Optimal Billing Solutions
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The denial-prevention checklist

The working list our teams run - front end to back end - to stop denials before they start.

Most denials are preventable, and the preventable ones are cheapest to fix at the front desk, not in an appeal letter ninety days later. This checklist follows a claim through its life. Print it, hand it to your team, and audit against it monthly.

Before the visit: eligibility and authorization

- ☐ Verify coverage and plan details electronically before every visit - not just new patients. Plans change in January and at job changes.
- ☐ Confirm the rendering and referring providers are credentialed and linked with the patient's plan.
- ☐ Identify services that need prior authorization from the schedule - and obtain it before the date of service. Track authorization numbers on the claim.
- ☐ Collect copays and known patient responsibility at the time of service.
- ☐ For dental: check frequency limitations, missing-tooth and alternate-benefit clauses before presenting the treatment plan.

At the visit: documentation and charge capture

- ☐ Documentation supports the level of service billed - and the diagnosis supports the procedure. Medical necessity is argued in the note, not in the appeal.
- ☐ Every service rendered becomes a captured charge the same day. Charge lag is revenue delay.
- ☐ Attach what the payer wants the first time: X-rays, perio charts, narratives, operative notes, invoices for DME or drugs.

Before the claim goes out: coding and scrubbing

- ☐ Code sets are current - this year's CPT/HCPCS/ICD-10-CM/CDT. Retired codes are automatic rejections.
- ☐ Modifiers are right, present, and defensible - especially 25, 59, and the professional/technical splits.
- ☐ NCCI and payer bundling edits are checked before submission, not after the CO-97 arrives.
- ☐ Place of service matches the setting - wrong POS means the wrong fee schedule column.
- ☐ Demographics are exact: subscriber ID, group number, date of birth, coordination of benefits. Top rejection causes are boring ones.

After submission: follow-up discipline

- ☐ Rejections are worked daily - they age in days, not weeks.
- ☐ Claim status is checked on anything unpaid at the payer's normal cycle time, not at month-end.
- ☐ Remittances are posted and reconciled against deposits; underpayments against contract rates are flagged, not written off.

- [ ] Every denial lands in a work queue with an owner and a deadline - and timely-filing limits for appeals are tracked per payer.
- [ ] Monthly: the denial mix is reviewed by reason code, and one root cause gets fixed at the front end. Denials are data.

The short version

Verify before, document during, scrub before it leaves, follow up on a schedule, and close the loop on every denial reason. Teams that run this list do not have denial problems; they have denial data.

If you would rather have a US-based, certified team run this inside your own systems - without adding payroll - that is exactly what Optimal Billing Solutions does. optimalbillingsolutions.com

Educational reference only - coding, coverage, and payment follow payer policy and contract in every case. Prepared November 2026. (c) 2026 Optimal Billing Solutions.