Outsmart denials with purpose-built technology

The future of denial prevention + automation is here

What's inside

Success strategies + a new research report on denials in partnership with the Healthcare Financial Management Association

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WAYSTAR

Waystar helps providers simplify healthcare payments through a smart platform and better experience that yield powerful results throughout the complete revenue cycle.

INTRODUCTION

The better path to decrease denials

IT'S NO SECRET

Claim denials are a constant thorn in the side of health organizations across the country. Between outdated technology and highly manual workflows, following up on denied claims drains significant time and monetary resources. In fact, unresolved claim denials can represent an average loss of up to 5% of net patient revenue.[1]

63%
of denied claims are recoverable[2]

YET

2/3
of denials are never worked[3]

If left unchecked, these trigger points only compound over time and lead to chronic problems that can have a serious impact on your organization's financial health — and future prosperity. To make matters more complex, denials can feel like a constantly moving target due to changes health organizations can't control, such as new payer rules or patients switching medical plans.

So, how can we get ahead of denials? With the proper insights and action on their side, health organizations can prevent more denials up front, empower staff with the right tools, and let less revenue slip through the cracks.

Take a deep dive into denials, examining where they most frequently originate to the latest research and strategies to stay ahead.

DISCOVER THE WAY FORWARD

Research Report: Sponsored by Waystar

Survey reveals 5 opportunities to tackle denial prevention and management

Organizations that devote greater resources to denial prevention see lower first-pass denial rates, a recent survey shows, but most steer more staff toward back-end denial management.

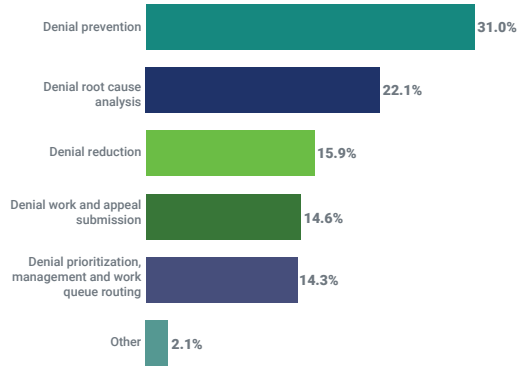
When it comes to denial management, 31% of healthcare finance professionals say their organizations are most focused on denial prevention — but that's not where they're putting the majority of revenue cycle resources, according to a recent HFMA survey.

The survey, sponsored by Waystar, a leading healthcare payments technology company, indicates nearly half of organizations (49.5%) allocate most of their denial-related resources toward back-end revenue cycle tasks like managing denials and submitting appeals. Just 17.3% devote more resources to front-end tasks focused on denial prevention. The difference between perception and resource-backed reality came as a surprise to revenue cycle experts, especially when compared with the decisions organizations are making around revenue cycle technology investments.

"We're seeing success among clients that address the root cause on the front end and implement automation and intelligence to help their revenue cycle staff prioritize the work," said Matt Hawkins, CEO, Waystar. "This approach enables providers to dedicate more time to higher-impact efforts and patient care."

Denial prevention tops list of revenue cycle priorities ... but it doesn't get the lion's share of resource allocation

What area of denial management is your organization most focused on?



Not surprisingly, the survey indicates when organizations devote greater resources to denial management than to denial prevention, their rate of first-pass denials is higher: 13.6% versus 10.9%, based on survey responses. The rate of first-pass denials among organizations that devote equal attention to denial prevention and denial management, meanwhile, falls in the middle at 12.5%.

The survey identified four additional areas where misalignment between resource allocation, priorities and performance have a negative impact on denial prevention and management, creating opportunity for revenue cycle leaders.

1 Inefficiencies in processes drive denials

Eight out of 10 healthcare finance leaders say there is room for process improvement in addressing and working denials — and nearly 30% say the need for improvement is significant, survey responses show. Interestingly, organizations prioritizing denial management were 77% more likely to cite a significant need for process improvement than those prioritizing denial prevention (37.89% versus 21.43%).

This could be because prior authorization denials were reported to represent the largest chunk of denials for healthcare organizations, at nearly 40%. Additionally, more than 70% of respondents indicated prior authorization is the most time-consuming front-end process, further exacerbating the pain point.

"Prior authorizations don't have to consume so much time and resource commitment. We've seen significant improvement for providers who implement holistic, end-to-end automation platforms," said Hawkins. For example, one client experienced a 46% decrease in authorization-related denials and a 340% improvement in working denials — going from nine days to fewer than three days.

One factor complicating prior authorization management for providers is payers' shifting policies, which makes it challenging for providers to stay on top of them.

"By the time they see a denied claim, a trend may have already been in play for 90 days, which forces providers to continually play catch up," Hawkins said.

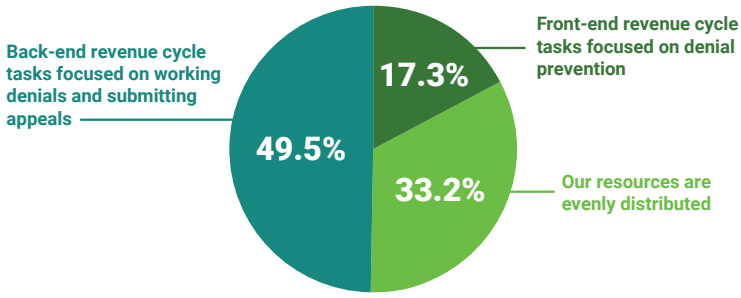
Leading providers are leveraging technology to discern the root cause of denials sooner — a top area of focus for 22.1% of survey respondents. They also are seeking ways to reduce inefficiencies in front-end revenue cycle processes — cited as the cause of 25% of denials, on average. A third of providers are considering investing in a new denial and appeal solution in the next one to two years, according to survey data.

Survey data also revealed that just 40% of healthcare organizations rely on an automated solution for identifying or detecting insurance coverage prior to claim submission. This could represent a missed opportunity to strengthen front-end processes, given that nearly 10% of denials are related to challenges in determining eligibility.

"Providers should not be experiencing the level of eligibility denials that these results suggest," Hawkins said. "Those are some of the easiest denials to get overturned or, better yet, to harness technology on the first pass to avoid a denial altogether."

It's an area where automating eligibility verification could not only optimize productivity and revenue, but also elevate the patient payment experience.

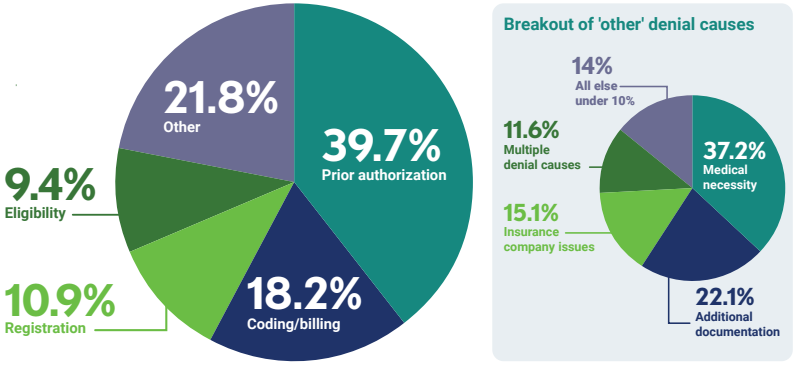
In your current revenue cycle business model, where do you allocate most of your denials-related resources?



Source: Waystar/HFMA survey, February-March 2023

Survey says: Prior authorization denials top list of denial pain points

What is the greatest cause of denials in your organization?



Source: Waystar/HFMA survey, February-March 2023

2 Low-balance denials merit greater attention

More than 70% of organizations surveyed have established a minimum balance write-off, accepting that they won't be able to work all denials. Another 10% of respondents shared that they don't have a way to filter or prioritize denials to support a minimum balance write-off.

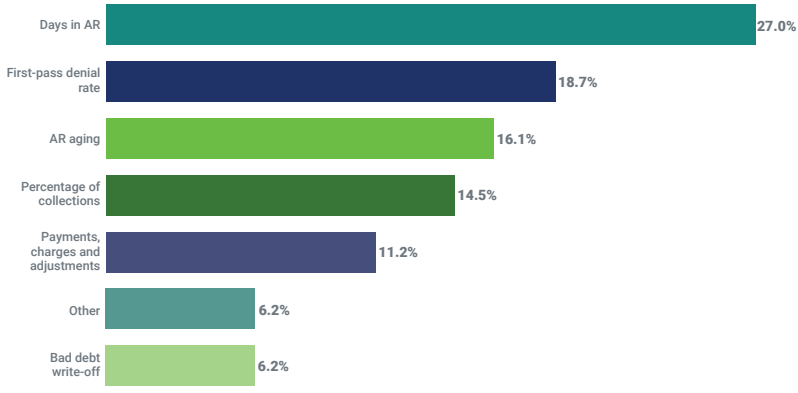
"Providers can prioritize appeals for those likely to yield the most reimbursement when they apply AI-enabled prioritization analytics and automation for low-balance appeals," Hawkins said.

One tactic revenue cycle teams may wish to consider: bulk automation for processing low-balance denials related to eligibility or denials from a single payer that exhibit a similar pattern.

"With automation, you can lump those denials together in a workflow tool, auto-populate the appeal letter with the information from a remit in the system and get dozens of appeals out at once, rather than one at a time," Hawkins said. "If there's an opportunity there and you can expedite the workflow, you should go after it, even if it's considered a low-balance claim."

Leaders prioritize these 7 revenue cycle KPIs

What metric/KPI related to denials is most important to your leadership team?



Source: Waystar/HFMA survey, February-March 2023

3 Revenue cycle leaders should take a closer look at metrics

When gauging revenue cycle performance, leaders cited days in accounts receivable (A/R) as the primary metric they look at, followed by first-pass denial rate, A/R aging and percentage of collections. Days in A/R is an important metric, Hawkins said, noting that he encourages providers to place emphasis on additional measures, such as percentage of collections.

"If you have a successful denials prioritization strategy in place, you will impact the percentage of dollars owed that are collected," he said. "First-pass denials rate is also a key metric to consider. If your team is skilled in tracing the root cause of denials and making sure they don't continue to occur, your first-pass denials rate will decrease. It's an excellent way to gauge the effectiveness of your team's denials management approach."

4 Automation is a proven lever to address revenue cycle staffing concerns

For Hawkins, the need to tackle inefficiencies in denials processes — cited as a key concern for 83% of respondents — isn't just important for financial performance. It's also an opportunity to help revenue cycle staff improve their skills and knowledge and feel more fulfilled in their work.

"Giving these professionals the tools to drive efficiency through advanced technology like machine learning and automation empowers them to perform at a higher level," he said. "The technology we can apply to healthcare payments today is incredible, and there is an increasing comfort with these tools among both seasoned and younger staff."

As revenue cycle leaders look for opportunities to engage team members more fully, such as by establishing career paths for their teams, providing modern technology to perform their work could be key to staff retention.

"In my conversations with revenue cycle leaders, I'm hearing thoughtful ideas around developing resources that help staff feel as though they have growth opportunities within their system," Hawkins said. "For organizations that are struggling to fill those roles, adopting a more modern approach to denial prevention and management, backed by technology and analytics, has proven to be impactful."

Making the right moves for improved performance

It's clear that leaders must take steps toward giving denial prevention the attention, staffing and resources it deserves. Bold action — including around process improvement and adoption of holistic healthcare payments platforms — will be key. Investigating how to apply automation and other technologies to system-specific opportunities for improved performance will differentiate mid-level performers from high achievers – and provide the capability to sustain success. ▮

4 STRATEGIES TO

Save staff time + gain upfront control over denials

Denials in healthcare are an ever-present — and ever-increasing — problem.

In fact, denial rates have only continued to rise, increasing more than 20% over the past few years.[1]

So how, exactly, do you ensure your organization is proactively preventing and managing denials? **Start with four steps.**

ONE

Know the most common causes for denials

Denials in healthcare occur for any number of reasons, but many stem from errors or omissions in one of the following:

+ **Registration errors** – Incorrect insurance details or data entry mistakes
+ **Medical necessity** – Procedure code isn't supported by the diagnosis(es)
+ **Timely filing** – Claim wasn't submitted to the payer within the required time frame
+ **Pre-authorization** – Payer didn't grant authorization to perform the service
+ **Duplication** – Claim has been submitted more than once
+ **Additional information** – Payer requires extra information from provider or patient to process the claim
+ **Coding** – Service was not coded in accordance with the payer's rules, or a combination of codes was used that the payer

Because payer rules are constantly changing, denials in healthcare are a moving target. Block the time and resources to properly analyze your denial data. Once you have a clear understanding of the most common denial reasons for your organization, you can prioritize the highest impact workflows and optimize with better technology and processes.

1 Journal of the American Health Information Management Association, Claim Denials: A Step-by-Step Approach to Resolution (2022)
2 Medical Group Management Association, 4 Keys to Driving Down Denials (2018)
3 Physician's Practice, Why Getting Claims Right the First Time Is Cheaper than Reworking Them (2019)
4 HealthLeaders, Reducing Denials Tops the List of Priorities for Revenue Cycle Leaders (2023)

TWO

Optimize workflows to prevent denials

The best way to combat denials is to prevent them.

Revenue cycle processes for eligibility verification, prior authorization, and claim follow-up have huge downstream impacts on denial rates.

Start with the basics

+ **Examine your** eligibility verification, prior authorization, and claim statusing **workflows.**
+ **Study your top payers' policies** related to medical necessity.
+ **Proactively integrate rules** within your EHR where possible.

Deploy purpose-built automation targeting denial prevention

+ **Eligibility verification:** Return richer, more accurate benefit information and identify missing coverage to augment missing data.
+ **Prior authorizations:** Pinpoint upcoming services requiring authorization to initiate and follow-up on authorization requests.
+ **Claim status checks:** Optimize when to check claim status, retrieve updated information, and normalize each payer's unique remark codes.

THREE

Build a complete, automated denials process

A timely, comprehensive process is key to managing denials, and that must include automation.

Predictive analytics can help identify those denials most likely to be successfully appealed and purpose-built automation can more effectively prioritize which denials to focus on first, more efficiently route work, and even automate the appeal process.

Automated action

Use technology to identify appropriate coverage.

Example

In the event of eligibility-related denials, AI-powered tech helps identify coverage for rebilling. Particularly sophisticated solutions can even do this prior to claim submission, avoiding the denial entirely and submitting the claim to the right payer the first time.

Automated action

Steer denials that require human intervention into smart work queues, which are prioritized via predictive analytics and machine learning.

Example

By deploying machine learning to account for the probability of the highest successful payment — not just highest dollar claims — appeals efforts can be intelligently prioritized for the greatest impact.

Automated action

Automate the completion of appeals.

Example

By automatically populating payer-specific appeals documentation, providers can respond to denials quickly and with very little staff effort, increasing accuracy and efficiency.

FOUR

Track, report + determine the root cause of denials

To continuously improve both denial prevention and denial management, tracking and reporting is crucial.

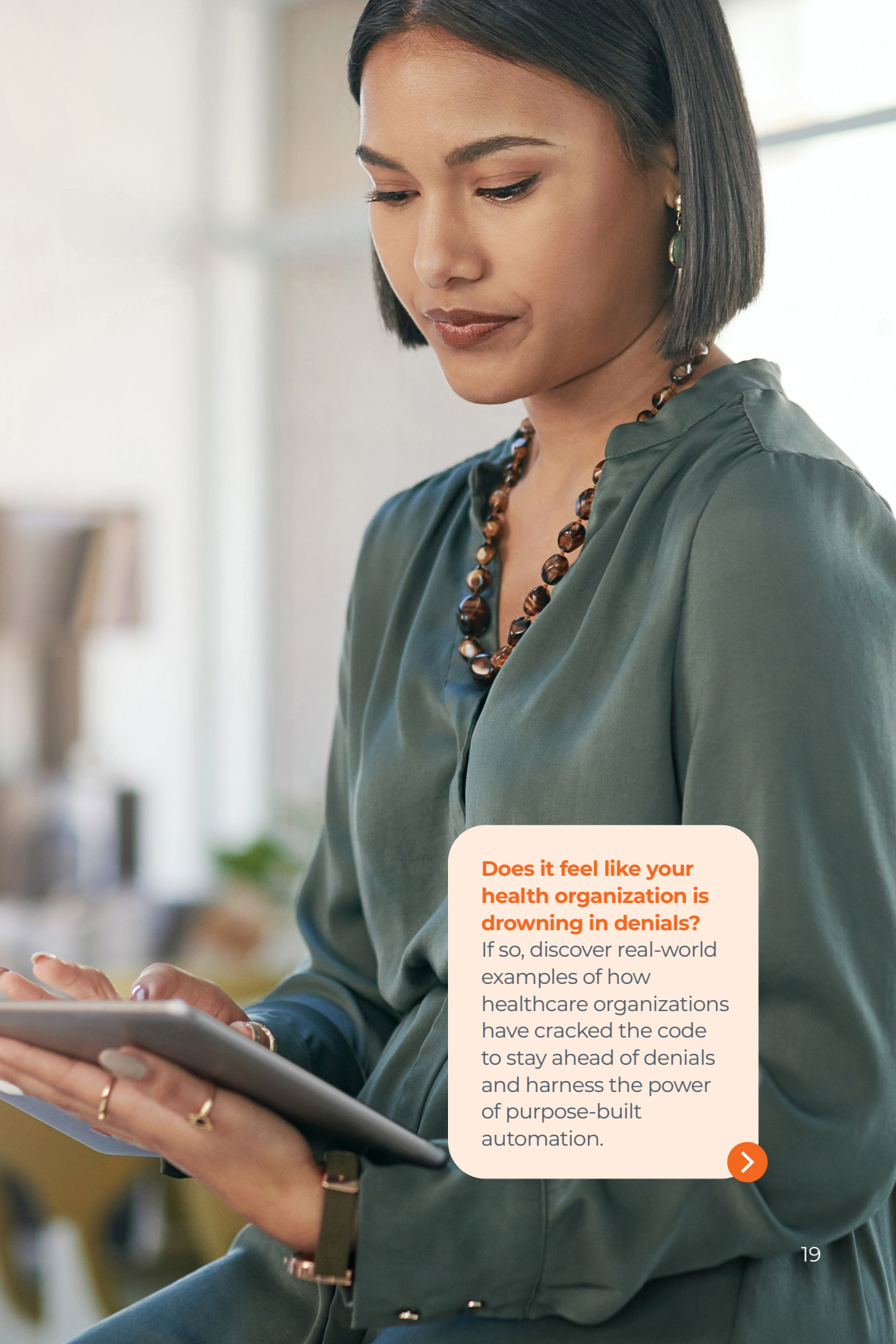
To do it well, you must systematically capture the reasons for denials.

+ Most are remitted electronically, but **don't ignore the denials that come in via direct correspondence** with payers.
+ **Create a process that captures and reports the root causes** of denials. Cataloging will enable you to monitor denials by type, frequency, value, and payer.
+ **Establish a team or workgroup** to address denials and report on trends.

If you stick with this process, it will reveal critical opportunities to make your revenue cycle run more smoothly.

SUCCESS SPOTLIGHT

How 4 organizations use Waystar's purpose-built automation to prevent denials + achieve powerful results



Does it feel like your health organization is drowning in denials?
If so, discover real-world examples of how healthcare organizations have cracked the code to stay ahead of denials and harness the power of purpose-built automation.

UCHealth automates prior authorizations to proactively prevent denials

UCHealth, a Colorado-based nonprofit integrated health system, transformed their prior authorization process to prioritize patient care and empower providers. After enhancing their revenue cycle management with AI from Waystar, UCHealth was able to speed up its authorization process, moving from handling authorizations just a few days before treatment to tackling them approximately two weeks in advance.

RESULTS

46%
decrease in denials related to prior auth

340%
increase in prior auth speed

The purpose-built technology has freed up their staff's time to focus more on people-to-people interactions, rather than manual efforts in the prior authorization and denials process which has led to a 46% reduction in denials related to authorizations. That means UCHealth can focus on what matters most — caring for their patients and community.

"We've optimized our workflow so that Waystar technology pulls the information from the physician order seamlessly to initiate an authorization on the payer website, statuses it, and then pulls the information back into our electronic health record."

–

Candice Hoshi, VP of Revenue Cycle, UCHealth

Proliance Surgeons cuts manual work + mitigates more denials

As Proliance Surgeons' business grew, the large multi-specialty surgical organization needed modern solutions to streamline their revenue cycle and stay ahead of denials.

Prior to partnering with Waystar, their team spent time and effort managing denials and submitting appeals manually on paper. Now, payer forms are auto-populated, claims are attached, and notes can be easily uploaded. The new process has led to a decrease in denials and improved workforce efficiency by 33%.

RESULTS

33%
improvement
in denial workflow
productivity

70%
decrease in time
spent per claim
status follow-up task

"Waystar's denials and appeals solution provided an enormous amount of automation and prioritization that we've never had before. It has changed our entire workflow allowing us to produce bigger results by knowing which denials to work and when."

–

Jessica Weathers, Senior Director of Revenue Cycle,
Proliance Surgeons

Avera Health automates claim status to decrease denials + improve cash flow

Avera Health, one of the leading integrated health systems in the Midwest, experienced rapid growth which created a sharp rise in outstanding claims, AR backlogs, and risk for timely filing denials.

With Waystar's technology, Avera Health automatically removed more than 80% of claims that used to require human intervention from their work queues. The technology has removed a heavy administrative burden on their team. Now, they can help prevent denials for timely filing and accelerate cash flow.

RESULTS

$20.6M
in accelerated cash flow

$1.1M
revenue improvement due to more timely filing

"Waystar's solution promised to alleviate the burden on my staff. For Avera, the cash improvements and cost savings have been very apparent — it's much less expensive to automate claim status verification with Waystar than add new staff."

–

Mary Wickersham, VP of Central Business Office Services, Avera Health

Shields Health Care Group optimizes patient access processes to prevent denials downstream

Shields Health Care Group provides MRI, PET/CT, and surgical services in New England, an area saturated with high competition.
To succeed as the first-choice value provider in the region, their team sought to lower bad debt and centralize patient access processes across their hubs.

RESULTS

$478K
decrease in auth- and eligibility-related denials

$807K+
reduction in bad debt

To achieve this goal, Shields Health Care Group leveraged Waystar's technology to create an exception-based revenue cycle team. This innovative approach helped drive down human error and improve efficiency in the eligibility and authorization processes. Since then, Shields Health Care Group has seen a significant drop in denials caused by eligibility and authorization, which amounts to $478K.

Your path to fewer denials

Discover how Waystar can help create a proactive denial prevention and management strategy, so you reach peak performance in your revenue cycle.

Scan the QR code to start your journey

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