NORWOOD

The Wild West of Medicare Advantage

Surviving in an Age of Regulatory Uncertainty

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NOTE FROM JASON JOBES

Wild Medicare Advantage Swings of Momentum Have Us All Hanging On

On May 21 CMS dropped one of the biggest announcements since the advent of ICD-10: An exponential increase of Medicare Advantage (MA) risk adjustment audits. The agency planned to hire 2,000 coders, ramp up its tools with AI and tech, and launch a full-on audit storm.

We were all braced for extrapolated, multi-million-dollar recoupments of every MA plan in the nation, per CMS.

And then, the other shoe dropped.

On Sept. 25, a TX district court vacated the 2023 Risk Adjustment Data Validation (RADV) rule. The court ruled that the CMS rule did not give adequate notice nor comment period to a groundbreaking piece of regulation that would have held MA plans to a higher standard of code validation.

The foundation for CMS' expanded MA audits, cracked.

If that wasn't enough, the very next day, a suspiciously well-timed CMS press release dropped, indicating that MA has never been healthier, and plan member premiums would be more affordable in 2026.

So where does this leave us—besides a front-row seat to the Wild West show?

MA is here to stay. We're all players in a program that bears close scrutiny. With its massive market share and federal support, MA is the bellwether for the health of healthcare and remains the best hope for a full 2030 transition to value-based care.

But nothing is certain, and it bears close scrutiny.

Despite the court ruling 2025-26 remains the year of compliance. The OIG has had a field day with audits of Medicare Advantage plans, and risk adjustmentcoding excesses remain under scrutiny. The transition from V24 to V28 of CMS-HCCs has led to tighter margins across the board,

Which makes revenue integrity and revenue protection a must.

The best news in these uncertain times? Norwood is here as your pilot and navigator.

We hope this report arms you with the information and tools to get you started on your MA revenue and compliance strategy—and reaffirms that we're your partner in success.

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Medicare Advantage:
A TUMULTOUS TIMELINE

Medicare Advantage seems constantly in the news, but the last six months have been a rollercoaster of non-stop coverage. Following is a recap to get you up to speed.

MAY 21
Audit Expansion Announced

SEP 25
Not So Fast, CMS-Court Tosses 2023 RADV Rule

SEP 26
CMS: All is well with Medicare Advantage!

May 21
Audit Expansion Announced

CMS on May 21 unveiled an "aggressive strategy" to enhance and accelerate Medicare Advantage (MA) audits. How aggressive? It began immediately, with the release.

"We are committed to crushing fraud, waste and abuse across all federal healthcare programs," said Dr. Mehmet Oz, CMS Administrator, in the release. "While the Administration values the work that Medicare Advantage plans do, it is time CMS faithfully executes its duty to audit these plans and ensure they are billing the government accurately for the coverage they provide to Medicare patients."

CMS planned to:

1. **Audit every MA contract annually**
   Expanding from ~60 audits per year to all 550+ contracts
2. **Clear the audit backlog**
   for payment years 2018 through 2024 — with all audits completed by early 2026.
3. **Ramp up staff**
   Increase its audit team from a scant 40 to nearly 2,000 coders and auditors by September 1, 2025.
4. **Deploy advanced analytics**
   Use NLP and AI to flag documentation issues and unsupported diagnoses.
5. **Increase sampling size**
   from ~35 records per audit to as many as 200 per plan, depending on enrollment.

It was a full-court press—and a clear signal that the days of light-touch oversight are over.

September 25:

Not So Fast, CMS-Court Tosses 2023 RADV Rule

But CMS' audit plans hit a roadblock on Thursday Sept. 25 when a Texas district court vacated the final risk adjustment data validation (RADV) rule of 2023.

The court ruled that the CMS rule did not give adequate notice nor comment period to a groundbreaking piece of regulation that would have held MA plans to a higher standard of code validation.

To recap: On Jan. 30, 2023, CMS issued a final rule adopting a new policy for calculating payment recoveries in MA audits. The final rule allowed CMS to recover suspected overpayments from audited MA contracts by sampling a small number of contract enrollees and extrapolating audit results across a contract's entire enrollee population. It could then recover contract-wide repayments based on those estimates.

But the plans led by Humana pushed back, claiming that the final rule was never open to comment, and moreover violated a longstanding "actuarial equivalence" standard needed to account for the differences in capitated, contracted payments vs. traditional Medicare fee-for-service. CMS had previously applied a fee-for-service adjuster to MA; Humana claimed that eliminating the FFS adjuster held private MA insurers to an unfair standard compared to traditional Medicare. The TX court sided with Humana, and the RADV rule was vacated.

Whether CMS is able to move forward with its dramatic expansion of MA audits as announced in May remains to be seen, but the picture is a lot murkier.

September 26:

CMS: All is well with Medicare Advantage!

On the very next day after the crushing court case, a press release from the Trump administration: Average MA premiums will decline slightly for the 2026 plan year, giving Americans more affordable healthcare if they stick with the embattled program. Average monthly premiums will fall to $14 from $16.40 in 2025.

CMS tempered the enthusiasm a bit, sharing payers' estimated projections of an overall MA enrollment decline, from 34.9 million last year to 34 million in 2026. However, CMS concluded on a note of disagreement, and optimism: "Enrollment in MA in 2026 will be more robust than the plans' projections and enrollment will be stable." And concluded with a statement of clear preference for MA over traditional Medicare:

"Millions of Medicare beneficiaries will continue to have access to a broad range of affordable coverage options in 2026," said CMS Administrator Mehmet Oz. "We want every beneficiary to take advantage of open enrollment—compare your options and choose the plan that gives you the right care at the best price."

Where Are We Now?

As of today CMS has not resumed its audits of Medicare Advantage, and a recent Bloomberg report indicates that it has not made progress on hiring its 2000 auditors. After the court's decision the ball is back in CMS' court.

Stay tuned.

When AI and Auditors Came Knocking:

A CASE STUDY OF EVERLANE HEALTH SYSTEM

Earlier this year, Everlane Health System * – a nationally recognized integrated delivery network and Medicare Advantage Organization (MAO) – found itself in the middle of CMS's crosshairs.

Everlane had built a stellar reputation on care coordination and preventative outreach. Like many provider-sponsored MAOs, it relied heavily on risk adjustment to fund proactive clinical programs.

But in Q2, it became one of the first large health systems audited under CMS's expanded RADV strategy.

What Made This Audit Different?

CMS employed a
Dual Force Model

- **A joint team of credentialed coders and clinical CDI specialists** reviewed over 150 charts across multiple service lines.
- **AI-driven NLP engines** combed through millions of lines of clinical text for signs of unsupported diagnoses, pattern mismatches, and risk inflation.

The results were stark.

Auditors flagged 18% of Everlane's submitted HCCs as unsupported—either due to vague provider notes/insufficient depiction of patient acuity, outdated problem lists, and insufficient linkage to active conditions. The key diagnoses in question?

- **Diabetes with complications**
- **Chronic kidney disease**
- **Major depressive disorder**

All coded. But in many cases, not clearly documented as monitored, evaluated, assessed, or treated during the year in question. At least by CMS' standards.

The Fallout: Extrapolated Risk

Under the new extrapolation methodology, CMS projected the unsupported HCC rate across Everlane's entire MA population for PY2022. The final number: $87.4 million in recouped overpayments.

This wasn't fraud. There was no intent to deceive. But in the eyes of CMS, it didn't meet audit standards — and that distinction was enough.

Operational Lessons from Everlane

1. You can't automate your way to compliance
   - Everlane used EHR-integrated risk adjustment tools. The problem? Those tools pulled from problem lists and past diagnoses—without enough checks on documentation integrity.

2. AI can spot patterns humans can't — and vice versa
   - CMS's NLP engine flagged providers who routinely reused note templates, failed to update condition status, or documented in ways inconsistent with clinical norms. Coders then validated those patterns.

3. Sample size doesn't mean small risk
   - Just 150 charts audited. But extrapolated across ~60,000 MA lives, the financial impact ballooned.

A Wake-Up Call for Provider-Affiliated MA Plans

If your health system owns or operates an MA plan, the compliance bar just got higher. Even good-faith efforts at accurate coding won't protect you if your documentation culture isn't airtight.

Everlane learned its lessons the hard way and is now

- **Doubling its CDI resources**
- **Conducting clinician documentation bootcamps**
- **Creating risk-specific audit units within the MAO**
- **Embedding real-time MEAT validation checkpoints in the EHR including hard-stops for at-risk diagnoses**

My Take

This isn't about policing your providers. It's about recognizing that risk-adjusted revenue is now tethered directly to documentation defensibility – and CMS is coming with both coders and code.

I would love to hear how others are preparing internally, especially across CDI, compliance, and MA leadership. These audits are just about to move from theoretical to very real.

– Jason

**Note: Everlane Health System is fictitious as is the audit result. But the recoupment numbers presented here are if anything, underestimated.*

Surviving a Medicare Advantage Audit You Can't Predict:

THE CASE FOR OUTPATIENT CDI

We believe CMS will renew its audits of Medicare Advantage. What's unknown is when the audits will begin — and exactly what they will target.

That uncertainty creates an uncomfortable question for health systems and physician organizations: How do you prepare for an audit when you can't predict the timing or its focus?

What you can't do is sit back and wait. **The answer is to build a robust outpatient clinical documentation improvement (OP CDI) program — one that operates as both a shield and a safety net.**

When done well, OP CDI offers audit prophylaxis: preventing unsupported diagnoses from entering the record while ensuring all legitimate conditions are captured and coded. The result is lawful reimbursement optimization, reduced compliance exposure, and a measurable return on investment.

Following is a look at how one of our partners did just that.

The Lifepoint Health Example: Scaling ROI Across a Network

LifePoint Health's AdvantagePoint clinically integrated network spans 40+ hospitals and 2,300+ providers. Its outpatient CDI journey began in 2021 with retrospective reviews and rebilled claims. By 2024, the program had evolved into a proactive, technology-enabled process embedded in everyday workflows.

The process is multi-pronged:

1. **Pre-Encounter Reviews**
   1–3 days before scheduled visits (often annual wellness visits), CDI specialists review 2–3 years of patient records — labs, imaging, consults — to find conditions lacking specificity or support. NLP technology flags likely opportunities, which human specialists then validate.

2. **Pre-Encounter Reviews**
   Providers receive targeted queries to clarify diagnoses during the patient visit.

3. **Post-Encounter Reviews**
   CDI specialists ensure that documented diagnoses are properly coded — adding missed conditions and removing unsupported ones.

This "before, during, after" model not only captures missed opportunities but also proactively removes high-risk codes that lack sufficient documentation. In 2024 alone, LifePoint's post-encounter process removed 18,786 unsupported conditions from records, greatly reducing audit vulnerability.

The Risk Landscape Has Shifted

Medicare Advantage enrollment now exceeds 67 million beneficiaries. Even a 0.01 increase in average risk score translates into more than $6 billion in additional annual revenue nationally. That means documentation accuracy is not just a compliance issue — it's a revenue driver.

But CMS and the Office of Inspector General (OIG) are watching these plans closely. In 2024, the OIG found nearly 10% of all Medicare Advantage revenue was unsupported by documentation. Nine OIG reviews alone identified $231 million in overpayments. With MA audits expanding, the stakes have never been higher.

Why OP CDI Is Your Best Defense (and Offense)

Outpatient CDI works by aligning the medical record with the true complexity of the patient's health status. That alignment drives accurate risk scores, which in turn determine per-member-per-month (PMPM) payments from payers. Done right, OP CDI protects revenue in three ways:

Increasing Reimbursement Through Accurate Risk Adjustment

- Comprehensive, compliant HCC capture ensures that you are paid appropriately for the care delivered.
- LifePoint Health's pre-encounter process powered by natural language processing (NLP) surfaced 68,108 potential HCCs in 2024, leading to 13,628 additional documented conditions — many of them risk-relevant. Note: staff also captured the conditions that added no HCC weight, because it's the right thing to do—and demonstrates that clinical accuracy is paramount. And coders also opted not to capture many flagged by the software.

Preventing Denials Before They Happen

- By identifying documentation gaps before the encounter and correcting unsupported diagnoses afterward, OP CDI ensures cleaner claims and fewer post-payment headaches.

Mitigating the Impact of Takebacks

- When all eligible conditions are properly captured, your overall reimbursement is maximized — so even if an audit results in takebacks, the percentage impact is smaller.

ROI in Action

While precise dollar impact depends on contractual arrangements, the ROI levers of OP CDI are clear:

- **Risk Score Accuracy** — Every incremental improvement in RAF score increases PMPM payments.
- **Revenue Protection** — By catching errors before claims are submitted, you avoid repayments later.
- **Operational Efficiency** — NLP allows CDI teams to scale their review capacity beyond what human capital alone can achieve.

One full-time CDI specialist at LifePoint can review approximately 20 visits per day, generating about 10 provider queries. With a 50% provider response rate and 80% query accuracy, that equates to four additional HCCs captured daily — a measurable and repeatable source of revenue integrity.

Barriers to Success – and How to Overcome Them

LifePoint's experience highlights common challenges in implementing OP CDI:

- **Chart Coverage & Provider Response** — Even the best technology can't capture opportunities if providers don't engage. Success requires sustained education and partnership with physicians. We recommend regular educational sessions, both in group settings and tailored 1:1 sessions.
- **Scheduling Gaps** — Missed appointments and low annual wellness visit completion rates mean fewer chances to capture complexity. Prioritize annual wellness visit (AWV) scheduling and completion.
- **Human Capital Limits** — Even large teams can't review every record. Technology like NLP is essential to extend reach and maintain scale.
- **Documentation Quality** — OP CDI depends on clear, specific documentation. Continuous feedback loops between CDI specialists and providers are critical. OP CDI is not "fire and forget."

Why NOW is the Time to Act

The shift from fee-for-service to value-based care is accelerating. In value-based arrangements, revenue is tied to both the accuracy of risk adjustment and the quality of outcomes. That means an audit doesn't just threaten compliance — it can disrupt your financial model.

By building OP CDI capacity now, you:

- **Shield your organization from unpredictable audits**
- **Maximize lawful reimbursement**
- **Protect against takebacks**
- **Improve patient outcomes through better care management**

As LifePoint's program shows, OP CDI is not a one-time project but a continuous evolution — one that combines technology, process, and provider engagement to deliver sustained ROI.

Conclusion

You don't know when the next Medicare Advantage audit will arrive — or what it will target — so you can't afford to be passive. A well-structured OP CDI program ensures that every patient's illness burden is fully, accurately, and compliantly captured.

It's not just about surviving an audit. It's about thriving in a value-based care world, where the stakes are high, the margins are thin, and the cost of inaction is measured in millions.

Survive the Audit You Can't Predict.

Build the Outpatient CDI Program You Can Control.

If you don't yet have an outpatient CDI program Norwood can get you there. We can build a process that aligns with your organizational goals, develop your dashboard, engage your physician stakeholders, educate your CDI team, and even staff your program with credentialed and experienced CDI professionals.

If you have an OP CDI program but aren't happy with its performance, let us fine tune it. You'll be happy when CMS' audits begin to roll out.

The ROI of Outpatient CDI: Additional Considerations

What Drives Total Premiums Received

In its simplest form, annual premiums received are calculated monthly and then aggregated across the 12-month period. The calculation uses the number of member months, the per member per month (PMPM) payment, and the RAF score. It is important to note that this is calculated at the patient level and added up but for illustrative purposes this is done in aggregate for the entire year below.

Eligible Population Member Months ✖ Per Member Per Month Payment ✖ Total RAF Score for all Patients = Total Premiums

	Member Months	PMPM	RAF Score	Premiums
Baseline	125,000	$800.00	1.00	$100,000,000
Scenario #2	125,000	$800.00	1.10	$110,000,000
Difference	0	0	0.10	$10,000,000

Fig. 1

A Patient Example of How Condition Capture Matters

A patient schedules an office visit for a prescription refill. Her care has been inconsistent as it is November, and this is the patient's first trip to her provider all year. Below are conditions that are noted on the problem list. Like relative weights, HCC weights can be multiplied by a factor to get the potential financial impact.

Condition	HCC Category (v28)	HCC Weight (v28)	Care Funding
E11620- Type 2 diabetes mellitus with diabetic dermatitis	37- Diabetes with Chronic Complications	0.166	$1,594
J449- Chronic obstructive pulmonary disease, unspecified	111- COPD, Interstitial Lung Disorders, and Other Chronic Lung Disorders	0.319	$3,062
I270- Primary pulmonary hypertension	226- Heart Failure, Except End-Stage and Acute	0.360	$3,456
N1831- Chronic kidney disease, stage 3a	329- Chronic Kidney Disease, Moderate (Stage 3, Except 3B)	0.127	$1,219
Interaction Factors Based on Conditions Above	• Diabetes + Heart Failure • Heart Failure + Chronic Lung Disorder • Heart Failure + Kidney	• 0.112 • 0.078 • 0.176	• $1,075 • $749 • $1,690
	Total- Assuming All Conditions Captured	1.338	$12,845

Sources: 1) https://www.cms.gov/files/document/2024-advance-notice-pdf.pdf | 2) Care Funding: Assumes $9,600 per point of RAF

Fig. 2

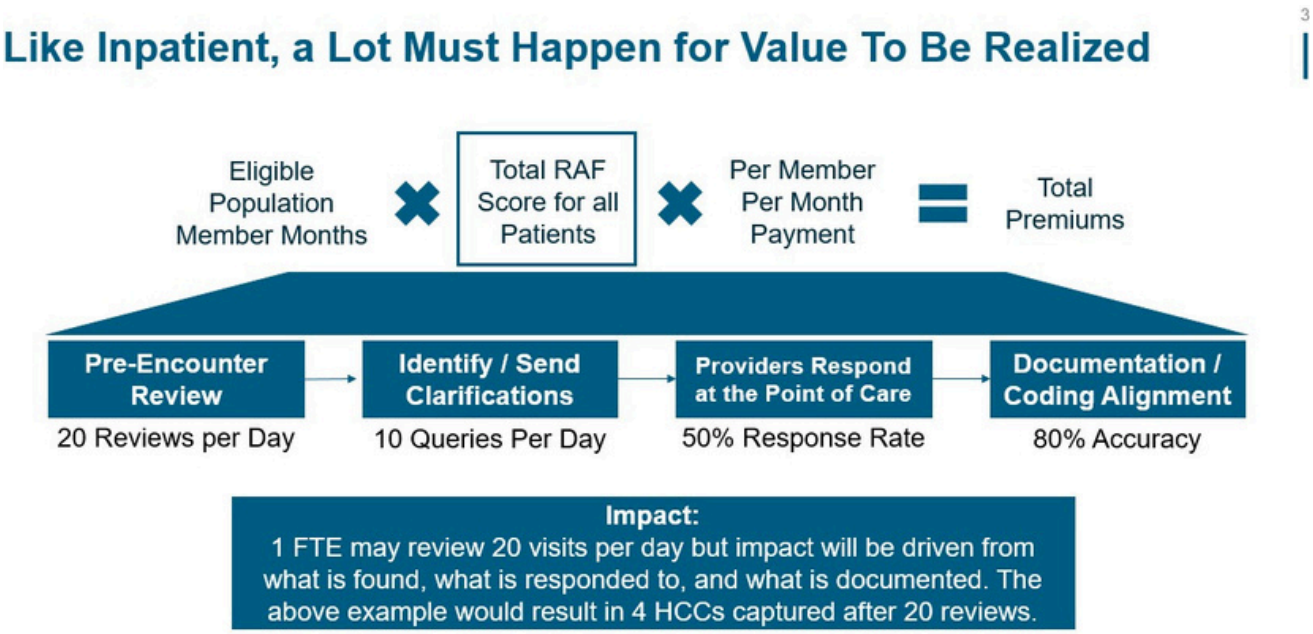

Like Inpatient, a Lot Must Happen for Value To Be Realized
3
Eligible Population Member Months
Total RAF Score for all Patients
Per Member Per Month Payment
Total Premiums
Pre-Encounter Review
20 Reviews per Day
Identify / Send Clarifications
10 Queries Per Day
Providers Respond at the Point of Care
50% Response Rate
Documentation / Coding Alignment
80% Accuracy
Impact:
1 FTE may review 20 visits per day but impact will be driven from what is found, what is responded to, and what is documented. The above example would result in 4 HCCs captured after 20 reviews.

Fig. 3

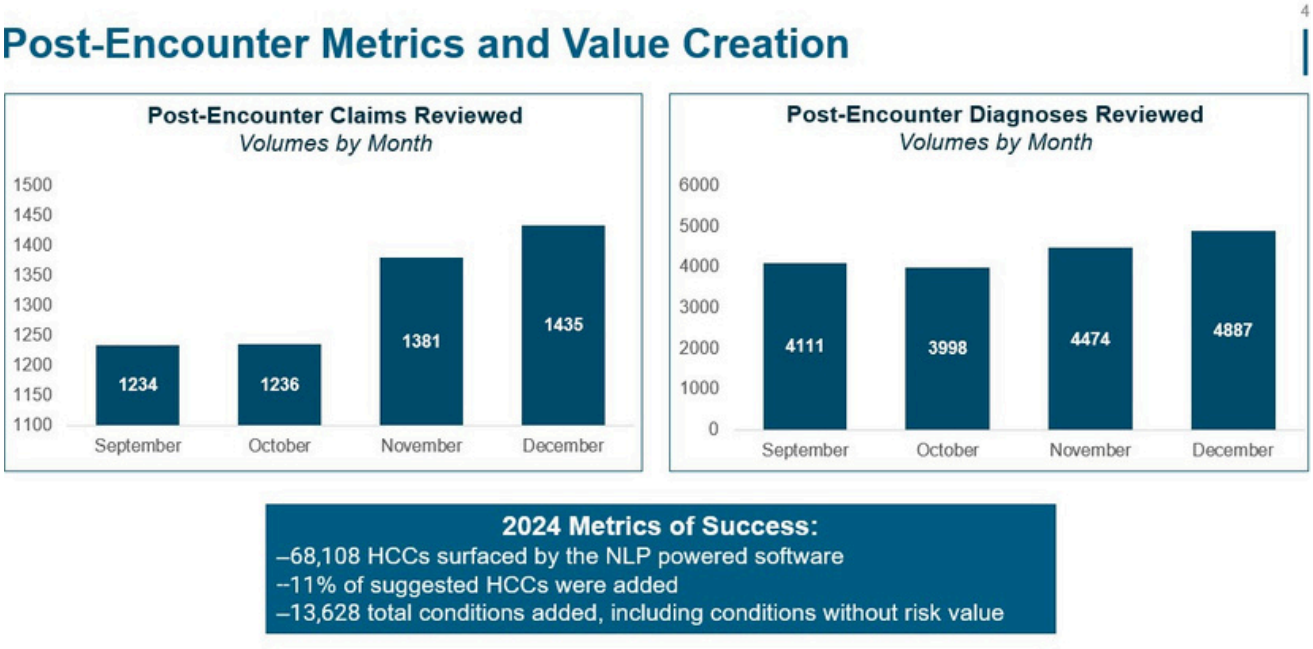

Post-Encounter Metrics and Value Creation
4
Post-Encounter Claims Reviewed
Volumes by Month
1500
1450
1400
1350
1300
1250
1200
1150
1100
1234
1236
1381
1435
September
October
November
December
Post-Encounter Diagnoses Reviewed
Volumes by Month
6000
5000
4000
3000
2000
1000
0
4111
3998
4474
4887
September
October
November
December
2024 Metrics of Success:
–68,108 HCCs surfaced by the NLP powered software
–11% of suggested HCCs were added
–13,628 total conditions added, including conditions without risk value

Fig. 4

Mitigating Compliance Risk Is Also ROI

Pre-Encounter

Specialists are not only expected to review records for net new conditions and clarifying current clinical conditions, they are also expected to review the record for clinical conditions that are no longer clinically valid.

Decreasing Over Capture Risk:
Hundreds of conditions for historical, acute conditions (e.g., stroke, heart attacks, and old cancers) were reviewed and prevented from being prompted at the point of care

Post-Encounter

The post-encounter process seeks to align documentation and coding. This is done by both evaluating conditions documented but not coded as well as removing codes that were coded but lacked supporting documentation.

Risk Mitigated:
18,786 conditions, both risk eligible and non-risk eligible have been removed from encounters due to insufficient documentation

Fig. 5

Returning to the ROI Concept: An Example of Performance

Due to the sensitive nature of financial performance, the example used below is both illustrative and can be used for you to determine your potential impact.

Pre-Encounter

Metric	Value
RAF Potential Identified per Review	0.27
RAF Captured per Review	0.11
Percent of RAF Potential Captured	40%
Impact per Review[1]	$272

Post-Encounter

Metric	Value
RAF Potential Identified per Review	0.31
RAF Captured per Review	0.06
Percent of RAF Potential Captured	20%
Impact per Review[1]	$154

Fig. 6

Key Takeaways

OP CDI Can Drive Tremendous Value – But It Is Complex

- With the continued shift from volume to value there is an increasing need to get the professional medical record complete and accurate
- You should consider processes before the visit, at the point of care, after the visit, and retrospectively
- Don't underestimate provider engagement, IT partnership, or data analytics in building a successful program

ROI Calculations are Imperfect But Don't Let That Stop You

- Tracking RAF across a lot of data is complex and requires data expertise
- 1 point of RAF can be worth more than 1 point of relative weights depending on your risk arrangement. Don't leave millions on the table
- Consider ROI calculations to be as much science as it is math. Strive to be directionally accurate but don't die on a hill attempting to be actuarially precise

Value Exists in Risk Score Accuracy – That Includes Revenue Protection

- The OIG says that nearly 10% of all Medicare Advantage revenue isn't supported by documentation in the record
- In 2024, the OIG identified $231M in overpayments across just 9 reviews. Protecting revenue is just as important as maximizing revenue.
- Compliance is a non-negotiable.

Medicare Advantage Optimization Checklist:
12 STEPS TO TACKLE TODAY

After digesting this report you might be feeling a bit overwhelmed on where to begin in these uncertain times. To help organize your efforts we offer a 12-step Medicare Advantage optimization checklist. This "dirty dozen" is not meant to be exhaustive but it's a great place to start.

1 Map Out Your Current Risk Adjustment Workflow

Assess your current state of documentation and billing practices.

If you don't have a flowchart or other map that shows everything from pre-admission to claims submission, get that started—it might reveal a loophole you've missed, or bottlenecks to remove for optimal performance.

2 Evaluate Current Compliance Practices and Tolerances

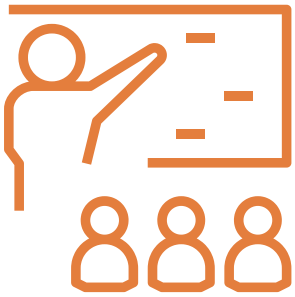
Evaluate your compliance, education, and data analytics programs to understand where you need to improve. Enlist your compliance department and organizational leadership.

Have you discussed your organizational tolerance for risk? That conversation needs to happen.

3 Audit your Documentation Culture

Are your providers consistently meeting MEAT or comparable RADV standards? Are chronic conditions being supported with clear, dated clinical engagement?

Start sampling provider notes yourself—target ones tied to high-risk HCCs. You're not waiting for CMS to catch errors, you're catching them now.



4 Educate Clinicians and Coders

Clarify documentation expectations, remove grey zone diagnosis practices, and enforce compliance checkpoints.

Bring specific performance back to providers to ensure they are empowered to document effectively.

5 Implement a Hard Stop on all Acute Conditions

Manually review any heart attacks, strokes, sepsis, and other acute conditions you would ordinarily not see in a providers' office setting.

Use "history of" codes instead. Allow providers to click the "resolved" button for acute conditions at discharge.

6 Use MEAT as your Documentation Standard

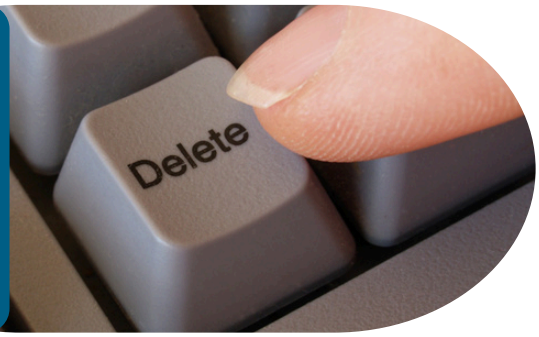
Make sure all conditions reported are either Monitored, Evaluated, Assessed, or Treated by a physician. It might not be a regulation but its an easy rule of thumb.

Other organizations prefer TAMPER: Treatment, Assessment, Monitor/Medicate, Plan, Evaluate, and Referral. This framework is particularly useful when reviewing problem lists or past medical history to ensure accurate and compliant coding, especially for risk adjustment purposes.

7 Remove Unsupported Conditions.

The OIG has stated in no uncertain terms that "upside only" reviews are frowned upon heavily.

If you see unsupported conditions, query the provider. If they are outdated or irrelevant, remove them.



8 Make Annual Wellness Visits (AWV) your Friend

Patient scheduling is the key to success in risk adjustment, which requires face-to-face encounters with the clinician for compliant coding. One great way to get patients seen is the underutilized AWV. Get them in, and seen, at least annually. Higher AWV rates have also been shown to improve HEDIS scores.

9 Keep your Problem Lists Clean

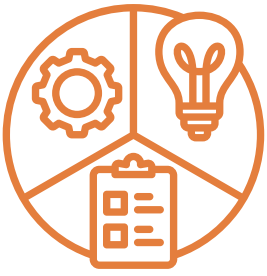
Who can maintain the problem list is a facility specific decision; we recommend that you allow CDI specialists to remove and add conditions (with provider approval) to take that onerous task off the plate of busy MDs.

10 Invest in Technology

Human capital cannot touch 100% of records. It's impossible in the OP setting. Leverage your EHR to its full potential. If it makes sense, invest in additional technology like natural language processing (NLP) to help assess record accuracy and surface undocumented conditions.

11 Invest in People

Use credentialed, experienced humans to review the output of NLP and other machine-assisted reviews. Machines (including AI) lack context and nuance and can misinterpret acronyms. Diagnoses can be hallucinated out of whole cloth. People must backstop even the most tech-forward organizations.



12 Plan for the Inevitable

Organize workflows to respond quickly to RADV audit notices. Understand submission windows, appeals stages, and gaps in historical documentation. Don't wait for the audit to arrive before building a response plan.

Your Insurance Policy for Audit Peace of Mind

Norwood's mission is Bringing Health to Hospitals' Bottom Lines.

To sum up in the starkest terms: Medicare Advantage is chaotic, messy, but here to stay. To chart a course to success you need the the right partner, one with a compass and a conscience.

Think of us like the insurance policy you already have for your home, your automobile, and your health. The financial health of your organization is no different. It's your greatest asset and we're here to protect it.

We're your partner, whether you need:

- **HCC and ICD-10-CM audits**
- **Provider and coder/CDI education**
- **Outsourced coding or CDI staff**
- **Consultation on KPIs, performance, and more**

We can help you implement OP CDI. If you have an OP program but aren't satisfied with the outcomes or ROI, we'll evaluate and optimize its performance.

Finally, don't just take our word for the quality of our work. Here's the words of one very happy partner:

"I'd like to take a moment to recognize the outstanding contributions of our outpatient CDI consultant, Norwood. Their depth of knowledge has been instrumental in helping us build the foundation of our new program. Many consultants know the data and can provide recommendations; where Norwood outperforms its competitors is its at-the-elbow operational and technical support.

From structuring workflows to onboarding and training new staff, their expertise has guided every step of the process. They consistently anticipate our needs, offer thoughtful solutions, and have truly been a strategic partner in this work.

Highly recommend to any organization looking to launch or elevate their outpatient CDI efforts!"

–Tracy Ferro, MSN, RN-BC, Corporate CDI Program Director, MUSC Health

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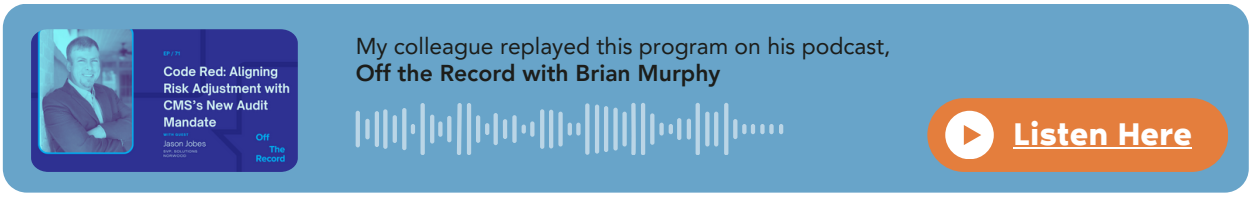
For Further Viewing
WEBINARS AND PODCAST

If you found this report helpful, you won't want to miss two of our most relevant and timely webinars. Both sessions offer insights that build on the themes of this guide—and give you practical strategies to take action.

"Code Red: Aligning Risk Adjustment with CMS's New Audit Mandate"

In this session, I take a deep dive into CMS's expanded audit efforts, including RADV changes, increased scrutiny of MA plans, and what providers and health plans need to do now to stay ahead of compliance risk.



"The ROI of Outpatient CDI"

In this collaborative webinar co-presented with Carol Ann Hudson from LifePoint Health, we explore how Outpatient CDI programs can drive measurable financial returns—not just through increased revenue, but also through risk protection, documentation accuracy, and stronger performance in a value-based care environment.

All the best,
Jason Jobes
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NORWOOD

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- Facility and Profee Coders
- Clinical Documentation Integrity
- HCC Auditors and Coders
- Trauma Registry Professionals
- Oncology Registry Professionals
- Department Leadership

CDI

Inpatient | Outpatient

Pediatric CDI

Chart Reviews & Compliance

CDI Program Implementations

Inpatient | Outpatient

Data Analysis

Payer Partnerships

Denials Management

Supplemental Diagnosis Submissions

Coding Audits

- CPT
- E/M
- HCPCS
- ICD-10-CM
- ICD-10-PCS
- HCC

MS-DRG

Optimization & Compliance

Managed Services

Outsourced Revenue Cycle Management

Risk Adjustment Factor (RAF)

Optimization & Compliance

Education

Live and Remote/Online

- CDI
- Coding
- Providers
- Outpatient CDI Boot Camp

If you don't see something here, ask. We're all about customization. You wouldn't expect to pluck an EHR off the shelf and use it. We feel the same about our solutions.

What Makes Us Different?

FLEXIBILITY

Whether implementing an outpatient CDI program, staffing your department, or auditing charts, we deliver flexibility with exceptional performance.

PEOPLE

We offer big-corporation resources with a small-company feel—Norwood is privately owned, independent, and values-driven.