Administrative Simplification

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Best Practice Recommendation for

Processing & Reporting Remittance Information (835 5010v)

Version 3.91

For use with ANSI ASC X12N 835 (005010X222)
Health Care Claim Payment/Advice
Technical Report Type 3

Version 3.91

This Best Practice Recommendation includes:

Exchanging Explanation of Payment Information between Providers and Health Plans http://www.onehealthport.com/sites/default/files/pdf/5010_Exchanging_EOP_Information.pdf

Version	
Issue Date	**Explanation**
02-19-10	Version 1.0
12-14-11	Version 2.0 Best practices related to ASC charges and duplicate claims (pg. 5), PLB reporting of health plan claim number & provider control number (pg. 6), recovering overpayments (pg. 6), 837P/D line level reporting (pg. 13), use of OA 23 (pg. 18), meaning of Claim Status Code=4 (pg. 19)
01-17-12	Formatting to consolidate common topics
02-06-12	Modify applicability to claims submitted on 837 or CMS-1500 (pg 2)
02-20-12	Add latest timeframe for takeback (pg 7)
04-16-12	Clarifying that CAS03 cannot be zero (pg 13) Remove section 'Handling Negative Balance on a Remit' under 'Using the PLB'
05-15-12	Clarifying that when a payment is taken back/reversed, the adjustment Group and Reason Codes reported on the reversal should be the same as the adjustment Group and Reason Codes reported on the original adjudication (pgs 8,9,13)
06-18-12	Define the display order in CLP segment for reversal & correction (pgs 8,10) Require patient control number in PLB 03-02 (pg 6,7) Define the display order for primary adjudication and secondary adjudication (pg 18)

Version	
Issue Date	**Explanation**
07-12-2012	Corrections to 835 locations for EDI Support Number and Claim Received Date (pg 19)
09-24-2012	A Provider's Preferred Best Practice was added to the section on Recovering Overpayments section (pg 7) Refined the wording to clarify when/how Pay To Address Name is used. (pg 10) Email address can be included in the PER segment of Loop 1000A, in addition to or in place of telephone number (pg 19).
10-16-2012	In 6.b. on page 13 replace "must respond" with "have the option of responding. Removed a confusing sentence that was at the end of the paragraph on page 7 that begins with "This combination of Federal and Washington State…"
03-20-2013	Addition of • Handling Forward Balances (pg 10) • Consumer Spending Accounts (pg 14)
04-16-2013	Addition of .. Technical Contact Telephone Number or Email can be put in the PER segment of Loop 2100 or Loop 1000A (pg 19)
05-09-13	Clarification that Claim Receive Date could be either date claim received or date when latest required documentation was received (pg.19)
09-03-13	Refer to the CORE 360 rule for appropriate used of CARCs, RARCs and Group Codes (pg 13)
04-21-14	• Clarification of use of REF*CE (pg 11-12 • Add Best Practice Recommendations for 'Reporting-Collecting Monies Due from a Claim Adjustment (pg 18-19)
11-13-14	Clarification that REF*CE only needs to be used if health plan has more that one contract under which claims are adjudicated (pg 11)

Version	
Issue Date	**Explanation**
11-29-14	Formatting
04-11-15	Update – OA23/CO45 reporting change (pg 18)
05-15-15	Addition of 13 under Reporting Coordination of Benefit Information
10-13-2015	Clarify situation when FB (Forward Balance) should be used in the PLB
11-17-2015	Clarify use of PLB-02
06-24-2016	CO45 cannot be used as a denial code

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Best Practice Recommendation

Processing & Reporting Payment Advice (5010v)

Topic: Electronic Remittance Advice Transaction

Goals: Enable providers to automatically post remittance advice information into their patient billing & accounting system(s) regardless of the health plan from which it was sent.

Summary: This document outlines how the 5010v of the HIPAA 835 transactions should be used by the health plan to send an electronic remittance advice to a provider.

Applicability: This BPR Document should be a useful guide for health plans and providers exchanging 835 transactions.

This BPR Document may be less useful when a provider, or other 835 transaction receiver, IS NOT exchanging the transaction directly with participating health plans. Information contained in this document **may not** apply to exchanges between:

- Providers and Medicare: Information about this programs is available at: **www.cms.gov**
- Providers and Clearinghouses: Providers should note that clearinghouses, and other intermediaries, may implement the transaction differently than what is outlined in this BPR Document. The clearinghouse may reformat the health plan's transaction before passing it along to the provider. This reformatting may add unforeseen complexity to the process of transaction exchange.

This BPR Document is intended to accompany the TR3 (previously referred to as Implementation Guides) for the ASC X12N Health Care Claim Payment/Advice: 835 Transactions. A complete version of the TR3s can be purchased at http://store.x12.org/

Objective & Scope of the 835 Best Practice Recommendation (BPR) Document

Health plans must be able to produce and send a compliant 835 to the provider or clearinghouse. The HIPAA mandated X12N 835 TR3 specifies the complete set of requirements that must be met in order to be compliant. The objective of this BPR document is to recommend practices for how the 835 transactions should be used to accomplish specific business objectives related to the processing and reporting of remittance advice information.

This document assumes that:
1. The reader is familiar with the HIPAA transaction and the related X12 TR3 and has experience implementing the transaction.
2. The creation and transmission of the 835 transaction by the health plan, and its receipt and processing by the provider, will comply with all requirements laid out in the TR3.

As such, the intent of this BPR document is to expand upon and NOT to repeat the requirements contained in the TR3. However, requirements from the TR3 will be included in this document when they: a) are in the 4010A1v but are typically not followed or are new to the 5010v and, as such, may be overlooked in the implementation process, AND b) would significantly enhance administrative simplicity if they were followed. In these cases, the appropriate section of the IG will be referenced, but the details of the requirement will not be repeated.

This document may also contain business and operation practices that are not addressed in the TR3.

<u>Within Scope of this Document</u>:

The intent of the best practices outlined in this document is to enable providers to auto-post reimbursement information into their patient accounts. As such, these practices will focus on exchanging information about how claims were adjusted and/or paid.

Though not yet required by HIPAA, some health plans may be implementing an 835 electronic funds transfer (EFT) transaction. Providers that are interested in receiving electronic funds transfer should contact their health plan trading partners.

<u>Outside Scope of this Document</u>:

The following business functions are outside of the scope of the 835 Companion Document.
- Use of the 835 for communicating Explanation of Benefit (EOB) information to the insured (i.e. member)

- Use of the 835 as a managed care capitation report. (Member roster information will not be included on the 835.)
- Use of the 835 for payment of claims to other payers in a post payment recovery situation.

Practices Common Across HIPAA Transactions

Health Plan Companion Documents: Prior to creating, submitting and/or receiving transactions to/from a health plan, providers should contact the health plan to get their list of any unique data or business requirements. The health plan's requirements are typically discussed in a document referred to by a variety of names such as Trading Partner Agreement, Companion Document, etc.

The health plan's document should make their unique requirements readily and clearly visible to the provider upon a quick glance at the document. Examples of unique requirements related to the 835 include, but may not be limited to:

REF 'CE' information and related provider/network designations. REF CE will contain a code that communicates to the provider which contract applies to the respective claim (per section 1.10.2.15 of the X12N835 TR3). This code corresponds to a provider/network designation that indicates the arrangement under which the claim will be adjudicated, e.g. Medicare Advantage, Selections, Heritage, etc.

A. General Processing & Reporting Practices for the 835RA

1. Returning line item control numbers

   All line item control numbers that are sent by the provider organization on the 837 should be returned by the health plan in the appropriate segment(s) of the corresponding 835(s).

2. Handling corresponding 837-835 information

   a. If the patient name, subscriber name and/or health plan member ID on the 837 is different than the information in the health plan's system, the 835 will appear as follows:
      - The NM1-Patient/Insured Name segment[*1] will reflect back what was submitted on the 837
      - The NM1-Corrected Patient/Insured Name segment[*1] will contain the information that is in the health plan's systems.

Providers should update their system to reflect the information in the health plan's system.

[*1] Note: refer to the 835 TR3 for more clarity about these segments.

b. The health plan will not change service-related information that was sent on the 837 to reflect what they think should have been submitted. On the 835, SVC06 will be used to reflect what was received on the 837. SVC01 will be used to reflect any differences, or changes, made by the health plan, e.g. if adjudication was done using a different code.

3. Adjudicating Ambulatory Service Center (ASC) Charges

ASC charges can be submitted either on an 837I using Revenue Codes or on an 837P using HCPC codes. When ASC charges are submitted on an 837I, health plans will adjudicate those charges, and report them on the corresponding 835, using Revenue Codes.

When ASC charges are submitted on an 837P, in some cases the health plan will adjudicate those charges, and report them on the corresponding 835, using HCPC codes. In other cases, health plans will adjudicate ASC charges, and report them on the 835, using Revenue Codes. When ASC charges are submitted using HCPC codes but adjudicated using Revenue Code, the health plan will use SVC01 in the 835 to report the type of code that was used for adjudication, i.e. Revenue Code, and SVC06 to report the type of code that was submitted on the 837P, i.e. HCPC code.

4. Denying Duplicate Claims

For the purposes of 835 reporting, a duplicate claim is when a provider resubmits a claim, either on paper or electronically, and makes absolutely no changes from the previous submission of that claim. When a resubmission such as this occurs, the second claim will be denied as a duplicate. This can occur even if the original claim is in a processing status waiting to be paid. CARC 18 will be used on the 835 to report no payment for those claims that meet this definition of a duplicate claim. Health plans will not use CARC 18 in any other situations.

Note - providers should avoid submitting duplicate claims. A Claims Status transaction/web site should be used to determine whether a submitted claim has been received by the health plan.

5. Balancing the 835

   Per section 1.10.2.1 of the X12N 835 TR3, the amounts reported in the 835, if present, ***MUST*** balance at three different levels - the service line, the claim, and the transaction.

6. Using the PLB

   The X12N835 TR3 discusses the situations under which the PLB segment should be used. The PLB should only be used in those situations and its use should follow the guidelines in that document.

   When using the PLB for reporting claim overpayment (e.g. WO) the following PLB field(s), as appropriate, should contain the health plan's claim number followed by the provider patient control number -- PLB03-02, PLB05-02, PLB07-02, PLC09-02, PLB11-02.

   When not reporting claim specific PLB information (e.g. FB) the relevant level of specificity (For FB a Check/EFT #) should be included in PLB03-02 etc.

To Recover Overpayments made to the Provider

The discussion below outlines best practices for **how** the 835 and other methods should be used to report the recovery of overpayments. The section titled 'Reporting-collecting Monies Due from a Claim Adjustment' outlines best practices related to **when** (i.e. the situations under which) overpayments will be recovered.

Per section 1.10.2.17 of the 5010 Implementation Guide, recovering overpayments made to the provider must be done in one of the following three methods:

1. A health plan may choose to recoup the overpayment immediately within the current remittance advice (835). When this is the business model, the reversal and corrections instructions in Section 1.10.2.8 - Reversals and Corrections describe the necessary actions. *1

2. A health plan may choose to not recoup the funds immediately and use manual reporting process to the provider. This process involves sending a letter identifying the claim, the changes to the adjudication, the balance due to the health plan and a statement identifying how long (or if) the provider has to remit that balance. This document must contain a financial control number (FCN) for tracking purposes. Upon receipt of the letter, the provider will

manually update the accounts receivable system to record the changes to the claim payment.*1

3. The health plan may use a combination of methods 1 and 2 for overpayment recovery. The reversal and correction process (Section 1.10.2.8 - Reversals and Corrections) would provide the claim specific information. Within the same 835, a PLB segment is then used to return the funds to the provider and NOT reduce the current payment. This is effectively delaying the recovery of funds within the 835. The FCN reported would be the health plan's internal control number for the claim involved in the recovery (CLP07). The external agreement identifying how the health plan is doing overpayment recovery would specify the time period within which the provider may send the payment or that the provider may not send the payment. PLB03-1 code WO (Overpayment Recovery) is used with a negative dollar amount to eliminate the financial impact of the reversal and correction from the current 835. When the payment is received from the provider, or the health plan recoups the funds, the process identified in option 2 is followed to report the payment or recoup the funds, as appropriate. *1

*1 Accredited Standards Committee X12, Insurance Subcommittee, ASC X12N. Health Care Claim Paymen/Advice), 005010X221. Washington Publishing Company, June, 2010. http://www.wpc-edi.com.

Per Washington State RCW 48.43.600, *"a carrier may not: (a) Request a refund from a health care provider of a payment previously made to satisfy a claim unless it does so in writing to the provider within twenty-four months after the date that the payment was made"*

This combination of Federal and Washington State requirements calls for health plans to notify a provider in writing of a take back before the 835 transactions can be used to actually recover the payment. Once the provider is notified in writing, method number 1 or method number 3 above can be used to recover the payment.

A synopsis of how those two methods are used is as follows:

Provider Preferred Best Practice: Written notification, recovery of payment using the 835

A. Notifying the Provider of a possible take-back

Per Washington State RCW 48.43.600, the health plan must notify the provider in writing of any request for a refund of a payment previously made to satisfy a claim. The provider has 30 days to contest the request, after which the request is deemed accepted and the refund must be paid.

If the provider does contest the request, the take back is placed on hold. The provider will be notified once a resolution has been determined by the plan.

B. Taking back the money

Health plans will take the money back from the provider no earlier than 31 days after initial notification. Typically the money will be taken back no later than 90 days after notification.

The health plan will send the provider an 835 with the following information pertaining to the take back:

a. A CLP reversing the previously processed claim

Example:
July 1, 2012 Remit #889900
CLP*AABBCC*22*-100*-80**12*1234500~
CAS*CO*45*-20

b. A CLP with the corrected claim information

Example:
July 1, 2012 Remit #889900
CLP*AABBCC*1*100*0**12*1234501~
CAS*PR*1*80
CAS*CO*45*20

Note: The reversal should show prior to the correction

c. No PLB segment is required when using this method

When payment is taken back/reversed, the adjustment Group and Reason Codes reported on the reversal should be the same as the adjustment Group and Reason Codes reported on the original adjudication. (also stated on pages 9 & 13)

Acceptable Best Practice: Written notification, advance notice of takeback using the 835, recovery of payment using the 835

A. Notifying the Provider of a possible take-back

1. Per Washington State RCW 48.43.600, the health plan must notify the provider in writing of any request for a refund of a payment previously

made to satisfy a claim. The provider has 30 days to contest the request, after which the request is deemed accepted and the refund must be paid.

2. In addition to the written notification, the health plan will send the provider an 835 with the following information pertaining to the take back:

   a. A CLP reversing the previously processed claim
   Example:
   July 1, 2012 Remit #889900
   CLP*AABBCC*22*-100*-80**12*1234500~
   CAS*CO*45*-20

   b. A CLP with the corrected claim information

   Example:
   July 1, 2012 Remit #889900
   CLP*AABBCC*1*100*0**12*1234501~
   CAS*PR*1*80
   CAS*CO*45*20

   Note: The reversal should show prior to the correction

   c. A populated PLB segment. This segment is used to NOT reduce the current payment. The PLB03-02 should contain the provider patient control number.

   Example:
   July 1, 2012 Remit #889900
   PLB*91667788*20121231*WO:1234500AABBCC*-80~

   For coding examples of how this would look – see the TR3**.**

When payment is taken back/reversed, the adjustment Group and Reason Codes reported on the reversal should be the same as the adjustment Group and Reason Codes reported on the original adjudication. (also stated on pages 8 & 13)

If the provider does contest the request, the take back is placed on hold. The provider will be notified once a resolution has been determined by the plan.

B. Taking back the money

Health plans will take the money back from the provider no earlier than 31 days after initial notification. Typically the money will be taken back no later than 90 days after notification.

One of these methods of take back will happen if the provider does not contest the request OR contests the request and it is not upheld.

a. If the provider sends in a refund check, a PLB is used to report the receipt of the payment.
Per Section 1.10.2.17 of the X12N835 TR3, the health plan will acknowledge the receipt of a provider's refund check using '72' - Authorized Return in the PLB segment of the 835

Example:
PLB*91667788*20121231*WO:1234500AABBCC*80*72:1234500AA
BBCC*-80~

b. If the provider does not send in a refund check, the health plan will recoup the funds using a PLB. The health plan will send the provider an 835 with a PLB with a code of WO. The provider's patient control number will be included in the PLB. PLB03-02 should contain the health plan's claim number followed by the provider patient control number.

Example:
PLB*91667788*20121231*WO:1234500AABBCC*80~

For more coding examples of how this would look – see the TR3

To Handle Forward Balances

Forward Balancing can occur when the dollar amount from reversal and correction claims, of all claims within a remit (within a TRN), exceeds the payments for new claims. Since the payment reflected on the 835 cannot be a negative amount, a balance forward process must be used. This requires the use of a PLB segment with a FB qualifier.

As outlined in section 1.10.2.12 of the TR3, the balance forward occurs only at the transaction level and not at a claim level. In other words, only a single PLB can be used regardless of the number of claims that put the remit into a negative situation.

A PLB segment is used with a FB (Forwarding Balance) in the Adjustment Reason Code field.

The following is an example of how a balance forward PLB might look.

Assume that the current net for the transaction is $-178.65 for provider 1326002049 and that the trace number in the TRN02 is CHKHST08781835. To move the balance forward, the TRN and PLB segment will read:

TRN*1***CHKHST08781835***1191128479~

PLB*1326002049*20131231*FB:**CHKHST08781835***-178.65~

When a balance forward adjustment was reported in a previous 835, a future 835 must add that money back in order to complete the process and actually recover the money. In this case, the PLB segment is used again as the mechanism. Continuing with the same example, an example of the PLB segment for the next remittance advice will read:

PLB*1326002049*20121231*FB: **CHKHST08781835***178.65~

B. Business Processing Practices relating to the 835RA

Pay To Organization and Contract Arrangement

1. When the health plan identifies the organization/person to whom they will pay . . .

   As discussed in the BPR - 837, the organization that originated the 837 is considered to be the Billing Provider. The address of the organization to be paid by the health plan for the service(s) is to be placed in the Pay-To-Address Name.

   However, the provider to be paid and the associated address are typically identified during the contracting process and are stored in the health plan's provider file. The Pay To Address Name loop in the transaction IS NOT intended to override the payment processes of the payer as defined within any contractual relationships that may exist between the payer and the provider.

   When processing a claim, it is the responsibility of the payer to determine the appropriate payee. Providers should contact the health plan if they have any questions about who the health plan has on file as the appropriate payee and/or the payee address. In the absence of any other agreement with the provider, the usage of the Pay To Address Name loop does provide the information on how a provider wishes to be reimbursed.

2. When the health plan reports the contract that applies to the claim . . .

   If the health plan has more than one contract under which claims could be adjudicated …

Section 1.10.2.15 of the X12N835 TR3 describes that REF*CE will contain information that communicates to a provider which contract applies to a particular claim.

- This information could be a code that corresponds to a specific contract arrangement under which the claim will be adjudicated, e.g. code x=Medicare Advantage, code y=Selections, Heritage, etc.

  The health plan will make available on their web site a mapping of their REF*CE codes to more informative descriptions of the contract that applies.

- Alternatively, the provider's preference is that the health plan will use the more informative descriptions of the contract arrangement as the information that is stored in REF*CE.

Splitting Claims & Service Lines

3. When the health plan splits a claim . . .

   There are cases when a health plan splits a claim (or a service line on a claim) and processes it as two or more separate claims. A table of the most common situations in which health plans split claims can be found at: www.onehealthport.com, under Admin Simp tab select Policies and Guideline, then select Claims Processing, then select Guideline Document under Conditions for Splitting Claims.

   Per section 1.10.2.11 of the X12N 835 TR3, when splitting a claim the health plans will report the RA information for each of the 'split' claims as separate entries on one or more 835s. Health plans must identify each separate claim as being part of a split claim by utilizing the MIA or MOA segment with Remittance Advice Remark Code MA15 on the 835 referring to each of the separate claims.

   In other words, though a provider may submit one claim or one service line, the RA information may appear as separate entries on one or more 835. Health plans will balance 835 entries to the claims as they appear in the health plans system, not as they were submitted by the provider. (These situations can occur when the submitted claim was a paper claim or an 837.)

4. When the health plan splits service line information . . .

   Section 1.10.2.14.1 of the X12N835 TR3 explains how service line splitting must be reported in the 835. The requirement is different depending upon the reason for splitting as described below:

- Business Issue: Line splitting reported in the 835 is acceptable if it is a result of a business issue, e.g. dates of service range crosses a change in coverage, some units process under one adjudicated procedure code/benefit rate and others process under another procedure code/benefit rate, etc.

- Technical Issue: Line splitting as a result of an adjudication system limitation is acceptable. However, the line information must be recombined prior to reporting on the 835, e.g. 101 units are submitted on the claim but the adjudication systems allows 2 place positions. For this example, the 835 must reflect 101 units, and not just 99 or just 2.

Reporting Payment and Adjustment Information

5. When the health plan reports the business reason for a denial or adjustment . . .

   a. Refer to the CORE-required Code Combinations for CORE-defined Business Scenarios for CAQH CORE 360 rule which can be found at http://www.caqh.org/CORE_phase3.php
   b. When payment is taken back/reversed, the adjustment Group and Reason Codes reported on the reversal should be the same as the adjustment Group and Reason Codes reported on the original adjudication. (also stated on pages 8 & 9).
   c. Do not use CO45 to represent a denial. CO45 is meant to identify a reduction in the charge and not a denial.

      X12 definition - http://www.wpc-edi.com/reference/codelists/healthcare/claim-adjustment-reason-codes/

45	**Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Note: This adjustment amount cannot equal the total service or claim charge amount; and must not duplicate provider adjustment amounts (payments and contractual reductions) that have resulted from prior payer(s) adjudication. (Use only with Group Codes PR or CO depending upon liability)** *Start: 01/01/1995 | Last Modified: 11/01/2015*

When using a CO45, the reported amount cannot equal the total service amount or claim charge amount. Also, no denial codes can be used in combination with CO45 on the same service line.

Unlike denials, provider systems are programmed to automatically write off any amounts reported with a CO45. Appropriate use of CO45 will prevent errors and manual rework of patient accounts.

6. When reporting service payment information for 837P and 837D claims at the line level . . .

   Per section 1.10.2.1.1 of the X12N 835 TR3, service payment information is required at the line level for professional and dental claims. As such, all adjustments must be reported on the individual service lines.

   The exceptions to this rule are:
   a. The deductible can be reported at either the claim or line level. The preferred method is to report the Deductible at the line level.
   b. If the secondary payer received COB payment information at the claim level then they have the option of responding at the claim level.

7. When a health plan prices claims at a service line level . . .

   Per section 1.10.2.4 of the X12N 835 Implementation Guide, when professional, dental and outpatient claims are priced at the service line level, the actual adjudication information for each service line should be placed in the SVC segment of Loop 2110.

8. When the health plan bundles or unbundles service information . . .

   Per section 1.10.2.6 of the X12N 835 TR3, when bundling or unbundling occurs, the information must be reported back to the payee accurately. Payers are to report bundling or unbundling in a consistent manner.

9. When the health plan reports adjustments using a Claims Adjustment Segment (CAS)

   a. Per section 1.10.2.4, each CAS can report up to six different adjustments related to a particular Claim Adjustment Group. For efficiency, the first significant adjustments is placed as the first trio - CAS02,03 and 04. The six iterations (trios) of the Adjustment Reason Code related to the Specific Adjustment Group Code must be exhausted before repeating a second iteration of the CAS using the same Adjustment Group Code.

   b. Per the X12N 835 TR3 usage notes related to the CAS segment, CAS03 cannot be zero

10. When the health plan processes and reports consumer spending account payments

    There are four possible scenarios for health plan processing & reporting consumer spending account payments.

    - In one of those scenarios, the health plan has no awareness of / involvement

with a consumer spending account for their member. For this scenario, there is no best practice for 835 reporting.

- In the other three scenarios, the health plan is aware of / involved with a consumer spending account for their member. For these scenarios, the associated best practice recommendations for 835 reporting are outlined below.

Ideally, in all three of these scenarios, if the primary health plan knows that their member has secondary coverage from another payer (that is not a consumer spending account), the primary payer will not post payments from that member's consumer spending account. Not applying these payments will minimize the refunds that providers will have to make if a secondary payer also makes payments. However, it is an industry challenge for health plans to collect and maintain accurate information about which of their members has additional coverage. And even in those situations where a payer "knows" that a member has secondary coverage, they don't know that their information is correct or current. As such, it is unlikely that this ideal can be a best practice.
For the three scenarios where a health plan is aware of / involved with a consumer spending account for their member, the associated best practice recommendations are:

a. The first two scenarios are where the health plan manages the Consumer Spending Account in some manner and applies a payment from the Consumer Spending Account.

   i. ***Scenario #1 - Single 835 reporting***: Situations where the Health Plan manages their payment and the Consumer Spending Account in an integrated manner. (The WEDI Portal calls this the "All in One" Model)

   A single 835/EFT is used to report both the healthcare insurance payment and the Spending Account payment in the same CLP. The spending account payment is reported using CARC 187 (Consumer Spending Account Payments).

   Example:
   CLP*ABC*1*200*180**12~
   CAS*PR*1*140**187*-140~
   CAS*CO*45*20~

   The preferred method is to report payments at the line level. In those situations where payments cannot be made and reported at the line level, reporting at the claim level is an acceptable method.

ii. Scenario #2 - Separate 835 reporting: Situations where the Health Plan also acts separately as the bank for the Consumer Spending Account (so interaction with the actual bank is transparent). (The WEDI Portal calls this the "COB" Model)

Due to the processing work flow, Health Plans send the healthcare payment and the Spending Account payment in 2 separate 835s/EFTs, within a close proximity of time (same day or within a few days of each other). The Health Plan 835 should use Remark Codes N367, N509, N510 or N511 (as applicable) to indicate subsequent payment may be forthcoming.

In the Spending Account Payment 835, the CLP02 (Claim Status) must equal one of the codes below, and Remark code N520 can be used to further indicate payment was made from a Spending Account.

Status Code (CLP02):

- 2 – Processed as Secondary
- 19 – Processed as Primary for the underlying plan payment, but with associated patient account payment
- 20 – Processed as Secondary for the underlying plan payment, but with associated patient account payment
- 21 – Processed as Tertiary for patient account payment but with associated additional patient account payment.

Healthcare payment - Primary
CLP*ABC123*1*200*50*130*12*123~
CAS*CO*45*20~
CAS*PR*1*130~
MOA***N509

Spending Account payment - Secondary
CLP*ABC123*2*200*130**12*123~
CAS*OA*23*70~ <<this identifies how much the primary paid and how much they asked the provider to write off>>
MOA***N520 << this identifies the payment as coming from a patient account>>

The preferred method is to report payments at the line level. In those situations where payments cannot be made and reported at the line level, reporting at the claim level is an acceptable method.

b. The third scenario is where the Health Plan is aware of the Consumer Spending Account but does not manage it in any way (The WEDI Portal calls this the "Two in One" Model).

Scenario #3 - Two payments are separately issued, one from the health plan and one from the manager of the Consumer Spending Account.

The Health Plan payment is generated with the patient portion in CLP05. Remark Code N367 should be used to indicate subsequent payment by a Spending Account may be forthcoming.

CLP*ABC*1*200*40*140*12~
CAS*PR*1*140~
CAS*CO*45*20~
MOA***N367

The preferred method is to report payments at the line level. In those situations where payments cannot be made and reported at the line level, reporting at the claim level is an acceptable method.

Ideally, the financial institution that manages the Spending Account will issue payment for the patient portion with limited claim detail. However, this is outside of the control of the health plan. As such, it is unlikely that this ideal can be a best practice.

Codes

Reason Code

187 - Consumer Spending Account payments (includes but is not limited to Flexible Spending Account, Health Savings Account, Health Reimbursement Account, etc.)

Remark Codes

- N367 Alert: The claim information has been forwarded to a Consumer Spending Account processor for review; for example, flexible spending account or health savings account.

- N509 Alert: A current inquiry shows the member's Consumer Spending Account contains sufficient funds to cover the member liability for this claim/service. Actual payment from the Consumer Spending Account will depend on the availability of funds and determination of eligible services at the time of payment processing.

- N510 Alert: A current inquiry shows the member’s Consumer Spending Account does not contain sufficient funds to cover the member's liability for this claim/service. Actual payment from the Consumer Spending Account will depend on the availability of funds and determination of eligible services at the time of payment processing.

- N511 Alert: Information on the availability of Consumer Spending Account funds to cover the member liability on this claim/service is not available at this time.

- N520 Alert: Payment made from a Consumer Spending Account

Reporting Coordination of Benefit Information

11. When the health plan adjudicates a claim as primary AND secondary payer . . .

    The health plan will send the provider an 835 Claim Payment/Advice record for each adjudication – the primary coverage adjudication and the secondary coverage adjudication, in that order if included in the same transaction. The 835 record for the primary coverage adjudication will contain the primary payment information along with the appropriate Crossover Carrier Name Segment in Loop 2100 with NM1-01 = "TT".

    In addition to including the Crossover Carrier Name Segment, the claim status code (CLP02) should reflect the appropriate code as follows:
    19 – processed as primary, forwarded to additional payer(s)
    20 – processed as secondary, forwarded to additional payer(s)
    21 – processed as tertiary, forwarded to additional payer(s)

    Finally, the remark code MA18 is added to the MIA/MOA segment to indicate that the claim was crossed to a subsequent payer.

    Example

    *CLP*XXXX*19*69.75*18.7**12*22334~*
    *NM1*TT*2*PREMERA*****PI*WABC1~*
    *MOA*** MA18~*

12. When the health plan adjudicates as secondary . . .

    a. A CO/PR 45 should be used to report the amount of their own contractual write off that is in addition to the amount the previous payer(s) asked the provider to contractually write-off. (i.e. this CO/45 amount does not include any contractual amount or payments from the prior payer(s)).

    b. An OA23 should be used to report the amount from the primary payer(s) that impacted the provider. In OA23, the secondary/tertiary payer reports the amount(s) the previous payer(s) paid plus all provider adjustment (PI and CO) amounts.

       The amounts reported in OA23 may or may not have been used by the current payer during their adjudication.

13. Health Plans will accept and process 837 claims as primary, secondary, tertiary or subsequent payer.

Assuming that the provider submits claims **sequentially** (per BPR above):

a) If a health plan receives a primary claim and their records show that they are not the primary payer, the health plan will respond with the following codes on the 835 Claim Payment/Advice:
   - Group Code: CO or PI (as appropriate)
   - Reason Code: 22
   - NM1: with payer and subscriber specific information

b) If a health plan receives a secondary/tertiary claim when their records show that they are the primary payer AND the health plan pays as primary, after processing the claim they will include the following remark code on the 835 Claim Payment/Advice.
   - Remark Code[*1]: MA17

     [*1] – See the TR3 for more information about the use of this Remark Code

Reporting-Collecting Monies Due from a Claim Adjustment

14. The section 'Using the PLB To Recover Overpayments made to the Provider' outlines the best practices for **how** the 835 and other methods should be used to report the recovery of overpayments. The discussion below outlines best practices related to **when** (i.e. the situations under which) overpayments will be recovered.
    a. Providers will have the option of selectively submitting claims, initial and/or corrected, depending upon the amount. Health plans will adjudicate all claims received, initial and corrected, and process an 835 no matter the billed amount.
    b. If/when a member is notified about the finalization of a claim reprocessing AND that reprocessing has a financial impact on the provider (including changes to patient responsibility), the 'pay to' provider for that claim will also be notified of the reprocessing.

       In subrogation situations, the provider will only be notified if the claim reprocessing has a financial impact on them (including changes to patient responsibility).
    c. In all situations when a provider is notified by the health plan about a claim reprocessing that results in monies due to the health plan, the health plan will collect that money from the provider, no matter the amount. (Health plan notification thresholds are consistent with this best practice. However, if the provider is notified, the money due will be collected),

15. In subrogation situations where:

    a. A health plan reimburses the provider for services and reports it to them in an 835, AND
    b. That health plan is reimbursed for those services by another entity, e.g. auto insurance company, L&I, etc.

    . . . upon receipt of the payment from the financially responsible entity, the health plan will reprocess their accounts. If, and only if, this reprocessing results in a different paid amount and/or adjusted amount to the provider from that reported on the previous 835, the health plan will report the reprocessing as a "takeback"of the original payment along with the new payment on the provider's 835.

    Information related to the payment from the financially responsible entity should not be reported in any way on the 835.

C. Practices for Using Specific Data Elements

1. The *Reassociation Trace Number (TRN)* in the Header needs to be unique within the sender/receiver relationship.

2. The *Payer's Technical Contact Telephone Number and/or Email Address* that providers can use to communicate directly with a knowledgeable EDI staff member should be put either in the PER segment of Loop 1000A (same contact for all claims in the Remittance Advice) or in the PER segment of Loop 2100 (contact for the specific claim).

3. A *Claim Status Code of 4*, in CLP02 of Loop 2100, should only be used if the patient/subscriber is not recognized by the payer, i.e. the payer has no record of ever providing coverage to the patient/subscriber and the claim was not forwarded to another payer.

   Note to Providers: Claim Status Code '4' will rarely, if ever, be seen. It should no longer be used as an indicator that a claim was denied

4. The *Claim Received Date* is required to be put into the DTM*050 segment of Loop 2100 since Washington State has prompt pay legislation.

   The date put into this field should be one of the following:
   a. The date that the claim was received by the health plan, OR

b. The most recent date that documentation required to adjudicate the claim was received by the health plan.

Validation findings will report which date is populated in the field by the health plan.

5. The *Service Date* must be provided at the claim level or each line level, as appropriate, using the DTP - Service Date of Loop 2110.