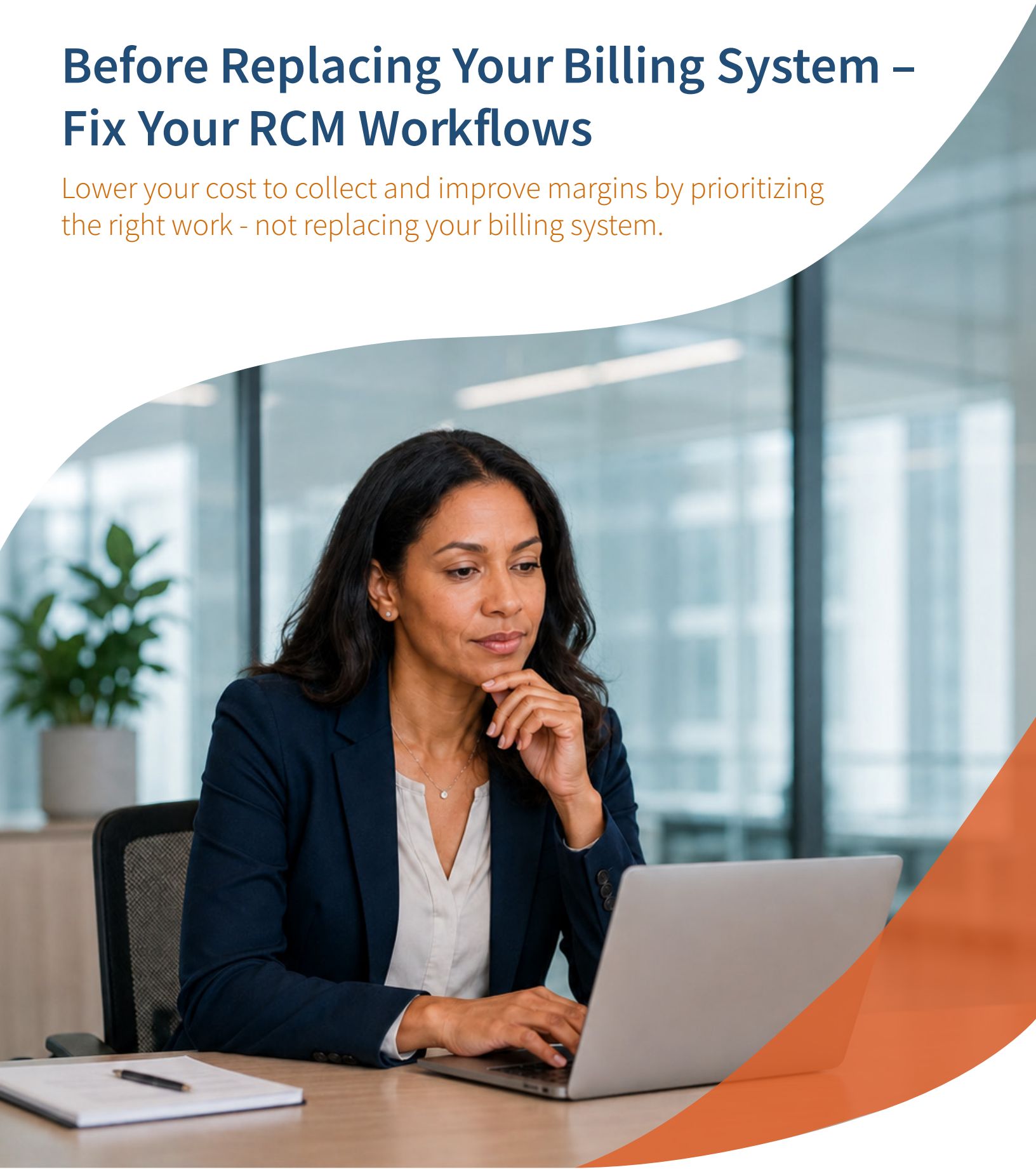
medevolve

Before Replacing Your Billing System – Fix Your RCM Workflows

Lower your cost to collect and improve margins by prioritizing the right work - not replacing your billing system.



The Real Problem Is Not Always the Billing System

Before investing in a new billing system, determine whether inefficient RCM workflows—not the technology itself—are driving up your cost to collect. Learn how smarter work prioritization can reduce wasted labor, accelerate payment, and improve collection margins using the systems and teams you already have.

The Hidden Work Behind Cost to Collect

Cost to collect is a core measure of revenue-cycle efficiency: total revenue-cycle cost divided by total patient-service cash collected. But the percentage alone cannot tell leaders where waste is occurring—or whether a system replacement will remove it.

The hidden problem is often the work beneath the metric. Representatives may revisit claims that are not ready for action, repeat payer follow-up that produces no new information, or work queues in an order that reflects age rather than financial urgency. Each activity looks legitimate in isolation. Across thousands of claims, it becomes expensive repetition.

HFMA's 2025 cost-to-collect framework makes the scope clear: the metric can include salaries and benefits, outsourced services, software, transaction fees, denials and appeals support, IT resources, analytics tools, and automation.[1] In other words, cost to collect is not simply the price of the billing platform. It is the total cost of the operating model used to convert services into cash.

If leadership can see the percentage but cannot see the claim touches, delays, and rework driving it, replacing technology may change the interface without changing the economics.

Why a System Replacement May Leave the Problem Intact

A billing-system replacement can be the right strategic decision when the current platform is unstable, unsupported, difficult to integrate, or unable to meet essential operational requirements. But it is a high-cost answer to a different question.

The Hidden Work Behind Cost to Collect

A conversion changes the system of record. It does not automatically change how work is prioritized, how avoidable touches are identified, or how leaders distinguish productive effort from repeated activity. If those operating rules remain the same, the organization can reproduce the same inefficiencies in a newer platform.

That distinction matters because the administrative burden is already substantial. The American Hospital Association cites an estimate that hospitals and health systems spend approximately $40 billion annually on billing and collections.[2] The first question should therefore be: Which part of that cost would a replacement actually remove?

- A replacement may be justified by core-platform limitations, risk, or long-term strategy.
- It should not be treated as a substitute for diagnosing workflow waste.
- New software can digitize an inefficient process without eliminating it.
- The business case should separate platform benefits from workflow benefits.
- Organizations should establish touch-, outcome-, and cost-level baselines before conversion.

Your cost to collect is driven by the work behind the metric—not just the system where it happens

Fix the Flow of Work First

CAQH estimates that fully electronic administrative workflows could unlock $20 billion in annual industry savings and save an average of 70 minutes per patient visit across administrative transactions.[3] The opportunity is not simply to move work to a new screen; it is to remove work that does not need to happen.

Every one of those steps involves a person doing work, and every touch has a cost.

For many organizations, the faster path is to improve the intelligence that sits between claim data and staff action. A workflow-intelligence layer can use data from the existing billing platform to organize work around payment likelihood, financial exposure, filing or appeal deadlines, denial characteristics, payer behavior, and the next best action.

The billing platform remains the system of record for claim submission, corrections, notes, posting, and rebilling. The workflow layer determines what deserves attention next and captures what happened when the claim was touched.

This approach does not make every system replacement unnecessary. It creates a disciplined way to determine whether the constraint is truly the platform—or the unmanaged work surrounding it.

One System of Record. A Smarter Work Queue.

The concern with any additional technology is predictable: another login, another queue, and another workflow for staff to learn. A well-designed overlay should minimize that burden—not create it.

System of Record

Claim corrections, notes, financial actions, and posting remain in the billing system.

Smarter Prioritization

Prioritized worklists direct staff to the claims with the greatest financial or time-sensitive opportunity.

Structured Inputs

A small set of structured fields captures the activity, current status, next action, and follow-up date.

Actionable Insights

Every classified touch creates data leadership can use to identify repetition, payer friction, and training needs.

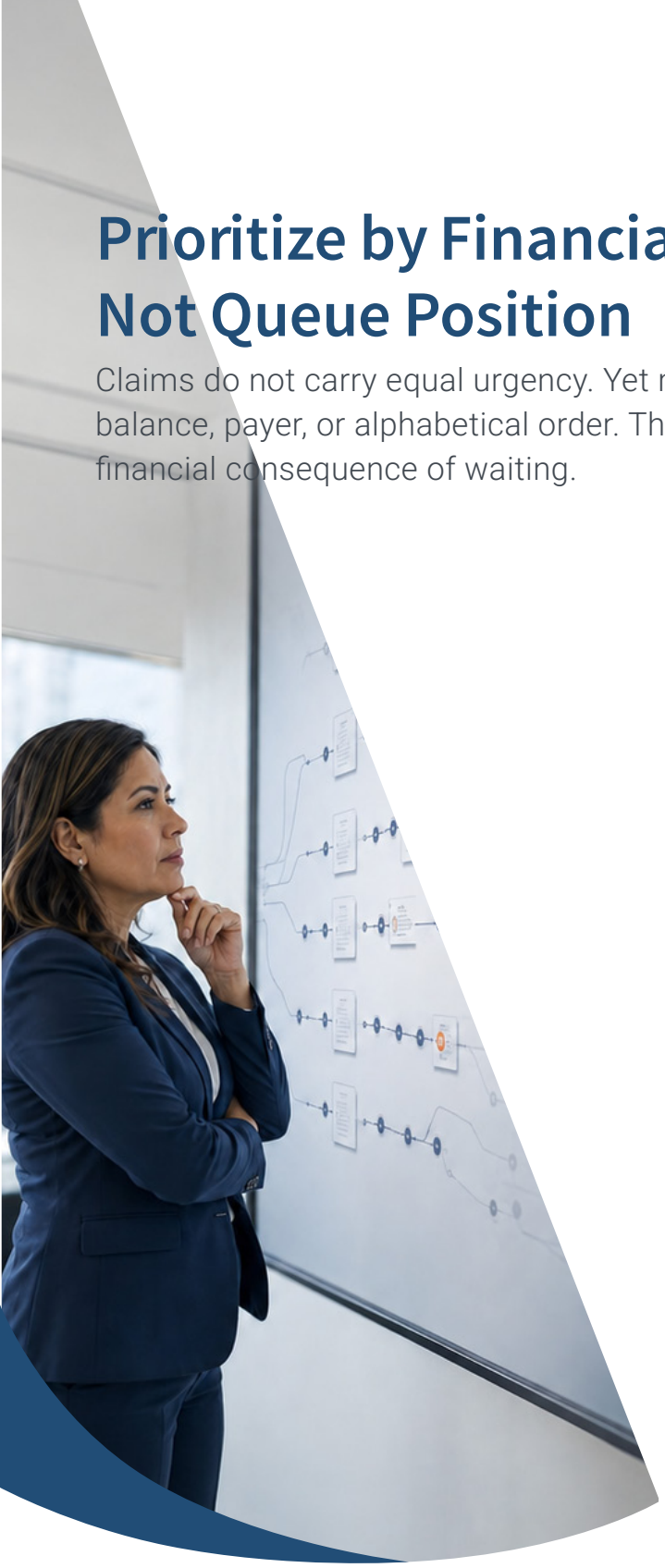
Productive Work

The goal is fewer unproductive touches—not simply more tasks completed per day.

Keep the system your team knows - while making every next-action smarter.

Prioritize by Financial Consequence - Not Queue Position

Claims do not carry equal urgency. Yet many work queues still rank them primarily by age, balance, payer, or alphabetical order. Those fields are useful, but no single field captures the financial consequence of waiting.



Prioritize Financial Impact

Consider two claims in the same queue. Claim A has an $80 balance, routine status, and no immediate deadline. Claim B has a $12,000 balance and is nine days from an appeal deadline. A simple queue may surface Claim A first. A financially intelligent workflow elevates Claim B because the cost of delay is dramatically higher.

At scale, prioritization should account for multiple signals at once:

- Dollar value and expected reimbursement
- Filing, appeal, and authorization deadlines
- Denial and remark codes
- Payer-, state-, and facility-specific behavior
- Claim age, status, and prior touch history
- CPT or service characteristics linked to payment risk

The Economic Shift: Instead of asking, “Which claim is next?” the workflow asks, “Where can the next unit of labor protect or accelerate the most cash?”

Turn Every Touch into Actionable Intelligence

Most billing platforms record that activity occurred. Fewer reveal whether the activity moved the claim toward payment. That difference separates workload reporting from operational intelligence.

Classifying each touch by activity, status, action, and result makes previously hidden patterns measurable:

First-touch resolution

Which claims reach resolution after one meaningful intervention?

Repeat work

Which claims are repeatedly reviewed without a status change or next-step outcome?

Avoidable follow-up

Which touches occur before the payer, patient, or internal team could reasonably respond?

Payer friction

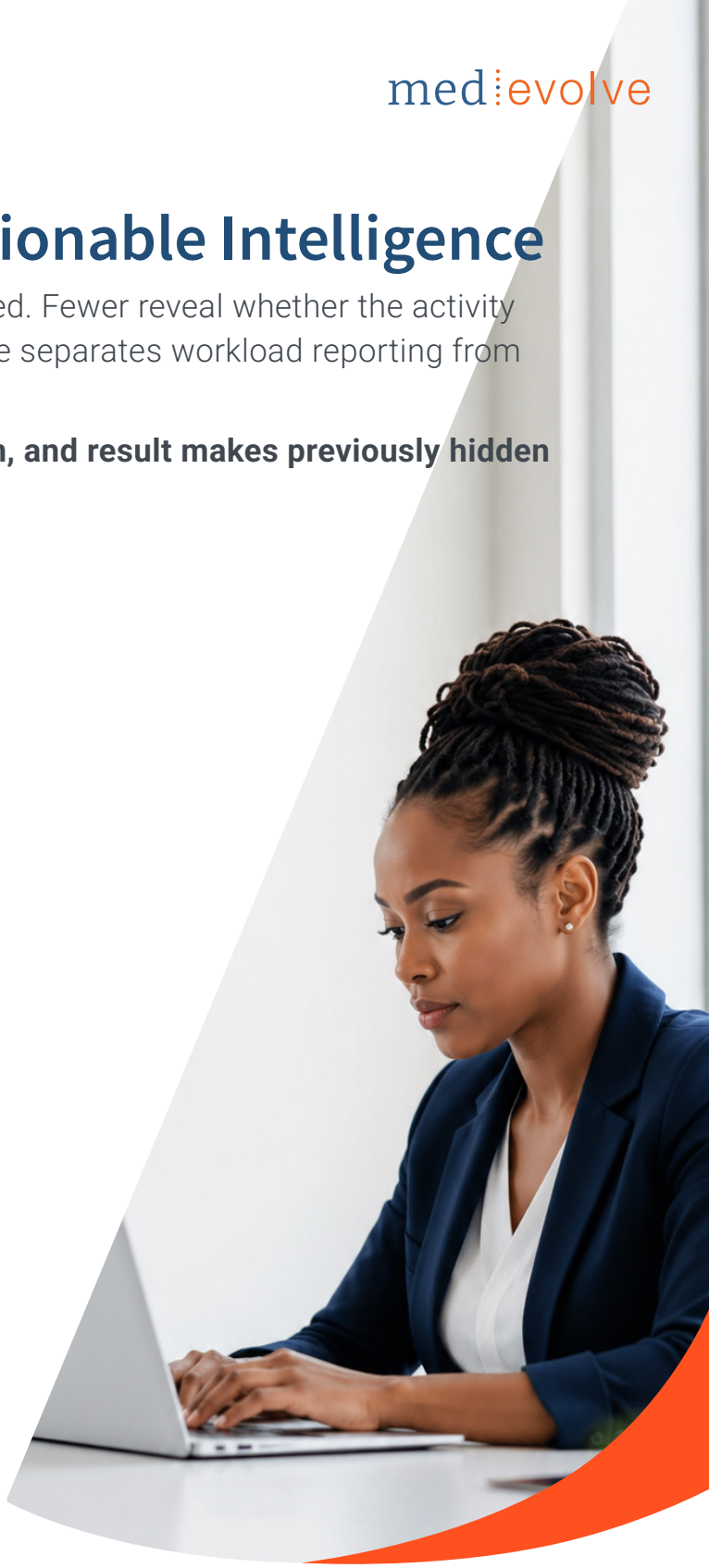
Which payers generate disproportionate denials, delays, documentation requests, or manual work?

Team effectiveness

Which workflows and representatives consistently convert effort into resolution?

Root causes

Which upstream eligibility, authorization, coding, or documentation failures are creating downstream cost?



This visibility is especially important as denials rise. AHA-reported data show care denials increased between 2022 and 2023 by 20.2% for commercial claims and 55.7% for Medicare Advantage claims.[2] HHS-OIG separately found that 18% of reviewed Medicare Advantage payment denials met both Medicare coverage and plan billing rules; many stemmed from manual-review or system-processing errors.[4]

Improve Capacity Before Adding Headcount

When volumes rise and worklists grow, the reflex is often to add staff. But hiring into an inefficient workflow scales the inefficiency along with the team.

Growth Without Added Headcount

A MedEvolve customer operating ambulatory surgery centers faced a post-pandemic volume surge while opening nine new centers. Rather than replacing its core systems or relying solely on additional headcount, the organization improved coordination and reduced redundant work.

Uncover Trapped Capacity

The lesson is not that every organization will achieve the same result. It is that leaders should first determine how much capacity is trapped in duplicate, premature, or low-value work. Until that is visible, headcount plans are built on workload rather than productive demand.

Capacity Before Hiring: Before adding headcount, identify and eliminate the low-value work consuming your team's existing capacity.

What Changes - and What Does Not

The value of a workflow layer is not wholesale disruption. It is a targeted change in how work is selected, measured, and improved.

WHAT STAYS THE SAME	WHAT CHANGES
The existing system of record	The order in which claims are worked
Claim correction and posting workflows	Visibility into productive vs. repetitive touches
Detailed notes and financial actions	How leaders identify payer and process friction
Core billing-system data	The ability to connect labor to financial outcomes

Add Intelligence, Not Disruption

This distinction matters because most organizations do not need another system to store claims, document activity, or process transactions. They need a more intelligent way to determine which claims deserve attention, what action is most likely to move each account forward, and whether that effort produces a meaningful financial result. By adding this decision-making layer above the billing system, leaders can improve productivity and collection performance without disrupting the workflows and infrastructure their teams already depend on.

Transformation does not require replacing the system of record - it requires making every action taken within it more purposeful, measurable, and financially productive.

Start with a Baseline, Not a Replacement

Before making a platform decision, establish what work is happening today and what that work produces. A practical first phase can be completed without committing to a system conversion.

Calculate Cost to Collect

Audit the full cost-to-collect calculation using a consistent framework.

Measure Workflow Efficiency

easure touches per claim or visit, first-touch resolution, repeat touches, and time between actions.

Target High-Cost Work

Identify one high-cost category—such as denial-driven rework or non-actionable follow-up—to address first.

Prioritize High-Value Claims

Configure prioritization rules around payer behavior, deadlines, financial exposure, and expected actionability.

Validate with Real Claims

Validate the workflow using real claims before rolling it out broadly.

Measure Against Baseline

Compare labor, throughput, cash, denials, and avoidable write-offs against the baseline.

Fix What Is Driving the Cost

THE QUESTION TO TAKE FORWARD

If we changed how work was prioritized tomorrow - with the same team and the same core platform - how much cost, rework, and financial risk could we remove?

HFMA defines cost to collect as total revenue-cycle cost divided by total patient-service cash collected

Use early to establish authority and clarify that cost to collect measures the entire operating model—not only software.

CAQH estimates fully electronic administrative workflows could unlock $20 billion in annual savings; automating claim-status inquiries can save staff up to 18 minutes per patient visit. Use to quantify the cost of manual administrative work without presenting it as a MedEvolve-specific outcome.

Hospitals and health systems spend an estimated $40 billion annually on billing and collections. Use to establish the scale of the financial problem.

HFMA's 2025 framework includes salaries and benefits, outsourced services, subscriptions, transaction fees, analytics/workflow tools, IT support, and AI/automation costs. Use to challenge the assumption that replacing the billing platform addresses every cost driver.

Care denials increased 20.2% for commercial claims and 55.7% for Medicare Advantage claims between 2022 and 2023, according to data cited by AHA. Use to show why teams must prioritize financial risk and deadline-sensitive work.

HHS-OIG found that 18% of reviewed Medicare Advantage payment denials met both Medicare coverage and plan billing rules; many resulted from manual-review and system-processing errors. Use to support better classification, prioritization, and root-cause visibility.

Sources

1. Healthcare Financial Management Association (HFMA), Guide to Better Practices in Measuring Cost-to-Collect, 2025. https://www.hfma.org/wp-content/uploads/2025/09/Cost-to-Collect-Better-Practices.pdf

2. American Hospital Association, Skyrocketing Hospital Administrative Costs, Burdensome Commercial Insurer Policies Are Impacting Patient Care, September 2024. https://www.aha.org/system/files/media/file/2024/09/Skyrocketing-Hospital-Administrative-Costs-Burdensome-Commercial-Insurer-Policies-Are-Impacting-Patient-Care.pdf

3. CAQH, 2024 CAQH Index Key Takeaways: From Transactions to Trust—Building Better Care Through Healthcare Automation, 2024. https://www.caqh.org/hubfs/Index/2024%20Index%20Report/CAQH%202024%20Index%20Report%20Key%20Takeaways%20FINAL.pdf

4. U.S. Department of Health and Human Services, Office of Inspector General, Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care, April 2022. https://oig.hhs.gov/reports/all/2022/some-medicare-advantage-organization-denials-of-prior-authorization-requests-raise-concerns-about-beneficiary-access-to-medically-necessary-care/