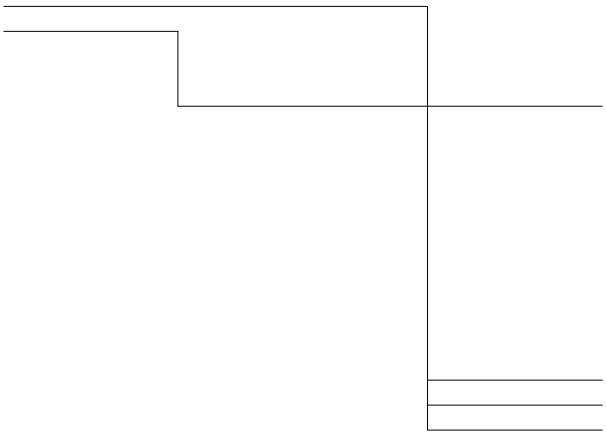
THE WEDI/X12 835 CLAIMS ADJUSTMENT REASON CODE / GROUP CODE MATRIX SURVEY



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CONTENTS

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Abstract

Implementation of the ASC X12NTG2WG3 835 Health Care Claim Payment/Advice ("Remittance Advice") transaction has been hampered by variations in the association of Claims Adjustment Reason Codes (CARCs) and Claim Adjustment Group Codes. Incorrect coding can lead to costly and unnecessary manual followups, faulty electronic secondary billing, and inappropriate write-offs of billable charges. The net effect can be a reluctance on the part of providers to employ the 835, reducing ROI for payers and providers alike.

This paper documents a joint effort between the X12NTG2WG3 835 workgroup and the WEDI Business Issues subworkgroup to survey payers, providers and vendors to collect aggregate responses on their interpretations. Rather than consensus, the responses reflected variations in interpretation, and suggested ways to improve the use of the codes and, perhaps the contents of the codesets themselves.

Specifically, our findings suggest it may be helpful to build an industry-wide consensus about how to code such responses if we wish to bring about consistency within the context of the

HIPAA standard. Bringing adjustment coding in line with provider business processes would lead to more widespread adoption of the 835 and reduce unnecessary followup activities for providers and payers alike.

Acknowledgements

This project was conceived and led by Debra Strickland, co-chair of the Accredited Standards Committee (ASC) X12NTG2WG3 (Health Care Claim Payments Workgroup) and by Martin Jensen, co-chair of the Workgroup for Electronic Interchange (WEDI) Business Issues subworkgroup. The organizers wish to extend their gratitude to the 60 volunteers who participated in the effort: Patricia Wijtyk, Deborah Conklin, Allen R. Johnson III, Sue Barnes, Pat Van Dyke, Chris Healy, Nick Widboom, Patrice Kuppe, Joan Boyle, Richard McNeil, Christopher Sawyer, Jennifer Massingale , Gale Scott, Geneane White, Mary Lou Jackson, Sandi Colón, Denise Swanson, Sue Barnes, Jack C. Jackson, Patricia Beeler, Jane Martin, J. Robert Barbour, Cheryl Parkins , Bob Ferguson, René Estrella-Doran, Peter VanKeuren, Grace Guthrie, Fern Knoch, Shay Vaughan , Damon Dunsmore, Jeanne Olson, Betsy B. Clore, Michael W. Irvine, Mac McElwee, Darren Kallod, Gregory M. Fisher, Barbara Sesny, Brenda Elthon, Robert Aliperto, Deborah Lelinksi, Gayle Galarneau, Kenneth Holmes, Shelly Meath, Lisa Douglass, Judy M. Scavo, Stephen F. Farmer, Tiffany Thompson, Yee Wong, Chris Lack, Jen Schenck, Mary Kay McDaniel, Suzanne Ronde, Jamie Baxter, Shari Back, Larry Morris, Helen Auteri, Sheryl Drexelius, Kathy Ochal , Gerald Land , Joey Lawhorn, Jeffrey S. Plombon, Cinda Morton, and Pam Jeroszko.

Disclaimer

Executive Summary

Problem Space

The question addressed by this paper concerns the use of 835 Group Codes (such as PR for Patient Responsibility, CO for Contractual Obligation, etc.) with specific 835 Claims Adjustment Reason Codes (such as 31 for "Claim denied as patient cannot be identified as our insured," B12 for "Services not documented in patient's medical records," etc.). In order to focus our work on the issue and avoid duplicating the efforts of other groups, we did not debate the meaning of any particular code, nor the relative merits of using one code over another.

Not A Recommendation or Industry Poll

While organizers had initially hoped a small group of industry participants, representing payers and providers alike, could reach quick consensus on a standard interpretation of the assignment of Group Codes to CARCs, the results of our analysis did not offer any such consistency. Instead, they pointed to particular sources of confusion and disagreement, despite a surprising alignment between payers and providers in overall response.

As a result, this report is not a recommendation for best practices – and it was never intended to be an industry-wide survey. Instead, it is the outcome of an analysis by an ad hoc workgroup of healthcare industry participants using a specific methodology to address a narrowly-focused challenge. A survey tool was used because the structure of the subject lent itself to a tremendous number of data points and the tool provided a way to gather detailed responses from the large group of volunteers.

Analytical Approach

The problem space was defined by the then-current CARC code set and the 4010A1 Implementation Guide for the X12N 835 Health Care Claim Payment Advice. To ensure participants were well-versed in the guide, we limited membership after a particular timeframe so that all participants could follow the same methodological approach: Discussion and documentation of 835 Group Code theory, tools and techniques for gathering consensus within their organization, and designating a representative to respond to the survey.

Snapshot in Time

The results represent a snapshot of participants' understanding at a particular point in time. Both the group leaders and the participants themselves acknowledged that the use of the 835 transaction is evolving and subject to further discussion, analysis and consensus.

Results

Neither providers nor payers agree on the a single interpretation of CARC/Group Code matching. Structurally, any Group Code can be matched with any CARC. Semantically, many possible pairings make little or no sense – at least to most observers. Still, we found a

great deal of ambiguity in the responses. And though we expected to find disagreement between providers and payers, it was most often a disagreement or confusion shared by many participants regardless of the type of organization they worked for.

Patterns in the responses suggest particular sources for such disagreements. We identified these sources as:

- Confusion as to how to code "technical" billing errors.
- Ambiguity in the meaning of the CARC that might be resolved in the Remark Code segment.
- Misconceptions as to the meaning of "Contractual Obligation."
- Reluctance to designate Patient Responsibility.
- Special regulatory circumstances for Medicaid reimbursement (and perhaps other government programs) that might call for using CO in a case that would typically imply a patient responsibility.
- Ambiguity in the code that made it a catch-all for many possible interpretations (in particular CARC 96 – "Non-covered charge(s)").
- Ambiguity in the code that might be corrected with new, more specific codes (i.e. Code 47, "This (these) diagnosis(es) is (are) not covered, missing, or are invalid" was recently de-activated and replaced with two more specific codes.)
- A distinct disagreement between providers and payers was rare, but did occur in some cases. (CARC 31 "Claim denied as patient cannot be identified as our insured" was seen by most providers as exclusively a case of Patient Responsibility, while the payer respondents gave various other possible interpretations.)

Commentary and Perspectives

Discussions within the workgroup and comments provided in the survey responses offer valuable feedback on the challenge of implementing automated 835 posting. Further reviews of the paper by non-participants also yielded thoughtful replies, which are likewise included. These are provided for consideration and further discussion, but should not necessarily be taken as recommendations of or endorsements by the group.

Some of these include:

- The 835 has enormous potential to save administrative costs on both sides of the payer/provider business process. Consensus and consistency in the use of CARCs and Group Codes would go a long way toward increasing the rate of adoption.
- The importance of following Group Code Theory in the assignment process, in particular, adhering to the sequence of steps defined in the Implementation Guide.

- Following the precise guidelines for assigning Contractual Obligations, in particular the constraint that it is to be used when a written or implied contract exists between payer and provider.

- The need to address payers' legal and commercial concerns when assigning Patient Responsibility.

- The value of referencing the additional guidance included in the 4050 version of the 835 implementation guide; while the guide has not been adopted for use under HIPAA, the authors specifically created it to conform to the needs of the 4010A1 and its intended use.

- Voluntary guidelines could be adopted after providers and payers discussed the issues further. It was specifically suggested that providers first reach agreement among themselves as to how the 835 could assist them in automating their processes, then bring specific recommendations to the rest of the industry for further discussion and consensus.

- Corrections and Reverals (Group Code CR) present a conundrum that prevents providers from knowing which category to adjust in an automated fashion. This is intrinsic to the design of the 4010A1 and is corrected in the 5010 version of the implementation guide.;

- Specific coding suggestions from participants are included in the report, but were not addressed by the group as a whole and should not be read as recommendations from the workgroup.

Introduction

Background

Late in 2004, a provider representative sat down with a payer representative to discuss some of the problems people were having deploying the 835 Remittance Advice transaction. In particular, they discussed the various ways that Claims Adjustment Reason Codes (CARCs) were being paired with Group Codes. In many cases the pairings didn't "make sense."

In the worst-case example, a payer had sent transactions with CARC=1 ("Deductible amount") matched with a Group Code of CO (Contractual Obligation) instead of the seemingly obvious PR (Patient Responsibility). To a provider, CO means "write this off," PR means "bill the patient or secondary insurer." If the provider had only relied on the Group Code, they would have been writing off cash receivables.

The provider happened to be a co-chair of the Workgroup for Electronic Data interchange (WEDI www.wedi.org) Business Issues subworkgroup, which had been collecting examples like this for a document titled "835 Potential Barriers to Implementation," in which the following quotation suggested the desired outcome:

> "One of the barriers to the 835 implementation is a lack of understanding of the processes an electronic remittance advice (ERA) is meant to automate. Understanding the data flow through each affected trading partner organization might make it easier for the industry to understand the importance of the data issues identified in this discussion paper. Each trading partner in the 835 transaction should communicate extensively with the other, negotiating interpretations, and documenting those mutually agreed upon terms in a companion document. Ideally, the payer trading partner should be uniform across their provider-base as much as possible creating a standard that clearinghouses, software vendors, and providers can consistently implement."

The health plan representative happened to be a co-chair of the Accredited Standards Committee (ASC) X12 (www.x12.org) workgroup (WG3) that created the 835 transaction. Together, they thought they could merge practice and theory and provide the industry with a matrix to show which CARCs went with which Group Codes.

The concept was to get a few knowledgeable people together and simply map out the structure, step by step. The reality proved to be a little more interesting.

The first few volunteers were from health plans. A message was sent out to the WEDI Business Issues list asking providers to participate. The response was so overwhelming, a new approach was necessary. This project is the result.

Scope of This Report

This report is an analysis of a survey conducted among volunteers at a particular point in time regarding a very specific topic: the mapping of 835 CARCs to specific Group Codes. Despite the original intentions of the effort, this report is neither a how-to guide nor a

compendium of best practices. We had hoped to find order, employing the survey tool merely to collect input from a large team. The surprising results suggested that the industry may not be ready for a roadmap, as so few agreed on the proper course to automated remittance posting. We had to settle on an attempt to make sense of the seeming chaos, in the hopes that those who follow us will be able to organize their efforts to build consensus.

It is also important to emphasize that we were not attempting to "make sense" of the entire 835, or even the use of individual CARCs. We felt we should limit the scope of our study to isolate our attention on a particular problem that was vexing implementers of the 835: The perception of a "mismatch" between the CARC and its corresponding Group Code.

In order to facilitate the immediate application of our results, we limited our consideration to the current HIPAA-approved version of the 835 standard (version 4010A1) and the content of the code set at the time of our study.

Methodology

In our initial conference call on January 18, 2005 we explained 835 Group Code theory, as summarized in the Goal and Purpose document distributed to the volunteers (See Appendix 1, p. 41). Because there was so much confusion in the industry, we felt that a solid basis in this theory was important before we collected our responses. We were not looking for how it was *being* done now so much as how it *should* be done. We directed anyone with questions about the summary to review the material in the 835 4010A1 implementation guide.

We also emphasized that the project would confine itself to what could be done with the current standard, via proper application of existing codes. This helped the team focus on real-world issues and immediate solutions. It might also provide clarity that would be useful in expanding the CARC codeset which, again, could benefit the industry without having to wait for the regulatory adoption of a new standard.

Many of our participants said they would need to conduct a detailed review of the CARC code list within their organizations. In order to facilitate this, we distributed a printable worksheet that would help them collect responses and comments.

The 4010A1 835 Implementation Guide (IG) is silent on the pairing of any particular CARC with the four relevant[1] Group Codes:

- PR – Patient Responsibility
- CO – Contractual Obligation
- PI – Payer Initiated
- OA – Other Adjustment

[1] Because the Corrections and Reversals (CR) Group Code, by definition, can be applied to any CARC to reverse any previous Reason Code, we did not include it in our survey effort.

This lack of specificity is by design: Any crosswalk within the IG would defeat the purpose of maintaining an external code set, as it would fix the relationships in time at the point of publication.

Some of the highlights of this presentation included the following:

- The steps are meant to be taken in sequence, and the first "match" should determine which group code to use. For instance, the PR step comes before the CO step, so if a co-payment, for example, is definitely a Patient Responsibility, that code should be used, whether or not the co-payment amount is also a contractual obligation between the payer and the provider.
- Which group code applies may depend on the relationship between the payer and a provider. Many adjustments that qualify as CO when the provider is in a payer's network should be coded as PI (Payer Initiated) for out-of-network providers. In that case, both CO and PI boxes should be checked.
- Sometimes a CO can be used by a non-network payer when there is an "implied contract," such as when a provider accepts a referral from a PCP, then bills the network payer.

We asked that only one person from each organization respond to the survey. The survey opened immediately after the January 18 call and closed on Thursday February 3, 2005. The respondents whose results appear in this analysis (and the organization they identified as representing) are Allen R Johnson III, (Labcorp); Barbara Sesny, (BCBSM); Bob Ferguson, (Clinitech); Brenda Elthon, (Mayo); Cheryl Parkins, (Wenatchee Valley Medical Center); Christopher Sawyer, (The SCOOTER Store); Cinda Morton, (Noridian Administrative Services); Damon Dunsmore, (St. Luke's Regional Medical Center); Debra Strickland, (Aetna); Denise Swanson, (Medica Electronic Commerce); Fern Knoch, (The Nebraska Medical Center); Gale Scott, (Tampa General Hospital); Gerald Land, (University of NC Healthcare); J Robert Barbour, (Montefiore Medical Center); Jane Martin, (Owensboro-Medical Health System); Jeffrey S Plombon, (UnitedHealthcare); Joey Lawhorn, (County of Sacramento DHHS); Kathy Ochal, (Siemens); Kenneth Holmes, (VMed); Larry Morris, (Stormontvail Healthcare Inc); Martin Jensen, (St. John Health System); Mary Lou Jackson, (Group Health Cooperative – provider operations); Mary Lou Jackson, (Group Health Cooperative – payer operations); Nick Widboom, (Rycan Technologies Inc.); Patrice Kuppe, (Allina); Richard McNeil, (Southcoast Hospitals Group); Sandi Colon, (Lehigh Valley Hospital); Shari Back, (SBHCS); Shelly Meath, (Methodist Hospital); Sue Barnes, (Valley Mental Health); and Tiffany Thompson, (Iowa Health System). NOTE: Because each participant was encouraged to gather input from their entire organization and also provided tools with which to gather such feedback, it should not be assumed that their responses indicate an individual preference or interpretation.

Survey Questions

The survey design was straightforward. We asked a single qualifying question to assist in our analysis, then presented the entire list of Claim Adjustment Reason Codes.

1. My primary business role is (must choose one)

- ❑ Health Plan
- ❑ Provider
- ❑ Health Plan Software Vendor
- ❑ Provider Software Vendor
- ❑ Other (specify)

2. Indicate the appropriate group codes for each Reason Code (check all that may apply)

This was followed by a listing of the 163 then-current Claim Adjustment Reason Codes. After each CARC, the respondent could check one or more Group Codes that might apply.

After completing the matrix, the respondent was presented with an extra Bonus Question:

What would you most like your trading partners to know about your own challenges in implementing this transaction?

Responses to this open-ended question can be found in Bonus Question Responses on p. 38.

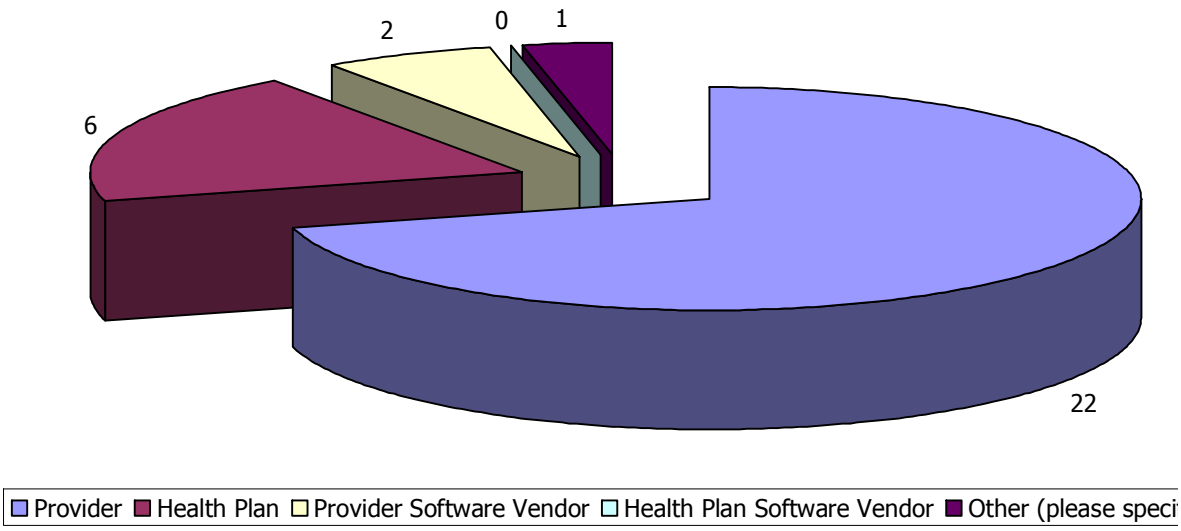
We then conducted a second conference call to review and discuss the results. Notes from this conference call and some subsequent email conversations with the organizers are covered in the section *Discussion* on page 34.

Survey Sample

The total number of volunteers who received all notifications and were invited to participate in the conference calls consisted of 60 individuals representing 41 organizations. We asked those organizations with multiple team members to select one person to respond for the organization as a whole. An exception was made for one company that had participants representing a provider business unit and a payer business unit.

We received 31 responses: 22 Providers, 6 Health Plans, 2 Provider Software Vendors and 1 "Other" (listed as "Operations-Claim production"). We did not receive a response from any Health Plan Software Vendors.

X12/WEDI CARC Matrix Survey
Primary Business Role



Matrix Totals

The "Totals" charts provide an overview of the aggregate survey responses for the entire data set—the CARC list at the time of our Survey (February 2005).[2]

Bar Length Differences: The length of the bars represents the total number of *responses*. The lengths of the colored segments within the bars represent the number of respondents who felt that specific CARC could be assigned a particular Group Code. Because respondents could pick more than one Group Code/CARC pair, most bars are longer than 31 units (the total number of respondents was 31). We allowed this flexibility because different Group Codes could apply under different circumstances—for instance, if the payer had a contract with the provider, the preferred Group Code might be CO, whereas if it were a non-par payer, the respondent might want to indicate a different Group Code.

Respondents also had the option to skip questions, so there are bars that are shorter than 31 units. Bars that are longer than 31 units may also represent responses from fewer than 31 individuals, as some respondents selected two or more answers, while others skipped the question altogether.

Total Bar Length: In general, the longer the bar, the greater the *ambiguity* respondents showed regarding the classification of that particular reason code: Respondents were saying, "Sometimes it should be *this* Group Code, but other times it could be *that* Group Code." Shorter bars tend to indicate that more respondents believed the CARC in question could only be classified with a single Group Code.

Mix of Colors Within Bar: Regardless of length, bars that show a broad mix of colors indicate a *lack of unanimity* about the purpose of that CARC. Again, that "disagreement" may suggest one or more conclusions:

- People are *confused* about appropriate categorization of the code.
- People *disagree* about appropriate categorization of the code.
- People *agree* that the code can be used in more than one way: "It depends."

Each of the CARCs is represented in the charts below. In the section that follows, we'll examine some specific CARCs in more detail to see whether we can learn more about which of these circumstances may apply.

In this context, we use the term "ambiguity" to describe a characteristic of the *individual respondents* toward a particular CARC, indicating, "It could be one of the other," or "I'm not sure." When a lot of respondents are ambiguous about a CARC, it shows up as a long bar on these charts, with a broad distribution of color.

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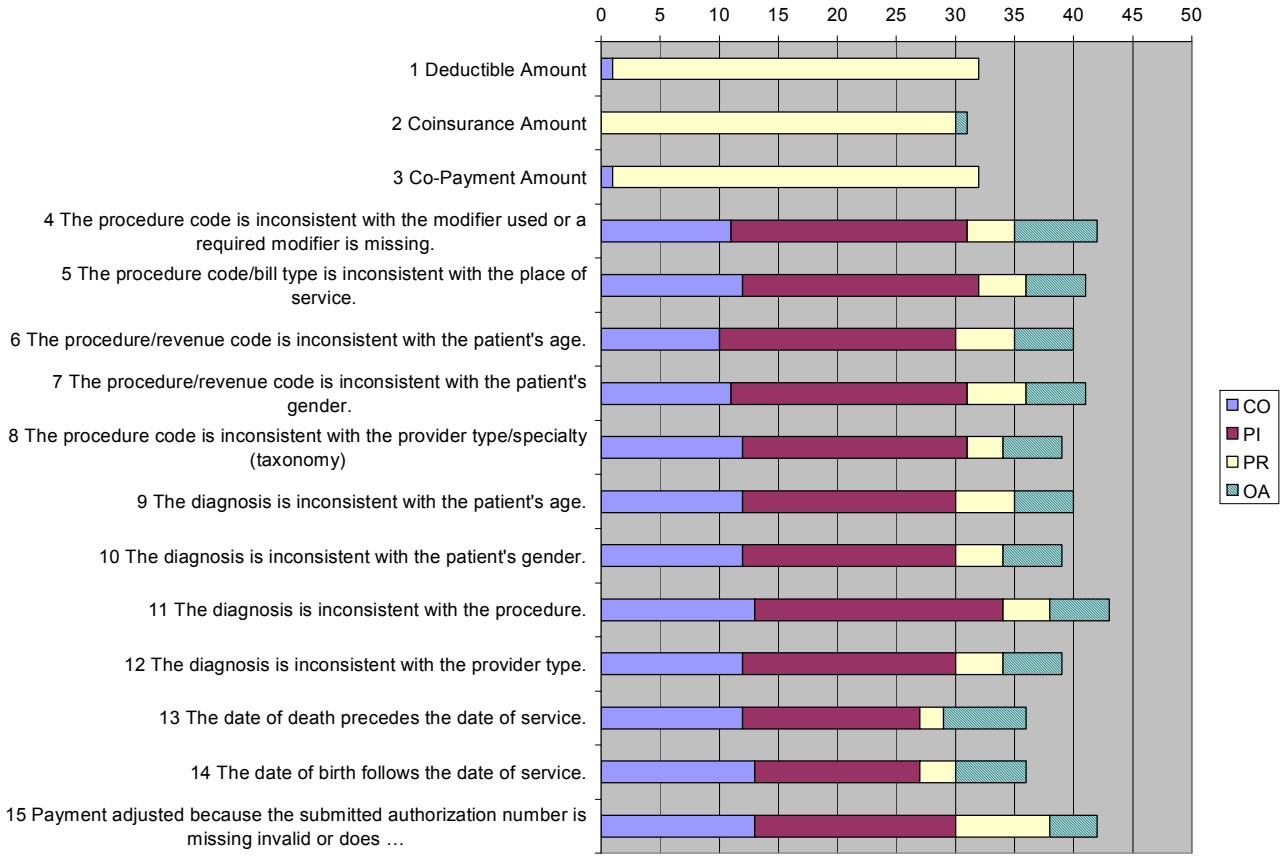
[2] Please note: The CARC code set is dynamic, and not dependent upon a particular version of an X12N Implementation Guide. Codes are added and removed and descriptive language may be modified. Under no circumstances should you rely on the listings in this document for coding purposes. For a current version of the CARC and other code lists, go to http://www.wpc-edi.com/codes.

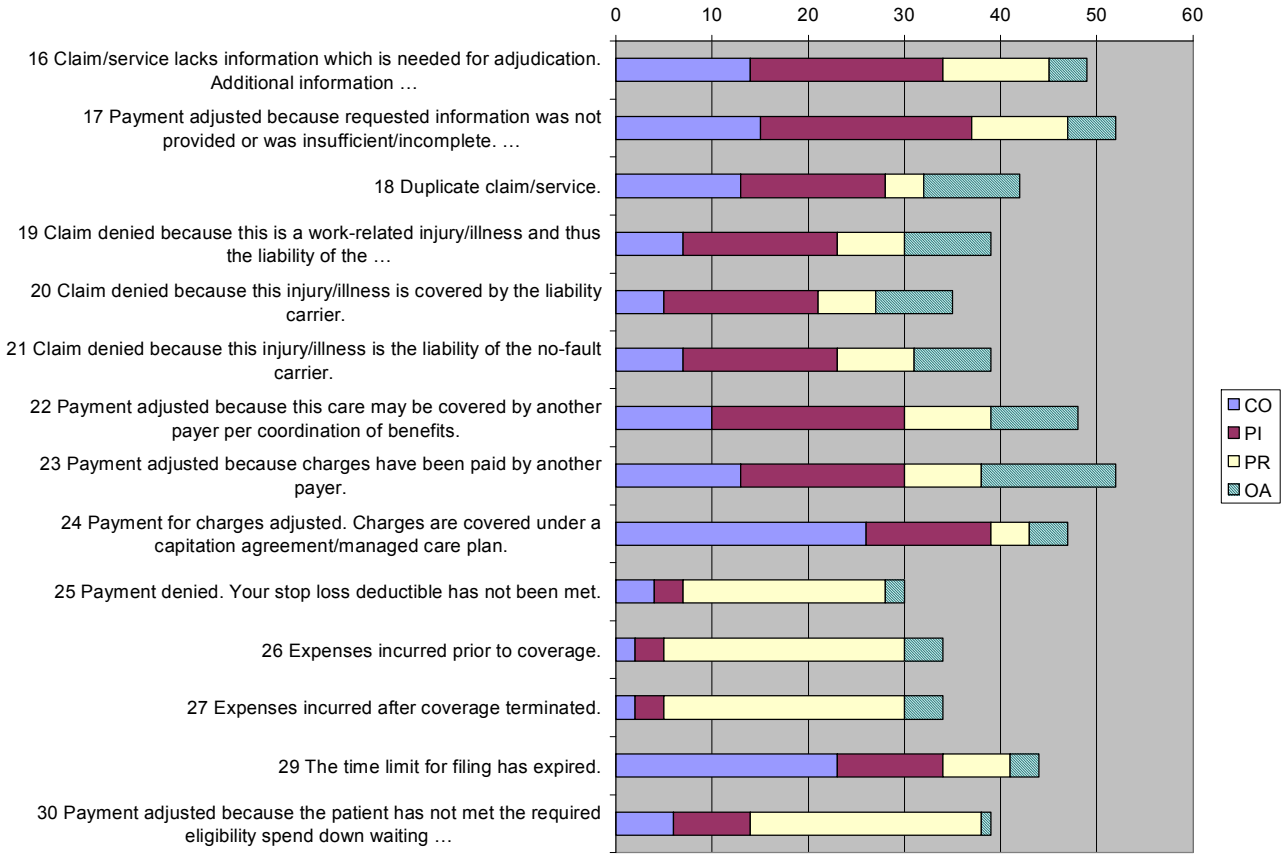
"Unanimity," on the other hand, describes a particular form of consensus agreement about the CARC: Most people assigned a *single* Group Code (they weren't personally ambiguous about it), and they usually picked *the same* Group Code as other respondents (they didn't disagree with their colleagues about which Group Code to use). These CARCs show up as shorter bars, with a single color predominating.

True "disagreement," where some participants are "sure" that one Group Code is correct while others are "sure" that a different Group Code is appropriate, show up as short bars with different colors battling for dominance. Many observers had anticipated that payers and providers "disagreed" on proper Group Coding – providers saw things one way while payers saw them a different, contradictory way. This phenomenon, as we shall see, is far less common than one might expect, a fact that offers substantial opportunities for consensus building.

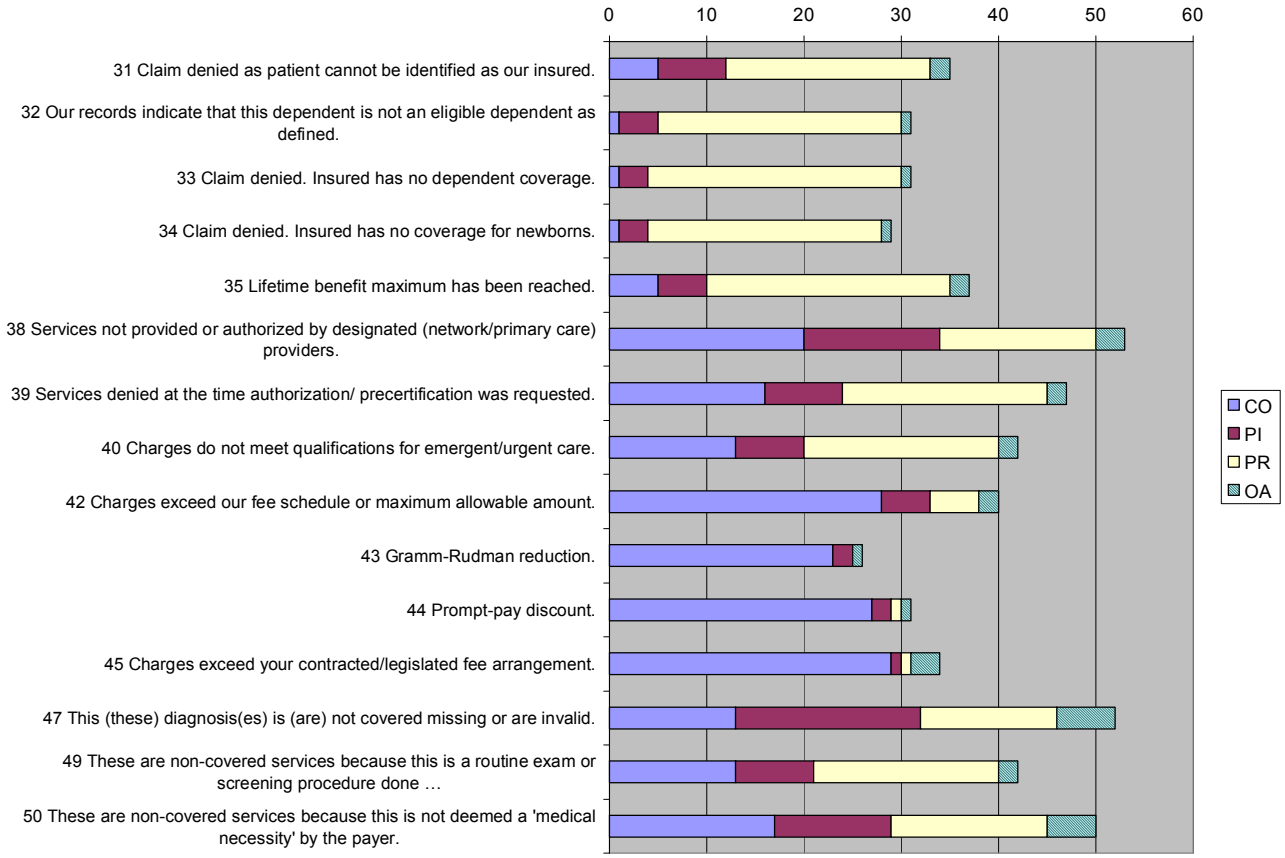
CARC Matrix Totals (1-15)



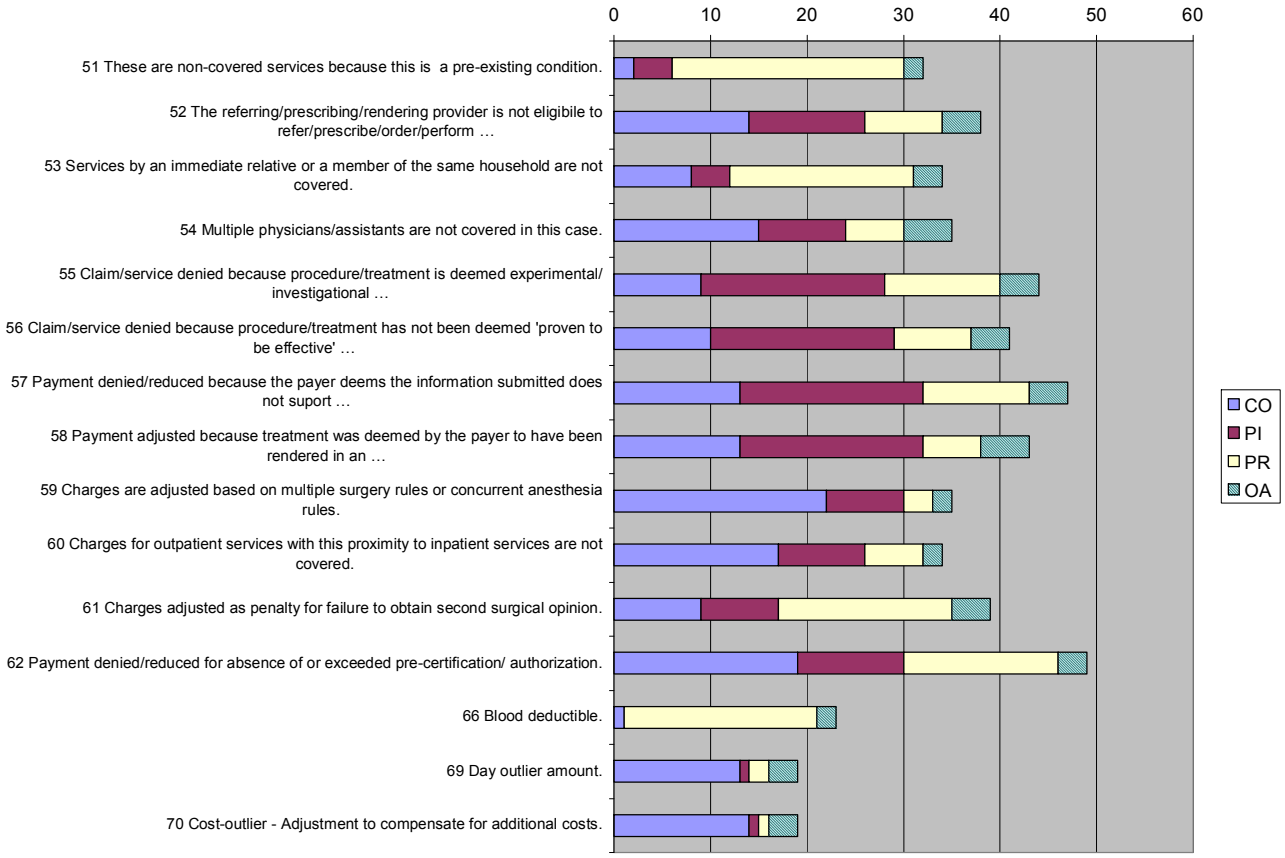
CARC Matrix Totals (16-30)



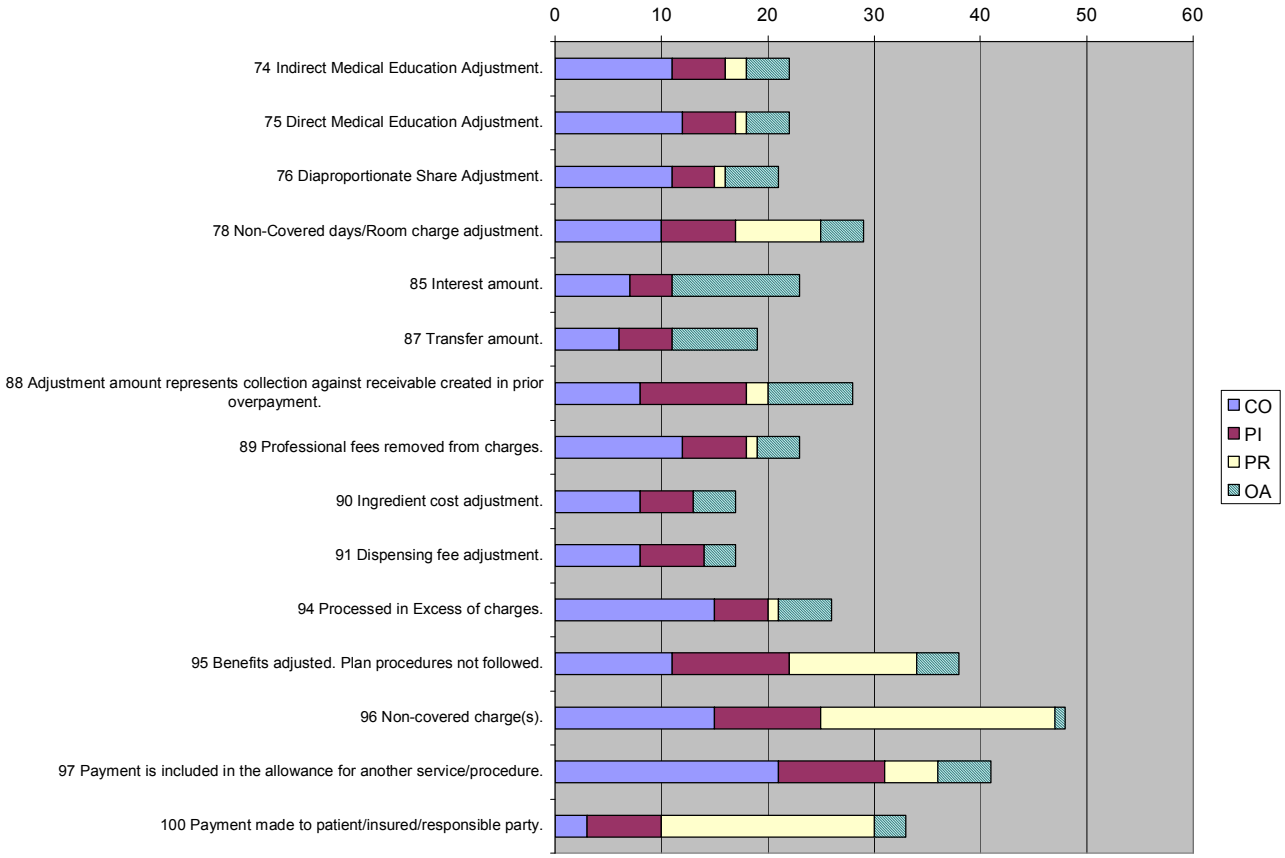
CARC Matrix Totals (31-50)



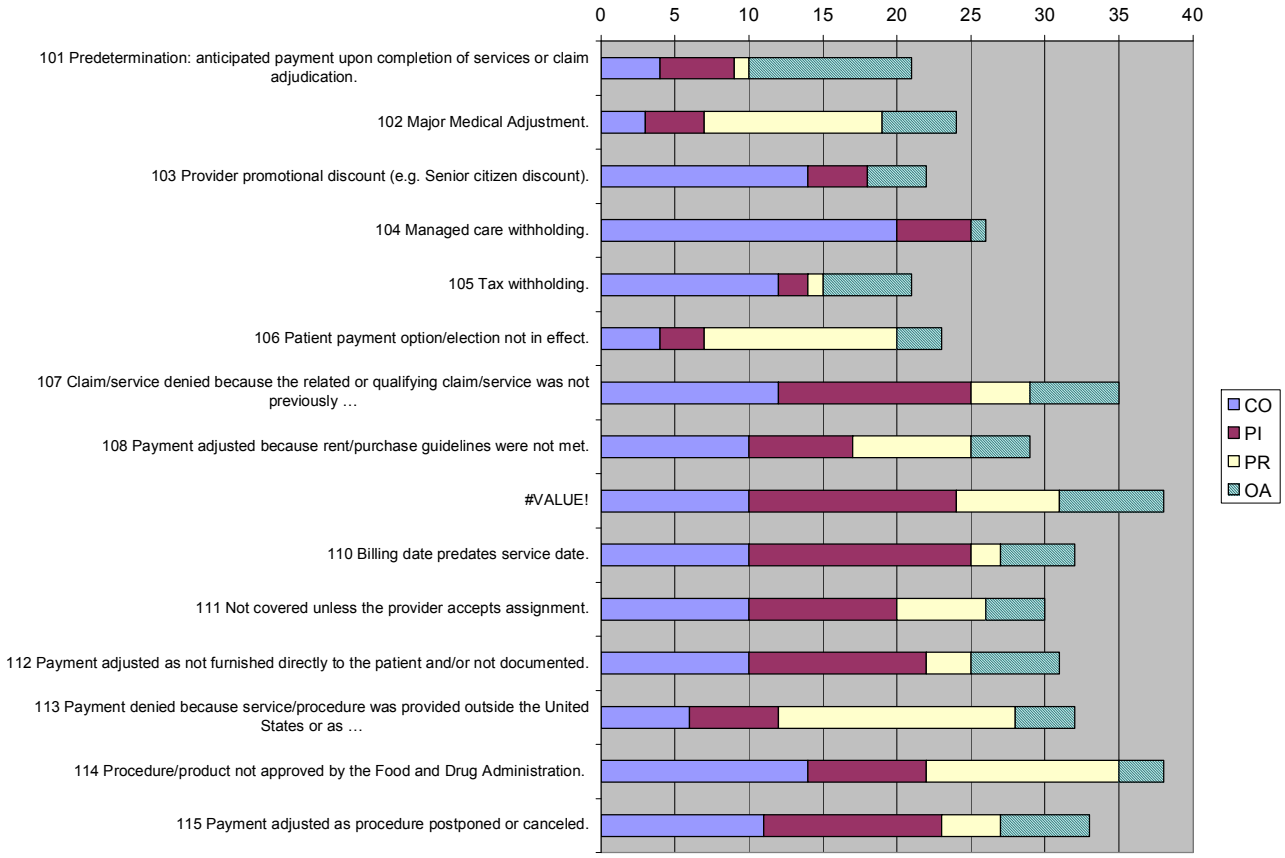
CARC Matrix Totals (51-70)



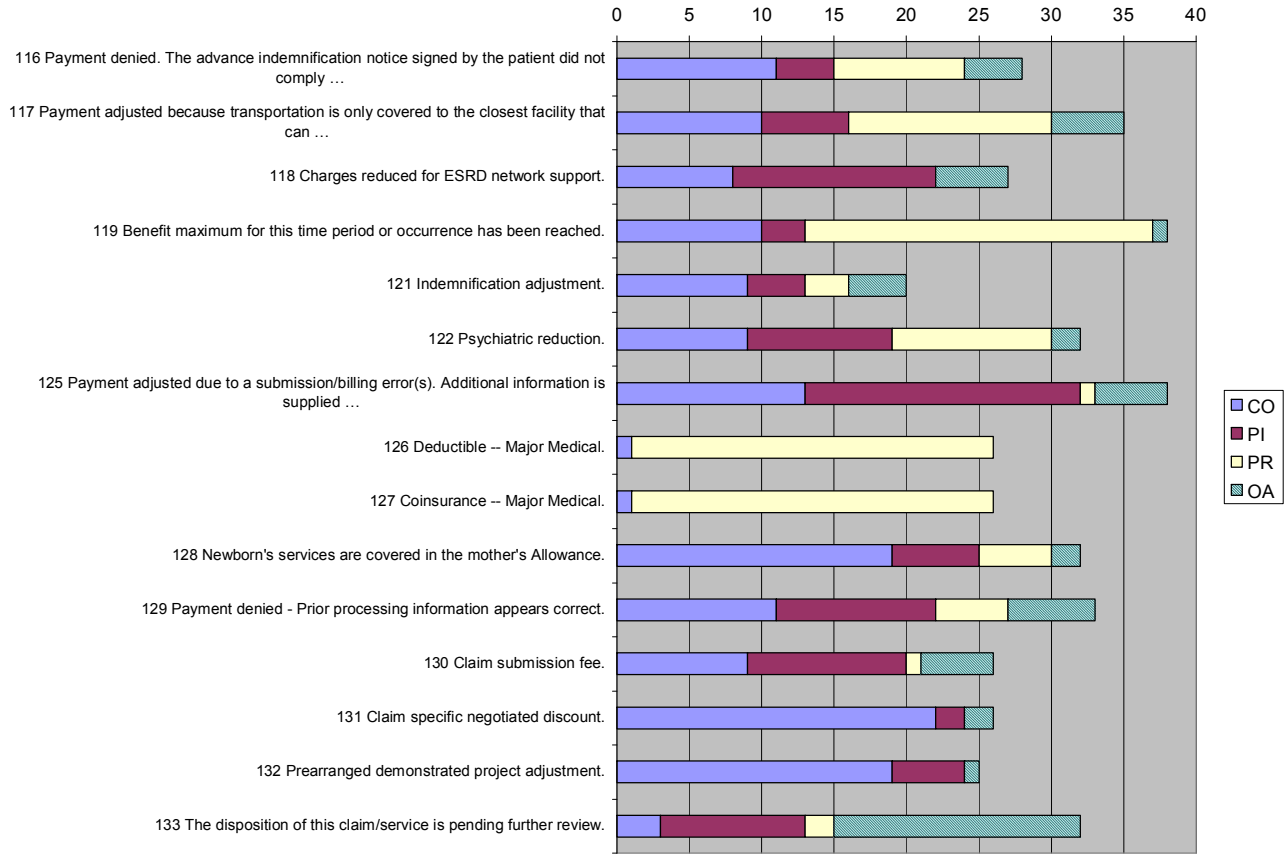
CARC Matrix Totals (74-100)



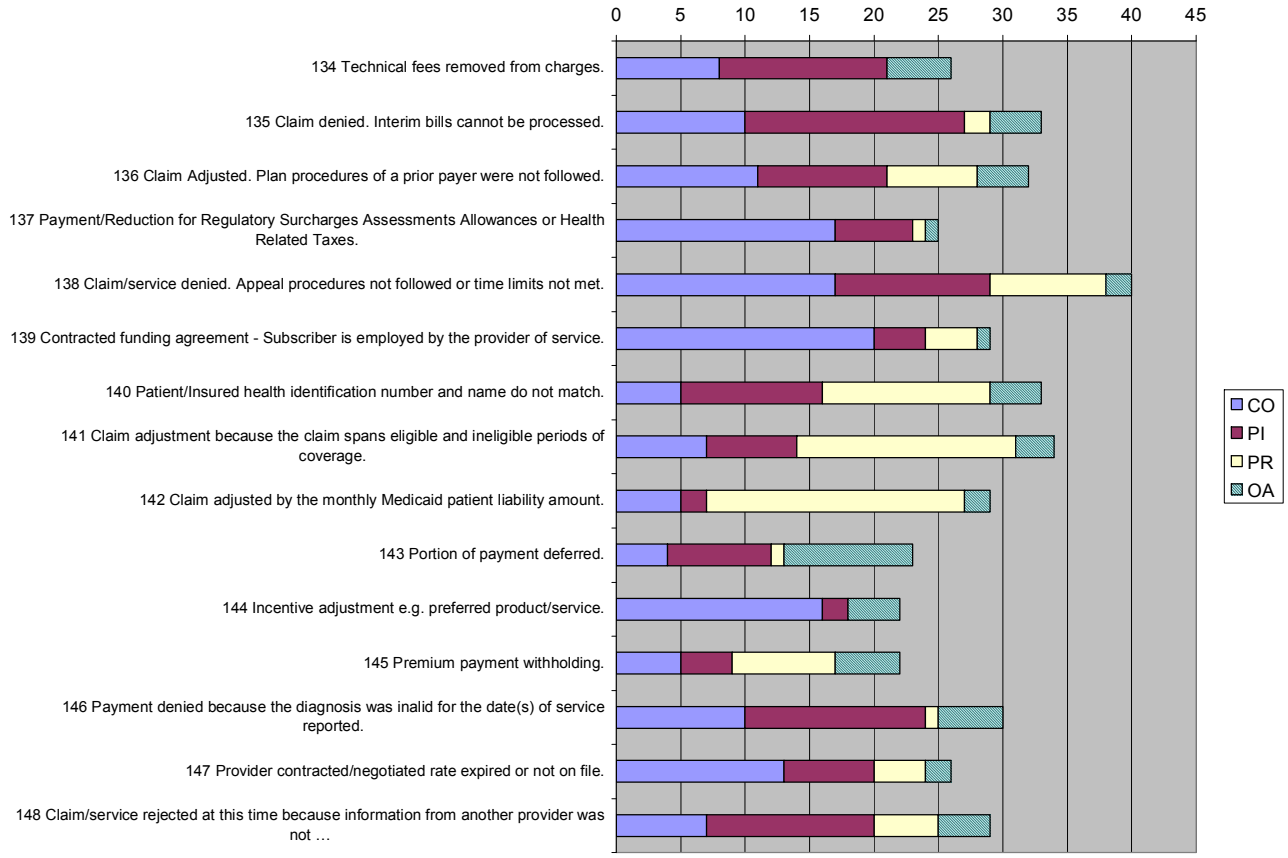
CARC Matrix Totals (101-115)



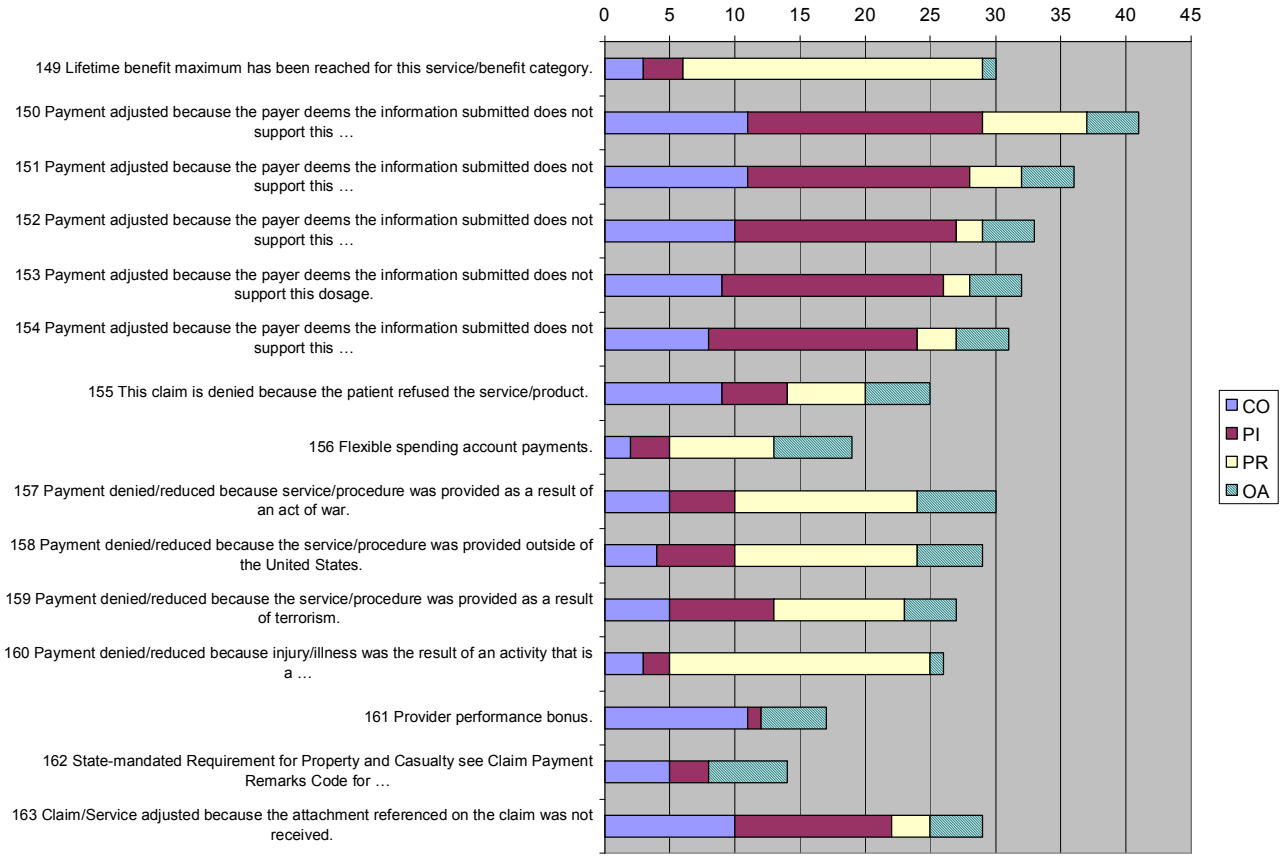
CARC Matrix Totals (116-133)



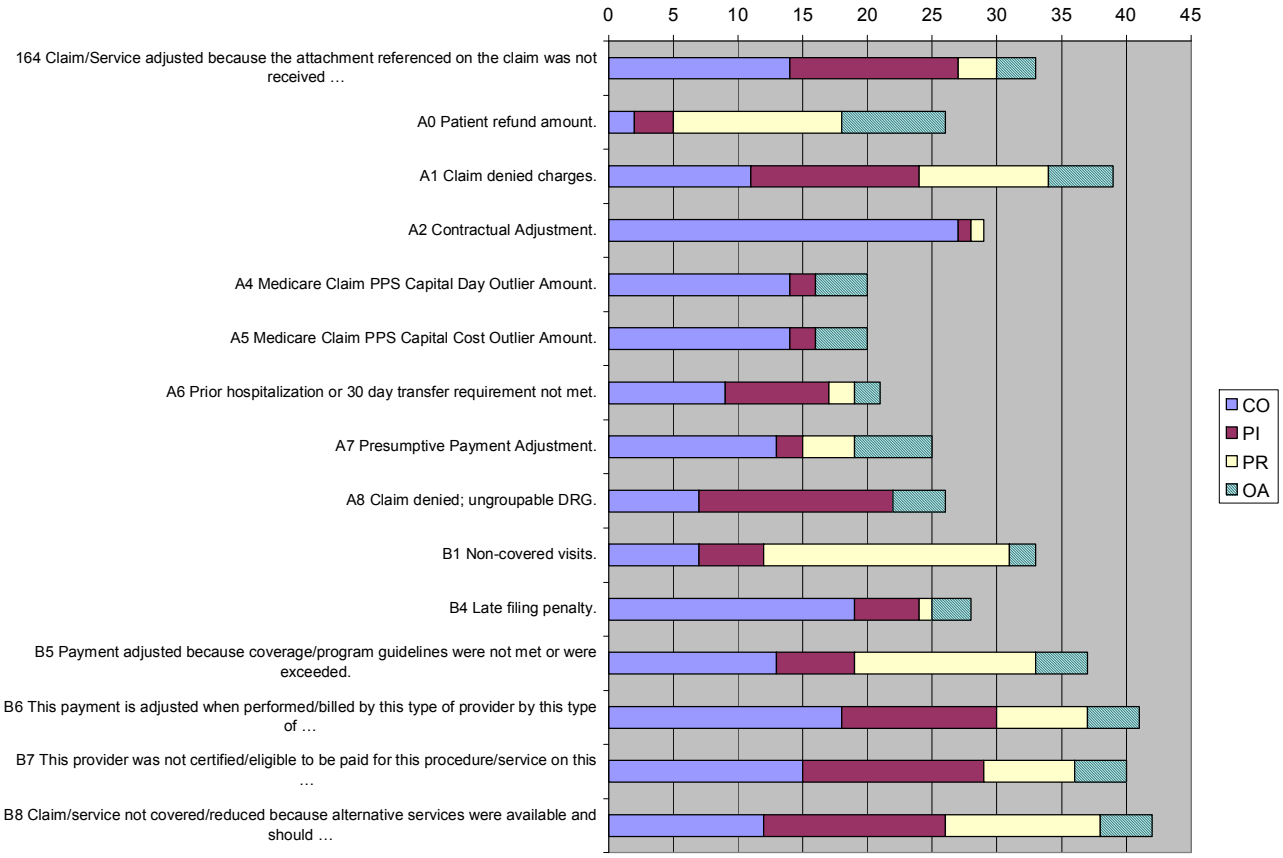
CARC Matrix Totals (134-148)

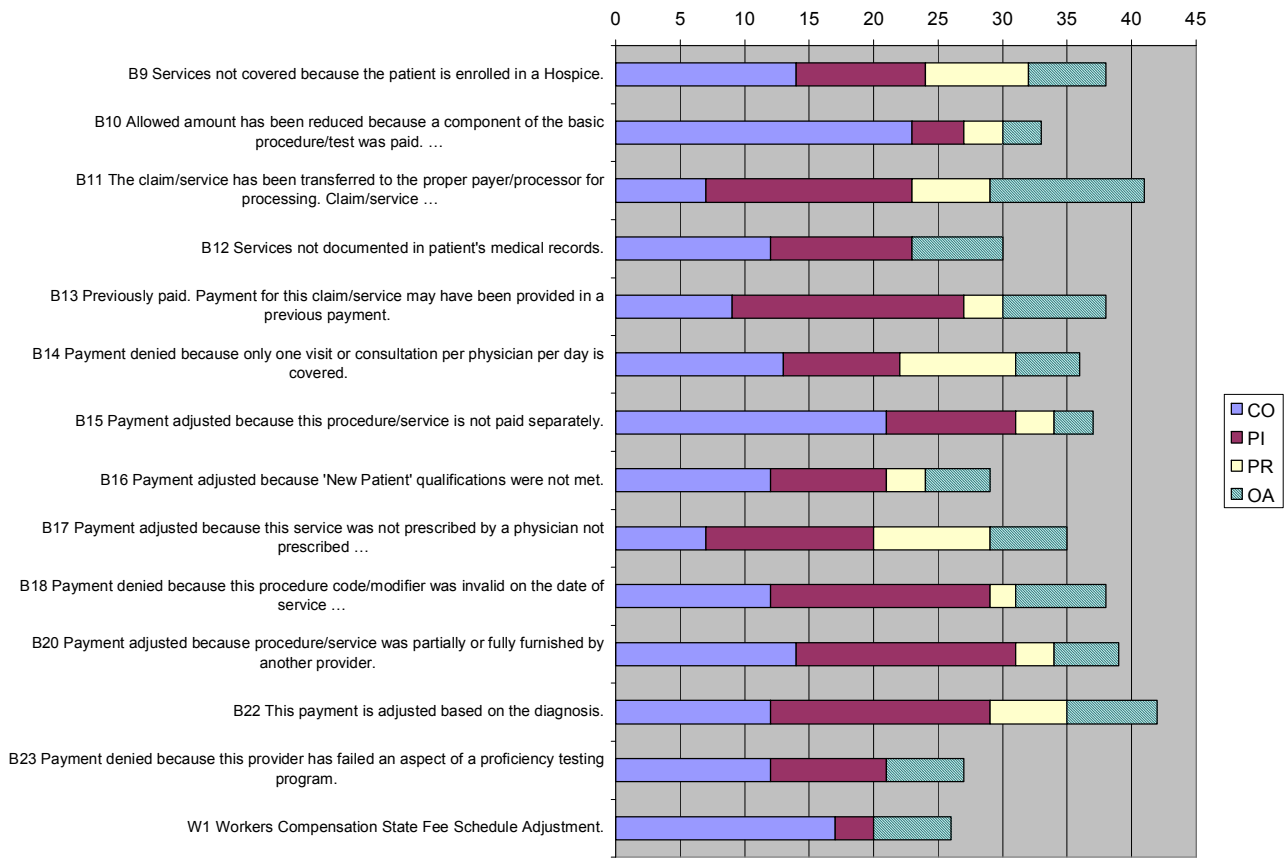


CARC Matrix Totals (149-163)



CARC Matrix Totals (164-B8)




CARC Matrix Totals (B9-W1)
0
5
10
15
20
25
30
35
40
45
B9 Services not covered because the patient is enrolled in a Hospice.
B10 Allowed amount has been reduced because a component of the basic procedure/test was paid. …
B11 The claim/service has been transferred to the proper payer/processor for processing. Claim/service …
B12 Services not documented in patient's medical records.
B13 Previously paid. Payment for this claim/service may have been provided in a previous payment.
B14 Payment denied because only one visit or consultation per physician per day is covered.
B15 Payment adjusted because this procedure/service is not paid separately.
B16 Payment adjusted because 'New Patient' qualifications were not met.
B17 Payment adjusted because this service was not prescribed by a physician not prescribed …
B18 Payment denied because this procedure code/modifier was invalid on the date of service …
B20 Payment adjusted because procedure/service was partially or fully furnished by another provider.
B22 This payment is adjusted based on the diagnosis.
B23 Payment denied because this provider has failed an aspect of a proficiency testing program.
W1 Workers Compensation State Fee Schedule Adjustment.
CO
PI
PR
OA

Breakdowns by Respondent Type

We developed two types of charts to examine the breakdown of responses by Respondent Type (Health Plan, Provider, and Provider Software Vendor/Other). As stated previously, the respondents identified themselves this way:

Respondent Type	Responses
Health Plan	6
Provider	22
Provider Software Vendor and Other	3

The first type of chart, "CARC-specific Counts by Respondent Type," simply mirrors format of the aggregate charts, but looks at a single CARC code, dividing the responses into three separate bars according to Respondent Type. As before, bar lengths represent the number of responses and the colored segments indicate the different Group Codes. Because the number of responses varied widely for each Respondent Type, the length of the "Health Plan" and "Provider Software Vendor and Other" bars are always much shorter than the "Provider" bars. For clarity, we'll refer to these Respondent Types as "Health Plan," "Provider," and "Vendor."

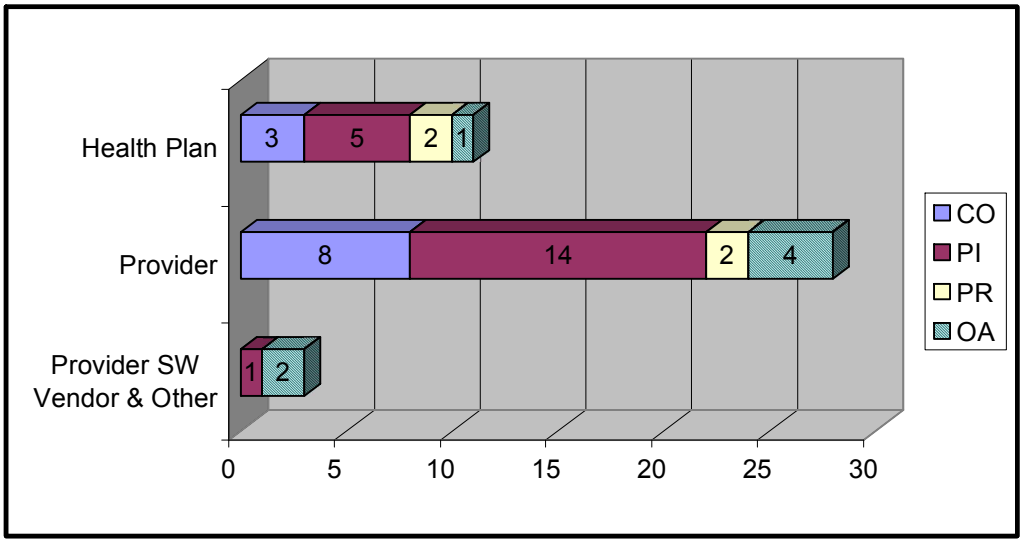
We can look at one of the longer bars on the aggregate chart and see whether its variations indicate a disagreement between providers and health plans, or if there might be another explanation.

CARC 4 – Conflict or Confusion?

For example, the breakdown for CARC 4, "The procedure code is inconsistent with the modifier used or a required modifier is missing," shows a bar length of 42. Since the number of responses is significantly higher than the number of respondents (31), this means that several individuals must have checked more than one Group Code. Likewise, the distribution of responses among the four group codes is broad – no single color segment dominates (see Totals on p. [11]). Does this indicate a disagreement between health plans and providers?

The breakdown for CARC 4 looks like this:

CARC-specific Counts by Respondent Type				
4 The procedure code is inconsistent with the modifier used or a required modifier is missing.	**CO**	**PI**	**PR**	**OA**
Health Plan	3	5	2	1
Provider	8	14	2	4
Provider SW Vendor & Other	0	1	0	2

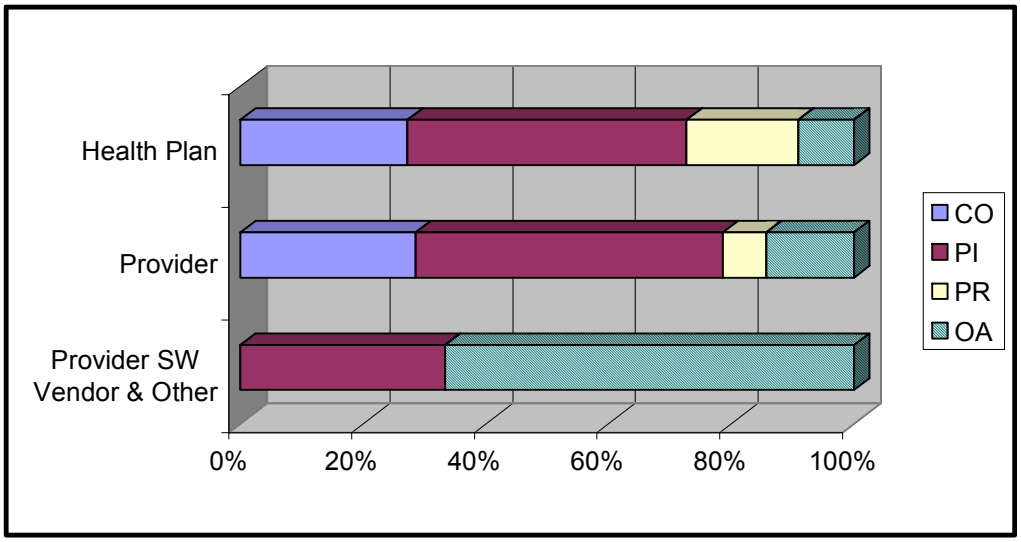


Numeric Chart: Segment size indicates total response volume.

The breakdown illustrates that, while there is no unanimity about how CARC 4 should be grouped, there doesn't seem to be a disagreement *between* providers and health plans on the issue so much as there is a lack of agreement among *all* parties.

Because the bars are so different in length, this is better illustrated by laying out the same data in a chart that treats each sample as 100% of the responses for that contingent, as illustrated in our second breakdown chart format, "CARC-specific Agreement Between Respondents." This type of chart effectively "stretches" the bars to the same length. This makes it easier to compare the color regions illustrating how each group flagged the CARC with the various group codes. Close vertical alignment between the various bars suggests more agreement between the respondent types on the use of a particular code – even where that "agreement" actually suggests "collective confusion."

CARC-specific Agreement Between Respondents				
4 The procedure code is inconsistent with the modifier used or a required modifier is missing.	**CO**	**PI**	**PR**	**OA**
Health Plan	3	5	2	1
Provider	8	14	2	4
Provider SW Vendor & Other	0	1	0	2



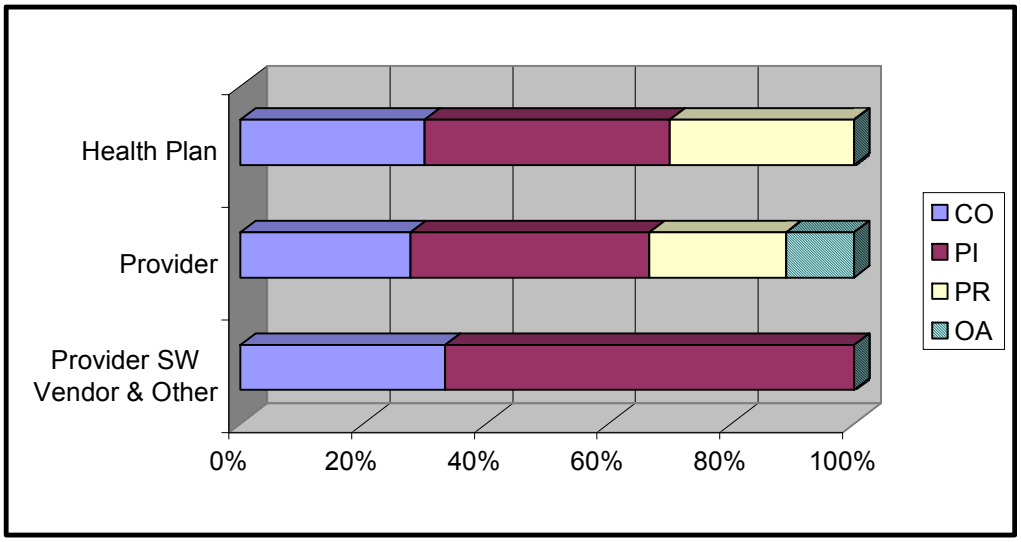
Percentage Chart: Color alignment indicates degree of agreement.

As you can see, the Health Plan and Provider bars tend to line up pretty closely, and the colored regions remain well spread out, with no single color segment predominating. This collective confusion serves to illustrate a common theme that arose in our discussions: There doesn't seem to be a consensus about how to apply Group Codes to "technical" billing errors. Such errors would include coding errors, missing information that prevented successful adjudication and other situations where the appropriate provider response would be to "correct and resubmit," rather than "write it off" or "bill the patient." CARC 4 is an example of a code that indicates such an error; the results of other, similar codes also reflected this disunity.

CARC 16 - More Collective Confusion?

This phenomenon is also illustrated by the results for CARC 16, "Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remark codes whenever appropriate." Again, we'll use the Agreement chart to compare the segments.

CARC-specific Agreement Between Respondents				
16 Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remark codes whenever appropriate.	**CO**	**PI**	**PR**	**OA**
Health Plan	3	4	3	0
Provider	10	14	8	4
Provider SW Vendor & Other	1	2	0	0



Percentage Chart: Color alignment indicates degree of agreement.

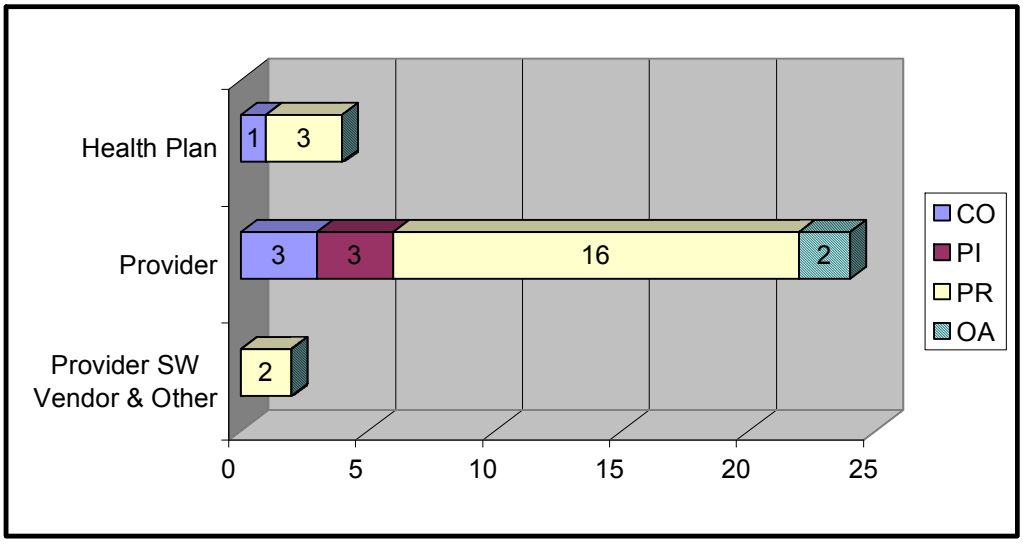
In this case, the code itself is ambiguous: It doesn't necessarily refer to a technical error; it doesn't even give enough information on its own to suggest that the adjustment be written off, billed to the patient or resubmitted with additional documentation. (The direction to use Remarks Codes is a recognition of this built-in ambiguity.)

As the broad spread of Group Codes indicates, our respondents felt the 835 criteria could be interpreted in a number of ways. This flexibility suggests that it may be helpful to build an industry-wide consensus about how to code such responses if we wish to bring about consistency within the context of the HIPAA standard.

CARC 25 Means Bill-the-Patient – Right?

Sometimes the results were difficult to explain. When a health plan made a clear statement that their policy terms did not cover the benefits, but did not call into question the coding or legitimacy of the treatment, why would this not trigger a Patient Responsibility response? It was not just the Health Plans that were confused. In fact, sometimes the providers themselves seemed unsure. This can be seen in the results for CARC 25 "Payment denied. Your Stop loss deductible has not been met." (See Totals on p. [11]) We'll use the Counts chart because the numbers are particularly important.

CARC-specific Counts by Respondent Type				
25 Payment denied. Your stop loss deductible has not been met.	**CO**	**PI**	**PR**	**OA**
Health Plan	1	0	3	0
Provider	3	3	16	2
Provider SW Vendor & Other	0	0	2	0



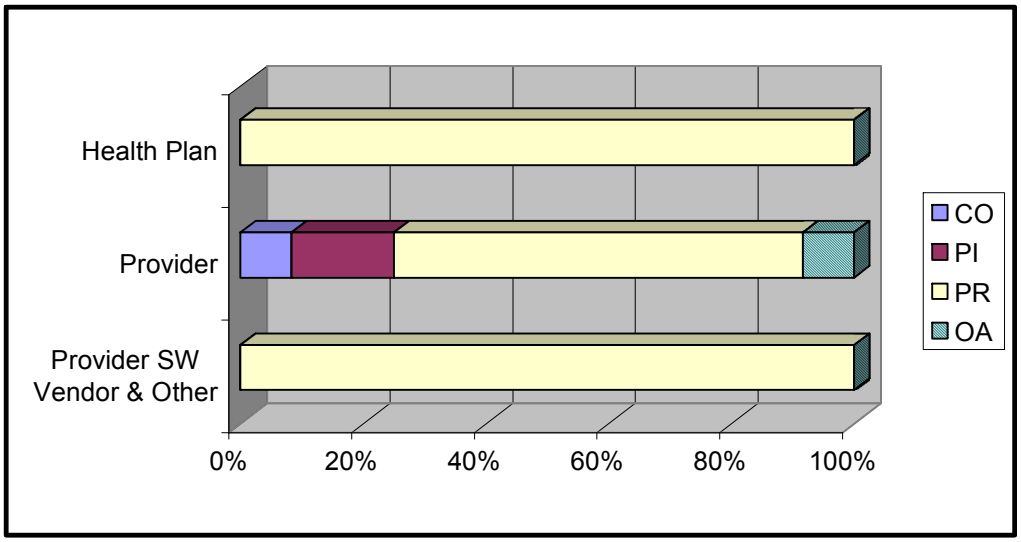
Numeric Chart: Segment size indicates total response volume.

The results were nearly unanimous that this should be coded as a Patient Responsibility. While there was one health plan respondent who felt a case could be made for Contractual Obligation, all the other dissenting opinions came from providers themselves. While, with a total number of responses at 30, this CARC generated the *least ambiguity* (people tended to choose only *one* Group Code apiece), it did not result in *unanimity* (people tended to choose the *same* Group Code as everyone else). The 22 providers gave only 24 total responses, but it appears that more than a few were "sure" the correct answer was *not* PR.

Preexisting Provider Confusion on CARC 51

Sometimes it appeared that only providers were confused about the use of a particular code. This appears in the case of CARC 51, "These are non-covered services because this is a pre-existing condition." While all the Health Plans and Vendors said the dreaded code meant only one thing, Providers were not so sure.

CARC-specific Agreement Between Respondents				
51 These are non-covered services because this is a pre-existing condition.	**CO**	**PI**	**PR**	**OA**
Health Plan	0	0	6	0
Provider	2	4	16	2
Provider SW Vendor & Other	0	0	2	0



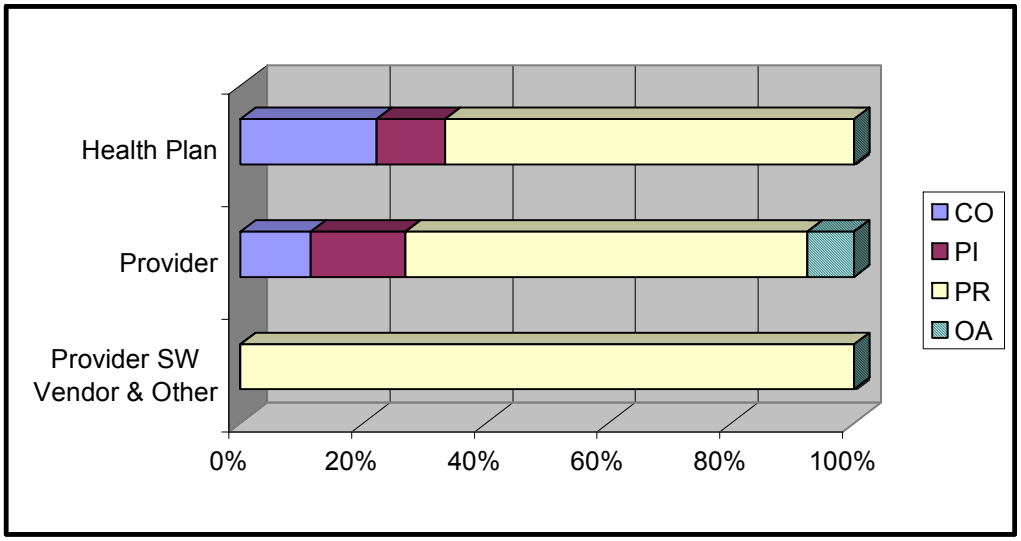
Percentage Chart: Color alignment indicates degree of agreement.

Does this represent a lack of understanding of the codeset, or is it perhaps just a reflection of providers' unwillingness to "give up?"

CARC 35: Whose Contract Are We Talking About Here?

Health Plans don't get off the hook in the confusion department, however. CARC 35, "Lifetime benefit maximum has been reached," seems to have been pretty obvious to almost everyone else who responded to the survey (taking into account, of course, the small group of providers who appeared to hedge their bets by clicking multiple columns on every question). When the benefits run out, the patient has to pay the difference, right? Our analysis suggested there were two cases where payers might dispute this. And both offer learning opportunities for our consideration.

CARC-specific Agreement Between Respondents				
35 Lifetime benefit maximum has been reached.	**CO**	**PI**	**PR**	**OA**
Health Plan	2	1	6	0
Provider	3	4	17	2
Provider SW Vendor & Other	0	0	2	0



Percentage Chart: Color alignment indicates degree of agreement.

Why would a third of payer respondents (two out of six individuals) indicate that a lifetime benefit maximum might be a Contractual Obligation?

First is the situation that applies in some situations under Medicaid (or perhaps other government plans) which has lifetime benefit maximum limits, but whose regulatory terms forbid the provider from collecting the adjusted amount from the patient. In this case, a Contractual Obligation does indeed apply. This underscores the need to consider the differing reimbursement laws that govern private and public health plans when establishing guidelines for CARC coding.

Another possible rationale for the unexpected payer response came out in discussion later. Private health plans aren't just concerned about their *provider* contracts; they are also concerned about contracts with employers and other plan sponsors. Does CO apply only to

Provider/Plan agreements? Providers seem to assume it does, but the view from the Payer side may be different.

The 4010 implementation guide section on Claim Adjustment and Service Adjustment Segment Theory is clear:

> Is the amount adjusted not the patient's responsibility under any circumstances due to either a contractual obligation between the provider and the payer or a regulatory requirement?
> Use code **CO - Contractual Obligation.**
>
> **Source**: ***004010X091 · 835 ASC X12N · Insurance Subcommittee Health Care Claim Payment/Advice Implementation Guide, p. 24***

The "C" in "CO" refers to the contract between the payer and the provider, not between the payer and a plan sponsor.

However, it's important to understand that the relationship between the payer and an employer/sponsor can *influence* whether a CO group code applies in a particular case.

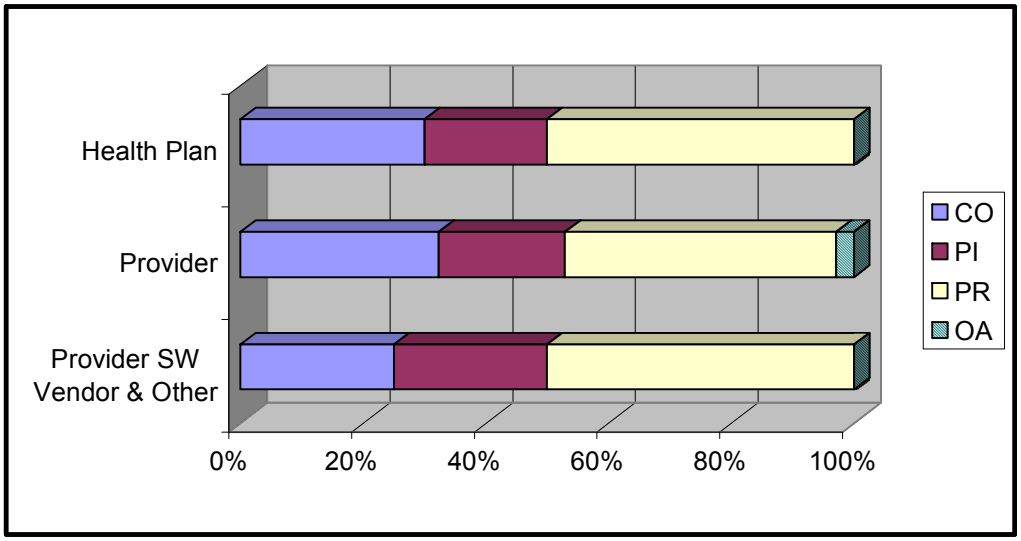
For example, Payer Z has contracts with Employer I and Employer IV. Z's contract with Employer I is based on a PPO network in which Provider A participates, while Z's contract with Employer IV is a simple indemnity plan. Therefore, Z might report a plan fee schedule adjustment as a Contractual Obligation for patients under Employer I's policy, and as a Payer Initiated adjustment or Patient Responsibility for patients who work for Employer IV. Provider A has a contract with Payer Z, but it's Z's relationship with the employer that governs whether that contract applies to a particular patient claim.

Moreover, it's conceivable that Payer Z could send the same CARC (for instance 42 - Charges exceed our fee schedule or maximum allowable amount) to Provider A with two different group codes: CO for the PPO patient, which the provider is obligated to write-off; and PI for the indemnity patient, which the provider makes the decision to bill the patient or write off. (A case could be made for the payer to avoid confusion in the case of the PPO by utilizing CARC 45 - Charges exceed your contracted/legislated fee arrangement.)

CARC 96 - Ambiguous Code, Ambiguous Results

In our discussions, a lot of criticism fell to one particular CARC: 96 "Non-covered charge(s)." What does it mean? Not much. How should it be coded? No one knows. At least, that's what the stripes on the chart say. Might a case be made to eliminate this code in exchange for more specific and actionable alternatives?

CARC-specific Agreement Between Respondents				
96 Non-covered charge(s).	**CO**	**PI**	**PR**	**OA**
Health Plan	3	2	5	0
Provider	11	7	15	1
Provider SW Vendor & Other	1	1	2	0



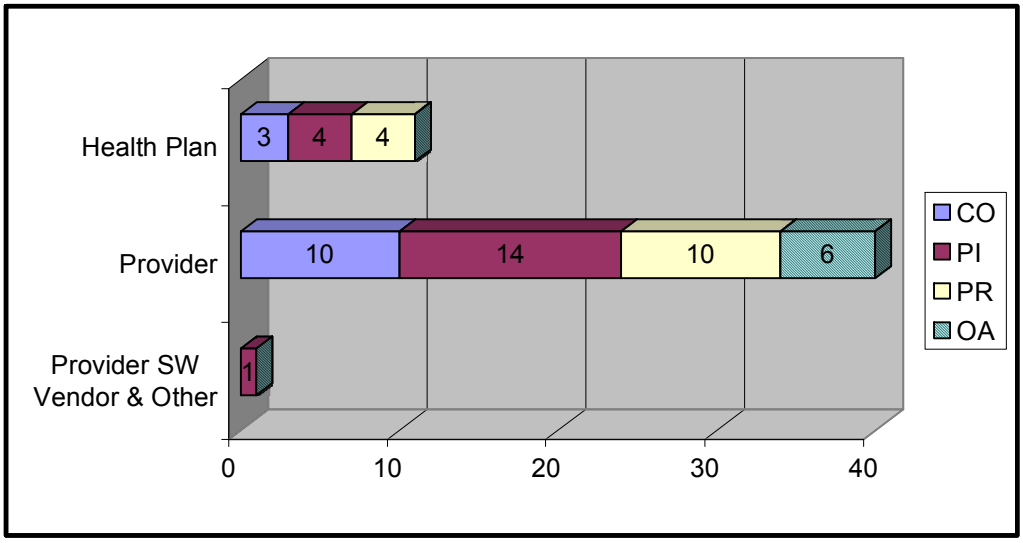
Percentage Chart: Color alignment indicates degree of agreement.

CARC 47 – Ambiguity Resolved

A more specifically ambiguous CARC is 47: "This (these) diagnosis(es) is (are) not covered, missing, or are invalid." In discussion, it was pointed out that if the diagnosis is *not covered*, it should probably be submitted as a PR (again, with possible exceptions for Medicaid). If the diagnosis is *missing or invalid*, then it should be billed as a technical denial.

Remembering that our results do not demonstrate a consensus on the coding of technical denials, the results show exactly what we would expect: A broad distribution across CO, PI, PR and OA, with many respondents checking multiple boxes. (We use the "Counts" chart here to demonstrate the number of duplicate answers: 11 responses from 6 health plans, 40 responses from 22 Providers.)

CARC-specific Counts by Respondent Type				
47 This (these) diagnosis(es) is (are) not covered missing or are invalid.	**CO**	**PI**	**PR**	**OA**
Health Plan	3	4	4	0
Provider	10	14	10	6
Provider SW Vendor & Other	0	1	0	0



Numeric Chart: Segment size indicates total response volume.

This situation has a happy ending, with CARC 47 scheduled for deactivation on 2/1/2006, replaced by the separate codes "167 This (these) diagnosis(es) is (are) not covered," and "D21 This (these) diagnosis(es) is (are) missing or are invalid." These new codes can be used today, thus demonstrating the value of bringing such concerns to the Health Care Claim Adjustment/Status/Category Code Maintenance Committee (http://www.wpc-edi.com/content/view/518/205).

CARC 31 – Finally Health Plans and Providers Disagree!

Despite the often-expressed presumption that payers and providers "just don't see the 835 the same way," we haven't seen a lot of evidence to support that conclusion so far. The distribution of colored segments the bar charts illustrate this. If payers thought a particular code should be CO, their bar would be mostly blue; if providers thought the same code should be a PR, their bar would be mostly red. Instead the colored patterns we've seen thus far are remarkably similar. This suggests that our providers and payers generally view things more or less the same way, but no one is getting a very clear picture.

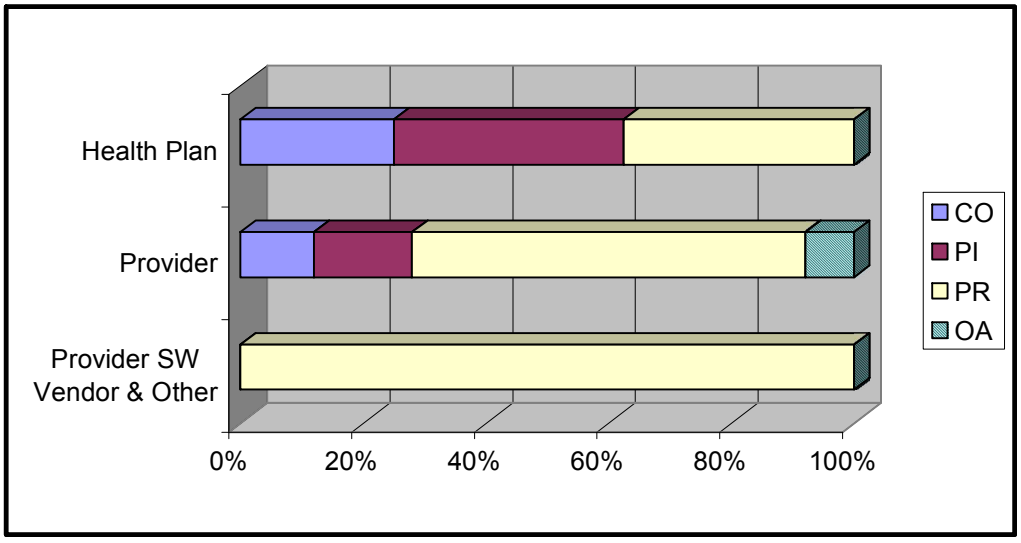
But there is at least one code that providers and health plans *can* disagree about. CARC 31 "Claim denied as patient cannot be identified as our insured," is a case in point.

In this case, Providers overwhelmingly saw this as a patient responsibility, and the two vendors who replied agreed. But while half the payers (3 out of 6) said PR *might* be appropriate, their overall response showed some hesitancy. "On the other hand, it could be CO or PI."

This reluctance to bill might reflect the impact of some recent court cases, cited by our payer participants, where health plans were penalized for assigning too much financial responsibility to patients. Their conclusion in terms of this particular code seems to have been, "It depends."

In this case, it seems, providers and health plans do see the 835 differently, and for good reason. And though it is most clearly illustrated in CARC 31, it is more than likely that this reluctance to assign PR shows up in other results as well.

CARC-specific Agreement Between Respondents				
31 Claim denied as patient cannot be identified as our insured.	**CO**	**PI**	**PR**	**OA**
Health Plan	2	3	3	0
Provider	3	4	16	2
Provider SW Vendor & Other	0	0	2	0

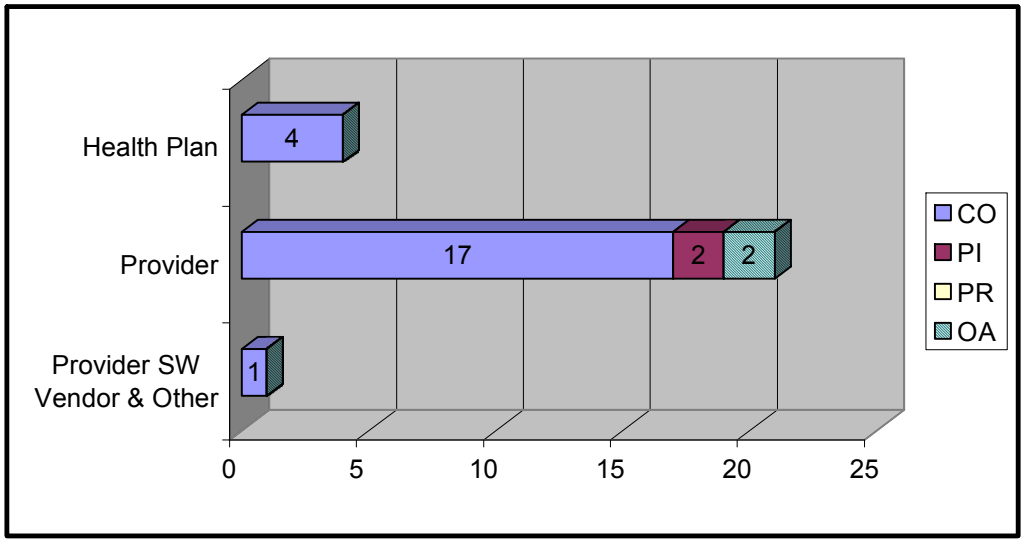


Percentage Chart: Color alignment indicates degree of agreement.

Restoring the Balance with CARC 131

Providers and health plans got back on track with CARC 131 "Claim specific negotiated discount." Not only did they agree with each other, they seem to have agreed with themselves, as almost everyone appears to have voted only once. The Counts chart demonstrates this best.

CARC-specific Counts by Respondent Type				
131 Claim specific negotiated discount.	**CO**	**PI**	**PR**	**OA**
Health Plan	4	0	0	0
Provider	17	2	0	2
Provider SW Vendor & Other	1	0	0	0



Numeric Chart: Segment size indicates total response volume.

Charting Your Own Course

In this chapter we've provided a few charts which we feel demonstrate some recurring themes in the overall survey results. It would be impractical to present all 163 CARCs in a single paper. Instead, we opted to provide the worksheets that generated these charts available for use by all interested parties. The Counts by Respondent Type charts can be generated using the spreadsheet CARCMatrixbyOrgType.xls. The Agreement Between Respondents charts can be generated using CARCMatrixbyAgreement.xls. A simple drop-down list lets you choose the CARC you are interested in and instantly display the results, which can then be printed or copied. Both files include How-To instructions.

Look for links to these files on either the WEDI SNIP Work Products page (http://www.wedi.org/snip/public/articles/index%7E3.shtml) or the WPC Claims Adjustment Reason Codes page (http://www.wpc-edi.com/codes/claimadjustment). NOTE: Login may be required prior to access.

Discussion and Implications

Team Discussion

We discussed these issues on the conference calls that took place before and after the survey, as well as via email and personal phone calls. More team feedback can be found in the section, *Bonus Question Responses* on p. 38.

Does the Group Code matter?

At least two providers raised the concept of ignoring the Group Code altogether. Why not simply post the payment based on the CARC alone? Further discussion revealed a couple of problems with this approach:

- Secondary claims are supposed to contain the original adjudication information. If the primary payer did not code PRs and other adjustments properly, it could affect reimbursement from the secondary payer. (Though, it must be acknowledged, some secondary payers do not look at the primary payer's adjustments.)
- Some providers may "correct" the original payer's Group Codes before passing along the adjustments in the secondary claim. This may raise legal concerns. At any rate, it is not possible in the case of payer-to-payer COB.
- Finally, there is the matter of the patient's understanding. If the patient's EOB indicates that the claim was adjusted by contractual obligation, but the provider's interpretation is that the amount is a patient responsibility, it may very well trigger disputes and poor relations between all parties.

Notable Insights

Discussions brought out useful insights into the processing of remittances in general and the coding of the 835 in particular:

- The sequence of steps in determining the Group Code is critical. The rules say the first step is to determine if the amount is a patient responsibility. If so, assign PR and stop. It is of no matter that this responsibility may be documented in a contract.
- Likewise, the rules for assigning Contractual Obligations are specific and narrow – at least in terms of how CO is currently being utilized. The existence of language in a payer/provider contract specifying patient responsibility does not make a PR adjustment into a CO. Likewise, the existence of other contracts outside the provider/payer relationship does not automatically turn a payer-designated adjustment into an obligatory CO write-off for the provider. Some scrutiny needs to be applied to different codes and different situations to determine whether such an adjustment should fall into the PR, PI or OA group.
- Not all Contractual Obligations involve a written contract. For instance, accepting a referral from a Primary Care Provider may signify an implied contract with a non-participating payer.

- As previously noted, Health Plans are cautious when assigning Patient Responsibility. More guidance may need to be given to protect payers in such decisions. The legal and financial implications of this reluctance—and the deleterious effect it may have on provider automation—must not be underestimated. At the very least, when adjustments for which the patient is truly responsible are assigned other group codes, additional manual processing may be required to sort out the issue. In the worst case, billable amounts may be blindly written off, creating negative return on investment (ROI) from a process that is supposed to save costs for all participants.

- Additional guidance is offered in the 4050 version of the X12 implementation guide. Much of this can be instructive when using the 4010A1, without violating the language in the current standard. (The 4050 guide can be downloaded for a nominal fee from Washington Publishing Company at www.wpc-edi.com).

Points of View

Opinions matter, and our respondents had a few.

- One provider commented on a number of CARCs that she believes are frequently coded improperly. She felt that codes 4-16, for example, should never be CO. If they come in as CO, then the common procedure would be to write them off, whereas the thing most providers would do would be to determine the cause of the error and rebill. She thinks that CO is overused. She made a definitive statement to this effect: "If providers can correct & resubmit, it should not be a CO."

- One participant summarized the use of Payer Initiated and Other Adjustment Groups this way: "Use PI to adjust when there is no actual or implied contract and PR does not fit. Use OA when other language does not fit. There may also be a need to use OA when bundling or unbundling charges.

- Two participants, including a WG3 Co-Chair, said PI should be used for coding errors. The claim may then be researched, corrected, rebilled, billed to pat or written off, as appropriate. There was a general consensus about this on the conference call (not all participants were on this call), though some expressed concern that patients see these and may not understand.

- One provider reported an additional problem that occurred in CO adjustments on secondary claims. Often, the secondary payer would send a CO amount that included the balance that had already been paid by the primary payer. Providers using cash accounting could not post such numbers to their systems. One of the WG3 Co-Chairs recommended that payers code such adjustments as OA, using CARC 23 "Payment adjusted because charges have been paid by another payer."

"Solvable" Issues

There was broad consensus that much progress could be made by defining and adopting voluntary guidelines that could be used with the existing 4010A1 standard. Bringing consistency to the usage would benefit providers by simplifying the autoposting process and reducing the need for follow ups. This would then benefit payers by making it easier to recruit providers to use the transaction, while simultaneously reducing followup calls, faxes and letters to explain coding that did not make sense to the recipient.

Specific areas that could be addressed include:

- Consensus guidelines for coding "technical" denials. The team made the recommendation that such denials be coded as PI. It's possible that a case might be made for use of OA in certain circumstances, but this was outside the scope of our discussion.

- Evaluating the entire codeset from the perspective of "backend" processing. Which code combinations facilitate autoposting and secondary billing? Which combinations will trigger a followup call to the payer? Expressing the information in this manner will help submitters see the costs and consequences of certain edits and encourage voluntary remediation better than a list of Thou Shalts or Dos and Don'ts.

- It is a generally accepted principle of EDI exchange that underlying the value and usefulness of the transaction is the automation of the recipient's business processes. If recipients cannot reliably automate, they will continue to rely on paper rather than adopt EDI. If the submitter cannot find enough willing trading partners, they will also be unable to achieve ROI. Therefore, it is in both parties' best interest for the recipients to examine their own processes and see how the transaction might accommodate them. Accordingly, the team consensus was that these guidelines should be created by providers, then refined in collaboration with payers and vendors, and that their adoption should be voluntary.

One Unsolvable Problem in the 4010A1

A fundamental problem that the team could not consider or address was that of the Corrections and Reversals (CR) Group Code. When a CR group code is used to report a previously adjudicated claim, the recipient does not necessarily know whether to apply it to a prior PR, CO, OA, or PI adjustment. The Final version of the 5010 Health Care Claim Payment/Advice 835 Technical Report 3 elegantly addresses this by eliminating the use of the CR group code altogether; reversals are now indicated by CLP02 = 22 and then simply changing the sign on the amount (i.e. positive to negative) and associating it with the original CARC and Group Code.

Reviewer Observations

Reviewers of this document submitted several additional concerns and observations.

- Some of the observed "inconsistency" may be due to variations in payer models. The special circumstances presented by Medicaid and other safety net health plans are a case in point. This part of the health community needs to be represented in any serious discussion, and their unique requirements need to be taken into consideration by all trading partners when it comes to establishing either strict edits or voluntary guidelines.

- The PI Group Code is felt to be overused. When liability can be assigned to the patient, PR should be used to facilitate automation of the provider's posting process. This is consistent with the usage defined in the implementation guide.

- The OA Group Code should be used in the context of secondary claims processing to account for a prior payer's adjudication. Instructions for this purpose can be found in later versions of the 835 Implementation Guides that are consistent with 4010A1.

- There are many additional issues that need to be addressed to enhance automation of the remittance process. Providers' adoption rates will remain low until they can reliably

post the contents of the 835s they receive; Payers will not achieve full ROI until they can boost their own rates while minimizing any impact on their provider relations operations.

- Payers who wish to minimize their own costs should re-examine the crosswalks between their proprietary remittance codes and their 835 codes. Payers who do not take advantage of the Remark Code segment should reconsider. They may find that adding this layer of detail increases their own rate of provider adoption, as providers see this information as a key factor in understanding the adjustments that have been applied.

- If an 835 was simple enough and consistent enough to encourage small provider adoption, the entire industry would benefit.

Bonus Question Responses

What would you most like your trading partners to know about your own challenges in implementing this transaction?
Different reasons as to why accounts adjusted, rejected, or partially paid will make automated noting at time of payment posting difficult. Ability to make automated work list to different responsible workers will be a major challenge because of no codes to replace visual of paper remit.
We need to have it standard, then we can automate our actions. Be specific as possible. Some of these codes are redundant or confusing. We will provide specific comments to the WG.
The providers you are encountering now are the technology leaders. It's important to understand their processes if you wish to expand the use of the 835 to your less tech-savvy providers. Modifying your own processes and edits to increase the ability of recipients to autopost the results will be the best way to reduce your own costs.
Every payer has mapped group codes to reason codes differently requiring special programming for each payer. It would help if payers used Remark Codes, which need to be systematically linked to the reason code.
The over use of the Group Code OA by some trading partners (payers) and the non usage of the Claim Adjustment Remark Codes, leaves providers with a ton of extra research to do in order to determine how to process the claims. Most of the time this means phone calls or pulling paper remits with the old proprietary remark codes to see what to do.
Trading partners expect a compliant and balanced 837, we as providers expect a compliant and balanced 835. A lot more time is spent to process a claim because of the general usage of reason codes without a more descriptive remarks code used. This causes us to look at the proprietary paper remittance advice or phone calls
Consistency in use among the payors would allow us to ensure accurate postings.
When not the primary payor, please report the amount of contractual obligation (CO) as per contract when secondary payor. Currently, secondary payors are only reporting the primary payor's CO which throws the account into a credit balance since primary CO already posted when payment rec'd. This requires manual correction. To post correctly, we need the secondary CO reported on 835 with group code "CO".
1) Need EFT 2) Need FTP for file transfers 3) Need Remittance Advice Remark Codes 4) If using PI or OA - unclear who is responsible for balance - prefer only CO or PR
The biggest challenge has been accurately crosswalking these codes to our proprietary

What would you most like your trading partners to know about your own challenges in implementing this transaction?
codes. It would be helpful if the group codes were based on the expected action by the provider. e.g. write off, appeal/rebill, bill patient, reverse, no action needed due to this processing.
The CO code should only be used when reporting Contractual Adjustment we are expected to take from that payer. If they are telling us the Primary payer's adjustment amount, then they need to use OA. Other than this example, reason codes should only be used with one group code. Payers should focus more on providing the correct Reason Codes, instead of using generic codes like 96. A lot of times, their paper remits show (their own proprietary) more detailed code (thereby proving they really can provide more detail than "Not Covered").
That the codes can fall into different categorical responsibilities depending on the situation surrounding the denial.
If payers could be consistent in the way they use adjustment codes, our hospital's 835 processing would really improve and our problems would decrease. It would be helpful if payers would consistently use the contracted/non-contracted adjustment codes. Last but not least, remember all adjustments are not contractual adjustments.
We need the payers to use the most up-to-date code lists and use Remark codes and fully disclose their internal crossmapping. We also need them to tell us what fee schedule they are using in the appropriate segment in the 835.
That when they put OA or PI on an adjustment it is unclear if we should bill the patient. Remark codes are very helpful to eliminate follow up calls. Need EFT.
CO group code continuously used inappropriately for provider posting to AR. No group code exists for items being returned. For the most part we would want to correct the claim and rebill. Most payers are ready with 835 [which] totally interrupts the entire flow. We can't move on to COB billing until most payers are ready with 835 -- too much manual data capture required. No consistency in the way payers are assigning these codes. All need to be on same page.
We are mapping hundreds of proprietary disallow codes to the ANSI equivalent, and there isn't always a clean 1:1 match. Many codes could be provider or patient liability depending upon circumstances (par or nonpar, referral, tiered benefits, etc.) list.
About secondary billing. Most secondaries, including Medicare, automatically consider based on what we send as PR figures and what is and isn't CO. However, some items sent to us as Contractual Obligation are NOT under a contract, in particular to deductibles, which affects the amount we get paid. I proposed a new group code, 'CX', that only submitters (837) should be able to use on the COB in order to protest a group code sent as CO, so the secondary knows that a contract does NOT exist with the

What would you most like your trading partners to know about your own challenges in implementing this transaction?
provider and should consider the full unpaid amount.
Some reason codes are too vague, and the remark codes used with them are also vague. We end up calling the payer. Payers do not use the reason/remark codes consistently or they do not use a code that correctly fits the denial. We end up calling the payer.

Appendix 1: Goal and Purpose Document

This document was distributed to the volunteers and discussed on our first conference call:

Goal and purpose:

The goal of this volunteer group is to come up with guidelines of how the group codes (found in the 835 4010 A1) and the Adjustment reason codes should be used together. Also how they should not be used i.e.: CO 1 or PR 45

This is not a requirement or an enforceable list. This is meant to help payers map their proprietary codes in a more user friendly manner.

The goal of the 835 transaction is to promote and support the auto posting of the remittance data at the provider site. Providing this listing and general understanding document is meant to help achieve this goal across the industry.

Scope of the Effort

Our focus will be on helping people implement this transaction as it exists today. For this reason, we are limiting our attention to the use of the existing 835 transaction (version 4010A1) and the current code sets. See www.wpc-edi.com to download. Issues related to changing the structure of the transaction or adding new codes may be addressed through appropriate venues, such as X12, the Code Set Committee, and/or the DSMO process. We encourage your active participation in that process!

Group codes:

The Claim Adjustment Group Code, CAS01, categorizes the adjustment reason codes that are contained in a particular CAS. The Claim Adjustment Group Codes are evaluated according to the following order:

1. Is the amount adjusted in this segment the patient's responsibility?

Use code **PR - Patient Responsibility.**

2. Is the amount adjusted not the patient's responsibility under any circumstances due to either a contractual obligation between the provider and the payer or a regulatory requirement?

Use code **CO - Contractual Obligation.**

An example of a contractual obligation might be a Participating Provider Agreement.

3. In the payer's opinion, is the amount in this segment not the responsibility of the patient, without a supporting contract between the provider and the payer?

Use code **PI - Payer Initiated.**

4. Is this claim the reversal of a previously reported claim or claim payment, indicated by Claim Status Code = 22, Reversal of Previous Payment?

Use code **CR - Correction and Reversals.**

5. If no other category is appropriate, do the following:

Use code **OA - Other Adjustment.**

Avoid using the Other Adjustment Group Code (OA) except for business situations described in sections 1.10.2.6, 1.10.2.7 and 1.10.2.13.

"005010X221 • 835 ASC X12N • INSURANCE SUBCOMMITTEE HEALTH CARE CLAIM PAYMENT/ADVICE TECHNICAL REPORT • TYPE 3"

Further defined usage

PR - Patient Responsibility – Used to report the amount the payer feels is the patients responsibility. NOTE: due to litigation etc payers may be very cautious with the use of this group code and only provide it if they are absolutely sure the amount can be billed to the patient.

CO - Contractual Obligation- This is generally used when there is a written contract or implied contractual relationship which effected the payment of the service. (Implied contract – If you were referred to by a PCP payer may assume an implied contract)

PI - Payer Initiated. – Payer initiated is an adjustment that could be used when there is no definite contract language that applied to the claim and the patient does not appear to be responsible for the amount.

CR - Correction and Reversals – This can be any adjustment reason code this always indicates the backing out of previously sent data.

OA - Other Adjustment – Most payers use this as a catch all if no others fit **however** that is **not** the intent of this code. This code is not advised for any other situations but those found in the front matter of the 835 implementation guide. This code if used with a vague adjustment reason code is sure to generate a phone call.

Review of this matrix with a group of payers and providers will help us to guide the industry to safer and more effective practices around the use of the 835.

A CARC worksheet file was attached to the message.

Appendix 2: Worksheet Files

The worksheet files used to generate the charts are embedded in this document. For the two break-down charts, follow the instructions on the How-To tab to generate charts for items of interest.


CARCMatrixTotals.xls


CARCMatrixbyOrgType.xls


CARCMatrixbyAgreement.xls

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