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FIGHTING DENIALS FASTER: HOSPITALS TACKLE REIMBURSEMENT DELAYS

HealthLeaders panel shares strategies for managing COB disputes, addressing payer requests for information, strengthening escalation pathways, and protecting the patient experience

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PANELISTS



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Fighting Denials Faster: Hospitals Tackle Reimbursement Delays

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Hospitals are under pressure to address reimbursement delays and denials, many of them tied to rising payer requests for additional information. These holdups drain staff resources through lengthy response and appeal processes, creating added stress for patients. Providers, however, are finding new ways to stay ahead.

From strengthening systems to manage incomplete or inaccurate information to working more closely with patients and insurers, hospitals are determined to resolve claims faster and with fewer bottlenecks. Additionally, automation and AI are emerging as the backbone of denial mitigation strategies, extending their reach into increasingly complex claims and appeals.

In the HealthLeaders webinar **From Delay to Pay: Solving Denial Disruptions, Patient Info Gaps, and COB Issues in the Revenue Cycle**, sponsored by Knowtion Health, panelists from Centra Health, MedStar Health, and Knowtion Health share how they are managing shifting payer strategies and risks to reimbursement. Here are the highlights of their discussion.

Revenue on the line: Setting priorities in a crowded queue

Hospitals are rethinking denial workflows as payer tactics evolve.

Robert Boos, VP of revenue cycle at Centra Health, stresses that two of the biggest priorities are pursuing high-value claims and maintaining a strong appeals strategy. Facing “thousands of denials on remittance advices every day,” he says the obvious step is to “go for the big money” on inpatient and outpatient surgery denials. He also urges leaders to pay close attention to each payer’s appeal process and allocate resources appropriately. “What is the structure for that first appeal?” he asks. “Are you a one-and-done?” If so, the strongest possible case must be made from the outset. Conversely, he adds,

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—Robert Boos, VP of revenue cycle at Centra Health

other payers may “need a first level of appeal just to get the process started,” in which case, “the real meat of the fight is your second and third-level appeal.”

Mikky Franklin, senior VP of revenue cycle at Knowtion Health, notes that automation is an essential component of denial prioritization, attributing “a lot of speed and a level of success” to advances in robotic process automation and machine learning, particularly when it comes to low balance recovery. “The right technology is the cornerstone of scalable workflows,” she says, adding that it can help determine how, when, and what type of account to work. Franklin also highlights the importance of assigning seasoned denials specialists to the most complex cases and creating clear payer resolution strategies.

When payers ask for more

Panelists shifted to addressing the deeper impact of payer requests for additional information and how hospitals are adapting. They say these demands increase A/R days and tie up staff, prompting organizations to rely on dedicated teams, automation, and closer tracking.

At MedStar Health, requests of this type have become a persistent financial strain. **Maria Brisueno-Burnett, AVP of patient financial services,** says they represent one of the top three denial categories. About 15% and 20% of claims are initially denied due to missing records, medical necessity documentation, need for itemized bills, and such. “We’ve seen as much as a 30% to 40% increase in our aged A/R due to initial denials from our major payers,” she says, adding that 75%–90% are overturned once the information is supplied.

To manage the volume, MedStar created a dedicated unit to handle all requests for additional information. The team reviews and scrubs each submission, uses vendor tools to automate workflows, and applies robotic process automation (RPA) to cut manual touches by 80%. “Finally, we track and trend the number of times that the payer continually asks for the same information so that we can identify patterns and opportunities to escalate back,” Brisueno-Burnett says.

“Patients don’t always understand what information is needed from them. Having an experienced specialist guide a three-way call with an insurer can often eliminate bottlenecks.”

—Mikky Franklin, senior VP of revenue cycle at Knowtion Health

Boos draws attention to the payer backlog that often follows the response to these inquiries. “We might get the information request turned around in three to four days,” he says, while the payers, on the other hand, might then take another 60 to 120 days to process the claims. He and the panel agree that payers must also be held accountable to prevent these delays from becoming the norm.

Advice on how to address COB and patient information denials

COB and patient information issues came up frequently during the panel discussion as among the most frustrating payment delay and denial categories, since they often hinge on information only the patient can provide. Franklin says 65% of COB and patient information denials are rarely resolved, accounting for about 2% of net patient revenue for a typical health system. She explains that managing denials effectively depends on having the right tools to discover coverage, clear workflows for follow-up, and staff expertise to guide both patients and payers through resolution.

Franklin emphasizes shifting the burden away from patients. “Modern COB teams like ours are using the latest in unidentified insurance discovery to expedite the process and not rely on the patient as much,” she says. Also, specialists have the knowledge of payer preferences and the workflow tools to quickly navigate eligibility issues and speed recovery and resolution.

She also recommends expanding patient outreach beyond letters and calls. Making use of texting, portals, and after-hours support can be effective. A skilled team for support is also important. “Patients don’t always understand what information is needed from them. Having an experienced specialist guide a three-way call with an insurer can often eliminate bottlenecks.” In certain situations, Knowtion specialists may even visit patients at home.

Top escalation approaches

The panelists also shared how they approach escalation when facing repeated payment delays or underpayment. They stress that structured

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—Maria Brisueno-Burnett,
AVP of patient financial
services at MedStar Health

pathways, data-driven insights, and leadership pressure are critical in moving payers toward more timely and accurate payment—and collaboration can make a difference, too.

For example, Boos says Centra Health uses payer scorecards developed through a Virginia hospital consortium. By pooling claims data with PHI removed, hospitals can compare payer behavior statewide and call out outliers. “Data is power,” he says. “When we’ve got 70%–80% of the state presenting their information together... payer A is going to pay attention.” The scorecards capture a wide range of denial types—COB, medical necessity, and ED level-of-care downgrades—and that collective reporting allows leaders to raise concerns at the highest levels. Boos says, “It’s really moved the needle considerably.”

Brisueno-Burnett outlined MedStar’s tiered approach for bringing issues to payers. “Our strategy involves using a system-structured escalation approach that includes tracking, following up, and pressure from our senior leadership,” she says. Each denial is assigned a payer tracking code so issues can be grouped and patterns identified. She adds that a dedicated managed care team works directly with payers to accelerate recovery and resolutions.

Fixing problems before patients feel them

Panelists also stress that denials don’t just affect revenue; they shape the patient experience in lasting ways. They agree that greater transparency and addressing potential sources of underpayment or denial are key to preventing billing surprises.

At Centra, Boos notes that denials have become one of the top five measures by which revenue cycle teams are judged. He highlights ED level-of-care downgrades as a major pain point, with patients often receiving surprise bills months later after a long appeals process. In response, Centra pushes back on payers, appealing all downgrades. Boos adds that scripting patient conversations is another safeguard to help staff explain the denial and appeal process clearly, so patients understand provider and payer actions and the impact on the time of billing.

About Knowtion Health:

Knowtion Health helps hospitals and health systems address coordination-of-benefit (COB) and patient involvement denials, improve clinical denial response, recover on low-balance accounts, resolve complex claims, and uncover missed reimbursement opportunities. In a world where the balance of power and complexity in insurance denials favor payers, our claim experts and technologies drive better outcomes and automation in insurance claim resolution. Providers achieve accelerated and increased revenue, solutions to labor shortages, and an optimized patient experience.

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Brisueno-Burnett says MedStar emphasizes early intervention to keep claims moving on time. To this point, she says a denials task force meets regularly to identify recurring payer behaviors, while financial clearance units work to confirm coverage and advocacy services assist with eligibility. Cleaning up recurring issues and addressing problems upstream, she says, “helps us ensure we get the bill out to the patient quicker.”

Franklin stresses that reviewing resource allocation is increasingly important to best anticipate and scale denial management efforts. “You really need to be thoughtful about where your teams are working to ensure the greatest impact from their efforts. Workflow prioritization and support from service providers with specialized solutions are increasingly important for succeeding with the necessary speed and effectiveness in today’s high-denial environment.■

