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REVENUE CYCLE MANAGEMENT · USA PHYSICIAN-OWNED

WHITEPAPER

Revenue Integrity Programs

Building a Sustainable Financial Framework

Why reactive revenue cycle management no longer protects earned revenue, and how to build the controls that do.

Prepared for: Healthcare executives, CFOs, practice administrators, and revenue cycle leaders

Published: October 2026 · **Edition:** 1.0

Applies to: Medical and dental practices, groups, and health systems across the United States

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Who this is written for

This whitepaper is written for the people who carry financial accountability in a provider organization: practice owners and executives, chief financial officers, revenue cycle directors, billing managers, and compliance leads. It assumes working familiarity with claims, denials, and accounts receivable, and it does not restate revenue cycle basics.

How the data in this document is sourced

Every figure in this whitepaper is attributed to a named primary source and dated. Where an industry estimate is widely repeated but originates from a single study, we identify the study rather than the organizations that later cited it. Where we could not verify a commonly quoted figure, we left it out. Full citations appear on the final page.

A note on scope

Revenue integrity is often discussed in hospital terms. The principles apply equally to independent medical practices, specialty groups, dental practices, and dental service organizations, and this document flags where the mechanics differ. The dollar magnitudes change with organization size. The failure modes do not.

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SECTION 01

Executive summary

Most healthcare organizations are organized to respond to revenue problems after they occur. Denials are worked after they arrive. Underpayments are found, if at all, during an audit. Missed charges are usually never found at all. Revenue integrity is the discipline of moving those controls upstream, so that revenue is protected before a claim is created rather than recovered afterward.

The financial case has strengthened sharply in the last two years. Kodiak Solutions, analyzing data from 2,300 hospitals and 350,000 physicians, reported that net revenue losses from final denials and bad debt reached **$48.4 billion in 2025, a 25 percent increase over the prior year**. Initial claim denial rates rose 2.4 percent to **11.81 percent in 2024**, and true accounts receivable days increased 5.2 percent over the same period.

At the same time, the cost of collecting what has already been earned has grown. The American Hospital Association reported that hospitals spent approximately **$43 billion in 2025** pursuing payments held up by claim denials, prior authorizations, repeated documentation requests, and changing billing rules.

These pressures do not respond to working harder at the back end. They respond to controls placed at the point where revenue is created: accurate registration, complete charge capture, documentation specific enough to support the code, coding accuracy verified before submission, and continuous monitoring that surfaces a pattern while it is still small.

$48.4B	+25%	11.81%	$43B
Lost to final denials and bad debt, 2025	Increase over 2024	Initial claim denial rate, 2024	Spent chasing owed payments, 2025

What this whitepaper provides

- A working definition of revenue integrity that distinguishes it from revenue cycle management
- The eight operational components of a program, with the specific control each one installs
- A revenue leakage inventory covering where losses actually originate
- Benchmark targets for the metrics that measure whether the program is working
- A phased implementation roadmap, including the barriers that most often stall these programs

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SECTION 02

Why revenue integrity has become a financial necessity

Five pressures have converged to make upstream revenue controls a matter of solvency rather than efficiency.

1. Denials are rising, and more of them are becoming permanent

The distinction that matters is not the denial rate but the final denial rate: claims that are denied and never recovered. Kodiak Solutions reported the median final denial rate rising from 2.5 percent to 2.7 percent and the median bad debt rate rising from 1.1 percent to 1.3 percent between 2024 and 2025. Those look like small movements. Across the measured population they represent $48.4 billion in lost net revenue, up 25 percent year over year.

2. The administrative cost of collection keeps climbing

The AHA found that hospitals average 64 administrative and billing employees, roughly 6.5 percent of total hospital employment, and spent about $43 billion in 2025 pursuing payments already owed. For an independent practice the proportions differ, but the structure is the same: a growing share of staff time is spent recovering revenue rather than earning it.

3. Margins leave no absorption capacity

The AHA reported total hospital expenses rose 7.5 percent in 2025, more than twice the growth rate of hospital prices, with workforce costs up 5.6 percent, supplies up 9.9 percent, and drugs up 13.6 percent. More than 56 percent of hospital costs were tied to service lines where reimbursement fell short of the cost of care. An organization operating at that margin cannot absorb a one percent revenue leak.

4. Administrative complexity is structural, not cyclical

The most widely cited estimate of administrative complexity waste in the US healthcare system is $265.6 billion annually, from a 2019 JAMA analysis by Shrank and colleagues that put total system waste at $760 billion to $935 billion per year. Nothing since has reduced it. The 2024 CAQH Index identifies roughly $20 billion in savings still available from shifting manual administrative transactions to electronic workflows.

5. Patient responsibility has moved a growing share of revenue outside payer control

Kodiak Solutions reported the patient collection rate for commercially insured patients fell to **34.4 percent in 2024**, down from 37.6 percent in 2023. Revenue that depends on patient payment behaves differently from revenue that depends on payer adjudication, and most revenue cycle controls were built for the latter.

> **THE UNDERLYING POINT**
>
> Each of these pressures is upstream of the billing office. Denials originate in registration, authorization, documentation, and coding. Collection difficulty originates in how financial responsibility was communicated before the visit. A back-end function cannot fix a front-end cause, which is the structural argument for revenue integrity as a distinct discipline.

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SECTION 03

What revenue integrity is, and what it is not

DEFINITION

Revenue integrity is the set of processes, controls, and accountability structures that ensure a healthcare organization captures all earned revenue accurately and in compliance with payer and regulatory requirements. It spans registration, charge capture, clinical documentation, coding, claim submission, payment posting, and collections, and its defining characteristic is that it operates preventively rather than correctively.

The distinction from revenue cycle management

Revenue cycle management and revenue integrity overlap substantially, and in smaller organizations the same people perform both. They are not the same function, and conflating them is why many programs underperform.

Where the two functions differ in practice

Dimension	Revenue cycle management	Revenue integrity
Primary question	Did we get paid for this claim?	Was this claim correct before it left?
Orientation	Corrective. Works what the payer returns	Preventive. Works what has not been submitted yet
Unit of work	The individual claim or account	The pattern across claims
Success measure	Collections, A/R days, denial recovery	Clean claim rate, charge capture rate, final denial rate
Reports to	Finance	Finance, with compliance and clinical accountability
Fails when	Follow up is inconsistent	Clinical and financial teams do not talk

The multidisciplinary requirement

Revenue integrity cannot be delegated entirely to the billing function, because the decisions that determine whether a claim is payable are made elsewhere. A provider decides how to document. A scheduler decides whether authorization was checked. A nurse decides whether a supply was recorded. A coder interprets what was written. Billing inherits all of it.

This is why governance matters more in revenue integrity than in most finance functions. A program without named clinical accountability produces reports that nobody is required to act on.

Core components

- Accurate charge capture at the point of care
- Clinical documentation integrity
- Coding accuracy and currency
- Pre-submission claim validation
- Compliance auditing on a defined schedule
- Denial prevention informed by root cause analysis
- Payment variance and underpayment detection
- Continuous performance monitoring against benchmarks

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SECTION 04

The eight components of a revenue integrity program

Each component installs a specific control at a specific failure point. The order below follows the revenue cycle, not priority.

Component 1: Patient access and registration accuracy

Eligibility and demographic errors are the single largest preventable denial category, and they are entirely front-end in origin. The control is verification discipline: eligibility checked electronically before every encounter and again 24 to 48 hours before the service date, benefits verified at procedure level for higher cost services, and demographic data confirmed with the patient rather than copied forward from the prior visit.

Copying information forward is the specific habit that converts a one-time error into a permanent one. A member ID entered incorrectly once will deny every claim it touches until somebody re-reads it from the card.

Component 2: Prior authorization and medical necessity management

Authorization denials are among the most damaging because they are frequently non-appealable. A service rendered without a required authorization is often simply not payable, regardless of clinical appropriateness.

The control is a payer-specific authorization matrix maintained as a living document, with requests initiated at scheduling rather than at check-in, centralized status tracking inside the practice management or EHR system, and expiration monitoring. Authorization details held in spreadsheets, email threads, or one staff member's notes are not a control, because the process stops when that person is unavailable.

An authorization must also match the patient, provider, payer, procedure, date range, and approved units. An authorization that exists but does not match one of those fields will not protect the claim.

Component 3: Clinical documentation integrity

Medical necessity denials are documentation failures, not clinical ones. The payer is not disputing that the service was appropriate. It is stating that the record submitted does not establish necessity against its coverage criteria.

The control is a CDI program that operates in both directions: prospective review of high-denial-risk cases before submission, and retrospective review of denied claims to identify which documentation gaps are recurring and with which providers.

- Build documentation templates that embed payer coverage criteria for the procedures that generate the most medical necessity denials
- Return findings to individual providers with the specific denied claim and its revenue effect attached
- Treat coder queries as a data source. A rising query rate for one provider is an early signal, not an administrative nuisance

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The eight components (continued)

Component 4: Charge capture

Charge capture is where revenue integrity differs most sharply from revenue cycle management, because a missed charge generates no work item. There is no denial, no rejection, and no report entry. The encounter simply never becomes revenue.

HFMA reports that as much as **one percent of net charges** is lost to charge integrity leakage. The scale becomes concrete in specific cases: Novant Health, a 14 hospital system with roughly $4.3 billion in annual net patient revenue, identified $7.5 million in recoverable net revenue during the first 15 months of a charge integrity program.

The controls are automation and reconciliation together. Automated charge generation, where a documented clinical activity triggers a charge record without manual entry, removes the largest failure category. Daily reconciliation comparing documented encounters against posted charges catches what automation misses, while the documentation is still fresh enough to correct.

The categories that leak most

Supplies, medications, and disposables; ancillary services; surgical add-on and secondary procedures; after-hours and modifier-dependent services; and anything documented clinically but never routed to billing. In dental practices, add medical cross-billing for medically necessary procedures, which many dental billing teams never evaluate at all.

Component 5: Coding accuracy and compliance

Coding errors cause denials, but the more expensive failure is undercoding, which produces a paid claim at the wrong amount and therefore generates no signal. The control is a quarterly audit comparing documentation against submitted codes across providers and service lines, current code libraries maintained through annual update cycles, certified coders on complex procedures, and pre-submission validation software that checks bundling logic, modifier requirements, and payer-specific coding rules.

Component 6: Pre-submission claim validation

Claims scrubbing is the highest-leverage single intervention available, and the difference between a 95 percent and a 75 percent first-pass rate is largely a function of scrubbing quality. Generic scrubbing catches common errors. Payer-specific edit libraries catch the rules that actually generate your denials.

- Configure payer-specific edits for your top payers by claim volume, not a generic ruleset
- Add custom rules derived from your own historical denial patterns
- Implement automated timely filing tracking with alerts before the window closes
- Measure first-pass rate by payer and by service line, because the aggregate hides where the problem is

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The eight components (continued)

Component 7: Payment variance and underpayment detection

Underpayments are structurally harder to find than denials. A denied claim creates a visible work item. An underpaid claim appears in the system as a successfully processed payment: the claim closes, the A/R clears, and nothing flags.

The control is automated payment-to-contract comparison on every remittance line, against the contracted rate applicable to that payer, service, and date of service. Manual verification does not scale. A practice submitting several hundred claims a month cannot reasonably check each payment against its fee schedule by hand.

Detection speed is part of the recovery. Most payer contracts allow 90 to 180 days from the original explanation of benefits to dispute an underpayment. Disputes filed after that window are frequently refused on procedural grounds regardless of merit.

Common underpayment causes and what each indicates

Pattern	Usual cause
Variance begins at a specific date	Fee schedule not updated after contract renewal or escalator effective date
Variance on multi-procedure claims only	Incorrect multiple procedure payment reduction applied
Variance when modifiers are present	Payer ignoring modifiers that support separate payment
Variance on one procedure across all payers	Internal coding or charge master issue, not a payer error
Variance on one payer across all procedures	Wrong fee schedule loaded in the payer's system

Component 8: Continuous monitoring and governance

The first seven components produce data. Without a governance structure that assigns each metric an owner and a response threshold, that data accumulates without changing anything. This is the most common point of failure in revenue integrity programs, and it is organizational rather than technical.

- **Executive sponsorship.** A program without a named executive owner loses to competing operational priorities within two quarters
- **Cross-functional committee.** Clinical, coding, billing, and compliance representation, meeting on a fixed cadence with a standing agenda
- **Metric ownership.** Every KPI has one named owner and a defined threshold that triggers a response
- **Corrective action tracking.** Findings become dated action items with owners, and the committee reviews closure, not just new findings

The governance test

If your revenue integrity reporting identified a problem last quarter that is still present this quarter, the issue is not measurement. It is that no one was accountable for the response. Adding another metric will not fix it.

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SECTION 05

Revenue leakage: finding it and preventing it

Revenue leakage is the aggregate of earned revenue that is never collected. It is rarely one large failure. It is usually a dozen small ones, each individually below the threshold that would attract attention, compounding across claim volume.

A leakage inventory

Where leakage originates, and whether it generates a visible signal

Source	Stage	Visible?
Missed charges	Point of care	No signal generated
Undercoding	Coding	No. Claim pays at the wrong amount
Underpayments	Payment posting	No. Appears as successful payment
Registration and eligibility errors	Front end	Yes, as a downstream denial
Missing authorization	Pre-service	Yes, often non-appealable
Timely filing failures	Submission or follow up	Yes, but too late to recover
Unworked denials	Back end	Yes, until the appeal window closes
Uncollected patient balances	Patient billing	Yes, as aging and bad debt
Premature write-offs	Account resolution	Recorded, but rarely reviewed

The important column is the third one. Four of the nine categories generate no signal at all, which means routine revenue cycle reporting cannot find them. They are found only by deliberate comparison: documented activity against billed charges, submitted codes against documentation, and actual payments against contracted rates.

The assessment sequence

1. **Establish the baseline.** Run a 90 day lookback across all nine categories before changing anything. Improvement measured against an unknown baseline cannot be defended
2. **Quantify by category.** Convert each finding to an annualized dollar figure. This determines sequence, because effort should follow magnitude rather than irritation
3. **Trace to origin.** For each category, identify the specific workflow step and the role that owns it. A finding without an owner does not become a fix
4. **Install the control.** Automation where the failure is a manual handoff, reconciliation where automation cannot reach, education where the cause is knowledge
5. **Re-measure on the same basis.** Repeat the lookback at 90 and 180 days using identical methodology, so the comparison is valid

Why the baseline matters more than it appears to

Most revenue integrity programs are evaluated on whether revenue improved. Revenue moves for many reasons, including volume and payer mix. A category-level baseline is what allows the program to demonstrate that a specific control produced a specific recovery, which is also what keeps it funded.

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SECTION 06

Compliance auditing and risk management

Compliance and revenue integrity are frequently treated as opposing interests, on the assumption that one constrains revenue while the other pursues it. In practice they are the same control viewed from two directions. An inaccurate claim is both a compliance exposure and a revenue problem, and the audit that finds one finds the other.

What a compliance audit should evaluate

- **Documentation to code alignment.** Does the record support the code submitted, at the level submitted
- **Code to claim alignment.** Did the claim transmit what the coder assigned, without system-level alteration
- **Charge capture consistency.** Is the same service billed the same way across providers and locations
- **Payer contract adherence.** Are claims submitted in accordance with the specific contract terms for that payer
- **Modifier usage.** Are modifiers applied consistently and supported by documentation
- **Medical necessity support.** For services with coverage criteria, does the record address those criteria explicitly

The bidirectional standard

Compliance requires two things simultaneously: every billed service must be supported by documentation, and every documented service should be billed in a consistent manner. Organizations tend to focus on the first and ignore the second.

The second matters for a reason that is not obvious. Inconsistent charge capture, where a service is billed in some encounters and omitted in others, is difficult to explain during an audit. It raises a question about whether billing practices are being applied uniformly, which is a harder question to answer than a single coding error.

Audit cadence

Audit type	Frequency	Scope
Coding accuracy	Quarterly	Sample across all providers and high-volume service lines
Charge capture	Quarterly	Clinical activity records against billed charges
Documentation	Monthly	High-denial-risk procedures and new providers
Payment variance	Continuous	Automated, every remittance line
Denial root cause	Monthly	Top five categories by volume and by dollar value
Write-off review	Monthly	Sample above a defined dollar threshold

Risk exposure

The consequences of sustained billing inaccuracy include payment recoupment, financial penalties, extrapolated repayment demands, increased future audit activity, and in serious cases government investigation. A program that finds and corrects its own errors on a documented schedule is in a materially different position than one that is first alerted to a pattern by a payer audit notice.

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SECTION 07

Technology, automation, and analytics

Technology does not replace revenue integrity expertise. It removes the manual handoffs where most errors originate and provides the visibility that makes patterns detectable at claim volume. The 2024 CAQH Index estimates roughly $20 billion in annual savings available from shifting manual administrative transactions to electronic workflows, with approximately $12.3 billion of that in eligibility and benefit verification alone.

Where automation produces the clearest return

Automation priorities ordered by typical return and implementation effort

Capability	What it prevents	Effort
Real-time eligibility verification	The largest preventable denial category	Low
Automated charge triggers	Missed charges from manual entry	Medium
Payer-specific claims scrubbing	First-pass rejections and technical denials	Low
Automated ERA posting	Posting errors and delayed variance detection	Low
Payment-to-contract comparison	Undetected underpayments	Medium
Authorization tracking and alerts	Expired and missing authorizations	Medium
Predictive denial scoring	Denials, before submission	High

Analytics: the distinction that matters

Reporting describes what happened during a closed period. Analytics isolates why and directs a response. The practical difference is whether the output names an owner and an action.

- **Reporting output:** the denial rate rose from 8 percent to 11 percent last month
- **Analytics output:** the increase came from three commercial payers, concentrated in two procedure codes, driven by eligibility and authorization failures at one location

Only the second can be assigned. Segmentation by payer, provider, location, service line, and denial reason is what converts a metric into a work plan.

On predictive models

Machine learning models that assign denial risk before submission are the highest-value analytics application, and they carry a practical constraint worth stating plainly: they require sufficient historical claim volume and standardized data to be reliable. Most independent practices do not generate enough claims to train a dependable model on their own data. This is one of the clearer arguments for working with an RCM partner, since the partner trains across a far larger claim population.

A caution on sequencing

Organizations frequently attempt predictive analytics before establishing data quality and standardized metric definitions. The result is a model trained on inconsistent inputs, producing outputs nobody trusts. Data standardization is unglamorous and it is the prerequisite.

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SECTION 08

Metrics, benchmarks, and governance

Revenue integrity is measured by a small set of indicators tracked consistently and segmented deliberately. The aggregate value tells you whether a problem exists. The segmentation tells you whose problem it is.

Core revenue integrity metrics with benchmark targets

Metric	Target	What it measures
Clean claim rate	97% or above	Error-free submission at the point of filing
First pass resolution rate	95% or above	Claims paid on first submission without rework
Initial denial rate	Below 5%	Overall front-end and coding control effectiveness
Final denial rate	Below 2%	Denials never recovered. The permanent loss measure
Charge capture rate	Establish baseline first	Documented services that became billed charges
Net collection rate	95% or above	Collectible revenue actually collected
Days in A/R	30 to 40 days	Revenue cycle velocity and cash flow
Cost to collect	2% to 3% outsourced	Operational efficiency of the billing function
Appeal success rate	65% or above	Denial recovery capability and documentation quality
Underpayment recovery	Track dollars, not rate	Payment variance identified and recovered

Charge capture rate deserves a separate note

It is the one metric on this list that most organizations do not currently calculate, and it is the direct measure of the largest invisible loss category. There is no useful industry benchmark to compare against, because practice mix and documentation conventions vary too widely. The baseline is your own, measured once and then tracked.

Reporting cadence

- **Daily:** charges posted against encounters documented, claims submitted, denials received
- **Weekly:** denial trending by category, first-pass rate, authorization aging, A/R by bucket
- **Monthly:** full metric set against benchmark and prior month, with segmentation
- **Quarterly:** audit results, root cause review, corrective action closure, benchmark reassessment

The single governance rule worth enforcing

Every metric has one named owner and a threshold that triggers a defined response. A dashboard without owners is documentation of a problem rather than management of it, and it will produce the same reading next quarter.

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SECTION 09

Implementation: barriers and a phased roadmap

The four barriers that stall these programs

- **Organizational silos.** Clinical, coding, billing, and compliance report through separate lines with no shared performance measure. This is the most common cause of failure and it is structural, not attitudinal
- **No baseline.** Without a category-level starting measurement the program cannot demonstrate its own return, which makes it vulnerable the first time budget is reviewed
- **Clinical resistance.** Documentation changes land on people already carrying administrative burden. Framing them as billing requirements guarantees resistance. Framing them with the specific denied claim and its effect changes the conversation
- **Data fragmentation.** When EHR, practice management, clearinghouse, and finance systems do not reconcile, every analysis starts with manual data assembly and most never get repeated

A phased roadmap

Phase	Focus	Typical duration
Phase 1: Assess	90 day leakage baseline across all categories; denial root cause analysis; charge capture audit; current-state metric definitions	4 to 6 weeks
Phase 2: Stabilize	Real-time eligibility verification; payer-specific claims scrubbing; daily charge reconciliation; denial triage standard	6 to 10 weeks
Phase 3: Govern	Executive sponsor named; cross-functional committee seated; metric ownership assigned; reporting cadence established	Concurrent with Phase 2
Phase 4: Deepen	CDI program; coding audit schedule; automated payment-to-contract comparison; provider feedback loops	3 to 6 months
Phase 5: Optimize	Predictive denial scoring; advanced segmentation; payer contract analytics; continuous improvement cycle	Ongoing

Sequencing principle

Phase 2 interventions are listed in that order deliberately. Eligibility verification addresses the largest preventable denial category with the lowest implementation effort. Claims scrubbing follows because it produces measurable first-pass improvement within one billing cycle. Charge reconciliation is third because it requires a defined owner and a daily habit, which takes longer to establish than a software configuration.

Organizations that begin with Phase 5 capabilities, which is a common pattern when a technology purchase drives the program rather than an assessment, generally find that the model produces unreliable output because the underlying data was never standardized.

Scale note

An independent practice does not need a revenue integrity committee or a dedicated department. It needs the same controls, owned by named individuals, reviewed on a fixed schedule. The governance scales down. The controls do not.

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SECTION 10

Frequently asked questions

What is a revenue integrity program?

A revenue integrity program is a structured set of controls ensuring a healthcare organization captures all earned revenue accurately and in compliance with payer and regulatory requirements. It spans registration through collections, and it operates preventively, identifying and correcting issues before claims are submitted rather than after they are denied.

How is revenue integrity different from revenue cycle management?

Revenue cycle management asks whether a claim was paid. Revenue integrity asks whether the claim was correct before it was submitted. RCM works individual claims correctively; revenue integrity works patterns preventively. In smaller organizations the same staff perform both, but the controls and the success measures are different.

How much revenue does a typical organization lose to leakage?

It varies substantially by organization, specialty, and automation level. For charge capture specifically, HFMA reports as much as one percent of net charges is lost to charge integrity leakage. Across all leakage categories, Kodiak Solutions reported that final denials and bad debt alone produced $48.4 billion in lost net revenue in 2025, up 25 percent from 2024. Your own figure requires a baseline assessment.

Which leakage categories are hardest to detect?

Missed charges, undercoding, underpayments, and premature write-offs, because none of them generate a signal. A missed charge produces no denial. An undercoded claim pays at the wrong amount. An underpaid claim appears as a successful payment. These are found only through deliberate comparison, not through routine reporting.

What should a practice measure first?

Clean claim rate, initial denial rate segmented by cause, and charge capture rate. The third is the one most practices do not currently calculate, and it measures the largest invisible category. Establish a baseline before attempting improvement, because improvement measured against an unknown starting point cannot be defended.

Does revenue integrity conflict with compliance?

No. They are the same control viewed from two directions. An inaccurate claim is simultaneously a compliance exposure and a revenue problem. The audit that identifies undercoding also identifies overcoding, and consistent billing practice is both a compliance requirement and a revenue protection.

How long before a program produces measurable results?

Front-end interventions such as eligibility verification and claims scrubbing typically show first-pass and denial rate movement within one to two billing cycles. Charge capture and documentation improvements take longer, generally 90 to 180 days, because they require workflow change rather than configuration change. Underpayment recovery depends on filing windows and usually resolves in 30 to 60 days per dispute.

Can a small practice run a revenue integrity program?

Yes, at proportionate scale. A small practice does not need a committee or a department. It needs the same controls with named owners and a fixed review schedule. The governance structure scales down; the controls themselves do not change.

Where do these programs most often fail?

Governance, not measurement. The common pattern is a program that produces accurate reporting identifying real problems, with no named owner accountable for the response. If the same finding appears in consecutive quarterly reviews, the issue is accountability rather than analysis.

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SECTION 11

Sources and references

All figures cited in this whitepaper are drawn from the following primary sources. Where a widely repeated industry estimate originates from a single study, the study is identified rather than the organizations that later cited it.

1. **Kodiak Solutions,** "State of the Healthcare Revenue Cycle" report, March 2026. Net revenue losses from final denials and bad debt of $48.4 billion in 2025, a 25 percent increase over 2024; median final denial rate 2.5 to 2.7 percent; median bad debt rate 1.1 to 1.3 percent. Based on data from 2,300 hospitals and 350,000 physicians.
2. **Kodiak Solutions,** initial claim denial rate data, May 2025. Initial denial rate of 11.81 percent in 2024, an increase of 2.4 percent; true accounts receivable days up 5.2 percent year over year.
3. **Kodiak Solutions,** patient collection rate data. Patient collection rate for commercially insured patients of 34.4 percent in 2024, down from 37.6 percent in 2023.
4. **American Hospital Association,** "Costs of Caring" annual report, March 2026. Approximately $43 billion spent in 2025 pursuing payments delayed by administrative requirements; total hospital expenses up 7.5 percent in 2025; average of 64 administrative and billing employees per hospital, approximately 6.5 percent of total hospital employment; more than 56 percent of hospital costs tied to service lines where reimbursement fell short of the cost of care.
5. **HFMA,** "Avoiding the High Cost of Charge Capture Leakage." As much as one percent of net charges lost to charge integrity leakage; Novant Health identified $7.5 million in recoverable net revenue over 15 months at a system with approximately $4.3 billion in annual net patient revenue.
6. **CAQH,** 2024 CAQH Index: From Transactions to Trust, published February 2025. Approximately $20 billion in annual savings available from shifting manual administrative transactions to electronic workflows; approximately $12.3 billion of that in eligibility and benefit verification.
7. **Shrank WH, Rogstad TL, Parekh N,** "Waste in the US Health Care System: Estimated Costs and Potential for Savings," JAMA, 2019. Administrative complexity waste estimated at $265.6 billion annually; total system waste estimated at $760 billion to $935 billion per year.
8. **HFMA MAP Keys,** standardized revenue cycle performance measures, used as the reference for benchmark definitions in Section 08.
9. **Centers for Medicare & Medicaid Services,** documentation, billing compliance, and administrative simplification guidance.

Disclaimer

This whitepaper is provided for general educational and informational purposes and does not constitute legal, coding, billing, or compliance advice. Reimbursement rules, payer policies, and regulatory requirements change and vary by payer, state, and service. Healthcare organizations should validate billing, coding, reimbursement, privacy, and compliance decisions against current CMS guidance, their own executed payer contracts, applicable federal and state regulations, and qualified professional advice. Benchmark figures represent industry aggregates and are not performance guarantees. Individual results depend on organization size, specialty mix, payer composition, and operational maturity.

Further reading from StafGo Health

- Reducing Claim Denials and Improving Collections: A Comprehensive RCM Framework
- Key Performance Metrics in Medical Revenue Cycle Management
- Data Analytics and Predictive Modeling for Improving RCM Outcomes
- Optimizing Patient Collections in the Era of High-Deductible Health Plans
- The Financial Impact of Missed Charges in Healthcare Revenue Cycle Management

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Find out where your revenue is leaking

StafGo Health offers a free, no-obligation RCM audit. We examine your actual claims, charges, payments, and A/R, and give you a written picture of what is being lost and what it would take to recover it.

What a free RCM audit covers

- A 90 day lookback comparing clinical activity against billed charges to quantify uncaptured revenue
- Denial analysis segmented by payer, category, and point of origin
- Payment variance against your contracted rates, with underpayments identified
- A/R aging review by payer and bucket, including recoverable legacy balances
- A written findings summary with prioritized recommendations

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About StafGo Health. StafGo Health is a USA physician-owned and managed revenue cycle management company providing end-to-end RCM services to medical and dental practices across the United States. Our services include credentialing and fee negotiation, insurance verification, prior authorization management, coding and billing, A/R and denial management, payment posting and EFT reconciliation, patient billing and support, legacy A/R resolution, credit A/R resolution, and practice transition planning. All services are delivered under HIPAA-eligible processes.