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Impact of Denial Management on improving A/R collections

A practical guide for DME/HME and Home-care providers

Turning denied claims into faster collections, lower cost to collect, and stronger revenue-cycle performance

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2026

Executive Summary

A denied claim can look like a billing problem. In DME/HME and home-care operations, it is often much more than that. By the time a denial appears, equipment or services may already have been delivered, staff time has already been spent, and the account may already be moving into older A/R. The longer the issue remains unresolved, the harder collection can become.

Denial management is therefore not only a recovery activity. It is a collection strategy. A well-run denial program can bring cash back into the business, reduce the amount of A/R that becomes difficult to recover, lower the cost of collection, and show the organization where its revenue cycle is breaking down.

This white paper looks at the connection between denial management and A/R collection. It keeps the practical perspective of a California DME/CRT provider, a provider of power mobility devices and home medical equipment, through the experience of a billing operations leader. Industry experience shows that denials can create a compounding operational burden because they delay cash, increase aging A/R, consume staff time, and make it harder to determine the appropriate next action.

The paper also brings in current Medicare requirements and selected industry information from the Texas Association for Home Care & Hospice (TAHC&H). These sources show why front-end accuracy matters. Centers for Medicare & Medicaid Services (CMS) requires documentation, correct coding and proof of delivery for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) claims, while certain products require additional face-to-face, written-order or prior-authorization steps. TAHC&H has also highlighted how missing or inaccurate visit data can affect home-care claims, payment and recoupment.

The central message is simple: every denial should answer two questions. First, how do we collect this money? Second, what can we change so the same problem does not reduce collection again? When these questions become part of one repeatable process, denial management stops being a back-end cleanup exercise. It becomes a feedback loop that improves A/R performance across the revenue cycle.

The A/R revenue opportunity hidden inside denials…



For many DME/HME providers, financial growth is associated with more referrals, more patients, more orders and more equipment delivered. But another opportunity already exists inside the organization: collecting more of the revenue that has already been earned.

A denied claim is different from a new sales opportunity. The patient relationship may already exist. The equipment may already be in the home. The order may already have been processed. Staff may already have invested time in eligibility, authorization, documentation, coding, billing and follow-up. When the claim is denied, much of that investment is already sunk.

The financial impact therefore has two parts. There is the unpaid balance itself, and there is the cost of recovering it. A collector may need to investigate the denial, review records, contact the payer, contact the ordering provider, correct information, resubmit the claim, prepare an appeal and continue follow-up. If the account ages further, the work may become more difficult while the probability of collection can decline.

Industry billing operations leaders commonly observe that:

"Denials create a compounding operational burden. They delay cash, increase aging A/R, consume staff time, and make it harder to determine whether a claim should be appealed, rebilled, adjusted, or escalated."

That observation connects denial management directly to A/R performance. A denial is not simply an item in a work queue. It can change the age, effort and recoverability of an account.

The goal is not to eliminate every denial. No provider can reasonably expect that. The goal is to separate preventable denials from legitimate payer decisions, resolve recoverable balances quickly, and use denial information to reduce repeat problems.

Why denials have a direct impact on A/R collections?

A/R collection depends on more than sending claims. It depends on the claim moving through the payment process without avoidable interruption. Denials interrupt that path.

- Cash is delayed. A claim that should have moved toward payment instead enters a correction, appeal or follow-up cycle.
- A/R ages. The balance remains open while staff determine what happened and what action is required.
- Cost to collect increases. Every additional touch consumes collector, billing, coding, clinical or administrative time.
- Recoverability can weaken. Older balances may face filing deadlines, missing records, payer restrictions or reduced internal attention.
- Collector productivity falls. A high denial workload can pull experienced staff away from clean claims and other high-value collection work.
- Root causes remain hidden. If teams only resolve individual denials, the same issue can continue to generate new A/R.



This is why denial management should be measured not only by the number of denials closed. A stronger view asks whether the program improves cash, reduces aging, lowers rework and prevents recurrence.

The DME/HME revenue cycle that has little room for error

DME/HME claims often depend on several requirements being correct at the same time. Eligibility, payer rules, authorization, medical necessity, documentation, coding, modifiers, delivery records and claim submission all have to align. A problem in one area can delay payment even when the equipment has already reached the patient.

CMS states that Medicare DMEPOS suppliers must meet documentation requirements that include a standard written order, medical record information, correct coding and proof of delivery. CMS also notes that proof of delivery must be retained for seven years from the date of service and made available to the DME MAC when requested. [1]



For certain DMEPOS items, additional requirements apply. CMS explains that some items are subject to face-to-face encounters and written orders prior to delivery, while others may be subject to prior authorization. As of October 28, 2026, CMS says its Required Face-to-Face Encounter and Written Order Prior to Delivery List will contain 105 items. [2]

For power mobility devices, the requirements are especially relevant to the experience of a provider such as a California DME/CRT provider. CMS states that power mobility devices require approval before delivery to the patient and that a claim can be denied when required prior authorization is not obtained before delivery. CMS also outlines documentation such as the standard written order, face-to-face supporting records, home assessment and proof of delivery. [3]

These rules make a useful point about denial management: the best denial is often the one prevented before the claim is released. When a missing document, invalid data element or authorization problem is found early, the organization has a chance to correct it without turning the issue into aged A/R.

Denial often begins before the claim is submitted

The denial queue is where a problem becomes visible. It is not necessarily where the problem began.

A claim can be affected by an eligibility issue at intake, an authorization problem during order processing, a documentation gap during clinical review, a coding error during billing, or a missing delivery record after the equipment has been delivered. If the organization waits until the payer rejects the claim, the correction becomes more expensive.

The same principle appears in home-care operations. TAHC&H reported that missing or incorrect EVV data elements can result in denied claims, recoupment during contract monitoring, contract actions and inaccurate or blank EVV reports. [4] In another TAHC&H update, providers were told that claims paid during an EVV claims-matching bypass could still be subject to recoupment if the required visit data was not maintained within the applicable period. [5]

The lesson is broader than EVV. When billing depends on information coming from multiple systems, people and workflow steps, data quality becomes part of collection performance. Denial management should therefore work with the teams that create the information, not only the team that receives the denial.

For DME/HME providers, common upstream risk areas include:

- Eligibility and benefits verification
- Prior authorization and authorization validity
- Medical-necessity and supporting documentation
- Standard written orders and required signatures
- HCPCS coding, modifiers and payer-specific billing rules
- Proof of delivery and related documentation
- Order and resupply processing
- Timely claim submission and correction workflows
- Payer-specific requirements and policy changes

From reactive follow-up to proactive denial management

Reactive denial management starts after the payer has already said no. The collector opens the account, identifies the denial code, researches the issue and decides what to do next. This work is necessary, but it should not be the entire denial strategy.

A proactive model adds a second question: what does this denial tell us about the revenue cycle?

For example, if the same documentation issue appears repeatedly, the answer may not be another collector. The answer may be a front-end checklist, an automated validation, a clearer ownership rule or payer-specific guidance. If the same authorization problem appears across a product category, the process may need to change before the claim is submitted.

Across the industry, denial knowledge can remain embedded in individual case resolutions, staff members, payer phone calls or one-off appeal examples. A claim may be resolved, but the lesson may not become a repeatable process for the next claim.

This is an important distinction. Working a denial is an activity. Preventing the same denial from happening again is a strategy.

A mature denial program therefore creates a feedback loop:

- Denial occurs and is categorized.
- Collector identifies the reason and next-best action.
- Resolution is documented.
- Recurring patterns are reviewed.
- Root cause is assigned to the appropriate upstream team.
- Process, system or training is changed.
- Future claims are monitored to confirm whether the denial rate falls.



This loop creates a direct connection between denial management and A/R collection. The first cycle recovers the current balance. The next cycles protect future balances.

How denial management improves A/R collection?

The impact can be understood through five collection levers.

1. Faster cash conversion

A claim that is corrected and resubmitted quickly has less time to sit in A/R. Faster action can prevent a small billing problem from becoming an older account requiring more research and escalation.

2. Lower A/R aging

A denial that remains untouched continues to age. Prioritizing denials by filing deadlines, financial value and recoverability helps the team focus on balances where delay can have the greatest financial effect.

3. Lower cost to collect

Every denial touch has a cost. Better categorization, standard work and automation can reduce repeated manual work. The objective is not simply to close more accounts; it is to collect more with fewer unnecessary touches.

4. Higher recovery of earned revenue

Some denied balances are recoverable. If the documentation is available and the denial can be corrected or appealed, timely intervention can turn an unpaid balance into collected revenue.

5. Fewer repeat denials

This is where denial management becomes a revenue-cycle improvement program. When the root cause is fixed, the organization protects future claims instead of repeatedly paying the cost of the same mistake.

A simple A/R denial economics model

Providers can make the financial impact easier to understand by measuring denial activity in dollars rather than only counts.

For example, consider a provider with $1,000,000 in monthly claims and a 10% initial denial rate. That creates $100,000 of denied claims in a month. If the organization recovers 70% of those denied dollars, $30,000 remains unresolved or lost. If a stronger process reduces the denial rate to 7% while maintaining the same recovery performance, the initial denied-dollar pool falls to $70,000. The difference is $30,000 of claims that did not enter the denial workload.



This is only an illustration, not the industry benchmark. The actual financial impact depends on payer mix, product mix, denial reason, recoverability, contract terms and operational performance. The point is to show why denial rate and recovery rate should be viewed together.

A useful dashboard should therefore connect denial activity to A/R outcomes:

- Initial denial rate by dollars and claim count
- Denial recovery rate
- Recovered dollars from appeals and corrections
- Denial dollars by A/R aging bucket
- Average days from denial to resolution
- Repeat denial rate
- Cost to collect per denied dollar
- Top denial root causes
- Top payer/product combinations generating denials
- Write-offs attributable to unresolved denials

What an effective denial management program looks like:

A strong program does not have to be complicated. It needs clear ownership, consistent information and a repeatable response.

1. Visibility

Teams need to know which denials are occurring, where they occur and whether they are increasing or decreasing. Reporting should show both volume and dollars.

2. Knowledge capture

A successful appeal or payer interaction should not remain inside one employee's memory. Document the reason, required evidence, payer response and successful resolution so the next collector has a starting point.

3. Prioritization

Not every denial deserves the same treatment. Prioritize by timely-filing risk, dollar value, likelihood of recovery, patient or provider impact and the amount of work required.

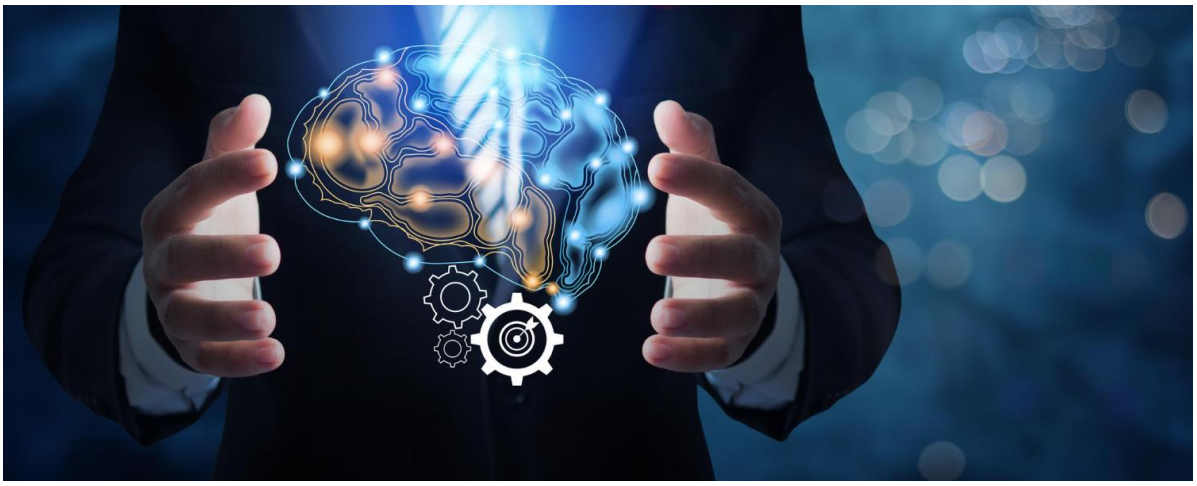
4. Accountability

A recurring denial should have an owner. Billing may identify the problem, but the root cause may belong to intake, authorization, clinical documentation, coding, order processing or another function.

5. Closed-loop prevention

The final step is often missed. After the denial is resolved, ask whether the workflow itself should change. A denial program that only closes accounts will keep seeing many of the same accounts again.

A California DME/CRT Provider: Turning Denial Knowledge into a Repeatable Process



For DME/CRT providers, denial management requires both collection discipline and organizational learning.

Denial work involves more than payment follow-up. Across the industry, the operational burden can include delayed cash, aging A/R, staff time and difficulty determining whether a claim should be appealed, rebilled, adjusted or escalated.

That perspective is important because different denial reasons require different actions. A missing document may require retrieval. A coding issue may require correction. A payer interpretation may require an appeal. A non-recoverable balance may require an adjustment. Treating all denials as one category can create unnecessary work and delay the accounts that need immediate attention.

Across the industry, important denial insights can remain embedded in individual resolutions. That creates a broader revenue-cycle challenge: the organization gets better at solving yesterday's problems without necessarily getting better at preventing tomorrow's problems.

The practical response is to convert experience into standard work. A payer call that clarifies a rule should become a documented payer-specific note. A successful appeal should become an example for future cases. A recurring documentation problem should trigger an upstream review. Over time, the denial queue becomes a source of operational intelligence rather than only a list of unpaid claims.

The role of automation and human judgment



Denial management is a good example of work that benefits from a combination of technology and experienced people.

Some tasks are repetitive. Claim status checks, work-queue routing, data validation, reporting and identification of missing information can often be standardized or automated. Automation can help teams identify a problem earlier and reduce manual touches.

Other decisions require context. A complex medical-necessity denial may require a person to review documentation. An appeal may depend on understanding the payer's reasoning. A collector may need to determine whether the account should be rebilled, appealed, adjusted or escalated.

The objective is therefore not to automate everything. It is to automate the predictable work so experienced staff can focus on decisions that require judgment.

For DME/HME providers, this can create a practical operating model:

- Automation identifies and routes predictable exceptions.
- Specialized billing staff research the denial and select the appropriate action.
- Experienced collectors handle complex appeals and payer conversations.
- Root-cause reporting identifies recurring patterns.
- Operations and front-end teams use the findings to prevent repeat errors.

This approach can also support scalability. Instead of adding staff every time denial volume increases, the provider can first ask which parts of the work can be standardized, automated or shifted to specialized support.

Regulatory and industry signals, that make prevention more important



Current Medicare requirements reinforce the value of getting claims right before they reach the payer.

CMS states that prior authorization helps DMEPOS suppliers confirm applicable coverage, payment and coding rules before certain items are delivered. CMS also announced updates to its DMEPOS lists in 2026, including additional codes on the Master List and Required Prior Authorization List. [6]

For power mobility devices, CMS specifically states that prior authorization is required before delivery and that the claim is denied when the required prior authorization is not obtained before delivery. [3]

CMS also states that Medicare claims generally must be received within 12 months, or one calendar year, from the date services were furnished. A claim denied for missing Timely Filing Limit (TFL) is not subject to appeal as an initial determination under the cited Medicare Claims Processing Manual provision. [7]

This creates an important A/R lesson: time is not neutral. A denial that sits untouched is not simply waiting. It is moving closer to operational and filing deadlines.

TAHC&H's industry updates provide another example from Texas home-care operations. Its reporting on EVV has highlighted the relationship between data accuracy, claim matching, payment and potential recoupment. [4][5] TAHC&H has also reported on proposed federal legislation concerning Medicare Advantage reimbursement and prompt payment of clean in-network claims. The 2025 article described the Prompt and Fair Pay Act as proposed bipartisan legislation; it should therefore be treated as a legislative proposal, not as a current payment rule. [8]

Across these examples, the message is consistent: payment depends on compliance, documentation, accurate data and timely action. Denial management sits at the point where those requirements become visible in the A/R.

The practical 90-day path to improve denial-driven A/R

Providers do not need to redesign the entire revenue cycle at once. A focused 90-day program can create a useful baseline and identify the highest-value opportunities.

Days 1-30: Establishing the baseline

- Pull 6–12 months of denial data.
- Group denials by reason, payer, product/service and dollar value.
- Measure denial rate, recovery rate and aging.
- Identify the top five denial categories by dollars and volume.
- Map the current workflow from denial receipt to resolution.
- Identify accounts at immediate filing or documentation risk.

Days 31-60: Building responses

- Create standard action paths for the major denial categories.
- Define when to correct, rebill, appeal, adjust or escalate.
- Create payer-specific notes and documentation checklists.
- Assign owners to recurring root causes.
- Automate simple validation and work-queue tasks where practical.
- Create a weekly denial review focused on patterns, not just closures.

Days 61-90: Closing the loop

- Compare denial and recovery results with the baseline.
- Measure repeat denials by root cause.
- Review whether upstream changes reduced new denials.
- Calculate recovered dollars and estimated avoided rework.
- Retire workflows that no longer add value.
- Set monthly ownership for the highest-impact denial categories.

The most important change is behavioral. The team should stop asking only, “How many denials did we close?” and begin asking, “How much A/R did we recover, how quickly did we recover it, and what did we change to prevent the next denial?”

Way ahead: From denial queue to A/R strategy…



Denial management has traditionally been viewed as a back-end function. The billing team receives the rejection, works the account and moves on to the next one. That model can recover money, but it can also keep the organization trapped in repeat work.

A stronger model connects every denial to A/R performance and upstream improvement. The organization measures the dollars at risk, prioritizes accounts based on recoverability and timing, captures the reason for the denial, and feeds the lesson back into the process.

For DME/HME providers, the benefit can be significant because the revenue has already been earned through referrals, order processing, equipment delivery and staff effort. Recovering that revenue can be more immediate than waiting for new volume to arrive.

Industry experience reinforces the operational reality. Denials create a compounding burden when they delay cash, age A/R and consume staff capacity. The solution is not simply to work harder. It is to make denial work more visible, more consistent and more preventive.

The result is a different relationship with the denial queue. It becomes a source of information. It tells the provider where documentation breaks down, where payer requirements create friction, where staff need better guidance and where technology can remove repetitive work.

Over time, better denial management can support four connected outcomes: faster collection, lower A/R aging, lower cost to collect and fewer repeat denials.

Denials may never disappear completely. But they do not have to control the revenue cycle. With the right structure, they can become one of the clearest sources of insight into how a provider can protect and collect more of the revenue it has already earned.

Summary: Protecting the revenue you have already earned

The financial impact of denial management is easy to underestimate because the work happens one account at a time. One claim is researched. One document is retrieved. One appeal is submitted. One balance is collected.

But the cumulative effect is much larger. When a provider reduces avoidable denials, resolves legitimate denials faster and prevents recurring problems, the organization changes the performance of its A/R.

The strongest denial programs therefore do three jobs at once. They recover today's denied dollars. They reduce tomorrow's rework. And they show leadership where the revenue cycle needs to improve.

For DME/HME and home-care providers operating in a complex payer environment, that combination matters. The objective is not simply fewer denials. It is better collection performance.

GeBBS Healthcare Solutions supports DME/HME providers with specialized revenue-cycle capabilities across claim research, denial follow-up, root-cause analysis, appeals and recovery. By combining experienced teams, structured workflows and automation where appropriate, providers can move from reactive denial work toward a more proactive A/R strategy.

The opportunity is already inside the claims you have earned. The next step is making sure more of that revenue reaches the finish line.

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Interview Perspective

The interview perspective used in this white paper is limited to general observations from a California DME/CRT provider represented by their Billing Operations Manager.