



# From Friction to Flow:

Building an Intelligence-Led Revenue Cycle for  
Faster, Cleaner Claim Throughput

Hospital and health system leaders are facing a troubling reality. Despite significant investments in denial management, denials continue to increase while reimbursement becomes less predictable.

Revenue is lost long before a claim reaches payer when denials are worked after the fact. Many organizations continue to focus on revenue recovery after it has been delayed rather than focus on the conditions that created the denial. The issue is not visibility. It is where and how problems are introduced. Revenue loss begins before a claim is submitted, but it is discovered after adjudication, when recovery is slower and more expensive.

Leading organizations are taking a different approach. Rather than treating denials as a back-end problem, they are redesigning revenue cycle operations to make decisions earlier and addressing payer requirements within the workflow. The focus is to resolve issues before the claim moves forward.

The result is cleaner claims, faster reimbursement, and more predictable financial performance.

## The Market Shift: From Reactive to Intelligence-Led RCM

Revenue cycle operations have historically been organized into separate stages with each stage evaluated on its own metrics while financial performance reflects the combined output of the process. Errors introduced early continue through the workflow and appear later as a denial or delayed payment.

The financial impact is significant.

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**15% of claims**

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Hospitals and health systems spent an estimated \$19.7 billion annually attempting to overturn denied claims, with roughly 15% of claims initially denied and more than half later reversed on appeal<sup>1</sup>. Those costs reflect work repeated because requirements weren't met at submission. Payer requirements have become more exacting. Claims are expected to meet authorization and documentation standards that are not always transparent before review.

Revenue cycle performance depends on how consistent decisions are made and executed before a claim leaves the organization. This requires an operating model where data guides workflow and accountability sits where issues are introduced. Without that structure, correction becomes the default.

High-performing organizations increasingly recognize that denials are not payer events. They are operational events that become visible during payer adjudication. The organizations outperforming their peers are focusing less on recovery and more on preventing denial conditions from occurring in the first place.

## The Throughput Imperative

Throughput breaks down when incomplete or misaligned information is allowed to move through the revenue cycle. A claim can leave access without complete eligibility verification, move past authorization without confirming payer requirements, or reach coding without documentation that supports the billed service. If these issues aren't resolved before submission, the claim reaches adjudication without meeting requirements and is denied or delayed. The work then shifts from claim completion to claim reprocessing. Teams must review the denial, compare it with the original submission, identify where the breakdown occurred, obtain or correct missing information, and often coordinate with the payer or provider. The claim is then rebuilt and resubmitted for adjudication.

The work then shifts from claim completion to reprocessing the claim. The denial reason is reviewed against the original submission and traced back to the point of failure. Missing information must be obtained or corrected, which may require contacting the payer or provider. The claim is then rebuilt and resubmitted for adjudication. This process constrains throughput because the claim reenters the workflow after submission, adding time and requiring coordination between teams that did not create the issue. Performance improves when issues are corrected before the claim moves forward. That requires clear decision points, consistent enforcement, and accountability built into the workflow.

## Denial Prevention: The Industry Moves Upstream

Traditional denial management efforts have focused on appeals and post-adjudication workflows. Those efforts address the outcome, not the root cause. The high volume of overturned denials shows that many claims were valid but failed to meet payer requirements when submitted. Prevention begins with how claims are built. Registration

must be complete before the encounter moves forward; authorization must reflect the service being delivered, and documentation must support what will be billed before coding. Payer requirements should be embedded in the workflow, so the claim meets them at submission. Outcomes related to payer policy should be evaluated by organization leaders to determine if payer escalation or payer alignment meetings are needed. Effective denial prevention starts where claims are created, ensuring accountability sits where the issue is introduced. Eligibility verification, authorization management, documentation integrity, and coding accuracy are not isolated functions. When that ownership is clear, issues are resolved before the claim moves forward. Analytics can identify patterns and direct attention, but performance improves only when those insights are used to correct the workflow as the work is being done.

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## Proactive Payer Management: Navigating a More Complex Reimbursement Environment

Payer requirements determine whether a claim that appears complete will be paid. Prior authorization must be secured before services are delivered, and approval depends on whether the claim meets payer rules at the time of review. Those payer expectations are not always clear at submission. A claim can meet internal standards and still fail because the payer applies different criteria. Medicare Advantage data reflects the same issue. Millions of prior authorization requests are denied each year. Some are appealed, with a high percent



overturned. This suggests many claims are misaligned to payer requirements at submission or the criteria is incorrectly applied, even when the underlying service may be appropriate. This reinforces the throughput issue described earlier. Claims that move forward without meeting payer requirements don't correct themselves at adjudication. They return as denials and reenter the workflow as a revised claim. Payer management must be embedded in daily operations. Authorization trends and denial patterns should be tracked and applied before submission. When those insights are addressed within the workflow, claims are constructed to meet payer requirements from the start, reducing the need for rework. Organizations that understand payer behavior before claims are submitted gain a measurable advantage. They reduce avoidable denials, accelerate reimbursement, and improve financial predictability without increasing staffing levels.

## Advanced Analytics: From Reporting to Action

Most organizations already have more revenue cycle data than they can effectively use. Historical data shows what has happened, and real-time data shows what is happening. Neither improves performance unless the information is used to intervene before a claim moves forward. The differentiator is turning data into action before submission.

Industry investment reflects this shift. Revenue cycle management remains a technology priority, and the use of AI in billing and related functions continues to expand. Yet many teams still lack a consistent way to act on the data while work is in progress. The value of analytics<sup>2</sup> depends on where it is applied. Identifying a high-risk claim doesn't improve performance if the claim continues through the workflow unchanged. Monitoring payer turnaround times has a limited impact unless it changes how work is prioritized or routed before submission. When analytics is tied to decision points, it becomes part of how claims are built. Risk can be identified before billing, documentation can be corrected while the encounter is still active, and payer requirements can be applied as the work is completed. Analytics then directs the work rather than simply reporting on it.

## Building the Intelligence-Led Revenue Cycle

An intelligence-led revenue cycle addresses the breakdown described earlier by changing where work is completed. Issues are resolved at the point where the requirement applies before claims are allowed to move forward. Analytics is integrated into the process to identify unmet requirements while the work is still in progress and direct attention to the right intervention points. Performance is measured across the full process, allowing variation to be identified and corrected earlier. The result<sup>3</sup> is a steadier flow from access to payment. Claims move forward once, and performance reflects how consistently the work is executed, not how effectively it is recovered after the fact.

## Outcomes: What High-Performing Organizations Achieve

High performing organizations achieve more than lower denial rates. They create a more predictable, cost-effective revenue cycle while maximizing appropriate revenue. It is critically important that denials are not simply written off or moved to contractuals. Payment timing becomes more predictable because fewer claims return for correction. Variability decreases because results are shaped by how the work is designed and executed. Teams spend more time completing new work and less time managing avoidable rework, improving throughput without adding staff. Fewer claims move backward through the process, and fewer issues require escalation.

Financial leaders gain greater confidence in forecasting because performance is driven by process discipline rather than denial recovery efforts.

## From Throughput to Revenue Resilience

Revenue cycle performance is determined long before a denial occurs. Organizations that continue to focus primarily on denial recovery will remain locked in a cycle of rework. The leaders outperforming the market are moving their focus upstream, embedding payer intelligence, analytics, and accountability into the process that creates the claim.



The goal is no longer simply managing denials. It is creating a revenue cycle designed to prevent them.

Revenue resilience is built before the claim is submitted, recognizing issues early and aligning operations to support it. Performance becomes predictable because it is built into the process.

## Sources

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