

MEDCARE ASSOCIATES

LG Pain-to-ROI Use Case

Applying the Full Methodology to Improve Revenue Cycle
Performance and Reduce Provider Administrative Burden

A Realistic Multi-Office Primary Care Case Study | San Antonio, Texas

MEDCARE ASSOCIATES – COMPANY SNAPSHOT

~\$42M

Annual Revenue

9 Offices

Locations

47
(MD/DO/NP/PA)

Providers

~58,000

Patients

Service Model

Multi-office primary care with integrated behavioral health, chronic care management, and value-based contracts (Medicare Advantage + ACO)

Payer Mix

42% Medicare / Medicare Advantage, 28% Commercial, 18% Medicaid, 12% Self-pay & Other

Geography

San Antonio metro and surrounding South Texas communities (Bexar, Comal, Guadalupe counties)

Leadership Goal

Improve operating margin by 300+ bps and reduce provider burnout while preparing for further growth to 12–14 locations

THE INITIAL CHALLENGE

High Claim Denial Rate & Revenue Leakage

Overall denial rate of 11.8%. Coding and documentation inconsistencies across offices caused avoidable denials, especially on chronic care and transitional care management codes.

Slow Cash Collection (High DSO)

Average Days in AR at 47 days. Significant variation by office (range 34–61 days). Medicare Advantage and Medicaid plans contributed to longer payment cycles.

Provider Administrative Burden

Providers spent an estimated 1.8 hours per day on inbox management, prior authorizations, and documentation cleanup — a major driver of burnout and turnover risk.

Fragmented Data Across Offices

Nine locations running the same EHR but with inconsistent templates, work queues, and reporting. Leadership lacked a single, trusted view of performance by provider, office, and payer.

STEP 1: TIER 0 – FOUNDATION & QUICK WINS

Denial Root-Cause Baseline

Pulled 6 months of denial data by reason code, payer, office, and provider. Found that 38% of denials were documentation or coding related and therefore preventable.

Standardized Charge Capture Checklist

Created a simple one-page charge capture and documentation checklist for the top 12 CPT codes that drove the majority of revenue and denials.

Weekly Denial Dashboard (v1)

Built a lightweight weekly view showing denial rate, top denial reasons, and dollars at risk by office — first time leadership could see variation in near real time.

Early Win – Prior Authorization Queue

Centralized and cleaned the prior-auth work queue. Reduced average time-to-decision on pending authorizations from 9.2 days to 4.1 days within 5 weeks.

STEPS 2 & 3: SURFACING PAINS & THE DATA GALAXY

High Claim Denial Rate

Data Sources: EHR claims data, Clearinghouse rejection logs, Payer portal reports, Coding audit samples

Elevated Days in AR / Slow Collections

Data Sources: Practice management AR aging, Payment posting history, Contractual adjustment logs, Payer scorecards

Provider Administrative Burden

Data Sources: EHR inbox & task volume metrics, Time-motion samples, Provider surveys, Prior-auth volume by type

Inconsistent Documentation Quality

Data Sources: EHR note templates & usage logs, Coding query volume, Internal audit scores by provider/office

Fragmented Performance Visibility

Data Sources: EHR + PM system reports, Manual Excel workbooks, Office manager weekly packets, ACO quality portal

STEPS 4 & 5: TOP 5 PAINS & SELECTING THE #1 PRIORITY

SELECTED #1 PRIORITY

High Claim Denial Rate + Revenue Cycle Leakage

1	High Claim Denial Rate & Revenue Leakage	Very High Medium	Direct, measurable cash impact; high leadership urgency
2	Provider Administrative Burden	High Medium-High	Strong link to retention & quality, harder to quantify short-term \$
3	Elevated Days in AR	High Medium	Closely related to denials; often improves as denials fall
4	Inconsistent Documentation Quality	Medium-High Medium	Root driver of many denials; addressed as part of #1
5	Fragmented Performance Visibility	Medium Low-Medium	Enabler; partially solved through Tier 0 dashboards

STEP 6: TIER SELECTION

SELECTED TIER: TIER 1 – Targeted Process + Analytics Intervention

Focused on denial reduction, charge capture, and revenue cycle visibility without full system replacement

Data Readiness

EHR + practice management system already contained the majority of required data. No major new integrations needed for Phase 1.

Pain Complexity

Root causes were primarily process, documentation, and workflow — not missing technology. Tier 2+ automation was premature.

Speed to Value

Leadership needed measurable cash impact within 4–6 months. Tier 1 delivered the majority of available value fastest.

Change Capacity

Providers and office staff had limited bandwidth. A focused intervention with clear ownership was more sustainable than a broad transformation.

STEP 7: ONBOARDING (5 WEEKS)

Week 1–2

Data Access & Baseline Lock

Secure EHR/PM extracts, denial reason mapping, final baseline metrics (denial rate, AR days, top denial codes by \$)

Week 2–3

Success Criteria & ROI Framework

Agreed targets: Denial rate $\leq 7.5\%$, AR days ≤ 38 , preventable denial \$ recovered. Monthly ROI dashboard defined.

Week 3–4

Team Enablement & Governance

Named denial reduction owner per office + central revenue cycle lead. Weekly 30-min stand-up established. Simple RACI published.

Week 4–5

Change Management & Quick Wins

Provider education sessions on top 5 denial drivers. Charge capture checklist rolled out. First office-level denial scorecards live.

STEP 8: EXECUTION & ROI MEASUREMENT (6-MONTH RESULTS)

Denial Rate

7.1%

from 11.8%

–40%

Days in AR

36 days

from 47 days

–23%

Preventable Denial \$
Recovered

\$1.9M

from —

Annualized

Provider Admin Time

1.3 hrs/day

from 1.8 hrs/day

–28%

Key Execution Elements

Sprint cadence: 2-week sprints focused on top denial reason codes and highest-volume offices

Real-time visibility: Weekly denial scorecards by office and provider; monthly executive ROI review

Course correction: Mid-engagement pivot to address a sudden spike in Medicare Advantage medical necessity denials

Quick wins celebrated: First office to reach <8% denial rate publicly recognized; shared playbook across remaining sites

STEP 9: EXPANDING TO THE NEXT PRIORITIES

Next Priority #2 – Provider Administrative Burden

With denial processes stabilized, attention shifted to inbox volume, prior-auth automation opportunities, and documentation templates. Early pilots reduced average daily admin time another 18 minutes.

Next Priority #3 – Value-Based Care Performance Visibility

Built a unified quality + risk-adjustment dashboard across all 9 offices, reducing the time to prepare ACO and Medicare Advantage reporting packages from 11 days to 3 days.

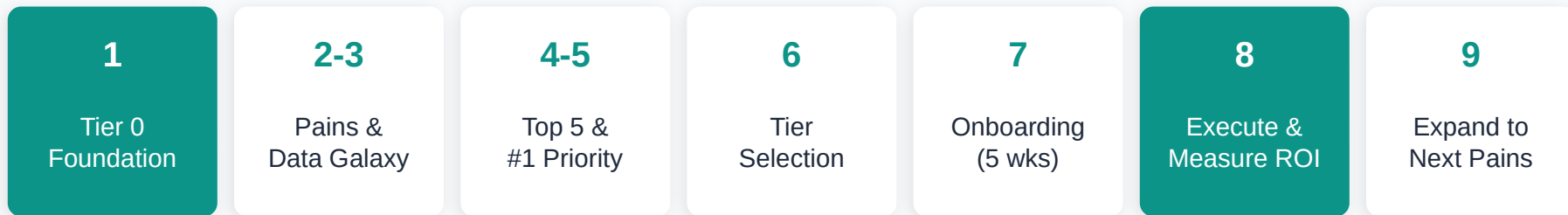
Capability Compounding

The original denial reduction team evolved into a standing Revenue Cycle Excellence committee. Monthly operating reviews now include denial rate, AR days, and quality metrics as permanent agenda items.

Tier Path Forward

Leadership is evaluating a selective Tier 2 investment in automated prior-authorization tooling and enhanced coding support for the highest-volume chronic care codes.

VISUAL MAP: LG METHODOLOGY APPLIED TO MEDCARE



KEY OUTCOMES FOR MEDCARE ASSOCIATES

- ▶ Denial rate reduced 40% (11.8% → 7.1%) within 6 months
- ▶ Days in AR improved from 47 to 36 days
- ▶ \$1.9M annualized preventable denial dollars recovered
- ▶ Provider daily admin time reduced 28%
- ▶ Standing Revenue Cycle Excellence committee embedded
- ▶ Clear path opened to Priority #2 (provider burden) and selective Tier 2 investments

KEY TAKEAWAYS

01

Pain-first prioritization works in healthcare

By focusing on the single highest-impact, most measurable pain (denials), Medicare achieved rapid, credible results that built trust for subsequent priorities.

02

Tier 1 was the right altitude

No new enterprise system was required. Targeted process redesign + focused analytics delivered the majority of available value in a resource-constrained environment.

03

Data already existed — it needed navigation

The EHR and practice management system contained the necessary signals. LG's role was to surface the right views and link them to clear ownership and action.

04

Momentum compounds

Success on denials created the political and operational space to address provider burden and value-based care visibility — the next most significant pains.

RECOMMENDED NEXT STEPS

Bring the LG Methodology to Your Organization

Schedule a focused discovery workshop to surface your top points of pain, map the relevant data sources, and identify the single highest-leverage starting point.

[Request a Discovery Workshop](#)

RECOMMENDED COMMERCIAL PATH – MEDCARE ASSOCIATES

LG Pain-to-ROI Platform | Tier 1 is the primary entry | No success fee

OPTIONAL – TIER 0

\$28,000 – \$35,000 fixed

3–5 weeks (optional)

Limited to foundation benefits only: baseline metrics, denial root-cause view, charge-capture checklist, and early quick wins. Not required to begin Tier 1.

TIER 1 – CORE ENGAGEMENT

\$18,500 – \$21,500 / month

6–9 months (primary entry)

Main commercial starting point. Focused delivery on the single highest-impact pain (claim denials + revenue cycle leakage). Sprints, scorecards, ROI tracking, and change management included.

LG PLATFORM SUBSCRIPTION

\$8,500 – \$10,000 / month

Ongoing after Tier 1

Maintains the governed data layer, monthly operating reviews, and supports expansion into the next prioritized pains (provider burden, value-based care visibility).

OPTIONAL EXPANSION

Project or higher monthly

As needed

Additional prioritized pains or selective Tier 2 automation (prior-auth tooling, enhanced coding support, etc.).

EXAMPLE 12-MONTH COMMERCIAL PATH (MEDCARE)

Tier 1 is the primary entry • Tier 0 is optional and limited to foundation benefits • No success fee

Period	Phase	Fee	Estimated Cost
Optional	Tier 0 – Foundation only	\$28k–\$35k fixed	\$0 – \$35,000
Months 1–7	Tier 1 – Core Engagement	\$20,000 / month	\$140,000
Months 8–12	LG Platform Subscription	\$9,000 / month	\$45,000
12-Month Total	Core path (Tier 1 + Platform)	—	\$185,000

Key Commercial Principles

- Tier 1 is the primary commercial entry point
- Tier 0 is optional and limited strictly to foundation benefits (baselines, quick wins, readiness)
- Straightforward monthly subscription only — no success fee or complex audit process