

COMPLETE CLAIM DENIAL FIX GUIDE

End-to-End Denial Management & Revenue Recovery Workflow

INTRODUCTION TO DENIAL MANAGEMENT

A claim denial occurs when an insurance company refuses to pay for a medical service after a claim has been submitted. Managing denials systematically is crucial to preventing permanent financial write-offs. This guide maps out a basic, step-by-step master workflow to trace, resolve, and prevent future healthcare claim denials.

THE 5-STAGE DENIAL MANAGEMENT CYCLE

- 1. Identification & Tracking:** Automatically route and log all electronic remittance advice (ERA) files containing denial codes from the clearinghouse.
- 2. Root Cause Categorization:** Determine why the claim failed. Is it a soft denial (temporary technical error that can be fixed and re-sent) or a hard denial (contractual or clinical restriction that requires an appeal)?
- 3. Data Rectification:** For technical errors, update the administrative or demographic database immediately to prevent the error from happening again.
- 4. Formal Appeals Processing:** Assemble clinical notes, medical policy evidence, and signed documentation to formally dispute the payer's decision.
- 5. Front-End Prevention Feedback Loop:** Update the practice management software's custom validation rules to catch errors before transmission.

COMMON PAYER ADJUSTMENT CODES (CARCS) & RESOLUTIONS

CARC CODE	PAYER DESCRIPTION	PLAIN-ENGLISH RESOLUTION ACTION
CO-16	Missing/Incomplete Info	Review the specific remark codes (RARC's). Correct the missing modifier, clear up subscriber demographics, or supply the required primary EOB, then resubmit as a corrected claim.
CO-50	Not Medically Necessary	Gather objective clinical chart notes, diagnostic printouts, and published medical guidelines that show the procedure was essential for the patient's condition. Submit a formal clinical appeal.
CO-197	Precertification/Auth Absent	Check if the insurance allows retroactive authorizations. If not, appeal by proving the service was an immediate clinical emergency that bypassed standard scheduling rules.

MASTER ACTION ITEM

Always file corrected claims using the proper resubmission indicator code (Frequency Code 7) and reference the original claim control number to prevent duplicate claim rejections.