Committee on Operating Rules For Information Exchange (CORE®)

Is Your Organization Ready to Meet the New Expectations for Processing Transactions?

- An Open Mic with CMS OESS -

February 20, 2013
2:00 pm – 3:00 pm ET
Participating in Today’s Interactive Event

• Download a copy of today’s presentation
• The phones will be muted upon entry and during the presentation portion of the session
• At any time throughout today’s session, you may communicate with our panelists via the web
  – Submit your questions on-line at any time by entering them into the Q&A panel on the right-hand side of the WebEx desktop
  – On-line questions will be addressed first
• There will be a brief opportunity for the audience to submit questions through the telephone
  – When directed by the operator, press * followed by the number one (1) on your keypad
Welcome and Introductions

ACA-mandated Eligibility and Claim Status Operating Rules
  - Q&A with OESS regarding compliance
  - Q&A on operating rules

ACA-mandated Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA) Operating Rules
  - Q&A with OESS on compliance
  - Q&A on operating rules

Upcoming CAQH CORE Operating Rule Development Activities

Wrap-Up
Polling Question #1:  
Eligibility and Claims Status Implementation

Which answer best describes the status of your organization’s Eligibility and Claims Status Operating Rule implementation effort?

- I Don’t Know
- Development Underway/Working with Trading Partners
- Nearing Completion/Done
- Not Applicable
Polling Question #2:  
**EFT & ERA Implementation Readiness**

Which answer best describes the status of your organization’s **EFT Standard and EFT & ERA Operating Rule** implementation effort?

- Not Started
- Planning/Design
- Development Underway/Working with Trading Partners
- Nearing Completion/Done
- Not Applicable
ACA Section 1104:
Mandated Eligibility and Claim Status Operating Rules

Scope and Compliance
Committee on Operating Rules for Information Exchange

- A multi-stakeholder collaboration established in 2005
- **Mission**: To build consensus among healthcare industry stakeholders on a set of operating rules that facilitate administrative interoperability between providers and health plans
  - Enable providers to submit transactions from the system of their choice (vendor agnostic) and quickly receive a standardized response
  - Facilitate administrative and clinical data integration
- Recognized healthcare operating rule author by NCVHS and HHS

CAQH CORE carries out its mission based on an integrated model
ACA Mandated Operating Rules Compliance Dates: Required for all HIPAA Covered Entities

Operating rules encourage an interoperable network and, thereby, are vendor agnostic

Compliance in Effect as of January 1, 2013

• Eligibility for health plan
• Claims status transactions
  HIPAA covered entities conduct these transactions using the CAQH CORE Operating Rules

Implement by January 1, 2014

• Electronic funds transfer (EFT) transactions
• Health care payment and remittance advice (ERA) transactions

Implement by January 1, 2016

• Health claims or equivalent encounter information
• Enrollment and disenrollment in a health plan
• Health plan premium payments
• Referral certification and authorization
• Health claims attachments

Rule requirements available.
Mandated Eligibility & Claim Status Operating Rules: Scope – Effective as of January 1, 2013

**Enforcement Action Begins March 31, 2013**

### Mandated Eligibility & Claim Status Operating Rules

**Type of Rule** | **Addresses** | **CAQH CORE Eligibility & Claim Status Operating Rules** | **Voluntary Eligibility & Claim Status Operating Rule**
---|---|---|---
**Data Content: Eligibility** | Need to drive further industry value in transaction processing | More Robust Eligibility Verification Plus Financials | **“We are addressing the important role acknowledgements play in EDI by strongly encouraging the industry to implement the acknowledgement requirements in the CAQH CORE rules we are adopting herein.”**
| | | Enhanced Error Reporting and Patient Identification | **HHS Interim Final Rule**

**Infrastructure: Eligibility and Claim Status** | Industry needs for common/accessible documentation | Companion Guides | Acknowledgements*
| | | System Availability | |
| | Industry-wide goals for architecture/performance/connectivity | Response Times | |
| | | Connectivity and Security | |

*Please Note: In the Final Rule for Administrative Simplification: Adoption of Operating Rules for Eligibility for a Health Plan and Health Care Claim Status Transaction, CORE 150 and CORE 151 are not included for adoption. HHS is not requiring compliance with any operating rules related to acknowledgement, the Interim Final Rule.*
### ACA Federal Compliance Requirement Highlights:

**Eligibility and Claim Status**

Three dates are critical for implementation of the first set of ACA mandated Operating Rules.

*There are two types of penalties related to compliance*.¹

<table>
<thead>
<tr>
<th>Key Area</th>
<th>HIPAA Mandated Implementation</th>
<th>ACA-required Health Plan Certification</th>
</tr>
</thead>
</table>
| **Dates**                 | **First Date**
|                           | January 1, 2013                                                                                  | **Second Date**
|                           | Compliance Date                                                                                 | December 31, 2013                                                                                  |
|                           | Enforcement Date Extension                                                                      | Health Plan Certification Date                                                                       |
|                           | March 31, 2013                                                                                   |                                                                                                        |
| **Description**           | **Who:** All HIPAA covered entities                                                               | **Who:** Health plans                                                                               |
|                           | **Action:** Implement CAQH CORE Eligibility & Claim Status Operating Rules                        | **Action:** File statement with HHS certifying that data and information systems are in compliance with the standards and operating rules² |
| **Applicable Penalties**  | **Amount:** Due to HITECH, penalties for HIPAA non-compliance have increased, now up to $1.5 million per entity per year | **Amount:** Fee amount equals $1 per covered life³ until certification is complete; penalties for failure to comply cannot exceed on an annual basis an amount equal to $20 per covered life or $40 per covered life for deliberate misrepresentation |

¹ CMS OESS is the authority on the HIPAA and ACA Administrative Simplification provisions and requirements for compliance and enforcement. The CMS website provides information on the ACA compliance, certification, and penalties and enforcement process.

² According to CMS, regulation detailing the health plan certification process is under development, and they will release details surrounding this process later this year; CAQH CORE will continue to offer its voluntary CORE Certification program and will share lessons learned with CMS as the Federal process is developed.

³ Covered life for which the plan’s data systems are not in compliance; shall be imposed for each day the plan is not in compliance

⁴ Per the Jan 2, 2013 CMS OESS announcement of the 90-day Period of enforcement extension Discretion for Compliance with Eligibility and Claim Status Operating Rules
Providers and Operating Rules: 
Eligibility/Claim Status

• **Benefits**: Educate yourself on what is now available to your practice, e.g.
  – Real-time access to:
    • Health plan eligibility
    • Benefit coverage
    • Patient financials, YTD deductibles, co-pays, in/out of network variances
    • Claim status
  – Decrease in claim denials based on early adopters
  – Ability to reduce connectivity time and costs
  – Ability to connect directly to health plans

• **Key actions** your practice can take/what are your responsibilities
  – If you conduct electronic eligibility/benefits (ASC X12 270/271) and claim status (ASC X12 276/277) transactions, these transactions must comply with the CAQH CORE Operating Rules
  – If you do conduct the transactions electronically, assess your organization’s readiness/compliance
    • Use the **CAQH CORE Analysis & Planning Guide for Adopting the CAQH CORE Eligibility & Claim Status Operating Rules** to help you assess your organization’s readiness
    • Speak with your **Practice Management System** (PMS) vendor* about their compliance/ability to support your practice, e.g. is the **product your practice uses** voluntarily CORE-certified?
    • Ask your **clearinghouse(s)** if the **product(s) your practice uses** is compliant (clearinghouses are HIPAA covered, and thus should already be compliant)

* REMINDER: PMSs are not HIPAA-covered entities, and thus are not mandated to be compliant - so provider requests are critical!
Compliance with Eligibility & Claim Status Operating Rules: 90-Day Period of Enforcement Discretion

- On January 2, 2013 CMS OESS* announced a 90-Day Period of Enforcement Discretion to reduce the potential of significant disruption to the healthcare industry
  - Notwithstanding OESS’ discretionary application of its enforcement authority, the compliance date for using the operating rules remains January 1, 2013
- Enforcement action will begin March 31, 2013 with respect to HIPAA covered entities (including health plans, health care providers, and clearinghouses, as applicable) that are not in compliance with the Federally mandated Eligibility and Claim Status Operating Rules
- HIPAA covered entities that are prepared to conduct transactions using the adopted operating rules and all applicable covered entities that are preparing to do so, are encouraged to determine their readiness to use the operating rules as of January 1, 2013 and expeditiously become compliant

* OESS is the U.S. Department of Health and Human Services’ (HHS) component that enforces compliance with HIPAA transaction and code set standards, including operating rules, Identifiers and other standards required under HIPAA by the Affordable Care Act.
Compliance with Eligibility & Claim Status Operating Rules: CMS OESS Complaint-Driven Enforcement Process

- OESS will accept complaints associated with compliance with the operating rules beginning January 1, 2013
  - If requested by OESS, covered entities that are the subject of complaints (known as “filed-against entities”) must produce evidence of either compliance or a good faith effort to become compliant with the operating rules during the 90-day period
- For more information review CMS’s Administrative Simplification Enforcement Tool (ASET), which is a web-based application where entities may file a complaint against a covered entity for potential non-compliance related to Transactions and Code Sets and Unique Identifiers
  - Anyone may use ASET to file a complaint
  - Each complaint is reviewed for validity and completeness by CMS OESS
- You can also submit an inquiry to the Office of OESS about health plan certification and audits of certification, when those proposed approaches are issued during 2013
Available CMS OESS Implementation Tools: Examples

- **HIPAA Covered Entity Charts**
  - Determine whether your organization is a HIPAA covered entity
- **CMS FAQs**
  - Frequently asked questions about the ACA, operating rules, and other topics
- **Affordable Care Act Updates**
  - Updates on operating rules; compliance, certification, and penalties; and engagement with standards and operating rules
- **Additional Questions**
  - Questions regarding HIPAA and ACA compliance can be addressed to:
    - Chris Stahlecker, OEM/OESS/ASG Acting Director, Administrative Simplification Group, Christine.Stahlecker@cms.hhs.gov
    - Geanelle Herring, Health Insurance Specialist, Geanelle.Herring@cms.hhs.gov
Q&A

ACA Federal Compliance
Eligibility & Claim Status Operating Rules

Compliance and Rule Requirements

Please submit your question:
• By Phone: Press * followed by the number one (1) on your keypad
• Via the Web: Enter your question into the Q&A pane in the lower right hand corner of your screen
CAQH CORE Implementation Tools: Examples

- **CORE Operating Rule Readiness**: If you are ready to test your implementation of operating rules with trading partners, then, **take 5 minutes** and tell others about your readiness
  - *Add your organization* to the **CORE Partner List** located on the **CAQH** website
  - *It take 5 minutes!*

- **Request Process**: Contact technical experts as needed at **CORE@caqh.org**

- **Voluntary CORE Certification**: **Phase I & Phase II**
  - Learn more about *voluntary* CORE Certification [here](#)
  - *Voluntary* CORE Certification provides verification that your IT systems or product operates in accordance with the federally mandated operating rules

- **FAQs**: CAQH CORE has a list of FAQs to address typical questions regarding the operating rules; updated FAQs being loaded to website on a regular basis
Voluntary CORE Certification: Overview of Certification Process

• Since its inception, CAQH CORE has offered a voluntary CORE Certification to health plans, vendors, clearinghouses, and providers
  – Learn more about voluntary CORE Certification here
  – Voluntary CORE Certification provides verification that your IT systems or product operates in accordance with the federally mandated operating rules

• Certification and testing are separate activities
  – Testing is completed by CORE-authorized testing entities and occurs on-line based on stakeholder-specific test scripts; test scripts developed by CORE participants
  – Cost of testing and certification is extremely low or free

• CORE Certification is a 4-step process:

  1. **Pre-certification Planning and Systems Evaluation:**
     – Understand requirements of the CORE Operating Rules and scope your internal efforts to adopt rules
     – CORE has free gap analysis tool; email CORE@CAQH.org
  2. **Sign and Submit the CORE Pledge:**
     – Formally communicate your intent to pursue CORE Certification
  3. **CORE Certification Testing:**
     – Comprised of three phases: Pre-testing, Testing and Post-testing
     – Testing is by stakeholder-specific test scripts by rule
  4. **Apply For the CORE Certification Seal:**
     – Entities successfully achieving CORE Certification will receive a CORE “Seal” from CAQH that corresponds with the CORE Phase and stakeholder-type
ACA Section 1104: Mandated EFT Standard and Healthcare Operating Rules for EFT and ERA

Compliance and Scope
Mandated EFT & ERA Operating Rules: Required for All HIPAA Covered Entities

Less than 11 months remaining to complete implementation

Implement by January 1, 2014

• Electronic funds transfer (EFT) transactions
• Health care payment and remittance advice (ERA) transactions

This second set of operating rules has been placed into Federal regulation.

August 2012: CMS published an Interim Final Rule with Comment, CMS-0028-IFC; adopts Phase III CAQH CORE Operating Rules for the Electronic Funds Transfer (EFT) and Health Care Payment and Remittance Advice (ERA) transactions except for rule requirements pertaining to Acknowledgements*

Entities should be actively working to be in compliance by January 1, 2014
Provider first enrolls in EFT and ERA with Health Plan(s) and works with bank to ensure receipt of the CORE-required Minimum ACH CCD+ Data Elements for reassociation.
# Mandated EFT & ERA Operating Rules:
## January 1, 2014 Requirements Scope
*(See Appendix overview on each rule)*

<table>
<thead>
<tr>
<th>Data Content</th>
<th>Rule</th>
<th>High-Level Requirements</th>
</tr>
</thead>
</table>
| **Uniform Use of CARCs and RARCs (835) Rule**  
Claim Adjustment Reason Code (CARC)  
Remittance Advice Remark Code (RARC)  
Rule 360 | • Identifies a minimum set of four CAQH CORE-defined Business Scenarios with a maximum set of CAQH CORE-required code combinations that can be applied to convey details of the claim denial or payment to the provider |
| **EFT Enrollment Data Rule**  
Rule 380 | • Identifies a maximum set of standard data elements for EFT enrollment  
• Outlines a flow and format for paper and electronic collection of the data elements  
• Requires health plan to offer electronic EFT enrollment |
| **ERA Enrollment Data Rule**  
Rule 382 | • Similar to EFT Enrollment Data Rule |
| **EFT & ERA Reassociation (CCD+/835) Rule**  
Rule 370 | • Addresses provider receipt of the CAQH CORE-required Minimum ACH CCD+ Data Elements required for re-association  
• Addresses elapsed time between the sending of the v5010 835 and the CCD+ transactions  
• Requirements for resolving late/missing EFT and ERA transactions  
• Recognition of the role of NACHA Operating Rules for financial institutions |
| **Health Care Claim Payment/Advice (835) Infrastructure Rule**  
Rule 350 | • Specifies use of the CAQH CORE Master Companion Guide Template for the flow and format of such guides  
• Requires entities to support the Phase II CAQH CORE Connectivity Rule.  
• Includes batch Acknowledgement requirements*  
• Defines a dual-delivery (paper/electronic) to facilitate provider transition to electronic remits |

* CMS-0028-IFC excludes requirements pertaining to acknowledgements.
CAQH CORE EFT & ERA Operating Rule Implementation Resources: *Get Started*

- Master the [CAQH CORE EFT & ERA Operating Rules](#)
- Jump start your implementation efforts, take advantage of the CAQH CORE EFT & ERA [Planning and Analysis Guide](#)
- Access CAQH CORE’s repository of [FAQs](#); new EFT & ERA FAQs posted regularly
- Submit your questions to the CAQH CORE Request Process by emailing [core@caqh.org](mailto:core@caqh.org)
- *Coming Soon:* [Voluntary CORE Certification Test Site](#) for conformance testing of the EFT & ERA Operating Rules; jointly offered by CAQH CORE-authorized testing entity Edifecs
- Learn about the NACHA EFT Standard (see Appendix for useful NACHA tools)
CAQH CORE Analysis & Planning Guide: EFT & ERA Operating Rules

• The new Analysis and Planning Guide provides guidance for Project Managers, Business Analysts, System Analysts, Architects, and other project staff to complete systems analysis and planning for implementation of the CAQH CORE EFT & ERA Operating Rules

• Guide should be used by project staff to:
  – Understand applicability of the CAQH CORE Operating Rule requirements to organization’s systems and processes that conduct the EFT and ERA transactions
  – Identify all impacted external and internal systems and outsourced vendors that process EFT & ERA transactions
  – Conduct detailed rule requirements gap analysis to identify system(s) that may require remediation and business processes which may be impacted

• The guide includes three tools to assist entities in completing analysis and planning:
  – Stakeholder & Business Type Evaluation
  – Systems Inventory & Impact Assessment Worksheet
  – Gap Analysis Worksheet
CAQH CORE Analysis & Planning Tools in Guide

**Stakeholder & Business Type Evaluation**

**Objective:** Understand what aspects of your business and/or outsourced functions are impacted by the CAQH CORE EFT & ERA Operating Rules (e.g., products, business lines, etc.)

**Systems Inventory & Impact Assessment Worksheet**

**Objective:** Understand how many of your systems/products are impacted by each CAQH CORE Operating Rule and understand with which vendors you will need to coordinate

**Gap Analysis Worksheet**

**Objective:** Understand level of system(s) remediation necessary for adopting each CAQH CORE Operating Rule requirement; results of completed *Gap Analysis Worksheet* will allow for development of a detailed project plan
Polling Question #3:

**EFT & ERA Operating Rules**

*During 2013, CAQH CORE intends to host in-depth education sessions on the specific EFT/ERA Operating Rules, but would like to hear which rules should be focused on first.*

Which EFT/ERA Operating Rule is your organization finding to be the most challenging to understand and/or implement?

- Health Care Claim/Payment Advice Infrastructure Rule
- Uniform Use of CARCs and RARCs Rule
- EFT & ERA Reassociation Rule
- EFT and ERA Enrollment Data Rules
Q&A

ACA Federal Compliance
EFT & ERA Operating Rules

Please submit your question:
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ACA Section 1104:  
Mandated Healthcare Operating Rules - Attachments, Prior Authorization, Enrollment, etc.
Mandated Attachments, Prior Auths, Enrollment, etc.: Third Set

• Remaining operating rule mandate, effective January 1, 2016, will address the following transactions:
  – Health claims or equivalent encounter information
  – Enrollment and disenrollment in a health plan
  – Health plan premium payments
  – Referral certification and authorization
  – Claims attachments

• Secretary of HHS recommended CAQH CORE as author for the remaining ACA mandated operating rules
  – Research and planning underway for rule development and activities including public surveys, in-depth interviews, summary of scope of current and draft standards and identification of potential rule opportunities/areas out scope
  – All CORE Guiding Principles will be followed, e.g., build on existing standards, align with other Federal health IT initiatives, address content and infrastructure
CAQH CORE Rules Development Process: 
*Third Set*

- CAQH CORE will use its open process and a timeline to complement ACA needs:
  - **Q1 2013**: Key opportunities/out of scope areas being identified via research, survey findings, and call discussions
  - **Q2 2013**: Potential rule options will be developed, reviewed, and agreed upon by CORE Subgroups and Work Groups
  - **Q3 2013**: CORE Subgroup and Work Group discussion and straw polling will be conducted
  - **Q4 2013**: Detailed documentation of draft rule requirements by CORE Participants
- CAQH CORE Participants are encouraged to identify internal subject matter experts to represent their organizations
  - Having experience with implementing the first and second rule sets will be very useful
Thank You for Joining Us!

See Appendix for more implementation guidance
# ACA Mandated CAQH CORE Operating Rules: Eligibility and Claim Status

Current healthcare operating rules build upon a range of standards – healthcare specific (e.g., ASC X12) and industry neutral (e.g., OASIS, W3C)

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<th>Rule Types</th>
<th>Transactions</th>
<th>Rule Areas</th>
<th>CAQH CORE Rule Numbers</th>
<th>Key Considerations</th>
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<td>Response Time Rules (Batch &amp; Real-Time) &amp; System Availability Rule</td>
<td>155, 156, 157, &amp; 250*</td>
<td>Interdependencies of the CAQH CORE Infrastructure Rules must be considered during implementation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Connectivity Rules</td>
<td>153, 270 &amp; 250*</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Companion Guide Rule</td>
<td>152 &amp; 250*</td>
<td></td>
</tr>
<tr>
<td><strong>Data Content</strong></td>
<td>X12 270/271 Eligibility &amp; Benefits</td>
<td>Patient Financial Data Content Rules</td>
<td>154 &amp; 260</td>
<td>Data Content Rules apply only to the Eligibility &amp; Benefits transaction</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Normalizing Patient Last Name &amp; AAA Error Code Reporting Rules</td>
<td>258 &amp; 259</td>
<td></td>
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</tbody>
</table>

*CAQH CORE Rule 250 applies the CAQH CORE Infrastructure Rules to the X12 276/277 Claims Status transaction.
Free Upcoming CAQH CORE Education

• **In-Person Conferences:** Look for us at the following upcoming events
  – [National HIPAA Summit West](#) – February 21, 2013
  – HIMSS Annual Conference, March 3-7, 2013 (we will be at booth #2468)
  – GE Users Conference – April
  – [NACHA: Payments 2013](#) – April

• Visit the CORE [Education Events](#) page of the CAQH website to access recordings of previous education events and see upcoming joint webinars being held with key partners such as NACHA, ASC X12, vendors and provider associations
EFT & ERA Enrollment Data Rules: Key Rule Requirements

A health plan (or its agent or vendors offering EFT enrollment) is required to:

- Collect no more data elements than the CORE-required Maximum EFT Enrollment Data Set; data elements marked optional may be collected at the entity’s discretion
- Use the format, flow, and data set including data element descriptions without modification in the Maximum EFT Enrollment Data Set
- Make available to the provider (or its agent):
  - specific written instructions/guidance to the healthcare provider for enrollment
  - instructions on the specific procedure to accomplish a change in/cancellation of their enrollment

- Include the name of the health plan/agent/ vendor offering EFT) & the purpose of the form at top of the form
- Provide additional information including where to send completed form, contact information, authorization language
- Provide instructions to access online instructions for status of enrollment
- Inform provider it must contact bank to arrange for delivery of the CORE Minimum CCD+ Reassociation Data Elements

- When using XML, exact Data Element Name and Sub-element Name must be enclosed in angle brackets (i.e., < >) for the standard XML element name; and all spaces replaced with an underscore [ _ ] character
- Offer an electronic way for provider to complete and submit the EFT enrollment
Health Care Claim Payment/Advice (835)  
Infrastructure Rule: Key Rule Requirements

Connectivity

• Entities must be able to support the Connectivity Rule Version 2.2.0 for transmission of the v5010 835

Dual Delivery

• A health plan that currently issues proprietary paper claim remittance advices is required to continue to offer such paper remittance advices to each provider during that provider’s initial implementation testing of the v5010 X12 835 for a minimum of 31 calendar days from the initiation of implementation
  • Upon mutual agreement between the provider and the health plan, the timeframe for delivery of the proprietary paper claim remittance advices may be extended
  • See 4.3 for more detail

Batch Acknowledgements

• A receiver of a v5010 X12 835 transaction must return:
  - A v5010 X12 999 Implementation Acknowledgement for each Functional Group of v5010 X12 835 transactions to indicate that the Functional Group was either accepted, accepted with errors or rejected, and
  - To specify for each included v5010 X12 835 transaction set that the transaction set was either accepted, accepted with errors or rejected
  • A health plan must be able to accept and process a v5010 X12 999 for a Functional Group of v5010 X12 835 transactions
  • When a Functional Group of v5010 X12 835 transactions is either accepted with errors or rejected, the v5010 X12 999 Implementation Acknowledgement must report each error detected to the most specific level of detail supported by the v5010 X12 999 Implementation Acknowledgement

Companion Guide

• Specifies use of the CAQH CORE Master Companion Guide Template for the flow and format of such guides for the v5010 835

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1 Requirements do not currently apply to retail pharmacy
2 NOTE: CMS-0028-IFC does not adopt the Batch Acknowledgement Requirements in Section 4.2 of CAQH CORE Rule 350, as the Secretary has not yet adopted HIPAA standards for acknowledgements.
Uniform Use of CARCs and RARCs Rule: Key Rule Requirements

Use of CORE-defined Business Scenarios

• A health plan or its PBM agent must
  - Align internal codes and business scenarios to the CORE-defined Business Scenarios
  - Support the maximum CORE-required Code Combinations as specified in CORE-required Code Combinations for CORE-defined Business Scenarios.doc

• NOTES:
  - An adjusted CORE-required Code Combinations for CORE-defined Business Scenarios.doc will be published no less than three times annually to account for updates to the published code lists.
  - Published new or modified codes per the codes committees can be used until the next version of the CORE-required Code Combinations for CORE-defined Business Scenarios.doc is published; a deactivated code must not be used
  - For more information on the CAQH CORE Code Combinations Maintenance Process click HERE

Requirements for Receivers of the v5010 835

• When receiving a v5010 X12 835, the product extracting the data (e.g., a vendor’s provider-facing system or solution) from the v5010 X12 835 for manual processing must make available to the end user:
  • Text describing the codes included in the remittance advice, ensuring that the actual wording of the text displayed accurately represents the corresponding code description specified in the code lists without changing the meaning and intent of the description and text describing the corresponding CORE-defined Claim Adjustment/Denial Business Scenario

1Requirements do not currently apply to retail pharmacy or to an entity that is simply forwarding the v5010 X12 835 to another system for further processing.
CAQH CORE Code Combinations Maintenance Process

- A CAQH CORE Code Combinations Task Group will convene three times per year to review the CORE-required Code Combinations for CORE-defined Business Scenarios.
- Two types of review and adjustment to the CORE Code Combinations including:

**Compliance-based Review & Adjustment**
- **Goal:** Align CORE-required Code Combinations for CORE-defined Business Scenarios and the code sets.
- **Frequency:** Occurs three times/year via Task Group.
- **Scope:** Only considers updates to the CARC and RARC lists published (occurs three or more times per year) since the last update to the CORE Code Combinations as required by the CAQH CORE Rule 360.
- Per CMS OESS¹, Compliance-based Adjustments will be *immediately recognized under HIPAA* given that CAQH CORE Rule 360 requires that publications from code authors be addressed.

**Market-based Review & Adjustment**
- **Goal:** Address evolving industry business needs.
- **Frequency:** Occurs once per year during last Task Group convening.
- **Scope:** Considers *industry submissions* based on real world usage data and/or a strong business case addressing:
  - Adjustments to the existing CORE-required Code Combinations for existing CORE-defined Business Scenarios.
  - Addition of new CORE-defined Business Scenarios and associated code combinations.
- The process for CMS OESS formally recognizing Market-based Adjustments will be finalized later this year (before the first Market-based Adjustment); entities should plan that their IT systems have the capability to no less than three times a year update their systems to meet the update Code Combinations lists.
# EFT & ERA Reassociation (CCD+/835) Rule: Key Rule Requirements

## Elapsed Time Requirements

### Elapsed Time Requirements¹

- Health plan must release the v5010 X12 835 corresponding to the Healthcare EFT Standards:
  - No sooner than three business days based on the time zone of the health plan prior to the CCD+ Effective Entry Date and no later than three business days after the CCD+ Effective Entry Date
- CCD+ Effective Entry Date must be a valid banking day and corresponding v5010 x12 835 BPR16 date is the same valid banking day

## CORE-required Minimum CCD+ Data

### CORE-required Minimum CCD+ Data

- Health plan must inform provider during EFT and ERA enrollment that it will need to contact its financial institution to arrange for the delivery of the CORE-required Minimum CCD+ Reassociation Data Elements necessary for successful reassociation
- Provider must proactively contact its financial institution to arrange for the delivery of the CORE-required Minimum CCD+ Reassociation Data Elements

## Elapsed Time Auditing Requirements

### Elapsed Time Auditing Requirements

- Health plan must ensure the v5010 X12 835 and corresponding Healthcare EFT Standards meet the elapsed time requirements ninety percent (90%) of the time as measured within a calendar month
- Health plan is required to have the capability to track and audit this elapsed time requirement

## Resolving Late/Missing EFTs and ERAs

### Resolving Late/Missing EFTs and ERAs

- Health plan must establish and delivery to the provider written Late/Missing EFT and ERA Transactions Resolution Procedures
- Late or missing is defined as a maximum elapsed time of four business days following the receipt of either the Healthcare EFT Standards or v5010 X12 835

¹ Specific requirements vary slightly for retail pharmacy; see Section 4 of rule for detailed requirements for retail pharmacy
### CORE-required Minimum CCD+ Reassociation Data Elements

<table>
<thead>
<tr>
<th>CCD+ Record #</th>
<th>Field #</th>
<th>Field Name</th>
<th>Corresponding v5010 X12 835 Data Elements</th>
<th>Data Element Segment Position, Number &amp; Name</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>9</td>
<td>Effective Entry Date</td>
<td>BPR16-373 Date <em>(EFT Effective Date)</em></td>
<td></td>
</tr>
<tr>
<td></td>
<td>6</td>
<td>Amount</td>
<td>BPR02-782 Monetary Amount <em>(Total Actual Provider Payment Amount)</em></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>3</td>
<td>Payment Related Information</td>
<td>TRN Reassociation Trace Number Segment, specifically data elements:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• TRN01-481 Trace Type Code</td>
<td>Required</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• TRN02-127 Reference Identification <em>(EFT Trace Number)</em></td>
<td>Required</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• TRN03-509 Originating Company Identifier <em>(Payer Identifier)</em></td>
<td>Required</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• TRN04-127 Reference Identification <em>(Originating Company Supplemental Code)</em></td>
<td>Situational</td>
</tr>
</tbody>
</table>
Healthcare EFT Standard Implementation Guide

- Healthcare EFT Standard Implementation Guide
  - What is the EFT standard?
  - How does it work?
  - Includes the CCD format
  - How to populate the specific fields
  - What are NACHA Operating Rules and how do they impact the standard?
- Available from NACHA at https://www.nacha.org/eStore
NACHA Resources

• Healthcare Payments Resources Website
  – Provides a repository of information on a wide variety of topics for both financial institutions and the healthcare industry. Includes links to many other resources, as well as customized information to help “translate” concepts from one industry to the other (FAQs, reports, presentations).
  – http://healthcare.nacha.org/

• Healthcare EFT Standard Information
  – Located within the healthcare industry tab of the above website, specific information can be found on the healthcare EFT standard.
  – http://healthcare.nacha.org/

• Healthcare Payments Resource Guide
  – Publication designed to help financial institutions in implementing healthcare solutions. It gives the reader a basic understanding of the complexities of the healthcare industry, identify key terms, review recent healthcare legislation, and discuss potential impacts on the financial services industry.
  – Order from the NACHA eStore “Healthcare Payments” section: www.nacha.org/estore.

• ACH Primer for Healthcare Payments
  – A guide to understanding EFT payment processing. Introduces the healthcare industry to the Automated Clearing House (ACH) Network, explains ACH transaction flow and applications, and includes two “next steps checklists,” one each for origination and receipt.
  – https://healthcare.nacha.org/ACHprimer

• Ongoing Education and Webinars
  – Check the Healthcare Payments Resource Website for “Events and Education”
CAQH EFT Enrollment Solution Overview

• Instead of enrolling individually with each payer, CAQH offers a secure, online system that allows providers to enroll in electronic payments with multiple payers at no cost.

• Benefits for providers
  – **One-Stop Shop**: Single, easy-to-use point of entry for providers to enroll in EFT and manage enrollment information with multiple payers; web-based with provider support center.
  – **No Cost**: No charge for providers to use; participating health plans pay a low annual subscription to cover the costs to build and run the service.
  – **Secure**: Robust encryption, firewalls and strong password requirements to safeguard sensitive data and ensure that providers have complete control of their data.
  – **Flexible**: Focused on enrollment; allows providers to use whichever downstream payment processing or remittance advice presentation solution that they prefer and is aligned with Federal mandates.