HEALTH OPS by SPIKE

Operational Automation in PT, OT, and SLP Therapy

How PT, OT, and SLP practices are **automating admin load.**

The daily reality of manual verification

Insurance verification and related administrative tasks now consume 30–40% of front desk staff time. Administrative costs now account for more than 40% of total healthcare operating expenses, with insurance verification representing a significant share of this burden for specialty clinics.

Key takeaways about manual verification:

Time per verification call	15–20 minutes average
Admin time consumed	30–40% of staff hours*
Annual cost per location	$40,000–$80,000+*
Claim denial rate (2024)	11.8%
The top cause of denials	Front-end revenue cycle errors
Cost to rework a denial	$25–$181 per claim

The daily reality of manual verification

8:47 AM at a typical therapy clinic:

- Front desk coordinator on hold with Blue Cross for 22+ minutes
- Patient arriving at 9:00 with unverified coverage
- Three patients are checking in simultaneously
- Phone ringing (a cancellation)
- Authorization from last week is still unresolved

The Result:

- The wrong patient file was pulled under pressure
- Copay quoted $40 short
- Frustrated patient, delayed therapist
- The transposed policy digit surfaces as a denial 3 weeks later

This isn't a bad day.
This is a daily situation.

How the front desk role expanded

In the past decade, the front desk role and workload expanded significantly, yet the headcount didn't.

2015

- Answer phones
- Schedule appointments
- Greet patients

When your staff is overworked, mistakes are bound to happen.

2025

- Answer phones
- Schedule appointments
- Greet patients
- **Verify insurance benefits**
- **Explain deductibles and copays**
- **Track prior authorizations**
- **Manage referral coordination**
- **Handle billing questions**
- **Follow up on coverage issues**

Operational and financial burden of manual verification

Error type	Consequence
Transposed policy digit	Claim denial, weeks to resolve
Missed visit limit	Unexpected patient bill, damaged trust
Lapsed authorization	Rescheduled appointment, lost revenue
Outdated coverage	Service delivered, reimbursement denied

Estimated annual verification costs by clinic size

Clinic size	Estimated annual cost based on internal calculations	Primary pain point
1-3 locations	$40K-$80K per site	Headcount constraints
5-15 locations	$200K-$600K total	Inconsistent processes across sites
25+ locations	$1M+ total	Scaling admin linearly with growth

The claim denial problem

Initial claim denial rates **increased to 11.8% in 2024,** up from approximately 10.2% just a few years earlier.

TOP CAUSE:

Front-end revenue cycle errors, including eligibility errors and missed prior authorizations

Cost to rework

Practices
$25 per claim

Hospitals
$181 per claim

Medicare Advantage denials
$47.77 average

Commercial denials
$63.76 average

Market shift toward automated verification

01 **Pulls data**
Patient and policy information from EMR

02 **Contacts the carrier**
Voice AI agent calls the insurance company directly

03 **Confirms coverage**
Verifies active eligibility

04 **Extracts benefits**
Documents deductibles, copays, limits

05 **Checks authorization**
Identifies prior auth requirements

06 **Documents automatically**
Writes results to EMR

Two delivery options

Everything is completed before the patient arrives, so any issues can be resolved beforehand.

Rapid delivery

Key eligibility data in under 3 hours (coverage varies by payor)

Full VoB

Complete benefits verification, same-day

WHAT SPIKE VOICE AI AGENTS HANDLE:

Instant eligibility confirmation	Verifies active coverage before the patient arrives
Benefits extraction	Documents deductibles, copays, and coverage limits
Visit limit flagging	Identifies caps and remaining visits automatically
Authorization discovery	Checks prior authorization requirements by payor and service type
Automatic documentation	Records all verification details in a standardized format
EMR integration	Syncs directly with existing practice management systems

Automation does not replace staff

A common concern is, "Does this replace my front desk team?" The short answer is no.

What changes after implementing automated verification:

BEFORE	AFTER
Sitting on hold with carriers	Focusing on patient experience at check-in
Manually documenting benefits	Handling exceptions and edge cases
Racing through verifications	Building patient relationships

Multi-layer accuracy validation

Health Ops by Spike uses layered verification:

01 Initial carrier contact

Voice AI agent calls the insurance carrier directly and speaks with a representative.

02 Secondary verification

A follow-up verification confirms benefit details and resolves any ambiguities.

03 Portal cross-reference

The system validates collected information against the carrier's online portal.

04 Human review for discrepancies

If sources conflict, our specialist intervenes to reconcile the data before it reaches your EMR.

Result **Consistent documentation, full audit trail, errors caught before they reach your EMR.**

Health Ops by Spike in practice

No admin input required	The system runs in the background, triggered automatically when appointments are schedule
Real-time status visibility	Staff can view verification progress in an observability dashboard without leaving their EMR
Direct EMR write-back	Benefits data flows directly into your practice management system; no copy-paste, no manual entry
Go-live in one week	Typical deployment includes an onboarding call, system calibration, and trial kick-off within 5–7 business days
Read-write integration	The system pulls patient and scheduling data and writes verification results back, with no middleware or manual sync

HEALTH OPS BY SPIKE INTEGRATES WITH:

WebPT, Raintree, Empower EMR, Clinicient, TheraOffice, and others

REPORTED OUTCOMES

Clinics that have adopted verification automation report:

- Fewer claim denials
- Faster reimbursement cycles
- Front desk staff focused on in-clinic patients
- Consistent verification quality across locations
- Reduced administrative overtime

Platform Highlights:

Capability	Detail
Payor coverage	1,000+ payors in 45+ states
Accuracy	4-source validation with human-in-the-loop review
Rapid delivery	Key eligibility data in under 3 hours (varies by payor)
Full VoB	Complete benefits verification on the same day
Compliance	HIPAA, GDPR, CCPA compliant; ISO 27001:2022 certified
Integration	Direct EMR connection, VoB details in existing workflow
Deployment	Trial kick-off in as little as one week
Specialty focus	Built for PT, OT, and SLP workflows

Our goal is to help clinics reduce administrative burden and eliminate the operational bottleneck between a patient wanting care and your practice getting paid.

BOOK A DEMO

To see how verification automation cuts denial rates, speeds up collections, and improves revenue cycle efficiency and patient access workflows.

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