

## Critical Access Hospital Finance and Operations Webinar Series

### Denials Management for CAHs January 20, 2026

*The mission of the Oregon Office of Rural Health is to improve the quality, availability and accessibility of health care for rural Oregonians.*

*The Oregon Office of Rural Health's vision statement is to serve as a state leader in providing resources, developing innovative strategies and cultivating collaborative partnerships to support Oregon rural communities in achieving optimal health and well-being.*



## Webinar Logistics

Audio is muted for all attendees.

Select to populate the to populate the chat feature on the bottom right of your screen. Please use either the chat function or raise your hand on the bottom of your screen to ask your question live.

Presentation slides and recordings will be posted shortly after the session at:  
<https://www.ohsu.edu/oregon-office-of-rural-health/critical-access-hospital-programs>.







**Claire Adams** is the Vice President of Healthcare Analytics at REDi Health, with over 10 years of experience delivering data-driven solutions to health care organizations. She specializes in building scalable analytic processes for small hospital systems, Accountable Care Organizations (ACOs), and physician practices. Claire is passionate about using data to identify health care disparities and improve processes across the care continuum. Her expertise in process development, data engineering and stakeholder engagement supports REDi Health's mission to improve health care outcomes for underserved communities.



**Kelsey Sullivan** joined Three Rivers Health in April 2022 and currently serves as Director of Clinic & Ancillary Services, overseeing clinic, radiology, laboratory, pharmacy and marketing and outreach operations. She holds a Bachelor of Health Science from Boise State University and is a Certified Professional Coder (CPC) with hands-on experience supporting the revenue cycle, including coding for internal medicine, cardiology, emergency medicine, general surgery and behavioral health. Kelsey brings a strong operational and revenue cycle perspective to her work, grounded in a patient-first approach.



# ORH Announcements

- Next CAH Finance and Operations Webinars:
  - Jan. 27 at 12 p.m. | Value-Based Care & Clinical Risk Stratification for CAHs ([Register here](#))
  - Feb. 3 at 12 p.m. | Revenue Integrity with ChargeMaster (CDM) Use Case ([Register here](#))
- Next ORH Community Conversations ([Register here](#)):
  - Jan. 29 at 12 p.m. | Oregon Legislative Update
  - March 19 at 12 p.m. | Rural Health Transformation Program Updates
- May 14-15, 2026 Virtual | 3<sup>rd</sup> Annual Forum on Rural Population Health ([More information here](#))
- Oct. 7-9, Bend, OR | 43rd Annual Oregon Rural Health Conference ([More information here](#))





# Denials Management

A Plan of Action for Revenue  
Cycle Optimization





# Rural Realities

- One-deep teams
- EMR transitions
- Denials from payers
- Constant interruptions while wearing many hats
- Physician recruitment/retention
- Trusted data seems hard to come by
- Working within constraints you may not be able to control





# Learning Objectives Denials Management

Understand how to:



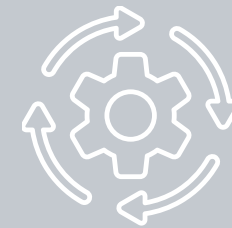
1) Get data from your systems



2) Look at a problem holistically and derive insights using data



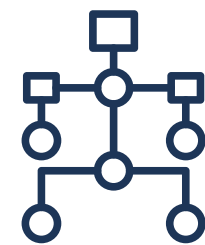
3) Communicate insights and best practices across teams



4) Implement change in processes = Change Management



5) Measure impact of adoption with data



6) Drill down on new opportunities



# Poll Question

What challenges prevent you from pulling data?

- a. Lack of internal report writing expertise
- b. Shared EMR instance prevents direct access to data
- c. Competing priorities put pulling data on the back burner
- d. EMR doesn't have a tool that allows report writing





# Data Landscape is Fragmented

- Data lives in many systems
- Access to data is limited
- Expertise is required to obtain data
  - Lack of internal expertise
  - Expensive EMR report writing services
- Other priorities always win

 athenahealth



***Epic***

ORACLE

Cerner

MEDITECH





# What data do we need?

What problem am I trying to solve?

What data elements are needed to understand the problem?

- Define the Population (Patient, Encounter, Claim)
- Add measures (Volumes, Amounts, Outcomes)

How can I represent the data holistically?

- Code grouping on ICD, CPT, etc.

What data is needed to evaluate improvement?





# Denials Management

What problem am I trying to solve?

- How can I quantify volume of denied claims?

What data elements are needed to represent the problem?

- Claims, Encounters, Denials data

How can I represent the data holistically?

- Code mappings to CARC and RARC

Destination Column Name	Source Column Name	Datatype	Required	Description
ClaimID		text	Y	Claim identifier
LineNumber		int	Y	Claim Line Number
EncounterID		text	Y	Foreign key for Encounter level information
AdmitDate		DateTime	Y	Date the patient was admitted or service was rendered
DischargeDate		DateTime	Y	Date the patient was discharged or service was rendered
PaidDate		DateTime	Y	Date the claim was paid
ProcedureCode		text	Y	CPT, HCPCS code
Modifier		text	Y	Modifier for CPT or HCPCS code
RevenueCode		text	Y	Revenue Code
Payer		text	Y	Medicare, Medicaid-State, BCBS, PEHP
HealthPlan		text	Y	Humana-MA, Medicare Part A, etc.
FinancialClass		text	Y	Medicare, Medicaid, Commercial
PayerType		text	Y	Primary, Secondary, etc.
CreatedDate		DateTime	Y	Date the claim was first created
FirstBilledDate		DateTime	Y	Date the claim was first billed
ChargeAmount		Decimal	Y	Charge Amount
AdjustmentAmount		Decimal	Y	Amount the line item was adjusted
PaymentAmount		Decimal	Y	Amount that was paid for the line item
Quantity		int	N	Quantity of services
ClaimType		text	Y	Inpatient, Outpatient, SNF. Can also use Bill Type
DiagnosisCode		text	Y	All diagnosis code fields (include all 8 columns if available)

Destination Column Name	Source Column Name	Datatype	Required	Description
FinancialEncounterID		text	Y	Foreign key for Encounter level information
AdmitDatetime		datetime	Y	Encounter admit date
DischargeDatetime		datetime	Y	Encounter discharge date
EncounterType		text	N	Description of encounter type (inpatient, outpatient, etc.)
Facility		text	N	Facility where encounter occurred
Department		text	N	Department where encounter occurred
ServiceStartDatetime		datetime	Y	Date and time of the service starting
ServiceEndDatetime		datetime	Y	Date and time of the service ending
RegistrationPersonnel		text	N	Person who registered the patient
MedicalService		text	Y	Medical service associated with the encounter
AdmittingPhysician		text	Y	Physician who admitted the patient
AdmittingPhysicianNPI		text	Y	National Provider ID for the admitting physician
RenderingPhysician		text	Y	Physician who rendered treatment for encounter
RenderingPhysicianNPI		text	Y	National Provider ID for the rendering physician
MRN		text	Y	Patient's medical record number
EncounterChargeAmount		decimal	N	Charge amount for the overall encounter
EncounterBalance		decimal	N	Remaining balance for the encounter





# Denials Typical Workflow (Kelsey)

- EMR work queues– sample instances
- Weekly meetings
- Hard to measure improvement

Encounter: 07/10/2023 - 07/10/2023								
Filters Search								
	#	Health Plan	Status	Claim	Total Charges	Payments	Adjustments	Remainder
	1	BCBS WY TRADITIO...	Denied Pe...		\$486.40	(\$117.00)	(\$13.00)	\$356.40
	1	BCBS WY TRADITIO...	Transmitted		\$262.10	(\$147.00)	(\$115.10)	\$0.00
	1	BCBS WY TRADITIO...	Canceled		\$356.40	(\$320.76)	(\$35.64)	\$0.00
					\$1,104.90	(\$584.76)	(\$163.74)	\$356.40
Summing 3 Items								





# Denials Hoslistic view (Claire)

Pull all claims for timeframe

Map key data points to meaningful groupings (Eligibility, Billing, Coding issue)

Assigning denials to key personnel in an upstream workflow

Prioritize on key metrics volume of \$\$ amount



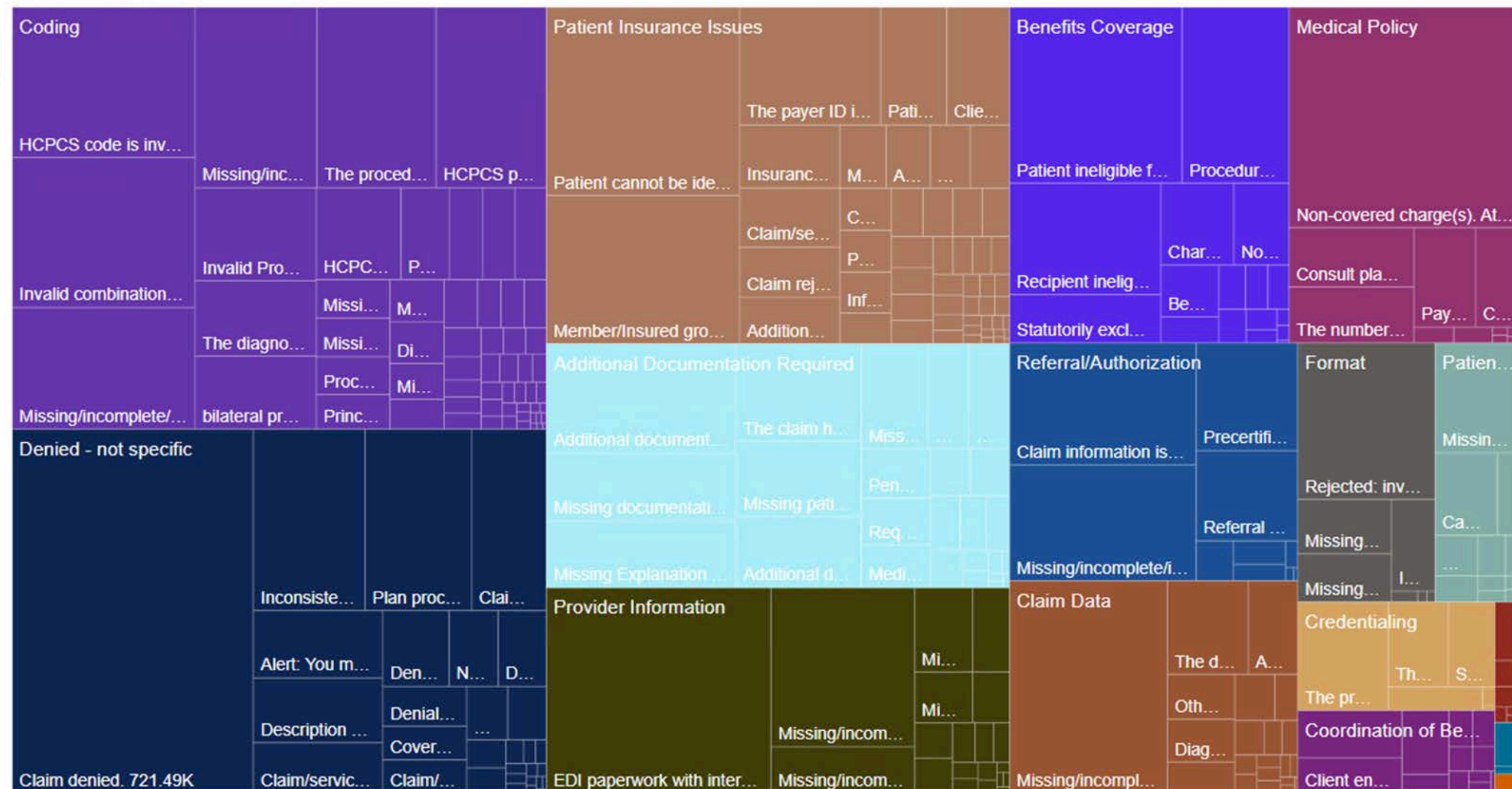


Select Amount or Volume

- Amount
- Claims

\$7M  
Denied Amount

## Denials





## Registration Denials

Claim\_InsID

All

1/1/2023

6/30/2025

513

Registration Denials

35K

Total Claims

1.5%

% Registration Denials

\$1M

Registration Denied AMT

Total Payment for Registration Denied Amount

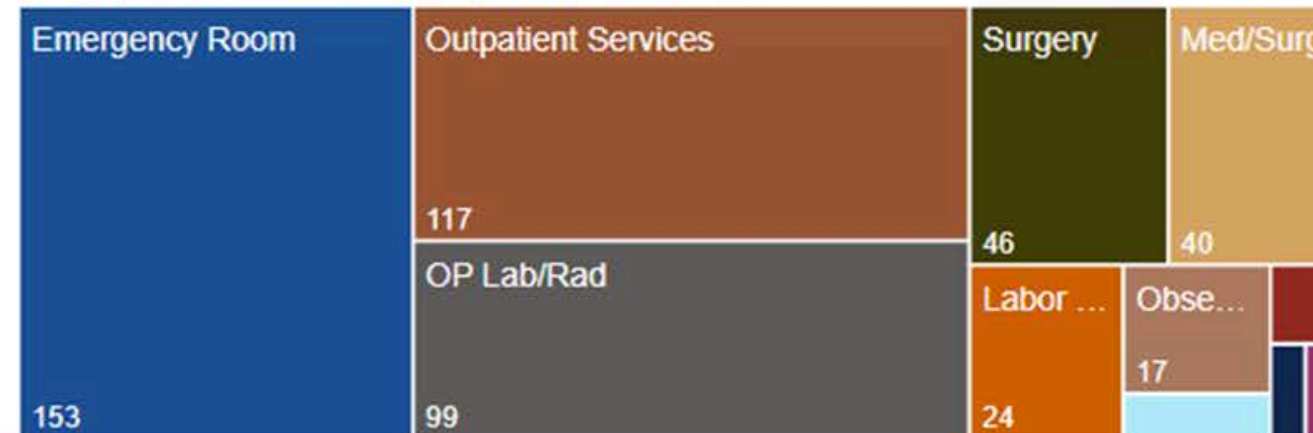


RegisteredBy	Total Claims	Registration Denials	% Registration Denials
Ischell	5,921	54	0.9%
rmikaila1	1,268	34	2.7%
sbenally1	1,243	32	2.6%
ccottman	1,266	30	2.4%
atrevizo3	1,158	24	2.1%
cbahe2	1,042	22	2.1%
natene	774	18	2.3%
hpalmer19	1,017	15	1.5%
rflannery3	2,205	14	0.6%
tjohnson794	760	14	1.8%
ayazzie15	626	13	2.1%
mholliday12	564	11	2.0%
twilliams1097	324	8	2.5%
amerritt56	318	7	2.2%
corr27	147	7	4.8%
kblack109	282	7	2.5%
nhunter36	400	7	1.8%
nalvarez64	326	6	1.8%
sperkins58	501	6	1.2%
kdye23	118	5	4.2%
mbegay11	637	5	0.8%
cholliday12	240	5	2.1%
<b>Total</b>	<b>34,998</b>	<b>513</b>	<b>1.5%</b>

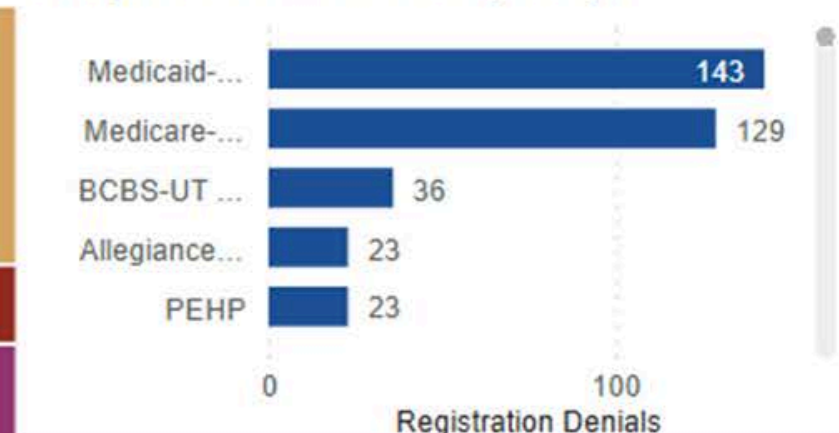
### Registration Denials over time



### Registration Denials by Department



### Registration Denials by Payer



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# Getting on the same page

It takes some time to build trust between the data and the processes the data represent

- How did we speak the same language?
- How did we ensure the data was accurately representing workflow?

Providers, business office, administration all have different perspectives

- How can we facilitate understanding between teams?







# Denials by Reason Code

total charge unpaid per code

ENCOUNTER\_T...

Multiple selections

Date

1/1/2024

9/26/2025



ORDERING\_PROVIDER

Denial  
Amount

Denied  
Claims

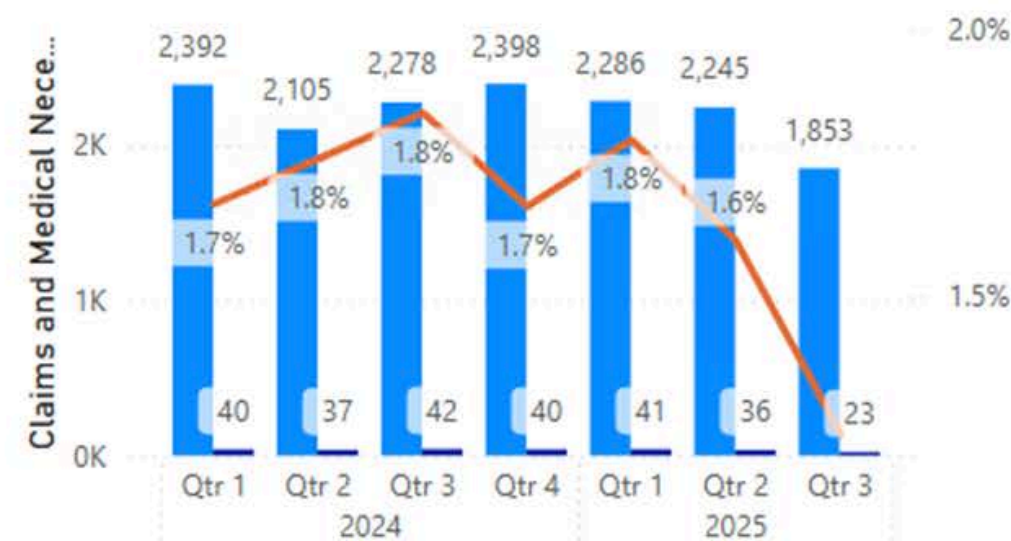
Claims

% Denied  
Claims

	\$10,523	40	2,454	50.4%
	\$9,761	33	2,354	56.1%
	\$35,335	28	1,296	35.1%
	\$21,170	7	948	37.0%
	\$6,623	22	901	58.6%
	\$13,960	9	799	37.3%
	\$1,332	6	779	46.7%
	\$6,004	17	706	51.0%
	\$2,609	5	611	46.8%
	\$4,368	7	515	46.8%
	\$927	5	422	36.5%
	\$120	1	216	47.2%
	\$3,243	7	177	54.2%
			169	61.5%
	\$281	1	153	39.2%
	\$6,320	9	151	55.0%
	\$610	3	116	46.6%
			109	
			108	42.6%
			106	49.1%
			104	51.0%
			101	44.6%
			96	53.1%
	\$136	1	94	12.8%
	\$749	1	90	31.1%
<b>Total</b>	<b>\$140,570</b>	<b>259</b>	<b>15,543</b>	<b>47.2%</b>

## Denied Claims by Year and Month

Claims Medical Necessity Denials Med Necessity % Denials



CPT\_Desc

Denied  
Claims

Denial  
Amount

83880 - Assay of na...	39	\$10,196
84443 - Assay thyro...	26	\$4,393
84153 - Assay of ps...	25	\$4,925
83540 - Assay of iron	23	\$2,902
80061 - Lipid panel	22	\$4,152
82306 - Vitamin d 2...	21	\$6,371
83036 - Glycosylate...	21	\$2,741
85025 - Complete c...	20	\$2,541
83735 - Assay of m...	19	\$1,993

**Total**

**259**

**\$140,570**

## Denied Amount by Year and Month



## Denied Claims by DEPARTMENT and HEALTH\_PLAN


Three Rivers Health Laboratory		TRH RAD
	M...	
	U...	MEDI...
MEDICARE A AND B	M...	ME... UN...
		Billings Cli...
		ME... ME...
MEDICARE WYOMING		BCB...

TM





Provider Level View




# Denials by Reason Code

total charge unpaid per code

ENCOUNTER\_T...  
Multiple selections

Date  
1/1/2024 5/29/2025



ORDERING_PROVIDER	Claims	Medical Necessity Denials	Med Necessity % Denials	ICD Codes Covered	Medical Necessity Denial Amount
84153 - Assay of psa total	32	7	21.9%	8	\$1,146
83540 - Assay of iron	14	6	42.9%	8	\$852
83880 - Assay of natriureti...	13	5	38.5%	6	\$1,225
83550 - Iron binding test	10	4	40.0%	6	\$251
82728 - Assay of ferritin	6	3	50.0%	2	\$503
87086 - Urine culture/colo...	52	3	5.8%	48	\$298
36415 - Routine venipunct...	388	2	0.5%		\$47
77078 - Ct bone density a...	25	2	8.0%		\$1,250
80061 - Lipid panel	110	2	1.8%	91	\$290
82306 - Vitamin d 25 hydr...	33	2	6.1%		\$558
83036 - Glycosylated hem...	73	2	2.7%	63	\$361
84443 - Assay thyroid sti...	107	2	1.9%	92	\$299
71250 - Ct thorax w/o dye	12	1	8.3%		\$543
74177 - Ct abd & pelv w/c...	8	1	12.5%		\$914
77067 - Scr mammo bi inc...	50	1	2.0%		\$540
82977 - Assay of ggt	1	1	100.0%	1	\$99
83735 - Assay of magnesi...	1	1	100.0%		\$96
85610 - Prothrombin time	62	1	1.6%	60	\$55
87077 - Culture aerobic id...	48	1	2.1%		\$57
87186 - Microbe suscepti...	48	1	2.1%		\$57
70200 - X-ray exam of eye...	2				
70260 - X-ray exam of skull	2				
70360 - X-ray exam of neck	4				
70450 - Ct head/brain w/o...	2			2	
Total	1,855	35	1.9%	515	\$9,441

### Not on List ICD

Diag	Claims
Z74.2	1,801
E11.9	1,111
I10	1,036
E03.9	1,021
Z87.891	1,010
R60.0	1,002
J44.9	923
Z79.84	911
Total	7,369

### Covered ICD

Diag	Claims
E11.9	285
Z79.84	170
R35.0	106
R53.81	104
Z79.01	98
Z51.81	86
E03.9	80
R30.0	71
Total	747

### Denied ICD

Diag	Claims
Z74.2	125
Z00.00	13
Z13.220	5
Z83.3	5
Z82.49	4
Z02.1	2
Z00.129	1
Z11.9	1
Total	156


### Claims by FinalResolutionCode (groups) and DiagnosisCode

FinalResolutionCode	DiagnosisCode	Claims
Not on List		
E11.9 1K	R32 1K	
	R41.3 ...	
	G43....	
	N40....	
	M54.9...	
	F41....	
	G47....	
	J06....	
	I50.9...	
	F17....	
	M25....	
	R30....	
I10 1K	R35.0 1K	
	F32.A 0K	
	G89.29 0K	
	I25.10 0K	
	I48.91 ...	
	E87.6 ...	
E03.9 1K		
J44.9 1K	I11.0 0K	



# Medical Necessity Denials

- Provider documentation



Blue Mountain Hospital

Medical Necessity Denials (EXTERNAL)

1/1/2023

9/16/2024

proccode

All

80061 82306 82728 83036 83540 84443 85025 87086

National Coverage Determinations

190.21B - Glycated Hemoglobin/Glycated ...

ICD Codes covered by Medicare

E1010 - Type 1 diabetes mellitus with keto...  
E109 - Type 1 diabetes mellitus without co...  
E1110 - Type 2 diabetes mellitus with keto...  
E1121 - Type 2 diabetes mellitus with diab...  
E1122 - Type 2 diabetes mellitus with diab...  
E113593 - Type 2 diabetes mellitus with pr...  
E1140 - Type 2 diabetes mellitus with diab...  
E1142 - Type 2 diabetes mellitus with diab...  
E1143 - Type 2 diabetes mellitus with diab...  
E1151 - Type 2 diabetes mellitus with diab...  
E11621 - Type 2 diabetes mellitus with foo...  
E11622 - Type 2 diabetes mellitus with oth...  
E11628 - Type 2 diabetes mellitus with oth...  
E11649 - Type 2 diabetes mellitus with hy...  
E1165 - Type 2 diabetes mellitus with hyp...  
E1169 - Type 2 diabetes mellitus with othe...  
E118 - Type 2 diabetes mellitus with unsp...  
E119 - Type 2 diabetes mellitus without co...  
E13621 - Other specified diabetes mellitu...  
E162 - Hypoglycemia, unspecified  
O24913 - Unspecified diabetes mellitus in ...  
R7301 - Impaired fasting glucose  
R7303 - Prediabetes  
R7309 - Other abnormal glucose  
R739 - Hyperglycemia, unspecified  
R7989 - Other specified abnormal findings...  
R799 - Abnormal finding of blood chemistr...

ICD codes denied

Z0000 - Encounter for general adult medical e...  
Z0001 - Encounter for general adult medical e...  
Z020 - Encounter for examination for admissi...  
Z1159 - Encounter for screening for other viral...  
Z117 - Encounter for testing for latent tubercul...  
Z130 - Encounter for screening for diseases o...  
Z1321 - Encounter for screening for nutritional...  
Z13220 - Encounter for screening for lipoid di...  
Z13228 - Encounter for screening for other m...  
Z1329 - Encounter for screening for other sus...  
Z1389 - Encounter for screening for other dis...  
Z139 - Encounter for screening, unspecified  
Z833 - Family history of diabetes mellitus

ICD codes that do not support medical necessity

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## A1C

CPT: 83036		CPT: 83036	
E11.9	Type 2 diabetes mellitus without complications	E11.69	Type 2 diabetes mellitus with other specified complication
E11.65	Type 2 diabetes mellitus with hyperglycemia	E13.621	Other specified diabetes mellitus with foot ulcer
Z79.899	Other long term (current) drug therapy	R79.89	Other specified abnormal findings of blood chemistry
Z79.4	Long term (current) use of insulin	Z79.85	Long-term (current) use of injectable non-insulin antidiabetic drugs
E11.22	Type 2 diabetes mellitus with diabetic chronic kidney disease	E10.9	Type 1 diabetes mellitus without complications
R73.03	Prediabetes	E11.8	Type 2 diabetes mellitus with unspecified complications
Z79.84	Long term (current) use of oral hypoglycemic drugs	E16.2	Hypoglycemia, unspecified
E11.10	Type 2 diabetes mellitus with ketoacidosis without coma	E10.10	Type 1 diabetes mellitus with ketoacidosis without coma
E11.40	Type 2 diabetes mellitus with diabetic neuropathy, unspecified	E11.52	Type 2 diabetes mellitus with diabetic peripheral angiopathy with gangrene
E11.42	Type 2 diabetes mellitus with diabetic polyneuropathy	E11.628	Type 2 diabetes mellitus with other skin complications
E11.621	Type 2 diabetes mellitus with foot ulcer	O24.913	Unspecified diabetes mellitus in pregnancy, third trimester
E11.649	Type 2 diabetes mellitus with hypoglycemia without coma	Z87.820	Personal history of traumatic brain injury
R73.9	Hyperglycemia, unspecified	Z79.891	Long term (current) use of opiate analgesic
Z13.1	Encounter for screening for diabetes mellitus		

## Order Reasons

### Common Order Reasons for Labs

- A1C Lab
  - Pre-surgery screening for diabetes to inform care under surgery
  - Z13.1: Encounter for screening for diabetes mellitus
  - Most Z codes are not coded as primary because most insurances don't accept them
- EKG
  - Pre-surgery screening to ensure the patient is safe for anesthesia and surgery
  - Z01.818: Encounter for other preprocedural examination
  - Most Z codes are not coded as primary because most insurances don't accept them
  - With more specificity, many other codes are covered
- BNP
  - Ordered if the patient has lower extremity edema
  - R60.1: Generalized edema
  - Condition as to be specified because there are also "unspecified" edema codes that are NOT covered
- Drug test
  - Sometimes ordered on patients as part of a psychiatric panel if there are suicidal ideations
  - T14.91XA/D: Suicide attempt initial encounter/subsequent encounter
  - Z51.81: Encounter for therapeutic drug level monitoring
  - Some codes for Poisoning by () or Abuse of ()
  - Doesn't list chest pain, but there are other codes for tachycardia



# Hospital Registration Denials

Claim\_InsID

All

1/1/2023

8/5/2025

542

Registration Denials

37K

Total Claims

1.5%

% Registration Denials

\$1M

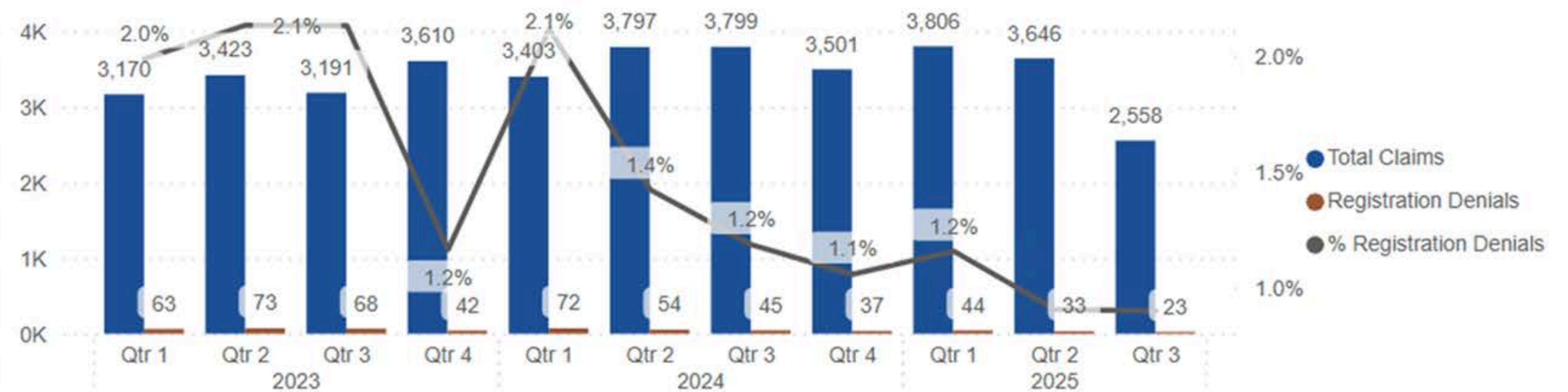
Registration Denied AMT

Total Payment for Registration Denied Amount



svc dprtmnt	Total Claims	Registration Denials	% Registration Denials
Emergency	7,366	163	2.2%
Outpatient Services	10,517	122	1.2%
OP Lab/Rad	10,788	102	0.9%
Med/Surg	1,734	46	2.7%
Surgery	3,538	46	1.3%
Labor & Delivery	720	25	3.5%
Observation	812	17	2.1%
OP Infusion Therapy	523	10	1.9%
Sleep Study	503	5	1.0%
OP Clinic	133	3	2.3%
Swingbed	122	3	2.5%
<b>Total</b>	<b>36,756</b>	<b>542</b>	<b>1.5%</b>

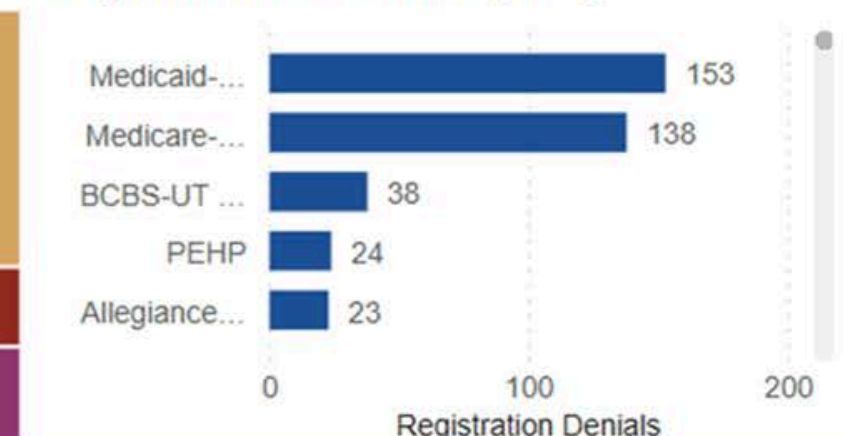
## Registration Denials over time



## Registration Denials by Department



## Registration Denials by Payer



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Version: 0.0.0



# Registration Denials

Training documentation

Blue Mountain Hospital	Protocol: Patient Registration
Protocol Number:	Department: Copy to:
Effective Date:	Developed By: Cari Spillman, Denise Arthur
Utah State Code:	Admin. Approval:
Federal Code:	EOCC Approval:
Page 1 of 1	Reviewed By: Date:

## PROTOCOL: Patient Registration

Blue Mountain Hospital will have a process to manage and standardize the registration process when patients present at the Front Desk or the ER. The process will be as follows:

1. Patient presents to Front Desk or window at ER.
2. Registration staff (RS) asks patient name and date of birth or SSN.
3. Returning patient: RS looks up patient in EMR starting with birth date, SSN, and then name. RS asks patient each demographic question in admissions and updates any changes. RS prints facesheet, gives to patient to verify and sign.
4. New patient: fills out demographic sheet. Explain each item as needed. RS staff enters demographic information into prognosis.
5. RS explains each section of the Consent To Treat answering all patient questions. Each patient must sign a Consent each visit.
6. Offer patient copies of POLST, Privacy Notification or Rights and Responsibilities. Give patient requested information.
7. Notify Patient of Healthcare Assistance Program (HAP). Offer patient copy of plain language HAP information.
8. Use Coordination of Benefits Guidelines to determine correct insurance.
9. If insurance is added after the visit is created, verify the insurance is in the MPI and also in current visit.
10. Create a visit in Prognosis. Answer Legal question and verify if POLST information was given.
11. Native American Patients need to complete and sign a Purchased/Referred Care (PRC) form.
12. Outpatient ancillary: do not create a visit unless you have a copy of the referral, and consent.
13. Make a copy of ID, and Insurance card. If patient did not bring either item, instruct them that they need to get a copy of each to the front desk within 24 hours. Provide card with BMH phone and fax number.

### ER:

1. Attach Registration checklist to packet and fill out correctly.
2. Completed packet and outpatient referrals go into bin for front desk to pick up.
3. Print patient labels, label first three pages of ER charge sheets. Also label the entire Registration packet. Leftover patient labels go to ER nurse, and armband goes on patient.

### Front Desk:

1. For ER visit- Front desk picks up paperwork in the ER, and verifies information in packets is entered correctly into Prognosis. Any paperwork with ancillary referrals scan into patients chart.
2. Any other visit- front desk already has paperwork, verify information is correct.
3. Scan in paperwork, do not shred until verification of upload into Prognosis is verified by another registration technician.





# Poll Question

What is change management?

- a. Implementing process change
- b. Communicating best practices to staff
- c. Coordinating across billing, providers, administration etc.
- d. All of the above





# How to Facilitate Change

## Change Management

**Leadership:** Executive Sponsorship– how does decision making and culture change work in the organization.

**Change Agent:** Right level of engagement. Communicating with the right person who can facilitate change

**Culture:** When we using data to show variability around a workflow we are scrutinizing with attribution. There needs to be a safe culture to explore these ideas.

**Data:** Having data that accurately represents a workflow

**Knowledge:** Having the right knowledge to create shared understanding between teams.

**Communication:** Who needs to be trained and how can it be rolled out?





# Change Management

- Who is best to facilitate change? Everyone
  - Executive Administration
    - Establish a culture of change
  - Department Level Leadership
    - Trust already exists within established teams
  - Third Party objective view with data
    - Let data drive those performing well to establish best practices

ORDERING_PROVIDER	Denial Amount	Denied Claims	Claims	% Denied Claims
	\$9,441	35	1,855	1.9%
	\$6,227	24	1,712	1.4%
	\$34,614	27	1,060	2.5%
	\$6,623	22	891	2.5%
	\$9,102	5	759	0.7%
	\$1,035	5	633	0.8%
	\$2,609	5	605	0.8%
	\$9,977	5	544	0.9%
	\$3,878	12	525	2.3%
	\$4,368	7	416	1.7%
	\$586	3	248	1.2%
			161	
	\$120	1	158	0.6%
	\$2,360	6	156	3.8%
	\$610	3	127	2.4%
	\$1,207	8	120	6.7%
			107	
			83	
			78	
			77	
			77	
	\$749	1	76	1.3%
			76	
			70	
			62	
<b>Total</b>	<b>\$107,362</b>	<b>219</b>	<b>12,042</b>	<b>1.8%</b>





# How do we know change will last?

Change Management without good data is difficult

If you don't have a good data steward and a good understanding of what the data represent, lasting change cannot be sustained

Measurement is one way we can ensure longevity

# How do we know change will last?

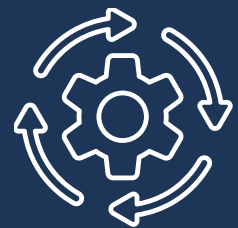
Determine baseline period and measures tracked

- # Denials, % Denials

Implement intervention

Compare before and after the Intervention: simple (communication)

Quantify improvement







# Denials by Reason Code

total charge unpaid per code

ENCOUNTER\_T...

Multiple selections

Date

1/1/2024

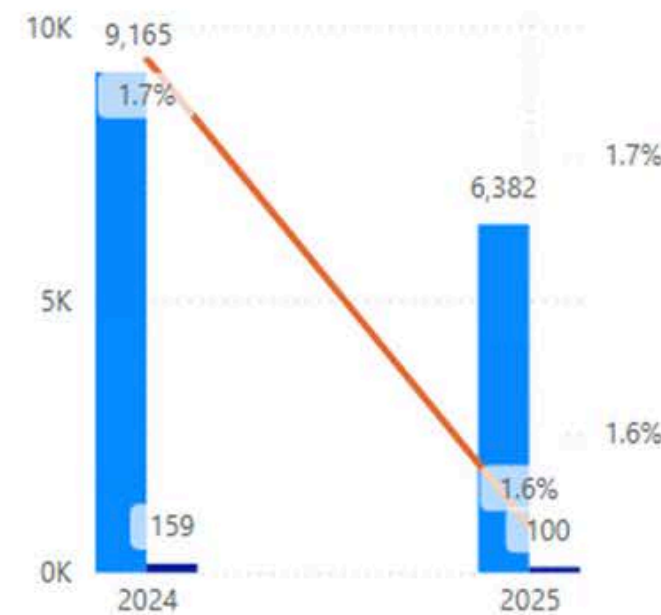
9/26/2025



ORDERING_PROVIDER	Denial Amount	Medical Necessity Denials	Claims	Med Necessity % Denials
	\$10,523	40	2,454	1.6%
	\$9,761	33	2,354	1.4%
	\$35,335	28	1,296	2.2%
	\$6,623	22	901	2.4%
	\$6,004	17	706	2.4%
	\$13,960	9	799	1.1%
	\$6,320	9	151	6.0%
	\$3,243	7	177	4.0%
	\$21,170	7	948	0.7%
	\$4,368	7	515	1.4%
	\$1,332	6	779	0.8%
	\$2,609	5	611	0.8%
	\$3,177	5	31	16.1%
	\$927	5	422	1.2%
	\$610	3	116	2.6%
	\$638	3	3	100.0%
	\$250	3	21	14.3%
	\$287	2	10	20.0%
	\$1,088	2	8	25.0%
	\$197	2	41	4.9%
	\$231	2	8	25.0%
	\$591	2	33	6.1%
	\$515	2	6	33.3%
	\$118	2	21	9.5%
	\$1,270	2	3	66.7%
<b>Total</b>	<b>\$140,570</b>	<b>259</b>	<b>15,543</b>	<b>1.7%</b>

## Denied Claims by Year and Month

Claims Medical Necess... Med Necess...



PROCEDURE_CD (groups)	Denied Claims	Denial Amount	Claims
<b>Intervention</b>	<b>172</b>	<b>\$99,386</b>	<b>6,515</b>
83880 - Natriuretic p...	39	\$10,196	386
84443 - Thyroid stim...	26	\$4,393	1,538
84153 - Prostate spe...	25	\$4,925	358
80061 - Lipid panel ...	22	\$4,152	1,083
83036 - Hemoglobin...	21	\$2,741	784
85025 - Blood count...	20	\$2,541	4,694
70450 - Computed t...	16	\$44,348	780
87086 - Culture, bac...	16	\$1,804	631
83540 - Iron	12	\$1,582	209
83540 - ASSAY OF IR...	11	\$1,320	196
72125 - Computed t...	8	\$21,383	350
<b>Other</b>	<b>122</b>	<b>\$41,185</b>	<b>15,341</b>
<b>Total</b>	<b>259</b>	<b>\$140,570</b>	<b>15,543</b>

## Denied Claims by Year and Month







# Denials

connecting services and denial codes to physicians

Dept

All

Date

1/1/2024

12/15/2025

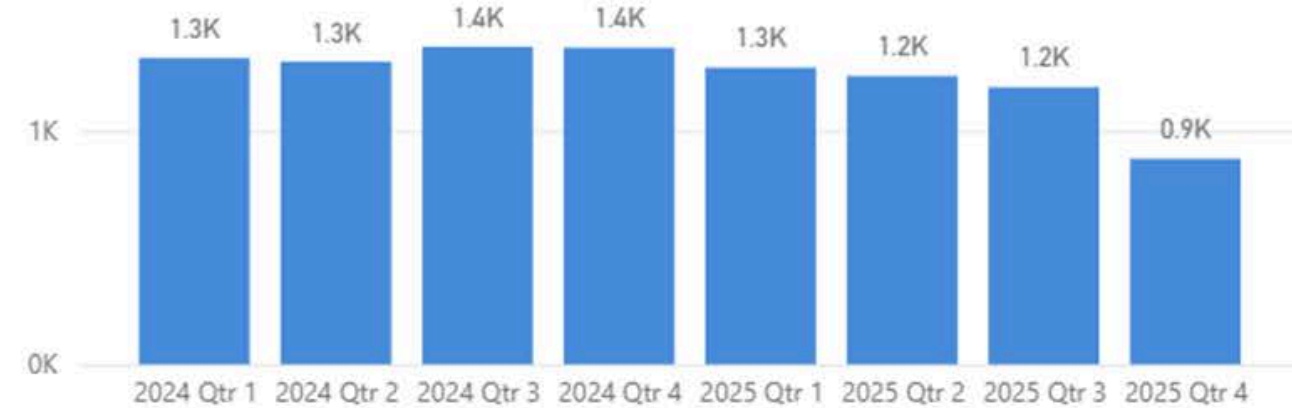
## Registration Denials by Payor

Financial Class	Claims	Registration Denials	% Registration Denial
Commercial	7,759	127	1.6%
Medicare	3,856	27	0.7%
MEDICARE	2,326	26	1.1%
MEDICARE A -OP	895	1	0.1%
UHC AARP MEDICARE ADVAN	144		
MEDICARE -O/P	58		
CIGNA MEDICARE SUPPLEMENT	52		
UHC MEDICARE ADVANTAGE -O	51		
AETNA MEDICARE-OP	43		
MEDICARE -O/P	42		
UHC AARP MEDICARE ADVANTA	39		
MEDICARE -O/P	30		
Total	9,891	165	1.7%

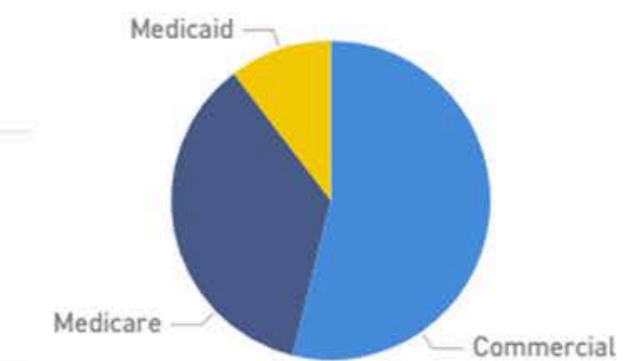
## Registration Denials by Category

Denial Category	Registration Denials	% Registration Denial
Eligibility	165	1.7%
31-Patient cannot be identified as our insured.	98	1.0%
27-Expenses incurred after coverage terminate...	50	0.5%
26-Expenses incurred prior to coverage.	12	0.1%
272-Coverage/program guidelines were not m...	3	0.0%
149-Lifetime benefit maximum has been reach...	1	0.0%
177-Patient has not met the required eligibility...	1	0.0%
200-Expenses incurred during lapse in coverage	1	0.0%
32-Our records indicate that this dependent is...	1	0.0%
Total	165	1.7%

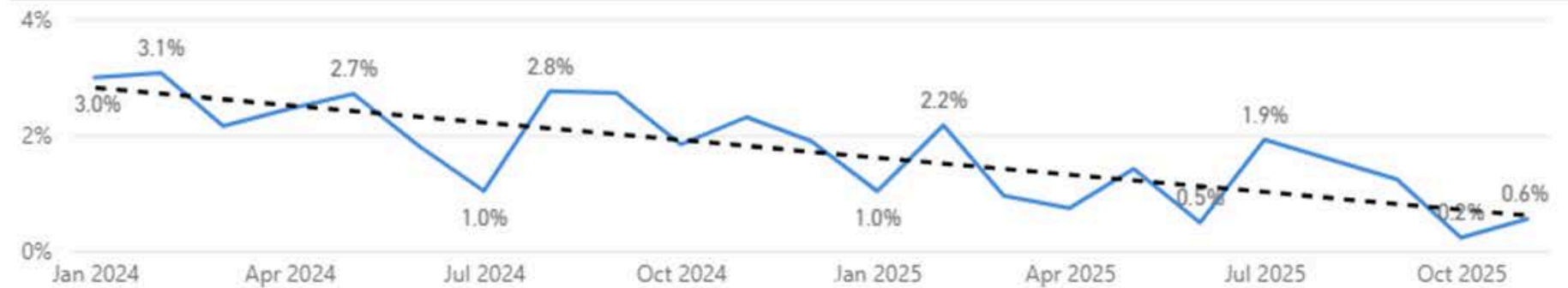
## Total Claims



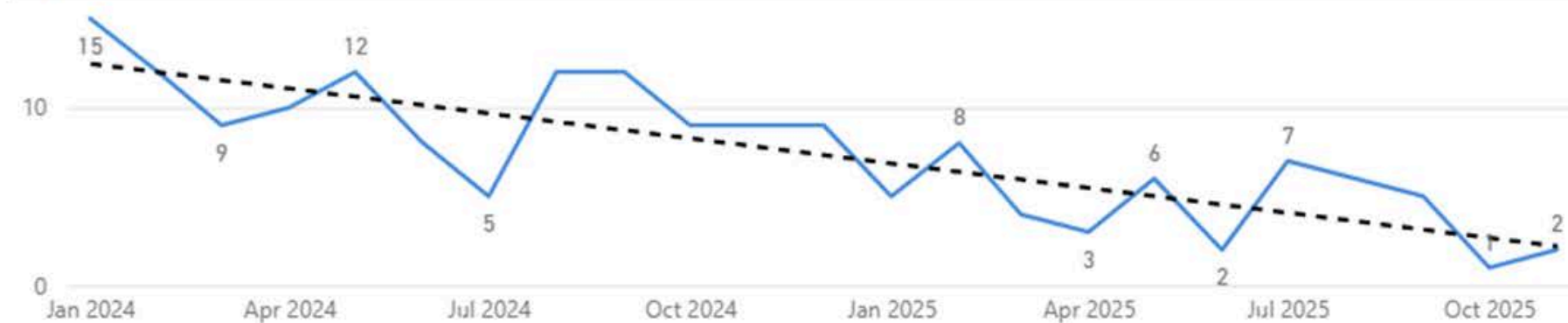
## Payor Mix



## Denial Ratio



## Registration Denials







# Registration Denials

connecting services and denial codes to registrars

\$534.55K

Detail Denied Amount

Date

1/1/2024

12/15/2025



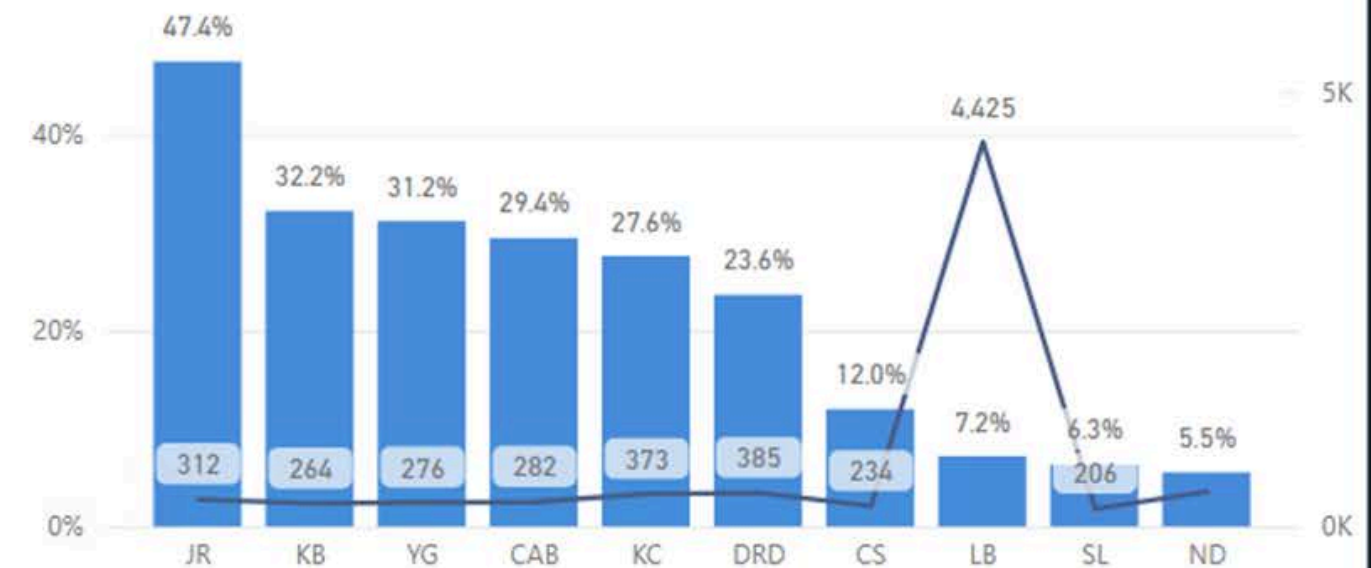
AdmitInitials

All

AdmitInitials (groups)	Registration Denials	Claims	% Registration Denial	Claims with Errors	Total Errors	% Claims with Errors	Denied Amount
Par Registration	58	5,320	1.1%	522	536	9.8%	\$111,715.35
Acute ER Observation	79	3,481	2.3%	929	1,009	26.7%	\$369,926.24
Business Office	26	950	2.7%	76	79	8.0%	\$46,203.86
Physical Therapy	2	137	1.5%	23	24	16.8%	\$6,705.95
(Blank)		3		3	3	100.0%	
<b>Total</b>	<b>165</b>	<b>9,891</b>	<b>1.7%</b>	<b>1,553</b>	<b>1,651</b>	<b>15.7%</b>	<b>\$534,551.40</b>

% Claims with Errors and Claims by AdmitInitials

% Claims with Errors Claims



Denials Trend

Claims Registration Detail Denials % Registration Detail Denial



Subcategory

	DUPLICATE	INCORRECT	MISSING	Total
GUARANTOR/SUBSCRIBER NAME		190	207	397
PRIMARY INSURANCE	28	213	117	358
SECONDARY INSURANCE	1	58	106	165
ER LEVEL CHARGE	6	3	139	148
CONSENT		1	70	71
ADDRESS		58	8	66
GROUP #		13	40	53
PHONE #		14	38	52
DISCHARGE CODE		39	7	46
CHIEF COMPLAINT		2	43	45
INSURANCE		43		43
REGISTRATION LOCATION		27	14	41
WITNESS			37	37
<b>Total</b>	<b>1</b>	<b>44</b>	<b>709</b>	<b>897</b>





# Registration Denial Improvement

Date

1/1/2024

12/15/2025

\$255,937

Improved AR

\$11,850

Re-work Savings

\$267,787

Total Impact

-64.75%

% Decrease

Rework Rate

150

Rework Hours

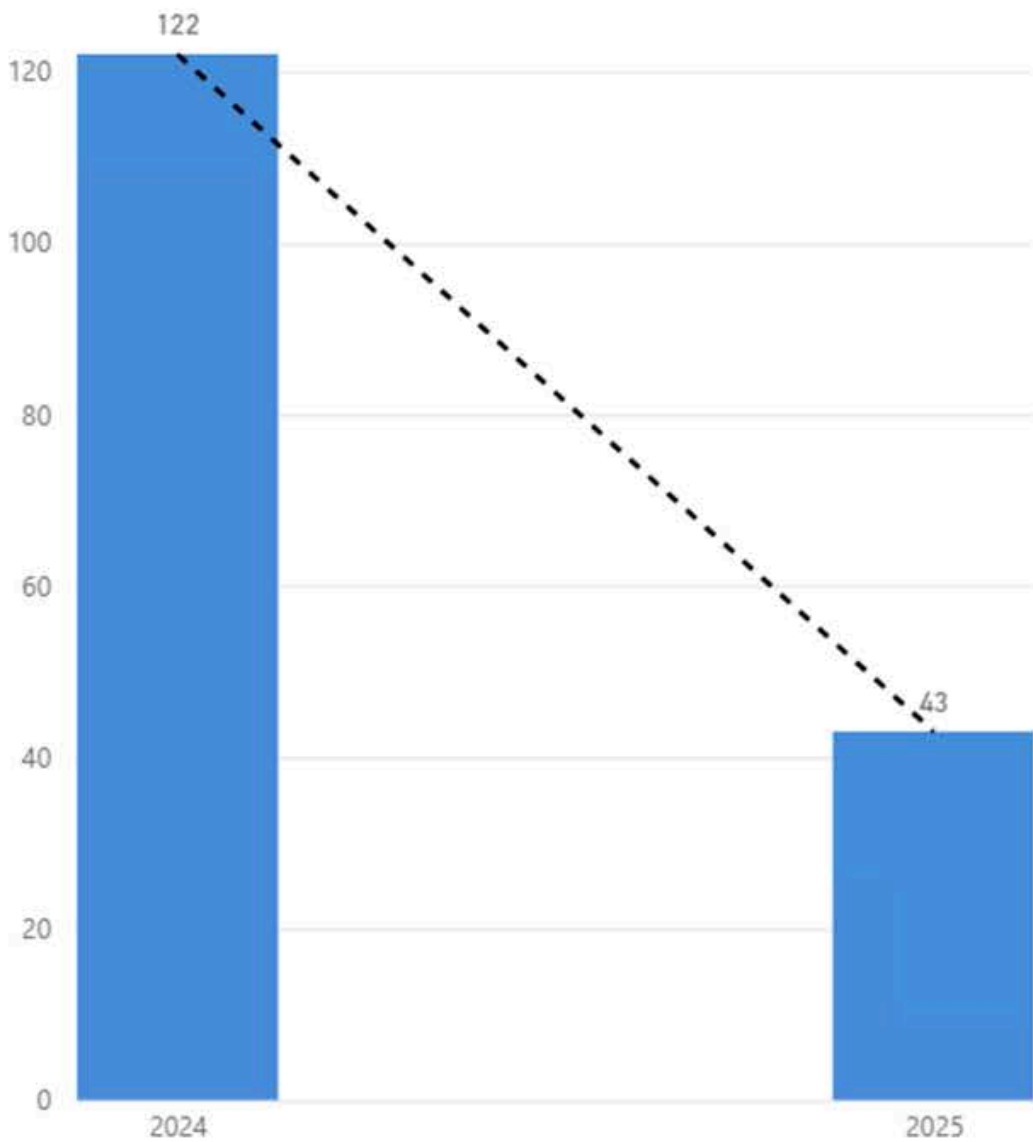
1

79

Decreased Denials

	2024	2025	Total
Claims	5,321	4,570	9,891
Registration Denials	122	43	165
% Registration Denial	2.3%	0.9%	1.7%
% Decrease		-64.75%	
Avg Denied Amount	\$3,176	\$3,421	\$3,240

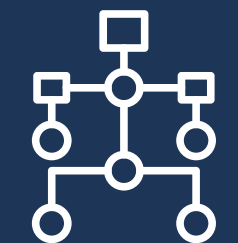
Registration Denials





# Drill Down on New Opportunities

- Service Line Profitability







# Mammo

HEALTH\_PLAN

ProcKey

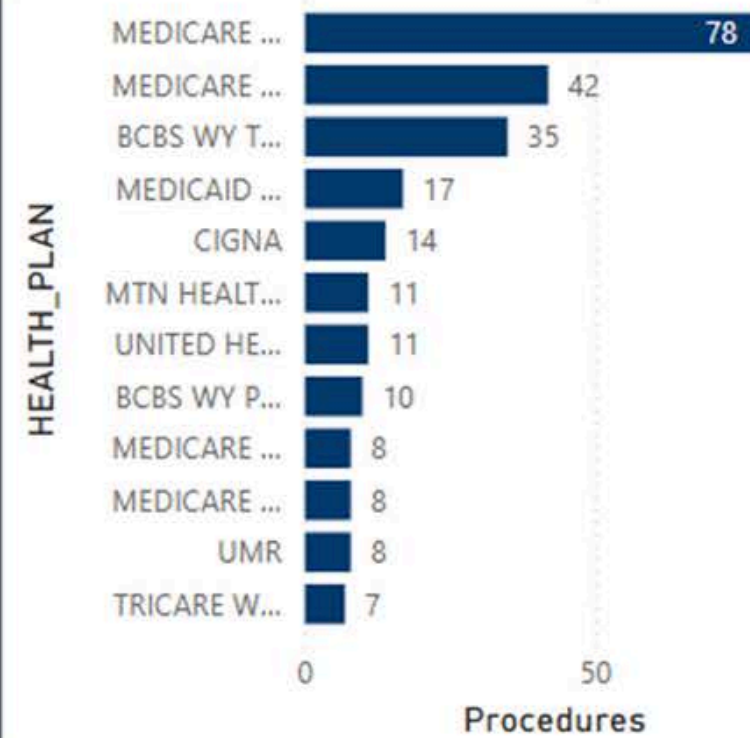
Date

1/1/2024

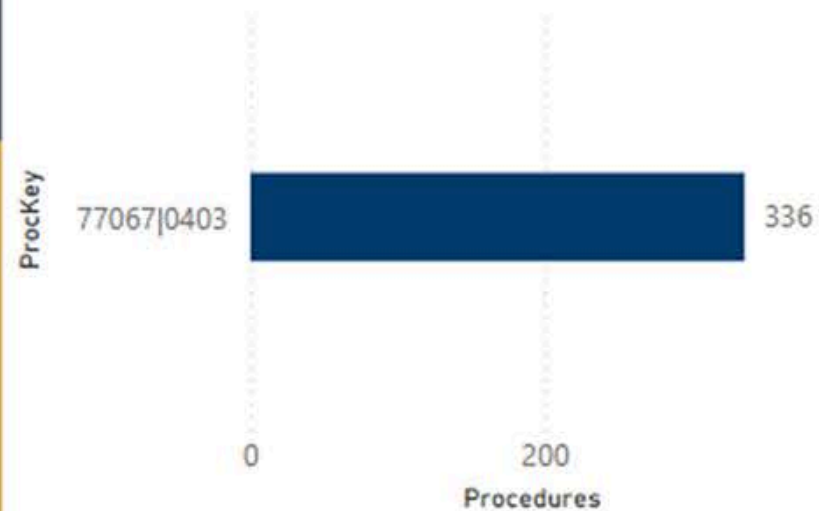
10/29/2025



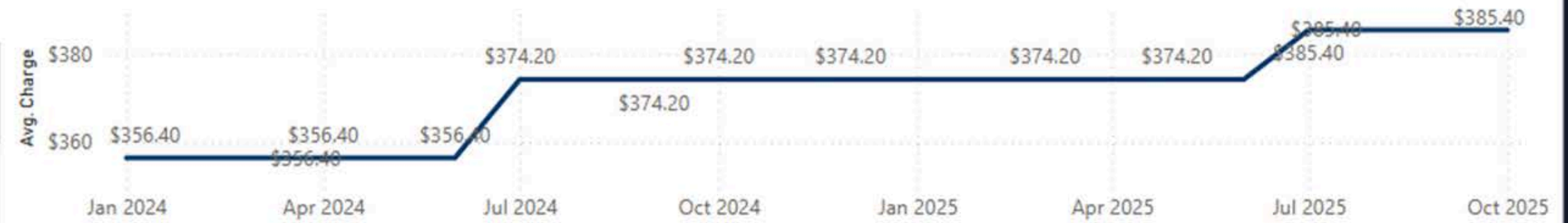
## Procedures by HEALTH\_PLAN



## Procedures by ProcKey



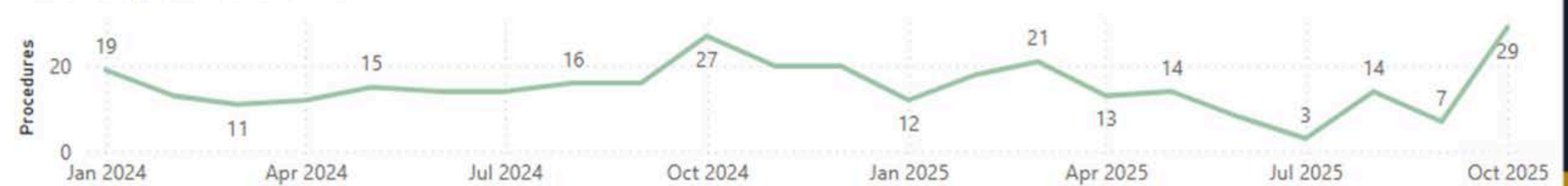
## Avg. Charge by Year and Month



## Avg. Paid by Year and Month



## Volume by Year and Month



## Details

FIN	HEALTH_PLAN	PROCEDURE_CD	PROCEDURE_DSC	REVENUE_CODE	REVENUE_CODE_DESCRIPTION	Charges	Sum of TOTAL_PAID	Estimated Proc Paid
Total						\$101,056.8	(\$118,815.6)	\$87,112.36

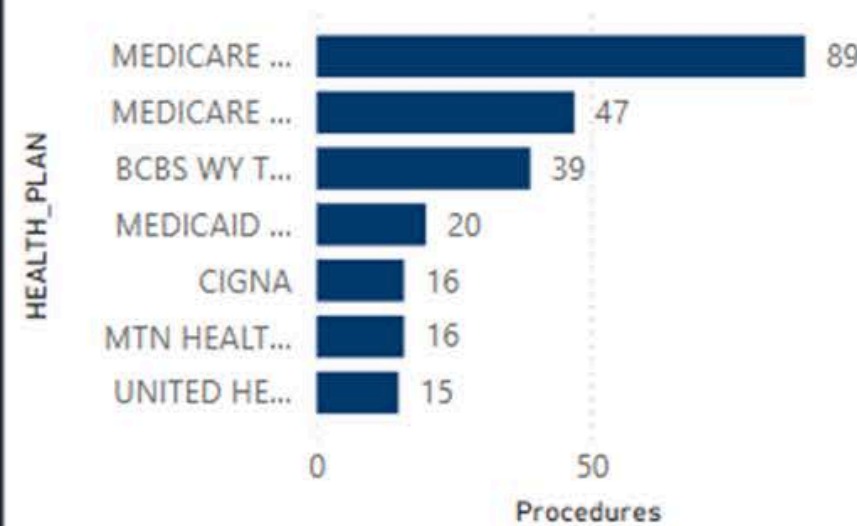




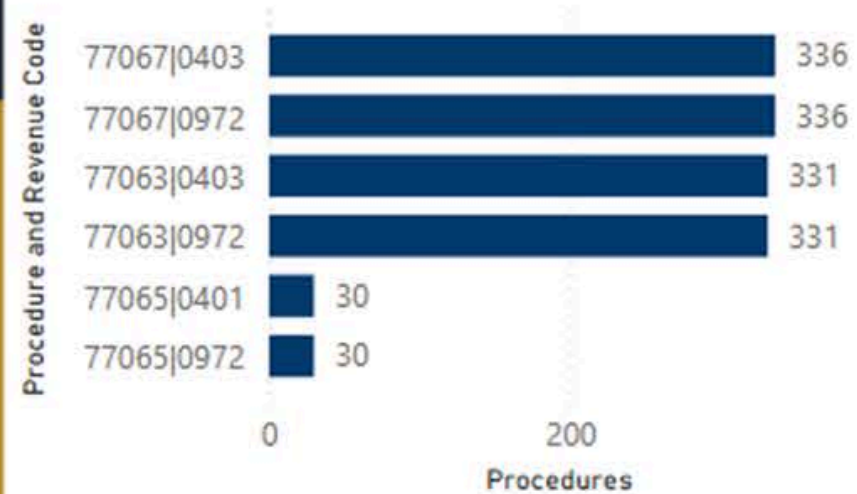
(\$4,753)

Net Profitability

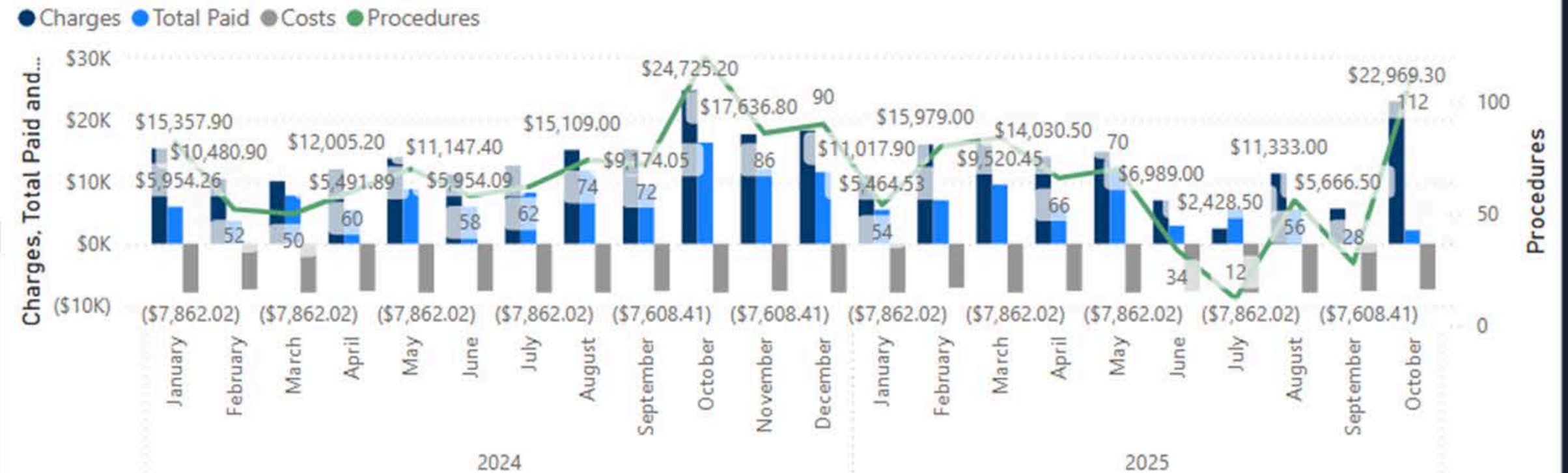
Procedures by HEALTH\_PLAN



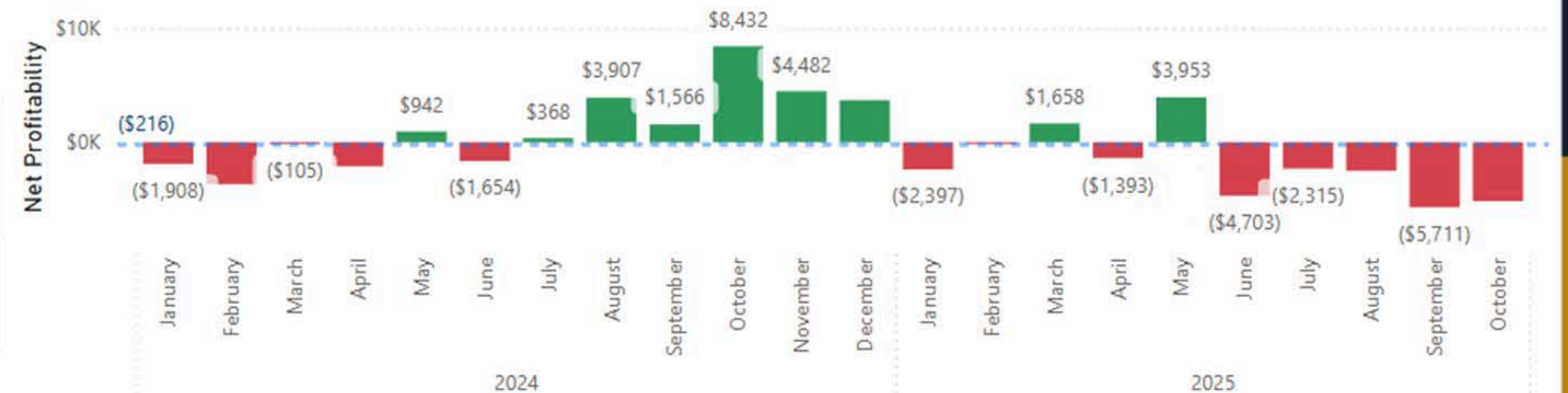
Procedures by Procedure and Revenue Code



Charges, Total Paid, Costs and Procedures by Year and Month



Net Profitability by Year and Month





# Expected Lift

- Core client team provides
  - 1-2 stewards over workflow + REDi
  - Participation in 2 weekly meetings (45-60 min)
  - Domain knowledge re: workflow/documentation
- REDi provides
  - Analytics
  - Project management
  - Data literacy training
  - Change management facilitation and training



## Weekly Project Check In

Recurring weekly 1-hour work sessions

- **Agenda:**
  - Review project updates
  - Tasks completed this week
  - Tasks planned for next week
  - Review key risks/blocking factors and propose mitigation
  - Surface escalations
- **Attendees:**
  - Client Program and Project Managers
  - Client SMEs
  - Owned by [TBD]

## Executive Strategic Partnership Review

Recurring monthly or bimonthly 15-20-minute meetings

- **Agenda:**
  - Brief and concise (15-20 min)
  - Strategic not tactical
  - Maintain continued engagement with [client] business owner/sponsors
  - Escalate key items needing business sponsorship/exec involvement to address
  - Foster alignment and forward motion
  - Expand influence and speed up impact (accelerate adoption)
- **Attendees:**
  - Owned by client engagement lead
  - Program Manager
  - Executive sponsor(s)





# Questions or Comments?

Get In Touch!



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# Thank you!

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