Underpayment Recovery

Whitepaper

How providers can reclaim under-billed revenue by adopting payer-grade precision

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EXECUTIVE SUMMARY

How providers can reclaim under-billed revenue by adopting payer-grade precision

For years, health systems have quietly accepted underpayments as a cost of doing business. But the truth is, those missed dollars can be recovered, and the playbook to do it already exists.

"Start small. A 30-day lookback on your top five CPT codes can reveal repeated small misses that add up."

– Sarah Armstrong, CEO, TREND Health Partners

Payers have built sophisticated, AI-backed payment integrity programs to find overpayments. Providers can do the same to find what is missing on their side. You don't need massive technology investments or a team of data scientists. You need focus, ownership, and a few smart moves.

This paper outlines three pragmatic moves any provider can take to uncover hidden revenue:

- ✓ Apply payer-grade analytical discipline to your own data.
- ✓ Start small with measurable pilots that prove results fast.
- ✓ Pair lightweight automation with clear operational accountability.

These steps reveal the places where money slips through the cracks with underpayments, billing oversights, and unworked accounts and turn them into fast measurable cash and lasting process change. The recommended operating playbook begins with a 30-day top-five CPT lookback and scales through focused ML pilots and a weekly payer-insight loop.

PART ONE

The Problem in Plain Language

Providers and payers may operate within the same healthcare ecosystem, but they run toward very different finish lines.

For most hospitals, the goal is a zero-balance account: process the claim, collect payment, and close the ledger. Payers, on the other hand, maintain an ongoing cycle of validation. They re-ingest data, coordinate benefits, analyze anomalies, and reconcile claims well after providers have moved on.

This operational asymmetry has created a capability gap. Payers use layered vendor networks and AI-based models to detect overpayments, while many providers lack equivalent tools to identify underpayments. The result is recoverable revenue that remains undiscovered within provider systems.

This is not an abstract challenge. It is an operational reality, especially for rural and community hospitals that face limited staffing and resource constraints. Manual reviews consume time that could be spent on patient care or higher-value revenue work.

The central question is straightforward-: Can providers level the field without transforming into payers? The answer is yes. The solution is tactical, measurable, and sustainable.

> ***"We don't have time for manual processes. We need automation that does the heavy lifting."***
>
> – Rachel Dallmann, Chief Ancillary Officer, Phelps Memorial Health Center

PART TWO

What Payers Actually Do (and why it matters)

Payers approach payment integrity as a long-term program rather than a periodic audit. They rely on data mining, vendor stacking, retrospective reviews, and sophisticated AI contract modeling to identify anomalies and recover funds. For payers, payment integrity is not a cost center but a revenue-generating function.

Translated into signals, payers look for patterns: inconsistent billing combinations, unexpected modifier usage, mismatches between claim history and member rosters, and contractual misalignment that produces systematic under- or over-reimbursement. The technology simply helps them scale pattern detection: models prioritize high-value targets and feed human review. Providers can borrow the methodology—not necessarily the exact models or proprietary datasets—and apply it to their own data to reveal underpayments.

Key Takeaway

The payer playbook is accessible conceptually—what matters for providers is adopting the same analytical discipline and prioritization, scaled to their resources.

"You're identifying trends, you're looking at patterns, you're modeling those types of things. Then humans take action—but you need the wrangling of data to get there."

– David Gaffey, Senior Vice President, Provider Operations, TREND Health Partners

PART THREE

Where Underpayments Hide: The Provider Blind Spots

This paper outlines three pragmatic moves any provider can take to uncover hidden revenue:

- ✓ **Payer contractual variances.** Payer modeling or adjudication that results in lower reimbursement than contractually expected. These are classic underpayments surfaced by model vs. payment comparisons.
- ✓ **Billing and charge errors.** Miskeyed codes, incorrect modifiers, or rev-code combinations that produce systematic shortfalls. These are often caused by process gaps or outdated contract modeling inside provider systems.
- ✓ **Underworked or prematurely closed accounts.** Accounts that were moved to self-pay, left unworked, or adjusted before adequate follow-up often hide because of staffing limits or confusing COB.

The operational roots are predictable: manual workflows, siloed ownership, and a tendency to focus only on "what's in front of us." Rachel's frontline view reinforces the urgency:

> ***"We're constantly looking at ways to be more efficient and to stop wasting time getting it right the first time."***
>
> – Rachel Dallmann, Chief Ancillary Officer, Phelps Memorial Health Center.

A practical self-diagnostic (3 quick checks) helps teams triage where to start:

1. Compare posted payments vs. modeled reimbursement for your top 5 CPT codes over the last 30 days.
2. Run a modifier frequency report to detect unusual or inconsistent code pairings.
3. Review accounts transferred to self-pay or left unworked in the last 90 days and identify recurring reasons like COB, registration errors, and authorization.

PART FOUR

Leveling The Field: Three Guiding Principles

Turning data into dollars doesn't start with technology. It starts with mindset.

1. MATCH THE RULES.

Payers use rules, models, and logic to find overpayments. You can use the same approach to find what is missing. Apply the same analytical rigor inside your organization and compare modeled reimbursement to what was actually paid and let the data guide where to prioritize claims for review.

> ***"Parity of rules means matching the rigor that's deployed on the other end."***
>
> – Sarah Armstrong, CEO, TREND Health Partners

> ***"Start small – baby steps can matter."***
>
> – Sarah Armstrong, CEO, TREND Health Partners

2. START SMALL, ITERATE QUICKLY.

Large, sprawling programs stall. Instead, narrow the scope of one CPT, one modifier, or one high-value service and run a short retrospective (30–60 days), measure recoverable dollars, learn and iterate.

3. PEOPLE AND TECHNOLOGY TOGETHER.

AI and machine learning can accelerate discovery, but they don't replace people. The real wins come from combining lightweight automation with clear operational ownership. Let technology do the scanning and flagging, while humans handle judgment and action.

Together, these principles make payer-grade precision attainable for any health system, even those with limited analytics or automation resources.

> ***"AI and machine learning are accelerators, not barriers, to an effective payment-integrity program."***
>
> – David Gaffey, Senior Vice President, Provider Operations, TREND Health Partners

PART FIVE

Practitioner Vignettes (what this looks like in the field)

Rural System: Reducing time-waste to protect margins

Rachel described the experience of small hospitals where thin margins and training gaps make manual underpayment reviews untenable. The team's goal was not heroic analytics but pragmatic process change: identify repetitive administrative failures, automate what is repeatable, and free staff for higher-value work.

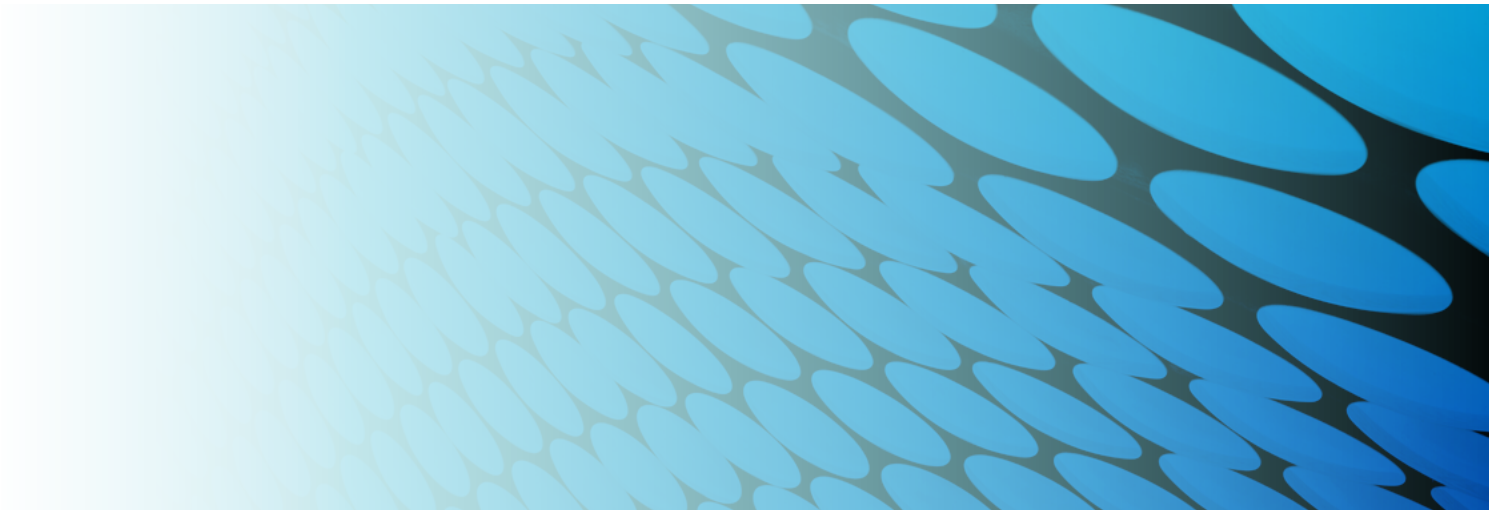
> ***"We don't have time for manual processes. We need automation that does the heavy lifting."***
>
> – Rachel Dallmann, Chief Ancillary Officer, Phelps Memorial Health Center

Mid-market pilot: A targeted ML test that proves value

David described the scaled-down pilot approach: pick a narrowly framed concept (modifier misuse on surgery or anesthesia rev codes), assemble a 100–500 claim retrospective, run a rule or lightweight model to flag likely misses, and validate with human review. The value is kinetic: a short pilot produces a recoverable dollar estimate, demonstrates ROI, and creates the case for a broader program.

> ***"Write one concept, start small, see what comes out of it, and then refine the model."***
>
> – David Gaffey, Senior Vice President, Provider Operations, TREND Health Partners

These examples prove that success doesn't require massive transformation. It starts with curiosity, focus, and small wins that add up quickly.



PART SIX

Implementation Roadmap & Operating Model

Building a scalable payment integrity capability requires structure. The following roadmap outlines how to move from pilot to full program.

PHASE 0 (0–30 DAYS): DIAGNOSE AND PRIORITIZE

- ✓ Run the 30-day top-5 CPT parity scan.
- ✓ Validate 100 claims per underpayment hypothesis.
- ✓ Assign clear ownership and review cadence.

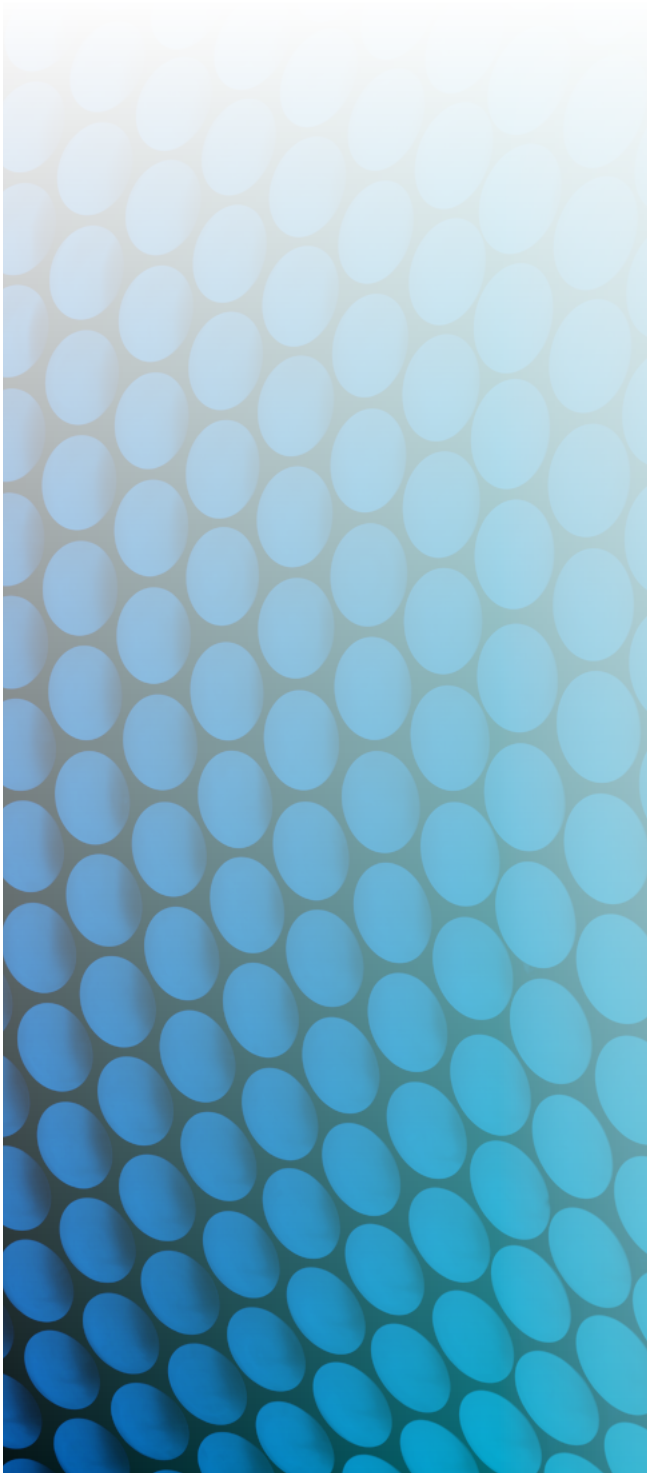
PHASE 1 (30–90 DAYS): PILOT & PROVE

- ✓ Deploy one targeted ML model or automation with rule-based pilot.
- ✓ Measure gross recovered dollars and time-to-resolution per case.
- ✓ Document root causes and embed findings into existing workflows for coding, registration, or authorization.

PHASE 2 (90–180 DAYS): SCALE & GOVERN

- ✓ Standardize what worked in the pilot into routine operations.
- ✓ Implement scheduled scans, role accountability, and KPI dashboards.
- ✓ Maintain a weekly payer-insight summary to sustain alignment with clinics, billing and executive partners.

This operating model requires cross-functional collaboration between analytics, operations, and clinical teams. The right mix of operational expertise, AI & technology, and resources keeps the work moving. Though the absence of any single element should not be a barrier to getting started.



PART SEVEN

KPIs That Matter

To track progress, focus on a few meaningful metrics that reflect both financial and operational impact.

- ✓ **Incremental recovered dollars** (monthly & annualized). Direct financial impact from underpayment pilot and production activities.
- ✓ **Time-to-recovery.** Days from flag to cash realization (shorter indicates operational efficiency).
- ✓ **Validated Claim Rate. P**ercentage of flagged claims that result in actual recoveries, helping refine model precision.
- ✓ **Repeat Issue Rate.** Are the same mistakes recurring post-remediation? This measures sustainability.
- ✓ **Payer Insight Report.** The frequency and cross-functional reach will show whether the feedback loop is driving upstream improvements.

PART EIGHT

Guardrails, Risks & Messaging

Don't publish payer proprietary data. The objective is method and signals, not reproducible copies of payer datasets or logic. Frame your arguments around methodology, not raw payer files.

Be realistic about resource needs. Not every team has advanced analytics or automation capacity. Scaling sophisticated automation requires operational expertise, AI skills, and resources. Consider vendor partnerships or incremental internal capability building. The panel stressed that AI and Machine Learning are accelerators, not prerequisites, and partnership options can bridge capability gaps.

Position internally as capability building, not vendor pitch. Present the program as a capability conversation: fix the process, recover revenue, and reduce repetitive administrative burden. This reduces skepticism and elevates the discussion to an investment decision.

PART NINE

Four Monday Moves

Here are four executable steps revenue cycle team can perform immediately. Each is designed to create measurable impact and to produce fast financial recovery or an operational lever for lasting improvement.

1

Run a 30-day top 5 CPT parity scan.

Compare what your contract model expected vs. what paid.

Time: 2–4 days to run and triage.

Expected outcome: Immediate pockets of recurring underpayment.

"Start small: a 30-day lookback on your top five CPTs."

– Sarah Armstrong, CEO, TREND Health Partners

2

Rank and validate underpayment hypotheses.

Pick your top three theories about where the gaps might be and assign an owner for each.

Pull 100 claims per hypothesis and validate.

Time: 1-2 weeks

Expected outcome: Validate recovery estimates and root cause

3

Pilot one narrow automation or ML concept.

Start small with modifier or bundling errors in anesthesia or surgical rev codes.

Time: Retrospective 30–90-day sample.

Expected outcome: Measurable recovered dollars & playbook for scaling.

"Anesthesia/rev-code combos are a practical pilot."

– David Gaffey, Senior Vice President, Provider Operations, TREND Health Partners

4

Create a weekly payer-insight one-pager.

Capture your top five claim issues, authorization gaps, and payer trends. Share with your billing, clinical, and executive teams.

Time: 1-2 hours to prepare

Expected outcome: Faster preventions and fewer repeat issues

Each move connects directly to key metrics such as validated claims, monthly recoveries, and time-to-cash. These quick wins lay the foundation for a more comprehensive payment integrity strategy.

CONCLUSION

Start small, validate quickly, and put people in charge of the outcomes.

The payer-provider tug of war has been a long-running drain on U.S. healthcare but it doesn't have to be a losing game. The good news is that providers can reclaim ground by borrowing the discipline payers use and operating it within manageable, operational bounds.

The first 30-day top five CPT scan is low cost, high signal, and often reveals recurring misses that compound into meaningful revenue. That's the kind of discovery that moves the needle not just for your balance sheet and stronger payer relationships, but for your teams, your patients, and your mission.

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– Sarah Armstrong, CEO, TREND Health Partners

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Acknowledgements

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