CAQH CORE and X12 Webinar Series: A Conversation on the 835 Transaction, Standard & Operating Rules

October 28, 2021

2:00-3:00pm ET

Logistics
Presentation Slides and How to Participate in Today's Session

- Accessing webinar materials

  - You can download the presentation slides now from the "Handouts" section of the GoToWebinar menu.

  - You can download the presentation slides and recording at www.caqh.org/core/events after the webinar.

  - A copy of the slides and the webinar recording will also 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.**
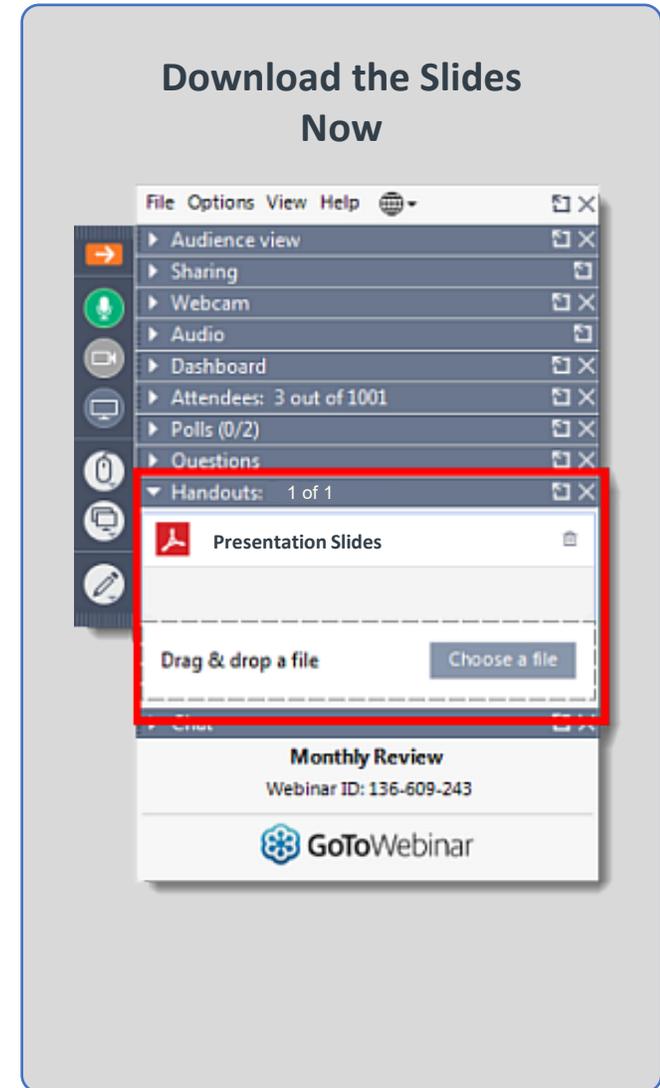
Session Outline

- Introduction to the 835 Transaction Standard

- Panel and Frequently Asked Questions

- Q & A

Thank You to Our Speakers

Patricia Wijtyk

Senior Associate, BPO Cognizant

Co-chair of X12N/TGB/WG3 Payment Information Work Group

Robert Bowman

Director

CAQH CORE

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.

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

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

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.

CAQH CORE

CAQH CORE Operating Rule Overview
Operating Rules Support the Full Continuum of the Healthcare Revenue Cycle

Rule Set	Infrastructure	Connectivity Rule Application	Data Content	Other
Eligibility & Benefits	Eligibility (270/271) Infrastructure Rule	Connectivity Rule vC1.0.0 Connectivity Rule vC2.0.0	Eligibility (270/271) Data Content Rule	Single Patient Attribution Data
Claim Status	Claim Status (276/277) Infrastructure Rule	Connectivity Rule vC2.0.0		
Payment & Remittance	Claim Payment/ Advice (835) Infrastructure Rule		EFT/ERA 835/CCD+ Data Content Rule	EFT/ERA Enrollment Data Rules
Prior Authorization & Referrals	Prior Authorization (278) Infrastructure Rule		Prior Authorization (278) Data Content Rule	Prior Auth Web Portal Rule
Health Care Claims	Health Care Claim (837) Infrastructure Rule	Connectivity Rule vC3.0.0		
Benefit Enrollment	Benefit Enrollment (834) Infrastructure Rule			
Premium Payment	Premium Payment (820) Infrastructure Rule			
Attributed Patient Roster	Attributed Patient Roster (834) Infrastructure Rule	Connectivity Rule vC4.0.0*	Attributed Patient Roster (834) Data Content Rule	

Rules in purple boxes are federally mandated.

*Connectivity Rule vC4.0.0 can be used to support all rule sets for CORE Certification.

CAQH CORE

X12 AND CORE - 835 TRANSACTION, STANDARD & OPERATING RULES

DISCLAIMER

→ This presentation is for informational purposes only

→ The content is point-in-time information, subject to revision

→ If you have questions regarding specific information shared during this presentation, please send them to info@x12.org

→ Visit www.x12.org for additional details about X12

X12 MISSION

X12 is an ANSI-accredited, consensus-based, non-profit organization focusing on the development, implementation, and ongoing use of interoperable electronic data interchange standards

X12 BACKGROUND

→ X12's diverse membership includes technologists and business process experts in health care, insurance, transportation, finance, government, supply chain and other industries

→ X12's transactions have been use-tested in production solutions for 40+ years

→ X12 transactions are scalable and support extremely large data transmissions as easily as individual data exchanges

→ Pairing existing and emerging technologies in new ways presents opportunities to better leverage the technology investments an organization has already made

X12 GOALS

→ Be a developer of stable and trusted products that support effective data exchange

→ Be open-minded with vision and insight related to exchanging transactions in both current and developing technologies

→ Be an enthusiastic collaborator with industry groups, government entities, and businesses

→ Maintain a financial model that distributes costs and ensures the fiscal health of the organization

WHY STANDARDS

→ Standardized computer-to-computer transactions are key to successful business communication

→ Consistent codified messages increase the value of the communication and reduce costs

→ Standardized syntax is critical, but data content must also be standardized to achieve efficiencies and maximize seamless exchanges across various ecosystems

835 VERSUS PAPER

→ EDI exchanges can automate the function of entering the data for payments, adjustments, and denials into the receiver's system

- Eliminates moving paper, making copies and manually posting payments/adjustments
- Improves the accuracy of payment/adjustments posting
- The 835 uses HIPAA-mandated Claim Adjustment Reason Codes (CARC) and Remittance Advice Remark Codes (RARC) versus proprietary codes
- Opportunity to facilitate faster transaction process

To view the first webinar in the series, which introduces the 835 transaction, please click https://www.youtube.com/watch?v=0kP1W4XWqp0

FAQs:
835 Overview and Benefits

FAQs:
CARCs and RARCs

CARCs & RARCs
Need for CORE Code Combinations Maintenance

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

Claim Adjustment Reason Codes - CARC
364 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.

Remittance Advice Remark Codes - RARC
1,116 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.

Claim Adjustment Group Codes - CAGC
4 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 Payment & Remittance 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**
384 code combos

CORE Business Scenario 2
**Additional Information Required –
Missing/Invalid/ Incomplete Data from
Submitted Claim**
424 code combos

CORE Business Scenario 3
Billed Service Not Covered by Health Plan
956 code combos

CORE Business Scenario 4
Benefit for Billed **Service** Not Separately Payable
66 code combos

CAQH CORE

CORE Code Combinations Maintenance

Code Combinations Task Group
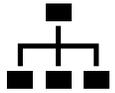
Compliance-based Reviews

Occur 3x per year.

Include only adjustments to align updates to published code lists.

Most Recent Publication: CORE Code Combinations *v3.6.3* in February 2021.

Market-based Reviews

Occur every other year.

Consider only adjustments to address evolving industry business needs. HIPAA-covered entities submit potential adjustments for Task Group consideration.
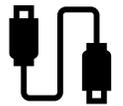
The **CAQH CORE Code Combinations Task Group**, responsible for maintaining the CORE-required Code Combinations, is open to representatives from any CORE Participating Organization. Individuals with knowledge of the related business process and workflow of the usage of the CARCs and RARCs are encouraged to join.

CAQH CORE

FAQs:
CARCs and RARCs

X12.ORG
CODE LISTS

X12.ORG CODE LISTS

X12.ORG
CODE LISTS

FAQs:
Resources

CARC/RARC TR2 SAMPLE

< Complete list of Claim Adjustment Reason Codes   © 2021 - X12 Incorporated

Code	Description
1	Deductible Amount
2	Coinsurance Amount
3	Co-payment Amount
4	The procedure code is inconsistent with the modifier used. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
5	The procedure code/type of bill is inconsistent with the place of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
6	The procedure/revenue code is inconsistent with the patient's age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
7	The procedure/revenue code is inconsistent with the patient's gender. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service...

CARC/RARC TR2 SAMPLE

< Complete list of Claim Adjustment Reason Codes   © 2021 - X12 Incorporated

4 **The procedure code is inconsistent with the modifier used. Usage: Refer to the 835 Healthcare Policy Identification Segment {loop 2110 Service Payment Information REF}, if present.**

Automobile	Yes
Workers' Compensation	Yes
Group Codes	CO PI
Institutional Claim EDI	2400 SV202-2 Procedure Code or SV202-3/6 Procedure Modifier as applicable or 2300 HI01-2 Principal Procedure Code or HIxx-2 Procedure Code
Institutional Claim Paper	FL44 - HCPCS/Accommodation Rates/HIPPS Rate Codes or FL74 - Principal Procedure Code and Date FL74a-e - Other Procedure Code and Date
Professional Claim EDI	2400 SV101-2 Procedure Code or SV101-3/6 Procedure Modifier as applicable
Professional Claim Paper	Item Number 24D Procedures, Services, or Supplies
Dental Claim EDI	2400 SV301-2 Procedure Code or SV101-3/6 Procedure Modifier as applicable
Professional Claim Paper	Item # 29 Procedure Code

MA130: Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.

N56 : Procedure code billed is not correct/valid for the services billed or the date of service billed.

N257 : Missing/incomplete/invalid billing provider/supplier primary identifier.

N517 : Resubmit a new claim with the requested information.

Workers' Compensation	Yes

FAQs:
Companion Guides

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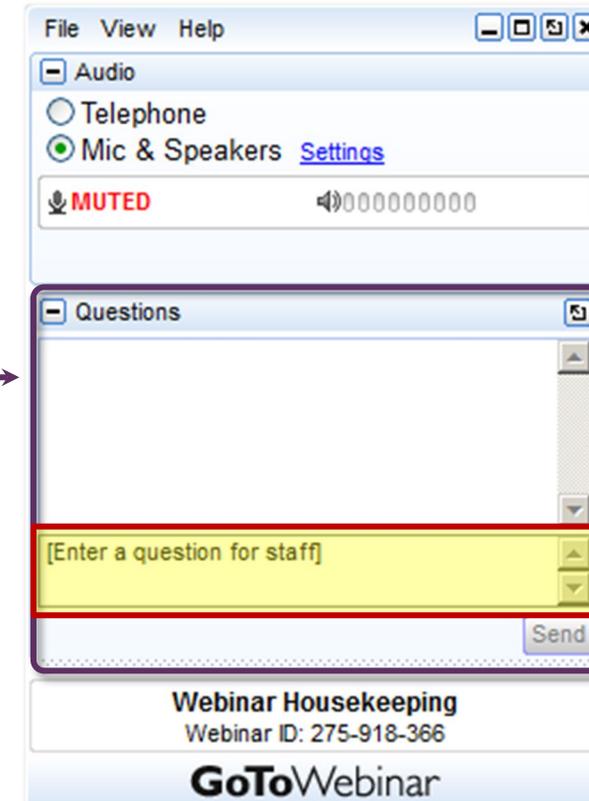
Download a copy of today's presentation slides at https://www.caqh.org/core/events

- 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.

Presentation Resources

- Webinar Recording
- Presentation Slides

WHAT CAN YOU DO

→ Become an X12 Member

→ Participate in X12 Standing Meetings

→ Submit requests for functionality your organization needs

X12 IS LISTENING

→ X12 is being more intentional about collecting input and feedback

→ Frequent surveys are issued to members, members and non-members, non-members, implementers, or other combinations of stakeholders

→ Utilize a permanent online feedback form, making it easy for anyone to provide X12 with ideas or comments: X12.org/feedback

Healthcare administration is rapidly changing.

Join Us

Collaborate across stakeholder types to develop operating rules.

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

Thank you for joining us!

 @CAQH

Website: www.CAQH.org/CORE

Email: CORE@CAQH.org

 @X12standards

Website: www.x12.org

Email: support@x12.org

Appendix

X12 ACTIVITIES

→ X12 focuses on:

- *Evaluating evolving business practices and activities to ensure X12 products continue to meet business needs and requirements*

- *Providing a forum for collaborative discussions and best practice recommendations*

- *Maintaining metadata related to specific business functions*

- *Maintaining the EDI Standard syntax*

- *Producing alternative syntaxes based on emerging or alternate technologies*

- *Maintaining implementation guides related to specific use cases and identified business practices*

X12 ACTIVITIES

→ X12 focuses on:

- *Maintaining code lists to support business functions, use cases, and business practices identified within X12's supported industries*

- *Producing training and educational materials to instruct implementers, trading partners, federal and state regulators, and other materially interested parties*

The X12 835 Overview

Introduction

The X12 835 Overview

Reporting Adjustments

Wrap-Up

835 VERSUS PAPER

→ EDI exchanges can automate the function of entering the data for payments, adjustments, and denials into the receiver's system

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835 OVERVIEW

→ Reports adjudication results for finalized claims

- *Payment*

- *Adjustments*

- *Patient liability*

- *Provider adjustment (for example, interest and overpayment recovery)*

- *Used to reconcile denials*

- *Used to resubmit corrected claims*

→ Reports remittance information to be used by the next payer (COB)

→ Facilitates claims payment

- *Provides ability for auto-posting*

- *Enables reassociation with check or EFT payment and bank account*

→ Adopted under HIPAA

835 OVERVIEW

→ Report adjudication results for claims using:

Claim Payment Information
- BPR Segment
  - BRP02 – Total payment amount
- CLP Segment
  - CLP03 – Total claim charge amount
  - CPL04 – Claim payment amount
  - CPL05 – Patient responsibility amount
- *PLB Segment – Provider Adjustment Information

Claim Adjustment or Service Adjustment Information
- CAS Segment
  - CAS01 – Claim adjustment group code
  - CAS02 – Adjustment reason code
  - CAS03 – Adjustment amount
  - CAS04 – Adjustment Quantity

Health Care Remark Codes
- LQ Segment
  - LQ01 – Code List Qualifier
  - LQ02 – Industry Code

Reporting Adjustments

Introduction

The X12 835 Overview

Reporting Adjustments

Wrap-Up

FINANCIAL BALANCING

→ Adjustments are integral to 835 balancing

- *3 levels within the 835*

  Service line

  Claim

  Transaction*

- *Adjustments can be both positive and negative*

  Positive amounts decrease payment amounts

  Negative amounts increase payment amounts

REPORTING ADJUSTMENTS

→ Adjustments explain changes to the payment amount

- *The change to the amount *******

- *Report the reasons, amounts and quantities of any adjustments that the payer made to either to the original submitted charge or the unites related to the service*

- *Reports responsibility for the adjustment*

- *The sum of the adjustments at the claim AND service levels is the total adjustment for the entire claim.*

    - Service level adjustments are not repeated at the claim level

- *Other messages related to the adjustment that are not related to amount – Remark Codes*

X12

CAS EXAMPLES

CAS*PR*1*300~

CARC 1 - Deductible Amount

SVC*AD:D0120*46*25~
CAS*CO*131*21~

CARC 131 - Claim specific negotiated discount.

CLP*PATACCT*1*40000*8000**MC*CLAIMNUMBER*11*1~
CAS*CO*197*2000*1*45*30000~

CARC 197 - Precertification/authorization/

notification/pre-treatment absent.

CARC 45 - Charges do not meet qualifications for

emergent/urgent care. Usage: Refer to the 835

Healthcare Policy Identification Segment (loop 2110

Service Payment Information REF), if present.

SVC*HC>99214*26.2*3.06~
CAS*CO*45*23.2**137*-.06~

CARC 137 - Regulatory Surcharges, Assessments, Allowances or

Health Related Taxes.

REPORTING ADJUSTMENTS

→ Explanatory codes are necessary for effective 835s

→ Codes Lists used in the 835

- *HIPAA-mandated Claim Adjustment Reason Codes – CARC*
  x12.org/codes

- *HIPAA-mandated Remittance Advice Remark Codes – RARC*
  x12.org/codes

- *Claim Adjustment Group Code*
  Internal list - included in the 835 TR3

REPORTING ADJUSTMENTS

→ Internal systems may use EOB codes that are mapped to a CARC, RARC, and Group Code

- *Map internal EOB to best and complete message*

- *Internal list must be updated regularly to reflect the current official code lists as published*

→ Select the right CARC and RARC

- *Tools Available*
  CARC/RARC TR2 – CARC-RARC Encyclopedia – Code Value Usage in Health Care Claim Payments and Subsequent Claims
  CAQH CORE Code Combinations for CORE-defined Business Scenarios

→ Organizations may need to request new codes to meet their business requirements

- *Request codes via x12.org/codes*