DO YOU REALLY KNOW WHAT YOU ARE BEING PAID?

835 PAYMENT ANALYSIS: DIAGNOSTICS AND CHECKUPS

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INTRODUCTION

So do you really know what you are being paid? That is the burning question for many health care executives and revenue cycle leaders.

You're seeing that magic number each month in terms of what your net revenue is in total or across service lines, and how it fluctuates accordingly. Your team processes payments and/or writes off denials, but what does it really mean? Are your payments reflecting your contracted terms with your commercial payors? Are your claims being submitted, processed, and paid in a timely manner?

The 835 payment file holds a wealth of information regarding the health of your revenue cycle. Learning how to effectively tap this information and use it to your advantage to assess the strengths and weaknesses of your revenue cycle is key. Pinpointing your actual payments and categorizing denials across various payors can provide a concrete assessment of where you may be encountering problems. It can help you create a baseline and roadmap for where you want to go and provide a mechanism for systematically measuring your performance on a go-forward basis. This white paper explores the concept of 835 data analysis as a holistic solution to replace historical methods of sporadically evaluating payments and denials. The intent of the 835 analysis is to apply a more global, concrete approach to payment and denial analysis to leverage key revenue cycle drivers and affect your overall bottom line performance.

CHALLENGE/BACKGROUND

How do you currently track your payment trends and denials? It is common practice that these trends and patterns are evaluated in pockets or only on an as-needed basis as problems are identified. Payments may only be trended for certain service lines or by specific payors for a particular issue. Denials may be handled based on dollar-value, high volume isolated coding issues, payor specific coding or reimbursement issues, or as a result of third-party audits (e.g., RAC reviews, commercial payor reviews).

Once issues are detected, are they fixed on an isolated basis to correct and resubmit a bill, evaluated and corrected globally and/or interdepartmentally, or is the path of least resistance taken and the claim or charge is written off?

In today's environment of rising costs and declining reimbursement, it is important to have both a commanding handle on the dynamics of your payments and denials and the ability to address critical questions such as:

- What revenue cycle issues may be impeding accurate payments to your facility?
- How do you measure and correct breakdowns in the charge capture, coding, and billing processes?
- Is it time to reevaluate your payor contracts?

Diving into the detail of your 835 payment files can help you answer these questions by measuring your current performance, creating a report card of where you're performing well and where there is opportunity for improvement, and developing a succinct roadmap of where you need to go and what actions need to be taken to achieve the greatest improvement to your bottom line.

SOLUTION

So where do you begin? Your 835 payment files may seem like a daunting source of information. However, by applying the appropriate tools and tactics to succinctly parse this data, these large payment files can be turned into a useful diagnostic tool and roadmap for where you need to go to achieve improvements to your bottom line. Furthermore, they can become a checkup device on an ongoing basis, enabling continued process and financial improvements for your revenue cycle.

Before embarking on the steps to the 835 analysis, it is important to approach the process with concrete goals. There are key things you want to be able to accomplish, as illustrated in Table 1 below.

Table 1: Key Goals of 835 Analysis Process

- Analyze Payment Data
- Illustrate Key Payment Indicators
- Identify Payment Trends
- Quantify Summarized Denial Reasons by Denial Categories
- Target Areas for Performance Improvement
- Isolate Payor Trends [Do you see contract/reimbursement concerns?]
- Identify Revenue Leakage
- Build Baseline and Roadmap for Checkups on Improvements [e.g., Quarter-to-Quarter Comparative Payment Analysis]

The analysis process begins with asking for, obtaining, and effectively parsing the right data. A good starting point is selecting your top 5 payors and concentrating on a finite time period. Three months of your most current paid claims for your top payors can provide a wealth of information, yet is manageable from a data processing and analysis perspective.

The Analysis Process: Payment Data and Key Indicators

The analysis process begins with classifying and validating your payor mix information. The first part of the analysis is summarizing your charge, payment, zero payment, and patient responsibility data by payor and month-to-month. This information is also broken out by patient type: inpatient vs. outpatient. This is the initial pass at looking to see if any particular payment variances, patterns, or other trends emerge within a payor class and/or across time periods. These data elements can be compared across payors to discern performance strengths and weaknesses, as well as any payment anomalies that may require further investigation. This information is also the basis for the essential payment and performance indicators [see Table 2] that are calculated and provide the baseline foundation for telling the story of how your facility is really performing by payor, by time period, and in whole. These payment and performance indicators can be contrasted and compared on a go-forward basis by analyzing comparative payment periods (e.g., quarter to quarter) to serve as a "check-up" in gaging improvements, setbacks, and the roadmap for where you need to go.

Table 2: Essential Payment and Performance Indicators

- Average Charge/Claim
- Average Payment/Claim
- Claim Counts
- Percent Gross Revenue Collectible
- Average Time to Bill
- Average Time to Pay

The Analysis Process: 835 Denials Analysis

The second part of the analysis focuses on those Zero Dollar Payments and the specific categorical areas where you are not being paid: 835 Denials Analysis. The hundreds of claims adjustment reason codes are compiled and mapped into appropriate Claims Adjustment Denial Categories. The focus is on reason codes that you can act upon and these main Claims Adjustment Denial Categories are highlighted in Table 3. Excluded from the denials analysis are the exclusionary and non-avoidable adjustment reason codes such as: Coinsurance, Deductible, Discounts, IME/DME, Tax Withholding, Regulatory Surcharge, etc.

Table 3: Claims Adjustment Denial Categories

- Authorization
- CDM/Charge Capture
- Claims Submission
- Claims Follow-Up
- Insurance Verification
- Diagnosis/Documentation
- Non-Coverage

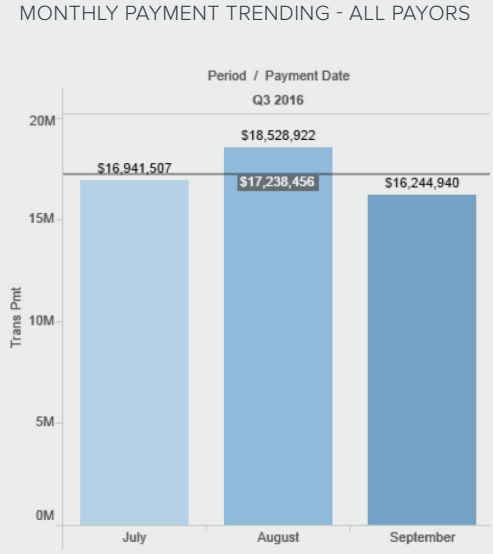
This level of analysis gives you a snapshot of your performance, strengths, and weaknesses relative to the denials by category and specific reason codes within that category. It can pinpoint where denials have increased or decreased in dollar value and/or claim volume, as well as by payor and facility for a multi-hospital health system, which is very valuable when comparing quarter-to-quarter or specific time periods of payment. The level of detail garnered from the denials analysis forms the foundation for your roadmap of next steps in enabling prioritization of performance improvement initiatives and achieving improvements in your bottom line.

The Output: Dashboard Reporting

The entire analysis: Payment Data, Key Indicators, and Denials Analysis is tabulated and graphically displayed in Tableau Reader. Additionally, a summary matrix of the key opportunities identified and prioritized, by value and level of effort, is provided [i.e., your roadmap of next steps]. This information is presented to you and the entire Tableau Reader file is your value-added takeaway that enables you and your team to perform user-friendly, "point and click" drill downs on all of the specific roadmap opportunities identified.

The following illustrates examples of the 835 Payment Analytics content provided through Tableau Reader:

Exhibit 1: Transaction Payment Trending by Month and Payor



PAYOR	JULY	AUG	SEPT	GRAND TOTAL
ANTHEM	$5,909,767	$7,950,929	$5,342315	$19,203,010
MEDICARE	$6,621,351	$6,320,521	$5,770,799	$18,712,671
AETNA	$2,496,822	$2,407,684	$2,830,489	$7,734,995
UNITED	$1,140,255	$1,267,194	$1,403,355	$3,810,803
MEDICAID	$773,313	$582,594	$897,982	$2,253,889
GRAND TOTAL	$16,941,507	$18,528,922	$16,244,940	$51,715,369

Exhibit 2: Payment Days

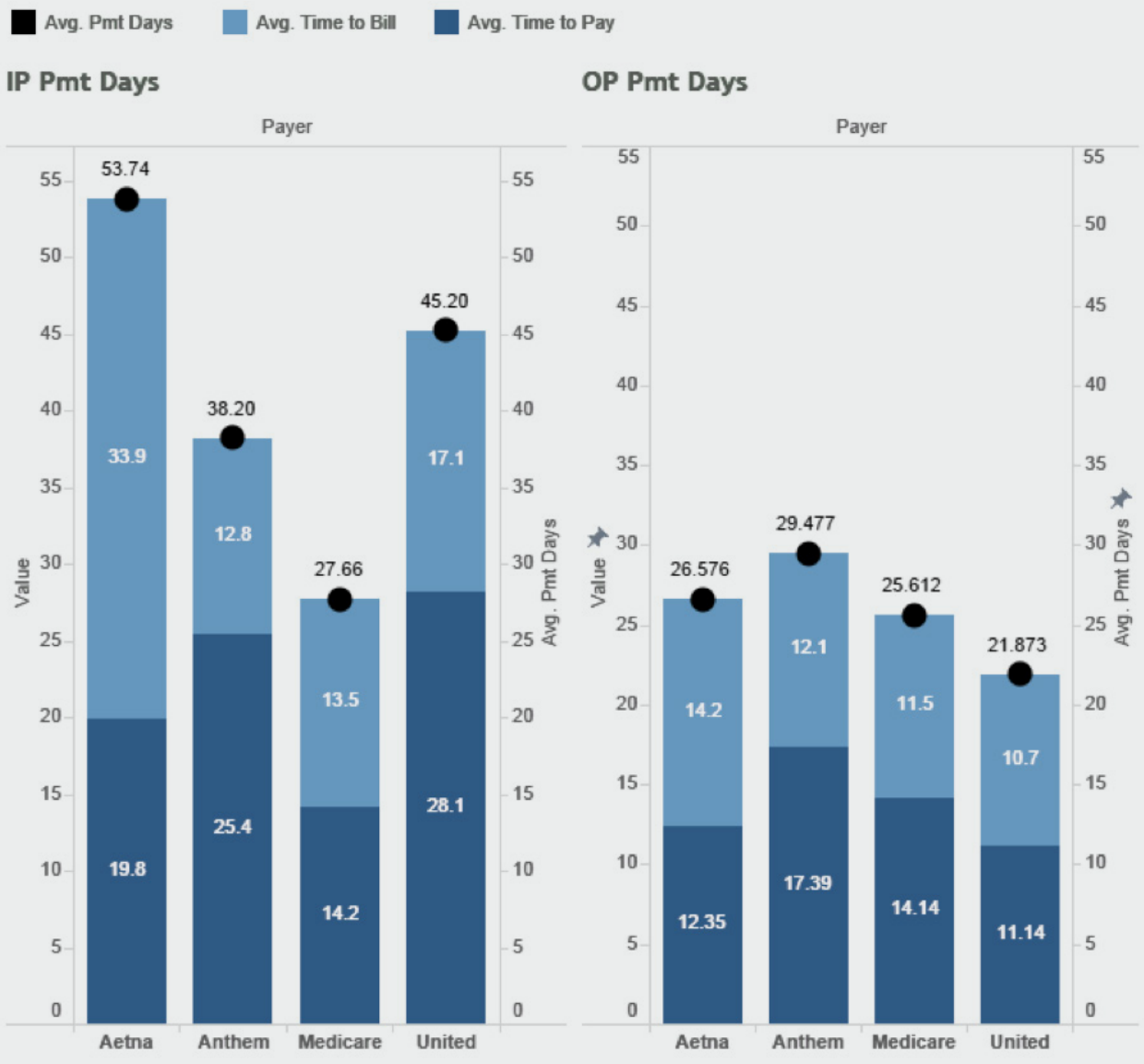


Exhibit 3: Claim Payment Performance Indicators:

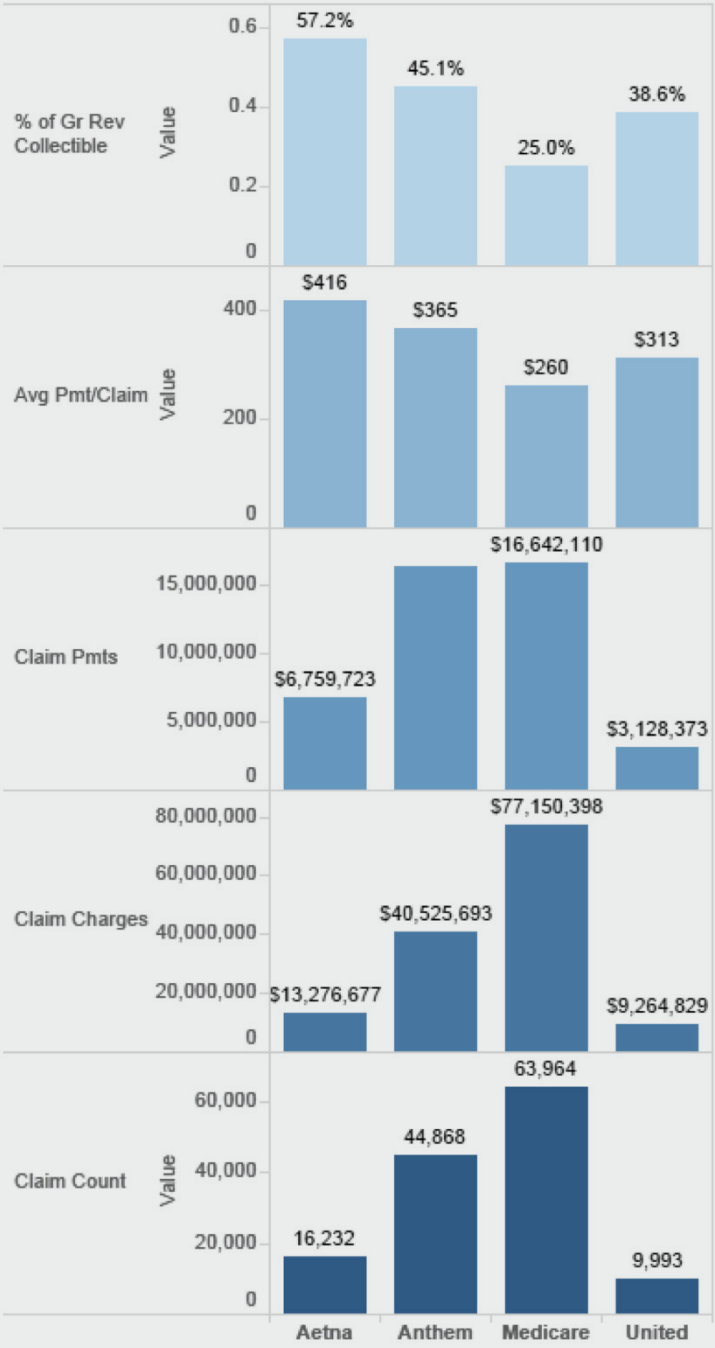
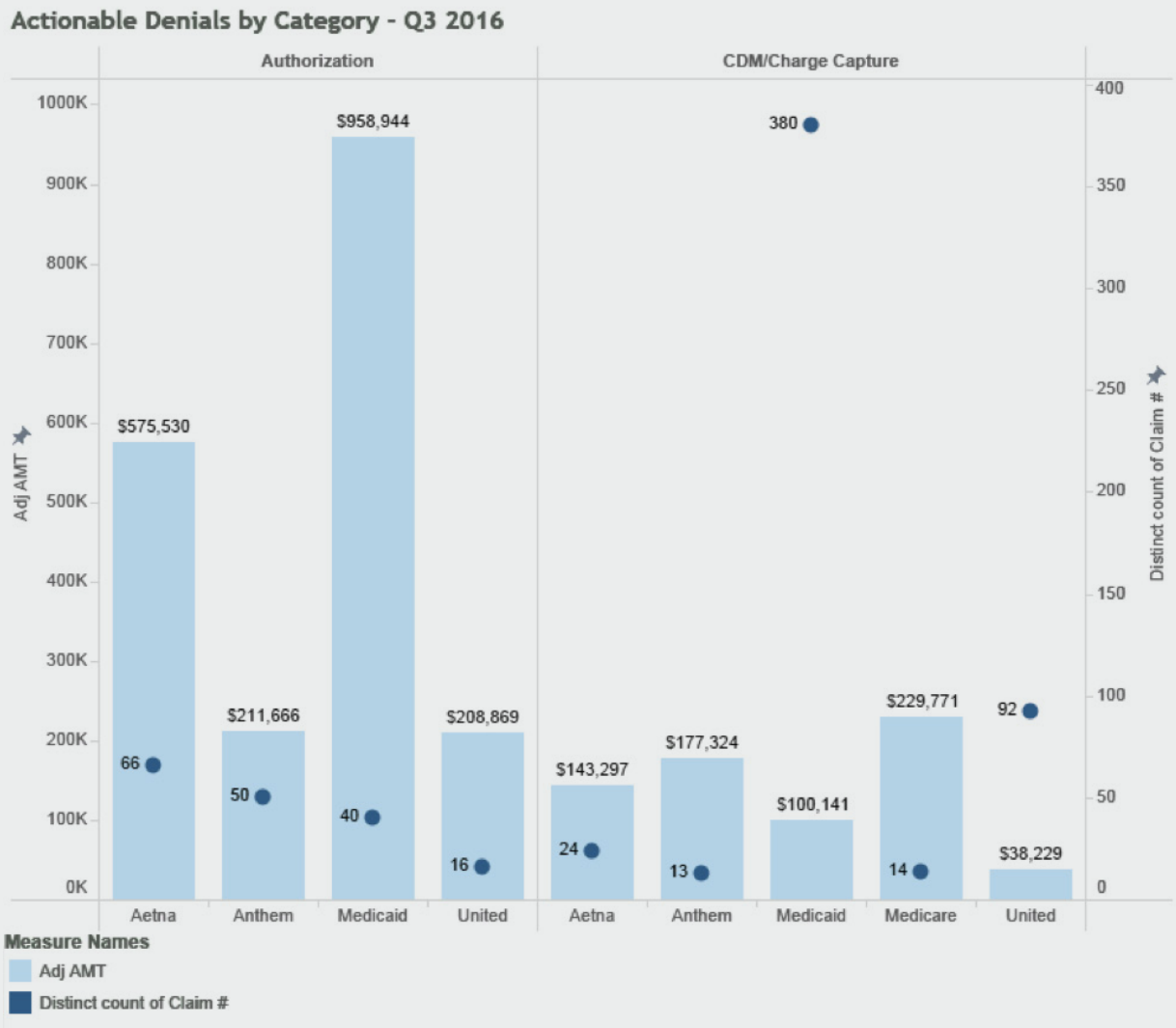


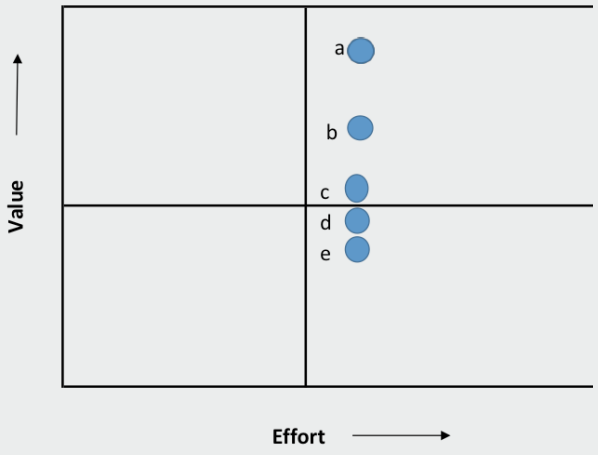
Exhibit 4: Denials by Category



Additionally, your Roadmap of Next Steps is your baseline source of initiatives that you want to consider pursuing and can be used as your report card and monitoring tool on a go-forward basis as you continue with quarterly period-to-period 835 payment analytics monitoring.

The following is an example of the **Roadmap of Next Steps**:

Value Matrix



a. Pricing Analysis

b. Process Review:
Claim Follow-Up/Documentation Requirements - Payor Focused

c. Process Review:
Authorization - OP Focal Areas

d. Process Review:
Medicare Medical Necessity Verification for OP Services

e. CDM E-Review/Charge Capture Focused Review

835 Analytics Findings

CATEGORY	FINDING	RECOMMENDATION	IMPACT	EFFORT	NEXT STEPS
A. Pricing Analysis	The 835 analysis identified instances where reimbursement was made on lessor of charges. Payor ABC had the greatest volume of accounts and associated charge for a variety of outpaitient services. For the 6 month period reviewed. ~200,000 in total claim charges paid on lessor of charge.	Perform a hospital pricing analysis to ensure charges are adequately represented based on the market area, payor stipulations, and hospital costs.	High	Med	Hospital Pricing Analysis

CONCLUSION

Monitoring payments and denials is paramount to survival in the healthcare industry today. The 835 Payment Analysis provides an automated mechanism to identify concrete findings related to your payments and denials, and the ability to trend on a go-forward, comparative payment period basis. All of the resulting analytics enables the development of a prioritized roadmap for instituting process changes and implementing performance improvement initiatives to improve your bottom line and revenue stream.

Call or email us today to find out how MedCom Solutions can help you improve your bottom line!

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