Phase III CORE 350 Health Care Claim Payment/Advice (835) Infrastructure Rule
version 3.0.0 June 2012

Table of Contents

1 Background Summary

Phase I CORE Rules focused on improving electronic eligibility and benefits verification, as eligibility is the first transaction in the claims process. Thus, if eligibility and benefits are correct, all the transactions that follow will be more effective and efficient. Building on Phase I, CORE determined that Phase II CORE should be extended to include rules around the claim status transaction to allow providers to check the status of a claim electronically, without manual intervention, or confirm receipt of claims.

Continuing to build on Phase I and Phase II CORE Rules, CAQH CORE determined that Phase III CORE should be extended to include rules around the health care claim payment/advice transaction to allow the industry to leverage its investment in the Phase I and Phase II CORE infrastructure rules and apply them to conducting the HIPAA-adopted ASC X12 005010X221A1 Health Care Claim Payment/Advice (835) transaction (hereafter referenced as v5010 X12 835). Benefits to the industry in applying these CAQH CORE infrastructure rules to the health care claim payment/advice transaction will provide for:

- Less staff time spent on phone calls and websites
- Increased ability to conduct targeted follow-up
- More accurate and efficient processing of claim payments

The inclusion of this Phase III CORE Rule for the v5010 X12 835 continues to facilitate the industry's momentum to increase access to the HIPAA-adopted administrative transactions, and will encourage entities to use the infrastructure they have for eligibility and claim status and apply this infrastructure to the health care claim payment/advice.

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 health care transaction standards. The legislation outlines three sets of health care 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.[1] 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,[2] 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

[1] 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 health care 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.

[2] 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.

Interim Final Rule with Comment (IFC)[3] adopting the NACHA ACH CCD plus Addenda Record (hereafter CCD+) and the X12 835 TR3 TRN Segment[4] 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

In order to electronically process a health care claim payment/advice, health plans and providers need to have a detailed health care claim payment/advice. This health care claim payment/advice includes health plans providing information regarding the payment of a claim and detailed information about why the total charges originally submitted on a claim have not been paid in full, information about denied claims, or that the claim is suspended and additional information is being requested, and the method and mode of payment (check, EFT). HIPAA provides a foundation for the electronic exchange of claim payment information, but does not ensure that today's paper-based system can be replaced by an electronic, interoperable system. HIPAA's mandated scope does not:

- Specify how the ASC X12 transactions are to be communicated
- Require the use of any of the ASC X12 standard acknowledgements
- Specify a common companion guide for the flow and format of such guides
- Address the need for providers to be able to conduct a parallel v5010 X12 835 implementation process whereby the health plan will continue to deliver its proprietary claim payment remittance advices while the provider assures itself that the v5010 X12 835 can successfully replace the proprietary remittance advices

Using the available but non-mandated ASC X12 standard acknowledgements, the sender of ASC X12 EDI interchanges will benefit from knowing that the receiving party has successfully received the transactions or has encountered errors that need to be reconciled, especially when sending remittance advice transactions. Requiring health plans that issue companion guides describing their implementation of the v5010 X12 835 Health Care Claim Payment/Advice transaction to use a common flow and format for them will enable providers to more efficiently and effectively configure their accounting systems to automatically process the health care claim payment/advice transaction successfully.

In Phase I CORE, several "infrastructure" rules were approved that are designed to bring consistency and to improve the timely flow of the eligibility transactions. These infrastructure rules require:

- Real time exchange of eligibility transactions within 20 seconds or less
- The consistent use of the ASC X12 standard ASC X12 005010X231A1 Implementation Acknowledgement for Health Care Insurance (999) (hereafter v5010 X12 999) for both real time and batch exchanges
- 86% system availability of a health plan's eligibility processing system components over a calendar week
- Use of the public internet for connectivity
- Use of a best practices companion guide template for format and flow of companion guides for entities that issue them

In Phase II CORE, these infrastructure rules were applied to the exchange of the HIPAA-adopted ASC X12 005010X212 Health Care Claim Status Request and Response (276/277) Technical Report Type 3 (TR3) implementation guide and associated errata (hereafter v5010 276, v5010 277 or v5010 276/v5010 277) transaction sets. Optionally, entities could go beyond the Phase I CORE connectivity requirements by using the more robust and comprehensive Phase II CORE Connectivity Rule if they wished.

---

[3] CMS-0024-IFC: Administrative Simplification: Adoption of Standards for Health Care Electronic Funds Transfers (EFTs) and Remittance Advice, 01/10/12.

[4] 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+.

During the Phase III CORE Rule-making, the Rules Work Group used discussion, research and straw poll results to determine which infrastructure requirements should be applied to the exchange of the v5010 X12 835. Listed below is an overview of the infrastructure requirements incorporated into this rule in §3 and §4.l.

Phase III Rules Work Group Infrastructure Rules for the v5010 X12 835 Transaction	
CORE Infrastructure Rule Description	**Apply to Phase III CORE Infrastructure Rule for the v5010 X12 835 Health Care Claim Payment/Advice**
Connectivity *(same as Phase II v5010)*	**Y**
Real Time Response Time	**N**
Batch Response Time	**N**
System Availability	**N**
Companion Guide	**Y**
Real Time Implementation Guide (TR3) Acknowledgement (999)	**N**
Batch Implementation Guide (TR3) Acknowledgement (999)	**Y**
Normalize Patient Last Name Rule	**N**
AAA Error Code Reporting Rule	**N**
Dual Delivery of the v5010 X12 835 and Proprietary Paper Remittance Advices	**Y**

This Phase III CORE 350 Health Care Claim Payment/Advice (835) Infrastructure Rule Version 3.0.0 defines the specific business information requirements that health plans must satisfy and which vendors, clearinghouses and providers should use. As with all CORE Rules, these requirements are intended as a base or minimum set of requirements, and it is expected that many entities will go beyond requirements as they work towards the goal of administrative interoperability. This Phase III CORE 350 Health Care Claim Payment/Advice (835) Infrastructure Rule Version 3.0.0 requires that health plans make appropriate use of the standard acknowledgements, support the CORE "safe harbor" connectivity requirement, use the CORE v5010 Master Companion Guide Template when publishing their v5010 X12 835 companion guide, and continue to provide dual delivery of their proprietary paper claim remittance advices along with the v5010 X12 835 for a period of time during which providers can ensure that their financial system can successfully use the v5010 X12 835 to post payments.

By requiring the delivery and use of these CORE infrastructure requirements when conducting the v5010 X12 835, the Phase III CORE 350 Health Care Claim Payment/Advice (835) Infrastructure Rule Version 3.0.0 helps provide the information that is necessary to electronically process a claim payment and corresponding remittance details and thus reduce the current cost of today's paper-based transaction process.

3 Scope

3.1 What the Rule Applies To

This CORE Rule builds upon and extends the Phase I and Phase II CORE infrastructure rules to the conduct of the v5010 X12 835. This rule specifies that a health plan or other entity must continue to deliver their proprietary paper claim remittance advices during a parallel implementation testing time period, and use the ASC X12 standard acknowledgments and support the CORE connectivity safe harbor requirements.

3.2 When the Rule Applies

This rule applies when any entity uses, conducts or processes the v5010 X12 835.

3.3 What the Rule Does Not Require

This rule does not address any data content requirements of the v5010 X12 835.

This rule does not require any entity to:

- Conduct, use or process the v5010 X12 835 Health Care Claim Payment/Advice transaction if it currently does not do so or is not required by Federal or state regulation to do so
- Build real time claim adjudication capabilities; entities only need to test for and meet batch rule requirements for health care claim payment/advice transactions

3.4 Outside the Scope of This Rule

This rule does not address the data content of the v5010 X12 835.

3.5 How the Rule Relates to Phase I and Phase II CORE

This rule adds to the Phase I and II CORE infrastructure rules requirements by specifying the use of the ASC X12 005010X231A1 Implementation Acknowledgement for Health Care Insurance (999) when conducting the v5010 X12 835.

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.

This rule supports the CORE Guiding Principles that CORE rules will not be based on the least common denominator but rather will encourage feasible progress, and that CORE rules are a floor and not a ceiling, e.g., entities can go beyond the Phase III CORE Rules.

3.6 Assumptions

A goal of this rule is to adhere to the principles of EDI in assuring that transactions sent are accurately received and to facilitate correction of errors for electronically submitted health care claims.

The following assumptions apply to this rule:

- A successful communication connection has been established
- This rule is a component of the larger set of Phase III CORE Rules; as such, all of the CORE Guiding Principles apply to this rule and all other rules
- This rule is not a comprehensive companion document addressing any content requirements of the v5010 835v5010 X12 835

4 Rule Requirements

4.1 Health Care Claim Payment/Advice Connectivity Requirements

An entity must be able to support the Phase II CORE 270 Connectivity Rule Version 2.2.0.

This requirement addresses usage patterns for batch transactions, the exchange of security identifiers, and communications-level errors and acknowledgements. It does not attempt to define the specific content of the message exchanges beyond declaring that the HIPAA-mandated ASC X12 formats must be used between covered entities, and security information must be sent outside of the ASC X12 payload.

The Phase II CORE 270 Connectivity Rule Version 2.2.0 is designed to provide a “safe harbor” that application vendors, providers and health plans (or other information sources) can be assured will be supported by any trading partner. All organizations must demonstrate the ability to implement connectivity as described in this section. These requirements are not intended to require trading partners to remove existing connections that do not match

the rule, nor is it intended to require that all trading partners must use this method for all new connections. CORE expects that in some technical circumstances, trading partners may agree to use different communication mechanism(s) and/or security requirements than that described by these requirements.

The requirement to support the Phase II CORE 270 Connectivity Rule Version 2.2.0 does not apply to retail pharmacy. For retail pharmacy the entity should reference the NCPDP Connectivity Operating Rule Version 1.0 that can be obtained from www.ncpdp.org. NCPDP/CAQH CORE support a shared goal of continued alignment for connectivity across retail pharmacy and medical.

4.2 Health Care Claim Payment/Advice Batch Acknowledgement Requirements

These requirements for use of acknowledgements for batch mode places parallel responsibilities on both receivers of the v5010 X12 835 and senders of the v5010 X12 835 for sending and accepting v5010 X12 999 acknowledgements. *The goal of this approach is to adhere to the principles of EDI in assuring that transactions sent are accurately received and to facilitate health plan correction of errors in their outbound transactions.*

The rule assumes a successful communication connection has been established.

4.2.1 Use of the v5010 X12 999 Implementation Acknowledgement for Functional Group Acknowledgement

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.

The requirements specified in this section do not currently apply to retail pharmacy.

4.3 Dual Delivery of v5010 X12 835 and Proprietary Paper Claim Remittance Advices

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. If the 31 calendar day period does not encompass a minimum of three payments to the provider by the health plan, the health plan is required to offer to continue to issue proprietary paper claim remittance advices for a minimum of three payments.

At the conclusion of this time period, delivery of the proprietary paper claim remittance advices will be discontinued. At the provider's discretion, the provider may elect to not receive the proprietary paper claim remittance advices, to choose a shorter time period, or to discontinue receiving the proprietary paper claim remittance advices before the end of the specified timeframe by notifying the health plan of this decision.

Upon mutual agreement between the provider and the health plan, the timeframe for delivery of the proprietary paper claim remittance advices may be extended by an agreed-to timeframe, at which time the health plan will discontinue delivery of the proprietary paper claim remittance advices.

If the provider determines it is unable to satisfactorily implement and process the health plan's electronic v5010 X12 835 following the end of the initial dual delivery timeframe and/or after an agreed-to extension, both the provider and health plan may mutually agree to continue delivery of the proprietary paper claim remittance advices.[5]

The requirements specified in this section do not currently apply to retail pharmacy.

4.4 Health Care Claim Payment/Advice Companion Guide

Health plans or information sources have the option of creating a "companion guide" that describes the specifics of how they will implement the HIPAA transactions. The companion guide is in addition to and supplements the ASC X12 TR3 implementation guide adopted for use under HIPAA.

Currently, health plans or information sources have independently created companion guides that vary in format and structure. Such variance can be confusing to trading partners/providers who must review numerous companion guides along with the ASC X12 TR3 implementation guides. To address this issue, CORE developed the CORE v5010 Master Companion Guide Template for health plans, or information sources. Using this template, health plans or information sources can ensure that the structure of their companion guide is similar to other health plans' documents, making it easier for providers to find information quickly as they consult each health plan's document on these important industry EDI transactions.

Developed with input from multiple health plans, system vendors, provider representatives and health care/ HIPAA industry experts, this template organizes information into several simple sections – General Information (Sections 1-9) and Transaction-Specific Information (Section 10) – accompanied by an appendix. Note that the companion guide template is presented in the form of an example of a fictitious Acme Health Plan viewpoint.

Although CORE Participants believe that a standard template/common structure is desirable, they recognize that different health plans may have different requirements. The CORE v5010 Master Companion Guide template gives health plans the flexibility to tailor the document to meet their particular needs.

The requirements specified in this section do not currently apply to retail pharmacy.

4.4.1 Health Care Claim Payment/Advice Companion Guide Requirements

An entity's Companion Guides covering the v5010 X12 835 must follow the format/flow as defined in the CORE v5010 Master Companion Guide Template for HIPAA Transactions. (CAQH CORE v5010 Master Companion Guide Template available here.)

NOTE: *This rule does not require any entity to modify any other existing companion guides that cover other HIPAA-adopted transaction implementation guides.*

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-

[5] Subject to Section 1104(d) of the Patient Protection and Affordable Care Act which amends Section 1862(a) of the Social Security Act to state:
Sec. 1862. [42 U.S.C. 1395y] (a) Notwithstanding any other provision of this title, no payment may be made under part A or part B for any expenses incurred for items or services—
(25) not later than January 1, 2014, for which the payment is other than by electronic funds transfer (EFT) or an electronic remittance in a form as specified by ASC X12 835 Health Care Payment and Remittance Advice or subsequent standard.

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.

6 Appendix

6.1 Appendix 1: Reference

- ASC X12 005010X231A1 Implementation Acknowledgement for Health Care Insurance (999) Technical Report Type 3
- ASC X12 005010X221A1 Health Care Claim Payment/Advice (835) Professional Technical Report Type 3 and associated errata