

REVENUE PROTECTION TOOLKIT

The Denial Prevention Checklist

32 checks that stop denials before claims leave your system

Most denials are not bad luck. They are documentation and coding gaps that were visible before the claim went out. Hospitals spent an estimated \$19.7 billion in 2022 just fighting denials, and medical necessity remains the top reason across most payers. Work through the checks below with your coding and CDI leads. Every box you cannot tick is a denial waiting to happen.

Front-end: eligibility and authorization

- Insurance eligibility is verified at or before the point of service, not after.
- Prior authorization is obtained and the auth number is on the claim for every service that requires it.
- The authorized procedure matches what was actually performed and documented.
- Referrals are on file and current for payers that require them.
- Patient demographic and policy data is validated against the payer record.

Documentation: medical necessity

- Admission documentation shows the clinical indicators that meet inpatient severity, not just the diagnosis.
- Continued-stay notes justify why care could not be delivered at a lower level.
- You know which criteria set each major payer uses (InterQual or MCG) and document to it.
- Diagnostic test orders carry a supporting diagnosis that meets the payer coverage policy.
- Signed and dated physician orders exist for every billable service.

Coding accuracy

- Codes are supported by documentation in the record, not inferred or assumed.
- Secondary diagnoses and comorbidities that affect DRG or risk score are captured.
- Modifiers are applied correctly and are consistent with the documented service.

- NCCI / CCI edits are checked before submission, not after a denial.
- Diagnosis specificity is to the highest level the documentation supports.
- Present-on-admission indicators are accurate for inpatient claims.

Process and oversight

- A pre-submission review catches medical necessity gaps before claims drop.
- Concurrent review runs during the stay for inpatient admissions, not just at discharge.
- A compliant physician query process exists for unclear or conflicting documentation.
- Denials are tracked by reason code so you can see patterns, not just totals.
- Your clean claim rate and denial rate are measured monthly against a target.
- Recurring denial reasons feed back into coder and physician education.

See where your denials are actually coming from

Our coding and medical necessity review teams run a no-cost analysis of your recent denials and show you the documentation gaps driving them.

medcodexhealth.com/clinical-documentation/medical-necessity-review

This checklist is general guidance, not coding or legal advice. Apply it against your own payer mix and compliance policies.