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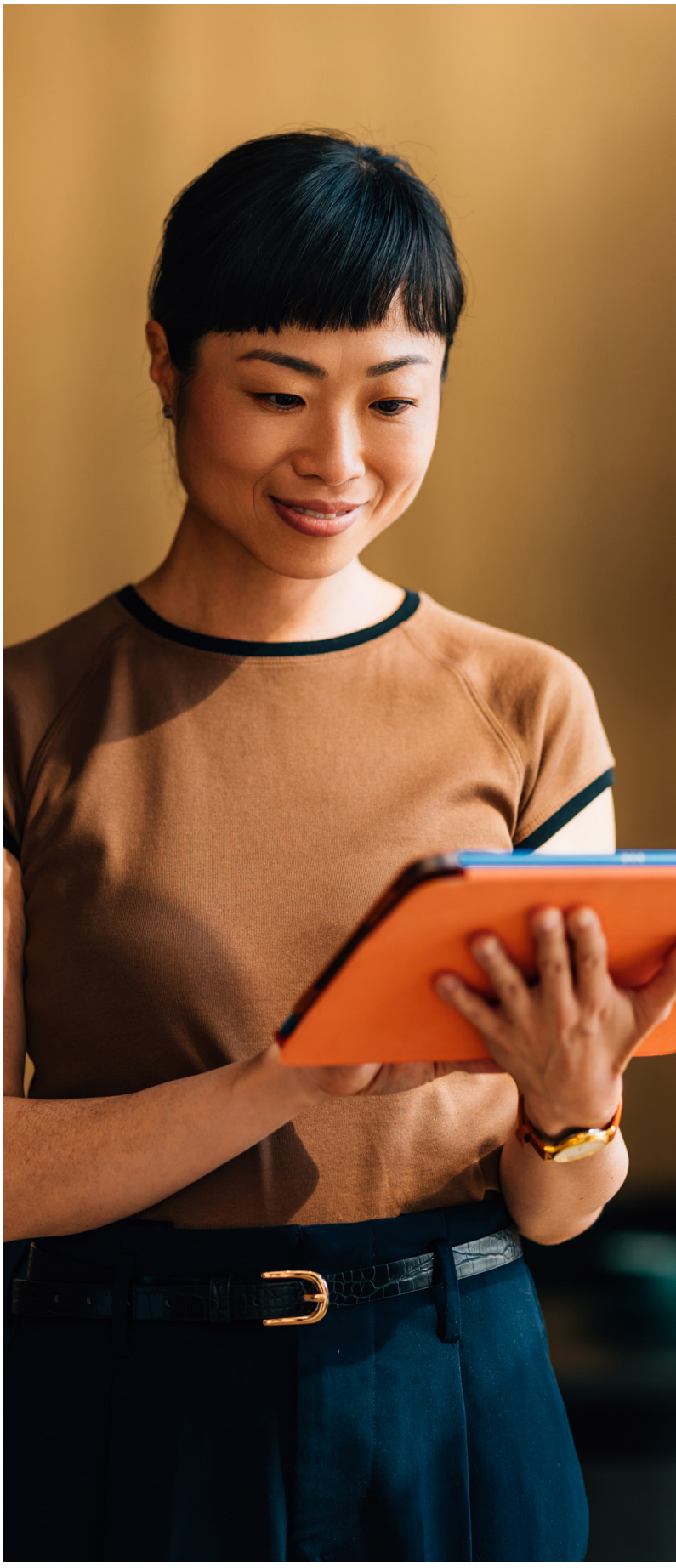
2025 State of the Revenue Integrity Industry Report

2025 STATE OF THE REVENUE INTEGRITY INDUSTRY REPORT

NAHRI is celebrating the eighth annual *Revenue Integrity Week* (June 2–6) to acknowledge and raise awareness of revenue integrity professionals' incredible contributions in the healthcare industry. To further support the goals and mission of revenue integrity and advance the development of revenue integrity programs, NAHRI is releasing the 2025 State of the Revenue Integrity Industry Report. The report, based on data from the 2025 State of the Revenue Integrity Industry Survey, digs into standards and trends from programs across the country to highlight the work revenue integrity professionals do. The report analyzes trends in revenue integrity program design, primary and supporting functions, and more.



Background and experience

Revenue integrity programs aren't homogenous—and neither are the professionals who support them. Some revenue integrity programs focus strictly on the chargemaster, while others include outpatient clinical documentation integrity (CDI), denials management, or ambulatory coding. Many organizations have formal revenue integrity departments, but others form revenue integrity committees or initiatives. The composition of revenue integrity teams and the skills and backgrounds represented on them, therefore, tends to be dictated by the specific program's functions, needs, and structure, as well as how the program has evolved and the type of organization it serves.

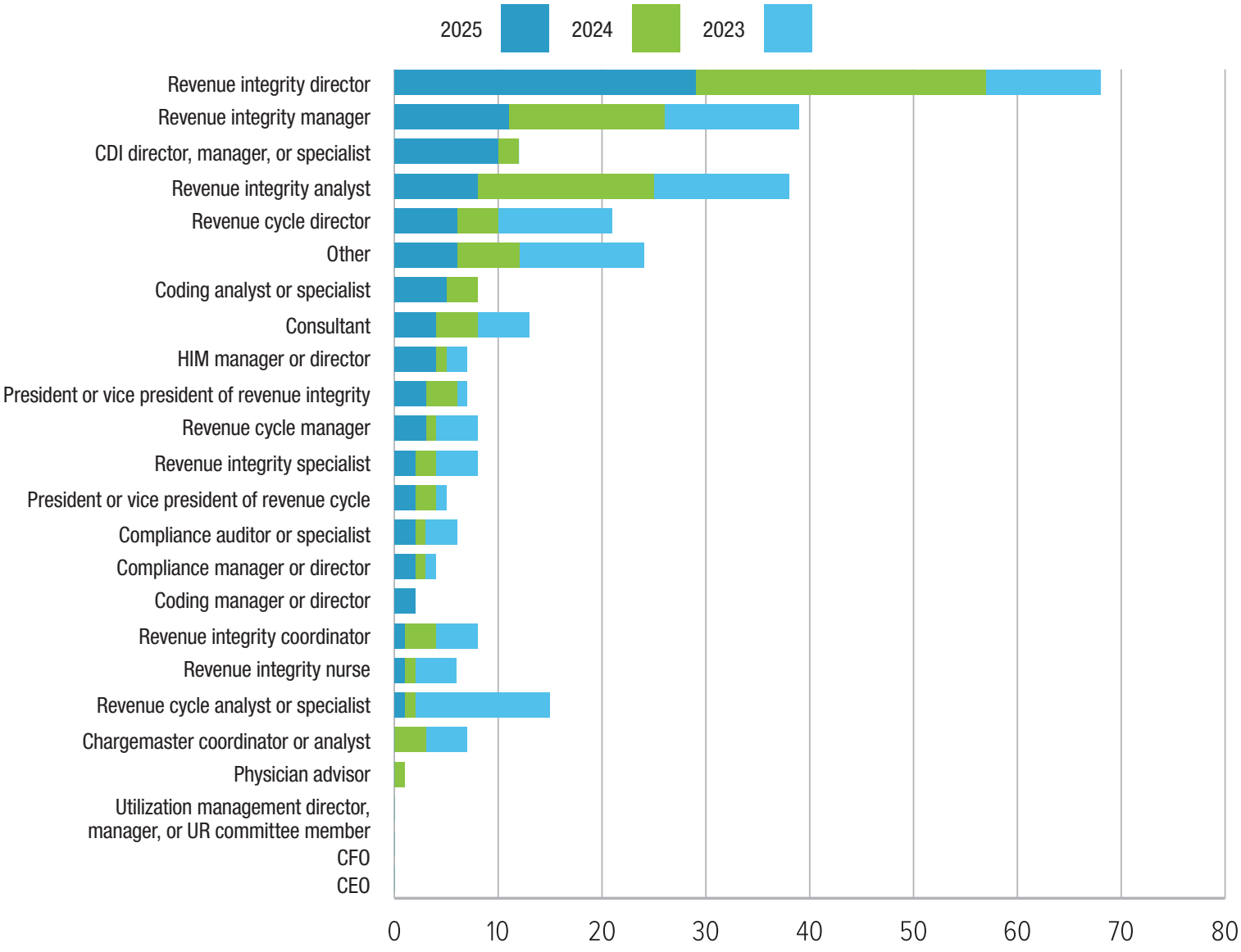
In 2025, 56% of respondents indicated they're employed by a multifacility health system, and 28% of respondents reported their organization has 1,000 or more beds.

About half (52%) of respondents reported they hold revenue integrity–specific job titles. The most commonly reported titles were revenue integrity director (26%) and revenue integrity manager (11%). Looking at titles not specific to revenue integrity, the most commonly reported were CDI director, manager, or specialist (10%).

When it comes to program type, three-quarters (75%) of respondents said their organization has a stand-alone revenue integrity department. Overall, respondents reported significant variation in staffing support for revenue integrity programs: 18% said their program is supported by more than 40 full-time employees (FTE), 13% said their program is supported by 16–20 FTEs, and 11% reported their program is supported by one FTE or less. Narrowing down to stand-alone revenue integrity departments, 20% are supported by more than 40 FTEs, 16% are supported by 16–20 FTEs, and 12% are supported by eight to 10 FTEs.

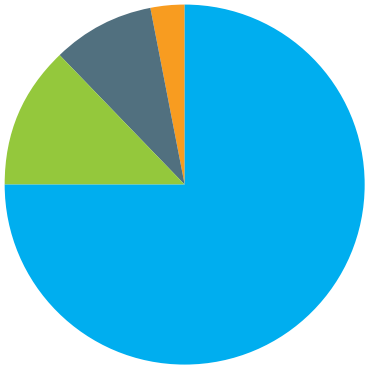
See Figures 1–3 for more information on job titles, staffing, and program structures.

Figure 1. **Which best describes your title?**



Source: 2025, 2024, and 2023 State of the Revenue Integrity Industry Surveys.

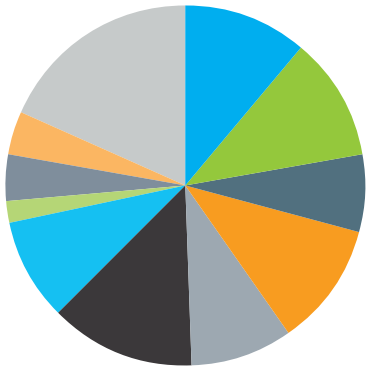
Figure 2: Does your organization have any type of revenue integrity program?



- We have a stand-alone revenue integrity department
- No, we do not have any type of revenue integrity program
- We have a revenue integrity initiative
- We have a revenue integrity committee

Source: 2025 State of the Revenue Integrity Industry Survey

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



- 0–1
- 2–4
- 5–7
- 8–10
- 11–15
- 16–20
- 21–25
- 26–30
- 31–35
- 36–40
- More than 40

Source: 2025 State of the Revenue Integrity Industry Survey.

Primary and supporting functions

Despite the diversity seen in their structures, most revenue integrity programs include some common primary functions. These core functions represent the program's daily work and overarching goals within the organization.

The five most common primary revenue integrity functions, according to survey respondents, are as follows:

- Chargemaster maintenance (72%)
- Chargemaster management (71%)
- Charge capture (64%)
- Charge audits (60%)
- Charge edits (57%)

Because of their role in the revenue cycle and the diversity of skills and experience often represented on revenue integrity teams, revenue integrity programs provide vital support across numerous functions even when they don't own the primary responsibility.

The top five most common secondary functions include:

- Denials management (59%)
- Claims audits (47%)
- Billing compliance/integrity (46%)
- Correcting claim edits (45%)
- Service line revenue management/support (45%)

However, there are some revenue cycle functions that revenue integrity programs are generally not involved in. According to survey respondents, these commonly include:

- Patient admission status (57%)
- Patient billing (51%)
- Quality programs/quality reporting (49%)
- CDI (48%)
- No Surprises Act compliance (47%)

At Adventist Health Glendale, in Glendale, California, the revenue integrity department includes several roles that handle dedicated functions, according to NAHRI Advisory Board member **Kay Larsen, CHRI,** revenue integrity senior charge assurance associate. The team includes a manager, CMD coordinator, and two charge assurance associates. The charge assurance associates' duties include finding missing charges; one focuses on observation charges and the other on emergency department (ED) charges.

"In my job, I try to be as proactive as I can," Larsen says. "I do carve outs for observation and I download

charges every day. I'm looking for what I call 'no-brainers': errors that I can fix before the claim drops. My goal is to resolve any issues that would prevent a claim from getting out the door clean."

At St. Joseph's/Chandler Health System in Savannah, Georgia, in addition to common chargemaster and charge functions, revenue integrity handles a significant amount of pre-bill edits, especially focusing on Medically Unlikely Edits and National Correct Coding Initiative edits along with missing procedure charge edits, and device without a procedure edits, says **LeAnn Luczek, CRCP,** revenue integrity director.

Luczek says her department also plays a role in patient billing, which is a less common revenue integrity function. They work closely with the billing team to resolve a variety of pre-bill charge or issues.

My goal is to resolve any issues that would prevent a claim from getting out the door clean.
-Kay Larsen, CHRI

Certain aspects of compliance with price transparency rules also fall to Luczek's department, related to shoppable services, machine-readable files, and providing support to the team that generates price estimates for patients. Although most revenue integrity departments have stepped back from being heavily involved in price transparency, Luczek expects that may change.

"There's so much out there about what the current administration is looking at and wanting hospitals to do around price transparency," she says. "I definitely think organizations are going to find that they will need more resources attached to those efforts."

Along with changes driven by regulatory focus, revenue integrity professionals should look at their current program and priorities to identify gaps and areas of potential growth. **Jayne Hildebrand, MBA, CHFP** executive director of revenue integrity at UnityPoint Health in West Des Moines, Iowa, says there are several areas she would like her revenue integrity team to become more involved with.

"We work in the chargemaster space in terms of maintenance and management, but I don't know how much we're actively looking for opportunities to perhaps improve the chargemaster in some of our markets where I think we might have some opportunity," she says.

However, it's just as important to know your program's limitations in terms of time and staffing. Revenue integrity professionals are highly knowledgeable and valuable assets to many revenue cycle projects, but there are only so many hours in the day and revenue integrity staffers can easily get swamped.

At the University of Maryland Medical System in Baltimore, Maryland, the revenue integrity team plays key roles in numerous revenue cycle initiatives and has become known as the go-to team for questions, says **Jennifer Gardiner, CPC,** senior director of revenue integrity. While that's a huge win for the program and a testament to the value of revenue integrity, Gardiner and her team must be judicious with their time, ensure requests don't inadvertently create bottlenecks, and move responsibility back to other departments once issues are resolved.

"I'm trying to manage the team to step back from things when we can, and push accountability to the department or help educate them to do this in the future," she says.

See Figures 4 and 5 for more details on revenue integrity functions.

AI has long been a buzzy topic, but the past year has seen it expand into widespread application. Does that include revenue integrity? To find out, NAHRI asked survey respondents whether their organizations are using AI, as distinct from automation, to support or perform any revenue functions. About half of the respondents (51%) reported their organization is not doing so. For those who are, the functions where AI is most commonly being applied include:

- Hospital coding (17%)
- Professional coding (11%)
- Charge capture (9%)
- CDI (7%)

- Billing compliance/integrity (6%)

Although it may still be some time before revenue integrity programs incorporate more AI into their workflows, AI will likely begin rolling out as part of system updates. Larsen says that her organization is planning to increase automation of some revenue integrity functions as part of changes to its system. Because the new builds are being developed now, facility-level revenue integrity managers have been in contact with the corporate office to oversee the builds and learn what functions may be automated. For revenue integrity professionals in similar situations, this is the perfect time to volunteer to be involved in testing and to provide feedback. When thoughtfully implemented and tested, AI can have a positive effect. However, without the proper guardrails and dialog with the teams creating builds and implementing the technology, revenue integrity professionals could find themselves doing more clean-up work than if they'd completed a process manually, Larsen points out.

"I'm excited," she says, "but sometimes I'm a little bit concerned."

AI applications that are currently used in coding could work well for revenue integrity when applied to shared functions, such as application of modifiers or missing or incorrect charges, Luczek says.

"Those could be automated in a way that would allow us to get more root cause results," Luczek says. "I see it as a huge win when it comes to volumes, just the ability for AI to analyze data and push data to us in a way that is [highlighting] trends, You have to validate. You have to to be careful not to structure it in a way that it's so rigid it's not producing the results that you intend. But to be able to analyze massive amounts of data, I see that as a big opportunity."

See Figure 6 for more information on where revenue integrity is currently using AI.

Continued on page 9.

Figure 4: **Primary functions of revenue integrity**

Chargemaster maintenance	72%
Chargemaster management	71%
Charge capture	64%
Charge audits	60%
Charge edits	57%
Correcting charge edits	55%
Charge reconciliation	46%
Billing compliance/integrity	44%
Price strategies/methodologies	39%
Educating revenue cycle/nonclinical staff	38%
Revenue reporting/analytics	37%
Service line revenue management/support	37%
Price transparency compliance	36%
Chart audits	36%
E/M leveling criteria	36%
Educating clinical staff	34%
Correcting claim edits	32%
Correcting coding edits (hospital and/or professional)	31%
Internal audit	25%
Payer audits/external audits	25%
Coding audits (hospital and/or professional)	24%
Claims audits	24%
Denials management	22%
Coding (professional)	21%
Decision-support functions	21%
CDI	19%
ED criteria management	18%
Surgery leveling matrix	18%
No Surprises Act compliance	17%
Coding (hospital)	17%
Claims/payment reconciliation	17%
Managed care/payer contract management	10%
Quality programs/quality reporting	10%
Patient billing	8%
Patient admission status	4%

Source: 2025 State of the Revenue Integrity Industry Survey

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Continued from page 7.

Figure 5: Secondary revenue integrity functions

Denials management	59%
Claims audits	47%
Billing compliance/integrity	46%
Correcting claim edits	45%
Service line revenue management/support	45%
Educating revenue cycle/nonclinical staff	44%
Decision-support functions	43%
Revenue reporting/analytics	42%
Educating clinical staff	41%
Chart audits	41%
Claims/payment reconciliation	41%
Charge reconciliation	40%
Payer audits/external audits	40%
Correcting coding edits (hospital and/or professional)	40%
ED criteria management	36%
Price strategies/methodologies	35%
Correcting charge edits	35%
Managed care/payer contract management	34%
Internal audit	34%
Charge edits	31%
Patient billing	31%
Quality programs/quality reporting	30%
Coding (hospital)	30%
Surgery leveling matrix	30%
Price transparency compliance	29%
Charge capture	28%
Coding audits (hospital and/or professional)	28%
Charge audits	27%
E/M leveling criteria	27%
CDI	26%
Coding (professional)	25%
No Surprises Act compliance	23%
Patient admission status	22%
Chargemaster maintenance	16%
Chargemaster management	16%

Source: 2025 State of the Revenue Integrity Industry Survey

Figure 6: Are you using AI (as distinct from automation) to support/perform any revenue integrity functions?

Other or N/A	51%
Coding (hospital)	17%
Coding (professional)	11%
Charge capture	9%
CDI	7%
Billing compliance/integrity	6%
Denials management	6%
Revenue reporting and/or analytics	6%
Charge reconciliation	5%
Claims audits	5%
Coding audits (hospital and/or professional)	5%
Charge audits	4%
Chargemaster maintenance	4%
Chargemaster management	4%
Chart audits	4%
Claims/payment reconciliation	3%
Patient billing	3%
Correcting claim edits	3%
Internal auditing	3%
Price transparency compliance	3%
Service line revenue management/support	3%
Correcting charge edits	2%
No Surprises Act compliance	2%
Price strategies/methodologies	2%
Correcting coding edits (hospital and/or professional)	1%
Patient admission status	1%
Payer audits/external audits	1%

Source: 2025 State of the Revenue Integrity Industry Survey

Q&A: IDENTIFYING OPPORTUNITIES FOR EXPANSION

Q: What areas or functions would you like to see your revenue integrity program take a bigger role in?

Jayne Hildebrand, MBA, CHFP, executive director of revenue integrity, UnityPoint Health, West Moines, Iowa:

I think one area we have some opportunity in is taking the data that we get and really taking that to our payer contracting team. There's some connection there, but it doesn't feel nearly as robust as I feel it needs to be. I think our contract management team doesn't always get the proper intel to really go in there and negotiate [with payers] on some of those challenges that we're seeing. So I'd like to see a little bit more improvement in that space.

Kay Larsen, CHRI, revenue integrity senior charge assurance associate, Adventist Health Glendale, Glendale, California:

I would like the revenue integrity team to be more involved with denials. We have a separate committee for that, but I would like to be more involved with that because I would like to get it at the root issue that we're always responding to.

LeAnn Luczek, CRCP, revenue integrity director, St. Joseph's/Chandler Health System, Savannah, Georgia:

The areas I'd like to see us more involved with would be coworker cross-training or more staff level training. From a billing standpoint, we have a number of newer billers in our organization, and and understanding all of the "whys" behind what they're doing is important. We do a tremendous amount of in-the-moment education. An enhanced training plan is in the works and that will be a great thing for the newer coworkers in the revenue cycle.

Chargemaster maintenance

For the majority of revenue integrity programs, the chargemaster remains the keystone. Maintaining and managing the chargemaster are core revenue integrity tasks and underpin the program's essential mission.

Chargemaster maintenance practices have generally held steady over the years even as other revenue integrity functions and practices have shifted. In 2025, 55% of respondents said that a team is responsible for chargemaster maintenance. At other organizations, one person is responsible for chargemaster maintenance (25%). Less common arrangements include making the department director/representative responsible for the structure and codes with the line items entered by a data entry specialist (5%), using a hybrid model involving internal staff and external consulting personnel (3%), or using different structures by service line (3%). At 2% of organizations, chargemaster maintenance is completely outsourced.

At Adventist Health Glendale, the corporate revenue integrity team manages overall chargemaster build and maintenance with individual facilities in the system taking more focused ownership, according to Larsen.

"Each hospital is individually responsible to make sure what is created is correct, to never take anything at face value," she explains. "We all have access to our individual chargemaster. We can't add anything, and we can't change things, but we can price [items]."

Larsen says she works with the CDM coordinator to price and verify new charges. She also manages updates.

"I'll go in and check things [when we get the] quarterly updates," she adds. "I go through and read them and then contact our corporate office if I don't find what I think I should be finding."

At her organization, Luczek currently has two coworkers responsible for the chargemaster, although she would like to expand that. maintenance is under

Source: 2024 and 2023 State of the Revenue Integrity Industry Surveys

Most chargemaster maintenance is under the revenue integrity department. Her department has responsibility for both ambulatory and hospital chargemaster maintenance.

"We manage most of it with a very small team, but there are others within the department that can assist," Luczek says. Pharmacy and lab have direct access to a vendor-supported chargemaster tool thath they use to communicate additions, deletions, and new requests directly to the chargemaster team, she adds. Other clinical departments currently communicate chargemaster changes through a more manual process using a worksheet, or they communicate directly with the chargemaster team.

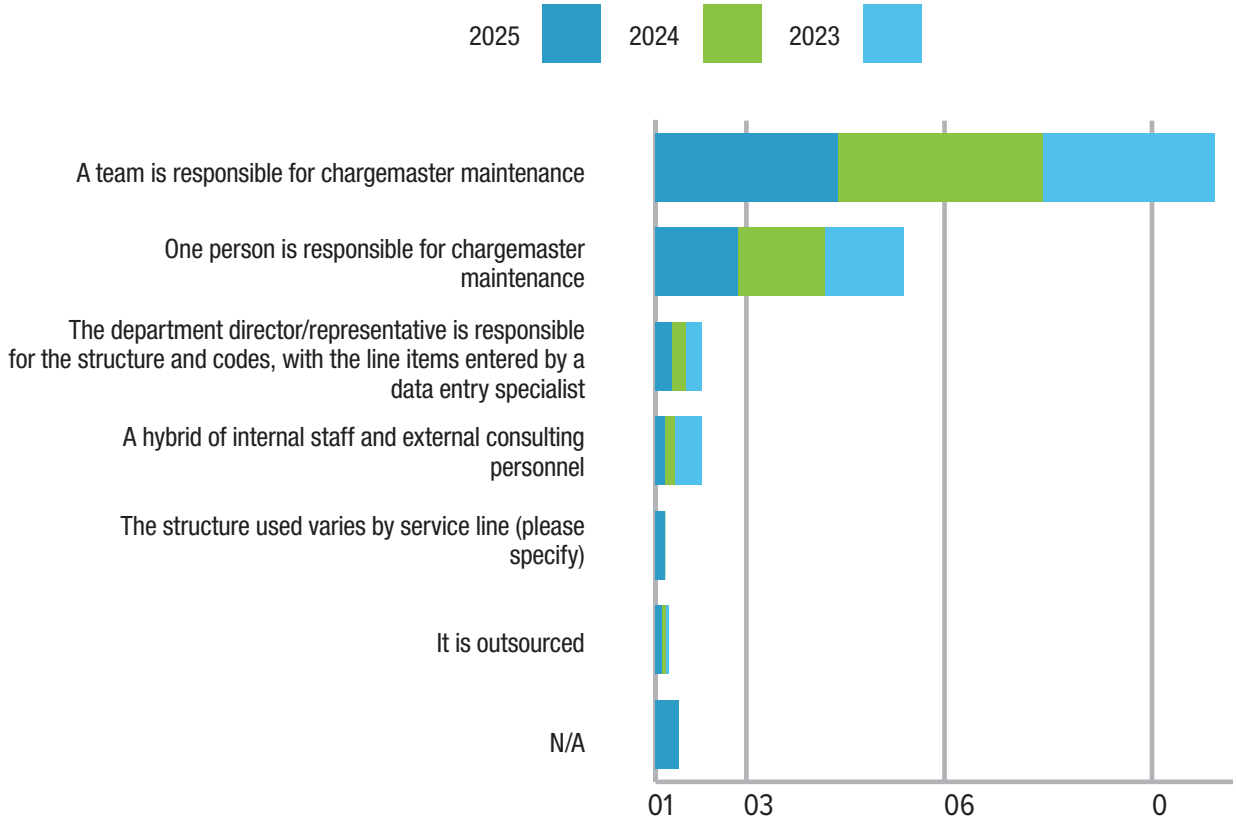
Chargemaster approval processes have evolved only slightly over the years. In 2025, 30% of respondents reported that individual requests are sent to a central person (24% in 2024), while 27% route individual requests to a team for approval (29% in 2024), and 22% employ a hybrid approach that uses chargemaster software and a central contact person (29% in 2024).

Luczek's organization is working toward an automated approval process but currently takes a hybrid approach with a central contact person—a CDM analyst—augmenting the chargemaster software.

See Figures 7 and 8 for more details on chargemaster maintenance and approval processes.

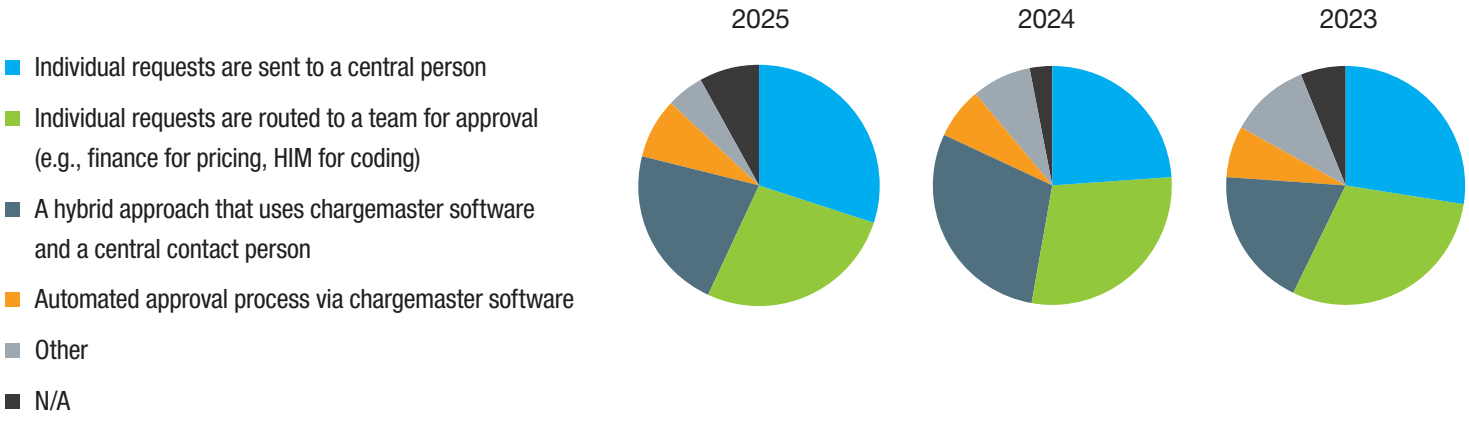
Although more than half (64%) of respondents assign Healthcare Common Procedure Coding System (HCPCS) codes to all drugs and supplies when such a code exists, other respondents take a more targeted approach. Some (22%) assign HCPCS codes to drugs and supplies when the code generates separate payment. Others (15%) assign HCPCS codes to drugs and supplies when the code resolves a procedure-to-device edit. Refer to Figure 9 for more information and a comparison to previous years.

Figure 7: **How is your chargemaster maintenance structured?**



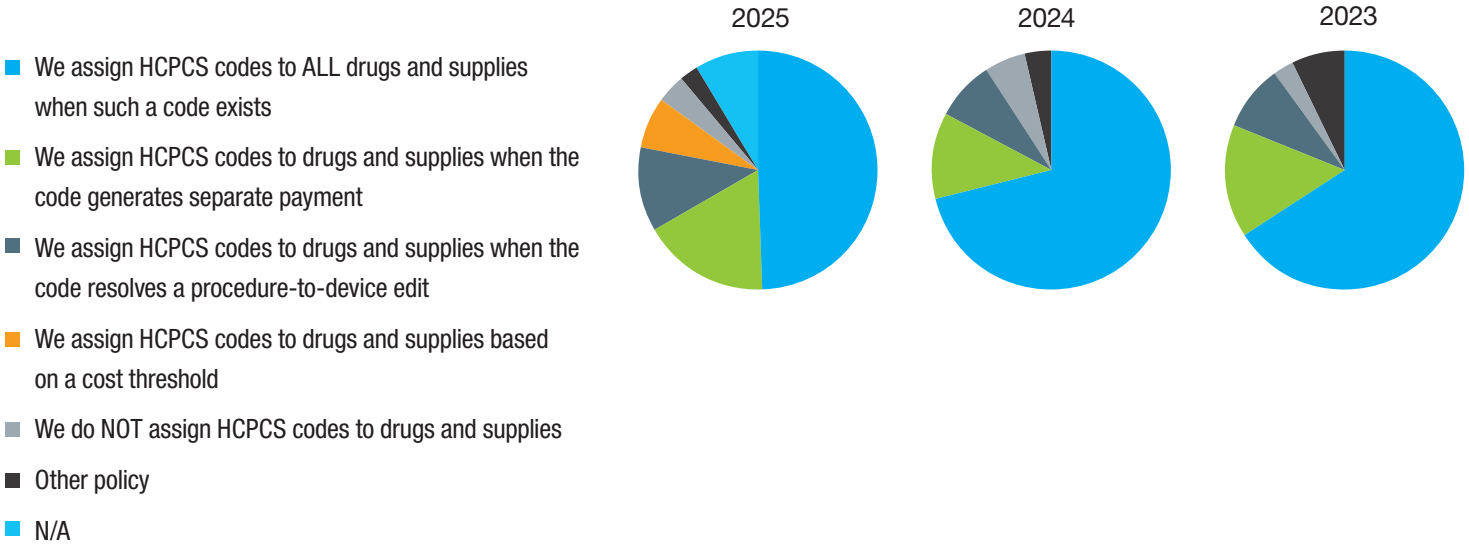
Source: 2025, 2024, and 2023 State of the Revenue Integrity Industry Surveys

Figure 8: How is the process for approving the addition of new codes to the chargemaster structured?



Source: 2025, 2024, and 2023 State of the Revenue Integrity Industry Surveys

Figure 9: When do you assign HCPCS codes to drugs and supplies?



Source: 2025, 2024, and 2023 State of the Revenue Integrity Industry Surveys

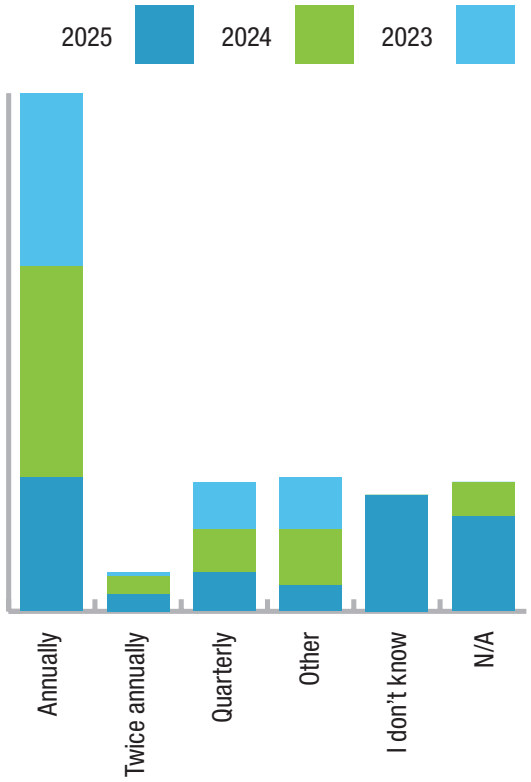
In specific circumstances, such as labs, it can be useful to have mechanisms to ensure that a single chargemaster number triggers the charging of multiple components. Examples include exploding charges and panel charges. However, these mechanisms require regular review and testing to be certain they're working as intended. In 2025, a plurality (31%) of respondents reported that these mechanisms are reviewed on an annual basis (see Figure 10).

Exploding charges for lab tests don't have a standard review time frame at Larsen's organization, but they are still subject to regular review.

"Part of my job is to provide the Z codes on any molecular diagnostic tests that are [sent to outside labs]," Larsen says. "When I'm doing that, if there are a lot of charges under an exploding charge, I'll double-check, because sometimes they'll have selected it but didn't do all the tests. I don't have a time frame on it, but I do go through them, usually before the month ends."

Similarly, chargemaster order sets can be very useful, but it's necessary to have a clear process for updating and maintaining them. Updates to chargemaster order sets are generally handled by IT (40%) or revenue integrity (31%) (see Figure 11).

Figure 10: **How often do you review exploding charges, panel charges, or other mechanisms to ensure a single chargemaster number triggers the charging of multiple components when appropriate?**



Source: 2025, 2024, and 2023 State of the Revenue Integrity Industry Surveys

Figure 11: **Who is responsible for making changes to chargemaster order sets?**

	2025	2024	2023
IT department	40%	51%	31%
Revenue integrity	31%	44%	27%
We use another method OR our order sets are maintained in the clinical application rather than in the chargemaster (please specify)	21%	N/A	N/A
The director of the department to which the charges are applicable	15%	25%	12%
Clinical staff	9%	12%	1%
I don't know	14%	N/A	N/A
N/A	5%	6%	11%

Source: 2025, 2024, and 2023 State of the Revenue Integrity Industry Surveys

Q&A: MANAGING CHARGEMASTER UPDATES AND MAINTENANCE

Q: At your organization, how are chargemaster updates and maintenance handled?

Kay Larsen, CHRI, revenue integrity senior charge assurance associate, Adventist Health Glendale, Glendale, California:

Our chargemaster resides under the corporate revenue integrity department. We all have access to our individual chargemaster, but we can't add [charges] or change them. If we notice [an error or missed update], we have to contact corporate for them to correct it or add to it. We have a process where we submit a request to add a new charge per a new CPT® code or new service line. We can price it, but that's all we have control over.

LeAnn Luczek, CRCP, revenue integrity director, St. Joseph's/Chandler Health System, Savannah, Georgia:

We have responsibility for the hospital chargemaster. As physician practices transition to our EMR, their respective chargemasters also transition to revenue integrity to manage. The lab and pharmacy have responsibilities for their portion of the chargemaster. Although the chargemaster is centrally managed, they initiate the changes, review the quarterly updates, and submit requests electronically for the revenue integrity chargemaster team to finalize. That collaborative approach works very well. We're working through a process improvement right now to automate requests, making it more efficient.

Charge reconciliation

Although revenue integrity staff don't typically perform charge reconciliation directly, it's essential to accurate, compliant reimbursement and remains a major touchpoint for revenue integrity.

Close to half (42%) of respondents said that all clinical departments are responsible for reconciling their own charges with regular support from revenue integrity. Less than one-quarter (23%) of respondents reported that all clinical departments are responsible for their own charges. Other organizations are centralized to various degrees: 14% said some clinical departments are responsible for reconciling their own charges while others are centralized under revenue integrity, and 6% said that all charge reconciliation is centralized under revenue integrity. See Figure 12 for more details.

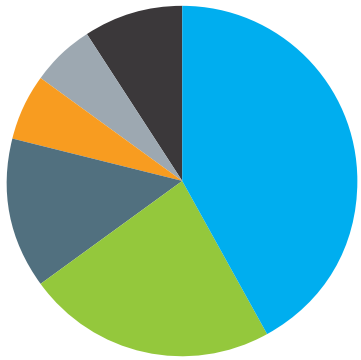
Although most clinical departments are responsible for their own charge reconciliation at Luczek's organization, she notes that there are some exceptions and the the revenue integrity team assists various clinical departments and teams. It's a shared responsibility."

It's not unusual for clinical departments to struggle with charge reconciliation—the challenge is finding a way to keep them on track. To help their clinical departments stay accountable for charge reconciliation, Adventist Health Glendale created a policy that requires all clinical departments to look at an individual report that lists their encounters from the previous day and confirm that they've reviewed the encounters, Larsen says.

This year, NAHRI asked respondents whether their organization has a formal charge reconciliation policy. Just less than half (44%) indicated that their organization has one (see Figure 13 for the complete details). Some respondents provided additional information about their organization's policy.

"Daily charge entry will be automated to the extent possible and will require minimal manual intervention. The EMR will allow for charges to drop within the system as documentation or services occur. When there are charge entry issues, departments will see these errors within work queues or reconciliation reports. Charges are captured/triggered at point of care or as close to point of care as reasonable, as part of clinical workflows, with a few minor exceptions requiring validation or manual charge entry in order to post to the patient's hospital/guarantor account accurately," one respondent said.

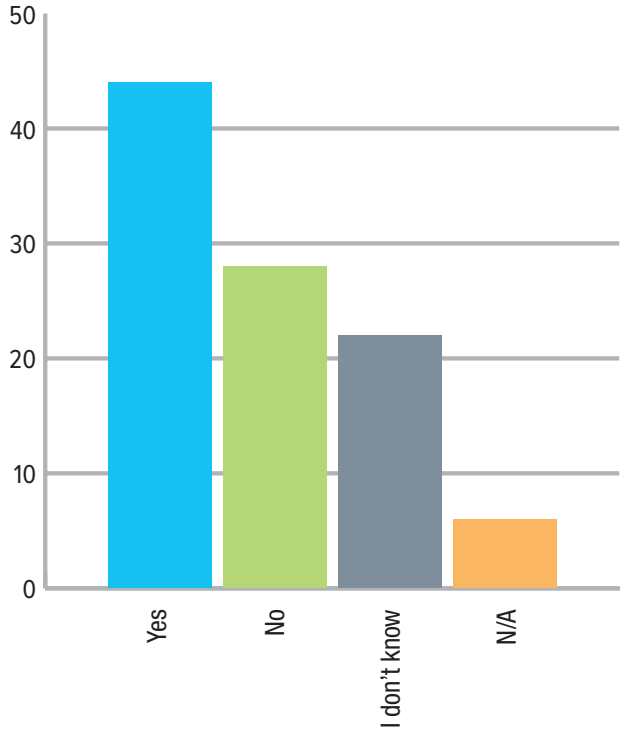
Figure 12: **Who is responsible for charge reconciliation?**



- 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
- All charge reconciliation is centralized under revenue integrity
- We do not have a charge reconciliation process in place
- N/A

Source: 2025 State of the Revenue Integrity Industry Survey

Figure 13: **Does your organization have a formal charge reconciliation policy?**



Source: 2025 State of the Revenue Integrity Industry Survey

As in previous years, about half (51%) said their time frame for reconciling and correcting charges is one to three business days. See Figure 14 for more information on charge reconciliation time frames.

"We have a five-day bill hold before the claim goes out the door, but we have been really pushing in the last couple of years for what we call late charges—our system defines a late charge as anything that is past 24 hours," Larsen says. "That has been a big change, but it seems to be helping."

Luczek's organization has different bill hold periods for different types of accounts. For example, the period is two days for most outpatient account types and four days for emergency department account types.

Luczek says her organization has also taken steps , such as setting up dashboards, to increase awareness and enforcement of the bill hold period. Her organization also uses reports that identify how each service area is doing on various metrics such as time to charge, time bill, percent of late charges compared to total revenue, and others.

This information is also provided to clinical departments, she adds. Revenue integrity works with departments that are falling short tto help identify and resolve barriers to bring them back into the expected parameters.

"The challenges tend to be because clinical departments feel like they don't have time, staff to do it, or they're already doing it in other systems."

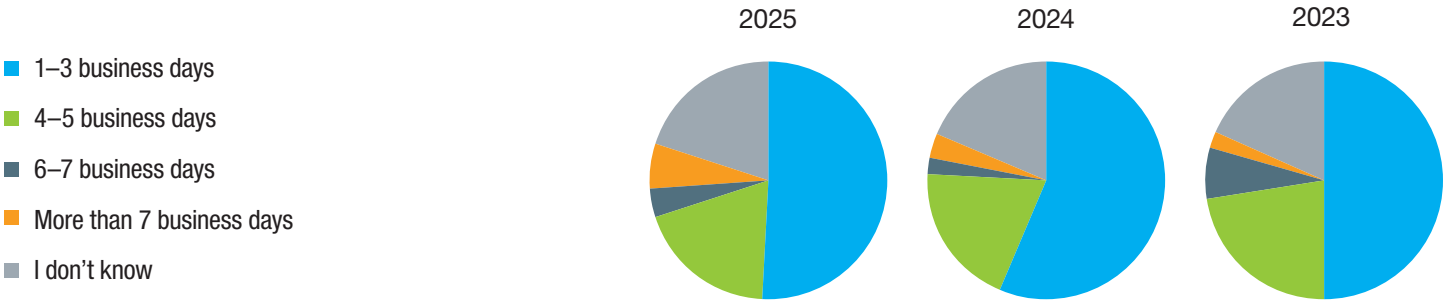
Larsen agrees that time is the biggest roadblock cited by clinical departments. However, listening to departments' concerns and responding with their perspective in mind can have a positive effect. Clinical departments often feel that charges, claims, and billing aren't their responsibility, but Larsen explains to them how documentation and charges translate to claims, which ultimately affects what is billed to the payer and potentially to the patient. Those are ramifications that may affect the patient's physical or mental well-being.

"Sometimes it's just a matter of understanding," Larsen says. "It just really opened up eyes and some of them [said] they never knew that. It also gave them pride in the work they did."

Even when charge entry isn't centralized, it's not always practical to have clinical staff in certain departments handle it—or to have charges trigger off documentation. As in previous years, ED/trauma department charges are least likely to be entered by clinical staff or triggered by their documentation (37% of respondents said these charges are not entered or triggered). Other charges unlikely to be entered by clinical staff include drug administration (31%), observation hours (29%), and cardiac cath lab (24%). See Figure 15 for more information.

To ensure they're working, charge reconciliation practices must be monitored for consistency and appropriateness. There are several ways organizations can accomplish this. A plurality of respondents (40%) said they use manual processes, while 24% use homegrown automation or technology (Figure 16).

Figure 14: **What is your time frame for reconciling and correcting charges?**



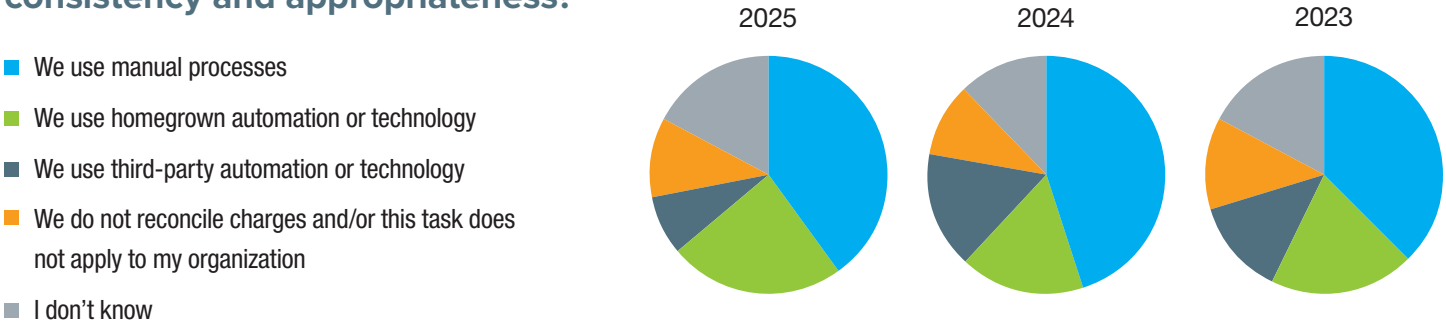
Source: 2025, 2024, and 2023 State of the Revenue Integrity Industry Surveys

Figure 15: **What types of charges are not entered by clinical staff or triggered by clinical staff documentation? (Top five)**

Emergency/trauma department	37%
Drug administration	31%
Observation hours	29%
Cardiac cath lab	24%
Room and board	24%

Source: 2025 State of the Revenue Integrity Industry Survey

Figure 16: **How does your organization monitor charge reconciliation practices for consistency and appropriateness?**



Source: 2025, 2024, and 2023 State of the Revenue Integrity Industry Surveys

Q&A: SOLVING CHARGE RECONCILIATION CHALLENGES

Q: What are some major charge reconciliation challenges, and how do you address them?

Kay Larsen, CHRI, revenue integrity senior charge assurance associate, Adventist Health Glendale, Glendale, California:

I think the most challenging thing for charge reconciliation is staff time. We're quite a large hospital, but we only have five people [on the revenue integrity team]; one's per diem and one is part time. It's a challenge to get through the work. The clinical departments also affect that. Sometimes it's just a matter of understanding. When I work with clinical departments, I often get the response, "Well, this isn't our responsibility; we deal with the patient's health." Yes, that is your primary responsibility. However, in this world, if you're not looking at the finance side or the charging side of it, then maybe it's time to rethink things because it's a whole different world and we're all responsible for this.

LeAnn Luczek, CRCP, revenue integrity director, St. Joseph's/Chandler, Savannah, Georgia:

Resources and time to complete charge reconciliation is a huge challenge. I think an important thing is for the clinical team to understand the impact of charge accuracy and timeliness of charge submission on their patients. We talk about patient care from a medical standpoint, but the overall well-being of the patient also includes whether their bill is accurate. Are they going to have questions and be upset because there's a delay in getting their bill? How delays or charge errors impact the patient and our community members resonated with the clinical leaders.

Denials management

Denials management remains a serious concern, and shifts in reimbursement policies and payer mix are likely to keep the pressure on. Organizations have adopted a variety of approaches and denials management structures, but a successful program calls for interdepartmental cooperation, policies that are clear and consistent, and support from the top down to resolve and prevent denials. Because revenue integrity professionals typically possess a breadth of revenue cycle knowledge and experience, they're often well positioned to support denials management.

According to survey respondents, organizations are increasingly leveraging revenue integrity to combat denials. In 2025, 61% said revenue integrity is responsible for denials management, up slightly from 59% in 2024. Patient financial services (PFS)/billing office ties revenue integrity at 61%, while denials management (57%) and HIM (31%) complete the top three. Refer to Figure 17 for full details and a comparison to 2024.

Luczek says she's seen an increase in payer audits and a higher volume of complex denials that revenue integrity assists with. "I think that is a challenge because it may not be those simple denials anymore. Maybe it's not evident upon looking at the remittance, really, what's going on. It's more complex."

Larsen says that when the revenue integrity team is looped into a denial, it's generally after the billing department has reviewed it and is looking for more information.

At Luczek's organization, different teams may be involved with different types of denials or processes in resolving a denial. For example, her organization has a dedicated denials management team but also has a team that handles initial claim rejections. A committee was formed last year to review preventive measures for denials and claim rejections. The committee identifies

root causes and implements process changes to improve clean claim rates and reduce avoidable denials.

Figure 17: **Which departments are responsible for denials management at your organization?**

	2025	2024
PFS/billing office	61%	62%
Revenue integrity	61%	59%
Denials management	57%	58%
HIM	31%	30%
UR	24%	20%
Case management	21%	24%
CDI	20%	15%
Compliance	10%	13%
Payer contracting/managed care	9%	13%
Other	5%	5%
I don't know	3%	1%
N/A	1%	N/A

Source: 2025, and 2024 State of the Revenue Integrity Industry Surveys

Data is crucial to identifying and resolving denials, and, according to survey respondents, most organizations are on top of it. More than half (66%) track their denial overturn rate, and a majority (83%) track denials by reason/type (see Figures 18 and 19).

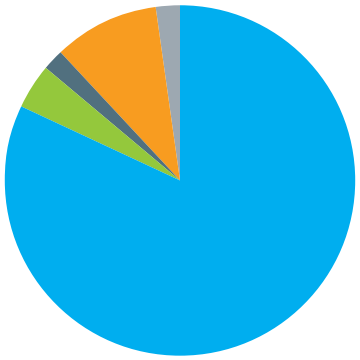
Most (84%) track denials by payer. Unsurprisingly, respondents said commercial payers issue the largest volume of denials (33%). Figures 20 and 21 show more information on tracking denials by payer.

Figure 18: Does your organization track its denial overturn rate?

Yes	66%
No	12%
I don't know	20%
N/A	2%

Source: 2025 State of the Revenue Integrity Industry Survey

Figure 19: **Do you track denials by reason/type?**



- Yes
- No, but we would like to in the future
- No, and we have no plans to do so
- I don't know
- N/A

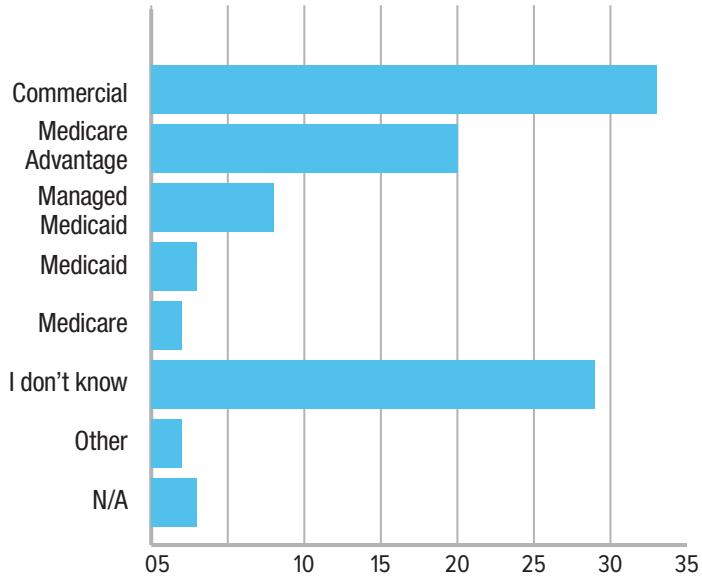
Source: 2025 State of the Revenue Integrity Industry Survey

Figure 20: **Do you track denials by payer?**

Yes	84%
No, but we would like to in the future	4%
No, and we have no plans to do so	1%
I don't know	10%
N/A	2%

Source: 2025 State of the Revenue Integrity Industry Survey

Figure 21: **Which payer issues the largest volume of denials?**



Source: 2025 State of the Revenue Integrity Industry Survey

Figure 22: **What departments are responsible for tracking denials by payer and reason/type?**

Denials management	54%
Revenue integrity	34%
HIM	12%
Case management	8%
UR	8%
Payer contracting/managed care	7%
CDI	4%
Compliance	3%
Other	15%
I don't know	10%
We don't track this data	2%
N/A	2%

Source: 2025 State of the Revenue Integrity Industry Survey

We structure it by types of denials as well as service line areas and then high-dollar ones and high We're looking at all kinds of different dynamics within that.

-LeAnn Luczek, CRCP

Responsibility for tracking denials by payer and reason/type tends to live with denials management (54%) and sometimes revenue integrity (34%) (see Figure 22).

Given revenue integrity's strength in data analysis and reporting, there may be an opportunity for programs to provide greater support in this area. Hildebrand says she's exploring opportunities for her team to take a larger role in denials data. "I think we do a good job presenting what the data is and trending it, but maybe not [as much at] actively pushing those opportunities forward, ensuring that we do close the loop on what we see, and managing the opportunities to make sure that we are making progress on the types of denials we see."

Claim edits

Billing holds or suspense periods allow time to review claims and correct errors or add missing information before they go out the door, making them valuable to ensuring complete, compliant revenue and avoid denials. Different parameters and limitations on billing holds may work best for some organizations, so it's important to consider the services, systems, and processes involved.

Most (65%) respondents reported that their organization has some type of billing hold or suspense period. For about half (54%) the hold is targeted for a specific scenario, such as inpatient-only procedures on outpatient claims.

Almost half (42%) said their billing hold/suspense period is three to four days, which remains the industry standard.

See Figures 23 and 24 for more on billing holds.

University of Chicago Medicine's billing hold is four days, according to NAHRI Advisory Board member **Stephanie Ellis, RN, BSN, COC, CHRI, CRCR,** director of revenue performance and audit management.

Q&A: STRUCTURING DENIALS MANAGEMENT

Q: How is revenue integrity involved in denials management?

Jayne Hildebrand, MBA, CHFP, executive director of revenue integrity, UnityPoint Health, West Des Moines, Iowa:

Our team is not necessarily working the denials but is focused on denials analysis and then trying to push those opportunities forward.

Kay Larsen, CHRI, revenue integrity senior charge assurance associate, Adventist Health Glendale, Glendale, California:

Revenue integrity does a lot of the groundwork. [Denials] come to us, and [we] will confirm the code. We'll contact the clinical department for a correction, [or] if everything is correct as-is, then it goes to the denial team.

LeAnn Luczek, CRCP, revenue integrity director, St. Joseph Chandler Health System, Savannah, Georgia:

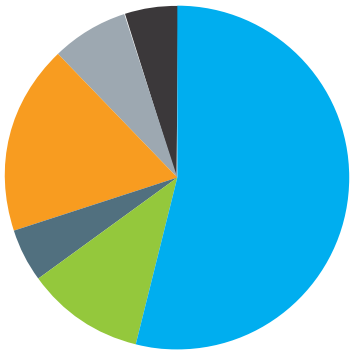
We look at denials as a whole to try to identify the root cause. We look at those trends in work groups and try to prevent them. We have the ongoing daily work, and then we have analytical [projects] that we're working on as well. Revenue integrity is involved with both.

"We do advise all of our departments that do charge capture to ensure that they have entered their charges within three days," she says. "So hopefully by the time they've gotten everything entered, it goes through the system and the bill can go out as clean as possible by the fourth day."

Similar to previous years, coding claim edits are usually resolved by HIM (75%), revenue integrity (56%), or PFS (35%).

Ellis says that her revenue integrity program is heavily involved in resolving outpatient coding claim edits. Those edits are handled by a team of certified coders who report to her and work closely with the outpatient

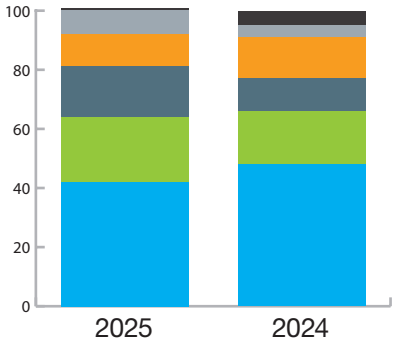
Figure 23: Does your organization have a billing hold/suspense period to review encounters/accounts?



- Yes, it's targeted for a specific scenario (e.g., inpatient-only procedures on outpatient claims)
- Yes, it's a random selection
- No
- I don't know
- Other
- N/A

Source: 2025 State of the Revenue Integrity Industry Survey

Figure 24: How long is your billing hold/suspense period?



- 3–4 days
- I don't know
- 5–6 days
- N/A
- 1–2 days
- 7 or more days

Source: 2025, and 2024 State of the Revenue Integrity Industry Survey

and ancillary departments to resolve them. Another team of coders is assigned edit work queues on a regular basis.

"That is where they find a lot of information about errors that are taking place," Ellis says. "[For example], incorrect charges that were captured or situations where the services are not being covered with the diagnoses that are associated with the account, then doing more investigation into some of the Medicare or commercial payer policies."

Where I notice a lot of our clinic issues coming from is the systems that are integrated into Epic, flowing over from our pharmacy and our lab.
-Jennifer Windham

Gardiner says that her team is also involved in resolving claim edits. They've recently expanded their focus to include professional as well as hospital billing. "We have a hospital-based and a physician-based scope now as part of the consolidation for our professional billing services. Coding now falls under revenue integrity for the professional billing side."

With revenue integrity's expertise in analysis, it's no surprise that they tend to take the lead on reviewing claim edit patterns for root cause analysis. More than half of respondents (63%) indicated that revenue integrity is involved in this function, while 55% reported PFS is involved, and 39% said HIM/coding plays a role.

Jennifer Windham, senior revenue integrity systems and regulatory analyst at Rush University Medical Center in Chicago, Illinois, says that she and a handful of her team members conduct root cause analysis of claim edit patterns. One common root cause she's discovered is related to system integrations.

"Where I notice a lot of our clinic issues coming from is the systems that are integrated into Epic, flowing over from our pharmacy and our lab," she explains. "We take a look, figure out why that particular edit is popping up or what's causing it. Recently I had one where we had a self-administered drug that was coming over with the wrong revenue code."

Ellis' team also takes a leading role in root cause analysis of claim edits.

"One of our recent finds is when charges were set up years ago, they were set up to clone [on both the hospital and professional claim]. But on the Medicare side, they will not allow [payment] for both," Ellis says. "You can bill it, but you will not get paid for both. We're taking that back to our executive leadership to take a look at."

Refer to Figures 25 and 26 for more on claim edit responsibilities.

Figure 25: **What departments are responsible for resolving coding claim edits at your facility?**

	2025	2024
HIM/coding	75%	80%
Revenue integrity	56%	60%
PFS/business office	35%	49%
Denials management	11%	10%
Compliance	1%	3%
IT	0%	3%
I don't know	4%	1%
Other	4%	4%
N/A	2%	N/A

Source: 2025, and 2024 State of the Revenue Integrity Industry Survey

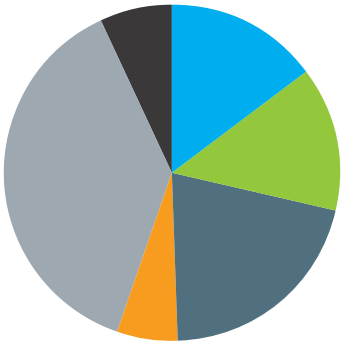
Figure 26: What departments are involved in reviewing claim edit patterns for root cause analysis?

	2025	2024
Revenue integrity	63%	69%
PFS/business office	55%	55%
HIM/coding	39%	31%
Denial management	30%	26%
CDM/chargemaster	29%	28%
Clinical department where the patient was treated	14%	9%
Compliance	4%	13%
IT/analytics	4%	13%
Other	3%	3%
I don't know	12%	5%
N/A	3%	2%

Source: 2025, and 2024 State of the Revenue Integrity Industry Survey

Although there are instances when submitting series or monthly claims for services is required or makes sense, this practice should be used judiciously. When series or monthly claims are submitted for services that don't require it, there may be a negative payment impact due to CMS' packaging logic. This year, NAHRI asked respondents how they're handling this scenario and whether they were aware of the potential revenue hit. Less than one-quarter (21%) said that their organization does not submit series or monthly claims for services that don't require it and they understand the possible payment impact. However, 15% reported that their organization does submit series or monthly claims for some services even when it's not required and are unable to make a change even though they are aware of the possible payment impact. Some (14%) said that they do submit such claims and were not aware of the payment impact. See Figure 27 for the full details.

Figure 27: Does your hospital submit series or monthly claims even for services that do not require this type of billing?



- Yes, and we are aware of the possible payment impact but haven't been able to make a change
- Yes, but we were not aware of the possible payment impact
- No, and we are aware of the possible payment impact
- No, but we were not aware of the possible payment impact
- I don't know
- N/A

Source: 2025 State of the Revenue Integrity Industry Survey

Challenges and benefits

Uncertainty is a fact of life in the healthcare industry. All revenue integrity professionals and programs must cultivate resilience and adaptability, while knowing when to advocate—within their organization, with payers, and at the state and national level. Rapid changes in healthcare delivery, such as the ongoing shift from inpatient to outpatient and the growing role of commercial and Medicare Advantage payers, mean provider organizations must be more vigilant than ever. Compliance, quality, and revenue are inextricably entwined, and clinical and revenue cycle professionals must understand how their actions affect the entire organization.

To fulfill their function, revenue integrity professionals don't just need top-notch analytical skills; they also need to be strong communicators and relationship builders. Fortunately, that's something most revenue integrity professionals excel at.

A majority (88%) of respondents said their relationship with clinical departments has a positive effect on their revenue integrity program's effectiveness, while

Q&A: CLAIM EDIT FOCUS AREAS

Q: What are some of the things you're currently focusing on for claim edits?

Stephanie Ellis, RN, BSN, COC, CHRI, CRCR, director of revenue performance and audit management, University of Chicago Medicine, Chicago, Illinois:

A big piece of the missing puzzle for us is the strengthening of our advance beneficiary notice process. That is part of the work that's being done this year—not necessarily by my team, but you can imagine how if we already have the ABN, the account will come through with appropriate codes or modifiers to show that the clinician has addressed the medical necessity piece, and we [wouldn't] need to go into any further research or review for that particular item.

Jennifer Gardiner, CPC, senior director of revenue integrity, University of Maryland Medical System, Baltimore, Maryland:

My team is pretty heavily involved with claim edits. We were always hospital based, but in the last year we took on the physician practices as well. Coding now falls under revenue integrity for the professional billing side. It's a very blended process. With our integration over the last year with taking on our professional services, our organization's revenue is split about 85% hospital and 15% professional. I think we all went into this integration thinking that's about how our time was going to be divided. But from a time perspective, my team is now spending about 85% on professional billing–related issues and about 15% on hospital.

80% cited their relationship with other middle revenue cycle departments as having a positive effect and 74% reported their relationship with IT/analytics has a positive effect.

[We] significantly reduced denials and edits by onboarding analysts focused specifically on pharmacy and lab services.
-Unknown respondent

"Those relationships with other folks in revenue cycle has been a very proactive, very specific approach to make those bonds stronger to try to work the most efficiently. I spend a lot of time in that process of team collaboration and fostering those relationships. I do see the impact of it, so it is valuable," Gardiner says.

Fostering relationships with clinical departments, such as pharmacy, is key to identifying and resolving root causes, Windham adds. At her organization, technical issues prevented pharmacy charges from transferring correctly between systems. Revenue integrity staff took a proactive approach and strengthened their relationship with the pharmacy department to learn about and troubleshoot their workflows.

"We've got the team going into the pharmacy, seeing how the system works, doing education. Hopefully we're bridging that gap there and it's going to be sunny skies ahead," she says.

Building and nurturing relationships can be more difficult in a remote environment, but being persistent, patient, and intentional will produce results, according to Ellis. "I started [at my current organization] during the pandemic, and you don't know who to go to for anything because everyone is remote. You don't understand the organizational setup, the departmental setup. But over time, I've found that those relationships have improved."

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

"[We] significantly reduced denials and edits by onboarding analysts focused specifically on pharmacy and lab services," one respondent said.

REVENUE INTEGRITY SUCCESS STORIES

NAHRI asked 2025 State of the Revenue Integrity Industry Survey respondents to share their revenue integrity success stories from the past 12 months. Here's some of what they told us.:

- "Increasing effective communication skills, increasing rate of clean claims."
- "Significantly reduced denials and edits by onboarding analysts focused specifically on pharmacy and lab services."
- "Identifying denial trends/providing education and reducing denials, increasing revenue per encounter and collection rate."
- "Adding staff to assist with charge reconciliation that was not being done upstream. We have been able to recover some revenue."
- "Charge automation in 10 additional departments."
- "Implementation of OB triage charging criteria for E/M visits. Hiring two new managers to assist with our revenue integrity department."
- "Identifying missed units of drug administration and correct coding for MABs."
- "Successful integration of adding an entire neuro/orthopedic clinic system and successful addition of additional teams within the revenue integrity department."
- "Implementation of additional revenue guardians/edits to protect against late charge adjustments. Implementation of a lag dashboard to break out service date to entry and entry to post data. Continued expansion/enhancement of our internal platform for recording of revenue integrity activity to report our value-add to the organization both in dollars and volume."
- "Automation of OB delivery flat rate charges, reduced inpatient-only write-offs, and implementing cellular therapy CDM."
- "Completed a robust department review that resulted in quality improvement and decreased revenue leakage. Leveraged technology to reduce numerous manual inefficient workflows. Established core policies and procedures."
- "Adding structure and revamping the job descriptions to be more aligned with market. Building out intake for transparency into what the team is working on."
- "We have grown the department and our scope. Aligned all CDI functions to revenue integrity (ambulatory, outpatient facility, inpatient) while also continuing to move forward with process improvement. This work has had a positive financial impact."

"We improved our employee engagement scores greatly over the last year. We finalized a number of large projects," another respondent said.

See the sidebar on p. 24 for more revenue integrity success stories.

On the flip side, as in previous years, a majority of respondents (60%) named a lack of qualified staff as producing a negative effect.

"We are involved in everything, but staff is not large enough, or experienced enough, to deal with the things that we are thrown into," a respondent said.

Particularly when seeking specialized skills, finding the right person is challenging, Luczek says. It often makes more sense to fill a position with a candidate who has the core skills needed and train them on the specifics for the job. Although that means more resources must be dedicated to training new hires, it's an investment in her coworkers and a successful approach for her team.

Other common roadblocks to success include payer audits (32%) and expansion of duties to functions unrelated to revenue integrity (29%).

For many respondents, ensuring charges are entered and reconciled is a significant pain point.

"[A top challenge is] improving HB charge lag because providers aren't documenting or signing notes timely," a respondent said.

The increasing volume and complexity of denials, technology limitations, and rapidly changing regulations were among some of the most common challenges respondents mentioned.

To serve their organizations, revenue integrity professionals must be forward thinking and constantly looking for ways to evolve their programs. NAHRI asked survey respondents what changes they would like to implement in their programs over the next 12 months.

"I would like to add FTEs to help support the increasing volume of work from additional new services/locations and patient volumes," one respondent said.

"I would like to develop a team of RI operational analysts that are structured to support service lines with both hospital and professional services," a respondent said.

"More rapid uptake of emerging technology [and a] dedicated resource for IT-related solution development and report building," another respondent said.

See the sidebar on p. 26 for more changes respondents would like to implement.

See Figure 28 for additional information on challenges and benefits.

Figure 28: **Please rate the effect of the following on your revenue integrity department's/program's effectiveness over the past 12 months.**

	Positive effect	Negative effect	No effect	N/A
Relationship with clinical departments	88%	7%	2%	3%
Relationship with other middle revenue cycle departments	80%	5%	10%	4%
Relationship with IT/analytics	74%	9%	9%	9%
Use of KPIs and/or benchmarks	68%	4%	11%	17%
Resolving claim edits	63%	9%	22%	7%
Managing denials	62%	11%	20%	8%
Conducting internal audits	60%	1%	19%	20%
Use of automation (e.g., automated charges, edit management)	59%	11%	12%	18%
Relationship with external vendors	56%	12%	20%	12%
Use of productivity measures	51%	12%	20%	18%
Payer audits	31%	32%	23%	14%
Expansion of duties to functions unrelated to revenue integrity	29%	29%	25%	16%
Lack of qualified staff	8%	60%	15%	16%

Source: 2025 State of the Revenue Integrity Industry Survey

LOOKING AHEAD

NAHRI asked respondents of the 2025 State of the Revenue Integrity Industry Survey about the changes they would like to implement in their programs. Following are some of the items on respondents' wish lists.

- "More rapid uptake of emerging technology. Dedicated resource for IT-related solution development and report building."
- "More input from payer contracting."
- "ED level automation."
- "Separation as our own department (not included in finance). Expanding to a revenue-generating department (external/outsourcing consulting services). Recognition as a contributing priority to the organization and a seat at the table—not as an afterthought only as a need/problem arises."
- "Interdepartmental rounding more frequently, easier ways to identify patterns, charge reconciliation."
- "Streamline functions of each facet of the department without overlap."
- "I would like to add FTEs to help support the increasing volume of work from additional new services/locations and patient volumes."
- "Workflow efficiencies to denials and audit workflows."
- "Smart use of automation and AI for charge capture. Packaged procedure costs vs. charging by phase of care."
- "A structure with staffing that allows for all needed work to be done on a proactive basis, instead of a reactive one."
- "Our revenue integrity has been in existence for 10 years, but we still struggle with our structure. I need an additional manager for my chargemaster/nurses. I would also like to implement a better structure for growing team and cross-training to make them more efficient. All of our team has multiple certifications with coding being the emphasis."
- "Productivity measures with accountability for claims resolution team and defense audit team."
- "I would like to develop a team of revenue integrity operational analysts that are structured to support service lines with both hospital and professional services."
- "Expansion to include support for PB services."
- "Increase outpatient CDI efforts. Implement AI. Full implementation of automated CDM request workflows."
- "Streamline, train staff on coding and billing, have supervisors to help manage the day to day."
- "Have a dedicated appeal staff that includes a physician advisor."
- "Clearly defined ownership of chargemaster maintenance process and payer appeal process."
- "I need to completely reorganize my department as we transition so we are better staffed to perform our core revenue integrity functions. We are heavily staffed with nursing team members that have not fully embraced the world of revenue integrity."
- "Culture of accountability around charge capture/reconciliation and revenue acumen of clinical staff."