837P – Professional Assessment of Changes (8010v)

1. Balancing

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

Claim Level:

In section 1.5 of the front matter, a few sentences were added to help with clarity and consistency.

- Claim Level, this sentence was 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, to support what is reported in Loop 2430 SVD01 the 8010 added this sentence at the end of 'Line Level Payments Amounts' section: "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, the 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 says the line adjudication loop must balance to the line-item charge amount for that service line. The 3rd paragraph in 1.4.5.2 Service Line is new to the guide. That is really the only big change for that section, and it is added for clarity.

2. Coordination of Benefit (COB)

The SVD03, OI07 and the AMT are changed capabilities. Most of the other changes are for clarity. 31 COB rows are highlighted.

- 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 in loop 2320 OI07 Provider Accepts Assignment Code is required. It supports the ability to report a different value than what was originally reported by the provider.
- 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).

In additional to the AMT segments, the front matter in section 14.2.1.1 has added in Step 2, 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 primary change is increasing the number of diagnoses from 12 to 24. 3 HI rows are highlighted.

- The HI segment holding the first 12 diagnosis had a name change
- The second HI is a new segment holding diagnosis codes 12 – 24.
- The 3rd HI change is a data element code value change, the principal diagnosis code qualifier was removed because the dx pointer at the line level dictates which claim dx pointer is principal for that specific line.

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 1.4.3 Property and Casualty, paragraph 7 supports factoring . Also, 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, upon X12 approval, a temporary solution for unexpected data requirements of regulatory action. It is not to be used for any other purpose.

Before using the K3, the requestor must submit a proposal for approval and include the business documentation for using the K3. After receiving the request, the X12 workgroup chairs must decide that there is no other option to meet the regulatory requirement. The K3 can be used after the X12 work group gives approval to use the K3. Use of the K3 is temporary until a permanent change is in a future TR3.

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.

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.

  Description of predeterminations (Predetermination of Benefits, Predetermination Request and Predetermination Status Request) was also added to section 1.5 Business.

- 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 actual reimbursement rates, patient responsibility or other situations of significance are to be based on the date of the payer adjudication.

- The CLM19 usage was changed. It was not used in 5010 and 8010 makes CLM19 situational and required if it is a predetermination claim.

- 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 837P 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.

Note:

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.

9. 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.

10. 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 repeat is now 1 because there is only one code qualifier.

11. UDI - Unique Device Identifier

The purpose of the Unique Device Identifier is to enable the recall of a device. (Prior to the mandated implementation date for the Unique Device Identifier, willing trading partners may agree to follow an early implementation approach.)

However, there needs to be an associated process for a recall, and such a process does not appear to exist.

- Section 1.12.7 Unique Identifier Reporting
- Add Loop 2400 CR8 - HIGH RISK IMPLANTED OR EXPLANTED DEVICE
- In Loop 2410 LIN - DRUG/SUPPLY IDENTIFICATION, for LIN02 add ID qualifier 'ZZ' - Use when reporting the Device Identifier of Unique Device Identifier)

12. 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