

MoodRx Reports Medical Claim Denial Rate Declined From More Than 10% to Less Than 0.5%

A year-long effort to reduce medical claim denials became the foundation for ClaimsRevenue™, built for independent healthcare practices.

ST PETERSBURG, FL, UNITED STATES, August 28, 2026 /EINPresswire.com/ -- When behavioral healthcare provider MoodRx began taking a closer look at its revenue cycle, more than 10% of its medical claims were being denied.

Rather than accepting denials as an unavoidable part of medical billing, the company spent approximately a year systematically examining its claims process and the factors associated with successful reimbursement.

The result was dramatic.

MoodRx reduced its claim denial rate from more than 10% to less than 0.5%.

What the company learned during that process ultimately became the foundation for ClaimsRevenue™, a healthcare claims technology platform launching September 1 for independent medical and allied health practices.

“We didn't get from more than 10% denials to less than 0.5% by finding one magic rule,” said Sami Quazi, Founder of ClaimsRevenue. “We got there by recognizing that a medical claim is part of a much larger process. There are many variables that can influence whether a claim is successfully adjudicated, and you have to look at those variables together.”

Looking Beyond Required Fields

The effort initially focused on improving the accuracy and completeness of professional medical



The graphic is a promotional announcement for ClaimsRevenue. At the top left is the ClaimsRevenue logo, which includes a blue bar chart icon and the text 'ClaimsRevenue™' with the tagline 'SMARTER CLAIMS. STRONGER REVENUE. BETTER PATIENT CARE.' below it. To the right of the logo, the text 'I'M PROUD TO ANNOUNCE' is in small blue letters, followed by 'I FOUNDED CLAIMSREVENUE™' in large, bold white letters. Below this, a paragraph states: 'After spending three years developing and refining claims accuracy technology and processes at MoodRx—and achieving a denial rate under 0.5%—I founded ClaimsRevenue™ to bring that same expertise to other healthcare practices.' A blue box with a calendar icon contains the text 'PUBLIC LAUNCH SEPTEMBER 1, 2026'. On the left side of the graphic is a photo of Sami Quazi, a man with a beard and mustache, wearing a black turtleneck, with his arms crossed. Below the photo, his name 'SAMI QUAZI' and title 'FOUNDER & CHAIRMAN ClaimsRevenue™' are listed. At the bottom left, a blue box with a bar chart icon says 'THREE YEARS. REAL RESULTS. NOW WE'RE BRINGING WHAT WE LEARNED TO YOU.' At the bottom right, a blue box with a shield icon says 'YOUR PRACTICE EARNED THE REVENUE. PROTECT IT.' In the center, between the photo and the bottom boxes, are five icons with corresponding text: a shield for 'CATCH CLAIM ISSUES BEFORE SUBMISSION', a magnifying glass for 'UNCOVER DENIAL TRENDS & PAYER BEHAVIOR', a brain for 'LEARN FROM YOUR OWN DATA TO IMPROVE FUTURE ACCURACY', a clock for 'SPEND LESS TIME ON BILLING & MORE ON PATIENTS', and a group of people for 'BUILT FOR INDEPENDENT HEALTHCARE PRACTICES'.



We reduced our own claim denial rate from more than 10% to less than 0.5% by treating every denial as information we could use to improve the next claim."

Sami Quazi, Founder & Chairman

claims before they were submitted.

It quickly became apparent, however, that checking whether required information was present was only the beginning.

A claim can contain all of the required information and still encounter problems during adjudication.

MoodRx therefore expanded its approach to examine claims more comprehensively, including the relationships

among clinical, billing, provider, payer, and historical claims information.

The question evolved from simply asking whether a claim was complete to asking whether the claim made sense as a whole.

That distinction eventually became an important principle behind Claims Validator™, one of the core capabilities within ClaimsRevenue.

Learning From Claims That Had Already Been Processed

Another important source of information was the practice's own claims history.

Every time a payer processes a claim, the result provides information about what happened.

Instead of viewing a denial or adjustment only as a transaction that needed to be corrected, MoodRx began treating previous payer outcomes as information that could help improve future claims.

Over time, the company systematically analyzed previously adjudicated claims to identify recurring patterns and better understand the factors associated with successful reimbursement.

That historical perspective became another important part of the methodology behind ClaimsRevenue.

"If something happened repeatedly in our previous claims, we wanted to understand it," Quazi said. "A denial shouldn't just tell you what happened yesterday. It should teach you something that can potentially make tomorrow's claim better."

That philosophy ultimately contributed to the development of ERA Analyzer™, which helps practices analyze Electronic Remittance Advice information and identify recurring patterns in

payer responses.

ClaimsRevenue connects those historical insights with future claim review so information from previous claims can become more useful to the practice over time.

The Claim Form Is Only Part of the Revenue Cycle

The work also reinforced an important lesson: not every denial begins with an error on the claim form.

Successful reimbursement depends on a broader revenue-cycle environment.

MoodRx strengthened the operational processes surrounding its claims, including payer participation, provider credentialing, and patient eligibility verification before services were provided.

Those operational controls worked alongside increasingly sophisticated claim review.

“We learned very quickly that you can't look at a CMS-1500 in isolation and expect to understand every denial,” Quazi said. “The claim is part of a larger process. You have to get the fundamentals right and then understand the information within the context of the entire claim.”

Approximately 20% Discipline and 80% Understanding the Environment

Quazi describes the approach that emerged as approximately 20% operational discipline and 80% understanding a multivariable environment.

The discipline involves consistently performing the fundamental revenue-cycle activities that every practice needs to get right.

The larger challenge is understanding how the many pieces of information surrounding a professional medical claim relate to one another and how those relationships can affect the probability of successful reimbursement.

ClaimsRevenue was developed around that concept.

Rather than viewing a professional claim as simply a collection of required fields, the platform evaluates claims within a broader context and helps identify conditions that may warrant additional review before submission.

The objective is not to guarantee that a payer will reimburse a particular claim. Payer adjudication ultimately remains outside the control of the provider and ClaimsRevenue.

The objective is to help practices identify more potential problems while they still have an opportunity to address them.

From an Internal Problem to a Commercial Product

ClaimsRevenue was not originally conceived as a commercial software product.

It grew out of an operational problem MoodRx was trying to solve within its own healthcare business.

Over approximately one year, the company continued refining its approach, measuring results, analyzing payer outcomes, and developing technology to make the process more systematic.

As the denial rate declined, the company recognized that the underlying approach could potentially help other independent healthcare practices facing many of the same challenges.

“ClaimsRevenue wasn't developed by building software first and then searching for a problem,” Quazi said. “We had the problem ourselves. We worked on it for a year, measured what happened, learned from the results, and built technology around what worked. Eventually we realized that other practices could benefit from what we had learned.”

That internal effort evolved into ClaimsRevenue.

Giving Smaller Practices Better Tools

Large healthcare organizations can employ teams dedicated to [revenue cycle management](#), coding, analytics, denials, credentialing, and payer management.

Independent practices frequently operate with far fewer resources while navigating many of the same billing requirements.

ClaimsRevenue was created specifically for those healthcare provider offices.

The platform combines Claims Validator and ERA Analyzer to help practices review professional claims before submission, understand what happened after payer adjudication, and make better use of their own historical claims experience.

ClaimsRevenue does not guarantee that customers will achieve MoodRx's denial rate. Every practice has different patients, providers, payers, procedures, workflows, and claims experience.

The MoodRx result demonstrates what prompted the development of the platform and the philosophy behind it: reducing denials requires looking beyond individual errors and

understanding the broader environment surrounding the claim.

“For us, getting below 0.5% wasn't the result of one breakthrough,” Quazi said. “It was the result of continually learning what contributed to successful claims and applying what we learned. ClaimsRevenue grew out of that experience.”

ClaimsRevenue officially launches to U.S. healthcare practices on September 1, 2026.

The platform supports professional medical claims using the CMS-1500/837P format and is designed for primary care, physician specialties, medical and surgical practices, behavioral and mental health practices, physical therapy, occupational therapy, and other medical and allied health provider offices.

More information and a product demonstration are available at ClaimsRevenue.com.

About ClaimsRevenue

ClaimsRevenue is a healthcare technology platform built for independent medical and allied health practices. The platform helps practices validate professional medical claims before submission, analyze Electronic Remittance Advice, and identify patterns that may contribute to claim denials, payment delays, and lost revenue.

By connecting pre-submission claim validation with insights from previously adjudicated claims, ClaimsRevenue helps healthcare provider offices make better use of their own claims experience when reviewing future claims.

ClaimsRevenue is operated by MoodRx LLC, d/b/a ClaimsRevenue, a Florida limited liability company.

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