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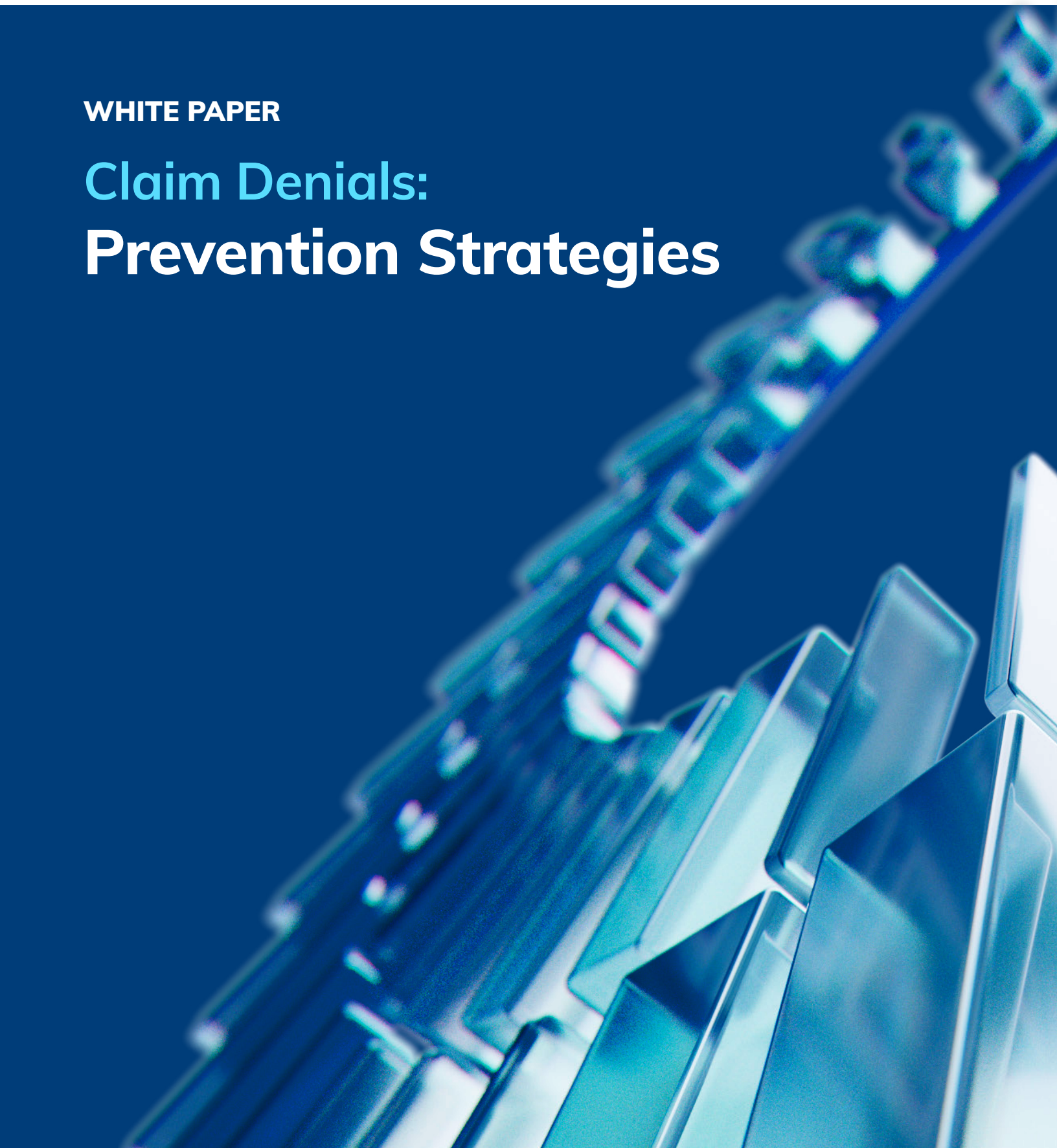
WHITE PAPER

Claim Denials:
Prevention Strategies



Introduction

The Problem of Claim Denials

Revenue cycle management (RCM) leaders and managers across healthcare describe a system under increasing strain, driven by shrinking reimbursements, shifting payer rules, rising denial rates, and growing financial and workforce pressures. Even when organizations secure authorizations and submit carefully prepared claims, denials still occur, which force staff to devote scarce resources to rework and appeal.

At the same time, declining reimbursement and rising labor and operating costs make revenue preservation as critical as revenue generation. As payer complexity grows and patients/residents struggle to navigate coverage rules, claim denials have evolved from a back-end billing issue into a systemic friction point – one that requires new tools, better insight, and smarter approaches to restore predictability and refocus attention on care.

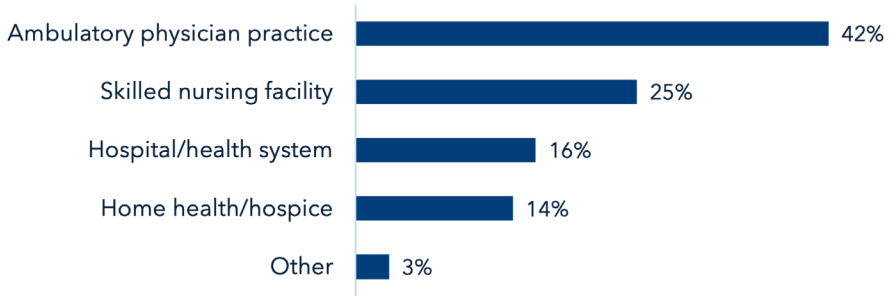
To further explore issues around claim denials, Inovalon conducted a survey of revenue cycle management leaders and managers to identify the challenge posed by claim denials and the strategies they are employing for prevention and management.

About the Research

Inovalon surveyed over 400 revenue cycle leaders and managers, representing acute hospitals, health systems, physicians, specialists, other ambulatory practices, and post-acute providers including skilled nursing facilities and home health agencies.

Survey participants who offered their opinions on this topic were screened for knowledge of initial claim denials. Initial claim denials occur after healthcare professionals guide the patient or resident through sequenced workflows, including access, registration, payment planning, and care delivery.

Lines of Business Represented: RCM Leaders and Managers

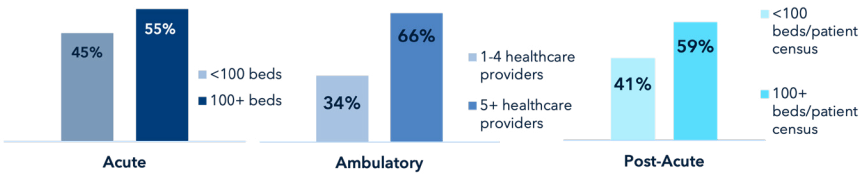


Ambulatory includes:

- Specialty physician
- Primary care physician
- Behavioral health
- Ambulatory surgical center

Participant Profile

- Acute hospital & health systems
- Ambulatory physicians & specialties
- Post-acute skilled nursing facilities, home health, and hospice



Key Findings

Inovalon's survey of over 400 revenue cycle management leaders and managers highlights the persistent challenges and emerging strategies shaping denial management. The findings below reflect both the scale of the issue and where organizations are focusing their efforts to reduce denials and improve performance.

Claim denials remain a leading revenue cycle challenge

Nearly three-quarters (72%) RCM leaders cite denials as a significant challenge, ranking it higher than any other revenue cycle issue evaluated.

Front-end workflows are seen as the primary drivers of denials

More than three-quarters (78%) attribute denied claims to front-end workflow issues. Insurance eligibility and benefits verification emerged as the single greatest contributor across care settings, with prior authorizations nearly as impactful for hospitals.

Denial prevention strategies focus on front-end improvements

The most common approaches to reducing denials center on strengthening front-end processes. Sixty-one percent report validating patient/resident demographic information, while 58% emphasize closer monitoring of insurance eligibility changes.

Back-end processes also play an important preventive role

Four in ten respondents (43%) use customized claim scrubbing to identify and resolve errors prior to submission, underscoring the value of back-end controls in denial prevention.

AI shows strong promise in denial prevention and management

RCM leaders view AI as a high-potential enabler of revenue cycle performance, with denial prevention and management cited as the workflow most likely to benefit from AI-driven capabilities.

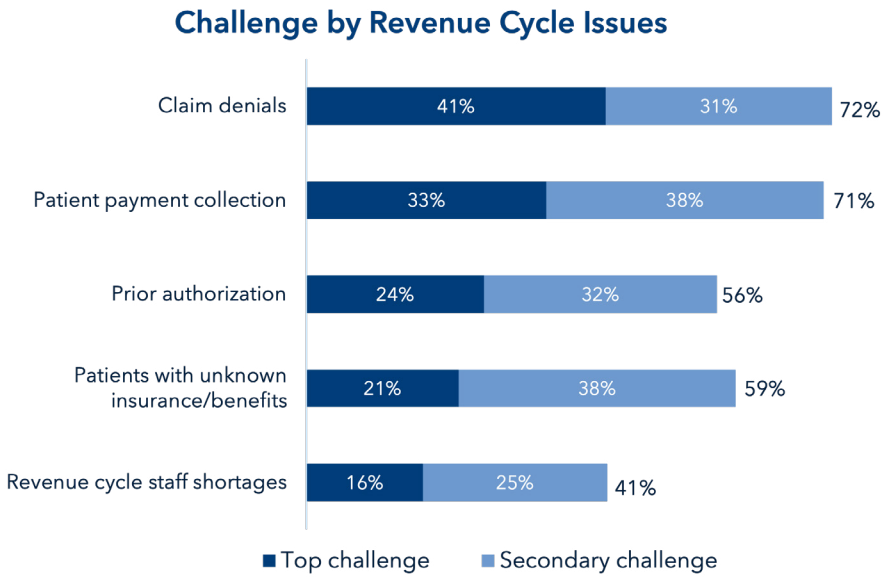
Revenue Cycle Challenges: Where Do Denials Fit?

Among persistent revenue cycle pain points, claim denials continue to stand out as the most frequently cited top challenge. No other revenue issue received as many “top challenge” ratings, underscoring the scale and consistency of the problem.

As reimbursement pressures intensify, revenue preservation has become as critical as revenue growth. In this environment, it is not surprising that patient payment collection ranks closely behind claim denials as a significant concern.

Front-end revenue cycle workflows – including prior authorization and managing patients or residents with unknown or incomplete insurance benefits – are also viewed as major challenges, reflecting the growing complexity and risk embedded early in the revenue cycle.

> “Payer claim denials have increased significantly, and it takes more staff time to file reconsiderations and appeals.”

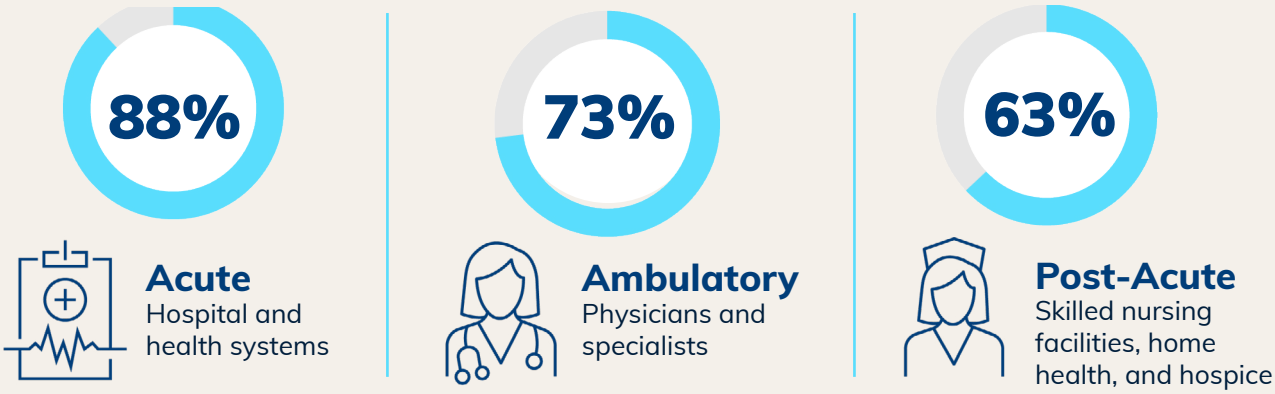


> “It seems like we have been getting more and more claim denials.”

Care Setting Differences on Denials

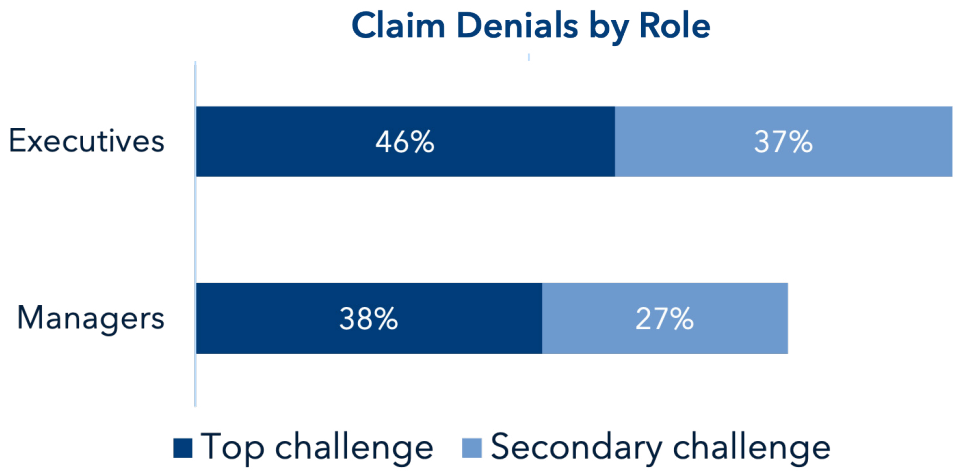
Claim denials are a significant challenge across care settings.

Claim Denials as a Significant Challenge by Care Setting



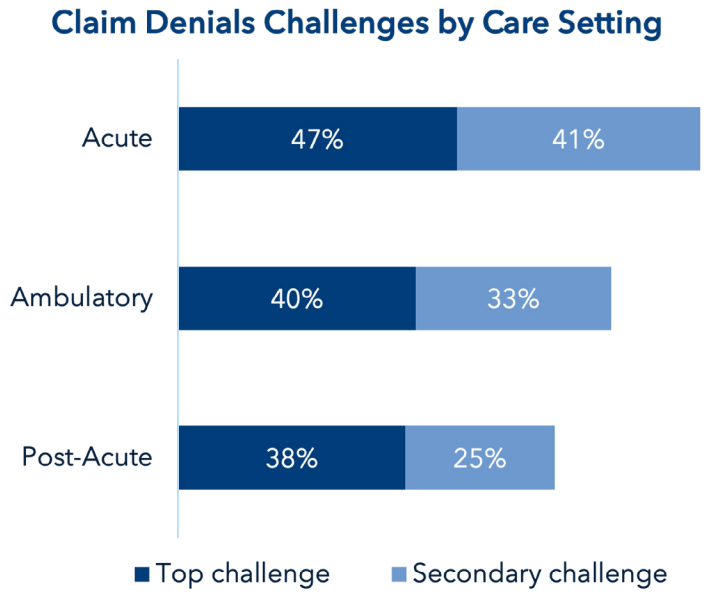
Role-Based Differences on Denials

Although executives are the most likely to view claim denials as painful, managers also consider denials to be a significant challenge.



Care Setting Differences on Denials

Hospitals continue to be the most affected by claim denials, but substantial numbers of ambulatory groups and post-acute organizations also feel the impact.

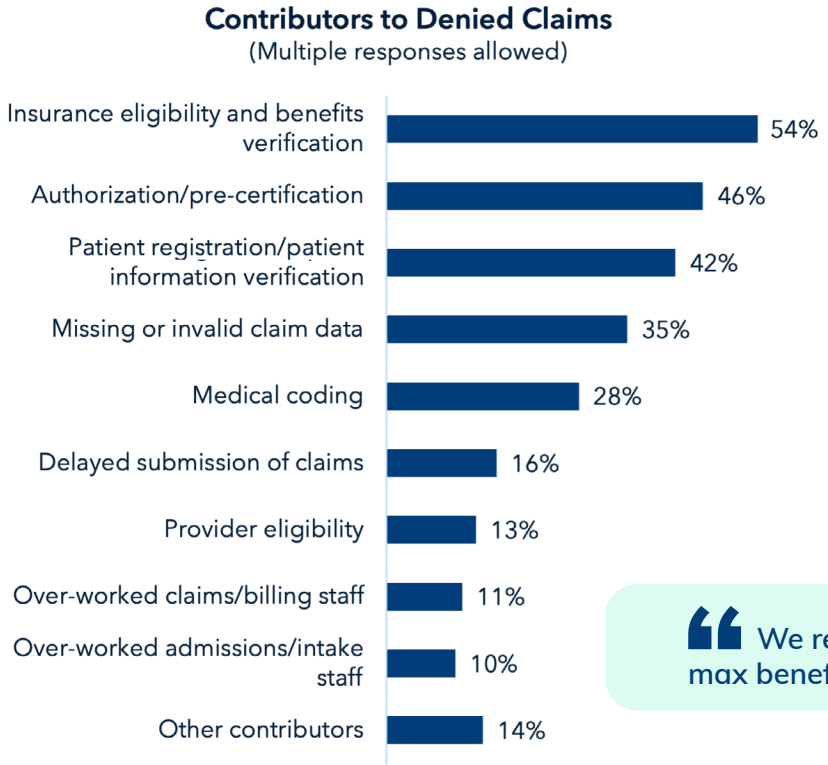


> “Staff spends countless hours refiling claims, researching and submitting additional information, etc.”

Revenue Cycle Components That Contribute to Denied Claims

Leaders who were familiar with claim denials were shown a list of workflows and asked to identify which they believe contribute to initial claim denials.

- Nearly four in five healthcare (78%) attributed denied claims to at least one front-end revenue cycle workflow, underscoring the outsized role of patient access and intake processes in denial prevention. The three most frequently cited contributors all occur early in the revenue cycle:
    - Insurance eligibility and benefits verification
    - Authorization and pre-certification
    - Patient registration and demographic verification
- Notably, 73% of healthcare identified more than one workflow as contributing to claim denials, highlighting the cumulative impact of errors or gaps across the front end of the revenue cycle.
- When given the opportunity to specify other contributors, respondents most often pointed to payer-related issues, including insurer errors and inconsistent or unpredictable payer rules.



> “Coverage no longer effective even though patients state their health plan is active.”

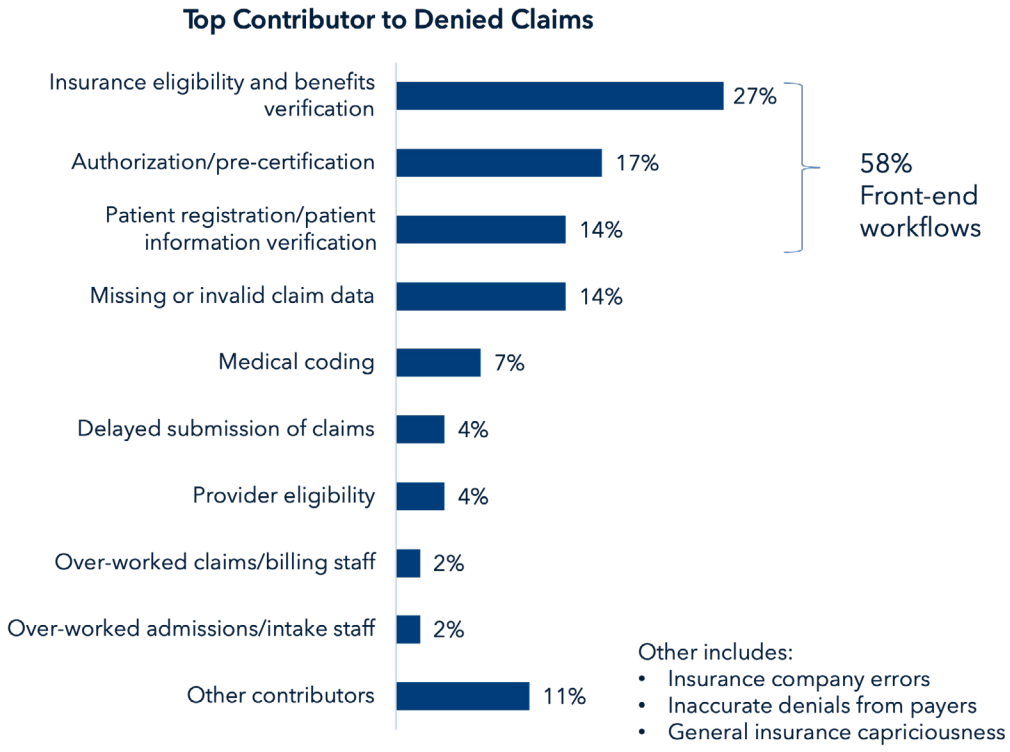
> “We received many denials based on authorization, max benefit, and wrong insurance picked.”

> “We verify eligibility, but some payers have ‘other insurance possible’ and will deny claims even though patient is eligible.”

The Single Biggest Driver to Denied Claims

Participants were asked to identify the single **top contributor** to denials at their organization.

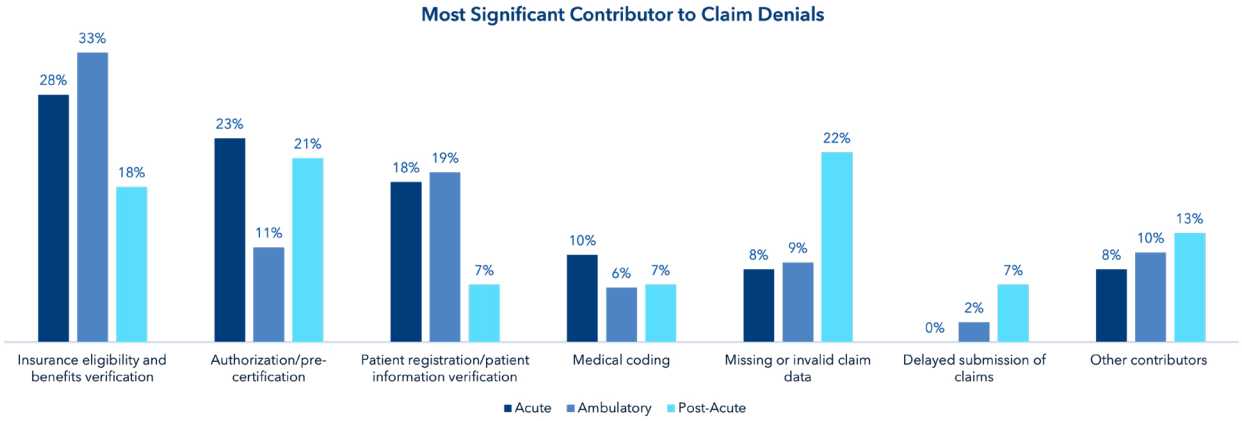
- More than half (58%) identified a front-end workflow as the top contributor to denials.
- Insurance eligibility and benefits verification was cited by 27% of respondents as the single top contributor to denials, making it the most frequently named individual workflow.
- References to "other contributors" doubled in 2026 compared to 2024 and now largely reflect payer-related issues, including insurer errors and inconsistent or shifting requirements, rather than internal operational challenges. Overall, respondents increasingly attribute denials to payer behavior, citing perceived arbitrariness, rapidly changing rules, and growing concern that payer use of AI may be contributing to higher denial rates.



> "Denials especially for coverage lost or change in insurance. We've hired an external company to assist with appeals."

Top Contributors by Care Setting

1. **Ambulatory:** Claim denials trace back primarily to insurance eligibility and patient registration data.
2. **Acute:** Denials span the front-end revenue cycle, led by insurance eligibility and prior authorizations.
3. **Post-Acute:** Three factors drive denials including missing or invalid claim data, prior authorization, and eligibility verification.



Diving Deeper Into Specific Claim Denials Challenges

While front-end revenue cycle workflows are widely viewed as primary contributors to claim denials, survey participants' open-ended responses suggest that the challenge extends beyond internal processes alone. Revenue cycle leaders and managers consistently expressed frustration with payer-related issues, citing errors, inconsistent decision-making, and frequently changing rules as significant drivers of denials. Many leaders perceive that claims are denied without clear justification, increasing the complexity, cost, and time required for denial management and appeals.

In response to this increasingly uncertain payer environment, providers are placing greater emphasis on ensuring claims are as accurate and as complete as possible prior to submission. Strengthening patient/resident demographic validation and insurance eligibility verification remains a critical strategy for mitigating avoidable denials.

> "Insurance carriers just deny, they don't need any reason. Timely and frustrating to continually follow up on. Try to submit the cleanest claims we can."

> "Uphill battle with payers. They want to deny everything. We need to be on top of all the ins and outs so that we don't experience high claim denials."

> "We would like to have no denials. But, they are digging deeper to find reasons to deny claims."

> "Insurance companies are denying more claims without adequate reasons for denial and more and more claims go into review. We are getting preapproval even with plans that do not require preapproval."

> "Claims being denied even with an authorization on file. We have been appealing the denials and some insurances we have stopped accepting that are habitual offenders."

> "We often see claim denials for errors on the payer side. Denials often get reversed and paid through appeals."

> "Payer claim denials have increased significantly, and it takes more staff time to file reconsiderations and appeals."

The Role of Front-End Workflows in Preventing Claim Denials

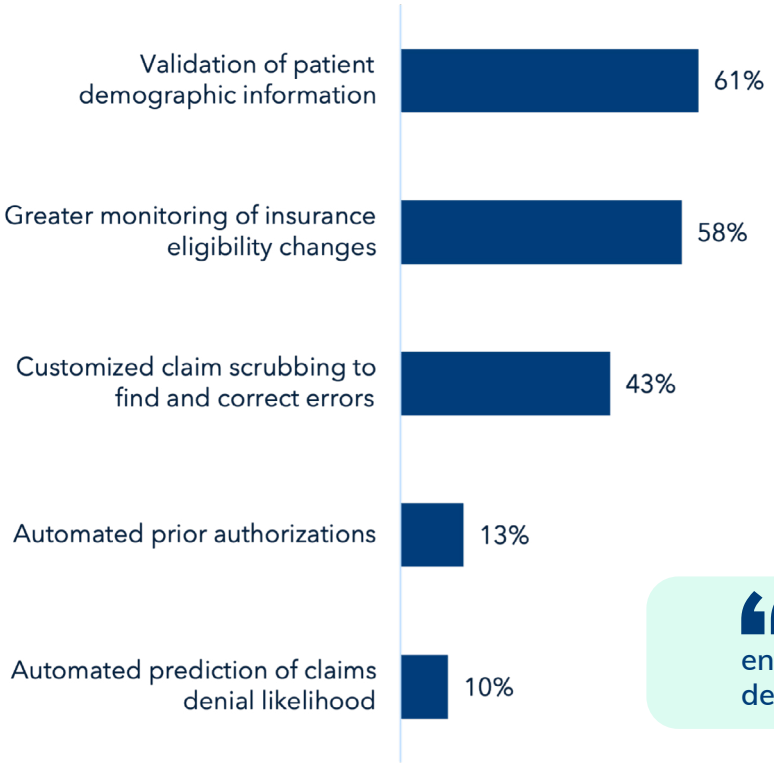
Revenue cycle leaders efforts to prevent claim denials continue to focus primarily on front-end revenue cycle workflows, particularly the validation of patient/resident demographic information and ongoing monitoring of insurance eligibility. These activities are widely viewed as foundational to reducing avoidable denials before a claim is submitted.

At the same time, many organizations are complementing front-end diligence with back-end solutions. Nearly half report using customized claim scrubbing to identify and correct errors prior to submission, reflecting the importance of claim accuracy even after patient access processes are complete. Smaller segments are beginning to adopt more advanced approaches, including automated prior authorizations and predictive analytics to assess denial risk.

Despite high denial volumes and increased payer complexity, only a small minority of organizations report using automated prediction of claim denial likelihood. This up-and-coming capability could potentially be a game changer – a clear opportunity for more advanced, data-driven tools to support proactive denial management.

> "Taking extra time and using additional staff to confirm coverage."

Strategies to Prevent Claim Denials



> "Making sure we have accurate insurance information and the correct authorization PRIOR to providing services."

> "We spend many hours reaching out to patients about the change in insurance."

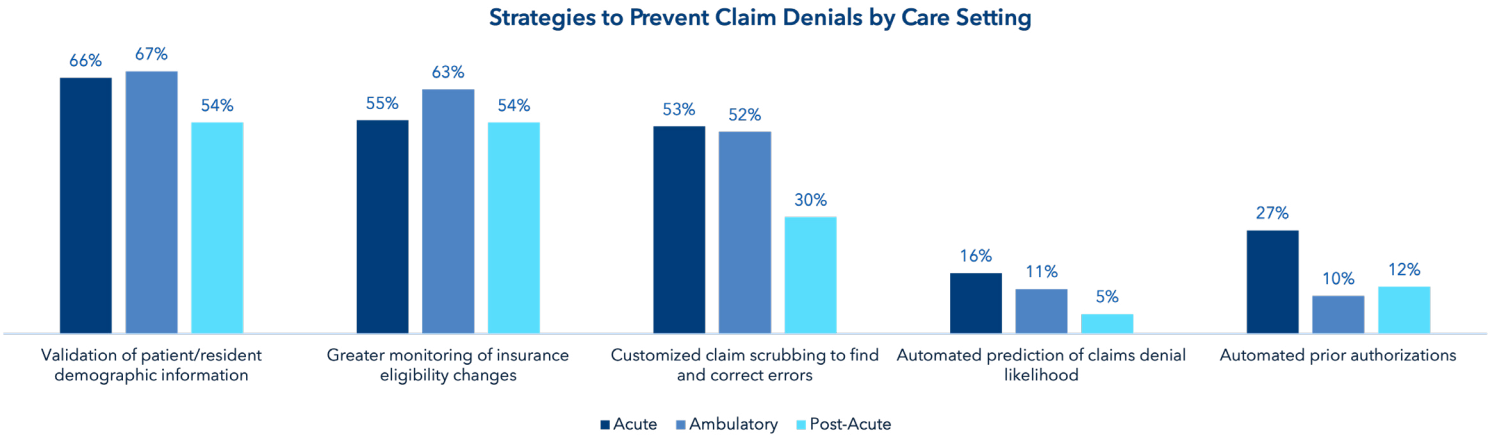
> "Insurance verification prior to visit, ensure auth is not needed and making sure demographics are correct."

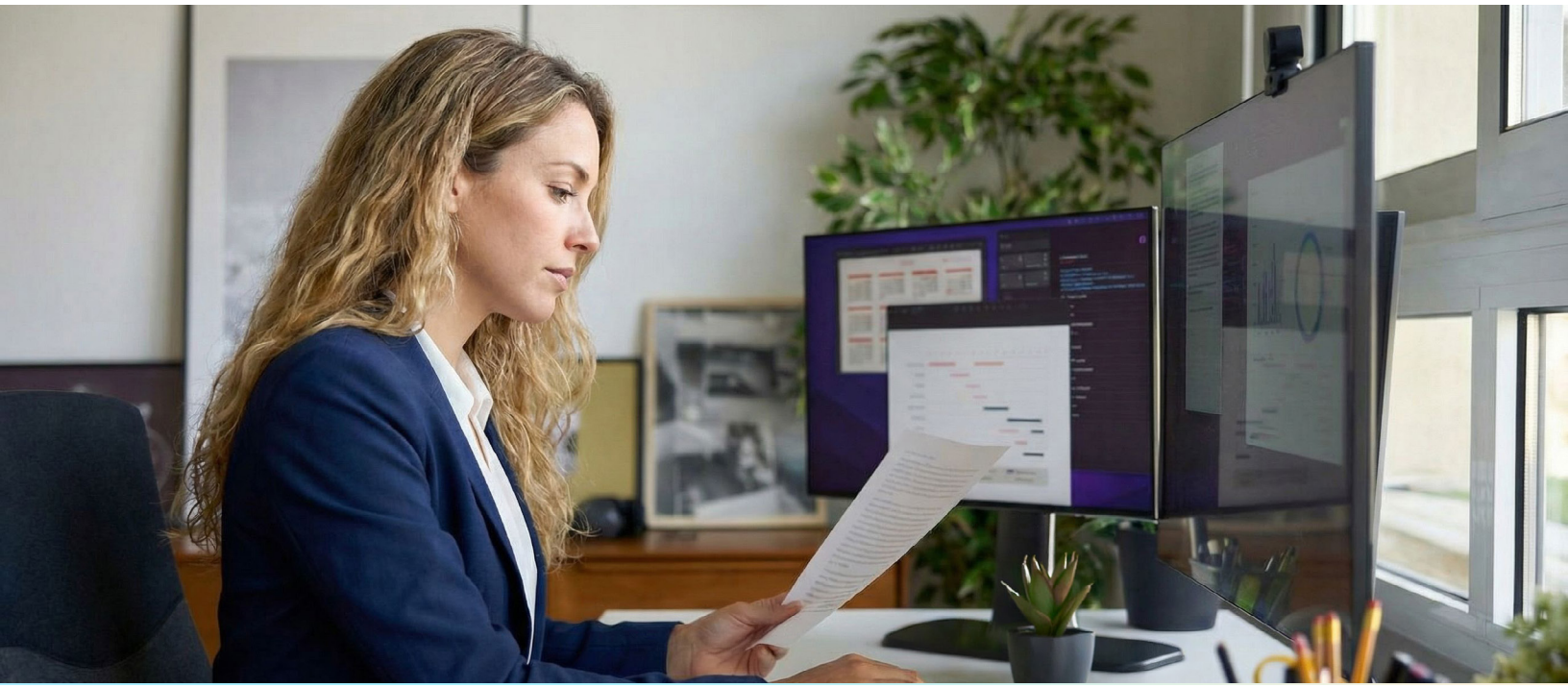
> "Claim denials due to the patient switching insurance during care. To mitigate the risk, we check eligibility every month."

Provider Denials Prevention Strategies

Across all care settings, strategies employed to prevent claim denials mostly involve validating patient and resident demographic information and greater monitoring of insurance eligibility changes.

- Hospitals and ambulatory physician practices are also relying on customized claim scrubbing to find and correct errors.
- Earlier we saw that prior authorizations are nearly as challenging as claims denials, but only 27% of hospitals report having automated their prior authorizations, and only about 10% in other care settings.





Survey responses point to three primary strategies provider organizations are using to prevent claim denials.

Strategy 1:
Focus on Front-End Workflow Improvements

Provider Strategy	Innovations for Further Improvement
Focus on ensuring correct patient/resident information and eligibility verification Many revenue cycle leaders and managers reported placing an emphasis on submitting clean claims. They typically mention claim scrubbing as a way of ensuring clean claims, but diligence on the front end with patient/resident information and insurance verification plays a part as well.	**Automation enablement for front-end workflows** Providers are increasingly investing in a unified front end of the revenue cycle that integrates patient/resident identity and demographic data, insurance coverage verification, and prior authorization requirements into a single, coordinated workflow. By establishing accuracy and securing required authorizations before care is delivered – particularly in an environment where physicians average nearly 40 prior authorizations per week and prior authorization-related denials place a material share of revenue at risk – organizations can reduce administrative rework, improve reimbursement predictability, and protect cash flow before services are rendered.

> “Check insurance verification prior to visit, ensure authorization is not needed, and make sure demographics are correct.”

> “We use AI to run eligibility checks, request prior authorization, verify correct intake data, claim scrubbing, denials workflow”

Strategy 2:
Automate Prior Authorizations

Provider Strategy

Avoiding denials due to prior authorization issues

Authorizations are the second leading contributor to claim denials, and while providers have strategies in place to cope, these often involve more manual methods. Automation of prior authorization workflows remains limited.

Innovations for Further Improvement

Electronic prior authorization (ePA)

Modern electronic prior authorization solutions streamline one of the most complex steps in the revenue cycle by replacing fragmented, manual workflows with a standardized, rules-driven, and interoperable approach. By aligning with emerging CMS prior authorization and interoperability standards, ePA reduces denial risk, improves cash-flow predictability, and unburdens staff.

For providers, ePA represents a step-change in certainty, ensuring that, at the point of care, authorization requirements have been consistently applied and a valid authorization is in place when required, helping prevent downstream denials and reimbursement delays.

> “Insurance denies, stating it wasn’t authorized when it was. We now have a centralized team that does our prior authorization, and so if they try to deny, that team steps in to help get that claim paid.”

> “Insurance denies for no authorization and we have to appeal with authorization proof.”

> “Insurance companies are denying more claims without adequate reasons for denial and more and more claims go into review. We are getting preapproval even with plans that do not require preapproval.”

Strategy 3:
Prioritize Clean Claims

Provider Strategy

Submitting the cleanest claims possible

Many revenue cycle leaders reported placing an emphasis on submitting clean claims. They typically mention claim scrubbing as a way of ensuring clean claims, but diligence on the front end with patient/resident information and insurance verification plays a part as well.

Innovations for Further Improvement

Predict claims likely to deny, coupled with effective claim scrubbing

Sophisticated claim management systems now serve as a critical last line of defense against denials.

Advanced, rules-based claim scrubbers target high-impact errors, while AI-driven alerts flag claims at risk of denial before submission. Additional capabilities enable providers to prioritize high-value claims and identify denial trends more effectively.

> “We scrub all claims manually prior to them being sent to insurance.”

> “We set up alerts and rules on front end to scrub to ensure clean claims.”

> “Small 30-bed facility that really can’t absorb denials of claims, so we need to be extra careful in submitting claims.”

> “We make sure the claims go out clean and the insurance is active – however, we still have some denials due to diagnosis or not authorization.”

> “Submitting clean claims and having continued authorization.”

Opportunities in Denials Prevention and Management: The Promise of AI in Addressing Claim Denials

When considering how artificial intelligence might enhance performance across the revenue cycle, leaders consistently surfaced claim denials as the area of greatest opportunity. In fact, denials reduction and management were cited more often than any other workflow, signaling where organizations most expect AI to drive meaningful improvement.

Specific claim denials management functions said they would like AI to provide:

- Enhanced claims scrubbing to prevent denials
- Predicting when a claim will be denied/likelihood of claim payment
- Assisting with appeal letters and packets of documentation
- Track denial trends and provide analytics

> “The process of denial management remains very manually intensive. We must find ways to automate that.”

How AI Might Address Claim Denials

> “Analytics so we can see what claims are denying more frequently and where our quick wins could be.”

> “Identify trends for root cause of denials. Aid in review to be proactive to address concerns prior to submission.”

> “Denial prediction, registration validation, denial analysis.”

> “Based on past claims history, AI might predict expected revenue and assist with denial responses.”

> “We’re already using certain AI to analyze claim dispute success likelihood and to automate our document management front-end processes.”

Where Innovation Is Shaping Denial Prevention

Declining reimbursements and increasingly unpredictable payer responses have made claim denials a critical financial risk for healthcare organizations. While some providers are adding or cross-training staff to manage growing denial volumes, this approach increases costs without addressing root causes.

The findings instead highlight the importance of getting claims right the first time, starting with accurate, up-to-date information at the front end of the revenue cycle. As a result, automation has emerged as a key path forward, with targeted AI-assisted capabilities offering a scalable way to reduce denials, limit rework, and protect revenue while supporting the expertise of revenue cycle teams.

Preventing and managing denials will require both operational rigor and intelligent systems. The future of denial reduction lies in aligning clean-claim fundamentals with data-driven capabilities that help organizations anticipate issues before they occur.

By combining accurate front-end information, robust back-end validation, and emerging AI-enabled insights, organizations can improve reimbursement predictability, reduce rework, and shift staff time toward higher-value activities. A more seamless financial experience can also strengthen patient and resident loyalty. In an environment of tightening margins and growing complexity, this balance of discipline and innovation offers a practical path to stronger financial performance and better care outcomes.

What's Driving Results

Front-end clearance through Registration Workflow™ and prior authorization – Eligibility, benefits, and missed prior authorization requirements remain leading contributors to initial denials. Real-time, upfront clearance helps ensure that patient/resident coverage is accurate and required authorizations are identified and addressed before care is delivered.

Automated identification of potential denials before claims are submitted – Advanced claim management systems provide a critical defense against denials by combining rules-based claim scrubbing with AI-driven denial risk alerts. By catching high-impact errors early, these tools enable providers to prioritize revenue-critical claims and gain deeper insight into recurring denial trends.

Holistic view of revenue cycle – As technology enhances front-end workflows and automates denials prediction and management on the back end, analytics offer a holistic view of the revenue cycle, enabling organizations to identify trends, mitigate denial risk, and drive more effective revenue optimization.

For more findings from Inovalon's research study related to prior authorization in healthcare revenue cycle management, view this white paper.

Explore Prior Authorization Findings

About us

Inovalon is a leading provider of data and solutions empowering data-driven healthcare. We bring together national-scale connectivity, real-time primary source data access, and advanced analytics into a sophisticated platform empowering improved outcomes and economics across the healthcare ecosystem. The company's analytics and capabilities are used by over 50,000 active, licensed customers. Learn more at www.inovalon.com.

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