MEDEOAN

HEALTHCARE REVENUE CYCLE MANAGEMENT

Top 10 Claim Denials & How to Fix Them

A practical guide to identifying, preventing, and appealing the most common denial codes that cost your practice revenue every day.

2026 Edition • Free Resource from Medeoan Healthcare

Why Denials Are Your Biggest Revenue Leak

Claim denials are the single largest controllable drain on healthcare revenue. Industry data shows that **the average denial rate across U.S. healthcare organizations is 8–12%**, and that rate has been climbing year over year. Even more alarming: **up to 65% of denied claims are never reworked**, representing pure revenue loss.

$5M+

Annual revenue at risk for a mid-size practice from denials

$25–$118

Cost to rework a single denied claim

90%

Of denials are preventable with proper processes

The good news? **The vast majority of denials are preventable.** The same 10 denial codes account for the bulk of all denials across specialties and payer types. If you can master these 10 codes — understand why they happen, how to prevent them, and how to fix them when they occur — you can recover a significant portion of lost revenue.

How to Use This Guide

For each of the top 10 denial codes, we provide:

- **What It Means** — Plain-language explanation of the denial reason
- **Common Root Causes** — The upstream problems creating these denials
- **Prevention Checklist** — Actionable steps to stop denials before they happen
- **Quick Fix** — What to do when you receive this denial today

At the end, you will find **three ready-to-use appeal letter templates** you can customize for your organization immediately.

#1 — CO-4

The procedure code is inconsistent with the modifier used

WHAT IT MEANS

> The modifier appended to the CPT/HCPCS code does not match the procedure billed. The payer sees a mismatch between what was done and how it was coded.

COMMON ROOT CAUSES

- Incorrect modifier selected (e.g., -25 on a procedure that doesn't qualify)
- Modifier required by the payer but omitted entirely
- Using outdated modifier guidelines
- Copy-paste errors from prior claims

PREVENTION CHECKLIST

- ✓ Implement modifier-validation edits in your billing software
- ✓ Train coders on payer-specific modifier rules quarterly
- ✓ Use CCI (Correct Coding Initiative) edits before submission
- ✓ Audit a random 5% of modifier usage monthly

QUICK FIX

> Review the operative/visit note, confirm the correct modifier, and resubmit with a corrected claim (not an appeal).

#2 — CO-16

Claim/service lacks information or has submission/billing error(s)

WHAT IT MEANS

> This is the most common denial code in healthcare. It is a catch-all for missing or invalid data on the claim form — demographic errors, missing fields, invalid codes, or formatting problems.

COMMON ROOT CAUSES

- Missing or invalid subscriber/patient ID number
- Incorrect date of birth, gender, or name spelling
- Missing referring/ordering provider NPI
- Invalid place of service or type of bill code

PREVENTION CHECKLIST

- ✓ Run real-time eligibility verification before every visit
- ✓ Implement front-end claim scrubbing with 100+ edit rules
- ✓ Verify demographics at every patient encounter
- ✓ Use clearinghouse rejection reports to catch errors pre-submission

QUICK FIX

> Identify the missing/incorrect field from the ERA/835 remark codes (e.g., N382, MA130), correct the data, and resubmit as a corrected claim (frequency code 7).

#3 — CO-18

Exact duplicate claim/service

WHAT IT MEANS

> The payer has already processed and adjudicated an identical claim. This means a claim with the same patient, provider, date of service, procedure, and charge was already received.

COMMON ROOT CAUSES

- Staff resubmitting claims without checking status first
- Clearinghouse auto-retry sending duplicates
- Multiple billing systems submitting the same charges
- Lack of claim status tracking workflow

PREVENTION CHECKLIST

- ✓ Check claim status (276/277 transaction) before resubmitting
- ✓ Implement a claim tracking dashboard with status flags
- ✓ Configure clearinghouse to prevent auto-duplicate submissions
- ✓ Assign one team member per payer for follow-up accountability

QUICK FIX

> Do NOT resubmit again. Pull up the original claim, verify it was paid or pended, and follow up on that original claim instead.

#4 — CO-22

This care may be covered by another payer per coordination of benefits

WHAT IT MEANS

> The payer believes another insurance is primary and should be billed first. The claim is being denied because the coordination of benefits (COB) information is missing or indicates this payer is secondary.

COMMON ROOT CAUSES

- Patient has undisclosed secondary/tertiary coverage
- COB information not updated in the payer's system
- Incorrect payer order on the claim
- Divorce, job change, or Medicare eligibility not captured at registration

PREVENTION CHECKLIST

- ✓ Ask about other insurance at every registration and annually
- ✓ Run eligibility checks across Medicare, Medicaid, and commercial payers
- ✓ Update COB with the payer proactively when changes are identified
- ✓ Flag patients with Medicare who may have an MSP (Medicare Secondary Payer) situation

QUICK FIX

> Contact the patient to verify all active coverages, determine the correct payer order, update COB with the denying payer, and resubmit.

#5 — CO-29

The time limit for filing has expired

WHAT IT MEANS

> The claim was submitted after the payer's timely filing deadline. Most commercial payers allow 90–180 days; Medicare allows 12 months. Once expired, the claim is typically non-recoverable.

COMMON ROOT CAUSES

- Claim stuck in a work queue or 'hold' status too long
- Initial submission rejected and corrected claim filed late
- Delayed charge capture from the clinical side
- Waiting on prior authorization that took too long

PREVENTION CHECKLIST

- ✓ Set up automated alerts at 50% and 75% of each payer's filing limit
- ✓ Work rejections within 48 hours of receipt
- ✓ Target claim submission within 3 business days of date of service
- ✓ Track and report on 'days to submit' as a KPI

QUICK FIX

> If you have proof of a prior timely submission (clearinghouse confirmation, prior rejection), appeal with that documentation. Otherwise, this revenue is likely lost.

#6 — CO-45

Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement

WHAT IT MEANS

> The billed amount exceeds what the payer has agreed to pay per their contract or fee schedule. The excess is a contractual write-off, not patient responsibility.

COMMON ROOT CAUSES

- Chargemaster rates set without reference to contracted rates
- Fee schedule updates from the payer not loaded into the system
- Out-of-network billing at in-network contracted rates
- Annual fee schedule changes not updated January 1

PREVENTION CHECKLIST

- ✓ Review and update fee schedules annually for every payer contract
- ✓ Set chargemaster rates at 200–300% of Medicare to avoid leaving money on the table
- ✓ Model financial impact before signing contract amendments
- ✓ Monitor allowed amounts in remittances for unexpected drops

QUICK FIX

> This is typically a contractual adjustment, not an error. Verify the contracted rate matches the ERA. If the allowed amount is lower than contracted, appeal with your contract.

#7 — CO-50

These are non-covered services because this is not deemed a 'medical necessity'

WHAT IT MEANS

> The payer has determined the service was not medically necessary based on the diagnosis submitted, clinical documentation, or their coverage policy (LCD/NCD for Medicare).

COMMON ROOT CAUSES

- Diagnosis code does not support the procedure per payer policy
- Insufficient clinical documentation to justify the service
- Service frequency exceeds payer guidelines
- Missing prior authorization for services that require it

PREVENTION CHECKLIST

- ✓ Verify medical necessity against LCD/NCD before scheduling
- ✓ Ensure diagnosis codes are specific (highest level of ICD-10 specificity)
- ✓ Obtain and document prior authorization when required
- ✓ Educate providers on documentation requirements for high-denial services

QUICK FIX

> Request the specific coverage policy used for denial, gather supporting clinical documentation, and submit a formal appeal with a physician letter of medical necessity.

#8 — CO-97

The benefit for this service is included in the payment/allowance for another service/procedure

WHAT IT MEANS

> The payer has bundled this service with another procedure per CCI edits or their own bundling rules. They consider it part of a more comprehensive service already paid.

COMMON ROOT CAUSES

- Billing unbundled codes that CCI edits say should be bundled
- Missing appropriate modifier to indicate separate service (e.g., -59, -XE)
- Performing and billing services that are inherent to the primary procedure
- Outdated coding practices or lack of CCI edit awareness

PREVENTION CHECKLIST

- ✓ Run CCI edit checks on every claim before submission
- ✓ Use modifier -59 or X{EPSU} modifiers only when clinically appropriate and documented
- ✓ Train coders on bundling rules specific to the specialty
- ✓ Review high-volume procedure pairs for bundling compliance

QUICK FIX

> If the services were truly separate and distinct, append the correct modifier (-59, -XE, -XP, -XS, -XU) with supporting documentation and resubmit.

#9 — PR-1

Deductible amount

WHAT IT MEANS

> The patient has not met their annual deductible. The amount denied is the patient's responsibility, not a payer error. This is technically a patient liability denial, not a claims error.

COMMON ROOT CAUSES

- Service rendered early in the plan year before deductible is met
- High-deductible health plan (HDHP) not identified at scheduling
- Remaining deductible amount not checked before service
- Patient not informed of expected out-of-pocket cost

PREVENTION CHECKLIST

- ✓ Check remaining deductible via real-time eligibility before every visit
- ✓ Collect estimated patient responsibility at time of service
- ✓ Flag HDHP patients in your scheduling system
- ✓ Provide cost estimates and financial counseling before high-cost procedures

QUICK FIX

> This is not a denial to appeal — the patient owes this amount. Send a patient statement promptly with clear explanation. Offer payment plans for large balances.

#10 — CO-167

This (these) diagnosis(es) is (are) not covered

WHAT IT MEANS

> The diagnosis code submitted is not a covered condition under the patient's plan, or the diagnosis code is invalid/unspecified for the date of service.

COMMON ROOT CAUSES

- Using unspecified ICD-10 codes when specificity is required
- Diagnosis is excluded from coverage under the patient's plan (e.g., cosmetic, experimental)
- ICD-10 code is invalid or truncated
- Annual ICD-10 code updates not loaded (October 1 changes)

PREVENTION CHECKLIST

- ✓ Code to the highest specificity — laterality, episode, severity
- ✓ Verify coverage of the diagnosis before scheduling elective procedures
- ✓ Update ICD-10 code sets annually on October 1
- ✓ Use encoder software to validate codes before claim submission

QUICK FIX

> Review the clinical documentation for a more specific or alternative covered diagnosis. If the diagnosis is accurate, appeal with clinical documentation supporting medical necessity.

Appeal Letter Templates

Use these templates as starting points for your denial appeals. Customize the placeholders (shown in red) with your specific information.

Template 1: Medical Necessity Appeal (CO-50)

MEDICAL NECESSITY APPEAL

Date: [DATE]
To: [PAYER NAME] Appeals Department
Re: Claim # [CLAIM NUMBER] | Patient: [PATIENT NAME] | Member ID: [MEMBER ID] | DOS: [DATE OF SERVICE]

Dear Appeals Review Committee,

I am writing to appeal the denial of the above-referenced claim under denial code **CO-50 (not medically necessary)**. After careful review of the clinical documentation, I believe this determination was made in error.

Clinical Justification:
The patient presented with [DIAGNOSIS/CONDITION] on [DATE]. The standard of care for this condition, as supported by [CLINICAL GUIDELINE / SOCIETY RECOMMENDATION], includes the procedure in question ([CPT CODE & DESCRIPTION]). Conservative treatments including [PRIOR TREATMENTS TRIED] were attempted from [DATE RANGE] without adequate clinical improvement.

Enclosed documentation:
• Office/operative notes from [DATE]
• Relevant diagnostic results ([LAB/IMAGING])
• Prior treatment records demonstrating medical necessity
• Applicable clinical guidelines / LCD reference

I respectfully request this claim be reconsidered and reprocessed for payment. Please contact our office at [PHONE] if additional information is required.

Sincerely,
[PROVIDER NAME, CREDENTIALS]
[PRACTICE NAME]
NPI: [NPI NUMBER]

Template 2: Timely Filing Appeal (CO-29)

TIMELY FILING APPEAL

Date: [DATE]
To: [PAYER NAME] Appeals Department
Re: Claim # [CLAIM NUMBER] | Patient: [PATIENT NAME] | DOS: [DATE OF SERVICE]

Dear Appeals Review Committee,

I am writing to appeal the denial of the above-referenced claim under denial code **CO-29 (timely filing limit expired)**. Our records demonstrate that the original claim was submitted within the contractual filing deadline.

Timeline of Events:
• Date of Service: [DOS]
• Original claim submitted: [SUBMISSION DATE] (within the [90/120/180/365]-day filing limit)
• Method of submission: [ELECTRONIC / CLEARINGHOUSE NAME]
• Confirmation/tracking number: [CONFIRMATION #]

Enclosed proof of timely filing:
• Clearinghouse transmission report showing accepted date
• 999/997 acknowledgment confirmation
• [ANY ADDITIONAL PROOF]

Based on this evidence, the claim was filed within the required timeframe. I respectfully request immediate reprocessing and payment of this claim.

Sincerely,
[YOUR NAME & TITLE]
[PRACTICE NAME]
Phone: [PHONE]

Template 3: Bundling/Unbundling Appeal (CO-97)

BUNDLING APPEAL

Date: [DATE]
To: [PAYER NAME] Appeals Department
Re: Claim # [CLAIM NUMBER] | Patient: [PATIENT NAME] | DOS: [DATE OF SERVICE]

Dear Appeals Review Committee,

I am writing to appeal the denial of CPT code [DENIED CPT CODE] under denial code **CO-97 (benefit included in another service)**. This code was bundled with [PRIMARY CPT CODE]; however, the services were clinically distinct and separately identifiable.

Clinical Rationale for Separate Reporting:
The procedure [DENIED CPT CODE & DESCRIPTION] was performed as a separate and distinct service from [PRIMARY CPT CODE & DESCRIPTION]. Specifically:
• [DIFFERENT ANATOMICAL SITE / DIFFERENT SESSION / DIFFERENT INDICATION]
• The operative note clearly documents [SPECIFIC DOCUMENTATION]
• This meets the criteria for modifier [-59 / -XE / -XP / -XS / -XU] per CCI guidelines

Enclosed documentation:
• Operative/procedure note with relevant sections highlighted
• CCI edit reference showing modifier allowance for this code pair
• Corrected claim with appropriate modifier appended

I respectfully request this claim be reprocessed with the separate service recognized. Please do not hesitate to contact our office for any additional clinical information.

Sincerely,
[PROVIDER NAME, CREDENTIALS]
[PRACTICE NAME]
NPI: [NPI NUMBER]

Ready to Eliminate Denials for Good?

Medeoan Healthcare provides end-to-end revenue cycle management that reduces denial rates by up to 35%. Let us handle the complexity so you can focus on patient care.

Schedule a Free RCM Audit

WEBSITE
medeoan.com

EMAIL
info@medeoan.com

PHONE
(833) 633-3626

MEDEOAN