Denials are escalating, but most are preventable. A data driven operating model, powered by AI, RPA, and real time KPIs, can reduce avoidable denials, accelerate reimbursement, and improve strengthen financial resilience.

Reimagining revenue: How AI turns denials into dollars

When every dollar matters, effective denial management is essential. Healthcare organizations face rising denial rates and tighter margins, but most denials are avoidable with the right processes, analytics and automation.

Across the industry, claim denial rates have climbed into double digits in recent years (averaging about 15% of claims compared with single-digit levels only a few years ago). This reflects more complex payer rules (especially related to prior authorization) and ongoing operational gaps. The result: delayed cash, higher costs-to-collect and unnecessary administrative work. Nearly $20 billion is spent by providers each year on reworking and appealing denials according to recent estimates.[1]

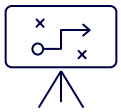
Industry analyses show that ~85% of claim denials are potentially avoidable through up-front improvements.[2] Front-end errors, in areas like registration, eligibility and authorization are the top drivers of preventable denials; therefore, in this “first mile” of the revenue cycle is where accuracy and verification deliver the greatest impact.

A prevention-first playbook: How can organizations put the right safeguards in place to manage growing denials?

1. Classify denials and target the avoidable ones.

Not all denials are created equal, so start by categorizing them and assigning actions to each category. For example:

Avoidable denials result from process errors under your control (such as missing or incorrect patient coverage information, authorization mistakes, timing issues and coding inaccuracies). These should be prevented through stronger workflows and targeted staff training.



Situationally avoidable denials stem from nuances like payer-specific rules or documentation gaps—some may be prevented by special handling or policy adjustments.

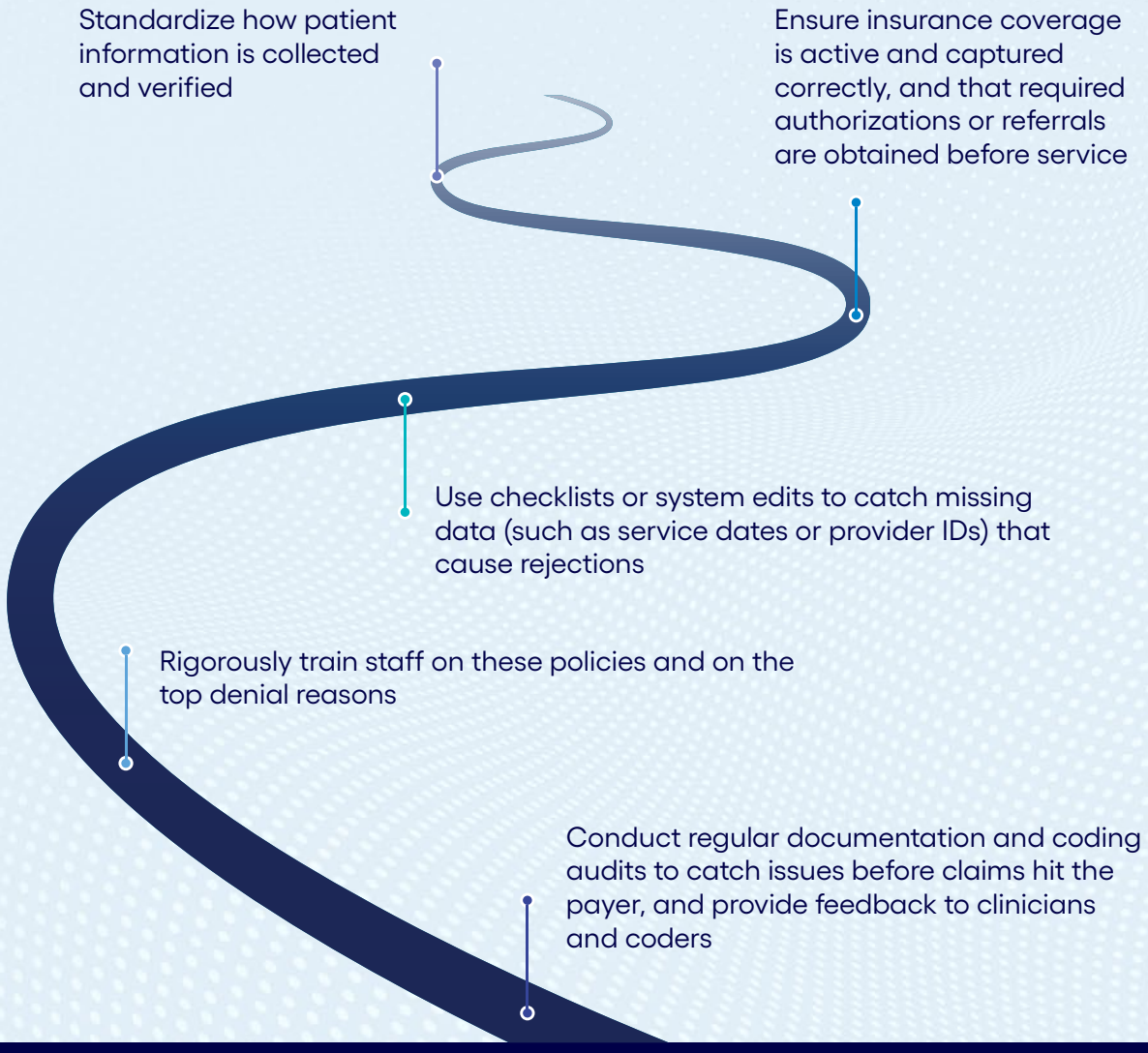
Unavoidable denials are those truly beyond provider control (for example, non-covered services or recent payer policy changes); while they should be tracked, they won't drive process changes. HFMA has emphasized standardizing denial definitions to help providers focus on the preventable 85% segment.[2]

By classifying denials in this way, teams can quantify the scope of avoidable revenue leakage and tackle root causes more effectively—one by one—instead of treating all denials as an inevitable cost of doing business.

2. Strengthen front-end processes to “get it right the first time.”

Many avoidable denials originate in patient access and documentation steps before a claim is ever submitted.[2]

That means addressing the common failure points at scheduling, registration and eligibility verification:



In short, an ounce of prevention is worth a pound of cure: An accurate, clean claim submitted today is far less costly than scrambling to fix or appeal it tomorrow.

3. Leverage automation and AI to augment your team.

Rule-based automation (RPA) and artificial intelligence are changing the denial management game. Automation can take over repetitive, error-prone tasks—for example, automated insurance eligibility checks and prior authorization status follow-ups, or deploying bots to retrieve claim status updates from payer portals. This ensures consistency and frees up staff time.

Meanwhile, AI-driven tools are enabling a more predictive and proactive approach: Advanced analytics can flag high-risk claims before submission (for example, an AI model that learns from past denials and identifies a likely coding issue or missing modifier on a claim).

AI can also help surface root causes by analyzing denial patterns hidden in large datasets and even draft appeal letters or recommended fixes for certain denial types.

Another emerging capability is AI "copilots" or assistants that make knowledge instantly accessible—for instance, staff can query an AI tool for payer-specific rules or documentation requirements in real time, getting answers on the fly instead of hunting through manuals.

Together, these automation and AI solutions reduce manual workload, improve first-pass claim acceptance and ensure that staff focus on exceptions rather than on every claim. It's worth noting that as of 2025, adoption of AI in revenue cycle is still low—only about 14% of healthcare providers have implemented AI in their claims process according to a recent industry survey.[3] However, early adopters report promising results:

Roughly 69% of organizations using AI have seen a reduction in claim denials or improved resubmission success rates.[3]

In other words, the technology is ready and showing ROI and provider adoption is poised to accelerate in the effort to curtail denials.

4. Make key performance indicators (KPIs) your North Star.

A high-performing revenue cycle measures what matters and acts on it daily. KPIs include:

5. Turn insight into action—use analytics to prioritize fixes.

Dashboards should visualize volumes, amounts over time (month-over-month, quarter-over-quarter, year-over-year), denial reason groups, regions, facilities and procedure codes. Use these insights to prioritize fixes and automate the highest-impact steps. Organizations that embed analytics into daily huddles and escalation routines see faster improvements in clean claim rates and lower total cost to collect.

6. Benchmark against the best.

Top performers keep denial rates near 5% of total volume. This is possible by focusing on front-end accuracy, using payer-specific edits and building preventive controls. Add selective automation—claim-status bots, document ingestion and interpretation, and denial prediction—and you turn chronic leakage into durable revenue.

Taking the next steps

Summary

Organizations that thrive treat denial management as a strategic, data-driven discipline—one that blends technology, analytics and operational rigor. By adopting a prevention-first mindset, investing in automation and AI, and relentlessly measuring and improving what matters, healthcare leaders can transform denials from a chronic drain into durable revenue. Top performers prove it's possible: They've turned "leakage" into cash flow, and they've reallocated staff from tedious rework to value-added activities. The future of revenue cycle management belongs to those who act decisively, empower their teams with actionable insights and keep the patient at the center of financial processes. The time to reimagine revenue—and reclaim what's rightfully earned—is now.

References

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