Denials Management Checklist: 15 Data Points CFOs Track

The following 15 data points form a comprehensive dashboard for denial management. They span volume, reasons, timeliness, and outcomes. Many CFOs will review such metrics monthly or quarterly as part of financial reviews.

Let’s dive into the checklist.

1. Initial Denial Rate (% of Claims Denied)

Definition: The percentage of claims submitted that receive an initial denial from payers. Typically measured as (# of claims denied initially) / (# of claims submitted) * 100.

Why CFOs Track It: This is the headline metric for revenue cycle efficacy. A lower initial denial rate means cleaner claims and smoother revenue. Industry benchmark: top performers might have <5% initial denial rate, average is ~10%. If your rate is above benchmark, there’s significant room for improvement (and likely cash stuck in limbo).

Use It To: Set improvement goals (e.g., reduce denial rate from 12% to 8% over 6 months). Also, to flag if something suddenly goes wrong, a spike might indicate a payer policy change or internal process breakdown that needs urgent attention.

2. Top 5 Denial Reasons (By Volume or Value)

Definition: The most frequent causes for denials, often categorized by reason codes (e.g., Eligibility/ Registration errors, Missing Authorization, Coding errors, Medical Necessity, Timely Filing, etc.). Track either by count of claims or denied dollar value.

Why CFOs Track It: Knowing the main reasons lets leadership focus resources. For instance, if “no authorization” is the #1 reason, the CFO can push operations to fix scheduling and authorization workflows. Often, a handful of reasons account for the majority of denials. A 2020 Change Healthcare report found registration/eligibility issues caused nearly 27% of denials, auth issues ~12%, and non-covered (medical necessity) ~11%.

Use It To: Prioritize initiatives and monitor changes. If you implement, say, an insurance eligibility tool, you’d expect eligibility-related denials to drop in rank. CFOs also share these with department heads (e.g., high coding denials with HIM/coding leadership) to align accountability.

(Consider putting these reasons in a table or chart for visualization – our internal dashboard provides a pie chart of top denial causes with percentages.)

3. Denial Rate by Payer

Definition: The initial denial rate segmented by payer (Medicare, Medicaid, Blue Cross, United, etc.).

Why CFOs Track It: Different payers have different rules and challenges. You might find one commercial payer has a 18% denial rate vs another at 5%. This could be due to specific policy quirks or contract issues. For example, some payers might deny more for authorization because of stricter requirements.

Use It To: Identify if certain payers need special attention or renegotiation. For instance, if many denials are technical and overturned on appeal for one payer, maybe contracting or provider reps can address it (it wastes everyone’s time). Also, allocate denial

management resources – e.g., assign more staff to work denials from Payer X if they're high volume. CFOs use this to engage in conversations with payers as well, bringing data to the table: "We see 20% of claims to you deny initially; that's double others – how can we work together to improve that?"

4. Denial Rate by Service/Department

Definition: Denials segmented by service line, department, or location (ER vs Surgery vs Radiology, inpatient vs outpatient, etc.).

Why CFOs Track It: Some departments might be denial hotspots. For instance, surgery claims often face more auth and medical necessity scrutiny, imaging might hit coding edits, and ER might have eligibility issues. A department with a higher denial percentage can indicate process issues in that area (or a need for better training of staff capturing info, etc.).

Use It To: Drive departmental accountability. Share denial metrics with department heads or physician leaders: e.g., "Cardiology is seeing 15% denials mostly due to authorization – let's work on ensuring preauth for stress tests," etc. Also helps in focusing education – perhaps the radiology coding team needs extra support if and radiology claims denial rate is high.

5. Total Denied Amount ($) and % of Total Charges

Definition: The sum of dollars denied initially in a period and what percentage of total gross charges or expected reimbursement that represents.

Why CFOs Track It: In dollar terms, how big is the denial problem? For example, "We had \$5 million denied this month, which is 8% of our total billed charges." This helps size the issue financially. A high percentage of charges denied can alarm leadership and justify investment in solutions.

Use It To: Evaluate the financial impact. Also, as a baseline to see if denial dollars go down after improvements. Some CFOs convert this to potential net revenue lost by applying expected reimbursement rates. E.g., \$5M in denied charges might be \$1.5M in net revenue at stake. That focuses the conversation, as \$1.5M can equal profit margin points.

6. Denials by Financial Class (Insurance vs Self-Pay)

Definition: Breakdown of denials by financial class or billing category, such as Medicare, Medicaid, Commercial, Self-Pay.

Why CFOs Track It: It may reveal patterns, like Medicaid claims often denied for eligibility issues (maybe patients lost coverage), or self-pay "denials," which could be cases where coverage was discovered later. While self-pay isn't a denial per se, tracking if accounts were classed as self-pay then later re-billed to insurance after verification can be useful (to ensure processes find coverage before billingthe patient incorrectly).
Use It To: Identify if certain payor types need extra attention. E.g., if Medicaid has a high denial rate, maybe it's due to the complexity of Medicaid plans or frequent eligibility lapses – the CFO might invest in eligibility counseling for patients or better Medicaid billing training. Also helps ensure focus not just on commercials; Medicare/Medicaid may deny less frequently percentage-wise, but can still be a large volume, and their reasons (like medical necessity for Medicare) need addressing too.

7. Timely Filing Denials (Count and $)

Definition: Number and dollar value of denials due to claims not being filed in the allowable timeframe.

Why CFOs Track It: Timely filing denials are 100% preventable and represent pure loss (most payers won't pay if you miss the window). If you have any significant dollars here, it signals a serious process failure. CFOs hate these because it's leaving money on the table due to internal inefficiency.

Use It To: Drive urgency in the billing process. If timely filing denials exist, fix the process (perhaps claims stuck in coding or edits for too long). Track this to zero – best practice is zero dollars lost to timely filing. Also can set internal KPI: e.g., 95% of claims out the door within 10 days of discharge to avoid this.

(One study suggests that each day of discharge-to-bill lag increases denial risk. Timely filing is the extreme end of that – a claim not billed at all in time.)

8. Appeal Success Rate (%)

Definition: Of the denied claims that are appealed, the percentage that are overturned/paid.

Why CFOs Track It: This indicates how effective your denials management team is at recovering revenue and also whether many denials are incorrect or preventable. A high success rate (e.g., >50% of appeals win) might imply many denials were avoidable or payer errors that you're managing to correct. A low success rate could mean either the denials are mostly legitimate or that your appeals process is not strong.

Use It To: Evaluate staff performance and denial quality. If success is low, the CFO might reconsider which denials to appeal (focus only on those with a chance) to not waste resources, or invest in better appeal letters or tools. If success is high, that's good, but also raises: why are we getting so many wrong denials upfront? Could we address root causes with payers?

Also, measure dollars recovered via appeals as a % of denied dollars – e.g., "We recover 30% of initially denied dollars after appeal."

9. Average Days to Resolve Denials

Definition: The average time from denial receipt to resolution (either paid or written off). Essentially, how long do denied claims linger in AR.

Why CFOs Track It: Denials represent delayed payments. The longer they take to resolve, the worse for cash flow. This metric shows the efficiency of denial follow-up. If it's, say, 60 days on average, that's like AR aging. Leading orgs try to resolve within 30 days for many denials.

Use It To: Set targets for the denial management team – e.g., “appeal or resolve all denials within 20 days of receipt.” CFOs know that a denial that drags on might eventually become a write-off due to time limits or stale information. This also affects accruals/reserves because the longer something is denied, the less likely it convert to cash.

10. Volume of Denials per Category (Front-end vs Back-end)

Definition: Classify denials into front-end vs back-end issues. Front-end includes eligibility, registration errors, no auth – things that happen before billing. Back-end includes coding errors, documentation/ medical necessity, late filing, etc.

Why CFOs Track It: It helps assign accountability internally – are most denials coming from front-end processes (scheduling/registration) or back-end (billing/coding)? HFMA estimates ~50% of denials are due to front-end issues. Knowing your split helps target interventions: front-end might mean training registrars or investing in auth tools; back-end might mean coding audits or physician documentation improvement (CDI).

Use It To: Align departments. CFOs might use this in management meetings: “We see 60% of our denial volume is due to front-end issues – let’s have our patient access director spearhead an improvement initiative, with support from finance.” Over time, you want to see front-end issues drop sharply (since they’re more preventable), and you monitor back-end as well.

11. Rework Cost of Denials

Definition: Estimated cost spent on managing denials. Could be measured by staff hours (e.g., X FTEs dedicated to denials * loaded salary) or using industry average cost per denial * number of denials worked.

Why CFOs Track It: Denials not only delay revenue, they consume resources. If you quantify that, it can justify process improvements or technology investments. For example, if you have 5 FTEs purely working denials at \$50k each, that’s \$250k/year spent.

Perhaps investing \$100k in a claim edit system could reduce denials and thus the staffing need, or allow reallocation.

Use It To: Calculate the ROI of denial reduction efforts. Show leadership, “We spend \$X reworking denials to recover \$Y. If we reduce denials by Z%, we save \$M in labor and increase revenue by \$N.” Also, track if the rework cost per denial is trending down (maybe through efficiency or automation).

*(Our checklist template can include a simple formula: Denials worked per month * $25 average cost = monthly rework cost.)*

12. Denial Write-off Rate (% of denied $ not recovered)

Definition: The percentage of initially denied dollars that ultimately get written off as uncollectible. Effectively, 1 minus the appeal/collection success rate in dollar terms.

Why CFOs Track It: This tells how much revenue you’re permanently losing due to denials. For instance, if 40% of denied dollars are never recovered and are written off (contractual or as bad debt if patient responsibility), that’s the true revenue leakage. CFOs often want this number as low as possible.

Use It To: Identify realistic improvement potential. No one gets a 0% write-off because some denials (like truly non-covered services) won’t be paid. But if you can shrink that rate, you directly boost revenue. Use it also for financial forecasting – set reserves for denials. For example, if you know historically 30% of denied dollars go uncollected, you can reserve that portion on the books upfront (conservative accounting) and then try to beat it.

13. Percent of Denials Avoided (via Edits or Pre-Auth)

Definition: A more forward-looking metric – how many potential denials are caught and fixed before submission. For example, if you have claim edits that caught 500 issues last month that would likely have been denied, that's "denials avoided."

Why CFOs Track It: This shows the value of proactive measures. It's a bit harder to quantify, but some organizations do measure edits triggered and resolved. CFOs like this because it proves ROI on tools/ process (like "our automated eligibility checks prevented 200 claims from going out to the wrong insurer, avoiding likely denials").

Use It To: Justify investments in RCM tech. Also to give positive feedback to teams: "We prevented X in denials – great job." If you implement a new edit for missing modifiers, track reduction in modifier-related denials as well as how many claims the edit fixed.

14. Denial Backlog (Aged Denials)

Definition: The number (or value) of denials that are still open/unresolved, possibly segmented by age (e.g., 0-30 days, 30-60, 60-90, 90+).

Why CFOs Track It: A large backlog, especially older denials, may indicate under-resourcing or inefficiency. Denials older than 90 or 120 days are at high risk of never being collected due to time limits or just staleness. CFOs want to ensure that the denial work is keeping up with the inflow.

Use It To: Manage staffing and priorities. If the backlog is growing, maybe hire temp help or outsource some denial follow-up. If certain aged buckets are big, focus there or write off if truly lost causes (clear the books). It also reflects on cash acceleration – less backlog means more timely cash.

15. Net Improvement from Denial Initiatives

Definition: When you implement specific denial reduction projects (like a new claims scrubber or a task force to get auths right), track the before-and-after metrics associated with that project.

For example, we started an authorization improvement project in Q1. We measure auth-related denial rate in Q4 vs Q1 to see improvement. Or dollars of auth denials Q4 vs Q1.

Why CFOs Track It: CFOs champion projects and need to see ROI. By isolating metrics related to initiatives, you prove the effort's value. E.g., "Our denial rate dropped from 10% to 8% after implementing the new edit checks, equating to \$500k more revenue this quarter."

Use It To: Celebrate successes and justify future investments. If something didn't work, you also see that and pivot. Essentially, this closes the loop: track specific KPIs tied to each denial management initiative to ensure it moved the needle.

How to Use This Checklist: CFOs can incorporate these data points into a monthly denial management report. Often, a dashboard is used where green/yellow/red indicators show how each metric is trending vs goals. The CFO might review these in finance meetings and with the revenue cycle director.

By regularly monitoring these 15 data points, organizations maintain a pulse on denials and can react quickly to adverse trends. More importantly, over time, you shift from putting out fires to preventing them – as evidenced by improved metrics (like declining denial rates, faster resolution, etc.).