Committee on Operating Rules for Information Exchange (CORE®)

Phase III CORE 382 ERA Enrollment Data Rule version 3.0.0

NOTE: This document is not the most current version of the Phase III CORE 382 ERA Enrollment Data Rule. The current version is available on the CAQH CORE website HERE.

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1 Background Summary

In Phase III, CORE built on the Phase I and Phase II foundation by adding a range of operating rule requirements for both the HIPAA-adopted ASC X12 005010X221A1 Health Care Claim Payment/Advice (835) Technical Report Type 3 Implementation Guide and associated errata (hereafter v5010 X12 835) transaction, also known as the Electronic Remittance Advice (ERA), and the Electronic Funds Transfer (EFT) by addressing operating rules related to the NACHA ACH CCD plus Addenda Record (hereafter CCD+) and the X12 835 TR3 TRN Segment (hereafter the CCD+ and X12 835 TR3 TRN Segment together are the Healthcare EFT Standards[1]).

This set of operating rules includes the application of the Phase I and Phase II CORE infrastructure rules to the conduct of the v5010 X12 835 (Phase III CORE 350 Health Care Claim Payment/Advice (835) Infrastructure Rule Version 3.0.0) so a focus can be placed on improving the conduct and exchange of electronic claim advice data given these transactions can have a direct impact on a provider's revenue cycle management process. The Phase III CORE Rule Set also includes a Phase III CORE 370 EFT & ERA Reassociation (CCD+/835) Rule Version 3.0.0, which has identified the critical data elements for reassociating the payment and remittance advice when they travel separately. Working together, the CORE rules complement each other in order to reduce the current cost of today's paper-based transaction process and to move the industry to fully embracing a real-time, transparent electronic world.

Along with the ERA, the EFT or electronic payment made to the provider from the health plan furthers the automated processing of healthcare payments; paper checks and their manual processing are eliminated. In addition to the aforementioned rules, Phase III also includes a CORE EFT Enrollment Data Rule which builds upon the other Phase III CORE EFT-and ERA-related rules by addressing a key barrier to the use of EFT by providers – a cumbersome, and in many cases, incomplete EFT enrollment data set that doesn't speak to the electronic needs of the system – and further enables the automated processing of healthcare payments. This rule addresses similar challenges related to provider ERA enrollment.

Currently, healthcare providers or their agents[2] face significant challenges when enrolling to receive ERAs from a health plan including:

- A wide variety in data elements requested for enrollment
- Variety in the enrollment processes and approvals to receive the ERA
- Absence of critical elements that would address essential questions regarding provider preferences on payment options

Conversely, health plans are also challenged by the effort and resources required to enroll providers and maintain changes in provider information over time. As a result, some plans may prioritize converting high volume claim submitters to ERA over converting lower volume submitters, even though the low volume submitters may account for the vast majority of providers submitting claims.

Consistent and uniform operating rules enabling providers to quickly and efficiently enroll for ERA will help to mitigate:

- Complex and varied enrollment processes
- Variation in data elements requested for enrollment

[1] The CCD+ and X12 835 TR3 TRN Segment are adopted together as the Federal Healthcare EFT Standards in CMS-0024-IFC: Administrative Simplification: Adoption of Standards for Health Care Electronic Funds Transfers (EFTs) and Remittance Advice, 01/10/12.

[2] One who agrees and is authorized to act on behalf of another, a principal, to legally bind an individual in particular business transactions with third parties pursuant to an agency relationship. Source: West's Encyclopedia of American Law, edition 2. Copyright 2008 The Gale Group, Inc. All rights reserved.

- Lack of electronic access to enrollments
- Missing requests for critical elements that help address system-wide automation

And provide for:

- Less staff time spent on phone calls and websites
- Increased ability to conduct targeted follow-up with health plans
- Broader adoption of ERA by providers
- An ability to ensure the enrollment process is coordinated with the next steps in payment process

1.1 Affordable Care Act Mandates

This rule is part of a set of rules that addresses a request from the National Committee on Vital and Health Statistics (NCVHS) for fully vetted CAQH CORE Operating Rules for the EFT and ERA transactions; the NCVHS request was made in response to NCVHS' role in Section 1104 of the Affordable Care Act (ACA).

Section 1104 of the ACA contains an industry mandate for the use of operating rules to support implementation of the HIPAA standards. Using successful, yet voluntary, national industry efforts as a guide, Section 1104 defines operating rules as a tool that will build upon existing healthcare transaction standards. The legislation outlines three sets of healthcare industry operating rules to be approved by the Department of Health and Human Services (HHS) and then implemented by the industry, the second set of which are those for EFT and ERA.[3] The ACA requires HHS to adopt a set of operating rules for both of these transactions by July 2012. In a letter dated 03/23/11,[4] NCVHS recommended that the Secretary "name CAQH CORE in collaboration with NACHA – The Electronic Payments Association as the candidate authoring entity for operating rules for all health care EFT and ERA transactions..."

Section 1104 of the ACA also adds the EFT transaction to the list of electronic health care transactions for which the HHS Secretary must adopt a standard under HIPAA. The section requires the EFT transaction standard be adopted by 01/01/12, in a manner ensuring that it is effective by 01/01/14. In January 2012, HHS issued an Interim Final Rule with Comment (IFC)[5] adopting the CCD+ and the X12 835 TR3 TRN Segment[6] as the Healthcare EFT Standards. These standards must be used for electronic claims payment initiation by all health plans that conduct healthcare EFT.

2 Issue to be Addressed and Business Requirement Justification

It is a challenge for each provider, whether large or small, to complete enrollment and maintain changes in their information for ERA uniquely with each payer. It is equally challenging for each payer to collect and implement identification and other information from every provider for ERA – moreover, common lessons learned on necessary requests to streamline the process are not being identified due to all this variation. Providers seeking to

[3] The first set of operating rules under ACA Section 1104 applies to eligibility and claim status transactions with an adoption date of 07/01/11 and effective date of 01/01/13; the third set of operating rules applies to healthcare claims or equivalent encounter information transactions, enrollment and disenrollment in a health plan, health plan premium payments and referral, certification and authorization with an adoption date of 07/01/14 and effective date of 01/01/16.
[4] NCVHS Letter to the Secretary - Affordable Care Act (ACA), Administrative Simplification: Recommendation for entity to submit proposed operating rules to support the Standards for Health Care Electronic Funds Transfers and Health Care Payment and Remittance Advice 03/23/11.
[5] CMS-0024-IFC: Administrative Simplification: Adoption of Standards for Health Care Electronic Funds Transfers (EFTs) and Remittance Advice, 01/10/12.
[6] The IFC requires health plans to input the X12 835 TR3 TRN Segment into the Addenda Record of the CCD+; specifically, the X12 835 TR3 TRN Segment must be placed in Field 3 of the Addenda Entry Record (''7 Record'') of a CCD+.

enroll for ERA often face different enrollment formats and requirements. For many providers the enrollment process is cumbersome and time-consuming.

2.1 Problem Space

CORE EFT & ERA Subgroup Participant surveys and discussion have identified significant barriers to achieving industry-wide rapid adoption of EFT and ERA; much of these findings have been reiterated by CAQH CORE and NACHA research as well as research by other industry efforts. One of the key barriers identified is the challenge faced by providers due to the variances in the processes and data elements requested when enrolling in ERA with a health plan.

Due to the variations across health plans in the data elements requested, providers manually process enrollment forms for each plan to which they bill claims and from which they wish to receive an ERA. This results in unnecessary manual processing of multiple forms requesting a range of information – not necessarily the same – as noted by research findings – and, in the case when it is the same, often using a wide variety of data terminology for the same semantic concept (i.e., "Provider" vs. "Name").

This inconsistent terminology for the same data element during ERA enrollment can cause confusion and incorrect data to be entered during the enrollment process resulting in further delays as manual processes are used to clarify the inaccurate data – telephone calls, faxes, emails and original enrollment documents are returned to the provider for review, correction and resubmission to the health plan.

The manual and time-consuming process required by many of the current enrollment processes today and the variety of enrollment forms and data requirements cost the industry time and money – and, in many cases, does not address the key items that are needed to use the ERA enrollment information to fully automate both claims payment and remittance advice posting processes. As a consequence, providers are often reluctant to implement ERA with many health plans, particularly those plans that have seemingly difficult or extensive requirements for enrollment.[7] It is well understood that ERA enrollment is not the only challenge with regard to provider adoption of ERA; however, it is one of the pieces of the puzzle and thus does need to be addressed, especially given the significant challenges that the other Phase III CORE Rules are working to improve.

2.2 CORE Process in Addressing the Problem Space

To address the Problem Space associated with ERA enrollment, the CORE EFT & ERA Subgroup and its Work Group conducted a series of surveys, numerous Subgroup discussions and significant review of industry ERA enrollment forms and research related to existing industry initiatives (e.g., Workgroup for Electronic Data Interchange [WEDI], etc.) to inform development of this Phase III CORE Rule.

2.2.1 Research and Analysis of EFT & ERA Enrollment Forms

The CORE EFT & ERA Subgroup completed a number of research steps to determine a set of data elements to serve as a maximum data requirement for ERA enrollment. These key research steps included:

- Created source list for representative sample of ERA enrollment forms
- Using source list, obtained a representative sample of approximately 45 enrollment forms from eight key industry sectors (National Plans, Regional Plans, State Medicaid, Medicare, Clearinghouses, Worker's Compensation, Employer Owned [including Provider Owned], Third-Party Administrators)

[7] CAQH CORE/NACHA White Paper: Adoption of EFT and ERA by Health Plans and Providers: A White Paper Identifying Business Issues and Recommendations for Operating Rules (2011)

- Identified frequency of data elements and key semantic concepts across source list enrollment forms and elements needing clarity; considered data elements utilized by external resources, e.g., the U.S. Postal Service, *NACHA Operating Rules*, etc.
- Using direct research findings and indirect sources (i.e., related white papers by WEDI, etc.), created a list of required data elements with definitions and other rule requirements using agreed-upon evaluation criteria
- Outlined the essential elements needed to address provider preferences and electronic transaction needs

CAQH CORE conducted substantial analysis to compare ERA enrollment forms from across the industry and follow-up with specific industry sectors such as pharmacy. Using Subgroup-approved evaluation criteria, a set of universally necessary ERA enrollment data elements was identified by the CORE Participants as well as the detailed Rule Requirements around these ERA enrollment data elements. The CORE Participants agreed that these data elements represented the *maximum* set of data elements required for successful ERA enrollment. Therefore, this Phase III CORE Rule addresses the maximum set of data elements required for providers enrolling for receipt of the ERA from a health plan.

2.2.1.1 Evaluation Criteria to Identify Required ERA Enrollment Data Elements

The following evaluation criteria were used by the Subgroup to identify the list of required ERA enrollment data elements using direct (e.g., ERA enrollment forms utilized by health plans and vendors) and indirect (e.g., white papers that address the topic of standardization of ERA enrollment) sources:

- Quantitative findings of research, e.g.,
  - Include data elements that are frequently included across direct and indirect sources (e.g., elements included in 65% or more of all enrollment forms or research)
  - For data elements that have different terms used for the same semantic concept, e.g., meaning/intent, select one term for each data element (i.e., term selected would be used on 65% of forms; e.g., "Provider" vs. "Name")
- Qualitative discussions for elements that are unclear in the quantitative findings, but are directly related to agreed upon CORE EFT & ERA Subgroup high priority goals
  - Identified strong business need to streamline the collection of data elements (e.g., Taxpayer Identification Number [TIN] vs. National Provider Identifier [NPI] numbers)
  - Essential data for populating the Healthcare EFT Standards and the v5010 X12 835
  - Balance between time and resources (cost) to provide enrollment data versus necessity (benefit) to procure data element
  - Consistent with CORE Guiding Principles

3 Scope

3.1 When the Rule Applies

This rule applies when a health plan or its agent is enrolling a healthcare provider (or its agent) for the purpose of engaging in the receipt by the provider of the claim payment remittance advice electronically (ERA) from a health plan.

3.2 CORE-required Maximum ERA Enrollment Data Element Set

The data elements identified in Table 4.2-1 in §4.2 are the maximum number of data elements that a health plan or its agent may require a healthcare provider or its agent to submit to the health plan for the purpose of engaging in receipt by the provider of the claim payment remittance advice electronically (ERA) from a health plan.

The enrollment data elements in Table 4.2-1 represent a "controlled vocabulary" as a means to provide a common, uniform and consistent way for health plans to collect and organize data for subsequent collection and use. A controlled vocabulary reduces ambiguity inherent in normal human languages (where the same concept can be given different names), ensures consistency and is potentially a crucial enabler of semantic interoperability. The CORE-required Maximum ERA Enrollment Data Set (i.e., a controlled vocabulary) mandates the use of predefined and authorized terms that have been preselected by CORE Participants.

3.2.1 Data Element Group: Elements that May Need to be Requested Several Times

Several of the data elements in Table 4.2-1 can be logically related where each single discrete data element can form a larger grouping or a set of data elements that are logically related, e.g., a provider contact name and a contact number are typically requested together, or should be. Such logical Data Element Groups are shown in Table 4.2-1 by assigning a Data Element Group identifier (e.g., DEG1, DEG2, etc.) to the discrete data element included in the set of logically related data elements.

There are ten of these Data Element Groups (DEGs); each represents a set of data elements that may need to be collected more than once for a specific context (e.g., multiple provider contacts). Examples of the DEGs are: Provider's Agent Name and Address. Multiple uses of the same Data Element Group to collect the same data for another context are allowed by this rule and do not constitute a non-conforming use of the CORE-required Maximum ERA Enrollment Data Set.

3.3 What the Rule Does Not Require

This rule does not require any health plan to:

- Engage in the process of paying for healthcare claims electronically
- Conduct either the v5010 X12 835 or the Healthcare EFT Standards transactions
- Combine EFT with ERA enrollment
- Re-enroll a provider if the provider is already enrolled and receiving the ERA

3.4 CORE Process for Maintaining CORE-required Maximum ERA Enrollment Data Set

The CORE-required Maximum ERA Enrollment Data Set is a set of data elements determined by CORE to be the most appropriate data set to achieve uniform and consistent collection of such data at the time this rule was developed. CORE recognizes that as this rule becomes widely adopted and implemented in health care – and as ERA changes in the marketplace – the experience and learning gained from ERA enrollment may indicate a need to modify the maximum data set to meet emerging or new industry needs.

Given this anticipated need for data set maintenance activity, CORE recognizes that the focus of this rule, coupled with this need for unique modification of the data set, will require a process and policy to enable the data set to be reviewed on an annual or semi-annual basis. Any revisions to the data set will follow standard CORE processes for rule revisions. CORE will develop such a process and policy in accordance with CORE Guiding Principles following the approval of the Phase III CORE Operating Rules for first review of potential revisions to the data set. The first review shall commence one-year after the passage of a Federal regulation requiring implementation of this CORE rule. Substantive changes necessary to the data set will be reviewed and approved by CORE as necessary to ensure accurate and timely revision to the data set.

3.5 Outside the Scope of this Rule

This rule does not address any business relationship between a health plan and its agent or a healthcare provider and its agent.

Outside the scope of this rule is:

- The need to collect other data for other business purposes and such data may be collected at the health plan's discretion
- The method or mechanism for how a health plan exchanges ERA data internally
- The method or mechanism for how a health plan collects ERA data externally

3.6 How the Rule Relates to Phase I and II CORE

As with other Phase I and Phase II CORE Rules, general CORE policies also apply to Phase III CORE Rules and will be outlined in the Phase III CORE Rule Set.

3.7 Assumptions

A goal of this rule is to establish a foundation for the successful and timely enrollment of healthcare providers by health plans to engage in the ERA.

The following assumption applies to this rule:

- This rule is a component of the larger set of Phase III CORE Rules; as such, all the CORE Guiding Principles apply to this rule and all other rules

4 Rule Requirements

4.1 Requirements for a Health Plan, its Agent or Vendors Offering ERA Enrollment

A health plan (or its agent or vendors offering ERA enrollment) must comply with all requirements specified in this rule when collecting from a healthcare provider (or its agent) the data elements needed to enroll the healthcare provider for ERA.

4.2 CORE-required Maximum ERA Enrollment Data Elements

A health plan (or its agent or vendors offering ERA enrollment) is required to collect no more data elements than the maximum data elements defined in Table 4.2-1 CORE-required Maximum ERA Enrollment Data Set. Table 4.2-1 lists all of the CORE-required maximum Individual Data Elements and data element descriptions, organized by categories of information, e.g., Provider Information, Provider Identifiers Information, Federal Agency Information, Retail Pharmacy Information, Electronic Remittance Advice Information and Submission Information. Both the Individual Data Element name and its associated description must be used by a health plan (or its agent or vendors offering ERA enrollment) when collecting ERA enrollment data either electronically or via a manual paper-based process. The Individual Data Element Name and its associated description must not be modified.

Table 4.2-1 includes ten Data Element Groups, each representing a set of data elements that may need to be collected more than once for a specific context (Reference §3.2.1 above). Multiple uses of the same Data Element Group to collect the same data for another context are allowed by this rule and do not constitute a non-conforming use of the CORE-required Maximum Enrollment Data Set. These ten Data Element Groups are:

- DEG1: Provider Information
- DEG2: Provider Identifiers Information
- DEG3: Provider Contact Information
- DEG4: Provider Agent Information
- DEG5: Federal Agency Information
- DEG6: Retail Pharmacy Information
- DEG7: Electronic Remittance Advice Information
- DEG8: Electronic Remittance Advice Clearinghouse Information
- DEG9: Electronic Remittance Advice Vendor Information
- DEG10: Submission Information

Within each information category some data elements may be grouped into specific Data Element Groups (Reference §3.2.1). A DEG may be designated as required or optional for data collection. Within each DEG, Individual Data Elements may be designated as required or optional for data collection.

- When a DEG is designated as required, all of the required Individual Data Elements within the DEG must be collected by the health plan; Individual Data Elements designated as optional may be collected depending on the business needs of the health plan.
- When a DEG is designated as optional, the collection of the optional DEG is at the discretion of the health plan. When a health plan exercises its discretion to collect an optional DEG, any included Individual Data Element designed as required must be collected.
- Some required or optional Individual Data Elements are composed of one or more Sub-elements, where a Sub-element is designated as either required or optional for collection. When a health plan collects an optional Individual Data Element that is composed of one more optional Sub-elements, the optional Sub-element may be collected at the discretion of the health plan. When a health plan collects a required Individual Data Element that is composed of one or more optional Sub-elements, the optional Sub-element may be collected at the discretion of the health plan.

Not collecting an individual data element identified as optional does not constitute a non-conforming use of the CORE-required Maximum ERA Enrollment Data Set. As specified in §3.2.1, the collection of multiple occurrences of DEGs for another context does not constitute a non-conforming use of the CORE-required Maximum ERA Enrollment Data Set.

A health plan must develop and make available to the healthcare provider (or its agent) specific written instructions and guidance for the healthcare provider (or its agent) when providing and submitting the data elements in Table 4.2-1. The health plan's specific instructions and guidance are not addressed in this CORE rule.

The data elements in Table 4.2-1 are for new enrollments. When an enrollment is being changed or cancelled, the health plan must make available to the provider instructions on the specific procedure to accomplish a change in their enrollment or to cancel their enrollment.

Table: 4.2-1 CORE-required Maximum ERA Enrollment Data Set					
Individual Data Element Name (Term)	**Sub-element Name (Term)**	**Data Element Description**	**Data Type and Format (Not all data elements require a format specification)**	**Data Element Requirement for Health Plan Collection (Required/Optional for plan to collect)**	**Data Element Group Number (DEG#)[8]**
PROVIDER INFORMATION (Data Element Group 1 is a Required DEG)					
Provider Name		Complete legal name of institution, corporate entity, practice or individual provider	Alphanumeric	Required	DEG1
Doing Business As Name (DBA)		A legal term used in the United States meaning that the trade name, or fictitious business name, under which the business or operation is conducted and presented to the world is not the legal name of the legal person (or persons) who actually own it and are responsible for it[9]	Alphanumeric	Optional	DEG1
Provider Address				Optional	DEG1
	Street	The number and street name where a person or organization can be found	Alphanumeric	Required	DEG1
	City	City associated with provider address field	Alphanumeric	Required	DEG1
	State/Province	ISO 3166-2 Two Character Code associated with the State/Province/Region of the applicable Country[10]	Alpha	Required	DEG1

[8] There are ten of these Data Element Groups, and each represents a set of data elements that may need to be collected more than once for a specific context. Multiple uses of the same Data Element Group to collect the same data for another context are allowed by this rule and do not constitute a non-conforming use of the CORE-required Maximum ERA Enrollment Data Set.
[9] http://en.wikipedia.org/wiki/Doing_business_as
[10] http://www.iso.org/iso/search.htm?qt=ISO+3166-2&searchSubmit=Search&sort=rel&type=simple&published=on

Table: 4.2-1 CORE-required Maximum ERA Enrollment Data Set					
Individual Data Element Name (Term)	**Sub-element Name (Term)**	**Data Element Description**	**Data Type and Format (Not all data elements require a format specification)**	**Data Element Requirement for Health Plan Collection (Required/Optional for plan to collect)**	**Data Element Group Number (DEG#)[8]**
	ZIP Code/Postal Code	System of postal-zone codes (zip stands for "zone improvement plan") introduced in the U.S. in 1963 to improve mail delivery and exploit electronic reading and sorting capabilities[11]	Alphanumeric, 15 characters	Required	DEG1
	Country Code[12]	ISO-3166-1 Country Code[13]	Alphanumeric, 2 characters	Optional	DEG1
PROVIDER IDENTIFIERS INFORMATION (Data Element Group 2 is a Required DEG)					
Provider Identifiers				Required	DEG2
	Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN)	A Federal Tax Identification Number, also known as an Employer Identification Number (EIN), is used to identify a business entity[14]	Numeric, 9 digits	Required	DEG2
	National Provider Identifier (NPI)[15]	A Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for covered healthcare providers. Covered healthcare providers and all health plans and healthcare	Numeric, 10 digits	Required when provider has been enumerated with an NPI	DEG2

[11] http://www.britannica.com/EBchecked/topic/657522/ZIP-Code
[12] See Footnote #4 above regarding *NACHA Operating Rules* International ACH Transactions (IAT)
[13] http://www.iso.org/iso/search.htm?qt=ISO+3166-1&searchSubmit=Search&sort=rel&type=simple&published=on
[14] A Taxpayer Identification Number (TIN) is an identification number used by the Internal Revenue Service (IRS) in the administration of tax laws. It is issued either by the Social Security Administration (SSA) or by the IRS. A Social Security number (SSN) is issued by the SSA whereas all other TINs are issued by the IRS. http://www.irs.gov/businesses/small/article/0,,id=98350,00.html
[15] An atypical provider not eligible for enumeration by an NPI must supply its EIN/TIN

Table: 4.2-1 CORE-required Maximum ERA Enrollment Data Set					
Individual Data Element Name (Term)	**Sub-element Name (Term)**	**Data Element Description**	**Data Type and Format (Not all data elements require a format specification)**	**Data Element Requirement for Health Plan Collection (Required/Optional for plan to collect)**	**Data Element Group Number (DEG#)[8]**
		clearinghouses must use the NPIs in the administrative and financial transactions adopted under HIPAA. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). This means that the numbers do not carry other information about healthcare providers, such as the state in which they live or their medical specialty. The NPI must be used in lieu of legacy provider identifiers in the HIPAA standards transactions[16]			
Other Identifier(s)				Optional	DEG2
	Assigning Authority	Organization that issues and assigns the additional identifier requested on the form, e.g., Medicare, Medicaid		Required if Identifier is collected	DEG2
	Trading Partner ID	The provider's submitter ID assigned by the health plan or the provider's clearinghouse or vendor		Optional	DEG2
Provider License Number				Optional	DEG2
	License Issuer			Required if License Number is collected	DEG2
Provider Type		A proprietary health plan-specific indication of the type of provider being enrolled for ERA		Optional	DEG2

[16] http://www.cms.gov/NationalProvIdentStand/

Table: 4.2-1 CORE-required Maximum ERA Enrollment Data Set					
Individual Data Element Name (Term)	**Sub-element Name (Term)**	**Data Element Description**	**Data Type and Format (Not all data elements require a format specification)**	**Data Element Requirement for Health Plan Collection (Required/Optional for plan to collect)**	**Data Element Group Number (DEG#)[8]**
		with specific provider type description included by the health plan in its instruction and guidance for ERA enrollment (e.g., hospital, laboratory, physician, pharmacy, pharmacist, etc.)			
Provider Taxonomy Code		A unique alphanumeric code, ten characters in length. The code set is structured into three distinct "Levels" including Provider Type, Classification and Area of Specialization[17]	Alphanumeric, 10 characters	Optional	DEG2
PROVIDER CONTACT INFORMATION (Data Element Group 3 is an Optional DEG)					
Provider Contact Name	Contact	Name of a contact in provider office for handling ERA issues		Required	DEG3
	Title			Optional	DEG3
	Telephone Number	Associated with contact person	Numeric, 10 digits [18]	Required	DEG3
	Telephone Number Extension			Optional	DEG3
	Email Address	An electronic mail address at which the health plan might contact the provider		Required; not all providers may have an email address	DEG3
	Fax Number	A number at which the provider can be sent facsimiles		Optional	DEG3
PROVIDER AGENT INFORMATION					

[17] http://www.nucc.org/index.php?option=com_content&task=view&id=14&Itemid=40
[18] ASC X12 005010X221 Health Care Claim Payment/Advice Technical Report Type 3

Table: 4.2-1 CORE-required Maximum ERA Enrollment Data Set					
Individual Data Element Name (Term)	**Sub-element Name (Term)**	**Data Element Description**	**Data Type and Format (Not all data elements require a format specification)**	**Data Element Requirement for Health Plan Collection (Required/Optional for plan to collect)**	**Data Element Group Number (DEG#)[8]**
(Data Element Group 4 is an Optional DEG)					
Provider Agent Name		Name of provider's authorized agent	Alphanumeric	Required	DEG4
Agent Address				Optional	DEG4
	Street	The number and street name where a person or organization can be found	Alphanumeric	Required	DEG4
	City	City associated with address field	Alphanumeric	Required	DEG4
	State/Province	ISO 3166-2 Two Character Code associated with the State/Province/Region of the applicable Country[19]	Alpha	Required	DEG4
	ZIP Code/Postal Code	System of postal-zone codes (zip stands for "zone improvement plan") introduced in the U.S. in 1963 to improve mail delivery and exploit electronic reading and sorting capabilities[20]	Alphanumeric, 15 characters	Required	DEG4
	Country Code	ISO-3166-1 Country Code[21]	Alphanumeric, 2 characters	Optional	DEG4
Provider Agent Contact Name		Name of a contact in agent office for handling EFT issues		Required	DEG4
	Title			Optional	DEG4
	Telephone Number	Associated with contact person	Numeric, 10 digits [22]	Required	DEG4

[19] http://www.iso.org/iso/search.htm?qt=ISO+3166-2&searchSubmit=Search&sort=rel&type=simple&published=on
[20] http://www.britannica.com/EBchecked/topic/657522/ZIP-Code
[21] http://www.iso.org/iso/search.htm?qt=ISO+3166-1&searchSubmit=Search&sort=rel&type=simple&published=on
[22] ASC X12 005010X221 Health Care Claim Payment/Advice Technical Report Type 3

Table: 4.2-1 CORE-required Maximum ERA Enrollment Data Set					
Individual Data Element Name (Term)	**Sub-element Name (Term)**	**Data Element Description**	**Data Type and Format (Not all data elements require a format specification)**	**Data Element Requirement for Health Plan Collection (Required/Optional for plan to collect)**	**Data Element Group Number (DEG#)[8]**
	Telephone Number Extension			Optional	DEG4
	Email Address	An electronic mail address at which the health plan might contact the provider		Required; not all providers may have an email address	DEG4
	Fax Number	A number at which the provider can be sent facsimiles		Optional	DEG4
FEDERAL AGENCY INFORMATION (Data Element Group 5 is an Optional DEG)					
Federal Agency Information		Information required by Veterans Administration		Optional	DEG5
	Federal Program Agency Name		Alphanumeric	Optional	DEG5
	Federal Program Agency Identifier		Alphanumeric	Optional	DEG5
	Federal Agency Location Code		Alphanumeric	Optional	DEG5
RETAIL PHARMACY INFORMATION (Data Element Group 6 is an Optional DEG)					
Pharmacy Name		Complete name of pharmacy	Alphanumeric	Required (if DEG5 is utilized)	DEG6
	Chain Number	Identification number assigned to the entity allowing linkage for a business relationship, i.e., chain, buying groups or third party contracting organizations. Also may be known as	Alphanumeric	Optional	DEG6

Table: 4.2-1 CORE-required Maximum ERA Enrollment Data Set					
Individual Data Element Name (Term)	**Sub-element Name (Term)**	**Data Element Description**	**Data Type and Format (Not all data elements require a format specification)**	**Data Element Requirement for Health Plan Collection (Required/Optional for plan to collect)**	**Data Element Group Number (DEG#)[8]**
		Affiliation ID or Relation ID			
	Parent Organization ID	Headquarter address information for chains, buying groups or third party contracting organizations where multiple relationship entities exist and need to be linked to a common organization such as common ownership for several chains	Alphanumeric	Optional	DEG6
	Payment Center ID	The assigned payment center identifier associated with the provider/corporate entity	Alphanumeric	Optional	DEG6
NCPDP Provider ID Number		The NCPDP assigned unique identification number	Alphanumeric	Optional	DEG6
Medicaid Provider Number		A number issued to a provider by the U.S. Department of Health and Human Services through state health and human services agencies		Optional	DEG6
ELECTRONIC REMITTANCE ADVICE INFORMATION (Data Element Group 7 is a Required DEG)					
Preference for Aggregation of Remittance Data (e.g., Account Number Linkage to Provider Identifier)		Provider preference for grouping (bulking) claim payment remittance advice – must match preference for EFT payment		Required; select from below	DEG7
	Provider Tax Identification Number (TIN)		Numeric, 9 digits	Optional – required if NPI is not applicable	DEG7

Table: 4.2-1 CORE-required Maximum ERA Enrollment Data Set					
Individual Data Element Name (Term)	**Sub-element Name (Term)**	**Data Element Description**	**Data Type and Format (Not all data elements require a format specification)**	**Data Element Requirement for Health Plan Collection (Required/Optional for plan to collect)**	**Data Element Group Number (DEG#)[8]**
	National Provider Identifier (NPI)		Numeric, 10 digits	Optional – required if TIN is not applicable	DEG7
Method of Retrieval		The method in which the provider will receive the ERA from the health plan (e.g., download from health plan website, clearinghouse, etc.)		Optional (Required if the provider is not using an intermediary clearinghouse or vendor)	DEG7
ELECTRONIC REMITTANCE ADVICE CLEARINGHOUSE INFORMATION (Data Element Group 8 is an Optional DEG)					
Clearinghouse Name		Official name of the provider's clearinghouse		Required	DEG8
Clearinghouse Contact Name		Name of a contact in clearinghouse office for handling ERA issues		Optional	DEG8
	Telephone Number	Telephone number of contact	Numeric, 10 digits	Optional	DEG8
	Email Address	An electronic mail address at which the health plan might contact the provider's clearinghouse		Optional	DEG8
ELECTRONIC REMITTANCE ADVICE VENDOR INFORMATION (Data Element Group 9 is an Optional DEG)					
Vendor Name		Official name of the provider's vendor		Required	DEG9
Vendor Contact Name		Name of a contact in vendor office for handling ERA issues		Optional	DEG9
	Telephone Number	Telephone number of contact	Numeric, 10 digits	Optional	DEG9
	Email Address	An electronic mail address at which the health plan might		Optional	DEG9

Table: 4.2-1 CORE-required Maximum ERA Enrollment Data Set					
Individual Data Element Name (Term)	**Sub-element Name (Term)**	**Data Element Description**	**Data Type and Format (Not all data elements require a format specification)**	**Data Element Requirement for Health Plan Collection (Required/Optional for plan to collect)**	**Data Element Group Number (DEG#)[8]**
		contact the provider's vendor			
SUBMISSION INFORMATION (Data Element Group 10 is a Required DEG)					
Reason for Submission				Required; select from below	DEG10
	New Enrollment			Optional	DEG10
	Change Enrollment			Optional	DEG10
	Cancel Enrollment			Optional	DEG10
Authorized Signature		The signature of an individual authorized by the provider or its agent to initiate, modify or terminate an enrollment. May be used with electronic and paper-based manual enrollment		Required; select from below	DEG10
	Electronic Signature of Person Submitting Enrollment			Optional	DEG10
	Written Signature of Person Submitting Enrollment	A (usually cursive) rendering of a name unique to a particular person used as confirmation of authorization and identity		Optional	DEG10
	Printed Name of Person Submitting Enrollment	The printed name of the person signing the form; may be used with electronic and paper-		Optional	DEG10

Table: 4.2-1 CORE-required Maximum ERA Enrollment Data Set					
Individual Data Element Name (Term)	**Sub-element Name (Term)**	**Data Element Description**	**Data Type and Format (Not all data elements require a format specification)**	**Data Element Requirement for Health Plan Collection (Required/Optional for plan to collect)**	**Data Element Group Number (DEG#)[8]**
		based manual enrollment			
	Printed Title of Person Submitting Enrollment	The printed title of the person signing the form; may be used with electronic and paper-based manual enrollment		Optional	DEG10
Submission Date		The date on which the enrollment is submitted	CCYYMMDD[23]	Optional	DEG10
Requested ERA Effective Date		Date the provider wishes to begin ERA; per Phase III CORE Health Care Claim Payment/Advice (835) Infrastructure Rule Version 3.0.0: there may be a dual delivery period depending on whether the entity has such an agreement with its trading partner	CCYYMMDD	Optional	DEG10

4.3 CORE Master Template for Collecting ERA Enrollment Data

4.3.1 Master Template for Manual Paper-Based Enrollment

The name of the health plan (or its agent or the vendor offering ERA) and the purpose of the form will be on the top of the form, e.g., Health Plan X: Electronic Remittance Advice (ERA) Authorization Agreement.

A health plan (or its agent or a vendor offering ERA) is required to use the format, flow and data set including data element descriptions in Table 4.2-1 as the CORE Master ERA Enrollment Submission form when using a manual paper-based enrollment method. All CORE-required ERA Enrollment data elements must appear on the paper form in the same order as they appear in Table 4.2-1.

A health plan (or its agent) cannot revise or modify:

- The name of a CORE Master ERA Enrollment Data Element Name
- The usage requirement of a CORE Master ERA Enrollment Data Element
- The Data Element Group number of a CORE Master ERA Enrollment Data Element

[23] ASC X12 Standards Version 005010 for X12 Data Element 373 Date used in the ASC X12 005010X221 Health Care Claim Payment/Advice Technical Report Type 3

Beyond the data elements and their flow, a health plan (or its agent) must:

- Develop and make available to the healthcare provider (or its agent) specific written instructions and guidance for the healthcare provider (or its agent) when completing and submitting the enrollment form, including when using paper
- Provide a number to fax and/or a U.S. Postal Service or email address to send the completed form
- Include contact information for the health plan, specifically a telephone number and/or email address to send questions
- Include authorization language for the provider to read and consider
- Include a section in the form that outlines how the provider can access online instructions for how the provider can determine the status of the ERA enrollment
- Clearly label any appendix describing its purpose as it relates to the provider enrolling in ERA

4.3.2 Master Template for Electronic Enrollment

When electronically enrolling a healthcare provider in ERA, a health plan (or its agent) must use the CORE Master ERA Enrollment Data Element Name and Sub-element Name without revision or modification.

When using an XML-based electronic approach, the Data Element Name and Sub-element Name must be used exactly as represented in the table enclosed in angle brackets (i.e., < >) for the standard XML element name and all spaces replaced with an underscore [_] character, e.g., <Provider_Address>.

As noted below in §4.4, a health plan (or its agent or vendors offering ERA enrollment) will offer an electronic way for provider to complete and submit the ERA enrollment. A health plan may use a web-based method for its electronic approach to offering ERA enrollment. The design of the website is restricted by this rule only to the extent that the flow, format and data set including data element descriptions established by this rule must be followed.

4.4 CORE Electronic Safe Harbor for ERA Enrollment to Occur Electronically

This rule provides an ERA enrollment "Electronic Safe Harbor" by which health plans, healthcare providers, their respective agents, application vendors and intermediaries can be assured will be supported by any trading partner. This ERA Enrollment Data Rule specifies that all health plans and their respective agents *must implement and offer to any trading partner (e.g., a healthcare provider) an electronic method (actual method to be determined by health plan or its agent) and process for collecting the CORE-required Maximum ERA Enrollment Data Set.* As an ERA enrollment "Safe Harbor," this rule:

- **DOES NOT** require health plans or their agents to discontinue using existing manual and/or paper-based methods and processes to collect the CORE-required Maximum ERA Enrollment Data Set.
- **DOES NOT** require health plans or their agents to use ONLY an electronic method and process for collecting the CORE-required Maximum ERA Enrollment Data Set.
- **DOES NOT** require an entity to do business with any trading partner or other entity.

CORE expects that in some circumstances, health plans or their agents may agree to use non-electronic methods and mechanisms to achieve the goal of the collection of ERA enrollment data – and that provider trading partners will respond to using this method should they choose to do so.

However, the electronic ERA enrollment "Safe Harbor" mechanism offered by a health plan and its agent MUST be used by the health plan or its agent if requested by a trading partner or its agent. The electronic ERA enrollment "Safe Harbor" mechanism is not limited to single entity enrollments and may include a batch of

enrollments. If the health plan or its agent does not believe that this CORE ERA Enrollment Safe Harbor is the best mechanism for that particular trading partner or its agent, it may work with its trading partner to implement a different, mutually agreeable collection method. However, if the trading partner insists on conducting ERA Enrollment electronically, the health plan or its agent must accommodate that request. This clarification is not intended in any way to modify entities' obligations to exchange electronic transactions as specified by HIPAA or other Federal and state regulations.

4.5 Time Frame for Rule Compliance[24]

Not later than the date that is six months after the compliance date specified in any Federal regulation adopting this CORE Operating Rule, a health plan or its agent that uses a paper-based form to collect and submit the CORE-required Maximum ERA Enrollment Data Set must convert all its paper-based forms to comply with the data set specified in this rule.[25] Should such paper forms be available at provider's offices or other locations, it is expected that such paper-based forms will be replaced.

If a health plan or its agent does not use a paper-based manual method and process to collect the CORE-required Maximum ERA Enrollment Data Set as of the compliance date specified in any Federal regulation adopting this CORE Rule, it is not required by this rule to implement a paper-based manual process on or after the compliance date.

It will be expected that all electronic ERA enrollment will meet this rule requirement as of the compliance date, and that the health plan (or its agent) will inform its providers that an electronic option is now available, if not previously available.

5 Conformance Requirements

Separate from any HHS certification/compliance program to demonstrate conformance as mandated under ACA Section 1104, CAQH CORE offers *voluntary* CORE Certification for all Phases of the CAQH CORE Operating Rules. CORE Certification is completely optional. Pursuing *voluntary* CORE Certification offers an entity a mechanism to test its ability to exchange EFT and ERA transaction data with its trading partners. A CORE-certified Seal is awarded to an entity or vendor product that voluntarily completes CORE certification testing with a CAQH CORE-authorized testing vendor. Key benefits of *voluntary* CORE Certification include:

- Demonstrates to the industry adoption of the Phase III CORE EFT & ERA Operating Rules via a recognized industry "Seal"
- Encourages trading partners to work together on transaction data content, infrastructure and connectivity needs
- Reduces the work necessary for successful trading partner testing as a result of independent testing of the operating rules implementation
- Promotes maximum ROI when all stakeholders in the information exchange are known to conform to the CORE Operating Rules

For more information on achieving *voluntary* CORE Certification for the CAQH CORE EFT & ERA Operating Rules, refer to the Phase III CORE EFT & ERA Operating Rules Voluntary Certification Master Test Suite Version 3.0.0 or contact CORE@caqh.org.

[24] Some health plans have expressed concern regarding the timeframe for effective date of EFT and ERA operating rules as specified in ACA Section 1104, i.e., not later than January 1, 2014, as being too restrictive, given the myriad other regulatory mandates currently being confronted by the industry.

[25] The rule recognizes that some public/Federal entities have review and approval processes that are unique and may require significant planning time and resources to meet the rule requirements.