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Eye On Denials

Insurers Getting Creative with Auto-downgrades, AI and more

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TABLE OF CONTENTS

Eye On Denials
Introduction

Healthcare margins are tightening –and not just for hospitals.

Payers are experiencing their HIGHEST Medical Loss Ratio (MLR) in years, driving down quarterly profits

The Result?

- **Narrowing Networks**
- **Reduced Member Benefits**
- **Provider Denials**

Respondents to the January ACDIS *CDI Industry Overview Survey* report that the majority of their denials originate from private payers.

UnitedHealthcare, Humana, and Blue Cross Blue Shield secured the top spots of denial-prone payers with Aetna close behind, per ACDIS.

But private payers aren't the only source: Medicare Administrative Contractors were up as the principal source of denial for some responsents, from 16% in 2024 to 21% in 2025.

Long story short: Denials are getting turned up, not down.

We anticipate the trend to accelerate. **And these aren't your grandfather's denials.** Aided by new technologies, payers are finding increasingly creative ways to deny claims outright or blanket reduce payments, a soft equivalent to a denial.

This report examines some of the latest trends and payer techniques—the ones we've heard about at least, as new and innovative denials keep popping up every day.

Aetna Level of Severity Inpatient Policy

This is one of the more creative and insidious payment reduction policies we've seen. While at first glance it seems to lower the bar to admission and therefore benefit hospitals with a higher DRG reimbursement rather than observation APC payment, the policy actually allows the insurer to **pay the majority of IP stays at a lower rate**.

Effective Jan. 1, Aetna's New Level of Severity Inpatient Payment Policy:

- **Applies to Medicare and Special Needs Plans (SNP) inpatient claims, and providers whose contracts are paid based upon DRG/Medicare Allowable.**
- **Authorizes the IP stay for urgent or emergency admissions one midnight or greater upon IP order**
- **Triggers a level of severity review on all IP stays where the member stays up to 5 midnights, to determine whether a claim is paid at the higher or lower level of severity rate using MCG severity criteria**

And then: Inpatient stays that do not meet MCG severity criteria will be paid at the lower level of severity rate.

For hospital stays where the member stays five (5) midnights and greater, Aetna will forgo severity review and pay the higher level of severity rate. Estimates for the average length of stay (LOS) vary, but the most up to date we found, an Oct. 2025 study by Definitive Healthcare of 3,857 U.S. hospitals, showed an average LOS of 4.96days.

Aetna wins all around with this policy. While framed as a need for payment accuracy by the insurer, this gives the insurer far more control over how much payment it will render.

On average Aetna is paying less per admission; in some cases we've heard the lower severity payment is less than the contracted observation payment. Not a "denial" but very much the equivalent. Experts are decrying the rule, stating that it violates contractual payrates.

See ICD-10 Monitor article cited below

Auto E/M Downgrades

In Nov. 2025 Blue Cross Blue Shield of Massachusetts began reviewing E/M claims from providers who consistently bill at levels 4 and 5. It then auto-reduces reimbursement if it decides overcoding has occurred.

Clinicians can submit additional documentation and appeal to have claims reinstated as originally billed (see Norwood article below).

BCBSMA estimates that just 1-2% of primary care physicians and 3-4% of specialists in its network will be subject to the expanded process.

Color us skeptical.

Cigna was poised to implement a very similar policy starting Oct. 1 but ultimately relented following pressure from physician groups in its network.

BCBS of MA moved ahead with the controversial policy despite pressure from the likes of the American Osteopathic Association, who wrote a strongly worded letter of opposition.

It's not just BCBSMA: Per an article from NBC News other insurers including Humana and Molina Healthcare have all acknowledged downcoding higher-level claims for certain office visits, or "adjusting" as it's sometimes called.

Is it possible some providers overcode? Absolutely.

But BCBSMA's policy does not account for providers whose populations are sicker, or who have done more documentation/coding work over their peers.

We fear this policy may lead to defensive coding and under-reflection of acuity.

AI Auto-Denials

Auto-downcoding
requires automation
Artificial Intelligence (AI)
is the tool enabling it.

Some AI vendors tout their AI tools as "revenue game-changers" and a net positive for hospitals and physician practices.

While we don't doubt they are in some circumstances, AI tools are also being used by payers to deny claims in volume.

The auto-downcoding practices above would not be possible without AI assistance.

AI is not a panacea, just the latest tool. And a tool that can be used to strengthen documentation in volume can also be used to scrutinize documentation in volume.

In short, AI is a neutral proposition.
You've got to have it because it will be used AGAINST you.

Sepsis

If AI is the new kid on the block, Sepsis is an oldie but a goodie

Some 85% of respondents to the ACDIS Industry Overview Survey reported that sepsis is their top denied diagnosis, beating out respiratory failure (77%), encephalopathy (57%), and malnutrition (52%).

How is it being denied? Payers are using the more stringent sepsis-3 definition to deny hospitals using more permissive sepsis-2 criteria.

Other payers are using SOFA criteria—which is explicitly intended for use only for sepsis screening—as a source of diagnostic presence and ultimately, denials.

Sepsis-3 defines sepsis as a life-threatening organ dysfunction caused by a dysregulated host response to infection—a much higher bar than sepsis-2, which characterizes sepsis as the presence of infection plus systemic inflammatory response syndrome (SIRS). It relies on identifying SIRS criteria—abnormal temperature, heart rate, respiration, or white blood cell count—in the context of suspected/proven infection.

There may be help forthcoming as a group has petitioned the Cooperating Parties for a new "early sepsis" code to bridge this sizeable definitional gap.

But until (and if) that change occurs,

hospitals will continue to have sepsis denied and stripped off their claims.

References & Resources

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