MDwerks, Inc.
Form 10KSB
March 27, 2008

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, DC 20549

FORM 10-KSB

(Mark One)

x **ANNUAL REPORT UNDER SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE OF 1934**

For the fiscal year ended December 31, 2007

o **TRANSITION REPORT UNDER SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE OF 1934**

For the transition period from _____ to _____

Commission file number 333-118155

MDWERKS, INC.
(Name of Small Business Issuer in Its Charter)

Delaware	**33-1095411**
(State or Other Jurisdiction of Incorporation or Organization)	(I.R.S. Employer Identification No.)

Windolph Center, Suite I
1020 N.W. 6th Street
Deerfield Beach, FL 33442
(Address of Principal Executive Offices and Zip Code)

Issuer's Telephone Number: (954) 389-8300

Securities registered under Section 12(b) of the Exchange Act: None

Securities registered under Section 12(g) of the Exchange Act: None

Check whether the issuer (1) filed all reports required to be filed by Section 13 or 15(d) of the Exchange Act during the past 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been

subject to such filing requirements for the past 90 days. Yes x No o

Check if there is no disclosure of delinquent filers in response to Item 405 of Regulation S-B is not contained in this form, and no disclosure will be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-KSB or any amendment to this Form 10-KSB. x

Revenues during the fiscal year ended December 31, 2007 were $577,251.

The aggregate market value of the issuer's common equity held by non-affiliates, as of March 24, 2008 was $4,826,584.

As of March 24, 2008, there were 12,940,065 shares of the issuer's common equity outstanding.

Documents incorporated by reference: None

Transitional Small Business Disclosure Format (*Check one*): Yes o No x

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PART I

ITEM 1. DESCRIPTION OF BUSINESS

Unless otherwise indicated, all references to ''we'', ''us'', ''our'', the ''Company'' and similar terms, as well as references to the ''Registrant'' in this Annual Report on Form 10-KSB, refer to MDwerks, Inc. (including its subsidiaries).

Description of Business

We offer a web-based comprehensive selection of electronic medical claims processing, funding and collection solutions to the healthcare provider industry. Our services can help doctors, clinics, surgical or hospital based practices, and other healthcare providers and their vendors significantly improve daily insurance claims transaction administration and management as follows:

- Increase office efficiencies and lower collection costs;
- Reduce administrative workload;
- Improve claims accuracy before submission to, and increase acceptance by, third party payers;
- Reduce payment cycle time;
- Improve cash flow management;
- Increase revenue control;
- Leverage receivables through competitive short term financing arrangements;
- Improve information management, financial security and provider regulatory compliance;
- ''End-to-end'' solution for claims management; and
- Fully automate the revenue process by the use of electronic claims and remittance advice, and payment reconciliation

MDwerks, Inc., an OTC Bulletin Board company (OTCBB:MDWK) conducts its business through four wholly owned subsidiaries of our wholly-owned subsidiary, MDwerks Global Holdings, Inc., namely: Xeni Medical Systems, Inc. (''Xeni Systems''); Xeni Medical Billing, Corp. (''Xeni Billing''); Xeni Financial Services, Corp. (Xeni Financial); and, Patient Payment Solutions, Inc. ("PPS"). Xeni Systems, Xeni Billing and Xeni Financial are the ''Xeni Companies''. PPS planned to offer healthcare providers a payment improvement process for "out of network" claims, but never became operational and is a dormant entity.

Business Services

Our CLAIMwerks™ solutions, which are offered through Xeni Systems, can provide actual contract based, insurance company comparable screening and analysis of medical claims directly from a healthcare provider's practice management system, so that deficiencies and errors can be corrected before they are submitted to insurance companies for electronic payment. Our CLAIMwerks™ solutions and services improve a healthcare provider's ability to process and manage claims for reimbursement from third party payers by consolidating the process (including clearinghouse, contract management and remittance functions). As part of CLAIMwerks™ services, we integrate transactions involving

insurance claims by providing a single interface for the healthcare provider, the payer (such as an insurance company) and the lender (when the healthcare provider elects to take advantage of receivables financing).

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Xeni Systems collects transaction fees from healthcare providers for: the analysis, automated processing, electronic submission, and reporting of claim information; management of healthcare provider contracts for pricing and rules; electronic remittance of payments; explanations of benefits (payments) ("EOB's") made available from payers; and, reconciliation and posting of the payments and EOB's. Fees may also be generated from lenders for the valuation of processed claims that are used as collateral for loans from lenders, as well as administrative tasks related to the disbursement of funds. Fees may also be collected from clearinghouses and insurance companies for submitting more accurate claims, once certain volume levels are achieved. Xeni Systems may also collect one-time implementation fees for initial set-up and training.

Although we do not currently offer asset and wealth management services, we may have the opportunity to offer asset and wealth management services through third party sources. We expect to receive referral or administrative handling fees for such services, as appropriate.

Billing Services

Our BILLwerks™ solutions provide value added billing services leveraging the Xeni Systems technology solutions and services for improved efficiencies. As part of our BILLwerks™ solutions, Xeni Billing offers collections and appeals services, as well as solutions for the collection of old existing medical claim submissions. Our BILLwerks™ solutions are designed to operate in an integrated fashion with the solutions and services offered by Xeni Systems. There are fewer manual and paper functions to be performed in the combined claims management processing/billing solutions process offered by Xeni Systems and Xeni Billing. This can reduce a healthcare provider's claims related operations even more than using the stand-alone solutions offered by Xeni Systems.

Xeni Billing typically charges providers (directly or as a subcontractor of Xeni Systems) fees as a percentage of collected claims. Xeni Billing also shares fees (as a channel associate) with Xeni Systems for supporting its claims process and information management. Additionally, Xeni Billing can collect one-time set-up fees, appeals and third party appeals work fees and any consulting fees for customization or support of the healthcare provider outside the scope of services. Finally, Xeni Billing may share in claims revenue recovered when contracted to perform reviews of unpaid claims that were submitted to payers prior to use of our automated claims submission solutions and services.

Lending Services

Our FUNDwerks™ solutions can electronically manage loans, loan repayments and the movement of funds through linked bank accounts.

Through Xeni Financial, we can offer to lend or arrange lending from third parties to healthcare providers on a short term, revolving line of credit and sometimes on a term loan basis. The loans are secured by claims receivable of the healthcare provider. Like Xeni Billing, Xeni Financial leverages the solutions and services offered by Xeni Systems to value the claims, score risk, document and track claims payment status, verify remittance of payments from insurance companies and sweep funds to the appropriate accounts with the assistance of electronic and automated processes. Xeni Financial is able to arrange loans at attractive rates and terms, since it has not had to invest significant capital to develop or make a major hardware and software purchase of a system to make loans secured by receivables. It also does not need to maintain a large workforce as it can manage many of its business processes through the solutions and services offered by Xeni Systems. Xeni Financial can lend to healthcare providers on the merit of the receivables and can even lend on Medicare claims.

Consulting Services

Although we provide Internet-based solutions that do not require our customers to purchase new hardware or software, healthcare providers can take advantage of customized and premium enhancements through our third party

associates, including enhanced billing and collection services. Consulting services are also available to enhance healthcare provider practices or business operations.

Workers' Compensation, Durable Medical Equipment and Pharmacy Claim Services

Our current products and services have been focused on improving the ability of healthcare providers to collect on commercial and government insurance claims, and to enhance their cash flow controls. We have decided to expand our current service offerings to include workers' compensation, durable medical equipment and pharmacy claims electronic processing, management, and funding.

By using our present technology we plan to offer a greatly improved electronic workers' compensation, durable medical equipment and pharmacy claims collections and remittance process to our clients in place of today's existing error ridden paper based method. Most provider practices avoid workers' compensation patients because of the time, effort, and cost associated with getting paid, thereby giving up perhaps as much as10% to 25% of their revenue. MDwerks can greatly improve the ability of healthcare providers to be paid on workers' compensation claims, and enable them to continue to provide or expand these services.

We can manage claims transactions electronically from three perspectives in connection with workers' compensation claims: the provider, the insurance company payer and the lender (when the provider elects to take advantage of our receivables financing). Our system can manage each workers' compensation claims transaction by leveraging our tools to automatically analyze claims, and record collections, appeals and funding. Since we designed our products and services to operate in a fully integrated electronic environment with provider and payer systems, there are fewer manual and paper functions to perform in the combined claims processing/billing solution, which should result in reduced errors as well as fewer payment delays and lower collection costs.

Through Xeni Billing, MDwerks can offer collections and appeals services for workers' compensation claims. This allows healthcare providers to outsource these tasks from their offices and focus resources in other areas.

Through Xeni Financial, MDwerks can offer funding to healthcare providers on a short term, revolving line of credit basis, or in some cases can purchase healthcare providers' receivables, which are secured by claims processed through the MDwerks System. Our system can also include MDwerks' tools to help lenders value claims, score risk, document and track claims payments, verify remittance and sweep funds to appropriate bank accounts with electronic and automated processes.

MDwerks can collect transaction fees for automated processing, submission, reporting and analysis of workers' compensation claims information and management of payer contracts rules and pricing. Fees can be collected for information management on processed claims that are used as collateral and for administrative tasks related to the movement of funds among bank accounts. Fees can also be collected from clearinghouses and insurance companies to which MDwerks sends cleaner claims electronically. One time fees can be charged for initial set-up and training.

Market for Our Solutions and Services

Healthcare providers face serious challenges in processing claims submitted to third party payers, as well as in getting correct and prompt payment from payers. Claims must be prepared by gathering data from the front office to the back, with processing often occurring at different times and locations for each procedure. Many healthcare providers' current billing systems require the performance of different steps by different third party sources. Claims can move among the healthcare provider's internal staff, through a practice management system and across multiple offices, to billing, editing engines, clearinghouse, contract management, banking and other resources.

The need for security and privacy of patient information requires complex data management. Claims may be processed on the payer end through out-of-network claims administrators, re-pricing organizations, third party administrators, managed care organizations, independent physician associations, and preferred provider organizations. Further, healthcare providers face continuing pressure from payers to accept lower fees on changing definitions of covered claims, with variations in customary remittance values. At the same time, payers require precise documentation and justification for covered claims.

Claims may be rejected for a variety of reasons including medical necessity, eligibility, coding errors, tardiness, deductibles, referrals, pre-certifications and improper documentation. Lack of access to basic, but important, claim information and the lack of real-time data and feedback may waste office hours and affect reimbursement. Repetitive paperwork and phone conversations dealing with disputes, errors and rejections may be typical occurrences in the provider's office. Additionally, the failure, or inability, to match claims against existing contracts, when added to these other factors, can make it extremely difficult to determine how much and when the healthcare provider will be paid.

Management of the status of claims and valuation, remittance and validation of proper payment and disbursement requires detailed real time information. If claims are not being compared to contracts in real time, and if robust tracking and auditing mechanisms are not in place, then the availability and transparency of data cannot be optimized. As a result, the healthcare provider's financial managers may only estimate results, with varying degrees of volatility, cash flow predictability and accuracy. Moreover, they may miss, ignore or abandon incorrect or partial payments.

The challenges faced in connection with claims management can result in lost revenue, volatile and unsatisfactory cash flow, inaccurate reporting, inefficient management of operations and attendant increases in office workload, expenses and costs of borrowing. In the past, healthcare providers have been required to use a patchwork of internal and third party resources to address these problems, with mixed results. For example, billing and practice management systems attempt to address the claims processing market predominantly by selling proprietary hardware and software products (and maintenance and upgrades or customization), with various degrees of success in features and benefits. They may or may not generate Health Insurance Portability and Accountability Act of 1996 (''HIPAA'') compliant electronic forms from their systems, and if they do, such forms may be mapped and formatted in different ways, leading to potential errors and problems with acceptance and payment. Ultimately, they offer tools that require office staff and/or external resources to perform critical claims management functions.

Claims-related management challenges have also greatly impacted the borrowing abilities of healthcare providers. Healthcare providers typically borrow by factoring their receivables arising out of non-Medicare insurance claims, personally guarantying a loan with their own credit, bundling large provider claims for sale to wealthy private investors or taking an expensive asset-based loan against claims receivables at a significant discount with significant required reserves. Lenders typically have not been able to offer short term, revolving credit lines on receivables arising out of insurance claims, because of the existing difficulty in qualifying them as low risk, high quality, and commoditized collateral. Lenders remain concerned about safely and accurately assessing either the true value or the payment risk associated with any given claim or group of claims. Any solution to this problem is further complicated by the lender's resistance to risking the purchase of an inadequate or expensive customized solution to serve this market.

Short term, revolving lines of credit on medical receivables require a solution that mitigates the uncertainty of quickly and accurately assessing the true market value of claims, their aging and cycle times and their inherent lending risk through a complex series of verifications and evaluations. Assessment, and the subsequent presentation of results, must be accomplished in a real time, secure environment. Cycle times for claims remittances must be short (ideally at or below 45-60 days). Additionally, the cost of administering and processing must leave net interest margins that justify the loan.

We believe our integrated suite of solutions and services are the first to market, offering healthcare providers and their lenders comprehensive, cost efficient and superior claims processing and management solutions over the Internet. Our system can become a healthcare provider's single source platform for integrating claims management and funding functions. Our solutions and services quickly improve claims accuracy, valuation and remittance success, enable outsourced payer contract management, facilitate prompt financing of claims, and produce superior cash and information management. Our technology also offers benefits to small and medium healthcare provider practices with limited resources and staff, allowing them to perform or facilitate the performance of tasks and functions previously only available to much larger practices capable of purchasing more sophisticated and expensive tools and hiring more people to use them. It also allows many financial institutions to lend to healthcare providers on qualified receivables, at risk and cost factors not previously available. With our products and services, healthcare providers of a variety of specialties and sizes have the ability to leverage an ''end-to-end'' claims management solution.

By combining automated batched and real time functionality into a proprietary ''end to end'' claims management and funding system, we believe that our solutions and services offer superior value and competitive advantages, including the following:

- Reduced Workload: Healthcare providers can reduce and/or eliminate manual, labor intensive, repetitive and inefficient administrative functions. The level of reduction depends on many factors, including the type of practice management and billing systems in use, number of staff members and their training and skills in operating existing systems, practice size and mix and contractual relationships with payers, and how paper intensive or electronic their existing process may be.

- ''Pay As You Go'': Fees charges to healthcare providers for processing insurance claims typically are fixed monthly or calculated as a percentage of each claim's contract valuation or predicted value, based on history and regional Medicare tables for reference, if, for example a healthcare provider is out-of-network. The use of our solutions and services doesn't require high up-front investment, hardware and software purchases, or payment based on the number of claims submitted or the amount of billed claims.

- Superior Cash Management: In as little as five business days or less, healthcare providers can borrow funds from us at competitive short-term rates against a determined value of each submitted claim. Healthcare providers and lenders can choose amounts or categories of claims for funding, including Medicare claims. Financial institutions have an automated risk profile and lending process available to them on a daily claim-by-claim basis, which is customized to their own lending parameters, without the necessity of building new lending tools.

- Increased Efficiency/Lower Costs: Claims that we process are ''flagged'' for potential errors as they are received, based on a combination of proprietary technology and use of the same type of rules engine as many insurance companies. Healthcare providers managing their own claims can edit flagged claims using simple prompts, so a ''cleaner'' claim can be submitted to the payer. Claim values are determined daily against actual contracts and payment tables, when available, and are adjusted for history and changes in insurance plans. Healthcare providers can know almost exactly how much they will get paid on claims. Also, multiple healthcare provider locations can be connected to capture information earlier and more accurately.

- Superior Information Management: Healthcare providers have access to daily reports on claims status, their expected (not just billed) value, and tools for tracking, auditing and confirming claims remittance, verification and payment. This means they can spend less time trying to determine what is owed and by whom and more time taking action to collect what is owed.

· Web-based, User Friendly Technology: The solutions and services that we offer can be accessed over the Internet using standard Microsoft Explorer software (or most other browser software) on standard Windows desktop hardware and software. The systems are designed to be used ‘‘off the shelf’’ with no need to purchase hardware or software, and are designed to support large numbers of users. They also can be easily expanded to accommodate future growth.

· Integrated Functions: Healthcare providers can integrate and consolidate, through a single source, multiple claims processing and management functions within their offices, across multiple offices and across third party vendors, including insurance companies, banks and clearinghouses.

We believe that the technology that we deploy offers the following competitive advantages:

- First In Marketplace: We believe we are one of the first application service providers to offer a fully electronic comprehensive bundled service that provides web-based insurance claims management, billing services and lending services (for both borrowers and lenders). This creates a unique, cost effective advantage in capturing clients and developing brand loyalty.

· Barriers to Entry: We believe potential competitors face significant barriers to duplicating what we have to offer, including the following:

Process: Aggregating and integrating healthcare providers, insurance companies and financial institutions in a legally compliant manner requires a very complex business process.

Cost to Develop: Matching features and benefits of our systems would require substantial investment and substantial time and technical resources.

Extensive/Proprietary Feature Set: We offer an extensive and unique feature set.

Complex to Build: The solutions and services that we offer were developed as a multi-tiered high availability solution, requiring substantial software engineering expertise. Solutions were derived from expertise in insurance, banking, medical, legal and other industries, requiring more than just technical production.

Extensive Compliance Issues: We operate amidst a highly regulated environment. For example, we must operate in accordance with HIPAA, the Financial Holding Company Act and the Gramm Leach Bliley Act. Requirements for handling patient information and claims securely are complex and may serve as a major development challenge to some competitors. Furthermore, we must operate in accordance with state regulations regarding fee-splitting with medical professionals.

· Features Appeal to Lenders: Our solutions and services appeal to lenders, because lenders do not have to negotiate to purchase receivables, acquire a system to process claims for financing or buy hardware and software from us. At the same time, asset based loan assessments can be performed against actual claims value and status on a daily basis, potentially increasing the value and collateral associated with a loan and reducing risk.

· Contract management is critical to maximizing reimbursement. Complying with terms for getting paid on a claim, accurately valuing the claim and monitoring pricing for each contract creates more reliable receivables and more desirable collateral to secure desired loans.

· Superior Claims Engine: We aggregate the insurance carrier network through the use of a combination of third party and proprietary claims engine functions. This enables healthcare providers to have access to all available insurance carriers for electronic claims handling through a single solution.

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·Module Independence: Many components of our solutions and services can be utilized independently of each other, making different technologies rapidly available, and allowing us to adapt quickly to new client requests.

Industry Analysis

Industry Size:

Healthcare has been called the single largest U.S. industry. According to the Centers for Medicare and Medicaid Services (CMS), it is expected to reach **$3.0 trillion plus** over the next three years. The National healthcare expenditure projections are produced annually by the Office of the Actuary at the CMS. They are based on historical national health expenditures and a model framework that incorporates actuarial, econometric and judgmental factors. National health expenditures are forecast to reach ***$3.3 trillion by 2012***, growing at a mean annual rate of 7.3%. During this period, health spending is expected to grow 2.5% per year faster than nominal gross domestic product (GDP), so that by 2012 it will constitute approximately 18.8% of GDP compared to its 2000 level of 13.8%.

The general term "Healthcare" encompasses a multitude of products and services. **In 2007, CMS forecasted *$2.33 trillion in health expenditures,*** expected to be distributed by type of expenditure as follows:

The source of payment for 2007 expenditures was distributed as follows (source: CMS): *Private health insurance: $806.2 billion*, Federal: $789.5 billion, out-of-pocket payments: $261.9 billion, state and local: $299.2 billion, and other private funds: $169.0 billion.

Market Needs

Technology has provided increased efficiency, especially in the delivery of healthcare. However, one of the most troubled areas is the medical claims billing, processing, and payment area. This segment continues to suffer errors and inefficiencies, as well as large amounts of paper transactions and piecemeal solutions, leaving a significant claims management burden in the provider’s back office.

Claims processing is a chief contributor, since the vast majority of claim transactions require a large amount of manual intervention. Healthcare is unlike many other businesses in that the value of the service is determined retrospectively. This negative aspect of the business becomes more evident and pronounced when coupled with Workers Compensation and Personal Injury medical services, which have additional administrative hurdles to overcome to receive payment. These facts, combined with a paper and manual work dependent system, result in significant inefficiencies in the claims filing, payment and reconciliation process. Our system can greatly reduce these inefficiencies by automating and replacing many manual labor intensive paper-ridden processes with fully electronic processes, which increase the information available to manage and collect outstanding claims. Medical claims processed in the United States escalated from just 5 billion in 1990 to more than 10 billion at the turn of the 21st century and this figure has been steadily increasing. According to the AMA, the average number of claims generated per doctor is 440 claims per month.

Payers realize the importance of moving claim transactions to electronic media through the Internet. From the payers' perspective, administrative costs could be substantially lowered if claims were submitted electronically and were accurate enough to be adjudicated by a computer system without any requirement for manual intervention and/or resubmission. Payers could also save administrative costs by implementing electronic payment systems, including electronic explanation of payments.

HIPAA requires payers to move to electronic claim transactions and establish format standards. Although payers continue to make significant technology investments to comply, as well as for their own e-commerce objectives, providers are behind in technical expertise and system resources necessary to effect change, and are burdened with paying for systems and processes to become compliant. As HIPAA compliance is now enforceable by fines, the pressure for secure and compliant solutions has become greater than ever.

HIPAA has compelled health plans, clearing houses and other healthcare providers to move to a uniform electronic format. Specifically, HIPAA requires standard electronic formats for the following transactions:

- Healthcare claims or equivalent encounter information;
- Healthcare payment and remittance advice;
- Coordination of benefits when separate plans have differing payment responsibilities;
- Health claims status when providers inquire about claims they have submitted;
- Plan enrollment and dis-enrollment;
- Health plan eligibility;