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Key Principles for Proactive Management of Patient Denials

The proliferation of claims denials, especially by Medicare Advantage payers, has become a pressing issue for health system operations. In 2023, [Medicare Advantage insurers fully or partially denied 3.2 million prior authorization requests](#)—or 6.4% of all requests, according to a Kaiser Family Foundation (KFF) report. The growth in denials can be partially explained by the increasing popularity of managed Medicare and Medicaid plans, but evolving payer practices, including the adoption of AI for algorithmic denials, have also contributed. Claims denials have emerged as one of the key points of payer-provider tension, and an effective claims denials management and prevention program is a powerful way for health systems to rebalance their payer relationships.

Denied claims result in reduced reimbursement, added administrative burdens, and patient and provider frustrations. Even when denials are successfully appealed and reversed—the KFF report found that in 2023, 82% of Medicare Advantage denials were partially or fully overturned—the time and resources devoted to the appeals process add to the costs of providing healthcare services. Optimizing pre-billing activities to reduce avoidable denials and improve and streamline the patient experience of care is as essential for health systems as a robust appeals strategy. This article addresses critical success factors for both preventing and appealing denials.

Preventing Claims Denials During Pre-Bill Period

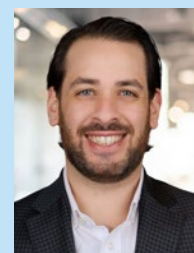
Successfully preventing denials requires a centralized program across the workforce, from frontline providers to clinical and revenue cycle staff, to manage pre-bill activities by focusing on identifying the correct patient insurance information, obtaining accurate authorizations, and preventing concurrent denials while the patient is still in the facility. Utilization review nurses, attending providers, and Physician Advisors should be attentive to documenting the full state of patient acuity, while



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collaborating with the revenue cycle team. This team should focus on the collection and reporting of medically necessary data and documentation, which serves as the evidence payers use to evaluate prior authorization requests. When information about a patient's condition isn't recorded, or acknowledged in an authorization request, unnecessary denials can result.

A successful denials prevention program expands beyond the utilization management (UM) team and includes revenue cycle, and provider collaboration. Revenue cycle pre-service procedures should focus on confirming insurance benefits and securing payer authorization for planned services while collaborating with UM and referral sources. A comprehensive and proactive denials prevention program helps convey to payers the full extent of inpatient clinical work, thanks to a collaborative effort to improve documentation. The following list can help organize denials prevention programs across all locations, clinics and practices:

- Establish an enterprise-wide denials prevention strategy which includes a multi-disciplinary denials management committee focused on identifying denials trends, conducting root cause analyses, developing proactive denials mitigation plans, creating enhanced reporting, monitoring improvement, and communicating risk

- Establish proactive revenue cycle, UM, pre-certification, and peer-to-peer workflows procedures to confirm completion of payer requirements prior to scheduled services and discharge
- Ensure patients are financially cleared through implementation of pre-service protocols, including enhanced medical necessity process for outpatient services, authorization defer and delay procedures to reduce rework and avoidable denials
- Identify pre-bill edits to increase “clean claim” efficiency, reducing initial denials and expediting reimbursement
- Deliver education to providers, care management, and nursing teams on key observation concepts, such as clinical documentation improvement, patient status documentation, medical necessity documentation and orders for the Two Midnights rule, and payer reimbursement methodologies

Pursuing Post-Bill Appeals, Reversals and Payer Escalation

A strong denials management and prevention program should include a robust post-bill appeals program with skilled coding, clinical and technical resources. A targeted and strategic appeal process can result in improved overturn rates and increased reimbursement. Appeal letters which are supported by clinical facts, payer policies, and a summary of key components relevant to each case and the associated denial increase the likelihood of success.

Components of the appeal program should include the following:

- Guidelines for when to appeal based on potential success by payer and appeal level
- Reviews of upheld appeals for second and third level appeals based on strategy by payer
- Trends for all upheld appeals by reason and by payer
- Dashboard for tracking denials activities

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- Appeal letter writing guidelines and tips to support
- Evaluation process for existing payer escalation workflows, tools and payer communication strategies with consideration for payer
- Process to measure and monitor overturn rates and improvement opportunities

The collaboration with managed care is vital to the success of the denials management/prevention program. A formal payer escalation process which facilitates transparency between the payer and provider can result in improved relations and a reduction in initial denials. Successful denials management/prevention payer escalation programs are strategic and focus on addressing unfair/incorrect denials and establishing clear bi-directional reporting and communications. These programs can result in improved contract negotiations and reduce incorrect denials.

Artificial Intelligence (AI) can support the post-bill appeals process and can be especially relevant when developing a strategy to combat denials. Not only are payers increasingly using AI to trigger denials, but health systems can also deploy AI to write appeal letters, analyze denial trends, and summarize medically necessary documentation. Although algorithmic denials have become a source of frustration for providers and patients, health systems can also deploy AI to their defense. While payers are often better positioned to devote AI resources to claims, a little bit of investment from health systems, deployed effectively, can go a long way toward evening the playing field.

Closing Thoughts and Seven Questions to Consider

A formal denials management and prevention program is essential to obtaining proper reimbursement for the care provided and reducing rework across the enterprise. A strong program should also improve the patient's experience of care: ideally, a patient should not need to interact with or hear from their provider between scheduling an appointment and checking in.

Denials management and prevention programs should be led by multi-disciplinary committees and focus on reducing avoidable denials and rework. Reducing denials requires the implementation of a multi-disciplinary program and collaboration between UM, revenue cycle, clinical documentation improvement, managed care, clinical operation and providers. Health systems reassessing their claims denials program should consider these questions:

1. Do you have a reactive or proactive denials management strategy in place?
2. Does your denials strategy include multi-disciplinary team representation?

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3. What reporting/tools are currently being used to track and manage denials?
4. What are your top five denial categories and what is being done to address the root cause of these denials?
5. How are avoidable denial risks managed, communicated and monitored?
6. Have you implemented a comprehensive denials management strategy with a multi-disciplinary committee?
7. Are the system's internal resources and expertise sufficient for addressing identified challenges, or should the system seek external partners to implement changes?

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