

WHITE PAPER

DENIAL AVOIDANCE GUIDE:

THE SHIFT FROM MANAGING
DENIALS TO PREVENTING THEM

EXECUTIVE SUMMARY

Why hospital revenue cycle leaders are moving from reactive workflows to predictive, signal-driven performance

Hospital revenue cycle leaders are operating in an increasingly difficult environment.

Denials are rising. Costs are climbing. Payers are accelerating the use of automation and AI. At the same time, staffing shortages and margin pressure are forcing organizations to do more with less.

For years, the industry has responded with denial management — building teams, refining workflows, and investing in appeals. But that approach has reached its limit.

Denial management is reactive. Denial avoidance is strategic.

This guide outlines the shift from managing denials after they occur to preventing them **before** they happen, and how Predictive Intelligence enables that transformation.

SECTION 1

THE REALITY: DENIALS ARE NO LONGER AN EXCEPTION

Hospital revenue cycle performance is under growing pressure from multiple directions. Denials are no longer isolated issues — they are happening at scale, with increasing frequency and financial impact. For many organizations, the challenge is no longer managing denials more efficiently, but preventing them altogether.

The data reflects just how significant this shift has become:

- **11.8%** of claims are denied on first submission¹
- Denial rates are increasing **2.4% year over year**¹
- Medicare Advantage denials have surged **56%**²
- **\$57.00** is now the average cost to rework a claim³
- Hospitals lose an avg of **4.8% net revenue** to denials⁴
- **\$19.7 Billion:** The estimated amount the industry spends managing denials each year⁵

Denials aren't isolated issues. They are predictable patterns.

SECTION 2

THE PROBLEM: MANAGING DENIALS IS A REACTIVE LOOP

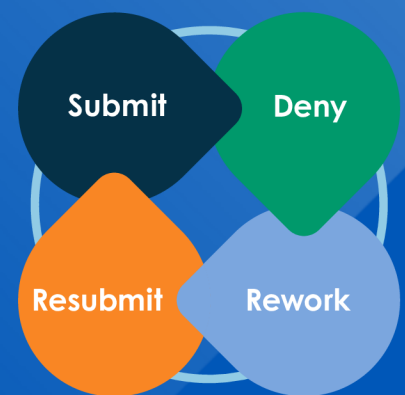
Traditional denial management follows a familiar pattern — submit, deny, rework, repeat. It's a reactive cycle that consumes time, labor, and resources without addressing the root cause. As denial volumes rise, this model becomes increasingly difficult to sustain and is breaking down under pressure.

Traditional denial management is a cycle built on response, not prevention.

Why this model is breaking down:

- **Too late:** Revenue is already delayed or at risk
- **Too expensive:** Each denial triggers avoidable cost
- **Too manual:** Staff time is consumed by preventable errors
- **Too inconsistent:** Outcomes depend on human intervention

Meanwhile, payers are evolving by using automation and AI to process and deny claims faster, placing increased pressure on already strained revenue cycle teams.



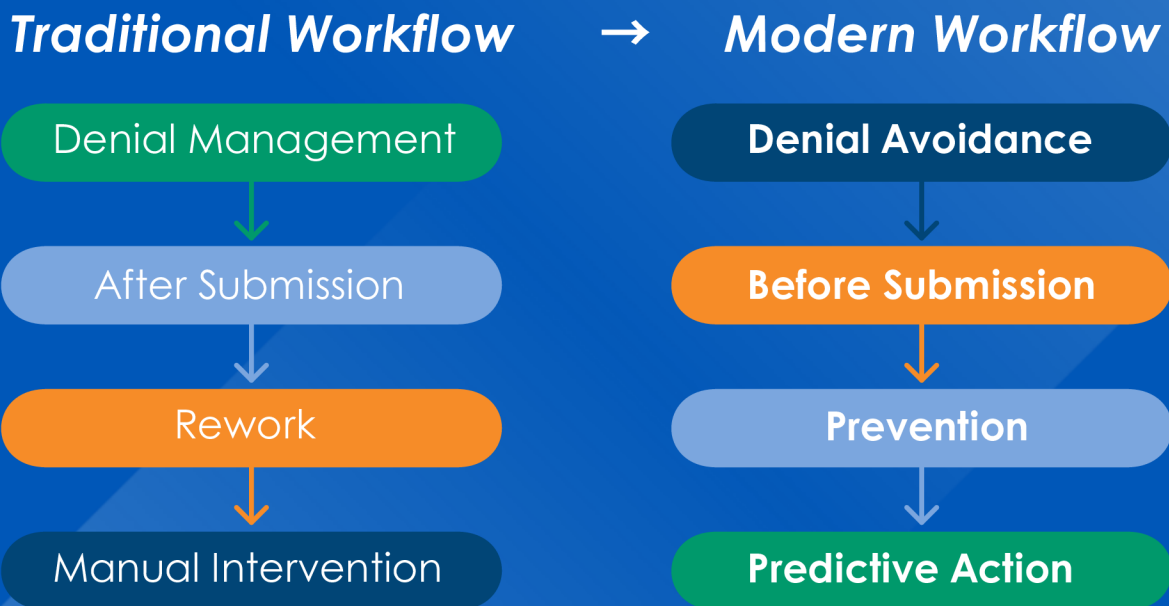
You can't outpace automated denials with manual rework.

SECTION 3

THE SHIFT: FROM MANAGING DENIALS TO PREVENTING THEM

Leading organizations are moving away from reactive denial management toward a more proactive approach. Instead of responding to denials after they occur, they are shifting focus upstream by identifying risk and resolving issues before claims are submitted.

This shift is redefining how the revenue cycle operates:



This is more than a workflow improvement.

It's a change in operating model.

Instead of asking: "What happened to this claim?" Organizations are asking: "What is most likely to happen and how do we stop it?"

Automated predictive validation can prevent up to 85% of avoidable denials.⁷

SECTION 4

THE SOLUTION: PREDICTIVE INTELLIGENCE

Rather than relying on retrospective reports or static rules, Predictive Intelligence uses machine learning to continuously analyze your organization's historical claims and remittance data. It identifies patterns tied to denials, adapts as payer behavior changes, and surfaces risk in real time within the workflow, allowing revenue cycle teams to move from reacting to outcomes, to influencing them.

Predictive Intelligence solutions analyzes claim data, payer behavior, and historical denial patterns to flag and prevent errors before claim submission.

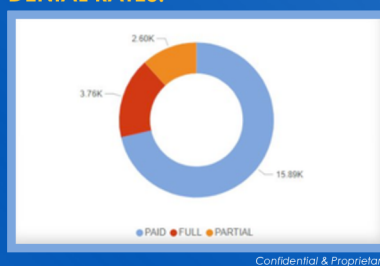
THE DIFFERENCE:

Traditional analytics tell you what already happened.

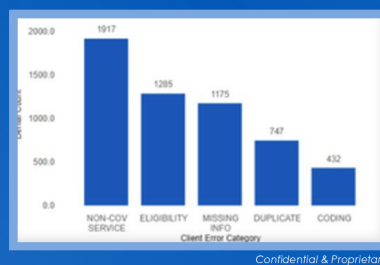
Predictive Intelligence tells you what is likely to happen next, and what to do about it. It is not a reporting tool. It is an execution layer.

- Continuously learns from new data
- Evolves with payer rules and behavior
- Embeds directly into daily operations
- Drives action, not just insight

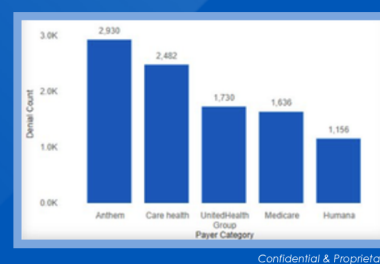
DENIAL RATES:



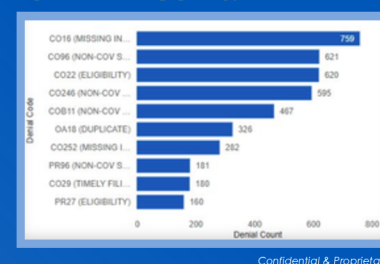
TOP ERROR CATEGORIES:



TOP PAYERS:



TOP DENIAL CODES:



Quadax's Predictive Intelligence solution answers the call by shifting the paradigm from denial management to denial avoidance, enabling organizations to resolve issues before claims are submitted, preventing downstream delays and improving overall financial performance.

SECTION 5

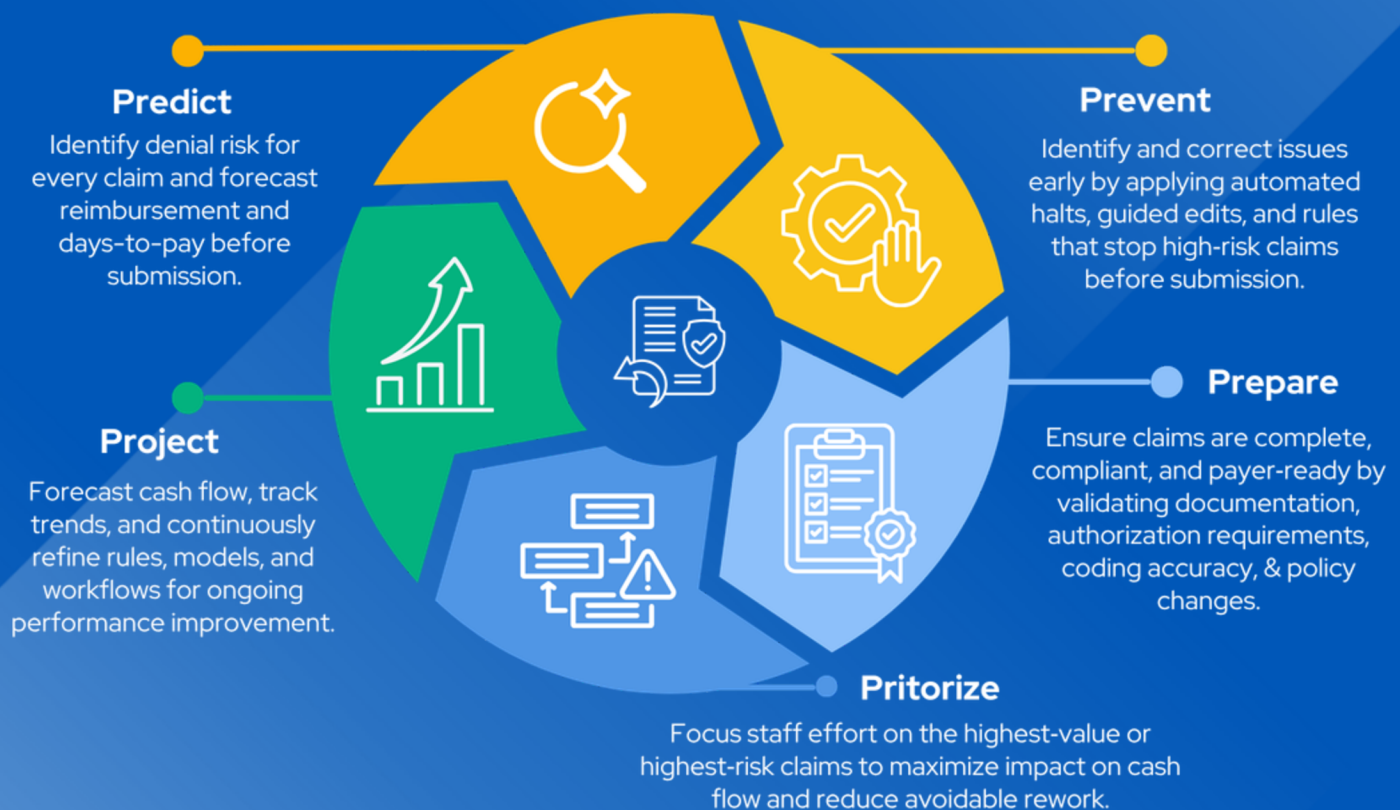
HOW PREDICTIVE INTELLIGENCE ENABLES DENIAL AVOIDANCE

Predictive Intelligence becomes most powerful when it is embedded directly into the daily workflow. Rather than operating as a separate analytics layer, it integrates into the claims process, guiding decisions in real time and ensuring issues are addressed before submission. This allows teams to act on risk immediately, improving claim quality without adding complexity or manual effort.

This approach comes to life through a continuous, repeatable model:

The Denial Avoidance Loop

Predictive Intelligence transforms your revenue cycle from reactive to proactive through a continuous, five-step loop:



Predictive Intelligence by Quadax (PIQ) operationalizes this approach directly within the claims workflow.

SECTION 6

PROVING THE MODEL: DENIAL AVOIDANCE AT WORK

How Predictive Intelligence Provided a 30x ROI in just 60 Days

Crisp Regional Health Services aimed to reduce denials tied to coding and non-covered services. Predictive Intelligence analyzed historical patterns, tuned models to Crisp's data, and implemented automated rules to hold at-risk claims. Predictive models flagged patterns within targeted denial codes and enabled corrections **before** submission.

Challenge

As a longtime Quadax client, Crisp sought to proactively reduce denial rates by targeting specific coding and non-covered error categories that accounted for the majority of denied claims.

Solution & Implementation

Quadax implemented PIQ tailored to Crisp's denial trends. The solution flagged patterns in error codes 182 and 96, enabling Crisp to:

- Automate predictive flags using XpressBiller rules.
- Correct claims before submission.
- Recover previously written-off revenue.

“Implementing PIQ into our existing workflow has exceeded our expectations and recovered money.”

— Marilee Bruns, Director of Patient Financial Services, Crisp Regional Hospital

VALIDATED OUTCOMES:

- **125%** increase in reimbursement
- **60%** reduction in denial codes 182 and 96
- **30X** their ROI in just two months
- **\$93,000+** recovered from previously written-off claims
- **Significant reduction** in manual touches per claim

SECTION 7

THE IMPACT BEYOND DENIALS

Denial avoidance delivers impact far beyond reducing individual claim issues. By addressing errors before they occur, it removes friction across the entire revenue cycle — improving efficiency, strengthening financial performance, and creating more consistent, scalable operations. What begins as a denial prevention strategy quickly becomes a broader performance advantage, influencing how teams work, how revenue flows, and how leaders plan.

That impact can be seen across three critical areas:



OPERATIONAL IMPACT

- Reduced staff burden
- Fewer manual touches
- Faster workflows



FINANCIAL IMPACT

- Improved reimbursement yield
- Reduced cost to collect
- Accelerated cash flow



STRATEGIC IMPACT

- Better forecasting
- Stronger alignment across teams
- Scalable performance improvement

For CFOs and Revenue Cycle leaders, the impact is both immediate and measurable. Denial avoidance strengthens revenue protection by reducing preventable losses, while improving cash flow visibility through more predictable reimbursement patterns. At the same time, it drives meaningful operational efficiency by reducing rework and freeing staff to focus on higher-value activities.

As payer complexity continues to increase, this approach also helps mitigate risk by identifying and resolving issues before they escalate. Most importantly, organizations begin to see tangible results quickly (often within 60 to 90 days) making denial avoidance not just a long-term strategy, but a near-term performance driver.



SECTION 8

CONCLUSION

A New Standard for Revenue Cycle Performance

Denial management was built for a different era.

Today's environment — defined by rising denials, increasing complexity, and payer automation — requires a different approach.

Denial avoidance is that approach.

Organizations that continue to react will fall behind. Those that adopt predictive, signal-driven decision-making will move ahead.



Payers are using AI to deny claims faster.

***The question is no longer whether denials will happen...
it's whether you can stop them before they start.***

MASTER REFERENCE LIST

All statistics used in this campaign are sourced from the following publications.

1. [HFMA: 'Why It's Important to Understand Friction Around Claims Denials' — Initial denial rate 11.8% in 2024, up 2.4% YOY (Kodiak Solutions data). <https://www.hfma.org/reference/understand-claims-denial-friction/>
2. HFMA: MA denial rate increase of 56%; initial denial rates at 11.8% in 2024. <https://www.hfma.org/revenue-cycle/denials-management/navigating-the-rising-tide-of-denials/>
3. Aptarro / HFMA: Admin cost per denied claim rose from \$43.84 (2022) to \$57.23 (2023). <https://www.aptarro.com/insights/us-healthcare-denial-rates-reimbursement-statistics>
4. HFMA Pulse Survey: Average hospital denial loss = 4.8% of net revenue (cited via HFMA OBBBA redesign article). <https://www.hfma.org/revenue-cycle/redesigning-denials-management-in-the-obbba-era/>
5. Premier Inc. report (via HFMA): Hospitals and health systems spend \$19.7B annually managing denied claims. <https://www.hfma.org/fast-finance/aca-marketplace-plans-payment-denial/>