

CASE STUDY

MAXIMIZING COLLECTIONS & REDUCING CLAIM DENIALS

BACKGROUND

In March 2024, a major healthcare provider with over 60 locations engaged BIS to tackle a critical challenge—reducing their high claim denial rate, which averaged 15 percent in 2023, across five key locations while maintaining steady collections.

The initial goal was to bring the denial rate below 8 percent within three months, but BIS quickly exceeded expectations. The success of the engagement led to a long-term partnership, allowing for continued process optimizations and sustained improvements in revenue recovery. What started as a targeted initiative soon revealed opportunities for scaling these efficiencies across the provider's broader network heading into 2025.

CHALLENGE SUMMARY

BIS team was assigned this task for 3 months with the goal of reducing denial rate below 8% and improve collections.

RESULTS SUMMARY

In 2023, the provider faced an average claim denial rate of 15%, impacting revenue and operational efficiency. BIS successfully reduced the denial rate to the targeted 8% within the first 30 days and continued optimizing processes, further lowering the average denial rate to just 4% by Q3 and Q4. This sustained improvement led to stronger revenue recovery and enhanced cash flow for the client.

FOCUS AREAS TO COMPLETE CHALLENGE



Prevention Measures -
Verification, Authorization, and Referral Management



Coding Review and Denial Analysis

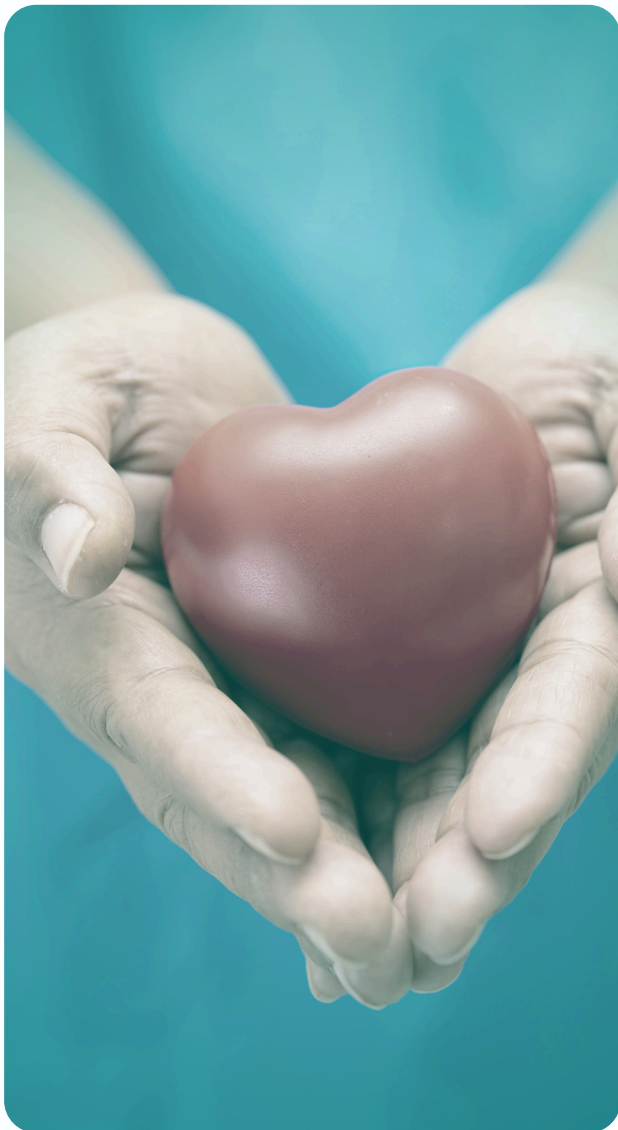


Insurance AR Team Progress

DIAGNOSING & FIXING THE PROBLEM

PREVENTION MEASURES

Achieving sustainable reductions in claims denial rates required a strategic, data-driven approach. BIS focused on proactive measures designed to prevent denials before they occurred, coupled with rigorous analysis and process improvements to address existing issues. The strategy centered around three key pillars: Prevention Measures, Coding Review & Denial Analysis, and Insurance AR Team Progress. BIS identified that many denials stemmed from preventable administrative errors. By reinforcing front-end processes, the team effectively reduced the chances of denials occurring in the first place.



VERIFICATION

BIS ensured that **100% of patient appointments** were thoroughly verified before services were rendered. This process included eligibility checks, coverage confirmation, and validation of patient demographics. This minimized eligibility-related denials.



REFERRALS – CLINIC VISITS

The BIS team took full ownership of the referral process. This included:

- Identifying the patient's Primary Care Provider (PCP)
- Submitting referral requests
- Proactive follow-ups to ensure timely approval

Streamlining the referral workflow reduced referral-related denials and improved appointment scheduling efficiency.



AUTHORIZATION – PROCEDURE

Prior to service delivery, BIS conducted comprehensive reviews of medical records and payer guidelines to ensure all procedures met medical necessity requirements. When discrepancies were identified, the client was promptly notified to amend the records. This preventive strategy significantly reduced authorization-related denials and will continue to do so moving forward.

CODING REVIEW AND DENIAL ANALYSIS

In addition to front-end prevention, BIS recognized the critical role that accurate coding plays in reducing claim denials. Errors in coding, particularly related to diagnosis and procedure modifiers, were key contributors to revenue loss.

COMPREHENSIVE MEDICAL RECORD REVIEW

BIS conducted a thorough review of all medical records to ensure accurate billing codes were applied.

This process involved:

- Verifying correct diagnosis codes (ICD-10)
- Ensuring modifier usage met payer-specific requirements
- Cross-checking documentation for completeness and compliance

This meticulous review process significantly reduced coding-related denials, contributing to overall denial rate reduction.

DENIAL TREND ANALYSIS

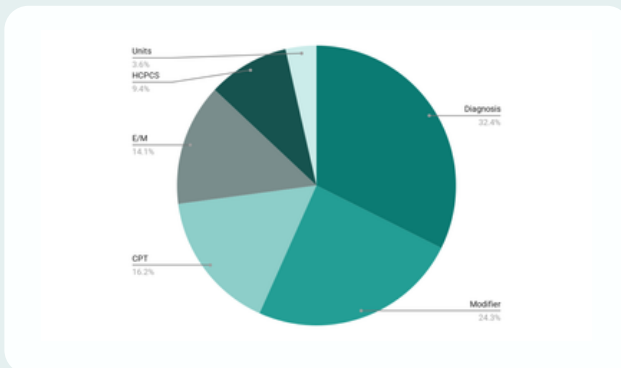
BIS implemented monthly denial trend tracking to identify recurring issues. This tracking process included:

- Root cause analysis of denied claims
- Categorizing denials by type (diagnosis, modifier, documentation errors, etc.)

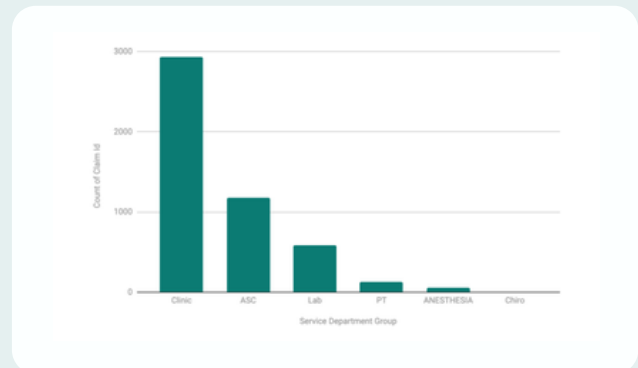
- Providing actionable insights to the healthcare provider's internal team for process adjustments

Identifying patterns allowed for proactive intervention, preventing similar denials in the future.

DENIAL REASONS



DENIAL TREND (By Serving Group)



SUMMARY FINDINGS

- The total coding denials from Mar'24 to Dec'24 was 5057.
- Diagnosis denials are the most significant contributor, accounting for 1637 overall coding denials, Modifier denials are the second most significant contributor, accounting for 1230 of the overall coding denials.

DEPLOYMENT OF CERTIFIED CODERS

BIS assigned two certified coders at no additional cost to the client. Their responsibilities included:

- Conducting monthly coding audits
- Reporting on denial trends

- Providing training sessions for the large healthcare provider's staff based on identified gaps

The presence of dedicated coders ensured continuous improvement and helped maintain low denial rates over time.

INSURANCE AR TEAM PROGRESS



To complement front-end and coding improvements, BIS concentrated efforts on Accounts Receivable (AR) management to maximize collections. The AR team focused on recovering outstanding claims while optimizing processes to improve cash flow.

COMPREHENSIVE MEDICAL RECORD REVIEW

BIS assigned 2 Full-Time Equivalents (FTEs) exclusively to manage AR for the focus locations. Their role in the cycle was to:

- Review outstanding AR from 2023 and 2024 to identify aged claims
- Prioritize high-dollar and high-risk claims for expedited resolution
- Work directly with payers to appeal denied claims and resolve disputes

AGED CLAIMS RECOVERY

An in-depth analysis was conducted of aged claims to identify patterns and bottlenecks causing payment delays. The findings led to the BIS team to

- Implement customized follow-up strategies based on payer-specific trends
- Leverage data analytics to track recovery progress and measure success

The AR team successfully recovered substantial amounts from claims that were previously written off or at risk of non-payment.

MEASURING PROGRESS

DENIAL STATS & CHARGES AND PAYMENTS STATS

DOS Month	2023				2024			
	Visits Count	Charges	Denial Count	% of Denials	Visits Count	Charges	Denial Count	% of Denials
Jan	2346	\$3,754,124	487	21%	2459	\$3,818,407	311	13%
Feb	2204	\$4,027,647	388	18%	2724	\$3,843,528	317	12%
*Mar	2690	\$3,768,310	438	16%	2376	\$4,011,909	188	8%
*Apr	2098	\$3,875,085	400	19%	2831	\$4,863,960	218	8%
*May	2592	\$3,516,650	454	18%	2855	\$4,774,329	194	7%
*Jun	2406	\$4,136,569	357	15%	2384	\$4,024,038	123	5%
*Jul	2051	\$2,941,527	206	10%	2701	\$4,199,442	134	5%
*Aug	2281	\$4,347,583	296	13%	2717	\$4,275,074	120	4%
*Sep	1913	\$3,684,502	228	12%	2289	\$3,805,997	102	4%
*Oct	2232	\$3,599,976	377	17%	2357	\$2,604,702	104	4%
*Nov	2313	\$3,859,494	253	11%				
*Dec	2125	\$3,650,925	240	11%				
Overall Total	27251	\$45,162,391	4124		25693	\$40,221,385	1810	
Average Per Month	2271	\$3,763,533	344	15%	2569	\$3,700,161	181	6%

SUMMARY OVERVIEW

The denial rate in focus locations dropped from 8% to 4% after BIS took over, achieving the challenge goal immediately and maintaining consistent improvements.

DOS Month	2023		2024		Charge Difference	Payments Collected		Payment Difference
	# of Claims	Total Charges	# of Claims	Total Charges		2023	2024	
Qtr1	7240	\$11,550,081	7559	\$11,673,844	1%	\$2,424,417	\$1,716,014	-29%
Qtr2	7096	\$11,528,304	8070	\$13,662,327	19%	\$1,804,178	\$2,322,035	29%
Qtr3	6245	\$10,973,613	7707	\$12,280,513	12%	\$1,937,474	\$2,383,752	23%
Oct	2232	\$3,599,976	2357	\$2,604,702	-28%	\$532,890	\$720,227	35%
Total Charges	22813	\$37,651,973	25693	\$40,221,385	7%	\$6,700,983	\$7,144,052	7%
Average of 3 Qtr	6860	\$11,350,666	7779	\$12,538,895	10%	\$2,055,356	\$2,140,600	4%

SUMMARY OVERVIEW

Charges increased by 7% compared to 2023, with a 15% surge in Q2 & Q3, aligning with the start of the BIS intervention.

Payments in focus locations rose by 25% in Q2 & Q3 compared to the same period in 2023.

The increase in payments averaged \$400K per quarter, with a potential \$1.6M annual uplift if the strategy is scaled across all of the client's locations.

FURTHER FINDINGS AND RECOMMENDATIONS FOR 2025

As a leading provider of Revenue Cycle Management (RCM) services, BIS identified the need to perform a structured Root Cause Analysis (RCA) for the large pain management organization to effectively improve claim submission accuracy, reduce denials, optimize revenue collection, and enhance overall operational performance.

The RCA systematically investigated and identified the underlying factors contributing to RCM denials.

The findings provided actionable recommendations aimed at addressing these issues.

CODING DENIALS

For 2025, an action plan was proposed to the large healthcare provider to further reduce coding denials.

ASSIGN



ASSIGN CERTIFIED CODERS

Focus on high-denial locations and providers to ensure proper first-pass documentation and billing accuracy.

PRIORITIZE



PRIORITIZE KEY DENIAL REASONS

Address diagnosis and Modifier coding errors as the largest contributors to denials.

MONITOR



MONITOR TRENDS

Continue tracking denial trends by month by location and providers to measure the effectiveness of interventions.

Overall coding denials for 2024 are currently at 24k claims impacting approximately \$5M in revenue (calculated based on average payment). This is on average \$480k per month.

To increase 2025 collections and for significant cost savings, BIS recommended a more targeted approach of front-end coding staff to review records and reduce denials.

Each denial costs an average of \$25 per claim to rework estimating \$600k (\$25 x 24k claims).

AUTHORIZATION PROCESS REVAMP

Due to limitations with BIS not handling authorization for all of the payers, procedure types or locations, additional recommendations were provided to the large healthcare provider to further improve their authorization processes across various authorization types and unassigned locations.

CONCLUSION / RESULTS / SUMMARY

The partnership between the large healthcare provider and BIS successfully transformed revenue cycle performance across the designated focus locations. By implementing proactive denial prevention measures, conducting in-depth coding reviews, and optimizing AR recovery strategies, BIS significantly reduced the denial rate from 8% to 4% in just a few months time, achieving the challenge goal immediately.

This reduction directly translated into a 25% increase in payments during Q2 and Q3 2024, contributing to an additional \$400K in collections per quarter. With a projected \$1.6M annual revenue

opportunity, scaling these strategies across more of the client's locations presents a significant financial upside.

Beyond the immediate impact, the refined workflows, trend analyses, and structured interventions introduced by BIS have created a sustainable framework for ongoing improvements. By maintaining these best practices and expanding targeted denial management efforts, the client can continue optimizing collections, improving cash flow, and ensuring long-term revenue cycle success.

Every denied claim is lost revenue.
Take the first step today.

Contact the BIS team for a **free denial trend analysis** and start recovering what you're owed!

1-800-592-6079