Top 20 Denial Codes Costing Practices Millions

& How To Fix Them

How revenue cycle management expertise can prevent costly claim denials and maximize practice revenue.

Whitepaper

published by liberty liens

www.libertyliens.com

Executive Summary

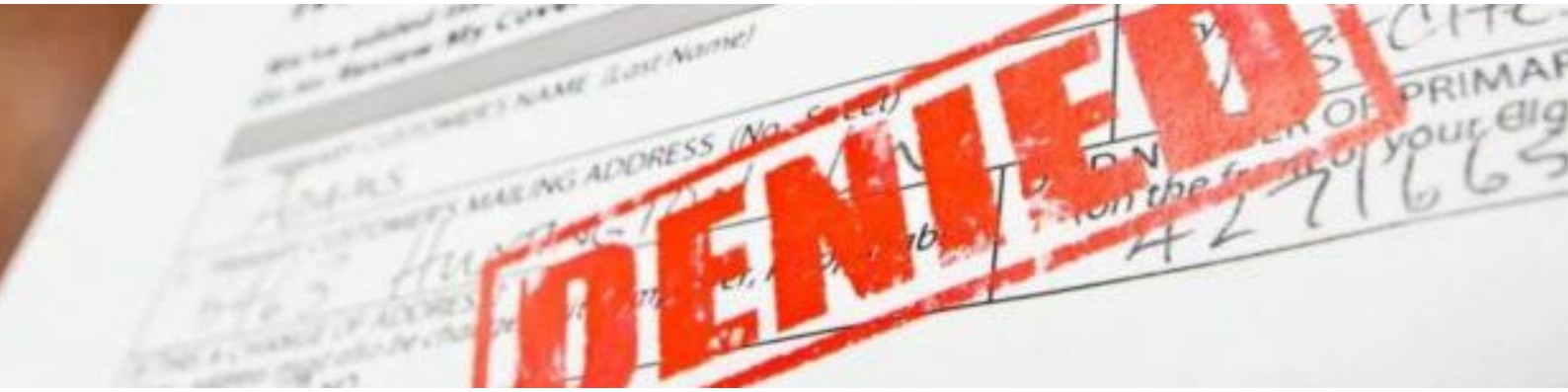
The healthcare industry claims denial is a critical challenge that threatens the financial viability of medical practices nationwide. Recent studies reveal that hospitals and health systems spend approximately $19.7 billion annually managing claim denials, with individual practices investing $25 to $118 per denied claim to rework submissions.

Current denial rates range from 10% to 15% of all submitted claims, representing millions in lost revenue for healthcare providers. More studies show that denial rates have increased by 51% for inpatient treatments, with 89% of hospitals reporting rising denial rates.

This white paper examines the 20 most common denial codes that cost practices the most money, analyzes why these denials occur, and demonstrates how Specialized revenue cycle management services can prevent these costly errors. Liberty Liens has developed comprehensive solutions specifically designed to address these challenges, helping healthcare providers recover lost revenue and maintain healthy cash flow.

Key findings include:

- Over 70 million claims are denied by insurers annually
- The majority of denials are preventable through proper verification and coding
- Missing or incorrect information accounts for the highest percentage of denials
- Professional revenue cycle management (RCM) services can reduce denial rates by 60-80%
- Proactive verification and coding expertise prevent denials before submission



The Problem: A Growing Crisis in Healthcare Revenue

The Financial Impact of Claim Denials

Medical practices face an escalating financial crisis from claim denials. The numbers paint a serious picture of the challenge facing healthcare providers today.

Healthcare providers invest valuable resources in fighting denials that should have been paidupon initial submission. Each denied claim requires staff time to identify the issue, gather additional documentation, correct errors, and resubmit to payers. This administrative burden diverts resources away from patient care and practice growth.

The downstream effects extend beyond direct costs. Delayed payments disrupt cash flow ,creating challenges in meeting payroll, purchasing supplies, and investing in practice improvements. Many practices write off denied claims rather than pursuing appeals, representing pure revenue loss.

Why Denials Are Increasing

Several factors contribute to the rising reasons behind claim denials facing medical practices:

1. Increasing Complexity
Medical coding systems grow more intricate each year, with thousands of codes that must be precisely matched to diagnoses and procedures.

2. Stricter Payer Requirements
Insurance companies implement increasingly strict requirements for prior authorizations, medical necessity documentation, and claims submission.

3. Automated Denial Systems
Payers deploy artificial intelligence and automated systems that flag and deny claims for minor discrepancies that would previously have been processed.

4. Staff Training Gaps
Front desk and billing staff often lack comprehensive training on current coding guidelines, payer requirements, and verification procedures.

5. Manual Processes
Many practices still rely on manual data entry and verification, creating opportunities for human error that result in denials.

The Patient Care Impact

Beyond financial implications, claim denials directly impact patient care and satisfaction. Patients experience confusion and frustration when they receive unexpected bills for services they believed were covered. Some patients delay or avoid necessary follow-up care due to medical billing disputes.

Administrative staff spend valuable time explaining denial letters and coordinating with insurance companies instead of supporting clinical operations. This reduces the overall quality of the patient experience and can damage the practice's reputation in the community

Top 20 Denial Codes Costing Practices Millions

Understanding specific denial codes is the first step toward prevention. These 20 codes represent the most common and costly denials facing healthcare providers today.

1. CO-16: Claim Lacks Information or Has Billing Error

This C0-16 denial indicates missing or incorrect information but does not specify the exact error. It may involve patient demographics, insurance details, service dates, or medical billing codes.

Common Causes Behind CO-16 Denials

Typographical errors in patient names, incorrect dates of birth, transposed policy numbers, missing referring physician information, or incomplete service dates.

Impact on Revenue Cycle

As one of the most frequent denial codes, CO-16 can affect 15-20% of claims, representing hundreds of thousands in delayed or lost revenue annually.

2. CO-4: Procedure Code Inconsistent with Modifier

The submitted procedure code conflicts with the modifier used, or a required modifier is missing entirely. Modifiers provide essential context about services offered.

Common Causes Behind C0-4

Using incorrect modifiers for bilateral procedures, missing modifiers for multiple procedures performed during the same session, or applying modifiers that contradict the primary procedure code.

Impact on Revenue Cycle

Modifier errors can reduce reimbursement by 50% or more, particularly for surgical and diagnostic procedures.

3. CO-11: Diagnosis Code Does Not Match Procedure

The diagnosis code submitted does not support the medical necessity of the billed procedure, or the diagnosis is not specific enough to justify treatment.

Common Causes Behind CO-11

Using outdated ICD codes, selecting diagnosis codes that are too general, failing to link diagnoses properly to procedures, or insufficient clinical documentation to support the diagnosis.

Impact on Revenue Cycle

Medical necessity denials are among the most challenging to overturn, often resulting in complete claim write-offs rather than resubmission.

4. CO-18: Duplicate Claim

The insurance company has already received and processed an identical claim. This indicates the service was billed multiple times.

Common Causes Behind CO-18

Accidental double-clicking during electronic submission, resubmitting denied claims incorrectly without a proper appeals process, or billing system errors that automatically regenerate claims.

Impact on Revenue Cycle

While individual duplicate claims may not represent large amounts, the administrative cost of researching and resolving these denials adds up quickly.

5. CO-22: Coordination of Benefits - Another Payer Responsible

The patient has multiple insurance policies, and the claim was submitted to the wrong primary payer. The denial indicates that another insurance company should be billed first.

Common Causes Behind CO-22

Failing to verify primary insurance during patient intake, outdated insurance information in the system, or not following the coordination of benefits rules for patients with Medicare and private insurance.

Impact on Revenue Cycle

These denials cause significant delays in payment, as the claim must be resubmitted to the correct payer and then potentially filed with the secondary insurance.

6. CO-27: Coverage Terminated or Expired

Services were provided after the patient's insurance coverage ended. The insurance company will not pay for services rendered beyond the termination date.

Common Causes Behind CO-27

Not verifying current eligibility at the time of service, delays in billing that push the submission date beyond the coverage period, or changes in patient employment status that affect coverage.

Impact on Revenue Cycle

Often results in complete write-offs, as the provider must either pursue payment directly from the patient or absorb the loss.

7. CO-29: Time Limit for Filing Has Expired

The claim was submitted after the payer's filing deadline. Each insurance company establishes specific timeframes for claim submission after service dates.

Common Causes Behind CO-29

Delayed medical record documentation, backlogs in the billing department, waiting for additional information before submission, or a lack of tracking systems for filing deadlines.

Impact on Revenue Cycle

These denials are typically non-appealable and result in complete revenue loss. For high-value procedures, a single missed deadline can cost thousands of dollars.

8. CO-45: Charge Exceeds Fee Schedule

The amount billed exceeds what the insurance company allows for that specific service according to their fee schedule or contracted rate.

Common Causes Behind CO-45
Outdated fee schedules in the billing system, failure to update contracted rates after negotiations, or incorrect billing codes that trigger higher rates.

Impact on Revenue Cycle
While payment may still be received at the allowed amount, these denials require staff time to process adjustments and can indicate systemic fee schedule problems.

9. CO-50: Service Not Deemed Medically Necessary

The payer determined that the service provided does not meet their criteria for medical necessity based on the clinical information submitted.

Common Causes Behind CO-50
Inadequate clinical documentation, failure to obtain prior authorization, services that do not align with payer guidelines, or insufficient evidence in the medical record to support necessity

Impact on Revenue Cycle
Medical necessity denials are among the most expensive to appeal, requiring extensive documentation review and clinical justification. Many practices write off these claims rather than investing in the appeals process.

10. CO-96: Non-Covered Service

The billed service is not included in the patient's insurance plan benefits. The policy specifically excludes coverage for this type of service.

Common Causes Behind CO-96
Failing to verify benefit coverage before providing services, billing for cosmetic procedures under medical codes, or providing services that fall under policy exclusions.

Impact on Revenue Cycle
Results in patient responsibility, but practices often have difficulty collecting payment when patients expect insurance coverage.

11. CO-97: Service Included in Another Service Already Billed

The billed service is bundled into another procedure already claimed. This is a bundling denial where the payer considers the service part of a larger procedure.

Common Causes Behind CO-97
Lack of knowledge about bundling rules, billing for individual components of a comprehensive service, or failure to apply appropriate unbundling modifiers when procedures are truly separate.

Impact on Revenue Cycle
Bundling denials can significantly reduce reimbursement for surgical and procedural specialties where multiple related services are commonly performed together.

12. CO-109: Benefit Maximum Has Been Reached

The patient has exhausted their maximum benefit limit for this particular service or treatment category under their insurance plan.

Common Causes Behind CO-109
Not checking benefit limits during eligibility verification, providing services without informing patients of their remaining benefits, or failing to track utilization for services with annual or lifetime limits.

Impact on Revenue Cycle
Creates patient collection challenges when patients were not informed upfront about benefit exhaustion and expected insurance payment.

13. CO-12: Service Required Prior Authorization

The service was provided without obtaining the required prior authorization from the insurance company. Many procedures require preapproval before services are rendered.

Common Causes Behind CO-12
Lack of awareness about which services require authorization, emergency situations where authorization could not be obtained, or administrative failures in the authorization request process.

Impact on Revenue Cycle
One of the most costly denial types, as many payers will not pay at all without prior authorization. Practices may be unable to collect from patients if authorization was the provider's responsibility.

14. CO-122: Charge Exceeds Maximum Allowed

The charges have exceeded the maximum amount allowed under the patient's health plan for that specific service.

Common Causes Behind CO-122
Billing amounts not aligned with contracted rates, failure to update fee schedules after contract renewals, or incorrect coding leading to higher reimbursement attempts.

Impact on Revenue Cycle
Results in contractual adjustments that reduce revenue, and repeated occurrences may indicate systemic pricing problems

15. CO-150: Service Level Does Not Support Medical Necessity

The level of care or service provided was not justified based on the clinical documentation submitted. This often applies to evaluation and management codes.

Common Causes Behind CO-150
Insufficient documentation to support the level of service billed, upcoding to higher complexity levels without appropriate clinical justification, or missing elements required for the billed service level.

Impact on Revenue Cycle
Payers may downcode to lower reimbursement levels rather than deny outright, but this still represents a significant revenue reduction.

16. CO-151: Service Frequency Does Not Support Medical Necessity

The frequency of services provided exceeds what the payer considers medically necessary or reasonable for the patient's condition.

Common Causes Behind CO-151
Providing services more frequently than payer guidelines allow, insufficient documentation explaining the need for increased frequency, or not obtaining prior authorization for extended treatment plans.

Impact on Revenue Cycle
Particularly affects physical therapy, chiropractic, and other services with frequency limitations built into coverage policies.

17. CO-167: Diagnosis Not Covered by Insurance Plan

The patient's diagnosed condition is not covered under their specific insurance plan, regardless of the treatment provided.

Common Causes Behind CO-167
Conditions excluded from coverage by policy terms, experimental or investigational diagnoses, or conditions related to excluded benefits.

Impact on Revenue Cycle
Creates difficult patient conversations and collection challenges when services were provided under the expectation of coverage.

18. CO-197: Service Not Authorized

The service, expense, or procedure has not been properly authorized. This differs from CO-12 as it may indicate authorization was attempted but not properly completed.

Common Causes Behind CO-197
Authorization numbers not properly documented on claims, services provided outside the scope of authorization, or authorizations that expired before services were rendered.

Impact on Revenue Cycle
High-cost procedures denied for authorization issues can represent tens of thousands of dollars in lost revenue per claim.

19. CO-204: Service Is Bundled or Included in Another Service

The insurance company has packaged or combined the invoiced service into another procedure's reimbursement.

Common Causes Behind CO-204
Billing for supplies or services considered inclusive to a primary procedure, not following National Correct Coding Initiative guidelines, or failing to understand which services can be billed separately.

Impact on Revenue Cycle
Systematic bundling issues can reduce practice revenue by 5- 10% if not properly addressed through coding education.

20. PR-227: Information Requested for Patient Liability Calculation

Additional information is needed to determine what portion of the bill the patient is responsible for paying.

Common Causes Behind PR-227
Incomplete coordination of benefits information, missing secondary insurance details, or insufficient documentation of patient payment responsibility.

Impact on Revenue Cycle
Delays in determining patient responsibility lead to delays in collecting patient portions, affecting cash flow and increasing bad debt risk.

How Liberty Liens Prevents Costly Denials?

Understanding denial codes is only the beginning. The real value comes from implementing systematic solutions that prevent denials before claims are submitted. Liberty Liens has developed comprehensive revenue cycle management services specifically designed to address the root causes of claim denials.

01 Comprehensive Insurance Verification

Liberty Liens eliminates CO-22, CO-27, and CO-109 denials through careful insurance verification processes performed before services are offered. Our team verifies active coverage, identifies primary and secondary payers, checks benefit limits, and confirms patient eligibility for scheduled services. This proactive verification prevents the costly delays associated with submitting claims to incorrect payers or discovering coverage issues after services are provided. Patients receive clear financial expectations upfront, reducing collection challenges and improving satisfaction.

02 Expert Medical Coding and Billing

Our certified coding specialists prevent CO-4, CO-11, CO-97, CO-150, and CO204 denials through expert knowledge of current coding guidelines, bundling rules, and payer-specific requirements. We ensure procedure codes align precisely with diagnoses, apply appropriate modifiers, and follow National Correct Coding Initiative guidelines. Liberty Liens maintains up-to-date knowledge of ICD-10 and CPT code changes, ensuring claims reflect the most current and specific codes available. This expertise directly translates to higher first-pass approval rates and increased reimbursement.

03 Prior Authorization Management

CO-12 and CO-197 denials are completely preventable with proper authorization management. Our team tracks which services require prior authorization for each payer, submits authorization requests with complete clinical documentation, and ensures authorization numbers are properly documented and included on claims.

We maintain authorization tracking systems that alert providers when authorizations are approaching expiration, preventing the costly mistake of providing services after authorization periods end. Our team also manages authorization appeals when initial requests are denied.

04 Medical Necessity Documentation Support

Liberty Liens helps practices prevent CO-50, CO-150, and CO-151 denials by ensuring documentation adequately supports medical necessity. We review clinical notes to verify they contain sufficient detail to justify services rendered, educate providers on documentation requirements for different service levels, and identify documentation gaps before claims are submitted.

Our team understands payer-specific medical necessity criteria and ensures documentation addresses these requirements, significantly reducing denials based on insufficient clinical justification.

05 Accurate Data Collection and Entry

CO-16 denials, the most common and frustrating denial type, are prevented by careful data collection and verification processes. We implement standardized data collection protocols at the front desk, verify patient demographic information at every visit, and use clearinghouse scrubbing before claim submission to catch errors.

Our quality control processes identify and correct typographical errors, transposed numbers, and incomplete information before claims reach payers. This attention to detail dramatically reduces vague CO-16 denials that require time-consuming research to resolve.

06 Timely Claims Submission

CO-29 denials are completely avoidable with proper workflow management. Our team maintains comprehensive tracking systems for each payer's filing deadlines, establishes efficient workflows to ensure timely documentation and coding, and monitors claim status to identify and resolve issues before deadlines expire.
We prioritize time-sensitive claims and implement automated alerts for approaching deadlines, ensuring no claim misses its filing window due to administrative delays.

07 Duplicate Prevention Systems

CO-18 denials waste administrative resources researching and resolving claims that should never have been submitted. Liberty Liens' billing software identifies potential duplicates before submission, tracks claim status to prevent inappropriate resubmission, and follows proper appeals processes when denied claims need correction.

08 Coverage Verification and Patient Communication

CO-96, CO-109, and CO-167 denials create difficult patient collection situations. Liberty Liens prevents these by verifying specific benefit coverage before services are provided, clearly communicating coverage limitations and patient financial responsibility, and offering alternative solutions when services are not covered.

When patients understand their financial obligations upfront, collection rates improve dramatically, and patient satisfaction remains high even when insurance coverage is limited.

09 Contract Compliance and Fee Schedule Management

CO-45 and CO-122 denials indicate systemic issues with fee schedule management. Liberty Liens maintains current fee schedules aligned with contracted rates, updates billing systems promptly when contracts are renewed, and monitors reimbursement patterns to identify pricing discrepancies.

Our team ensures practices bill appropriately according to contractual agreements while maximizing allowable reimbursement under those contracts.

10 Denial Management and Appeals

When denials do occur, Liberty Liens manages the entire appeals process efficiently. We analyze denial patterns to identify systemic issues, prepare comprehensive appeals with supporting documentation, track appeal deadlines and follow up persistently, and provide regular reporting on denial trends and resolutions.

Our experienced team knows which denials are worth appealing and how to present the strongest case for overturning inappropriate denials. This expertise translates to higher appeal success rates and recovered revenue.

Turning Revenue Challenges into Measurable Gains

Healthcare practices that partner with Liberty Liens experience measurable improvements in revenue cycle performance. Our comprehensive approach to denial prevention delivers tangible financial benefits that far exceed the cost of our services.

Reduced Denial Rates: Practices working with Liberty Liens typically reduce their denial rates by 60-80%. For a practice processing $2 million in annual claims with a 12% denial rate, reducing denials to 3% recovers $180,000 in revenue annually that would otherwise require expensive rework or be written off entirely.

Eliminated Rework Costs: At $25 to $118 per denied claim to rework, preventing denials saves substantial administrative costs. A practice reducing denials from 300 per month to 75 per month saves $67,500 to $318,600 annually in rework costs alone, freeing staff to focus on revenue-generating activities rather than correcting errors.

Faster Payment Cycles: Clean claims submitted the first time are paid faster, improving cash flow. Liberty Liens clients typically see days in accounts receivable decrease by 15-25%, providing working capital that can be invested in practice growth, equipment, or staff development.

Increased Collection Rates: Proactive verification and patient communication improve collection rates for patient-responsible amounts. Practices see patient collection rates improve by 20-30% when patients understand their financial obligations before services are provided.

Reduced Write-Offs: Preventing non-appealable denials like CO-29 (timely filing) and CO-12 (missing prior authorization) eliminates pure revenue loss. For practices with high write-off rates, partnering with Liberty Liens can recover hundreds of thousands of dollars annually that would otherwise be lost.

Staff Efficiency Gains: When Liberty Liens handles revenue cycle management, practice staff can focus on patient care and clinical operations rather than wrestling with insurance companies. This improves job satisfaction, reduces turnover, and allows the practice to serve more patients without expanding administrative staff.

Secure Your Practice's Financial Future

Claim denials have become a significant and growing threat to practice profitability. The good news is that most denials are preventable with the right revenue cycle expertise, systems, and processes.

Liberty Liens specializes in helping healthcare practices reduce denials, strengthen revenue cycle performance, and maximize revenue recovery. Our comprehensive approach addresses every stage of the revenue cycle from initial patient engagement through final payment collection, ensuring fewer disruptions, faster reimbursements, and stronger financial outcomes.

LIBERTY LIENS

Outsource Your Billing & Lien Work.

Book Your Free Audit Today!

(714) 251-6140
(657) 348-2557
info@libertyliens.com
www.libertyliens.com