BENEFITS AND IMPACT OF UPDATES TO THE HIPAA 837 AND 835 TRANSACTION STANDARDS

Introduction and Background

WEDI, a multistakeholder, non-profit organization named in HIPAA as an advisor to the U.S. Department of Health and Human Services, is conducting a survey to determine the impact recommended updates to X12 administrative transactions would have on the health care system.

Considering there have been no changes to the X12 standard (v.5010) in over ten years, we seek to better understand difficulties arising from any gaps in the current standard, and which shortcomings would be resolved by upgrading the transactions as recommended by X12. The following survey will ask you to rate the potential business value of the features within the next version of selected X12 standards to your organization (X12 has recommended version 008020 to be considered for adoption for HIPAA) and to your constituency (clients, users, or members). Business value should be considered as the extent to which the changes will improve your revenue cycle management/adjudication processes. We are also asking that you estimate the effort required to implement these changes and encourage you to provide additional feedback in the open comments box following each question.

NOTE: The identification of potential benefits was identified by WEDI, not by X12 or any other organization.

The survey is related to the following Implementation Guides:

X12 005010X221 Health Care Claim Payment/Advice (835)

X12 005010X222 Health Care Claim: Professional (837P)(837)

X12 005010X223 Health Care Claim: Institutional (837I)(837)

X12 005010X224 Health Care Claim: Dental (837D)(837)

(see https://x12.org/news-and-events/letter-to-ncvhs-set-1 for the specific recommendations made to the National Committee for Vital and Health Statistics by X12)

Please forward this survey to a colleague or trading partner if you are not the appropriate person within your organization to answer the questions, and to other trading partners or organizations that could also complete the survey.

The questions should take approximately 20 minutes to complete. No individual identifiable information is collected in the survey, so responses are completely anonymous. We ask that one person consolidates the responses on behalf of their organization. The data being collected is for informational purposes only. We appreciate your feedback. If you have any questions about the survey, please submit to apoole@wedi.org. This survey will close June 30, 2024.

BENEFITS AND IMPACT OF UPDATES TO THE HIPAA 837 AND 835 TRANSACTION STANDARDS

STAKEHOLDER QUESTION:

* 1. Which of the following best identifies the type of organization you represent? Choose one. If your organization conducts functions of more than one category below, please complete the survey separately for each function. For example, a payer that has a clearinghouse should complete the survey twice, answering for the payer and the clearinghouse separately.

- ◯ Provider
- ◯ Payer
- ◯ Clearinghouse
- ◯ Vendor

BENEFITS AND IMPACT OF UPDATES TO THE HIPAA 837 AND 835 TRANSACTION STANDARDS

PROVIDER QUESTIONS:

2. What type of provider are you?

- ◯ Hospital (single location)
- ◯ Health system (multiple facilities and locations)
- ◯ Group practice (more than one clinician or specialty)
- ◯ Single clinician practice
- ◯ Ambulatory surgery center
- ◯ Skilled nursing facility
- ◯ Home health agency
- ◯ Other inpatient facility
- ◯ Other (please describe)

3. What are your approximate yearly billing charges?

- ◯ Small - Less than $5,000,000
- ◯ Medium - $5,000,001 – 50,000,000
- ◯ Large – Greater than $50,000,000

4. What transactions does your organization conduct?

- ◯ 837 only
- ◯ 835 only
- ◯ Both

BENEFITS AND IMPACT OF UPDATES TO THE HIPAA 837 AND 835 TRANSACTION STANDARDS

PAYER QUESTIONS

5. What type of payer are you?

- [ ] Private/commercial payer
- [ ] Medicare
- [ ] Medicaid
- [ ] Federal program other than Medicare or Medicaid
- [ ] Workers' compensation, property and casualty, or auto insurance payer
- [ ] Other (please describe)

6. Number of covered lives?

- ◯ Less than 1 million
- ◯ 1 million up to 5 million
- ◯ 5 million up to 10 million
- ◯ 10 million up to 25 million
- ◯ Greater than 25 million

7. What transactions does your organization conduct?

- ◯ 837 only
- ◯ 835 only
- ◯ Both

BENEFITS AND IMPACT OF UPDATES TO THE HIPAA 837 AND 835 TRANSACTION STANDARDS

CLEARINGHOUSE QUESTIONS:

8. What is your annual gross revenue?

- ◯ Small (Gross Revenue less than $10M)
- ◯ Medium (Gross Revenue $10M to $50M)
- ◯ Large (Gross Revenue $50M to $100M)
- ◯ XL (Gross Revenue $100M+)

9. What transactions does your organization conduct?

- ◯ 837 only
- ◯ 835 only
- ◯ Both

BENEFITS AND IMPACT OF UPDATES TO THE HIPAA 837 AND 835 TRANSACTION STANDARDS

VENDOR QUESTIONS:

10. What type of vendor are you?

- [ ] Electronic payment vendor
- [ ] Practice Management System Vendor
- [ ] Electronic Health Records Vendor
- [ ] Data Analytics Vendor
- [ ] Other

11. What is your footprint in the market?

- ◯ State
- ◯ Regional (multiple states)
- ◯ National

12. What transactions does your organization conduct?

- ◯ 837 only
- ◯ 835 only
- ◯ Both

BENEFITS AND IMPACT OF UPDATES TO THE HIPAA 837 AND 835 TRANSACTION STANDARDS

BOTH 835 & 837 QUESTIONS

When implementing the specific new features below, what is the perceived benefit to your constituency from your organization's point of view?

13. More code sets will be maintained external to the TR3. Several code lists were built into the TR3 and could only be changed with a new version. These code sets are now external to the guides and can be updated as necessary.

- ◯ 1-Not beneficial
- ◯ 2- Slightly beneficial
- ◯ 3- Somewhat beneficial
- ◯ 4 – Moderately beneficial
- ◯ 5 -Highly beneficial
- ◯ Need More Information
- ◯ Abstain

Comment

14. In prior version, the predeterminiation/preadjudication function was a separate guide and not supported in the claims guide. Now, the ability to prepare a predetermination request is part of the claims guide which could assist the industry with generating good faith estimates

- ◯ 1- Not beneficial
- ◯ 2- Slightly beneficial
- ◯ 3- Somewhat beneficial
- ◯ 4- Moderately beneficial
- ◯ 5- Highly beneficial
- ◯ Need More Information
- ◯ Abstain

Comment

15. Real-time adjudication – the guides have been updated with more detailed instructions on how to perform real-time submission of claims and creation of a remittance advice supporting the real-time adjudication results. It is hoped that this will spur more real-time use.

- ◯ 1-Not beneficial
- ◯ 2- Slightly beneficial
- ◯ 3- Somewhat beneficial
- ◯ 4 – Moderately beneficial
- ◯ 5 -Highly beneficial
- ◯ Need More Information
- ◯ Abstain

Comment

16. Allowed Amount has changed in both the 837 and 835 TR3s. In the 837, for Coordination of Benefits (COB) situations, a new segment (Claim Allowed Amount) will report the claim allowed amount, which is required when the other payer has adjudicated the claim or the other payer has issued a paper, electronic or proprietary format remittance advice with the allowed amount reported. In the 835, the allowed amount is now always required.

- ◯ 1-Not beneficial
- ◯ 2- Slightly beneficial
- ◯ 3- Somewhat beneficial
- ◯ 4 -Moderately beneficial
- ◯ 5 -Highly beneficial
- ◯ Need More Information
- ◯ Abstain

Comment

17. A new claim and service adjustment information segment (RAS) has replaced the adjustment segment (CAS) in both the 837 and 835. This new segment allows the transactions to supply all Claim Adjustment Reason Codes (CARC) along with associated Remark Codes related to a specific adjustment amount. This adjustment information is intended to help the provider reconcile the remittance information to the payment and to provide all adjustments and associated Remark Codes at one time. Adjustment amounts must fully explain the difference between submitted charges and the amount paid.

- ◯ 1-Not beneficial
- ◯ 2- Slightly beneficial
- ◯ 3- Somewhat beneficial
- ◯ 4 – Moderately beneficial
- ◯ 5 -Highly beneficial
- ◯ Need More Information
- ◯ Abstain

Comment

18. For the claim, added ability to send the original National Drug Code (NDC) when a drug has been repacked. Added clarifying note on what billing unit to report in CTP05-01. In 837P added SV4 and SV7 segments for sending additional prescription information (e.g., Dispense as Written (DAW) or Compound Indicator) and Drug Utilization Review information.

- ◯ 1-Not beneficial
- ◯ 2- Slightly beneficial
- ◯ 3- Somewhat beneficial
- ◯ 4 – Moderately beneficial
- ◯ 5 -Highly beneficial
- ◯ Need More Information
- ◯ Abstain

Comment

19. For the claim, added new fields for diagnosis codes 13-24. In the 837P a new repeat of the Health Information (HI) segment (Health Care Diagnosis Code) increased the maximum number of codes able to be sent on a single claim from 12 to 24. In Version 8040 and later this was changed to allow a maximum of 99 diagnosis codes on the 837P claim.

- ◯ 1-Not beneficial
- ◯ 2- Slightly beneficial
- ◯ 3- Somewhat beneficial
- ◯ 4 – Moderately beneficial
- ◯ 5 -Highly beneficial
- ◯ Need More Information
- ◯ Abstain

Comment

20. Multiple minor format changes to address industry needs such as field length, repetitions, and updated qualifiers to accommodate industry needs. A number of field lengths, data element repeats, and segment repeats were modified in the Standard. In some cases, the segment repeats were modified in the TR3 based upon usage or the qualifiers used.

- ◯ 1-Not beneficial
- ◯ 2- Slightly beneficial
- ◯ 3- Somewhat beneficial
- ◯ 4 – Moderately beneficial
- ◯ 5 -Highly beneficial
- ◯ Need More Information
- ◯ Abstain

Comment

21. Multiple segment and element usage changes.
Examples in the 837s:
SV1 – additional procedure modifiers were added, additional diagnosis code pointers were added
SV4 Drug Service – added to 837P
SV7 Drug Adjudication – added to 837P
TOO Tooth Information – added to 837P moved from K3 segment
Examples in the 835:
Provider REF TIN is required
SVC05 units are required
AMT allowed amount is required
REF Original Claim Information is situationally required.

- 1-Not beneficial
- 2- Slightly beneficial
- 3- Somewhat beneficial
- 4 – Moderately beneficial
- 5 -Highly beneficial
- Need More Information
- Abstain

Comment

22. In both the 837 and 835, the remark code (LQ) segment is now at both the claim and service level to allow remark codes to be sent that are not associated with a specific CARC. The remark codes were removed from the MIA and MOA segments.

- 1-Not beneficial
- 2- Slightly beneficial
- 3- Somewhat beneficial
- 4 – Moderately beneficial
- 5 -Highly beneficial
- Need More Information
- Abstain

Comment

23. A new remark code list, the Insurance Industry Specific Remark Code (external code list), was added. This new list is used in both the 837 and 835 transactions in the RAS and LQ segments to provide more specific remark codes for specific industry segments like Property & Casualty or dental.

- ◯ 1-Not beneficial
- ◯ 2- Slightly beneficial
- ◯ 3- Somewhat beneficial
- ◯ 4 – Moderately beneficial
- ◯ 5 -Highly beneficial
- ◯ Need More Information
- ◯ Abstain

Comment

24. Both the 837 and 835 include modifications to allow for the sending of the Device identifier section of the Unique Device Identifier for high-risk implantable devices.

- ◯ 1-Not beneficial
- ◯ 2- Slightly beneficial
- ◯ 3- Somewhat beneficial
- ◯ 4 – Moderately beneficial
- ◯ 5 -Highly beneficial
- ◯ Need More Information
- ◯ Abstain

Comment

25. The 835 added the ability to report payments made via a Virtual Credit Card.

- ◯ 1-Not beneficial
- ◯ 2- Slightly beneficial
- ◯ 3- Somewhat beneficial
- ◯ 4 – Moderately beneficial
- ◯ 5 -Highly beneficial
- ◯ Need More Information
- ◯ Abstain

Comment

26. The 835 adds the ability to report invalid procedure codes in the SVC segment, for situations where those invalid procedure codes were sent on the original claim and must be reflected in the 835.

- ◯ 1-Not beneficial
- ◯ 2- Slightly beneficial
- ◯ 3- Somewhat beneficial
- ◯ 4 – Moderately beneficial
- ◯ 5 -Highly beneficial
- ◯ Need More Information
- ◯ Abstain

Comment

27. The 835 updates the requirements for reporting the patient liability amount (CLP05) and the balancing required for patient liability amount.

- ◯ 1-Not beneficial
- ◯ 2- Slightly beneficial
- ◯ 3- Somewhat beneficial
- ◯ 4 – Moderately beneficial
- ◯ 5 -Highly beneficial
- ◯ Need More Information
- ◯ Abstain

Comment

28. The 835 replaces the Claim Filing Indicator previously reported in CLP06 with the Source of Payment Typology Code (external list) to provide more granular information to the provider.

- ◯ 1-Not beneficial
- ◯ 2- Slightly beneficial
- ◯ 3- Somewhat beneficial
- ◯ 4 – Moderately beneficial
- ◯ 5 -Highly beneficial
- ◯ Need More Information
- ◯ Abstain

Comment

29. The 835 enhances DRG reporting to include all current DRG types.

- ◯ 1-Not beneficial
- ◯ 2- Slightly beneficial
- ◯ 3- Somewhat beneficial
- ◯ 4 – Moderately beneficial
- ◯ 5 -Highly beneficial
- ◯ Need More Information
- ◯ Abstain
- ◯ None of the above

Comment

30. The 835 adds a new loop for reporting multiple Corrected Priority Payers, along with the associated subscriber information.

- ◯ 1-Not beneficial
- ◯ 2- Slightly beneficial
- ◯ 3- Somewhat beneficial
- ◯ 4 – Moderately beneficial
- ◯ 5 -Highly beneficial
- ◯ Need More Information
- ◯ Abstain

Comment

31. The 835 updates the processes required for reversals and correction claims to include all information from the original claim on the reversal.

- ◯ 1-Not beneficial
- ◯ 2- Slightly beneficial
- ◯ 3- Somewhat beneficial
- ◯ 4 – Moderately beneficial
- ◯ 5 -Highly beneficial
- ◯ Need More Information
- ◯ Abstain

Comment

32. The 835 updates the processes required for the Overpayment Recovery and Forward Balance processes. In addition, Provider Level Adjustments were updated to allow reporting of these adjustments for specific claims, including instructions for reporting the Reference ID for those claims.

- ◯ 1-Not beneficial
- ◯ 2- Slightly beneficial
- ◯ 3- Somewhat beneficial
- ◯ 4 – Moderately beneficial
- ◯ 5 -Highly beneficial
- ◯ Need More Information
- ◯ Abstain

Comment

BENEFITS AND IMPACT OF UPDATES TO THE HIPAA 837 AND 835 TRANSACTION STANDARDS

837 ONLY QUESTIONS

When implementing the specific new features below, what is the perceived benefit to your constituency from your organization's point of view?

33. More code sets will be maintained external to the TR3. Several code lists were built into the TR3 and could only be changed with a new version. These code sets are now external to the guides and can be updated as necessary.

- ◯ 1-Not beneficial
- ◯ 2- Slightly beneficial
- ◯ 3- Somewhat beneficial
- ◯ 4 – Moderately beneficial
- ◯ 5 -Highly beneficial
- ◯ Need More Information
- ◯ Abstain

Comment

34. Real-time adjudication – the guides have been updated with more detailed instructions on how to perform real-time submission of claims and the creation of a remittance advice supporting the real-time adjudication results. It is hoped that this will spur more real-time use.

- ◯ 1-Not beneficial
- ◯ 2- Slightly beneficial
- ◯ 3- Somewhat beneficial
- ◯ 4 – Moderately beneficial
- ◯ 5 -Highly beneficial
- ◯ Need More Information
- ◯ Abstain
- ◯ None of the above

Comment

35. Allowed Amount has changed in the 837 TR3s. In the 837, for COB situations, a new segment (Claim Allowed Amount) will report the claim allowed amount, which is required when the other payer has adjudicated the claim or the other payer has issued a paper, electronic or proprietary format remittance advice with the allowed amount reported.

- ◯ 1-Not beneficial
- ◯ 2- Slightly beneficial
- ◯ 3- Somewhat beneficial
- ◯ 4 – Moderately beneficial
- ◯ 5 -Highly beneficial
- ◯ Need More Information
- ◯ Abstain

Comment

36. A new claim and service adjustment information segment (RAS) replaces the adjustment segment (CAS) in the 837s. This new segment allows the transactions to supply all Claim Adjustment Reason Codes (CARC) along with associated Remark Codes related to a specific adjustment amount. This adjustment information is intended to help the provider reconcile the remittance information to the payment and to provide all adjustments and associated remark codes at one time. Adjustment amounts must fully explain the difference between submitted charges and the amount paid.

- ◯ 1-Not beneficial
- ◯ 2- Slightly beneficial
- ◯ 3- Somewhat beneficial
- ◯ 4 – Moderately beneficial
- ◯ 5 -Highly beneficial
- ◯ Need More Information
- ◯ Abstain

Comment

37. For the claim, added ability to send the original NDC code when a drug has been repacked. Added clarifying note on what billing unit to report in CTP05-01. In 837P added SV4 and SV7 segments for sending additional prescription information (e.g., DAW or Compound Indicator) and Drug Utilization Review information.

- ◯ 1-Not beneficial
- ◯ 2- Slightly beneficial
- ◯ 3- Somewhat beneficial
- ◯ 4 – Moderately beneficial
- ◯ 5 -Highly beneficial
- ◯ Need More Information
- ◯ Abstain

Comment

38. For the claim, adds new fields for diagnosis codes 13-24. In the 837P a new repeat of the HI segment (Health Care Diagnosis Code) increased the maximum number of codes able to be sent on a single claim from 12 to 24. In Version 8040 and later this was changed to allow a maximum of 99 diagnosis codes on the 837P claim.

- ◯ 1-Not beneficial
- ◯ 2- Slightly beneficial
- ◯ 3- Somewhat beneficial
- ◯ 4 – Moderately beneficial
- ◯ 5 -Highly beneficial
- ◯ Need More Information
- ◯ Abstain

Comment

39. Multiple minor format changes to address industry needs such as field length, repetitions, and updated qualifiers to accommodate industry needs. A number of field lengths, data element repeats, and segment repeats were modified in the Standard. In some cases, the segment repeats were modified in the TR3 based upon usage or the qualifiers used.

- ◯ 1-Not beneficial
- ◯ 2- Slightly beneficial
- ◯ 3- Somewhat beneficial
- ◯ 4 – Moderately beneficial
- ◯ 5 -Highly beneficial
- ◯ Need More Information
- ◯ Abstain

Comment

40. The 837s include modifications to allow for the sending of the Device identifier section of the Unique Device Identifier for high-risk implantable devices.

- ◯ 1-Not beneficial
- ◯ 2- Slightly beneficial
- ◯ 3- Somewhat beneficial
- ◯ 4 – Moderately beneficial
- ◯ 5 -Highly beneficial
- ◯ Need More Information
- ◯ Abstain

Comment. {Please now skip to Section Two}

41. Multiple segment and element usage changes. Examples in the 837s:
SV1 – additional procedure modifiers were added, additional diagnosis code pointers were added
SV4 Drug Service – added to 837P
SV7 Drug Adjudication – added to 837P
TOO Tooth Information – added to 837P moved from K3 segment

- ◯ 1-Not beneficial
- ◯ 2- Slightly beneficial
- ◯ 3- Somewhat beneficial
- ◯ 4 – Moderately beneficial
- ◯ 5 -Highly beneficial
- ◯ Need More Information
- ◯ Abstain

Comment

42. In the 837s, the remark code (LQ) segment is now at both the claim and service level to allow remark codes to be sent that are not associated with a specific CARC. The remark codes were removed from the MIA and MOA segments.

- ◯ 1-Not beneficial
- ◯ 2- Slightly beneficial
- ◯ 3- Somewhat beneficial
- ◯ 4 – Moderately beneficial
- ◯ 5 -Highly beneficial
- ◯ Need More Information
- ◯ Abstain

Comment

43. A new remark code list, the Insurance Industry Specific Remark Code (external code list), was added. This new list is used in the 837 in the RAS and LQ segments to provide more specific remark codes for specific industry segments like Property & Casualty or dental.

- ◯ 1-Not beneficial
- ◯ 2- Slightly beneficial
- ◯ 3- Somewhat beneficial
- ◯ 4 – Moderately beneficial
- ◯ 5 -Highly beneficial
- ◯ Need More Information
- ◯ Abstain

Comment

BENEFITS AND IMPACT OF UPDATES TO THE HIPAA 837 AND 835 TRANSACTION STANDARDS

835 ONLY QUESTIONS

When implementing the specific new features below, what is the perceived benefit to your constituency from your organization's point of view?

44. More code sets will be maintained external to the TR3. Several code lists were built into the TR3 and could only be changed with a new version. These code sets are now external to the guides and can be updated as necessary.

- ◯ 1-Not beneficial
- ◯ 2- Slightly beneficial
- ◯ 3- Somewhat beneficial
- ◯ 4 – Moderately beneficial
- ◯ 5 -Highly beneficial
- ◯ Need More Information
- ◯ Abstain

Comment

45. Real-time adjudication – the guides have been updated with more detailed instructions on how to perform real-time submission of claims and the creation of a remittance advice supporting the real-time adjudication results. It is hoped that this will spur more real-time use.

- ◯ 1-Not beneficial
- ◯ 2- Slightly beneficial
- ◯ 3- Somewhat beneficial
- ◯ 4 – Moderately beneficial
- ◯ 5 -Highly beneficial
- ◯ Need More Information
- ◯ Abstain
- ◯ None of the above

Comments

46. Allowed Amount has changed in 835 TR3 to aways be required.

- ◯ 1-Not beneficial
- ◯ 2- Slightly beneficial
- ◯ 3- Somewhat beneficial
- ◯ 4 – Moderately beneficial
- ◯ 5 -Highly beneficial
- ◯ Need More Information
- ◯ Abstain

Comment

47. A new claim and service adjustment information segment (RAS) has replaced the claim adjustment segment (CAS) in the 835. This new segment allows the transactions to supply all Claim Adjustment Reason Codes (CARC) along with associated Remark Codes related to a specific adjustment amount. This adjustment information is intended to help the provider reconcile the remittance information to the payment and to provide all adjustments and associated remark codes at one time. Adjustment amounts must fully explain the difference between submitted charges and the amount paid.

- ◯ 1-Not beneficial
- ◯ 2- Slightly beneficial
- ◯ 3- Somewhat beneficial
- ◯ 4 – Moderately beneficial
- ◯ 5 -Highly beneficial
- ◯ Need More Information
- ◯ Abstain

Comment

48. Multiple minor format changes to address industry needs such as field length, repetitions, and updated qualifiers to accommodate industry needs. A number of field lengths, data element repeats, and segment repeats were modified in the Standard. In some cases, the segment repeats were modified in the TR3 based upon usage or the qualifiers used.

- ◯ 1-Not beneficial
- ◯ 2- Slightly beneficial
- ◯ 3- Somewhat beneficial
- ◯ 4 – Moderately beneficial
- ◯ 5 -Highly beneficial
- ◯ Need More Information
- ◯ Abstain

Comment

49. Multiple segment and element usage changes.
Examples in the 835:
Provider REF TIN is required
SVC05 units are required
AMT allowed amount is required
REF Original Claim Information is situationally required

- ◯ 1-Not beneficial
- ◯ 2- Slightly beneficial
- ◯ 3- Somewhat beneficial
- ◯ 4 – Moderately beneficial
- ◯ 5 -Highly beneficial
- ◯ Need More Information
- ◯ Abstain

Comment

50. In the 835, the remark code (LQ) segment is now at both the claim and service level to allow remark codes to be sent that are not associated with a specific CARC. The remark codes were removed from the MIA and MOA segments.

- ◯ 1-Not beneficial
- ◯ 2- Slightly beneficial
- ◯ 3- Somewhat beneficial
- ◯ 4 – Moderately beneficial
- ◯ 5 -Highly beneficial
- ◯ Need More Information
- ◯ Abstain

Comment

51. A new remark code list, the Insurance Industry Specific Remark Code (external code list), was added. This new list is used in the 835 transaction in the RAS and LQ segments to provide more specific remark codes for specific industry segments like Property & Casualty or dental.

- ◯ 1-Not beneficial
- ◯ 2- Slightly beneficial
- ◯ 3- Somewhat beneficial
- ◯ 4 – Moderately beneficial
- ◯ 5 -Highly beneficial
- ◯ Need More Information
- ◯ Abstain

Comment

52. The 835 includes modifications to allow for the sending of the Device identifier section of the Unique Device Identifier for high-risk implantable devices.

- ◯ 1-Not beneficial
- ◯ 2- Slightly beneficial
- ◯ 3- Somewhat beneficial
- ◯ 4 – Moderately beneficial
- ◯ 5 -Highly beneficial
- ◯ Need More Information
- ◯ Abstain

Comments

53. The 835 added the ability to report payments made via Virtual Credit Card.

- ◯ 1-Not beneficial
- ◯ 2- Slightly beneficial
- ◯ 3- Somewhat beneficial
- ◯ 4 – Moderately beneficial
- ◯ 5 -Highly beneficial
- ◯ Need More Information
- ◯ Abstain

Comment

54. The 835 updates the requirements for reporting the patient liability amount (CLP05) and the balancing required for patient liability amount.

- ◯ 1-Not beneficial
- ◯ 2- Slightly beneficial
- ◯ 3- Somewhat beneficial
- ◯ 4 – Moderately beneficial
- ◯ 5 -Highly beneficial
- ◯ Need More Information
- ◯ Abstain

Comment

55. The 835 replaces the Claim Filing Indicator previously reported in CLP06 with the Source of Payment Typology Code (external list) to provide more granular information to the provider.

- ◯ 1-Not beneficial
- ◯ 2- Slightly beneficial
- ◯ 3- Somewhat beneficial
- ◯ 4 – Moderately beneficial
- ◯ 5 -Highly beneficial
- ◯ Need More Information
- ◯ Abstain

Comment

56. The 835 enhances DRG reporting to include all current DRG types.

- ◯ 1-Not beneficial
- ◯ 2- Slightly beneficial
- ◯ 3- Somewhat beneficial
- ◯ 4 – Moderately beneficial
- ◯ 5 -Highly beneficial
- ◯ Need More Information
- ◯ Abstain

Comment

57. The 835 adds the ability to report invalid procedure codes in the SVC segment, for situations where those invalid procedure codes were sent on the original claim and must be reflected in the 835.

- ◯ 1-Not beneficial
- ◯ 2- Slightly beneficial
- ◯ 3- Somewhat beneficial
- ◯ 4 – Moderately beneficial
- ◯ 5 -Highly beneficial
- ◯ Need More Information
- ◯ Abstain

Comment

58. The 835 adds a new loop for reporting multiple Corrected Priority Payers, along with the associated subscriber information.

- ◯ 1-Not beneficial
- ◯ 2- Slightly beneficial
- ◯ 3- Somewhat beneficial
- ◯ 4 – Moderately beneficial
- ◯ 5 -Highly beneficial
- ◯ Need More Information
- ◯ Abstain

Comment

59. The 835 updates the processes required for reversals and correction claims to include all information from the original claim on the reversal.

- ◯ 1-Not beneficial
- ◯ 2- Slightly beneficial
- ◯ 3- Somewhat beneficial
- ◯ 4 – Moderately beneficial
- ◯ 5 -Highly beneficial
- ◯ Need More Information
- ◯ Abstain

Comment

60. The 835 updates the processes required for the Overpayment Recovery and Forward Balance processes.
In addition, Provider Level Adjustments were updated to allow reporting of these adjustments for specific claims, including instructions for reporting the Reference ID for those claims.

- ◯ 1-Not beneficial
- ◯ 2- Slightly beneficial
- ◯ 3- Somewhat beneficial
- ◯ 4 – Moderately beneficial
- ◯ 5 -Highly beneficial
- ◯ Need More Information
- ◯ Abstain

Comment

BENEFITS AND IMPACT OF UPDATES TO THE HIPAA 837 AND 835 TRANSACTION STANDARDS

SECTION TWO

From your (your organization's) perspective, when implementing new standards overall, what is the perceived disruption or value to your organization? Rank the effort (or cost, disruption) against the perceived value to the industry (return on investment)

61. Planning and analysis

- ◯ 1-High Cost with Low Perceived Value
- ◯ 2- Somewhat High Cost with Lower Perceived Value
- ◯ 3- Medium Cost with Moderate Perceived Value
- ◯ 4 – Somewhat Low Cost with Higher Perceived Value
- ◯ 5 – Low Cost with High Perceived Value

Comment

62. Development

- ◯ 1-High Cost with Low Perceived Value
- ◯ 2- Somewhat High Cost with Lower Perceived Value
- ◯ 3- Medium Cost with Moderate Perceived Value
- ◯ 4 – Somewhat Low Cost with Higher Perceived Value
- ◯ 5 – Low Cost with High Perceived Value

Comment

63. Testing (internal and external, end to end)

- ◯ 1-High Cost with Low Perceived Value
- ◯ 2- Somewhat High Cost with Lower Perceived Value
- ◯ 3- Medium Cost with Moderate Perceived Value
- ◯ 4 – Somewhat Low Cost with Higher Perceived Value
- ◯ 5 – Low Cost with High Perceived Value

Comment

64. Outreach and User Education

- ◯ 1-High Cost with Low Perceived Value
- ◯ 2- Somewhat High Cost with Lower Perceived Value
- ◯ 3- Medium Cost with Moderate Perceived Value
- ◯ 4 – Somewhat Low Cost with Higher Perceived Value
- ◯ 5 – Low Cost with High Perceived Value

Comment

65. Deployment

- ◯ 1-High Cost with Low Perceived Value
- ◯ 2- Somewhat High Cost with Lower Perceived Value
- ◯ 3- Medium Cost with Moderate Perceived Value
- ◯ 4 – Somewhat Low Cost with Higher Perceived Value
- ◯ 5 – Low Cost with High Perceived Value

Comment

66. Funding (for example, will you need to add staff, secure funding, or incur capital expense in order to meet the revised standard)

- ◯ 1-High Cost with Low Perceived Value
- ◯ 2- Somewhat High Cost with Lower Perceived Value
- ◯ 3- Medium Cost with Moderate Perceived Value
- ◯ 4 – Somewhat Low Cost with Higher Perceived Value
- ◯ 5 – Low Cost with High Perceived Value

Comment

67. Additional Staffing / Workload

- ◯ 1-High Cost with Low Perceived Value
- ◯ 2- Somewhat High Cost with Lower Perceived Value
- ◯ 3- Medium Cost with Moderate Perceived Value
- ◯ 4 – Somewhat Low Cost with Higher Perceived Value
- ◯ 5 – Low Cost with High Perceived Value

Comment

68. Opportunity costs forfeited in order to allocate resources to this implementation

- ◯ 1-High Cost with Low Perceived Value
- ◯ 2- Somewhat High Cost with Lower Perceived Value
- ◯ 3- Medium Cost with Moderate Perceived Value
- ◯ 4 – Somewhat Low Cost with Higher Perceived Value
- ◯ 5 – Low Cost with High Perceived Value

Comment

BENEFITS AND IMPACT OF UPDATES TO THE HIPAA 837 AND 835 TRANSACTION STANDARDS

CONCLUSION

* 69. For your partner organizations that do not process claims, but use claim data outside the adjudication process, what is the impact or benefit from these changes?
(Please encourage them to also complete the survey)

- ◯ 1- Low
- ◯ 2- Somewhat Low
- ◯ 3- Medium
- ◯ 4 – Somewhat High
- ◯ 5 – High

Comment

* 70. If your trading partners were able to accept the next version of transactions now, how long do you estimate it would it take your organization to implement changes?

- ◯ 6 months or less
- ◯ 1 year or less
- ◯ 2 years or less
- ◯ More than 2 years
- ◯ Abstain

Comment

* 71. Historically, CMS has mandated a single go-live deadline for a new transaction version. Because organizations work at different paces, this can force others with dependencies to wait to move to the next stage. For example, you may be ready to test but your partners aren't ready to receive test files. This method often results in everyone converging on the timeline at the same time, which can also result in the deadline being delayed. Would you prefer the industry identify certain interim milestones that will ensure everyone has access to the resources needed and can complete testing prior to the final deadline or would you prefer to keep the current model of a single final deadline?

- ◯ Interim milestones
- ◯ Single final deadline
- ◯ Abstain

Comment

72. Please provide any other information you would like to share about the benefits and impacts of updating the 837 and 835 transactions.

On behalf of WEDI, thank you for submitting your comments. If you have any questions or additional comments, please submit them to apoole@wedi.org.

Thank you for taking time to complete the survey. Click "Done" when you are finished.

Done