Provider Adjustments (PLB) in the X12N 005010x221 Health Care Claim Payment/Advice (835)

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Purpose

The purpose of this paper is to provide guidance and information on the functionality and usage of the Provider Adjustment Segment (PLB) within the electronic remittance advice (X12N 835 transaction or 835) for specific business use cases, as described in the appendices. This paper is not intended to be a primer on the 835 transaction itself but instead focuses on this specific function within the 835 transaction and assumes some knowledge of the transaction for the reader. This paper is not a substitute for the X12N 005010x221 Health Care Claim Payment/Advice (835) Implementation Guide, which can be found at www.x12.org.

The PLB segment has historically been problematic for both Health Plans and providers. Health Plans often do not provide all the necessary information in the 835 transaction (for example, the Reference Identifier), and providers often are not able to correctly interpret the information provided.

In this paper, the SWG has looked at the different business use cases of the PLB, issues that commonly appear for those use cases, and provided some best practices to remediate challenges that both Health Plans and providers experience. The initial sections of the document provide some level-setting information about the PLB and its usage, and then each appendix outlines a specific use case, along with challenges and best practices for that use case.

Background

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) established standards for electronic transactions for electronic remittance advice and electronic funds transfer[1], which includes the X12N 005010x221 Health Care Claim Payment/Advice (835). The HIPAA regulation also includes a requirement that providers cannot be dis-incentivized from using the standard transactions, for example by providing more information on a paper remittance advice or web portal than is available within the standard transaction.

The 835 transaction includes adjudication information for health care claims, including payments and adjustments.

Within the 835 transaction, the summary level contains the Provider Adjustment Segment (PLB), which provides information related to adjustments to the payment amount not specific to the claim and service level. These adjustments can either increase or decrease the total actual payment. The PLB segment provides for reporting increases or reductions to the total payment amount in conjunction with reference numbers for further identification.

[1] 45 CFR Part 162, "Administrative Simplification: Adoption of Operating Rules for Health Care Electronic Funds Transfers (EFTs) and Remittance Advice Transactions; Final Rule"

Scope

This paper provides guidance and information on the functionality and usage of the PLB segment within the 835 transaction for specific business use cases, as described in the appendices.

Usage of provider adjustments on a paper remittance advice or web portal is not included.

Structure of the Provider Adjustment Segment (PLB)

The PLB segment includes the following elements:
PLB01 – Provider Identifier. This identifies the provider receiving the payment that is being adjusted in this segment
PLB02 – Fiscal Period Date. This is the last date of the provider's fiscal year.
PLB03 – This is a composite element made up of the reason and identifiers for the amount being adjusted.

PLB03-01 – The first element of the composite is the Adjustment Reason Code. This code outlines the reason for the adjustment being made and is a standard code specific to the PLB segment identified in the 835 Implementation Guide.

PLB03-02 – The second element of the composite is the Reference Identifier (ID). This critical element provides information to the provider about what account or transaction is related to the adjustment. This element should contain a transaction trace number, claim Internal Control number, or patient account number to direct the provider to the specific information related to the adjustment. The information contained in the Reference ID will vary depending on the business use case (as defined in the appendices).

PLB04- Provider Adjustment Amount. This is the amount being adjusted from the total payment amount. This amount can be positive or negative. A positive adjustment amount REDUCES the payment, and a negative amount INCREASES the payment.

The element pairs of Adjustment Reason Code / Reference Identifier and Provider Adjustment Amount can be repeated up to 5 additional times, so that a total of 6 combinations of Adjustment Reason Codes and Amounts can be reported in a single PLB segment. If more than 6 adjustments need to be reported, then an additional PLB segment is used.

Use of the Provider Adjustment Segment (PLB)

The PLB segment should be used to report increases or reductions to the total payment amount within the 835 transaction. The amounts in the PLB segment are generally not related to specific

claim balances in this 835 transaction; they apply to general ledger information - for instance, in the case of overpayment recovery for claims not paid in this 835 transaction. The amounts are posted to the general ledger and not to the individual patient accounts. The amounts in the segment must be reported in conjunction with reference numbers that identify the transaction or other relevant identifiers in order for the amounts to be posted appropriately. Even when individual claim identifiers are reported as the reference identifier, the PLB amounts are posted to the general ledger and not to the individual patient accounts.

The PLB segment is used to convey information for multiple business scenarios, including Interest and Prompt Pay Discounts, Overpayment Recovery and Balance Forwards, Capitation, Federal/Regulatory, Periodic Interim Payments (PIP) and Other Adjustments. See the appendices of this document for specific use cases for the PLB.

Transaction Balancing, Including the PLB Adjustments

Adjustment amounts within the 835 transaction in either the CAS or PLB segments can be positive or negative. A positive adjustment amount REDUCES the payment, and a negative amount INCREASES the payment.

For example, if the total provider payment amount would be $500 and there is a PLB adjustment for $-50, then the total payment amount for the 835 would be $500 – ($-50) or $550. If the PLB adjustment amount was $50, then the total payment amount for the 835 would be $500 - $50 or $450.

To balance the 835 transaction, the sum of all claim payments (CLP04) minus all Provider Level Adjustments (PLB04, PLB06, PLB08, PLB10, PLB12, PLB14) must equal the Total Actual Provider Payment Amount (BPR02).
i.e.
Sum of ALL CLP04s – Sum of All PLB Amounts = BPR02

Example (not all segments are included):

ST*835*1234~
BPR*I*149996.5*C*ACH*CCP*01*88899977*DA*24681012*193566554**01*111333555*DA*144444*20180316~
TRN*1*12345*1512345678~ **TRANSACTION BALANCING**:
DTM*405*20180316~ **138018.40 + 11980.33 - (-1.27) - 3.50 = 149996.50**
N1*PR*INSURANCE COMPANY OF TIMBUCKTU*XV*1234567890~
N1*PE*REGIONAL HOPE HOSPITAL*XX*6543210903~
LX*110212~
CLP*666123*1*211366.97*138018.4**MA*1999999444444*11*1~ :
CAS*CO*45*73348.57~
LX*130212~
CLP*777777*1*15000*11980.33**MB*1999999444445*13*1~
CAS*CO*45*3019.67~
PLB*6543210903*20181231*CV:12345*-1.27*CR:234567*3.5~
SE*20*1234~

Transaction Balancing:

CLP04	+	CLP04	-	PLB04	-	PLB06	=	BPR02
138018.4	+	11980.33	-	(-1.27)	-	3.5	=	149996.50

PLB Only Remit

The 835 transaction supports delivery of detailed payment information relative to the health care claim(s) and information describing why the total original charges have not been paid in full (if applicable). The 835 transaction also supports delivery of remittance information that is not specific to a claim in the Provider Level Adjustment segment. The 835 transaction can contain the detailed claim payment information only, both claim payment and provider level adjustments, or only provider level adjustments.

For example, capitation payments may be made in an 835 transaction that does not include any other fee-for-service payments, so a PLB would be included to reflect the capitation payments, but no claim payment detail would be included. Periodic Interim Payments (PIP) may be treated the same way. A health plan acknowledging receipt of a check could be done in a PLB-only remit, if needed (see Appendix D.)

Provider Usage of the PLB Adjustment Information

The PLB includes identifying information for adjustments made to the total provider payment amount. The PLB03-1 Adjustment Reason Code and the PLB03-2 Reference Identification are the primary data elements that allow providers to understand and auto-post the amounts in the PLB.

If all the pertinent information to track and reference adjustments is included in the PLB, provider systems should be able to accurately auto post 835 transactions to the general ledger system. NOTE: For providers to track adjustments directly to specific claims, manual processing may be required. The current implementation guide intends for amounts to be posted at a general ledger level.

Practice Management Systems vary from provider to provider. Some systems may allow more flexibility in posting PLB data, while others may require manual intervention.

Providers use the Reference Identifier to track the amounts that are included in the PLB and reconcile amounts that carry forward from one 835 transaction to another (see appendix D on Overpayment Recovery and Balance Forward). Providers must monitor the amounts that are being recouped to ensure that the amounts are accurate and often may have to use a spreadsheet or other manual method to track that information. Because of the tracking required, providers depend upon the

Reference Identifier being the same from one 835 transaction to the next to ensure that they are able to follow the amounts as they are recouped.

States may have a waiting period which requires the amount to be recouped at a later time, requiring providers to track the amount. Health Plans need to use the same Reference ID to facilitate tracking.

The Reference Identifier Within the PLB Segment

The Reference Identifier (Reference ID) should be an identifier that allows the provider to associate the adjustment with a prior claim or transaction on their Practice Management System. The Reference ID should not be only a Health Plan-assigned number like the Health Plan's internal control number (ICN), as that does not allow the provider to identify the information on their system. The Health Plan's ICN is useful if the provider needs to contact the Health Plan about the adjustment (see the section below, "What to do if there are issues with the PLB" for further information on contacting the Health Plan) but does not provide information needed for posting.

As described in the section "Common Issues with the PLB Adjustment Segment", information sent on paper will likely not be accessible to the resources posting the remittance information. As a result, using a reference ID in the PLB that refers to a paper letter will not be meaningful and may cause delays. The provider will have to call the Health Plan to get information on the reason for the PLB adjustment, and the information on the claim or transaction related to the adjustment.

Depending on the business use case, the reference ID may need to refer to the transaction as a whole, or a specific patient account number. Refer to the appendices below for information on reference IDs for each business use case.

X12's Request for Interpretation (RFI) portal (See Appendix B, Resources) includes three different RFI's that describe usage of a Reference ID that relates to a specific claim. RFI's 1976, 1956, and 1386 all include instructions for using a claim-level identifier for situations related to overpayment recovery (See Appendix D).

Common Issues With the PLB Adjustment Segment

- Provider staff may be unable to determine what the PLB adjustment is for or what original claim the adjustment is related to
  - Best Practice – PLB adjustments most often will refer to claims in a previous 835 transaction, so providers should review those previous remits will assist in identifying the original claim for the adjustment.
  - Best Practice – Health Plans should ensure that the most detailed Provider Adjustment Code is used to ensure the provider understands the reason for the adjustment.
  - Best Practice – Health Plans should ensure that the Reference ID includes the most relevant information to allow the provider to identify the original claim for the adjustment
- Provider staff may not be trained on PLB interpretation

  - Best Practice – Providers should ensure that their staff receives training on the use and meaning of the PLB adjustments, and that they have access to the external code list site at www.x12.org to be able to reference the description and information on the Provider Adjustment Codes.
- Practice Management Systems may not track or map PLB data appropriately and may not have the ability to correctly post PLB data to debits or credits
  - Best Practice – Practice Management Systems should have the ability to receive and process PLB data appropriately and ensure it is posted correctly to the general ledger.
- Positive and negative offsets in the PLB can be complicated; for instance, amounts the provider has refunded by check to the Health Plan for overpayments, or Health Plan recoupment of overpayments that result in a forward balance (refer to Appendix D)
  - Best Practice – Health Plans and Providers should refer to the X12 835 Implementation Guide for specific instructions on including positive or negative adjustments in the PLB adjustment amounts.
- Reference ID Usage may not be correct. For instance, for partial recoveries, predecessor and current reference ID must be present. If both aren't, the amounts may be difficult to post. (refer to Appendix D)
  - Best Practice – As discussed in the section "The Reference Identifier Within the PLB Segment," the Reference ID is a critical piece of information needed by the provider to understand what the adjustment pertains to and how to correctly update accounts. The Health Plan should follow the guidance described in each appendix for the specific use cases to ensure that the Reference ID gives the provider the information needed. This may include providing specific claim information like a patient account number in the Reference ID. The provider should take advantage of the information included in the Reference ID to identify the claim or transaction impacted by the adjustment.
- The physical address where mail is received / processed is likely not the same location where posting of the 835 transaction occurs. Information sent via mail will probably not be seen by the people posting the 835 transaction, so information related to a PLB adjustment that is sent via paper may not be accessible to those resources.
  - Best Practice - The Reference ID included by the Health Plan on both the letter and 835 transaction should be the same and should be related to information available to the provider (like original transaction trace number or patient account number) and not a separate identifier.

When the PLB is not used correctly:

Impact to the Health Plan:

- Time/resources required to handle calls from provider and/or patient
- Audit issues due to incorrect information
- Additional handling of resubmitted claims due to confusion by the provider

Impact to the Provider

- Amounts are not applied to provider accounts correctly.
  - May be applied to individual patient accounts instead of the general ledger, causing incorrect patient balances
- Provider must call Health Plans to get correct information about debits or credits.
- Provider may have to expend resources to track information manually

Impact to the Patient

When the PLB amounts are not applied to the provider accounts correctly or applied to the individual patient accounts instead of the general ledger, then this impacts the patient balances owed and will result in incorrect billing statements being sent to the patient. This, then, results in increased dissatisfaction on the part of the patient and increased calls to the provider to correct the issue (with corresponding increase in time required by the provider to research and remediate the issue). There may even be situations where the patient does not realize that they have been billed an incorrect amount, and they may pay the incorrect amount. This has an even larger impact on the patient by having a financial burden on them.

Impact:

Extra time and resources required

Audit issues

Patients billed incorrectly

What to do if There are Issues With the PLB

When there are issues or there is a lack of clarity with the information in the PLB, the provider will need to contact the Health Plan to get additional information. It is imperative that the provider has the correct information for contacting the Health Plan to avoid additional delays.

The PER Segment in the 835 Transaction

The PER segment within the 835 transaction contains information for who to contact at the Health Plan in case of issues. Two types of PER segments can be supplied: a business contact from the Claims Office (qualifier CX) and a technical contact from the technical department (qualifier BL).

It is critical that this information includes a valid phone number or email address, and that the contact included in this PER segment fully understands the 835 transaction segments and requirements and be able to respond to the provider's inquiry. The phone number included should be as direct as possible (avoid automated or complicated voice response systems) and should direct the provider to a contact that has the information and expertise necessary to respond to issues. The Health Plan resources should also have access to the information included in the 835 transaction– often providers are told that what is on the 835 transaction is not what they have in their system. They then refer the provider to their paper remittance advice, which is not beneficial to the provider.

When the provider cannot determine from the 835 transaction the intent or source of the PLB adjustment, and cannot get clarification from the Health Plan, they are unable to post the information. The providers have growing lists of PLB's that are not posted because there is not enough information to know what the Health Plan is trying to communicate.

Handing Compliance Issues in the 835 Transaction

When a trading partner is out of compliance, the first step should always be to approach and work with that trading partner directly to resolve the issue. X12's Request for Interpretation (RFI) portal (See Appendix B, Resources) is a resource that can assist in discussions with trading partners to gain understanding of the X12 implementation guides.

In the situation where compliance issues cannot be resolved, however, CMS does offer a mechanism for bringing visibility to the issue and working through a corrective action plan to resolve the issue.

The CMS Administrative Simplification Enforcement and Testing Tool (ASETT) is available for reporting issues that need assistance in creating or working through a corrective action plan. This tool is not intended as a mechanism for imposing fines or penalties, but rather as a way to engage CMS in working through compliance issues and implementing plans to remediate these issues. Issues can be reported through this tool anonymously and provide CMS a way to gain visibility into the issues that are occurring in the industry that may require additional education, guidance, or regulation[2].

Summary

This paper seeks to identify and explain the complexities of the Provider Adjustment Segment (PLB). The PLB segment is necessary to convey specific information related to adjustments to the total provider payment amount but is often used incorrectly or misunderstood. The Health Plan's technical team and the business teams must work together to identify the data to be reported and how to include the data in the 835 transaction to clearly identify to the provider how to use the information. It is critical that the Health Plan pay close attention to instructions in the X12 835 Implementation Guide when implementing the PLB in order to correctly convey the information to the provider.

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[2] https://asett.cms.gov/ASETT_HomePage

This paper outlines specific business use cases for the PLB, and how information should flow from the Health Plan to the provider. It is important that the provider's practice management system manage the PLB segments correctly, in order to get the information posted correctly without unnecessary manual intervention by the provider.

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APPENDIX A – Abbreviations, Acronyms, and Definitions

ANSI – American National Standards Institute is the organization that accredits U.S. Standards Development Organizations, ensuring that their methods for creating standards are open and follow due process.

ASC – Accredited Standards Committee

ERA – The Electronic Remittance Advice is an EDI transaction describing the Health Plan, payee, payment amount and other identifying information about the payment. It also includes other information that resulted from the adjudication process, including denial information and adjustment reasons and amounts.

ICN – Internal Control Number. This is a number assigned by the Health Plan to claims that are received into their processing system.

Operating Rules – The Patient Protection and Affordable Care Act defines operating rules as "the necessary business rules and guidelines for the electronic exchange of information that are not defined by a standard or its implementation specifications."

PIP - Periodic Interim Payments

PLB – Provider Level Adjustment segment

PMS – Practice Management System

RFI – Request for Interpretation. X12's Request for Interpretation portal provides access to information related to the meaning, use, and interpretation of X12 Standards, Guidelines, and Technical Reports, including implementation guides. The information is available in the form of responses to questions submitted by implementers of the X12 products.

X12 - ANSI accredited standards development organization, and one of the Designated Standards Maintenance Organizations (DSMO) tasked to develop, update and maintain the administrative and financial transactions standards.

X12N – Insurance Subcommittee within X12 responsible for developing standards and related technical reports for the insurance industry.

X12N 835/ERA – The X12N 835 transaction is the X12N transaction for the Health Care Claim Payment/Advice and is the HIPAA-required transaction set to use for health care claim payments, using the X12N/005010x221 Health Care Claim Payment/Advice (835) Implementation Guide.

APPENDIX B – Resources

The X12 Standards for Electronic Data Interchange Technical Report Type 3, Health Care Claim Payment/Advice (835) is available at www.wpc-edi.com.

The X12 Request for Interpretation Portal is available at http://rfi.x12.org/.

CAQH CORE Phase III EFT and ERA Operating Rules and associated FAQs are available at Operating Rules | CAQH CORE.

Additional papers on the 835 and EFT transactions published by the WEDI Remittance Advice and Payments SWG are available at www.wedi.org.

The CMS Administrative Simplification Enforcement and Testing Tool (ASETT) - https://asett.cms.gov/ASETT_HomePage

APPENDIX C – Interest and Prompt Pay Discount

Interest and prompt pay discounts are adjustments in payment between the provider and Health Plan and are not specific to the patient's accounts receivable. The additional or reduced payment amounts are not included as part of the claim or service line balancing but must balance at the payment level. These adjustments are handled in the PLB – provider level balancing section of the transaction set.

The addition or removal of interest and/or a prompt pay discount will adjust the payment to the provider but will not adjust the billed charges or payment due on the individual member claim. The actual claim billed charges and adjustments are kept whole but the provider payment is adjusted.

If a payment includes interest amounts, all interest should be consolidated into one amount in the PLB adjustment using the '**L6**' (Interest Owed) qualifier. The same consolidation of adjustment occurs with a prompt pay discount amount using one PLB adjustment with a '90' (Early Payment Allowance) qualifier.

To identify which claim(s) is owed interest, a Claim Supplemental Information Segment, (**AMT**) is added with qualifier 'I' in AMT01 to indicate there is interest owed on that claim. The amount is not included in balancing calculations but is informational. In the case of a prompt pay discount that the Health Plan has permitted, the claim will be identified using the AMT segment with a 'D8' qualifier.

If a claim is reversed or corrected that had interest or a prompt pay discount originally applied, that amount needs to be negated in the AMT segment of the impacted reversal claim.

Example: (not all segments included in example)

BPR*I*102*C
CLP*PATIENTX*1*200*45*5*12
CAS*PR*5
SVC*HC:12345*200*45
CAS*CO*45*150
AMT*I*5
CLP*PATIENTY*1*100*50*12
SVC*HC:23455*100*50
CAS*CO*45*50
AMT*I*2
PLB*1234567893*20181231***L6***-7

Key Concept:
All interest amounts are added into one L6 adjustment amount for the PLB, and each claim that is included in that amount has an AMT segment to indicate the interest amount that applies to that claim.

Recommended Reference ID to include / Best Practices

Because all of the interest amounts are consolidated into a single PLB amount, interest amounts for this remittance advice do not need to include a reference identifier. If there is an interest amount related to a previous remittance advice, then the reference identifier should be the TRN02 (EFT Trace Number/ Check Number) from that previous remittance advice so that the provider can refer back to that previous payment.

Common issues seen with Interest and Prompt Pay Discount reporting

- Interest may be reported in a CAS segment at the claim level, rather than following the documented procedures for aggregating the interest amount and reporting as one amount in the PLB. When this occurs, the interest amount is then applied to the patient's account and can impact the balance on the account (either positively or negatively) and cause the provider to bill the patient for an incorrect amount. Interest amounts should be noted on the claim in the AMT segment, but not in the CAS so that the amount will not impact the patient's balance.

- Rather than being aggregated into one single amount in the PLB segment, Health Plans may report each individual interest payment as a separate PLB adjustment amount, listing the claim patient account number as the reference ID. This does not follow the procedures outlined in the 835 Implementation Guide and can cause additional work for the provider to post each individual interest amount separately to the general ledger. Because the AMT segment is available at the claim level to identify which claims are included in the PLB interest amount, it is not necessary to have an individual PLB adjustment to identify the specific claims.

- Providers may not be reconciling the claims identified as having an interest amount with the interest amount reported in the PLB and then ensuring that the correct interest amount is posted to their general ledger account. When this reconciliation does not occur in a timely manner, additional work is required by the Health Plan to correct any issues that occur.

- The Health Plan may include the interest or prompt pay discount amount in the EFT or check payment but not include the information in the corresponding 835 transaction. This will cause the payment amount reported in the 835 transaction to not match the payment amount of the check or EFT and will result in a call to the Health Plan to determine the reason for the out of balance situation.

APPENDIX D – Overpayment Recovery

All Health Plans strive for accurate adjudication of claims; however, occasionally additional information arises that results in changes to the information reported on the previous remittance advice. This results in a need to reprocess or adjust the claim and/or claim payment information and generate a remittance advice. The changes are reflected on the claim payment in the new remittance advice by using a reversal and correction process.

Examples of situations when a reversal and correction are needed (not limited to):

- When the claim payment amount changes
- When the financial responsibility (e.g., contractual obligation versus patient responsibility) changes with or without a change in payment
- When the CARC or RARC changes
- Change in priority of Health Plans (primary / secondary)
- Interest paid on a previously paid claim (see Appendix C)
- Bonus payments (e.g., MIPS) on a previously paid claim
- New claim with frequency 7 (void and replace)

When the reversal and correction results in a reduction of the original payment amount, recovering the overpayment from the provider becomes necessary. There are three business approaches to recovering overpayment amounts from providers, as defined in the 835 Implementation Guide. The health plan should specify its methodology for overpayment recovery in either a trading partner agreement, a provider contract, or a companion guide (if not provider-specific).

Below are the three business approaches to recovering overpayment amounts:

1. The simplest and most preferred option is to recoup the overpayment immediately within the current remittance advice (835 transaction). This notifies the provider of the recoupment and performs the recoupment at the same time. In this situation, the Health Plan reverses the original claim payment, which is intended to restore the provider's patient accounting system to the pre-posting balance for this patient. Within the same 835 transaction, the Health Plan sends the corrected claim payment to the provider.

   The reversal claim is sent with claim status code "22", "reversal of previous payment", and all original charge, payment, and adjustment amounts are reversed. The corrected claim payment is reported as if it were an original payment. The net result of the reversal and corrected claim payment amounts results in the recoupment of the overpayment.

   These reversal and correction claims should not be reported in a separate standalone 835 transaction if there are other claim payments to be reported.

   If the reversal and correction process cause the total provider payment amount (BPR02) to become negative, then the Balance Forward process must be used (see Balance Forward section below).

2. In some situations, for example due to state regulations or contractual obligations, the Health Plan may choose to not recoup the funds immediately and instead 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. The notification FCN should include CLP01 (Provider's Assigned Claim Identifier) and CLP07 (Health Plan Claim Control Number) from the 835 transaction, separated by a space. Upon receipt of the letter, the provider will manually update their accounts receivable system to record the changes to the claim payment. Because the provider's accounts receivable system relies on CARCs and RARCs to identify the reason for adjustments, the letter should include this detailed information for posting.

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 transaction. (See Appendix H)

Example: A health plan sends a letter to a provider (provider number 1234) identifying an overpayment of $37.50 for a claim with patient account number 12345 and internal control number 56473. The FCN reflected on the document is "12345 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*20191231*WO:12345 56473*37.5*72:12345 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 transaction. 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 as a result of the letter received. PLB code WO (Overpayment Recovery) is used to accomplish the recoupment. If the recoupment process causes the total provider payment amount (BPR02) to become negative, then the Balance Forward process must be used (see Balance Forward section below).

Example: A health plan sends a letter to a provider (provider number 1234) identifying an overpayment of $37.50 for a claim with patient account number 12345 and internal control number 56473. The FCN reflected on the document is "12345 56473". The provider does not remit the overpayment to the health plan. A PLB segment in the next 835 transaction would report the overpayment recovery.

PLB*1234*20191231*WO:12345 56473*37.5~

3. In other situations where the recoupment must be delayed, but the health plan does not want to use a paper notification method, the health plan may use a combination of options 1 and 2 for overpayment recovery. The reversal and correction process is used to provide the notification and claim-specific information about the changes in adjudication, rather than a paper document. Within the same 835 transaction, a 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 transaction. The Reference ID reported in the PLB would be a combination of the patient account number (CLP01) and the health plan's internal control number for the claim involved in the recovery (CLP07), separated by spaces. (See RFI #2370 for additional information)

   The external agreement identifying how the health plan is doing overpayment recovery would specify the time period within which the provider may send the payment or that the provider

may not send the payment. Provider Adjustment 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 transaction. When the payment is received from the provider, or the health plan recoups the funds, the process identified in 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 for claim with patient account number 12345. In this example, state regulations require a 30-day delay before the funds are actually recouped from the provider. The reversal and correction are reported in the 835 transaction (not shown) to notify the provider of the changes, with a PLB segment to reverse the current financial impact to accommodate the 30-day delay in recoupment.

PLB*1234*20191231*WO:12345 837483*-37.5~

The examples shown above in option 2 outline how the 835 transaction would reflect the information based upon whether the provider returned the overpayment by check, or if it was recouped in a subsequent 835 transaction.

OverPayment Recovery can be accomplished in one of three ways, depending on the requirements around notification and ability to recoup the funds immediately or if a delay is required. The first method, recouping the funds immediately using a reversal and correction, is preferable, when possible. When a delayed recoupment is necessary, it is critical to include clear and accurate identification to the provider on what claim is involved in the recoupment by including the patient account number and internal control number (separated by a space) in the Reference ID element in the 835, along with any paper notifications that are sent.

Balance Forward

Since the 835 transaction is a financial transaction and not just a report, the total provider payment amount (BPR02) cannot be negative. In situations where the overpayment recovery process exceeds the payments for new claims, resulting in a net negative payment amount, the Balance Forward process prevents the total provider payment amount from being negative.

The Balance Forward process allows a Health Plan to move the negative balance from the current 835 transaction into a future transaction (835). The Balance Forward process objectives are:

- The payment amount of the current 835 transaction cannot be less than zero.
- In some situations, due to contractual or other requirements, the payment amount cannot be zero.
- The previous negative balance will be added into a future 835 transaction.
- The 835 transaction must identify to the provider what has happened.
- A reference number must be included for reconciliation of the balance forward process.
- The provider must be able to reconcile the recoupment to the original balance forward amount and the original claim so that the monies do not sit in clearing accounts on the provider's system.

Moving a negative balance out of the current 835 transaction:

When a negative total provider payment amount (BPR02) is detected in the current 835 transaction, this is corrected by adding a balance forwarding adjustment in the PLB segment. The Provider Adjustment code used will be FB, "Forwarding Balance". The reference ID will contain the same number as the trace number used in TRN02 of the current transaction, along with the CLP01 (Patient Account Number) and CLP07 (Health Plan Claim Control Number) of the claim involved in the Forward Balance. (See RFI #2370 for additional information). This reference ID will facilitate tracking by the provider. The dollar amount will be the same as the current, negative, balance. The end result of this forward balance adjustment in the PLB will be a total provider payment amount (BPR02) of 0.

In situations where, due to contractual or other requirements, the payment amount cannot be zero, the provider adjustment amount will be more than the current negative balance, to allow for a positive payment to the payee.

Assume that the current net for the transaction for provider "1234567890" is $-200.00 and that the trace number in TRN02 is "1234554". The claim involved has patient account number 12345 and Health Plan claim control number 837483. To move the balance forward, the PLB segment will read:

PLB*1234567890*20191231*FB:12345 837483 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 transaction:

When a balance forward adjustment was reported in a previous 835 transaction, a future 835 transaction must add that money back in order to complete the process of recouping the funds. In this case, the PLB segment is again used as the mechanism. The provider adjustment code again contains FB, "Forwarding Balance". The reference ID contains the same reference number from the PLB segment of the previous 835 transaction. This allows the receiver to quickly reconcile the two balance forward adjustments. The adjustment amount contains the same dollar amount as the prior forwarded balance, but as a positive value. The positive number reduces the payment in this 835 transaction.

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

PLB*1234567890*20191231*FB:12345 837483 1234554*200~

NOTE
If the total provider payment amount (BPR02) for this new 835 transaction is negative, the balance forward process would be repeated. Since this is a new 835 transaction with a new balance forward amount, the reference number in the appropriate adjustment identifier composite (i.e., PLB03-2) will contain the same number as the trace number assigned in TRN02 of this new 835 transaction, along with the patient account number and Health Plan claim control number of the claim involved.

Recommended Reference ID to include / Best Practices

When an Overpayment Recovery can't be accomplished using method 1 above (reversal and correction), the provider needs specific information on the claim involved in the overpayment. The Reference ID that should be included when the recoupment is done should include both the patient account number (CLP01) and Health Plan internal control number (CLP07) of the original claim (separated by a space) to ensure that the provider can trace the amount back to the original claim. (See RFI #2370 for additional information).

When the overpayment recovery process results in a negative payment amount for the 835 transaction and the balance forward process is needed, the Reference ID will contain the same number as the trace number used in TRN02 of the current transaction, along with patient account number (CLP01) and Health Plan internal control number (CLP07) of the claim involved in the Forward Balance. (See RFI #2370 for additional information).

For Overpayment Recovery, the Reference ID should include both the CLP01 and CLP07 of the original claim. For Balance Forward, the Reference ID will contain the TRN02 of the current transaction, along with CLP01 and CLP07 of the claim involved.

Common issues seen with OverPayment Recovery and Balance Forward

- Health Plans may be using the PLB to recoup an overpayment when there is no requirement for paper notification or delayed recoupment. The easiest method for overpayment recovery, and the method that gives the provider the most information about what is occurring, is to use the reversal and correction process as described in method 1 above. This is the preferred and recommended method for overpayment recovery.

The preferred method for overpayment recovery is to use the reversal and correction process as described in method 1 above.

- Health Plans may not use the PLB uniformly or may customize the information provided in the Reference ID. Inconsistent usage of the PLB is very problematic for providers, and requires that they handle each situation manually, rather than allowing for any automated posting of the information. Health Plans must handle overpayment recovery as described above in methods 1-3 above and should follow the best practices described above by including the Patient Account Number (CLP01) and Internal Control Number (CLP07) from the original claim as the Reference ID in the PLB adjustment.

- Health Plans may group all recoupments together into one amount in the PLB. This becomes an issue for providers who are then unable to trace the recoupment back to the original claim. Overpayment recovery should be separated by claim in the PLB, and each recoupment should

include the Patient Account Number (CLP01) and Internal Control Number (CLP07) of the original claim in the Reference ID to allow the provider to trace the amount back to the original claim.

- Health Plans may put verbiage in the Reference ID field to give information to the provider about the recoupment. For example, in situations where an overpayment is not being recouped immediately, the Health Plan may include a reversal and correction claim in the 835 transaction, and then a negative PLB adjustment to delay recoupment of the funds (option 3 above) and include the word "DEFER" in the Reference ID to alert the provider (Example: '06123456789DEFER.') Because this practice prevents automation, it is not considered a best practice, and should be avoided. Health Plans must handle overpayment recovery as described in methods 1-3 above and should follow the best practices described above by including the Patient Account Number (CLP01) and Internal Control Number (CLP07) from the original claim as the Reference ID in the PLB adjustment. Additionally, when the recoupment occurs in a future 835 transaction PLB adjustment, the same Reference ID must be included.

- Health Plans may put a reversal in the body of the 835 transaction without a corrected claim. Because the Health Plan has not sent a corrected claim along with the reversal, there is no new payment amount posted to that patient account, which causes the provider to report their cash incorrectly on financial statements and reporting. Health Plans must handle overpayment recovery as described above in methods 1-3 above and should follow the best practices described above by including the Patient Account Number (CLP01) and Internal Control Number (CLP07) from the original claim as the Reference ID in the PLB adjustment.
- Some Health Plans handle the Forward Balance and Overpayment Recovery process incorrectly, using the FB qualifier for both the Forward Balance and the OverPayment Recovery. This gives incorrect information to the provider about the amounts in the PLB and what the purpose is and will result in a phone call to the Health Plan. Health Plans must handle overpayment recovery as described above in methods 1-3 to recoup the overpayment that has been made and should follow the processes for Forward Balance described above in situations where the total provider payment amount in the 835 transaction becomes negative. Health Plans should follow the Recommended Reference ID best practices described above for the Reference ID in the PLB adjustment.

- In Forward Balance situations, providers need to know what original claim the Forward Balance is related to. Health Plans may not provide information in the Reference ID that allows the provider to trace the Forward Balance back to the original claim. Health Plans should follow the best practices described above by including the TRN02 of the transaction, Patient Account Number (CLP01) and Internal Control Number (CLP07) from the original claim as the Reference ID in the PLB adjustment for the Forward Balance.

- In the Forward Balance process, some Health Plans use the check/EFT Trace number (TRN02) as the PLB Reference ID, but then in a later 835 transaction when the funds are recouped, split the Forward Balance into multiple PLB adjustments using the patient account number, never referencing the PLB Reference ID used in the advance. This causes challenges for the provider who is unable to link the recoupments to the Forward Balance amounts. Health Plans should follow the best practices described above by using the TRN02, along with the Patient Account Number (CLP01) and Internal Control Number (CLP07) from the original claim as the Reference ID in the PLB adjustment for the original Forward Balance.

- Rather than including the detailed overpayment recovery information in the 835 transaction, the Health Plan may provide a separate "Overpayment Report" to the clearinghouse, which may not make it to the provider, so the provider is unable to determine what claims the Overpayment Recovery is related to. When the provider requests a letter or other clarifying information from the Health Plan, the Health Plans have been known to charge the provider for sending the letter. Health Plans should utilize the 835 transaction to convey information correctly to the provider, using methods 1-3 described above, and should follow the best practices described above by including the Patient Account Number (CLP01) and Internal Control Number (CLP07) from the original claim as the Reference ID in the PLB adjustment.

- The Health Plan may refer the Provider to the paper remittance advice or a paper letter to give more information on the reversal and correction or overpayment recovery information. In addition, the paper remittance advice or letter may not contain specific enough information to allow the Provider to understand the reason behind the overpayment recovery. A health plan may not delay or reject a transaction, or attempt to adversely affect the other entity or the transaction, because the transaction is a standard transaction(i.e., by providing more information on a paper document).[3] Health Plans should utilize the 835 transaction to convey information correctly to the provider, using methods 1-3 described above, and should follow the best practices described above by including the Patient Account Number (CLP01) and Internal Control Number (CLP07) from the original claim as the Reference ID in the PLB adjustment.

- Health Plans may provide generic adjustment reason codes (CARCs) or remark codes (RARCs) in the reversal and correction claims in the 835 transaction, which may not provide enough information to the Provider to understand the reason for the reversal and correction. The Health Plan must utilize valid, clear, and specific CARCs and RARCs to ensure that the message is clear to the provider about the reason for the overpayment recovery. If the Provider or Health Plan feels that existing CARCs/ RARCs do not convey the appropriate message, new codes or description modifications can be requested at www.x12.org/codes/. Entities should also have a governance process to review the codes that they use to ensure that updates to the code lists are incorporated in their processes. See WEDI paper "Usage of Claim Adjustment Reason Code (CARC) and Remittance Advice Remark Codes (RARC) in the X12 835 Transaction" (dated June 2026, available at www.wedi.org) for additional information.

Health Plans must utilize valid, clear, and specific CARCs and RARCs to ensure that the message is clear to the provider about the reason for the overpayment recovery.

[3] [65 FR 50367, Aug. 17, 2000, as amended at 74 FR 3325, Jan. 16, 2009]

- Health Plans may use deactivated or out of date CARCs and RARCs in the reversal and correction claims in the 835 transaction, providing incorrect information to the provider. Health Plans must have a governance process around their CARC / RARC tables to ensure that they make appropriate updates as the different codes committees update the CARC and RARC codes. Updates to the CARCs and RARCs are announced three times per year, and all changes announced must be incorporated into the Health Plans' systems.

- In some situations, a Health Plan may use a clearinghouse, utilization manager, or other vendor (business associate) to provide services like origination of the payment or creation of the 835 transaction. This adds some complexity when issues arise. When providers call the Health Plan with a question or issue with the 835 transaction, the Health Plan may refer the provider to their business associate to answer the question. The business associate, however, does not always have the adjudication logic or other information needed to answer the question, and may refer the provider back to the Health Plan. The provider is caught in the middle without a way to resolve their issue. In this situation, the Health Plan is ultimately responsible for the content and compliance of the files (payment and remittance advice) that are created and must ensure that appropriate measures are followed to provide complete and accurate information. The PER segment provided in the 835 transaction (as described above) must provide accurate information about who the provider can contact to get information or assistance with their remittance advice file.

  - The Health Plan may send the remittance information in an 835 transaction or some other format to a clearinghouse or vendor; but the clearinghouse may transform that into another format that the provider is able to receive, based on a contract with the Health Plan or provider. For example, the Health Plan may send proprietary information to the vendor who converts it to an 835 transaction, or the Health Plan may send an 835 transaction to the vendor/clearinghouse, who converts it to a report for the provider. In this situation, the provider may not get all the information that was originally supplied by the Health Plan, even though the Health Plan sent it to the clearinghouse / vendor. Clearinghouses or other business associates should send the complete remittance information / content to the Provider as it was received from the Health Plan, to ensure that the Provider receives the complete message intended by the Health Plan. When questions arise, the Health Plan is the source of truth for adjudication information or questions, and content of the file, and the clearinghouse/vendor is the place for information around file formatting or transformation. The PER segment provided in the 835 transaction (as described above) must provide accurate information about who the provider can contact at the Health Plan to get information or assistance with their remittance advice file. Ultimately, all three entities (Health Plan, Provider, and clearinghouse / vendor) may need to be involved in conversations to resolve issues.

  - Providers have reported that there are situations where a clearinghouse or vendor may not pass through the RARCs that come in the 835 transaction from the Health Plan or may change the CARCs/RARCs in the 835 transaction that they receive. To ensure that the Provider receives the message intended by the Health Plan, it is necessary for Clearinghouses, vendors, or other business associates to send the 835 transaction information and content to the Provider as it was originally received from the Health Plan, without modification. The Health Plan is the source of truth for adjudication information and

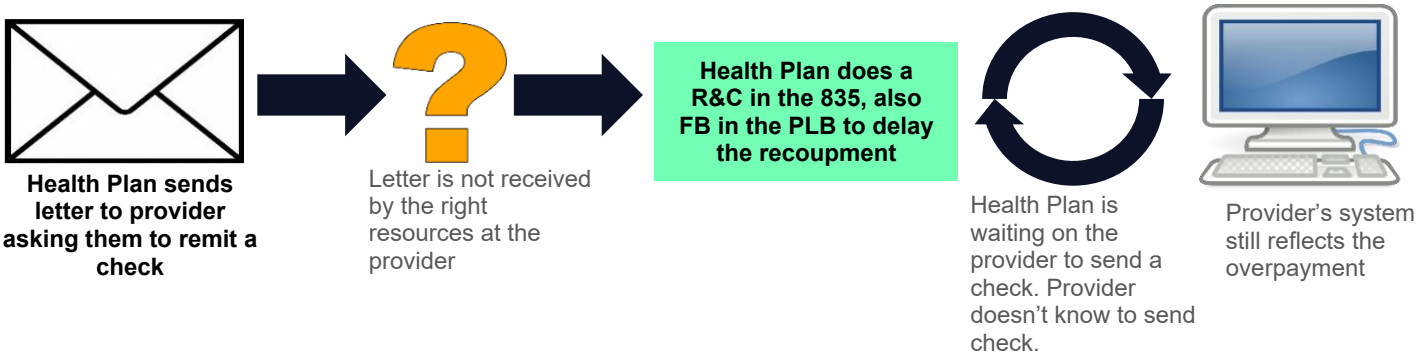
questions, and the clearinghouse/vendor is the place for information around file formatting and transformation. The Provider may need to initiate inquiries with the Health Plan, since that is who they are contracted with, but ultimately may end up contacting the clearinghouse/vendor if it is determined that content was not passed as received.

- Some PMS systems may not correctly manage adjustments contained in the 835 transaction. They may not use the CARCs / RARCs that are sent in the 835 transaction or may not correctly handle the PLB segments. PMS systems must process both the CARC and RARC to ensure that the provider has complete information about adjustments made to their claim. In addition, PMS systems must process the PLB segments received in the 835 transaction and handle appropriately to ensure that accounts are updated as expected without manual intervention by the provider.

- As a rule, there is no overall required timeframe for the Health Plan to recoup any overpayment, even when they continue to pay new 835 transactions that include enough claim payments to cover the outstanding balances. This means that the provider must continue to track the outstanding amounts indefinitely, without knowing when the funds might be recovered. Health Plans should recoup any outstanding overpayments as quickly as they are allowed by contracts or regulations to avoid having outstanding balances for extended periods of time.

- In some situations, the original claim and recoupment may happen under one NPI/TIN that causes a Forward Balance process to occur. As that Forward Balance moves forward, the provider's NPI/TIN changes (maybe through acquisition or consolidation), and the new entity assumes the remaining Forward Balance. How is that outstanding amount moved to the new NPI/TIN when it applies to the new entity? As a best practice, the affected entities should contact the Health Plan to change their system to the new NPI/TIN, as applicable, to ensure that all subsequent actions take place with the correct NPI/TIN. Until that change occurs, the provider should manually move the funds outside of the 835 transaction.

- In another scenario, recoupments may get delayed indefinitely. The Health Plan sends a letter notifying the provider of an overpayment and requests the provider remit a check for the amount. The letter doesn't make it to the appropriate contacts at the provider site. The Health Plan then does a Reversal & Correction in the 835 transaction and also includes an adjustment in the PLB to delay the recoupment, waiting on the provider to send them a check. Since provider didn't get the notification letter, they don't send a check, so the provider's system is still reflecting the monies included in the overpayment (maybe in a clearing account), waiting on the Health Plan to recoup. The Provider doesn't want to send a check in case the Health Plan does a recoupment in the 835 transaction because this would cause additional delays while they work with the Health Plan to get refunded after the "double recoupment". Health Plans should work with the provider to ensure that they have the correct contact and address information for any letters that are sent. Providers should notify the Health Plan during the registration process (or when changes are made) where notification letters should be sent. As a best practice, Health Plans should establish a process outlined in the provider contract that includes specific timeframes for recoupments based on information received in the 835 transaction. If they request a provider to remit a check, but the check is not remitted within a specific timeframe, then the Health Plan should do the recoupment within the 835 transaction.



- Sometimes when an overpayment has occurred, the provider does not have enough claim activity to allow the Health Plan to recoup the overpayment in an 835 transaction within a reasonable timeframe. The Health Plan may have to recoup the overpayment from another provider within the same provider group. If this is not possible, the Health Plan will ultimately have to notify the provider via letter or other notification to remit a check for the remaining balance. The Health Plan should establish timeframes in the provider's contract for when overpayments will be recouped.

- As a follow-up to this situation, there are times where the Provider gets a notification from the Health Plan to remit a check and sends a check for the overpayment; however, then sufficient claim activity occurs, and the Health Plan's system automatically recoups the funds. Now the Health Plan needs to reimburse the amount that the provider has paid twice, but this may or may not happen automatically. The Provider may need to contact the Health Plan to request the reimbursement. Often this is a difficult process for the provider to get their reimbursement. It is very important for the Health Plan to define the timeframes for recoupment of overpayments to avoid the situation where a "double recoupment" occurs. As a best practice, the Health Plan should put a hold on any auto-recoupments in situations where a letter or notification has been sent.

- What happens in situations where the payee is not the provider? There are situations where a corporate entity is the payee, but individual providers provide services and submit the claims (e.g., pharmacy). When a Forward Balance occurs, because the corporate entity was the payee, they are the ones with the forward balance; however, the Health Plan may report the individual provider identifier in the PLB. Being the payee, the corporate entity owes the dollars included in the forward balance, not the individual provider. The Health Plan should report the payee identifier in the PLB01, not the individual provider identifier.

Examples:
Full Recoupment - No Balance Moving Forward

Initial 835 Original:
CLP*12345*1*1000*500*300**987654321*11*1~
CAS*CO*45*200~
CAS*PR*1*300~

Second 835 Reversal and Correction:
BPR*I*590*C*ACH*CCP*01*123465789*DA*123458*012345678901*12345*DA*123456*20190101~**
CLP*12345*22*-1000*-500*-300987654321*11*1~**
CAS*CO*45*-200~
CAS*PR*1*-300~

MIA*1**N692~**
CLP*12345*1*1000*340*300987654321*11*1~**
CAS*CO*45*360~
CAS*PR*1*300~
CLP*543210*1*3000*750*500123654321*11*1~**
CAS*CO*45*1750~
CAS*PR*1*500~

The total of all of the non-reversal claim payments in this 835 is $1090. The reversal claim reduces that amount by $500. Because the resulting payment amount of $590 is still positive, no Forward Balance is required. (The sum of all CLP04 amounts is positive, so no Forward Balance is required.)

Partial Recoupment – with Forward Balance (check amount does not cover the recoupment amount or other regulations or contracts limit the amount that can be recouped)

Initial 835 Original**:**

CLP*12345*1*1000*500*300**987654321*11*1~
CAS*CO*45*200~
RAS*PR*1*300~

Second 835 Reversal and Correction:
BPR*H*0*C*NON**********20190101~
CLP*7890123456*22*-1000*-500*-300**987654321*11*1~
CAS*CO*45*-200~
CAS*PR*1*-300~
MIA*1****N692~
CLP*7890123456*1*1000*340*300*12*987654321*11*1~
CAS*CO*45*360~
CAS*PR*1*300~
CLP*543210*1*300*100*200**123654321*11*1~
CAS*PR*1*200~
PLB*12345*20190128*FB>7890123456 987654321*-60~

The total of all of the non-reversal claim payments in this 835 transaction is $440. The reversal claim reduces that amount by $500. Because the resulting payment amount would be negative, the payment is reduced to $0 and a Forward Balance amount of $60 is required. (The sum of all CLP04 amounts is negative, so Forward Balance is required.)

Next 835:
In the next 835, the Forward Balance amount of $60 is recouped
BPR*I*40*C*ACH*CCP*01*123465789*DA*123458*0123456789**01*12345*DA*123456*20190401~
CLP*653210*1*300*100*200**123786543*11*1~
CAS*PR*1*200~
PLB*12345*20190128*FB>7890123456 987654321*60~

The total of all of the non-reversal claim payments in this 835 transaction is $100. The recoupment of the Forward Balance amount reduces the payment by $60, resulting in a net payment of $40.

APPENDIX E – Capitation

The 835 transaction is used to provide financial notification of capitation payments from a Managed Care Organization (MCO) to a capitated care provider. The 835 transaction does not contain the capitation details or membership roster. The Eligibility and Benefits Notification Transaction (271) is used to provide these details.

Some of the Provider Adjustment Codes used in the PLB to report capitation information include "Capitation" in the description of the codes. Other codes, as described in the "Capitation and Related Payments or Adjustments" section of the 835 Implementation Guide include Bonus, Withholding, Incentive Premium Payments, Penalty, and others.

Recommended Reference ID to include / Best Practices

When reporting information on capitation payments, the Reference Identifier in the PLB should include the Reassociation Key segment (TRN) identifying the associated 271 roster.

Common issues seen with Capitation PLB Adjustments

Issues arise with capitation information sent in the 835 transaction when membership information changes mid-month. Health Plans may use different processes or Provider Adjustment Codes to reflect these changes. Often, "Retroactive Adjustment" is used when new members are added mid-month, or when membership terminates mid-month. Health Plans may include all membership changes in the 835 transaction in one "Retroactive Adjustment," but represent the information on the printed roster in a different way. Other Health Plans may split the "Retroactive Adjustment" into two, one for new members, and one for terminated members. Some Health Plans may include free-form messaging into the Reference ID field to indicate which are new members and which are terminated members. All of these inconsistent processes cause issues reconciling the print roster to the PLB adjustments in the 835 transaction and hinder the ability to automatically post the information.

Best Practice: Include both new members and terminated members in one single PLB adjustment, since these will be posted as one adjustment in the general ledger system. The printed roster should clearly reflect members that have been added in this period, as well as those that have been terminated, and the adjustment amount should balance to that in the 835 transaction. The Reference ID in the 835 transaction should include the Reassociation Key segment (TRN) identifying the associated 271 roster.

APPENDIX F – Regulatory PLBs, Including Medicare-Specific

There are situations where regulatory requirements or federal programs may require the Health Plan to adjust the provider's payment. The PLB adjustment can be used for these situations, and there are Provider Adjustment Codes that are present to reflect those types of adjustments. This section describes those adjustments and typical scenarios where those Provider Adjustment Codes may be used. The use cases described here may not be comprehensive, but provide information to reflect common usage, including Medicare's usage of these codes. The 835 Implementation Guide, as referenced in Appendix B – Resources, includes additional information. Companion Guides provided by individual Health Plans may also contain guidance on their usage of the PLB for specific regulatory situations.

These use cases highlight scenarios that reflect regulatory usage of these Provider Adjustment Codes but does not indicate a restriction that these codes are ONLY used for a regulatory purpose.

Penalties or Late Charges
Several of the Provider Adjustment Codes have descriptions that include "Late Charge" or "Penalty". These Provider Adjustment codes are used to provide Late Claim Filing Penalties, late charges, or other penalty amounts.

Discounts or Bonuses
Provider Adjustment Codes whose descriptions include "Early" or "Accelerated" payment amounts, "Discount", or "Bonus" are used to reflect amounts not related to capitation that are for prompt or accelerated payments, or bonus amounts for the provider.

If the discount or bonus is related to a specific claim, the Reference ID must contain the CLP01 and CLP07 of the claim, separated by a space; otherwise, the Reference ID must be blank.

Bad Debt
Provider Adjustment Codes indicating "Bad Debt" include an amount that is written off due to a bad debt amount or bad debt passthrough.

If the bad debt is related to a specific claim, the Reference ID must contain the CLP01 and CLP07 of the claim, separated by a space; otherwise, the Reference ID must be blank.

Settlements
PLB adjustments made to reflect an amount agreed upon as a "settlement" or overall "lump sum adjustment" may have an initial amount, and then a final amount, and can be included using Provider Adjustment Codes that include "Allowance", "Settlement", "Lump Sum", "Final", and "Repayment" in the description.

The specific agreement or reason for the settlement must be included in the Reference ID.

Tax Adjustments
Provider Adjustment Codes whose descriptions include "Internal Revenue Service" or "IRS" indicate that the adjustment is a withholding from the Internal Revenue Service. The specific code used will indicate if the amount is a 1099 or non-1099 amount.

In situations where the amount is a non-1099 amount, the Reference ID must identify the reason or specific program that initiated the withholding. With a 1099 withholding, the Reference ID must be blank.

Medicare Specific
Some Provider Adjustment Codes are used to provide amounts that are specific to Medicare. Most of these include “Passthru”, “Supplement”, or “Offset” in the description.

When the adjustment is an Offset for Affiliated Providers, the Reference ID must include the NPI (or other identifier for atypical providers). In other situations, the Reference ID must contain the CLP01 and CLP07 of the claim related to the amount, separated by a space.

General Adjustments
Some PLB adjustments include amounts that are more general or overall adjustments. These adjustments use a code whose description includes “Rebate”, “Adjustment”, “Withholding”, “Nonreimbursable”, “Recovery”, or “Return”. These codes should only be used when no other more specific Provider Adjustment Code is available.

For Unspecified Recoveries, the Reference ID must identify the reason or specific program that initiated the withholding. Otherwise, the Reference ID must contain the CLP01 and CLP07 of the related claim, separated by a space.

Recommended Reference ID to include / Best Practices

Best Practice – providers should have a review process within their organization to evaluate regulations or legislation and the financial impact of the regulations.

Best Practice – in most cases, the Reference ID should contain the CLP01 and CLP07 of the related claim, separated by a space. In situations where the adjustment is related to a specific program, the Reference ID should include the information on the program that initiated the adjustment.

Common issues seen with Regulatory PLB Adjustments

Providers often have challenges understanding the purpose or source of the adjustment that is included. Health Plans should include information in the Reference ID that reflects the program that initiated the adjustment (when applicable), or specific information on the claim impacted (CLP01 and CLP07 of the claim separated by a space) to give the provider that reference. In their companion guide or web portal, Health Plans should make information available about how these provider adjustments are reported.

APPENDIX G – Periodic Interim Payments

In some situations, the Health Plan may make periodic advance lump sum payments against expected claim volume from the provider at the beginning of some time period. The Health Plan will then make subsequent adjustments against the advance as the actual claims are processed during the period. These are known as Periodic Interim Payments or “PIP.” This payment and subsequent recoupment are effectively a loan to the provider and loan repayment.

These lump sum payments and adjustments are reported within the PLB segment using the “PI” (Periodic Interim Payment) qualifier. This process is described in the “Advance Payments and Reconciliation” section of the 835 Implementation Guide.

Recommended Reference ID to include / Best Practices

When reporting a PIP payment, the Health Plan-assigned Financial Control Number or ICN should be included in the Reference Identifier. This same control number must be supplied on all adjustments related to a payment to facilitate reconciliation by the provider.

APPENDIX H – Other Adjustments

Some PLB adjustments include amounts that are more general or are for overall adjustments. These adjustments use a code whose description includes “Rebate”, “Adjustment”, “Withholding”, “Nonreimbursable”, “Recovery”, or “Return”. These codes should only be used when no other more specific Provider Adjustment Code is available.

Recommended Reference ID to include / Best Practices

For Unspecified Recoveries, the Reference ID must identify the reason or specific program that initiated the withholding. Otherwise, the Reference ID must contain the CLP01 and CLP07 of the related claim, separated by a space.

Best Practice – in most cases, the Reference ID should contain the CLP01 and CLP07 of the related claim, separated by a space. In situations where the adjustment is related to a specific program, the Reference ID should include the information on the program that initiated the adjustment.

Common issues seen with General PLB Adjustments

Providers often have challenges understanding the purpose or source of the adjustment that is included. Health Plans should include information in the Reference ID that reflects the program that initiated the adjustment (when applicable), or specific information on the claim impacted (CLP01 and CLP07 of the claim separated by a space) to give the provider that reference. In their companion guide or web portal, Health Plans should make information available about how these provider adjustments are reported.

APPENDIX I – 8060 Updates to the PLB, Processes to Request a New Provider Adjustment Code

While the current, mandated version of the 835 transaction is the 005010x221, X12 has continued to make updates to the transaction to meet ongoing industry needs. The latest version, 008060x322, has been recommended by X12 to become the next HIPAA version.

As part of these updates, changes have been made to the PLB segment.

WHAT'S NEW

- Adjustment Reason Code length increased to 30 to allow for an increase in the code source scheme
- The Provider Adjustment Reason Codes are now external and maintained by X12, found at www.x12.org, and will be updated on a periodic basis. This new external code list will be available in the 8060 version.
- Reference Identifier length increased to 80 to allow for more detailed information related to the adjustment
  - An Appendix will contain directions to populate the Reference Identifier for the business use associated to each code.
  - Some use cases will refer to using claim identifiers in the Reference ID to tie back to the claims involved in the adjustment. Refer to front matter sections of the implementation guide for more detailed directions.

One of the biggest changes in the new version is in the Reference Identifier. Additional guidance is provided on what information should be included in the Reference Identifier for specific use cases, and in many cases that includes reporting the adjustment information for a specific claim, with that claim's identifier in the Reference Identifier. Some adjustments that were previously lumped together will now need to be split apart and reported for each claim. This gives providers specific information about the claims related to the adjustments and allows them to post the information appropriately.

Another major change is the movement of the Provider Adjustment Codes to an external code list. This allows the list to be updated more frequently, without requiring a new version of the transaction. This gives flexibility to the codes and allows new codes to be added as needed to meet changing or evolving industry and business needs.

Anyone can request a new Provider Adjustment Code for use in version 8060 and beyond through a simple maintenance request form. The codes are maintained by X12 in an ongoing maintenance process, and the list can be viewed at https://x12.org/codes/provider-adjustment-reason-codes. This is also the location to request a new code through the maintenance request form, which is reviewed periodically by an X12 codes committee.

For version 8060 Implementation Guide and beyond, these PLB changes are in effect, including the movement of the Provider Adjustment Reason Codes to an external code list maintained by X12. Provider Adjustment Reason Codes for version 5010 remain embedded in the 835 Implementation Guide.