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**CAQH**<sup>®</sup>

**Committee on Operating Rules  
For Information Exchange  
(CORE<sup>®</sup>)**

*CAQH CORE Phase III EFT & ERA Operating Rules  
Overview*

# Mandated EFT & ERA Operating Rules:

## *January 2014 Compliance Deadline*

- Status: The second set of operating rules has been adopted into Federal regulation
  - August 2012, CMS published [CMS-0028-IFC](#) with the following features:
    - Adopted Phase III CAQH CORE Operating Rules for the Electronic funds transfer (EFT) and Health care payment and remittance advice (ERA) transactions except for rule requirements pertaining to Acknowledgements.<sup>\*</sup> Covered entities must be in compliance by January 1, 2014
  - The interim final rule comment period will remain open for 60 days (10/9/2012)
    - CAQH CORE will distribute a model letter in coming weeks for use by entities as they see appropriate
- Background:
  - Spring 2011 - NCVHS recommended:
    - NACHA as healthcare EFT SDO and ACH CCD+ as healthcare EFT standard
    - CAQH CORE, in collaboration with NACHA, as author for EFT and ERA operating rules (pharmacy to be addressed as appropriate)
  - Winter 2011:
    - NCVHS issued letter recommending HHS adopt Draft CAQH CORE EFT & ERA Rule Set
  - Summer 2012:
    - CMS announces the Interim Final Rule ([CMS-0024-IFC](#)) adopting healthcare EFT standards is a final rule that is in effect now (These Standards influence Operating Rules)

<sup>\*</sup>Only CORE Participating entities that create, transmit or use the transactions (thus implement the rules) may vote in Final CORE Membership Vote

# CAQH CORE EFT & ERA Operating Rules: *Overview*

Rule Type	Rule #	Rule Name	High-Level Requirements	Slides
Data Content	360	<b><i>Uniform Use of CARCs and RARCs (835) Rule</i></b>	<ul style="list-style-type: none"> <li>Identifies a <i>minimum</i> set of four CAQH CORE-defined Business Scenarios with a <i>maximum</i> set of CAQH CORE-required code combinations that can be applied to convey details of the claim denial or payment to the provider</li> </ul>	4-5
Infrastructure	350	<b><i>Health Care Claim Payment/Advice (835) Infrastructure Rule</i></b>	<ul style="list-style-type: none"> <li>Specifies use of the CAQH CORE Master Companion Guide Template for the flow and format of such guides</li> <li>Requires entities to support the Phase II CAQH CORE Connectivity Rule</li> <li>Includes batch Acknowledgement requirements</li> <li>Defines a dual-delivery (paper/electronic) to facilitate provider transition to electronic remits</li> </ul>	6-7
	370	<b><i>EFT &amp; ERA Reassociation (CCD+/835) Rule</i></b>	<ul style="list-style-type: none"> <li>Addresses provider receipt of the CAQH CORE-required Minimum ACH CCD+ Data Elements required for reassociation</li> <li>Addresses elapsed time between the sending of the v5010 835 and the CCD+ transactions</li> <li>Requirements for resolving late/missing EFT and ERA transactions</li> <li>Recognition of the role of <i>NACHA Operating Rules</i> for financial institutions</li> </ul>	8-9
	380	<b><i>EFT Enrollment Data Rule</i></b>	<ul style="list-style-type: none"> <li>Identifies a maximum set of standard data elements for EFT enrollment</li> <li>Outlines a straw man template for paper and electronic collection of the data elements</li> <li>Requires health plan to offer electronic EFT enrollment</li> </ul>	10-11
	382	<b><i>ERA Enrollment Data Rule</i></b>	<ul style="list-style-type: none"> <li>Similar to EFT Enrollment Data Rule</li> </ul>	12-13

Complete CAQH CORE EFT & ERA Operating Rules Set available [HERE](#).



# CAQH CORE 360: Uniform Use of CARCs and RARCs (835) Rule - *Problem Addressed & Key Impact*

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

# CAQH CORE 360: Uniform Use of CARCs and RARCs (835) Rule - *Scope & High-level Rule Requirements*

- Scope of the rule:
  - Applies to entities that use, conduct or process the v5010 835 transaction
- High-level rule requirements:
  - Identifies minimum set of four CORE-defined Business Scenarios with maximum set of code combinations to convey claim denial/adjustment details (codes in separate document):

CORE-defined Business Scenario	Total CORE-required Code Combinations
<b>Scenario #1:</b> Additional Information Required – Missing/Invalid/Incomplete Documentation	Includes approximately 160 code combinations
<b>Scenario #2:</b> Additional Information Required – Missing/Invalid/Incomplete Data from Submitted Claim	Includes approximately 300 code combinations
<b>Scenario #3:</b> Billed Service Not Covered by Health Plan	Includes approximately 375 code combinations
<b>Scenario #4:</b> Benefit for Billed Service Not Separately Payable	Includes approximately 35 code combinations

- Establishes QI maintenance process to review and update CORE-required Code Combinations
- Enables health plans and PBM agents to:
  - Use new/adjusted codes with CORE-defined Business Scenarios prior to QI review
  - Develop additional, non-conflicting business scenarios when CORE-defined Business Scenario do not meet business needs
- Identifies applicable CORE-defined Business Scenarios for retail pharmacy

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# CAQH CORE 350: Health Care Claim Payment/Advice (835) Infrastructure Rule - *Problem Addressed & Key Impact*

- Problem addressed by the rule:
  - HIPAA provides a foundation for the electronic exchange of claim payment information, but does not provide infrastructure to promote the move from today's paper-based system to an electronic, interoperable system
- Key impact:
  - Enables providers, health plans and intermediaries to extend and leverage investment in connectivity infrastructure by requiring support of Phase II CORE Connectivity Rule version 2.2.0
  - Continues to build on Phase I/II use of CORE Master Companion Guide Template so that providers can quickly find details necessary for the exchange of the v5010 X12 835
  - Reduces probability that providers will discontinue receipt of v5010 835 due to system issues for effective use of remittance advice data to post to patient account

# CAQH CORE 350: Health Care Claim Payment/Advice (835) Infrastructure Rule - *Scope & High-Level Rule Requirements*

- Scope of the rule:
  - Applies to entities that use, conduct or process the v5010 X12 835 transaction
- High-level rule requirements:
  - Specifies use of the CORE Master Companion Guide Template for flow and format of such guides
  - Requires entities to support Phase II CORE Connectivity Rule
  - Includes batch acknowledgement requirements
    - Requirements place parallel responsibilities on both senders and receivers of the v5010 X12 835 for sending and accepting v5010 999 Acknowledgements to assure transactions are accurately received and facilitate health plan correction of errors in outbound transactions
  - Addresses health plans' dual delivery of the v5010 835 and proprietary remittance advices
    - Addresses the need of providers to continue to receive proprietary remittance advice and the v5010 X 12 835 concurrently so that the provider can effectively migrate to the v5010 X12 835 alone (31 days/ 3 payment cycles)
  - Rule explicitly states the above rule requirements do not apply to retail pharmacy; rule references the NCPDP Connectivity Rule Version 1.0 which is aligned with the CORE Connectivity Rule for use with retail pharmacy

# CAQH CORE 370: EFT & ERA Reassociation (CCD+/835) Rule - *Problem Addressed & Key Impact*

- Problem addressed by the rule:
  - Challenges with provider reassociation of *remittance* data to *payment* data because necessary data provider requires are incorrect, missing, not available, or have not been requested on the two transactions in a way that is meaningful to the provider or its financial institution
- Key impact of rule:
  - Coordinates health care and financial services industry
    - When receipt of payment occurs with minimal elapsed time between receipt of remittance advice, providers can more quickly match payments with data and post to patient accounts on a more timely basis
  - Provides assurance that trace numbers between payments and remittance can be used by providers
  - Reduces level of open accounts receivable by enabling provider to generate cross-over claims to other payers and to collect payment from patient
  - Enables provider to more quickly address denials or appeal adjustments to claim amount

# CAQH CORE 370: EFT & ERA Reassociation (CCD+/835) Rule - *Scope & High-Level Rule Requirements*

- Scope of the rule:
  - Applies to entities that use, conduct or process v5010 835 and CCD+ transactions
- High-level rule requirements:
  - Addresses provider receipt of *CORE-required Minimum ACH CCD+ Data Elements* (e.g., Effective Entry Date, Amount, Payment Related Information) required by providers for successful reassociation
  - Addresses elapsed time between sending of v5010 835 and CCD+ transactions
    - Medical: Health plan must release for transmission to provider the v5010 835 corresponding to the CCD+ no sooner than three business days prior to CCD+ Effective Entry Date and no later than three business days after CCD+ Effective Entry Date
    - Retail pharmacy: Health plan may release for transmission v5010 835 any time prior to the CCD+ Effective Entry Date of corresponding EFT and no later than three days after CCD+ Effective Entry Date
  - Outlines requirements for resolving late/missing EFT and ERA transactions
  - Recognizes the role of *NACHA Operating Rules* for financial institutions and potential changes to the *NACHA Operating Rules*

# CAQH CORE 380: EFT Enrollment Data Rule

## *Problem Addressed & Key Impact*

- Problem addressed by the rule:
  - Separate, non-standard provider EFT enrollment required by health plans; key elements excluded from many enrollment forms include those:
    - With a strong business need to streamline the collection of data elements (e.g., TIN vs. NPI provider preference for payment)
    - Essential for populating the ACH CCD+ Standard and the ASC X12 v5010 835
- Key impact:
  - Simplifies provider EFT enrollment by having health plans collect the same consistent data from all providers – mitigates hassle factor for providers when enrolling in EFT with multiple health plans and addresses existing issue that many elements needed for EDI aren't collected, e.g., requires health plans to support electronic collection of data (paper can continue)
  - Addresses situations where providers outsource financial functions
  - Enables health plans to collect standardized data for complex organizational structures and relationships, e.g., retail pharmacy chains

# CAQH CORE 380: EFT Enrollment Data Rule

## *Scope & High-Level Rule Requirements*

- Scope of the rule:
  - Applies to entities that enroll providers in EFT
  - Outlines what is out of scope for the rule, e.g., the collection of data for other business purposes and how health plans may use or populate the enrollment data
- High-level rule requirements:
  - Identifies a maximum set of approximately 70 standard data elements for enrollment; with related data elements grouped into 8 Data Element Groups (DEGs)
    - Includes a DEG specific to retail pharmacy information
  - Outlines a strawman template for paper and electronic collection of the data elements
  - Should a health plan decide to have a combined EFT/ERA form or other combined enrollment form, the CORE required data elements for EFT enrollment, including terminology, must be included in the combined form
  - Requires health plan to offer electronic EFT enrollment
    - A specific electronic method is not required
  - Identifies that a process will be used to review the maximum data element set on an annual or semi-annual basis to meet emerging or new industry needs

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# CAQH CORE 382: ERA Enrollment Data Rule

## *Problem Addressed & Key Impact*

- Problem addressed by the rule:
  - Separate, non-standard provider ERA enrollment required by health plans; key elements excluded from many enrollment forms include those:
    - With a strong business need to streamline the collection of data elements (e.g., preference for aggregation of remittance data – TIN vs. NPI)
    - Essential for populating the ACH CCD+ Standard and the ASC X12 v5010 835
- Key impact:
  - Simplifies provider ERA enrollment by having health plans and their agents to collect the same consistent data from all providers – mitigates hassle factor for providers when enrolling in ERA with multiple health plans and addresses existing issue that many elements needed for EDI aren't collected, e.g., requires health plans to support electronic collection of data (paper can continue)
  - Addresses situations where providers outsource financial functions
  - Enables health plans and their agents to collect standardized data for complex organizational structures and relationships, e.g., retail pharmacy chains

# CAQH CORE 382: ERA Enrollment Data Rule

## *Scope & High-Level Rule Requirements*

- Scope of the rule:
  - Applies to entities that enroll providers in ERA
  - Outlines what is out of scope for the rule, e.g., the collection of data for other business purposes and how health plans may use or populate the enrollment data
- High-level rule requirements:
  - Identifies a maximum set of approximately 65 standard data elements for enrollment; with related data elements grouped into 10 Data Element Groups (DEGs)
    - Includes a DEG specific to retail pharmacy information
  - Outlines a strawman template for paper and electronic collection of the data elements
  - Should a health plan decide to have a combined EFT/ERA form or other combined enrollment form, the CORE required data elements for ERA enrollment, including terminology, must be included in the combined form
  - Requires health plan to offer electronic ERA enrollment
    - A specific electronic method is not required
  - Identifies that a process will be used to review the maximum data element set on an annual or semi-annual basis to meet emerging or new industry needs