"HIPAA 835 Claims Adjustment Reason Code/Group Code"

OVERVIEW

The Health Insurance Portability and Accountability Act proposed, in part, to standardize and privatize the electronic exchange of information between providers and payers. The ASC X12N 835 Health Care Payment/Advice (Remittance Advice) transaction was adopted by HIPAA to be the standard communication tool for reporting payments, adjustments, and patient responsibility. Intuitively, one would expect that healthcare providers would be able to program their systems one time to process payments from all payers from whom they receive electronic files.

However, implementation of the ASC X12 835 transactions have 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 follow-up, faulty electronic secondary billing, inappropriate write-offs of billable charges, and incorrect billing of patients for co-pays and deductibles. The net effect can be reluctance on the part of providers to employ the 835, reducing ROI for payers and providers alike. In addition, lack of implementation standards for Health Savings Accounts (HSA) will bring another level of confusion. Without direction, each HSA implementation will be different, thus eliminating the capability to implement a standard solution. This is seen as a subversion of one of the major purposes of the HIPAA legislation.

The Workgroup for Electronic Data Interchange or WEDI (www.wedi.org) Business Issues sub-workgroup has collected examples of miscoding and the affect on health industry business practice. In a worst case example, a payer has sent transactions with CARC=1 ("Deductible amount" matched with a Group Code of CO (Contractual Obligation) rather than the seemingly obvious PR (Patient Responsibility). To a provider, CO means "write this off" and PR means "bill the patient or secondary insurer." If the provider has relied only on the Group Code, they would be writing off cash receivables, which could ultimately result in increased charges. Examples of the opposite situation have also been seen. These are cases in which the payer has reported the CO (Contractual Obligation) as PR (Patient Responsibility). This scenario can result and has resulted in patients being billed for amounts that providers should have written off in accordance with their contract.

Perhaps the most clear cut example of the difficulties payers are having with implementing the standards is an insurance company merger that results in one insurer operating several different claims adjudication systems. ASC X12 835 files sent from this insurer each have different interpretations of how CARCs and Group Codes are matched. This results in providers having to program multiple times to process payments from one insurance company. Each variation of these programs can cost the provider between $3,000.00 and $5,000.00. Multiplied over the number of healthcare providers in the United States, this would cause severe inflation in healthcare costs from legislation that was designed to do just the opposite.

WEDI and ASC have conducted a survey of healthcare providers and insurance companies further documenting the confusion that exists in the industry over the proper use of CARCs and Group Codes.

AAHAM POSITION

In light of the documentation of over billings, under billings and escalating costs in the healthcare industry, we would recommend the creation of a designated "Standards and Practice Committee" whose purpose would be to review and certify the matching of CARCs and Group Codes of all payers' ASC X12 835 files to ensure that they are correct. This committee should be composed of payer and provider representatives who are members of WEDI and ASC X12. The committee could publish a recommended code set with which all payers would need to comply. In this way, healthcare providers and the public can be assured that payments, adjustments, and patient liability amounts posted to patients' bills will be correct and consistent across all trading partners in the healthcare industry. In fact, WEDI is in the process of forming an 835 Special Interest Group (835 SIG) to work on coding as well as other issues with the ASC X12 835 file. This committee is composed of several subgroups: Financial Subgroup, Codes Subgroup, Policy Subgroup, Technical Subgroup, Education Subgroup, and ROI Subgroup.

While it is beyond AAHAM's purview to know exactly how the Practice and Standards Committee can be established, it would seem reasonable to conclude that the HIPAA legislation could be amended to command the creation of such a Committee or designate the outcome of the WEDI process to be adopted by all entities covered under HIPAA.

ABOUT AAHAM

The American Association of Healthcare Administrative Management (AAHAM) is the premier professional organization for patient financial services professionals. Founded in 1968, to serve the interests of hospital patient account managers, AAHAM has evolved into a national membership association that represents a broad-based constituency of healthcare professionals.

Professional development of its members is one of the primary goals of the association. Publications, conferences and seminars, benchmarking, professional certification and networking offer numerous opportunities for increasing the skills and knowledge that are necessary to function effectively in today's healthcare environment. AAHAM actively represents the interests of healthcare administrative management professionals through a comprehensive program of legislative and regulatory monitoring and its participation in industry groups such as WEDI, X12, DISA, and NUBC.

AAHAM comprises thirty-eight chapters in twenty-seven states, with a total membership of 2,560 healthcare professionals. Our members direct the activities of the thousands of people who are employed in the healthcare industry, in hospitals, doctors' offices and allied vendors.

AAHAM
Sharon R. Galler, CMP, Executive Director
11240 Waples Mill Road - Suite 200
Fairfax VA 22030
703/281-4043
www.aaham.org