Coding Impact on Denials -

Top Denials and how to work them effectively and prevent them in the future

> “The best denial is the one that never happens—and coding plays a significant role in making that possible.”

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November 6, 2026

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Conflict of Interest Disclosure

- I declare that I have no actual or potential conflict of interest to disclose in relation to this program/presentation.

About the Presenter

Jennifer Swindle, RHIT, CCS, CCS-P, CDIP, CPC-M, CPC, CIC, CPMA, CEMC, CFPC, AAPC Fellow

- 40 years Revenue Cycle Service Experience
- Large portion of that time spent on physician and/or staff education
- Serve as a Compliance Officer and Strategic Leader of Coding

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Our Focus

“Every denial tells a story—and often, that story begins long before the claim reaches the payer. Coding sits at a critical intersection between clinical documentation, compliance, and reimbursement. When coding is accurate and supported, it helps move claims cleanly through the revenue cycle. When there are gaps, inconsistencies, or misunderstandings, the result can be delayed payment, unnecessary rework, lost revenue, and increased compliance risk. Today, we’re going to look beyond the denial itself and examine how coding decisions influence denials—and, more importantly, how we can use those insights to prevent them.”

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Objectives

- Understanding Denial Reasons
- Review Common Denial Codes
- Effectiveness of working Top Types of Denials
- Means to reduce denials in the future
- Handling Payer Differences challenge

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The Reality

No organization can afford to leave any money on the table

Due to many challenges, healthcare organizations are under pressure to make sure their healthcare revenue cycle is operating at maximum efficiency

U.S. healthcare spending grew by an estimated 4.2% in 2021 to $4.3 trillion

According to AHA, more than a third of hospitals have negative operating margins due to pandemic-related losses

Covid brought about “the great resignation” from burn-out, which has caused a staffing crisis in healthcare; also “quiet quitting” is a reality

Silos continue to exist in revenue cycle operations in many organizations, causing inefficiencies that translate to revenue loss

Claim denials continue to steadily increase year over year, placing a heavy burden (COST) on hospitals to appeal

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Statistics

75%

Of surveyed providers reported increasing claim denials

Experian Health, 2026 Experian

40%

Reported denial rates exceeding 10% of claims

Experian Health, 2026 Experian

89%

Identified reducing denials as an organizational priority

Experian Health, 2026 Experian

67%

Of appealed Medicare Advantage prior authorization denials were overturned

KFF, 2025 data KFF

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Common Denials

Duplicate Claim

Patient has other primary insurance

Not covered with reported diagnosis

Missing/incomplete/invalid diagnosis

Authorization Issues

- Claim inconsistent with authorized services
- Authorization not obtained
- Services not authorized for date of service

Timely Filing

Modifier Issue

- Bundled with another service
- Inclusive to primary procedure
- Duplicate service
- Missing modifier
- Modifier inconsistent with CPT/HCPCS code

NPI not credentialed

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Things to think about

Not all payers utilize denial codes the same

Denial codes may not be reflective of what is really needed to make the correction

Staff must be experts and reading an EOB and the payer website

Often need to ‘read between the lines’

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Let’s tackle one denial type at a time

Duplicate Claim

1

Duplicate claims may be submitted, if late charges result in a new claim being created and updated

2

Corrections made to an initial claim and refiled, without updating the type of bill

3

More than one person working on the same account, both submitting a claim

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Patient has other Primary Insurance

Patient access team loading the incorrect insurance

Insurance not being updated and verified

Third party liability based on encounter that is not created (MVA, Work Comp, etc.)

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Not Covered with Reported Diagnosis

Medical necessity not being met (LCD and NCD guidelines)

Not coded correctly

Documentation concerns with provider, not allowing most accurate coding

No strong ABN process in place

- Or alerts in the system

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Missing/Invalid/Incomplete Diagnosis

Codes not expanded to full complement of characters

Code expired for date of service captured

Code not covered by payer contract

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Authorization Issues

Claim submitted has different code than that which was authorized

- Top issue many places; most common areas GI, Cardio, Vascular, Ortho

Date of service different than that which was authorized

Authorization not obtained prior to service being rendered

Authorization obtained, but number not submitted on claim form

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Timely Filing

Payers have different time parameters for timely filing

Filed on the initial claim presentation outside of the filing requirements

Modifier Issue

Modifier needed due to CCI edits

Modifier needed to identify it is not part of a global package

Modifier needed to show a service done more than once

NPI not credentialed

NPI for the treating (rendering) provider not on file with the insurance payer

Prevention

Identify the root cause of the problem	Need to know why it happened in the first place System problem, process problem, people problem
Analysis of the root cause will prevent future denials	Fix the upstream process

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Root Cause Analysis

- Analysis techniques include the “5 Whys”
  - This is a simple technique that moves past symptoms by continuing to ask “why” until you reach the root cause



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Resolution

- Visualize the process through process mapping
- Gather feedback from employees involved in the upstream process
- Benchmark against industry standards to identify areas for improvement
- Implement solutions and continually monitor the process for further improvement

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Some Quick Examples

Let's take a look



DENIED-WHY?

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Let's take a look

How many errors do you see?
Why was this claim denied?

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A.	D12.4	B.	Z11.12	C.		D.	
E.	D12.2	F.		G.		H.	
I.	D12.5	J.		K.		L.	

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
06	03	26	06	03	26	11		45380		A,B,C,D	1400.00	3		NPI	NPI43004300
														NPI	
														NPI	
														NPI	

CIAN OR SUPPLIER INFORMATION

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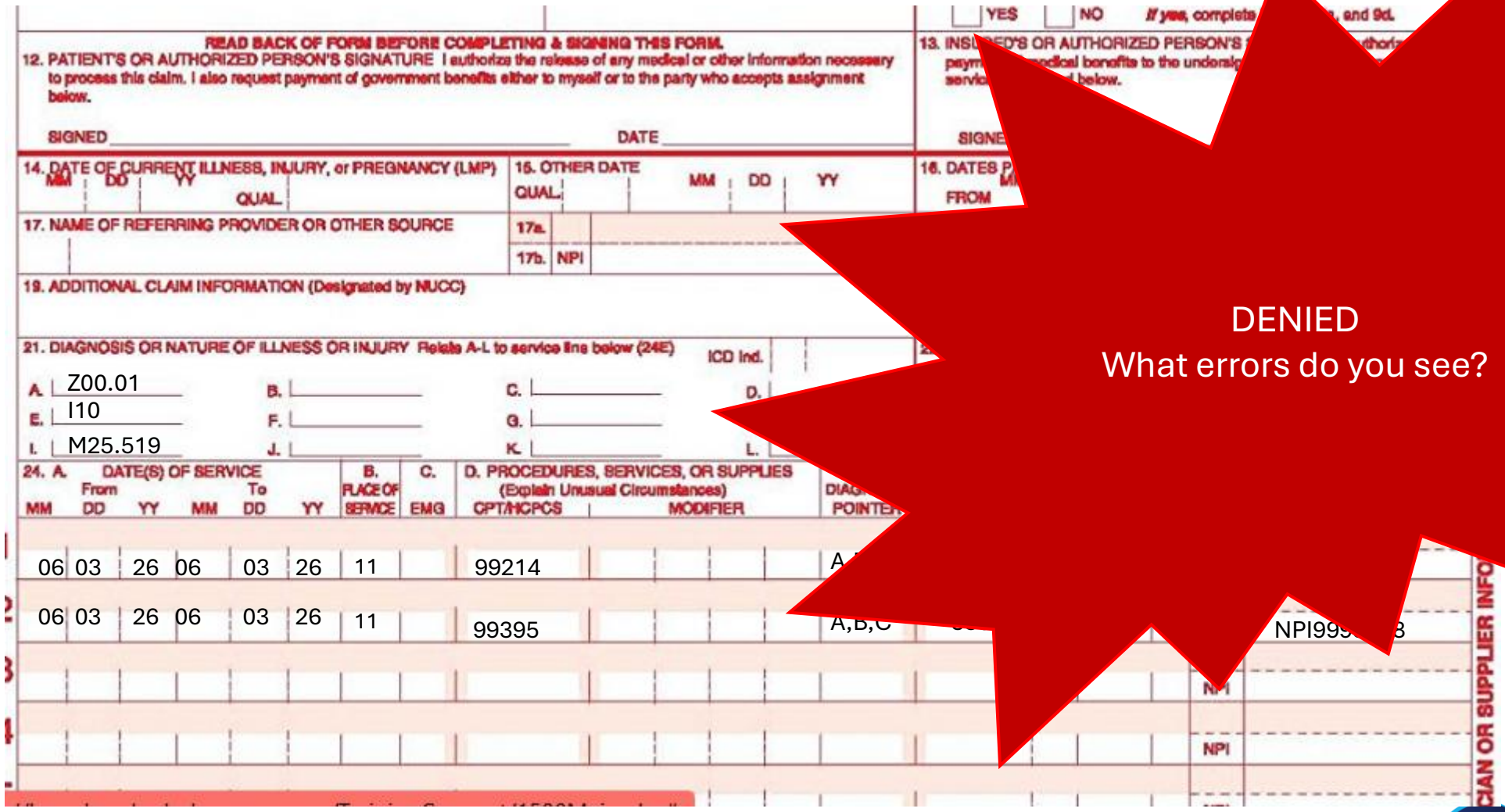
Let's take a look


READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S ... payment of medical benefits to the undersig... service ... below.

SIGNE...

YES NO If yes, complete ... and 9d.

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES P... FROM

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. Z00.01 B. C. D.

E. I10 F. G.

I. M25.519 J. K. L.

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	DIAG... POINTER
06	03	26	06	03	26	11		99214		A
06	03	26	06	03	26	11		99395		A,B,C

NPI99...3

...CIAN OR SUPPLIER INFO...

NPI

NPI

DENIED

What errors do you see?

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Outcome

Reduction in denials

Increase in cash collected



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Wrap Up

The best denial is the one that never happens—and prevention starts long before the claim reaches the payer.

- Coding is more than assigning codes; it is a critical link between clinical documentation, compliance, and reimbursement. By understanding denial trends, identifying root causes, and turning those findings into education and process improvement, coding teams can have a direct and measurable impact on the health of the revenue cycle.

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Every denial is an opportunity to learn—but our greatest success is using what we learn today to prevent the denials of tomorrow.

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Resources

- https://www.experianplc.com/newsroom/press-releases/2026/experian-health-s-annual-state-of-claims-survey-finds-denials-re?utm_source=chatgpt.com
- https://www.cms.gov/data-research/monitoring-programs/medicare-fee-service-compliance-programs/review-reason-codes-and-statements?utm_source=chatgpt.com
- https://oig.hhs.gov/reports/all/2026/the-three-largest-medicare-advantage-organizations-denied-requests-for-long-term-acute-care-and-inpatient-rehabilitation-at-some-of-the-highest-rates/?utm_source=chatgpt.com
- https://www.kff.org/patient-consumer-protections/prior-authorization-metrics-provide-new-insights-into-insurer-practices-but-gaps-remain/?utm_source=chatgpt.com

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Thank You

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