<u>837D - Dental Assessment of Changes (8010v)</u>

1. **Balancing**

Balancing changes are primarily related to providing clarification about how balancing should be done, not about changing the balancing.

Claim Level:

In section 1.4.5.1 Claim Level of the front matter, a few sentences were added to help with clarity and consistency.

- Claim Level added: "When a previous payer's adjudication is only at the claim level, the claim level Payer Paid Amount (Loop ID-2320 AMT02) must equal the Total Claim Charge Amount (Loop ID-2300 CLM02) less any claim level adjustment amounts for that payer (Loop ID-2320 RAS adjustments)".

- Line Level for support of Loop 2430 SVD01 the sentence, "The value reported in this field must match the corresponding Other Payer Responsibility Sequence Code reported in Loop ID-2320 SBR01". The 5010 says that the value must match the identifier in 2330B NM109.   This is saying, 8010 uses the 2330B REF Other Payer Identification, instead of the 2330B-NM109.

Line Level:

The 5010-guide said that Line Adjudication information loop must balance, but the 8010 for clarity says the line adjudication loop must balance to the line-item charge amount for that service line.

Both the Claim Level and Line Level say that balancing does not apply to predetermination requests.

2. **Coordination of Benefit (COB)**

The SVD03, OI07 and the AMT are the most changed. Most of the others are for clarity.

- SVD03-07 – Procedural Code Description was changed to Not Used. The guide says that it is not necessary when reporting COB claims.

- A new data element situational note was added in loop 2320 OI07 Provider Accepts Assignment Code. OI07 is required when the other payer reported in 2320 is Medicare, including Medicare Fee For Service (FFS) or a Medicare Advantage Plan (Medicare Part C) .

- New data element code values were added to OI07 in the 2320 Other Insurance Coverage Information. It is Provider Accepts Assignment Code. It provides 3 choices: A (assigned), B (Assignment Accepted on Clinical Lab Services Only) and C (not Assigned).

- AMT - this is a new segment (Allowed Amount). Payers can report the allowed amount at both the claim and service line.   The claim level amounts reported in the 835 are reported in the 2320 AMT segment with the qualifier B6 (allowed – actual). The line level allowed amounts reported in the 835 are reported in the 837 in the 2430 AMT segment with the qualifier B6(allowed – actual). Any total amounts paid will go in the AMT segment with the qualifier D (Payor Amount Paid).

In addition to the AMT segments, section 1.4.2.1 of the Front Matter Added a new sentence to Step 2 below Figure 1.1. The sentence "*Upon receipt of the 835, the provider sends a second health care claim transaction (837) to Payer B, the secondary payer. The subscriber loop (Loop ID-2000B) now contains information about the subscriber who holds the policy with payer B*."   *** Note: This practice is also called out in the Washington State Best Practice Recommendation (BPR).*** Step 2 in the front matter added those two sentences and the two sentences that describe how the allowed amount is reported.

Note: Examples of COB will be in the TR2's the front matter does not include COB examples.

3. **Diagnosis**

The support for Advanced Billing Concept Codes (ABC) across the TR3s was removed as HHS has discontinued the associated pilot project.   ABK (International Classification of Diseases Clinical Modification (ICD-10-CM) Diagnosis)

4. **Factoring**

This is a new capability that appears to be of value to Property and Casualty - but of limited value, if any, to healthcare.

These are claims that are sold to another entity at a discount. Property and Casualty needed the ability to report external entities who purchased accounts for a payer (factoring agent).

A non-healthcare provider entity can purchase claims from a healthcare provider and will own full rights to the financial obligation. In many cases, the Pay-to Factoring Agent will receive the initial bill from the provider. The Pay-to Factoring Agent will submit the claim to the payer and based on adjudication will receive the payment for the services rendered.   This is done to improve cash flow for the provider that is selling the claims and also helps enhance their business connectivity.

The front matter was updated in Section 1.4 to supporting factoring . It states that the factoring agent that purchased the receivable but has not provided the medical service may originate an 837 to another payer for reimbursement.   X12 added a new loop to the TR3.

Loop (2010AD) was added for Factoring Agent information. The loop contains new segments, data elements and code values to support factoring.

5. K3

The 8010 created a K3 segment to support a temporary solution for unexpected data requirements of regulatory action. It is not to be used for any other purpose. If a temporary use is required until an updated version of the TR3 is required, an entity must submit a change request to X12 containing a business documentation of the need. If X12 agrees there is a need a temporary permission is granted to use the solution.

The 8010 has added 3 new sections to the front matter on using the K3 segment. They are 1.4.6.1 Requester Submission, 1.4.6.2 ASC X12 Review/Approval and 1.4.6.3 Formatting of K3 Content.

K3 is in multiple TR3's.

6. Predetermination

A claim can be submitted for a predetermination as well as for claims adjudication.

- The first sentence in the first paragraph of section 1.4 Business Usage was modified as highlighted in blue below.

    "This transaction set can be used to submit health care claim billing information, encounter information, or requests for predetermination from providers of health care services to payers, either directly or via intermediary billing services and claims clearinghouses.

- Section 1.12.6 Date of Service for Predetermination Requests explains the date used to support predeterminations. The date of service associated with a predetermination is the date the transaction was created, and all medical codes is based on the Original Claim Creation Date. The reimbursement rates, patient responsibility or other situations of significance are to be based on the date of the payer adjudication.

- 835 will report the results of pre-determination requests. Section 1.7.1 Health Care Claim Payment added the last two paragraphs to support how the 835 will handle the predetermination request. Basically, it says that an 835 response will be returned and to check the 835 TR3 for coding specifics. Also, it says if the information in the 837 predetermination is rendered, then another 835 response will be returned.

    See 1.10.2.7 in the 8010 835. It states "A predetermination must balance within a transaction set in the same way that claim payments must balance. Because the payment amount is actually zero now, adjustments must be adequate to reduce the claim balance to zero".

- *BPR opportunity* – clarify change in amounts reported as a result of predetermination may be different than the actual claim amount due to difference in dates.

7. PWK

Segment code notes have been added or updated to clarify code values

8010 837I PWK

CODE	DEFINITION			
AA	**Available on Request at Provider Site**			
	Use when the provider deems it necessary to identify additional information that is being held at the provider's office and is available upon request by the payer (or appropriate entity).			
BM	**By Mail**			
	Use when paper attachments are sent by mail.			
EL	**Electronically Only**			
	Use when attachments are sent electronically and transmitted in another functional group (for example, X12N 275 - Additional Information to Support a Health Care Claim or Encounter).			
EM	**E-Mail**			
	Use when attachments are sent by e-mail.			
FT	**File Transfer**			

	Use when attachments are sent by File Transfer to payer or maintained by an attachment warehouse or similar vendor.				
FX	**By Fax**				
	Use when paper attachments are sent by fax.				

8. **RAS**

RAS Segments are new to the 8010 version.   CAS segments changed to RAS segment at the Claim (2320 Other Subscriber Information) and Service level (2430 Line Adjudication Information).

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.

9. 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

10. 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 in CLP02 (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.

11. Repeat/Count Change

For a number and variety of data elements in the 8010, there is a change in the repeat/count.

- These represent the REF segments that were greater than one. The repeat is now changed to match the possible number of occurrences, e.g. Prior Auth Ref segment now repeats 11 times to match the number of payers that can be reported.

- The HI Condition Information segment is a new segment in the 837D and, similar to the 837P, the repeat is 1 because there is only one code qualifier.

12. Change in Loop Ids

These are the changes in the 2330 Loop Ids from 5010 to 8010. For some reason, Supervising Provider was moved to the bottom and the other 3 shifted up.

5010 Loop IDs & Names
2330E Other Payer Supervising Provider
2330F Other Payer Billing Provider
2330G Other Payer Service Facility Location
2330H Other Payer Assistant Surgeon

8010 Loop IDs & Names
2330E Other Payer Billing Provider
2330F Other Payer Service Location
2330G Other Payer Assistant Surgeon
2330H Other Payer Supervising Provider

13. 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.