

↳ REVENUE CYCLE · MEDICAL CODING · CLAIMS OPTIMISATION

Every dollar your hospital *is leaving behind.*

\$262B

lost annually in the US to billing errors
and denied claims

80%

of medical bills contain at least one
error

42%

of claim denials caused directly by
coding issues

THE PROBLEM

The clinical act and the bill *don't match.*

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- 01 Reconciliation fails between the clinical record and the invoice. What the physician did and what was billed are frequently different — not from fraud, but from documentation gaps and coding errors that nobody caught.
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- 02 Medical coding is manual, slow, and error-prone. Over 70,000 ICD-10 codes. Coders working under time pressure. Errors that compound into denials, rework, and lost revenue.
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- 03 Charge capture gaps are invisible until it's too late. Procedures performed but never billed. Services documented but not captured. Revenue that evaporates before anyone notices.
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- 04 Denials are analysed after the damage is done. Most hospitals review denials retrospectively. The root cause is upstream — in the clinical documentation, not the billing system.

WHAT IT COSTS

Revenue leakage is *structural*.

3–5%

OF HOSPITAL REVENUE LOST TO CHARGE CAPTURE GAPS ALONE

\$118

AVERAGE COST TO REWORK A SINGLE DENIED CLAIM

63%

OF HEALTHCARE ORGS HAVE AI-POWERED RCM – BUT STILL RELY ON MANUAL REVIEW FOR COMPLEX CASES

56%

OF CLAIM DENIALS CAUSED BY PATIENT INFORMATION ERRORS UPSTREAM

The root cause is always upstream. In the clinical data — not the billing system.

THE AGENTS

Six agents.

Every leak closed.

01

Clinical-to-billing reconciliation

Automatically matches every clinical act recorded in the EHR against the corresponding billing entry — flagging discrepancies before the claim is submitted.

02

Medical coding validation

Reads clinical notes and validates ICD-10, CPT, and DRG codes automatically — suggesting corrections and surfacing under-coded procedures in real time.

03

Documentary discrepancy detection

Identifies inconsistencies between clinical documentation, imaging reports, lab results, and discharge summaries that create audit risk or denial triggers.

04

Charge capture gap detection

Scans clinical activity across all systems to identify services performed but not billed — recovering revenue that would otherwise be permanently lost.

05

Denial analysis & root cause

Analyses denial patterns by payer, DRG, and procedure — tracing each denial back to its clinical documentation root cause so teams fix the process, not just the claim.

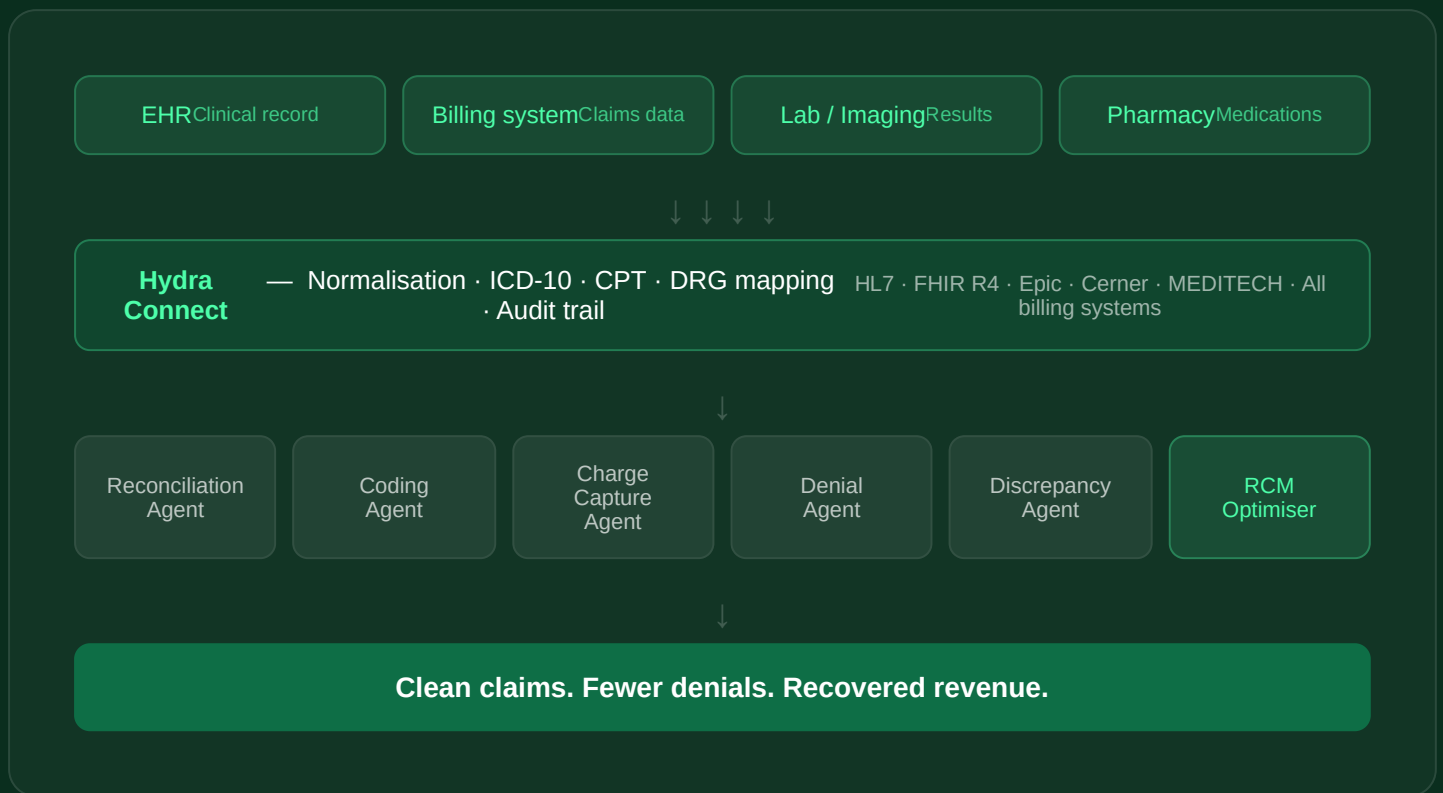
06

Revenue cycle optimisation

Continuous monitoring of the full revenue cycle pipeline — identifying bottlenecks, predicting high-risk claims, and prioritising the cases that most need human review.

WHY HYDRA MAKES IT POSSIBLE

Agents only work *on clean data.*



WHAT CHANGES

Before and after *Hydra.*

Coding *errors*

Coders reviewing 70,000+ ICD-10 codes manually under time pressure → AI coding agent validates and suggests corrections on every note before submission.

Charge *capture*

Services performed but never billed, discovered weeks later in retrospective audit → Charge capture agent flags gaps in real time, before the billing window closes.

Claim *denials*

Denials analysed after submission, reworked at \$118 per claim → Denial prediction agent identifies high-risk claims before they leave the system.

Doc *gaps*

Discrepancies between clinical notes, lab results, and discharge summaries discovered during payer audit → Discrepancy agent detects and flags documentation gaps before the claim is built.

THE PLATFORM

Six agents. *One infrastructure.*

6

REVENUE CYCLE AGENTS –
PRE-BUILT, PRODUCTION-READY

50+

SYSTEM CONNECTORS – EHR,
BILLING, LABS, PHARMACY

Real- time

DETECTION – BEFORE THE CLAIM
LEAVES THE SYSTEM

Hours

TO DEPLOY – NO UPFRONT
INVESTMENT, PAY AS YOU GO

ICD-10 · CPT · DRG · FHIR R4 · HL7 · Epic · Cerner · MEDITECH · All billing systems

WHAT IT MEANS FOR YOUR TEAM

Different roles.
Same outcome.

CFO / REVENUE CYCLE

Recover revenue.
Reduce rework.

Charge capture gaps of 3–5% of total revenue are recovered automatically. Denial rates drop because coding errors and documentation discrepancies are caught before the claim is submitted — not after. Your team spends time on complex cases, not rework.

CIO / VP OPERATIONS

No new systems.
No integration project.

Hydra connects to your existing EHR, billing system, and lab infrastructure — Epic, Cerner, MEDITECH, any billing platform. No rip-and-replace. FHIR R4 native. HIPAA-compliant. Live in hours. Your team owns the workflow, Hydra handles the data.

PAYER / INSURANCE OPS

Cleaner claims.
Fewer disputes.

Claims arrive with complete clinical documentation, correctly coded, and reconciled against the source EHR record. Discrepancies are resolved before submission — reducing the volume of denials, appeals, and audit investigations on both sides.

THE QUESTION

How much revenue is your hospital *leaving on the table this month?*

The root cause is always upstream.
Hydra catches it before it becomes a denial.

[See how it works →](#)