials are increasing?



Denial Category	% Increase (2020-2024)	Notes
Administrative Errors	Up 18%	Growth in coding/data errors from automation
Medical Necessity	Up 15%	Increasing documentation and review stringency
Prior Authorization / Referral	Up 13%	Driven by stricter requirements/automation
Excluded Services / Policy	Up 9%	Due to frequent benefit changes/exclusions
Overall (all categories)	Up 15-23%	Overall increase in initial denials

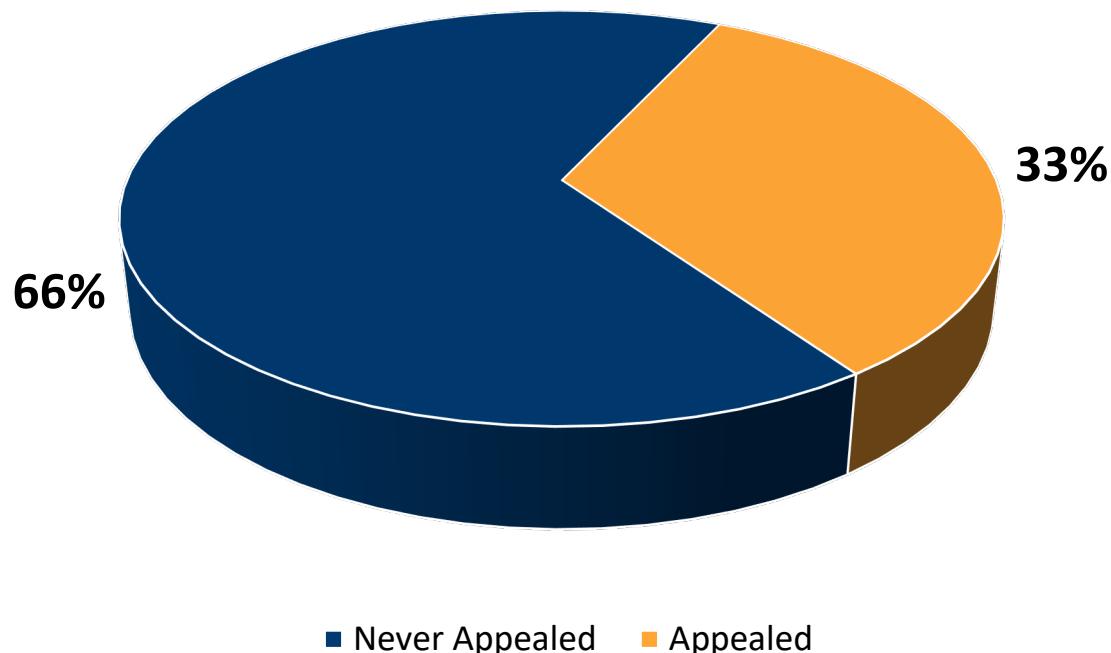
Overall Increase in Denials

15-23%

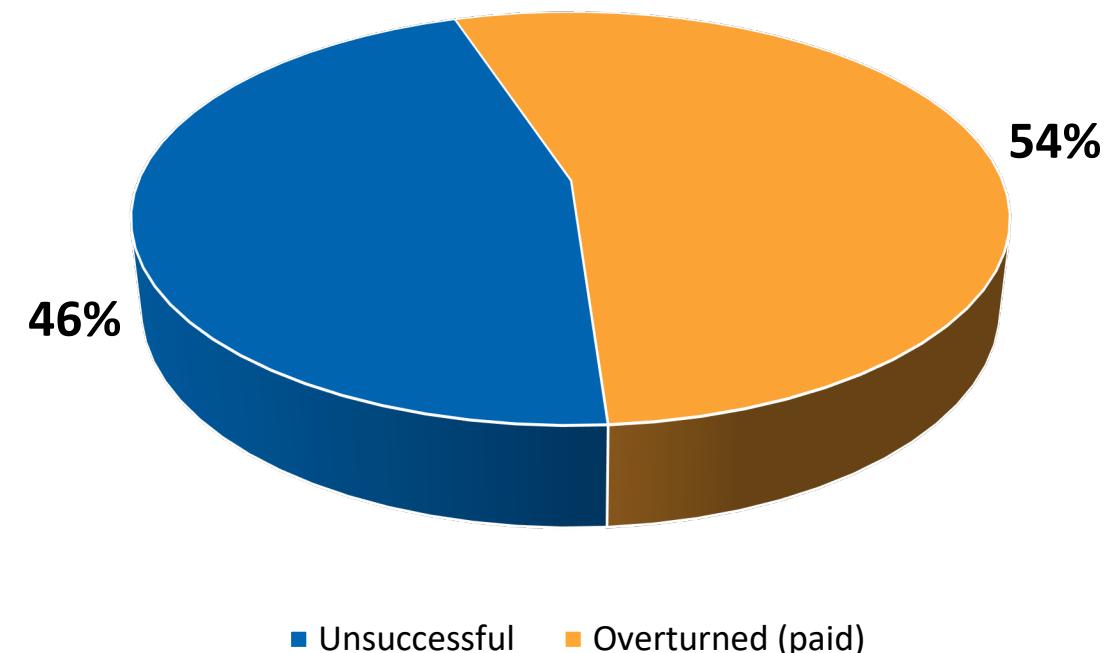
Appeal Trends



Percentage of DenialsAppealed



Percentage of DenialsOverturned



- The average appeal takes 3 interactions with the payer and takes 30-60 days.
- Denied claims often take 2-6 months to resolve completely.
- Administrative cost to work a denied claim is \$25 - \$118
- Average cost to work a denied claim - \$43.84

Average Cost to Work a Denied Claim

\$43.84

- Decreased Cash Flow
 - 30–60-day delay in payment (even if successful)
- Higher Risk of Nonpayment
 - 2/3 of denials are never appealed
- Increased Admin Costs
 - Average cost to work a denial \$43.84
- Decreased Patient Satisfaction
 - Denied claims lower patient satisfaction scores by 8.2%

\$75K to \$200k Per Provider Lost

Monetary losses due to denials vary by specialty but typically range between \$75K to \$200k per provider annually.

Unique Denial Trends and Dynamics in California



• Transparency and Oversight Legislation

- CA considering landmark legislation (**SB 363, 2025**) to require insurers to publicly disclose denial rates and provide detailed reasons for every denied claim.
- Bill proposes penalties (up to \$1 million per case) if more than half of insurer denials are overturned on appeal.
- 72% of appeals to the California Department of Managed Health Care result in the initial denial being reversed.

• Increased Medical Necessity and Prior Authorization Requirements

- Insurers more aggressively scrutinizing claims for medical necessity, resulting in higher denial rates.
- Prior authorization denials are on the rise for outpatient visits, telehealth, and new therapies, largely due to expanded prior authorization requirements.

• Medicare Advantage Plan Denials Trending Up

- Denial rates for Medicare Advantage are much higher (about 17%) than traditional Medicare (8%)

• Rise of AI-Driven Audits

- CA insurers leading adoption of AI for payment integrity and retrospective claims audits
- Automated audits are also flagging discrepancies in social determinants of health documentation

• Social Determinants of Health (SDOH) Data

- CA providers are experiencing denials due to lack of documented SDOH factors (housing, food, transport), as California payers connect these with care coverage and population health initiatives.

• Persistent Administrative and Eligibility Issues

- Coding and clinical documentation errors remain a major driver — especially as CA payers continually update billing matrices and evidence-based guidelines for claims.
- Coverage denials due to eligibility, expired insurance, and coordination of benefits are rising as payers leverage real-time verification tools in California.



Discover what denials are.

How to measure them.

How to identify the root cause of each.

Effective strategies to address & prevent denials.

Improve financial performance.



Education

- **Reason Codes (Claim Adjustment Reason Codes - CARCs)**

- Explain why a claim or service line was paid differently than it was billed.
- Provide the primary reason for any financial adjustment to the claim, such as denials, reductions, or increases in payment.
- Reason codes help healthcare providers understand the main cause of payment adjustments or denials on the claim.

- **Remark Codes (Remittance Advice Remark Codes - RARCs)**

- Provide additional or supplemental information about an adjustment already described by a reason code.
- Give more specific clarification or convey non-financial information related to claim adjudication or remittance processing that cannot be expressed solely by the reason codes.
- Remark codes help clarify the underlying details or policy context behind the primary adjustment.

- **Summary:**

- **Reason Codes** explain the core reason for a claim payment adjustment.
- **Remark Codes** give **supplementary details** or **clarifications** about that adjustment.
- Both are part of the remittance advice to assist providers in understanding claim outcomes and guiding any needed follow-up actions such as appeals or corrections.

Education – Most Common Reason (CARC) Codes



Top Reason Codes (CARCs)

Reason Code (CARC)	Reason Code (CARC)
CO-45 - Charge exceeds fee schedule or maximum allowable amount	PR-12 - Benefits reduced due to patient's failure to furnish required information
CO-97 - The benefit for this service is included in the payment for another service	CO-24 - Position status indicator for the claim is missing or invalid
CO-18 - Duplicate claim/service	CO-96 - Non-covered charge(s) at least one remark code required
PR-1 - Patient responsibility, co-payment amount	CO-109 - Claim not covered by this payer/contractor
PR-2 - Patient responsibility, coinsurance amount	CO-197 - Precertification/authorization/notification absent
PR-3 - Patient responsibility, deductible amount	CO-69 - Billing provider not eligible to receive payment
CO-22 - Payment adjusted because patient is not covered for this service	PR-96 - Non-covered charge(s)
CO-16 - Claim/service lacks information that is needed for adjudication	PR-97 - Patient deductible amount not met
CO-29 - The time limit for filing has expired	PR-21 - Patient is responsible for the services
CO-50 - These are non-covered services because this is not deemed a medical necessity	CO-50 - Non-covered service; not a medical necessity

Most Common Remark Codes



Top Remark Codes (RARCs)

Remark Code (RARC)
N130: Additional documentation required for claim processing
M15: Separately billed services must be submitted as a new claim
N517: Requested information was not received in a timely manner; claim denied
M20: HCPCS code missing, incomplete or invalid
N365: Address has been changed from that submitted by provider
N386: Billing provider must be enrolled to receive payment
M27: Patient is responsible for waived charges since services are not medically necessary
M31: Missing required documentation (e.g., radiology report)
N71: Adjustment due to timely filing limit
M12: Duplicate claim/service
M51: Missing or invalid procedure code
N74: Service not covered in this setting
M87: Diagnosis code missing or does not meet policy guidelines
N76: Benefit maximum reached

Most Common Denials by Frequency



Denial Reason	Denial Reason
Duplicate Claims / Duplicate Service	Authorization Number Missing or Invalid
Eligibility/Insurance Coverage Issues (including expired coverage)	Patient Responsibility (Co-pay, Deductible, Coinsurance)
Lack of Prior Authorization or Pre-Certification	Service Not Covered in This Setting
Missing or Incorrect Patient Information (demographics, ID)	Billed Amount Exceeds Fee Schedule or Maximum Allowed
Non-Covered Services / Excluded Services	Claim Not Submitted to Primary Payer First
Medical Necessity Not Met	Coding Errors/Inconsistencies (ICD-10, CPT)
Incorrect or Missing Procedure Codes	Documentation Issues or Missing Documentation
Timely Filing Limit Exceeded (Late Submission)	Provider Not Credentialed or Eligible to Bill
Coordination of Benefits / Other Payer Responsible	Bundled Services / Services Included in Other Payments
Incorrect or Missing Modifier	Duplicate Diagnosis or Procedure on Same Date of Service

Key Insight

Key Performance Indicator performance can always be traced back to operational issues.



Why should a practice know their KPIs?

“If you can't measure it, you can't improve it.”

- Peter Drucker

What KPIs should I be measuring?



Top KPIs Every Practice Should Measure

Key Performance Indicator	Shorthand
Accounts Receivable Greater Than 120 Days	AR > 120
Days in Accounts Receivable	AR Days
Insurance Days in Accounts Receivable	Insurance AR Days
Patient Days in Accounts Receivable	Patient AR Days
Gross Collection Rate	GCR
Revenue Realization Rate	RRR
Net Collection Rate	NCR
Average Reimbursement per Encounter	ARE
Percentage of Claims Denied	Denial Rate / Initial / Final

A semi-transparent blue overlay covers the background image, which depicts a medical professional in a white coat sitting at a desk. Their hands are visible: one is resting on the desk, and the other is holding a pen over a document. A stethoscope lies on the desk in front of them. The text "Denials Skill Building" is overlaid on this image.

Denials Skill Building

SKILL – Benchmarking Denial Rate



Definition: Percentage of claims denied by payers out of the total claims submitted.

Initial Denial Rate: Percentage of claims denied by payers upon first submission.

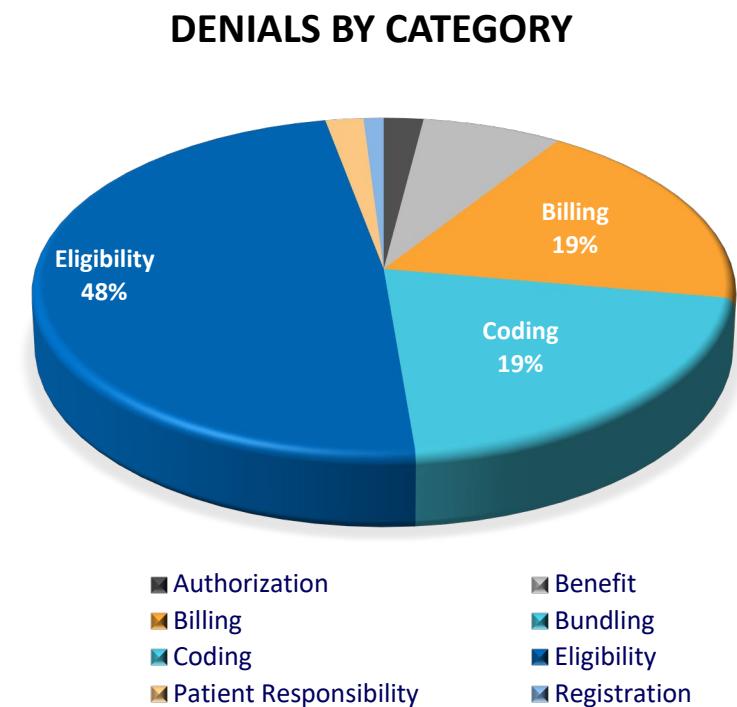
Final Denial Rate: Percentage of claims that remain denied after all appeals have been exhausted.

Benchmarks:

- **Initial Denial Rate:** 16-20%
- **Final Denial Rate:** 2-5%

Implications:

- Decreased Cash Flow (Delayed Revenue)
- Higher Risk of Nonpayment
- Increased Admin Costs (follow-up efforts, increased HR costs)
- Decreased Patient Satisfaction
- Increased Financing Costs (if loans are required)
- Lower Practice Value



SKILL – How to Calculate Denial Rates



Initial Denial Rate: Total Number Denied Claims / Total Number of Claims Submitted

Final Denial Rate: Number of Denied Claims After Appeals / Total Number of Claims Submitted

Tips:

- Many practice management systems do not report denials well
- Consider getting data from your clearinghouse
- Focus on initial denials
- Avoid duplication
- Measure both percentage and dollar values (Dollar-Based Denial Rate)
- Run at least monthly



EXAMPLE:

Total Denied Claims (1 Month) = 562
Total Claims (1 Month) = 7013

RESULTS:

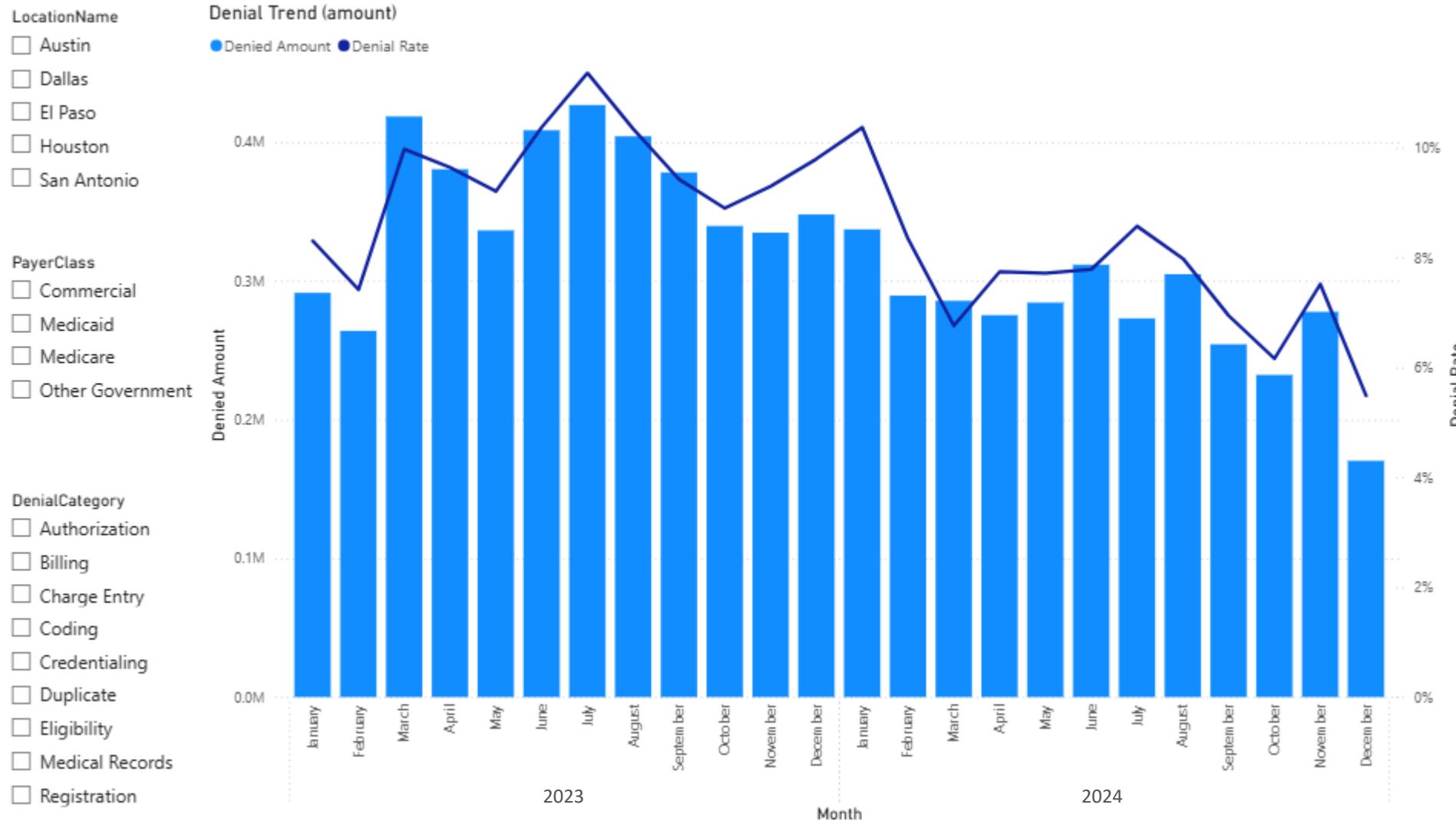
562 / 7013 = 8.01% Denial Rate

Steps:

1. Calculate KPIs
2. Analyze
3. Prioritize
4. Implement



How Analyze and Prioritize Denials



Break Down Denial Data

- Service Location
- Payer & Financial Class
- Service Item, CPT and Service Grouping Categories
- Denial Code & Category

How Analyze and Prioritize Denials



DenialCategory	DeniedAmount	DenialRate_Amount	DeniedVolume	DenialRate_Volume
Registration	2,802,585.31	3.15%	16,303	5.72%
Authorization	1,635,171.28	1.84%	9,898	3.47%
Coding	993,440.69	1.12%	5,687	2.00%
Medical Records	726,834.17	0.82%	3,550	1.25%
Billing	546,818.62	0.62%	2,776	0.97%
Eligibility	454,373.92	0.51%	2,560	0.90%
Duplicate	407,348.88	0.46%	2,141	0.75%
Credentialing	57,764.59	0.07%	346	0.12%
Charge Entry	3,190.70	0.00%	20	0.01%
Total	7,627,528.16	8.58%	43,281	15.19%

How Analyze and Prioritize Denials



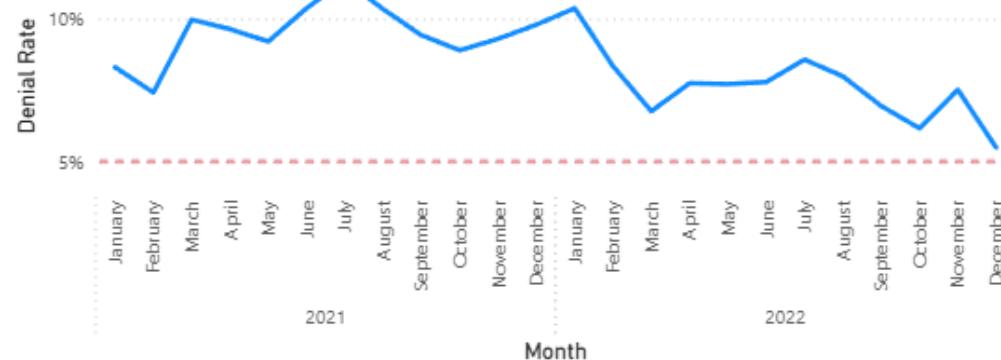
7.63M

BilledAmountDenied

8.58%

DenialRate_Amount

Denial Trend (amount)



DenialCode	DeniedAmount	DenialRate_Amount	DeniedVolume	DenialRate_Volume
N130	1,539,763.23	1.73%	8,380	2.94%
CO197	1,441,403.45	1.62%	8,923	3.13%
N19	428,641.72	0.48%	3,261	1.14%
CO97	425,035.19	0.48%	3,015	1.06%
OA22	305,891.20	0.34%	1,751	0.61%
CO29	240,499.22	0.27%	1,351	0.47%
OA18	238,518.88	0.27%	1,239	0.43%
CO16	222,747.99	0.25%	1,124	0.39%
MA04	196,528.23	0.22%	1,055	0.37%
CO22	181,279.08	0.20%	968	0.34%
N4	166,338.34	0.19%	899	0.32%
PR27	160,297.44	0.18%	947	0.33%
Total	7,627,528.16	8.58%	43,281	15.19%

CPTCode	DeniedAmount	DenialRate_Amount	DeniedVolume	DenialRate_Volume
99213	1,675,008.25	11.09%	12,984	11.08%
99203	904,888.92	11.47%	4,722	11.24%
99214	808,681.95	14.11%	4,226	14.01%
17110	607,064.84	8.45%	3,000	8.45%
99204	385,690.66	15.65%	1,313	15.27%
17000	240,553.22	4.28%	1,619	4.28%
Total	7,627,528.16	8.58%	43,281	15.19%

LocationName	DeniedAmount	DenialRate_Amount	DeniedVolume	DenialRate_Volume
Houston	2,225,861.85	12.53%	13,529	17.06%
El Paso	2,127,822.88	11.25%	11,992	21.03%
Austin	1,523,222.11	8.68%	8,236	16.14%
San Antonio	1,158,984.30	7.52%	6,587	13.58%
Dallas	591,637.02	3.07%	2,937	5.98%
Total	7,627,528.16	8.58%	43,281	15.19%

PayerClass	DeniedAmount	DenialRate_Amount	DeniedVolume	DenialRate_Volume
Medicaid	3,657,799.28	27.22%	22,018	38.34%
Commercial	2,366,224.45	7.88%	13,417	12.27%
Medicare	1,437,084.12	3.59%	6,932	7.17%
Other Government	166,420.31	3.09%	914	4.25%
Total	7,627,528.16	8.58%	43,281	15.19%

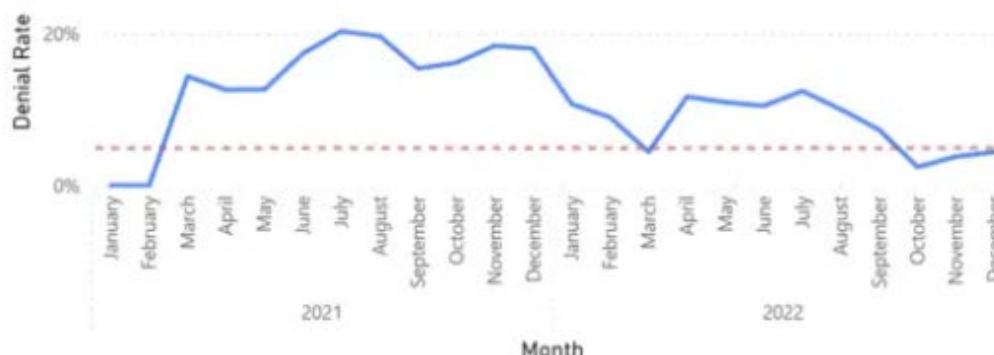
DenialCategory	DeniedAmount	DenialRate_Amount	DeniedVolume	DenialRate_Volume
Registration	2,802,585.31	3.15%	16,303	5.72%
Authorization	1,635,171.28	1.84%	9,898	3.47%
Coding	993,440.69	1.12%	5,687	2.00%
Medical Records	726,834.17	0.82%	3,550	1.25%
Billing	546,818.62	0.62%	2,776	0.97%
Eligibility	454,373.92	0.51%	2,560	0.90%
Duplicate	407,348.88	0.46%	2,141	0.75%
Credentialing	57,764.59	0.07%	346	0.12%
Charge Entry	3,190.70	0.00%	20	0.01%
Total	7,627,528.16	8.58%	43,281	15.19%

How Analyze and Prioritize Denials



1.41M
BilledAmountDenied

Denial Trend (amount)



DenialCode	DeniedAmount	DenialRate_Amount	DeniedVolume	DenialRate_Volume
CO197	1,414,503.03	11.24%	8,737	16.27%
N130	1,082,382.53	8.60%	5,975	11.13%
N19	273,912.82	2.18%	2,095	3.90%
N448	90,752.29	0.72%	459	0.85%
CO22	66,857.38	0.53%	386	0.72%
CO96	15,712.23	0.12%	103	0.19%
N381	14,693.48	0.12%	79	0.15%
NS2	14,054.73	0.11%	90	0.17%
PI197	8,206.19	0.07%	54	0.10%
CO15	4,787.65	0.04%	28	0.05%
OA22	3,557.44	0.03%	27	0.05%
CO273	1,300.00	0.01%	1	0.00%
Total	2,994,061.81	23.78%	18,061	33.63%

CPTCode	DeniedAmount	DenialRate_Amount	DeniedVolume	DenialRate_Volume
99213	296,392.72	11.04%	2,297	11.02%
99203	217,652.93	11.70%	1,133	11.49%
99214	178,002.00	11.31%	930	11.25%
17110	163,305.30	11.55%	807	11.56%
99204	98,775.02	11.47%	336	11.27%
95165	50,700.00	14.08%	80	13.96%
Total	1,414,503.03	11.24%	8,737	16.27%

LocationName	DeniedAmount	DenialRate_Amount	DeniedVolume	DenialRate_Volume
Houston	586,716.83	13.03%	3,816	18.36%
El Paso	419,579.19	11.07%	2,539	16.44%
Austin	266,803.53	10.41%	1,577	14.98%
San Antonio	141,403.48	8.16%	805	11.59%
Dallas	465.45	0.05%	4	0.11%
Total	1,414,968.48	10.53%	8,741	15.22%

PayerClass	DeniedAmount	DenialRate_Amount	DeniedVolume	DenialRate_Volume
Medicaid	1,414,503.03	11.24%	8,737	16.27%
Commercial	15,394.07	0.06%	103	0.11%
Medicare	3,933.47	0.01%	26	0.04%
Other Government	320.45	0.01%	2	0.01%
Total	1,434,151.02	2.11%	8,868	3.84%

DenialCategory	DeniedAmount	DenialRate_Amount	DeniedVolume	DenialRate_Volume
Authorization	1,414,503.03	11.24%	8,737	16.27%
Total	1,414,503.03	11.24%	8,737	16.27%



Guidance

- Prioritize by Impact and Importance
- Look for Worst Offenders
- Look for Best Cases too
- Continually Monitor and Iterate

A semi-transparent blue overlay covers the background image, which depicts two medical professionals in white coats. One is seated at a desk, writing on a clipboard with a pen. The other is standing behind them, with their hands clasped together. A stethoscope lies on the desk between them. The scene is set in a clinical or office environment.

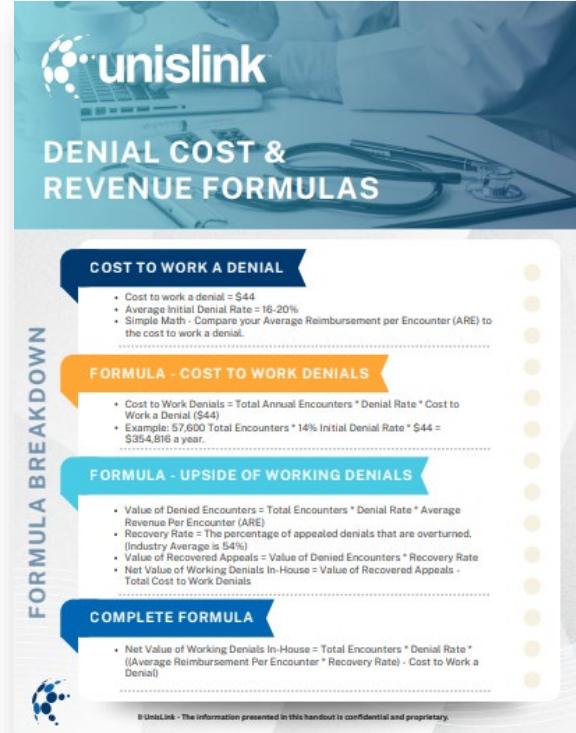
The Cost of Managing Denials

How Much Are My Denials Costing Me - Handout



- Cost to work a denial = \$44
- Average Initial Denial Rate = 16-20%
 - Simple Math – Compare your Average Reimbursement per Encounter (ARE) to the cost to work a denial
- Formula – Cost to Work Denials:
 - Cost to Work Denials = Total Annual Encounters * Denial Rate * Cost to Work a Denial (\$44)
 - **Example:** 57,600 Total Encounter * 14% Initial Denial Rate * \$44 = \$354,816 a year.
- Formula – Upside of Working Denials:
 - Value of Denied Encounters = Total Encounters * Denial Rate * Average Revenue Per Encounter (ARE)
 - Recovery Rate = The percentage of appealed denials that are overturned. (Industry Average is 54%)
 - Value of Recovered Appeals = Value of Denied Encounters * Recovery Rate
 - Net Value of Working Denials In-House = Value of Recovered Appeals – Total Cost to Work Denials
- Complete Formula:

Net Value of Working Denials In-House = Total Encounters * Denial Rate * ((Average Reimbursement Per Encounter * Recovery Rate) - Cost to Work a Denial)



The handout cover features the Unislink logo at the top left. The title "DENIAL COST & REVENUE FORMULAS" is centered in a large, bold, white font. The background is a blue-toned image of a medical professional in a white coat and stethoscope. The right side of the cover has a vertical "FORMULA BREAKDOWN" column with four sections: "COST TO WORK A DENIAL", "FORMULA - COST TO WORK DENIALS", "FORMULA - UPSIDE OF WORKING DENIALS", and "COMPLETE FORMULA". Each section contains a bulleted list of formulas and descriptions. At the bottom right, a small note reads "© UnisLink - The information presented in this handout is confidential and proprietary."



<https://bit.ly/4myJO66>

How Much Are My Denials Costing Me? (EXAMPLE)



Practice Metrics

- Total Annual Encounters – 57,600
- Average Revenue Per Encounter (ARE) - \$131
- Initial Denial Rate – 14%
- Denial Recovery Rate – 54%
- Cost to Work Per Denial - \$43.84

Primary Care Clinic

Denial Cost Worksheet

Number of Annual Encounters	57600
Average Revenue Per Encounter	\$ 131.00
Initial Denial Rate	14%
Denial Recovery Rate	54%
Cost to Work Per Denial	\$ 43.84

Use a number between 16 and 20% if you do not know.

On average 54% of appeals are paid

Industry average is \$44 per denial

Value of Annual Services	\$ 7,545,600.00
Number of Encounters Denied	8064
Value of Denied Encounters	\$ 1,056,384.00
Cost to Work Denials	\$ 353,525.76
Expected Recovery	\$ 570,447.36
Net Gain Working Denials In-House	\$ 216,921.60

Results

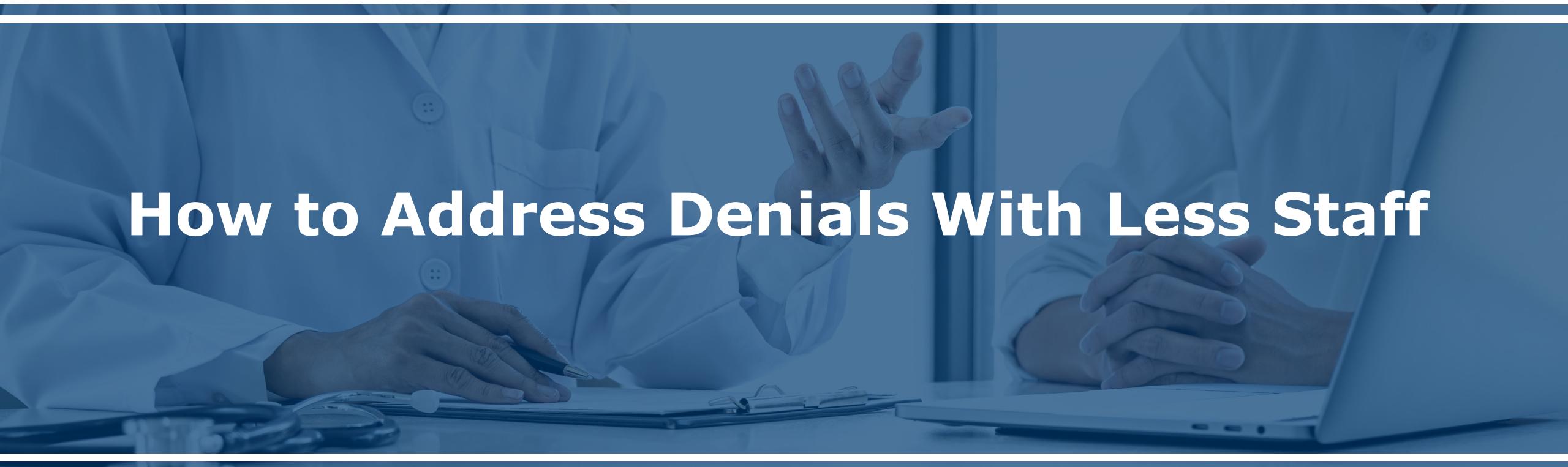
- Value of Annual Services - \$7,545,600
- Annual Encounter Denied – 8,064
- Value of Denied Encounters - \$1,056,384
- Total Cost to Work Denials - \$353,525.76
- Expected Recovery - \$570,447.36
- Net Gain Working Denials In-House - \$216,921.60



<https://bit.ly/4myJO66>

Key Insight

Improving denial rates will have massive impact on practice financial performance.

A blue-tinted photograph showing the lower half of two medical professionals in white coats. One person is on the left, looking down at a clipboard and pen. The other person is on the right, with their hands clasped together on the desk. A stethoscope lies across the desk between them. The background is slightly blurred.

How to Address Denials With Less Staff

Key Insight

Prevention is the best strategy.

90% of All Denials Are Preventable



Denial Reason	Preventable?	Explanation
Duplicate Claims / Duplicate Service	Preventable	Usually preventable with good claims tracking and submission processes.
Eligibility/Insurance Coverage Issues (including expired coverage)	Preventable	Preventable by verifying patient insurance eligibility before service.
Lack of Prior Authorization or Pre-Certification	Preventable	Preventable through obtaining required authorizations upfront.
Missing or Incorrect Patient Information (demographics, ID)	Preventable	Preventable by careful data entry and verification during registration.
Incorrect or Missing Procedure Codes	Preventable	Preventable by proper coding practices and continuous coder education.
Timely Filing Limit Exceeded (Late Submission)	Preventable	Preventable by managing submission deadlines closely.
Coordination of Benefits / Other Payer Responsible	Preventable	Preventable by verifying primary/secondary payer information.
Incorrect or Missing Modifier	Preventable	Preventable with correct and complete billing details.
Authorization Number Missing or Invalid	Preventable	Preventable by proper authorization processes.
Claim Not Submitted to Primary Payer First	Preventable	Preventable by following payer rules and claim order.
Coding Errors/Inconsistencies (ICD-10, CPT)	Preventable	Preventable with proper coding.
Documentation Issues or Missing Documentation	Preventable	Preventable by submitting complete medical records and supporting documents.
Provider Not Credentialed or Eligible to Bill	Preventable	Preventable through credentialing verification prior to billing.
Bundled Services / Services Included in Other Payments	Preventable	Preventable by understanding bundling rules and correctly grouping services.
Non-Covered Services / Excluded Services	Preventable	Preventable by checking benefit coverage before service.
Medical Necessity Not Met	Not Preventable	Often not fully preventable as it depends on payer policies and clinical judgment; sometimes appeals and additional documentation can overturn.
Patient Responsibility (Co-pay, Deductible, Coinsurance)	Not Preventable	Not a denial due to error, but a billing responsibility of the patient, but can be preempted or offset by doing patient estimation and collecting before service.
Billed Amount Exceeds Fee Schedule or Maximum Allowed	Not Preventable	Not preventable (but expected) if payers set fixed fee schedules.
Out-of-Network Services	Not Preventable	If services are provided outside a patient's network with no prior authorization or coverage, these denials are generally not preventable by providers.

Key Insight

The majority of denials ambulatory clinics face are preventable with improved administrative process and technology.

Maximize effectiveness by preventing errors and rework.

Get it right the first time. Do it right. Do it once.

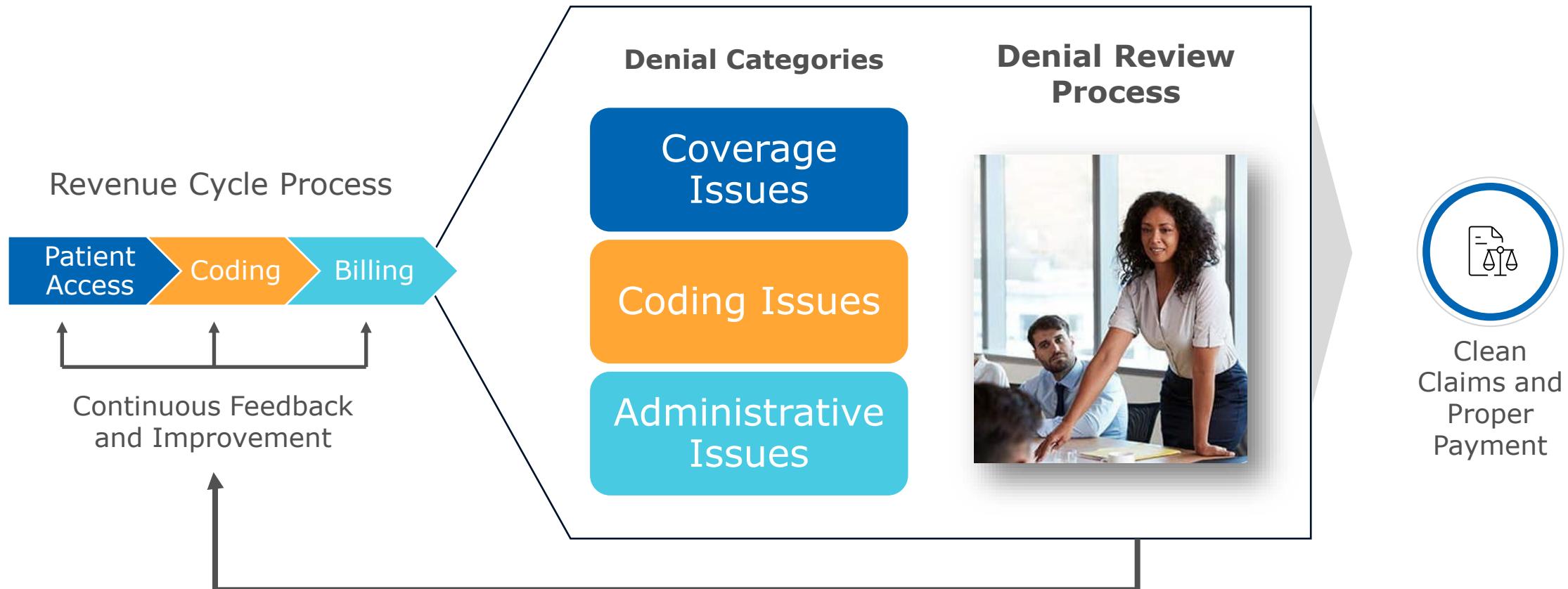
Key Insight

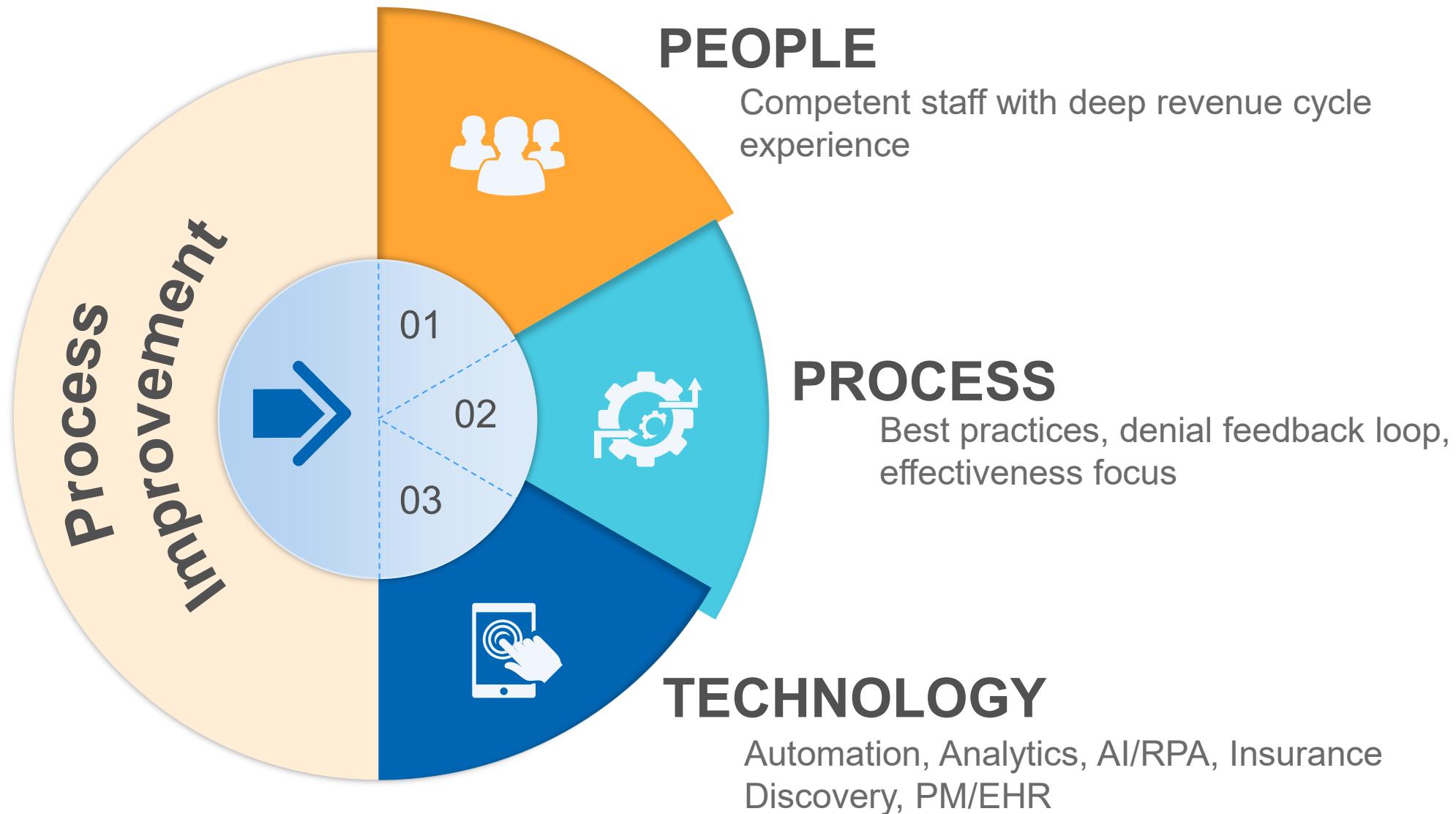
Adopt a zero-tolerance mindset when it comes to preventable denials.

Denial Review and Feedback



Prevent the root cause of denials to ensure claims are submitted cleanly the first time.







People

3 Key Performance Indicators (KPIs) to Look at:

1. Revenue Realization Rate
2. Insurance AR Over 120
3. Accounts Receivable Days

KPI – Revenue Realization Rate (RRR)



Definition: Percentage of Charges either collected or adjusted off. (regardless of reason)

Benchmark: 99-100%

(For reporting periods 90+ days in the past.)

Calculation Formula:

- **Revenue Realization Rate** = (Payments + Adjustments) / Charges

Utility:

- Useful for determining if staff are able to keep up with workloads.



Calculating A/R > 120



CALCULATION: Dollar Value of A/R >120 Days / Dollar Value of Total A/R

Example:

Total A/R = \$538,874

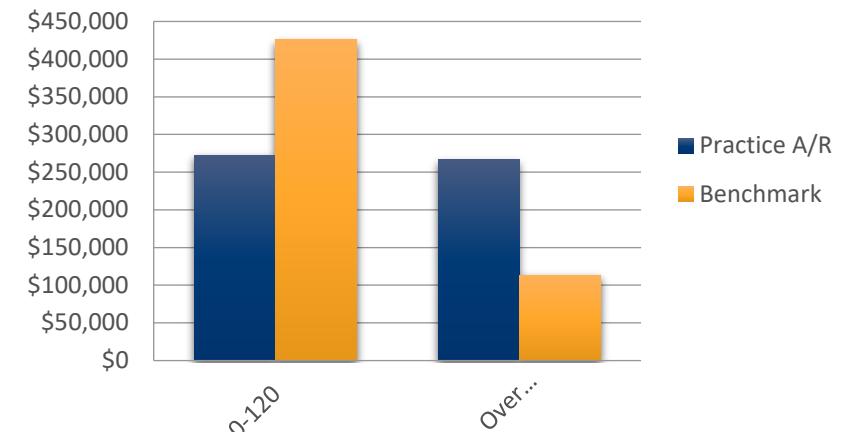
A/R > 120 = \$266,275

$\$266,275 / \$538,874 = 49\%$

Practice A/R	0-120	Over 120	Balance
No Unapplied Amts	\$272,599.33	\$266,275.16	\$538,874.49
Percentages	50.6%	49.4%	100%

Practice A/R	0-120	Over 120	Balance
No Unapplied Amts	\$272,599.33	\$266,275.16	\$538,874.49
Percentages	50.6%	49.4%	100%

A/R > 120 Days Compared to Benchmark



Special Nuance – Calculating A/R > 120



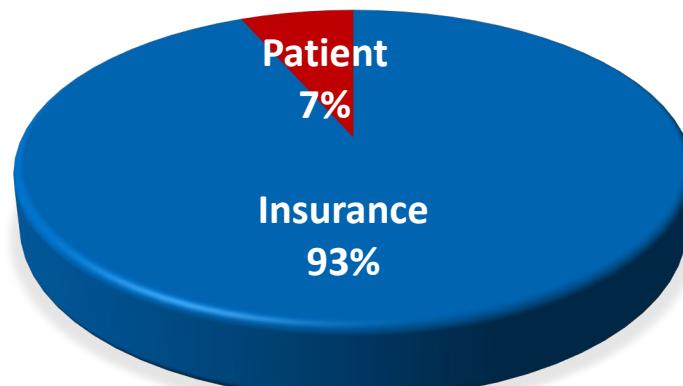
CALCULATION: Dollar Value of Patient A/R >120 Days / Dollar Value of Total A/R

CALCULATION: Dollar Value of Insurance A/R >120 Days / Dollar Value of Total A/R

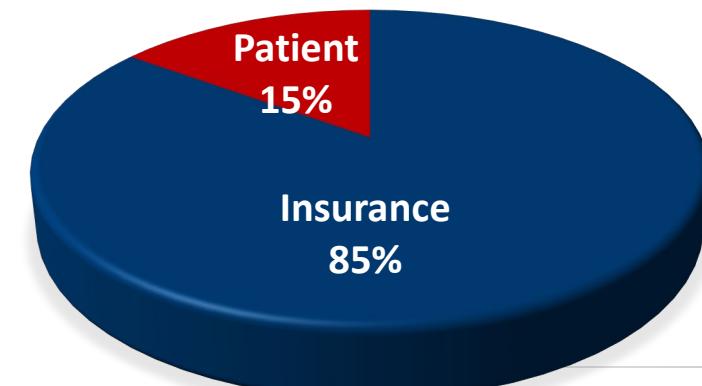
Aging by Responsibility

Responsibility	Current	31-60	61-90	91-120	121-up	Balance
Insurance	\$ 392,769.38	\$ 258,040.40	\$ 30,341.68	\$ 47,901.14	\$ 431,144.02	\$ 1,160,196.62
Patient	\$ -	\$ 740.00	\$ 2,750.99	\$ 1,982.00	\$ 75,577.73	\$ 81,050.72
Total	\$ 392,769.38	\$ 258,780.40	\$ 33,092.67	\$ 49,883.14	\$ 506,721.75	\$ 1,241,247.34

TOTAL AR BY RESPONSIBILITY



AR > 121 BY RESPONSIBILITY



KPI – Days in A/R (AR Days)



Definition: Average number of days it takes a practice to get paid.

Benchmark: 30 Days. For some specialties, a 40 Days is acceptable.

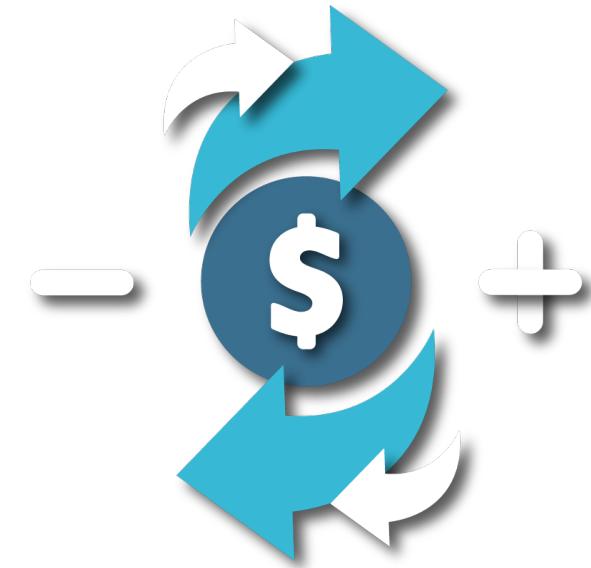
Preferred is < 30 Days.

Calculation Formula:

- **Total Accounts Receivable** divided by your **Average Daily Charge Amount**.

Warning:

- Day in AR can be gamed.
- Low AR Days alone doesn't mean you are collecting all the money you could be collecting or that you are keeping up with workloads.
- This metric must be combined with **Net Collection Rate** to be fully meaningful.



Days in AR
Cash Flow Metric

How can I tell if I have sufficient staff for the workload?



Key Performance Indicator	Explanation
Revenue Realization Rate	Because RRR is calculated 90 days in arrears, a Revenue Realization Rate less than 99 suggests that staff unable to fully keep up with the workload. The farther below 99% the indicator is, the greater the sign that staff is unable to keep up.
Insurance AR Over 120	A large percentage of AR Over 120 Days old that is still out to payers is a strong indicator that staff is unable to keep up with the workload coming in from payers.
Accounts Receivable Days	Because AR Days is an indicator of the speed at which AR get resolved, a high AR Days over 30 can suggest that staff is unable to keep up with workloads. In the context of evaluating sufficiency of staff to address denials, this KPI is subordinate to RRR and AR Over 120 by Insurance because AR Days looks at all AR and can be manipulated by write-offs.

- **Improve Staff Competency** (more effective, more efficient)

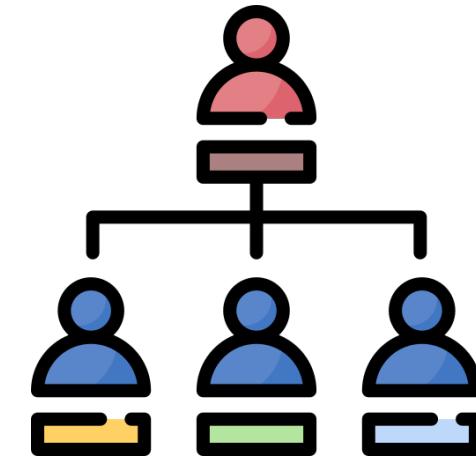
- Workflow Training (see also process)
- Front-end Process and Registration
- Claims Submission Workflow
- Denial Management
- Technology Training

- **Coding and Documentation**

- Medical Coding Education / Certification
- Clinical Documentation Improvement (CDI) Training
- Coding Updates and Trends

- **Hire Additional Resources**

- **Outsource**



People Strategies – Hiring Dynamics



- Use Indeed.com to research salaries
- Currently a Shortage of Qualified AR and Coding Staff
 - Top MGMA challenge for 3 years
- Finding staff takes time:
 - Hiring revenue cycle specialists with 0-5 years of experience costs \$2,167 to hire and takes 84 days.
 - Hiring revenue cycle specialists with 10 years of experience costs \$5,699 to hire and takes 207 days.

Revenue Cycle Analyst III / IS - Revenue Cycle / Full-time / Days

Children's Hospital Los Angeles
Remote in Los Angeles, CA

\$99,008 - \$169,728 a year

Revenue Cycle Analyst II / IS - Revenue Cycle / Full-time / Days

Children's Hospital Los Angeles
Remote in Los Angeles, CA

\$88,962 - \$152,506 a year

Full-time



Process

Denials by Functional Area



Prevent denials by addressing the processes that are at the root cause of the denial.

Functional Area	Top Reason Codes (CARCs)	Example / Description
Front Desk / Registration	CO-27, CO-22, CO-29	Patient coverage expired (CO-27), coordination of benefits (CO-22), late claim submission (CO-29). Issues here arise from insurance eligibility verification failures or missing patient info.
Authorization / Pre-Certification	CO-197, CO-109	Missing or invalid precertification/authorization (CO-197), claim not covered by this payer (CO-109). Problems here arise when prior authorizations or coverage approvals are missing.
Medical Billing / Coding	CO-4, CO-11, CO-16, CO-18, CO-45	Missing modifier (CO-4), incorrect coding (CO-11), missing info or invalid data (CO-16), duplicate claim (CO-18), billed amount exceeds fee schedule (CO-45). Coding errors drive many denials.
Clinical / Providers	CO-50, CO-97, CO-96	Non-covered service/not medically necessary (CO-50), patient deductible not met (CO-97), non-covered charge with remark required (CO-96). Clinical documentation and medical necessity issues reflect here.
Claims Submission / Follow-Up	CO-45, CO-109, PR-1, PR-3	Payment adjusted due to fee schedule (CO-45), claim not covered by payer (CO-109), patient co-pay (PR-1), patient deductible (PR-3). Claim follow-up includes managing patient responsibility and payer rules.

Pursue Best Practices



Societies

- MGMA – Medical Group Management Association
- HFMA – Healthcare Financial Management Association
- AMA – American Medical Association
- HLA – Healthcare Leaders Association
- AMGA – American Medical Group Association

Books

- Operating Policies and Procedures Manual for Medical Practices 5th Edition by Elizabeth W Woodcock MBA
- Fundamentals of Medical Practice Management - by Stephen Wagner
- Secrets of the Best-Run Practices, 3rd Edition by Judy Capko

Consulting Firms

- Deloitte Healthcare
- McKinsey & Company (Healthcare Division)
- Huron Consulting Group
- ECG Management Consultants



OPERATING POLICIES AND PROCEDURES MANUAL FOR MEDICAL PRACTICES

CHAPTER 9 PROCEDURES:

Financial Management

[POLICY 9.01 - "Time-of-Service Payment Controls and Daily Close"](#)
[POLICY 9.02 - "Deposit of Patient Receipts"](#)
[POLICY 9.03 - "Bank Statement Reconciliation"](#)
[POLICY 9.04 - "Month-End and Year-End Closing"](#)
[POLICY 9.05 - "Authorized Check Signing"](#)
[POLICY 9.06 - "Reimbursed Expenses"](#)
[POLICY 9.07 - "Check Requests"](#)
[POLICY 9.08 - "Check Processing Cycle"](#)
[POLICY 9.09 - "Petty Cash Transactions"](#)
[POLICY 9.10 - "Internal Controls"](#)
[POLICY 9.11 - "Online Banking"](#)
[POLICY 9.12 - "Operating Budget"](#)
[POLICY 9.13 - "Payroll Expenses"](#)

FINANCIAL MANAGEMENT - POLICY 9.01

Time-of-Service Payment Controls and Daily Close

It is the policy of the Practice to ensure timely and accurate tracking, reconciliation, and deposits of all payments received at the time of service.

1. Each employee logs into the practice management system using his or her personal user identification. No charges and payments will be entered by an employee under or using another employee's workstation or login credentials. Each employee is responsible for all transactions occurring at his or her workstation and under his or her login credentials.

2. All charges and payments are entered into the practice management system at the time of patient check-out, unless otherwise designated to be the responsibility of the business office.

3. All payments are linked to the appropriate charges at check-out. All unassigned payments will be resolved by the end of the business day.

4. Every check received by the patient at time of service is endorsed with the Practice's bank endorsement stamp at the time of check-out. Alternatively, the Practice may process checks at the time of service utilizing automated check handling (ACH), in which case employees are provided training and instructions regarding ACH protocols. The payment is posted and a statement reflecting the application of the payment is given to the patient.

5. Credit and debit card payments are transmitted immediately or, at maximum, daily in accordance with the service procedure found at each credit card terminal or online merchant processor.

6. At the end of the shift, each employee entering charges and/or time-of-service payments runs a daily system summary in the practice management system, showing all patient charges and payments (cash, check, debit card and credit card) by user identification. This report is balanced against the practice management system, and reported as part of the daily close.

7. Each employee responsible for charge and/or payment entry must balance patient charges as well as receipts for his or her allotted shift under his or her user identification.

8. At the daily close of business, the manager or designated employee prepares and signs a daily close sheet that records credit/debit card payments, cash and personal checks received at the Practice. If using ACH or another automated transmission process, the

Best Practice Processes



- Insurance Verification and Verification of Benefits for Every Encounter
- Patient Estimation and Upfront Collection of Patient Balances Before Service
- Robust Prior Authorization Process
- Optimize Coding Accuracy
- Improve Clinical Documentation
- Use Claim Scrubbing Software
- Submit Claims Timely
- Regular Denial Analysis and Root Cause Identification
- Appeal Denials Effectively
- Leverage Technology and Automation
- Cross-Departmental Training and Communication
- Documented Policies and Procedures



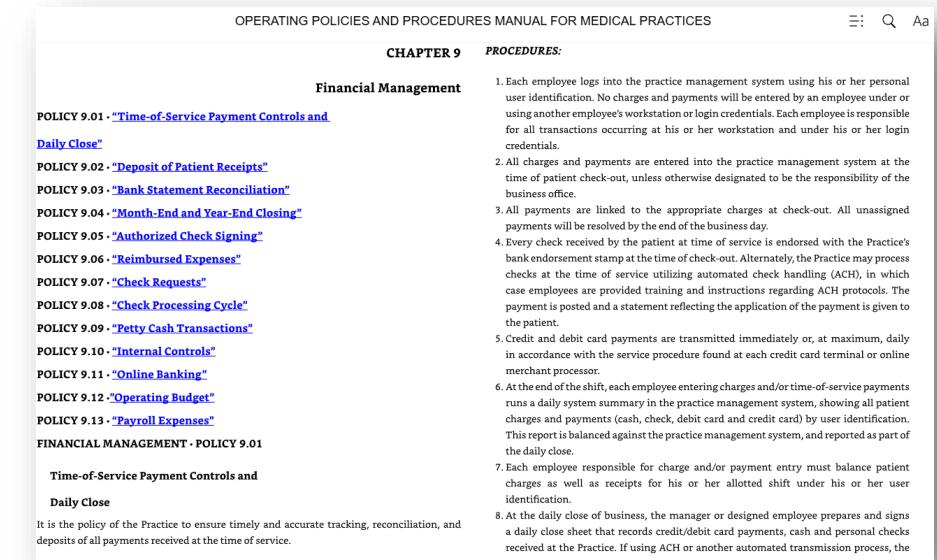
Standard Operating Procedures (SOPs)



Standard Operating Procedure – Set of detailed, step-by-step instructions to help workers carry out routine or complex operations consistently and efficiently.

Keys:

- Identify the goal
- Involve key stakeholders
- Document them clearly and concisely
- Document who is responsible for what
- Distribute to all relevant personnel



OPERATING POLICIES AND PROCEDURES MANUAL FOR MEDICAL PRACTICES

CHAPTER 9

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POLICY 9.05 • ["Authorized Check Signing"](#)

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Cheat Code: Operating Policies and Procedures Manual for Medical Practices 5th Edition by Elizabeth W Woodcock MBA



Technology

Practice Management Systems



- A good EHR/Practice Management system will come with many workflow and time-saving elements built-in.
- In a denials-prevention context look for:
 - Automated Eligibility Checking and Verification of Benefits (and supporting workflows)
 - Sophisticated Claims Edits (best if supports custom edits)
 - Good denials reporting / analytics
 - Denial Management System
 - Workflow System for Allocating Work & Secure Messaging
 - Document Imaging
 - Coding Assistance / Coding Calculators
 - Customizable EHR Templates
 - Pre-Authorization Automation and Workflows



Eligibility Checking and Verification of Benefits



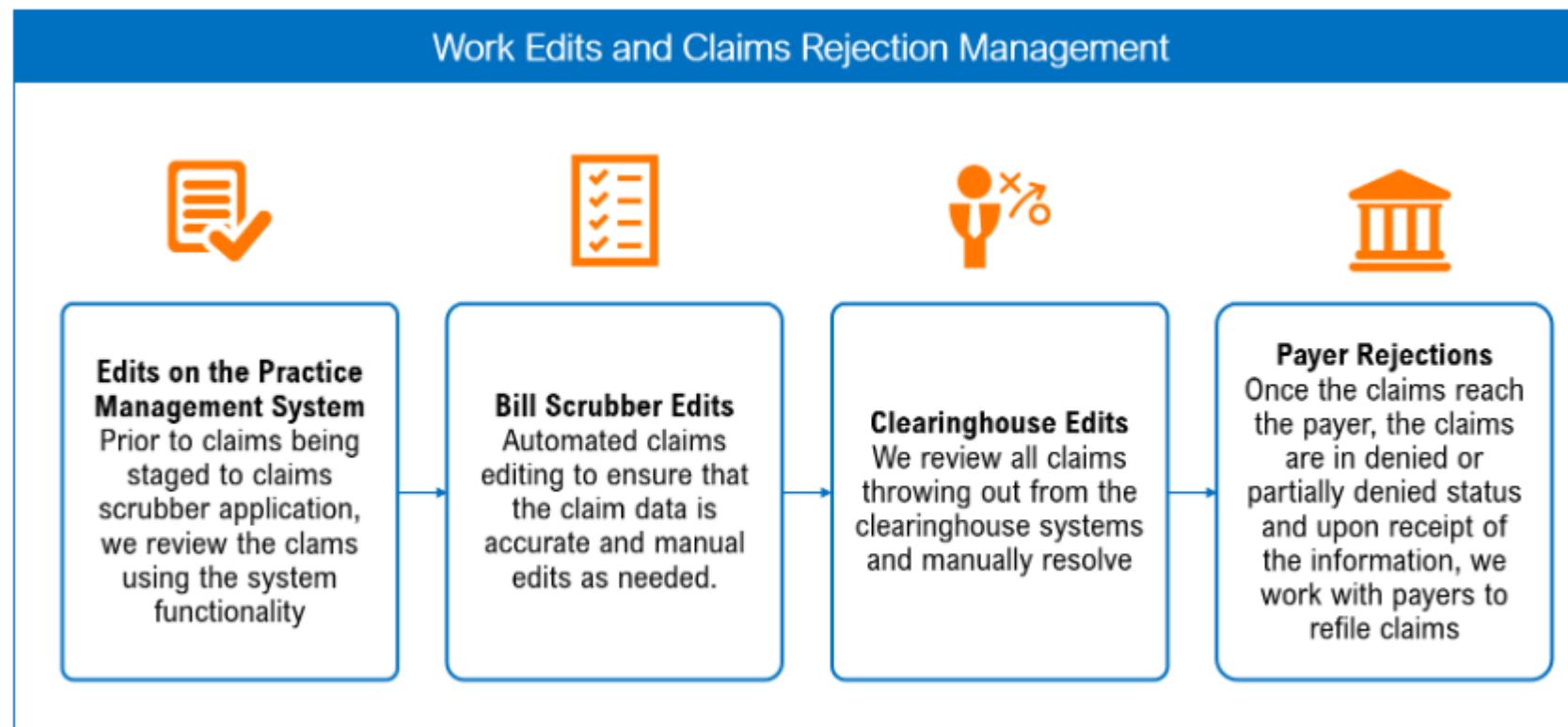
- Your practice management system probably already has this built-in.
- Note the difference between:
 - Active Coverage
 - Verification of Benefits
- It's best if the system can return a 271 benefits file
- Few systems can reliably read a benefits file
 - That means your staff may have to read the file
 - Even that won't always work so expect to have to do some insurance portal checks or calls
 - Incorporate that into your process



Claims Edits (Claim Scrubbing)



Claims Edits – An automated system that scans medical claims to detect and correct errors or inconsistencies that could cause a claim to be delayed or denied by the payer.



Claims Edits (Claim Scrubbing)

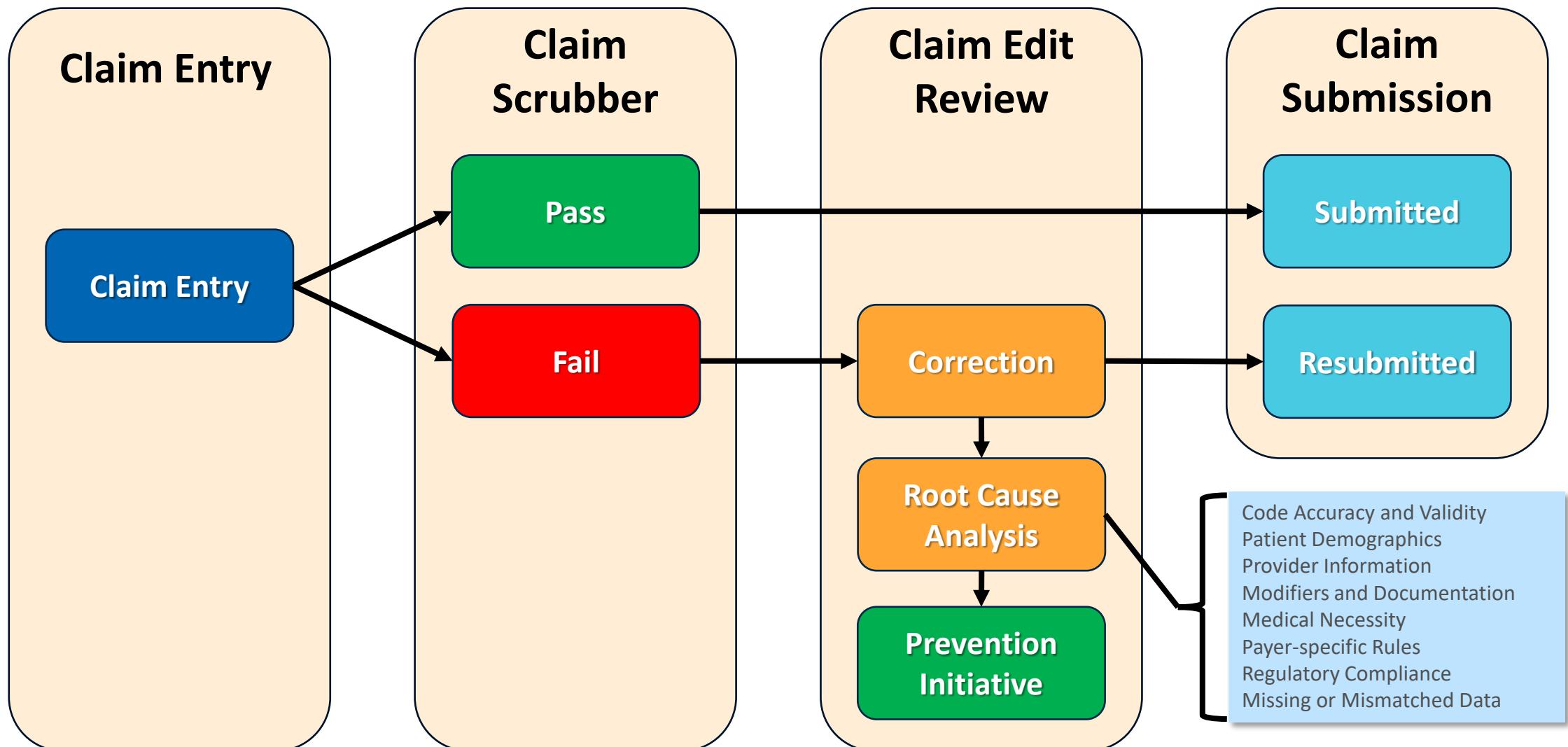


What things do claims edits look for?

Category	Description
Code Accuracy and Validity	Checks that CPT, HCPCS, ICD-10, and other medical codes are correct, up to date, and accurately paired (e.g., diagnosis and procedure codes must align)
Patient Demographics	Verifies that patient information such as name, date of birth, and insurance details are correctly entered and match payer records.
Provider Information	Ensures the provider's National Provider Identifier (NPI) and credentials are accurate.
Modifiers and Documentation	Flags missing or invalid modifiers and ensures required documentation or authorizations are included.
Medical Necessity	Confirms that the services billed align with payer or Medicare guidelines for medical necessity.
Payer-specific Rules	Validates compliance with insurance-specific billing rules, formatting requirements, frequency limitations, and pre-authorization where needed.
Regulatory Compliance	Checks adherence to regulatory standards like HIPAA and CMS guidelines.
Missing or Mismatched Data	Flags any missing fields or data inconsistencies that could trigger denials.

Look for the ability to add your own custom edits for the unique requirements for your practice and market.

Claims Edits Workflow



Claims Edits – Where does AI fit in?



- How are AI claims edits different than typical claims edits?

Aspect	Traditional Claims Edits	AI-Enabled Claims Edits
Approach	Rule-based, static, predefined rules	Dynamic, learning-based, predictive analytics
Error Detection	Flags known, predefined errors	Identifies complex, evolving and nuanced errors
Adaptability	Requires manual updates for rule changes	Automatically adapts to new regulations and payer rules
Processing Speed	Often slower, manual or semi-automated	Fast, automated real-time processing
Accuracy	Limited to rule coverage, misses subtle issues	Higher accuracy with continuous learning from data
Integration to Systems	Typically tied into a given practice management system	Currently typically, an external application that must integrate into a PM system
Handling Complex Cases	Often struggles with complex coding scenarios	Better at complex coding, sequencing, and billing scenarios
Impact on Denials	Reduces common denials, but can miss emerging patterns	Reduces denials with proactive error prevention
Human Effort	Requires substantial manual review and updates	Reduces manual effort, frees staff for higher-value tasks

AI Coding – AI Coding vs. Provider/Certified Coding



Category	AI Coding Software	Provider / Certified Coders
Accuracy & Consistency	Reduces manual coding errors, increases consistency	Subject to human error and inconsistencies
	Consistent application of updated coding rules	Variable accuracy depending on learning, experience and workload
Speed & Efficiency	Faster coding and claims processing	Time-consuming manual process
	Automates routine coding freeing up staff	Coding speed limited by coder availability
Complex Cases	May struggle with ambiguous or incomplete notes	Expert judgement for complex and nuanced cases
	Effective on common, routine coding tasks	Better at interpreting clinical nuances
Cost & Resource	Potential cost saving by automating routine tasks	Higher labor costs due to manual intensive work
	Free up coders to value-added activities	Requires continuous training and updates
Compliance & Updates	Automatically updated with latest coding regulations	Coders must manually keep up-to-date
	Reduced risk of compliance-related denials	Possible risk of non-compliance due to oversight
Workflow Integration	Can potentially integrate in real-time	May require separate workflows and double-checking
	Provides instant feedback and analytics	Dependent on coder documentation quality

AI Coding vs. Human Coding – Reality Check



Category	AI Coding	Human Coding
Dependence on Documentation	Both AI and Human coding rely heavily on the quality and completeness of the clinical notes and medical records.	
Routine Cases	Both AI and Human coders perform well on routine, straightforward coding cases.	
Need for Interpretation	Both AI and Human coders require interpretation and judgement for ambiguous, complex, and unusual cases.	
Continuous Learning	Both AI and Human coders require continuous learning and updates through training. Each specialty must be trained.	
Quality Assurance / Oversight	Both AI and Human coders require oversight and quality checks to maintain accuracy and compliance.	
Availability		Currently certified coders are in short supply.
Complex Cases	AI struggles more with rare and complex cases.	
Consistency		Human coders (especially providers) are more prone to inconsistency.
Vendor Dependence	AI Coding is highly dependent on vendor updates.	

What to Look for When Evaluating AI Coding



Category	Key Feature / Function / Service
Core Features	AI-powered code suggestions using NLP and machine learning
	Modifier, bundling, and payer-specific logic automatically applied
	Real-time clinical documentation improvement (CDI) support
	Built-in audit, compliance checks, and alerts for coding errors
	Customizable workflows supporting roles across coders, auditors, providers
	Seamless integration with EHR and practice management systems
	Automated updates for coding guidelines and payer rules
	Support for real-time and retrospective coding
	Risk adjustment and evaluation & management (E/M) code analysis
	Exception handling and low confidence flagging for human review
Essential Functions	Explainability and transparency of AI suggestions for auditing (how it arrived at conclusions)
	Robust security and data privacy (PHI compliance)
	Guaranteed accuracy of 95% or better
	Integration options for hybrid AI-human coding workflows
	Regular AI model updates and compliance audits
Vendor	Guidance on government and payer regulatory compliance
	Vendor viability and long-term sustainability



Summary and Conclusion

Summary – Key Points to Remember



1. Claim Denials are a Big Problem and Getting Worse

- Costing \$75k-\$200k per provider per year
- The problem is not going away. The only answer is to become excellent.

2. Know How to Measure Your Denials

- Initial Denial Rate
- Final Denial Rate

3. Prevention is the Best Strategy

- Create a denial feedback loop process

4. Use Strategies in:

- People, Process, and Technology
- To decrease Initial and Final Denial Rates

Getting Help Identifying Denials



Complimentary Assessment

Scan the below QR code for a **FREE** Revenue Cycle Assessment, exclusive for CAP Members



<https://bit.ly/465iPZw>

www.UnisLink.com



Thank You

For More Information Contact: james.m@unislink.com

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