FinThrive

Denial Management Best Practices

Bend the denials curve in a hostile provider-payer environment

The battle lines have been drawn between healthcare providers and insurance companies

At the heart of the fight lies denials—a mountain-sized problem costing hospitals millions of dollars in lost revenue and labor every year.[1] In the healthcare industry, however, denials have always been an intrinsic part of the provider-payer relationship, so what's different now?

"The industry has been dealing with denials for 30 years. What's new is that there's explosive friction right now between providers and payers, and it's frankly over denials."

—Jonathan Wiik, Vice President of Healthcare Insights, FinThrive

This guide explores the reasons why denials have become an even larger problem in recent years—and offers three proven solutions providers can use to flip the script in their favor.

Denial rates are rising

Recent research shines a spotlight on the denials conundrum. Today, insurers initially deny between 10% and 20% of all claims they receive,[2] mostly as the result of coding errors, missed deadlines and other provider internal errors.[3] Many of these claims are eventually paid; however, some are ultimately written off, leaving providers to foot the bill—and this number is rising.

Average denial write-off rates are now almost four times what they were in 2018, rising from .8% in 2018 to 4.6% at the end of 2023.[4] That's well above the industry best-practice benchmark of less than 1% net patient revenue (NPR), as well as what's budgeted by most providers.

What's behind the rise

So why are denials rising? In Wiik's opinion, it's because insurance payers are turning up the heat.

"Payers have only so many levers they can pull to manage care and support margins," he says. "The first is that they can add more members, but the commercial insured market is shrinking, so they have a lot fewer premium dollars to make their margins. The second way payers can improve margins is through more aggressive utilization review. That has manifested in the form of denying claims—that is, paying less on the claim inventory that's there—and that's absolutely what they're doing."

The effects on providers and patients

For providers, rising denial rates mean critical losses in income, as well as increased administrative burden, with too many hours spent fighting denials. And, as providers are growing increasingly frustrated with payers, many have been forced to turn to costly litigations to resolve their disputes.[6]

Patients also bear the negative effects of elevated denial rates. When faced with the prospect of undergoing treatments that may not be approved by their insurance provider, patients are put in a position of weighing unfavorable options like delaying treatment, paying for it themselves or avoiding it altogether—a dangerous predicament. And while preauthorizations can help reduce denials, waiting for insurer approval can also delay treatment.

Top reasons for claim denials[5]

- No prior authorizations
- Level of care downgrades (ED E&M and IP DRG)
- Out-of-network provider
- Coding inaccuracies
- Incorrect modifiers
- Failure to meet submission deadlines
- Patient information inaccuracy
- Missing or inaccurate claim data
- Not enough staff to keep up
- Formulary changes
- Changing policies
- Procedure changes
- Improperly bundled services
- Service not covered

Providers face obstacles to remedy the denials problem

In the denials showdown, payers have the advantage. Automated claims clearinghouses, sophisticated actuarial analysis, powerful technology resources and the ability to endlessly change the rules give payers the upper hand. And there is no urgency for them to pay.

On the provider side, in contrast, market headwinds have made it challenging to manage insurance claims and denials, and as a result, their margins are shrinking. Providers suffered the worst year in history in 2022 from a financial performance standpoint,[8] and while margins are recovering, they're still well below historical levels. Compounding the issue, most hospitals contract with hundreds of payers, each with its own set of rules that can change at any time. With fewer resources to tap into, it's become increasingly difficult for providers to keep up.

Three contributing factors to shrinking provider margins and denials-related losses

1 Decreased volumes

Hospital acute visit volumes remain below pre-pandemic levels, despite marginal improvements in the past year.[9]

"We have not fully recovered to pre-pandemic volumes in three years, and I don't think those volumes are ever going to come back, especially in emergency department settings," Wiik says. "There was a fundamental macroeconomic shift to patient visit volumes. They've either gone to other places like telemedicine or urgent care, or to other places that aren't affiliated with hospitals—or, they haven't gone at all, which is somewhat scarier."

2 Increased expenses

Expenses have continued to rise in recent years, particularly related to the cost of labor shortages. While workforce shortages have been an issue for some time, with typically 500,000 more open positions than hires, the situation worsened when many healthcare workers left following the pandemic, and the delta between open positions and hires widened to 1.3 million in 2022.[10] The gap is once again closing, but labor levels have not returned to their pre-pandemic norms. "That means there's increased competition and cost to get the right skills in an organization, especially in revenue cycle." Wiik explains, "So from a labor standpoint, the cards are stacked against providers to manage denials in that it's highly reliant on manual processes."

3 Strained relationship

With denials on the rise, the provider-payer relationship has become increasingly strained, with 78% of hospitals and health systems reporting that their experience with commercial insurers is getting worse.[11] "Basically, in a metaphorical sense, the survey indicated we need to go to couples therapy, or we're getting a divorce," Wiik says.

Providers are also experiencing growing workforce burden related to managing denials. An overwhelming 95% of hospitals and health systems report an increase in staff time spent seeking prior authorization approvals,[11] and 84% report that the cost of complying with insurer policies is increasing.[11]

On top of that, the labor cost of staff battling payers is increasing, as 62% of prior authorization denials and 50% of initial claim denials that are appealed are ultimately overturned.[11] "That's a lot of administrative waste on both the payer and the provider side, and it's getting worse, not better," Wiik says.

The need for a path forward

When it comes to managing denials, clearly the approach that has worked in the past for providers isn't working today. Providers simply have fewer people to work on denials, less negotiating power as part of the payer mix, and more claims that are ultimately at risk of being denied. And many providers are relying on incumbent electronic health record technology that is not providing the insight into claims that they need to prevent or effectively mitigate denials.

The urgent need for change is driving providers to budget for upgrades to their denials management processes and technology. According to FinThrive research, in 2024, 57% of survey respondents are prioritizing denials management, and nearly 30% plan to invest in a denials management solution.[12]

"Providers can't be complacent," Wiik says. "There is a cost in doing nothing, and that decision is resulting in revenue leakage."

Taking action to meet the denials challenge

While the denials situation may seem discouraging, the good news is that 86% of denials are potentially avoidable[13]—with the right approach. To truly remedy the denials situation, Wiik says payers and providers need to start working together rather than against each other. "Let's talk about why we're not getting along and how we can make it better by starting to exchange data, looking at the contracts and understanding how we can best collaborate," he says. The data signals this is starting to happen, as organizations like Banner Health[14] and Geisinger[15] have partnered with payers on aspects of their business to make it better for the patient—and the member. However, there is still a long way to go.

Common reasons for slow A/R recovery and denial management

Internal teams manually piecing together claim information from multiple data sources

Multiple staffers researching and trying to resolve the same issues

Not flagging "irrelevant" denials that don't need to be worked (e.g., those with zero expected reimbursement)

Traditional processes that don't identify systemic root causes of denials and underpayments, allowing issues to persist and grow

Key questions can help determine why a claim hasn't been paid correctly

What's the status of the claim?

Did the payer receive it?

Has the claim been processed within the threshold?

Is it paid and posted correctly according to the contract?

Is it underpaid and are there other claims with a similar issue?

Is it denied and what's the root cause?

If denied, what's its likelihood of overturn on appeal?

What it will take to bend the curve

Until this collaboration improves, providers need to institute a strategic denial management system and prevention task force to effectively bend the denials curve. Wiik has identified three strategies providers can focus on to reduce denials and ultimately increase revenue.

1 Know the rules

Providers should know payers' payment requirements and preauthorization rules at all times, and they should always be up to date when the rules change.

"This comes down to the claims, contracts, operations and technology," Wiik says. "When leveraging a prior authorization solution, for example, taking information from past claims, as well as keeping tabs on the latest payer bulletins, should afford a near real-time rules engine so stopgaps for documentation are in place."

This ensures that authorizations, precertifications, referrals, network, benefits and other requirements are consistently and accurately documented on every claim prior to billing.

2 Document that the payment requirements have been met

The provider's team should have a seamless, integrated workflow for generating claims. Alerts and statuses are critical so that the teams can work the right accounts, with the right people, at the right time. Technology solutions can help providers work smarter instead of harder to help ensure claims are in the best shape possible before they go to the payer.

"Clean claim and low denial rates come from efficiency, accuracy and discipline," Wiik says. "Make sure you've got a hardwired process where you're not just running a transaction for the sake of running it."

3 Leverage end-to-end platform analytics

Payers are sophisticated, and technology is always evolving for clinical care. Changes come in the form of new codes, new payment rules and new denials. A robust technology platform with analytics can help providers evaluate the longitudinal lifecycle of the claim from every failure point along the way to understand where the problems occurred, such as eligibility, benefits, coding, billing or the contract.

"There are about 14 touchpoints between when a doctor schedules to when the bill gets paid, and each one can fail if the claim is missing any little piece of information," Wiik says. "Analytics enable providers to understand the root cause of denials and prevent them downstream, and also hold payers accountable to their own contracts."

Automated workflow solutions that reduce accounts receivable (A/R) days can save an average of **$3 million annually** and can result in **300 to 500 fewer denials per month**.[16]

What's next?

Even with the best people, processes and technology, there is room to move the denials management system from good to great. The time is now to take action.

Learn how FinThrive can help proactively address prior authorization and denials to increase efficiencies and revenue for your healthcare organization.

About FinThrive

FinThrive is advancing the healthcare economy. Our 1,600-plus colleagues rethink revenue management to pave the way for a healthcare system that ensures every transaction and patient experience is addressed holistically. We're making breakthroughs in technology—developing award-winning revenue management solutions that adapt with healthcare professionals, freeing providers and payers from complexity and inefficiency, so they can focus on doing their best work.

Our end-to-end revenue management platform delivers a smarter, smoother revenue experience that increases revenue, reduces costs, expands cash collections, and ensures regulatory compliance. We've delivered over $10 billion in net revenue and cash to more than 3,245 customers worldwide. When healthcare finance becomes effortless, the boundaries of what's possible in healthcare expand. For more information on our new vision for healthcare revenue management, visit finthrive.com.

SOURCES

1 "2024 RCM Transformative Trends Report." FinThrive.

2 Fields, Robin. "How Often Do Health Insurers Say No to Patients? No One Knows." ProPublica, June 28, 2023. https://www.propublica.org/article/how-often-do-health-insurers-deny-patients-claims.

3 Cass, Andrew. "13 top reasons for claims denials." Becker's Hospital CFO Report, January 23, 2023. https://www.beckershospitalreview.com/finance/13-top-reasons-for-claims-denials.html.

4 Clarivate, 2023. https://clarivate.com/products/healthcare-business-insights.

5 Pollitz, Karen, Justin Lo, Rayna Wallace, and Salem Mengistu. Claims Denials and Appeals in ACA Marketplace Plans in 2021. Kaiser Family Foundation, February 9, 2023. https://www.kff.org/private-insurance/ issue-brief/claims-denials-and-appeals-in-aca-marketplace-plans.

6 Bailey, Victoria. "UnitedHealthcare Pays $91.2M After Underpaying Envision for Medical Care." HealthPayer Intelligence, May 04, 2023. https://healthpayerintelligence.com/news/unitedhealthcare-pays-91.2m-after-underpaying-envision-for-medical-care; Gamble, Molly. "MaineHealth says $70M in unpaid claims reason to drop Anthem." Becker's Healthcare, April 6, 2022. https://www.beckerspayer.com/contracting/mainehealth-says-70m-in-unpaid-claims-reason-to-drop-anthem.html; Minemyer, Paige. "Bright Health on the hot seat—again—as SSM Health sues for $13M in unpaid claims." Fierce Healthcare, April 19, 2023. https://www.fiercehealthcare.com/payers/bright-health-hot-seat-again-ssm-health-sues-13m-unpaid-claims; Parks, Troy. "Court decides whether insurers can be sued for underpaid claims." AMA, November 30, 2015. https://www.ama-assn.org/practice-management/claims-processing/court-decides-whether-insurers-can-be-sued-underpaid-claims; Pifer, Rebecca. "AdventHealth sues MultiPlan for alleged 'cartel' with health insurers to fix prices." Healthcare Dive, August 14, 2023. https://www.healthcaredive.com/news/adventhealth-multiplan-lawsuit-price-fixing/690736; Pifer, Rebecca. "Bon Secours sues Anthem BCBS over unpaid claims." Healthcare Dive, August 29, 2023. https://www.healthcaredive.com/news/bon-secours-anthem-bcbs-lawsuit-unpaid-claims/692109; Wilson, Rylee. "Prisma Health files for temporary restraining order against UnitedHealthcare amid contract negotiations." Becker's Healthcare, August 29, 2023. https://www.beckerspayer.com/payer/prisma-health-files-for-temporary-restraining-order-against-unitedhealthcare-amid-contract-negotiations.html.

7 "The Change Healthcare 2020 Revenue Cycle Denials Index." Change Healthcare, 2020. https://www.ache.org/-/media/ache/about-ache/corporate-partners/the_change_healthcare_2020-revenue_cycle_denials_index.pdf.

8 Condon, Alan. "Hospitals faced 'worst operating year' ever in 2022: Fitch." Becker's Hospital CFO Report, April 7, 2023. https://www.beckershospitalreview.com/finance/hospitals-faced-worst-operating-year-ever-in-2022-fitch.html#:~:text=Last%20year%20is%20shaping%20up,5%20presentation%2C%20according%20to%20Bloomberg.

9 "2024 RCM Transformative Trends Report." FinThrive.

10 US Healthcare Open Positions and Hirings, 2018–2023 YTD (000s). US Bureau of Labor Statistics, Job Openings and Labor turnover (JOLTS) Survey. https://www.bls.gov/jlt.

11 "Survey: Commercial Health Insurance Practices that Delay Care, Increase Costs Infographic." American Hospital Association, 2022. https://www.aha.org/infographics/2022-11-01-survey-commercial-health-insurance-practices-delay-care-increase-costs-infographic

12 "2024 RCM Transformative Trends Report." FinThrive.

13 "The Change Healthcare 2020 Revenue Cycle Denials Index." Change Healthcare, 2020. https://www.ache.org/-/media/ache/about-ache/corporate-partners/the_change_healthcare_2020-revenue_cycle_denials_index.pdf.

14 "Banner|Aetna Long-Term Contract Extension." Banner|Aetna, February 1, 2021. https://www.banneraetna.com/en/about-us/news/long-term-contract-extension.html.

15 "Risant Health launches with Geisinger." Kaiser Permanente, April 26, 2023. https://about.kaiserpermanente.org/news/risant-health-launches-with-geisinger#:~:text=In%20an%20innovative%20move%20designed,health%20system%20to%20join%20Risant.

16 FinThrive data, 2023.

FinThrive™