

Denials Don't Start at Submission

How upstream coding quality
can help reduce downstream
revenue leakage.

A CodaMetrix Informative Series



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For many health systems, denials are treated as a downstream revenue cycle problem.

A claim is submitted. The payer rejects or denies it. A team reviews the payer response, investigates the issue and works the denial after revenue has already been delayed, reduced or lost. But the denial is often only the symptom.

In many cases, denials are not simply a billing issue. They are a signal of upstream coding quality, documentation alignment and workflow variability. When diagnosis codes are incomplete, inconsistent or not fully aligned to the clinical encounter, the impact can move across the revenue cycle—from claim edits and payer reviews to denials, rework, write-offs and preventable administrative burden.

That means reducing denials requires more than working them faster. It requires addressing the issue closer to where it begins.

The Hidden Cost of Waiting Until Denial

Denial management has become a major focus for healthcare finance leaders because the operational and financial stakes are high. Every denied claim can create additional touches across coding, billing, clinical documentation, revenue integrity and payer follow-up.

The cost is not only the denied dollars. It is the time spent investigating the denial, correcting the claim, appealing the decision and identifying whether the same issue is likely to happen again. With the average cost to rework a denied claim estimated at roughly \$55.00 according to recent Healthcare Financial Management Association (HFMA) estimates.

For health systems already facing margin pressure, staffing constraints and rising administrative complexity, that kind of rework is difficult to absorb at scale. And while many organizations have invested in denial management workflows, analytics and follow-up teams, those efforts often happen after the claim has already moved through the system.

The more strategic question is not only:
How do we resolve denials more efficiently?

But also:
How do we prevent more of them from happening in the first place?

Denials Are Often an Upstream Signal

Denials may surface at the end of the revenue cycle, but the root cause often begins earlier.

A diagnosis may not fully reflect the clinical context. A specific CPT/ICD combination may trigger payer scrutiny. A documentation pattern may repeatedly create friction. A payer may behave differently by plan, service line or code set. A coding decision may appear acceptable in isolation but create risk once it reaches claim submission.

These issues can be difficult to identify when coding, billing and denial data live in separate systems or are reviewed through separate workflows.

Without a connected view, teams may see the denial without seeing the coding pattern that contributed to it. They may see the payer reason code without understanding whether the issue is concentrated by provider, specialty, service line or code combination. They may resolve the claim without addressing the repeatable root cause.

That is where upstream visibility matters.

Why Diagnostic Coding Matters

Diagnostic coding plays a critical role in how a claim tells the story of care.

Procedure coding captures what was performed. Diagnosis coding helps explain why it was clinically necessary. Together, they help a claim tell the full story of care—including whether the encounter aligns with payer expectations.

When diagnosis coding is incomplete, inconsistent or misaligned, downstream risk increases. As an example, unspecified diagnosis codes are often denied by payers because they lack clinical specificity, even when the service itself was appropriate.

That risk can show up as:

- Medical necessity denials
- Payer requests for additional information
- Coding-related claim edits
- Increased manual review
- Delayed reimbursement
- Rework across coding and revenue cycle teams
- Lost revenue from preventable denials

This is especially important in complex service lines where documentation, specialty-specific coding requirements and payer policies can vary widely.

Diagnostic coding is not just a compliance function. It is a financial performance lever.

From Denial Management to Denial Prevention

Traditional denial management is reactive by design. It tells organizations what happened after a payer response.

A more effective approach connects coding decisions to billing outcomes and first-pass payer responses, creating a feedback loop that helps organizations understand what is happening, why it is happening and where to take action.

This is where a **more connected coding model** can help health systems move from denial management to denial prevention by linking upstream coding quality to downstream financial impact.

When AI-powered coding automation is connected with feedback loop data and denials data, health systems can identify patterns across payer, plan and code combinations, revealing where coding decisions may be contributing to revenue leakage and where targeted improvements can reduce repeat issues.

This is the difference between working denials one claim at a time and improving performance across the system.

The Data That Makes the Difference

To understand how coding decisions affect revenue cycle outcomes, health systems need a connected view of two critical data feeds.

Feedback Loop Data

This shows whether cases moved through the revenue cycle without manual intervention or were modified before billing. It helps organizations understand where AI-driven coding automation is performing as expected and where manual intervention may still be occurring.

Denials Data

This captures first-pass payer outcomes, including denial reason codes such as CARC and RARC codes. It helps organizations see how payer decisions connect back to specific coding patterns, workflows and service lines.

Together, these data feeds create the feedback loop AI needs to learn from real payer outcomes, adapt coding predictions to each health system's workflows and payer guidelines and continuously improve performance over time.

From Denial Data to Revenue Cycle Action

When coding decisions, billing outcomes and denial patterns are connected, health systems can move from reacting to denials to addressing the root causes behind them.

A more connected approach can help organizations:



Prevent denials, not just work them

Identify patterns across payer, plan and code combinations to address root causes earlier, reduce coding-related denial rates and avoid repeat issues.



Uncover root causes of revenue leakage

Drill into CPT/ICD combinations and denial reason codes, including CARC and RARC codes, to better understand why denials are happening and what actions may help prevent them.



Benchmark performance with more confidence

Compare automated and manual outcomes across providers, service lines and payers to understand variation, quantify performance and guide where automation may be scaled.



Connect coding to financial impact

Tie denial patterns to workflows and coding decisions to reveal where revenue may be getting lost — insight that is not easily surfaced through the EHR alone.



Continuously improve over time

Use denial insights to refine coding workflows, quality processes and automation logic based on payer mix, documentation patterns and service-line needs.

What Health Systems Can See More Clearly

Instead of relying on broad denial reports, teams can begin asking more specific, actionable questions about where issues are concentrated and what can be done next.

These insights can help answer questions such as:

- Which coding-related denials are occurring most often?
- Which payer mix or plans are driving the highest denial volume?
- Which CPT/ICD combinations create the most friction?
- Where are automated coding workflows outperforming manual workflows?
- Where are denial dollars concentrated?
- What documentation, workflow or payer alignment actions could reduce repeat issues?

This level of insight gives coding, operations and finance teams a common view of the problem and a clearer path to resolution.

A More Connected Way to Improve Performance

Reducing denials is not only about improving coding accuracy. It is about creating a learning system.

When denial patterns are visible, those insights can be fed back into coding workflows, quality processes and AI automation logic. Over time, the system can better reflect each organization's payer mix, documentation patterns, specialties and operational realities.

That matters because denial prevention is not static. Payer policies change. Documentation practices vary. Service lines evolve. Coding guidance is updated. Health systems need a process that can keep improving as the environment changes.

CodaMetrix supports this continuous improvement model by connecting coding decisions to financial outcomes and using that insight to help organizations refine performance over time.







The result is automation that does more than code encounters. It helps health systems understand how coding quality affects the business of care.

What This Means for Health Systems

For healthcare leaders focused on revenue cycle performance, denial reduction and margin protection, upstream coding quality represents a major opportunity.

When organizations can connect coding decisions to payer outcomes, they can reduce preventable denials, lower rework, improve prioritization and align teams around measurable financial impact.

That can mean:

 Lower coding-related denial rates	 Reduced administrative burden	 Faster identification of root causes
 More targeted documentation and workflow improvements	 Stronger alignment across coding, operations, finance and revenue integrity	 Scalable automation backed by measurable performance

A New Era in Denial Reduction Starts Upstream

Denials will always be part of the healthcare revenue cycle. But too many organizations are still forced to respond to them after the damage has been done.

The opportunity now is to move earlier. By connecting diagnostic coding quality, automation performance and denial outcomes, health systems can identify revenue leakage at its source and take action before the same issues repeat across hundreds or thousands of claims.

Denials do not start at submission. They start upstream— in the clinical, coding and workflow decisions that shape the claim before it ever reaches the payer.

CodaMetrix helps health systems address those decisions earlier, with AI-powered coding automation and revenue cycle insight designed to reduce denials, improve performance and support more sustainable financial outcomes.

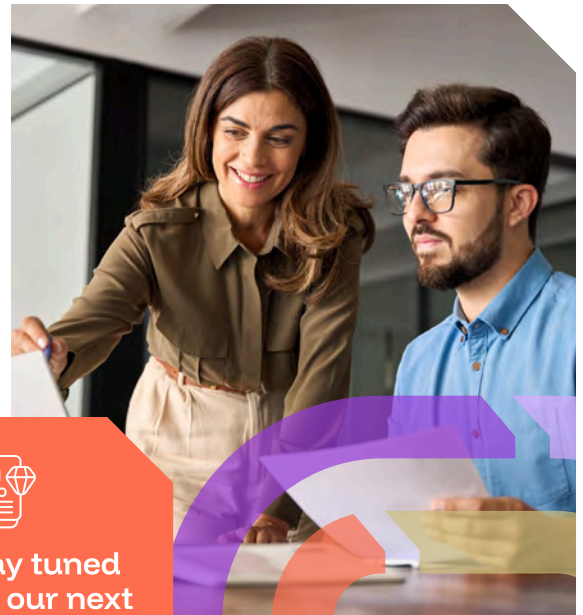
Closing: The Conversation Continues

This is part of a series of honest, plain-language discussions about how healthcare organizations can think differently about AI, automation and the operational pressures shaping the future of care.

When it comes to reimbursement denials, the challenge is complex, but the path forward starts upstream. By connecting coding decisions to payer outcomes, health systems can better understand where revenue leakage begins, where repeat issues are occurring and how to take more targeted action before the same denials happen again.

CodaMetrix helps bring those connections into focus.

Join us to be part of the conversation.



Stay tuned
for our next
publication.