

THE INNER ROOM

COST SAVINGS & PROGRAM SUPPORT PROPOSAL

A flexible approach to group coverage, clinical capacity and documentation quality.

Better Groups. Better Coverage. Less Operational Burden.

MAKE THE GROUP PROGRAM WORK HARDER FOR THE FACILITY.

The Inner Room helps treatment programs target three expensive operational pressure points:

1

CONTROL LABOR COST

Purchase the group coverage you actually need instead of automatically adding another 40-hour position.

2

PROTECT CLINICAL TIME

Return recurring group hours to therapists for individual sessions, treatment planning, assessments and documentation.

3

STRENGTHEN DOCUMENTATION

Improve documentation practices that support medical necessity, payer requirements and cleaner claims.

THE FINANCIAL STORY AT A GLANCE

\$57,720

ILLUSTRATIVE ANNUAL DIFFERENCE

10 groups/week at \$105 vs. a \$112,320 full-time compensation benchmark

260 HOURS

THERAPIST CAPACITY RETURNED/YEAR

when five recurring weekly groups are shifted to dedicated facilitator coverage

\$17,500

FEWER INITIALLY DENIED DOLLARS/MONTH

illustrative \$250,000 monthly claims example when denial rate moves from 12% to 5%

WHAT AN INNER ROOM PARTNERSHIP CAN PROVIDE

- Flexible recurring, volume and PRN group coverage
- Less dependence on therapists or leadership for routine coverage
- Experienced behavioral-health facilitators and structured curriculum
- Documentation training and program-quality support
- Capacity that can scale with census and operational needs

THE GOAL: LOWER OPERATIONAL FRICTION WHILE PROTECTING CLINICAL CAPACITY.

The following pages show illustrative labor, therapist-time and claim-denial scenarios.

Actual savings depend on staffing, payer mix, utilization, reimbursement and facility-specific operations.

theinnerroomfacilitation.com

THE INNER ROOM

FLEXIBLE GROUP PROGRAMMING WITHOUT ANOTHER FULL-TIME HIRE

Better Groups. Better Coverage. Less Operational Burden.

HOW MANY GROUP HOURS DO YOU ACTUALLY NEED?

Purchase the coverage your program needs instead of automatically adding 40 paid hours per week.

FULL-TIME PRIVATE-INDUSTRY EMPLOYEE

\$112,320

illustrative annual employer compensation

\$54.00/hour x 2,080 hours

THE INNER ROOM - 10 GROUPS/WEEK

\$54,600

annualized at \$105 per group

Pay for scheduled coverage, not 40 hours.

ILLUSTRATIVE DIFFERENCE: \$57,720 / YEAR

SIMPLE, SCALABLE COVERAGE

VOLUME PARTNER

\$95

per group
20+ groups/week

PREFERRED PARTNER

\$105

per group
10-19 groups/week

FLEXIBLE COVERAGE

\$115

per group
5-9 groups/week

RAPID COVERAGE

\$145

per group
PRN / same-day

THE LABOR COST FACILITIES DON'T ALWAYS SEE

- Private-industry employer compensation averaged \$46.89/hour in June 2026.
- Benefits accounted for about 30% of total private-industry compensation.
- Businesses with 1-49 workers averaged \$37.64/hour in total compensation.
- The Inner Room model is strongest when the alternative is adding staff, overtime, or pulling clinical staff into coverage.

PAY FOR THE GROUP COVERAGE YOU NEED.

Illustrative comparison only. Actual savings depend on staffing model, utilization, benefits, overtime and coverage needs.

BLS Employer Costs for Employee Compensation, June 2026 | theinnerroomfacilitation.com

THE INNER ROOM

PROTECT YOUR THERAPISTS' TIME

Let clinicians focus on the work only they can do.

WHEN A THERAPIST COVERS A GROUP, WHAT ELSE ISN'T GETTING DONE?

Individual sessions • treatment planning • assessments • documentation • care coordination • discharge work

5 HOURS/WEEK OF PROFESSIONAL TIME

\$20,501

estimated annual employer cost

5 hrs × \$78.85 × 52 weeks

BLS management/professional compensation benchmark

THE INNER ROOM: 5 GROUPS/WEEK

\$29,900

annual flexible coverage at \$115/group

260 groups/year

buys back 260 hours of therapist capacity

THE VALUE ISN'T ONLY THE GROUP — IT'S THE CLINICAL TIME YOU GET BACK.

WHAT RECLAIMED THERAPIST TIME CAN LOOK LIKE

Illustrative professional-cost benchmark: \$78.85/hour

GROUP COVERAGE	THERAPIST TIME RETURNED	TIME COST / YEAR
3 hrs/week	156 hrs/year	\$12,301
5 hrs/week	260 hrs/year	\$20,501
8 hrs/week	416 hrs/year	\$32,802
10 hrs/week	520 hrs/year	\$41,002

KEEP HIGH-VALUE CLINICAL STAFF ON HIGH-VALUE CLINICAL WORK

- Every recurring group handed off can return that hour to the therapist's clinical workload.
- The facility may reduce schedule disruption and the need to reshuffle individual sessions or documentation.
- Consistent facilitator coverage can help preserve therapist capacity as census and programming needs change.
- The financial benefit depends on what the therapist can accomplish with the reclaimed time; no revenue is assumed here.

CURRENT LABOR CONTEXT

BLS June 2026: management/professional private-industry compensation ≈ \$78.85/hr.

BLS May 2025: median substance-use/behavioral-disorder/mental-health counselor wage = \$59,350/year.

DON'T USE A THERAPIST AS YOUR DEFAULT COVERAGE PLAN.

Illustrative cost-of-time model; actual therapist compensation, duties, productivity and reimbursement vary by facility.

Sources: U.S. Bureau of Labor Statistics, June 2026 ECEC and May 2025 Occupational Outlook data.

THE INNER ROOM

DOCUMENTATION THAT SUPPORTS THE CARE YOU BILL

Strong documentation helps reduce preventable denials, rework and delayed reimbursement.

A PROVIDED SERVICE ISN'T THE SAME AS A PAYABLE CLAIM.

If the record doesn't support the billed service, medical necessity or payer requirements, payment can be delayed or denied.

~12%

INITIAL DENIALS

Initial claim denials reached nearly 12% in 2024, according to data cited by HFMA.

77.17%

DOCUMENTATION

Of FY2025 Medicaid improper payments, 77.17% resulted from insufficient documentation.

6.55%

MEDICARE FFS

FY2025 Medicare FFS estimated improper payment rate: \$28.83B, or 6.55%.

DENIALS DON'T JUST DELAY MONEY — THEY CREATE MORE WORK TO GET PAID.

ILLUSTRATIVE MONTHLY CLAIM SCENARIO

Example only — use your facility's actual payer mix and allowed amounts.

MEASURE	12% DENIAL	5% DENIAL
Monthly claims submitted	\$250,000	\$250,000
Initial denial rate	12%	5%
Initially denied dollars	\$30,000	\$12,500
Dollars not initially denied	\$220,000	\$237,500

ILLUSTRATIVE REDUCTION IN INITIALLY DENIED DOLLARS
\$17,500 / MONTH • \$210,000 / YEAR

DOCUMENTATION SHOULD SUPPORT THE CLAIM THE FIRST TIME

- Connect the service provided, treatment goals and the patient's/client's clinical needs.
- Document individualized participation/progress rather than generic or duplicated language.
- Include required dates, times, credentials/signatures and service details consistent with the claim.
- Demonstrate medical necessity and applicable payer-specific coverage requirements.

WHY THIS MATTERS

CMS identifies insufficient documentation and failure to demonstrate medical necessity as major improper-payment causes. Not every denial is documentation-related, and improved documentation alone cannot guarantee a lower denial rate.

DOCUMENT THE CARE. SUPPORT THE CLAIM. REDUCE PREVENTABLE REWORK.

Illustrative scenario; denied dollars may be recovered through correction or appeal and are not necessarily permanent losses.

Sources: CMS FY2025 Improper Payments Fact Sheet; CMS CERT; HFMA denial-rate reporting.