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2026

State of the Revenue Integrity Industry Report

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2026 STATE OF THE REVENUE INTEGRITY INDUSTRY REPORT



NAHRI's ninth annual *Revenue Integrity Week* (June 1–5) shines a spotlight on revenue integrity professionals' important contributions to the healthcare industry. To help advance the revenue integrity field and support revenue integrity professionals, NAHRI is releasing the *2026 State of the Revenue Integrity Industry Report*. The report, based on data from the 2026 State of the Revenue Integrity Industry Survey, analyzes revenue integrity standards and trends across the country to raise awareness of the work revenue integrity professionals do and provide them with insights and data to move their programs and careers forward. It looks at trends in revenue integrity program design, primary and supporting functions, and more.

Background and experiences

Revenue integrity programs and professionals need to be agile, adapting to rapid shifts in payer reimbursement and denial patterns, regulatory changes, new services, and the evolving needs of the communities they serve. While some programs focus strictly on the chargemaster and charges, others include outpatient clinical documentation integrity (CDI), denials management, coding, or even credentialing under the revenue integrity umbrella. With that in mind, it's no surprise that

revenue integrity roles and required skill sets can vary greatly from one organization to the next.

In 2026, 64% of respondents indicated they're employed by a multifacility health system, and 42% of respondents reported their organization has 1,000 or more beds.

Thirty-six percent of respondents reported they hold revenue integrity-specific job titles. The most commonly reported of these were revenue integrity director (15%) and revenue integrity manager (10%).

For titles not specific to revenue integrity, the most commonly reported was CDI director, manager, or specialist (20%).

Looking at program type, three-quarters (75%) of respondents said their organization has a stand-alone revenue integrity department. Over a quarter (27%) of respondents said their program is supported by more than 40 full-time employees, while 13% said their program is supported by 8–10 full-time employees, and 10% reported their program is supported by 11–15 full-time employees. Breaking out just stand-alone revenue integrity departments, 28% are supported by more than 40 full-time employees, 13% are supported by 8–10 full-time employees, and 11% are supported by 21–25 full-time employees.

This year, NAHRI asked respondents whether their organization’s revenue integrity staffing has changed over the past 12 months. Most (36%) said revenue integrity staffing has increased, and only 11% said it’s decreased.

Jaclyn Woolnough, director of revenue integrity at MetroHealth in Cleveland, Ohio, said that staffing in her department has increased and decreased over the past year. In the first part of the year, her program’s staffing decreased due to retirements and regular turnover. Initially, those positions weren’t slated to be filled. However, as the year progressed, it became apparent that wasn’t the correct approach: Not only were those vacancies filled, but the department added postings for additional staff.

See Figures 1–4 for more details on job titles, programs, and staffing.

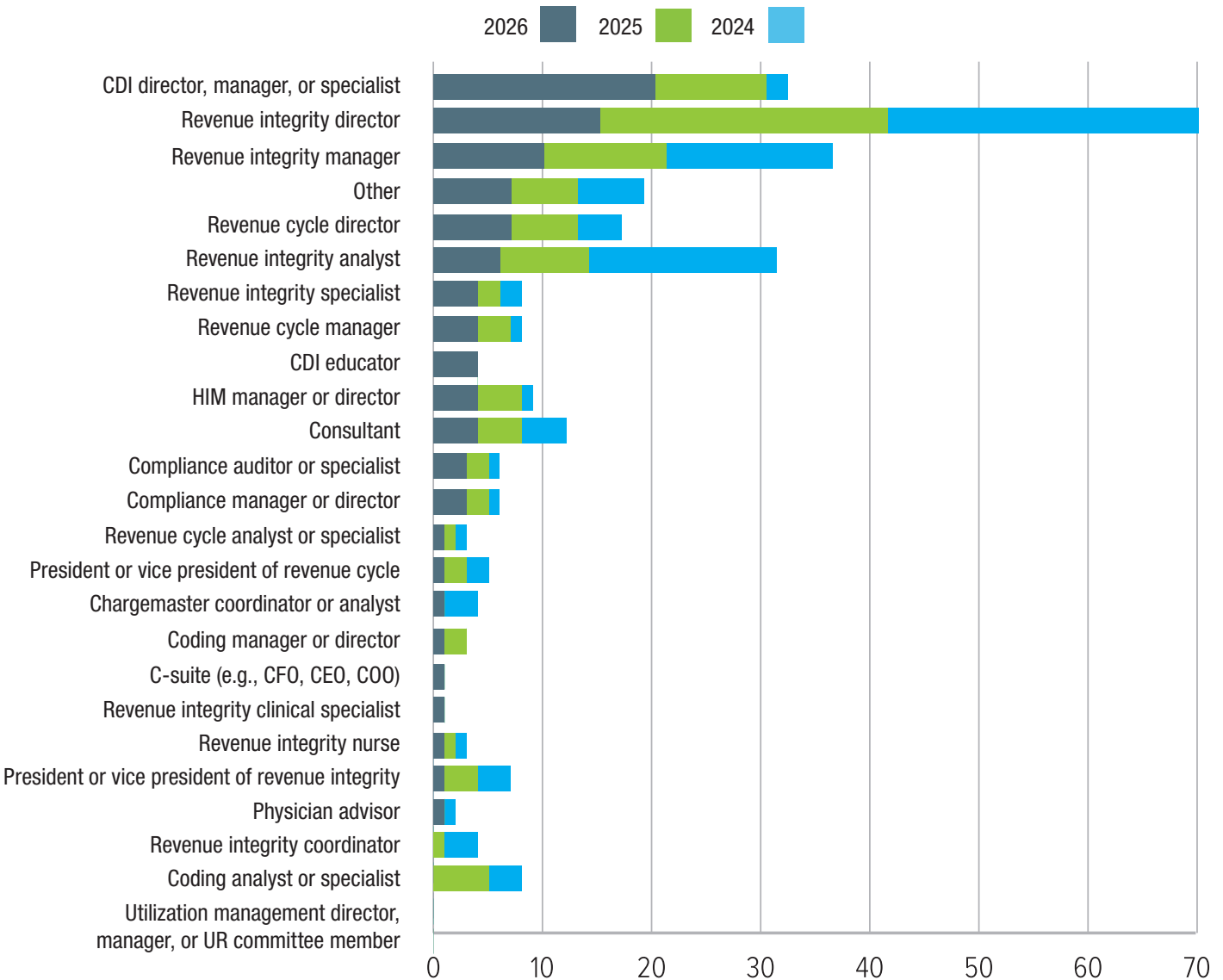
Primary and supporting functions

Although revenue integrity programs can differ, key functions remain common across the industry. Core primary revenue integrity functions support the program’s basic goals and day-to-day work.

In 2026, the five most common primary revenue integrity functions, according to survey respondents, are:

- Charge capture workflow design/optimization (i.e., revenue integrity staff support charge capture workflow within the EHR and/or billing system): 76%

Figure 1. Which best describes your title



Source: NAHRI’s 2026, 2025, and 2024 State of the Revenue Integrity Industry Surveys.

Figure 2: Does your organization have any type of revenue integrity program?

	2026	2025
We have a stand-alone revenue integrity department	75%	75%
We have a revenue integrity initiative (informal or distributed, not a formal department or committee)	10%	9%
We have a revenue integrity committee	9%	3%
No, we do not have any type of revenue integrity program	6%	13%

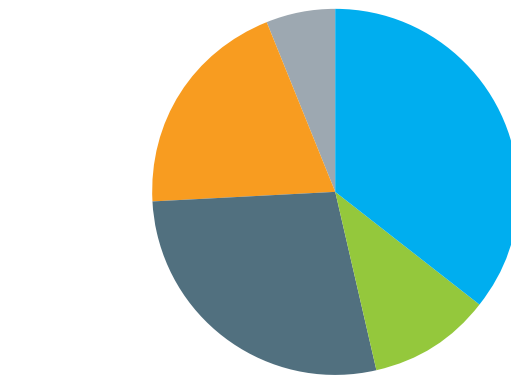
Sources: NAHRI's 2026 and 2025 State of the Revenue Integrity Industry Surveys.

Figure 3: How many full-time employees support your organization's revenue integrity program?

	2026	2025
0-1	6%	11%
2-4	7%	11%
5-7	9%	7%
8-10	13%	11%
11-15	10%	9%
16-20	6%	13%
21-25	8%	9%
26-30	8%	2%
31-35	3%	4%
36-40	3%	4%
More than 40	27%	18%

Sources: NAHRI's 2026 and 2025 State of the Revenue Integrity Industry Surveys.

Figure 4: Has your organization's revenue integrity staffing changed in the past 12 months?



- Increased
- Decreased
- No change
- I don't know
- N/A

Source: 2026 State of the Revenue Integrity Industry Survey.



- Chargemaster maintenance: 75%
- Chargemaster management: 74%
- Charge audits: 66%
- Charge edits: 64%

Because revenue integrity's work is so closely interwoven with other departments, it often plays a strong supporting role in a wide variety of functions. According to survey respondents, the top five most common secondary functions are:

- Decision support functions: 52%
- Denials management: 48%
- Charge reconciliation: 44%
- Charge entry (i.e., revenue integrity staff enter charges): 43%
- Correcting claim edits: 42%

Despite revenue integrity's broad reach, there are some functions it's generally not involved with. Following are the five functions that revenue integrity is least likely to be involved with:

- Inpatient CDI: 49%
- Professional coding: 47%
- Patient admission status: 45%
- Hospital coding: 44%
- Outpatient CDI: 43%

Kelli L. Howard, MS, CSPPM, senior manager of revenue integrity at Mayo Clinic in Phoenix, Arizona, says that several years ago her organization took inventory of and categorized revenue integrity's work to help define its scope and functions, including core functions and overlap with other departments. Some of these primary functions at Mayo Clinic include revenue analysis, charge reconciliation and charge capture, education, chargemaster management, denials liaison, payment integrity, and work queue management and maintenance.

The program's scope and functions are reviewed annually to ensure it reflects ongoing changes in duties and practice. "While the functions themselves may not at a categorical level change, the tasks and project work within the function may evolve," Howard says.

Defining the program's scope is essential to keeping scope creep at bay and ensuring the department is appropriately staffed and trained. Gaining executive support for developing a scope of work and establishing

primary functions can be a significant boost to completing this work, Woolnough says.

"We've obtained executive interest in working with us to help define what the system expects revenue integrity to be, [defining] what we're already doing combined with what does the system think we should be doing," she says. "The end goal is to, by the end of 2026, have a pretty well-defined parameter of what is and isn't going to fall into the revenue integrity structure, and staff it accordingly."

See Figures 5 and 6 and the sidebar on p. 8 for more details on revenue integrity functions.

Although some healthcare functions are seeing AI pick up steam, it's been slower to affect most revenue integrity functions. In 2026, 46% of respondents said they are not using AI, as distinct from automation, in any revenue integrity functions, compared to 51% in 2025. Of those who are using AI for some revenue integrity functions, the five most common functions are:

- Appeals writing: 25%
- Professional coding: 21%
- Hospital coding: 20%
- Inpatient CDI: 16%
- Charge capture: 14%

Survey respondents who have implemented AI for some revenue integrity functions were asked to weigh in on the primary benefits they've seen. Many cited a reduction in administrative burden and manual tasks, as well as a reduction in the time it takes to complete certain tasks.

"The primary benefit has been a reduction in administrative burden through automation of routine review tasks, allowing staff to focus on high-risk, high-value cases. Additionally, AI has improved accuracy and enabled earlier identification of documentation and coding gaps, which has helped prevent denials and accelerate claims processing," a respondent said.

"Leveraging AI to assist with chargemaster maintenance has created significant efficiencies related to keeping the CDM updated," another respondent said.

Respondents were also asked about challenges they've faced using AI. Some of the most common pain points mentioned include the time required to train and

validate the AI, finding and correcting errors generated by it, and lower accuracy than expected.

“The primary challenge has been ensuring accuracy and appropriate validation of AI-generated outputs. While AI improves efficiency, it still requires human oversight to prevent errors, particularly in complex coding and documentation scenarios. Integrating AI into existing workflows and ensuring staff trust and adoption has also required ongoing training and monitoring,” a respondent said.

“For coding, AI is pulling incorrectly from documentation and does not understand coding guidelines,” another respondent said.

Some respondents noted that although revenue integrity is not currently using AI for any of its primary functions, revenue integrity staff are involved in monitoring for risks and errors in AI systems used at their organization.

See Figure 7 for details.

Organizations should take a strategic, thoughtful approach to AI to ensure they’re making the best use of resources and remaining aligned with the organization’s goals and needs. Woolnough says MetroHealth established an AI steering committee to develop standards and governance for AI use, including addressing cybersecurity and workforce concerns. The steering committee includes several subcommittees to address AI in specific use cases, such as revenue cycle and finance. Committee members gather information on AI technology that may support their area and present it to the committee. If the committee opts to further explore a particular AI product, that product then goes through approvals and implementation processes under the governance of the steering committee.

“The birthplace of the steering committee was really over appropriate use and guidelines and security,” Woolnough says. “One of the risks—at least we consider it a risk right now—is a reduction in force, because our goal is not to reduce our staff and replace them with AI. We are instead really focused on how do we upskill our staff to work with AI and not be replaced by AI.”

See the sidebar on p. 9 for more on AI in revenue integrity.

Figure 5: Primary revenue integrity functions

Charge capture workflow design/optimization (i.e., revenue integrity staff support charge capture workflow within the EHR and/or billing system)	76%
Chargemaster maintenance	75%
Chargemaster management	74%
Charge audits	66%
Charge edits	64%
Billing compliance/integrity	58%
Revenue reporting/analytics	50%
Price strategies/methodologies	48%
Charge reconciliation	46%
Educating revenue cycle/nonclinical staff	46%
Service line revenue management/support	44%
Price transparency compliance	44%
Charge entry (i.e., revenue integrity staff enter charges)	40%
E/M leveling criteria	38%
Correcting claim edits	36%
Chart/documentation audits	36%
Claims audits	36%
Internal audits	34%
Payer audits/external audits	34%
Denials management	33%
Correcting coding edits (hospital and/or professional)	33%
Educating clinical staff	33%
Coding audits (hospital and/or professional)	30%
Claims/payment reconciliation	28%
Clinical documentation integrity (outpatient)	27%
Clinical documentation integrity (inpatient)	26%
ED criteria management	24%
No Surprises Act compliance	24%
Coding (professional)	23%
Decision-support functions	22%
Coding (hospital)	20%
Surgery leveling matrix	19%
Patient billing	18%
Managed care/payer contract management	17%
Patient admission status	16%
Quality programs/quality reporting	13%

Source: 2026 State of the Revenue Integrity Industry Survey.

Figure 6: Secondary revenue integrity functions

Decision-support functions	52%
Denials management	48%
Charge reconciliation	44%
Charge entry (i.e., revenue integrity staff enter charges)	43%
Correcting claim edits	42%
Internal audits	40%
Educating clinical staff	40%
Chart/documentation audits	40%
Claims audits	40%
ED criteria management	39%
Managed care/payer contract management	39%
Educating revenue cycle/nonclinical staff	38%
Revenue reporting/analytics	38%
Surgery leveling matrix	38%
Billing compliance/integrity	37%
Payer audits/external audits	37%
Patient billing	37%
Correcting coding edits (hospital and/or professional)	35%
Claims/payment reconciliation	34%
Quality programs/quality reporting	32%
Charge edits	31%
E/M leveling criteria	31%
No Surprises Act compliance	30%
Service line revenue management/support	29%
Charge audits	29%
Price strategies/methodologies	29%
Coding audits (hospital and/or professional)	29%
Patient admission status	29%
Coding (hospital)	28%
Price transparency compliance	27%
Coding (professional)	23%
Charge capture workflow design/optimization (i.e., revenue integrity staff support charge capture workflow within the EHR and/or billing system)	20%
Clinical documentation integrity (outpatient)	18%
Chargemaster management	16%
Chargemaster maintenance	16%
Clinical documentation integrity (inpatient)	16%

Source: 2026 State of the Revenue Integrity Industry Survey.

Figure 7: What revenue integrity functions are you supporting or performing through AI (as distinct from automation)?

Appeals writing	25%
Coding (professional)	21%
Coding (hospital)	20%
Clinical documentation integrity (inpatient)	16%
Charge capture	14%
Denials management	13%
Chart/documentation audits	8%
Revenue reporting and/or analytics	8%
Billing compliance/integrity	8%
Charge audits	8%
Clinical documentation integrity (outpatient)	7%
Other	7%
Charge reconciliation	6%
Chargemaster maintenance	6%
Coding audits (hospital and/or professional)	6%
Correcting charge edits	5%
Correcting claim edits	5%
Internal auditing	5%
Automated risk adjustment for audits	4%
Correcting coding edits (hospital and/or professional)	4%
Real-time claim validation	4%
Chargemaster management	3%
Claims audits	3%
Claims/payment reconciliation	3%
Patient billing	3%
Patient admission status	2%
Payer audits/external audits	2%
Predictive denial avoidance	2%
Price transparency compliance	2%
Price strategies/methodologies	2%
Service line revenue management/support	2%
No Surprises Act compliance	1%
None of the above	46%

Source: 2026 State of the Revenue Integrity Industry Survey.

DEFINING PRIMARY FUNCTIONS

Q: What are your organization's primary revenue integrity functions, and how is this defined? Do you have a formal scope of work?

Kelli L. Howard, MS, CSPPM, senior manager of revenue integrity at Mayo Clinic in Phoenix, Arizona:

We do have a [formal scope of work] at Mayo Clinic. We went through a very intense activity a few years back to really take inventory of everything we did and categorize it. Based off that, it helped us to define what our standard core functions are and where there is overlap with other departments, [meaning] shared ownership or collaborative ownership within certain categories. Revenue analysis definitely fits as a top core function. There's a lot of activity in that space: Charge reconciliation [and] charge capture are another core function. Education is a very large one for us. That education drives primarily back to the practice, but also points over to revenue cycle colleagues and other areas outside of revenue cycle. We do have CDM and fee schedule involvement as a core function where we are directing amendments but work in collaboration with our CDM and pricing team, so there's that shared ownership. Denials liaison is another core function. Lastly payment integrity and work queue maintenance /management are core functions but primarily reside in dedicated sub teams. In summary, revenue analysis, charge capture/charge reconciliation, education, CDM, fee schedules and denials liaison are the core primary functions for our revenue integrity department. We do have several supportive functions identified as well.

Brenda L. Melone, MS, RN, CPC, senior director of revenue cycle at Sturdy Health in Attleboro, Massachusetts:

This is a brand-new department. I oversee the hospital revenue cycle as well as revenue integrity for the hospital spaces. We have a very large outpatient footprint as well as for the ambulatory provider side. But the revenue integrity department is very niched, meaning that it's strictly revenue integrity. What that involves is really charge description maintenance and management strictly. So in other words, anytime new charges come out or [there are] Current Procedural Terminology (CPT®) updates or deletions, things of that nature, this department is responsible for updating our CDM.



USING AI IN REVENUE INTEGRITY

Q: Is your organization using AI to support any revenue integrity functions? If so, what has that experience been like? If not, what are some of the barriers to implementing AI?

Ashley Brown, CHRI, RH-RCMS, RH-CBS, CAH-CBS, CH-CBS, CH-RCMS, revenue cycle analyst at La Paz Regional Hospital in Parker, Arizona:

Currently the organization is not utilizing any AI systems for revenue cycle. For us as a small organization, obviously money is very important. We have to weigh the cost of everything that we do, of course, and the time. I'm a small department of one at the moment, so getting with each individual director and discovering their pain points and trying to help them solve problems with a department of one is time consuming, especially while trying to create this department. So some things are just not prioritized at the moment, and AI is just one of those items.

Kelli L. Howard, MS, CSPPM, senior manager of revenue integrity at Mayo Clinic in Phoenix, Arizona:

We are in the adoption and evaluation phase across several platforms, but not necessarily directly related in revenue integrity. Because of the sheer complexity and variability of the work within revenue integrity, there haven't been many opportunities identified. That being said, one of my favorite AI uses that we just stood up a few months ago, reviews documentation for adequate teaching physician attestations. Being an academic facility, resident billing and attestation documentation are extremely important. So from a compliance perspective, coding quality, education to providers, so on and so forth—the AI model reviews documentation, and then categorizes [it in one of two ways]: Either there's absolutely no attestation present where it would have been expected, [or] we have an attestation but it's either missing documentation for physical presence, or a tie to the resident note or lacking medical decision making. That data has helped us to streamline which providers require education, where opportunities for coding education may be needed, and where there could be compliance risks or opportunities. It's been pretty slick and very value added.

Brenda L. Melone, MS, RN, CPC, senior director of revenue cycle at Sturdy Health in Attleboro, Massachusetts:

We use computer-assisted coding, autonomous coding, for our inpatient applications. We also use a vendor who does our professional coding in our emergency departments only, and they have a tool which is very AI based. The AI that's coming in the health-care space is going to really be a game changer for so many people. I'm definitely embracing it, and I have my finger on the pulse of rolling it out to all other areas: registration, claim solution, denials management, etc.

Jaclyn Woolnough, director of revenue integrity at MetroHealth in Cleveland, Ohio:

Metro Health is currently utilizing AI, and the revenue integrity structure here does include both hospital and professional coders reporting up indirectly through me. Right now outside [of our EHR] we are using [a third-party vendor solution] that includes some AI functions for both professional and hospital coding. We're also looking at implementing AI in certain charge reviews or queues that are currently worked by members of the revenue integrity team today, but our eyes are, I think, a little bit more on the future. We have established an AI steering committee. There are subcommittees of the steering committee, and one of those subcommittees is revenue cycle and finance AI. We individually—all the members of that committee—are the ones who listen to what's available [and] see what's out there; [then we] take it to that committee, and then we have a process for approvals and implementation through the governance of the steering committee.

Chargemaster maintenance

The chargemaster remains at the heart of revenue integrity for most programs. Ensuring the chargemaster is correct, updated, and compliant is an essential task and supports the primary goals of revenue integrity and many functions throughout the organization.

Although many other revenue integrity functions, practices, and priorities have seen major changes over the years, chargemaster maintenance practices have generally remained the same.

In 2026, 68% of respondents said that a team is responsible for chargemaster maintenance. At 13% of organizations, one person is responsible for chargemaster maintenance, and 11% reported that they use a hybrid of internal staff and external resources (e.g., external personnel, software purchased from a vendor). See Figure 8 for the full list of responses.

Brenda L. Melone, MS, RN, CPC, senior director of revenue cycle at Sturdy Health in Attleboro, Massachusetts, says that her organization takes a structured, formal approach to help ensure a consistent and accurate chargemaster. “We have a formal process. When the annual and quarterly updates come out, I look at them, [then] I send them out to the respective service line areas [and ask what they think they’re] going to use. [Then] it’ll come back and my analyst will build the charges for them,” she says.

Chargemaster processes often evolve with the organization, particularly when a new revenue integrity program is created. La Paz Regional Hospital in Parker, Arizona, recently established a formal revenue integrity program, necessitating some changes in its established chargemaster management and maintenance processes, according to **Ashley Brown, CHRI, RH-RCMS, RH-CBS, CAH-CBS, CH-CBS, CH-RCMS**, revenue cycle analyst at La Paz Regional Hospital. She says that currently one staff member handles chargemaster maintenance and creation of new codes.

“Historically, that has been done by our patient financial services director, which is transitioning to me,” Brown says. “We do of course expect our revenue cycle department to grow, so that structure may change moving forward.”

When it comes to chargemaster approval processes, 40% said that individual requests are sent to a central person, up from 30% in 2025. Thirty-seven percent reported that individual requests are routed to a team for approval, such as finance for pricing or HIM for coding (up from 27% in 2025), while 10% take a hybrid approach that uses chargemaster software and a central contact person (down from 22% in 2025). See Figure 9 for more information.

The majority (83%) of respondents indicated that Healthcare Common Procedure Coding System (HCPCS) codes are assigned to all applicable drugs and supplies when such a code exists. Other approaches reported include assigning HCPCS codes to support compliance, reporting, or audit requirements (e.g., LCD/NCD, MUE) (25%); assigning HCPCS codes to drugs and supplies when the code generates separate or packaged payment (25%); and assigning HCPCS codes when needed to resolve procedure-to-device (PTD) or other National Correct Coding Initiative (NCCI) edits (19%). See Figure 10 for more details.

Exploding charges, panel charges, and similar mechanisms that ensure a single chargemaster number triggers the charging of multiple components can be useful tools, but they need regular review and careful monitoring to ensure they are functioning appropriately and as intended. In 2026, almost half (46%) of respondents said that these mechanisms are reviewed annually (31% in 2025). See Figure 11 for more details.

Exploding charges are often a pain point for revenue integrity because of how complex they are behind the scenes, which may be compounded by the nuances of an organization’s EHR, Melone says. “For example, lab panels, the way our CDM is structured, those children exploding charges can belong to 500 [different] tests. So when you do your annual CPT updates, what are the charges that have the majority of changes? I know in my organization it’s labs. You have to be very careful when you’re pulling your entire CDM if you are inactivating a parent-child that it doesn’t go to another one. That is a challenge.”

On the other hand, some organizations find that exploding charges make hospital-based and professional charge reconciliation easier. “[Exploding charges] makes it a lot easier for PB to HP reconciliation activity

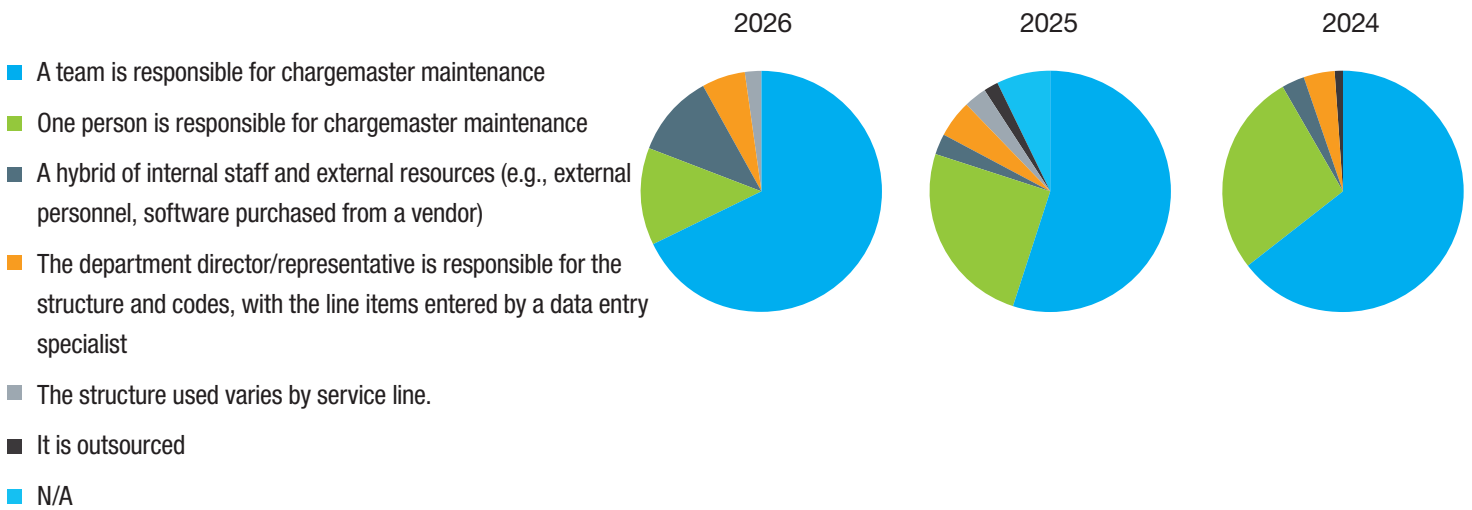
when we know what to expect,” Howard says. “That being said, I think the biggest disconnect on occasion is if there is something unexpected from a PB perspective performed in a department where we would expect the HB and we haven’t built out the HB. That’s where the reconciliation component becomes very important to catch those missed charge opportunities.”

Chargemaster order sets can be another useful tool, but, like exploding charges, they require diligent

monitoring and thoughtful implementation. In 2026, responsibility for making changes to chargemaster order sets generally falls to revenue integrity (44%; 31% in 2025) or IT (43%; 40% in 2025). See Figure 12 for more responses.

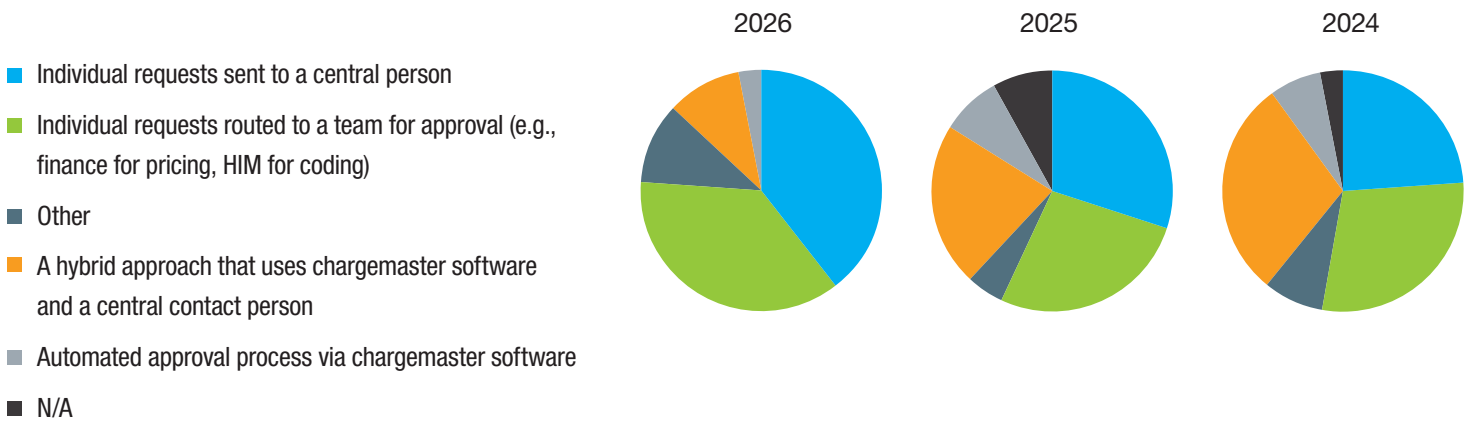
See the sidebar on p. 12 for more on chargemaster maintenance.

Figure 8: How is your chargemaster maintenance structured?



Source: NAHRI’s 2026, 2025, and 2024 State of the Revenue Integrity Industry Surveys.

Figure 9: What is your organization’s process for approving the addition of new codes to the chargemaster



Source: NAHRI’s 2026, 2025, and 2024 State of the Revenue Integrity Industry Surveys.

Figure 10: When do you assign HCPCS codes to drugs and supplies?

	2026	2025	2024
We assign HCPCS codes to all applicable drugs and supplies when such a code exists	83%	64%	79%
We assign HCPCS codes to drugs and supplies when the code generates separate or packaged payment	25%	22%	13%
We assign HCPCS codes to support compliance, reporting, or audit requirements (e.g., LCD/NCD, MUE)	25%	N/A	N/A
We assign HCPCS codes when needed to resolve procedure-to-device (PTD) or other NCCI edits	19%	15%	9%
We assign HCPCS codes to drugs and supplies based on a defined cost threshold	6%	9%	N/A
We do not assign HCPCS codes to drugs and supplies	5%	5%	6%
Other policy	2%	3%	4%
N/A	2%	11%	N/A

Source: NAHRI's 2026, 2025, and 2024 State of the Revenue Integrity Industry Surveys.

Figure 11: How often do you review exploding charges, panel charges, or other mechanisms to ensure a single chargemaster number triggers the appropriate charging of multiple components when appropriate?

	2026	2025	2024
Quarterly	14%	9%	10%
Twice annually	3%	4%	4%
Annually	46%	31%	49%
Other	10%	6%	13%
I don't know	17%	27%	N/A
N/A - We do not use these mechanisms	10%	22%	8%

Source: NAHRI's 2026, 2025, and 2024 State of the Revenue Integrity Industry Surveys.

Figure 12: Who is responsible for making changes to chargemaster order sets?

	2026	2025	2024
Revenue integrity	44%	31%	44%
IT department	43%	40%	51%
The director of the department to which the charges are applicable	17%	15%	25%
We use another method OR our order sets are maintained in the clinical application rather than the chargemaster (please describe and specify)	17%	21%	N/A
Clinical staff	6%	9%	12%
I don't know	3%	14%	N/A
N/A	2%	5%	6%

Source: NAHRI's 2026, 2025, and 2024 State of the Revenue Integrity Industry Surveys.

STRUCTURING CHARGEMASTER MAINTENANCE

Q: How is chargemaster maintenance structured at your organization?

Kelli L. Howard, MS, CSPPM, senior manager of revenue integrity at Mayo Clinic in Phoenix, Arizona:

While we do have a CDM hub team outside of the revenue cycle, the process is really that the revenue analysts know when a new service is coming online that would warrant a new code creation. We have an intake process where the revenue analyst fills out the information that's associated with those services. It's similar regarding the annual CPT load. We don't just automatically load; we only fully build codes out when they are going to be utilized. Revenue integrity controls the aspects associated with the EAP builds, or procedure code builds, and then pushes it over to the CDM team to incorporate changes into the system.

Jaclyn Woolnough, director of revenue integrity at MetroHealth in Cleveland, Ohio:

I only have a single individual who is doing all chargemaster maintenance. We have our revenue integrity team really doing that initial intake and getting the information needed for a new build, but as far as ongoing maintenance, that is a team of one right now.

Charge reconciliation

Charge reconciliation underpins essential revenue integrity functions and tasks, but it's generally not directly performed by revenue integrity staff and is often not one of the program's primary responsibilities. Although it makes sense for clinical staff to perform charge reconciliation in most settings, this also means revenue integrity sometimes struggles to ensure that it is performed timely and correctly.

Almost half (44%) of respondents indicated that all clinical departments are responsible for reconciling their own charges with regular support from revenue integrity, similar to previous years. About one-quarter (24%) said that all clinical departments are responsible for their own charges. Other, less common charge reconciliation structures include having some clinical departments responsible for reconciling their own charges while others are centralized under revenue integrity (16%), or having all charge reconciliation centralized under revenue integrity. See Figure 13 for more details.

A formal charge reconciliation policy helps set expectations and create accountability by clarifying responsibilities. About half (51%) of respondents reported that their organization has a formal charge reconciliation policy (see Figure 14 for more responses). Some respondents provided additional information about their organization's policies.

"We have a table of expected reports for outpatient clinical managers to run and how frequently. We also use a monitoring report to make sure that they are running these reports and have action plans within their department. We score them on a risk level based on how many reports they are running and how frequently," one respondent said.

"Each revenue-generating department is responsible for reviewing the prior day's charges for accuracy, utilizing system-generated reports and methods taught to them by the revenue integrity team," another respondent said.

"We have AI that compares charges with orders for some departments," one respondent said.

Charge reconciliation is often a tricky topic because much of it depends on clinical staff, which may lead to problems getting buy-in from clinical departments.

"Ninety-eight percent of our charges are triggered clinically; very little is actually touched by a coder anymore," Woolnough says. "And when you have that much that is triggered clinically, the reconciliation of those charges really needs to live in that clinical space as well. So where we have struggled, and I'm hoping we're making some improvement here, is really just getting the entire health system to march to the same drum as it comes to who should be in charge of reconciliation and why."

Melone agrees with Woolnough's assessment. "The charges really are clinically driven secondary to operations in those clinical workflows, and we do hold the clinical areas responsible for charge reconciliation," she says.

Over half (60%) said their time frame for reconciling and correcting charges is one to three business days, similar to previous years. See Figure 15 for more on time frames.

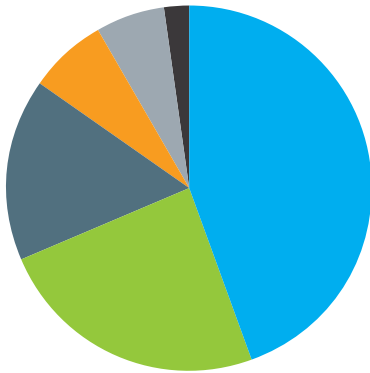
Melone says that although her organization doesn't have a formal charge reconciliation policy, clinical departments are still expected to adhere to specific time frames for reconciliation. "We do have an unwritten rule. Certain different departments, like the OR, the charges have to be in within 24 hours. Some other areas they have to be in within 48 hours or two business days."

Although clinical staff are often best positioned to handle charge reconciliation, it's not always practical for them to do so. In these instances, other staff take on the task, including revenue integrity. Emergency/trauma department charges are least likely to be entered by clinical staff or triggered by their documentation (38%), similar to previous years. Other charges that are generally not entered by clinical staff include observation hours/time-based charges (27%), drug administration (26%), and supplies or implants charged via chargemaster/CDM rules rather than clinical documentation (24%). See Figure 16 for more details.

Charge reconciliation practices need to be monitored to ensure they're appropriate and being consistently followed. Just under half (44%) use manual processes to accomplish this task, and 26% use homegrown automation or technology. See Figure 17 for more information.

See the sidebar on p. 15 for more on charge reconciliation.

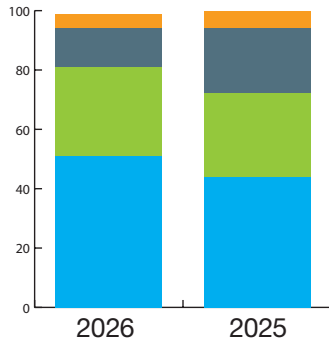
Figure 13: Who is responsible for charge reconciliation?



- All clinical departments are responsible for reconciling their own charges with regular support from revenue integrity
- All clinical departments are responsible for their own charges
- Some clinical departments are responsible for reconciling their own charges while others are centralized under revenue integrity
- We do not have a charge reconciliation process in place
- All charge reconciliation is centralized under revenue integrity
- N/A

Source: NAHRI's 2026 State of the Revenue Integrity Industry Survey.

Figure 14: Does your organization have a formal charge reconciliation policy?



- Yes
- No
- I don't know
- N/A

Source: NAHRI's 2026 and 2025 State of the Revenue Integrity Industry Surveys.

Figure 15: What is your time frame for reconciling and correcting charges?

	2026	2025	2024
1–3 business days	60%	51%	52%
4–5 business days	11%	19%	18%
6–7 business days	9%	4%	2%
More than 7 business days	7%	6%	3%
I don't know	13%	20%	17%

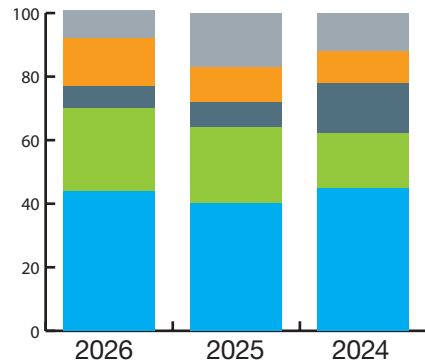
Source: NAHRI's 2026, 2025, and 2024 State of the Revenue Integrity Industry Surveys.

Figure 16: What types of charges are not entered by clinical staff or triggered by clinical staff documentation?

	2026	2025
Emergency/trauma department	38%	37%
Observation hours/time-based charges	27%	29%
Drug administration	26%	31%
Supplies or implants charged via chargemaster/CDM rules rather than clinical documentation	24%	N/A
Cardiac cath lab	23%	24%

Source: NAHRI's 2026 and 2025 State of the Revenue Integrity Industry Surveys.

Figure 17: How does your organization monitor charge reconciliation practices for consistency and appropriateness?



- We use manual processes
- We use homegrown automation or technology
- We use third-party automation or technology
- We do not reconcile charges and/or this task does not apply to my organization
- I don't know

Source: NAHRI's 2026, 2025, and 2024 State of the Revenue Integrity Industry Surveys.

DEFINING REVENUE INTEGRITY'S ROLE IN CHARGE RECONCILIATION

Q: How is revenue integrity involved in charge reconciliation at your organizations? Do you have a formal charge reconciliation policy?

Ashley Brown, CHRI, RH-RCMS, RH-CBS, CAH-CBS, CH-CBS, CH-RCMS, revenue cycle analyst at La Paz Regional Hospital in Parker, Arizona:

Every department is responsible for their own charges for charge reconciliation and charge rejections, but in the past there were unwritten rules around these two functions. I am in the process of creating a universal rule for the departments to follow, but getting buy-in from the directors that have never been responsible for this process in the past has been our largest struggle here.

Kelli L. Howard, MS, CSPPM, senior manager of revenue integrity at Mayo Clinic in Phoenix, Arizona:

While we do have a CDM hub team outside of the revenue cycle, the process is really that the revenue analysts know when a new service is coming online that would warrant a new code creation. We have an intake process where the revenue analyst fills out the information that's associated with those services. It's similar regarding the annual CPT load. We don't just automatically load; we only fully build codes out when they are going to be utilized. Revenue integrity controls the aspects associated with the EAP builds, or procedure code builds, and then pushes it over to the CDM team to incorporate changes into the system.

Denials management

“Denials management is no longer a back-end recovery function: It signals upstream breakdowns in documentation, coding, and clinical decision-making. As payer behavior grows more stringent and variable, shifting coverage policies, evolving medical necessity criteria, and automated edits increase denial risk even when care is appropriate. Health systems must move from hindsight to prevention by addressing issues in real time. That requires automation to surface denial risk early, operationalize payer rules, and route fixes to the right owner before submission, letting teams focus on the most complex, high-impact exceptions. Solventum™ Revenue Integrity System supports this shift by connecting clinical documentation, coding workflows, and audit intelligence to identify risk sooner, improve accuracy at the point of care, and reduce avoidable rework. The result? Fewer appeals, less margin leakage, and more sustainable financial performance.”

-Thea Campbell, MBA, RHIA, FAHIMA, global business director, revenue cycle – revenue integrity, Solventum

Managing and avoiding payer denials has always been a major concern for provider organizations, but as denial volumes have increased, hospital margins have shrunk, and payers are adopting increasingly sophisticated and technology-driven denial strategies. Organizations are developing a variety of processes and structures to keep up, but denials remain a moving target. Clear and consistent internal policies and guidelines, interdepartmental collaboration, and executive-level support are foundational to sound denials management and prevention programs. Within these programs,

revenue integrity professionals often lend their expertise to support or lead critical efforts.

Most survey respondents are taking an organized approach to denials management and prevention. Just over half (55%) said they have a stand-alone denials management department, and 62% have a denials prevention program. Denials management (67%), PFS/billing (46%), and revenue integrity (38%) are the departments that most commonly own denials management as a primary responsibility, according to survey respondents. See Figures 18 and 19 for more details.

When it comes to preventing denials, 30% of respondents said their organization's primary strategy is improving clinical documentation, and 25% noted their organization's primary strategy involves improving prior authorization processes. See Figure 20 for more responses.

However, despite organizations' best efforts, most report that denials have increased. Almost half (47%) of respondents said they've seen denial rates increase over the past 12 months (see Figure 21).

Woolnough says that her organization, like many others, has seen an increase in denials, particularly emergency department (ED) claims. "Payers are adopting their own policy to what constitutes an ED level of service, and they are, in some cases, downcoding those ED levels of service and other cases. They are flat out denying, saying that it doesn't meet their policy. This is actually becoming a bigger issue with some of our commercial payers as we speak."

Thirty-three percent of respondents reported that Medicare Advantage payers issue the largest volume of denials. Common denial reason/types include insufficient documentation to support medical necessity (16%), missing prior authorization/missing appeal of prior authorization denial (16%), and DRG coding downgrades (15%). Denials management (58%) and revenue integrity (42%) are typically responsible for tracking denials by payer and reason/type, according to survey respondents. See Figures 22, 23, and 24 for additional details.

Howard says her organization is seeing many of the same denial trends as other organizations across the industry, particularly medical necessity denials on outpatient claims. However, she notes that they are successfully appealing many denials.

See the sidebar on p. 19 for more on denials management.

Figure 18: Does your organization have a stand-alone denials management department?

Yes	55%
No	45%

Source: NAHRI's 2026 State of the Revenue Integrity Industry Survey



Figure 19: Which departments are responsible for denials management or prevention at your organization?

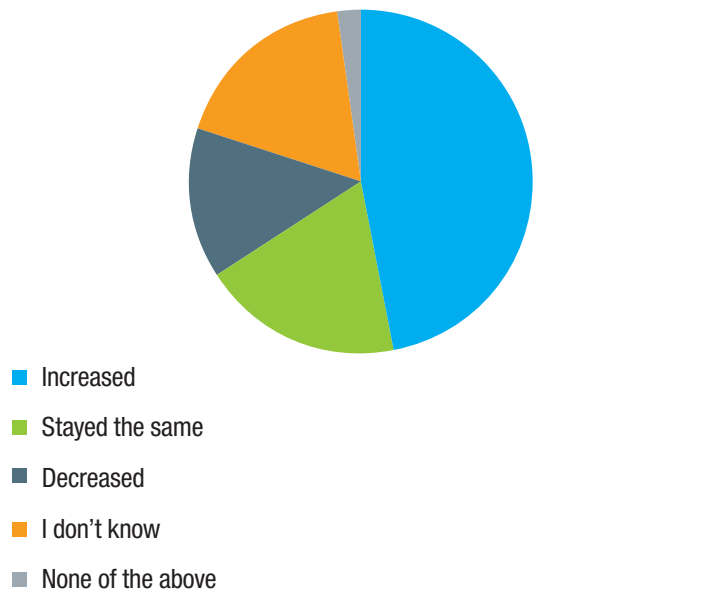
Denials Management					
	Primary responsibility	Secondary responsibility	Not involved	I don't know	N/A
Case management	13%	32%	6%	12%	7%
CDI	14%	34%	8%	8%	4%
Compliance	13%	20%	12%	18%	10%
Denials management	67%	3%	0%	8%	18%
HIM	15%	32%	10%	13%	7%
Payer contracting/managed care	21%	28%	7%	15%	11%
PFS/billing office	46%	22%	2%	11%	5%
Revenue integrity	38%	29%	1%	5%	5%
UR	24%	36%	1%	7%	5%

Denials Prevention					
	Primary responsibility	Secondary responsibility	Not involved	I don't know	N/A
Case management	8%	15%	7%	12%	7%
CDI	11%	15%	6%	8%	4%
Compliance	6%	9%	12%	18%	10%
Denials management	3%	1%	0%	8%	18%
HIM	8%	7%	7%	13%	7%
Payer contracting/managed care	5%	4%	9%	15%	11%
PFS/billing office	5%	7%	2%	11%	5%
Revenue integrity	9%	13%	1%	5%	5%
UR	10%	10%	6%	7%	5%

Figure 20: Which of the following best describes your organization's primary denials prevention strategy?

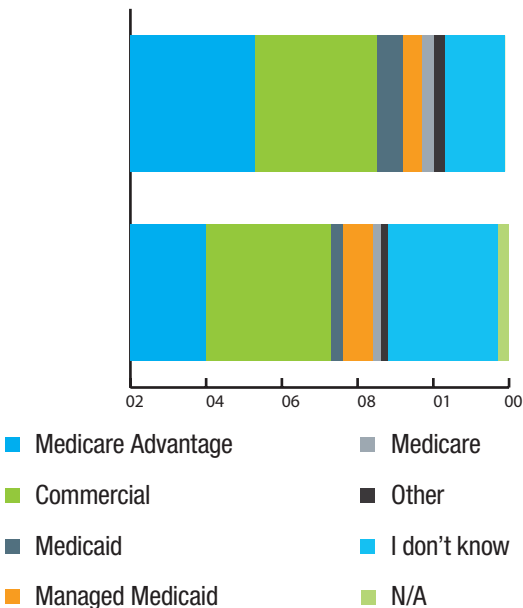
Clinical documentation improvement	30%
Prior authorization process improvement	25%
Other	12%
I don't know	10%
Real-time eligibility/verification	9%
Technology/AI-driven edits	8%
Staff education	5%
N/A	1%

Figure 21: Over the past 12 months, has your organization's denial volume/rate increased, decreased, or stayed the same?



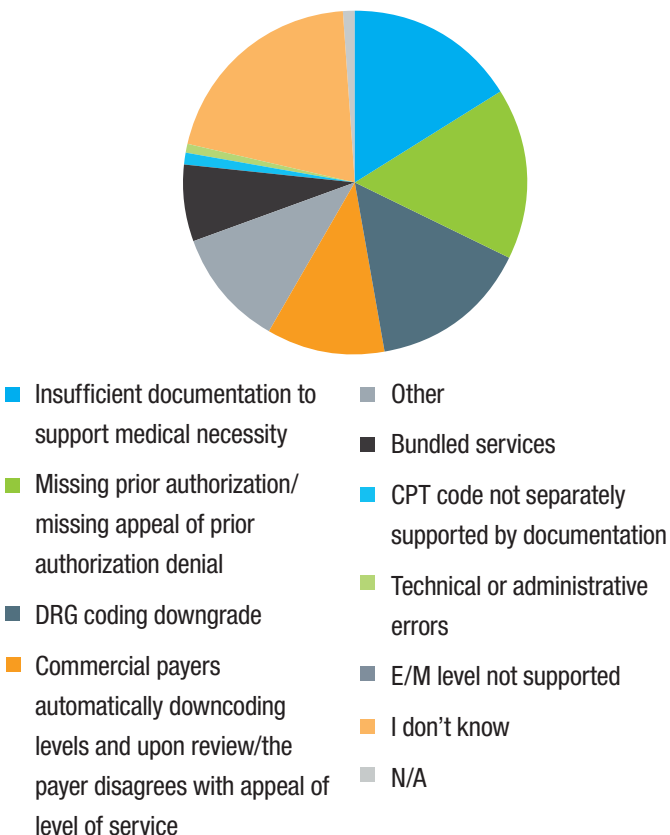
Source: 2026 State of the Revenue Integrity Industry Survey

Figure 22: Which payer issues the largest volume of denials?



Source: NAHRI's 2026 and 2025 State of the Revenue Integrity Industry Surveys.

Figure 23: At your organization, what is the most common denial reason/type?



Source: 2026 State of the Revenue Integrity Industry Survey

Figure 24: Which department(s) are responsible for tracking denials by payer and reason/type?

Denials management	58%
Revenue integrity	42%
UR	19%
Other	19%
HIM	14%
CDI	10%
Case management	9%
Payer contracting/managed care	8%
Compliance	4%
We don't track this data	0%
I don't know	7%
N/A	0%

Source: 2026 State of the Revenue Integrity Industry Survey

Challenges and benefits

Revenue integrity professionals are used to navigating complex topics and tackling tough problems. Whether they're unraveling the intricacies of a CMS rule, troubleshooting a broken workflow, or building relationships with their colleagues across the revenue cycle and clinical departments, revenue integrity professionals bring their wide-ranging skills and breadth of knowledge to each situation. In an increasingly uncertain reality with the only constant being rapid change, healthcare organizations have more need of revenue integrity's unique skills than ever. Fortunately, revenue integrity professionals are up to the challenge, despite facing some persistent issues.

The majority (84%) of survey respondents said their relationship with other middle revenue cycle departments has had a positive effect on their revenue integrity department/program's effectiveness over the past 12 months, while 79% cited their relationship with IT/analytics/reporting teams as having a positive effect and 78% gave credit to their relationship with clinical departments as having a positive effect.

Relationship management and communication skills are major drivers of success in any revenue integrity role, Howard says.

"We have to constantly tailor our styles of communication to best reach the audience that varies from clinical practice providers and administrators, to revenue

MONITORING DENIAL VOLUMES

Q: Are you seeing an increase in denials at your organization?

Ashley Brown, CHRI, RH-RCMS, RH-CBS, CAH-CBS, CH-CBS, CH-RCMS, revenue cycle analyst at La Paz Regional Hospital in Parker, Arizona:

We have seen an increase with the downcoding of the levels. Our two biggest culprits of that, however, [on the commercial side] have been Humana and Cigna. We've submitted a lot of appeals and overturned some of those denials, but there's definitely been a large increase in that particular area.

Kelli L. Howard, MS, CSPPM, senior manager of revenue integrity at Mayo Clinic in Phoenix, Arizona:

We're seeing a lot of the same trends that others are seeing: a lot more of the initial denials but appeals are often successful. Medical necessity in the outpatient space is always a tricky one with our commercial contract payers and more difficult to mitigate.

Jaclyn Woolnough, director of revenue integrity at MetroHealth in Cleveland, Ohio:

Where we're seeing a lot of that is really in two areas. One is within our emergency department (ED) setting, where payers are adopting their own policy as to what constitutes an ED level of service. They are, in some cases, downcoding those ED levels of service and other cases they are flat out denying, saying that it doesn't meet their policy. This is actually becoming a bigger issue with some of our commercial payers as we speak. Another area that we have seen a pretty significant increase is in lab services. Different payers again adopt different medical necessity policies around when a lab is justified versus when it is not, and trying to manage which payers will accept which labs under which circumstances is one of our bigger focuses right now.

cycle staff, while effectively translating between the worlds to be a trustworthy employee consistently providing value-added information. Fostering those varying relationships through effective communication is vital to success in the role," she says.

These relationships call for intentional effort, so revenue integrity professionals can thrive in an organizational culture that emphasizes direct communication, Woolnough says. "It's a lot of meetings and time scheduled and devotion of time that is [sometimes] very difficult to keep up with. But that direct one-on-one, or sometimes two-on-one, interaction with the leaders of the departments is oftentimes the only thing that keeps the relationship good. Email doesn't really cut it around here. [Microsoft] Teams® messaging isn't fantastic, but even if it's a 15-minute conversation, I have found that that really seems to help."

Revenue integrity professionals with a clinical background may have an advantage when working with clinical departments. "I think what makes my role a little bit unique, and easier, is I happen to be a nurse leader as well. I'm an RN, and so working with all the clinical areas, I can speak their language—and honestly, it's made a tremendous difference," Melone says.

See Figure 25 for more details on positive and negative effects on revenue integrity programs performance.

To learn more about revenue integrity wins, NAHRI asked respondents to share their top success stories from the past 12 months.

"We have been able to successfully audit our entire formulary and update cost, NDCs, and QCFs to ensure accurate charge capture. We also completed a strategic pricing project. We have captured millions in missed charges through our charge auditing processes," a respondent said.

"Increased support from executive leadership, increased staffing to support expanded responsibilities, and increased charge reconciliation from departments," another respondent said.

"Improvement in encounter closures, successful projects involving additional charge capture and denial reductions, AR acceleration," one respondent said.

See the sidebar on p. 22 for more revenue integrity success stories.

On the other hand, revenue integrity continues to struggle with staffing issues: 54% said a lack of qualified staff has had a negative effect on their revenue integrity

department/program's effectiveness over the past 12 months.

Other common hurdles include responding to commercial payer audits (16%), responding to government audits (15%), and expansion of duties beyond traditional revenue integrity functions (11%).

Some respondents reported looking to AI to help alleviate chronic staffing shortages.

"Trying to find AI solutions that cover staffing shortages, working to implement AI productivity tools, and finding AI tools to verify billing integrity," a respondent said.

Staffing shortages don't just mean that work piles up; it also means that staff don't have the time to learn deeply about areas, develop true expertise, and continue their education.

"We are not staffed to meet the demands of the system. Our staff is responsible for 8–10 departments apiece, which does not allow for robust learning of one area," another respondent said.

Other respondents cited challenges due to AI implementation, ensuring accurate and timely charge reconciliation, and managing denials.

However, respondents aren't just throwing in the towel. Many are working on finding or implementing solutions to these problems. For example, one respondent noted that to address the increased administrative burden of external audits, they're using automation to help process audit requests. This respondent also noted that to address problems finding experienced staff, they're cross-training existing staff and working with a third party to provide additional education. And to fix chargemaster compliance issues, they're using third-party software to more easily identify areas where the chargemaster needs to be cleaned up.

Looking at upcoming challenges, many respondents are keeping an eye on the effects of AI, noting the need for ongoing monitoring for accuracy and concerns about lack of oversight. Other issues they're remaining vigilant about include increasingly aggressive payer denials, audits, and reimbursement downgrades, as well as effectively educating staff and maintaining relationships with other departments.

"I feel that one of the biggest challenges that revenue cycle as a whole [faces] is the divide between revenue cycle and clinical. Remote work is part of our new normal and takes everyone being intentional around communication and connection," a respondent said. "Revenue cycle is a service department, but there is still a stereotype of revenue cycle being revenue cycle's problem. We need education for clinical areas and a way to help them engage and understand their revenue and budgets so that we can partner together for their success."

When it comes to making changes, revenue integrity professionals have no shortage of ideas. Respondents shared some changes they'd like to make to their programs.

"I would love to see silos knocked down and contracting working with us to combat payer clinical criteria and getting together to put in hospital systemwide definitions for the top five or six denied diagnoses and have that put in contracts," one respondent said.

"I am working towards greater charge automation with the intent to promote charge auditor staff to analysts. They will shift their focus from charge entry to charge reconciliation and partner with each clinical leader to drive their revenue," another respondent said.

"Right now, revenue integrity can feel transactional and siloed, rather than fully integrated into clinical reimbursement workflows. I would like to shift that perception so revenue integrity is viewed as part of the core operation—working alongside clinical and operational teams instead of feeling like a consulting vendor," a respondent said.

See the sidebar on p. x to learn about more changes revenue integrity professionals plan to implement.

While revenue integrity professionals are keeping their eyes on the horizon and preparing for what's next, it's also important to acknowledge and elevate the wins they've achieved in the past year. NAHRI asked respondents to share some of their successful projects and biggest accomplishments from the past 12 months.

"We have implemented a systemwide annual/quarterly code update process that ensures stakeholder involvement and awareness of quarterly/annual code changes and ensures system updates accordingly,"

one respondent said. “Expansion of our charge audit team to allow shifting charge inputs from clinical front-line staff to nurses and coders focused on accurate and full charge capture. Correction of a large number of system structures that were causing revenue capture bottlenecks. Enhanced automation in charge creation to optimize revenue capture. Implementation of a formal revenue reconciliation program training and monitoring across the system. Implementation of an arm of our department focused on Epic WQ health across the system to track, trend, and ensure WQ ownership, WQ activity, and value of each WQ structure.”

“We have been extremely successful at identifying and reacting to trends in edit management, which has reduced repetitive tasks and reduced our CFB (DNFB) holding. We have also implemented a great deal of real-time reporting, monthly revenue and usage

snapshots, [and] weekly late charge reports that has improved outcomes related to revenue capture and charging accuracy,” another respondent said.

Many respondents shared major wins that resulted in tangible revenue gains for their organizations.

“[We implemented] an aggressive and fruitful fiscal year pricing strategy that achieved that exact aggregate increase. [We now have] three full-time FTEs approved to support centralized audit intake. [We pivoted our] audit strategy that resulted in several large wins in excess of \$500,000,” a respondent said.

“[We saw a] \$25 million increase in cash with implementation of revenue leakage project,” another respondent said. “Successful implementation of financial ECMO program [and] decrease to unbilled OR case logs to meet goal of \$3–5 million pending.”

Figure 25: Please rate the effect the following have had on your revenue integrity department/program's effectiveness over the past 12 months.

	Positive effect	Negative effect	No effect	N/A—This does not apply to my organization.
Use of automation (e.g., automated charges, edit management)	60%	1%	16%	23%
Use of AI as distinct from automation	33%	1%	16%	50%
Managing denials	61%	5%	23%	12%
Conducting internal audits	61%	1%	25%	13%
Lack of qualified staff	10%	54%	18%	18%
Use of productivity measures	49%	7%	30%	14%
Use of KPIs and/or benchmarks	64%	3%	22%	11%
Relationship with IT/analytics/reporting teams	79%	5%	10%	7%
Relationship with other middle revenue cycle departments	84%	5%	2%	9%
Relationship with clinical departments	78%	5%	10%	7%
Relationship with external vendors	55%	8%	19%	18%
Expansion of duties beyond traditional revenue integrity functions	49%	11%	22%	18%
Responding to commercial payer audits	43%	16%	22%	19%
Responding to government audits	48%	15%	21%	16%
Early involvement in implementing new services/technology	63%	4%	13%	21%

Source: NAHRI's 2026 State of the Revenue Integrity Industry Survey

REVENUE INTEGRITY WINS

NAHRI asked 2026 State of the Revenue Integrity Industry Survey respondents to share their revenue integrity wins from the past 12 months. Here's some of what they told us.

- “Establishing coding checks in various formats to ensure charges correctly captured.”
- “Developing a process for AI-driven payer denials.”
- “Revenue cycle committee, education, and standardized workflows.”
- “1. Operational onboarding and training program for all new leaders over revenue generating departments to cover CDM responsibilities and charge capture/reconciliation expectations and resources. 2. Shared operationalized document between billing and IT to gather project criteria and test outcomes. 3. Revenue cycle risk program development.”
- “Denial prevention, maximizing net revenue in new clinical service areas.”
- “Tighter relationship with the compliance department.”
- “Increased support from executive leadership, increased staffing to support expanded responsibilities, increased charge reconciliation from departments.”
- “We have been able to successfully audit our entire formulary and update cost, NDCs, and QCFs to ensure accurate charge capture. We also completed a strategic pricing project. We have captured millions in missed charges through our charge auditing processes.”
- “Successful appeals at the peer-to-peer physician level for payers with this option.”
- “Reducing denials for Biofire panels, creating education and billing guidance for clinical staff, and catching up on our past due dollars from our companies who use our occupational medicine services.”
- “Implementation of AI coding software.”
- “1. An aggressive and fruitful fiscal year pricing strategy that achieved that exact aggregate increase. 2. Having 3 full-time FTEs approved to support centralized audit intake. 3. Pivot in audit strategy that resulted in several large wins in excess of \$500,000.”
- “We reduced excessive HB charge attempts by physicians, new wound care charging model, revamped respiratory flowsheet.”
- “Stem cell therapy program implementation and CDM build and rev tracking process for it.”
- “Reviewing 100% of denials for traditional Medicare and Medicaid with trend reporting. Developed the standardized facility E/M acuity tool. Advanced compliance and operational efficiency through expanded automation, reducing both work queue volume and CBO claim edits OB monitoring automation.”
- “Creation of dashboards that measure the financial success of the department. Holding [third-party] auditors accountable for not following payer policies for external audits.”
- “Capturing over \$30 million in net revenue from revenue integrity efforts/findings; preparation for WISeR; successful (so far) IPO elimination phase I.”
- “Continuing advancement of efficient charge capture through EHR documentation. Leadership support for tasks such as clinical charge capture, clinical charge reconciliation, and clinical decision support.”

PLANNING FOR THE FUTURE

NAHRI asked respondents of the 2026 State of the Revenue Integrity Industry Survey to share what changes they would like to implement in their programs. Following are some of the projects respondents would like to implement.

- “Increased staff and increased attention to retention of staff, better/user friendly education and research resources, closer collaboration with billing company and payer contracts.”
- “Methods to report AI errors so they can be fixed.”
- “Level-setting payer contracts and what will be allowed in the future.”
- “System specialists in analyzing, who can educate every department that drives revenue and their own reconciliation process.”
- “More charge automation, better reconciliation processes in clinical areas.”
- “AI program for authorizations and training for end users.”
- “Re-structuring revenue integrity functions, goals, and metrics.”
- “Continuing to implement automation to do some of the busy work, freeing the team up for more detail audits.”
- “Upskilling of team and integration with reimbursement.”
- “Accountability from the top down for charge reconciliation.”
- “Diversify responsibilities within revenue integrity which includes infusing IT support, analytics support, and physician advisor support into the department structure. Standardized charge reconciliation support driven by EHR automation is a significant focus.”
- “Implement specific policies to increase consistency and standardization, use of AI/technology, increase efforts related to denials prevention and management.”
- “I would like revenue integrity charging teams to be able to move from charge corrections to proactive monitoring and reporting.”
- “Clearer lines between the responsibility of revenue integrity vs. operations. Increased and improved structure of the chargemaster roles.”
- “Create a more robust and automated charge reconciliation program with bridge to nursing informatics.”
- “Actively working on centralized audits and audit tracking.”

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It's a continuous process.**

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- Align revenue cycle teams around shared insights
- Transform audit findings into ongoing improvement
- Reduce preventable denials and revenue leakage

See how a more proactive approach can help protect every dollar you've earned.

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