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*Advancing Health in America*

KNOWLEDGE EXCHANGE

# Breaking the Claims Denials Cycle

*Fostering better outcomes, cleaner claims and greater leverage with payers*

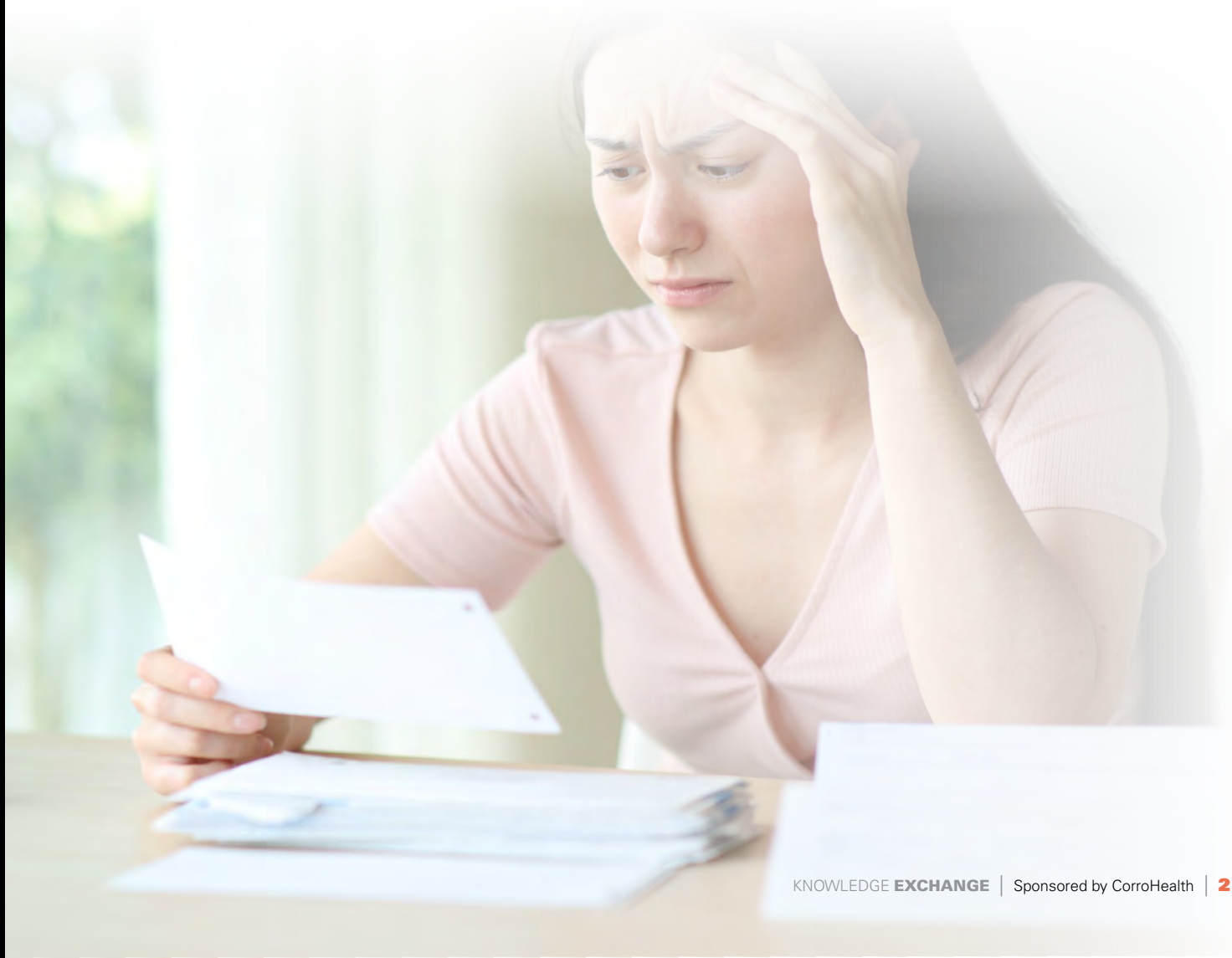
*Sponsored by:* CorroHealth

## Introduction

# Breaking the Claims Denials Cycle

Hospitals and health systems are grappling with rising frustration from both providers and patients as claims denials continue to surge. These denials often lead to unexpected medical expenses for patients and financial strain for organizations that already have delivered essential care. Despite rigorous documentation by hospitals, artificial intelligence (AI)-based medical necessity reviews increasingly have become prevalent, contributing to a sharp increase in rejected claims. As advocacy efforts continue to hold corporate health plans accountable for covering medically necessary treatment, there's a growing need to rethink payer engagement. By harnessing the power of technology, health systems can shift from chasing approvals to preventing denials.

This Knowledge Exchange e-book explores a proactive payer strategy by tackling denials at the source and shifting the focus from reactive appeals to real-time intervention to drive better outcomes for both patients and providers.



# Action Items

## 7 high-impact strategies driving measurable improvement across care quality, documentation and payer engagement

### 1 Prioritize documentation as a clinical and strategic asset.

Embed certified clinical documentation specialists to ensure that coding aligns with care delivered. Use natural language processing (NLP)-enabled software and clinical documentation improvement (CDI) prioritization tools to support accurate documentation in real time. Reframe documentation for clinicians, not as billing but as storytelling for continuity of care.

### 2 Target denials with precision and data.

Conduct weekly denial meetings and use aging claims reports to track unresolved high-dollar cases. Break down denials by root cause; identify patterns like coding mismatches and downgrades. Improve win rates by using short, bulleted, physician-authored justification sheets.

### 3 Improve claims cleanliness with front-end tech.

Adopt AI-powered tools to reduce variation and catch documentation errors before submission. Deploy computer-assisted coding and CDI software to flag missing data and prevent denials. Coordinate across case managers, revenue cycle staff and CDI teams weekly.

### 4 Leverage claim and payer data for negotiation.

Share claim denial analytics with payers to gain leverage and foster accountability. Hold monthly meetings with payer representatives to compare narratives and drive engagement. Benchmark observation case rates and escalate concerns when data misalign.

### 5 Advocate for legislative and policy reform on prior authorization.

Push for standardized turnaround times, coding consistency and appropriate waivers. Collaborate with state governments on oversight of payer practices and consider broader adoption of programs like Gold Card status to streamline approvals.

### 6 Align language between clinicians and coders.

Match physician documentation language with coding standards through regular education and assign coding specialists to work directly with providers. Implement embedded documentation tools that automatically translate clinical language into compliant format.

### 7 Engage physicians and the public in system improvement.

Host lunch-and-learns during enrollment to clarify Medicare vs. Medicare Advantage differences. Educate physicians on best practices for preauthorization and denial mitigation Promote real-time documentation support tools that reduce manual effort and errors.

# Participants

**Kurt Barwis, FACHE**
*President and CEO*
*Bristol (Conn.) Health*

**Glenn Crotty Jr., M.D.**
*Executive vice president, Vandalia Health*
*President and CEO, CAMC*
*Charleston, W.Va.*

**Jennifer Eslinger, MBA, FACHE**
*President, health care operations, and chief operating officer*
*Rochester (N.Y.) Regional Health*

**Michelle Fenoughty, M.D., MBA, FACHE**
*President and CEO*
*Hendricks Regional Health*
*Danville, Ind.*

**Phillip Kambic, MBA, LHD, FACHE**
*President and CEO*
*Riverside Healthcare*
*Kankakee, Ill.*

**Joe Meador, CPA, MBA, FHFMA**
*Senior vice president and chief financial officer*
*Augusta Health*
*Fishersville, Va.*

**Jerilyn Morrissey, M.D.**
*Chief medical officer*
*CorroHealth*
*Plano, Texas*

**Thomas Scott, FACHE, FABC**
*President and CEO*
*CentraState Healthcare System*
*Freehold, N.J.*

**MODERATOR**
**Suzanna Hoppszallern**
*Senior editor*
*Center for Health Innovation*
*American Hospital Association*
*Chicago*

**MODERATOR SUZANNA HOPPSZALLERN** *(American Hospital Association):* **Since claims denials almost always stem from insufficient or incorrect documentation submission, where does optimizing documentation practices rank among your organization's top priorities in 2025?**

**KURT BARWIS** *(Bristol Health):* It's at the top of the list. If the documentation is wrong, you're not getting paid.

**THOMAS SCOTT** *(CentraState Healthcare System):* While documentation plays a key role, several other factors contribute as well. One is eligibility issues. Even with preapprovals, denials can occur. Insurance exclusions are another consideration, as are bundling challenges — whether services should be included or excluded. We also see automatic denials for high-dollar claims, which have nothing to do with documentation, as well as payer processing errors on their end. That said, documentation is critical. We emphasize that it must be clear, complete and accurate. The Clinical Documentation Integrity team at CentraState is focused on optimizing the convergence of clinical care, documentation and coding processes, which is vital to appropriate reimbursement, accurate quality scores and informed decision-making to support high-quality patient care.

**JOE MEADOR** *(Augusta Health):* Beyond the financial impact, there's also a quality dimension. One of our eight key metrics this year is the mortality observed/expected ratio. It's not just about delivering excellent clinical care, it's about ensuring that care is accurately documented. When there's an expected mortality, it's critical that we capture it in the record. Documentation plays a significant role in that process.

**JERILYN MORRISSEY** *(CorroHealth):* I was going to echo that point and add that safety, quality and morbidity also impose additional documentation demands beyond the revenue cycle, which further complicates the conversation.

**MICHELLE FENOUGHTY** *(Hendricks Regional Health):* We need to focus on the specific reasons for prior authorization denials and the policies needed to address them. In Indiana, a new law prevents insurers from revoking approved prior authorizations. We faced millions of dollars in denials last year for patients who were previously authorized care and then denied on the back end. It drains resources and, worse, creates hardships and risks delaying care for patients. Prior authorization shouldn't be required for standard-of-care procedures like routine mammograms. If criteria are met, authorization should be automatic. To make real progress, we must break down denials by root cause and pursue targeted legislative solutions. Broad conversations aren't moving the needle because we're not digging deep enough and educating decision-makers effectively.

**GLENN CROTTY** *(Vandalia Health):* In our experience, insurance companies, especially managed Medicare and Medicaid plans, typically deny around 20% of claims. Often, it takes six to eight months to receive reimbursement for care provided. Considerable documentation is required to support a claim, which is often requested and transmitted by faxed correspondence, which may often be lost or misdirected, resulting in significant delays. Claims are reviewed using varying criteria like InterQual or Milliman, which adds further complexity to the payment process. At Vandalia, we have formed a dedicated Physician Advisory Team comprising a multispecialty group of trained physicians who review and appeal denials when appropriate. They have made a significant impact on our success rate in getting claims paid.

**GLEN CROTTY** | VANDALIA HEALTH
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**MODERATOR: What policies, processes and technology have you implemented to improve documentation to support patient status, procedures and diagnoses? What barriers or challenges are preventing your organization from achieving documentation accuracy?**

**JENNIFER ESLINGER** *(Rochester Regional Health):* We've adopted AI tools and centralized intake to reduce variation and improve error detection. While helpful, the real challenge remains front-end processes.

One of the most critical discussion points is the actual data. We hold monthly high-level meetings with our payer to review the data, because theirs tell a different story. The system suffers from inefficiencies and inconsistent denial criteria across payers. Now, instead of outright denials, we're seeing a rise in downgrades.

**MEADOR:** MA payers briefly adhered to the two-midnight rule, but when profits dipped, compliance faded. We constantly wrestle with whether to reduce denials or push the envelope on patients — especially when inpatient criteria clearly are met. Peer reviews and payer conversations rarely help, despite significant resource investment. We benchmark observation case rates to guide strategy and continue exploring the best path forward. And because observation status limits discharge options, patients needing skilled nursing facilities often don't qualify, even with similar clinical needs.

**CROTTY:** Over the past year, Vandalia has invested in standing up a more robust physician education program around coding and documentation on the professional fee side. This team provides newly hired physicians needed coding education, keeps our providers up to date on rule changes and provides targeted education when needs arise. We also have ongoing work with the clinical documentation improvement team members who interact with physicians daily to clarify documentation. Our multispecialty Physician Advisory Team reviews medical record documentation to support claims submissions and to ensure that patients are put in the right status and review disagreements with payers over status.

**BARWIS:** The Centers for Medicare & Medicaid Services (CMS) can't intervene in contractual disputes, leaving providers on their own with rigid national contracts and limited legal recourse — often confined to arbitration. Without strong contract language, hospitals miss out on full Medicare rates, losing up to 12% and spending heavily on administrative efforts. State governments currently lack authority beyond licensing plans but empowering them to mediate these disputes could level the playing field, especially for small hospitals with no negotiating leverage.

**MEADOR:** We've analyzed MA plans based on payment rates and bad debt reimbursement and plan to drop underperforming ones. Some systems are even using requests for proposals to pare down from eight plans to just two or three, keeping only those with strong contractual terms.

**SCOTT:** We use certified clinical documentation specialists — physicians and nurses trained through the Association of Clinical Documentation Integrity Specialists and American Health Information Management Association — to ensure best practices. The CDI specialists perform concurrent analytical review of clinical and coding data with a goal of improving documentation for all conditions and treatments from a patient's point of entry to discharge, ensuring an accurate reflection of the patient condition in the associated diagnosis related group (DRG) assignments, case-mix index, severity of illness and risk of mortality profiling, as well

**JENNIFER ESLINGER** | ROCHESTER REGIONAL HEALTH
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as health care-acquired conditions/patient-safety indicators. Tools for computer-assisted coding and CDI prioritization help us catch errors early and submit clean claims, minimizing denials for insufficient information.

**MODERATOR: What technology investments have you made to meet payer requirements and improve response time and claims review? How effective are they and where do they fall short?**

**BARWIS:** Despite using advanced tools, we faced repeated denials for a $2.2 million intensive care unit claim, even after proper authorization and timely billing — first, a filing denial and then a readmission denial, dragging payment out for 15 months.

**SCOTT:** Given that 70% of denials we appeal get overturned automatically, it raises questions about consistency and the intent behind initial determinations.

In New Jersey, six health care systems, including CentraState and our partner Atlantic Health System, formed the Healthcare Transformation Consortium — like-minded organizations united to collectively bid out for third-party administration of their self-insured employee health plans. The group selected a single carrier with the aim of reducing administrative fees associated with providing health care benefits and providing more choice and access for covered employees and their dependents while reducing costs.

**BARWIS:** Despite our evidence-based, safety-first approach, prior authorizations are segmented into arbitrary time frames like seven hours or 48 hours —potentially leading to real patient harm. Cancer treatment delays now exceed 30 days, up from 13-15, due to authorization bottlenecks. Reporting issues go nowhere, as state agencies lack jurisdiction and CMS doesn't track the impact. Unless we spotlight these consequences and advocate for reform, the likelihood of patient harm will continue.

**MODERATOR: Which proactive strategies have been successful in aligning claim documentation and workflow processes with payer expectations?**

**SCOTT:** The Gold Card program has shown success in some states. If providers demonstrate a high rate of overturned denials, they can earn Gold Card status — meaning payers stop requiring prior authorizations and denials for qualifying services. We're advocating for broader adoption because the current system wastes valuable time and resources for both sides without benefiting the patient. If clear criteria are met, we should be able to skip unnecessary steps and move straight to adjudication.

**ESLINGER:** Are there national data on the cost of this whole process?

**BARWIS:** The AHA report "The Cost of Caring: Challenges Facing America's Hospitals in 2025" includes national data.

**MEADOR:** MA has grown significantly. We're inviting the public and brokers during enrollment periods to lunch-and-learns to highlight the differences between traditional Medicare and Medicare Advantage. We're also pushing for preauthorization waivers on routinely approved services to reduce wasted effort and improve efficiency for everyone.

**CROTTY:** We've started challenging denials using a

**THOMAS SCOTT** | CENTRASTATE HEALTHCARE SYSTEM
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**JERILYN MORRISSEY** | CORROHEALTH

"Physician notes and hospital coding are like two foreign languages, and you end up spending a lot of resources translating between them. The worst part? It's all retrospective. Two weeks after discharge, no physician can recall the level of detail needed. Part of the solution is technology and tools that are embedded into the physician's workflow in real time, translating seamlessly in the background without human effort."

short, bulleted, one-page synopsis: diagnosis, treatment, and justification. That focused, streamlined approach has allowed us to reverse nearly 70% of denials (a significant improvement over the previous 20% reversal rate). In addition, our experienced physician reviewers now engage directly with payers, cutting through delays and consistently overturning denials. West Virginia also passed legislation setting clear time frames for pre-authorizations and preventing denials based on mismatched coding. The real challenge is aligning physician language with coding standards so that documentation supports the claim. We have to close that gap.

**MORRISSEY:** Physician notes and hospital coding are like two foreign languages, and you end up spending a lot of resources translating between them. The worst part? It's all retrospective. Two weeks after discharge, no physician can recall the level of detail needed. Part of the solution is technology and tools that are embedded into the physician's workflow in real time, translating seamlessly in the background without human effort.

**BARWIS:** We hold weekly denial meetings with our physician adviser and leverage NLP-enabled software to improve CDI compliance. A coding specialist now works directly with physicians to strengthen documentation. As president, I attend revenue cycle meetings weekly, set expectations and track key performance indicators closely. When risk-adjustment rules change, we move fast to identify and implement countermeasures. I've successfully advanced prior authorization legislation, but coverage gaps remain for MA and employer-sponsored plans. Vigilance is essential. Each morning, I review length of stay reports and investigate any length of stay longer than 15 days. I also rely on a custom aging claims report; if I see a claim sitting at 76 days for $100,000, I expect answers and immediate action. The goal is simple: Prevent claims from hitting 90 days.

**PHILLIP KAMBIC** *(Riverside Healthcare):* We aggressively deploy technology with Epic, especially AI, to improve documentation and reduce denials. I also have developed reports for length of stay and observation. What really moves the needle is coordination. Clinicians, case managers, CDI teams, and revenue cycle staff meet weekly to align documentation standards. Our chief medical officer plays a key role in educating physicians on accurate documentation. We're actively working on eliminating issues like copy and paste. We also engage on policy. In Illinois, new Medicaid preauthorization rules allow automatic behavioral health admissions for three days, which is a win for care continuity. But the challenge remains. Medicare Advantage, commercial and Medicaid Managed Care denials are all different, making proactive management essential. At the end of the day, we focus on what we can control.

**FENOUGHTY:** Our focus is on what we can control. We've built out Epic's payer platform, but insurers often choose not to use it, despite its seamless communication potential. We prioritize supporting physicians directly, helping them see documentation not as a billing task, but as a way to clearly tell the patient's story for the next clinician. That framing makes all the difference in engagement, and it's why we've seen stronger results.

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