THE NEPHRIQ WHITEPAPER

From kidney claims to *accountable savings.*

A transparent operating model for pricing, human review, member navigation, and financial reconciliation.

A kidney cost-management program connects several kinds of work. Analysts review claims and evidence. Reviewers authorize reimbursement. Finance verifies the actual payment. Advocates help members understand their next benefits-navigation step.

Nephriq brings these workflows into one shared application, with role-specific views and scoped records. The aim is simple: make each decision traceable, each handoff visible, and each savings figure explainable.

THREE PRINCIPLES

Evidence travels with the decision.
Recommendations retain methodology and evidence context.

Progress reflects completed work.
Trackers represent saved milestones and reviewed records.

Savings follow the payment.
Only reconciled payments contribute to validated savings.

About this paper: product demonstration only. Records and examples are fictional. Rates, AI summaries, document analysis, and external feed behavior are illustrative or simulated.

01 / CONNECT THE WORK

Follow the decision from intake to reconciliation.

A shared workflow makes the reasoning and remaining work visible.

01 Review the claim

Start with service details, line items, original allowed amounts, coding indicators, and supporting documents. Search and scoped work queues help analysts organize the population.

02 Generate a recommendation

PriceIQ applies a versioned methodology to illustrative benchmark data. The decision records calculations, adjustments, a reviewable range, and evidence. Deterministic rules and simulated assistant summaries support the demonstration.

03 Approve the decision

An authorized human confirms the amount and records a rationale. Required plan and benchmark evidence must be included. Approval locks the decision snapshot, preserving the historical basis even when methodologies later change.

04 Resolve exceptions

Record offers and human-reviewed settlements when negotiation is needed. Appeals have review states and deadlines. Negotiation is optional: an approved amount can proceed directly to reconciliation when the payment matches.

05 Reconcile the payment

Finance records a remittance reference and verifies final payment. Duplicate references are rejected, and a payment variance must be resolved through a reviewed settlement. Only then does the claim contribute to validated savings.

A connected record: claim detail, evidence, approvals, offers, payments, and audit history show what happened and what comes next.

02 / EXPLAIN THE VALUE

Make every savings figure explainable.

Keep an opportunity, an authorized decision, and a reconciled outcome distinct.

Projected gross savings

Original allowed amount minus the pricing recommendation. This describes potential value, not a validated payment result.

Adjudicated gross savings

Original allowed amount minus the accepted settlement when one exists; otherwise, minus the approved amount.

Validated gross savings

Original allowed amount minus actual final paid, after reconciliation. Unreconciled claims do not contribute to this measure.

A FICTIONAL WORKED EXAMPLE

Original allowed amount	**$100,000**
Reconciled final paid amount	**$60,000**
Validated gross savings	**$40,000**
Assumed fee: 10% of positive gross	**$4,000**
Net savings after fee	**$36,000**
ROI: net savings / fee	**9.0x**

The example assumes a 10% fee. It is not a commercial quote or a forecast. The $40,000 difference becomes validated only after payment reconciliation.

Calculation details: monetary values are stored in integer cents. Fees apply to positive validated gross savings using the recorded fee basis. Negative savings remain visible. ROI is undefined when the fee is zero. Reports compare baselines and final payments for the same reconciled population.

03 / PUT THE MODEL TO WORK

Connect the financial work to the people doing it.

A shared operating model for benefits teams, finance, and member advocates.

A visible member journey

Milestones, next actions, due dates, advocate notes, and educational coordination information bring the benefits journey together. Members view their own journey and save messages in a demonstration inbox. Authorized advocates record case notes and milestone updates. These tools support communication and follow-up; they do not provide diagnosis or treatment.

Launch with clear ownership

The 17-step onboarding checklist organizes program setup. Owners, due dates, notes, and progress trackers make unfinished work visible. The go-live gate requires implementation blocker tasks to be resolved.

Establish the program Employer, contacts, broker, TPA, and stop-loss or captive relationships.

Define the configuration Health plan, documents, benefit settings, methodology, and fee schedule.

Prepare data and experience Eligibility, claims, remittance, member communications, and testing.

Confirm readiness Launch review, completed blocker tasks, and go-live approval.

A completed checklist records the team's review. It does not independently verify external contracts, integrations, or data quality.

A CLEARER VIEW STARTS HERE.

Explore a fictional claim. Inspect its evidence. Follow the financial stages. Use the savings calculator to test explicit assumptions.

Production readiness requires verified enterprise identity, live data and rate providers, operational security controls, and qualified clinical and legal review. Use fictional data only.