

WHY YOUR REQUEST WAS DENIED

And what to do about it

A denial is not a final answer. It is usually a statement about documentation and coverage rules.

This guide is for informational purposes only and does not constitute legal, medical, or financial advice.

NITI LOGIC · DECISION SYSTEMS, DECODED. · nitilogic.com

A Denial Is Not a Judgment

Receiving a denial can be frustrating, especially when your provider believes the treatment is appropriate. In most cases, a denial does not mean the care is unnecessary. It usually means the submitted information did not meet the insurer's criteria at the time of review.

Understanding the most common reasons gives you and your care team the information needed to respond effectively.

The Most Common Denial Reasons

1. Incomplete Documentation

Insurance reviewers make decisions based only on what is submitted. If important details are missing, the reviewer may not be able to determine that the criteria are met.

Common missing elements:

- Prior treatments that were tried but not documented
- Physical therapy or conservative care history
- Outside testing or specialist evaluations
- Medication history from other providers
- Functional limitations or severity of symptoms

Information that exists but is not included in the authorization request is typically not considered. Documentation must be submitted, not just available.

2. Step Therapy Requirements Not Met

Many plans require lower-cost or less intensive treatments to be attempted before approving more advanced options.

- Trying standard medications before specialty drugs
- Completing physical therapy before surgery
- Attempting conservative treatment before advanced imaging
- Using preferred formulary medications first

If prior treatments were completed years ago or at another clinic, documentation may not be available unless it is specifically requested and provided.

3. Diagnosis Does Not Match Coverage Criteria

Coverage policies often specify which diagnoses qualify for a service. If the diagnosis code submitted does not align with those criteria, the request may be denied — even if the treatment is medically appropriate. In some cases, additional related diagnoses or comorbidities were not included even though they are relevant.

4. Insufficient Severity or Functional Impact

Some approvals depend on demonstrating how significantly the condition affects daily life. Documentation may need to show:

- Limitations in work or daily activities
- Reduced mobility or endurance
- Sleep disruption
- Inability to perform self-care tasks
- Failure to improve with prior treatment

If symptoms are described in general terms without indicating impact, the request may not meet criteria.

5. Administrative or Technical Errors

Denials sometimes occur due to non-clinical issues:

- Incorrect patient information
- Missing forms or signatures
- Submission to the wrong payer or processor
- Coding errors or incomplete attachments

6. Service Not Covered or Excluded

Some treatments are excluded entirely or covered only under specific conditions. Coverage rules vary widely between plans, even within the same insurer. Examples include off-label medication use, experimental treatments, weight loss medications on plans that exclude them, or procedures deemed not medically necessary for the submitted diagnosis.

7. Automated Screening Decisions

Many insurers use structured criteria and automated systems to evaluate requests. If the submitted information does not match expected patterns, the system may generate a denial before a human reviewer evaluates the case — even when the treatment is clearly appropriate.

What Happens Next

A denial is usually a statement about documentation and coverage rules — not a final verdict on whether you deserve care. Many denials can be addressed by:

- Providing additional documentation
- Correcting errors or missing information
- Demonstrating prior treatment history
- Submitting a formal appeal
- Requesting peer-to-peer review between your doctor and the insurer

Need step-by-step guidance specific to your denial? Run a PRISM analysis at nitilogic.com to identify which escalation path applies to your specific plan type, payer, and denial reason.

This guide is for informational purposes only and does not constitute legal, medical, or financial advice. © 2026 Niti Logic · nitilogic.com