

From Recovery to Resilience

Whitepaper

How Health Systems Break the Denial Cycle by Rebuilding Trust, Discipline, and Accountability Upstream

A Trust-Led Perspective on Denial Prevention, Operational
Discipline, and Sustainable Revenue Integrity



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Denial Prevention Is Not a Tool. It's an Organizational Discipline.

Denials have become an accepted cost of doing business in healthcare. Most health systems no longer question whether denials will occur. Instead, they've adapted to managing them, building teams, workflows, and vendor relationships designed to recover as much denied revenue as possible, as efficiently as possible.

That adaptation is understandable. In many organizations, denial recovery feels like survival.

But survival is not the same as progress.

This paper argues that meaningful, sustainable improvement in net revenue comes from shifting focus upstream, from denial recovery to denial prevention, through trust-led leadership, operational discipline, and cross-functional accountability.

When done well, this shift reduces administrative waste on both the provider and payer sides, improves net revenue performance and overall accounts receivable health, strengthens payer-provider relationships, and delivers a more predictable, transparent experience for patients.

This is not a call for perfection. It is not a call to stop working denials. And it is not a call for wholesale disruption of existing operations.

It is a practical framework for leaders who recognize that the way denials are currently managed may be necessary but is no longer sufficient.

The Structural Trap: Why Health Systems Over-Invest Downstream

When Survival Becomes Strategy

Most revenue cycle leaders did not choose to over-invest downstream. They were pushed there.

Quarter-to-quarter cash pressure. Aging A/R. Executive scorecards built on lagging indicators. Teams already stretched thin. In that environment, denial recovery becomes the safest place to apply resources. The work is visible. The outcomes are measurable. The impact, even if partial, can create significant relief for anemic margins.

Over time, this creates a structural trap.

Denial recovery begins to dominate attention, staffing, and investment not because it delivers the greatest long-term value, but because it feels controllable in the short term. Meanwhile, upstream issues like authorization gaps, documentation inconsistencies, status determination errors, and misaligned workflows persist largely unchanged.

The result is a cycle many organizations recognize all too well:

- **The same denial categories reappear month after month**
- **Teams work harder, not smarter**
- **Burnout increases**
- **Marginal returns diminish**
- **Net revenue erodes**

None of this reflects a lack of effort or intelligence. It reflects a system optimized for reaction rather than prevention.

And when evidence arrives late, in the form of denial reports, appeals outcomes, and retroactive adjustments, trust erodes. Internally, teams question whether progress is even possible. Externally, payers and patients experience friction that feels unnecessary and avoidable.



Reframing the Opportunity: Denial Prevention as a Trust-Led Strategy

Prevention Is Not About Automation, It's About Alignment

Denial prevention is often discussed as though it were a product, a rule set, or a switch that can be turned on. That framing sets organizations up for disappointment.

There is no installable version of denial prevention.

In practice, prevention lives at the intersection of three forces:

Operational discipline

Consistent execution of known best practices, even when it slows things down temporarily.

Clear ownership

Explicit accountability for where denials originate, not just where they are worked.

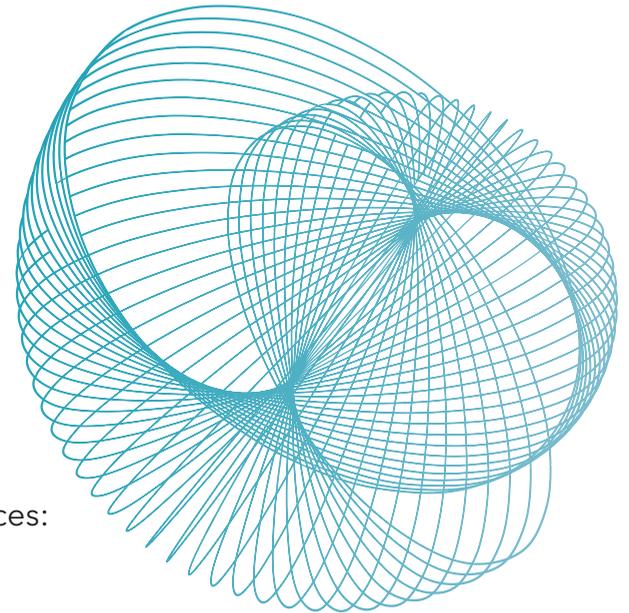
Shared incentives

Alignment across functions that have historically been measured and rewarded differently.

When those elements come together, denial data stops being a scoreboard and starts becoming a learning system.

Patterns emerge. Context becomes visible. Insights gain credibility because they are grounded in frontline reality, not abstract analytics. Leaders stop debating whose fault a denial is and start asking a more useful question: What would prevent this from happening again?

That shift, from blame to learning, is where trust begins to form.



Where It Starts: Seeing the Work as It Actually Happens

From Dashboards to Daylight

Data is essential. But data alone is not enough.

Many organizations understand how their top denials occur. No authorization denials are not mysterious. Status downgrades are not confusing. Documentation gaps are rarely surprising.

The real challenge is not awareness, it's execution.

Knowing that authorizations are being missed is different from building a reliable system that ensures every scheduled service requiring authorization is flagged, reviewed, and resolved before the claim ever goes out the door. Understanding that one- and two-day stays are being downgraded is different from implementing a workflow that pauses those claims long enough to validate status, without destabilizing billing performance.

Prevention does not fail because leaders lack insight. It fails because operationalizing that insight requires coordinated discipline across scheduling, access, clinical documentation, billing, and analytics, and that level of coordination is difficult to sustain without clear ownership and executive backing.

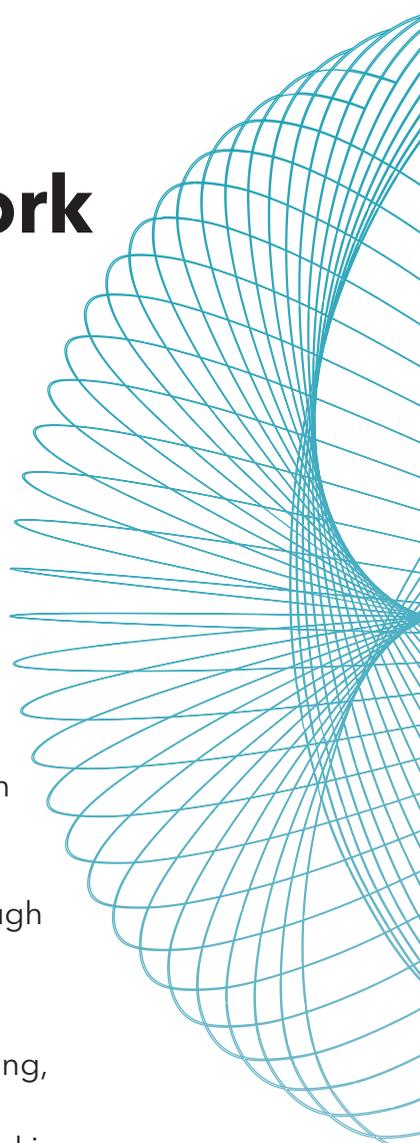
That discipline reveals important truths:

- **Which errors are truly systemic versus situational**
- **Where staff are compensating for broken processes**
- **How often speed is prioritized over accuracy, not out of carelessness, but necessity**

For many organizations, this is also where a critical mindset shift occurs. The goal is no longer to get claims out the door as fast as possible, but to get them right the first time, recognizing that speed without accuracy often creates more work downstream than it saves upstream.

In some cases, this may require short-term tolerance for modest increases in DNFB in exchange for more accurate claim submissions. That tradeoff must be intentional, monitored, and supported at the leadership level, not absorbed silently by billing teams trying to protect their metrics.

When leaders make that tradeoff explicit, rather than forcing teams to choose between conflicting incentives, something important happens. Trust deepens. Teams feel seen. Conversations become more honest. And improvement becomes possible.



Executive Air Cover: The Non-Negotiable Condition for Success

Why This Cannot Live in Revenue Cycle Alone

Denial prevention fails quietly when it is treated as a revenue cycle initiative.

The reason is simple: siloed success metrics pull organizations in opposite directions.

Billing teams are measured on DNFB and throughput. Denials teams are measured on overturn rates. Patient access teams are measured on scheduling efficiency. Each function may be performing well by its own definition, while the organization as a whole struggles.

Shifting focus upstream introduces tension. Holding claims for review. Pausing workflows. Reallocating resources. These

actions feel risky, especially when cash pressure is real.

Without executive alignment, that risk is rarely tolerated.

Sustainable prevention requires leadership at the top to redefine what success looks like, create latitude for short-term discomfort, and make denial prevention an organizational priority, not a departmental experiment.

When leaders model that commitment, trust scales. Silos soften. And teams begin to believe that upstream improvement is not only allowed; it's expected.

Operational Discipline in Practice (Across the Revenue Cycle)

One Strategy. Many Roles. Shared Accountability.

Denial prevention does not belong to a single team. It is the product of coordinated execution across multiple functions, each contributing in different but essential ways.

Patient Access

Prevention begins before care is delivered. Reliable authorization workflows, visibility into recurring services, and disciplined follow-up reduce avoidable denials long before claims are submitted.

Billing & Coding

This work requires comfort with strategic pauses. Edit rigor aligned to payer rules. And a willingness to trade “clean claim” optics for downstream clarity and stability.

Clinical Documentation Improvement (CDI / CDE)

Strong documentation is foundational. Aligning clinical narratives with medical necessity requirements reduces queries, rework, and downstream friction, while preserving clinical integrity.

Denials & Follow-Up

Precision matters. Accurate categorization and high-quality data capture transform denial work from reactive cleanup into actionable insight.

Analytics & Decision Support

Prevention must be supported, not sidelined. Analytics teams play a critical role in surfacing trends, validating impact, and guiding prioritization.

Across all roles, discipline creates the evidence that trust requires.

Extending the Loop: Denial Prevention as a Payer-Provider Efficiency Play

When Trust Replaces Friction

Not all denials are created equal.

High overturn rates are not a badge of honor. They are a signal; often of shared administrative waste.

When providers can demonstrate, with specificity, that certain denials are consistently overturned, new conversations become possible. In some cases, the work belongs on the provider side. In others, payer policies or system flags may warrant refinement.

This is also where the right partner can accelerate progress.

TREND has worked alongside providers and payers to identify patterns where repeated denials are overturned on appeal, signaling opportunities for policy clarification or system adjustment. In multiple cases, this collaborative approach has led to meaningful policy changes, eliminating unnecessary rework for both sides. For example, when a specific category of readmission denials was consistently overturned due to clinical nuance in the underlying diagnosis, the data supported a direct dialogue with the payer. The result was refinement of audit criteria and removal of certain diagnosis codes from automatic review, reducing administrative burden without compromising appropriate oversight.

These conversations succeed not through escalation, but through credibility: clear data, shared context, and a mutual interest in reducing unnecessary rework.

Shared facts change behavior faster than shared frustration.

The Patient Impact: The Cost No One Sees on the Denial Dashboard

Accuracy Is a Patient Experience Issue

Patients see denials. They see them in the form of an explanation of benefits (EOB) that reflects a denied claim and, in many cases, a balance that appears to be their responsibility.

What they do not see is whether that denial will be appealed, overturned, or corrected, or how long that process may take.

First-pass denials often trigger confusing EOBs, perceived financial liability, and status changes that significantly alter out-

of-pocket responsibility. In many cases, patient statements are delayed for months, sometimes more than a year, long after care was delivered.

Even when corrections eventually occur, trust has already been strained.

Predictability matters. Transparency matters. Getting it right the first time is one of the most effective ways to reduce patient confusion and dissatisfaction.

Patients experience the consequences of operational misalignment, whether organizations acknowledge it or not.

Measuring What Matters (and When)

Leading Indicators for a Long-Term Play

Denial prevention requires patience and the right metrics.

Fatal denials are a lagging indicator. They tell a story, but too late to guide early decision-making.

More useful signals include:

- **First-pass denial rates**
- **Category-specific trends**
- **Behavioral compliance across functions**

Progress should be measured quarter-over-quarter, not week-over-week. Not because urgency is misplaced, but because operational change takes time to move through the system. Claims must be scheduled, authorized, documented, billed, adjudicated, and reported before meaningful trend shifts appear in the data. That cycle cannot compress into a few weeks.

Expectations must be explicit and shared. Leaders should anticipate a lag between behavior change and visible financial impact, and define in advance which indicators will validate that the strategy is working before bottom-line metrics fully reflect it.

Trust grows when leaders align not just on what success looks like, but when it should reasonably appear.

CONCLUSION

Slowing Down to Finally Get Ahead

From Transactional Recovery to Systemic Resilience

Denial prevention works when embraced fully, and fails quietly when adopted halfway.

Organizations that commit to this shift do not stop working denials. They simply stop letting denials define their strategy.

The payoff is meaningful:

- **Lower administrative burden**
- **Stronger payer relationships**
- **Better patient experiences**
- **A healthier, more resilient revenue system**

Trust is not built by fixing errors faster. It is built by creating fewer errors to fix.

For many organizations, making this shift raises a practical concern: how to invest upstream without destabilizing current cash performance. This is where the right partnership matters. TREND can support denial recovery efforts while internal teams redirect focus toward prevention, providing continuity of performance as operational discipline takes root upstream.

Prevention requires intention. Execution requires capacity. With the right alignment and support, health systems do not have to choose between protecting today's revenue and building tomorrow's resilience.

Contact and Follow Up

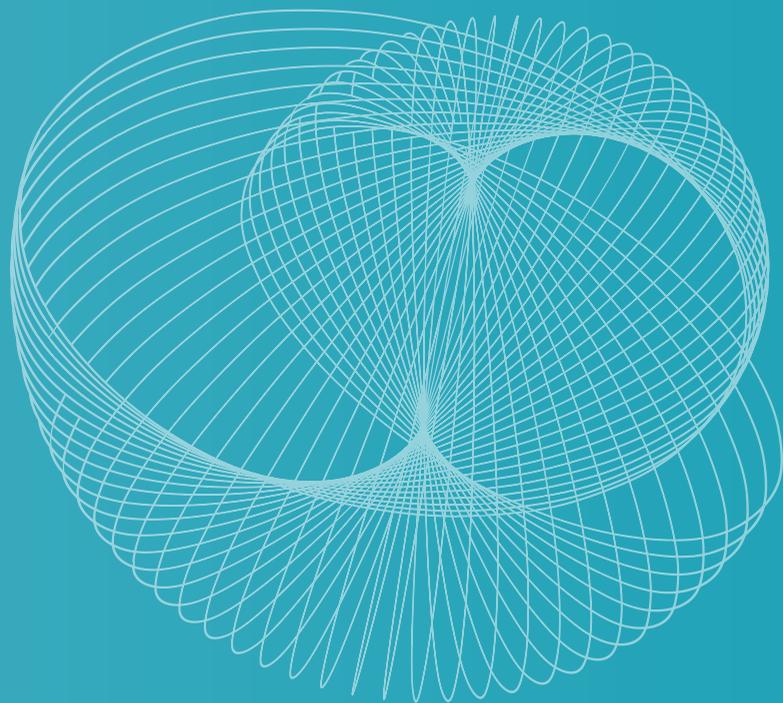
If your organization is ready to look beyond recovery and toward prevention, TREND can help you get there. Our team partners with payers to identify root causes, strengthen upstream processes, and build lasting integrity into the system itself.

Connect with TREND to explore what a complete payment integrity strategy can look like for you.



PATRICK
WARREN

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