# Implementing the 835 Remittance Advice: A Precursor to Submitting COB Claims

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# The Health Care Interchange of Michigan

- RSA for Michigan
- Non-profit membership organization of key payers, providers and clearinghouses
- Ongoing workgroups in HIPAA Privacy, Security and Transactions
- Looking to begin initiatives for standardized exchange of clinical information

# HCIM Mission Statement

*Leading the Michigan collaborative effort to improve health care quality and reduce costs through the effective exchange of information*

# Current Status

- Major progress on 837 primary claims – maybe 50% implemented
- While testing is often completed, roll-out has lagged
- Little testing of 835s, even less in production
- Significant 834 usage by major employers and payers
- Little progress on other HIPAA transactions
- Several payers implementing 277 Unsolicited

# Michigan Experience

- Most providers are either in production or test for primary claims
- Many providers in production for primary claims are trying to test secondary COB claims
- Very few providers are even in test with the 835 remittance advice

# The challenge

- Both billers and programmers who did primary 837 claims are anxious to move on to secondary claims
- These staff are not experts in posting remittances
- Accounts receivable business staff have not yet been actively involved in implementing the 835

# COB Claims – Two Models

- **Model 1**: Provider -> Payer 1 -> Provider -> Payer 2

  Primary payer returns the 835 to the provider. Provider creates a secondary 837 and sends to the secondary payer.
- **Model 2**: Provider -> Payer 1 -> Payer 2

  Primary payer sends 835 back to provider and sends a reformatted 837 on to secondary payer

**Lets focus on Model 1**

# Basic Steps – 837 to Primary

- Subscriber loop (2000B) identifies person how has coverage with Payer 1
- Other subscriber(s) information goes in 2320 loop
  - Other subscriber name and number
  - Associated other payer name and numbers
  - Other payer associated provider number(s)
- Can repeat up to 10 times

# Payer 1 returns 835

- Displays adjudication results
  - Amounts paid and why at the claim level in 2100 loop
  - Amounts paid and why at the service line level in 2110 loop
  - Other adjustments in PLB segment

# Provider Creates 837 Claim to Secondary Payer

- Secondary subscriber and payer now identified in 2000B loop
- Information about primary subscriber and payer now in 2320 loop
- Total amount paid goes in AMT segment in 2300 loop
- Claim level payments and adjustments from primary payer are reported in the 2320 loop
- Any service line level payments and adjustments from the primary payer are reported in the 2430 loop

# Claim level information in 2320 loop of secondary 837

- claim level adjustments (CAS segment)
- other subscriber demographics
- various amounts
- other payer information
- assignment of benefits indicator
- patient signature indicator

# Claim level information from the 835

- claim level adjustments (CAS segment)
- various amounts (AMT segments)

# Service line level information in the 2430 loop of secondary 837

- ID of the payer who adjudicated the service line (SVD segment)
- amount paid for the service line (SVD segment)
- procedure code upon which adjudication of the service line was based. (SVD segment) This code may be different than the submitted procedure code.
- paid units of service (SVD segment)
- service line level adjustments (CAS segment)
- adjudication date (DTP segment)

# Service line info from 835

- amount paid for the service line (SVC segment)
- procedure code upon which adjudication of the service line was based. (SVC segment)
- paid units of service (SVC segment)
- service line level adjustments (CAS segment)
- adjudication date (DTM segment)

# With the 835 – No Worries

- Needed information is either in original 837 or in 835 from primary payer
- Move info around in 837; primary to 2320 loop and secondary to 2000B loop
- Copy and paste CAS segments from 835 at claim and service line level
- Copy and paste other needed info from 835 SVC, DTM and AMT segments

# Working from legacy RAs - Worries

- Where do you find needed information?
- Is the format "HIPAA compliant"?
  - Dates
  - Codes
  - Adjustment codes and reasons
- Do payments balance?

# Claim Adjustment Reason Codes

- Required national list of about 200 codes
- Different and shorter list from legacy proprietary codes
- Do you have the payer's map from legacy codes to national codes?
- Maps are often inconsistent between payers, even those with the same legacy systems

# Claim adjustment group codes

- Every claim adjustment reason code in the CAS segment must be preceded by a claim adjustment group code (e.g. – "CO" is contractual obligation, "PR" is patient responsibility)
- Most legacy RAs do not have claim adjustment group codes
- Many maps do not include claim adjustment group codes

# Remittance Advice Remark Codes

- Again, a national set of allowable codes
- Different and shorter list from legacy proprietary codes
- Do you have the payer's map from legacy codes to national codes?
- Maps are often inconsistent between payers, even those with the same legacy systems
- Remittance advice remark codes are not included in secondary 837s

# Conclusion

- Design of HIPAA compliant 837s to secondary payers "assumes" they are built using 835 from primary payer
- Building compliant 837s to secondary payers without an 835 poses difficulties
- Implementing 835s (both at payer and provider) before tackling secondary 837s is not always the "natural" evolution

# Suggestions

- Understanding the difficulties of either implementation path is important
- Providers should work with payers to understand the payer's approach to EDI secondary claims
- Consider implementing "simple" secondary claims first

# QUESTIONS