

Closing the Gap

Revenue Integrity as the Key to Denials Management
Iowa Hospital Association, October 2026



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Presenters



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Session Agenda

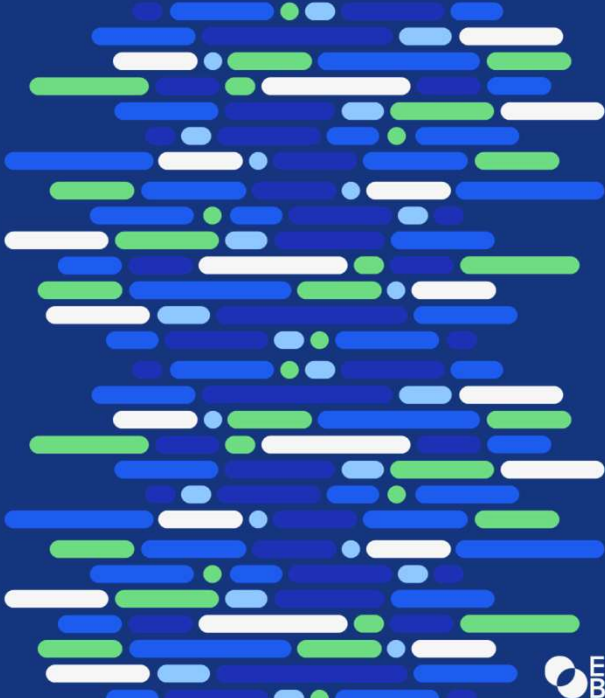
- Explore how denial data becomes actionable intelligence and recoverable revenue.
- Recognize leading practices for denial identification and prevention.
- Implement an effective denials prevention and management program
- Connect revenue integrity to the overall health of the revenue cycle.



Every denial tells a story. Revenue integrity helps the organization identify and address the root cause before revenue is lost.



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Setting the Stage

Why denials are a revenue integrity issue — not just an A/R issue



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THE LANDSCAPE

Denials are Preventable — and Recoverable



Denials are not an unavoidable cost of doing business. The industry data shows most are preventable at the source, and the majority of those that occur can still be overturned.

~90% Of rejected claims Are considered preventable	>70% Of denied claims Can be overturned on appeal	\$25–\$117 Cost to rework Administrative cost per denied claim	9–10% First-pass denial rate Industry average, creeping to 10–12%
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What denials mean for the organization: revenue leakage that becomes permanent write-offs, rework loops that consume limited staff capacity, and clinician time diverted from patient care to appeals.

Today's challenge is not recovering more denials. It is preventing them from occurring at all.



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SETTING THE STAGE

The Cost of Denials

Financial implications

- **Revenue loss:**
 - Direct impact on the organization's revenue stream.
- **Increased operational costs:**
 - Additional resources required for rework and appeals.
- **Impact on patient care:**
 - Fewer resources available for direct patient care.

Why proactive management matters

- **Mitigating financial risk:**
 - Proactive measures reduce the risks associated with denials.
- **Optimizing revenue streams:**
 - Focus on prevention and resolution, not repeated rework.
- **Protecting staff capacity:**
 - Every denial costs multiple touches across departments.

Bottom line: denials are not only a cash issue — they are a workload, morale, and compliance issue.



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THE SHIFT

From Reactive Rework to Proactive Prevention

REACTIVE · TODAY

- Denials are worked one by one, as they appear.
- Categorization and tracking are inconsistent.
- Appeals are reinvented every time.
- Root causes persist and denials recur.
- Month-end surprises drive the conversation.

PROACTIVE · TARGET

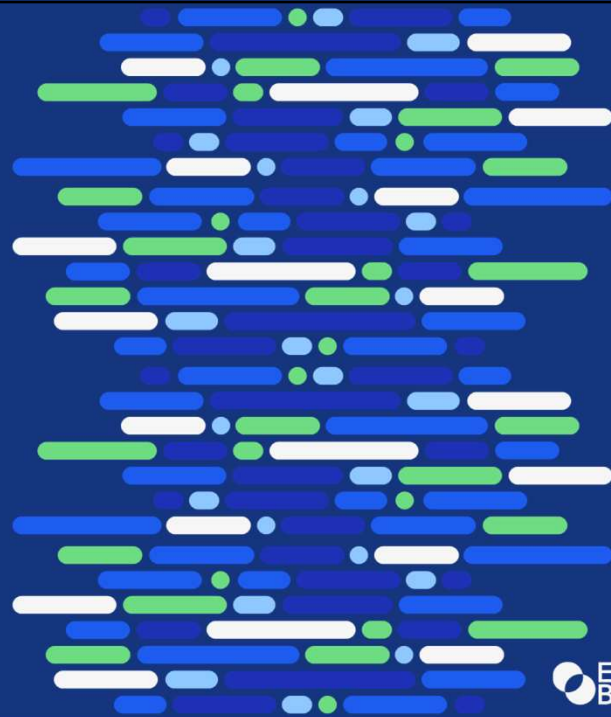
- Preventive controls and data-driven prioritization.
- Clear ownership by denial category.
- Standard workflows and appeal templates.
- Closed-loop education and process correction.
- Real-time dashboards steer the month.

The goal: not simply winning more appeals — fewer denials entering the system at all.



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Transforming Denials into Dollars

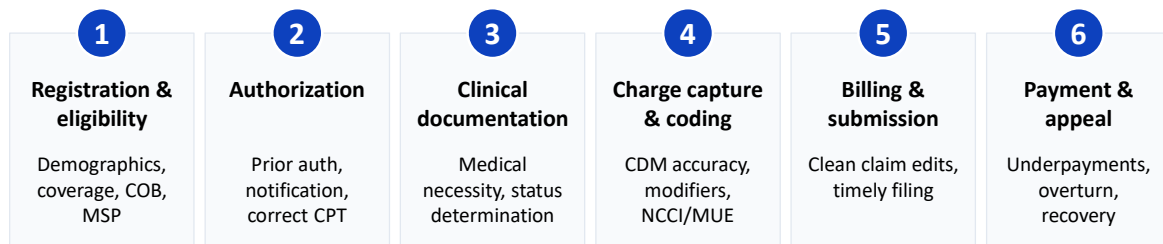


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WHERE DENIALS ORIGINATE

The Denial Lifecycle

A denial is rarely a billing problem. It is a process signal pointing back to an earlier step in the revenue cycle.



Bottom line: denials become operational intelligence when data is translated into ownership, action, and measurable results.



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WHERE THE REVENUE LEAKS

High-impact Denial Categories

Six categories account for the majority of preventable denial volume and dollars in most organizations.

Eligibility & coverage

Inactive coverage, wrong plan, demographic errors at registration.

Prior authorization

Service scheduled without auth, or the wrong CPT authorized.

Medical necessity & status

Documentation or payer criteria do not support the service billed.

Coding edits

NCCI/MUE edits, missing or mismatched modifiers, diagnosis mismatch.

Timely filing

Claims held too long due to rework, handoffs, or unresolved edits.

COB / MSP

Other insurance not captured or sequenced correctly upfront.

Common payer reason codes: 16/140 (patient information) · 197/198 and CO-15 (authorization) · 50 and CO-50 (medical necessity) · 96 (non-covered) · 29 (timely filing) · 22 and CO-27 (COB/coverage) · CO-4 and CO-11 (modifier/diagnosis coding).



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FOCUS WHERE THE RETURN IS GREATEST

Prioritizing the Opportunity

Preventability

Could a process change have stopped this denial from ever occurring?

Value

What dollars are at risk, written off, or recoverable?

Volume

How frequently does this denial repeat across payers and departments?

Control

Is the root cause within our process, or driven by payer policy?

The “Top 5 Denials” scorecard

- Refresh monthly; keep it to one page.
- Rank by dollars at risk and volume.
- Name an owner for each category.
- Track the corrective action to closure.
- Report progress to leadership.

A Pareto approach works: the top 20% of denial categories typically drive the majority of the impact.

Reality check: we cannot work every denial equally — prioritization turns limited capacity into measurable progress.



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STRATEGY, DATA, AND PROOF

Turning Denials Into Dollars

Strategy

- Develop robust appeal strategies by denial type.
- Implement targeted, timely follow-up procedures.
- Use negotiation and payer escalation effectively.
- Track underpayments, not just denials.

Data

- Analyze patterns and trends by payer and department.
- Make data-driven prioritization decisions.
- Use predictive modeling to anticipate denial risk.
- Build dashboards that surface issues earlier.

Proof

- Document real cases where denials became revenue.
- Quantify the financial gain from each fix.
- Share wins to build organizational momentum.
- Re-audit to confirm the fix held.

Recovery matters. Prevention matters more. The strongest programs deliver both.



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APPLYING THE MODEL

From Trend to Corrective Action

01

The trend

A recurring high-dollar denial category appears month after month for the same service line.



02

The root cause

Root cause analysis shows the issue began upstream — in scheduling, authorization, or charge setup.



03

The intervention

Targeted education, workflow change, and a system or charge correction, with a named owner.



04

The outcome

Denied claims are recovered, and the same denial stops entering the system going forward.

Discussion prompt: which denial category creates the greatest challenge in your organization — and where does it originate?



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Identification and Prevention Best Practices



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BEST PRACTICE 01

Build a Consistent Denial Taxonomy

- Build a consistent denial category list — 10 to 15 categories is usually enough.
- Map payer reason codes to internal categories so reporting is repeatable.
- Require a category selection for every denial worked.
- Distinguish rejections, denials, and underpayments — each requires a different fix.

CAPTURE FOR EVERY DENIAL

- Denial date and payer.
- Reason code and internal category.
- Root cause.
- Assigned owner.
- Resolution and outcome.
- Dollars at risk.

Test it: if two staff members would categorize the same denial differently today, the data cannot yet drive decisions.



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BEST PRACTICE 02

Ownership, Front-end Controls, and Documentation

Cross-functional ownership

- Define swim lanes by denial category.
- Establish escalation paths and decision rights.
- Reduce hand-offs between teams.
- Standard documentation notes for every account.

Front-end controls

- Eligibility verification standards — timing and proof.
- Benefit validation for high-risk services.
- Authorization workflows with escalation.
- Accurate demographics, payer order, and COB.

Documentation & coding alignment

- Feedback loop between denials, CDI, coding, and providers.
- Documentation tip sheets for common procedures.
- Payer policy library for medical necessity.
- Monitor inpatient vs. outpatient status denials.

In smaller organizations the goal is clarity, not complexity — simple checklists and minimum documentation standards go a long way.



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BEST PRACTICE 03

Data, Technology, and Root Cause Review

Surface trends earlier

- Automated claim edits and scrubbing before submission.
- Denial work queues routed by category and owner.
- Dashboards trending denials by payer, department, and dollars.
- Analytics to assess whether interventions actually worked.
- Predictive modeling to flag at-risk claims before billing.

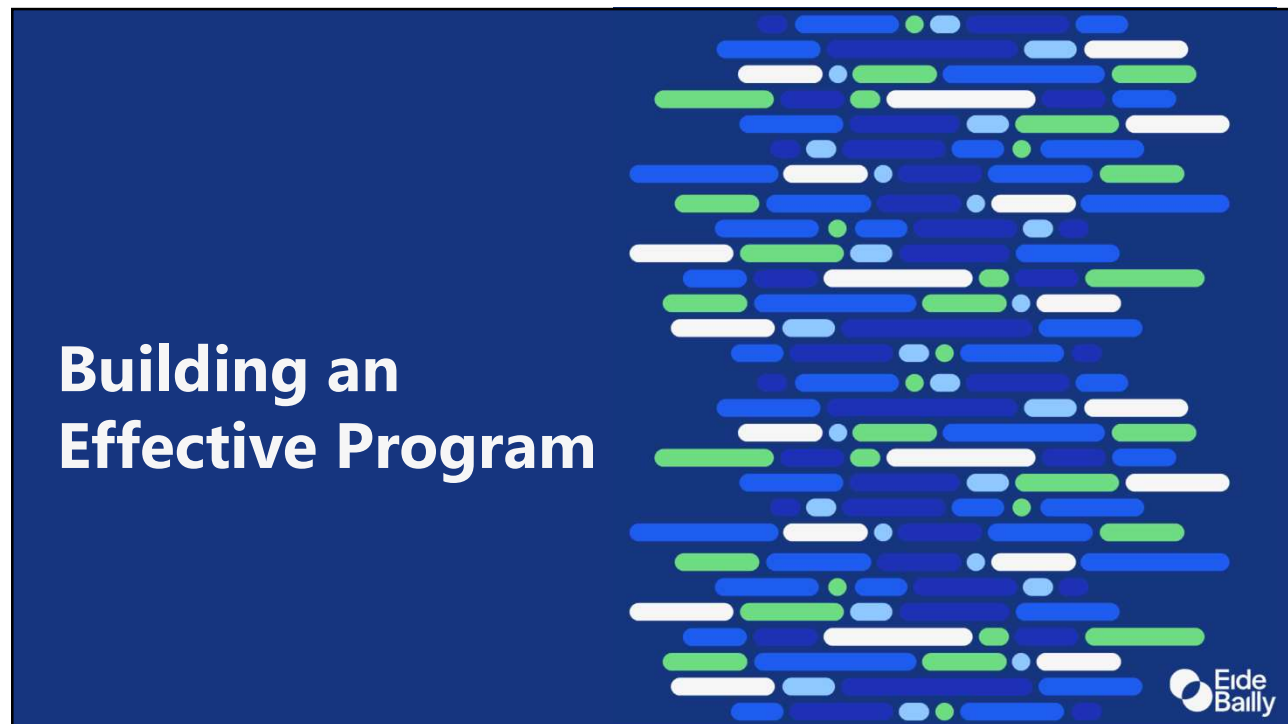
Root cause analysis that sticks

- Move from “fix the claim” to “fix the process”.
- Use a simple method — 5 Whys (people, process, technology, payer, policy).
- Document the corrective action: what changed, who was trained, when it is re-audited.
- Hold a recurring review that separates symptoms from true causes.

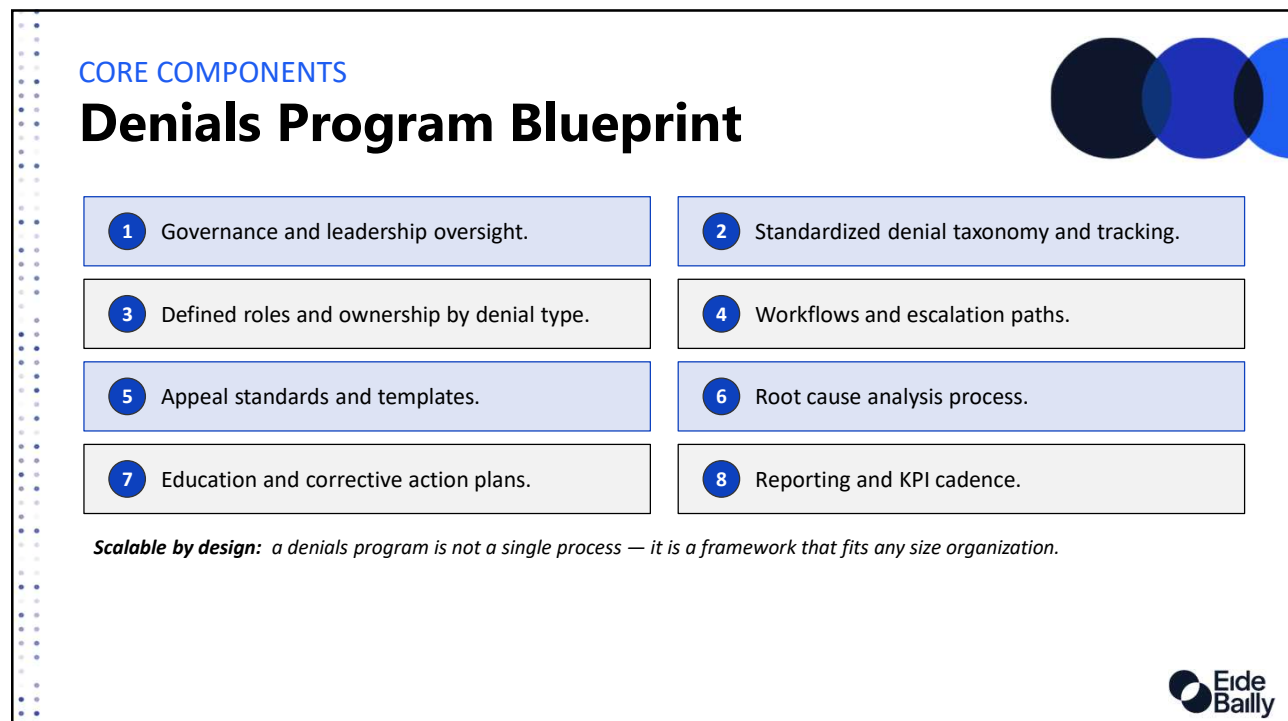
In short: prevention depends on coordinated people, standardized processes, reliable data, and enabling technology.



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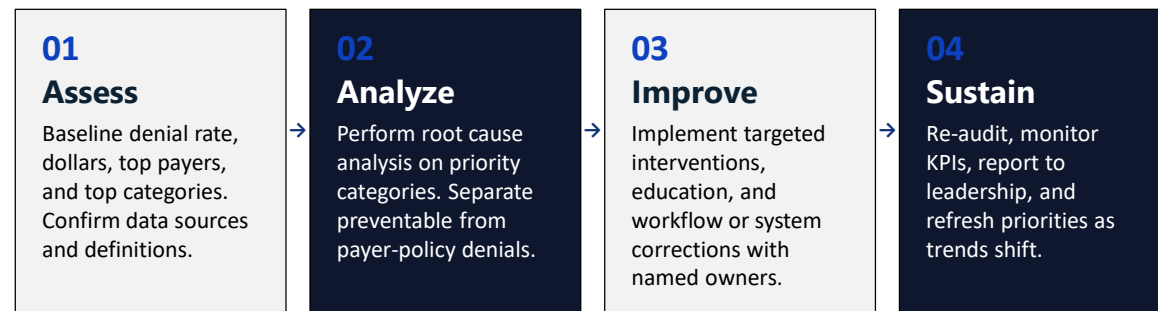


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THE REPEATABLE CYCLE

Assess, Analyze, Improve, Sustain

Each pass through the cycle narrows the gap between where denials occur and where they are prevented.



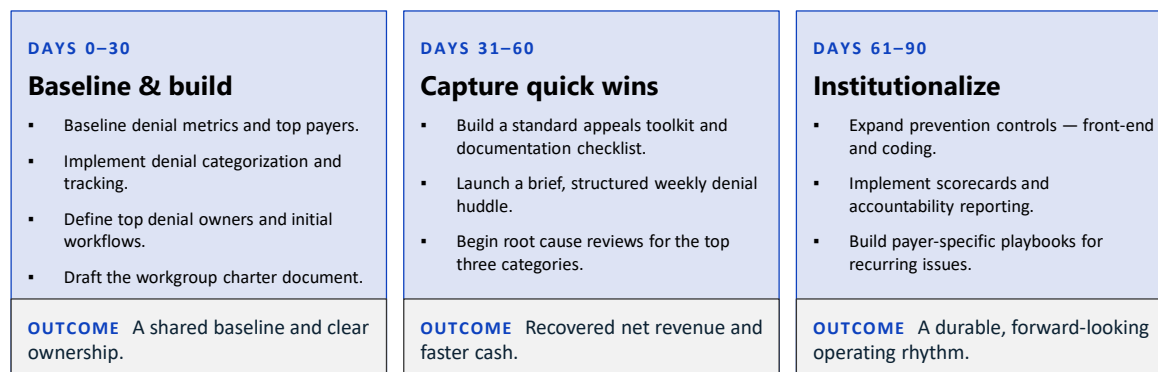
Sustainability: a durable program moves continuously through all four stages rather than stopping at recovery.



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PUTTING IT TO WORK

A 90-day Path to Proactive Denials Management



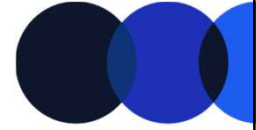
Momentum matters more than perfection — small, structured steps build sustainable improvement.



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STRUCTURE THAT CREATES ACCOUNTABILITY

The Denials Workgroup Charter



Mission and purpose

Proactively identify, analyze, and reduce preventable denials; improve first-pass clean claim rates and support financial sustainability.

Scope

Denial trend monitoring, root cause analysis, corrective action plans, workflow and policy updates, staff communication, and leadership reporting.

Team members

Core: executive sponsor, revenue cycle leadership, coding representative, facilitator. Ad hoc: patient access, prior auth, billing, clinic and ancillary leaders.

Cadence

Defined meeting frequency, duration, and standing agenda — with preparation and follow-up expectations.

Data sources

Clearinghouse, EMR, payer remittances, coding audit results, registration quality reports.

Goals and deliverables

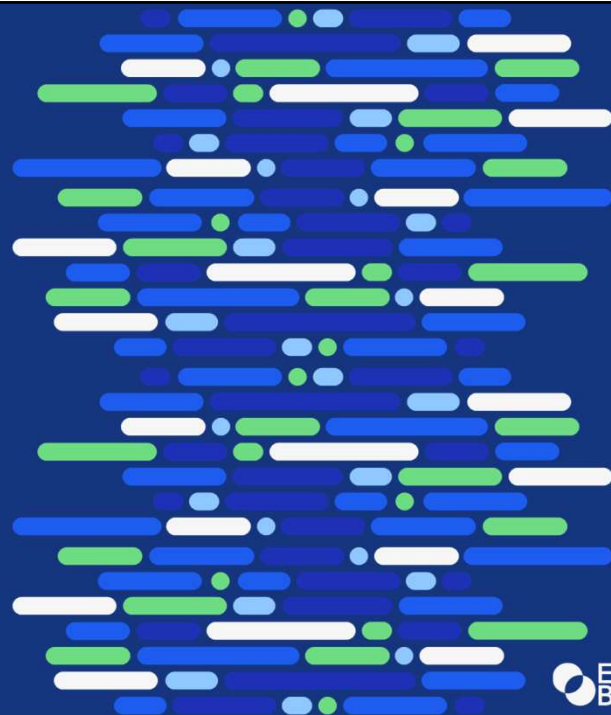
Annual and quarterly targets, denial trend dashboard, action plans, updated SOPs, payer issue logs, and staff education.

Workgroup responsibilities: identify denial trends, note process improvement opportunities, locate root causes, recommend tasks to prevent recurrence, and determine how improvements will be monitored and sustained.



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The Revenue Integrity Impact



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BRINGING IT ALL TOGETHER

What Revenue Integrity Delivers

Revenue integrity is a strategic discipline that aligns people, processes, data, and technology to strengthen the full revenue cycle.

01 Financial performance

Reduced revenue leakage, improved net collections, and more predictable cash flow.

02 Operational efficiency

Lower administrative burden, fewer touches, and less avoidable rework.

03 Patient experience

More accurate front-end and billing processes mean fewer surprises for patients.

04 Compliance confidence

Fewer repeat issues reduce payer scrutiny, pre-pay review, and takeback exposure.



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THE DASHBOARD

The Metrics That Drive Decisions

A single denials scorecard aligns revenue cycle, coding, and clinical leaders around the same numbers — refreshed continuously, not at month-end.

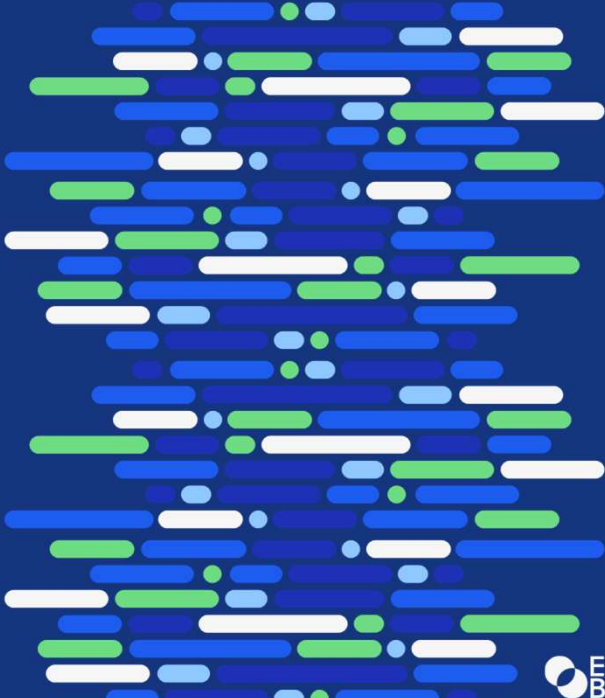
Core denial metrics	Resolution metrics	Front-end metrics	Revenue integrity metrics
- Initial denial rate. - Preventable denial rate. - Denial dollars and % appealed.	- Appeal overturn rate. - Denial aging — days to resolve. - Final denial write-offs.	- Clean claim rate / first-pass yield. - Eligibility error rate. - Auth-related denial rate.	- Charge capture accuracy. - Timely filing denial rate. - Net collections and revenue recovered.

Denial rate = $\text{denied claims} \div \text{claims submitted} \times 100$ · Overturn rate = $\text{denials overturned} \div \text{total denials} \times 100$ · Payment variance = $\text{actual} \div \text{expected payment} \times 100$

The goal is not perfect data. It is consistent trending that drives action rather than reporting.



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Q&A and Key Takeaways

What to do first when you return to your organization.



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KEY TAKEAWAYS

Four Decisions that Close the Gap

01 Prevent before you appeal

Prevention is more effective — and far less costly — than repeated rework.

03 Own it by category

Accountability by denial category is what makes improvement sustainable.

02 Build the structure

Revenue integrity creates the framework for identifying and eliminating root causes.

04 Decide with data

Analytics, ownership, and continuous improvement turn lost revenue into performance.

Your first 30 days: baseline the metrics, name your top five denial categories and payers, schedule the huddle, and launch corrective action tracking.



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"Revenue integrity is not simply a department or function. It is a shared organizational discipline that closes gaps, prevents avoidable denials, and supports the long-term health of the revenue cycle."



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 An abstract graphic at the top of the slide showing several clusters of dots connected by thin lines. The dots are colored blue, green, and black, and the lines are thin and grey, creating a network-like structure.

Questions?

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 The Eide Bailly logo, featuring a stylized circular icon to the left of the company name "Eide Bailly" in a sans-serif font.

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