




2026 Recovery Trends & Best Practices



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Poll Question

What impact are denials and contractual underpayments having on your net revenue?



- < 2%
- 2 - 5%
- 6 - 10%
- >10%
- Don't know the real impact

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Revenue Challenges



2 in 5 Hospitals

Negative Operating Margins in 2024



\$25+ Billion Loss

Annually to Denials



~50% Decline

Margins Compared to Pre-Pandemic

"We lose money on 60% of what we do... hopefully at the end of the year we can break even or have a 1-2% margin."

- CEO of Partners Healthcare
Becker's Hospital Review

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Article & Key Stats: All Around Denials




- Claim Denials increased 16% from 2018 to 2024, accounting for over \$43B spent on payment collection (AHA)
- Administrative cost per denied claim: \$40 - \$45 in 2022 to \$55 - \$65 in 2024.
- Median Denial rates sit at ~13-15% in 2025
- Providers' average success in overturning those dipped from 42.7% to 42.1%
- Average time to insurance payment declined from 57.4 days in 2024 to 55.2 days in 2025

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Baseline Definition


Denial Management & Contractual Underpayment Recovery is:

-  The evaluation and understanding of why a medical claim is being denied and/or underpaid.
-  Determining and implementing best practices for reducing denials and underpayments from occurring.
-  Creating processes, procedures and review strategies to ensure the organization collects its full reimbursement on the services that have been provided.


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Reimbursement Maturity




Variations happen due to breakdowns across the revenue cycle, such as:







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Causes of Reimbursement Variations



Variations happen due to breakdowns across the revenue cycle, such as:

PEOPLE	PROCESS	TECHNOLOGY	DATA
<ul style="list-style-type: none"> Staffing issues Front-end denial causes not understood 	<ul style="list-style-type: none"> Organizations take a reactive-only approach to denials 	<ul style="list-style-type: none"> Systems not in place for analyzing denial reasons and categories 	<ul style="list-style-type: none"> No method for deriving meaningful info from data

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Poll Question



As a healthcare organization, are you planning on spending on AI technology for your Revenue Cycle?

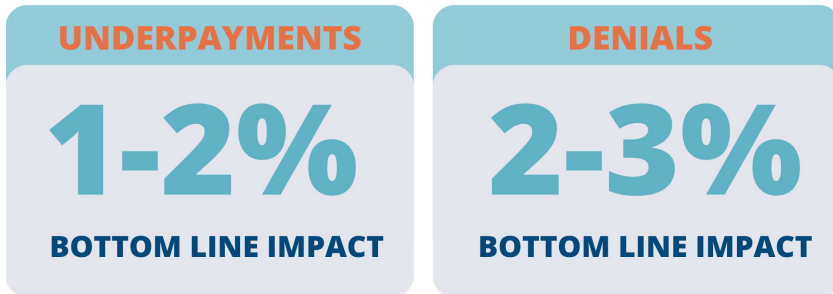


- We have a fully integrated AI plan and are seeing results
- We have a company initiative to incorporate AI but have not done so
- We talk about AI but there is no implementation as of yet
- No conversations about AI, what is it?

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All Variances Impact Your Bottom Line



Let's look at what PMMC is seeing among our clients:
Top Denial Codes
Top Underpayment Areas

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Top Contractual Underpayment Issues

TREND	SOLUTION	COMMON VARIANCES <ul style="list-style-type: none"> CO-97 & CO-45 Stop/Loss Outliers Add-on items Prior rate schedules DRG Downgrade & ER Downgrade Multi-Proc Discount / Incorrect surgery rate Per visit reimbursement issue % of Charge Paid Incorrectly Codes billed by Rev Code that are not separately reimbursed (636 Rx) Unknown rate paid <div style="background-color: #f4a460; padding: 5px; margin-top: 10px;"> CONTRACTUAL VARIANCES: Accounts where the payer does not pay the negotiated contractual rate and/or terms </div>
Incorrect contractual bundling (bundling implants, surgeries, etc.. incorrectly)	Confirm what should and should not be bundled.	
Revenue code issues	At times, the revenue code can dictate the payment and some services are billable on more than one revenue code. Verifying which codes to use could increase payment amount.	
MCR Advantage policy updates not being applied timely <small>(usually in the first month or two of a new quarter)</small>	Verify the timeframe for underpaid claims based on updates not being applied.	

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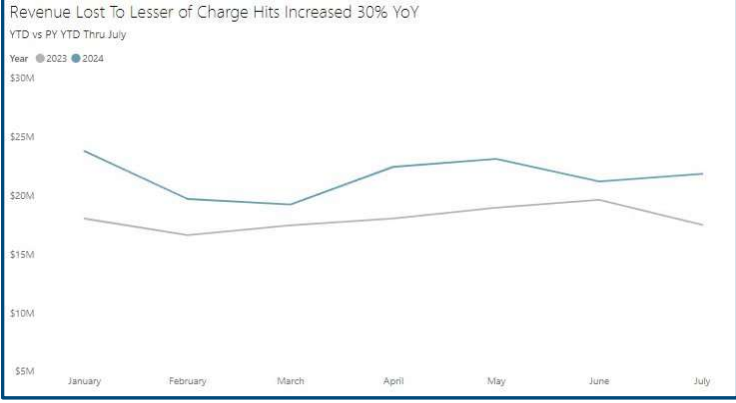
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PMMC Business Intelligence Trend

Lesser of Charge Hits Increasingly Eating Into Hospital Revenue

- Rate of net revenue lost to lesser of charges hits increased ~30% across the data set
- 43% of clients saw an increase in lost revenue YoY
- Of hospitals that lost revenue to lesser of hits, the average loss is -0.6% of net revenue
 - vs +0.2% for hospital with a revenue increase

Revenue Lost To Lesser of Charge Hits Increased 30% YoY
YTD vs PY YTD Thru July



Month	2023 Revenue Lost (\$M)	2024 Revenue Lost (\$M)
January	~\$18M	~\$23M
February	~\$17M	~\$20M
March	~\$18M	~\$20M
April	~\$19M	~\$22M
May	~\$19M	~\$23M
June	~\$20M	~\$21M
July	~\$18M	~\$22M

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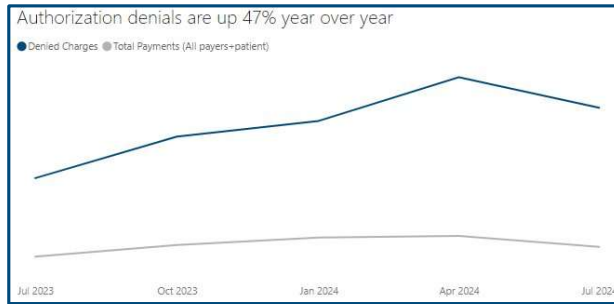
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PMMC Business Intelligence Trend



Authorization Denials Increasingly Eating Into Hospital Revenue

- HFMA survey of 134 CFOs found 51.5% ranked 'Prior Authorization' Denials as one of their top-3 areas of revenue cycle department stress
- Auth denials have some of the lowest initial payment rates at 7.4% of charges compared to the 22% average and the total payment rate is 11% lower than average
- BCBS appears to have the greatest YoY increase



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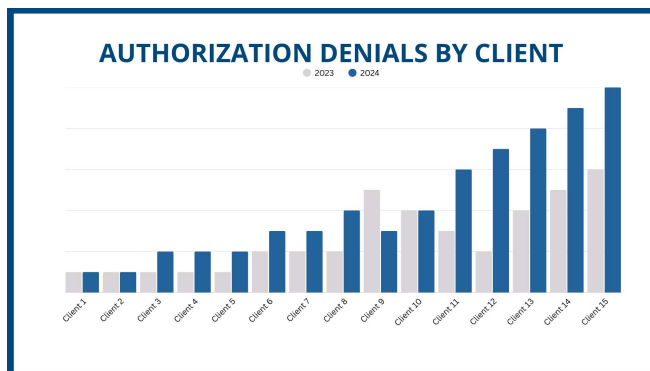
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PMMC – Client Impact



Things to know


- Commercial payers and Medicare Advantage payers both show the trend but BCBS, Aetna and UHC have the largest increases
- Prevent authorization denials by creating internal processes to ensure all authorization requirements by payer are met
- Checks are done to see if authorization is necessary
- Authorization is documented and billing documentation is correct
- Required documentation is included with claims to prove treatment is correct and authorization was received



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No Authorization



Common CARC Codes:
197, 198, 210, 39

Check to see if an authorization was originally requested


→

- If Yes, attempt to send the claim back with the available authorization number (occasionally an authorization code is valid, but the payer does not process the authorization with the claim).
- If No Authorization as requested or the auth was not valid for the billed services, recommend appealing with medical records and extenuating circumstantial documentation that the provide service was medically necessary.

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Medical Necessity



Common CARC Codes:
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When a claim is denied for medical necessity, start with the Medical Record.


→

- Submit your appeal based on the medical record.
- Build your case for why the services were medically necessary for treatment.

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Missing Documentation



Common CARC Codes:
252, 226

Occurs with full or partial claim denials and often can be avoided with correct support documentation submitted on the front end.




Determine from the payer exactly what documentation is needed and submit that material for review.

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Missing Device Code



Common CARC Codes:
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Commonly see device dependent procedures billed without the applicable device code. In these scenarios, a device was used or implanted but was left off the billed claim.



Rebill with the applicable device code. Example 27447 is a code commonly used for a total knee arthroplasty (replacing knee joint with prosthetic implants). The implant (device code) must be billed for the code to pay.

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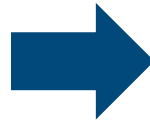
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Missing/Invalid Modifier



Common CARC Codes:
4

Certain codes require a modifier that is applicable to the treatment to be billed so the claim is processed appropriately.



- Research to determine the appropriate modifier.
- Rebill to add or change to the appropriate modifier.
- Common issues:
 - Missing modifier on E/M codes that need modifier 25 to indicate a significant separately identifiable service
 - Missing modifier 59 to indicate distinct service
 - Missing LT?RT modifier to indicate which side was treated

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Eligibility



Common CARC Codes:
24, 26, 27, 31, 32, 200

Check to determine if the member did have active coverage during the date of service.



- Research the payers' online portals and review past or future claims to determine if the patient had another plan that may have been active during the DOS.
- Often, an incorrect subscriber ID is used, the patient's name was misspelled, the policy holder name was used instead of the patient's name or the patient had other active coverage that was not added or used.
- Once verified, then rebill to correct the information or rebill to the active plan.

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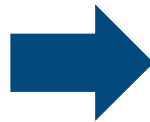
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Incorrect Discharge Status Billed



Common CARC Codes:
193,18

Occasionally, a provider will bill a discharge status that is inconsistent with the information the payer has.



- For example, discharge status 01 (discharged home) may be billed but the payer has information that the patient was transferred to home health (06).
- Once this denial is received, contact the payer to retrieve the information they have and rebill to change to the correct discharge status code.

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Coordination of Benefits



Common CARC Codes:
22, 227

Providers are seeing a large increase in claims that deny requesting a COB update or additional information from the member.



Recommend consistently checking with the payer to verify if the member has updated the needed information.

- If yes, the claim should be sent for reprocessing or request a rebill if needed for that payer (sometimes this step is not automatically done).
- If no, follow up with the member by phone call or letter to inform them that their insurance company is requesting additional information.
- Often the provider will coordinate with the patient but never follow up with the payer.

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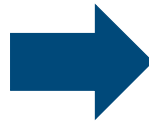
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Bilateral Procedures with Mod 5 Incorrectly Billed



Common CARC Codes:
16, 18, 4

When billing a bilateral procedure, one (1) unit should be billed on one line with modifier 50 appended



- Commonly see bilateral procedures billed incorrectly with two (2) units, LT/RT modifiers used instead of modifier 50.
- Also commonly see modifier 50 left off entirely.
- Action item is to rebill to change the billing for correct compliance with bilateral procedures.

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Self-Administered Drugs (Rev Code 0637)



Common CARC Codes:
16, 216

Commonly see Self-Administered drugs billed on outpatient claims using the revenue code 0637 with no CPT.



Some payers (most common with UHC and Cigna) will deny the 0637 charge for billing errors and the rest of the claim as contractual, paying \$0. In these cases, rebill to remove the 0637 charge entirely.

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No JZ/JW Modifier Used to Indicate Drug Waste



Common CARC Codes:
16, 4

Drugs billed from single-dose containers require the use of JZ or JW modifier to indicate waste.

This is needed with Medicare and MCR Adv plans but will sometimes apply to commercial payers as well.



- Commonly see hospitals billing high-cost drugs from single-dose containers but leaving off JZ/JW modifier entirely, resulting in a denial.
- Rebill to add the applicable modifier (JZ if the entire drug amount was administered or splitting to 2 lines and appending modifier JW to one line if a portion of the drug was discarded and not given to the patient).

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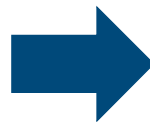
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Medicare IP/OP 72-hour Rule



Common CARC Codes:
18, 193

Medicare requires hospitals to bundle all outpatient diagnostic and related non-diagnostic services provided within 72 hours before an inpatient admission to the inpatient claim. Many claims billed separately or billed without the appropriate condition codes.



- If this happens, rebill to cancel the outpatient claim and combine with the inpatient claim if services were related.
- If services were unrelated, rebill to append the correct condition code indicating services were unrelated.

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Observation Charges Billed Incorrectly



**Common CARC Codes:
16, 216**

Per CMA guidelines, observation charges should generally be billed on a single line for the entire duration of the stay, including all hours up to 72, with the DOS reflecting the say observation began.



- Often, we will see observation charges separated on multiple lines by calendar day, instead of combining to one line, resulting in a denial.
- In this case, rebill to combine observation charges to one line with the appropriate units.

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Units Exceeding the MUE



**Common CARC Codes:
151, 119, 16**

If a claim is billed with more units than the "Medically Unlikely Edit" for a specific code this will result in a denial.



- Often, this denial appears to be related to a benefits issue based on the CARC codes applied to the EOB and is incorrectly attributed to patient responsibility.
- Commonly see this with surgical procedures. For example, 27130 has an MUE of one (1), billing with two (2) units will result in a denial.
- Rebill to correct the units billed to comply with the MUE.

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Readmission



Common CARC Codes:
249, 272, 96

Each payer has a readmission rule outlined in their policy (commonly 30 days)



- If a patient is discharged and then readmitted during that time frame for a related condition, the claim is denied.
- Review the claim that is denied as well as the surrounding claims billed to determine if the denied claim qualifies as a readmission. If the claim denied was billed outside of the readmission window, then appeal due to the incorrect denial or send the claim back for correct processing.
- If the claim denied was unrelated to the previous admission or was an unavoidable circumstance, appeal with medical records for medical necessity stating the two admissions were unrelated or unavoidable.

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Timely Filing



Common CARC Codes:
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Determine if there were extenuating circumstances that prevented the claim from being billed within the payer's time frame parameters.



- Examples would be the patient providing incorrect insurance or personal/demographic information at the time of service
- Build the appeal process with timeline notes outlining how the claim would have been submitted within the deadline had the extenuating circumstance not occurred.

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Example A9595 Claims: Same Billing, Different Outcomes

SCENARIO 1	SCENARIO 2
Paid Then Retracted	Paid as Billed
<ul style="list-style-type: none"> • 9 units billed • Initially Paid • CO-97 retraction (appeals unsuccessful) 	<ul style="list-style-type: none"> • 9 units billed • Paid as billed • No retraction to date

Inconsistent payer behavior for identical billing


\$90k retracted in 2025
\$100k at risk for retraction

A9595 is included on the fee schedule, yet identical billing produces different outcomes, suggesting inconsistent policy application.

Requires standardization and payer alignment to ensure consistent reimbursement

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Recommended Approach: Example A9595 Reimbursement Alignment

Based on observed reimbursement inconsistency, we recommend the following approach:

VALIDATE AND QUANTIFY	ENGAGE THE PAYER
<ul style="list-style-type: none"> • Analyze paid vs retracted claim patterns • Identify variance in reimbursement for identical billing • Quantify financial impact and consistency gaps 	<ul style="list-style-type: none"> • Present findings and claim examples • Seek methodology clarification • Align on consistent reimbursement approach

Payer alignment = Predictable reimbursement

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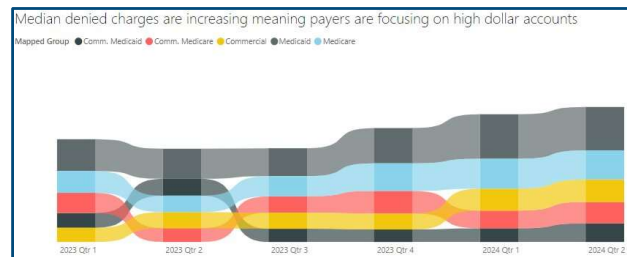
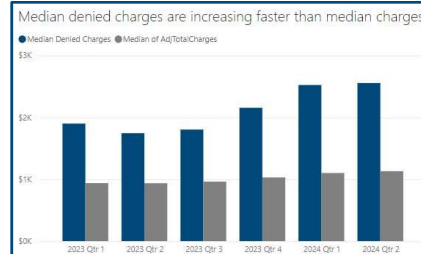
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PMMC Business Intelligence Trend



Payers Are Denying High Dollar Accounts At A Greater Rate

- Median denied charges have increased 54% year over year while the median charges for all accounts has only increased 18%
- Higher charge accounts (>\$25,000) make up 66% of denied revenue in the first quarter of 2024 so as this trend continues a greater portion of clients' highest revenue accounts will be at risk due to denials
- Documentation, Authorization, Coding, Credentialing and Non-Covered have the highest increases in Median denied charges
 - Hospitals should ensure authorization, coding and documentation processes are followed on high dollar accounts to prevent denials



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Reimbursement Maturity



Variations happen due to breakdowns across the revenue cycle, such as:



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Analytical Reporting



Reporting dashboards should be designed to provide visibility into recovery performance, opportunity, and workflow.

- **Transparency**
Comprehensive insight into submissions, collections, inventory, and closures - providing a full view of total performance
- **Accountability**
Clear visibility into productivity, follow-up activity, and recovery performance to ensure consistent execution and results
- **Collaboration**
Actionable insights that align your teams to identify trends, address root causes, and drive continuous improvement



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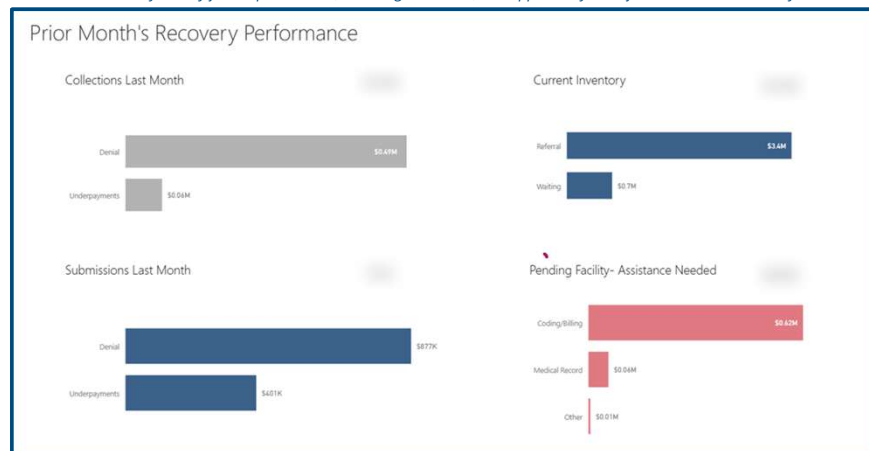
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Prior Month Recovery Performance



Monitor recovery activity for the prior month, including collections, new opportunity identified and current inventory status.

- **Collections**
Broken down between denials and underpayments, reflecting cash recovered during the previous month
- **Submissions**
Represent new opportunities and what has been added to inventory for potential recovery
- **Current Inventory**
Reflect accounts actively being pursued, with a breakdown of:
 - *Referral: Accounts currently with the payer for review*
 - *Waiting: Accounts pending additional information or action from client*



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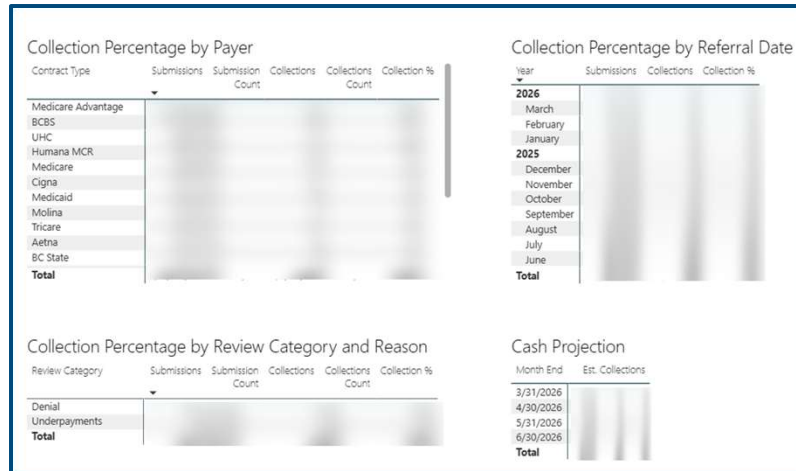
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Collections and Submissions Analysis



Compares what has been submitted to payers against what has been collected, providing visibility into overall recovery performance

- Measure success rates by payer, highlighting where recovery efforts are most effective
- Track month-over-month performance based on when accounts were submitted
- Breakdown by review category to identify trends in denials vs. underpayments
- Includes a cash projection based on prior submissions, outlining expected collections in subsequent months



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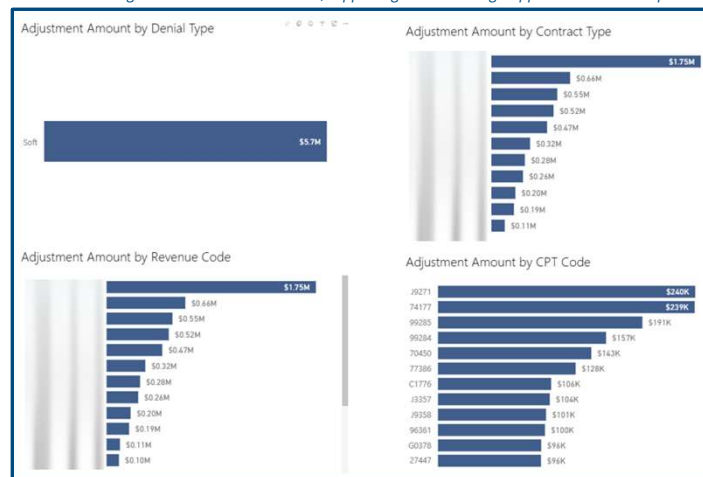
Line Level Denials



Provides detailed insight into denial at the line level, supporting a more strategic approach to revenue optimization.

- Identify trends by denial type, contract, revenue code, and CPT code
- Highlight specific areas where denials and underpayments are occurring most frequently
- Incorporate drill-down to pinpoint root causes and patterns

This allows your team to proactively address issues related to billing, coding, authorization, and registration that may be impacting reimbursement.



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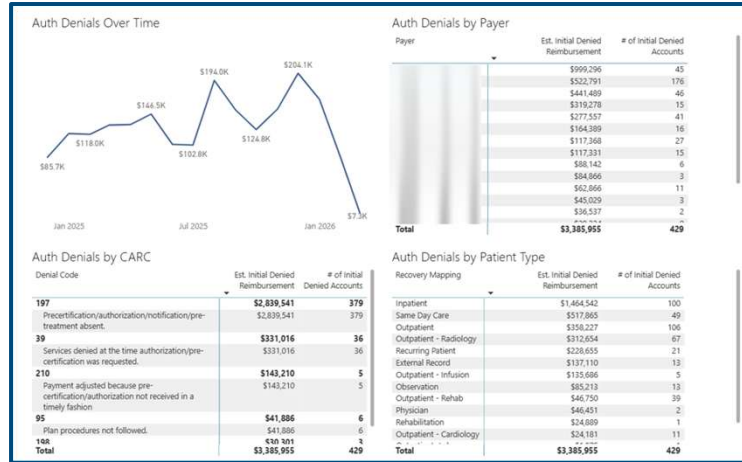


No Auth Denial Analysis

Authorization related denials represent avoidable revenue loss and unnecessary rework.

- Pinpoint trends by payer, CARC, and patient type
- Expose gaps in authorization, registration, intake workflows, etc.
- Quantify the financial impact of preventable denials

By addressing these drivers upstream, organizations can reduce denials, improve efficiency, and drive more consistent reimbursement.



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Days to Pay Summary

Tracks trends in payer response times, measured from when accounts are worked to when payment is received

- Display days-to-pay by payer, highlighting payer-specific patterns
- Breakdown by review reason to identify drivers of delays
- Trend analysis over time to monitor changes in payer behavior

Understanding these trends helps optimize follow-up strategies and improve recovery timelines



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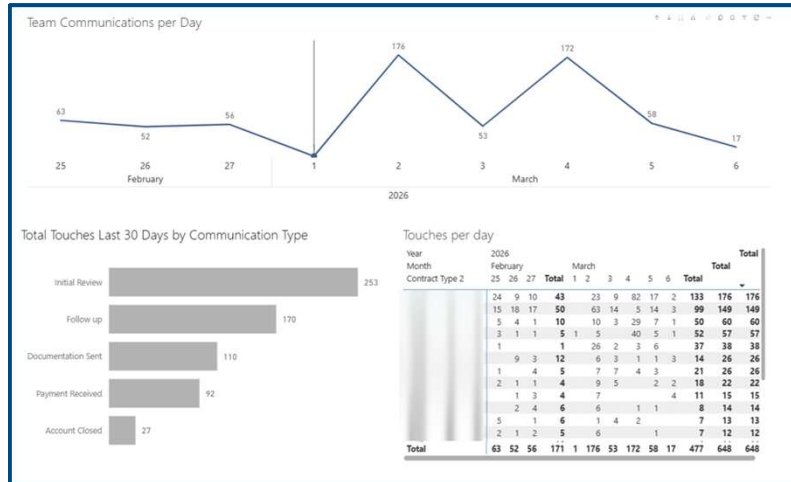
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Daily Productivity

- Track daily touch activity across accounts being worked
- Provides visibility into team engagement and consistency

This ensures consistent activity across accounts and reinforces accountability in driving recovery outcomes.



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Recovery Touches Summary

- Track the number of touches required to achieve successful recovery
- Displays total touch activity by communication type, including follow-up, review, and documentation efforts
- Tracks trends in average touches over time, providing visibility into workflow efficiency and consistency

Often accounts follow up can for 120-180 days post-ZB date, with follow-up occurring every 15-30 days to maintain consistent payer engagement.

Insight into the level of effort and engagement applied to accounts throughout the recovery process



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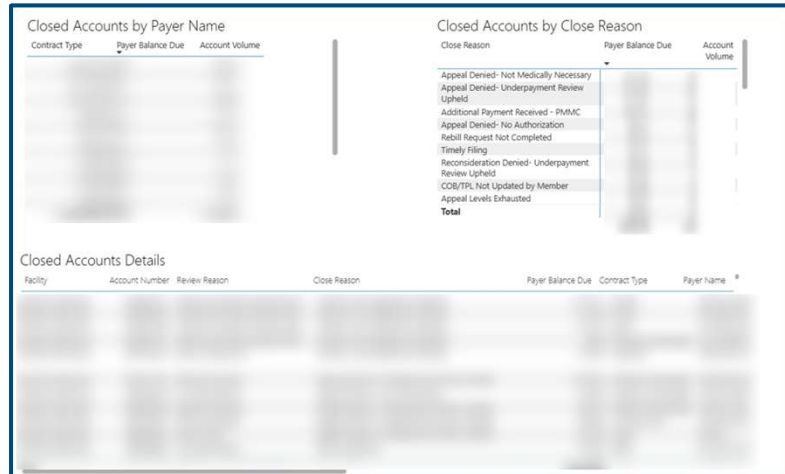
Closed



Insight into accounts closed from inventory and the reasons behind closure.

While the goal is always to recover additional dollars, this report provides transparency into both successful recoveries and accounts closed after all efforts have been exhausted.

- Breakdown of closed accounts by payer and close reason
- Visibility into outcomes, including successful recoveries and exhausted efforts
- Allows for deeper analysis of closure trends and helps identify patterns impacting recovery performance.



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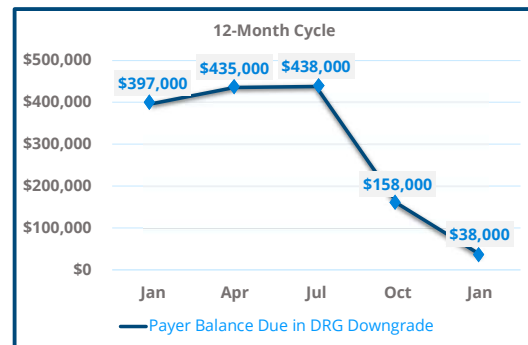
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93% Decrease in DRG related Denials/Underpays



DRG downgrades impacted 0.11% of net revenue during the fiscal year

- PMMC identified a trend in DRG-related denials and underpayments through custom insights.
- The client used this intelligence to:
 - Engage payers regarding the downgrade patterns
 - Decrease down-grade related denials and underpayments by 93% in 6 months
 - Monitor reimbursement discrepancies & outcomes moving forward




Mid West US | 9 Hospitals | 300+ Beds | 600+ Physicians | EHR: Oracle - Cerner

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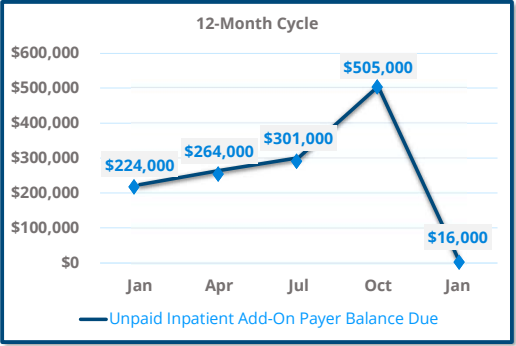
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\$1.3M Unpaid Inpatient Add-Ons Opportunity

88% drop in unpaid add-ons since providing insight

- PMMC identified a 94% increase in the payer balance due for unpaid add-ons.
- The client used this intelligence to:
 - Develop more effective negotiation strategies for future payer contracts.
 - Hold payers accountable and ensure proper reimbursement for add-on cases.
 - Reduce unpaid add-ons by 88%.




Month	Unpaid Inpatient Add-On Payer Balance Due
Jan	\$224,000
Apr	\$264,000
Jul	\$301,000
Oct	\$505,000
Jan	\$16,000

Southwest US | 30+ Hospitals | 3500+ Beds | 6500+ Physicians | EHR: EPIC

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Poll Question

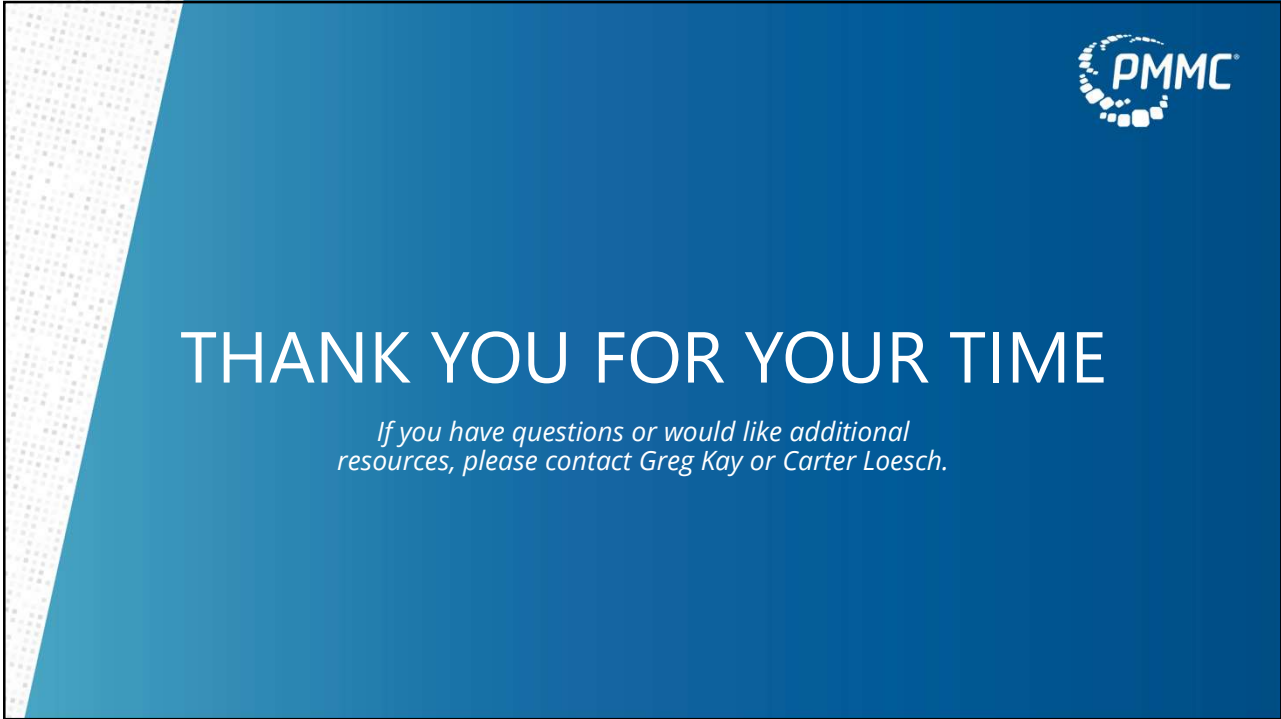
How effectively are you using analytics today to manage your underpayments and denials?



- **Very Effectively:** Analytics identifies underpayment trends and manages collections
- **Somewhat Effectively:** We use analytics but lack true insight
- **Not Effectively:** We either don't use them or they don't help

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THANK YOU FOR YOUR TIME

If you have questions or would like additional resources, please contact Greg Kay or Carter Loesch.