TO: All Providers

RE: Implementation of ACA 1104 Phase III Operating Rules - EFT and ERA Changes

This bulletin serves to communicate new and important changes coming soon to the Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA) transactions.

Section 1104 of the Patient Protection and Affordable Care Act (ACA) establishes new requirements for administrative transactions that will improve the utility of the existing Health Insurance Portability and Accountability Act (HIPAA) transactions and reduce administrative costs. The Department of Social Services (DSS) and HP are in the process of implementing changes required under Phase III - Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE) Electronic Funds Transfer (EFT) & Electronic Remittance Advice (ERA) Operating Rules.

The following rules are covered under Phase III:

- CAQH CORE 350: Health Care Claim Payment/Advice (835) Infrastructure Rule
- CAQH CORE 360: Uniform Use of CARCs and RARCs (835) Rule
- CAQH CORE 370: EFT & ERA Reassociation (CCD+/835) Rule
- CAQH CORE 380: EFT Enrollment Data Rule
- CAQH CORE 382: ERA Enrollment Data Rule

The rules should be reviewed by all providers and their trading partners to determine impacts to their systems. The rules can be accessed on the CAQH Web site at http://www.caqh.org/ORMandate_EFT.php.

The remainder of this bulletin provides information on changes that will be occurring within the Connecticut Medical Assistance Program to support the rule requirements.

CAQH CORE 350: Health Care Claim Payment/Advice (835) Infrastructure Rule

This rule states that the receiver (trading partner/provider) of an X12 835 transaction must return the following:

- An X12 999 Implementation Acknowledgment that specifies for each functional group of X12 835 transactions that the functional group was either accepted, accepted with errors, or rejected.
- X12 999 must specify for each included X12 835 transaction set that the transaction set was either accepted, accepted with errors, or rejected.

CMAP will be modified to accept and process an incoming X12 999 for a Functional Group of v5010 X12 835 transactions.

Trading partner agreements will be modified to include the inbound X12 999 Functional Acknowledgement and the Companion Guide will be updated to conform to the required template.

CAQH CORE 360: Uniform Use of CARCs and RARCs (835) Rule

Conformance to Rule 360 requires the uniformed usage of valid Claim Adjustment Reason Codes (CARC)/ Remittance Advice Remark Codes (RARC)/ Claim Adjustment Group Code (CAGC) reject code combinations or CARC/National Council of Prescription Drug Programs (NCPDP) Claim Adjustment Group Code (CAGC) reject code combinations, by all payers based upon four CORE defined Business Scenarios, to communicate claims processing information to the submitter of the claim. The codes are used to communicate why claims are not paid at the billed rate, and are currently posted on the X12 835 ERA. 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.

The requirements of the rule may result in changes to existing CARC and RARC. The existing Connecticut Medical Assistance Program EOB (Explanation of Benefit) Crosswalk will be updated to reflect any changes. It is currently posted to the provider Web portal at www.ctdssmap.com under information publications> claims processing information> medical assistance program EOB crosswalk. The crosswalk will contain the EOB, EOB Description, Business Scenario, CARC, RC and the Claim Adjustment Group Code (CAGC).

CAQH CORE 370: EFT & ERA Re-association (CCD+/835) Rule

Rule 370 specifies the requirements and methods used by providers and healthcare systems to properly re-associate an ERA (X12 835) to an EFT payment. The rule specifies the minimum data elements that must be provided by the healthcare system and outlines where those data elements must be placed on the X12 835 and ACH/CCD+ transactions.

As a result of this rule, an addenda record will now be sent to a provider by their financial institution with each EFT payment. That addenda record will have the same data as the TRN segment on the ASC X12 N 835. Providers will need to ensure their systems are modified to accept the addenda.

The EFT fields on the ASC X12N 835, ERA transaction will only change minimally. The fields impacted by the change are:

- TRN02 – This field will be updated to remove the routing number and will only contain the EFT trace number.
- BPR16 – This date will reflect the Wednesday after the financial cycle, to match the EFT payment date.

You must contact your financial institution to arrange for the delivery of the CORE-required Minimum CCD+ data elements needed for re-association of the payment and the electronic remittance advice ERA.

CAQH CORE 380/382: EFT/ERA Enrollment Data Rules

In order to meet the ACA requirements for Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA), modifications are required 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 a trading partner agreement, new fields will be presented to providers/trading partners so that all information required by the rule is collected.

Although this bulletin serves to communicate new and important changes coming soon to the EFT and ERA transactions, please continue to monitor provider bulletins for more detailed information and implementation timeframes.

Providers will be notified when these changes occur. It is strongly suggested that providers contact their billing agency, software vendor or clearing house to ensure they are aware of and prepared for the forthcoming changes.