835 Assessment of Changes (8010v)

1. RAS (Claim Adjustment Information)

   RAS Segments are new to the 8010 version. The RAS segments offer a way of associating multiple Remark codes with a single CARC for the respective adjustment amount.

   - The 5010 version used the CAS segment to explain why the claim was not paid in full (including dollar amounts, group code and CARC code). Remark Codes that were related to these adjustment amounts were reported in the MIA or MOA segment at the claim level or the LQ segment at the service level. Consequently, the Remark Codes were not directly related to CARC codes.
   - In the 8010 version, the RAS segment replaced the CAS segment. With the RAS segment, the Remark Codes must now be associated directly with the related CARC, when a relationship to a specific CARC exists.

     Each RAS segment identifies a single adjustment to the original submitted charge for the claim/service by:

     RAS01 = Adjustment Amount – this is the amount of the adjustment.

     RAS02 = Claim Adjustment Group Code – identifies and categorizes the general class of the adjustment and any related responsibility from a set of codes in a standard external code list.

     RAS03 Adjustment Reason is a composite element

     RAS03-01 = Claim Adjustment Reason Code (CARC) – identifies the reason for the adjustment using a code from a standard external code list.

     RAS03-02 = Code List Qualifier Code

     RAS03-03 = Remark Code – Identifies additional information related specifically to a CARC that further clarifies the adjustment. The 835 can include up to 5 remark codes.

   BPR opportunity – Recommend 837 and 835 best practices for handling situations when a 5010 837 is submitted with a CAS segment and a corresponding 8010 837 corrected or secondary payer claim is submitted with a RAS segment.

2. Remark Codes

   In the 8010, remark codes are linked directly to the CARC code when appropriate.

Remark Codes serve multiple functions within the 835 transaction. Sometimes they are related to a CARC and are a critical part of the message of a specific RAS segment/CARC. Other times they have no correlation to the RAS segment and provide additional information that is part of the general claim or service adjudication message.

RAS Segment - Remark Codes are situational in the RAS segment but are required when they are necessary to fully explain the adjustment message and the related CARC.

LQ Segment - Certain informational Remark Codes can be used without any association to a specific CARC, at either the claim or service level. Remark codes used without any association to a specific CARC are included in the LQ (Health Care Remark Codes) segments at the claim level or service level.

Additionally, there is a new remark code qualifier that supports industries needing very specific regulatory language that does not fit the criteria for a remark code. It is RM (Industry Specific Remark Codes) and is located in the RAS and LQ segments in the Code List Qualifier Codes field.

3. Invalid Procedure/Service Code

   In the 8010, a new code was added for use when an invalid or unrecognized procedure/ service code was submitted on the claim and used for adjudication. This new code - RA (Return Code) - is located in the Product or Service ID Qualifier in the SVC segment.

4. Tooth information

   In the 8010, a new segment was added that identifies tooth, number, tooth surface, or oral cavity area used in the adjudication of the claim or when it was submitted on the claim.

5. Card Payments

   The 8010 allows for payments made by credit cards.

   For Providers that choose to receive card payments (p-card, debit card, and credit card), the 835 allows for remittance information to be conveyed for them. This must be agreed upon in advance by all trading partners for this payment type.

6. Multiple Payers

   In the 8010, new Corrected Priority Payer Name loop and segments are added for use when a payers records indicate that another payer has responsibility for processing the claim. This can also accommodate multiple payers. Only use when the claim is not being transferred to that payer.

Also, Crossover Carrier Name segment repeat is expanded to handle multiple occurrences. The crossover carrier is any payer to which the claim is transferred for further payment after being finalized by the current payer.

7. New Dates

   3 new date segments were added in the 8010.

   - Corrected Onset of Current Symptoms or Illness Date
   - Corrected Accident Date
   - Clean Claim Date

   BPR opportunity – Recommend usage practices for these dates.

8. Real-Time Claim

   The 5010 implementation guide was only intended to support use in batch mode. It stated that the implementation guide is not intended to support use in real-time mode. That changed in 8010 and the 835 now is intended to support batch and real-time mode.

   In Real-Time claim mode the computer to computer communication link remains open until it receives an 835. Using Real Time must be agreed on between trading partners.

   There are two types of Real Time Claims identified. The Real Time Predetermination/Estimation and Real Time Adjudication.

   - Real Time Predetermination/Estimation submits a claim for a proposed service and gets a response in real time of the anticipated payment. This allows the providers to identify member responsibility and patient financial expectations before service. A predetermination is identified by Claim Status Code value 25 (predetermination pricing only – no payment). Use CARC 101 (Predetermination: anticipated payment upon completion of services or claim adjudication) to balance the 835.
   - The Real Time Adjudication adjudicates the claim in real time returning the payment or denial information. This allows the providers to collect member responsibility based on the finalized claim adjudication results. The actually provider payment is sent in a subsequent batch 835. Use BPR01=K (Reimbursement to Follow) to balance the 835.

9. Submission Changes

   The 8010 requires reporting of information that was changed during processing so that it is different than what was submitted on the 837

Corrected Patient/Subscriber Name segment repeat expanded. Now you can indicate if it is the Patient name and/or the Subscriber name is being corrected. Must use if the information submitted on the claim is different from the information in the payer's systems.

New segment Original Claim Information must reflect the original claim type (professional, institutional inpatient, institutional outpatient, dental, pharmacy) if different than the claim type submitted on the 837.

10. External Code List

Many codes that used to be found in the TR3s are now located in the TR2s so they can be modified without waiting for a version change.

The new codes will be listed on X12.org and the new codes and instructions for using them will be in the TR2 that is posted in Glass