TO: All Providers (Except Pharmacy Providers)

RE: Implementation of ACA 1104 Phase III Operating Rules - EFT and ERA Changes (Non-RX claims)

This bulletin serves to inform all providers that the Department of Social Services (DSS) and HP will be making updates to the providers' 835 Electronic Remittance Advice (ERA) transactions and changes in the Electronic Funds Transfer (EFT) in order to comply with Phase III - Council of Affordable Quality Healthcare (CAQH) Committee for Operating Rules for Information Exchange (CORE) Electronic Remittance Advice (ERA) Operating Rules.

These changes were previously communicated in Provider Bulletin 2013-78 "Implementation of ACA 1104 Phase III Operating Rules - EFT and ERA Changes". **Please continue to monitor additional provider communications through important messages on the Web site www.ctdssmap.com to inform you of when these changes will be in effect.**

The CAQH CORE's mission, defined by the Affordable Care Act (ACA), is to use common business rules (operating rules) to promote interaction of healthcare trading partners and the exchange of healthcare-related information in a consistent, clear, and standardized manner, and in compliance with applicable laws and regulations. Providers may visit the CAQH CORE Web site at www.caqh.org in order to obtain additional information.

CAQH CORE 360: Rule 360 specifies the combination of codes that can be included on the v5010 X12 835 data for certain Business Scenarios. HIPAA legislation dictated the use of a common set of codes to communicate claims processing information to the submitter of the claim. HIPAA codes sets include the uniform use of Claim Adjustment Reason Codes (CARCs), Remittance Advice Reason Codes (RARCs) and Claim Adjustment Group Code (CAGC) reject code combinations by all payers, based upon four CORE defined Business Scenarios

The CORE defined Business Scenarios (BS) are:

BS #1 - Additional Information Required. Missing/Invalid/Incomplete Documentation: defined as additional documentation needed from the billing provider or an ERA from a prior payer to accurately process the healthcare claim.

BS #2 - Additional Information Required. Missing/Invalid/Incomplete Data from Submitted Claim: defined as additional data needed from the billing provider for missing or invalid data on the submitted claim.

BS #3 - Billed Service not Covered by Health Plan: defined as a billed service not covered by the health plan.

BS #4 - Benefit for Service is not Separately Payable: defined as a billed service acting as a bundled service or not separately payable by the health plan.

CORE 360: Change to the 835 Remittance Advice

In conformance to CAQH CORE Rule 360, HP will return Claim Adjustment Reason Codes (CARC)/ Remittance Advice Remark Codes (RARC) combinations on the provider's 835 ERA. The codes are used to communicate why claims are not paid at the billed rate.

Changes to Explanation of Benefits (EOB) Crosswalk

The Medical Assistance Program EOB Crosswalk will be updated on the Web site www.ctdssmap.com under Publications → Claim Processing Information → Medical Assistance Program EOB Crosswalk. The crosswalk will contain the EOB, EOB Description, Business Scenario, Claim Adjustment Reason Code (CARC), Remark Code, and the Claim Adjustment Group Code (CAGC). Once this crosswalk is posted to the Web, it will be updated weekly, so providers should refer to this document periodically.

CAQH CORE 370: Rule 370 specifics the requirements and methods used by providers and healthcare systems to properly re-associate the X12 835 ERA to an Electronic Funds Transfer (EFT) payment. The underlying assumption of Rule 370 is that there is a one-to-one relationship between an EFT and an ERA such that each EFT has one, and only one, associated ERA.

CORE 370: Change to the 835 Remittance Advice

A translator mapping modification is required for the X12 835 transaction. The TRN02 field will be modified to include only the EFT Trace Number. Currently, it contains the bank, provider's bank routing numbers, and the EFT Trace Number. Per Rule 370, the TRN02 field should only contain the EFT Trace Number.

The BPR16 field will begin to reflect the Wednesday after the financial cycle, to match the EFT payment date.

CAQH CORE 380/382: The ACA rules dictate the information that must be collected in order for a provider to enroll in 380 EFT Enrollment Data Rule and 382 ERA Enrollment Data Rule. In order to meet the ACA requirements for Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA), modifications have already been implemented to the existing EFT and ERA information collected both via the Web portal and on paper.

Providers and/or trading partners already enrolled in EFT and/or ERA will not need to make any changes at the current time. Upon provider re-enrollment or upon updates to an EFT record or trading partner agreement, the new fields will be presented to providers/trading partners so that all information required by the rule is collected.

The Trading Partner Agreement form used for new enrollments and updates has been modified in accordance with the rule and all Trading Partners who submit paper enrollments and updates must begin using the new form **immediately**. The Trading Partner Agreement is available on the Web site www.ctdssmap.com under Trading Partner → EDI → EDI Documents → Trading Partner Agreement. Any Trading Partner Agreements submitted on the old form on or after August 1, 2014 will be returned to the trading partner for resubmission on the new form.

Additional information on these requirements can be found on the CAQH Web site at http://www.caqh.org/ORMandate_EFT.php.