ORIGINAL ARTICLE

OBJN
Online Brazilian Journal of Nursing
ISSN: 1676 - 4285 | www.objnursing.uff.br

Submission: 20-Mar-2025
Approved: 12-Aug-2025

ANALYSIS OF HOSPITAL CLAIM DENIALS AND THEIR RELATIONSHIP WITH NURSING DOCUMENTATION: A RETROSPECTIVE STUDY

ANÁLISE DAS GLOSAS HOSPITALARES E SUA RELAÇÃO COM O REGISTRO DE ENFERMAGEM: ESTUDO RETROSPECTIVO

ANÁLISIS DE GLOSAS HOSPITALARIAS Y SU RELACIÓN CON REGISTROS DE ENFERMERÍA: ESTUDIO RETROSPECTIVO

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How to cite: Bruzaferro MF, Tinoco JMVP, Flores PVP, Fiore ACM, Souza PA, Dantas RDS. Analysis of hospital claim denials and their relationship with nursing documentation: a retrospective study. Online Braz J Nurs. 2026;25(1):e20266911. http://doi.org/10.17665/1676-4285.20266911

RESUMO

Objetivo: Analisar a prevalência das glosas hospitalares relacionadas ao registro de enfermagem de uma Unidade Coronariana de um hospital privado. **Método:** Estudo retrospectivo, exploratório e descritivo, com coleta de dados de glosas junto às operadoras de planos de saúde entre março de 2023 e março de 2024. **Resultados:** Foram analisadas 1567 glosas, totalizando R$ 21.329,47 em prejuízos. Os itens mais glosados foram materiais para punção venosa (26%), curativos (23%) e medicamentos (20%). As principais causas foram ausência de cobertura e uso sem justificativa (71%), além da falta de registros, responsável por 70% do valor monetário glosado. **Conclusão:** O estudo evidencia desafios na gestão de materiais e cuidados de enfermagem, reforçando a necessidade de registros precisos para melhorar a segurança do atendimento e a sustentabilidade financeira dos serviços hospitalares. A falta e/ou incompletude de registros nos prontuários contribuiu significativamente para as glosas avaliadas na Unidade Coronariana.

Descritores: Instituições Privadas de Saúde; Planos de Saúde; Registros de Enfermagem; Glosas Hospitalares.

ABSTRACT

Objective: To analyze the prevalence of hospital claim denials related to nursing documentation in a Coronary Care Unit of a private hospital. **Method:** A retrospective, exploratory, descriptive study, with data collection on claim denials from health insurance operators between March 2023 and March 2024. **Results:** A total of 1,567 claim denials were analyzed, amounting to R$ 21,329.47 in financial losses. The most frequently denied items were venous puncture materials (26%), dressings (23%) and medications (20%). The main reasons were lack of coverage and use without justification (71%), in addition to missing documentation, which accounted for 70% of the monetary value denied. **Conclusion:** The study highlights challenges in material management and nursing care, reinforcing the need for accurate documentation to improve patient safety and the financial sustainability of hospital services. Absence and/or incompleteness of documentation in medical records significantly contributed to the claim denials assessed in the Coronary Care Unit.

Descriptors: Private Health Institutions; Health Plans; Nursing Records; Hospital Claim Denials.

RESUMEN

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Publisher:
Escola de Enfermagem Aurora de Afonso Costa – UFF
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INTRODUCTION

The right to health in Brazil receives constitutional guarantee as a state duty and universal right, operationalized mainly through the Unified Health System (*Sistema Único de Saúde*, SUS), which engages federal, state, and municipal levels to deliver health services to all citizens. However, implementation of this right confronts challenges such as economic inequality and vast territory, leading to resource scarcity and higher poverty incidence that primarily affect primary health care and hinder access to specialized services[1-2].

The private sector emerges as an alternative to SUS for part of the population. In Brazil, private health services complement and expand health service availability. This sector displays considerable diversity, ranging from small clinics and offices to large hospitals and health networks[3-4]. Challenges prove substantial, including rising medical costs and health insurance premiums that often exceed inflation[5]. This scenario underscores the importance of effective regulations to control prices and ensure service access without compromising care quality. To address these challenges, many institutions adopt a business approach, employing tools such as cost analysis and audits to balance expense reduction with maintenance of high care standards, thus securing market competitiveness[6-8].

Audits play an essential role in analyzing services provided by health institutions. During this process, health insurance operators can identify alignment and communication failures, whether technical or administrative[9]. Inadequate information absence, incorrect equipment use, and excessive charges can result in reimbursement denials by health plans. A common example involves hospital claim denials, frequently caused by missing documentation, particularly nursing activities[8].

Hospital claim denials receive definition as billings not received or rejected by health organizations due to communication problems between health services and health plans. They represent inconsistencies identified by the auditing nurse in patient medical record entries that prevent payment by the health plan[9]. Most of these inconsistencies arise from missing annotations, especially by medical and nursing teams[10]. According to the National Health Surveillance Agency (*Agência Nacional de Vigilância Sanitária*, ANVISA), complete registration of all patient care in the medical record proves fundamental[11].

Proper registration of the Nursing Process proves essential to ensure care quality, transmit relevant information, and integrate the care plan. It reflects patient conditions and activities, serving as one of the main instruments to validate nursing practice, since approximately half of care-related information derives from these records. When performed incompletely or incorrectly, records can lead to hospital claim denials, compromising both remuneration and care continuity[9].

In this context, nursing audit assumes a strategic role by evaluating care from admission to hospital discharge, ensuring complete and consistent medical record information. The most common failures in nursing documentation fall into legal, technical, and prescription verification categories, all with potential to generate hospital claim denials. Moreover, auditing nurses not only secure proper procedure remuneration but also guide the team to reduce inconsistencies and enhance financial outcomes[8,11].

The entire nursing team must follow legal guidelines, such as Law No. 7,498/1986 on Professional Nursing Practice[12], which requires clear, objective, and detailed records of all care activities, and COFEN Resolution No. 736/2024[13], which regulates Nursing Process implementation across contexts. These legal instruments reinforce the importance of well-structured documentation to guarantee care quality and safety.

Despite the topic's relevance, scientific literature remains limited. A search in the Virtual Health Library (*Biblioteca Virtual em Saúde*, BVS) using the term "hospital claim denials" yielded only 168 articles published in the last five years, most adopting integrative or systematic literature review approaches and not addressing closed units, thus evidencing the need for more in-depth and systematic studies on the impact of hospital claim denials in the private health sector. This topic holds great relevance, with implications for both institutional financial sustainability and care quality delivered.

Thus, this study aims to analyze the prevalence of hospital claim denials related to nursing documentation in a coronary care unit of a private hospital in Belo Horizonte, Minas Gerais.

METHOD

Type of study

This constitutes a cross-sectional, retrospective, and descriptive study, structured according to the STrengthening the Reporting of OBservational studies in Epidemiology (STROBE)[14] checklist criteria.

Context

The research occurred in the coronary care unit of a private hospital located in Belo Horizonte, Minas Gerais, accredited by 73 health insurance operators. The sector shows an epidemiological profile with approximately 2,500 monthly admissions, predominantly older adults patients (mean age of 71 years old), with prevalence of cardiovascular conditions, especially patients in postoperative coronary angioplasty.

Eligibility criteria and participants

Inclusion criteria:

All hospital claim denials notified by health operators between March 2023 and March 2024, related exclusively to the studied hospital's Coronary Care Unit; claim denials involving items, procedures, or documentation under direct responsibility of the nursing team.

Exclusion criteria:

Claim denials with incomplete or inconsistent documentation, including absence of formal justification from the health operator; incongruent or insufficient clinical data for analysis; lack of clear linkage between documentation and procedure performed.

Data sources and collection procedures

Data extraction came from sectoral claim denial spreadsheets provided semiannually by hospital administrative management. The spreadsheets contained the following information: patient name, specification of denied item or service, operator justification for payment refusal, occurrence date, item quantity, and monetary value of the claim denial (in reais).

Collection occurred exclusively by the principal researcher, using an institutional computer located in the coronary care unit nursing coordination room. The spreadsheets remained in protected, non-editable format, ensuring data integrity.

Study size

The study included all claim denials identified within the delimited period (from March 2023 to March 2024), related to the coronary care unit, totaling 1,567 occurrences.

Variables and measures

The quantitative variables analyzed consisted of denied monetary values, expressed in reais (R$). The qualitative variables received description in two categories: specificities of denied items, which include: dressing materials; venous puncture materials (needles, syringes, taps, sets, extenders, peripheral venous catheter); monitoring materials (electrodes, cables, sensors); medications; exams; ventilatory materials (humidifiers, nasal catheter, endotracheal tube, bacterial filters); other materials (gauze pads, diapers, suture threads, bandages, scalpel blades, collectors, lancets, hypoallergenic tape, probes); operator justifications for claim denials: absence of contractual coverage; use without plausible justification; lack of verification; improper dispensing; lack of stamp or signature; use exceeding plan standard; lack of use documentation; absence of report, prescription, or medical order; discrepancy between charged and performed quantity; improper charging.

Categorization followed criteria defined by health operators, as detailed in Figure 1.

Claim Denial Justification	Definition
Material or service without coverage by the health plan	The provided item or service lacks inclusion by the health operator.
Use without plausible justification	Absence of use justification documentation for health item or service, incorrect system completion.
Lack of verification	Prescribed material, care, or procedures, yet medical/nursing prescription lacks verification (confirming execution).
Improper dispensing	No medical record documentation describes reason for this item use. The material received use without justification.
Lack of report; Lack of prescription; Lack of medical order	Material, exam, and/or care used/performed yet without prescription, medical order to prove execution.

Figure 1 - Definition of Claim Denial Justifications indicated by health operators. Belo Horizonte, MG, Brazil, 2025

Statistical analysis

Data organization occurred through creation of an electronic spreadsheet in Microsoft Excel, based on obtained claim denial spreadsheets. Descriptive statistics received application, using absolute and relative frequencies (percentages) for categorical variables, plus 95% confidence interval. For quantitative variables, mean calculation occurred.

Ethical aspects

This study received approval from the participating institution's Research Ethics Committee. The organization received proper information about all research objectives and procedures, with execution of the Commitment Term for Data Use and obtention of institutional authorization for study conduct.

RESULTS

Of the 73 accredited health plans in the study context, one received exclusion due to data integration failures into the institution's operating system, compromising information reliability. As presented in Table 1, a total of 1,567 hospital claim denials occurred between March 2023 and March 2024, with a monthly mean of 120 claim denials. The total denied value amounted to R$ 21,329.47, with a monthly mean of R$ 1,064.73.

The categories with highest prevalence included: venous puncture materials, representing 26% (95% CI: 23.8–28.2); dressings, with 23% (95% CI: 20.8–25.2); medications, 20% (95% CI: 17.9–22.2); electrodes and monitoring accessories, 18% (95% CI: 15.9–20.1); and other materials, 11% (95% CI: 9.4–12.7).

Table 2 shows that throughout the period, 836 claim denial justifications received registration. Of these, 612 (71%) refer to absence of contractual coverage and use of items without plausible justification, these being the only causes present in all analyzed months. Justifications related to use exceeding operator standard and lack of verification also stood out, totaling 161 occurrences (19%).

Among the justifications, those associated with absence or incompleteness of documentation, such as use without plausible justification, lack of verification, absence of use documentation, and lack of signature, added up to 415 occurrences (48.4%; 95% CI: 45.1–51.7).

Table 3 highlights the monetary cost of claim denials related to justifications due to absence of medical record documentation, which include: use without plausible justification; lack of verification; absence of use documentation; and lack of stamp or signature. Over one year, R$ 14,698.72 associated with absence of these documentation items, corresponding to 70% of total claim denial value. January 2024 showed the highest denied value in the studied unit.

DISCUSSION

This study analyzed, retrospectively, the prevalence of hospital claim denials in a coronary care unit of a private hospital. A total of 1,567 denied items received registration in patient medical records. Regarding reasons related to missing medical record documentation, these corresponded to 48.4% of total claim denials. The most frequent justifications cited by health plan operators included lack of plan coverage and use of material/service without plausible justification (71%). Additionally, absence or incompleteness of health care documentation proved responsible for 70% of total monetary value of claim denials. These results reflect a

significant limitation in nursing documentation, preventable by care team and hospital management. However, they evidence opportunities for improvement in practices, such as internal medical record audits and team training for effective nursing documentation.

Table 1 - Prevalence of hospital claim denial specificities from March 2023 to March 2024. Belo Horizonte, MG, Brazil, 2025

Materials	N (%)of hospital claim denials, by month/year, and occurrences by type in the period												
	2023										2024		
	Mar. (68)	Apr. (31)	May (197)	June (82)	July (126)	Aug. (225)	Sept. (212)	Oct. (101)	Nov. (8)	Dec. (71)	Jan (246)	Feb. (116)	Mar. (84)
Dressings	31(46)	12(39)	32(16)	23(28)	21(17)	51(23)	52(25)	24(24)	3(38)	21(30)	36(15)	31(27)	23(27)
Venous puncture materials	12(18)	-	36(18)	17 (21)	14(11)	76(34)	46 (22)	13(13)	5 (63)	18(26)	110(45)	44(38)	14(16)
Electrodes and monitoring accessories	8(12)	10(32)	33(17)	26 (32)	20(16)	32(14)	46 (22)	26(26)	-	23(32)	30(12)	30(26)	-
Other materials	3 (4)	3 (10)	27(14)	5(6)	21(17)	39(17)	19(9)	8(8)	-	3(4)	17(7)	10(9)	12(14)
Medications	12(18)	6(19)	46(23)	11 (13)	47(37)	22(10)	48 (23)	30(30)	-	6(8)	50(20)	-	33(39)
Exams			32(16)		3(2)						1(1)		
Ventilatory material	2(3)	-	1(1)	-	-	5(2)	1(0)	-	-	-	2(1)	1(1)	2(2)
Monetary value	R$ 463.43	R$ 142.70	R$ 3,024.41	R$ 1,042.33	R$ 1,975.92	R$ 2,376.16	R$ 2,312.41	R$ 3,048.49	R$ 166.99	R$ 793.76	R$ 2,994.36	R$ 841.81	R$ 1,817.18

Table 2 - Prevalence of justifications for hospital claim denial occurrences from March 2023 to March 2024. Belo Horizonte, MG, Brazil, 2025

Justification for material/ service denial	N (%) of hospital claim denials, by month/year, and occurrences by period													Total
	2023										2024			
	Mar.	Apr.	May	June	July	Aug.	Sept.	Oct.	Nov.	Dec.	Jan.	Feb.	Mar.	
Without coverage by the health plan	27(60)	9(60)	23(21)	20 (40)	19(11)	42(31)	41(37)	21(41)	2(33)	21(47)	33(27)	26(43)	21(48)	305 (36.4)
Use without plausible justification	11(28)	1(7)	35(32)	16(32)	17(12)	58(42)	31(28)	12(23)	4(67)	9(20)	60(50)	26(43)	7(16)	287(34.33)
Lack of verification	3(8)	1(7)	6(6)	0	2(4)	16(12)	18(16)	7(14)	0	8(18)	7(6)	0	5(11)	73 (8.73)
Improper dispensing	0	0	20(19)	0	0	0	0	0	0	0	0	0	0	20(2.39)
Without stamp or signature	0	0	10(9)	11(22)	0	1(1)	1(1)	0	0	0	0	0	1(2)	24(2.87)
Use exceeding operator standard	1(3)	4(27)	9(8)	3(6)	4(24)	19(14)	13(12)	9(18)	0	6(13)	10(8)	9(15)	4(9)	91(10.88)
Without use documentation	0	0	3(3)	0	0	1(1)	2(2)	1(4)	0	1(2)	10(8)	0	3(7)	21(2.51)
Lack of report, prescription	0	0	2(2)	0	9(18)	0	3(3)	0	0	0	0	0	0	14(2.0)
Charged quantity different from performed	0	0	0	0	0	0	1(1)	0	0	0	0	0	0	1(0.11)
Improper charging	0	0	0	0	0	0	0	0	0	1(2)	0	0	3(7)	4(0.47)
Total (by month)	40	15	108	50	49	137	110	50	6	46	120	61	44	836

Table 3 - Financial value of claim denials in the Coronary Care Unit from March 2023 to March 2024. Belo Horizonte, MG, Brazil, 2025

Value of Claim Denials in the Coronary Care Unit			
Month/Year	Value total associated with absence of medical record documentation	Total claim denial value by month (R$)	Financial percentage of claim denial associated with absence of medical record documentation (%)
Mar-23	R$ 70.13	R$ 489.85	14
Apr-23	R$ 15.59	R$ 142.70	11
May-23	R$ 2,308.96	R$ 3,024.41	76
Jun-23	R$ 852.48	R$1,042.33	82
Jul-23	R$ 1,185.50	R$ 1,975.92	60
Aug-23	R$ 1,502.44	R$ 2,376.16	63
Sept-23	R$ 1,863.53	R$ 2,312.41	81
Oct-23	R$ 1,676.23	R$ 3,048.49	55
Nov-23	R$ 139.36	R$ 166.99	83
Dec-23	R$ 594.88	R$ 793.76	75
Jan-24	R$ 2,557.21	R$ 2,994.36	85
Feb-24	R$ 487.27	R$ 841.81	58
Mar-24	R$ 1,445.14	R$ 1,817.18	80
Total (R$)	R$ 14,698.72	R$ 21,026.37	70

Corroborating findings of this study, a previous retrospective research that evaluated hospital claim denials in 194 patient medical record financial statements identified highest prevalence of claim denials related to dressings, with justifi-

cation associated with nursing documentation failure[15]. Literature recognizes that hospital claim denial effects result in financial losses for health institutions and affect care quality delivered, since for audit purposes, absence or incompleteness of documentation implies that care did not occur[15-18]. Although this study evaluated hospital claim denials only retrospectively, and not longitudinally, inference suggests that lack of completeness and/or adequate documentation directly impacts values billed by the institution. This scenario can compromise quality of services provided, since it reduces financial resources available for incorporation of new technologies and human resources.

Deficiencies in medical record documentation significantly compromise care quality, care continuity, and financial management of health institutions, hindering both audit processes and validation of services provided[19]. Complementing previous findings[20], prior studies corroborate the negative impact of documentation failures on hospital claim denials. In an investigation conducted in a surgical center, finding showed that most items rejected by health operators related to the "materials" accounting group, with main causes consisting of lack of adequate clinical justifications and documentation incompleteness. This result clearly demonstrates how omission of essential information in medical records prevents appeal against claim denials and causes substantial financial losses for institutions[21].

Corroborating findings of this study, an integrative review identified that errors in nursing documentation, including absence of fundamental data, terminological inconsistencies, and omission of performed procedures, deteriorate clinical information quality and increase technical claim denial occurrence. These joint evidences highlight the urgent need to develop an organizational culture focused on continuous improvement of clinical documentation, through investments in: systematic professional training; implementation of preventive audits; and adoption of standardized documentation protocols[22].

Data on hospital claim denials point to important challenges in material management and nursing care execution. Items such as dressings, exams, medications, electrodes, needles, and syringes, frequently denied, indicate problems ranging from appropriate material selection to precise documentation of its use. Thus, hospital audit proves fundamental to identify claim denial incidences and justifications, as demonstrated in this study and previous research[16,18-19,23].

Considering that most hospital expenses associate with material use, procedures, and medications, subjective, illegible, or incomplete documentation contributes to increased claim denials, causing relevant financial deficits. Therefore, understanding financial effects of claim denials together with their causes proves crucial, reinforcing that medical record completion must prove precise and complete to enable appropriate evaluations and decisions[24].

To reduce claim denial incidence and enhance operational and financial efficiency, strengthening nursing team training and continuously reviewing processes related to clinical information documentation proves fundamental. The Federal Nursing Council (*Conselho Federal de Enfermagem*, COFEN) recommends implementation of standardized protocols, continuing education, and internal audits to ensure documentation quality and integrity, plus use of technological tools that facilitate precise and complete documentation[25].

Oliveira, Souza, and Costa conducted a cross-sectional study in a public hospital, analyzing 720 records before and after training and audits, with significant reduction of technical claim denials and improvement in documentation quality[26]. Thus, this study, by describing and analyzing documentation failures that caused hospital claim denials, contributes to development of improvements in health documentation and registration.

Nursing and medical team activities involve significant costs, and the main way to ensure payment for services provided consists of careful, objective, and comprehensive documentation. Claim denials generally occur due to uncertainties related to materials used or care quality[23,25]. Therefore, the role of auditing nurses, coordinators, and on-duty staff proves fundamental to ensure documentation precision. Discrepancies between team documentation and billed values negatively impact institution billing[17-18,20,23,25-29].

Sectoral mapping of claim denials, with their justifications and financial losses, represents an important strategy to diagnose problems and develop action plans that promote standardization of products and processes according to local reality. Many denied items link directly to nursing care, highlighting the need to enhance documentation and conduct training and awareness actions. Additionally, practices such as continuing education on use guidelines and documentation, implementation of rigorous verification and validation systems, and regular internal audits help identify documentation failures before account submission to operators, reducing claim denials and promoting more consistent practices.

Study limitations

One of the main limitations of this study consists of sample restriction, since research occurred in a specific sector of a hospital unit. Such fact may compromise result generalization. Additionally, lack of sample diversity may influence analysis and understanding of causes and frequencies of hospital claim denials in distinct contexts. Future longitudinal studies receive recommendations to monitor claim denial occurrence evolution over time, enabling early actions for continuous improvement of medical record documentation quality and contributing to hospital financial sustainability.

CONCLUSION

Absence and/or incompleteness of medical record documentation contributed significantly to claim denials assessed in the Coronary Care Unit. Challenges became evident in material management and nursing care delivery, which highlight the importance of precise documentation as an essential element to reduce these failures, as well as to promote care safety and institutional financial sustainability. Findings reinforce the need for periodic nursing team training and implementation of regular internal audits as a measure for improvement execution.

CONFLICT OF INTERESTS

The authors have declared that there is no conflict of interests.

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