

INSIDER TIPS TO PREVENT DENIALS

What healthcare insiders do before submitting

Preemptive documentation strategies that stop denials before they happen.

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Preventing a Denial Is Easier Than Reversing One

These strategies are drawn from real-world experience working inside medical practices, on the insurance side, and advising patients through complex cases. Even when everything is done correctly, denials can still occur due to plan rules or automated review processes. Preparation reduces risk but cannot eliminate it entirely.

The 8 Strategies

Strategy	How to Apply It
1. Provide complete history up front	Do not assume your provider has access to records from other systems. Supply prior treatments, medication history, outside testing, and specialist notes directly. If records are fragmented, assume they are.
2. Document functional impact clearly	Vague descriptions like "pain" or "not feeling well" are often insufficient. Be specific: difficulty walking more than one block, unable to work full days, requires assistance with self-care. Concrete functional limitations are what reviewers look for.
3. Confirm step therapy requirements early	Ask your provider or insurer what must be tried first, how long, and what documentation is needed. If you have already completed these steps — even years ago — make sure that history is documented and included.
4. Verify coverage and network status before submission	Even medically appropriate care may be denied if the provider is out of network, a referral was not obtained, or authorization was not requested before scheduling. Confirm all administrative requirements first.
5. Provide a pharmacy history printout	For medication authorizations, request a printed medication history from your pharmacy — especially if you have used multiple pharmacies over time. This is one of the most requested documents and one patients rarely think to bring.
6. Keep insurance information current	Outdated or incorrect insurance details can cause a denial before clinical review even occurs. Notify the office of any plan changes, new insurance cards, or secondary coverage immediately.
7. Respond quickly to any information requests	Authorization staff often work under strict timelines. Delayed responses can stall the process or result in incomplete submissions. Check your portal, voicemail, and email regularly while a request is pending.
8. Ask what the insurer's criteria actually require	Coverage policies are often publicly available on insurer websites. Knowing what criteria apply — specific diagnoses, required prior treatments, BMI thresholds — allows you and your provider to build a more targeted submission.

The Single Most Common Preventable Denial

Missing step therapy documentation is the leading cause of preventable denials. Insurance companies routinely deny requests because prior treatment history is missing — not because the care is inappropriate.

If you completed step therapy years ago or with a different provider, that history must be actively gathered and submitted. It does not transfer automatically between systems.

What to gather before submission:

- Pharmacy medication history printout (ask your pharmacy directly)
- Records from previous providers — even from years ago
- Physical therapy documentation
- Hospital or ER visit summaries related to the condition
- Any specialist evaluations, even outside your current network

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