WHITEPAPER

Revenue Cycle Management for Multi-Specialty Practices

Key Challenges and Solutions for Groups Running Several Service Lines

A multi-specialty group is several billing operations sharing a tax ID. This guide covers where the complexity concentrates, what to standardise and what to leave specialised, and why segmented reporting comes before every other intervention.

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1. Executive Summary

Multi-specialty groups rarely designed their revenue cycle. It accumulated. A service line was added, its billing staff and processes came with it, and the pattern repeated. Several years later there are four ways of verifying eligibility, three denial workflows and one aggregate report that conceals all of it.

The financial consequence is not that any one service line performs badly. It is that nobody can tell which one does, because the group figure averages a strong line and a weak one into a number that looks acceptable.

> **The core finding**
>
> Segmented reporting by service line is the **prerequisite for every other improvement**, not one item among many.
>
> Until performance can be seen per line, improvement effort is spread evenly across service lines that need very different things, and the weak line stays hidden inside the average.

2. Why Multi-Specialty Is Structurally Harder

Dimension	The complication
Coding	Each specialty has its own code sets, modifier conventions and update cycles
Payer policy	The same payer applies different medical policies to different specialties
Prior authorisation	Requirements vary enormously. A shared team built for average load fails the heavy line
Documentation	Requirements are specialty specific, so a single standard does not transfer
Claim value	Mixed values mean a uniform follow up priority misallocates effort
Contracts	Rate adequacy differs by specialty within the same agreement
Systems	Acquired practices arrive with their own platforms
Staff capability	Uneven, and often dependent on one experienced individual per line

The last row is worth examining in any group. Service lines frequently perform well because one long serving biller knows that specialty's payers and quirks. That is a dependency, not a system, and it becomes visible only when the person leaves.

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Per service line
Where every metric must be measured

Common core
Registration, eligibility, posting, reporting

Specialty specific
Coding, payer policy, authorisation

3. Segmented Reporting, the Prerequisite

This comes first because without it no intervention can be targeted and no improvement can be demonstrated.

- **Define every metric once, for the whole group.** Service lines commonly calculate days in A/R differently, which makes comparison meaningless before it makes it wrong.
- **Report by service line first, aggregate second.** The aggregate is for the board. The segmented view is what management acts on.
- **Segment by payer within service line.** Payer behaviour differs by specialty, and that interaction is where most actionable patterns sit.
- **Establish baselines before changing anything.** Without a baseline, improvement cannot be shown and a deterioration cannot be detected.
- **Show each line its own numbers alongside its peers.** Visibility changes behaviour more reliably than instruction.

What groups usually find in the first segmented report

That one service line is carrying the group, and one is performing substantially below the others in a way the aggregate concealed.

Most groups also find that this is actionable immediately, without further analysis, because the causes concentrate in a small number of payer and procedure combinations.

4. Coding Across Specialties

The most common and most expensive transformation error in multi-specialty groups is consolidating coding into a single generalist team to reduce headcount.

Approach	Result
One generalist team across all specialties	Accuracy falls in every specialty. Denials concentrate in lower volume lines
Coders assigned by specialty, common quality standards	Accuracy maintained. Requires sufficient volume per line

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Approach	Result
Specialty coders with planned cross coverage	Accuracy maintained with resilience. The workable model for most groups
External partner with specialty depth	Accuracy without the volume requirement. Common where lines are small

Why the saving does not materialise

The headcount saving from consolidation is visible immediately. The denial increase appears one to two quarters later and frequently exceeds it.

Coding accuracy comes from repeated exposure to a specialty's codes, payer policies and documentation conventions. A coder handling six specialties is less accurate in all six.

What should be common: quality standards, audit process, documentation feedback loops to clinicians, and reporting definitions. What should stay specialised: the coding itself, and the payer policy knowledge that supports it.

See How Each of Your Service Lines Is Actually Performing

Our free RCM audit segments your revenue cycle performance by service line and payer, and identifies which lines are carrying the group and which are being carried.

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5. Prior Authorisation at Varying Intensity

Authorisation burden differs enormously between service lines. A group with primary care and orthopaedics has one line requiring authorisation rarely and another requiring it routinely. A shared team sized for the average fails the heavy line first.

- **Pool the capacity, specialise the knowledge.** A central team benefits from shared capacity, but each specialty needs its own requirement matrix.
- **Maintain a payer and procedure matrix per specialty.** Requirements differ by payer, by plan within a payer, and change without notice.
- **Size the team against the heaviest line, not the average.** Otherwise the heavy line absorbs the shortfall as denied claims.
- **Make the authorisation check a hard stop in scheduling**, consistently across all lines.
- **Record number, approved units and validity window**, since payers deny for unit and date mismatches even where authorisation exists.
- **Track authorisation related denials by service line**, because these are the least recoverable category.

6. Payer Contracts Across Service Lines

A single agreement can be adequate for one specialty and inadequate for another, and groups rarely examine rate adequacy at the service line level.

- **Assess rate adequacy per specialty**, not per contract. A rate that works for primary care may not cover the cost of a procedural specialty.
- **Identify carve outs that exist and are not being paid.** Common where the contract was negotiated for the group and implemented generically.
- **Verify payments against contracted rates per service line.** A systemic underpayment affecting one specialty will be invisible in a group total.
- **Use group leverage in negotiation.** Multi-specialty scale is a genuine advantage and is frequently unused. A payer error affecting three service lines is a stronger position than the same error raised by one.
- **Track administrative burden by payer and by line.** A payer that is rate competitive but denial heavy in one specialty may be costing more than it pays.

7. Front End Standardisation

Front end variation is the largest source of avoidable denials in multi-specialty groups, and the cheapest to fix because the required processes genuinely are common.

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Element	Standard	Specialty variation
Registration	One data capture standard across all lines	None required
Eligibility verification	One timeline, 48 to 72 hours ahead	Which benefits are checked
Authorisation	One tracking system and hard stop	Requirement matrices per specialty
Financial clearance	One policy on estimates and collection	Threshold may vary by procedure value
Referral management	One process where plans require it	Which lines require referrals

Patients seen across several service lines should also receive one consistent experience. A group where the cardiology desk collects at time of service and the dermatology desk does not is creating both a revenue gap and a patient confusion problem.

8. Denial Management Across Lines

Element	Common or specialised
Denial capture and categorisation	Common. One taxonomy across the group
Routing and prioritisation	Common. By value and proximity to timely filing
Root cause analysis method	Common method, segmented output by line
Appeal construction	Specialised. Requires specialty and payer knowledge
Payer escalation	Common. Group leverage exceeds single line leverage
Reporting	Common definitions, segmented results

The advantage groups consistently underuse

A denial pattern appearing in three service lines simultaneously is almost always a payer system error rather than a clinical or coding issue.

That is a considerably stronger escalation position than the same pattern reported by one line, and it is only visible if denials are categorised consistently across the group.

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9. Technology and System Fragmentation

- **A single practice management platform is preferable but rarely immediate.** Where multiple systems persist, build a reporting layer that normalises across them rather than forcing a premature migration.
- **Standardise data definitions before consolidating systems.** Merging inconsistently defined data produces a consolidated system containing inconsistent data.
- **Automate the rules based work first.** Payment posting, eligibility batch checking and claim scrubbing generalise well across specialties.
- **Do not automate a process that does not work.** Automation applied to a broken workflow produces faster failure and discredits the investment.
- **Sequence migration last.** It is the most disruptive change and benefits from settled processes preceding it.

10. Staffing and Capability

- **Map capability by service line before restructuring.** Groups frequently discover that one line's performance rests on a single individual.
- **Document what that person knows.** Payer quirks, workaround processes and escalation contacts are usually undocumented and leave with them.
- **Build a second person into every line.** Planned cross coverage rather than ad hoc reassignment when someone is absent.
- **Train to common standards, specialise in application.** Everyone works to the same quality bar. What they apply it to differs by line.
- **Use group scale for development and retention.** A larger organisation can offer progression that a single practice cannot, which helps retain the specialty knowledge that is expensive to rebuild.

11. What to Measure

Metric	Segmented by	Why
Days in A/R	Service line, then payer	Collection velocity per line
Denial rate by reason	Service line, then payer	Where causes concentrate
Denied dollars written off	Service line	The real loss. Percentages conceal it
Clean claim rate	Service line	Upstream quality per line

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Metric	Segmented by	Why
Net collection rate	Service line	What was collected against what was collectable
Authorisation related denials	Service line	Least recoverable category
Payment variance against contract	Service line	Rate adequacy and underpayment per line
Patient A/R	Service line	Where high value balances age

Every row in that table is segmented. That is the point. Aggregate reporting is the central reporting failure in multi-specialty organisations, and correcting it typically produces improvement on its own, because visibility changes behaviour before any process is redesigned.

12. Self Assessment

Work through this per service line rather than for the group as a whole. Any box you cannot tick for every line is a gap.

Visibility

- ☐ Every core metric is defined identically across all service lines
- ☐ Every metric is reported by service line before it is aggregated
- ☐ Metrics are segmented by payer within each service line
- ☐ Baselines exist for each line against which change can be measured
- ☐ Each service line sees its own numbers alongside its peers

Coding and authorisation

- ☐ Coders are assigned by specialty rather than working generically
- ☐ Common quality standards and audit processes apply across all lines
- ☐ Planned cross coverage exists, with named secondary coders per line
- ☐ A payer and procedure authorisation matrix is maintained per specialty
- ☐ Authorisation capacity is sized against the heaviest line, not the average

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Front end and denials

- ☐ One registration and eligibility standard applies across every line
- ☐ One authorisation tracking system with a hard stop in scheduling
- ☐ One denial taxonomy is used consistently across the group
- ☐ Root cause analysis output is segmented by service line
- ☐ Denial patterns appearing across several lines are escalated as a group

Contracts and capability

- ☐ Rate adequacy has been assessed per specialty, not per contract
- ☐ Payments are verified against contracted rates per service line
- ☐ We know which service lines depend on a single individual
- ☐ What those individuals know has been documented

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13. Frequently Asked Questions

Should a multi-specialty group centralise its billing?

Centralise what does not vary by specialty and keep specialised what genuinely does. Registration standards, eligibility verification, payment posting, patient billing, denial workflow and reporting benefit from centralisation. Coding, payer policy knowledge and authorisation requirements are specialty specific and lose accuracy when handled generically. The common failure is consolidating coding to reduce headcount and then absorbing a denial increase that exceeds the saving.

Why does our group report acceptable numbers while one location struggles?

Because the aggregate averages a strong service line and a weak one into a figure that conceals both. This is the most common reporting failure in multi-specialty organisations. Segmenting every metric by service line before aggregating usually reveals the problem immediately, and in most groups the causes concentrate in a small number of payer and procedure combinations that are actionable straight away.

What should we do first?

Define metrics consistently across the group and produce a segmented report by service line, with baselines. That single step is the prerequisite for everything else, and it frequently produces improvement on its own because a service line that can see its own denial rate against its peers usually acts before being instructed to. Front end standardisation follows, since it is the largest source of avoidable denials and the cheapest to correct.

How do we handle a service line that depends on one experienced person?

Treat it as a risk to be managed rather than a strength to rely on. Document what that person knows, including payer quirks, workarounds and escalation contacts, and build a named second person into the line with planned cross coverage. Groups usually discover this dependency when the individual leaves, at which point the knowledge is gone and the line's performance falls before anyone understands why.

Does group scale actually help in payer negotiations?

It does, and it is frequently unused. A denial pattern appearing across three service lines is almost certainly a payer system error rather than a clinical issue, and raising it as a group position is considerably stronger than raising it from one line. Rate adequacy should also be assessed per specialty within a group contract, since an agreement can be adequate for one line and inadequate for another.

14. How StafGo Health Helps

StafGo Health is a USA physician-owned revenue cycle management company supporting multi-specialty groups, DSOs and provider organisations nationwide. Multi-specialty work is structural before it is operational, which is why our engagements begin with visibility rather than with process change.

- **Segmented performance analysis.** Every metric by service line and payer, with baselines established before any intervention.

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- **Specialty specific coding.** Coders working each specialty regularly, under common quality standards and audit processes.
- **Prior authorisation management.** Pooled capacity with specialty specific requirement matrices and tracked queues.
- **Denial management.** One taxonomy across the group, root cause analysis segmented by line, and group level payer escalation.
- **Contract and payment verification.** Rate adequacy assessed per specialty, payments verified against contracted rates.
- **Reporting.** Monthly reporting segmented by service line, in plain language, against the metrics in section eleven.

See Your Group the Way It Actually Performs

In 30 minutes we will segment your revenue cycle performance by service line and show you which lines are carrying the group and which need attention.

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