UNIFIED HEALTH SERVICES

The Executive Guide to Reducing Workers' Compensation Denials

How health systems can prevent avoidable denials, accelerate cash, and reduce the operational burden of a highly specialized financial class

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Executive Summary

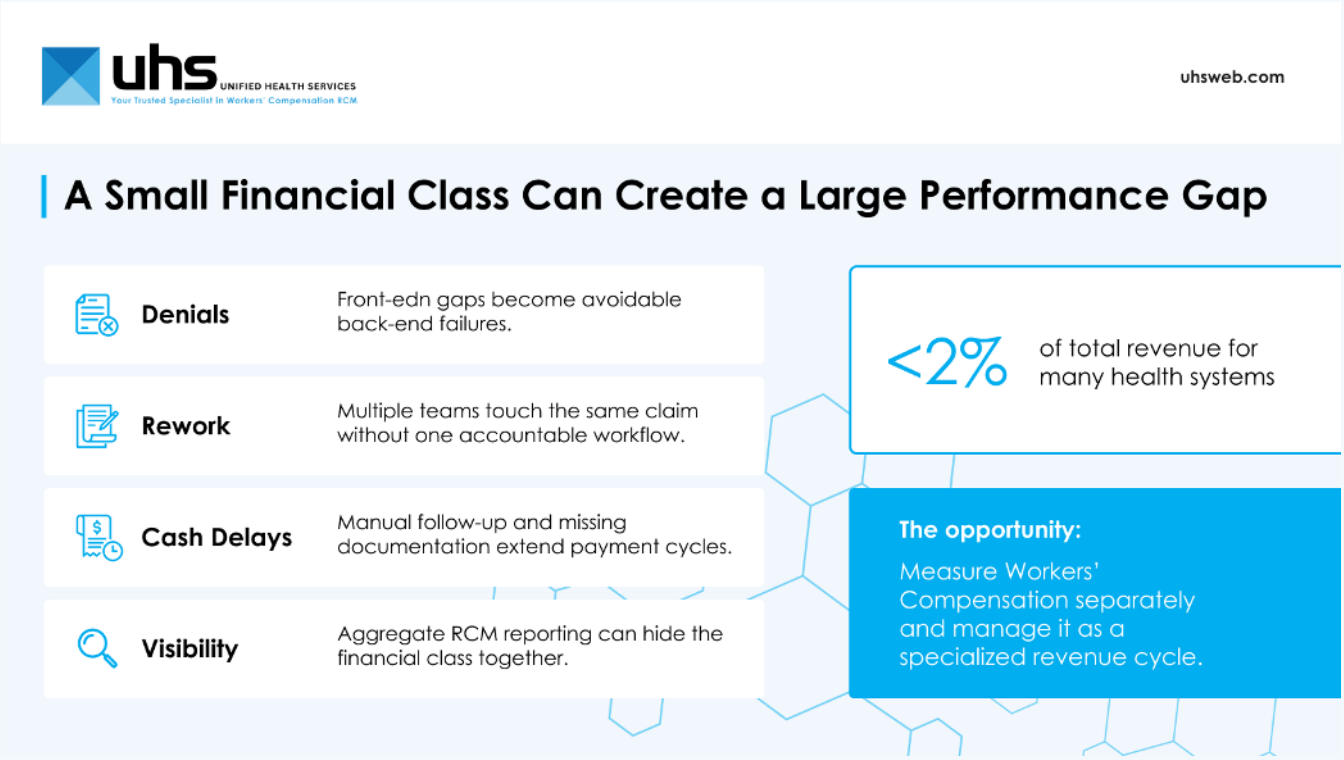
Workers' Compensation may account for less than 2% of revenue for many health systems, but the financial class can generate a disproportionate amount of manual work, denials, payment delay, and patient confusion. The primary reason is structural: Workers' Compensation does not behave like a standard commercial or government claim.

The workflow begins with injury, employer, carrier, jurisdiction, claim, and authorization information that may not be available through conventional eligibility tools. It continues through state- or federal-specific billing, documentation, bill review, payment integrity, appeals, cash processing, and reporting. When those steps are owned by separate teams, the health system may not see the entire performance gap.

The evidence for prevention

In a UHS analysis of more than 320,000 Workers' Compensation claims, the denial rate was 15.15% when eligibility and authorization were not completed, compared with 1.88% when those steps were completed. The result supports an upstream denial-prevention model rather than a purely back-end collection strategy.

This guide provides a practical framework for evaluating the financial class: why it is different, where denials begin, what an end-to-end workflow should include, which metrics matter, how to estimate financial impact, how implementation can work within existing systems, and what to ask a potential partner.



1. Why Workers' Compensation Is Different

Traditional health insurance begins with a member, plan, coverage, and standardized electronic transactions. Workers' Compensation begins with a workplace injury and a responsibility determination. The health system may need to identify the employer, carrier, third-party administrator, jurisdiction, claim number, adjuster, authorization requirements, and bill-to entity before it can submit a clean claim.

The financial class has several defining characteristics

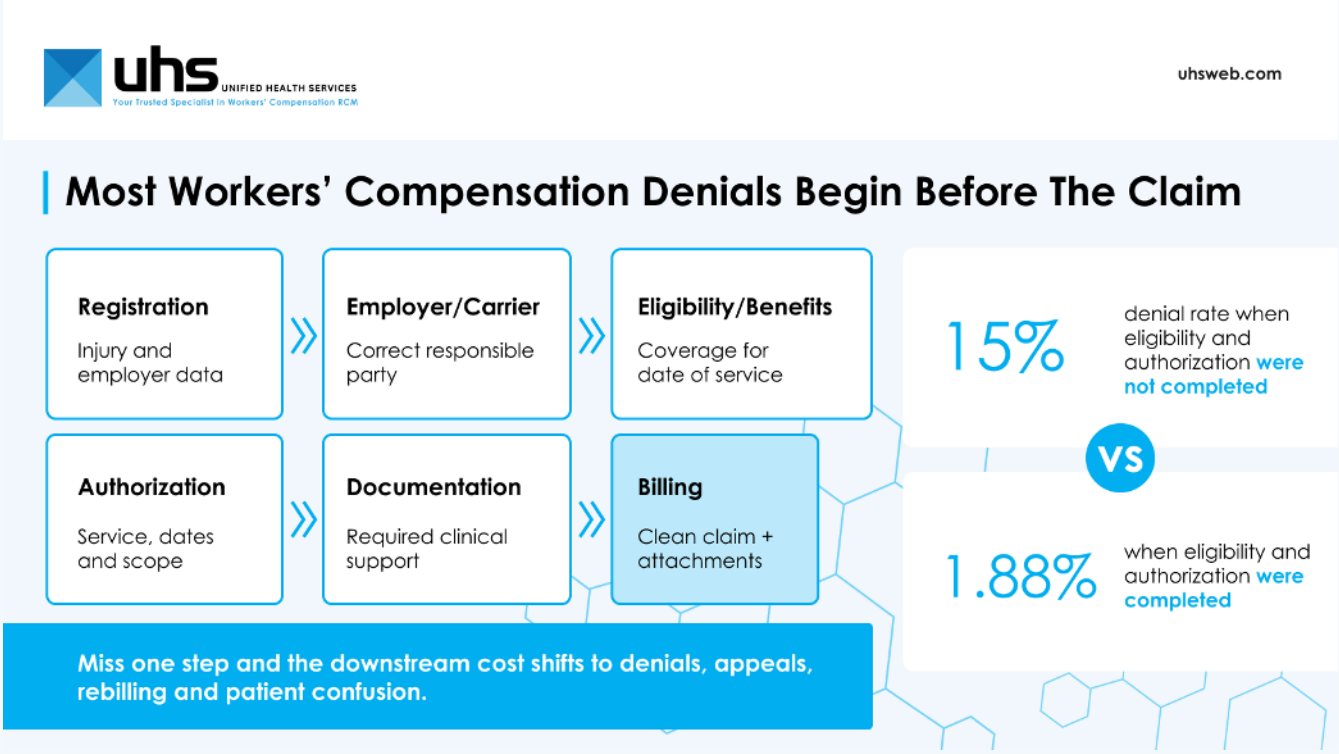
- Responsibility may depend on employer, carrier, injury date, jurisdiction, and claim acceptance rather than a conventional insurance member record.
- Billing and payment may be governed by state or federal fee schedules, network agreements, bill review rules, and payer-specific edits.
- Claims and attachments may still require manual or paper processes when payer connectivity is limited.
- Remittance, payment posting, underpayment identification, interest, penalties, and dispute workflows can be inconsistent across payers.
- The account may involve the patient, employer, carrier, adjuster, third-party administrator, bill review company, attorney, and provider.

The result is a specialized financial class that requires both technology and expert intervention. Generic automation can process predictable transactions, but Workers' Compensation contains exceptions that require payer research, documentation, communication, judgment, and jurisdictional knowledge.

Patient and employer impact

An administrative error can cause an injured employee to receive an incorrect bill while recovering from a workplace injury. Accurate routing and communication protect the patient experience and the health system's relationship with major employers.

2. Where Denials Begin



Workers' Compensation denials are often back-end symptoms of front-end failures. A denial team may correct the account, but the organization incurs the cost of rework and risks missing authorization, documentation, filing, or appeal deadlines.

Employer and carrier identification

The workflow needs reliable injury, employer, jurisdiction, carrier, claim, adjuster, and bill-to information. Missing or inconsistent data can route the claim to the wrong entity or hold it in an unworked queue. The final denial may say no coverage or no claim on file even though the original failure occurred at registration.

Eligibility and benefits

Verification should confirm responsibility for the date of service and document who was contacted, what was confirmed, the reference information, and unresolved issues. Days to verify and backlog by reason should be visible to management.

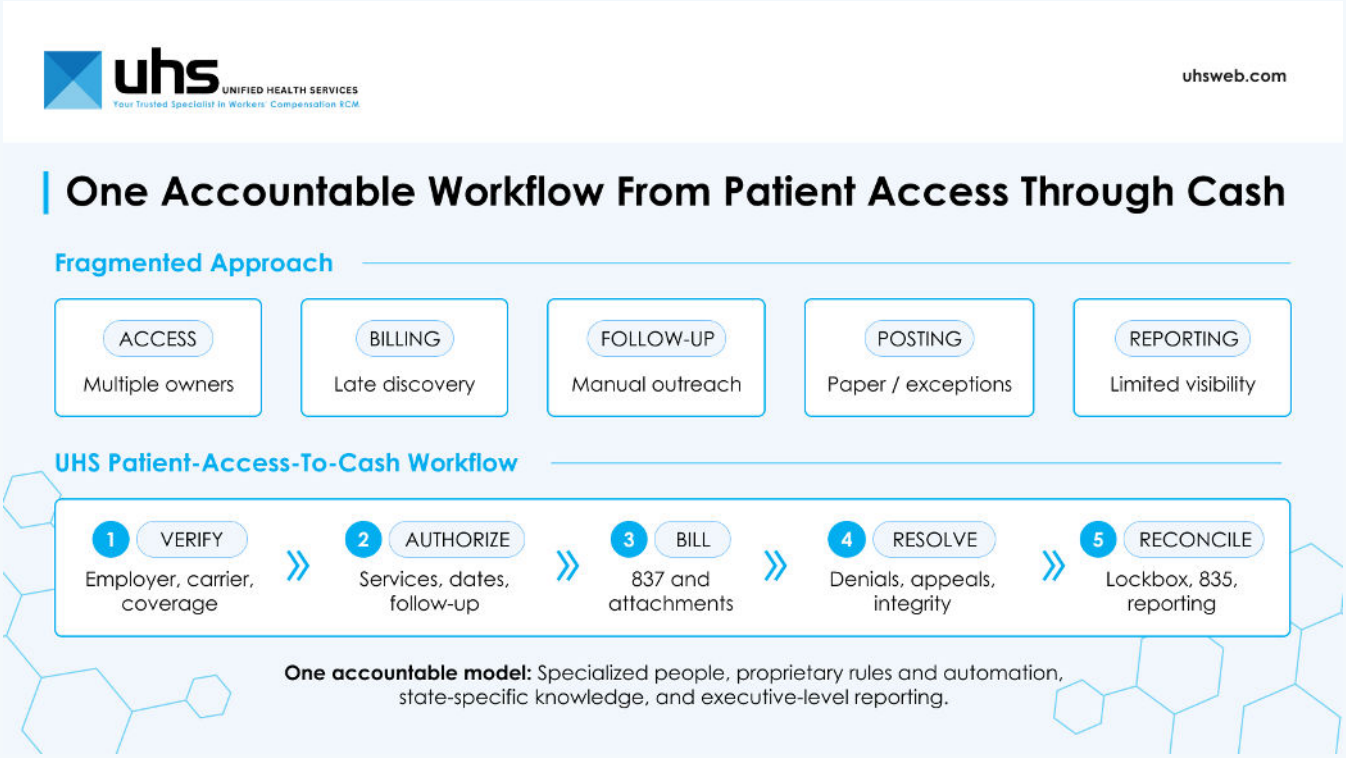
Authorization and documentation

Authorization requires structured ownership, service dates, diagnosis, scope, expiration, reauthorization, required clinical records, follow-up cadence, and escalation. Billing should not be the first point at which the organization discovers that approval or documentation is missing.

Operational principle

Move denial prevention upstream. The workflow should identify missing information before claim submission and measure the service levels required to resolve it.

3. The Patient-Access-to-Cash Workflow



1. Registration and Intake

Capture injury date, employer, work status, jurisdiction, claim number, carrier, adjuster, and required contacts as early as possible.

2. Employer and Carrier Verification

Identify the responsible employer and carrier, resolve ambiguous bill-to information, and create an auditable record of outreach and confirmation.

3. Eligibility and Benefits

Confirm coverage for the date of service and validate the information required to route the claim correctly.

4. Authorization and Reauthorization

Track service, diagnosis, dates, scope, and renewal requirements; escalate pending items before they become denials.

5. Billing and Attachments

Validate jurisdiction-specific requirements, submit the ANSI X12 837, and transmit required medical documentation electronically whenever possible.

6. AR, Denials, and Appeals

Prioritize follow-up, identify root causes, manage reconsiderations and appeals, and return exhausted accounts through an agreed workflow.

7. Payment Integrity and Contract Compliance

Compare adjudication to expected allowed amounts, state or federal fee schedules, and applicable network agreements; challenge incorrect discounts and underpayments.

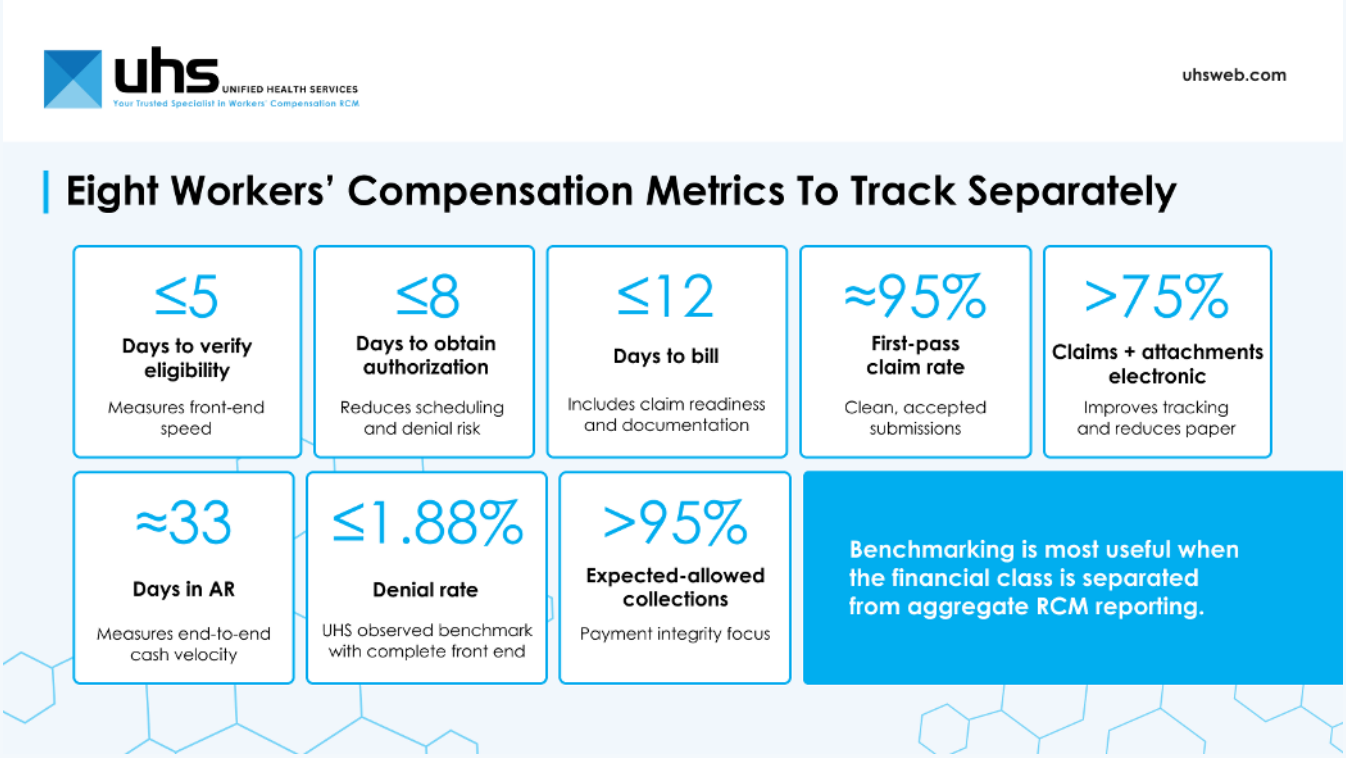
8. Cash, Remittance, and Reporting

Support lockbox, EFT, paper-to-835 conversion, posting, reconciliation, executive dashboards, and recurring business reviews.

Additional value-added workflows

- Legal document requests and coordination with attorneys
- Litigated-claim support and administrative compliance
- Legacy AR and written-off account review
- Corrected-claim workflows
- Bill review company management and disputes
- Consultation on payer and network agreements
- Multi-jurisdiction claim support
- Customized reporting and recurring business reviews

4. The Metrics That Matter



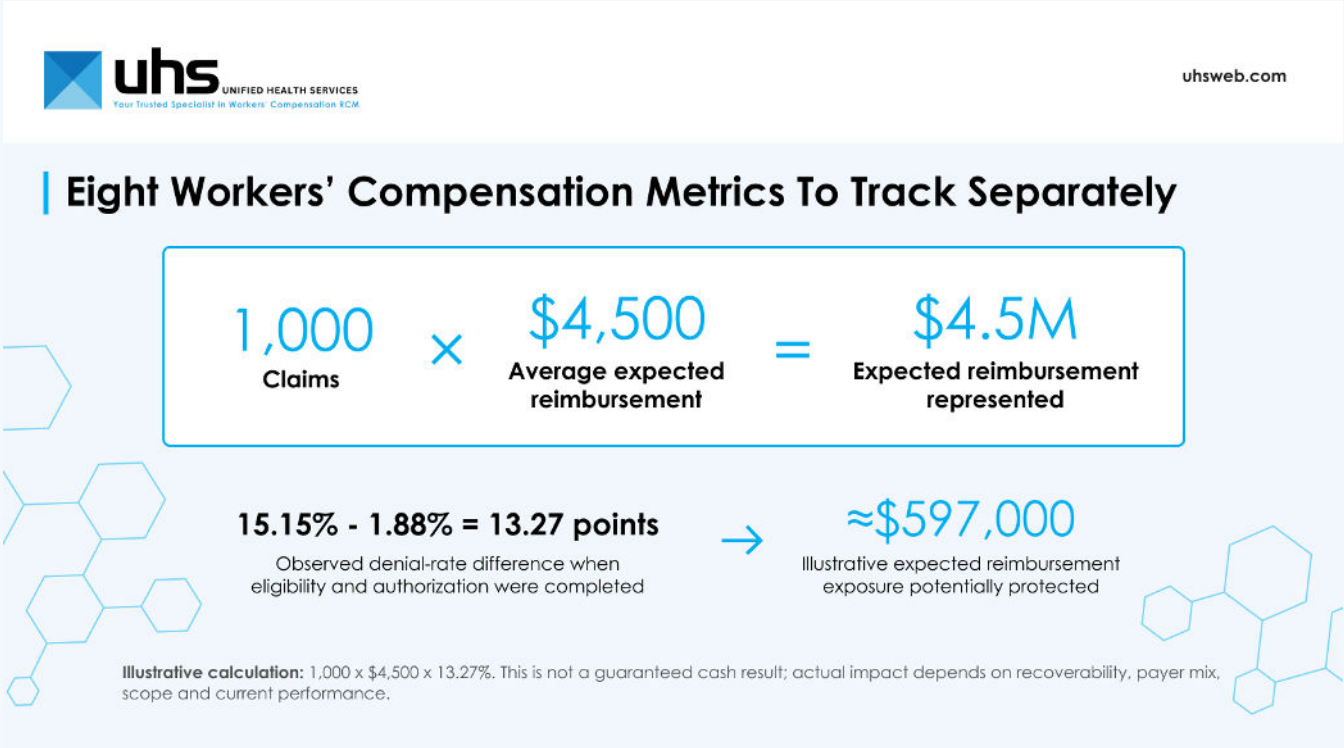
The scorecard should measure process and outcome. A low denial rate achieved through excessive manual work may still be costly. A strong collection rate may still conceal underpayments, slow cash, or missed discounts. Review the metrics together and segment them by payer, jurisdiction, service line, and workflow status when possible.

Metric	UHS performance target	Management question
Days to verify eligibility	5 days or less	What prevents verification from being completed sooner?
Days to obtain authorization	8 days or less	Which services or payers create the largest pending backlog?
Days to bill	12 days or less	Are claims waiting on documentation, payer data, or internal workflow?
First-pass claim rate	Approximately 95%	Which rejection categories are preventable?
Electronic claims and attachments	Greater than 75%	Which payers still require paper or manual submission?
Days in AR	Approximately 33 days	Which workflow status or payer drives aging?
Denial rate	1.88% or less	What is the original root cause, not only the final denial code?
Collections against expected allowed	Greater than 95%	Are fee schedules, discounts, interest, and underpayments being audited?

Important qualification

Targets are directional UHS performance expectations. Exact baselines and achievable results depend on service scope, payer mix, jurisdiction, data quality, current workflow, claim maturity, and recoverability.

5. The Financial Impact of Prevention



A credible financial model begins with expected reimbursement, not charges. The basic formula is annual claim volume multiplied by average expected reimbursement, multiplied by the difference between current and target denial rates.

Illustrative claim volume	1,000 claims
Average expected reimbursement	$4,500 per claim
Expected reimbursement represented	$4,500,000
Observed denial-rate difference	15.15% - 1.88% = 13.27 percentage points
Illustrative reimbursement exposure	$4,500,000 x 13.27% = approximately $597,000

The $597,000 amount represents expected reimbursement exposure potentially protected by preventing denials under the assumptions. It is not automatically the same as incremental cash. The model should apply a recoverability percentage and account for payer mix, timing, appeal success, solution cost, and whether the underlying service is payable.

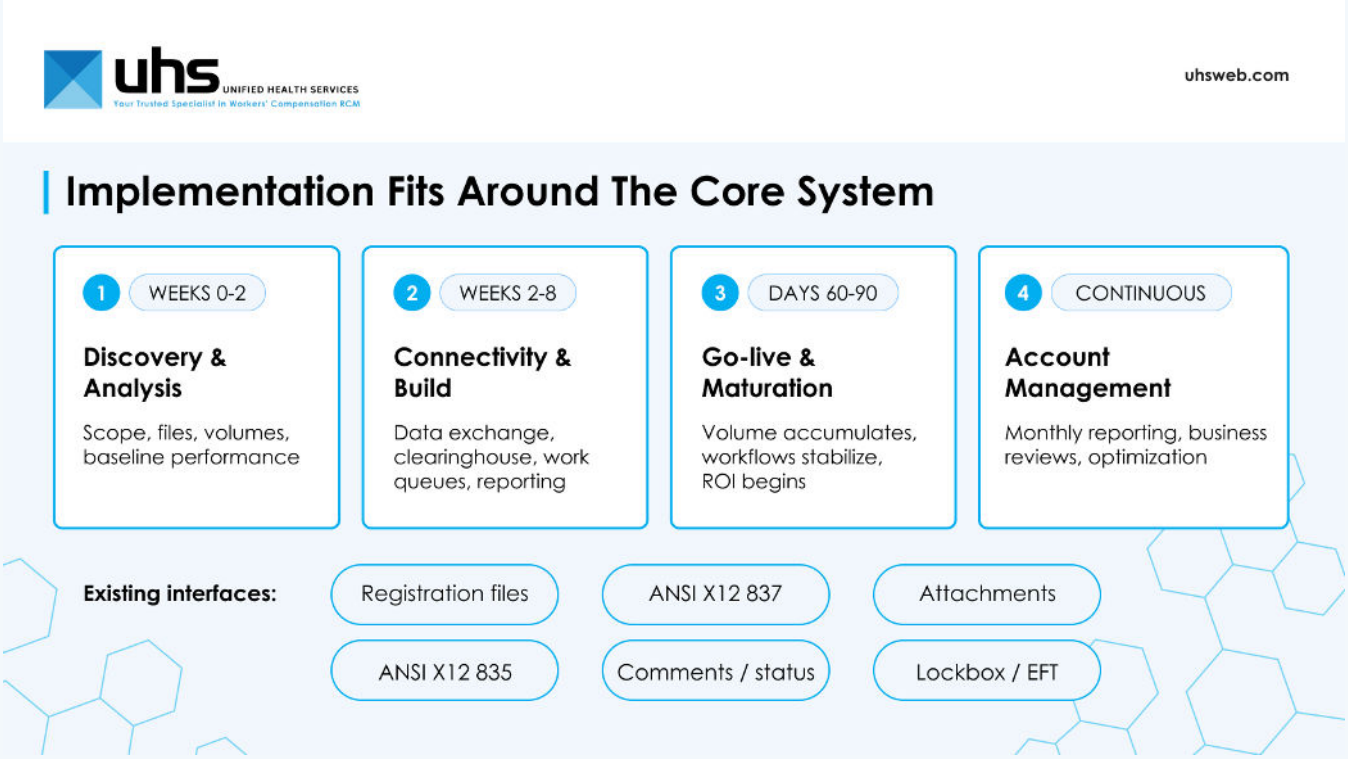
Add operational value separately

- Redeployed FTE capacity used for carrier searches, authorizations, paper claims, denials, appeals, posting, and reconciliation
- Reduced clearinghouse, mailing, lockbox, banking, and payment-posting expense where applicable
- Faster cash and fewer accounts moving into aged AR
- Reduced patient billing corrections and employer escalation
- Improved underpayment, fee schedule, network discount, interest, and penalty recovery

Avoid double counting

Keep incremental collections, labor capacity, transaction savings, and payment-integrity recovery in separate lines. Include implementation and service fees before presenting first-year or recurring net impact.

6. Implementation Without Replacing the Core System



A specialty workflow should work with the systems and files the health system already uses. UHS commonly supports registration or patient files, ANSI X12 837 claims, electronic attachments, ANSI X12 835 remittance, comments or status files, clearinghouses, work queues, lockbox, EFT, and provider banking arrangements.

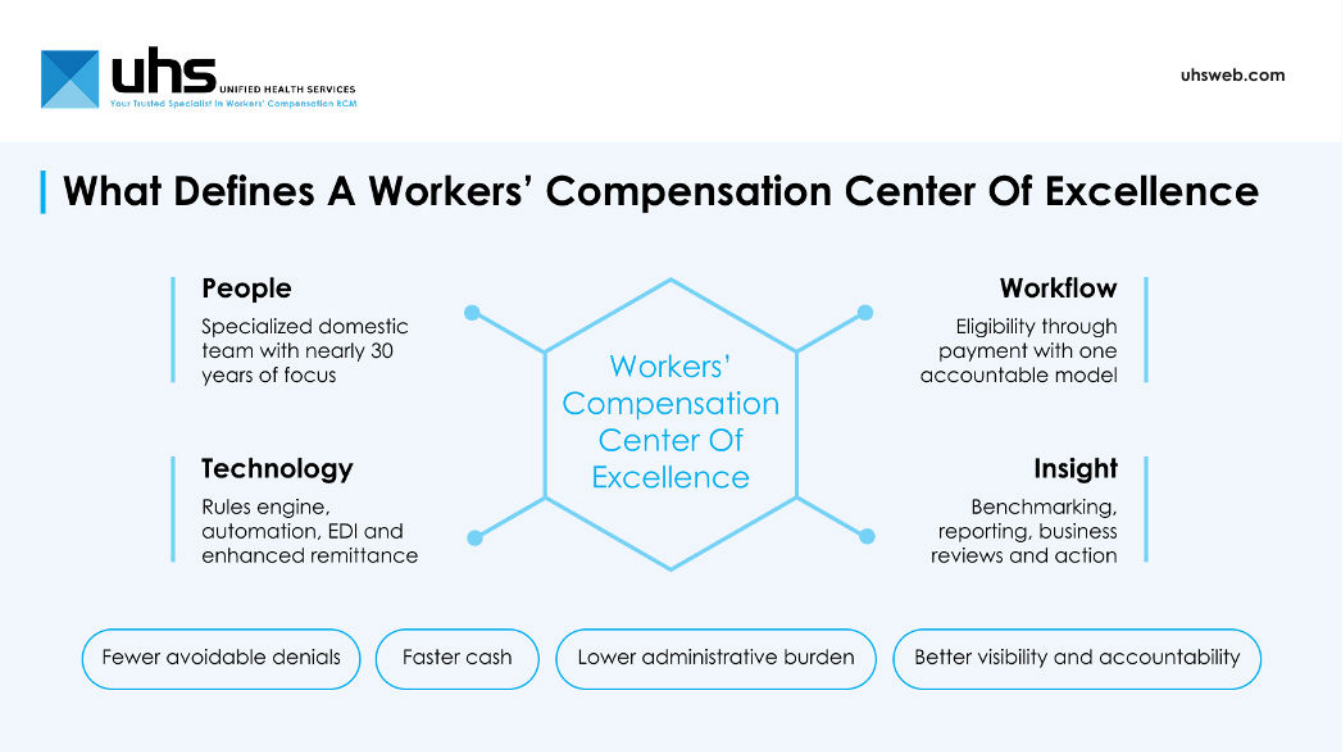
Phase	Typical timing	Primary activities
Discovery and analysis	Approximately 2 weeks	Confirm scope, volumes, services, baseline performance, files, governance, and project plan.
Connectivity and build	Approximately 4-8 weeks	Configure secure exchange, clearinghouse, work queues, banking, reporting, training, testing, and go-live criteria.
Go-live and maturation	Commonly 60-90 days	Begin production, monitor exceptions, refine workflows, and allow claim volume to reach a stable run rate.
Account management	Continuous	Monthly reporting, AR reconciliation, business reviews, recommendations, and optimization.

Timing is service-line dependent and finalized through the implementation plan. The most effective projects use named owners, weekly milestone calls, documented test criteria, issue escalation, training, and a clear go/no-go decision.

Technical questions to answer early

- Which files and standard transactions already exist?
- How are attachments transmitted and matched to claims?
- How are status updates and comments returned to the source system?
- How are paper checks and EOBs converted to structured remittance?
- What are the secure-transfer, access, monitoring, backup, and business-continuity controls?
- What exceptions require provider action after go-live?
- How are AR totals and cash reconciled between organizations?

7. Building a Workers' Compensation Center of Excellence



A Center of Excellence combines four capabilities. Specialized people provide payer communication, exception management, appeals, and operational judgment. A complete workflow connects patient access through cash. Technology enforces rules, automates repeatable work, supports electronic transactions, and surfaces exceptions. Insight turns account data into benchmarks, reconciliation, business reviews, and action.

What to expect from the operating model

- One accountable status, next action, owner, and service level for every account
- Jurisdiction-specific rules and payer workflows rather than generic collection scripts
- Electronic claim, attachment, remittance, and reporting capabilities
- Payment-integrity review against expected allowed amounts
- Transparent reporting and regular operating reviews
- Clear escalation and return criteria for accounts that will no longer be pursued
- Continuous workflow recommendations shared with the health system

8. Questions to Ask a Potential Partner

Evaluation area	Question
Scope and ownership	Which steps are included from registration through cash? What remains with the health system?
Front-end controls	How are employer/carrier verification, eligibility, authorization, reauthorization, and documentation managed?
Jurisdictional expertise	How are state and federal rules maintained, tested, and applied?
Technology	What is proprietary? Which standard transactions and files are supported? How are exceptions handled?
Payment integrity	How are fee schedules, network agreements, incorrect discounts, underpayments, penalties, and interest evaluated?
Reporting	Can the partner reconcile AR, explain every workflow status, and provide executive-level benchmarks?
Implementation	What are the milestones, test criteria, resources, dependencies, and expected maturation period?
Security and continuity	What HIPAA, SOC 2, access, monitoring, backup, and business-continuity controls are in place?
Staffing model	Where is the work performed? Who leads the account? How are turnover and training managed?
Accountability	What service levels, escalation paths, business reviews, references, and return protocols are provided?

9. A Practical Next Step

The first step does not require a complete data warehouse or a formal procurement process. Begin by separating the financial class and comparing the metrics the organization already has with a defined benchmark scorecard.

1. Confirm annual claim volume, expected reimbursement or average expected reimbursement, cash, current AR, and denial volume.
2. Map ownership from intake through payment and identify where work changes hands.
3. Measure the eight core metrics or document which are not currently available.
4. Use the financial-impact model with conservative recoverability and cost assumptions.
5. Prioritize the largest operational and financial gap for deeper analysis.

Request a benchmark analysis

Unified Health Services can begin with benchmark data and the metrics your team already has. When detailed claims data is available, UHS can evaluate volume, expected reimbursement, cash, AR, denial trends, electronic submission, staffing, and cost to collect.

Visit uhsweb.com or contact Unified Health Services at (888) 510-2667.

About the Author

Hank Owings is Chief Revenue Officer at Unified Health Services and has more than 30 years of experience in healthcare revenue cycle management. His work has included provider, payer, technology, and complex-claims organizations, with a focus on improving financial performance and building practical operating models for health systems.

About Unified Health Services

Founded in 1997, Unified Health Services specializes in Workers' Compensation and complex-claims revenue cycle management. UHS combines specialized domestic operations, proprietary rules and automation, multijurisdiction knowledge, electronic transaction capabilities, payment integrity, cash and remittance support, reporting, and continuous account management. UHS supports HIPAA-compliant workflows and maintains SOC 2 controls.

Source Notes and Disclaimer

1. Denial analysis: UHS internal analysis of more than 320,000 Workers' Compensation claims. The observed denial rate was 15.15% when eligibility and authorization were not completed and 1.88% when those steps were completed.
2. Illustrative financial impact: 1,000 claims x $4,500 average expected reimbursement x 13.27 percentage-point denial-rate difference = approximately $597,000 in expected reimbursement exposure.
3. Performance targets: UHS operational targets and observed performance for applicable populations. Results vary based on scope, payer mix, jurisdiction, data quality, workflow, claim maturity, and recoverability.
4. This guide is educational and does not provide legal, coding, clinical, or reimbursement advice. Organizations should validate applicable payer contracts, state and federal requirements, and their own data before making decisions.