REVCO SOLUTIONS

WHITE PAPER

DENIALS IN 3D

Provider, Patient, and Payer Perspectives on Preventable Revenue Loss & Systemic Misalignment

Introduction

Healthcare claim denials in the United States continue to rise in both frequency and complexity, representing a growing challenge for providers, patients, and payers alike. Recent data from Change Healthcare[1] shows that the average hospital denial rate reached nearly 11% in 2023, with more than half of initial denials never recovered—resulting in billions of dollars in lost or delayed revenue for providers.

Providers face growing reputational risks, concern for the well-being of the communities they serve, and increasing pressure to meet quality metrics and regulatory compliance standards all while navigating evolving patient expectations and technology demands.

Patients often face surprise medical bills, delayed treatments, or the emotional stress of navigating appeals for care that was already delivered.

Meanwhile, payers are contending with their own challenges: processing large volumes of claims with limited visibility into provider workflows, managing cost containment, and responding to regulatory scrutiny over denial patterns.

Despite sharing common goals—doing what is best for the patient, supporting their teams, and maintaining financial sustainability—stakeholders across the healthcare system often find themselves at odds. The result is a fragmented system where friction between stakeholders is high, and the human cost—confusion, frustration, burnout—too often goes unaddressed.

In this white paper, we aim to humanize the issue of denials by sharing real impacts from across the care continuum looking at some common, and some not so common causes of denials. We will highlight actionable strategies that providers can use to manage, but more importantly, prevent denials—without losing sight of the people behind every transaction from all sides.

86% of denials are potentially avoidable, often stemming from breakdowns in front-end processes like eligibility verification, prior authorization, and clinical documentation. [2]

68% of Revco's active inventory is made up of avoidable denials resulting from patient access, authorization, and eligibility errors.[3]

Denials are not just billing events; they are a symptom of broader misalignments in how care is delivered, documented, and reimbursed.

[1] HFMA.org | Actionable Insights & Strategies from the Change Healthcare 20222 Denial Index | 5.2023

[2] Becker'sHospitalReview.com | 86% of denials are potentially avoidable: Strategies to better prevent, manage denials | 11.6.2020

[3] Based on active Revco Solutions denials management inventory as of the date of this publication | 5.2025

[4] Journal of AHIMA |Claims Denials: A Step-by-Step Approach to Resolution |4.2022

[5] AHA.org | Payer Denial Tactics – How to Confront a #20 Billion Problem | 4.2.2024

Behind the Denial

The Price Patients Pay

When Policy Language Collides with Real Life

28-year-old John joined a few friends for a night out to celebrate a new promotion at work. The social gathering took a serious turn when John drank over the legal limit, resulting in injuries that required emergency medical care. His health insurer denied the claim, categorizing his injuries as self-inflicted and therefore not covered under his plan. In addition to dealing with the physical and emotional aftermath of his injuries and the loss of his new role at work, John faced mounting medical bills.

The appeal argued there was no clear intent to self-harm, as the event was social and the harm accidental. Based on the design of John's plan and policy language, coverage hinged on whether the act was intentional or unintentional, making these distinctions crucial. A subsequent claim with the same payer and similar facts was not overturned as the distinction between intentional and unintentional was removed from the patient's policy.

The Consequences of Administrative Oversight

Maria struggled with obesity for most of her adult life, managing multiple comorbidities including Type 2 diabetes, sleep apnea, and hypertension. At age 56, after years of medically supervised weight loss attempts, her physician recommended bariatric surgery as a clinically appropriate next step. But Maria's procedure was denied by her insurer. The reason: her claim documentation didn't specifically outline a six-month supervised nutritional counseling program as required by her plan. The delay from the appeal caused months of anxiety, worsened her condition, and undermined her trust in the care system.

Cosmetic procedures like bariatric surgery are frequently denied unless proven medically necessary. Some plans outright exclude coverage, while others impose conditions—like participation in supervised weight loss programs. To overturn these denials, accurate coding and thorough documentation is essential. Despite letters of medical necessity and documented clinical failure of non-surgical interventions, Maria's plan's rigid approval criteria remained a barrier. Eventually, after provider advocacy and supplemental documentation confirming her eligibility, the denial was overturned.

Innovation Outpaces Policy & Leaves Patients Behind

After months of unexplained symptoms, 42-year-old Mark was diagnosed with a rare form of retinal disease that threatened to leave him blind. His specialist recommended a promising gene therapy that had shown success in similar patients through clinical trials and international case studies. Despite this, his insurer denied the claim, citing the treatment as experimental and not medically necessary.

Experimental denials often arise when treatments haven't received FDA approval or mainstream adoption. The appeal focused on several key arguments: the growing body of evidence supporting the gene therapy's effectiveness, approval by other carriers including Medicare for similar cases, and a cost analysis showing the therapy was less expensive than years of ongoing supportive care. Still, the initial rejection caused weeks of delay and placed the burden of proof squarely on Mark's providers—underscoring how innovation often outpaces policy and leaves patients vulnerable in the gap.

Beyond the Balance Sheet

The Impacts of Denials on Healthcare Organizations & the Patients They Serve

Healthcare providers are the first to feel the effects of denials. While each denial may begin as a claims issue, its impact quickly extends to financial stability, staff morale, and ultimately the quality of care, leaving providers in a constant state of reactive problem-solving. Denials don't just disrupt billing—they ripple through nearly every aspect of provider operations. Lost revenue, staff frustration, and strained patient relationships just scratch the surface.

Impact #1: Financial Strain

From a financial perspective, denials have a substantial and often compounding impact on healthcare organizations, and. providers are feeling this financial strain from all angles.

- **Delayed reimbursement** timelines due to lengthy back-and-forths with payers, especially when clinical intent is subjective.
- **Increased cost to collect**, as these cases often require coordination between clinical, legal, and billing teams to resolve.
- **Direct revenue loss** from denied claims that will likely never be recovered.
- **Denials pushed into older A/R buckets** reduce the likelihood of reimbursement and weaken the overall financial health.
- **A lower net collection rate** signals to boards, investors or potential partners that there are systemic inefficiencies.

According to the American Hospital Association, hospitals and health systems spent an estimated $19.7 billion in 2022 trying to overturn denied claims.[5] While 54% of those denials were ultimately reversed, the appeals process is time-intensive and costly, often requiring multiple touchpoints and repeated submission of supporting documentation.

This creates a double-edged sword: even successful appeals come at a high operational cost, straining both financial and human resources that could otherwise be directed toward patient care or strategic initiatives.

Policy-based denials are among the most difficult to overturn, making the appeal process feel like a losing battle. But choosing not to appeal—even when there's a chance of success—can result in unreimbursed care and sets a precedent that ultimately benefits payers.

$5M

On average, hospitals face an annual loss of $5 million due to health care claim denials, amounting to 5% of their net patient revenue.[4]

Denied claims can make up 2-3% of a hospital's net revenue, but **up to 5x** that in resources required to resolve them.

JOHN'S CASE

Consider John's case, which required substantial legal review and a lengthy appeals process as a result of complex policy language tied to self-inflicted injury. Denials based on plan design raise not only significant financial and operational burdens, but also policy and regulatory questions that require costly and time-intensive legal review to resolve.

There are exceptions! The industry benchmark for recovery on non-covered service or policy-based denials is 5-15%. **Today Revco is recovering 31.3% for one of our loyal clients.**[3]

Impact #2: Operational Challenges

A significant portion of claim denials can be traced back to issues that occur during the patient access and registration process. Common errors in this phase include inaccurate patient information, failure to verify insurance eligibility and benefits, and the omission of required prior authorizations. These missteps often result in eligibility and authorization denials—two of the most prevalent categories found in denial management reports —and are largely preventable with proper training and the right technology.

Beyond registration, additional denials arise from coding and documentation inaccuracies. These may include the use of invalid codes or incorrect coding at the outset, potentially leading to denials related to medical necessity. Furthermore, errors in the initial claims submission process can also contribute to issues downstream. Collectively, these denials have a lasting impact on the revenue cycle, manifesting as delayed payments, increased rework, and a growing A/R backlog.

Denials rooted in registration, eligibility, and authorization are often symptoms of broader operational inefficiencies. These include:

- **Workflow Gaps:** Lack of standardized workflows or checkpoints in patient intake and insurance verification can lead to missed steps, such as prior authorizations or eligibility checks, increasing denial risk.
- **Staff Training and Accountability:** Inadequate training or oversight in front-end processes can result in incorrect patient data entry or missed documentation requirements. Frontline staff may not fully understand payer rules or plan designs.
- **Technology and Integration Shortfalls:** When registration, eligibility, coding, and billing systems aren't fully integrated—or when data isn't updated in real-time—errors go undetected until the claim is denied.
- **Lack of Real-Time Denial Intelligence:** Providers without proactive denial analytics may fail to identify and resolve recurring issues, perpetuating operational inefficiencies across departments.

Over time, these inefficiencies erode margins and strain both financial and clinical resources.

Access related denials make up 62.3% of all denied accounts in Revco's active inventory, accounting for $124M in placements. [3]

MARIA'S CASE

Maria's case illustrates how proper documentation can be the difference between denial and approval. Missteps—such as missing clinical rationale or using incorrect procedural codes —can lead to wrongful denials. Even procedures like breast reconstruction post-mastectomy or bariatric surgery may be denied if incorrectly coded or lacking documentation, despite their clear medical necessity for the patient. These experiences can be financially devastating, emotionally disheartening, and ultimately, erode trust in the healthcare system.

Impact #3: The Patient-Provider Relationship

Continuity of patient care is becoming an increasingly critical concern for providers. While it's well understood that claim denials can take a financial, physical, and emotional toll on patients, the broader impact inevitably circles back to the provider. Even though patients may be restricted by in-network requirements and insurance policies, maintaining their trust and loyalty remains a challenge—especially when denials disrupt their care experience.

EROSION OF TRUST

When a claim is denied—especially after the patient has received care—they often direct their frustration at the provider, not the insurer, even if it was not the provider's fault.

Patients may feel:

- Misled about what was covered
- Angry over unexpected bills
- Confused about who is responsible (provider or payer)

DECREASED LOYALTY

Patients who face claim denials often associate the experience with poor service or disorganization at the provider's office—particularly if communication about benefits or billing was unclear.

This can lead to:

- Negative reviews or survey scores
- Loss of return visits
- Switching to competing providers with perceived better billing support

INCREASED BURDEN

Patients who are undergoing medical distress do not need the increased administrative burden of denied claims. If the provider's office is not seen as a helpful advocate, patients may feel abandoned or unsupported—further damaging the relationship.

And in cases where the provider doesn't bear the burden of filing an appeal, that weight also lands on the patient's shoulders.

Denials don't just cost money. They cost trust, loyalty, and continuity of care, ultimately impacting the provider's bottom line. Addressing these issues requires systemic changes to ensure transparency, fairness, and patient-centered approaches in the healthcare reimbursement process.

Addressing the Root Cause

To mitigate these challenges, providers must strengthen their denial management strategy by:

- Enhancing front-end education and documentation, especially for sensitive behavioral health and emergency cases.
- Standardizing workflows based on an understanding of each payer's processes – lighten this lift by investing in technology and integration.
- Investing in expert-driven appeals processes, including legal and clinical review of ambiguous policy language.
- Tracking denial trends using real-time denial analytics to flag patterns and reduce repeat occurrences.

Ultimately, addressing these operational and financial complexities requires a proactive, multidisciplinary approach to ensure appropriate reimbursement while safeguarding patient care continuity—especially in cases where compassion and compliance must go hand-in-hand.

The Payer Perspective

Balancing Integrity, Cost & Care

Denials in healthcare are often seen by providers as a reflection of profit-driven priorities—after all, many would argue that the largest payers are more focused on margins than medicine. But the rationale behind denials is more complex. From a payer perspective, it can be argued that denials serve to enforce system integrity, plan compliance, and clinical appropriateness. While payers have legitimate concerns—such as preventing overutilization, guarding against fraud and abuse, and ensuring only covered services are reimbursed—these motivations often conflict with provider workflows and, ultimately, patient outcomes.

Cost Containment vs. Integrity Enforcement

It's true that denials reduce payer expenses in the short term. Many payer organizations operate on quarterly and annual performance cycles and denying high-cost services can defer or eliminate significant expenditures. Additionally, payers assume a certain level of member turnover—reducing incentives to approve expensive, long-term treatments that might not benefit them directly if the member changes plans.

However, denials aren't solely about this quarter's profit and loss statement. They play a key role in:

- Preventing overutilization of procedures that may not meet evidence-based standards of care.
- Detecting patterns of abuse, such as chronic over-ordering of diagnostics or services.
- Enforcing benefit design, ensuring that only services covered by a member's plan are paid for.
- Curbing coding abuse, such as upcoding or unbundling, which can result in inflated reimbursements across large provider networks.

DENIALS AREN'T FREE

Administrative handling of appeals, clinical review, and external arbitration can range from $25 per appeal to over $1,000 for independent review. These costs often exceed what it would take to get the claim right the first time.

These guardrails are necessary—but they come at a cost, both operationally and relationally.

The Operational & Legal Risks of Inaccurate Denials

While denials can help manage costs, inaccurate or overly aggressive denial strategies expose payers to costly regulatory, legal, and reputational risks. Improper adjudication can trigger CMS or state-level audits, result in costly settlements, and tarnish the payer's brand with both members and providers. Not to mention navigating increasingly restrictive regulations.

For example, the CMS Prior Authorization Final Rule mandates greater transparency and faster turnaround for prior authorizations by 2026, requiring significant technology investment and operational changes across the payer industry. In the most severe cases, inappropriate denials—particularly those affecting life-saving treatments—can result in legal action, including class-action lawsuits.

56.2% of all denied accounts in Revco's active inventory are related to authorization issues. [3]

The impacts of the CMS Prior Authorization Rule will go beyond payers, creating confusion and even more administrative denials while payers and providers alike learn to navigate.

The Cost of Good Relationships

Both payers and providers approach their business models with the patients' best interests in mind. Despite that, from the patient's perspective, a denied claim often feels personal as a result of delayed or denied care—even if it was justified from a utilization management standpoint. For payers, this leads to:

- Negative member sentiment, impacting Net Promoter Scores (NPS)
- Grievances and complaints
- Potential churn as members look for alternative plans or coverage

One area where this tension becomes particularly acute is with medical necessity denials. These are among the most emotionally and financially difficult for patients to navigate. The core reason behind such a denial from the payer's perspective is to ensure that care is clinically effective and appropriate for the symptoms and diagnosis, and in line with current standards of care. The considerations are aimed at reducing overutilization, especially when there are less costly or intensive alternatives available.

Medical necessity denials make up 30.9% of the cost of all claims in Revco's active inventory, accounting for more than $65M. [3]

These situations can quickly escalate into high-profile complaints, social media backlash, and even litigation. In contrast, if a payer is seen as flexible, especially when supported by strong provider documentation or precedent from programs like Medicare, it can boost member loyalty and public perception. When they don't, the reputational cost can far outweigh the financial savings of the initial denial.

Repeated denials can also strain payer-provider relationships, especially in value-based care arrangements. When providers feel that payers routinely deny necessary services, they become less inclined to engage in innovative contracts or expand in-network partnerships.

MARK'S CASE

The impacts of a medical necessity assessment go well beyond bad PR. It can be life-altering for patients like Mark who are facing serious or rare conditions and turn to experimental treatments in hopes of finding relief or prolonging life. When those treatments are denied under the classification of "medical necessity," the result feels deeply personal. It signals to the patient that their plan doesn't support their most viable option—sometimes their only option—and feels more like a denial of hope.

Shared Frustration, **Shared Opportunity**

Despite the often-adversarial nature of denials management, both payers and providers are ultimately aligned in one key objective: delivering quality, cost-effective care to their patients and members. The frustration surrounding denials is real on both sides—but within that shared struggle lies the opportunity to collaborate more meaningfully.

	PROVIDER IMPACT	PAYER IMPACT	SHARED OPPORTUNITY
FINANCE	Revenue loss, increased cost to collect, aged A/R, low net collection rate	Administrative cost of appeals, enforcing plan design, curbing overutilization and upcoding	Align on pre-authorization and documentation requirements; invest in first-pass claim accuracy
OPERATIONS	Workflow breakdowns, technology gaps, staff rework, delays in reimbursement	Regulatory and legal risks, strained UM and customer service teams, provider friction and network risk	Streamline front-end processes with shared data tools; enhance real-time denial intelligence
REPUTATION	Eroded patient trust, poor reviews, patient attrition, perceived disorganization	Negative NPS, complaints, social media backlash, member churn	Promote collaborative appeals process; support transparency and communication between all parties

90,000 Possible Points of Failure

One of the most pressing barriers to efficient denials resolution is the lack of standardization across the healthcare revenue cycle ecosystem. With over 90,000 unique billing and clinical codes in use—spanning CPT (and its modifiers), ICD, DRG, HCPCS, and Revenue codes—the sheer volume of data introduces countless points of failure. When layered with the unique and often inconsistent requirements of individual payers, financial classes, and service lines, it's easy to understand why denials occur. In fact, it's almost surprising that overall denial rates aren't higher, given how complex and fragmented the system is.

One way healthcare organizations can navigate this complexity is by partnering with an insurance revenue recovery partner that specializes in understanding and adapting to the ever-changing, often contradictory requirements set by payers. By leveraging their deep expertise, scalable technology, and payer-specific workflows, they help providers recover revenue that might otherwise be lost in the noise of nonstandard processes. This added layer of support not only accelerates resolution times but also strengthens the provider's ability to stay compliant and financially resilient in a highly fragmented landscape.

Three Touchpoints for Improvement

This issue isn't just technical—it's also relational. Communication remains a critical, often underleveraged tool in the fight against preventable denials. While most facilities have payer representatives they work with, these interactions typically happen after a claim has already been denied. This reactive model contributes to the cycle of administrative waste and delayed reimbursement.

A more proactive approach requires providers and payers to engage at three critical touchpoints:

- Before care is rendered: Collaboration around eligibility checks and prior authorizations can eliminate two of the most common sources of denials right at the start.
- During care delivery: Real-time communication regarding changes in treatment plans can preempt medical necessity disputes and avoid denials related to level of care or length of stay.
- After care is delivered: Post-service coordination on coding, documentation, and billing accuracy can resolve many of the downstream issues that delay or prevent payment.

Establishing a formal payer communication program can build consistency and a professional relationship beyond individual claim disputes. By using denial data to drive these conversations, it is possible to shift the conversation from anecdotal complaints and appeals to actionable insights that actually prevent denials.

Denial insights and payer feedback can also be used to educate internal teams. By leveraging these points of communication into short trainings, tip sheets, or to build out internal payer repositories you can keep intake, coding, and clinical teams in sync with evolving payer behavior, improve accuracy, and reduce repeated errors.

The Final Appeal

Ultimately, denials should not be viewed as an inevitable part of the revenue cycle, but as a signal for where improvement is needed. The goal isn't just fewer denials—it's fewer unnecessary denials, better patient outcomes, and a more sustainable system for all stakeholders.

REVCO SOLUTIONS

LARGE NORTHEASTERN NON-PROFIT HEALTH SYSTEM RECOVERS LOST CASH, IDENTIFIES REVENUE LEAK WITH REVCO [3]

36.05%

AVG. RECOVERY RATE

$54.4M

IN LOST REVENUE RECOVERED

One of the country's leading integrated health networks has partnered with Revco Solutions since 2022. Our team reworks denied claims inventory 60 days after the system has written it off. In just three years we have **helped the system recover $54.4M** in lost revenue.

But equally as impactful – and underscoring the importance of taking preventative measures – is the $21.4M in unrecoverable revenue lost to avoidable authorization, billing, and other technical denials in that same time. Since Revco's real-time reporting and analytics identified the leak, we have **recovered $13.3M in preventable write offs.**

ABOUT REVCO

Revco Solutions is a trusted leader in healthcare revenue cycle management (RCM), specializing in end-to-end accounts receivable recovery for thousands of physician practices, hospitals, and health systems across the country. We offer scalable solutions designed to reduce denials, improve cash flow, lower bad debt, and enhance the patient financial experience. Revco is HITRUST r2 and SOC II certified, our operations are backed by an experienced U.S.-based workforce, and our dedicated compliance team ensures every engagement meets the highest standards of regulatory integrity. But at the core of our business is a commitment to serving each other and our clients. By combining technology, talent, and a culture of service, Revco Solutions delivers measurable results that support the long-term financial well-being of our healthcare clients and the communities they serve. To learn more visit RevcoSolutions.com.

REVCOSOLUTIONS.COM
MAIL@REVCOSOLUTIONS.COM

2700 MERIDIAN PKWY
DURHAM, NC 27713

REVCO SOLUTIONS

RevcoSolutions.com