Why clinical criteria gaps are driving up insurance denials

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Denials from insurance payers have increased over the past several years, intensifying pressure on hospital revenue cycles. National denial rates have climbed from just over 10% in 2020 to nearly 12% in 2026, and more than 40% of providers now report denial rates above that threshold.[1,2] As a result, industry estimates suggest that billions in hospital claims are initially denied each year.[1] This places denials among the most significant sources of revenue disruption in healthcare.

Denials are shifting from administrative to clinical

Today, hospitals not only face payer denials tied to medical necessity, missing or incomplete prior authorization, and eligibility volatility, they are also increasingly receiving denials driven by insufficient clinical documentation. Many health systems report missing or unclear clinical indicators for high-acuity diagnoses such as acute respiratory failure and severe protein-calorie malnutrition as some of the most common reasons claims are denied.

Sepsis reveals a growing mismatch clinical practice and payer criteria

While denials tied to diagnoses like acute respiratory failure and severe protein-calorie malnutrition are familiar to most providers, sepsis denials have become more complex. Many clinicians, health systems, and CMS continue to rely on Sepsis-2 criteria, which emphasize early recognition and treatment of infection and inflammatory response. At the same time, many payers have shifted to Sepsis-3 criteria, which define sepsis based on documented organ dysfunction. As part of this shift, payers increasingly look for documentation aligned with the Sequential Organ Failure Assessment (SOFA), a standardized framework introduced in 2016 to assess the presence and severity of organ dysfunction.

This disconnect is not always visible at the bedside. During Optum[3]-led physician documentation integrity education sessions, providers frequently expressed surprise at how often their sepsis diagnoses were being denied. Providers do not use Sepsis-3 criteria when diagnosing sepsis, emphasizing that their clinical focus is on preventing organ dysfunction, not documenting it once it occurs. As a result, documentation may accurately reflect clinical intent but still fall short of payer expectations.

Regulatory scrutiny is reinforcing this shift. The Office of Inspector General is currently auditing Medicare sepsis billing, focusing on the gap between older sepsis standards and newer, organ-failure-based criteria. In response, Optum is expanding documentation education beyond traditional clinical documentation improvement (CDI) to help providers better understand how sepsis diagnoses are evaluated by payers and to ensure that supporting clinical criteria and links to organ dysfunction are clearly documented when present.

Other examples of documentation-driven denials

Beyond sepsis, several other diagnoses are frequently targeted because payers view the documentation as insufficiently specific or internally inconsistent.

Acute respiratory failure

As the second most frequently denied diagnosis, acute respiratory failure is often challenged when documentation does not clearly demonstrate respiratory compromise. payers commonly scrutinize cases where the diagnosis appears alongside notes indicating:

- No respiratory distress
- No shortness of breath
- Ability to speak in complete sentences

When documented findings don't clearly align with the patient's diagnosis, claims are more likely to be denied, even if the clinical intent was appropriate.

Severe protein-calorie nutrition

Severe protein-calorie malnutrition, another high-risk diagnosis, is often denied when provider documentation does not clearly establish the diagnosis and its severity. Although dietitian assessments may include detailed clinical evidence, coding rules require that the provider explicitly document the diagnosis to validate it for billing. When that step is missed, well-supported cases become vulnerable to denial.

How leaders can rethink denial prevention

As clinical denials become more criteria-driven, preventing them can no longer sit solely within the revenue cycle. Preventing denials requires leadership alignment around documentation quality, clinical practice, and how diagnoses are evaluated after the fact. For executive teams, that raises several critical questions:

- Do providers understand which diagnoses are most vulnerable to clinical denials and why?
- Is documentation quality treated as a clinical and financial priority, or as a downstream coding issue?
- Are CDI teams positioned to intervene in real time, while documentation can still be clarified, rather than after claims are denied?
- Is there alignment between clinical leadership, CDI, and revenue cycle teams around evolving payer and regulatory expectations?

Organizations that address these questions proactively are better positioned to reduce denials before they occur, rather than relying on costly and often unsuccessful appeals.

Endnotes

1. The Optum 2024 Revenue Cycle Denials Index. Optum. November 2024.
2. Experian Health's 3rd Annual State of Claims Survey Finds Denials Still on the Rise Amid Escalating Challenges. Experian. September 22, 2025.
3. Advisory Board is a subsidiary of Optum. All Advisory Board research, expert perspectives, and recommendations remain independent.

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