

*The Case for Pursuing*  
**Overpayment Recovery and  
Underpayment Remediation**

A Guide for Plan Sponsors and Trustees  
of ERISA - Regulated Health & Welfare Plans

*Includes the results of our survey of companies that offer  
Payment-Error Remediation services to self-funded plans*



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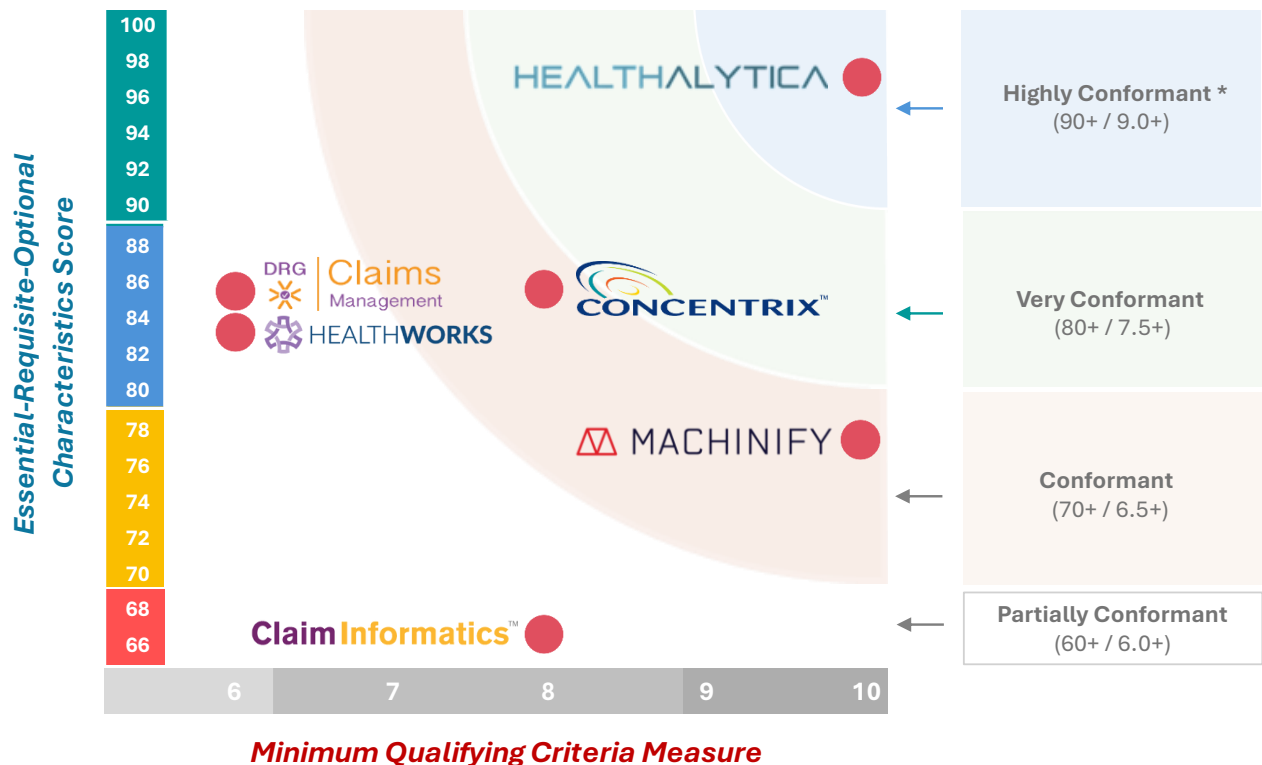
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*This report was originally commissioned by a law firm that advises labor union and multi-employer health and welfare funds that sponsor ERISA health plans. Whereas its original scope was limited to identifying vendors of payment error remediation services, realizing that its contents would be of interest and value to health plan overseers and their professional advisors, it was greatly expanded to be more informative.*

## Executive Summary

The purpose of this **TPA NETWORK Research Consortium Report** is to inform ERISA health plan sponsors and trustees about why it is vital to address provider errors—meaning recovering provider overpayments and correcting underpayments. The report also offers advice for choosing a vendor specializing in these services. Below is a summary of the report and our survey results on these vendors.

- Health plans constitute one of the largest unaudited operating expenses for many organizations.
  - Despite advanced claim processing technologies and sophisticated administration, errors in health plan claim payments are inevitable due to several unavoidable factors.
  - Such errors can result from both inadvertent and intentional provider mistakes, payer business decisions, and network-imposed limitations on pre-processing claim adjustments.
  - The majority of these discrepancies cannot be identified or resolved prior to payment by the payer.
  - Provider overpayments result in the misuse of plan assets, increasing plan and participant costs; and provider underpayments result in plan participants being overcharged at the expense of the plan.
  - Administrators of self-funded health plans bear a fiduciary responsibility under ERISA to protect plan assets, which includes proactively pursuing and recovering any overpayments. Equally critical is the fiduciary obligation to ensure that providers are not undercompensated to the detriment of plan participants. Any breach of these duties — such as imprudent management of plan assets or allowing participant overcharging — subjects plan sponsors and trustees to unnecessary risks and liabilities.
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- Specialty vendors provide payment-error remediation services to help plans fulfil ERISA overpayment recovery and underpayment correction requirements.
  - We surveyed these vendors, evaluating them on service scope, usability, and ERISA compliance.
  - Only six service vendors met our **Minimum Qualifying Criteria** and scored above 65 out of 100 on the **Essential-Requsite-Optional Characteristics** scale, to become finalists. The results of our survey are graphically presented below (with considerably more detail contained within).



## I. Sources of Payment Errors

This section aims to provide the reader with background information regarding the causes of healthcare provider payment errors and why they present significant challenges to pre-payment prevention efforts.

### A. Unavoidable Errors that Impact All Payers

Payers face many payment challenges that can pose a real threat to the financial viability of their health plans over time ... including *overpayments* for healthcare services, and the cost of avoiding and correcting them ... and *underpayments*, which result in plan participants shouldering costs that are rightly those of the plan. To address these challenges, the \$15 billion “payment integrity” industry emerged.

*Payment Integrity* describes the many practices employed to ensure that claim payments are accurate, proper and fraud free; eliminating and mitigating errors that emanate from many sources, which include:

- medical records and EHRs that are incorrect, inaccurate or outdated,
- provider and billing system generated errors,
- incorrect eligibility information,
- misrepresentations by patients and providers,
- coding-related errors and schemes (e.g., upcoding, unbundling),
- erroneous application of plan participant deductibles, co-pays and coinsurance,
- incorrect discounting by provider networks,
- regulatory changes that result in time-related errors,
- medical guideline changes that result in time-related errors, and
- claim intake and claims adjudication decisions.

These inevitable errors in provider payment cannot be resolved prior to payment. Further, payers must address these challenges amid the inherent complexities of claims processing, constraints posed by siloed data and outdated legacy claim systems, compliance with prompt pay regulations and other factors.

### B. Payer and Network Created Challenges

Payers and networks create other challenges that result in avoidable payment errors, including these:

- *Unintended consequences of claims auto-adjudication:* In an effort to enhance claim processing efficiency and reduce staffing requirements, payers increasingly implement technology that automates adjudication for more than 70% of submitted claims. While this approach expedites processing, decreases manual errors, and reduces administrative costs, it may also allow certain claims to bypass standard edits and analyses, potentially resulting in payment inaccuracies.
- *Unavailability of claims data:* Some payers are reluctant to provide the claims data needed to identify payment errors, creating a direct conflict with the plan’s legitimate duty to remediate them.
- *Limitations made by provider networks:* Some provider networks limit the ability of payers to make valid claim corrections, edits, modifications, etc. prior to payment ... resulting in payment errors.
- *Constraints in the payment-error remediation process:* Some payer/network contracts contain restrict how payment-error remediation can be performed (e.g., limiting the number of claims or providers audited, permitting only annual audits, requiring the TPA to re-work the claim to reflect any changes, insisting on being involved in the remediation process) ... hindering resolution efforts.

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The inherent and process-related payment challenges outlined above greatly hinder plans from achieving accurate provider payments the post-payment pursuit and remediation of the provider overpayments and underpayments that result — particularly in light of available contingent, no-risk fee arrangements.

## II. Payment-Error Remediation: *The Last Line of Defense*

While payer claim processing systems perform hundreds of payment and coding checks to catch errors before adjudication and payment, achieving 100% pre-payment accuracy remains an ideal, not a reality.

As a result, even the most advanced payers use several post-payment remediation processes to address cases where payment mistakes were not detected and corrected before the payment was made. These include:

- *Clinical reviews and audits* of complex, high-dollar and unusual claims to validate medical necessity, assess care appropriateness, justify treatment reviews, avoid excess expense, etc.,
- *Compliance reviews* to ensure adherence to contractual agreements, payment policies, etc.,
- *Coordination-of-benefits reviews* to resolve issues related to participants' primary coverage,
- *Subrogation reviews* to identify at-fault-parties (re: accidents, negligence claims, etc.), and
- *Fraud, waste and abuse reviews* to identify and defeat illegal, for-profit claim schemes.

Collectively, these activities represent the standard scope of post-payment *recovery* strategies employed by most payers, utilizing either internal or external resources. It is important to note, however, that none of these post-payment processes and initiatives address *provider underpayment correction*.

We differentiate these targeted processes from those used by specialty service vendors whose focus is on identifying and rectifying the limited range of *incorrectly priced* payments discussed in Sections 1 above. We call this payment integrity sub-category “payment-error remediation” ... which we define as:

"Human and electronic post-payment retrospective billing analysis employed to identify and validate incorrectly under- and over-priced claims — including data-driven claim reviews that employ advanced analytics to identify one-off and systemic claim errors — and associated efforts taken to both recover incorrectly spent plan assets and remediate provider underpayments".

This solution works for all medical claims — regardless of type, origin or amount — to identify and remediate individual and systemic payment errors, which can be mitigated with root-cause analysis.

Intrinsic conflicts between payers, networks, the plan and participants introduce additional complexity:

*Payer Conflicts:* Payers face challenges because some payment-error remediation efforts may upset providers, (with whom they strive to contract and keep happy). Further, these actions can be wrongly perceived as evidence of “incorrectly processed” claims and may reflect poorly on payer competence.

*Provider Network Conflicts:* Most networks avoid pursuing payment-error corrections or action against the providers they worked hard to recruit and retain; instead, they set coding standards and payment guidelines for payers. Conflicted, they cannot act in the plan participant’s exclusive best interest.

In summary, *unavoidable* and *process-related* payment errors, coupled with intrinsic *payer and provider network conflicts*, make payment-error remediation the last line of defense to ensure proper payment.

Because paid claims fall outside of the claims lifecycle, correcting payment errors does not require involving either the payer or the provider network, as these errors are not claim processing related. However, niche-specific infrastructure and skilled experts are needed to carry out the complex analysis required to identify, validate and pursue remediation of payment errors, and to do so without conflict.

Because of this, specialty payment integrity vendors have emerged in recent years, concentrating on this type of error correction. These companies generally work independently, without direct interaction with payers or networks. They offer valuable services to plan overseers who do not want to disrupt the operation of their plan, create provider or participant abrasion, or suffer the impact of payment error.

### III. Regulatory Compliance Liability: Meeting ERISA’s Fiduciary Responsibility

Until now, there has been no need to differentiate between “payers” (such as health insurers, MCOs, ACOs) and self-funded health plans since the focus has been solely on payment-error remediation. However, since payers are regulated by states and self-funded plans fall under federal regulation, it is important to clarify this distinction as it relates to performing payment-error remediation in compliance with ERISA’s requirements. In part, this is because contributions from plan sponsors and participants become “plan assets,” which are governed by specific fiduciary duties under ERISA. The details of these duties — who they apply to and how they relate to payment-error remediation — are explained below.

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#### A. The adverse effects of provider overpayment and underpayment

Overpayments made to providers have consequences for the plan, trustees and participants as they inflate healthcare costs and increase expenses for plan sponsors and participants alike. As such, recovery must be pursued. This requires using plan assets to fund the cost of recovery and taking necessary care to ensure that recovery is handled carefully so as to avoid provider abrasion that could impact access to care.

Provider underpayments can lead to repercussions that are not immediately apparent. Most plans require participants to contribute toward plan costs — typically with deductibles, co-payments or coinsurance — as a way to discourage unnecessary utilization. However, due to factors such as incorrect claim system set-up, these cost-sharing requirements may be misapplied, resulting in provider underpayments. The following examples illustrate how these underpayments can affect both the plan and its participants:

- A plan requires a \$25 copay for primary care office visits and a \$75 copay for specialist visits. If a plan participant visits a PCP and the larger \$75 copay is mistakenly applied, the result is that the plan underpaid the provider by \$50 and simultaneously *overcharged the plan participant by \$50*.
- If a plan has a 20% coinsurance requirement for in-network services, and a 50% requirement for non-network services, and the wrong rate is applied to a \$2,000 service, the plan underpaid the provider by \$600 at the expense of the participant, who would be *overcharged by \$600*.

Provider underpayments are common and can accumulate significantly *over time*, particularly when systemic underpayments are left unaddressed. Payment shortfalls can also delay or restrict provider access, negatively affecting care delivery and outcomes. For these reasons, they cannot be ignored.

Lastly, while courts have ruled that provider contracts directly related to the provision of ERISA benefits can activate ERISA’s broad preemption clause, *underpaid* providers can sue a plan in state court and bypass a plan’s appeal process as ERISA does not preempt state law re: “rate of payment” like it does the “right to payment” ... since benefits have been approved and the dispute is only about the amount due.

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Fiduciary” is a legal term that applies to a situation in which a person or entity (the *beneficiary*) places confidence and trust in another person or entity (the *fiduciary*), re: the former seeking advice or assistance from the latter in some way. Holding a special position of legal responsibility, fiduciaries are held to the highest standard of conduct and expected to act in the beneficiary’s exclusive best interest, not their own.

A fiduciary’s duties correspond to the type of beneficiary served and their relationship, e.g., attorney/client, guardian/ward, trustee/beneficiary. Generally, fiduciary duties include a duty of care, loyalty, good faith, confidentiality, prudence, and disclosure. In relation to ERISA, it is important to distinguish between “acting as a fiduciary” and serving as the plan’s Fiduciary (with a capital “F”). The latter, defined in ERISA Section 3(21)(A), refers to individuals tasked with making decisions on behalf of the plan and managing or controlling plan assets. Conversely, under ERISA, a fiduciary (lowercase “f”) includes any individual who exercises authority or control over plan assets, or who possesses discretionary authority in the management or administration of a plan. This distinction is important as it underscores the fact that an individual does not require a fiduciary “title” to be considered a fiduciary under ERISA (Section III).

As a practical matter, to determine who qualifies as an ERISA fiduciary it is important to distinguish between ERISA's two main types of health plan activities: "settlor acts" and "fiduciary acts." Settlor acts are ministerial in nature and do not require control or management of plan assets (i.e., selecting the type of plan for employees, drafting or amending plan documents, deciding on contributions, or ending a plan). These actions are not treated as fiduciary acts under ERISA. However, a person who has discretionary authority over a plan's administration, management or assets will be deemed to be a fiduciary under ERISA.

Understanding the above, under ERISA, all fiduciaries have a legal obligation to:

- act in the exclusive best interests of plan participants/beneficiaries (the duty of loyalty),
- ensure wise, informed management and oversight of plan assets and operations,
- follow all plan document provisions (unless inconsistent with ERISA),
- employ prudent decision-making in the selection of service vendors to the plan,
- monitor plan service vendors with respect to payment errors, violations and compliance failures,
- ensure that all plan fees are reasonable and that all fees and expenses are disclosed,
- make certain that all plan terms and contracted provider payment rates are enforced,
- engage in independent oversight to avoid conflicts-of-interest in plan decision-making,
- take all appropriate measures to ensure plan and participant data is kept private and secure, and
- identify leakage and waste re: claim, fee and expense payments, contribution collections, etc.

ERISA clearly requires plan fiduciaries to take specific measures not only to protect plan assets but to also remedy operational failures (e.g., provider-error remediation). Because payment errors are common — and payer and network imposed limits on editing and remediation increase the incidence of these errors — it is not only reasonable, but necessary, for plans to periodically audit and correct payment mistakes.

Beyond protecting plan assets, ERISA-regulated plans must also remediate provider underpayments under ERISA's duty of loyalty provisions, which are unambiguous and uncompromising: fiduciaries must act solely in the interest of plan beneficiaries and for the exclusive purpose of providing benefits and defraying reasonable plan costs, acting impartially toward all plan participants. While pursuing provider overpayments helps to satisfy a fiduciary's duty to preserve plan assets, it does not fulfill their broader obligation to loyalty to plan participants. *Ignoring provider underpayment is inconsistent with the "prudent expert" level of care, diligence and judgment required by ERISA.* Indeed, pursuing the recovery of provider overpayments while ignoring provider underpayments favors plan sponsors to the detriment, and at the expense of, plan participants. Being one-sided could also be construed to signal a conflict of interest

Fiduciaries are responsible for ensuring that all payments are processed accurately, addressing both underpayments and overpayments appropriately. Focusing solely on overpayment recovery overlooks the reality that provider underpayments can unfairly transfer financial responsibility to plan participants, rather than the plan itself. Plan overseers must recognize their ERISA fiduciary obligations to act solely in the interest of plan beneficiaries and take provider underpayment as seriously as provider overpayment.


Further, health plan sponsors and trustees (as fiduciaries) unnecessarily assume considerable risk by mistakenly believing that can "contract away" own fiduciary status by outsourcing claims administration and other plan functions to third parties: they cannot. To this point, several high-profile class action lawsuits are moving through the courts alleging that plan fiduciaries imprudently selected their service provider (e.g., PBM, TPA), failed to negotiate competitive pricing, did not monitor vendor performance and compensation, etc., thereby resulting in plan participants having to pay more in premiums and out-of-pocket costs. These cases raise potential legal risks for ERISA fiduciaries, and plan service vendors.

## B. Are payment-error remediation service vendors fiduciaries under ERISA?

Fiduciary responsibility is not optional. Under ERISA, anyone who has discretionary control over a plan's administration, management or assets is a fiduciary. The key issue is whether payment-error remediation vendors have this authority over plan assets. So far, based on case law, courts have determined that payers, TPAs, brokers, benefits consultants and similar groups are fiduciaries if they exercise authority over plan assets. Indeed, recent 2024/25 legal cases aim to expand fiduciary responsibility, making TPAs liable for actions that harm plan assets, even if their contracts include clauses meant to limit their accountability.

- In *Tiara Yachts, Inc. v. Blue Cross Blue Shield of Michigan*, the plaintiff engaged BCBSM to administer its self-funded health plan and alleged that BCBSM systematically overpaid certain, subsequently profiting from these overpayments by clawing them back and retaining 30% of the recovery as a fee via a shared savings program. The court determined that the payer's control over the claims-processing apparatus, and its discretion over plan assets (re: its ability to improperly pay providers and then profit from the overpayments) established fiduciary status, rejecting claims that contract provisions shielded BCBSM.
- In *W.W. Grainger Inc. v. Aetna Life Insurance Co.*, Grainger claims that Aetna improperly handled its self-funded health plan by approving false and excessive claims, paying providers less than what it charged Grainger, and keeping the difference. Grainger argues this exceeded its ministerial decision-making authority and amounted to discretionary control over the plan's assets, making Aetna a functional fiduciary. Additionally, Grainger alleges that Aetna engaged in "active deception to conceal its breaches of its duties to the plan" by "limiting audit rights ... and preventing Grainger from obtaining or accessing data about the actual financial transactions between Aetna and the health care providers."

Under ERISA, TPAs who control and profit from plan assets are fiduciaries. By extension, payment-error remediation service vendors are also seen as fiduciaries because they exercise discretion over plan assets and make decisions about which to pursue, which not to pursue (e.g., remediation costs exceed the remediated amount) and how much to pursue (e.g., settling for less). Ergo, payment-error remediation vendors exercise discretionary "signature authority" re: plan assets as they can sign off on the remediated amount. When vendors profit from plan assets, there is a risk of conflicts of interest or partiality, given their fees depend directly on what they recoup. This leads many to argue that payment-error remediation vendors must be treated as ERISA fiduciaries. Since fiduciary duties cannot be transferred, plan overseers should require every service vendor to explicitly acknowledge their fiduciary status and agree to meet ERISA's standard of care in their service agreements, especially in that all individuals that make fiduciary decisions for the plan share co-liability with the plan sponsor and trustees.



December 11, 2025

To: Fortune 500 Companies  
From: State Financial Officers  
Subject: Companies Should Analyze Healthcare Spend to Protect Shareholder Value

We, the undersigned state financial officers, act as fiduciaries for public investment funds that hold shares in your company. We write to request that you undertake a detailed payment-integrity analysis of your healthcare spending in order to control costs, mitigate risk, and protect shareholder value.

President Trump is advancing reforms to finally bring the free market to the healthcare industry. Thanks to President Trump's push for "radical price transparency" in healthcare, employers will have access to actual healthcare prices and the underlying claims data for insurers. This empowers your company to negotiate better rates, ensure appropriate costs are paid, and capture material savings, helping to avoid what the President has identified as "inflated healthcare costs."<sup>1</sup>

Healthcare spending in the U.S. is clearly material, as it reached nearly \$5 trillion in 2023, constituting 17.6% of GDP,<sup>2</sup> with employer spending comprising approximately \$1.3 trillion in 2024.<sup>3</sup> President Trump has cited a 2024 report that "suggested healthcare price transparency could help employers reduce healthcare costs by 21 percent across 500 common healthcare services."<sup>4</sup> President Trump's orders on these topics were some of the first he issued in his second term, and built on orders he issued in his first term,<sup>5</sup> underscoring the issue's importance to the President and the American people.

Using this newly available data aligns with your fiduciary duties. Healthcare overcharging in the United States erodes shareholder value by driving up costs for employers (and employees' patients).<sup>6</sup> As shareholders, we write to encourage you to take advantage of these initiatives by comparing pricing data with your claims data to identify potential savings. Such a payment integrity analysis<sup>7</sup> could include categories of information about healthcare vendors that the Department of Labor (DOL) directs employers to consider and monitor as fiduciaries.<sup>8</sup>

In summary, failing to remediate payment errors allows improper (and often systemic) payments to go undetected and unaddressed. This amounts to a failure of fiduciaries to fulfill their ERISA duties to prudently manage and protect plan assets and be loyal to participants.

In a rare December 11, 2025 [letter](#) — entitled "Companies Should Analyze Healthcare Spend to Protect Shareholder Value" — several state financial officers urged [Fortune 500](#) firms to "undertake a detailed payment-integrity analysis of your healthcare spending in order to control costs, mitigate risk, and protect shareholder value" noting that 835/837 claim data "can also be used to evaluate performance based on actual charges and payments", boldly asserting that "self-analyzing audits" done by payers "are often insufficient because those vendors: (1) have conflicts of interest in exposing practices that may reduce their profitability; and (2) may review only a small sample of claims".

#### IV. Selecting a Vendor of Payment-Error Remediation Services

To help ERISA health plans with the selection of a payment-error remediation service vendor we developed a method by which to identify, evaluate, score and rank vendors. In doing so we focused on issues of concern to ERISA plan overseers prioritizing minimal disruption and alignment with ERISA oversight duties.

Key criteria include the vendor’s capacity to perform payment-error remediation services in a manner that meets the needs of ERISA-regulated self-funded health plans; their posture and approach to remediation; and operational factors that could impact claim processing, require payer or network involvement, etc. (recognizing that other analysts may prioritize and value service vendor qualifications differently).

Below is an overview of the selection criteria employed, and the weighing assigned to each item.

<b>Service Definition</b>	1	Offers Payment-Error Remediation Services	✓	<i>Minimum Qualifying Criteria</i> distinguish vendors of payment-error remediation services from other payment integrity vendors and ensure that all fully satisfy essential service requirements (e.g., addressing under- and overpayments). Only vendors that satisfied these criteria were considered. See page 15 for details.
	2	Services Available on Stand-Alone Basis	✓	
	3	Overpayments are Collected by Vendor	✓	
	4	Assumes 2nd/3rd Pass Non-Exclusive Position	✓	
	5	Services Small Self-Funded Health Plans	✓	
<b>Disqualifying</b>	6	Remediates Underpayment with 835/837 Info	✓	
	7	Operates in Cyber-Secured Environment	✓	
	8	No Carrier or Network Provider Restrictions	✓	
	9	No Carrier or Network Involvement Required	✓	
	10	Independent, Unbiased and Neutral Vendor	✓	
<b>Essential &amp; Requisite Characteristics</b>	11	Will Be an Unqualified ERISA Plan Fiduciary	15	The <i>Essential and Requisite Service Characteristics</i> ensure payment-error remediation occurs without delaying or affecting payer claim processing, or requiring payer or network involvement, all while supporting ERISA compliance. Failure to satisfy the majority of these requisites would likely be disqualifying.
	12	No Claim Processing Interference or Delay	10	
	13	No Electronic Payer Interface Necessary	10	
	14	Only 835 and 837 EDI Claim Feeds Required	8	
	15	Obtains Provider Sign-Off on All Recoveries	8	
	16	Error Root Cause Identification Report	8	
	17	Provider Notification re: Participant Refund	8	
	18	No-Risk Contingency Fee Payment Basis	6	
	19	No Material Set-Up or Implementation Fee	6	
	20	No Excessive Minimum Monthly Claim Volume	6	
<b>Options</b>	21	Offers Optional Per Recovery Fee Cap	5	Recognition of <i>Optional</i> services such as preferred payment arrangements.
	22	Hybrid Payment Option (e.g., PEPM, Flat Fee)	4	
	23	Ongoing Monthly Monitoring Option	3	
	24	In-house Clinical Review Option	3	
	25	Negative / Disqualifying Characteristic		Penalty for a major service shortcoming
			100	

Vendors were evaluated using a 100-point scale. Vendors that fully satisfied the criteria received a "Yes" designation and were awarded the full score, while those failing to meet the requirements were marked as "No" and received zero points. To ensure fairness for vendors indicating flexibility or a willingness to accommodate, a "Y/N" was assigned and 50% of the total points were granted.

Below is a more detailed explanation of the evaluation criteria, including precise definitions for each.

Minimum Qualifying Criteria	Service Definition	1	Offers Payment-Error Remediation Services	Vendor performs payment-error remediation services (as defined herein) for healthcare payers as part of its standard service offering
		2	Services Available on Stand-Alone Basis	Vendor offers payment-error remediation services on a stand-alone basis, not only as a part of an integrated payment integrity solution
		3	Overpayments are Collected by Vendor	Vendor actually collects all overpayments from providers vs. relying on payer to pursue collection or credit balance resolution services
		4	Assumes 2nd/3rd Pass Non-Exclusive Position	Vendor will perform its services on a 2 <sup>nd</sup> - or 3rd-pass basis (after other vendors and/or technologies) and on a non-exclusive basis
		5	Services Small Self-Funded Health Plans	Vendor has experience performing payment-error remediation services for small, ERISA-regulated self-funded health plans
	Disqualifying	6	Remediates Underpayments with 835/837 Info	Vendor performs provider underpayment remediation with only 835/837 info and reports results to plan sponsor and/or provider
		7	Operates in Cyber-Secured Environment	Vendor performs its service in a cyber-secured environment
		8	No Carrier or Network Provider Restrictions	Vendor is not restricted by any carrier or network requirement or contract that limits its ability to pursue recovery from any provider
		9	No Carrier or Network Involvement Required	Vendor does not require payer or network involvement to effectively perform its services (e.g., no post-recovery claim reprocessing)
		10	Independent, Unbiased and Neutral Vendor	Vendor is an independent, unbiased and neutral service provider that is not owned, controlled or limited by its owner or affiliates
Essential -Requisite -Optional Characteristics	Essential & Requisite Characteristics	11	Will Be an Unqualified ERISA Plan Fiduciary	Vendor will “sign-on” and assume the full responsibilities / duties of an ERISA health plan fiduciary without limitation / qualification
		12	No Claim Processing Interference or Delay	Vendor’s service does not interfere with payer’s claim processing workflow or require payer to delay claim adjudication or payment
		13	No Electronic Payer Interface Necessary	Vendor does not require the creation of a direct electronic interface with the payer’s claims processing system to perform its services
		14	Only 835 and 837 EDI Claim Feeds Required	Vendor fully performs its services with only 835 / 837 EDI claim feeds (e.g., no provider contracts, eligibility data, claim history, etc.)
		15	Obtains Provider Sign-Off on All Recoveries	Vendor obtains a written sign-off from the provider on <i>all</i> recoveries
		16	Error Root Cause Identification Report	Vendor issues a report that identifies the root causes of each overpayment to mitigate waste of future plan assets on overpayments
		17	Provider Notification re: Participant Refund	Vendor identifies / calculates amounts overpaid by plan participant and sends a refund request to provider on participant’s behalf
		18	No-Risk Contingency Fee Payment Basis	Vendor offers traditional no-risk contingency fee payment option
		19	No Material Set-Up or Implementation Fee	Vendor offers services with no material implementation / set-up fee
		20	No Excessive Minimum Monthly Claim Volume	Vendor offers services with no minimum monthly claim or recovery volume requirement that would essentially exclude small plans
	Options	21	Offers Optional Per Recovery Fee Cap	Vendor offers the option to place a dollar cap on each recovery to be compliant with ERISA’s reasonable compensation requirement
		22	Hybrid Payment Option (e.g., PEPM, Flat Fee)	Vendor offers hybrid payment options (e.g., PEPM + success fee, flat PEPM) for plans seeing this as more ERISA-compliant
		23	Ongoing Monthly Monitoring Option	Vendor offers an ongoing monthly claim payment monitoring option
		24	In-house Clinical Review Option	Vendor offers optional in-house clinical review for certain cases
		25	Negative / Disqualifying Characteristic	Vendor’s service offering has one or more unsurmountable negative requirements / limitations (not addressed here) that is disqualifying

## V. Payment-Error Remediation Service Vendor *Survey Methodology*

Drawing on information obtained from seven research organizations and our own research, we identified 110 payment integrity vendors serving payers, with six having merged.

With the purpose of assess whether vendors fulfilled the *Minimum Qualifying Criteria*, we performed a comprehensive website review and conducted an internet search. This process allowed us to identify dozens of vendors that did not meet the established criteria. Subsequently, we administered a 16-question survey to the remaining vendors (see Appendix 3). The vast majority provided thorough and accurate responses; when clarification was required, we followed up via email, telephone, or Zoom.

Drawing upon the findings of this research, we have identified several key observations:

- Many payment integrity vendors include payment-error remediation in their offerings, but only a few provide this as a stand-alone service separate from an integrated pre- or post-payment solution.
- Many payment-error remediation vendors offer data, software or support solutions ...not a service.
- Many payment-error remediation vendors do not actually remediate errors (e.g., they perform credit balance reconciliations, provide data to support payer collection/remediation teams, etc.).
- Other vendors that met the *Minimum Qualifying Criteria* were excluded from consideration because they serve only large government or commercial payers, not self-funded ERISA-regulated plans.

Accordingly, we excluded 97 vendors from consideration. Details regarding the reasons for each exclusion are provided below. While the primary reason for a vendor’s exclusion is noted, it may not have been the sole factor as many excluded service vendors did not meet two or more of the *Minimum Qualifying Criteria*.

<b><i>Payment Integrity Service Vendors that were Excluded from Consideration</i></b>
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**Technology Solution**

Vendor offers a technology (support) solution not a service	33
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**Miscellaneous & Other**

Vendor supports payment integrity or overpayment recovery services in a very limited form, but does not offer a complete solution as defined herein (e.g., PBM, clinical or eligibility audits; EHR, data or other service provider)	16
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**Audits, No Recovery**

Vendor audits for improper payments, but does not recover overpayments	15
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**Doesn't Service Small Plans**

Vendor focuses on large payers and does not service small health plans	11
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**No Underpayment Remediation**

Vendor does not perform underpayment remedication services	8
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**Consulting Services Only**

Vendor provides consulting rather than overpayment recovery services	6
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**Plan Administration Platform**

Vendor is a plan administration platform that facilitates various payment integrity / overpayment recovery services on its platform, for its clients only	4
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**Pre-Payment or Subrogation Only**

Vendor's offering is limited to only pre-payment or subrogation services	4
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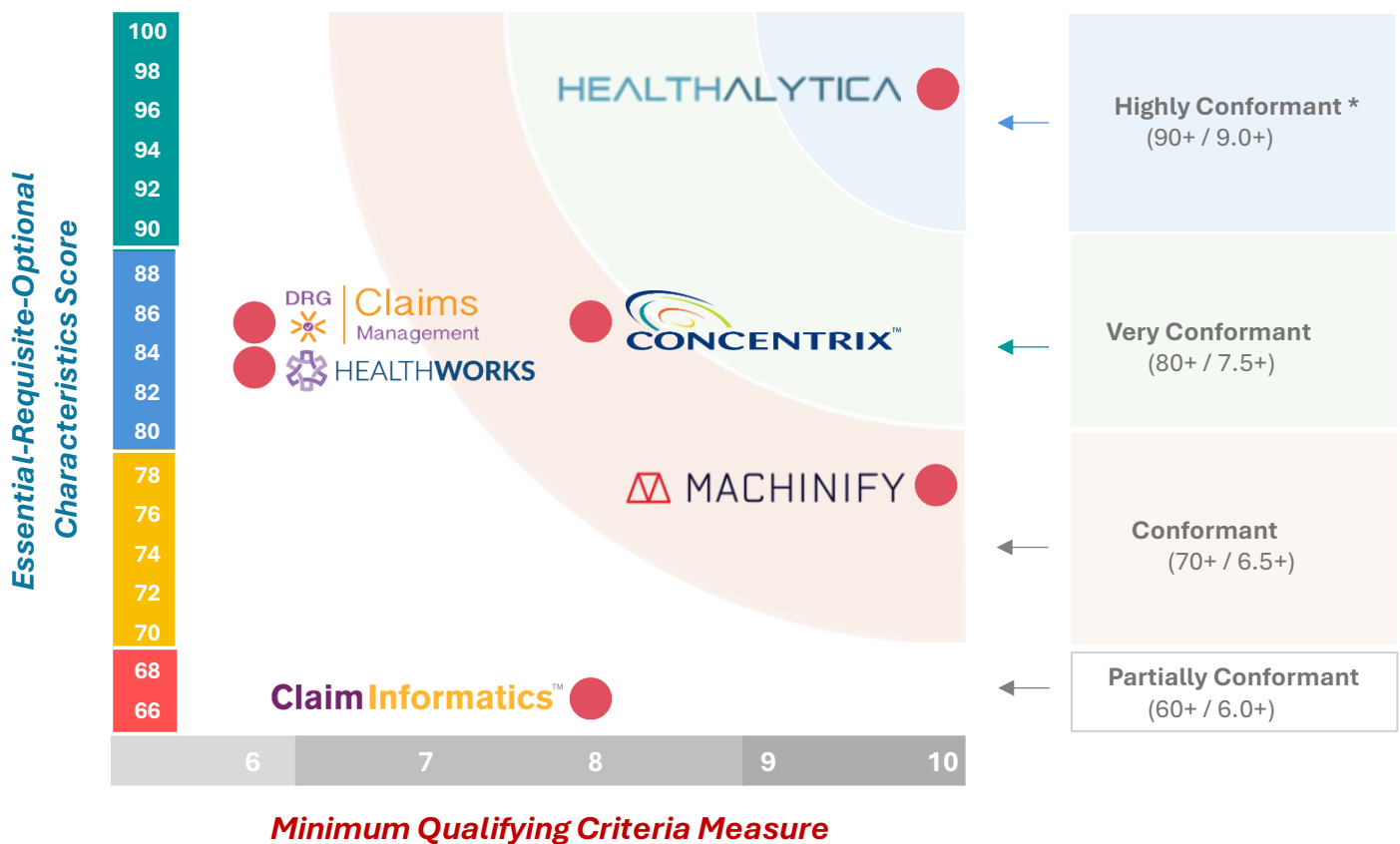
97

Further detail on each of the excluded vendors may be found in *Appendix 4*.

## VI. Vendor Survey Results

Below is a graphic illustration of the survey results for the six payment-error remediation service vendors that both satisfied our *Minimum Qualifying Criteria* ... and scored at least 65 out of 100 points on the *Essential-Requisite-Optional Characteristics* scale ... qualifying them to be finalists.

The illustration was created by plotting the *Minimum Qualifying Criteria* measure along the horizontal axis and the *Essential-Requisite-Optional Characteristics* score along the vertical axis. It provides a complete and accurate depiction of the relative qualifications of each service vendor with respect to our measures. See *Appendix 1* for a complete description of the methodology used to create the illustration above.



Below is a summary of our findings:

- Only six service vendors satisfied the *Minimum Qualifying Criteria* measure and scored above 60 on the *Essential-Requisite-Optional Characteristics* scale (Ave. = 82). In alphabetical order these are: *ClaimInformatics*, *Concentrix*, *DRG Claims Management*, *Healthalytica*, *HealthWorks* and *Machinify*.
- *Healthalytica* earned top ranking with a score of 97 of 100; appreciably higher than the next vendor.
- Surprisingly, only two service vendors ... *Healthalytica* and *Machinify* ... fully satisfied both all ten *Minimum Qualifying Criteria* and all ten *Essential-Requisite-Optional Characteristics*.
- The *Essential-Requisite-Optional Characteristic* that was most often unmet was (#11), which is the vendor's willingness to act as an ERISA fiduciary. Most vendors are unwilling to sign-on as an unqualified ERISA fiduciary, and many will only do so with certain conditions or limitations.

The conformance measure above indicates how closely a vendor aligns with *our* established criteria. While plan overseers may vary re: the criteria used for comparison, their value and weight, in practice, measuring a vendor's effectiveness in remediating payment errors is virtually impossible unless the same claims data is submitted to each vendor and results are compared — an approach that is not at all feasible.

## VII. Vendor Survey Finalist Profiles

Below are brief profiles of the service vendor finalist that summarize their qualifications and shortcomings as it relates to satisfying the *Minimum Qualifying Criteria* and *Essential-Requisite–Optional Characteristics*. To access additional information about a vendor, click on the corresponding logo to visit their website..

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### Top-Ranked: *Healthalytica*



**Healthalytica** topped our ranking with a score of 97 out of 100. Equally important, it is one of only two service vendors that fully and unconditionally satisfied all ten *Minimum Qualifying Criteria*.

It is the only vendor to fully satisfy all ten *Essential-Requisite–Characteristics* ... and it appears that its only insufficiency is its inability to offer full clinical review services, an *Optional Characteristic*.

Unlike many other vendors, **Healthalytica** is independent and not part of a larger conglomerate that services both providers and payers, thereby avoiding the conflicts of interest that can arise from such affiliations. Its team is a deeply experienced group of “benefit nerds” that are equally versed in finance and technology, with experience in both payer and provider billing ecosystems that provides valuable insight and expertise. **Healthalytica** claims can save up to 3% of a payer’s medical and drug spend.

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### Finalist: *Concentrix*



**Concentrix** scored 85 out of 100, just above the average of 82 for all finalists. Note that this score does not reflect that this vendor did not fully satisfy one of the ten *Minimum Qualifying Criteria* (i.e., #8 *No Carrier or Network Provider Restrictions*). With regard

to satisfying all ten of the *Essential-Requisite–Optional Characteristics*, **Concentrix** does not notify providers re: refunds due plan participants; and it requires more claims data and plan documentation than other vendors and more than many plans may be able or willing to provide. While its fee is contingency based, there may impose setup and other fees ... important considerations for many.

**Concentrix** is a global organization that operates in 70 countries. It services more than 2,000 clients in a wide variety of industries (from automotive to banking to energy to travel to healthcare). In the healthcare sector, **Concentrix** services payers, providers, pharmaceutical and health/med tech firms. Its broad range of payer services include member engagement, lead generation, enrollment, eligibility maintenance and claim processing, network and care coordination ... in addition to payment integrity.

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### Finalist: *DRG Claims Management*



**DRG Claims Management’s** score of 85 out of 100 is above the finalist average (82). Note that this score does not reflect that this vendor did not fully satisfy two of the *Minimum Qualifying Criteria* (i.e., #8 *No Carrier or Network Provider Restrictions* and #9 *No Carrier or Network Involvement Required*). This vendor is unable

to satisfy all ten *Essential-Requisite–Optional Characteristics* because of its reluctance to sign-on as an unconditional ERISA fiduciary ... a serious (and possibly fatal) deficit for many plan overseers.

DRG stands for documentation, review and guidance. The vendor offers end-to-end payment integrity services, from audits and data mining to clinical reviews and overpayment recovery. Its team includes clinical auditors with AHIMA credentials in the HIM field and CCS certification; healthcare veterans with management expertise in health care delivery, medical economics, managed care, IT, etc.

**Finalist:** *HealthWorks*



**HealthWorks** scored 84.5; above the average of all finalists (82). Note that this score does not reflect that this vendor did not fully satisfy two of the *Minimum Qualifying Criteria* (i.e., #8 No Carrier or Network Provider Restrictions and #9 No Carrier or Network Provider Restrictions); this, as a result of its deference to state and contract law versus ERISA supremacy. As it relates to meeting the *Essential-Requisite–Optional Characteristics*, **HealthWorks** is not anxious to sign-on as a full ERISA fiduciary, does not normally obtain provider sign-offs and does not typically notify providers re: refunds due plan participants ... important (and possibly fatal) considerations for many ERISA plan overseers.

**HealthWorks** represents itself as “a healthcare transformation company committed to aligning payers, providers, and patients around accuracy, efficiency, and trust” that creates “a connected ecosystem that aligns people, processes, and purpose” ... and, as such, it services both payers and providers. Its payer offering ranges from pre-payment to post-payment services, including medical record review, member monitoring subrogation, credit balance automation and various patient engagement services.

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**Finalist:** *Machinify*



**Machinify** scored 77; below the average of all finalists (82). It is however one of only two service vendors that fully satisfied all ten *Minimum Qualifying Criteria*. This service vendor is unable to

satisfy all ten *Essential-Requisite–Optional Characteristics* because of its reluctance to sign-on as an unconditional ERISA fiduciary ... and it does not typically notify providers about refunds that are due plan participants. These represent serious (and possibly fatal) deficits for many plan overseers.

**Machinify** was created by a roll-up of several companies (Performant Healthcare, Rawlings Group, VARIS and Apixio’s Payment Integrity business). In doing so, it made a strategic pivot from a broad vision to democratize AI with a SaaS platform to empower businesses to a focus on healthcare payment integrity and technology. **Machinify** and its legacy sub-brands employ 2,000+ professionals who service 75+ health plans, having 170+ million members. It offers a suite of pre- and post-payment services that includes audit/bill review, coordination of benefits and subrogation support and repricing.

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**Finalist:** *ClaimInformatics*



**ClaimInformatics** scored 66.5; far below the finalist average (82). Note that this score does not reflect that this vendor did not fully satisfy one of the *Minimum Qualifying Criteria* (i.e., #8 No Carrier

or Network Provider Restrictions. Re: satisfying the *Essential-Requisite–Optional Characteristics*, this vendor is reluctant to sign-on as an *unconditional* ERISA fiduciary; does not notify providers about refunds that are due plan participants; and provides only limited root cause reporting (re: standardized adjustment rationale). **ClaimInformatics** charges a large, one-time, often six-figure, set-up fee that is intended, but not guaranteed, to be offset by anticipated savings .. plus monthly PEPM fee, annual licensing fees, etc. in addition to a savings-based fee. These service limitations and fees represent serious (and possibly fatal) deficits for many plan overseers and resulted in a 5 point scoring penalty.

**ClaimInformatics** bills itself as “the gold standard in fiduciary protection for self-funded and captive health plans and TPAs” offering “100% claim data analysis and continuous monitoring” that it claims helped identify an average of \$82.37 PEPY in improper payments (and that actual results may vary). It states that its “Pre-Payment Fiduciary Review system integrates seamlessly with a TPA’s claims workflow to deliver compliance, accuracy and transparency in one solution”.

## Appendix 1: Vendor Comparison Support Exhibits

The scoring of finalists re: our *Essential-Requisite-Optional Characteristics* scale is shown below.

				HEALTHLYTICA	DRG   Claims Management	CONCENTRIX	HEALTHWORKS	MACHINIFY	Claim Informatics®	
				97.0	85.0	85.0	84.5	73.0	66.5	
<b>Minimal Qualifying Criteria</b>	<b>Service Definition</b>	1	Offers Overpayment Recovery Services	✓ Yes	Yes	Yes	Yes	Yes	Yes	
		2	Services Available on Stand-Alone Basis	✓ Yes	Yes	Yes	Yes	Yes	Yes	
		3	Overpayments are Collected by Vendor	✓ Yes	Yes	Yes	Y/N	Yes	Yes	
		4	Assumes 2nd/3rd Pass Non-Exclusive Position	✓ Yes	Yes	Yes	Yes	Yes	Yes	
		5	Services Small Self-Funded Health Plans	✓ Yes	Yes	Yes	Yes	Yes	Yes	
	<b>Disqualifying</b>	6	Performs Provider Underpayment Remediation	✓ Yes	Yes	Yes	Yes	Yes	Yes	
		7	Operates in Cyber-Secured Environment	✓ Yes	Yes	Yes	Yes	Yes	Yes	
		8	No Carrier or Network Provider Restrictions	✓ Yes	Y/N	Y/N	Y/N	Yes	Y/N	
		9	No Carrier or Network Involvement Required	✓ Yes	Y/N	Yes	Yes	Yes	Yes	
		10	Independent, Unbiased and Neutral Vendor	✓ Yes	Yes	Yes	Yes	Yes	Yes	
<b>Essential-Requisite-Optional Characteristics</b>	<b>Essential &amp; Requisite Characteristics</b>	11	Will Be an Unqualified ERISA Plan Fiduciary	15 Y 15	No 0	Y 15	Y/N 7.5	No 0	Y/N 7.5	
		12	No Claim Processing Interference or Delay	10 Y 10	Y 10	Y 10	Y 10	Y 10	Y 10	
		13	No Electronic Payer Interface Necessary	10 Y 10	Y 10	Y 10	Y 10	Y 10	Y 10	
		14	Only 835 and 837 EDI Claim Feeds Required	8 Y 8	Y 8	Y/N 4	Y 8	Y 8	Y 8	
		15	Obtains Provider Sign-Off on All Recoveries	8 Y 8	Y 8	Y 8	Y/N 4	Y 8	No 0	
		16	Error Root Cause Identification Report	8 Y 8	Y 8	Y 8	Y 8	Y 8	Y/N 4	
		17	Provider Notification re: Participant Refund	8 Y 8	Y 8	No 0	Y/N 4	No 0	Y 8	
		18	No-Risk Contingency Fee Payment Basis	6 Y 6	Y 6	Y 6	Y 6	Y 6	Y 6	
		19	No Material Set-Up or Implementation Fee	6 Y 6	Y 6	Y/N 3	Y 6	Y 6	No 0	
		20	No Excessive Minimum Monthly Claim Volume	6 Y 6	Y 6	Y 6	Y 6	Y 6	Y 6	
<b>Options</b>	21	Offers Optional Per Recovery Fee Cap	5 Y 5	Y 5	Y 5	Y 5	Y 5	Y 5		
	22	Hybrid Payment Option (e.g., PEPM, Flat Fee)	4 Y 4	Y 4	Y 4	Y 4	Y 4	Y 4		
	23	Ongoing Monthly Monitoring Option	3 Y 3	Y 3	Y 3	Y 3	Y 3	Y 3		
	24	In-house Clinical Review Option	3 No 0	Y 3	Y 3	Y 3	Y 3	No 0		
	25	Negative / Disqualifying Characteristic							-5	
				<b>100</b>	<b>97.0</b>	<b>85.0</b>	<b>85.0</b>	<b>84.5</b>	<b>77.0</b>	<b>66.5</b>

Note: Comparisons of service vendors can only be fairly made by considering the service vendor's *Essential-Requisite-Optional Characteristics* score in conjunction with its ability to satisfy the *Minimum Qualifying Criteria*, ergo, the importance of the illustration that blends these measures.

In addition to these finalists, the responses of several other payment-error remuneration service vendors were tabulated. As these vendors scored less than 65 out of 100, and because we did not find anything distinctive about their offerings that warranted more consideration, we did no additional profiling of them.

Below is more detailed illustration of *Minimum Qualifying Criteria* results, along with some observations.

Vendor	Minimum Qualifying Criteria									
	Service Definition					Disqualifying				
	1	2	3	4	5	6	7	8	9	10
	Offers Overpayment Recovery Services	Services Available on Stand-Alone Basis	Overpayments are Collected by Vendor	Assumes 2nd/3rd Pass Non-Exclusive Position	Services Small Self-Funded Health Plans	Performs Underpayment Remediation	Operates in Cyber-Secured Environment	No Carrier or Network Provider Restrictions	No Carrier or Network Involvement Required	Independent, Unbiased and Neutral Vendor
1 <b>Healthalytica</b>	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
2 <b>DRG Claims Mgmt</b>	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Y/N	Y/N	Yes
3 <b>Concentrix</b>	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Y/N	Yes	Yes
4 <b>HealthWorks</b>	Yes	Yes	Y/N	Yes	Yes	Yes	Yes	Y/N	Yes	Yes
5 <b>Machinify</b>	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
6 <b>Claiminformatics</b>	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Y/N	Yes	Yes

Vendors that fully satisfied the criteria were tabulated as a Yes, and those that failed to satisfy the criteria were tabulated as a *No*. Note that only two finalists were able to fully satisfy all of the ten *Minimum Qualifying Criteria*.

To be both fair and equitable, vendors that expressed *flexibility* or a *willingness to accommodate* with respect to satisfying specific criteria, were tabulated as a *Y/N*, saving four vendors from being excluded.

For the purposes of comparing vendors, a *Y/N* designation should be considered a shortcoming versus a *Y* designation.







Because service vendor comparisons can only be accurately made by considering both the service vendor’s *Essential-Requisite-Optional Characteristics* score as well as its ability to satisfy all of the *Minimum Qualifying Criteria*, we developed an illustration that blends these measures so that the differentiation between the service vendor finalists may be visualized. The methodology by which this illustration was created is detailed below.

A scoring measure was created to quantify the extent to which a service vendor satisfied each *Minimum Qualifying Criteria* which consist of

- assigning 1 point for each *Yes* response
- subtracting 1 point for each *Y/N* response
- subtracting 2 points for each *N* response.

These results were tabulated to arrive at a score that reflects the degree to which each vendor satisfied our *Minimum Qualifying Criteria*.

We then plotted the *Minimum Qualifying Criteria* and *Essential-Requisite-Optional Characteristics* results to create the subject graphical illustration which blends these two measures to create a fair, realistic and comprehensive portrayal of each service vendor finalist’s comparative strengths and shortcomings.

Finalists	Minimum Qualifying Criteria Measure			Score	Essential-Requisite-Optional Characteristics Score
	Yes	Y/N	N		
 HEALTHALYTICA	10	0	0	10	97.0
 MACHINIFY	10	0	0	10	77.0
 CONCENTRIX™	9	1	0	8	85.0
 Claim Informatics™	9	1	0	8	66.5
 DRG   Claims Management	8	2	0	6	85.0
 HEALTHWORKS	8	2	0	6	84.0

Note: To recap, it would a mistake for the reader to rely exclusively upon the tabulated results of either the *Minimum Qualifying Criteria* measure or *Essential-Requisite-Optional Characteristics* score alone. For a more realistic portrayal, see the illustration in the Executive Summary and on page 11.

## Appendix 2: Sources of Payment Integrity Service Vendors

Seven market intelligence and research firms were identified as covering the healthcare payment integrity sector. These organizations evaluated, and in some instances scored and ranked, payment integrity vendors serving healthcare payers. We used the surveys, reports and evaluations produced by these organizations as a means by which to identify key payment-error remediation players in this space. To access additional information about a report, click on the corresponding title to visit the company website.



### [Payment Integrity Solutions PEAK Matrix® Assessment 2025](#)

*Everest Group's* Payment Integrity Solutions PEAK Matrix® Assessment evaluates service providers based on their capabilities, technology, and market impact within the payment integrity solutions industry. PEAK Matrix® assessments help its clients make informed sourcing decisions based on the true and complete picture of the supplier space. This report analyzes twenty-four payment integrity solutions providers and includes their relative positioning on the PEAK Matrix® Assessment for payment integrity solutions; capabilities and market shares; and key strengths and limitations. The Assessment is available for purchase for \$6,500.



### [Global Healthcare Payment Integrity Market Report 2025](#)

*Mordor Intelligence* is a leading market intelligence firm, built on more than a decade of trusted insights and proven industry expertise. It provides actionable, fact-based insights that drive better decisions and help shape the future of industries ... by leveraging AI, next-generation analytics and deep industry expertise. Its research spans the entire healthcare value chain, including biotechnology, diagnostics, devices, digital platforms, and patient behavior, and delivers clear, actionable insights. This report provides a detailed description of the market and identifies "major players" in the payment integrity space.



### [Pre-Payment Accuracy & Integrity Solutions \(Payer\)](#)

*KLAS Research* claims to be the premier healthcare IT insights company, consulting with thousands of providers and payers about the software and services their organizations use. Its researchers, analysts, and consultants give its clients insights and expertise they need to succeed. The annual *Best in KLAS* report recognizes software and services companies that excel in helping healthcare organizations accomplish the Quadruple Aim. All rankings are a direct result of feedback collected throughout the year from thousands of professionals at both provider and payer organizations. The *Best in KLAS* awards identify the healthcare industry's top pre- and post-pay vendors used by payers to help ensure accurate payment and reimbursement.



### [Payment Integrity in Healthcare 2024: Market Outlook and Analysis](#)

*Datos Insights* is the advisor of choice to the banking, insurance, securities, and retail technology industries – and the financial institutions and the tech providers who serve them. It helps its clients make better technology decisions so they can protect and grow their customers' assets. This report provides an overview of major vendor offerings and capabilities, the impact of market trends, and perspective on the outlook and opportunities in the payment integrity space moving forward. Using market research, technology developments, and insights from payment integrity and healthcare stakeholders, the report builds a qualitative analysis and forecast for the payment integrity market ... and identifies leading service vendors in this space.



### [U.S. Payment Integrity Market Size, Share, and Trends 2025 to 2034](#)

Based in Canada and India, *Precedence Research* delivers strategic, actionable insights, not just data and charts. Its team specializes in customized market analysis, executive-level consulting, and tailored research solutions that go beyond traditional survey methodologies to support business growth with precision and confidence. From market entry strategies to product positioning, it tailor's solutions that drive tangible results and guide clients through the complexities of today's dynamic markets with clarity and precision. This payment Integrity market report provides detailed information and data about market size and scope; market drivers, restraints and opportunities; recent developments; and identifies the leading service vendors tin this space.

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### [Kisaco Research Healthcare Payment & Revenue Integrity Congress](#)

*Kisaco Research* brings its clients both intensively researched conference programs and the most influential networks to help them set and reset their business destinations and chart their own courses. It works with early adopters and leaders of growth markets to provide the right knowledge, learning and social opportunities to stimulate business growth quickly. The *Healthcare Payment & Revenue Integrity Congress* is an industrywide conference focused on payment integrity and the only event driving collaboration across all stakeholders of the claim lifecycle. The service vendors identified as *HPRI Partners* are thought to be significant players in this space.

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### [IDC Market Glance: Payer Payment Integrity, 2Q25](#)

*International Data Corporation* is a premier global market intelligence, data and events provider for the information technology, telecommunications, and consumer technology markets. The *IDC MarketScape* vendor analysis is designed to provide an overview of the competitive fitness of organizations. To conduct its research it uses a rigorous scoring methodology based on both qualitative and quantitative criteria that provides a 360-degree assessment of the strengths and weaknesses of current and prospective vendors. This *IDC Market Glance* provides a glimpse at the current makeup of the payer payment integrity landscape, depicting the segments and structure of the market and identifying significant service vendors in this space. The report is available for \$2,500.

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### [TPA NETWORK Research Consortium Payment Integrity Vendors](#)

The **TPA NETWORK Research Consortium** is an emerging non-profit research facility that helps providers evaluate and assess new medical technologies and innovations, plan participants obtain leading-edge health care, scientists advance medical research, and payers reduce risk. The **Research Consortium** created this guide and designed and conducted the payment-error remediation service vendor survey. The service vendors identified by the **Research Consortium** were not listed in any of the other market reports; they were identified through web searches and recommendations by a wide variety of self-funded health plan stakeholders (and helpful payment integrity vendors that only service large-scale payers).

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Note: The database of payment integrity vendors that we used to identify the universe of potential payment-error remediation service vendors is available, in Excel format, upon request.

### Appendix 3: Vendor Survey Questionnaire

Below is the questionnaire used in our survey of payment-error remediation services vendors.

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- 1) We differentiate between *payment integrity services* and payment-error remediation services ... which we define as "human and electronic post-payment retrospective billing analysis employed to identify and validate incorrectly priced claims and the efforts undertaken to recover provider overpayments and correct provider underpayments ... separate and apart from COB, subrogation, FW&A, medical necessity and high-dollar-claim audits and associated recovery efforts.
  - Do you perform payment-error remediation services (PERS) consistent with this definition?
- 2) Can you perform your PERS without interfacing with the provider network, the payer or its claims processing workflow ... and without requiring the payer to delay claim adjudication or payment?
- 3) Can you perform your PERS using only data contained in 837 (claim) and 835 (payment) files?
- 4) Are your PERS available on a stand-alone basis vs a part of an integrated payment integrity solution?
- 5) After identifying payment-error remediation opportunities, do you actually remediate payment errors with providers vs performing credit balance reconciliation or supporting payer collections?
- 6) Do you identify / calculate provider *underpayments* and do you report them to the plan sponsor?
- 7) Are you willing to perform PERS on a 2<sup>nd</sup> or 3<sup>rd</sup> pass basis, i.e., subsequent to the payer's PI process?
- 8) Do you obtain a written sign-off from the provider with every remediation?
- 9) Do you have any network- or payer-imposed restrictions that limit your ability to seek remediation of under- and overpayments from any (network) provider?
  - Do state, or payer/network contract, restrictions limit your remediation efforts?
- 10) How do you charge for PERS (e.g., contingency, PEPM, hybrid)?
  - Are there up-front fees or minimum monthly claim/recovery volume requirements?
  - If contingency, will you agree to a per recovery cap?
- 11) Are you willing to “sign-on” as an ERISA fiduciary to the plan and assume full responsibility and duties of an ERISA health plan fiduciary on a complete and unqualified basis?
- 12) Do you typically perform PERS for small self-funded plans (e.g., having as few as 5,000 members)?
- 13) Do you provide a detailed report to the plan that identifies the root causes of all payment errors so as to mitigate future under- and overpayment errors and related expense?
- 14) Do you operate in a cyber-secure environment?
- 15) Do you identify and calculate the portion of the under- or overpayment amount that is due the plan participant and send a refund request to the provider on the plan participant's behalf?
- 16) Can you perform in-house clinical reviews and analysis on large payment errors when appropriate?

## Appendix 4: Excluded Payment Integrity Service Vendors

Below are the 97 payment integrity vendors that were excluded from consideration because they did not satisfy one of more **Minimum Qualifying Criteria**. The primary reason for excluding the vendor is noted.

Note: A “Y” denotes the 52 vendors that were excluded from consideration as a result of information obtained from responding to our survey or an email inquiry. An “N” denotes the 45 vendors for which disqualifying information was acquired via a website review or internet search.

1	Vendor	Everest Group	Modor Intelligence	KLAS	Datos Insight	Precedence	HPRI	International Data Corp	Research Consortium	Survey or Email Response	Offers Payment Integrity Services	Minimum Qualifying Criteria										Primary Reason for Excluding Service Vendor from Consideration
												Service Definition					Disqualifying					
												1	2	3	4	5	6	7	8	9	10	
												Offers Overpayment Recovery Services	Services Available on Stand-Alone Basis	Overpayments are Collected by Vendor	Assumes 2nd/3rd Pass Non-Exclusive Position	Services Small Self-Funded Health Plans	Performs Underpayment Remediation	Operates in Cyber-Secured Environment	No Carrier or Network Provider Restrictions	No Carrier or Network Involvement Required	Independent, Unbiased and Neutral Vendor	
1	4L Data Intelligence	E					H	I		Y	Yes	Yes		No								Technology Solution
2	6 Degrees Health						H	I		Y	Yes	Yes			No							Doesn't Service Small Plans
3	Aarete Payment Intelligence								R	Y	Yes	Yes		No								Consulting Services Only
4	Accenture PLC							I		N	Yes	Yes		No								Consulting Services Only
5	Acentra Health LLC							I		N	Yes	Yes		No								Technology Solution
6	Advanced Medical Strategies						H	I		Y	Yes	Yes		No								Technology Solution
7	Alaffia	E						I		N	Yes	Yes		No								Technology Solution
8	Alivia Analytics	E	M		D		H	I		Y	Yes	Yes			No							Doesn't Service Small Plans
9	Alliant Health Solutions								R	N	Yes	Yes		No								Consulting Services Only
10	ASP-RCM Solutions						H			N	No	No										Misc - Provider-Side Svcs Only
11	Availity					P				N	Yes	No										Pre-Payment Tech Solution
12	Brown & Joseph								R	Y	Yes	Yes				No						No Underpayment Remediation
13	Capital Recovery Corporation								R	Y	No	No										Misc - Collection Agency
14	CAQH						H			N	No	No										Misc - Data Solution
15	Carelon	E					H	I		Y	Yes	Yes			No					No		Misc - Carrier/Network Owned
16	Ceris		M			P	H			Y	Yes	Yes		No								Audits, No Recovery
17	CGI	E			D			I		Y	Yes	Yes				No						No Underpayment Remediation
18	Chartis Group		M					I		Y	Yes	Yes		No								Consulting Services Only
19	Claimsight / AMPS								R	Y	Yes	Yes				No						No Underpayment Remediation
20	Claim Technologies, Inc								R	Y	Yes	Yes		No								Audits, No Recovery
21	ClaimReturn								R	Z	Yes	Yes				No			No			Audit Limits, Services TPAs
22	ClarisHealth	E	M		D	P		I		Y	Yes	Yes		No								Audits, No Recovery
23	Claritec (f/k/a MultiPlan)	E		K	D	P		I		N	Yes	Yes						No		No		Misc - Carrier/Network Owned
24	Codoxo				D		H	I		Y	Yes	Yes		No								Audits, No Recovery
25	Cogitativo							I		Y	Yes	Yes				No						Doesn't Service Small Plans
26	Cognizant					P		I		N	Yes	No										Plan Admin Platform
27	Cohere Health (Phare Health)						H			Y	Yes	Yes				No						Doesn't Service Small Plans
28	Conduent	E	M		D			I		Y	Yes	Yes				No						No Underpayment Remediation
29	Consova Corp.							I		N	Yes	No										Misc - Eligibility Integrity Only
30	Constellation Quality Health						H			Y	Yes	Yes		No								Misc - Clinical Reviews Only
31	Cotiviti	E	M	K	D	P		I		Y	Yes	Yes				No						Doesn't Service Small Plans
32	CoventBridge Group						H			Y	Yes	Yes										No Underpayment Remediation
33	CoverSelf						H	I		N	Yes	Yes		No								Technology Solution
34	D4 Solutions						H			N	Yes	Yes		No								Technology Solution
35	Datavant (Apixio)		M		D					Y	No	No										Misc - EHR Retrieval Only
36	DXC Technology Co.							I		N	Yes	Yes		No								Technology Solution
37	eviCore Healthcare							I		N	No	No										Misc - Implant Mgmt Only
38	Exela Technologies / EXP	E						I		Y	Yes	Yes										Misc - Svc Not Provided in US
39	EXL Service	E	M	K	D	P	H	I		Y	Yes	Yes				No						Doesn't Service Small Plans
40	Exponential AI Inc.							I		N	Yes	Yes		No								Technology Solution

	Vendor	Everest Group	Modor Intelligence	KLAS	Datos Insight	Precedence	HPRI	International Data Corp	Research Consortium	Survey or Email Response	Offers Payment Integrity Services	Minimum Qualifying Criteria										Primary Reason for Excluding Service Vendor from Consideration	
												Service Definition					Disqualifying						
												1	2	3	4	5	6	7	8	9	10		
												Offers Overpayment Recovery Services	Services Available on Stand-Alone Basis	Overpayments are Collected by Vendor	Assumes 2nd/3rd Pass Non-Exclusive Position	Services Small Self-Funded Health Plans	Performs Underpayment Remediation	Operates in Cyber-Secured Environment	No Carrier or Network Provider Restrictions	No Carrier or Network Involvement Required	Independent, Unbiased and Neutral Vendor		
41	Fair Isaac Corporation							I		N	Yes	Yes		No									Technology Solution
42	Fathom						H			N	Yes	Yes		No									Technology Solution
43	Financial Recovery Group								R	Y	Yes	Yes		No									Audits, No Recovery
44	FraudLens							I		Y	Yes	Yes		No									Technology Solution
45	Gainwell Technologies	E	M		D			I		Y	Yes	Yes			No								Doesn't Service Small Plans
46	GYNISUS INC.							I		N	Yes	Yes		No									Technology Solution
47	Health-at-Scale						H			N	Yes	Yes		No									Technology Solution
48	Healthcare Fraud Shield				D		H	I		Y	Yes	Yes		No									Audits, No Recovery
49	Healthcare Horizons									Y	Yes	Yes		No		No				No			Audits, No Recovery, Svcs Payers
50	HealthEdge	E	M	K	D	P	H	I		N	Yes	No											Plan Admin Platform
51	IBM							I		N	Yes	Yes		No									Technology Solution
52	InstaMed Communications							I		N	Yes	Yes		No									Technology Solution
53	Integrity Advantage		M		D					Y	Yes	Yes	No	No									Misc - Integrated Solution
54	Intellivo						H			N	Yes	No											Subrogation Only
55	J. Graham Inc.								R	Y	Yes	Yes		No									Audits, No Recovery
56	J29Solutions								R	Y	Yes	Yes				No							Doesn't Service Small Plans
57	Katch						H			Y	Yes	No											Subrogation Only
58	Launch Consulting		M							N	Yes	Yes		No									Technology Solution
59	Lexis/Nexis Risk Solutions		M		D			I		N	Yes	Yes		No									Technology Solution
60	Lifetime Benefit Solutions								R	Y	Yes	Yes		No									Audits, No Recovery
61	Lyric	E	M	K	D		H	I		Y	Yes	Yes		No		No							Technology Solution
62	Magical						H			N	Yes	Yes		No									Technology Solution
63	Mastercard Healthcare Svcs				D					N	Yes	Yes		No									Technology Solution
64	MedReview	E					H	I		Y	Yes	Yes		No									Audits, No Recovery
65	Micro-Dyn Medical Systems						H			N	Yes	Yes		No									Technology Solution
66	Moxe Health							I		N	Yes	Yes		No									Technology Solution
67	Navigis								R	Y	Yes	Yes		No									Technology Solution
68	Nokomis Health						H			Y	Yes	Yes		No									Audits, No Recovery
69	NTT Data	E	M		D			I		N	Yes	Yes		No									Technology Solution
70	Optum (Change / Insight)		M		D			I		Y	Yes	Yes				No							Doesn't Service Small Plans
71	Outsource 2 India								R	Y	Yes	Yes		No		No							Doesn't Service Small Plans
72	Pareto Intelligence							I		Y	Yes	Yes		No									Audits, No Recovery
73	Payment Integrity Solutions								R	N	Yes	Yes		No									Technology Solution
74	Penstock Group	E					H	I		Y	Yes	Yes				No							Doesn't Service Small Plans
75	Performant (part of Machinify)	E			P		H	I		N	Yes	Yes											Misc - Merged Out of Existence
76	PLEXIS Healthcare Systems							I		N	Yes	No											Plan Admin Platform
77	Provider Trust				D					N	Yes	No											Misc - Data Solution
78	PWC, LLP							I		N	Yes	Yes		No									Consulting Services Only
79	Rialtic					P	H	I		Y	Yes	No											Pre-Payment Tech Solution
80	Sagility Technologies	E						I		Y	Yes	Yes		No		No							Audits, No Recovery
81	Salient Health							I		N	Yes	Yes		No									Technology Solution
82	SAS Institute		M		D			I		Y	Yes	Yes		No									Technology Solution
83	Shift Technology				D		H			Y	Yes	Yes		No									Technology Solution
84	SuperDial						H			N	Yes	Yes		No									Technology Solution
85	Syrtis Solutions					P				N	Yes	No											Misc - Pharmacy Audits Only
86	Tegria Services Group							I		N	Yes	Yes		No									Consulting Services Only
87	The Phia Group						H			Y	Yes	No											Misc - Recovery, No Audit
88	Thomson Reuters Corp.							I		N	No	No											Misc - Publishing Corporation
89	Trend Health Partners			K						Y	Yes	Yes					No						No Underpayment Remediation
90	UST HealthProof							I		N	Yes	No											Plan Admin Platform
91	Valenz Health						H			Y	Yes	Yes					No						No Underpayment Remediation
92	Wipro Limited							I		N	Yes	Yes		No									Technology Solution
93	Wolters Kluwer							I		N	Yes	Yes		No									Technology Solution
94	XSOLIS, Inc.							I		N	Yes	Yes		No									Technology Solution
95	Zelis	E	M	K	D	P	H	I		Y	Yes	Yes		No									Audits, No Recovery
96	Zoll Data Systems						H			N	Yes	Yes		No									Technology Solution
97	Vendor Requested Anonymity							I		Y	Yes	Yes					No						No Underpayment Remediation

## About the Author

Richard Nicholas is a seasoned industry veteran having nearly five decades of executive experience in the self-funded, managed care and business process outsourcing sectors. Richard began his career in 1978 pioneering capitation dental programs and was a contributing editor of the American Dental Association's publication *On Capitation Dentistry*. He has owned and held senior leadership positions with national third party administrators and managed care organizations and created one of the first HMOs in Mexico. For years, he facilitated TPA mergers and acquisitions for many of the nation's leading insurers and TPAs.

Mr. Nicholas has lectured extensively, domestically and abroad, on topics of interest to a wide variety of healthcare stakeholders, including at annual meetings of the *National Association of Health Underwriters*, the *Society of Professional Benefits Administrators*, the Mexican Social Security Institute (IMMS) and the *Mexican Foundation for Health*. He has testified on regulatory matters at hearings before the *U. S House of Representatives Ways & Means Committee* where he represented the plan sponsors of nearly 200 TPAs.

Richard has authored articles for, and been quoted in, many publications including *The Wall Street Journal*, *USA Today*, *HR Horizons* and *Mexico Business*. He was the author of one of the earliest books on corporate healthcare cost management and authored many white papers, reports and scholarly presentations that have provided authoritative guidance to TPAs on topics ranging from exposing the devious practices of pharmacy benefit managers to using artificial intelligence in healthcare, to gaining control of cancer risk by incorporating cost and value data into the treatment selection process at the point-of-care.

At the start of the pandemic, Mr. Nicholas authored the first and most comprehensive employer guide on face masks (which was downloaded more than one million times). He participated in the workgroup established by the *American Association of Textile Chemists and Colorists* that created the world's first community face covering specification and the *American Society of Testing and Materials International* workgroup that, under the direction and leadership of the Center for Disease Control and Prevention, created the first U. S. barrier face covering specification for non-medical use face masks.

A newly-minted "social entrepreneur", at the behest of other industry veterans, Richard established the **TPA NETWORK Research Consortium**, a healthcare-focused non-profit enterprise, to help payers assess new medical technologies and healthcare innovations by conducting much-needed translational research initiatives and comparative effectiveness analysis in real-world settings. Mr. Nicholas holds a BA *with distinction* from Boston College and an MBA from the Duke University Graduate School of Business.



The **TPA NETWORK Research Consortium** is a non-profit, industry-wide health-care research initiative that helps providers evaluate and assess new medical technologies and healthcare innovations, plan participants obtain leading-edge health care, scientists advance medical research, and payers reduce risk.