Before You Automate Revenue Cycle, Ask What You're About to Scale

Revenue cycle has no shortage of technology. There are tools to code, tools to route, tools to predict, tools to remind, tools to collect, tools to post, and tools to tell you which other tools are underperforming.

Some of them are useful. Some of them are very useful.

But before a medical group adds another layer of automation, there's a harder question worth asking: *What are we about to scale?*

Because automation does not only scale efficiency. It scales whatever is already present in the system.

If the workflow is clear, the data is reliable, the payer logic is current, and the team knows who owns what, automation can create real capacity. It can reduce manual touches, move staff toward higher-value work, and help the organization respond faster.

If the workflow is inconsistent, the inputs are wrong, or payer requirements live in someone's head, automation can move the wrong work faster.

That's not progress. That's a bigger mess with better software.

Medical groups don't have much room for small misses

This matters in medical groups because the environment is built on volume, with smaller balances. A registration decision may look small in the moment. A payer selection. A date of birth. A policyholder field. A reason for visit. An authorization requirement. One data element in one workflow.

But in a high-volume medical group, small misses do not stay small. They become denied claims, staff rework, patient confusion, delayed cash, and a higher cost to collect.

According to Joy Houk, Senior Revenue Cycle Consultant at Ancore Health: the foundational operations and workflow of revenue cycle has not fundamentally changed. Technology changes how the work gets done, but the work still launches with getting the consumer registered correctly into the billing system, capturing the right information, submitting clean claims, adjudicating them correctly, and collecting any dollars owed from the patient.

That foundation matters even more when the dollars are spread across thousands of interactions. In the medical group world, the office visit itself may not be where the greatest loss of revenue risk sits. Labs, imaging, procedures, and ancillary services often carry more payer-specific rules, more documentation requirements, and more opportunity for preventable rework.

That is where automation can help. But only if the organization has already done the harder work of defining the rules.

Bad inputs still create bad outputs

A mistake in revenue cycle automation is assuming that a downstream tool can compensate for an upstream miss.

It usually can't.

Take a simple example: the patient is registered with Blue Cross on file, but they actually have Aetna.

If eligibility fails or the claim is forced through the billing system with the wrong payer, an automated coding tool may do exactly what it is supposed to do. It may apply the coding logic tied to Blue Cross. The claim may launch more quickly and possibly move through the system. But the premise was wrong.

Aetna may require something different. A modifier. A different documentation requirement. A different billing pathway.

So now the organization has a front-end rejection, or possibly, if pushed through, a denial that is reported statistically as a back-end problem, even though it started at the front end.

That is the operational reality of revenue cycle. The work is connected. The problem did not start in the denial queue. That's just where it became visible.

This is also why the front end deserves more respect than it often gets. Many organizations have less experienced staff in registration or check-in, even though those teams are making decisions that determine whether the claim has a clean path to payment. The payer specific rules and complexity continue to increase and the front-end resources have more responsibilities.

This staff continues to be the "face of the practice" but the level of knowledge required has significantly increased. That is not just an administrative role. It is revenue protection.

Some work is repeatable. Some work only looks repeatable.

Automation belongs in revenue cycle.

There is no good reason for skilled staff to spend their days doing work an automated agent can learn and perform efficiently and consistently. Payment posting, simple status checks, routing, reminders, and other standardized tasks are often better handled through technology.

Prior authorization can also be a reasonable candidate when the workflow is clear enough: build table files specific to payers and services that require authorization, gather the required medical information, submit it to the payer via the claim, check status, and route the response.

But not all revenue cycle work is that clean.

Joy draws an important distinction between processes that are truly repetitive and work that becomes more complicated and requires critical thinking because of payer complexity, service type, coverage, modifiers, documentation, denial reason, and patient responsibility.

Denials and follow-up may look repeatable from a distance. In practice, they often depend on the specific payer, the specific service, the specific rule, and the specific reason the claim failed.

That does not mean automation has no role. It means leaders need to know the difference between work that is repeatable and work that only looks repeatable because we have not looked closely enough.

Readiness is operational, not technical

A medical group can buy sophisticated technology and still be unprepared to automate.

That sounds obvious until you sit inside the work.

One location follows the standard registration process. Another has its own workaround. One payer requires a specific modifier. Another changes its documentation rules and the update is in a multi-page update in a bulletin. One team knows how to handle the exception, but procedures have not been updated. One report says denials are improving. Another tells finance cash is still lagging.

This is where automation can expose the difference between a process that is documented and a process that is actually governed.

Readiness is not just whether the tool can perform the task. Readiness is whether the organization can define the task, support the exceptions, update the rules, test the technology process and outcomes, trust the data, and hold the right people accountable when the workflow breaks.

That requires more than implementation. It requires structure.

Automation should refocus expertise

The goal is not a people-less revenue cycle. The goal is a revenue cycle where people are doing work that requires critical thinking and is productive and outcome driven.

Exceptions. Judgment. Pattern recognition. Payer escalation. Workflow redesign. Patient conversations that require nuance. Decisions that connect revenue cycle performance to operations, finance, access, and physician leadership.

That distinction matters because many revenue cycle teams are already stretched. If automation only removes the easy work, leaders may end up with fewer people managing more complicated exceptions in a system that is still poorly defined.

Leaders also have to be careful about how they interpret productivity after automation.

If technology removes the clean, repeatable work, the remaining work may take longer because it is complicated and time consuming. Staff may appear less productive on paper while actually working the exceptions that require the most judgment. According to Joy, automation can reduce repetitive work, but it leaves people focused on more complex tasks that do not always fit old productivity measures.

That is a measurement problem, not necessarily a people problem.

And it is exactly why automation has to be paired with governance, reporting, and a clear view of what kind of work remains.

Ask the better question

Before asking, “What can we automate?” revenue cycle leaders should ask a more useful set of questions:

- What process are we considering for technology?
- Is the process consistent across locations, payers, specialties, and teams?
- Are the inputs reliable?
- Are payer requirements built into the workflow and documented, or are they knowledge that has been communicated verbally and staff “know” it?
- Who owns the exceptions when the automated process needs review / corrections?
- How do we measure the impact and improvement from the automation?

And then the bigger question:

- What are we about to scale?

If the answer is a consistent, repeatable workflow, clean data, clear payer logic, reliable reporting, and strong governance, automation can create real capacity and impact overall performance

If the answer is inconsistent processes, unclear ownership, and workarounds no one has fully mapped, automation may only move the problem faster.

The goal is not a more automated revenue cycle. The goal is a stronger one.