



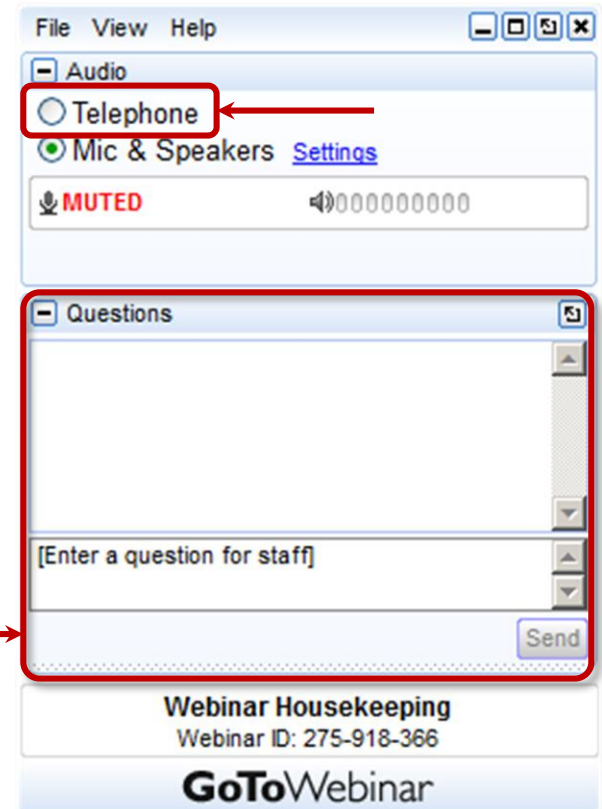
Matching Payments to Services Delivered

What Every Provider
and Health Plan
Should Expect, and
What Every Trading
Partner Should Deliver

Tuesday,
November 10th, 2015
2:00-3:00pm ET

Logistics – *How to Participate in Today's Session*

- Download a copy of today's presentation on the [CAQH.org website](http://CAQH.org)
 - Navigate to the CORE Education Events page and access a pdf version of today's presentation under the list for today's event
- The phones will be muted upon entry and during the presentation portion of the session
- At any time throughout the session, you may communicate a question via the web
 - Questions can be submitted **at any time** with the **Questions panel on the right side of the GoToWebinar desktop**
 - On-line questions will be addressed first



Thank You Speakers!

CAQH CORE would like to thank our guest presenters for today's webinar.



Pat Wijtyk
Senior Health Reimbursement Specialist
ASC X12



Priscilla C. Holland AAP
Senior Director Healthcare Payments
NACHA

Session Outline

1. Welcome and Introduction
2. Value of Interconnected Remittance-Payment Transactions
3. ASC X12 v5010 835
4. NACHA CCD+ Specification
5. CAQH CORE Reassociation Rule
6. Q & A

Polling Question #1:

Use of EFT/ERA Transactions

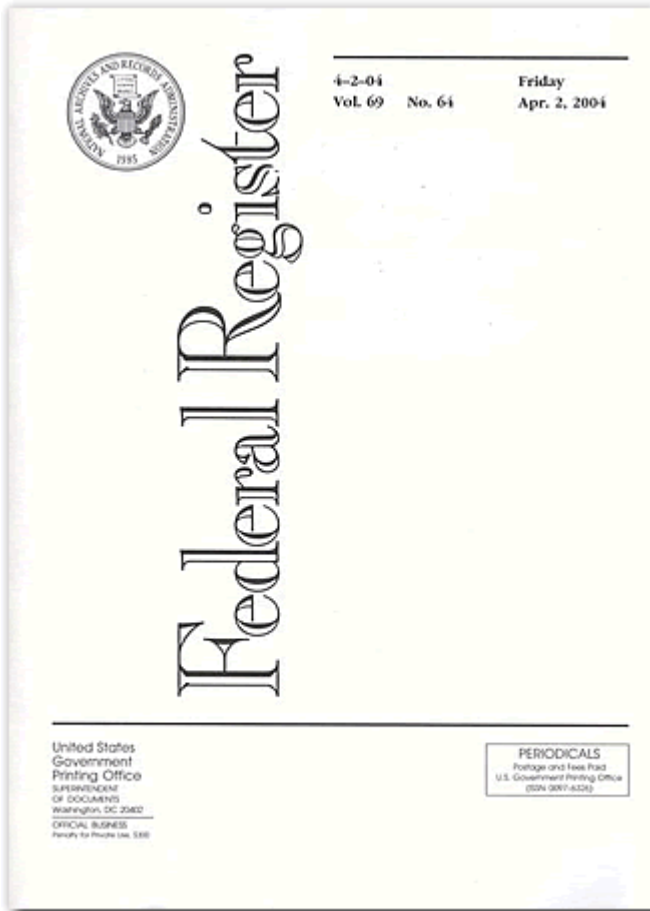
Please indicate the extent to which your organization sends or receives health care payments through EFT (ACH Network only).

1. 1%-25% of the time
2. 26%-50% of the time
3. 51% - 75% of the time
4. Above 75% of the time
5. We neither send nor receive health care payments through EFT (ACH Network only)

Value of Interconnected Payment-Remittance Transactions

Robert Bowman
Senior Manager

Barrier to Electronic Payments



From the ***Federal Register***:

“A barrier for health care providers to the use of Electronic Funds Transfer (EFT) for health care claim payments is that the Electronic Remittance Advice (ERA) arrives at a different time than the associated health care payment/processing information that is transmitted via EFT.”

EFT and ERA: Operating Rules Build On Standards

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



ACH CCD+ & X12 v5010 835

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

CAQH CORE EFT & ERA Operating Rules

- Provider enrollment in EFT and ERA
- Infrastructure for supporting the ERA
- Uniform use of codes for conveying claim adjustments/denials
- Reassociation of the EFT and ERA

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

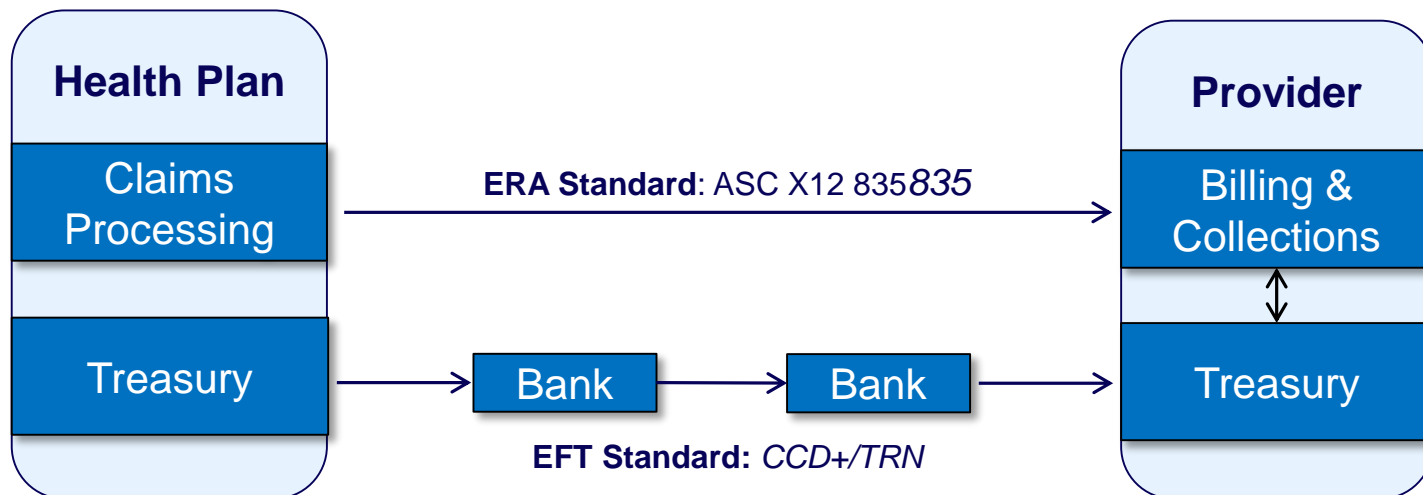
EFT and ERA Transaction Flow

EFT and ERA Operating Rules represent the convergence of financial services and healthcare:

- Both transactions are sent using “recognized” electronic HIPAA standards.
- Aim is to increase adoption of both standards in healthcare.

Together the transactions foster the goals of administrative simplification by moving the process of reimbursement from paper to electronic:

- ERA is an electronic transaction that enables providers to receive claims payment information from health plans electronically; ERA files are intended to replace the paper Explanation of Payment (EOP).
- EFT enables providers to receive payments from health plans electronically.



Polling Question #2: ***EFT/ERA Implementation***

Has your use of EFT (ACH) for health care payments saved your organization time/money?

1. Yes, a substantial amount
2. Yes, somewhat
3. No
4. Do not know
5. We do not conduct this transaction



ASC X12N

ASC X12 835 V5010

November 10, 2015

Pat Wijtyk
Senior Health Reimbursement Specialist



LEGAL DISCLAIMER

This presentation is for informational purposes only.

- The content should not be construed as legal advice.
- 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 ASC X12.

ABOUT ASC X12

- Chartered by the American National Standards Institute more than 30 years ago.
- Develops and maintains EDI and CICA standards and XML schemas which drive business processes globally.
- ASC X12 membership includes technologists and business process experts, encompassing health care, insurance, transportation, finance, government, supply chain and other industries.
- For additional information, visit www.x12.org.

HEALTH CARE CLAIM PAYMENT ADVICE (835)

Compliant ASC X12 5010 835 Transaction

Some challenges with the 835:

- Reassociation – 1 835 (ST-SE) to 1 payment
- Balancing
- Payment – EFT vs. Check
- Timing of receipt of 835 and associated payment
- Understanding reason why amount was adjusted (360)
- Structure of 5010 835 transaction
- Responsibilities of Trading Partners

HEALTH CARE CLAIM PAYMENT ADVICE (835)

Compliant ASC X12 5010 835 Transaction

Some challenges with the 835:

- **Reassociation – 1 835 (ST-SE) to 1 payment**
- Balancing
- Payment – EFT vs. Check
- Timing of receipt of 835 and associated payment
- Understanding reason why amount was adjusted (360)
- Structure of 5010 835 transaction
- Responsibilities of Trading Partners

835 & CCD+ REASSOCIATION

CCD+ Reassociation Data Elements			835 data Elements		
CCD+ Record #	Field #	Field Name	Segment	Element	Element Name
6	7	Identification Number	REF	02	1000B Loop TJ Reference Identification (TIN)
5	9	Effective Entry Date	BPR	16	Date (<i>EFT Effective Date</i>)
6	6	Amount	BPR	02	Monetary Amount (<i>Total Actual Provider Payment Amount</i>)
7	3	Payment Related Information	TRN	01	Trace Type Code
			TRN	02	Reference Identification (<i>EFT Trace Number</i>)
			TRN	03	Originating Company Identifier (<i>Payer Identifier</i>)
			TRN	04	Reference Identification (<i>Originating Company Supplemental Code</i>)



HEALTH CARE CLAIM PAYMENT ADVICE (835)

Compliant ASC X12 5010 835 Transaction

Some challenges with the 835:

- Reassociation – 1 835 (ST-SE) to 1 payment
- **Balancing**
- Payment – EFT vs. Check
- Timing of receipt of 835 and associated payment
- Understanding reason why amount was adjusted (360)
- Structure of 5010 835 transaction
- Responsibilities of Trading Partners

HEALTH CARE CLAIM PAYMENT ADVICE (835)

Compliant ASC X12 5010 835 transaction

Balanced 835:

- Common reason for an out of balanced transaction is incorrect adjustments
 - Missing dollar amounts
 - Adjustment repeated at line and claim
 - Provider level adjustments
- The 835 TR3 contains front matter section **1.10.2.1 Balancing** that explains how the transaction must balance at all 3 levels

HEALTH CARE CLAIM PAYMENT ADVICE (835)

Compliant ASC X12 5010 835 Transaction

Some challenges with the 835:

- Reassociation – 1 835 (ST-SE) to 1 payment
- Balancing
- **Payment – EFT vs. Check**
- **Timing of receipt of 835 and associated payment**
- **Understanding reason why amount was adjusted (360)**
- Structure of 5010 835 transaction
- Responsibilities of Trading Partners

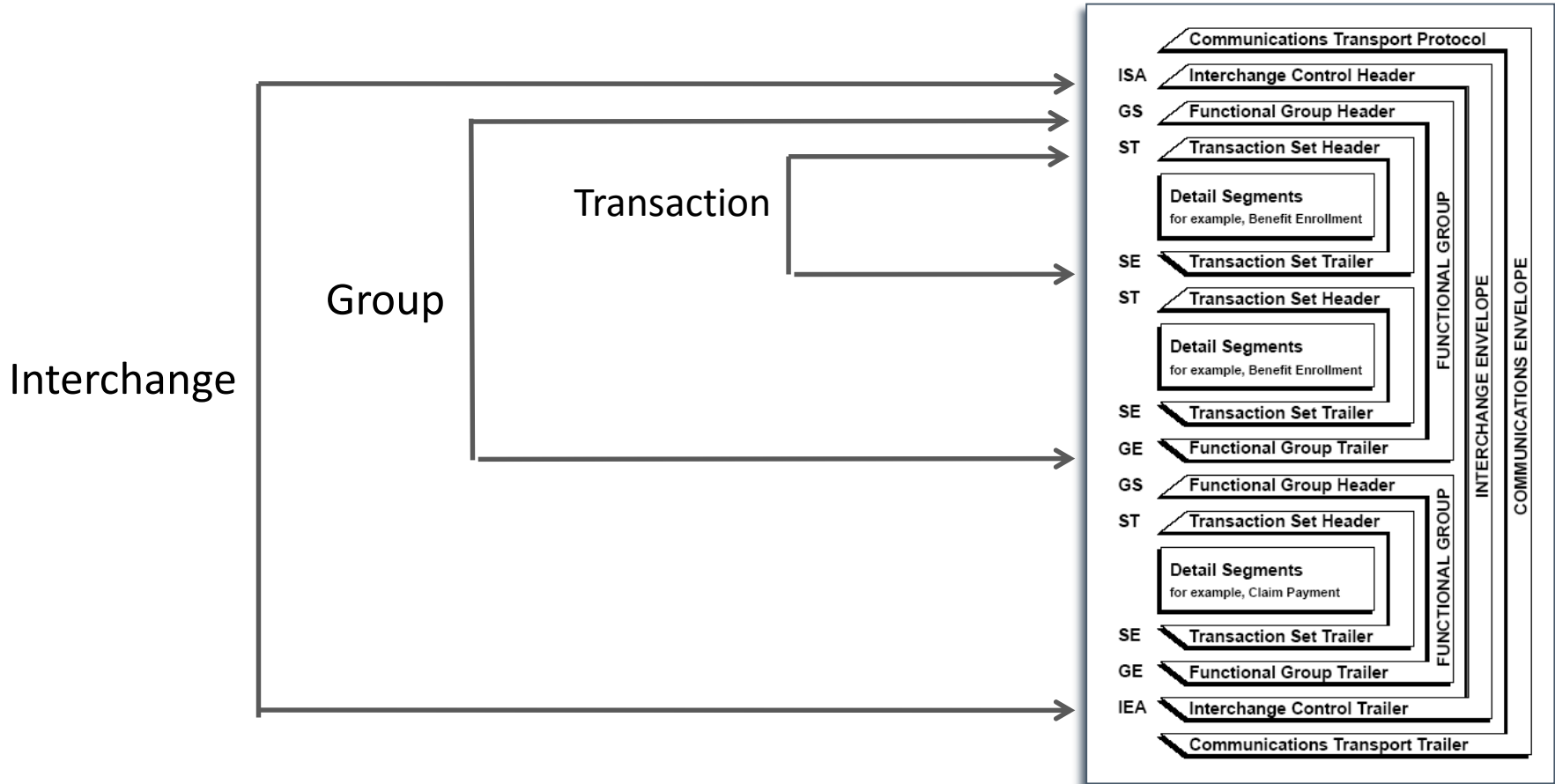
HEALTH CARE CLAIM PAYMENT ADVICE (835)

Compliant ASC X12 5010 835 Transaction

Some challenges with the 835:

- Reassociation – 1 835 (ST-SE) to 1 payment
- Balancing
- Payment – EFT vs. Check
- Timing of receipt of 835 and associated payment
- Understanding reason why amount was adjusted (360)
- **Structure of 5010 835 transaction**
- Responsibilities of Trading Partners

HEALTH CARE CLAIM PAYMENT ADVICE (835)



HEALTH CARE CLAIM PAYMENT ADVICE (835)

Compliant ASC X12 5010 835 transaction

Structure of the 835 transaction:

Enveloping Theory

- One transaction contains ONLY one payment
- One Functional Group contains 1 or more transaction
 - Contains 1 or more than 1 payment
- One Interchange contains 1 or more than 1 payment
- **One payment** = one EFT or one check = one trace number

HEALTH CARE CLAIM PAYMENT ADVICE (835)

Compliant ASC X12 5010 835 Transaction

Some challenges with the 835:

- Reassociation – 1 835 (ST-SE) to 1 payment
- Balancing
- Payment – EFT vs. Check
- Timing of receipt of 835 and associated payment
- Understanding reason why amount was adjusted (360)
- Structure of 5010 835 transaction
- **Responsibilities of Trading Partners**

HEALTH CARE CLAIM PAYMENT ADVICE (835)

Responsibilities of Trading Partners

- All covered entities MUST comply with all HIPAA and ACA mandated rules.
- Any entity that has a contract or business associate agreements with a covered entity MUST comply with all HIPAA and ACA mandated rules.
- This includes: compliant transaction, CAQH CORE rules, EFT rules

HEALTH CARE CLAIM PAYMENT ADVICE (835)

Compliance

- Resolution of compliance issues

RFI Portal – The portal provides access to information related to the meaning, use, and interpretation of ASC X12 Standards, Guidelines, and Technical Reports, including Technical Report Type 3 (TR3) implementation guidelines. The information is available in the form of responses to questions submitted by implementers of the ASC X12 products.

<http://www.x12.org/x12org/subcommittees/x12rfi.cfm>

- Enforcement of 835 transaction

Lies within the 5010 TR3

HEALTH CARE CLAIM PAYMENT ADVICE (835)

Resources

- Accredited Standards Committee X12
 - ASC X12 develops and maintains EDI and CICA standards which drive business processes globally. Membership encompasses health care, insurance, transportation, finance, government, supply chain, and other industries
 - [X12.org](http://www.x12.org)
- Purchase Guides
 - Source for ASC X12 EDI products, version 005010 and others
 - <http://store.x12.org/store/>
- Code Lists external to the X12 family of standards
 - Includes CARCs, RARCs, Claim Status and Category Codes, for example [wpc-edi.com](http://www.wpc-edi.com)
- RFI Portal
 - RFI Portal provides access to information related to the meaning, use, and interpretation of ASC X12 Standards, Guidelines, and Technical Reports, including Technical Report Type 3 (TR3) implementation guidelines.
 - <http://www.x12.org/x12org/subcommittees/x12rfi.cfm>

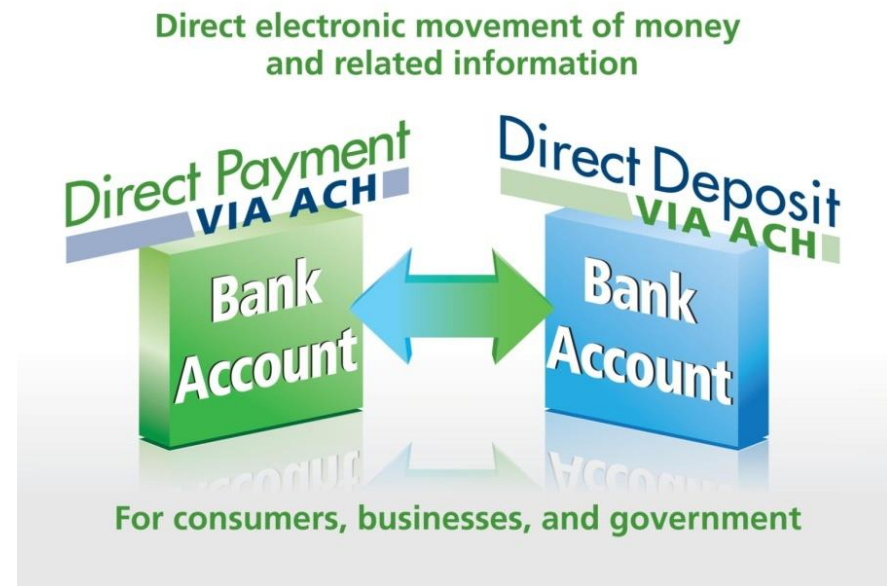
NACHA CCD+ Specifications

Priscilla C. Holland AAP, Senior Director
Healthcare Payments

NACHA – The Electronic Payments Association

Brief Introduction to NACHA and the ACH Network

- NACHA is the private sector rule-making organization that administers the ACH Network.
- NACHA is the standards organization for the healthcare EFT standard.
- Develops, maintains, and enforces the *NACHA Operating Rules*.
- The ACH Network:
 - Facilitates global commerce by serving as a safe, efficient, ubiquitous and high-quality electronic payment system; it is best known for Direct Deposit and Direct Payment.
 - Is accessible via more than 13,000 U.S. financial institutions.
 - Processed close to 22 billion ACH payments in 2013, moving almost \$39 trillion in value.
 - Provides funds transfer and settlement of credit and debit card transactions.



Value Proposition for Providers of Automation of EFT & ERA

- The 2014 CAQH Report indicates that a provider will save an estimated \$3.04 per payment received by EFT via ACH over check payments. Combining EFT & ERA with auto posting can save a provider an estimated \$7.21 per payment.
- Reducing administrative work and days in accounts receivable (NACHA Case study went from 25 days to 13 days in A/R with EFT via ACH and ERA).
- Reducing account receivable processing costs by moving from paper checks to EFT via ACH and ERA (NACHA Case study – hospital reduced A/R costs by 70%).
- Auto Reconciliation reduces posting errors (NACHA Case Study has a 76% match on day received and 98% by day 2).
- Receive health plan payments weeks faster to bill and collect remaining patient payment responsibility sooner.

Case Studies

CASE STUDY SMALL PROVIDER PRACTICE

PERFORMANCE PEDIATRICS REAPS SAVINGS, EFFICIENCIES FROM NEW HEALTHCARE EFT STANDARD

On Jan. 1, 2014, the new Healthcare Electronic Funds Transfer (EFT) Standard went into effect as part of the Patient Protection and Affordable Care Act. The new standard and operating rules help provide for the efficient and standardized use of electronic payments for healthcare claims reimbursements.

All health plans are now required to be in compliance with the new standard, meaning they must be able to deliver claims reimbursement payments via the ACH (COD+ Addenda). For providers of healthcare services, the new rule means that they may request delivery of claims payments via ACH and health plans will be required to promptly comply.

The new standard offers healthcare providers the opportunity to reduce costs, streamline accounting and administrative processes, and improve operating efficiencies. In the first four months after the standard went into effect—January 2014—more than 35.3 million healthcare EFTs using the new standard took place. The ACH Network is on pace to move at least 100 million EFTs in 2014 alone, transferring about \$900 billion from health plans to providers.

One provider taking advantage of the new standard—and seeing cost savings and efficiency benefits as a result—is Performance Pediatrics in Plymouth, Mass.

PERFORMANCE PEDIATRICS—EFTs SAVE TIME, MONEY

Started in 2006, Performance Pediatrics is a micropractice. In a micropractice, just one or two medical providers work with little to no support staff. Providers in a micropractice see fewer patients in a day than most doctors and spend more time with each patient.

Performance Pediatrics' primary doctor, Dr. Terence R. McAlister, began his career in the All France, where he was sometimes responsible for more than 6,000 patients at a time and had to see them in his-on-site appointments. "It was definitely not why he wanted to go into primary pediatric care," said Leanne DiDomenico, McAlister's wife and Performance Pediatrics' administrative director. "When he finished, he looked at me and said, 'Can we find a way to do this differently?'"

Today, Performance Pediatrics serves just over 700 patients in its four-person office. The small practice is profitable as long as it maintains low overhead, which DiDomenico works to ensure by leveraging new technologies that boost efficiencies and increase savings.

One way DiDomenico has done that is by switching to electronic payments. At Performance Pediatrics, more than 1,500 of the 1,500 deposits it received last year were made via EFTs. Just 9 percent of the practice's payments came in the form of paper checks, and 1 percent came through virtual cards.

Electronic payments not only ensure that Performance Pediatrics receives payments more quickly, but they also cut down on the amount of time spent reconciling accounts, DiDomenico said.



NACHA
The Electronic Payments Association

Receiving health plan payments weeks faster allows for earlier billing and collection of remaining patient payment responsibility (i.e., deductibles)

CASE STUDY MID-SIZE PROVIDER PRACTICE

ONE YEAR LATER, VALUE PROPOSITION OF HEALTHCARE EFTs BECOMES REALITY FOR MEDICAL GROUP

The federally mandated Healthcare Electronic Funds Transfer (EFT) Standard, which became effective January 1, 2014, as part of the Patient Protection and Affordable Care Act, requires that all health plans deliver the healthcare EFT standard via ACH if it is requested by the provider.

The EFT standard offers healthcare providers the opportunity to reduce costs, streamline accounting and administrative processes, and improve operating efficiencies. In 2014, the ACH Network moved more than 149 million EFTs, transferring about \$876.6 billion in claim payments from health plans to providers. The estimated savings to the healthcare industry overall is approximately \$295 million compared to using paper checks, according to the 2013 CAQH U.S. Healthcare Efficiency Index.

Midwest Center for Women's Health Care (MCWHC), a group of 11 OB/GYN practices in the Chicago area, is one of the many providers taking advantage of the new Healthcare EFT Standard—and reaping its benefits.

SAVING MONEY AND TIME


Founded in 2002, MCWHC is a collection of semi-autonomous OB/GYN practices located in the northern and northwest suburbs of Chicago. Operating as one group allows the practices to maintain independence while saving on costs, creating economies of scale with purchasing, and centralizing certain services. MCWHC has more than 50 providers, 19 medical locations, and a central business office. In 2014, it served more than 15,000 patients and expects to grow even further in 2015.

For several years, the MCWHC billing office has been working with insurers to convert to electronic payments whenever possible. The company worked first with the insurers it billed most—Aetna, United, Humana, Cigna and Blue Cross-Blue Shield—to switch to EFT. It then worked to convert smaller insurers, as well. Today, roughly 90 percent of the company's payments are electronic. Eventually, MCWHC would like to receive all of its payments electronically.

According to Eric Brodsky, MCWHC's director of billing and operations, the healthcare group has experienced significant cost savings by converting to electronic payments. Not only are EFTs more secure than traditional checks, but they offer a potential savings of \$1.68 per payment, according to the 2013 CAQH U.S. Healthcare Efficiency Index.

MCWHC also has seen cost savings related to staffing thanks to EFTs. Staffers are able to process EFT payments more easily because each payment is linked to a unique electronic remittance advice (ERA) number, making it easy to identify the service and patient covered by the payment. "On a daily basis, we might receive \$100,000 to \$200,000 from Blue Cross, and we know right away what that payment amount consists of and which accounts that payment is for," Brodsky said.

According to Eric Brodsky, MCWHC's director of billing and operations, the healthcare group has experienced significant cost savings by converting to electronic payments.



NACHA
The Electronic Payments Association

Cost savings related to staffing thanks to EFT and ERA

CASE STUDY HOSPITAL GROUP

HOW HCA IS BENEFITING FROM THE NEW HEALTHCARE EFT STANDARD

On Jan. 1, 2014, the new Healthcare Electronic Funds Transfer (EFT) Standard went into effect as part of the Patient Protection and Affordable Care Act. The new standard and operating rules help provide for the efficient and standardized use of electronic payments for healthcare claims reimbursements.

All health plans are now required to be in compliance with the new standard, meaning they must be able to deliver claims reimbursement payments via the ACH (COD+ Addenda). For providers of healthcare services, the new rule means that they may request delivery of claims payments via ACH and health plans will be required to promptly comply.

The new standard offers healthcare providers the opportunity to reduce costs, streamline accounting and administrative processes, and improve operating efficiencies. In the first month that the standard went into effect—January 2014—more than 8.1 million healthcare EFTs using the new standard took place. The ACH Network is on pace to move at least 100 million EFTs in 2014 alone, transferring about \$900 billion from health plans to providers.

One of the providers taking advantage of the new Healthcare EFT Standard is Nashville-based HCA—Hospital Corporation of America.

HCA—COMMITTED TO INCREASING ADOPTION OF EFTs

Founded in 1968, HCA is the nation's leading provider of healthcare services. The company is comprised of 105 locally managed hospitals and 115 freestanding surgery centers in 20 states and England, and it employs more than 200,000 people. Roughly 4 to 5 percent of all inpatient care delivered in the United States is provided by HCA facilities.

To help manage that care more efficiently, HCA has been steadily adopting electronic payment methods for more than 20 years. EFTs eliminate the need to manually post and then paper checks.

In 2008, HCA processed more than 3.5 million check payments from health plans. By 2013, thanks to its efforts to move to EFTs, HCA processed fewer than 2.5 million check payments, a 30 percent reduction.

EFTs—REDUCING COSTS AND MANUAL PROCESSING

With the new EFT standard in place, HCA expects its EFT conversions to accelerate now that health plans are required to provide the option. "In the past, we'd have the EFT discussion with health plan and they could say, 'Thanks for the discussion' and change nothing. Now, with the Healthcare EFT Standard in effect, they must comply," Doug Dooney, HCA's assistant vice president, treasury.

Thanks to the new standard, HCA is experiencing a 70 percent reduction in processing costs with EFTs when compared to paper checks. HCA is also seeing a vast reduction in the number of manual reconciliation items its hospitals must deal with. Previously, EFTs and their accompanying electronic remittance advice (ERA) would process to different systems before meeting on a common ledger, which often resulted in multiple items that needed to be reconciled by staff members. Under the new standard, EFTs and ERAs are processed together, so the information passed back to hospitals is less error prone. "I believe we've nearly eliminated manual reconciliation items," Dooney said.

In the past, we'd have the EFT discussion with health plans and they could say, 'Thanks for the discussion' and change nothing. Now, with the Healthcare EFT Standard in effect, they must comply.



NACHA
The Electronic Payments Association

Reduce receivables costs By 70%

Common Industry Issues with Healthcare EFT Standard

1. Health Plans **STILL** not offering to deliver the healthcare EFT standard for claims reimbursement payments if it is requested
2. Health Plans with Business Associates that do not support the healthcare EFT standard or ERA
3. Incorrectly formatted TRN Reassociation Trace Number in the healthcare EFT standard addenda
4. Incorrect information in the Company Name field identifying the health plan sending the ACH payment

Healthcare EFT Standard – HIPAA Standard

- Patient Protection Affordable Care Act (ACA) Section 1104 Administrative Simplification mandates the identification of a *healthcare EFT standard transaction and development of operating rules for HIPAA standard transactions*
- 45 CFR 162.1602 identifies the healthcare EFT standard as the NACHA CCD+Addenda **(effective Jan 1, 2014)**
 - Addenda must be populated with the TRN Reassociation Trace Number as defined in the ASC X12 835 version 5010 TR3 Report (Implementation Guide)
 - The TRN data segment is carried in the healthcare EFT standard and the Electronic Remittance Advice (ERA) 835 and used to reassociate the payment with the ERA
 - All health plans must be able to deliver the healthcare EFT standard for claims reimbursement payments if it is requested by the provider
 - Allows for payments processed through other electronic payment methods including cards and wire transfer BUT they are not the healthcare EFT standard

HIPAA Standard Transaction Requirements for Covered Entities

45 C.F.R. § 162.925 Additional requirements for health plans, (a):

- 1) If an entity requests a health plan to conduct a transaction as a standard transaction, the health plan must do so.
- 2) A health plan may not delay or reject a transaction, or attempt to adversely affect the other entity or the transaction, because the transaction is a standard transaction.

Health Plan's Business Associate Does Not Offer Healthcare EFT Standard

- Business Associates of a Covered Entity that don't comply or offer HIPAA standard transactions - is a HIPAA Violation
- 45 C.F.R. §162.923 (c) Use of a business associate.
 - A covered entity may use a business associate, including a health care clearing house, to conduct a transaction covered by this part. If a covered entity chooses to use a business associate to conduct all or part of a transaction on behalf of the covered entity, the covered entity must require the business associate to do the following:
 1. Comply with all applicable requirements of this part (*HIPAA*).
 2. Require any agent or subcontractor to comply with all applicable requirements of this part.

Changes to the *NACHA Operating Rules* to Align with Healthcare

- Details within the *NACHA Operating Rules* and CCD+ Standard were modified to align with Healthcare EFT Standard and EFT & ERA Operating Rules

Overview of NACHA Rule Changes	Detail
Standard Identification of Health Care EFTs	The rule requires health plans to clearly identify CCD Entries that are Health Care EFT Transactions through the use of the specific identifier “HCCLAIMPMT”
Additional Formatting Requirements for Health Care EFTs	For a CCD Entry that contains the healthcare indicator, as described above, the health plan must include an addenda record that contains the ASC X12 Version 5010 835 TRN (Reassociation Trace Number) data segment, and to identify itself in the transaction by its name as it would be known by the provider
Delivery of Payment Related Information (Reassociation Number)	The rule requires an RDFI to provide or make available, either automatically or upon request, all information contained within the Payment Related Information field of the Addenda Record, no later than the opening of business on the second Banking Day following the Settlement Date. Further, <u>this Rule requires the RDFI to offer or make available to the healthcare provider an option to receive or access the Payment Related Information via secure, electronic means</u>
Addition of New EDI Data Segment Terminator	The rule provides for the use of a second data segment terminator, the tilde (“~”), to any data segments carried in the Addenda Record of the CCD Entry
Health Care Terminology within the NACHA Operating Rules	The rule includes healthcare-related definitions

TRN Reassociation Trace Number

- CCD Addenda must be populated with the TRN Reassociation Trace Number as defined in the ASC X12 835 version 5010 TR3 Report (Implementation Guide)
- Format incorporated into the NACHA Operating Rules
- Allows banks to review TRN for compliance and return entry if the TRN Reassociation Trace Number is not formatted correctly
- Also allows a financial institution to file a potential violation through NACHA's National System of Fines

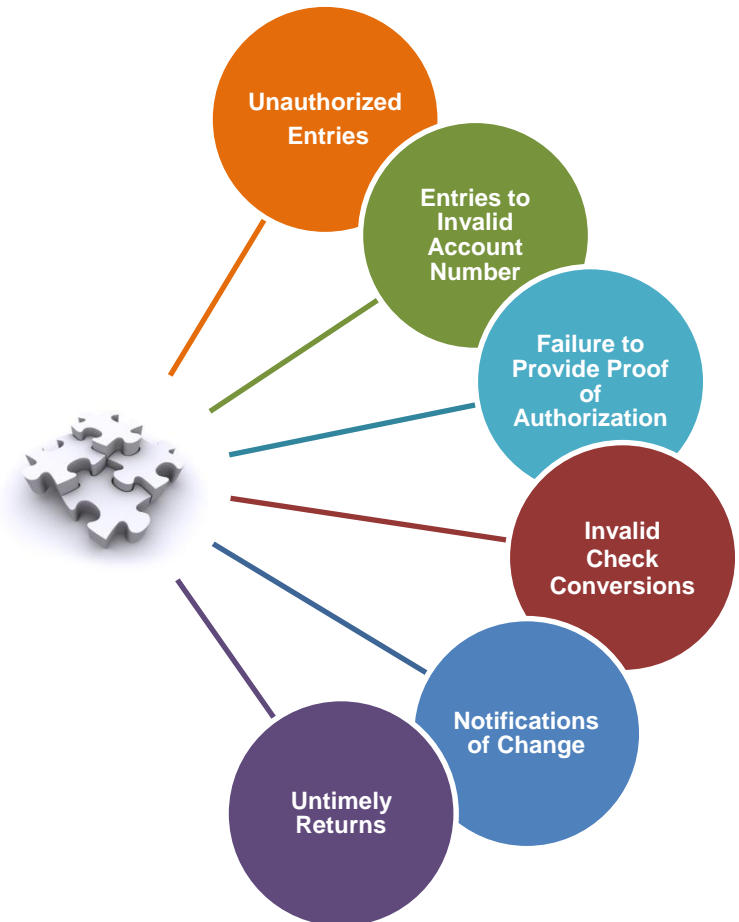
Correct Company Name

- *NACHA Operating Rules* require that the Company Name field for healthcare claims payments must contain the name of the Health Plan originating the payment, or, where an organization is self-insured, the name of the organization's third-party administrator that is recognized by the healthcare provider and to which the health care provider submits its claims.
 - The name of a health plan's vendor should not be included in the Company Name field
 - Without the correct name in the Company Name field may providers cannot post the claim payment or cannot contact the sender of the payment if there are questions

About the System of Fines

The National System of Fines is the enforcement mechanism for the ACH Network:

- Provides a means for FIs to report and resolve alleged violations of the *Rules*
- Provides a formal channel for the evaluation of circumstances related to possible rules violations and the imposition of fines if appropriate
- Reduces exception processing for FIs
- Maintains the reputation of the ACH Network



NACHA Resources

- Healthcare Payments Resources Website
 - Provides a repository of information on a wide variety of topics for both financial institutions and the healthcare industry. Includes links to many other resources, as well as customized information to help “translate” concepts from one industry to the other (FAQs, reports, presentations).
 - <http://healthcare.nacha.org/>
- Healthcare EFT Standard Information
 - Located within the healthcare industry tab of the above website, specific information can be found on the healthcare EFT standard.
 - <http://healthcare.nacha.org/>
- Healthcare Payments Resource Guide
 - Publication designed to help financial institutions in implementing healthcare solutions. It give the reader a basic understanding of the complexities of the healthcare industry, identify key terms, review recent healthcare legislation, and discuss potential impacts on the financial services industry.
 - Order from the NACHA eStore “Healthcare Payments” section: www.nacha.org/estore.
- Healthcare ePayments Newsletter
 - Quarterly newsletter for healthcare and financial services industry. Must register to receive the free newsletter at listrequest@nacha.org
- ACH Primer for Healthcare Payments
 - A guide to understanding EFT payment processing. Introduces the healthcare industry to the Automated Clearing House (ACH) Network, explains ACH transaction flow and applications, and includes two “next steps checklists,” one each for origination and receipt. (Free pdf publication)
 - <https://healthcare.nacha.org/ACHprimer>

CAQH
CORE

CAQH CORE Reassociation Rule

Improve Provider Revenue Cycle Management
and Health Plan Resource Allocation

Robert Bowman
Senior Manager

CAQH CORE EFT & ERA Reassociation (CCD+/835) Rule -- *Problem Addressed & Key Impact*

Problem Addressed by Rule

Challenges with provider reassociation of remittance data to payment data because necessary data provider requires are incorrect, missing, not available, or have not been requested on the two transactions in a way that is meaningful to the provider or its financial institution.

Key Impacts

1. Coordinates healthcare and financial services industry.
2. Provides assurance that trace numbers between payments and remittance can be used by providers.
3. Reduces level of open accounts receivable by enabling provider to generate cross-over claims to other payers and to collect payment from patient.
4. Enables provider to more quickly address denials or appeal adjustments to claim amount.

EFT & ERA Reassociation (CCD+/835) Rule: Three Key Rule Requirements

Pre- Payment: Provider Enrollment



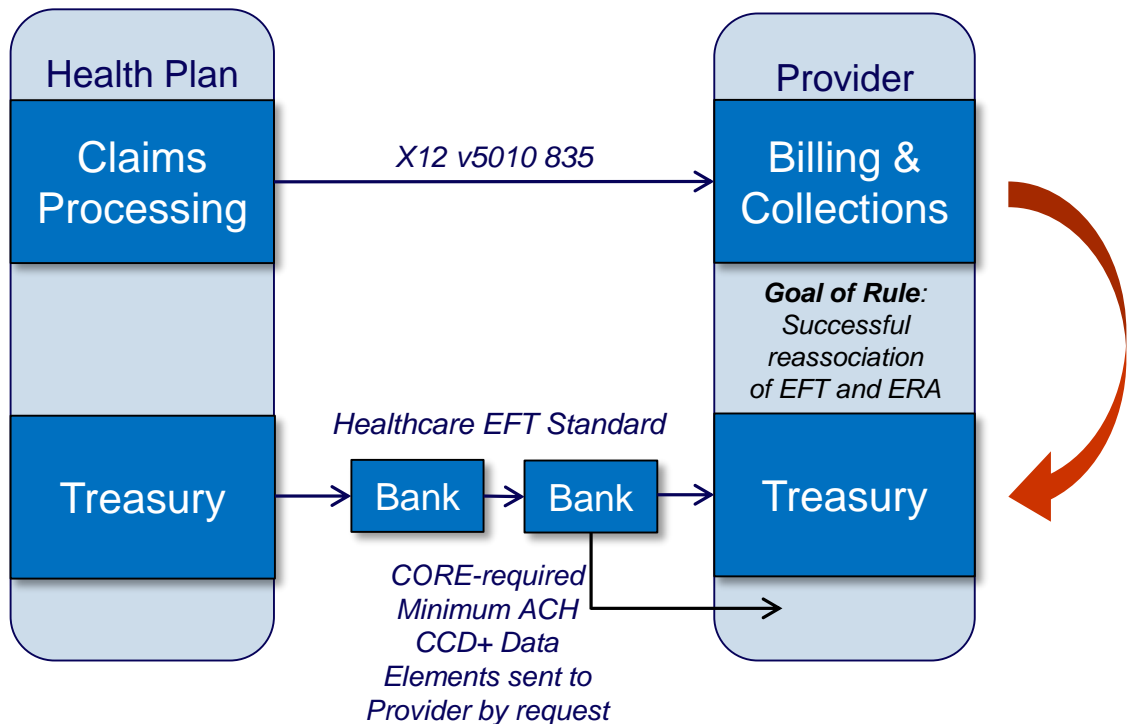
1. CORE-required Minimum CCD+ Reassociation Data Elements:

- Health plan must inform provider during enrollment to contact bank for the delivery of CORE-required Minimum CCD+ Reassociation Data Elements (*banks not required to report*)
- Provider must proactively contact bank for data
- NOTE: The CAQH CORE EFT & ERA Enrollment Data Rules contain complementary requirements

Claims Payment Process

2. Elapsed Time Requirements:

Health plan must release the 835 no sooner than three business days before and no later than three business days after the CCD+ Effective Entry Date 90% of time and track/audit this elapsed time requirement



3. Resolving Late/Missing EFTs/ERAs:

Health plan must establish written Late/Missing EFT and ERA Transactions Resolution Procedures

Industry Issues & Potential Solutions



Lack of Uniformity in the CARCs & RARCs

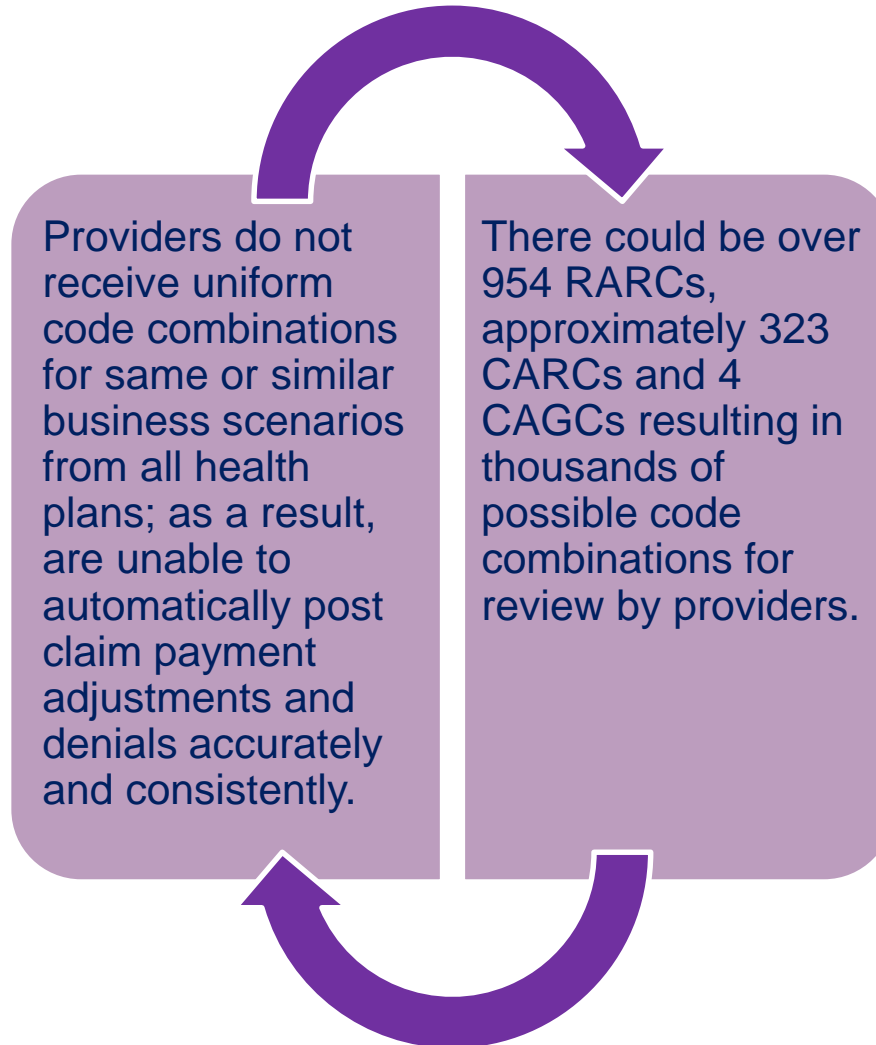
Enrollment & ACH



CAQH CORE Uniform Use of CARCs & RARCs (835) Rule

Problem Addressed

Problems Addressed by Rule:

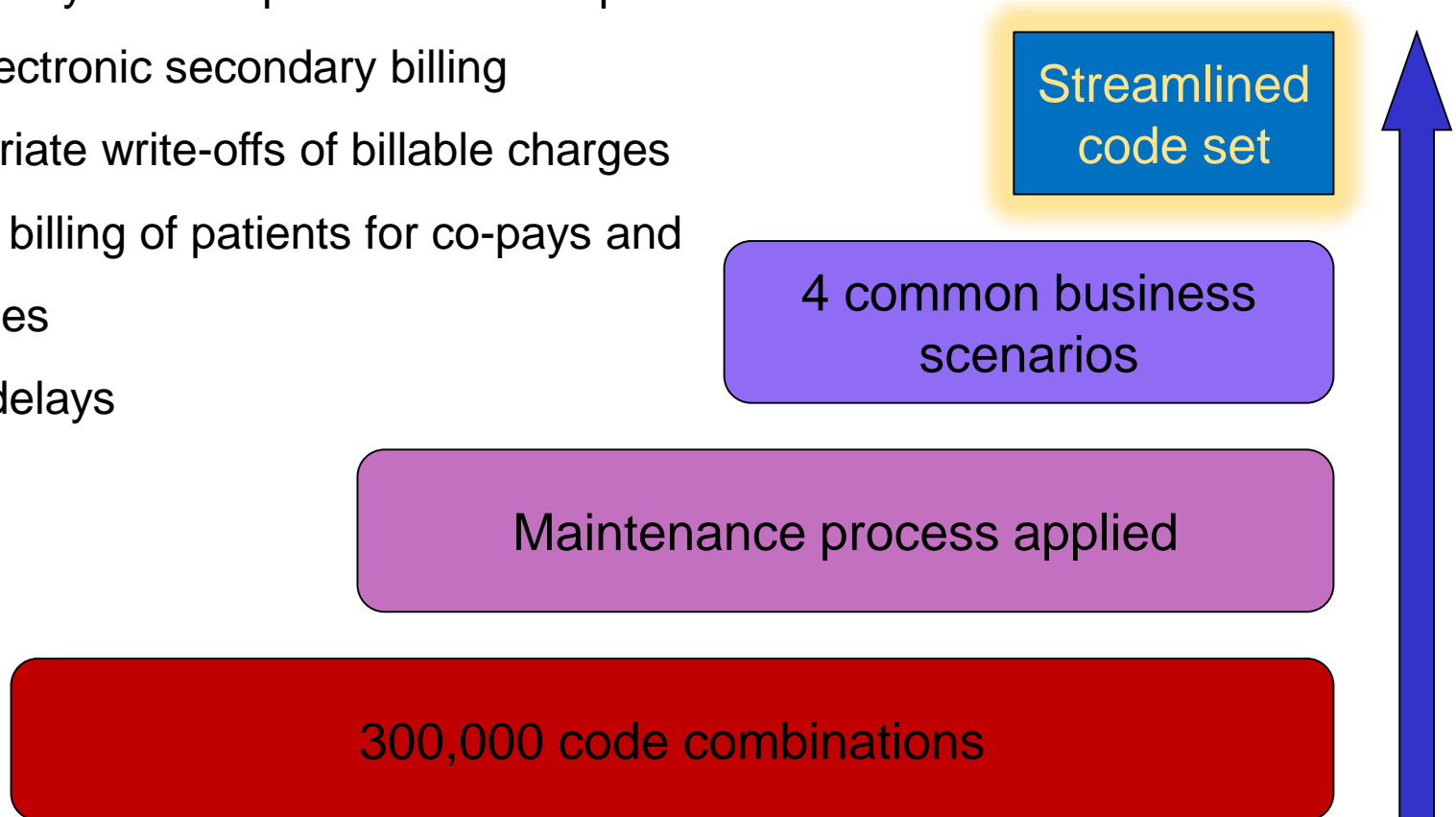


Potential Solution: Uniform Use of CARCs and RARCs Rule

CORE Code Combination Adjustments

Key Impacts -- Use of CORE 360 Rule has Mitigated:

- ✓ Unnecessary manual provider follow-up
- ✓ Faulty electronic secondary billing
- ✓ Inappropriate write-offs of billable charges
- ✓ Incorrect billing of patients for co-pays and deductibles
- ✓ Posting delays



CAQH CORE EFT & ERA Enrollment Data Rules

Problem Addressed

Problems Addressed by Rule

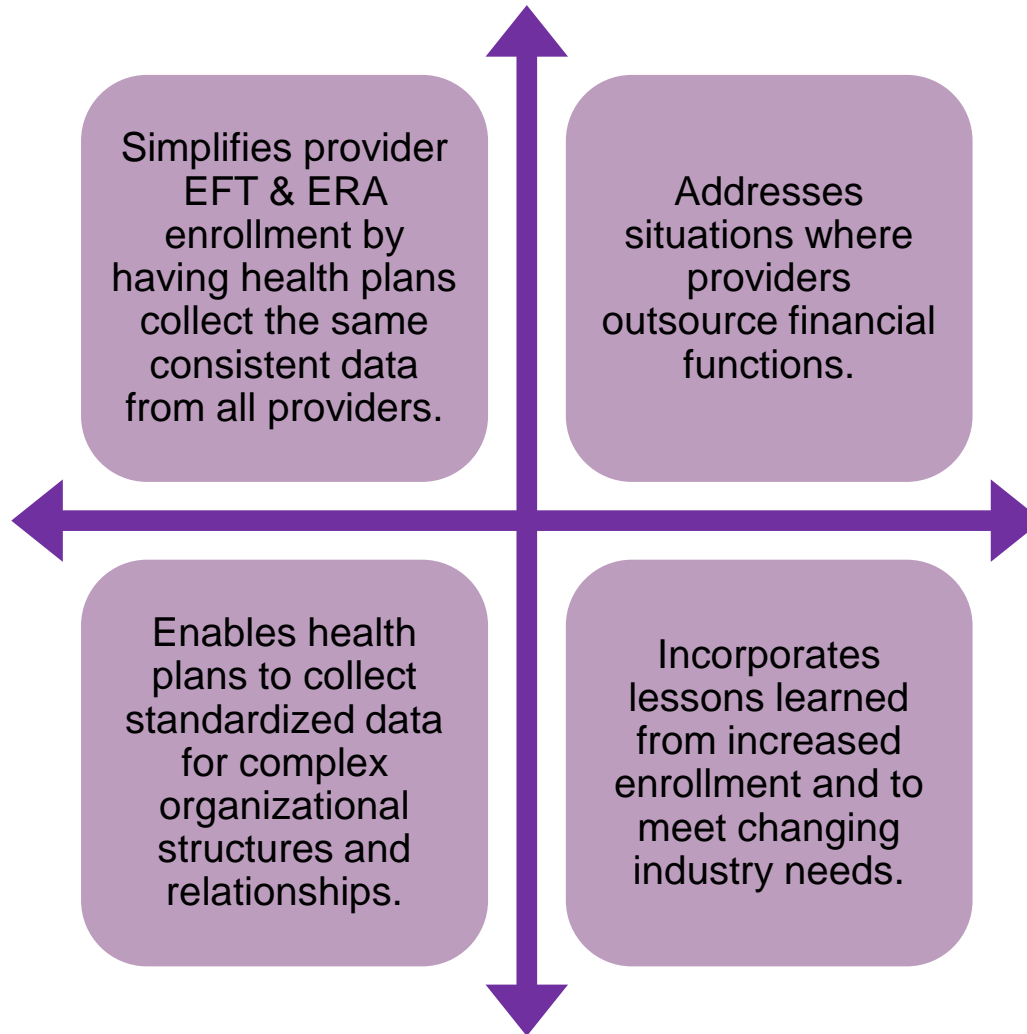
Providers are challenged by variances in the processes and data elements requested when enrolling in EFT & ERA across multiple Health Plans.

There are unnecessary manual processing of multiple forms requesting a range of information – not necessarily the same information between Health Plans—often using a wide variety of data terminology for the same concept (“Routing Number” vs. “Bank Routing Number”).

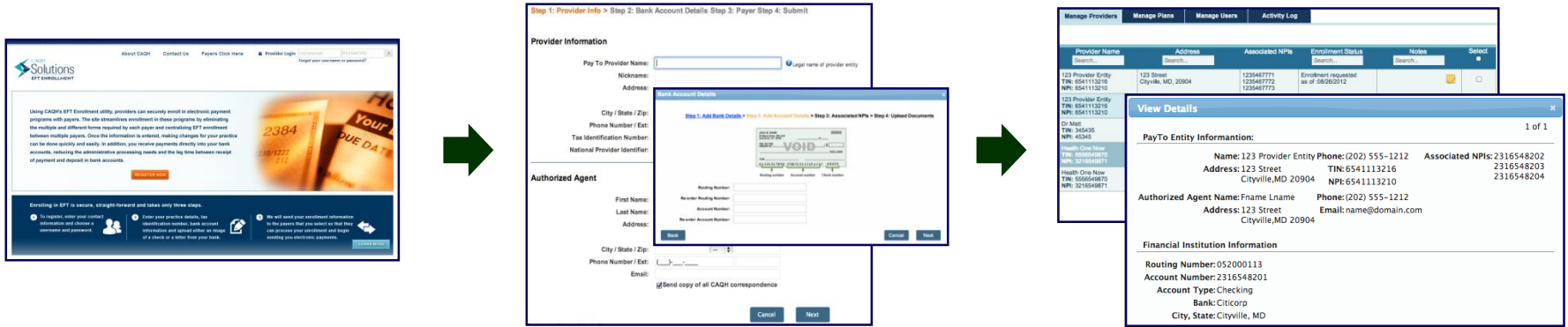
Key elements are excluded from enrollment forms including those with a strong business need to streamline the collection of data elements and those essential for populating the EFT Standard (ACH CCD+) and the ASC X12 v5010 835.

Potential Solution: CAQH CORE EFT & ERA Enrollment Data Rules

Key Impacts



Streamlined Enrollment – CAQH EnrollHub



- Web-based data entry for provider EFT and ERA enrollment information.
- Alignment with federally-mandated operating rules for definition of the standard enrollment data set and supporting documents.
- Web-based access portal for health plan customers.
- Multi-payer provider adoption campaigns.
- Telephonic provider support center.
- Voided check and other uploaded document processing.
- Pre-note transactions via ACH partners to validate bank account information.

CAQH CORE Resources for EFT & ERA



Contact Your Health Plans!

To benefit from the EFT and ERA mandates, ensure your provider organization has requested the transactions from its health plans. To help facilitate this request, CAQH CORE developed the [**Sample Provider EFT Request Letter.**](#)

- ✓ Providers can use this sample letter as template email or talking points with health plan contacts to request enrollment in EFT/ERA and benefits of operating rules.
- ✓ The tool includes background on the benefits of EFT, key steps for providers, an actual letter template, and glossary of key terms.



Polling Question #3:

EFT & ERA Implementation Challenges

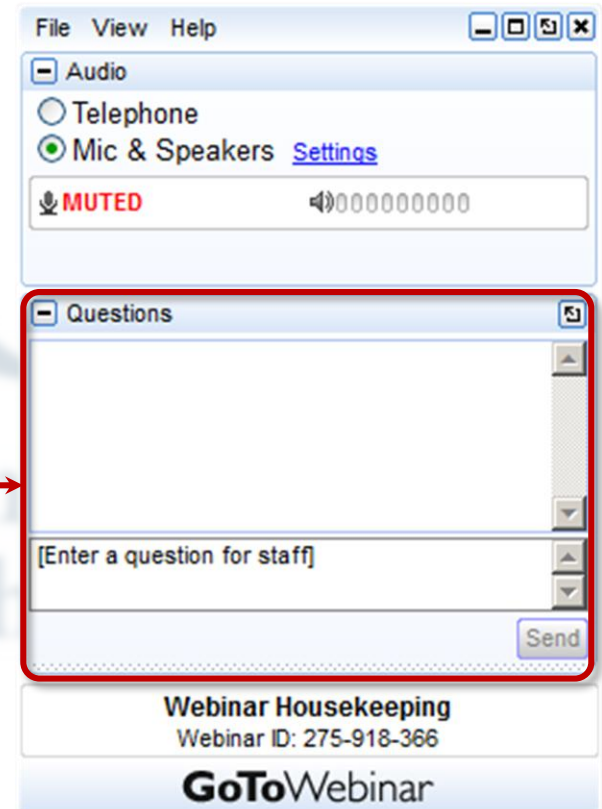
Which of the following would you consider to be the biggest challenge to your organization's implementation of the CAQH CORE EFT/ERA Operating Rules:

1. Fully understanding the EFT & ERA Operating Rules
2. Overcoming resource constraints (i.e. time, staff, internal expertise)
3. Identifying and completing necessary system updates
4. Working and testing with Trading Partners (e.g. lack of communication between your organization and your vendor)
5. Have not encountered challenges/Not applicable

Audience Q & A

Please submit your questions

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



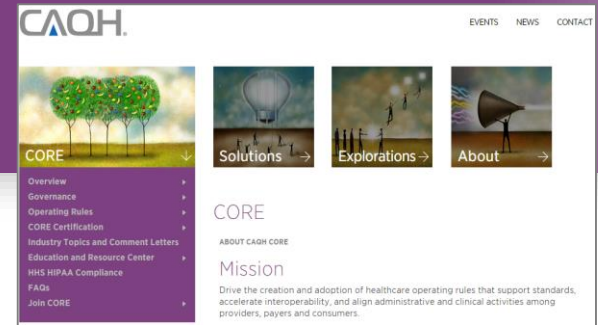
Key Takeaways

- There is lack of understanding among all stakeholders of how easy it now is to use the NACHA CCD+ specification, the v5010 835 and the CAQH CORE Reassociation Rule to pair together and thus drive the full value of the interconnected payment-remittance transactions.
- EFT and ERA Operating Rules represent the convergence of financial services and healthcare and aim to move the process of reimbursement from paper to electronic.
- Understanding how the ASC X12 835 and the NACHA ACH CCD+ work together, as well as how the CORE Reassociation Rule adds value to the process leads to positive impacts to provider revenue cycle management.

Engage with CAQH CORE!

[CAQH CORE Website](#)

or contact us at CORE@CAQH.org



Participate in the CAQH CORE Code Combinations Task Group (CCTG) or the Enrollment Data Task Group

Become a [CAQH CORE Participating Organization](#)

Explore Voluntary CORE Certification

Register for our educational [webinars](#)

Dedicated webpages:

- ✓ [Code Combination Maintenance](#)
- ✓ [EFT/ERA Enrollment Maintenance](#)
- ✓ [Voluntary CORE Certification](#)
- ✓ [CAQH CORE Phase IV Operating Rules](#)

Thank you for joining us!

Website: www.CAQH.org/CORE

Email: CORE@CAQH.org



@CAQH