

Denial Cleanse Guide

How to Identify, Resolve, and Prevent Claim Denials in Your Medical Practice

Introduction

Claim denials cost healthcare providers billions of dollars every year. This quick guide is designed to help you assess your denial trends, identify root causes, and implement actionable solutions to clean up your revenue cycle.

Step 1: Know Your Denial Rate

Key Question: What percentage of your claims are being denied on first submission?

Target: < 5% Denial Rate

Action: Use your billing software to generate denial reports monthly. Highlight high-volume denial codes.

Step 2: Identify Common Denial Reasons

Some of the top denial reasons include:

- Missing or invalid patient information
- Eligibility not verified
- Duplicate claims
- Coding errors
- Authorization required

Tip: Create a denial reason tracker to spot recurring issues.

Step 3: Fix the Process, Not Just the Claim

Denials are often symptoms of deeper process issues. Don't just resubmit-fix the source.

Denial Cause	Fix It By
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Insurance expired	Real-time eligibility checks
Incorrect codes	Conduct regular coding audits
Authorization missing	Create pre-checklists before visits

Step 4: Automate What You Can

Manual workflows = more room for error. Use automation for:

- Eligibility verification
- Coding suggestions
- Claim status tracking
- Denial alerts

Step 5: Educate Your Team

Ensure your front desk, billers, and coders:

- Understand payer rules
- Follow consistent intake processes
- Know the appeal procedures

Tip: Hold short denial review meetings monthly.

Bonus: Denial Cleanse Checklist

We track denial trends monthly

Eligibility is checked before every visit

Front-desk follows standardized intake process

Coding is audited at least quarterly

Appeals are tracked and followed up within 14 days

Denial rate is < 5%

Need Help?

Let RevIQ Health help you cleanse your revenue cycle.

We offer expert denial analysis, process audits, and full RCM support.

Visit: www.reviqhealth.com

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