

**Transaction Validation Question Sheet**  
**BPR – Processing and Reporting Remittance Information**

For more detail about any of the questions, see the corresponding BPR page #.  
[http://www.onehealthport.com/pdf/5010\\_Processing\\_Reporting\\_Remittance\\_Information.pdf](http://www.onehealthport.com/pdf/5010_Processing_Reporting_Remittance_Information.pdf)

***Report the requested answers & information in the attached Answer Sheet!*** They do not need to be reported in this Questions sheet.

**A. General Processing & Reporting Practices**

1. Were the line item control numbers in the 837 *always* returned? Yes/No: \_\_\_\_\_  
(837 2400 loop, REF\*6R BPR- pg 5 #1)

If no, what line item control numbers were not returned? \_\_\_\_\_  
\_\_\_\_\_

2. Did the 835 reflect the following information that you submitted on the 837? (BPR pg 5 #2)

- Patient Name? (2000B/C NM1\*QC) Yes/No: \_\_\_\_\_
- Subscriber Name? (2000B NM1\*IL) Yes/No: \_\_\_\_\_
- Health Plan Member ID? (2000B/C NM109) Yes/No: \_\_\_\_\_
- Service Related Information? (2400 SV1(p) SV2(i) or SV3(d)) Yes/No: \_\_\_\_\_

If no, what 837 information was not returned on the 835? \_\_\_\_\_  
\_\_\_\_\_

3. Did you submit Ambulatory Service Center (ASC) charges? Yes/No: \_\_\_\_\_  
(2400 loop SV1(p) SV2(i) BPR – pg 6 #3)

If Yes, did the 835 appropriately report Revenue Codes and/or HCPC codes?  
Yes/No: \_\_\_\_\_

If no, what code(s) were not returned? \_\_\_\_\_

4. Did the 835 contain a CARC 18? Yes/No: \_\_\_\_\_  
(BPR – pg. 6 #4)

If Yes, was it in response to a duplicate claim that was submitted?  
Yes/No: \_\_\_\_\_

5. Does the 835 balance ...

(BPR – pg. 7 #5)

- At the service line level? Yes/No: \_\_\_\_\_
- At the claim level? Yes/No: \_\_\_\_\_
- At the transaction level? Yes/No: \_\_\_\_\_

6. Was there a PLB in the 835? Yes/No: \_\_\_\_\_

If Yes,

a. Does PLB03-02, PLB05-02, PLB07-02, PLC09-02, PLB11-02 contain the health plans claim number (that which is contained in CLP07) followed by the patient control number (that which is contained in CLP01).

(BPR – pg. 7 #6)

Yes/No: \_\_\_\_\_

If no, which field does not? \_\_\_\_\_

b. Did the 835 reflect the recovery of overpayments made to the provider?  
(BPR – pg. 7-8 Recovering Overpayments)

Yes/No: \_\_\_\_\_

If Yes,

i. Was the reporting consistent with pages 7-8 of the BPR? Yes/No: \_\_\_\_\_

If no, how was the reporting inconsistent? \_\_\_\_\_

ii. Were the adjustment Group and Reason Codes reported on the reversal the same as the adjustment Group and Reason Codes reported on the original adjudication? Yes/No: \_\_\_\_\_

**B. Business Processing Practices**

*Pay To Organization and Contract Arrangement*

1. Was the Pay To organization correct? Yes/No: \_\_\_\_\_  
(BPR – pg. 9 #1)  
If no, what should have been the correct Pay To Organization? \_\_\_\_\_  
  
\_\_\_\_\_
  
2. Did the 835 report the correct contract that applied to the claim? (BPR – pg. 10 #2)  
Yes/No: \_\_\_\_\_  
  
If no, what contract was not correctly reported? \_\_\_\_\_

*Splitting Claims & Service Lines*

3. Did the health plan split one of more of the service lines on a claim?  
(BPR – pg. 10 #3)  
Yes/No: \_\_\_\_\_  
  
If Yes, was each separate claim identified as being part of a split claim by utilizing the MIA or MOA segment with Remittance Advice Remark Code MA15?  
Yes/No: \_\_\_\_\_  
  
If no, in what way was the reporting of the split erroneous? \_\_\_\_\_  
  
\_\_\_\_\_

*Reporting Payment and Adjustment Information*

4. When reporting the business reason for a denial or adjustment,  
(BPR – pg. 11 #5)
  - Were only active CARC/RARCs used? Yes/No: \_\_\_\_\_  
  
If no, what inactive CARC/RARCs were used? \_\_\_\_\_  
  
\_\_\_\_\_
  
  - Were appropriate CARC/RARCs used in compliance with the BPR-Standard Coding of Denials and Adjustment in the HIPAA 835 Remittance Advice Transaction? Yes/No: \_\_\_\_\_  
If no, for what denial or adjustment were the CARC/RARC inappropriate?  
  
\_\_\_\_\_

5. Is this 835 related to an 837P, 837D or an 837I for an outpatient visit? Yes/No:

\_\_\_\_\_

If Yes,

a. Were claim level adjustments reported on the 835? (BPR – pg. 131 #6)

Yes/No: \_\_\_\_\_

If Yes, were they appropriate? Yes/No: \_\_\_\_\_

If No, identify what payment information was inappropriately reported at the claim level? \_\_\_\_\_

b. Was the claim priced at the service line level? (BPR – pg. 11 #7)

Yes/No: \_\_\_\_\_

If Yes, was the adjudication information for each service line placed in the SVC segment of Loop 2110? Yes/No: \_\_\_\_\_

If no, for which service line(s) was the adjudication information not handled appropriately? \_\_\_\_\_

6. Did the health plan bundle or unbundle service information in ways that were not submitted on the 837? Yes/No: \_\_\_\_\_  
(BPR – pg. 11 #8)

If Yes, does the 835 contain the information that was submitted on the 837 as well as information about how the health plan adjudicated the service(s)? Yes/No: \_\_\_\_\_

If no, what 837 information was not reported on the 835?

\_\_\_\_\_

7. Were all CAS03 = non zero values? Yes/No: \_\_\_\_\_  
(BPR – pg. 12 #9b)

If No, which CAS contained a 0 in CAS03? \_\_\_\_\_

\_\_\_\_\_

*Reporting Coordination of Benefit Information*

8. Did the claim reflect multiple coverage from the same health plan?  
(BPR – pg 12 #10)

Yes/No: \_\_\_\_\_

If Yes,

- Did the health plan adjudicate the claim using the primary coverage and automatically adjudicate the claim using the secondary coverage?  
Yes/No: \_\_\_\_\_
- Did the 835(s) report separate adjudications for each coverage? Yes/No: \_\_\_\_\_
- For the primary coverage adjudication, did the 835 report the appropriate crossover information? Yes/No: \_\_\_\_\_

9. Is the 835 from a non-primary health plan? Yes/No: \_\_\_\_\_  
(BPR – pg 12 #11)

If Yes, did the health plan appropriately report their financial impact using a CO/PI 45 AND the financial impact of the previous payer(s) by appropriately using the OA23. Yes/No: \_\_\_\_\_

### **C. Practices for Using Specific Data Elements**

1. Was the health plan's EDI Support Telephone Number put in PER03 of Loop 1000A?  
Yes/No: \_\_\_\_\_  
(BPR – pg 12 #2)

2. Was a Claim Status Code of 4 used? Yes/No: \_\_\_\_\_  
(BPR – pg 12 #3)

If Yes, was it used appropriately, i.e. the patient/subscriber was not recognized by the health plan? Yes/No: \_\_\_\_\_

3. What the Claim Received Date put in DTM segment of Loop 2100?  
Yes/No: \_\_\_\_\_  
(BPR – pg 13 #4)

4. Was the Service Date provided at the claim level or each line level, as appropriate, using the DTM segment of Loop 2110? Yes/No: \_\_\_\_\_  
(BPR – pg 13 #5)

If no, what service dates were not provided: \_\_\_\_\_

\_\_\_\_\_

**Answer Sheet**  
**Transaction Validation Worksheet**  
**BPR - Processing and Reporting Remittance Information**

Name: \_\_\_\_\_ Organization: \_\_\_\_\_

Health Plan Being Validated: \_\_\_\_\_ Date: \_\_\_\_\_

Identify each 835 that you will be referencing				
	835 - #1	835 - #2		
835 File Name				
TRN02				
Remittance Advice Date				
Provider NPI				

BPR Capability	Req. or Rec.	Yes, No, or NA	If 'No'		
			What information is missing or in error? (From Question Sheet)	Which 835(s)? Use #1, #2, etc (From table above)	Include and the Patient control number (835- CLP01) and payer claim number (835-CLP07)
<b>A. General Processing &amp; Reporting Practices</b>					
1. Were the line item control numbers in the 837 <i>always</i> returned?	Rec				
2. Did the 835 appropriately reflect the information that you submitted on the 837?	<b>Req</b>				
3. If ASC charges, did the 835 appropriately report Revenue Codes and/or HCPC codes?	<b>Req</b>				
4. If CARC 18, was it in response to a	Rec				

			If 'No'		
BPR Capability	Req. or Rec.	Yes, No, or NA	What information is missing or in error? (From Question Sheet)	Which 835(s)? Use #1, #2, etc (From table above)	Include and the Patient control number (835- CLP01) and payer claim number (835-CLP07)
duplicate claim that was submitted					
5. Does the 835 balance at all 3 levels – service line, claim & transaction?	<b>Req</b>				
6. If PLB, a. Do the appropriate fields contain the claim number followed by control number? b.i. IF payment recovery, was reporting consistent with pages 7-8? b.ii. Were the adjustment Group and Reason Codes reported on the reversal the same as the adjustment Group and Reason Codes reported on the original adjudication?	Rec  <b>Req</b>  <b>Req</b>				
<b>B. Business Processing Practices</b>					
1. Was the Pay To organization correct?	<b>Req</b>				
2. Did the 835 report the correct contract that applied to the claim?	Rec				
3. IF split claim, was each separate claim identified as being part of a split claim by utilizing the MIA or MOA segment with Remittance Advice Remark Code MA15?	Rec				
4. CARC/RARC a. Were only active CARC/RARCs used? b. Were appropriate	<b>Req</b>  <b>Req</b>				

			If 'No'		
BPR Capability	Req. or Rec.	Yes, No, or NA	What information is missing or in error? (From Question Sheet)	Which 835(s)? Use #1, #2, etc (From table above)	Include and the Patient control number (835- CLP01) and payer claim number (835-CLP07)
CARC/RARCs used in compliance with the BPR-Standard Coding of Denials and Adjustment?					
5. IF 837P, 837D or 837I for outpatient a. IF Claim level adjustments were reported on 835 Were they appropriate? b.i. Was the claim priced at the service line level? & b.ii Was the adjudication information for each service line placed in the SVC segment of Loop 2110	<i>Req</i>   <i>Req</i>  <i>Req</i>				
6. IF bundle/unbundle, does the 835 contain the information that was submitted on the 837 as well as information about how the health plan adjudicated the service(s)?	Rec				
7. Were all CAS03 = non zero values?	<i>Req</i>				
8. IF multiple coverages from same health plan a. Did the health plan adjudicate the claim using the primary coverage and automatically adjudicate the claim using the secondary coverage? b. Did the 835(s) report separate	Rec   Rec				

			If 'No'		
BPR Capability	Req. or Rec.	Yes, No, or NA	What information is missing or in error? (From Question Sheet)	Which 835(s)? Use #1, #2, etc (From table above)	Include and the Patient control number (835-CLP01) and payer claim number (835-CLP07)
adjudications for each coverage? c. For the primary coverage adjudication, did the 835 report the appropriate crossover information?	Rec				
9. IF 835 from a non-primary health plan, did the health plan appropriately report their financial impact using a CO/PI 45 AND the financial impact of the previous payer(s) by appropriately using the OA23.	<b>Req</b>				
<b>C. Practices for Using Specific Data Elements</b>					
1. Was the health plan's EDI Support Telephone Number put in PER03 of Loop 1000A	Rec				
2. IF Claim Status Code of 4 was used, was it used appropriately, i.e. the patient/ subscriber was not recognized by the health plan	<b>Req</b>				
3. Was the Claim Received Date put in DTM segment of Loop 2100?	Rec				
4. Was Service Date provided at the claim level or each line level, as appropriate, using the DTM segment of Loop 2110?	<b>Req</b>				
<b>Other</b>					

BPR Capability	Req. or Rec.	Yes, No, or NA	If 'No'		
			What information is missing or in error? (From Question Sheet)	Which 835(s)? Use #1, #2, etc (From table above)	Include and the Patient control number (835- CLP01) and payer claim number (835-CLP07)

Legend: **Req** - A Best Practice required by the TR3 and by the BPR Rec – A Recommended Best Practice.