Denial Analysis Report

Last modified on 11/06/2026 12:56 pm EST

The **Denial Analysis Report** provides deeper insights into payer denials, helping identify denial patterns and uncover root causes. Use these insights to address issues and proactively reduce future denials.

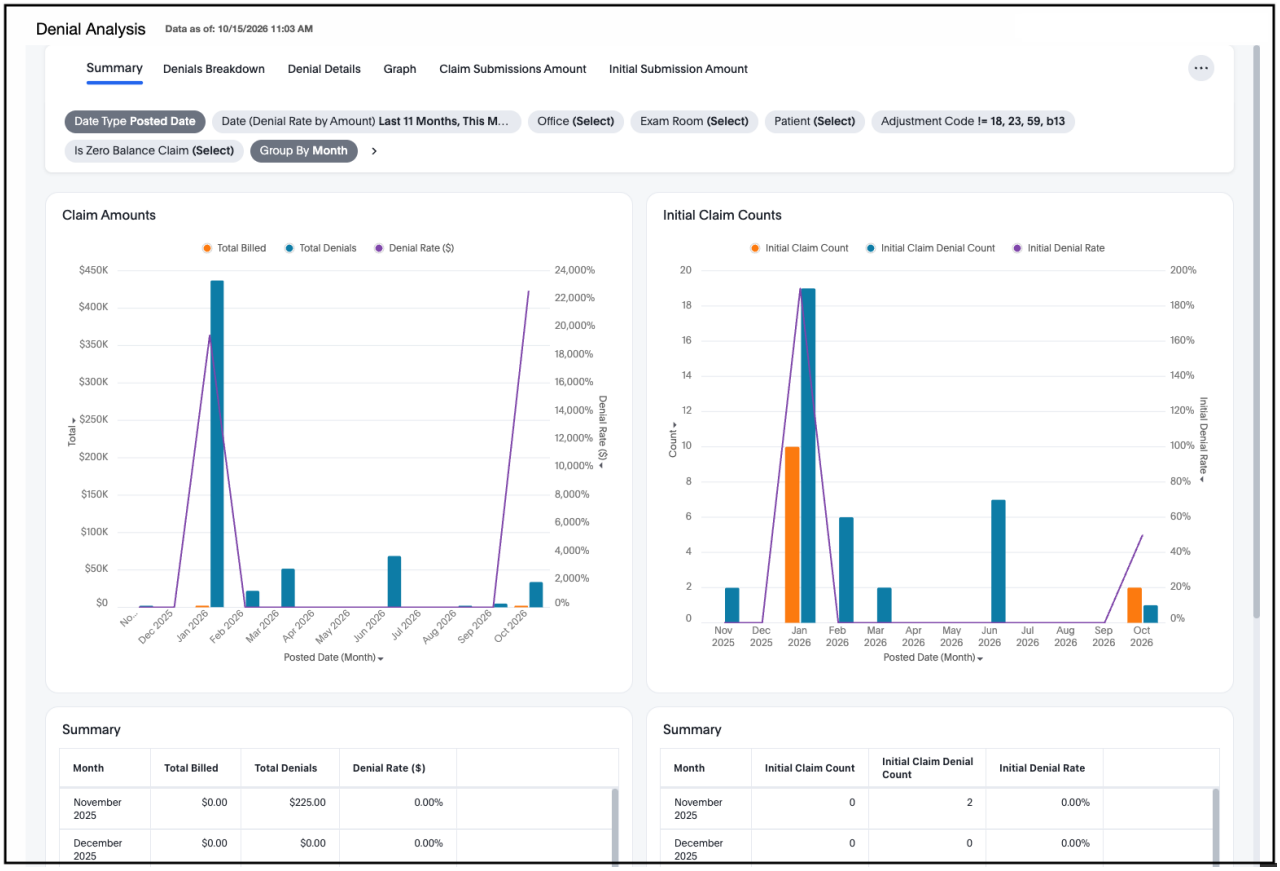
Summary | Save View | Denials Breakdown | Denial Details | Graph | Claim Submission Amount | Initial Submission Amount

Summary

Use this tab to set the parameters for the report, including which information to include and how it is displayed.

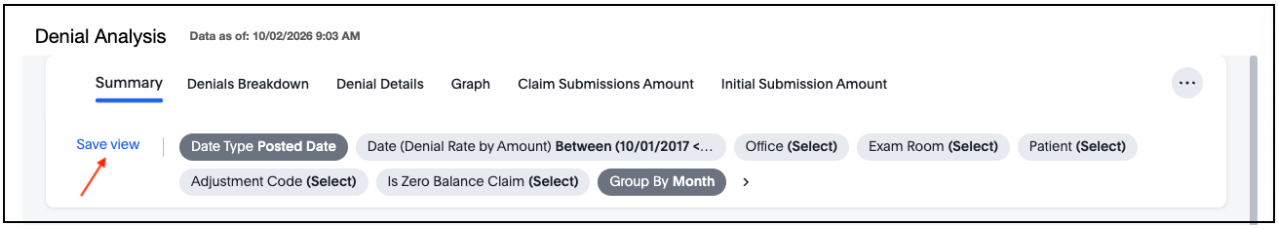
Available options include **Start Date Parameter**, **End Date Parameter**, **Filter By Appt Date**, **Patient Name**, **Chart ID**, **Authorization Number**, **Provider Name**, **Procedure Code**, and **Status**. For most options, select a single value, multiple values, or **All**.

Once the parameters are selected, the report will automatically generate.

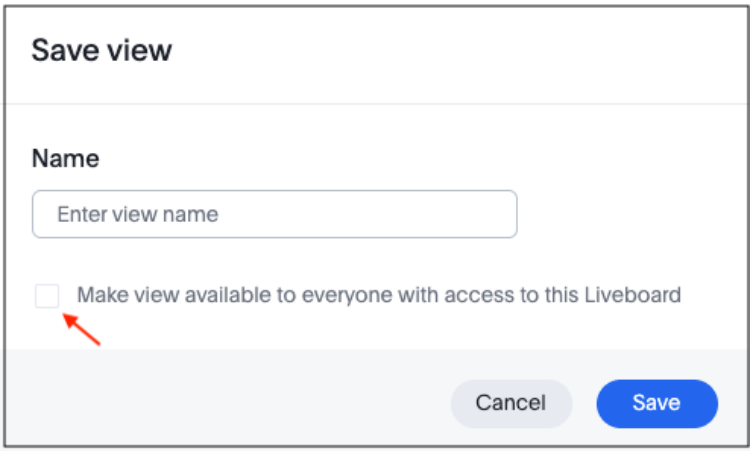


Save View

To save the filters set, press **Save View** on the left side of the screen.

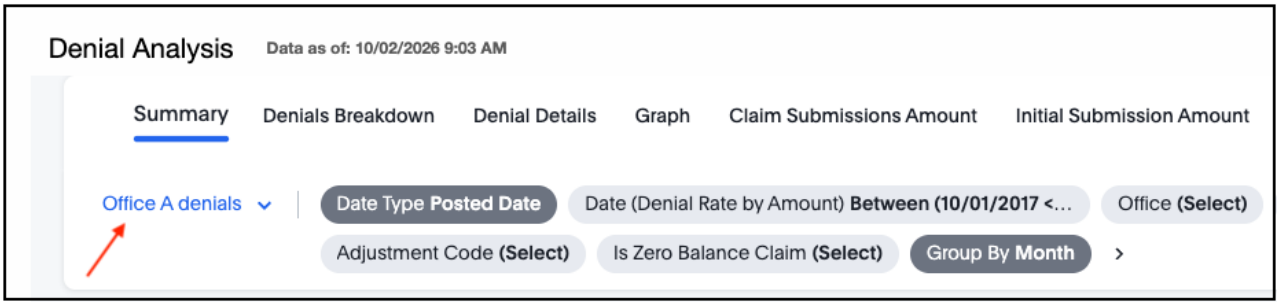


Enter a name for the view when prompted. To share the view with colleagues, check the box next to **Make view available to everyone with access to this Liveboard**.



Saved views preserve all filter selections, including date type and grouping. They do not save a specific date range.

To rerun the report, select it from the left side of the screen. If it is not showing, press the down arrow for additional saved views.

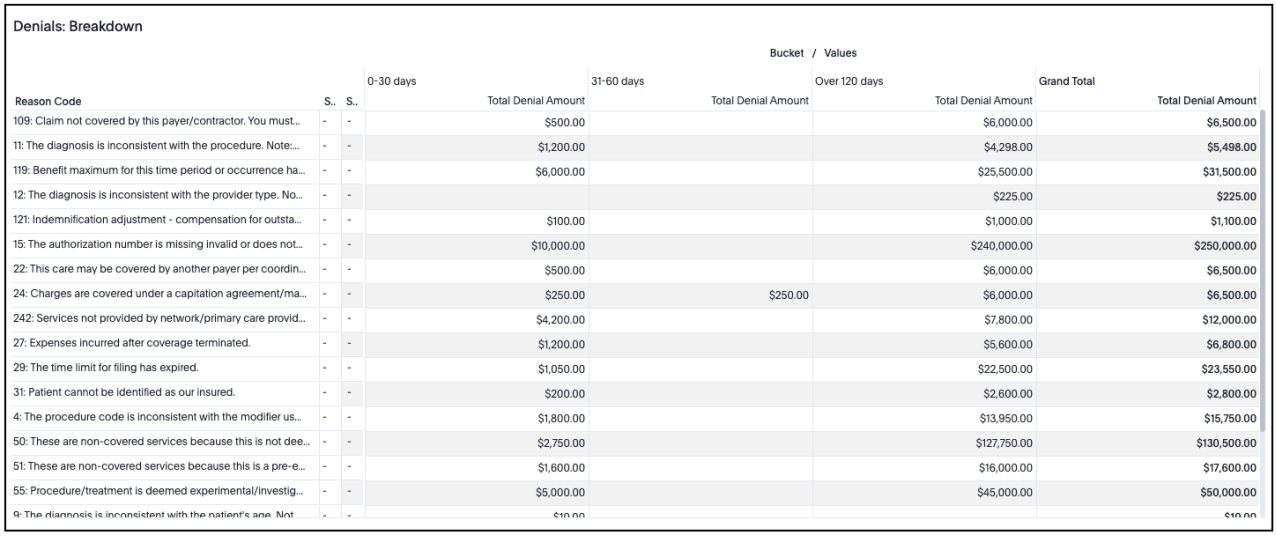


Denials Breakdown

The **Denials Breakdown** page groups denials by the selected field and displays the total dollar amount, including

their aging. A primary, sub-group, and tertiary reason of your choosing can group denials.

Hover over the upper right side of the report to access additional options, including showing the underlying data, downloading the report, and displaying the information on the screen in present mode.



Denials: Breakdown

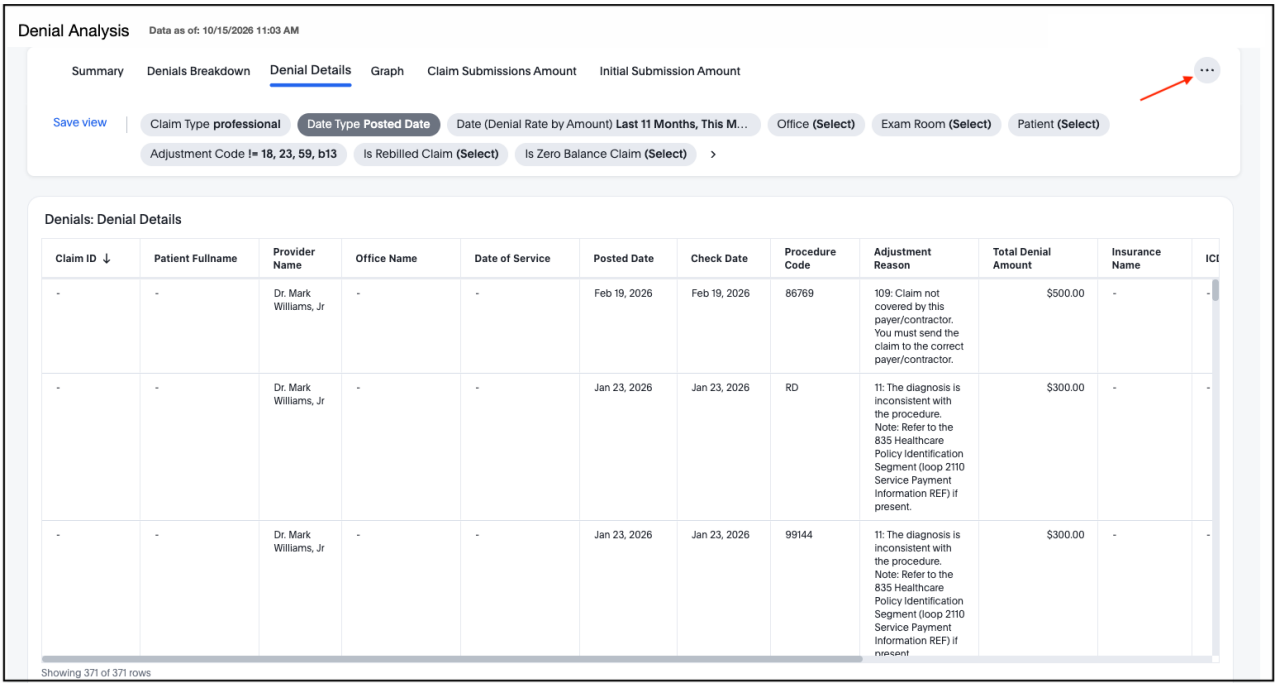
Bucket / Values

Reason Code	S..	S..	0-30 days Total Denial Amount	31-60 days Total Denial Amount	Over 120 days Total Denial Amount	Grand Total Total Denial Amount
109: Claim not covered by this payer/contractor. You must...	-	-	$500.00		$6,000.00	$6,500.00
11: The diagnosis is inconsistent with the procedure. Note:...	-	-	$1,200.00		$4,298.00	$5,498.00
119: Benefit maximum for this time period or occurrence ha...	-	-	$6,000.00		$25,500.00	$31,500.00
12: The diagnosis is inconsistent with the provider type. No...	-	-			$225.00	$225.00
121: Indemnification adjustment - compensation for outsta...	-	-	$100.00		$1,000.00	$1,100.00
15: The authorization number is missing invalid or does not...	-	-	$10,000.00		$240,000.00	$250,000.00
22: This care may be covered by another payer per coordin...	-	-	$500.00		$6,000.00	$6,500.00
24: Charges are covered under a capitation agreement/ma...	-	-	$250.00	$250.00	$6,000.00	$6,500.00
242: Services not provided by network/primary care provid...	-	-	$4,200.00		$7,800.00	$12,000.00
27: Expenses incurred after coverage terminated.	-	-	$1,200.00		$5,600.00	$6,800.00
29: The time limit for filing has expired.	-	-	$1,050.00		$22,500.00	$23,550.00
31: Patient cannot be identified as our insured.	-	-	$200.00		$2,600.00	$2,800.00
4: The procedure code is inconsistent with the modifier us...	-	-	$1,800.00		$13,950.00	$15,750.00
50: These are non-covered services because this is not dee...	-	-	$2,750.00		$127,750.00	$130,500.00
51: These are non-covered services because this is a pre-e...	-	-	$1,600.00		$16,000.00	$17,600.00
55: Procedure/treatment is deemed experimental/investig...	-	-	$5,000.00		$45,000.00	$50,000.00
9: The diagnosis is inconsistent with the patient's age. Not	-	-	$10.00			$10.00

Denial Details

The **Denial Details** tab displays patient and denial information based on the report parameters.

Hover over the upper right side of the report to access additional options, including showing the underlying data, downloading the report, and displaying the information on the screen in present mode.



Denial Analysis Data as of: 10/15/2026 11:03 AM

Summary | Denials Breakdown | Denial Details | Graph | Claim Submissions Amount | Initial Submission Amount

Save view | Claim Type **professional** | Date Type **Posted Date** | Date (Denial Rate by Amount) **Last 11 Months, This M...** | Office **(Select)** | Exam Room **(Select)** | Patient **(Select)**

Adjustment Code **!= 18, 23, 59, b13** | Is Rebilled Claim **(Select)** | Is Zero Balance Claim **(Select)**

Denials: Denial Details

Claim ID	Patient Fullname	Provider Name	Office Name	Date of Service	Posted Date	Check Date	Procedure Code	Adjustment Reason	Total Denial Amount	Insurance Name	ICI
-	-	Dr. Mark Williams, Jr	-	-	Feb 19, 2026	Feb 19, 2026	86769	109: Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.	$500.00	-	-
-	-	Dr. Mark Williams, Jr	-	-	Jan 23, 2026	Jan 23, 2026	RD	11: The diagnosis is inconsistent with the procedure. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.	$300.00	-	-
-	-	Dr. Mark Williams, Jr	-	-	Jan 23, 2026	Jan 23, 2026	99144	11: The diagnosis is inconsistent with the procedure. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present	$300.00	-	-

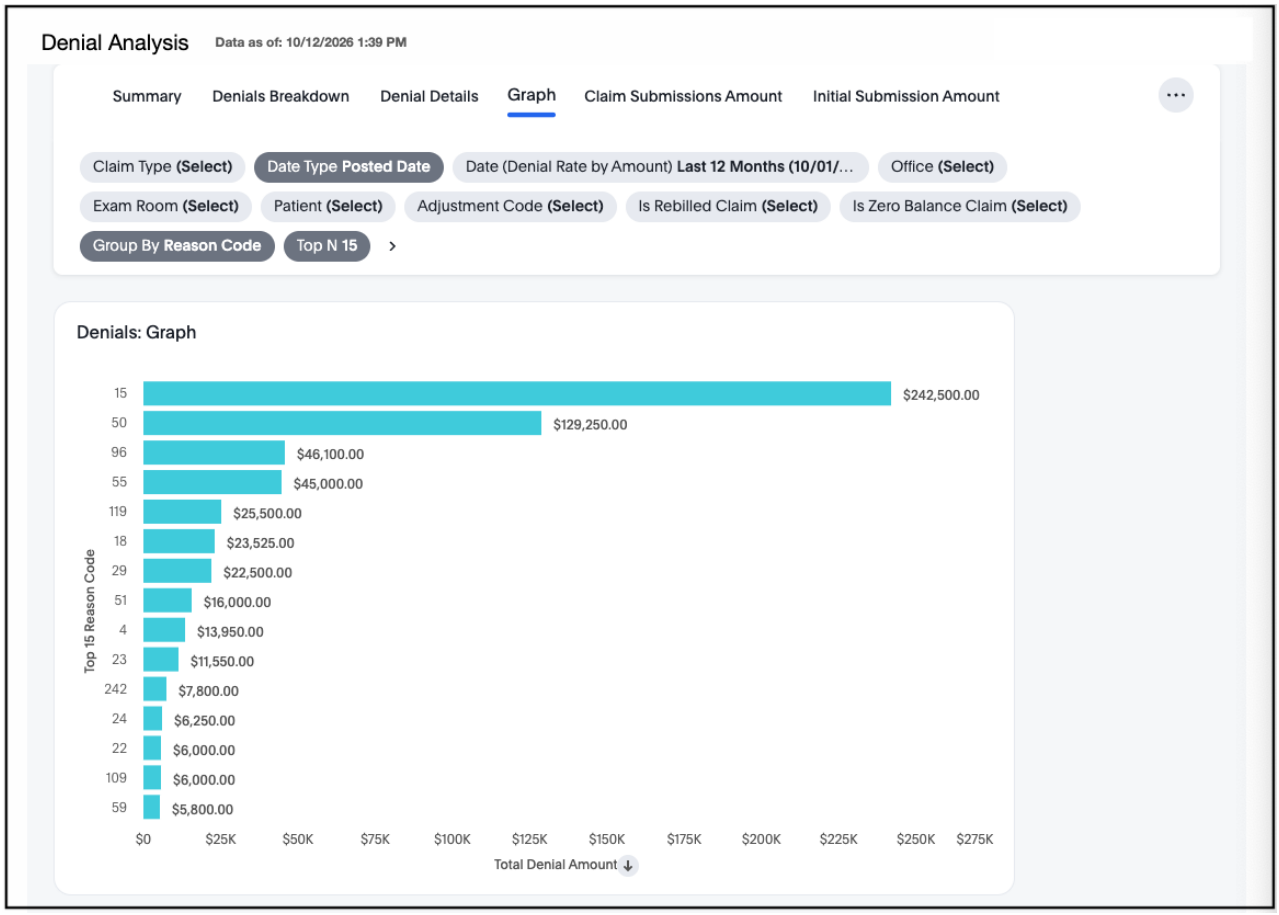
Showing 371 of 371 rows

Graph

The graph displays report information as a bar graph.

Hover over the upper right side of the report to access additional options, including showing the underlying data,

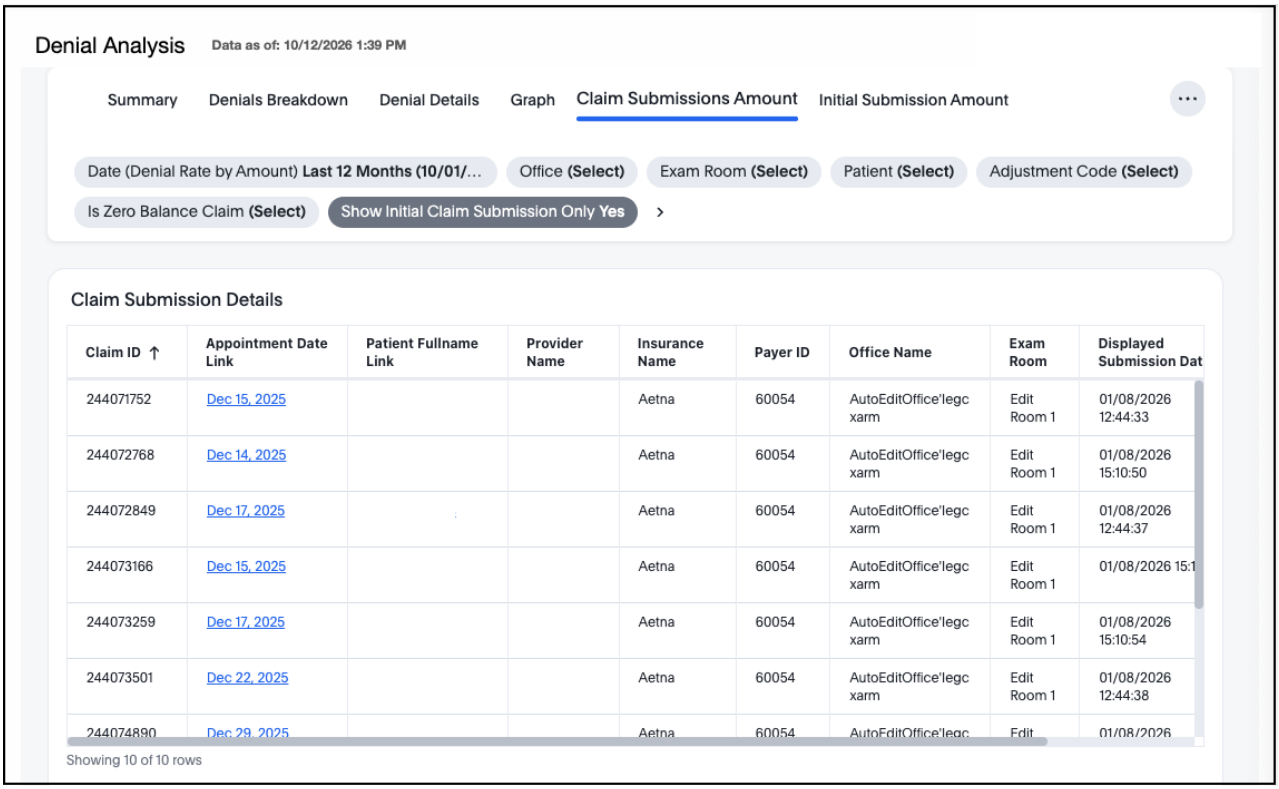
downloading the report, and displaying the information on the screen in present mode.



Claim Submission Amount

The Claim Submission Amount tab will provide patient-level details that meet the report parameters.

Hover over the upper right side of the report to access additional options, including showing the underlying data, downloading the report, and displaying the information on the screen in present mode.



Initial Submission Amount

The Initial Submission Amount tab will provide patient-level details that meet the report parameters.

