Jorie AI ADVANCED AUTOMATION
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Leveraging Jorie AI to Address Private Payers' Tactics in Claims Denial Management: A Comprehensive Approach and Response to BECKER'S Hospital CFO Report

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Abstract:
In March of 2024, BECKER'S Hospital CFO Report released an article titled 'Claims Denials Are Costing Hospitals Nearly $20B Per Year".[1] The article was written in response to a survey conducted within the healthcare industry, as highlighted in the Premier Inc. article "Trend Alert: Private Payers Retain Profits by Refusing or Delaying Legitimate Medical Claims,".[2] The outcome of this report suggested that hospitals and healthcare systems spend roughly $19.7 billion dollars a year to contest denied claims.

The following paper not only aims to explore the underlying challenges that pose these significant financial burdens on healthcare institutions, amounting to nearly $20 billion annually but also to offer comprehensive, rapid solutions that will aid in overcoming such incumbrances. By adopting a complete, fully automated Revenue Cycle Management (RCM) technology equipped with advanced predictive analytics, streamlined workflow automation, enhanced documentation accuracy, compliance optimization, and other cutting-edge features, Jorie AI bestows a transformative solution for addressing claims denial management challenges.

Through the seamless integration and implementation of this innovative technology, hospitals and healthcare institutions not only position themselves for guaranteed financial sustainability but they are also able to relieve the overwhelming burden of denial claims that are currently being placed on providers. Ultimately, this end-to-end advanced automation allows for the delivery of unrushed, high-quality patient care, all while ensuring that providers receive their due compensation promptly and equitably.

Key Words: Revenue Cycle Management, Medical Claims, Medical Billing, Claims Denials, Medical Reimbursement, Adjudication, Jorie AI

Abbreviations: Revenue Cycle Management (**RCM**), Artificial Intelligence (**AI**), Electronic Health Record (**EHR**), Ambulatory Surgical Center (**ASC**), American Medical Association (**AMA**)

I. Introduction:

Medical claim denials continue to suffocate healthcare institutions, with private payers employing various tactics to retain profits, as revealed in the study discussed in the Premier Inc. article.[2] This white paper examines the intricate challenges posed by private payer tactics in claims denial management and explores how Jorie AI serves as a strategic solution to address these challenges comprehensively.

Before addressing how Jorie AI can solve such challenges it is crucial to understand the details around the financially alarming study and survey that was performed by Premier and reviewed in a recent 2024 Becker's Hospital CFO report. Premier Inc., a longtime leader in healthcare improvement, decided to collect data to show its support on behalf of the many healthcare members experiencing persistent payment denials and delays by healthcare plans. A survey created by Premier, utilized voluntary data from 516 hospitals, across 36 states in the United States of America. The information gathered, focused on all medical claims from the year 2022 and clear-cut calculations were created to identify the total costs associated with combating medical claims that had been denied for the year 2022 across these 516 hospitals, which accounted for a total of 52,123 acute care beds.

II. Findings:

The study highlighted in the Premier Inc. article sheds insight on the disturbing trend of payers refusing or delaying legitimate medical claims as a possible strategy to enhance profitability. A practice that continues to raise concern for practitioners, hospitals and healthcare institutions nationwide. Unfortunately, there haven't been advancements strong enough to reverse this matter and its time that payers stop this unwarranted and unfair way of business.

These tactics include complex pre-authorization processes, arbitrary claim rejections, and deliberate delays in claims processing, all of which lead to significant financial losses and operational inefficiencies across healthcare organizations. Of the many key takeaway points that can be found from the survey results, Premier focuses on four major ones:

1. Nearly 15 percent of all claims submitted to private payers for reimbursement are initially denied, including many that were pre-approved to move forward through the prior authorization process. *(See Figure 1)*

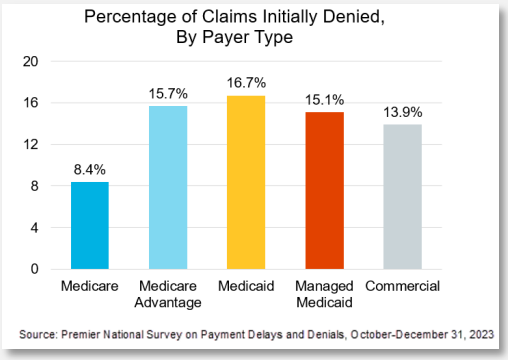

Figure 1: Percentage of Claims Initially Denied, By Payer Type. Source: Premier National Survey on Payment Delays and Denials, 2024. "Private payers retain profits by refusing or delaying legitimate medical claims." Population Health Cost Management. Retrieved from https://premierinc.com/newsroom/blog/trend-alert-private-payers-retain-profits-by-refusing-or-delaying-legitimate-medical-claims

2. Denied claims tended to be more prevalent for higher-cost treatments, with the average denial pegged to charges of $14,000 and up. *(See Figure 2)*

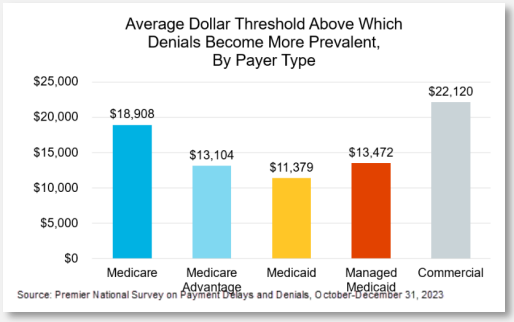

Figure 2: Average Dollar Threshold Above Which Denials Become More Prevalent, By Payer Type. Source: Premier National Survey on Payment Delays and Denials, 2024. "Private payers retain profits by refusing or delaying legitimate medical claims." Population Health Cost Management. Retrieved from https://premierinc.com/newsroom/blog/trend-alert-private-payers-retain-profits-by-refusing-or-delaying-legitimate-medical-claims

3. Over half (54.3%) of denials by private payers were ultimately overturned and the claims paid, but only after multiple, costly rounds of provider appeals. *(See Figure 3)*

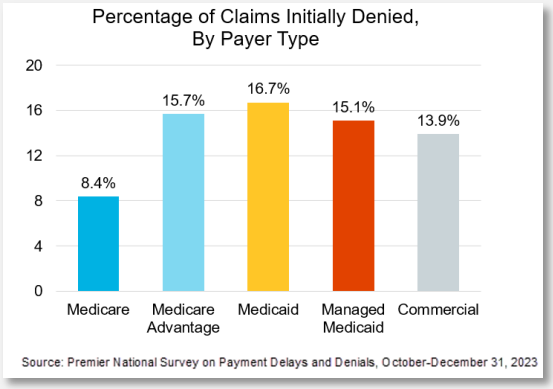

Figure 3: Percentage of Claims Initially Denied, By Payer Type. Source: Premier National Survey on Payment Delays and Denials, 2024. "Private payers retain profits by refusing or delaying legitimate medical claims." Population Health Cost Management. Retrieved from https://premierinc.com/newsroom/blog/trend-alert-private-payers-retain-profits-by-refusing-or-delaying-legitimate-medical-claims

4. The average cost incurred by providers fighting denials is $43.84 per claim – meaning that providers spend $19.7 billion a year just to adjudicate with payers *(See Figure 4)*. It is important to note that the following figure provided by Premier does not include the costs associated with added clinical labor; According to the report, the American Medical Association (AMA) estimates that this adds and additional $13.29 to the adjudication cost per claim for a general inpatient stay and $51.20 to the cost of inpatient surgery.

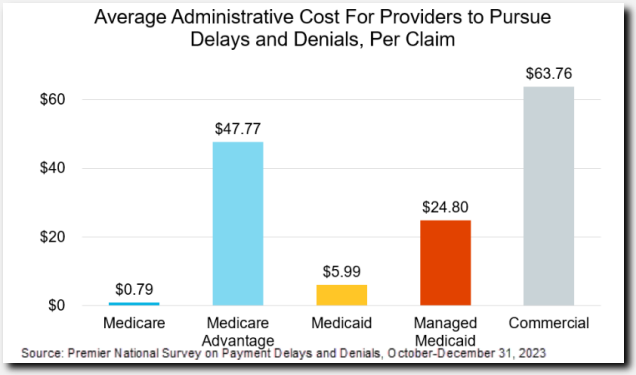

Figure 4: Average Administrative Cost For Providers to Pursue Delays and Denials, Per Claim. Source: Premier National Survey on Payment Delays and Denials, 2024. "Private payers retain profits by refusing or delaying legitimate medical claims." Population Health Cost Management. Retrieved from https://premierinc.com/newsroom/blog/trend-alert-private-payers-retain-profits-by-refusing-or-delaying-legitimate-medical-claims

As it was briefly mentioned earlier, other findings hint towards the fact that private payers likely employ tactics such as pre-authorization requirements and claims rejections as a means for retaining profits. These practices include arbitrary claim denials and delays which hinder timely reimbursement, leading to strain on the healthcare institutions' financial resources. Furthermore, manual claims management processes exacerbate the impact of payer tactics, leading to inefficiencies and revenue leakage.

When integrating Jorie AI's automation into a healthcare system, organizations gain the advantage of automating pre-billing processes. These automated procedures encompass, but are not restricted to, the following:

- Eligibility verification
- Prior Authorization
- Claim edits
- Coding

Such pre-billing automation empowers front office staff with comprehensive information prior to patient encounters, thereby mitigating denials stemming from non-coverage issues. With regard to coding, this empowers the organization's coding teams to concentrate on discerning trends and preparing for forthcoming guideline alterations. This automated methodology fosters a proactive billing approach rather than a reactive one, thus further averting claims denials.

Through the utilization of proprietary tools within the Jorie AI technology, it is now evident that medical claim denials often stem from a myriad of factors, including coding errors, documentation errors, insufficient documentation, and regulatory compliance issues. A table has been provided below to further explain each of the major claim denials.

Reasons For Major Claim Denials

Coding Errors:
These are errors which occur when the assigned diagnostic or procedural codes do not accurately reflect the services provided. These errors can arise due to numerous reasons, such as misunderstandings of coding guidelines, clerical mistakes, and more often than not, inadequate training of coding staff.
Documentation Errors:
These errors arise when there is insufficient or inaccurate documentation leading to the failure of adequately supporting the medical necessity of the services rendered. Documentation errors lead to both claim rejections and or partial reimbursements. Examples for such errors include but are not limited to incomplete patient histories, inconsistent treatment notes, or missing signatures, all of which jeopardize the integrity of the claim.
Insufficient Documentation:
Distinct from documentation errors, insufficient documentation refers to cases where the documentation provided does not meet the stringent requirements set forth by payers or regulatory bodies. Even if the services were medically necessary and appropriately performed, inadequate documentation can result in claims being denied due to lack of supporting evidence or justification.
Regulatory Compliance Issues:
Regulatory compliance poses a significant challenge in claims management. Healthcare providers find themselves having to navigate through a complex web of regulations and payer policies, ensuring adherence to billing and coding guidelines, as well as compliance with federal and state healthcare laws. Non-compliance not only leads to claim denials, but it can also cause warrant for audits, fines, and legal repercussions.

Table 1: Reasons For Major Claim Denials

Addressing these factors requires a multifaceted approach that incorporates comprehensive training, meticulous documentation practices, and strict adherence to regulatory requirements. By proactively identifying and mitigating these challenges, healthcare organizations can minimize claim denials, optimize revenue cycle management, and ensure financial sustainability. Nevertheless, implementing such practices is a formidable task, and most hospitals and healthcare institutions lack the time or resources to create entirely new policies and procedures that can ensure compliance from practitioners accustomed to long-standing practices. With that said, solutions such as Jorie AI has been developed in such a manner that healthcare institutions are able to address and mitigate the challenges without the need of an entire ‘re-set’ of polices and procedures.

Jorie AI’s role in Revenue Cycle Management (RCM) involves overseeing the entire spectrum of financial processes during a patient's experience, spanning from appointment scheduling to patient encounter to claim processing, documentation, and reimbursement, it is a true ‘end-to-end’ revenue cycle solution that can be implemented into any of the

existing electronic health record (EHR) systems used today. This revolutionary technology is one that is dedicated to hospitals, physician groups, and ambulatory surgery centers (ASC's). Through the development of state-of-the-art AI platforms, bot technology and learned algorithms, Jorie AI combines administrative and clinical tasks for seamless streamline billing, enhanced revenue collection, and an overall reduction in financial losses.

As it pertains to the specific challenges around claim denials, Jorie AI offers a fully automated comprehensive solution to mitigate the impact of private payer tactics in claims denial management through the following key features:

Enhanced Predictive Analytics:

- By analyzing historical claims data and payer behaviors, Jorie AI identifies patterns and predictive indicators of claims denials. By doing so, healthcare organizations can avoid costly mistakes that lead to hold ups in medical claim collections.
- Predictive insights also enable healthcare organizations to anticipate denial risks and implement preemptive measures to mitigate financial losses. The technology allows for hospitals and institutions to forecast potential losses before they ever occur.

Streamlined Workflow Automation:

- Jorie AI automates repetitive tasks in claims management, such as claims scrubbing and eligibility verification, reducing manual intervention, manual entry errors, and improving overall operational efficiency.
- Intelligent and automated workflow orchestration prioritizes claims based on denial severity and financial impact, optimizing resource allocation, and accelerating revenue recovery efforts, so that hospitals and healthcare institutions are well-prepared if claims do get held up from time to time.

Improved Documentation Accuracy:

- Utilizing natural language processing (NLP) algorithms, Jorie AI analyzes clinical documentation in real time to identify deficiencies and coding errors. In most instances these deficiencies are automatically corrected. However, in cases when this is not possible, the technology will immediately notify the appropriate party and inform them of the error(s) and corrective measures that need to be taken.
- Jorie AI has a continuously developing library within its infrastructure that offers clinical decision support features and provides actionable insights to clinicians. These insights aid in the enhancement of documentation quality and reducing the risk of denials due to incomplete or ambiguous medical records.

Compliance Optimization:

- Jorie AI ensures compliance with regulatory requirements and payer policies by continuously monitoring changes and conducting automated assessments. This all happens in real-time and feeds directly from the sources responsible for these changes, therefore ensuring that all requirements are being always met.
- This automated practice is an added benefit to the proactive compliance training and education initiatives healthcare organizations already take to in hopes of maintaining regulatory compliance and minimizing denials associated with billing errors or improper coding.

III. Conclusion:

Overall, the study conducted within the healthcare industry, as discussed in the Premier Inc. article "Trend Alert: Private Payers Retain Profits by Refusing or Delaying Legitimate Medical Claims," sheds light on the formidable challenges posed by private payer tactics in claims denial management. These tactics, ranging from complex pre-authorization requirements to arbitrary claim rejections, significantly impact the financial stability and operational efficiency of healthcare organizations. However, amidst these challenges lies an opportunity for innovation and transformation. Through the strategic implementation of Jorie AI, healthcare organizations can navigate the complexities of claims denial management with speed, confidence, and efficacy. Jorie AI offers a multifaceted solution that addresses the root causes of denials while optimizing revenue cycle performance and safeguarding quality patient care. At the heart of Jorie AI's transformative impact lies its advanced predictive analytics capabilities. By analyzing vast datasets and identifying patterns indicative of claims denials, Jorie AI empowers healthcare organizations to anticipate and preemptively address denial risks. This proactive approach not only minimizes financial losses but also creates an environment of continuous improvement.

Jorie AI's streamlined workflow automation revolutionizes claims management processes, reducing manual intervention, manual errors, and accelerating revenue recovery efforts. The one-of-a-kind intelligent workflow orchestration ensures optimal resource allocation and guides staff actions to

resolve denials efficiently, thereby enhancing operational efficiency and revenue integrity. Furthermore, Jorie AI enhances documentation accuracy through real-time analysis of clinical documentation using natural language processing (NLP) algorithms. By identifying documentation deficiencies and coding errors, Jorie AI enables clinicians to improve documentation quality and specificity, reducing the risk of denials due to incomplete or ambiguous medical records. Jorie AI also ensures compliance with regulatory requirements and payer policies through continuous monitoring and automated mini audits. By proactively addressing compliance, Jorie AI supports healthcare organizations in maintaining regulatory compliance and minimizing denials associated with billing errors or improper coding.

In conclusion, Jorie AI represents a paradigm shift in claims denial management, offering healthcare organizations a comprehensive solution to navigate the complexities of the modern healthcare landscape and to offer a real fighting chance against the current issues around private payers and medical claims. By leveraging advanced analytics, automation, and sophisticated decision support capabilities, Jorie AI ensures financial sustainability, operational efficiency, and quality patient care amidst the evolving challenges mentioned throughout this paper. As healthcare organizations embrace innovation and technology-driven solutions, Jorie AI stands at the forefront of progress, empowering them to thrive in an era of unprecedented complexity and change.

REFERENCES:

1. Cass, Andrew. “Claims Denials Are Costing Hospitals Nearly $20B per Year.” *Becker’s Hospital Review*, 25 Mar. 2024, Becker's Hospital Review. Claims denials are costing hospitals nearly $20 billion per year. Retrieved from https://www.beckershospitalreview.com/finance/claims-denials-are-costing-hospitals-nearly-20b-per-year.html
2. Premier Inc. Trend Alert: “Private payers retain profits by refusing or delaying legitimate medical claims.” Population Health Cost Management, 21 Mar. 2024, Population Health Cost Management. Retrieved from https://premierinc.com/newsroom/blog/trend-alert-private-payers-retain-profits-by-refusing-or-delaying-legitimate-medical-claims

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