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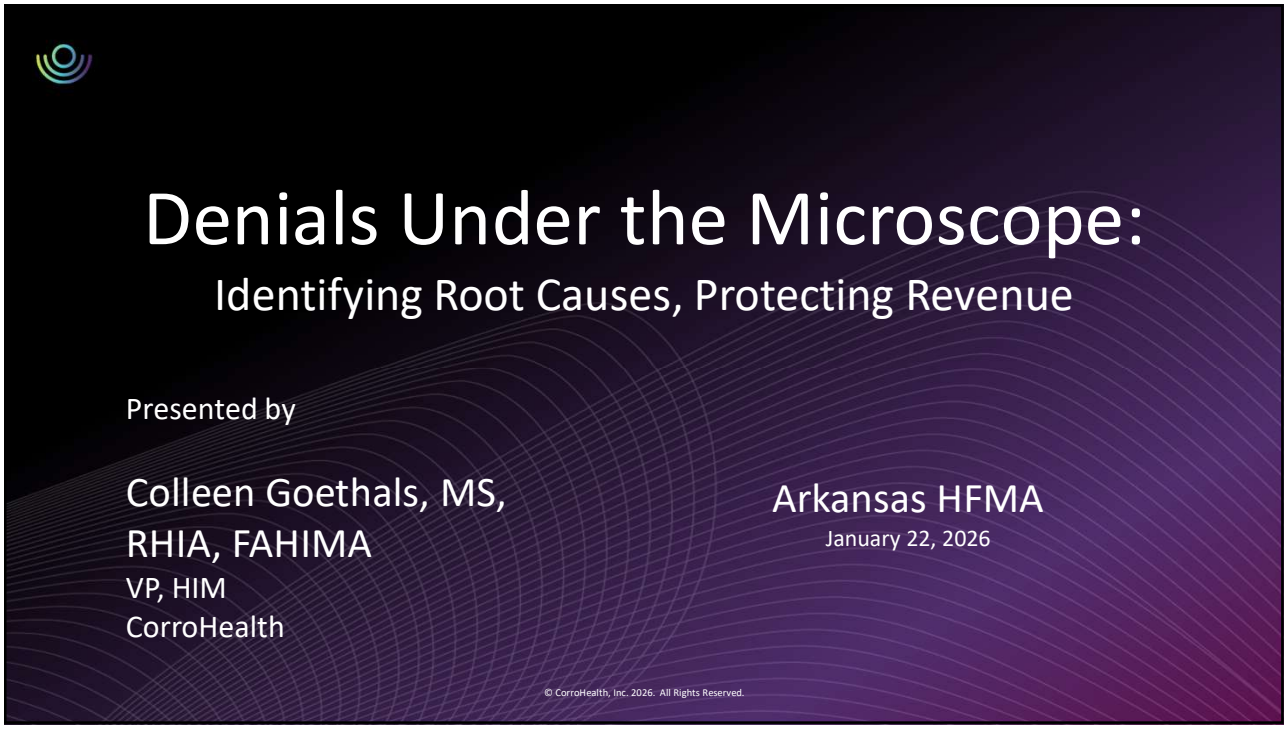
Denials Under the Microscope:
Identifying Root Causes, Protecting Revenue
Presented by
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CorroHealth
Arkansas HFMA
January 22, 2026
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Discussion Points

Impact of Denials

Strategies:

- Data & Root Cause
- Review Workflow
- Accurate and Complete Documentation
- Robust Appeals Process
- Monitor, Track, Report
- Education and Training
- Continuous Process Improvement

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Impact of Denials

1. Report: The State of Claims 2022, Experian Health (www.experian.com/healthcare/resources-insights/thought-leadership/white-papersinsights/state-claims-report)
2. RCM Admin Tasks Driving Up Costs. Payer Tech to Blame, HealthLeaders, September 16, 2024
3. Success in Proactive Denials Management and Prevention, HFMA, May 1, 2021

- **89%** of all hospitals have seen a significant **increase** in denied claims[1]
  - **15%** in a most recent survey
- Providers spent **$20B** in 2022 pursuing delayed and denied claims from payors
  - Average of **3 rounds of reviews**; 45-60 days each round
- **11.8% of hospital claims are initially denied.**
- **AR days** increased **5.2%** year over year
- **90% of denied claims are preventable**[3]
  - **35%** of providers appeal denials even though **67%** of denied claims are **recoverable**[3]
- Providers collected about **$3 less in 2024 for every $100** that insured patients on their portion of the bill

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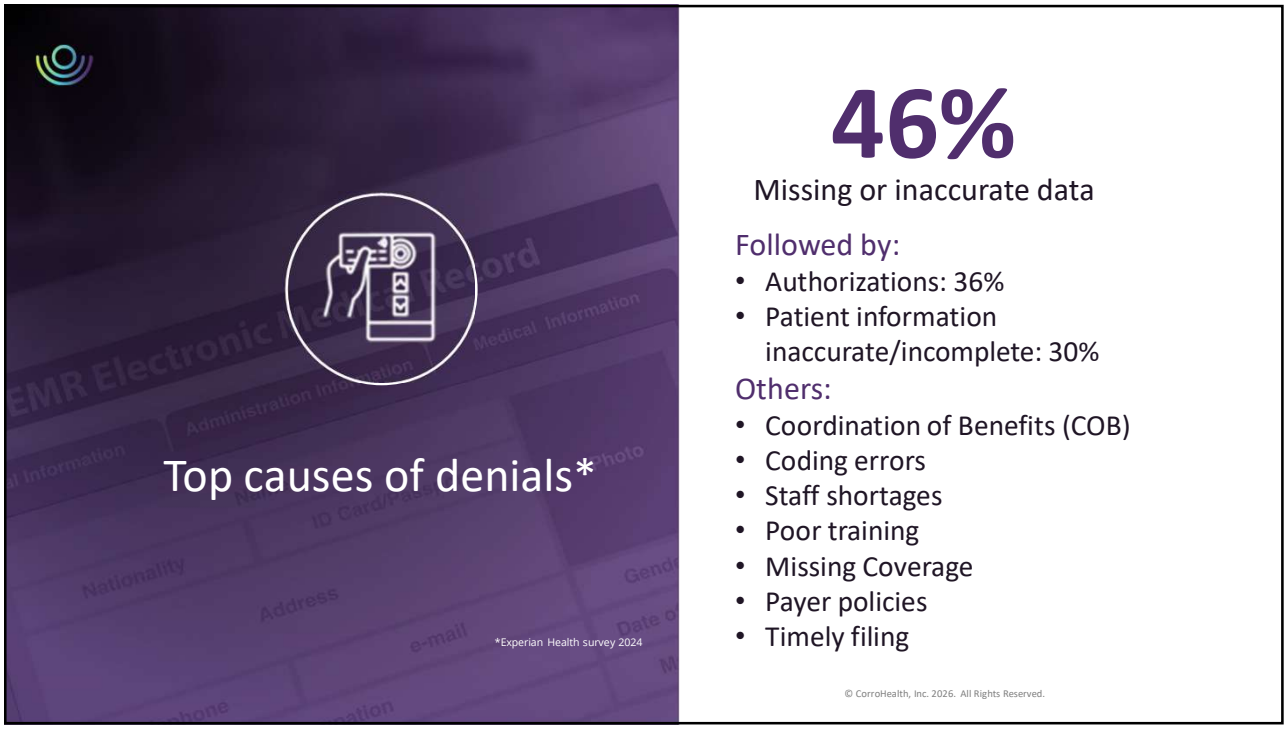
Top causes of denials*
*Experian Health survey 2024
46%
Missing or inaccurate data
Followed by:
• Authorizations: 36%
• Patient information inaccurate/incomplete: 30%
Others:
• Coordination of Benefits (COB)
• Coding errors
• Staff shortages
• Poor training
• Missing Coverage
• Payer policies
• Timely filing
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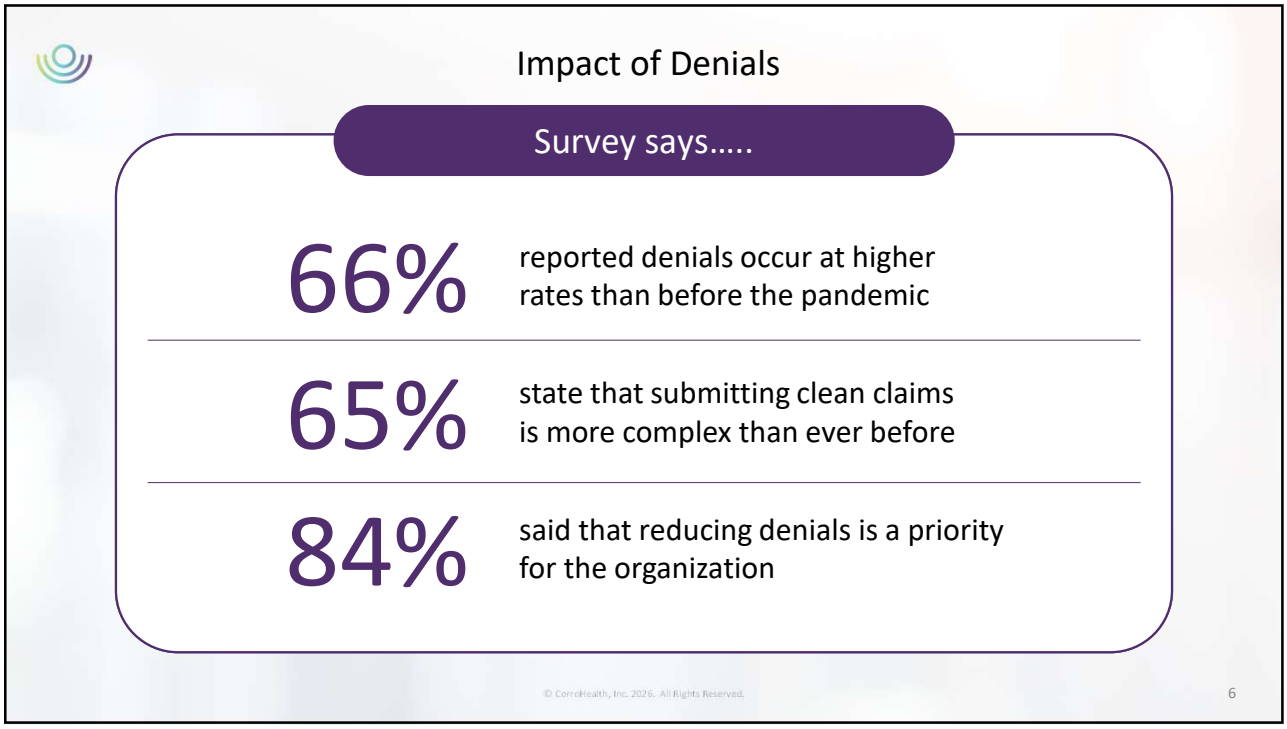
Impact of Denials
Survey says…..
66%
reported denials occur at higher rates than before the pandemic
65%
state that submitting clean claims is more complex than ever before
84%
said that reducing denials is a priority for the organization
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Factors for the Increase In Denials

- **Payer policy changes occurring more frequently**
- Lack of denials resources
- Staff attrition and training
- Growing denials backlog
- Pre-authorization tracking
- Technology challenges

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Strategies

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Denials Management Process

- Prevention
- Investigating
- Analyzing
- Resolving

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Know Your Denials Rates

Denials statistics

Calculate your denial rate

Number of zero paid claims denied by total claims remitted.

Strive for <5%; Best practice is 2% or lower

Calculate your claims and dollars rate

Total dollars remitted – total dollars paid/by total dollars remitted

Know your rate of appeals

Best practice: 85 – 88% of denials should be appealed

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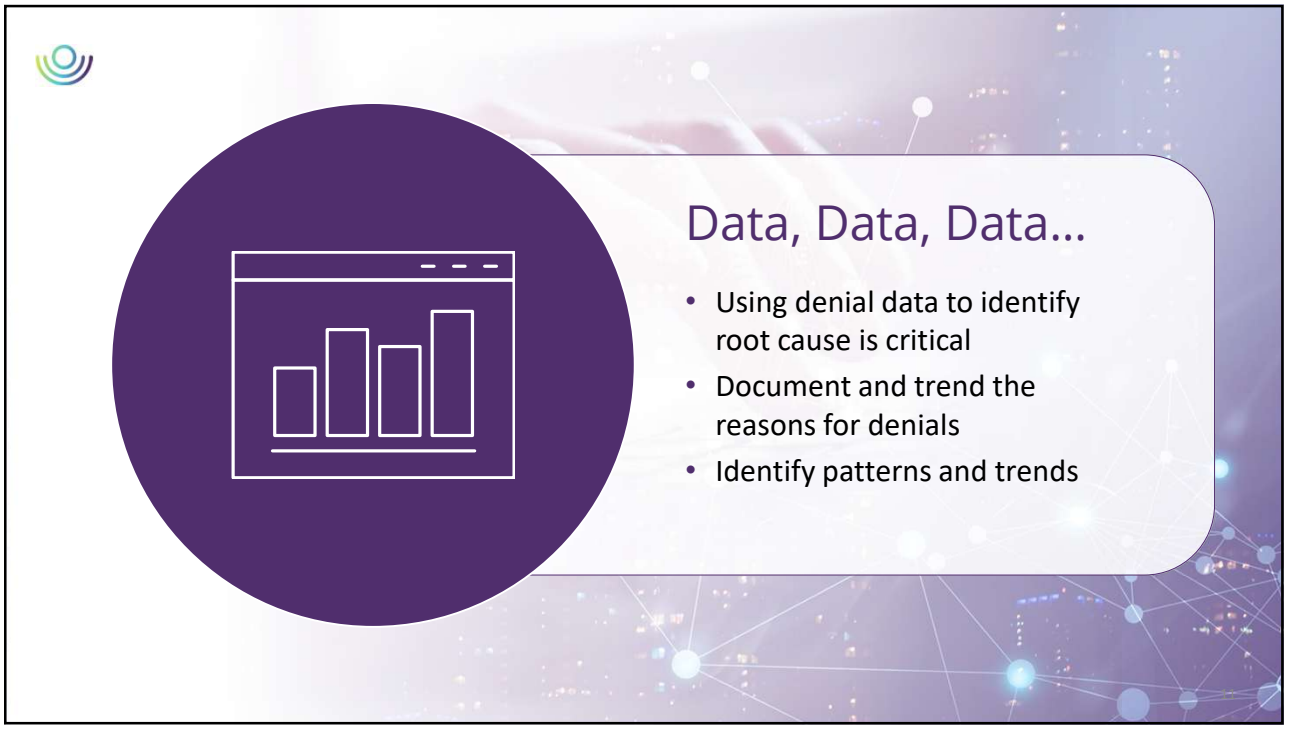
Data, Data, Data…
• Using denial data to identify root cause is critical
• Document and trend the reasons for denials
• Identify patterns and trends

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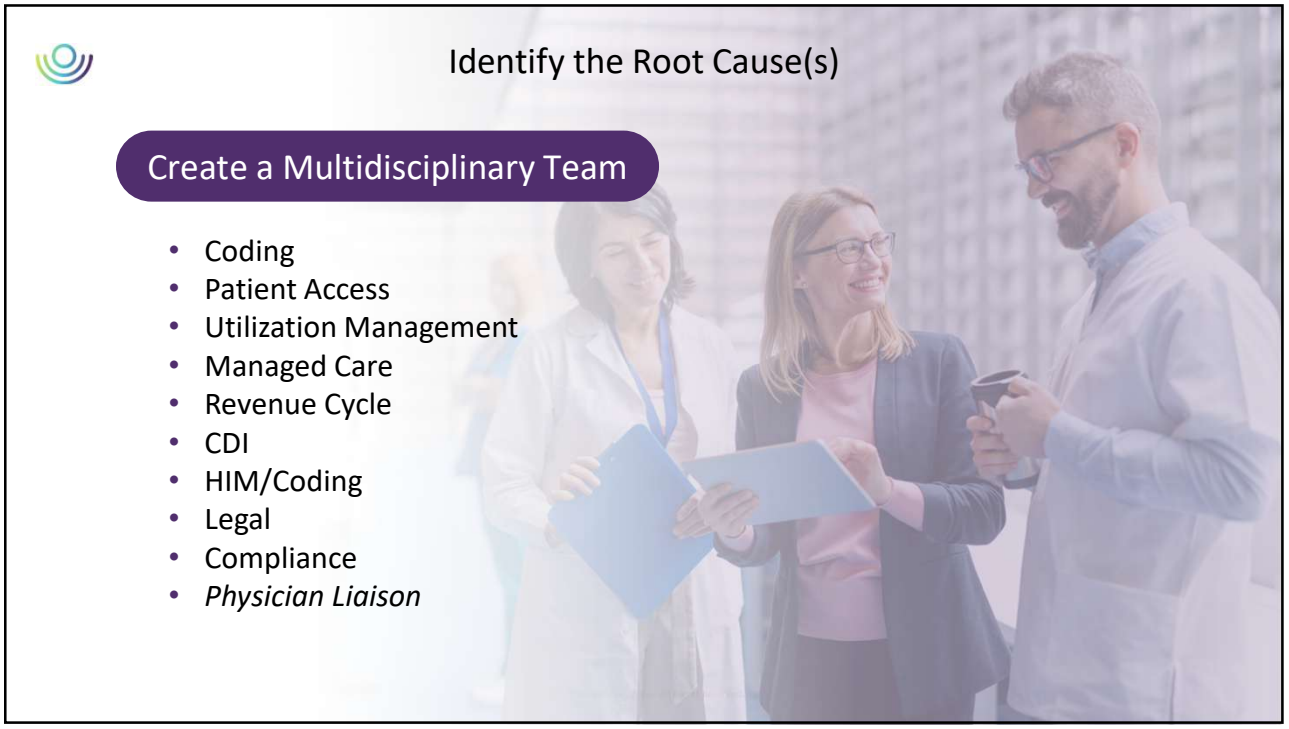
Identify the Root Cause(s)
Create a Multidisciplinary Team
• Coding
• Patient Access
• Utilization Management
• Managed Care
• Revenue Cycle
• CDI
• HIM/Coding
• Legal
• Compliance
• *Physician Liaison*

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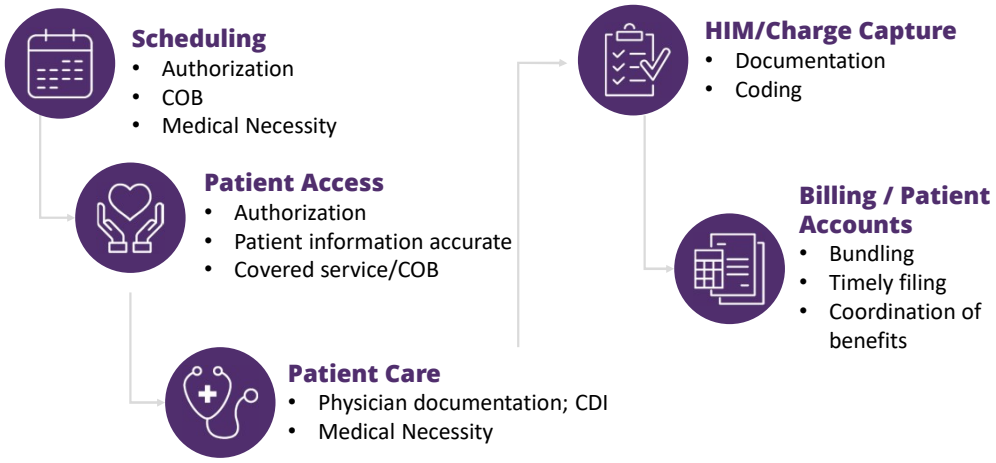
Review Workflow



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Coordination of Benefits Denials

CO-22 Denial Code

- Indicates the service billed may be covered by another insurance provider
- Typically occurs when a patient has multiple insurance plans in which the primary insurance has not been correctly identified; or,
  - Wrong payer billed first
  - Incorrect insurance information
  - Timely filing issue
  - Out of Network Provider
  - Duplicate claims
  - Termination of Coverage
  - Non-covered services

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Accurate and Complete Documentation/Coding

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Documentation Drives Revenue

- Clinical documentation is the “workhorse” of the revenue cycle.
- Major pain point for clinicians
- Often a lack of understanding of how critical timely, accurate documentation directly influences quality scores, clinical outcome and reimbursement.
- Improvements:
  - Educate physicians
  - Use technology as reminders and
  - Provide feedback—including positive
  - Include the entire enterprise—not just the hospital

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Denials Prevention – Coding

Code to the highest level of specificity

- Capture acuity by coding CCs and MCCs according to the updated coding clinics and coding guidelines
- Look for missed documentation opportunities
- Focus on DRGs with CC's and MCC's
- Productivity is important, but quality is key

Develop a robust query process to prevent under-coding

- Quality queries based on ACDIS query guidelines

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Denials Requiring Appeal

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Appeals

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Appealing Denials

Need a strong denials team to write the appeals letters

85-88%

is the recommended appeal rate

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Tips to Writing Appeal Letters

- Appeal every case where there is documentation to support the original coding
- Keep the appeal letter concise to the reason for the denial
- Include Clinical and Coding Expertise to write the appeal
- Include copies of the medical record where helpful
- Include official coding guidelines
- Include the credentials of those who have reviewed and are involved in the appeal

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Monitor, Track, Report

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Monitor, Track and Report

- Total denials
- Total appeals
- Cases not appealed and why
- Total cases overturned and financial impact
- Second-level denials
- Failed appeals

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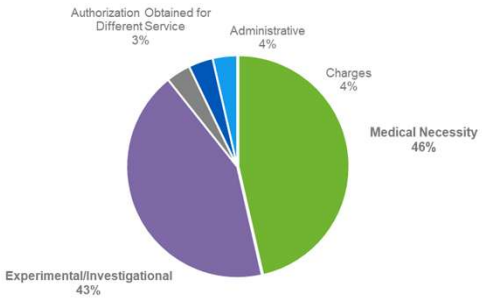
Monthly Clinical Denials



Denial Reason	Total # Accts	Acct Balance	% of Total Denials	% of Acct Balance
Medical Necessity	13	$58,512	53%	46%
Experimental/ Investigational	12	$44,570	41%	43%
Authorization Obtained for Different Service	1	$4,187	4%	4%
Administrative	1	$1,287	1%	4%
Charges	1	$1,113	1%	4%
Grand Total	28	$109,668	100%	100%

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Education, Training, Report & Continuous Process Improvement

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Educate, Train, Report

and Continuous Improvement

- Regular performance audits
- Review denials analysis data
- Work together
- Education – Physicians, Coders, Billers
- Collaborate with Payors
- Know the healthcare trends
- **Engage in continuous process improvement**

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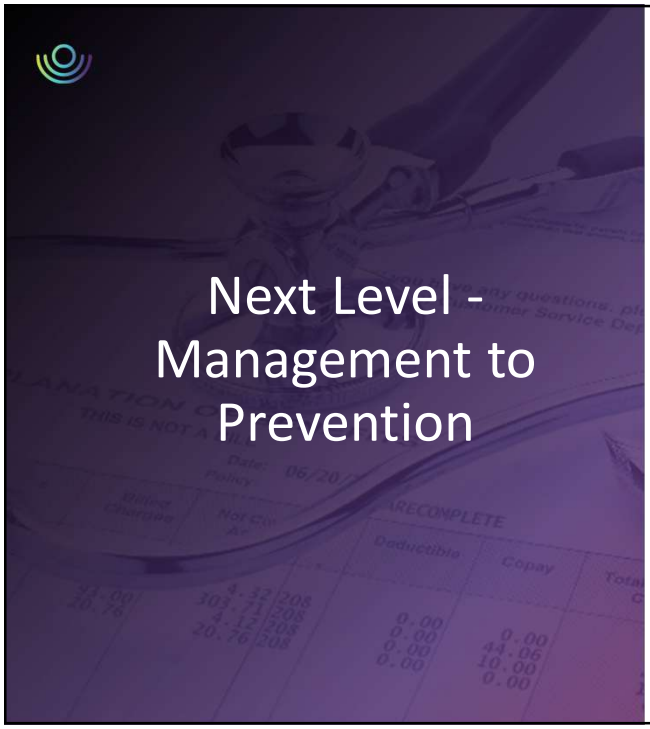

Transition to Denials Prevention

- Departmental training
- Engage clinical staff
- Build out front-end edits to stop denials before admission or service
- Implement technology to combat denials, i.e. Predictive Analytics tool; Front-end software
- Outsource denial management services

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Benefits for Prevention Management

- Improved clean claim rate = Increased net revenue collection
- Enhanced patient experience
- Reduce revenue leakage
- Decrease administrative burden
- Achieve optimal operational efficiencies

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In Conclusion

Ongoing communication and collaboration

Consistent and timely review of denial data

Successful appeals letter writing

Prevention

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Questions?

Thank you for y our time

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References

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- The State of Claims, 2024 Survey, Experian Health, June 2024
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- Keeping Pace with Payers, Knowton Health, 2025

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Your Partner for Clinical Revenue Cycle Management

Seamless strategies to align patient care, operational efficiency, and financial health.

FRONT END		MID CYCLE			BACK END
Patient Experience • Registration & Scheduling • Insurance Eligibility & Authorization • Financial Counseling	**Chargemaster Services** • Market-Based Pricing • Chargemaster • Price Transparency • No Surprises Act	**Utilization Management** • Admission Status Reviews • Physician Advisors • Peer-to-Peer Reviews • Analytics as a Service	**Clinical Documentation** • Inpatient CDI • Outpatient CDI • HCC Coding & HEDIS Abstraction • Provider Education	**Coding** • Coding Automation • Outsourced Coding • Coding Audits and Education	**Claims Management** • Billing & Claim Edits • AR Management & Follow-Up • Specialized AR • Payment Posting Reconciliation • Self-pay

Denials	Value-Based Care	Technology
• Denials Prevention • Denials Management • DRG Downgrades • Transfer DRGs	• RAF Accuracy • Risk Adjustment Program • VBC Strategy & Action Plan	• PULSE Coding Automation Technology™ • VISION Clinical Validation Technology™ • REVIVE Specialized RCM Automation™ • The Smart App®

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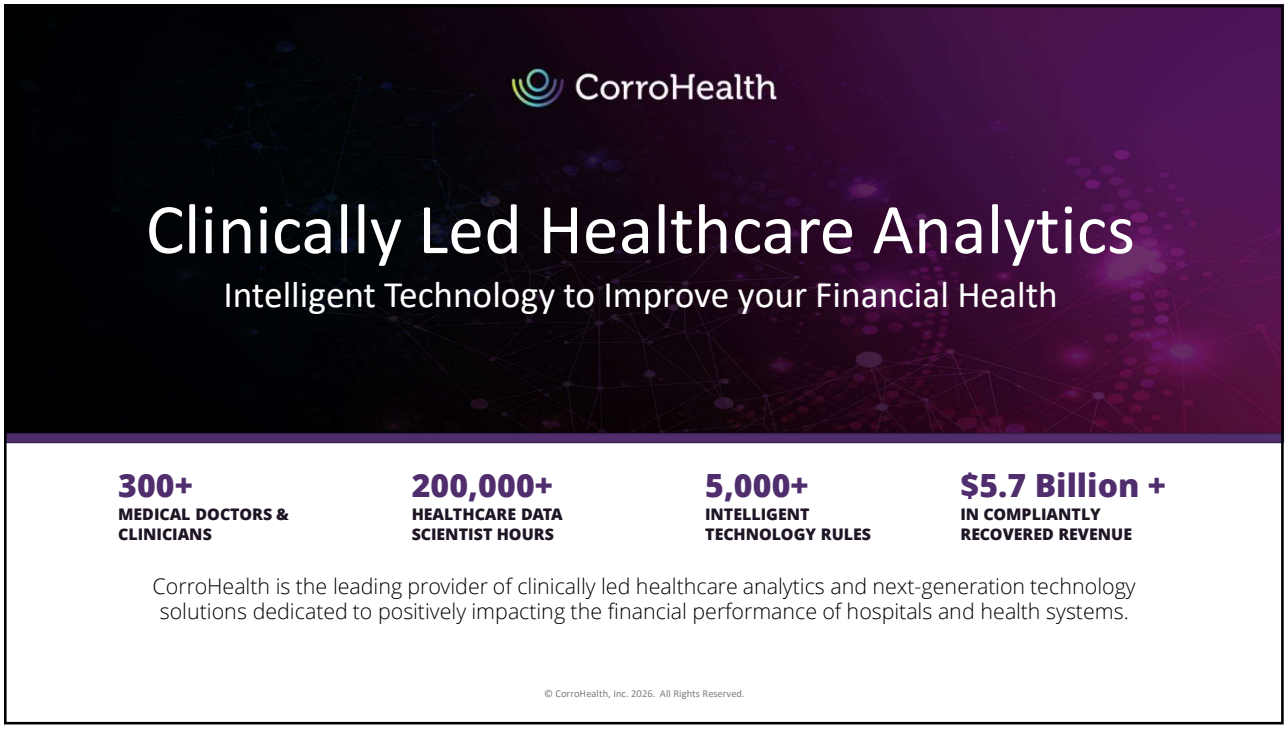
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Clinically Led Healthcare Analytics
Intelligent Technology to Improve your Financial Health
300+
MEDICAL DOCTORS & CLINICIANS
200,000+
HEALTHCARE DATA SCIENTIST HOURS
5,000+
INTELLIGENT TECHNOLOGY RULES
$5.7 Billion +
IN COMPLIANTLY RECOVERED REVENUE
CorroHealth is the leading provider of clinically led healthcare analytics and next-generation technology solutions dedicated to positively impacting the financial performance of hospitals and health systems.
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