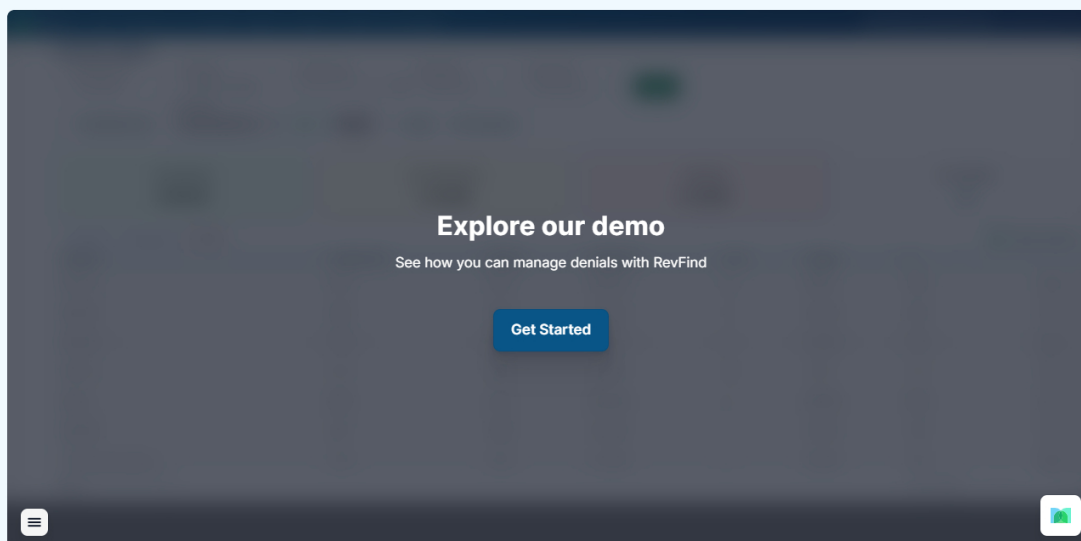


Manage Denials

Payer denials drain provider cash flow by driving costly rework and write-offs. Payers deny 15% of claims on average, but with sophisticated software you can get your denials rate closer to the 5% benchmark that leaders recommend. Click through this interactive walkthrough to see denials improvement in action.



75% of revenue cycle leaders say reviewing denials and submitting appeals is the most time-consuming part of their jobs. You put in this work because you know that many denied claims can be recovered, but tedious denial management drains your team's valuable time.

RevFind simplifies and streamlines denial management by organizing denials by payer, CPT code, denial reason, and more. It enables you to identify root causes and redesign workflows to improve your first-pass resolution rate. Appeal generation and tracking workflows complete your denial process.

With **RevFind**, denials backlogs shrink, workloads ease, and your organization maximizes reimbursement.

Conquer systemic, persistent denial trends

Denials persist because constant appeals and reworking without root cause analysis doesn't stem problems where they originate. Instead, it takes clear data to identify critical denial areas.

The most common root causes of denials are:

- insufficient prior authorizations
- inaccurate or insufficient documentation
- insurance coverage issues
- coding errors
- lack of medical necessity
- timely filing limit exceeded

Once discovered, each of these workflows can be improved with proactive strategies.

RevFind highlights the CPT codes and payers triggering denials. Root cause identification and trend analysis pinpoint your lost revenue, while **Clarity Flow** reduces denials from prior authorization and coverage gaps, preventing additional losses.

Streamline appeals

Clearly defined workflows and assignment of responsibilities ensure that denial appeals are managed efficiently.

RevFind catches each denial on arrival and automatically sends it to the right worklist for staff investigation. Assignments can be automated by denial type, insurance, provider, facility, or other relevant criteria. Team members can leverage flexible status labeling to designate which denied claims are ready for appeal. With a proactive appeals process and clear task delegation, denial tasks become less onerous to manage.

Once a denial has been automatically assigned to staff by denial type, they can use **RevFind** to generate batches of denials that have shared characteristics and are ready to appeal. These appeal-ready batches simplify appeals submission reducing the need for manual intervention.

Track denials recovery for continuous improvement

Track appeals progress by viewing expected versus actual reimbursement for previously denied claims. **RevFind** analyzes appeal progress by denial reason, payer, and other criteria to pinpoint opportunities for process improvement. Executive-ready dashboards give key stakeholders a unified view of denial appeal trends.

Recover the revenue you've earned

Find and fix your most common sources of denials, create reliable denials workflows, and forge a powerful appeals process.

Recover the revenue you've earned

Find and fix your most common sources of denials and create reliable denials workflows.

 [Get a Demo](#)

“

A more effective way to increase our overall collection percentage... the team's enthusiasm for tackling this was day and night over other vendors.

- Director of Finance

“

MD Clarity provides quality driven outcomes and high-level professional support.

- Senior Director of Managed Care

“

Great product, responsive support, easy to work with!

- Director of Business Services

“

MD Clarity was the only software that we found on the market that could provide the level of accuracy we were looking for.

- Head of Patient Accounts

Get paid in full by bringing clarity to your revenue cycle

 [Get a Demo](#)



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