CAQH CORE

Phase III Operating Rules: Streamlining Claims Payment Reconciliation

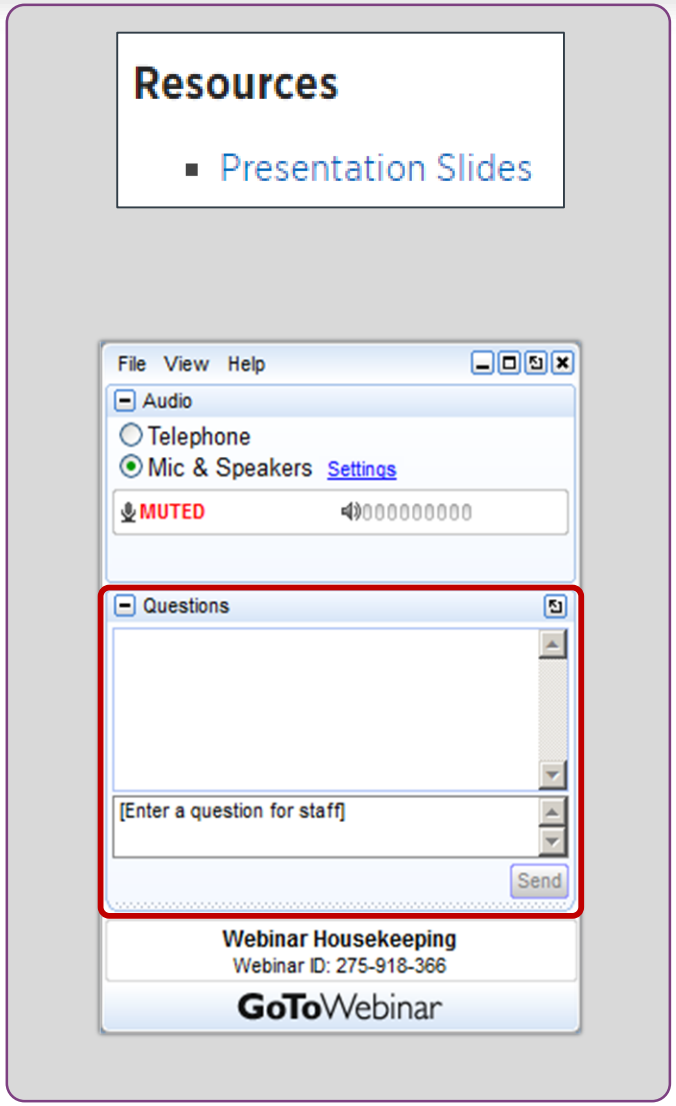
August 8, 2019

2:00 – 3:00 PM ET

Logistics

Presentation Slides and How to Participate in Today's Session

- **You can download the presentation slides at www.caqh.org/core/events after the webinar.**
- Click on the listing for today's event, then scroll to the bottom to find the Resources section for a PDF version of the presentation slides.
- A copy of the slides and the webinar recording will be emailed to all attendees and registrants in the next 1-2 business days.
- Questions can be submitted ***at any time*** using the **Questions panel on the GoToWebinar dashboard.**



Session Outline

- Operationalizing the Phase III CAQH CORE EFT & ERA Operating Rules
- CORE Code Combinations Maintenance Process
- 2019 Market-based Adjustments Survey
- Q & A

Thank You to Our Speakers

Lynn Franco
Business Process Manager
UnitedHealthcare

Robert Bowman
Director
CAQH CORE

Helina Gebremariam
Manager
CAQH CORE

Operationalizing the Phase III CAQH CORE EFT & ERA Operating Rules

Robert Bowman
CAQH CORE Director

CAQH CORE Mission/Vision & Industry Role

Industry-led, CAQH CORE Participants include healthcare providers, health plans, vendors, government entities, associations and standard-setting organizations. Health plans participating in CAQH CORE represent **75 percent of the insured US population.**

MISSION Drive the creation and adoption of healthcare operating rules that **support standards**, **accelerate interoperability and align administrative and clinical activities** among providers, payers and consumers.

VISION An **industry-wide facilitator** of a trusted, simple and sustainable healthcare data exchange that evolves and aligns with market needs.

DESIGNATION CAQH CORE is the **national operating rule author to improve the efficiency, accuracy and effectiveness of industry-driven business transactions.** The Department of Health and Human Services (HHS) designated CAQH CORE as the author of national operating rules for the HIPAA-covered administrative transactions.

INDUSTRY ROLE **Develop business rules to help industry** effectively and efficiently use electronic standards while remaining technology- and standard-agnostic.

CAQH CORE BOARD **Multi-stakeholder.** Members include health plans, providers (some of which are appointed by associations such as the AHA, AMA, MGMA), vendors, and government entities. Advisors to the Board include SDOs (X12, HL7, NACHA, NCPDP) and WEDI.

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What are Operating Rules?

Operating Rules are the necessary business rules and guidelines for the electronic exchange of information that are not defined by a standard or its implementation specifications as adopted.

Operating Rules	Phase I	Phase II	Phase III	Phase IV	Phase V	Phase VI
Transactions	Eligibility	Eligibility Claims Status	Electronic Funds Transfer (EFT) Electronic Remittance Advice (ERA)	Health Claims Referral, Certification and Authorization Enrollment Premium Payments	Prior Authorization	Attachments
	Active					***In Progress***

CAQH CORE is also evaluating opportunities to build on existing rules to support Value-Based Payment.

Industry Use Case	Standard	Operating Rule
Healthcare	Providers and health plans must use the ASC X12 v5010 270/271 Eligibility Request and Response transaction to exchange patient eligibility information.	When using the eligibility transaction, health plans must return patient financial information including copay and deductible in real-time.
Finance	Financial organizations must use ASC X9 standards in all ATM transactions with their clientele, standardizing layout, data content and messaging.	Financial organizations must use NACHA, the Electronic Payments Association, and the Federal Reserve operating rules for every automated clearinghouse (ACH) Transaction which allows consumers to use any debit card in any ATM around the world regardless of bank affiliation.

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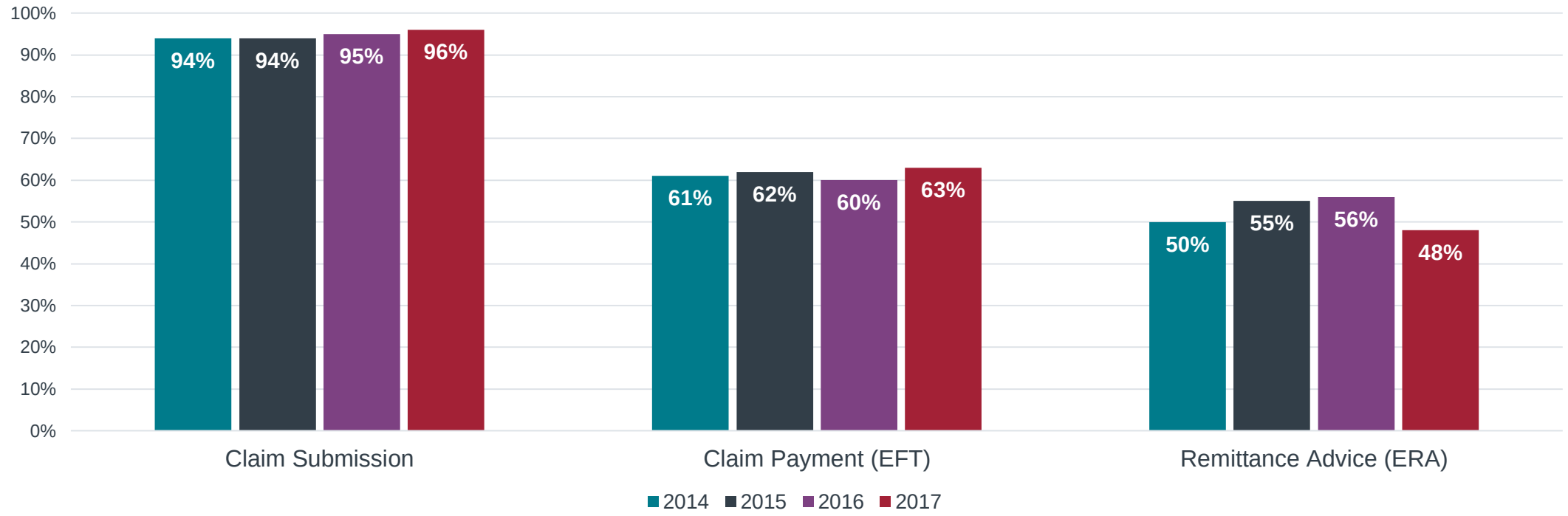
2018 CAQH Index Report

Medical Industry Electronic Transaction Adoption

While claims submissions continue to be the most widely adopted electronic transaction, use of electronic claim payment, also referred to as electronic funds transfer (EFT), and electronic remittance advice has lagged. The EFT and ERA work in tandem to enable automated reconciliation and communication of reimbursement. An ERA is an electronic explanation of payments made to the provider by the health plan.



Numerous factors, including gaps in communication and misconceptions, contribute to slow adoption of these transactions. The CAQH CORE Phase III Operating Rules address some of these common challenges to encourage increased industry adoption.

Source: 2018 CAQH Index

CAQH CORE EFT & ERA Operating Rule Requirements

EFT & ERA Operating Rules

Phase III CAQH CORE Operating Rules for the EFT and ERA transactions are federally mandated, except for rule requirements pertaining to Acknowledgements.

INFRASTRUCTURE			DATA CONTENT
Health Care Claim Payment/Advice (835) Infrastructure Rule ▪ Includes CAQH CORE Master Companion Guide. ▪ Requires CAQH CORE Connectivity Rule. ▪ Details batch acknowledgement requirements.	**EFT/ERA Reassociation (CCD+/835) Rule** ▪ Addresses provider receipt of the CAQH CORE-required minimum ACH CCD+ Data Elements required for re-association as well as elapsed time between sending and receipt. ▪ Determines requirements for resolving late/missing EFT/ERA transactions.	**EFT & ERA Enrollment Data Rules** ▪ Identifies a maximum set of standard data elements for EFT enrollment. ▪ Requires health plan to offer electronic EFT enrollment. ▪ Requires providers to specify how payments should be made.	**Uniform Use of CARCs & RARCs (835) Rule** ▪ Identifies four CAQH CORE-defined Business Scenarios with a set of required code combinations that convey details of the claim denial or payment to the provider.

Benefits of the Phase III CAQH CORE EFT & ERA Operating Rules

Key Benefits

- Improves cash flow via expedited payment and remittance reconciliation through the receipt of electronic payments and remittances.

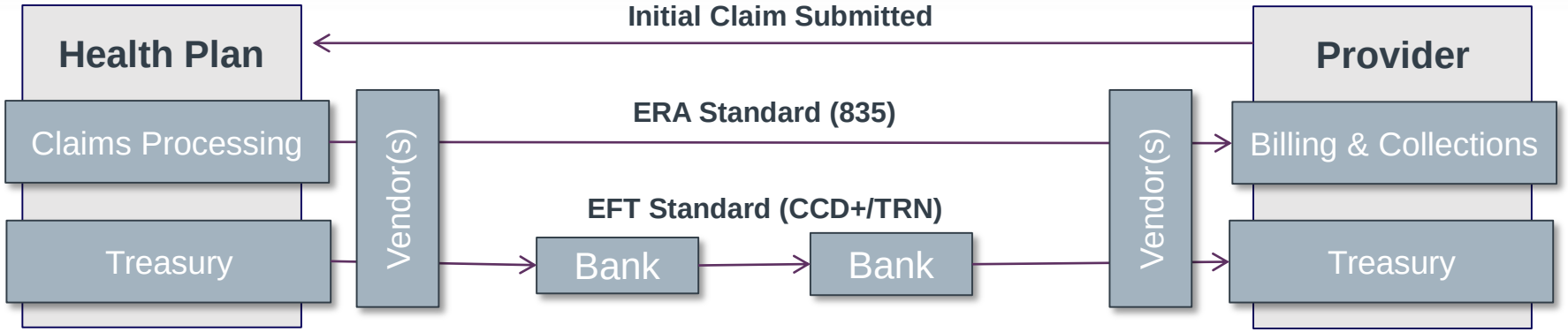
- Eliminates the need for manual re-keying of reconciliations of EFTs and ERAs by requiring a trace number that links the two transactions.
- Increases ability to conduct targeted payment issue follow-ups through uniform and maintained ERA codes (CARCs, RARCs, and CAGCs).

- Standardizes enrollment for EFT/ERA so providers can sign up for both EFT and ERA electronically.
- Automates re-association of EFT and ERA leading to efficiencies and reduced errors.

- Saves an estimated $300 million and $3.3 billion per year* for providers—including hospitals and health systems—and health plans.

* Administrative Simplification: Adoption of Operating Rules for Eligibility for a Health Plan and Health Care Claim Status Transactions

CAQH CORE Resources to Support Providers Implementing EFT & ERA



Provider Action	Steps	Resources
Determine if you are conducting the applicable electronic transactions.	If you conduct the X12 v5010 835 and ACH CCD+, these transactions must comply with the CAQH CORE Operating Rules. Assess organizational readiness/compliance and identify all systems and vendors that touch the X12 v5010 835 and EFT Standard transactions.	Use CAQH CORE Analysis and Planning Guide.
Understand health plan agreements and options for payment and remittance information.	Request healthcare EFT payments from your payers, both public and private.	Use the Sample Provider EFT Request Letter.
Contact financial institution.	Request delivery of the EFT and payment-related information including the reassociation trace numbers.	Use the CAQH CORE Sample Provider EFT Reassociation Data Request Letter to help facilitate this request.
Assess vendor conformance.	Ensure vendor has updated its systems to align with the CAQH CORE Operating Rules.	Encourage your vendor (and Health Plan) to become CAQH CORE Certified.

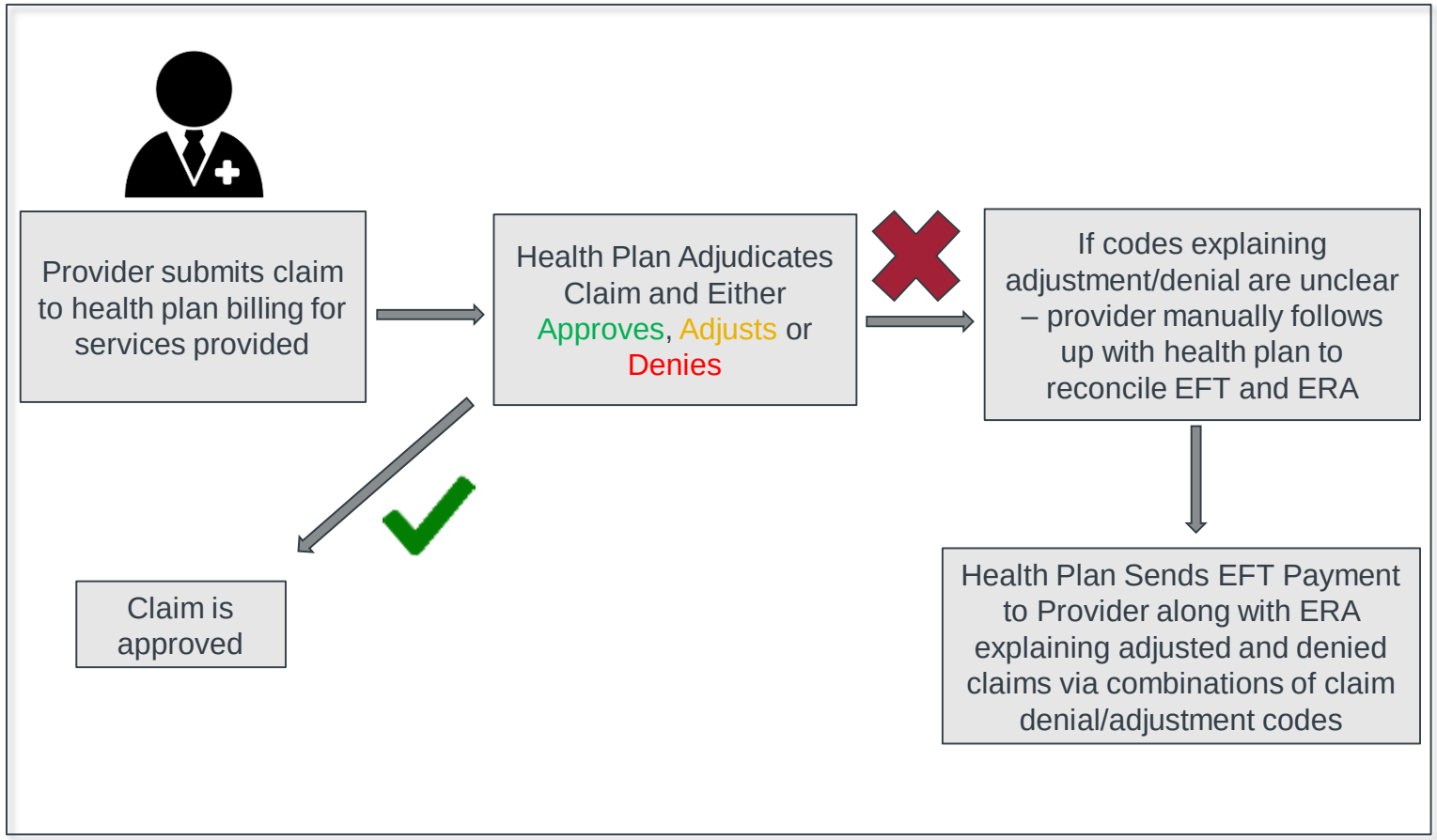
Overview of the CORE Code Combinations Maintenance Process

Lynn Franco
Business Process Manager
UnitedHealthcare

Electronic Remittance Advice

Explaining Claim Adjustments & Denials

The ERA 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 using combinations of claim denial/adjustment code sets that, when used in combination, should supply the provider with necessary detail regarding the payment of the claim.



Pain Points

There was extensive confusion throughout the healthcare industry regarding the use of the claim denial/adjustment codes including:

- Unnecessary manual provider follow-up, faulty electronic secondary billing.
- Inappropriate write-offs of billable charge.
- Incorrect billing of patients for co-pays/ deductibles and posting delays.

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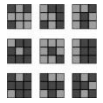
CAQH CORE Code Combinations Maintenance

Why Was This Needed?

There was extensive confusion throughout the healthcare industry regarding the use of these codes.

Providers did not receive the same uniform and consistent CARC/RARC/CAGC combinations from all health plans requiring manual intervention.



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

Decisions on the CARC and/or RARC used to explain a claim payment business scenario were left to the health plans, lending a high level of subjectivity and interpretation to the process.

Codes are updated three times a year, so many plans and providers were not using the most current codes and continued to use deactivated codes.

The healthcare industry worked in partnership to establish requirements for the consistent and uniform use of these codes.

CARCs & RARCs

Need for CORE Code Combinations Maintenance

CAQH CORE is responsible for maintaining the **CORE Code Combinations** via the Code Combinations Maintenance Process.

CARC

Claim Adjustment Reason Codes

Provides the reasons for positive/ negative financial adjustment to a claim.

This list is maintained by ASC X12 and updated three times per year.

RARC

Remittance Advice Remark Codes

Provides supplemental information about why a claim or service line is not paid in full.

This list is maintained by CMS and updated three times per year.

CAGC

Claim Adjustment Group Codes

Categorizes the associated CARC based on financial liability.

This list is maintained by ASC X12 and updated when base standard is updated.

The CAQH CORE 360: Uniform Use of CARCs & RARCs (835) Rule includes a maximum set of code combinations to be used for high-volume Business Scenarios.

- Created four CORE-defined Business Scenarios which represent some of the most confusing and high-volume scenarios that are exchanged between health plans and providers.
- Defined maximum set of CORE-required Code Combinations for the four CORE-defined Business Scenarios based on extensive data.
- Established maintenance process which requires the list of CORE-required Code Combinations to be revisited at least three times annually.

CORE Business Scenario 1

Additional Information Required – Missing/Invalid/ Incomplete Documentation

376 code combos

CORE Business Scenario 2

Additional Information Required – Missing/Invalid/ Incomplete Data from Submitted Claim

413 code combos

CORE Business Scenario 3

Billed Service Not Covered by Health Plan

910 code combos

CORE Business Scenario 4

Benefit for Billed Service Not Separately Payable

66 code combos

How CORE Code Combinations Benefit Providers

Denial Management is Expensive and Time Consuming

Denial rates ranged from 1% to 40% across ACA Marketplace plans.

(AAFP, 2019)

Average cost is $25.00 and 71 minutes per denial.

(MGMA, 2018)

While two out of three denials are recoverable, providers spend roughly $118 per claim on appeals.

(Becker's Hospital Review, 2017)

Key Benefits of CORE Code Combinations

Standardized use of CARCs/RARCs/CAGCs

Providers are able to receive the same CARC and RARC combinations electronically with all health plans.

Potential reduction in manual claim rework

With health plans more consistently using denial and adjustments codes per the CORE-defined Business Scenarios, providers have less rework.

Reduction in A/R days

Automated and timely re-association of EFT and ERA lead to efficiencies and reduced errors for payment posting.

CORE Code Combinations Maintenance

Code Combinations Task Group

Compliance-based Reviews

Occurs 3x per year.

Include only adjustments to align updates to published code lists.

Most Recent Publication: CORE Code Combinations *v3.5.3* in June 2019.

Market-based Reviews

Occurs every other year.

Consider only adjustments to address evolving industry business needs. HIPAA-covered entities submit potential adjustments for Task Group consideration.

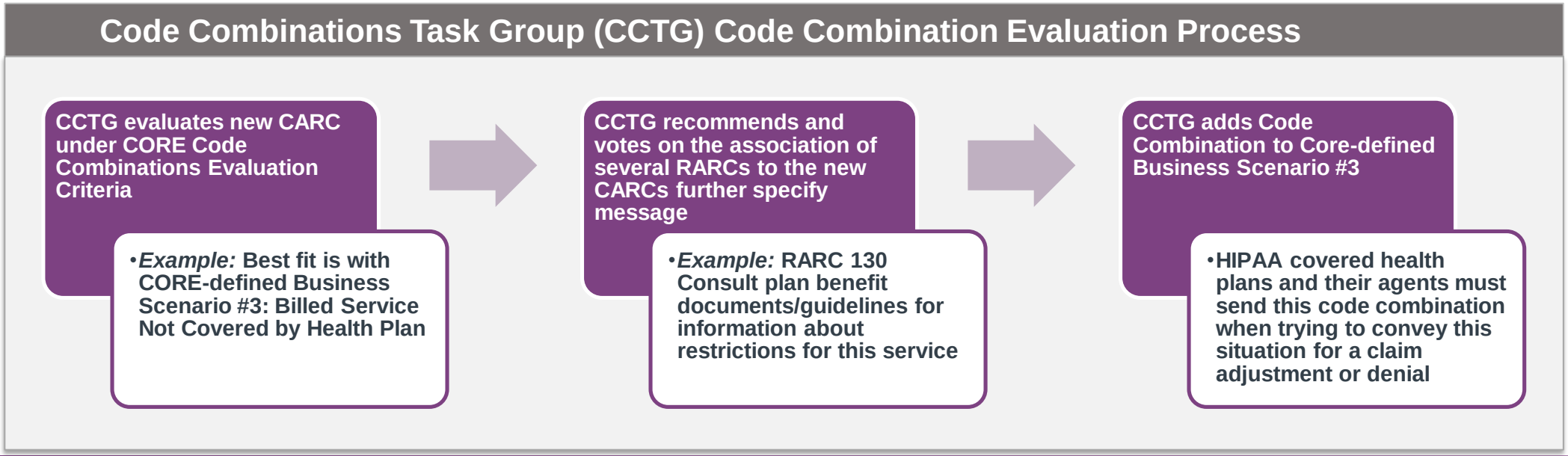
The **CAQH CORE Code Combinations Task Group**, responsible for maintaining the CORE-required Code Combinations, is open to representatives from any CORE Participating Organization. Individuals with knowledge of the related business process and work flow of the usage of the CARCs and RARCs are encouraged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

CORE Code Combinations Maintenance in Action

- In the updated code lists published March 1st 2019, X12 approved the creation of two new CARCs requested by stakeholders:

297	Claim received by the medical plan, but benefits not available under this plan. Submit these services to the patient's vision plan for further consideration.
298	Claim received by the medical plan, but benefits not available under this plan. Claim has been forwarded to the patient's vision plan for further consideration.

- These new CARCs clarify next steps for providers when benefits are unavailable under a new plan – whether providers should wait for a response or should they take action.



Polling Question #1

Do you feel the four current Business Scenarios meet industry needs or should CAQH CORE pursue additional?

1. Existing Business Scenarios are sufficient.
2. Need new Business Scenario – member-submitted claims.
3. Need new Business Scenario – dental-specific.
4. Need new Business Scenario – worker's compensation-specific.
5. Other (specify in Questions panel).

CORE Business Scenario 1

Additional Information Required – Missing/Invalid/ Incomplete Documentation

CORE Business Scenario 2

Additional Information Required – Missing/Invalid/ Incomplete Data from Submitted Claim

CORE Business Scenario 3

Billed Service Not Covered by Health Plan

CORE Business Scenario 4

Benefit for Billed Service Not Separately Payable

2019 Market-based Adjustments Survey Overview

Helina Gebremariam
CAQH CORE Manager

Ensuring the *CORE Code Combinations* Work for You

2019 Market-based Adjustments Survey

- **What Is It?**
  - Industry's annual opportunity to ensure the CORE Code Combinations are meeting business needs.
- **Who Can Respond?**
  - Open to all entities that create, use or transmit HIPAA-covered transactions, plus all CORE Participants.
- **What Does the Survey Ask?**
  - Survey seeks input on the CORE Code Combinations within the four CORE-defined Business Scenarios.
  - Potential code combination adjustments that can be submitted include additions, removals or relocations.
  - Enhance your submission with supporting evaluation criteria, a strong business case and real-world usage data.*
- **When Can I Submit?**
  - Submission period will open on Monday, August 19, 2019 and will close **5 PM ET on Friday, October 11, 2019.**
- **Great! How Can I Get Started?**
  - Review the sample Market-based Adjustments Survey to help you plan your submission.
  - Complete the Market-based Adjustments Survey beginning August 19, 2019 HERE.

*Submission of real-world usage is discretionary.

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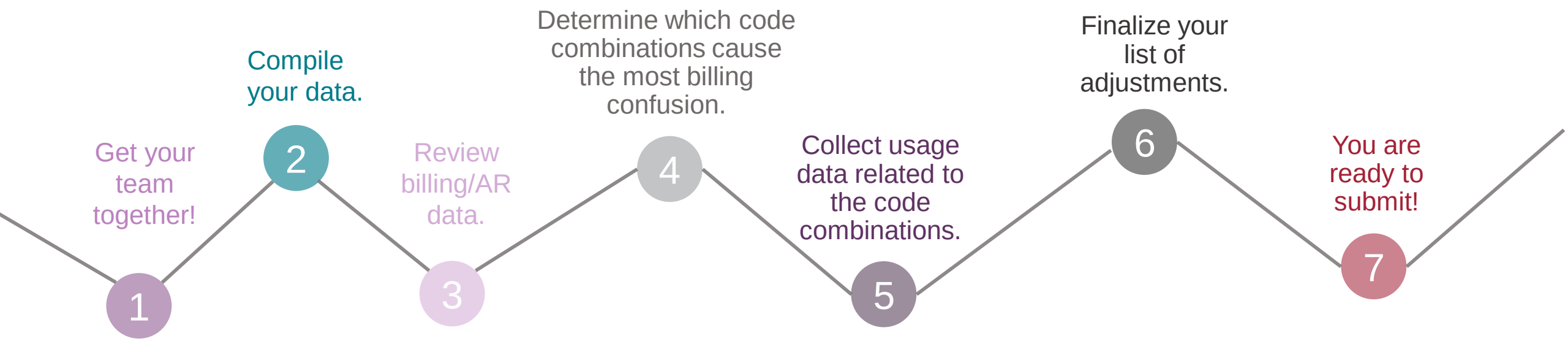
2019 Market-based Adjustments Survey

Process to Prepare and Submit Your Response

Take steps <u>now</u> to submit your survey response by October 11th !



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CAQH CORE 2019 Market-based Adjustment Survey

CAQH CORE 2019 Market-based Adjustments Form

Part I. General Overview & Submitter Information

Section I: Background, Scope, Format and Instructions

The goal of the CAQH CORE 360: Uniform Use of CARCs and RARCs (835) Rule is to ensure consistent use of the Claim Adjustment Reason Codes (CARCs), Remittance Advice Remark Codes (RARCs) and the Claim Adjustment Group Codes (CAGCs) across the industry. To meet this goal, the CAQH CORE 360 Rule specifies a minimum set of CORE-defined Business Scenarios with an applicable maximum set of CORE-required CARC, RARC, CAGC, and NCPDP Reject Code Combinations. As of 01/01/2014, all HIPAA covered entities must comply with the ACA-mandated CAQH CORE EFT & ERA Operating Rules when using the HIPAA-mandated EFT and ERA transaction standards. This set of CORE Code Combinations must be maintained to align with the current published CARC and RARC lists that are maintained by the respective Code Committees via the CAQH CORE Code Combinations Maintenance Process.

Per the CAQH CORE Code Combinations Maintenance Process, the CAQH CORE Code Combinations Task Group (CCTG) conducts two types of review and adjustment to the *CORE Code Combinations*: Compliance-based Reviews and Market-based Reviews. Market-based Reviews occur once a year and for 2017 will consider industry submissions addressing additions, removals, and relocations to the *existing CORE Code Combinations* in *existing* CORE-defined Business Scenarios.

The CCTG will review and update the *CORE Code Combinations* based on a review of the submissions. Individuals from any CAQH CORE Participating Organization, particularly those with knowledge of the business process of the usage of CARCs and RARCs, are encouraged to join the CCTG by emailing core@caqh.org. Any entity can join CAQH CORE.

Scope of 2019 Market-based Review

The 2019 Market-based Review will consider adjustments to CORE Code Combinations in the existing four CORE-defined Business Scenarios only.[1] The purpose of this 2019 Market-based Adjustments Form is to enable entities to submit requests for additions, removals, and relocations to the code combinations in the existing CORE-defined Business Scenarios.As shown in Table 1 below, potential code combination adjustments for the existing CORE-defined Business Scenarios may include:

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

Table 1: Potential Code Combination Adjustments To Existing CORE-defined Business Scenarios

Additions	Removals	Relocations
1. Add CARC and RARC	1. Remove CARC and all associated RARCs	1. Remove CARC and all associated RARCs from an *existing* CORE-defined Business Scenario and add to another *existing* CORE-defined Business Scenario with associated CAGC(s)

CAQH CORE 2019 Market-based Adjustments Form

Part II. Adjustments to *Existing* CORE-defined Business Scenarios

Section 1. Type of Adjustment

1. Please select the type of adjustment you would like to perform.

- (●) Addition
- ( ) Removal
- ( ) Relocation

*__NOTE:__ Per the CORE Code Combinations Task Group Criteria, all appropriate CAGCs will be included should the Task Group approve the code combination for addition. For requests to add a CAGC to an existing CARC or CARC/RARC combination, respondents should ensure that the submitted CAGC(s) align with the CORE Code Combinations Task Group Evaluation Criteria. If needed, submissions may be adjusted by the CORE Code Combinations Task Group to ensure alignment.

2. Please select the sub-type of adjustment you would like to perform.

Addition Types

- ( ) Addition Type #1: Add CARC and RARC
- ( ) Addition Type #2: Add CARC
- ( ) Addition Type #3: Add RARC to an existing CARC
- ( ) Addition Type #4: Add CAGC(s) to an existing CARC
- ( ) Addition Type #5: Add CAGC(s) to an existing CARC and its associated RARC

Removal Types

- ( ) Removal Type #1: Remove CARC and all associated RARCs
- ( ) Removal Type #2: Remove RARC from existing CARC
- ( ) Removal Type #3: Remove CAGC(s) from existing CARC
- ( ) Removal Type #4: Remove CAGC(s) from existing CARC and its associated RARC

Relocation Types

- ( ) Relocation Type #1: Remove CARC and all associated RARCs from this CORE-defined Business Scenario and add to another existing CORE-definedB suiness Scenario with associated CAGC(s)
- ( ) Relocation Type #2: Remove CARC and all associated RARCs from this CORE-defined Business Scenario and add CARC and some or no associated RARCs to another existing CORE-defined Business Scenario with associated CAGC(s)

2019 Market-based Adjustments Survey

Tips and Best Practices

Use a Single Email Address for Submissions

- Create a shared email for the organization team completing the submissions.
- If team member is out of office, ensure another person is responsible for coverage to keep process going.

Keep a Detailed Spreadsheet of Submissions

- Add Entry ID to allow you to easily find the number of any submitted adjustments that you need to alter or delete.

Real World Data

- If you have access to a person with real world usage data, try to include them in your organization team completing the submission.

2019 Market-based Adjustments Survey

Frequently Asked Questions & Additional Resources

Where can I see what a completed 2019 Market-based Adjustments looks like?

See a sample Market-based Adjustments Survey to help you plan your submission.

Is there anything that will walk me through the Market-based Adjustments Survey Submission Process?

Video recordings and materials from the CAQH CORE MBR training are available via the online CAQH CORE Education and Implementation Resource Center.

What if I have any other questions?

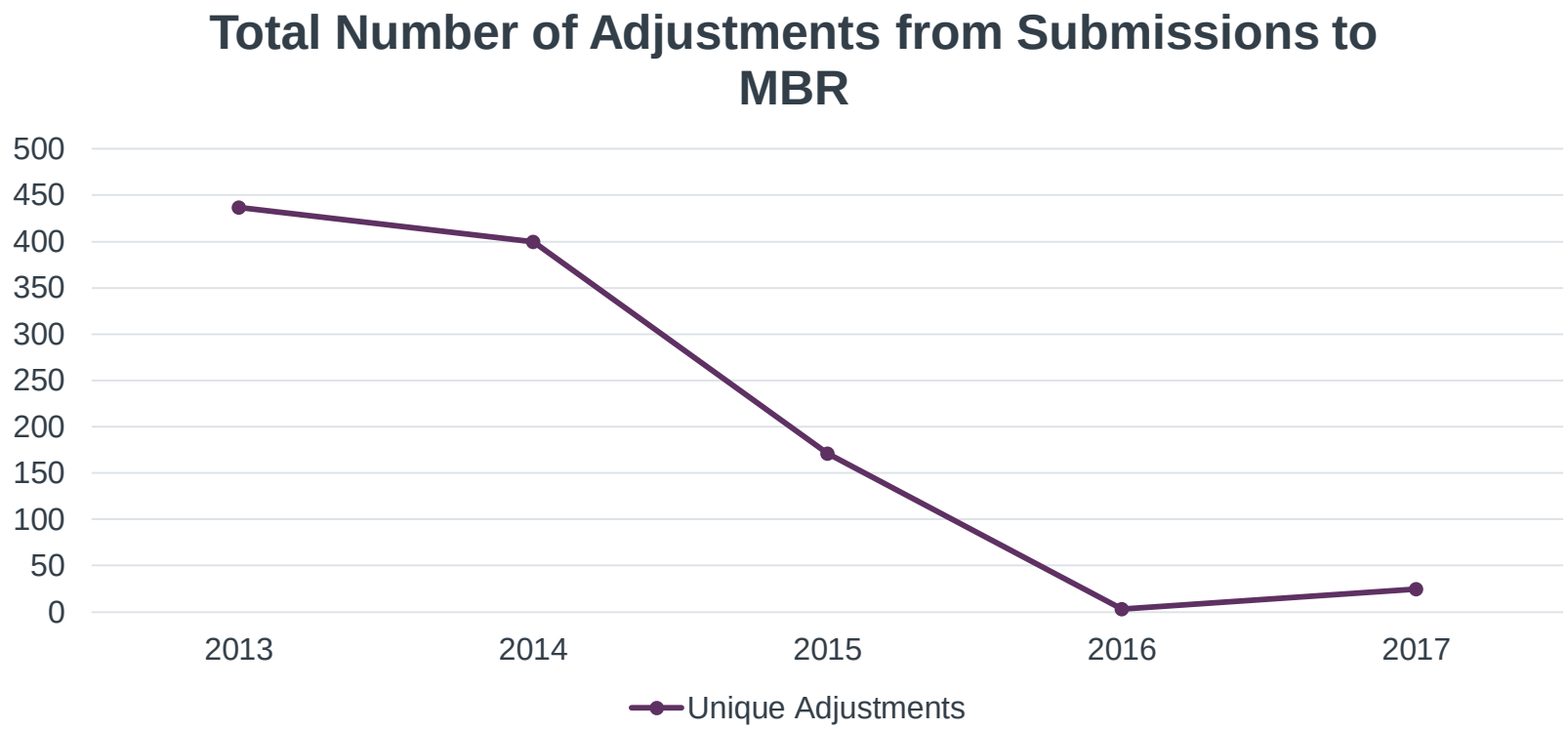
If you have questions or need additional assistance, please contact us at CORE@caqh.org.

CORE Code Combinations

Industry Utilization of Market-based Review (MBR)

- The latest published version of the CORE Code Combinations from the most recent Compliance Based Review (CBR) included six total adjustments.
- The next publication of the CORE Code Combinations includes the most recent CBR and will be released October 1, 2019. The results of the 2019 MBR will be published and released February 3, 2020.

Over time, MBR submissions have decreased dramatically; CORE Code Combinations are being used consistently by the industry, requiring fewer modifications that could not be addressed during CBRs.



Polling Question #2

Does your organization intend to submit a response to the Market-based Adjustments Survey?

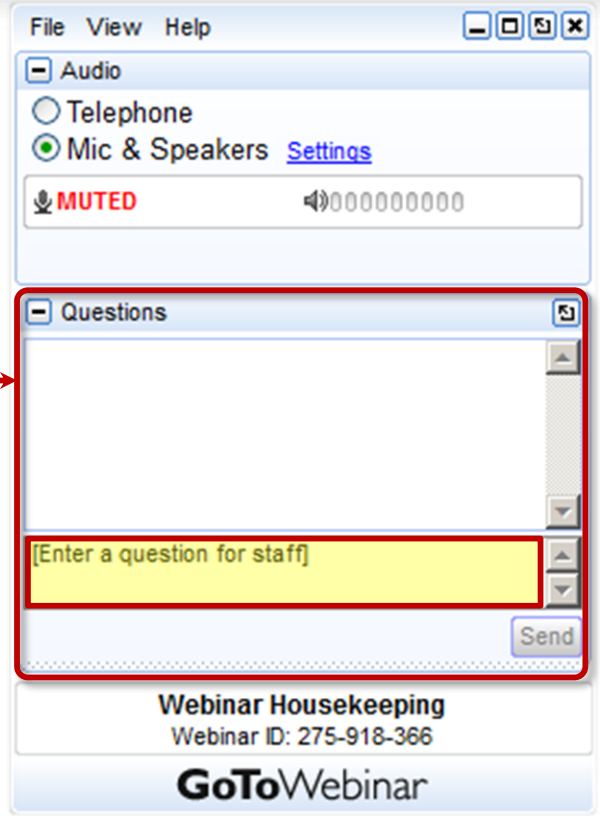
1. Yes
2. No
3. Unsure

Audience Q&A

Please submit your questions

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

You can also submit questions at any time to CORE@caqh.org



Download a copy of today’s presentation slides at https://www.caqh.org/core/events

- Navigate to the Resources section for today’s event to find a PDF version of today’s presentation slides.
- Also, a copy of the slides and the webinar recording will be emailed to all attendees and registrants in the next 1-2 business days.

Resources

- Presentation Slides

CAQH CORE

Healthcare administration is rapidly changing.

Join Us

Collaborate with over 130 organizations around the industry.

Present on CAQH CORE education sessions.

Engage with the decision makers that comprise 75% of the industry.

Represent your organization in work groups.

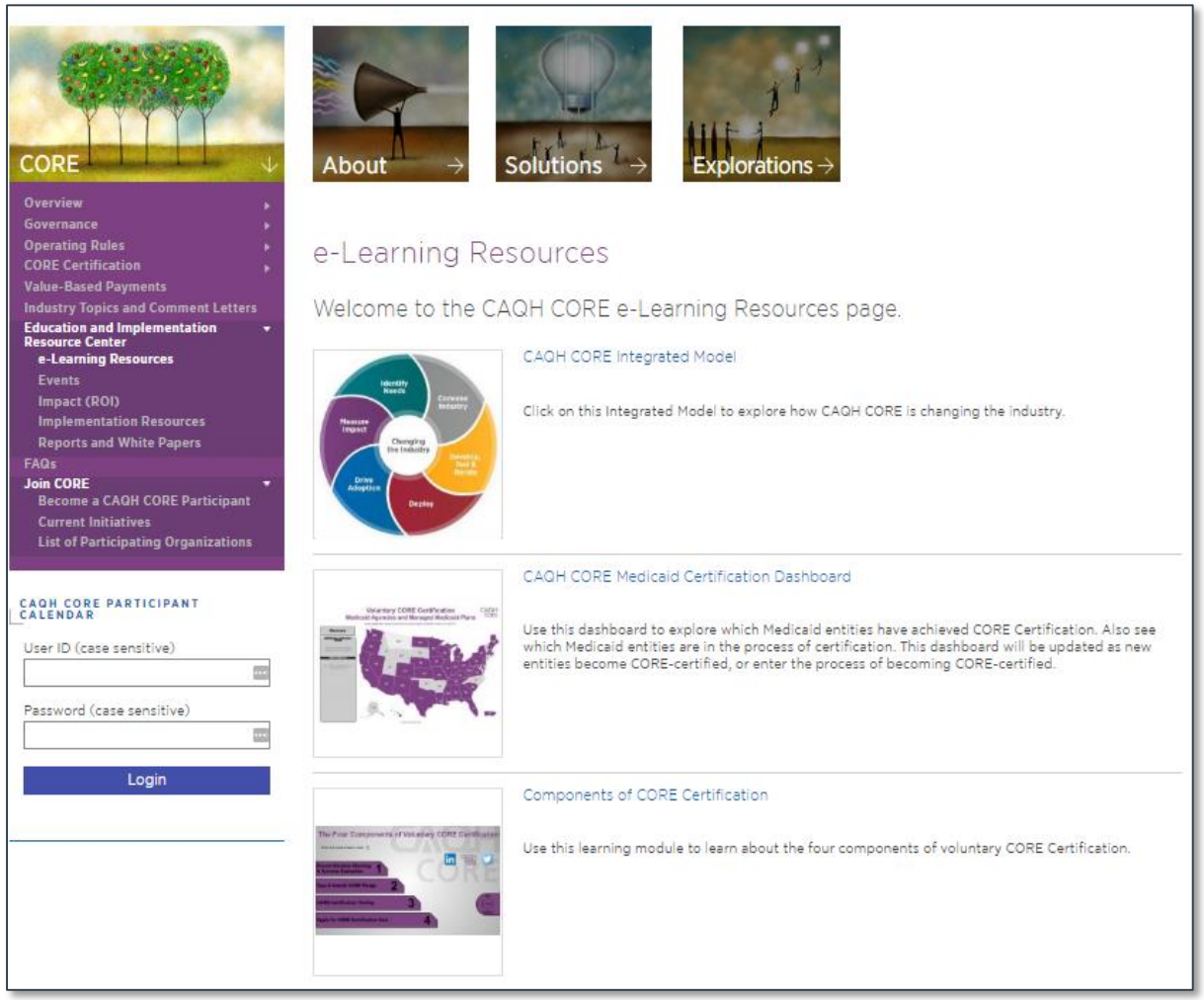
Influence the direction of health IT policy

Drive the creation of operating rules to accelerate interoperability

Click here for more information on joining CAQH CORE as well as a complete list of Participating Organizations.

CAQH CORE

Resource Library



Utilize our interactive online tools to learn more about the CORE Certification process and the CAQH CORE model.

Explore our YouTube page to access over 75 CAQH CORE tutorials and webinar recordings.

Listen to a tutorial on the Phase V Operating Rules.

Go to our FAQs page to for answers to questions on topics such as operating rule implementation and CORE Participation.

Read out our recent white paper "Moving Forward: Building Momentum for End-to-End Automation of the Prior Authorization Process."

Upcoming CAQH CORE Education Sessions

Delivering Efficient Prior Authorization and Attachment Transactions

Hosted by HFMA (For HFMA Members)

AUGUST 14, 2019 3:00-4:30 PM EST

CAQH CORE Town Hall National Webinar

OCTOBER 10, 2019 2:00-3:00 PM EST

Thank you for joining us!

@CAQH

Website: www.CAQH.org/CORE

Email: CORE@CAQH.org

The CAQH CORE Mission

Drive the creation and adoption of healthcare operating rules that support standards, accelerate interoperability and align administrative and clinical activities among providers, payers and consumers.