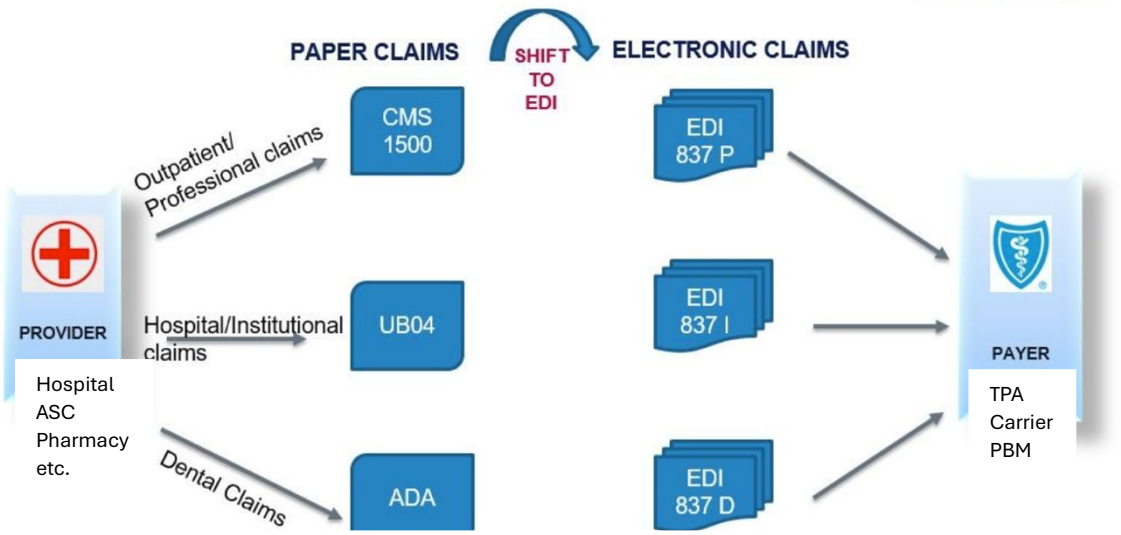
837 and 835 Electronic File Claim Transactions

prepared by Employers' Forum of Indiana, 9-23-24

1. **The standard for which medical and pharmacy claims are BILLED by a Provider to a Payer is done using an 837 electronic file claims transaction.**
   a. **837 P** (provider) electronic file claim transaction notes the BILLED amount per patient visit from a physician office clinic, ambulatory surgery center, or hospital outpatient clinic representing just the professional physician fee. The CMS 1500 Form is the paper claim version of the 837 P e-claim.
   b. **837 I** (institution) electronic file claims transaction notes the BILLED amount per patient visit from a long-term care facility, hospital inpatient, hospital outpatient clinic representing only the hospital facility fee, and other institutions. UB04 (aka CMS 1450 Form) is the paper claim version of the 837 I e-claim.



2. Claims are PAID by a Payer to a Provider via 835 electronic file claims transaction.

3. Auditing: the value of 837 and 835 claims data is that it allows employers upon AUDIT to ascertain if their payer partner charged them appropriately. It assists employers in meeting their fiduciary duty by identifying if they are making appropriate payments & helping them identify fraudulent activity. Specifically, it identifies:

1. **Spread Pricing** is the difference between what the employer was charged by the payer for each claim and what the payer paid the provider via the 835 claims transaction. Example, TPA/PBM tells their employer client that the lab/medication was $500 but the TPA/PBM paid that provider/pharmacy for $50 and kept $450.
2. **Overpayments** can be identified by comparing the 837 and 835 data at the claims level. TPAs often charge employers a 20-40% 'recovery fee'. Example: Provider X bills TPA B $1,000 >>> TPA B overpays the claim to Provider X $10,000 >>> Payer B later requests Provider X to pay them back $9,000 as they consider it overpayment and Provider X complies >>> Payer X charges the employer a 30% 'recovery fee' and passes ONLY 70% of the overpayment back to the employer, instead of 100% of the recovered amount that they 'mistakenly' overpaid. Persistent overpayments which are considered a mistake may become a payer revenue stream. Employers often see a dollar 'recovery fees' on the reports provided to them by their payer, but are not typically provided claims level details.
3. **Underpayments** to competitors may be made to stifle competition. Example, due to vertical integration, a PBM may underpay (pay less than the drug acquisition cost) to a competitor pharmacy versus paying their own pharmacy partner higher prices.

Below provided by Marilyn Bartlett, CPA and senior fellow at the National Academy for State Health Policy, 2024

Background: What are 837 and 835 Transaction Sets?

HIPAA required HHS to establish national standards for electronic transactions to improve the efficiency and effectiveness of the nation's health care system. ASC X12 Version 5010 is the adopted standard Electronic Data Interchange (EDI) format for moving data from one entity to another. Healthcare providers and payers utilize these transaction sets to bill for and pay for medical services.

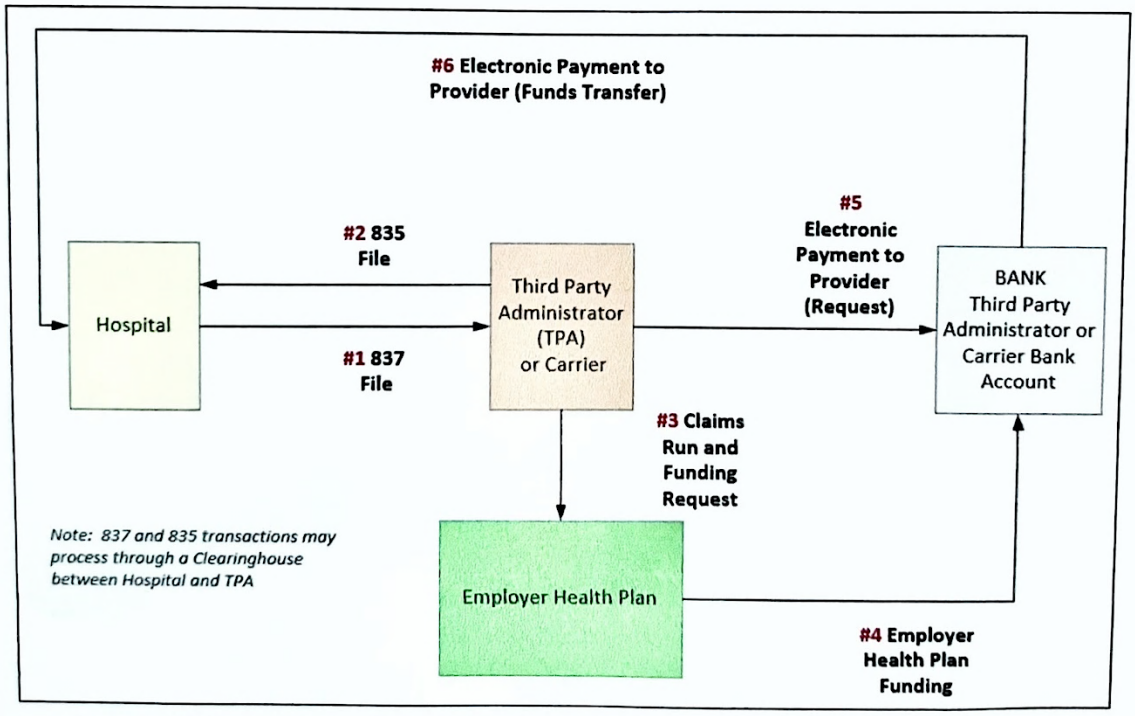
ASC X12N 837 *(837 file*) is the electronic file containing the medical claim and billing information sent from healthcare providers to a Third Party Administrator (TPA) or Insurer.

ASC X12N835 (*835 file)* is the Electronic Remittance Advice (ERA) transmission and includes the amount paid to the provider for the medical claim.

How does a Group Health Plan use the 837 and 835 Transaction Sets to manage the Plan?

Claim and Bill Review. Group Health Plan or independent contracted analytics firm can audit the billing ***#1 837 File*** with the calculations of the TPA reported in ***#3 Claims Run and Funding Request.***

Reconciliation. Group Health Plan can reconcile the amount paid to the TPA on ***#3 Claims Run and Funding Request*** with the amount paid to the provider ***#2 835 File***



Do the 837 and 835 Transaction Sets help a Plan Administrator perform their Fiduciary responsibilities?

The duty to act prudently is one of the Fiduciary's central responsibilities and access to these data sets is therefore key. The Fiduciary must pay "only reasonable plan expenses". By monitoring plan assets through accessing, analyzing, and reconciling claims payment activity, the plan Fiduciary will achieve this assurance.

APPENDIX: The History and Importance of X12 File Formats in Healthcare

Prepared by Chris Deacon, JD, CEO of Versan Consulting

The 835 (Remittance Advice) and 837 (Claims) file formats, key components of Electronic Data Interchange (EDI) in healthcare, were developed to standardize and streamline the exchange of critical financial and clinical information between healthcare providers and payers. Their adoption was driven by rising administrative costs, inefficiencies in data exchange, and legislative mandates, most notably the Health Insurance Portability and Accountability Act (HIPAA).

Before standardization, healthcare relied on disparate, proprietary data formats that led to delays, errors, and high administrative costs in claims processing and payments. The industry recognized the need for a unified approach, resulting in the creation of the X12 EDI standards, overseen by the Accredited Standards Committee (ASC) X12.

Why These Standards Matter

The 837 and 835 files are integral to the healthcare system:

- Efficiency: Automating claims submission and remittance reduces manual errors and speeds up processing.
- Cost Savings: Standardized formats lower administrative overhead by eliminating the need for paper-based systems.
- Accuracy: Ensures consistent data interpretation, improving payment accuracy and reconciliation.
- Compliance: HIPAA mandates these formats, ensuring all electronic healthcare transactions follow a uniform structure.

The Role of HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandated the adoption of standardized EDI formats to improve the efficiency and security of healthcare transactions. These standards apply to:

- Claims (837)
- Remittance Advice/Payments (835)
- Eligibility Verification (270/271)
- Claim Status (276/277)
- Referral Authorizations (278)

HIPAA also enforced stringent privacy and security rules to protect patient information, ensuring secure transmission of data.

The Role of National Automated Clearing House Association (NACHA)

NACHA supported the adoption of the 835 file for Electronic Funds Transfers (EFTs), enabling seamless integration of payments with claims data. Using the same reassociation trace number (TRN) in both the EFT and 835 files allows providers to efficiently reconcile payments with claims.

The 835 and 837 file formats remain foundational to modern healthcare, ensuring transparency, efficiency, and compliance.

Reassociation Trace Number in the 837 File:

When a healthcare provider submits an 837 claim to a payer, it includes a trace number that uniquely identifies the claim. This trace number is referred to as the Claim Payment Trace Number (often called the TRN Segment). It is generated by the provider's billing system and sent to the payer within the 837 file.

Reassociation Trace Number in the 835 File:
The payer uses this same trace number in the 835 remittance advice file when sending payment or denial information back to the provider. The TRN segment in the 835 file includes this reassociation trace number, allowing the provider to match the payment to the specific claim that was submitted in the 837 file.

How Reassociation Works:

1. **837 Submission:** A healthcare provider submits a claim in an 837 file, and the file includes a trace number that uniquely identifies the claim.
2. **835 Remittance:** The payer processes the claim and sends an 835 file back to the provider. The 835 file contains a trace number that matches the one submitted in the 837 file.
3. **Matching Process:** The provider uses the reassociation trace number to match the remittance advice in the 835 file to the corresponding claim in the 837 file. This is crucial for accurate accounting, especially when payments for multiple claims are bundled together.

Example of a Reassociation Trace Number:
- In the **837 file**, the trace number might look like this: TRN*1*123456789*987654321~
- In the **835 file**, the trace number will appear similarly in the TRN segment to confirm that the payment or denial corresponds to the original claim.

Why It's Important:
- **Accuracy:** Helps ensure that payments are properly matched to the correct claims, which is critical when managing multiple claims and payments.
- **Efficiency:** Automates the reconciliation process, reducing manual errors and making financial operations smoother for healthcare providers.

This reassociation process prevents confusion between the claims and payments, especially when multiple claims are sent or when payments are bundled together.

Adjustment Codes in 835s

Claim Adjustment Reason Codes (CARCs) are included in the **835 file**. These codes play a critical role in explaining why the payment amounts differ from the amounts originally billed by the healthcare provider. CARCs are standardized codes used across the healthcare industry to provide a consistent explanation for payment adjustments, such as denials, partial payments, or reductions in the claim amount.

Purpose of CARCs in the 835 File:
When a healthcare provider submits a claim, the amount they bill often does not match the amount that the payer (insurance company) reimburses. These discrepancies can arise from various reasons, such as contractual adjustments, coverage limitations, or claim errors. CARCs explain these adjustments, helping the provider understand why the payment is different from what was billed.

How CARCs are Used in the 835 File:
In the 835 remittance advice file, CARCs are included in the adjustment segments that accompany the payment information. The most relevant segments for claim adjustments are:

CAS Segment (Claim Adjustment Segment): This segment contains the CARCs, explaining any adjustments to the original billed amount.

Each adjustment is tied to a reason code that clarifies the specific cause for the reduction, denial, or change in the amount.

Common Types of Claim Adjustments Explained by CARCs:

1. Contractual Adjustments: These occur when there is a difference between the billed amount and the payer's allowed amount, as agreed upon by contract.
    - Example CARC: Code 45 - "Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement."
2. Patient Responsibility: This includes amounts the patient must pay, such as copayments, deductibles, or coinsurance.
    - Example CARC: Code 1 - "Deductible Amount."
3. Denials or Rejections: The claim may be denied for various reasons, such as lack of coverage, incorrect coding, or other eligibility issues.
    - Example CARC: Code 16 - "Claim/service lacks information or has submission/billing error(s)."
4. Non-covered Services: Certain services might not be covered under the patient's health plan.
    - Example CARC: Code 96 - "Non-covered charge(s)."
5. Bundling or Unbundling of Services: Sometimes, services are bundled together or split into multiple components, resulting in payment adjustments.
    - Example CARC: Code B5 - "Coverage/program guidelines were not met or were exceeded."
6. Authorization or Referral Issues: If preauthorization or referral requirements were not met, the payer might deny or reduce the payment.
    - Example CARC: Code 197 - "Precertification/authorization/notification absent."

Remittance Advice Remark Codes (RARCs):

In addition to CARCs, the 835 file may also include Remittance Advice Remark Codes (RARCs). These codes provide further details about the adjustments when additional explanation is needed. RARCs often supplement CARCs to give a fuller picture of why a claim adjustment was made.

- Example RARC: Code N95 - "This provider was not certified/eligible to be paid for this procedure/service on this date of service."
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How Providers Use CARCs in the 835 File:

- Reconciliation: Providers use CARCs to reconcile their accounts by matching the adjustments listed in the 835 file to their original claims. This helps them understand the reason for each adjustment and take appropriate action if necessary (e.g., billing the patient, appealing a denial).
- Appeals and Follow-up: If a claim is underpaid or denied, providers can use the CARC and RARC information to file appeals or take corrective action, such as resubmitting the claim with the correct information.