A Groundbreaking Strategy to Overcoming Healthcare Denials

June 19, 2025

HOST

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VP of Medical Affairs

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TOPIC HIGHLIGHTS

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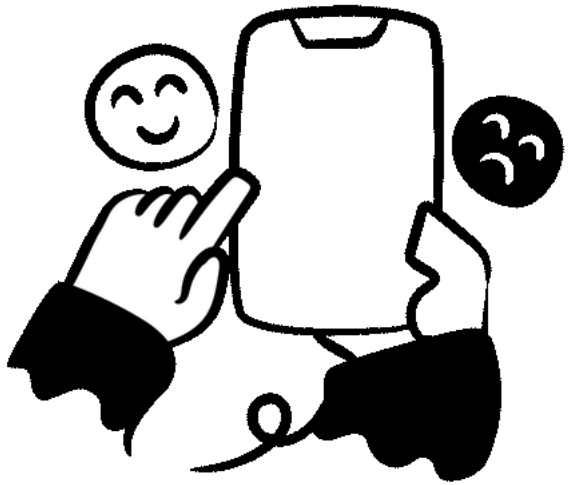
IT'S TIME FOR A POLL!

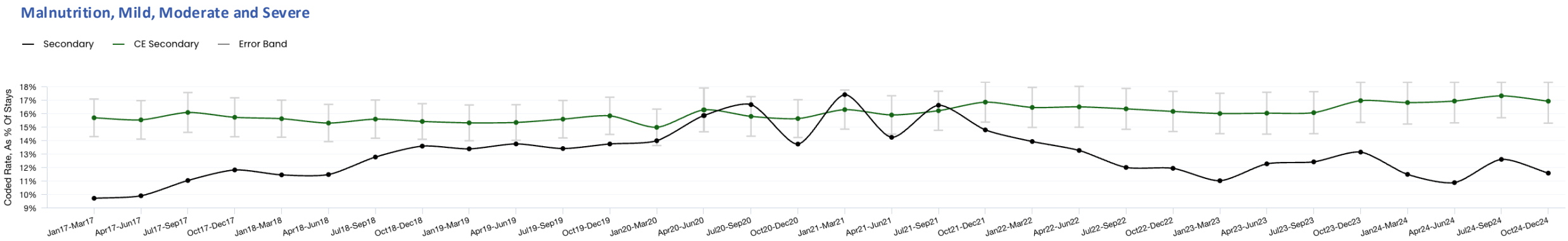


The Cost from Insufficient Documentation

$5M+/year average lost revenue per hospital from denied claims (Advisory Board, 2023)

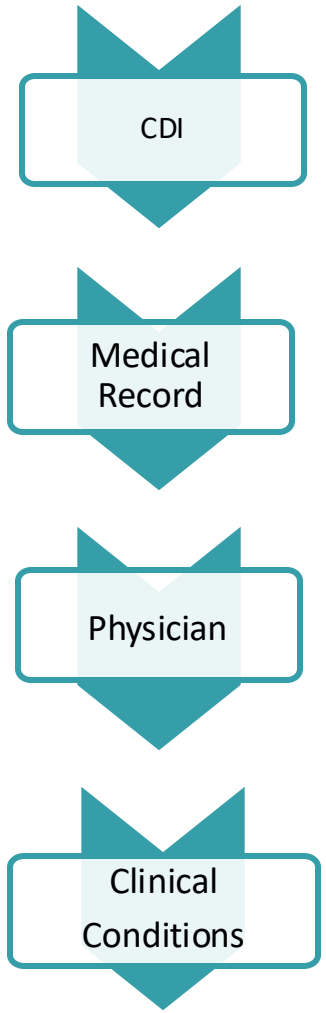
ROOT CAUSE: Insufficient documentation

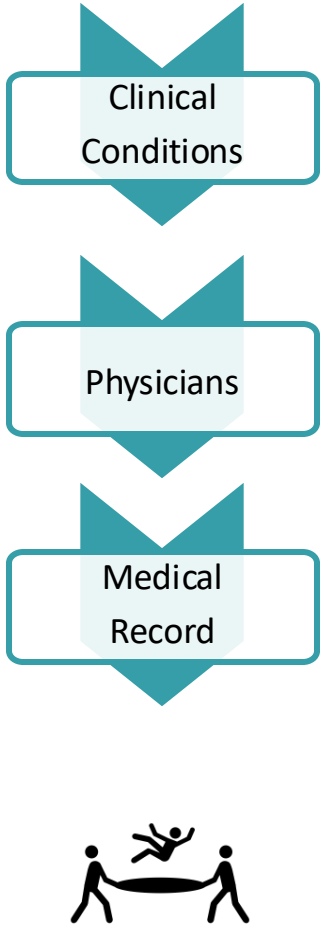
- Unspecified Diagnoses > Not Medically Necessary
- Missing Evaluation/Management Linkage > Patient Status
- Incomplete-Condition Capture > DRG Downgrades
- Delayed or Unanswered Queries > Missed Severity Capture Opportunity

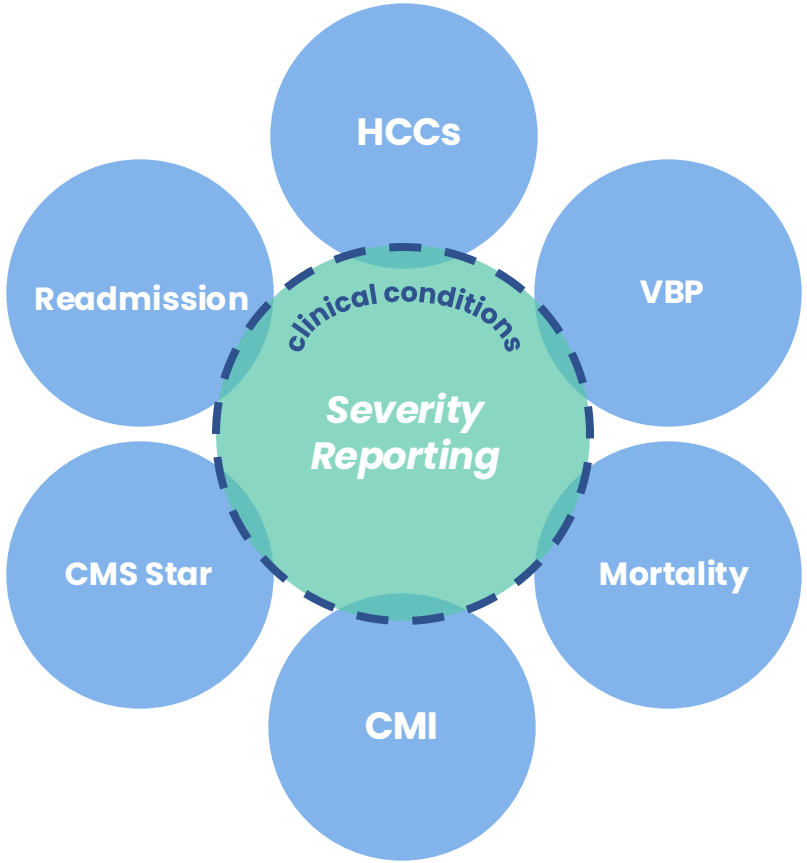


Claim Denials = Missed Revenue + Risk Adjustment Value + Higher Admin Burden

The Problem Isn't Physician Skill



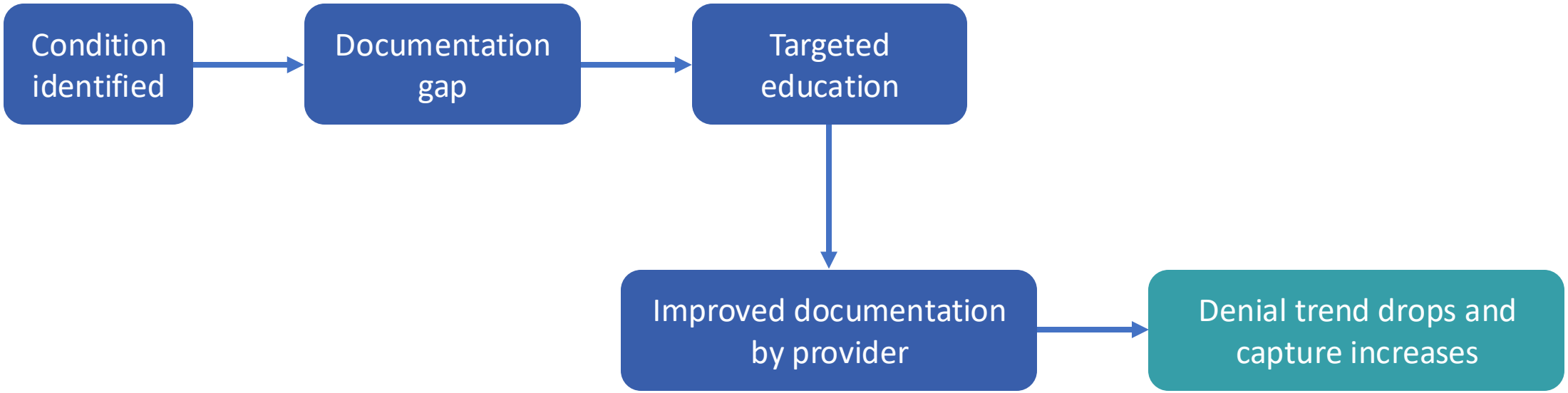




DRG Downgrades Miss the Forest *and* the Trees

DRG-Level Tracking	Condition-Level Tracking
Looks at the final outcome	Track condition reporting gaps and denials
Tied to payment analytics/billing categories, not clinical practice	Tied to documentation behavior change opportunity
Non-actionable feedback for the source of documentation	Physicians have targeted severity documentation goals (80/20)
Supports reactive defense	Supports proactive defense

Documentation Practices Drive Denial Prevention



The Inefficiency of Appeals: Band-Aid vs. Cure

Insufficient Documentation at Point of Care

- Lacking specificity
- Lacks E/M documentation
- Failure to capture severity

Denied Claim

- DRG Downgrade
- CC/MCC rejection
- Cannot validate diagnosis rationale

Manual, Costly Appeals Process

- Chart review and record requests
- Nurse CDI and Physician time
- Administrative overhead and resubmissions
- Success rate often <60% even with good documentation

Financial and Operational Loss

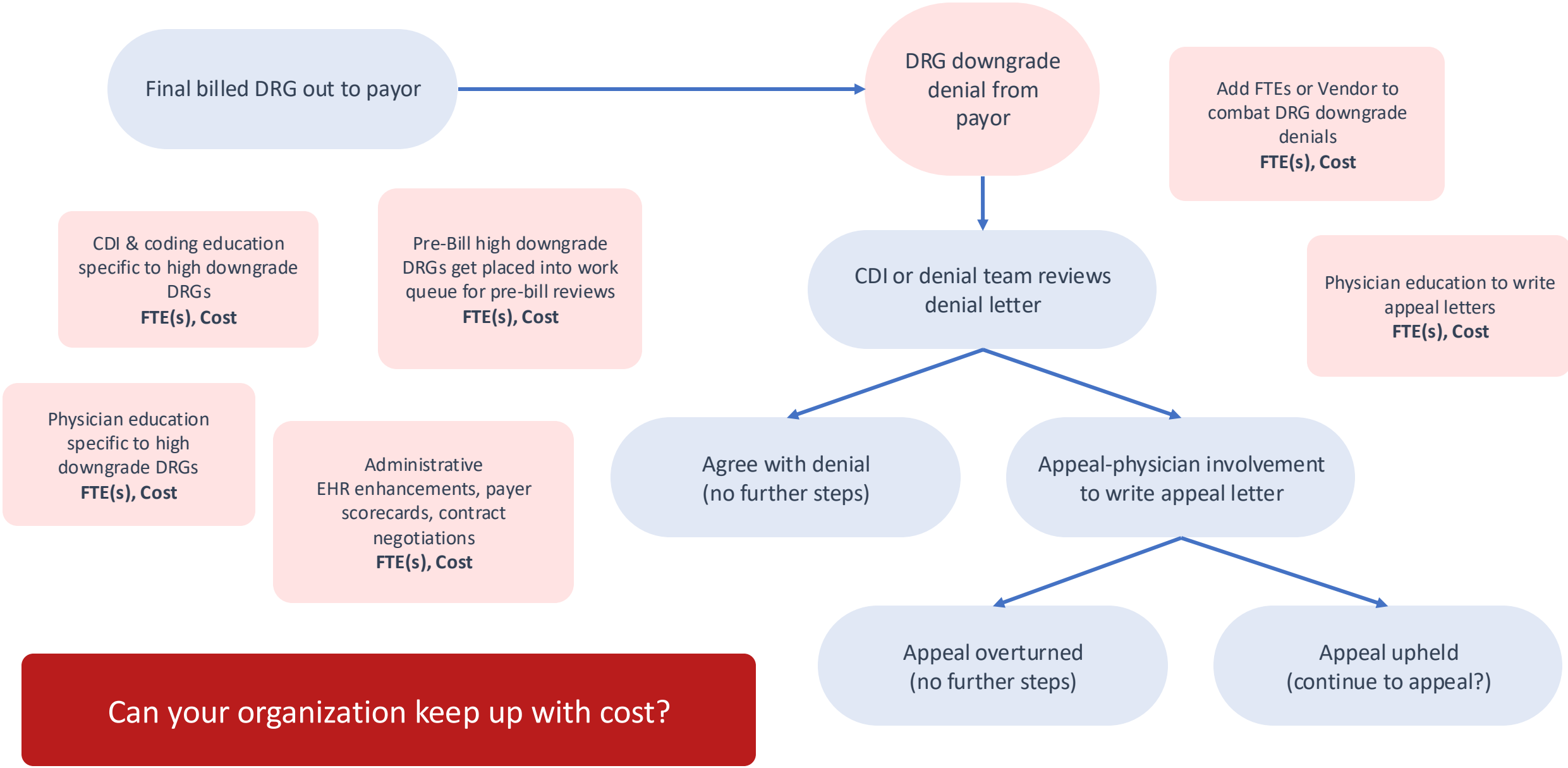
- Delayed or lost revenue
- Increased cost per claim
- Burnout and wasted FTE capacity
- Opportunity cost with teams spending time defending vs. true improvement

The Denials – Appeal Trap

- $118 per appeal (avg. admin cost per claim)
- Takes approx. 20–60 minutes per denial to investigate
- Denials recur if behavior doesn't change
- High staffing costs: appeals teams, auditors
- Success rate: <50% on appealed claims
- Outcome: Payer wins by default

Appeals = Financial Cost + HR Burden + Time to Resolution + Impact on Outcomes

Claim Denials = Missed Revenue + Risk Adjustment Value + Higher Admin Burden



Can your organization keep up with cost?

Most Challenged Diagnoses by Payors

- **Sepsis** (all variants)
  - Payors often question whether clinical criteria are met
- **Respiratory Failure** (acute, chronic, or combined)
  - Denials arise when documentation lacks clear clinical findings or support for specific code selection
- **Acute Kidney Injury (AKI)**
  - Typically denied when documentation doesn't cite KDIGO lab thresholds or diagnostic reasoning
- **Encephalopathy**
  - Often denied due to vague descriptors or missing supporting exam or metabolic data
- **Malnutrition**
  - Submissions are rejected if provider notes lack clinical justification or validation
- **Pneumonia (notably aspiration pneumonia)**
  - Denied when documentation does not show consistency in the findings or sometimes choice of treatment

The Cost of Physician Variability in Condition Definitions

AKI:

- Dr. A documents AKI based on creatinine rise

- Dr. B insists that he needs nephrology consultation first
- Dr. C never documents AKI unless dialysis is discussed or previously documented by a peer

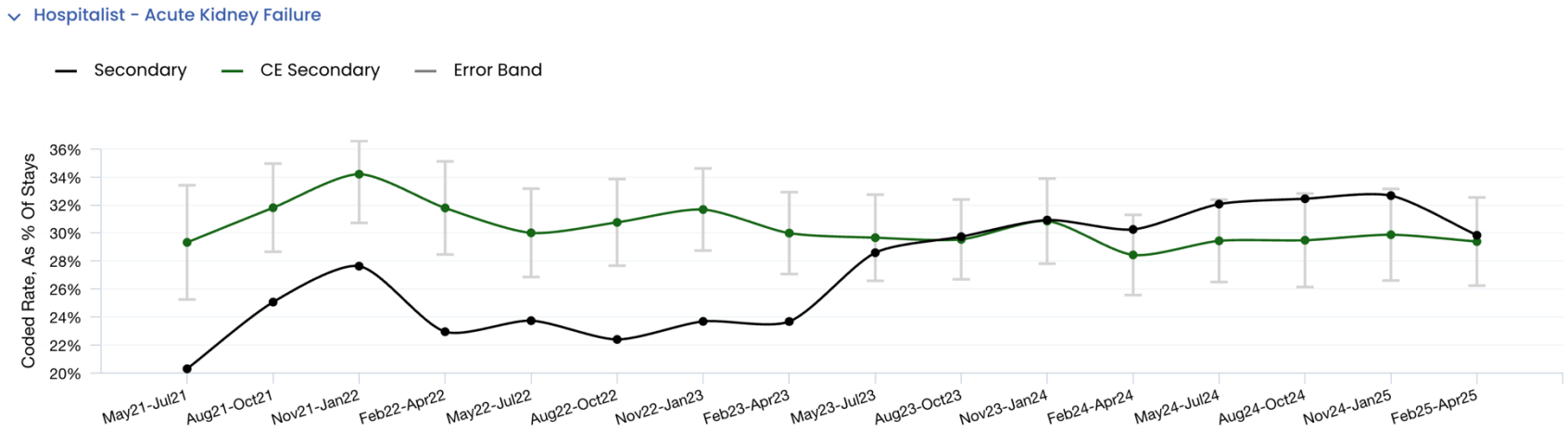
❌ **None of them know which "baseline" creatinine to reference**

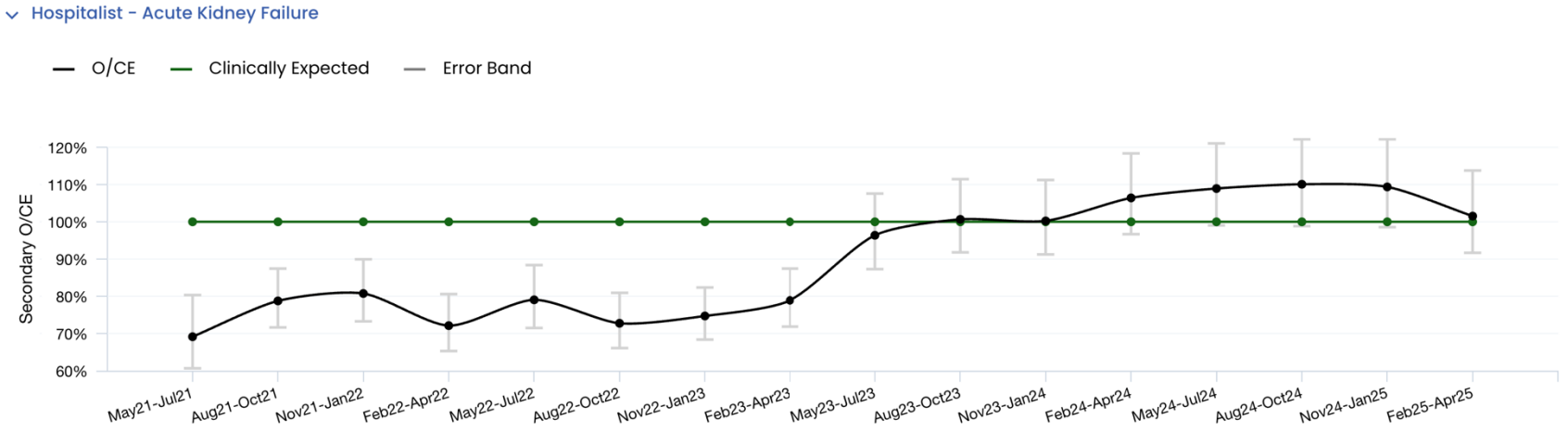
Result:

- Inconsistent DIAGNOSING and DOCUMENTATION of AKI
- Missed CC/MCC capture
- High denial rates
- Subpar risk adjustment

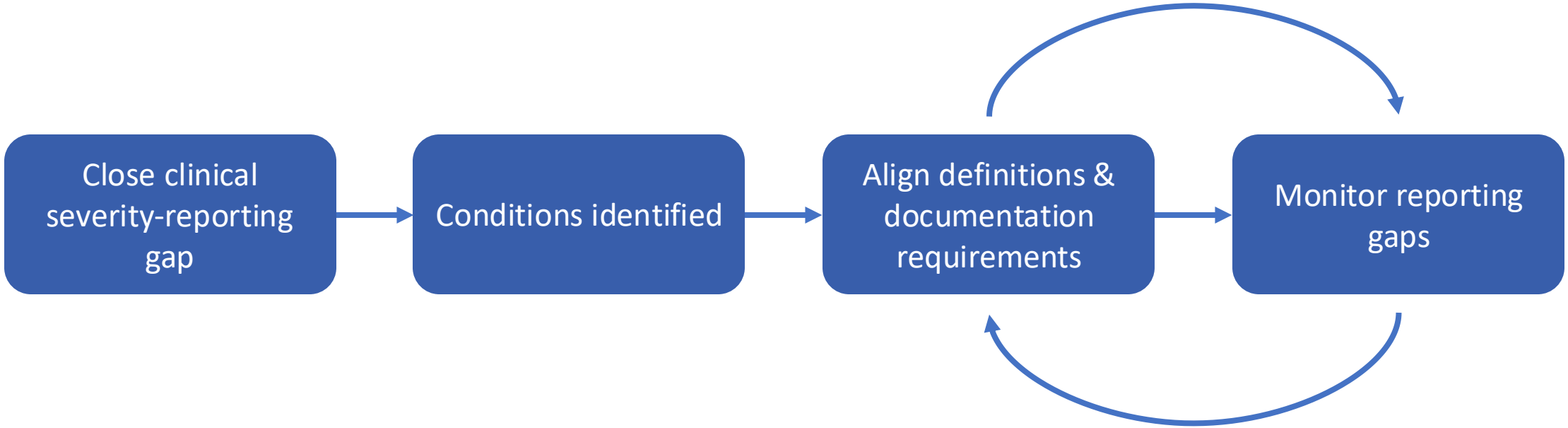
Condition Definition Variation = Clinical Variation + [Revenue + RA] Loss + Denials + COMPLIANCE RISK

The Value of Approved & Enforced Condition Definitions





Cleaning Denials With SOAP



- Raised awareness clinically on whether your patients have AKI based on the approved criteria
- Accurate Documentation of the condition
- Evaluation, Management, Risk Factors

Subjective

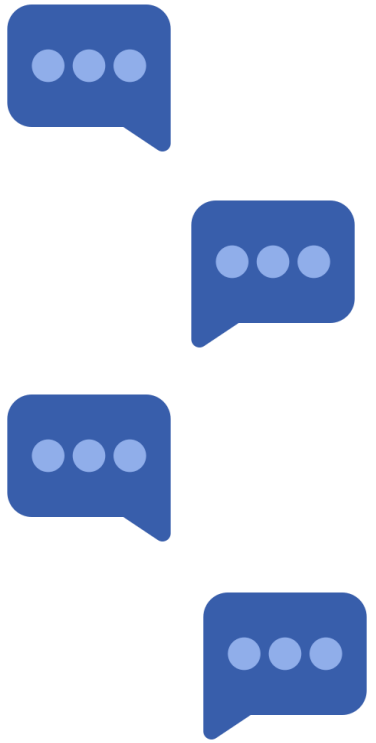
Objective

Assessment

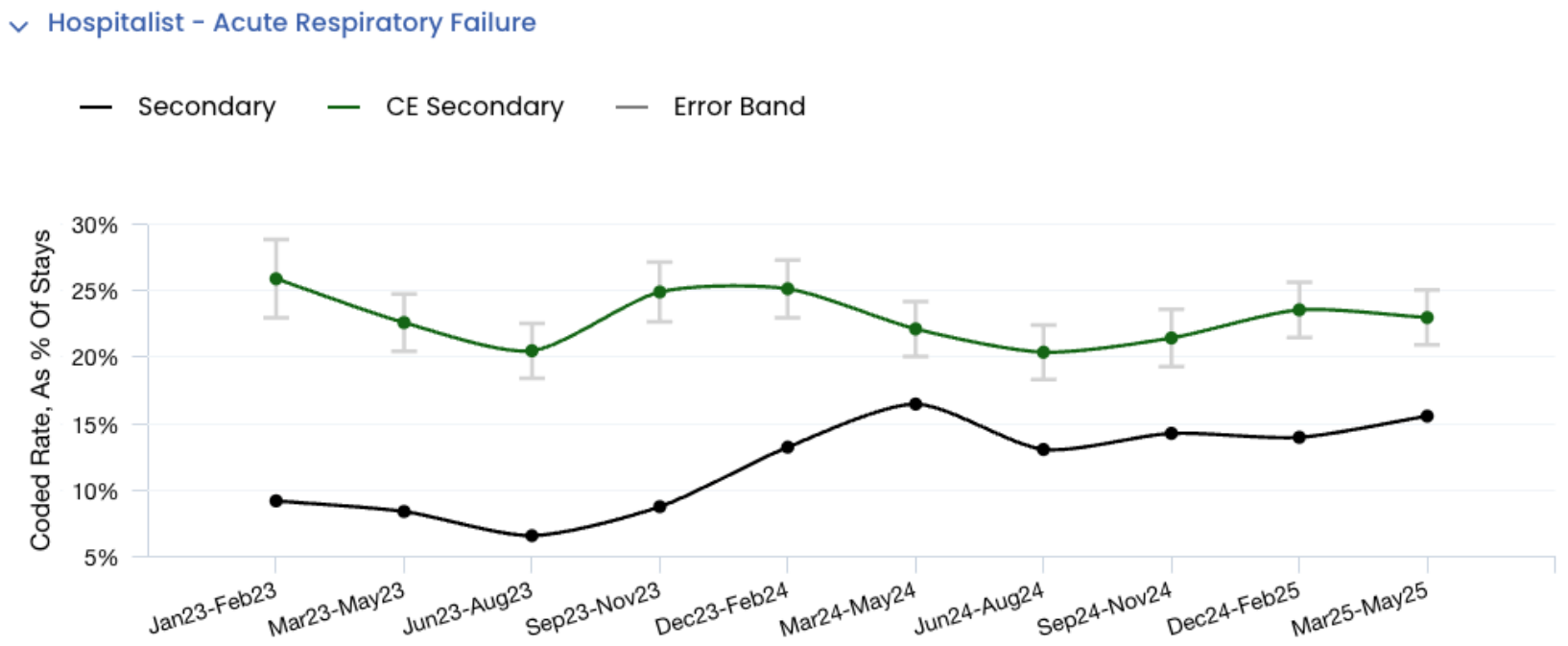
Plan

Addressing the Naysayers

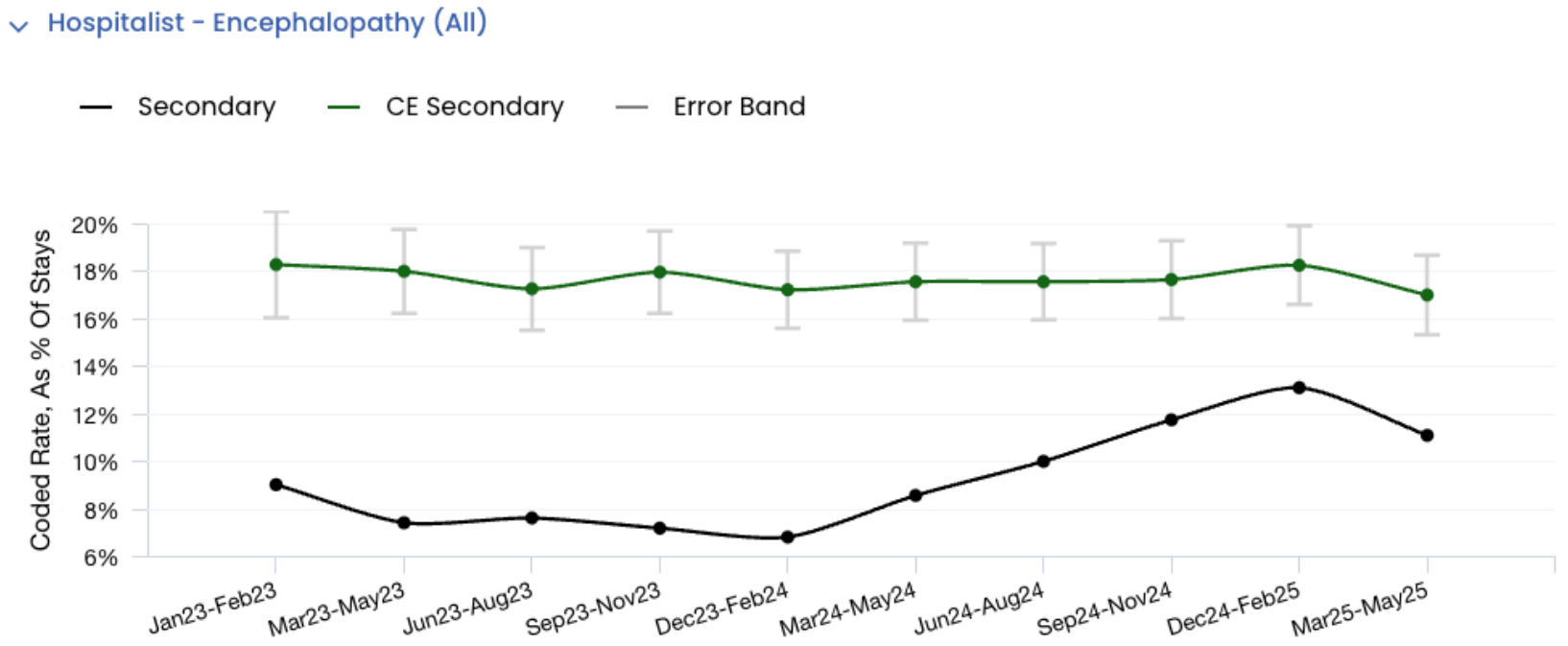
- “We already tried educating physicians”
- “We already have definitions”
- “The payors will deny no matter what”
- “You can’t change documentation habits”
- “We do chart reviews every day – what more can we do?”



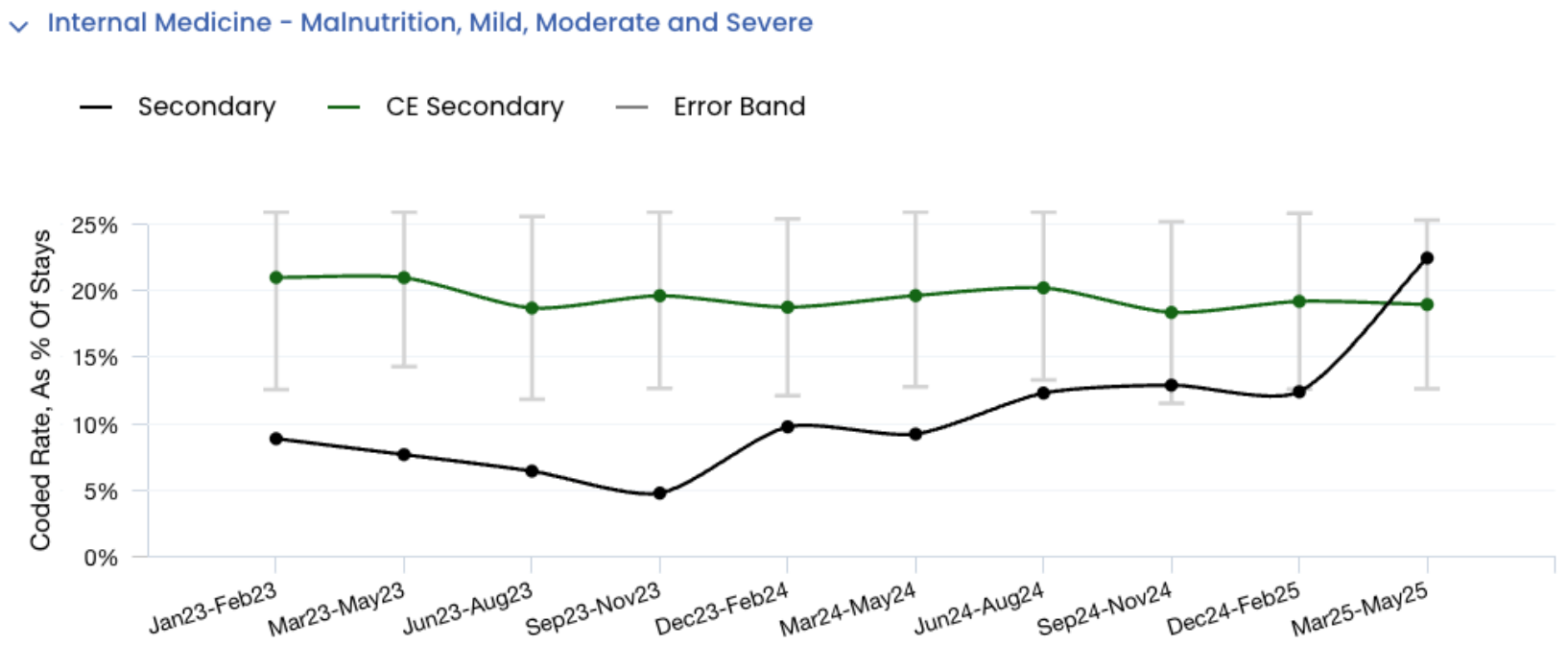
The Data Speaks for Itself – Acute Respiratory Failure



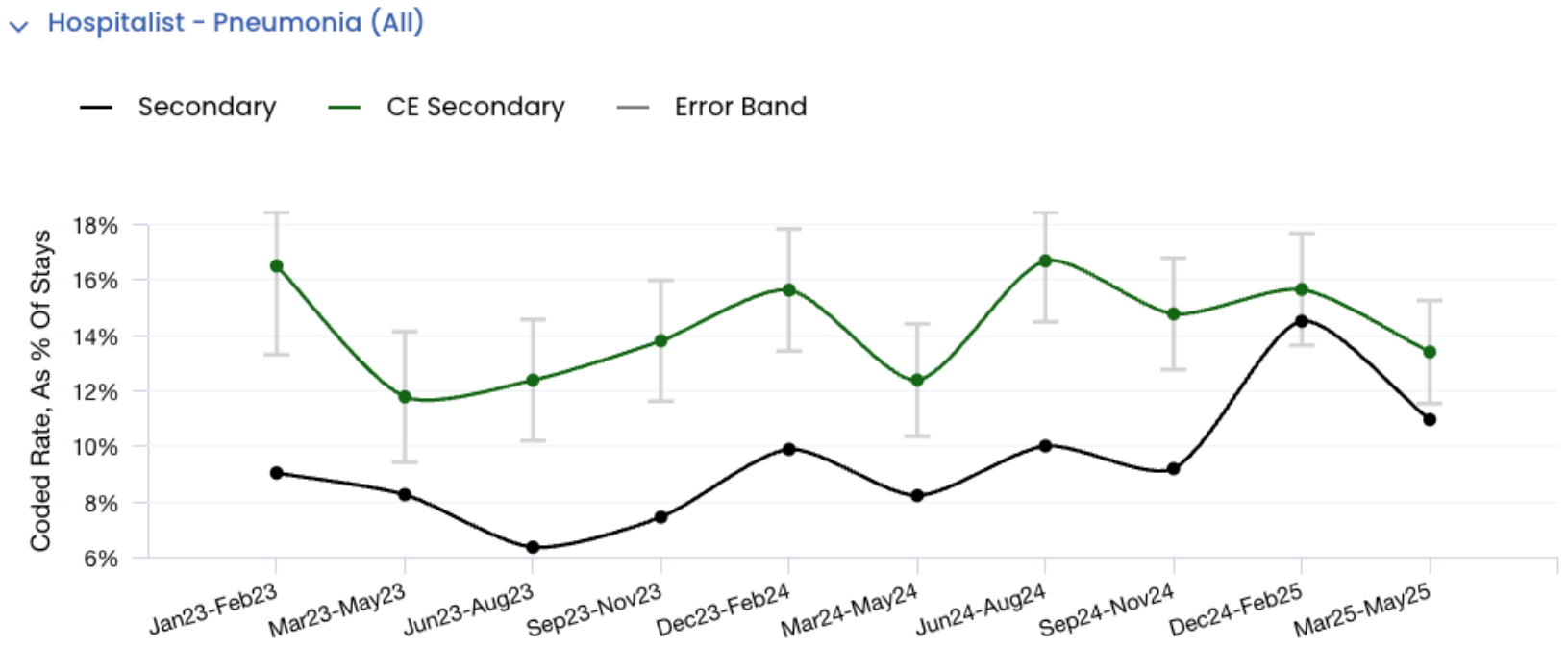
The Data Speaks for Itself – Encephalopathy



The Data Speaks for Itself – Malnutrition

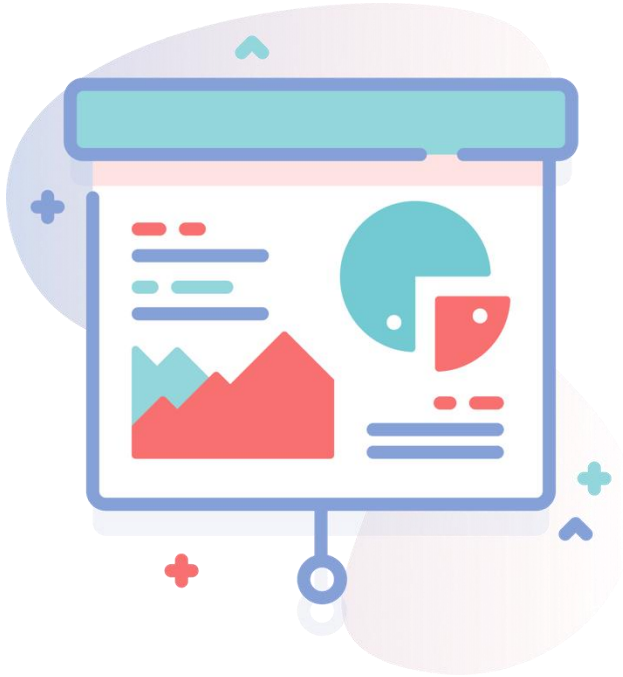


The Data Speaks for Itself – Pneumonia



Summary

- Denials are not just a revenue problem – it's a documentation clarity and hence a clinical problem first
- Traditional Approaches to address are reactive and unsustainable
- Conditions definitions are key
- Accountability and enforcement is non-negotiable
- Change IS possible – and fast!



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