case study

REVENUE CYCLE OPTIMIZATION

A five-hospital system with 250+ care sites and more than 25K team members faced various challenges within its Revenue Cycle Management function, including process inefficiencies, lack of standardized reporting, and siloed approaches to denial management.

An initial Revenue Cycle assessment showed that improvements could be made by optimizing the use and configuration of Epic technology, closing process gaps to prevent revenue leakage, and establishing a standardized process for collecting outstanding balances.

Multiple workstreams were implemented, leading to transformative operational, technical, and financial improvements across the organization.

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$97M in Margin Improvement Achieved

To address critical inefficiencies and unlock significant financial opportunity, a prominent health system launched an ambitious revenue cycle transformation project aimed at achieving $70 million in margin improvement over 12 months. To lead the effort, the organization partnered with Impact Advisors, leveraging their deep expertise in Revenue Cycle and Epic optimization.

Following a comprehensive initial assessment, the joint team identified foundational gaps across technology, workflows, reporting, and organizational alignment. A targeted improvement plan was developed—centered on optimizing Epic to support industry best practices and driving performance through strategic workstreams. Each workstream was assigned clear objectives and financial savings targets, designed to produce measurable impact across the Revenue Cycle.

Denials and Avoidable Write-Off Reduction

The organization sought to decrease denials and avoidable write-offs by approximately $41 million across both hospital-based and professional billing through the implementation of upstream operational and technical fixes. To achieve this, Impact Advisors' approach was to build a culture of deeper learning and root-cause analysis/resolution to proactively identify and mitigate key denial issues while optimizing Epic's capabilities to its fullest potential.

After standing up a best practice Denial & Avoidable Write-Off governance and accountability structure, the team focused on the top preventable denial and write-off areas by ensuring proper authorization protocols, timely filing of claims, meeting medical necessity criteria, and improving registration processes.

The health system had utilized Epic as its core revenue cycle platform for over 10 years and implemented many customizations in their Epic build. Impact Advisors' experts helped bring the organization back to Epic best practice or "foundation." Optimizations included:

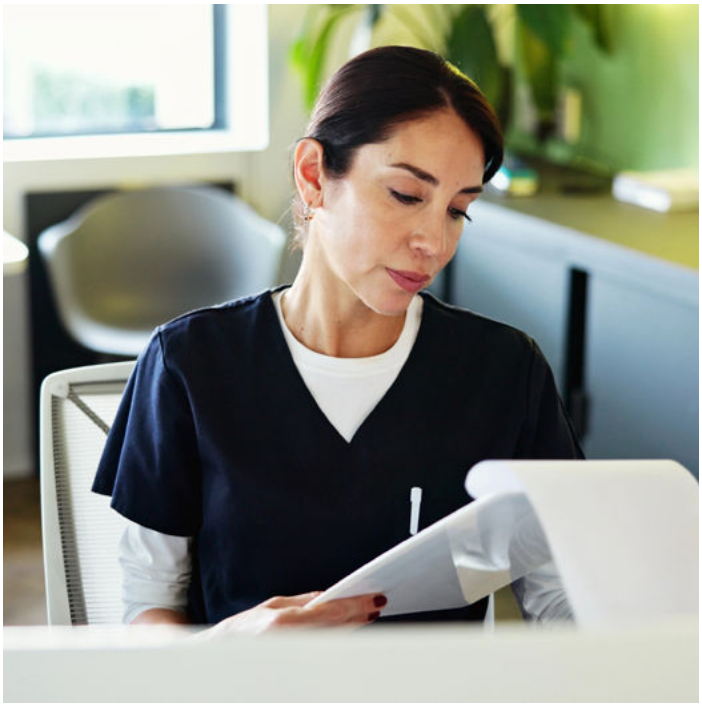
- Remittance code mapping to route denials automatically to the appropriate owning and source areas for actionable reporting and resolution
- Leveraging Epic's new machine learning model—Likelihood of Payment—to identify denial automation opportunities
- Adjustment code mapping of avoidable write-offs to correct use cases aligned with the corresponding denial codes
- Registration checklist improvements to reduce registration and eligibility denials
- Upstream denials mitigation strategies via insurance plan code optimization, claim edits, and charge review logic
- Account activity weights and standardized account note types to efficiently monitor productivity of collectors
- SlicerDicer and denials & avoidable write-off reporting from Epic, eliminating the need for manual reports

These focused denial and avoidable write-off improvements resulted in **$78.9M of annualized net revenue**.

Patient Collections at Time of Service

The hospital system wanted to address its significantly below-target copay collection rates of 40% and front-desk prior balance collection rates of 2%. The assessment revealed a deeply rooted cultural reluctance to collect patient payments at the point of service across both hospital and ambulatory departments, resulting in low collection rates, particularly for prior balances. Staff had limited training and inconsistent understanding of workflows, minimal visibility into team performance due to reporting gaps, and inadequate scripting support when discussing financial responsibilities with patients.

Impact Advisors led a strategic initiative to increase point of service collections through a multi-faceted approach that emphasized transparency, accountability, and staff empowerment. They implemented a weekly dashboard to track performance by department and user, revamped operational scripting, and trained over 900 patient access team members, increasing confidence in patient financial conversations. Epic workflows were enhanced to improve registration and liability accuracy, while the organization embraced a cultural shift toward compassionate, proactive collections. Clear accountability plans and health system leadership ensured consistent adoption across departments. **$6.2M in annualized net patient revenue was achieved** over the course of the project.



AR Management & Epic WQ Optimization

The revenue cycle assessment revealed Epic workqueues (WQs) were not aligned with Epic best practice, and back-end revenue cycle teams were managing too many WQs with limited WQ ownership, accountability, and frequent account transfers. Epic foundational tools such as The Watchlist and WQ Scoring were not being leveraged, leaving the potential for accounts to fall into "black holes" and high-risk accounts to age over time.

To address these issues, Impact Advisors partnered with the health system to implement 688 back-end WQ redesign changes, including 217 WQ deactivations, aligning operations with Epic foundation best practices. Hospital Billing Watchlist alerts were optimized, and a Professional Billing Watchlist was developed to prioritize high-dollar and high-risk accounts on the AR. A responsibility matrix was introduced to clarify ownership of both WQ "black holes" and high-risk alerts. Workqueue Scoring was enhanced for 294 WQs to support daily prioritization, helping staff reduce accounts receivable and aging. Clear processes for WQ ownership, oversight, and maintenance were defined, and account routing was updated to prevent many unnecessary transfers.

Additionally, staff were trained on Epic Foundation Productivity Scorecards and a new Quality Assurance process to reinforce accountability and performance tracking.

Patient Access Redesign

The Patient Access Redesign initiative addressed significant gaps in pre-service and financial clearance governance and processes. The initial assessment revealed a siloed structure with fragmented oversight, where multiple teams redundantly reviewed financial clearance, leading to coordination issues, missed registration requirements, and increased risk of avoidable write-offs. Patient Access functions, including scheduling, insurance verification, prior authorization, and point-of-service collections, were not centrally governed, and key functions reported to different leadership and departments.

In response, Impact Advisors partnered with the health system to establish a centralized Pre-Service department to ensure full financial clearance prior to each patient's date of service. This Pre-Service Team was piloted for the Neurology service line as well as one of the hospital's surgical centers. In addition, Impact Advisors attacked patient access denials by creating a front-end focused Denials Committee to address root causes of registration and authorization-related denials and consolidated

over 300 WQs to streamline pre-service and registration error management. Additionally, a new productivity and QA process was implemented to enhance front-end accountability, and a registration float pool was piloted to ensure complete and accurate registrations on patients in the hospitals prior to discharge by augmenting FTEs during high volume periods in the EDs.

Epic Revenue Cycle Reporting and Training

The health system's revenue cycle faced significant challenges with manual Excel-based reporting, non-standardized KPIs, and inconsistent Quality Assurance (QA) and productivity tracking across revenue cycle departments. The health system wanted to leverage Epic's reporting and standard dashboards to its fullest potential.

Impact Advisors trained revenue cycle leaders and staff on Epic's best practice foundational dashboards, reporting, and SlicerDicer across departments, mapping and sunsetting numerous manual reports to reduce redundancy and improve data reliability. A new QA and productivity monitoring process was introduced for both front- and back-end teams, enabling qualitative and quantitative performance tracking. Training sessions were conducted with all revenue cycle managers to ensure adoption and understanding of the new scorecards and processes. Standardized expectations for KPI and report monitoring by department and role were established, giving teams a consistent framework for reviewing results and making data-driven decisions. Executive dashboards and Epic tools like SlicerDicer and Reporting Workbench empowered leaders to perform self-service root cause analyses, enhancing transparency, accountability, and operational efficiency.

Hierarchical Condition Category (HCC) Recapture

The health system also sought to improve its Accountable Care Organization (ACO) performance. Success in a Medicare Shared Savings Program (MSSP) is highly dependent upon having the right systems and processes to accurately identify, diagnose, and capture risk-factors through clinical documentation.

Impact Advisors established a formal governance structure to monitor and drive ACO performance, specifically focused on Hierarchical Condition Category (HCC) Recapture. Epic dashboards and member data reporting were developed to provide multi-level analysis on ACO performance using real-time patient visit information. A key part of the program was successfully implementing the Epic Healthy Planet module and outpatient Clinical Documentation chart reviews, which enable the providers to identify and proactively develop a care plan for ACO members who have chronic conditions or HCCs.

The pre- and post-chart review workflows for the Outpatient Clinical Data Improvement (CDI) team increased annual wellness visit (AWV) efficiency for providers so they could spend more time engaging with the patient at the point of care. In preparation for the launch of this new workflow, Impact Advisors held daily stand-up meetings with the Outpatient CDI team to conduct query workflow training, Epic education, document implementation defects, and escalate issues to the technical team for resolution.

Enhancements to existing physician documentation tools and resources improved code specificity and risk identification at both primary and secondary care levels. Physicians received training on new Epic tools, desktop guides, and general information on the Medicare Shared Savings Plan program. Impact Advisors developed a staged and targeted training program to level-set primary care and hospitalist physicians about the importance of specific diagnosis descriptions, completing supporting documentation, and identifying applicable HCCs.

As a result of these efforts, the ACO leadership team gained better visibility into HCC re/capture, enabling more informed decision-making, improved risk scores, and reduced churn in the attributed patient population, leading to an increase in projected shared savings value.

Results Summary

Through the combined efforts of the health system and Impact Advisors, the team was able to achieve $97M in margin improvement over the year-long engagement, surpassing the original target by $27M. ■