Altair

Unlocking 835 Remittance Files with Self-Service Data Preparation

With an increased focus on controlling costs and improving the quality of care, the healthcare industry has implemented new technologies to increase operational efficiencies. Electronic Medical Record (EMR), Computer Physician Order Entry system (CPOE), or bedside monitoring software, are a few examples of these new technologies. Regardless of what is deployed, a healthcare claim needs to be submitted to a payor for adjudication. The result is a flurry of 835 EDI remittance files that are transmitted back from multiple payors. 835s contain a wealth of information about whether claims were paid or denied and the specific reasons why claims were adjusted. Understanding and unlocking the data contained within an 835 file in a timely fashion can have a significant impact on revenue cycle management and the financial health of providers of all sizes.

The purpose of this whitepaper is to review the challenges, opportunities, and analytics that 835s can provide by utilizing self-service data prep tools to unlock them.

Understanding the challenges in working with 835 data

Approaches to understanding 835 remittance data

Four opportunities for 835 Analytics

Introduction

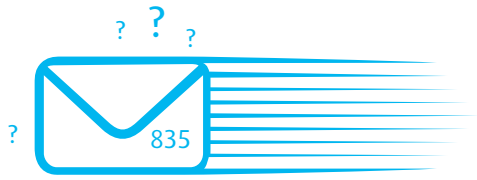
Today's healthcare providers are faced with the convergence of remittance data from multiple payors, all of which occur at different frequencies (e.g., daily, weekly, and monthly). Over 70% of remittance data is provided via 835s. Providers can also receive paper remittance advices or electronic PDFs that contain a smaller subset of remittance data that is contained in the 835. This data is often hand-typed into practice management systems, financial applications, General Ledgers, etc. Consequently, the revenue cycle process is inefficient and is fraught with potential data quality errors when humans are manually updating accounts with remittance data.

Overcoming the Roadblocks in Understanding 835s

Utilizing 835 EDI data as a source file for analytic purposes poses numerous reporting challenges. The 835 file format wasn't built with analytics and reporting in mind; it was built for transmission purposes between payors or clearinghouses and providers. However, the 835 is the first opportunity to understand the claims adjudication results from a payor and indicates whether a claim is paid or denied.

Unlocking the key data elements in the 835 within the file, claim header, and service line can give providers a competitive advantage, as they can derive immediate value upon receipt of an 835. Compare this to the normal back-office process of posting remittance information to a HIS system, practice management system, etc., and generating reports, all of which usually takes a couple of days to a week, depending on IT processing schedules.

835 files are often not used, understood, or only partially processed because providers often don't have the existing IT infrastructure, EDI translators, or 835 transaction set knowledge to break apart the 835 and understand its complicated structure and format.



A U.S. healthcare provider with more than $175 million in revenue and 250 beds is a prime example of how 835s are underutilized. Currently, the hospital receives 835s on a daily or weekly basis depending on the adjudicating payor. The files are received and stored on their internal servers, but are never accessed, translated, used for posting remittance data, or analyzed. The files are simply stored on the server, which means the hospital is unaware of how much they have been paid or denied until a small team of staff members in patient financial services receives the paper remittance advices, usually one to two weeks after receiving the 835, and then types the results into their MEDITECH system.

Gains in efficiencies and revenue could be derived by using data preperation to retrieve key data elements from the 835. A reduction in denials of three to five percent has the potential to increase revenue by $5-$10 million revenue. The ability to identify denied service lines will provide the healthcare provider an opportunity to fix the incorrectly billed CPT-4 ,correct payments for existing claims, and process future claims with the same codes.

The Reporting Challenges for an 835 Can Be Broken Down Into Four Themes:

- Complex format and structure
- Multiple versions (4010/5010) and receipt frequency (daily, weekly, monthly)
- Data elements require code set translation
- Lack of data visualization capabilities for 835 analysis

Below is a typical 835 file that contains masked claims data, illustrating the intricate nature of the file and its data. Without a significant understanding of an 835 file, the average end-user wouldn't be aware of the number of claims contained within this file, claim status (paid, denied, pended, etc.), claim paid amount at both the header and service line levels, the rendering provider, or the payor. We will delve into five significant reporting opportunities that providers could benefit from by unlocking the 835 data, but let's first understand the challenges that exist in trying to create reporting and analytics from an 835 file.

To increase the analytic value of an 835, healthcare organizations should define key performance indicators (KPIs) that can be measured for individual files, and applied over a period of measurable time. Using BI tools to align KPIs, users can quickly and intuitively navigate the data. One can drill down into the data to understand the drivers behind financial performance and claims adjudication results for claims from multiple payors, time periods, or for certain types of claims (e.g., by DRG). The diagram above depicts a series of dashboards created with 835 files.

The transformation of 835 EDI files into dashboards requires an extensive knowledge of their structure and format. Altair's unique and powerful data preparation solution extracts and integrates key data elements needed for 835 reporting.

Inconsistent 835 Reporting Strategies and Priorities

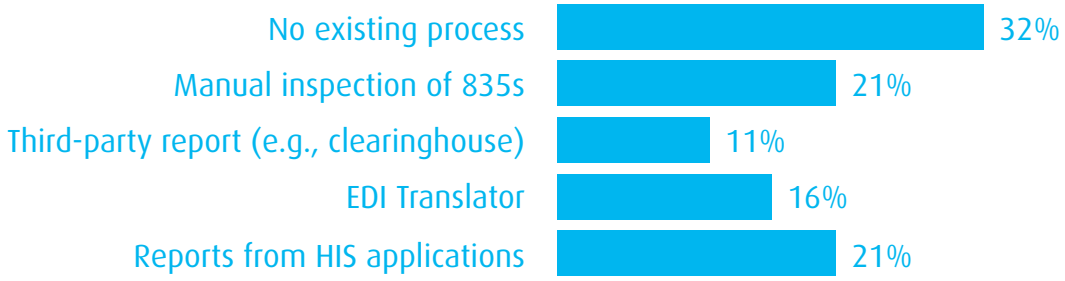
An "835 Analytics" survey conducted by Altair identified an interesting, yet alarming trend in how healthcare organizations compile and analyze 835 data today. Based on the survey results, the varying ways of creating 835 analytics have inherent issues with reporting latency, data quality, manual data entry, or use of external 3rd-party EDI translators and clearinghouses. There is no uniform approach to extracting and analyzing 835 data.

There is consensus across the survey respondents to develop consistent, reusable, and measurable 835 analytics. Data extraction, transformation, and visualization (e.g., dashboards) accounted for 91% of the primary challenges in reporting on 835 data. The primary challenges comes in trying to extract, normalize, transform, and output the 835 data into a format that permits end-users to further aggregate and summarize data. The complexity cannot be understated since 835 data can be repeated in multiple loops, segments, and field elements. The nature of the 835 and healthcare claims requires that an 835 analytics and reporting process must account for the nuances and variations in how claims can be organized by payor, pay date, provider, and patient. Regardless of the size of the provider organization, healthcare organizations who wish to derive immediate benefits from the 835 need to understand their current reporting mechanisms, their downfalls, and what 835 analytic questions they would like to answer. The 835 provides so much information that understanding its value is often looked at in measurable categories. Listed here are four opportunities that IT programming, EDI developers, and financial analysts could start to measure and monitor with the implementation of an 835 data preparation solution.

In an effort improve financial and operational performance healthcare providers are constantly trying to understand and interpret why claims are denied, especially at the service line level.

The 835 is critical because it's the most immediate source of data to better to understand what occurred with a claim; with this understanding future claims with similar characteristics can be paid at the highest possible rates and in the quickest manner possible.

Survey: Existing 835 Analytic Processes



Using Data Preparation for 835 Analytics: Four Opportunities for Financial Improvement

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1

Denied Claims

A denied claim can have a significant financial impact on a hospital, especially if it's for a lengthy hospital admission. Although claims are denied for numerous reasons, there are no quicker ways to identify denied claims than by recognizing them within an 835.

Claims can be fully or partially denied, which means there are service lines that were denied. To truly understand the issues impacting the clean adjudication of a claim, both claim header and service line detail information need to be extracted, aggregated, and reported on. Whether measuring denials by payor, DRG, procedure code, adjustment reason code, etc., the data is all contained within the 835 and just needs to be unlocked, transformed, and analyzed. Once this information is understood at both the claim level and aggregate level, healthcare organizations can identify how to resolve issues prior to billing the payor. This will significantly reduce accounts receivables and improve cash flow for hospitals.

The benefits of reducing denied claims have a positive impact to both providers and payors who are in an endless loop of processing claims, often multiple times. A 2-3% reduction in denied claims would provide significant financial improvements, reduce claims workloads, and provide opportunities to utilize existing resources for different tasks in patient financial services, revenue cycle, and finance. Denied claims that can be improved upon by interpreting the 835 upon receipt of the file, as well as over a period of time to better understand the real drivers why claims are denied.

2

Reconciliation - Outbound Claims vs. Inbound Remittances

Healthcare providers often don't have an automated way to track the outbound claims that were submitted on 837s or with paper claims and correlate whether those claims were paid or denied via an 835. As a result, claims can go unaccounted for and uncollected unless a manual review and audit is done to ensure that all claims have been accounted for, regardless if they were paid or denied. This is a cumbersome process and involves a lot of effort to identify the claims, payors, and to initiate a collection process of outstanding claims that may be several months outstanding.

3

Crossover / Coordination-of-Benefit (COB) Claims

In today's healthcare marketplace, patients often have multiple insurance plans which require healthcare providers to properly identify, bill, and collect from multiple payors. There are rules and regulations to determine who the primary, secondary, and tertiary payors are for certain types of healthcare claims. Currently, healthcare providers work retrospectively to identify claims after they have been denied by the incorrect payor to get them submitted to the correct payor.

However, this information is contained in an 835 if the primary payor determines there is a crossover/COB carrier who should be paying. The 835 will identify the new payor who will be paying the remainder of the claim, as well as how much has been paid or denied because it was a COB claim. Managing this process and determining what has been paid, re-directed for payment, and reconciled against the original claim is a daunting task, often manual, and usually not well managed.

Proactively identifying information upon receipt of an 835 and a process to track claims when COB is involved requires the ability to automatically clean and transform new claims records as they arrive into the healthcare system. Complex claims in which there are multiple payors can be dealt with more easily using data transformation tools that can work to remove the complexity of 835 files by aggregating data points together and transforming volumes of 835 files into usable data for automatic claim processing.

4 Provider Level Adjustments

Depending on the patient mix, Medicare and Medicaid are likely to be a larger percentage of a healthcare provider's payer mix. Level adjustment adds even more complexity when Medicare and Medicaid is involved. For most healthcare providers, payer mix will likley grow due to changes in age demographics. With a shift towards bundled payments for Medicare patients it is probable that there will be increased scrutiny on the financial performance of Medicare and Medicaid claims.

Medicare and Medicaid 835s often utilize the Provider Level Adjustment segment located towards the end of an 835 This segment reports on adjustments that are neither at a claim or service line level, but impact the actual payment to a provider, positively and negatively.

The sample below depicts an 835 provider level adjustment that without proper understanding and accounting can a significant impact on a provider's finances. Regrettably there are many healthcare providers, hospitals, IPAs, etc. who not only don't translate and post their remittance results, but also don't even extract major pieces of information such as provider adjustments. Provider level adjustments occur for a variety of reasons, including, but not limited to: late charges, interest, rebates, allowances, bonuses, adjustments, bad debt, capitation, penalties, IRS withholdings, interim payments, etc. So, healthcare providers need to account for these adjustments more than ever to understand the financial impact retrospectively, as well as for predictive modeling and understanding the impact to accounts receivable, cash flow, etc. With the advent of bundled payments for new reimbursement programs, there will be an increase in provider adjustments that are submitted on an 835 in the provider level adjustment segment. In addition, the volume of patients and claims will significantly increase for both Medicare and Medicaid, which is another reason why analyzing the provider level adjustment data is essential.

Sample Provider Level Adjustment:

PLB*123456789*20101231*WU*985450.87*AP>TLC JER082910*-887349~

Once translated, this adjustment provides:

- An unspecified recovery adjustment by the payor of almost $1 million
- Accelerated payment of benefits of $887,349

835: Migrating From Translation Engines to Self-Service Data Preparation

Once thought to be an EDI file with a difficult to understand structure, syntax and code, it's he 835 is in fact an untapped resource for analytics. The data contained within the 835 can provide useful analytics such as:

- Total Paid Amount by Payor
- Total Paid Amount by Pay Date
- Volume of Denied Claims by Pay Date
- Volume of Denied Claims by Adjudicated Reason
- Code l Inpatient vs. Outpatient Comparison
- (Total Charges and Paid Amounts)
- DRG Utilization – Total Charges and Paid
- by DRG l Claim Status Distribution
- Units & Charges by Revenue Code
- Number of Days
- Number of Visits
- Number of Services
- Total Charges
- Total Paid
- Total Patient Responsibility

The commitment from healthcare providers to 835 analytics needs to harness both the point-in-time and on-going trending opportunities. Without a committed effort to unlocking its value, the 835 will continue to be an underutilized asset derived as part of a greater vision from the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Altair self-service data prep solutions takes report mining to a new level: enterprise level capabilities that transforms static, isolated data from existing reports into a dynamic framework for self-service analysis and visualization.

Altair automates the processes that enable users to easily access, extract and incorporate data from any combination of existing reports already published inside or outside the enterprise, then create, publish and distribute the resulting dynamic, interactive reports throughout the enterprise – without requiring the time, expense or expertise of valuable IT resources.