CAQH Committee on Operating Rules for Information Exchange (CORE)
FAQs Part D: CAQH CORE EFT & ERA Operating Rules

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CAQH CORE is the authoring entity for two sets of ACA Section 1104 mandated Federal operating rules.

This document is for informational purposes only; in the case of a discrepancy between this document and CAQH CORE Operating Rule text and/or Federal regulations, the latter take(s) precedence.

I. Overview of CAQH CORE EFT & ERA Operating Rules

1. What do the Phase III CAQH CORE EFT & ERA Operating Rules address?

Payment and remittance advice processing are faster when a provider receives payment via Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA) instead of via paper check and corresponding paper remittance advice. Despite these administrative savings, it is estimated that currently only 30% of all health care payments are made electronically. Several key barriers exist to achieving rapid, industry-wide adoption of EFT and ERA including:

- Non-uniform and inconsistent use of the 1000+ Claims Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARCs)
- Inconsistent data elements required by health plans for provider EFT and ERA enrollment
- In-ability of providers to specify to the health plan how payments should be made, i.e., by National Provider Identifier (NPI) or Tax ID
- Challenges to provider reassociation of the EFT and ERA due to non-matching trace numbers and extensive time delays between receipt of the EFT and ERA

The Phase III CAQH CORE EFT & ERA Operating Rules address these challenges by requiring:

Rules		Key Rule Requirements
Data Content	*CAQH CORE 360: Uniform Use of CARCs and RARCs (835) Rule*	• Identifies a *minimum* set of four CAQH CORE-defined Business Scenarios with a *maximum* set of CAQH CORE-required code combinations that can be applied to convey details of the claim denial or payment to the provider
Infrastructure	*CAQH CORE 350: Health Care Claim Payment/Advice (835) Infrastructure Rule*	• Specifies use of the CAQH CORE Master Companion Guide Template for the flow and format of such guides • Requires entities to support the Phase II CAQH CORE Connectivity Rule. • Includes batch Acknowledgement requirements* • Defines a dual-delivery (paper/electronic) to facilitate provider transition to electronic remits
	CAQH CORE 370: EFT & ERA Reassociation (CCD+/835) Rule	• Addresses provider receipt of the CAQH CORE-required Minimum ACH CCD+ Data Elements required for re-association • Addresses elapsed time between the sending of the v5010 835 and the CCD+ transactions • Requirements for resolving late/missing EFT and ERA transactions • Recognition of the role of NACHA Operating Rules for financial institutions
	CAQH CORE 380: EFT Enrollment Data Rule *CAQH CORE 382: ERA Enrollment Data Rule*	• Identifies a maximum set of standard data elements for EFT enrollment • Outlines a flow and format for paper and electronic collection of the data elements • Requires health plan to offer electronic EFT enrollment • Requires providers to specify how payments should be made, i.e., by NPI or by Tax ID, as part of the EFT &/or ERA enrollment process

* CMS-0028-IFC excludes requirements pertaining to acknowledgements.

2. Who should implement the Phase III CAQH CORE EFT & ERA Operating Rules?

The Phase III CAQH CORE EFT & ERA Operating Rules apply to all HIPAA covered entities that conduct the ASC X12 005010X221A1 Health Care Claim Payment/Advice (835) and the HIPAA-mandated Healthcare EFT

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Standards (NACHA CCD+ and the X12 v5010 835 TR3 TRN Segment) transactions. ACA Section 1104 requires all HIPAA covered entities to comply with the HIPAA-mandated EFT and ERA operating rules. Entities acting in the role of a Business Associate of a HIPAA covered entity may also need to implement various aspects of the Phase III CAQH CORE EFT & ERA Operating Rules. The CMS website provides charts HERE to help organizations determine whether they are a HIPAA covered entity.

3. What transactions are addressed by the Phase III CAQH CORE EFT & ERA Operating Rules?

The Phase III CAQH CORE EFT & ERA Operating Rules apply to use, conduct, or processing of the ASC X12 005010X221A1 Health Care Claim Payment/Advice (835) transaction and the HIPAA-mandated Healthcare EFT Standards (NACHA CCD+ and the X12 v5010 835 TR3 TRN Segment).

4. What are the HIPAA-mandated Healthcare EFT Standards?

ACA Section 1104(c)(2) adds the EFT transaction to the list of electronic health care transactions for which the HHS Secretary must adopt a HIPAA standard. Specifically, ACA Section 1104 requires the HHS Secretary to promulgate a final rule to establish a HIPAA transaction standard for healthcare EFT no later than January 1, 2012, with the rule effective January 1, 2014.

In January 2012, HHS issued an Interim Final Rule with Comment (IFC) adopting the NACHA CCD+ and the X12 v5010 835 TR3 TRN Segment together as the Healthcare EFT Standards. On July 10, 2012, CMS announced that the IFC is a Final Rule now in effect. The CMS announcement notes that "*we have decided not to change any of the policies established in CMS-0024-IFC.*"

NOTE: The HHS Final Rule adopting the Healthcare EFT Standards does not prohibit use of other EFT transaction standards (e.g., Fedwire, card payment networks, CTX, etc.) to make electronic healthcare claim payments. However, per CMS, "*if a provider requests that a health plan conduct EFT using the ACH Network, the health plan is required to do so.*" See CMS FAQ #6343.

5. Do the CAQH CORE EFT & ERA Operating Rules apply when entities make electronic healthcare payments via other Electronic Funds Transfer (EFT) standards (e.g., Fedwire, card payment networks, CTX, etc.) instead of the HIPAA-mandated Healthcare EFT Standards (NACHA CCD+ and the X12 v5010 835 TR3 TRN Segment)?

No. The CAQH CORE EFT & ERA Operating Rules apply only when entities are using the HIPAA-mandated EFT & ERA standards. While the HHS Final Rule permits entities to use EFT transaction standards beyond the HIPAA-mandated Healthcare EFT Standards (the NACHA CCD+ and the X12 v5010 835 TR3 TRN Segment), these other standards are outside the scope of the CAQH CORE EFT & ERA Operating Rules.

NOTE: The HHS Final Rule adopting the Healthcare EFT Standards does not prohibit use of other EFT transaction standards outside of the ACH Network (e.g., Fedwire, card payment networks, CTX, etc.) to make electronic healthcare payments. However, per CMS, "*if a provider requests that a health plan conduct EFT using the ACH Network, the health plan is required to do so.*" See CMS FAQ #6343.

6. My organization is a health plan. We currently send a paper Remittance Advice (RA) and *do not* support the X12 v5010 835. As we do not use the X12 v5010 835, are we exempt from conformance with the CAQH CORE Operating Rules? Or do the CAQH CORE EFT & ERA Operating Rules require us to implement the X12 v5010 835 transaction in order to conform to the applicable rule requirements?

Under the HIPAA provisions, health plans are "*required to have the capacity to accept and/or send (either itself, or by hiring a health care clearinghouse to accept and/or send on its behalf) a standard transaction that it otherwise conducts but does not currently support electronically*" (see CMS FAQ #8121). This requirement applies to all HIPAA-mandated transaction standards, including the X12 v5010 835 transaction standard. When using the HIPAA-mandated X12 v5010 835, operating rules apply for HIPAA covered entities. In August 2012, HHS issued an IFR adopting the CAQH CORE EFT & ERA Operating Rules to fulfill the ACA Section 1104 mandate, *with the exception of rule requirements pertaining to use of Acknowledgements*. On April 19, 2013, HHS issued an industry notice that the IFR is a Final Rule now in effect.

ACA Section 1104 requires all HIPAA covered entities, including health plans, to comply with the mandated standards and applicable operating rules. It is a health plan's individual business decision whether or not to deliver a proprietary paper RA **in addition to** supporting the X12 v5010 835 and applicable CAQH CORE Operating Rules. If a health plan offers a paper RA it must still implement the X12 v5010 835 transaction and applicable CAQH CORE Operating Rules.

The ACA-mandated CAQH CORE EFT & ERA Operating Rules include four rules that specify data content and infrastructure requirements applicable to the X12 v5010 835 (the fifth CAQH CORE Rule applies to the HIPAA-mandated healthcare EFT standard transaction):

- CAQH CORE 350: Health Care Claim Payment/Advice (835) Infrastructure Rule
- CAQH CORE 360: Uniform Use of CARCs and RARCs (835) Rule
- CAQH CORE 370: EFT & ERA Reassociation (CCD+/835) Rule
- CAQH CORE 382: ERA Enrollment Data Rule

7. My organization is a health plan. We currently deliver *both* a proprietary paper Remittance Advice (RA) and the X12 v5010 835. Do the CAQH CORE Operating Rules addressing the X12 v5010 835 require us to stop sending a paper RA and *only* provide remittance information via the X12 v5010 835?

The CAQH CORE EFT & ERA Operating Rules do not require any health plan to send remittance information via the X12 v5010 835 **only**.

Under the HIPAA provisions, health plans are "*required to have the capacity to accept and/or send (either itself, or by hiring a health care clearinghouse to accept and/or send on its behalf) a standard transaction that it otherwise conducts but does not currently support electronically*" (see CMS FAQ #8121). This requirement applies to all HIPAA-mandated transaction standards, including the X12 v5010 835 transaction standard. It is a health plan's individual business decision whether or not to deliver a proprietary paper RA **in addition to** supporting the X12 v5010 835 and applicable CAQH CORE Operating Rules.

The CAQH CORE 350: Health Care Claim Payment/Advice (835) Infrastructure Rule does include a requirement that applies to health plan delivery of a proprietary paper RA. Specifically, Section 4.3, *Dual Delivery of X12 v5010 835 and Proprietary Paper Claim Remittance Advices*, of the CAQH CORE 350 Rule requires health plans that currently deliver a proprietary paper RA to support a parallel processing period during which providers can continue to receive a paper RA while they test the use of the X12 v5010 835 standard and associated operating rules. The required timeframe for the dual delivery period is 31 days (or a minimum of 3 payments). **NOTE:** If a health plan does not currently deliver proprietary paper RAs, the CAQH CORE 350 Rule **does not** require the plan to start doing so.

At the end of the parallel processing period, "*if the provider determines it is unable to satisfactorily implement and process the health plan's electronic X12 v5010 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*." Additionally, "*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*."

8. My organization is a health plan. We currently *do not* support claim payments via the HIPAA-mandated Healthcare EFT Standards. As we do not use the transaction standards, are we exempt from conformance with the CAQH CORE Operating Rules? Or do the CAQH CORE EFT & ERA Operating Rules require us to implement the HIPAA-mandated Healthcare EFT Standards in order to conform to applicable rule requirements?

ACA Section 1104 requires all HIPAA covered entities, including health plans, to comply with the mandated standards and applicable operating rules. ACA Section 1104 adds Electronic Funds Transfer (EFT) to the list of electronic health care transactions for which the HHS Secretary must adopt a HIPAA standard. In January 2012, HHS issued an IFR adopting the NACHA CCD+ and X12 v5010 835 TR3 TRN Segment together as the HIPAA-mandated Healthcare EFT Standards. On July 10, 2012, CMS announced that the IFC is a Final Rule now in effect. As of January 1, 2014, health plans must support the CCD+ to initiate EFT payment through the Automated Clearing House (ACH) Network (see CMS FAQ #6357). **NOTE:** The HHS Final Rule **does not** prohibit health plans and providers from using the CTX format to conduct EFT via the ACH Network or using non-ACH networks (e.g., Fedwire, card payment networks, etc.) to send/receive EFT claim payments (see CMS FAQ#6343).

Under the HIPAA provisions, health plans are "*required to have the capacity to accept and/or send (either itself, or by hiring a health care clearinghouse to accept and/or send on its behalf) a standard transaction that it otherwise conducts but does not currently support electronically*" (see CMS FAQ #8121). This requirement applies to all HIPAA-mandated transaction standards, including the EFT transaction standard.

When using the Healthcare EFT Standards, the ACA-mandated operating rules apply for HIPAA covered entities. In August 2012, HHS issued an IFR adopting the CAQH CORE EFT & ERA Operating Rules to fulfill the ACA Section 1104 mandate, *with the exception of rule requirements pertaining to use of Acknowledgements*. On April 19, 2013, HHS issued an industry notice that the IFR is a Final Rule now in effect. The ACA-mandated CAQH CORE EFT & ERA Operating Rules include two rules that apply to the Healthcare EFT Standards (the remaining three rules apply to the X12 v5010 835 transaction):

- CAQH CORE 370: EFT & ERA Reassociation (CCD+/835) Rule
- CAQH CORE 380: EFT Enrollment Data Rule

9. My organization is a provider office. We currently *do not* receive electronic claim payment and remittance information from all health plan trading partners. Do the CAQH CORE EFT & ERA Operating Rules require us to accept claim payment and remittance information via the Healthcare EFT Standards and X12 v5010 835 from *all* health plans?

The CAQH CORE EFT & ERA Operating Rules do not require any provider to accept claim payment and remittance information via the HIPAA-mandated X12 v5010 835 and Healthcare EFT Standards (CCD+ and X12 v5010 835 TR3 TRN Segment).

Under the HIPAA provisions, health plans are "*required to have the capacity to accept and/or send (either itself, or by hiring a health care clearinghouse to accept and/or send on its behalf) a standard transaction that it*

otherwise conducts but does not currently support electronically" (see CMS FAQ #8121). This requirement applies to all HIPAA-mandated transaction standards, including the EFT and ERA transaction standards.

Providers are **not** required to send or receive any of the HIPAA-mandated transactions in order to comply with the HIPAA provisions (see CMS FAQ #1809). However, if a provider **chooses** to receive claim payment and remittance information electronically via the HIPAA-mandated X12 v5010 835 and Healthcare EFT Standards, the provider must comply with the applicable ACA-mandated CAQH CORE EFT & ERA Operating Rules.

CAQH CORE offers a Sample Provider EFT Request Letter, with instructions, that a provider can email to health plans or use as talking points with health plan contacts to request payment via EFT and EFT & ERA Operating Rule implementation status.

NOTE: While Federal law does not require providers to use the HIPAA-mandated transaction standards, certain states or health plans may require providers to conduct the electronic transactions.

CMS is the HHS designated authority on any decisions regarding interpretation, implementation, and enforcement of the regulations adopting the HIPAA and ACA Administrative Simplification standards and provisions; for additional questions regarding the regulations, please contact CMS.

10. My organization is a provider office. We currently receive claim payment via paper with accompanying electronic remittance information from some of our health plan trading partners. Do the CAQH CORE EFT & ERA Operating Rules require us to receive claim payment electronically via the Healthcare EFT Standards (CCD+ and X12 v5010 835 TR3 TRN Segment) in order to continue to receive the X12 v5010 835?

The CAQH CORE EFT & ERA Operating Rules do not require any provider to accept claim payment or remittance information via the HIPAA-mandated X12 v5010 835 and Healthcare EFT Standards (CCD+ and X12 v5010 835 TR3 TRN Segment).

The HIPAA Administrative Simplification provisions **do not** require providers to send or receive any of the HIPAA-mandated transaction standards (see CMS FAQ #1809) nor do they require providers to accept claim payment via EFT (see CMS FAQ #6343). A provider can **choose** to receive remittance information electronically via the X12 v5010 835 ERA while receiving claim payment via paper.

However, if a provider chooses to receive remittance information electronically via the X12 v5010 835, while receiving claim payment via paper, the provider **must** implement and comply with the following ACA-mandated CAQH CORE Operating Rules addressing use of the X12 v5010 835:

- CAQH CORE 350: Health Care Claim Payment/Advice (835) Infrastructure Rule
- CAQH CORE 360: Uniform Use of CARCs and RARCs (835) Rule
- CAQH CORE 382: ERA Enrollment Data Rule

CAQH CORE offers a Sample Provider EFT Request Letter, with instructions, that a provider can email to health plans or use as talking points with health plan contacts to request payment via EFT and EFT & ERA Operating Rule implementation status.

NOTE: While Federal law does not require providers to use the HIPAA-mandated transaction standards, certain states or health plans may require providers to conduct the electronic transactions.

CMS is the HHS designated authority on any decisions regarding interpretation, implementation, and enforcement of the regulations adopting the HIPAA and ACA Administrative Simplification standards and provisions; for additional questions regarding the regulations, please contact CMS.

11. My entity is a provider organization. We currently cannot access EFT and/or ERA from some of the health plans we work with but would like to begin using the transactions. Do health plans need to offer these transactions and does CAQH CORE have any tools to assist us with this?

Yes. As of January 1, 2014 all HIPAA covered health plans must offer to providers an electronic payment option via the newly mandated Healthcare EFT Standard (e.g. NACHA CCD+). Health plans have been required to offer payment via the X12 v5010 835 HIPAA standard for ERA for many years. Additionally, health plans must be compliant with the ACA mandated EFT & ERA Operating Rules which support more efficient provider use of both EFT and ERA. CAQH CORE offers the following tools to assist providers seeking to utilize EFT and/or ERA:

- Contact your Health Plans - *Sample Provider EFT Request Letter*: A sample letter, with instructions, that a provider can email to health plans or use as talking points with health plan contacts to request payment via EFT and EFT & ERA Operating Rule implementation status.
- Contact Your Banks - *Sample Provider EFT Reassociation Data Request Letter*: A sample letter, with instructions, that a provider receiving EFT payments may customize and email to its banks or use as talking points for a phone or in-person meeting with its bank contacts to request delivery of the ACH Payment Related Information via a secure, electronic means. The ACH Payment Related Information contains the necessary data to reassociate EFTs and ERAs and is not automatically delivered to providers unless requested by the provider.

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II. Interdependent CAQH CORE EFT & ERA Requirements

1. Where can I obtain the NACHA implementation specifications for the HIPAA-mandated CCD+ standard format?

NACHA – The Electronic Payments Association is the Standards Development Organization (SDO) that maintains the ACH Corporate Credit or Debit with Addenda Record (CCD+) standard format. NACHA develops rules, published in the NACHA Operating Rules & Guidelines, which govern electronic transmissions conducted through the ACH Network. The HHS Final Rule adopting the Healthcare EFT Standards (CCD+ and X12 v5010 835 TR3 TRN Segment) adopts the implementation specifications in the NACHA Operating Rules & Guidelines as the HIPAA-mandated standard for the CCD+.

NOTE: NACHA updates its operating rules and guidelines every year with a new version for use by financial institutions. Per CMS, any version of the NACHA Operating Rules & Guidelines can be used as long as the implementation specifications for the CCD+ do not differ from those in the 2011 version. (See CMS FAQ #6353)

2. Do the CAQH CORE EFT & ERA Operating Rules alter the BPR segment data elements in the X12 v5010 835 transaction that may be used in the CCD+ EFT?

The CAQH CORE EFT & ERA Operating Rules do not change the meaning, usage, or definition of the X12 v5010 835 data elements.

Use of the X12 v5010 835 BPR Segment data elements is referenced in the following sections of the CAQH CORE 370: EFT & ERA Reassociation (CCD+/835) Rule:

- Table 3.3-1 in Section 3.3, *CORE-required Minimum CCD+ Data Elements for Successful Reassociation*, identifies the CORE-required minimum set of CCD+ data elements necessary for successful reassociation of the CCD+ and the X12 v5010 835. The CORE-required Minimum CCD+ Reassociation Data Elements include CCD+ Record #5, Field 9, *Effective Entry Date*, CCD+ Record #6, Field 6, *Amount*, and CCD+ Record #7, Field 3, *Payment Related Information*. CCD+ Records #5 and #6 correspond to BPR16 Date *(EFT Effective Date)* and BPR02 Monetary Amount *(Total Actual Provider Payment Amount)* respectively in the X12 v5010 835. BPR16 and BPR02 provide information required for the successful reassociation of the X12 v5010 835 and the CCD+.
- Section 4.2, *Elapsed Time between Sending the X12 v5010 835 and the CCD+ Transaction*, specifies requirements for health plans to ensure that the CCD+ Effective Entry Date is a valid banking day and that the corresponding X12 v5010 835 BPR16 *(EFT Effective Date)* is the same valid banking day.

For further guidance on the CAQH CORE 370 Rule, including requirements addressing use of the X12 v5010 835 BPR Segment data elements, please see *Section V. CAQH CORE 370: EFT & ERA Reassociation (CCD+/835) Rule*.

Please Note: As the Standards Development Organization (SDO) that develops and maintains the X12 v5010 835 standard, guidance on implementation of the X12 v5010 835 TR3 implementation guide, and its underlying standard, should be obtained from ASC X12. Information related to the meaning, use, and interpretation of ASC X12 Standards, Guidelines, and Technical Reports can be obtained via the online ASC X12 Interpretation Portal.

3. Is a *health plan* Taxpayer Identification Number (TIN) required to be included in the HIPAA-mandated Healthcare EFT Standards (NACHA CCD+ and the X12 v5010 835 TR3 TRN Segment)?

Yes, inclusion of a health plan TIN is required for the X12 v5010 835 TR3 TRN Segment component of the Healthcare EFT Standards.

The January 2012 HHS Final Rule for the HIPAA-mandated EFT transaction standard adopts the NACHA CCD+ and the X12 v5010 835 TR3 Reassociation Trace Number (hereafter TRN) Segment together as the Healthcare EFT Standards. The *NACHA Operating Rules* do not require use of a TIN in the CCD+ component of the Healthcare EFT Standards. However the X12 v5010 835 TR3 Implementation Guide does require inclusion of the health plan/payer's TIN in the TRN03 data element within the X12 v5010 835 TR3 TRN Segment. The CAQH CORE EFT & ERA Operating Rules do not change the meaning, usage, or definition of the X12 v5010 835 data elements or the CCD+ data fields.

Beyond the standard requirements, use of the X12 v5010 835 TR3 TRN Segment is referenced in Table 3.3-1 in Section 3.3, *CORE-required Minimum CCD+ Data Elements for Successful Reassociation*, of the CAQH CORE 370: EFT & ERA Reassociation (CCD+/835) Rule. Table 3.3-1 identifies the CORE-required minimum set of CCD+ data elements necessary for successful reassociation of the CCD+ and the X12 v5010 835 and their corresponding data elements in the X12 v5010 835:

Table 3.3-1

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 *(EFT Effective Date)*	
6	6	Amount	BPR02-782 Monetary Amount *(Total Actual Provider Payment Amount)*	
7	3	Payment Related Information	TRN Reassociation Trace Number Segment, specifically data elements:	
			• TRN01-481 Trace Type Code	Required
			• TRN02-127 Reference Identification (EFT Trace Number)	Required
			• TRN03-509 Originating Company Identifier (Payer Identifier)	Required
			• TRN04-127 Reference Identification (Originating Company Supplemental Code)	Situational

Source: CAQH CORE 370 Rule, §3.3 - *CORE-required Minimum CCD+ Data Elements for Successful Reassociation*

As shown in Table 3.3-1, CCD+ Record #7, Field 3 corresponds to the X12 v5010 835 TR3 TRN Segment. The X12 v5010 835 TR3 TRN Segment is composed of three required data elements and one situational data element. The X12 v5010 835 TR3 Implementation Guide requires the health plan/payer's TIN to be included in the required TRN03-509 data element within the X12 v5010 835 TR3 TRN Segment.

For further guidance on the CAQH CORE 370 Rule, including requirements addressing use of the X12 v5010 835 TRN Segment, please see *Section V. CAQH CORE 370: EFT & ERA Reassociation (CCD+/835) Rule*.

Please Note: As the Standards Development Organization (SDO) that develops and maintains the X12 v5010 835 standard, guidance on implementation of the X12 v5010 835 TR3 implementation guide, and its underlying

standard, should be obtained from ASC X12. Information related to the meaning, use, and interpretation of ASC X12 Standards, Guidelines, and Technical Reports can be obtained from ASC X12 via its online ASC X12 Interpretation Portal. NACHA – The Electronic Payments Association is the SDO that maintains the CCD+ standard format. For questions related to the CCD+, or to NACHA in general, contact Priscilla Holland, Senior Director, at pholland@nacha.org.

4. Do the CAQH CORE EFT & ERA Operating Rules apply to payment and remittance provided in response to paper-based healthcare claims?

Submission of a healthcare claim and the payment of the claim (and delivery of the applicable remittance advice) are separate transactions. A provider may receive healthcare EFT and/or ERA in response to claims submitted both via paper and electronic methods. Currently, many providers submit paper-based claims to health plans and receive claim payment and remittance via the healthcare EFT and ERA standard transactions. For example, a provider may be required to send a claim that requires a clinical attachment via paper to the health plan but choose to receive an EFT and ERA.

The CAQH CORE EFT & ERA Operating Rules apply specifically to the use, conduct, or processing of the ASC X12 005010X221A1 Health Care Claim Payment/Advice (835) transaction and the HIPAA-mandated Healthcare EFT Standards (the NACHA CCD+ and X12 v5010 835 TR3 TRN Segment). Therefore, if a provider submits a paper-based claim to a health plan and receives back from the health plan claim payment and remittance via the X12 v5010 835 and/or HIPAA-mandated Healthcare EFT Standards transactions, the CAQH CORE EFT & ERA Operating Rules would apply.

In sum: A health plan's use of the healthcare EFT and ERA to provide payment and remittance to a provider is independent of the method in which the healthcare claim was submitted (paper or electronic).

5. We are a health plan and do not currently populate the TRN04 situational data element in the TRN Trace Number data segment in our X12 v5010 835. Will the Reassociation Trace Number information we include in the TRN01 through TRN03 of the TRN Segment still pass through to the CCD+?

Yes, as long as the X12 v5010 835 TRN Reassociation Trace Number Segment (hereafter TRN Segment) is a valid segment with acceptable delimiters per the *NACHA Operating Rules* and does not exceed the 80 character overall maximum as required by the *NACHA Operating Rules*. The CAQH CORE EFT & ERA Operating Rules do not change the meaning, usage, or definition of the X12 v5010 835 data elements or the NACHA CCD+ data fields.

Use of the X12 v5010 835 TRN Segment data elements is referenced in Table 3.3-1 in Section 3.3, *CORE-required Minimum CCD+ Data Elements for Successful Reassociation*, of the CAQH CORE 370: EFT & ERA Reassociation (CCD+/835) Rule. Table 3.3-1 identifies the CORE-required minimum set of CCD+ data elements necessary for successful reassociation of the CCD+ and the X12 v5010 835. The CORE-required Minimum CCD+ Reassociation Data Elements include CCD+ Record #5, Field 9, *Effective Entry Date*, CCD+ Record #6, Field 6, *Amount*, and CCD+ Record #7, Field 3, *Payment Related Information*.

CCD+ Record #7 Field 3 corresponds to the X12 v5010 835 TRN Segment. As identified in the table, the X12 v5010 835 TRN Segment is composed of three required data elements (TRN01-481 Trace Type Code, TRN02-127 Reference Identification, and TRN03-509 Originating Company Identifier) and one situational data element (TRN04-127 Reference Identification). Combined with the X12 v5010 835 data elements from the BPR segment (BPR16 and BPR02), the X12 v5010 835 TRN Segment provides information required for the successful reassociation of the X12 v5010 835 and the CCD+.

For further guidance on the CAQH CORE 370 Rule requirements, please see *Section V. CAQH CORE 370: EFT & ERA Reassociation (CCD+/835) Rule*.

Please Note: As the Standards Development Organization (SDO) that develops and maintains the X12 v5010 835 standard, guidance on implementation of the X12 v5010 835 TR3 implementation guide, and its underlying standard, should be obtained from ASC X12. Information related to the meaning, use, and interpretation of ASC X12 Standards, Guidelines, and Technical Reports can be obtained from ASC X12 via its online ASC X12 Interpretation Portal. NACHA – The Electronic Payments Association is the SDO that maintains the CCD+ standard format. For questions related to the CCD+, or to NACHA in general, contact Priscilla Holland, Senior Director, at pholland@nacha.org.

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III. CAQH CORE 350: Health Care Claim Payment/Advice (835) Infrastructure Rule

NOTE: *The HHS Final Rule for operating rules for the EFT and ERA transactions adopts all the Phase III CAQH CORE EFT & ERA Operating Rules* ***except*** *those requirements pertaining to the use of Acknowledgements. Entities seeking CORE Certification must implement all of the CAQH CORE EFT & ERA Operating Rules applicable to their stakeholder type,* ***including*** *those rules & rule requirements pertaining to use of Acknowledgments.*

1. Why develop an infrastructure rule for exchange of the ASC X12 Health Care Claim Payment/Advice (835) transaction?

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

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

The following CAQH CORE Eligibility & Claim Status infrastructure requirements apply to the exchange of the X12 v5010 835:

CORE Infrastructure Rule Description	Applies to CAQH CORE Health Care Claim Payment/Advice (835) Infrastructure Rule?
Response Time	**N**
System Availability	**N**
Real Time Implementation Guide (TR3) Acknowledgement (999)	**N**
CORE Connectivity Safe Harbor	**Y**
Companion Guide	**Y**
Batch Implementation Guide (TR3) Acknowledgement (999)	**Y**
Dual Delivery of the X12 v5010 835 and Proprietary Paper Remittance Advices	**Y**

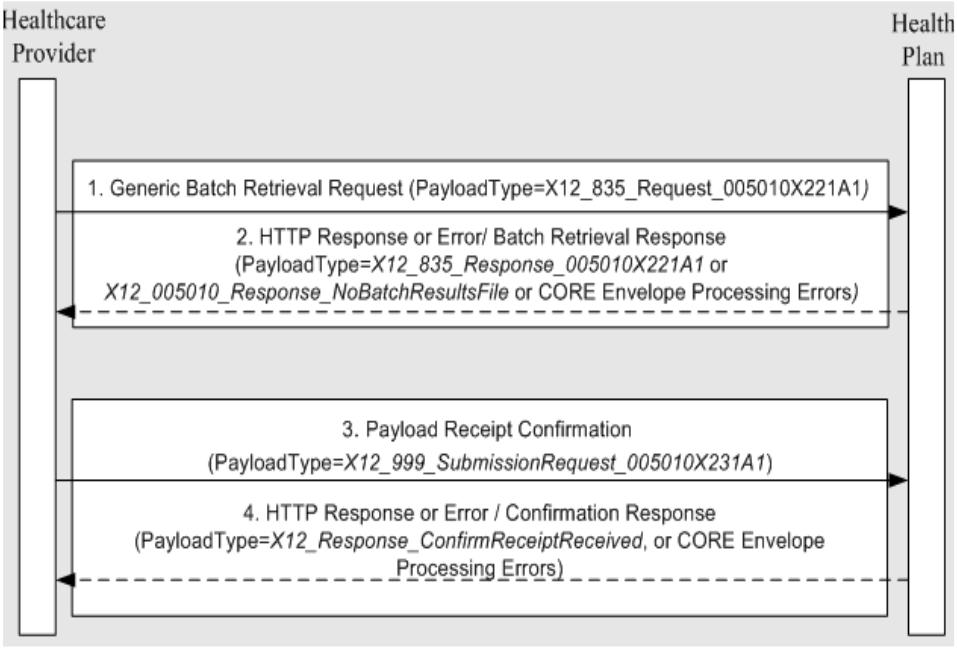
2. What are the CAQH CORE 350 Rule connectivity requirements for transmission of the X12 Health Care Claim Payment/Advice (835) transaction?

CAQH CORE 350: Health Care Claim Payment/Advice (835) Infrastructure Rule requires health plans to support the Phase II CAQH CORE 270: Connectivity Rule Version 2.2.0 to transmit the X12 v5010 835 ERA to providers. The CAQH CORE 153: Connectivity Rule, Version 1.1.0 and the CAQH CORE 270: Connectivity Rule, Version 2.2.0 together specify business rules and technical specifications for the CAQH CORE Connectivity "Safe Harbor". The CAQH CORE Safe Harbor is the connectivity method that application vendors,

providers, and health plans (or other information sources) can be assured will be supported by any HIPAA covered entity. Supporting the CAQH CORE Safe Harbor means the entity is capable and ready at the time of the request from a trading partner to exchange the transaction using the CORE Connectivity Rules. The CAQH CORE 350 Rule does *not* require trading partners to remove existing connections that do not match the rule, nor does is it require that all covered entities use only this method for all new connections. In some circumstances, you and your trading partners may decide to continue to use your current connection; *however, you must implement the capability to use the CAQH CORE Connectivity Safe Harbor and be capable and ready to use it when requested*.

3. What CAQH CORE Connectivity Rule requirements apply to the X12 v5010 835 per the CAQH CORE 350 Rule?

Only the batch requirements of the CAQH CORE 270: Connectivity Rule apply to the X12 v5010 835. Requirements for batch retrieval (pick up) and acknowledgements are identified in the CAQH CORE 270 Rule, Section 4. Additionally, CAQH CORE 270 Rule, Table 4.4.4.3.2 in Section 4.4.3, *Enumeration of Processing Mode and Payload Type Fields,* specifies the request and response payload types for batch interactions. As an example, the sequence diagram below depicts how the CAQH CORE 270 Rule requirements for a generic batch retrieval apply to the X12 v5010 835 transaction.



For further guidance on the CAQH CORE 270 Rule please see *Section XV. CAQH CORE 270: Connectivity Rule* of the CAQH CORE FAQs Part C: CAQH CORE Eligibility & Claim Status Operating Rules.

4. What are the CAQH CORE 350 Rule requirements for HIPAA covered entities to support dual delivery of the ERA and proprietary paper remittance advices?

Section 4.3 of the CAQH CORE 350 Rule includes a requirement for a "dual or parallel processing period" during which providers can continue to receive proprietary paper remittance advices as well as the HIPAA-mandated X12 v5010 835 standard transactions while they test the use of the X12 v5010 835 standard and associated operating rules. At the end of the dual or parallel processing period, "*If the provider determines it is unable to*

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

5. 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?

No. The CAQH CORE Operating Rules do not require any entity to publish a companion guide. CAQH CORE 350, Section 4.4, *Health Care Claim Payment/Advice Companion Guide*, specifies that, should an entity publish a company guide, it must conform to the format/flow as defined in the CAQH CORE v5010 Master Companion Guide Template.

6. Can I combine multiple transaction sets (i.e., X12 270/271 and X12 835) in a single companion guide?

Yes. Entities, may, if they wish, combine their companion guides for separate transactions into a single document. The flow and format of the CAQH CORE v5010 Master Companion Guide Template would still need to be followed, but sections could be repeated, tables added for the second transaction, etc., without altering said flow and format.

7. Is there a specific proprietary paper claim remittance advice format that health plans must use during the dual delivery period?

No. Section 4.3 of the CAQH CORE 350 Rule includes a requirement for a dual or parallel processing period during which providers can continue to receive proprietary paper claim remittance advice(s) as well as the HIPAA-mandated X12 v5010 835 standard format while they test the use of the X12 v5010 835 standard. The CAQH CORE 350 Rule does not define what type of a document constitutes a proprietary paper claim remittance advice or address the method used to deliver the proprietary paper claim remittance advice.

8. 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?

Per the CAQH CORE 350 Rule, Section 4.3, *Dual Delivery of X12 v5010 835 and Proprietary Paper Claim Remittance Advices*, at the end of the 31-day (or a minimum of 3 payments) dual or parallel processing period, "*If the provider determines it is unable to satisfactorily implement and process the health plan's electronic X12 v5010 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*." The rule also notes, "*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*."

9. Does the requirement for a dual delivery period in Section 4.3 of the CAQH CORE 350 Rule mean that health plans must create and send a proprietary paper claim remittance advice if they do not currently do so?

No. The CAQH CORE 350 Rule, Section 4.3, *Dual Delivery of X12 v5010 835 and Proprietary Paper Claim Remittance Advices*, requires a health plan to support dual delivery of the X12 v5010 835 and proprietary paper claim remittance advices for a period of 31 days (or a minimum of 3 payments), *if the health plan currently*

delivers proprietary paper claim remittance advices. If a health plan does not currently deliver proprietary paper claim remittance advices, the CAQH CORE 350 Rule does not require a health plan to start doing so.

NOTE: The CAQH CORE 350 Rule does not require health plans to continue to deliver proprietary paper claim remittance advices after the dual delivery period ends. However, "*If the provider determines it is unable to satisfactorily implement and process the health plan's electronic X12 v5010 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*."

10. My health plan provides the X12 v5010 835 via an online application only, do the CAQH CORE 350 Rule requirements apply?

The CAQH CORE Operating Rules apply to HIPAA transactions, which are healthcare electronic data interchanges (EDI); as such, the CAQH CORE 350 Rule does not apply when the X12 v5010 835 is provided via Direct Data Entry. However, CAQH CORE 350 Rule, Section 4.1, *Health Care Claim Payment/Advice Connectivity Requirements* requires health plans and other information sources to support the CAQH CORE 270: Connectivity Rule Version 2.2.0 to **transmit** the X12 v5010 835 ERA to providers. Thus while health plans may continue to offer the X12 v5010 835 via DDE, use of a website *only* to provide the X12 v5010 835 to providers *does not* satisfy the connectivity requirements of the CAQH CORE 350 Rule.

For further guidance on the CAQH CORE 270 Rule please see *Section XV. CAQH CORE 270: Connectivity Rule* of the CAQH CORE FAQs Part C: CAQH CORE Eligibility & Claim Status Operating Rules.

11. Are HIPAA covered entities required to implement the requirements in Section 4.2, *Health Care Claim Payment/Advice Batch Acknowledgement Requirements*, of the CAQH CORE 350 Rule to comply with the ACA Section 1104 Federal mandate?

No. The August 2012 HHS Final Rule adopting the CAQH CORE EFT & ERA Operating Rules *does not* adopt the Acknowledgement requirements in Section 4.2 of the CAQH CORE 350 Rule. The Final Rule does note that, *"without Acknowledgements, it is difficult for the sender to know whether the intended recipient received the transmission, which often results in the sender repeatedly querying the intended receiver as to the status of the transmission...until such time as the {Health and Human Services} Secretary adopts a standard for Acknowledgments, we support the industry's ongoing voluntary use of Acknowledgements and encourage even more widespread use."* The CAQH CORE 350 Rule supports the use of Acknowledgements.

12. 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?

No. Section 4.1, *Health Care Claim Payment/Advice Connectivity* Requirements, of the CAQH CORE 350 Rule requires all HIPAA covered entities to support use of the CORE Connectivity Safe Harbor described in the CAQH CORE 270: Connectivity Rule Version 2.2.0 to **transmit** or **receive** the X12 v5010 835. However, the CAQH CORE 350 Rule does not prohibit entities from using other connectivity methods to conduct the X12 v5010 835 or require entities to remove existing connections that do not match the CAQH CORE 270 Rule.

As a "Safe Harbor", the CAQH CORE 270 Rule specifies connectivity methods that application vendors, providers, and health plans can be assured will be supported by any HIPAA covered entity and/or a CORE-certified entity. Supporting the CAQH CORE Connectivity Safe Harbor means that the entity is capable and ready

to exchange data using the CAQH CORE 270 Rule at the time a request is made by a trading partner. The CORE Safe Harbor allows for an automated EDI-based process to conduct the X12 v5010 835 rather than a manual download process. In some circumstances, you and your trading partners may decide to continue to use your existing connection **transmit** or **receive** the X12 v5010 835, as permitted by the CAQH CORE Connectivity Safe Harbor. **However, you must implement the capability to use the CAQH CORE Connectivity Safe Harbor and be capable and ready to use it when requested by a trading partner**.

For further guidance on the CAQH CORE 270 Rule please see *Section XV. CAQH CORE 270: Connectivity Rule* of the CAQH CORE FAQs Part C: CAQH CORE Eligibility & Claim Status Operating Rules.

13. Section 4.1 of the CAQH CORE 350 Rule requires entities to support the CAQH CORE 270: Connectivity Rule Version 2.2.0 to send/receive the X12 v5010 835. The CAQH CORE 270 Rule requires health plans and clearinghouses to publish a Connectivity Companion Guide. Is this Connectivity Companion Guide the same as the health care claim payment/advice Companion Guide referenced in Section 4.4 of the CAQH CORE 350 Rule?

Connectivity Companion Guides are entity-specific guides that outline the requirements to establish and maintain a connection with the entity. Section 4.3.7, *Publication of Entity Specific Connectivity Guide*, of the CAQH CORE 270 Rule **requires** that all information servers (i.e., health plans and clearinghouses) publish an entity-specific Connectivity Companion Guide on their public web site. The Connectivity Companion Guide must include the entity's detailed specifications for the CAQH CORE Connectivity Safe Harbor as well as all custom extensions to the CAQH CORE Connectivity Safe Harbor and/or additional non-CAQH CORE connectivity methods supported by the entity. Per the requirements in Section 4.1, *Health Care Claim Payment/Advice Connectivity Requirements*, of the CAQH CORE 350 Rule, the Connectivity Companion Guide must also include the entity's connectivity requirements for transmitting the X12 v5010 835.

Beyond the Connectivity Companion Guide, health plans and clearinghouses can also choose to publish a Companion Guide describing the specifics of how the entity implements a particular HIPAA-mandated transaction standard. Companion Guides are entity-specific and "*define the health plans' requirements for situational data elements, and provide special instructions and further guidance on how the health plan is interpreting the* [HIPAA-mandated transaction standard] *Implementation Guides*." (See CMS FAQ#1819) Health plan and clearinghouse Companion Guides often vary in format and structure, which can be confusing to trading partners and providers. To address this issue, the CAQH CORE Operating Rules require that entity Companion Guides follow the flow and format defined in the CAQH CORE v5010 Master Companion Guide Template.

The CAQH CORE Operating Rules do not require any entity to publish a Companion Guide if they do not already do so. However, per Section 4.4, *Health Care Claim Payment/Advice Companion Guide*, of the CAQH CORE 350 Rule, if a health plan or clearinghouse **chooses** to publish a Companion Guide for the X12 v5010 835 transaction, it **must** conform to the format/flow as defined in the CAQH CORE v5010 Master Companion Guide Template.

If a health plan or clearinghouse chooses to publish an X12 v5010 835 Companion Guide, it may choose to include the Connectivity Companion Guide in the X12 v5010 835 Companion Guide or choose to publish it separately.

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14. My organization is a provider-facing clearinghouse. Are we required by the CAQH CORE 350 Rule to return an X12 v5010 999 Implementation Acknowledgement to health plans that do not request to receive the X12 v5010 999?

The CAQH CORE 350 Rule specifies requirements for use of the X12 v5010 999 Implementation Acknowledgement that are applicable to both senders and receivers of the X12 v5010 835. Per Section 4.2.1, *Use of the X12 v5010 999 Implementation Acknowledgement for Functional Group Acknowledgement*, of the CAQH CORE 350 Rule:

- Receivers of the X12 v5010 835 (i.e., providers and provider-facing clearinghouses) must return an X12 v5010 999 for each Functional Group of X12 v5010 835 transactions indicating that the Functional Group was either accepted, accepted with errors, or rejected and must also specify for each included X12 v5010 835 transaction set that the transaction set was either accepted, accepted with errors, or rejected.
- Senders of the X12 v5010 835 (i.e., health plans and health plan-facing clearinghouses) must be able to accept and process an X12 v5010 999 for a Functional Group of X12 v5010 835 transactions.

Good business practices for electronic message exchange encourage all senders and receivers to appropriately acknowledge both receipt and acceptance/rejection with errors found in any message. Therefore, the CAQH CORE 350 Rule requires that receivers of the X12 v5010 835 return an X12 v5010 999 to **all** trading partner senders, including those that do not explicitly request to receive the X12 v5010 999.

NOTE: The HHS Final Rule adopting the CAQH CORE EFT & ERA Operating Rules to fulfill the ACA Section 1104 mandate **does not** adopt the batch acknowledgement requirements in Section 4.2 of the CAQH CORE 350 Rule. Conformance with the CAQH CORE 350 Rule requirements regarding acknowledgements remains. Therefore, to meet the Federal requirements under the ACA entities do not have to comply with the rule requirements for Acknowledgements.

15. Does the CAQH CORE 350 Rule specify processing mode requirements for exchange of the X12 v5010 835?

Yes. Section 4.1, *Health Care Claim Payment/Advice Connectivity Requirements*, of the CAQH CORE 350 Rule requires entities to support the use of the CORE Connectivity Safe Harbor, as described in the CAQH CORE 270: Connectivity Rule Version 2.2.0, to send/receive the X12 v5010 835. Per Section 4.1, "*This requirement addresses usage patterns for **batch transactions**, the exchange of security identifiers, and communications-level errors and acknowledgements*."

To comply with the CAQH CORE 350 Rule requirements, entities must support batch processing of the X12 v5010 835, in conformance with the CAQH CORE 270 Rule requirements for batch processing mode. While the CAQH CORE 350 Rule does not require the exchange of the X12 v5010 835 in real time, it does not prohibit it. Therefore, conducting the X12 v5010 835 in real time could be mutually agreed to between trading partners.

For further guidance on the CAQH CORE 270 Rule please see *Section XV. CAQH CORE 270: Connectivity Rule* of the CAQH CORE FAQs Part C: CAQH CORE Eligibility & Claim Status Operating Rules.

16. Per Section 4.2 of the CAQH CORE 350 Rule, "*health plans must be able to accept and process an X12 v5010 999 for a Functional Group of X12 v5010 835 transactions*." Does the CAQH CORE 350 Rule explicitly define what "processing" means for this requirement?

No. The CAQH CORE 350 Rule does not explicitly define what it means to "process" an X12 v5010 999 Implementation Acknowledgement. Receivers of the X12 v5010 835 (i.e., providers and provider-facing clearinghouses) return an X12 v5010 999 to indicate that a Functional Group of X12 v5010 835 transactions has been accepted, accepted with errors, or rejected. Given the different scenarios that the X12 v5010 999 could be indicating, a health plan could have internal logic for how to process and respond to each particular scenario. For example, a health plan might determine that processing an X12 v5010 999 indicating a rejection would lead to correction of errors and resending of the Functional Group of X12 v5010 835s.

NOTE: The HHS Final Rule adopting the CAQH CORE EFT & ERA Operating Rules to fulfill the ACA Section 1104 mandate **does not** adopt the batch acknowledgement requirements in Section 4.2 of the CAQH CORE 350 Rule. Conformance with the CAQH CORE 350 Rule requirements regarding acknowledgements remains. Therefore, to meet the Federal requirements under the ACA entities do not have to comply with the CAQH CORE 350 Rule requirements for Acknowledgements.

17. The CAQH CORE 350 Rule requires entities to support the requirements for batch processing of the X12 v5010 835 specified in the CAQH CORE 270: Connectivity Rule Version 2.2.0. In Section 4.2.2.1 of the CAQH CORE 270 Rule the payload value for the Batch Results Retrieval Request is specified as "*minOccurs='0'*." Does this value mean that entities are not required to include a Payload in the request?

Yes. Section 4.2.2.1, *CORE Phase II Connectivity XML Schema Specification (normative)*, of the CAQH CORE 270 Rule specifies a value of minOccurs="0" for the Payload element because the Batch Results Retrieval Request does not always require a payload (e.g., if there is no batch available for retrieval). As the intent of the Batch Results Retrieval Request is to pick up a batch (or batches) and not to deliver a payload, the Batch Results Retrieval Request may have only a SOAP envelope and no payload.

Please Note: The CAQH CORE 350 Rule does not prohibit entities from using other connectivity methods to conduct the X12 v5010 835 or require entities to remove existing connections that do not match the CAQH CORE 270 Rule.

For further guidance on the CAQH CORE 270 Rule please see *Section XV. CAQH CORE 270: Connectivity Rule* of the CAQH CORE FAQs Part C: CAQH CORE Eligibility & Claim Status Operating Rules.

18. Does the CAQH CORE 350 Rule require health plans to support transmission of the X12 v5010 835 to providers via the public Internet?

Yes. Section 4.1, *Health Care Claim Payment/Advice Connectivity Requirements*, of the CAQH CORE 350 Rule requires health plans and other information sources to support the CAQH CORE 270: Connectivity Rule Version 2.2.0 to **transmit** the X12 v5010 835 ERA to providers. (**NOTE:** Other connectivity methods can also be used.) The CAQH CORE 270 Rule requires entities to support delivery of the X12 v5010 835 via the public Internet using HTTP with SSL as the minimum security for the communications channel with specific envelopes, metadata, and submitter authentication methods.

Please Note: As noted above, the CAQH CORE 350 Rule **does not** prohibit entities from using other connectivity methods to transmit the X12 v5010 835 nor require entities to remove existing connections that do not match the CAQH CORE 270 Rule.

For further guidance on the CAQH CORE 270 Rule please see *Section XV. CAQH CORE 270: Connectivity Rule* of the CAQH CORE FAQs Part C: CAQH CORE Eligibility & Claim Status Operating Rules.

CAQH CORE is the authoring entity for two sets of ACA Section 1104 mandated Federal operating rules.

This document is for informational purposes only; in the case of a discrepancy between this document and CAQH CORE Operating Rule text and/or Federal regulations, the latter take(s) precedence.

19. My organization is a health plan that sends the X12 v5010 835 to some providers through a clearinghouse acting as a business associate of the provider. Does the CAQH CORE 350 Rule require that we accept an X12 v5010 999 Implementation Acknowledgement from this clearinghouse?

NOTE: The HHS Final Rule adopting the CAQH CORE EFT & ERA Operating Rules to fulfill the ACA Section 1104 mandate **does not** adopt the batch acknowledgement requirements in Section 4.2 of the CAQH CORE 350 Rule. HIPAA covered entities **do not** have to comply with the CAQH ORE 350 Rule requirements for Acknowledgements to meet the Federal requirements under the ACA.

Good business practices for electronic message exchange encourage all senders and receivers to appropriately acknowledge both receipt and acceptance/rejection with errors found in any message. Therefore, the CAQH CORE 350 Rule specifies requirements for use of the X12 v5010 999 Implementation Acknowledgement that apply to **both** senders and receivers of the X12 v5010 835, *although conformance with these requirements remains under the ACA Federal mandate.*

Per Section 4.2.1, *Use of the X12 v5010 999 Implementation Acknowledgement for Functional Group Acknowledgement*, of the CAQH CORE 350 Rule:

- Receivers of the X12 v5010 835 (i.e., providers and clearinghouses acting as a business associate of a provider) must return an X12 v5010 999 for each Functional Group of X12 v5010 835 transactions indicating that the Functional Group was either accepted, accepted with errors, or rejected and must also specify for each included X12 v5010 835 transaction set that the transaction set was either accepted, accepted with errors, or rejected.
- Senders of the X12 v5010 835 (i.e., health plans and clearinghouses acting as a business associate of a health plan) must be able to accept and process an X12 v5010 999 for a Functional Group of X12 v5010 835 transactions.

20. My organization is a health plan. As part of our X12 v5010 835 error handling process, we currently send a proprietary paper remittance advice (RA) in lieu of an out of balance X12 v5010 835. Does the CAQH CORE 350 Rule require that we discontinue this error handling process after the dual-delivery period has ended?

The CAQH CORE 350 Rule does not address a health plan's internal error handling processes that may require the plan to send a paper RA to a provider in lieu of an out-of-balance X12 v5010 835.

Section 4.3, *Dual Delivery of X12 v5010 835 and Proprietary Paper Claim Remittance Advices*, of the CAQH CORE 350 Rule requires health plans that currently deliver a proprietary paper RA to support a dual or parallel processing period during which providers can continue to receive proprietary paper RAs while they test the use of the X12 v5010 835 standard and associated operating rules. The required timeframe for the dual delivery period is 31 days (or a minimum of 3 payments). **Note:** If a health plan does not currently deliver proprietary paper RAs, the CAQH CORE 350 Rule **does not** require the plan to start doing so.

At the end of the dual delivery period, "*both the provider and health plan **may mutually agree** to continue delivery of the proprietary paper claim remittance advices*." Additionally, "*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*."

Please Note: The CAQH CORE 350 Rule builds on the ASC X12 v5010 835 transaction standard. In addition to complying with the CAQH CORE 350 Rule requirements, health plans must also comply with the ASC X12N v5010 835 TR3 implementation guide when using the X12 v5010 835. Therefore, health plans should ensure that the balancing requirements specified in the ASC X12N v5010 835 TR3 implementation guide are met. 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 via its online ASC X12 Interpretation Portal.

21. The CAQH CORE 350 Rule requires health plans to support the CAQH CORE 270: Connectivity Rule to transmit the X12 v5010 835. Our organization is a health plan that currently transmits several X12 v5010 835 transactions in a single payload. Does the CAQH CORE 270 Rule specify a maximum number of X12 v5010 835 transactions that can be sent in a single payload?

No. Section 4.1, *Health Care Claim Payment/Advice Connectivity Requirements,* of the CAQH CORE 350 Rule requires all health plans to support use of the CAQH CORE Connectivity Safe Harbor described in the CAQH CORE 270: Connectivity Rule Version 2.2.0 to **transmit** the X12 v5010 835. (**NOTE:** Providers are also required to support use of the CAQH CORE 270 Rule to **receive** the X12 v5010 835.)

The CAQH CORE 270 Rule neither requires nor prohibits the inclusion of multiple transaction sets, Functional Groups, or ASC X12 Interchanges in a single payload. Section 6.1, *Appendix and Definitions Used in this Rule*, of the CAQH CORE 270 Rule defines a payload of batch files as a single submission containing either:

- **One** X12 Interchange containing **one** Functional Group containing **one** X12 transaction set consisting of more than one business transaction. **OR**
- **More than one** ASC X12 Interchange, each of which may contain **one or more** Functional Groups, each of which may contain **one or more** ASC X12 transaction sets.

Information sources of the X12 v5010 835 (i.e., health plans and clearinghouses/vendors acting as a business associate of a health plan) may choose to include multiple X12 v5010 835s in a single payload or send each X12 v5010 835 transaction in separate payloads.

22. The CAQH CORE 350 Rule requires health plans to support the CAQH CORE 270: Connectivity Rule to transmit the X12 v5010 835. Our organization is a health plan that currently limits the size of the batch X12 v5010 835 file sent in a single payload to prevent problems with the receiver's system performance. Does the CAQH CORE 270 Rule prohibit health plans from setting a maximum limit for the size of the X12 v5010 835 batch file sent in a single payload?

No. Section 4.1, *Health Care Claim Payment/Advice Connectivity Requirements*, of the CAQH CORE 350 Rule requires all health plans to support use of the CAQH CORE Connectivity Safe Harbor described in the CAQH CORE 270: Connectivity Rule Version 2.2.0 to **transmit** the X12 v5010 835. (**NOTE:** Providers are also required to support use of the CAQH CORE 270 Rule to **receive** the X12 v5010 835).

Section 3.6, *Outside the Scope of this Rule*, of the CAQH CORE 270 Rule specifies that the maximum size of a batch file accepted by a server is out of scope of the CAQH CORE 270 Rule. This applies both when batch files are "pushed" by the health plan to the provider (i.e., the health plan acts as a server) and when the provider sends a request to receive available files (i.e., the provider is acting minimally as a client). The CAQH CORE 270 Rule does require entities that conduct batch processing to have the capability to receive and process large batch transaction files (see Section 4.3.5.2). However, per Section 4.3.5, *Capacity Plan*, of the CAQH CORE 270 Rule,

the maximum number of transaction sets to be included in a large batch file is an issue to be negotiated between trading partners.

Senders of the X12 v5010 835 (i.e., health plans and clearinghouses/vendors acting as a business associate of a health plan) should work with their trading partners to establish reasonable limits for the maximum size of batch files that can be supported by their trading partners. Any system size limitations should be specified in an entity's Connectivity Companion Guide. For additional guidance on the Connectivity Companion Guide required by the CAQH CORE 270 Rule see "*Is this Connectivity Companion Guide the same as the health care claim payment/advice Companion Guide referenced in Section 4.4 of the CAQH CORE 350 Rule?*"

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IV. CAQH CORE 360: Uniform Use of CARCs and RARCs (835) Rule

1. Does my health plan organization have to support CORE-required Code Combinations that are not applicable to our business needs?

No. If a health plan does not have a business requirement to use a specific combination(s) within the maximum set of CORE-required Code Combinations for each CORE-defined Business Scenario, the CAQH CORE 360 Rule does not require the health plan, or its PBM agent, to use the code combination(s). CAQH CORE 360 Rule, Section 4.1.3, *Use of CORE-required CARC/RARC/CAGC/NCPDP Reject Code Combinations*, specifies that: "*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 is not required to use them.*"

2. Do all of the CARCs in the CORE-required Code Combinations tables have to be used with a corresponding RARC?

No. Any CARC in the CORE-required Code Combinations tables that is not required, by definition, to be used with a corresponding RARC may be used without any associated RARCs.

Claim Adjustment Reason Codes (CARCs) communicate the reason for a financial adjustment to a particular claim or service referenced in the X12 v5010 835. Remittance Advice Remark Codes (RARCs) provide supplemental information about why claim or service line has not been paid in full.

The majority of CARCs do not require RARCs to complete the message; however, there are some specific CARCs that always require use of an explanatory RARC. The CARC definition identifies if the code requires the use of a RARC. The Claim Adjustment Reason Codes list, which includes the code definitions, is available at the Washington Publishing Company website HERE.

3. To what types of entities do the requirements in Section 4.2, *Basic Requirements for Receivers of the X12 v5010 835,* of the CAQH CORE 360 Rule apply?

Section 4.2 of the CAQH CORE 360 Rule specifies requirements applicable to provider-facing vendor products that receive the X12 v5010 835 and extract the data content. Section 4.2 specifies the descriptive text that the provider-facing products must display to the provider end-user.

4. Why does the CAQH CORE 360 Rule require a minimum set of CORE-defined Business Scenarios with a maximum set of CORE-required Code Combinations to be supported by all health plans and their PBM agents?

As outlined in Section 1, *Background Summary*, of the CAQH CORE 360 Rule, the X12 v5010 835 delivers information to the provider regarding the payment of a claim and why the claim has not been paid in full (or has been rejected). This information is delivered via combinations of codes from four code sets (CARCs, RARCs, CAGCs, and NCPDP Reject Codes), used to supply the provider with the necessary detailed information regarding the payment of the claim.

Extensive confusion throughout the healthcare industry due to the inconsistent and varied use of these codes led the CORE Participants to determine that the healthcare industry would greatly benefit from operating rules that

establish a maximum set of code combinations to be used for common Business Scenarios (in order to drive consistent and uniform use of these codes).

A maximum set of code combinations was determined for four common, high-volume Business Scenarios in the CAQH CORE 360 Rule. The CAQH CORE 360 Rule allows a health plan to develop additional Business Scenarios to meet its business needs. Long-term, a goal for the industry is to develop a uniform maximum set of code combinations for all Business Scenarios, but a multi-step process is needed to reach such a goal—in order to provide clear, well-researched requirements and build upon real-world results.

5. How were the *minimum* CORE-defined Claim Adjustment/Denial Business Scenarios and applicable *maximum* set of CORE-required Code Combinations identified?

The four specific Business Scenarios in the CAQH CORE 360 Rule were selected as they represent some of the most confusing and high volume scenarios that are exchanged between health plans and providers. The CORE Participants then agreed on a maximum set of CORE-required Code Combinations for the four CORE-defined Business Scenarios based on extensive data, and with the knowledge that the CAQH CORE 360 Rule specifically requires the list of CORE-required Code Combinations to be revisited at least three times annually. The data used included a mix of public surveys to target the issue, in-depth analysis of real-world code combinations in use by many existing industry initiatives, and claims-based CARC/RARC usage data by public and private entities. This cross-industry analysis led to the development of the CORE-required Code Combinations.

NOTE: The CAQH CORE 360 Rule does allow health plans, or their PBM agents, to develop additional Business Scenarios, and applicable code combinations, when the CORE-defined Business Scenarios do not meet their business needs. Additionally, per the CAQH CORE Code Combinations Maintenance Process, the *CORE-required Code Combinations for CORE-defined Business Scenarios* are maintained and updated due to evolving code lists and industry needs.

6. 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?

Yes. Section 4.2 of the CAQH CORE 360 Rule requires that products extracting data from an X12 v5010 835 for manual processing must make available to the end user:

- *"Text describing the CARC/RARC/CAGC and CARC/NCPDP Reject Codes included in the remittance advice, 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*
- *Text describing the corresponding CORE-defined Claim Adjustment/Denial Business Scenario*"

Descriptions of each CORE-defined Claim Adjustment/Denial Business Scenario can be found in Table 4.1.1-1 in the CAQH CORE 360 Rule. For the text describing the CARC/RARC/CAGC and CARC/NCPDP Reject Codes, see:

- For descriptions of the CARCs and RARCs: The Washington Publishing Company website Claim Adjustment Reason Codes list HERE and Remittance Advice Remark Codes list HERE
- For descriptions of the CAGC: The ASC X12N v5010 835 Technical Report Type 3
- For descriptions of the NCPDP Reject Codes: The NCPDP External Code List HERE

7. Does my provider-facing product satisfy the requirements under Section 4.2, *Basic Requirements for Receivers of the X12 v5010 835*, of the CAQH CORE 360 Rule if it displays only the descriptions of the CARC/RARC/CAGC and CARC/NCPDP Reject Codes include in the X12 v5010 835?

No. Section 4.2 of the CAQH CORE 360 Rule requires that products extracting data from an X12 v5010 835 for manual processing must make available to the end user:

- *"Text describing the CARC/RARC/CAGC and CARC/NCPDP Reject Codes included in the remittance advice, 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*
- *Text describing the corresponding CORE-defined Claim Adjustment/Denial Business Scenario*"

Displaying only the description of the CARCs and RARCs does not satisfy the Section 4.2 requirement.

Descriptions of each CORE-defined Claim Adjustment/Denial Business Scenario can be found in Table 4.1.1-1 in the CAQH CORE 360 Rule. For the text describing the CARC/RARC/CAGC and CARC/NCPDP Reject Codes, see:

- For descriptions of the CARCs and RARCs: The Washington Publishing Company website Claim Adjustment Reason Codes list HERE and Remittance Advice Remark Codes list HERE
- For descriptions of the CAGC: The ASC X12N v5010 835 Technical Report Type 3
- For descriptions of the NCPDP Reject Codes: The NCPDP External Code List HERE

8. How does the CAQH CORE 360 Rule address the need for the CORE-required Code Combinations for CORE-defined Business Scenarios to align with changes to the published CARC and RARC lists made by the respective Code Maintenance Committees as well as ongoing and evolving industry business needs?

The goal of the CAQH CORE 360 Rule is to ensure consistent use of the CARCs and RARCs across the industry. Section 3.5, *CORE Process for Maintaining CORE-defined Claim Adjustment Reason Code, Remittance Advice Remark Code & Claim Adjustment Group Code Combinations*, of the CAQH CORE 360 Rule supports the concept that the CORE-defined Business Scenarios and the CORE-required Code Combinations will evolve over time to ensure ongoing compliance with the published code lists and evolving industry needs.

Section 3.5 of the CAQH CORE 360 Rule highlights key components for a CAQH CORE Code Combinations Maintenance Process; specifically, the rule:

- Recognizes that the CAQH CORE 360 Rule supports the X12 v5010 835 mandated standard
- Focuses on four key business scenarios (with associated code combinations) as a starting point
- Recognizes that the CAQH CORE 360 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 and meet at least three times per year
- Recognizes that the CAQH CORE 360 Rule 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
- 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*

Additionally, the CAQH CORE Guiding Principles require that the CAQH CORE Operating Rules align with current standards, codes sets, and other Federal initiatives.

Per the CAQH CORE Code Combinations Maintenance Process updated versions of the *CORE-required Code Combinations for CORE-defined Business Scenarios* have been released. For more detail on the CAQH CORE Code Combinations Maintenance Process see "*How are the CORE-required Code Combinations for CORE-defined Business Scenarios maintained via the CAQH CORE Code Combinations Maintenance Process?"*

9. How are the *CORE-required Code Combinations for CORE-defined Business Scenarios* maintained via the CAQH CORE Code Combinations Maintenance Process?

To meet the requirements of the CAQH CORE 360 Rule for an open, consensus-based maintenance process and ensure ongoing alignment with the current published CARC and RARC lists maintained by their respective Code Maintenance Committees, the CAQH CORE Code Combinations Maintenance Process was launched in 2012 via the CAQH CORE Code Combinations Task Group.

CAQH CORE conducts two types of review and adjustment of the CORE Code Combinations:

- **Compliance-based Reviews**: Occur three times per year and **only** consider additions, deactivations, or modifications to the current published CARC and RARC lists by the code committees since the last update to the *CORE-required Code Combinations for CORE-defined Business Scenarios*
- **Market-based Reviews:** Occur once a year and address ongoing and evolving industry business needs, a Market-based Review considers **industry submissions** addressing:
    - Adjustments to the **existing** CORE-required Code Combinations for **existing** CORE-defined Business Scenarios (additions, removals, etc.) based on real world usage data and/or a strong business case
    - Addition of **new** CORE-defined Business Scenarios and associated code combinations based on real world usage data and a strong business case

The CAQH CORE Code Combinations Task Group, which is responsible for maintaining the CORE-required Code Combinations, is open to representatives from any CORE Participating Organization. Individuals from CORE Participating Organizations with knowledge of the related business process and work flow of the usage of the CARCs and RARCs are encouraged to join.

10. What is a CAQH CORE Code Combinations Compliance-based Review? When do these reviews occur?

Per the CAQH CORE Code Combinations Maintenance Process, Compliance-based Reviews occur three times per year and **only** consider additions, deactivations, or modifications to the published CARC and RARC lists by the code committees since the last update to the *CORE-required Code Combinations for CORE-defined Business Scenarios*.

A Compliance-based Review is triggered when the current published CARC and RARC lists are updated, which occurs three times per year. The CAQH CORE Code Combinations Task Group, which is responsible for maintaining the CORE-required Code Combinations, will review any additions, deactivations, or modifications to the published CARC and RARC lists by the code committees since the last update to the *CORE-required Code Combinations for CORE-defined Business Scenarios*. Once the Task Group agrees on adjustments a new version of the *CORE-required Code Combinations for CORE-defined Business Scenarios* is published, an announcement to the industry is distributed, and the CAQH CORE website is updated.

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11. What is a CAQH CORE Code Combinations Market-based Review? When do these reviews occur?

Per the CAQH CORE Code Combinations Maintenance Process, Market-based Reviews occur once a year and address ongoing and evolving industry business needs, a Market-based Review considers **industry submissions** addressing:

- Adjustments to the **existing** CORE-required Code Combinations for **existing** CORE-defined Business Scenarios (additions, removals, etc.) based on real world usage data and a strong business case
- Addition of **new** CORE-defined Business Scenarios and associated code combinations based on real world usage data and a strong business case

12. How can my organization submit codes for consideration during the CAQH CORE Code Combinations Market-based Review?

Per the established CAQH CORE Code Combinations Maintenance Process, Market-based Reviews occur once a year. The 2015 Market-based Review (MBR) of the CORE-required Code Combinations for CORE-defined Business Scenarios launched in December 2015. The 2015 MBR will consider adjustments to the code combinations in the *existing* four CORE-defined Business Scenarios.

CAQH CORE distributed a call for industry submissions with a link to an online form that entities can use to submit recommendations for potential Market-based Adjustments during the 60-day submission period. Email core@caqh.org to be added to the distribution list. You can also access the online CAQH CORE 2015 Market-based Adjustments Form HERE during the 60-day submission period.

13. Our health plan uses a code combination that meets the definition of a CORE-defined Business Scenario but is not currently included in the scenario's maximum set of CORE-required Code Combinations in the *CORE-required Code Combinations for CORE-defined Business Scenarios*. How can we request addition of this code combination to the CORE-required maximum set?

To better align with the existing CORE-required Code Combinations for CORE-defined Business Scenarios, your health plan should first consider if there is CORE-required Code Combination already in the current, published version of the *CORE-required Code Combinations for CORE-defined Business Scenarios* that conveys the same meaning as the excluded code. If so, your health plan could use the published code combination in order to align with the goals of the CAQH CORE 360 Rule, which promotes uniform and consistent code usage across the industry.

Additionally, your health plan may elect to submit a request for the code combination to be added to the CORE-defined Business Scenario for consideration during the annual Market-based Review of the *CORE Code Combinations*. Market-based Reviews occur once a year and address ongoing and evolving industry business needs. For each annual Market-based Review, CAQH CORE will distribute a call for industry submissions with a link to an online form that entities can use to submit recommendations for potential Market-based Adjustments. For more information on how to submit a request for a potential Market-based Adjustment to the *CORE Code Combinations*, contact core@caqh.org.

Health plans can also evaluate if the code combination constitutes a potential "emergency code combination addition" to the *CORE Code Combinations.* A criteria-based CAQH CORE Emergency Code Combination Addition Process, developed in collaboration with and response to the CMS Office of E-Health Standards and Services (OESS), enables a nimble emergency review and potential emergency addition of existing code combinations. Such an emergency addition would mean the codes are not included in the most current version of

the *CORE Code Combinations* and the entity cannot wait until the next Compliance-based or Market-based Review due to new legislation, regulation, or a brand new product. The process outlines steps and criteria to ensure adherence to the term "emergency" and a focus by the industry on planning for the reoccurring Market-based and Compliance-based Reviews. The CAQH CORE Emergency Code Combination Addition Process will evolve over time based on industry experience. If you determine the code combinations meets the criteria outlined, please submit an Emergency Update Request using the form found HERE.

14. Does the CAQH CORE 360 Rule apply to batch, real time, or both batch and real time processing of the X12 v5010 835?

The CAQH CORE 360 Rule applies to both batch and real time processing. Per Section 3.3, *When the Rule Applies*, of the CAQH CORE 360 Rule, "*This rule applies when an entity uses, conducts or processes the X12 v5010 835.*" Therefore, anytime an entity uses, conducts, or processes the X12 v5010 835, whether in real time or in batch processing mode, the rule applies.

15. How can my organization submit new Business Scenarios for consideration during the CAQH CORE Code Combinations Market-based Review?

Per the established CAQH CORE Code Combinations Maintenance Process, CAQH CORE conducts two types of review and adjustment of the CORE Code Combinations: Compliance-based Reviews and Market-based Reviews occur once a year and address ongoing and evolving industry business needs. A Market-based Review considers industry submissions addressing:

- Adjustments to the *existing* CORE-required Code Combinations for *existing* CORE-defined Business Scenarios (additions, removals, etc.) based on real world usage data and/or a strong business case
- Addition of *new* CORE-defined Business Scenarios and associated code combinations based on real world usage data and a strong business case

The 2015 Market-based Review (MBR) of the CORE-required Code Combinations for CORE-defined Business Scenarios will **only** consider adjustments to the code combinations in the *existing* four CORE-defined Business Scenarios. Entities can submit requests for Market-based Adjustments to the *existing* CORE-defined Business Scenarios via the online CAQH CORE 2015 Market-based Adjustments Form. Requests for new CORE-defined Business Scenarios cannot be submitted via the 2015 MBR form.

NOTE: The CORE Code Combinations Task Group is currently considering the 2014 industry submissions for new CORE-defined Business Scenarios. During its review of the 2014 new CORE-defined Business Scenario submissions, the Task Group will determine a later date to collect additional submissions for potential *new* CORE-defined Business Scenarios. To be added to the distribution list to receive notification when additional potential *new* CORE-defined Business Scenarios are collected, email core@caqh.org.

16. My organization is a health plan. What adjustments do we need to make to our internal system to conform to the CAQH CORE 360 Rule requirements for health plan use of the CORE-defined Claim Adjustment/Denial Business Scenarios and CORE-required Code Combinations?

The CAQH CORE 360 Rule specifies a **minimum** set of CORE-defined Claim Adjustment/Denial Business Scenarios with an associated **maximum** set of CORE-required Code Combinations. CAQH CORE 360 Rule Sections 4.1.2, *Uniform Use of Claim Adjustment Reason Codes, Remittance Advice Remark Codes, Claim Adjustment Group Codes & NCPDP Reject Codes*, and 4.1.3, *Use of CORE-required CARC/RARC/CAGC/NCPDP Reject Code Combinations*, require a health plan, or its PBM agent, to:

- Align its internal codes and corresponding business scenarios to the CORE-defined Business Scenarios and code combinations specified in the *CORE-required Code Combinations for CORE-defined Business Scenarios*
    - **NOTE:** If a health plan does not have a business requirement to use a specific CORE-required Code Combination(s), the health plan, or its PBM agent, is **not** required to use the code combination(s).
- Support the **maximum** set of CORE-required code combinations as specified in the *CORE-required Code Combinations for CORE-defined Business Scenarios*; no other code combinations beyond the CORE-required set are allowed for use with the CORE-defined Business Scenarios.
    - **NOTE:** When a new code is created or an existing code adjusted by the respective code maintenance committees, the new or adjusted code can be used with the CORE-defined Business Scenarios until its continued used is reviewed per the CAQH CORE Code Combinations Maintenance Process.

Additionally, the CAQH CORE 360 Rule allows a health plan, or its PBM agent, to use additional business scenarios, and associated code combinations, beyond those specified in the *CORE-required Code Combinations for CORE-defined Business Scenarios* when the CORE-defined Business Scenarios do not meet its business needs.

17. As a health plan, are we allowed by the CAQH CORE 360 Rule to use code combinations that are *not* included in the *CORE-required Code Combinations for CORE-defined Business Scenarios* for *other* business scenarios beyond the minimum set of CORE-defined Business Scenarios?

Yes. The CAQH CORE 360 Rule allows a health plan, or its PBM agent, to develop additional business scenarios, and associated code combinations, when the CORE-defined Business Scenarios do not meet its business needs.

However, per Section 4.1.3, *Use of CORE-required CARC/RARC/CAGC/NCPDP Reject Code Combinations*, of the CAQH CORE 360 Rule, a health plan, or its PBM agent, cannot use other code combinations beyond the CORE-required maximum set **with the CORE-defined Business Scenarios.** Additionally, per Section 4.1.1, *CORE-defined Claim Adjustment/Denial Business Scenarios*, any **additional** business scenarios **must not** conflict with the CORE-defined Business Scenarios.

NOTE: Per the CAQH CORE Code Combinations Maintenance Process, the CORE-defined Business Scenarios and CORE-required Code Combinations will evolve over time; new CORE-defined Business Scenarios and associated code combinations will be added based on real world usage data and a strong business case. For information on how to submit Business Scenarios for consideration to be added to the CORE-defined set, see "*How can my organization submit new Business Scenarios for consideration during the CAQH CORE Code Combinations Market-based Review?*"

18. Within the *CORE-required Code Combinations for CORE-defined Business Scenarios*, there are code combinations that include the same RARC in *multiple* CORE-defined Business Scenarios. As a health plan, to which CORE-defined Business Scenario should we map this RARC within our internal system?

Per Section 4.1.2, *Uniform Use of Claim Adjustment Reason Codes, Remittance Advice Remark Codes, Claim Adjustment Group Codes & NCPDP Reject Codes*, of the CAQH CORE 360 Rule, a health plan (or its PBM agent) must "*align its internal codes and corresponding business scenarios to the 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 CORE-required Code Combinations for CORE-defined Business Scenarios.doc*."

If a single RARC is included in code combinations for **multiple** CORE-defined Business Scenarios, the health plan should map the RARC to **all associated CORE-defined Business Scenarios.**

NOTE: If a health plan does not have a business requirement to use a specific CORE-required Code Combination(s), the health plan, or its PBM agent, is **not** required to use the code combination(s).

19. Within the *CORE-required Code Combinations for 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?

Per Section 4.1.2, *Uniform Use of Claim Adjustment Reason Codes, Remittance Advice Remark Codes, Claim Adjustment Group Codes & NCPDP Reject Codes*, of the CAQH CORE 360 Rule, a health plan (or its PBM agent) must "*align its internal codes and corresponding business scenarios to the 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 CORE-required Code Combinations for CORE-defined Business Scenarios.doc*."

If a single RARC is included in **multiple** code combinations for **a single** CORE-defined Business Scenario, the health plan should map the RARC to **one or all associated code combinations** for the specific CORE-defined Business Scenario.

NOTE: If a health plan does not have a business requirement to use a specific CORE-required Code Combination(s), the health plan, or its PBM agent, is **not** required to use the code combination(s).

20. My organization is a health plan. *All* of the CORE-required Code Combinations for a specific CORE-defined Business Scenario are not applicable to our business needs. Does the CAQH CORE 360 Rule require a health plan to use CORE-defined Business Scenarios for which none of the maximum set of CORE-required Code Combinations is applicable to its business needs?

No. If a health plan does not adjust or deny claims according to any of the CORE-required Code Combinations for a specific CORE-defined Business Scenario, the CAQH CORE 360 Rule does not require the health plan, or its PBM agent, to use that Business Scenario.

Section 4.1.3, *Use of CORE-required CARC/RARC/CAGC/NCPDP Reject Code Combinations*, of the CAQH CORE 360 Rule specifies that: "*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 is not required to use them".* If **all** of the CORE-required Code Combinations for a specific CORE-defined Business Scenario are not applicable to a health plan's business needs, the health plan is not required to use any of the code combinations and, therefore, would not use the CORE-defined Business Scenario.

21. My organization is a health plan. We currently use some of the CARCs and RARCs in the CORE-required Code Combinations for *additional* business scenarios (and associated code combinations) that we maintain in conjunction with the four CORE-defined Business Scenarios. Does the CAQH CORE 360 Rule permit us to continue to use these codes in our additional (non-CORE) business scenarios and code combinations?

Yes. A health plan, or its PBM agent, may use any CARCs, RARCs, NCPDP Reject Codes, and/or CAGCs included in the CORE-required Code Combinations for **additional** (non-CORE) business scenarios, and associated code combinations, *providing that the additional business scenarios, and code combinations, **do not***

conflict with the CORE-required Code Combinations for the CORE-defined Business Scenarios, e.g. the same code combination cannot be used for multiple business scenarios.

Per Sections 4.1.1, *CORE-defined Claim Adjustment/Denial Business Scenarios*, and 4.1.2, *Uniform Use of Claim Adjustment Reason Codes, Remittance Advice Remark Codes, Claim Adjustment Group Codes & NCPDP Reject Codes*, of the CAQH CORE 360 Rule, a health plan (or its PBM agent):

- Must align its internal codes and corresponding business scenarios to the CORE-defined Business Scenarios, and associated code combinations, as specified in the *CORE-required Code Combinations for CORE-defined Business Scenarios*. No additional code combinations beyond the CORE-required maximum set are allowed **for use with the CORE-defined Business Scenarios**.
    - **NOTE:** Per Section 4.1.3, *Use of CORE-required CARC/RARC/CAGC/NCPDP Reject Code Combinations*, when a new code is created or an existing code adjusted by the respective code maintenance committees, the new or adjusted code can be used with the CORE-defined Business Scenarios until its continued used is reviewed per the CAQH CORE Code Combinations Maintenance Process.
- May develop additional business scenarios, and associated code combinations, when the CORE-defined Business Scenarios do not meet its business needs. Any additional business scenarios **must not** conflict with the CORE-defined Business Scenarios.

Please Note: The intent of the CAQH CORE 360 Rule is that all CARCs should be mapped to a single claim denial/adjustment business scenario in order to promote uniform and consistent CARC use across the industry. This intent is highlighted in the evaluation criteria that were used by the CORE Participants to develop the CORE-required Code Combinations and are also used by the CAQH CORE Code Combinations Task Group to evaluate potential adjustments to the CORE-required Code Combinations. The criteria state that "*Each* (CORE-required) *CARC must be used with only one CORE-defined Business Scenario"*.

22. Some of the CORE-required Code Combinations in the *CORE-required Code Combinations for CORE-defined Business Scenarios* include only a CARC and CAGC (i.e., these is no RARC listed for use). As a health plan, does the CAQH CORE 360 Rule allow us to include a RARC in this CORE-required Code Combination for use with the CORE-defined Business Scenario?

No. A health plan must not add a RARC to any CORE-required Code Combinations that include only a CARC and a CAGC. Including an unlisted RARC constitutes creation of a new code combination beyond the maximum CORE-required Code Combinations. As noted below, the CAQH CORE 360 Rule prohibits a health plan, and its PBM agent, from using additional code combinations beyond the CORE-required maximum set **with the CORE-defined Business Scenarios**.

Per Sections 4.1.1, *CORE-defined Claim Adjustment/Denial Business Scenarios*, and 4.1.2, *Uniform Use of Claim Adjustment Reason Codes, Remittance Advice Remark Codes, Claim Adjustment Group Codes & NCPDP Reject Codes*, of the CAQH CORE 360 Rule, a health plan (or its PBM agent):

- Must align its internal codes and corresponding business scenarios to the CORE-defined Business Scenarios, and associated code combinations, as specified in the *CORE-required Code Combinations for CORE-defined Business Scenarios*. No additional code combinations beyond the CORE-required maximum set are allowed for use **with the CORE-defined Business Scenarios**.
    - **NOTE:** Per Section 4.1.3, *Use of CORE-required CARC/RARC/CAGC/NCPDP Reject Code Combinations*, when a new code is created or an existing code adjusted by the respective code maintenance committees, the new or adjusted code can be used with the CORE-defined Business Scenarios until its continued used is reviewed per the CAQH CORE Code Combinations Maintenance Process.

- May develop additional business scenarios, and associated code combinations, when the CORE-defined Business Scenarios do not meet its business needs. Any additional business scenarios **must not** conflict with the CORE-defined Business Scenarios.

23. Does the CAQH CORE 360 Rule specify a maximum length for the description of the CARCs and RARCs that provider facing products extracting data from the X12 v5010 835 must display to the end user, per Rule Section 4.2?

No. The CAQH CORE 360 Rule does not specify requirements regarding the length of the text describing the CARC/RARC/CAGC and CARC/NCPDP Reject Codes that provider facing products extracting data from the X12 v5010 835 must display to the end user per Section 4.2, *Basic Requirements for Receivers of the X12 v5010 835*.

To meet the Section 4.2 requirements for descriptions of the CARC/RARC/CAGC and CARC/NCPDP Reject Code/CAGC vendor products should provide text using the code descriptions issued in the published code lists which are authored by the code committees. For the code descriptions, see:

- For descriptions of the CARCs and RARCs: The Washington Publishing Company website Claim Adjustment Reason Codes list HERE and Remittance Advice Remark Codes list HERE
- For descriptions of the CAGC: The ASC X12N v5010 835 Technical Report Type 3
- For descriptions of the NCPDP Reject Codes: The NCPDP External Code List HERE

24. Does the CAQH CORE 360 Rule require health plans to develop and use additional business scenarios beyond those included in the minimum set of CORE-defined Business Scenarios?

No, the CAQH CORE 360 Rule does not require health plans to develop and use additional business scenarios beyond the CORE-defined Business Scenarios.

Section 4.1.1, *CORE-defined Claim Adjustment/Denial Business Scenarios*, of the CAQH CORE 360 Rule specifies that, "*When a specific CORE-defined Business Scenario is not applicable to meet the health plan's, or its PBM agent's, business needs, a health plan or its PBM agent* ***may*** *develop additional Business Scenarios and code combinations for them. Any additional Business Scenarios must not conflict with the CORE-defined Claim Adjustment/Denial Business Scenarios defined in this section.*" This language is included to clarify that the CAQH CORE Rule allows health plans to develop additional business scenarios to fulfill business needs not addressed by the minimum set of CORE-defined Business Scenarios. However, the CAQH CORE Rule does not **require** health plans to develop these scenarios.

25. My organization is a health plan. We currently use CARCs, RARCs, and/or CAGCs that are *n*ot included in the maximum set of CORE-required Code Combinations and *do not* apply to any of the CORE-defined Business Scenarios. Does the CAQH CORE 360 Rule require us to make any changes to our internal system mappings specific to these CARCs, RARCs, or CAGCs?

No. The CAQH CORE 360 Rule does not require health plans to alter their internal system mappings for CARC, RARC, or CAGC codes that are not included in the *CORE-required Code Combinations for CORE-defined Business Scenarios*. Beyond the requirement for health plans to align their internal codes and business scenarios with the CORE-required Code Combinations, the CAQH CORE 360 Rule does not require additional changes to a health plan's internal code mapping.

Please Note:

- Per Section 4.1.3, *Use of CORE-required CARC/RARC/CAGC/NCPDP Reject Code Combinations*, of the CAQH CORE 360 Rule, a health plan, or its PBM agent, cannot use other code combinations beyond the CORE-required maximum set **with the CORE-defined Business Scenarios.** If a health plan's internal system currently maps additional code combinations beyond the CORE-required maximum set to the CORE-defined Business Scenarios, the health plan will have to remediate it system to remove these non-conformant mappings.
- The CAQH CORE Code Combinations Maintenance Process anticipates that the *CORE-required Code Combinations for CORE-defined Business Scenarios* will be adjusted at least three times per year to ensure ongoing compliance with the published code lists and address evolving industry needs. New Business Scenarios, and associated code combinations, will be added based on real world usage data and a strong business case. Your organization should check the CAQH CORE website periodically as reviews occur. CAQH CORE also sends an email notification when an updated version of the *CORE-required Code Combinations for CORE-defined Business Scenarios* is published; email core@caqh.org to be added to the distribution list.

26. Section 4.2 of the CAQH CORE Rule specifies requirements for text that a product extracting the data from the X12 v5010 835 for manual processing must make available to the end user. How is "manual processing" defined for this requirement?

Section 4.2, *Basic Requirements for Receivers of the X12 v5010 835*, of the CAQH CORE 360 Rule requires products extracting the data from the v5010 X12 835 for manual processing to display:

- *"Text describing the CARC/RARC/CAGC and CARC/NCPDP Reject Codes included in the remittance advice, 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*
- *Text describing the corresponding CORE-defined Claim Adjustment/Denial Business Scenario*"

As referenced in the CAQH CORE 360 Rule, "manual processing" refers to any data processing conducted via human manipulation, i.e., processing not done automatically by a machine. This reference includes any manual intervention by a human that is required to post the X12 v5010 835 to the provider's Practice Management System (PMS).

27. Per Section 3.3, the CAQH CORE 360 Rule applies when entities process the X12 v5010 835 in either real time or batch. Does this requirement mean that the CAQH CORE 360 Rule requires entities to support *both* batch and real time processing of the X12 v5010 835?

No. Per Section 3.3, *When the Rule Applies*, of the CAQH CORE 360 Rule, the CAQH CORE 360 Rule applies when an entity uses, conducts, or processes the X12 v5010 835, **either** in real time or batch processing mode. The CAQH CORE 360 Rule **does not** specify requirements regarding what processing mode entities must support for the X12 v5010 835.

The CAQH CORE 350: Health Care Claim Payment/Advice (835) Infrastructure Rule does specify one processing mode that entities must offer for the X12 v5010 835 (other processing modes can also be offered). Section 4.1, *Health Care Claim Payment/Advice Connectivity Requirements*, of the CAQH CORE 350 Rule requires entities to support the use of the CORE Connectivity Safe Harbor, as described in the CAQH CORE 270: Connectivity Rule Version 2.2.0, to send/receive the X12 v5010 835. Per Section 4.1, "*This requirement addresses usage patterns for **batch transactions**, the exchange of security identifiers, and communications-level errors and acknowledgements*."

To comply with the CAQH CORE 350 Rule requirements, entities must support batch processing of the X12 v5010 835, in conformance with the CAQH CORE 270 Rule requirements for batch processing mode. While the CAQH 350 CORE Rule does not require the exchange of the X12 v5010 835 in real time, it does not prohibit it. Therefore, conducting the X12 v5010 835 in real time could be mutually agreed to between trading partners.

28. How will organizations be notified about and access new versions of the *CORE-required Code Combinations for CORE-defined Business Scenarios*?

Per the CAQH CORE Code Combinations Maintenance Process, CAQH CORE conducts two types of review and adjustment to the CORE-required Code Combinations and CORE-defined Business Scenarios:

- **Compliance-based Reviews**: Occur three times per year and **only** consider additions, deactivations, or modifications to the current published CARC and RARC lists by the code committees since the last update to the *CORE-required Code Combinations for CORE-defined Business Scenarios*
- **Market-based Reviews:** Occur once a year and address ongoing and evolving industry business needs; consider **industry submissions** for adjustments to the ***existing*** CORE-required Code Combinations for existing CORE-defined Business as well as addition of ***new*** CORE-defined Business Scenarios, and associated code combinations, based on real world usage data and a strong business case
    - **NOTE:** Any organization can submit potential adjustments for consideration during the Market-based Review. A call for submissions of Market-based Adjustments via a pre-defined template will be distributed by CAQH CORE and recommendations can be submitted via the template during the submission timeframe.

Once the Compliance-based and/or Market-based Adjustments have been approved, an updated version of the *CORE-required Code Combinations for CORE-defined Business Scenarios* will be published. Publication of an updated version of the *CORE-required Code Combinations for the CORE-defined Business Scenarios* will be announced on the CAQH CORE webpage. CAQH CORE will also send email notifications when updated versions of the *CORE-required Code Combinations for CORE-defined Business Scenarios* are published; email core@caqh.org to be added to the distribution list. Updated versions of the *CORE-required Code Combinations for CORE-defined Business* can be accessed free of charge via the CAQH CORE website HERE.

For more detail on the CAQH CORE Code Combinations Maintenance Process see "*How are the CORE-required Code Combinations for CORE-defined Business Scenarios maintained via the CAQH CORE Code Combinations Maintenance Process?*"

29. What is the schedule for adjustments to be made to the *CORE-required Code Combinations for CORE-defined Business Scenarios*?

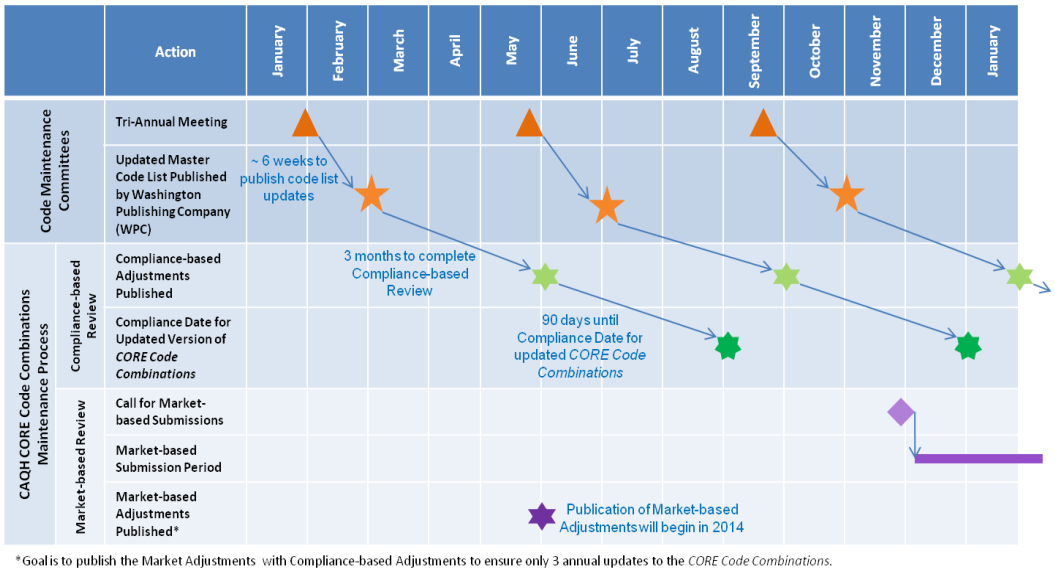
Per the CAQH CORE Code Combinations Maintenance Process, CAQH CORE conducts two types of review and adjustment to the CORE-required Code Combinations and CORE-defined Business Scenarios:

- **Compliance-based Reviews**: Occur ***three times per year*** and **only** consider additions, deactivations, or modifications to the current published CARC and RARC lists by the code committees since the last update to the *CORE-required Code Combinations for CORE-defined Business Scenarios*
    - Compliance-based Reviews are triggered when the current published CARC and RARC lists are updated, which occurs three times per year.
- **Market-based Reviews:** Occur once a year and address ongoing and evolving industry business needs; consider **industry submissions** for adjustments to the ***existing*** CORE-required Code Combinations for existing CORE-defined Business as well as addition of ***new*** CORE-defined Business Scenarios, and associated code combinations, based on real world usage data and a strong business case

- **NOTE:** Any organization can submit potential adjustments for consideration during the Market-based Review. A call for submissions of Market-based Adjustments via a pre-defined template will be distributed by CAQH CORE and recommendations can be submitted via the template during the submission timeframe.

The goal for the CAQH CORE Code Combinations is to publish three versions of the *CORE-required Code Combinations for CORE-defined Business Scenarios* per year to ensure ongoing compliance with the published code lists and address evolving industry needs. One version of the document will include both Compliance and Market-based updates. As entities align their systems to the CORE-required Code Combinations and CORE-defined Business Scenarios, they should incorporate processes that allow system remediation to occur three times per year.

Timeline for Maintenance of CORE-required Code Combinations for CORE-defined Business Scenarios



*Goal is to publish the Market Adjustments with Compliance-based Adjustments to ensure only 3 annual updates to the *CORE Code Combinations*.

For more detail on the CAQH CORE Code Combinations Maintenance Process see "*How are the CORE-required Code Combinations for CORE-defined Business Scenarios maintained via the CAQH CORE Code Combinations Maintenance Process?*"

30. What is an Entry Confirmation Email?

An Entry Confirmation Email is sent to the submitter after each new entry (e.g., a specific code combination addition, removal, or relocation) is received by CAQH CORE. The Entry Confirmation Email is useful to submitters as it includes a copy of that entry for their records (including evaluation criteria selected, business case, usage data, etc.).

The Entry Confirmation Email also includes a Unique Entry ID. The Unique Entry ID allows the submitter to track the progress of their submissions and avoid duplicate entries given you can delete entries. Submitters will receive an Entry Confirmation Email for each entry made in Part II of the online CAQH CORE 2015 Market-based Adjustments Form. As an example, if a submitter includes **5** code additions, **2** code deletions, and **2** code relocations in their organization's total submission, they will receive **9** confirmation emails. You **MUST** complete all required fields in order to finalize an entry and receive your Entry Confirmation Email.

31. What is the purpose of the Unique Entry ID?

The Unique Entry ID allows the submitter to track the progress of their submissions and avoid duplicate entries. For submitters that start and stop their submission over multiple days, these emails will help them track where they are in the submission process. Additionally, submitters can use the Unique Entry ID to identify an entry if they decide to delete it.

32. How can an entry be deleted?

To delete an entry, submitters will need either the Unique Entry ID associated with the entry to be deleted or the specific codes submitted in the entry. From the *Navigation Page for 2015 Market-based Adjustments Submissions* webpage, select "Delete a Previous Entry". A drop down list will be provided from which submitters can select a previously entered submission. The submissions will be identified by the Unique Entry ID and the CARC/RARC/CAGC combination submitted.

33. What type of adjustments to the *CORE-required Code Combinations for CORE-defined Business Scenarios* will be considered during the 2015 Market-based Review?

The 2015 Market-based Review (MBR) will **only** consider adjustments to the code combinations in the *existing* four CORE-defined Business Scenarios. The online CAQH CORE 2015 Market-based Adjustments Form will enable entities to submit requests for additions, removals, and relocations to the code combinations in the *existing* four CORE-defined Business Scenarios.

NOTE: As the CORE Code Combinations Task Group is currently considering the 2014 industry submissions for new CORE-defined Business Scenarios, CAQH CORE is **not** collecting additional submissions for potential new CORE-defined Business Scenarios as part of the 2015 MBR. During its review of the 2014 new CORE-defined Business Scenario industry submissions, the Task Group will determine a later date to collect additional submissions for potential *new* CORE-defined Business Scenarios. To be added to the distribution list to receive notification when additional potential *new* CORE-defined Business Scenarios are collected, email core@caqh.org.

34. What type of adjustments to the code combinations in the *existing* CORE-defined Business Scenarios can be submitted on the CAQH CORE 2015 Market-based Adjustments Form?

As shown in the table below, potential adjustments to the code combinations in the *existing* CORE-defined Business Scenarios may include:

- **Addition** or **removal** of existing *CORE Code Combinations*
- **Relocation** of a *CORE Code Combination* from an *existing* CORE-defined Business Scenario to another *existing* CORE-defined Business Scenario

Additions	Removals	Relocations
1. Add CARC and RARC along with a CAGC(s)	1. Remove CARC and all associated RARCs and CAGC(s)	1. Remove CARC and ***all*** associated RARCs from an *existing* CORE-defined Business Scenario and add to another *existing* CORE-defined Business Scenario with associated CAGC(s)
2. Add CARC along with a CAGC(s)	2. Remove RARC and associated CAGC(s) from existing CARC	2. Remove CARC and ***all*** associated RARCs from an *existing* CORE-defined Business Scenario and add CARC and ***some or no***

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This document is for informational purposes only; in the case of a discrepancy between this document and CAQH CORE Operating Rule text and/or Federal regulations, the latter take(s) precedence.

Additions	Removals	Relocations
		associated RARCs to another *existing* CORE-defined Business Scenario with associated CAGC(s)
3. Add RARC to an existing CARC along with a CAGC(s)	3. Remove CAGC(s) from existing CARC	
4. Add CAGC(s) to an existing CARC	4. Remove an existing CAGC(s) from an existing CARC and RARC combination	
5. Add CAGC(s) to an existing CARC and its associated RARC		

35. Can adjustments for potential new CORE-defined Business Scenarios can be submitted via the online CAQH CORE 2015 Market-based Adjustments Form?

No, adjustments for *new* CORE-defined Business Scenarios **cannot** be submitted via the CAQH CORE 2015 Market-based Adjustments Form. The 2015 MBR will **only** consider adjustments to the code combinations in the *existing* CORE-defined Business Scenarios.

NOTE: As the CORE Code Combinations Task Group is currently considering the 2014 industry submissions for new CORE-defined Business Scenarios, CAQH CORE is **not** collecting additional submissions for potential new CORE-defined Business Scenarios as part of the 2015 MBR. During its review of the 2014 new CORE-defined Business Scenario industry submissions, the Task Group will determine a later date to collect additional submissions for potential *new* CORE-defined Business Scenarios. To be added to the distribution list to receive notification when additional potential *new* CORE-defined Business Scenarios are collected, email core@caqh.org.

36. Does the Market-based Review (MBR) Form validate the CARCs and RARCs to ensure that they are valid codes?

Yes, the online CAQH CORE 2015 Market-based Adjustments Form validates CARC and RARC entries against the 11/01/15 code lists published by the Washington Publishing Company (WPC), the authorized publisher of the CARC and RARC lists. The Code Committee authors have designated WPC as their publisher. CAQH CORE is validating the codes against these lists given all entities must use the codes that the independent CARC and RARC Committees publish three times a year; the 11/01/15 lists are the current list of codes.

NOTE: CAQH CORE is not the entity that develops and maintains the CARC and RARC lists:

- The CARC list is maintained by the Claim Adjustment Status Code Maintenance Committee. The Committee meets during each ASC X12 trimester meeting to determine any additions, modifications, or deactivations to the published CARC list. Updated lists are published online in March, July, and November by WPC.
- The RARC list is maintained by the CMS Remittance Advice Remark Code Committee. The published RARC list is updated tri-annually at the end of March, July, and November and published online by WPC.

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37. When will the approved Market-based Adjustments be published?

After the Market-based Review (MBR) Submission Period closes on 02/10/16, the CORE Code Combinations Task Group (CCTG) will begin its review of submissions. It is expected that the review process will take several CCTG meetings, given the potential volume of MBR submissions. CAQH CORE anticipates that the updated version of the CORE-required Code Combinations for CORE-defined Business Scenarios, scheduled for publication on 06/06/16, will include both the Market-based and Compliance-based adjustments (due to the 03/01/16 published code list updates) approved by the CCTG.

For more information on the CCTG and timeline for publication of new versions of the CORE-required Code Combinations see *"What is the schedule for adjustments to be made to the CORE-required Code Combinations for CORE-defined Business Scenarios?"*

38. If I submit an adjustment via the Market-based Review (MBR), will it automatically be added to the CORE-required Code Combinations?

No. The CORE Code Combinations Task Group (CCTG) will review all entries and supporting information for each entry (i.e., Evaluation Criteria, Business Case, and Discretionary Usage Data) submitted via the MBR submission process.

Using the CORE-required Code Combinations Evaluation Criteria, the CCTG will discuss and conduct straw polls as needed to determine CCTG support for Market-based code combination adjustments to the *CORE-required Code Combinations* and the addition of new CORE-defined Business Scenarios. These evaluation criteria were used by the CORE Participants to develop the CORE-required Code Combinations and are also used by the Task Group to evaluate potential adjustments to the *CORE-required Code Combinations*.

The CCTG may not approve all MBR submissions received given the goal of the CAQH CORE 360 Rule is to enable more uniform use of the CARC, RARC, and CAGCs across the industry. Rather than increasing the number of code combinations in use in the industry, the CAQH CORE 360 Rule aims to identify CARC/RARC/CAGC combinations that clearly convey the reason for a claim payment adjustment/denial while avoiding redundant code combinations.

For more information on the CCTG and the CAQH CORE Code Combinations Maintenance Process see "*How are the CORE-required Code Combinations for CORE-defined Business Scenarios maintained via the CAQH CORE Code Combinations Maintenance Process?*"

39. Why do I have to submit supporting information (i.e., an assessment of the CORE-required Code Combination Evaluation Criteria, a Business Case, and discretionary Real World Usage Data) for each Market-based Review (MBR) entry in my submission?

The CORE Code Combinations Task Group (CCTG) spent significant time and effort to design the CAQH CORE Market-based Adjustments Form. The CCTG reached agreement on a set of evaluation criteria and useful supporting information to ensure meaningful submissions from the industry to help to inform their review process. Thus, the online MBR Form includes collection of critical supporting information related to each individual entry on a submission, i.e., an assessment of the CORE Code Combinations Evaluation Criteria, a Business Case, and discretionary Real World Usage Data.

The purpose of collecting this supporting information for each entry is two-fold:

1. It prevents entities from submitting lists of code combinations without fully considering the rationale for an adjustment or denial and the value it adds to the *CORE-required Code Combinations*. This ensures a clean, useful set of code combinations is received.
2. It will inform CCTG discussion and decisions related to MBR submissions and help ensure thoughtful maintenance occurs.

40. My organization is a health plan that currently has a code combination that we use consistently. We have submitted this code combination for addition to the CORE-required Code Combinations. However, as the Market-based Review (MBR) updates will not be published until 06/01/14, how can we ensure compliance with CAQH CORE 360 Rule for 01/01/14?

The HHS Final Rule adopting the Federally-mandated CAQH CORE EFT & ERA Operating Rules was announced in April 2013 and requires HIPAA covered entity compliance by 01/01/14. As of 01/01/14, the CMS Office of E-Health Standards and Services (OESS) and HHS will enforce compliance with the CAQH CORE 360 Rule and the *CORE-required Code Combinations for CORE-defined Business Scenarios* using its HIPAA enforcement processes. CAQH CORE conducted extensive outreach and education to build awareness of the compliance timeline, the CAQH CORE Code Combinations Maintenance Process, and the need for entities to develop ongoing maintenance processes to implement updated versions of the *CORE Code Combinations* via free industry education sessions, presentations at industry events, distribution of tools and educational materials, etc.

The goal of CAQH CORE 360 Rule is to enable more uniform use of the CARC, RARC, and CAGCs across the industry. Rather than increasing the number of code combinations in use in the industry, the CAQH CORE 360 Rule aims to identify CARC/RARC/CAGC combinations that clearly convey the reason for a claim payment adjustment/denial while avoiding redundant code combinations. As such, some entities will need to remediate their systems to allow for ongoing alignment with the current version of the CORE-required Code Combinations for CORE-defined Business Scenarios.

As a reminder, the CAQH CORE 360 Rule allows a health plan, or its PBM agent, to develop additional business scenarios, and associated code combinations, when the CORE-defined Business Scenarios do not meet its business needs. However, per Section 4.1.3 of the CAQH CORE 360 Rule, a health plan, or its PBM agent, cannot use other code combinations beyond the CORE-required maximum set **with the CORE-defined Business Scenarios.** Additionally, per Section 4.1.1, *CORE-defined Claim Adjustment/Denial Business Scenarios*, of the CAQH CORE 360 Rule any **additional** business scenarios **must not** conflict with the CORE-defined Business Scenarios.

For more information on the CAQH CORE 360 Rule requirements for health plans see "*My organization is a health plan. What adjustments do we need to make to our internal system to conform to the CAQH CORE 360 Rule requirements for health plan use of the CORE-defined Claim Adjustment/Denial Business Scenarios and CORE-required Code Combinations?*"

41. Does CAQH CORE offer additional methods that organizations can use to submit Market-based Review (MBR) submissions beyond the online CAQH CORE 2015 Market-based Adjustments Form?

No. The online MBR Form is the only method entities may use to submit requests for additions/removals and/or relocations to the code combinations in the *existing* CORE-defined Business Scenarios. Use of the online MBR Form ensures proper tracking and aggregation of submissions.

42. If I hit "Finish Survey" on Part II of my organization's online CAQH CORE 2015 Market-based Adjustments Form and realize, prior to the 02/10/16 submission deadline that I need to add additional entries to my submission, is a process available for my organization to add these entries?

Yes. Your organization may use your unique survey link from your Part I confirmation email to add any additional entries prior to the 02/10/16 submission deadline even if you selected "Finish Survey" previously.

43. My organization is a subsidiary of a much larger company. The online Market-based Review (MBR) Form requires one submission per organization. However, I do not know who will be submitting from my organization. Can I submit a separate online MBR Form?

No. Only one MBR Form may be submitted per legal entity. Entities are encouraged to coordinate within their organization to ensure only one MBR Form is submitted. The online MBR Form allows multiple users within one organization to access and submit entries. This functionality allows organizations to coordinate their submission entry in the most appropriate way for their individual organization. For example, an organization may choose to have a single individual responsible for submitting each entry or choose to have several individuals located in various subsidiaries each submit individual entries that are coordinated within your organization prior to entry on the MBR.

44. What resources are available to assist entities in submitting potential Market-based Adjustments for consideration during the CAQH CORE 2015 Market-based Review of the *CORE-required Code Combinations for CORE-defined Business Scenarios*?

There are several resources available to assist entities in submitting a response for the 2015 Market-based Review (MBR):

- Detailed instructions to assist in the completion of the online form are available HERE.
- A sample completed CAQH CORE 2015 Market-based Adjustments Form is also available HERE for consultation as entities plan their submission. **NOTE:** The Sample Form is to be used only as a guide for entities to consider their submissions The Sample Form **cannot** be used to submit requests for Market-based Adjustments to the *CORE-required Code Combinations for the CORE-defined Business Scenarios* for consideration by the CORE Code Combinations Task Group.
- On 12/16/15, CAQH CORE held a training session to provide the industry with guidance on completing the 2015 MBR submission process. Materials from this training, including a video recording of the training, are available online HERE.

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V. CAQH CORE 370: EFT & ERA Reassociation (CCD+/835) Rule

1. What is the intent of the enhancement to the *NACHA Operating Rules* described in the CAQH CORE 370 Rule, Section 4.4, *Cross-Industry Needs: Role of NACHA Operating Rules for the Financial Institutions to Support Health Care*?

Section 4.4 of the CAQH CORE 370 Rule identifies several cross-industry needs identified by CORE Participants during development of the Phase III CAQH CORE EFT & ERA Operating Rules. NACHA – The Electronic Payments Association is the organization responsible for the development and maintenance of the *NACHA Operating Rules* which govern the ACH Network and maintains the CCD+ standard format. To address the identified cross-industry needs, in November 2012, NACHA adopted a new healthcare payments rule as part of the *NACHA Operating Rules*. The rule supports health plans' and health care providers' use of the CCD+ for electronic healthcare claims payments, and the electronic "reassociation" of these payments with electronic remittance advices (ERAs).

As the authoring entity for the operating rules governing the ACH Network and standards development organization (SDO) for the CCD+, guidance on industry implementation of the CCD+ should be sought from NACHA. Questions can be sent to Priscilla Holland, Senior Director, at pholland@nacha.org. Information on the new health care EFT and ERA standards, and other health care payments news is also available on NACHA's Healthcare Payments Resource Site at http://healthcare.nacha.org.

2. What method should health plans use to inform providers to contact their financial institution to arrange for delivery of the CORE-required Minimum CCD+ Data Required for Reassociation?

Section 4.1, *Receipt of the CORE-required Minimum CCD+ Data Required for Reassociation,* of the CAQH CORE 370 Rule requires health plans to "*proactively inform the healthcare provider during EFT (Healthcare EFT Standards) and ERA (X12 v5010 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*…" The CAQH CORE Rule does not specify a method that health plans must use to inform providers to contact their financial institutions; the method used can be determined by each entity.

One potential method is to include a notification in the instructions for completing the EFT enrollment form. The CAQH CORE 380: EFT Enrollment Data Rule requires health plans to "*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*." Health plans may choose to use these instructions to inform providers to contact their financial institutions.

Additionally, CAQH CORE has developed a Sample Provider EFT Reassociation Data Request Letter which contains instructions and a letter template that a provider receiving EFT payments may customize and email to its banks or use as talking points for a phone or in person meeting with its bank contacts to request delivery of the CORE-required Minimum CCD+ Data Elements (i.e. the ACH Payment Related Information) via a secure, electronic means. Health plans may share this sample letter with providers to assist them with contacting their financial institutions.

3. Does the CAQH CORE 370 Rule apply to healthcare claim payments made via EFT transaction standards (e.g., Fedwire, card payment networks, CTX, etc.) other than the HIPAA-mandated Healthcare EFT Standards (the NACHA CCD+ and the X12 v5010 835 TR3 TRN Segment)?

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No. Per Section 3.4, *When the Rule Applies*, of the CAQH CORE 370 Rule, "*This rule applies when an entity uses, conducts, or processes the X12 v5010 835 and the Healthcare EFT Standards*." Healthcare claim payments made via non-HIPAA-mandated EFT transaction standards (e.g., Fedwire) are out of scope for the CAQH CORE 370 Rule.

4. What data elements should health plans track to demonstrate conformance with the CAQH CORE 370 Rule required maximum elapsed time between release of the CCD+ and the X12 v5010 835?

Section 4.2.2 of the CAQH CORE 370 Rule requires that health plans track and audit the elapsed time between sending of the X12 v5010 835 and the CCD+ to ensure the elapsed time requirement is met ninety percent of the time as measured within a calendar month.

The CAQH CORE 370 Rule does not specify the exact data elements to be included in the audit log; this data can be determined by each entity. However, as the CAQH CORE 370 Rule, Section 4.2 specifies that the release date for the X12 v5010 835 must be based on the CCD+ Effective Entry Date, CAQH CORE recommends that the data elements captured in the audit log include both the CCD+ Effective Entry Date and the date on which the X12 v5010 835 was actually released for transmission.

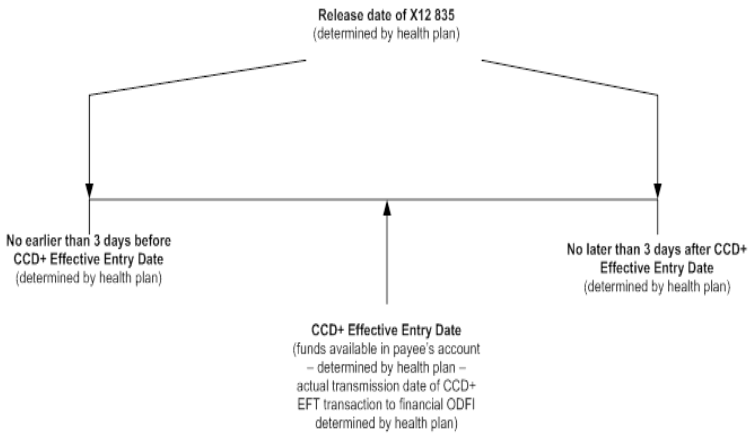
5. When does the "three business days" maximum elapsed timeframe between release of the CCD+ and the X12 v5010 835 begin and end?

Section 4.2, *Elapsed Time between Sending the X12 v5010 835 and the CCD+ Transactions*, of the CAQH CORE 370 Rule requires health plans to release the X12 v5010 835:

- *"No sooner than three business days based on the time zone of the health plan prior to the CCD+ Effective Entry Date*
  And
- *No later than three business days after the CCD+ Effective Entry Date."*

The elapsed time requirement means that a health plan *must not* send the corresponding X12 v5010 835 earlier than three business days *prior to* the CCD+ Effective Entry Date or later than three business days *after* the CCD+ Effective Entry Date.

The figure below presents a visual representation of the requirement for the timeframe of the release of the X12 v5010 835 with respect to the CCD+ Effective Entry Date.



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6. If the CCD+ Effective Entry Date is a Thursday and a valid banking day, e.g., Thursday, May 4, 2013, what is the earliest and latest date that the health plan can release the X12 v5010 835 and meet the elapsed time requirements of the CAQH CORE 370 Rule?

For the example described above, if the CCD+ Effective Entry Date is Thursday, May 4 (and a valid banking day), assuming the health plan's business days are Monday through Friday, the timeline would be the following:

- Monday, May 1 would be "three business days" *prior* to the CCD+ Effective Entry Date.
- Tuesday, May 2 would be "two business days" *prior* to the CCD+ Effective Entry Date.
- Wednesday, May 3 would be "one business day" *prior* to the CCD+ Effective Entry Date.
- Friday, May 5 would be "one business day" *after* the CCD+ Effective Entry Date.
- Monday, May 8 would be "two business days" *after* the CCD+ Effective Entry Date.
- Tuesday, May 9 would be "three business days" *after* the CCD+ Effective Entry Date.

Therefore, the health plan could release the X12 v5010 835 *as soon as, but not before*, Monday, May 1, and *as late as, but not after*, Tuesday, May 9.

7. Does the "three business days" maximum elapsed time between release the X12 v5010 835 and the CCD+ Effective Entry Date have hour-to-hour requirements?

No. The CAQH CORE 370 Rule requirement for health plans to release the X12 v5010 835 "*no sooner than three business days based on the time zone of the health plan prior to the CCD+ Effective Entry Date*" and "*No later than three business days after the CCD+ Effective Entry Date*" for transmission to the provider means that a health plan must not send the corresponding X12 v5010 835:

- Earlier than three business days **prior to** the CCD+ Effective Entry Date
- Or later than three business days **after** the CCD+ Effective Entry Date.

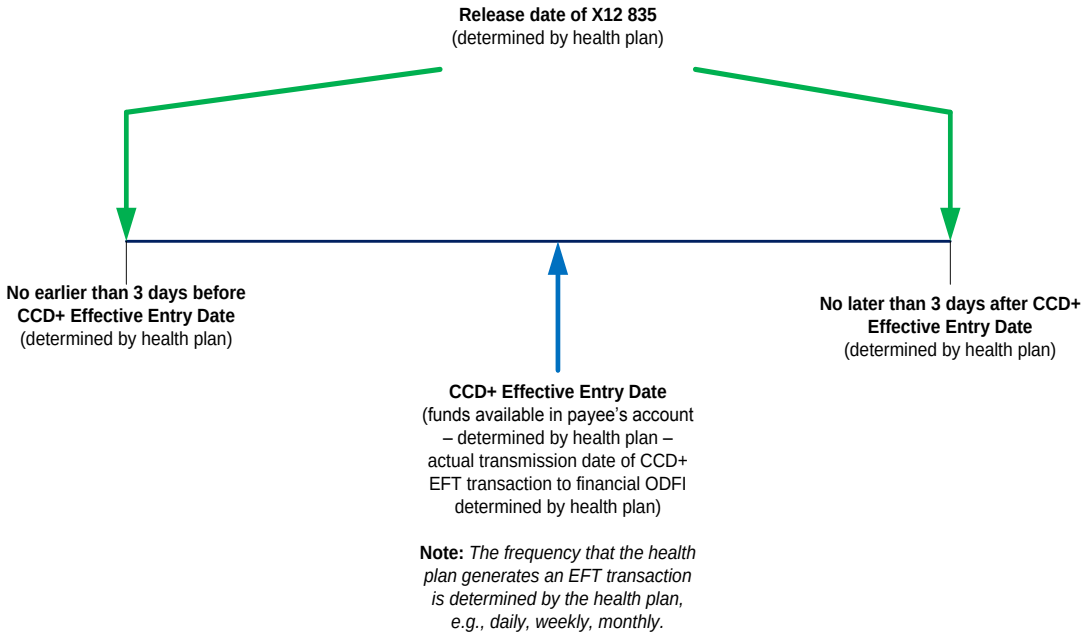
This requirement **does not** have *to-the-hour* specificity; the requirement only specifies the number of "business days". Business days are defined in Section 6.1, *Glossary of Terms and Definitions*, of the CAQH CORE 370 Rule.

8. Does the CAQH CORE 370 Rule specify requirements for how frequently a health plan should generate an X12 v5010 835 and corresponding claim payment?

No. The CAQH CORE 370 Rule does not specify how frequently a health plan must generate a claim payment and corresponding X12 v5010 835. For example a health plan may generate claim payments on a daily, weekly, or monthly cycle.

Note: The CAQH CORE 370 Rule does specify requirements for the elapsed time between release of the X12 v5010 835 and Effective Entry Date specified in the CCD+ (i.e., the date funds are available in the provider's account). Specifically, Section 4.2, *Elapsed Time between Sending the X12 v5010 835 and the CCD+ Transactions*, of the CAQH CORE 370 Rule requires health plans to release the X12 v5010 835:

- *"No sooner than three business days based on the time zone of the health plan prior to the CCD+ Effective Entry Date*
  And
- *No later than three business days after the CCD+ Effective Entry Date."*



9. What delimiters should be used in the X12 v5010 835 TR3 TRN Segment sent in the CCD+ Record #7?

The CAQH CORE EFT & ERA Operating Rules do not address which delimiters should be used in the X12 v5010 835 TRN Segment sent in the CCD+ Record #7. The X12 v5010 835 TR3 allows for the delimiters to be defined by the sender of the transaction. The *NACHA Operating Rules* require the use of the asterisk (*) as the delimiter between data elements and either the backslash (\) or tilde (~) as the segment terminator.

Please Note: As the Standards Development Organization (SDO) that develops and maintains the X12 v5010 835 standard, guidance on implementation of the X12 v5010 835 TR3 implementation guide, and its underlying standard, should be obtained from ASC X12. Information related to the meaning, use, and interpretation of ASC X12 Standards, Guidelines, and Technical Reports can be obtained from ASC X12 via its online ASC X12 Interpretation Portal. NACHA – The Electronic Payments Association is the SDO that maintains the CCD+ standard format. For questions related to the CCD+, or to NACHA in general, contact Priscilla Holland, Senior Director, at pholland@nacha.org.

10. Does the CAQH CORE 370 Rule prohibit a health plan from including additional information beyond the X12 v5010 835 TRN Reassociation Trace Number Segment (hereafter TRN Segment) in Record #7, Field #3 of the CCD+?

No. The CAQH CORE 370 Rule does not prohibit a health plan from including additional information in Record #7, Field #3, *Payment Related Information*, of the CCD+, **understanding that entities ensure the field contains the required X12 v5010 835 TR3 TRN segment information and conforms to the *NACHA Operating Rules.***

NOTE: The CAQH CORE EFT & ERA Operating Rules do not change the meaning, usage, or definition of the X12 v5010 835 data elements or the NACHA CCD+ data fields.

Use of the X12 v5010 835 TRN Segment data elements is referenced in Table 3.3-1 in Section 3.3, *CORE-required Minimum CCD+ Data Elements for Successful Reassociation*, of the CAQH CORE 370 Rule. Table 3.3-

1 identifies the CORE-required minimum set of CCD+ data elements necessary for successful reassociation of the CCD+ and the X12 v5010 835. The CORE-required Minimum CCD+ Reassociation Data Elements include CCD+ Record #5, Field 9, *Effective Entry Date*, CCD+ Record #6, Field 6, *Amount*, and CCD+ Record #7, Field 3, *Payment Related Information*. CCD+ Record #7, Field 3 corresponds to the X12 v5010 835 TRN Segment.

As identified in the table, the X12 v5010 835 TRN Segment is composed of three required data elements (TRN01-481 Trace Type Code, TRN02-127 Reference Identification, and TRN03-509 Originating Company Identifier) and one situational data element (TRN04-127 Reference Identification). Combined with the X12 v5010 835 data elements from the BPR segment (BPR16 and BPR02), the X12 v5010 835 TRN Segment provides information required for the successful reassociation of the X12 v5010 835 and the CCD+.

For further guidance on the CAQH CORE 370 Rule requirements, please see *Section V. CAQH CORE 370: EFT & ERA Reassociation (CCD+/835) Rule*.

Please Note: NACHA – The Electronic Payments Association is the Standards Development Organization (SDO) that develops and maintains the CCD+ standard format. For questions related to the CCD+, or NACHA in general, contact Priscilla Holland, Senior Director, at pholland@nacha.org.

11. What data elements should health plans track to demonstrate conformance with the requirement that health plans ensure the CCD+ Effective Entry Date and X12 v5010 835 BPR16 EFT Effective Date are the same valid banking day?

Section 4.2, *Elapsed Time between Sending the X12 v5010 835 and the CCD+ Transactions,* of the CAQH CORE 370 Rule requires that a health plan *must not* release the X12 v5010 835 earlier than three business days *prior to* the CCD+ Effective Entry Date or later than three business days *after* the CCD+ Effective Entry Date. As part of this elapsed time requirement, the CAQH CORE 370 Rule also requires that "*a health plan must ensure that the CCD+ Effective Entry Date is a valid banking day and that the corresponding X12 v5010 835 BPR16 date is the same valid banking day*."

To demonstrate that the elapsed time requirement has been met ninety percent of the time (as measured within a calendar month), Section 4.2.2 requires health plans to track and audit the elapsed time between sending of the X12 v5010 835 and the CCD+. The CAQH CORE 370 Rule does not specify the exact data elements to be included in the audit log. However, CAQH CORE recommends that the captured data elements include the CCD+ Effective Entry Date and the date on which the X12 v5010 835 was actually released for transmission. To demonstrate conformance with the requirement to ensure the CCD+ Effective Entry Date and X12 v5010 835 BPR16 EFT Effective Date are the same valid banking day, a health plan may choose to also include the X12 v5010 835 BPR16 EFT Effective Date in the audit log.

Please note: The CAQH CORE 370 Rule builds on the NACHA CCD+ standard format. In addition to compliance with the CAQH CORE 370 Rule requirements, health plans must also comply with the *NACHA Operating Rules*. Health plans should ensure that the Effective Entry Date included in the CCD+ complies with the NACHA requirements. For questions related to use of the CCD+ or NACHA in general, contact Priscilla Holland, Senior Director, at pholland@nacha.org or 703-561-3916.

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12. My organization is a health plan. Does the CAQH CORE 370 Rule require us to track the CCD+ to ensure the transfer of funds from our Originating Depository Financial Institution (ODFI) to the provider's Receiving Depository Financial Institution (RDFI)?

Section 4.2, *Elapsed Time between Sending the X12 v5010 835 and the CCD+ Transactions,* of the CAQH CORE 370 Rule requires that "*a health plan must ensure that the CCD+ Effective Entry Date is a valid banking day and that the corresponding X12 v5010 835 BPR16 date is the same valid banking day*." However, the CAQH CORE 370 Rule does not place further requirements around confirming the transfer of funds from the health plan's financial institution to provider's financial institution.

Section 4.2.2, *Elapsed Time Auditing Requirements*, requires the health plan to have the capability to track and audit the elapsed time between sending of the X12 v5010 835 and the CCD+ to ensure the elapsed time requirement is met ninety percent of the time, as measured within a calendar month. The CAQH CORE 370 Rule does not specify the exact data elements to be included in the audit log. However, CAQH CORE recommends that the captured data elements include the CCD+ Effective Entry Date and the date on which the X12 v5010 835 was actually released for transmission.

13. My organization is a health plan that outsources delivery of the X12 v5010 835 to a vendor business associate. Does the CAQH CORE 370 Rule still require us to conform to the maximum elapsed time requirements for sending the X12 v5010 835 and CCD+, and have the capacity to track and audit the elapsed time?

Section 4.2, *Elapsed Time between Sending the X12 v5010 835 and the CCD+ Transactions,* of the CAQH CORE 370 Rule requires that a health plan *must not* release the X12 v5010 835 earlier than three business days *prior to* the CCD+ Effective Entry Date or later than three business days *after* the CCD+ Effective Entry Date. Section 4.2.2, *Elapsed Time Auditing Requirements*, of the CAQH CORE 370 Rule requires that health plans track and audit the elapsed time between sending of the X12 v5010 835 and the CCD+ to ensure the elapsed time requirement is met ninety percent of the time, as measured within a calendar month.

In some cases, health plans (or other HIPAA covered entities) may outsource some or all of their covered functions to a non-covered business associate. It is the responsibility of the HIPAA covered entity to ensure that their business associate(s) supports the HIPAA covered entity in being compliant. Therefore, whether the health plan releases the X12 v5010 835 directly to the provider or outsources that function to a business associate such as a vendor or clearinghouse, the X12 v5010 835 must be made available to the provider no sooner than three business days prior to, and no later than three business days after, the corresponding CCD+ Effective Entry Date.

Health plans that outsource delivery of the X12 v5010 835 to a business associate must also ensure that they have the have the capability to track and audit data to ensure that they are properly delivering the X12 v5010 835 to the provider so that the elapsed time requirement is being met at least ninety percent of the time as measured within a calendar month. The tracking and auditing can be done either directly by the health plan or through its business associate.

14. The CAQH CORE 370 Rule requires providers to proactively contact their financial institutions to arrange for the delivery of the CORE-required Minimum CCD+ Data Elements necessary for successful reassociation of the EFT and ERA. As a provider, what information do I need to send to my financial institution to arrange for delivery of these data elements?

The CAQH CORE 370 Rule does not specify what information providers must send to their financial institutions to arrange for delivery of the CORE-required Minimum CCD+ Data Elements.

This said, to assist providers with requesting delivery of the CORE-required Minimum CCD+ Data Elements (i.e. the ACH Payment Information), CAQH CORE has developed a Sample Provider EFT Reassociation Data Request Letter which contains instructions and a letter template that a provider receiving EFT payments may customize and email to its banks or use as talking points for a phone or in person meeting with its bank contacts to request delivery of the ACH Payment Related Information via a secure, electronic means. Health plans may share this sample letter with providers to assist them with contacting their financial institutions.

The NACHA Healthcare EFT Standard FAQs also offer guidance for providers on working with their financial institutions to arrange for delivery of the CORE-required Minimum CCD+ Data Elements. This guidance includes direction regarding the specific information that providers should request, i.e., the "*ACH Payment Related Information***"** and the staff members at the financial institution that providers should contact. The *NACHA Operating Rules* require all financial institutions to deliver the CORE-required Minimum CCD+ Data Elements upon request. Additionally, as of September 20, 2013, all financial institutions must be able to deliver the CORE-required Minimum CCD+ Data Elements to providers through a secure electronic delivery method.

Please Note: NACHA – The Electronic Payments Association is the authoring entity for the *NACHA Operating Rules* which govern the ACH Network and the standards development organization (SDO) that maintains the CCD+ standard format. For questions related to the CCD+, or to NACHA in general, contact Priscilla Holland, Senior Director, at pholland@nacha.org. Information on the new health care EFT and ERA standards, and other health care payments news is also available on NACHA's Healthcare Payments Resource Site at http://healthcare.nacha.org.

15. The CAQH CORE 370 Rule specifies timeframe requirements for health plans to "release for transmission" the X12 v5010 835 relative to the Effective Entry Date specified in the CCD+. How is "release for transmission" defined for this requirement?

Section 4.2, *Elapsed Time between Sending the v5010 X12 835 and the CCD+ Transactions,* of the CAQH CORE 370 Rule specifies that "*a health plan must release for transmission to the healthcare provider the v5010 X12 835 corresponding to the Healthcare EFT Standards*:

- *"No sooner than three business days based on the time zone of the health plan prior to the CCD+ Effective Entry Date*
  And
- *No later than three business days after the CCD+ Effective Entry Date."*

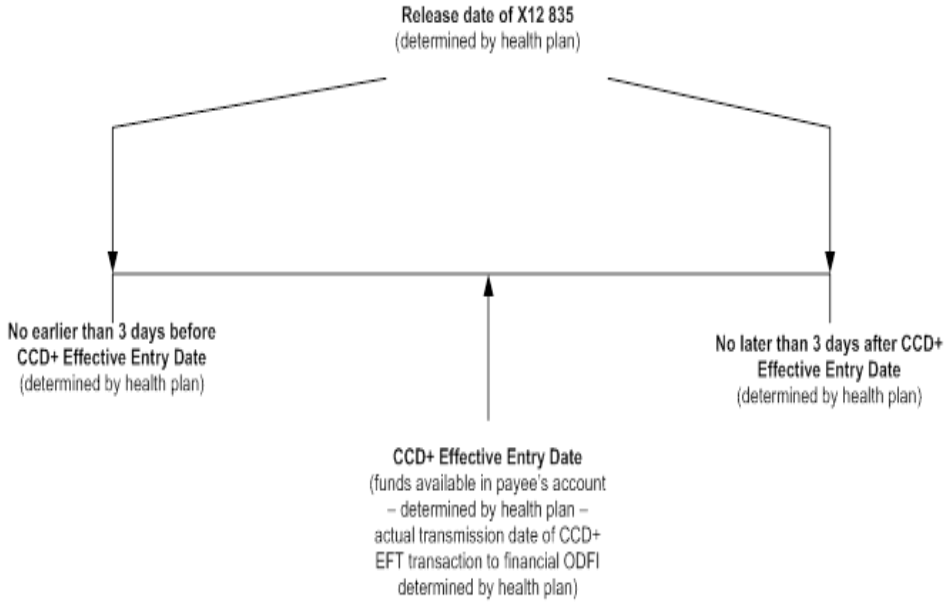
Releasing the X12 v5010 835 for transmission is defined as making the X12 v5010 835 available for pick-up by the provider.

16. Section 4.2 of the CAQH CORE 370 Rule specifies a maximum timeframe within which health plans must release the X12 v5010 835 for transmission (i.e., make the transaction *initially* available for pick-up). Does the CAQH CORE 370 Rule also require the pick-up of the X12 v5010 835 to occur within this timeframe?

No. The CAQH CORE 370 Rule does not require the pick-up of the X12 v5010 835 to occur within the specified maximum timeframe for release of the X12 v5010 835.

Section 4.2, *Elapsed Time between Sending the X12 v5010 835 and the CCD+ Transactions,* of the CAQH CORE 370 Rule requires that a health plan **must not** release the X12 v5010 835 (i.e., make the file **initially** available for

pick-up) earlier than three business days **prior to** the CCD+ Effective Entry Date or later than three business days **after** the CCD+ Effective Entry Date.



As shown in the figure above, the CAQH CORE 370 Rule timeframe requirement is specific to when the X12 v5010 835 will initially be made available for pick-up. Based on the CAQH CORE 370 Rule elapsed time requirements, the X12 v5010 835 transaction will not be **initially** available for pick-up **earlier than** three days **prior to** the CCD+ Effective Entry Date and **no later than** three days **after** the CCD+ Effective Entry Date, based on the time zone of the health plan.

However, the CAQH CORE Rule timeframe requirement **does not** require that the pick-up of the available X12 v5010 835 transaction occur during this timeframe. A provider (or other entity acting as the receiver) may pick-up the X12 v5010 835 any time after it has been made available by the health plan.

Additionally, while the CAQH CORE 370 Rule places timing requirements around when the X12 v5010 835 will initially be made available, the CAQH CORE 370 Rule does not constrain the ongoing availability of the X12 v5010 835 after it has been released by the health plan, in conformance with the maximum elapsed time requirements. It is a health plan's individual business decision to specify how long the X12 v5010 835 will be available for pick-up after it has been released by the health plan.

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VI. CAQH CORE 380: EFT Enrollment Data Rule

1. If we already offer EFT enrollment electronically, must we also implement a paper process?

No. The CAQH CORE 380 Rule, Section 4.5 specifies that "*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 CORE Rule, it is not required by this rule to implement a paper-based manual process on or after the compliance date.*"

NOTE: The CAQH CORE 380 Rule addresses electronic and paper-based collection and submission of the enrollment data. It does not specify the health plan's internal enrollment process.

2. What are the requirements for presentation of the CORE-required Maximum EFT Enrollment Data Elements?

Section 4.3.2 of the CAQH CORE 380 Rule, requires that the CORE-required Maximum EFT Enrollment Data Set be used without revision or modification, and that the order of the data conforms to the flow, format, and data set (including data element descriptions) established in Table 4.2-1 of the rule. This requirement applies to both electronic enrollment data collection forms and manual paper-based forms, should a health plan or its agent offer a paper-based data collection process. In order to comply with the CAQH CORE 380 Rule requirements a health plan (or its agent or a vendor offering EFT) must not modify or vary the CORE EFT enrollment form template *and* EFT enrollment forms must follow the flow, format, and data set as specified in the rule.

3. What are the requirements for use of the CORE-required Maximum EFT Enrollment Data Elements Data Element Groups (DEGs)?

The CAQH CORE 380 Rule establishes a maximum set of data elements for both paper and electronic EFT enrollment data collection and submission. This maximum set of CORE-required EFT Enrollment Data Elements is specified in Table 4.2-1 of the rule, organized by categories of information referred to as "Data Element Groups". The CAQH CORE 380 Rule, Section 4.3 and its subsections specify the requirements for how the CORE-required Maximum EFT Enrollment Data Elements must be presented in both paper and electronic based EFT enrollment forms. Specifically, the rule requires that health plans (or their agents or vendors offering EFT) use the format, flow, and data set (including data element descriptions) as given in Table 4.2-1. Additionally, all CORE-required EFT Enrollment data elements (including DEGs) must appear in the same order as they appear in Table 4.2-1.

4. Can additional data elements beyond the CORE-required Maximum EFT Enrollment Data Elements be collected for EFT enrollment?

The CAQH CORE 380 Rule establishes a **maximum** set of data elements for both paper and electronic EFT enrollment. This maximum set of CORE-required EFT Enrollment Data Elements is specified in Table 4.2-1 of the rule. Section 4.3 and its subsections describe how the CORE-required Maximum EFT Enrollment Data Elements must be presented.

Also, the CAQH CORE 380 Rule does not preclude health plans (or their agents) from collecting additional data elements in locations beyond the EFT enrollment form for other purposes beyond EFT enrollment. Additionally, the CAQH CORE 380 Rule does not prohibit health plans and their agents from adding capabilities to the

electronic EFT enrollment method designed to improve functionality and ensure data integrity and comprehensiveness. Examples of functional and data improvements that may be added to the electronic submission tool include:

- Use of drop-down selection lists and/or radio buttons to respond to each CORE-required Data Element or Sub-element
- Requiring re-entry of key data to ensure accuracy
- Inclusion of a context-specific "Help" button to display a window that provides a detailed description of the CORE-required Data Element or other guidance, e.g., data format, etc.
- Enabling the end user to assign nicknames to certain data fields to more easily manage his/her data
- Displaying all data entered to the end user for final review/correction prior to actual "submission"

5. Can my health plan use a single form for both EFT and ERA enrollment?

Yes. CAQH CORE 380: EFT Enrollment Data Rule and CAQH CORE 382: ERA Enrollment Data Rule establish a maximum set of data elements to be included on enrollment forms for EFT and ERA, as well as a required flow and format for presentation of the data elements on the form. The two rules were developed independent of each other as some health plans enroll providers separately for EFT and ERA while other combine the enrollments.

The CAQH CORE Enrollment Data Rules do not require or prohibit entities from creating a single form for the purposes of both EFT and ERA enrollment as long as the format, flow, and data set (including data element descriptions) are used as specified in CAQH CORE 380 Rule Table 4.2-1 **and** CAQH CORE 382 Rule Table 4.2-1. Sections 4.5 of the CAQH CORE 380 and 382 Rules specify the timeframe for converting existing paper-based EFT and ERA enrollment forms to comply with the rules.

6. My health plan currently uses one inclusive form to enroll providers to receive all healthcare electronic transactions. Can we use this same form to collect CORE-required Maximum EFT Enrollment Data Elements?

Yes. The CAQH CORE 380 Rule establishes a maximum set of data elements to be included on an EFT enrollment form, as well as a required flow and format for presentation of the data elements on the form. The CAQH CORE 380 Rule does not require or prohibit entities from using an inclusive form for the purposes of EFT Enrollment as long as the format, flow, and data set (including data element descriptions) are used as given in CAQH CORE 380 Rule, Table 4.2-1, *CORE-required Maximum EFT Enrollment Data Set*. Section 4.5 of the CAQH CORE 380 Rule specifies the timeframe for converting existing paper-based enrollment forms to comply with the rule.

NOTE: Section 4.4 of the CAQH CORE 380 Rule also requires all health plans, and their agents or vendors offering EFT enrollment, to *"implement and offer to any trading partner (e.g., a healthcare provider) an electronic method (actual method to be determined by health plan or its agent) and process for collecting the CORE-required Maximum EFT Enrollment Data Set.*"

7. Does the CAQH CORE 380 Rule, Section 4.4 requirement for health plans to offer an electronic safe harbor method for data collection mean health plans can *only* collect the EFT enrollment data elements electronically (i.e., cannot use paper-based enrollment forms)?

No. Per the CAQH CORE 380 Rule, Section 4.4, *CORE Electronic Safe Harbor for EFT Enrollment to Occur Electronically*, all health plans must "*implement and offer to any trading partner (e.g., a healthcare provider) an*

electronic method (actual method to be determined by health plan or its agent) and process for collecting the CORE-required Maximum EFT Enrollment Data Set."

Rule Section 4.4 also notes that the rule "*DOES NOT require health plans or their agents to use ONLY an electronic method and process for collecting the CORE-required Maximum EFT Enrollment Data Set*." Health plans must offer an electronic method for collection and submission of the CORE-required Maximum EFT Enrollment Data Set, but they may continue to also offer a paper-based method of enrollment, provided that the paper-based method of enrollment also meets all applicable rule requirements (see especially Section 4.3.1, *Master Template for Manual Paper-Based Enrollment*).

8. The CAQH CORE 380 Rule, Section 4.3.1, *Master Template for Manual Paper-Based Enrollment,* requires the EFT enrollment form to include a section outlining how providers can access online instructions to determine their enrollment status. Does this mean health plans must also enable providers to view their enrollment status online?

No. Section 4.3.1 of the CAQH CORE 380 Rule requires that health plans provide instructions online for how providers can determine the status of the enrollment. The EFT enrollment form must include a section outlining how to access these online instructions. The CAQH CORE 380 Rule **does not** require that that the status of enrollment must be able to be determined via online tool.

9. As a health plan, am I required to include only the Individual Data Elements within ***required* Data Element Groups (DEGs) on my EFT Enrollment form?**

The CORE-required Maximum EFT Enrollment Data Set includes eight Data Element Groups (DEGs). A DEG may be designated as **required** or **optional** for data collection. Additionally, within each DEG, Individual Data Elements may be designated as **required** or **optional** for data collection.

When a DEG is designated as **required**:

- The health plan must collect all Individual Data Elements within the DEG that are designated as **required.**
- The health plan may elect not to collect any Individual Data Elements within the DEG that are designated as **optional.**

When a DEG is designated as **optional**:

- The health plan may elect not to include this optional DEG for collection on the EFT Enrollment Form.
- However, if the health plan chooses to collect this optional DEG, the health plan *must* collect all Individual Data Elements within the DEG that are designated as **required**; the health plan may elect not to collect any Individual Data Elements within the optional DEG that are designated as **optional.**

10. As a health plan, if I choose to include an *optional* Data Element Group (DEG) on my enrollment form, must I include all of the Individual Data Elements within the DEG?

No. If a health plan chooses to collect an **optional** DEG:

- The health plan **must** collect all Individual Data Elements within the optional DEG that are designated as **required.**
- However, the health plan may elect **not** to collect any Individual Data Elements within the optional DEG that are designated as **optional**.

11. As a health plan, if I collect some of the data elements in the CAQH CORE Maximum EFT Enrollment Data Set as part of another enrollment process (e.g., provider credentialing), must I still include these data elements on my EFT enrollment form?

Not collecting an Individual Data Element identified as **optional** is not prohibited by the CAQH CORE 380 Rule requirements for the CORE-required Maximum EFT Enrollment Data Set. **However,** the CAQH CORE 380 Rule requires that the following Individual Data Elements must be collected during the EFT Enrollment process:

- All **required** Individual Data Elements within **required** DEGs
- All Individual Data Elements designated as **required** within **optional** DEGs, **if the health plan chooses to collect the optional DEG.**

NOTE: The CAQH CORE 380 Rule does not prevent a health plan from pre- or auto-populating the form with known data (for the provider to confirm or change), but the required Individual Data Elements must still be collected during the process.

12. What Individual Data Elements must be included in the electronic enrollment method required under Section 4.4 of the CAQH CORE 380 Rule?

Section 4.4 of the CAQH CORE 380 Rule requires all health plans to offer an "electronic safe harbor" enrollment method/process for collecting the CORE-required Maximum EFT Enrollment Data Set. The CAQH CORE 380 Rule requires that the following Individual Data Elements must be included in the electronic enrollment method:

- All **required** Individual Data Elements within **required** DEGs
- All Individual Data Elements designated as **required** within **optional** DEGs, **if the health plan chooses to collect the optional DEG.**

13. If a health plan or its agent uses a web-based enrollment method to fulfill the CORE Electronic Enrollment Safe Harbor required by Section 4.4 of the CAQH CORE 380 Rule do all of the EFT Enrollment Data Elements have to be included on a single webpage?

No. The CAQH CORE 380 Rule, Section 4.3.2, *Master Template for Electronic Enrollment*, requires that a web-based method of enrollment is restricted "*only to the extent that the flow, format and data set including data element descriptions established by this rule must be followed*." The CAQH CORE 380 Rule does not include any language surrounding pagination or other contiguity of the data. Therefore, a web-based enrollment method with data elements on different pages would be compliant with the rule requirements.

14. For health plans that use a web-based EFT enrollment method to fulfill the CAQH CORE Electronic Enrollment Safe Harbor, does CAQH CORE have an XML Schema Specification that can be used to create a web-based enrollment method?

No. There is no XML Schema Specification (.xsd file) for the CAQH CORE EFT & ERA Operating Rules, including the CAQH CORE 380 Rule. However, to assist implementers, CAQH CORE has published Excel-based versions of both the CORE-required Maximum EFT Data Set and CORE-required Maximum ERA Enrollment Data Set tables. The Excel Workbooks are available at the links below and on the CAQH CORE website:

- Excel Copy of the CORE-required Maximum EFT Enrollment Data Set
- Excel Copy of the CORE-required Maximum ERA Enrollment Data Set

NOTE: CAQH CORE 380 Rule, Section 4.3.2, *Master Template for Electronic Enrollment*, does specify that: **"***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>.*" There are no additional XML specifications for a web-based enrollment method beyond this requirement.

15. Are there available data file examples (e.g., DOC, XLS ,TXT, CSV, XML, etc.) of the CORE-required Maximum EFT Enrollment Data Set that health plans, their agents and/or vendors offering EFT Enrollment, can use to develop their enrollment form/utility?

Yes. As noted above, CAQH CORE has published an Excel-based version of Table 4.2-1, *CORE-required Maximum EFT Enrollment Data Set*. The Excel Workbooks are available at the links below and on the CAQH CORE website:

- Excel Copy of the CORE-required Maximum EFT Enrollment Data Set
- Excel Copy of the CORE-required Maximum ERA Enrollment Data Set

Beyond this Excel document and the table in the CAQH CORE 380 Rule, there are no other available data file examples of the CORE-required Maximum EFT Enrollment Data Set.

16. Does the reference to a "Safe Harbor" in Section 4.4 of the CAQH CORE 380 Rule mean that health plans must support data collection through the CAQH CORE 270: Connectivity Rule?

No. The reference in the CAQH CORE 380 Rule to a "safe harbor" **does not** mean that health plans must support the CAQH CORE Connectivity Safe Harbor for collection of the CORE-required Maximum EFT Enrollment Data Set.

Section 4.4, *CAQH CORE Electronic Safe Harbor for EFT Enrollment*, of the CAQH CORE 380 Rule requires all health plans to offer an "electronic safe harbor" enrollment method/process for collecting the CORE-required Maximum EFT Enrollment Data Set. The CAQH CORE 380 Rule does not specify the electronic method that health plans must use to fulfill the safe harbor requirement.

While the CAQH CORE 380 Rule does not require health plans to do so, health plans may choose to use the CAQH CORE 270 Connectivity Safe Harbor to fulfill the CAQH CORE Electronic Enrollment Safe Harbor. The CAQH CORE Connectivity Rule is payload agnostic and thus can carry both X12 and non-X12 administrative transaction payloads. Section 4.4.4 of the CAQH CORE 270 Rule specifies how to enumerate non-X12 payloads in the PayloadType field.

17. Does the CAQH CORE 380 Rule require health plans to process a provider's EFT enrollment within a specific time period?

No. The CAQH CORE 380 Rule establishes a *maximum* set of data elements for both paper and electronic EFT enrollment as well as how the CORE-required Maximum EFT Enrollment Data Elements must be presented in both paper and electronic based EFT enrollment forms The CAQH CORE 380 Rule **does not** establish a required timeframe for processing a provider's EFT Enrollment.

NOTE: Section 4.2, *CORE-required Maximum EFT Enrollment Data Elements*, of the CAQH CORE 380 Rule requires the health plan to "*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."

The CAQH CORE 380 Rule does not specify the exact wording for the instructions and guidance that must be provided by the health plan. In anticipation of provider questions, the health plan could choose to describe its expected timeframe for processing enrollments in these instructions.

18. By what date does my health plan, or agent or vendor offering EFT enrollment, need to convert our paper-based EFT enrollment forms to comply with the *CORE-required Maximum EFT Enrollment Data Set*, per the CAQH CORE 380 Rule?

Section 4.5 of the CAQH CORE 380 Rule specifies a time frame for health plans to convert all paper-based EFT enrollment forms relative to the compliance date for any Federal regulation that adopts the CAQH CORE 380 Rule for mandatory implementation. Specifically the rule states: *"Not later than the date that is **six months after** the compliance date specified in any Federal regulation adopting this CORE Operating 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 convert all its paper-based forms to comply with the data set specified in this rule."*

NOTE: The CAQH CORE 380 Rule requirement applies **only** if a health plan, or its agent or vendor offering EFT enrollment, has an existing paper-based enrollment form or chooses to use a paper-based form. The CAQH CORE 380 Rule **does not** require health plans to use a paper-based enrollment form if they do not currently do so. However, an electronic method for collecting and submitting the enrollment data elements is required.

In August 2012, HHS issued an Final Rule that adopts all of the CAQH CORE EFT & ERA Operating Rules to fulfill the Federal mandate under ACA Section 1104, *with the exception of rule requirements pertaining to use of Acknowledgements*. Per ACA Section 1104, the compliance date for the ACA-mandated EFT & ERA operating rules is **January 1, 2014**. Section 4.5 of the CAQH CORE 380 Rule requires health plans to modify their paper-based enrollment forms to conform to the CORE-required Maximum EFT Enrollment Data Set no later than **six months after** the January 1, 2014 Federal compliance date.

For more information on the ACA Section 1104 requirements for Federal operating rules, please see CAQH CORE FAQs Part B: ACA Section 1104 Mandate for Federal Operating Rules.

19. Does the CAQH CORE 380 Rule specify requirements for how health plans should verify the accuracy of the enrollment data submitted by providers?

No. Verifying the accuracy of the data collected from the provider during the EFT enrollment process is out of scope for the CAQH CORE EFT & ERA Operating Rules. The policies and methods that a health plan uses to verify accuracy of data are business decisions on the part of the health plan or its agent or vendor offering EFT enrollment.

20. As a health plan, we have chosen to include the optional "*Include with Enrollment Submission*" Data Element to collect a voided check or bank letter for the purposes of provider account authentication. What submission method should we use to obtain the required documentation?

Data Element Group (DEG) 8: *Submission Information* in the *CORE-required Maximum EFT Enrollment Data Set* includes as an ***optional*** Individual Data Element "*Include with Enrollment Submission*". This data element allows a health plan (or its agent or vendor offering EFT enrollment) to require providers to submit a voided

check or bank letter for the purposes of authenticating the provider's financial account. The CAQH CORE 380 Rule does not specify the method that health plans must use to obtain the check or bank letter. It is the health plan's individual business decision what submission method it chooses to use to obtain the documentation from the provider.

21. As a health plan, do we have to collect *required* Individual Data Elements for which we do not have a business need?

Yes. A health plan (or its agent or vendor offering EFT enrollment) must collect all Individual Data Elements per the CAQH CORE 380 Rule requirements, including those for which the health plan has no business need.

The CORE-required Maximum EFT Enrollment Data Elements were identified after substantial industry research and analysis to compare EFT enrollment forms from across the industry. The CORE Participants agreed that these data elements represented the maximum set of data elements required for successful EFT enrollment. The CORE-required Maximum EFT Enrollment Data Set includes eight Data Element Groups (DEGs) designated as **required** or **optional** for data collection. Per Section 4.2, *CORE-required Maximum EFT Enrollment Data Elements*, of the CAQH CORE 380 Rule, the following Individual Data Elements must be included on either a paper-based or electronic enrollment form:

- All **required** Individual Data Elements within **required** DEGs
- All Individual Data Elements designated as **required** within **optional** DEGs**, if the health plan chooses to collect the optional DEG.**

22. As a health plan, do I conform to the CAQH CORE 380 Rule requirements for presentation of the CORE-required EFT Enrollment Data Elements if I use abbreviated Data Element Names on my electronic enrollment form and provide the full Data Element Names via a "mouse hover" function?

No. Section 4.3.2, *Master Template for Electronic Enrollment*, of the CAQH CORE 380 Rule specifies that health plans "*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****."* As described in Section 3.2, *CORE-required Maximum EFT Enrollment Data Element Set*, this requirement serves to provide consistency across health plans' enrollment processes and promotes provider adoption of EFT.

To meet the requirements specified in Section 4.3.2, the Data Element Name must be used in full on the electronic enrollment form. Use of an abbreviated Data Element Name on an electronic enrollment form does not satisfy the rule requirement.

23. As a health plan, do I conform to the CAQH CORE 380 Rule requirements for presentation of the CORE-required EFT Enrollment Data Elements if I use a "mouse hover" function to provide the descriptions of the enrollment data elements?

Yes. Although a health plan (or its agent or vendor offering EFT enrollment) may not use a "mouse hover" function to provide the Data Element Names, the CAQH CORE 380 Rule does permit a health plan to use a "mouse hover" to display supplemental information about the enrollment data elements, such as the Data Element Description, or to provide further guidance to the provider on completing the enrollment form.

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24. Do the CAQH CORE EFT & ERA Enrollment Data Rules (CAQH CORE 380 & 382) specify requirements regarding whether a health plan can make provider EFT enrollment contingent upon the provider also enrolling to receive the X12 v5010 835 ERA?

No. The CAQH CORE EFT & ERA Enrollment Data Rules (CAQH CORE 380 & 382 Rules) establish a maximum set of data elements to be included on an EFT and/or ERA enrollment form, as well as a required flow and format for presentation of the data elements on the form. The CAQH CORE EFT & ERA Enrollment Data Rules **do not** address whether or not health plans can make provider enrollment to receive healthcare EFT contingent on the provider also enrolling to receive the X12 v5010 835 ERA, or vice versa. Such a requirement is a health plan's individual business decision.

25. Section 4.3, *CORE Master Template for Collecting EFT Enrollment Data*, of the CAQH CORE 380 Rule requires a health plan EFT enrollment form to follow the "format, flow, and data set" specified in Table: 4.2-1. How are format, flow, and data set defined for this requirement?

Section 4.3 of the CAQH CORE 380 Rule requires health plans "*to use the format, flow and data set including data element descriptions in Table 4.2-1 as the CORE Master EFT Enrollment Submission form*" for both paper-based and electronic EFT enrollment methods. The intent of the reference to "format, flow, and data set" is:

- "Flow" means the order/sequence of the data elements in Table: 4.2-1
- "Data Set" is the set of elements specified in Table: 4.2-1
- "Format" refers to the Data Type and Format as specified in Table: 4.2-1 (e.g., alphanumeric, 15 characters for Zip Code).

26. Does CAQH CORE have a glossary that defines the terms used in Table: 4.2-1, CORE-required Maximum EFT Enrollment Data Set of the CAQH CORE 380 Rule?

CAQH CORE 380 Rule Table: 4.2-1 provides Data Element Descriptions and Data Types and Formats (when necessary) for the Individual Enrollment Data Elements in the CORE-required Maximum EFT Enrollment Data Set. Beyond the Data Element Descriptions and Data Types and Formats, further descriptive information (including citations) clarifying the terms used in Table 4.2-1 is provided via footnotes included for many of the Individual Data Elements. Beyond these references in the rule, there is not a separate glossary of terms.

27. Section 4.4 of the CAQH CORE 380 Rule requires health plans, or their agents/vendors offering EFT, to implement and offer an electronic method and process for *collecting* the CORE-required Maximum EFT Enrollment Data Set. What specific format(s) constitute an "electronic" method in accordance with the CAQH CORE 380 Rule requirement?

The CAQH CORE 380 Rule does not define a specific format(s) that constitutes an electronic method and process for collecting the CORE-required Maximum EFT Enrollment Data Set.

CAQH CORE does not provide a definition of "electronic" methods specific to implementation of the CAQH CORE Operating Rules. Rather, CAQH CORE has relied on various HIPAA regulations to do so for the industry. Currently, there are many ways entities can implement an "electronic" collection method. In the broader context of the mission and vision of CAQH CORE, the goal is to assist the industry to adopt uniform and consistent automated electronic processes to reduce costs and build efficiencies.

CMS is the HHS designated authority on any decisions regarding interpretation, implementation, and enforcement of the regulations adopting the HIPAA and ACA Administrative Simplification standards and provisions. As the regulatory authority, the determination of what constitutes an "electronic" method for collecting the CORE-

required Maximum EFT Enrollment Data Set must be made by the CMS Office of E-Health Standards and Services (OESS). The January 2013 HHS HIPAA Privacy and Security omnibus final rule includes a definition of "electronic media," and CAQH CORE has asked CMS OESS to provide further guidance to the industry on the regulatory language, and what constitutes an "electronic" method. It is anticipated that a CMS OESS FAQ will be published shortly; thereafter CAQH CORE will provide detailed examples of the multiple ways to meet the requirements for both electronic collection and submission.

28. If a health plan, or its agent or vendor offering EFT and ERA enrollment, chooses to use a single form for the purposes of both EFT and ERA enrollment, how should the EFT and ERA Enrollment Data Element Groups in the CAQH CORE Enrollment Data Rules (CAQH CORE 380 Rule and CAQH CORE 382 Rule) be presented on the form?

The CAQH CORE Enrollment Data Rules do not prohibit entities from creating a single form for the purposes of both EFT and ERA enrollment. A combined EFT and ERA enrollment form must contain all of the required Data Element Groups (DEGs) and required Individual Data Elements from Table: 4.2-1, *CORE-required Maximum EFT/ERA Enrollment Data Set*, in CAQH CORE 380 Rule ***and*** CAQH CORE 382 Rule. **NOTE:** Entities are not required to repeat DEGs that are identical in both enrollment data rules (e.g., DEG1).

Although the CAQH CORE Enrollment Data Rules do not explicitly outline the flow and format for a combined EFT and ERA enrollment form, DEGs unique to either of the CAQH CORE Enrollment Data Rules would need to be collected using the same general flow and format. For example, "*Financial Institution Information*" (DEG7 in the CAQH CORE 380 Rule) and "*Electronic Remittance Advice Information*" (DEG7 in the CAQH CORE 382 Rule) are both required for collection on a combined EFT and ERA enrollment form. Both DEGs would be collected after DEGs 1 through 6 in the CAQH CORE 380 and CAQH CORE 382 Rules, and before "*Submission Information*", DEG 10 in the CAQH CORE 382 Rule.

29. My organization is a health plan. Do the CAQH CORE EFT & ERA Operating Rules specify requirements for how soon after we receive a provider EFT and/or ERA enrollment form that we must process the enrollment and implement a connection with the provider to deliver the transactions?

No. The CAQH CORE EFT & ERA Operating Rules **do not** specify timeframe requirements regarding how soon a health plan must process a provider's EFT and/or ERA enrollment and/or implement a connection with the provider to deliver the transactions.

However, the CAQH CORE EFT & ERA Operating Rules do specify timeframe requirements that address exchange of the NACHA CCD+ and X12 v5010 835 transactions such as:

- CAQH CORE 350: Health Care Claim Payment/Advice (835) Rule: Section 4.3, *Dual Delivery of v5010 X12 835 and Proprietary Paper Claim Remittance Advices*, requires health plans to support a dual or parallel processing period during which providers can continue to receive proprietary paper RAs while they test the use of the X12 v5010 835 standard and associated operating rules. The dual delivery period must be a period of 31 days or a minimum of 3 payments, whichever is longer.
    - **NOTE:** The dual delivery requirement applies **only if the health plan currently delivers proprietary paper RAs**. If a health plan does not currently deliver proprietary paper RAs, the CAQH CORE 350 Rule does not require a health plan to start doing so.
- CAQH CORE 370: EFT & ERA Reassociation (CCD+/835) Rule: Section 4.2, *Elapsed Time between Sending the X12 v5010 835 and the CCD+ Transactions*, requires health plans to release the X12 v5010 835: *"No sooner than three business days based on the time zone of the health plan prior to the CCD+ Effective Entry Date **And** No later than three business days after the CCD+ Effective Entry Date."*

- The elapsed time requirement means that a health plan *must not* send the corresponding X12 v5010 835 **earlier than three business days prior to** the CCD+ Effective Entry Date or **later than three business days after** the CCD+ Effective Entry Date.

30. Section 4.3.2 of the CAQH CORE 380 Rule requires that a health plan (or its agent or vendor offering EFT enrollment) offer an electronic way for providers to *submit* the CORE-required Maximum EFT Enrollment Data Set. What specific format(s) constitute an "electronic" submission method in accordance with the CAQH CORE 380 Rule requirement?

The CAQH CORE 380 Rule does not define a specific format(s) that constitutes an electronic method and process for submitting the CORE-required Maximum EFT Enrollment Data Set.

CAQH CORE does not provide a definition of "electronic" methods specific to implementation of the CAQH CORE Operating Rules. Rather, CAQH CORE has relied on various HIPAA regulations to do so for the industry. Currently, there are many ways entities can implement "electronic" methods for data submission. In the broader context of the mission and vision of CAQH CORE, the goal is to assist the industry to adopt uniform and consistent automated electronic processes to reduce costs and build efficiencies.

CMS is the HHS designated authority on any decisions regarding interpretation, implementation, and enforcement of the regulations adopting the HIPAA and ACA Administrative Simplification standards and provisions. As the regulatory authority, the determination of what constitutes an "electronic" method for submitting the CORE-required Maximum EFT Enrollment Data Set must be made by the CMS Office of E-Health Standards and Services (OESS). The January 2013 HHS HIPAA Privacy and Security omnibus final rule includes a definition of "electronic media," and CAQH CORE has asked CMS OESS to provide further guidance to the industry on the regulatory language, and what constitutes an "electronic" method. It is anticipated that a CMS OESS FAQ will be published shortly; thereafter CAQH CORE will provide detailed examples of the multiple ways to meet the requirements for both electronic collection and submission.

31. Table 4.2-1 in the CAQH CORE 380 Rule includes "*Provider Contact Name*" as a required Data Element in Data Element Group (DEG) 3 with the Sub-element "*Email Address*". The specified requirement for collection of "*Email Address*" is "*Required; not all providers may have an email address*". Does the CAQH CORE 380 Rule define what data a health plan should collect when the provider does not have an email address?

No. The CAQH CORE 380 Rule does not explicitly define what a health plan must collect for the Sub-element "*Email Address*" when a provider does not have an email address. However, Section 4.2, *CORE-required Maximum EFT Enrollment Data Elements* requires a health plan to "*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*." The health plan could, in these instructions, describe what the provider should enter in the event that the provider does not have an email address (e.g., "If you do not have an email address, please leave the field blank," or "If you do not have an email address, please enter 'NONE'," etc.)

32. My organization is a clearinghouse that enrolls providers to receive EFT payments from multiple health plan trading partners (i.e., conducts mass EFT enrollment). Can we continue to conduct mass enrollment using the CAQH CORE-required Maximum EFT Enrollment Data Set?

Yes. The CAQH CORE 380 Rule provides a uniform and consistent maximum set of data elements that can be used by any health plan (or its agent/vendor offering EFT enrollment) for the purposes of enrolling any healthcare

provider to receive claim payment electronically. This data set is the same for all providers and all health plans (or their agents/vendors); the CAQH CORE 380 Rule, therefore, can support approaches that are designed to enroll all providers with all plans (i.e., mass enrollment).

Section 4.2 of the CAQH CORE 380 Rule requires a health plan (or its agent/vendor offering EFT enrollment) to "*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".* A clearinghouse, or other intermediary, could include in these instructions guidance specific to the health plans for which it is authorized to collect enrollment data.

The CAQH CORE 380 Rule **does not** address the functionality or capability of an EFT enrollment ***system or process***, which may include other data functions/capabilities beyond the collection of the CORE-required Maximum EFT Enrollment Data Set. A clearinghouse, or other intermediary, that conducts mass enrollment may include data fields in its enrollment process to collect information such as with which health plans providers want to enroll (specific to the health plans for which the clearinghouse is authorized to collect such provider enrollment data). Such a data field could be included in the enrollment process ***prior to or after*** collection of the CORE-required Maximum EFT Enrollment Data Set.

The CAQH CORE 380 Rule also permits clearinghouses, and other entities conducting EFT enrollment, to include other functionalities in the enrollment process (e.g., requiring a username/password to log on to the health plan's website to begin the enrollment process, use of a mouse hover to display supplemental information about data elements, etc.). For further guidance, see "*Can additional data elements beyond the CORE-required Maximum EFT Enrollment Data Elements be collected for EFT enrollment?"*)

33. Section 4.3.1 of the CAQH CORE 380 Rule requires health plans to "use *the format, flow, and data set including data element descriptions of Table 4.2-1*" when using a manual *paper-based* enrollment form. Does including the Data Element Descriptions in an Appendix to the paper-based enrollment form conform to the Section 4.3.1 requirements?

Section 4.3.1, *Master Template for Manual Paper-Based Enrollment*, of the CAQH CORE 380 Rule requires that a health plan (or its agent/vendor offering EFT enrollment) "*use the format, flow and data set including data element descriptions in Table 4.2-1 as the CORE Master EFT Enrollment Submission form when using a manual paper-based enrollment method*." The CAQH CORE 380 Rule **does not** require that the Data Element Descriptions be included directly next to the Individual Data Element Name on the paper-based form. A health plan may include the Data Element Descriptions in an Appendix to the paper-based enrollment form provided that the health plan, as required by Section 4.3.1, "*clearly label*[s] *any appendix describing its purpose as it relates to the provider enrolling in EFT*."

NOTE: The CAQH CORE 380 Rule **does not** require health plans to use a paper-based enrollment form if they do not currently do so. However, an electronic method for collecting and submitting the enrollment data elements is required. As with the paper-based form, the Data Element Descriptions are not required to be included directly next to the Individual Data Element Name on the **electronic** enrollment form. Health plans may use a function such as a "mouse hover" to display the Data Element Descriptions. (See FAQ "*As a health plan, do I conform to the CAQH CORE 380 Rule requirements for presentation of the CORE-required EFT Enrollment Data Elements if I use a "mouse hover" function to provide the descriptions of the enrollment data elements?"*)

34. The HIPAA provisions require use of a National Provider Identifier (NPI) only to identify HIPAA covered providers in a transaction standard. Why does the CAQH CORE 380 Rule require inclusion of

both TIN and NPI as sub-elements for the "*Provider Identifier*" Data Element in DEG2 and "*Account Number Linkage to Provider Identifier*" Data Element in DEG7?

Per the HIPAA Administrative Simplification provisions, as of May 2008, HIPAA covered entities must use the National Provider Identifier (NPI) only to identify a group or individual as a HIPAA covered provider in the HIPAA transaction standards. A Taxpayer Identification Number (TIN), e.g., Social Security Number (SSN) or Employer Identification Number (EIN), can only be used when identifying a HIPAA covered provider as a tax payer.

These requirements do not apply to providers that are **not HIPAA covered** as non-HIPAA covered providers are not required to obtain and use an NPI. Per CMS, a non-HIPAA covered provider that does not have an NPI should be identified in the HIPAA transaction standards by "*its SSN or EIN as its Primary Identifier in standard transactions designed to capture a Primary and a Secondary Identifier for a health care provider* [or] *by one of the qualifiers (other than the qualifier for the NPI) listed in the Implementation Guides that are designed to capture a single identifier for a health care provider*" (see CMS FAQ#1949).

The CAQH CORE 380 Rule requires inclusion of both NPI and TIN as "*Provider Identifier*" and "*Account Number Linkage to Provider Identifier*" sub-elements to allow for enrollment of a non-HIPAA covered provider that does not have an NPI.

35. Why does the CORE-required Maximum EFT Enrollment Data Set require health plans to collect a National Provider Identifier (NPI) and/or Taxpayer Identification Number (TIN) in both DEG2 and DEG7?

Data Element Groups (DEGs) 2 and 7 represent two different sets of data elements that are necessary to enroll a provider to receive claim payments via EFT:

- DEG2: *Provider Identifiers Information* collects information related to the enrolling provider identified in DEG1: *Provider Information*. Within DEG2, health plans (or their agent/vendor offering EFT enrollment) are required to collect a "*Provider Identifier*" which must be the identification number, NPI or TIN for non-HIPAA covered providers, **for the legal entity** reported under the "*Provider Name*" Data Element in DEG1.
- DEG7: *Financial Institution Information* collects information related to the Receiving Depository Financial Institution (RDFI) where the provider maintains the account to which claim payments are to be deposited. Within DEG7, health plans (or their agent/vendor offering EFT enrollment) are required to collect an "*Account Number Linkage to Provider Identifier*", which must be the identification number, NPI or TIN for non-HIPAA covered providers, **linked to the provider's RDFI account**.

The identification number linked to the provider's RDFI account may differ from the identification number used to identify the legal entity. As such, the CAQH CORE 380 Rule requires health plans (or their agent/vendor offering EFT enrollment) to collect an identification number in both DEG2 and DEG7.

36. The CORE-required Maximum EFT Enrollment Data Set requires health plans to collect a National Provider Identifier (NPI) and/or Taxpayer Identification Number (TIN) in both DEG2 and DEG7. Does the CAQH CORE 380 Rule require the identifier collected in DEG2 to be the same as the identifier collected in DEG7?

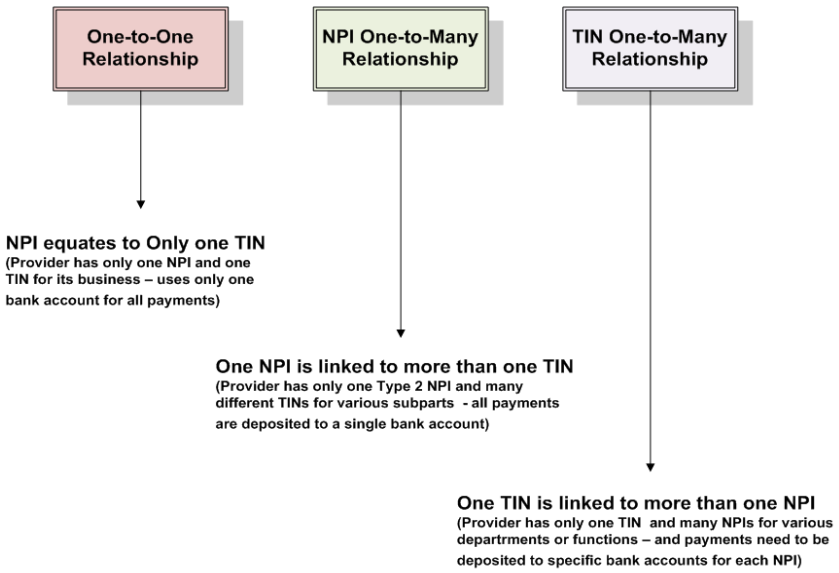
No. While the identifier collected for DEG2: *Provider Identifiers Information* can be the same as the identifier collected for DEG7: *Financial Institution Information*, the CAQH CORE 380 Rule **does not** require them to be the same.

Data Element Groups (DEGs) 2 and 7 represent two different sets of data elements that are necessary to enroll a provider to receive claim payments via EFT:

- DEG2: *Provider Identifiers Information* collects information related to the enrolling provider identified in DEG1: *Provider Information*. Within DEG2, health plans (or their agent/vendor offering ERA enrollment) are required to collect a "*Provider Identifier"*, which must be the identification number, NPI or TIN for non-HIPAA covered providers, **for the legal entity** reported under the "*Provider Name*" Data Element in DEG1: *Provider Information*.
- DEG7: *Financial Institution Information* collects information related to the Receiving Depository Financial Institution (RDFI) where the provider maintains the account to which claim payments are to be deposited. Within DEG7, health plans (or their agent/vendor offering ERA enrollment) are required to collect an "*Account Number Linkage to Provider Identifier*" which must be the identification number, NPI or TIN for non-HIPAA covered providers, **linked to the provider's RDFI account**.

Depending on how a provider has established its financial accounting structure, the provider's RDFI account could be linked to an identification number that is different from the identification number used to identify the legal entity being enrolled for EFT. As shown in the figure below, a number of arrangements may exist:

- A provider, individual or group, can have a single TIN that is linked to both a single NPI and a single RDFI account.
- A provider group can have a single TIN that is linked to multiple NPIs, representing both individual provider subparts and the provider entity as a whole, with each NPI linked to a different RDFI account.
- A provider individual can have a single NPI that is linked to multiple TINs, representing different provider organizations, and a single RDFI account.



As the identification number linked to the provider's RDFI account may differ from the identification number used to identify the legal entity, the CAQH CORE 380 Rule does not require the identification numbers collected within DEG2 and DEG7 to be the same.

Please note: As the X12 v5010 835 TR3 requires a single X12 v0510 835 to correspond to a single EFT payment,

the CAQH CORE 380 Rule **does** require the identifier collected for "*Account Number Linkage to Provider Identifier*" during EFT enrollment to be the same as the identifier collected for "*Preference for Aggregation of Remittance Data*" during ERA enrollment (see CAQH CORE 382: ERA Enrollment Data Rule).

37. Does the CAQH CORE 380 Rule specify requirements for how health plans must group claim payments to providers (i.e., by NPI or TIN)?

The CAQH CORE 380 Rule includes the following requirements for collection of National Provider Identifier (NPI) and Taxpayer Identification Number (TIN) within the CORE-required Maximum EFT Enrollment Data Set:

- DEG2: *Provider Identifiers Information* collects information related to the enrolling provider identified in DEG1: *Provider Information*. DEG2 requires health plans (or their agent/vendor offering EFT enrollment) to collect a "*Provider Identifier*" which must be the identification number, NPI or TIN for non-HIPAA covered providers, **for the legal entity** reported under the "*Provider Name*" Data Element in DEG1: *Provider Information*.
- DEG7: *Financial Institution Information* collects information related to the Receiving Depository Financial Institution (RDFI) where the provider maintains the account to which claim payments are to be deposited. DEG7 requires health plans (or their agent/vendor offering EFT enrollment) to collect an "*Account Number Linkage to Provider Identifier*" which must be the identification number, NPI or TIN for non-HIPAA covered providers, **linked to the provider's RDFI account**.

The CAQH CORE 380 Rule addresses the data to be collected during EFT enrollment; it does not specify requirements for health plans to implement a certain process after the data is collected. Beyond the data collection requirements, how a health plan groups claim payments to providers is a business decision and contract issue to be negotiated between the health plan and its provider trading partners.

Section 4.2 of the CAQH CORE 380 Rule requires health plans to "*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*". The health plan could include in these instructions a description of its entity-specific process to reach agreement on payment grouping.

38. My organization is a health plan. As part of our EFT enrollment form/method, we currently ask providers to identify the service location for which they want to enroll to receive EFT via a proprietary location identifier. Can we continue to collect this location identifier using the CAQH CORE-required Maximum EFT Enrollment Data Set?

Yes. The CAQH CORE 380 Rule provides a uniform and consistent maximum set of data elements that can be used by any health plan (or its agent or vendor) for the purposes of enrolling any healthcare provider (or its agent) to receive claim payment via EFT. This maximum set of data elements is specified in Table 4.2-1 of the CAQH CORE 380 Rule, organized by categories of information referred to as "Data Element Groups" (DEGs).

As part of DEG2: *Provider Identifiers Information* (DEG2), a health plan (or its agent or vendor offering EFT enrollment) can choose to collect an optional *Other Identifier(s).* The *Other Identifier(s)* Individual Data Element allows a health plan to collect proprietary provider identifiers specific to its individual business needs. The CAQH CORE 380 Rule does not specify a data type or format for this identifier. Therefore, a health plan can use the *Optional Identifier(s)* data element to collect identification numbers for all service locations for which the enrolling provider wants to receive EFT.

Section 4.2, *CORE-required Maximum EFT Enrollment Data Elements*, in the CAQH CORE 380 Rule requires a health plan to "*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."* A health plan can include guidance in these instructions for how providers should complete the *Other Identifier(s)* data element.

The CAQH CORE 380 Rule also permits health plans, and their agents or vendors offering EFT enrollment, to include other functionalities in the enrollment process improve functionality and ensure data integrity and comprehensiveness. For example, a health plan may use a drop down list to identify the optional service locations (via their proprietary identifiers) for which the providers can enroll to receive EFT. For further guidance, see "*Can additional data elements beyond the CORE-required Maximum EFT Enrollment Data Elements be collected for EFT enrollment?"*)

39. The CORE-required Maximum EFT Enrollment Data Set specified in Table: 4.2-1 includes an optional Data Element Group, DEG4, to collect information about a "provider agent". How is "provider agent" defined for this DEG?

As specified in Section 3.1, *When the Rule Applies*, the CAQH CORE 380 applies "*when a health plan or its agent is enrolling a healthcare provider **(or its agent)**"* to receive claim payment electronically via the Healthcare EFT Standards. As referenced, a "provider agent" is an entity that that has been designated and sufficiently authorized by the provider to receive EFT payments on the provider's behalf. DEG4: *Provider Agent Information* in the CORE-required Maximum EFT Enrollment Data Set enables a health plan (or its agent/vendor offering EFT enrollment) to collect information about the provider's designated agent.

40. Does the CAQH CORE 380 Rule require health plans to include DEG numbers on their EFT enrollment method/form?

No. The CAQH CORE 380 Rule **does not** require a health plan, or its agent/vendor offering EFT enrollment, to include the DEG number on its electronic or paper-based EFT enrollment form/method. **NOTE:** Use of paper-based method is optional.

Section 4.3, *CORE Master Template for Collecting EFT Enrollment Data*, of the CAQH CORE 380 Rule requires health plans "*to use the format, flow and data set including data element descriptions in Table 4.2-1 as the CORE Master EFT Enrollment Submission form*" for both paper-based and electronic EFT enrollment methods. To conform to the flow, format, and data content requirements, a health plan, or its agent/vendor offering EFT enrollment, must include the data element name and data element description, without revision or modification, on its EFT enrollment form/method and follow the order/sequence as given in Table: 4.2-1.

NOTE: The CAQH CORE 380 Rule **does not** require health plans to offer a paper-based enrollment form. However, an electronic method for collection and submission of the CORE-required Maximum EFT Enrollment Data Set must be offered. If a health plan chooses to also offer a paper-based enrollment form it must conform to all applicable CAQH CORE 380 Rule requirements.

41. Does the CAQH CORE 380 Rule require health plans to include the Column Headers in Table 4.2-1 on their EFT enrollment method/form?

No. The CAQH CORE 380 Rule **does not** require a health plan, or its agent/vendor offering EFT enrollment, to include the column header labels in Table 4.2-1 (e.g., "Individual Data Element", "Sub-Element name", "Data

Element Description", "Data Element Requirement for Health Plan Collection", etc.) on its electronic or paper-based EFT enrollment form/method. **NOTE:** Use of a paper-based method is optional.

Section 4.3, *CORE Master Template for Collecting EFT Enrollment Data*, of the CAQH CORE 380 Rule requires health plans "*to use the format, flow and data set including data element descriptions in Table 4.2-1 as the CORE Master EFT Enrollment Submission form*" for both paper-based and electronic EFT enrollment methods. To conform to the flow, format, and data content requirements, a health plan, or its agent/vendor offering EFT enrollment, must include the data element name and data element description, without revision or modification, on its EFT enrollment form/method and follow the order/sequence as given in Table 4.2-1.

NOTE: The CAQH CORE 380 Rule **does not** require health plans to offer a paper-based enrollment form. However, an electronic method for collection and submission of the CORE-required Maximum EFT Enrollment Data Set must be offered. If a health plan chooses to also offer a paper-based enrollment form it must conform to all applicable CAQH CORE 380 Rule requirements.

42. Section 4.3.1 of the CAQH CORE 380 Rule specifies several items beyond the CORE-required Enrollment Data Elements that must be included on a paper-based EFT enrollment form. Does the CAQH CORE 380 Rule require all of these items to be included on a single page?

No. Section 4.3.1, *Master Template for Manual Paper-Based Enrollment*, of the CAQH CORE 380 Rule requires a health plan (or its agent/vendor offering EFT enrollment) to include the following items on its paper-based EFT enrollment form:

- Specific written instructions and guidance for completing and submitting the enrollment form
- A number to fax and/or a U.S. Postal Service or email address to send the completed form
- Contact information for the health plan, specifically a telephone number and/or email address to send questions
- Authorization language for the provider to read and consider
- A section that outlines how the provider can access online instructions for how to determine the status of the EFT enrollment
- Clear labels for any appendix describing its purpose as it relates to the provider enrolling in EFT
- Information that the provider must contact its financial institution to arrange for the delivery of the CORE-required Minimum CCD+ data elements needed for reassociation of the payment and the ERA.

The CAQH CORE 382 Rule does not specify any requirements regarding pagination. A health plan may choose to include the above additional items on a single page of the enrollment form or on a separate page at the health plan's discretion. **NOTE:** To conform to the flow and format requirements specified in Section 4.3 of the CAQH CORE 380 Rule, the above items **cannot** appear within or between the Maximum Enrollment Data Elements.

NOTE: The CAQH CORE 380 Rule **does not** require health plans to offer a paper-based enrollment form. However, an electronic method for collection and submission of the CORE-required Maximum EFT Enrollment Data Set must be offered. If a health plan chooses to also offer a paper-based enrollment form it must conform to all applicable CAQH CORE 380 Rule requirements.

43. The CAQH CORE 380 Rule requires health plans to collect a signature for the individual authorized to initiate, modify, or terminate the provider's EFT enrollment. What data collection method should health plans use to obtain this signature (i.e., electronically or "wet")?

Data Element Group (DEG) 8: *Submission Information* in the CORE-required Maximum EFT Enrollment Data Set includes as a required Individual Data Element "*Authorized Signature*". This data element allows a health plan

(or its agent/vendor offering EFT enrollment) to collect the "*signature of an individual authorized by the provider or its agent to initiate, modify or terminate an enrollment*". As specified in Table: 4.2-1, a health plan (or its agent/vendor offering EFT enrollment) can require this signature to be submitted either electronically or written (i.e., "wet"). It is the health plan's individual business decision what method it chooses to use to obtain the authorizing signature.

Section 4.2 in the CAQH CORE 380 Rule requires a health plan to "*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*." Depending on what method the health plan chooses to obtain the authorized signature, the health plan could provide guidance to the provider in the instructions for how providers should submit the signature (e.g., if the health plan chooses to include "*Written Signature of Person Submitting Enrollment*" in its electronic enrollment method, the health plan could instruct the provider how to deliver the required wet signature prior to/along with/after completion of the electronic enrollment in EFT).

44. How are the CAQH CORE EFT & ERA Enrollment Data Sets maintained via the CAQH CORE EFT & ERA Enrollment Data Maintenance Process?

As specified in Section 3.4, *CORE Process for Maintaining CORE-required Maximum EFT Enrollment Data Set*, of the Phase III CAQH CORE 380: EFT Enrollment Data Rule and Phase III CAQH CORE 382 ERA Enrollment Data Rule, the CAQH CORE-required Maximum EFT & ERA Enrollment Data Sets are reviewed and updated on an annual basis. Section 3.4 in the CAQH CORE 380 and CAQH CORE 382 Rules requires that the first review of the enrollment data sets commence one year after the rules were adopted into federal regulation. This first review occurred in 2014.

- **Limited Reviews**: Occur biennially and consider *only* non-substantive adjustments to the Enrollment Data Sets; occur on an alternating schedule with Comprehensive Reviews (next Limited Review is in 2016)
- **Comprehensive Reviews**: Occur biennially and consider *both* substantive and non-substantive adjustments to the Enrollment Data Sets; occur on an alternating schedule with Limited Reviews (next Comprehensive Review is in 2017)

NOTE: Adjustments pertaining to rule language and requirements beyond the CAQH CORE-required Maximum EFT & ERA Enrollment Data Sets are out of scope for the CAQH CORE EFT & ERA Enrollment Data Maintenance Process.

In keeping with the CAQH CORE multi-stakeholder, collaborative and transparent rule development process, participation in the CAQH CORE Enrollment Data Task Group is open to representatives from any CORE Participating Organization. There is no limit to the number of representatives that a CORE Participating Organization can assign to the Task Group. Individuals with knowledge of the business processes and work flows for EFT and ERA enrollments are strongly encouraged to join the Task Group. Interested participants can send their name, title, organization name, email address, and telephone number to core@caqh.org.

45. What are the CAQH CORE Comprehensive and Limited Reviews of the CAQH CORE-required Maximum EFT & ERA Enrollment Data Sets? When do these reviews occur?

Per the CAQH CORE EFT & ERA Enrollment Data Sets Maintenance Process, the CAQH CORE Enrollment Data Task Group conducts two types of review of the CAQH CORE-required Maximum EFT & ERA Enrollment Data Sets:

- Comprehensive Reviews consider both potential substantive and non-substantive adjustments to the CORE-required Maximum EFT & ERA Enrollment Data Sets.

- Limited Reviews consider potential non-substantive adjustments to the CORE-required Maximum EFT & ERA Enrollment Data Sets.

Comprehensive and Limited Reviews occur biennially on alternating years; i.e., if a Comprehensive Review occurs one year, a Limited Review will occur the following year.

As defined in the CAQH CORE EFT & ERA Enrollment Data Sets Maintenance Process, substantive adjustments address addition of new data elements/Data Element Groups (DEGs) to address emerging, new, or changing industry needs. Non-substantive adjustments improve usability of the enrollment data set but *do not* change the name, position, or collection requirements for the CORE-required EFT & ERA Enrollment data elements, sub-elements, or DEGs.

Once the CAQH CORE Enrollment Data Task Group approves a set of substantive and/or non-substantive adjustments to the CAQH CORE EFT & ERA Enrollment Data Sets, updated CAQH CORE EFT & ERA Enrollment Data Rules will be published. HIPAA-covered entities will need to update their EFT and ERA enrollment forms/systems to ensure conformance with any *substantive* adjustments applied to the data sets as a result of a Comprehensive Review. **NOTE**: HIPAA-covered entities will *not* need to update their EFT and ERA enrollment forms/systems as a result of a Limited Review.

46. What adjustments have been made to the CAQH CORE Maximum EFT & ERA Enrollment Data Sets to date?

2014 Review

In Q2 2014, the CAQH CORE Enrollment Data Task Group conducted the first Limited Review of the CORE-required Maximum EFT & ERA Enrollment Data Sets.

In this Limited Review, Task Group members identified and addressed non-substantive adjustments in the CORE-required Maximum EFT & ERA Enrollment Data Sets to improve implementer usability of the Enrollment Data Sets, including formatting inconsistencies and typographical errors, consistency between data elements, and improving clarity on data elements that generated questions from implementers. These non-substantive updates did not require HIPAA-covered entities to update their enrollment forms/systems.

Versions 3.0.1 of the Phase III CAQH CORE 380: EFT Enrollment Data Rule and Phase III CAQH CORE 382: ERA Enrollment Data Rule were distributed to the industry in September 2014.

2015 Review

The CAQH CORE Enrollment Data Task Group convened in Q4 2015 to conduct its first scheduled Comprehensive Review of the CORE-required Maximum EFT & ERA Enrollment Data Sets. During the Task Group's 2015 Review, Task Group members reviewed the rationale for and against conducting a Comprehensive Review. Upon consideration, the Task Group elected NOT to conduct a Comprehensive Review. This decision was based on several factors, which included:

- Industry resources better spent on higher-priority items such as ICD-10, completing implementations of mandated operating rules, and preparing for Phase IV implementation
- Lack of an industry-wide call to action for adjustments to the Enrollment Data Sets, i.e. CAQH CORE did not receive any Requests related to the Data Sets in 2015
- Current Data Sets are successfully implemented in the market, i.e. more than 30 organizations are Phase III CORE Certified and in conformance with the Data Sets

Additionally, the Task Group sought to collect non-substantive adjustments as part of a Limited Review. As no non-substantive adjustments were proposed, the Task Group did not update the Enrollment Data Sets in 2015.

47. How can my organization submit potential substantive adjustments to the CORE-required Maximum EFT & ERA Enrollment Data Sets for consideration during the next Comprehensive Review?

The next Comprehensive Review of the CORE-required Maximum EFT & ERA Enrollment Data Sets is schedule to occur in 2017. Per the CAQH CORE EFT & ERA Enrollment Data Sets Maintenance Process, the Comprehensive Reviews consider both substantive and non-substantive adjustments to the CORE-required Maximum EFT & ERA Enrollment Data Sets. More information on the 2017 Comprehensive Review will be shared later in 2017.

48. How will the CAQH CORE Enrollment Data Task Group evaluate potential substantive adjustments to the CORE-required Maximum EFT & ERA Enrollment Data Sets?

The CAQH CORE Enrollment Data Task Group uses a set of Enrollment Data Evaluation Criteria to evaluate potential *substantive* adjustments to the CORE-required Maximum EFT & ERA Enrollment Data Sets. When submitting potential substantive adjustments for Task Group consideration, stakeholder entities will be required to confirm that their submission meets at least four of the seven criteria listed below:

1. Supports the vision of the CAQH CORE Enrollment Data Rules to move the industry toward a uniform, standard maximum set of required EFT and ERA enrollment data elements
2. Promotes EFT and ERA enrollment efficiency (e.g., reduction in staff time and resources required to complete enrollment) and increases provider adoption by reducing the range of enrollment information requested and variation in terms used to collect the same/similar information
3. Does not result in addition of data elements that are semantic variations of existing data elements; i.e., data elements must collect unique and distinctly separate information
4. Meets a demonstrated, new or current industry-wide multi-stakeholder business need not addressed by the existing Enrollment Data Set
5. Ensures collection of key items needed to fully automate both claims payment and remittance advice posting processes
6. Balances return on investment (ROI) and industry-wide benefit against the significant lift required for health plans or agents to revise enrollment systems and paper-based forms and for providers to provide the data
7. Consistent with Phase III CAQH CORE Guiding Principles

In addition to alignment with the above Evaluation Criteria, the Enrollment Data Task Group's policy is to collect Supporting Information including a Business Case and any applicable Supporting Data for each submitted potential substantive adjustment to the CORE-required Maximum EFT & ERA Enrollment Data Sets.

For more information on the CAQH CORE EFT & ERA Enrollment Data Sets Maintenance Process, see the CAQH CORE EFT & ERA Enrollment Data Set Maintenance Process webpage.

49. How will organizations be notified about and access new versions of the CAQH CORE EFT & ERA Enrollment Data Rules?

Once the CAQH CORE Enrollment Data Task Group approves a set of substantive and/or non-substantive adjustments to the CORE-required Maximum EFT & ERA Enrollment Data Sets, an updated version of the CAQH CORE EFT & ERA Enrollment Data Rules will be published. Publication of updated versions of the CAQH CORE EFT & ERA Enrollment Data Rules will be announced on the CAQH CORE webpage and via an industry-wide email notification.

CAQH CORE is the authoring entity for two sets of ACA Section 1104 mandated Federal operating rules.

This document is for informational purposes only; in the case of a discrepancy between this document and CAQH CORE Operating Rule text and/or Federal regulations, the latter take(s) precedence.

50. How long will my organization have to update our EFT and/or ERA enrollment system or forms after publication of *substantive* adjustments to the CAQH CORE EFT & ERA Enrollment Data Rules?

HIPAA-covered entities will need to update their EFT and ERA enrollment forms/systems to ensure conformance with any *substantive* adjustments applied to the data sets as a result of a Comprehensive Review. Per the CAQH CORE EFT & ERA Enrollment Data Sets Maintenance Process, a health plan, or its agent offering EFT and/or ERA enrollment, will have:

- **NINE calendar months** to update their **electronic** EFT and/or ERA enrollment systems or forms and
- **TWELVE calendar months** to update their **paper-based** EFT and/or ERA enrollment forms.

The compliance timeframe for HIPAA-covered entities to adjust their systems and/or forms begins on the date of publication of the updated versions of the CORE-required Maximum EFT & ERA Enrollment Data Sets.

51. What is the schedule for CAQH CORE to publish adjustments to CAQH CORE EFT & ERA Enrollment Data Rules?

Per the CAQH CORE EFT & ERA Enrollment Data Sets Maintenance Process, Comprehensive and Limited Reviews of the CORE-required Maximum EFT & ERA Enrollment Data Sets occur biennially on alternating years (i.e., if a Comprehensive Review occurs one year, a Limited Review will occur the following year). The 2016 Review is scheduled to be a Limited Review followed by a Comprehensive Review in 2017.

52. How can my organization get involved in the CAQH CORE EFT & ERA Enrollment Data Sets Maintenance Process?

Entities are encouraged to join CAQH CORE as a CORE Participating Organization to contribute to the evolution of the CORE-required Maximum EFT & ERA Enrollment Data Sets via the CAQH CORE Enrollment Data Task Group. Participation in CAQH CORE also enables industry entities to have a say in the development of operating rules, and be part of a solution that diminishes the cost and complexity within the healthcare system. CAQH CORE welcomes Participating Organizations representing a range of stakeholder groups.

The CAQH CORE EFT & ERA Enrollment Data Sets Task Group is open to representatives from any CORE Participating Organization. There is no limit to the number of representatives that a CORE Participating Organization can assign to the Task Group. Individuals with knowledge of the business processes and work flows for EFT and ERA enrollments are strongly encouraged to join the Task Group. Interested participants can send their name, title, organization name, email address, and telephone number to core@caqh.org.

Entities can also contribute a number of other ways, including attendance on bimonthly CAQH CORE Town Hall Calls. Interested entities should email core@caqh.org for further information.

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VII. CAQH CORE 382: ERA Enrollment Data Rule

1. If we already offer ERA enrollment electronically, must we also implement a paper process?

No. The CAQH CORE 382 Rule, Section 4.5 specifies that "*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 CORE Rule, it is not required by this rule to implement a paper-based manual process on or after the compliance date.*"

NOTE: The CAQH CORE 382 Rule addresses electronic and paper-based collection and submission of the enrollment data. It does not specify the health plan's internal enrollment process.

2. What are the requirements for presentation of the CORE-required Maximum ERA Enrollment Data Elements?

Section 4.3.2 of the CAQH CORE 382 Rule requires that the CORE-required Maximum ERA Enrollment Data Set be used without revision or modification, and that the order of the data conforms to the flow, format, and data set (including data element descriptions) established in Table 4.2-1 of the rule. This requirement applies to both electronic enrollment data collection forms and manual paper-based forms, should a health plan or its agent offer a paper-based data collection process. In order to comply with the CAQH CORE 382 Rule requirements a health plan (or its agent or a vendor offering ERA) must not modify or vary the CORE ERA enrollment form template *and* ERA enrollment forms must follow the flow, format, and data set as specified in the rule.

3. What are the requirements for use of the CORE-required Maximum ERA Enrollment Data Elements Data Element Groups (DEGs)?

The CAQH CORE 382 Rule establishes a maximum set of data elements for both paper and electronic ERA enrollment data collection and submission. This maximum set of CORE-required ERA Enrollment Data Elements is specified in Table 4.2-1 of the rule, organized by categories of information referred to as "Data Element Groups". CAQH CORE 382, Section 4.3 and its subsections specify the requirements for how the CORE-required Maximum ERA Enrollment Data Elements must be presented in both paper and electronic based ERA enrollment forms. Specifically, the rule requires that health plans (or their agents or vendors offering ERA) use the format, flow, and data set (including data element descriptions) as given in Table 4.2-1. Additionally, all CORE-required ERA Enrollment Data Elements (including DEGs) must appear in the same order as they appear in Table 4.2-1.

4. Can additional data elements beyond the CORE-required Maximum ERA Enrollment Data Elements, be collected for ERA enrollment?

The CAQH CORE 382 Rule establishes a **maximum** set of data elements for both paper and electronic ERA enrollment. This maximum set of CORE-required ERA Enrollment Data Elements is specified in Table 4.2-1 of the rule. Section 4.3 and its subsections describe how the CORE-required Maximum ERA Enrollment Data Elements must be presented.

Also, the CAQH CORE 382 Rule does not preclude health plans (or their agents) from collecting additional data elements in locations beyond the ERA enrollment form for other purposes beyond ERA enrollment. Additionally, the CAQH CORE 382 Rule does not prohibit health plans and their agents from adding capabilities to the electronic ERA enrollment method designed to improve functionality and ensure data integrity and

comprehensiveness. Examples of functional and data improvements that may be added to the electronic submission tool include:

- Use of drop-down selection lists and/or radio buttons to respond to each CORE-required Data Element or Sub-element
- Requiring re-entry of key data to ensure accuracy
- Inclusion of a context-specific "Help" button to display a window that provides a detailed description of the CORE-required Data Element or other guidance, e.g., data format, etc.
- Enabling the end user to assign nicknames to certain data fields to more easily manage his/her data
- Displaying all data entered to the end user for final review/correction prior to actual "submission"

5. Can my health plan use a single form for both EFT and ERA enrollment?

Yes. CAQH CORE 380: EFT Enrollment Data Rule and CAQH CORE 382: ERA Enrollment Data Rule establish a maximum set of data elements to be included on enrollment forms for EFT and ERA, as well as a required flow and format for presentation of the data elements on the form. The two rules were developed independent of each other as some health plans enroll providers separately for EFT and ERA while other combine the enrollments.

The CAQH CORE Enrollment Data Rules do not require or prohibit entities from creating a single form for the purposes of both EFT and ERA enrollment as long as the format, flow, and data set (including data element descriptions) are used as specified in CAQH CORE 380 Rule Table 4.2-1 ***and*** CAQH CORE 382 Rule Table 4.2-1. Sections 4.5 of the CAQH CORE 380 and 382 Rules specify the timeframe for converting existing paper-based EFT and ERA enrollment forms to comply with the rules.

6. My health plan currently uses one inclusive form to enroll providers to receive all healthcare electronic transactions. Can we use this same form to collect CORE-required Maximum ERA Enrollment Data Elements?

Yes. The CAQH CORE 382 Rule establishes a maximum set of data elements to be included on an ERA enrollment form, as well as a required flow and format for presentation of the data elements on the form. The CAQH CORE 382 Rule does not require or prohibit entities from using an inclusive form for the purposes of ERA Enrollment as long as the format, flow, and data set (including data element descriptions) are used as given in CAQH CORE 382 Rule, Table 4.2-1, *CORE-required Maximum ERA Enrollment Data Set*. Section 4.5 of the CAQH CORE 382 Rule specifies the timeframe for converting existing paper-based enrollment forms to comply with the rule.

NOTE: Section 4.4 of the CAQH CORE 382 Rule also requires all health plans, and their agents or vendors offering ERA enrollment, to *"implement and offer to any trading partner (e.g., a healthcare provider) an electronic method (actual method to be determined by health plan or its agent) and process for collecting the CORE-required Maximum ERA Enrollment Data Set.*"

7. Does the CAQH CORE 382 Rule, Section 4.4 requirement for health plans to offer an electronic safe harbor method for data collection mean health plans can *only* collect the ERA enrollment data elements electronically (i.e., cannot use paper-based enrollment forms)?

No. Per the CAQH CORE 382 Rule, Section 4.4, *CORE Electronic Safe Harbor for ERA Enrollment to Occur Electronically*, all health plans must "*implement and offer to any trading partner (e.g., a healthcare provider) an electronic method (actual method to be determined by health plan or its agent) and process for collecting the CORE-required Maximum ERA Enrollment Data Set*."

CAQH CORE is the authoring entity for two sets of ACA Section 1104 mandated Federal operating rules.

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Rule Section 4.4 also notes that the rule "*DOES NOT require health plans or their agents to use ONLY an electronic method and process for collecting the CORE-required Maximum ERA Enrollment Data Set*." Health plans must offer an electronic method for collection and submission of the CORE-required Maximum ERA Enrollment Data Set, but they may continue to also offer a paper-based method of enrollment, provided that the paper-based method of enrollment also meets all applicable rule requirements (see especially Section 4.3.1, *Master Template for Manual Paper-Based Enrollment*).

8. The CAQH CORE 382 Rule, Section 4.3.1, *Master Template for Manual Paper-Based Enrollment,* requires the ERA enrollment form to include a section outlining how providers can access online instructions to determine their enrollment status. Does this mean health plans must also enable providers to view their enrollment status online?

No. Section 4.3.1 of the CAQH CORE 382 Rule requires that health plans provide instructions online for how providers can determine the status of the enrollment. The ERA enrollment form must include a section outlining how to access these online instructions. The CAQH CORE 382 Rule **does not** require that that the status of enrollment must be able to be determined via online tool.

9. As a health plan, am I required to include only the Individual Data Elements within ***required* Data Element Groups (DEGs) on my ERA Enrollment form?**

The CORE-required Maximum ERA Enrollment Data Set includes ten Data Element Groups (DEGs). A DEG may be designated as **required** or **optional** for data collection. Additionally, within each DEG, Individual Data Elements may be designated as **required** or **optional** for data collection.

When a DEG is designated as **required**:

- The health plan must collect all Individual Data Elements within the DEG that are designated as **required.**
- The health plan may elect not to collect any Individual Data Elements within the DEG that are designated as **optional.**

When a DEG is designated as **optional**:

- The health plan may elect not to include this optional DEG for collection on the ERA Enrollment Form.
- However, if the health plan chooses to collect this optional DEG, the health plan *must* collect all Individual Data Elements within the DEG that are designated as **required**; the health plan may elect not to collect any Individual Data Elements within the optional DEG that are designated as **optional.**

10. As a health plan, if I choose to include an *optional* Data Element Group (DEG) on my enrollment form, must I include all of the Individual Data Elements within the DEG?

No. If a health plan chooses to collect an **optional** DEG:

- The health plan **must** collect all Individual Data Elements within the optional DEG that are designated as **required.**
- However, the health plan may elect **not** to collect any Individual Data Elements within the optional DEG that are designated as **optional**.

11. As a health plan, if I collect some of the data elements in the CAQH CORE Maximum ERA Enrollment Data Set as part of another enrollment process (e.g., provider credentialing), must I still include these data elements on my ERA enrollment form?

Not collecting an Individual Data Element identified as **optional** is not prohibited by the CAQH CORE 382 Rule requirements for the CORE-required Maximum ERA Enrollment Data Set. **However**, the CAQH CORE 382 Rule requires that the following Individual Data Elements must be collected during the ERA Enrollment process:

- All **required** Individual Data Elements within **required** DEGs
- All Individual Data Elements designated as **required** within **optional** DEGs, **if the health plan chooses to collect the optional DEG.**

NOTE: The CAQH CORE 382 Rule does not prevent a health plan from pre- or auto-populating the form with known data (for the provider to confirm or change), but the required Individual Data Elements must still be collected during the process.

12. What Individual Data Elements must be included in the electronic enrollment method required under Section 4.4 of the CAQH CORE 382 Rule?

Section 4.4 of the CAQH CORE 382 Rule requires all health plans to offer an "electronic safe harbor" enrollment method/process for collecting the CORE-required Maximum ERA Enrollment Data Set. The CAQH CORE 382 Rule requires that the following Individual Data Elements must be included in the electronic enrollment method:

- All **required** Individual Data Elements within **required** DEGs
- All Individual Data Elements designated as **required** within **optional** DEGs, **if the health plan chooses to collect the optional DEG.**

13. If a health plan or its agent uses a web-based enrollment method to fulfill the CORE Electronic Enrollment Safe Harbor required by Section 4.4 of the CAQH CORE 382 Rule do all of the ERA Enrollment Data Elements have to be included on a single webpage?

No. The CAQH CORE 382 Rule, Section 4.3.2, *Master Template for Electronic Enrollment*, requires that a web-based method of enrollment is restricted "*only to the extent that the flow, format and data set including data element descriptions established by this rule must be followed*." The CAQH CORE 382 Rule does not include any language surrounding pagination or other contiguity of the data. Therefore, a web-based enrollment method with data elements on different pages would be compliant with the rule requirements.

14. Are the *Assigning Authority* and *Trading Partner ID* Individual Data Elements in the CORE-required Maximum ERA Enrollment Data Set the same as the Interchange ID Qualifier, Interchange Receiver ID, and Application Receiver's Code data elements identified in the X12 v5010 835 ISA and GS control segments?

No. The CAQH CORE 382 Rule establishes a maximum set of data elements to be collected by the health plan from the provider for ERA enrollment, as well as a required flow and format for the data elements on a web-based or paper-based enrollment form. It does not address data elements in the X12 v5010 835 ISA and GS control segments. These data elements are outside the scope of the CAQH CORE 382 Rule, and would need to be collected from the provider external to the ERA Enrollment process.

15. For health plans that use a web-based ERA enrollment method to fulfill the CAQH CORE Electronic Enrollment Safe Harbor, does CAQH CORE have an XML Schema Specification that can be used to create a web-based enrollment method?

No. There is no XML Schema Specification (.xsd file) for the CAQH CORE EFT & ERA Operating Rules, including the CAQH CORE 382 Rule. However, to assist implementers, CAQH CORE has published Excel-based versions of both the CORE-required Maximum EFT Data Set and CORE-required Maximum ERA Enrollment Data Set tables. The Excel Workbooks are available at the links below and on the CAQH CORE website:

- Excel Copy of the CORE-required Maximum EFT Enrollment Data Set
- Excel Copy of the CORE-required Maximum ERA Enrollment Data Set

NOTE: CAQH CORE 382 Rule, Section 4.3.2, *Master Template for Electronic Enrollment*, does specify that: **"***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>.*" There are no additional XML specifications for a web-based enrollment method beyond this requirement.

16. Are there available data file examples (e.g., DOC, XLS ,TXT, CSV, XML, etc.) of the CORE-required Maximum ERA Enrollment Data Set that health plans, their agents and/or vendors offering ERA Enrollment, can use to develop their enrollment form/utility?

Yes. As noted above, CAQH CORE has published an Excel-based version of Table 4.2-1, *CORE-required Maximum ERA Enrollment Data Set*. The Excel Workbooks are available at the links below and on the CAQH CORE website:

- Excel Copy of the CORE-required Maximum EFT Enrollment Data Set
- Excel Copy of the CORE-required Maximum ERA Enrollment Data Set

Beyond this Excel document and the table in the CAQH CORE 382 Rule, there are no other available data file examples of the CORE-required Maximum ERA Enrollment Data Set.

17. Does the reference to a "Safe Harbor" in Section 4.4 of the CAQH CORE 382 Rule mean that health plans must support data collection through the CAQH CORE 270: Connectivity Rule?

No. The reference in the CAQH CORE 382 Rule to a "safe harbor" **does not** mean that health plans must support the CAQH CORE Connectivity Safe Harbor for collection of the CORE-required Maximum ERA Enrollment Data Set.

Section 4.4, *CAQH CORE Electronic Safe Harbor for ERA Enrollment*, of the CAQH CORE 382 Rule requires all health plans to offer an "electronic safe harbor" enrollment method/process for collecting the CORE-required Maximum ERA Enrollment Data Set. The CAQH CORE 382 Rule does not specify the electronic method that health plans must use to fulfill the safe harbor requirement.

While the CAQH CORE 382 Rule does not require health plans to do so, health plans may choose to use the CAQH CORE 270 Connectivity Safe Harbor to fulfill the CAQH CORE Electronic Enrollment Safe Harbor. The CAQH CORE Connectivity Rule is payload agnostic and thus can carry both X12 and non-X12 administrative transaction payloads. Section 4.4.4 of the CAQH CORE 270 Rule specifies how to enumerate non-X12 payloads in the PayloadType field.

18. Does the CAQH CORE 382 Rule require health plans to process a provider's ERA enrollment within a specific time period?

No. The CAQH CORE 382 Rule establishes a *maximum* set of data elements for both paper and electronic ERA enrollment as well as how the CORE-required Maximum ERA Enrollment Data Elements must be presented in both paper and electronic based ERA enrollment forms The CAQH CORE 382 Rule **does not** establish a required timeframe for processing a provider's ERA Enrollment.

NOTE: Section 4.2, *CORE-required Maximum ERA Enrollment Data Elements*, of the CAQH CORE 382 Rule requires the health plan to "*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.*"

The CAQH CORE 382 Rule does not specify the exact wording for the instructions and guidance that must be provided by the health plan. In anticipation of provider questions, the health plan could choose to describe its expected timeframe for processing enrollments in these instructions.

19. Per the CAQH CORE 350 Rule, health plans must support use of the CAQH CORE Connectivity Safe Harbor when conducting or processing the X12 v5010 835. As a provider, can I request to receive the X12 v5010 835 via the CAQH CORE Connectivity Safe Harbor during ERA Enrollment?

Yes. Data Element Group 7: *Electronic Remittance Advice Information* within the CORE-required Maximum ERA Enrollment Data Set includes as an Individual Data Element "*Method of Retrieval*". "*Method of Retrieval*" is described in Table: 4.2-1, *CORE-required Maximum ERA Enrollment Data Set*, as the "*the method in which the provider will receive the ERA from the health plan (e.g., download from health plan website, clearinghouse, etc.)*."

As noted, the CAQH CORE 350: Health Care Claim Payment/Advice (835) Infrastructure Rule requires a health plan, or clearinghouse acting on behalf of a health plan, to support use of the CAQH CORE 270 Rule Connectivity Safe Harbor when conducting or processing the X12 v5010 835. Therefore, the CAQH CORE Connectivity Safe Harbor should be included as one of the ERA retrieval methods available to providers.

NOTE: When the provider is retrieving the X12 v5010 835 directly from a health plan (i.e., without an intermediary) this data element is required. However, when the provider is using an intermediary clearinghouse or vendor its use is optional.

20. By what date does my health plan, or agent or vendor offering ERA enrollment, need to convert our paper-based ERA enrollment forms to comply with the CORE-required Maximum ERA Enrollment Data Set, per the CAQH CORE 382 Rule?

Section 4.5 of the CAQH CORE 382 Rule specifies a time frame for health plans to convert all paper-based ERA enrollment forms relative to the compliance date for any Federal regulation that adopts the CAQH CORE 382 Rule for mandatory implementation. Specifically the rule states: *"Not later than the date that is **six months after** the compliance date specified in any Federal regulation adopting this CORE Operating 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 all its paper-based forms to comply with the data set specified in this rule."*

NOTE: The CAQH CORE 382 Rule requirement applies **only** if a health plan, or its agent or vendor offering ERA enrollment, has an existing paper-based enrollment form or chooses to use a paper-based form. The CAQH

CORE 382 Rule **does not** require health plans to use a paper-based enrollment form if they do not currently do so. However, an electronic method for collecting and submitting the enrollment data elements is required.

In August 2012, HHS issued an Final Rule that adopts all of the CAQH CORE EFT & ERA Operating Rules to fulfill the Federal mandate under ACA Section 1104, *with the exception of rule requirements pertaining to use of Acknowledgements*. Per ACA Section 1104, the compliance date for the ACA-mandated EFT & ERA operating rules is **January 1, 2014**. Section 4.5 of the CAQH CORE 382 Rule requires health plans to modify their paper-based enrollment forms to conform to the CORE-required Maximum ERA Enrollment Data Set no later than **six months after** the January 1, 2014 Federal compliance date.

For more information on the ACA Section 1104 requirements for Federal operating rules, please see CAQH CORE FAQs Part B: ACA Section 1104 Mandate for Federal Operating Rules.

21. Does the CAQH CORE 382 Rule specify requirements for how health plans should verify the accuracy of the enrollment data submitted by providers?

No. Verifying the accuracy of the data collected from the provider during the ERA enrollment process is out of scope for the CAQH CORE EFT & ERA Operating Rules. The policies and methods that a health plan uses to verify accuracy of data are business decisions on the part of the health plan or its agent or vendor offering ERA enrollment.

22. As a health plan, do we have to collect *required* Individual Data Elements for which we do not have a business need?

Yes. A health plan (or its agent or vendor offering ERA enrollment) must collect all Individual Data Elements per the CAQH CORE 382 Rule requirements, including those for which the health plan has no business need.

The CORE-required Maximum ERA Enrollment Data Elements were identified after substantial industry research and analysis to compare ERA enrollment forms from across the industry. The CORE Participants agreed that these data elements represented the maximum set of data elements required for successful ERA enrollment. The CORE-required Maximum ERA Enrollment Data Set includes ten Data Element Groups (DEGs) designated as **required** or **optional** for data collection. Per Section 4.2, *CORE-required Maximum ERA Enrollment Data Elements*, of the CAQH CORE 382 Rule, the following Individual Data Elements must be included on either a paper-based or electronic enrollment form:

- All **required** Individual Data Elements within **required** DEGs
- All Individual Data Elements designated as **required** within **optional** DEGs, **if the health plan chooses to collect the optional DEG.**

23. As a health plan, do I conform to the CAQH CORE 382 Rule requirements for presentation of the CORE-required ERA Enrollment Data Elements if I use abbreviated Data Element Names on my electronic enrollment form and provide the full Data Element Names via a "mouse hover" function?

No. Section 4.3.2, *Master Template for Electronic Enrollment*, of the CAQH CORE 382 Rule specifies that health plans "*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****."* As described in Section 3.2, *CORE-required Maximum ERA Enrollment Data Element Set*, this requirement serves to provide consistency across health plans' enrollment processes and promotes provider adoption of ERA.

CAQH CORE is the authoring entity for two sets of ACA Section 1104 mandated Federal operating rules.

This document is for informational purposes only; in the case of a discrepancy between this document and CAQH CORE Operating Rule text and/or Federal regulations, the latter take(s) precedence.

To meet the requirements specified in Section 4.3.2, the Data Element Name must be used in full on the electronic enrollment form. Use of an abbreviated Data Element Name on an electronic enrollment form does not satisfy the rule requirement.

24. As a health plan, do I conform to the CAQH CORE 382 Rule requirements for presentation of the CORE-required ERA Enrollment Data Elements if I use a "mouse hover" function to provide the descriptions of the enrollment data elements?

Yes. Although a health plan (or its agent or vendor offering ERA enrollment) may not use a "mouse hover" function to provide the Data Element Names, the CAQH CORE 382 Rule does permit a health plan to use a "mouse hover" to display supplemental information about the enrollment data elements, such as the Data Element Description, or to provide further guidance to the provider on completing the enrollment form.

25. Do the CAQH CORE EFT & ERA Enrollment Data Rules (CAQH CORE 380 & 382) specify requirements regarding whether a health plan can make provider EFT enrollment contingent upon the provider also enrolling to receive the X12 v5010 835 ERA?

No. The CAQH CORE EFT & ERA Enrollment Data Rules (CAQH CORE 380 & 382 Rules) establish a maximum set of data elements to be included on an EFT and/or ERA enrollment form, as well as a required flow and format for presentation of the data elements on the form. The CAQH CORE EFT & ERA Enrollment Data Rules **do not** address whether or not health plans can make provider enrollment to receive healthcare EFT contingent on the provider also enrolling to receive the X12 v5010 835 ERA, or vice versa. Such a requirement is a health plan's individual business decision.

26. Section 4.3, *CORE Master Template for Collecting ERA Enrollment Data*, of the CAQH CORE 382 Rule requires a health plan ERA enrollment form to follow the "format, flow, and data set" specified in Table: 4.2-1. How are format, flow, and data set defined for this requirement?

Section 4.3 of the CAQH CORE 382 Rule requires health plans "*to use the format, flow and data set including data element descriptions in Table 4.2-1 as the CORE Master ERA Enrollment Submission form*" for both paper-based and electronic ERA enrollment methods. The intent of the reference to "format, flow, and data set" is:

- "Flow" means the order/sequence of the data elements in Table: 4.2-1
- "Data Set" is the set of elements specified in Table: 4.2-1
- "Format" refers to the Data Type and Format as specified in Table: 4.2-1 (e.g., alphanumeric, 15 characters for Zip Code).

27. Does CAQH CORE have a glossary that defines the terms used in Table: 4.2-1, CORE-required Maximum EFT Enrollment Data Set of the CAQH CORE 382 Rule?

CAQH CORE 382 Rule Table: 4.2-1 provides Data Element Descriptions and Data Types and Formats (when necessary) for the Individual Enrollment Data Elements in the CORE-required Maximum ERA Enrollment Data Set. Beyond the Data Element Descriptions and Data Types and Formats, further descriptive information (including citations) clarifying the terms used in Table 4.2-1 is provided via footnotes included for many of the Individual Data Elements. Beyond these references in the rule, there is not a separate glossary of terms.

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28. Section 4.4 of the CAQH CORE 382 Rule requires health plans, or their agents/vendors offering ERA, to implement and offer an electronic method and process for collecting the CORE-required Maximum ERA Enrollment Data Set. What specific format(s) constitute an "electronic" method in accordance with the CAQH CORE 382 Rule requirement?

The CAQH CORE 382 Rule does not define a specific format(s) that constitutes an electronic method and process for collecting the CORE-required Maximum ERA Enrollment Data Set.

CAQH CORE does not provide a definition of "electronic" methods specific to implementation of the CAQH CORE Operating Rules. Rather, CAQH CORE has relied on various HIPAA regulations to do so for the industry. Currently, there are many ways entities can implement an "electronic" collection method. In the broader context of the mission and vision of CAQH CORE, the goal is to assist the industry to adopt uniform and consistent automated electronic processes to reduce costs and build efficiencies.

CMS is the HHS designated authority on any decisions regarding interpretation, implementation, and enforcement of the regulations adopting the HIPAA and ACA Administrative Simplification standards and provisions. As the regulatory authority, the determination of what constitutes an "electronic" method for collecting the *CORE-required Maximum ERA Enrollment Data Set* must be made by the CMS Office of E-Health Standards and Services (OESS). The January 2013 HHS HIPAA Privacy and Security omnibus final rule includes a definition of "electronic media," and CAQH CORE has asked CMS OESS to provide further guidance to the industry on the regulatory language, and what constitutes an "electronic" method. It is anticipated that a CMS OESS FAQ will be published shortly; thereafter CAQH CORE will provide detailed examples of the multiple ways to meet the requirements for both electronic collection and submission.

29. If a health plan, or its agent or vendor offering EFT and ERA enrollment, chooses to use a single form for the purposes of both EFT and ERA enrollment, how should the EFT and ERA Enrollment Data Element Groups in the CAQH CORE Enrollment Data Rules (CAQH CORE 380 Rule and CAQH CORE 382 Rule) be presented on the form?

The CAQH CORE Enrollment Data Rules do not prohibit entities from creating a single form for the purposes of both EFT and ERA enrollment. A combined EFT and ERA enrollment form must contain all of the required Data Element Groups (DEGs) and required Individual Data Elements from Table: 4.2-1, *CORE-required Maximum EFT/ERA Enrollment Data Set* in CAQH CORE 380 Rule ***and*** CAQH CORE 382 Rule. **NOTE:** Entities are not required to repeat DEGs that are identical in both enrollment data rules (e.g., DEG1).

Although the CAQH CORE Enrollment Data Rules do not explicitly outline the flow and format for a combined EFT and ERA enrollment form, DEGs unique to either of the CAQH CORE Enrollment Data Rules would need to be collected using the same general flow and format. For example, "*Financial Institution Information*" (DEG7 in the CAQH CORE 380 Rule) and "*Electronic Remittance Advice Information*" (DEG7 in the CAQH CORE 382 Rule) are both required for collection on a combined EFT and ERA enrollment form. Both DEGs would be collected after DEGs 1 through 6 in the CAQH CORE 380 and CAQH CORE 382 Rules, and before "*Submission Information*", DEG 10 in the CAQH CORE 382 Rule.

30. My organization is a health plan. Do the CAQH CORE EFT & ERA Operating Rules specify requirements for how soon after we receive a provider EFT and/or ERA enrollment form that we must process the enrollment and implement a connection with the provider to deliver the transactions?

No. The CAQH CORE EFT & ERA Operating Rules **do not** specify timeframe requirements regarding how soon a health plan must process a provider's EFT and/or ERA enrollment and/or implement a connection with the provider to deliver the transactions.

However, the CAQH CORE EFT & ERA Operating Rules do specify timeframe requirements that address exchange of the NACHA CCD+ and X12 v5010 835 transactions such as:

- CAQH CORE 350: Health Care Claim Payment/Advice (835) Rule: Section 4.3, *Dual Delivery of v5010 X12 835 and Proprietary Paper Claim Remittance Advices*, requires health plans to support a dual or parallel processing period during which providers can continue to receive proprietary paper RAs while they test the use of the X12 v5010 835 standard and associated operating rules. The dual delivery period must be a period of 31 days or a minimum of 3 payments, whichever is longer.
    - **NOTE:** The dual delivery requirement applies **only if the health plan currently delivers proprietary paper RAs**. If a health plan does not currently deliver proprietary paper RAs, the CAQH CORE 350 Rule does not require a health plan to start doing so.
- CAQH CORE 370: EFT & ERA Reassociation (CCD+/835) Rule: Section 4.2, *Elapsed Time between Sending the X12 v5010 835 and the CCD+ Transactions*, requires health plans to release the X12 v5010 835: *"No sooner than three business days based on the time zone of the health plan prior to the CCD+ Effective Entry Date* ***And*** *No later than three business days after the CCD+ Effective Entry Date."*
    - The elapsed time requirement means that a health plan *must not* send the corresponding X12 v5010 835 **earlier than three business days prior to** the CCD+ Effective Entry Date or **later than three business days after** the CCD+ Effective Entry Date.

31. Section 4.3.2 of the CAQH CORE 382 Rule requires that a health plan (or its agent or vendor offering ERA enrollment) offer an electronic way for providers to *submit* the CORE-required Maximum ERA Enrollment Data Set. What specific format(s) constitute an "electronic" submission method in accordance with the CAQH CORE 382 Rule requirement?

The CAQH CORE 382 Rule does not define a specific format(s) that constitutes an electronic method and process for submitting the CORE-required Maximum ERA Enrollment Data Set.

CAQH CORE does not provide a definition of "electronic" methods specific to implementation of the CAQH CORE Operating Rules. Rather, CAQH CORE has relied on various HIPAA regulations to do so for the industry. Currently, there are many ways entities can implement "electronic" methods for data submission. In the broader context of the mission and vision of CAQH CORE, the goal is to assist the industry to adopt uniform and consistent automated electronic processes to reduce costs and build efficiencies.

CMS is the HHS designated authority on any decisions regarding interpretation, implementation, and enforcement of the regulations adopting the HIPAA and ACA Administrative Simplification standards and provisions. As the regulatory authority, the determination of what constitutes an "electronic" method for submitting the CORE-required Maximum ERA Enrollment Data Set must be made by the CMS Office of E-Health Standards and Services (OESS). The January 2013 HHS HIPAA Privacy and Security omnibus final rule includes a definition of "electronic media," and CAQH CORE has asked CMS OESS to provide further guidance to the industry on the regulatory language, and what constitutes an "electronic" method. It is anticipated that a CMS OESS FAQ will be published shortly; thereafter CAQH CORE will provide detailed examples of the multiple ways to meet the requirements for both electronic collection and submission.

32. Table 4.2-1 in the CAQH CORE 382 Rule includes "*Provider Contact Name*" as a required Data Element in Data Element Group (DEG) 3 with the Sub-element "*Email Address*". The specified requirement for collection of "*Email Address*" is "*Required; not all providers may have an email address*". Does the CAQH CORE 382 Rule define what data a health plan should collect when the provider does not have an email address?

No. The CAQH CORE 382 Rule does not explicitly define what a health plan must collect for the Sub-element "*Email Address*" when a provider does not have an email address. However, Section 4.2, *CORE-required Maximum ERA Enrollment Data Elements*, requires a health plan to "*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.*" The health plan could, in these instructions, describe what the provider should enter in the event that the provider does not have an email address (e.g., "If you do not have an email address, please leave the field blank," or "If you do not have an email address, please enter 'NONE'," etc.)

33. My organization is a clearinghouse that enrolls providers to receive the X12 v5010 835 from multiple health plan trading partners (i.e., conducts mass ERA enrollment). Can we continue to conduct mass enrollment using the CAQH CORE-required Maximum ERA Enrollment Data Set?

Yes. The CAQH CORE 382 Rule provides a uniform and consistent maximum set of data elements that can be used by any health plan (or its agent/vendor offering ERA enrollment) for the purposes of enrolling any healthcare provider to receive remittance information electronically. This data set is the same for all providers and all health plans (or their agents/vendors); the CAQH CORE 382 Rule, therefore, can support approaches that are designed to enroll all providers with all plans (i.e., mass enrollment).

Section 4.2 of the CAQH CORE 382 Rule requires a health plan (or its agent/vendor offering ERA enrollment) to "*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".* A clearinghouse, or other intermediary, could include in these instructions guidance specific to the health plans for which it is authorized to collect enrollment data.

The CAQH CORE 382 Rule **does not** address the functionality or capability of an ERA enrollment ***system or process***, which may include other data functions/capabilities beyond the collection of the CORE-required Maximum ERA Enrollment Data Set. A clearinghouse, or other intermediary, that conducts mass enrollment may include data fields in its enrollment process to collect information such as with which health plans providers want to enroll (specific to the health plans for which the clearinghouse is authorized to collect such provider enrollment data). Such a data field could be included in the enrollment process ***prior to or after*** collection of the CORE-required Maximum ERA Enrollment Data Set.

The CAQH CORE 382 Rule also permits clearinghouses, and other entities conducting ERA enrollment, to include other functionalities in the enrollment process (e.g., requiring a username/password to log on to the health plan's website to begin the enrollment process, use of a mouse hover to display supplemental information about data elements, etc.). For further guidance, see "*Can additional data elements beyond the CORE-required Maximum ERA Enrollment Data Elements be collected for ERA enrollment?"*)

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34. Section 4.3.1 of the CAQH CORE 382 Rule requires health plans to "*use the format, flow, and data set including data element descriptions of Table 4.2-1*" when using a manual *paper-based* enrollment form. Does including the Data Element Descriptions in an Appendix to the paper-based enrollment form conform to the Section 4.3.1 requirements?

Section 4.3.1, *Master Template for Manual Paper-Based Enrollment*, of the CAQH CORE 382 Rule requires that a health plan (or its agent/vendor offering ERA enrollment) "*use the format, flow and data set including data element descriptions in Table 4.2-1 as the CORE Master ERA Enrollment Submission form when using a manual paper-based enrollment method*." The CAQH CORE 382 Rule **does not** require that the Data Element Descriptions be included directly next to the Individual Data Element Name on the paper-based form. A health plan may include the Data Element Descriptions in an Appendix to the paper-based enrollment form provided that the health plan, as required by Section 4.3.1, "*clearly label*[s] *any appendix describing its purpose as it relates to the provider enrolling in ERA*."

NOTE: The CAQH CORE 382 Rule **does not** require health plans to use a paper-based enrollment form if they do not currently do so. However, an electronic method for collecting and submitting the enrollment data elements is required. As with the paper-based form, the Data Element Descriptions are not required to be included directly next to the Individual Data Element Name on the **electronic** enrollment form. Health plans may use a function such as a "mouse hover" to display the Data Element Descriptions. (See FAQ "*As a health plan, do I conform to the CAQH CORE 382 Rule requirements for presentation of the CORE-required ERA Enrollment Data Elements if I use a "mouse hover" function to provide the descriptions of the enrollment data elements?"*)

35. The HIPAA provisions require use of a National Provider Identifier (NPI) only to identify HIPAA covered providers in a transaction standard. Why does the CAQH CORE 382 Rule require inclusion of both TIN and NPI as sub-elements for the "*Provider Identifier*" Data Element in DEG2 and "*Preference for Aggregation of Remittance Data (e.g., Account Number Linkage to Provider Identifier)*" Data Element in DEG7?

Per the HIPAA Administrative Simplification provisions, as of May 2008, HIPAA covered entities must use the National Provider Identifier (NPI) only to identify a group or individual as a HIPAA covered provider in the HIPAA transaction standards. A Taxpayer Identification Number (TIN), e.g., Social Security Number (SSN) or Employer Identification Number (EIN), can only be used when identifying a HIPAA covered provider as a tax payer.

These requirements do not apply to providers that are **not HIPAA covered** as non-HIPAA covered providers are not required to obtain and use an NPI. Per CMS, a non-HIPAA covered provider that does not have an NPI should be identified in the HIPAA transaction standards by "*its SSN or EIN as its Primary Identifier in standard transactions designed to capture a Primary and a Secondary Identifier for a health care provider* [or] *by one of the qualifiers (other than the qualifier for the NPI) listed in the Implementation Guides that are designed to capture a single identifier for a health care provider*" (see CMS FAQ#1949).

The CAQH CORE 382 Rule requires inclusion of both NPI and TIN as "*Provider Identifier*" and "*Preference for Aggregation of Remittance Data (e.g., Account Number Linkage to Provider Identifier)"* sub-elements to allow for enrollment of a non-HIPAA covered provider that does not have an NPI.

36. Why does the CORE-required Maximum ERA Enrollment Data Set require health plans to collect a National Provider Identifier (NPI) and/or Taxpayer Identification Number (TIN) in both DEG2 and DEG7?

Data Element Groups (DEGs) 2 and 7 represent two different sets of data elements that are necessary to enroll a provider to receive the X12 v5010 835:

- DEG2: *Provider Identifiers Information* collects information related to the enrolling provider identified in DEG1: *Provider Information*. Within DEG2, health plans (or their agent/vendor offering ERA enrollment) are required to collect a *Provider Identifier*, which must be the identification number, NPI or TIN for non-HIPAA covered providers, **for the legal entity** reported under the "*Provider Name*" Data Element in DEG1.
- DEG7: *Electronic Remittance Advice Information* collects information related to how the provider wishes to receive the X12 v5010 835 transaction. Within DEG7, health plans (or their agent/vendor offering ERA enrollment) are required to collect a "*Preference for Aggregation of Remittance Data (e.g., Account Number Linkage to Provider Identifier)*". The X12 v5010 835 TR3 requires ***a single X12 v0510 835 transaction to correspond to a single EFT payment***. Therefore, to identify the EFT payment corresponding to the X12 v5010 835 transaction, the identifier collected in DEG7 **must** be the identification number, NPI or TIN for non-HIPAA covered providers, **linked to the provider's Receiving Depository Financial Institution (RDFI) account**.

The identification number linked to the provider's RDFI account may differ from the identification number used to identify the legal entity. As such, the CAQH CORE 382 Rule requires health plans (or their agent/vendor offering ERA enrollment) to collect an identification number in both DEG2 and DEG7.

37. The CORE-required Maximum ERA Enrollment Data Set requires health plans to collect a National Provider Identifier (NPI) and/or Taxpayer Identification Number (TIN) in both DEG2 and DEG7. Does the CAQH CORE 382 Rule require the identifier collected in DEG2 to be the same as the identifier collected in DEG7?

No. While the identifier collected for DEG2: *Provider Identifiers Information* can be the same as the identifier collected for DEG7: *Electronic Remittance Advice Information*, the CAQH CORE 382 Rule **does not** require them to be the same.

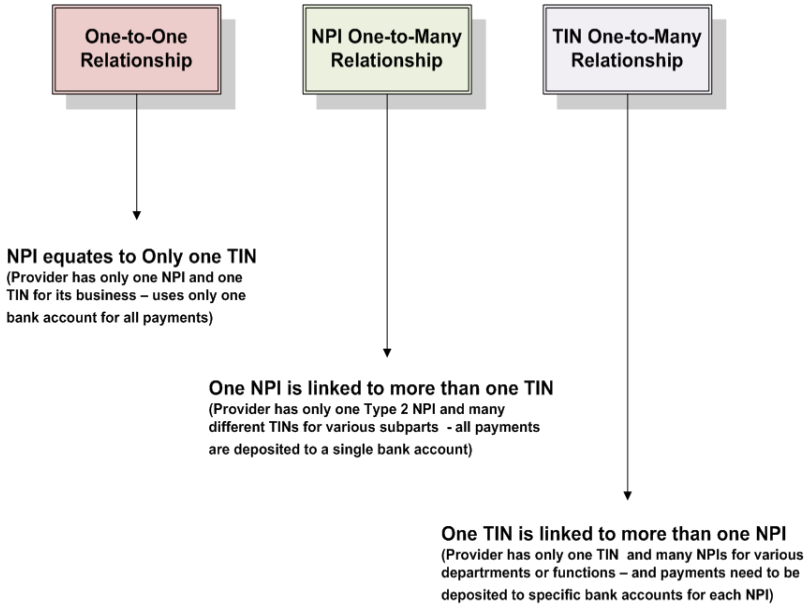
Data Element Groups (DEGs) 2 and 7 represent two different sets of data elements that are necessary to enroll a provider to receive the X12 v5010 835:

- DEG2: *Provider Identifiers Information* collects information related to the enrolling provider identified in DEG1: *Provider Information*. Within DEG2, health plans (or their agent/vendor offering ERA enrollment) are required to collect a *Provider Identifier*, which must be the identification number, NPI or TIN for non-HIPAA covered providers, **for the legal entity** reported under the "*Provider Name*" Data Element in DEG1: *Provider Information*.
- DEG7: *Electronic Remittance Advice Information* collects information related to how the provider wishes to receive the X12 v5010 835 transaction. Within DEG7, health plans (or their agent/vendor offering ERA enrollment) are required to collect a "*Preference for Aggregation of Remittance Data (e.g., Account Number Linkage to Provider Identifier)*". The X12 v5010 835 TR3 requires ***a single X12 v0510 835 transaction to correspond to a single EFT payment***. Therefore, to identify the EFT payment corresponding to the X12 v5010 835 transaction, the identifier collected in DEG7 **must** be the identification number, NPI or TIN for non-HIPAA covered providers, **linked to the provider's Receiving Depository Financial Institution (RDFI) account**.

Depending on how a provider has established its financial accounting structure, the provider's RDFI account could be linked to an identification number that is different from the identification number used to identify the

legal entity being enrolled for ERA. As shown in the figure below, a number of arrangements may exist:

- A provider, individual or group, can have a single TIN that is linked to both a single NPI and a single RDFI account.
- A provider group can have a single TIN that is linked to multiple NPIs, representing both individual provider subparts and the provider entity as a whole, with each NPI linked to a different RDFI account.
- A provider individual can have a single NPI that is linked to multiple TINs, representing different provider organizations, and a single RDFI account.



As the identification number linked to the provider's RDFI account may differ from the identification number used to identify the legal entity, the CAQH CORE 382 Rule does not require the identification numbers collected within DEG2 and DEG7 to be the same.

Please note: As the X12 v5010 835 TR3 requires a single X12 v0510 835 to correspond to a single EFT payment, the CAQH CORE 382 Rule **does** require the identifier collected for "*Preference for Aggregation of Remittance Data*" during ERA enrollment to be the same as the identifier collected for "*Account Number Linkage to Provider Identifier*" during EFT enrollment (see CAQH CORE 380: EFT Enrollment Data Rule).

38. Does the CAQH CORE 382 Rule specify requirements for how health plans must group X12 v5010 835 ERAs sent to providers (i.e., by NPI or TIN)?

The CAQH CORE 382 Rule includes the following requirements for collection of National Provider Identifier (NPI) and Taxpayer Identification Number (TIN) within the CORE-required Maximum ERA Enrollment Data Set:

- DEG2: *Provider Identifiers Information* requires health plans (or their agent/vendor offering ERA enrollment) to collect a "*Provider Identifier*" which must be the identification number, NPI or TIN for non-HIPAA covered providers, **for the legal entity** reported under the "*Provider Name*" Data Element in DEG1: *Provider Information*.
- DEG7: *Electronic Remittance Advice Information* requires health plans (or their agent/vendor offering

ERA enrollment) to collect a "*Preference for Aggregation of Remittance Data (e.g., Account Number Linkage to Provider Identifier)*" As the X12 v5010 835 TR3 requires a single X12 v0510 835 transaction to correspond to a single EFT payment, this identifier must be the identification number, NPI or TIN for non-HIPAA covered providers, **linked to the provider's Receiving Depository Financial Institution (RDFI) account** to which claim payments should be deposited.

The CAQH CORE 382 Rule addresses the data to be collected during ERA enrollment; it does not specify requirements for health plans to implement a certain process after the data is collected. Beyond the data collection requirements, how a health plan groups X12 v5010 835 ERAs to providers is a business decision and contract issue to be negotiated between the health plan and its provider trading partners.

Section 4.2 of the CAQH CORE 382 Rule requires health plans to "*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*". The health plan could include in these instructions a description of its entity-specific process to reach agreement on grouping of the X12 v5010 835.

39. My organization is a health plan. As part of our ERA enrollment form/method, we currently ask providers to identify the service location for which they want to enroll to receive ERA via a proprietary location identifier. Can we continue to collect this location identifier using the CAQH CORE-required Maximum ERA Enrollment Data Set?

Yes. The CAQH CORE 382 Rule provides a uniform and consistent maximum set of data elements that can be used by any health plan (or its agent or vendor) for the purposes of enrolling any healthcare provider (or its agent) to receive claim payment via ERA. This maximum set of data elements is specified in Table 4.2-1 of the CAQH CORE 382 Rule, organized by categories of information referred to as "Data Element Groups" (DEGs).

As part of DEG2: *Provider Identifiers Information* (DEG2), a health plan (or its agent or vendor offering ERA enrollment) can choose to collect an optional *Other Identifier(s).* The *Other Identifier(s)* Individual Data Element allows a health plan to collect proprietary provider identifiers specific to its individual business needs. The CAQH CORE 382 Rule does not specify a data type or format for this identifier. Therefore, a health plan can use the *Optional Identifier(s)* data element to collect identification numbers for all service locations for which the enrolling provider wants to receive ERA.

Section 4.2, *CORE-required Maximum ERA Enrollment Data Elements*, in the CAQH CORE 382 Rule requires a health plan to "*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."* A health plan can include guidance in these instructions for how providers should complete the *Other Identifier(s)* data element.

The CAQH CORE 382 Rule also permits health plans, and their agents or vendors offering ERA enrollment, to include other functionalities in the enrollment process improve functionality and ensure data integrity and comprehensiveness. For example, a health plan may use a drop down list to identify the optional service locations (via their proprietary identifiers) for which the providers can enroll to receive ERA. For further guidance, see "*Can additional data elements beyond the CORE-required Maximum ERA Enrollment Data Elements be collected for ERA enrollment?"*)

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40. The CORE-required Maximum ERA Enrollment Data Set specified in Table: 4.2-1 includes an optional Data Element Group, DEG4, to collect information about a "provider agent". How is "provider agent" defined for this DEG?

As specified in Section 3.1, *When the Rule Applies*, the CAQH CORE 382 applies "*when a health plan or its agent is enrolling a healthcare provider **(or its agent)**"* to receive the X12 v5010 835. As referenced, a "provider agent" is an entity that that has been designated and sufficiently authorized by the provider to receive ERA payments on the provider's behalf. DEG4: *Provider Agent Information* in the CORE-required Maximum ERA Enrollment Data Set enables a health plan (or its agent/vendor offering ERA enrollment) to collect information about the provider's designated agent.

41. Does the CAQH CORE 382 Rule require health plans to include DEG numbers on their ERA enrollment method/form?

No. The CAQH CORE 382 Rule **does not** require a health plan, or its agent/vendor offering ERA enrollment, to include the DEG number on its electronic or paper-based ERA enrollment form/method. **NOTE:** Use of paper-based method is optional.

Section 4.3, *CORE Master Template for Collecting ERA Enrollment Data*, of the CAQH CORE 382 Rule requires health plans "*to use the format, flow and data set including data element descriptions in Table 4.2-1 as the CORE Master ERA Enrollment Submission form*" for both paper-based and electronic ERA enrollment methods. To conform to the flow, format, and data content requirements, a health plan, or its agent/vendor offering ERA enrollment, must include the data element name and data element description, without revision or modification, on its ERA enrollment form/method and follow the order/sequence as given in Table: 4.2-1.

NOTE: The CAQH CORE 382 Rule **does not** require health plans to offer a paper-based enrollment form. However, an electronic method for collection and submission of the CORE-required Maximum ERA Enrollment Data Set must be offered. If a health plan chooses to also offer a paper-based enrollment form it must conform to all applicable CAQH CORE 382 Rule requirements.

42. Does the CAQH CORE 382 Rule require health plans to include the Column Headers in Table: 4.2-1 on their ERA enrollment method/form?

No. The CAQH CORE 382 Rule **does not** require a health plan, or its agent/vendor offering ERA enrollment, to include the column header labels in Table 4.2-1 (e.g., "Individual Data Element", "Sub-Element name", "Data Element Description", "Data Element Requirement for Health Plan Collection", etc.) on its electronic or paper-based ERA enrollment form/method. **NOTE:** Use of a paper-based method is optional.

Section 4.3, *CORE Master Template for Collecting ERA Enrollment Data*, of the CAQH CORE 380 Rule requires health plans "*to use the format, flow and data set including data element descriptions in Table 4.2-1 as the CORE Master ERA Enrollment Submission form*" for both paper-based and electronic ERA enrollment methods. To conform to the flow, format, and data content requirements, a health plan, or its agent/vendor offering ERA enrollment, must include the data element name and data element description, without revision or modification, on its ERA enrollment form/method and follow the order/sequence as given in Table 4.2-1.

NOTE: The CAQH CORE 382 Rule **does not** require health plans to offer a paper-based enrollment form. However, an electronic method for collection and submission of the CORE-required Maximum ERA Enrollment Data Set must be offered. If a health plan chooses to also offer a paper-based enrollment form it must conform to all applicable CAQH CORE 382 Rule requirements.

43. Section 4.3.1 of the CAQH CORE 382 Rule specifies several items beyond the CORE-required Enrollment Data Elements that must be included on a paper-based ERA enrollment form. Does the CAQH CORE 382 Rule require all of these items to be included on a single page?

No. Section 4.3.1, *Master Template for Manual Paper-Based Enrollment*, of the CAQH CORE 382 Rule requires a health plan (or its agent/vendor offering ERA enrollment) to include the following items on its paper-based ERA enrollment form:

- Specific written instructions and guidance for completing and submitting the enrollment form
- A number to fax and/or a U.S. Postal Service or email address to send the completed form
- Contact information for the health plan, specifically a telephone number and/or email address to send questions
- Authorization language for the provider to read and consider
- A section that outlines how the provider can access online instructions for how to determine the status of the ERA enrollment
- Clear labels for any appendix describing its purpose as it relates to the provider enrolling in ERA

The CAQH CORE 382 Rule does not specify any requirements regarding pagination. A health plan may choose to include the above additional items on a single page of the enrollment form or on a separate page at the health plan's discretion. **NOTE:** To conform to the flow and format requirements specified in Section 4.3 of the CAQH CORE 382 Rule, the above items **cannot** appear within or between the Maximum Enrollment Data Elements.

NOTE: The CAQH CORE 382 Rule **does not** require health plans to offer a paper-based enrollment form. However, an electronic method for collection and submission of the CORE-required Maximum ERA Enrollment Data Set must be offered. If a health plan chooses to also offer a paper-based enrollment form it must conform to all applicable CAQH CORE 382 Rule requirements.

44. The CAQH CORE 382 Rule requires health plans to collect a signature for the individual authorized to initiate, modify, or terminate the provider's ERA enrollment. What data collection method should health plans use to obtain this signature (i.e., electronically or "wet")?

Data Element Group (DEG) 8: *Submission Information* in the CORE-required Maximum ERA Enrollment Data Set includes as a required Individual Data Element "*Authorized Signature*". This data element allows a health plan (or its agent/vendor offering ERA enrollment) to collect the "*signature of an individual authorized by the provider or its agent to initiate, modify or terminate an enrollment*". As specified in Table: 4.2-1, a health plan (or its agent/vendor offering ERA enrollment) can require this signature to be submitted either electronically or written (i.e., "wet"). It is the health plan's individual business decision what method it chooses to use to obtain the authorizing signature.

Section 4.2 in the CAQH CORE 382 Rule requires a health plan to "*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*." Depending on what method the health plan chooses to obtain the authorized signature, the health plan could provide guidance to the provider in the instructions for how providers should submit the signature (e.g., if the health plan chooses to include "*Written Signature of Person Submitting Enrollment*" in its electronic enrollment method, the health plan could instruct the provider how to deliver the required wet signature prior to/along with/after completion of the electronic enrollment in ERA).

45. How are the CAQH CORE EFT & ERA Enrollment Data Sets maintained via the CAQH CORE EFT & ERA Enrollment Data Maintenance Process?

As specified in Section 3.4, *CORE Process for Maintaining CORE-required Maximum EFT Enrollment Data Set*, of the Phase III CAQH CORE 380: EFT Enrollment Data Rule and Phase III CAQH CORE 382 ERA Enrollment Data Rule, the CAQH CORE-required Maximum EFT & ERA Enrollment Data Sets are reviewed and updated on an annual basis. Section 3.4 in the CAQH CORE 380 and CAQH CORE 382 Rules requires that the first review of the enrollment data sets commence one year after the rules were adopted into federal regulation. This first review occurred in 2014.

- **Limited Reviews**: Occur biennially and consider *only* non-substantive adjustments to the Enrollment Data Sets; occur on an alternating schedule with Comprehensive Reviews (next Limited Review is in 2016)
- **Comprehensive Reviews**: Occur biennially and consider *both* substantive and non-substantive adjustments to the Enrollment Data Sets; occur on an alternating schedule with Limited Reviews (next Comprehensive Review is in 2017)

NOTE: Adjustments pertaining to rule language and requirements beyond the CAQH CORE-required Maximum EFT & ERA Enrollment Data Sets are out of scope for the CAQH CORE EFT & ERA Enrollment Data Maintenance Process.

In keeping with the CAQH CORE multi-stakeholder, collaborative and transparent rule development process, participation in the CAQH CORE Enrollment Data Task Group is open to representatives from any CORE Participating Organization. There is no limit to the number of representatives that a CORE Participating Organization can assign to the Task Group. Individuals with knowledge of the business processes and work flows for EFT and ERA enrollments are strongly encouraged to join the Task Group. Interested participants can send their name, title, organization name, email address, and telephone number to core@caqh.org.

46. What are the CAQH CORE Comprehensive and Limited Reviews of the CAQH CORE-required Maximum EFT & ERA Enrollment Data Sets? When do these reviews occur?

Per the CAQH CORE EFT & ERA Enrollment Data Sets Maintenance Process, the CAQH CORE Enrollment Data Task Group conducts two types of review of the CAQH CORE-required Maximum EFT & ERA Enrollment Data Sets:

- Comprehensive Reviews consider both potential substantive and non-substantive adjustments to the CORE-required Maximum EFT & ERA Enrollment Data Sets.
- Limited Reviews consider potential non-substantive adjustments to the CORE-required Maximum EFT & ERA Enrollment Data Sets.

Comprehensive and Limited Reviews occur biennially on alternating years; i.e., if a Comprehensive Review occurs one year, a Limited Review will occur the following year.

As defined in the CAQH CORE EFT & ERA Enrollment Data Sets Maintenance Process, substantive adjustments address addition of new data elements/Data Element Groups (DEGs) to address emerging, new, or changing industry needs. Non-substantive adjustments improve usability of the enrollment data set but *do not* change the name, position, or collection requirements for the CORE-required EFT & ERA Enrollment data elements, sub-elements, or DEGs.

Once the CAQH CORE Enrollment Data Task Group approves a set of substantive and/or non-substantive adjustments to the CAQH CORE EFT & ERA Enrollment Data Sets, updated CAQH CORE EFT & ERA Enrollment Data Rules will be published. HIPAA-covered entities will need to update their EFT and ERA

enrollment forms/systems to ensure conformance with any *substantive* adjustments applied to the data sets as a result of a Comprehensive Review. **NOTE**: HIPAA-covered entities will *not* need to update their EFT and ERA enrollment forms/systems as a result of a Limited Review.

47. What adjustments have been made to the CAQH CORE Maximum EFT & ERA Enrollment Data Sets to date?

2014 Review

In Q2 2014, the CAQH CORE Enrollment Data Task Group conducted the first Limited Review of the CORE-required Maximum EFT & ERA Enrollment Data Sets.

In this Limited Review, Task Group members identified and addressed non-substantive adjustments in the CORE-required Maximum EFT & ERA Enrollment Data Sets to improve implementer usability of the Enrollment Data Sets, including formatting inconsistencies and typographical errors, consistency between data elements, and improving clarity on data elements that generated questions from implementers. These non-substantive updates did not require HIPAA-covered entities to update their enrollment forms/systems.

Versions 3.0.1 of the Phase III CAQH CORE 380: EFT Enrollment Data Rule and Phase III CAQH CORE 382: ERA Enrollment Data Rule were distributed to the industry in September 2014.

2015 Review

The CAQH CORE Enrollment Data Task Group convened in Q4 2015 to conduct its first scheduled Comprehensive Review of the CORE-required Maximum EFT & ERA Enrollment Data Sets. During the Task Group's 2015 Review, Task Group members reviewed the rationale for and against conducting a Comprehensive Review. Upon consideration, the Task Group elected NOT to conduct a Comprehensive Review. This decision was based on several factors, which included:

- Industry resources better spent on higher-priority items such as ICD-10, completing implementations of mandated operating rules, and preparing for Phase IV implementation
- Lack of an industry-wide call to action for adjustments to the Enrollment Data Sets, i.e. CAQH CORE did not receive any Requests related to the Data Sets in 2015
- Current Data Sets are successfully implemented in the market, i.e. more than 30 organizations are Phase III CORE Certified and in conformance with the Data Sets

Additionally, the Task Group sought to collect non-substantive adjustments as part of a Limited Review. As no non-substantive adjustments were proposed, the Task Group did not update the Enrollment Data Sets in 2015.

48. How can my organization submit potential substantive adjustments to the CORE-required Maximum EFT & ERA Enrollment Data Sets for consideration during the next Comprehensive Review?

The next Comprehensive Review of the CORE-required Maximum EFT & ERA Enrollment Data Sets is schedule to occur in 2017. Per the CAQH CORE EFT & ERA Enrollment Data Sets Maintenance Process, the Comprehensive Reviews consider both substantive and non-substantive adjustments to the CORE-required Maximum EFT & ERA Enrollment Data Sets. More information on the 2017 Comprehensive Review will be shared later in 2017.

49. How will the CAQH CORE Enrollment Data Task Group evaluate potential substantive adjustments to the CORE-required Maximum EFT & ERA Enrollment Data Sets?

The CAQH CORE Enrollment Data Task Group uses a set of Enrollment Data Evaluation Criteria to evaluate potential *substantive* adjustments to the CORE-required Maximum EFT & ERA Enrollment Data Sets. When submitting potential substantive adjustments for Task Group consideration, stakeholder entities will be required to confirm that their submission meets at least four of the seven criteria listed below:

1. Supports the vision of the CAQH CORE Enrollment Data Rules to move the industry toward a uniform, standard maximum set of required EFT and ERA enrollment data elements
2. Promotes EFT and ERA enrollment efficiency (e.g., reduction in staff time and resources required to complete enrollment) and increases provider adoption by reducing the range of enrollment information requested and variation in terms used to collect the same/similar information
3. Does not result in addition of data elements that are semantic variations of existing data elements; i.e., data elements must collect unique and distinctly separate information
4. Meets a demonstrated, new or current industry-wide multi-stakeholder business need not addressed by the existing Enrollment Data Set
5. Ensures collection of key items needed to fully automate both claims payment and remittance advice posting processes
6. Balances return on investment (ROI) and industry-wide benefit against the significant lift required for health plans or agents to revise enrollment systems and paper-based forms and for providers to provide the data
7. Consistent with Phase III CAQH CORE Guiding Principles

In addition to alignment with the above Evaluation Criteria, the Enrollment Data Task Group's policy is to collect Supporting Information including a Business Case and any applicable Supporting Data for each submitted potential substantive adjustment to the CORE-required Maximum EFT & ERA Enrollment Data Sets.

For more information on the CAQH CORE EFT & ERA Enrollment Data Sets Maintenance Process, see the CAQH CORE EFT & ERA Enrollment Data Set Maintenance Process webpage.

50. How will organizations be notified about and access new versions of the CAQH CORE EFT & ERA Enrollment Data Rules?

Once the CAQH CORE Enrollment Data Task Group approves a set of substantive and/or non-substantive adjustments to the CORE-required Maximum EFT & ERA Enrollment Data Sets, an updated version of the CAQH CORE EFT & ERA Enrollment Data Rules will be published. Publication of updated versions of the CAQH CORE EFT & ERA Enrollment Data Rules will be announced on the CAQH CORE webpage and via an industry-wide email notification.

51. How long will my organization have to update our EFT and/or ERA enrollment system or forms after publication of *substantive* adjustments to the CAQH CORE EFT & ERA Enrollment Data Rules?

HIPAA-covered entities will need to update their EFT and ERA enrollment forms/systems to ensure conformance with any *substantive* adjustments applied to the data sets as a result of a Comprehensive Review. Per the CAQH CORE EFT & ERA Enrollment Data Sets Maintenance Process, a health plan, or its agent offering EFT and/or ERA enrollment, will have:

- **NINE calendar months** to update their **electronic** EFT and/or ERA enrollment systems or forms and
- **TWELVE calendar months** to update their **paper-based** EFT and/or ERA enrollment forms.

The compliance timeframe for HIPAA-covered entities to adjust their systems and/or forms begins on the date of publication of the updated versions of the CORE-required Maximum EFT & ERA Enrollment Data Sets.

52. What is the schedule for CAQH CORE to publish adjustments to CAQH CORE EFT & ERA Enrollment Data Rules?

Per the CAQH CORE EFT & ERA Enrollment Data Sets Maintenance Process, Comprehensive and Limited Reviews of the CORE-required Maximum EFT & ERA Enrollment Data Sets occur biennially on alternating years (i.e., if a Comprehensive Review occurs one year, a Limited Review will occur the following year). The 2016 Review is scheduled to be a Limited Review followed by a Comprehensive Review in 2017.

53. How can my organization get involved in the CAQH CORE EFT & ERA Enrollment Data Sets Maintenance Process?

Entities are encouraged to join CAQH CORE as a CORE Participating Organization to contribute to the evolution of the CORE-required Maximum EFT & ERA Enrollment Data Sets via the CAQH CORE Enrollment Data Task Group. Participation in CAQH CORE also enables industry entities to have a say in the development of operating rules, and be part of a solution that diminishes the cost and complexity within the healthcare system. CAQH CORE welcomes Participating Organizations representing a range of stakeholder groups.

The CAQH CORE EFT & ERA Enrollment Data Sets Task Group is open to representatives from any CORE Participating Organization. There is no limit to the number of representatives that a CORE Participating Organization can assign to the Task Group. Individuals with knowledge of the business processes and work flows for EFT and ERA enrollments are strongly encouraged to join the Task Group. Interested participants can send their name, title, organization name, email address, and telephone number to core@caqh.org.

Entities can also contribute a number of other ways, including attendance on bimonthly CAQH CORE Town Hall Calls. Interested entities should email core@caqh.org for further information.

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VIII. Resources for Implementing the CAQH CORE EFT & ERA Operating Rules

1. CAQH CORE Resources to Assist with Implementation of the Phase III CAQH CORE EFT & ERA Operating Rules

CAQH CORE has a number of resources and tools available at no cost to assist entities with implementing the Phase III CAQH CORE EFT & ERA Operating Rules.

- On the CAQH website:
  - Federally Mandated Operating Rules Timeline with Associated Resources provides an overview of CAQH CORE activities related to the ACA Section 1104 mandated operating rules
  - CAQH CORE EFT & ERA webpage provides an overview of CAQH CORE activities specific to the ACA-mandated second set
- The Sample Provider EFT Reassociation Data Request Letter contains instructions and a letter template that a provider receiving EFT payments may customize and email to its banks or use as talking points for a phone or in person meeting with its bank contacts to request delivery of the ACH Payment Related Information via a secure, electronic means. The ACH Payment Related Information contains the necessary data to reassociate EFTs and ERAs and is not automatically delivered to providers unless requested by the provider.
- The *CAQH CORE Analysis & Planning Guide for Implementing the CAQH CORE EFT & ERA Operating Rules* assists entities in determining which CAQH CORE rule requirements are applicable to their organization. This Analysis & Planning Guide helps organizations to identify which CAQH CORE Rule requirements may be outsourced to a Business Associate or vendor, and the system and/or process remediation necessary to ensure conformance with the CAQH CORE Rules. The Analysis & Planning Guide includes three tools:
  - *CAQH CORE Stakeholder & Business Type Evaluation* to determine your organization's stakeholder type(s) and understand the role of your vendors, intermediaries, or Business Associates in conducting the EFT and/or ERA transactions
  - *CAQH CORE Systems Inventory & Impact Assessment Worksheet* to assess your organization's external and internal systems that conduct EFT and/or ERA transactions and are impacted by the CAQH CORE Operating Rules
  - *CAQH CORE Gap Analysis Worksheet* to determine the level of system and/or process remediation necessary for your organization to adopt the business and technical requirements of the CAQH CORE Operating Rules
- CAQH CORE holds frequent education sessions with various industry partners on implementation of the CAQH CORE Operating Rules. Information on upcoming sessions and materials (both slides & audio) from past sessions is available on the CAQH website. CAQH CORE also holds free monthly industry-wide Town Hall calls to update the industry on CAQH CORE activities.
- CORE Certification offers a useful resource for entities to ensure successful implementation of applicable CAQH CORE EFT & ERA Rule requirements. CORE Certification has been embraced by many entities given its value in assisting with CAQH CORE Operating Rule implementation and ensuring the greatest ROI is achieved with trading partners. Currently, over 60 organizations and vendor products are CORE-certified with several more in the pipeline to achieve CORE Certification this year. CORE Certification testing with a CAQH CORE-authorized testing vendor is available online at no cost to entities.
- For each phase of CAQH CORE Operating Rules, a CORE Certification Master Test Suite is developed that outlines all of the requirements for entities seeking CORE Certification on the various phases of CAQH CORE Operating Rules. The *Phase III CORE EFT & ERA Operating Rules Certification Master*

CAQH CORE is the authoring entity for two sets of ACA Section 1104 mandated Federal operating rules.

This document is for informational purposes only; in the case of a discrepancy between this document and CAQH CORE Operating Rule text and/or Federal regulations, the latter take(s) precedence.

Test Suite includes information about key concepts, such as the role of trading partners, which apply beyond CORE Certification to general implementation of the CAQH CORE EFT & ERA Operating Rules.

2. Additional Resources to Assist with Implementation of the Phase III CAQH CORE EFT & ERA Operating Rules

- CMS Administrative Simplification/Affordable Care Act FAQs *(FAQs are also available on a wide range of other topics)*
- 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 Priscilla Holland at pholland@nacha.org

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IX. Phase III CORE Certification

For policies and procedures related to achieving Phase III CORE Certification, including guidance on completing Phase III CORE Certification testing, please see CAQH CORE FAQs Part F: ACA Section 1104 Certification, CORE Certification, Proposed CORE HIPAA Credential, and CORE Endorsement.

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