WEBILL HEALTH · WHITE PAPER · 2026 EDITION

The Denial Root Cause Playbook

How to find the three denial patterns costing your practice the most, trace each one to its cause, and close it at the source. With the remittance code map, the appeal deadline table and a worksheet you can run this week.

For practice owners and administrators

Independent and specialty practices with 1 to 20 providers

WeBill Health

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WHY THIS PAPER EXISTS

The rework treadmill

Most practices work denials one at a time. A claim comes back, somebody fixes it, it goes out again. The claim gets paid and the cause survives. Next month the same denial arrives with a different patient's name on it.

Rework grows quietly because it feels productive. Somebody is busy, money is coming in, and the breakdown underneath is never named. Meanwhile the claims nobody had time to rework age past their appeal deadline and become write offs.

The numbers say the treadmill is speeding up. Across more than 2,100 hospitals and 300,000 physicians, the average initial denial rate reached 11.81% in 2024 (Kodiak Solutions, published May 2025). In Experian Health's 2025 State of Claims survey, 41% of providers reported denial rates of 10% or higher, up from 30% in 2022. Two thirds said clean claims are harder to submit than a year ago.

Each denial is expensive even when you win it. Hospitals spent $57.23 per claim contesting denials in 2023, up from $43.84 the year before (Premier). For a physician practice the rework cost runs about $25 per claim (Change Healthcare, cited by MGMA). And most of that spend was avoidable. Change Healthcare's Denials Index found 86% of denials potentially avoidable, and nearly half of all denials begin at the front end, in registration, eligibility and authorization.

What a root cause approach changes

A root cause approach asks a different question of every denial: what produced this, and how many more of it are already in the pipeline. The answer is usually three causes. In most practices three denial groups carry more than half of the denied dollars. Close those three and the rest of the denial queue shrinks on its own.

Who this paper is for

Practice owners and administrators who want to see their own denial pattern without buying anything. You need your remittance detail, a spreadsheet and one afternoon. Every code, rule and deadline in this paper is explained in plain words, and every number carries its source and year.

Sources on this page: Kodiak Solutions Revenue Cycle Benchmarking Report (2024 data, May 2025); Experian Health, 3rd Annual State of Claims Survey (September 2025, 250 respondents); Premier Inc., Trend Alert on private payer denials (March 2024 and 2025 update); Change Healthcare Revenue Cycle Denials Index (2020), cited in MGMA Stat (March 2021).

PART ONE

Find your own pattern in one afternoon

You do not need software to do this. You need the electronic remittance advice (the 835 file, or the paper EOBs) for the last 90 days and a spreadsheet. Export every denied or zero paid line with these columns: date of service, payer, CPT or HCPCS code, modifier, billed amount, the Claim Adjustment Reason Code (CARC) and the Remittance Advice Remark Code (RARC).

01 **Pull every denial from the last 90 days with the remittance detail attached.**

Include partial denials and lines paid at zero. A claim that paid two of three lines still has a denial on it.

02 **Group by three fields at once: CARC code, payer and CPT code.**

Grouping by any one of them alone hides the pattern. A CO 197 from one payer on one procedure is a fixable rule. The same code spread across every payer is a front desk process.

03 **Rank the groups by dollars denied, never by count.**

A $40 denial repeating 200 times and a $3,000 denial repeating twice are different problems with different owners. Only dollars show you which one to fix first.

04 **Open the top three groups and read ten claims from each.**

In most practices those three carry more than half the denied dollars. Everything below the top three waits until these are closed.

What the ranked list usually looks like

The table below is an illustration built from the denial groups we see most often in a four provider practice. Your numbers will differ. The shape rarely does: three groups at the top, then a long tail.

RANK	CARC	PAYER	CODE	LINES	DOLLARS DENIED	SHARE
1	**CO 197**	Regional commercial plan	Imaging and injections	62	$41,800	31%
2	**CO 4**	All payers	99213 and 99214 with 25	188	$22,100	16%
3	**CO 50**	Medicare Advantage	Therapy frequency	74	$14,600	11%
4 to 19	Mixed	Mixed	Mixed	410	$56,900	42%

Illustrative figures. Three groups hold 58% of the denied dollars, and each has a different owner: the front desk, the clinicians, and the biller who tracks payer policy.

> Denial work fails when it is spread evenly across every problem you have. Three named causes, each with a named owner, is the whole method.

PART TWO

Read the remittance like the payer wrote it

Every denied line carries a group code and a reason code. The group code says who absorbs the loss. CO means contractual obligation, so the practice cannot bill the patient. PR means patient responsibility. OA is other adjustment, used for duplicates and coordination of benefits. PI is a payer initiated reduction. The reason code (CARC) says why. The remark code (RARC) adds detail.

The map below translates the codes you will meet most often into plain words, names the root cause behind each, and says who owns the fix. Code descriptions are from the X12 code list maintained by X12 Incorporated, current as of October 2026.

CODE	WHAT THE PAYER IS SAYING	ROOT CAUSE	OWNER OF THE FIX
CO 197	Precertification, authorization or notification was absent	Front end	Front desk, authorization staff
CO 198	The authorization was used up: visits or units exceeded	Front end	Authorization staff, scheduler
CO 27	Coverage had ended before the date of service	Front end	Front desk, eligibility check
CO 31 / CO 140	The patient cannot be matched to a member, or the ID and name disagree	Front end	Front desk, registration
PR 204	The service is not covered under the patient's plan	Front end	Front desk, benefits check
CO 22	Another payer may be primary (coordination of benefits)	Front end	Registration
CO 242 / CO 243	Out of network, or no referral from the primary care provider	Front end	Front desk, referral tracking
CO 50	The payer does not consider the service medically necessary	Documentation	Clinician, note template
CO 16	The claim lacks information or has a billing error (always paired with a RARC)	Documentation or coding	Biller, read the RARC
CO 252	The payer wants records or an attachment before it will decide	Documentation	Biller, medical records
CO 151	The documentation does not support this many services or this frequency	Documentation	Clinician and biller together
CO 4	The procedure code and the modifier disagree, or a required modifier is missing	Coding	Coder
CO 11	The diagnosis does not support the procedure	Coding	Coder and clinician
CO 97	This service was bundled into another service already paid	Coding	Coder, bundling edits

CODE	WHAT THE PAYER IS SAYING	ROOT CAUSE	OWNER OF THE FIX
CO 236	This code pair is not allowed on the same day under NCCI edits	Coding	Coder
CO 119	The benefit maximum for the period has been reached	Policy drift or front end	Benefits check, scheduler
CO 96	Non covered charge (always paired with a RARC that says why)	Policy drift	Biller, rule library
CO 29	The time limit for filing has expired	Process	Billing manager
OA 18	Exact duplicate of a claim already received	Process	Biller, resubmission control
CO 109	Wrong payer. Send it to the correct payer or contractor	Front end	Registration
CO B7 / CO 185	This provider was not certified or eligible to be paid for this service on this date	Credentialing	Credentialing owner
CO 45	Charge exceeds the contracted fee. Not a denial, a contractual write down	Contract	Nobody. Exclude from denial counts

Source: X12 Claim Adjustment Reason Codes and Claim Adjustment Group Codes, x12.org/codes, read October 2026. Code 15 (authorization number missing or invalid) was retired by X12 on May 1, 2018; payers now use 197 or 198 with a remark code.

PART THREE

The four root causes

Almost every repeating denial traces back to one of these four. Naming which one you are looking at decides who fixes it, and that decision is the one most practices skip.

1. Front end: eligibility, benefits and authorization

The claim was decided before it existed. These denials show up as CO 197 for a missing authorization, CO 27 for coverage that had ended, and PR 204 for a service the plan never covered. No coder recovers a service that was never authorized, and no appeal restores coverage the patient did not have.

This is the largest group almost everywhere. Experian Health's 2025 survey put missing or inaccurate data at the top of denial causes (50% of providers), with authorization issues at 35% and registration errors at 32%. KFF's review of HealthCare.gov plans found 9% of in network denials in 2024 were for a missing authorization or referral, and another 25% for administrative reasons.

The fix sits at the desk, not in billing. Verify eligibility before every visit, including established patients, and record the benefit check. Track authorization units and end dates on the schedule, so the visit that would exceed them is flagged before it happens.

2. Documentation alignment

The note does not carry what the code claims. These denials show up as CO 50 medical necessity, CO 151 frequency, and CO 252 when the payer asks for records. The clinician and the note template decide the outcome long before billing sees the claim.

The fix is a template change and a ten minute conversation with the clinician, repeated for each denied service. Payers publish what the note has to show. Medicare does this in Local Coverage Determinations by region and in National Coverage Determinations. Commercial plans publish medical policies. Pull the policy, compare it to five denied notes, and change the template so the required elements are prompted.

3. Coding specificity and modifiers

CO 4 where the procedure and the modifier disagree or a required modifier is missing. CO 11 where the diagnosis does not support the procedure. CO 97 and CO 236 where the service was bundled or the code pair is not allowed on the same day. These are the denials a coder can own outright.

The fix is a payer specific edit list, applied before submission, and reviewed by a person who knows the specialty. Bundling rules come from the National Correct Coding Initiative (NCCI), updated quarterly by CMS. Commercial plans add their own edits on top.

4. Payer policy drift

The rule changed and nobody applied it. This one is invisible from the inside, because the claim was correct last quarter and nothing about your process went wrong. It shows up as CO 96 non covered, CO 119 benefit maximum, or a sudden CO 50 on a service that paid for years.

The fix is a rule library someone owns. Every payer bulletin is read, dated, and written into a carrier specific list that the biller meets at submission. A rule that lives in one person's memory is not a control.

Sources: Experian Health State of Claims (2025); KFF, Claims Denials and Appeals in ACA Marketplace Plans in 2024 (March 2026); CMS NCCI policy manual and quarterly edit files.

PART FOUR

What the pattern looks like by billing type

Denial patterns are specialty specific. A playbook that treats every claim the same way will find nothing, because payers do not treat every claim the same way. Below are the groups that most often sit at the top of the ranked list, by the kind of billing a practice does.

Office visit and consultation billing

- Modifier 25 on a same day evaluation and management service billed with a procedure. CMS has proposed paying the lesser of the two services at 50% from January 1, 2027 (CY2027 physician fee schedule proposed rule, July 14, 2026; final rule expected in early November), so payer scrutiny of this pairing is rising.
- Level disputes on established patient visits (99214 and 99215), paid at a lower level after review.
- Place of service 20 against 11 on urgent care claims, where the contract pays a case rate for one and a fee schedule for the other.
- G2211 add on billed with modifier 25 on the same claim, denied under payer edits.

Pediatrics and primary care

- Vaccine administration components (90460 and 90461) counted per component, denied when the count does not match the vaccine.
- Well child and sick visit on the same day without modifier 25 and a distinct diagnosis.
- Medicaid managed care plan variants with their own authorization and frequency rules.

Time based therapy billing

- Unit counting against the 8 minute rule for Medicare timed codes, with units rounded up where they should round down.
- Authorization lapsing partway through a treatment plan (CO 198), because units were tracked in the chart and not on the schedule.
- Session limits reached mid course (CO 119).
- Telehealth modifier and place of service errors after a parity change.

Procedure and surgical billing

- Global period misapplication: post operative visits billed inside the 10 or 90 day window without modifier 24 or 79.
- Modifier 25 and 59 challenges where the payer asks for records (CO 252).
- Medical necessity denials on therapy frequency inside the post operative window, where nobody is watching the count.
- Laterality and frequency limits on injections under the regional LCD.

The Medicare Advantage exception

Medicare Advantage plans deny more often than traditional Medicare and overturn most denials on appeal. KFF found 7.7% of 52.8 million prior authorization determinations were denied in 2024, only 11.5% of those denials were appealed, and 80.7% of appeals were overturned. In the first half of 2026 traditional Medicare's initial denial rate was 4.21% (Kodiak Solutions). If one plan sits at the top of your ranked list, that plan's appeal process belongs in your monthly routine.

Sources: CMS, CY2027 Medicare Physician Fee Schedule proposed rule and fact sheet (July 14, 2026); KFF, Medicare Advantage prior authorization determinations 2024 (January 2026); Kodiak Solutions (September 2026).

PART FIVE

The deadlines you cannot miss

A denial you can fix becomes a write off the day its deadline passes. Two clocks run on every claim: the time limit for filing, and the time limit for appeal. Both differ by payer type. Put the dates below on the wall of the billing office.

Appeal deadlines by payer type

PAYER TYPE	FIRST APPEAL	DECISION DUE	NEXT LEVELS
Traditional Medicare (Part B)	Redetermination within 120 days of the initial determination. No minimum dollar amount	MAC decides within 60 days	Reconsideration by the QIC within 180 days; ALJ hearing within 60 days, $200 minimum in 2026; Appeals Council within 60 days; federal court within 60 days, $1,960 minimum in 2026
Medicare Advantage	Reconsideration within 65 calendar days of the denial notice for members and non contracted providers, effective January 1, 2025 (was 60)	Standard reconsideration 30 days; expedited 72 hours	Independent review entity, then ALJ as above. Contracted providers follow the dispute clause in the plan contract
Commercial and ACA marketplace	Set by contract. Most plans allow 90 to 180 days from the remittance date. Members have 180 days for an internal appeal under the ACA	Typically 30 to 60 days by contract	Second level internal appeal, then external review where the state provides it
Medicaid and Medicaid managed care	Set by state and plan. Commonly 60 to 120 days	Set by state	State fair hearing

Timely filing limits

PAYER TYPE	LIMIT FOR THE ORIGINAL CLAIM	NOTE
Traditional Medicare	12 months from the date of service	Fixed by law since 2010. Very few exceptions
Medicare Advantage	By contract, often 90 days to 12 months	Non contracted providers usually follow the Medicare limit
Commercial	By contract, commonly 90 to 180 days	Some plans allow 365 days. The contract governs, not the plan's website
Medicaid	By state, commonly 90 days to 12 months	Managed care plans may be shorter than the state program

> Pull the exact limit from every contract you hold and write it into the rule library beside the payer's name. A CO 29 denial is the only denial on the map that is 100% the practice's own doing.

What changed in 2026

The CMS Interoperability and Prior Authorization final rule (CMS 0057 F) took effect January 1, 2026 for Medicare Advantage, Medicaid and CHIP managed care, and marketplace plans on the federal exchange. Those payers must now decide an urgent authorization within 72 hours and a standard one within 7 calendar days, and must give a specific reason for every denial. From January 1, 2027 they must also offer a prior authorization API that returns the decision electronically. The specific reason requirement matters for root cause work: a denial that names its reason can be traced. Keep every denial letter.

Sources: CMS, First Level of Appeal: Redetermination; CGS Medicare, Five Levels of Appeals; Federal Register, December 4, 2025, amount in controversy thresholds for 2026; CMS Medicare Advantage appeals changes effective January 1, 2025, as published in plan provider bulletins; CMS 0057 F (February 2024).

PART SIX

Close it at source

Four moves, in this order. The order matters because the first move is the cheapest and removes the denials no appeal can recover.

01 **Fix the front desk before you fix the coder.**

Eligibility and authorization failures cannot be appealed into payment, so they are the cheapest denials to eliminate and the most expensive to ignore. Give the desk a written verification standard by visit type, and check it weekly against the CO 197, CO 27 and PR 204 lines on the remittance.

02 **Write the rule where the biller will meet it.**

A payer policy that lives in somebody's memory is not a control. It belongs in a carrier specific rule library that one person owns and updates, with the bulletin date beside every rule. Every claim is read against that library by a person before it goes out.

03 **Review your top three groups again every month.**

A closed cause reopens the moment a payer revises policy. The monthly review is thirty minutes: rerun the ranked list, confirm the three groups shrank, and name the new third group if one appeared.

04 **Measure denied dollars, not denial rate.**

A falling rate alongside rising denied dollars is a worse month, and the rate alone will tell you the opposite. Track both, but decide on dollars.

The five numbers to watch

MEASURE	HOW TO COMPUTE IT	WHERE A WELL RUN PRACTICE SITS
Denied dollars by top three groups	Sum of denied charges in the three largest CARC, payer and CPT groups, monthly	Falling month over month after each fix
First pass denial rate	Denied lines divided by submitted lines, excluding CO 45 contractual adjustments	Under 5% is best practice; 7% to 8% is typical for practices (MGMA, July 2026)
Clean claim rate	Claims accepted and paid without any edit or denial, divided by claims submitted	98% (MGMA and Conifer KPI benchmarks, 2023)
Appeal overturn rate	Appeals paid divided by appeals filed, by payer	Above 50% on the groups you choose to appeal; below that, the fix belongs upstream
Accounts receivable over 90 days	Dollars older than 90 days divided by total A/R	Under 10% (MGMA and Conifer, 2023)

One warning on the second row. Count only true denials. A CO 45 line is the payer paying its contracted rate, and practices that include it in a denial rate frighten themselves with a number that has no fix.

Sources: MGMA Stat poll on first submission denial rates (July 2026); MGMA and Conifer Health, revenue cycle KPI white paper (2023).

PART SEVEN

The thirty minute checklist

Run this quarterly with the ranked list in front of you. If you cannot answer one of these from your own data, that is the gap, and it is usually one of the four root causes wearing a different name.

- [ ] Do you know your top three denial groups by dollars this quarter, by CARC, payer and CPT code together?
- [ ] Does someone own each of those three by name, and did the owner change anything since last quarter?
- [ ] Can you say which payer policy changed most recently, when the bulletin was dated, and where that rule is written down?
- [ ] Is eligibility verified before the patient is seen, every time, including established patients, and is the check recorded?
- [ ] Are authorization units and end dates visible on the schedule, so the visit that would exceed them is flagged before it happens?
- [ ] Does your aged accounts receivable have claims past their appeal deadline sitting in it right now?
- [ ] Do you know the timely filing limit for each of your top five payers from the contract, not from memory?

- [ ] Do you exclude contractual adjustments (CO 45) from your denial rate, so the number you track has a fix behind it?
- [ ] Do you see denial performance weekly, in dollars, or do you find out at quarter end?
- [ ] Have you read ten denied notes against the payer's published policy for your largest CO 50 group?

The worksheet

Fill this in from the ranked list in Part one. Three rows, nothing more. Bring it to the monthly review and update the last two columns.

GROUP (CARC, PAYER, CODE)	DOLLARS DENIED, 90 DAYS	ROOT CAUSE	OWNER	FIX APPLIED, DATE	DOLLARS DENIED, NEXT 90 DAYS
1.					
2.					
3.					

HOW WEBILL HEALTH WORKS

Where we hold our own work

WeBill Health maintains internal payer rule libraries organized by specialty and by carrier, built and updated by people who work claims in your specialty every day. Every claim receives human pre submission review against them before it goes out.

There is no black box and no algorithm we ask you to take on faith. When a payer changes a policy, a person updates the library and a person applies it to your claims. The four moves in this paper are our daily operating standard, run by a named billing manager you can call.

Our fee is a share of what you actually collect, so a denial costs us as well as you. That alignment is why the root cause work gets done instead of deferred.

98%	48 hr	40%	500+
clean claim rate	claim submission guarantee	A/R reduction within 90 days	payer rulesets in the internal libraries

Clients see an average 25% increase in collections within six months, through specialty specific coding and reduced days in accounts receivable.

Want your own pattern found for you?

A Revenue Health Audit is a forensic review of your existing accounts receivable and your last 90 days of remittances. You get the ranked list from Part one built from your own data, the three root causes named, and the dollars attached to each. Free, with no obligation.

Get my Revenue Health Audit →

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SOURCES

Where every number comes from

1. Kodiak Solutions, Revenue Cycle Benchmarking Report, 2024 data (May 2025) and first half 2026 update (September 2026). Initial denial rate 11.81% in 2024; 10.63% all payers and 4.21% traditional Medicare in the first half of 2026.
2. Experian Health, 3rd Annual State of Claims Survey, September 2025, 250 revenue cycle respondents. 41% report denial rates of 10% or higher; causes: missing or inaccurate data 50%, authorization 35%, registration 32%; 68% say clean claims are harder to submit. experian.com
3. Premier Inc., Trend Alert: Private Payers Retain Profits by Refusing or Delaying Legitimate Medical Claims, March 21, 2024, and 2025 update. 516 hospitals; nearly 15% initial denial rate; $43.84 per claim in 2022 rising to $57.23 in 2023; 54.3% of denials overturned. premierinc.com
4. MGMA Stat, 6 keys to addressing denials in your medical practice's revenue cycle, March 18, 2021, citing Change Healthcare's 2020 Revenue Cycle Denials Index: $25.20 rework cost per claim; 86% of denials potentially avoidable; registration and eligibility 27% of denials. mgma.com
5. MGMA Stat poll, July 2026: typical first submission denial rate 7% to 8%, best practice under 5%; 48% of practice leaders name denials and appeals their largest revenue leakage.
6. MGMA and Conifer Health Solutions, revenue cycle key performance indicators white paper, 2023: clean claim rate 98%, A/R over 90 days under 10%, days in A/R 30 to 40, net collection rate 95% to 99%.
7. KFF, Claims Denials and Appeals in ACA Marketplace Plans in 2024, March 24, 2026. 19% of in network claims denied (insurer range 3% to 36%); fewer than 1% appealed; 66% of appeals upheld; reasons: administrative 25%, excluded service 13%, authorization or referral 9%, medical necessity 5%. kff.org
8. KFF, Medicare Advantage prior authorization determinations in 2024, January 2026. 52.8 million determinations; 7.7% denied; 11.5% of denials appealed; 80.7% of appeals overturned.
9. X12 Incorporated, Claim Adjustment Reason Codes and Claim Adjustment Group Codes, read October 2026. x12.org/codes
10. CMS, Original Medicare appeals: First Level of Appeal, Redetermination (120 days to file, 60 day decision, no minimum amount). cms.gov. CGS Medicare, Five Levels of Appeals (180, 60, 60 and 60 day filing limits for levels two to five).
11. Federal Register, December 4, 2025: Medicare amount in controversy thresholds for calendar year 2026, $200 for ALJ hearings and $1,960 for judicial review. govinfo.gov
12. CMS Medicare Advantage appeals timeframe change, 60 to 65 calendar days, effective January 1, 2025, as published in plan provider bulletins (Wellcare, 2025).
13. CMS, Interoperability and Prior Authorization Final Rule, CMS 0057 F, February 2024. 72 hour and 7 calendar day decision deadlines effective January 1, 2026; prior authorization API January 1, 2027.
14. CMS, National Correct Coding Initiative policy manual and quarterly practitioner edit files; Medicare timely filing limit of 12 months from the date of service, Affordable Care Act section 6404 (2010).
15. CMS, Calendar Year 2027 Medicare Physician Fee Schedule proposed rule and fact sheet, July 14, 2026: proposed 50% payment reduction for the lesser of an E/M service billed with modifier 25 and a same day global procedure, effective January 1, 2027 if finalized. cms.gov

Third party figures are quoted as published and are not WeBill Health performance claims. WeBill Health metrics appear only on page 9. This paper is general information for practice management and is not legal or payer specific advice. Confirm every deadline against your own contracts.

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