Annual Benchmark Report

2025 EDITION

Revenue Integrity Redefined

Billing Compliance, HIM/Coding, and Revenue Cycle

MDaudit

Minimize Billing Risks. Maximize Revenues.

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INTRODUCTION:

Executive Summary

Revenue Integrity Redefined

2025 marked a defining moment in the evolution of revenue integrity, the central theme of this year's Benchmark Report. Too often, health systems take a defensive stance – fixing denials after they occur or responding to compliance findings after the fact. This reactive model is both costly and unsustainable. Today's leading healthcare organizations using revenue integrity as a proactive discipline, unite charge capture, coding, billing compliance, and denials management within a connected, data-driven framework. When these functions operate from a shared technology platform that enables data intelligence and automation, leaders can shift from managing crises to protecting revenue with foresight and confidence.

At MDaudit, we have long believed that revenue integrity is the foundation where risk mitigation, revenue optimization, and operational efficiency converge. Human ingenuity augmented with AI is here to transform revenue integrity over the next decade.

This shift is more urgent than ever. Payers have rapidly accelerated their use of artificial intelligence (AI). A 2024 survey revealed that insurance companies now lead nearly all industries, including technology, media, and telecommunications, in the adoption and testing of predictive and generative AI systems. This acceleration has contributed to unprecedented levels of claim denials, payment delays, workforce strain, and financial pressure throughout the healthcare sector.

In this environment, revenue integrity must be recognized and resourced as a mission-critical capability – one that safeguards the organization's financial health while supporting its ability to deliver quality care.

Ritesh Ramesh
Chief Executive Officer
MDaudit

Redefining Revenue Integrity

Revenue integrity ensures that healthcare providers accurately and ethically capture and optimize their revenue for the services they provide patients. An organization's daily revenue integrity activities are essential to maintaining financial stability, viability, and compliance while continuing to provide high-quality care to patients.

Revenue integrity needs a cross-functional approach across the organization

REVENUE CYCLE
- Are the bills going out at the right time/right place/ right payer?
- Are we paid on time/why are claims denied?

BILLING COMPLIANCE
- Are proper billing/coding rules being followed?
- Is there proper medical documentation?

PATIENT EXPERIENCE
- Am I paying the right amount for high-quality care and experience?
- How much do I owe out-of-pocket?

BILLING OPS
- Is all the information on the bill correct?
- Have we captured all the charges?
- Are there billing errors?

CODING
- Are the coders coding properly?
- Are we aware of recent regulatory updates?

CLINICAL/IT
- Am I documenting encounters properly?
- Are the billing edits in the system correct?
- Are my code scrubbers applying the correct rules?

Different stakeholders are asking different questions from the same data

ORGANIZATIONS SUCCESSFULLY DRIVING OUTCOMES WITH REVENUE INTEGRITY ARE:

Breaking down silos and working across the aisle with other functional teams – including compliance, coding, RCM, and clinical – to drive a unified revenue retention and growth agenda.

Setting up a formal revenue integrity program and a steering committee of cross-functional leaders to meet and share insights on a regular cadence.

Leveraging data and insights as a storytelling mechanism to deliver value by removing bias and injecting objectivity into discussions and decision-making.

Defining success metrics and leveraging powerful technology to boost team productivity, streamline manual processes, and establish accountability for tangible outcomes.

Keeping an open mind to learn from other organizations and peers about best practices to drive outcomes.

Key Takeaways: Top 2025 Trends

Healthcare providers are navigating a complex set of financial and regulatory pressures to drive sustainability. Providers who invest in emerging technologies to drive operational efficiency and empower their staff will be successful.

1 DENIALS ON THE RISE

In 2025, the average denied amount across hospital inpatient and outpatient settings increased by double digits - **14% in hospital outpatient and 12% in inpatient settings.**

2 PAYER AUDITS INCREASE

In 2025, the total at-risk amount and cases per customer **increased by 30%** for external payer audits. The average amount per claim also **increased by 18%.**

3 TECHNOLOGY UNLOCKS OUTCOMES

Revenue integrity teams are using data and AI driven approaches to unlock revenue opportunities and risk mitigation. Risk-based audits within the platform **increased by 25%** in MDaudit in 2025. Pre-bill audits **increased by 30%.**

4 OUTPATIENT CODING WORSENS

Coding-related denials continued to rise in outpatient settings in 2025. **There was a 26% increase** in coding-related denials, incremental to last year's 126% increase.

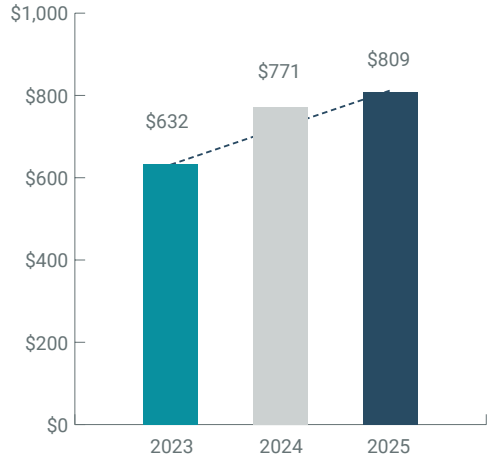
Who is this report for?

With industry insights, trends, and data, the annual MDaudit Benchmark Report empowers Compliance, HIM/Coding, Revenue Integrity, and Finance Executives to identify risks and opportunities to drive action and improve outcomes within healthcare. We hope you enjoy the report and find the insights and data actionable.

- **Chief Compliance Officers**
- **Chief Financial Officers**
- **Director of Professional / Hospital Billing Compliance**
- **VP or Director of HIM / Coding**
- **VP or Director of Revenue Integrity**
- **VP or Director of Revenue Cycle**

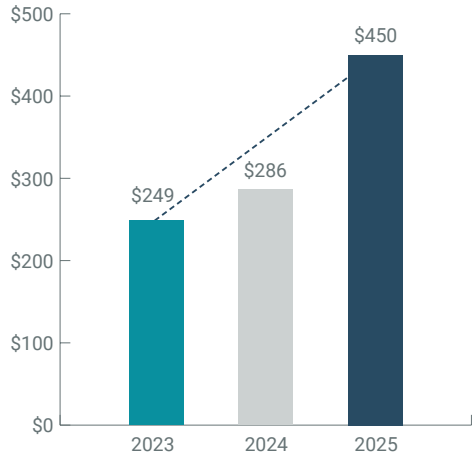
Year-over-year (YoY) Trends - At a Glance

Average Denied Amount - Coding Related



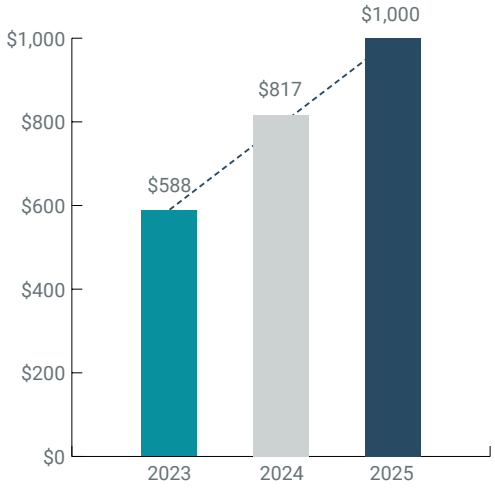
1. Coding-related denials across professional and hospital claims

Average Denied Amount - Information Needed/ Medical Necessity



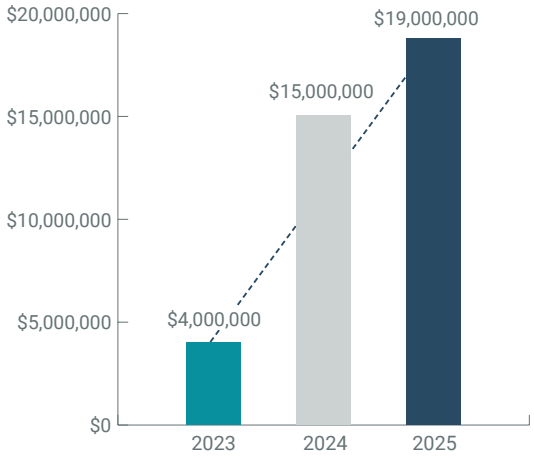
2. Information Needed/Medical Necessity-related denials across professional and hospital claims

Average Denied Amount - Medicare Advantage



3. Medicare Advantage related denials across professional and hospital claims

At-Risk Revenue per Customer - External Payer Audits



4. At-risk revenue per customer from payer audits across professional and hospital claims

How was this report compiled?

30 years
Industry experience serving Compliance and Revenue cycle

20
Payer Types including Federal, State and Commercial Payers

45
States across the U.S.

$20B+
Annual Charges Audited

4,500+
Facilities

1.2M+
Providers

140,000+
Coders

1.5M+
Annual Cases Audited

20M+
Annual Actionable Findings

5B+
Volumes of Claims and Remits Used for Benchmarking

$200B+
Denials Analyzed Annually

The data in this report was compiled from the first three quarters of 2025.

Billing Compliance

The billing compliance function plays a critical role in ensuring that healthcare organizations are billing properly to ensure long-term financial stability, promoting easier healthcare access to patients in their communities.

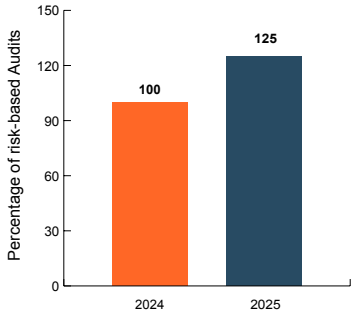
Chief Compliance Officers are transforming billing compliance functions to be a core component of the RCM value chain to drive exponential value with risk mitigation.

Traditionally, the billing compliance function has been hamstrung by manual processes, lack of technology investments, and management support. As you will see in this report, organizations that transform their billing compliance function do so with **people, processes, technology, and analytic investments** that drive exponential value to every stakeholder – their organization, patients, and the federal government.

INSIGHT #1: Risk-based audits increased by 25%

Compliance teams are leveraging data-driven approaches and benchmarking to discover real-time risks as they emerge. Risk-based audits within the platform increased by 25% in 2025, compared to 2024, in MDaudit.

Organizations that leverage data-driven platforms and deploy real-time, continuous risk monitoring, rather than traditional, schedule-driven, ad hoc audits, have an upper hand in being two steps ahead of payers in understanding their billing, coding, and payment trends in real-time and taking proactive action to educate providers and coders, as well as address issues.

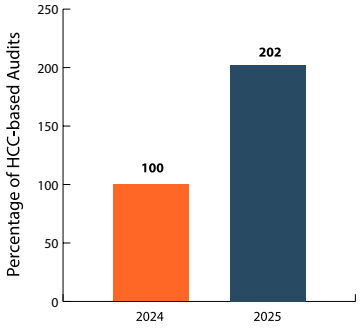


INSIGHT #2: HCC audits increased 102% driven by payer scrutiny on risk adjustment coding

In January 2025, the Wall Street Journal published an extensive article titled, '*How Health Insurers Racked Up Billions in Extra Payments from Medicare Advantage.*' The article estimated $50 billion in overpayments from 2019 to 2021, despite no doctor ever treating the diseases.

In May 2025, the Centers for Medicare & Medicaid Services (CMS) announced a significant expansion of its auditing efforts for Medicare Advantage (MA) plans. CMS planned to audit all eligible MA contracts for each payment year in all newly initiated audits and invest additional resources to expedite the completion of audits for payment years 2018 through 2024.

Hierarchical Condition Coding (HCC)-based audits within the platform increased by 102% in MDaudit in 2025 relative to 2024. The audits targeted diagnoses, rendering providers, and drug units administered. The majority of these audits were risk-based audits, where data anomalies and trends played a significant role in identifying audit targets, as opposed to relying solely on human intuition.



INSIGHT #3: Prospective or Pre-bill audits jumped by 30%

Compliance teams are adopting a hybrid strategy that involves conducting both retrospective and prospective audits. Gleaning risk insights from their large volumes of historical data and applying them prospectively provides them with more foresight, enabling them to get ahead of problems before they occur, anticipate payer actions, and mitigate financial disruption.

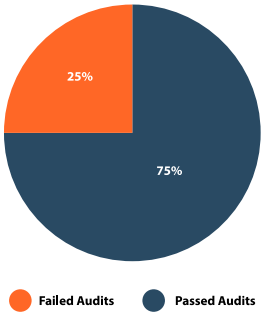
We often see organizations build their programs around retrospective auditing and expand the spectrum of their program to include prospective or pre-bill auditing. It's a holistic way of balancing both compliance and revenue risk, which is the hallmark of driving towards best-in-class revenue integrity assurance.

INSIGHT #4: 25% of the Telehealth audits completed failed

Telehealth services remained a critical component of care delivery in 2025. The top three reasons for failures include:

- Clinical Documentation Issues
- Incorrect Coding to the Right Levels
- Billing Errors

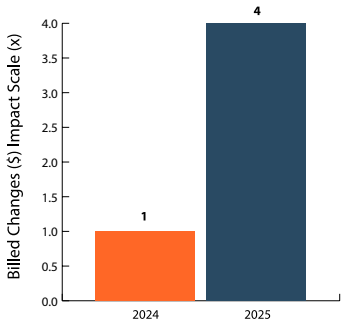
Many of the audits focused on new providers or coders who were involved in providing Telehealth services, and a robust post-audit education program may drive successful corrective actions.



INSIGHT #5: Billed charges impacted by clinical documentation audits increased by 4x

Clinical documentation audits in the system continued to increase this year with the advent of many new technologies deployed by healthcare providers in the outpatient setting. Total billed charges impacted by clinical documentation errors increased by 4X in 2025 compared to last year. Payers have been extremely diligent on documentation issues on medical necessity denials, driving healthcare providers to scramble to find ways to accelerate the claim adjudication cycle or high-value claims.

Failed audit reasons include a lack of documentation support for billed codes or missed revenue due to coding issues, even when documentation existed. Many customers are targeting high-profitability services like elective surgeries, cancer therapies, and cardiac treatments. Using these audits to drive coordination and education between clinical documentation improvement, providers, and coding teams to drive timely reimbursement and mitigate payer audits.



INSIGHT #6: Total At-risk Amount and Audit Requests Per Customer Increased by 30% for External Payer Audits

The total at-risk amount and cases per customer increased by 30% for external payer audits. Out of the top payer types, 45% of the at-risk amount was driven by commercial payers, while Medicare and Medicaid accounted for 28%. There have been numerous reports indicating that the percentage and number of denials by commercial payers have been steadily increasing this year, and our data appears to validate this trend.

The average at-risk amount for a payer audit at a hospital setting was approximately $17,000, whereas the average at-risk amount at a professional setting was $1,172.

In the **hospital setting,** the top three reasons for external payer audit requests were driven by:

25%	5%	5%
coding errors	medical necessity	billing errors

In the **professional setting,** the payer audit requests were driven by:

10%	10%	5%
missing information	coding errors	billing errors

The coding errors on the hospital side were primarily driven by errors in Diagnosis-Related Group (DRG) coding, procedure coding, and the use of investigational medical devices.

Insights Corner: Billing Compliance

A. Team Size

Number of Auditors	Distribution
1-5	36%
6-10	24%
11-20	21%
20+	14%

We are seeing the emergence of new teams within the revenue cycle, specifically *revenue cycle compliance*, alongside billing compliance teams in large health systems. These teams aim to address both overcoding risks and missed revenue.

Best-in-class revenue integrity teams will ensure that both revenue and risk are on the same side of the coin. Focusing on one aspect while ignoring the other will not drive a holistic agenda towards financial sustainability.

B. What's Being Audited

B.1 Professional billing

Retrospective – Top 5 Audit Types
1. Annual Review
2. New Provider
3. HCC
4. Risk Audit
5. Vendor Performance Audit

Prospective – Top 5 Audit Types
1. Pre-bill review
2. HCC
3. Annual Audit
4. Routine E&M Audit
5. Procedures Audit

B.2 Hospital billing

Retrospective – Top 5 Audit Types
1. IP Coding Review
2. OP Coding Review
3. ED Coding Review
4. Research Audits
5. Coder Quality Assurance Review

Prospective – Top 5 Audit Types
1. DRG Review
2. Facility Coding Review
3. Facility Star Audit
4. New Coder
5. Coding Quality

C. Audit Outcomes

25%
of rendering providers failed professional audits

33%
of the facilities under scope failed hospital audits

36%
of the coders audited failed hospital audits

D. External Payer Audits

Hospital Outpatient - Top 5 CPT/ HCPCS codes under scrutiny	
80048	Metabolic panel
85025	complete cbc w/auto diff cbc
85027	complete cbc automated
j2704	propofol, 10 mg injection
j3010	fentanyl citrate injection

Hospital Inpatient - Top 5 DRG codes under scrutiny	
871	Septicemia Or Severe Sepsis Without Mv >96 Hours With Mcc
219	Cardiac Valve And Other Major Cardiothoracic Procedures Without Cardiac Catheterization With Mcc
003	Ecmo Or Tracheostomy With Mv >96 Hours Or Principal Diagnosis Except Face, Mouth And Neck With Major O.R. Procedures
853	Infectious And Parasitic Diseases With O.R. Procedures With Mcc
329	Major Small And Large Bowel Procedures With Mcc

Professional - Top 5 codes under scrutiny	
96413	Chemo Iv Infusion 1 Hr
22853	Insj Biomechanical Device
76937	Us Guide Vascular Access
j0775	Collagenase, Clost Hist Inj
20527	Inj Dupuytren Cord W/Enzyme

Revenue Cycle Insights

The data in this year's report reveal how key market shifts, driven by financial and regulatory pressure, are impacting providers across the healthcare ecosystem. Financial leaders can no longer ignore the fact that revenue risk and growth are two sides of the same coin; ignoring one for the other will not result in financial sustainability. Commercial payers took longer to respond to initial claims submissions across all care settings, resulting in longer revenue cycles and higher costs. Average denied amounts surged into double digits for hospital inpatient and outpatient settings, driven primarily by Medicare, Managed Medicaid, and commercial payers. For Medicare Advantage plans, denial amounts increased by 20%, with requests for information (RFI) and denials related to medical necessity jumping nearly fivefold.

As data illustrates, the future of revenue integrity depends on moving from retrospective management to **real-time intelligence.** Organizations that invest in modern systems of intelligence, utilize AI and data to anticipate denials, automate workflows, and continuously measure coding and billing performance, are better equipped to weather payer behavior shifts and protect their financial health.

The insights that follow provide a clear picture of the challenges and opportunities shaping revenue integrity today, as well as how healthcare leaders can utilize data to strengthen compliance, accelerate reimbursements, and achieve sustainable financial outcomes in the year ahead.

INSIGHT #1: Average Lag Days For Initial Claims Response Increased for all care settings From Commercial Payers

Commercial payers took longer time to respond to initial claims submission. Time taken to adjudicate the initial claim submissions increased by three days for inpatient, seven days for outpatient in the hospital setting. Time taken to adjudicate the initial professional claims increased by nine days. On average, it took 30+ days for the hospital inpatient and outpatient claims and almost five weeks for professional claims. 2025 saw an increase in medical utilization of services, exposing commercial payers to higher medical loss ratio than what they estimated coming into the year.

Average Lag Days is a leading indicator for the total timeline of getting a claim paid effectively with lower processing costs. As the average days to adjudicate a claim increase, it puts the providers at a significant financial disadvantage as this issue scales across millions of encounters and claims. Health systems that track this metric perform well in fixing their upstream billing, coding and claim submissions processes and then holding payers accountable for their initial response times in their negotiations.

Claim Type	Average Lag Days (2024)	Average Lag Days (2025)
Hospital - Inpatient	36	39
Hospital - Outpatient	34	41
Professional	15	24

Average Lag Days by Commercial Payers for Initial Claims Response

INSIGHT #2: Average Denied Amount Across Hospital Inpatient And Outpatient Settings Increased in Double Digits

Average Denied Amount across hospital inpatient and outpatient settings increased by double digits – 14% in hospital outpatient and 12% in inpatient settings. The average denied amount in the professional setting fell by 1.3%. The top two payer types responsible for incremental increase in inpatient denials were Medicare and Managed Medicaid plans whereas the incremental increase in outpatient denials were driven by Medicare and commercial payers.

Medicaid, Medicare and Managed Medicaid plans were the top three payer types driving professional claim denials in 2025.

INSIGHT #3: For Medicare Advantage Plans, Average Denied Amount Increased by 20% and RFI/Medical neccesity related denials increased 5X

Medicare advantage plans have been in the news this year for all the wrong reasons. The federal government launched an investigation into coding practices of major health plans as outlined in this article in the billing compliance section. Many hospitals and health systems have been rejecting these plans for payments due to aggressive RFI and pre-authorization maneuvers from payers. Our data supports this trend.

The average denied amount for Medicare Advantage plans increased by 20% in 2025. The denial volumes increased as well by 2%. For RFI and medical necessity-related denials, the average denied amount for Medicare Advantage plans **increased almost 5X from $161 to $789 in 2025 vs. 2024.**

INSIGHT #4: Coding-Related Denials Increased 26% Across Professional and Hospital Outpatient Settings

Coding-related denials continued to rise in outpatient settings in 2025. **The 26% increase this year is incremental to the trend we reported in our last year's report where coding-related denials increased by 126% compared to 2023.** Errors with diagnoses coding, modifier usage and lack of support with medical records were the top three reasons that drove coding-related denials. Health systems have been facing shortage of coding professionals in the industry and deploying autonomous coding technologies or offshoring that can help augment the shortage of onshore coding talent. When governance and human controls are not put in place with these emerging AI technologies, it can introduce significant financial risks driven by coding decisions at scale from erroneous reasoning and logic by algorithms.

Healthcare organizations that augment their coding technology investments with a closed-loop coding integrity layer will end up winning the accurate coding and reimbursement race.

Claim Type	Average Denied Amount (2024)	Average Denied Amount (2025)	% Increase
Hospital - Outpatient	368	453	23%
Professional	115	148	29%

Average Denied Amount from Coding Related Denials

INSIGHT #5: Average Denied Amount From RFI and Medical Neccesity Denials Increased by 70% Across All Settings

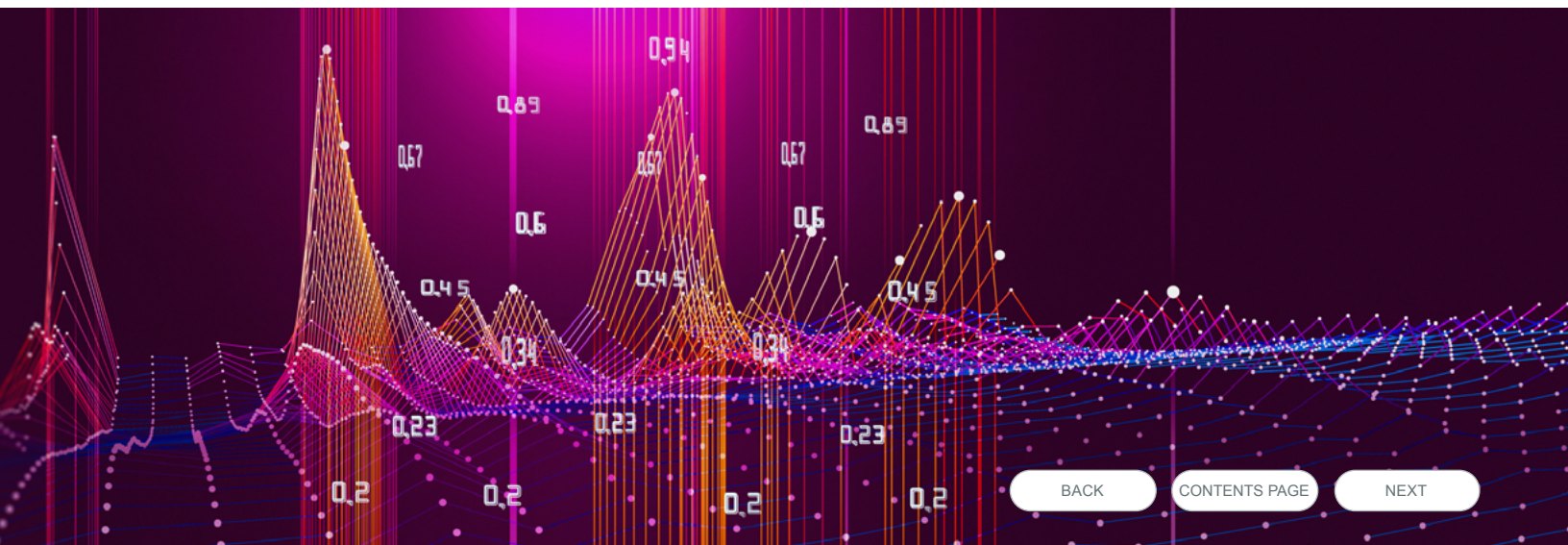
RFI and medical necessity-related to average denial dollars increased by 60% in the professional setting, 28% in the hospital outpatient setting and 123% in the inpatient setting in 2025 relative to 2024. The top payer types that drove the denial dollars were commercial insurance with an incremental increase of 176% and Medicare Advantage plans that increased 390% in this category this year.

Claim Type	Average Denied Amount (2024)	Average Denied Amount (2025)	% Increase
Hospital - Inpatient	787	1,760	123%
Hospital - Outpatient	314	402	28%
Professional	114	182	60%

Average Denied Amount from RFI and Medical Neccesity Denials

INSIGHT #6: Denials Related to Telehealth Services Provided at Home Increased by 47%

Telehealth-related denials, where the service was provided at home, increased by 84% in 2025 compared to 2024. Telehealth-related denials where the service was provided other than in the patient's home increased by 7% in 2025. The majority of these claims were denied due to missing information, errors in claim submission, non-covered charges, or duplicate claims.



Insights Corner: Revenue Cycle

A. AVERAGE DENIED AMOUNT

Claim Type	Average Denied Amount		% Increase
	2024	2025	
Professional	$229	$226	(1.31)%
Hospital Inpatient	$4,730	$5,390	14%
Hospital Outpatient	$504	$565	12%

B.1 TOP 5 DENIED DRG CODES BY AMOUNT

Code	DRG Name	Average Denied Amount
018	Chimeric Antigen Receptor (Car) T-Cell and Other Immunotherapies	$92,963
007	Lung Transplant	$55,989
014	Allogeneic Bone Marrow Transplant	$40,928
001	Heart Transplant or Implant of Heart Assist System with Mcc	$35,286
927	Extensive Burns or Full Thickness Burns with Mv >96 Hours with Skin Graft	$30,957

B.2 TOP 5 FREQUENTLY DENIED DRG CODES

Code	DRG Name	Average Denied Amount
871	Septicemia Or Severe Sepsis Without Mv >96 Hours with Mcc	$5,778
291	Heart Failure and Shock with Mcc	$4,450
807	Vaginal Delivery Without Sterilization Or D&C Without Cc/Mcc	$1,693
795	Normal Newborn	$717
853	Infectious And Parasitic Diseases with O.R. Procedures with Mcc	$8,721

C.1 TOP 5 CPT/HCPCS CODES BY AMOUNT

Code	CPT/HCPCS Name	Average Denied Amount
Q2055	Idecabtagene Vicleucel Car	$1,144,696
J3399	Inj Onase Abepar-Xioi Treat	$671,275
Q2054	Lisocabtagene Mara Car Pos T	$487,535
31554	Laryngoplasty Laryngeal Sten	$438,862
Q2041	Axicabtagene Ciloleucel Car+	$395,847

C.2 TOP 5 FREQUENTLY DENIED CPT/HCPCS CODES

Code	CPT/HCPCS Name	Average Denied Amount
85025	Complete Cbc W/Auto Diff Wbc	$134
36415	Coll Venous Bld Venipuncture	$53
80053	Comprehen Metabolic Panel	$286
93005	Electrocardiogram Tracing	$407
J2704	Inj, Propofol, 10 Mg	$93

D.1 TOP 5 E&M CODES BY AMOUNT

Code	CPT/HCPCS Name	Average Denied Amount
99468	Neonate Crit Care Initial	$1,696
99471	Ped Critical Care Initial	$1,569
99226	SUBSEQUENT OBSERVATION CARE	$1,230
99475	Ped Crit Care Age 2-5 Init	$1,227
99469	Neonate Crit Care Subsq	$930

D.2 TOP 5 E&M FREQUENTLY DENIED CODES

Code	CPT/HCPCS Name	Average Denied Amount
99214	Office O/P Est Mod 30 Min	$201
99213	Office O/P Est Low 20 Min	$138
99232	Sbsq Hosp Ip/Obs Moderate 35	$167
99233	Sbsq Hosp Ip/Obs High 50	$239
99204	Office O/P New Mod 45 Min	$252

E.1 TOP 5 CODING RELATED DENIALS - PROFESSIONAL

Denial Reason	Average Denied Amount
The procedure code is inconsistent with the modifier used or a required modifier is missing.	$150
The diagnosis is inconsistent with the procedure.	$98
This procedure or procedure/modifier combination is not compatible with another procedure or procedure/modifier combination provided on the same day according to the National Correct Coding Initiative or workers compensation state regulations/ fee schedule requirements.	$199
The procedure code/type of bill is inconsistent with the place of service.	$186
'New Patient' qualifications were not met.	$101

E.2 TOP 5 CODING RELATED DENIALS - OUTPATIENT

Denial Reason	Average Denied Amount
The diagnosis is inconsistent with the procedure.	$315
The procedure code is inconsistent with the modifier used or a required modifier is missing.	$901
The benefit for this service is included in the payment/allowance for another service/ procedure that has already been adjudicated.	$48
Payer deems the information submitted does not support this level of service.	$894
Charges do not meet qualifications for emergent/urgent care.	$728

E.3 TOP 5 CODING RELATED DENIALS - INPATIENT

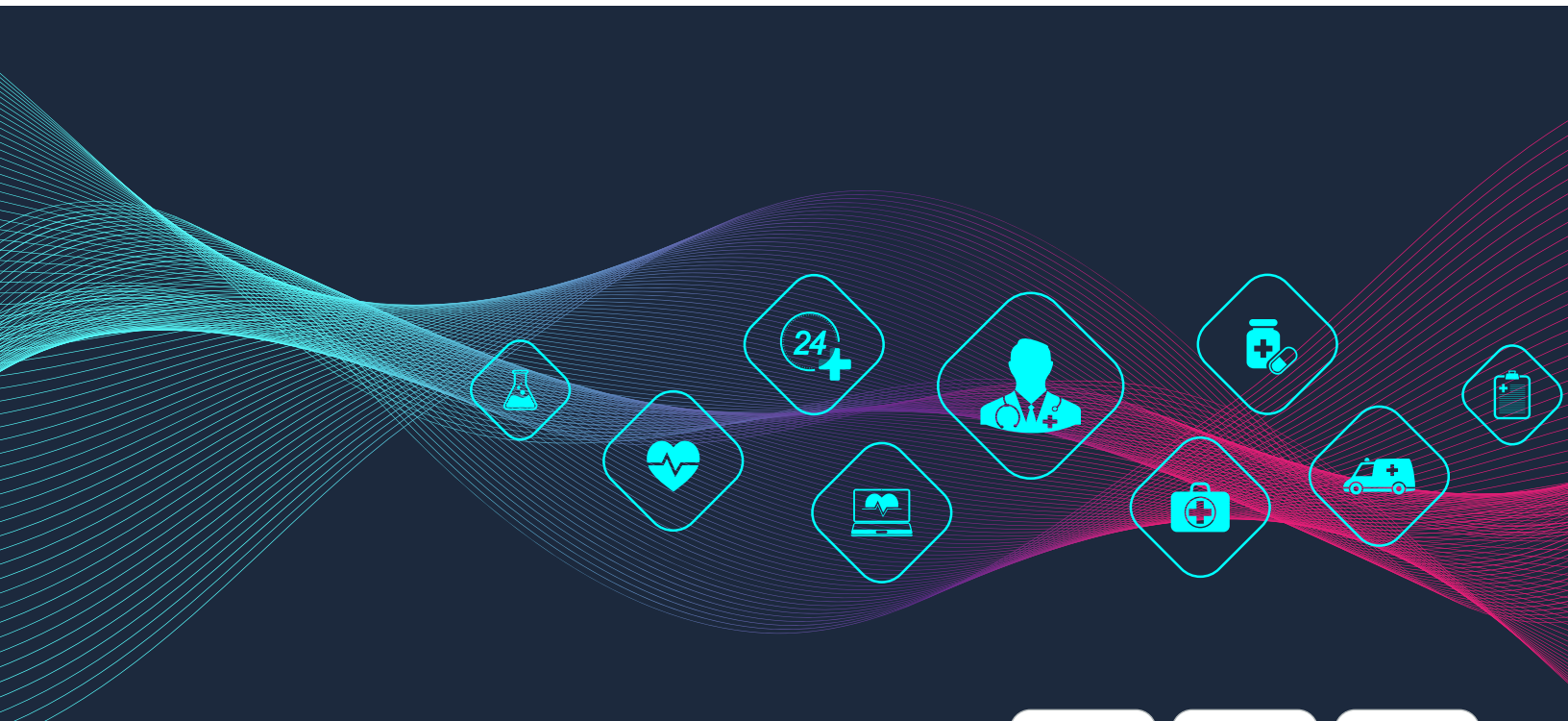
Denial Reason	Average Denied Amount
Payer deems the information submitted does not support this level of service.	$3,474
Services not documented in patient's medical records.	$401
This (these) diagnosis(es) is (are) not covered.	$62,635
The benefit for this service is included in the payment/allowance for another service/ procedure that has already been adjudicated.	$5,232
The diagnosis is inconsistent with the procedure.	$2,425

F. TOP 5 TELEHEALTH-RELATED DENIAL REASONS

Place of Service	Denial Reason	Average Denied Amount
Telehealth Provided Other than in the Patient's Home	Payer deems the information submitted does not support this day's supply.	$1,238
	Service/procedure was provided as a result of an act of war.	$779
	Payment denied based on the Medical Payments Coverage (MPC) and/or Personal Injury Protection (PIP) Benefits jurisdictional regulations, or payment policies.	$627
	Insured has no coverage for newborns.	$591
	Workers' Compensation claim is adjudicated as non-compensable.	$539

G. RFI / MEDICAL NECESSITY-RELATED DENIALS

	Average Denied Amount		% Increase
	2024	2025	
All Payers	$294	$465	37%
Medicare Part A	$618	$758	23%
Medicaid	$991	$1,100	11%
Commercial Insurance	$146	$403	176%
Medicare Advantage	$161	$789	390%



2026 Predictions: The Road Ahead for Revenue Integrity

The defining story of 2026 will be the shift from ***retrospective denial management to predictive, data-driven revenue optimization.*** Organizations that integrate AI responsibly and unite teams across multiple functions around real-time performance data will emerge more financially resilient in the year ahead.

1 Denials Will Become More Complex – and More Preventable

As payers refine their AI-driven adjudication processes, providers should anticipate further rise in denials, but not necessarily in volume alone – complexity will increase. Expect a shift toward multifactor denial reasons combining coding, medical necessity, and documentation gaps.

Prediction:

Health systems that deploy pre-bill revenue integrity solutions with predictive analytics and workflows will reduce preventable denials.

2 Payer Audits Will Escalate, Requiring Continuous Monitoring

Audit activity from commercial and government payers will likely intensify as AI continues to identify anomalies at scale. The number of high-dollar audits and recoupment cases is expected to increase, resulting in extended resolution timelines.

Prediction:

Organizations utilizing continuous risk monitoring tools will reduce payer audit response times by half and maintain tighter oversight of at-risk revenue through automation and centralized audit tracking.

3 Technology Adoption Will Drive Competitive Advantage

Revenue integrity teams that pair automation with intelligent human oversight will see measurable gains in accuracy, compliance, and speed. The integration of autonomous coding, predictive audit sampling, and workflow automation is expected to expand across the industry.

Prediction:

Providers who leverage AI-powered revenue integrity platforms will experience exponential lifts in operational efficiency and denial overturn success rates compared to those who do not adopt these technologies.

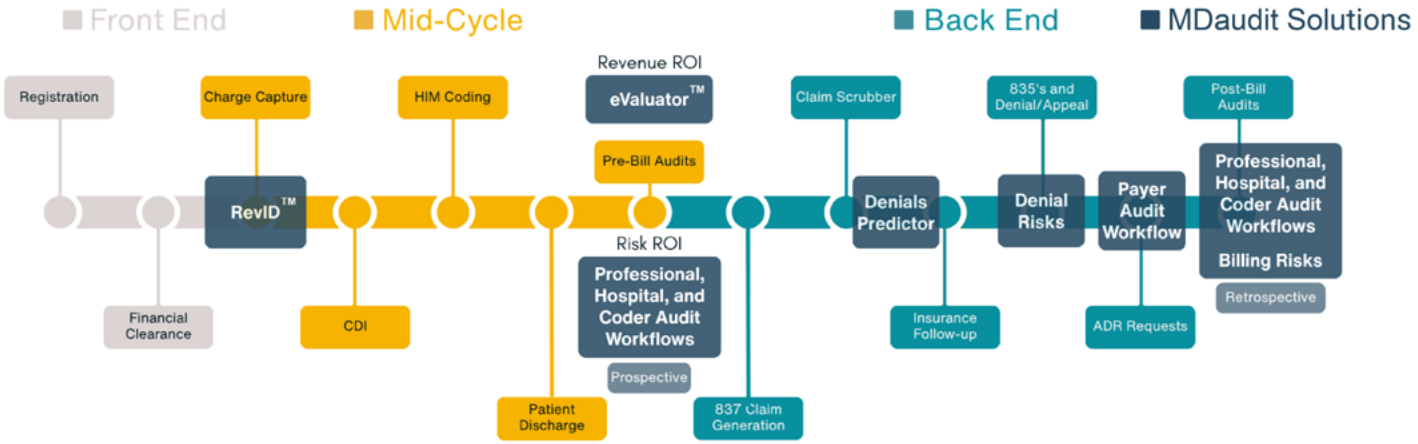
4 Outpatient Coding Accuracy Will Define Financial Performance

As outpatient volumes continue to grow and coding-related denials rise, the quality and oversight of outpatient coding will become a key performance differentiator. The shortage of certified coders is expected to persist, leading to an increased reliance on hybrid (human + AI) coding models.

Prediction:

Healthcare organizations that augment their coding technology investments with a closed-loop coding integrity layer will end up winning the accurate coding and reimbursement race.

MDaudit Solutions Map across the Revenue Cycle Continuum



MDaudit
Minimize Billing Risks. Maximize Revenues.

streamline HEALTH® by MDaudit

Solutions across the ***Revenue Cycle***

About MDaudit

MDaudit is an award-winning AI-powered continuous risk monitoring platform and trusted revenue integrity partner to healthcare organizations nationwide. Working in the background, we deliver the insights you need to face the future with confidence. Our sustainable solution enables teams to achieve more with less, driving an efficient and compliant revenue cycle in a rapidly evolving environment.

The 2025 acquisition of Streamline Health by MDaudit represents a strategic alignment of technology and expertise. Together, our solutions embody the four key characteristics we believe every best-in-class revenue integrity platform must deliver:

1. **Comprehensive Visibility** – Blind spots in charge capture or denials create unnecessary revenue leakage. With Billing Risks, RevID, and Denial Risks, organizations gain a real-time, end-to-end view of risks and opportunities across the revenue cycle.
2. **Proactive Risk Prevention** – Revenue and compliance risks must be addressed before they leave the door. Denials Predictor, eValuator, and our pre-bill solutions allow leaders to anticipate payer actions and strengthen their defenses in advance.
3. **Automation and Efficiency** – Healthcare teams are expected to accomplish more with limited resources. By automating repetitive workflows, our technology enables staff to focus on higher-value activities, such as education, analysis, and strategy.
4. **Measurable Financial Impact** – The true test of any solution is in its results. RevID has helped organizations recover millions of dollars in missed charges annually, while our Revenue Integrity Suite prevents denials and protects against audits that can jeopardize their financial health.

Together, we are **revenue integrity assurance** – bridging the gap between risk and revenue.

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To learn more, visit
www.mdaudit.com