Internship Report

On

Insurance Claim Denials Management and Its Impact on Revenue Cycle Management in the Healthcare Industry: A Case Study of Commure.

Submitted By:

Siam Hossain Orgo

ID: BBA2203027088

Program: BBA (Major in Marketing)

Submitted to:

Department of Business Administration

Submitted for The Partial Fulfilment Requirement of the Degree of Bachelor of Business Administration

Sonargaon University (SU)

Date of Submission: September 5, 2026

Internship Report

On

Insurance Claim Denials Management and Its Impact on Revenue Cycle Management in the Healthcare Industry: A Case Study of Commure.

Prepared By:

Siam Hossain Orgo

ID: BBA2203027088

Program: BBA (Major in Marketing)

Supervised by:

Natasha Shikder

Lecturer

Department of Business Administration

Submitted for The Partial Fulfilment Requirement of the Degree of Bachelor of Business Administration



Sonargaon University (SU)

Date of Submission: September 5, 2026

Letter of Transmittal

Date: September 5, 2026

To
Natasha Shikder
Lecturer
Department of Business Administration
Sonargaon University (SU)

Subject: Submission of Internship Report

Dear Madam,

It is my pleasure to submit my internship report entitled "**Insurance Claim Denials Management and Its Impact on Revenue Cycle Management in the Healthcare Industry: A Case Study of Commure**", prepared in partial fulfillment of the requirements for the Bachelor of Business Administration (BBA) degree at Sonargaon University (SU).

The report is based on my employment experience at Commure Bangladesh, where I gained practical exposure to Revenue Cycle Management (RCM), particularly in insurance claim denials management. This report presents an overview of the organization's operational practices, analyzes the impact of claim denials on the revenue cycle, and offers recommendations for improving operational efficiency.

I have made every effort to ensure that the report is accurate, objective, and prepared in accordance with academic standards. I sincerely hope that it meets your expectations and fulfills the requirements of the internship program.

I would like to express my gratitude for your continuous guidance, encouragement, and valuable suggestions throughout the preparation of this report.

Sincerely,

_____

Siam Hossain Orgo
Student ID: BBA2203027088
Department of Business Administration
Sonargaon University (SU)

Letter of Acceptance

This is to certify that the internship report entitled "**Insurance Claim Denials Management and Its Impact on Revenue Cycle Management in the Healthcare Industry: A Case Study of Commure**" has been submitted by Siam Hossain Orgo, Student ID: BBA2203027088, Department of Business Administration, Sonargaon University (SU), in partial fulfillment of the requirements for the Bachelor of Business Administration (BBA) degree.

The report has been prepared under my supervision and guidance. To the best of my knowledge, it represents the student's original work and is suitable for evaluation and acceptance.

I therefore recommend this report for final assessment.

_____

Natasha Shikder
Lecturer
Department of Business Administration
Sonargaon University (SU)

Student Declaration

I hereby declare that the internship report entitled "**Insurance Claim Denials Management and Its Impact on Revenue Cycle Management in the Healthcare Industry: A Case Study of Commure**" is my original work and has been prepared as part of the requirements for the Bachelor of Business Administration (BBA) degree at Sonargaon University (SU).

The information and analyses presented in this report are based on my Employment experience, observations, publicly available information, and academic references. Where I used information from published sources, I provided appropriate acknowledgments and citations.

I further declare that this report has not been submitted, either in whole or in part, to any other institution or university for the award of any degree or qualification.

Sincerely yours,

_____

Siam Hossain Orgo
Student ID: BBA2203027088

Department of Business Administration
Sonargaon University

Preface

The internship program serves as a bridge between academic learning and professional practice, enabling students to apply theoretical concepts in real-world business environments. It provides valuable exposure to organizational operations, workplace culture, and industry practices while developing analytical, communication, and problem-solving skills.

This internship report, titled "**Insurance Claim Denials Management and Its Impact on Revenue Cycle Management in the Healthcare Industry: A Case Study of Commure**," has been prepared based on my employment experience at Commure. The report examines the insurance claim denials management process and analyzes its influence on revenue cycle performance within the healthcare industry.

The report combines practical observations with relevant academic concepts to provide an understanding of denial management processes, operational challenges, and opportunities for process improvement. It is expected that this study will contribute to a better understanding of Revenue Cycle Management and the importance of effective claim denial resolution in healthcare organizations.

Acknowledgment

First and foremost, I express my sincere gratitude to Almighty Allah for granting me the strength, patience, and opportunity to complete my internship and prepare this report.

I would like to express my heartfelt appreciation to my academic supervisor, Natasha Shikder, Department of Business Administration, Sonargaon University, for providing valuable guidance, constructive suggestions, and continuous encouragement throughout the internship report.

I am also grateful to the management and colleagues at Commure Bangladesh for providing me with the opportunity to gain practical experience in Revenue Cycle Management. Their professional support, cooperation, and willingness to share knowledge significantly enhanced my understanding of insurance claim denials management and healthcare operations.

Finally, I extend my sincere thanks to my family, friends, and everyone who encouraged and supported me throughout my academic journey and internship experience.

Executive Summary

This internship report, "**Insurance Claim Denials Management and Its Impact on Revenue Cycle Management in the Healthcare Industry: A Case Study of Commure**," examines the role of insurance claim denials management in maintaining an efficient healthcare revenue cycle.

The report is based on practical experience gained during the internship at Commure, where responsibilities included reviewing insurance claim denials, analyzing denial reasons, supporting denial resolution activities, and contributing to operational workflows within the Revenue Cycle Management (RCM) department.

The study discusses the healthcare revenue cycle, the causes of insurance claim denials, their financial and operational impact, and the importance of timely denial management. It also identifies common challenges faced during denial processing and highlights best practices that contribute to improving operational efficiency and revenue recovery.

The report concludes that effective insurance claim denial management plays a vital role in reducing revenue leakage, improving reimbursement timelines, and strengthening the overall financial performance of healthcare organizations. Based on the findings, several recommendations are provided to support continuous process improvement and operational excellence in Revenue Cycle Management.

LIST OF ACRONYMS

AI	Artificial Intelligence
AMA	American Medical Association
BBA	Bachelor of Business Administration
CARC	Claim Adjustment Reason Code
EHR	Electronic Health Record
HFMA	Healthcare Financial Management Association
HIPAA	Health Insurance Portability and Accountability Act
NDA	Non-Disclosure Agreement
PHI	Protected Health Information
RCM	Revenue Cycle Management
RARC	Remittance Advice Remark Code
SU	Sonargaon University
SWOT	Strengths, Weaknesses, Opportunities, and Threats
U.S.	United States
USD	United States Dollar

Table of Contents

LETTER OF TRANSMITTAL..... II
LETTER OF ACCEPTANCE..... III
STUDENT DECLARATION.....IV
EXECUTIVE SUMMARY..... V
PREFACE.....VI
ACKNOWLEDGEMENT……...VI
EXECUTIVE SUMMARY……VII
LIST OF ACRONYMS……VIII
CHAPTER ONE: INTRODUCTION……..……..1
1.1 BACKGROUND OF THE STUDY……..……. 2
1.2 BROAD OBJECTIVES……..…….3
1.2.1 SPECIFIC OBJECTIVES……..……... 3
1.3 SCOPE OF THE STUDY……... 3
1.4 METHODOLOGY……...……4
1.4.1 PRIMARY SOURCES……...……...……...…4
1.4.2 SECONDARY SOURCES……...……...……5
1.5 LIMITATIONS OF THE STUDY……...……...……5-6
CHAPTER TWO: ORGANIZATIONAL OVERVIEW……..……7
2.1 COMPANY BACKGROUND……...……...……8
2.2 MISSION AND VISION……...……...…9
2.3 PRODUCTS AND SERVICES……...……...…9-10
2.4 ORGANIZATIONAL STRUCTURE……...……11
2.5 RELEVANCE TO WORK EXPERIENCE……...……...……12
2.6 INDUSTRY OVERVIEW……...……...…13
2.7 INDUSTRY TRENDS……...……14
2.8 COMPETITIVE POSITION AND MARKET PRESENCE……...……15
CHAPTER THREE: JOB DESCRIPTION AND WORK EXPERIENCE...……...…16
3.1 POSITION DESCRIPTION……...……...…17
3.1.1 DENIAL MANAGEMENT WORKFLOW……18
3.2 DEPARTMENT OVERVIEW ……...……...……...18
3.3 MAJOR RESPONSIBILITIES……...……...……19
3.3.1 DENIAL REVIEW AND ANALYSIS……...……19
3.3.2 ROOT CAUSE IDENTIFICATION……..……19
3.3.3 APPEALS AND RECONSIDERATION ACTIVITIES ……...……...……20
3.3.4 DOCUMENTATION AND ACCOUNT MAINTENANCE……...……20
3.3.5 PRODUCTIVITY AND QUEUE MANAGEMENT ……21
3.4 DAILY WORKFLOW……...……21
3.5 TEAM COORDINATION ACTIVITIES……...……22

3.6 LEADERSHIP AND COMMUNICATION RESPONSIBILITIES ……...…23
3.7 SKILLS DEVELOPED DURING INTERNSHIP……..……24
3.8 CHALLENGES ENCOUNTERED……..…25
3.9 PRACTICAL REFLECTION……...……26
CHAPTER FOUR: ANALYSIS OF DENIAL MANAGEMENT…….……28
4.1 CONCEPT OF REVENUE CYCLE MANAGEMENT……...……29
4.2 OVERVIEW OF REVENUE CYCLE MANAGEMENT……...…….30
4.3 TYPES OF CLAIM DENIALS…….……...…31-32
4.4 IMPORTANCE OF DENIAL MANAGEMENT……...……...…33
4.5 CURRENT DENIAL RESOLUTION PROCESS…….……34
4.6 ANALYSIS OF OPERATIONAL EFFICIENCY……..…34
4.7 ROLE OF TEAM LEADERSHIP AND DENIAL MANAGEMENT……...……35
4.7.1 KNOWLEDGE MANAGEMENT……...……36
4.7.2 EMPLOYEE MOTIVATION AND PERFORMANCE……...…..…36
4.7.3 LEADERSHIP AS A STRATEGIC RESOURCE…….……37
4.8 SWOT ANALYSIS……...……37-40
CHAPTER FIVE: FINDINGS AND RECOMMENDATIONS…….…...……41
5.1 KEY FINDINGS……...……41-43
5.2 RECOMMENDATIONS……..……44-47
CHAPTER SIX: CONCLUSION……...……49
6.1 SUMMARY OF LEARNING……...……50
6.2 CONCLUSION……...……51
REFERENCES……...……...……52-5

CHAPTER ONE

INTRODUCTION

1.1 Background of the Study

Healthcare organizations operate within a highly intricate financial landscape where successful reimbursement hinges on precise documentation, accurate coding, effective billing practices, compliance with payer regulations, and diligent claims management. This comprehensive process that healthcare providers engage in to capture, manage, and collect revenue is known as Revenue Cycle Management (RCM).

The RCM process commences when a patient schedules an appointment and continues until final payment is received. This journey involves a myriad of administrative and clinical activities that significantly impact the organization's ability to realize timely and complete reimbursement. It is crucial to understand that any errors or omissions at any stage of this process can lead to claim denials, frustrating payment delays, or even substantial revenue loss, thereby threatening the financial stability of the organization.

In recent years, Claim Denial Management has emerged as a critical component of financial operations in healthcare. A denied claim is not merely an inconvenience; it represents a formal request for reimbursement that has been partially or entirely rejected by a payer/insurance following their adjudication process. Various factors contribute to claim denials, including patient eligibility issues, deficiencies in authorization, coding inaccuracies, documentation gaps, medical necessity concerns, and violations related to timely filing.

The increasing complexity of payer policies and the evolving landscape of healthcare regulations have underscored the necessity for effective denial management strategies. In response to these challenges, many contemporary healthcare organizations are leveraging technology, advanced analytics, and automation to identify denial trends and enhance reimbursement outcomes. The integration of AI-powered platforms is particularly noteworthy, as these systems are becoming more prevalent in revenue cycle operations, emphasizing both claim management and proactive denial prevention.

This report explores the intricacies of denial management from both operational and managerial perspectives, drawing on practical experiences gained in the field of healthcare RCM

operations. Through this examination, we provide insights into effective denial management mechanisms and their broader implications for the financial health of healthcare organizations.

1.2 Broad Objective

To examine the practices of insurance claim denial management and assess their impact on the performance and efficiency of the U.S. healthcare revenue cycle management process.

1.2.1 Specific Objectives

- To analyze the operational framework of denial management within healthcare Revenue Cycle Management (RCM).
- To identify and evaluate the major causes of insurance claim denials in healthcare reimbursement processes.
- To assess the impact of claim denials on revenue recovery, cash flow, and operational efficiency.
- To examine the role of technology, automation, and data analytics in improving denial management outcomes.
- To explore the application of business administration concepts, including Operations Management, Organizational Behavior, Strategic Management, Human Resource Management, and Business Communication, within denial management operations.
- To evaluate the challenges associated with insurance claim denial management and their implications for healthcare organizations.
- To provide practical recommendations for enhancing denial management effectiveness and overall revenue cycle performance.

1.3 Scope of the Study

This study focuses on denial management activities within healthcare Revenue Cycle Management operations.

The report covers:

- Healthcare RCM concepts.
- Claim denial management practices.

- Operational workflows associated with denial resolution.
- The relationship between denial management and organizational performance.
- Personal workplace observations obtained through professional experience.

The report excludes confidential client information, patient data, proprietary organizational processes, and non-public financial information to ensure compliance with privacy, confidentiality, and healthcare data protection requirements, including the Health Insurance Portability and Accountability Act (HIPAA).

1.4 Methodology

This report has been prepared using both primary and secondary sources of information to ensure a comprehensive understanding of insurance claim denial management and its impact on healthcare revenue cycle performance. The methodology combines practical workplace experience with academic and industry-based research. The purpose of adopting this approach was to integrate theoretical knowledge with real-world operational practices and provide an analytical perspective on denial management within the healthcare industry.

1.4.1 Primary Sources

Primary data refers to information obtained directly through practical experience and observation during professional engagement within the Revenue Cycle Management (RCM) department at Commure. As an Operations Analyst in the Denials Management team, I had the opportunity to observe various operational activities related to claim denial resolution, workflow management, and reimbursement processes. These firsthand experiences provided valuable insights into the challenges and operational realities of denial management in the U.S. healthcare industry.

The primary sources of information used in this report include:

- Direct workplace experience.
- Practical involvement in denial management activities.
- Observation of operational workflows.
- Professional discussions with colleagues and supervisors.

The observations and experiences gained through these activities contributed significantly to understanding how denial management functions within the broader revenue cycle process and how operational decisions affect reimbursement outcomes.

1.4.2 Secondary Sources

Secondary data was collected from publicly available and credible sources to support the analysis and provide industry context. These sources were used to understand healthcare revenue cycle management practices, denial management trends, technological developments, and relevant business concepts. Information obtained from secondary sources helped establish the theoretical foundation of the study and allowed for comparison between academic knowledge and practical workplace observations.

The secondary sources of information include:

- Official Commure publications and website.
- Industry reports and market analyses.
- Healthcare revenue cycle management publications.
- Academic journals and research articles.
- Books related to healthcare management and business administration.
- Professional healthcare management resources.

The combination of primary and secondary data strengthened the reliability of the study by enabling a balanced analysis of both practical experience and established knowledge. All publicly available information included in this report has been reviewed to ensure relevance, accuracy, and consistency with the objectives of the study.

1.5 Limitations of the Study

Several limitations were encountered during the preparation of this report.

First, access to certain organizational information was restricted due to confidentiality requirements. As a healthcare technology company operating within the U.S. healthcare ecosystem, Commure handles sensitive operational, financial, and healthcare-related information. Consequently, a significant portion of internal data, performance metrics, client

information, and proprietary operational practices could not be disclosed for academic purposes.

Second, internal financial performance data and client-specific business information were not accessible for inclusion in this report. Therefore, the analysis is primarily based on publicly available information, academic resources, and professional observations obtained through workplace experience.

Third, patient-specific information, healthcare records, and any form of Protected Health Information (PHI) have been strictly excluded from this study to ensure compliance with healthcare privacy regulations, including the Health Insurance Portability and Accountability Act (HIPAA), as well as organizational privacy and security policies. The healthcare revenue cycle industry operates within a highly regulated environment where the protection of patient data is of paramount importance.

Additionally, certain operational procedures, workflow methodologies, client engagement practices, and performance management mechanisms could not be discussed in detail due to confidentiality obligations and the Non-Disclosure Agreement (NDA) signed as part of my employment. Although access to such information would have enabled a deeper operational analysis, ethical and legal responsibilities required that these details remain undisclosed.

Furthermore, the healthcare revenue cycle management industry is highly sensitive in nature because it involves healthcare reimbursement processes, insurance claims, patient-related data, payer interactions, and financial transactions. As a result, considerable care was taken to ensure that no confidential, proprietary, or regulated information was included in this report.

Finally, portions of the study rely on personal observations and professional experiences gained within a specific organizational context. Therefore, some findings may not fully represent the practices, challenges, or operational structures of all healthcare organizations or revenue cycle management providers.

CHAPTER TWO

ORGANIZATIONAL OVERVIEW

2.1 Company Background

Commure is a healthcare technology company headquartered in Mountain View, California, United States. The company develops AI-powered solutions designed to improve healthcare operations, clinical workflows, patient engagement, and revenue cycle management. Commure's platform integrates multiple healthcare functions, including patient access, clinical intelligence, revenue cycle management, and operational automation into a unified technology ecosystem.

The healthcare industry faces numerous challenges related to administrative complexity, reimbursement management, workforce shortages, documentation requirements, and rising operational costs. Commure addresses these challenges by leveraging technology, automation, and artificial intelligence to streamline healthcare workflows and improve operational efficiency. The company states that its products are developed in close collaboration with healthcare organizations to ensure practical applicability and measurable impact in real-world healthcare environments.

Commure positions itself as an AI-native healthcare platform that supports various stages of the healthcare delivery and reimbursement process. Its solutions encompass patient scheduling, prior authorization, clinical documentation, coding, claims processing, denial management, appeals management, payment reconciliation, and revenue cycle optimization. Through these capabilities, the company aims to reduce administrative burdens while enabling healthcare providers to focus more on patient care.

In addition to its operations in the United States, Commure utilizes a global workforce model to support its healthcare technology and revenue cycle operations. The company maintains operational teams across multiple regions, including Bangladesh, where professionals contribute to various healthcare support functions, technology operations, and revenue cycle management activities. This global operational structure enables continuous workflow support and facilitates efficient service delivery for healthcare organizations operating in the U.S. market.

As an Operations Analyst within the Denials Management team, I contribute to Revenue Cycle Management (RCM) operations from Bangladesh, supporting healthcare reimbursement processes within the U.S. healthcare system. This experience has provided valuable exposure

to international healthcare operations and the complexities of insurance claim management within a highly regulated industry.

Commure has experienced significant growth in recent years and has established itself as a prominent organization within the healthcare technology sector. Commure raised additional funding in 2026, resulting in an estimated valuation of approximately USD 7 billion. This valuation reflects investor confidence in the company's AI-driven healthcare technology platform and its long-term growth potential within the healthcare industry.

2.2 Mission and Vision

Commure states that its mission is to simplify healthcare through technology. The company seeks to reduce administrative complexity for healthcare providers, staff, and patients by developing technology solutions that streamline workflows, improve operational efficiency, and enhance the delivery of healthcare services. Through the integration of artificial intelligence, automation, and healthcare focused software solutions, Commure aims to support healthcare organizations in managing both clinical and administrative functions more effectively.

2.3 Products and Services

Commure offers a portfolio of healthcare technology solutions spanning the entire healthcare revenue cycle and clinical workflow.

A. Patient Access Solutions

These solutions focus on activities that occur before patient encounters, including:

- Appointment scheduling
- Care navigation
- Referrals
- Patient intake
- Check-in processes
- Prior authorization support

These functions aim to reduce delays and improve patient access to healthcare services.

B. Clinical Intelligence Solutions

The company provides tools designed to support healthcare providers during patient encounters.

These include:

- Ambient AI documentation
- Clinical copilot tools
- Autonomous coding
- Charge capture support
- Clinical documentation improvement

The objective is to reduce the documentation burden and improve clinical productivity.

C. Revenue Cycle Management Solutions

Commure's RCM platform includes:

- Eligibility verification
- Claims submission
- Payment posting
- Denial management
- Appeals automation
- Revenue analytics
- Financial reporting

The company highlights automation of coding, claim submission, reconciliation, and denial management activities.

D. AI-Powered Denial Management

A particularly relevant service for this report is Commure's denial management capability.

- Denial trend identification
- Bulk denial resubmission

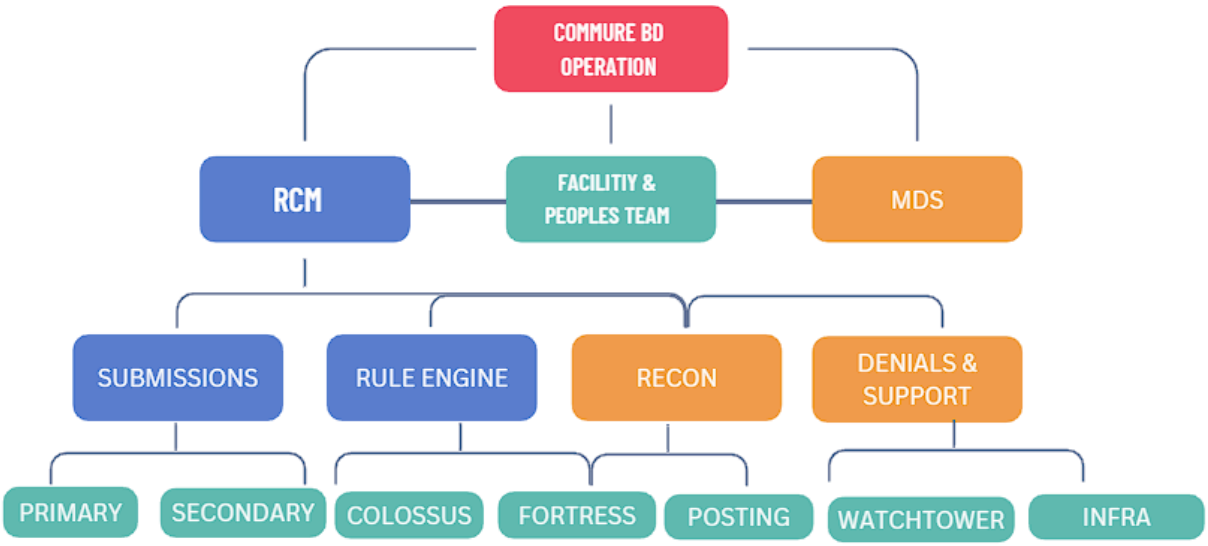
- Automated correction rules
- AI-assisted appeals generation
- Historical denial analysis

2.4 Organizational Structure

Commure operates through a multi-functional organizational structure designed to support healthcare technology, clinical operations, artificial intelligence solutions, and revenue cycle management services. The company maintains leadership teams in the United States that oversee strategic decision-making, product development, operational performance, client success, and business growth initiatives.

At the corporate level, Commure's operations are supported by executive leadership and functional departments responsible for technology development, engineering, product management, clinical solutions, revenue cycle management, customer success, sales and marketing, finance, and human resources. These departments work collaboratively to deliver integrated healthcare technology solutions and operational support services to healthcare organizations across the United States.

As this report focuses on my professional experience within Revenue Cycle Management (RCM), emphasis has been placed on the operational structure of the RCM division rather than the overall corporate hierarchy.



Source: Prepared by the author based on information from Commure.

2.5 Relevance to Work Experience

My work experience was situated within Revenue Cycle Management operations, specifically Denials Management. This function contributes to the broader organizational objective of improving reimbursement performance and reducing revenue leakage.

2.6 Industry Overview

Healthcare Revenue Cycle Management (RCM) refers to the financial and administrative processes involved in managing healthcare revenue from the initial patient interaction through the final collection of payment. It connects clinical services with the financial operations of healthcare organizations and plays an important role in maintaining a stable and efficient revenue flow.

The RCM process involves several interconnected activities, including patient registration and eligibility verification, authorization, clinical documentation, medical coding, claim submission, payment posting, accounts receivable follow-up, denial management, and patient billing. Since these activities are closely connected, an issue at one stage can affect subsequent stages of the revenue cycle. For example, inaccurate patient information, eligibility issues, coding errors, or incomplete documentation may result in claim delays or denials.

A general overview of the healthcare revenue cycle is presented in the following diagram, which illustrates the major stages involved in the process.

The healthcare RCM industry has become increasingly complex due to changes in payer requirements, regulatory compliance, documentation standards, and prior authorization procedures. Healthcare providers must also manage a large volume of claims while maintaining accuracy and meeting the requirements of different insurance payers. As a result, organizations increasingly rely on specialized RCM teams and technology-driven solutions to improve operational efficiency, reduce revenue leakage, and manage outstanding claims.

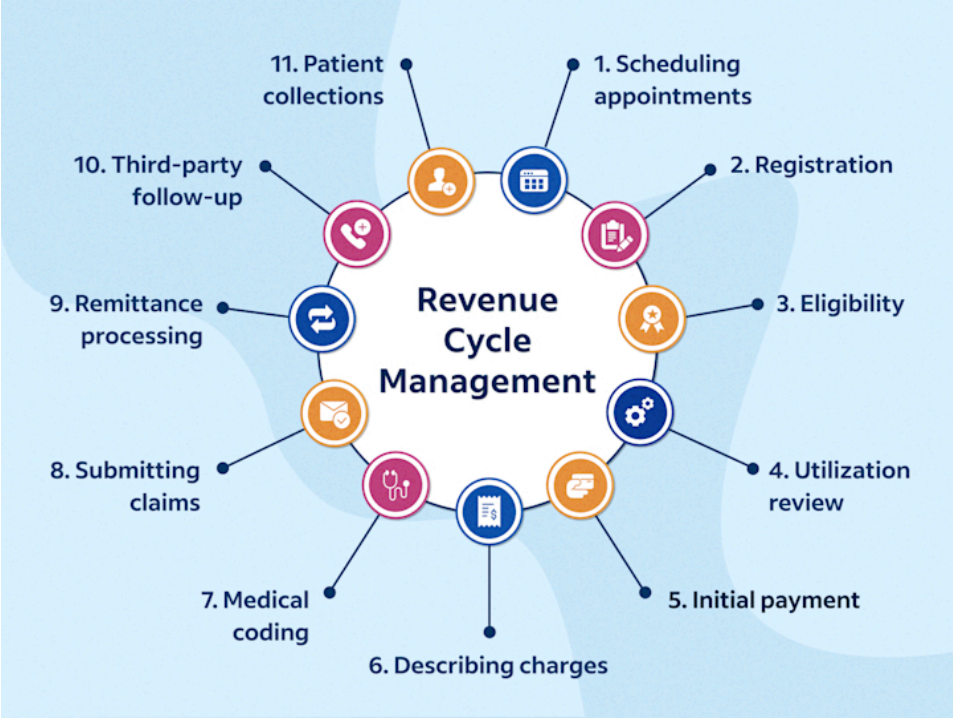


Figure 2.1: Healthcare Revenue Cycle Management Process

2.7 Industry Trends

The healthcare RCM industry is currently undergoing significant technological and operational changes. One of the major developments is the increasing use of artificial intelligence and automation in revenue cycle processes. AI-based solutions are being applied to areas such as medical coding, claim review, denial prediction, revenue analysis, and the preparation of appeal documentation. These technologies can support RCM teams by identifying patterns in large volumes of data and assisting with repetitive operational activities.

Another important trend is the industry's increasing emphasis on denial prevention rather than only denial correction. Traditionally, denial management has often focused on identifying and resolving claims after they have already been denied. However, healthcare organizations are increasingly attempting to identify the underlying causes of denials and address them earlier in the revenue cycle. Predictive analytics, automated workflows, and claim validation tools are being used to identify potential issues before claims are submitted to payers.

The industry is also moving toward more integrated technology platforms. Healthcare organizations often manage multiple functions across different systems, which can create information gaps and increase operational complexity. Integrated platforms aim to connect different parts of the revenue cycle and provide greater visibility across financial and operational processes. This approach can support better coordination between teams and improve the ability to monitor claims, payments, accounts receivable, and denials within a connected workflow.

Overall, the development of healthcare RCM is increasingly influenced by automation, data-driven decision-making, denial prevention, and system integration. These developments have increased the importance of specialized RCM operations and technology in supporting healthcare organizations in managing their revenue cycle more efficiently.

2.8 Competitive Position and Market Presence

Commure operates within a highly competitive healthcare technology market. The company states that its platform supports:

- More than 130 health systems
- Over 2,000 sites of care
- More than $25 billion in annual claims
- Integration with more than 60 EHR systems

These figures are publicly reported by the company. The organization competes in segments including:

- Revenue Cycle Management
- Clinical Documentation
- Ambient AI
- Healthcare Analytics
- Practice Management Technology

Recently, continued investor confidence in the company's growth strategy, including a funding round announced in 2026 that valued the company at approximately $7 billion.

CHAPTER THREE

JOB DESCRIPTION AND WORK EXPERIENCE

3.1 Position Description

As part of my professional experience at Commure, I'm working as an **Operations Analyst – Denials** within the Revenue Cycle Management (RCM) department. My role focused on reviewing, analyzing, and resolving denied healthcare claims to support reimbursement processes and improve revenue realization for healthcare providers.

Denial management serves as a critical component of healthcare revenue cycle operations because denied claims directly affect cash flow, reimbursement timelines, and overall financial performance. The primary objective of my role was to identify the causes of claim denials, determine appropriate corrective actions, and facilitate claim resolution in accordance with payer requirements and organizational guidelines.

The position required a combination of analytical thinking, problem-solving ability, communication skills, and attention to detail. Each denial required careful examination to determine the root cause and identify the most effective resolution strategy.

From an operations management perspective, denial management can be viewed as a quality control function within the revenue cycle. The objective is not only to resolve existing denials but also to identify recurring issues and contribute to process improvements that reduce future denials.

3.1.1 Denial Management Workflow

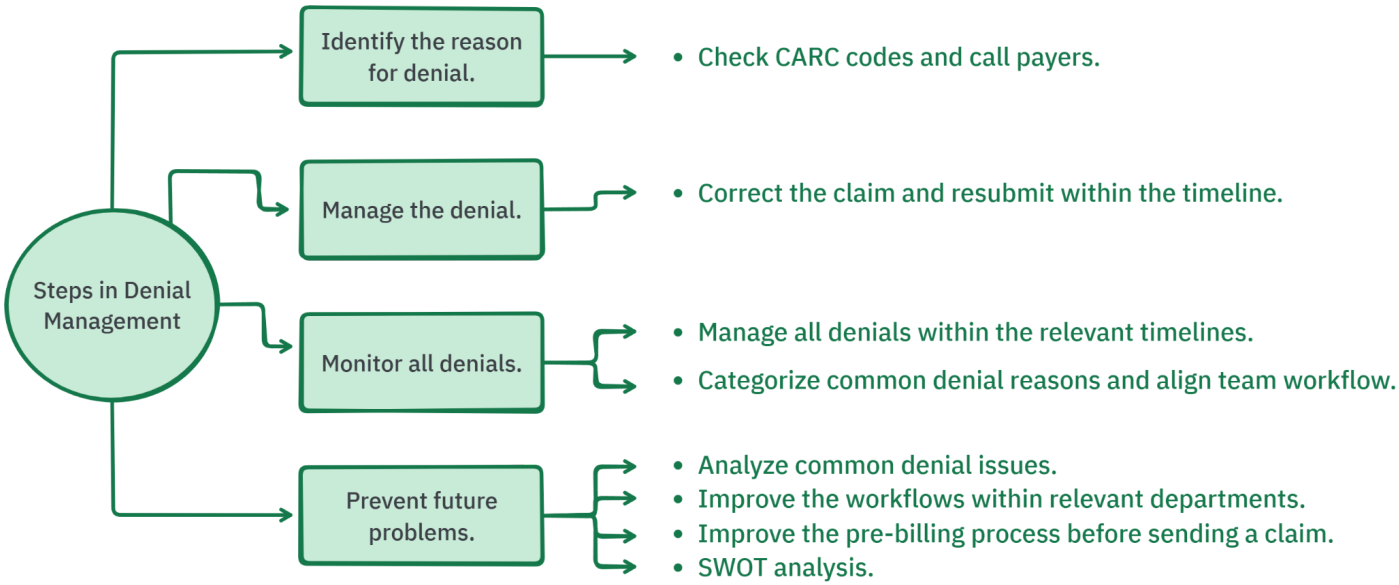


Figure 3.1: Denial Management Workflow

3.2 Department Overview

The Revenue Cycle Management department plays a significant role in ensuring that healthcare providers receive reimbursement for services rendered. The department supports various stages of the revenue cycle, including patient eligibility verification, claim submission, payment posting, denial management, appeals processing, and account resolution.

Within the RCM structure, the Denials Management team focuses specifically on claims that have been rejected, reduced, or delayed by insurance payers.

The team's responsibilities generally include:

- Reviewing denied claims.
- Investigating denial causes.
- Correcting claim errors.
- Preparing appeals.
- Communicating with relevant stakeholders.

- Monitoring denial trends.
- Supporting revenue recovery efforts.

The Denials Management team functions as a bridge between claim submission activities and reimbursement realization. Effective performance within this area directly influences organizational revenue collection outcomes.

3.3 Major Responsibilities

As an Operations Analyst – Denials, I am responsible for managing various denial-related activities within healthcare revenue cycle operations.

My major responsibilities included:

3.3.1 Denial Review and Analysis

One of my primary responsibilities involved reviewing denied claims and identifying the reason for denial.

This required:

- Reviewing payer responses.
- Examining claim history.
- Assessing documentation requirements.
- Determining appropriate corrective actions.

3.3.2 Root Cause Identification

Every denial has an underlying reason. A significant portion of my work involved identifying root causes rather than addressing symptoms.

Common denial categories included:

- Benefit Maximum denials.
- Fee Schedule-related denials.
- Eligibility denials.
- Authorization denials.

- Medical Necessity denials.
- Documentation deficiencies.
- Coding-related denials.
- Timely Filing denials.

Identifying the correct root cause is essential because different denial categories require different resolution approaches.

3.3.3 Appeals and Reconsideration Activities

When claims meet payer requirements for reconsideration or appeal, I participate in preparing supporting documentation and initiate appropriate resolution processes.

This process requires:

- Reviewing payer policies.
- Evaluating supporting records.
- Ensuring compliance with appeal requirements.

3.3.4 Documentation and Account Maintenance

Maintaining accurate documentation is an important aspect of the role.

Activities included:

- Updating account notes.
- Recording actions taken.
- Tracking payer responses.
- Maintaining workflow transparency.

Proper documentation supports continuity of work and enables effective collaboration among team members.

3.3.5 Productivity and Queue Management

The position also requires effective workload management.

This involved:

- Prioritizing high-impact accounts.
- Managing assigned work queues.
- Meeting operational deadlines.
- Ensuring timely follow-up on unresolved cases.

3.4 Daily Workflow

Although denial types varied significantly, a general workflow is followed when reviewing denied claims.

Step 1: Claim Assignment - Claims are assigned through operational work queues based on organizational workflow processes.

Step 2: Initial Review - The denied claim needs to be reviewed to understand:

- Denial reason.
- Payer response.
- Service details.
- Account history.
- Carc & Rarc code

Step 3: Investigation - The next step involved gathering relevant information to determine the root cause of the denial. This included reviewing:

- Insurance information.
- Authorization status.
- Documentation availability.
- Prior claim actions.

Step 4: Resolution Strategy Selection - Based on the findings, an appropriate resolution path was selected. Possible actions included:

- Claim correction.
- Appeal submission.
- Reconsideration request.
- Documentation update.
- Account closure when applicable.

Step 5: Action Implementation - The selected action will be executed according to payer requirements and organizational procedures.

Step 6: Documentation - All activities were documented to ensure accountability and facilitate future follow-up.

Step 7: Monitoring - Accounts remained under observation until final payer determination or resolution.

3.5 Team Coordination Activities

Denial management is rarely an isolated function. Successful claim resolution often requires collaboration among multiple stakeholders. My role involved coordination with:

- Team leaders.
- Supervisors.
- Quality analysts.
- Other operational teams.
- Internal support personnel.

Team coordination contributed to:

- Knowledge sharing.
- Consistent decision-making.
- Escalation management.
- Process improvement discussions.

In many cases, complex denials required consultation with experienced colleagues or supervisory staff to ensure appropriate resolution strategies were applied. This collaborative environment highlighted the importance of teamwork within healthcare operations.

3.6 Leadership and Communication Responsibilities

Although my primary responsibilities focused on operational analysis, leadership and communication skills played a significant role in daily performance.

Communication Responsibilities

Effective communication is necessary for:

- Clarifying denial scenarios.
- Escalating complex issues.
- Providing account updates.
- Participating in team discussions.

Clear communication reduces misunderstandings and improves operational efficiency.

Leadership Exposure

Through daily operational responsibilities, I observed several leadership practices, including:

- Performance monitoring.
- Work allocation.
- Process improvement initiatives.
- Employee support and coaching.

These observations provided practical insights into management and leadership concepts studied during the BBA program.

Business Communication Perspective

Business Communication theory emphasizes clarity, accuracy, timeliness, and professionalism.

The healthcare revenue cycle environment reinforces these principles because inaccurate communication can result in delayed resolutions and financial consequences.

3.7 Skills Developed During Internship

The role contributed significantly to both professional and personal development.

Analytical Skills

Denial management requires careful examination of complex situations.

Over time, I developed stronger abilities in:

- Data interpretation.
- Problem identification.
- Root cause analysis.
- Decision-making.

Time Management

Managing multiple accounts simultaneously required effective prioritization and scheduling.

This improved my ability to:

- Meet deadlines.
- Organize workloads.
- Maintain productivity.

Problem-Solving Skills

Each denial presented unique challenges.

Repeated exposure to complex scenarios strengthened my ability to:

- Evaluate alternatives.
- Identify solutions.
- Adapt to changing circumstances.

Communication Skills

Regular interaction with team members improved:

- Professional communication.
- Reporting skills.
- Information sharing.
- Collaborative problem-solving.

Industry Knowledge

The role significantly expanded my understanding of:

- Healthcare reimbursement.
- Insurance payer behavior.
- Revenue cycle management.
- Operational healthcare processes.

3.8 Challenges Encountered

Working within denial management presented several operational challenges.

Complex Payer Requirements

- Different insurance payers maintain different rules, policies, and documentation standards.

- This creates complexity because resolution strategies must be adapted according to payer-specific requirements.

Frequent Policy Changes

- Healthcare reimbursement policies evolve continuously.
- Operational staff must remain informed about changing requirements to ensure compliance and effectiveness.

Documentation Limitations

- Certain denials occur because necessary supporting documentation is unavailable or incomplete.
- These situations can restrict available resolution options.

High Workload Variability

- Denial volumes often fluctuate based on operational conditions.
- Managing workload during peak periods requires strong prioritization and time management skills.

Decision-Making Under Uncertainty

- Not all denial cases have straightforward solutions.
- Analysts frequently encounter situations where multiple factors influence outcomes, requiring careful judgment and analysis.

3.9 Practical Reflection

My experience as an Operations Analyst – Denials provided an opportunity to observe how healthcare organizations manage one of the most challenging aspects of the revenue cycle.

Prior to working in denial management, many of the concepts learned in academic courses such as Operations Management, Organizational Behavior, and Business Communication existed primarily in theory. Through practical experience, I observed how these concepts influence real business operations.

I learned that denial management extends beyond correcting rejected claims. It involves process analysis, operational efficiency, communication, teamwork, decision-making, and continuous improvement.

The experience strengthened my understanding of how operational activities contribute to broader organizational objectives and highlighted the importance of analytical thinking in healthcare revenue cycle management.

CHAPTER FOUR

Analysis of Denial Management on Healthcare Revenue Cycle Performance

4.1 Concept of Revenue Cycle Management

Revenue Cycle Management (RCM) refers to the financial process that healthcare organizations use to manage administrative and clinical functions associated with patient service revenue. The cycle begins when a patient schedules an appointment and continues until final reimbursement is received and posted. A standard revenue cycle includes:



Figure 4.1: Elements of Revenue Cycle Management

Modern healthcare organizations increasingly rely on technology-driven RCM platforms to automate these processes. Commure publicly states that its platform supports end-to-end revenue cycle automation, including eligibility verification, claim submission, payment posting, denial management, appeals, and reimbursement optimization through AI-powered workflows.

From an operations management perspective, RCM functions as a value chain where each activity influences the effectiveness of downstream processes. Errors during registration, authorization, coding, or documentation often lead to claim denials later in the cycle.

Therefore, denial management should not be viewed as an isolated function. It represents the final checkpoint where operational failures from earlier stages become visible.

4.2 Overview of Claim Denials

A claim denial occurs when a payer reviews a submitted healthcare claim and determines that reimbursement cannot be approved fully or partially based on policy requirements, coverage limitations, documentation standards, coding rules, or administrative conditions.

Unlike claim rejections, which occur before claim adjudication, denials occur after payer review and often require additional corrective actions, resubmissions, or formal appeals.

Industry research indicates that revenue cycle leaders consistently identify claim denials as one of the most significant threats to healthcare financial performance. A survey conducted in partnership with the Healthcare Financial Management Association (HFMA) found that denial volume was considered the most significant revenue cycle threat by many healthcare leaders.

Financial Impact of Denials

Denials affect healthcare organizations through:

- Delayed cash flow
- Increased administrative workload
- Additional labor costs
- Revenue leakage
- Reduced operational efficiency
- Increased accounts receivable days

Even when denials are eventually overturned, significant organizational resources are required to recover the revenue.

This demonstrates that denial management influences not only reimbursement outcomes but also organizational productivity and resource utilization.

4.3 Types of Claim Denials

Throughout my experience in denial management operations, several denial categories appeared frequently. Although payer-specific requirements differ, the underlying denial causes often fall into common patterns.

Eligibility Denials

Eligibility denials occur when patient's insurance coverage cannot support reimbursement for the services billed. Common causes include:

- Coverage termination
- Incorrect member information
- Coverage effective date issues
- Coordination of benefits problems

Eligibility denials frequently originate from front-end registration processes.

Authorization Denials

Authorization denials occur when required prior approvals are absent, expired, incomplete, or inconsistent with services provided. These denials demonstrate how communication gaps between operational departments can directly affect reimbursement outcomes.

Medical Necessity Denials

Medical necessity denials arise when payers determine that submitted documentation does not sufficiently support the clinical necessity of the service. These denials often require:

- Clinical review
- Additional documentation
- Formal appeal processes

Benefit Maximum Denials

Benefit maximum denials occur when a patient's insurance plan has reached predefined coverage limitations. In many cases, reimbursement becomes restricted regardless of documentation quality or coding accuracy. Working these denials often requires careful policy review and benefit verification analysis.

Fee Schedule Related Denials

Fee schedule denials occur when reimbursement disputes arise regarding contracted payment amounts, allowable charges, or payer reimbursement calculations. These denials require detailed examination of:

- Contractual arrangements
- Reimbursement methodologies
- Payer policies

Coding-Related Denials

Coding denials arise when:

- Diagnosis codes are inconsistent
- Procedure codes are inaccurate
- Modifier usage is incorrect
- Coding guidelines are not followed

These denials highlight the relationship between clinical documentation and reimbursement accuracy.

Documentation Denials

Documentation denials occur when supporting records fail to satisfy payer requirements. Examples include:

- Missing records
- Incomplete documentation
- Insufficient clinical justification

Timely Filing Denials

Timely filing denials occur when claims are submitted after payer deadlines. These denials are particularly significant because recovery opportunities may be limited once filing windows expire.

4.4 Importance of Denial Management

Denial management serves as both a corrective and preventive function within healthcare organizations. Historically, denial management focused primarily on recovering revenue from already denied claims. However, modern approaches increasingly emphasize denial prevention through process improvement and predictive analytics.

Revenue Recovery

The most immediate purpose of denial management is recovering revenue that would otherwise remain unpaid. Each successfully resolved denial contributes directly to financial performance.

Operational Feedback Mechanism

Denials provide valuable information regarding weaknesses within organizational processes. Recurring denial patterns often reveal issues involving: Registration procedures, Authorization processes, Documentation practices, Coding accuracy. Thus, denial management functions as a diagnostic tool for operational improvement.

Continuous Improvement

Organizations that analyze denial trends effectively can implement process changes that reduce future denial volumes. This shift from reactive correction to proactive prevention represents a significant advancement in revenue cycle strategy.

Strategic Importance

Healthcare leaders increasingly recognize denial management as a strategic function rather than merely an administrative task. Industry surveys show that claim denials remain among the highest-priority challenges facing revenue cycle leaders.

4.5 Current Denial Resolution Process

Based on practical workplace observations, denial resolution generally follows a structured workflow.

Stage 1: Denial Identification - The process begins when payer responses indicate denial, reduction, or non-payment. The denial reason is reviewed to determine the nature of the issue.

Stage 2: Root Cause Analysis - The next step involves identifying why the denial occurred. Root cause analysis may involve reviewing: Insurance information, Authorization status, Documentation, Coding records, Claim history.

Stage 3: Resolution Planning - Once the root cause is identified, an appropriate strategy is selected. Possible actions include: Corrected claim submission, Appeal preparation, Reconsideration requests, Documentation updates

Stage 4: Execution - The selected corrective action is implemented according to payer-specific requirements.

Stage 5: Monitoring and Follow-Up - After submission, claims are monitored until final payer determination.

Stage 6: Trend Analysis - Organizations increasingly analyze denial data to identify recurring issues and improve future performance. This aligns with Commure's publicly stated focus on AI-assisted denial management, automated correction rules, denial trend analysis, and bulk resubmission capabilities.

4.6 Analysis of Operational Efficiency

One of the most important observations from denial management operations is that denial resolution alone does not determine organizational success. True efficiency is measured by the organization's ability to prevent denials before they occur. A recurring pattern observed within healthcare revenue cycle operations is that many denials originate upstream from the denial

management team itself. Issues involving eligibility verification, prior authorization, registration accuracy, documentation completeness, and coding practices frequently determine claim outcomes long before a denial analyst reviews the account. From an Operations Management perspective, denial management can be analyzed through the concept of process flow efficiency. When a claim is denied:

- Additional labor is required.
- Processing time increases.
- Cash collection is delayed.
- Administrative costs increase.

Therefore, every preventable denial represents operational waste.

The most effective organizations focus on:

- Front-end accuracy.
- Process standardization.
- Automation.
- Real-time validation.
- Cross-functional communication.

Commure's publicly available RCM platform emphasizes automation across eligibility verification, claim submission, denial correction, appeals generation, and reimbursement workflows. This reflects a broader industry movement toward reducing manual intervention and improving operational efficiency through technology.

4.7 Role of Team Leadership in Denial Management

While denial management is often viewed as a technical function, effective leadership significantly influences operational performance. During my experience in denial operations, I observed that leadership extends beyond assigning workloads and monitoring productivity. Leaders contribute to decision-making, knowledge sharing, quality assurance, employee development, and process improvement initiatives. The denial management environment is characterized by:

- Complex payer policies.

- Frequent procedural changes.
- High volumes of account reviews.
- Time-sensitive reimbursement requirements.

Under these conditions, leadership becomes essential for maintaining consistency and operational stability. Effective leaders support teams by:

- Clarifying expectations.
- Providing coaching and feedback.
- Facilitating communication.
- Addressing operational challenges.
- Encouraging collaboration.

These activities contribute directly to service quality and workflow efficiency.

4.7.1 Knowledge Management

One significant challenge within denial management is the continuous evolution of payer rules and reimbursement policies. Leadership plays an important role in:

- Disseminating updated information.
- Supporting employee learning.
- Standardizing best practices.
- Reducing process variability.

Organizations that invest in knowledge-sharing systems are generally better positioned to respond to changing payer requirements.

4.7.2 Employee Motivation and Performance

The work associated with denial management can be repetitive and mentally demanding. Employees frequently encounter complex cases requiring detailed analysis and careful decision-making. Organizational Behavior theory suggests that employee motivation influences performance outcomes. Supportive leadership practices can improve:

- Employee engagement.
- Work quality.

- Problem-solving effectiveness.
- Team morale.

These factors ultimately affect denial resolution performance and reimbursement outcomes.

4.7.3 Leadership as a Strategic Resource

From a strategic management perspective, leadership should not be viewed merely as a supervisory function. Effective leadership contributes to:

- Operational efficiency.
- Knowledge retention.
- Process improvement.
- Organizational adaptability.

Therefore, leadership quality becomes a competitive advantage within revenue cycle operations.

4.8 SWOT Analysis

A SWOT analysis provides a structured framework for evaluating denial management operations by examining strengths, weaknesses, opportunities, and threats.

Strengths

Strengths	Impact
Specialized denial expertise.	Improves resolution quality.
Structured workflows.	Enhances consistency.
Access to technology and automation.	Increases productivity.
Data-driven decision making.	Supports trend analysis.
Experienced operational teams.	Improves problem-solving effectiveness.

Denial management teams develop substantial institutional knowledge regarding payer behavior and reimbursement processes. This expertise contributes to more effective claim resolution and operational efficiency.

Weaknesses

Weakness	Impact
Dependence on upstream processes	Creates vulnerabilities
High complexity of payer rules	Increases workload
Frequent policy changes	Requires continuous learning
Labor-intensive review processes	Limits scalability
Variability across payers	Reduces standardization

Many denial causes originate outside the denial management department itself.As a result, denial teams often address problems created by earlier stages of the revenue cycle.

Opportunities

Opportunity	Potential Benefit
AI-powered automation	Increased efficiency

Predictive analytics	Denial prevention
Process standardization	Reduced error rates
Workforce development	Improved performance
Enhanced reporting systems	Better decision-making

Healthcare organizations increasingly invest in automation and predictive technologies designed to reduce denial volumes and improve reimbursement outcomes. These developments create opportunities for continuous operational improvement.

Threats

Threat	Impact
Increasing payer complexity	Higher denial rates
Regulatory changes	Compliance challenges
Workforce shortages	Reduced operational capacity
Rising administrative burden	Increased costs

Reimbursement pressures	Revenue risks

The healthcare reimbursement environment remains highly dynamic and subject to ongoing change. Organizations must continuously adapt to maintain performance.

CHAPTER 5

FINDINGS AND RECOMMENDATIONS

5.1 Key Findings

The study examined denial management practices within healthcare Revenue Cycle Management (RCM) operations and evaluated their relationship with overall revenue cycle performance. Based on workplace observations, industry research, and academic analysis, several significant findings emerged.

Finding 1: Denial Management Is a Strategic Revenue Function

One of the most important findings of this study is that denial management extends beyond the correction of rejected claims. The function directly contributes to revenue protection, cash flow stability, and operational performance. Effective denial management not only addresses outstanding claims but also provides information that can be used to identify recurring problems within the revenue cycle.

Finding 2: Many Denials Are Preventable

The study found that a substantial portion of denial categories originates from operational issues occurring before claim submission. Issues related to patient information, insurance eligibility, authorization, documentation, coding, and billing can create problems that ultimately result in claim denials. This indicates that improving upstream processes can reduce the occurrence of avoidable denials and the additional work required to resolve them.

Finding 3: Root Cause Analysis Improves Performance

Organizations that systematically analyze denial causes are better positioned to implement corrective measures. Reviewing only the immediate reason for a denial may resolve an individual claim without addressing the underlying problem. Identifying recurring root causes allows organizations to introduce targeted process improvements and reduce the likelihood of similar issues occurring repeatedly.

Finding 4: Technology Improves Denial Management Efficiency

The healthcare industry increasingly relies on technology to manage complex reimbursement processes. Automated workflows, claim validation tools, analytics, and other technology-based solutions can assist teams in identifying potential problems, organizing denial work, and

prioritizing cases. Technology can therefore reduce repetitive manual activities while allowing employees to focus on cases requiring greater investigation and judgment.

Finding 5: Collaboration Is Essential

Denial management outcomes depend heavily on cooperation among various departments. Many denial causes originate outside the denial management function and may involve registration, eligibility, authorization, coding, documentation, or billing activities. Effective communication between these functions is therefore important for resolving existing denials and addressing the operational causes behind recurring problems.

Finding 6: Workforce Knowledge Directly Influences Outcomes

Healthcare reimbursement rules change frequently, and payer requirements can vary across different insurance plans. Organizations that invest in employee training and continuous learning are better positioned to adapt to these changes. Employees with stronger knowledge of payer requirements, denial categories, and internal workflows can investigate claims more effectively and determine appropriate resolution strategies.

Finding 7: Denial Management Requires Timely Action

The timing of denial follow-up is an important aspect of effective revenue cycle operations. Once a claim is denied, the responsible team needs to identify the issue, determine the appropriate action, and proceed within applicable payer requirements and filing limitations. Delays can increase outstanding accounts and create additional administrative workload. Timely review and appropriate prioritization are therefore important elements of denial management.

Finding 8: Denial Reasons Must Be Distinguished from Root Causes

A denial reason provided by a payer does not necessarily represent the underlying operational cause of the problem. A claim may be denied for a particular reason, while further investigation reveals that the issue originated from an earlier process. Distinguishing the immediate denial reason from its root cause allows RCM teams to develop more targeted corrective actions rather than simply resolving individual claims.

Finding 9: Denial Data Can Support Process Improvement

Denial information can provide valuable insight into weaknesses within the revenue cycle. Analyzing denial patterns by category, payer, workflow, or other relevant factors can help organizations identify recurring problems. This makes denial data useful not only for claim resolution but also for identifying areas where workflow changes, additional training, or process controls may be required.

Finding 10: Payer Specific Knowledge Is Important for Effective Denial Resolution

Insurance payers may have different requirements relating to eligibility, authorization, documentation, coding, and claim submission. As a result, effective denial resolution often requires an understanding of the specific requirements applicable to a particular payer. Payer-specific knowledge enables RCM professionals to determine the appropriate course of action, whether that involves correction, resubmission, additional documentation, or an appeal.

Finding 11: Documentation Quality Has a Significant Effect on Claim Reimbursement

Accurate and complete documentation supports several stages of the revenue cycle, including coding, medical necessity review, and claim submission. When documentation does not adequately support the services reported on a claim, the risk of payment delays, additional information requests, or denials may increase. Documentation quality is therefore an important component of both clinical and financial operations.

Finding 12: Denial Management Involves Both Financial and Operational Costs

The impact of a denial extends beyond the unpaid value of an individual claim. Denied claims require additional administrative effort for investigation, correction, communication, resubmission, or appeal. Recurring denials can therefore increase workload and consume resources that could otherwise be used for other revenue cycle activities. Effective denial management should consequently consider both financial recovery and operational efficiency.

Finding 13: Denial Prevention Requires Feedback Across the Revenue Cycle

Information obtained during denial resolution can be used to improve earlier stages of the revenue cycle. When recurring denial patterns are communicated to teams responsible for registration, authorization, coding, documentation, or billing, those teams can address the

underlying issues at their source. This creates a feedback mechanism that supports continuous improvement rather than relying exclusively on post-denial correction.

Finding 14: Standardized Denial Categories Improve Analysis

Consistent classification of denial reasons is important for meaningful analysis and reporting. When similar denial issues are categorized differently, it becomes more difficult to identify trends and compare performance. Standardized denial categories and definitions can therefore improve the quality of reporting and help management identify which denial areas require attention.

Finding 15: Effective Denial Management Should Be Measured Through Multiple Performance Indicators

Denial management performance cannot be fully evaluated by considering denial volume alone. A more comprehensive assessment can include indicators such as denial rate, denial value, time to appeal, time to resolution, recovery or overturn rate, and denial-related write-offs. Using multiple performance indicators provides a broader view of both the financial and operational effectiveness of denial management.

5.2 Recommendations

Based on the findings and analysis presented throughout this report, several recommendations are proposed to strengthen denial management practices and improve the overall effectiveness of healthcare Revenue Cycle Management (RCM) operations. The recommendations focus on addressing denial causes at their source, improving the efficiency of denial resolution, strengthening workforce capabilities, and using data and technology to support continuous improvement.

Recommendation 1: Strengthen Front-End Processes to Reduce Preventable Denials

Greater attention should be given to the accuracy of activities performed before claim submission, particularly patient registration, insurance eligibility verification, authorization, documentation, and other claim-related information. Recurring denial patterns should be

reviewed to identify whether errors are originating from these earlier stages of the revenue cycle. Where recurring issues are identified, appropriate process controls, training, or workflow adjustments should be introduced to address them before claims reach the payer.

Recommendation 2: Establish a Structured Denial Prevention and Root Cause Analysis Process

Denial management should incorporate a structured approach for identifying and analyzing the underlying causes of recurring denials. Instead of treating each denied claim as an isolated case, denial teams should examine whether similar issues are occurring across multiple claims, payers, or workflows. The results of root cause analysis should be communicated to the relevant operational teams so that corrective actions can be taken at the source of the problem.

Recommendation 3: Standardize Denial Classification and Reporting

A consistent framework should be used to classify and report denial reasons. Standardized categories can make it easier to identify recurring patterns, compare performance, and determine which denial types require management attention. Reporting should distinguish between the immediate payer denial reason and the underlying operational cause where sufficient information is available. This would provide a clearer basis for operational decision-making and process improvement.

Recommendation 4: Develop a Data-Driven Denial Prioritization Framework

Denial teams should establish clear criteria for prioritizing cases within their work queues. Factors such as claim value, payer requirements, filing deadlines, denial category, and the potential for successful recovery may be considered when determining the urgency of individual cases. A structured prioritization approach can help allocate available resources more effectively and ensure that time-sensitive or financially significant cases receive appropriate attention.

Recommendation 5: Strengthen Continuous Employee Development and Payer-Specific Knowledge

Regular training and knowledge-development activities should be maintained for employees involved in denial management and related RCM functions. Training should cover payer requirements, denial categories, documentation standards, claim-resolution procedures, and

relevant changes in reimbursement requirements. Since payer requirements may differ, employees should also have access to current payer-specific guidelines when reviewing and resolving claims. Knowledge-sharing sessions based on recurring denial trends can further improve employees' ability to identify and resolve common issues.

Recommendation 6: Improve Cross-Department Feedback and Accountability

Denial management should maintain effective communication with the departments responsible for activities that influence claim outcomes. Recurring denial trends should be shared with relevant teams such as registration, eligibility, authorization, coding, documentation, and billing. Establishing a clear feedback mechanism can help ensure that information obtained during denial resolution is used to improve upstream processes rather than remaining within the denial management function.

Recommendation 7: Improve Documentation Quality and Completeness

Greater emphasis should be placed on the completeness and accuracy of documentation supporting submitted claims. Documentation-related denial patterns should be reviewed to identify recurring issues and determine where additional guidance or process improvements may be appropriate. Strengthening documentation practices can support accurate coding and claim submission while reducing the need for additional clarification or corrective action.

Recommendation 8: Use Technology to Support, Rather Than Replace, Denial Management Expertise

Organizations should continue evaluating technology and automation that can support repetitive and data-intensive denial management activities. Potential applications include claim-status monitoring, work-queue management, data analysis, identification of potential claim issues, and case prioritization. At the same time, complex claims should continue to receive appropriate human review because effective resolution may require interpretation of payer requirements, documentation, coding, or other claim-specific information.

Recommendation 9: Strengthen Timely Denial Follow-Up

A structured approach should be maintained for monitoring and following up on denied claims within applicable payer requirements and filing limits. Denial work queues should be reviewed regularly, with appropriate attention given to time-sensitive and financially significant accounts.

Clear follow-up procedures can help reduce unnecessary delays in claim resolution and support more effective recovery of outstanding reimbursement.

Recommendation 10: Enhance Denial Data Analytics Capabilities

Organizations should strengthen their use of denial-related data to support operational decision-making. Analytics can be used to identify recurring denial categories, payer-specific patterns, high-value claims, and areas with increasing denial activity. These insights can help management prioritize improvement initiatives, allocate resources, and evaluate whether corrective actions are producing meaningful results.

Recommendation 11: Establish a Comprehensive Denial Performance Measurement Framework

Denial management performance should be evaluated using multiple financial and operational indicators rather than relying on denial volume alone. Relevant measures may include denial rate, denial value, time to appeal, time to resolution, recovery or overturn rate, and denial-related write-offs. Regular review of these indicators can help management identify performance trends, determine areas requiring attention, and assess the effectiveness of denial-management initiatives.

Overall, the recommendations emphasize a shift from a predominantly reactive approach to a more preventive and data-driven model of denial management. Addressing the causes of denials at earlier stages, strengthening collaboration between RCM functions, developing employee capabilities, maintaining payer-specific knowledge, and using appropriate technology and performance measures can support more effective management of denied claims and contribute to stronger revenue cycle performance.

CHAPTER 6

CONCLUSION

6.1 Summary of Learning

This internship experience provided valuable exposure to the operational and strategic dimensions of healthcare Revenue Cycle Management, particularly within the field of denial management.

Working as an Operations Analyst – Denials enabled me to gain practical insights into the challenges associated with healthcare reimbursement processes. The experience demonstrated how administrative accuracy, communication effectiveness, process efficiency, and analytical decision-making influence organizational performance.

The study explored the role of denial management within healthcare revenue cycle operations and examined how denial-related activities contribute to financial performance, operational efficiency, and process improvement efforts.

Through both academic analysis and practical observation, it became evident that denial management extends beyond claim correction. The function serves as a critical mechanism for revenue protection, operational feedback, and continuous improvement.

The internship also provided opportunities to apply concepts learned throughout the Bachelor of Business Administration program, including:

- Operations Management
- Organizational Behavior
- Human Resource Management
- Strategic Management
- Service Quality Management
- Business Communication

Observing these concepts within a professional environment strengthened my understanding of their practical relevance and business applications.

6.2 Conclusion

Healthcare organizations operate within an increasingly complex reimbursement environment where financial success depends on efficient revenue cycle processes.

Claim denials remain one of the most significant obstacles to timely reimbursement and organizational financial performance. As a result, denial management has become a critical operational function within modern healthcare organizations.

The findings of this study indicate that effective denial management contributes to:

- Revenue recovery.
- Process improvement.
- Operational efficiency.
- Organizational sustainability.

The analysis also demonstrates that many denial-related challenges originate outside the denial management department itself, highlighting the importance of collaboration across the entire revenue cycle.

Advancements in technology, analytics, and automation are creating new opportunities to improve denial management performance. Organizations that embrace these developments while investing in employee development and process optimization are likely to achieve stronger reimbursement outcomes.

From a personal perspective, this internship experience enhanced my analytical abilities, problem-solving skills, communication competencies, and understanding of healthcare operations. The experience provided meaningful professional growth while reinforcing the practical value of business administration concepts.

In summary, denial management plays a vital role in healthcare revenue cycle performance, and its continued evolution will remain an important factor in the financial success of healthcare organizations in the years ahead.

REFERENCES

American Medical Association. (2024). Revenue cycle management: Improving financial performance in healthcare organizations. https://www.ama-assn.org

Commure. (n.d.). Company overview. Retrieved June 7, 2026, from https://www.commure.com/company

Commure. (n.d.). Revenue cycle management solutions. Retrieved June 7, 2026, from https://www.commure.com/rcm

Commure. (n.d.). Official website. Retrieved June 7, 2026, from https://www.commure.com

Healthcare Business Management Association. (2025). What is denial management? RCM Advisor. https://www.hbma.org

Healthcare Financial Management Association. (2024). Revenue cycle management best practices. https://www.hfma.org

Reuters. (2026, May 19). Healthcare AI firm Commure is valued at $7 billion after a new funding round. Reuters. https://www.reuters.com

Techtarget. (2024). Claim denials remain a major threat to revenue cycle performance. RevCycle Management. https://www.techtarget.com/revcyclemanagement

Wager, K. A., Lee, F. W., & Glaser, J. P. (2021). Health care information systems: A practical approach for health care management (5th ed.). Jossey-Bass.

Gapenski, L. C., Reiter, K. L., & Pink, G. H. (2023). Understanding healthcare financial management (9th ed.). Health Administration Press.

Nowicki, M. (2022). Introduction to the financial management of healthcare organizations (8th ed.). Health Administration Press.

Ginter, P. M., Duncan, W. J., & Swayne, L. E. (2022). Strategic management of health care organizations (9th ed.). Jossey-Bass.

Robbins, S. P., & Judge, T. A. (2023). Organizational behavior (19th ed.). Pearson Education.

Daft, R. L. (2022). Management (15th ed.). Cengage Learning.

Dessler, G. (2023). Human resource management (17th ed.). Pearson Education.

Kotler, P., Keller, K. L., & Chernev, A. (2022). Marketing management (16th ed.). Pearson Education.