



Phase III CORE EFT & ERA Operating Rules
Approved June 2012

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Phase III CORE 350 Health Care Claim Payment/Advice (835)
Infrastructure Rule
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1 Background Summary

Phase I CORE Rules focused on improving electronic eligibility and benefits verification, as eligibility is the first transaction in the claims process. Thus, if eligibility and benefits are correct, all the transactions that follow will be more effective and efficient. Building on Phase I, CORE determined that Phase II CORE should be extended to include rules around the claim status transaction to allow providers to check the status of a claim electronically, without manual intervention, or confirm receipt of claims.

Continuing to build on Phase I and Phase II CORE Rules, CAQH CORE determined that Phase III CORE 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 CORE infrastructure rules and apply them to conducting the HIPAA-adopted ASC X12 005010X221A1 Health Care Claim Payment/Advice (835) transaction (hereafter referenced as v5010 X12 835). Benefits to the industry in applying these CAQH CORE infrastructure rules to the health care claim payment/advice transaction 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 inclusion of this Phase III CORE Rule for the v5010 X12 835 continues to facilitate the industry's momentum to increase access to the HIPAA-adopted administrative transactions, and will encourage entities to use the infrastructure they have for eligibility and claim status and apply this infrastructure to the health care claim payment/advice.

1.1 Affordable Care Act Mandates

This rule is part of a set of rules that addresses a request from the National Committee on Vital and Health Statistics (NCVHS) for fully vetted CAQH CORE Operating Rules for the EFT and ERA transactions; the NCVHS request was made in response to NCVHS' role in Section 1104 of the Affordable Care Act (ACA).

Section 1104 of the ACA contains an industry mandate for the use of operating rules to support implementation of the HIPAA standards. Using successful, yet voluntary, national industry efforts as a guide, Section 1104 defines operating rules as a tool that will build upon existing health care transaction standards. The legislation outlines three sets of health care industry operating rules to be approved by the Department of Health and Human Services (HHS) and then implemented by the industry; the second set of which are those for EFT and ERA.¹ The ACA requires HHS to adopt a set of operating rules for both of these transactions by July 2012. In a letter dated 03/23/11,² NCVHS recommended that the Secretary "name CAQH CORE in collaboration with NACHA – The Electronic Payments Association as the candidate authoring entity for operating rules for all health care EFT and ERA transactions..."

Section 1104 of the ACA also adds the EFT transaction to the list of electronic health care transactions for which the HHS Secretary must adopt a standard under HIPAA. The section requires the EFT transaction standard be adopted by 01/01/12, in a manner ensuring that it is effective by 01/01/14. In January 2012, HHS issued an

¹ The first set of operating rules under ACA Section 1104 applies to eligibility and claim status transactions with an adoption date of 07/01/11 and effective date of 01/01/13; the third set of operating rules applies to health care claims or equivalent encounter information transactions, enrollment and disenrollment in a health plan, health plan premium payments and referral, certification and authorization with an adoption date of 07/01/14 and effective date of 01/01/16.

² NCVHS [Letter to the Secretary](#) - Affordable Care Act (ACA), Administrative Simplification: Recommendation for entity to submit proposed operating rules to support the Standards for Health Care Electronic Funds Transfers and Health Care Payment and Remittance Advice 03/23/11.

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Interim Final Rule with Comment (IFC)³ adopting the NACHA ACH CCD plus Addenda Record (hereafter CCD+) and the X12 835 TR3 TRN Segment⁴ as the Healthcare EFT Standards. These standards must be used for electronic claims payment initiation by all health plans that conduct healthcare EFT.

2 Issue to Be Addressed and Business Requirement Justification

In order to electronically process a health care claim payment/advice, health plans and providers need to have a detailed health care claim payment/advice. This health care claim payment/advice includes health plans providing information regarding the payment of a claim and detailed information about why the total charges originally submitted on a claim have not been paid in full, information about denied claims, or that the claim is suspended and additional information is being requested, and the method and mode of payment (check, EFT). HIPAA provides a foundation for the electronic exchange of claim payment information, but does not ensure that today's paper-based system can be replaced by an electronic, interoperable system. HIPAA's mandated scope does not:

- Specify how the ASC X12 transactions are to be communicated
- Require the use of any of the ASC X12 standard acknowledgements
- Specify a common companion guide for the flow and format of such guides
- Address the need for providers to be able to conduct a parallel v5010 X12 835 implementation process whereby the health plan will continue to deliver its proprietary claim payment remittance advices while the provider assures itself that the v5010 X12 835 can successfully replace the proprietary remittance advices

Using the available but non-mandated ASC X12 standard acknowledgements, the sender of ASC X12 EDI interchanges will benefit from knowing that the receiving party has successfully received the transactions or has encountered errors that need to be reconciled, especially when sending remittance advice transactions. Requiring health plans that issue companion guides describing their implementation of the v5010 X12 835 Health Care Claim Payment/Advice transaction to use a common flow and format for them will enable providers to more efficiently and effectively configure their accounting systems to automatically process the health care claim payment/advice transaction successfully.

In Phase I CORE, several "infrastructure" rules were approved that are designed to bring consistency and to improve the timely flow of the eligibility transactions. These infrastructure rules require:

- Real time exchange of eligibility transactions within 20 seconds or less
- The consistent use of the ASC X12 standard ASC X12 005010X231A1 Implementation Acknowledgement for Health Care Insurance (999) (hereafter v5010 X12 999) for both real time and batch exchanges
- 86% system availability of a health plan's eligibility processing system components over a calendar week
- Use of the public internet for connectivity
- Use of a best practices companion guide template for format and flow of companion guides for entities that issue them

In Phase II CORE, these infrastructure rules were applied to the exchange of the HIPAA-adopted ASC X12 005010X212 Health Care Claim Status Request and Response (276/277) Technical Report Type 3 (TR3) implementation guide and associated errata (hereafter v5010 276, v5010 277 or v5010 276/v5010 277) transaction sets. Optionally, entities could go beyond the Phase I CORE connectivity requirements by using the more robust and comprehensive Phase II CORE Connectivity Rule if they wished.

³ [CMS-0024-IFC](#): Administrative Simplification: Adoption of Standards for Health Care Electronic Funds Transfers (EFTs) and Remittance Advice, 01/10/12.

⁴ The IFC requires health plans to input the X12 835 TR3 TRN Segment into the Addenda Record of the CCD+; specifically, the X12 835 TR3 TRN Segment must be placed in Field 3 of the Addenda Entry Record ("7 Record") of a CCD+.

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During the Phase III CORE Rule-making, the Rules Work Group used discussion, research and straw poll results to determine which infrastructure requirements should be applied to the exchange of the v5010 X12 835. Listed below is an overview of the infrastructure requirements incorporated into this rule in §3 and §4.1.

Phase III Rules Work Group Infrastructure Rules for the v5010 X12 835 Transaction	
CORE Infrastructure Rule Description	Apply to Phase III CORE Infrastructure Rule for the v5010 X12 835 Health Care Claim Payment/Advice
Connectivity (<i>same as Phase II v5010</i>)	Y
Real Time Response Time	N
Batch Response Time	N
System Availability	N
Companion Guide	Y
Real Time Implementation Guide (TR3) Acknowledgement (999)	N
Batch Implementation Guide (TR3) Acknowledgement (999)	Y
Normalize Patient Last Name Rule	N
AAA Error Code Reporting Rule	N
Dual Delivery of the v5010 X12 835 and Proprietary Paper Remittance Advices	Y

This Phase III CORE 350 Health Care Claim Payment/Advice (835) Infrastructure Rule Version 3.0.0 defines the specific business information requirements that health plans must satisfy and which vendors, clearinghouses and providers should use. As with all CORE Rules, these requirements are intended as a base or minimum set of requirements, and it is expected that many entities will go beyond requirements as they work towards the goal of administrative interoperability. This Phase III CORE 350 Health Care Claim Payment/Advice (835) Infrastructure Rule Version 3.0.0 requires that health plans make appropriate use of the standard acknowledgements, support the CORE “safe harbor” connectivity requirement, use the CORE v5010 Master Companion Guide Template when publishing their v5010 X12 835 companion guide, and continue to provide dual delivery of their proprietary paper claim remittance advices along with the v5010 X12 835 for a period of time during which providers can ensure that their financial system can successfully use the v5010 X12 835 to post payments.

By requiring the delivery and use of these CORE infrastructure requirements when conducting the v5010 X12 835, the Phase III CORE 350 Health Care Claim Payment/Advice (835) Infrastructure Rule Version 3.0.0 helps provide the information that is necessary to electronically process a claim payment and corresponding remittance details and thus reduce the current cost of today’s paper-based transaction process.

3 Scope

3.1 What the Rule Applies To

This CORE Rule builds upon and extends the Phase I and Phase II CORE infrastructure rules to the conduct of the v5010 X12 835. This rule specifies that a health plan or other entity must continue to deliver their proprietary paper claim remittance advices during a parallel implementation testing time period, and use the ASC X12 standard acknowledgments and support the CORE connectivity safe harbor requirements.

3.2 When the Rule Applies

This rule applies when any entity uses, conducts or processes the v5010 X12 835.

3.3 What the Rule Does Not Require

This rule does not address any data content requirements of the v5010 X12 835.

This rule does not require any entity to:

- Conduct, use or process the v5010 X12 835 Health Care Claim Payment/Advice transaction if it currently does not do so or is not required by Federal or state regulation to do so
- Build real time claim adjudication capabilities; entities only need to test for and meet batch rule requirements for health care claim payment/advice transactions

3.4 Outside the Scope of This Rule

This rule does not address the data content of the v5010 X12 835.

3.5 How the Rule Relates to Phase I and Phase II CORE

This rule adds to the Phase I and II CORE infrastructure rules requirements by specifying the use of the ASC X12 005010X231A1 Implementation Acknowledgement for Health Care Insurance (999) when conducting the v5010 X12 835.

As with other Phase I and Phase II CORE Rules, general CORE policies also apply to Phase III CORE Rules and will be outlined in the Phase III CORE Rule Set.

This rule supports the CORE Guiding Principles that CORE rules will not be based on the least common denominator but rather will encourage feasible progress, and that CORE rules are a floor and not a ceiling, e.g., entities can go beyond the Phase III CORE Rules.

3.6 Assumptions

A goal of this rule is to adhere to the principles of EDI in assuring that transactions sent are accurately received and to facilitate correction of errors for electronically submitted health care claims.

The following assumptions apply to this rule:

- A successful communication connection has been established
- This rule is a component of the larger set of Phase III CORE Rules; as such, all of the CORE Guiding Principles apply to this rule and all other rules
- This rule is not a comprehensive companion document addressing any content requirements of the v5010 835v5010 X12 835

4 Rule Requirements

4.1 Health Care Claim Payment/Advice Connectivity Requirements

An entity must be able to support the Phase II CORE 270 Connectivity Rule Version 2.2.0.

This requirement addresses usage patterns for batch transactions, the exchange of security identifiers, and communications-level errors and acknowledgements. It does not attempt to define the specific content of the message exchanges beyond declaring that the HIPAA-mandated ASC X12 formats must be used between covered entities, and security information must be sent outside of the ASC X12 payload.

The Phase II CORE 270 Connectivity Rule Version 2.2.0 is designed to provide a “safe harbor” that application vendors, providers and health plans (or other information sources) can be assured will be supported by any trading partner. All organizations must demonstrate the ability to implement connectivity as described in this section. These requirements are not intended to require trading partners to remove existing connections that do not match

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the rule, nor is it intended to require that all trading partners must use this method for all new connections. CORE expects that in some technical circumstances, trading partners may agree to use different communication mechanism(s) and/or security requirements than that described by these requirements.

The requirement to support the Phase II CORE 270 Connectivity Rule Version 2.2.0 does not apply to retail pharmacy. For retail pharmacy the entity should reference the NCPDP Connectivity Operating Rule Version 1.0 that can be obtained from www.ncdp.org. NCPDP/CAQH CORE support a shared goal of continued alignment for connectivity across retail pharmacy and medical.

4.2 Health Care Claim Payment/Advice Batch Acknowledgement Requirements

These requirements for use of acknowledgements for batch mode places parallel responsibilities on both receivers of the v5010 X12 835 and senders of the v5010 X12 835 for sending and accepting v5010 X12 999 acknowledgements. *The goal of this approach is to adhere to the principles of EDI in assuring that transactions sent are accurately received and to facilitate health plan correction of errors in their outbound transactions.*

The rule assumes a successful communication connection has been established.

4.2.1 Use of the v5010 X12 999 Implementation Acknowledgement for Functional Group Acknowledgement

A receiver of a v5010 X12 835 transaction must return:

- A v5010 X12 999 Implementation Acknowledgement for each Functional Group of v5010 X12 835 transactions to indicate that the Functional Group was either accepted, accepted with errors or rejected

And

- To specify for each included v5010 X12 835 transaction set that the transaction set was either accepted, accepted with errors or rejected.

A health plan must be able to accept and process a v5010 X12 999 for a Functional Group of v5010 X12 835 transactions.

When a Functional Group of v5010 X12 835 transactions is either accepted with errors or rejected, the v5010 X12 999 Implementation Acknowledgement must report each error detected to the most specific level of detail supported by the v5010 X12 999 Implementation Acknowledgement.

The requirements specified in this section do not currently apply to retail pharmacy.

4.3 Dual Delivery of v5010 X12 835 and Proprietary Paper Claim Remittance Advices

A health plan that currently issues proprietary paper claim remittance advices is required to continue to offer such paper remittance advices to each provider during that provider's initial implementation testing of the v5010 X12 835 for a minimum of 31 calendar days from the initiation of implementation. If the 31 calendar day period does not encompass a minimum of three payments to the provider by the health plan, the health plan is required to offer to continue to issue proprietary paper claim remittance advices for a minimum of three payments.

At the conclusion of this time period, delivery of the proprietary paper claim remittance advices will be discontinued. At the provider's discretion, the provider may elect to not receive the proprietary paper claim remittance advices, to choose a shorter time period, or to discontinue receiving the proprietary paper claim remittance advices before the end of the specified timeframe by notifying the health plan of this decision.

Upon mutual agreement between the provider and the health plan, the timeframe for delivery of the proprietary paper claim remittance advices may be extended by an agreed-to timeframe, at which time the health plan will discontinue delivery of the proprietary paper claim remittance advices.

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If the provider determines it is unable to satisfactorily implement and process the health plan's electronic v5010 X12 835 following the end of the initial dual delivery timeframe and/or after an agreed-to extension, both the provider and health plan may mutually agree to continue delivery of the proprietary paper claim remittance advices.⁵

The requirements specified in this section do not currently apply to retail pharmacy.

4.4 Health Care Claim Payment/Advice Companion Guide

Health plans or information sources have the option of creating a "companion guide" that describes the specifics of how they will implement the HIPAA transactions. The companion guide is in addition to and supplements the ASC X12 TR3 implementation guide adopted for use under HIPAA.

Currently, health plans or information sources have independently created companion guides that vary in format and structure. Such variance can be confusing to trading partners/providers who must review numerous companion guides along with the ASC X12 TR3 implementation guides. To address this issue, CORE developed the CORE v5010 Master Companion Guide Template for health plans, or information sources. Using this template, health plans or information sources can ensure that the structure of their companion guide is similar to other health plans' documents, making it easier for providers to find information quickly as they consult each health plan's document on these important industry EDI transactions.

Developed with input from multiple health plans, system vendors, provider representatives and health care/HIPAA industry experts, this template organizes information into several simple sections – General Information (Sections 1-9) and Transaction-Specific Information (Section 10) – accompanied by an appendix. Note that the companion guide template is presented in the form of an example of a fictitious Acme Health Plan viewpoint.

Although CORE Participants believe that a standard template/common structure is desirable, they recognize that different health plans may have different requirements. The CORE v5010 Master Companion Guide template gives health plans the flexibility to tailor the document to meet their particular needs.

The requirements specified in this section do not currently apply to retail pharmacy.

4.4.1 Health Care Claim Payment/Advice Companion Guide Requirements

An entity's Companion Guides covering the v5010 X12 835 must follow the format/flow as defined in the CORE v5010 Master Companion Guide Template for HIPAA Transactions. (CAQH CORE v5010 Master Companion Guide Template available [here](#).)

***NOTE:** This rule does not require any entity to modify any other existing companion guides that cover other HIPAA-adopted transaction implementation guides.*

5 Conformance Requirements

Separate from any HHS certification/compliance program to demonstrate conformance as mandated under ACA Section 1104, CAQH CORE offers voluntary CORE Certification for all Phases of the CAQH CORE Operating Rules. CORE Certification is completely optional. Pursuing voluntary CORE Certification offers an entity a mechanism to test its ability to exchange EFT and ERA transaction data with its trading partners. A CORE-

⁵ Subject to Section 1104(d) of the Patient Protection and Affordable Care Act which amends Section 1862(a) of the Social Security Act to state:

Sec. 1862. [42 U.S.C. 1395y] (a) Notwithstanding any other provision of this title, no payment may be made under part A or part B for any expenses incurred for items or services—

(25) not later than January 1, 2014, for which the payment is other than by electronic funds transfer (EFT) or an electronic remittance in a form as specified by ASC X12 835 Health Care Payment and Remittance Advice or subsequent standard.

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certified Seal is awarded to an entity or vendor product that voluntarily completes CORE certification testing with a CAQH CORE-authorized testing vendor. Key benefits of *voluntary* CORE Certification include:

- Demonstrates to the industry adoption of the Phase III CORE EFT & ERA Operating Rules via a recognized industry “Seal”
- Encourages trading partners to work together on transaction data content, infrastructure and connectivity needs
- Reduces the work necessary for successful trading partner testing as a result of independent testing of the operating rules implementation
- Promotes maximum ROI when all stakeholders in the information exchange are known to conform to the CORE Operating Rules

For more information on achieving *voluntary* CORE Certification for the CAQH CORE EFT & ERA Operating Rules, refer to the Phase III CORE EFT & ERA Operating Rules Voluntary Certification Master Test Suite Version 3.0.0 or contact CORE@caqh.org.

6 Appendix

6.1 Appendix 1: Reference

- ASC X12 005010X231A1 Implementation Acknowledgement for Health Care Insurance (999) Technical Report Type 3
- ASC X12 005010X221A1 Health Care Claim Payment/Advice (835) Professional Technical Report Type 3 and associated errata

Acme Health Plan

HIPAA Transaction Standard Companion Guide

**Refers to the Implementation Guides
Based on ASC X12 version 005010**

**CORE v5010 Master Companion Guide
Template**

March 2011

Disclosure Statement

This document ...

Preface

This Companion Guide to the v5010 ASC X12N Implementation Guides and associated errata adopted under HIPAA clarifies and specifies the data content when exchanging electronically with Acme Health Plan. Transmissions based on this companion guide, used in tandem with the v5010 ASC X12N Implementation Guides, are compliant with both ASC X12 syntax and those guides. This Companion Guide is intended to convey information that is within the framework of the ASC X12N Implementation Guides adopted for use under HIPAA. The Companion Guide is not intended to convey information that in any way exceeds the requirements or usages of data expressed in the Implementation Guides.

EDITOR'S NOTE:

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1 INTRODUCTION

This section describes how ASC X12N Implementation Guides (IGs) adopted under HIPAA will be detailed with the use of a table. The tables contain a row for each segment that Acme Health Plan has something additional, over and above, the information in the IGs. That information can:

1. Limit the repeat of loops, or segments
2. Limit the length of a simple data element
3. Specify a sub-set of the IGs internal code listings
4. Clarify the use of loops, segments, composite and simple data elements
5. Any other information tied directly to a loop, segment, composite or simple data element pertinent to trading electronically with Acme Health Plan

In addition to the row for each segment, one or more additional rows are used to describe Acme Health Plan's usage for composite and simple data elements and for any other information. Notes and comments should be placed at the deepest level of detail. For example, a note about a code value should be placed on a row specifically for that code value, not in a general note about the segment.

The following table specifies the columns and suggested use of the rows for the detailed description of the transaction set companion guides.

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
193	2100C	NM1	Subscriber Name			This type of row always exists to indicate that a new segment has begun. It is always shaded at 10% and notes or comment about the segment itself goes in this cell.
195	2100C	NM109	Subscriber Primary Identifier		15	This type of row exists to limit the length of the specified data element.
196	2100C	REF	Subscriber Additional Identification			
197	2100C	REF01	Reference Identification Qualifier	18, 49, 6P, HJ, N6		These are the only codes transmitted by Acme Health Plan.
			Plan Network Identification Number	N6		This type of row exists when a note for a particular code value is required. For example, this note may say that value N6 is the default. Not populating the first 3 columns makes it clear that the code value belongs to the row immediately above it
218	2110C	EB	Subscriber Eligibility or Benefit Information			
231	2110C	EB13-1	Product/Service ID Qualifier	AD		This row illustrates how to indicate a component data element in the Reference column and also how to specify that only one code value is applicable.

SCOPE

This section specifies the appropriate and recommended use of the Companion Guide.

OVERVIEW

This section specifies how to use the various sections of the document in combination with each other.

REFERENCES

This section specifies additional documents useful for the read. For example, the X12N Implementation Guides adopted under HIPAA that this document is a companion to.

ADDITIONAL INFORMATION

This section, completed by the payer, includes other information useful to the reader. For example:

- Assumptions regarding the reader
- Advantages / benefits of EDI

2 GETTING STARTED

WORKING WITH ACME HEALTH PLAN

This section describes how to interact with Acme Health Plan's EDI Department.

TRADING PARTNER REGISTRATION

This section describes how to register as a trading partner with Acme Health Plan.

CERTIFICATION AND TESTING OVERVIEW

This section provides a general overview of what to expect during any certification and testing phases.

3 TESTING WITH THE PAYER

This section contains a detailed description of the testing phase.

4 CONNECTIVITY WITH THE PAYER/COMMUNICATIONS

PROCESS FLOWS

This section contains process flow diagrams and appropriate text.

TRANSMISSION ADMINISTRATIVE PROCEDURES

This section provides Acme Health Plan's specific transmission administrative procedures.

RE-TRANSMISSION PROCEDURE

This section provides Acme Health Plan's specific procedures for re-transmissions.

COMMUNICATION PROTOCOL SPECIFICATIONS

This section describes Acme Health Plan's communication protocol(s).

PASSWORDS

This section describes Acme Health Plan's use of passwords.

5 CONTACT INFORMATION

EDI CUSTOMER SERVICE

This section contains detailed information concerning EDI Customer Service, especially contact numbers.

EDI TECHNICAL ASSISTANCE

This section contains detailed information concerning EDI Technical Assistance, especially contact numbers.

PROVIDER SERVICE NUMBER

This section contains detailed information concerning the payment of claims, especially contact numbers.

APPLICABLE WEBSITES/E-MAIL

This section contains detailed information about useful web sites and email addresses.

6 CONTROL SEGMENTS/ENVELOPES

ISA-IEA

This section describes Acme Health Plan's use of the interchange control segments. It includes a description of expected sender and receiver codes, authorization information, and delimiters.

GS-GE

This section describes Acme Health Plan's use of the functional group control segments. It includes a description of expected application sender and receiver codes. Also included in this section is a description concerning how Acme Health Plan expects functional groups to be sent and how Acme Health Plan will send functional groups. These discussions will describe how similar transaction sets will be packaged and Acme Health Plan's use of functional group control numbers.

ST-SE

This section describes Acme Health Plan's use of transaction set control numbers.

7 PAYER SPECIFIC BUSINESS RULES AND LIMITATIONS

This section describes Acme Health Plan's business rules, for example:

1. Billing for specific services such as DME, Ambulance, Home Health
2. Communicating payer specific edits
3. CORE Level of Certification

8 ACKNOWLEDGEMENTS AND/OR REPORTS

This section contains information and examples on any applicable payer acknowledgements

REPORT INVENTORY

This section contains a listing/inventory of all applicable acknowledgement reports

9 TRADING PARTNER AGREEMENTS

This section contains general information concerning Trading Partner Agreements (TPA). An actual TPA may optionally be included in an appendix.

TRADING PARTNERS

An EDI Trading Partner is defined as any Acme customer (provider, billing service, software vendor, employer group, financial institution, etc.) that transmits to, or receives electronic data from Acme.

Payers have EDI Trading Partner Agreements that accompany the standard implementation guide to ensure the integrity of the electronic transaction process. The Trading Partner Agreement is related to the electronic exchange of information, whether the agreement is an entity or a part of a larger agreement, between each party to the agreement.

For example, a Trading Partner Agreement may specify among other things, the roles and responsibilities of each party to the agreement in conducting standard transactions.

10 TRANSACTION SPECIFIC INFORMATION

This section describes how ASC X12N Implementation Guides (IGs) adopted under HIPAA will be detailed with the use of a table. The tables contain a row for each segment that Acme Health Plan has something additional, over and above, the information in the IGs. That information can:

1. Limit the repeat of loops, or segments
2. Limit the length of a simple data element
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5. Any other information tied directly to a loop, segment, composite or simple data element pertinent to trading electronically with Acme Health Plan

In addition to the row for each segment, one or more additional rows are used to describe Acme Health Plan's usage for composite and simple data elements and for any other information. Notes and comments should be placed at the deepest level of detail. For example, a note about a code value should be placed on a row specifically for that code value, not in a general note about the segment.

The following table specifies the columns and suggested use of the rows for the detailed description of the transaction set companion guides.

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
193	2100C	NM1	Subscriber Name			This type of row always exists to indicate that a new segment has begun. It is always shaded at 10% and notes or comment about the segment itself goes in this cell.
195	2100C	NM109	Subscriber Primary Identifier		15	This type of row exists to limit the length of the specified data element.
196	2100C	REF	Subscriber Additional Identification			
197	2100C	REF01	Reference Identification Qualifier	18, 49, 6P, HJ, N6		These are the only codes transmitted by Acme Health Plan.
			Plan Network Identification Number	N6		This type of row exists when a note for a particular code value is required. For example, this note may say that value N6 is the default. Not populating the first 3 columns makes it clear that the code value belongs to the row immediately above it
218	2110C	EB	Subscriber Eligibility or Benefit Information			
231	2110C	EB13-1	Product/Service ID Qualifier	AD		This row illustrates how to indicate a component data element in the Reference column and also how to specify that only one code value is applicable.

APPENDICES

This section contains one or more appendices.

1. Implementation Checklist

This appendix contains all necessary steps for going live with Acme Health Plan.

2. Business Scenarios

This appendix contains free format text descriptions of typical business scenarios. The transmission examples for these scenarios are included in Appendix 3.

3. Transmission Examples

This appendix contains actual data streams linked to the business scenarios from Appendix 2.

4. Frequently Asked Questions

This appendix contains a compilation of questions and answers relative to Acme Health Plan and its providers. Typical question would involve a discussion about code sets and their effective dates.

5. Change Summary

This section describes the differences between the current Companion Guide and previous guide(s).



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Codes and Remittance Advice Remark Codes (835) Rule
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*NOTE: This document is not the most current version of the *CORE Code Combinations*. The current version is available on the CAQH CORE website here: http://www.caqh.org/Host/CORE/EFT-ERA/CORE-required_CodeCombos.xlsx.

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1 Background Summary

In Phase III, CORE built on the Phase I and Phase II foundation by adding a range of operating rule requirements for both the HIPAA-adopted ASC X12 005010X221A1 Health Care Claim Payment/Advice (835) Technical Report Type 3 Implementation Guide and associated errata (hereafter v5010 X12 835) transaction, also known as the Electronic Remittance Advice (ERA), and the Electronic Funds Transfer (EFT) by addressing operating rules related to the NACHA ACH CCD plus Addenda Record (hereafter CCD+) and the X12 835 TR3 TRN Segment (hereafter the CCD+ and X12 835 TR3 TRN Segment together are the Healthcare EFT Standards¹). The Phase III CORE 350 Health Care Claim Payment/Advice (835) Infrastructure Rule Version 3.0.0 focused on improving the conduct and exchange of electronic claim advice data. The Phase III CORE 360 Uniform Use of Claim Adjustment Reason Codes and Remittance Advice Remark Codes (835) Rule Version 3.0.0 builds upon the Phase III CORE 350 Health Care Claim Payment/Advice (835) Infrastructure Rule Version 3.0.0 by establishing data content rule requirements for conducting the v5010 X12 835 transaction.

The v5010 X12 835 provides data content to the provider regarding the payment of a claim including why the total charges originally submitted on a claim have not been paid in full or a claim payment has been denied. The denial or adjustment of a claim is identified by the health plan or its Pharmacy Benefits Manager (PBM) agent using combinations of four claim denial/adjustment code sets that, when used in combination, should supply the provider with necessary detail regarding the payment of the claim. These code sets are Claim Adjustment Reason Codes² (hereafter CARCs), Remittance Advice Remark Codes³ (hereafter RARCs), and Claim Adjustment Group Codes (hereafter CAGCs), and NCPDP External Code List⁴ Reject Codes (hereafter NCPDP Reject Codes).

Currently, there is extensive confusion throughout the healthcare industry regarding the use of the claim denial/adjustment codes. CORE determined that the healthcare industry requires operating rules establishing data content requirements for the consistent and uniform use of CARCs, RARCs, CAGCs and NCPDP Reject Codes when transmitting the v5010 X12 835. Consistent and uniform use of CARCs, RARCs, CAGCs and NCPDP Reject Codes for electronic reporting of claims adjustment and denials will help to mitigate:

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

And provide for:

- Less staff time spent on phone calls and websites
- Increased ability to conduct targeted follow-up with health plans and/or patients
- More accurate and efficient payment of claims

Achieving a consistent and uniform approach in such a complex area requires using a multi-step process that is focused on actively enabling the industry to reach its long-term goal of a maximum set of CARC/RARC/CAGC and CARC/NCPDP Reject Code/CAGC Combinations. This initial rule provides a clear set of reasonable and well-researched requirements and a process to create future requirements that are based upon real-world results.

¹ The CCD+ and X12 835 TR3 TRN Segment are adopted together as the Federal Healthcare EFT Standards in [CMS-0024-IFC: Administrative Simplification: Adoption of Standards for Health Care Electronic Funds Transfers \(EFTs\) and Remittance Advice, 01/10/12.](#)

² ASC X12 assists several organizations in the maintenance and distribution of code lists external to the X12 family of standards. <http://www.wpc-edi.com/reference/>

³ Ibid.

⁴ http://www.ncpdp.org/members/members_download.aspx. NCPDP Reject Codes are in Appendix A.

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1.1 Affordable Care Act Mandates

This rule is part of a set of rules that addresses a request from the National Committee on Vital and Health Statistics (NCVHS) for fully vetted CAQH CORE Operating Rules for the Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA) transactions; the NCVHS request was made in response to NCVHS' role in Section 1104 of the ACA.

Section 1104 of the ACA contains an industry mandate for the use of operating rules to support implementation of the HIPAA standards. Using successful, yet voluntary, national industry efforts as a guide, Section 1104 defines operating rules as a tool that will build upon existing healthcare transaction standards. The legislation outlines three sets of healthcare industry operating rules to be approved by the Department of Health and Human Services (HHS) and then implemented by the industry; the second set of which are those for EFT and ERA.⁵ The ACA requires HHS to adopt a set of operating rules for both of these transactions by July 2012. In a letter dated 03/23/11,⁶ NCVHS recommended that the Secretary “name CAQH CORE in collaboration with NACHA – The Electronic Payments Association as the candidate authoring entity for operating rules for all health care EFT and ERA transactions...”

Section 1104 of the ACA also adds the EFT transaction to the list of electronic health care transactions for which the HHS Secretary must adopt a standard under HIPAA. The section requires the EFT transaction standard be adopted by 01/01/12, in a manner ensuring that it is effective by 01/01/14. In January 2012, HHS issued an Interim Final Rule with Comment (IFC)⁷ adopting the CCD+ and the X12 835 TR3 TRN Segment⁸ as the Healthcare EFT Standards. These standards must be used for electronic claims payment initiation by all health plans that conduct healthcare EFT.

1.2 Existing Standards/Operating Rules

1.2.1 v5010 X12 835 Health Care Claim Payment/Advice Transaction

The ERA is an electronic version of a payment explanation (remittance advice) submitted by a health plan or its PBM agent to a provider that explains the payment a provider receives for a service claim. If a claim is denied or payment adjusted, the ERA would contain the required explanations. The v5010 X12 835 Health Care Claim Payment/Advice transaction was adopted under HIPAA for electronic reporting of all healthcare claim payment and remittance information. The v5010 X12 835 implementation guide provides the standardized data requirements to be implemented. The diagram below outlines the structure of the v5010 X12 835. Detailed information about the remittance advice, including the use of CARCs and RARCs (the focus of this rule), is contained in Table 2 Detail Claim Payment and Service Payment Information.

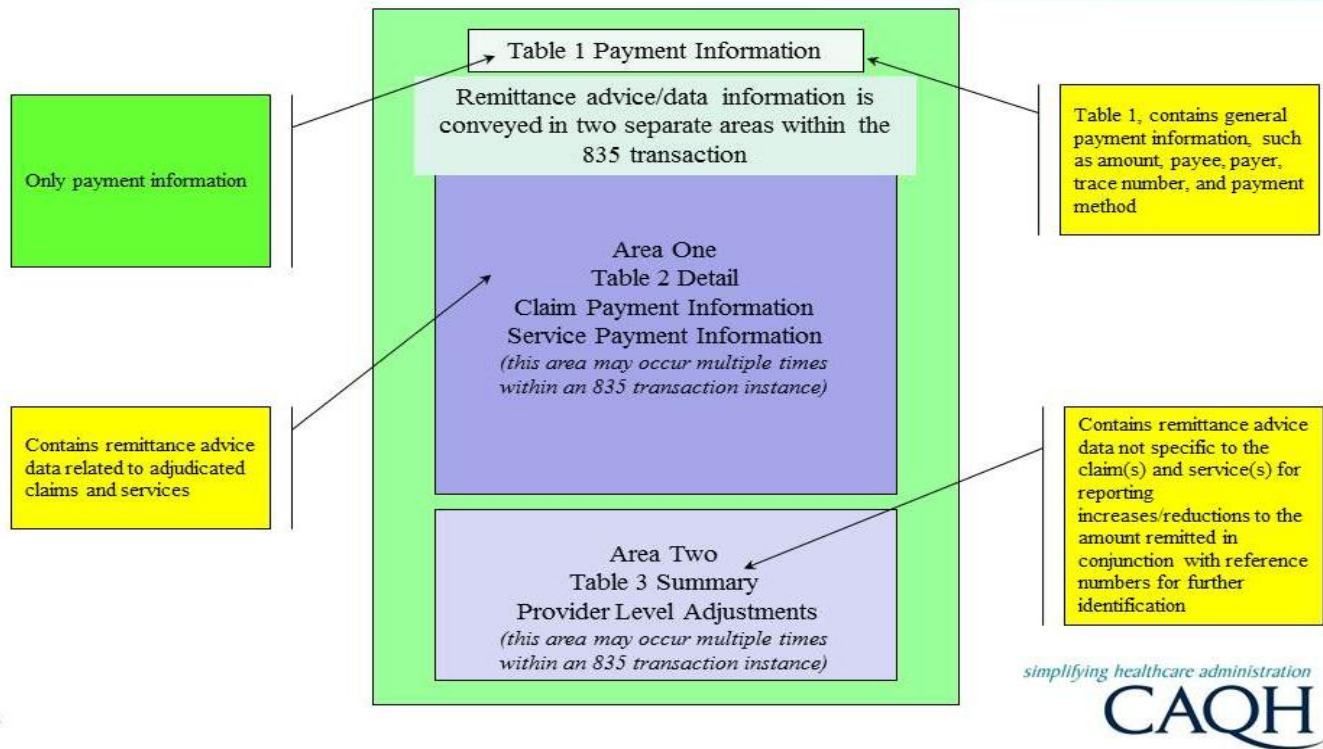
⁵ The first set of operating rules under ACA Section 1104 applies to eligibility and claim status transactions with an adoption date of 07/01/11 and effective date of 01/01/13; the third set of operating rules applies to healthcare claims or equivalent encounter information transactions, enrollment and disenrollment in a health plan, health plan premium payments and referral, certification and authorization with an adoption date of 07/01/14 and effective date of 01/01/16.

⁶ NCVHS [Letter to the Secretary](#) - Affordable Care Act (ACA), Administrative Simplification: Recommendation for entity to submit proposed operating rules to support the Standards for Health Care Electronic Funds Transfers and Health Care Payment and Remittance Advice 03/23/11.

⁷ [CMS-0024-IFC](#): Administrative Simplification: Adoption of Standards for Health Care Electronic Funds Transfers (EFTs) and Remittance Advice, 01/10/12.

⁸ The IFC requires health plans to input the X12 835 TR3 TRN Segment into the Addenda Record of the CCD+; specifically, the X12 835 TR3 TRN Segment must be placed in Field 3 of the Addenda Entry Record (“7 Record”) of a CCD+.

ASC X12 835 Health Care Claim Payment/Advice Transaction: Overall Structure



The v5010 X12 835 provides a range of information to the provider regarding the payment of a claim, why the total charges originally submitted on a claim have not been paid in full and/or information about denied claims. The denial or adjustment of a claim is identified by the health plan or its PBM agent using the following code sets that, when used in combination, should supply the provider with necessary detail regarding the payment of the claim:

- CARCs (Required/external code list)⁹
- RARCs (Required/external code list)¹⁰
- CAGCs (Required/internal code list)¹¹
- NCPDP External Code List (Required/external code list)¹²

NOTE: The first two code lists above (CARCs and RARCs) are used to explain payment adjustments in remittance advice transactions. CARCs identify reasons why healthcare claims or services are not being paid at submitted charges; RARCs provide supplemental information about the adjudication of claims or services. The reason for pursuing this rule area for the Federally mandated EFT & ERA transactions is further defined in §2.1 and centers around requirements for the consistent use of specific combinations of CAGCs/CARCs/RARCs and CAGCs/CARCs/NCPDP Reject Codes based on four specific business scenarios.

⁹ <http://www.wpc-edi.com/content/view/695/1>

¹⁰ <http://www.wpc-edi.com/content/view/739/1>

¹¹ ASC X12 005010X221A1 Health Care Claim Payment/Advice (835) Technical Report Type 3 and associated errata

¹² http://www.ncpdp.org/members/members_download.aspx. NCPDP Reject Codes are in Appendix A.

2 Issue to be Addressed and Business Requirement Justification

The v5010 X12 835 implementation guide provides a range of information to the provider regarding the adjudication and payment information of a claim: the v5010 X12 835 can be used to make a payment, send an Explanation of Payment (EOP) remittance advice or make a payment and send an EOP jointly.

2.1 Problem Space: Medical

As a remittance advice, the v5010 X12 835 provides detailed payment information relative to adjudicated healthcare claim(s) and describes why payment for a submitted claim has been adjusted or denied. The v5010 X12 835 requires health plans or their PBM agents to use CARCs, RARCs, NCPDP Reject Codes and CAGCs to convey the rationale for claim payment adjustments to providers. If a claim payment has been adjusted, health plans or their PBM agents provide the reasons for such adjustments using a combination of:

- **CAGC:** Categorizes the associated CARC based on financial liability. Unlike CARCs and RARCs, which number in the hundreds, there are only 4 CAGCs identified for use in the v5010 X12 835: PR – Patient Responsibility; CO – Contractual Obligations; PI – Payor Initiated Reductions; OA – Other Adjustments. CARCs are always associated with a specific CAGC in the v5010 X12 835. The CAGCs are maintained by the ASC X12 Standards Committee.
- **CARC:** Provides the reason for the positive or negative financial adjustment specific to particular claim or service referenced in the transmitted v5010 X12 835. The external list of CARCs is maintained by the Codes Maintenance Committee established by the Blue Cross and Blue Shield Association, with a multi-stakeholder voting membership.
- **RARC:** Provides supplemental information about why a claim or service line is not paid in full. The external list of RARCs is maintained by the Centers for Medicare & Medicaid Services (CMS). The majority of CARCs do not require RARCs to complete the message; however, there are some specific CARCs that require use of an explanatory RARC.
- **NCPDP Reject Code:** Provides reasons why a retail pharmacy claim was rejected. The external list is maintained by NCPDP.

Often, providers do not receive the same uniform and consistent CARC/RARC/CAGC combinations for the same or similar business scenarios from all health plans and, as a result, are unable to automatically post claim payment adjustments and claim denials accurately and consistently. Two primary causes of the problem surrounding the reporting of claim payment adjustments include:

1. Use of code combinations based on proprietary, health plan specific business scenarios
2. Use of unique, individual health plan approaches to mapping of internal proprietary codes to CARCs/RARCs

Providers are challenged to understand the hundreds of different CARC/RARC/CAGC combinations, which can vary based on health plans' internal proprietary codes and business scenarios.

The v5010 X12 835 does not provide guidance for health plans around the selection of appropriate CARCs or RARCs; decisions on the CARC and/or RARC to explain a claim payment business scenario are left to the health plans. There is a high level of subjectivity to both the interpretation of the codes and their combinations. The various interpretation of the meaning of each code leads to a wide variety of code combinations used to address similar business situations.

Health plans and providers are also challenged by familiarity with the full scope of the CARC and RARC codes sets. Many health plans do not use the most current codes as the codes may be updated three times a year. This results in the inconsistent use of new or modified codes, as well as use of deactivated codes. Many providers are also unfamiliar with the current codes and their use.

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CAQH CORE and NACHA co-sponsored multi-stakeholder research to identify the barriers to achieving industry-wide rapid adoption of EFT and ERA and to develop initial recommendations on topics that operating rules and other industry efforts must address in order to facilitate adoption of EFT and ERA. The findings identified the challenges faced by providers due to inconsistent and non-uniform use of CARCs, RARCs and CAGCs.

First, due to the variations across health plans in the use of CARC/RARC/CAGC code combinations, provider interpretation is required to make sense of confusing and often contradictory reporting of claim payment adjustments. This may result in unnecessary manual provider follow-up, faulty electronic secondary billing and inappropriate write-offs of billable charges. Incorrect billing of patients for co-pays and deductibles may often result. Each of these outcomes costs providers and patients time and money.

Secondly, inconsistent or incomplete utilization of the CARCs/RARCs/CAGCs across the industry makes it difficult for providers to understand payment decisions and to automate posting to patient accounts. As a consequence, providers are often reluctant to implement the v5010 X12 835 transaction, or resort to developing their own tools to support payer-specific code mapping, reducing the return on investment for both providers and payers.¹³

2.2 Retail Pharmacy Claim Process Overview

The pharmacy industry adjudicates claims differently than the medical sector of health care, both with regard to process as well as with regard to codes used in that process.

In pharmacy, there are two key steps to claims adjudication that occur consistently across the millions of claims processed each day:

1. The service (claim) is adjudicated in real-time using the NCPDP Telecommunication Standard.
2. The v5010 X12 835 is then sent on the appropriate cycle.

Using the NCPDP Telecommunication Standard, pharmacies send a real-time request and receive an immediate real-time response from the processor.¹⁴ If the claim is rejected, the NCPDP Reject Codes must be used consistently and uniformly across all trading partners; each NCPDP Reject Code is tied to a specific reason/field in the NCPDP Telecommunication Standard. Agreement on the use of these Reject Codes allows the pharmacy to ensure all required data for real-time adjudication are available. Once the adjudication process is completed, the processor then reports the final result of adjudication via a real-time response which includes payment information, payment reductions, etc.

At the appropriate timeframe (most processors have weekly or two week payment cycles) the processor generates the v5010 X12 835.

If necessary, adjustments are reported on the v5010 X12 835 using an appropriate CARC that the pharmacy industry has agreed upon. NCPDP has created a mapping document to tie claim response fields to CARCs in the v5010 X12 835.

The reporting of a rejected claim in a v5010 X12 835 transaction occurs only rarely given that the pharmacy already has the rejection information from the real-time processing of the claim and the v5010 X12 835 does not require the subsequent reporting of a rejected claim. Any such reporting is based on non-real-time claims processing and mutual trading partner agreement using the NCPDP Reject Codes combined with CARC 16.

¹³ CAQH CORE/NACHA White Paper: Adoption of EFT and ERA by Health Plans and Providers: A White Paper Identifying Business Issues and Recommendations for Operating Rules (2011)

¹⁴ For the purposes of this overview, the term processor refers to the adjudication entity, whether health plan, pharmacy benefit manager (PBM), payer, etc.

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Overview of NCPDP Reject Codes and Process

Over 21 years ago, NCPDP created Reject Codes for pharmacy claims processing. As the industry evolved and the number of codes increased and pharmacy adjudication moved to real-time, the industry agreed upon consistency in how the Reject Codes are applied and what fields are identified that need correction in the standard so IT systems could be built using this consistent list.

Currently, new NCPDP Reject Codes are requested by the industry via a submission process and are discussed and voted on for approval during NCPDP Work Group meetings which occur four times a year. An NCPDP Reject Code is approved upon a demonstrated business need by a consensus process which includes providers, payers, vendors, etc. An NCPDP Reject Code corresponds to a field in the NCPDP standards. Approved NCPDP Reject Codes are published in the NCPDP External Code List document quarterly.

The NCPDP Reject Codes are used consistently, as required under HIPAA, across the pharmacy industry. The reporting of rejects on claims requires all processors to use the NCPDP Reject Codes in the same manner. For example, if the plan requires Prescriber ID, but it is not present on the claim, the processor must reject with code “25” (Missing/Invalid Prescriber ID). It is recognized that not all processors may have the need to use all of the approximately hundreds of NCPDP Reject Codes but if used they must be used in the same manner. For example, one processor may have a business need for a given plan to require the Prescriber ID on a claim and edit for the proper ID; another processor may not need the Prescriber ID on a claim and ignore the field. To ensure consistent and uniform use, the NCPDP Reject Codes are located in a table that contains a reference to the field(s) in error.

Example Table

NCPDP Reject Code	Explanation	D.0 Field # and Name Possibly in Error
Ø7	M/I Cardholder ID	3Ø2-C2 (Cardholder ID)
25	M/I Prescriber ID	411-DB (Prescriber ID)

2.3 CORE Process in Addressing the Problem Space

To address this Problem Space associated with the v5010 X12 835 transaction, the CORE EFT & ERA Subgroup conducted a series of three surveys, numerous Subgroup discussions and significant review of research related to existing industry initiatives (e.g., CMS, Minnesota, NCPDP, Washington State, WEDI, etc.) to ultimately identify and agree on a single CORE Rule Option for which to develop Rule Requirements to address the Rule Opportunity Area: *Uniform Use of CARCs and RARCs*. The CORE Rule Option identified was:

- Identify and agree on a targeted *minimum* set of common or problematic Business Scenarios with a *maximum* specified set of code combinations for each Business Scenario based on those identified via existing efforts (CARC/RARC/CAGC or CARC/NCPDP Reject Codes/CAGC). (Note: CARC and RARC requirements do not include business scenarios in the v5010 X12 835 standard.)

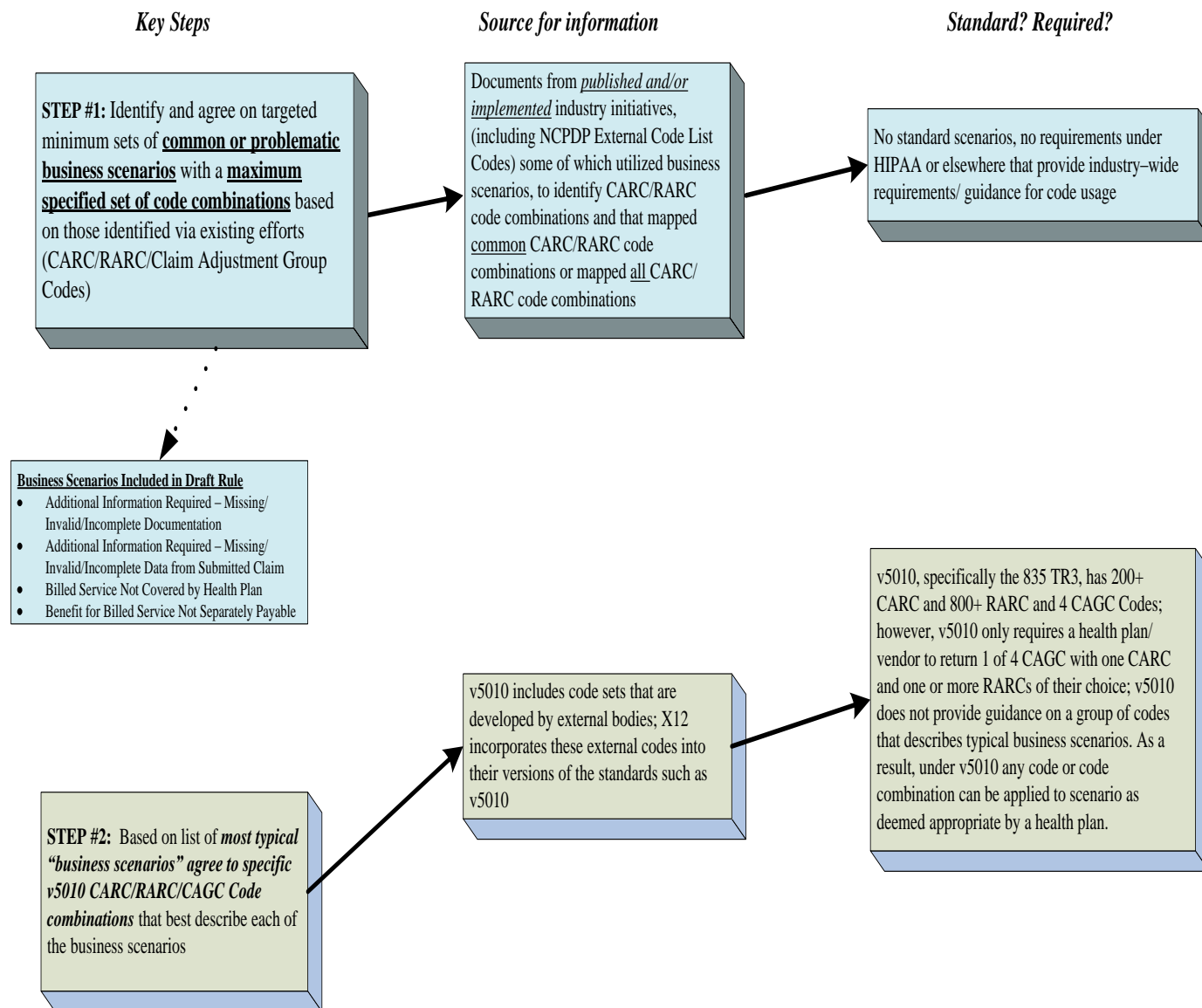
Therefore, this Phase III CORE rule addresses the consistent use of these *maximum* CARC/RARC/CAGC and CARC/NCPDP Reject Code/CAGC code combinations mapped to a *minimum* set of CORE-defined Business Scenarios for reporting claim payment adjustments and denials in the v5010 X12 835. A health plan may develop additional Business Scenarios and associated code combinations for such Business Scenarios to meet its business needs.

The figure below depicts a high-level process and key steps that CAQH CORE used to complete its work. It should be noted that this rule is the first *national* approach to create operating rules to address the critical area of uniform use of CARC/RARC/CAGC code combinations. Establishing CORE’s long-term commitment to regular enhancements of this operating rule is similar to the process that has been taken with other CORE rules, which state that the initial rule is the starting point and future CORE phases will expand upon the initial rule to ensure the industry meets its goal of administrative simplification. This milestone-driven approach addresses the ongoing

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CORE goal that the industry must begin to reduce administrative costs today and not wait until 100% of all issues and associated costs can be resolved.

Overview of Rule Development Process for Phase III Uniform Use of CARCs & RARCs Rule



Upon agreement on a Rule Option, the Subgroup agreed the next step in the rule development process was to identify and review detailed Rule Requirements focused on a *minimum* set of Business Scenarios with a *maximum* set of CARC/RARC/CAGC or CARC/NCPDP Reject Code/CAGC code combinations for each Business Scenario. The Subgroup also noted that key to identification of Rule Requirements is building on *existing published and/or implemented industry initiatives* for which data source/analysis methods are verifiable. CAQH CORE conducted substantial analysis to compare the business scenarios related to the initiatives below to identify common business situations:

- Washington State Healthcare Forum: The WorkSMART Institute's Business & Technology Workgroup identified problematic situations for provider organizations where health plans use different CARCs/RARCs

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on the v5010 X12 835 for the same denial/adjustment reason. The result was identification of three global business reasons for denial/payment adjustment within each of which were more specific situations (e.g., pathology report is missing for Business Scenario 1: *Provided information had invalid or missing information*). After identifying the common problematic business situations, the Work Group provided a mapping of the appropriate CARC/RARC/CAGC code combination to be used for each of the specific situations within the three global business reasons.

- WEDI: WEDI's Strategic National Implementation Process (SNIP) 835 Subworkgroup developed a white paper to provide a guidance tool for health plans mapping their internal proprietary codes to industry standard CARCs/RARCs. As part of this effort, the Subworkgroup created an associated CARC/RARC code combinations mapping tool in which they identified nine common business scenarios based on mapping proprietary codes from various health plans to all of the standard CARCs with associated CAGCs and RARCs. WEDI's effort built on the work done by LINXUS, a Greater New York Hospital Association effort, in 2008.
- Business Scenarios currently used by the CORE Participants.

Findings of this analysis identified four CORE-defined Claim Adjustment/Denial Business Scenarios. For each of the four CORE-defined Claim Adjustment/Denial Business Scenarios, an analysis of common CARC/RARC/CAGC and CARC/NCPDP Reject Code/CAGC code combinations between the WEDI and Washington State efforts was conducted to identify a maximum set of code combinations, which was compared to code combinations used by additional industry initiatives:

- Centers for Medicare and Medicaid Services (CMS): For Medicare, CMS analyzed CARCs utilized in FY 2010, and their associated RARCs. Their analysis showed that the top ten CARCs most frequently reported on the v5010 X12 835 accounted for 75% of total annual CARC usage across all v5010 X12 835 transactions. CMS also reported that the top 25 CARCs account for 85% of total CARC usage on an annual basis.
- Minnesota Department of Health: The Minnesota Uniform Companion Guide for the Implementation of the ASC X12/005010X221A1 Health Care Claim Payment/Advice v2.0 (the use of which is required by law in MN) addresses all allowed CARCs and RARCs combinations, excluding RARC Alerts, in the Minnesota Crosswalk for CARCs, CAGCs and RARCs.
- Code combinations currently used by the CORE Participants.

Out of this cross-industry analysis, the maximum set of CARC/RARC/CAGC or CARC/NCPDP Reject Code/CAGC combinations included in this rule for each of the four CORE-defined Claim Adjustment Business Scenarios was identified.

3 Scope

3.1 What the Rule Applies To

This CORE rule conforms with and builds upon the v5010 X12 835 by specifying that health plans or their PBM agents use a uniform set of CAGCs, CARCs, RARCs and NCPDP Reject Codes for specified CORE-defined Claim Adjustment/Denial Business Scenarios.

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3.2 Applicable Loops, Data Elements & Code Sources

This rule covers the following data elements and loops in the v5010 X12 835 transaction. The scope of this rule is limited to the detail level, Table 2, Loop ID 2100 and Loop ID 2110 and applies to use of CAGCs, CARCs, RARCs and NCPDP Reject Codes at the claim and service levels.

Loop ID and Name
Loop 2100 Claim Payment Information
Data Element Segment Position, Number & Name
CAS01 – 1033 Claim Adjustment Group Code
CAS02 – 1034 Claim Adjustment Reason Code
CAS05 – 1034 Claim Adjustment Reason Code
CAS08 – 1034 Claim Adjustment Reason Code
CAS11 – 1034 Claim Adjustment Reason Code
CAS14 – 1034 Claim Adjustment Reason Code
CAS17 – 1034 Claim Adjustment Reason Code
MIA05, 20, 21, 22, 23 – 127 Reference Identification (Claim Payment Remark Code)
MOA03, 04, 05, 06, 07 – 127 Reference Identification (Claim Payment Remark Code)

Loop ID and Name
Loop 2110 Service Payment Information
Data Element Segment Position, Number & Name
CAS01 – 1033 Claim Adjustment Group Code
CAS02 – 1034 Claim Adjustment Reason Code
CAS05 – 1034 Claim Adjustment Reason Code
CAS08 – 1034 Claim Adjustment Reason Code
CAS11 – 1034 Claim Adjustment Reason Code
CAS14 – 1034 Claim Adjustment Reason Code
CAS17 – 1034 Claim Adjustment Reason Code
LQ01 – 1270 Code List Qualifier Code
LQ02 – 1271 Remark Code
MIA05, 20, 21, 22, 23 – 127 Reference Identification (Claim Payment Remark Code)
MOA03, 04, 05, 06, 07 – 127 Reference Identification (Claim Payment Remark Code)

This rule covers the following external code sources specified in the v5010 X12 835 transaction for the data elements listed in the table above:

v5010 X12 835 Code Source Reference # and Name
139 – Claim Adjustment Reason Code
411 – Remittance Advice Remark Codes
530 – NCPDP Reject/Payment Code [sic]

3.3 When the Rule Applies

This rule applies when an entity uses, conducts or processes the v5010 X12 835.

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3.4 *What the Rule Does Not Require*

This rule does not require any entity to conduct, use or process the v5010 X12 835 if it currently does not do so or is not required by Federal or state regulation to do so.

3.5 *CORE Process for Maintaining CORE-defined Claim Adjustment Reason Code, Remittance Advice Remark Code & Claim Adjustment Group Code Combinations*

The CARC, RARC and NCPDP Reject Code codes sets are used to report payment adjustments and denials in the v5010 X12 835. The CARC, RARC and NCPDP Reject Codes are maintained by organizations external to the ASC X12 Standards Committee. As such, these code lists are subject to revision and maintenance three or more times a year. Such revision and maintenance activity can result in new codes, revision to existing codes' definitions and descriptions, or a stop date assigned to a code after which the code should no longer be used.

Given this code list maintenance activity, CORE recognizes that the focus of this rule, coupled with this unique maintenance activity, will require a process and policy to enable the various CARC/RARC/CAGC and CARC/NCPDP Reject Code/CAGC combinations specified in the companion document to this rule, *CORE-required Code Combinations for CORE-defined Business Scenarios.doc*, to be revised and modified. CAQH CORE will establish an open process for soliciting feedback and input from the industry on a periodic basis, no less than three times per year, on the CARC/RARC/CAGC and CARC/NCPDP Reject Codes/CAGC combinations in the *CORE-required Code Combinations for CORE-defined Business Scenarios.doc* and convene a Subgroup to agree on appropriate revisions.¹⁵ As part of this process, it will be expected that health plans/providers/vendors will report to CORE additional Business Scenarios that health plans or their PBM agents may be using on a frequent basis that are not covered by this CORE rule for consideration for additional Business Scenarios. A public request will be made to receive this real-world data and the analysis of the data will incorporate traditional Quality Improvement (QI) reviews as well as commitment to CORE Guiding Principles.

Both retail pharmacy and medical sectors are committed to continue to improve the process for reporting claim rejections and adjustments to providers consistently and uniformly across the industry. To further this commitment, both sectors will continue to collaborate and to take lessons learned from the industry to develop and enhance an ongoing QI process for maintaining, updating and supporting a stable industry-wide claim payment adjustments/denials code combination and code/field set.

3.6 *Abbreviations and Definitions Used in this Rule*

CORE-defined Claim Adjustment/Denial Business Scenarios: In general, a business scenario provides a complete description of a business problem such that requirements can be reviewed in relation to one another in the context of the overall problem. Business scenarios provide a way for the industry to describe processes or situations to address common problems and identify technical solutions. By making obvious what is needed, and why, the trading partners and vendors are able to solve problems using open standards and leveraging each other's skills.

Thus, in the context of this CORE rule, a CORE-defined Claim Adjustment/Denial Business Scenario describes at a high level the category of the denial or payment adjustment of a healthcare claim within the health plan's or PBM agent's adjudication system to which various combinations of CARC/RARC/CAGC or CARC/NCPDP Reject Code/CAGC can be applied so that details can be conveyed to the provider using the v5010 X12 835. The CORE-defined Claim Adjustment/Denial Business Scenarios are specified in §4.1.1.

¹⁵ Research shows that there has been little volatility in the code sets.

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3.7 How the Rule Relates to Phase I and II CORE

This rule builds upon and extends the Phase III CORE 350 Health Care Claim Payment/Advice (835) Infrastructure Rule Version 3.0.0 by requiring the v5010 X12 835 to use a uniform set of CAGC, CARC, RARC or CARC/NCPDP Reject Code/CAGC codes for specified CORE-defined Claim Adjustment/Denial Business Scenarios.

As with other Phase I and Phase II CORE rules, general CORE policies also apply to Phase III CORE EFT & ERA rules and will be outlined in the Phase III CORE EFT & ERA Rule Set.

This rule supports the CORE Guiding Principles that CORE rules will not be based on the least common denominator but rather will encourage feasible progress, and that CORE rules are a floor and not a ceiling, e.g., entities can go beyond the Phase III CORE Rules.

3.8 Assumptions

A goal of this rule is to establish a foundation for semantic interoperability of EDI in assuring that content of the transactions being exchanged conveys a consistent business message about any claim payment, adjustments or denials by the uniform use of a set of specified codes.

The following assumptions apply to this rule:

- A successful communication connection has been established
- This rule is a component of the larger set of Phase III CORE EFT & ERA Rules; as such, all the CORE Guiding Principles apply to this rule and all other rules
- This rule is not a comprehensive companion document of the v5010 X12 835 Health Care Claim Payment/Advice transaction set

4 Rule Requirements

4.1 Basic Requirements for Uniform Use of Claim Adjustment Reason Codes, Remittance Advice Remark Codes & Claim Adjustment Group Codes

This section addresses the requirements for a health plan or its PBM agent when sending a v5010 X12 835 with a claim payment adjustment or claim denial, submitted either in real time or in batch.

4.1.1 CORE-defined Claim Adjustment/Denial Business Scenarios

A CORE-defined Claim Adjustment/Denial Business Scenario describes, at a high level, the category of the denial or payment adjustment of a healthcare claim within the health plan's or its PBM agent's adjudication system. For each business scenario, specific combinations of CARC/RARC/CAGC or CARC/NCPDP Reject Code/CAGC codes can be applied to convey details of the claim denial or payment to the provider using the v5010 X12 835.

The four CORE-defined Claim Adjustment/Denial Business Scenarios represent a *minimum* set of Business Scenarios. 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.

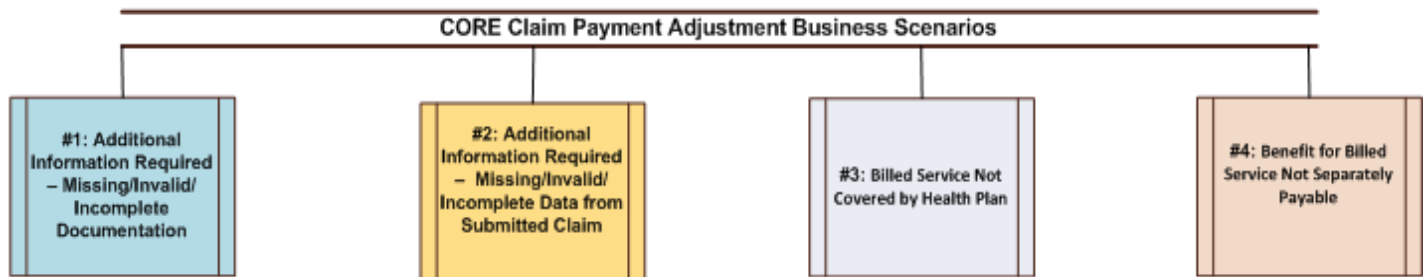
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Table 4.1.1-1 defines four Claim Adjustment/Denial Business Scenarios.

Table 4.1.1-1	
CORE-defined Claim Adjustment/Denial Business Scenario	CORE Business Scenario Description
Scenario #1: Additional Information Required – Missing/Invalid/Incomplete Documentation	Refers to situations where additional documentation is needed from the billing provider or an ERA from a prior payer. The maximum set of CORE-defined code combinations to convey detailed information about the denial or adjustment for this business scenario is specified in <i>CORE-required Code Combinations for CORE-defined Business Scenarios.doc</i> .
Scenario #2: Additional Information Required – Missing/Invalid/Incomplete Data from Submitted Claim	Refers to situations where additional data are needed from the billing provider for missing or invalid data on the submitted claim, e.g., an 837 or D.O. The maximum set of CORE-defined code combinations to convey detailed information about the denial or adjustment for this business scenario is specified in <i>CORE-required Code Combinations for CORE-defined Business Scenarios.doc</i> .
Scenario #3: Billed Service Not Covered by Health Plan	Refers to situations where the billed service is not covered by the health plan. The maximum set of CORE-defined code combinations to convey detailed information about the denial or adjustment for this business scenario is specified in <i>CORE-required Code Combinations for CORE-defined Business Scenarios.doc</i> .
Scenario #4: Benefit for Billed Service Not Separately Payable	Refers to situations where the billed service or benefit is not separately payable by the health plan. The maximum set of CORE-defined code combinations to convey detailed information about the denial or adjustment for this business scenario is specified in <i>CORE-required Code Combinations for CORE-defined Business Scenarios.doc</i> .

Note: Business Scenario 4 does not apply to Retail Pharmacy because a prescription drug claim is reported at the service level as one Rx, e.g., prescription, which corresponds to the claim billed via the NCPDP Telecommunication standard.

Below is a graphical representation of the CORE Claim Adjustment/Denial Business Scenarios.



4.1.2 Uniform Use of Claim Adjustment Reason Codes, Remittance Advice Remark Codes, Claim Adjustment Group Codes & NCPDP Reject Codes

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*.

4.1.3 Use of CORE-required CARC/RARC/CAGC/NCPDP Reject Code Combinations

Specific details about a claim payment adjustment or denial are conveyed to the provider by the health plan or its PBM agent in the v5010 X12 835 by the combined use of a:

- Specified CAGC, a specified CARC and optionally one or more RARCs

Or

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- Specified CAGC, a specified CARC with one or more NCPDP Reject Codes

These code combinations are defined as CORE-required CARC/RARC/CAGC or CARC/NCPDP Reject Code/CAGC combinations. The CORE required *maximum* CORE CARC/RARC/CAGC or CARC/NCPDP Reject Code/CAGC Code Combinations for each CORE-defined Claim Adjustment/Denial Business Scenario are specified in the *CORE-required Code Combinations for CORE-defined Business Scenarios.doc*. This document is available at http://www.caqh.org/Host/CORE/EFT-ERA/CORE-required_CodeCombos.xlsx.

A health plan or its PBM agent must support the maximum CORE-required CARC/RARC/CAGC or CARC/NCPDP Reject Code/CAGC combinations in the v5010 X12 835 as specified in *CORE-required Code Combinations for CORE-defined Business Scenarios.doc*; no other CARC/RARC/CAGC or CARC/NCPDP Reject Codes/CAGC combinations are allowed for use in the CORE-defined Claim Adjustment/Denial Business Scenarios. 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.

The only exception to this maximum set of CORE-required CARC/RARC/CAGC or CARC/NCPDP Reject Code/CAGC combinations is when the respective code committees responsible for maintaining the codes create a new code or adjust an existing code. Then the new or adjusted code can be used with the Business Scenarios and a CORE process for updating the Code Combinations will review the ongoing use of these codes within the maximum set of codes for the Business Scenarios. A deactivated code must not be used.

In the case where a health plan or its PBM agent wants to use an existing code combination that is not included in the maximum code combination set for a given CORE-defined Business Scenario, a new CARC/RARC code combination must be requested in accordance with the CORE process for updating the *CORE-required Code Combinations for CORE-defined Business Scenarios.doc*.

4.2 Basic Requirements for Receivers of the v5010 X12 835

When receiving a v5010 X12 835, a product extracting the data (e.g., a vendor's provider-facing system or solution) from the v5010 X12 835 for manual processing must make available to the end user:

- 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

And

- Text describing the corresponding CORE-defined Claim Adjustment/Denial Business Scenario.

The requirement to make available to the end user text describing the corresponding CORE-defined Claim Adjustment/Denial Business Scenario does not apply to retail pharmacy.

This requirement does not apply to an entity that is simply forwarding the v5010 X12 835 to another system for further processing.

5 Conformance Requirements

Separate from any HHS certification/compliance program to demonstrate conformance as mandated under ACA Section 1104, CAQH CORE offers voluntary CORE Certification for all Phases of the CAQH CORE Operating Rules. CORE Certification is completely optional. Pursuing voluntary CORE Certification offers an entity a mechanism to test its ability to exchange EFT and ERA transaction data with its trading partners. A CORE-certified Seal is awarded to an entity or vendor product that voluntarily completes CORE certification testing with a CAQH CORE-authorized testing vendor. Key benefits of voluntary CORE Certification include:

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- Demonstrates to the industry adoption of the Phase III CORE EFT & ERA Operating Rules via a recognized industry “Seal”
- Encourages trading partners to work together on transaction data content, infrastructure and connectivity needs
- Reduces the work necessary for successful trading partner testing as a result of independent testing of the operating rules implementation
- Promotes maximum ROI when all stakeholders in the information exchange are known to conform to the CORE Operating Rules

For more information on achieving *voluntary* CORE Certification for the CAQH CORE EFT & ERA Operating Rules, refer to the Phase III CORE EFT & ERA Operating Rules Voluntary Certification Master Test Suite Version 3.0.0 or contact CORE@caqh.org.

6 Appendix

6.1 References

- ASC X12 005010X221A1 Health Care Claim Payment/Advice (835) Professional Technical Report Type 3 and associated errata
- Claim Adjustment Reason Codes: <http://www.wpc-edi.com/content/view/695/1>
- Remittance Advice Remark Codes: <http://www.wpc-edi.com/content/view/739/1>
- CAQH CORE/NACHA White Paper: Adoption of EFT and ERA by Health Plans and Providers: A White Paper Identifying Business Issues and Recommendations for Operating Rules (2011)
- Minnesota Uniform Companion Guide for the Implementation of the ASC X12/005010X221A1 Health Care Claim Payment/Advice v2.0 (2010)
- NCPDP External List Code: http://www.ncdp.org/members/members_download.aspx. NCPDP Reject Codes are in Appendix A.
- Washington State Healthcare Forum. Best Practice Recommendation for Standard Coding of Denials and Adjustments in the HIPAA 835 Remittance Advice Transaction (835 v4010A1 & 5010) (2010)
- WEDI. A Practical Guide for the Mapping and Use of Claim Adjustment Reason Codes and Remittance Advice Remark Codes (2010)



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1 Background Summary

In Phase III, CORE built on the Phase I and Phase II foundation by adding a range of operating rule requirements for both the HIPAA-adopted ASC X12 005010X221A1 Health Care Claim Payment/Advice (835) Technical Report Type 3 Implementation Guide and associated errata (hereafter v5010 X12 835) transaction, also known as the Electronic Remittance Advice (ERA), and the Electronic Funds Transfer (EFT) by addressing operating rules related to the NACHA ACH CCD plus Addenda Record (hereafter CCD+) and the X12 835 TR3 TRN Segment (hereafter the CCD+ and X12 835 TR3 TRN Segment together are the Healthcare EFT Standards¹).

The Phase III CORE 350 Health Care Claim Payment/Advice Infrastructure (835) Rule Version 3.0.0 focused on improving the conduct and exchange of electronic claim advice data as these transactions can have a direct impact on a provider's revenue cycle management process. The Phase III CORE 350 Health Care Claim Payment/Advice Infrastructure (835) Rule Version 3.0.0 requires that health plans make appropriate use of the standard acknowledgements, support the CORE "safe harbor" connectivity requirement, use the CORE v5010 Master Companion Guide template when publishing their v5010 X12 835 companion guide, and continue to provide dual delivery of their proprietary claim remittance advices along with the v5010 X12 835 transaction for a period of time during which providers can ensure that their financial system can successfully use it to post payments. Both the Phase III CORE 380 EFT Enrollment Data Rule Version 3.0.0 and the Phase III CORE 382 ERA Enrollment Data Rule Version 3.0.0 ensure that the necessary data for reassociation is collected for reassociation.

Requiring the delivery and use of the Phase III CORE 350 Infrastructure Rule for the v5010 X12 835 continues to facilitate the industry's momentum to increase access to the HIPAA-adopted administrative transactions, and will encourage entities to use the infrastructure they have for eligibility and claim status, and apply this infrastructure to the health care claim payment/advice.

Currently, there is confusion throughout the healthcare industry in effectively using electronic funds transfer (EFT) for claim payments with ERA for remittance advice due to challenges and issues encountered by the provider in matching the payment to the remittance advice detail so that subsequent posting to the patient account is correct.

Consistent and uniform rules enabling providers to match and process both the EFT payment and the v5010 X12 835 will help to mitigate:

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

And provide for:

- Less staff time spent on phone calls and websites
- Increased ability to conduct targeted follow-up with health plans and/or patients
- More accurate and efficient payment of claims

1.1 Affordable Care Act Mandates

¹ The CCD+ and X12 835 TR3 TRN Segment are adopted together as the Federal Healthcare EFT Standards in [CMS-0024-IFC](#): Administrative Simplification: Adoption of Standards for Health Care Electronic Funds Transfers (EFTs) and Remittance Advice, 01/10/12.

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This rule is part of a set of rules that addresses a request from the National Committee on Vital and Health Statistics (NCVHS) for fully vetted CAQH CORE Operating Rules for the EFT and ERA transactions; the NCVHS request was made in response to NCVHS' role in Section 1104 of the Affordable Care Act (ACA).

Section 1104 of the ACA contains an industry mandate for the use of operating rules to support implementation of the HIPAA standards. Using successful, yet voluntary, national industry efforts as a guide, Section 1104 defines operating rules as a tool that will build upon existing healthcare transaction standards. The legislation outlines three sets of healthcare industry operating rules to be approved by the Department of Health and Human Services (HHS) and then implemented by the industry; the second set of which are those for EFT and ERA.² The ACA requires HHS to adopt a set of operating rules for both of these transactions by July 2012. In a letter dated 03/23/11,³ NCVHS recommended that the Secretary "name CAQH CORE in collaboration with NACHA – The Electronic Payments Association as the candidate authoring entity for operating rules for all health care EFT and ERA transactions..."

Section 1104 of the ACA also adds the EFT transaction to the list of electronic health care transactions for which the HHS Secretary must adopt a standard under HIPAA. The section requires the EFT transaction standard be adopted by 01/01/12, in a manner ensuring that it is effective by 01/01/14. In January 2012, HHS issued an Interim Final Rule with Comment (IFC)⁴ adopting the CCD+ and the X12 835 TR3 TRN Segment⁵ as the Healthcare EFT Standards. These standards must be used for electronic claims payment initiation by all health plans that conduct healthcare EFT.

As described in the IFC, the healthcare payment flow through the ACH Network occurs in three chronological stages, each of which includes a separate electronic transmission of information:

- *Stage 1 Payment Initiation:* The health plan (i.e., Originator) authorizes its financial institution (i.e., Originating Depository Financial Institution or ODFI) to make an EFT healthcare claims payment through the ACH Network on its behalf. (The Healthcare EFT Standards adopted in the IFC address only this stage.)
- *Stage 2 Transfer of Funds:* Funds from the payer's account at the ODFI are moved, through a series of interactions, into the payee's (i.e., Receiver's) account at the payee's financial institution (i.e., Receiving Depository Financial Institution or RDFI).
- *Stage 3 Deposit Notification:* The RDFI transmits information to the Receiver indicating the payment has been deposited into the Receiver's account.

1.2 Existing Standards and Operating Rules

1.2.1 ASC X12 v5010 X12 835 Health Care Claim Payment/Advice

The ERA is an electronic version of a payment explanation (remittance advice) submitted by a health plan to a provider that explains the payment a provider receives for a service claim. If a claim is denied or the payment adjusted, the ERA would contain the required explanations. The v5010 X12 835 provides the standardized data

² The first set of operating rules under ACA Section 1104 applies to eligibility and claim status transactions with an adoption date of 07/01/11 and effective date of 01/01/13; the third set of operating rules applies to healthcare claims or equivalent encounter information transactions, enrollment and disenrollment in a health plan, health plan premium payments and referral, certification and authorization with an adoption date of 07/01/14 and effective date of 01/01/16.

³ NCVHS [Letter to the Secretary](#) - Affordable Care Act (ACA), Administrative Simplification: Recommendation for entity to submit proposed operating rules to support the Standards for Health Care Electronic Funds Transfers and Health Care Payment and Remittance Advice 03/23/11.

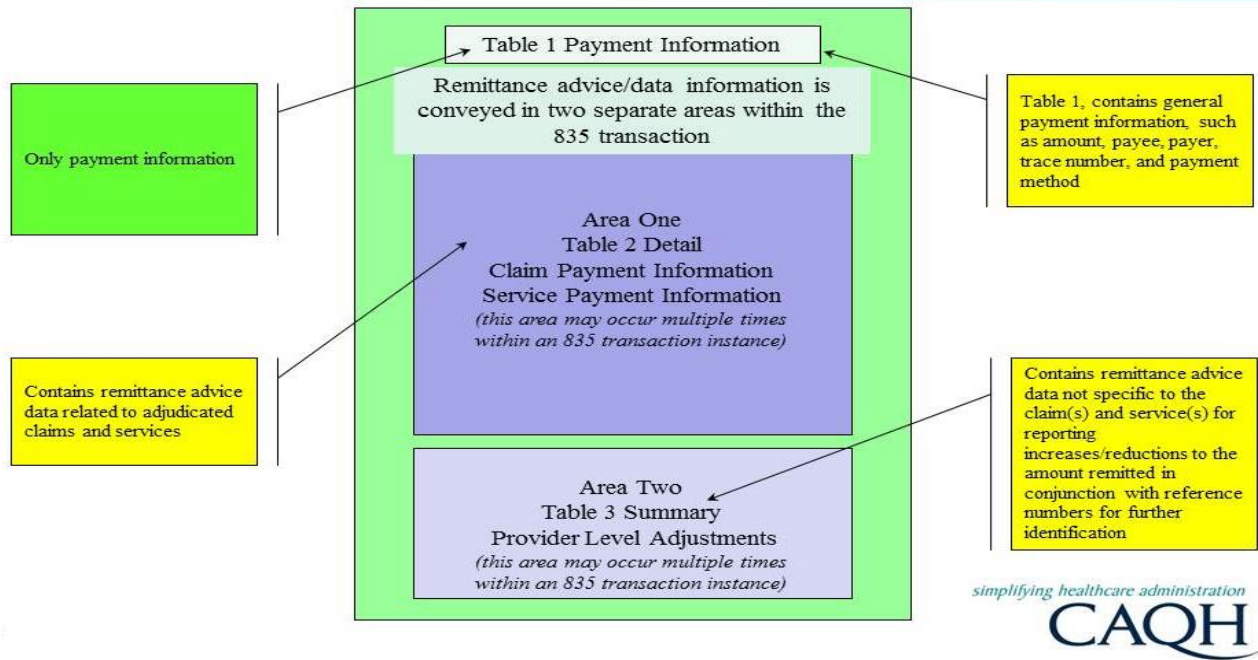
⁴ [CMS-0024-IFC](#): Administrative Simplification: Adoption of Standards for Health Care Electronic Funds Transfers (EFTs) and Remittance Advice, 01/10/12.

⁵ The IFC requires health plans to input the X12 835 TR3 TRN Segment into the Addenda Record of the CCD+; specifically, the X12 835 TR3 TRN Segment must be placed in Field 3 of the Addenda Entry Record ("7 Record") of a CCD+.

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requirements to be implemented. The diagram below outlines the structure of the v5010 X12 835. Detailed information about the payment (the focus of this rule), is contained in Table 1 Payment Information.

ASC X12 835 Health Care Claim Payment/Advice Transaction: Overall Structure



1.2.2 NACHA Operating Rules and the ACH EFT Standards

Today, many EFT payments throughout the United States are guided by the *NACHA Operating Rules*, which support the implementation of the existing ACH CCD+ and CTX EFT standards. These standards and their associated operating rules guide over 8 million EFTs each day, many of which are healthcare payments, via the ACH Network (a secure electronic network for the direct transfer of funds and data from one depository institution [e.g., bank] account to another). To date, healthcare-specific EFT operating rules for claim payments to providers have not been developed.

Within the financial industry, the data elements of the ACH CCD+ and CTX standards are fully described by the *NACHA Operating Rules*, which build upon the ACH standards. At a high level, the standards carry all necessary information for an EFT to be correctly processed, recorded, posted and identified by all parties to the EFT. The financial industry has made a focused effort to ensure data elements have clear, unambiguous terms that complement set values in other fields. NACHA continues to review these rules for updates and adjustments that speak to this goal. The current EFT standard, developed and maintained by NACHA, is being used successfully by some 14,000 banking institutions.

2 Issue to be Addressed and Business Requirement Justification

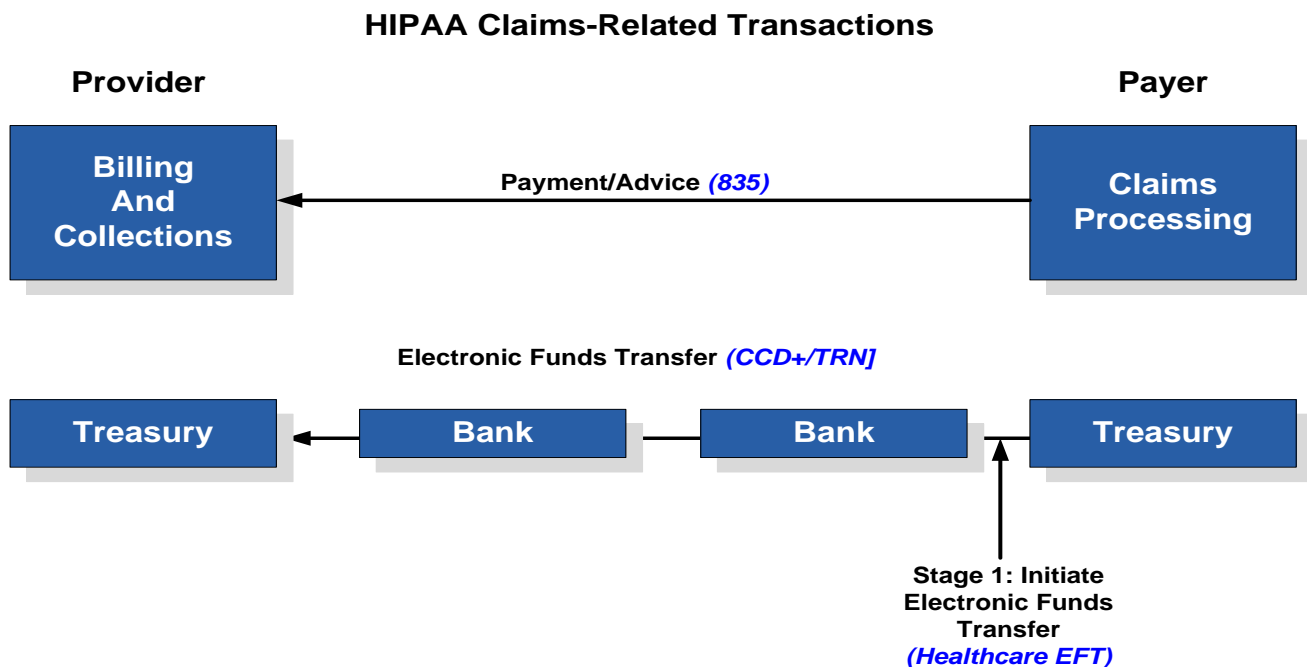
The v5010 X12 835 implementation guide provides a range of information to the provider regarding the details of the claim payment and whether the payment method is electronic using the Healthcare EFT Standards or paper check.

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2.1 Problem Space

NACHA and CAQH CORE research, as well as CORE EFT and ERA Subgroup surveys and discussion have identified that providers report reassociation of the remittance data to the payment data as a significant problem. This problem often occurs because the necessary data required by the provider are incorrect, missing, or not available, or have not been requested in a way that is meaningful to the provider’s financial institution. Providers are at a great disadvantage when attempting to reassociate their payment with the remittance advice as a result of the frequency of these types of errors and the confusion and misunderstanding of the existing standards and operating rules or lack of operating rules that govern them.

EFT and ERA operating rules represent the convergence of financial services and health care as outlined in the diagram below. With the HHS-adopted Healthcare EFT Standards the EFT and ERA travel separately to the provider. The v5010 X12 835 travels from the payer to the provider either directly or through a clearinghouse or other intermediary, whereas the CCD+ is initiated by the payer or a third party processor but then must travel through the ACH Network from the Originating Depository Financial Institution (the payer’s bank) to the Receiving Depository Financial Institution (the provider’s bank). The provider must then reassociate the EFT and ERA using a reassociation trace number.



When a provider receives payment via EFT and an ERA, payment and remittance advice processing are typically much faster than when a paper check and corresponding paper remittance advice are received. Providers save considerable time and expense from not sorting mail, opening envelopes, posting the checks, depositing the checks, and ultimately reconciling the paper remittance advice with the patient accounts. Currently, however, payers still reimburse providers via paper checks and explain the payment with an attached paper remittance advice. Statistically, it is difficult to determine how extensively EFTs and ERAs are used in the industry today. According to the US Healthcare Efficiency Index, currently only ten percent of all healthcare payments are made electronically.⁶ Other industry research estimates this percentage at around thirty percent.⁷ These low rates of

⁶ Source: US Healthcare Efficiency Index, 2007: <http://ushealthcareindex.com>

⁷ Source: Overhauling the US Healthcare Payment System, McKinsey Quarterly, June 2007

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adoption may be due to the many unique complexities related to ERA and EFT that serve as difficult barriers to broader adoption. These key business issues are outlined below.

2.1.1 Matching Payment to Remittance Data

When the correct ASC X12 835 EFT Reassociation Trace Number is sent in the CCD+, providers are able to “reassociate” funds that are sent separately from the ERA with the remittance advice information in the v5010 X12 835.⁸ Currently, there are many problems in the industry that result in the lack of a correct ASC X12 EFT Reassociation Trace Number being included in the EFT payment. Frequently, health plans simply do not include the ASC X12 EFT Reassociation Trace Number from the v5010 X12 835 with the EFT payment. When the reassociation trace number is included, it may be incorrectly placed in the ACH Trace Number field and not in the CCD+ Addenda Record Payment Related Information field. (See §2.1.1.1 for a more detailed explanation of this issue.) If the reassociation trace number is placed in the ACH trace number field, it will be replaced by the Originating Depository Financial Institution (ODFI), which is the financial institution originating the EFT payment into the ACH Network – as required by the *NACHA Operating Rules*. The ODFI is responsible for populating the ACH Trace Number field. Even if the health plan or a third-party populates the field it will be replaced by the ODFI. It is also possible for the EFT data received by the provider to include a trace number that has been altered during the transaction process or an incorrect trace number that is different from the ASC X12 EFT Reassociation Trace Number the health plan placed in the ERA. Additionally, although the *NACHA Operating Rules* require the financial institution to deliver the reassociation trace number to the provider, the provider must first request such delivery. Most providers are unaware of this *NACHA Operating Rule* requirement.

2.1.1.1 ASC X12 EFT Reassociation Trace Number and ACH Trace Number

The table below describes the two trace numbers that often are confused with each other. Both trace numbers are required data in the Healthcare EFT Standards; however, each trace number is specific either to the CCD+ or the v5010 X12 835 transaction. The ASC X12 EFT Reassociation Trace Number is the only trace number that is used to match the EFT to the corresponding ERA.

	ACH Trace Number	ASC X12 EFT Reassociation Trace Number
Creator	<ul style="list-style-type: none"> • ODFI 	<ul style="list-style-type: none"> • Health Plan/Payer
Source	<ul style="list-style-type: none"> • NACHA CCD+ Field 11 of Entry Detail Record • The ACH Trace number is assigned by the ODFI as specified in the <i>NACHA Operating Rules</i> 	<ul style="list-style-type: none"> • HIPAA-adopted ASC X12N 005010X221A1 835, Table 1 TRN Reassociation Trace Number Segment (<i>see Note 1 below</i>) TRN02-127 Trace Number • ASC X12 EFT Trace number is placed in the Payment Related Information field of the CCD+ Addenda Record as part of the entire TRN Reassociation Trace Number Segment (<i>this number is assigned by the payer</i>)
Primary Function	<ul style="list-style-type: none"> • Uniquely identifies each Entry within a batch in an ACH input File 	<ul style="list-style-type: none"> • Uniquely identifies the transaction set and aids in reassociating payments and remittance advices that have been separated • Source: HIPAA-adopted ASC X12N 005010X221A1 835
Delivery to Provider	<ul style="list-style-type: none"> • Flows unchanged from the ODFI to the RDFI through the ACH Network 	<ul style="list-style-type: none"> • ASC X12 EFT Trace Number as part of the entire TRN Reassociation Trace Number Segment is placed in the CCD+ Addenda Record Payment Related Information field and flows through the ACH Network unchanged • Flows unchanged from the payer to the ODFI and then through ACH Network to the RDFI and then to the provider

⁸ In addition to trace number confusion, sometimes the ‘Company Name’ field in the CCD+ is often used incorrectly to identify the third party sender or intermediary rather than the health plan making the payment. The *NACHA Operating Rules* require the ‘Company Name’ field to identify the ‘originator’ (i.e., health plan) of the CCD+ to identify itself in the EFT by the name that it is known and recognized by the ‘Receiver’ (i.e., provider).

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	ACH Trace Number	ASC X12 EFT Reassociation Trace Number
Issues	<ul style="list-style-type: none"> The ACH Trace Number is not used to reassociate the EFT and ERA; it is used primarily for customer service and transaction research, and to aid in identifying returned transactions If a health plan creates an ACH Trace Number it will be modified or overwritten by the ODFI to conform with NACHA rule requirements and the ODFI's numbering system 	<ul style="list-style-type: none"> When CCD does not include the Addenda Record containing the Payment Related Information field the CCD cannot carry the ASC X12 EFT Trace Number <i>NACHA Operating Rules</i> require the RDFI to provide the ASC X12 EFT Trace Number as part of the entire TRN Reassociation Trace Number Segment in the CCD+ Payment Related Information field to the Provider by opening of business on the 2nd banking day – <u>if it has been requested by the Provider</u> The <i>NACHA Operating Rules</i> are silent on how this information is provided - providers should contact their banks to arrange for the method and timing of delivery. Matching the ASC X12 EFT Trace Number as part of the entire TRN Reassociation Trace Number Segment from the CCD+ Addenda Record with the TRN02-127 EFT Trace Number in the v5010 835
SDO	NACHA	ASC X12
<i>Explanatory Note 1</i>		TRN Reassociation Trace Number <i>Segment (composed of 4 data elements)</i> is sometimes referred to as: <ul style="list-style-type: none"> TRN 02 Reference ID Segment X12 TRN Segment Reassociation segment ERA TRN Trace Segment TRN segment
<i>Explanatory Note 2</i>		The trace number in the TRN Reassociation Trace Number <i>Segment described in Note 1 (TRN02-127 Trace Number)</i> is sometimes referred to as: <ul style="list-style-type: none"> EFT Reference number The Trace Number
<i>Explanatory Note 3</i>	<u>The ACH Trace Number and the X12 EFT Trace Number are NOT the same number.</u>	

2.1.2 Timely Receipt of Correct Matching Data

Providers frequently report a lengthy duration of time between the receipt of the ERA and the availability of funds for use in their bank accounts via EFT. This delay does not occur in the paper world if the check and paper remittance advice arrive together in the same envelope. Some health plans indicated that contractual requirements are the cause of the EFT payment delay. Some providers perceive that the banks are holding onto their EFT deposits, but the date on which funds are made available by the financial institution to the provider is controlled by the ACH Originator (the payer). The delay in receipt between the ERA and the EFT by more than two or three days presents providers with significant reassociation and reconciliation management issues. When an EFT is received more than two or three days after an ERA, the provider is forced to take one of two possible actions: post the payment information from the ERA and conduct follow-up revenue cycle activity (e.g., billing secondary insurance, billing patients, and issuing refunds to patients) without knowing that the ERA will be correctly reconciled to the EFT, or hold the ERA and not post the payments until the EFT arrives. The first option can cause significant rework and compromise the integrity of the provider's financial statements. Alternatively, holding the ERA until the EFT arrives results in increased accounts receivable outstanding and perhaps providing incorrect information to patients about the amount that they owe or that their insurance has paid.

To address these problems CORE Participants developed this rule by achieving substantial consensus that a CAQH CORE rule should address reassociation by establishing the minimum data needs of a provider to reassociate the EFT with the ERA and defining the maximum elapsed time between the receipt of the v5010 X12 835 and the corresponding Healthcare EFT Standards.

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3 Scope

3.1 What the Rule Applies To

This CORE rule conforms with and builds upon the:

- HIPAA-adopted ASC X12 005010X221A1 Health Care Claim Payment/Advice (835) Technical Report Type 3 implementation guide

And

- NACHA 2011 ACH File Specifications for the CCD+

3.2 Applicable Data Elements

This rule addresses the following specified records and fields in the CCD+(Table 3.2-1a) and loops, segments and data elements in the v5010 X12 835 (Table 3.2-1b):

Table 3.2-1a		
CCD+ Data Elements		
CCD+ Record #	Field #	Field Name <i>(See §6 Glossary for Definition of these Terms)</i>
5	9	Effective Entry Date ⁹
6	6	Amount
7	3	Payment Related Information

Table 3.2-1b
v5010 X12 835 Data Elements
Data Element Segment Position, Number & Name
BPR Financial Information
BPR16-373 EFT Effective Date
TRN Reassociation Trace Number Segment
TRN02-127 Reference Identification (EFT Trace Number)
TRN03-509 Originating Company Identifier (Payer Identifier)

⁹ The date the payer intends to provide good funds to the payee via EFT as specified in the Healthcare EFT Standards in Field #9 of the Company Batch Header Record 5.

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3.3 CORE-required Minimum CCD+ Data Elements for Successful Reassociation

This rule addresses two standards: the CCD+ and the v5010 X12 835. The data elements identified in the column titled “Focus of this Rule” in Table 3.3-1 below are the CORE-required Minimum Data Elements from the CCD+ necessary for successful reassociation of the EFT payment with the corresponding v5010 X12 835.

Table 3.3-1			
Focus of this Rule			Informational Only
CORE-required Minimum CCD+ Reassociation Data Elements ¹⁰			Corresponding v5010 X12 835 Data Elements
CCD+ Record #	Field #	Field Name <small>(See §6 Glossary for Definition of these Terms)</small>	Data Element Segment Position, Number & Name
5	9	Effective Entry Date	BPR16-373 Date (<i>EFT Effective Date</i>)
6	6	Amount	BPR02-782 Monetary Amount (<i>Total Actual Provider Payment Amount</i>)
7	3	Payment Related Information	TRN Reassociation Trace Number Segment, specifically data elements: <ul style="list-style-type: none"> • TRN01-481 Trace Type Code Required • TRN02-127 Reference Identification <i>(EFT Trace Number)</i> Required • TRN03-509 Originating Company Identifier <i>(Payer Identifier)</i> Required • TRN04-127 Reference Identification <i>(Originating Company Supplemental Code)</i> Situational

3.4 When the Rule Applies

This rule applies when an entity uses, conducts, or processes the v5010 X12 835 and the Healthcare EFT Standards.

3.5 What the Rule Does Not Require

This rule does not require any entity to conduct either the v5010 X12 835 or the Healthcare EFT Standards.

3.6 Outside the Scope of This Rule

This rule does not address any business relationship between a health plan and a healthcare provider or their respective financial institutions.

3.7 How the Rule Relates to Phase I and II CORE

As with other Phase I and Phase II CORE Rules, general CORE policies also apply to Phase III CORE Rules and will be outlined in the Phase III CORE Rule Set.

This rule supports the CORE Guiding Principles that CORE rules will not be based on the least common denominator but rather will encourage feasible progress, and that CORE rules are a floor and not a ceiling, e.g., entities can go beyond the Phase III CORE Rules.

¹⁰ NOTE: The [01/10/12 HHS IFC](#) adopts the CCD+ and the X12 835 TR3 TRN Segment together as the Healthcare EFT Standards.

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3.8 Assumptions

A goal of this rule is to establish a foundation for the successful and timely reassociation of the Healthcare EFT Standards transaction being exchanged between a health plan and a healthcare provider through the ACH Network and the corresponding v5010 X12 835 being exchanged by a separate mechanism.

The following assumptions apply to this rule:

- This rule is a component of the larger set of Phase III CORE Rules; as such, all the CORE Guiding Principles apply to this rule and all other rules
- This rule is not a comprehensive implementation guide for the Healthcare EFT Standards

The v5010 X12 835 states in §1.10.2.2 that “there is a one to one relationship between any specific 835¹¹ [sic] and the related payment mechanism (check or EFT). One 835 [sic] must only relate to a single payment mechanism and one payment mechanism must only relate to a single 835 [sic].”

4 Rule Requirements

4.1 Receipt of the CORE-required Minimum CCD+¹² Data Required for Reassociation

A health plan must proactively inform the healthcare provider during EFT (Healthcare EFT Standards) and ERA (v5010 X12 835) enrollment that it will need to contact its financial institution to arrange for the delivery of the CORE-required Minimum CCD+ Data Elements necessary for successful reassociation of the EFT payment with the ERA remittance advice as defined in §3.3 Table 3.3-1.

A healthcare provider must proactively 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 as defined in §3.3 Tables 3.3-1.

The CORE-required Minimum CCD+ Data are defined in Table 4.1-1 below and in Table 3.3-1 above. This rule does not prohibit a healthcare provider and its financial institution from mutually agreeing to exchange more Healthcare EFT Standards data in addition to the required minimum data.

Table 4.1-1		
CORE-required Minimum CCD+¹³ Reassociation Data Elements		
CCD+ Record #	Field #	Field Name (See §6 Glossary for Definition of these Terms)
5	9	Effective Entry Date
6	6	Amount
7	3	Payment Related Information

¹¹ See Section 6.1 Glossary

¹² **NOTE:** The [01/10/12 HHS IFC](#) adopts the CCD+ and the X12 835 TR3 TRN Segment together as the Healthcare EFT Standards.

¹³ Ibid.

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4.2 Elapsed Time between Sending the v5010 X12 835 and the CCD+ Transactions¹⁴

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 days¹⁵ based on the time zone of the health plan prior to the CCD+ Effective Entry Date¹⁶

And

- No later than three business days after the CCD+ Effective Entry Date.

A health plan must ensure that the CCD+ Effective Entry Date is a valid banking day and that the corresponding v5010 X12 835 BPR16 date is the same valid banking day.¹⁷

4.2.1 Retail Pharmacy Coordination

For retail pharmacy, the health plan may release for transmission the v5010 X12 835 any time prior to the CCD+ Effective Entry Date of the corresponding EFT; and no later than three days after the CCD+ Effective Entry Date. Such a release shall not be considered out of conformance with §4.2 above.

4.2.2 Elapsed Time Auditing Requirements

A health plan must ensure the v5010 X12 835 and corresponding Healthcare EFT Standards meet the elapsed time requirements specified in §4.2 ninety percent (90%) of the time as measured within a calendar month. A health plan is required to have the capability to track and audit this elapsed time requirement.

4.3 Resolving Late/Missing EFT and ERA Transactions

A health plan must establish written Late/Missing EFT and ERA Transactions Resolution Procedures defining the process a healthcare provider must use when researching and resolving a late or missing Healthcare EFT Standards payment and/or the corresponding late or missing v5010 X12 835. Late or missing is defined as a maximum elapsed time of four business days following the receipt of either the Healthcare EFT Standards or v5010 X12 835.

¹⁴ Issue still exists on how to address the situation when a public or private health plan has no funds available to initiate the Healthcare EFT Standards.

During the development of this rule CORE Participants discussed the situation where a public or private health plan may not have funds available to initiate an EFT, and whether this rule should address such situations by including rule language regarding allowing an exception to the requirement to release the v5010 X12 835 in relationship to the Effective Entry Date specified in the Healthcare EFT Standards. In reality, no Healthcare EFT Standards can be initiated since there are no funds available to the health plan to transfer to a healthcare provider. When there are no funds being transferred to the healthcare provider, the health plan has no payment date on which to base the release of the corresponding v5010 X12 835. The concept of the Doctrine of Constructive Receipt (See Appendix 6.1 Glossary) as defined by the IRS was discussed as that Doctrine may apply to a potential requirement set forth in this rule. At issue is whether or when a health plan should be required to release a v5010 X12 835 for transmission to the healthcare provider in this situation. Some healthcare providers want to receive the v5010 X12 835 regardless of when funds may become available to fund the EFT while others do not want to receive the v5010 X12 835 until the actual funds are transferred into their bank account. CORE is requesting further examination of this issue by NCVHS and CMS.

¹⁵ A business day consists of the 24 hours commencing with 12:00 am (Midnight or 00:00 hours) of each designated day through 11:59 pm (23:59 hours) of that same designated day. The actual calendar day(s) constituting business days are defined by and at the discretion of each health plan. See Phase I CORE 155 Eligibility and Benefits Batch Response Time Rule version 1.1.0 March 2011 and CORE Phase I Glossary. A business day is not required to also be a valid Banking Day. See §6.1 Glossary for definition of Banking Day.

¹⁶ Effective Entry Date is the date the payer intends to provide good funds to the payee via EFT which date must also be a valid Banking Day (see Section 6.1 Glossary.) A valid Banking Day is not required to also be a business day for entities that are not financial institutions.

¹⁷ See §6.1 Glossary for definition.

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For retail pharmacy, a late or missing v5010 X12 835 is defined as a minimum elapsed time of four business days following the receipt of the Healthcare EFT Standards.

The Late/Missing EFT and ERA Resolution Procedures must be delivered to the healthcare provider during its EFT and ERA enrollment with the health plan.

4.4 Cross-Industry Needs: Role of NACHA Operating Rules for the Financial Institutions to Support Health Care

Section 1104 of the ACA requires use of the Healthcare EFT Standards for all electronic healthcare claims payments. CORE addresses operating rules for health plans, healthcare providers, clearinghouses/vendors/PMS and large providers. CORE recognizes that to comprehensively solve the issue of reassociation health care must coordinate with the financial services industry given financial institutions are another key stakeholder in the reassociation process.

NACHA – The Electronic Payments Association is the organization responsible for the development and maintenance of operating rules governing the ACH Network, through which all financial institutions conduct EFTs. NACHA also writes the ACH standards for the payment transactions that flow over the ACH Network. Only financial institutions are able to vote on *NACHA Operating Rules*. Therefore, to address the role of financial institutions in healthcare payments related to the ACH Network, the healthcare industry must look to the *NACHA Operating Rules* to address reassociation challenges in health care that are essential and applicable to financial institutions.

With regard to the ACA, the 01/10/12 HHS IFC has adopted the CCD+ and X12 835 TR3 TRN Segment as the Healthcare EFT Standards. The CCD+ standard is used by many industries, and due to the ACA, the use of the CCD+ payment transaction will now play a formal role in improving the EFT process in health care for both health plans and healthcare providers.

During the development of this CORE reassociation rule, the CORE Participants reaffirmed that close coordination between CORE healthcare operating rules and *NACHA Operating Rules* is essential to achieving the goals of administrative simplification as envisioned by the ACA legislation. The CORE Participants identified key areas where enhancements to the *NACHA Operating Rules* could address current issues in using the NACHA CCD+ when doing EFT healthcare payments. The combination of healthcare operating rules and enhanced *NACHA Operating Rules* have the potential to offer substantial benefit for reducing costs and enabling a more effective future use of the ACH Network for the billions of healthcare claim payments that will be exchanged over the ACH Network due to the ACA. To assist with promoting cross-industry needs, CORE communicated to NACHA areas to be considered for *NACHA Operating Rules* enhancements in order to have substantial healthcare improvements. Highlights of these key areas are below; additional enhancements to *NACHA Operating Rules* unique to health care will be coordinated with the healthcare operating rules effort.

Identified NACHA Operating Rule Enhancement	Goal of Identified Recommended Enhancement
Establish a standard format for the electronic delivery of the CORE-required Minimum CCD+ Reassociation Data Elements between the provider and the financial institutions; include relation to CCD+	A standard format used by <i>all parties</i> encourages the market to have the information needed to create tools that will enable effective and efficient processing of billions of healthcare CCD+ payment transactions
Require all financial institutions to deliver the CORE-required Minimum CCD+ Reassociation Data Elements to healthcare providers	Consistent provider receipt from financial institutions of the CORE-required Minimum CCD+ Reassociation Data Elements is needed by the provider so that the provider can successfully match the CCD+ payments from health plans with the corresponding v5010 X12 835

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Identified <i>NACHA Operating Rule</i> Enhancement	Goal of Identified Recommended Enhancement
Establish a standard connectivity “safe harbor” for the delivery of the CORE-required Minimum CCD+ Reassociation Data Elements to providers that aligns with current healthcare industry efforts	Financial services alignment with the healthcare industry’s movement towards a common, reliable and secure method to exchange both administrative and clinical information

5 Conformance Requirements

Separate from any HHS certification/compliance program to demonstrate conformance as mandated under ACA Section 1104, CAQH CORE offers *voluntary* CORE Certification for all Phases of the CAQH CORE Operating Rules. CORE Certification is completely optional. Pursuing *voluntary* CORE Certification offers an entity a mechanism to test its ability to exchange EFT and ERA transaction data with its trading partners. A CORE-certified Seal is awarded to an entity or vendor product that voluntarily completes CORE certification testing with a CAQH CORE-authorized testing vendor. Key benefits of *voluntary* CORE Certification include:

- Demonstrates to the industry adoption of the Phase III CORE EFT & ERA Operating Rules via a recognized industry “Seal”
- Encourages trading partners to work together on transaction data content, infrastructure and connectivity needs
- Reduces the work necessary for successful trading partner testing as a result of independent testing of the operating rules implementation
- Promotes maximum ROI when all stakeholders in the information exchange are known to conform to the CORE Operating Rules

For more information on achieving *voluntary* CORE Certification for the CAQH CORE EFT & ERA Operating Rules, refer to the Phase III CORE EFT & ERA Operating Rules Voluntary Certification Master Test Suite Version 3.0.0 or contact CORE@caqh.org.

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6 Appendix

6.1 Glossary of Terms and Definitions

Term	Definition
835	See entry for the ASC X12 Health Care Claim Payment/Advice Transaction Set
ABA Routing Number (also ABA Transit Routing Number)	<p>The ABA Routing Number serves to identify the specific financial institution responsible for the payment of a negotiable instrument. Originally designed to identify only check processing endpoints, the ABA Routing Number has evolved to designate participants in automated clearinghouses, electronic funds transfer, and on-line banking. The ABA Routing Number has changed over the years to accommodate the Federal Reserve System, the advent of MICR, the implementation of the Expedited Funds Availability Act (EFAA), and, most recently, Check 21. An ABA Routing Number will only be issued to a Federal or State chartered financial institution which is eligible to maintain an account at a Federal Reserve Bank.¹⁸</p> <p>The ABA transit number appears on a standard check in the <u>MICR</u> (magnetic ink character recognition) form, consists of nine digits, is printed in magnetic ink, is machine-readable and appears at the bottom left of a check. The MICR number is of the form:</p> <p>XXXXXXXXYC</p> <p>where XXXX is Federal Reserve Routing Symbol, YYYY is ABA Institution Identifier, and C is the Check Digit.¹⁹</p>
ACH (Automated Clearing House)	<p>The ACH Network is a batch processing, electronic payments system governed by <i>The NACHA Operating Rules</i>,²⁰ which provide for the interbank clearing of electronic payments for participating depository financial institutions. Transactions received by the financial institution during the day are stored and processed later in a batch mode. This provides faster processing than paper checks.</p> <p>ACH payments include:</p> <ul style="list-style-type: none"> • Direct Deposit of payroll, Social Security and other government benefits, and tax refunds • Direct Payment of such consumer bills as mortgages, loans, utility bills and insurance premiums • Business-to-business payments • e-Commerce payments • Federal, state and local government payments <p>The number of ACH payments in 2010 exceeded 19.4 billion transactions.</p>
ACH Operator	An entity that acts as a central facility for the clearing, delivery, and settlement of Entries between or among Participating DFIs ²¹
ACH Payment Acknowledgement	A rarely used non-monetary entry initiated by the RDFI to provide the payee an acknowledgement of a payment.
Addenda Record	A record that contains supplemental data related to an Entry (See CCD+ [Entry]) ²²

¹⁸ American Bankers Association http://www.aba.com/products/ps98_routing.htm

¹⁹ http://en.wikipedia.org/wiki/Routing_transit_number#Routing_number_format

²⁰ NACHA Operating Rules & Guidelines 2011

²¹ Ibid.

²² Ibid.

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Term	Definition
Agent	One who agrees and is authorized to act on behalf of another, a principal, to legally bind an individual in particular business transactions with third parties pursuant to an agency relationship. ²³ Also A party authorized to act on behalf of another and to give the other an account of such actions. ²⁴
ASC X12 835 (ASC X12 Health Care Claim Payment/Advice) Transaction Set	An electronic transaction based on the ASC X12 standards implemented in accordance with either the ASC X12N 835 004010X091A1 or the ASC X12N 835 Health Care Claim Payment/Advice implementation guides as defined in 005010X221A1.
ASC X12 835 Implementation Guide	Implementation guides provide a detailed explanation of the transaction set by defining data content, identifying valid code tables, and specifying values that are applicable for electronic claims payment. ²⁵
Banking Day	Pursuant to U.C.C. § 4-104, a banking day means a day on which a bank is open to the public for carrying on substantially all of its banking functions. Banking day is the business day of a bank. Banking days include all the days when offices of a bank are open for business to the public. Business includes all banking functions. Usually a banking day is any day except Saturday, Sunday and legally defined holidays. Regulations D and CC of Federal Reserve Regulations deal with public holidays. ²⁶
Business Day	A business day consists of the 24 hours commencing with 12:00 am (Midnight or 00:00 hours) of each designated day through 11:59 pm (23:59 hours) of that same designated day. The actual calendar day(s) constituting business days are defined by and at the discretion of each health plan. See Phase I CORE 155 Eligibility and Benefits Batch Response Time Rule Version 1.1.0 March 2011 and CORE Phase I Glossary.
CARC (Claims Adjustment Reason Code)	A Claims Adjustment Reason Code provides an overall explanation for the financial adjustment to the amount submitted on a healthcare claim. ²⁷
CCD+ [Entry]	The Corporate Credit or Debit is an ACH standard for EFT which is used to make/collect payments to/from other corporate entities. The CCD+ ACH Standard can include one record of payment-related information of up to 80 characters. Health plans use the CCD+ to send payments via EFT, with a reassociation number that matches the EFT to its associated ERA. (See also CTX ACH Standard.) ²⁸
CTX	The Corporate Trade Exchange is an ACH standard for EFT which supports the transfer of funds (debit or credit) with another entity for which there is an existing trading relationship. This standard includes ASC X12 835 payment related information, which can be placed in multiple (up to 9,999) addenda records. ²⁹
Company Descriptive Date	A date established by the Originator as the date it would like displayed to the Receiver for descriptive purposes. ³⁰
Company Entry Description	Established by the Originator to provide the Receiver with a description of the purpose of the Entry. ³¹

²³ West's Encyclopedia of American Law, edition 2. © 2008 The Gale Group, Inc. All rights reserved.

²⁴ Mosby's Medical Dictionary, 8th edition. © 2009, Elsevier.

²⁵ ASC X12N 004010A1 Implementation Guide dated May 2000 and ASC X12N 005010X221A1 Implementation Guide dated April 2006.

²⁶ NACHA Operating Rules & Guidelines 2011

²⁷ <http://www.wpc-edi.com/content/view/711/401/>

²⁸ NACHA Operating Rules & Guidelines 2011

²⁹ Ibid.

³⁰ Ibid.

³¹ Ibid.

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Term	Definition
Company Identification	An alphanumeric code used to identify the Originator of an ACH transaction. ³²
Company Name	Identifies the source of the Entry and is used for descriptive purposes for the Receiver and is the name by which the Originator is known to and readily recognized by the Receiver of the Entry. In an ACH transaction in which the Originator of a credit Entry is not the payer of the transaction (the party from which payment is ultimately being directed), the Company Name must be the name by which the payer is known to and readily recognized by the Receiver of the Entry. ³³
Constructive Receipt, Doctrine of ³⁴	For Federal income tax purposes, the doctrine of constructive receipt is used to determine when a cash-basis taxpayer has received gross income. A taxpayer is subject to tax in the current year if he or she has unfettered control in determining when items of income will or should be paid. Unlike actual receipt, constructive receipt does not require physical possession of the item of income in question. The full text of the IRS regulation defining constructive receipt states as follows: <i>“Income although not actually reduced to a taxpayer's possession is constructively received by him in the taxable year during which it is credited to his account, set apart for him, or otherwise made available so that he may draw upon it at any time, or so that he could have drawn upon it during the taxable year if notice of intention to withdraw had been given. However, income is not constructively received if the taxpayer's control of its receipt is subject to substantial limitations or restrictions.”</i>
Corporate Credit or Debit	See CCD+
Corporate Trade Exchange	See CTX
DFI Account Number	The RDFI's customer's account number (Receiver/Payee/Provider). ³⁵
Discretionary Data	A field in the Entry Detail Record of an ACH transaction allowing ODFIs to use code of significance to them to enable specialized handling of the Entry. There is no standardized interpretation of this data. ³⁶
Effective Entry Date	The date the payer intends to provide good funds to the payee via EFT as specified in the ACH CCD+ Standard in Field #9 of the Company Batch Header Record 5. ³⁷
EFT (Electronic Funds Transfer)	The electronic exchange or transfer of money from one account to another, either within a single financial institution or across multiple institutions, through computer-based systems. ³⁸
Entry	An order or request for the transfer of money from one account to another, e.g., a CCD+ is a type of Entry. A non-monetary transaction is also an Entry.
EOB (Explanation of Benefits)	A document from an insurance company giving details regarding how the insurance company processed medical insurance claims. Although EOBs often look like a medical bill, the EOB tells the patient what portion of a claim was paid to the healthcare provider and what portion of the payment, if any, the individual is responsible for.
ERA (Electronic Remittance Advice)	An electronic version of a payment explanation which provides details about providers' claims payment. ERAs are provided by health plans to providers. The industry standard for sending ERA data is the HIPAA-adopted ASC X12 835 standard. If the claims are denied, the ERA would contain the required explanations.

³² Ibid.

³³ NACHA Operating Rules & Guidelines 2011

³⁴ http://en.wikipedia.org/wiki/Constructive_receipt

³⁵ NACHA Operating Rules & Guidelines 2011

³⁶ Ibid.

³⁷ Ibid.

³⁸ http://en.wikipedia.org/wiki/Electronic_funds_transfer

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Term	Definition
Healthcare EFT Standards	The combined use of the ACH CCD+ Standard and the X12 835 TR3 TRN Segment to originate/initiate an electronic healthcare claim payment. These standards must be used for claims payment initiation by all health plans that conduct healthcare EFT. ³⁹
Health Plan	Title 45, Code of Federal Regulations. Section 160.103— (1) Health plan includes the following, singly or in combination: <ul style="list-style-type: none"> (i) A group health plan, as defined in this section. (ii) A health insurance issuer, as defined in this section. (iii) An HMO, as defined in this section. (iv) Part A or Part B of the Medicare program under title XVIII of the Act. (v) The Medicaid program under title XIX of the Act, 42 U.S.C. 1396, et seq. (vi) An issuer of a Medicare supplemental policy (as defined in section 1882(g)(1) of the Act, 42 U.S.C. 1395ss(g)(1)). (vii) An issuer of a long-term care policy, excluding a nursing home fixed- indemnity policy. (viii) An employee welfare benefit plan or any other arrangement that is established or maintained for the purpose of offering or providing health benefits to the employees of two or more employers. (ix) The healthcare program for active military personnel under title 10 of the United States Code. (x) The veterans' healthcare program under 38 U.S.C. chapter 17. (xi) The Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)(as defined in 10 U.S.C. 1072(4)). (xii) The Indian Health Service program under the Indian Health Care Improvement Act, 25 U.S.C. 1601, et seq. (xiii) The Federal Employees Health Benefits Program under 5 U.S.C. 8902, et seq. (xiv) An approved State child health plan under title XXI of the Act, providing benefits for child health assistance that meet the requirements of section 2103 of the Act, 42 U.S.C. 1397, et seq. (xv) The Medicare + Choice program under Part C of title XVIII of the Act, 42 U.S.C. 1395w-21 through 1395w-28. (xvi) A high risk pool that is a mechanism established under State law to provide health insurance coverage or comparable coverage to eligible individuals. (xvii) Any other individual or group plan, or combination of individual or group plans, that provides or pays for the cost of medical care (as defined in section 2791(a)(2) of the PHS Act, 42 U.S.C. 300gg-91(a)(2)).
Individual ID Number	The accounting number by which the Receiver (Payee) is known to the Originator (Payer). ⁴⁰
Intermediary	A public or private entity, including a billing service, repricing company, community health management information system or community health information system, and "value-added" networks and switches, that processes or facilitates the processing of health information received from another entity or provides other services that facilitate the exchange, delivery or transfer of electronic health information between organizations.

³⁹ [CMS-0024-IFC](#): Administrative Simplification: Adoption of Standards for Health Care Electronic Funds Transfers (EFTs) and Remittance Advice, 01/10/12.

⁴⁰ NACHA Operating Rules & Guidelines 2011

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Term	Definition
	Used interchangeably with the terms “SWITCH” and “CLEARINGHOUSE” in the context of CORE rules. ⁴¹
NPI (National Provider Identifier)	A unique 10-digit identification number issued to healthcare providers by the Centers for Medicare and Medicaid Services.
ODFI (Originating Depository Financial Institution)	A NACHA participating financial institution that originates ACH payments at the request of and by (ODFI) agreement with its customers. ODFIs must abide by the provisions of <i>The NACHA Operating Rules</i> . ⁴²
Originator	The entity that authorizes the ODFI to send on its behalf EFT transactions to a Receiver’s (payee’s) account. The Originator may also authorize a Third Party Sender to initiate EFT transactions on its behalf to a Receiver’s (payee’s) account. ⁴³
Payee (Healthcare Provider)	The Receiver of an EFT payment. See Receiver.
Payer	The entity that pays a healthcare claim submitted by a Healthcare Provider for reimbursement of healthcare services delivered to a health plan beneficiary.
Payment Related Information	A field in the CCD+ Addenda Record containing payment-related ASC X12 data segments. ⁴⁴
Posting (See Reconciliation)	Applying remittance advice data to open patient accounts in order to relieve the open account receivable.
Remittance (Remit)	The sending of money to someone at a distance. The sum of money sent. To transmit (money) in payment.
RA (Remittance Advice)	A document that describes payments that are being made. The person or company that is making the payment will sometimes include a remittance advice, which is like a receipt of payment. A remittance advice is usually used by companies either processing a purchase or a filed claim. ⁴⁵
RARC (Remittance Advice Remark Code)	Remittance Advice Remark Codes are used to convey information about remittance processing or to provide a supplemental explanation for an adjustment already described by a Claim Adjust Reason Code. ⁴⁶
Reassociation	Matching a payment to the remittance advice data received.
RDFI (Receiving Depository Financial Institution)	Any financial institution qualified to receive ACH payments that agrees to abide by the <i>NACHA Operating Rules</i> . ⁴⁷
Receiver	An entity that has authorized an Originator of an EFT transactions to initiate EFT transactions to its deposit account. ⁴⁸
Receiving Company Name	Established by Originator to provide additional identification of the Receiver (Payee). ⁴⁹
Reconciliation (See Posting)	Balancing information from two or more sources, like a payment and a remittance advice or a remittance advice and a posting report, to ensure that the amount(s) reported on one source are equivalent to the amount(s) reported on the other(s).
Sending Point	An organization that transmits Entries to an ACH Operator on behalf of an ODFI. A Sending Point may be an ODFI acting on its own behalf or a participating DFI, or Third-Party Service provider acting on behalf of one or more ODFIs. ⁵⁰

⁴¹ CORE™ Phase I Rules and Policies Glossary of Terms

⁴² <http://www.nacha.org/c/Intro2ACH.cfm>, NACHA, Intro to the ACH Network

⁴³ NACHA Operating Rules & Guidelines 2011

⁴⁴ Ibid.

⁴⁵ http://www.investorwords.com/6904/remittance_advice.html

⁴⁶ <http://www.wpc-edi.com/content/view/711/401/>

⁴⁷ <http://www.nacha.org/c/Intro2ACH.cfm>, NACHA, Intro to the ACH Network

⁴⁸ NACHA Operating Rules & Guidelines 2011

⁴⁹ Ibid.

⁵⁰ Ibid.

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Term	Definition
Standard Entry Class Code	A code identifying an Entry initiated to an organization to transfer funds to or from an account of that organization to another organization. ⁵¹
Third Party Sender (also Third Party Service Provider, Third Party Payment Vendor)	An entity authorized by the Originator to initiate EFT transactions on its behalf to a Receiver's (payee's) account. ⁵²
Unsecured Electronic Network	A public or private network not entirely located within a single, contiguous facility not dedicated to communication between two end-points. From the <i>NACHA Operating Rules</i> perspective the Internet is considered to be an unsecured network even though secure transmissions may be made over that otherwise unsecure network. ⁵³

6.2 References

- ASC X12 005010X221A1 Health Care Claim Payment/Advice Professional Technical Report Type 3 (835) and associated errata
- NACHA 2011 Operating Rules & Guidelines, A Complete Guide to the Rules Governing the ACH Network
- CAQH CORE/NACHA White Paper: [Adoption of EFT and ERA by Health Plans and Providers: A White Paper Identifying Business Issues and Recommendations for Operating Rules](#) (2011)
- [CMS-0024-IFC](#): Administrative Simplification: Adoption of Standards for Health Care Electronic Funds Transfers (EFTs) and Remittance Advice, 01/10/12.

⁵¹Ibid.

⁵² NACHA Operating Rules & Guidelines 2011

⁵³ Ibid.



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REVISION HISTORY FOR PHASE III CAQH CORE 380 EFT ENROLLMENT DATA RULE

Version	Revision	Description	Date
3.0.0	Initial Version	Phase III CAQH CORE 380 EFT Enrollment Data Rule balloted and approved via CORE Voting Process	June 2012
3.0.1	Non-substantive <i>(Entities do not need to update enrollment forms/systems)</i>	Non-substantive adjustments to the CORE-required Maximum EFT Enrollment Data Set to improve usability: <ul style="list-style-type: none"> • Further distinguished Data Elements that do not obligate the provider to submit any associated data but provide essential context for related Sub-elements • Addressed table formatting inconsistencies • Ensured consistency between data elements 	July 2014

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1 Background Summary

In Phase III, CORE built on the Phase I and Phase II foundation by adding a range of operating rule requirements for both the HIPAA-adopted ASC X12 005010X221A1 Health Care Claim Payment/Advice (835) Technical Report Type 3 Implementation Guide and associated errata (hereafter v5010 X12 835) transaction, also known as the Electronic Remittance Advice (ERA), and the Electronic Funds Transfer (EFT) by addressing operating rules related to the NACHA ACH CCD plus Addenda Record (hereafter CCD+) and the X12 835 TR3 TRN Segment (hereafter the CCD+ and X12 835 TR3 TRN Segment together are the Healthcare EFT Standards¹).

This set of operating rules includes the application of the Phase I and Phase II CORE infrastructure rules to the conduct of the v5010 X12 835 (Phase III CORE 350 Health Care Claim Payment/Advice (835) Infrastructure Rule Version 3.0.0) so a focus can be placed on improving the conduct and exchange of electronic claim advice data, given these transactions can have a direct impact on a provider's revenue cycle management process. The Phase III CORE EFT & ERA Rule Set also includes a Phase III CORE 370 EFT & ERA Reassociation (CCD+/835) Rule Version 3.0.0, which has identified the critical data elements for reassociating the payment and remittance advice when they travel separately. Working together, the CORE rules complement each other in order to reduce the current cost of today's paper-based transaction process and to move the industry to fully embracing a real-time, transparent electronic world.

Along with the ERA, the EFT or electronic payment made to the provider from the health plan furthers the automated processing of healthcare payments; paper checks and their manual processing are eliminated. This rule builds upon the other Phase III CORE EFT- and ERA-related rules by addressing a key barrier to the use of EFT by providers – a cumbersome and, in many cases, incomplete EFT enrollment data set that doesn't speak to the electronic needs of the system – and further enables the automated processing of healthcare payments.

Currently, healthcare providers or their agents² face significant challenges when enrolling to receive EFT payments from a health plan including:

- A wide variety in data elements requested for enrollment
- Variety in the enrollment processes and approvals to receive the EFT
- Absence of critical elements that would address essential questions regarding provider preferences on payment options

Conversely, health plans are also challenged by the effort and resources required to enroll providers and maintain changes in provider information over time. As a result, some plans may prioritize converting high volume claim submitters to EFT over converting lower volume submitters, even though the low volume submitters may account for the vast majority of providers submitting claims.

Consistent and uniform operating rules enabling providers to quickly and efficiently enroll for EFT will help to mitigate:

- Complex and varied enrollment processes
- Variation in data elements requested for enrollment
- Lack of electronic access to enrollments
- Missing requests for critical elements that help address provider preference and system-wide automation

¹ The CCD+ and X12 835 TR3 TRN Segment are adopted together as the Federal Healthcare EFT Standards in [CMS-0024-IFC: Administrative Simplification: Adoption of Standards for Health Care Electronic Funds Transfers \(EFTs\) and Remittance Advice](#), 01/10/12.

² One who agrees and is authorized to act on behalf of another, a principal, to legally bind an individual in particular business transactions with third parties pursuant to an agency relationship. Source: West's Encyclopedia of American Law, edition 2. Copyright 2008 The Gale Group, Inc. All rights reserved.

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And provide for:

- Less staff time spent on phone calls and websites
- Increased ability to conduct targeted follow-up with health plans
- Broader adoption of EFT by providers
- An ability to ensure the enrollment process is coordinated with the next steps in payment process

1.1 Affordable Care Act Mandates

This rule is part of a set of rules that addresses a request from the National Committee on Vital and Health Statistics (NCVHS) for fully vetted CAQH CORE Operating Rules for the EFT and ERA transactions; the NCVHS request was made in response to NCVHS' role in Section 1104 of the Affordable Care Act (ACA).

Section 1104 of the ACA contains an industry mandate for the use of operating rules to support implementation of the HIPAA standards. Using successful, yet voluntary, national industry efforts as a guide, Section 1104 defines operating rules as a tool that will build upon existing healthcare transaction standards. The legislation outlines three sets of healthcare industry operating rules to be approved by the Department of Health and Human Services (HHS) and then implemented by the industry, the second set of which are those for EFT and ERA.³ The ACA requires HHS to adopt a set of operating rules for both of these transactions by July 2012. In a letter dated 03/23/11,⁴ NCVHS recommended that the Secretary "name CAQH CORE in collaboration with NACHA – The Electronic Payments Association as the candidate authoring entity for operating rules for all health care EFT and ERA transactions..."

Section 1104 of the ACA also adds the EFT transaction to the list of electronic health care transactions for which the HHS Secretary must adopt a standard under HIPAA. The section requires the EFT transaction standard be adopted by 01/01/12, in a manner ensuring that it is effective by 01/01/14. In January 2012, HHS issued an Interim Final Rule with Comment (IFC)⁵ adopting the CCD+ and the X12 835 TR3 TRN Segment⁶ as the Healthcare EFT Standards. These standards must be used for electronic claims payment initiation by all health plans that conduct healthcare EFT.

As described in the IFC, the healthcare payment flow through the ACH Network occurs in three chronological stages, each of which includes a separate electronic transmission of information:

- *Stage 1 Payment Initiation:* The health plan (i.e., Originator) authorizes its financial institution (i.e., Originating Depository Financial Institution or ODFI) to make an EFT healthcare claims payment through the ACH Network on its behalf. (The Healthcare EFT Standards adopted in the IFC address only this stage.)
- *Stage 2 Transfer of Funds:* Funds from the payer's account at the ODFI are moved, through a series of interactions, into the payee's (i.e., Receiver's) account at the payee's financial institution (i.e., Receiving Depository Financial Institution or RDFI).

³ The first set of operating rules under ACA Section 1104 applies to eligibility and claim status transactions with an adoption date of 07/01/11 and effective date of 01/01/13; the third set of operating rules applies to healthcare claims or equivalent encounter information transactions, enrollment and disenrollment in a health plan, health plan premium payments and referral, certification and authorization with an adoption date of 07/01/14 and effective date of 01/01/16.

⁴ NCVHS [Letter to the Secretary](#) - Affordable Care Act (ACA), Administrative Simplification: Recommendation for entity to submit proposed operating rules to support the Standards for Health Care Electronic Funds Transfers and Health Care Payment and Remittance Advice 03/23/11.

⁵ [CMS-0024-IFC](#): Administrative Simplification: Adoption of Standards for Health Care Electronic Funds Transfers (EFTs) and Remittance Advice, 01/10/12.

⁶ The IFC requires health plans to input the X12 835 TR3 TRN Segment into the Addenda Record of the CCD+; specifically, the X12 835 TR3 TRN Segment must be placed in Field 3 of the Addenda Entry Record ("7 Record") of a CCD+.

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- *Stage 3 Deposit Notification:* The RDFI transmits information to the Receiver indicating the payment has been deposited into the Receiver’s account.

2 Issue to be Addressed and Business Requirement Justification

It is a challenge for each provider, whether large or small, to complete enrollment and maintain changes in their banking information for EFT uniquely with each payer. It is equally challenging for each payer to collect and implement banking and identification information from every provider that they pay – moreover, common lessons learned on necessary requests to streamline the process are not being identified due to all this variation. Additionally, provider bank account information may change frequently due to providers changing banks and changes in bank account information for providers that join and leave provider group organizations such as group practices. Providers seeking to enroll for EFT often face different enrollment formats and requirements. For many providers the enrollment process is cumbersome and time-consuming, and can require the provider to initiate a relationship with a new bank and more than one bank.

2.1 Problem Space

CORE EFT & ERA Subgroup Participant surveys and discussion have identified significant barriers to achieving industry-wide rapid adoption of EFT and ERA; much of these findings have been reiterated by CAQH CORE and NACHA research as well as research by other industry efforts. One of the key barriers identified is the challenge faced by providers due to the variances in the processes and data elements requested when enrolling in EFT with a health plan.

Due to the variations across health plans in the data elements requested, providers manually process enrollment forms for each plan to which they bill claims and from which they wish to receive an EFT payment. This results in unnecessary manual processing of multiple forms requesting a range of information – not necessarily the same – as noted by research findings – and, in the case when it is the same, often using a wide variety of data terminology for the same semantic concept (i.e., “Routing Number” vs. “Bank Routing Number”).

This inconsistent terminology for the same data element during EFT enrollment can cause confusion and incorrect data to be entered during the enrollment process resulting in further delays as manual processes are used to clarify the inaccurate data – telephone calls, faxes, emails and original enrollment documents are returned to the provider for review, correction and resubmission to the health plan.

The manual and time-consuming process required by many of the current enrollment processes today and the variety of enrollment forms and data requirements cost the industry time and money – and, in many cases, does not address the key items that are needed to use the EFT enrollment information to fully automate payments. As a consequence, providers are often reluctant to implement the EFT payment with many health plans, particularly those plans that have seemingly difficult or extensive requirements for enrollment.⁷ It is well understood that EFT enrollment is not the only challenge with regard to provider adoption of EFT; however, it is one of the pieces of the puzzle and thus does need to be addressed, especially given the significant challenges that the other Phase III CORE Rules are working to improve.

2.2 CORE Process in Addressing the Problem Space

To address the Problem Space associated with EFT enrollment, the CORE EFT & ERA Subgroup and its Work Group conducted a series of surveys, numerous Subgroup discussions and significant review of industry EFT enrollment forms and research related to existing industry initiatives (e.g., Workgroup for Electronic Data

⁷ CAQH CORE/NACHA White Paper: Adoption of EFT and ERA by Health Plans and Providers: A White Paper Identifying Business Issues and Recommendations for Operating Rules (2011)

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Interchange [WEDI], American Medical Association [AMA], etc.) to inform development of this Phase III CORE Rule.

2.2.1 Research and Analysis of EFT & ERA Enrollment Forms

The CORE EFT & ERA Subgroup completed a number of research steps to determine a set of data elements to serve as a maximum data requirement for EFT enrollment. These key research steps included:

- Created source list for representative sample of EFT and ERA enrollment forms
- Using source list, obtained a representative sample of approximately 45 enrollment forms from eight key industry sectors (National Plans, Regional Plans, State Medicaid, Medicare, Clearinghouses, Worker's Compensation, Employer Owned [including Provider Owned], Third-Party Administrators)
- Identified frequency of data elements and key semantic concepts across source list enrollment forms and elements needing clarity; considered data elements utilized by external resources, e.g., the U.S. Postal Service, *NACHA Operating Rules*, etc.
- Using direct research findings and indirect sources (i.e., related white papers by WEDI, AMA, etc.), created a list of required data elements with definitions and other rule requirements using agreed-upon evaluation criteria
- Outlined the essential elements needed to address provider preferences and electronic transaction needs

CAQH CORE conducted substantial analysis to compare EFT enrollment forms from across the industry and follow up with specific industry sectors such as pharmacy. Using Subgroup-approved evaluation criteria, a set of universally necessary EFT enrollment data elements was identified by the CORE Participants as well as the detailed rule requirements around these EFT enrollment data elements. The CORE Participants agreed that these data elements represented the *maximum* set of data elements required for successful EFT enrollment. Therefore, this Phase III CORE Rule addresses the maximum set of data elements required for providers enrolling for receipt of the EFT from a health plan.

2.2.1.1 Evaluation Criteria to Identify Required EFT Enrollment Data Elements

The following evaluation criteria were used by the Subgroup to identify the list of required EFT enrollment data elements using direct (e.g., EFT enrollment forms utilized by health plans and vendors) and indirect (e.g., white papers that address the topic of standardization of EFT enrollment) sources:

- Quantitative findings of research, e.g.,
 - Include data elements that are frequently included across direct and indirect sources (e.g., elements included in 65% or more of all enrollment forms or research)
 - For data elements that have different terms used for the same semantic concept, e.g., meaning/intent, select one term for each data element (i.e., term selected would be used on 65% of forms; e.g., “Bank Transit Number” vs. “Bank Routing Number” vs. “Transit/Routing Number”)
- Qualitative discussions for elements that are unclear in the quantitative findings, but are directly related to agreed-upon CORE EFT & ERA Subgroup high priority goals
 - Identified strong business need to streamline the collection of data elements (e.g., Taxpayer Identification Number [TIN] vs. National Provider Identifier [NPI] provider preference)
 - Essential data for populating the Healthcare EFT Standards and the v5010 X12 835
 - Balance between time and resources (cost) to provide enrollment data versus necessity (benefit) to procure data element
 - Consistent with CORE Guiding Principles

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3 Scope

3.1 *When the Rule Applies*

This rule applies when a health plan or its agent is enrolling a healthcare provider (or its agent) for the purpose of engaging in the payment of healthcare claims electronically using the Healthcare EFT Standards.

3.2 *CORE-required Maximum EFT Enrollment Data Element Set*

The data elements identified in Table 4.2-1 in §4.2 are the maximum number of data elements that a health plan or its agent may require a healthcare provider or its agent to submit to the health plan for the purpose of engaging in the payment of healthcare claims electronically.

The enrollment data elements in Table 4.2-1 represent a “controlled vocabulary” as a means to provide a common, uniform and consistent way for health plans to collect and organize data for subsequent collection and use. A controlled vocabulary reduces ambiguity inherent in normal human languages (where the same concept can be given different names), ensures consistency and is potentially a crucial enabler of semantic interoperability. The CORE-required Maximum EFT Enrollment Data Set (i.e., a controlled vocabulary) mandates the use of predefined and authorized terms that have been preselected by CORE Participants.

3.2.1 Data Element Group: Elements that May Need to be Requested Several Times

Several of the data elements in Table 4.2-1 can be logically related where each single discrete data element can form a larger grouping or a set of data elements that are logically related, e.g., a bank account number and a taxpayer identification number are typically requested together, or should be. Such logical Data Element Groups are shown in Table 4.2-1 by assigning a Data Element Group identifier (e.g., DEG1, DEG2, etc.) to the discrete data element included in the set of logically related data elements.

There are eight of these Data Element Groups (DEGs); each represents a set of data elements that may need to be collected more than once for a specific context [e.g., multiple bank accounts at a bank with different linked Taxpayer Identification Numbers (TIN)⁸ or National Provider Identifiers (NPIs)⁹]. Examples of the DEGs are: Provider’s Agent Name and Address. Multiple uses of the same Data Element Group to collect the same data for another context are allowed by this rule and do not constitute a non-conforming use of the CORE-required Maximum Enrollment Data Set.

3.3 *What the Rule Does Not Require*

This rule does not require any health plan to:

- Engage in the process of paying for healthcare claims electronically
- Conduct either the v5010 X12 835 or the Healthcare EFT Standards transactions
- Combine EFT with ERA enrollment
- Re-enroll a provider if the provider is already enrolled and receiving the EFT

This rule does not prohibit or require a health plan from obligating a provider to agree to engage in EFT in order to receive an ERA.

⁸ A Taxpayer Identification Number (TIN) is an identification number used by the Internal Revenue Service (IRS) in the administration of tax laws. It is issued either by the Social Security Administration (SSA) or by the IRS. A Social Security number (SSN) is issued by the SSA whereas all other TINs are issued by the IRS. <http://www.irs.gov/businesses/small/article/0,,id=98350,00.html>

⁹ <http://www.cms.gov/NationalProvIdentStand/>

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3.4 CORE Process for Maintaining CORE-required Maximum EFT Enrollment Data Set

The CORE-required Maximum EFT Enrollment Data Set is a set of data elements determined by CORE to be the most appropriate data set to achieve uniform and consistent collection of such data at the time this rule was developed. CORE recognizes that as this rule becomes widely adopted and implemented in health care – and as EFT changes in the marketplace – the experience and learning gained from EFT enrollment may indicate a need to modify the maximum data set to meet emerging or new industry needs.

Given this anticipated need for data set maintenance activity, CORE recognizes that the focus of this rule, coupled with this need for unique modification of the data set, will require a process and policy to enable the data set to be reviewed on an annual or semi-annual basis. Any revisions to the data set will follow standard CORE processes for rule revisions. CORE will develop such a process and policy in accordance with CORE Guiding Principles following the approval of the Phase III CORE Operating Rules for first review of potential revisions to the data set. The first review shall commence one year after the passage of a Federal regulation requiring implementation of this CORE rule. Substantive changes necessary to the data set will be reviewed and approved by CORE as necessary to ensure accurate and timely revision to the data set.

3.5 Outside the Scope of this Rule

This rule does not address any business relationship between a health plan and its agent, a healthcare provider and its agent, nor their financial institutions.

Outside the scope of this rule is:

- The need to collect other data for other business purposes and such data may be collected at the health plan's discretion
- The method or mechanism for how a health plan exchanges EFT data internally
- The method or mechanism for how a health plan collects EFT data externally

3.6 How the Rule Relates to Phase I and II CORE

As with other Phase I and Phase II CORE Rules, general CORE policies also apply to Phase III CORE Rules and will be outlined in the Phase III CORE Rule Set.

3.7 Assumptions

A goal of this rule is to establish a foundation for the successful and timely enrollment of healthcare providers by health plans to engage in the payment of healthcare claims electronically.

The following assumption applies to this rule:

- This rule is a component of the larger set of Phase III CORE Rules; as such, all the CORE Guiding Principles apply to this rule and all other rules

4 Rule Requirements

4.1 Requirements for a Health Plan, its Agent or Vendors Offering EFT Enrollment

A health plan (or its agent or vendors offering EFT enrollment) must comply with all requirements specified in this rule when collecting from a healthcare provider (or its agent) the data elements needed to enroll the healthcare provider for the payment of healthcare claims electronically.

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4.2 CORE-required Maximum EFT Enrollment Data Elements

A health plan (or its agent or vendors offering EFT enrollment) is required to collect no more data elements than the maximum data elements defined in Table 4.2-1 CORE-required Maximum EFT Enrollment Data Set. Table 4.2-1 lists all of the CORE-required maximum Individual Data Elements organized by categories of information, e.g., Provider Information, Provider Identifiers Information, Federal Agency Information, Retail Pharmacy Information, Financial Institution Information and Submission Information. Both the Individual Data Element name and its associated description must be used by a health plan (or its agent or vendors offering EFT enrollment) when collecting EFT enrollment data either electronically or via a manual paper-based process. The Individual Data Element Name and its associated description must not be modified.

Table 4.2-1 includes eight Data Element Groups, each representing a set of data elements that may need to be collected more than once for a specific context (Reference §3.2.1 above). Multiple uses of the same Data Element Group to collect the same data for another context are allowed by this rule and do not constitute a non-conforming use of the CORE-required Maximum Enrollment Data Set. These eight Data Element Groups are:

- DEG1: Provider Information
- DEG2: Provider Identifiers Information
- DEG3: Provider Contact Information
- DEG4: Provider Agent Information
- DEG5: Federal Agency Information
- DEG6: Retail Pharmacy Information
- DEG7: Financial Institution Information
- DEG8: Submission Information

Within each information category some data elements may be grouped into specific Data Element Groups (Reference §3.2.1). A DEG may be designated as required or optional for data collection. Within each DEG, Individual Data Elements may be designated as required or optional for data collection.

- When a DEG is designated as required, all of the Individual Data Elements designated as required within the DEG must be collected by the health plan; Individual Data Elements designated as optional may be collected depending on the business needs of the health plan.
- When a DEG is designated as optional, the collection of the optional DEG is at the discretion of the health plan. When a health plan exercises its discretion to collect an optional DEG, any included Individual Data Element designated as required must be collected.
- Some required or optional Individual Data Elements are composed of one or more Sub-elements, where a Sub-element is designated as either required or optional for collection. When a health plan collects an optional Individual Data Element that is composed of one more optional Sub-element, the optional Sub-element may be collected at the discretion of the health plan. When a health plan collects a required Individual Data Element that is composed of one or more optional Sub-elements, the optional Sub-element may be collected at the discretion of the health plan.

Not collecting an Individual Data Element identified as optional does not constitute a non-conforming use of the CORE-required Maximum Enrollment Data Set. As specified in §3.2.1, the collection of multiple occurrences of DEGs for another context does not constitute a non-conforming use of the CORE-required Maximum Enrollment Data Set.

A health plan must develop and make available to the healthcare provider (or its agent) specific written instructions and guidance for the healthcare provider (or its agent) when providing and submitting the data elements in Table 4.2-1. The health plan's specific instructions and guidance are not addressed in this CORE rule.

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The data elements in Table 4.2-1 are for new enrollments. When an enrollment is being changed or cancelled, the health plan must make available to the provider instructions on the specific procedure to accomplish a change in their enrollment or to cancel their enrollment.

Table: 4.2-1 CORE-required Maximum EFT Enrollment Data Set					
Individual Data Element Name¹⁰ (Term)	Sub-element Name (Term)	Data Element Description	Data Type and Format (Not all data elements require a format specification)	Data Element Requirement for Health Plan Collection (Required/Optional for plan to collect)	Data Element Group Number (DEG#)¹¹
PROVIDER INFORMATION (Data Element Group 1 is a Required DEG)					
<i>Provider Name</i>		Complete legal name of institution, corporate entity, practice or individual provider	Alphanumeric	Required	DEG1
<i>Doing Business As Name (DBA)</i>		A legal term used in the United States meaning that the trade name, or fictitious business name, under which the business or operation is conducted and presented to the world is not the legal name of the legal person (or persons) who actually own it and are responsible for it ¹²	Alphanumeric	Optional	DEG1

¹⁰ Shaded Individual Data Element Names provide essential context for related Sub-element Names but do not obligate providers to submit any associated data for that specific Data Element on the enrollment form/system. Individual Data Element Names that are not shaded do obligate the provider to submit associated data.

¹¹ There are eight of these Data Element Groups, and each represents a set of data elements that may need to be collected more than once for a specific context. Multiple uses of the same Data Element Group to collect the same data for another context are allowed by this rule and do not constitute a non-conforming use of the CORE-required Maximum Enrollment Data Set.

¹² http://en.wikipedia.org/wiki/Doing_business_as

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Table: 4.2-1 CORE-required Maximum EFT Enrollment Data Set

Individual Data Element Name ¹⁰ (Term)	Sub-element Name (Term)	Data Element Description	Data Type and Format (Not all data elements require a format specification)	Data Element Requirement for Health Plan Collection (Required/Optional for plan to collect)	Data Element Group Number (DEG#) ¹¹
PROVIDER INFORMATION (Continued) (Data Element Group 1 is a Required DEG)					
<i>Provider Address</i>				Optional	DEG1
	Street	The number and street name where a person or organization can be found	Alphanumeric	Required	DEG1
	City	City associated with provider address field	Alphanumeric	Required	DEG1
	State/Province ¹³	ISO 3166-2 Two Character Code associated with the State/Province/Region of the applicable Country ¹⁴	Alpha	Required	DEG1
	ZIP Code/ Postal Code	System of postal-zone codes (zip stands for "zone improvement plan") introduced in the U.S. in 1963 to improve mail delivery and exploit electronic reading and sorting capabilities ¹⁵	Alphanumeric, 15 characters	Required	DEG1
	Country Code ¹⁶	ISO-3166-1 Country Code ¹⁷	Alphanumeric, 2 characters	Optional	DEG1

¹³ CCD+ transaction cannot be used to make payments to or from financial institutions outside the territorial jurisdiction of the United States. Effective September 18, 2009, NACHA introduced the use of the International ACH Transaction (IAT) standard. The IAT standard applies to all consumer, corporate and government payments that involve a financial institution outside the territorial jurisdiction of the United States (US). The territorial jurisdiction of the US includes all 50 states, the District of Columbia (DC), US territories, US military bases and US embassies in foreign countries. A foreign address is not an indicator of whether the payment is an IAT. Source: NACHA 2011 Operating Rules and Guidelines

¹⁴ <http://www.iso.org/iso/search.htm?qt=ISO+3166-2&searchSubmit=Search&sort=rel&type=simple&published=on>

¹⁵ <http://www.britannica.com/EBchecked/topic/657522/ZIP-Code>

¹⁶ See Footnote #4 above regarding NACHA Operating Rules International ACH Transactions (IAT)

¹⁷ <http://www.iso.org/iso/search.htm?qt=ISO+3166-1&searchSubmit=Search&sort=rel&type=simple&published=on>

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Table: 4.2-1 CORE-required Maximum EFT Enrollment Data Set					
Individual Data Element Name¹⁰ (Term)	Sub-element Name (Term)	Data Element Description	Data Type and Format (Not all data elements require a format specification)	Data Element Requirement for Health Plan Collection (Required/Optional for plan to collect)	Data Element Group Number (DEG#)¹¹
PROVIDER IDENTIFIERS INFORMATION (Data Element Group 2 is a Required DEG)					
<i>Provider Identifiers</i>				Required	DEG2
	Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN)	A Federal Tax Identification Number, also known as an Employer Identification Number (EIN), is used to identify a business entity ¹⁸	Numeric, 9 digits	Required	DEG2
	National Provider Identifier (NPI) ¹⁹	A Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for covered healthcare providers. Covered healthcare providers and all health plans and healthcare clearinghouses must use the NPIs in the administrative and financial transactions adopted under HIPAA. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). This means that the numbers do not carry other information about healthcare providers, such as the state in which they live or their medical specialty. The NPI must be used in lieu of legacy provider identifiers in the HIPAA standards transactions ²⁰	Numeric, 10 digits	Required when provider has been enumerated with an NPI	DEG2

¹⁸ A Taxpayer Identification Number (TIN) is an identification number used by the Internal Revenue Service (IRS) in the administration of tax laws. It is issued either by the Social Security Administration (SSA) or by the IRS. A Social Security number (SSN) is issued by the SSA whereas all other TINs are issued by the IRS. <http://www.irs.gov/businesses/small/article/0,,id=98350.00.html>

¹⁹ An atypical provider not eligible for enumeration by an NPI must supply its EIN/TIN

²⁰ <http://www.cms.gov/NationalProvIdentStand/>

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Table: 4.2-1 CORE-required Maximum EFT Enrollment Data Set

Individual Data Element Name ¹⁰ (Term)	Sub-element Name (Term)	Data Element Description	Data Type and Format (Not all data elements require a format specification)	Data Element Requirement for Health Plan Collection (Required/Optional for plan to collect)	Data Element Group Number (DEG#) ¹¹
PROVIDER IDENTIFIERS INFORMATION (Continued) (Data Element Group 2 is a Required DEG)					
<i>Other Identifier(s)</i>			Alphanumeric	Optional	DEG2
	Assigning Authority	Organization that issues and assigns the additional identifier requested on the form, e.g., Medicare, Medicaid	Alphanumeric	Required if Identifier is collected	DEG2
	Trading Partner ID	The provider's submitter ID assigned by the health plan or the provider's clearinghouse or vendor	Alphanumeric	Optional	DEG2
<i>Provider License Number</i>			Alphanumeric	Optional	DEG2
	License Issuer		Alphanumeric	Required if License Number is collected	DEG2
<i>Provider Type</i>		A proprietary health plan-specific indication of the type of provider being enrolled for EFT with specific provider type description included by the health plan in its instruction and guidance for EFT enrollment (e.g., hospital, laboratory, physician, pharmacy, pharmacist, etc.)		Optional	DEG2
<i>Provider Taxonomy Code</i>		A unique alphanumeric code, ten characters in length. The code set is structured into three distinct "Levels" including Provider Type, Classification and Area of Specialization ²¹	Alphanumeric, 10 characters	Optional	DEG2

²¹ http://www.nucc.org/index.php?option=com_content&task=view&id=14&Itemid=40

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Table: 4.2-1 CORE-required Maximum EFT Enrollment Data Set

Individual Data Element Name ¹⁰ (Term)	Sub-element Name (Term)	Data Element Description	Data Type and Format (Not all data elements require a format specification)	Data Element Requirement for Health Plan Collection (Required/Optional for plan to collect)	Data Element Group Number (DEG#) ¹¹
PROVIDER CONTACT INFORMATION (Data Element Group 3 is an Optional DEG)					
<i>Provider Contact Name</i>		Name of a contact in provider office for handling EFT issues	Alphanumeric	Required	DEG3
	Title		Alphanumeric	Optional	DEG3
	Telephone Number	Associated with contact person	Numeric, 10 digits ²²	Required	DEG3
	Telephone Number Extension			Optional	DEG3
	Email Address	An electronic mail address at which the health plan might contact the provider		Required; not all providers may have an email address	DEG3
	Fax Number	A number at which the provider can be sent facsimiles		Optional	DEG3

²² ASC X12 005010X221 Health Care Claim Payment/Advice Technical Report Type 3

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Table: 4.2-1 CORE-required Maximum EFT Enrollment Data Set

Individual Data Element Name ¹⁰ (Term)	Sub-element Name (Term)	Data Element Description	Data Type and Format (Not all data elements require a format specification)	Data Element Requirement for Health Plan Collection (Required/Optional for plan to collect)	Data Element Group Number (DEG#) ¹¹
PROVIDER AGENT INFORMATION (Data Element Group 4 is an Optional DEG)					
<i>Provider Agent Name</i>		Name of provider's authorized agent	Alphanumeric	Required	DEG4
<i>Agent Address</i>				Optional	DEG4
	Street	The number and street name where a person or organization can be found	Alphanumeric	Required	DEG4
	City	City associated with address field	Alphanumeric	Required	DEG4
	State/Province	ISO 3166-2 Two Character Code associated with the State/Province/Region of the applicable Country ²³	Alpha	Required	DEG4
	ZIP Code/Postal Code	System of postal-zone codes (zip stands for "zone improvement plan") introduced in the U.S. in 1963 to improve mail delivery and exploit electronic reading and sorting capabilities ²⁴	Alphanumeric, 15 characters	Required	DEG4
	Country Code	ISO-3166-1 Country Code ²⁵	Alphanumeric, 2 characters	Optional	DEG4

²³ <http://www.iso.org/iso/search.htm?qt=ISO+3166-2&searchSubmit=Search&sort=rel&type=simple&published=on>

²⁴ <http://www.britannica.com/EBchecked/topic/657522/ZIP-Code>

²⁵ <http://www.iso.org/iso/search.htm?qt=ISO+3166-1&searchSubmit=Search&sort=rel&type=simple&published=on>

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Table: 4.2-1 CORE-required Maximum EFT Enrollment Data Set

Individual Data Element Name ¹⁰ (Term)	Sub-element Name (Term)	Data Element Description	Data Type and Format (Not all data elements require a format specification)	Data Element Requirement for Health Plan Collection (Required/Optional for plan to collect)	Data Element Group Number (DEG#) ¹¹
PROVIDER AGENT INFORMATION (Continued) (Data Element Group 4 is an Optional DEG)					
<i>Provider Agent Contact Name</i>		Name of a contact in agent office for handling EFT issues	Alphanumeric	Required	DEG4
	Title		Alphanumeric	Optional	DEG4
	Telephone Number	Associated with contact person	Numeric, 10 digits ²⁶	Required	DEG4
	Telephone Number Extension			Optional	DEG4
	Email Address	An electronic mail address at which the health plan might contact the provider		Required; not all providers may have an email address	DEG4
	Fax Number	A number at which the provider can be sent facsimiles		Optional	DEG4
FEDERAL AGENCY INFORMATION (Data Element Group 5 is an Optional DEG)					
<i>Federal Agency Information</i>		Information required by Veterans Administration		Optional	DEG5
	Federal Program Agency Name		Alphanumeric	Optional	DEG5
	Federal Program Agency Identifier		Alphanumeric	Optional	DEG5
	Federal Agency Location Code		Alphanumeric	Optional	DEG5

²⁶ ASC X12 005010X221 Health Care Claim Payment/Advice Technical Report Type 3

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Table: 4.2-1 CORE-required Maximum EFT Enrollment Data Set

Individual Data Element Name ¹⁰ (Term)	Sub-element Name (Term)	Data Element Description	Data Type and Format (Not all data elements require a format specification)	Data Element Requirement for Health Plan Collection (Required/Optional for plan to collect)	Data Element Group Number (DEG#) ¹¹
RETAIL PHARMACY INFORMATION (Data Element Group 6 is an Optional DEG)					
<i>Pharmacy Name</i>		Complete name of pharmacy	Alphanumeric	Required	DEG6
	Chain Number	Identification number assigned to the entity allowing linkage for a business relationship, i.e., chain, buying groups or third party contracting organizations. Also may be known as Affiliation ID or Relation ID	Alphanumeric	Optional	DEG6
	Parent Organization ID	Headquarter address information for chains, buying groups or third party contracting organizations where multiple relationship entities exist and need to be linked to a common organization such as common ownership for several chains	Alphanumeric	Optional	DEG6
	Payment Center ID	The assigned payment center identifier associated with the provider/corporate entity	Alphanumeric	Optional	DEG6
<i>NCPDP Provider ID Number</i>		The NCPDP-assigned unique identification number	Alphanumeric	Optional	DEG6
<i>Medicaid Provider Number</i>		A number issued to a provider by the U.S. Department of Health and Human Services through state health and human services agencies		Optional	DEG6

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Table: 4.2-1 CORE-required Maximum EFT Enrollment Data Set

Individual Data Element Name ¹⁰ (Term)	Sub-element Name (Term)	Data Element Description	Data Type and Format (Not all data elements require a format specification)	Data Element Requirement for Health Plan Collection (Required/Optional for plan to collect)	Data Element Group Number (DEG#) ¹¹
FINANCIAL INSTITUTION INFORMATION (Data Element Group 7 is a Required DEG)					
<i>Financial Institution Name</i>		Official name of the provider's financial institution	Alphanumeric	Required	DEG7
<i>Financial Institution Address</i>				Optional	DEG7
	Street	Street address associated with receiving depository financial institution name field	Alphanumeric	Required	DEG7
	City	City associated with receiving depository financial institution address field	Alphanumeric	Required	DEG7
	State/Province	ISO 3166-2 Two Character Code associated with the State/Province/Region of the applicable Country ²⁷	Alpha	Required	DEG7
	ZIP Code/ Postal Code	System of postal-zone codes (zip stands for "zone improvement plan") introduced in the U.S. in 1963 to improve mail delivery and exploit electronic reading and sorting capabilities ²⁸	Alphanumeric, 15 characters	Required	DEG7
<i>Financial Institution Telephone Number</i>		A contact telephone number at the provider's bank	Numeric, 10 digits	Optional	DEG7
	Telephone Number Extension			Optional	DEG7

²⁷ <http://www.iso.org/iso/search.htm?qt=ISO+3166-2&searchSubmit=Search&sort=rel&type=simple&published=on>

²⁸ <http://www.britannica.com/EBchecked/topic/657522/ZIP-Code>

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Table: 4.2-1 CORE-required Maximum EFT Enrollment Data Set

Individual Data Element Name ¹⁰ (Term)	Sub-element Name (Term)	Data Element Description	Data Type and Format (Not all data elements require a format specification)	Data Element Requirement for Health Plan Collection (Required/Optional for plan to collect)	Data Element Group Number (DEG#) ¹¹
FINANCIAL INSTITUTION INFORMATION (Continued) (Data Element Group 7 is a Required DEG)					
<i>Financial Institution Routing Number</i>		A 9-digit identifier of the financial institution where the provider maintains an account to which payments are to be deposited	Numeric, 9 digits	Required	DEG7
<i>Type of Account at Financial Institution</i>		The type of account the provider will use to receive EFT payments, e.g., Checking, Saving		Required	DEG7
<i>Provider's Account Number with Financial Institution</i>		Provider's account number at the financial institution to which EFT payments are to be deposited		Required	DEG7
<i>Account Number Linkage to Provider Identifier</i>		Provider preference for grouping (bulking) claim payments – must match preference for v5010 X12 835 remittance advice		Required; select from one of the two below	DEG7
	Provider Tax Identification Number (TIN)		Numeric, 9 digits	Optional – required if NPI is not applicable	DEG7
	National Provider Identifier (NPI)		Numeric, 10 digits	Optional – required if TIN is not applicable	DEG7
SUBMISSION INFORMATION (Data Element Group 8 is a Required DEG)					
<i>Reason for Submission</i>				Required; select from below	DEG8
	New Enrollment			Optional	DEG8
	Change Enrollment			Optional	DEG8
	Cancel Enrollment			Optional	DEG8

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Table: 4.2-1 CORE-required Maximum EFT Enrollment Data Set					
Individual Data Element Name¹⁰ (Term)	Sub-element Name (Term)	Data Element Description	Data Type and Format (Not all data elements require a format specification)	Data Element Requirement for Health Plan Collection (Required/Optional for plan to collect)	Data Element Group Number (DEG#)¹¹
SUBMISSION INFORMATION (Continued) (Data Element Group 8 is a Required DEG)					
<i>Include with Enrollment Submission</i>				Optional; select from below	DEG8
	Voided Check	A voided check is attached to provide confirmation of Identification/Account Numbers		Optional	DEG8
	Bank Letter	A letter on bank letterhead that formally certifies the account owners routing and account numbers		Optional	DEG8
<i>Authorized Signature</i>		The signature of an individual authorized by the provider or its agent to initiate, modify or terminate an enrollment. May be used with electronic and paper-based manual enrollment		Required; select from below	DEG8
	Electronic Signature of Person Submitting Enrollment			Optional	DEG8
	Written Signature of Person Submitting Enrollment	A (usually cursive) rendering of a name unique to a particular person used as confirmation of authorization and identity		Optional	DEG8
	Printed Name of Person Submitting Enrollment	The printed name of the person signing the form; may be used with electronic and paper-based manual enrollment		Optional	DEG8
	Printed Title of Person Submitting Enrollment	The printed title of the person signing the form; may be used with electronic and paper-based manual enrollment		Optional	DEG8

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Table: 4.2-1 CORE-required Maximum EFT Enrollment Data Set					
Individual Data Element Name¹⁰ (Term)	Sub-element Name (Term)	Data Element Description	Data Type and Format (Not all data elements require a format specification)	Data Element Requirement for Health Plan Collection (Required/Optional for plan to collect)	Data Element Group Number (DEG#)¹¹
SUBMISSION INFORMATION (Continued) (Data Element Group 8 is a Required DEG)					
<i>Submission Date</i>		The date on which the enrollment is submitted	CCYYMMDD ²⁹	Optional	DEG8
<i>Requested EFT Start/Change/Cancel Date</i>		The date on which the requested action is to begin	CCYYMMDD	Optional	DEG8

4.3 CORE Master Template for Collecting EFT Enrollment Data

4.3.1 Master Template for Manual Paper-Based Enrollment

The name of the health plan (or its agent or the vendor offering EFT) and the purpose of the form will be on the top of the form, e.g., Health Plan X: Electronic Funds Transfer (EFT) Authorization Agreement.

A health plan (or its agent or a vendor offering EFT) is required to use the format, flow, and data set including data element descriptions of Table 4.2-1 as the CORE Master EFT Enrollment Submission form when using a manual paper-based enrollment method. All CORE-required EFT Enrollment data elements must appear on the paper form in the same order as they appear in Table 4.2-1.

A health plan (or its agent) cannot revise or modify:

- The name of a CORE Master EFT Enrollment Data Element Name
- The usage requirement of a CORE Master EFT Enrollment Data Element
- The Data Element Group number of a CORE Master EFT Enrollment Data Element

Beyond the data elements and their flow, a health plan (or its agent) must:

- Develop and make available to the healthcare provider (or its agent) specific written instructions and guidance for the healthcare provider (or its agent) when completing and submitting the enrollment form, including when using paper
- Provide a number to fax and/or a U.S. Postal Service or email address to send the completed form
- Include contact information for the health plan, specifically a telephone number and/or email address to send questions
- Include authorization language for the provider to read and consider
- Include a section in the form that outlines how the provider can access online instructions for how the provider can determine the status of the EFT enrollment
- Clearly label any appendix describing its purpose as it relates to the provider enrolling in EFT

²⁹ ASC X12 Standards Version 005010 for X12 Data Element 373 Date used in the ASC X12 005010X221 Health Care Claim Payment/Advice Technical Report Type 3

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- Inform the provider that it 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. *See Phase III CORE EFT & ERA Reassociation (CCD+/835) Rule Version 3.0.0.*

4.3.2 Master Template for Electronic Enrollment

When electronically enrolling a healthcare provider in EFT, a health plan (or its agent) must use the CORE Master EFT Enrollment Data Element Name and Sub-element Name as specified in Table 4.2-1 without revision or modification.

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>.

As noted below in §4.4, a health plan (or its agent or vendors offering EFT enrollment) will offer an electronic way for provider to complete and submit the EFT enrollment. A health plan may use a web-based method for its electronic approach to offering EFT enrollment. The design of the website is restricted by this rule only to the extent that the flow, format and data set including data element descriptions established by this rule must be followed.

4.4 CORE Electronic Safe Harbor for EFT Enrollment to Occur Electronically

This rule provides an EFT enrollment “Electronic Safe Harbor” by which health plans, healthcare providers, their respective agents, application vendors and intermediaries can be assured will be supported by any trading partner. This EFT Enrollment Rule specifies that all health plans and their respective agents *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.* As an EFT enrollment “Safe Harbor,” this rule:

- **DOES NOT** require health plans or their agents to discontinue using existing manual and/or paper-based methods and processes to collect the CORE-required Maximum EFT Enrollment Data Set.
- **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.
- **DOES NOT** require an entity to do business with any trading partner or other entity.

CORE expects that in some circumstances, health plans or their agents may agree to use non-electronic methods and mechanisms to achieve the goal of the collection of EFT enrollment data – and that provider trading partners will respond to using this method should they choose to do so.

However, the electronic EFT enrollment “Safe Harbor” mechanism offered by a health plan and its agent **MUST** be used by the health plan or its agent if requested by a trading partner or its agent. The electronic EFT enrollment “Safe Harbor” mechanism is not limited to single entity enrollments and may include a batch of enrollments. If the health plan or its agent does not believe that this CORE EFT Enrollment Safe Harbor is the best mechanism for that particular trading partner or its agent, it may work with its trading partner to implement a different, mutually agreeable collection method. However, if the trading partner insists on conducting EFT Enrollment electronically, the health plan or its agent must accommodate that request. This clarification is not intended in any way to modify entities’ obligations to exchange electronic transactions as specified by HIPAA or other Federal and state regulations.

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4.5 Time Frame for Rule Compliance³⁰

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.³¹ Should such paper forms be available at provider's offices or other locations, it is expected that such paper-based forms will be replaced.

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.

It will be expected that all electronic EFT enrollment will meet this rule requirement and that of the compliance date, and that the health plan (or its agent) will inform its providers that an electronic option is now available, if not previously available.

5 Conformance Requirements

Separate from any HHS certification/compliance program to demonstrate conformance as mandated under ACA Section 1104, CAQH CORE offers voluntary CORE Certification for all Phases of the CAQH CORE Operating Rules. CORE Certification is completely optional. Pursuing voluntary CORE Certification offers an entity a mechanism to test its ability to exchange EFT and ERA transaction data with its trading partners. A CORE-certified Seal is awarded to an entity or vendor product that voluntarily completes CORE certification testing with a CAQH CORE-authorized testing vendor. Key benefits of voluntary CORE Certification include:

- Demonstrates to the industry adoption of the Phase III CORE EFT & ERA Operating Rules via a recognized industry "Seal"
- Encourages trading partners to work together on transaction data content, infrastructure and connectivity needs
- Reduces the work necessary for successful trading partner testing as a result of independent testing of the operating rules implementation
- Promotes maximum ROI when all stakeholders in the information exchange are known to conform to the CORE Operating Rules

For more information on achieving voluntary CORE Certification for the CAQH CORE EFT & ERA Operating Rules, refer to the Phase III CORE EFT & ERA Operating Rules Voluntary Certification Master Test Suite Version 3.0.0 or contact CORE@caqh.org.

³⁰ Some health plans have expressed concern regarding the timeframe for effective date of EFT and ERA operating rules as specified in the ACA Section 1104, i.e., not later than January 1, 2014, as being too restrictive, given the myriad other regulatory mandates currently being confronted by the industry.

³¹ The rule recognizes that some public/Federal entities have review and approval processes that are unique and may require significant planning time and resources to meet the rule requirements.



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REVISION HISTORY FOR PHASE III CAQH CORE 382 ERA ENROLLMENT DATA RULE

Version	Revision	Description	Date
3.0.0	Initial Version	Phase III CAQH CORE 382 ERA Enrollment Data Rule balloted and approved via CORE Voting Process	June 2012
3.0.1	Non-substantive <i>(Entities do not need to update enrollment forms/systems)</i>	Non-substantive adjustments to the CORE-required Maximum ERA Enrollment Data Set to improve usability: <ul style="list-style-type: none"> • Further distinguished Data Elements that do not obligate the provider to submit any associated data but provide essential context for related Sub-elements • Addressed table formatting inconsistencies • Ensured consistency between data elements • Corrected two minor typographical errors 	July 2014

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1 Background Summary

In Phase III, CORE built on the Phase I and Phase II foundation by adding a range of operating rule requirements for both the HIPAA-adopted ASC X12 005010X221A1 Health Care Claim Payment/Advice (835) Technical Report Type 3 Implementation Guide and associated errata (hereafter v5010 X12 835) transaction, also known as the Electronic Remittance Advice (ERA), and the Electronic Funds Transfer (EFT) by addressing operating rules related to the NACHA ACH CCD plus Addenda Record (hereafter CCD+) and the X12 835 TR3 TRN Segment (hereafter the CCD+ and X12 835 TR3 TRN Segment together are the Healthcare EFT Standards¹).

This set of operating rules includes the application of the Phase I and Phase II CORE infrastructure rules to the conduct of the v5010 X12 835 (Phase III CORE 350 Health Care Claim Payment/Advice (835) Infrastructure Rule Version 3.0.0) so a focus can be placed on improving the conduct and exchange of electronic claim advice data given these transactions can have a direct impact on a provider's revenue cycle management process. The Phase III CORE Rule Set also includes a Phase III CORE 370 EFT & ERA Reassociation (CCD+/835) Rule Version 3.0.0, which has identified the critical data elements for reassociating the payment and remittance advice when they travel separately. Working together, the CORE rules complement each other in order to reduce the current cost of today's paper-based transaction process and to move the industry to fully embracing a real-time, transparent electronic world.

Along with the ERA, the EFT or electronic payment made to the provider from the health plan furthers the automated processing of healthcare payments; paper checks and their manual processing are eliminated. In addition to the aforementioned rules, Phase III also includes a CORE EFT Enrollment Data Rule which builds upon the other Phase III CORE EFT-and ERA-related rules by addressing a key barrier to the use of EFT by providers – a cumbersome, and in many cases, incomplete EFT enrollment data set that doesn't speak to the electronic needs of the system – and further enables the automated processing of healthcare payments. This rule addresses similar challenges related to provider ERA enrollment.

Currently, healthcare providers or their agents² face significant challenges when enrolling to receive ERAs from a health plan including:

- A wide variety in data elements requested for enrollment
- Variety in the enrollment processes and approvals to receive the ERA
- Absence of critical elements that would address essential questions regarding provider preferences on payment options

Conversely, health plans are also challenged by the effort and resources required to enroll providers and maintain changes in provider information over time. As a result, some plans may prioritize converting high volume claim submitters to ERA over converting lower volume submitters, even though the low volume submitters may account for the vast majority of providers submitting claims.

Consistent and uniform operating rules enabling providers to quickly and efficiently enroll for ERA will help to mitigate:

- Complex and varied enrollment processes
- Variation in data elements requested for enrollment

¹ The CCD+ and X12 835 TR3 TRN Segment are adopted together as the Federal Healthcare EFT Standards in [CMS-0024-IFC: Administrative Simplification: Adoption of Standards for Health Care Electronic Funds Transfers \(EFTs\) and Remittance Advice](#), 01/10/12.

² One who agrees and is authorized to act on behalf of another, a principal, to legally bind an individual in particular business transactions with third parties pursuant to an agency relationship. Source: West's Encyclopedia of American Law, edition 2. Copyright 2008 The Gale Group, Inc. All rights reserved.

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- Lack of electronic access to enrollments
- Missing requests for critical elements that help address system-wide automation

And provide for:

- Less staff time spent on phone calls and websites
- Increased ability to conduct targeted follow-up with health plans
- Broader adoption of ERA by providers
- An ability to ensure the enrollment process is coordinated with the next steps in payment process

1.1 Affordable Care Act Mandates

This rule is part of a set of rules that addresses a request from the National Committee on Vital and Health Statistics (NCVHS) for fully vetted CAQH CORE Operating Rules for the EFT and ERA transactions; the NCVHS request was made in response to NCVHS' role in Section 1104 of the Affordable Care Act (ACA).

Section 1104 of the ACA contains an industry mandate for the use of operating rules to support implementation of the HIPAA standards. Using successful, yet voluntary, national industry efforts as a guide, Section 1104 defines operating rules as a tool that will build upon existing healthcare transaction standards. The legislation outlines three sets of healthcare industry operating rules to be approved by the Department of Health and Human Services (HHS) and then implemented by the industry, the second set of which are those for EFT and ERA.³ The ACA requires HHS to adopt a set of operating rules for both of these transactions by July 2012. In a letter dated 03/23/11,⁴ NCVHS recommended that the Secretary "name CAQH CORE in collaboration with NACHA – The Electronic Payments Association as the candidate authoring entity for operating rules for all health care EFT and ERA transactions..."

Section 1104 of the ACA also adds the EFT transaction to the list of electronic health care transactions for which the HHS Secretary must adopt a standard under HIPAA. The section requires the EFT transaction standard be adopted by 01/01/12, in a manner ensuring that it is effective by 01/01/14. In January 2012, HHS issued an Interim Final Rule with Comment (IFC)⁵ adopting the CCD+ and the X12 835 TR3 TRN Segment⁶ as the Healthcare EFT Standards. These standards must be used for electronic claims payment initiation by all health plans that conduct healthcare EFT.

³ The first set of operating rules under ACA Section 1104 applies to eligibility and claim status transactions with an adoption date of 07/01/11 and effective date of 01/01/13; the third set of operating rules applies to healthcare claims or equivalent encounter information transactions, enrollment and disenrollment in a health plan, health plan premium payments and referral, certification and authorization with an adoption date of 07/01/14 and effective date of 01/01/16.

⁴ NCVHS [Letter to the Secretary](#) - Affordable Care Act (ACA), Administrative Simplification: Recommendation for entity to submit proposed operating rules to support the Standards for Health Care Electronic Funds Transfers and Health Care Payment and Remittance Advice 03/23/11.

⁵ [CMS-0024-IFC](#): Administrative Simplification: Adoption of Standards for Health Care Electronic Funds Transfers (EFTs) and Remittance Advice, 01/10/12.

⁶ The IFC requires health plans to input the X12 835 TR3 TRN Segment into the Addenda Record of the CCD+; specifically, the X12 835 TR3 TRN Segment must be placed in Field 3 of the Addenda Entry Record ("7 Record") of a CCD+.

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2 Issue to be Addressed and Business Requirement Justification

It is a challenge for each provider, whether large or small, to complete enrollment and maintain changes in their information for ERA uniquely with each payer. It is equally challenging for each payer to collect and implement identification and other information from every provider for ERA – moreover, common lessons learned on necessary requests to streamline the process are not being identified due to all this variation. Providers seeking to enroll for ERA often face different enrollment formats and requirements. For many providers the enrollment process is cumbersome and time-consuming.

2.1 Problem Space

CORE EFT & ERA Subgroup Participant surveys and discussion have identified significant barriers to achieving industry-wide rapid adoption of EFT and ERA; much of these findings have been reiterated by CAQH CORE and NACHA research as well as research by other industry efforts. One of the key barriers identified is the challenge faced by providers due to the variances in the processes and data elements requested when enrolling in ERA with a health plan.

Due to the variations across health plans in the data elements requested, providers manually process enrollment forms for each plan to which they bill claims and from which they wish to receive an ERA. This results in unnecessary manual processing of multiple forms requesting a range of information – not necessarily the same – as noted by research findings – and, in the case when it is the same, often using a wide variety of data terminology for the same semantic concept (i.e., “Provider” vs. “Name”).

This inconsistent terminology for the same data element during ERA enrollment can cause confusion and incorrect data to be entered during the enrollment process resulting in further delays as manual processes are used to clarify the inaccurate data – telephone calls, faxes, emails and original enrollment documents are returned to the provider for review, correction and resubmission to the health plan.

The manual and time-consuming process required by many of the current enrollment processes today and the variety of enrollment forms and data requirements cost the industry time and money – and, in many cases, does not address the key items that are needed to use the ERA enrollment information to fully automate both claims payment and remittance advice posting processes. As a consequence, providers are often reluctant to implement ERA with many health plans, particularly those plans that have seemingly difficult or extensive requirements for enrollment.⁷ It is well understood that ERA enrollment is not the only challenge with regard to provider adoption of ERA; however, it is one of the pieces of the puzzle and thus does need to be addressed, especially given the significant challenges that the other Phase III CORE Rules are working to improve.

2.2 CORE Process in Addressing the Problem Space

To address the Problem Space associated with ERA enrollment, the CORE EFT & ERA Subgroup and its Work Group conducted a series of surveys, numerous Subgroup discussions and significant review of industry ERA enrollment forms and research related to existing industry initiatives (e.g., Workgroup for Electronic Data Interchange [WEDI], etc.) to inform development of this Phase III CORE Rule.

2.2.1 Research and Analysis of EFT & ERA Enrollment Forms

The CORE EFT & ERA Subgroup completed a number of research steps to determine a set of data elements to serve as a maximum data requirement for ERA enrollment. These key research steps included:

⁷ CAQH CORE/NACHA White Paper: Adoption of EFT and ERA by Health Plans and Providers: A White Paper Identifying Business Issues and Recommendations for Operating Rules (2011)

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- Created source list for representative sample of ERA enrollment forms
- Using source list, obtained a representative sample of approximately 45 enrollment forms from eight key industry sectors (National Plans, Regional Plans, State Medicaid, Medicare, Clearinghouses, Worker’s Compensation, Employer Owned [including Provider Owned], Third-Party Administrators)
- Identified frequency of data elements and key semantic concepts across source list enrollment forms and elements needing clarity; considered data elements utilized by external resources, e.g., the U.S. Postal Service, *NACHA Operating Rules*, etc.
- Using direct research findings and indirect sources (i.e., related white papers by WEDI, etc.), created a list of required data elements with definitions and other rule requirements using agreed-upon evaluation criteria
- Outlined the essential elements needed to address provider preferences and electronic transaction needs

CAQH CORE conducted substantial analysis to compare ERA enrollment forms from across the industry and follow-up with specific industry sectors such as pharmacy. Using Subgroup-approved evaluation criteria, a set of universally necessary ERA enrollment data elements was identified by the CORE Participants as well as the detailed Rule Requirements around these ERA enrollment data elements. The CORE Participants agreed that these data elements represented the *maximum* set of data elements required for successful ERA enrollment. Therefore, this Phase III CORE Rule addresses the maximum set of data elements required for providers enrolling for receipt of the ERA from a health plan.

2.2.1.1 Evaluation Criteria to Identify Required ERA Enrollment Data Elements

The following evaluation criteria were used by the Subgroup to identify the list of required ERA enrollment data elements using direct (e.g., ERA enrollment forms utilized by health plans and vendors) and indirect (e.g., white papers that address the topic of standardization of ERA enrollment) sources:

- Quantitative findings of research, e.g.,
 - Include data elements that are frequently included across direct and indirect sources (e.g., elements included in 65% or more of all enrollment forms or research)
 - For data elements that have different terms used for the same semantic concept, e.g., meaning/intent, select one term for each data element (i.e., term selected would be used on 65% of forms; e.g., “Provider” vs. “Name”)
- Qualitative discussions for elements that are unclear in the quantitative findings, but are directly related to agreed upon CORE EFT & ERA Subgroup high priority goals
 - Identified strong business need to streamline the collection of data elements (e.g., Taxpayer Identification Number [TIN] vs. National Provider Identifier [NPI] numbers)
 - Essential data for populating the Healthcare EFT Standards and the v5010 X12 835
 - Balance between time and resources (cost) to provide enrollment data versus necessity (benefit) to procure data element
 - Consistent with CORE Guiding Principles

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3 Scope

3.1 *When the Rule Applies*

This rule applies when a health plan or its agent is enrolling a healthcare provider (or its agent) for the purpose of engaging in the receipt by the provider of the claim payment remittance advice electronically (ERA) from a health plan.

3.2 *CORE-required Maximum ERA Enrollment Data Element Set*

The data elements identified in Table 4.2-1 in §4.2 are the maximum number of data elements that a health plan or its agent may require a healthcare provider or its agent to submit to the health plan for the purpose of engaging in receipt by the provider of the claim payment remittance advice electronically (ERA) from a health plan.

The enrollment data elements in Table 4.2-1 represent a “controlled vocabulary” as a means to provide a common, uniform and consistent way for health plans to collect and organize data for subsequent collection and use. A controlled vocabulary reduces ambiguity inherent in normal human languages (where the same concept can be given different names), ensures consistency and is potentially a crucial enabler of semantic interoperability. The CORE-required Maximum ERA Enrollment Data Set (i.e., a controlled vocabulary) mandates the use of predefined and authorized terms that have been preselected by CORE Participants.

3.2.1 Data Element Group: Elements that May Need to be Requested Several Times

Several of the data elements in Table 4.2-1 can be logically related where each single discrete data element can form a larger grouping or a set of data elements that are logically related, e.g., a provider contact name and a contact number are typically requested together, or should be. Such logical Data Element Groups are shown in Table 4.2-1 by assigning a Data Element Group identifier (e.g., DEG1, DEG2, etc.) to the discrete data element included in the set of logically related data elements.

There are ten of these Data Element Groups (DEGs); each represents a set of data elements that may need to be collected more than once for a specific context (e.g., multiple provider contacts). Examples of the DEGs are: Provider’s Agent Name and Address. Multiple uses of the same Data Element Group to collect the same data for another context are allowed by this rule and do not constitute a non-conforming use of the CORE-required Maximum ERA Enrollment Data Set.

3.3 *What the Rule Does Not Require*

This rule does not require any health plan to:

- Engage in the process of paying for healthcare claims electronically
- Conduct either the v5010 X12 835 or the Healthcare EFT Standards transactions
- Combine EFT with ERA enrollment
- Re-enroll a provider if the provider is already enrolled and receiving the ERA

3.4 *CORE Process for Maintaining CORE-required Maximum ERA Enrollment Data Set*

The CORE-required Maximum ERA Enrollment Data Set is a set of data elements determined by CORE to be the most appropriate data set to achieve uniform and consistent collection of such data at the time this rule was developed. CORE recognizes that as this rule becomes widely adopted and implemented in health care – and as

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ERA changes in the marketplace – the experience and learning gained from ERA enrollment may indicate a need to modify the maximum data set to meet emerging or new industry needs.

Given this anticipated need for data set maintenance activity, CORE recognizes that the focus of this rule, coupled with this need for unique modification of the data set, will require a process and policy to enable the data set to be reviewed on an annual or semi-annual basis. Any revisions to the data set will follow standard CORE processes for rule revisions. CORE will develop such a process and policy in accordance with CORE Guiding Principles following the approval of the Phase III CORE Operating Rules for first review of potential revisions to the data set. The first review shall commence one-year after the passage of a Federal regulation requiring implementation of this CORE rule. Substantive changes necessary to the data set will be reviewed and approved by CORE as necessary to ensure accurate and timely revision to the data set.

3.5 Outside the Scope of this Rule

This rule does not address any business relationship between a health plan and its agent or a healthcare provider and its agent.

Outside the scope of this rule is:

- The need to collect other data for other business purposes and such data may be collected at the health plan's discretion
- The method or mechanism for how a health plan exchanges ERA data internally
- The method or mechanism for how a health plan collects ERA data externally

3.6 How the Rule Relates to Phase I and II CORE

As with other Phase I and Phase II CORE Rules, general CORE policies also apply to Phase III CORE Rules and will be outlined in the Phase III CORE Rule Set.

3.7 Assumptions

A goal of this rule is to establish a foundation for the successful and timely enrollment of healthcare providers by health plans to engage in the ERA.

The following assumption applies to this rule:

- This rule is a component of the larger set of Phase III CORE Rules; as such, all the CORE Guiding Principles apply to this rule and all other rules

4 Rule Requirements

4.1 Requirements for a Health Plan, its Agent or Vendors Offering ERA Enrollment

A health plan (or its agent or vendors offering ERA enrollment) must comply with all requirements specified in this rule when collecting from a healthcare provider (or its agent) the data elements needed to enroll the healthcare provider for ERA.

4.2 CORE-required Maximum ERA Enrollment Data Elements

A health plan (or its agent or vendors offering ERA enrollment) is required to collect no more data elements than the maximum data elements defined in Table 4.2-1 CORE-required Maximum ERA Enrollment Data Set. Table 4.2-1 lists all of the CORE-required maximum Individual Data Elements and data element descriptions, organized

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by categories of information, e.g., Provider Information, Provider Identifiers Information, Federal Agency Information, Retail Pharmacy Information, Electronic Remittance Advice Information and Submission Information. Both the Individual Data Element name and its associated description must be used by a health plan (or its agent or vendors offering ERA enrollment) when collecting ERA enrollment data either electronically or via a manual paper-based process. The Individual Data Element Name and its associated description must not be modified.

Table 4.2-1 includes ten Data Element Groups, each representing a set of data elements that may need to be collected more than once for a specific context (Reference §3.2.1 above). Multiple uses of the same Data Element Group to collect the same data for another context are allowed by this rule and do not constitute a non-conforming use of the CORE-required Maximum Enrollment Data Set. These ten Data Element Groups are:

- DEG1: Provider Information
- DEG2: Provider Identifiers Information
- DEG3: Provider Contact Information
- DEG4: Provider Agent Information
- DEG5: Federal Agency Information
- DEG6: Retail Pharmacy Information
- DEG7: Electronic Remittance Advice Information
- DEG8: Electronic Remittance Advice Clearinghouse Information
- DEG9: Electronic Remittance Advice Vendor Information
- DEG10: Submission Information

Within each information category some data elements may be grouped into specific Data Element Groups (Reference §3.2.1). A DEG may be designated as required or optional for data collection. Within each DEG, Individual Data Elements may be designated as required or optional for data collection.

- When a DEG is designated as required, all of the required Individual Data Elements within the DEG must be collected by the health plan; Individual Data Elements designated as optional may be collected depending on the business needs of the health plan.
- When a DEG is designated as optional, the collection of the optional DEG is at the discretion of the health plan. When a health plan exercises its discretion to collect an optional DEG, any included Individual Data Element designated as required must be collected.
- Some required or optional Individual Data Elements are composed of one or more Sub-elements, where a Sub-element is designated as either required or optional for collection. When a health plan collects an optional Individual Data Element that is composed of one more optional Sub-elements, the optional Sub-element may be collected at the discretion of the health plan. When a health plan collects a required Individual Data Element that is composed of one or more optional Sub-elements, the optional Sub-element may be collected at the discretion of the health plan.

Not collecting an individual data element identified as optional does not constitute a non-conforming use of the CORE-required Maximum ERA Enrollment Data Set. As specified in §3.2.1, the collection of multiple occurrences of DEGs for another context does not constitute a non-conforming use of the CORE-required Maximum ERA Enrollment Data Set.

A health plan must develop and make available to the healthcare provider (or its agent) specific written instructions and guidance for the healthcare provider (or its agent) when providing and submitting the data elements in Table 4.2-1. The health plan's specific instructions and guidance are not addressed in this CORE rule.

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The data elements in Table 4.2-1 are for new enrollments. When an enrollment is being changed or cancelled, the health plan must make available to the provider instructions on the specific procedure to accomplish a change in their enrollment or to cancel their enrollment.

Table: 4.2-1 CORE-required Maximum ERA Enrollment Data Set					
Individual Data Element Name⁸ (Term)	Sub-element Name (Term)	Data Element Description	Data Type and Format (Not all data elements require a format specification)	Data Element Requirement for Health Plan Collection (Required/Optional for plan to collect)	Data Element Group Number (DEG#) ⁹
PROVIDER INFORMATION (Data Element Group 1 is a Required DEG)					
<i>Provider Name</i>		Complete legal name of institution, corporate entity, practice or individual provider	Alphanumeric	Required	DEG1
<i>Doing Business As Name (DBA)</i>		A legal term used in the United States meaning that the trade name, or fictitious business name, under which the business or operation is conducted and presented to the world is not the legal name of the legal person (or persons) who actually own it and are responsible for it ¹⁰	Alphanumeric	Optional	DEG1

⁸ Shaded Individual Data Element Names provide essential context for related Sub-element Names but do not obligate providers to submit any associated data for that specific Data Element on the enrollment form/system. Individual Data Element Names that are not shaded do obligate the provider to submit associated data.

⁹ There are ten of these Data Element Groups, and each represents a set of data elements that may need to be collected more than once for a specific context. Multiple uses of the same Data Element Group to collect the same data for another context are allowed by this rule and do not constitute a non-conforming use of the CORE-required Maximum ERA Enrollment Data Set.

¹⁰ http://en.wikipedia.org/wiki/Doing_business_as

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Table: 4.2-1 CORE-required Maximum ERA Enrollment Data Set					
Individual Data Element Name⁸ (Term)	Sub-element Name (Term)	Data Element Description	Data Type and Format (Not all data elements require a format specification)	Data Element Requirement for Health Plan Collection (Required/Optional for plan to collect)	Data Element Group Number (DEG#)⁹
PROVIDER INFORMATION (Continued) (Data Element Group 1 is a Required DEG)					
<i>Provider Address</i>				Optional	DEG1
	Street	The number and street name where a person or organization can be found	Alphanumeric	Required	DEG1
	City	City associated with provider address field	Alphanumeric	Required	DEG1
	State/Province	ISO 3166-2 Two Character Code associated with the State/Province/Region of the applicable Country ¹¹	Alpha	Required	DEG1
	ZIP Code/ Postal Code	System of postal-zone codes (zip stands for "zone improvement plan") introduced in the U.S. in 1963 to improve mail delivery and exploit electronic reading and sorting capabilities ¹²	Alphanumeric, 15 characters	Required	DEG1
	Country Code ¹³	ISO-3166-1 Country Code ¹⁴	Alphanumeric, 2 characters	Optional	DEG1

¹¹ <http://www.iso.org/iso/search.htm?q=ISO+3166-2&searchSubmit=Search&sort=rel&type=simple&published=on>

¹² <http://www.britannica.com/EBchecked/topic/657522/ZIP-Code>

¹³ See Footnote #4 above regarding *NACHA Operating Rules* International ACH Transactions (IAT)

¹⁴ <http://www.iso.org/iso/search.htm?q=ISO+3166-1&searchSubmit=Search&sort=rel&type=simple&published=on>

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Table: 4.2-1 CORE-required Maximum ERA Enrollment Data Set					
Individual Data Element Name⁸ (Term)	Sub-element Name (Term)	Data Element Description	Data Type and Format (Not all data elements require a format specification)	Data Element Requirement for Health Plan Collection (Required/Optional for plan to collect)	Data Element Group Number (DEG#)⁹
PROVIDER IDENTIFIERS INFORMATION (Data Element Group 2 is a Required DEG)					
<i>Provider Identifiers</i>				Required	DEG2
	Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN)	A Federal Tax Identification Number, also known as an Employer Identification Number (EIN), is used to identify a business entity ¹⁵	Numeric, 9 digits	Required	DEG2
	National Provider Identifier (NPI) ¹⁶	A Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for covered healthcare providers. Covered healthcare providers and all health plans and healthcare clearinghouses must use the NPIs in the administrative and financial transactions adopted under HIPAA. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). This means that the numbers do not carry other information about healthcare providers, such as the state in which they live or their medical specialty. The NPI must be used in lieu of legacy provider identifiers in the HIPAA standards transactions ¹⁷	Numeric, 10 digits	Required when provider has been enumerated with an NPI	DEG2

¹⁵ A Taxpayer Identification Number (TIN) is an identification number used by the Internal Revenue Service (IRS) in the administration of tax laws. It is issued either by the Social Security Administration (SSA) or by the IRS. A Social Security number (SSN) is issued by the SSA whereas all other TINs are issued by the IRS. <http://www.irs.gov/businesses/small/article/0,,id=98350.00.html>

¹⁶ An atypical provider not eligible for enumeration by an NPI must supply its EIN/TIN

¹⁷ <http://www.cms.gov/NationalProvIdentStand/>

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Table: 4.2-1 CORE-required Maximum ERA Enrollment Data Set					
Individual Data Element Name⁸ (Term)	Sub-element Name (Term)	Data Element Description	Data Type and Format (Not all data elements require a format specification)	Data Element Requirement for Health Plan Collection (Required/Optional for plan to collect)	Data Element Group Number (DEG#)⁹
PROVIDER IDENTIFIERS INFORMATION (Continued) (Data Element Group 2 is a Required DEG)					
<i>Other Identifier(s)</i>			Alphanumeric	Optional	DEG2
	Assigning Authority	Organization that issues and assigns the additional identifier requested on the form, e.g., Medicare, Medicaid	Alphanumeric	Required if Identifier is collected	DEG2
	Trading Partner ID	The provider's submitter ID assigned by the health plan or the provider's clearinghouse or vendor	Alphanumeric	Optional	DEG2
<i>Provider License Number</i>			Alphanumeric	Optional	DEG2
	License Issuer		Alphanumeric	Required if License Number is collected	DEG2
<i>Provider Type</i>		A proprietary health plan-specific indication of the type of provider being enrolled for ERA with specific provider type description included by the health plan in its instruction and guidance for ERA enrollment (e.g., hospital, laboratory, physician, pharmacy, pharmacist, etc.)		Optional	DEG2
<i>Provider Taxonomy Code</i>		A unique alphanumeric code, ten characters in length. The code set is structured into three distinct "Levels" including Provider Type, Classification and Area of Specialization ¹⁸	Alphanumeric, 10 characters	Optional	DEG2

¹⁸ http://www.nucc.org/index.php?option=com_content&task=view&id=14&Itemid=40

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Table: 4.2-1 CORE-required Maximum ERA Enrollment Data Set					
Individual Data Element Name⁸ (Term)	Sub-element Name (Term)	Data Element Description	Data Type and Format (Not all data elements require a format specification)	Data Element Requirement for Health Plan Collection (Required/Optional for plan to collect)	Data Element Group Number (DEG#)⁹
PROVIDER CONTACT INFORMATION (Data Element Group 3 is an Optional DEG)					
<i>Provider Contact Name</i>	<i>NOTE: In v3.0.0 of this rule, the data element "Contact" was inadvertently included in this cell. Entities that accommodated this error do not need to adjust their data sets to comply with v3.0.1 in which "Contact" has been removed from this cell for clarity.</i>	Name of a contact in provider office for handling ERA issues	Alphanumeric	Required	DEG3
	Title		Alphanumeric	Optional	DEG3
	Telephone Number	Associated with contact person	Numeric, 10 digits ¹⁹	Required	DEG3
	Telephone Number Extension			Optional	DEG3
	Email Address	An electronic mail address at which the health plan might contact the provider		Required; not all providers may have an email address	DEG3
	Fax Number	A number at which the provider can be sent facsimiles		Optional	DEG3

¹⁹ ASC X12 005010X221 Health Care Claim Payment/Advice Technical Report Type 3

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Table: 4.2-1 CORE-required Maximum ERA Enrollment Data Set					
Individual Data Element Name⁸ (Term)	Sub-element Name (Term)	Data Element Description	Data Type and Format (Not all data elements require a format specification)	Data Element Requirement for Health Plan Collection (Required/Optional for plan to collect)	Data Element Group Number (DEG#)⁹
PROVIDER AGENT INFORMATION (Data Element Group 4 is an Optional DEG)					
<i>Provider Agent Name</i>		Name of provider's authorized agent	Alphanumeric	Required	DEG4
<i>Agent Address</i>				Optional	DEG4
	Street	The number and street name where a person or organization can be found	Alphanumeric	Required	DEG4
	City	City associated with address field	Alphanumeric	Required	DEG4
	State/Province	ISO 3166-2 Two Character Code associated with the State/Province/Region of the applicable Country ²⁰	Alpha	Required	DEG4
	ZIP Code/ Postal Code	System of postal-zone codes (zip stands for "zone improvement plan") introduced in the U.S. in 1963 to improve mail delivery and exploit electronic reading and sorting capabilities ²¹	Alphanumeric, 15 characters	Required	DEG4
	Country Code	ISO-3166-1 Country Code ²²	Alphanumeric, 2 characters	Optional	DEG4

²⁰ <http://www.iso.org/iso/search.htm?qt=ISO+3166-2&searchSubmit=Search&sort=rel&type=simple&published=on>

²¹ <http://www.britannica.com/EBchecked/topic/657522/ZIP-Code>

²² <http://www.iso.org/iso/search.htm?qt=ISO+3166-1&searchSubmit=Search&sort=rel&type=simple&published=on>

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Table: 4.2-1 CORE-required Maximum ERA Enrollment Data Set					
Individual Data Element Name⁸ (Term)	Sub-element Name (Term)	Data Element Description	Data Type and Format (Not all data elements require a format specification)	Data Element Requirement for Health Plan Collection (Required/Optional for plan to collect)	Data Element Group Number (DEG#)⁹
PROVIDER AGENT INFORMATION (Continued) (Data Element Group 4 is an Optional DEG)					
<i>Provider Agent Contact Name</i>		Name of a contact in agent office for handling ERA issues	Alphanumeric	Required	DEG4
	Title		Alphanumeric	Optional	DEG4
	Telephone Number	Associated with contact person	Numeric, 10 digits ²³	Required	DEG4
	Telephone Number Extension			Optional	DEG4
	Email Address	An electronic mail address at which the health plan might contact the provider		Required; not all providers may have an email address	DEG4
	Fax Number	A number at which the provider can be sent facsimiles		Optional	DEG4
FEDERAL AGENCY INFORMATION (Data Element Group 5 is an Optional DEG)					
<i>Federal Agency Information</i>		Information required by Veterans Administration		Optional	DEG5
	Federal Program Agency Name		Alphanumeric	Optional	DEG5
	Federal Program Agency Identifier		Alphanumeric	Optional	DEG5
	Federal Agency Location Code		Alphanumeric	Optional	DEG5

²³ ASC X12 005010X221 Health Care Claim Payment/Advice Technical Report Type 3

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Table: 4.2-1 CORE-required Maximum ERA Enrollment Data Set					
Individual Data Element Name⁸ (Term)	Sub-element Name (Term)	Data Element Description	Data Type and Format (Not all data elements require a format specification)	Data Element Requirement for Health Plan Collection (Required/Optional for plan to collect)	Data Element Group Number (DEG#)⁹
RETAIL PHARMACY INFORMATION (Data Element Group 6 is an Optional DEG)					
<i>Pharmacy Name</i>		Complete name of pharmacy	Alphanumeric	Required (if DEG6 is utilized)	DEG6
	Chain Number	Identification number assigned to the entity allowing linkage for a business relationship, i.e., chain, buying groups or third party contracting organizations. Also may be known as Affiliation ID or Relation ID	Alphanumeric	Optional	DEG6
	Parent Organization ID	Headquarter address information for chains, buying groups or third party contracting organizations where multiple relationship entities exist and need to be linked to a common organization such as common ownership for several chains	Alphanumeric	Optional	DEG6
	Payment Center ID	The assigned payment center identifier associated with the provider/corporate entity	Alphanumeric	Optional	DEG6
<i>NCPDP Provider ID Number</i>		The NCPDP assigned unique identification number	Alphanumeric	Optional	DEG6
<i>Medicaid Provider Number</i>		A number issued to a provider by the U.S. Department of Health and Human Services through state health and human services agencies		Optional	DEG6

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Table: 4.2-1 CORE-required Maximum ERA Enrollment Data Set					
Individual Data Element Name⁸ (Term)	Sub-element Name (Term)	Data Element Description	Data Type and Format (Not all data elements require a format specification)	Data Element Requirement for Health Plan Collection (Required/Optional for plan to collect)	Data Element Group Number (DEG#)⁹
ELECTRONIC REMITTANCE ADVICE INFORMATION (Data Element Group 7 is a Required DEG)					
<i>Preference for Aggregation of Remittance Data (e.g., Account Number Linkage to Provider Identifier)</i>		Provider preference for grouping (bulking) claim payment remittance advice – must match preference for EFT payment		Required; select from below	DEG7
	Provider Tax Identification Number (TIN)		Numeric, 9 digits	Optional – required if NPI is not applicable	DEG7
	National Provider Identifier (NPI)		Numeric, 10 digits	Optional – required if TIN is not applicable	DEG7
<i>Method of Retrieval</i>		The method in which the provider will receive the ERA from the health plan (e.g., download from health plan website, clearinghouse, etc.)		Optional (Required if the provider is not using an intermediary clearinghouse or vendor)	DEG7
ELECTRONIC REMITTANCE ADVICE CLEARINGHOUSE INFORMATION (Data Element Group 8 is an Optional DEG)					
<i>Clearinghouse Name</i>		Official name of the provider’s clearinghouse	Alphanumeric	Required	DEG8
<i>Clearinghouse Contact Name</i>		Name of a contact in clearinghouse office for handling ERA issues	Alphanumeric	Optional	DEG8
	Telephone Number	Telephone number of contact	Numeric, 10 digits	Optional	DEG8
	Email Address	An electronic mail address at which the health plan might contact the provider’s clearinghouse		Optional	DEG8

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Table: 4.2-1 CORE-required Maximum ERA Enrollment Data Set					
Individual Data Element Name⁸ (Term)	Sub-element Name (Term)	Data Element Description	Data Type and Format (Not all data elements require a format specification)	Data Element Requirement for Health Plan Collection (Required/Optional for plan to collect)	Data Element Group Number (DEG#)⁹
ELECTRONIC REMITTANCE ADVISE VENDOR INFORMATION (Data Element Group 9 is an Optional DEG)					
<i>Vendor Name</i>		Official name of the provider's vendor	Alphanumeric	Required	DEG9
<i>Vendor Contact Name</i>		Name of a contact in vendor office for handling ERA issues	Alphanumeric	Optional	DEG9
	Telephone Number	Telephone number of contact	Numeric, 10 digits	Optional	DEG9
	Email Address	An electronic mail address at which the health plan might contact the provider's vendor		Optional	DEG9
SUBMISSION INFORMATION (Data Element Group 10 is a Required DEG)					
<i>Reason for Submission</i>				Required; select from below	DEG10
	New Enrollment			Optional	DEG10
	Change Enrollment			Optional	DEG10
	Cancel Enrollment			Optional	DEG10

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Table: 4.2-1 CORE-required Maximum ERA Enrollment Data Set					
Individual Data Element Name⁸ (Term)	Sub-element Name (Term)	Data Element Description	Data Type and Format (Not all data elements require a format specification)	Data Element Requirement for Health Plan Collection (Required/Optional for plan to collect)	Data Element Group Number (DEG#)⁹
SUBMISSION INFORMATION (Continued) (Data Element Group 10 is a Required DEG)					
<i>Authorized Signature</i>		The signature of an individual authorized by the provider or its agent to initiate, modify or terminate an enrollment. May be used with electronic and paper-based manual enrollment		Required; select from below	DEG10
	Electronic Signature of Person Submitting Enrollment			Optional	DEG10
	Written Signature of Person Submitting Enrollment	A (usually cursive) rendering of a name unique to a particular person used as confirmation of authorization and identity		Optional	DEG10
	Printed Name of Person Submitting Enrollment	The printed name of the person signing the form; may be used with electronic and paper-based manual enrollment		Optional	DEG10
	Printed Title of Person Submitting Enrollment	The printed title of the person signing the form; may be used with electronic and paper-based manual enrollment		Optional	DEG10
<i>Submission Date</i>		The date on which the enrollment is submitted	CCYYMMDD ²⁴	Optional	DEG10
<i>Requested ERA Effective Date</i>		Date the provider wishes to begin ERA; per Phase III CORE Health Care Claim Payment/Advice (835) Infrastructure Rule Version 3.0.0: there may be a dual delivery period depending on whether the entity has such an agreement with its trading partner	CCYYMMDD	Optional	DEG10

²⁴ ASC X12 Standards Version 005010 for X12 Data Element 373 Date used in the ASC X12 005010X221 Health Care Claim Payment/Advice Technical Report Type 3

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4.3 CORE Master Template for Collecting ERA Enrollment Data

4.3.1 Master Template for Manual Paper-Based Enrollment

The name of the health plan (or its agent or the vendor offering ERA) and the purpose of the form will be on the top of the form, e.g., Health Plan X: Electronic Remittance Advice (ERA) Authorization Agreement.

A health plan (or its agent or a vendor offering ERA) is required to use the format, flow and data set including data element descriptions in Table 4.2-1 as the CORE Master ERA Enrollment Submission form when using a manual paper-based enrollment method. All CORE-required ERA Enrollment data elements must appear on the paper form in the same order as they appear in Table 4.2-1.

A health plan (or its agent) cannot revise or modify:

- The name of a CORE Master ERA Enrollment Data Element Name
- The usage requirement of a CORE Master ERA Enrollment Data Element
- The Data Element Group number of a CORE Master ERA Enrollment Data Element

Beyond the data elements and their flow, a health plan (or its agent) must:

- Develop and make available to the healthcare provider (or its agent) specific written instructions and guidance for the healthcare provider (or its agent) when completing and submitting the enrollment form, including when using paper
- Provide a number to fax and/or a U.S. Postal Service or email address to send the completed form
- Include contact information for the health plan, specifically a telephone number and/or email address to send questions
- Include authorization language for the provider to read and consider
- Include a section in the form that outlines how the provider can access online instructions for how the provider can determine the status of the ERA enrollment
- Clearly label any appendix describing its purpose as it relates to the provider enrolling in ERA

4.3.2 Master Template for Electronic Enrollment

When electronically enrolling a healthcare provider in ERA, a health plan (or its agent) must use the CORE Master ERA Enrollment Data Element Name and Sub-element Name without revision or modification.

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>.

As noted below in §4.4, a health plan (or its agent or vendors offering ERA enrollment) will offer an electronic way for provider to complete and submit the ERA enrollment. A health plan may use a web-based method for its electronic approach to offering ERA enrollment. The design of the website is restricted by this rule only to the extent that the flow, format and data set including data element descriptions established by this rule must be followed.

4.4 CORE Electronic Safe Harbor for ERA Enrollment to Occur Electronically

This rule provides an ERA enrollment “Electronic Safe Harbor” by which health plans, healthcare providers, their respective agents, application vendors and intermediaries can be assured will be supported by any trading partner. This ERA Enrollment Data Rule specifies that all health plans and their respective agents *must implement and*

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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. As an ERA enrollment “Safe Harbor,” this rule:

- **DOES NOT** require health plans or their agents to discontinue using existing manual and/or paper-based methods and processes to collect the CORE-required Maximum ERA Enrollment Data Set.
- **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.
- **DOES NOT** require an entity to do business with any trading partner or other entity.

CORE expects that in some circumstances, health plans or their agents may agree to use non-electronic methods and mechanisms to achieve the goal of the collection of ERA enrollment data – and that provider trading partners will respond to using this method should they choose to do so.

However, the electronic ERA enrollment “Safe Harbor” mechanism offered by a health plan and its agent **MUST** be used by the health plan or its agent if requested by a trading partner or its agent. The electronic ERA enrollment “Safe Harbor” mechanism is not limited to single entity enrollments and may include a batch of enrollments. If the health plan or its agent does not believe that this CORE ERA Enrollment Safe Harbor is the best mechanism for that particular trading partner or its agent, it may work with its trading partner to implement a different, mutually agreeable collection method. However, if the trading partner insists on conducting ERA Enrollment electronically, the health plan or its agent must accommodate that request. This clarification is not intended in any way to modify entities’ obligations to exchange electronic transactions as specified by HIPAA or other Federal and state regulations.

4.5 Time Frame for Rule Compliance²⁵

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.²⁶ Should such paper forms be available at provider’s offices or other locations, it is expected that such paper-based forms will be replaced.

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.

It will be expected that all electronic ERA enrollment will meet this rule requirement as of the compliance date, and that the health plan (or its agent) will inform its providers that an electronic option is now available, if not previously available.

5 Conformance Requirements

Separate from any HHS certification/compliance program to demonstrate conformance as mandated under ACA Section 1104, CAQH CORE offers voluntary CORE Certification for all Phases of the CAQH CORE Operating Rules. CORE Certification is completely optional. Pursuing voluntary CORE Certification offers an entity a

²⁵ Some health plans have expressed concern regarding the timeframe for effective date of EFT and ERA operating rules as specified in ACA Section 1104, i.e., not later than January 1, 2014, as being too restrictive, given the myriad other regulatory mandates currently being confronted by the industry.

²⁶ The rule recognizes that some public/Federal entities have review and approval processes that are unique and may require significant planning time and resources to meet the rule requirements.

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mechanism to test its ability to exchange EFT and ERA transaction data with its trading partners. A CORE-certified Seal is awarded to an entity or vendor product that voluntarily completes CORE certification testing with a CAQH CORE-authorized testing vendor. Key benefits of voluntary CORE Certification include:

- Demonstrates to the industry adoption of the Phase III CORE EFT & ERA Operating Rules via a recognized industry “Seal”
- Encourages trading partners to work together on transaction data content, infrastructure and connectivity needs
- Reduces the work necessary for successful trading partner testing as a result of independent testing of the operating rules implementation
- Promotes maximum ROI when all stakeholders in the information exchange are known to conform to the CORE Operating Rules

For more information on achieving voluntary CORE Certification for the CAQH CORE EFT & ERA Operating Rules, refer to the Phase III CORE EFT & ERA Operating Rules Voluntary Certification Master Test Suite Version 3.0.0 or contact CORE@caqh.org.