



# Dialogue with Anthem

How Hassles of Claims  
Denial Management Are  
Reducing Through the  
*CORE Code Combinations*

Tuesday,  
October 4th, 2016  
2:00 – 3:00 PM ET

# Logistics

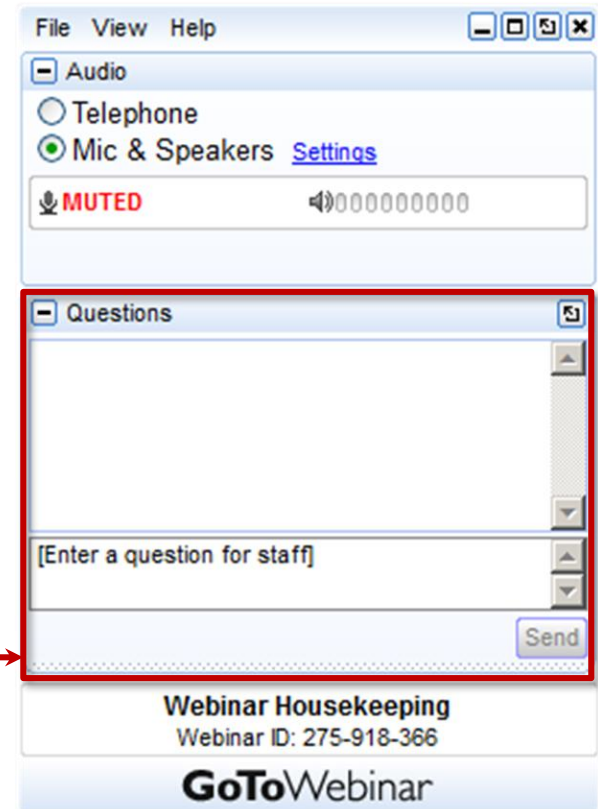
## *Presentation Slides & How to Participate in Today's Session*

- Download a copy of today's presentation slides at [caqh.org/core/events](http://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 in the next 1-2 business days
- The phones will be muted upon entry and during the presentation portion of the session
- At any time throughout the session, you may communicate a question via the web

Questions can be submitted **at any time** with the **Questions panel on the right side of the GoToWebinar desktop**

### Resources

- [Presentation Slides](#)



# Thank You Speakers!

**CAQH CORE would like to thank our guest presenters for today's webinar.**

The Anthem logo is displayed in a large, blue, serif font. The word "Anthem" is underlined with a thick blue horizontal bar. A registered trademark symbol (®) is located at the end of the word.

**Margaret (Meg) Kutz**  
Senior Business  
Consultant, E-Solutions

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**Scott Munich**  
Business Consultant

# Session Outline

- Welcome and Introduction
- *CORE Code Combinations* Improve Denial Management
- Anthem Case Study: Uniform Use of CARCs and RARCS - How to Improve Your Denial Management Process
- Virtual Dialogue with Anthem
- Q&A

CAQH  
CORE

# ***CORE Code Combinations*** **Improve Denial Management**

**Robert Bowman**  
Associate Director

**Omoniyi Adekanmbi**  
Project Manager

# CAQH CORE Code Combinations Maintenance

## What is this?

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

Health plans deny or adjust claims via combinations of claim denial/adjustment codes sets that are meant to supply the provider with the necessary detail regarding the payment or denial of the claim.

### CARC

Claim  
Adjustment  
Reason  
Codes

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

- This list is maintained by ASC X12.

### 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.

### CAGC

Claim  
Adjustment  
Group  
Codes

Categorizes the associated CARC based on financial liability. There are only 4 CAGCs identified for use with the claim:

- |             |                                       |
|-------------|---------------------------------------|
| <b>PR -</b> | <b>PATIENT<br/>RESPONSIBILITY</b>     |
| <b>CO -</b> | <b>CONTRACTUAL<br/>OBLIGATIONS</b>    |
| <b>PI -</b> | <b>PAYOR INITIATED<br/>REDUCTIONS</b> |
| <b>OA -</b> | <b>OTHER<br/>ADJUSTMENTS</b>          |

- This list is maintained by ASC X12.

# CAQH CORE Code Combinations Maintenance

## *Why was this needed?*

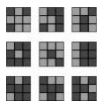
The industry determined that the healthcare industry required operating rules to establish requirements for the consistent and uniform use of these codes:



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.

# Claim Denial Process

## *BEFORE the CORE Code Combinations*

**Large number of available CARCs and RARCs and health plan use of proprietary codes meant providers did not receive uniform and consistent CARC/RARC combinations across all health plans.**

### **Resulted in:**

- Provider confusion about reasons for claim payment adjustments and denials.
- Multiple claim re-submissions attempting to receive payment, wasting time and money.

**This was an animated slide in the live presentation. To view the animation, please view the webinar recording [HERE](#).**

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# CAQH CORE Code Combinations Maintenance

## *Improve Denial Management Process*

This consistent and uniform use of the codes for electronic reporting of claims denials and adjustments 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
---------------------------------------	-------------------------------------	--	---	----------------

This effort has led to demonstrated improvements:

Less staff time spent on phone calls and websites and greater process automation	Increased ability to conduct targeted follow-up with health plans and/or patients	More accurate and efficient payment of claims
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Note: It is expected that a responsive and accurate set of *CORE Code Combinations* saves the industry time and money through increased provider adoption of the X12N v5010 835 ERA transaction, reducing cost-to-collect, expediting reimbursement, improving denials management, and reducing time-consuming and costly manual claim reconciliation.

# Claim Denial Process

## *AFTER the CORE Code Combinations*

**Because of *CORE Code Combinations*, standardized CARC and RARC combinations are provided to indicate:**

- Additional Information Required – Missing/Invalid/ Incomplete Documentation
- Additional Information Required – Missing/Invalid/ Incomplete Data from Submitted Claim
- Billed Service Not Covered by Health Plan
- Benefit for Billed Service Not Separately Payable

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# CAQH CORE Code Combinations Maintenance

## *Business Scenarios Drive Efforts*

### **CORE Business Scenario #1:**

**Additional Information Required**

-

**Missing/Invalid/  
Incomplete  
Documentation**

(~365 code combos)

### **CORE Business Scenario #2:**

**Additional Information Required**

-

**Missing/Invalid/  
Incomplete Data from  
Submitted Claim**

(~390 code combos)

### **CORE Business Scenario #3:**

**Billed Service Not  
Covered by Health  
Plan**

(~810 code combos)

### **CORE Business Scenario #4:**

**Benefit for Billed  
Service Not  
Separately Payable**

(~60 code combos)

# CAQH CORE Code Combinations Maintenance

## *CORE Code Combinations Task Group (CCTG)*

- Responsible for ongoing review and adjustment of the *CORE Code Combinations* via the [CORE Code Combinations Maintenance Process](#).
- Composed of more than 40 CORE Participating Organizations from a wide variety of stakeholders; led by four multi-stakeholder Co-Chairs:
  - **Shannon Baber**, *UW Medicine*
  - **Heather Morgan**, *Aetna*
  - **Lynn Franco**, *UnitedHealth Group*
  - **Erica Zendell**, *RelayHealth*

## STATUS

### Recently Completed

- Compliance-based Review in response to code adjustments published on July 1<sup>st</sup>
- Updated *October 2016 CORE Code Combinations v3.3.1* published 10/03/16

### Upcoming November 2016

- Compliance-based Review in response to code adjustments to be published on November 1<sup>st</sup>
- Launch of 2016 Industry Survey on potential Market-based Adjustments

# Claim Denial Process Example

## *Business Scenario 1: Incomplete Documentation*

**CARC 163:** *Attachment/other documentation referenced on the claim was not received.*

**Adjustment:** Removal of RARC N679

**Rationale:** RARC identifies document is *incomplete/invalid*. CARC indicates document *not received*.

**Claim corrected and sent back to payer**



**Leads to improved accuracy and timely posting.**

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# Claim Denial Process Example

## *Business Scenario 2: Incomplete Claim Data*

**CARC 175: *Prescription is incomplete.***

**Adjustment:** Addition of RARCs N319, N378, N388, & N389

**Rationale:** RARCs specify *what data* in the prescription is incomplete (i.e., hearing or vision prescription date, prescription quantity, prescription number, or duplicate prescription number)

**Claim corrected and sent back to payer**

**Less or no staff time spent on phone, fax, and websites.**

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# Claim Denial Process Example

## *Business Scenario 3: Billed Service Not Covered*

**CARC 49:** *This is a non-covered service because it is a routine/preventive exam or a diagnostic/screening procedure done in conjunction with a routine/preventive exam.*

**Adjustment:** Addition of RARCs M90 & N129

**Rationale:** RARCs specify service is not covered due to frequency (i.e., only once in 12 month period or patient age).

**Patient is billed for service.**

**Unnecessary manual provider follow up.**

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# Claim Denial Process Example

## *Business Scenario 3: Billed Service Not Covered*

**CARC 22:** *This care may be covered by another payer per coordination of benefits.*

**Adjustment:** Addition of RARC N376

**Rationale:** RARC specifies that TRICARE is the primary payer.

**Claim sent to  
TRICARE**

**Ensures proper  
electronic  
secondary billing.**

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# Polling Question #1

Approximately what percent of your remittance advices in the past year included a situation addressed by the CORE-defined Business Scenarios?

1. 1-25%
2. 26-50%
3. 51-75%
4. 76-100%
5. Uncertain

# **Uniform Use of CARCs and RARCS: How to Improve Your Denial Management Process with a Case Study Presentation from Anthem**

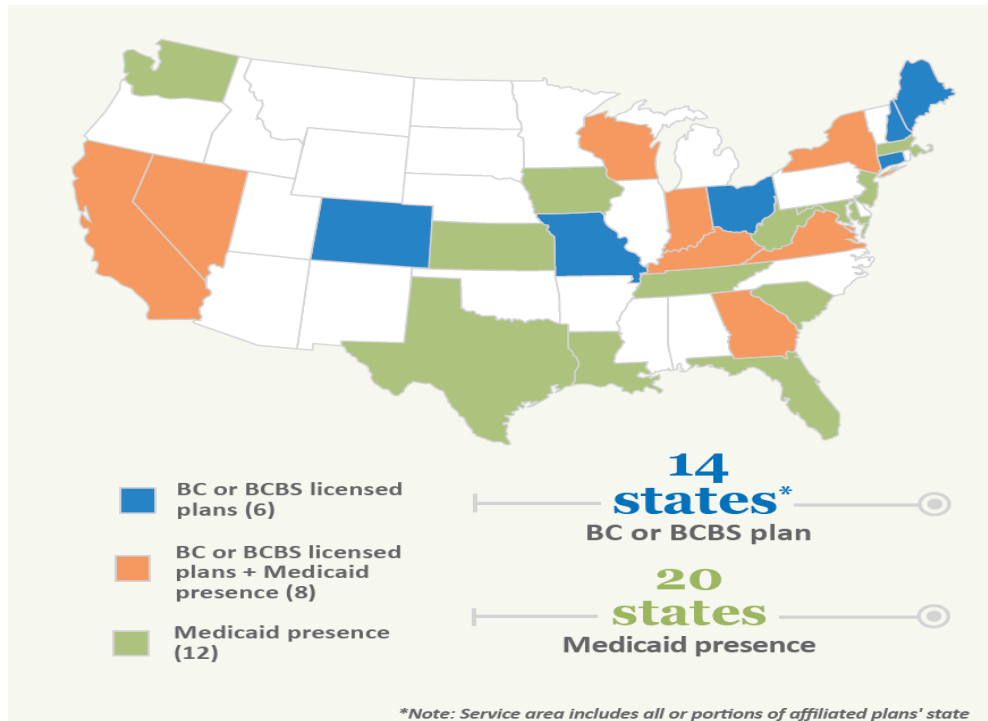


**Presented by: Meg Kutz, Senior Business Consultant, E-Solutions**

# Anthem, Inc. at a Glance

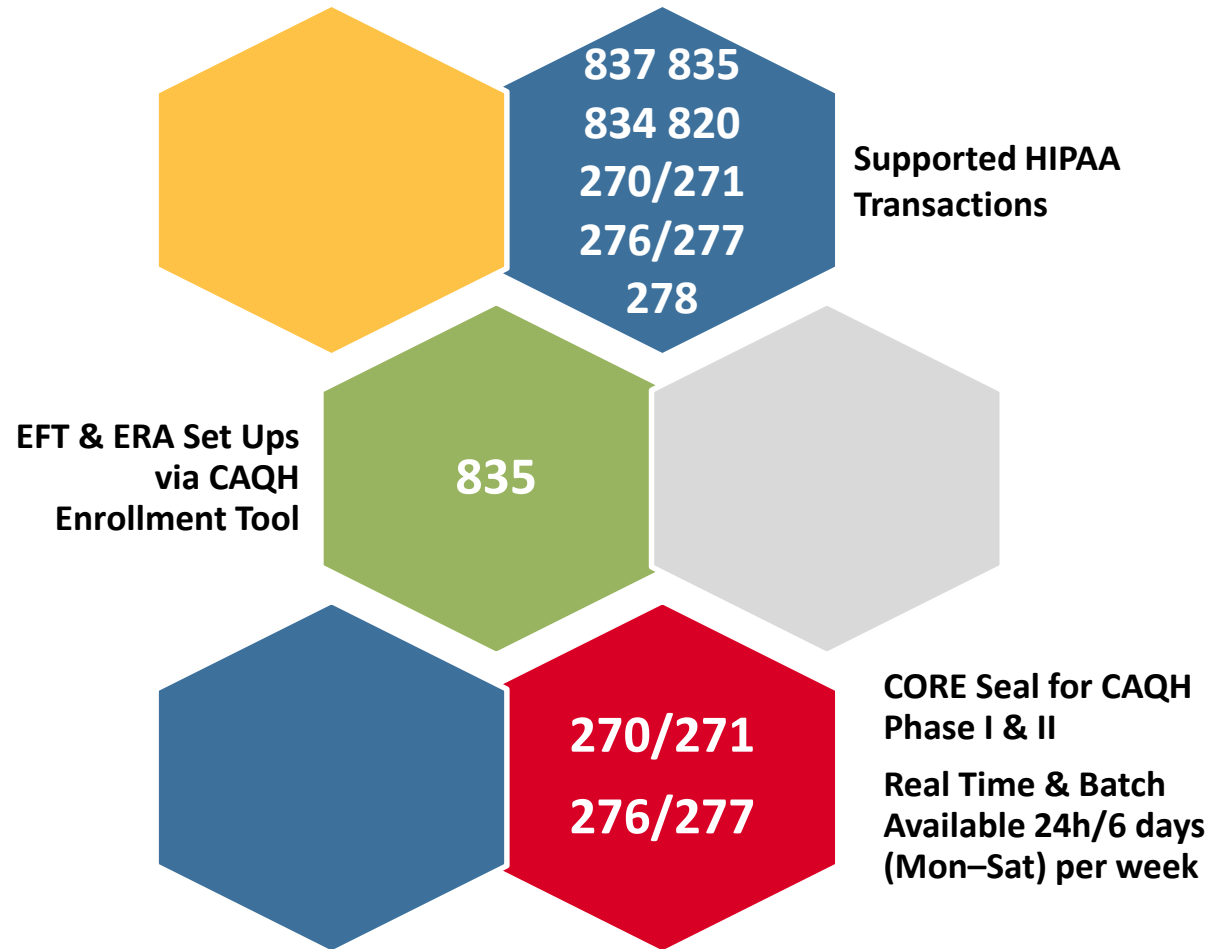
One of the largest US health benefits companies

- Approximately 73 million individuals served through our affiliated companies
- More than 39.8 million members enrolled in our affiliated health plans

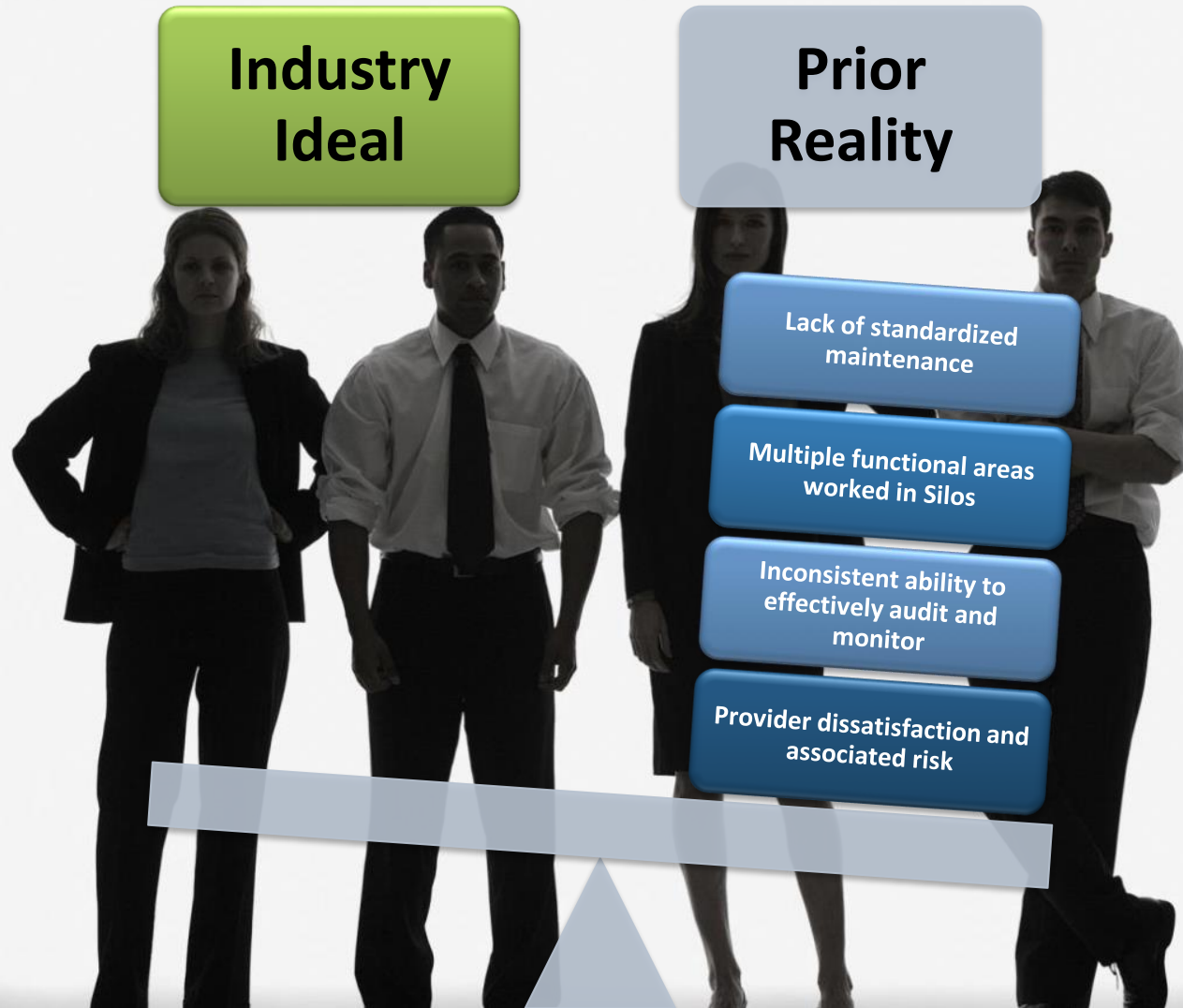


2015 Monthly Average Transmissions	
ERA	EFT
3,147,819	869,716

# Current Anthem, Inc. EDI Landscape



# Where We Were Before CORE Code Combinations



# Where We Are Now



# Highlights of Governance Roles & Responsibilities

## STEWARDSHIP COMMITTEE

### Key Stakeholders – Director/Mgr Level

- Champion Governance objectives and policies within respective function and commit resources as Information Custodians.
- Serve as filtering/gating committee for all EOB, ANSI 835, or 277 code changes
- Render Tier 2 decisions on code change requests (pre-development approval)

## INFORMATION CUSTODIANS

### Cross-Functional Process Experts / SME's

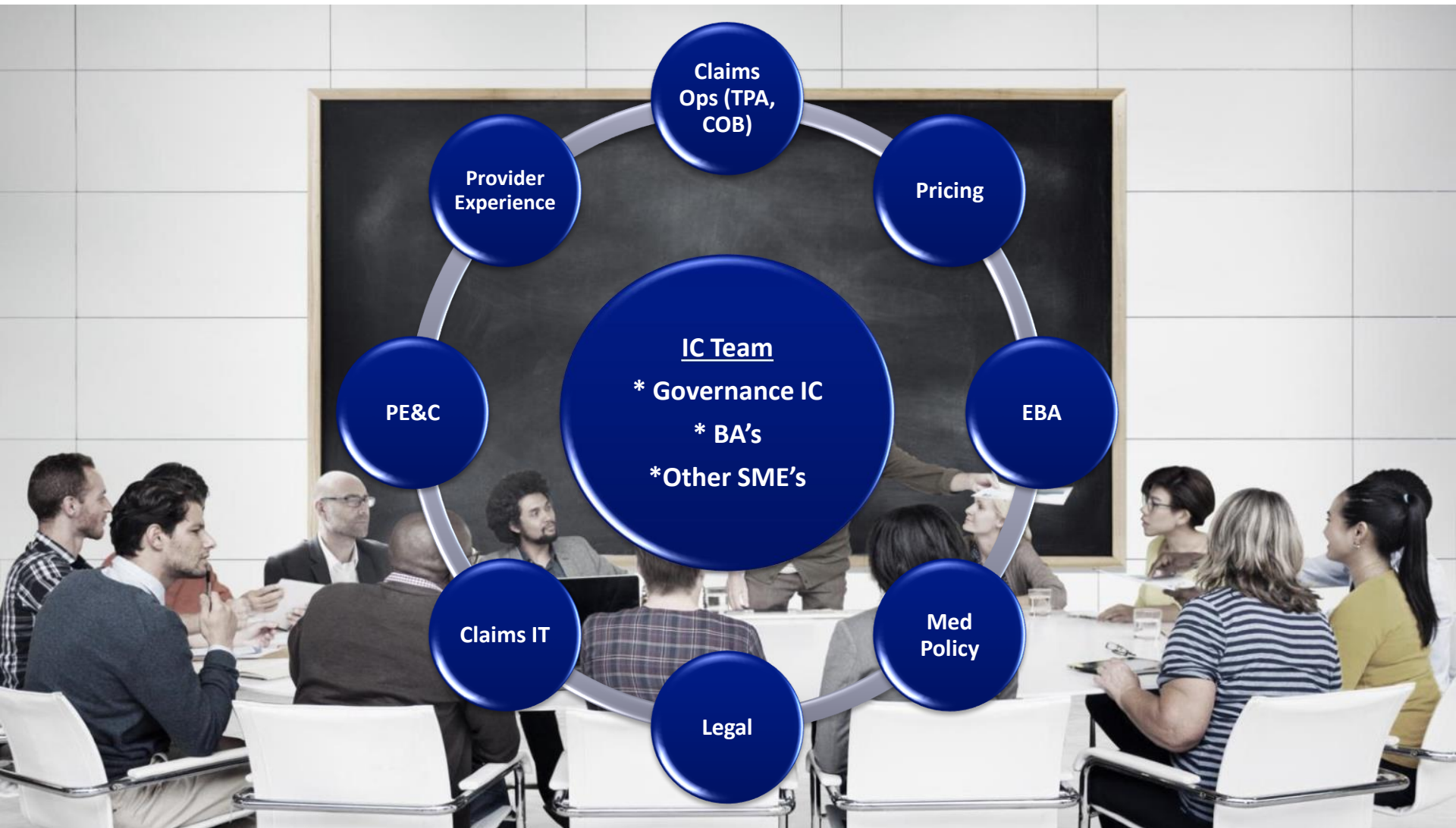
- Serve as business and technical experts to affected function or process (Claims adjudication, Contracting, HIPAA Compliance, etc)
- Own corresponding data/mapping definitions of respective system or function required for governance
- Support Impact Analysis activities and provide Tier 1 recommendation for respective function to Stewardship Committee

## GOVERNANCE LEAD

### E-Solutions

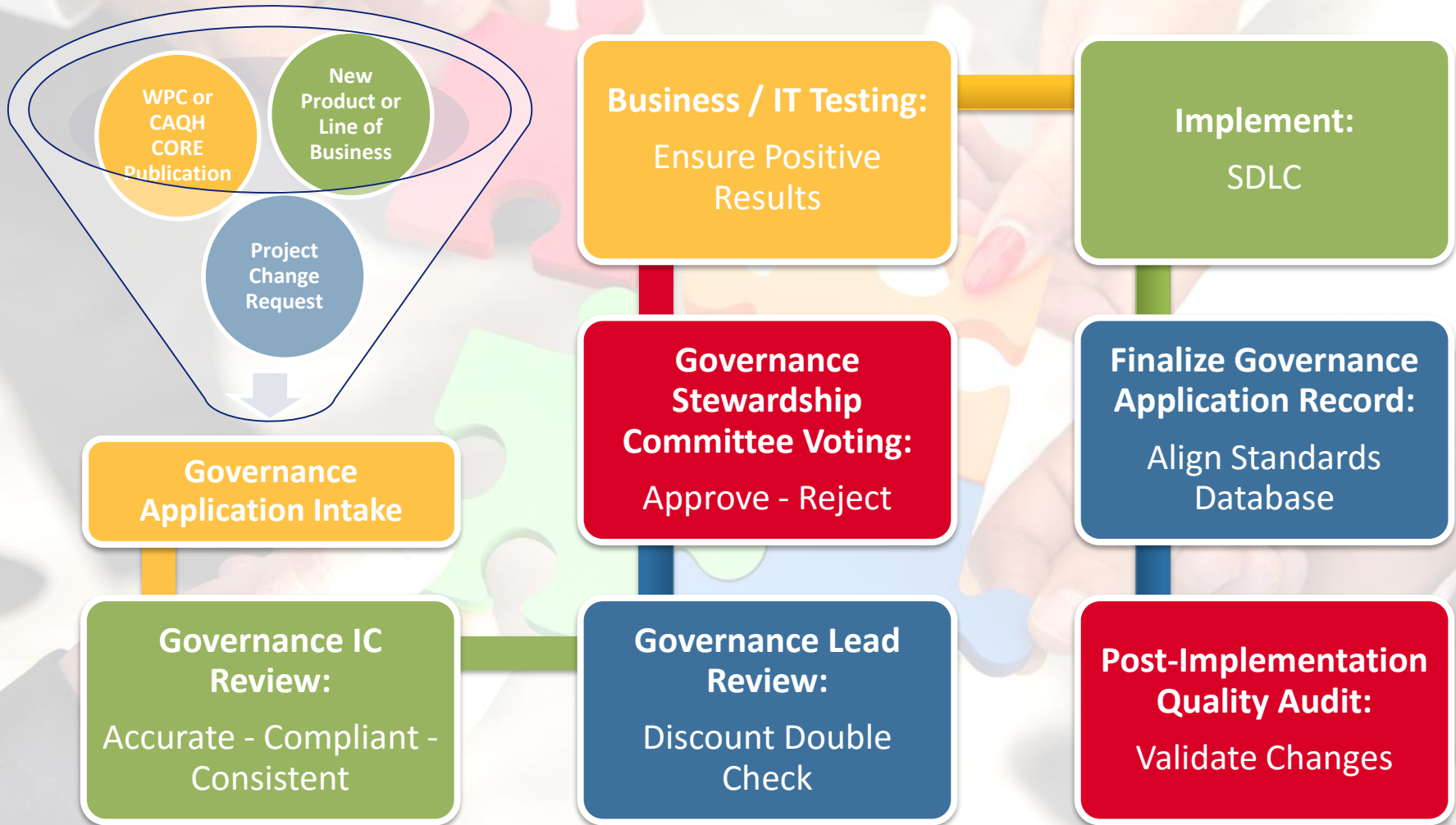
- Responsible for oversight & management of Governance model and all associated processes, deliverables, and communications.
- Oversees Intake and Triage of all Code Change Requests and respective communications back to Requestor.
- Facilitate cross-functional meetings/discussions across Tiers 1-2 as necessary to fulfill governance objectives
- Coordinate with in-flight initiatives (Projects, Quality Audits, etc) to ensure alignment and proactive risk assessment

# Information Custodian (IC) Review Team Structure





# Governance Model



# Anthem's B's and C's

## Benefits (+)

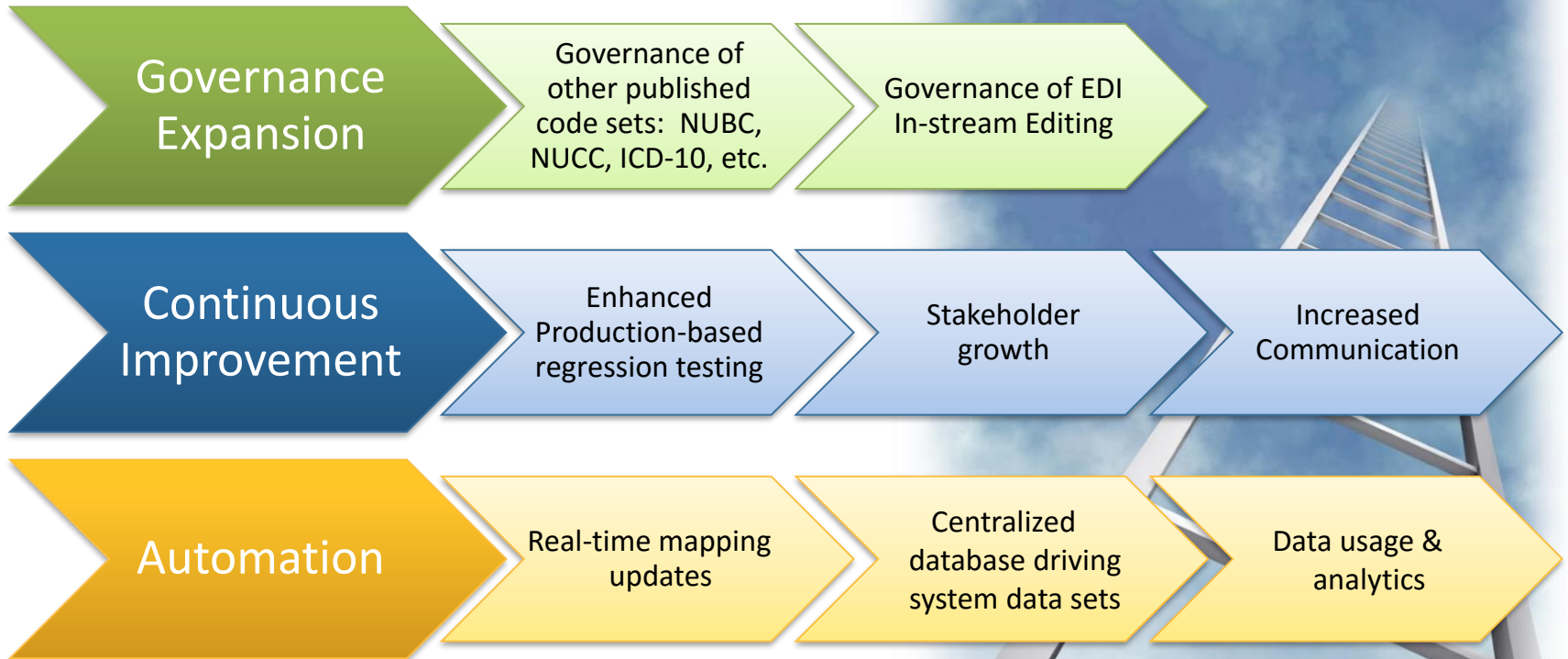
- Provider organizations sent positive feedback; seeing improvements in reporting payments and claim status
- Internal operational areas welcoming the guidance for usage
- Providing a new refreshed baseline update
- Promoting consistency in reporting to the providers
- Governance model can be deployed for other code sets
- EDI 835 /EFT Enrollment increase adoption\*

\*No specific stats directly tied to the 360 rule. We believe this is due to overall HCA rules.

## Challenges (-)

- Managing competing project impacts
- Real-time data usage and code logic is not always easily accessible (historical data)
- End to end Testing is complex and time consuming
- WPC and CAQH publication schedules
  - Updates 6 times per year, combined
  - Potential for mapping rework with CAQH review 3 months after WPC's
  - Anticipation for what will be adopted
- Concerns with different 'interpretation' of the code meanings within the industry and auto post capability (impacts adoption and call volume)

# In Progress and Future



CAQH  
CORE

# Virtual Dialogue with Anthem

**Moderator: Jessica Porras**  
Senior Manager, CAQH CORE

# Virtual Dialogue with Anthem



**Margaret (Meg) Kutz**  
Senior Business  
Consultant, E-Solutions

**Scott Munich**  
Business Consultant



**Robert Bowman**  
CAQH CORE  
Associate Director

**Omoniyi Adekanmbi**  
CAQH CORE  
Project Manager

**Jessica Porras**  
CAQH CORE  
Senior Manager

## Polling Question #2

What benefits has your organization experienced from the past three years of *CORE Code Combinations* implementation? (Check all that apply)

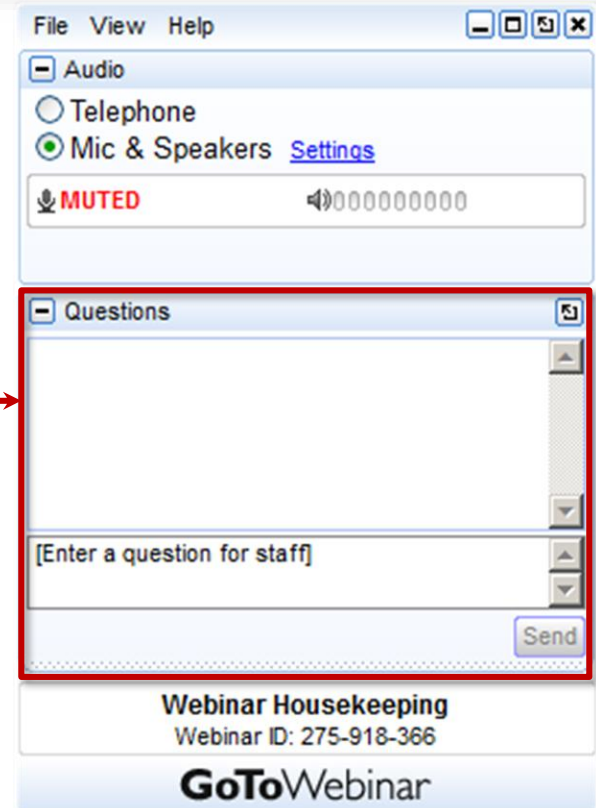
1. Reduction in unnecessary manual provider follow-up
2. Decreases in faulty electronic secondary billing
3. Fewer inappropriate write-offs of billable charges
4. Improved billing of patients for co-pays and deductibles
5. Unaware of measurable benefits experienced

# 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**



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## Resources

- [Presentation Slides](#)

# Potential Solution: Streamlined Enrollment CAQH *EnrollHub*



Step 1: Provider Info > Step 2: Bank Account Details Step 3: Payer Step 4: Submit

**Provider Information**

Pay To Provider Name:  Legal name of provider entity

Nickname:

Address:

City / State / Zip:

Phone Number / Ext:

Tax Identification Number:

National Provider Identifier:

**Authorized Agent**

First Name:

Last Name:

Address:

City / State / Zip:

Phone Number / Ext:

Email:

Send copy of all CAQH correspondence

**Bank Account Details**

Step 1: Add Bank Details > Step 2: Add Account Details > Step 3: Associated NPIs > Step 4: Upload Documents

Routing Number:

Account Number:

Provider Account Number:



Manage Providers | Manage Plans | Manage Users | Activity Log

Provider Name	Address	Associated NPIs	Enrollment Status	Notes	Select
123 Provider Entity TIN: 054113210 NPI: 054113210	123 Street Cityville, MD 20904	1234567771 1234567772 1234567773	Enrollment requested as of 08/20/2012		
123 Provider Entity TIN: 054113210 NPI: 054113210					

**View Details** 1 of 1

**PayTo Entity Information:**

Name: 123 Provider Entity Phone: (202) 555-1212 Associated NPIs: 2316548202, 2316548203, 2316548204

Address: 123 Street Cityville, MD 20904 TIN: 054113216 NPI: 054113210

**Authorized Agent Name:** Fname Lname Phone: (202) 555-1212 Email: name@domain.com

Address: 123 Street Cityville, MD 20904

**Financial Institution Information**

Routing Number: 052000113  
Account Number: 2316548201  
Account Type: Checking  
Bank: Citicorp  
City, State: Cityville, MD

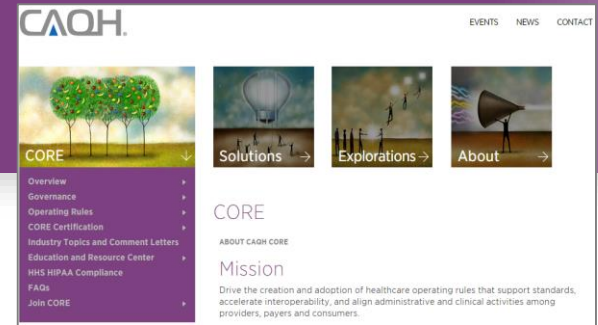
- Web-based data entry for provider EFT and ERA enrollment information.
- Alignment with federally-mandated operating rules for definition of the standard enrollment data set and supporting documents.
- Web-based access portal for health plan customers.
- Multi-payer provider adoption campaigns.
- Telephonic provider support center.
- Voided check and other uploaded document processing.
- Pre-note transactions via ACH partners to validate bank account information.



# Engage with CAQH CORE!

## [CAQH CORE Website](#)

or contact us at [CORE@CAQH.org](mailto:CORE@CAQH.org)



**Participate** in the CAQH CORE Code Combinations Task Group (CCTG) or the Enrollment Data Task Group

**Become** a [CAQH CORE Participating Organization](#)

**Explore** Voluntary CORE Certification

**Register** for our educational [webinars](#)

Dedicated webpages:

- ✓ [Code Combination Maintenance](#)
- ✓ [EFT/ERA Enrollment Maintenance](#)
- ✓ [Voluntary CORE Certification](#)
- ✓ [CAQH CORE Phase IV Operating Rules](#)

# Upcoming CAQH CORE Education Sessions

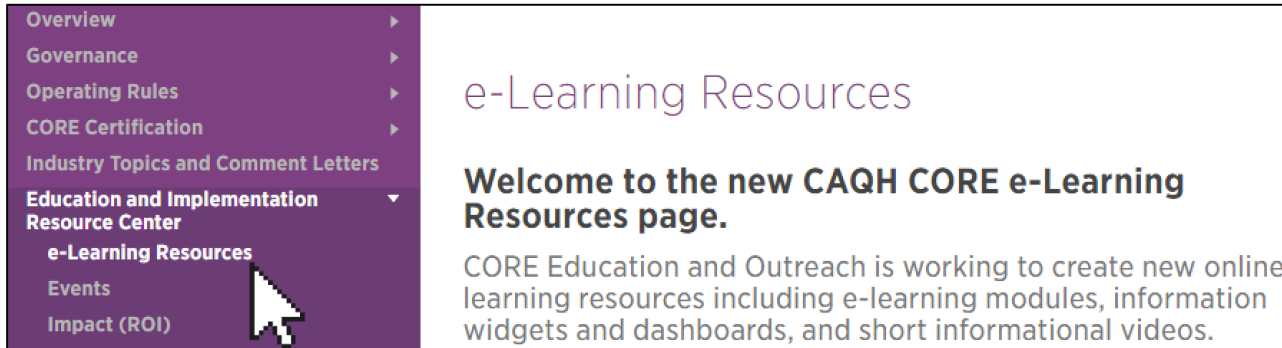
**CAQH CORE Town Hall National Webinar**  
**THURSDAY, NOVEMBER 3, 2016 – 2 PM ET**

**Latest News and Dialogue on the Value of Healthcare e-Payments**  
**THURSDAY, NOVEMBER 17, 2016 – 2 PM ET**

To register, please go to [www.caqh.org/core/events](http://www.caqh.org/core/events)

# New e-Learning Resources from CORE

[www.caqh.org/core/elearning-resources](http://www.caqh.org/core/elearning-resources)



Overview

Governance

Operating Rules

CORE Certification

Industry Topics and Comment Letters

Education and Implementation Resource Center

**e-Learning Resources**

Events

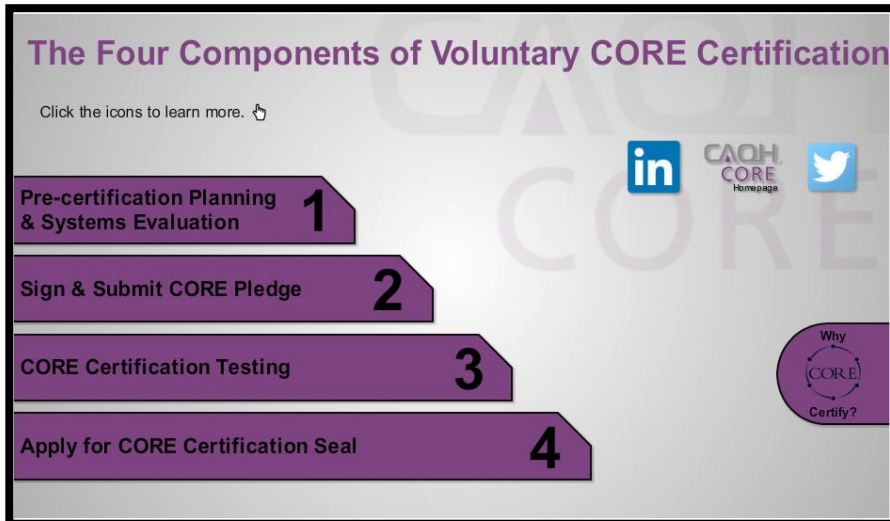
Impact (ROI)

## e-Learning Resources

**Welcome to the new CAQH CORE e-Learning Resources page.**

CORE Education and Outreach is working to create new online learning resources including e-learning modules, information widgets and dashboards, and short informational videos.

Learn about the four components needed to complete voluntary CORE Certification



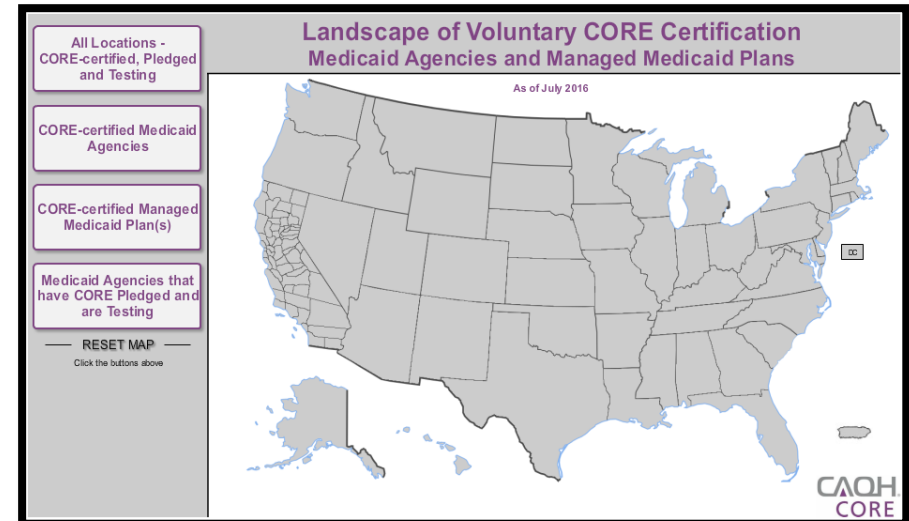
## The Four Components of Voluntary CORE Certification

Click the icons to learn more.

- 1 Pre-certification Planning & Systems Evaluation
- 2 Sign & Submit CORE Pledge
- 3 CORE Certification Testing
- 4 Apply for CORE Certification Seal

Why CORE? Certify?

Explore our new interactive map to learn which Medicaid agencies are achieving CORE Certification.



## Landscape of Voluntary CORE Certification Medicaid Agencies and Managed Medicaid Plans

As of July 2016

- All Locations - CORE-certified, Pledged and Testing
- CORE-certified Medicaid Agencies
- CORE-certified Managed Medicaid Plan(s)
- Medicaid Agencies that have CORE Pledged and are Testing

RESET MAP  
Click the buttons above

# Thank you for joining us!

Website: [www.CAQH.org/CORE](http://www.CAQH.org/CORE)

Email: [CORE@CAQH.org](mailto:CORE@CAQH.org)



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