

The denial-proof practice playbook

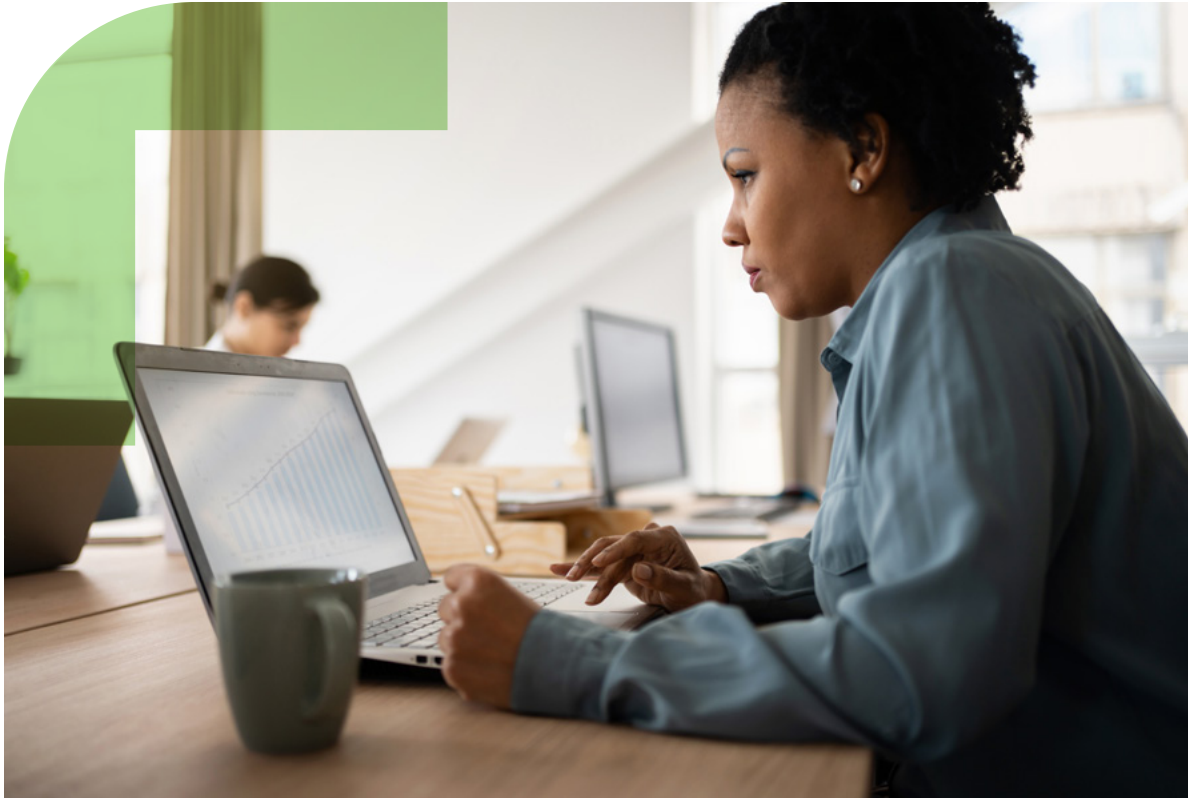


Table of contents

<u>The hidden traps leading to denials—and how to avoid them</u>	4
<u>The real cost of denials—and why you can't afford to ignore them</u>	7
<u>Your action plan for slashing denials</u>	9
<u>Revenue Cycle Management could help you</u>	12
<u>Denied claims checklist</u>	14

Accurate and timely payments are vital to the sustainability and success of your practice. Unfortunately, denied claims are a common challenge, creating financial strain and consuming valuable time and energy.

Fortunately, most denials are preventable. With the right strategies and tools, you can minimize rejections, maximize revenue, and create a more efficient practice.



The hidden traps leading to denials—and how to avoid them

Understanding why claims get denied is the first step to preventing them. Denials fall into three main categories: pre-service, time of service, and post-service. Each type occurs at a different stage of the client journey, and knowing where they happen helps you pinpoint exactly where to focus your efforts.

Pre-service denial: The intake process



- Incorrect or missing client information on intake forms
- Unverified insurance benefits
- Lack of necessary pre-authorization

Time-of-service denial: The clinician's role



- Invalid codes or authorized units exceeded
- Unaware of payer guidelines before service occurs
- Billing for unverified authorizations

Post-service denial: The billing process



- Waiting too long to file claims and missing payer deadlines
- No system to track the lifecycle of submitted claims
- No system to file claims on a regularly scheduled time line

Pre-service denials: the front lines of prevention

Pre-service denials are the most common—and the most preventable. These issues that happen *before* your client even walks through the door.

Think of the intake process. A pre-service denial might occur because, as an example, your front desk staff (or you) incorrectly enters the client's insurance details or fails to confirm active coverage, the claim will likely be denied.

Similarly, if a service requires prior authorization and you don't have it, the payer won't approve the claim.

These issues are entirely within your control, which is why pre-service denials are so frustrating—they're avoidable with the right processes in place.

Train your intake team thoroughly or, if you're handling it yourself, double-check that you're collecting all necessary information accurately. Small mistakes here can lead to big headaches later.

However, it usually requires manual entry, which sounds like you're doing today. But most of our EHR systems allow for automated eligibility verifications. So usually, you can do that in a batch. You could set like a cadence of how often you want to run those checks, and it will go out for all those patients at once. And you can see what the coverage is, if it's still active or not. We definitely recommend taking advantage of that feature if you're not today. You can contact our support team to get kind of step-by-step help.

Time of service denials: the clinician's role

Time of service denials occur when something goes wrong during the actual therapy session. These are often clinician-related errors, like using invalid codes or exceeding authorized units. For instance, if your therapist submits a code that doesn't match the payer's requirements, the claim will be denied. Or, even if your intake team handled authorizations, a therapist providing a service outside of the approved authorization — exceeding units or types of service — will trigger a denial.

These denials can feel out of your hands, especially if you're relying on clinicians to input accurate information. However, clear communication and training can make a huge difference. Regularly review payer guidelines with your clinicians and double-check authorizations before each session. A little extra effort upfront saves time and money later.

Post-service denials: after the session

Post-service denials happen during the billing process, after the client has left your office. Common issues include timely filing limits and duplicate charges. For example, if you wait too long to submit a claim, the payer may deny it for missing their filing deadline. Or, if you accidentally submit the same claim twice, you'll get hit with a duplicate denial.

These errors often stem from disorganized billing practices or a lack of follow-through, so attention to detail is critical. If you have a billing team, make sure they're submitting claims promptly and tracking submissions carefully. If you handle billing yourself, set reminders to stay on top of deadlines and double-check your work.

PRO TIP: Use a billing calendar or software to track claim submission dates and flag unbilled charges. This simple step can prevent timely filing denials and keep your cash flow steady.

Most denials are preventable. Understanding why they occur and addressing the root causes allows you to significantly reduce their impact on your practice.



The real cost of denials—and why you can't afford to ignore them

Denied claims aren't just a minor inconvenience—they have far-reaching consequences that affect your practice's finances, operations, and even your relationships with clients. Let's break down how denials can disrupt your practice and why addressing them is critical to your success.



Denied claims cost money

Denials hit your practice where it hurts most: your wallet. Here's how:

Delayed cash flow

When a claim is denied, it doesn't just disappear. You have to resubmit it, which restarts the entire billing cycle. You might submit a claim a few days after a session, expecting payment in a few weeks. But a denial means waiting for that denial, then resubmitting the claim. For example, if it typically takes 2–4 weeks to receive payment for a claim, a denial adds another 2–4 weeks to the process, effectively doubling the time it takes to get paid.

This delay can strain your cash flow, making it difficult to meet payroll, pay your own bills, and invest in your practice. Your staff expect regular paychecks, and your bills are due monthly. If your revenue is tied up in denied claims, you might struggle to meet these obligations. Delayed cash flow creates a ripple effect, making it harder to manage expenses and plan for the future.

According to the [Medical Group Management Association \(MGMA\)](#) [50% to 65% of denied claims will never be reworked](#), which makes it incredibly challenging to catch up if you fall behind.

Increased operational costs

Every denied claim requires time and effort to resolve. Whether it's you or your billing staff, someone has to investigate the denial, correct the error, and resubmit the claim.

Let's say a claim is worth \$100, and it takes an hour to resolve the denial. If your staff's time is worth \$25 per hour, that claim's effective value drops to \$75. Over time, these lost dollars add up, eating into your bottom line.

And it's not just about the money—it's about the time. Every hour spent on denied claims is an hour not spent on growing your practice or caring for clients.

The hidden costs of denials

The erosion of client trust

While financial impacts are easy to measure, the damage to client trust is just as significant—and harder to repair. Your clients expect you to handle their billing professionally and accurately. When denials lead to unexpected bills or confusion about coverage, it reflects poorly on your practice.

Imagine receiving a bill for a service you thought was covered. You'd likely feel frustrated, confused, and maybe even distrustful of your provider. That's exactly how your clients feel when billing errors occur. They may question your expertise or hesitate to return for future sessions. Over time, this can lead to lost clients and a damaged reputation.

Stress and burnout

Let's not forget the emotional toll. Dealing with denials is stressful. It adds another layer of complexity to your already busy day, pulling you away from the work you love—helping your clients. For your billing staff or even yourself, constantly chasing denials can lead to burnout, making it harder to stay motivated and focused.



Your action plan for slashing denials

Reducing denied claims requires a proactive approach, focusing on strong processes and attention to detail. Here are key strategies to implement:

1

Optimize your front-end processes

Most denials happen before the client even walks through your door. That's why your front-end processes are your first line of defense.

Accurate data collection

Ensure that anyone gathering client information is trained to collect complete and *accurate* data. This includes:

- **Insurance details:** Double-check policy numbers, payer IDs, and coverage details. Scanning insurance cards can prevent errors.
- **Client information:** Verify names, addresses, dates of birth, and contact info. Small typos can lead to big denials.
- **Required fields:** Train your intake team (or yourself) to understand what information is needed for a claim. Missing fields are a common reason for denials.

PRO TIP: Use an EHR that offers automated eligibility verification. This tool helps you batch-check coverage for multiple clients at once. It saves time and ensures you verify benefits frequently, giving you a clear picture of client coverage without the manual work. Be sure to check that they do this for Medicaid as well!

Insurance eligibility verification

Don't assume coverage stays the same. Verify benefits before each appointment, even for returning clients, especially for payers like Medicaid or managed care organizations (MCOs) that frequently change. Coverage gaps can sneak up on you (and clients aren't always proactive about letting you know about changes—if they even know their insurance is different).

Prior authorizations

Know which payers require authorizations for specific services—and get them before the appointment. Communicate authorization status clearly to your clinicians to avoid providing unauthorized services.

2

Submit clean claims: reduce errors from the start

A clean claim is one that's complete, accurate, and compliant with payer requirements. Here's how to ensure yours meet the mark:

Use a claim scrubber

Most EHRs have a claim scrubber that checks for missing or incorrect information. It's a powerful tool, but don't rely on it alone. Double-check fields like patient addresses, member IDs, and dates of birth—especially for new clients.

Submit claims frequently

The longer you wait to submit a claim, the higher the risk of timely filing denials. Aim to submit claims weekly or bi-weekly. Frequent submissions also help you catch issues like expired authorizations sooner.

Monitor unbilled charges

Ensure that all services are billed. Unbilled charges can linger in your system, leading to timely filing denials. Regularly review your system for incomplete progress notes, unsigned sessions or other unbilled items. Set reminders to ensure all charges are billed promptly. Some EHRs include alerts that let you know automatically if you have pending unbilled items.

3

Understand your denial reasons (and act accordingly)

Track denials

Group denials by type (e.g., eligibility issues, missing authorizations, coding errors). Categorizing denials helps you identify patterns in your processes. Are the problems mostly pre-service, time of service, or post-service?

Monitor recurring issues

Look for common denial reasons. Are you seeing a lot of denials for lack of coverage? Maybe you need to verify benefits more often. Are claims denying for exceeded authorizations? Your clinicians might need better communication about limits. Analyze your most frequent issues to see what needs to be changed.

Build prevention plans

Once you've identified trends, create actionable plans to address them. For example, if eligibility issues are common, implement a policy to verify benefits before every appointment.

4

Follow up on denied claims

Don't let denied claims slip through the cracks. Take these steps to resolve them effectively:

Take corrective action

Resubmitting a claim without fixing the error is a waste of time. Investigate the denial reason, make the necessary corrections, and then resubmit.

Communicate with staff

Denials often result from breakdowns in communication. Talk to your intake team, clinicians, and billing staff to ensure everyone understands their role in prevention. Share information about denials, and work together to develop a plan to prevent similar issues from happening again.

Monitor resolution activity

Track how long it takes to resolve denials and whether they're being handled correctly. Regularly review your denial resolution process to identify areas for improvement.

5

Stay proactive

Reducing denials isn't a one-time fix—it's an ongoing effort. Stay proactive by:

- Training your team regularly on payer requirements and best practices.
- Reviewing your processes quarterly to ensure they're up to date.
- Leveraging technology, like automated eligibility checks and claim scrubbers, to streamline your workflow.



Revenue Cycle Management could help you

Denied claims, slow payments, and complex billing processes can steal valuable time and energy. What if you could recapture those resources and focus more fully on your clients? Revenue Cycle Management (RCM) services are designed to do just that. They handle the complexities of billing, helping you maximize revenue and streamline your operations.



How RCM works for you

RCM goes beyond billing supports. It simplifies and speeds up key parts of your revenue cycle, including claim submission and payment posting. Here's what you can expect:

- **Denial prevention:** Our team identifies and fixes issues before claims are submitted, reducing denials and rejections.
- **Faster payments:** We streamline the billing process to ensure you get paid quickly and accurately. Faster payment cycles create a more stable and predictable financial picture.
- **Improve your bottom line:** RCM services help ensure you get paid fairly for the services you provide, maximizing your revenue.
- **Cash flow optimization:** With fewer denials and faster payments, your practice enjoys steady, predictable revenue.
- **Reduce administrative burden:** Spend less time on billing and more time with your clients.
- **Expert support:** Our RCM specialists handle the complexities of billing, so you can focus on client care.

Partnership in action



Here's a real example. One of our partners, a practice owner, was having a tough time with denied claims and slow payments. Even though they were dedicated to their clients, unpaid claims and delays were causing a lot of stress and financial pressure. When they partnered with our RCM team, things changed for the better.

Increased reimbursement by 44%:

Their practice saw a significant jump in revenue, thanks to fewer denials and faster payments.

Reduced payment collection time from 90 to 22 days:

Claims were processed and paid in a fraction of the time, improving cash flow dramatically.

Improved cash flow:

With steady, predictable revenue, they finally had the financial freedom to take a long-delayed mission trip—something they'd dreamed of for years.

This success story is a testament to how RCM can help you reclaim your time, reduce stress, and focus on what you love.

Ready to explore RCM?

We understand that every practice is unique. To help you explore how RCM could benefit you, we offer a free, no-obligation consultation.

During this consultation, we'll:

Analyze

your current billing process and identify areas for improvement.

Provide

a detailed report on potential revenue gains and cost savings.

Answer

any questions you have about RCM and how it works.

Join the 600+ practices nationwide that we support to increase their revenue, reduce stress, and give them more time back.

[Schedule your free consultation.](#)



Denied claims checklist

Use this quick self-check before your next billing cycle to avoid costly denials:

- Verified active insurance for all clients—including returners
- Confirmed prior authorizations for any services that require them
- Double-checked claims for errors using your EHR's claim scrubber
- Submitted claims on schedule, well before payer deadlines
- Audited for unbilled sessions, unsigned notes, or missing documentation
- Tracked common denial reasons (eligibility, code issues, etc.) to spot patterns
- Set reminders or workflows to catch denials early and rework them efficiently

Small habits prevent big headaches.

Keep this list handy and share it with your team!

Take aways

Remember, the knowledge you've gained here is a starting point. Continue to monitor your denial trends, stay updated on payer requirements, and adapt your strategies as needed. The goal is to create a smoother, more efficient billing process that allows you to focus on your clients. Embrace these strategies, and you will see a positive impact on your practice's financial well-being and your ability to deliver the care your clients deserve. We wish you the best on your journey!

