THE HOSPITAL DENIAL AUDIT

5 Numbers Every Case Management Director Must Know — And How to Fix Them

From the Desk of Augusta Uwah, MD, MPH
Board-Certified Internist · Physician Advisor · Founder, Clinefficiency Pro

I spent years doing utilization review — writing peer-to-peer letters, chasing documentation gaps, watching avoidable denials slip through. Most of those denials weren't clinical failures. They were operational ones. The numbers below are what I wish someone had handed me on Day 1.

If any of these five metrics are in the red at your hospital, you have a fixable problem — and I'll show you exactly what to do about it.

~$5M	65%	4 hrs
avg annual denial write-offs■per 150-b	of denials are preventable■with better do	avg daily time spent■on UR documentation

1 YOUR INITIAL DENIAL RATE

Initial Denial Rate

■ ***Industry benchmark: under 3%***

Why This Number Matters

Your initial denial rate tells you how often payers reject your claims on first submission. Most hospitals track this — but few break it down by payer, DRG, or admitting physician. That breakdown is where the money hides.

■ **Red Flag:** If your rate is above 5%, your documentation workflows have a structural problem — not a one-off documentation issue.

How to Calculate It

Pull your last 90 days of claims data. Filter by denied on first submission. Divide by total claims submitted. Then segment by payer.

THE FIX

Map your top 3 denial reasons to specific DRGs. In most hospitals, 20% of DRG codes drive 80% of denials. CLIP Suite's GapDetect™ module flags documentation gaps before submission — at the point of care, not after the denial lands.

2 YOUR DENIAL OVERTURN RATE

Denial Overturn Rate

■ ***Industry benchmark: above 60% on appeal***

Why This Number Matters

This is the number hospitals underinvest in. A high overturn rate means your clinical arguments are strong and your peer-to-peer process is working. A low overturn rate means you're writing appeals that payers are trained to reject.

■ **Red Flag:** If you're winning fewer than 50% of appeals, your peer-to-peer narratives are missing the clinical specificity payers require.

How to Calculate It

Divide successful appeals by total appeals submitted in the last 6 months. Track separately by payer — overturn rates vary wildly by insurer.

THE FIX

Payers reject vague appeals. Winning appeals cite specific clinical indicators, reference InterQual or MCG criteria by name, and document medical necessity with measurable parameters. CLIP Suite's NarrativeGen™ generates payer-specific appeal language calibrated to the denial reason code.

3 YOUR AVOIDABLE WRITE-OFF RATE

Avoidable Write-Off Rate

■ ***Target: under 1.5% of gross revenue***

Why This Number Matters

Not every denial becomes a write-off — but too many do because hospitals lack the bandwidth to appeal everything. The cases that get written off are often the most winnable ones: they just never made it to appeal.

■ **Red Flag:** If write-offs from denials exceed 2% of gross revenue, you have a capacity problem in your denial management workflow, not a clinical one.

How to Calculate It

Pull write-offs coded to denial-related adjustments. Calculate as a percentage of gross charges. Then ask: what percentage had a completed appeal?

THE FIX

Triage your denial queue by dollar value and overturn probability. High-dollar + high-overturn = always appeal. CLIP Suite's DenyGuard™ module risk-scores every denial automatically, so your team focuses appeal energy where it recovers the most revenue.

4 YOUR OBSERVATION VS. INPATIENT CONVERSION RATE

Obs-to-Inpatient Conversion Rate

■ ***Benchmark varies; track your trend, not just the number***

Why This Number Matters

Observation status is one of the most expensive misclassification errors in hospital medicine. Patients who should be inpatient — and whose care meets inpatient criteria — leave revenue on the table when kept on obs status due to documentation gaps at admission.

■ **Red Flag:** If more than 15% of your observation patients retrospectively met inpatient criteria, your admission documentation is not capturing medical necessity at the point of decision.

How to Calculate It

Review last quarter's observation cases. Have a physician advisor retroactively apply InterQual or MCG criteria. Count how many would have qualified for inpatient.

THE FIX

The decision has to be made — and documented — at admission. CLIP Suite's StatusIQ™ module analyzes admission notes in real time and alerts case managers when inpatient criteria are met but not yet documented, before the window closes.

5 YOUR PHYSICIAN ADVISOR RESPONSE TIME

Physician Advisor Response Time

■ ***Target: under 4 hours for urgent concurrent reviews***

Why This Number Matters

Slow physician advisor response is the silent denial driver no one tracks. When a concurrent review request sits unanswered for 12 hours, payers make their own determination — and it's rarely in your favor. Speed here is not just

operational; it's clinical and financial.

■ **Red Flag:** If your average PA response time exceeds 6 hours for urgent reviews, you are likely losing winnable concurrent denials.

How to Calculate It

Pull your concurrent review log. Filter by urgent/expedited requests. Calculate average time from case manager escalation to PA response and documentation.

THE FIX

Most PA response delays aren't a staffing issue — they're a documentation burden issue. When PAs spend 45 minutes per case pulling chart context, they can't respond to 8 cases in a day. CLIP Suite's NarrativeGen™ pre-populates the clinical summary so PAs review and refine, not build from scratch.

YOUR DENIAL AUDIT SCORECARD

Use this table to assess your hospital's current position on each metric. Be honest. These numbers don't lie — and they're the first thing I review when a hospital reaches out about CLIP Suite.

METRIC	YOUR NUMBER	BENCHMARK	STATUS
Initial Denial Rate		< 3%	
Denial Overturn Rate		> 60%	
Avoidable Write-Off Rate		< 1.5% of gross rev.	
Obs → Inpatient Conversion		Track trend	
PA Response Time (urgent)		< 4 hours	

═ Print this page and fill it in during your next team meeting, or request a complimentary 20-minute Denial Diagnostic call at clip.clinefficiency.com.

Ready to Close the Gap?

CLIP Suite is a multi-agent AI platform built by a physician advisor for physician advisor teams. NarrativeGen™ · DenyGuard™ · StatusIQ™ · GapDetect™

Book a complimentary 20-minute Denial Diagnostic Demo →

clip.clinefficiency.com

Augusta Uwah, MD, MPH is a board-certified internist, certified physician advisor, and AI consultant. She is the founder and CEO of Clinefficiency Pro and the creator of CLIP Suite — the only utilization review AI platform built from the physician advisor's chair.