CAQH CORE and ASC X12
Open Mic

Compliance with the ERA Standard
and the EFT & ERA Operating Rules

October 15, 2013
2:30pm – 4:00pm 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

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Session Topics

• Introduction and Level-setting
  – ACA Section 1104 – Administrative Simplification
• HIPAA-mandated v5010 ASC X12 835 (ERA) Transaction Standard
  – Overview of ERA Standard
  – Challenges to ERA Standard Compliance
    • Balancing
    • Structure
    • Responsibilities of Trading Partners
• Second Set of CAQH CORE Operating Rules – EFT and ERA
  – Overview, Rule Requirements and Benefits
  – Implementation Perspectives from Aetna
• Questions?
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
  • 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.

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 Mandated Operating Rules Compliance Dates: Required for all HIPAA Covered Entities

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.
EFT and ERA Transaction Flow

- EFT and ERA operating rules represent the convergence of financial services and healthcare.
- Together the transactions foster the goals of administrative simplification by moving the process of reimbursement from paper to electronic.
  - ERA is an electronic transaction that enables providers to receive claims payment information from health plans (payers) electronically; ERA files are intended to replace the paper Explanation of Payment (EOP).
  - EFT enables providers to receive claims payments electronically.
ASC X12 Overview:

HIPAA Mandated v5010

ASC X12 835 Transaction Standards
HIPAA-ADOPTED EDI TRANSACTION STANDARDS

Most HIPAA-adopted EDI transaction standards are ASC X12 standards

- Current mandated version is ASC X12 5010; mandated as of January 2012
- For each standard, ASC X12 Technical Report Type 3 (TR3) specifies:
  - Data segments must be used
  - Segment sequence, whether segments are mandatory or optional, when segments can be repeated
  - How loops are structured and used
HIPAA Mandated ASC X12 5010 835 Transaction Standard is structured as follows:

- **Table 1 Header**
  - Contains the payment details, sender and receiver and other information about the specific 835

- **Table 2 Detail**
  - Contains claim payment detail related to the claim and services being reported and adjudication information

- **Table 3 Summary**
  - Contains provider level adjustment details
Compliant 835 transaction
Some challenges with the 835:

• Balancing
• Understanding the overall structure of the 835 transaction
• Responsibilities of Trading Partners
• Understanding the reason why an amount was adjusted
• Payment – EFT vs. Check
• Timing of receipt of the 835 and the associated payment
Compliant 835 transaction

- **Balancing**
  - Understanding the overall structure of the 835 transaction
  - Responsibilities of Trading Partners
  - Understanding the reason why an amount was adjusted
  - Payment – EFT vs. Check
  - Timing of receipt of the 835 and the associated payment
Balanced 835 - 3 levels of balancing

- Service line
  - Charge amount – adjustments = payment

- Claim
  - Total claim charge amount – adjustment = payment
    - Note – adjustments at service or claim (but not both)

- Transaction
  - Sum all claim payment amounts – provider level adjustment = total payment
Balanced 835 - 3 levels of balancing

- Common reason for an out of balanced transaction is incorrect adjustments
  - Missing dollar amounts
  - Adjustment repeated at line and claim
  - Provider level adjustments

- The 835 TR3 contains front matter section 1.10.2.1 Balancing that explains how the transaction must balance at each level when using the 835
Compliant 835 transaction

- Balancing
- **Understanding the overall structure of the 835 transaction**
- Responsibilities of Trading Partners
- Understanding the reason why an amount was adjusted
- Payment – EFT vs. Check
- Timing of receipt of the 835 and the associated payment
Structure of 835 transaction
Enveloping theory

- Interchange ISA/IEA
  - Identifies the sender, receiver, interchange ID, date/time and delimiters
    - One interchange can contain multiple Group envelopes
- Functional Group GS/GE
  - Identifies the sender, receiver, date/time, group ID and transaction version
    - One functional group can contain multiple transactions
Structure of 835 transaction

Enveloping theory

- Transaction ST/SE
  - Identifies the transaction type
  - Contains a single business transaction (i.e., 835)
  - Contains the set of data starting with Table 1 (payment, payer, payee), Table 2 (claim detail) and Table 3 (provider level adjustment).
  - The total of the claim payment(s) must equal the transaction payment amount = EFT or Check
Structure of 835 transaction

Enveloping theory

- One transaction contains **ONLY** one payment
- One Functional Group contains one or more transactions (each of which has one payment per transaction)
- One Interchange contains one or more payments

- **One payment** = one EFT or one check = one trace number
Compliant 835 transaction

- Balancing
- Understanding the overall structure of the 835 transaction
- **Responsibilities of Trading Partners**
  - Understanding the reason why an amount was adjusted
  - Payment – EFT vs. Check
  - Timing of receipt of the 835 and the associated payment
Responsibilities of Trading Partners

All covered entities MUST comply with all HIPAA and ACA mandated operating rules.

Any entity that has a contract or business associate agreements with a covered entity MUST comply with all HIPAA and ACA mandated operating rules.
Compliant 835 transaction

CAQH CORE Operating Rules help address these issues:

- Balancing
- Understanding the overall structure of the 835 transaction
- Responsibilities of Trading Partners
- Understanding the reason why an amount was adjusted
- Payment – EFT vs. Check
- Timing of receipt of the 835 and the associated payment
Second Set of CAQH CORE Operating Rules: 

*EFT & ERA*
EFT & ERA Operating Rules
Rules in Action

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

Infrastructure Rules

- Uniform Use of CARCs & RARCs Rule

Provider

- Billing & Collections

Electronic Funds Transfer (CCD+/TRN)

Stage 1: Initiate EFT

Bank

Treasury

Payment/Advice (835)

Increased System Availability

Internet Connectivity and Security

Real-time and Batch Response Times

Standard Companion Guides

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

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

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

<table>
<thead>
<tr>
<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) |  
• 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** |  
• 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 |
| **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](#).
EFT and ERA: Operating Rules Build On Standards

- Healthcare operating rules pair data content and infrastructure operating rules to help data flow consistently in *varied settings and with various vendors*.
- Operating Rules can address gaps in standards, such as additional content available with further use of standard, or identify infrastructure needed to ensure electronic transaction flow among standards.

**CAQH CORE EFT & ERA Operating Rules**
- Provider enrollment in EFT and ERA
- Infrastructure for supporting the ERA
- Uniform use of codes for conveying claim adjustments/denials
- Reassociation of the EFT and ERA

**ACH CCD+ & X12 v5010 835**
- **EFT**: NACHA CCD+ Addenda *must* contain the TRN Reassociation Trace Number data segment as defined by X12 835 TR3 version 5010.
- **ERA**: X12 v5010 835

Together, EFT & ERA Standards and Operating Rules will deliver efficiency and consistency across the healthcare industry.

*In July 2012, CMS announces adoption of NACHA ACH CCD+ as federally mandated EFT Standard.*

Compliance date for both the Healthcare EFT Standard and EFT & ERA Operating Rules is January 1, 2014; requirements to support the X12 v5010 835 are already in effect.
Snapshot of Aetna

Aetna is one of the nation's leaders in health care, dental, pharmacy, group life, and disability insurance, and employee benefits.

Membership

– Over 18 million medical members
– More than 13 million dental members
– Approximately 8.7 million pharmacy members

Health care networks

– More than 1 million health care professionals
– More than 597,000 primary care doctors and specialists
– More than 5,400 hospitals

• Broad range of insurance and employee benefits products:
  – Consumer-directed health plans such as Health Savings Account, Health Reimbursement Account and Retiree Reimbursement Accounts
  – Case management; disease management and patient safety programs; integrated medical, dental, pharmaceutical, behavioral health and disability information
  – Convenient tools and easy-to-understand information for members that can help them make better-informed decisions about their health and financial well-being

• National Presence
  – Benefits through employers in all 50 states, with products and services targeted specifically to small, mid-sized and large multi-site national employers
  – Serves individuals and Medicare and Medicaid beneficiaries in certain markets
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

• These operating rules **DO NOT** preclude health plans or their agents 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
  – Creating a single form for the purposes of both EFT and ERA enrollment*
  – Using an inclusive form (i.e. a single form to enroll providers in ALL electronic transactions) for the purposes of EFT Enrollment*

* As long as the flow, format and included data elements adhere to those outlined in the CORE 380 & 382 Rules
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

• 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
ERA and EFT Enrollment processes

✓ Complete revision of our paper enrollment forms, ensuring they are compliant with all operating rules
  • These updated forms to be published later this year.

✓ Entered into a partnership with CAQH to provide electronic EFT enrollment for providers through their enrollment tool.

✓ Electronic ERA enrollment available on Aetna.com
Second Set of CAQH CORE Operating Rules:

ERA Infrastructure Rule
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

Companion Guide

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

**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 Claim Payment/Advice (835) Infrastructure Rule

**Problem Addressed & Key Impact**

- **Problem addressed by rule:**
  - HIPAA provides a foundation for the electronic exchange of claim payment information, but does not provide infrastructure to promote the move from today’s paper-based system to an electronic, interoperable system

- **Key impact:**
  - Enables providers, health plans and intermediaries to extend and leverage investment in connectivity infrastructure by requiring support of Phase II CAQH CORE Connectivity Rule
  - Continues to build on Phase I/II use of CAQH CORE Master Companion Guide Template so that providers can quickly find details necessary for the exchange of the X12 v5010 835
  - Reduces probability that providers will discontinue receipt of X12 v5010 835 due to system issues for effective use of remittance advice data to post to patient account
Aetna

- Aetna has implemented and continues to support the requirements of the CAQH CORE Infrastructure rule
  - We use and maintain CORE Operating Rule compliant Companion Guides, listing those items where our implementation may not utilize data included in the HIPAA Implementation Guide (TR3)
  - We offer compliant connectivity options to those submitters who request them, while continuing to support our current submitters without disruption as allowed by the CORE Operating Rules
  - We support dual delivery during the transition period for new adopters of the Electronic Remittance Advice.
    - Our dedicated ERA team members work closely with providers during the enrollment and transition period to ensure a smooth transition
    - We reviewed our internal processes to identify changes as a result of the CORE Operating Rule requirements. These process adjustments will not create any changes to our interactions with the provider outside those directly related to a rule, e.g., ERA or EFT Enrollment

If you are a provider and would like more information about ERA/EFT with Aetna, go to:
http://www.aetna.com/healthcare-professionals/claims-administration/billing-payment-reimbursement.html
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

Health Plan

Claims Processing

Treasury

X12 v5010 835

Bank

Bank

Provider

Billing & Collections

Healthcare EFT Standard

Goal of Rule: Successful reassociation of EFT and ERA

CORE-required Minimum ACH CCD+ Data Elements sent to Provider by request
CAQH CORE EFT & ERA Reassociation (CCD+/835) Rule

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
EFT & ERA Reassociation (CCD+/835) Rule: Aetna

✓ Success of the CCD+ portion of the CORE Reassociation Rule required that we make a small change in our EFT file.

✓ We implemented a change in our CCD+ Addenda record to remove the provider business grouping (PBG), which allows us to meet the compliance requirement for this CORE Operating Rule.
  – Without this change, the matching process between the ERA and the EFT would not be successful - the two would not be equal
  – Our change was implemented in August 2013
EFT & ERA Reassociation (CCD+/835) Rule: Aetna

- Requirements of the Elapsed Time portion of the CORE Reassociation Rule require that we be able to monitor the time between release of the ERA and the EFT.
  - We will be creating internal reporting to allow us to monitor the elapsed time between the release of these two files
  - This change will be implemented in 4Q 2013
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

323 CARCs × 954 RARCs × 4 CAGCs = Inconsistent Use of Tens of Thousands of Potential Code Combinations

Post CORE Rules

CORE Business Scenario #1: Additional Information Required – Missing/Invalid/Incomplete Documentation (≈332 code combos)

CORE Business Scenario #2: Additional Information Required – Missing/Invalid/Incomplete Data from Submitted Claim (≈306 code combos)

CORE Business Scenario #3: Billed Service Not Covered by Health Plan (≈452 code combos)

CORE Business Scenario #4: Benefit for Billed Service Not Separately Payable (≈40 code combos)

Four Common Business Scenarios

Code Combinations not included in the CORE-defined Business Scenarios may be used with other non-CORE Business Scenarios

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CAQH CORE Code Combinations Maintenance Process

CORE Business Scenario #1:  
Additional Information Required – Missing/Invalid/Incomplete Documentation  
(≈332 code combos)

CORE Business Scenario #2:  
Additional Information Required – Missing/Invalid/Incomplete Data from Submitted Claim  
(≈306 code combos)

CORE Business Scenario #3:  
Billed Service Not Covered by Health Plan  
(≈452 code combos)

CORE Business Scenario #4:  
Benefit for Billed Service Not Separately Payable  
(≈40 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

Stability of CORE Code Combinations maintained

Supports ongoing improvement of the CORE Code Combinations
CAQH CORE Uniform Use of CARCs & RARCs (835) Rule
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 954 RARCs, approximately 323 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: **323**
  - 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: **954**
  - 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](#)*
There are two components to support for this CORE Operating Rule:

- Initial implementation of support for the Scenarios and Code Combinations
- Ongoing support of code changes and/or new scenarios (if applicable)

It is important to remember that the concept of the codes changing or being added up to 3 times a year is not new. It has always been required to create a compliant electronic remittance advice (835) transaction. The CORE Operating Rules add the concept of ‘scenarios’ and code combinations.
Initial implementation of support for the CORE Scenarios and Code Combinations

- We reviewed approximately 6,000 internal “action codes” that were mapped to Group/CARC/RARC codes
- These “action codes” and their associated Group/CARC/RARC code combinations were assigned, where applicable, into the 4 CORE-defined Business Scenarios
  - We are currently comparing the code combinations for the Group/CARC/RARC mappings to the [October 2013 CORE Code Combinations v3.0.3](#)
  - Changes to mappings may be necessary as a result of this process
Ongoing support of CORE Combination changes and/or new CORE Scenarios (if applicable)

− We have subscribed to CORE’s Constant Contacts list so that we receive all updates to the CORE Code Combinations and scenarios*

− CORE Code Combination changes identified in the communications receive review to ensure that our existing mapping is consistent with what is required by the CORE Operating Rule

− Changes to mappings may be necessary as a result of this process

*We also monitor the WPC-EDI.com for other updates to these code lists, which is incorporated into a similar process
Uniform Use of CARCs and RARCs Rule Resources:  
**CAQH CORE 360 Rule FAQs**

**Q:** As a health plan, are we allowed by the CAQH CORE 360 Rule to use code combinations that are not included in the CORE-required Code Combinations for CORE-defined Business Scenarios for other business scenarios beyond the minimum set of CORE-defined Business Scenarios?

**Q:** I am a vendor, CAQH CORE 360 Rule, Section 4.2, Basic Requirements for Receivers of the X12 v5010 835, requires that provider facing products display text describing the CORE-defined Claim Adjustment/Denial Business Scenarios and Code Combinations to the end user. Is there specific text that such products must display?

**Q:** To what types of entities do the requirements in Section 4.2, Basic Requirements for Receivers of the X12 v5010 835, of the CAQH CORE 360 Rule apply?

**Q:** How long does my health plan have to comply with the updates to the CAQH CORE CARC/RARC Code Combinations for the existing scenarios?

*Access answers to these, as well as many other, FAQs HERE*
New CAQH CORE 360 Rule and the Code Combinations Maintenance Process Website

• A free and accessible “one stop shop” website to provide resources and tools to implementers of the CAQH CORE 360 Rule
• Interactive website includes easy to access information and valuable tools for implementers including:
  – Access to current and past versions of the CORE Code Combinations
  – Publication schedule and Compliance Dates for updated versions of the CORE Code Combinations
  – Status of CORE Code Combinations Task Group efforts
  – Process and online form for industry submission of Market-based Adjustments
  – Outline the impact of updated versions of the CORE Code Combinations for each stakeholder
  – Online submission of questions/feedback regarding the CORE Code Combinations Maintenance Process
  – Lists of Internal and External Resources Related to the CARCs and RARCs

Please send any additional ideas or needs for this website to CORE@caqh.org
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
Thank You for Joining Us!