Resolving Healthcare Claim Disputes and Denials

Written By Laura Carabello

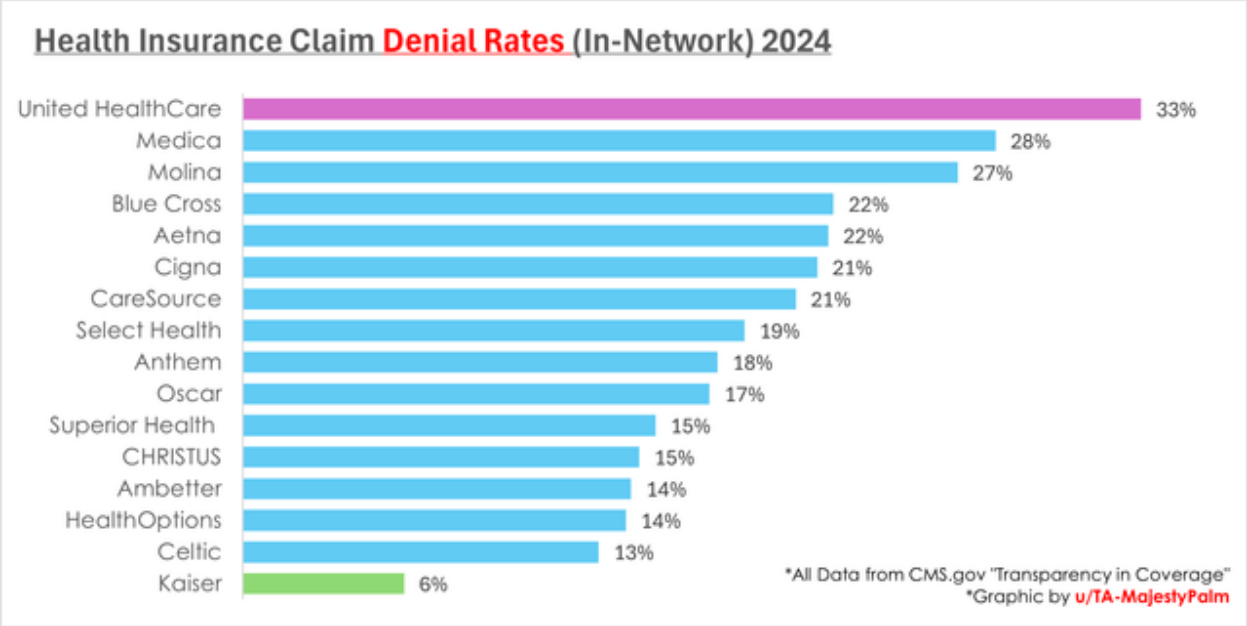
What industry observers describe as the 'new normal,' record-high statistics on the rate of claims denials are anything but comforting to healthcare providers and plan members alike.

In the newest analysis of more than four billion claims by the health analytics company, Komodo Health, prescription drug denials by private insurers in the US jumped 25 percent from 2016 to 2023. While most private insurers keep that information confidential, Komodo draws from private databases that collect denial details from pharmacies, insurers, and intermediaries.

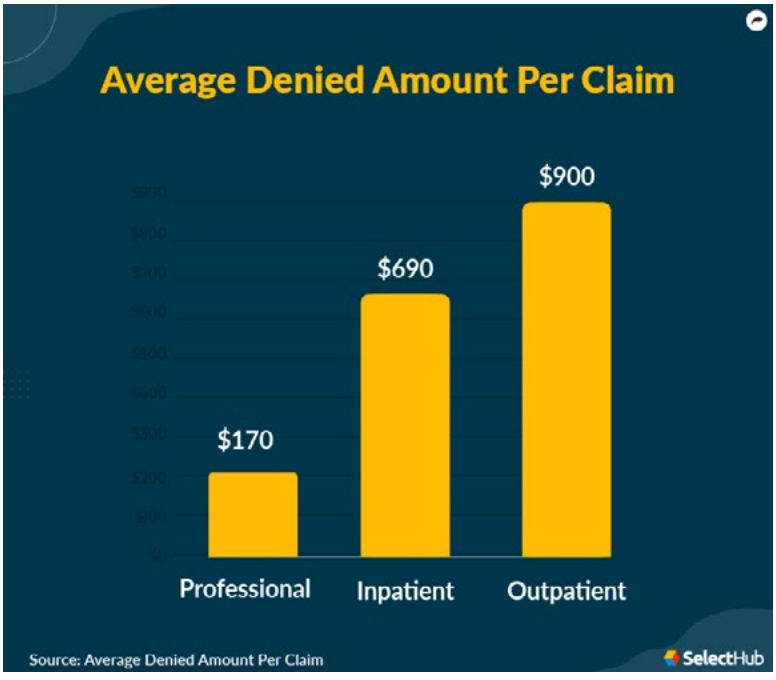
Meanwhile, the American Medical Association reports that denial rates jumped to 11% in 2023, up from 8% just two years prior. Healthcare revenue cycle management professionals at Aspirion advise that for an average health system, this translates to approximately 110,000 unpaid claims—a financial burden that no healthcare organization can afford to ignore.

In fact, the American Hospital Association reports that nearly 15% of all claims submitted to private payers initially are denied, including many that were preapproved during the prior authorization (PA) process. Overall, 15.7% of Medicare Advantage and 13.9% of commercial claims were initially denied.

In the opposite corner of the ring stand self-insured employers that need a comprehensive strategy to address claims disputes and denials -- issues that impact employee satisfaction, increase administrative burdens, and can lead to financial losses. These matters increasingly confront plan sponsors as they face tougher compliance scrutiny than ever before – from complex treatment reviews to urgent appeals.



In contrast, the insurance trade organization AHIP says that health plans approve the majority of claims submitted. In a statement, AHIP spokesperson Chris Bond stated, "There are valid reasons for the small percentage of claims subject to further review, and we recognize this can be frustrating. ... An appeal is always available for patients and providers with internal and external review processes in place and communicated to health plan members."

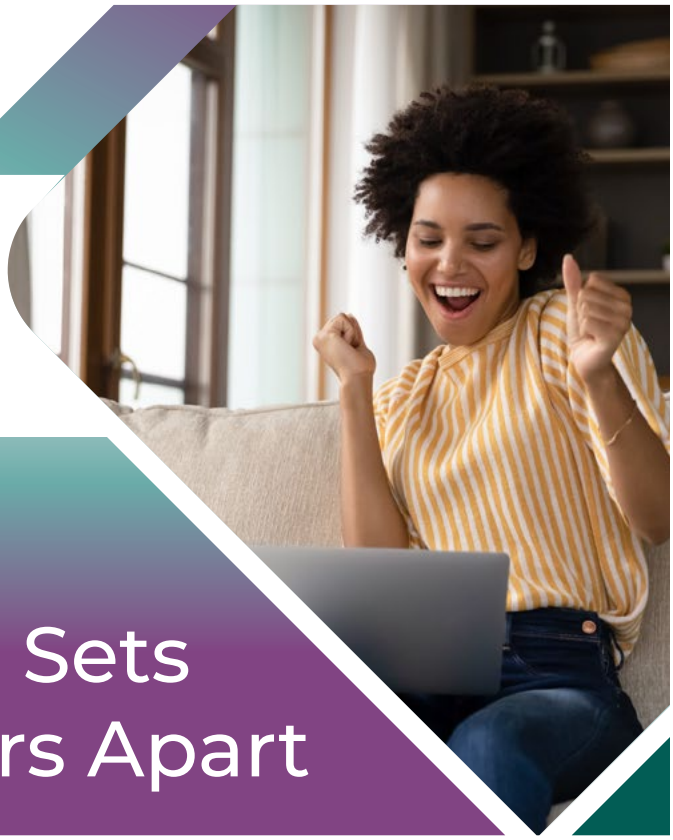


CAN EMPLOYERS DO MORE TO EASE THE BURDEN ON PROVIDERS?

A recent survey conducted earlier this year by Delaware-based Intelliworx reports that healthcare providers 'chafe' when insurance companies second-guess their medical decisions. Half of the providers surveyed said that employers could do more to ease the weight of denials and help them manage these challenges. They contend that the frustration level has grown to the extent that nearly 4 in 10 providers have considered quitting.

PLAN PARTICIPANTS CAUGHT IN THE MIDDLE

Christine Cooper, CEO of aequum, which represents plan members with dispute resolution on both the Federal and State level, says, "The member needs someone on their side to navigate the complex world of claims processing and medical billing. Plan members benefit from advocacy during claim disputes."



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Christine Cooper

She says that often, when the NSA does not apply, "The plan member can be caught in the middle of their health plan and the provider. It is not unusual for members to receive bills -- maybe even for the full billed charge -- as disputes regarding medical necessity or other reasons for denial are ongoing.

Cooper rightfully maintains that the member deserves an advocate to aid them through the claim resolution process.

For Peggy Plair, Senior Director of Claims, UnitedAg, providing member advocacy can reduce the stress and burden on the member and, ultimately, increase satisfaction with their health plan.

She acknowledges that claim disputes are just part of doing business, noting, "Members should absolutely have the right to question a decision if they think something was processed incorrectly. But one of the biggest challenges we see is that members and providers often don't fully understand what's covered under their plan — especially when they appeal decisions for services that aren't included."

When it comes to making determinations, she states that external review agencies, both state and federal, tend to side with the member.

"That can be good or bad, depending upon the case and how much clinical detail is involved," says Plair.

One area that she feels is often misunderstood is medical necessity, adding, "We're not here to override the provider, but we do want to advocate for our members. It's about making sure they get the right care, at the right time, for the right reasons. That's where TPAs can really help — by balancing clinical needs with what the plan allows and helping everyone make sense of it."


Chris Harber

Chris Harber, chief operating officer at Vālenz Health®, contends that plan members should largely be excluded from the dispute process, adding, "The extent of their involvement should be following the appropriate channels through their TPA. TPAs and vendors should be responsible for ensuring all member communication from the provider ceases, so we can engage in coming to a reasonable resolution. Therefore, the first step of the resolution process should always be a request that the provider puts the patient account on hold."

DISPUTES OR DENIALS – WHAT'S THE DIFFERENCE?

Claims Disputes

Disputes are initiated when the denial is believed to be incorrect or unjustified. The process usually involves gathering additional documentation, submitting an appeal, and potentially engaging in further review or legal action. Essentially, this term reflects a difference of opinion regarding what the provider should be paid for its services.

Claim Denials

A claim denial applies to a claim that has been processed and found to be unpayable. This means the insurer has finished reviewing the

claim and decided not to pay based on the policy. Claim denials fall into three categories: administrative, clinical, and policy, with the majority of claim denials due to administrative errors. Denials can happen for various reasons, such as missing information, incorrect billing codes, lack of pre-authorization, or the service being deemed not medically necessary. Providers typically appeal the denial to attempt to get the payment.

"Coverage denials are becoming more frequent and more legally fraught," says Bruce D. Roffé, president and CEO, H.H.C. Group. "As insurers and TPAs lean into AI-based tools and automated decision engines, the margin for error grows. Denials issued too quickly or without clinical rigor are increasingly challenged by members, regulators, and courts."

When a dispute gets out of control, Roffé explains that the consequences can include:

- Compliance breaches that lead to investigations or fines.
- Litigation risks that drain resources and damage credibility.
- Unpaid claims ballooning into larger financial liabilities.
- Reputation loss that undermines confidence with plan participants.

"In most states, once the internal appeal process is exhausted, insurers must refer the external review to the state, which assigns it to an approved Independent Review Organization (IRO)," he continues. "In others, insurers can contract directly with an IRO like H.H.C. that is fully equipped to support both pathways. Having a medical review process in place isn't enough. It must be structured, defensible and trusted—internally and externally."

He describes that what used to be routine coverage decisions are now potential compliance flashpoints, adding, "Minor disputes are under legal and regulatory microscopes and outdated processes; slow responses or patchwork expertise can put an entire plan at risk. In today's environment, it's not enough to stay compliant. Plan sponsors need to lead with confidence and promote faster resolutions, airtight compliance and decisions that stand up to any challenge."

With all that has transpired in the last year, claim denials are now under the microscope for many organizations.

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1 Based on medical record review of 573 patients, from multiple employers, referred into the Mayo Clinic Complex Care Program in 2024.

2 American Health Policy Institute (AHPI); High Cost Claimants: Private vs. Public Sector Approaches

Harber affirms, "Whether it be pre-certification denials or post-service claim appeals, the Vālenz Health® goal is to ensure we are looking out for the best interest of the plan and the employer by executing based on their plan document. While there are certain guidelines and processes vendors can put in place, they should be done with the best intentions of the plan and its participants — meaning we should make informed decisions based on their expectations. Denials only become an issue when a party in the value chain has an incentive for them to be."

Vālenz Health® is involved in dispute resolution, primarily at the federal level and occasionally at the state level.

"We handle as much of the process as a group or TPA is willing to cede to us," states Harber. "As a cost-containment vendor, we have the data and resources to support complex negotiations and provide the required support should a claim enter IDR. This includes assistance with IDR fees and final offer submissions that provide detail on each decision point the IDR entity may use to make a decision."

Addressing the issues of claims denials and appeals – not disputes related to the No Surprises Act -- Joanna Wilmot, director, PACE®(Plan Appointed Claim Evaluator®), The Phia Group, offers this perspective of a consultant, not a plan sponsor:

"As a vendor working in the appeal space, when a plan design, supporting policies and a claim system are developed and applied accurately, the claim denial rate should mirror the plan's intent," says Wilmot. "However, with economic concerns, the denial rate could increase if a plan is looking to reduce its expenses by reducing benefits. If a plan is well designed and well applied, a reduction in benefits becomes a moot point. PACE relies upon the plan language, policies, and procedures to make a non-biased decision regarding any claim denial. "

Her organization determines medical necessity by collecting and submitting medical records and claim-related documents to physicians specializing in the related medical condition at a URAC-accredited organization.

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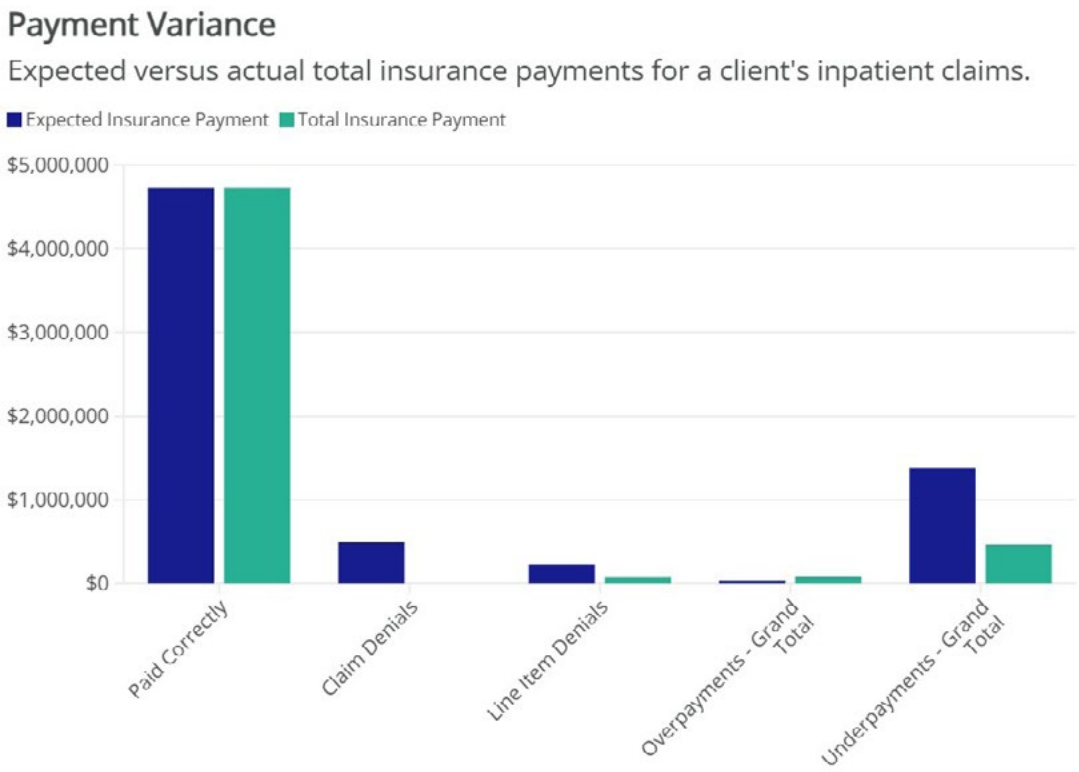
She says that often, plan members require support or advocacy regarding claim disputes, adding, "Yes, we see plan members require support, and this comes from the administrator or another advocate group. Many appeals that we evaluate are submitted by the medical provider on behalf of the member."



Source: 2025 Forvis Mazars

Julie A. Wohlstein, M.A.S., CSFS, board member, HCAA, president/CEO, Centrix Benefit Administrators, Inc., offers this perspective from the vantage point of a TPA: "We view claim disputes and denials not as administrative hurdles, but as opportunities to reinforce our value to both plan sponsors and members. While denial rates themselves aren't our primary concern, the clarity and consistency behind those decisions are. Our role is to ensure plan documents are precisely interpreted, and that claims are adjudicated fairly, transparently, and in alignment with ERISA and applicable state or federal laws."

She explains that medical necessity and appropriateness determinations follow evidence-based criteria and URAC-accredited guidelines, though her organization regularly engages an IRO for nuanced or emerging treatments.

"We also participate in dispute resolution at both the state and federal level, particularly with increased regulatory scrutiny under the No Surprises Act," she continues. "In our experience, claim resolutions—especially in arbitration settings—have increasingly leaned in favor of providers, which can create sustainability concerns for self-funded plans. This makes proactive oversight and rigorous plan design more important than ever."

Conceding that plan members often feel lost navigating denials, Wohlstein observes, "Yes—they do require support. We see advocacy not as optional, but essential. Educating members, communicating clearly, and walking them through their options preserves trust and strengthens the long-term success of the plan."

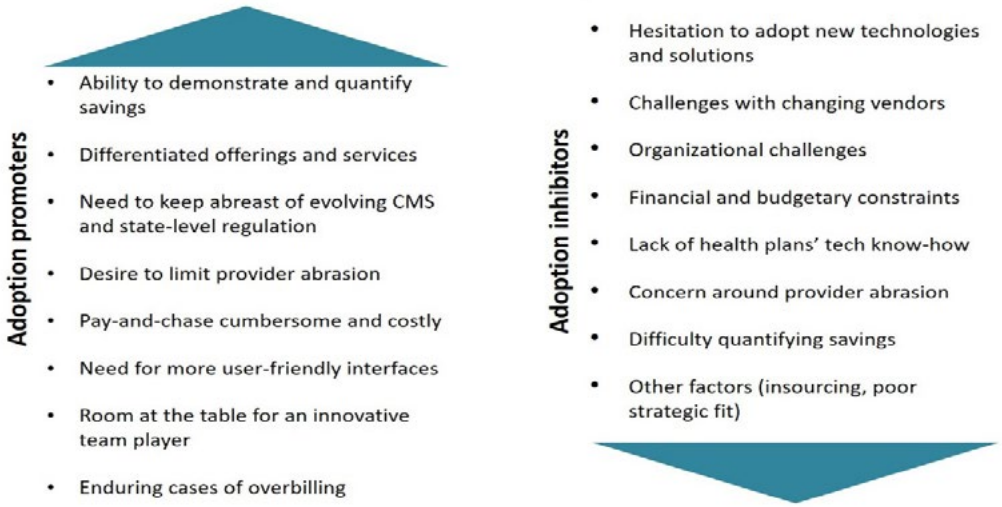
IMPORTANCE OF CLAIM PAYMENT INTEGRITY

High-dollar facility (inpatient and outpatient) claims pose significant financial risk for health plans, employers, reinsurers and TPAs. In recent years, plans have reported seeing a significant rise in potentially undetected charge irregularities, resulting in significant financial challenges across the sector.

In FY2024, CMS reported over $85 billion in improper payments, primarily due to overpayments. Wrongful billing practices can range from duplicate and redundant billing, upcoding, charges for non-covered services and differences for services received by the patient yet billed at a higher intensity or acuity.

If undetected, these practices lead to substantial financial losses for health plans and overstated costs of care. This underscores the importance of payment integrity, which is based on due diligence charge reviews and identification of charge adjustments to ensure that claims are paid timely and accurately.

Payment Integrity in Healthcare: Factors for and Against Adoption
Source: Aite Group



Jakki Lynch, RN, CCM, CMAS, CCFA, director of cost containment, Carbon Stop Loss Solutions, maintains, "Claim payment integrity processes are a best practice solution to address the increasingly complex claims and to proactively ensure correct health plan or third-party administrator payments based on defined plan benefits. Payment integrity processes should include a detailed review of each charge and supporting medical records performed by specialty clinicians, the determination of plan-covered services, and the validation of charge accuracy based on transparent industry references and plan payment policies."


Jakki Lynch

She says that these processes support timely claim review and payment due diligence to ensure plans control costs, address regulatory compliance, and ensure fair and defensible payments to providers and facilities.

"Our complex claim payment integrity review program is not a formulaic or software-based solution as these reviews result in limited savings and they do not identify high-value key clinical charge adjustments and communicate the findings to the providers and facilities to ensure consensus for resolution and payment transparency," she continues. "Charges identified on a claim that are determined to be not separately payable stem from a combination of plan policy and regulatory compliance. Identifying the distinct charge adjustments and supporting them with the detailed references (Plan and

Regulatory) to substantiate the audit exceptions is material to the defensibility and final claims settlement based on our work product."

Lynch offers these guidelines when evaluating plan-eligible charges:

- Are they investigational, experimental, or unproven?
- Are they effective and safe?
- Are they plan benefits since coverage is based on the definitions identified in the plan document, and in accordance with the services documented in the medical record?

At Vālenz Health®, Harber states that the company leverages comprehensive evidence-based criteria developed via a thorough review of the most recent research, academic articles, and data.

"To ensure the most accurate information, we leverage review by a third-party vendor and only update criteria when there's a preponderance of evidence that something should be covered," he explains. "In other words, just because something has worked in an experimental use case does not mean that we would approve it in the same use case. Instead, we require additional research, literature, and data to conclusively confirm that this is the right clinical care in the right clinical setting (i.e., inpatient vs. outpatient) under the correct clinical circumstances."

PRIOR AUTHORIZATION QUANDARY

In virtually every discussion of healthcare claims denials, issues around Prior Authorization (PA) of treatment and services rise to the top. Receiving PA does not automatically ensure payment, although it is a crucial step in the process and indicates the payer's intention to cover the service.

As providers view denials as a growing problem, a recent AMA survey shows that 61% of physicians fear payers' unregulated use of AI tools will increase prior authorization denials. They point to a payer's automated decision-making system as the culprit in creating systemic batch denials with little or no human review.

PA is not a definitive guarantee of payment, and it is not binding. Claim reviews following a service may deny payment for various reasons, such as member eligibility or coverage status on the date of service. Here are some of the other reasons for potential denials:

- Retrospective review by the payer that deems the service experimental, unnecessary or that the provider billed for a different service than the one authorized.
- Ineligibility or benefit limitations that deem the service not medically necessary or inappropriate for the healthcare setting.
- Incorrect paperwork, missing information, or outdated information.
- Payer failure to notify the pharmacy/provider of the approval.
- Expired approval, since PAs are typically only valid for a limited time period, and resubmission may be required.
- Failure to try a less expensive option before approving more costly alternatives.

UNDERSTANDING THE REVIEW AND APPEALS PROCESS

Essentially, self-insured employers should focus on a proactive and data-driven approach to claims denial management. By preventing errors in the first place, implementing efficient claims processing systems, and strategically managing the appeals process, employers can significantly reduce denied claims, improve cost-efficiency and enhance the overall experience for their employees.

Self-insured employers use two main types of appeal processes for healthcare claims: internal and external.

Timelines for Private Health Plans' Internal Appeal Decisions

	Urgent	Pre-Service	Post-Service
Time to File an Appeal	180 days	180 days	180 days
Initial Review Determination	72 hours	● 30 days (1 appeal) ● 15 days (2 appeals)	● 60 days (1 appeal) ● 30 days (2 appeals)

Note: State laws can shorten these timeframes.

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INTERNAL REVIEWS AND APPEALS

Internal appeals are handled by the employer or their third-party administrator (TPA) to make critical decisions about medical necessity, experimental treatments, and clinical appropriateness. The initial appeal is handled within the employer's health plan or by their TPA and typically adheres to a timeframe for filing after receiving a denial. If the internal appeal is denied, the claimant can proceed to an external appeal.

Under self-insured plans, the employer assumes responsibility for all financial risks of claims and costs. For administrative convenience, self-insured plan sponsors typically rely on a TPA to make claims decisions and handle internal appeals.

“When the health plan’s internal team or TPA lacks a specific specialty or when time is short and objectivity matters, an outside resource like H.H.C. Group provides board-certified experts who step in with fast, unbiased, evidence-based opinions that support plan integrity and protect against downstream risk,” explains Roffé. “These reviews are your frontline clinical decision support and are essential for preventing costly coverage errors. Responding quickly to complex or high stakes claims and strengthening claims defensibility before external escalation. Internal reviews that defuse problems early and keep decisions aligned with medical necessity turn disputes into decisive wins.”

EXTERNAL REVIEWS AND APPEALS:

External reviews must be conducted by an IRO that is approved by the state, which recognizes the organization's clinical excellence, compliance standards and operational reliability.

“External reviews are typically assigned by state regulators when a member challenges a denial,” clarifies Roffé. “These reviews carry legal weight and must be handled with precision, providing fair, balanced and

fully documented reviews that meet or exceed state requirements. Stakeholders call upon an organization like H.H.C. Group to ensure that disputes are resolved cleanly, with no regulatory gaps or friction."

An Independent Review Organization like H.H.C. Group directs its board-certified specialists to determine if the insurer must provide coverage and decide whether or not to pay for the treatment or service. Coverage questions usually regard medical necessity, medical appropriateness or whether the treatment is experimental or investigational.

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At Carbon Stop Loss Solutions, Lynch explains, "Our process utilizes a proactive facility outreach to resolve the audit adjustments based on the detailed work product. This approach is resource-intensive and demonstrates a good-faith effort based on engagement and transparency to encourage dialogue and resolution of the audit exceptions while demonstrating to the facility that we stand behind the quality of the audit findings."

She says this proactive approach often results in facility acceptance of the payment integrity charge adjustments, reducing potential appeals, provider abrasion, and effectively mitigating member balance billing.

Lynch expands, "Our claim review determinations are nearly absent appeals (3-4%) due to findings that are thoroughly documented from medical record excerpts and substantiated using provider-considerate means of resolving the issues identified. All appeals are addressed fairly and timely as a part of the overall process and are based on the facility documentation provided for potential charge payment consideration."

Lynch and colleagues coordinate their appeal responses with TPAs or Health Plans to ensure alignment and compliance with plan appeals procedures.

"Our payment integrity program is high value with average savings of 23% and is based on medical record documentation supported by provider communication, including timely appeal resolution, "she concludes.

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Key Differences:

Feature	Internal Appeal	External Appeal
Reviewer	Employer, TPA, or appeals committee	Independent review organization (IRO), state regulator, etc.
Timeframe	Often 60 days, varies by plan	Within four months of internal denial
Independence	May be less independent than external review	Independent from the employer
Decision	May be subject to further external review	Generally binding
State/Federal	Primarily managed by the employer or TPA	State or federal regulated

OUT-OF-NETWORK DISPUTES: WHO'S WINNING?

A much higher volume of out-of-network pay disputes was being filed and processed through the first half of 2024 than during 2023, reports Health Affairs Forefront. While federal government data shows that cases remain concentrated among a small handful of states and large provider groups, providers are still topping health plans in most out-of-network pay disputes.

The report reviewed independent dispute resolution (IDR) cases and outlined a continuation of plans' low win rates: 14% of resolved cases in the first quarter of 2024 and 18% of resolved cases in the second quarter of 2024.

The Georgetown University researchers who conducted the analysis concluded that in cases where plans prevailed, the median prevailing offer amount was 105% of the qualifying payment amount (or the QPA, the price point used during the arbitration process that is meant to represent the median amount an insurer would pay for a service in a particular region.

These analysts demonstrate that historically, provider groups have initiated the majority of IDR cases, with a high volume in just a few states like Texas, Florida, and Arizona. What they say is escalating is the amounts they won: While median prevailing provider offers ranged between 320% and 350% of QPA across 2023, they rose to 383% in the first quarter of 2024 and even higher to 447% in the second quarter of 2024.

Amid providers' greater share of wins, the researchers also noted that resolved cases "predominantly" came from a few large provider organizations that tended to have private equity backing.

Cooper adds this observation, "If we are talking about NSA IDR awards, then yes, claim resolutions are primarily in favor of providers rather than payers. This is backed by the statistics each time they are released by the government. However, with the recent decision out of the 5th Circuit in Guardian Flight, LLC, et al. v. Health Care Service Corporation, holding that there is no mechanism for providers to enforce the awards, the awards are useless. This was a huge oversight by Congress in drafting the NSA."

As background, there is no provision in the No Surprises Act that allows the provider to sue to enforce the IDR awards. The NSA does not provide any private right of action for a provider -- or plan. For that matter,

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to bring an action under the NSA for enforcement or reversal of the award.

The court decision referenced above technically only applies to the 5th Circuit (Texas, Louisiana, and Mississippi). While some courts may not agree with the decision, Cooper says other courts may adopt the decision, potentially the US Court of Appeals for the Second Circuit, located in New York City, that exercises appellate jurisdiction over courts in six districts within the states of Connecticut, New York, and Vermont.

The latest response to this issue came in late July when bipartisan members of the US House and Senate again proposed legislation -- the No Surprises Act Enforcement Act -- that would punish payers that refuse to reimburse claims for out-of-network healthcare services. Providers continue to report problems with insurers refusing to pay up following "independent dispute resolution" (IDR) rulings.

Sponsors of the legislation attest that it will crack down on those who are willfully defying the law and double down on protecting patients by increasing penalties for not complying with payment deadlines and increasing reporting transparency. Three medical societies-The American College of Radiology, American College of Emergency Physicians, and the American Society of Anesthesiologists – are voicing support for the bill. Radiology and emergency medicine were the two specialties with the highest volume of resolved cases under the NSA, accounting for about two-thirds of all determinations in 2024, according to a recent Health Affairs study.

Harber perceives that claim resolutions still favor providers, "... mainly because they are privy to the information required in an IDR situation. Many times, the payer tries to gather certain information but is unable to retrieve it from the provider.

Thus, the QPA calculation becomes critical, even more so when explaining to the IDR entity how you arrived at that number. In certain cases, there are flaws with the provider's case. We see this most often in the air ambulance space."

William Figueroa, chief information technology officer of RxLogic, a technology company for pharmacy benefit claims processing that provides a SaaS-based platform of smart adjudication solutions, states that claim denial rates are a major concern for their customers.

"We focus on delivering tools that enhance transparency and reduce avoidable denials," says Figueroa. "The RxLogic platform can integrate clinical rules and evidence-based guidelines to help determine medical necessity and experimental status. We support, but do not directly participate in, dispute resolution—our role is to facilitate compliance with both federal and state requirements through configurable workflows."

He maintains that claim resolutions often trend toward providers, reinforcing the need for clear documentation.

"Members benefit from integrated advocacy and support tools in our solution," he explains. "This offsets the perceived favorability towards providers."

Mike Lanza

RESPONSIBILITY OF THIRD-PARTY ADMINISTRATORS

Mike Lanza, senior vice president, USBenefits Insurance Services, LLC, enlightens the complex role of TPAs, "The best starting point of a TPA's role is from the employer's expectation due to fiduciary obligations and to mitigate other legal consequences. That said, the TPA must review each claim against the Plan document to ensure claims are paid appropriately. Denials should be clear and state exactly what Plan provision is being used to deny the claim."

With respect to claims for medical necessity/experimental treatment, he says it is critical to utilize cost containment services to review the appropriate claim documents and medical notes.

The service should have the medical expertise to review the specific claim and produce a report that is based on current medical protocols," he continues. "When done properly and timely, this will reduce appeals/disputes. Having a thorough report upfront puts the TPA and Plan in the best position should the provider dispute the analysis."

Lanza maintains that since the member will trust their provider and follow their instructions, the TPA should support the member by directly communicating with the provider to resolve any claim disputes.

"Another important variable is the relationship between the TPA and Stop-Loss carrier," he adds. "Working in concert ensures the best outcome for all parties. In our experience, this process has been shown to financially benefit the plan."

Advisors at NFP, an AON company, further explain that employers sponsoring group health plans subject to ERISA must determine their role in deciding appeals of denied claims. They counsel that plan sponsors can either designate a TPA as claims fiduciary with final decision-making authority over appeals or assume the role of claims fiduciary themselves.

Importantly, they recommend that even if the claims fiduciary role has been delegated to a TPA, the plan sponsor's broader fiduciary duty to monitor the TPA's service to the plan cannot be delegated. In these instances, monitoring can become particularly challenging when the plan sponsor does not play the role of final decision-maker.

In this litigious environment, however, serving as a claims fiduciary demands strict compliance with considerable regulatory claims and appeals procedures. The decision whether to play a more hands-on role as claims fiduciary requires weighing the ability to monitor the TPA and the ability to satisfy the regulatory requirements related to appeals processes.


Nick Soman

WHEN DENIALS ARE NOT AN ISSUE

Claim denials aren't a major concern for Nick Soman, CEO, Decent, and his staff.

"We work with a Utilization Management partner that looks at each case carefully using medical evidence and the member's records," maintains Soman. "If there's a disagreement, we help manage the appeal process and may even take part in external reviews if it escalates."

Since his organization runs ERISA health plans, Soman says, "We sometimes have to be involved at the federal level. Members can file disputes on their own, but we offer extra support when it's needed, like in surprise billing situations. We always aim for decisions that are fair and easy to understand."

SURPRISE MEDICAL BILLS STILL ARRIVING

These unwelcome invoices were supposed to be a thing of the past – but they're not, reports KFF.

New accounts relate that while the No Surprises Act (NSA) is successfully protecting insured patients from certain types of unexpected out-of-network charges—primarily those involving emergency care or unintentional out-of-network services—NSA does not cover a wide range of other unexpected charges from in-network providers or services lacking clear cost estimates.

Members may have been led to believe that provisions in the law intended to provide cost transparency for insured patients—such as good-faith estimates—have not yet been implemented. This leaves many individuals vulnerable to unexpected and confusing charges, even when they believe they are following all necessary procedures.

As a result, and despite the law, many people are caught off guard and face unanticipated medical bills with unclear explanations and complex billing systems. Clearly, the law's intentions and the actual patient experience are not aligned, fueling calls for broader reforms and enforcement.

The road ahead for employers may be littered with even more claims disputes and denials. ■

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