A physician's guide to effective revenue cycle management

Executive summary

This report equips physicians with key insights and best practices for effective revenue cycle management. Rather than adding to their administrative burden, understanding payment mechanics allows physicians to streamline workflows and maximize reimbursement. Proper compensation can ease the pressure to see more patients, making each encounter more financially sustainable.

The financial health of health care organizations is fundamental to delivering high-quality patient care. From solo physician practices to expansive academic health systems, achieving financial stability requires effective revenue cycle management (RCM). As margins shrink, payer landscapes grow increasingly complex, and demands on physicians continue to rise, optimizing RCM can empower physicians to take control of care delivery. Effective execution of RCM not only supports organizational financial wellness but also fosters sustainable work-life integration for physicians and ensures the highest standards of patient care.

However, five critical barriers impede effective RCM across practice settings:

- **Physicians are often not educated on the mechanics or importance of RCM,** which creates a vacuum in physicians' understanding of the business of medicine.
- **Fragmented workflows and siloed practice functions** that lead to errors and inefficiencies.
- **Evolving payer rules and government regulations** that demand constant vigilance.
- **Limited time and resources**, making it challenging to prioritize RCM tasks.
- **Low patient financial health literacy**, positioning physicians as mediators between patients and payers and potentially impacting the patient experience.

Addressing these challenges requires collaboration across clinical and administrative teams, with physicians playing a pivotal role as leaders, owners, and practitioners. High-performing health care practices demonstrate that success in RCM hinges on five key strategies:

- **Contextualizing revenue cycle processes** to ensure everyone knows the "why" behind the process and empower ownership
- **Emphasize collaborative learning** to foster ongoing mastery of payer rules, set clear expectations, and drive performance
- **Addressing low patient health financial literacy** with transparent engagement to build trust and increase goodwill throughout care delivery
- **Utilizing AI and automation** to unburden physicians and administrative staff to spend more time on higher value responsibilities
- **Monitoring revenue cycle key performance indicators** to quickly identify and address any issues

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By implementing these best practices, health care organizations can overcome barriers, optimize financial health, and enhance patient care outcomes.

This report provides guidance in three ways:

- First, it offers an introduction to the revenue cycle and how the cycle supports high-quality care delivery.
- Second, the report briefly discusses each barrier and connects it with strategies to overcome these challenges. Each strategy is illustrated by case studies to highlight best practices in action.
- Finally, additional resources and tools are compiled in the Appendix, including a detailed, step-by-step breakdown of the revenue cycle and checklists that can be used to evaluate your own organization's revenue cycle management processes.

Capturing perspectives in revenue cycle management: Methodology

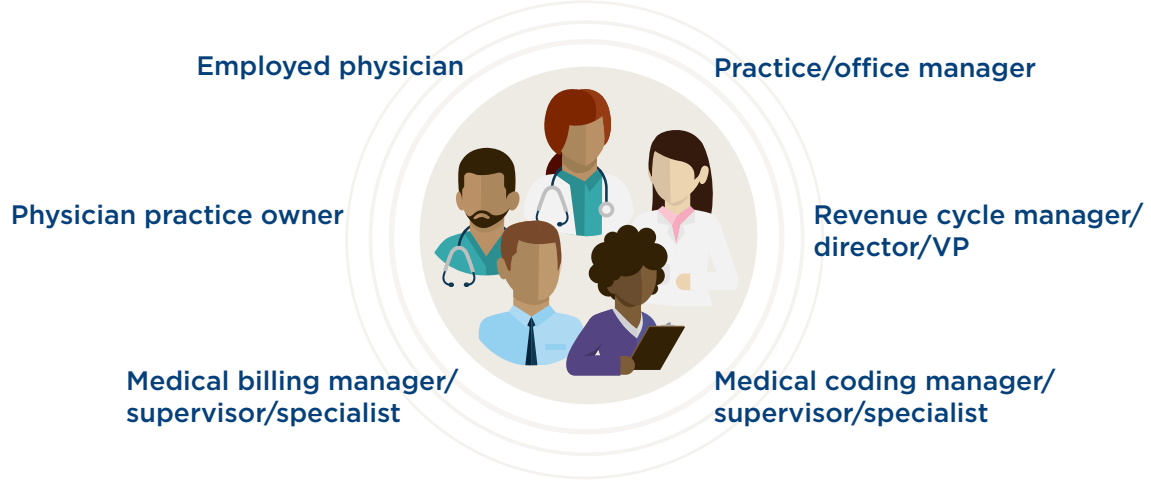
Health care delivery varies based on factors like practice size, specialty, ownership model, and staffing structure. The findings and best practices outlined in this report aim to address the revenue cycle challenges a physician may face in a range of practice settings.

To help you identify information applicable to your needs, the icons below appear throughout the report and indicate guidance relevant to the needs of these specific practice settings:

- S/SGP — **Solo/small group practices** (<10 physicians)
- M/LGP — **Medium/large group practices** (11–99 physicians)
- SHS — **Small health systems** (100–200 physicians)
- M/LHS — **Medium/large health systems** (200+ physicians)

This report was developed from conversations with 40 industry professionals whose responsibilities span the revenue cycle in a range of practice settings. Interviews were conducted between Nov. 12 and Nov. 22, 2024. These conversations informed a comprehensive analysis of the responsibilities, challenges, and opportunities related to revenue cycle management approaches in academic and community-based practices.

Findings are meant to guide physicians on optimizing their role in effective revenue cycle management. Topics of discussion included key performance indicators, barriers and methods in overcoming them, training and development, patient involvement, and team composition. Select quotations from the interviews are included in the report to demonstrate support for the themes identified. **The specific roles and practice types of these respondents are summarized as follows:**



For more information, refer to this report's Appendix and the section, "The revenue cycle: Step-by-step."

Introduction to revenue cycle management: More than the bottom line is at stake

"[Revenue cycle management] is part of the patient's care. Not direct patient care, but it's like little pieces in a puzzle. And if they don't align, they don't make the perfect puzzle; if you're not billing the patient, how do you expect to get paid?"

– Employed physician, large multi-specialty group practice

Although front office staff and billing teams handle much of the day-to-day work in revenue cycle management (RCM), its impact extends to every member of a practice, including physicians. Challenges within the RCM process can exacerbate barriers to delivering optimal patient care. According to the Linus Group, the next generation of physicians identifies non-clinical tasks—particularly administrative burdens and inadequate reimbursement—as the primary obstacles to effective practice.

Revenue cycle management is a critical determinant in these dimensions of health care:

Financial viability of practices
Small practices, safety net hospitals, and rural health care facilities face heightened risks, with financial instability threatening their ability to serve communities

Access to care
When financial pressures force practices to close, hospitals to cut services, or patients to forgo care due to denied coverage, access to essential health services is jeopardized.

Quality of care
Limited resources and shrinking margins hinder investments in staff, technology, and infrastructure, directly affecting patient outcomes.

Physician well-being
Systemic barriers that prevent physicians from providing care undermine their moral and professional fulfillment, contributing to burnout.

What is revenue cycle management?

Revenue cycle management or RCM describes the procedures health care organizations use to organize their financial operations. In short, it is the process by which physicians are paid for the care they provide. Optimal RCM maximizes reimbursement, enhances patient experience, reduces physician burden, and leverages support staff for greater efficiency. To achieve these outcomes, RCM must be a collaborative process, where each player understands their role and how it fits in the broader cycle, and is continuously evaluated to ensure the process is resilient in the face of changes to the health care landscape.

RCM activities are embedded in each patient encounter, from initial registration to payment collection. The cycle, which generally spans three phases, can be summarized in **nine key steps** as outlined below. A more detailed resource with strategies for effective RCM can be found in the appendix of this report.

FRONT END

1. Patient registration
2. Insurance verification
3. Check-in and check-out procedures

MID CYCLE

4. Patient visit
5. Medical coding, billing, compliance
6. Preparing and submitting claims

BACK END

7. Claims monitoring, payer remittance, denials management
8. Preparing patient bills and statements
9. Management patient payments and collections

Note: The revenue cycle discussed in this report is relevant for practices that accept insurance. For practices that are cash-pay only, not all steps will apply.

Key strategies to more effective revenue cycle management

Effective revenue cycle management (RCM) is critical to a health care organization's ability to deliver high-quality patient care. While physicians understand the financial realities of health care as a business, medical education often overlooks the intricacies of RCM. With minimal exposure during training and cursory on-the-job guidance, physicians are left to navigate RCM through trial and error—often finding the process daunting and their role unclear.

Despite the barriers that stand in the way of effective RCM, many health care practices and organizations are successful in establishing processes that maximize reimbursement and foster involvement by physicians. We will explore five strategies and the barriers they address with case studies applicable to various practice types and sizes.

Five key strategies

1

Lead with "Why," not just what: Contextualizing revenue cycle processes to overcome fragmented workflows and siloed practice functions

2

Emphasize collaborative learning to drive continuous mastery and performance

3

Addressing low patient health financial literacy and fostering trust with transparent engagement

4

Utilizing automation and AI to efficiently and effectively use limited time and resources

5

Monitoring revenue cycle key performance indicators

Strategy 1

Lead with "Why," not just what: Contextualizing revenue cycle processes to overcome fragmented workflows and siloed practice functions

Siloed practice functions disrupt the revenue cycle by preventing individuals from fully understanding or maximizing their contributions before passing tasks to the next phase. Without clear expectations about how each person's input impacts subsequent steps, the process becomes inefficient, and opportunities for optimization are lost. As a result, physicians and their teams risk forfeiting rightful reimbursements, undermining both financial stability and patient care.

Example: **Impact of siloed practice functions**

1. The physician sees a patient on Thanksgiving Day.
2. The physician is over-scheduled with patients and is (1) unaware that they could code for holiday care, or (2) forgot to code for holiday care, despite it being accurate and appropriate for the situation.

   Note: Coding guidelines for holiday care are discussed in the August 2010 issue of *CPT® Assistant*, "Coding Brief: After Hours Office Services (Codes 99050-99051)".
3. The billing team doesn't regularly provide feedback on clinical documentation and coding, in part because they are not co-located at the practice. The billing specialist submits the claim as-is, without the Current Procedural Terminology (CPT®) code representing holiday care.

Impact

- **Loss of revenue:** The practice and the physician miss out on the maximum, appropriate reimbursement from the holiday patient encounter.
- **Unclear patient expectations:** The patient may be surprised and confused to see holiday-hours charges or a difference in payer coverage the next time they receive care on a holiday care.

Example: **Impact of integrated practice functions**

1. The physician sees a patient on Thanksgiving Day.
2. The physician is over-scheduled with patients, but the billing team shared holiday coding guidance with the clinical team before the long weekend. The physician references the guidance and adds the appropriate holiday code.
3. The billing team performs a quality control check for all visits performed on Thanksgiving Day and briefly thanks the physician for their attention to detail.

Impact

- **Preservation of revenue:** The practice and the physician are reimbursed to the appropriate level for the holiday patient encounter.
- **Setting patient expectations:** The patient recognizes that their coverage or health care bill will be different when they receive care on a holiday.

Many physicians express frustration with the constant stream of queries—requests from coding and billing teams that ask physicians about modifying their documentation and coding—from coders and billers, which can feel overwhelming and unrelenting. Some practices, particularly large health systems, attempt to address delays by imposing punitive measures, such as threatening practice privileges. However, these tactics can backfire, fostering resentment rather than cooperation. The lack of collaboration between business office staff and physicians—exacerbated by the siloed nature of their roles—further deepens this divide. Without clear communication or context about why changes are needed, physicians are left feeling disengaged and dissatisfied, and administrative staff are left feeling like they aren't being heard.

"There's a big gap. We just get emails [from billing] but not in a teaching way. Even if they just told us the numbers, I would know I'm doing the hospital a good job by being thorough. There has to be a better way [to educate physicians about coding] than to be punitive by removing privileges."

– Employed physician, anesthesiology, large community health system

By contextualizing individual tasks within the larger revenue cycle, physicians and administrative staff are empowered to do what they can to ensure the process runs unimpeded.

Visit these resources for additional support with coding:

- Coding resources list
- Common coding mistakes
- The CPT® Developer Program

"I drop the CPT® codes myself and then it goes to the billers. They check and request clarification if necessary. They correct my work, basically. I wish it was a little bit more thorough; I need the reasons. Instead of just asking, or demanding, what they need. You pick up the nuances after some time because you get the same emails over and over, but it would be helpful to have it explained to catch it earlier on."

– Employed physician, surgery, large academic health system

Case study

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Moving beyond the query: Coding content built for physicians

Large health care organizations navigate a visible disconnect between physicians and their coding teams. Especially for practice settings in which coding teams are remote or off-site, a barrage of queries not accompanied by opportunities for learning or changes in behavior only add to physicians' overwhelm. Physicians are left feeling unclear about deficits in their documentation, and frustrated by repeated queries.

One employed physician envisions a protocol for coding specialists to approach physicians to offer in-person feedback on notes and charting. In this scenario, the in-house coding specialist visits the physician's department and offers actionable critiques to improve documentation. This approach provides an opportunity to empower physicians in providing comprehensive documentation.

"They're real people. [Coding specialists] don't have to call you or message you. They can just come to your department and be like, 'Hey Doctor, can we sit for five minutes so I can show you what you've been doing every month and we can just improve this little thing?' I just learn better that way."

– Employed physician, anesthesiology, large community health system

For practice settings where in-person connections between coding specialists and physicians may not be possible, there are still clear opportunities to provide physicians with meaningful education on documentation and its relationship to successful coding. One health system provides five-minute videos to walk through commonly missed conditions or documentation inefficiencies. This kind of virtual education provides physicians with on-demand learning opportunities without the need for in-person visits from coding specialists between patient encounters.

Case study

Documenting—and sharing—the value of real-time clinical documentation and integrity review to increase reimbursement by $1MM each month

Health care organizations are persistently challenged by the need to educate busy physicians on the importance of accurate documentation and coding. One health system made progress by documenting the impact of modifications to diagnosis related groups on the revenue the hospital generates. While this example is specific to large health systems with multiple hospitals and outpatient clinics, all practices can apply the lesson of showing the tangible effect of coding changes.

A large health system has enacted a structure to help track revenue results its coding department generates by quering and assisting physicians with their documentation practices. This system-wide tracking structure, which also monitors facility-specific metrics, shows the financial impact that properly addressed queries can have. The director of clinical documentation estimates the system receives an additional $1 million per month in revenue when physicians provide further documentation in response to queries.

"We have about a million dollars a month in revenue just from provider queries. It's significant and we use that to help drive people to realize this is why the queries are so important, because that's revenue that would not be here if we didn't ask those questions."

– Director of clinical documentation, large community health system

By identifying the additional revenue generated from having a more proactive querie process, the clinical intelligence team has data to demonstrate the importance of detailed documentation for the financial health of both the system and the physicians. This approach highlights the value of queries in revenue cycle efficiency; urging physicians to preemptively document in a higher level of detail to ensure they are paid what they deserve, therefore reducing the need for queries over time.

Strategy 2

Emphasize collaborative learning to drive continuous mastery and performance

Health insurance is a complex network of companies and plans. Every year, the coverage details for private and government insurance plans change to respond to medical advancements, shifting priorities, and state and federal regulations. The proliferation of companies, plans, supplemental insurance and annual policy changes makes it necessary for medical practices to learn by trial and error how to best document and chart to maximize reimbursement. Because of this, many staff in charge of coding, preparing and submitting claims to payers may not bother to formally document specific changes, and many physicians give up on keeping track of updated guidance. This leaves practices vulnerable to higher rates of claims denials, repeat errors and makes training new staff difficult.

Example: Impact of ever-changing rules and regulations

A multi-specialty practice also operates an infusion suite, where they buy and bill various generic and brand name medications for about half of their patients.

Buy-and-bill describes the process by which physicians purchase medication for their patients, administer the medication to the patients, and submit a reimbursement claim for the medication itself and its administration.

For one kind of treatment, the physicians prescribe a generic medication when possible because it is less expensive than the brand name medication and provides the same benefit to patients.

However, an insurance company has changed their policy and has lowered the covered percentage of the allowed amount for the generic drug and the practice is purchasing the generic drug for more than the insurer will pay.

The practice manager catches the discrepancy during the claims preparation process, but only after several patients receive the generic drug.

The practice manager communicates the coverage change to physicians and collaborates to identify treatment options for the affected patients.

Together, the practice manager and physicians present the updated treatment plans to the rest of the practice's staff. It takes several months before everyone is fully compliant, leaving additional money on the table.

Value-based care adds to the complexity of revenue cycle management. These types of outcomes-oriented agreements come in many forms, but a common element is full reimbursement is held back until quality measures are reported and analyzed, typically on an annual basis. Because the initial reimbursement may only be partial, it's even more important to be accurate when coding and billing, because mistakes can compound before they are noticed during reconciliation.

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Case study

Leverage physician billing patterns to evaluate opportunities for coding and billing education

Practices of all sizes use billing data to identify typical patterns and outliers, both within their organization and compared to similar institutions. This insight helps pinpoint opportunities to improve billing accuracy and boost revenue without increasing patient volume. Additionally, it can pinpoint whether challenges are the result of a larger process breakdown or an individual contributor who requires coaching.

An academic hospital leverages national benchmarking data integrated into its EHR to compare physicians' billing patterns for patients with similar acuity in comparable markets. Revenue cycle leaders and physician champions share de-identified data at faculty meetings to highlight variances within the hospital, followed by individualized feedback sessions for physicians to address specific opportunities for improvement and recognition.

"[Seeing the data] was eye-opening for some. It's already making a difference and getting their attention."

– Infectious disease service line manager, academic hospital

Common sources of benchmarking data

- Medical Group Management Association (MGMA)
- Healthcare Financial Management Association (HFMA)
- Clinical Practice Solutions Center (CPSC)
- Data made available by EHR providers

Strategy 3

Addressing low patient financial health literacy and fostering trust with transparent engagement

"Patients are asking about billing before going into surgery. I have had patients refuse procedures, like nerve blocks, because they are afraid of being billed more. Maybe once or twice, I might have done it and didn't charge it. I try to do whatever is best for the best experience of the patient, not thinking of how they will pay at the end of the day."

– Employed physician, anesthesiology, multi-specialty group practice

Patient-centered care calls for physicians and other health professionals to individualize care for each person and engage in shared decision making based on available evidence and the patient's goals, preferences, and values. However, as health care costs have risen, patients' health care decisions are increasingly dictated by their understanding, or lack thereof, of their financial responsibility. And the uncertainty of how much care will cost can be detrimental to patients' emotional well-being; over half of Gen Z and Millennial patients report being more stressed about medical bills than the quality of the care they receive.

Often, patients rely on their physicians and health care workers to coordinate with insurers and explain coverage and bills, but it can be time-consuming. Patients' lack of financial health literacy can also get in the way of the practice obtaining accurate patient information, collecting co-pays and deductibles at the time of service, and collecting the amount remaining after payer reimbursement. Unreliable information from patients and a general lack of financial health literacy puts the onus on the practice to verify insurance, watch out for other potential errors, and shepherd patients through the billing process.

Example: Impact of low patient financial health literacy

The patient is scheduled for a procedure in January. Their insurance has changed, but they don't think to share this information and no one at the practice asks to confirm.

↓

The patient undergoes the procedure as scheduled.

↓

The practice submits the claim but learns the patient has to meet a deductible.

↓

The patient receives a bill for the full amount of the procedure and calls the practice, confused about why they owe so much money.

↓

The front desk staff, physician, and practice manager must take time out of their days to explain the situation to the patient, who remains angry and distrustful of the practice.

Example: Impact of addressing patient financial health literacy

The patient is scheduled for a procedure in January. The practice has a protocol to ask all patients one week prior to procedures whether their insurance has changed, and the patient confirms that it has.

↓

Because the patient's insurance has changed, the practice provides a handout explaining the patient's estimated financial responsibility and the meaning of policy terms like deductible, copay, etc.

↓

Before the procedure, the billing team requests the full co-pay and deductible amount owed by the patient as permitted by health plan contracts and offers to answer any questions they have.

↓

The patient undergoes the procedure as scheduled.

↓

If the patient must pay anything in addition to the copay and deductible, the bill clearly outlines what the patient has already paid, and what the additional fees are for.

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Case study

Improving the patient experience by building trust across departments

Specialized functions in health care organizations can build deep expertise but can also create confusion for patients seeking help with access or billing issues. For example, a children's hospital faced repeated complaints from parents unsure where to turn for answers, particularly about unexpected out-of-pocket costs.

"It felt like everyone was pointing the finger elsewhere until it got to the end of the cycle [in patient billing] and then we got the brunt of [patient ire]."

– Medical billing manager, children's hospital

The billing team implemented a multi-faceted strategy to help all revenue cycle teams understand their role and impact:

- **Emphasized cost transparency**: Focused on providing accurate cost estimates to prevent unexpected bills.
- **Hosted cross-department education:** Organized "road shows" to demonstrate how teams like Patient Access, Patient Finance, Registration, and Revenue Integrity contribute to the revenue cycle.
- **Fostered collaboration:** Worked across departments to map the patient and employee journey, identify pain points, and improve processes.

Real process changes were enacted in response to what was shared and learned. For instance, the billing team was previously tasked with correcting errors made by the registration team. To address this, the teams agreed to send returned mail back to registration. Confronted with the impact of inaccurate patient information, the registration team recognized its importance and improved their accuracy. This shift not only enhanced performance but also fostered a more positive, collaborative atmosphere.

Strategy 4

Utilizing automation and AI to efficiently and effectively use limited time and resources

"The margins are so tight you really need to stay on top of [the business]. We're paid less but working more. It's even harder to squeeze out the time to look at the revenue cycle."

– Physician owner, independent multi-specialty group, ophthalmology,

Revenue cycle management operates under the constant pressure of time. As the time between a patient visit and billing statement increases, the likelihood of collection decreases. Just one claim denial can delay reimbursement from the payer by several weeks, and therefore further reduces the probability of successfully collecting the patient's responsibility. Collecting the patient's financial share has been increasingly important as more patients enroll in high-deductible health plans with the potential for larger out-of-pocket costs.

Furthermore, physicians' available time for patient care, let alone revenue cycle management, is dwindling; Medicare reimbursement has declined 29% since 2001 in inflation-adjusted dollars, and the pressure to increase patient volume in response to repeat pay cuts is high. It is not surprising then that around 63% of physicians across various specialties are experiencing burnout. This burnout is largely caused by growing administrative responsibilities like documenting visits in the EHR that add hours of non-reimbursable work to physicians' schedules each week.

Many health care organizations have started to use automation and AI tools to support health care workers and physicians in tackling repetitive, time-consuming, and non-clinical tasks. The full potential of AI is still being realized, but there are several ways it's currently in use by physicians and health care practices to optimize RCM.

- **Ambient AI scribe tools:** Software listens to patient encounters and drafts clinical notes in the EHR. Physicians must approve each note for accuracy, but not having to start from scratch could save physicians hours each week. This approach ensures greater detail in physicians' documentation, contributing to optimized coding and billing downstream.
- **Medical coding AI support:** AI suggests modifications or queries based on its knowledge of payer rules and regulations. The AAPC (formerly the American Academy of Professional Coders) is beginning to offer specialized courses for AI-enabled coding to prepare the next generation of coding professionals
- **Autonomously drafting payer communications:** AI drafts correspondence to inquire about the status of claims, speeding up throughput and positively improving coding productivity.

PRACTICE SETTINGS

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Case study

Use of AI scribes to reduce cognitive burden and support accurate notes

Ambient AI scribes are growing in popularity as a tool to reduce time spent on administrative tasks while also contributing to accurate documentation and improved patient encounters. AI-enabled scribing during the patient visit assumes the responsibility of notetaking, allowing physicians to focus on connecting with the patient. These tools also save time post-visit, allowing physicians to spend less time closing charts and more time seeing patients.

One independent hospital has provided the infrastructure for all physicians to take advantage of AI notetaking. Integration of this technology has directly improved the hospital's RCM processes, where improvements in documentation accuracy have streamlined the coding and billing process while increasing patient and physician satisfaction.

"We saw higher RVU-to-encounter ratios because the note had everything in there… what this [AI scribe] allows us to do is reconnect with the patient. Our Press Ganey scores went up, the physicians know that when the application is recording their note will be ready and done…there is a reduction of cognitive burden because they don't have to remember every detail, just be in the moment with the patient."

– Director of strategic growth and orthopedics service line manager, community hospital

Strategy 5

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Monitoring revenue cycle key performance indicators

"We had been seeing patients from a mental health facility and a low security prison as community service. A few months ago we realized those claims were taking two years to process. We immediately addressed the issue but why did it take so long for us to figure out we weren't being paid?"

– Physician owner, independent multi-specialty group, ophthalmology

Understanding a practice's current performance is the first step to optimizing revenue cycle management. High-performing RCM relies on continuous monitoring of key performance indicators. Tracking these metrics helps practices quickly identify workflow issues, address potential disruptions, and adapt to changes in payer rules before they result in significant revenue loss. Three critical categories of RCM metrics to monitor are:

1. Overall accuracy: Ensure valid patient information, accurate coding and precise charge capture			
	How it is measured	**Goal**	**Physician's role**
Coding accuracy	Percentage of codes that are accurately assigned based on clinical documentation. Feedback will be received in the form of denials if inaccurate.	Aim for 95% accuracy in coding patient charts based on documentation.	Respond promptly to queries from coders/billers; adjust future coding practices based on feedback from the admin team whenever possible.
Missed charges	Coding audits identify charges that are accurate but have been missed.	Aim for monthly to quarterly audits.	Physician owners and employed physicians at smaller practices may collaborate with the coding and billing staff to ensure the audit occurs on a regular basis.

Patient information	Monitor errors in demographics, contact, or insurance details. Errors may be discovered when performing insurance verification, submitting claims to a clearinghouse for "scrubbing," or when patient bills are returned to sender.	Aim for 99% accuracy	Physician's role: Physician owners and employed physicians at smaller practices should request reports from administrative staff to verify accuracy on a regular basis. Feedback and coaching should be given if accuracy is a challenge.

2. Productivity: Measure efficiency in coding and charge processing			
	How it is measured	**Goal**	**Physician's role**
Charge capture lag	Evaluate how long it takes physicians to close charts post-encounter.	Same-day closure is ideal, and three days is acceptable.	Prompt chart closure is a critical component of the revenue cycle for all physicians in all practice settings.
Discharged, not final billed	Track the percentage of discharged patients with open charts in inpatient facilities.	Aim for less than 5%.	Ensure charts are closed in a timely manner to ensure the medical coding team can perform their duties.
Coding productivity	Reports can be generated to quantify how many closed charts are waiting to be coded and prepared for submission.	Strive for 95% of closed charts coded daily, with only 5% remaining in the queue.	Physician owners at practices of all sizes should request reports that track this metric.

3. Revenue reconciliation: Verify expected reimbursements and address discrepancies			
	How it is measured	**Goal**	**Physician's role**
First-pass resolution	The percentage of claims that are approved on first submission without payer adjustment.	Aim for 95% of claims approved on the first submission.	Ensure they integrate the latest guidance on coding and documentation.
Denial volume	The percentage of all claims that are denied.	Keep claim denial rates below 10%; 2–3% is exceptional.	Ensure they integrate the latest guidance on coding and documentation. Promptly respond to any queries to resolve possible reasons for denial before claim submission.
Denial appeal rate	The percentage of all denials that are appealed.	arget a 95% appeal rate, with 100% being ideal.	Physicians should monitor this metric over time to watch for trends, especially physician owners and employed physicians at smaller practices.
Days in A/R	The amount of billed money that has yet to be paid.	Reduce outstanding payments, aiming to collect within 30 days.	Physician leaders should collaborate with their business office colleagues to identify issues throughout the revenue cycle that may be negatively impacting this critical metric.

For a comprehensive list of key performance indicators, including definitions and common data sources, visit the health financial Management Association's MAP Keys resource.

Conclusion: Moving forward for stronger revenue cycle management

Revenue cycle management (CRM) can be overlooked by physicians, but being curious about how it works in one's practice setting can pay dividends beyond income. The benefits cannot be realized overnight, but when physicians take ownership of the role they play in revenue cycle management, they have the potential to improve the financial outlook for themselves and their organization, patients' access to care, the quality of care, and even improve their well-being as physicians.

These five questions are a good place to start when evaluating where and how to address revenue cycle management in one's own practice or organization.

1. **How is my practice addressing potential siloing of work functions?**
   Check for: Coding content for physicians, in-person or virtual physician education opportunities, opportunities for specific feedback from coding team, systems to account for administrative staff turnover or absences.

2. **How can my practice leverage collaborative learning to mitigate the effects of payer coverage volatility?**
   Check for: Peer institution benchmarking data integrated with the EHR, billing and coding accuracy at both an institutional and individual level, including missed charges.

3. **Is my practice transparently engaging with patients about their bills to address low patient financial health literacy and foster trust within the health care system?**
   Check for: Patient health financial literacy education including detailed estimates and tools for understanding coverage, cross-department education and collaboration.

4. **Where are there opportunities to leverage AI and automation?**
   Check for: Ambient AI scribes, medical coding support, payer communications, and other inefficient manual processes identified by KPI tracking and exploration of existing workflows.

5. **What revenue cycle KPIs are tracked by my practice?**
   Check for: Overall accuracy in charges and patient information, productivity in closing charts, revenue reconciliation (i.e., in terms of resolution vs. denial).

Resources

American Academy of Professional Coders: AI in Medical Coding and Billing Course

The CPT® Developer Program

CPT® coding resources

Eight Medical Coding Mistakes That Could Cost You

What Is Value-Based Care?

References

Alnijadi AA, Li M, Wu J, Xiong X, Lu ZK. Trend and effects of high-deductible health insurance plans in the health care system: financial access problems in management of cognitive impairment. *J Manag Care Spec Pharm*. 2022;28(1):7-15. doi:10.18553/jmcp.2022.28.1.07

Berg S. Family doctors spend 86 minutes of "Pajama time" with Ehrs Nightly. American Medical Association. September 11, 2017. Accessed February 1, 2025. www.ama-assn.org/practice-management/digital-health/family-doctors-spend-86-minutes-pajama-time-ehrs-nightly.

Caine NA, Ebbert JO, Raffals LE, et al. A 2030 vision for the Mayo Clinic Department of Medicine. *Mayo Clinic Proceedings*. 2022;97(7):1232-1236. doi:10.1016/j.mayocp.2022.02.010

Health 2035: A bold path through the Uncharted Future of Health. The Linus Group. December 16, 2024. Accessed February 1, 2025. thelinusgroup.com/reports/health-2035/.

Henry TA. Medicare physician pay has plummeted since 2001. find out why. American Medical Association. April 21, 2025. Accessed February 1, 2025. ama-assn.org/practice-management/medicare-medicaid/medicare-physician-pay-has-plummeted-2001-find-out-why.

JPM25, day 1: Chai Launches Working Group on use of AI for Prior Auth; IU Health's focus on Team Culture. Fierce Healthcare. January 13, 2025. Accessed February 1, 2025. www.fiercehealthcare.com/finance/jpm25-day-1-healthcare-industry-descends-san-francisco.

Map Keys. HFMA. March 27, 2024. Accessed February 1, 2025. www.hfma.org/data-and-insights/map-initiative/map-keys/.

Patients more stressed about medicals bills than about care. Waystar. March 2, 2021. Accessed February 1, 2025. www.waystar.com/news/waystar-survey-finds-patients-more-stressed-about-medicals-bills-than-about-care/.

What should be done about the physician burnout epidemic. American Medical Association. February 16, 2023. Accessed February 1, 2025. www.ama-assn.org/practice-management/physician-health/what-should-be-done-about-physician-burnout-epidemic.

Research collaboration and acknowledgements

About the AMA

The American Medical Association is the physicians' powerful ally in patient care. As the only medical association that convenes 190+ state and specialty medical societies and other critical stakeholders, the AMA represents physicians with a unified voice to all key players in health care. The AMA leverages its strength by removing the obstacles that interfere with patient care, leading the charge to prevent chronic disease and confront public health crises, and driving the future of medicine to tackle the biggest challenges in health care.

For more information, visit ama-assn.org

About The LINUS Group

LINUS is a strategy and innovation consultancy focused on helping the world's leading organizations grow and be relevant in the evolving health landscape. With nearly three decades of expertise, LINUS has developed models for how technical audiences such as scientists, physicians, engineers, and business teams make decisions, and strategies for influencing those decisions through effective market research, brand strategy, commercial approaches, and product roadmapping innovation.

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Research collaboration led by LINUS

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Appendix: Practical guidance for strengthening RCM

PRACTICE SETTINGS
S/SGP M/LGP SHS M/LHS

The revenue cycle: Step-by-step

Patient registration

- What's happening: Capture accurate patient information, including contact information, demographics, and medical history. Can be completed via phone or patient portal during scheduling or in person at the time of appointment.
- Why it's important: This step lays the foundation for timely and accurate billing and reimbursement later in the cycle.
- Key staff: Front desk/reception, schedulers, practice or office managers.
- Key performance indicators: Patient information accuracy, completeness of patient information.

Insurance verification

- What's happening: Ensure patient coverage details are current, confirm the patient's coverage, check for exceptions like secondary insurance, and inquire about any prior authorizations needed for exams, tests and procedures.
- Why it's important: This step validates the source or sources of reimbursement for medical services and may trigger workflows that are specific to a given insurer.
- Key staff: Front desk/reception, schedulers, practice or office managers.
- Key performance indicators: Rate of verification before each patient appointment, annual updates to patient records to keep records current.

Check-in and check-out procedures

- What's happening: Confirm all patient information is accurate, collect necessary paperwork, and collect copays, coinsurance and/or outstanding balances.
- Why it's important: Collecting the patient's responsibility as soon as possible is the best way to avoid outstanding balances.
- Key staff: Front desk/reception, schedulers, practice or office managers.
- Key performance indicators: Percent of total patient responsibility collected (total dollar value and percentage of available money collected), patient information accuracy, completeness of patient information.

Patient visit

- What's happening: The patient is seen by the clinical team. The physician may be documenting the visit in the EHR live, or they may be documenting the visit after the fact.
- Why it's important: The patient encounter and subsequent medical chart is the foundational document of the revenue cycle. Care without documentation cannot be billed and subsequently reimbursed.
- Key staff: Clinical team, including medical assistant, nurse, technicians, physicians and advanced practice providers like nurse practitioners and physicians' assistants.

- Key performance indicators: Patient visit volume, relative value unit (RVU) volume, RVU per visit, RVU per year per physician.

Medical coding, billing and compliance

- What's happening: Physicians complete documentation in the electronic health record (EHR), select CPT® codes, and close the patient chart. The chart is then reviewed by medical coding administrative staff. The administrative staff are responsible for ensuring the documentation and codes are concordant. If they identify a possible misalignment, they may send a query to the clinical team requesting additional information.

- Why it's important: Medical coding is somewhat subjective, and the rules are always changing. Administrative staff play a critical role in applying what they know about insurance requirements for certain services, the documentation that needs to be included if certain codes are needed, and "reading between the lines" to identify when codes may be missing based on the documentation.

- Key staff: Medical coder, medical biller, clinical documentation and integrity team (medium and large health systems), practice manager, office manager (solo and small group practices).

- Key performance indicators: Coding accuracy, missed charges, charge lag time, time to resolve queries, medical coding productivity.

Preparing and submitting claims

- What's happening: The billing team reviews each claim to ensure all required information is included and the claim is accurate. In some practices, a clearinghouse reviews and "cleans" the claim before submission to the payer. In others, the practice's billing team reviews the claim for accuracy and directly submits the claim to the payer.

- Why it's important: Denied claims delay reimbursement for physicians by at least a couple of weeks. Great care should be taken to avoid denials for reasons within the physician's control.

- Key staff: Medical coder, medical biller, clinical documentation and integrity team (medium and large health systems), practice manager, office manager (solo and small group practices).

- Key performance indicators: Clean claim submission rate, claim submission productivity.

Claims monitoring, payer remittance and denials management

- What's happening: Once they have been submitted, staff must monitor payer portals and communication sources for the status of claims. Approved claims should proceed to payment from the payer, often through a clearinghouse. Denied claims must be reviewed for rationale, discussed with clinicians if necessary, and promptly appealed if appropriate.

- Why it's important: While medical practices can't control what payers deny, they can control how they respond. Most, if not all, claims and denials should be appealed to ensure practices receive their rightful reimbursement.

- Key staff: Medical biller, practice manager, office manager.

- Key performance indicators: Denial appeal rate, payer accounts receivable aging report (30/60/90 days is common; 120 and 180 days also noted by some practices).

Preparing patient bills or statements

- What's happening: The billing team assesses any outstanding balance on the patient's account, and communicates this balance to the patient via a patient portal, paper bill, or both.
- Why it's important: While most reimbursement comes from payers, patients' financial responsibility has increased with the adoption of high-deductible plans.
- Key staff: Medical biller, practice manager, office manager.
- Key performance indicators: Patient accounts receivable aging report (30/60/90/120 days).

Managing patient payments and collections

- What's happening: The billing team collects the patient's payment for their care and resolves the balance on the patient's account. The front desk staff and/or billing teams may also field questions and concerns from patients about the amount owed.
- Why it's important: A good care experience can be sullied if the patient has a poor billing experience. Navigating insurance and understanding out-of-pocket costs can be complicated, so practices are often required to step in to act as a guide for the patient.
- Key staff: Medical biller, front desk staff, practice manager, office manager.
- Key performance indicators: Patient satisfaction levels (as measured by online surveys), patient accounts receivable aging report (30/60/90/120 days).

Double click: Practice type nuances of siloed practice functions and disjointed workflows

The practice type greatly influences how the challenge of siloed practice functions manifests. Key nuances are outlined below.

PRACTICE SETTINGS S/SGP

Solo physician and small group practices

Direct physician involvement: In smaller practices, physicians—especially practice owners—often take an active role in overseeing revenue cycle tasks.

Challenges of smaller practices: Lower patient volumes result in tighter margins, requiring practices to minimize staff overhead while maximizing reimbursement.

Reliance on key staff: Many small practices depend on one or two trusted experts (e.g., practice managers, billing specialists, or medical coders) with years of experience navigating health insurance complexities.

Vulnerability to disruption: Without proper documentation of best practices, overreliance on these individuals can leave practices exposed to operational challenges if key staff depart.

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Medium and large group practices; small, medium and large health systems

- Larger practices and health systems require dedicated teams to handle revenue cycle functions, which makes them more resilient to staff turnover.
- But clinical functions are often physically separated from administrative functions in central business offices or remote environments. This has a few negative effects:
  - **Physical or mental distance can make it difficult or cumbersome to communicate about patient charts, coding and billing**. Rather than walk down the hall to confirm a detail about a patient's chart, a medical biller must place a phone call or more often, submit a query to the clinical team via the EHR system.
  - **Feedback from the billing team is often not accompanied with education and/or explanation**, reducing the effectiveness of the feedback and making it likely that the same problem may come up again.
  - **Physicians may have an easier time dismissing revenue cycle functions as out of sight, out of mind**. When admin queries feel like a nuisance, physicians may grow frustrated and feel less satisfied in their role. Many health care organizations have rules that dictate how quickly queries must be resolved, which adds to physicians' administrative burden and can feel punitive.
  - **Administrative functions don't always see the bigger picture**. Even within the revenue cycle functions, specialized teams don't always see how their work affects other aspects of the revenue cycle. For example, front desk staff responsible for patient registration may not be aware of how errors in patient information slow down reimbursement and result in extra work for the billing team. One biller in a small health system rerouted all patient bills that were returned to sender to the front desk staff to be fixed. Once front desk staff saw the effect of their inaccuracy firsthand, the volume of patient information errors decreased.

What to look for: Revenue cycle management KPI checklist

Physician owner

- Am I tracking relative value units (RVUs) per year per physician?
- Have I ensured each of the below list items for my practice?

Employed physician

- Am I keeping track of my total RVUs?
- Am I keeping track of my RVUs per visit?
- Is my coding accuracy for patients 95% or above?
- Do I typically close charts in three days or less?
- How long does it take me to resolve queries, on average?

Front desk and reception

- Is our rate of accuracy and completeness for patient information 99% or more?
- Are we tracking the rate of patients whose information we verify prior to their appointment?
- Do we have a system to ensure patients' information is updated on a yearly basis, at minimum?
- Am I tracking patient visit volume overall?
- Am I tracking patient visit volume per patient?

Coding and billing

- Are we providing feedback to physicians on a regular basis for their documentation (other than queries)?
- Are we providing education to physicians on coding best practices for our organization?
- Are we providing education to physicians on CPT® codes?
- Are we measuring the percentage of total patient responsibility collected across the practice?
- What is our coding accuracy rate?
- How are we measuring missed charges?
- How are we measuring charge lag time?
- Have we coded 95% or more of the closed charts at any given point in time?
- Are 95% or more of our claims approved upon first submission?
- Are our claim denial rates below 10%?
- Are 95% or more of our claim appeals approved?
- Are our days in A/R for each bill below 30 days?

DOWNLOAD:
Health plan 101 for patients at physician practices

PRACTICE SETTINGS

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This resource is designed to help patients understand the basics of their health insurance and understand important health insurance terms and definitions.

Methodology

The American Medical Association strives to provide evidence-based resources for physicians and their practices across a wide range of topics. Because Revenue cycle management (RCM) represents a critical aspect of constantly-changing pressures in delivering health care, the goal of the research informing this report is to help alleviate the associated burden on physicians.

Key questions for the research included:

- How does RCM impact delivery of care to patients?
- What are the most common barriers in RCM?
- How are high-performing practices addressing these barriers?
- What must be true for practices and health systems to optimize RCM processes?

Sampling strategy and selection

Maintaining respondent anonymity, we leveraged a global knowledge services provider to engage with 40 health care professionals who hold a range of responsibilities throughout the revenue cycle. Respondents were deemed eligible for participation based on their answers to a series of screening questions, including:

- Which title best describes your current role?
- What best describes the organization you work for?
- What is the size of the organization where you work?
- What is the payer mix of your practice?
- How would you describe your involvement in revenue cycle management at your practice?
- Which aspect(s) of the revenue cycle are you directly responsible for (i.e., a primary part of your job responsibilities) most of the time?

As described in the "Executive summary" of this report, we selected respondents according to a desired mix of area of focus in RCM, role, and type and size of health care organization to ensure diversity of the sample. **The final selection of respondents is summarized below:**

Area of focus

- Front desk / reception (n=6)
- Medical billing / coding (n=11)
- Overall RCM oversight (n=23)

Practice size

- Solo/small group practice (n=10)
- Medium/large group practice (n=8)
- Small health system (n=9)
- Medium/large health system (n=13)

Recruitment and interview structure

Respondents were contacted via telephone and answered the screening questions summarized above during a phone call. They were contacted via telephone a second time after being selected for the research to schedule their in-depth interviews. Each respondent was sent a follow-up email outlining the details of their interview. To maintain confidentiality, respondent contact was entirely the responsibility of the knowledge services provider to maintain confidentiality.

Interviews were conducted via the Discuss.io platform by Lindsey Schott, director of strategy at LINUS. The interviews were dyads, where two respondents with similar roles were interviewed simultaneously. Each conversation lasted 60 minutes, and respondents were compensated through the knowledge services provider. **The moderator followed a discussion guide composed of the following sections:**

- "Introduction to Respondent's Role and Responsibilities"
- "Revenue Cycle Challenges and Opportunities"
- "Detailed Exploration of Revenue Cycle Steps"

Data analysis and limitations

Interview notes and transcripts were reviewed to identify themes regarding challenges and best practices throughout the revenue cycle, as well as how those dimensions affect physicians. Members of the LINUS and AMA teams met regularly to discuss findings and refine themes. Quotes and key strategies outlined in this report represent the themes resulting from this analysis.

Qualitative themes are often meant to be directional rather than imply quantitative findings representing the thoughts, feelings, and approaches of a total population. Some findings may not be applicable to all practice settings or specialty types.