MBS MEDICAL BILLING SERVICES

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Denial Prevention, Not Denial Chasing

A reason-code framework and ownership model that stops the same denials repeating.

Written for: Owners, CFOs, and revenue cycle leads

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Executive summary

Most practices manage denials one claim at a time: a denial arrives, someone appeals or corrects it, and the same denial arrives again next month. That is denial chasing. It keeps staff busy but does not change the denial rate.

Denial prevention treats every denial as data. Group denials by root cause, give each cause an owner, and fix the process that produced it. This paper sets out a practical framework for doing that.

Key points

- Group reason codes by **cause**, not by payer. The same cause produces denials across payers.
- Separate **preventable** denials (fix the process) from **contractual** ones (appeal or renegotiate).
- Assign each category to the team that can actually prevent it.
- Review the numbers monthly with a fixed agenda, and track whether each category shrinks.

Why chasing denials fails

Reworking a denied claim costs time, and some denials are never recovered because appeal windows close or documentation cannot be obtained. The deeper problem is that rework hides the cause. When a biller fixes a missing-authorization denial, the front desk that missed the authorization never finds out.

Prevention closes that loop. The goal is not faster appeals. The goal is fewer denials to appeal.

Grouping reason codes by cause

Claim Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARCs) tell you why a payer denied or reduced a claim. Map them into a small set of cause categories:

Cause category	Typical reason codes / signals	Usually preventable?
Eligibility & registration	Coverage terminated, patient not found, COB issues	Yes: front end
Authorization & referral	Precertification absent, referral missing	Yes: front end / scheduling
Coding & bundling	Procedure inconsistent with diagnosis, NCCI edits, modifier issues	Yes: coding
Medical necessity & documentation	Not deemed necessary, records requested	Mostly: clinical documentation
Timely filing	Claim past filing limit	Yes: billing workflow
Duplicate claim	Exact duplicate submitted	Yes: billing workflow
Contractual & fee schedule	Charge exceeds fee schedule, non-covered by contract	No: contract / payer relations
Provider enrollment	Rendering provider not eligible / not enrolled	Yes: credentialing

Keep the category list short, eight to ten at most. Too many categories and nobody owns them.

Who owns which denials

A category without an owner will not shrink. Ownership means the team is accountable for the trend, not for reworking each claim.

Owner	Categories	What prevention looks like
Front desk / scheduling	Eligibility, registration, authorization	Three-pass verification; authorization tracked against scheduled services
Coding	Coding, bundling, modifiers	Edit rules, coder feedback, documentation templates
Providers & clinical	Medical necessity, documentation	Payer-specific documentation checklists for high-risk services
Billing	Timely filing, duplicates	Submission SLAs, duplicate edits, work queue ageing alerts
Credentialing	Provider enrollment	Enrollment tracked to effective date before scheduling
Leadership / payer relations	Contractual, fee schedule	Contract load audits, underpayment tracking, renegotiation

Appeal timelines and documentation

Preventable or not, some denials must be appealed. Appeal windows vary by payer and contract, so keep a payer-by-payer reference. Typical levels:

Level	What it is	What to include
Reconsideration / corrected claim	Fix and resubmit, or ask the payer to reprocess	Corrected claim or short cover note citing the error
First-level appeal	Formal written appeal to the payer	Appeal letter, relevant records, policy or contract citation
Second-level appeal	Review by a different payer reviewer or panel	Everything above plus a response to the first-level decision
External / independent review	Review outside the payer, where available	Full file; follow state or federal process rules

Appeal habits that improve outcomes

- Track every appeal deadline from the remittance date, not the date you notice the denial.
- Cite the specific payer policy, contract clause, or coding guideline you are relying on.
- Send only the records that support the point in dispute. Clear and complete beats large.

- Record the outcome by category so you learn which appeals are worth pursuing.

Measuring denials the same way every month

Use consistent definitions or month-to-month comparisons mean nothing:

- **Initial denial rate** = claims denied on first adjudication ÷ claims adjudicated in the period.
- **Denial rate by dollars** = denied charges ÷ adjudicated charges. It shows financial impact.
- **Overturn rate** = denials successfully appealed ÷ denials appealed.
- **Final write-off from denials** = denied dollars never recovered ÷ adjudicated charges.

State your time period and scope (all payers, all locations) whenever you share a denial figure.

Monthly denial review agenda

Sixty minutes, same attendees, same order every month. Bring the numbers below.

Item	Bring	Time
1. Headline trend	Initial denial rate and dollars, last 6 months	5 min
2. Top five categories	Count, dollars, and change vs last month for each	15 min
3. Owner updates	Each owner: what changed, what they tried, what is next	20 min
4. Payer spotlight	One payer with a rising trend: policy changes, patterns	10 min
5. Actions	Named owner and due date for every action	10 min

Signs the framework is working

- ☐ Top categories are shrinking quarter over quarter, not just being reworked faster
- ☐ Owners bring root causes, not just claim counts
- ☐ Front-end categories fall first. They are usually the fastest to fix.
- ☐ Contractual denials are fed into payer negotiations

Want this run against your own numbers?

MBS can walk through your first-pass resolution, denial categories, and aged A/R with you using your own data. Request a custom billing review at **www.mbsrcm.com/contact**, or try the free A/R & Denial Benchmark at **www.mbsrcm.com/tools/ar-denial-benchmark**.

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