in2itive.

Case Study

Revenue Cycle Decisions, Revisited

Analytics, Automation, and Rethinking Follow-Up Practices

Executive Summary

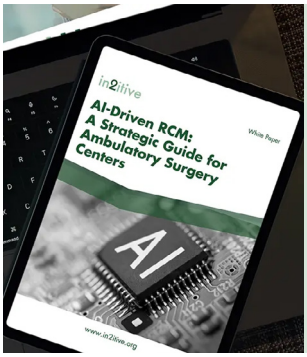
As the inevitability of AI and automation becomes ingrained into everyday life, every vertical has been impacted, including ASCs. The landscape of ASCs has been changing rapidly, underscoring the importance of implementing these evolving technologies into everyday processes.

And yet, revenue cycle follow-up practices in ASCs continue to be shaped by legacy workflows. Early outreach became standard when visibility depended on phone calls and staff intervention, and those habits persisted even as payer systems and automation evolved.

At in2itive, we tested whether those assumptions still hold true by analyzing claims adjudication patterns across consolidated clearinghouse and EMR data. Using descriptive and predictive analytics, we examined how claims actually move once submitted and when intervention meaningfully affects outcomes. The data showed that many claims resolve through routine payer activity without early human involvement.

Acting on that evidence led to a recalibration of follow-up timing, supported by automation and guided by prescriptive analytics rather than habit. Applying the same analytical framework also surfaced additional opportunities to refine revenue cycle operations.

This case study shows how evidence-led decision-making is reshaping follow-up strategy in practice and how continued refinement builds on those early findings.



Explore how technology can positively impact ASC revenue cycle operations in our white paper.

Does early outreach meaningfully affect patient payment?

Evidence suggests there's a better way forward.

How Early Follow-Up Took Hold

Early follow-up thresholds emerged when revenue cycle visibility required manual effort. Payer status checks, documentation requests, and payment confirmation depended on phone calls, and delays created real financial risk. In that environment, early outreach was a practical response.

Over time, that outreach hardened into expectation. Many ASCs adopted KPIs requiring every account to be touched within a fixed window, often 30 days, with some workflows initiating outreach as early as Day 21. The approach reflected the tools and visibility available at the time.

ASCs have also tended to adopt advanced analytics more cautiously than other healthcare settings, reinforcing reliance on familiar operational models rather than data-driven redesign of workflows.[1] Without clear insight into how claims actually move once submitted, activity often replaced evidence.

What Claims Behavior Made Clear

Testing assumptions required moving beyond static reports and dashboards. Instead of focusing on point-in-time status, we examined claims behavior across the full adjudication lifecycle.

Using a *Single Pane of Glass* approach, we consolidated data pulled directly from clearinghouses, EMR systems, and internal operational sources into a unified analytical environment. Descriptive analytics established historical patterns, while predictive analytics clarified what typically occurred within defined windows.

The results challenged long-held norms. A significant portion of claims reached resolution through standard payer processing without any manual follow-up; data further revealed that three out of four claims will either pay, deny, request documentation, or move to a terminal status within 30-41 days, while outreach frequently occurred before payers were positioned to act and rarely influenced outcomes.

Read our white paper to see how consolidating clearinghouse, EMR, and operational data enables repeatable, evidence-led decision-making rather than one-off analysis.

Single Pane of Glass approach

Multiple data sources→Unified view→Insights

Reframing Follow-Up Timing

Claims behavior pointed to a clear conclusion: timing mattered more than volume. Early intervention consumed staff time and created queue noise without improving results for most accounts.

Based on that evidence, follow-up strategy shifted. The first human touch moved later in the claim lifecycle, allowing routine adjudication to occur while automated monitoring tracked payer status. Human expertise remained focused on accounts that failed to resolve within that window, where judgment and experience could influence outcomes.

Adopted at the end of 2024, this approach replaced inherited timelines with decision rules grounded in observed claims behavior, with prescriptive analytics translating insight into operational action. By implementing automation and AI technology, efficiency dramatically increased across the payer continuum—eliminating needless early-cycle labor efforts, reducing friction in follow-up queues, and creating a new baseline for true exception intervention after the 41-day mark.

Across RCM touchpoints,
timing matters more than volume.

From Idea to Implementation

The impact of this shift became clear in work with a large multispecialty surgery center. Claims data showed that roughly **70% to 80% of claims resolved naturally within 30 to 41 days without any manual follow-up**, and 98% received some form of payer response within that same window. Early outreach did not change those outcomes.

Follow-up timing was adjusted to allow adjudication to run its course while automation monitored status. Human effort was reserved for accounts that remained unresolved beyond that point. The change aligned staff work with payer behavior and reinforced the value of letting evidence, not habit, drive operational decisions. As a result, days in accounts receivable remained at 28 days over the subsequent three months—**a more than 34% decrease in days in A.R.!**

Outdated Approach

Days 21-30

Human intervention to encourage payment yields little result

Days 30-41

Continued human intervention, costing teams time and energy

The Natural Progression

Days 30-41

~75% of claims resolve naturally with no manual follow-up

A Better Way with in2itive

Days 30-41

Allow claims to resolve naturally with no manual touchpoints

Day 41+

Added human touch from in2itive to encourage payment

Applying Insights Across the Revenue Cycle

Applying the same analytical framework revealed additional areas where unnecessary work had become routine. Claims with preventable errors were entering payer workflows and generating downstream rework with no operational benefit. Addressing those issues at submission reduced avoidable follow-up and reinforced a broader shift toward intervening only where action can change an outcome.

Automation supports this model early in the claim lifecycle by monitoring payer activity without human involvement. AI is harnessed to reinforce early-cycle visibility with regular follow-ups, reserving human intervention after day 41. Across both, the focus remains practical: reducing unnecessary work, improving consistency, and preserving human judgment where it matters.

As claims behavior continues to be examined and tested, follow-up timing, automation strategy, and staff effort can be refined rather than locked into inherited routines. Early adopters already working this way gain clarity sooner and adjust faster, while others continue to rely on timelines shaped by past conditions.

The evolution of claims follow-up is just one way that the right blend of automation, AI, and human expertise can help reduce revenue leakage and maximize returns. in2itive stands at the forefront of emerging technology and vanguard **innovations in data analytics and ASC revenue cycle management.**

Contact us today to begin making revenue cycle decisions grounded in real-life data—not outdated industry standards.

About in2itive

We are a fully integrated revenue cycle management partner working exclusively with ambulatory surgery centers. Our approach combines ASC-specific expertise with analytics-led operational design, consolidating data across clearinghouses, EMRs, and internal systems to provide a unified view of revenue cycle performance.

By applying descriptive, predictive, and prescriptive analytics, we help clients refine follow-up strategy, prevent avoidable rework, and apply automation and AI where they create real operational value. Our focus is practical and disciplined: grounding decisions in how claims actually behave so teams can operate more effectively while staying focused on patient care.

your revenue cycle SPECIALISTS

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Sources

1. Paone, Joe. "Trend to Watch: Data Revolution." Outpatient Surgery Magazine, October 10, 2023. AORN. https://www.aorn.org/outpatient-surgery/article/trend-to-watch--data-revolution