MDaudit

Minimize Billing Risks. Maximize Revenues.

2024 EDITION

Annual Benchmark Report

Healthcare Billing Compliance, Coding, and Revenue Integrity

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MDaudit

Minimize Billing Risks. Maximize Revenues.

Introduction

EXECUTIVE SUMMARY

In our last report published in November 2023, we forecasted 2024 as a year of strong volumes but with operational headwinds on controlling costs, improving margins, and seizing opportunities to generate new revenue streams for healthcare organizations. As we look back on 2024, these forecasts have largely held true and there have been some positive trends toward regaining financial stability for healthcare providers through the year. According to recent reports[1], operating margins continue to improve at 4.1% national average. While some health systems realized improvements in patient volumes and operating margins, those with weaker financials are still struggling to recover after the pandemic. We are seeing the consolidation of health systems accelerating due to these financial pressures and market conditions directly affecting consumer choice and healthcare costs. This year continues to pose some of the same constraints as prior years for rising costs due to labor shortages, as well as new risks around timely payer reimbursement and the vital expense of cybersecurity insurance. Payers continue to deny claims at a higher rate, pay lower dollars per claim, and take longer to pay claims which contributes to financial instability for healthcare organizations.

Against this backdrop of challenges, revenue cycle management (RCM) transformation is the most critical strategic imperative for health systems in 2025. ***Continuous monitoring of financial risk*** is essential for proactively identifying potential issues and mitigating their impact on operations. This approach involves using real-time data, AI and analytics, and automation to detect, assess, and fix risks as they arise both on a short-term and long-term basis. Implementing an RCM strategy that prioritizes revenue optimization and risk mitigation while strategically coordinating resources across the mid-cycle and back-end functions with continuous risk monitoring capabilities will help ensure a more resilient and adaptive organizational strategy.

Revenues and Operating Margins improved through 2024. Cybersecurity and Timely Payer reimbursement are the two biggest risks that threatens the financial stability of healthcare providers. Continuous risk monitoring for RCM is critical.

[1] https:/www.kaufmanhall.com/sites/default/files/2024-09/KH-NHFR_Report-July-2024-Metrics.pdf

TOP TRENDS IN 2024

Trends	Insights
Cyber-attacks, ransomware, and breaches continue to be a threat to an organization's operations	According to the HIPAA journal[2], there were more than 350+ security incidents in H1 2024 that impacted more than 45M+ patients. The Change Healthcare cyberattack in February left the U.S. healthcare system reeling in terms of payment delays and liabilities. Any level of attack exposes an organizations' system vulnerabilities, impacts healthcare delivery, patient data, and further intensifies the financial instability of a healthcare system.
Payment Rates continue to decline	According to MDaudit data, the Average Denied Amount per claim increased 3% and 7% across both outpatient and inpatient settings respectively in 2024 vs. 2023.
Payers are doubling down on Medical Necessity Issues	According to MDaudit data, the Total Denials Amount related to the Medical Necessity and Information Needed category increased 75% on the Outpatient and 140% on the Inpatient in 2024 vs. 2023.
There is intense scrutiny of Medicare Advantage Plans around Fraud and Abuse	Medicare Risk Adjustment Data Validation (RADV) audits revealed a high risk of overpayments to Medicare Advantage (MA) plans resulting in an increase in RADV audits. The Centers for Medicare and Medicaid Services (CMS) estimates it will recover $4.7 billion[3] from Medicare Advantage plans between 2023 and 2032. Many healthcare providers are considering dropping MA plans due to authorization requirements and high denial rates. According to MDaudit data, the Total Denials Amount for MA plans increased by 51% in 2024 vs. 2023.
Medical Fee Schedule Rate Cuts for 2025 are coming	A proposed 2.8% reduction from last year; Telehealth waivers to expire end of 2024, changes to Merit-based Incentive Payment System (MIPS). The Centers for Medicare and Medicaid Services CMS issued the calendar year (CY) 2025 Medicare Physician Fee Schedule (PFS) proposed rule (CMS-1807-P) that includes changes to the Shared Savings Program to further advance Medicare's value-based care (VBC) strategy of growth, alignment, and equity.
OIG is focused on reducing costs on High-Cost Drugs	The Office of Inspector General (OIG) estimates a substantial decrease in Part B spending and low drug costs for beneficiaries by $400M+ by implementing the least costly alternative (LCA) policies and incentivizing use of Biosimilars. Drug utilization patterns will attract more scrutiny from payers in the year ahead for reimbursement.
Payer Audits doubled in volumes in 2024	External Payer Audit Volumes increased 2.2x and at-risk dollars increased 5x in 2024 vs. 2023. Many of these audits were pre-payment audits. Payers have traditionally conducted post-payment audits resulting in clawbacks, but prepayment audits expose a health system to potential denials and cash flow issues. Payers issued more requests for information (RFIs) in 2024 vs. 2023.
Department of Justice (DOJ) Guidance on AI and Analytics in Compliance Programs	The DOJ updated its guidelines for compliance (healthcare and non-healthcare) around artificial intelligence (AI) and analytics. This brings AI risks under the cadence of compliance officers for American corporations, including healthcare. The DOJ advocates for continuous improvement of compliance programs. This is where continuous monitoring and the use of data analytics to monitor risks in real time will become extremely valuable. According to the DOJ, those who invest in data analytic capabilities, and have a robust internal compliance program, may be shown good faith in investigations as a reward[4] for implementing these capabilities.

[2] https://www.hipaajournal.com/h1-2024-healthcare-data-breach-report/#:~:text=Healthcare%20Data%20Breaches%20Up%20Year,have%20come%20to%20an%20end

[3] https://www.federalregister.gov/documents/2023/02/01/2023-01942/medicare-and-medicaid-programs-policy-and-technical-changes-to-the-medicare-advantage-medicare

[4] https://www.wsj.com/articles/justice-department-pushes-companies-to-consider-ai-risks-116cfcf7?st=kdRWTt&reflink=article_copyURL_share

WHO IS THIS REPORT FOR?

With industry insights, trends, and data, our Annual 2024 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

HOW WAS THIS REPORT COMPILED?

The data compiled in this report comes from a vibrant sample of real-world data within the MDaudit platform, as shown below. This report aggregates all trends securely to deliver insights to the healthcare community. The data represents the period of Q1 - Q3 2024.

30 years
Industry experience serving Compliance and Revenue cycle

20
Payer Types including Federal, State and Commercial Payers

43
States across the U.S.

$8B+
Annual Charges Audited

2,200+
Facilities

650,000+
Providers

75,000+
Coders

1.5M+
Annual Cases Audited

8M+
Annual Actionable Findings

5B+
Volumes of Claims and Remits Used for Benchmarking

$150B+
Denials Analyzed Annually

Billing Compliance

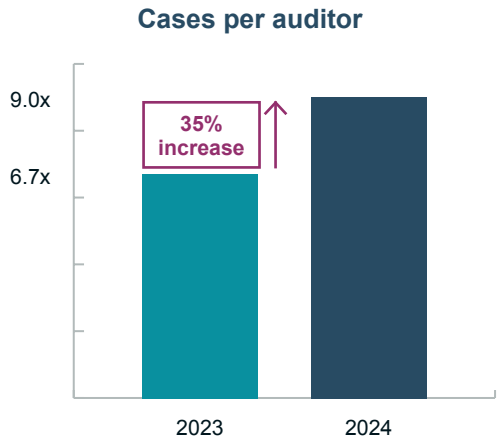
The billing compliance function plays a critical role in ensuring that healthcare organizations are billing properly to ensure long-term financial stability, promoting easier healthcare access to patients in their communities.

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

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.

Many MDaudit customers have not only been able to monitor their billing to be compliant so that they mitigate risk, but they're also double down on their revenue optimization agenda by teaming up with their financial leaders as they unearth improper billing that leaves revenues on the table.

INSIGHT #1 The Use of Technology and Analytics is Driving Substantial Productivity Gains Resulting in Healthier Margins



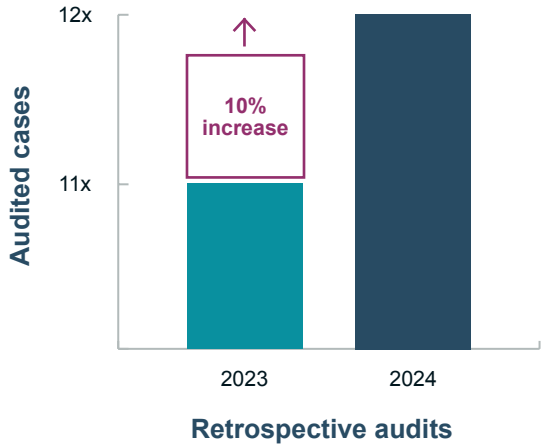
Strategic Insight:

Auditor productivity (cases audited per auditor) increased **35%** in 2024 vs. 2023 with no increase or a slight decrease to their teams. Increasing the volume of cases audited with a risk-based, data-driven approach enables billing compliance to function efficiently on both risk and revenue optimization agendas.

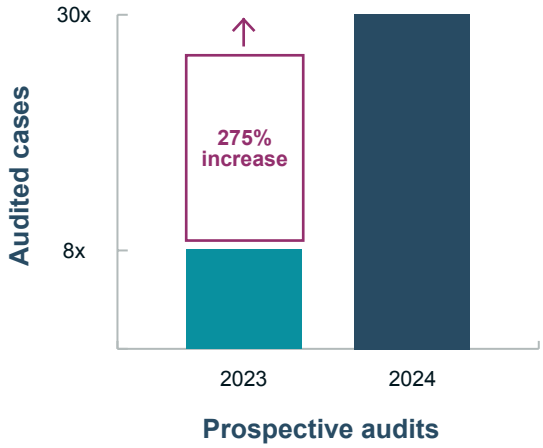
Implication:

The difference between winners and losers in the healthcare margin race will essentially be their investments in technology, data, and analytics to enable **real-time monitoring of billing risks.** People who rely on spreadsheets, random data samples, and manual processes will be left behind. For consecutive years now, the productivity data in our report has told this story.

INSIGHT #2 Organizations are Proactively Addressing Billing Issues by Leveraging Data and Insights from Their Historical Data



Retrospective audits



Prospective audits

Strategic Insight:

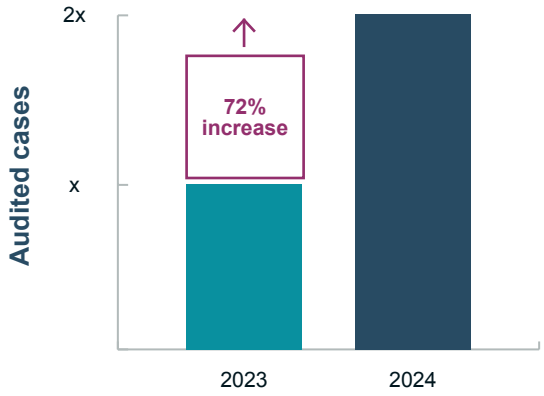
Retrospective audits in the platform increased by 10% and prospective audits increased by 275% in 2024 vs. the same period in 2023. Organizations are leveraging data and AI to unlock insights and patterns from their historical data and applying them prospectively to fix errors before bills get sent for payment.

Implication:

A hybrid auditing strategy approach of doing both retrospective **AND** prospective audits will result in organizations catching more errors in their charges and addressing them before payment. This approach will result in cleaner claims and higher first-pass payment rates translating into higher cash flows and margins.

INSIGHT #3

Risk Adjustment and HCC audits increased exponentially as scrutiny over Medicare Advantage plans accelerate



Strategic Insight:

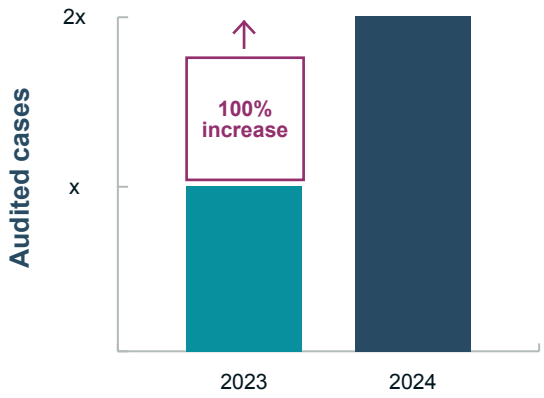
There has been much noise around the MA plans this year with one report alluding to almost $50B in overpayments[5] from the federal government. Hierarchical condition category (HCC) and Risk Adjustment audits in MDaudit **surged 72% in 2024 vs. 2023.** Billing compliance and coding teams are focused in this area to ensure there are no improper billing and coding practices that will lead to heavy fines and penalties from the government.

Implication:

As many health systems and practices are trying to transition to a VBC model, they must invest in technology and data-driven billing compliance function in-house or through their Management Services Organizations (MSOs) to ensure there is no systemic fraud or abuse in their system since this will pose one of the biggest financial risks. As the federal government looks for opportunities to balance the budget, it has heavily invested in OIG payment integrity programs to rein in fraud, abuse, and waste. We expect increased scrutiny around MA plans in the coming years.

[5] https://www.wsj.com/health/healthcare/medicare-health-insurance-diagnosis-payments-b4d99a5d

INSIGHT #4 Clinical Documentation Audits Increased Exponentially



Strategic Insight:

Clinical documentation audits and reviews surged by 100% in 2024 vs. 2023. According to MDaudit data, clinical denials have increased 51% in the last 3 years, and this should not come as a surprise. Payers have been increasingly denying claims due to clinical documentation issues. This includes missing details on patient diagnoses or specificity on treatment paths. Many MDaudit customers are laser-focused on having a clinical documentation improvement (CDI) integrity program that drives outcomes tied to their RCM and denial management metrics.

Implication:

Healthcare organizations are laser-focused on driving healthy operating margins this year and beyond. These margins are primarily enabled by high-value outpatient services like elective surgeries and some inpatient services. Organizations can start to identify those services and ensure that their CDI, billing, coding, and RCM programs are tightly coupled to implement a 'closed feedback loop' from the backend to the mid-cycle to drive efficiencies. An increase in AI-powered systems can amplify errors at scale and having '**humans in the loop**' is critical as they implement technology platforms.

INSIGHT #5

More than 25% of Providers on Average Failed Audits Across Both Professional and Hospital Care Settings

PROFESSIONAL BILLING

24%

Of cases audited were unsatisfactory

33%

Rendering Providers audited failed audits

HOSPITAL BILLING

22%

Of cases audited were unsatisfactory

23%

Attending Providers audited failed audits

Strategic Insight:

33% of rendering providers audited for professional failed their audits whereas 23% of the attending providers failed audits in the hospital setting. As patient visits have surged[6] post-COVID coupled with increases in mergers and acquisitions (M&A) this year compared to previous years, many hospitals are aggressively recruiting providers to keep up with the demand. This 'New Provider' cohort introduces risks to billing compliance programs. Many MDaudit customers have a streamlined provider education program that is focused on collaboration and education with the providers enabled by strong data, facts, and mitigation strategies to eliminate compliance and revenue risks.

Implication:

Healthcare organizations should focus on implementing a scalable provider education and compliance program that encourages collaboration and transparency. Leveraging data and insights across various domains like claims, denials, and audits with benchmarking details for provider education, will foster knowledge sharing and camaraderie vs. a punitive compliance program that does not incentivize performance improvements and results.

[6] https://www.healthleadersmedia.com/ceo/pumping-volume-boosting-advocate-healths-bottom-line

MDaudit Billing Compliance Solutions

MDaudit's billing compliance solutions have strong risk-based analytics capabilities and streamline audit workflows by offering a single-source solution within your organization, including hospital, professional, and coder records, both in real-time and retrospectively. Audits become more efficient through the use of templated and customizable workflows, automated scheduling, task assignments, and digital document management. Additionally, MDaudit provides robust audit reporting capabilities with advanced analytics dashboards that enables users to uncover insights quickly.

1	2	3	4
Drive productivity by doing more audits to detect compliance and revenue risks	Identify real time billing risks with analytics and benchmarking	Educate physicians and coders to mitigate systemic compliance and revenue risks	Measure ROI and value of your compliance program in driving business value
• Intuitive Automation and Workflows (retrospective and prospective) • Scheduled Audit Planner • Robust E&M and Risk Area Worksheets • QA workflow	• E&M Utilization • Procedure Utilization • Facility Metrics • Proprietary Benchmarking	• Management and Ad hoc Reporting • Corrective Action Plans and Tasks Management	• Audit Insights • Insights.ai • Financial Impact Summary

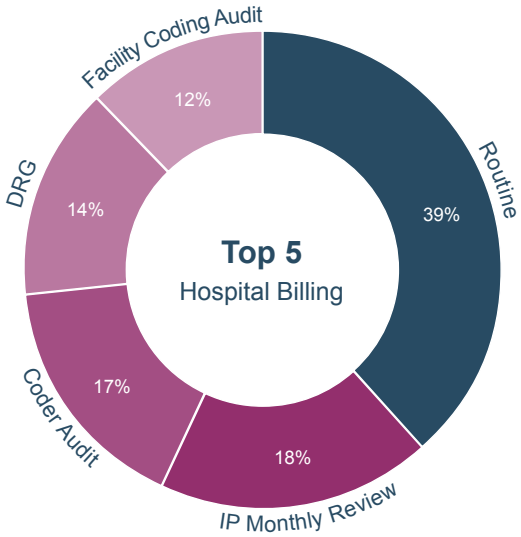
Workflows & Billing risks:
https://www.mdaudit.com/solutions/billing-compliance/audit-workflows/

> *"The effectiveness, the efficiency, the confidence that we can have in the results that come out of MDaudit have been vital. There hasn't been a question that's been asked from our compliance leaders or operational leaders that MDaudit hasn't been able to answer."*
>
> **– Director of Compliance**

With MDaudit, Approximately $6M of Annual Charges and 1,500+ Providers were Audited in the first 12 Months[7]

[7] https://www.mdaudit.com/resource/case-study/nonprofit-health-system/

AUDIT TYPES



CASE ACCURACY

E&M services

Professional Case Accuracy	
Retrospective	Prospective
78%	73%

Hospital Case Accuracy	
Retrospective	Prospective
86%	81%

Procedure services

Professional Case Accuracy	
Retrospective	Prospective
81%	71%

Hospital Case Accuracy	
Retrospective	Prospective
86%	77%

AUDIT FAILURE REASONS

PROFESSIONAL BILLING

- **58%** Diagnosis Documented not Billed
- **12%** Modifier Required not Billed
- **12%** E&M Service Overcoded 1 Level
- **8%** Diagnosis linked incorrectly
- **10%** E&M Service Undercoded 1 Level

HOSPITAL BILLING

- **39%** Medical Coding
- **37%** Secondary Diagnosis documented not Billed
- **9%** Add Secondary Diagnosis Code
- **7%** Diagnosis Documented but not Coded
- **7%** Procedure Documented but not Billed

REVENUE OPPORTUNITY FOR BILLING A CLAIM CORRECTLY (UNDERCODING)

Professional Billing

- **$55** CT/HCPCS
- **$202** Diagnoses
- **$13** Modifiers

Hospital Billing

- **$212** CT/HCPCS
- **$4,901** DRG
- **$1,980** Drug Units
- **$3,923** Diagnoses
- **$191** Modifiers

MDaudit's curated list of the most frequently overcoded and undercoded CPT/HCPCS codes

Professional Billing

UNDERCODED - TOP 5 CPT/HCPCS CODES

Code	Description
99213	Office O/P Est Low 20 Min
99203	Office O/P New Low 30 Min
99214	Office O/P Est Mod 30 Min
99212	Office O/P Est Sf 10 Min
99222	1St Hospital Ip/Obs Care Moderate Mdm 55 Minutes

OVERCODED - TOP 5 CPT/HCPCS CODES

Code	Description
99214	Office O/P Est Mod 30 Min
99204	Office O/P New Mod 45 Min
96413	CHEMO IV INFUSION 1 HR
99215	Office O/P Est Hi 40 Min
99233	Sbsq Hospital Ip/Obs Care High Mdm 50 Minutes

Hospital Billing

UNDERCODED - TOP 5 CPT/HCPCS CODES

Code	Description
G0463	HOS OP CLIN VISIT ASSESS & MGMT PT
58571	TLH W/T/O 250 G OR LESS
33224	INSERT PACING LEAD & CONNECT
99285	Emergency Department Visit High Mdm
99284	Emergency Department Visit Moderate Mdm

OVERCODED - TOP 5 CPT/HCPCS CODES

Code	Description
27130	TOTAL HIP ARTHROPLASTY
Q4081	INJ EPOETIN ALFA 100 UNITS
J9035	INJECTION BEVACIZUMAB 10 MG
G0378	HOSPITAL OBSERVATN SERVICE PER HOUR
G0390	TRAUMA RESPONSE TEAM W/HOSP CC SERV

Revenue Integrity

Revenue integrity ensures that healthcare providers accurately and ethically capture and maximize 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.

REVENUE INTEGRITY INTRODUCTION

2024 was a different year in the supply-demand story for U.S. Healthcare. Patient volumes surged[8] to pre-pandemic levels across outpatient and inpatient settings with outpatient care projected to surge almost 17% in the next decade. The volumes primarily were the driver behind better operating margins this year

Does this mean all is well when it comes to profitability across all health systems? The answer is no – there is a huge chasm between high-performing health systems and poorly performing ones. The strong performers are making the right investments in M&A, AI, data, and technology and while transforming their people operations with internal and external workforce to enable efficient operations and keep administrative costs low.

RCM leaders who drive a progressive data-driven, people-led, and technology-enabled approach to the revenue cycle will position their organizations to be steps ahead of the payers towards a sustainable financial future.

The regulatory headwinds and payer pressure on RCM is not going anyway soon when it comes to a seamless and predictable cash flow. Hence revenue integrity and revenue cycle leaders should continue to look for technology-enabled opportunities for their operations that yield the best return on investment and enable them to monitor real-time financial risks on payer trends and denial management, while kickstarting automation opportunities that drive operating margins. There is enormous upside on the operating margins as technology and AI-enabled productivity improves in the next decade. It needs an open mind – **a data-driven, people-led, and technology-enabled approach to revenue cycle management.**

REVENUE INTEGRITY INSIGHTS

INSIGHT #1 Average Denied Amount Per Claim Increased Across Professional and Hospital Care Settings

	Increase from 2023 (%)
Professional	4.2%
Hospital - Outpatient	4.8%
Hospital - Inpatient	6.9%

Medicare (Part A / Part B)	Increase from 2023 (%)
Professional	(7.2%)
Hospital - Outpatient	7.4%
Hospital - Inpatient	30.2%

Commercial Insurance	Increase from 2023 (%)
Professional	30%
Hospital - Outpatient	1%
Hospital - Inpatient	(54%)

Strategic Insight:

The average denied amount per claim increased by 4.2% – 6.9% in 2024 across professional, hospital–outpatient, and hospital–inpatient settings in 2024 vs. 2023. This was led by Medicare Part A impacting inpatient denials by a 30% increase and Commercial Payers impacting professional denials by 30%.

Implication:

Organizations need to understand trends around payer behavior, patient demographics served by their payers, and what it means to their bottom line. By doing so, they can allocate resources appropriately to drive sustainable financial outcomes. It's not a surprise that Medicare is zeroing in on services in inpatient settings due to the complexity of care associated with the Medicare population. Meanwhile, office and emergency department (ED) visits surged this year, post-COVID with commercial payers zeroing in on professional claims.

[8] https://www.advisory.com/daily-briefing/2024/06/18/hospital-volumes

INSIGHT #2 Average Lag Days is 18-24 Days Across Professional and Hospital Care Settings

	2024 Average Lag Days
Professional	18 days
Hospital -Outpatient	19 days
Hospital - Inpatient	24 days

Strategic Insight:

The time taken by payers to respond to the initial claim submission by providers **improved** overall this year across care settings and all payers between **2-5 days** but still the *average lag days* is anywhere between **18-24 days for a claim.** These trends came amidst the Change Healthcare cyberattack disruption in late Q1, 2024 that disrupted payment operations for many providers and forced them to submit claims manually. Many providers are still recovering from the impact.

Implication:

Improving *average lag days* is a positive first step for providers in getting their claims paid. This metric tracks their claims' operational efficiency in the RCM lifecycle. If the current 4-to-5-week initial response window from the payer deteriorates further, it will impact positive cash flows and accounts receivable (AR) for healthcare organizations. Hence RCM leaders need to track this metric in real-time by payer type and payer, to plan their AR strategies.

INSIGHT #3 Payers Denied More Dollars Due to Information Needed and Medical Necessity Reasons

Payer Type	Increase from 2023 (%)
Professional	34%
Hospital Outpatient	84%
Hospital Inpatient	**148%**

Payer Type	Increase from 2023 (%)
Medicare Part A	**56%**
Medicare Part B	5%
Medicare Advantage	34%
Commercial Insurance	**122%**

Strategic Insight:

Medicare and commercial payers denied more claim dollars in 2024 due to a lack of information submitted for the service and medical necessity. Final denial dollars across professional, hospital outpatient, and hospital inpatient surged 34%, 84%, and 148%, respectively. These high numbers were driven by commercial payer's RFI denials that increased by 122% in 2024.

Implication:

There have been several headlines this year around commercial payers issuing RFI and denying claims leading providers to complain about the timeliness of payments. As volumes have returned to pre-pandemic levels and provider fee schedules have been shrinking, we expect payers (both federal and commercial) to continue their scrutiny of claims for medical necessity including labs, specialty drugs, medical implants, and high-cost treatments. Providers should tighten their CDI programs to integrate with their billing and coding programs.

INSIGHT #4 Medicare Advantage-Related Denials Increased by 59% on Average Across Professional and Hospital Settings in 2024

	Increase from 2023 (%)
Professional	36%
Hospital Outpatient	36%
Hospital Inpatient	**87%**

Strategic Insight:

MA denials increased by 87% in the inpatient setting and 36% in the professional and outpatient setting in 2024. Many providers have been worried[9] about the increasing number of pre-authorizations and denials associated with MA plans this year leading many to abandon taking patients with these plans. OIG and CMS for their part have been scrutinizing MA plans[10] for overpayments which they estimate run into billions of dollars.

Implication:

Billing and revenue cycle compliance teams should be laser-focused on HCC audits, risk adjustment coding, and any value-based reimbursements associated with the MA plans. This is a huge driver of financial risk for healthcare organizations. OIG, CMS, and External Audit Contractors are scrutinizing services associated with these plans for overpayment, fraud, abuse, and waste.

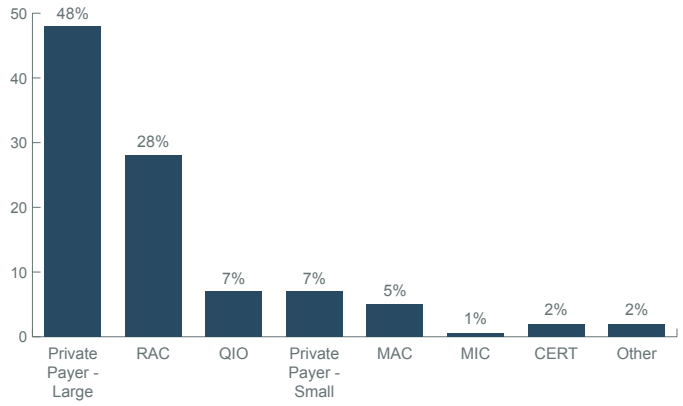
[9] https://kffhealthnews.org/news/article/health-202-hospitals-doctors-medicare-advantage/

[10] https://www.mintz.com/insights-center/viewpoints/2406/2024-02-06-enforcemintz-government-scrutiny-medicare-advantage

INSIGHT #5 Total At-risk Dollars from Payer Audits increased 5x in 2024

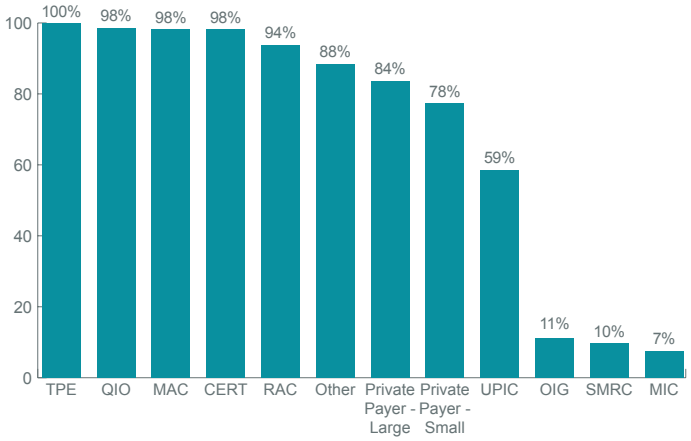
At Risk Dollars per MDaudit Customer (2023)

$2.6M



At Risk Dollars per MDaudit Customer (2024)

$11.2M



Strategic Insight:

External Payer Audits increased nearly 5x in terms of at-risk dollars in 2024 vs. 2023. The average at-risk dollar per customer in the MDaudit community increased from $2.M to almost $11.2M. These audits are primarily coming from large private payers as well as Recover Audit Contractor (RAC) and Medicare Administrative Contractor (MAC). Many revenue integrity departments are struggling to defend revenue from the onslaught of these payer audits due to limited resources or working with external partners who are not technology-enabled to be effective. Many of our customers shared that these audits have moved from being post-payment to pre-payment this year, which potentially means more denials, constraining cash flows for providers.

Implication:

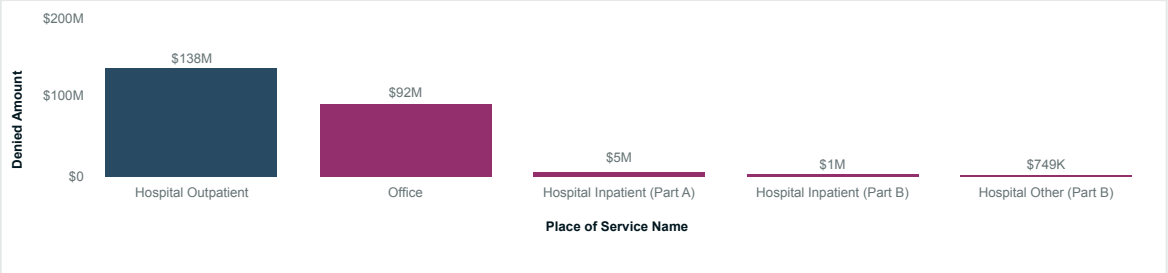
Revenue integrity and compliance programs should view this area as a low-hanging revenue capture opportunity since these audits are now being deployed in pre-payment mode. Investments in technology and analytics will ensure that additional documentation requests (ADRs) are being received, processed, and answered on time by the providers within the timely filing limits so that they can defend and retain revenue.

In the last 12 months, customers in the MDaudit community have retained more than $100M in revenue by transforming their revenue integrity function with streamlined workflows and analytics to tackle payer audits. Additionally, having a strong internal compliance program and an operating model that cross-functionally connect the dots between billing, coding, CDI and revenue integrity is what differentiates winners from laggards.

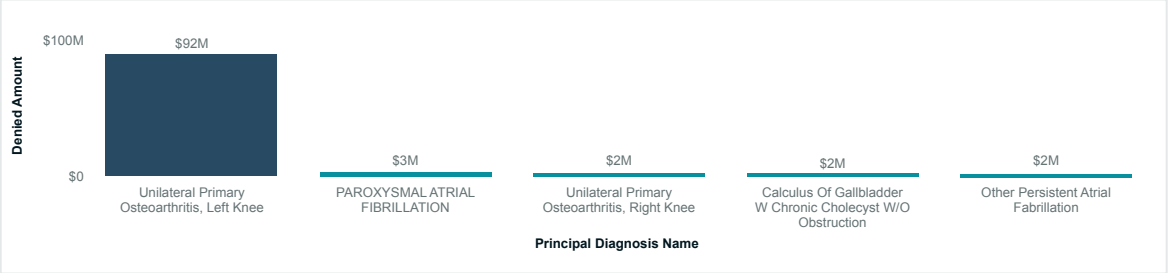
INSIGHT #6 There is Increased Payer Scrutiny of GLP-1 Drugs

Initial Denied Dollars	Final Denied Dollars	Initial to Final ratio
$256M	$237M	92%

Top 5 – Place of Service settings



Top 5 Diagnosis codes denied



Strategic Insight:

There has been lots of scrutiny[11] from both commercial payers, as well as Medicare and Medicaid when it comes to compliance and reimbursement of GLP-1 drugs like Ozempic, Wegovy, Rybelsus, and Trulicity. These drugs have proven to be truly transformational in driving patient outcomes and quality of life like lowering diabetes, metabolic disorders, and weight loss but the demand for these drugs has skyrocketed in the past year, driving costs higher for the payers.

This has led payers to scrutinize[12] medical necessity and utilization of these drugs across the provider base.

Implication:

In 2024 alone, more than $250M+ were denied by payers across the MDaudit community for GLP-1 utilization. More alarming is the fact that 95% of the initial denials were final denials. Two-thirds of these denials came from hospital outpatient and office settings.

[11] https://www.beckerspayer.com/payer/elevance-seeks-clawbacks-for-off-label-ozempic-prescriptions-report.html

[12] https://www.drugdiscoverytrends.com/can-payers-afford-the-new-era-of-glp-1-drugs-or-can-they-afford-not-to/

MDaudit Revenue Integrity Solutions

MDaudit's Revenue Integrity solutions ensures that users maintain a robust bottom line. By consolidating proven integrated risk capabilities and workflows within a single platform, our Revenue Integrity Suite establishes a closed-loop feedback process that connects insights, actions, and outcomes for effective high-impact denial management. This platform proactively prevents denials by automating an end-to-end prevention process that utilizes payer remittance data to identify systemic risks based on trends. It applies these insights to pre-payment charges, identifying potential denials, and recommending proactive audits and corrections for erroneous claims before they are submitted to payers.

Business Benefits:

1	2	3	4
Understand payer behavior and revenue risks	Take proactive action to produce clean claims and accelerate cashflow	Educate physicians and coders to mitigate systemic financial risks	Manage your payer audits to respond in a timely manner and retain revenue
• AI-powered analytics to diagnose your denials across payers • Actionable insights on your denial's population • Full integration into auditing workflows from denial root causes • Proprietary Benchmarking	• Payer-centric Policy Engine • Prospective Auditing Workflow • Historical Denial Insights	• Interactive Visualization • Management Reporting	• Payer Audit Insights • Smart Scan of Payer Letters (Smartscan.ai) • Insights.ai

Revenue Integrity Suite:
https://www.mdaudit.com/solutions/revenue-integrity/revenue-integrity-suite/

> *"Revenue Optimizer allows us to make sure that we are getting that message out consistently between the billing company and us. This collaboration has allowed the coders to receive the same education and information the providers receive."*
>
> **– Manager of Provider Compliance Revenue Integrity**

Non-Profit Health System Experiences a $9M Decrease in Denials Associated with PB Coding[13]

[13] https://www.mdaudit.com/resource/case-study/non-profit-health-system-experiences-decrease-denials/

Top 5 – Principal Diagnosis Codes Denied

Professional	
Principle Diagnosis Code	**Principle Diagnosis Name**
Z00.00	Encounter For General Adult Medical Exam W/O Abnormal Findings
Z51.11	Encounter For Antineoplastic Chemotherapy
M81.0	Age-Related Osteoporosis W/O Current Pathological Fracture
M17.12	Unilateral Primary Osteoarthritis, Left Knee
Z51.12	Encounter For Antineoplastic Immunotherapy

Hospital – Outpatient	
Principle Diagnosis Code	**Principle Diagnosis Name**
Z51.11	Encounter For Antineoplastic Chemotherapy
I48.0	Paroxysmal Atrial Fibrillation
Z12.11	Encounter For Screening For Malignant Neoplasm Of Colon
M17.11	Unilateral Primary Osteoarthritis, Right Knee
M17.12	Unilateral Primary Osteoarthritis, Left Knee

Hospital – Inpatient	
Principle Diagnosis Code	**Principle Diagnosis Name**
A41.9	Sepsis, Unspecified Organism
I13.0	Hyp Hrt & Chr Kdny Dis W Hrt Fail And Stg 1-4/Unsp Chr Kdny
Z38.01	Single Liveborn Infant, Delivered By Cesarean
I21.4	Non-St Elevation (Nstemi) Myocardial Infarction
Z38.00	Single Liveborn Infant, Delivered Vaginally

Top 5 – E&M Codes Denied

Professional	
E&M Code	**E&M Name**
99214	Office O/P Est Mod 30 Min
99213	Office O/P Est Low 20 Min
99233	Sbsq Hospital Ip/Obs Care High Mdm 50 Minutes
99291	Critical Care First Hour
99232	Sbsq Hospital Ip/Obs Care Mod Mdm 35 Minutes

Hospital – Outpatient	
E&M Code	**E&M Name**
99285	Emergency Department Visit High Mdm
99284	Emergency Department Visit Moderate Mdm
99283	Emergency Department Visit Low Mdm
99291	Critical Care First Hour
99282	Emergency Department Visit Straightforward Mdm

Hospital – Inpatient	
E&M Code	**E&M Name**
99499	Unlisted E&M Service
99285	Emergency Department Visit High Mdm
99291	Critical Care First Hour
99213	Office O/P Est Low 20 Min
99283	Emergency Department Visit Low Mdm

Top 5 – CTC/HCPCS Codes Denied

Hospital – Outpatient	
HCPCS Procedure Code	**HCPCS Procedure Name**
G0378	Hospital Observatn Service Per Hour
C1776	Joint Device
74177	Ct Abd & Pelv W/Contrast
99285	Emergency Department Visit High Mdm
80053	Comprehen Metabolic Panel

Hospital – Inpatient	
HCPCS Procedure Code	**HCPCS Procedure Name**
97810	Acupunct W/O Stimul 15 Min
Q2041	Kte-C19 To 200 M A Anti-Cd19 Car P
78999	Nuclear Diagnostic Exam
99199	Special Service/Proc/Report
J7189	Factor Viia 1 Microgram

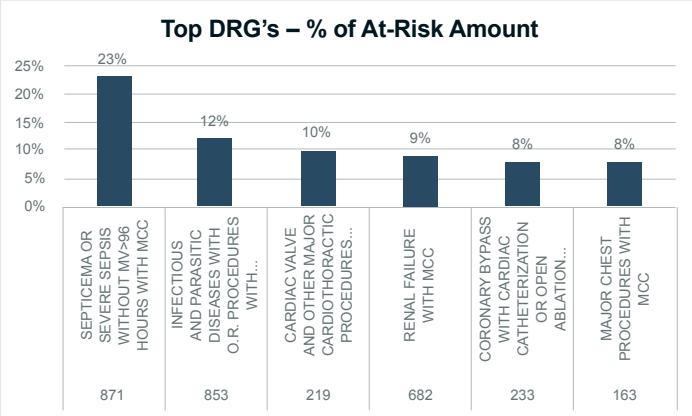
Top 5 – DRG and HCC Codes Denied

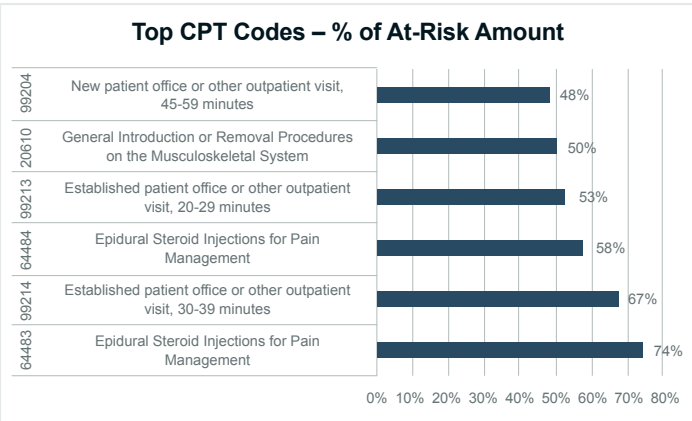
DRG Code	DRG Name
871	Septicemia Or Severe Sepsis Without Mv >96 Hours With Mcc
003	Ecmo Or Tracheostomy With Mv >96 Hours Or Principal Diagnosis Except Face, Mouth And Neck With Major O.R. Procedures
853	Infectious And Parasitic Diseases With O.R. Procedures With Mcc
291	Heart Failure And Shock With Mcc
001	Heart Transplant Or Implant Of Heart Assist System With Mcc

HCC – Outpatient	
Principal Diagnosis HCC Code	**Principal Diagnosis HCC Name**
142	Specified Heart Arrhythmias
11	Colorectal, Breast (Age < 50), Kidney, and Other Cancers
9	Lung, Brain, and Other Severe Cancers, Including Pediatric Acute Lymphoid Leukemia
12	Breast (Age 50+) and Prostate Cancer, Benign/Uncertain Brain Tumors, and Other Cancers and Tumors
130	Heart Failure

HCC – Inpatient	
Principal Diagnosis HCC Code	**Principal Diagnosis HCC Code**
2	Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/Shock
130	Heart Failure
127	Cardio-Respiratory Failure and Shock, Including Respiratory Distress Syndromes
131	Acute Myocardial Infarction
146	Ischemic or Unspecified Stroke

Payer Audits – Top 5 DRGs and HCCs





* There can be multiple CPT codes in a payer audit request. The above percentages represent the coverage across all payer requests and total at-risk dollars.

HIM/Coding

Based on MDaudit data, billing and coding issues contributed to 11% of the total denial dollars rejected by payers in 2024. Coding-related denials surged 126% in 2024. Coding continues to be the biggest opportunity for revenue optimization for healthcare providers.

One of our hypotheses is that although huge investments are being made in coding platforms and operations, they are not enough to improve coding and coder integrity. The coding integrity layer should involve analytics, and technologies with benchmarking data that monitor coding accuracy and coder performance risks continuously in real-time, enabling healthcare provider organizations to take corrective action and provide coder education to drive sustainable outcomes.

Coding-related denials continue to surge by 126% in 2024, and coding integrity remains one of the biggest revenue optimization opportunities.

Health system leaders are progressively considering a 60/40 coding strategy. This strategy involves having people oversee and code for 60% of the most complex and critical claims that significantly impact organization profitability while simultaneously entrusting machines with handling 40% of the simpler claims where the rules are straightforward. AI provides opportunities for automation but introduces risks to amplify errors at scale. It's critical to integrate 'humans in the loop' to validate coding and coder integrity.

INSIGHT #1 Coding-related Denials Increase by more than 100% in 2024

	2023	2024	Increase % from 2023
Average Denied Amount	297	631	126%

	Average Denied $ (2024)	Increase from 2023
Professional	$140	24%
Hospital – Outpatient	$825	32.5%
Hospital – Inpatient	$10K	219%

Strategic Insight:

Coding remains one of the biggest improvement opportunities for revenue capture and margin expansion. Despite billions of dollars spent on outsourcing coding operations and investing in automated coding technologies, the average denied amount increased by 126% in 2024 vs. 2023. This represents one of the biggest increases we have seen in the last three years. The average denied amount increased across all care settings, but hospital inpatient-related denials increased by 200%+ in 2024. The Change Healthcare cyberattack disrupted the payment flow in the mid-cycle and back-end RCM processes, which included coding for a prolonged period. Many organizations depended on manual processes to capture charges and submit them for payments. Also, payer scrutiny continues for the most complex services in the inpatient setting, including complication or comorbidity (CC), major complication or comorbidity (MCC), and HCCs with risk adjustment payment models.

Implication:

Organizations must invest in technologies and education initiatives that constantly monitor coding integrity and coder performance to improve accuracy and continuously improve the respective programs with coder education and long-term sustainable fixes in the operational systems. Unless a baseline is established in terms of what good looks like for coding accuracy in a care setting, no continuous or long-term improvement is possible. The introduction of AI-based and autonomous systems for coding will only amplify errors downstream when there is no coding integrity layer with humans in the loop. This is one of the biggest risks for hospital coding in the upcoming year.

INSIGHT #2 More than 50% of Coders Continue to Fail Audits Across Professional and Hospital Settings

59%

Coders who failed audits

58.5%

Professional Coders who failed audits

62.5%

Hospital Coders who failed audits

22%

Cases that failed Professional Coder Audits

36%

Cases that failed Hospital Coder Audits

Professional	
Denial Reason	**Average Denied Amount**
The procedure code is inconsistent with the modifier used or a required modifier is missing.	$129
The diagnosis is inconsistent with the procedure.	$94
The procedure code/type of bill is inconsistent with the place of service.	$145
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.	$174
Payer deems the information submitted does not support this level of service.	$285

Hospital - Outpatient	
Denial Reason	**Average Denied Amount**
The procedure code is inconsistent with the modifier used or a required modifier is missing.	$523
The diagnosis is inconsistent with the procedure.	$261
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.	$356
Payer deems the information submitted does not support this level of service.	$849
Charges do not meet qualifications for emergent/urgent care.	$720

Hospital - Inpatient	
Denial Reason	**Average Denied Amount**
This (these) diagnosis(es) is (are) not covered.	$48,676
Payer deems the information submitted does not support this level of service.	$4,849
The diagnosis is inconsistent with the procedure.	$5,086
Services not documented in patient's medical records.	$2,224
Procedure/service was partially or fully furnished by another provider.	$3,401

MDaudit Coder Auditing Solutions

MDaudit's Coder Auditor Workflow features sophisticated analytics and AI to offer actionable insights that enhance collaboration between your organization's teams. This allows seamless coding integrity, accuracy, and performance for successful long-term outcomes.

Business Benefits:

1	2	3
Understand coding behavior and revenue risks	Educate coders to eliminate systemic coding errors resulting in improved revenue outcomes	Produce clean claims with proper coding to get paid faster
• AI-powered analytics to diagnose your coding risks • Retrospective coder audit workflows • Workflow to improve communications between auditors and coders	• Coder analytics and reporting • Insights.ai	• Prospective coder audit workflows

"Our team has found multiple instances of misbilling during surgical audits resulting from a lack of coder education. There were also issues around modifier 59 and a change in CPT prolonged-service rules that led to underbilling; both were quickly corrected with education once they were identified. Altogether, this led to just under $15,000 in additional charges."

– **Coding Compliance Director** of a large Midwestern Pediatric Hospital

Increased Frequency by Identifying $100K+ in Compliance Risk case study[14]

Coder Workflows and Risk Analytics:
https://www.mdaudit.com/who-we-serve/him-coding/

[14] https://www.mdaudit.com/resource/case-study/automation-helps-pediatric-group-shift-to-risk-based-audits-and-dramatically-increases-frequency-with-over-100k-of-compliance-risks-identified/

Looking Ahead

SOLUTIONS FOR A NEW ERA OF HEALTHCARE

While there are signs of recovery, with some health systems showing improvements in patient volumes, operating margins, and profitability, many are still grappling with the lingering financial strains of the past few years. These challenges continue to impact healthcare organizations' bottom lines.

Our data suggests a chasm between top performers and those still struggling to regain their footing post-COVID. Without intervention, external factors, such as heightened scrutiny of MA plans and anticipated cuts to the Medicare Fee Schedule in 2025, may broaden this divide.

MINIMIZE BILLING RISKS AND MAXIMIZE REVENUES AS WE HEAD INTO 2025

To close the gap caused by today's external pressures, healthcare organizations must take a proactive and progressive approach to revenue cycle management. As health systems face increasing complexity in their operations, those who have embraced data-driven strategies and invested in AI to enable automation and analytics have been able to identify potential issues early and act swiftly. The days of surviving with a reactive approach are over.

CONTRIBUTING TO BETTER FUTURE OUTCOMES

This year has shown that the ability to monitor and address financial risks continuously in real-time is no longer optional but critical to positive financial outcomes. MDaudit's risk-oriented investment in AI believes in keeping people at the forefront[15] of proactive decision-making. This effective approach has proven essential in maintaining financial resilience amid a challenging and ever-shifting healthcare environment. MDaudit's customer base has taken advantage of our innovations in AI to drive more than 200M+ in business value[16] in revenue capture, risk mitigation, and human productivity. AI is no longer a hype but a force multiplier to solve complex challenges in healthcare and drive value.

About MDaudit

Bringing solutions to an industry in transformation, MDaudit enables organizations to minimize billing risks and maximize revenue – all from an AI-powered, integrated, cloud-based platform. We believe in the power of collaboration between people and sophisticated technology to drive sustainable change. Always keeping people at the forefront of decision-making.

To learn more, visit www.mdaudit.com

MDaudit

Minimize Billing Risks. Maximize Revenues.

[15] https://www.beckershospitalreview.com/innovation/effective-ai-in-healthcare-rcm-requires-humans-in-the-loop.html

[16] https://www.mdaudit.com/resources/case-studies/