Administrative Simplification

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Best Practice Recommendation for

Electronic Processing of Corrections to Institutional Claims (5010 version of the HIPAA 837 and 835 transactions)

For use with ANSI ASC X12N
Health Care Claim Institutional (837),
Health Care Claim Payment/Advice (835)
Implementation Guides

Version 1.2

Version	
Issue Date	**Explanation**
02-22-10	Initial release
02-14-11	Clarification about sending of late charges (pg 5).
04-19-11	Refined definition of an initial claim (pg 3) & outlined best practice for handling late charges (pg. 5)

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Best Practice Recommendation

Electronic Processing of Corrections to Institutional Claims using the 5010v of the HIPAA 837 and 835 transactions

Topic: Electronically Submitting and Processing Institutional Claims

Note: If the provider organization does not have the capability to electronically submit a corrected claim, they should refer to the Admin Simp Guideline for Submitting Corrected Claims on Paper, which can also be found on the WorkSMART web site.

Goal: Expedite the processing of corrected claims and reduce the number of situations when corrected claims are denied as duplicates.

Summary: This Best Practice Recommendation addresses the following operational processes:

a) Processing charges for dates of service not previously billed
b) Processing provider-initiated corrections to previously billed services, e.g. data entry errors or omissions by providers
c) Processing provider-identified discrepancies between 837 information and 835 information. Examples include but are not limited to
    - A unit count of 30 was submitted on the 837, but a unit count of 3 was processed and reported on the 835
    - 5 service lines were submitted on the 837, but only 4 service lines were processed and reported on the 835

Applicability: All providers and health plans are encouraged to follow these Recommended Best Practices.

How this document is organized

The information in this document is presented as follows:

First, the following terms will be defined

- Claims and Claim Lines
- Initial Claim / Initial Claim Resubmission
- Replacement Claim
- Voided Claim

Second, best practice recommendations for submitting and processing corrected claims will be outlined

Third, the best practice recommendation for each of the following operational processes will be outlined

- Processing charges for dates of service not previously billed
- Processing provider-initiated corrections to previously billed services, e.g. data entry errors or omissions by providers
- Processing provider-identified discrepancies between 837 information and 835 information

Fourth, an addendum will outline how health plans will handle refund checks generated by and received from providers.

I. Definitions and Clarifications

a) Claims and Claim Lines

Claims consist of one or more claim lines, where each claim line represents a billed service. Institutional claims can be one of two types:

- One or more services, on one or more dates, within a specified date range.
- One or more recurring services, on one or more dates, within a specified date range, e.g. Physical Therapy claim. This is typically referred to as Series Billing

b) Initial Claim / Initial Claim Resubmission

In most cases, a provider will need to submit an 837 to the health plan only once.

However, in the following cases the provider will need to resubmit the claim (typically referred to as Resubmission or Rebilling):

- If the Initial Claim is not received by the health plan, or
- If the Initial Claim has errors that prevent it from being entered into the health plan's adjudication system, e.g. the claim was submitted without a procedure code, (In these situations the health plan will send the provider a 999 transaction and they need to correct the claim and resubmit as an original claim.)

An Initial Claim is the original claim submitted by the provider. An Initial Claim Resubmission is either an exact replication of that original claim or a correction to an Initial Claim that was not input into the health plan's adjudication system In both cases, the Claim Frequency Type Code field will be set to a value between 1-4 as appropriate (depending upon whether the claim is an interim bill). Since these claims will not have been loaded into the health plan's adjudication system, there will not be a health plan generated internal control number for them.

Some providers resubmit a claim to the health plan as a technique for finding out the status of that claim. This technique creates work for provider and health plan. A

much easier way for providers to get status information on a claim is to access the health plan's web site or to use the 276/277 Claim Status transaction.

c) Replacement Claim

A Replacement Claim is a change to an Initial Claim that has been processed by the health plan's adjudication system. The Claim Frequency Type Code field will be equal to 7 and there will be a health plan generated internal control number for that Initial Claim.

Information on a Replacement Claim will differ from the information contained in the respective Initial Claim in one of the following four ways:

1) The information contained within one or more of the service lines will be different
2) Additional services lines will be added that fall with the date range as previously submitted
3) Previously submitted services lines will be omitted
4) The information on the Replacement Claim may not be different than the Initial Claim, but the provider wants to draw the health plan's attention to a discrepancy between the information contained on the Initial Claim and the information reported back to the provider on the 835. Examples include but are not limited to:
   - A unit count of 30 was submitted on the 837, but a unit count of 3 was processed and reported on the 835
   - 5 service lines were submitted on the 837, but only 4 service lines were processed and reported on the 835

There are cases when an Initial Claim is split by the health plan as part of the adjudication process. In these cases, each split claim will be assigned a different internal control number. When creating a Replacement Claim for any Initial Claim, the provider does not need to be concerned about if or how the claim was split. A Replacement Claim should be created as if the Initial Claim was not split by the health plan and any one of the health plan assigned internal control numbers can be used.

d) Voided Claim

A Voided Claim indicates that the service should never have been billed and neither an Initial Claim Resubmission nor a Replacement Claim will be sent. A Voided Claim is the instruction to the health plan to deactivate, i.e. "back out of the system", an Initial Claim that has been processed by the health plan's adjudication system. The Claim Frequency Type Code field will be equal to 8 and there will be a health plan generated internal control number for that Initial Claim.

A Voided Claim will contain all of the claim lines that were previously submitted in or as an Initial Claim, exactly as they appeared on the Initial Claim.

II. Best Practice Recommendations for Submitting and Processing Corrected Claims

A. Providers will use corrected claims to address errors in the billing or processing of a claim. For example, a corrected claim SHOULD be used if a service was mistakenly included on the initial claim, or if the units of service were incorrect, or if it was coded incorrectly, etc.

B. Late charges are not considered to be errors in the billing or processing of a claim. The recommended best practice is for provider organizations to structure their operational processes so that all charges are captured and reflected on the initial bill before it is submitted to the payer. Recognizing that it is not always possible to reduce late charges to zero it should be the goal of all providers to reduce them to the least amount possible, knowing that accurate, one-time billing for patient encounters is more likely to result in accurate, timely reimbursement from health plans.

   In those situations when a late charge(s) must be sent that is related to a previously submitted institutional claim, the late charge(s) should be included along with the entire original claim and sent as a corrected claim with Claim Frequency Type = 7.

C. A corrected claim may be considered a "clean claim" if the health plan has the documentation that they need to process the claim.

D. The timeframes for processing corrected claims will follow state guidelines for claims processing.

III. Best Practice Recommendations for Operational Processes

The chart at the end of this document contains a synopsis of the best practice recommendations for the following 3 operational processes.

A. Processing Charges for Dates of Service Not Previously Billed

   Providers may want to bill the health plan for services that were left off of a previously submitted claim. These services must be for a date of service that is outside of the date range submitted on a previous claim.

   1. **Providers** will create an Initial Claim as discussed in Definition #I.b. above.

      The Claim Frequency Type Code field (CLM05–3) = 1-4.

   2. The claim will ONLY contain previously unbilled services.

3. **Health Plans** will handle this claim as an Initial Claim.

B. Processing Provider-Initiated Corrections to Previously Billed Services, e.g. data entry errors or omissions by providers

Providers may want to correct information that was previously ***submitted*** on a claim, e.g. to correct data entry errors or omissions. Changes can include:

- Modifying information contained within one or more of the service lines that were previously submitted
- Adding services lines that fall with the date range as previously submitted
- Removing previously submitted service lines

1. These types of corrections will be handled as Replacement Claims.

2. **Providers** will create a Replacement Claim as discussed in Definition #I.c. above.

   a) The Claim Frequency Type Code field (CLM05–3) will be set to 7.
   b) The Payer Claim Control Number segment of the 2300 loop will contain . . .
      - Reference Identification Qualifier REF 01 = F8
      - Reference Identification REF 02 = the health plan's Payer Claim Control Number that was assigned to the previously submitted Initial Claim

3. The Notes field will be used to indicate why this claim is being submitted as a Replacement Claim.
   - Use the Billing Note segment of Loop 2300
   - Set Note Reference Code NTE01 = 'UPI'
   - For Description NTE02 . . .
     - ♦ Update NTE02 to include - A very brief description of the type of correction that was made, e.g. 'charges removed', 'qty changed', 'proc. code changed', etc.

4. **Health Plans** will use the Claim Frequency Type Code field (CLM05–3), Payer Claim Control Number segment and the appropriate Note field(s) to recognize the Replacement Claim and will process the correction.

   Per the 835 Implementation Guide (section 1.10.2.8), once the health plan has processed the corrected claim these changes will be reflected on the 835. Each corrected claim will result in the following two entries on the 835, excluding a possible PLB segment. (Note: there may be more than two entries when health plans split a claim.)

   - Reversal of the Initial Claim will be communicated by setting CLP02 = 22 along with the appropriate CAS segments to negate the original charge, payment and adjustment amounts.

- Processing of the Corrected Claim will be communicated by setting CLP02 = 1,2,3,19,20,21 according to how the claim is processed, along with the appropriate CAS segments.

C. Processing Provider-Identified Discrepancies between 837 Information and 835 Information

Providers may want to notify the health plan when there is a difference between claim information submitted on an Initial Claim and what was reported on the 835. Examples include but are not limited to:

- A unit count of 30 was submitted on the 837, but a unit count of 3 was processed and reported on the 835
- 5 service lines were submitted on the 837, but only 4 service lines were processed and reported on the 835

These types of claims will be referred to a Discrepancy Claims.

1. Reporting of discrepancies will be handled as Replacement Claims.

2. **Providers** will create a Replacement Claim as discussed in Definition #I.c. above.

   a) The Claim Frequency Type Code field (CLM05–3) will be set to 7.
   b) The Payer Claim Control Number segment of the 2300 loop will contain . . .
      - Reference Identification Qualifier REF 01 = F8
      - Reference Identification REF 02 = the health plan's Payer Claim Control Number that was assigned to the previously submitted Initial Claim

3. The Notes field will be used to indicate why this claim is being submitted as a Replacement Claim.

   - Use the Billing Note segment of Loop 2300
   - Set Note Reference Code NTE01 = 'UPI'
   - For Description NTE02 . . .
     - ♦ Update NTE02 to include - A very brief description of the discrepancy.

4. **Health Plans** will use the Claim Frequency Type Code field (CLM05–3), Payer Claim Control Number segment (which contains the health plan's original Internal Control Number), and the appropriate Note field(s) to recognize the Replacement Claim and will process the discrepancy as follows . . .

   Per the 835 Implementation Guide (section 1.10.2.8), once the health plan has processed the corrected claim these changes will be reflected on the 835. Each corrected claim will result in the following two entries on the 835, excluding a

possible PLB segment. (Note: there may be more than two entries when health plans split a claim.)

- Reversal of the Initial Claim will be communicated by setting CLP02 = 22 along with the appropriate CAS segments to negate the original charge, payment and adjustment amounts.

- Processing of the Corrected Claim communicated by setting CLP02 = 1,2,3,19,20,21 according to how the claim is processed, along with the appropriate CAS segments.

The chart provides a synopsis of the best practice recommendations for the above three operational processes.

Operational Process	Type of Claim	Value of Claim Frequency Code[*1]	Original ICN[*2]	Note Fields (Claim Level and Line Level) [*3]
A. Charges not Previously Billed	Initial	CLM05-3 = 1	Not Applicable	Not Applicable
B. Provider Initiated Correction	Replacement	CLM05-3 = 7	REF01=F8 REF02=ICN	• NTE01 = 'UPI' • NTE02= Brief description of the correction
C. Provider Identified Discrepancy between 837 and 835.	Replacement	CLM05-3 = 7	REF01=F8 REF02=ICN	• NTE01 = 'UPI' • NTE02= Brief description of the discrepancy

[*1] – Claim Frequency Code is contained in CLM05-3.

[*2] – Assigned by health plan and stored in the ICN/DCN segment of Loop 2300.

[*3] – Institutional Claims have a Claim Level Note in Loop 2300 of the 837.

IV. Addendum – Guideline for Health Plans

There are a few cases when it is appropriate for a provider to generate a refund check and send it to the health plan. In these cases, if the health plan agrees with the amount of the refund, the health plan will electronically process the refund on the 835 Remittance Advice transactions as described below.

Per the 835 Implementation Guide (section 1.10.2.17 #2), acknowledge receipt of the check in the PLB segment using offsetting adjustments, PLB03-1 codes 72 (Authorized Return) and WO (Overpayment Recovery).