



BUYER'S GUIDE

Medicare Revenue Integrity:

How to choose the right technology partner for Medicare-dependent organizations

OVERVIEW

Traditional Medicare operates on its own data structures, adjudication logic, and regulatory requirements that shift independently of commercial markets. Most revenue cycle technology was not built with that in mind, and many organizations don't realize it until the denial rate starts climbing and no one can explain why.

That pattern is even more pronounced for Medicare-dependent organizations. Seven in ten revenue cycle leaders name denials a top challenge, and 78% trace those denials back to a front-end workflow failure.¹ The problem is what happens before the claim goes out. And when Medicare is involved, the margin for error is narrower. The program reimburses 83 cents on the dollar on average, generating more than \$100 billion in annual underpayments across the industry.²

This guide is for revenue cycle and finance leaders at Medicare-dependent organizations evaluating technology or questioning whether their current vendor is truly built for this space. It covers where operational gaps create the most loss, what good looks like, and the questions that separate vendors with purpose-built Medicare infrastructure from those who work around it.



Five Questions To Ask Any Vendor

These questions will help you identify a partner who will protect your program.

- 1 Are you directly connected to HETS, or is Medicare access something you built on top of a commercial framework?**

The HIPAA Eligibility Transaction System (HETS) is CMS's primary source for Medicare eligibility data. Direct connection means faster, fresher data. Every handoff through an intermediary is another place data can lag or fall out of sync.

- 2 How do you handle MBI re-issues and mismatches in real time?**

When CMS re-issues a Medicare Beneficiary Identifier (MBI), you need to validate the current identifier at the point of registration, not rely on what's on file from the last visit. Ask what that workflow looks like and who's accountable when something doesn't match.

- 3 Is your DDE connection direct to FISS, or are you routing through a partner?**

Direct Data Entry (DDE) access into the Fiscal Intermediary Standard System (FISS) means working at the Medicare data source. Vendors routing through a partner add a translation layer that introduces latency and limits what can be caught and corrected in real time.

- 4 How do you surface and route ADRs from esMD before the documentation window closes?**

A missed Additional Documentation Request (ADR) deadline isn't recoverable. Ask whether electronic submission of Medical Documentation (esMD) monitoring is built into the same workflow or is a separate manual step that depends on someone logging into FISS.

- 5 Can you show us claims data front-end to back-end in a single view?**

Rather than a claims tool with a reporting layer dropped on top, look for a solution with real visibility into which procedure types, intake workflows, and payers are generating the most loss, and what's aging, what's recoverable, and what's already past the filing window.



You cannot pursue revenue you cannot see. Organizations need an aggregated, analytics-driven view of their entire Medicare claims cycle, not just a list of denials, but the ability to identify patterns."

Jeremy Swanson, Manager, Back-End Revenue Cycle Management, Inovalon

The Vendor Evaluation Checklist

Use this to evaluate any vendor on your shortlist. The vendors who are purpose-built for Medicare answer all of these, while those who work around the Medicare infrastructure won't.

Infrastructure

- ☐ Direct HETS connectivity (not routed through an intermediary)
- ☐ DDE/FISS real-time access for working directly at the Medicare data source
- ☐ esMD integration for managing CMS documentation requests within the workflow
- ☐ Full-cycle analytics, not just a claims tool with a reporting layer on top
- ☐ Customer references from organizations with infrastructure that look like yours

Regulatory depth

- ☐ Established MAC relationships (Medicare Administrative Contractors are where adjudication rules live)
- ☐ Network Service Vendor (NSV) connectivity to keep Medicare access always open
- ☐ Health Information Handler (HIH) ability to manage and navigate esMD and the electronic Medicare Documentation Reviewer (eMDR)
- ☐ Direct CMS engagement and regulatory signal access
- ☐ Medicare has been a core capability, not an add-on, for 10+ years



The vendors who built for Medicare 10 or 15 years ago have a different foundation than those who added it as a feature to a commercial payer platform. That foundation shows up in ways that are easy to miss in a demo and expensive to discover post-implementation.

What Inovalon Does Differently

Once you understand what Medicare-specific infrastructure looks like, the differences between vendors become easier to evaluate. Most vendors were built for commercial payers and work around Medicare. Inovalon was built with Medicare at the center, and that infrastructure difference shows up where it matters.

Direct Medicare infrastructure

- Largest and longest-standing NSV, with direct CMS connectivity
- Direct HETS access for Medicare eligibility, not routed through an intermediary
- Direct DDE/FISS access for working at the Medicare data source in real time
- HIE connectivity for esMD and eMDR, so ADR requests surface automatically within the workflow
- Established MAC relationships across all jurisdictions

Full end-to-end RCM visibility

- Front-end to back-end claims visibility in a single platform, not a claims tool with reporting added on
- Continuous eligibility monitoring across long episodes of care, not just at intake
- Proactive insurance discovery across commercial, Medicaid, Medicare, and secondary payers
- Claims aging, underpayment identification, and esMD audit tracking in one workflow

Direct Access Shows Up on Both Ends of the Revenue Cycle

Front-end RCM: Prevent revenue loss before claim submission

Eligibility Verification™

Real-time monitoring catches coverage gaps early, filling 97% of missing data before it reaches the payer.³

Insurance Discovery™

Identifies unknown primary, secondary, or tertiary coverage, uncovering billable insurance on 43% of uninsured accounts.⁴

Medicare Beneficiary Identifier (MBI)

Validate and search for the most current MBI instantly, preventing Medicare rejections caused by outdated identifiers.

Registration Workflow™

Lead with confidence from day one and verify coverage, demographic data, and current MBI upfront in one unified workflow.

Back-end RCM: Get paid faster, defend what you've earned

Claims Management Pro™

CMS aligned scrubbing and AI-driven review flags at-risk claims before submission, delivering an average 98% first-pass acceptance rate.⁵

Claims Management Medicare Pro™

Modern Medicare interface reduces keystrokes by 74%, with real-time visibility into rejected and suspended claims.⁶

Claims Management Medicare Starter™

ADRs, RAC reviews, and appeals tracked in one dashboard with esMD submission built in.

RCM Intelligence™

Unified analytics surface denial drivers and revenue leakage, enabling issues to be addressed faster.

Customer Story: MGM Healthcare

Medicare billing for a skilled nursing facility ran through DDE: one claim at a time, manually keyed, status tracked across multiple portals. Coverage changes slipped through until they showed up as denials. With Inovalon's Claims Management Medicare Pro, the team moved out of the green screen. Claims run against current CMS rules before submission. Coverage is confirmed at registration, not after the denial comes back.

Operational Impact

The organization achieved a **20%** reduction in denials after switching from manual DDE.



Claims Management Medicare Pro is amazing. We can do the same thing, but in a better way."

Marco Ochoa, A/R Manager, MGM Healthcare

Three Practical Next Steps

The organizations that close the revenue gap can see the whole picture: front-end to back-end, in one place. Here is where to start.

1 Use the five questions in your next vendor conversation

They are vendor-agnostic by design. The answers, and the gaps, will tell you everything you need to know about each partner's real Medicare infrastructure.

2 Run the checklist against your current vendor

If you are questioning whether your current vendor is truly built for Medicare, the checklist in this guide will tell you a lot. The honest answers are the ones that matter.

3 Talk to a Medicare expert

If you are evaluating vendors, Inovalon's Medicare team can walk you through how direct NSV, HETS, and FISS connectivity translates into your specific workflow, and what that means for your organization's denial rate.

Ready to see how direct Medicare access can improve reimbursement?

Schedule a Conversation

1. "Claims Denials: Prevention Strategies," Inovalon, April 2026

2. "Costs of Caring: Challenges Facing America's Hospitals as They Care for Patients in 2026," American Hospital Association, March 2026, <https://www.aha.org/costsofcaring>

3. Internal reporting, Inovalon, Eligibility Verification Pro transactions missing Member ID or first/last name, April 2026. Individual results may vary.

4. Inovalon internal reporting, January 2026. Individual results may vary.

5. Inovalon internal reporting, Claims Management Pro, January 2026

6. Internal reporting of keystroke reduction using Claims Management Medicare Pro vs. DDE, Inovalon, July 2025