

# Reducing denials at the source

# Agenda



- 1** About me
- 2** Current state
- 3** Where technology can improve denials - starting with the contract
- 4** Where technology can help improve speed of denial resolution
- 5** Closing thoughts

# Trusted by the nation's largest health systems

300+ forward-thinking healthcare organizations partner with Turquoise, including many of the nation's largest health systems, and are rapidly expanding usage as active users grow and platform engagement increases 5x YOY.

**5X** Increase in user engagement



**30+** Health Systems >\$5B in Revenue

**150+**  
Health systems  
10/Top 25

**30+**  
Payers  
4/Top 5

**50+**  
Life Sciences  
8/Top 10



# Turquoise Presenters



- 15 years in healthcare
- Background in consulting, underpayment recovery, contract modeling and healthcare technology
- [Rachelle@turquoise.health](mailto:Rachelle@turquoise.health)

## Rachelle Puccioni Rehs

RVP, Growth

1 in 9 claims is denied. Most teams are still fighting them one at a time.



# 11.8%

## Denial rates are on the rise

Initial denial rate was 11.8% 2024, up from 10.2% just a few years earlier

# 43bn

## Chasing payments is a \$43B problem

\$43B was spent in 2025 trying to collect payments already owed

# >50%

## Momentum is not on your side

50% of appealed denials are ultimately overturned.

**Business Wire:** Rate of initial denials of medical insurance claims continued to rise in 2024, Kodiak Solutions' proprietary data show

**Chief Healthcare Executive:** Hospitals spent \$43 billion to get payments from insurers

**Healthcare Dive:** More insurance claims denials are being overturned upon appeal, study finds

# Your contract is either working for you or against you.

## What tiggers a denial?

- Coding error
- Medical necessity
- Timely filing



Which high-volume services face both policy challenges and unfavorable contract terms?

Several high-volume services face both policy challenges and unfavorable contract terms, creating potential revenue and operational risks. Based on your rate data and contract/policy analysis, here are the key service areas of concern:

### High-Volume Services by Volume

Service Line	Volume	Avg Rate	Key Challenges
MSK (Musculoskeletal)	48.9M	\$9,471	Prior auth requirements; case rate caps <sup>1</sup>
Radiology	42.1M	\$830	Fee schedule limitations; prior auth <sup>2</sup>
Lab/Pathology	37.5M	\$186	Low reimbursement; fee schedule caps <sup>3</sup>
Cardiovascular	21.2M	\$12,964	Prior auth; case rate limitations <sup>4</sup>

### Policy Challenges Identified

- **Prior Authorization Requirements:** Multiple payers (Blue Cross, BCBS Michigan, HealthPartners, CareSource) require prior authorization for elective procedures, with services potentially denied if PA is not obtained before rendering services.<sup>56</sup>
- **Quantity/Frequency Limitations:** Cigna and HealthPartners impose quantity limits on medical injectables and high-volume supplies, with claims denied if quantities exceed limits or are given earlier than frequency limits.<sup>78</sup>
- **Medical Necessity Reviews:** CareSource and Horizon NJ Health require medical necessity documentation for medications exceeding quantity limits, adding administrative burden.<sup>910</sup>

### Unfavorable Contract Terms Identified

- **Chargemaster Increase Caps:** Aetna limits chargemaster increases to 4% inpatient / 2.75% outpatient, with automatic discount adjustments if exceeded.<sup>11</sup> Cigna caps at 5% with automatic discount increases.<sup>12</sup>
- **High-Cost Drug/Implant Pass-Through:** UHC contracts reimburse high-cost implants and drugs at only 60% of billed charges above a \$5,000 threshold.<sup>13</sup>
- **Observation Services:** Multiple contracts cap observation at 35-70% of billed charges with fixed dollar caps (e.g., \$5,000-\$7,560).<sup>1415</sup>
- **Lab/Radiology Fee Schedules:** UHC uses fee schedules at 150-200% of source fees, with unlisted codes defaulting to 60% PPR.<sup>1617</sup>
- **Audit Rights:** Payers retain rights to audit chargemaster increases and retroactively adjust rates.<sup>18</sup>

### Services with Combined Risk

Sources ⓘ

\$ Clear Rates



Contracts



Policies



All Sources ▾



Audience question:

**How many know which contract clause or service line is behind your top denial reason code?**



# Defending your revenue on the front end

- 1** Know which payers and denial categories are costing you the most and how often you're winning.
- 2** Then you can push for explicit language on high-exposure categories: auth requirements, bundling logic, medical necessity criteria tied to named clinical guidelines
- 3** Build in dispute resolution language with timelines, written justification requirements, and escalation paths

Through better contract language and rate structure on the front end, links and ties to common denials.



# Contract intelligence platforms can now..

- Ingest remittance data and map denial patterns to the specific contract provisions (or missing language) driving them

T Claims Submission 60 days

4.2 Timely Submission of Claims. All information necessary to process a claim must be submitted no more than sixty (60) days from the date all Covered Services were rendered. In the event Plan requests additional information in order to process a claim, Facility will provide that additional information within thirty (30) days of such request.

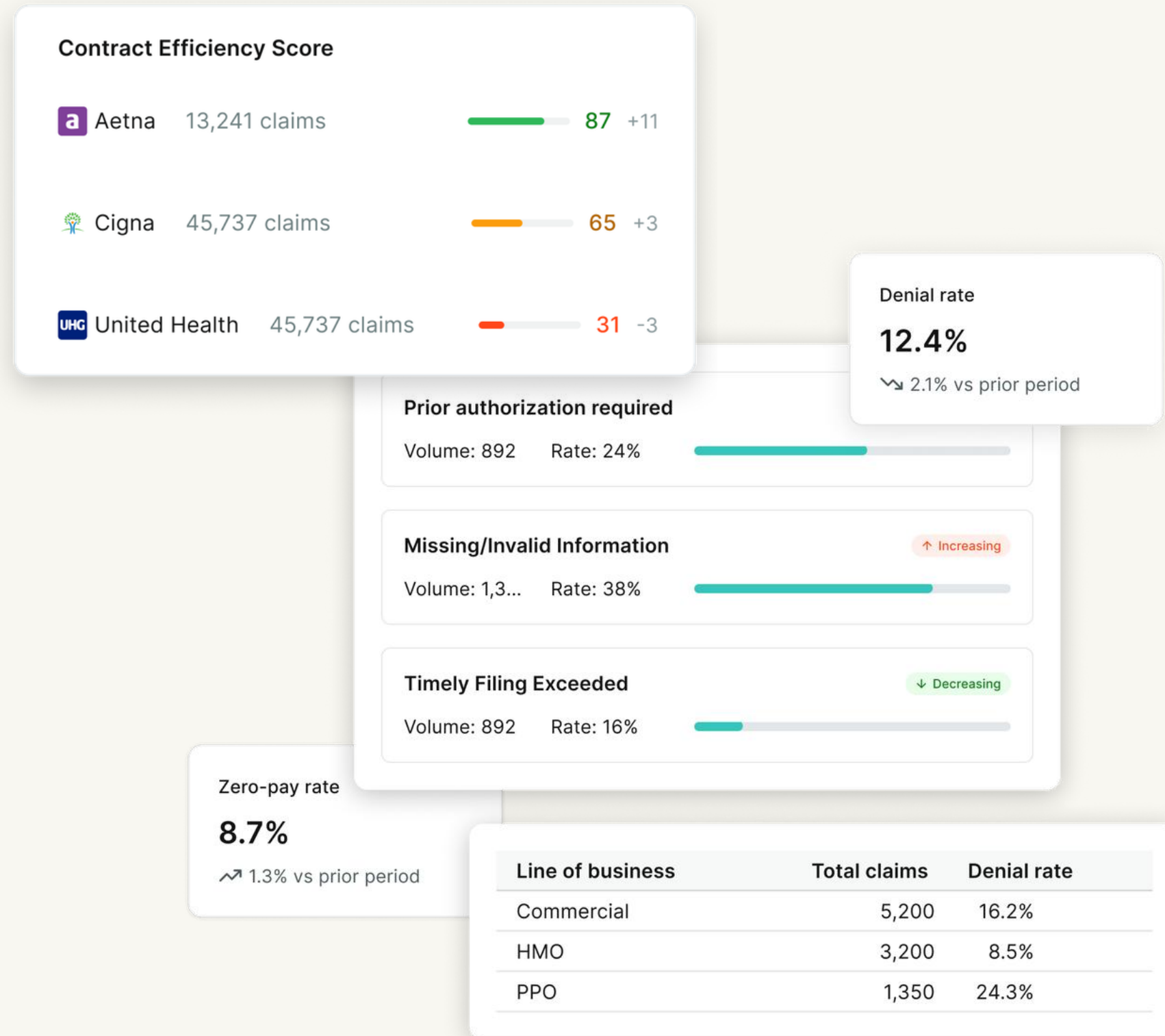
4.3 Prompt Payment of Claims. Plan shall process and pay all Clean Claims within ninety (90) days of receipt. In the event Plan does not process and pay any Clean Claim within this timeframe, Plan shall pay 1.5% per month on the amount due and unpaid.

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t be submitted no more  
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requests additional  
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s of receipt. In the  
Clean Claim  
per month on

# Contract intelligence platforms can now..

- Surface which payers and which categories are generating the most exposure, and quantify it in dollars



# Contract intelligence platforms can now..

Model proposed contract changes before you sign, so you can forecast the revenue impact of a new rate structure or added auth language



### Rate Escalators with 3% CDM increase

Apply contact rate escalator clauses for future years with 3% CDM increase.

---

**Structure Editing (1)** 👤 Edited      **Rate Editing** ✂ Not Edited

Review and update the contract structure if changes are needed for this scenario.      Review the rate table and apply or adjust any escalator-based pricing changes.

[🛠 Edit Contract Structure](#)      [⚙ Edit Rates](#)

---

S1 > **Rate Escalators with 3% CDM increase**  
Apply contact rate escalator clauses for future years with 3% CDM increase. ...

S2 > **Rate Escalators with no CDM increase**  
Apply contact rate escalator clauses for future years as is without ad  adjustments. ...

[+](#) **Create Scenario**

**Scenario 1**   Scenario 2   Scenario 3

---

### Scenario 1: Rate Escalators with 3% CDM increase

Apply contact rate escalator clauses for future years with 3% CDM increase.

[View Rules](#)

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### Projected Revenue

● All Facilities

Year	Projected Revenue
Base	\$1.0M
2025	\$1.2M
2026	\$1.7M
2027	\$1.7M



# Even with the best contracts and the most proactive negotiating posture, denials will happen.

Your strongest weapon is the agreement the payer already signed.

The question is whether your team can get to it fast enough.

- 1** Use the specific written obligation the payer failed to meet. Cite the specific contract provision or payer policy section by name.
- 2** Connect that provision to the clinical facts.
- 3** Close with a specific request and a hard deadline.



# Defending the revenue you've already signed for: Can your team work it fast enough?

# 60%

of denied claims are never appealed; not because they couldn't be won, but because teams run out of time or capacity (1)

# \$20bn

spent annually by hospitals on denial management alone

# Contract intelligence platforms can now..

Extract key provisions and rates from your contracts

**Hospital Services Agreement**

Commercial

Line of Business

Provider Type

The Plan will reimburse for services furnished in an Ambulatory Surgery Center in accordance with the ASC Fee Schedule.

Appeals Timeline

If the Provider disputes a denied claim, Provider may submit a written appeal for review within sixty (60) days.

II. Outpatient Service Inclusions

Description	Code	Reimbursement
Total Shoulder Arthroscopy	23472	\$16,500
Treat Clavicle Fracture	23515	\$4,900
	29827	\$6,100

12 Rates

**Risks And Opportunities**

- ⚠ New site-of-service criteria may affect reimbursement for orthopedic procedures.
- ⬆ Market research shows trend of 3% annual rate increase for similar providers.

# Contract intelligence platforms can now..

Query and compare the typically hidden information in seconds

PROMPT

Can you provide a summary of current neonatal service qualifier rates, reimbursement methods, and all contract terms?

[View 4 source and steps](#) >

Here is a summary of all current neonatal service rates across your contracts:

#### Crimson Shield Health Plan (Effective 2026-01-01)

Service	Qualifier	Rate	Reimbursement
Neonatal Intensive Care (NICU) Level 4	RC: 174	\$4,220	Per Diem
Neonatal Intensive Care (NICU) Level 3	RC: 173	\$3,818	Per Diem
Neonatal Intensive Care (NICU) Level 2	RC: 172	\$1,980	Per Diem
General Nursery / Boarder Baby	RC: 170 - 171	\$1,511	Per Diem <sup>1</sup>

#### HeritageCare Health Plans (Effective 2025-03-01)


Service	Qualifier	Rate	Reimbursement
Nursery Level 3	MS-DRG: 791	\$1,450	Case Rate Per Diem
Nursery Level 2	MS-DRG: 789	\$1,045	Case Rate Per Diem
Normal Newborn	MS-DRG: 795	\$1,027	Per Diem <sup>2</sup>

#### Key Findings


- **Highest NICU Level 4 rate:** Crimson Shield Health Plan at \$4,220 per diem
- **Lowest NICU Level 4 rate:** Nimbus Health Insurance at \$3,920 per diem
- **Most common reimbursement method:** Per Diem across all contracts
- **Qualifiers used:** Revenue Codes (RC 170-174) and MS-DRGs (789-795)
- HeritageCare uses a Case Rate Per Diem hybrid method for some nursery levels


# Contract intelligence platforms can now..

Get notified about silent changes so you can act fast


 Weekly Payer Policy Digest

These updates may impact some of your active agreements. See what's changed:


 Modified Texts

 Insuracare of MI  
New site-of-service criteria may affect reimbursement for orthopedic procedures

[Review ↗](#)

 Removed Texts

Insuracare to reduce about one-third of prior authorization requirements for outpatient services by January 1, 2026

 Added Texts

[See all 40](#)



Audience question:

**How is your team staying on top of payer policy changes that affect reimbursement today?**

# Contract intelligence platforms can now..

Send you proactive policy change alerts, and allow you to search and scan for the updates that make a difference to your bottom line with AI.

Reference Library > 25-hydroxyvitamin D Testing in Children and Adolescents
AskTQ

Previous Version - Sep 1, 2024
Current Version - Sep 1, 2025

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**Table 1: CPT codes not medically necessary when billed with a corresponding ICD-10-CM diagnosis code in Table 2.**

CPT® Codes	Description
82306	Vitamin D; 25 hydroxy, includes fraction(s), if performed

**Table 2: ICD-10-CM diagnosis codes not medically necessary when billed with a corresponding CPT code in Table 1.**

ICD-10-CM Code	Description
E66.01	Morbid (severe) obesity due to excess calories
E66.09	Other obesity due to excess calories
E66.1	Drug-induced obesity
E66.3	Overweight
E66.8	Other obesity
E66.9	Obesity, unspecified
Z00.00	Encounter for general adult medical examination without abnormal findings
Z00.129	Encounter for routine child health examination without abnormal findings
Z00.8	Encounter for other general examination
Z68.52	Body mass index (BMI) pediatric, 5 <sup>th</sup> percentile to less than 85 <sup>th</sup> percentile for age
Z68.53	BMI pediatric, 85 <sup>th</sup> percentile to less than 95 <sup>th</sup> percentile for age

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convened by the European Society for Pediatric Endocrinology.<sup>2,3,6,7</sup>

**Coding Implications**  
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E66.8	Other obesity
E66.81	Obesity class
E66.811	Obesity, class 1
E66.812	Obesity, class 2
E66.813	Obesity, class 3
E66.89	Other obesity not elsewhere classified
E66.9	Obesity, unspecified
Z00.00	Encounter for general adult medical examination without abnormal findings

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**CLINICAL POLICY**  
Hydroxyvitamin D Testing in Children

ICD-10-CM Code	Description
Z68.54	BMI pediatric, greater than or equal to 95 <sup>th</sup> percentile for age

ICD-10-CM Code	Description
Z00.129	Encounter for routine child health examination without abnormal findings
Z00.8	Encounter for other general examination
Z68.52	Body mass index (BMI) pediatric, 5 <sup>th</sup> percentile to less than 85 <sup>th</sup> percentile for age
Z68.53	BMI pediatric, 85 <sup>th</sup> percentile to less than 95 <sup>th</sup> percentile for age
Z68.54	BMI pediatric, 95 <sup>th</sup> percentile for age to less than 120% of the 95 <sup>th</sup> percentile for age

**Reviews, Revisions, and Approvals**

Revision Date	Approval Date
12/17	12/17
02/20	02/20
12/20	01/21
11/21	11/21
09/22	09/22
09/23	09/23
09/24	09/24

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**Reviews, Revisions, and Approvals**

Revision Date
12/17
02/20
12/20
11/21

**Policy Changes**

Summary AI Preview: Sonnet Set global

This policy underwent an annual review with no changes to coverage criteria. The policy continues to deem 25-hydroxyvitamin D testing not medically necessary for healthy children ages 1-18, including those who are obese but otherwise healthy. The update added four new ICD-10 codes (E66.81, E66.811, E66.812, E66.813, E66.89) to further classify obesity categories and modified one existing obesity code definition to specify BMI parameters more precisely (95th percentile to less than 120% of 95th percentile).

[View Less](#)

AI summaries may have mistakes. Please double-check.

**Added Texts** 21

**Modified Texts** 11

"Date of Last Review: 09/25"

"Page 1 of 6"

"2024, American Medical Association. All rights reserved. CPT codes and CPT descriptions are"

Previous Text

"2023, American Medical Association. All rights reserved. CPT codes and CPT descriptions are"

"ICD -10 -CM"

"Page 2 of 6"

"www.uptodate.com. Published October 30, 2024. Accessed August 12, 2025."

"Page 3 of 6"

"Accessed August 14, 2025."

"Updated April 24, 2024. Accessed August 14, 2025."



# Generic CLMs won't connect the dots

Tell tale signs your CLM is not build for healthcare

- You find out about payer policy changes when a claim comes back denied.
- Generic AI doesn't understand the nuance of line of business or provider type specifics in Managed Care contracts.
- There's no way to see how a contract is actually performing against what you're being paid.
- The system can store a contract but can't tell you what it says about prior auth for a specific service.
- You can't model what a rate change would actually mean for your revenue before you sign.

Matrix

Payer ▾ Provider ▾ Status ▾ Labels ▾ Tags ▾ State ▾ All Contracts ▾

	PCPS Commercial Effective 2019-01-01 Open Contract	Insuracare PPO Effective 2019-01-01 Open Contract	OthelloHealth CCH Agre... Effective 2019-01-01 Open Contract
State	Arizona	Arizona	Arizona
Payer	PurpleCross PurpleShield	Insuracare	Cigna
Plan	HMO, PPO, POS	PPO, HDHP	PPO
Provider	Cherry Creek East	Cherry Creek Hosiptal	Cherry Creek Hosiptal
Appeals Timeline	60 days	90 days	90 days 60 days
Claim Submission	180 days	90 days	90 days
Continuation of Benefits	<a href="#">View Clause</a>	-	90 days
Initial Terms	1 year	3 years	-
Material Breach Cure	30 days	30 days	30 days
Material Breach Notice in D...	30	60	60
Prompt Pay	-	90 days for claim submissio...	90 days for claim submissio...



# How to set up your teams for continued success in today's world

**Does your denial data live in one place, or is it scattered across systems that don't talk to each other?**

**Can any member of your team find the governing contract clause for a denial in under five minutes, or does that capability live with one or two people who have been doing this long enough to know where to look?**

**When a payer updates a policy, does your team find out proactively, or do you find out when the denials start coming back? How long does it take you each week or month to find these?**

**Does your managed care team see denial patterns before a contract renewal, or are they negotiating on rate alone?**

# Thank You

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