The Optum 2024 Revenue Cycle Denials Index

Review of national medical claim denial trends, with strategies to help providers decrease their denial rate

Optum

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Executive Summary: Denial rates remain staggeringly high in 2023

12%

average denial rate in 2023 compared with a similar rate in 2022, up from 10% in 2020 and 9% in 2016

16%

denial rate in the Pacific region, 7% of which is the result of registration and eligibility denials

44%

of denials were front-end denials

24%

of denials were caused by registration and eligibility, an increase from 2022

84%

of denials are potentially avoidable, while 22% of these are not recoverable

Denials Index research methodology

The Optum 2024 Revenue Cycle Denials Index is based on an internal analysis of approximately 124 million hospital claim remits valued at $500 billion in total charges across more than 1,400 U.S. hospitals.*

Optum revenue cycle analysts used primary institutional inpatient and outpatient claims submitted by a range of small, medium and large facilities. These claims and associated payment files were delivered through Optum's clearing house and revenue cycle offerings from January through December 2023..

The 2023 data was then compared and trended against data reported in the 2022, 2020 and 2017 Denials Index reports.

* All data was acquired and used in accordance with contractual requirements and applicable laws.

Data drives identification, prioritization and strategy efforts

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A data-driven approach is the key to implementing denial prevention strategies. Data and analytics allow for the identification of denial hot-spots, and proper root-cause analysis facilitates the identification of preventable denials for prioritization. Leveraging that data is equally important in order to effectively monitor denial prevention strategies that have been put into place."

Erica Zendel

Senior Product Manager, Revenue Cycle Analytics, Optum

National denial rates remain around 12%

The average denial rate is up 3% since 2016.

National denial trends

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9%	10%	11%	12%	12%
2016	2020	2021 (2nd half)	2022 (1st half)	2023
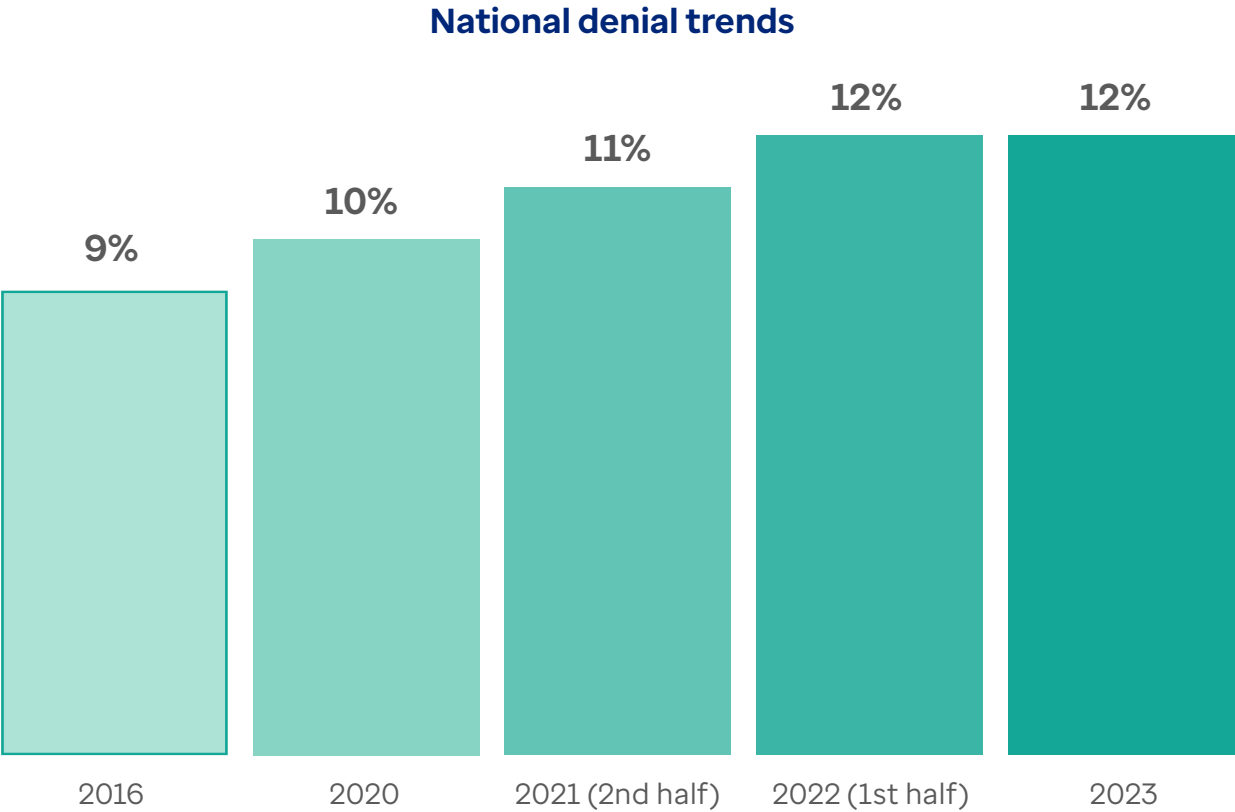
Regional breakdown of denial rates categories

The Mid-Atlantic region tops the charts in denials across authorization and precertification and medical documentation requested

2023 authorization and precertification denial rates by region
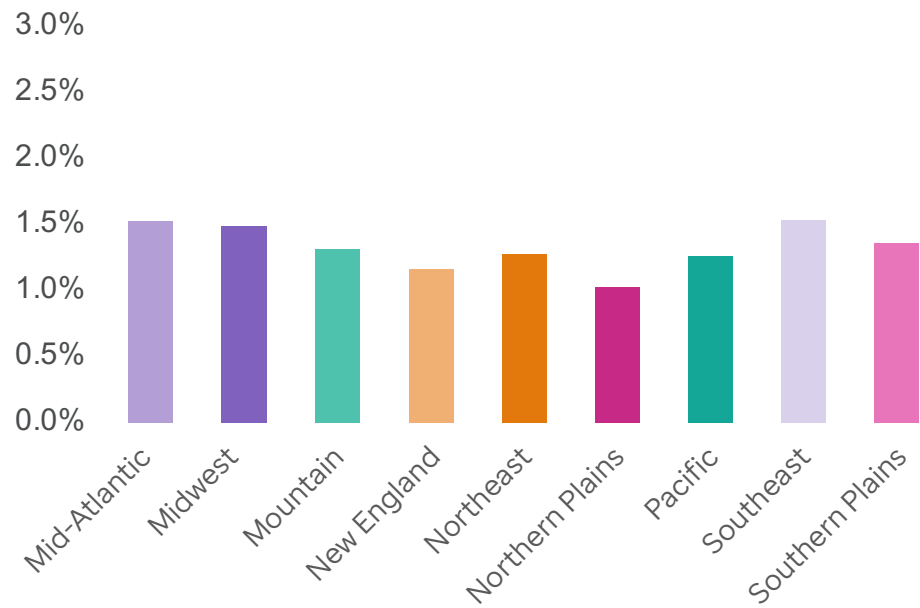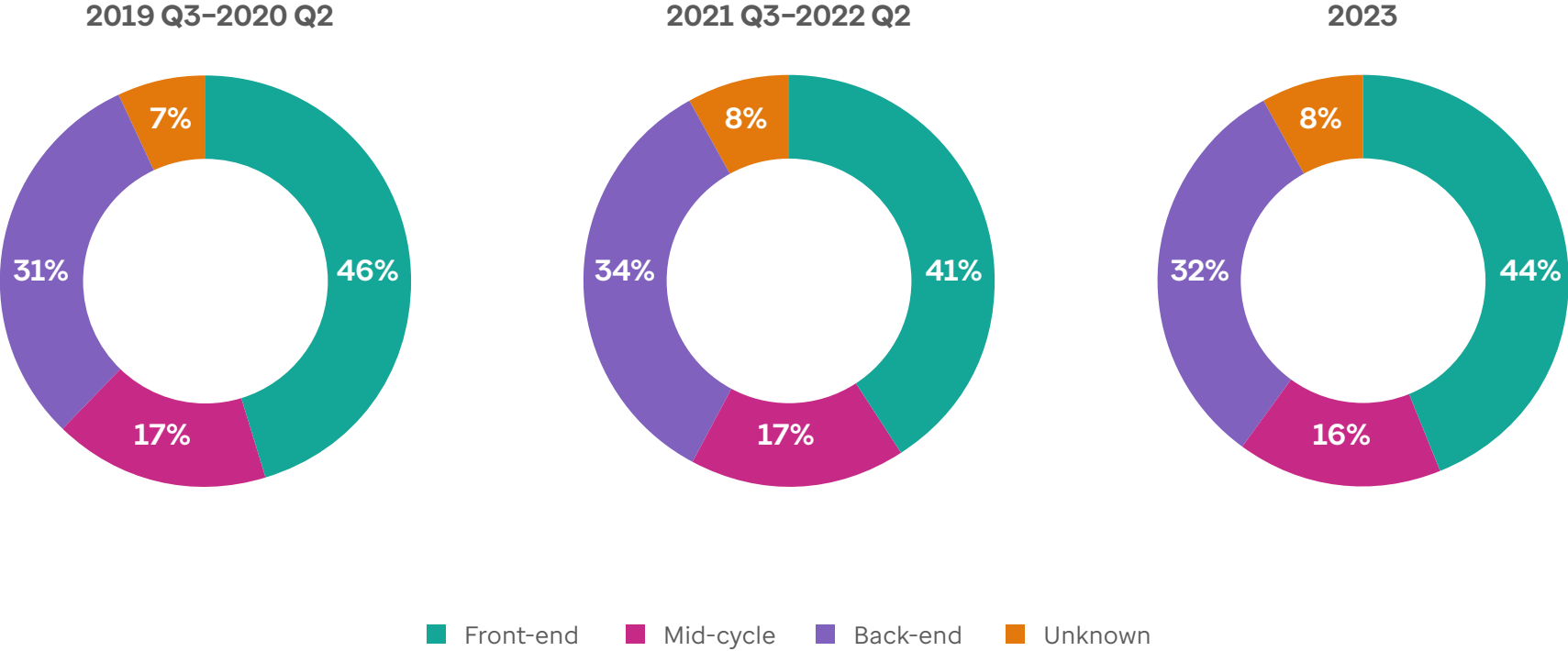
2023 medical documentation requested denial rates by region
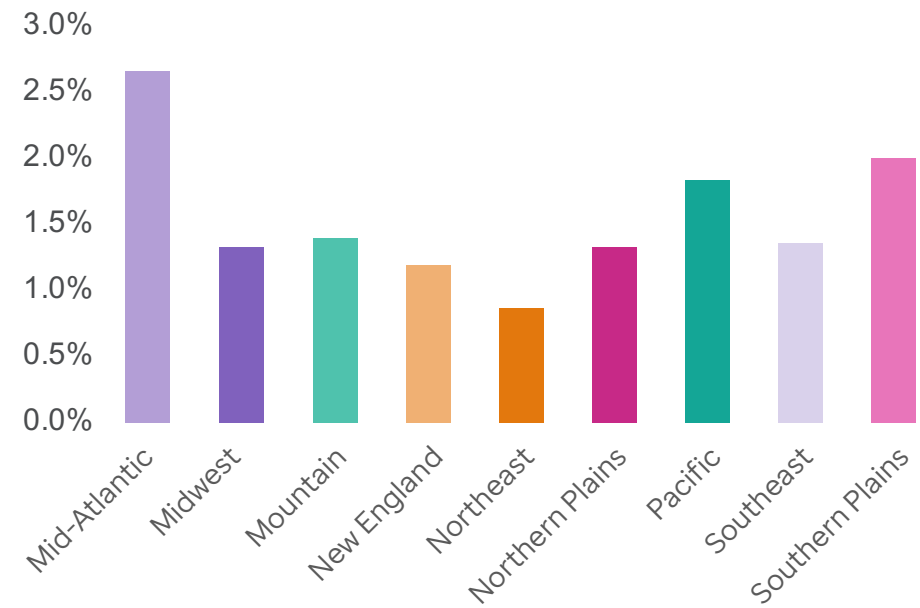
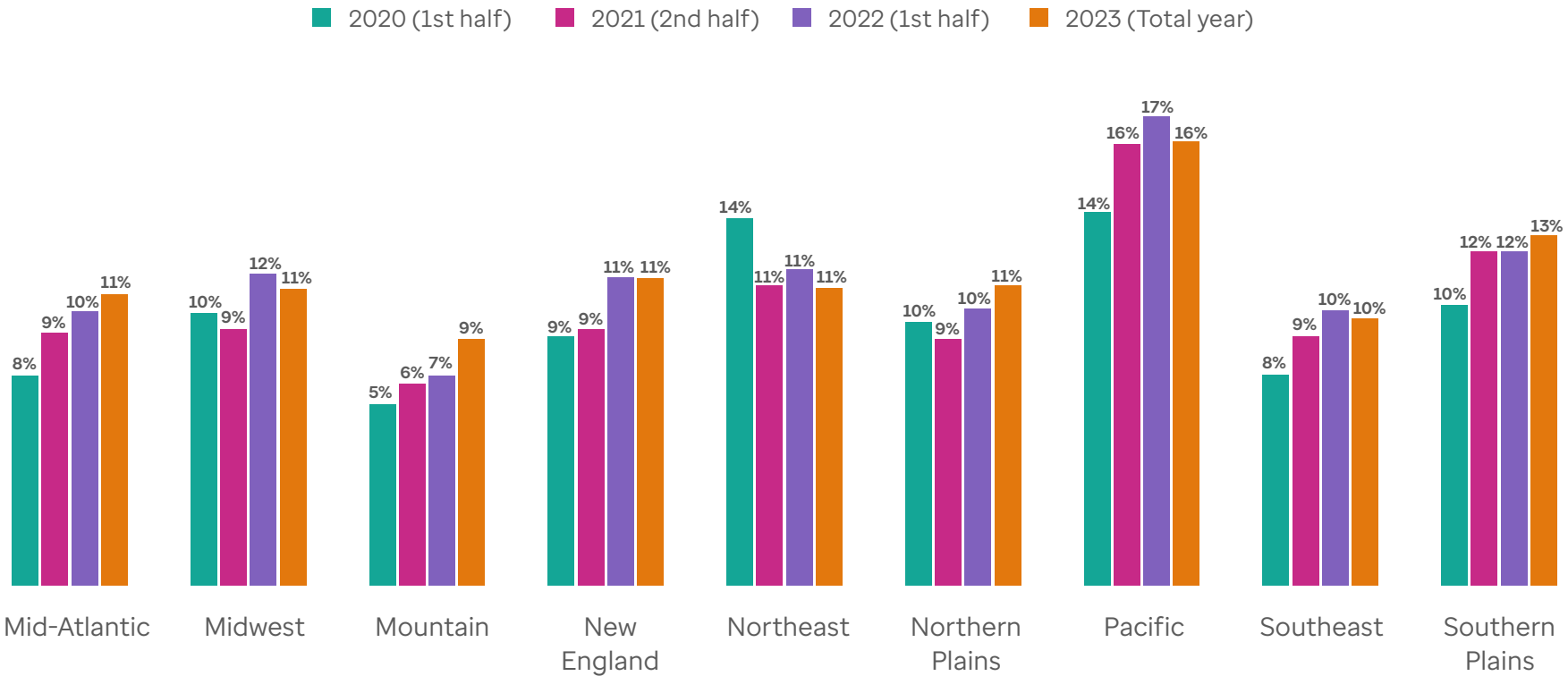# Denials by revenue cycle stage spanning 4 years

Year over year, nearly half of all denials are caused by front-end revenue cycle issues

2019 Q3–2020 Q2

- 7%
- 31%
- 17%
- 46%

2021 Q3–2022 Q2

- 8%
- 34%
- 17%
- 41%

2023

- 8%
- 32%
- 16%
- 44%

■ Front-end   ■ Mid-cycle   ■ Back-end   ■ Unknown

Denial rates ebb and flow across the country

Majority of regions continue to see upward trend in denials.

■ 2020 (1st half)   ■ 2021 (2nd half)   ■ 2022 (1st half)   ■ 2023 (Total year)

Region	2020 (1st half)	2021 (2nd half)	2022 (1st half)	2023 (Total year)
Mid-Atlantic	8%	9%	10%	11%
Midwest	10%	9%	12%	11%
Mountain	5%	6%	7%	9%
New England	9%	9%	11%	11%
Northeast	14%	11%	11%	11%
Northern Plains	10%	9%	10%	11%
Pacific	14%	16%	17%	16%
Southeast	8%	9%	10%	10%
Southern Plains	10%	12%	12%	13%

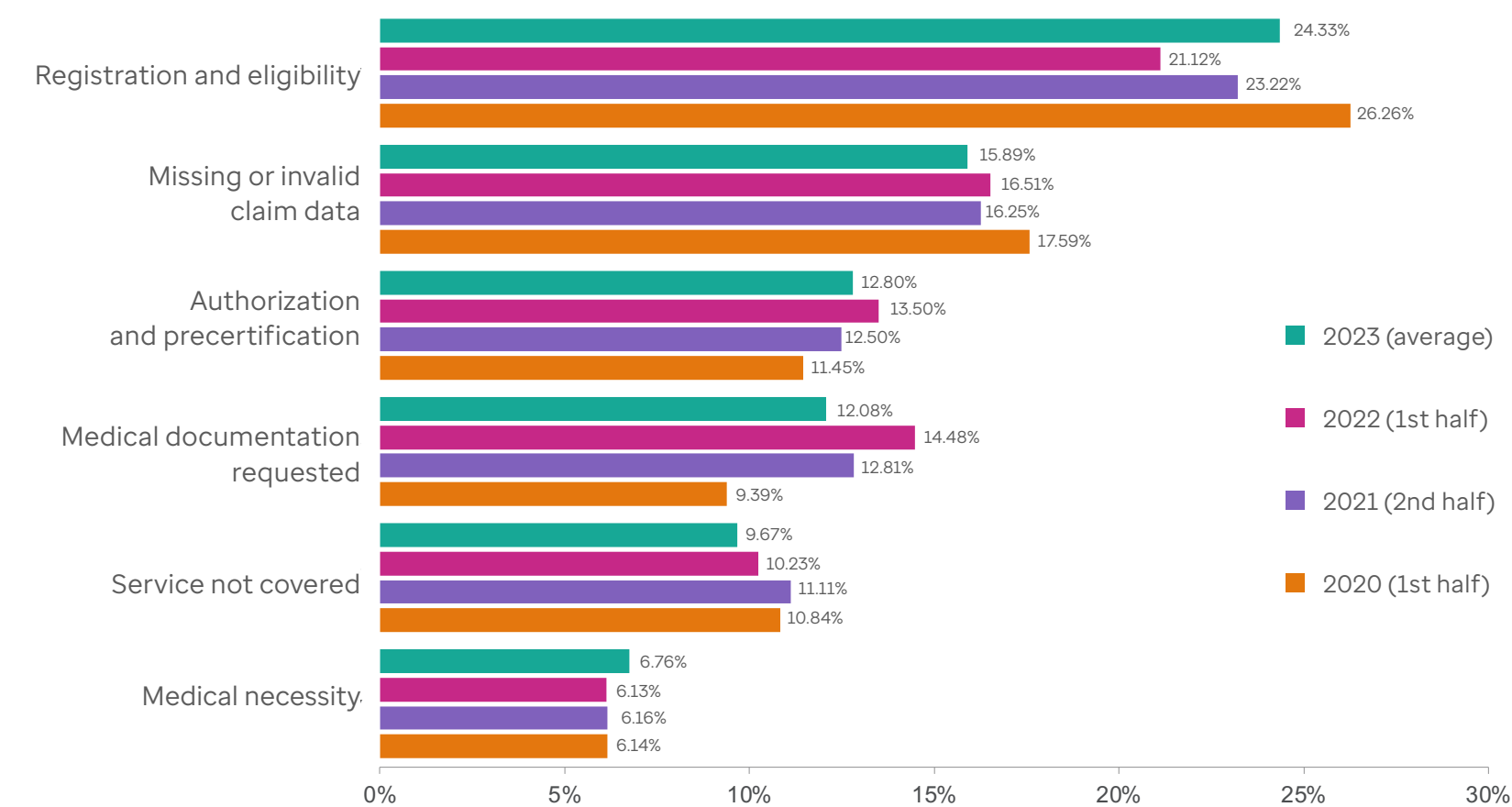*Percentages have been rounded

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Breakdown of denial rates by region in 2023

The highest denial rates nationally are in the Pacific and the Southern Plains.
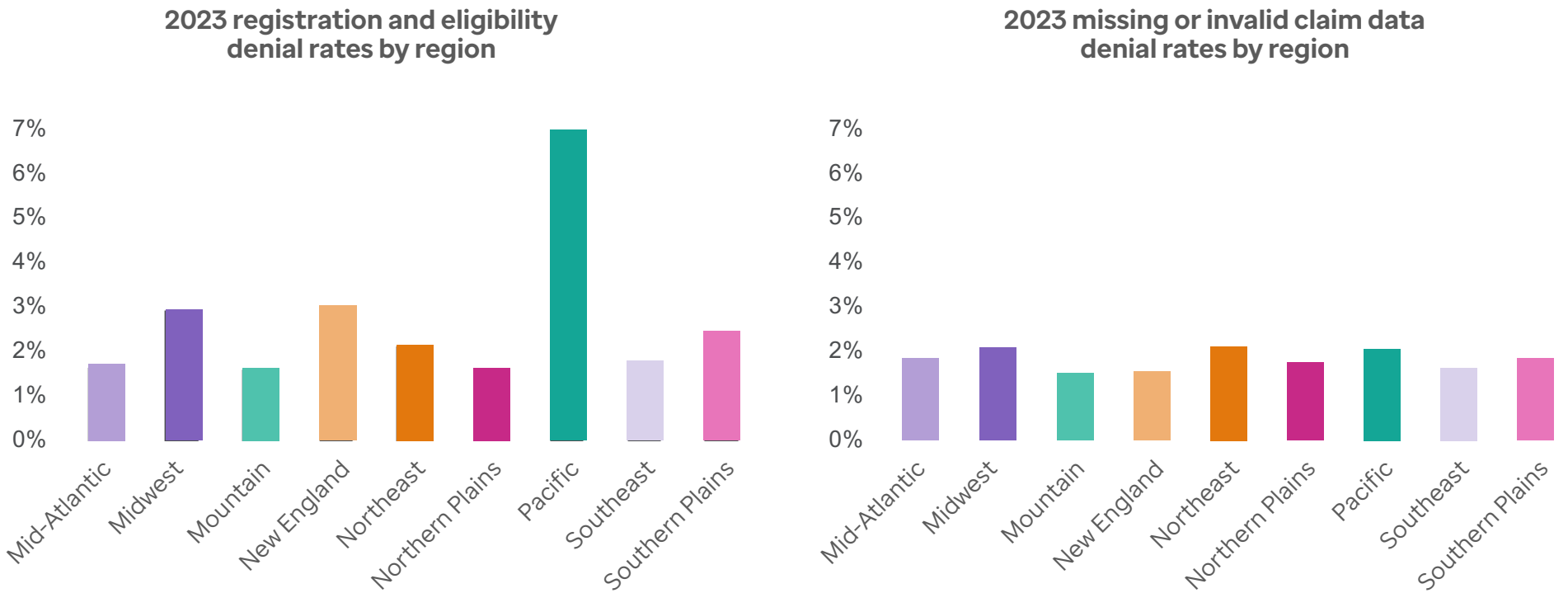
Region	Rate
Pacific	16.48%
Mountain	9.16%
Northern Plains	11.13%
Southern Plains	12.53%
Midwest	11.02%
Mid-Atlantic	10.80%
Southeast	9.90%
Northeast,	11.05%
New England	11.40%
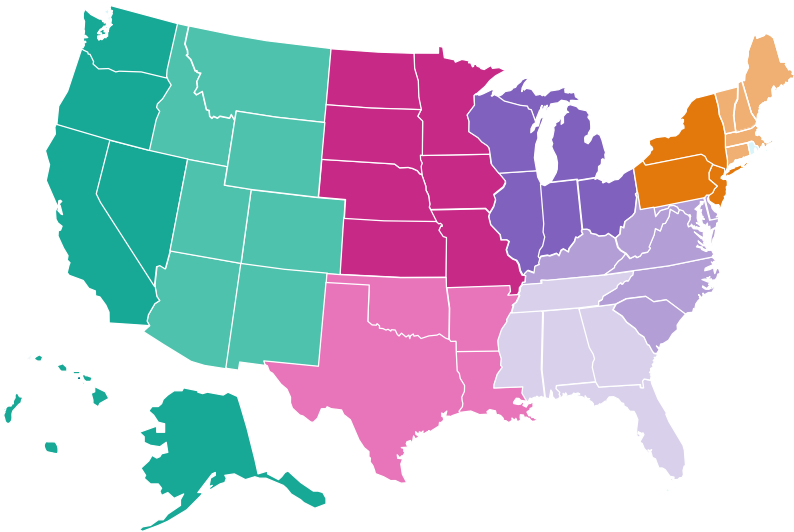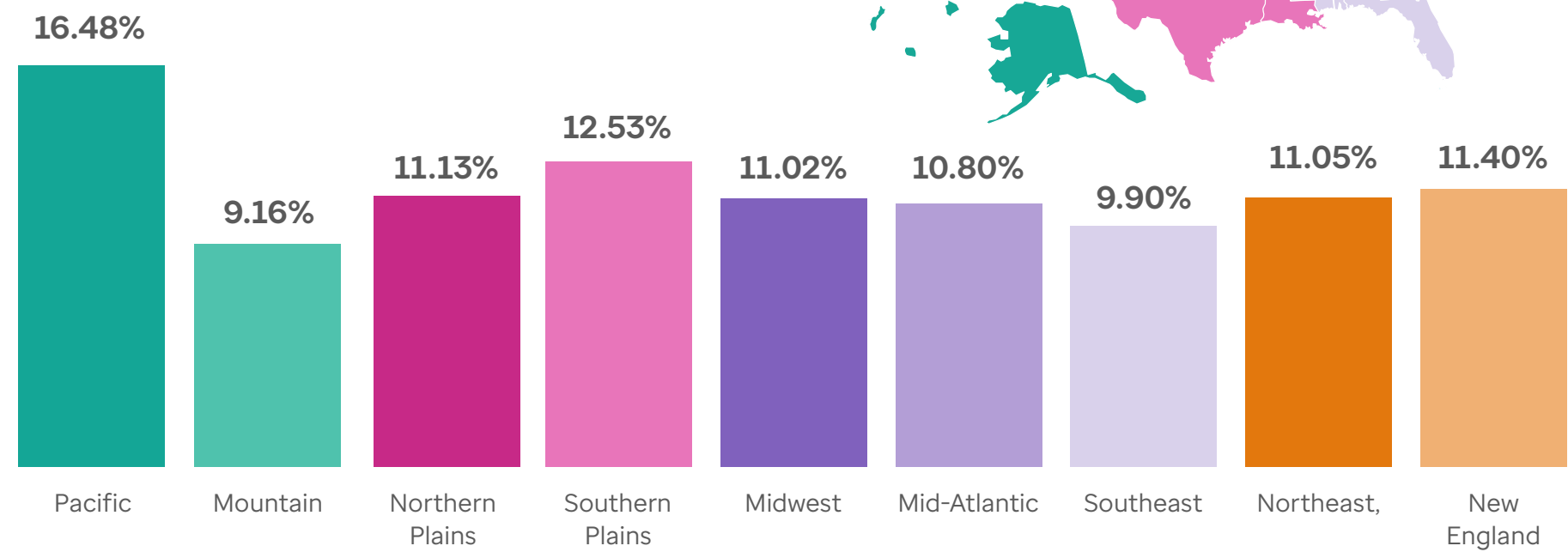
Registration and eligibility remain the top cause of denials

Category	2023 (average)	2022 (1st half)	2021 (2nd half)	2020 (1st half)
Registration and eligibility	24.33%	21.12%	23.22%	26.26%
Missing or invalid claim data	15.89%	16.51%	16.25%	17.59%
Authorization and precertification	12.80%	13.50%	12.50%	11.45%
Medical documentation requested	12.08%	14.48%	12.81%	9.39%
Service not covered	9.67%	10.23%	11.11%	10.84%
Medical necessity	6.76%	6.13%	6.16%	6.14%

Legend:
- 2023 (average)
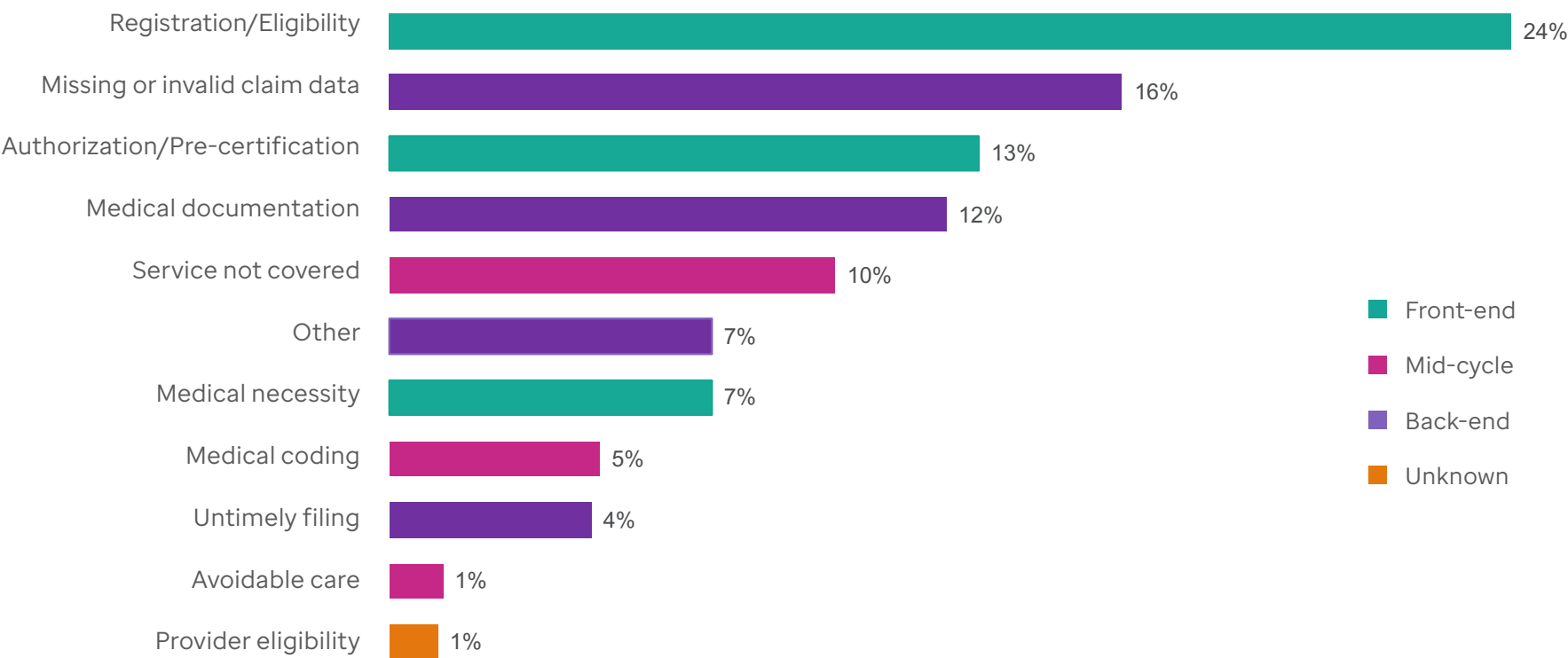- 2022 (1st half)
- 2021 (2nd half)
- 2020 (1st half)

Regional breakdown of denial rates categories

The Pacific and Midwest regions show higher rates consistently across the top 2 denials categories.

2023 registration and eligibility denial rates by region

2023 missing or invalid claim data denial rates by region

Denials throughout the revenue cycle

Category	Percentage
Registration/Eligibility	24%
Missing or invalid claim data	16%
Authorization/Pre-certification	13%
Medical documentation	12%
Service not covered	10%
Other	7%
Medical necessity	7%
Medical coding	5%
Untimely filing	4%
Avoidable care	1%
Provider eligibility	1%

Legend:
- Front-end
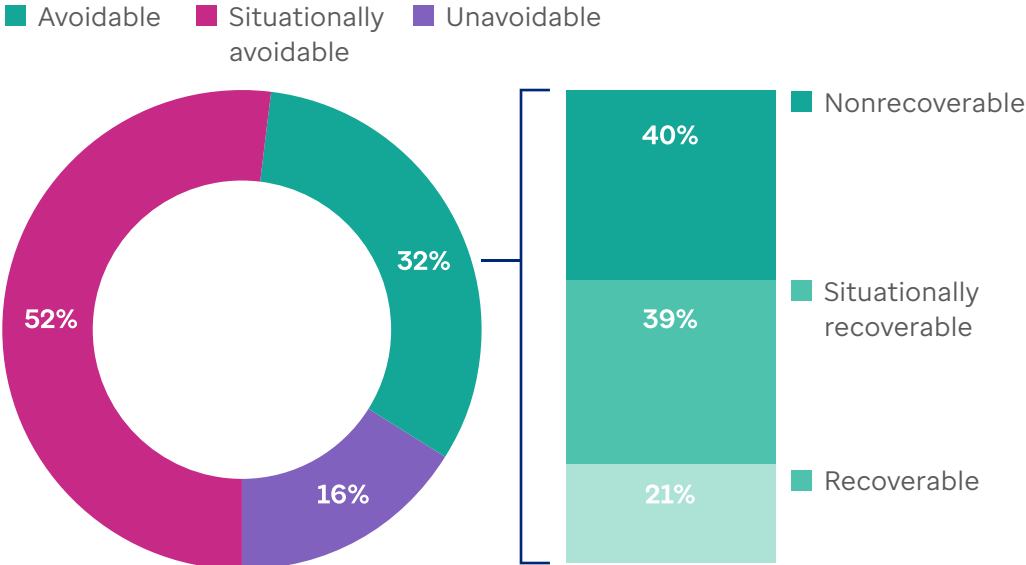- Mid-cycle
- Back-end
- Unknown

Denial analysis: Constructive categorization

Provides actionable insights to drive denial prevention strategies

Prioritizes appeals workflow to maximize recoveries and minimize cost to collect

	Unavoidable	Avoidable
Nonrecoverable	Analyze current workflow and processes	Prevent future denials
Recoverable	Manage appeal processes	Prevent future denials and manage appeals

A lot of denials are preventable

Of the almost 32% of denials that are unequivocally avoidable, 40% cannot be recovered. Prevention is the key to prevent revenue loss.
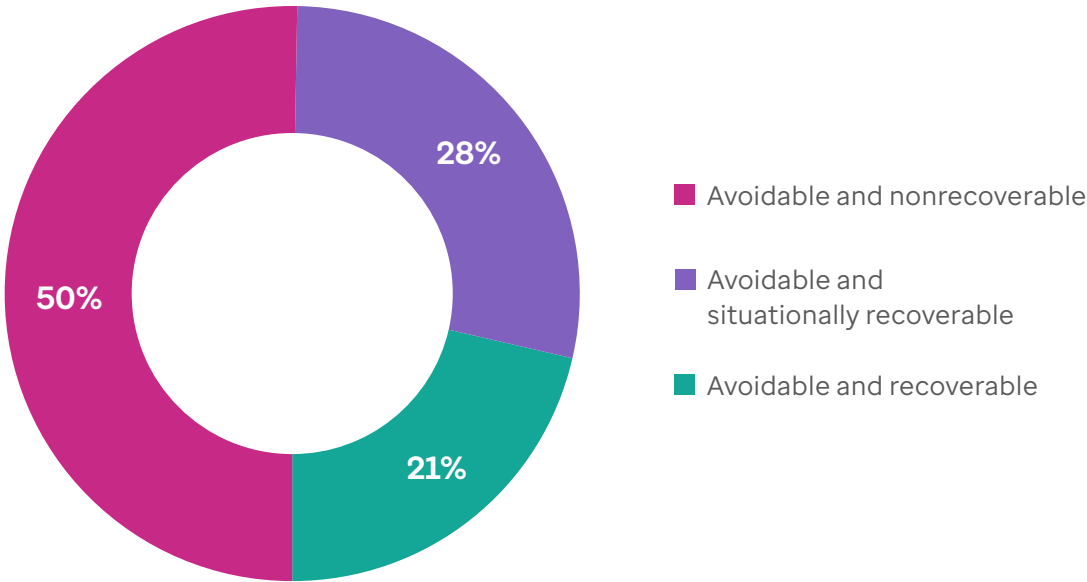
■ Avoidable ■ Situationally avoidable ■ Unavoidable

52%

32%

16%

40% — Nonrecoverable

39% — Situationally recoverable

21% — Recoverable

*Percentages have been rounded

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Registration and eligibility denials are avoidable

Half of these avoidable denials are nonrecoverable.

Registration and eligibility denials make up the **largest percentage of avoidable denials,** which are frequently nonrecoverable.

28%

50%

21%

- Avoidable and nonrecoverable
- Avoidable and situationally recoverable
- Avoidable and recoverable

Investigating beyond root causes is essential to defining goals and determining strategy

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Bryce Bruner

Senior Director, Product Management and Analytics, Optum

Identifying denial root causes is an important first step. Understanding whether denials are avoidable, recoverable, nonrecoverable, etc. enables organizations to strategically prioritize improvement efforts aligned with their goals, such as maximizing potential reimbursement alongside actual reimbursement."

Breakout: Top denials root causes

Registration and eligibility	24%
Coordination of benefits	50%
Benefit maximum	27%
Plan coverage	17%
Patient eligibility	6%
Missing or invalid claim data	**16%**
Missing/invalid/incomplete data on claim	71%
Missing or invalid EOB	18%
Missing or invalid documentation	6%
Invalid provider information	2%
Authorization or precertification	**13%**
Authorization missing or invalid	60%
Authorization denied	30%
Services exceed authorization	6%
Service not performed by authorized provider	3%

Medical documentation requested	12%
Missing or invalid documentation	95%
Medical records requested	5%
Service not covered	**10%**
Service not covered	55%
Guidelines not met/exceeded	24%
Managed care	12%
Noncovered days	6%
Other	**7%**
Unspecified billing issue	99.8%
Primary insurance denied claim	0.2%

Staffing, volume and varying commitment to technology improvements contribute to persistently high denials

Staffing

- Tight labor market impacts hiring and retaining qualified staff

- Complexity of denials requires robust training and education programs

- Clinical staff required to manage growing number of clinical denials

- Inadequate access to data for root cause analysis and expertise on interpreting it

Volume

- Peak seasons and staffing challenges expand denial backlogs while managing against timely filing deadlines

- Focus on remedying individual denials versus analyzing root causes fails to reduce volume

- Lack of denial prevention strategies on the front end and mid-cycle

Technology

- Scarce resources focused on maintaining status quo — ongoing regulatory changes and constant need to update revenue cycle management (RCM), hospital information systems, and disparate technologies

- No or limited investment across modern analytics, AI or automation to unlock next-step function of resource productivity

- Knowledge gaps or lack of resource commitment frequently result in failed technology programs, preventing quantifiable productivity improvements

Alignment on denials reduction strategy

A 3-pronged strategy:
The collective success of high-performing revenue cycle teams leverages the interdependencies across people, process and technology to drive continuous improvement. Once they all start working together, you can accelerate the results they collectively deliver.

People

Training your team to flag and understand root causes will decrease preventable denial rates. Implement proper training, including automated feedback loops providing personalized, as well as aggregated insights, to help staff identify trends quickly and prevent unnecessary denials.

Process

Data and insights are only helpful if action is taken. Ensure a proper feedback loop exists so teams take action to improve processes and workflows. Identify opportunities to better manage how resources are used or employ technology to supplement or drive team productivity. Automate workflows to address volume and prioritize work.

Technology

Providers are being squeezed with workforce challenges, high denial rates and historically low margins. Technology can reduce the strain and create efficiency in the revenue cycle. Deploy automation and analytics-driven workflow solutions so providers have an opportunity to prioritize and meet the increasing scale at which they need to operate.

Leverage your data to identify, prevent and monitor denials

Identify root causes

Use your data to identify and understand root causes behind your denials. Which area of the revenue cycle is most affected?

Engage your strategic partner

Work together to optimize capabilities in denial prevention efforts across the revenue cycle.

Prioritize

Quantify improvement opportunity and effort, relate the information to organizational goals to gain buy-in in order to prioritize remediation in specific areas of the revenue cycle.

Benefit from AA and AI

Deploy data-driven automation to manage frequent and low effort denials.

Integrate advanced analytics into your workflow to augment real-time decision-making.

Power of a strategic RCM partner

Optum software solutions streamline RCM, enhancing the patient experience and reducing friction between providers and payers. With clinical insights and intelligent automation, Optum delivers superior results and a seamless end-to-end RCM experience.

Front-end solutions

Patient access and engagement helps prevent denials by correcting issues within registration and intake forms, confirming patient eligibility prior to appointment and providing direct integration with EHRs to help ensure accurate patient information.

Patient financial clearance helps accelerate reimbursement, reduce denials and optimize workflows from registration through point-of-service collections.

Coverage Insight™ helps accurately identify and verify insurance coverage enabling providers to bill the correct payers for reimbursement, leading to reduced denials, accelerated payments and efficient workflows.

Mid-cycle solutions

Enterprise CAC & CDI 3D helps hospitals and health systems with coding, clinical documentation improvement and auditing needs.

Professional computer-assisted coding helps large physician groups and billing companies with automated coding.

Lynx outpatient charge capture helps protect revenue and support compliant, consistent charging across outpatient operations. Our algorithms capture resource use and patient care complexity for consistent charging.

InterQual® helps ensure clinically appropriate medical utilization decisions with evidence-based criteria. InterQual AutoReview automates the creation and population of the medical review with data from the EHR. These solutions mitigate denial risk by delivering accurate and defensible medical necessity reviews.

Back-end solutions

Assurance reimbursement management™ helps automate workflows to prevent denials and facilitate fast reimbursement, enabling staff to focus on other tasks.

Claims manager helps lower denial rates and identify unbilled revenue by automatically flagging claims for inaccurate coding and billing documentation prior to payer submission.

Provider communication gateway helps prevent unnecessary claim denials and rework by delivering payer-specific edits into the provider workflow at the point of coding.

Acuity revenue cycle analytics™ helps determine root causes to reimbursement barriers, and delivers actionable insights to support tactical and strategic decisions.

Gain actionable insights through your strategic partner

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Engaging with a strategic partner who has the tools, technology and expertise across the revenue cycle to bring insights at the point where they are actionable is a critical decision for preventing denials on the back-end."

Patrick Leonpacher

Vice President, Product Management, Optum

How Optum can help

Our end-to-end RCM suite uses innovative technology and expert services to create exception-based workflows to help prevent denials and accelerate reimbursement.

The same advanced analytics and talent that revealed this report's insights can help you improve your organization's performance.

Learn how Optum can become your strategic partner for avoiding denials.