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Significance of Denial Management in Addressing Revenue Leakage

How home respiratory and medical equipment providers prevent recurring claim errors and protect revenue capture

Whitepaper

Executive Summary

Fixing a denied claim doesn't always fix the problem that caused it. If the same missing diagnosis or documentation gap keeps showing up on new claims, reimbursement remains at risk even while the billing team works through individual corrections. Some claims may eventually pay. Others may reach a point where the organization can no longer meet the requirements needed for payment. That is where a recurring billing issue can become avoidable revenue leakage.

Denial management helps protect that revenue when teams use what they learn from a denial to change what happens on the next claim. They need to understand why the issue occurred, who can address it, and where an earlier check would help. Better visibility gives teams a way to act before the same error puts more reimbursement at risk.

Rotech Healthcare's experience illustrates this approach in home respiratory and medical equipment billing. The organization improved denial reporting, assigned responsibility to the appropriate teams, and began addressing recurring issues earlier. As a response to invalid diagnosis codes, it confirmed payer requirements, obtained diagnosis lists specific to each item, and implemented system logic to flag invalid or missing diagnoses before claim release. Staff education reinforced those changes, with reported results including lower denial volume, less manual rework, and improved revenue capture.

The significance of these changes lies in their connection to revenue leakage. Identifying an error earlier gives the organization more opportunity to resolve it while reimbursement is still achievable. Automated checks can support that work by consistently flagging known issues, while clear workflows help staff obtain missing information and complete the necessary corrections. Together, these practices can reduce the risk that a recurring process failure becomes a permanent payment loss.

This whitepaper explores how suppliers can make that connection between a denied claim and the process that needs to change while examining the sources of avoidable payment loss, how to turn recurring denial patterns into earlier controls, and how to assess whether those controls protect reimbursement.

How Denial Related Revenue Leakage Develops

Revenue leakage means the avoidable loss of reimbursement that could have been received if applicable requirements had been met and supported. The distinction here matters because an initially denied claim may still be corrected and paid, so its full value should not automatically be counted as lost revenue. A covered claim becomes a leakage concern when preventable process failures leave some or all of the appropriate reimbursement unrealized.

The progression from an error to a loss



A billing error first creates exposure. The organization then has an opportunity to resolve it, depending on the nature of the issue and the payer's rules. If the missing information cannot be obtained, a required condition was not met at the necessary time, or the available action window closes, the organization may be unable to secure payment. Denial management is significant because it can identify these weaknesses before they affect more claims.

Consider a recurring diagnosis mismatch. Correcting one claim addresses that account, but an unchanged entry process may continue producing the same mismatch. Staff can appear productive because they are touching claims and resolving exceptions, while new claims continue entering the same failure path. The source of leakage remains active until the requirement is understood and the workflow changes.

Lost reimbursement vs. cost of rework

The labor required to investigate, correct, and resubmit a claim is a separate economic consequence. Rework can consume capacity even when the claim eventually pays in full. Leaders should distinguish that expense from unrecovered reimbursement so they can assess whether a change protected revenue, reduced administrative effort, or achieved both. Combining these effects into one figure can obscure what actually improved.

The same discipline applies to amounts. Gross billed charges can exceed the reimbursement the organization reasonably expects under the applicable payment terms. Estimating exposure using the expected collectible amount provides a more useful basis for assessing loss. Any calculation should also account for amounts already received and avoid counting repeated denials of the same claim as separate losses.

Identifying the preventable side of denials

Some nonpayment reflects a legitimate coverage decision or an unsupported service. Denial prevention does not make those claims payable. Its purpose is to help the organization meet and demonstrate applicable requirements for claims that can appropriately be reimbursed. Analysis should distinguish avoidable billing and documentation failures from situations in which payment was never supported.

In Rotech's experience, identifying the source is crucial. *"One of the biggest challenges was limited visibility into the root cause of denials,"* said Michelle Harkins, VP-Revenue Management, Rotech Healthcare.

Without that visibility, teams can keep correcting individual claims while the same source of payment risk remains active. The organization's diagnosis checks addressed an identifiable recurring issue before claim release, giving staff an earlier opportunity to resolve it.

Why Payer Requirements Create Leakage Risk



For a home respiratory and medical equipment supplier, accurate claim fields must be supported by the documentation and coverage requirements that apply to the item. A record can appear complete to an employee while still missing evidence needed for reimbursement. The operational challenge is translating the payer's requirements into actions that staff can carry out consistently before the relevant deadline or billing event.

"Payer requirements and documentation expectations have generally become more complex and more stringent in recent years, especially with the use of AI. These changes have increased the administrative burden across the organization and impacted timely reimbursement." - Harkins's observation highlights why a prevention process needs an owner for interpreting requirements and updating workflows. Without it, they might be following instructions that once worked even after the applicable requirement changes. Until that change reaches the claim entry process, similar claims may remain exposed to the same denial.

Requirements can apply before claim submission

CMS's Medicare Program Integrity Manual states that DMEPOS items require a written order for Medicare payment. Order timing varies: specified items require a written order prior to delivery, while other items require the order before claim submission. [1] This distinction explains why a later billing correction may be insufficient when a payment condition had to be satisfied earlier.

CMS-hosted standard documentation guidance also addresses the medical record evidence needed to support medical necessity and the supplier's obligation to maintain proof of delivery. It explains that supplier-prepared statements and physician attestations alone do not establish sufficient medical necessity documentation. [2] An automated check for a completed field therefore cannot, by itself, demonstrate that the supporting record meets coverage requirements.

Translate the requirement into a usable control



A practical control should tell staff what is missing, which requirement applies, and who can resolve the exception. Simply displaying a denial category or a generic warning leaves employees to interpret the problem again. If the information must come from a treating practitioner, the workflow should distinguish that request from a correction the billing team can make using existing documentation.

Requirements should be reviewed by payer, item, and applicable date. A diagnosis list or documentation rule for one situation should not be assumed to apply across all claims. The organization needs a reliable way to retain the policy source and revise the control when the source changes. That makes the connection between the requirement and the staff action easier to maintain.

Rotech's response to diagnosis issues demonstrates this translation. The team moved from recurring denials to an item-specific understanding of payer requirements, then embedded that understanding in system logic and staff education. The significance for leakage prevention lies in making an identified requirement actionable before another affected claim is released.

Use Root Cause Visibility to Find the Source of Leakage

Rotech's challenge with root cause visibility points to an important distinction. A denial reason identifies how a payer handled a claim; the root cause explains why the organization reached that outcome. A missing-diagnosis denial could result from incomplete intake, an entry omission, an outdated reference list, or a problem transferring information between systems. Each explanation points to a different corrective action.

"Our shift toward a more proactive approach has included improving denial reporting, identifying recurring denial trends, assigning ownership to the appropriate teams, and addressing issues earlier."

Michelle Harkins, VP-Revenue Management, Rotech Healthcare

Connect the denial to the originating process



Rotech's account describes the foundations of a prevention process. Reporting makes the pattern visible, investigation identifies the source, and ownership creates a path to change it. Without that connection, the billing team can repeatedly fix the same issue while the upstream process continues generating it. The organization needs to know where the information was first required and where the failure occurred.

A useful review follows a sample of affected claims through the actual workflow. It asks whether the required information was absent, present but entered incorrectly, or available in one system but not another. It also checks whether staff understood the requirement when they handled the account. Reviewing the record alongside the denial prevents the team from selecting a broad remedy that does not address the specific failure.

Prioritize recurring exposure rather than volume alone



High denial counts deserve attention, but counts alone do not identify the greatest threat to revenue capture. A frequent error may be readily correctable, while a less common documentation failure may leave reimbursement unsupported. Leaders should assess the expected collectible dollars involved, how often the issue recurs, and whether earlier intervention can materially change the outcome.

Patterns should be reviewed within the relevant payer and item group. Aggregating unrelated claims can hide a concentrated problem or imply that a rule applies more broadly than it does. A targeted view also helps explain whether the source is a specific requirement, a local process, or a wider training gap. Those distinctions determine who should own the response.

Ownership should include the prevention change

Assigning someone to work denied accounts is only part of ownership. The appropriate process owner should also be responsible for changing the action that allowed the error to recur. Billing can provide the evidence and confirm the outcome, while the team controlling the entry point implements the correction. The handoff should identify what will change and how the organization will verify it.

Rotech's statements support this broader view of denial management. Improved reporting and clearer ownership were components of a shift toward earlier action. For other suppliers, the practical lesson is to make every significant recurring denial trend answerable to a process change, then check whether the same cause continues appearing in new claims.

Rotech Addresses Recurring Diagnosis Errors Before Release

Rotech identified a recurring problem involving invalid diagnosis codes. The issue provided a specific opportunity to reduce leakage risk because the organization could identify the relevant requirements and check the claim before submission. Its response combined payer-specific information, a system control, and education for the teams handling the data.

Establish the item specific requirement

Rather than continuing to correct the same claims after denial, Rotech "identified the payer requirements and obtained a valid list of diagnoses specific to each item," states Harkins.

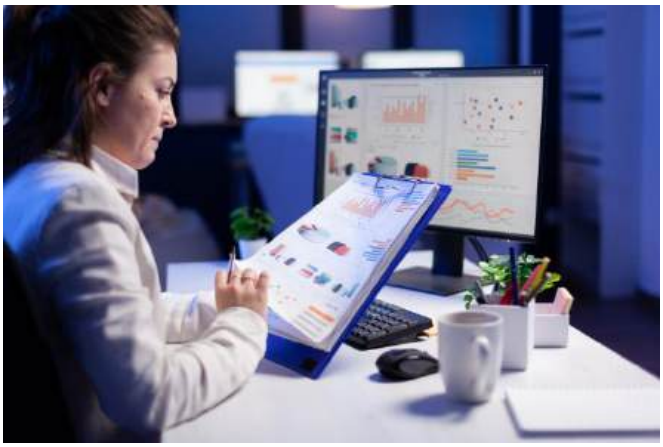
That step gave the team a defined reference for identifying invalid or missing diagnoses. The item-specific approach matters because a general list of valid codes does not necessarily establish which diagnoses meet the requirements for a particular item and payer.

The broader operational lesson is to verify what the payer requires before designing the check. A code may be structurally valid but unsuitable for the applicable claim. Conversely, an exception may require review because the documentation is incomplete rather than because the code itself is invalid. Understanding the actual requirement helps the organization avoid treating all diagnosis problems as the same error.

Place the check before the known error reaches the payer

Rotech implemented system logic that flagged invalid or missing diagnoses before claims were released. The control moved detection into the submission workflow, where the organization could address the known issue earlier. It reduced reliance on a denial to tell staff that the diagnosis needed attention.

For suppliers considering a similar approach, the check should reflect documented clinical information. A flag should prompt validation, clarification, or a request for missing information. Selecting a diagnosis simply because it appears on a payer's accepted list does not establish that it accurately describes the patient or supports the claim. The purpose of the control is to identify an exception that needs a legitimate resolution.



Help staff understand the reason for the change

Rotech also reeducated front-end and billing teams. That made education part of the prevention response rather than leaving staff to learn the new requirement from an alert alone. A useful training explanation links the data staff enter to the specific payer requirement and shows how an unresolved issue can place reimbursement at risk.

System logic and education serve different roles. The check identifies a potentially affected claim at the point of release; education helps employees understand how to prevent or resolve the problem. Together, they can make the response more consistent than a repeated instruction to correct errors after denial. Rotech reported lower denial volume and less rework for collections staff following its response.

Automation Can Interrupt a Recurring Source of Leakage

"GeBBS Healthcare has played a key role in helping us identify opportunities for automation to prevent recurring denials. By implementing automated checks and workflows, we are able to identify issues earlier and prevent claims from being submitted with known errors."

Michelle Harkins, VP-Revenue Management, Rotech Healthcare

Harkin identifies a specific role for GeBBS in Rotech's prevention work: helping find opportunities to automate checks and workflows for recurring denials. The value of this approach comes from applying a known requirement consistently at the point where an error can still be addressed. Automation is most useful when the team already understands what caused the denial and what an appropriate correction requires.

Make the exception actionable

An alert alone does not protect reimbursement. The organization must define what happens after the alert appears. A useful exception workflow identifies the missing or conflicting information, routes the account to someone able to resolve it, and records the action taken. Otherwise, automation can move an unresolved problem from the denial queue into a pre-submission queue without reducing the underlying exposure.

The response should match the issue. A missing field that can be completed from an existing record differs from a coverage question requiring interpretation or a documentation request requiring outside input. Different routing prevents routine corrections from absorbing specialist attention and helps more complex exceptions reach the right reviewer. These are recommended design considerations, not additional descriptions of Rotech's implementation.

Keep the rule connected to current requirements

Automated checks need maintenance. The team should retain the payer requirement behind a rule, its applicable dates, and the claims to which it applies. When a requirement changes, the organization should evaluate whether the control needs revision and test it against representative cases. A check that was appropriate when introduced can become inaccurate if its reference information is no longer current.

Reviewing exceptions and overrides can reveal whether the rule is useful. Frequent unnecessary alerts may indicate an overly broad check or a missing distinction between payers or items. Repeated overrides without documented resolution may indicate that staff cannot complete the required action. Both patterns warrant attention because a poorly designed control can delay supported claims while still allowing the original error to recur.

Verify that the intervention protects payment

Rotech's reported outcome connects earlier detection with claims progressing to payment and less manual work. For organizations adopting this approach, that connection should remain the basis of evaluation. Counting alerts or completed automated actions measures system activity. Following the affected claims through resolution shows whether the intervention addressed the recurring error and supported appropriate reimbursement.

Measure Whether Prevention Protects Revenue Capture

A prevention program needs evidence that the original source of leakage is shrinking. Overall denial volume can change because of payer mix, claim volume, product mix, or billing timing. A narrower review of the affected claim group helps leaders determine whether a specific control is working. The review should connect early exceptions to eventual payment and final unresolved balances.

Compare claims by their outcomes

Before implementing a change, define the payer, item group, denial cause, and measurement period. After implementation, review the same group and allow sufficient time for payment or final disposition. Where volume changes, compare rates as well as counts. Explain any changes in policy or claim mix that could influence the result so that a decrease in denials is not automatically attributed to the intervention.



Track each claim once for the financial analysis, even if it moves through multiple corrections or denials. Separate expected reimbursement at risk from confirmed avoidable write-offs. Also review claims held before submission, because a lower denial rate can coexist with an expanding unresolved queue. Prevention should resolve the requirement rather than simply postpone submission.

Use a small set of connected measures

Recurring denials within the targeted claim group show whether the same cause continues reaching the payer. Exceptions resolved before submission show whether staff can act on the control. The age and expected reimbursement value of unresolved holds show whether the intervention is creating a new bottleneck. Final payment outcomes and avoidable write-

offs indicate whether the affected claims ultimately produced the reimbursement they supported.

These measures work together. For example, fewer diagnosis-related denials accompanied by a growing diagnosis exception queue would call for a review of routing, documentation access, or staff instructions. Fewer recurring denials with stable hold times and better payment outcomes would provide stronger evidence of an effective prevention change. Neither pattern should be interpreted from denial counts alone.

Protect the remaining opportunity to act

CMS's Medicare Claims Processing Manual generally requires Medicare fee-for-service claims to be filed within one calendar year of the date of service, subject to specified exceptions. [3] Initial filing, claim correction, and appeal requirements are distinct. Teams should track the applicable deadline for the action needed on each account rather than use one generic deadline for every exception.



A prevention hold then, needs an owner, a next action, and escalation when resolution is approaching a relevant limit, and the same applies when an external party is the one applying the documentation: the request should remain visible until it is resolved or the organization establishes the appropriate disposition. Earlier detection creates an opportunity, but the opportunity still requires follow-through.

Rotech's reported progress connects the intervention to payment. "As a result, we are seeing more claims successfully process and result in payment, while reducing the manual rework required by our billing and A/R teams," said Harkins.

Protect Revenue by Resolving the Cause of Repeat Denials

Rotech's experience shows how denial management can address revenue leakage through earlier identification of recurring errors. Better reporting made denial patterns more visible. Assigning ownership connected those patterns to the teams able to change the process.

Item-specific diagnosis information, system logic, and staff education then provided a concrete response to a known source of claim failure.

GeBBS's role, as described by Harkins, was to help identify automation opportunities that prevented recurring denials and supported earlier detection. Reflecting on the results, she said, "This has helped improve revenue capture and reduce avoidable revenue leakage." That assessment connects Rotech's work on recurring errors to the purpose of the program: protecting reimbursement by addressing the issues that put payment at risk.

For a supplier evaluating its own approach, the starting point is a recurring denial cause that can be traced to a controllable process. Confirm the requirement, identify where the error begins, and define the action that resolves it. Then review whether the change reduces repeat failures and supports appropriate payment. This keeps the program focused on the reimbursement at risk and the specific weakness that threatens it.

The significance of denial management lies in that connection. When a denial leads to a verified change in the originating process, the organization can reduce the likelihood that subsequent claims will encounter the same avoidable obstacle. Rotech's experience provides a practical example of how that work can strengthen revenue capture in home respiratory and medical equipment billing.

Disclaimer

Rotech statements and outcomes are based exclusively on the client responses supplied for this whitepaper and are presented as client-reported experience.

Medicare policy context sources:

1. CMS Medicare Program Integrity Manual Chapter 5 — Sections 5.2 through 5.2.4
2. CMS Medicare Coverage Database Article A55426 — Standard Documentation Requirements for All Claims Submitted to DME MACs
3. CMS Medicare Claims Processing Manual Chapter 1 — Section 70 and related subsections