# X12 and CAQH CORE Webinar Series: Introduction to the 835 Transaction, Standard & Operating Rules

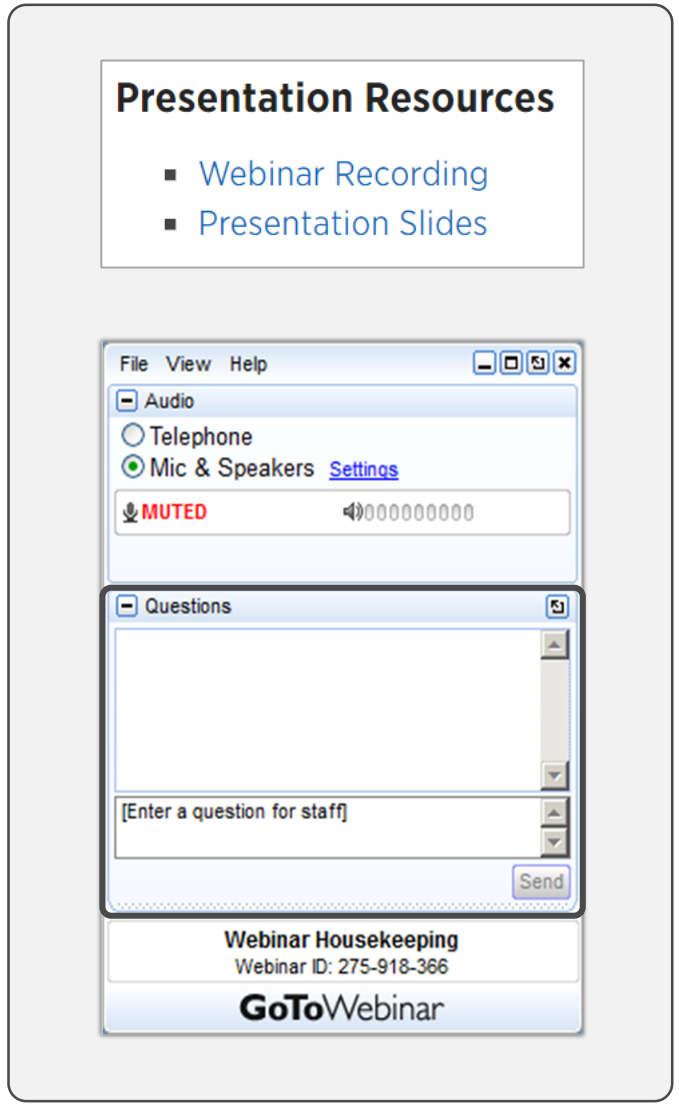
November 5, 2019

3:00-4:00pm ET

# Logistics

*Presentation Slides and How to Participate in Today's Session*

- **You can download the presentation slides at [www.caqh.org/core/events](www.caqh.org/core/events) after the webinar.**
- A copy of the slides and the webinar recording will be emailed to all attendees and registrants in the next 1-2 business days.
- Questions can be submitted ***at any time*** using the **Questions panel on the GoToWebinar dashboard.**



# Session Outline

- Introduction to the 835 Transaction Standard
- Phase III CAQH CORE EFT & ERA Operating Rules
- Q & A

# Thank You to Our Speakers

**Patricia Wijtyk**

Senior Associate, BPO Cognizant

Co-chair of X12N/TGB/WG3
Payment Information Work Group

**Robert Bowman**

Director

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# Introduction to the 835 Transaction Standard

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Senior Associate, BPO Cognizant

Co-chair of X12N/TGB/WG3 Payment Information Work Group

# DISCLAIMER

## This presentation is for informational purposes only

- This presentation is not intended to represent legal advice
- The content is point-in-time information, which is subject to revision
- If you have questions regarding specific information shared during this presentation, please send them to info@x12.org
- Visit www.x12.org for additional details about X12

# ABOUT X12

- Established by the American National Standards Institute (ANSI) more than 35 years ago
- Develops, establishes and maintains Electronic Data Interchange (EDI) standards, technical reports type 3 (TR3) as well as Extensible Markup Language (XML) schemas which drive business processes globally
- X12 membership includes providers, technologists, and business process experts across all industries which range from health care insurance, transportation, finance, logistics, supply chain management and other industries
- For more information about what we do and how you can become a member, visit us at www.x12.org

# HEALTH CARE CLAIM PAYMENT/ADVICE (835)

- Agenda
  - Purpose and Scope
  - 835 vs. paper
  - Uses of the 835
  - Who uses the 835
  - How the 835 is created and moved
  - 835 Enrollment
  - Remittance Advices within an 835
  - X12 Envelopes
  - What can you do

# PURPOSE AND SCOPE

The purpose of this implementation guide is to provide standardized data requirements and content for all users of the ASCX12 Health Care Claim Payment/Advice (835). The 835 also may contain information about future remittances that are to be paid when specified services are completed. This implementation guide provides a detailed explanation of the transaction set by defining data content, identifying valid code tables, and specifying values that are applicable for electronic claims payment. The intention of the developers of the 835 is represented in this guide.

This implementation guide is designed to assist those who send and/or receive Electronic Remittance Advice (ERA) and/or payments in the 835 format.

# 835 VS. PAPER

- EDI exchanges can automate the function of entering the data for payments, adjustments, and denials into the receiver's system
  - Eliminates moving paper, making copies, manually posting of payment/adjustments
  - Improves the accuracy of payment/adjustments posting
  - The 835 uses HIPAA-mandated Claim Adjustment Reason Codes (CARC) and Remittance Advice Remark Codes (RARC) vs proprietary codes
  - Opportunity to facilitate faster transaction processing
  - Opportunity to reduce FTEs required to support remittance processing

# USES OF THE 835

- Reports adjudication results for finalized claims
  - Payment
  - Adjustments
  - Patient liability
  - Provider adjustment (for example, interest)
  - Used to reconcile denials
  - Resubmit corrected claims
- Facilitates claims payment
  - Provides ability for auto-posting
  - Enables reassociation with payment and bank account
- Reports remittance information to the next payer (COB)
- Adopted under HIPAA

# WHO USES THE 835

- Organizations sending the 835 include:
  - Health Plans
  - Third Party Administrators (TPAs)
  - Service Corporations
  - State and Federal Agencies
- Organizations receiving the 835 include:
  - Hospitals
  - Nursing homes
  - Laboratories
  - Physicians practices
  - Dentist
  - Allied professionals
  - Vendors or Clearinghouses

# HOW THE 835 IS CREATED AND MOVED

- Payer's system adjudicates claims
- 835s are created from the finalized claims
  - The 835s must be HIPAA compliant
- 835 transactions are grouped into a file for each receiver
- 835s are sent to the receivers
  - Provider, Vendor or Clearinghouse
- The receiver's system generates a 999 acknowledging the receipt
- The 835 is consumed by the receiver's system

# 835 ENROLLMENT

- Each payer will have specific instructions for 835 enrollment
  - Providers may exchange EDI transactions, including the 835, directly with the payer
  - The payer or provider may utilize a clearinghouse to exchange EDI transactions
- CAQH CORE has related Operating Rules
  - CAQH CORE 380: EFT Enrollment Data Rule
  - CAQH CORE 382: ERA Enrollment Data Rule

# REMITTANCE ADVICES WITHIN AN 835

- One 835 transaction set contains a single payment to a single payee
  - One check or one EFT
- Multiple claims can be reported within one 835
- Multiple transactions can be included in a physical file

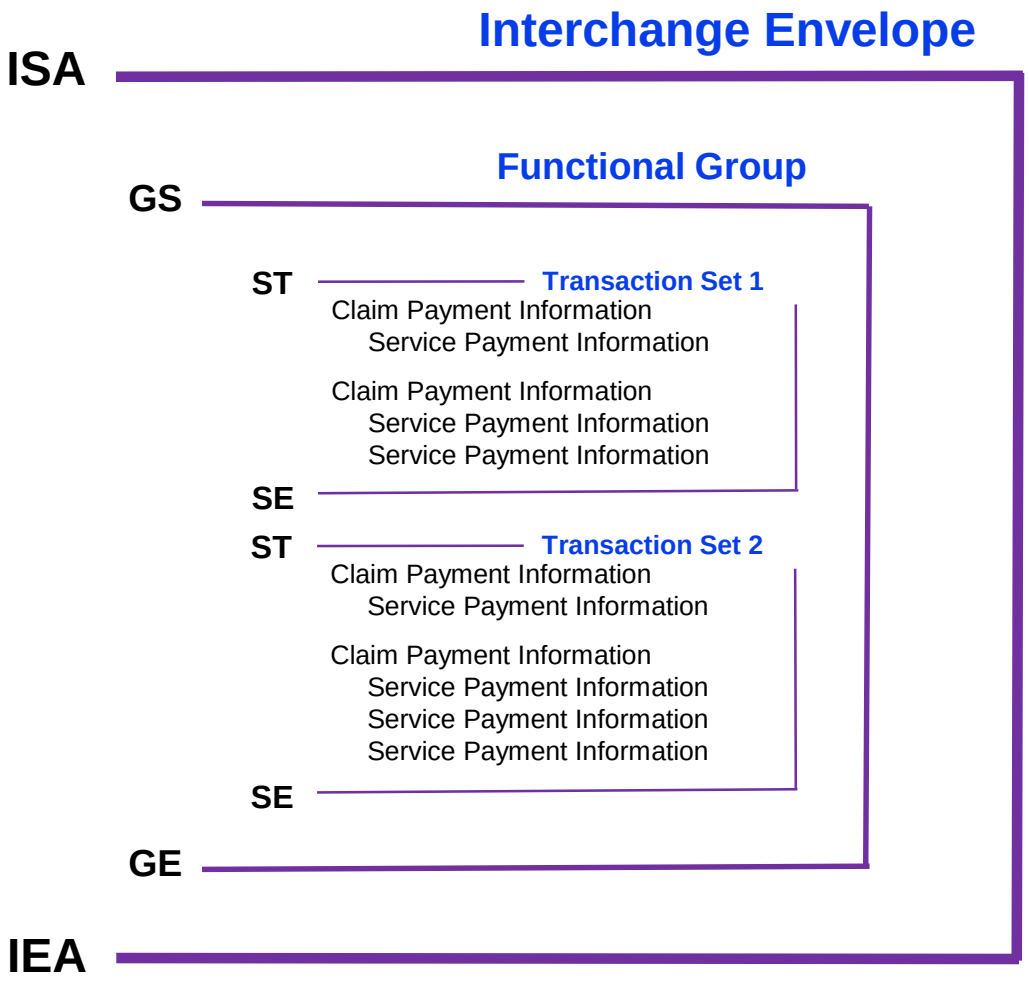
# X12 ENVELOPES

## ENVELOPE LEVELS:

**1st: Interchange (ISA/IEA)**

**2nd:Functional Group (GS/GE)**

**3rd:Transaction Set (ST/SE)**



# WHAT CAN YOU DO

- Become an X12 member
- Participate in X12 standing meetings
- Review draft implementation guides prior to publication
- Submit requests for functionality your organization needs

# THANK YOU

- If you have feedback or questions regarding the information presented, post them at www.x12.org/forms/feedback
- More information about X12 is at www.x12.org
- Stay informed by following X12 on Social Media

  **Twitter: @x12standards**

  **LinkedIn: #X12**

# Phase III CAQH CORE EFT & ERA Operating Rules

**Robert Bowman**
CAQH CORE Director

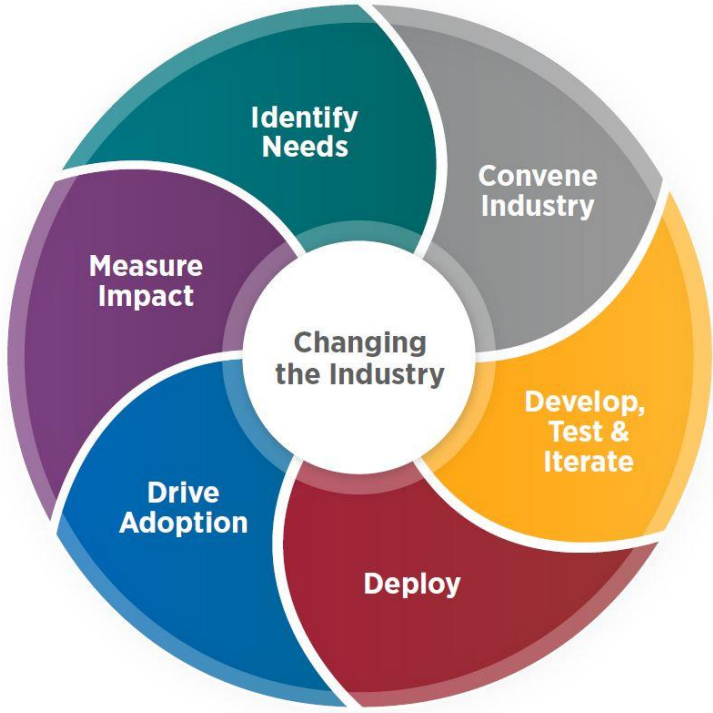
# CAQH CORE Mission/Vision & Industry Role

Industry-led, CAQH CORE Participants include healthcare providers, health plans, vendors, government entities, associations and standard-setting organizations. Health plans participating in CAQH CORE represent **75 percent of the insured US population.**

**MISSION** Drive the creation and adoption of healthcare operating rules that **support standards**, **accelerate interoperability and align administrative and clinical activities** among providers, payers and consumers.

**VISION** An **industry-wide facilitator** of a trusted, simple and sustainable healthcare data exchange that evolves and aligns with market needs.

**DESIGNATION** CAQH CORE is the **national operating rule author to improve the efficiency, accuracy and effectiveness of industry-driven business transactions.** The Department of Health and Human Services (HHS) designated CAQH CORE as the author of national operating rules for the HIPAA-covered administrative transactions.




**INDUSTRY ROLE** **Develop business rules to help industry** effectively and efficiently use electronic standards while remaining technology- and standard-agnostic.

**CAQH CORE BOARD** **Multi-stakeholder.** Members include health plans, providers (some of which are appointed by associations such as the AHA, AMA, MGMA), vendors, and government entities. Advisors to the Board include SDOs (X12, HL7, NACHA, NCPDP) and WEDI.

# What are Operating Rules?

**Operating Rules** are the necessary business rules and guidelines for the electronic exchange of information that are not defined by a standard or its implementation specifications as adopted.

| Operating Rules | Phase I | Phase II | Phase III | Phase IV | Phase V | Phase VI |
|---|---|---|---|---|---|---|
| **Transactions** | Eligibility | Eligibility<br><br>Claims Status | Electronic Funds Transfer (EFT)<br><br>Electronic Remittance Advice (ERA) | Health Claims<br><br>Referral, Certification and Authorization<br><br>Enrollment<br><br>Premium Payments | Prior Authorization | Attachments |
| | ***Active*** | | | | | ***In Progress*** |

***CAQH CORE is also evaluating opportunities to build on existing rules to support Value-Based Payment.***

| Industry Use Case | Standard | Operating Rule |
|---|---|---|
| **Healthcare** | Providers and health plans must use the ASC X12 v5010 270/271 Eligibility Request and Response transaction to exchange patient eligibility information. | When using the eligibility transaction, health plans must return patient financial information including copay and deductible in real-time. |
| **Finance** | Financial organizations must use ASC X9 standards in all ATM transactions with their clientele, standardizing layout, data content and messaging. | Financial organizations must use NACHA, the Electronic Payments Association, and the Federal Reserve operating rules for every automated clearinghouse (ACH) Transaction which allows consumers to use any debit card in any ATM around the world regardless of bank affiliation. |

# CAQH CORE EFT & ERA Operating Rule Requirements

## EFT & ERA Operating Rules

Phase III CAQH CORE Operating Rules for the EFT and ERA transactions are federally mandated, except for rule requirements pertaining to Acknowledgements.

| INFRASTRUCTURE | | | DATA CONTENT |
|---|---|---|---|
| **Health Care Claim Payment/Advice (835) Infrastructure Rule**<br>▪ Includes CAQH CORE Master Companion Guide.<br>▪ Requires CAQH CORE Connectivity Rule.<br>▪ Details batch acknowledgement requirements. | **EFT/ERA Reassociation (CCD+/835) Rule**<br>▪ Addresses provider receipt of the CAQH CORE-required minimum ACH CCD+ Data Elements required for re-association as well as elapsed time between sending and receipt.<br>▪ Determines requirements for resolving late/missing EFT/ERA transactions. | **EFT & ERA Enrollment Data Rules**<br>▪ Identifies a maximum set of standard data elements for EFT enrollment.<br>▪ Requires health plan to offer electronic EFT enrollment.<br>▪ Requires providers to specify how payments should be made. | **Uniform Use of CARCs & RARCs (835) Rule**<br>▪ Identifies four CAQH CORE-defined Business Scenarios with a set of required code combinations that convey details of the claim denial or payment to the provider. |

# Benefits of the Phase III CAQH CORE EFT & ERA Operating Rules

## Key Benefits

- Improves cash flow via expedited payment and remittance reconciliation through the receipt of electronic payments and remittances.

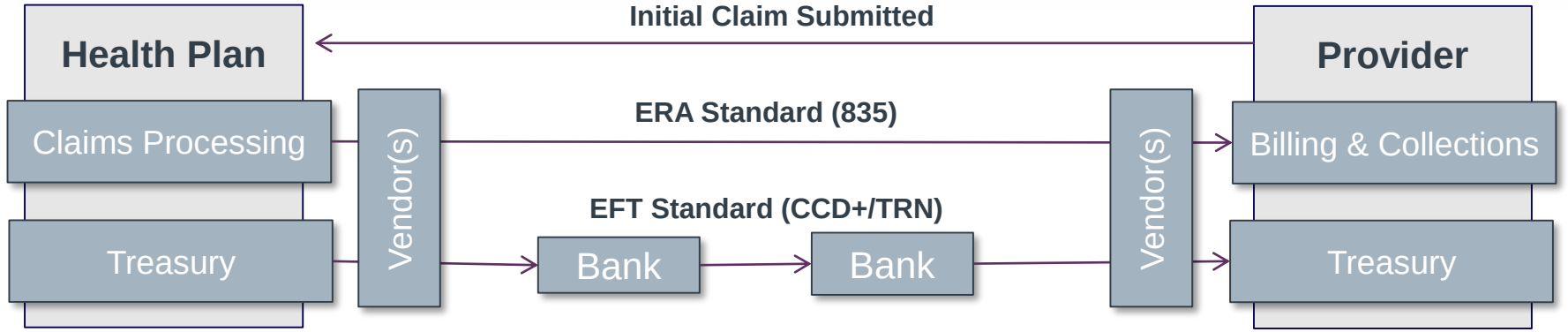
- Eliminates the need for manual re-keying of reconciliations of EFTs and ERAs by requiring a trace number that links the two transactions.
- Increases ability to conduct targeted payment issue follow-ups through uniform and maintained ERA codes (CARCs, RARCs, and CAGCs).

- Standardizes enrollment for EFT/ERA so providers can sign up for both EFT and ERA electronically.
- Automates re-association of EFT and ERA leading to efficiencies and reduced errors.

- Saves an estimated $300 million and $3.3 billion per year* for providers—including hospitals and health systems—and health plans.

* Administrative Simplification: Adoption of Operating Rules for Eligibility for a Health Plan and Health Care Claim Status Transactions

# CAQH CORE Resources to Support Providers Implementing EFT & ERA




| Provider Action | Steps | Resources |
|---|---|---|
| Determine if you are conducting the applicable electronic transactions. | If you conduct the X12 v5010 835 and ACH CCD+, these transactions must comply with the CAQH CORE Operating Rules.<br><br>Assess organizational readiness/compliance and identify all systems and vendors that touch the X12 v5010 835 and EFT Standard transactions. | Use CAQH CORE Analysis and Planning Guide. |
| Understand health plan agreements and options for payment and remittance information. | Request healthcare EFT payments from your payers, both public and private. | Use the Sample Provider EFT Request Letter. |
| Contact financial institution. | Request delivery of the EFT and payment-related information including the reassociation trace numbers. | Use the CAQH CORE Sample Provider EFT Reassociation Data Request Letter to help facilitate this request. |
| Assess vendor conformance. | Ensure vendor has updated its systems to align with the CAQH CORE Operating Rules. | Encourage your vendor (and Health Plan) to become CAQH CORE Certified. |

# CARCs & RARCs

*Need for CORE Code Combinations Maintenance*

CAQH CORE is responsible for maintaining the **CORE Code Combinations** via the Code Combinations Maintenance Process.

## CARC

**Claim Adjustment Reason Codes**

Provides the reasons for positive/ negative financial adjustment to a claim.

*This list is maintained by ASC X12 and updated three times per year.*

## RARC

**Remittance Advice Remark Codes**

Provides supplemental information about why a claim or service line is not paid in full.

*This list is maintained by CMS and updated three times per year.*

## CAGC

**Claim Adjustment Group Codes**

Categorizes the associated CARC based on financial liability.

*This list is maintained by ASC X12 and updated when base standard is updated.*

The CAQH CORE 360: Uniform Use of CARCs & RARCs (835) Rule includes a maximum set of code combinations to be used for high-volume Business Scenarios.

- Created four CORE-defined Business Scenarios which represent some of the most confusing and high-volume scenarios that are exchanged between health plans and providers.
- Defined maximum set of CORE-required Code Combinations for the four CORE-defined Business Scenarios based on extensive data.
- Established maintenance process which requires the list of CORE-required Code Combinations to be revisited at least three times annually.

## CORE Business Scenario 1

Additional Information Required – Missing/Invalid/ Incomplete Documentation

*376 code combos*

## CORE Business Scenario 2

Additional Information Required – Missing/Invalid/ Incomplete Data from Submitted Claim

*422 code combos*

## CORE Business Scenario 3

Billed Service Not Covered by Health Plan

*937 code combos*

## CORE Business Scenario 4

Benefit for Billed Service Not Separately Payable

*66 code combos*

# CAQH CORE EFT/ERA Enrollment Data Sets Maintenance

Section 3.4 of the CAQH CORE EFT/ERA Enrollment Data Operating Rules requires a policy and process to review the Enrollment Data Sets on an annual basis.

| | |
|---|---|
| **Maintenance Goal** | ▪ Address emerging, new, or changing industry business needs to the CAQH CORE EFT & ERA Enrollment Data Sets through an annual review process. |
| **Review Requirements** | There are two types of reviews:<br>▪ **Limited Review**: Address only non-substantive adjustments; HIPAA-covered entities do not need to update enrollment forms/systems.<br>▪ **Comprehensive Review**: Address substantive and non-substantive adjustments; if substantive adjustments are approved, HIPAA-covered entities are required to update enrollment forms/systems. |
| **Timeline & Commitment** | ▪ **The 2019 Enrollment Data Maintenance Process is a Comprehensive Review. The review is scheduled to take place Q4 2019**.<br>▪ CAQH CORE Participants who identify potential substantive and/or non-substantive adjustments to the EFT and/or ERA Enrollment Data Sets to address changing business needs will have the opportunity to submit recommendations through an online feedback form. |

The EFT & ERA Enrollment Data Sets Maintenance Process webpage provides more details on past reviews, key policies and procedures and how to get involved with the CAQH CORE Enrollment Data Task Group.

# Polling Question #1

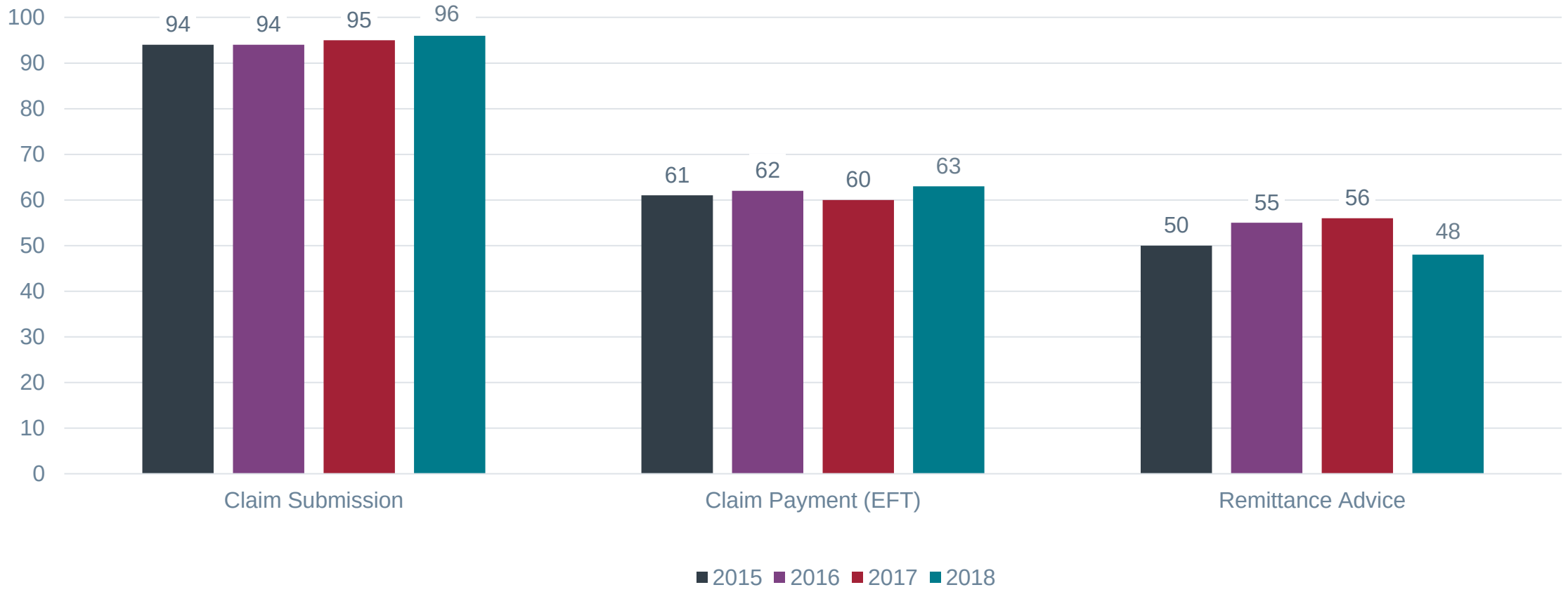
**To better inform CAQH CORE's education priorities for 2020, please indicate the level of industry awareness of and compliance with the CAQH CORE EFT & ERA Enrollment Data Set Requirements from your organization's perspective.**

- Low Industry Awareness/Compliance
- Limited Industry Awareness/Compliance
- Moderate Industry Awareness/Compliance
- High Industry Awareness/Compliance
- Very High Industry Awareness/Compliance

# 2018 CAQH Index Report

*Medical Industry Electronic Transaction Adoption*

While claims submissions continue to be the most widely adopted electronic transaction, use of electronic claim payment, also referred to as electronic funds transfer (EFT), and electronic remittance advice has lagged. The EFT and ERA work in tandem to enable automated reconciliation and communication of reimbursement. An ERA is an electronic explanation of payments made to the provider by the health plan.




Source: 2018 CAQH Index





CAQH CORE

# Polling Question #2

**What topic would be of most interest for the next webinar in the series? Select all that apply.**

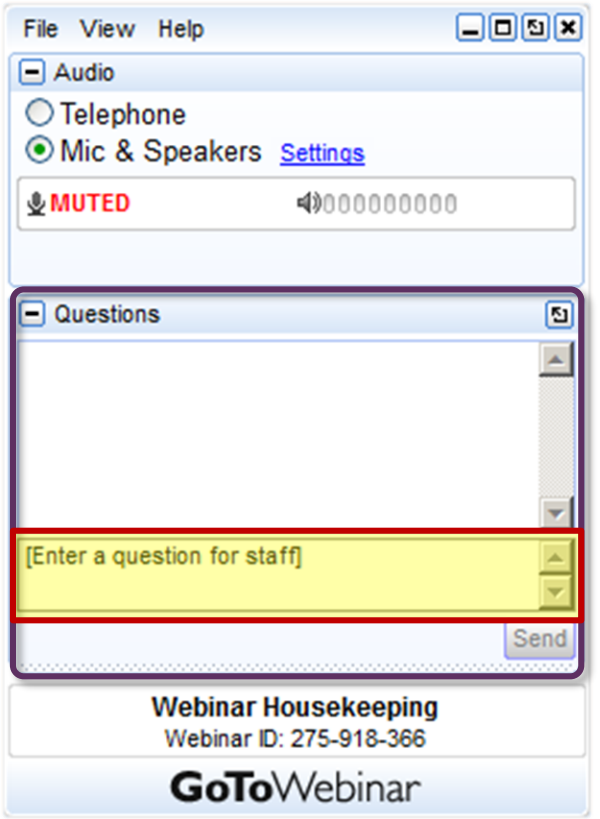
- Deep-dive webinar on the 835 (Electronic Remittance Advice) transaction
- Introductory webinar on the 278 (Healthcare Services Review and Response) transaction
- Deep-dive webinar on the 278 (Healthcare Services Review and Response) transaction
- Introductory webinar on the 837 (Health Care Claim) transaction
- Deep-dive webinar on the 837 (Health Care Claim) transaction

# Audience Q&A

**Please submit your questions**

Enter your question into the “Questions” pane in the lower right hand corner of your screen.

**You can also submit questions at any time to CORE@caqh.org**

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**Presentation Resources**

- Webinar Recording
- Presentation Slides

# Thank you for joining us!


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