CAQH CORE and X12 Webinar Series: 835 Transaction, Standard & Operating Rules for an Advanced User

April 8, 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.
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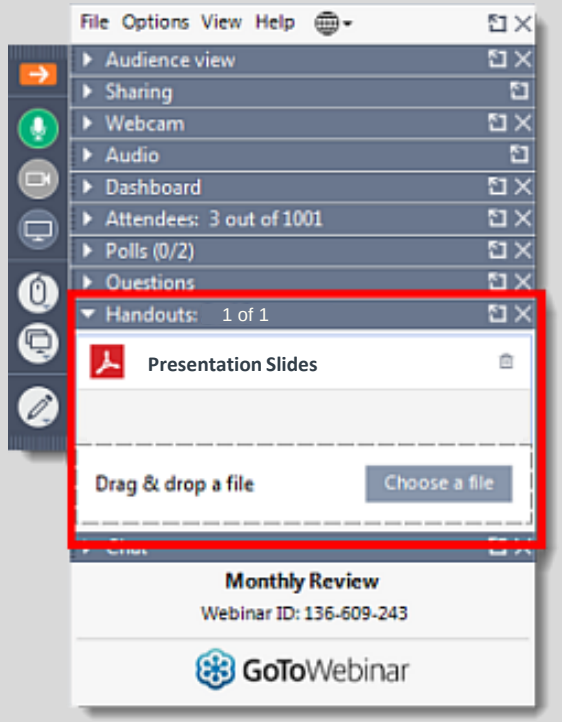

Session Outline

- Introduction to the 835 Transaction Standard
- CAQH CORE Payment and Remittance Operating Rules
  - CORE Code Combinations
- 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

X12 835 AND CORE OPERATING RULES – REPORTING ADJUSTMENTS

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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

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OUTLINE

- Introduction
- The X12 835 Overview
- Reporting Adjustments
- Wrap-Up

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Introduction

Introduction

The X12 835 Overview

Reporting Adjustments

Wrap-Up

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

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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

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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

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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*

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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*

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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

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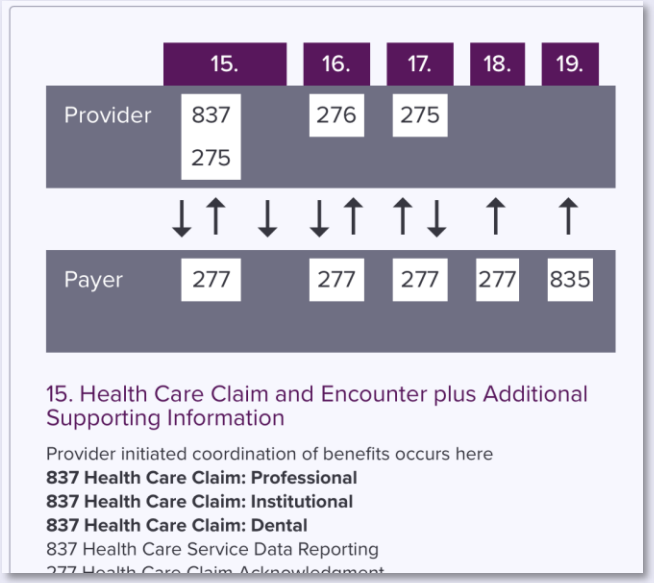
X12 HEALTH CARE TRANSACTION FLOW

X12's Health Care Transaction Flow

Visit X12.org/flow

Illustrates how X12 implementation guides and the transactions they're built upon support business-to-business data exchange in the health care industry

For example, Post-Health Care Delivery:



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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
  - 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

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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

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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

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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

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REPORTING ADJUSTMENTS

Adjustments explain changes to the payment 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*

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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.

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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

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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*

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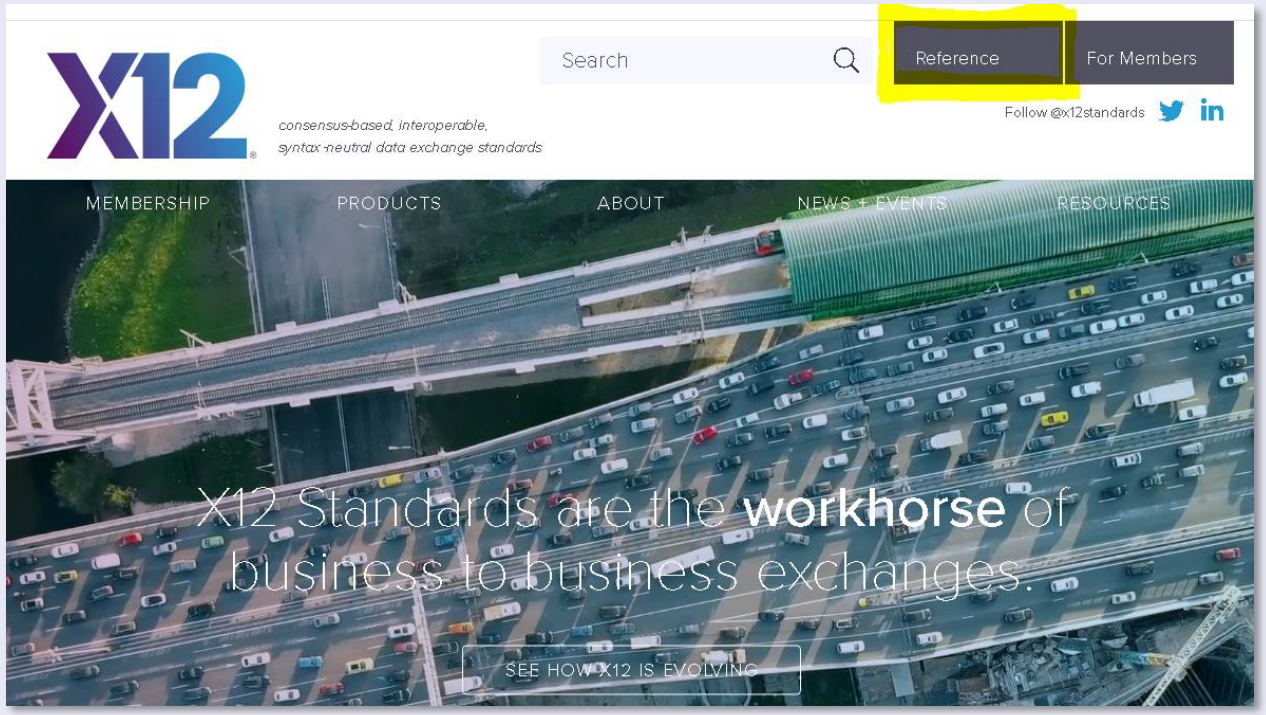
X12.ORG CODE LISTS



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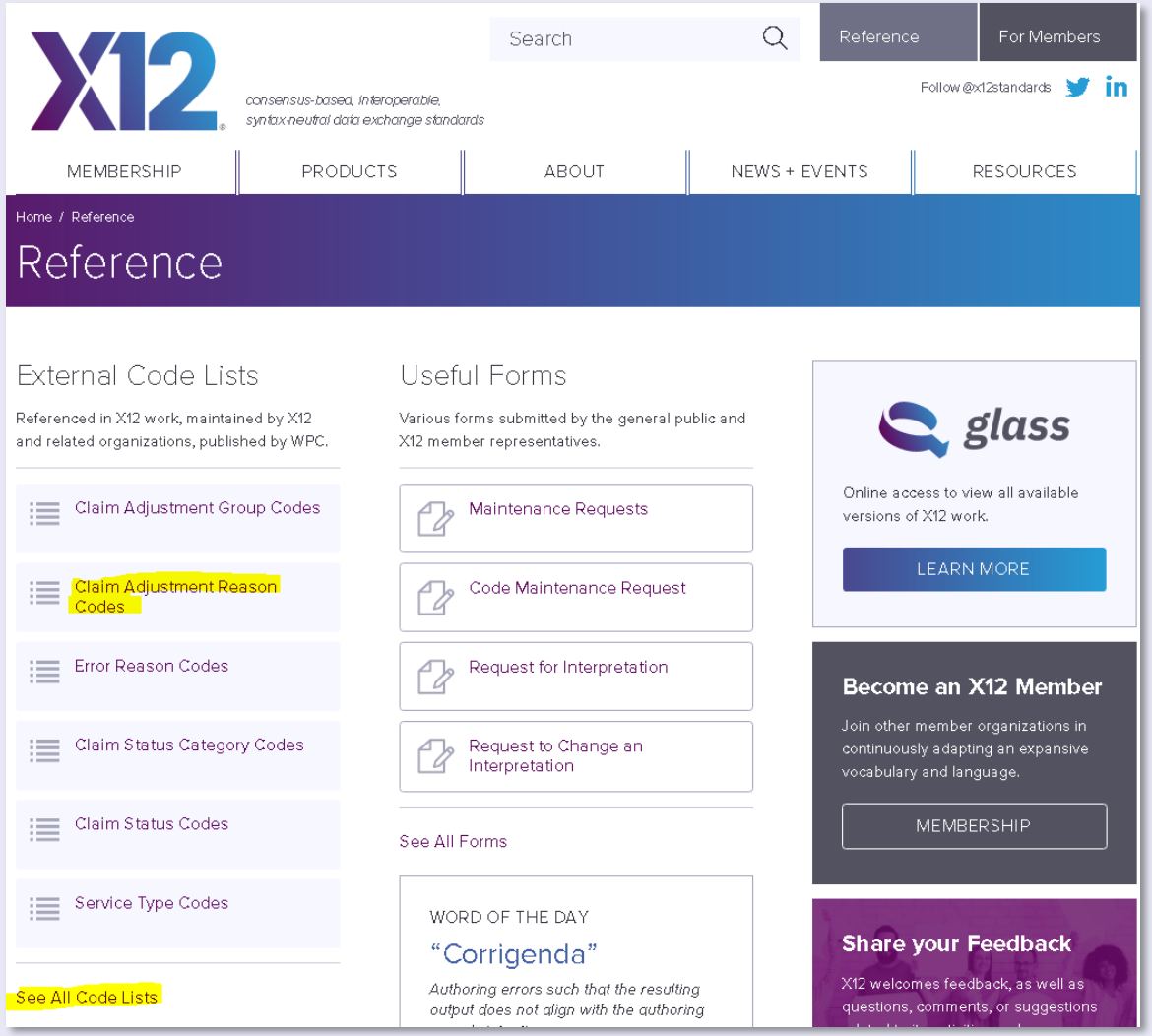
X12.ORG CODE LISTS



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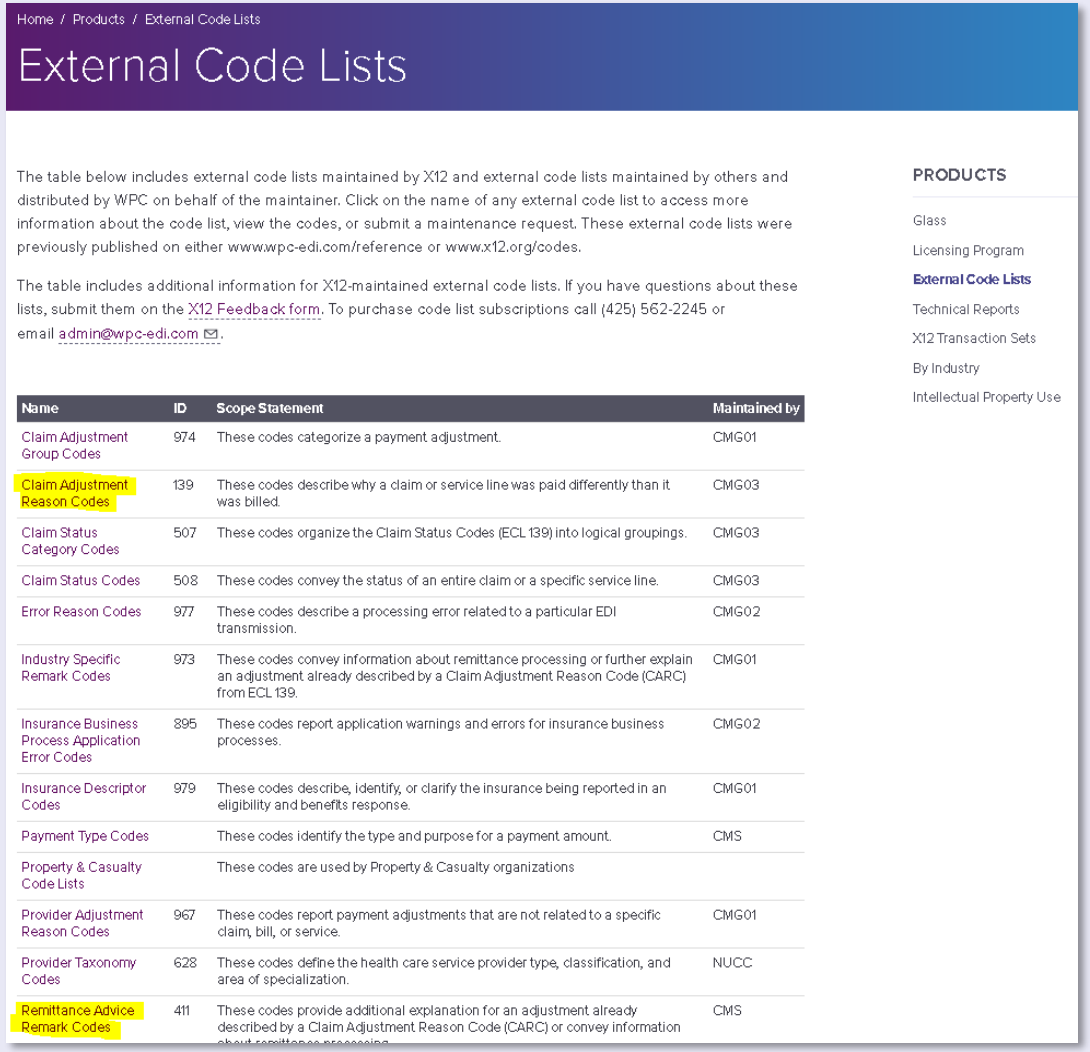
X12.ORG CODE LISTS



Home / Products / External Code Lists

External Code Lists

The table below includes external code lists maintained by X12 and external code lists maintained by others and distributed by WPC on behalf of the maintainer. Click on the name of any external code list to access more information about the code list, view the codes, or submit a maintenance request. These external code lists were previously published on either www.wpc-edi.com/reference or www.x12.org/codes.

The table includes additional information for X12-maintained external code lists. If you have questions about these lists, submit them on the X12 Feedback form. To purchase code list subscriptions call (425) 562-2245 or email admin@wpc-edi.com.

Name	ID	Scope Statement	Maintained by
Claim Adjustment Group Codes	974	These codes categorize a payment adjustment.	CMG01
Claim Adjustment Reason Codes	139	These codes describe why a claim or service line was paid differently than it was billed.	CMG03
Claim Status Category Codes	507	These codes organize the Claim Status Codes (ECL 139) into logical groupings.	CMG03
Claim Status Codes	508	These codes convey the status of an entire claim or a specific service line.	CMG03
Error Reason Codes	977	These codes describe a processing error related to a particular EDI transmission.	CMG02
Industry Specific Remark Codes	973	These codes convey information about remittance processing or further explain an adjustment already described by a Claim Adjustment Reason Code (CARC) from ECL 139.	CMG01
Insurance Business Process Application Error Codes	895	These codes report application warnings and errors for insurance business processes.	CMG02
Insurance Descriptor Codes	979	These codes describe, identify, or clarify the insurance being reported in an eligibility and benefits response.	CMG01
Payment Type Codes		These codes identify the type and purpose for a payment amount.	CMS
Property & Casualty Code Lists		These codes are used by Property & Casualty organizations	
Provider Adjustment Reason Codes	967	These codes report payment adjustments that are not related to a specific claim, bill, or service.	CMG01
Provider Taxonomy Codes	628	These codes define the health care service provider type, classification, and area of specialization.	NUCC
Remittance Advice Remark Codes	411	These codes provide additional explanation for an adjustment already described by a Claim Adjustment Reason Code (CARC) or convey information	CMS

PRODUCTS

- Glass
- Licensing Program
- External Code Lists
- Technical Reports
- X12 Transaction Sets
- By Industry
- Intellectual Property Use

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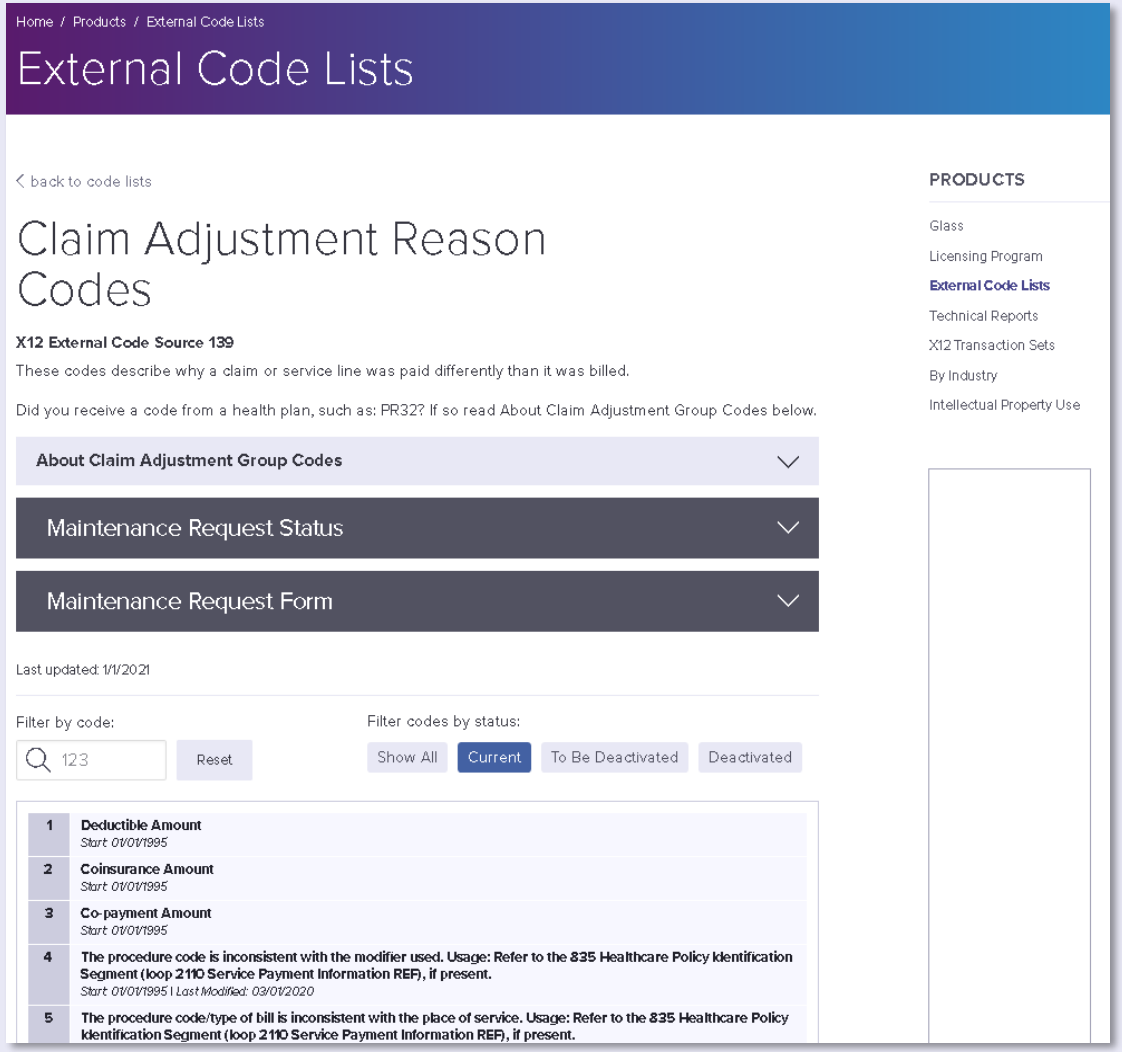
X12.ORG CODE LISTS



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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

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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

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CORE CODE COMBINATIONS

CAQH Committee on Operating Rules for Information Exchange (CORE)
Phase III CORE 360 Uniform Use of CARCs and RARCs (835) Rule
CORE-required Code Combinations for CORE-defined Business Scenarios
version 3.6.3 February 2021

Code Combinations for Business Scenarios #1, #2, #3, #4: Master Code List

The table also includes columns which contain values that indicate CARC changes (description modification, addition), RARC changes (description modification, addition) and wheth

Table 7-1
Code Combinations for CORE-defined Business Scenarios #1, #2, #3, #4: Master Code Li
Reference for all non-retail pharmacy scenarios (i.e., CORE-defined Business Scenarios #1 throu

CARC	CARC Description*	RARC*	RARC Description*	ASC X12 CAGC	CORE-defined Business Scenario	
A8	Ungroupable DRG.			CO or PI	**2**	
A8	Ungroupable DRG.	N647	Adjusted based on diagnosis-related group (DRG).	CO or PI	**2**	
A8	Ungroupable DRG.	N657	This should be billed with the appropriate code for these services.	CO or PI	**2**	
P7	The applicable fee schedule/fee database does not contain the billed code. Please resubmit a bill with the appropriate fee schedule/fee database code(s) that best describe the service(s) provided and supporting documentation if required. To be used for Property and Casualty only.			CO or PI	**2**	
P7	The applicable fee schedule/fee database does not contain the billed code. Please resubmit a bill	M51	Missing/incomplete/invalid procedure code(s).	CO or PI	**2**	
P7	The applicable fee schedule/fee database does not contain the billed code. Please resubmit a bill	M119	Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code	CO or PI	**2**	
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			CO, PI or PR	**3**	
5	The procedure code/type of bill is inconsistent with the place of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop	M77	Missing/incomplete/invalid/inappropriate place of service.	CO, PI or PR	**3**	
5	The procedure code/type of bill is inconsistent with the place of service. Usage: Refer to the 835	MA109	Claim processed in accordance with ambulatory surgical guidelines.	CO, PI or PR	**3**	
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			CO, PI or PR	**3**	
6	The procedure/revenue code is inconsistent with the patient's age. Usage: Refer to the 835	M37	Not covered when the patient is under age 35.	CO, PI or PR	**3**	

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WHAT'S NEXT FOR ADJUSTMENT REPORTING

In the next version of the 835:

- RAS Segment
  Replaced the CAS Segment with RAS
  Report all reasons (multiple CARCs and RARCs) for an dollar amount
- MIA/MOA Segments
  Remark Code elements set to Not Used
- LQ Segment
  Added LQ segment at the 2100 Claim loop
  To report RARCs that are not paired with a CARC in the RAS Segment
- Claim Adjustment Group Codes are external X12 code list
  Can be updated separate from the TR3
  Industry Specific Remark Codes (IISRC) for codes that so not meet the criteria for RARC list

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WHAT CAN YOU DO

- Become an X12 Member
- Participate in X12 Standing Meetings
- Submit requests for functionality your organization needs

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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

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THANK YOU

WE WANT TO HEAR IT ALL,

TELL US AT

X12.ORG/FEEDBACK

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STAY CONNECTED

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CAQH CORE Overview

Robert Bowman
Director, CAQH CORE

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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.

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CAQH CORE

CAQH CORE Participating Organizations

Over 120 CAQH CORE Participating Organizations work together to develop and implement rules of the road that streamline the business of healthcare, across all components of the revenue cycle.

A Sample of Organizations that Participate in CAQH CORE

(See full list here)

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What are Operating Rules?

Definition and CAQH CORE Role

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.

CAQH CORE is the HHS-designated Operating Rule Author for all HIPAA-covered transactions.

Operating Rules are Crucial in a Technology-driven World

- To effectively share electronic healthcare data, stakeholders from across the industry – **CAQH CORE Participants** – have come together to develop and adopt common sets of operating rules.
- Operating Rules **do not** specify how a payer/provider structures a business process supported by an electronic transaction.
  - Example: Operating rules do not stipulate when or how prior authorization is used by a health plan; if prior authorization is used, operating rules indicate how information regarding that transaction is electronically exchanged.

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CAQH CORE Operating Rules

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 Rule
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	Connectivity Rule vC3.0.0	Prior Authorization (278) Data Content Rule	Prior Auth Web Portal Rule
Health Care Claims	Health Care Claim (837) Infrastructure Rule			
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.

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CAQH CORE Operating Rules – Payment & Remittance

Robert Bowman
Director, CAQH CORE

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Electronic Remittance Advice

Explaining Claim Adjustments & Denials

Pain Points:

- 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

CAQH CORE Payment & Remittance Operating Rule Requirements

CAQH CORE Payment & Remittance Operating Rules 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 preference for 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.

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Benefits of CAQH CORE Payment & Remittance 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.

2020 CAQH Index

Medical plan adoption of electronic remittance advice continued to increase, rising six percentage points (51% to 57%).

Dental plans also showed an increase in adoption year over year, rising three percentage points to 25 percent.

The medical and dental industries combined spent $7 billion on remittance advice transactions, representing the second highest transaction expense after eligibility and benefit verification.

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CORE Code Combinations

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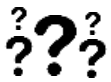
CAQH CORE Code Combinations Maintenance

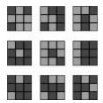
Why Was This Needed?

Pain Points:



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 interpretatio**n 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.

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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

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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.

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Use Case Driven Approach: Electronic Remittance Advice

How CORE Code Combinations Improve Automation & Adjudication

Patient presents with abdominal pain and Physician orders an imaging service. Prior to completing the service, the Physician receives a prior authorization approval for the service: CT scan with contrast.

1 Physician submits Claim to Health Plan for payment of imaging service rendered using the code for CT scan WITHOUT contrast.

Provider includes data identifying the patient, the provider, the specific diagnosis code and service code.

2 Health Plan receives Claim and completes adjudication process.

Adjudication process includes member and provider look ups, eligibility and benefits review, specific procedure and revenue code analysis.

Health plans ensure that service is covered, matches the diagnosis and was deemed medically necessary.

Health Plan determines that the patient received a prior authorization for a CT with contrast and not for a CT without contrast

3 Health Plan denies the claim and sends an ERA explaining the denial.

In the ERA, the Health Plan sends the following code combination: CORE-defined Business Scenario #2 CARC 16/ RARC N54.

4 Provider receives claim denial and ERA with extracted message from Health Plan.

Provider receives ERA and the following message:

CORE-defined Business Scenario #2 – Additional Information Required Missing/Incomplete/Invalid Data From Claim.

CARC 16: Claim/service lacks information or has submission/billing error(s).

RARC N54: Claim information is inconsistent with pre-certified/authorized services.

5 Provider sends corrected claim with the service code for a CT with contrast.

The extracted message clearly outlines the next steps necessary for the Physician to reclaim payment.

Physician sends corrected claim to Health Plan with the authorized service code without unnecessary follow-up with the Health Plan..

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Polling Question #1

What topic would be of more interest for the next webinar in the series?

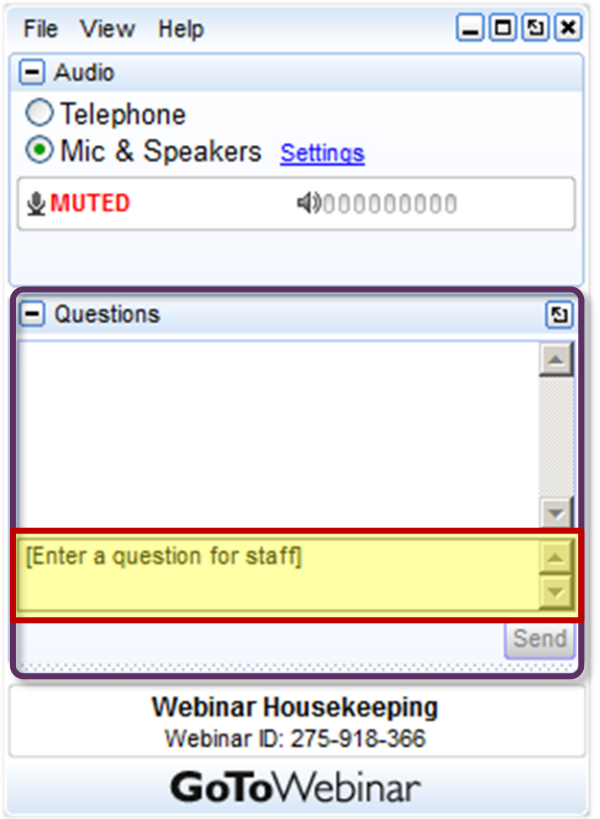
- Technical webinar on the 278 (Healthcare Services Review and Response) transaction.
- X275 Attachments for the 278 (Healthcare Services Review and Response) transaction.
- X275 Attachments for the 837 (Health Care Claim) transaction.
- Beginner webinar on the 837 (Health Care Claim) transaction.
- Technical webinar on 837 (Health Care Claim) transaction.

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

Thank you for joining us!

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Website: www.CAQH.org/CORE

Email: CORE@CAQH.org

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Website: www.x12.org

Email: support@x12.org