



ACUA

Association of College
& University Auditors

March 24-26, 2026

ACUA VIRTUAL SPRING SUMMIT

Audit in Action



From Denials to Dollars

A Comprehensive Audit Boot Camp for Healthcare Revenue
Integrity

(Academic Medical Centers + Faculty Practice Plans)

100-Minute Virtual CPE (ACUA)



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A \$5 Million Audit Finding

Metric	Example
Denied claims last quarter	\$20,000,000
Denials never worked	40%
Appeal success rate	65%
Estimated recoverable revenue	\$5,200,000



Session Purpose

- This boot camp teaches internal auditors how to evaluate, analyze, and improve claim denial prevention, denial follow-up, and denial recovery across the healthcare revenue cycle.
- It uses HFMA-aligned denial management concepts to show why most denials are preventable and why failure to correct/resubmit denials creates permanent revenue leakage.
- You will leave with a practical audit program, analytics tests, and case-study experience for both facility (hospital) and professional (faculty practice plan) billing.

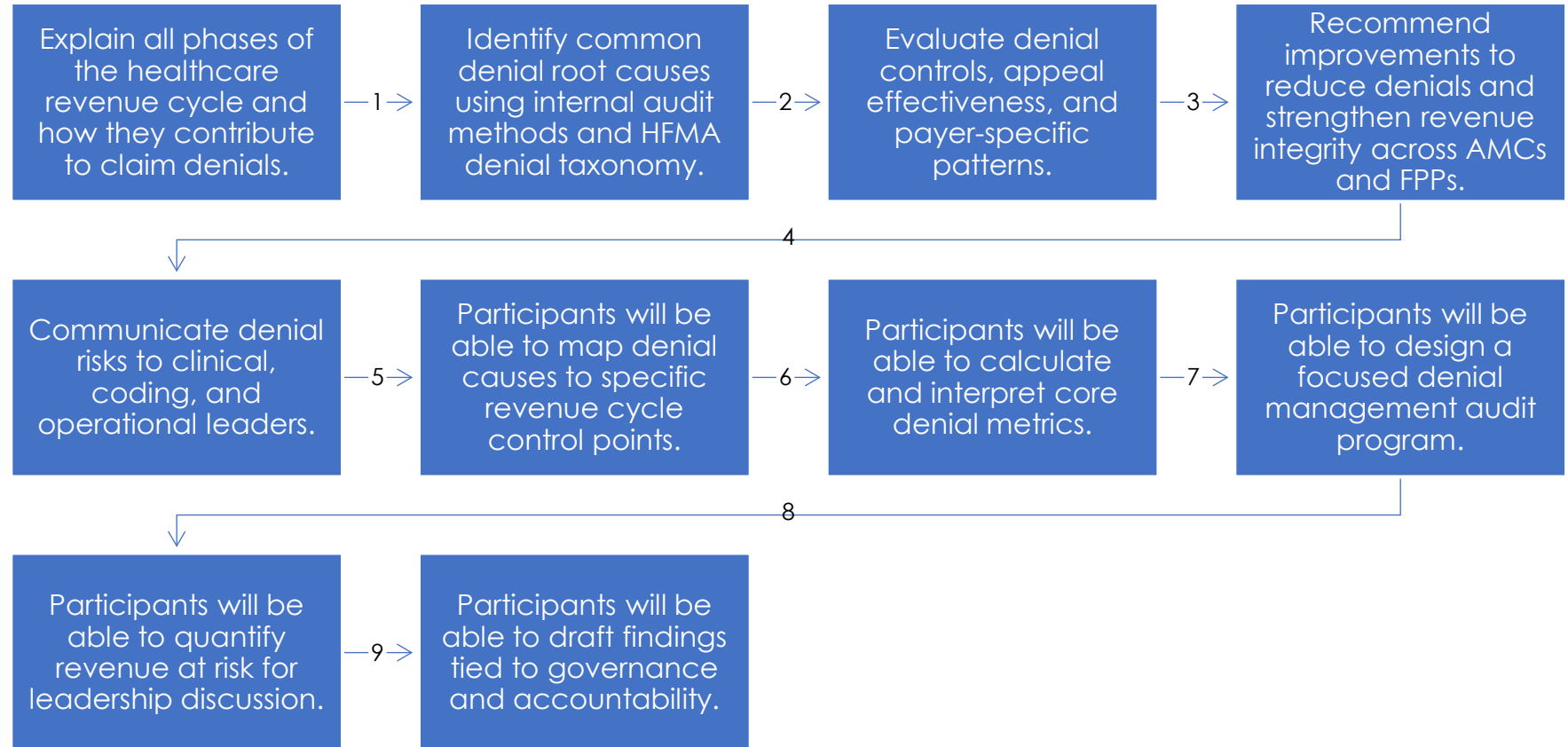


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Learning Objectives & Outcomes



Agenda (100 Minutes)

- 0–10 min: Healthcare 101 for auditors + quick poll
- 10–25 min: Denials fundamentals + HFMA-style framing (reason vs root cause)
- 25–45 min: Denial taxonomy + AMC/FPP hotspots + common denial codes
- 45–60 min: Metrics, dashboards, and revenue-at-risk modeling (with a worked example)
- 60–85 min: Internal audit approach + analytics tests + case study #1 (Facility)
- 85–100 min: Case study #2 (Professional/FPP) + governance reporting + wrap-up



Healthcare 101: Revenue Cycle in One Sentence

Revenue cycle = turning clinical care into collected cash, with proof (documentation/coding) that satisfies payer rules.



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Hospital (Facility) Revenue Cycle — Detailed Flow

- Scheduling / Registration: verify insurance, obtain authorization.
- Clinical Service: admission or outpatient encounter.
- Documentation: physician + nursing + diagnostics.
- Coding & Charge Capture: DRG/APC assignment.
- Claim Submission (UB-04).
- Payer Adjudication → Payment or Denial.
- Denial Follow-Up / Appeal.



Faculty Practice Plan (Professional) Revenue Cycle — Detailed Flow

- Scheduling: verify coverage, CPT-specific authorization.
- Provider Visit / Procedure: documentation created.
- Coding: CPT + modifiers (e.g., GC, 25, 59).
- Claim Submission (CMS-1500).
- Payer Adjudication → Paid, Denied, or Downcoded.
- Appeal / Rebill if necessary.



Where Claim Denials Actually Start

PRE-SERVICE (Patient Access)	SERVICE (Clinical Care)	POST-SERVICE (Coding & Billing)	BACK-END (Denials & Recovery)
Eligibility verification	Clinical documentation	Coding accuracy	Appeals
Prior authorization	Medical necessity	Charge capture	Follow-up
Demographics accuracy	Physician orders	Claim edits / scrubber	Write-offs
Coordination of benefits	Diagnostic support	Claim creation	Denial analysis

Most claim denials originate in PRE-SERVICE or DOCUMENTATION — not in billing.



Two Billing Worlds: Facility vs Professional (Why AMCs Feel 'Hard')

- Facility/hospital billing (UB-04 / institutional): inpatient/outpatient technical charges, DRG/APC logic, clinical validation/medical necessity.
- Professional billing (CMS-1500): physician services, CPT/modifiers, E/M rules, teaching physician documentation requirements.
- AMCs + FPPs deal with BOTH, plus split billing and shared workflows.



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Revenue Cycle Overview — Two Parallel Billing Systems (Insert After Objectives)

Academic Medical Centers operate TWO revenue cycles simultaneously:

- 1) Hospital / Facility (technical billing — DRG/APC logic)
- 2) Faculty Practice Plan / Professional (physician CPT billing)

Same patient encounter can generate TWO separate claims with different denial patterns.



What Is a Claim?

Element	What It Means
WHO	Patient and provider information
WHAT	Procedure or service performed
WHY	Diagnosis supporting medical necessity
WHEN	Date of service
WHERE	Location of care
HOW MUCH	Amount billed to the payer

If any element is missing or incorrect, the claim may be delayed or denied.



What Is a Denial (Operational Definition)?

Concept	Explanation
Denial	A payer decision that a claim cannot be paid as submitted
Result	Claim must be corrected, documented, appealed, or written off
Operational Impact	Rework, delays, and increased cost to collect
Audit Insight	Denials signal upstream process failures



Reason Code vs Root Cause (The #1 Concept Auditors Need)

What the Payer Says	What Actually Went Wrong
Missing Authorization	Authorization workflow failed
Not Medically Necessary	Documentation did not support medical necessity
Missing Information	Registration or claim edits failed
Coding Error	Coding or documentation process failed



Where Denials 'Start' (Control Point View)

Process Area	Typical Root Cause
Patient Access	Eligibility errors, missing authorizations
Clinical Documentation	Medical necessity not clearly documented
Coding & Charge Capture	Incorrect codes or modifiers
Billing & Claims Processing	Missing or invalid claim data



POLL #1 (Warm-Up)

Which denial signal most often indicates a broken *front-end* control?

- A. Timely filing exceeded
- B. Missing/invalid authorization
- C. Duplicate claim
- D. Contractual adjustment (fee schedule)



Denials Management = A System, Not a Work Queue

- If denials are treated as 'billing clean-up,' denial rates stay high.
- If denials are treated as a control system, denials drop and recovery improves.
- Auditors test whether denials are measured, analyzed, corrected, and prevented.



Internal Audit Lens for Denial Management

PREVENTION	DETECTION	RECOVERY
Eligibility verification	Denial dashboards	Appeal effectiveness
Authorization controls	Root cause analytics	Work queue discipline
Coding/documentation	Repeat denial monitoring	Write-off governance



POLL #2 (Governance Signal)

If appeal success is high BUT denial volume stays high, what's the likely story?

- A. Payers are random
- B. Strong prevention controls
- C. Upstream errors are not being fixed (rework culture)
- D. Coding is perfect



HFMA-Aligned Denial Categories (Audit-Friendly)

Denial Category	Typical Example
Authorization	Missing or incorrect prior authorization
Documentation / Medical Necessity	Clinical documentation insufficient
Coding / Modifiers	Incorrect CPT code or modifier
Administrative Errors	Demographics or insurance errors
Timely Filing	Claim submitted after payer deadline



AMC Hotspots (Facility Side)

Risk Area	Why It Matters
Clinical Documentation	Complex care requires strong documentation
Authorization Management	High-cost services often require approval
Charge Capture	Complex procedures increase billing risk
Denial Work Queues	High-dollar claims may remain unresolved
Appeal Documentation	Records retrieval can delay appeals



FPP Hotspots (Professional Side)

Risk Area	Typical Issue
Authorization Updates	Procedure changes after scheduling
Modifier Usage	Missing or incorrect CPT modifiers
Documentation	Physician notes insufficient for payer rules
Coordination of Benefits	Secondary insurance not updated
Timely Filing	Delays in coding or billing



POLL #3 (Root Cause Thinking)

'60% of returned claims are never resubmitted' most likely reflects:

- A. A coding accuracy issue only
- B. A broken denial/appeals operating model (capacity + accountability)
- C. A patient satisfaction problem only
- D. A clinical documentation template issue only

Correct Answer: B



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Core Denial Metrics (What You Ask For)

Metric	Why It Matters
Denial Rate	Signals upstream control failure
Denied Dollars	Shows financial magnitude
% Unworked	Shows operational discipline
Appeal Success Rate	Indicates recoverability
Repeat Denials	Indicates prevention failure



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DENIAL RED FLAGS

Red Flag	What It May Indicate
More than 30–40% of denials never worked	Weak denial management process
High appeal success but high denial volume	Upstream errors not corrected
Same denial category repeating each month	Root cause not addressed
Large backlog of 90-day denials	Operational capacity issue
Significant denial write-offs	Weak governance oversight



Why Denials Hurt Beyond Lost Revenue: Rework Cost

- Denials create labor: research, documentation chase, correction, rebill, appeal.
- Industry articles cite significant rework cost differences (practice vs hospital).
- Audit angle: quantify BOTH revenue leakage and cost-to-collect impact.



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Revenue at Risk: A Simple Audit Model

Denied Dollars
Total value of denied claims
Example:
\$20,000,000

X

% Unworked / Unappealed
Denials that receive no follow-up
Example:
40%

X

Expected Recoverability
Historical appeal success rate
Example:
65%

Revenue at Risk = \$5,200,000

Denial backlogs often hide millions in recoverable revenue.



Worked Example (Step-by-Step)

- Denied dollars (quarter): \$20,000,000
- % unworked/unappealed: 40%
- Expected recoverability: 65%
- Revenue at Risk = $\$20,000,000 \times 0.40 \times 0.65 = \$5,200,000$



POLL #4 (Metric Discipline)

Which metric best reflects operational discipline (not payer behavior)?

- A. Denial rate
- B. Denied dollars
- C. % unworked / % un-appealed
- D. Payer mix



DATA IA SHOULD REQUEST

Data Set	Purpose
Denial extract (12 months)	Identify denial trends
Appeal outcome report	Estimate recoverable revenue
Denial aging report	Identify backlog of unworked claims
Top denial categories by payer	Root cause analysis
Denial write-off report	Evaluate governance oversight



Basic Analytics Trend + Concentration (Counts + Dollars)

Analysis Type	What It Shows
Trend Analysis	Denial rate changes over time
Payer Analysis	Which insurers generate the most denials
Service Line Analysis	Departments driving denied dollars
Aging Analysis	Denials sitting 30 / 60 / 90 days
Outlier Detection	Sudden spikes or unusual patterns



How Denial Backlogs Hide Millions in Recoverable Revenue

Even a moderate denial backlog can hide more than \$20 million in recoverable revenue each year.

Metric	Quarterly	Annual Impact
Denied claims	\$20,000,000	\$80,000,000
Denials never worked (40%)	\$8,000,000	\$32,000,000
Recoverable revenue (65%)	\$5,200,000	\$20,800,000



Advanced Analytics: Preventability + Repeatability

Analysis Focus	Purpose
Preventable Denials	Identify process failures
Repeat Denials	Detect recurring issues
Payer Patterns	Identify payer-specific denial behavior
Procedure Clusters	Link denials to specific CPT codes
Control Failures	Identify known issues not corrected



Audit Test 1: Authorization Integrity (FPP + Outpatient)

- Population: denials with CO-197 (auth) and high-dollar outpatient procedures.
- Test steps:
 - 1) Select sample of denied claims; obtain scheduling record + auth request record.
 - 2) Compare authorized CPT list vs billed CPT list (mismatch = root cause).
 - 3) Verify auth validity dates and payer requirements met.
 - 4) Determine whether workflow updates auth when procedure changes.
 - 5) Quantify dollars tied to CPT mismatch vs missing auth vs expired auth.



Audit Test 2: Medical Necessity / Documentation Support (Facility + FPP)

- Population: CO-50 and other medical necessity denials by dollars.
- Test steps:
 - 1) Identify required documentation elements (payer policy/LCD/NCD when applicable).
 - 2) For sample: compare clinical note to policy requirements (missing elements).
 - 3) Determine whether documentation improvement workflow exists (CDI, templates, feedsicck).
 - 4) Trace denial back to control point: provider note, coder query, claim edit, or appeal packet failure.
 - 5) Confirm corrective action implemented and monitored (repeat denial test).



Audit Test 3: Clean Claim Controls (Admin/Data Denials)

- Population: CO-16 and similar missing/invalid information denials.
- Test steps:
 - 1) Identify fields missing (DOB, member ID, plan code, modifier, rendering NPI, etc.).
 - 2) Trace to source: registration, scheduling, provider setup, charge entry, claim scrubber edits.
 - 3) Test whether edits fire BEFORE submission and whether edits are overridden.
 - 4) Measure rework time/cost and resubmission timeliness.
 - 5) Identify training/control gaps and assign ownership.



Audit Test 4: Timely Filing Control Breakdown

- Population: timely filing denials by payer and by department.
- Test steps:
 - 1) Compare service date → claim submit date → denial date.
 - 2) Identify delays (coding lag, charge lag, claim edit queue backlog, COB delay).
 - 3) Validate escalation rules for approaching filing limits.
 - 4) Confirm whether secondary billing and COB updates are causing avoidable misses.
 - 5) Quantify avoidable write-offs attributable to process lag.



Audit Test 5: Denial Work Queue Effectiveness (The 'Never Resubmitted' Problem)

Stage	Example
Total Denied Claims	\$20M
Claims Worked / Appealed	\$12M
Revenue Recovered	\$7.8M
Unworked Denials	\$8M left unresolved

High appeal success + large backlog of unworked denials
= **recoverable revenue leakage**



POLL #5 (Audit Priority)

If you can only audit ONE area first, which yields fastest ROI?

- A. Denial work queue (unworked/unappealed)
- B. Charge capture
- C. Contract modeling
- D. Patient satisfaction

Best Answer for most orgs: A (quick win)



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CASE STUDY #1 (Facility / Hospital): Scenario Setup

Academic Medical Center – Facility billing (UB-04).

Quarter snapshot: Denied dollars = \$28.5M

% unworked/unappealed = 38%

Appeal success rate (worked claims) = 64%

Top denial categories by dollars: Medical Necessity, Authorization, Missing Info, Timely Filing

Problem statement: CFO believes 'payers are just denying everything.'



CASE #1: Mini Dataset (Use for Breakout)

Medical Necessity (CO-50): \$12.0M denied | 30% unworked | 70% win rate

Authorization (CO-197): \$7.5M denied | 45% unworked | 55% win rate

Missing/Invalid Info (CO-16): \$5.0M denied | 50% unworked | 60% win rate

Timely Filing: \$4.0M denied | 65% unworked | 20% win rate



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CASE #1: Breakout Prompts (Facility)

- 1) Calculate Revenue at Risk for each category (Denied \$ × % unworked × win rate).
- 2) Which category is your first audit target and why?
- 3) For your top category, name the MOST likely root cause control point.
- 4) Draft one governance finding sentence (discipline/accountability lens).



CASE #1: Debrief – Expected Direction

- Revenue at Risk highlights where governance + triage matters most (often medical necessity + missing info).
- High unworked % is a management-control issue (capacity, prioritization, accountability).
- Medical necessity denials are often documentation + policy alignment issues (CDI and appeal packet discipline).
- Timely filing denials usually require process-timing fixes, not appeals.



CASE STUDY #2 (FPP / Professional): Scenario Setup

Faculty Practice Plan – Professional billing (CMS-1500).

Quarter snapshot: Denied dollars = \$9.8M

% unworked/unappealed = 52%

Appeal success rate (worked claims) = 72%

Top denial categories by dollars: Authorization, Coding/Modifier, COB, Timely Filing



CASE #2: Mini Dataset (Use for Breakout)

Authorization (CO-197): \$4.1M denied | 60% unworked | 65% win rate

Coding/Modifier (CO-11 + modifier issues): \$3.0M denied | 45%
unworked | 80% win rate

COB: \$1.7M denied | 55% unworked | 60% win rate

Timely Filing: \$1.0M denied | 70% unworked | 25% win rate



CASE #2: Breakout Prompts (Professional / FPP)

- 1) Compute Revenue at Risk by category.
- 2) Which two root causes are most plausible? (auth mismatch, missing modifier, documentation, COB workflow, etc.)
- 3) What TWO questions would you ask the billing manager AND the clinical leader?
- 4) Draft one recommendation tied to accountability + monitoring (not 'train people').



CASE #2: Debrief – Expected Direction

High appeal success + high unworked % = recoverable revenue left on the table.

Auth denials often trace to scheduling/procedure changes and missing CPT updates.

Modifier/coding denials often trace to templates, documentation prompts, or coder-provider feedback loops.

COB denials often trace to patient access + billing follow-up discipline.



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POLL #6 (Comfort Talking to Clinicians)

Which question is most effective with a physician leader?

- A. 'Can you explain DRGs?'
- B. 'Who is responsible for ensuring documentation meets payer policy before billing?'
- C. 'Why do you deny claims?'
- D. 'Do you like the claim scrubber?'



Governance: What a Denials Dashboard Must Show

- Denied dollars and denial rate trend (by payer and service line).
- % unworked / % unappealed and backlog aging.
- Appeal success rate (by payer/category) and time-to-resolution.
- Repeat denial rate after corrective action date.
- Write-offs: dollars + reason codes + approval level.
- Top 5 root causes with named owners and due dates.



Governance: Escalation Thresholds (Example)

If denial rate rises $> X\%$ for 2 months \rightarrow formal root cause review.

If % unworked exceeds $Y\%$ or backlog $> Z$ days \rightarrow staffing/triage action.

If repeat denial rate $> R\%$ in a category \rightarrow corrective action plan required.

If write-offs increase $> \$$ threshold \rightarrow CFO review and IA follow-up.



How to Draft Audit Findings (Meaty Example Language)

Condition: X% of high-dollar denials were not appealed within payer deadlines; backlog exceeded policy thresholds.

Criteria: Denial policy requires triage within N days and escalation at M days; payer filing windows require action by D days.

Cause: Denial work queue lacks ROI-based prioritization, documented ownership, and performance monitoring; documentation retrieval SLAs not defined.

Effect: Estimated revenue at risk of \$_____ for the quarter; increased cost-to-collect due to rework; risk of recurring preventable denials.

Recommendation: Implement prioritized work queues, escalation SLAs, denial owner accountability, and monthly dashboard reporting to leadership.



POLL #7 (Best 'Audit Value' Move)

Which recommendation is most 'audit-grade' (systemic) vs generic?

- A. 'Train staff to do better'
- B. 'Implement ROI-based denial triage + monthly root cause dashboard with named owners'
- C. 'Hire more coders'
- D. 'Ask payers to be nicer'



Action Plan: What You Can Do in 30 Days

- Request 6–12 months denial extract (counts + dollars) with appeal outcomes.
- Build top-10 denial categories by dollars and % unworked/aging.
- Run 2 quick-win tests: auth mismatch sample + unworked high-dollar backlog sample.
- Quantify revenue at risk for top categories and draft 1–2 findings.
- Present a dashboard proposal with thresholds and named ownership.



Side-by-Side Comparison: Facility vs Professional

Claim Form: UB-04 (facility) vs CMS-1500 (professional).

Payment Logic: DRG/APC vs CPT fee schedule.

Typical High-Risk Denials: Medical necessity (facility) vs Authorization/modifier (professional).

Dollar Pattern: Larger per-case (facility) vs Higher frequency (professional).

Governance Risk: Clinical validation vs Documentation & modifier discipline.



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Commercial Payer Denial Variability

Denial aggressiveness varies by contract terms.

Varies by service line and market region.

Influenced by utilization management and authorization rules.

Audit conclusion must be data-driven — not anecdotal.



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Denials Are Not a Billing Problem

Denials are a control problem.

They signal process breakdown, governance tolerance, and accountability gaps.

Recurring denials indicate upstream failure.

Internal audit's role is to quantify and trace breakdown to control point.



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Denial Reason \neq Root Cause

Payer reason code explains outcome — not the failure.
Root cause exists upstream in workflow, documentation, or authorization.

Auditors fix root causes. Billing staff fix reason codes.
Testing must trace denial back to originating control.



Common Denial Reasons (Practice + Hospital Context)

- Prior authorization missing (practice + outpatient).
- Missing/incorrect information (demographics, plan codes, modifiers).
- Medical necessity not met (documentation gaps).
- Procedure not covered, out-of-network, duplicates.
- COB not updated; bundling; timely filing exceeded.



POLL #8

If you see denial dollars concentrated in ONE payer and ONE denial category, your first move is:

- A. Audit every department at once
- B. Validate payer policy change + run root-cause drill-down for that category
- C. Replace the billing system
- D. Stop seeing patients from that payer

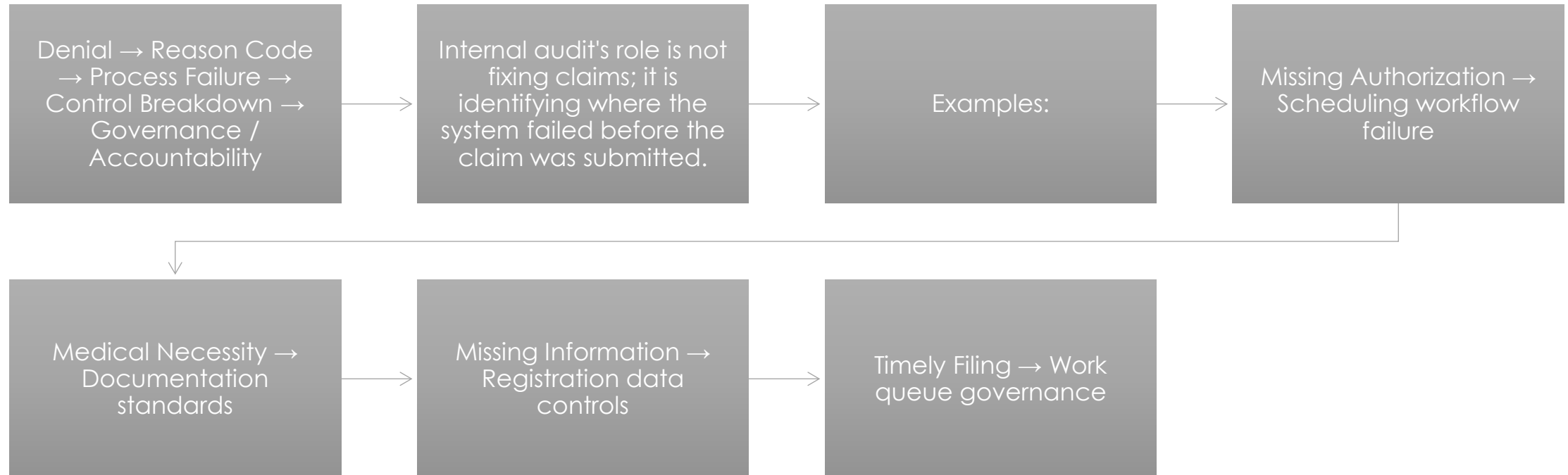


Key Lessons

Key Lesson	Meaning for Internal Audit
Denials reveal control breakdowns	Not just payer behavior
Reason codes are not root causes	Audit the process that caused the denial
Unworked denials hide recoverable revenue	Governance and accountability issue
Prevention is more valuable than recovery	Fix upstream controls



Denials Are a Signal — Not the Problem



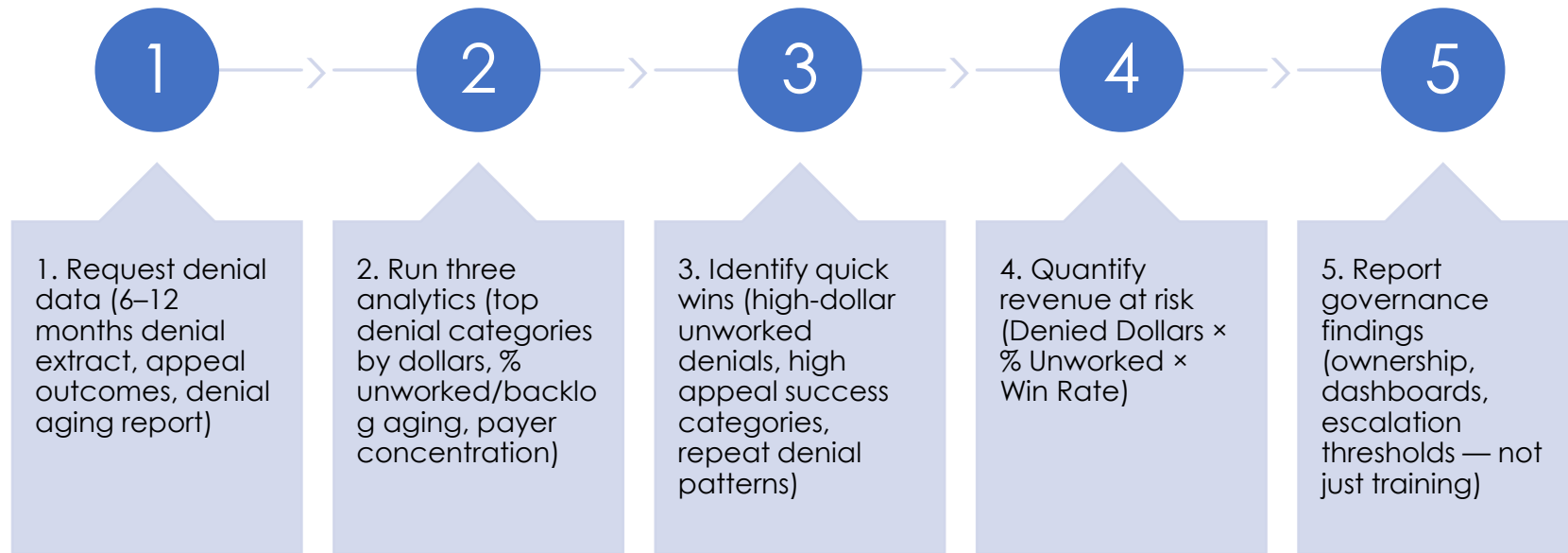
Why Denial Audits Matter

Financial Impact	- Millions in recoverable revenue	- Faster cash flow	- Better payer performance
Operational Impact	- Reduced rework cost	- Fewer billing delays	- Improved documentation
Governance Impact	- Accountability for process owners	- Clear ownership of denial categories	- Stronger executive oversight

Example: \$20M
Denials × 40%
Unworked × 65%
Recoverable = \$5.2M
opportunity



Your First 30 Days After This Session



WHERE INTERNAL AUDIT CREATES THE MOST VALUE IN THE REVENUE CYCLE

Audit Focus	What Auditors Evaluate	Value Delivered
Denial Prevention	Authorization workflows, documentation standards, coding accuracy	Fewer denials before claims are submitted
Denial Management	Work queue discipline, aging controls, appeal processes	Recoverable revenue captured
Denial Governance	Dashboards, ownership of denial categories, escalation thresholds	Sustainable control improvement



The Five Denial Signals Every Auditor Should Watch

Signal	What It Means	Audit Action
High denial volume + high appeal success	Recoverable revenue left unworked	Review denial work queues
Repeat denial categories	Root cause not corrected	Trace to upstream workflow
Large 90+ day backlog	Filing deadline risk	Test escalation controls
Payer concentration	Policy or contract issue	Analyze payer trends
Service line concentration	Documentation/coding issue	Target operational audit

Denials are data.
Internal audit's job is to turn that data into operational insight.



Denials Are Not a Billing Problem



Denials are a CONTROL problem.



They expose:



- Broken workflows



- Missing accountability



- Weak monitoring



- Preventable revenue leakage



Internal auditors help organizations fix the systems that create denials — not just the claims themselves.

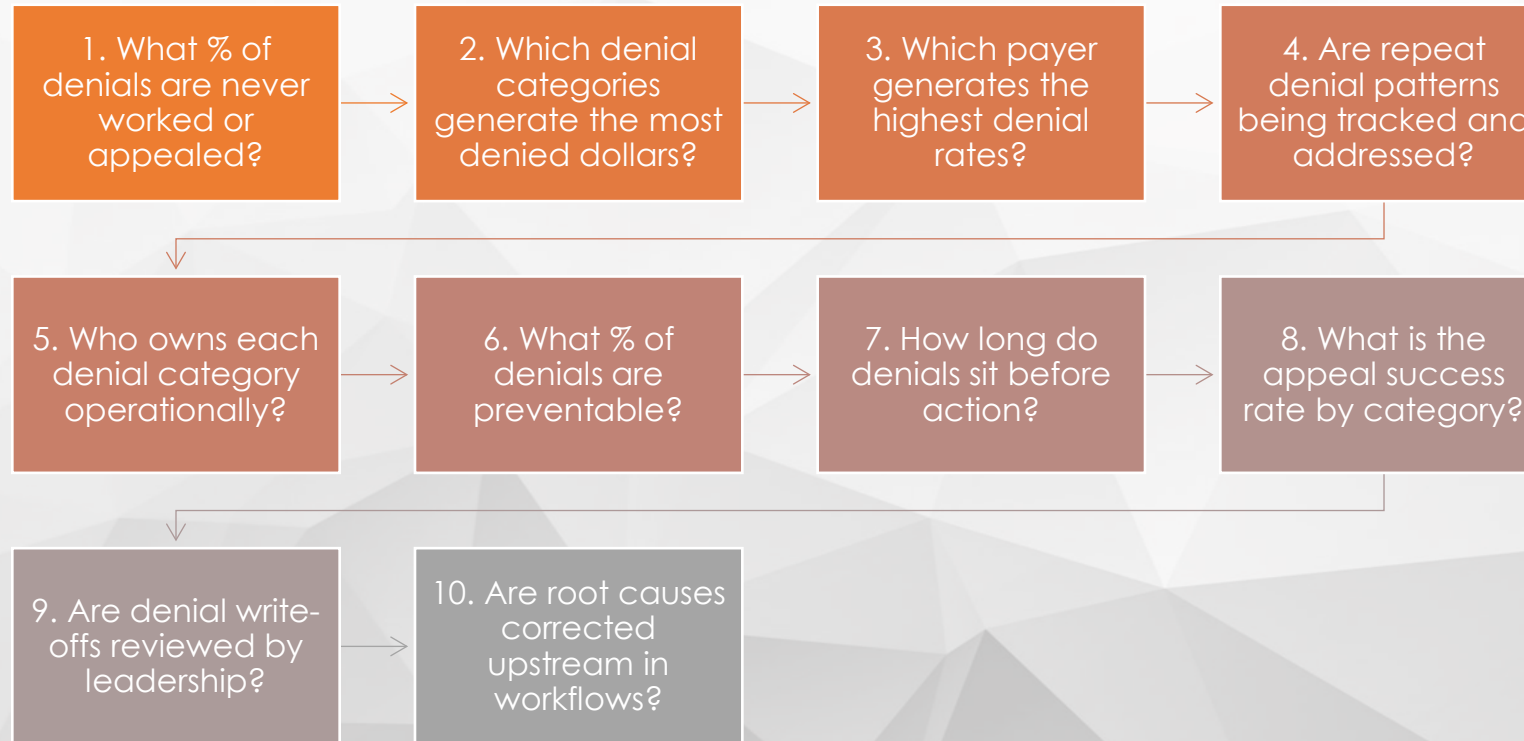


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10 Questions Internal Auditors Should Ask About Denials



APPENDIX



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Definitions: Pre-Service / Front-End / Post-Service / Back-End

Pre-service (front-end): scheduling, registration, eligibility, prior auth, estimate/financial counseling.

Service: care delivery + clinician documentation (what/why/how).

Post-service: coding, charge capture, claim edits/scrubbing, claim creation.

Back-end: claim submission → payer adjudication → denial/underpay → appeal → payment posting → secondary billing → write-off.



Visual Example — Denials Dashboard

- Key Dashboard Elements:
 - Overall Denial Rate: 8.4% (Target <5%)
 - Revenue in Denial: \$5.8M
 - Unworked Denials: 42%
 - 90+ Day Aging: \$1.8M
 - Top Categories: Authorization, Medical Necessity, Coding



High-Frequency Denial Codes (Examples to Know)

- CO-50 = Not medically necessary (often documentation/medical necessity).
- CO-197 = Authorization/precertification absent/invalid.
- CO-16 = Claim/service lacks required information (admin/data).
- CO-11 = Diagnosis/procedure coding mismatch (coding).
- CO-45 = Charges exceed fee schedule/contract (payment variance lens).



Denial Analytics: Minimum Data Fields (Facility + Professional)

- Claim/Account ID; patient class (IP/OP/Pro); service date; bill date.
- Payer/plan; denial category; denial code; denial date; denied amount.
- Service line/department; provider; location; CPT/HCPCS/DRG as applicable.
- Authorization number/status (if applicable).
- Appeal status, appeal dates, outcome; write-off indicator/reason; cash recovered.







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SAMPLE DASHBOARD COMPONENTS:

SAMPLE DASHBOARD COMPONENTS:

Overall Denial Rate: 8.4% Aging in Denial Buckets:

0–30 Days: \$2.1M

31–60 Days: \$1.3M

61–90 Days: \$600K

90+ Days: \$1.8M

Key Audit Questions:

- What % remains unworked?
- Are repeat denial categories trending upward?
- Is there ownership and escalation?

Target: <5%



Visual Example — What a Claim Denial Looks Like

Explanation of Benefits (EOB) Sample:

- Billed Amount: \$12,450
 - Paid Amount: \$0
 - Denial Code: CO-197
- Reason: Prior authorization missing

Audit Insight: Denial code explains outcome, not root cause.



Closing: Tie Back to Objectives & Outcomes

You now have: revenue cycle control points, denial taxonomy, metrics, audit tests, and two cases (facility + FPP).

Use the models to quantify impact and the governance lens to drive prevention.



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