835 – Significant Changes
2nd Round Review

1. RAS (Claim Adjustment Information) (Service Adjustment Information)

   The RAS segment (Loop 2100/2100 RAS) replaces the CAS segments for reporting adjustment amount and codes. The RAS segment appears at the claim and service line level.

   RAS Segments are new to the 8010 version. The RAS segments offers a way of associating the adjusted dollar amount with CARC code(s) and corresponding Remark code(s).

   - 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 an 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 (CARC) – identifies and categorizes the general class of the adjustment and any related responsibility from a set of codes in a standard external code list. (PR, CO, PI, OA)

     RAS03 Adjustment Reason is a composite element

     RAS03-01 = Adjustment Reason Code (CARC) – identifies the reason for the adjustment. At least one is required (though it can repeat if appropriate). Additional CARCs can be provided if each CARC applies to the entire RAS01 amount. Example of repeated CARC code Show example of CARC code and how it looks when it repeats: **RAS✱200✱CO✱39^61~**

     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.

     See front matter 1.10.2.4.2 Claim/Service Adjustment Information Segment for more information.

BPR Considerations:

1. As outlined in the TR3, the 8010 version RAS segment reports an amount and allows for multiple CARCs to associated with that amount. (**RAS✱200✱CO✱6^7~).**

   However, it is much more frequently the case that providers process amounts differently depending upon the CARC. As such, a best practice recommendation should be considered where amounts are separated by their respective CARCs and reported in separate RAS segment **RAS✱100✱CO✱6~, RAS✱100✱CO✱7**

2. 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. (also if NCVHS does not put 837s and 835s in the same sequence what do we do with RAS and remark codes)

   Examples from the X12 5010 TR3 (x222)

   CAS✱PR✱1✱125.32~
   CAS✱OA✱93✱15.06~

   Examples from the X12 8010 TR3 (x323)

   RAS✱125.32✱PR✱1~
   RAS✱25✱PR✱3~
   RAS✱200✱CO✱6^7~
   RAS✱500✱CO✱45:HE:MA01~
   RAS✱1225✱CO✱16:HE:M24^15:HE:N517~
   RAS✱2225✱CO✱16:HE:M44:M45:M49^146:HE:MA63:MA65~
   RAS✱2100✱OA✱18:HE:N522:N702~

2. Remark Codes

Biggest changes in remark codes:

- New RAS segment (Loop 2100/2110 RAS)
- Remark codes removed from the MIA and MOA segments. (Loop 2100 MIA/ MOA)
- LQ segment added to the claim level - (Loop 2100LQ)

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

Both the RAS segment and LQ segments appear at the claim and service line level. A new LQ segment is added at the claim level to hold these codes that are not related to a CARC.

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. (See RAS information above)

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) segment.

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. Tooth information

   In the 8010, a new segment (Loop 2110 TOO) 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.

4. Submission Changes

   The 8010 requires reporting of information that was changed during the adjudication process, e.g. (Loop 2100. REF).

   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.

5. Expanded DRG categories

   In the 5010 CLP11 contained a DRG. The 8010 they expanded CLP11 to be a composite element. Now CLP11-01 reports the DRG type qualifier (i.e. APG, DR, etc) and CLP11-02 reports the related code used to adjudicate the claim.

6. Forced Balancing. (1.10.2.1 paragraph 2)

   The TR3 now explicitly states that force balancing is not allowed in the 835. Payers occasional use adjustment codes that are not relevant to the adjudication of the claim just to make the claim balance. Inappropriate use of adjustment codes strictly for the purpose of balancing is not allowed.

7. Member not Recognized

   In the 4010 CLP02 (claim status code) qualifier code 4 was used to represent a denied claim.

   In the 5010 CLP02 (claim status code) qualifier code 4 definition was changed to patient/subscriber not recognized. However, some payers never changed their systems to represent the new definition causing much confusion to the providers.

   In the 8010 Loop 2100 CLP, CLP02 (claim status code) qualifier code 4 was deleted from the code list. This will force payers to remove the inappropriate coding.

   In the 8010 CLP02 (claims status code) qualifier 35 was added to represent patient/subscriber not recognized.

8. Message Matching. (1.10.2.21)

   The TR3 now explicitly states that the messages on the 835 must be consistent with the business messages provider through other delivery methods. Providers have complained the lack of matching of the messages causing them confusion.

9. Clean Claim Date

   New DTM segment (Loop 2100 DTM) Clean Claim Date to support State and Federal regulations. This represents the date the claim has no defects or special circumstances that would delay a timely payment.

   WAC 284-170-431 - (3): For purposes of this section, "clean claim" means a claim that has no defect or impropriety, including any lack of any required substantiating documentation, or particular circumstances requiring special treatment that prevents timely payments from being made on the claim under this section.

10. Payment Methodology

    New REF Payment Determination Methodology segments at the claim and service line level (Loop 2100/2110 REF) to report the methodology used to derive allowed amount in adjudication.

Claim level qualifier examples: 9V- payment category, AFT-Fee Schedule Identifier, APC-Ambulatory Payment Classification, etc.

Service line qualifier examples: 1S-Ambulatory Patient Group (APG) Number, 9V- payment category, AFT-Fee Schedule Identifier, etc.

11. Self-Insured or workers comp information

    New PER segment Entity Self-Insured Plan/Jurisdiction Contact (Loop 2100 PER) to support situations when the member is in a self-insured plan that is different than the Payer identified in loop 1000A. This information identifies for the provider the contact to discuss coverage issues, etc. Probable BPR needed for this new segment.

    New PER segment Workers' Compensation Payer Website to support the website location where the provider can obtain description of the jurisdiction rule/statute.

    BPR Considerations:

    Determine if a BPR is necessary to ensure consist implementation of "the contact to discuss coverage issues, etc. Probable BPR needed for this new segment."

12. X-Clarify, X-TR3: Consistency

    These rows indicate changes that we made not to alter the business concept but to add a little more clarification.

    - *'X-Clarify*' are changes that apply just to this transaction.
    - *'X-TR3: Consistency*' are changes that apply to more than one TR3, but may not be in all TR3s. X12's aim is to promote consistency between all transactions where/as appropriate.