Closing the Ambition-Execution Gap:

C-Suite Perspectives on Reaching Mid-Revenue Cycle AI Maturity

July 2026

Executive Summary

Mid-revenue cycle management (MRCM) sits at a crossroads between growing ambition and resource constraint. Health systems have higher and more proactive aspirations for MRCM, including upstream denial prevention, higher clean claim rates, and AI-enabled clinical documentation improvement. However, most lack the infrastructure, alignment, and financial flexibility to execute. This gap is not driven by internal constraints alone. External pressure, especially rapidly shifting payer-provider dynamics, is forcing health systems to intervene earlier in the revenue cycle.

This acceleration is most evident in payer adoption of AI, enabling them to scale denial and claim rejection capabilities at a pace traditional health system infrastructure was not built to absorb. A recent report found final denial rates reaching over 14%, translating to $48.4B in lost revenue, a more than 25% increase over 2024.[1] Health systems still depending on a legacy mid-cycle posture risk continually accelerating forgone revenue, which only compounds as payer algorithms grow more sophisticated.

A reactive approach to MRCM is no longer sustainable. As payer AI adoption increases and algorithms grow more advanced, denial volumes will continue to increase. To avoid getting left behind, health system leaders must realign their strategy around foresighted intervention by building necessary operational infrastructure and layering AI capabilities as the foundation for long-term effective revenue management.

This report synthesizes findings from a survey of 81 senior revenue cycle leaders across U.S. health systems. Quantitative findings were contextualized through 5 in-depth qualitative interviews with C-suite executives. Together, these sources reveal how organizations are positioned across a MRCM AI maturity continuum and what separates those building durable mid-cycle performance from those falling behind.

Four key findings define where the ambition-execution gap is widest:

1. **AI augments existing architecture; it does not replace it.** Systems that sequence revenue integrity infrastructure and identify inefficiencies before layering AI realize sustained value over time. Those that deploy AI before building the foundation miss the compounding returns of an already optimized mid-cycle.

2. **Outsourcing trades operational burden for strategic distance.** The decision to offload mid-cycle functions has meaningful downstream consequences for visibility, alignment, and AI readiness. A growing subset of systems is reclaiming strategic ownership while maintaining external execution.

3. **Durable ROI requires separating lift from long-term value.** Accurately capturing the value of AI investment requires measuring long-term performance gains over traditional ROI metrics like revenue lift. Systems that conflate the two risk underinvesting in mid-cycle AI and underestimating the cost of persistent gaps.

4. **Payer-provider friction increases the cost of inaction.** Payers are automating their offense at a pace reactive mid-cycle postures cannot match. Health systems staying ahead of the curve share a common sequencing logic: build a robust revenue integrity foundation first, then deploy targeted AI to address specific pain points human intervention alone cannot fix.

1. Kodiak Solutions. State of the Healthcare Revenue Cycle: Kodiak RCA Benchmarking Analysis. Kodiak Solutions; March 2026. https://www.kodiaksolutions.io/internal/benchmarking_reports/march_2026_benchmarking_intelligence_report

Section 1:

The State of Mid-Revenue Cycle Management

"I feel like we're always at the payer's mercy…Even if we're so perfect internally, you still are up against incorrect denials from a payer…It's trying to stay a step ahead of them when you never really are."

- ***VP of Revenue Cycle,*** *Regional IDN*

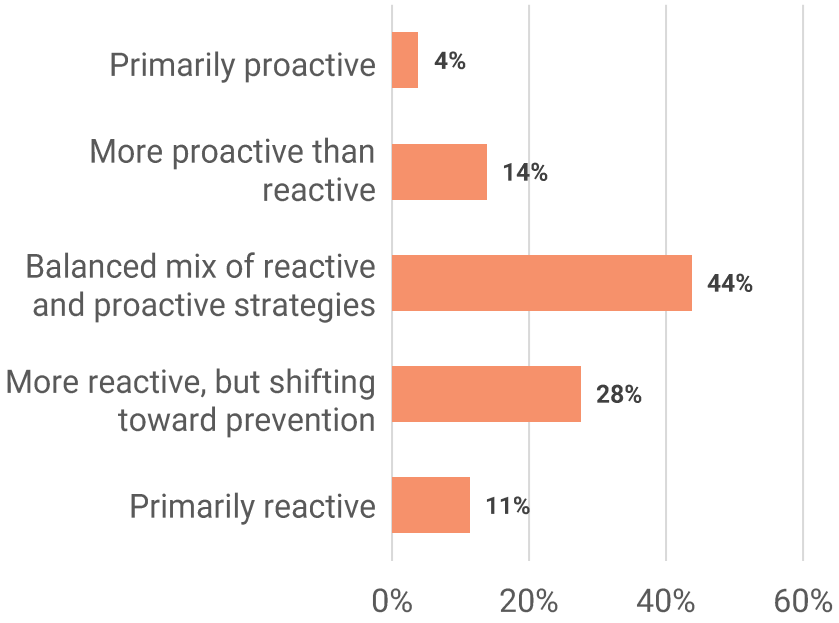
The State of Mid-Revenue Cycle Management

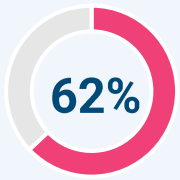
Broadly, health system leaders acknowledge the strategic importance of investment in MRCM AI. However, the way organizations define and resource it varies considerably. A proactive MRCM posture prioritizes upstream intervention, including denial prevention, documentation accuracy, and pre-submission validation, while a reactive posture addresses revenue loss after it occurs through appeals, rework, and retrospective audit.

Currently, the status quo of MRCM at health systems appears balanced between a mix of proactive and reactive tactics (44%) but skews downstream: only 18% of respondents described their organization as having a more proactive (or primarily proactive) approach compared to 39% describing theirs as reactive. Regardless of current disposition, the future direction is clear: 62% of respondents expect their MRCM strategy to evolve toward prevention-first tactics.

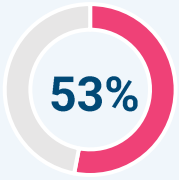
How does your organization currently approach mid-revenue cycle management (MRCM)?

Percentage of respondents

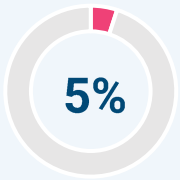




62% anticipate shifting their MRCM upstream significantly



53% foresee focusing on the efficiency of existing processes



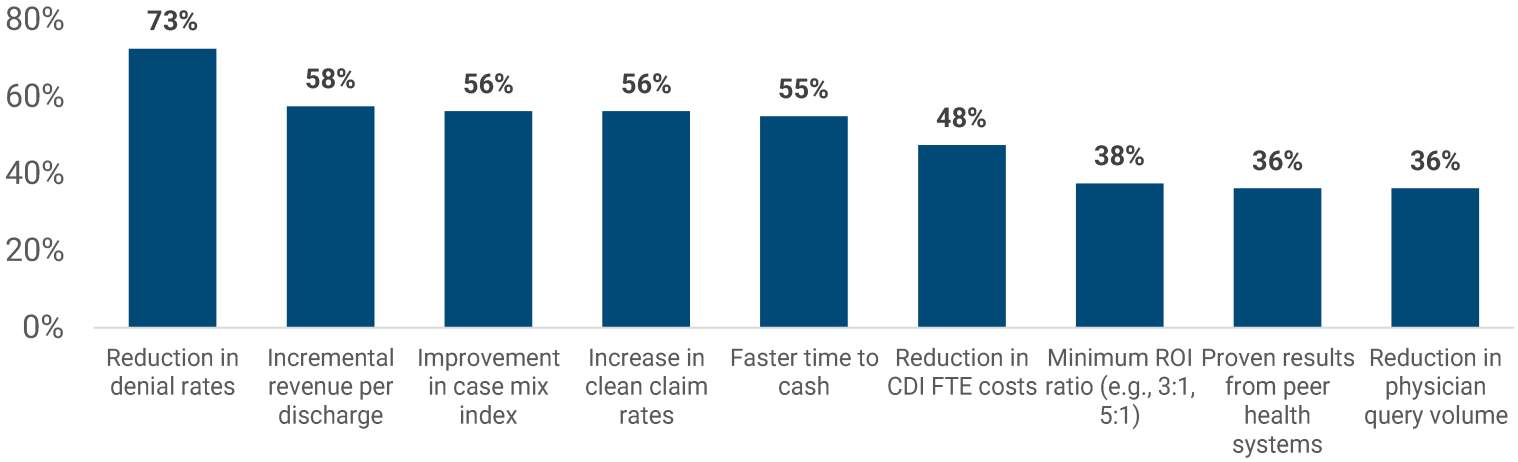
5% expect their MRCM approach to stay unchanged

How quickly systems close this distance between their aspirations and operational reality depends on how well they can identify inefficiencies. Today, notable gaps remain. For example, most systems (73%) do not systematically quantify mid-cycle inefficiency costs despite MRCM being a C-suite priority. Those operating without this visibility are more prone to aspirational bias: without hard data, self-assessment drifts toward where leaders want the system to be rather than how it currently operates.

Denials are the most acute pressure point impacting mid-revenue cycle strategy, and how systems approach them is equally indicative of their ability to shift incrementally upstream. 73% of respondents selected denial rate reduction as a top ROI metric for AI investment, reflecting how universally felt this tension is. The way systems respond to it reveals diverging strategic philosophies: some double down on denial management as a reactive function, while others are investing upstream in prevention-first strategies, using AI to preemptively flag emerging payer trends before they materialize as denials.

What measurable ROI outcomes would justify investment in AI MRCM solutions?

Percentage of respondents

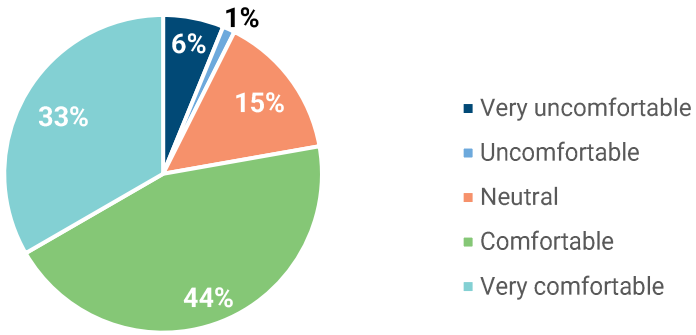


Revenue cycle leaders view AI as a ubiquitous optimizer

Despite implementation challenges, health systems still demonstrate urgency, likely due in part to the belief that without AI adoption, they have exhausted most other mid-cycle improvement strategies. AI is viewed as a universal lever to optimize mid-cycle revenue across every segment of the market, even among systems with no near-term plans to invest. 85% of respondents cited AI as the top opportunity to optimize revenue and 78% reported comfort or high comfort with leveraging AI. This appetite creates both genuine urgency and hype-driven noise that systems must navigate in an already crowded vendor landscape. While internal skepticism or hesitancy is mostly not a limiting factor, AI adoption must clear other persistent barriers to entry like budget constraints, integration complexity, ROI, and hallucination control.

How comfortable are you with leveraging AI MRCM tools in your health system?

Percentage of respondents



> *Payers are already using AI to automatically deny things, or we feel that they are automatically denying, and downcoding. So, the pressure is even more. The more we can automate things, get that autonomous coding utilizing AI, [we] will make our staff's lives better and easier to get through the volume, [we can] more accurately code and get the payments that we're due."*
>
> - ***SVP of Revenue Cycle***
> *Southern AMC/IDN*

Section 2:

Building a Mature, AI-Ready MRCM Strategy

"You know, this concept of AI for the last 10 years, let's say, has been a bit of a vaporware. It was a cool buzzword…Now that's changed in the last 24 months, it's becoming more of a reality…. But just to be transparent, [AI] has also presented [the system] and the industry with some new challenges. How do you vet these solutions? How do you make sure the solutions are really adding value?"

- ***Chief Revenue Officer,*** *National IDN*

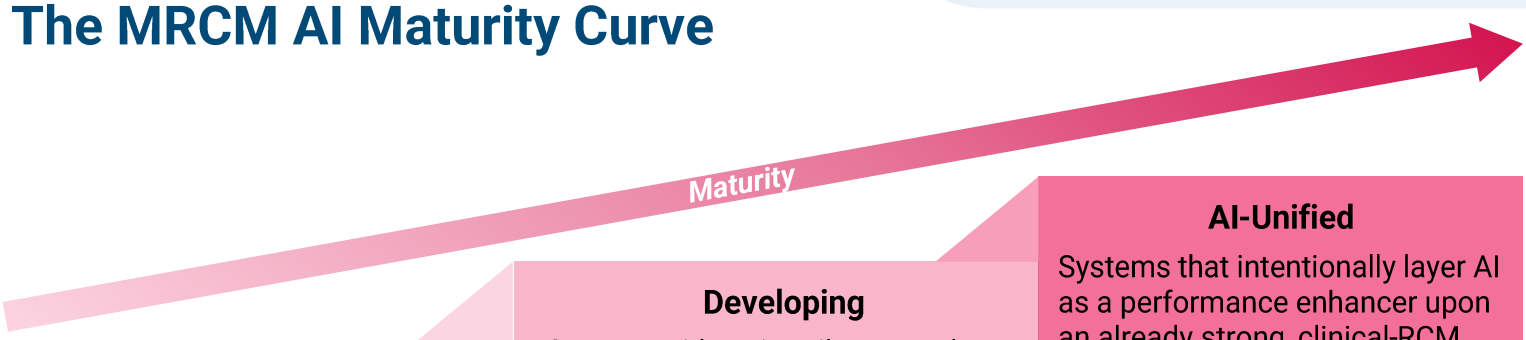
Building a Mature, AI-Ready MRCM Strategy

Organizational MRCM AI investment tracks with infrastructure potential, not just executive intent

AI investment for mid-cycle revenue management is accelerating, with 75% of leaders expecting increased spending over the next three years. However, adoption remains fragmented: 44% are piloting AI, while only 30% have deployed it at scale. As a result, health systems are positioned at distinct points across a MRCM AI maturity continuum; fundamentally, they diverge on how to diagnose inefficiencies and measure success. Across the collected data, three distinct archetypes emerged, each reflecting a different relationship between AI investment, operational infrastructure, and strategic ambition.

> *"In the mid-revenue cycle, we have just onboarded an AI solution for capturing areas for documentation and coding completeness...We already had two vendors in that space and a look back on the post bill, so one would say we're kind of heavy...[but] we've had quite a lot of opportunities that we could close documentation gaps on...If you took an organization who didn't have a robust program, they would probably see even bigger impacts."*
>
> - ***Chief Revenue Officer,*** *Eastern AMC/IDN*

The MRCM AI Maturity Curve



Traditional

Systems with the least advanced MRCM AI capacity that rely on manual-intensive downstream effort.

- By maintaining a reactive posture, these systems may struggle to root cause inefficiencies and implement systematic fixes
- Cross-departmental alignment that exists between clinical and revenue cycle teams leans superficial (like a shared dashboard rather than shared accountability of outcomes)

Organizations at this end of the spectrum remain susceptible to payer AI aggression through a lack of robust MRCM AI strategy of their own.

Developing

Systems with active pilots or early deployments of MRCM AI.

- These systems are restricted by budget or pilot justification but pulled by the potential of AI offloading labor-intensive mid-cycle processes
- Other workforce considerations further complicate this decision
- These systems recognize AI will fundamentally change CDI roles and current outsourcing agreements but remain unsure of how to navigate the transition complexities

In the interim, some may continue to investigate additional outsourcing and offshoring opportunities as a stopgap to delay comprehensive AI transformation absent of pilot-proven ROI.

AI-Unified

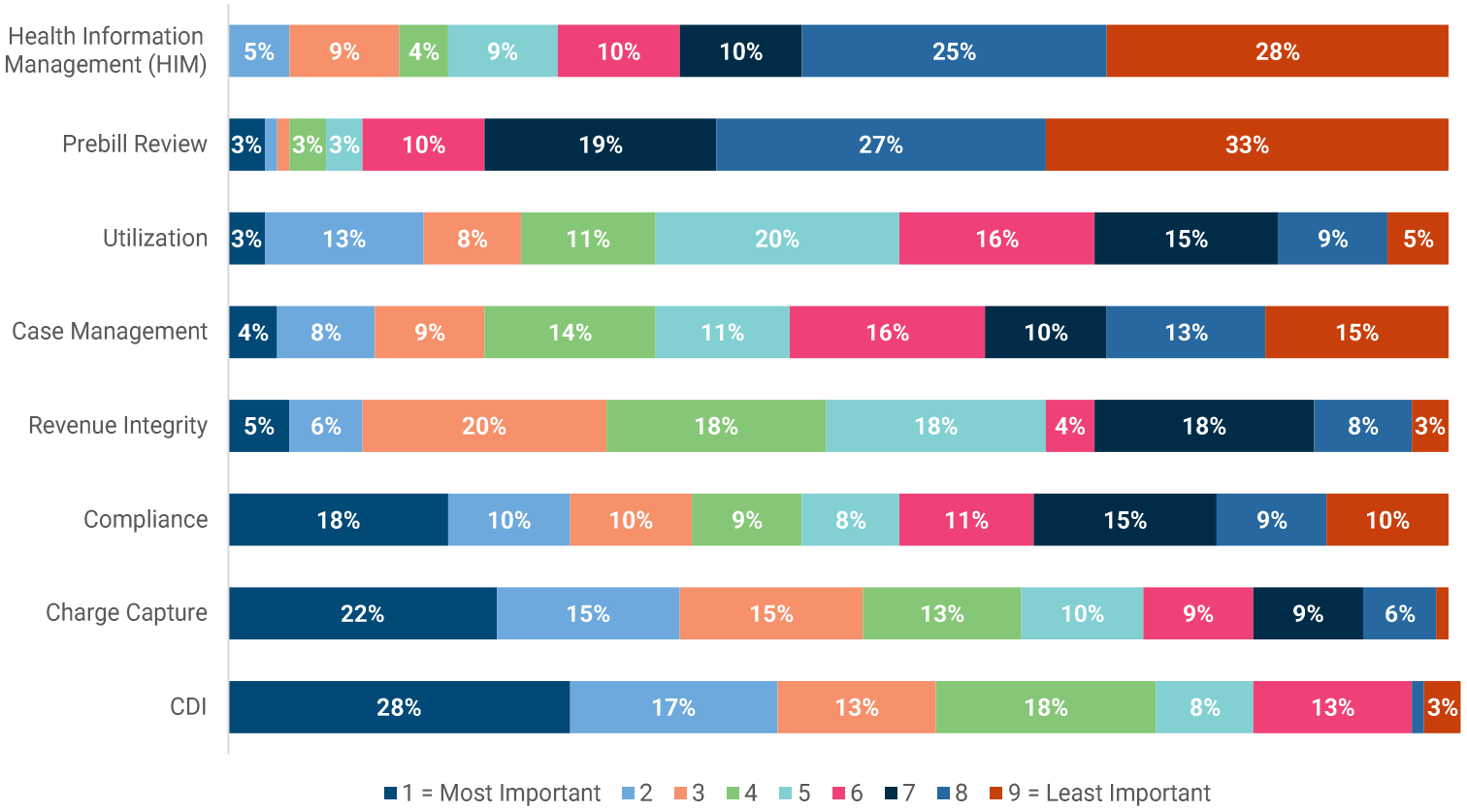
Systems that intentionally layer AI as a performance enhancer upon an already strong, clinical-RCM aligned foundation rather than treating it as an organizational panacea.

- These organizations maintain tempered expectations of AI transformation within MRCM
- Some retain select reactive processes
- Requires formal governance structures and revenue integrity-first dispositions

These health systems position as an AI augmenter, rather than an end unto itself.

Which upstream interventions are your organization's top priorities for preventing MRCM revenue leakage?

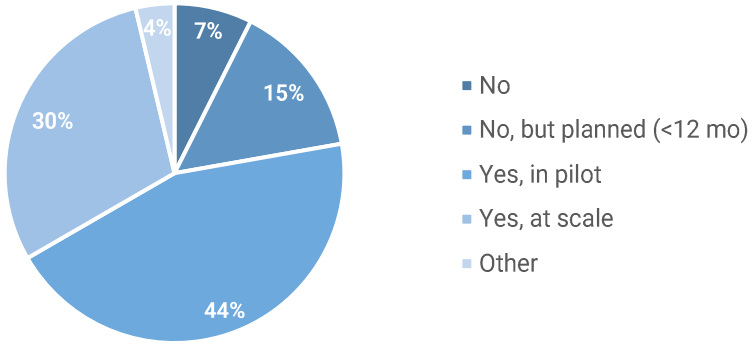
Percentage of respondents by ranking



Regardless of AI maturity levels, respondents were aligned on key strategic MRCM functions, including clinical documentation improvement, medical coding completeness, and charge capture maximization. This consensus reflects the ideal state of mid-cycle operations, and not necessarily their current operational reality. In practice, progress varies based on systems' self-rated proactivity, clinical-revenue collaboration, and the use of leakage-mitigating tactics.

Is your organization actively investing in AI MRCM transformation initiatives?

Percentage of respondents

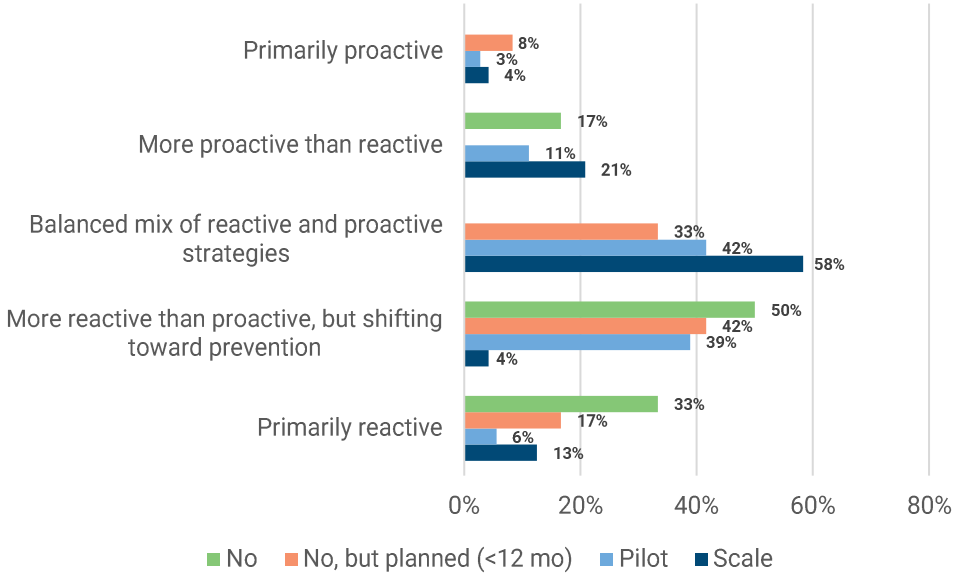


> *"I led our AI denials, and we didn't present the AI [as] 'we're going to get more denials overturned' because we went in with the foundation that our [CDI function] does a great job in overturn[ing]. What we did is [approach it as] a productivity [lever] – we're going to get twice as many out with less staff and that was our cost analysis on ROI. And then if we overturn more then that's great, right?"*
>
> – ***SVP of Revenue Cycle,*** *Southern AMC/IDN*

Those with a MRCM AI program at scale reported a more balanced than reactive mid-revenue cycle disposition (58%), compared to those with pilots (42%), systems planning to invest (33%), or respondents with no anticipated MRCM AI investment (0%). Similarly, scaled-AI systems indicated higher rates of proactive-leaning strategy (25%), relative to pilot (14%), or planning systems (8%). Unexpectedly, among respondents with no anticipated MRCM AI investment, 17% rated their systems as more proactive than not, though this may reflect a subset of high-performing organizations that deprioritized AI in the near-term.

How does your organization currently approach its mid-revenue cycle management (MRCM)?

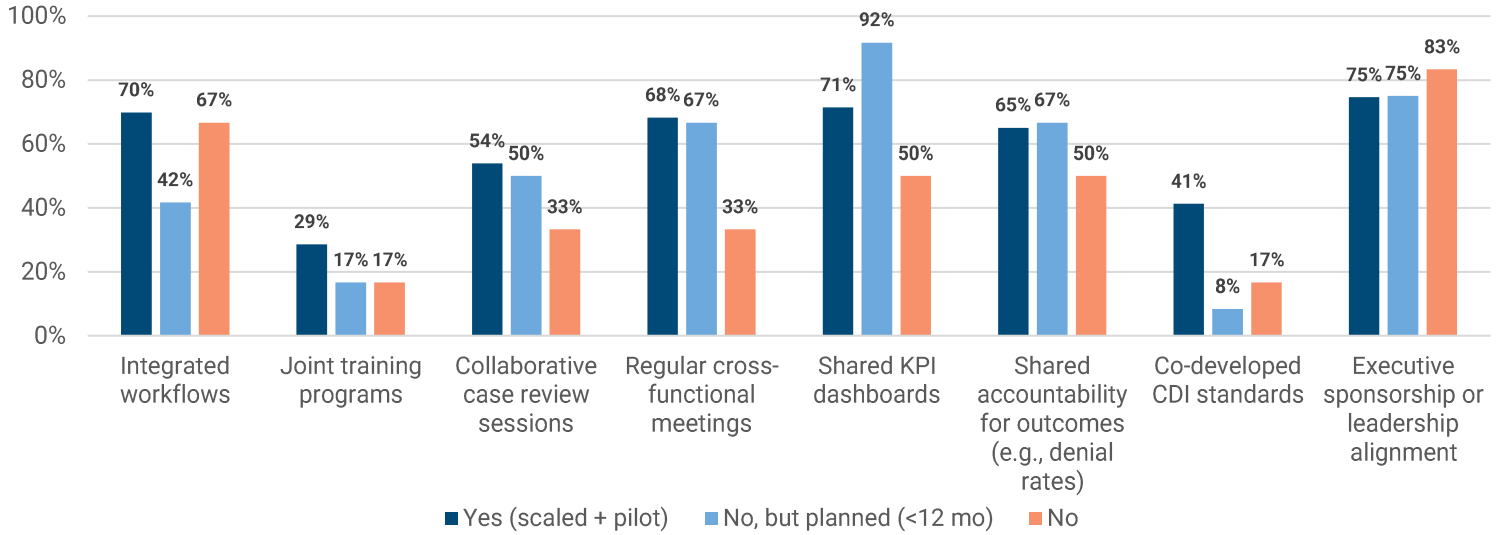
Percentage of respondents by AI deployment



The robustness of a system's clinical and revenue cycle relationships, which enables increasingly complex upstream intervention, follows a trend comparable to MRCM proactivity. On average, those with MRCM AI at scale indicated a broader range of clinical-revenue alignment strategies relative to respondents from less mature organizations; these efforts also often required more complex and integrated workflows. For instance, compared to non-investing systems, organizations with an active MRCM AI investment (pilot and scaled) reported more joint training (29% versus 17%), co-developed CDI standards (41% versus 17%), and shared accountability (65% versus 50%). Non-investing organizations reported higher rates of executive sponsorship compared to those with active mid-cycle AI investment (83% versus 75%); executive urgency in isolation, however, does not appear to translate into successful cross-stakeholder alignment.

How are clinical and revenue cycle teams currently aligned to improve MRCM performance?

Percentage of respondents by AI deployment

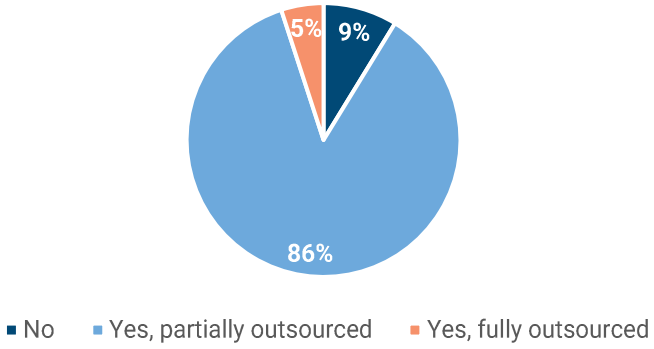


The concealed strategic implications of outsourcing

91% of health system respondents reported a form of outsourcing, with an overwhelming majority of that group partially outsourcing revenue cycle functions rather than comprehensive external execution. Regardless of outsourcing philosophy, health systems' strategic priorities and ultimate ambitions remain largely consistent across the market: denial reduction, clean claim rates, and upstream prevention. Instead, where they diverge lies within how systems pursue these goals operationally, as well as their tolerance for opacity.

Does your system outsource any portion of its revenue cycle?

Percentage of respondents

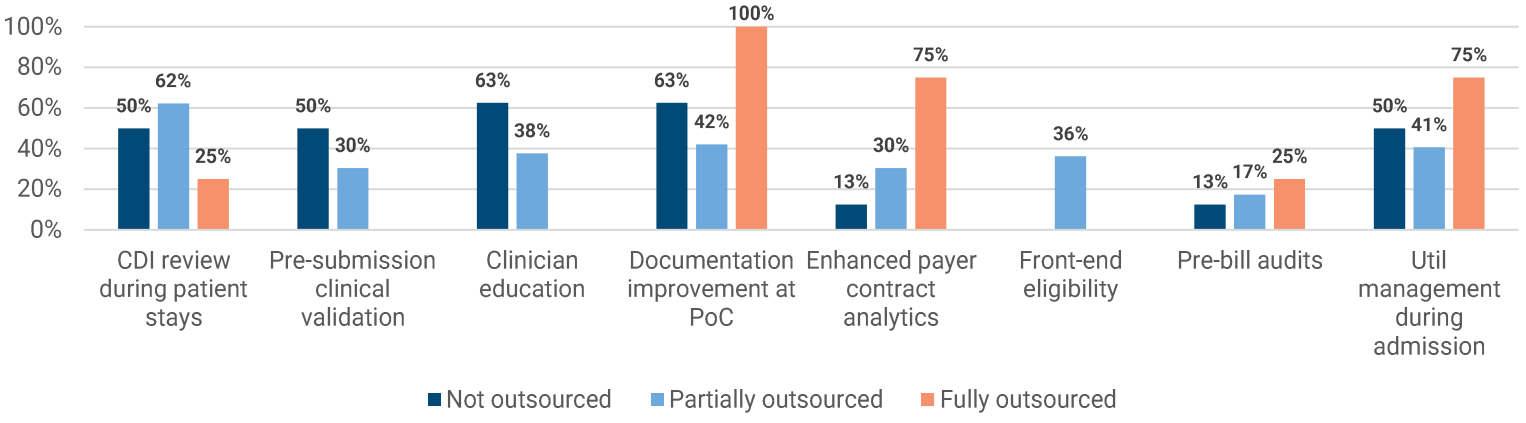


Outsourcing obscures actionable MRCM intervention

Outsourcing augments a health system's MRCM capacity but also can obscure visibility into outcomes, particularly when vendors own data workflows end-to-end. Consequently, a lack of comprehensive insight complicates data-informed strategic planning, potentially leading to decisions that address reactive symptoms rather than systemic root causes; for some, strategic decision-making, and not operational control, becomes the primary MRCM tool, narrowing their purviews to contract accountability and regulatory carve-outs. Additionally, of systems that fully outsource, 0% indicated they prioritize clinical validation prior to submission, clinician education, or front-end eligibility checks as MRCM leakage prevention strategies. Yet 75% of fully outsourced systems desire real-time revenue risk identification, revealing that the desire for continuous insight persists even when the in-house infrastructure to generate it does not.

Which upstream interventions are your organization's top priorities for preventing MRCM revenue leakage?

Percentage of respondents by outsourcing type



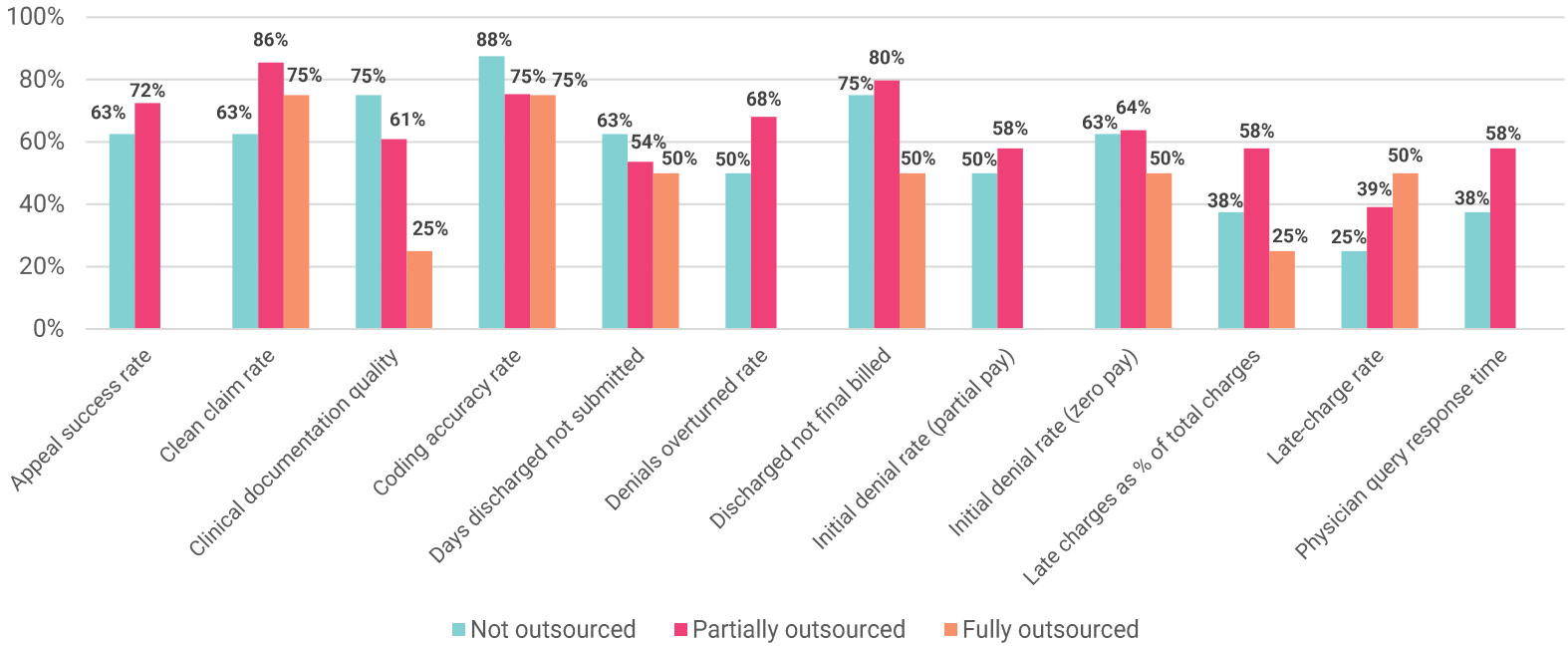
> *"8 years ago, somebody gave [the outsourcing partner] the keys to [our] revenue cycle and then everybody kind of walked away and said 'OK, we can kind of take our eyes off [it] because we've outsourced,' and that was a mistake. You can't take your eyes off revenue cycle and assume that it would be managed the way you would manage it."*
>
> - ***Chief Revenue Officer,*** *National IDN*

Operational ownership rewards workload with precise insight

Health systems that retain mid-revenue cycle operations take on more operational burden but also realize a meaningful return in visibility. Non-outsourcing systems tracked more metrics across revenue cycle domains on average (7.14 compared to 4.00 for fully outsourced systems) and also reported maintaining a systematic approach to MRCM inefficiency tracking. Clinical and revenue cycle alignment among these organizations appears less dependent on executive sponsorship, with non-outsourcing systems reporting lower rates of executive sponsorship as an alignment mechanism (50% versus 78% among outsourcing peers). This health system archetype invests more in human-powered infrastructure that underpins CDI, prioritizing clinician education as a core leakage prevention strategy at nearly twice the rate of outsourcing peers (63% versus 36%). What outsourcing trades in operational burden, these systems retain as leverage, including the internal expertise needed to evaluate and justify future MRCM decisions on their own terms.

Beyond denial rates, which MRCM revenue metrics are you actively monitoring?

Percentage of respondents by outsourcing type



System-vendor dissonance ignites strategic control reclamation

A growing subset of health systems is recalibrating its outsourcing approach by reclaiming decision-making ownership in-house while retaining external execution. In this model, core functions, like coding or prebill review, remain outsourced. At the same time, strategic control shifts as systems rebuild internal revenue integrity infrastructure to reassert control over mid-cycle decision-making.

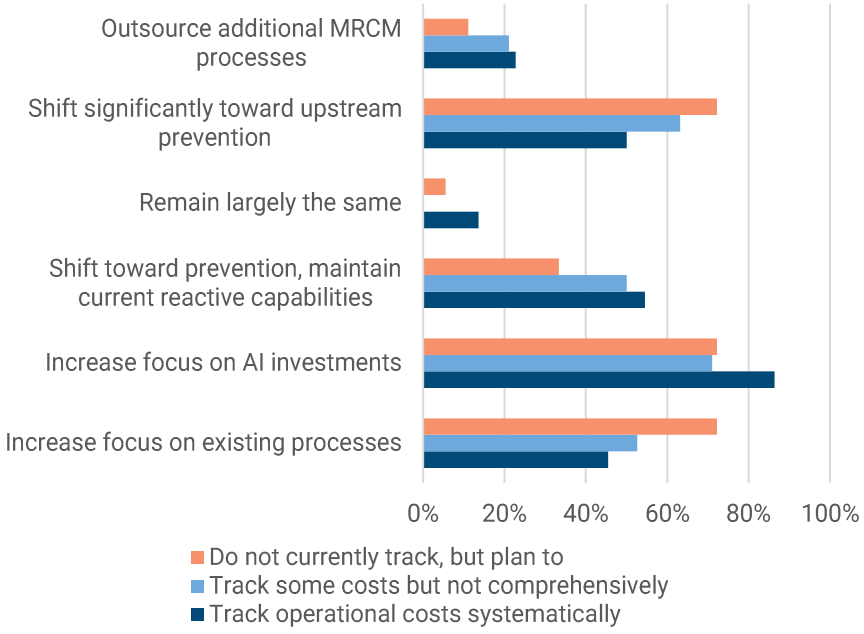
This recalibration often begins when misalignment occurs between a vendor's revenue integrity priorities and the health system's own priorities. In response, some organizations build robust internal revenue integrity functions that span front-end, mid-cycle, and back-end revenue cycle operations; multi-market systems structure these initiatives to be self-funding, using the lift from each market to finance the next expansion. As payer AI sophistication grows and mid-cycle complexity deepens, strategic ownership over revenue integrity decisions will become an increasingly pertinent competitive differentiator.

Organizations without systematic analytic infrastructure consistently overstate their proactive ambitions relative to their operational reality

The gap between where systems want to go and their current state is most pronounced among those without the analytic infrastructure to measure and attribute inefficiency costs. Organizations in this cohort were more likely to rate themselves as proactive relative to peers, indicating the most aggressive upstream ambitions (72%) and the highest identification of AI capabilities as an opportunity (94%), while simultaneously reporting the lowest urgency in near-term AI prioritization. The vision is present but the architecture to measure revenue leakage reliably is not. As a result, these organizations target broader interventions rather than the data-driven variables that systematic trackers prioritize, positioning AI as the solution to a gap they have not yet fully quantified.

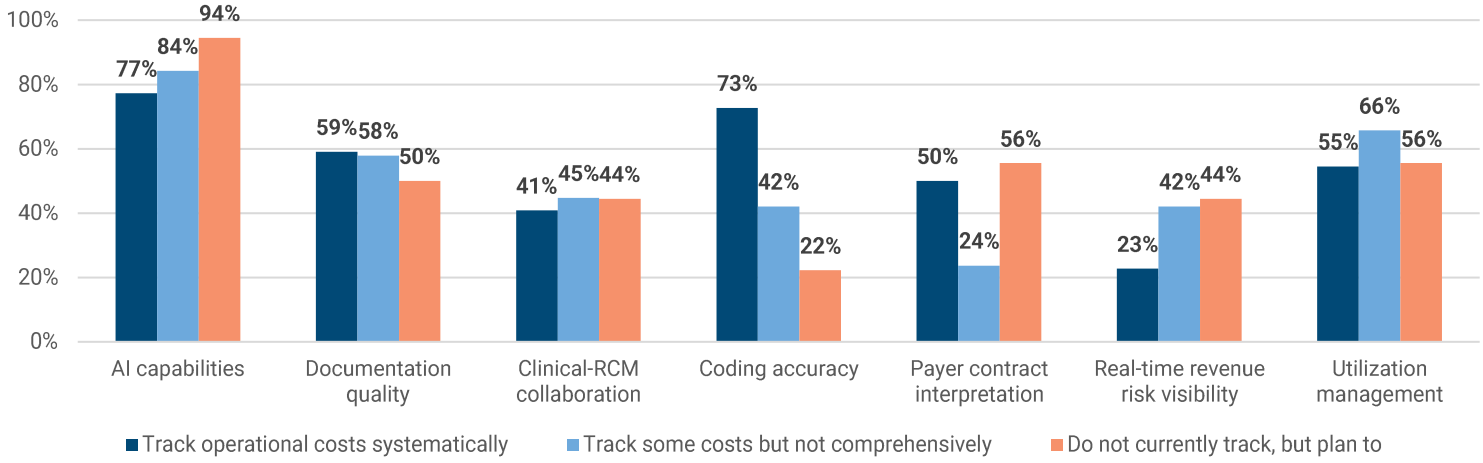
Over the next 3 years, how do you expect your MRCM strategy to evolve?

Percentage of respondents by inefficiency cost tracking strategy



Where do you see the largest opportunities to optimize revenue in your MRCM today?

Percentage of respondents by inefficiency cost tracking strategy



As health systems mature in their ability to quantify inefficiency costs, AI ambitions shift from broad and aspirational to narrow and operational. Mature systems operate a closed loop: they measure where inefficiencies concentrate, deploy AI against the root causes, and use the resulting data to refine where they invest next. Closing the gap is less a matter of ambition than of building that loop, aligning stakeholders cross-functionally, and owning the tactical vision. These prerequisites elevate AI from a catch-all fix to a precision instrument.

Section 3:

Investing in Mid-Cycle AI: What It Takes

"A lot of times [vendors' ROI estimates] have a lot of smoke and mirrors...This was based on us, and this was what we're seeing. I feel pretty comfortable with the company, and I think that was a big bonus for them, to be accurate on their assessments."

- ***Chief Revenue Officer,*** *Eastern IDN/AMC*

Investing in Mid-Cycle AI: What It Takes

Deploying AI in the mid-revenue cycle requires sequential alignment of organizational, political, and analytical conditions across the health system. Executive sponsorship, although important, does not sufficiently catalyze investment. To translate ambition into deployment, system leadership must first establish a platform strategy, deliberately outlining how AI capabilities connect across the mid-revenue cycle rather than accumulate as disjointed point solutions scattered across multiple vendors. From there, engaging stakeholders and ensuring measurement infrastructure is in place must precede any anticipated ROI actualization.

EHR roadmaps serve as a default, but not final filter for new technology investments

For several health systems, evaluating a third-party AI solution investment begins not with clinical impact assessment but with a platform strategy question: can their EHR achieve this, and if so, when? Effectively, this mandate functions as the default filter for third-party AI vendors, with most systems benchmarking upcoming roadmaps against add-on vendor functionality. Importantly, an EHR-first posture is not an impenetrable wall, rather it is a raised bar of value-expectations cleared through performance validation with peer systems, data-driven system-specific projections, and contingency cost arrangements. Even if vendors exceed this threshold, the solution may serve as a bridge until EHR capability maturation, unless the partnership proves ongoing value to justify investment.

> *"You really have to kind of measure everything, whether it's Epic or Cerner. What's on their road map? How long? What am I losing now? Can I wait for it? And if I can't, who do we partner with until then?"*
>
> - ***SVP of Revenue Cycle,*** *Southern AMC/IDN*

For health system leaders, a more critical risk lies within what systems forego while waiting for EHR roadmaps to materialize. When EHR functionality timelines misalign with a system's strategic imperatives, the decision to delay translates to unrealized efficiency, revenue, or accuracy gains. Therefore, treating the EHR roadmap as an omnipresent constraint rather than one consideration among many underemphasizes opportunity costs, especially when another solution can deliver results on a faster timeline.

Buying committees and organizational politics dictate whether AI investments stall

MRCM AI investment decisions rarely rely on a single person or function for sign-off. In practice, it involves multi-stakeholder alignment with operational leadership close to the work offering decisive authority. Across the market, formal governance structures vary, but the composition of these committees is consequential. Effective evaluation convenes clinical, operations, revenue cycle, finance, and IT, for each function to provide a distinct vantage point. As a result, unanticipated consequences proactively surface in planning rather than appearing during rollout.

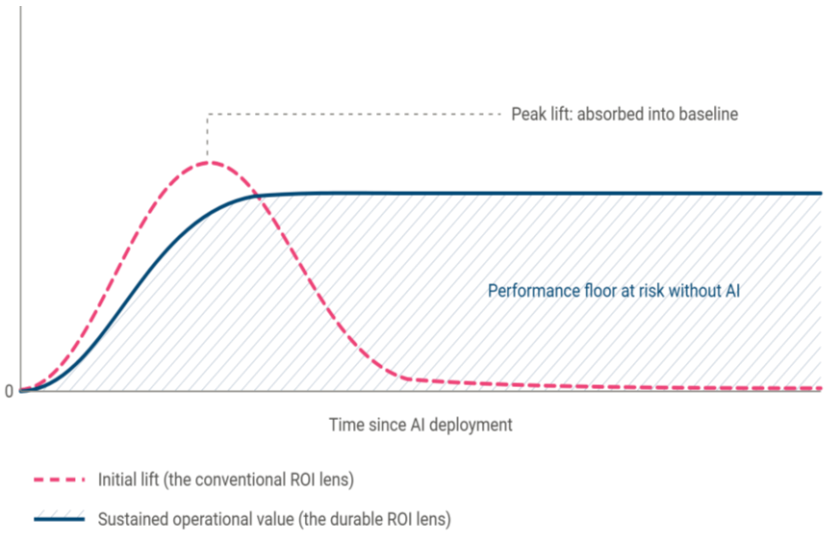
Those who can successfully bridge clinical and financial fluency accelerate decision-making, and translate operational need into business case urgency. These individuals also can effectively address skepticism that centers on data security, vendor reliability, and EHR roadmap overlap. Health systems that resolve concerns during evaluation are better positioned to make decisions with confidence and align on a vendor that fits the system's unique priorities, infrastructure, and constraints.

For MRCM AI, durable return on investment necessitates a value reframe

How health systems measure mid-cycle inefficiencies is one of the most consequential determinants of how AI is deployed, and the expected downstream results. According to respondents, clean claim rates (83%), discharged not final bill rates (78%), and coding accuracy rates (77%) remain notable inefficiency indicators, but the rigor of how these metrics are monitored varies from system-to-system. Systems with built-out metric infrastructure tended to pilot AI rigorously with internal validation before scaling, whereas organizations with more nascent tracking may rely on vendor-reported outcomes rather than internally validated ones; this shifts performance accountability rather than retaining it internally.

The differences in how systems monitor impact do not just shape how they deploy AI, but also frames the value they expect. The most common ROI indicator is the initial lift from how AI improves MRCM's baseline performance through charge and risk capture. For many, this metric can justify initial investment. In practice, however, assessing ROI solely on primary gains provides an incomplete picture that yields diminishing returns. Once absorbed into the baseline, AI MRCM provides consistent, underlying value; and documentation gaps closed in the first year after AI deployment continually addresses leakage, regardless of whether a measurable revenue lift reoccurs in the following year.

AI ROI requires repositioning 'value' as ongoing



Leading health systems have moved beyond assessing initial lift as the primary ROI metric toward a more durable perspective: sustained operational value or the performance a system could not maintain without continued investment. This framing accounts for the continuous nature of the mid-revenue cycle: new providers regularly reset previously addressed documentation gaps, emerging service lines introduce new leakage points, and payer behavior evolution requires continuous upstream adjustment. Thus, revenue integrity is a dynamic dilemma, not a single fix. Health systems that integrate this understanding reframe AI as an enduring component of a proactive mid-revenue cycle management strategy.

> *"You know [RCM] is an ever-evolving landscape, meaning you don't fix revenue integrity and then go 'it's fixed.' We stop the leak and we go on to the next job, new services, new products, it's an ongoing initiative to try to make sure that you're capturing the right charges on the right patient at the right time."*
>
> - ***Chief Revenue Officer,*** *National IDN*

Conclusion

The robustness of a health system's mid-revenue cycle is a key strategic differentiator. How health systems measure inefficiencies, sequence AI investments, and structure operational ownership will increasingly separate those with durable financial performance from others reacting to increasingly complex payer strategy. Four key findings define where this gap is widest:

1. **AI acts as scaffolding for existing architecture, not a substitute for one**
   Systems that sequence revenue integrity infrastructure and identify inefficiencies before layering AI realize, validate, and sustain value over time. Those that deploy AI before building the foundation miss the compounding returns of an already optimized mid-cycle.

2. **Outsourcing trades operational burden for strategic distance**
   The decision to offload mid-cycle functions shapes visibility, alignment, and AI readiness – impacts that leaders rarely anticipate. Increasingly, systems are reclaiming strategic ownership while maintaining external execution.

3. **A durable ROI assessment separates lift from value**
   Accurately capturing the value of AI investment requires measuring long-term performance gains over traditional ROI metrics like revenue lift. Systems that conflate the two risk underinvesting in mid-cycle AI and underestimating the cost of persistent gaps.

4. **Dynamic payer-provider friction increases the cost of inaction**
   Payers are automating their offense at a pace traditional mid-cycle infrastructure cannot absorb, and systems depending on reactive-first positioning risk falling further behind. The health systems outpacing payers within the payer-provider AI race share a common sequencing logic. First, build a robust, active revenue integrity foundation then augment with targeted AI to address specific pain points human intervention alone cannot fix.

Methodology Overview

The Health Management Academy (THMA), in partnership with SmarterDx, surveyed 81 revenue cycle leaders across US health systems. Participants answered questions that detailed how their systems position, resource, and enable MRCM strategy. The survey also assessed leaders' perceptions of MRCM-specific AI, including comfort, functions augmented, and future investment efforts. Additionally, five in-depth interviews with key informants were conducted to provide nuance. Findings throughout reflect insights synthesized across both data sources.

About The Health Management Academy

Since 1998, The Health Management Academy has cultivated the premier community of influential changemakers in healthcare. Our members are aligned around a common goal of improving health for all, and a core belief that partnership will accelerate progress. Our member community includes Leading Health Systems – the approximately 150 innovative integrated delivery systems with over $2B in total operating revenue – and innovative Industry Partners that are working alongside health systems to drive health forward. We power our members by building our community and fostering connections through executive peer learning. We support professional growth through talent and development. We accelerate understanding by delivering timely and actionable data and insights on key challenges. And we catalyze transformation by building alliances in areas where the power of the collective is greater than the power of one.

The Health Management Academy Project Team

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About SmarterDx

Health systems deliver the care. SmarterDx helps them capture its full value. Their clinical AI platform interprets complex, fragmented EHR data, recreates clinical reasoning, and surfaces the evidence needed to accurately reflect the patient journey across every stage of the revenue cycle — from care to claim to payment. Built by physician-data scientists and trained on clinically-validated truths, like 17M+ validated hospital encounters and over 10,000 unique diagnoses and procedures, SmarterDx helps health systems recover millions in earned revenue, reduce and overturn denials, improve quality metrics, and capture proven 5:1 ROI starting Day 1. Discover how SmarterDx's connected clinical intelligence platform is transforming the revenue cycle at smarterdx.com.