ClaimCatch AI Free Denial Audit Report

Fictional finished sample. No real patient data or PHI.

Client: Bright Spine Chiropractic

Prepared by: ClaimCatch AI

Prepared date: July 11, 2026

Audit tracker source: ClaimCatch AI - Block 4 - Free Denial Audit Workflow - Audit Tracker Template

Audit scope: 10 denied or written-off chiropractic claims

Important note: This audit is an administrative review based only on records provided by the clinic. It does not guarantee payer payment and does not replace the clinic's clinical, coding, billing, or legal responsibilities.

1. Executive Summary

ClaimCatch AI reviewed 10 old denied or written-off chiropractic claims with a total denied amount of $4,860. The review found that 7 of the 10 claims have a realistic next action, either immediate appeal, corrected claim submission, or appeal after one missing proof item is added. Three claims should not be worked yet because the documentation packet or deadline proof is not strong enough.

Category	Count	Estimated Denied Amount
Strong appeal candidates	3	$1,690
Possible appeal candidates	2	$980
Corrected claim needed first	2	$860
Missing documentation	2	$980
Payer record/EOB incomplete	0	$0
Deadline risk	1	$350
Weak/do not pursue	0	$0
Total reviewed	10	$4,860

Estimated recovery opportunity: $1,650 - $2,850

Confidence: Medium

Main finding: The strongest recovery path is concentrated in Medicare-style maintenance denials where active treatment is supported by objective documentation, plus one commercial bundling denial where modifier 59 appears supported by distinct anatomical sites.

Immediate work queue:

- Appeal now: Claims 01, 03, and 07.
- Correct first, then resubmit/appeal if needed: Claims 02 and 06.
- Work only after missing proof is added: Claims 04, 05, 08, 09, and 10.

2. Top Denial Patterns Found

1. Active chiropractic treatment was denied as maintenance even though notes showed recent injury or exacerbation, PART findings, functional deficit, and measurable progress.
2. Modifier handling created preventable denials, especially missing AT on Medicare-style active treatment and modifier 59 support for separately payable manual therapy.
3. Documentation gaps are delaying otherwise possible appeals, especially missing treatment plans, functional progress measures, region-count support, and appeal-deadline proof.

3. Claim-by-Claim Summary

Audit ID	Payer	DOS	CPT/Modifier	Denial Reason	Denied Amount	Score	Category	Recommended Action
Claim 01	Medicare Part B	03/14/2026	98941-AT	CO-50, maintenance	$620	5	Strong appeal candidate	Appeal with active-care proof
Claim 02	Medicare Part B	03/18/2026	98940	Maintenance/no AT	$310	4	Corrected claim needed first	Submit corrected claim with AT and billing-error explanation
Claim 03	BCBS PPO	03/20/2026	98942 + 97140-59	97140 bundled into CMT	$540	5	Strong appeal candidate	Appeal 97140 with distinct-region documentation
Claim 04	Aetna PPO	03/21/2026	98941	Records insufficient	$460	3	Missing documentation	Obtain initial exam and treatment plan before appeal
Claim 05	UHC Medicare Advantage	03/25/2026	98941-AT	Medical necessity	$590	4	Possible appeal candidate	Appeal after progress note or OAT measure is added
Claim 06	Cigna PPO	03/26/2026	98942	Region count unsupported	$550	3	Corrected claim needed first	Downcode/correct if only 3-4 regions are documented
Claim 07	Medicare Part B	03/29/2026	98940-AT	CO-50, maintenance	$530	5	Strong appeal candidate	Appeal with exacerbation, PART findings, and treatment-plan goals
Claim 08	BCBS PPO	04/01/2026	99213-25 + 98940	E/M bundled	$390	3	Possible appeal candidate	Appeal only if separate E/M rationale is documented
Claim 09	Humana MA	04/04/2026	98941-AT	Documentation missing	$520	2	Missing documentation	Request SOAP note, initial exam, treatment plan, and payer record
Claim 10	Medicare Part B	01/05/2026	98941-AT	CO-50, maintenance	$350	2	Deadline risk	Verify appeal deadline before any appeal work

4. Strongest Recovery Opportunities

Claim 01 - Medicare Part B

Why it is worth action:

- The denial states maintenance, but the file describes an acute exacerbation after a lifting injury.
- Initial exam documents subluxations at L3-L5 and T10-T12.
- PART findings are present: pain on palpation, asymmetry, restricted lumbar range of motion, and hypertonicity.
- Functional improvement is measurable: ODI improved from 42% to 30%, and lumbar flexion improved from 40 degrees to 48 degrees.
- AT modifier was present, supporting active/corrective treatment rather than maintenance care.

Recommended next step: Prepare and submit a Medicare medical-necessity appeal with the SOAP note, initial exam, treatment plan, ODI scores, ROM findings, and the payer EOB.

Missing proof: None identified from the sample packet.

Estimated recoverable: $470

Claim 03 - BCBS PPO

Why it is worth action:

- Denial bundled 97140 into 98942, but the SOAP note separates the anatomical sites.
- Manual therapy was documented in the cervical region.
- CMT was documented in the lumbar, thoracic, and pelvic regions.
- Modifier 59 was billed and appears supported because the services were performed on distinct regions.
- The payer policy path is narrow but favorable when distinct-region documentation is clear.

Recommended next step: Submit an appeal for separate payment of 97140 using the SOAP note, modifier 59 explanation, and payer policy language on distinct procedural service.

Missing proof: Confirm the current BCBS PPO modifier 59 policy excerpt before submission.

Estimated recoverable: $350

Claim 07 - Medicare Part B

Why it is worth action:

- The denial states maintenance, but the note supports active corrective care for a documented flare.
- Subluxation level and PART findings are present.
- Treatment plan includes frequency and a measurable ROM goal.
- The patient had not returned to baseline at the date of service.

- AT modifier was present.

Recommended next step: Appeal with a maintenance-care rebuttal, emphasizing active treatment, objective findings, measurable goals, and lack of return to baseline.

Missing proof: Add prior baseline note if available.

Estimated recoverable: $425

Claim 02 - Medicare Part B

Why it is worth action:

- The denial appears driven by a front-desk billing error: AT modifier was omitted.
- Clinical file supports active treatment for C5-C6 subluxation with radiating arm pain after an MVA.
- Active treatment plan is on file with 2x/week frequency and measurable goals.
- The patient was improving, which weakens the maintenance-care denial.

Recommended next step: Submit a corrected claim with the AT modifier first. Include a short appeal cover letter stating that the missing modifier was a billing error and that active-treatment documentation is enclosed.

Missing proof: Attach the initial exam, active treatment plan, and most recent progress note.

Estimated recoverable: $230

5. Claims Not Recommended Right Now

Audit ID	Reason Not Recommended Right Now	What Would Change the Decision
Claim 04	Payer requested records, but the sample packet does not include the initial exam or treatment plan	Initial exam, treatment plan, and SOAP note for DOS
Claim 09	Documentation packet is too incomplete to rebut the payer's reason	SOAP note, initial exam, treatment plan, payer request, and EOB
Claim 10	Appeal deadline may already be expired	EOB showing deadline or proof the appeal window is still open

6. Missing-Proof List

The following items should be collected before finalizing the appeal packet:

- Claim 04: initial exam, treatment plan, and DOS SOAP note.
- Claim 05: progress note or objective OAT/ROM measure showing improvement.
- Claim 06: region-count support for 98942, or corrected CPT level if only 3-4 spinal regions are documented.
- Claim 08: separately identifiable E/M rationale supporting modifier 25.
- Claim 09: complete documentation packet and payer records request.
- Claim 10: EOB or portal screenshot confirming the appeal deadline.

7. Recommended Next 7 Days

1. Build appeal packets for Claims 01, 03, and 07 first because they have the clearest documentation support and highest appealability scores.
2. Submit corrected billing work for Claims 02 and 06 before writing full appeals.
3. Request missing documents for Claims 04, 05, 08, 09, and 10 using a one-page clinic checklist.
4. Confirm appeal deadlines for every claim before spending time on packet drafting.
5. Log final status in the audit tracker under Recommended Action, Estimated Recoverable, Reviewer Notes, and Client Follow-Up Needed?.

8. Tracker Notes for Internal Use

This sample report was built from the audit tracker layout. The most important columns for report generation are:

- Denied Amount
- CARC
- RARC
- Payer Denial Wording
- Documents Received
- Missing Documents
- AT Modifier Needed?
- AT Modifier Present?
- Separate Site Support for 59?
- Separate E/M Support for 25?
- Primary Category
- Appealability Score
- Recovery Confidence
- Recommended Action
- Estimated Recoverable
- Reviewer Notes

For real client work, the tracker should be completed before the report is generated. The report should never invent missing documentation; it should either use the exact evidence present in the tracker or list the missing item under Missing-Proof List.

9. How ClaimCatch AI Can Help

ClaimCatch AI can prepare the appeal packets, corrected-claim recommendations, and missing-document request list for claims marked as strong, possible, or corrected-claim-first candidates.

Standard ongoing structure:

- $299/month
- 15% of recovered revenue
- No recovery fee unless money comes back

Suggested first paid work order:

- Appeals: Claims 01, 03, and 07.
- Corrected claims: Claims 02 and 06.
- Documentation retrieval: Claims 04, 05, 08, 09, and 10.

10. Disclaimer

This fictional report is for demonstration only. Real audit conclusions must be based on the clinic's actual records, payer policy, claim status, plan terms, prior submissions, and appeal deadlines. ClaimCatch AI does not guarantee payment and does not provide legal, medical, or clinical services.