

Building a Healthier Revenue Cycle

Strategies for Reducing Denials and Improving Financial Performance

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operation

Today's medical practices often struggle to meet the increasingly complex demands of revenue cycle management (RCM).¹ Despite this increased complexity, many practices still rely on error-prone manual processes for submitting, tracking, and following up on claim submissions.^{2,3}

Often, individual submissions lack clear ownership, resulting in sporadic follow-up. The essential work of researching and appealing denials often slips through the cracks. If required appeals are not resubmitted before payer deadlines, the practice can lose the opportunity to recover payment, even when the initial denial was in error.⁴

In the past few years, evolving government regulations, complicated billing codes, and payers' highly variable claim submission requirements have led to increased claim denials and steadily declining reimbursement rates.⁵ Every one of those denials comes at a high cost, adding time, decreasing patient satisfaction, and delaying payments.⁶ The result? The traditional claim submission workflows, employed by many independent practices, are no longer adequate to navigate the rapidly changing healthcare reimbursement landscape.³





Independent practices lose more revenue to billing than they realize

CLAIM DENIALS ARE NO LONGER THE RARE EXCEPTION, BUT A PERSISTENT AND WELL-DOCUMENTED CHALLENGE IN HEALTHCARE REIMBURSEMENT.^{7,8}

This section reveals how rising claim denials, costly appeals, and manual billing processes create significant revenue loss for independent practices. As denials and administrative burdens increase, delayed payments, write-offs, and manual lag can further erode a practice's financial performance.

Increasing denial rates

Claim denial rates, the frequency with which claims are rejected, are clearly increasing.^{8,9} The American Medical Association (AMA) reported a 37% increase in claims denials from 2021 to 2023.⁵ Similarly, a Medical Group Management Association (MGMA) poll found 60% of 235 medical groups surveyed reported higher denial rates in 2024 than in the previous year.¹⁰

Nearly 15% of all claims submitted to private payers were initially denied, even though an average of 3.2% of those denied claims were pre-approved. In other words, claims were denied even after the practice had invested time and energy in pre-approval to avoid the risk of denials and the added time and effort required by an appeal.¹¹

Some analysts suggest payers have started employing a "deny first, ask questions later" policy to delay payment. Another popular strategy is nicknamed "Death by a Thousand Requests," where payers use requests for information to initially deny and ultimately delay claims.^{5,12}

As a result, claim denials have become one of the biggest revenue leaks in health care. This is partly due to denials that remain unresolved and unpaid.^{8,13} The financial impact of unresolved claims is evident in industry data for HealthCare.gov insurers, a group that denied about 19% of in-network claims in 2023. These denials totaled \$73 million out of \$319 million worth of claims filed. For the \$33 million of out-of-network claims, the denial rate was even higher at 37%.⁴

The high cost of appeals & write-offs

More than 54% of initially rejected claims are ultimately overturned and paid, but only after multiple, costly rounds of appeals.¹⁴ In a single year (2023), fighting denials cost providers an estimated \$19.7 billion. More than half that amount (\$10.6 billion) was spent arguing claims that should have been paid when first submitted.¹¹

Research suggests that reworking a denied claim costs practices between \$25 and \$181 and places a significant additional burden on revenue cycle teams.^{4,8} This number does *not* include costs associated with added clinical labor, which the AMA estimates add between \$13.29 for claims related to general inpatient stay and \$51.20 for claims related to inpatient surgery.¹¹

These high costs mean about two-thirds of denials go unaddressed.⁴ Some practices may decide appeals are not worth the effort. Others lack the time and resources needed to dispute every rejected claim. Thirty-six percent of practices report that staffing shortages slow their claim submissions, further exacerbating the problem.^{15,16} Even when staff are available, they often lack the specialized training required to successfully appeal every type of denied claim.⁵

This means 65% of denials are simply written off, directly impacting the practice's financial stability.^{17,18}

The invisible drain caused by manual lag

Claim denials have become an operational bottleneck for today's medical practices. The hours spent on rework, resubmission, and follow-up on denied claims consume additional resources, which, in turn, have a financial cost. That cost is visible in healthcare's rising administrative costs: in 2025, the U.S. healthcare system spent \$60 billion on administrative tasks, a 4-year increase of \$18 billion.¹⁸



37%

INCREASE IN CLAIM DENIALS FROM 2021 TO 2023, PER THE AMA



\$19.7B

SPENT BY PROVIDERS FIGHTING DENIALS IN A SINGLE YEAR

However, practices often fail to recognize the downstream financial consequences resulting from claim denials, consequences beyond the payment delays caused by the time required to rework, resubmit, and follow up on denials. For many practices, though, each denial also creates a “manual lag” that further delays or interferes with payment.

Many practices use manual processes for part or all of claims submission, resubmission, and follow-up. Manual lag refers to the impact these manual steps have on charge lag, which is the time gap between a patient visit and when the associated claim is actually submitted.^{19,20} When eligibility checks, coding, charge entry, claim scrubbing, and other steps are performed manually, that gap increases. Every extra day a claim remains unsubmitted increases the number of billing days in accounts receivable (A/R), representing cash earned that has not been collected.²¹

As manual lag increases, it increases the likelihood of encountering other obstacles to reimbursement. Claims become more likely to exceed payers’ timely filing deadlines. Claims filed past these deadlines result in hard denials that often cannot be appealed. Increased manual lag may also mean staff have to handle appeal and follow-up processes manually, further delaying denial processing.

As manual lag increases, the number of denials that are not reworked and eventually written off also increases. Even denials that are paid eventually increase administrative and clinical labor costs. They also delay payments, often significantly. As a result, each denial incrementally reduces your practice’s potential revenue.¹⁶



The hidden cost of using multiple disconnected billing vendors

LARGE PRACTICES MANAGE 6 TO 8 RCM VENDORS ON AVERAGE,²³ AND EVEN A SOLO OR TWO-PROVIDER PRACTICE FEELS THE SAME FRAGMENTATION, JUST WITHOUT THE STAFF TO ABSORB IT.

Managing multiple billing vendors can create hidden costs and inefficiencies across the revenue cycle, impacting everything from productivity and data accuracy to revenue and patient satisfaction.

The need for seamless coordination

A common myth in the healthcare industry is that the optimal RCM system is created by assembling the best individual solution for each step. This is why many providers adopt different software solutions for different tasks. For example, a practice might adopt different software tools for scheduling, invoicing, and compliance tracking.²²

However, the complexities of medical billing require seamless coordination between every step in the process: scheduling, client management, billing, compliance management, and more. Relying on multiple disconnected platforms may seem effective initially, but can quickly create inefficiencies and increase operational costs.²²

By juggling multiple specialized vendors, providers lose the opportunity to work with a single accountable partner.²³ This means the average ambulatory practice loses a significant amount of collectible revenue.²⁴ This financial loss is not due to fraud, difficult payers, or undercoding, but rather to administrative friction caused by the need to manage multiple RCM vendors.

A one- or two-provider practice may not be running eight separate systems, but it’s often juggling several: scheduling, billing, a clearinghouse, patient payments, without a dedicated person to manage the handoffs between them. That’s what makes fragmentation expensive at any size. It’s not the number of vendors, it’s the absence of someone whose job it is to make them talk to each other.

THE COST OF A
FRAGMENTED
RCM STACK



6-8 VENDORS

USED IN A TYPICAL LARGE-
PRACTICE RCM WORKFLOW



40+ HOURS PER
MONTH

SPENT MANAGING VENDORS
AT LARGE PRACTICES



18-24 MONTHS

NEEDED FOR MAJOR SYSTEM
CHANGES AT LARGE PRACTICES

The resulting costs

Using multiple systems for RCM workflows can quickly become a financial burden. Each software system comes with its own subscription, training, and maintenance costs. These expenses quickly add up, often making the system more expensive than a single, all-in-one software solution.²²

One of the greatest costs of using multiple software systems is the increased time required and the resulting loss of productivity. Both providers and staff often have to switch between multiple systems to complete routine tasks, such as updating a patient's care plan. Every time work is duplicated, it wastes time and increases the risk of errors.²²

Integration costs also escalate with each additional vendor system added. System complexities can necessitate custom integrations costing between \$50,000 and \$200,000 each, plus the added cost of dedicated IT resources required for ongoing maintenance. Complexities can also extend beyond simple software integrations. For example, separate systems can create data silos that interfere with data visibility. This can force staff to transfer data manually, creating bottlenecks that affect users throughout the practice.²³

Another resulting cost is management overhead, arising from the need for clinical and administrative leaders to serve as full-time vendor coordinators in addition to their other responsibilities. The average practice spends more than 40 hours monthly on vendor management.²³

Innovation paralysis cost emerges when fragmented software systems are unable to evolve together. This forces a technological freeze in which only major system changes are possible, and these can require 18 to 24 months of implementation time due to the complexity of coordinating the various software components.²³

Data discrepancies, errors, & lack of accountability

Data discrepancies and errors also become a significant issue when practice data is spread across multiple platforms. Unconsolidated data can result in inconsistent client records, scheduling conflicts, and incorrect billing information. Such errors, in turn, lead to delayed payments and compliance violations.²²

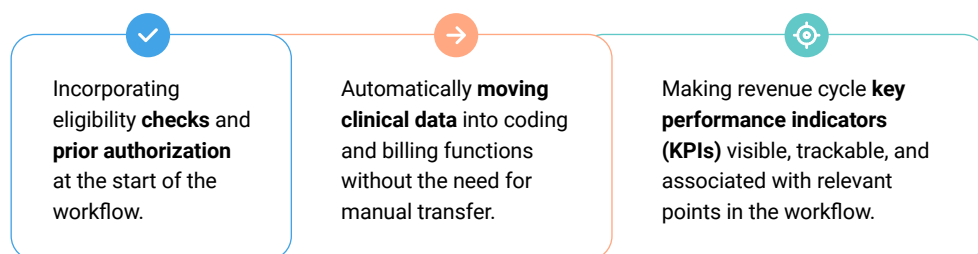
In a fragmented RCM environment, accountability often becomes an issue. When errors arise, no one wants to take responsibility. The burden of resolving such errors, which often involve multiple software platforms, falls back on your practice.²³

Client satisfaction

Another hidden cost of employing multiple systems is the impact on client satisfaction. Multiple systems often create communication delays between clients, providers, and administrative staff. When providers cannot easily access up-to-date patient information, it can delay coordination of patient services and interfere with care management, frustrating both patients and caregivers.²²



Accurate RCM management requires a system that treats clinical documentation and revenue cycle management as parts of a single workflow rather than as separate, independent functions.²⁴



The evidence is clear—nearly all of practices using an end-to-end RCM solution, rather than a collection of separate “optimal” software platforms, report decreases in claim denial rates, faster resolution of claim denials and appeals, and lower RCM operational costs.²³



Measuring the health of your billing operation

A HEALTHY MEDICAL BILLING PROCESS AND RCM WORKFLOW ARE ESSENTIAL FOR YOUR PRACTICE'S LONG-TERM FINANCIAL SUCCESS.

Tracking key revenue cycle KPIs against industry benchmarks can help practices identify revenue leaks, prevent denied claims, and assess overall financial performance. The KPIs in this section are among the most critical.^{19, 25}



MONITORING KPIs ENABLES YOUR PRACTICE TO:

- ✓ **Compare** performance with industry benchmarks
- ✓ **Identify** inefficiencies and bottlenecks
- ✓ **Implement** targeted improvements
- ✓ **Streamline** workflows
- ✓ **Measure** progress over time
- ✓ **Catch** revenue leaks and billing problems early

Sources: 18, 19, 25

Clean claim rate

WHAT IT IS

The percentage of claims accepted on initial submission without correction or denial.^{19, 25}

WHY IT MATTERS

Indicates billing accuracy; higher rates reduce rework, denial-management costs, and payment delays.¹⁹

TARGET

95% or higher for top-performing practices^{19, 25, 26}

A high clean claim rate indicates a high level of overall billing accuracy. Improving this KPI translates to benefits such as helping your practice reduce time spent on administrative rework for returned claims and reduce denial management costs. Most importantly, improvements will help your practice reduce payment delays.¹⁹

A low clean claims rate reveals weakness in the quality of your claims processing, particularly in the front end. Numerous factors can cause your clean claim rate to decrease, such as missing or inaccurate information, incomplete documentation, or imprecise coding. Information from returned claims can help you pinpoint exactly where your process needs improvement.²⁵

Claim denial rate

WHAT IT IS

The percentage of submitted claims denied due to errors.²⁷

WHY IT MATTERS

Higher rates increase administrative costs and may signal eligibility, PA, documentation, or coding issues.^{16, 19}

TARGET

Under 5% ideal; 2% for top performers^{16, 19, 25, 27, 28}

Higher denial rates indicate preventable RCM problems such as eligibility check failures, PA issues, documentation deficiencies, or coding errors.^{16, 19} Tracking this KPI allows your practice to make corrections and improvements. Improving this KPI requires you to monitor denial trends to identify patterns: Are denials associated with a particular payer? Is there a common reason for denials? By identifying such patterns, you gain insight into the causes of denials, allowing you to make changes to decrease your overall denial rate.^{19, 25}

Net collection rate

WHAT IT IS

Adjusted collection rate—percentage of collectible reimbursement actually received.²⁵

WHY IT MATTERS

Measures collection effectiveness; low rates can indicate billing errors, poor follow-up, underpayments, or excessive write-offs.^{19, 27}

TARGET

95% or higher; highest performers achieve a min. of 99%^{19, 27}

A low net collection rate suggests the need to improve your practice's payor contract management. It may indicate problems with billing errors, ineffective follow-up, or underpayments. It may also reflect an inappropriate number of write-offs in the collections process.^{19, 27} By monitoring collection data, you can identify missed charges, underpayments, and other instances where an insurance company failed to provide the contractually specified payment for service.²⁵

Days in A/R

WHAT IT IS

Average time between providing services and receiving reimbursement.

WHY IT MATTERS

Measures collection efficiency; higher A/R delays cash flow and can reveal billing inefficiencies.^{20, 27}

TARGET

30–40 days preferred; under 50 days minimum.^{19, 25, 27}

Increasing days in A/R directly delays cash flow and can affect a practice's financial stability.²⁷ Tracking this KPI helps identify opportunities to improve the revenue cycle.²⁰ This KPI has multiple potential causes, such as documentation inefficiencies or a failure to track claims and follow up when needed. Days in A/R can also result from unidentified bottlenecks in the claims process. This makes it important to identify the exact reasons for payment delays to identify targets for improvement.²⁵

Charge lag days

WHAT IT IS

Days-to-bill—average time from a patient visit to submission of the related claim.

WHY IT MATTERS

Longer lag delays the entire revenue cycle, increases A/R, and can reveal manual workflow or documentation/coding issues.^{2, 3, 9, 21, 23}

TARGET

Under 3–5 days^{21, 29}

High charge lag can signal workflow issues in documentation or coding and is often increased by manual processes such as eligibility checks, charge entry, and claim scrubbing.^{2, 3, 9, 23} To improve this KPI, examine the amount of time currently required for each step in the billing workflow. What steps are performed manually? Automating steps such as eligibility checks, coding, charge entry, and claim scrubbing can significantly reduce the time required to prepare and submit claims.^{2, 3, 9, 13, 25}

WARNING SIGNS YOUR CURRENT BILLING SETUP IS UNDERPERFORMING

Tracking these KPIs can help practices identify where billing processes need improvement. By monitoring trends and identifying patterns, practices can pinpoint the causes of payment delays and denials and target opportunities for improvement.

MEASURE	WARNING	WHAT IT MAY INDICATE
Clean claim rate too low	Below 90%	Weakness in claims processing, particularly the front end
Claim denial rate too high	10%	Coding errors, incomplete documentation, or eligibility and prior authorization issues
Net collection rate too low	90%	Missed charges, underpayments, or payor contract management issues
Days in A/R too high	50+ days	Documentation inefficiencies, follow-up issues, or claims-process bottlenecks
Charge lag days too high	Above 3–5 days	Delays in early billing steps, often from manual revenue cycle processes

Sources: 16, 18, 19, 21, 25, 28, 29



What to look for when choosing an integrated system

HOW DO YOU IDENTIFY THE RIGHT TECHNOLOGY FOR YOUR PRACTICE AND SITUATION?
YOU START BY IDENTIFYING YOUR PRACTICE'S REVENUE CYCLE NEEDS.

To successfully fight claim denials, your practice requires the right technology resources, not just a collection of solutions that may not work together effectively.

Revenue cycle front end

The front end of the revenue cycle is the initiation point for many issues with charge lag and claim denials. Each of these features helps tackle preventable denials at their source, making them essential elements of an effective integrated system:^{18,30} Key features include:

■ Automatic benefits and eligibility verification

Look for a system that verifies patient eligibility and benefits automatically before their visit. Clarify whether checks are performed in real time or require staff to key in individual requests for each patient visit.

■ Automatic patient data verification

Ensure the system verifies and updates patient information in a timely manner. Where needed, the system should also educate staff on ways to improve the quality of patient data.

■ Automatic flow of charges from clinical notes

An effective system will automate the flow of charges directly from patients' clinical notes, without the need for staff to re-enter them. This step eliminates one of the major causes of charge lag. It is also the single clearest sign of a true integrated system rather than 2 systems simply bolted together. To check whether this step is effective, ask providers how many steps they must complete after closing a note before the claim is ready.

Quality of submitted claims

Mid-revenue cycle optimization is also crucial for increasing your practice's clean claim rate and decreasing your denial rate. Key features to look for include:³⁰

■ Integrated claim scrubber software

Look for a system that automatically uses payer rules to "scrub" claims before submission. How are the rules used for scrubbing kept up to date? How often are they updated? Using the most up-to-date scrubbing rules is essential to improving your clean claim rate.

■ Relevant payer/clearinghouse connectivity

Confirm that the system covers the actual payer mix relevant to your practice's needs, without requiring a separate clearinghouse contract.

Revenue cycle back end: Denials and collections

The revenue cycle back end is where claim denials are resolved or fall through the cracks. An effective revenue cycle system should not simply identify problems in the revenue cycle; it needs to include tools to ensure denials are routed, tracked, and reworked to help you fix those problems.³⁰ Key features to look for include:

■ Structured denial management workflow

An effective system will help provide a structured denial management workflow to help you stay better organized and informed about the root cause of claim denials. This workflow should make it easy for users to respond quickly to correct denials and to consistently meet payer deadlines.

■ Automated claims management

An integrated system should not force users to review and track claims manually. It needs to provide technology to help you proactively identify, resolve, and prevent issues that might interfere with claims processing. It also needs to automate the process in a way that enables you to correct denied claims more quickly, preferably within a week, a goal that becomes possible with an established workflow to track claims through the system.

■ Track revenue cycle progress

Ask whether the system tracks the metrics introduced in the previous section. An effective system needs to track metrics *and* provide a dashboard where these and other metrics are easy to view and understand without ordering a custom-built report. Easy access to statistics such as denial rate, net collection, and total claims in A/R over 90 days gives insight into the reasons for high denial rates. Only with information about the causes of denials can you effectively improve workflows and make the corrections needed to reduce or eliminate problems.

Patient side of the revenue cycle

As patient payment responsibility increases, an increasing number of small practices experience quiet, but significant, revenue leakage in patient payments, making it essential to look for a system that incorporates patient-friendly features.

■ Integrated patient-friendly payment options

Today's integrated revenue cycle systems need to include patient-friendly options such as point-of-service collection, online payments, and clear statements accessible both on- and offline.

Product pricing, privacy, and support

Although the listed system features are crucial for identifying the right revenue cycle solution for your practice, it is equally important to investigate the system's cost, the vendor providing the system, and the quality of service and support provided with the system. Specific things to look for include:

■ System pricing

Look at *how* a system is priced, not just initial or month-to-month costs. Are charges based on a percentage of collections, a flat fee, per-provider fees, or some other payment model? Are there any additional costs, such as setup fees, support fees, or a clearinghouse connection fee? Always confirm that any price quote includes the system's total cost to avoid being surprised later by hidden costs.

■ Support and service model

Clarify whether the system provides "software" versus "software plus a billing service." These 2 billing models serve distinct practice needs. For instance, a 2-provider practice with no billing staff may need a system that includes both software and billing services; a practice with an experienced billing team is likely to need a software-only option. An integrated revenue cycle system is not the best answer for every practice. It is important to identify what setup will best fit your practice's unique needs.

■ Data ownership

Also learn who owns the patient data after it is entered into the system, and how you could export it if needed. Not all vendors make this information easily available, so practices need to ensure they have a clear understanding of data portability in case the need arises.

■ HIPAA compliance

Before selecting a new integrated system, confirm that every aspect of the system is HIPAA-compliant, and that the vendor has a signed Business Associate Agreement confirming they will handle patients' Protected Health Information securely and in compliance with federal privacy and security regulations.



YOUR NEXT STEP
TO A HEALTHY
BILLING
OPERATION

Although claim denial rates are steadily increasing, automation has the capacity to change the reimbursement landscape for your practice. By automating key steps in the revenue cycle process, you can significantly decrease errors, data discrepancies, and time spent re-working claims.⁸ You can increase your practice's clean claims rate and decrease the denial rate while simultaneously reducing costs and staff time demands.¹⁸

The most effective way to automate your practice's revenue cycle is not by adding on a host of separate solutions. The complexities of the modern healthcare revenue cycle necessitate a single integrated system, one that can seamlessly coordinate the many required steps in the revenue cycle, from patient intake and scheduling to billing to claim tracking and follow-up.²²

When you are ready to learn more about how an integrated revenue cycle system would benefit your practice, schedule a call today with one of our Practice Fusion Billing Specialists and prepare to see the difference it makes for your practice.

READY TO GET STARTED?

Contact us today at 415-993-4977 to schedule time with a representative | sales@practicefusion.com

GET STARTED TODAY

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