Chapter 8 Companion Guide 835 Payment & Remittance Advice

This companion guide for the ASC X12N 835 Healthcare Claim Payment/Advice transaction has been created for use in conjunction with the *ASC X12N 835 004010A1 Healthcare Claim Payment and Remittance Advice Implementation Guide*. It should not be considered a replacement for the *ASC X12N 835 004010A1 Healthcare Claim Payment and Remittance Advice Implementation Guide*, but rather used as an additional source of information.

28 Texas Administrative Code (TAC) §133.240(e) requires insurance carriers to provide the explanation of benefits (EOB) in the "form and manner prescribed by the Division." Rule 133.501(a) states: "(e)lectronic medical bill processing is the exclusive process to exchange medical bill data in accordance with §133.500 of this chapter (relating to Electronic Formats for Electronic Medical Bill Processing) for professional, institutional/hospital, pharmacy, and dental services. Accordingly, the "form and manner" for electronic EOBs is governed by the provisions of §§133.500 and 133.501, which requires the use of the ASC X12N 835 format and code values.

Claim Adjustment Group Codes

The ASC X12N 835 format requires the use of Claim Adjustment Group Codes. The most current, valid codes should be used as appropriate for workers' compensation. The Claim Adjustment Group Code represents the general category of payment, reduction, or denial. For example, the Group Code 'CO' (Contractual Obligation) might be used in conjunction with a Claim Adjustment Reason Code for a network contract reduction.

The Claim Adjustment Group Code transmitted in the ASC X12N 835 is the same code that is transmitted in the IAIABC 837 Medical State Reporting EDI reporting format. The TDI-DWC accepts Claim Adjustment Group Codes that were valid on the date the insurance carrier paid or denied a bill.

Claim Adjustment Reason Codes

The ASC X12N 835 format requires the use of codes as the electronic means of providing specific payment, reduction, or denial information. As a result, use of the ASC X12N 835 eliminates the use of proprietary reduction codes and free form text used on paper Explanation of Benefits (EOB)/DWC-62 forms. Accordingly, insurance carriers that provide the required ASC X12N 835 information in the transmission, including the use of the standard and jurisdictional claim adjustment reason codes, are complaint with 28 TAC §§133.240 (e) and 133.501.

Remittance Remark Codes

The ASC X12N 835 format supports the use of Remittance Advice Remark Code to provide supplemental explanation for a payment, reduction or denial already described by a Claim Adjustment Reason Code. Insurance carriers should use the remittance remark codes to provide additional information to the health care provider regarding why a bill was adjusted or denied. The use of the ASC X12N 835 eliminates the use of proprietary reduction codes and free form text used on paper Explanation of Benefits (EOB)/DWC-62 forms. Remittance Remark Codes are not associated with a Group or Reason Code in the same manner that a Claim Adjustment Reason Code is associated with a Group Code.

Code Reference Information

The ASC X12 Claim Adjustment Status Code Committee maintains Claim Adjustment Group Codes, Claim Adjustment Reason Codes and Remittance Remark Code sets adopted by HIPAA. The current code sets are available from the Washington Publishing Company at http://www.wpc-edi.com/codes .

Product/Service ID Qualifier

The Product/Service Identification Number transmitted in the inbound electronic billing format is returned in the ASC X12N 835 SVC Service Payment Information Segment with the appropriate qualifier. For example, a Revenue Code billed with a HCPCS on a UB-04 is transmitted to the insurance carrier. The Revenue Code qualifier and Revenue Code are returned in the ASC X12N 835, not the HCPCS Code.

Reference Information

The implementation guide for the ASC X12N 835 *004010A1* Health Care Claim Payment/Remittance Advice transaction is available through the Washington Publishing Company, www.wpc-edi.com.

Instructions for Texas specific requirements are also provided in Chapter 3 Texas Workers' Compensation Requirements. When the application for Texas workers' compensation is different than the HIPAA implementation, it is identified in the following table:

Loop	Segment or Element	Value	Description	Texas Workers' Compensation Instructions
1000A	**PER**		**Submitter Contact Information**	
	PER03	TE	Communication Number Qualifier	Value must be 'TE' Telephone Number.
	PER04		Communication Number	Value must be the Telephone Number of the submitter.
2100	**CLP**		**Claim Level Data**	
	CLP06	WC	Claim Filing Indicator Code	Value must be 'WC' – Workers' Compensation