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Disclaimer

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I  Purpose and Scope

The WEDI-X12 Real-Time Transactions and Business Process Modeling Workgroup was formed in the fall of 2007. The workgroup was asked to do the following:

- Meet with various industry segments to discuss their business processes and how they may be affected by Real-Time Adjudication (RTA).
- Review existing uses of RTA
- Develop models representing the interests of the various stakeholders
- Review existing and proposed transactions and recommend transactions to be used to conduct RTA. The intent would be that the recommended transactions would become standards in the industry.

In order to meet the above tasks, the workgroup defined the following objectives:

- Identify stakeholders
- Document opportunities and benefits of RTA
- Document challenges and barriers of RTA
- Document how RTA would impact existing workflows and data flows by all stakeholders
- Recommend “best practice” from both a business and technical perspective
- Identify specific transactions to select as standard for support of RTA

The results of broad industry outreach and participation/collaboration from interested stakeholders are presented in this paper.
II Background

In 2007, WEDI and X12 began collaborating on an initiative to bring widespread real-time adjudication (RTA) to the health care industry. Approximately 200 people attended a conference hosted by WEDI and X12 in February 2007 to explore the topic of RTA. The conference included presentations and panel discussions emphasizing the need for RTA and the current environment that presents both barriers and catalysts for moving to RTA. The conference concluded with breakout sessions in which the attendees discussed the business and technical implications of implementing RTA processes. Discussions focused on the need to develop business process models, define a common language, set communication protocols, identify security and privacy needs, research the topic of Health Information Portability and Accountability Act [HIPAA] waivers, and market RTA. The level of participation and engagement by the attendees emphasized the interest by the industry to develop a standardized approach to conducting RTA.

The six priorities identified at the conference were turned into joint WEDI-X12 work groups as part of an overall RTA initiative. The RTA Transactions and Business Process Modeling work group was formed with a charter of developing business process models for RTA and for recommending the transactions to be used to conduct RTA.

The workgroup began its work in the Fall of 2007. Since that time the workgroup has conducted interviews with several provider groups, repricing organizations, health plans and clearinghouses and has presented its preliminary findings to many diverse organizations. During the Summer of 2008, both WEDI and X12 approved the workgroup’s preliminary models and transaction recommendations with comments. The decisions and workflows from this workgroup have served as the baseline for several other workgroups in the Joint WEDI-X12 RTA Initiative.

In developing its models and transaction recommendations, the workgroup adopted several constraints. These constraints are considered to be beyond the scope of the workgroup’s efforts.

- The workgroup’s transactions and models do not include the repricing function(s). The workgroup found that repricing organizations are not yet capable of fully supporting RTA.
- The workgroup did not address support of secondary claims in a real-time manner. The workgroup determined that support for Coordination of Benefits is too complex for the initial implementation of RTA.
- The workgroup determined that it could not address real-time support for requests for additional information and the various responses to the request(s). Requests for information and the responses to those requests are conversational in nature and are beyond the scope of the initial implementation.
- The workgroup did not address real-time payment. The workgroup recognized that real-time adjudication does not require real-time payment.
III Terminology

The following terms and acronyms are frequently used within the health care industry. The RTA Transactions and Business Processing Modeling Workgroup has used the following ‘working’ definitions in the development of its products based on the preliminary work of the RTA Glossary Workgroup of the joint WEDI-X12 RTA Initiative. These definitions were part of the development for the RTA Transactions and Business Process Modeling workgroup at the time of building the models.

*** These terms are representative of the proposed definitions at the time of the writing of this paper. For the most updated comprehensive list of all terms consult the WEDI – X12 RTA Glossary. Please see Appendix B Other WEDI-X12 RTA Workgroups for more information.

Real-Time Adjudication [RTA]
The process of a single claim being submitted by a provider to a payer. The payer fully adjudicates the claim to its final disposition. The payer responds to the provider advising of denial reason(s) or amount to be paid, patient responsibility and adjustments and explanations. The whole process is completed in a single communications session that is established and remains open and active until the adjudicated transaction is received by the entity initiating the communication session.

Source: WEDI-X12 RTA Glossary Work Group

Note: The term real-time claims adjudication is also used in the industry. Real-time adjudication and real-time claims adjudication are defined the same.

Note: At this time, the RTA Glossary work group and the WEDI-X12 RTA Initiative are not defining a specific time limit in which the adjudication transaction must be completed.

Estimators
A process employed by a payer to calculate an estimated payment to be paid to the provider for the services reported on the claim. The final adjudication and subsequent payment may differ from the response provided at the time of the estimation.

Source: WEDI-X12 RTA Glossary Work Group

Predeterminations
A pre-service request for a statement of what benefits may be payable under the health plan, provided everything remains the same (e.g., eligibility, plan, services rendered) as reported in pre-determination at the time the service is actually rendered. The predetermination request would include all data necessary to fully adjudicate a claim except for date(s) of service.

Source: WEDI-X12 RTA Glossary Work Group

Claim Denial
The final claim adjudication disposition resulted in non-payment of the claim based on business rules as defined by the contract. A business contract can be between the provider and the payer or the member and the payer.
Related Terms: Claim Adjudication, Finalized Claim

Note: Do not confuse a zero claim denial with a zero payment which can be the result of other payer or patient responsibility.
Source: WEDI-X12 RTA Glossary Work Group

Claim Rejection
The process whereby a received claim is not accepted for claim adjudication due to either format issues, or payer specific business edits.
Source: WEDI-X12 RTA Glossary Work Group

Real-Time Claim Advice
The Real-Time Claim Advice is a specific implementation of the existing 835 Health Care Claim Payment / Advice transaction. At the time of this writing, the X12 workgroup (X12N/TG2/WG3) is working on additional guidance for use of the 835 as a response to a real-time claim.

Health Care Claim Acknowledgment
The Health Care Claim Acknowledgment (277CA) is one of the possible responses to a real-time claim or predetermination. The transaction is a response showing acceptance or rejection of the claim. Subsequent sections in this document indicate when the 277CA should be returned.

This paper uses the terms ‘health plan’ and ‘payer’ to refer to the ‘health plan’ as defined in the HIPAA regulations.
IV Claim Adjudication Business Process Model Diagrams

A Current (Non-Real-Time Adjudication) Business Process Model

Figure 1. Current Business Process Model
B Complete Real-Time Adjudication Business Process Model

Use Case 2: RealTime Flow

Figure 2. Real-Time Adjudication Business Process Model
**Pre-service transactions**
Pre-service transactions are not shown in the diagram of the real-time model but the workgroup recognizes the need to conduct either eligibility inquiries, predetermination requests or both. See further comments on page 28.

The differences between the batch and the real-time process are the following:

<table>
<thead>
<tr>
<th>Billing Process</th>
<th>Batch</th>
<th>Real-Time</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• After the service is performed, all data needed for the claim is prepared and validated.</td>
<td>• The provider documents the encounter at the point of care.</td>
</tr>
<tr>
<td></td>
<td>• The claim is batched with other services and sent to the payer either directly, or to a clearinghouse that combines the provider’s batch with batches from other providers and routes the resulting batches to the payer.</td>
<td>• The claim is prepared and validated while the patient is still at the point of care (potentially) with the assistance of automated tools.</td>
</tr>
<tr>
<td></td>
<td>• Multiple clearinghouses (or hops) could be involved before the claim reaches the payer.</td>
<td>• The claim is individually sent to the payer either directly, or to a clearinghouse that routes the claim to the payer.</td>
</tr>
<tr>
<td></td>
<td>• When the claim is billed by the provider, it creates an accounts receivable balance in the provider’s accounting system.</td>
<td>• Multiple clearinghouses (or hops) could be involved before the claim reaches the payer.</td>
</tr>
<tr>
<td></td>
<td>• Claim preparation may require many hours or days in duration. Submission and delivery of claim batches may take hours or days.</td>
<td>• When the claim is billed by the provider, it creates an accounts receivable balance in the provider’s accounting system.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Claim preparation is immediate and takes place while the patient is still at the point of care. Submission and delivery of the claim is also immediate.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Adjudication Process</th>
<th>Health Plan Payer Gateway:</th>
<th>Health Plan Payer Gateway:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• The payer receives batches of claims submitted by providers, billing services, clearinghouses, re-pricers, etc.</td>
<td>• The payer gateway receives a single claim in real-time and performs initial validation of the claim.</td>
</tr>
<tr>
<td></td>
<td>• Payers usually perform front-end editing of claims so that “clean claims” are entered into their adjudication systems. This function may be administered by a payer or outsourced to a clearinghouse.</td>
<td>• During validation if any exceptions are found, the claim will be processed in batch mode. This function may be administered by a payer or outsourced to a clearinghouse.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• If the claim fails this step an acknowledgement is returned to the submitter.</td>
</tr>
<tr>
<td>Adjudication Process (continued)</td>
<td>Batch</td>
<td>Real-Time</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>-------</td>
<td>-----------</td>
</tr>
<tr>
<td><strong>Payer Adjudication:</strong></td>
<td>• The final adjudication of the claim results in a remittance advice (paper or electronic) and a check (paper or electronic funds transfer (EFT)).&lt;br&gt;• Claims that pend or reject are exceptions notified to the provider in a batch process.&lt;br&gt;• Final results of adjudication are communicated via the payment process.&lt;br&gt;• Adjudication of claim may take hours or days.</td>
<td><strong>Payer Adjudication:</strong>&lt;br&gt;• The adjudication process results in a real-time claim advice clearly identifying the Patient Responsibility Amount.&lt;br&gt;• The response of either a real-time claim advice or a claim status acknowledgement is returned to the provider in real-time.</td>
</tr>
<tr>
<td><strong>Payment Process</strong></td>
<td>• The provider receives the remittance advice from the payer (could be via a clearinghouse or other third party entity) and may elect to post information from the remittance to their accounts receivable (A/R) system.&lt;br&gt;• Many providers wait to post the actual payment into the A/R system until funds are received.&lt;br&gt;• The provider generally has to wait for the payment to determine the full patient liability and to post the payment to their A/R system.&lt;br&gt;• Payer payment may take days or weeks.</td>
<td>• The provider receives the real-time claim advice from the payer (could be via a clearinghouse or other third party entity).&lt;br&gt;• The provider may elect to post information from the real-time claim advice to their A/R system.&lt;br&gt;• Many providers wait to post the actual payment into the A/R system until funds are received.&lt;br&gt;• The provider can determine and collect actual patient payments at the time of service and post them to their A/R system.&lt;br&gt;• Payer payment may take days or weeks.</td>
</tr>
</tbody>
</table>
Figure 3. Real-Time Adjudication Business Process Model - Provider Directly to Payer
D. Payer Real-Time Adjudication Flow

Health Plan Payer Gateway

Figure 4 Payer Real-Time Adjudication Flow summarizes, at a high-level, a payer’s gateway or triage process that occurs prior to the claim being accepted into adjudication and illustrates the possible outcomes of this process. A real-time claim submission will only receive one response. The response generated is based on how far the claim moves through the payer’s process.
The payer gateway receives the claim in real-time. The transmission mode or envelope indicates that the claim is a real-time transaction. The gateway process includes all pre-adjudication functions performed once the claim is received. This process may include the following steps. The order of these steps may vary by payer process.

- Authorization
- X12 validation
- HIPAA compliance validation
- Business editing
- Real-time appropriateness validation
- Translation of the claim into internal format

The business edits will generally vary by payer. They could include verification of membership and/or status and provider validation, although these are not requirements of real-time front-end editing and may actually occur during claim adjudication.

There are three possible outcomes to the gateway (front-end) process as a result of the editing and real-time suitability decisions:

- Claim accepted for RTA and passed to the adjudication process.
- Claim rejected back to the submitter by a front-end acknowledgement (TA1, 997 or 999, 277CA), depending on where the rejection occurs. Note: The 999 is the preferred acknowledgment, instead of the 997, as the industry transitions into version 5010 for the claim.
- Claim accepted into the adjudication process, but not suitable for real-time processing and is moved to a batch mode of processing. A real-time 277CA would be returned acknowledging receipt and acceptance into the adjudication process. The claim would not be acknowledged in the payer’s batch 277CA.

The decision labeled “Pass Front-end Edits” means the claim has passed all of the payer’s front-end editing processes. If the claim fails a level of editing, it will be rejected with an appropriate acknowledgment dependent on the level and/or type of error. The acknowledgement must be returned in real-time.

- Interchange errors - the claim rejection would be handled with a TA1.
- X12 syntax or structure errors - the claim rejection would be handled with a 997 or 999.
- Business edits - the claim rejection would be handled with a 277CA.

The decision labeled “Claim Suitable for RT” indicates the claim has met the payer’s rules for acceptance into the adjudication process as a claim that can potentially be processed in real-time. If the claim passes all front-end editing, but for some reason is not ‘Suitable for RT’, the claim should be moved to batch processing. For example, a payer imposed service line limit for real-time claims or multiple claims being sent instead of a single claim would make a claim ‘not suitable’ for real-time. A 277 Claim Acknowledgment would be returned to indicate the claim(s) has been moved to batch processing. The 277CA would report a status of:

- Claim Status Category Code - A2: Acknowledgment/Acceptance into adjudication system.

**Health Plan Adjudication Process**

Figure 5 summarizes, at a high-level, the claim adjudication process and illustrates the possible outcomes of this process. The outcomes are similar to those in pre-adjudication processes.

The health plan adjudication process performs various functions which include, but are not limited to verifying patient membership, verifying provider status and additional validation of edits, if applicable. The end result of adjudication is to determine the patient financial liability and provider payment/adjustment amounts of the claim based on, but not limited to, medical policy, member benefits and provider contracts. A claim that completes processing in real-time generates an 835 real-time response that contains the finalized results from successful claim adjudication, but does not contain the actual payment information. Actual payment for real-time adjudicated claims will be generated through daily and weekly payment cycles and be subsequently reported in the respective batch payment cycles or payment 835.

Note: In some situations a claim can be successfully processed, but does not result in a positive provider payment. For example, the entire service allowance is applied to the patient’s
deductible or the services are not covered benefits under the plan. In these situations an 835 with zero dollars payable would be returned.

During adjudication, issues can occur that will cause the claim to suspend or pend for data correction, additional information or other types of payer intervention. Resolution of suspensions (pending reasons) and/or correction of claim data must occur automatically in order to complete processing in real-time. Any decision point that occurs during adjudication which requires manual or delayed payer intervention to resolve the pending situations, suspensions or claim correction will cause the claim to be processed in batch mode. The order of the decision points referenced in the adjudication flow may vary by payer process.

There are three possible outcomes to the claim as a result of the adjudication process:

- Claim processes to finalized status in real-time and a real-time 835 response is sent with the adjudication results.
- Claim is denied back to the submitter as a result of an adjudication process edit or issue. A denial from the adjudication process is sent using a real-time 835 response.
- Claim can not complete processing in real-time and is moved to batch mode of processing. A real-time 277CA would be returned acknowledging receipt and acceptance into adjudication. The claim would not be acknowledged in the payer’s batch 277CA.

The decision labeled “Pass” indicates the claim passed all validation types edits within the adjudication process. If the claim does not pass, it will be denied based on issues found during the adjudication process. A claim that does not pass adjudication data verification is denied. A denial from the adjudication process is sent via an 835 real-time response.

The decision labeled “Claim Processable for RT” indicates the adjudication process can process the claim in real-time and there are no constraints (system, time, suspensions, etc.) that are preventing the claim from finalizing. For example, a claim that requires human review to determine the correct payment amount is not able to be processed in real-time. A claim that cannot be processed in real-time is moved to the batch process and notification is sent in real-time using a 277CA.

The 277CA would report the status as:

- Claim Status Category Code - A2: Acknowledgment/Acceptance into adjudication system
- Claim Status Code - 685: Claim could not complete adjudication in Real-Time. Claim will continue processing in a batch mode. Do not resubmit

The decision labeled “Enough Info” indicates that adjudication may not be completed in real-time because additional information is needed to process the claim. The payer’s rules for additional information development will determine if the claim is moved to batch processing for development of the additional data or denied for lack of necessary processing information.

Claim Suspends for Development: If the payer keeps the claim in a pending status while performing development for additional information, the claim is moved to batch processing and notification is sent in real-time using a 277CA. The 277CA would use the following status:
• Claim Status Category Code - A2: Acknowledgment/Acceptance into adjudication system
• Claim Status Code - 685: Claim could not complete adjudication in Real-Time. Claim will continue processing in a batch mode. Do not resubmit.

Payers are encouraged to use additional status codes if possible to indicate what type of information is needed. For example:

• Claim Status Code – 21: Missing or invalid information. Note: At least one other status code is required to identify the missing or invalid information.

This real-time notification is not the actual request for the additional information generated by the payer. At this time, that request would follow the same payer process used for requesting additional information on batch claims.

Claim Denied for Lack of Information: If the payer denies the claim for lack of information, rather than pending the claim while performing development for additional information, a denial notification is sent in real-time using an 835 real-time response. The 835 real-time response would indicate the claim was denied for lack of information and provide what type of information is missing. For example, Claim Adjustment Reason Code 16 and Remittance Advice Remark Code N29:

• Claim Adjustment Reason Code – 16: Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)

It is important that payers report the Claim Adjustment Reason Codes and Remittance Advice Remark Codes to the highest level of specificity so the provider can easily determine the exact follow up they need to do without having to call the payer for additional information.
Provider Real-Time Adjudication Flow
This section of the model covers the business process from the time the services are rendered through the submission of a claim. Some steps may not performed by all providers, depending on the type and size of the organization.

Provider Billing Process

![Figure 6. Provider Billing Process](image)

**Health Care Service**

**Pre-bill Steps include the following steps:**

- **Transcription** to ensure there is enough clinical information to complete coding of the claim, such as: operative reports, doctor’s notes

- **Coding** which is the application of the appropriate procedure codes and diagnosis codes as determined by all providers. Small group practices or specialty clinics may have standardized encounter forms or “super-bills” that include the most commonly used codes for that group. Larger organizations and more complicated services may require that a coder determine these from the service provider documentation. In these cases, it is unlikely that the coding could be completed before the patient leaves the office, so using RTA to determine patient responsibility may not be feasible. Routine, easily coded procedures are the best candidates for RTA.

- **Data Entry** of charges into the billing systems varies widely among providers. They could be manually keyed from a paper encounter form or super-bill or captured using a sophisticated charge entry system in which doctors can select the appropriate procedures and diagnoses electronically. They could be entered directly in the billing system that creates the claim or into a specialty application.
(for example, an electronic health record (EHR) system or a radiology system) that interfaces to the central billing system.

- **Validation** edits can occur at multiple stages. There could be real-time edits as the keyer enters the charges, such as invalid procedure codes, modifiers, diagnoses, NDC or other situational data required. There may be more complicated edits performed in a batch job to catch incorrect use of component codes, cross-checks between diagnosis and procedure codes, and duplicate services before a claim is created, which may be harder to implement in a real-time environment.

- **Provider Signoff** is when the Doctor would approve of and signoff on transcriptions and the summary of the claim. In some cases, the provider may need to prepare a discharge summary. Signoff may occur either before or after claim coding.

- **Collects Services** from integrated systems (for some providers)
  Large multi-specialty provider organizations may choose to consolidate the charges from various departments that the patient visited during the same encounter. For example, a patient seen in the emergency room may also have lab work and x-rays done the same day. Each department could have their own system and data entry methods.

- **Consolidates Bills** (for some providers)
  After initial data collection, the charges often flow through direct interfaces from the feeder systems to the central billing system that creates the claim. Sometimes one or more departments may not have any mechanism to enter the charges themselves and must send the charges on paper encounter forms to be keyed by a central data entry department.
  - There may be internal edits in place to prevent charges from being billed until the related charges from other departments have been received. Consolidation of charges could be completed as quickly as one day, but may take as long as 10 days when there are delays in keying or edits on the data need to be resolved.
  - At this point, some providers have batch edits as described in the data entry section above.

**Patient Account System Processing**

This is where the Provider collects a co-pay from patient either at check-in or check-out and posts into the billing system. This process creates the claim and for some providers, validation edits can also occur during the claim generation process which would prevent submission of the claim until the errors are corrected.

**Final claim validation after creation of claim** (for some providers)
Some providers run claims through claims validation software once the claim is created by the patient account system.

**Decision – is claim suitable for real-time?**

If there is no established connection with a payer, the provider would not even attempt to submit a real-time claim. The provider may be able to build in known payer restrictions on submitting real-time to prevent useless submissions. Also, the provider may choose not to attempt certain types of claims, (e.g., claims needing attachments and provider is unable to create an electronic attachment).

- Yes – claim is submitted in real-time
- No – claim follows normal batch process

**Adjudication Process**

![Patient Accounting System Diagram](image)

*Figure 7. Patient Accounting System*

**Patient Accounting System**

The provider receives a response to the claim. Once the real-time claim has been submitted, the provider can expect ONE of the following responses, depending on the disposition of the claim. Multiple response transactions will NOT be sent. The status below indicating whether or not RTA was successful is based on a useful response being received before the patient leaves. Other reasons for using RTA, such as denial management, may not require this to be successful.
RTA not successful. Provider experiences a lost connection or receives a communications error that cannot be reported in an X12 transaction. The provider should not resubmit the claim (batch or real-time) without doing a claim status inquiry to determine if the claim was received. If the claim is not in the payer’s system, the provider may resubmit. In either case, the delay due to the extra steps makes it questionable that a useful response would occur while the patient is still present.

RTA not successful. Provider receives a 997 or 999 acknowledgment from either the clearinghouse or the payer if the claim is rejected because of X12 syntax or implementation guide errors. The provider would probably need to involve the internal electronic data interchange (EDI) department or software vendor to correct the error. The claim must be resubmitted.

RTA not successful. Provider receives a 277CA reporting that the claim was accepted, but sent to batch. The provider should NOT resubmit the claim. Payers may not be able to handle some types of claims in a real-time environment or the claim may pend in the adjudication process for additional information or review.

RTA not successful. Provider receives a 277CA rejecting the claim due to errors preventing acceptance into the adjudication process. The provider may correct the error and resubmit the claim. Depending on how quickly the error can be corrected, it may be possible to get another response that is successful before the patient leaves.

RTA successful! Provider receives an informational 835 denial or real-time claim advice. The provider can choose whether or not to post the information into the accounting system. The actual payment information will be received in a batch 835 with the same claim information repeated. ASC X12 is developing a guidance document concerning the use of the 835 for information only in real-time. Providers should carry out a thorough evaluation of how the implementation of RTA will impact their systems and processes, including if and how they will record informational 835 denials and real-time claim advices.

Decision - Balance Due?
When the 835 is returned, the provider can rely on this information to determine the amount the patient owes. The appropriate Patient Responsibility (PR) claim adjustment reason code will be in the real-time claim advice (835). If there is no balance due, the check-out process is complete. If there is a balance due, the provider
collects either the whole amount or else establishes a payment plan with the patient. A statement or receipt is generated.

A new process may be needed for the provider to generate a receipt at the time of service based on the real-time claim advice. The standard patient statement can be produced once the batch 835 is received and posted. The standard patient statement could be produced after the receipt of the batch 835.

**Payment Process**

![Payment Process Diagram](image)

- **Patient Accounting System**
  - The provider receives either the EFT or check payment on the normal payment cycle. The batch 835 communicates the same payment or denial information as received in the informational 835, but includes the actual payment. Additional patient payments may be received and posted if the entire balance was not collected during the visit. Information is now available in the patient accounting system to generate an accurate statement.
F Clearinghouse Real-Time Adjudication Role

This section of the model covers health care clearinghouses (aka clearinghouses, switches, health data networks, health information exchanges). Health Care Clearinghouses are entities that act as ‘hubs’ in the communication flow, allowing each trading partner to communicate to one entity in order to reach all other trading partners. Some organizations may not take advantage of this layer, choosing to establish direct communication with each of their trading partners. This flow is from a claim submitter (provider) to a clearinghouse and from the clearinghouse to the payer. The submitter has an indirect link to a variety of payers via one or more clearinghouses. The clearinghouse maintains distinct communication with each trading partner.

Receipt and delivery of claims

![Figure 9. Clearinghouse Receipt and Delivery of Claim](image)

Communication

The clearinghouse establishes communication with each trading partner according to the trading partner’s capability and need. For the purposes of RTA, the transactions that are used in a real time mode typically are those that require an immediate response. In a real time mode, the sender sends a claim transaction to the receiver, either directly or through a clearinghouse and remains connected while the receiver processes the transaction or returns a response transaction to the original sender.

Translation

Health Care Clearinghouses are specifically identified in the HIPAA regulations (DEFINITIONS - HEALTH CARE CLEARINGHOUSE, SECTION 160.103) as a covered entity that:

1. Processes or facilitates the processing of health information received from another entity in a nonstandard format or containing nonstandard data content into standard data elements or a standard transaction.
2. Receives a standard transaction from another entity and processes or facilitates the processing of health information into nonstandard format or nonstandard data content for the receiving entity.

If required by a trading partner, the clearinghouse shall perform translation as described above as defined in the trading partner agreement.
**Validation:**
The transaction may be validated at varied levels of rigor depending on the Trading Partner Agreement. These may include but should not be limited to: Trading Partner Authentication, Format Validation, (WEDI Type 1-2), Content Validation (WEDI Type 3-7). (WEDI types as described in the WEDI White paper WEDI Transaction Compliance and Certification Published 08/2002 for use with the 4010A1 implementation validation. The WEDI White Paper is available for download on the WEDI web site [http://www.wedi.org](http://www.wedi.org).

*Trading Partner Authentication*
The clearinghouse identifies and authenticates submitters. This authentication is required for a claim to be submitted. This authentication is linked to the trading partner agreement to validate that the submitter is operating under the terms of the trading partner agreement.

*Format Validation*
The clearinghouse shall validate that the transaction received is in the mutually agreed format. Variation from the format or gaps in required content may result in processing errors being returned to the submitter. This validation corresponds to the WEDI Type 1 and WEDI Type 2 validation.

*Content Validation*
The clearinghouse may validate that the transaction received meets proscribed content including:
- Financial balancing;
- Validation of external code sets;
- Situational usage validation;
- Conditions based on Product Type or Line of Service;
- Implementation Guide conditions specific to trading partners.

This validation corresponds to the WEDI Type 3 - 7. Variation from the format or gaps in required content may result in processing errors being returned to the submitter.

*Trading Partner Business Logic*
In order to support RTA, the clearinghouse shall at a minimum perform format and content validation as defined in the Trading Partner Agreements. A clearinghouse may agree with a Trading Partner to apply additional business logic to facilitate transaction processing. This may include identification of claims that meet a trading partner’s conditions to be removed from real-time transaction flow and moved to the batch transaction flow or ‘rejection’ of the transaction with instruction to resubmit via batch claim submission. If a clearinghouse invokes this type of business logic on behalf of a trading partner, the clearinghouse will return a response to the provider on behalf of the trading partner notifying them of the processing of the transaction.

*Delivery*
The clearinghouse will deliver transactions to the payer, or the payer’s designated clearinghouse for delivery to the payer. In an RTA process, the clearinghouse will then wait a mutually agreed upon timeframe for response. If no response is received, the clearinghouse will notify the submitter of the error condition.
Response Handling

The clearinghouse shall validate the response consistently with the claim validation described above. The clearinghouse may optionally perform additional business logic on the response in order to facilitate processing by their trading partner.

Response Translation
Just as with the claim, the clearinghouse may translate the response from a standard format to a non-standard format, or from a non-standard format to the standard format in accordance with the definition of a clearinghouse in the HIPAA Regulations (see above).

Delivery
The clearinghouse shall return the response (997/999, 277CA or 835 or functional equivalent) received from the payer within the defined timeframe to the provider in the format defined in the trading partner agreement. If an error condition is encountered or trading partner business logic is invoked by the clearinghouse, the clearinghouse shall generate an appropriate response and return it to the provider. A clearinghouse shall provide a response (997/999, 277CA, 835 or functional equivalent) to all claims it receives from submitters.
V  Transaction Recommendations

Claim Submission
The workgroup considered whether to use the Interactive Claim (IHCLME) as authored by X12N/TG2/WG12 or the Health Care Claim (837D, 837I and 837P) as authored by X12N/TG2/WG2. As part of the decision process, the workgroup determined that there were no additional functional requirements needed. Since the industry has already implemented the Health Care Claim, the workgroup recommends the use of the 837D, 837I and 837P transactions for submitting real time claims.

Responses to a Real-Time Claim
Each real-time claim results in a single real-time response. The workgroup recommends the use of the 835 Health Care Claim Payment/Advice transaction to report adjudication results (payments and/or denials). The 835 conveys the information of what the payment would be along with any appropriate adjustments, but does not reflect an actual payment. Health plans should issue a second 835 reflecting the actual payment, if any, for the claim once the check / EFT has been produced.

The workgroup recognized that if the health plan wanted to issue and immediate real time payment, then the current 835 would also be used. The Claim Payments workgroup of X12 (ASC X12 TG2/WG3) is developing a TR2 guidance document to detail the responses to a real-time claim.

The workgroup recommends the 277 Health Care Claim Acknowledgment transaction to:
- Report errors in the claim (such as missing information, subscriber not found, etc.)
- Report that the real-time claim was accepted and will be processed in batch mode
- Report timeouts

The workgroup recommends the use of the 999 Implementation Acknowledgment transaction to report X12 and/or Implementation Guide (TR3) compliance errors. Finally, the workgroup recommends the use of the TA1 Interchange Acknowledgment transaction as needed to report problems with the transaction envelope.

The workgroup also made the following specific recommendations:
- Use the 999 instead of the 997. The 999 supports all of the functionality of the 997 and adds additional reporting capabilities.
- Do not use the 824 Application Acknowledgment in response to a real-time claim. The 824 uses a mixture of free-form text and codes and is not suitable for automation by the receivers.
- The recommended implementation guide for the 277 Health Care Claim Acknowledgment transaction is the 5010 version of the transaction (005010X214).
- In case of a timeout, the entity recognizing the timeout – whether the entity is the payer, a clearinghouse or a VAN -- should send a 277 Claim Acknowledgment to its submitter.

**Predetermination / Estimate Requests**
For Dental predeterminations, the workgroup recommends the 837 Dental Claim. The transaction fully supports predeterminations and is universally used in the Dental Benefits industry today. In recognition of the need to standardize transactions for Professional and Institutional predetermination requests, X12N/TG2/WG2 has developed TR3’s for predetermination requests for Professional and Institutional claims based on the HIPAA-compliant 5010 claim formats.

**Predeterminations and Estimates -- Responses**
The responses to a real-time predetermination are the same as the responses to a real-time claim. The current implementation guides for the 835 fully support and provide examples for responding to a predetermination. When the predetermination cannot be fully adjudicated in real-time, the workgroup recommends using the same responses as recommended for the real-time claim.

**Eligibility Transactions**
The workgroup reviewed the use of Predeterminations and the Eligibility Inquiry / Response transactions. The recommendation is to use both transactions. Each transaction can be used in real-time prior to the services being performed. When the submitter wants a full adjudication of the proposed services, use the predetermination. When the submitter wants to verify coverage, check the remaining deductibles, out-of-pocket limits, etc, use the eligibility transactions.
VI Use Cases

1) Patient goes to the doctor. The office staff submits the claim and receives a payment decision before the patient leaves the office.

![Diagram of RTA Scenario 1: Patient Visits Provider, Claim Direct to Payer](image-url)

Figure 11. Patient Visits Provider, Claim Direct to Payer
2) Patient goes to the doctor. The office staff submits the claim before the patient leaves the office. The claim is routed via a single clearinghouse to the payer. The payer adjudicates the claim and returns the results to the Provider office before the patient leaves the office.

Figure 12. Patient Visits Provider, Claim to Payer Via Single Clearinghouse
3) Patient goes to the doctor. The office staff submits the claim before the patient leaves the office. The claim is routed via more than one clearinghouse to the payer. The payer adjudicates the claim and returns the results to the Provider office before the patient leaves the office.

![Diagram](image)

Figure 13. Patient Visits Provider, Claim to Payer Via Multiple Clearinghouses
4) Patient goes to the doctor. The office staff submits the claim before the patient leaves the office. Payer receives the claim and is processing it but cannot complete processing within the defined time. Payer sends back 277CA. Patient leaves office without adjudication results.

Figure 14. Patient Visits Provider, Claim to Payer - Payment Decision Pended
5) Patient goes to the doctor. The office staff submits the claim before the patient leaves the office. Payer receives the claim but needs additional info so claim is pended and moved to batch queue. Payer sends back 277CA. Patient leaves office without adjudication results. Adjudication is completed after additional info is supplied.

Figure 15. Patient Visits ProviderClaim to Payer, Add'l Information Requested
6) Patient goes to the doctor. The office staff attempts to submit the claim before the patient leaves the office but can not connect to the payer. Patient leaves office without adjudication results. Office staff either tries real time connection at a later time or submits via batch method at a later time. Payer adjudicates claim and returns results.

Figure 16. Patient Visits Provider, Connection to Payer Cannot be Completed
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Appendix A  Opportunities and Challenges

One of the responsibilities of the workgroup was to determine if implementation of Real-Time Adjudication (RTA) was warranted. The workgroup consulted various stakeholders to determine the opportunities and challenges for each.

The provider community would directly benefit from RTA by:
- Collecting patient responsibility amounts while the patient is in the office
- Reducing Patient AR days
- Reducing bad debt
- Supporting “consumerism”
- Improving turnaround times for denial management

Challenges to the provider community include:
- Potential workflow changes to support RTA
- Increased number of claims since RTA claims are submitted one at a time
- Payment paradigm shift for patients

The payer community would directly benefit from RTA by:
- Resolving Patient Responsibility right away thus eliminating many follow-up questions
- Reducing customer service events
- Reducing duplicate claim submissions
- Encouraging and enabling consumers to make better health care decisions

Challenges to the payer community include:
- Potential system upgrades required to support RTA
- Adapting batch-based systems to support RTA
- Implementing modified transactions to support RTA
Appendix B  Other WEDI-X12 RTA Workgroups

The joint WEDI-X12 RTA Initiative is comprised of six workgroups. Each of the workgroups will be publishing documents on their work. Workgroup products will be available to WEDI and/or X12 members when published on the WEDI and X12 web sites (http://www.wedi.org or http://www.x12.org ). [URL to be added by WEDI and DISA staff when available.]

- Transactions and Business Process Modeling Workgroup
- Glossary Workgroup
- Communications Workgroup
- Security and Privacy Workgroup
- HIPAA Exceptions Workgroup
- RTA Implementation Workgroup

The Transactions and Business Process Modeling Workgroup (this workgroup) has created models for RTA, has recommended specific transactions to use in conducting RTA and has made ‘best practice’ recommendations for RTA.

The Glossary Workgroup has created a glossary of terms common to each of the workgroups in support of RTA. The Communications Workgroup has studied the specific communication challenges posed by RTA. The Security and Privacy Workgroup studied potential issues that could be caused by RTA. The HIPAA Exceptions Workgroup made specific recommendations and comments to promote compliance with the Transactions and Code Sets Final Rule of HIPAA in order to conduct RTA. The Implementation Workgroup is assisting organizations that are considering adding RTA to their capabilities.

Comment [td1]: Replaced ‘ensure’ with ‘promote’ since there is no guarantee, expressed or implied, that the recommendations of the HIPAA Exceptions Workgroup are indeed compliant with the HIPAA Transactions and Code Sets Final Rule.
Appendix C  X12 Publications

X12N is currently working on several publications in support of RTA:

- A Predetermination Guide (TR3) for Professional Predeterminations (005010X291) has been approved for publication.
- A Predetermination Guide (TR3) for Institutional Predeterminations (005010X292) has been approved for publication.
- Guidance for the proper use of the Health Care Claim Payment / Advice (835) transaction in response to real-time claims will be published as a Technical Report Type 2 (TR2) and will include the electronic remittance advice, the claim and the health care claim acknowledgment.
- The Health Care Claim Acknowledgment guide (TR3) guide (005010X214) has been published and is available for use.