CAQH CORE and State Medicaid Agencies

Operating Rule Implementation: The Road to Compliance and Lessons Learned

October 10, 2013
1:30pm – 3:00pm ET
Participating in Today’s Interactive Event

• Download a copy of today’s presentation HERE
• 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 an opportunity for the audience to submit questions through the telephone during today’s presentation
  – When directed by the operator, press * followed by the number one (1) on your keypad
Session Topics

• Introduction to Administrative Simplification
• First Set of CAQH CORE Operating Rules – Eligibility and Claims Status
  – Overview and General Implementation Perspectives
  – Eligibility Data Content Rules:
    • Requirements and Implementation Perspectives
  – Eligibility Infrastructure Rules:
    • Requirements and Implementation Perspectives
• Second Set of CAQH CORE Operating Rules – EFT and ERA
  – Overview, Rule Requirements and Benefits
  – EFT & ERA Enrollment Rules
  – Reassociation Rule
  – Uniform Use of CARCs and RARCs Rule
• Questions?
Today’s Speakers

- Melissa Moorehead, Michigan Public Health Institute (MPHI)
- Linda Gonzales, New Mexico Human Services Department
- Chad Warmack, Xerox Government Healthcare Solutions
- Tammie Savage, Michigan Department of Community Health
- Samantha Cook, Missouri Department of Social Services
- Bob Bowman, CAQH CORE
Introduction:

*Affordable Care Act (ACA) Section 1104*
Overview of ACA Section 1104
An Amendment to HIPAA

• **HIPAA - Administrative Simplification Provisions**
  – *Requires the establishment of national standards* for electronic health care transactions and national identifiers for providers, health insurance plans, and employers

• **ACA Section 1104**
  • Defines Operating Rules as necessary business rules and guidelines for electronic exchange of information not defined by a standard
  • Requires HHS to adopt a single set of consensus-based operating rules for each transaction for which standard has been adopted
  • Defines criteria for qualified nonprofit entities to provide recommendations on operating rules (entities such as CAQH CORE)
  • Assigns the National Committee on Vital and Health Statistics (NCVHS) to advise HHS on whether nonprofit entity meets criteria, and whether the recommended operating rules shall be adopted

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1 Administrative Simplification: Adoption of Operating Rules for Eligibility for a Health Plan and Health Care Claim Status Transactions; Interim Final Rule Federal Register / Vol. 76, No. 131 / Friday, July 8, 2011 / Rules and Regulations

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Who Must Comply With ACA Section 1104? 
Required of all HIPAA Covered Entities

• ACA Section 1104 mandates that all HIPAA covered entities comply with healthcare operating rules; additional guidance on HIPAA covered entity designations may be found HERE.

• HIPAA Administrative Simplification standards, requirements and implementation specifications apply to:
  – Healthcare Providers: Any person or organization who furnishes, bills, or is paid for healthcare in the normal course of business.
    • Covered ONLY if they transmit protected health information electronically (directly or through a business associate) in connection with a transaction covered by the HIPAA Transaction Rule.
    • Examples include but are not limited to: Doctors, Clinics, Psychologists, Dentists, Chiropractors, Nursing Homes, and Pharmacies
  – Health Plans (including Long-term Care, Medicare, Medicaid, etc.)
  – Health Care Clearinghouses

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1 Understanding HIPAA Privacy: For Covered Entities and Business Associates
2 HIPAA Administrative Simplification: 45 CFR §§ 160.102, 164.500
3 HIPAA Administrative Simplification: 45 CFR § 160.103
ACA Impacts on Medicaid

MITA 3.0 State Self-Assessment

State Health Insurance Exchange

1-4-12 Adult Quality Measures rule; 9-2012 TA, ACA §1139B

§2001 Medicaid Eligibility Increase, MAGI, Premium Assistance, Parallel Eligibility

State Medicaid Health IT Plan

Medicare/Medicaid Provider EHR Incentive Program

§1104, 1561 Operating Rules and Standards Development Cycles

2011

CLASS Act Suspended
RAC required for Medicaid
HIPAA 5010
MLR rebates
§2704 Bundled Payments Available

§6401 / 42 CFR, Part 455 Provider Screening & Enrollment Fees (SPA)

§1104 Eligibility for a health plan and health claim status OR*, EFT standard

4-1

§4106 +1% FMAP for Prevention

10-201 / 42 CFR, Part 431 Review & Approval changes to §1115 demos

2012

4-27

§1203 Medicare DSH Reductions (H.R. 4872)

§1201 Medicaid Expansion

1-1

1-1

§2201 Provider Payment Adjustments (H.R. 4872)

§1203 Medicaid DSH Reductions (H.R. 4872)

12-31

12-31

Certify OR* compliance

10-1

ICD-10

11-5

10-1

State HIXs

Stage 2 MU

CHIP FMAP Increase

2013

10-1

§1104 Electronic Funds Transfer and Remittance Advice OR*

§2202 Presumptive Eligibility

§1104 Health care claims, COB, health plan enrollment, health plan premium payment, referral certification OR*

2014

12-31

§2001 Medicaid Expansion

11-7

Full HPID implementation

2015

12-31

§1104 Health care claims, COB, health plan enrollment, health plan premium payment, referral certification OR*

2016

11-7

§1104 Electronic Funds Transfer and Remittance Advice OR*

§2502 no prescription exclusions on certain drugs

*OR = Operating Rules

Last edit: 1/7/2013
CMS Office of Civil Rights (OCR) oversees privacy and security standards and now enforces monetary penalties
  - Can be fined for breaches of privacy, but also failure to follow regulations discovered during audit
Office of E-Health Standards and Services (OESS) oversees transactions and code sets standards and operating rules
  - Can enforce fines up to $1.5 M for not meeting standards NOW
ICD–10 coding changes are part of administrative simplification
  - Required for HIPAA–compliant electronic data interchange (EDI)
  - Changes the way medical encounters must be recorded starting with physicians
New mandatory enumeration system for health plans – Health Plan Identifier or HPID
  - Can’t be used for individuals. Unique individual identifiers still a challenge
Ongoing process of rulemaking leaving many unknowns and compliance challenges
Operating rules encourage an interoperable network and are therefore 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

  HIPAA covered entities will need to conduct these transactions using the CAQH CORE Operating Rules

**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.

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Standards
- ERA Standard (ASC X12 835 v5010) www.x12.org
- EFT Standard (NACHA CCD+)
  https://healthcare.nacha.org/
- HL7 www.hl7.org

Operating Rules Authors
- CAQH CORE (for HIPAA standards) www.caqh.org/core
- NACHA (EFT standard)

General
- NCVHS www.ncvhs.hhs.gov
- CMS FAQS on Administrative Simplification
  https://questions.cms.gov/faq.php?id=5005&rtopic=1851
- NMEH mmoorehe@mphi.org for instructions
- WEDI (?) www.wedi.org
First Set of CAQH CORE Operating Rules: *Eligibility, Benefits & Claims Status*
Eligibility & Claim Status Operating Rules

Rules in Action

Pre- or At-time of Service

Provider -> Health Plan

Eligibility Inquiry (270)

Eligibility Response (271)

Content: Enhanced Patient Identification

Content: Uniform Error Reporting

Content: Robust Eligibility Data, e.g., Patient Financials (YTD deductibles, Co-pay, Co-insurance, in/out network variances)

Post-Claim Submission

Provider -> Health Plan

Claim Status Request (276)

Claim Status Response (277)

Infrastructure Rules

Standard Companion Guides
Real-time and Batch Response Times
Internet Connectivity and Security
Increased System Availability

Indicates where a CAQH CORE Rule comes into play
Eligibility & Claim Status Operating Rules

Benefits

The ACA mandated Eligibility & Claim Status Operating Rules ensure real-time access to robust eligibility and claim status data for providers

• **More accurate patient eligibility verification:**
  – Real-time information on health plan eligibility and benefit coverage before or at the time of service

• **Improved point of service collections:**
  – Real-time provider access to key patient financials including YTD deductibles, co-pays, coinsurance, in/out of network variances via the ASC X12 v5010 270/271 transactions

• **Revenue-cycle Efficiency:**
  – Real-time data ensures provider is aware of Claims Status in billing process

* Based on the CAQH CORE Phase I [Measures of Success](#) Study when working with Phase I CORE Certified health plans.
First Set of CAQH CORE Operating Rules:
General Implementation Challenges
and Lessons Learned

Linda Gonzales
New Mexico Human Services Department
General Challenges

Cost

- Challenges
  - Sticker shock by cost; especially since a shared solution with a translator
  - Coming up with 10% in the middle of a budget year is difficult

- Mitigation
  - Meeting with fiscal agent to discuss cost—due diligence, an understanding of high cost
  - What was needed and what was included
  - Infrastructure leveraged for future Operating Rules
General Challenges

Tight Time Frames
- Challenges
  - Costs associated with short time frame
  - Could have used home grown solution with more time
- Mitigation
  - Had to use an off the shelf product due to time constraints
  - Getting the attention of leadership
    - Penalties in the millions

Competing Projects and Priorities
- Affordable Care Act
- ICD-10
- Seven Conditions and Standards
Future Considerations

- Rules Keep Coming
  - Cost and contention with other priorities
  - Too much change in healthcare environment at the same time; causes high risk

- Limited Resources
  - No time to participate in forming next set of rules due to current activities

- Jealous and Grateful to Other States
  - For supporting these initiatives; attending the calls, contributing input, etc.
Implementation Challenges

- **Staffing**
  - Staff pulled in multiple directions
  - Lack of dedicated/focused State staff to keep up
  - Fortunate if you have one expert to make it happen

- **Fiscal Agent**
  - State completely dependent on the fiscal agent
  - Operating own translator
  - Dealing with resource constraints

- **Compliance**
  - Non-compliant for 27X transactions– Clearinghouse complained to CMS and NM had to issue a Corrective Action Plan (CAP) to CMS; Implemented 27X transactions with Operating Rules
How do we get to the finish line faster?

- **Effective Communication**
  - Start early and communicate often
  - Early and regular communication between disparate groups involved

- **Priority List**
  - Get the project on everyone’s priority list early

- **Testing**
  - Allow plenty of time for integrated system testing
First Set of CAQH CORE Operating Rules: 
*Eligibility & Benefits - Data Content Rules*
# Mandated Eligibility & Claim Status Operating Rules

## High-level Rule Requirements

<table>
<thead>
<tr>
<th>Rules</th>
<th>High-Level CAQH CORE Key Requirements</th>
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| **Data Content** | Respond to generic and explicit inquiries for a defined set of 50+ high volume services with:  
- Health plan name and coverage dates  
- Static financials (co-pay, co-insurance, base deductibles)  
- Benefit-specific and base deductible for individual and family  
- In/Out of network variances  
- Remaining deductible amounts  
- Enhanced Patient Identification and Error Reporting requirements |
| **Eligibility & Benefits** | **Eligibility, Benefits & Claims Status** |
| • Companion Guide – common flow/format  
• System Availability service levels – minimum 86% availability per calendar week  
• Real-time and batch turnaround times (e.g., 20 seconds or less for real time and next day for batch)  
• Connectivity via Internet and aligned with NHIN direction, e.g., supports plug and play method (SOAP and digital certificates and clinical/administrative alignment)  
• Acknowledgements (transactional)* |

*NOTE: In the Final Rule for Administrative Simplification: Adoption of Operating Rules for Eligibility for a Health Plan and Health Care Claim Status Transaction, requirements pertaining to use of Acknowledgements are NOT included for adoption. Although HHS is not requiring compliance with any operating rule requirements related to Acknowledgements, the Final Rule does note “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.”

A PowerPoint overview of the Phase I & II CAQH CORE Rules is available [here](#); the complete rule sets are available [here](#).
First Set of Data Content Operating Rules

Implementation Challenges and Lessons Learned

Chad Warmack
Tammie Savage
Samantha Cook
Challenges in Implementing the Eligibility and Claim Status HIPAA Operating Rules

- Determining and Reporting Patient Responsibility
- Providing consistent Eligibility information across all systems
- Infrastructure Planning and Sizing
Explicitly determining patient responsibility is not always possible with just the information supplied on a 270 eligibility request.

If your system cannot explicitly determine patient responsibility, what should your system report?

- Minimum possible amount?
- Maximum possible amount?
- Mean amount?
- Median amount?
Consistency of Eligibility Information Provided

- Does your system provide eligibility information via mechanisms other than 270/271 transactions such as an automated voice response system or DDE web portal?

- Have you considered the implications of providing different levels of eligibility information via different reporting mechanisms?

- Do you plan to modify those other reporting mechanisms to be content compliant with the HIPAA Operating Rules?

- The answers to these questions can have a significant impact on your project scope.
Reference database needed to accommodate levels of service and new service type codes (STC)
- Patient Pay Amount and level of care needed to be added to the 271

Expanding the service type codes with different amounts will give more detail for providers to determine what the beneficiary should pay when being seen.

Eligibility dates: A single date of service or a date range (not to exceed 3 months from the current date) and maximum of one year prior or up to the last day of the current month.
- Need to include in the 271 response the AAA segment with code 62 to give specific errors to the submitter: date of service not within allowable inquiry period in the AAA03–901 segment. Use rejection code reason code for inquiry date outside the allowable benefit coverage date.
Normalizing patient last name

- Situational
  - Beneficiary ID may match, but not last name
  - Last name may be misspelled by provider, or name changes may not have come through the system
- Return with the AAA segment the stored last name in our eligibility file. If normalized name invalid, return the specified AAA code. We will return un-normalized submitted last name in the NM103-1035 and return the INS segment.
Financial Responsibility
  ◦ Unable to determine patient copayment amount based only on an eligibility request. Need information from the claim such as diagnosis, performing provider, and place of service.

Service Type Reporting
  ◦ System was not set up based on a traditional benefit package. It was challenging to determine coverage at a service type level.

Applying Data Content Changes
  ◦ All rules were implemented for 270/271 as required. Chose to apply data content changes to the web eligibility tool on the provider portal for consistency; however, the interactive voice response (IVR) system was not modified.
First Set of CAQH CORE Operating Rules:
Eligibility, Benefits & Claims Status - Infrastructure Rules
## Mandated Eligibility & Claim Status Operating Rules
### High-level Rule Requirements

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| **Infrastructure**                         | *NOTE*: In the [Final Rule for Administrative Simplification: Adoption of Operating Rules for Eligibility for a Health Plan and Health Care Claim Status Transaction](https://www.gpo.gov/fdsys/pkg/FR-2013-07-26/pdffile.pdf), requirements pertaining to use of Acknowledgements are NOT included for adoption. Although HHS is not requiring compliance with any operating rule requirements related to Acknowledgements, the Final Rule does note “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.” A PowerPoint overview of the Phase I & II CAQH CORE Rules is available [HERE](https://www.caqh.org); the complete rule sets are available [HERE](https://www.caqh.org).}
Eligibility, Benefits & Claims Status
Infrastructure Operating Rules
Implementation Challenges and Lessons Learned

Chad Warmack
Tammie Savage
Samantha Cook
Some private insurance companies have seen drastic increases in 270 volume after implementing the HIPAA Operating Rules. Do you anticipate increases in your transaction volume?

Could the implementation of the Health Exchanges have an impact on your 270/271 volume?

Can your infrastructure handle a significant increase in transaction volume?

Would a drastic increase in transaction volume affect your system’s ability to meet response time requirements?
Had to expand server capacity to allow higher volume response.

Response time and acknowledgements*
- Previously batch transactions response time was 24 hours
- Did not offer Real-Time transactions
- Major system changes necessary

999s* were returned only if fewer than 100 errors
- We monitor the system and have e-mails generated every 3 hours for any transaction status as failure and we determine the error and contact the appropriate Trading Partner.

System Availability dependent on more than one department
- Instituted new process to collect all departmental schedules and system issues more frequently to update published availability on website

*In the Final Rule for Administrative Simplification: Adoption of Operating Rules for Eligibility for a Health Plan and Health Care Claim Status Transaction, requirements pertaining to use of Acknowledgements (999) are NOT included for adoption.
Connectivity Rule for Safe Harbor Connections
- Only accepted batch transactions
- We had to have a separate User Account for new CORE connection authentication
  - Decide whether to set up a new User ID or use existing Provider ID.
- How to handle initial notification to all active Trading Partners with the User ID and password
  - Created a new self-service online screen to have the ability to Manage Password, security questions, and reset password
  - Security questions when a password needs to be reset that would make sense to the provider
  - Ensured that the password would not be reset automatically.
  - Follow a protocol on password recovery
Tracking of Status Downtime
- Had to create a mechanism to track access to eligibility and claim status transactions. It was challenging to track access through our web portal for unplanned outages. There are several points in the system that can go down making it difficult to determine when the specific transaction was impacted.

Eligibility Web Services Connectivity
- Unable to find a provider to test or implement web services connectivity when we went live. Unfortunately the project had to be closed with code that had not been tested by a provider or used in production.
Second Set of CAQH CORE Operating Rules: 

EFT & ERA
Pre-Payment: Provider Enrollment

- EFT Enrollment Data Rule
- ERA Enrollment Data Rule

Content: 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.

Claims Payment Process

- Health Plan
- Claims Processing
- Treasury
- Bank
- Bank
- Treasury

Stage 1: Initiate EFT

Electronic Funds Transfer (CCD+/TRN)

Payment/Advice (835)

Content: Uniform Use of CARCs & RARCs Rule

Content: EFT & ERA Reassociation (CD+/835) Rule

Infrastructure Rules

- Standard Companion Guides
- Real-time and Batch Response Times
- Internet Connectivity and Security
- Increased System Availability

Indicates where a CAQH CORE EFT/ERA Rule comes into play.

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# Mandated EFT & ERA Operating Rules:
**Effective January 1, 2014**

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<td></td>
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<tr>
<td><em>Uniform Use of CARCs and RARCs (835) Rule</em> <em>(Claim Adjustment Reason Code (CARC) Remittance Advice Remark Code (RARC))</em></td>
<td><em>Identifies a <em>minimum</em> set of four CAQH CORE-defined Business Scenarios with a <em>maximum</em> set of CAQH CORE-required code combinations that can be applied to convey details of the claim denial or payment to the provider</em></td>
</tr>
</tbody>
</table>
| *EFT Enrollment Data Rule* | *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* | *Similar to EFT Enrollment Data Rule* |
| **Infrastructure** | |
| *EFT & ERA Reassociation (CCD+/835) Rule* | *Addresses provider receipt of the CAQH CORE-required Minimum EFT Standard (ACH CCD+) Data Elements required for re-association*  
*Addresses elapsed time between the sending of the ERA (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* | *Specifies flow and format of any proprietary companion guide provided by Health Plans**  
*Requires entities to support the standard electronic connectivity requirements outlined in the Phase II Connectivity Rule.*  
*Includes batch Acknowledgement requirements*  
*Defines a dual-delivery (paper/electronic) method and process to facilitate provider transition to electronic remits* |

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**CMS-0028-IFC** excludes requirements pertaining to acknowledgements. The complete Rule Set is available [HERE](#).

** Committee on Operating Rules for Information Exchange  
A CAQH Initiative  
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Health Care Claim Payment/Advice (835)
Infrastructure Rule: Key Rule Requirements

**Connectivity**
- Entities must be able to support the CAQH CORE 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

1 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.
CAQH CORE Operating Rules and CORE Certification do **NOT** require any entity to submit its Companion Guide to ASC X12 for review and approval prior to publication.
Second Set of CAQH CORE Operating Rules:

*EFT & ERA Enrollment Data Rules*
EFT & ERA Enrollment Data Rules:  
**Key Rule Requirements**

• A health plan (or its agent or vendors offering EFT enrollment) is required to:
  – Offer an electronic way for provider to **complete and submit** the EFT enrollment
  – Collect only the CORE-required Maximum EFT Enrollment Data Set; includes some optional data elements
  – Use the format, flow, and data element descriptions without modification in the EFT Enrollment Data Set
  – Make available to the provider (or its agent) specific written instructions/guidance to the provider for enrollment and the specific procedure to accomplish a change in/cancellation of their enrollment
  – Additional requirements specific to electronic and paper-based enrollment noted in the rule and in appendix of this presentation

• These operating rules **DO NOT** preclude health plans from:
  – Adding Capabilities to the electronic EFT enrollment method designed to improve functionality and ensure data integrity and comprehensiveness
  – Collecting additional data elements in locations beyond the EFT enrollment form for other purposes beyond EFT enrollment
Problem Addressed & Key Impact

- Problem addressed by rule:
  - Providers are challenged by the variances in the processes and data elements requested when enrolling in EFT and ERA across multiple Health Plans.
  - This results in unnecessary manual processing of multiple forms requesting a range of information – not necessarily the same information between Health Plans – and, in the case when it is the same, often using a wide variety of data terminology for the same semantic concept (i.e. “Routing Number” vs. “Bank Routing Number”).
  - Key elements are excluded from many enrollment forms including those with a strong business need to streamline the collection of data elements (e.g. TIN vs. NPI provider preference for payment) and those essential for populating the EFT Standard (ACH CCD+) and the ASC X12 v5010 835.

- Key impact:
  - Simplifies provider EFT & ERA enrollment by having health plans collect the same consistent data from all providers – mitigates hassle factor for providers when enrolling in EFT & ERA with multiple health plans and addresses existing issue that many elements needed for EDI aren’t collected, e.g., requires health plans to support electronic collection of data (paper can continue).
  - Addresses situations where providers outsource financial functions.
  - Enables health plans to collect standardized data for complex organizational structures and relationships, e.g., retail pharmacy chains.
Maintaining CAQH CORE-required Maximum EFT and ERA Enrollment Data Sets

- These two enrollment operating rules each contain an Enrollment Data Set to achieve uniform and consistent collection of necessary data to assist with the EFT and ERA transactions
  - Data set was developed based on extensive research of existing on-line/paper forms as well as extensive dialog and voting; findings showed that there were very inconsistent data element sets
- Both of these CAQH CORE rules include a direct recognition that the experience and learning gained from increased EFT/ERA enrollment may identify ways in which the maximum data sets need to be modified, e.g.
  - Meet emerging, new or changing industry needs
  - Business rationale to add/remove data elements or adjust definitions
- Per the mandated rule, this maintenance and review of the data sets will occur on an annual or semi-annual basis; first review shall commence one year after the final passage of the Federal regulation requiring implementation
EFT & ERA Enrollment Data Rules
Implementation Challenges and Lessons Learned

Chad Warmack
Tammie Savage
Samantha Cook
If you already support electronic enrollment, can you separate the EFT and ERA enrollment functions from the rest of the provider enrollment system?

Do you intend to support paper enrollment going forward?

Does your system support “Aggregation of ERA and EFT data” by NPI or TIN?
Michigan EFT Enrollment Challenges

- Treasury system does not differentiate types of vendors
  - Use a mail code to designate health care payment

- Sunsetting Treasury database limited capacity
  - 3rd-party interface collects/validates new Michigan vendor information, needed new button to show correct enrollment data element names and descriptions to health care providers
  - Especially challenging for vendors already enrolled who want to change from paper to EFT

- Not able to use some required information collected
  - Account linkage preference
  - NPI
  - Reason for submission
    - What is meaning of collection?
Minimum & Maximum Fields

- Required to capture minimum fields that will not be used. Maximum fields eliminate the ability to request additional information.

Changing ERA Enrollment

- ERA enrollment is automatic. A trading partner agreement is needed to exchange 835s so a separate ERA enrollment form is not needed.

Temporary Solution

- In the process of implementing a new provider enrollment system, had to modify EFT enrollment in a legacy system that will only be used for a short time.
Second Set of CAQH CORE Operating Rules: 
Reassociation (CCD+/835) Rule
EFT & ERA Reassociation (CCD+/835) Rule:
Three Key Rule Requirements

1. CORE-required Minimum CCD+ Reassociation Data Elements:
   • Health plan must inform provider during enrollment to contact bank for the delivery of CORE-required Minimum CCD+ Reassociation Data Elements (banks not required to report)
   • Provider must proactively contact bank for data
   • NOTE: The CAQH CORE EFT & ERA Enrollment Data Rules contain complementary requirements

2. Elapsed Time Requirements:
   Health plan must release the 835 no sooner than three business days before and no later than three business days after the CCD+ Effective Entry Date 90% of time and track/audit this elapsed time requirement

3. Resolving Late/Missing EFTs/ERAs:
   Health plan must establish written Late/Missing EFT and ERA Transactions Resolution Procedures

Pre- Payment: Provider Enrollment

Claims Payment Process

Health Plan

Claim Processing

Treasury

X12 v5010 835

Provider

Billing & Collections

Healthcare EFT Standard

CORE-required Minimum ACH CCD+ Data Elements sent to Provider by request

Goal of Rule: Successful reassociation of EFT and ERA

Bank

Bank

Treasury

Committee on Operating Rules for Information Exchange
A CAQH Initiative

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Problem Addressed & Key Impact

• Problem addressed by rule:
  – Challenges with provider reassociation of *remittance* data to *payment* data because necessary data provider requires are incorrect, missing, not available, or have not been requested on the two transactions in a way that is meaningful to the provider or its financial institution

• Key impact:
  – Coordinates healthcare and financial services industry
    • When receipt of payment occurs with minimal elapsed time between receipt of remittance advice, providers can more quickly match payments with data and post to patient accounts on a more timely basis
  – Provides assurance that trace numbers between payments and remittance can be used by providers
  – Reduces level of open accounts receivable by enabling provider to generate cross-over claims to other payers and to collect payment from patient
  – Enables provider to more quickly address denials or appeal adjustments to claim amount
Reassociation (CCD+/-835) Rule
Implementation Challenges and Lessons Learned

Chad Warmack
Tammie Savage
Samantha Cook
Challenges to Implementing the ERA/EFT Reassociation Rule

- Does your system already use the CCD+ standard for communicating EFT?

- Does your state treasury support non-healthcare payments?
Michigan Reassociation Challenges

- Identify Providers that need to switch from CTX version to upgrade to CCD+
- Contact Trading Partners for new format for TRN02 (Reassociation Trace Number)
- Create a new REF segment for the ODFI provider detail
- Work out details on recovery of money
- Resolve issues with late or missing EFT and ERA transactions
Delaying RAs
- Challenging to hold RA disbursement. One sister state agency, acting as a health plan, needs the RA immediately following the financial cycle in order to do processing for disbursement to their providers. Had to develop a method to hold some RAs and send others immediately.

Payment File Format
- Lack of knowledge around EFT payment process. CCD+ addenda record was not populated with all of the required information.
Second Set of CAQH CORE Operating Rules: 
*Uniform Use of CARCs and RARCs Rule*
CORE 360 Rule: Uniform Use of CARCs and RARCs

Four Business Scenarios

Pre-CORE Rules

- 241 CARCs
- 880 RARCs
- 4 CAGCs

Inconsistent Use of Tens of Thousands of Potential Code Combinations

Post CORE Rules

Four Common Business Scenarios

- **CORE Business Scenario #1:**
  - Additional Information
  - Required – Missing/Invalid/Incomplete Documentation
  - (≈316 code combos)

- **CORE Business Scenario #2:**
  - Additional Information
  - Required – Missing/Invalid/Incomplete Data from Submitted Claim
  - (≈289 code combos)

- **CORE Business Scenario #3:**
  - Billed Service Not Covered by Health Plan
  - (≈343 code combos)

- **CORE Business Scenario #4:**
  - Benefit for Billed Service Not Separately Payable
  - (≈31 code combos)

Code Combinations not included in the CORE-defined Business Scenarios may be used with other non-CORE Business Scenarios.
### CAQH CORE Code Combinations Maintenance Process

| CORE Business Scenario #1: Additional Information Required – Missing/Invalid/Incomplete Documentation | ≈316 code combos |
| CORE Business Scenario #2: Additional Information Required – Missing/Invalid/Incomplete Data from Submitted Claim | ≈289 code combos |
| CORE Business Scenario #3: Billed Service Not Covered by Health Plan | ≈343 code combos |
| CORE Business Scenario #4: Benefit for Billed Service Not Separately Payable | ≈31 code combos |

#### CAQH CORE Compliance-based Reviews
- Occur 3x per year
- Triggered by tri-annual updates to the published CARC/RARC lists by code authors
- Include only adjustments to code combinations to align with the published code list updates (e.g. additions, modifications, deactivations)

#### CAQH CORE Market-based Reviews
- Occur 1x per year
- Considers industry submissions for adjustments to the **CORE Code Combinations based on business needs** (addition/removal of code combinations and potential new Business Scenarios)
- Opportunity to refine the **CORE Code Combinations as necessary to ensure the CORE Code Combinations** reflect industry usage and evolving business needs
Problem Addressed & Key Impact

• Problem addressed by rule:
  – Providers do not receive uniform code combinations for same or similar business scenarios from all health plans; as a result, are unable to automatically post claim payment adjustments and denials accurately and consistently
  – Focus on minimum business scenarios with maximum set of code combinations targeting major provider usage problems/high volume code combinations
    • Without business scenarios and maximum set of code combinations, there are over 770 RARCs, approximately 220 CARCs and 4 CAGCs resulting in thousands of possible code combinations for review by providers

• Key impact:
  – Potential reduction in manual claim rework: With more consistent use of denial and adjustments codes per the CORE-defined Business Scenarios, providers will have less rework and can automate payment posting
    • Less staff time spent on phone calls and websites and increased ability to conduct targeted follow-up
  – Improved denials management: Providers will be able to more accurately understand reasons for claim adjustments and denials due to more consistent use of codes across health plans
  – Improved collections: Providers can more effectively obtain payment from patients, more quickly generate cross-over claims to other payers, and reduce open accounts receivable
  – Reduction in cost-to-collect: Consistent use of the CARCs and RARCs will enable providers spent less time/money resolving adjustments and denials
CARCs and RARCs Code List Maintenance
External to CAQH CORE

As the recognized Federal standard/code authors, ASC X12 and the Code Maintenance Committees (which are separate from ASC X12) are responsible for maintaining CARC/RARC/CAGC definitions. Adjustments to the definition of such codes must be addressed via the specific author.

**CARCs**
(CARC Code Committee)

- Total # of CARCs: **241**
  - not all in CORE Code Combinations
- There are approximately 35 CARC Committee members representing a variety of stakeholder including health plans, associations, vendors, and government entities
- Entities can complete the CARC Change Request Form found [HERE](#)*

**RARCs**
(RARC Code Committee)

- Total # of RARCs: **880**
  - not all in CORE Code Combinations
- The RARC Committee members represent various components of CMS
- Entities can complete the RARC Change Request Form found [HERE](#)

**CAGCs**
(ASC X12)

- Total # of CAGCs: **4**
  - All are in CORE Code Combinations
- Part of the ASC X12 standard, therefore, can only be revised when a new HIPAA mandated version of X12 standards is issued; current version is ASC X12 v5010
- Entities can submit a request to ASC X12

*Before submitting a CARC Change Request Form, entities are first encouraged to contact a member of the committee to “facilitate their request by allowing someone familiar with the approval process to discuss an alternate solution (if appropriate) for their need, or enabling that committee member to obtain additional background information which could help with the request”. Committee list is available [HERE](#).
Uniform Use of CARCs and RARCs Rule
Implementation Challenges and Lessons Learned

Chad Warmack
Tammie Savage
Samantha Cook
Challenges Implementing the Uniform use of CARC/RARC Rule

- Does your system currently facilitate regular updates to CARC/RARC values?
- Do you have procedures in place to determine when new CARC/RARC code combinations are published?
- Do you have procedures in place to apply updates once they are identified?
- Do you have procedures in place to notify providers of updates to CARC/RARC codes that your system will use?
Verifying the CARCs/RARCs that are returned to provider on 835/RA meets any of the four business scenarios.

Changes to up front edits from informational to deny before submission of claim for end dated CARC/RARC codes.

Challenges are to locate an appropriate message that clearly defines the Program’s coverage/payment intent. Some do not fit into the standard four business scenarios making it difficult for providers to understand the rejections.

Staff time for going thru each internal error code in the system and make sure crosswalk to appropriate CARC/RARC. Plan time on maintenance of CARC/RARC codes and submit changes in timely manner.
Missouri CARC/RARC Challenges

- Adapting Policy to CORE Scenarios
  - Difficult to find code to match business scenario.
  - Different terms are used, it is difficult to find the appropriate code using a word search.
  - Scenarios prevented us from using some RARCs that worked perfectly.
  - Not allowed to report RARCs with some CARCs, but our system has a RARC with every edit.

- Set-Up and Maintenance
  - Very time consuming. Still doing initial review when the May/July changes came out. This caused a lot of rework because of the CARC 16 and 125 changes.
Please submit your question:

- **Via the Web**: Enter your question into the Q&A pane in the lower right hand corner of your screen
- **By Phone**: When prompted by the operator, press * followed by the number one (1) on your keypad
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Transition to ICD–10 | [www.cms.gov/icd10](http://www.cms.gov/icd10)
Medicare and Medicaid Electronic Health Records (EHR) Incentive Programs | [www.cms.gov/ehrincentiveprograms](http://www.cms.gov/ehrincentiveprograms)
Second Set of CAQH CORE Operating Rules:

Infrastructure Rule – Companion Guides