



**Analysis & Planning Guide for Implementing the  
CAQH CORE Payment & Remittance Operating Rules  
May 2020**

**CAQH Committee on Operating Rules for Information Exchange (CORE)  
Analysis & Planning Guide for Implementing the CAQH CORE Payment & Remittance Operating Rules**

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## **1. Introduction: Analysis & Planning for CAQH CORE Operating Rule Implementation**

This CAQH CORE Analysis & Planning Guide provides a resource for entities preparing to implement the CAQH CORE Payment & Remittance Operating Rules. A solid understanding of the CAQH CORE Payment & Remittance Operating Rules, combined with an effective planning effort, is the basis for a successful implementation project.

This document provides guidance for Project Managers, Business Analysts, System Analysts, Architects, and other project staff to complete the first step of a typical systems development life cycle: Systems Analysis & Planning. The purpose of this guide is to enable Project Managers and other staff to:

- Understand the applicability of the CAQH CORE Payment & Remittance Operating Rule requirements to your organization's systems and business processes that support EFT & ERA transactions
- Identify and inventory all impacted external and internal systems and business processes (manual and automated) and outsourced vendors that process EFT and/or ERA transactions
- Perform a detailed rule requirements gap analysis to identify system(s) that may require remediation in order to conform to the CAQH CORE Payment & Remittance Operating Rule requirements and to identify business process which may be impacted by the CAQH CORE Payment & Remittance Operating Rules (e.g., need for internal testing, project management, EFT & ERA resources, etc.)

The appendices of this CAQH CORE Analysis & Planning Guide include the following:

- [Stakeholder & Business Type Evaluation](#): Use to determine your stakeholder type(s) and understand the role of your intermediaries and business associates<sup>1</sup> that process the EFT and/or ERA transactions
- [Systems Inventory & Impact Assessment Worksheet](#): Use to do a high-level inventory of all external and internal systems that process the EFT and/or ERA transactions and are impacted by the CAQH CORE Payment & Remittance Operating Rules
- [Gap Analysis Worksheet](#): Use to determine the level of system(s) remediation necessary for implementing the business requirements of the CAQH CORE Payment & Remittance Operating Rules
- [Dollars and Data Flow Diagram](#): Use to assist with planning for the various entities that may be involved in your CAQH CORE Payment & Remittance Operating Rules implementation

### **NOTES:**

- This document is for educational purposes only; in the case of a question between this document and CAQH CORE Operating Rule text or Federal regulations, the latter take precedence.
- This Analysis & Planning Guide is scoped to *general* implementation planning of the CAQH CORE Payment & Remittance Operating Rules and can assist with compliance with the ACA Section 1104 mandate or detailed voluntary CORE Certification (these are, however, separate projects requiring analysis and planning beyond that described in this document).

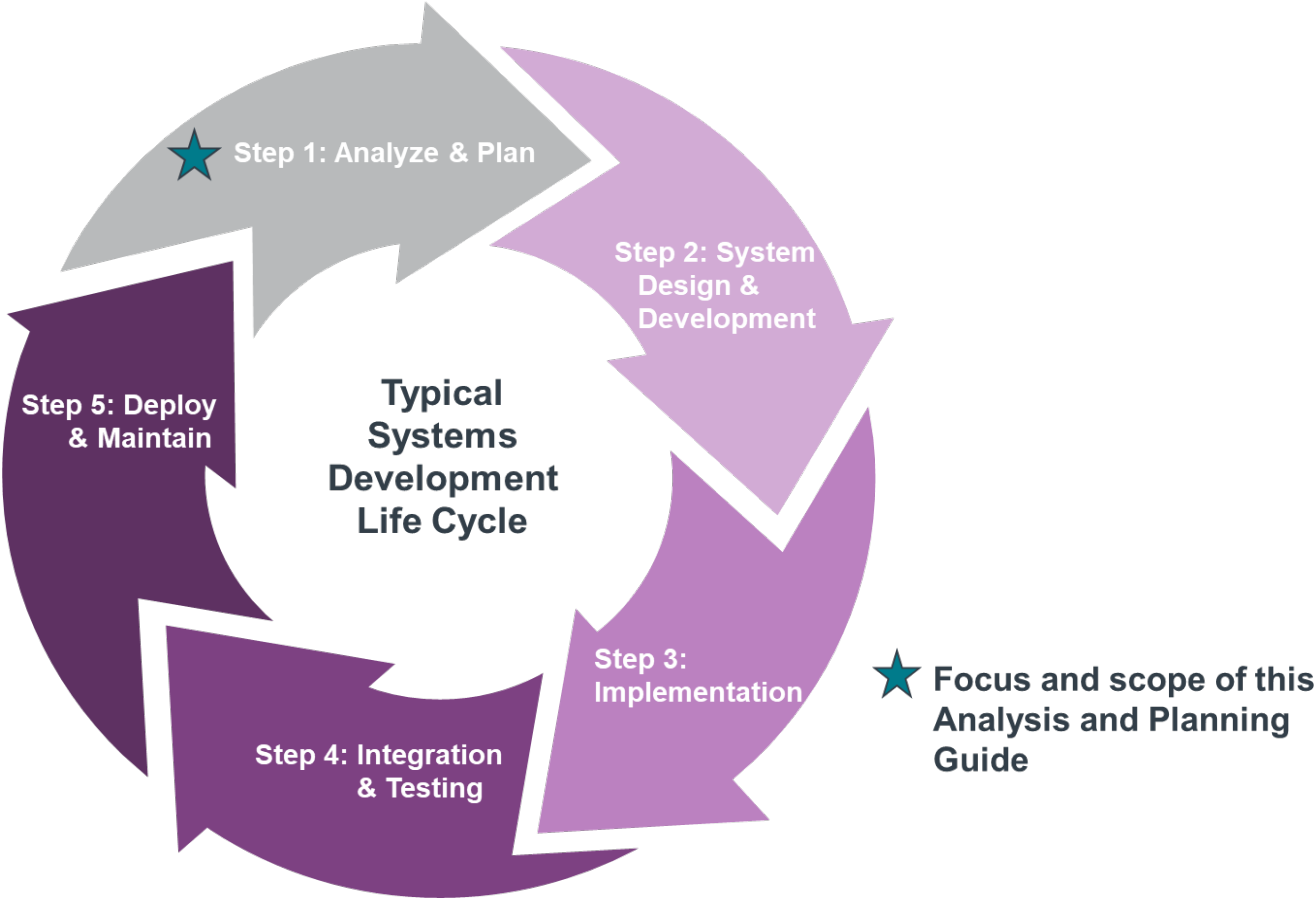
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<sup>1</sup> The term "business associate" is used in this document to describe entities that provide outsourced functions/activities on behalf of health plans providers (i.e., covered entities). The full definition can be found in the [Electronic Code of Federal Regulations](#) (Title 45, Subtitle A, Subchapter C, Part 160.103)

2. Systems Development Life Cycle

The diagram below illustrates a typical systems development life cycle (SDLC) for developing or remediating information systems. SDLC includes five key steps, beginning with analysis and planning through deployment and ongoing maintenance. This Analysis & Planning Guide is scoped to assist your organization in the first step of an SDLC for the implementation of the CAQH CORE Payment & Remittance Operating Rules given Step 1 sets the stage for all other steps. Note: The impacted system(s) may include an in-house developed system, COTS (commercial off-the-shelf) system, or an outsourced solution from a third party. The “system” in certain cases may also be a manual process or even include activities performed on your behalf by one or more business associates.

Typical Systems Development Life Cycle



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**3. Analysis & Planning for the CAQH CORE EFT & ERA Operating Rules: Key Tasks**

The following table outlines the key tasks necessary to complete Step 1: Analyze & Plan of a Systems Development Life Cycle. When the analysis and planning is completed, you will have created a high-level systems impact analysis and developed a detailed project plan for adopting the CAQH CORE Payment & Remittance Operating Rule requirements.

| <b>Analysis and Planning: Key Tasks</b>   |  |
|---|--|
| <b>Task</b>   | <b>Activity</b>  |
| <p><b>Task A – Complete Staff Education and Training on the CAQH CORE Payment &amp; Remittance Operating Rules</b></p>  | <ul style="list-style-type: none"> <li>• Thoroughly review and understand the <a href="#">CAQH CORE Payment &amp; Remittance Operating Rules</a></li> <li>• Conduct general education and awareness of the CAQH CORE Payment &amp; Remittance Operating Rules for the impacted areas in your organization (see Section 4 of this document for additional resources available to educate staff on the CAQH CORE Operating Rules)</li> </ul>   |
| <p><b>Task B – Determine Your Organization’s Stakeholder &amp; Business Type(s) (<a href="#">Stakeholder &amp; Business Type Evaluation</a>)</b></p> <p><i>CAQH CORE Payment &amp; Remittance Operating Rule requirements are tied to applicable stakeholder type(s): provider, health plan, clearinghouse, and vendor</i></p> <p><i>Please note that specific stakeholder types (providers, health plans, clearinghouses) are <a href="#">HIPAA covered entities</a>, and are therefore required by Federal mandate to implement relevant rule requirements. Other stakeholders (software or services or third-party payment or billing vendors) are not directly required by Federal mandate to implement rule requirements, but may need to as a result of being a business associate of one or more HIPAA covered entities (i.e., if they perform certain functions on behalf of a HIPAA covered entity).</i></p> | <ul style="list-style-type: none"> <li>• Determine your stakeholder and business type(s) to understand which CAQH CORE Payment &amp; Remittance Operating Rules apply to your organization</li> <li>• Understand the role of intermediaries and business associates that provide EFT and/or ERA services or process these transactions on your behalf</li> <li>• Consider the following based on your stakeholder type(s): <ul style="list-style-type: none"> <li>• If your organization is a <u>health plan</u>: <ul style="list-style-type: none"> <li>- The majority of the CAQH CORE Payment &amp; Remittance Operating Rule requirements will apply to your systems.</li> <li>- Health plans that outsource to a clearinghouse or business associate the processing of the ASC X12 v5010 835 or Healthcare EFT Standard<sup>2</sup> transactions to providers may have some unique implementation considerations. Depending on the scenario between the health plan and its clearinghouse/intermediary/business associate, the health plan may not need to implement some rule requirements directly while the clearinghouse/intermediary/business associate will need to implement them on behalf of the health plan. For the EFT and ERA transactions, intermediaries/business associates may include other types of entities not involved in the implementation of the ACA-mandated CAQH CORE Eligibility &amp; Benefits and Claim Status Operating Rules, such as third-party payment vendors. The health plan, therefore, might have different trading partners to consider when implementing the CAQH CORE Payment &amp; Remittance Operating Rules. (See <a href="#">Appendix D</a> for a diagram of dollars and data flow that may assist with identifying all entities involved.)</li> </ul> </li> <li>• If your organization is a <u>provider</u>: <ul style="list-style-type: none"> <li>- You likely are outsourcing some of the CAQH CORE Payment &amp; Remittance Operating Rule requirements to a clearinghouse or business associate (e.g., your</li> </ul> </li> </ul> </li> </ul> |

<sup>2</sup> In January 2012, HHS issued an Interim Final Rule with Comment (IFC) adopting the NACHA ACH CCD plus Addenda Record (CCD+) and the X12 835 TR3 TRN Segment as the Healthcare EFT Standards. ([CMS-0024-IFC](#): Administrative Simplification: Adoption of Standards for Health Care Electronic Funds Transfers (EFTs) and Remittance Advice, 01/10/12.) 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+.

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| Analysis and Planning: Key Tasks   |   |
|--|---|
| Task   | Activity  |
|  | <p>software vendor or a third-party billing/collection service). Provider organizations using a clearinghouse, a software vendor, or a third-party billing/collection service to process the ASC X12 v5010 835 or Healthcare EFT Standard transactions with health plans may have some unique implementation considerations, as the clearinghouse/software vendor/billing/collection services is performing some functions on behalf of the provider as a business associate.</p>   |
|  | <ul style="list-style-type: none"> <li>• If your organization is a <u>clearinghouse</u>: <ul style="list-style-type: none"> <li>- You are responsible for implementing the CAQH CORE Payment &amp; Remittance Operating Rule requirements applicable to you as a clearinghouse.</li> <li>- Additionally, if a health plan and/or provider outsource(s) certain functions to you to perform on their behalf, you are responsible for implementing all CAQH CORE Payment &amp; Remittance Operating Rule requirements which have been outsourced to you. In this instance, your organization will need to work with your business partners to determine applicable rule requirements.</li> </ul> </li> </ul>  |
|  | <ul style="list-style-type: none"> <li>• If your organization is a <u>software or services vendor</u>: <ul style="list-style-type: none"> <li>- You may be responsible for implementing many of the CAQH CORE Payment &amp; Remittance Operating Rule requirements into your services or software as a result of being a business associate of a HIPAA covered entity.</li> <li>- Note: If your services or software are provider-facing, you will have a unique set of requirements to implement that are different than a health plan-facing vendor's services or software.</li> </ul> </li> <li>• If your organization is a <u>third-party billing vendor or third-party payment vendor</u>: <ul style="list-style-type: none"> <li>- You may be responsible for implementing many of the CAQH CORE Payment &amp; Remittance Operating Rule requirements into your services or software as a result of being a business associate of a HIPAA covered entity.</li> <li>- Note: Vendors (and their financial institutions) sending health care transactions over the ACH Network should also be familiar with the <a href="#">NACHA Operating Rules</a>, which include requirements for <a href="#">Health Care Payments via ACH</a>.</li> </ul> </li> </ul> |
| <p><b>Task C - Conduct a Systems Inventory (<a href="#">Systems Inventory &amp; Impact Assessment Worksheet</a>)</b></p> | <p><i>Relative to your stakeholder type(s):</i></p> <ul style="list-style-type: none"> <li>• Identify and inventory all impacted external and internal systems and outsourced vendors that process the v5010 X12 835 and Healthcare EFT Standard transactions <ul style="list-style-type: none"> <li>○ NOTE: Especially with respect to the CAQH CORE EFT and ERA Enrollment Data Rules, these internal systems may include manual as well as automated processes.</li> </ul> </li> <li>• Determine which functions for each identified impacted system/outsourced vendor are in-house developed and maintained, commercial off the shelf (COTS) system, or outsourced to a third party</li> <li>• Determine potential options for addressing the CAQH CORE Payment &amp; Remittance Operating Rule requirements applicable to your stakeholder type(s) (e.g., remediate an in-</li> </ul>  |

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| <b>Analysis and Planning: Key Tasks</b>  |  |
|--|--|
| <b>Task</b>  | <b>Activity</b>  |
|  | house developed system, replace or upgrade any COTS system, or work with third party vendor to ensure they meet CAQH CORE Payment & Remittance Operating Rule requirements)  |
| <b>Task D - Conduct Detailed Rule Requirements Gap Analysis (<a href="#">Gap Analysis Worksheet</a>)</b> | <ul style="list-style-type: none"> <li>• Identify the impacted systems (identified via the <i>Systems Inventory &amp; Impact Assessment Worksheet</i>) responsible for satisfying each requirement of the CAQH CORE Payment &amp; Remittance Operating Rules</li> <li>• Determine and document any gaps between the existing system's capability and each rule requirement</li> <li>• Identify and document any business process which may also be impacted by each CAQH CORE Payment &amp; Remittance Rule requirement and to what extent the process is impacted               <ul style="list-style-type: none"> <li>○ For example, a health plan must proactively inform the healthcare provider during EFT (Healthcare EFT Standards) and ERA (v5010 X12 835) enrollment that it will need to contact its financial institution to arrange for the delivery of the CORE-required Minimum CCD+ Data Elements necessary for successful reassociation of the EFT payment with the ERA remittance advice, and a healthcare provider must proactively contact its financial institution to arrange for the delivery of those CORE-required Minimum CCD+ Data Elements</li> </ul> </li> </ul> |
| <b>Task E - Develop a Detailed Project Plan</b>  | <ul style="list-style-type: none"> <li>• A detailed project plan typically outlines steps for completion of the following key activities as Steps 2-5 of the System Development Life Cycle:               <ul style="list-style-type: none"> <li>- Determine required resources to complete the project (i.e., estimate resources, time, system release schedules, and money)</li> <li>- Develop a detailed Functional Requirements Document</li> <li>- Create a detailed Systems Design Document describing, in detail, the required functions and capabilities necessary to implement the CAQH CORE Payment &amp; Remittance Operating Rules</li> <li>- Implement necessary system(s) enhancements</li> <li>- Test impacted systems to ensure conformance to the requirements set forth in the Functional Requirements Document</li> <li>- Deploy (i.e., implement system(s) into production environment)</li> <li>- Conduct trading partners implementation testing</li> </ul> </li> </ul>  |

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| Analysis and Planning: Key Tasks          |  |
|---|--|
| Task                                      | Activity   |
| Other Considerations – CORE Certification | <ul style="list-style-type: none"> <li>• Consider CORE Certification as part of your project plan<sup>3</sup> <ul style="list-style-type: none"> <li>- CAQH CORE offers <a href="#">CORE Certification</a> to the four stakeholder types that create, transmit or use EFT and ERA data: health plans, providers, software/services vendors, and clearinghouses.</li> <li>- Key benefits to completing CORE Certification include:                             <ul style="list-style-type: none"> <li>▪ Certification Testing provides an online mechanism for a stakeholder to test its systems ability to exchange eligibility and claim status data with its trading partners using the CAQH CORE Payment &amp; Remittance Operation Rules</li> <li>▪ Demonstrates via a recognized industry “Seal” your organization’s adoption of the CAQH CORE Payment &amp; Remittance Operating Rules to the industry</li> <li>▪ Encourages trading partners to work together on transaction data content, infrastructure and connectivity needs</li> <li>▪ Promotes maximum ROI when all stakeholders in the information exchange are known to conform with the CAQH CORE Payment &amp; Remittance Operating Rules</li> </ul> </li> </ul> </li> <li>• More information on the CORE Certification process is available on the CAQH website <a href="#">HERE</a>.</li> </ul> |

<sup>3</sup> **NOTE:** The CORE Certification Program offered by CAQH CORE is separate from the CMS Federal operating rules compliance program mandated by the ACA. Information on the CMS compliance program regarding operating rules is under development and can be found [HERE](#).



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#### 4. Additional Resources

Beyond the information provided in this CAQH CORE Analysis & Planning Guide, there are additional resources for entities preparing to implement the CAQH CORE Payment & Remittance Operating Rules:

- [CAQH CORE Payment & Remittance Operating Rules](#)
- [Payment & Remittance CAQH CORE Certification Master Test Suite](#) (initially developed for CORE Certification but same concepts, e.g., role of trading partners, apply for general adoption of the CAQH CORE Operating Rules)
- [CAQH CORE FAQs](#) address typical questions regarding the CAQH CORE Operating Rules<sup>4</sup>
  - If your question is not answered by the FAQ, email question to [CORE@caqh.org](mailto:CORE@caqh.org) to have it entered into the formal CAQH CORE Request Process
- Upcoming CAQH CORE [Education Sessions](#) (as well as presentations and recordings from previous sessions) for further clarification on rule requirements
- January 2012 Interim Final Rule with Comment ([CMS-0024-IFC](#)): Administrative Simplification: Adoption of [Standards](#) for Health Care Electronic Funds Transfers (EFTs) and Remittance Advice
- August 2012 Interim Final Rule with Comment ([CMS-0028-IFC](#)): Administrative Simplification: Adoption of [Operating Rules](#) for Health Care Electronic Funds Transfers (EFT) and Remittance Advice Transactions
- [CMS Administrative Simplification/Affordable Care Act FAQs](#) (FAQs on a wide range of other topics, as well)
- CARCs/RARCs Resources: [Claim Adjustment Reason Codes List and related FAQs](#) and [Remittance Advice Remark Codes List and related FAQs](#) (Washington Publishing Company)
- [ASC X12 Interpretation Portal](#) Information related to the meaning, use, and interpretation of ASC X12 Standards, Guidelines, and Technical Reports, including implementation guideline for the ASC X12N v5010 835 can be obtained from ASC X12.
- [NACHA Operating Rules](#), which include requirements around [Health Care Payments via ACH](#)
  - Any questions related to the *NACHA Operating Rules* can be directed to [NACHA](#)

Entities seeking to implement the CAQH CORE Payment & Remittance Operating Rules are encouraged to note the following:

- The CAQH CORE Payment & Remittance Operating Rules assume that any HIPAA covered entity implementing the operating rules is compliant with the most recently mandated version of HIPAA; HIPAA compliance is not defined by CAQH CORE.
- The CAQH CORE Payment & Remittance Operating Rule requirements are tied to the applicable stakeholder type(s). The applicability of a specific CAQH CORE Payment & Remittance Operating Rule requirement may vary according to trading partner relationship, contracted services, and other arrangements. If you have specific questions concerning applicability, please [contact CAQH CORE Staff](#).

CAQH CORE staff is available to assist with questions about understanding the requirements of the CAQH CORE Payment & Remittance Operating Rules in regard to your stakeholder type(s); gap analysis and systems remediation are the responsibility of the implementing entities.

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<sup>4</sup>As of February 2013, the FAQs page contains general FAQs for CAQH CORE as well as rule-specific technical FAQs for the Eligibility and Claim Status Operating Rules. Technical FAQs for the EFT & ERA Operating Rules are under development and will be posted in Q1 2013.

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**5. Appendix**

**Appendix A: CAQH CORE Stakeholder & Business Type Evaluation**

**Purpose:** After becoming educated on the CAQH CORE Payment & Remittance Operating Rules, you will need to determine your stakeholder type(s). The *CAQH CORE Payment & Remittance Stakeholder & Business Type Evaluation* below will assist you in determining which CAQH CORE Payment & Remittance Operating Rules apply to your organization and to generally consider which trading partners you need to work with on planning and implementation. Knowing your stakeholder type(s) will help you complete the *Systems Inventory & Assessment Worksheet*.

**NOTE:** Applicability of a specific rule requirement may vary according to trading partner relationship, contracted services, and other arrangements. Some example business models include:

- Provider direct-to-health plan connection:
  - Health plan implements all requirements of the CAQH CORE Payment & Remittance Operating Rules
  - Large payer organizations' treasury management functions will play a role
- Single/dual clearinghouse-to-health plan connection:
  - Health plan outsources infrastructure and connectivity functions to a clearinghouse
  - Health plan-facing clearinghouse acts as a proxy for health plan's Rule conformance for the contracted services
- Provider-to-clearinghouse/vendor:
  - Provider outsources ERA retrieval function to clearinghouse/vendor
  - Provider-facing clearinghouse or vendor solution acts as a proxy for provider's conformance for the contracted services
  - Provider might engage (and therefore need to consider) business associates specific to EFT/ERA that were not involved in implementation of other Operating Rules, such as collection/billing services vendors
- Health plan-to-clearinghouse/vendor:
  - Health plan outsources the creation of the EFT transaction to a third-party payment vendor
  - Health plan outsources the creation of the ERA transaction to a clearinghouse or business associate

**Key Takeaway:** Understand what aspects of your business and/or outsourced functions are impacted by the CAQH CORE Payment & Remittance Operating Rules (e.g. products, business lines, etc.).

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| <b>Stakeholder &amp; Business Type Evaluation</b>   |  |                      |
|---|--|----------------------|
| <b>Question</b>   | <b>Points for Consideration</b>  | <b>Your Response</b> |
| 1. What is your stakeholder type(s)? (e.g., health plan, provider, vendor, clearinghouse; see question 3 for more information on other trading partners)  | The CAQH CORE Payment & Remittance Operating Rules define four stakeholder types that implement the operating rules: health plan, clearinghouse, provider, and vendor; the applicability of specific CAQH CORE Payment & Remittance Operating Rule requirements vary according to stakeholder type.  |                      |
| 2. What role and responsibilities does my organization have for implementing the CAQH CORE Payment & Remittance Operating Rules, given our stakeholder type(s) (e.g. health care electronic funds transfers and/or electronic remittance advice)?   | The CAQH CORE Payment & Remittance Operating Rules outline the specific roles and responsibilities for each stakeholder type; review CAQH CORE Payment & Remittance Operating Rule text for more detail.   |                      |
| 3. Does my organization rely on trading partners (e.g., software vendors, clearinghouses, banks/financial services institutions, third-party payment vendors, collection/billing services vendors) to assist with health care electronic funds transfers and/or electronic remittance advice? | <p>The applicability of a specific CAQH CORE Payment &amp; Remittance Operating Rule requirement may vary according to trading partner relationship, contracted services, and other arrangements. If your organization relies on a software vendor or a clearinghouse or other business associate to meet any of the CAQH CORE Payment &amp; Remittance Operating Rule requirements you will need to coordinate with that entity as part of your pre-implementation planning and outline applicability of each requirement to the vendor, clearinghouse or business associate. See Section 4 of this document (above) for additional resources.</p> <p>Ensure appropriate business associate agreements are in place with necessary stakeholders (e.g., third-party payment vendors, collection/billing services vendors).</p> |                      |

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**Appendix B: CAQH CORE Systems Inventory & Impact Assessment Worksheet**

**Purpose:** After you complete the *Stakeholder & Business Type Evaluation*, your next step is to complete the *CAQH CORE Systems Inventory & Impact Assessment Worksheet* which enables you to identify and inventory all impacted systems that process health care electronic funds transfers and/or electronic remittance advice transactions.

This assessment worksheet will help you identify your systems impacted by the implementation of the CAQH CORE Payment & Remittance Operating Rules, including in-house developed and maintained systems, COTS systems, those functions outsourced to a third party. While completing this analysis you should also consider potential options for addressing applicable CAQH CORE Payment & Remittance Operating Rule requirements (e.g., remediate an in-house developed system, replace or upgrade any COTS system, or work with third-party vendor).

**Instructions:**

1. In the second column of the worksheet, note if one of your system(s) is impacted by each rule and list the name of the impacted system(s).
  - **NOTE:** The impacted system(s) may include an in-house developed system, COTS system, or an outsourced solution from a third party. The “system” in certain cases may also be a manual process.
2. In the third column, identify potential options for addressing the rule requirements for each impacted system(s).
3. Use the worksheet findings to inform completion of the *Gap Analysis Worksheet* for any identified system impacted by the rule requirements.

**Key Takeaway:** Understand how many of your systems/products are impacted by each CAQH CORE Payment & Remittance Operating Rule and understand with which vendors you will need to coordinate.

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| <b>CAQH CORE Systems Inventory &amp; Impact Assessment Worksheet</b>  |  |  |   |
|---|--|--|---|
| <b>CAQH CORE Payment &amp; Remittance Operating Rule</b>  | <b>Are One or More Systems/Processes Impacted?</b><br><i>(Yes/No; Name of Impacted System/Process)</i> | <b>Is the System/Process In-House, COTS, or Outsourced to a Third Party?</b> | <b>Potential Options to Address Rule Requirements</b><br><i>(e.g. remediate an in-house developed system, replace or upgrade any COTS system, work with third party vendor to ensure they meet CAQH CORE Operating Rule requirements, or update manual processes)</i> |
| <b>Data Content Rules</b>   |  |  |   |
| <a href="#">CAQH CORE Payment &amp; Remittance CARCs and RARCs Rule</a> (aligning internal codes with CORE-required Code Combinations for CORE-defined Business Scenarios)  |  |  |   |
| <a href="#">CAQH CORE Payment &amp; Remittance Reassociation (CCD+835) Rule</a> (elapsed time between CCD+ and 835, minimum CCD+ data elements for successful reassociation, resolving late/missing transactions, etc.) |  |  |   |
| <a href="#">CAQH CORE Payment &amp; Remittance EFT Enrollment Data Rule</a> (maximum data elements for manual and electronic EFT Enrollment)  |  |  |   |
| <a href="#">CAQH CORE Payment &amp; Remittance ERA Enrollment Data Rule</a> (maximum data elements for manual and electronic ERA enrollment)  |  |  |   |
| <b>Infrastructure Rule</b>  |  |  |   |
| <a href="#">CAQH CORE Payment &amp; Remittance (835) Infrastructure Rule</a> (ability to support CAQH CORE Connectivity Rule vC2.2.0)   |  |  |   |

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**Appendix C: CAQH CORE Gap Analysis Worksheet**

**Purpose:** After the *Systems Inventory & Impact Assessment*, the next task is for entities to determine the level of system(s) remediation necessary for adopting the business and technical requirements of the CAQH CORE Payment & Remittance Operating Rules using the *CAQH CORE Gap Analysis Worksheet*. Each rule requirement in the *Gap Analysis Worksheet* includes a section reference for the corresponding operating rule for more detail.

**NOTES:**

- For more detail on rule requirements refer to the actual CAQH CORE Operating Rule text which takes precedence over this worksheet.
- If your entity has identified more than one impacted system you may need to complete a *Gap Analysis Worksheet* for each system.

**Instructions:**

1. The *Gap Analysis Worksheet* contains each CAQH CORE Payment & Remittance Operating Rule Requirement in the first column by CAQH CORE Payment & Remittance Operating Rule. In the second column, enter the system(s) impacted by the CAQH CORE Payment & Remittance Operating Rule Requirement. If there is no system impacted by the requirement, enter N/A.
  - **NOTE:** The impacted system(s) may include an in-house developed system, a COTS system, or an outsourced solution to a third party or business associate.
2. In the third column note if the system currently meets the CAQH CORE Payment & Remittance Operating Rule Requirement or not.
3. In the fourth column, briefly describe any gap between the CAQH CORE Payment & Remittance Operating Rule Requirement and the system under evaluation, if applicable. The high level findings from the *Systems Inventory & Impact Assessment* will inform the input in this column.
4. In the fifth column estimate the effort required to remediate the impacted system(s). This can include the type of skilled resource required, the number of such resources, and the potential hours required to fill the gap identified.
5. In the sixth column identify and describe any impacted business process. These often include potential training and education of staff, clients, and other users of the system's new capabilities.
6. In the seventh column estimate and describe the effort required to revise the impacted business process. This can include the type of skilled resources required, the number of such resources, and the potential hours required to fill the gap identified.
7. The results of the completed *Gap Analysis Worksheet* will allow for the development of a detailed project plan.

**Key Takeaway:** Understand the level of system(s) remediation necessary for adopting each CAQH CORE Payment & Remittance Operating Rule requirement.

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| <b>Rule Req. #</b>   | <b>CAQH CORE Operating Rule Requirement</b>   | <b>System/Process Impacted</b><br><i>(Based on results from System Inventory and Impact Analysis Worksheet-if no impact enter N/A)</i> | <b>System/Process Currently Meets the Requirement</b><br><i>(Yes/No)</i> | <b>Gap</b><br><i>(Briefly describe gap)</i> | <b>Estimated System/Process Remediation Effort</b><br><i>(Required number, type of skilled resource, person hours required)</i> | <b>Business Processes Impacted</b><br><i>(Briefly describe)</i> | <b>Business Processes/Documentation Revisions Required &amp; Effort Estimates</b> |
|--|---|--|--|---|---|---|---|
| <b><u>CAQH CORE Payment &amp; Remittance (835) Infrastructure Rule vPR1.0</u></b>                      |   |  |  |   |   |   |   |
| <i>Health Care Claim Payment/Advice Connectivity Requirements (§4.1 of rule)</i>                       |   |  |  |   |   |   |   |
| <b>1</b>   | Entities must be able to support the CAQH CORE Connectivity Rule vC2.2.0.   |  |  |   |   |   |   |
| <b>2</b>   | The requirement to support the CAQH CORE Connectivity Rule vC2.2.0 does not apply to retail pharmacy.   |  |  |   |   |   |   |
| <i>Health Care Claim Payment/Advice Batch Acknowledgement Requirements (§4.2 of rule) <sup>5</sup></i> |   |  |  |   |   |   |   |
| <b>3</b>   | A receiver of a v5010 X12 835 transaction must return:<br>a. 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<br>b. To specify for each included v5010 X12 835 transaction set that the transaction set was either accepted, accepted with errors or rejected. |  |  |   |   |   |   |
| <b>4</b>   | A health plan must be able to accept and process a v5010 X12 999 for a Functional Group of v5010 X12 835 transactions.  |  |  |   |   |   |   |
| <b>5</b>   | 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   |  |  |   |   |   |   |

<sup>5</sup> See footnote on page 3 for detail on the Federal mandate and requirements pertaining to the use of Acknowledgements.

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|   | level of detail supported by the v5010 X12 999 Implementation Acknowledgement.  |  |  |   |   |   |   |
| <b>6</b>  | The requirements specified in §4.2 do not currently apply to retail pharmacy.   |  |  |   |   |   |   |
| <i>Dual Delivery of v5010 X12 835 and Proprietary Paper Claim Remittance Advices (§4.3 of rule)</i> |   |  |  |   |   |   |   |
| <b>7</b>  | <p>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.</p> <ul style="list-style-type: none"> <li>a. 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.</li> <li>b. 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.</li> <li>c. Upon mutual agreement between the provider and the health plan, the timeframe for delivery</li> </ul> |  |  |   |   |   |   |



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|   | 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.<br><br>d. 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. |  |  |   |   |   |   |
| 8   | The requirements specified in §4.3 do not currently apply to retail pharmacy.   |  |  |   |   |   |   |
| <i>Health Care Claim Payment/Advice Companion Guide (§4.4 of rule)</i>  |   |  |  |   |   |   |   |
| 9   | An entity's Companion Guide covering the v5010 X12 835 must follow the format/flow as defined in the CAQH CORE v5010 Master Companion Guide Template for HIPAA Transactions.  |  |  |   |   |   |   |
| 10  | The requirements specified in §4.4 do not currently apply to retail pharmacy.   |  |  |   |   |   |   |
| <a href="#"><u>CAQH CORE Payment &amp; Remittance CARCs and RARCs Rule vPR1.0</u></a>   |   |  |  |   |   |   |   |
| <i>Uniform Use of Claim Adjustment Reason Codes, Remittance Advice Remark Codes, Claim Adjustment Group Codes &amp; NCPDP Reject Codes (§4.1.2 of rule)</i> |   |  |  |   |   |   |   |
| 1   | A health plan or its PBM agent must align its internal codes and corresponding business scenarios to the  |  |  |   |   |   |   |

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|--|---|--|--|---|---|---|---|
|  | CORE-defined Claim Adjustment/Denial Business Scenarios specified in §4.1.1 and the CARC, RARC, CAGC and NCPDP Reject Code combinations specified in the <i>CORE-required Code Combinations for CORE-defined Business Scenarios.doc</i> .   |  |  |   |   |   |   |
| <i>Use of CORE-required CARC/RARC/CAGC/NCPDP Reject Code Combinations (§4.1.3 of rule)</i> |   |  |  |   |   |   |   |
| 2  | <p>A health plan or its PBM agent must support the maximum CORE-required CARC/RARC/CAGC or CARC/NCPDP Reject Code/CAGC combinations in the v5010 X12 835, as specified in <i>CORE-required Code Combinations for CORE-defined Business Scenarios.doc</i>.</p> <ul style="list-style-type: none"> <li>a. No other CARC/RARC/CAGC or CARC/NCPDP Reject Codes/CAGC combinations are allowed for use in the CORE-defined Claim Adjustment/Denial Business Scenarios.</li> <li>b. When specific CORE-required CARC/RARC/CAGC or CARC/NCPDP Reject Code/CAGC combinations are not applicable to meet the health plan's or its PBM agent's business requirements within the CORE-defined Business Scenarios, the health plan and its PBM agent are not required to use them.</li> <li>c. An adjusted <i>CORE-required Code Combinations for CORE-defined Business Scenarios.doc</i> will be published no less than three times annually to account for updates to the published code lists.</li> </ul> |  |  |   |   |   |   |

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|   | <p>d. Published new or modified codes per the codes committees can be used until the next version of the <i>CORE-required Code Combinations for CORE-defined Business Scenarios.doc</i> is published; see the <a href="#">CAQH CORE Code Combinations Maintenance Process</a> for more detail.</p> <p>e. A deactivated code must not be used.</p>  |  |  |   |   |   |   |
| 3   | <p>In the case where a health plan or its PBM agent wants to use an existing code combination that is not included in the maximum code combination set for a given CORE-defined Business Scenario, a new CARC/RARC code combination must be requested in accordance with the CORE process for updating the <i>CORE-required Code Combinations for CORE-defined Business Scenarios.doc</i>.</p>   |  |  |   |   |   |   |
| <i>Basic Requirements for Receivers of the v5010 X12 835 (§4.2 of rule)</i> |  |  |  |   |   |   |   |
| 4   | <p>When receiving a v5010 X12 835, the product extracting the data (e.g., a vendor's provider-facing system or solution) from the v5010 X12 835 for manual processing must make available to the end user:</p> <p>a. Text describing the CARC/RARC/CAGC and CARC/NCPDP Reject Codes <i>included in the remittance advice</i>, ensuring that the actual wording of the text displayed accurately represents the corresponding code description specified in the code lists without changing the meaning and intent of the description</p> |  |  |   |   |   |   |

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|--|---|--|--|---|---|---|---|
|  | And<br>b. Text describing the corresponding CORE-defined Claim Adjustment/Denial Business Scenario.   |  |  |   |   |   |   |
| <b>5</b>   | The requirement to make available to the end user text describing the corresponding CORE-defined Claim Adjustment/Denial Business Scenario does not apply to retail pharmacy.   |  |  |   |   |   |   |
| <b>6</b>   | The requirement to make available to the end user text describing the corresponding CORE-defined Claim Adjustment/Denial Business Scenario does not apply to an entity that is simply forwarding the v5010 X12 835 to another system for further processing.  |  |  |   |   |   |   |
| <b><u><a href="#">CAQH CORE Payment &amp; Remittance Reassociation (CCD+835) Rule vPR1.0</a></u></b> |   |  |  |   |   |   |   |
| <i>Receipt of the CORE-required Minimum CCD+ Data Required for Reassociation (§4.1 of rule)</i>      |   |  |  |   |   |   |   |
| <b>1</b>   | A health plan must proactively inform the healthcare provider during EFT (Healthcare EFT Standards) and ERA (v5010 X12 835) enrollment that it will need to contact its financial institution to arrange for the delivery of the CORE-required Minimum CCD+ Reassociation Data Elements necessary for successful reassociation of the EFT payment with the ERA remittance advice. |  |  |   |   |   |   |
| <b>2</b>   | A healthcare provider must proactively contact its financial institution to arrange for the delivery of the CORE-required Minimum CCD+ Reassociation Data Elements necessary for successful reassociation of the EFT payment with the ERA remittance advice.  |  |  |   |   |   |   |
| <i>Elapsed Time between Sending the v5010 X12 835 and the CCD+ Transactions (§4.2 of rule)</i>       |   |  |  |   |   |   |   |

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|---|--|--|--|---|---|---|---|
| <b>3</b>  | A health plan must release for transmission to the healthcare provider the v5010 X12 835 corresponding to the Healthcare EFT Standards:<br><ul style="list-style-type: none"> <li>a. No sooner than three business days based on the time zone of the health plan prior to the CCD+ Effective Entry Date and</li> <li>b. No later than three business days after the CCD+ Effective Entry Date.</li> </ul> |  |  |   |   |   |   |
| <b>4</b>  | A health plan must ensure that the CCD+ Effective Entry Date is a valid banking day and that the corresponding v5010 x12 835 BPR16 date is the same valid banking day.   |  |  |   |   |   |   |
| <b>5</b>  | For retail pharmacy, the health plan may release for transmission the v5010 X12 835 any time prior to the CCD+ Effective Entry Date of the corresponding EFT; and no later than three days after the CCD+ Effective Entry Date (§4.2.1).   |  |  |   |   |   |   |
| <i>Elapsed Time Auditing Requirements (§4.2.2 of rule)</i>            |  |  |  |   |   |   |   |
| <b>6</b>  | A health plan must ensure the v5010 X12 835 and corresponding Healthcare EFT Standards meet the elapsed time requirements ninety percent (90%) of the time as measured within a calendar month.  |  |  |   |   |   |   |
| <b>7</b>  | A health plan is required to have the capability to track and audit this elapsed time requirement.   |  |  |   |   |   |   |
| <i>Resolving Late/Missing EFT and ERA Transactions (§4.3 of rule)</i> |  |  |  |   |   |   |   |
| <b>8</b>  | A health plan must establish written Late/Missing EFT and ERA Transactions Resolution Procedures defining the process a healthcare provider must use when researching and resolving a late or missing Healthcare   |  |  |   |   |   |   |

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|--|---|--|--|---|---|---|---|
|  | EFT Standards payment and/or the corresponding late or missing v5010 X12 835.   |  |  |   |   |   |   |
| <b>9</b>   | Late or missing is defined as a maximum elapsed time of four business days following the receipt of either the Healthcare EFT Standards or v5010 X12 835.<br>For retail pharmacy, a late or missing v5010 835 is defined as a maximum elapsed time of four business days following the receipt of the CCD+. |  |  |   |   |   |   |
| <b>10</b>  | The Late/Missing EFT and ERA Resolution Procedures must be delivered to the healthcare provider during its EFT and ERA enrollment with the health plan.   |  |  |   |   |   |   |
| <b><u><a href="#">CAQH CORE Payment &amp; Remittance EFT Enrollment Data Rule vPR1.0</a></u></b> |   |  |  |   |   |   |   |
| <i>CORE-required Maximum EFT Enrollment Data Elements (§4.2 of rule)</i>                         |   |  |  |   |   |   |   |
| <b>1</b>   | A health plan (or its agent or vendors offering EFT enrollment) is required to collect no more data elements than the maximum data elements defined in Table 4.2-1 CORE-required Maximum EFT Enrollment Data Set.   |  |  |   |   |   |   |
| <b>2</b>   | Both the Individual Data Element name and its associated description must be used by a health plan (or its agent or vendors offering EFT enrollment) when collecting EFT enrollment data either electronically or via a manual paper-based process.   |  |  |   |   |   |   |
| <b>3</b>   | The Individual Data Element Name and its associated description must not be modified.   |  |  |   |   |   |   |
| <b>4</b>   | When a Data Element Group (DEG) is designated as required, all of the Individual Data Elements designated as required within the DEG must be collected by the health plan.  |  |  |   |   |   |   |

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| 5                  | Individual Data Elements designated as optional may be collected depending on the business needs of the health plan.  |  |  |   |   |   |   |
| 6                  | When a DEG is designated as optional, the collection of the optional DEG is at the discretion of the health plan.   |  |  |   |   |   |   |
| 7                  | When a health plan exercises its discretion to collect an optional DEG, any included Individual Data Element designated as required must be collected.  |  |  |   |   |   |   |
| 8                  | 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.   |  |  |   |   |   |   |
| 9                  | 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.   |  |  |   |   |   |   |
| 10                 | Not collecting an Individual Data Element identified as optional does not constitute a non-conforming use of the CORE-required Maximum Enrollment Data Set.   |  |  |   |   |   |   |
| 11                 | The collection of multiple occurrences of DEGs for another context does not constitute a non-conforming use of the CORE-required Maximum Enrollment Data Set.   |  |  |   |   |   |   |
| 12                 | 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. |  |  |   |   |   |   |

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|   | a. The health plan's specific instructions and guidance are not addressed in this rule.   |  |  |   |   |   |   |
| <b>13</b>   | 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.  |  |  |   |   |   |   |
| <i>CORE Master Template for Collecting Manual Paper-Based Enrollment EFT Enrollment Data (§4.3.1 of rule)</i> |   |  |  |   |   |   |   |
| <b>14</b>   | The name of the health plan (or its agent or the vendor offering EFT) and the purpose of the form will be on the top of the form, e.g., Health Plan X: Electronic Funds Transfer (EFT) Authorization Agreement.   |  |  |   |   |   |   |
| <b>15</b>   | A health plan (or its agent or a vendor offering EFT) is required to use the format, flow, and data set including data element descriptions of Table 4.2-1 as the CORE Master EFT Enrollment Submission Form when using a manual paper-based enrollment method.   |  |  |   |   |   |   |
| <b>16</b>   | All CORE-required EFT Enrollment data elements must appear on the paper form in the same order as they appear in Table 4.2-1.   |  |  |   |   |   |   |
| <b>17</b>   | A health plan (or its agent) cannot revise or modify: <ul style="list-style-type: none"> <li>a. The name of a CORE Master EFT Enrollment Data Element Name</li> <li>b. The usage requirement of a CORE Master EFT Enrollment Data Element</li> <li>c. The Data Element Group number of a CORE Master EFT Enrollment Data Element</li> </ul> |  |  |   |   |   |   |
| <b>18</b>   | Beyond the data elements and their flow, a health plan (or its agent) must:   |  |  |   |   |   |   |



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|--------------------|---|--|--|---|---|---|---|
|                    | <ul style="list-style-type: none"> <li>a. 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</li> <li>b. Provide a number to fax and/or a U.S. Postal Service or email address to send the completed form</li> <li>c. Include contact information for the health plan, specifically a telephone number and/or email address to send questions</li> <li>d. Include authorization language for the provider to read and consider</li> <li>e. 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 EFT enrollment</li> <li>f. Clearly label any appendix describing its purpose as it relates to the provider enrolling in EFT</li> <li>g. Inform the provider that it must contact its financial institution to arrange for the delivery of the CORE-required Minimum CCD+ Reassociation Data Elements needed for reassociation of the payment and the ERA. See <a href="#">CAQH CORE Payment &amp; Remittance Reassociation (CCD+835) Rule</a> .</li> </ul> |  |  |   |   |   |   |

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|---|--|--|--|---|---|---|---|
| <i>CORE Master Template for Electronic Enrollment EFT Enrollment Data (§4.3.2 of rule)</i>        |  |  |  |   |   |   |   |
| 19  | When electronically enrolling a healthcare provider in EFT, a health plan (or its agent) must use the CORE Master EFT Enrollment Data Element Name and Sub-element Name as specified in Table 4.2-1 without revision or modification.  |  |  |   |   |   |   |
| 20  | The flow, format and data set including data element descriptions established by this rule must be followed.   |  |  |   |   |   |   |
| 21  | 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>. |  |  |   |   |   |   |
| 22  | A health plan (or its agent or vendors offering EFT enrollment) will offer an electronic way for provider to complete and submit the EFT enrollment.   |  |  |   |   |   |   |
| <i>CAQH CORE Electronic Safe Harbor for EFT Enrollment to Occur Electronically (§4.4 of rule)</i> |  |  |  |   |   |   |   |
| 23  | Specifies that all health plans and their respective agents must implement and offer to any trading partner an electronic method and process for collecting the CORE-required Maximum EFT Enrollment Data Set.   |  |  |   |   |   |   |
| <i>Time Frame for Rule Compliance (§4.5 of rule)</i>  |  |  |  |   |   |   |   |
| 24  | Not later than the date that is six months after the compliance date specified in any Federal regulation adopting this rule, a health plan or its agent that uses a paper-based form to collect and submit the CORE-required Maximum EFT Enrollment Data Set must  |  |  |   |   |   |   |

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| <b>Rule Req. #</b>   | <b>CAQH CORE Operating Rule Requirement</b>  | <b>System/Process Impacted</b><br><i>(Based on results from System Inventory and Impact Analysis Worksheet-if no impact enter N/A)</i> | <b>System/Process Currently Meets the Requirement</b><br><i>(Yes/No)</i> | <b>Gap</b><br><i>(Briefly describe gap)</i> | <b>Estimated System/Process Remediation Effort</b><br><i>(Required number, type of skilled resource, person hours required)</i> | <b>Business Processes Impacted</b><br><i>(Briefly describe)</i> | <b>Business Processes/Documentation Revisions Required &amp; Effort Estimates</b> |
|--|--|--|--|---|---|---|---|
|  | convert <u>all</u> its paper-based forms to comply with the data set specified in this rule.   |  |  |   |   |   |   |
| <b>25</b>  | If a health plan or its agent does not use a paper-based manual method and process to collect the CORE-required Maximum EFT Enrollment Data Set as of the compliance date specified in any Federal regulation adopting this rule, it is not required by this rule to implement a paper-based manual process on or after the compliance date. |  |  |   |   |   |   |
| <b>26</b>  | It will be expected that all electronic EFT 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.   |  |  |   |   |   |   |
| <b><u><a href="#">CAQH CORE Payment &amp; Remittance ERA Enrollment Data Rule vPR1.0</a></u></b> |  |  |  |   |   |   |   |
| <i>CORE-required Maximum ERA Enrollment Data Elements (§4.2 of rule)</i>                         |  |  |  |   |   |   |   |
| <b>1</b>   | 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.  |  |  |   |   |   |   |
| <b>2</b>   | 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.  |  |  |   |   |   |   |
| <b>3</b>   | The Individual Data Element Name and its associated description must not be modified.  |  |  |   |   |   |   |

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| <b>Rule Req. #</b> | <b>CAQH CORE Operating Rule Requirement</b>   | <b>System/Process Impacted</b><br><i>(Based on results from System Inventory and Impact Analysis Worksheet-if no impact enter N/A)</i> | <b>System/Process Currently Meets the Requirement</b><br><i>(Yes/No)</i> | <b>Gap</b><br><i>(Briefly describe gap)</i> | <b>Estimated System/Process Remediation Effort</b><br><i>(Required number, type of skilled resource, person hours required)</i> | <b>Business Processes Impacted</b><br><i>(Briefly describe)</i> | <b>Business Processes/Documentation Revisions Required &amp; Effort Estimates</b> |
|--------------------|---|--|--|---|---|---|---|
| 4                  | When a Data Element Group (DEG) is designated as required, all of the Individual Data Elements designated as required within the DEG must be collected by the health plan.                            |  |  |   |   |   |   |
| 5                  | Individual Data Elements designated as optional may be collected depending on the business needs of the health plan.  |  |  |   |   |   |   |
| 6                  | When a DEG is designated as optional, the collection of the optional DEG is at the discretion of the health plan.   |  |  |   |   |   |   |
| 7                  | When a health plan exercises its discretion to collect an optional DEG, any included Individual Data Element designated as required must be collected.  |  |  |   |   |   |   |
| 8                  | 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.   |  |  |   |   |   |   |
| 9                  | 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. |  |  |   |   |   |   |
| 10                 | Not collecting an Individual Data Element identified as optional does not constitute a non-conforming use of the CORE-required Maximum Enrollment Data Set.   |  |  |   |   |   |   |
| 11                 | The collection of multiple occurrences of DEGs for another context does not constitute a non-conforming use of the CORE-required Maximum Enrollment Data Set.   |  |  |   |   |   |   |

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| <b>Rule Req. #</b>  | <b>CAQH CORE Operating Rule Requirement</b>  | <b>System/Process Impacted</b><br><i>(Based on results from System Inventory and Impact Analysis Worksheet-if no impact enter N/A)</i> | <b>System/Process Currently Meets the Requirement</b><br><i>(Yes/No)</i> | <b>Gap</b><br><i>(Briefly describe gap)</i> | <b>Estimated System/Process Remediation Effort</b><br><i>(Required number, type of skilled resource, person hours required)</i> | <b>Business Processes Impacted</b><br><i>(Briefly describe)</i> | <b>Business Processes/Documentation Revisions Required &amp; Effort Estimates</b> |
|---|--|--|--|---|---|---|---|
| 12  | 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.<br>a. The health plan's specific instructions and guidance are not addressed in this rule. |  |  |   |   |   |   |
| 13  | 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.   |  |  |   |   |   |   |
| <i>CORE Master Template for Collecting Manual Paper-Based Enrollment ERA Enrollment Data (§4.3.1 of rule)</i> |  |  |  |   |   |   |   |
| 14  | 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.   |  |  |   |   |   |   |
| 15  | 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 of Table 4.2-1 as the CORE Master ERA Enrollment Submission Form when using a manual paper-based enrollment method.  |  |  |   |   |   |   |
| 16  | 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.  |  |  |   |   |   |   |
| 17  | A health plan (or its agent) cannot revise or modify:<br>a. The name of a CORE Master ERA Enrollment Data Element Name<br>b. The usage requirement of a CORE Master ERA Enrollment Data Element  |  |  |   |   |   |   |

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| <b>Rule Req. #</b> | <b>CAQH CORE Operating Rule Requirement</b>  | <b>System/Process Impacted</b><br><i>(Based on results from System Inventory and Impact Analysis Worksheet-if no impact enter N/A)</i> | <b>System/Process Currently Meets the Requirement</b><br><i>(Yes/No)</i> | <b>Gap</b><br><i>(Briefly describe gap)</i> | <b>Estimated System/Process Remediation Effort</b><br><i>(Required number, type of skilled resource, person hours required)</i> | <b>Business Processes Impacted</b><br><i>(Briefly describe)</i> | <b>Business Processes/Documentation Revisions Required &amp; Effort Estimates</b> |
|--------------------|--|--|--|---|---|---|---|
|                    | c. The Data Element Group number of a CORE Master ERA Enrollment Data Element  |  |  |   |   |   |   |
| 18                 | <p>Beyond the data elements and their flow, a health plan (or its agent) must:</p> <ul style="list-style-type: none"> <li>a. 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</li> <li>b. Provide a number to fax and/or a U.S. Postal Service or email address to send the completed form</li> <li>c. Include contact information for the health plan, specifically a telephone number and/or email address to send questions</li> <li>d. Include authorization language for the provider to read and consider</li> <li>e. 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</li> <li>f. Clearly label any appendix describing its purpose as it relates to the provider enrolling in ERA</li> <li>g. Inform the provider that it must contact its financial institution to arrange for the delivery of the CORE-required Minimum CCD+ data</li> </ul> |  |  |   |   |   |   |

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|---|--|--|--|---|---|---|---|
|   | elements needed for reassociation of the payment and the ERA. See <a href="#">CAQH CORE Payment &amp; Remittance Reassociation (CCD+835) Rule</a>  |  |  |   |   |   |   |
| <i>CORE Master Template for Electronic Enrollment ERA Enrollment Data (§4.3.2 of rule)</i>        |  |  |  |   |   |   |   |
| 19  | 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 as specified in Table 4.2-1 without revision or modification.  |  |  |   |   |   |   |
| 20  | The flow, format and data set including data element descriptions established by this rule must be followed.   |  |  |   |   |   |   |
| 21  | 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>. |  |  |   |   |   |   |
| 22  | 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.   |  |  |   |   |   |   |
| <i>CAQH CORE Electronic Safe Harbor for ERA Enrollment to Occur Electronically (§4.4 of rule)</i> |  |  |  |   |   |   |   |
| 23  | Specifies that all health plans and their respective agents must implement and offer to any trading partner an electronic method and process for collecting the CORE-required Maximum ERA Enrollment Data Set.   |  |  |   |   |   |   |
| <i>Time Frame for Rule Compliance (§4.5 of rule)</i>  |  |  |  |   |   |   |   |
| 24  | Not later than the date that is six months after the compliance date in any Federal regulation adopting this   |  |  |   |   |   |   |

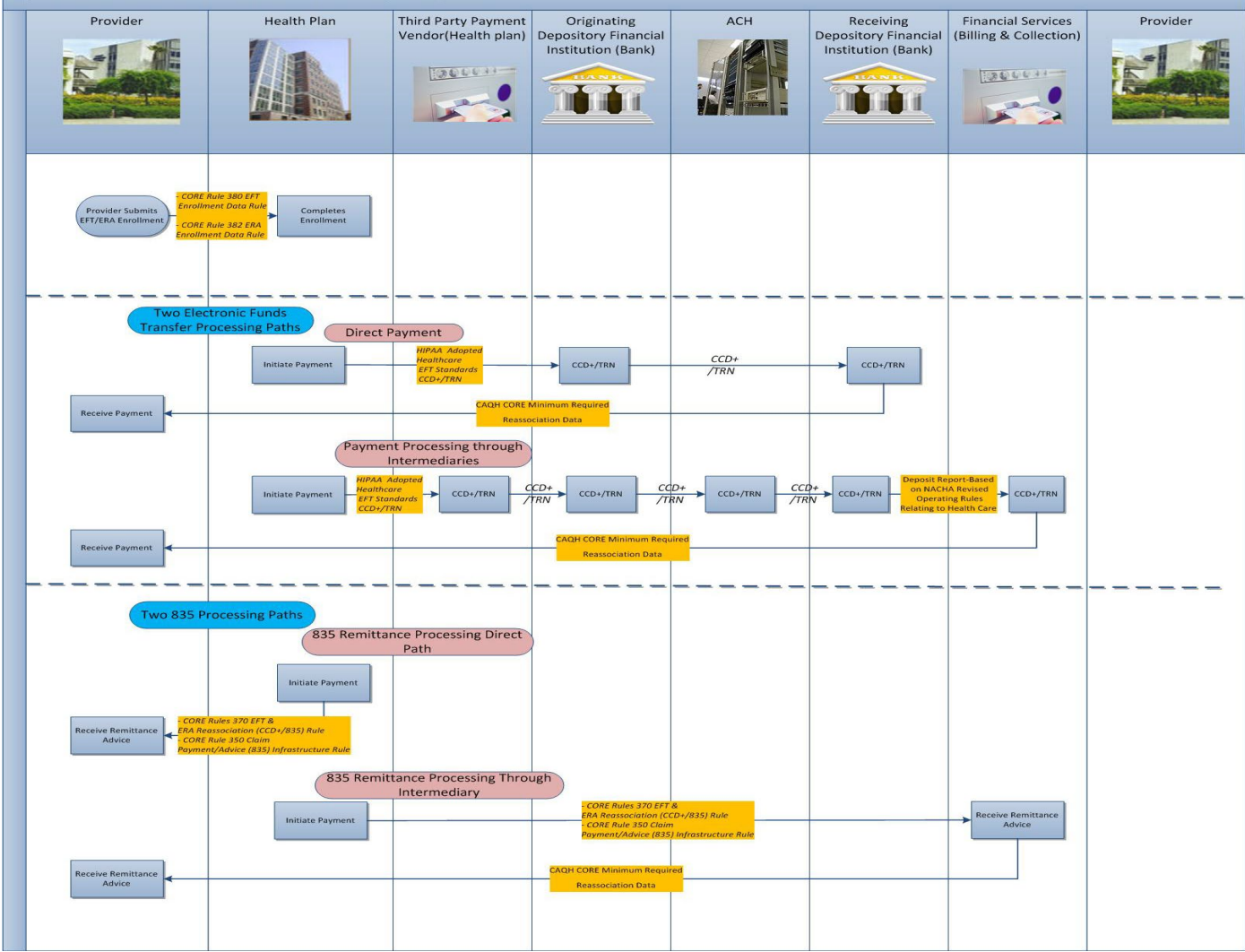
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| <b>Rule Req. #</b> | <b>CAQH CORE Operating Rule Requirement</b>  | <b>System/Process Impacted</b><br><i>(Based on results from System Inventory and Impact Analysis Worksheet-if no impact enter N/A)</i> | <b>System/Process Currently Meets the Requirement</b><br><i>(Yes/No)</i> | <b>Gap</b><br><i>(Briefly describe gap)</i> | <b>Estimated System/Process Remediation Effort</b><br><i>(Required number, type of skilled resource, person hours required)</i> | <b>Business Processes Impacted</b><br><i>(Briefly describe)</i> | <b>Business Processes/Documentation Revisions Required &amp; Effort Estimates</b> |
|--------------------|--|--|--|---|---|---|---|
|                    | 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 <u>all</u> its paper-based forms to comply with the data set specified in this rule.  |  |  |   |   |   |   |
| <b>25</b>          | 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 rule, it is not required by this rule to implement a paper-based manual process on or after the compliance date. |  |  |   |   |   |   |
| <b>26</b>          | It will be expected that at the time of certification 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.  |  |  |   |   |   |   |



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**Appendix D: Dollars and Data Flow Diagrams<sup>6</sup>**



<sup>6</sup> The diagrams make reference to the [NACHA Operating Rules](#), which include requirements around [Health Care Payments via ACH](#) (amendment approved 10/31/2012 and effective 09/20/2013).

# EFT and ERA Process Flow

