



# **CAQH CORE and ASC X12**

## **Mastering the Fundamentals: *Second in a Series***

*An In-depth Look at Electronic Funds Transfer (EFT) and  
Electronic Remittance Advice (ERA) Operating Rules*

May 1, 2013  
2pm - 3pm ET

# Participating in Today's Interactive Event

- Download a copy of today's presentation
- The phones will be muted upon entry and during the presentation portion of the session
- At any time throughout today's session, you may communicate with our panelists via the web
  - Submit your questions on-line at any time by entering them into the Q&A panel on the right-hand side of the WebEx desktop

# Session Topics

---

- Welcome and Introduction
- Level Set
  - ACA Section 1104: Compliance Requirements
  - January 2014 EFT/ERA Operating Rule Mandate
- The ERA Standard: ASC X12 v5010 835
- CAQH CORE EFT & ERA Operating Rules
  - Focus of today's call
    - Reassociation Rule
    - ERA Infrastructure
    - ERA Data Content: CARCs and RARCs
- Implementing EFT & ERA Operating Rules
  - Health Plan Perspective
  - Available Resources
- Q&A

# Polling Question #1: *Awareness of ACA-mandated EFT & ERA Operating Rules*

**How would you rate your overall level of understanding of the ACA mandated EFT & ERA Operating Rules effective January 2014?**

1. Very Strong
2. Strong
3. Fair
4. Limited
5. Very Limited

---

ACA Section 1104 Compliance Requirements:  
*CAQH CORE EFT & ERA Operating Rules*

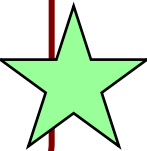
# ACA Mandated Operating Rules Compliance Dates: *Required for all HIPAA Covered Entities*

Operating rules encourage an interoperable network and, thereby, are vendor agnostic

**Compliance in Effect  
as of January 1, 2013**

- Eligibility for health plan
- Claims status transactions

*HIPAA covered entities conduct these transactions  
using the CAQH CORE Operating Rules*



**Implement by  
January 1, 2014**

- Electronic funds transfer (EFT) transactions
- Health care payment and remittance advice (ERA) transactions



**Implement by  
January 1, 2016**

- Health claims or equivalent encounter information
- Enrollment and disenrollment in a health plan
- Health plan premium payments
- Referral certification and authorization
- Health claims attachments



Rule requirements available.

# Who Must Comply with ACA Section 1104? *Required of all HIPAA Covered Entities<sup>1</sup>*

- ACA Section 1104 mandates that all HIPAA covered entities comply with *healthcare operating rules*; additional guidance on HIPAA covered entity designations may be found [HERE](#)
- HIPAA Administrative Simplification standards, requirements and implementation specifications apply to<sup>2</sup>:
  - Healthcare Providers: *Any person or Organization who furnishes, bills, or is paid for healthcare in the normal course of business<sup>3</sup>.*
    - Covered **ONLY** if ***they transmit protected health information electronically (directly or through a business associate) in connection with a transaction covered by the HIPAA Transaction Rule<sup>2</sup>.***
    - Examples include but are not limited to: Doctors, Clinics, Psychologists, Dentists, Chiropractors, Nursing Homes, and Pharmacies
  - Health Plans
  - Health Care Clearinghouses

<sup>1</sup> [Understanding HIPAA Privacy: For Covered Entities and Business Associates](#)

<sup>2</sup> [HIPAA Administrative Simplification](#): 45 CFR §§ 160.102, 164.500

<sup>3</sup> [HIPAA Administrative Simplification](#): 45 CFR § 160.103

# EFT Standard and EFT & ERA Operating Rules: *Required of All HIPAA Covered Entities*

- **Healthcare EFT Standard:** July 2012 CMS announces [CMS-0024-IFC](#) is in effect
  - Adopts the NACHA ACH CCD plus Addenda Record (CCD+) and the X12 835 TR3 TRN Segment as the HIPAA mandated healthcare EFT standard
- **EFT & ERA Operating Rules:** August 2012 CMS published an Interim Final Rule with Comment, [CMS-0028-IFC](#); adopts Phase III CAQH CORE Operating Rules for the Electronic Funds Transfer (EFT) and Health Care Payment and Remittance Advice (ERA) transactions *except for rule requirements pertaining to Acknowledgements\**
  - **April 2013:** CMS issues announcement that the IFC should be considered the Final Rule and is now in effect. CMS also confirms that the CORE Code Maintenance processes updates are immediately effective.

Compliance date for both the Healthcare EFT Standard and EFT & ERA Operating Rules is January 1, 2014

\* [CMS-0028-IFC](#) excludes requirements pertaining to acknowledgements.

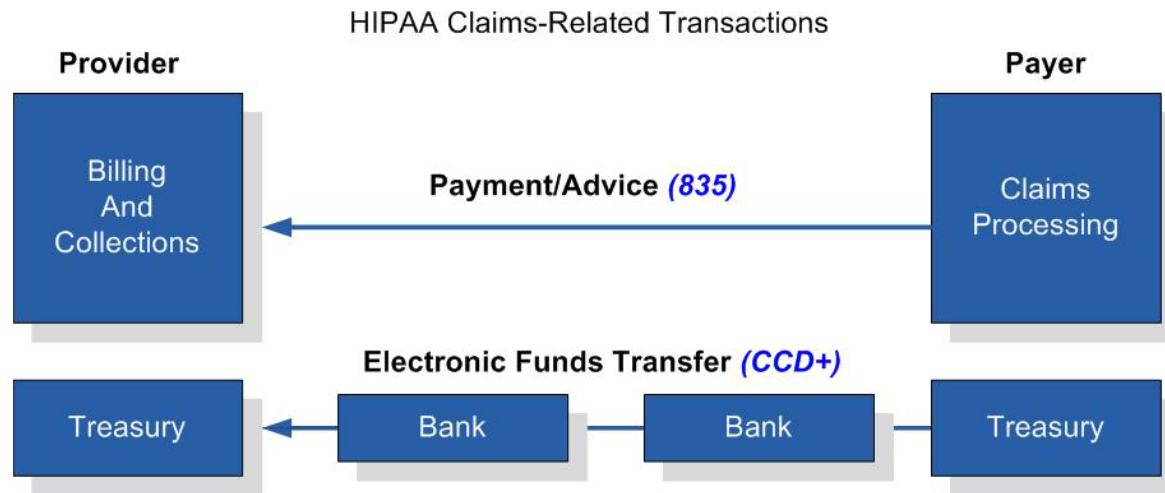
---

# January 2014 Operating Rule Mandate:

*With Focus on ERA Standard and  
CAQH CORE EFT & ERA Operating Rules*

# EFT and ERA Transaction Flow

- EFT and ERA operating rules represent the convergence of financial services and 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 (payers) electronically; ERA files are intended to replace the paper Explanation of Payment (EOP)
  - EFT enables providers to receive claims payments electronically



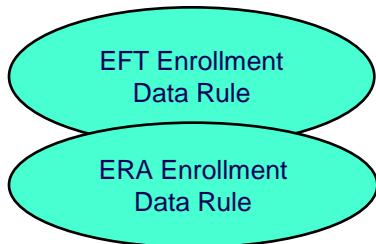
\* NCVHS recommended standard, see [February 17, 2011 NCVHS Recommendation to HHS Secretary](#).

# EFT & ERA Operating Rules

## Effective as of January 1, 2014

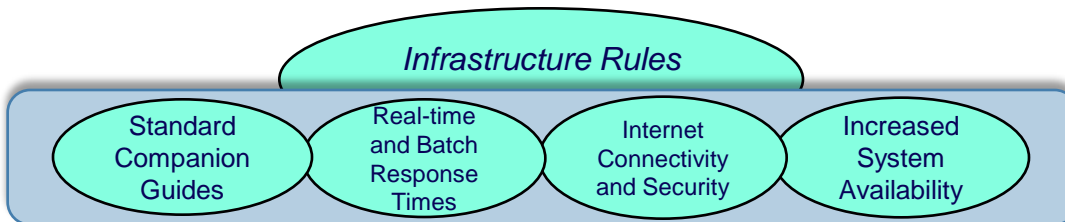
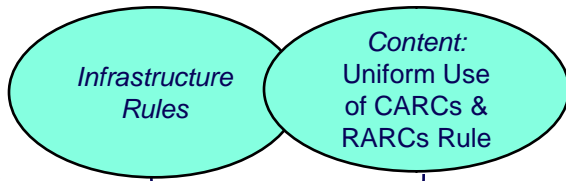
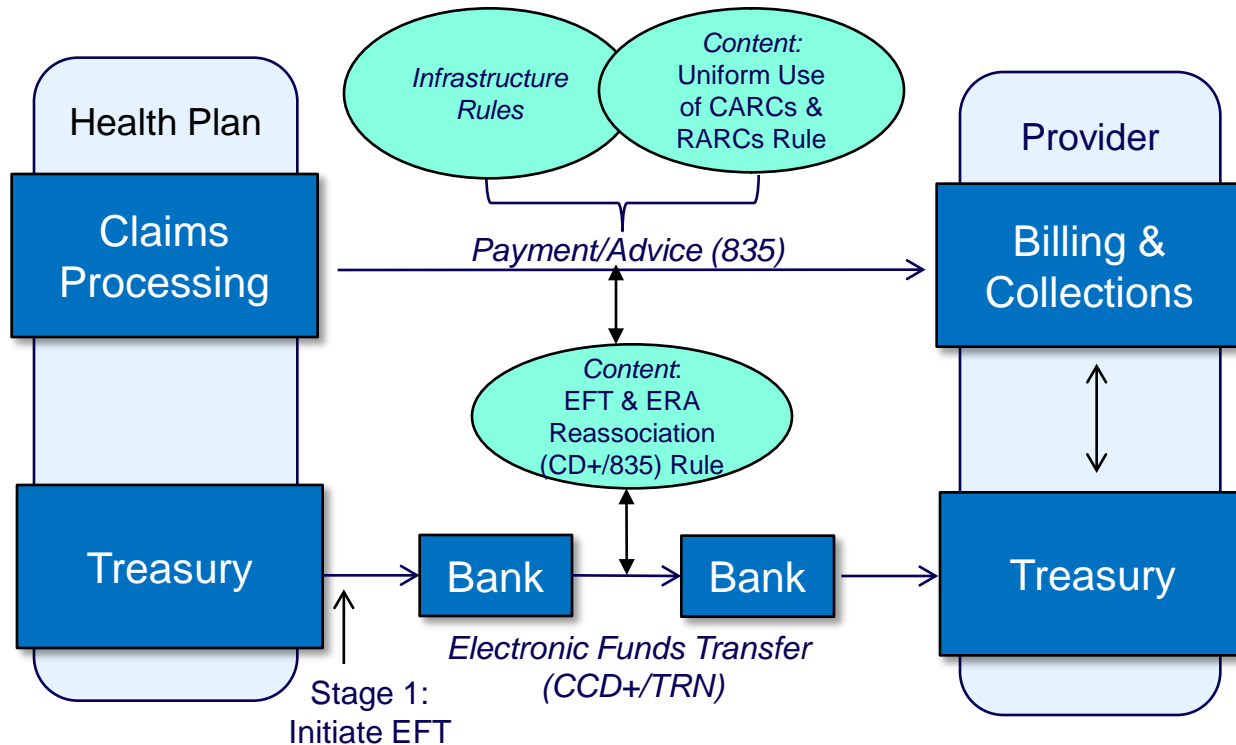
Indicates where a CAQH CORE EFT/ERA Rule comes into play

### Pre- Payment: Provider Enrollment



Content: Provider first enrolls in EFT and ERA with Health Plan(s) and works with bank to ensure receipt of the CORE-required Minimum ACH CCD+ Data Elements for reassociation

### Claims Payment Process



# 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
- ACA-mandated EFT/ERA Operating Rules support
  - ***The use of v5010 for ERA***
    - HIPAA covered entities should have completed their v5010 implementation
    - ERA operating rules build upon the existing HIPAA-adopted ASC X12 005010X221 Health Care Claim Payment/Advice (835) Technical Report Type 3
  - ***The NACHA ACH CCD+ format for EFT***
    - Conforms with the NACHA Operating Rules and serves as the standard format for the healthcare EFT standard when EFT and ERA are sent separately\*
    - *NACHA ACH CCD+ Standard* is an ACH standard for EFT
    - CCD is a Corporate Credit or Debit entry which is used to make/collect payments to/from corporate organizations

\* NCVHS recommended standard, see [February 17, 2011 NCVHS Recommendation to HHS Secretary](#):

# Mandated EFT & ERA Operating Rules:

## *January 1, 2014 Requirements Scope*

	Rule	High-Level Requirements
Data Content	<b><i>Uniform Use of CARCs and RARCs (835) Rule</i></b> Claim Adjustment Reason Code (CARC) Remittance Advice Remark Code (RARC) <a href="#">Rule 360</a>	<ul style="list-style-type: none"> <li>Identifies a <i>minimum</i> set of four CAQH CORE-defined Business Scenarios with a <i>maximum</i> set of CAQH CORE-required code combinations that can be applied to convey details of the claim denial or payment to the provider</li> </ul>
	<b><i>EFT Enrollment Data Rule</i></b> <a href="#">Rule 380</a>	<ul style="list-style-type: none"> <li>Identifies a maximum set of standard data elements for EFT enrollment</li> <li>Outlines a flow and format for paper and electronic collection of the data elements</li> <li>Requires health plan to offer electronic EFT enrollment</li> </ul>
Infrastructure	<b><i>ERA Enrollment Data Rule</i></b> <a href="#">Rule 382</a>	<ul style="list-style-type: none"> <li>Similar to EFT Enrollment Data Rule</li> </ul>
	<b><i>EFT &amp; ERA Reassociation (CCD+/835) Rule</i></b> <a href="#">Rule 370</a>	<ul style="list-style-type: none"> <li>Addresses provider receipt of the CAQH CORE-required Minimum ACH CCD+ Data Elements required for re-association</li> <li>Addresses elapsed time between the sending of the v5010 835 and the CCD+ transactions</li> <li>Requirements for resolving late/missing EFT and ERA transactions</li> <li>Recognition of the role of <i>NACHA Operating Rules</i> for financial institutions</li> </ul>
	<b><i>Health Care Claim Payment/Advice (835) Infrastructure Rule</i></b> <a href="#">Rule 350</a>	<ul style="list-style-type: none"> <li>Specifies use of the CAQH CORE Master Companion Guide Template for the flow and format of such guides</li> <li>Requires entities to support the Phase II CAQH CORE Connectivity Rule.</li> <li>Includes batch Acknowledgement requirements*</li> <li>Defines a dual-delivery (paper/electronic) to facilitate provider transition to electronic remits</li> </ul>

\* [CMS-0028-IFC](#) excludes requirements pertaining to acknowledgements.

# Polling Question #2:

## *EFT & ERA Operating Rule Readiness*

**Select the response that best describes how far along your organization is with implementing EFT & ERA Operating Rules:**

1. Awareness
2. Getting Started
3. Fully Underway
4. Completed
5. None of the Above

---

# ASC X12 Overview:

*HIPAA Mandated v5010  
ASC X12 835 Transaction Standards*

# HIPAA-adopted EDI Transaction Standards and ASC X12

- HIPAA requires the establishment of national standards for electronic health care transactions and national identifiers for providers, health insurance plans, and employers
- Most HIPAA-adopted EDI transaction standards are ASC X12 standards
  - Current mandated version is ASC X12 5010; ***mandated as of January 2012***
  - For each standard, ASC X12 Technical Report Type 3 (TR3) specifies:
    - Data segments to be used
    - Segment sequence, whether segments are mandatory or optional, when segments can be repeated
    - How loops are structured and used

# Health Care Claim Payment/Advice (835) – *About the Transaction*

- The Health Care Claim Payment/Advice (835) transaction's purpose is
  - To provide a standard for a Health Plan to report payment and adjustment information detail about a claim
  - A financial transaction and represents real money and is tied to a check or EFT
  - Auto-posting
- Has no limit to the number of claims reported and not associated with any specific submitted claim batch
- Organization utilizing the v5010 835 include Health Plans, TPAs, state and federal agencies and their contractors, DFIs, billing services, consulting companies, vendors and clearinghouses.
- Used by traditional Health Care, Dental, Pharmacy, Auto and Workers' Compensation
- The receiver may be a Payee (provider) or an agent of the provider

# Health Care Claim Payment/Advice (835) – *Business Utility*

- The front matter section provides additional detail on how to report data in the transaction and rules from processing claim data.
- Such as:
  - Use in batch or real time mode
  - Besides reporting remittance information, the 835 is used to make a payment, report EOB information or both
  - Instructions for balancing at multiple levels
  - Used to provide financial notification of capitation payments. It does not contain the capitation details or membership roster. That information is reported in unison with the Eligibility and Benefits Notification Transaction (271). Refer to Section 1.10.2.10 for additional information
  - Used to report predetermination of benefits
  - Provides for communication of an adjustment using Claim Adjustment Reason Codes and Remittance Advice Remark Codes
  - Reporting of periodic advance payments (PIP)
  - Rules for bundling and unbundling

# Health Care Claim Payment/Advice (835) – *Reassociation*

- Reassociation must occur when the remittance data is sent separately from the monetary amount, which is a common practice.
  - For an EFT payment, there are 3 key pieces needed to facilitate reassociation:
    - TRN02 is the EFT Trace Number which is a unique number assigned by the sender and is the EFT reference number
    - TRN03 is the Payer Identification which is the payer's TIN prefixed with a '1'
    - BPR16 is the EFT Effective Date which is the date the money is available to the payee
  - The TRN segment and related elements are also defined in the NACHA rule and sent in the ACH addenda record
  - CCD+ TRN is the ACA mandated healthcare EFT standard
    - When EFT is requested by a provider it must be supplied by the health plan

# Health Care Claim Payment/Advice(835) – *Structure*

- HIPAA Mandated ASC X12 5010 835 Transaction Standard is structured as follows:
- Table 1 Header
  - Contains the payment details, sender and receiver and other information about the specific 835
- Table 2 Detail
  - Contains claim payment detail related to the claim and services being reported and adjudication information
- Table 3 Summary
  - Contains provider level adjustment details

---

# CAQH CORE EFT & ERA Operating Rule Requirements

# Healthcare EFT & ERA Standards + Operating Rules



## 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 will deliver efficiency and consistency across the healthcare industry

Compliance date for both the Healthcare EFT Standard and EFT & ERA Operating Rules is January 1, 2014; requirements to support the X12 v5010 835 are already in effect.

# **ERA/EFT Reassociation Rule (CCD+/835)**

## **CORE Rule 370**

# CAQH CORE EFT & ERA Reassociation (CCD+/835) Rule

## *Problem Addressed, Key Impact & Scope*

- 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 impact:
  - Coordinates healthcare and financial services industry
    - When receipt of payment occurs with minimal elapsed time between receipt of remittance advice, providers can more quickly match payments with data and post to patient accounts on a more timely basis
  - Provides assurance that trace numbers between payments and remittance can be used by providers
  - Reduces level of open accounts receivable by enabling provider to generate cross-over claims to other payers and to collect payment from patient
  - Enables provider to more quickly address denials or appeal adjustments to claim amount
- Scope of the rule:
  - Applies to entities that use, conduct or process X12 v5010 835 and ACH CCD+ transactions
  - Builds on your existing X12 v5010 835 implementation

# EFT & ERA Reassociation (CCD+/835) Rule:

## Three Key Rule Requirements

### Pre- Payment: Provider Enrollment



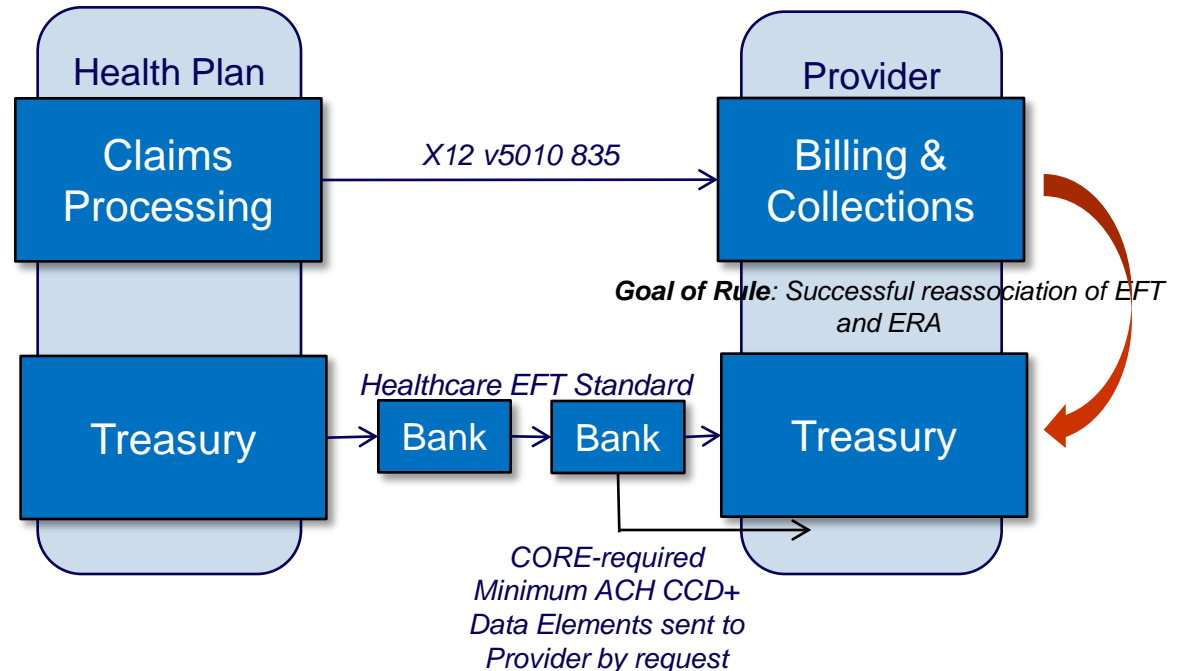
#### 1. CORE-required Minimum CCD+ Reassociation Data Elements:

- 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

# CORE-required Minimum CCD+ Reassociation

## Data Elements: *TRN Segment Role and Use*

Focus of Rule			Informational Only
CORE-required Minimum CCD+ Reassociation Data Elements			Corresponding v5010 X12 835 Data Elements
CCD+ Record #	Field #	Field Name (See §6 Glossary for Definition of these Terms)	Data Element Segment Position, Number & Name
5	9	Effective Entry Date	BPR16-373 Date ( <i>EFT Effective Date</i> )
6	6	Amount	BPR02-782 Monetary Amount ( <i>Total Actual Provider Payment Amount</i> )
7	3	Payment Related Information	TRN Reassociation Trace Number Segment, specifically data elements: <ul style="list-style-type: none"> <li>• TRN01-481 Trace Type Code Required</li> <li>• TRN02-127 Reference Identification (<i>EFT Trace Number</i>) Required</li> <li>• TRN03-509 Originating Company Identifier (<i>Payer Identifier</i>) Required</li> <li>• TRN04-127 Reference Identification (<i>Originating Company Supplemental Code</i>) Situational</li> </ul>

**Healthcare Claim Payment/Advice (835)  
Infrastructure Rule  
CORE Rule 350**

# CAQH CORE Claim Payment/Advice (835) Infrastructure Rule

## *Problem Addressed, Key Impact & Scope*

- Problem addressed by rule:
  - HIPAA provides a foundation for the electronic exchange of claim payment information, but does not provide infrastructure to promote the move from today's paper-based system to an electronic, interoperable system
- Key impact:
  - Enables providers, health plans and intermediaries to extend and leverage investment in connectivity infrastructure by requiring support of Phase II CAQH CORE Connectivity Rule 270 version 2.2.0
  - Continues to build on Phase I/II use of CAQH CORE Master Companion Guide Template so that providers can quickly find details necessary for the exchange of the X12 v5010 835
  - Reduces probability that providers will discontinue receipt of X12 v5010 835 due to system issues for effective use of remittance advice data to post to patient account
- Scope of the rule:
  - Applies to entities that use, conduct or process the *v5010 835 transaction*
  - HIPAA covered entities should have completed implementation of the first set of ACA-mandated operating rules; this rule extends the CORE Infrastructure Operating Rules to the 835 transaction

# Health Care Claim Payment/Advice (835) Infrastructure Rule: Key Rule Requirements

## Connectivity

- Entities must be able to support the Connectivity Rule Version 2.2.0 for transmission of the v5010 835

## Companion Guide

- Specifies use of the CAQH CORE Master Companion Guide Template for the flow and format of such guides for the v5010 835

## Dual Delivery

- 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
- Upon mutual agreement between the provider and the health plan, the timeframe for delivery of the proprietary paper claim remittance advices may be extended
- See §4.3 for more detail

## Batch Acknowledgements<sup>1</sup>

- A receiver of a v5010 X12 835 transaction must return:
  - A v5010 X12 999 Implementation Acknowledgement for each Functional Group of v5010 X12 835 transactions to indicate that the Functional Group was either accepted, accepted with errors or rejected, and
  - To specify for each included v5010 X12 835 transaction set that the transaction set was either accepted, accepted with errors or rejected
- A health plan must be able to accept and process a v5010 X12 999 for a Functional Group of v5010 X12 835 transactions
- When a Functional Group of v5010 X12 835 transactions is either accepted with errors or rejected, the v5010 X12 999 Implementation Acknowledgement must report each error detected to the most specific level of detail supported by the v5010 X12 999 Implementation Acknowledgement

<sup>1</sup> NOTE: CMS-0028-IFC does not adopt the Batch Acknowledgement Requirements in Section 4.2 of CAQH CORE Rule 350, as the Secretary has not yet adopted HIPAA standards for acknowledgements.

# **Uniform Use of CARCs and RARCs (835) Rule**

## **CORE Rule 360**

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

## *Problem Addressed & Key Impact*

- Problem addressed by rule:
  - Providers do not receive uniform code combinations for same or similar business scenarios from all health plans; as a result, are unable to automatically post claim payment adjustments and denials accurately and consistently
  - Focus on minimum business scenarios with maximum set of code combinations targeting 80% of major provider usage problems/high volume code combinations
    - Without business scenarios and maximum set of code combinations, there are over 800 RARCs, approximately 200 CARCs and 4 CAGCs resulting in thousands of possible code combinations for review by providers
- Key impact:
  - Begins to address a significant industry challenge by addressing high-volume issues
  - Providers can more effectively use ERA data when definitions for claim payment adjustments or denials are consistent across all health plans, resulting in better revenue cycle and cash flow management
  - Providers can more effectively obtain payment from patients, more quickly generate cross-over claims to other payers, and reduce open accounts receivable
  - Requires more focus on the use of standard codes (not proprietary codes)
- Scope:
  - Focuses on the CAS, LQ, MIA and MOA segments where CARCs, RARCs, and CAGCs are used
  - Builds on your existing X12 v5010 835 implementation bringing consistency and uniformity by establishing business scenarios and code combinations

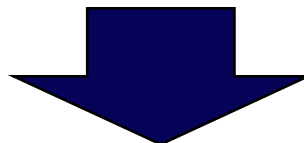
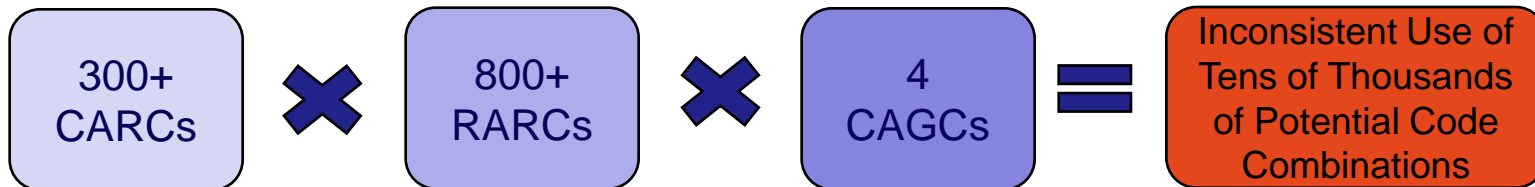
# CAQH CORE Uniform Use of CARCs & RARCs (835) Rule

## *Scope & High-level Rule Requirements*

- Foundational requirements
  - HIPAA covered entities should currently support v5010 835
- Scope of the rule
  - Applies to entities that use, conduct or process the X12 v5010 835 transaction
- High-level rule requirements
  - Identifies minimum set of four CORE-defined Business Scenarios with maximum set of code combinations to convey claim denial/adjustment details (codes in separate document):
  - Establishes maintenance process to review and update CORE-required Code Combinations
  - Enables health plans and PBM agents to:
    - Use new/adjusted codes with CORE-defined Business Scenarios prior to CAQH CORE Compliance-based review
    - Develop additional, non-conflicting business scenarios when CORE-defined Business Scenario do not meet business needs
  - Identifies applicable CORE-defined Business Scenarios for retail pharmacy

# Example: CAQH CORE Uniform Use of CARCs and RARCs Rule - Four Business Scenarios

**Pre-CORE Rules**



**Post CORE Rules**

## Four Common Business Scenarios

### CORE Business Scenario #1:

Additional Information Required – Missing/Invalid/Incomplete Documentation (≈470 code combos)

### CORE Business Scenario #2:

Additional Information Required – Missing/Invalid/Incomplete Data from Submitted Claim (≈300 code combos)

### CORE Business Scenario #3:

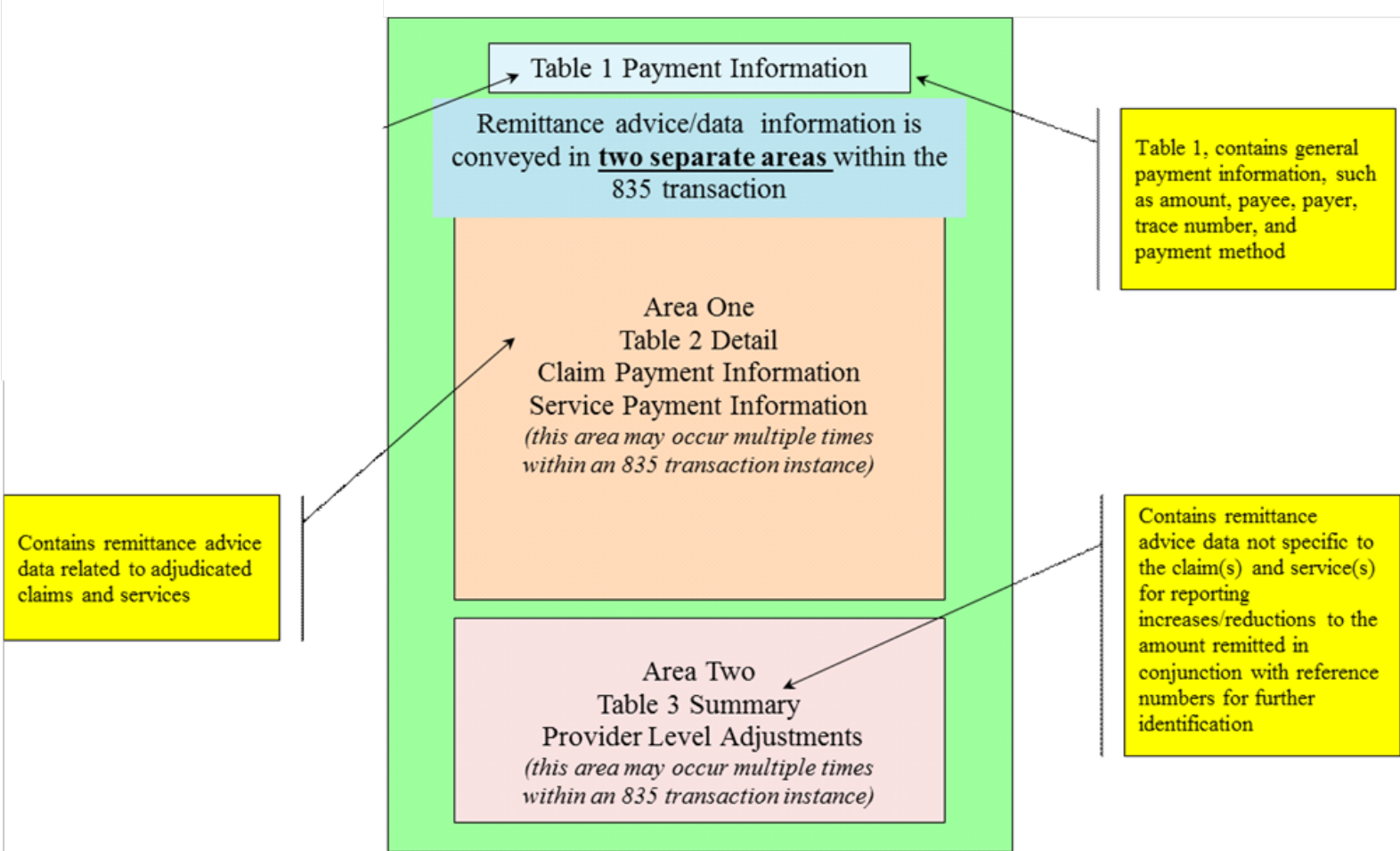
Billed Service Not Covered by Health Plan (≈330 code combos)

### CORE Business Scenario #4:

Benefit for Billed Service Not Separately Payable (≈30 code combos)

Code Combinations not included in the CORE-defined Business Scenarios may be used with other non-CORE Business Scenarios

# Reminder: ASC X12 835 Structure



# CAQH CORE Code Combinations Maintenance Process

- Level Set: *What is required by Section 3.5 of the CAQH CORE 360 Rule?*
  - Like all operating rules, CAQH CORE 360 Rule supports the published standards:
    - Recognizes that the rule supports the ASC X12 v5010 835 mandated standard
    - Recognizes that the rule supports code sets that are subject to revision three or more times a year; for the CARCs and RARCs, Code Committees external to the ASC X12 Standards Committee are authors of the published codes
  - Focuses on four key business scenarios (with associated code combinations) as a starting point
  - Enables immediate use by the industry of new codes added to the code lists since the last adjustments to the [CORE-required Code Combinations for CORE-defined Business Scenarios](#) and prohibits the use of deactivated codes after deactivation date (determined by code committees)
  - Establishes an open CAQH CORE process for soliciting feedback and input from the industry on a periodic basis, no less than three times per year for updating the [CORE-required Code Combinations for CORE-defined Business Scenarios](#)

# Two Types of Review

- A CAQH CORE Code Combinations Task Group is convened at least three times per year to review the [CORE-required Code Combinations for CORE-defined Business Scenarios](#)
- Two types of review and adjustment to the CORE Code Combinations including:

## Compliance-based Review & Adjustment

- **Goal:** Ensure ongoing alignment of the [CORE-required Code Combinations for CORE-defined Business Scenarios](#) and the published code sets
- **Frequency:** Occurs three times/year via Task Group
- **Scope:** Only considers updates to the CARC and RARC lists published (occurs three or more times per year; removed, modified description, and new codes) since the last update to the CORE Code Combinations as required by the CAQH CORE 360 Rule
- Per CMS OESS, Compliance-based Adjustments will be ***immediately recognized under HIPAA*** given the CAQH CORE Rule 360 requires that publications from code authors be addressed

## Market-based Review & Adjustment

- **Goal:** Address ongoing and evolving industry business needs
- **Frequency:** Occurs once per year during last Task Group convening
- **Scope:** Considers *industry submissions* based on real world usage data and/or a strong business case addressing:
  - Adjustments to the *existing* CORE-required Code Combinations for *existing* CORE-defined Business Scenarios
  - Addition of *new* CORE-defined Business Scenarios and associated code combinations
- Per CMS OESS, Market-based Adjustments will be recognized after approved by CAQH CORE

**NOTE:** The criteria-based [CAQH CORE Emergency Code Combination Addition Process](#) outlines a process for requesting code combinations not included in the most current version of the CORE-required Code Combinations when an entity cannot wait until the Market-based Review given new legislations, regulation, or a brand new product.

# CORE-required Code Combinations for CORE-defined Business Scenarios

- By January 1, 2014, entities should have a process to implement the CORE Code Combination updates
  - NOTE: Updates are made **three times per year – similar to what entities already experience with the Code Committee authors**
- Accessing the current version:
  - The [CORE-required Code Combinations for CORE-defined Business Scenarios](#) are updated three times a year
  - The most current version is ALWAYS available for free at the link and on multiple locations on the CAQH CORE website
    - Entities may email [core@caqh.org](mailto:core@caqh.org) to request a marked-up version of the *CORE-required Code Combinations for the CORE-defined Business Scenarios* that highlights adjustments made between versions
  - CAQH CORE will offer a dedicated webpage for the CAQH CORE 360 Rule and the CAQH CORE Code Combinations Maintenance Process
    - Future versions of the CORE-required Code Combinations for the CORE-defined Business Scenarios will be announced on the webpage
    - Current and moving forward, announcements are sent to all stakeholders through multiple channels when new versions are issued, and a request that stakeholders distribute the update

---

# Health Plan Perspective: Implementing EFT & ERA Operating Rules

# Snapshot of Aetna

**Aetna is one of the nation's leaders in health care, dental, pharmacy, group life, and disability insurance, and employee benefits.**

## **Membership**

- Over 18 million medical members
- More than 13 million dental members
- Approximately 8.7 million pharmacy members

## **Health care networks**

- More than 1 million health care professionals
- More than 597,000 primary care doctors and specialists
- More than 5,400 hospitals

- Broad range of insurance and employee benefits products:
  - Consumer-directed health plans such as Health Savings Account, Health Reimbursement Account and Retiree Reimbursement Accounts
  - Case management; disease management and patient safety programs; integrated medical, dental, pharmaceutical, behavioral health and disability information
  - Convenient tools and easy-to-understand information for members that can help them make better-informed decisions about their health and financial well-being
- National Presence
  - Benefits through employers in all 50 states, with products and services targeted specifically to small, mid-sized and large multi-site national employers
  - Serves individuals and Medicare and Medicaid beneficiaries in certain markets

# Efforts to Drive Provider EFT and ERA Adoption

- Aetna's business strategy to shift providers toward automated payments includes two key components:
  - Focus on turning off provider's paper Explanation of Benefits (EOBs) and checks
  - Drive to an electronic solution such as encouraging the enrollment in ERA or if appropriate, our on-line EOB
- Aetna tracks and measures success for paper shut off as a percent of claims off paper, e.g. no paper EOB **or** check
  - Medical and Dental combined = 67% (Medical only is 74%)
  - If we look at total providers in our database, the figure is around 43%



# Communication is Key

- Aetna uses a multi-channel communication strategy related to EFT and ERA
- Communication methods include:
  - Changes to the transactions are communicated via internal and external communications to ensure that all staff and receivers are aware of changes
  - Encourage enrollment in EFT, partnerships with ERA vendors to build support for provider outreach to enroll in ERA and/or EFT
  - Outreach phone calls to providers who submit ERA enrollment without enrolling in EFT, attaching an EFT enrollment form to ERA confirmation emails
  - Articles published in Aetna's Provider Newsletters marketing the value of electronic solutions
  - Distribution of hundreds of thousands of EFT enrollment forms with paper checks to providers to encourage them to enroll in EFT
  - Monthly live webinars to educate providers on Aetna's reconciliation tools and the benefits of EFT
  - Collaboration with industry groups such as the Health Billing Management Association to educate their members on the benefits of EFT and to gain the organization's support to encourage their membership to enroll

***In our experience, it takes multiple attempts and follow-up to get the provider's attention and for the provider to then follow-up and submit their EFT enrollment form. Persistence pays off.***

# Progress Toward EFT & ERA Operating Rule Implementation

- Aetna is fine-tuning its existing procedures to ensure compliance – and to be able to demonstrate compliance – with all the provisions of the ACA mandated CAQH CORE EFT & ERA Operating Rules
  - Examples:
    - Partnering with CAQH to offer an electronic solution for provider EFT enrollment
    - Close examination of our ERA and EFT enrollment forms and processes, and updating where necessary
    - Removal of extraneous data item (Provider Business Grouping) from EFT Addenda
    - Creation of a report to confirm ERAs and EFTs are created within 3 business days of each other
    - Review of approximately 6,000 internal “action codes” that are mapped to Group/CARC/RARC codes, sorting them where applicable into the 4 CORE-defined Business Scenarios, and ensuring mapping is appropriate
- Work is already underway and we expect to complete these activities before the end of 2013

# Role of Financial Institutions to Support Provider Adoption

- How can financial services institutions assist in efforts to drive provider adoption of EFT and ERA?
  - Aetna receive consistent feedback from providers refusing to enroll in EFT unless banks “eliminate EFT per-transaction fees”
  - Presenting a short business case helps providers understand total transaction cost is less even with transaction fees
    - While the fees are a real issue for providers, much is likely to be gained through education; financial institutions can:
      - Assist with educating providers in the savings to be realized by going to electronic solutions
      - While an immediately visible fee will be encountered, financial institution and health plans need to work together to help providers understand the savings they will see through elimination of manual, paper processes

***If we work together, we will move the paper process to an electronic solution that is more efficient for each organization, small or large.***

# CAQH CORE EFT & ERA Operating Rule Tools Available for Each Stage of Implementation

- ***Just Getting Started/Planning & Analysis***
  - [CAQH CORE EFT & ERA Operating Rules](#): Master your understanding of the ACA mandated EFT & ERA operating rule requirements
  - The [Analysis and Planning Guide](#) provides guidance to complete systems analysis and planning for implementation of the CAQH CORE EFT & ERA Operating Rules
- ***Systems Design/Implementation***
  - [Education Sessions](#): CAQH CORE holds frequent sessions with partners such as WEDI, associations, and Medicaid workgroups that often include speakers from organizations that have implemented the CAQH CORE Operating Rules
  - [FAQs](#): CAQH CORE has a list of FAQs to address typical questions regarding the operating rules; *new EFT & ERA FAQs are being posted regularly*
  - [Request Process](#): Contact technical experts as needed at [CORE@caqh.org](mailto:CORE@caqh.org)
- ***Integration/Testing***
  - *Coming Soon for EFT & ERA*: HIPAA covered entities can quickly communicate their organization's readiness to testing their conformance with trading partners by adding their company information to the CORE Partner Testing page of the CAQH website
- ***Deployment/Maintenance***
  - *Coming Soon for EFT & ERA*: *Voluntary* CORE Certification Test Site for conformance testing of the EFT & ERA Operating Rules; jointly offered by CAQH CORE-authorized testing entity Edifecs

# Q&A

Please submit your question:

- By Phone: Press \* followed by the number one (1) on your keypad
- Via the Web: Enter your question into the Q&A pane in the lower right hand corner of your screen

---

Thank You for Joining Us

*Appendices: Implementation Tools and References*

# Upcoming CAQH CORE Education Events

- Participate in CAQH CORE’s Public Town Hall Call on May 21, 2013 from 3:00 pm to 4:00 PM ET
- Join us for a free CAQH CORE webinar
  - “Open Mic”: Dialog on EFT/ERA existing and new FAQs
  - “*Save the Dates*” for a series of joint CAQH CORE and Edifecs *voluntary* EFT & ERA CORE Certification education sessions
    - Tuesday, May 7, 2013 from 1:00 pm - 2:00 pm ET
    - Monday, June 10, 2013 from 1:00 pm – 2:00 pm ET
- Hear More about Operating Rules at an industry event
  - [Annual WEDI National Conference](#), May 13 – May 16
- Visit the CORE [Education Events](#) page of the CAQH website
  - Access *free* recordings of previous education events & stay informed of upcoming joint webinars with key partners such as NACHA, ASC X12, vendors and provider associations

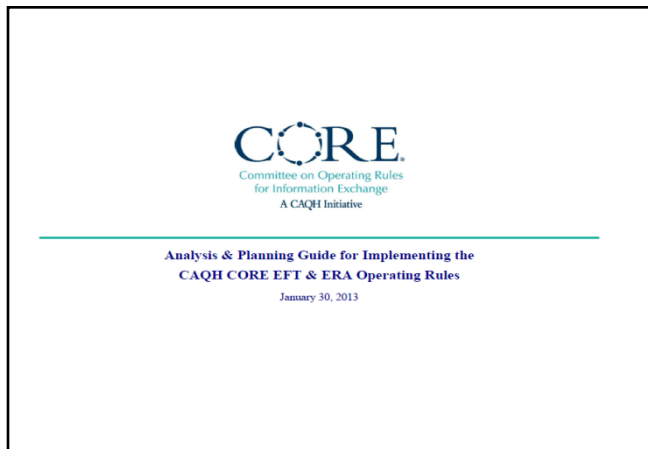
# Examples of Available EFT & ERA Operating Rule FAQs: *Get Your Answers Today!*

- Uniform Use of CARCs and RARCs - CORE Rule 360
  - Do all of the CARCs in the CORE-required Code Combinations tables have to be used with a corresponding RARC?
  - CAQH CORE 360 Rule, Section 4.2, *Basic Requirements for Receivers of the X12 v5010 835*, requires that provider facing products display text describing the CORE-defined Claim Adjustment/Denial Business Scenarios and Code Combinations to the end user. Is there specific text that such products must display?
  - Within the *CORE-required Code Combinations for the CORE-defined Business Scenarios*, the same RARC is included in *multiple* code combinations for a *single* CORE-defined Business Scenario. As a health plan, to which code combination should we map this RARC within our internal system?
- Reassociation Rule - CORE Rule 370
  - When does the “three business days” maximum elapsed timeframe between release of the CCD+ and the X12 v5010 835 begin and end?
  - Does the CAQH CORE 370 Rule specify requirements for how frequently a health plan should generate an X12 v5010 835 and corresponding claim payment?
- ERA Infrastructure Rule - CORE Rule 350
  - I am a provider organization that currently receives the X12 v5010 835 via manual download from a health plan’s web portal. Does the connectivity requirement specified in Section 4.1 of the CAQH CORE 350 Rule mean that my organization can now only receive the X12 v5010 835 via the CAQH CORE Connectivity Safe Harbor?
  - If the provider chooses not to continue the dual delivery period beyond 31 days (or a minimum of 3 payments) after the implementation of the X12 v5010 835, must the health plan stop sending proprietary paper claim remittance advices?
  - Does the CAQH CORE 350 Rule require HIPAA covered entities to publish a companion guide for the X12 v5010 835 if they do not currently do so?

Visit our [Website](#) to find the answers to an ever-expanding list of questions about EFT & ERA Operating Rules

# CAQH CORE Analysis & Planning Guide: *EFT & ERA Operating Rules*

- The new [Analysis and Planning Guide](#) provides guidance for Project Managers, Business Analysts, System Analysts, Architects, and other project staff to complete systems analysis and planning for implementation of the CAQH CORE EFT & ERA Operating Rules
- Guide should be used by project staff to:



- Understand applicability of the CAQH CORE Operating Rule requirements to organization's systems and processes that conduct the EFT and ERA transactions
- Identify all impacted external and internal systems and outsourced vendors that process EFT & ERA transactions
- Conduct detailed rule requirements gap analysis to identify system(s) that may require remediation and business processes which may be impacted

- The guide includes three tools to assist entities in completing analysis and planning:
  - Stakeholder & Business Type Evaluation
  - Systems Inventory & Impact Assessment Worksheet
  - Gap Analysis Worksheet

# Voluntary CORE Certification

- Since its inception, CAQH CORE has offered a *voluntary* CORE Certification to health plans, vendors, clearinghouses, and providers
  - Learn more about *voluntary* CORE Certification [here](#)
  - *Voluntary* CORE Certification provides verification that your IT systems or product operates in accordance with the federally mandated operating rules
- Certification and testing are *separate activities*
  - Testing is completed by *CORE-authorized testing entities* and occurs on-line based on stakeholder-specific test scripts; test scripts developed by CORE participants
  - Cost of testing and certification is extremely low or free
- CORE Certification is a 4-step process:
  - 1. Pre-certification Planning and Systems Evaluation:**
    - Understand requirements of the CORE Operating Rules and scope your internal efforts to adopt rules
    - CORE has free gap analysis tool; email [CORE@CAQH.org](mailto:CORE@CAQH.org)
  - 2. Sign and Submit the CORE Pledge:**
    - Formally communicate your intent to pursue CORE Certification
  - 3. CORE Certification Testing:**
    - Comprised of three phases: Pre-testing, Testing and Post-testing
    - Testing is by stakeholder-specific test scripts by rule
  - 4. Apply for the CORE Certification Seal:**
    - Entities successfully achieving CORE Certification will receive a CORE “Seal” from CAQH that corresponds with the CORE Phase and stakeholder-type

# ASC X12's Interpretation Process

---

**Technical or Implementation questions may be submitted to ASC X12. Such a question is called a Request for Interpretation (RFI).**

**Submit an RFI at:**

[www.x12.org/x12org/subcommittees/x12rfi.cfm](http://www.x12.org/x12org/subcommittees/x12rfi.cfm)

An RFI and the associated response is reviewed and approved at several levels before being published as a final ASC X12 interpretation.

# Available CMS OESS Implementation Tools:

## *Examples*

- HIPAA Covered Entity Charts
  - Use the [HIPAA Covered Entity Charts](#) to determine whether your organization is a HIPAA covered entity
- FAQs
  - Frequently asked questions about the ACA, operating rules, and other topics
  - [CMS FAQs](#)
- Affordable Care Act Updates
  - Updates on operating rules; compliance, certification, and penalties; and engagement with standards and operating rules
  - Access these updates [here](#)
- Additional Questions
  - Questions regarding HIPAA and ACA compliance can be addressed to:
    - Chris Stahlecker, OEM/OESS/ASG Acting Director, Administrative Simplification Group, [Christine.Stahlecker@cms.hhs.gov](mailto:Christine.Stahlecker@cms.hhs.gov)
    - Geanelle Herring, Health Insurance Specialist, [Geanelle.Herring@cms.hhs.gov](mailto:Geanelle.Herring@cms.hhs.gov)

# Additional 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](http://www.nacha.org/estore).
- Revised 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.
  - <https://healthcare.nacha.org/ACHprimer>
- Ongoing Education and Webinars
  - Check the Healthcare Payments Resource Website for “Events and Education”