FAQ (Frequently Asked Questions):

A. Can I use my company’s internal claim reject codes in the 835 transaction? No. The 835 transaction requires use of the standard Claim Adjustment Reason Codes owned by the Blue Cross Blue Shield Association. Payers must map their internal reject and reduction reasons to this list and, if applicable, the Claim Payment Remark Codes. The Internet sites where these code lists are available are listed under "Links to related sites".

B. In the version 4010 implementation guide, the alternate reversal and correction description is missing. Can I still do reversals and corrections using that method?

No. Due to problems posting using the alternate reversal and correction method, the only method compliant with version 4010 of the 835 is a complete reversal and subsequent re-adjudication of the claim. See section 2.2.8 of the 4010 guide.

C. How do I handle situations where the 835 net has gone negative, requiring funds from the provider?

The Work Group has added specific instructions for this in the draft for the next Claim Payment implementation guide. They read:

2.2.12 Balance Forward Processing

A common practice within Health Care claim processing is the review and re-adjudication of claims. This practice sometimes results in additional payments to the provider. Other times it results in a reduction in the payment amount. While the reversal and correction process (see section 2.2.8) identifies the process for reporting these changes, one aspect has been left out. Since the 835 is a financial transaction and not just a report, the payment amount can not be negative. The question then arises, what do you do when refunds from reversals and corrections exceed the payments for new claims, resulting in a net negative payment? The answer is Balance Forward Processing.

The PLB segment’s ability to report adjustments not related to a specific claim also allows for a balance forward adjustment. This capability allows a payer to move the negative balance from the current 835 transaction into a future transaction. The business objectives are:

- Increase the net for the current 835 to $0.00.
- Add the previous balance into a future 835 transaction.
- Identify to the provider what has happened.
- Identify a reference number for reconciliation of the balance forward process.
Moving a negative balance out of the current 835:

When a net negative payment is detected in an 835, this is corrected by adding a balance forwarding adjustment in the PLB segment. While any adjustment pair can be used in the PLB, PLB03 and PLB04 will be used for illustrative purposes. The adjustment reason used in PLB03-1 will be FB, "Forwarding Balance". The reference number in PLB03-2 will contain the same number as the trace number used in TRN02 of the current transaction. This reference number will facilitate tracking by the provider. The dollar amount in PLB04 will be the same as the current, negative, balance. Since the balancing section, 2.2.1.3, specifies that the transaction balance is the claim payment total minus the provider level adjustments, the transaction payment amount will now be $0.00. The value in BPR02 will be 0.

Assume that the current net for the transaction for provider "ABA8789" is $-200.00 and that the trace number in TRN02 is "1234554". To move the balance forward, the PLB segment will read:

```
PLB*ABA8789*19991231*FB:1234554*-200~
```

Since -200 minus -200 equals 0, the BPR segment will contain 0 in BPR02.

Adding the previously forwarded balance to a new 835:

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. In this case, the PLB segment is again used as the mechanism. PLB03-1 contains FB, "Forwarding Balance". PLB03-2 contains the same reference number from the PLB segment of the previous 835. This allows the receiver to quickly reconcile the two balance forward adjustments. PLB04 contains the same dollar amount as the previous day, but as a positive value. The positive number reduces the payment in this 835.

Continuing the same example, the PLB segment for the next remittance advice for the provider will be:

```
PLB*ABA8789*19991231*FB:1234554*200~
```

Note: The sign of the dollar amount in the PLB segment determines whether the balance forward is moving from today into tomorrow or from yesterday into today.

If the net for this new 835 is negative, the balance forward process would be repeated.
For information about specific Medicare Part A usage see the PLB03-1 code FB and PLB03-2 detail in section 3.

D. How do I report the primary payer paid amount when paying a secondary claim?

The work group has added a section specifically addressing this issue to the draft of the next Claim Payment implementation guide. That section reads:

2.2.13 Secondary Payment Reporting Considerations

Many patients are covered by more than one health benefit payer. In multi-payer situations, a hierarchy is established as to which plan is primary, secondary, or tertiary as applicable for payment of a patient’s health care expenses. Secondary and tertiary payers are frequently referred to as “secondary” payers. Most secondary payers adjust their payments so that the total payments, primary and secondary, do not exceed the billed charges for covered services.

Each health plan defines when that plan is primary, secondary, or tertiary for a covered individual. Each payer’s plan also generally defines its calculation methodology to determine its payment for services when another payer is primary. The calculation methodology often includes adjustments when the primary allows a higher or lower payment amount for a service than the secondary, if the primary’s plan does not cover one or more services on a multi-service claim, if the amounts of deductible or coinsurance differ under the plans, or for other variables. To eliminate a possible disincentive for enrollment in more than one plan, some payers do not consider the full amount of the primary’s payment when calculating their secondary payment.

From the perspective of the secondary payer, the impact of the primary’s payment is a reduction in their payment amount. This "impact" may be up to the actual amount of the primary payment.

Report the “impact” primary payment in the appropriate claim or service level claim adjustment segment (CAS) with reason code 23 (Claim adjusted because charges have been paid by another payer as part of coordination of benefits). It is essential that any secondary payer report in the remittance advice only the primary amount that has actually impacted their secondary or tertiary payment. In many cases, this “impact” primary payment is less than the actual primary payment. When this happens, reporting the “actual” primary payment would prevent the transaction from balancing.

The claim status code in CLP02 must report whether the claim is being paid as primary, secondary, or tertiary. An 835 transaction does not allow a secondary
payer to report the “actual” amount of a primary’s payment if different than the “impact” amount. Only a primary payer sends that information to a provider.

E. Can you explain reporting service codes in the 835 in more detail?

The work group has added a new section to the draft next version Claim Payment implementation guide addressing this issue. It reads:

2.2.14 Service Line Issues

While previous sections touched upon usage of the service line information, there is a basic philosophy in the 835 related to the service line that is critical to proper use of the 835.

Much of the information usage in the 835 depends upon the context of a particular service. Since the Claim Adjustment Reason Codes used in the CAS segment tend to be more generic than the codes traditionally used by payers, they depend on the context to create a complete message. Information in the SVC segment must frequently work with the Claim Adjustment Reason Codes to give the provider a message that will not result in calls to customer service.

The SVC segment provides two locations for service line procedure information. SVC01 always contains the coding for the procedure used in adjudication. SVC06 contains the original procedure code submitted by the provider when it is different than the coding in SVC01. Use of both of these locations is necessary to maximize administrative simplification benefits.

For instance, when reporting an adjustment for a post operative visit service that is being denied because the payment was included in the payment for the surgery, the CAS and SVC segments must work together to report the complete message. This situation is similar to procedure code bundling, except that one of the submitted services is the adjudicated procedure code. The CAS segment will report an adjustment code of 97 (Payment is included in the allowance for another service/procedure). But, this information is not adequate without reporting the surgery procedure code in SVC01 as well as the post operative procedure code in SVC06.

This ability to report an adjudicated and submitted procedure code should always be implemented to report changes in coding by the payer and when the adjudication decision is based upon a service other than what was submitted by the provider.

F. How do I identify different networks or provider organizations in the 835?
The work group has added a new section to the draft next version Claim Payment implementation guide addressing this issue. It reads:

2.2.15 PPOs Networks and Contract Types

Many payers may encounter a situation where a particular provider has contracted with several different Preferred Provider Organizations, contract types or networks (PPOs) offered by that payer. This transaction set provides a method for communicating to a provider which contract applies to a particular claim.

When adjusting the claim for the PPO discount, the amount of the adjustment is reported in the Claim Adjustment segment contained in loop 2100. The adjustment amount is reported in the CAS segment using group code CO, contractual obligation in CAS01, an appropriate adjustment reason code and amount. (Note: The CAS segment utilizes up to six “adjustment trios”. This information could be reported in any of the trios.) To report the name or identifier of the PPO, use the REF segment, Other Claim Related Information. The code CE should be used in REF01 and the name or identifier of the PPO should be reported in REF02. While it is possible that free-form text may be transmitted in the REF segment, it is recommended that each payer develop a standardized list of PPOs (or other payment arrangements), to facilitate automated processing by providers.

For example, assume that Provider P has contracted with two PPOs, A and B. Assume further that the claim was submitted as $75.00 and has been repriced by PPO B to $55.00. The pertinent parts of the claim would then appear as follows:

<table>
<thead>
<tr>
<th>CAS</th>
<th>CO</th>
<th>45</th>
<th>20~</th>
</tr>
</thead>
<tbody>
<tr>
<td>REF</td>
<td>CE</td>
<td>B~</td>
<td></td>
</tr>
</tbody>
</table>

G. How does the 835 recover claim overpayments?

The work group has added a new section to the draft next version Claim Payment implementation guide addressing this issue. It reads:

2.2.17 Claim Overpayment Recovery

While all health plans strive for accurate adjudication on the first pass, occasionally adjudication mistakes are detected (sometimes through an appeal process) that result in changes to either the amount paid or the allocation of further responsibility for unpaid balances. When the payment increases or the responsibility (contractual obligation versus patient responsibility) changes without a change in payment the reversal and correction process described in section 2.2.8 describes the necessary actions within the 835. However, when the review results in a reduction of the claim payment amount, the business gets more complicated in how to accomplish an overpayment recovery. Basically, there are three business approaches to claim overpayment recovery. The health plan
should specify its methodology for claim overpayment recovery in either a trading partner agreement or a provider.

1 – A health plan may choose to immediately recoup the overpayment within the current remittance advice (835). When this is the business model, the reversal and corrections instructions in section 2.2.8 describe the necessary actions.

2 – A health plan may choose to not immediately recoup the funds and use a 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.

If the provider chooses to remit the balance due within the specified time period with a check, the health plan will acknowledge the receipt of the check using the PLB segment of the next 835. In order to maintain a balanced 835, this is accomplished using offsetting adjustments in the PLB. PLB03-1 codes 72 (Authorized Return) and WO (Overpayment Recovery) are used.

Example: A health plan sends a letter to a provider (number 1234) identifying an overpayment of $37.50. The FCN of the document is 56473. Before the specified deadline, the provider remits the overpayment to the health plan, identifying the FCN with the payment. A PLB segment in the next 835 would report this payment.

PLB*1234*20011231*WO:56473*37.5*72:56473*-37.5~

If the provider chooses (or is instructed) to not remit the overpayment by the established deadline, then the health plan will recoup the funds in an appropriate 835. This is accomplished using the PLB segment, and NOT the reversal and correction procedure. Reversal and correction is not appropriate since the provider’s system has already been updated manually to reflect the adjudication changes. PLB code WO (Overpayment Recovery) is used to effect the recovery.

Example: A health plan sends a letter to a provider (number 1234) identifying an overpayment of $37.50. The FCN of the document is 56473. The provider does not remit the overpayment to the health plan. A PLB segment in the next 835 would report the overpayment recovery.

PLB*1234*20011231*WO:56473*37.5~

3 – The health plan can use a combination of methods 1 and 2 for overpayment recovery. The reversal and correction process (section 2.2.8) would provide the claim specific information. Within the same 835, a provider level entry (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 can send the payment or that the provider should 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 is option 2 is followed to report the payment or recoup the funds, as appropriate.

Example: The health plan re-adjudicates a claim (number 837483) resulting in an overpayment recovery of $37.50 from provider number 1234. The reversal and correction are reported in the 835 (not shown) with a PLB segment to reverse the current financial impact.

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PLB*1234*20011231*WO:837483*-37.5~
```

The provider remits the balance before the deadline identified in the agreement with the health plan. The next 835 reconciles the payment with the previous receivable using the PLB segment.

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PLB*1234*20011231*WO:837483*37.5*72:837483*-37.5~
```

Note – If any of the above processes result in an 835 with a negative balance (BPR02<0), the balance forwarding process identified in section 2.2.12 is used to eliminate the negative value in BPR02.

H. Some of the total sections of the 835 are restricted to Medicare only, and other totals just don’t exist. How are other Health Plans expected to report totals to providers using the 835?

Per a DSMO decision, many of the Medicare specific totals are being changed to “not used” in the next implementation guide. The work group has added a new section to the draft next version Claim Payment implementation guide addressing this issue. It reads:

**2.2.18 Totals within the 835**

The 835 does not provide extensive totaling of claim payment information. While may older proprietary formats provided this information, the generation of totals is mostly left to the receiver of the transaction, if they desire the information. Since the 835 is expected to be an electronically processed transaction, the totals are seen as an output from that process, rather than as a direct part of the 835.
The total that is always included in the 835 is the total paid amount in the BPR segment, element 2. In instances where the business situation makes use of the TS3 segment required, the TS3 segment will provide total number of claims for a 2000 loop in element 4 and the total claim charge in element 5.

Some of the other totals that can be calculated are described below. This is not an all inclusive list. Other desired totals can be calculated in similar ways.

Total Number of claim – count of the number of CLP segments in the 835.

Total Claim Charge – sum of the CLP segment, element 3 values in the 835.

Total Covered Charge – sum of all AMT segment, element 2 values where AMT element 1 equals “AU”. See the note in the Claim Supplemental Information AMT segment element 1, code “AU” for additional information.

Total Non-Covered Charge - sum of the CAS segment, element 3,6,9,12, 15 & 18 values in the 835 or appropriate 2000 loop where CAS segment element 2, 5, 8, 11, 14 or 17 equals values desired by the provider as defining “non-covered charges”. The term non-covered charges includes various portions of the rejected claim charge, depending upon interpretation. For example, specific Claim Adjustment Reason codes that can be included here are 47, 49, 50, 51, 53, 54, 60, 78, 96, 111, 117, B1, B8, B9, B11, B14, and 119. Please see the code list for the various definitions. The general code for non-covered charges is 96.

Total Claim Provider payment – sum of the CLP segment, element 4 values in the 835 or appropriate 2000 loop.

Total Provider Patient Responsibility amount - sum of the CLP segment, element 5 values in the 835 or appropriate 2000 loop.

Total Interest – PLB segment, element 4, 6, 8, 10, 12 & 14 when the related adjustment Reason code is “L6”.

Total Provider Contractual Obligation Adjustment – sum of the CAS segment, element 3,6,9,12, 15 & 18 values in the 835 or appropriate 2000 loop where CAS01 equals “CO”. The desired amount may be refined by providers based upon specific Adjustment Reason Code information, if appropriate.

Total Coinsurance Amount - sum of the CAS segment, element 3,6,9,12, 15 & 18 values in the 835 or appropriate 2000 loop where CAS segment element 2, 5, 8, 11, 14 or 17 equals value “2”.

Total Deductible Amount - sum of the CAS segment, element 3,6,9,12, 15 & 18 values in the 835 or appropriate 2000 loop where CAS segment element 2, 5, 8, 11, 14 or 17 equals value “1”.