The Quadrant Company

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Denial Software Sorts and Drafts Well. Keep the Decision With a Person.

Denial software sorts your claims and drafts your appeals. The published record splits hard on whether it should ever decide one, and the numbers in the pitch usually arrive with no baseline behind them.

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You and your accounts receivable lead are watching the vendor demo. She has spent her career learning that a payer's technical denial, the refusal that turns on a paperwork problem, is usually a registration mistake made three weeks earlier by someone who has since left. On the screen the software reads a remittance, the payer's notice of what was paid and what was refused, tags the denial, and drafts the appeal before anyone finishes their coffee. Her question is what happens when that software meets your data. Nobody has answered that for you, because the published record on denial software has never been assembled in one place for a buyer. What follows assembles it and names where it splits.

Where the record splits

The vendor and governance writing below is summarized rather than linked, so check any claim against your own vendor's material. Vendor case studies and marketing pieces report drops in denials and better appeal outcomes, while governance minded analyses warn against leaning on tools nobody has independently tested. Professional association commentary and legal writing on accountability agree that the hospital or practice owns a wrong denial decision, and the software company does not.

Measurement is where the disagreement gets sharpest. Vendor case studies lead with relative improvement, denials down and appeal success up against their own earlier number, while leaving out the starting rate, the confidence behind the number, and what else changed that quarter. That last gap does the most damage, because teams that buy denial software almost always rebuild work queues, retrain staff, and tighten registration at the same time.

The second split is how far to push the tool. One set of sources argues AI should take on denial categories long treated as unworkable. That includes a severity downgrade, where the payer agrees you treated the patient but pays the stay at a lower level of illness than you billed. Another set says start small, a few high value categories in one or two service lines, because sweeping automation is premature.

The third split matters most. Some vendor aligned material describes software that needs no configuration and runs across your systems on its own. Governance focused analyses argue that AI deciding a denial with nobody in the loop is unsafe and out of step with compliance expectations, and those are two different products with only one defensible later.

One question stays open. A few sources argue that better eligibility and coverage data protects patients from surprise balances, while most vendor material never measures patients and counts revenue and staff hours instead. If patient financial harm matters to your board, ask for that number yourself, because the pitch will not volunteer it.

What practitioners report

Everything below is practitioner report from public forums rather than published evidence, and while the detail is specific and unflattering, nobody publishes a controlled result here.

On r/revenuecycle, the recurring design is a work queue, the list your staff pulls denials from, built on four buckets: front end, clinical, technical, and payer behavior. Posters recommend a small dedicated pod for complex denials from Medicaid managed care plans, Medicare Advantage, and value based contracts, and they keep that work off the general accounts receivable team. They also want hard stops at scheduling and registration that catch missing authorization or invalid coverage before it becomes a denial.

On r/PrivatePracticeDocs, real use is narrower than the marketing. AI runs as a triage layer that sorts denials by payer and reason, flags exceptions, and routes work, while people still decide. The reported wins come from narrow tasks running on clean data: checking eligibility, scrubbing claims before they go out, spotting denial patterns, posting payments, and chasing unpaid claims.

On r/CodingandBilling, the clearest reported win is appeal drafting, where the software maps the payer's denial language back to that payer's own rules, the procedure and supply codes on the claim, and the supporting documentation. Billers in a separate thread push back, since routine denials already have templates and standard rebuttals and the value drops once the pattern is familiar.

Practitioners contradict each other on scope. Prior authorization is the payer's approval you have to get before the care happens. On r/Businessideas, the argument is that AI pays off only when it runs the whole prior authorization and appeal workflow end to end, from intake and routing through follow up and document generation. The r/PrivatePracticeDocs view runs the other way, since the software is reliable on specific tasks and comes apart when asked to manage everything. That is the strongest argument against starting small, because if the payback arrives only at full scale, a narrow pilot buys a rounding error and one more system to maintain.

For r/BusinessIntelligence posters, the failure is messy data and weak process design, well upstream of the model. You already own the rules, handoffs, and ownership that decide this, and until they are standardized, the software only gets you to the mistakes you were already making faster. Nobody has published a controlled comparison, so that failure mode decides the scope question. Practitioners there insist on human oversight for uncertain cases: software flags risk, people decide.

What to do this week

Seven items, and only one has to happen now. If your queue is already past what your team can clear this quarter, do the third item and let the rest wait, because the dated baseline is the only item you cannot recreate later.

1. **1.** Fix the front door before you shop, with a hard stop at scheduling and registration for missing authorization and invalid coverage.
2. **2.** Put last quarter's denials into the four buckets: front end, clinical, technical, payer behavior. You cannot judge a pitch until you know which bucket is bleeding.

3. Record your denial rate and your appeal overturn rate, the share of appeals the payer reverses, for each payer this week, in a dated file every later claim gets measured against.
4. Point the first pilot at narrow tasks with clean data: checking eligibility, scrubbing claims, spotting denial patterns.
5. Keep it on appeal drafts and keep the decision with a person.
6. Leave your routine templated denials alone, since that work is already cheap and software adds little to a familiar pattern.
7. Staff the complex pod with people, because Medicaid managed care, Medicare Advantage, and value based contracts are where judgment earns its keep.

Guardrails

A person reviews and signs every appeal. The software assembles the argument out of the payer's own rules and your documentation, and a named human being reviews it and takes responsibility for what goes out under your organization's name.

Your carve outs go in writing before go live. A carve out is a category you rule off limits for the software, and yours name which payers, which denial types, and which dollar amounts are off the table. One invented after a bad month is an excuse dressed as a control.

Make the vendor show you a baseline. A baseline is the rate that client was running before the software arrived, so for any number in the pitch, ask what the rate was before and what else that client changed the same quarter. Without an answer, you are looking at a number that describes one project, and it tells you nothing about the product you would be buying.

Do not accept a demo run on the vendor's data. Ask for a trial on your own remittance files, including the payers that give you the most trouble, because clean demo data hides the exact failure practitioners report most.

Keep a weekly root cause review that no software attends. People look at what denied and why, then fix the cause upstream, because sorting denials faster without closing that loop only makes the same leak more organized.

Log every automated action so you can reconstruct it. When a payer, an auditor, or your board asks why a claim was handled a certain way, you need a trail showing who or what decided and who reviewed it.

The short version

The tool is real and smaller than the pitch. It sorts well and drafts well, and the field reports say it comes apart on messy data or when asked to make the call. The software brings the labor and the speed, and you bring the judgment about which denial is worth the fight. Buy it for triage and drafting. Master it in those two lanes, keep a person on the signature line, and set your baseline first, because in a year that dated file is the only thing that will tell you whether the money was well spent.

Get the playbook

Email us the word [BASELINE] and we will send the denial and appeal baseline tracker, the one page file that makes every vendor claim measurable against your numbers. info@thequadco.ai

Sources

- https://www.reddit.com/r/PrivatePracticeDocs/comments/1qw09w4/ai_revenue_cycle_billing/
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