**Transaction Validation Question Sheet**
**BPR – Processing and Reporting Remittance Information**

For more detail about any of the questions, see the corresponding BPR page #.
The BPR can be found at

- www.onehealthport.com
- Under the Admin Simp tab select Best Practice Recommendations
- Scroll down to Processing & Reporting Remittance Information(HIPAA 835)
- Click on BPR

***Report the requested answers & information in the attached Answer Sheet!*** They do not need to be reported in this Question sheet.

## A. General Processing & Reporting Practices

1. Were the line item control numbers in the 837 ***always*** returned? Yes/No: _____
(837 2400 loop, REF*6R BPR- pg 4 #1)

   If no, what line item control numbers were not returned? _____

   _____

2. Did the 835 reflect the following information that you submitted on the 837? (BPR pg 4 #2)
   - Patient Name? (2000B/C NM1*QC) Yes/No: _____
   - Subscriber Name? (2000B NM1*IL) Yes/No: _____
   - Health Plan Member ID? (2000B/C NM109) Yes/No: _____
   - Service Related Information? (2400 SV1(p) SV2(i) or SV3(d)) Yes/No: _____

   If no, what 837 information was not returned on the 835? _____
   _____

   a. On the 835 - Was the corrected information appropriately reported in NM1*74? Yes/No: _____

   b.i. On the corresponding 271, was the corrected ID sent in NM109 with the original id sent in the REF*Q4 segment? Yes/No: _____

   b.ii. If the ID was corrected, on the corresponding 271 was INS03=001 and INS04=25? Yes/No: _____

   c. Was the NPI returned in the 835 Payee loop (1000B N104) equal to either the NPI submitted for the Billing Provider in the 837 or the NPI that is written into

the provider-payer contract? Yes/No: _____

3. Did you submit Ambulatory Service Center (ASC) charges? Yes/No: _____
(2400 loop SV1(p) SV2(i) BPR – pg 5 #3)

If Yes, did the 835 appropriately report Revenue Codes and/or HCPC codes?
Yes/No: _____

If no, what code(s) were not returned? _____

4. Did the 835 contain a CARC 18? Yes/No: _____
(BPR – pg. 6 #4)

If Yes, was it in response to a duplicate claim that was submitted?
Yes/No: _____

5. Does the 835 balance …
(BPR – pg. 6 #5)
   - At the service line level? Yes/No: _____
   - At the claim level? Yes/No: _____
   - At the transaction level? Yes/No: _____

6. Was there a PLB in the 835? Yes/No: _____

If Yes,

a. Does PLB03-02, PLB05-02, PLB07-02, PLC09-02, PLB11-02 contain the patient control number (that which is contained in CLP01).
(BPR – pg. 6 #6)
Yes/No: _____

If No, which field does not? _____

b. Did the 835 reflect the recovery of overpayments made to the provider?
Yes/No: ____
(BPR – pg. 6-10 Recovering Overpayments Made to the Provider)

If Yes,

i. Was the reporting consistent with pages 6-8 of the BPR? Yes/No: _____

If No, how was the reporting inconsistent? _____

ii. Was the reversal displayed prior to the correction? Yes/No: _____

iii. Were the adjustment Group and Reason Codes reported on the reversal the same as the adjustment Group and Reason Codes reported on the original adjudication? Yes/No: _____

c. Did the 835 reflect a Balance Forward Situation? Yes/No: _____
(BPR – pg. 11 Handling Forward Balances)

If Yes,

i. Was the reporting consistent with page 10 of the BPR? Yes/No: _____

If No, how was the reporting inconsistent? _____

**B. Business Processing Practices**

*Pay To Organization and Contract Arrangement*

1. Was the Pay To organization correct? Yes/No: _____
(BPR – pg. 11 #1)
If no, what should have been the correct Pay To Organization? _____

_____

2. From the information contained in REF*CE, along with information on the health plan's web site if necessary, were you able to determine the contract that applied to the claim? (BPR – pg. 12 #2) Yes/No: _____

If 'Yes', was the correct contract reported? Yes/No: _____

*Splitting Claims & Service Lines*

3. Did the health plan split one of more of the service lines on a claim?
(BPR – pg. 12 #3)
Yes/No: _____

If Yes, was each separate claim identified as being part of a split claim by utilizing the MIA or MOA segment with Remittance Advice Remark Code MA15?
Yes/No: _____

If no, in what way was the reporting of the split erroneous? _____

_____

*Reporting Payment and Adjustment Information*

4. When reporting the business reason for a denial or adjustment, (BPR – pg. 13 #5)

- Were only active CARC/RARCs used? Yes/No: _____

  If no, what inactive CARC/RARCs were used? _____

  _____

- Were appropriate CARC/RARCs used in compliance with the CORE-required Code Combinations for CORE-defined Business Scenarios for CAQH CORE 360? Yes/No: _____

  If no, for what denial or adjustment were the CARC/RARC inappropriate?

  _____

- Was CO45 used appropriately as defined in the BPR, e.g. not used as a denial and not used on the same service line with a denial code? Yes/No: _____

5. Is this 835 related to an 837P, 837D or an 837I for an outpatient visit? Yes/No: _____

If Yes,

a. Were claim level adjustments reported on the 835? (BPR – pg. 14 #6) Yes/No: _____

   If Yes, were they appropriate? Yes/No:_____

   If No, identify what payment information was inappropriately reported at the claim level?

   _____

b. Was the claim priced at the service line level? (BPR – pg. 14 #7) Yes/No: _____

   If Yes, was the adjudication information for each service line placed in the SVC segment of Loop 2110? Yes/No: _____

   If no, for which service line(s) was the adjudication information not handled appropriately? _____

6. Did the health plan bundle or unbundle service information in ways that were not submitted on the 837? Yes/No: _____
(BPR – pg. 15 #8)

   If Yes, does the 835 contain the information that was submitted on the 837 as well as information about how the health plan adjudicated the service(s)? Yes/No: _____

   If no, what 837 information was not reported on the 835? _____
   _____

7. Were all CAS03 = non zero values? Yes/No: _____
(BPR – pg. 15 #9b)

   If No, which CAS contained a 0 in CAS03? _____

   _____

8. Did the 835 reflect a payment from a Consumer Spending Account?
(BPR – pg. 15-18 #10)
Yes/No: _____

   If Yes, was the reporting consistent with page 13-17 of the BPR? Yes/No: _____

   If No, how was the reporting inconsistent? _____

*Reporting Coordination of Benefit Information*

9. Did the claim reflect multiple coverage from the same health plan?
(BPR – pg 19 #11)
Yes/No: _____

   If Yes,

   a. Did the health plan adjudicate the claim using the primary coverage and automatically adjudicate the claim using the secondary coverage?
   Yes/No: _____

   b. Did the 835(s) report separate adjudications for each coverage?
   Yes/No: _____

   c. If both adjudications were on the same 835, was the primary adjudication

displayed prior to the secondary adjudication? Yes/No: _____

d. For the primary coverage adjudication, did the 835 report the appropriate crossover information? Yes/No: _____

e. Were the primary and secondary coverage adjudications reported at the Service Line level? Yes/No: _____

10. Is the 835 from a non-primary health plan? Yes/No: _____
(BPR – pg 20 #12)

If Yes, did the non-primary health plan appropriately report their financial impact using a CO/PI 45 AND the financial impact of the previous payer(s) by appropriately using the OA23. Yes/No: _____

11. For all takebacks reported on the 835, is the money collected by the health plan? Yes/No: _____ (BPR – pg 21 #14c)

12. If the claim was subject to the Balance Billing Protection Act, was the 835 reporting appropriate?
Yes/No: _____ (BPR – pg 22 #16)

**C. Practices for Using Specific Data Elements**

1. Was the Payer's Technical Contact Telephone Number and/or Email Address put in the PER segment of Loop 1000A or in the PER segment of Loop 2100?
Yes/No: _____
(BPR – pg 26 #2)

2. Was a Claim Status Code of 4 used? Yes/No: _____
(BPR – pg 26 #3)

If Yes, was it used appropriately, i.e. the patient/subscriber was not recognized by the health plan? Yes/No: _____

3. Was the Claim Received Date put in DTM*050 segment of Loop 2100?
Yes/No: _____
(BPR – pg 26 #4)

4. Was the Service Date provided at the claim level or each line level, as appropriate, using the DTM segment of Loop 2110? Yes/No: _____
(BPR – pg 26 #5)

If no, what service dates were not provided: _____

**Answer Sheet**
**Transaction Validation Worksheet**
**BPR – Processing and Reporting Remittance Information**

**Name: _____ Organization: _____**

**Health Plan Being Validated: _____ Date: _____**

**Products to be Excluded from the Validation: _____**

The relevant BPRs can be found at

- www.onehealthport.com
- Under the Admin Simp tab select Best Practice Recommendations
- Scroll down to Processing & Reporting Remittance Information( HIPAA 835) Click on BPR
- Scroll down to Exchanging Explanation of Payment Information between Providers and Health Plans (HIPAA 837 & 835) Click on BPR

| | **Identify each 835 that you will be referencing** | | | |
|---|---|---|---|---|
| | **835 - #1** | **835 - #2** | | |
| 835 File Name | | | | |
| Provider NPI | | | | |
| Remittance Advice Date – BPR16 | | | | |
| Check Amount – BPR02 | | | | |
| Check Number - TRN02 | | | | |

| | | | **If 'No'** | | |
|---|---|---|---|---|---|
| **BPR Capability** | **Med. Or High Impact** | **Yes, No, or NA** | **What information is missing or in error? (From Question Sheet)** | **Which 835(s)? Use #1, #2, etc (From table above)** | **Include the Patient control number (835-CLP01) and payer claim number (835-CLP07)** |
| **A. General Processing & Reporting Practices** | | | | | |

| | | | If 'No' | | |
|---|---|---|---|---|---|
| **BPR Capability** | **Med. Or High Impact** | **Yes, No, or NA** | **What information is missing or in error? (From Question Sheet)** | **Which 835(s)? Use #1, #2, etc (From table above)** | **Include the Patient control number (835-CLP01) and payer claim number (835-CLP07)** |
| 1. Were the line item control numbers in the 837 ***always*** returned? | Med | | | | |
| 2. Did the 835 appropriately reflect the information that you submitted on the 837? | **High** | | | | |
| a. On the 835 - Was corrected information appropriately reported in NM1*74? | **High** | | | | |
| b.i. On the 271 - Was the corrected ID sent in NM109 with the original id sent in the REF*Q4 segment? | **High** | | | | |
| b.ii. If the ID was corrected on the 271, was INS03=001 and INS04=25 | **High** | | | | |
| c. Was the NPI returned in the 835 Payee loop (1000B N104) equal to either the NPI submitted for the Billing Provider in the 837 or the NPI that is written in the contract | **Med** | | | | |
| 3. If ASC charges, did the 835 appropriately report Revenue Codes and/or HCPC codes? | **High** | | | | |
| 4. If CARC 18, was it in response to a duplicate claim that was submitted | Med | | | | |

| BPR Capability | Med. Or High Impact | Yes, No, or NA | If 'No' | | |
|---|---|---|---|---|---|
| | | | What information is missing or in error? (From Question Sheet) | Which 835(s)? Use #1, #2, etc (From table above) | Include the Patient control number (835-CLP01) and payer claim number (835-CLP07) |
| 5. Does the 835 balance at all 3 levels – service line, claim & transaction? | **High** | | | | |
| 6. If PLB, | | | | | |
| a. Do the appropriate fields contain the patient control number? | **High** | | | | |
| b.i. IF payment recovery, was reporting consistent with pages 7-8? | **High** | | | | |
| b.ii. Was the reversal displayed prior to the correction? | **High** | | | | |
| b.iii Were the adjustment Group and Reason Codes reported on the reversal the same as the adjustment Group and Reason Codes reported on the original adjudication? | **High** | | | | |
| c. IF balance forward, was reporting consistent with the BPR? | **High** | | | | |
| **B. Business Processing Practices** | | | | | |
| 1. Was the Pay To organization correct? | **High** | | | | |
| 2. Using the REF*CE and any information on the health plan web site, were you able to determine the contract that applies to the claim? | Med | | | | |
| 3. IF split claim, was each separate claim identified as being part of a | Med | | | | |

| BPR Capability | Med. Or High Impact | Yes, No, or NA | If 'No' | | |
|---|---|---|---|---|---|
| | | | What information is missing or in error? (From Question Sheet) | Which 835(s)? Use #1, #2, etc (From table above) | Include the Patient control number (835-CLP01) and payer claim number (835-CLP07) |
| split claim by utilizing the MIA or MOA segment with Remittance Advice Remark Code MA15? | | | | | |
| 4. CARC/RARC | | | | | |
| a. Were only active CARC/RARCs used? | **High** | | | | |
| b. Were appropriate CARC/RARCs used in compliance with the CORE 360 Operating Rule? | **High** | | | | |
| c. Was CO45 used appropriately? | **High** | | | | |
| 5. IF 837P, 837D or 837I for outpatient | | | | | |
| a. IF Claim level adjustments were reported on 835 | **High** | | | | |
| Were they appropriate? | | | | | |
| b.i. Was the claim priced at the service line level? & | **High** | | | | |
| b.ii Was the adjudication information for each service line placed in the SVC segment of Loop 2110 | **High** | | | | |
| 6. IF bundle/unbundle, does the 835 contain the information that was submitted on the 837 as well as information about how the health plan adjudicated the service(s)? | Med | | | | |
| 7. Were all CAS03 = non zero values? | **High** | | | | |

| | | | If 'No' | | |
|---|---|---|---|---|---|
| **BPR Capability** | **Med. Or High Impact** | **Yes, No, or NA** | **What information is missing or in error? (From Question Sheet)** | **Which 835(s)? Use #1, #2, etc (From table above)** | **Include the Patient control number (835-CLP01) and payer claim number (835-CLP07)** |
| 8. IF a consumer spending account payment, was reporting consistent with the BPR? | **High** | | | | |
| 9. IF multiple coverages from same health plan | | | | | |
| a. Did the health plan adjudicate the claim using the primary coverage and automatically adjudicate the claim using the secondary coverage? | Med | | | | |
| b. Did the 835(s) report separate adjudications for each coverage? | Med | | | | |
| c. If both adjudications were on the same 835, was the primary adjudication displayed prior to the secondary adjudication? | **High** | | | | |
| d. For the primary coverage adjudication, did the 835 report the appropriate crossover information? | Med | | | | |
| e. Were the primary and secondary adjudications reported at the Service Line levels? | Med | | | | |
| 10. IF 835 from a non-primary health plan, did the non-primary health plan appropriately report their financial impact using a CO/PI 45 | **High** | | | | |

| | | | If 'No' | | |
|---|---|---|---|---|---|
| **BPR Capability** | **Med. Or High Impact** | **Yes, No, or NA** | **What information is missing or in error? (From Question Sheet)** | **Which 835(s)? Use #1, #2, etc (From table above)** | **Include the Patient control number (835-CLP01) and payer claim number (835-CLP07)** |
| AND the financial impact of the previous payer(s) by appropriately using the OA23. | | | | | |
| 11. For all takebacks reported on the 835, is the money collected by the health plan. | **High** | | | | |
| 12. If BBPA claim, was it reported appropriately | **High** | | | | |
| **C. Practices for Using Specific Data Elements** | | | | | |
| 1. Was the Payer's Technical Contact Telephone Number and/or Email Address put in the PER segment of Loop 1000A OR in the PER segment of Loop 2100? | Med | | | | |
| 2. IF Claim Status Code of 4 was used, was it used appropriately, i.e. the patient/ subscriber was not recognized by the health plan | **High** | | | | |
| 3. Was the Claim Received Date put in DTM segment of Loop 2100? | Med | | | | |
| 4. Was Service Date provided at the claim level or each line level, as appropriate, using the DTM segment of Loop 2110? | **High** | | | | |
| **Other** | | | | | |
| | | | | | |
| | | | | | |

| | | | If 'No' | | |
|---|---|---|---|---|---|
| **BPR Capability** | **Med. Or High Impact** | **Yes, No, or NA** | **What information is missing or in error? (From Question Sheet)** | **Which 835(s)? Use #1, #2, etc (From table above)** | **Include the Patient control number (835-CLP01) and payer claim number (835-CLP07)** |
| | | | | | |
| | | | | | |

Legend: **High** – The implementation of this Best Practice will have a high level of positive impact on the provider's processing Med – The implementation of this Best Practice will have a medium level of positive impact on the provider's processing