837P – Significant Changes
2nd Round Review

Coordination of Benefits

The largest change for the COB 8010 updates are:

- the new 2320 AMT – Claim Allowed Amount and 2430 AMT – Service Allowed Amount segment for allowed amount, and
- the changes to the 2320 OI Other Insurance Coverage.

The 8010 has added a new segment (2320 AMT – Claim Allowed Amount) to report the claim allowed amount . The situational rule for the segment tells when the new segment is required. The allowed amount is required when the other payer has adjudicated the claim or the other payer has issued a paper or virtual or other format with the allowed amount reported. There are several sections in the front matter that have been updated for more clarity on COB.

The other update for COB was the 2320 OI segment 'Other Insurance Coverage'. All of the data elements used in 5010 were changed to 'Not Used' and three new data elements were added. The data element OI07 Provider Accepts Assignment and OI08 a yes/no for payer to payer adjustment code and OI10 a yes/no for payer to payer void code.

The OI07 Provider Accepts Assignment has 3 code values, they are

A Assigned

B Assignment accepted to clinical labs service only

C Not assigned

The OI08 yes/to for adjudicated code is required when the claim is for payer to payer COB. Y is a payer to payer adjustment, N is the claim is not a payer to payer adjustment.

The OI10 is a yes/no code indicating the claim is a payer to payer VOID. It is required when the claim is a payer to payer COB. Y indicates a payer to payer COB claim is a VOID, N indicates the payer to payer COB claim is not a VOID.

Diagnosis

The 8010 was updated to support an additional 12 diagnosis codes. To do this a new HI segment was added. It also changed where and how to report the principal diagnosis code.

The new segment to support the additional codes is, 2300 HI Health Care Diagnosis Codes 13-24.

The principal diagnosis code in 5010 was the first diagnosis data element in the HI Health Care Diagnosis Code segment. The data element (HI01-01) used the ABK ICD-10 Principal Diagnosis Code to report the principal diagnosis. In the 8010, 2300 HI01-01 is no longer the principle. It is a diagnosis code and uses the ABF ICD-10 Diagnosis Codes.

In 2400 SV1, the line level SV107 dictates which claim diagnosis code is the principal diagnosis code. It was modified from being a composite data element holding 4 diagnosis pointers to being a repeating data element. In 8010 the diagnosis pointer can repeat 12 times. The order of the diagnosis codes in SVD107 is significant because the pointers are reported in the order of importance with the first one being the principal diagnosis code.

MOA

In 8010, 2320 MOA - MOA03 to MOA07 to 'not used'. The MOA can't be used to send remark codes.

RAS

Refer to this section in the '835 Significant Changes' Document.

Predetermination

The 8010 837P has updated the TR3 to support predeterminations. It has added three new segments for predetermination and changed the usage in two segments.

The new segments are in the 2300, 2330B and the 2400 loops.

- 2300 added the REF Predetermination Identification.
- 2330B added the REF Predetermination Identification
- 2400 added the REF Service Predetermination Identification.

The usage of CLM19 (2300 CLM) was changed from not used to situational. It is required when the claim is a predetermination claim.

The usage of the Service Date (2400 DTP) has been changed from Required to Situational. If the claim is a predetermination claim, the Service Date is not used.

NOTE:

Neither the 837 TR3s nor the CAQH CORE web site indicate whether use of Predetermination is required upon request of the provider or whether it is subject to agreement between trading partner.

As such, we are assuming that this question will be addressed as part of the regulatory process.

Prior Authorization

The structure of the transaction for reporting prior-authorization numbers did not change. However, with changes in the TR3 notes, X12 has tried to clarify that prior-authorization numbers may apply to individual services at the line level and not to all services at the claim level. And the number of possible prior-authorizations for a service has changed from 5 to 11.

The Prior Authorization Ref segments are found in the 2300 and 2400 loops. The only noticeable change in the 2300 Loop is the updating of the 2300 REF Prior Authorization's situational rule and TR3 notes and the 2400 REF segment rule.

2300 REF Prior Authorization TR3 notes

The second rule was dropped that says the authorization applies to the entire claim unless overridden in the REF segment of 2400. This information is now found at the 2400 line level.

2400 REF – Service Predetermination Identification segment

The 2400 Prior Authorization says that when the service line involves a prior authorization number that is different than the number reported at the claim level (Loop ID-2300) or when the prior authorization applies to the service line then it needs to be reported in the 2400 loop.

Balancing

Updated front matter:

The concept of how to balance has not changed. They have renamed and updated section 1.4.5. The 8010 Section 1.4.5 is called Balancing. In 5010 it was called Allowed/Approved Amount Calculation. The 8010 section 1.4.5 has added 2 new sections, one for Claim level and one for Service level balancing. Each level provides an example of how to balance. Below is an example of the 1.4.5.2 that balances the service line

As an example, the service line level, Section 1.4.5.2 was updated to say, the line adjustment and the line payment must balance to the line charge amount service line and it provides an example. Below is an example.

Line 1 adjustment ($10) plus Line 1 payment $70 (2430 SVD02) = Line 1 charge $80 (2400 SV102)

Updates to Other Payer Identifier code notes

X12 has updated code notes on two Other payer identifier data elements. This was done to help the payers identity get reported correctly. The payer identifiers are: 2330 SBR01 (Payer Responsibility Sequence Number Code) and 2430 SVD01 (Other Payer Primary Identifier).

K3

K3 segments are for a temporary solution to a regulatory/legislative requirement.

Before using a K3 you have to submit a change request for approval. X12N will review the request and determine the business need for it and validate that there is a need for it. X12N will work with the requester if there is a need and X12 and the requester will define a format. X12N will approve the K3 and ensure that the requirements and the format will work for the good of all X12 trading partners.

For more information the 8010 has added section 1.4.6 for information on how/when to use the K3 segments. K3 segments are in the 2300 loop and the 2400 loop.

UDI – Unique Device Identifier

Prior to the mandated implementation date for the Unique Device Identifier, willing trading partners may agree to follow an early implementation approach.

The purpose of the Unique Device Identifier is to enable the recall of a device. However, there needs to be an associated process for a recall, and such a process does not appear to exist.

The 8010 has updated the TR3 to support unique device identifiers. This required a new section to the Front Matter, a new segment in the 2400 loop, an update to the segment LIN and a new code value added to the LIN02 product/service qualifier

- The new Front Matter section is section 1.12.7 Unique Device Identifier Reporting
- The new 2400 segment is the CR8 High Risk Implanted or Explanted Device
- Modified the 2410 LIN segment name from LIN Drug to LIN Drug/Supply

- The data element 2410 LIN02 added the new product/service qualifier ZZ (mutually defined)

Repeat/Count Changes

Many REF segments have had their segment repeats changed. The main reason for the change were to match number of repeats of the secondary identification to the actual number of payers or providers.

These are common examples, not a complete list. Red are also highlighted in Organized Change Log as examples.

Changed to support the number of Providers

2310A REF - Referring Provider Secondary Identification - Changed to: 1 from 3

2310B REF - Rendering Provider Secondary Identification - Changed to: 2 from 4

2310C REF - Service Location Secondary Identification - Changed to: 2 from 3

Changed to support the number of Payers

2010BB REF - Payer Secondary Identification - Changed to: 1 from 3

2330B REF - Other Payer Secondary Identifier - Changed to: 1 from 2

2330C REF - Other Payer Referring Provider Secondary Identification - Changed to: 1 from 3

2330D REF - Other Payer Rendering Provider Secondary Identification - Changed to: 2 from 3

2330E REF - Other Payer Service Location Secondary Identification - Changed to: 2 from 3

2420B REF - Purchased Service Provider Secondary Identification - Changed to: 11 from 20

2420E REF - Ordering Provider Secondary Identification - Changed to: 11 from 20

2420F REF - Referring Provider Secondary Identification - Changed to: 11 from 20

Other Repeat/Change Counts

2300 DTP - Assumed Care Date - Changed to: 1

2300 HI - Health Care Diagnosis Codes 1 – 12 - Changed to: 1

2400 REF - Prior Authorization - Changed to: 11 from 5

2400 REF - Referral Number - Changed to: 11 from 5

2420C REF - Service Location Secondary Identification - Changed to: 20 from 3

2420E PER - Ordering Provider Contact Information - Changed to: 2 from 1

X-TR3: Change & Consistency

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

These are the type of 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. The below is not an exhaustive list. Red are also highlighted in Organized Change Log as examples.

Yes/No Indicator

In the 8010 when the data element is a Yes/No indicator the data element was changed from situational to required. A Yes or No must be returned. In the 5010 the data element for a yes/no indicator was situational, it was assumed No and if it was a Yes then Y was entered. This change is in all transactions, all guides.

An example of the yes/no change is found in the 2400 loop, segment SV1 and data element SV109.

NM102 Entity Type Qualifier

The non-person entity type was removed from the Entity Qualifier. In 5010 you could use 1 for person or 2 for non-person. In 8010 you can only use 1 (for person). Entity Type is found in the NM102 data element of 2310B, 2330D and 2420A.

Code Notes

The code note for NM108 was removed. This was part of removing code notes from various segments. Notes that X12 felt were not needed. An example of the types of code notes being deleted can be found in loop 1000A and segment NM1. The note for the data element NM108 code value had a code note that said, 'Established by trading partner agreement'. This code note was removed. Several code notes similar were removed.

Lower Level changes

There were many changes made to make the TR3s consistent. Below is a list of the types of changes that were done but don't have a major impact on the changes to make. They were done to provide better clarity in the 8010 TR3's.

- Add data element notes
- Delete data element notes
- Modify data element notes
- Add segment note
- Delete segment note
- Modify segment name
- Add data element situational rule
- Delete data element situational rule
- Modify data element situational rule
- Add segment code note
- Modify segment code note
- Delete segment code note
- Modify segment situational rule