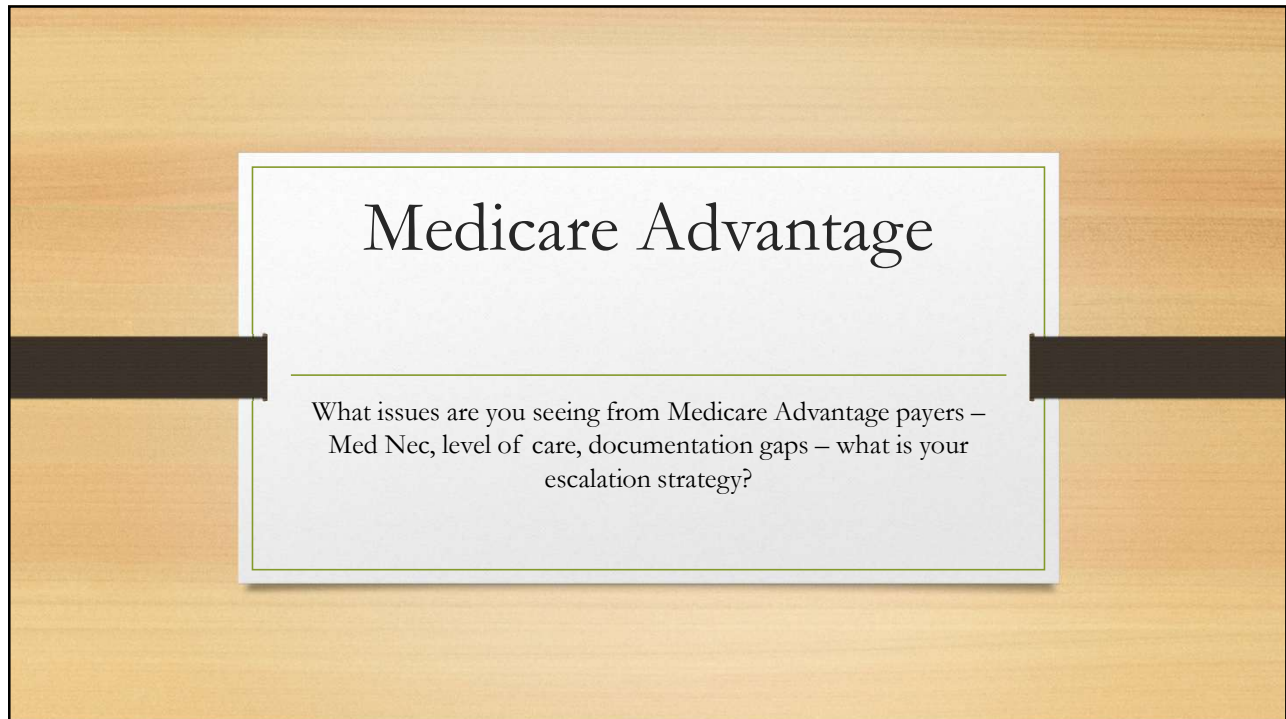




1



2

Missing Records / Lack of Payer Response:

- When you are told records are not rec'd, or are missing, how are you submitting, how are you creating a paper trail that could hold up against an appeal, is there any particular language you are using with the payers to get their attention?

3

Policy changes
that affect
reimbursement
issues - non-
patient labs /
site of service

UHC / Aetna – biggest offenders. REV 510
vs 761

Do you have a front-end process to identify
non-patient lab claims? Has anyone been
successful more often than not, in avoiding
denials?

When non-patient lab denials do happen do
you appeal? Is there any particular approach
or strategy you have found successful?

4

Downcoding – how do you identify downcoded claims?

- Are you tracking downcoded claims separately from traditional denials — and if so, what does your overturn rate look like on appeals, and what documentation or coding arguments have proven most effective?
-
- Have downcoding practices by specific payers reached the point where they've entered your contract renegotiation conversations — and if so, how are you using denial data as leverage at the table?

5

Out of Network

- What out of network issue are you having and how are you handling?

6

Use of AI – to Trust or not to trust?

- What AI or automation tools are you currently using in your denial management or claims workflow and how do you measure their actual impact versus the promises made in the sales process?
- Where do you see the biggest near-term opportunity for AI to reduce your denial rate or administrative burden — is it on the front-end prevention side, the back-end appeals side, or somewhere else entirely?