

SWARM STUDY BRIEF • THE CLEAN CLAIMS CHALLENGE

Standardizing claim edits emerges as key opportunity to reduce claims denials

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A focus group of more than 70 provider, payer and technology representatives indicates providers are prepared to adopt standardized edits within a year.

The “bot for bot” battles between payers and providers over claim rejections contribute unnecessary administrative strain and cost to an already overburdened system. Now, there are signs the industry could be ready for a transformative solution — one that would involve standardizing payer claim edits to improve claim acceptance rates, accelerate payment and ease patients’ concerns around medical payment.

Administrative complexity has long been recognized as a major contributor to healthcare costs. A 2019 *JAMA* study found that administrative complexity alone adds more than \$265 billion in waste to the U.S. healthcare system every year.^{1a} Meanwhile, a 2021 study identified 30 interventions that could reduce administrative waste by a quarter trillion dollars annually.^{2b} One of the areas ripe for intervention and cost savings: administrative modernization of the healthcare claims process.

Recently, HFMA’s Vitalic Health initiative sought to reduce administrative waste related to healthcare claims by:

- Establishing a nationally recognized and operationally consistent definition of a “clean claim”
- Developing a core set of standardized payer claim edits
- Creating implementation guidance to improve claim acceptance rates, reducing administrative waste while accelerating accurate payment and supporting timely access to care

a. Shrank, W.H., Rogstad, T.L., and Parekh, N., “Waste in the U.S. healthcare system: Estimated costs and potential for savings,” *JAMA*, Oct. 7, 2019.

b. Sahni, N.R., Mishra, P., Carrus, B., and Cutler, D.M., “Administrative simplification: How to save a quarter-trillion dollars in U.S. healthcare,” McKinsey & Co., Oct. 20, 2021.

WHAT IS A VITALIC HEALTH SWARM STUDY?

Vitalic Health is a multi-stakeholder framework designed to move the needle on affordability, better outcomes and financial sustainability in U.S. health-care. Vitalic Health swarm studies are designed to identify key healthcare industry problems perceived as difficult to solve due to their complex and interconnected nature. Through the swarm studies, Vitalic Health will partner with stakeholders to explore new solutions for driving meaningful change.

The study comes at a time when the rate of initial claim denials rose to 11.65% through November 2025, up from 11.41% in 2024, according to Kodiak Solutions.^c Initial denial rates related to prior authorization and precertification rose to 1.56% in 2025 through November, up from 1.46% in 2024, Kodiak Solutions research found.

FIRST STEPS TOWARD A COLLABORATIVE APPROACH

In early 2026, HFMA’s Vitalic Health initiative brought together providers, payers, technology providers, and experts in healthcare policy and operations to uncover a solution that would reduce the administrative strain and expense of claim rejections.

c. Williams, J., “Battle of the Bots intensifies over denials,” *hfm*, February-March 2026.

Claim rejections resulting from payer edits have long been an issue in healthcare. As early as 2011, the Washington Healthcare Forum — a forum for senior healthcare executives — advocated for adoption of industry-standard coding policies and transparency around payer-specific deviations, with the goal of reducing denials through consistent coding and edits.^d The same year, an American Medical Association whitepaper underscored the inefficiencies and complexity created by payer-specific code edits and advocated for a standard code-editing system.

By 2014, reports indicated that 61% of claim denials resulted from payer-specific edits.^e And in 2022, a *RACmonitor* article presented a compelling case for redefining, modernizing and standardizing the definition of the clean claim.^f “The Medicare and Medicaid billing, reimbursement, and appeals processes are clear as mud — and sometimes run contrary to American values and concepts,” the article states.

The Vitalic Health clean claims swarm study combined two research methodologies: a digital survey of 64 revenue cycle professionals from 54 organizations plus a live discussion group — enabled by AI — where more than 70 participants deliberated in real-time.

The dual-phase approach was intentional. The survey captures what individuals think independently, while the swarm study session reveals the top points stakeholders agreed on when engaging in structured real-time discourse. (See the study design and methodology located at right.)

Together, these methods both validated significant market demand for a standardized approach to payer claim edits and revealed nuanced implementation priorities.

THE FINDINGS

The swarm study revealed that the desire for a standardized approach to claim edits is overwhelming. Nearly 70% of Swarm Study participants and survey respondents indicated they are fully ready to adopt standardized edits. Just 6% reported they were “not ready,” indicating low organizational resistance.

However, it is important to note that just three of the participants in the swarm study represented payers. This indicates the need for a call to action across key stakeholder groups to drive change.

The following is a breakdown of the responses by question.

d. Washington Healthcare Forum, “Administrative simplification: A program of the Washington Healthcare Forum operated by OneHealthPort,” March 23, 2011.

e. Staff news writer, “No more secrets: Insurer claim edits come into the light,” American Medical Association, April 25, 2014.

f. Emanuel, K.C., “Making the case for clean claims,” *RACmonitor*, May 4, 2022.

The study design and methodology drove dynamic input

The Vitalic Health clean claims swarm study comprised a sequential, mixed-methods design that paired asynchronous individual assessment with synchronous collective deliberation.

Phase 1: Digital survey

A 22-question Qualtrics survey was distributed to healthcare professionals across the provider, payer, clearinghouse and technology sectors. The survey assessed five domains: clean claim definition and elements, claim failure root causes, payer-specific edit burden, automation maturity and readiness for standardization.

Phase 2: Thinkscape swarm intelligence session

A live 56-minute session was conducted on Feb. 11, 2026, using the Unanimous AI Thinkscape platform. More than 70 participants were organized into 18 collaborative ThinkTanks. They were then asked seven focused questions. The platform enabled real-time ideation and discussion, enabling groups to come to a consensus with measurable statistical certainty (e.g., support percentage, conviction score and certainty level).

Dimension	Digital Survey	Swarm Session
Format	Individual structured responses	Real-time collaborative deliberation
Participants	54 organizations	70+ participants across 18 ThinkTanks
Duration	Self-paced (multi-day window)	56 minutes (7-8 minutes per question)
Interaction	None (independent responses)	Cross-pollination between rooms
Output	Rankings, selections, open-ended text	Consensus answers with statistical certainty
Strength	Breadth across 22 questions	Depth and convergence on seven questions

Methodological Note: In peer-reviewed research, swarm intelligence methodologies have been proven to amplify group decision accuracy by more than 30% compared with traditional polling. The methodology produces statistically validated consensus rather than simple majority preference, enabling distinction between strong agreement (>99% certainty) and genuinely contested topics (58% certainty).

FINDING 1:

The definition is not the problem

The digital survey demonstrated near-unanimous consensus on what constitutes a clean claim. This finding was confirmed in the swarm session, where questions around the definition of a clean claim generated little disagreement. The implication is clear: Efforts to create a universal definition of a clean claim — while symbolically important — will not reduce claim denials or their associated administrative burden and cost.

FINDING 2:

Payer-specific edits drive most claim rejections and denials

Sixty-nine percent of respondents reported that payers use proprietary claim edits. This results in significant variation in how payers implement and enforce claim requirements. It also places intense burden on healthcare revenue cycle teams to keep up with rules that vary by payer. In fact, 42% of providers participating in the swarm study maintain more than 100 distinct edits per payer.

These findings reframe the clean claim narrative. The prevailing industry assumption has been that claim failures are primarily a provider-side quality issue — inadequate coding, incomplete documentation or insufficient technology investment. The swarm consensus — corroborated by survey data — identifies the root cause as systemic fragmentation.

The top opportunity for payer claim edit reform: modifier standardization, according to participants.

FINDING 3:

Providers are challenged to keep up with changing claim requirements

Variable and continually changing payer requirements at the coding level were identified as the factors that most often lead to initial claim denials. Even if a provider correctly maintains payer-specific edits, those edits may become obsolete without standardized notification of changes made by the payer. The absence of a transparent, industry-wide change management process means organizations must independently monitor, detect, interpret and implement payer rule changes or risk an initial claim rejection. It's a redundancy that represents significant avoidable cost.

According to the digital survey, just 28% of respondents have fully automated their claims submission process. More than half (58%) rely on a hybrid of automation and manual intervention. Partial automation leaves organizations particularly vulnerable to unannounced changes in payer edits.

BY THE NUMBERS

7 OUT OF 10 Participants report that payers use proprietary edits

42% Maintain 100+ payer-specific edits

69% say they are ready to adopt standardized claim edits

72% anticipate standardization would reduce claim rejections by 26%

FINDING 4:

Providers' No. 1 ask: Standardized claim edits across payers

If all payers were to follow the same set of rules around claim edits, this move would substantially improve claim accuracy and acceptance, participants agreed.

This consensus represents the study's most consequential finding. It is derived from structured deliberation among more than 70 professionals representing diverse organizational roles. Multiple respondents independently suggested Medicare edits as the logical standardization baseline, indicating organic alignment as a starting point for improvement.

The digital survey found that most respondents are ready or mostly ready to adopt standardized edits, with most believing standardization could eliminate more than a quarter of their claim rejections.

FINDING 5:

Front-end claim scrubbers are highly effective in strengthening clean claims rates

Front-end claim scrubbers were identified as the most effective tool for promoting claim accuracy and accelerating claim approval and payment.

Front-end scrubbers catch errors before submission, reducing the downstream cost of denials, appeals and rework. However, participants noted that the effectiveness of these tools is dependent on real-time access to updated payer edits.

FINDING 6:

Rejection code clarity is an industry fault line

When asked which claim rejections create the greatest administrative burden, respondents were split between vague payer rejections lacking specific claim adjustment reason codes/remittance advice remark codes and generic rejections that include a code but provide no actionable detail.

This was the sole question where participants did not reach a strong consensus. The lack of convergence is significant. It reveals a tension between stakeholders that prioritize better rejection details (a data standards issue) and those that prioritize better rejection descriptions (a communication and transparency issue). Both camps agree that current rejection practices are inadequate; however, they disagree on the remedy. This represents a high-priority area for further investigation in subsequent swarm studies.

FINDING 7:

Real-time deliberation surfaced deeper insights than the digital survey alone

The two-phase methodology revealed a consistent pattern: Individual survey responses tended to identify proximate, operational-level symptoms, while the swarm session elevated systemic, structural-level causes of claim rejections and denials.

Example: The survey ranked insurance validation/coordination of benefits errors as the No. 1 reason behind claim rejections. The swarm study elevated non-standardized, payer-specific edits to the top spot. This shift suggests that insurance validation errors are often upstream consequences of payer-specific rule fragmentation — a root cause that individual respondents may not articulate in isolation but will converge around through structured discourse.

This methodological finding validates the solve-based convening model and suggests that traditional survey-only research may systematically understate the structural drivers of healthcare's administrative challenges.



LEARN MORE ABOUT VITALIC HEALTH

Powered by HFMA, Vitalic Health strives to advance financial sustainability and better health outcomes in U.S. healthcare. It facilitates solve-based convening among leading industry stakeholders to boldly address the complexities of lowering health expenditure and increasing health and life span to improve the vitality of our communities. Learn more at www.hfma.org/vitalichealth

3 VITAL OPPORTUNITIES

What could help propel adoption of uniform claim edits? Vitalic Health leaders identified three opportunities.

► Opportunity 1

Establish a national claim edit library. Convening payers, providers and tech vendors to develop a core national claim edit library would create a consistent rule set that could be adopted across payers and embedded in clearinghouses, EHRs and claim scrubbers. The impact: reduced initial claim denials and administrative rework.

► Opportunity 2

Create an industry claim edit change notification system. When payer edit rules change frequently without a common notification mechanism, this puts pressure on providers to independently detect and interpret rule changes. Developing an automated edit change notification framework would empower vendors and providers to update systems in near real time. This would significantly decrease operational friction. It would also reduce outdated edits and preventable claim rejections.

► Opportunity 3

Launch a payer-provider clean claims implementation consortium. While provider readiness for standardized payer edits is high, payer alignment is essential for meaningful progress. A multi-stakeholder clean claim consortium would seek to bring together payers, providers, clearinghouses and technology firms to establish governance, adoption timelines and implementation guidance. This group would oversee development of industry guidance, manage updates and ensure coordinated rollout across the industry. Benefits would include reduced administrative waste and improved payment accuracy.



Affordability is a movement.

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