What's new in Version 8020 X12 Implementation Guides

Reversals and Corrections in the 835 transaction set

When the claim adjudication results have been modified from previous reporting, the new information must be sent back to the provider in such a way that it can be automatically posted to the accounts receivable system without causing incorrect balances. In this situation, the original claim adjudication results are reversed, and the updated adjudication information is sent in a corrected claim. The 008020X322 Health Care Claim Payment/Advice (835), hereafter referred to as the '835 IG' has enhanced the method for reporting this information to facilitate automated posting.

What's New

- Section 1.10.2.8 Reversals and Corrections has been updated with new instructions for the process
- When the claim adjudication results have been modified from previous reporting, the method for revision is to first reverse the entire claim and then resend modified data
- If the reversal and correction appear in the same transaction, the reversal must appear in the transaction first, then the correction.
- New Claim Status Codes (CLP02) are available to clarify reporting of the reversal:
  - 32-Reversal of Previous Payment for Primary Claim
  - 32-Reversal of Previous Payment for Secondary Claim
  - 32-Reversal of Previous Payment for Tertiary Claim
- All original charge, payment, adjustment, and other informational amounts are reversed. This includes all AMT segments and CLP05.
- Remittance Advice Remark Codes (RARCs) indicate "Reversal" must be included to reflect the reason for the reversal. These codes used in the RAS segment include (as of the publishing of this document) N687, N688, N689, N690, N691, N692, N693, N694, N695, N696, N697, and N698. Additional code may be added to the code list in the future for this purpose.
- While the CLP07 Payer Claim Control Number in the reversal must be identical to the CLP07 value in the original claim payment, the CLP07 value for the correction claim may be a different value. When the CLP07 value for the corrected claim is different than the CLP07 value from the original claim, one iteration of the Loop ID 2100 REF-ORIGINAL PAYER CLAIM CONTROL NUMBER segment with REF01 equal to F8 (Original Reference Number) and REF02 equal to the original CLP07 value is required in the correction claim.

How can this benefit you?

- Receiving all information reversed on the reversal claim clears out the accounts receivable system, allowing for "clean" posting of the correction claim
- Receiving the reversal first in the transaction ensures that all amounts are reversed before the correction claim is posted to ensure correct balances on the accounts receivable system.
- Information is available on the reversal to indicate primary, secondary, or tertiary being reversed
- Enhanced information is available on the reason for the reversal through use of the new RARCs
- Including the original payer claim control number in the correction claim facilitates linking the correction claim to the original/reversed claim and tracking for the provider
- Improved payer to provider automated communication
- Reduce phone calls
- Incentivize 835 transaction set adoption

How can this impact you?

- Payer and Business Associates business processes
  - Update internal systems to report additional information needed and to report the reversal first in the transaction, then correction claim after the reversal
  - Update database structure
  - Update CARC/RARC mapping to include usage of new RARCs
  - Internal education e.g., EDI and help desk
  - External education to providers via companion guides or bulletins

- Practice Management System (PMS)
  - Update software to receive and utilize additional information that is provided
  - Update remit viewer tool to reflect new RARCs, new claim status codes and additional payer claim control numbers
  - Internal education e.g., client facing staff
  - External education to customers

- Provider business processes
  - Update business processes for reconciliation of reversed/corrected claims and action that may be needed based upon the RARC provided
  - Review and update reports as needed
  - Internal education

- Clearinghouse
  - Update internal systems to facilitate additional information included in the 835
  - Update database structure
  - Update remit viewer tool to reflect new RARCs, new claim status codes and additional payer claim control numbers
  - Internal education e.g., EDI and help desk
  - External education to customers

Refer to X12's 008020X322 Health Care Claim Payment/Advice 835 for additional information on reversals and corrections in the 835.