

# Denial Review Decision Tree

A no-guessing decision path for reading the denial reason before choosing a next action.

**TYPE** Decision Tree

**WHO** Denial learners, AR Follow-Up Specialists, Medical Billers, and RCM beginners.

**WHEN** Use when a claim is denied or unpaid and the correct next action is not obvious.

**HOW** Start with the actual payer reason, then follow the safest investigation path using proof.

## Workflow stage: Back-End RCM - denial triage and next-action routing

### Start

Read actual denial reason, CARC/RARC, EOB/ERA, portal status, and system notes.

### Data wrong?

If claim data is wrong/incomplete, corrected claim or rebill route may be needed per SOP.

### Payer decision?

If payer decision is being challenged, appeal/reconsideration may need proof and documentation.

### Missing proof?

If records/auth/timely filing/COB proof is missing, gather source of truth before acting.

### Patient route?

Only consider patient responsibility after payer processing and current policy support it.

### Escalate

Escalate unclear, high-dollar, deadline-risk, medical necessity, coding, or permission-limited cases.

## COMMON MISTAKE AVOIDED

Avoid jumping to appeal before reading the actual reason and reviewing the proof.

## NO-PHI REMINDER

Do not use or enter real patient names, dates of birth, insurance IDs, member IDs, claim numbers, medical record numbers, addresses, phone numbers, diagnoses, treatment details, login details, or protected health information. Use fictional data only when practicing.

## EDUCATIONAL DISCLAIMER

This resource is for beginner-friendly healthcare admin education only. It is not medical advice, legal advice, coding certification, payer-specific billing authority, a replacement for employer training, or a guarantee of employment. Always verify current requirements with official sources, employer policy, payer rules, client instructions, and updated guidance.

## SOURCE / REVIEW NOTE

This beginner resource explains general claim and billing workflow concepts. Requirements can vary by payer, plan, provider type, specialty, place of service, contract, and current policy. Last reviewed: July 2026.