CASE STUDY: TURNING COLLABORATION INTO RESULTS

How one behavioral healthcare organization improved reimbursement, reduced denials, and strengthened cash flow through a partnership-driven approach to revenue cycle management.

THE CHALLENGE

A 72-bed behavioral healthcare provider offering residential, PHP, IOP, and outpatient services was experiencing significant revenue cycle challenges despite a strong clinical reputation and consistent patient census.

- Claims were frequently delayed due to incomplete documentation and missed authorization updates.
- Authorization gaps resulted in lost treatment days and revenue leakage.
- Denials averaged 16%, driven by medical necessity, documentation, and coding issues.
- Days in Accounts Receivable (A/R) averaged 63 days.
- Leadership lacked real-time visibility into revenue cycle performance.

Although each department was working hard, communication gaps and siloed processes prevented the organization from achieving optimal financial results.

THE SOLUTION

Panacea Healthcare Services partnered with the organization to redesign workflows, improve collaboration, and create accountability across the entire revenue cycle. Together, we implemented the following strategies:

- **Daily Interdisciplinary Huddles:** A 15-minute daily meeting between admissions, clinical, utilization review, and RCM to review new admissions, authorizations, discharges, and potential barriers.
- **Standardized Documentation Timelines:** Clear expectations for clinical note completion, physician documentation, and treatment plans within 24–48 hours.
- **Shared Authorization Tracking Dashboard:** Real-time visibility into authorization status, approved days, expiration dates, and concurrent review timelines.
- **Automated Claim-Ready Alerts:** Notifications triggered when documentation, orders, and coding criteria were met for timely claim submission.
- **Weekly Executive KPI Reviews:** Leadership received a concise dashboard highlighting revenue cycle trends, denials, A/R aging, and opportunities for improvement.

THE RESULTS

Within six months of implementation, the organization achieved significant and measurable improvements across all key revenue cycle metrics.

32% REDUCTION in average claim submission time	**27%** DECREASE in overall denial rate	**18** DAY improvement in Days in A/R
14% INCREASE in clean claim rate	**96%** AUTHORIZATION continuity rate achieved	**11%** INCREASE in net collection rate

> *Panacea didn't just help us submit claims faster—they helped us work better together. The transparency, accountability, and communication have transformed our entire revenue cycle."*
>
> *– Chief Financial Officer*
> *Behavioral Healthcare Organization*

REVENUE CYCLE JOURNEY BEFORE VS. AFTER

BEFORE	AFTER
Delayed communication between departments	Daily huddles and real-time updates
Incomplete documentation and missed deadlines	Standardized timelines and accountability
Authorization gaps and lost days	Proactive authorization tracking and alerts
High denial rate (16%)	Denial rate reduced to 11.7%
Slow claim submission (avg. 5–7 days)	Claims submitted within 1–2 days
Limited visibility into performance	Real-time dashboards and KPI monitoring
Cash flow fluctuations and revenue delays	Improved cash flow and financial stability

KEY SUCCESS FACTORS

- Leadership commitment to collaboration
- Clear communication across departments
- Standardized processes and documentation
- Proactive utilization review partnership
- Real-time data driving decision-making
- Accountability and shared ownership

ABOUT THE ORGANIZATION

This 72-bed behavioral healthcare organization provides a full continuum of care including Residential Treatment, Partial Hospitalization, Intensive Outpatient, and Outpatient Services. The organization is accredited and works with multiple commercial and Medicaid payers.

LEADERSHIP TAKEAWAY

Revenue cycle excellence is not achieved in isolation. It is built through alignment, accountability, and a true partnership between your organization and your RCM partner.

Better collaboration drives better outcomes—for patients and for your bottom line.

KPI SUMMARY (6-MONTH RESULTS)

METRIC	BEFORE		AFTER
Clean Claim Rate	86%	→	98%
Denial Rate	16%	→	11.7%
Days in A/R	63 Days	→	45 Days
Net Collection Rate	89%	→	100%
Authorization Continuity	82%	→	96%