Committee on Operating Rules for Information Exchange (CORE®)

Phase III CORE 360 Uniform Use of Claim Adjustment Reason Codes and Remittance Advice Remark Codes (835) Rule

*NOTE: This document is not the most current version of the CORE Code Combinations. The current version is available on the CAQH CORE website here: http://www.caqh.org/Host/CORE/EFT-ERA/CORE-required_CodeCombos.xlsx.

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1 Background Summary

In Phase III, CORE built on the Phase I and Phase II foundation by adding a range of operating rule requirements for both the HIPAA-adopted ASC X12 005010X221A1 Health Care Claim Payment/Advice (835) Technical Report Type 3 Implementation Guide and associated errata (hereafter v5010 X12 835) transaction, also known as the Electronic Remittance Advice (ERA), and the Electronic Funds Transfer (EFT) by addressing operating rules related to the NACHA ACH CCD plus Addenda Record (hereafter CCD+) and the X12 835 TR3 TRN Segment (hereafter the CCD+ and X12 835 TR3 TRN Segment together are the Healthcare EFT Standards[1]). The Phase III CORE 350 Health Care Claim Payment/Advice (835) Infrastructure Rule Version 3.0.0 focused on improving the conduct and exchange of electronic claim advice data. The Phase III CORE 360 Uniform Use of Claim Adjustment Reason Codes and Remittance Advice Remark Codes (835) Rule Version 3.0.0 builds upon the Phase III CORE 350 Health Care Claim Payment/Advice (835) Infrastructure Rule Version 3.0.0 by establishing data content rule requirements for conducting the v5010 X12 835 transaction.

The v5010 X12 835 provides data content to the provider regarding the payment of a claim including why the total charges originally submitted on a claim have not been paid in full or a claim payment has been denied. The denial or adjustment of a claim is identified by the health plan or its Pharmacy Benefits Manager (PBM) agent using combinations of four claim denial/adjustment code sets that, when used in combination, should supply the provider with necessary detail regarding the payment of the claim. These code sets are Claim Adjustment Reason Codes[2] (hereafter CARCs), Remittance Advice Remark Codes[3] (hereafter RARCs), and Claim Adjustment Group Codes (hereafter CAGCs), and NCPDP External Code List[4] Reject Codes (hereafter NCPDP Reject Codes).

Currently, there is extensive confusion throughout the healthcare industry regarding the use of the claim denial/adjustment codes. CORE determined that the healthcare industry requires operating rules establishing data content requirements for the consistent and uniform use of CARCs, RARCs, CAGCs and NCPDP Reject Codes when transmitting the v5010 X12 835. Consistent and uniform use of CARCs, RARCs, CAGCs and NCPDP Reject Codes for electronic reporting of claims adjustment and denials will 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

And provide for:

- Less staff time spent on phone calls and websites
- Increased ability to conduct targeted follow-up with health plans and/or patients
- More accurate and efficient payment of claims

Achieving a consistent and uniform approach in such a complex area requires using a multi-step process that is focused on actively enabling the industry to reach its long-term goal of a maximum set of CARC/RARC/CAGC and CARC/NCPDP Reject Code/CAGC Combinations. This initial rule provides a clear set of reasonable and well-researched requirements and a process to create future requirements that are based upon real-world results.

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[1] The CCD+ and X12 835 TR3 TRN Segment are adopted together as the Federal Healthcare EFT Standards in CMS-0024-IFC: Administrative Simplification: Adoption of Standards for Health Care Electronic Funds Transfers (EFTs) and Remittance Advice, 01/10/12.

[2] ASC X12 assists several organizations in the maintenance and distribution of code lists external to the X12 family of standards. http://www.wpc-edi.com/reference/

[3] Ibid.

[4] http://www.ncpdp.org/members/members_download.aspx. NCPDP Reject Codes are in Appendix A.

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1.1 Affordable Care Act Mandates

This rule is part of a set of rules that addresses a request from the National Committee on Vital and Health Statistics (NCVHS) for fully vetted CAQH CORE Operating Rules for the Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA) transactions; the NCVHS request was made in response to NCVHS' role in Section 1104 of the ACA.

Section 1104 of the ACA contains an industry mandate for the use of operating rules to support implementation of the HIPAA standards. Using successful, yet voluntary, national industry efforts as a guide, Section 1104 defines operating rules as a tool that will build upon existing healthcare transaction standards. The legislation outlines three sets of healthcare industry operating rules to be approved by the Department of Health and Human Services (HHS) and then implemented by the industry; the second set of which are those for EFT and ERA.[5] The ACA requires HHS to adopt a set of operating rules for both of these transactions by July 2012. In a letter dated 03/23/11,[6] NCVHS recommended that the Secretary "name CAQH CORE in collaboration with NACHA – The Electronic Payments Association as the candidate authoring entity for operating rules for all health care EFT and ERA transactions..."

Section 1104 of the ACA also adds the EFT transaction to the list of electronic health care transactions for which the HHS Secretary must adopt a standard under HIPAA. The section requires the EFT transaction standard be adopted by 01/01/12, in a manner ensuring that it is effective by 01/01/14. In January 2012, HHS issued an Interim Final Rule with Comment (IFC)[7] adopting the CCD+ and the X12 835 TR3 TRN Segment[8] as the Healthcare EFT Standards. These standards must be used for electronic claims payment initiation by all health plans that conduct healthcare EFT.

1.2 Existing Standards/Operating Rules

1.2.1 v5010 X12 835 Health Care Claim Payment/Advice Transaction

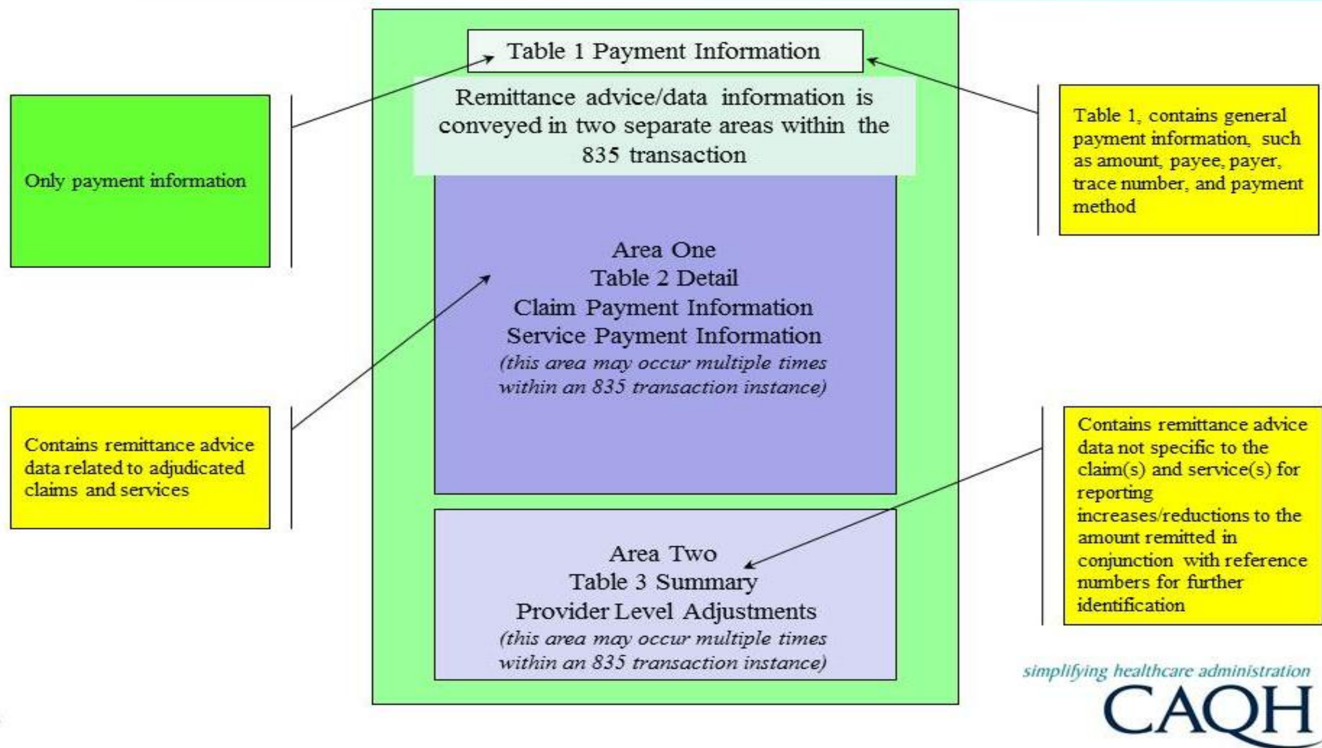
The ERA is an electronic version of a payment explanation (remittance advice) submitted by a health plan or its PBM agent to a provider that explains the payment a provider receives for a service claim. If a claim is denied or payment adjusted, the ERA would contain the required explanations. The v5010 X12 835 Health Care Claim Payment/Advice transaction was adopted under HIPAA for electronic reporting of all healthcare claim payment and remittance information. The v5010 X12 835 implementation guide provides the standardized data requirements to be implemented. The diagram below outlines the structure of the v5010 X12 835. Detailed information about the remittance advice, including the use of CARCs and RARCs (the focus of this rule), is contained in Table 2 Detail Claim Payment and Service Payment Information.

[5] The first set of operating rules under ACA Section 1104 applies to eligibility and claim status transactions with an adoption date of 07/01/11 and effective date of 01/01/13; the third set of operating rules applies to healthcare claims or equivalent encounter information transactions, enrollment and disenrollment in a health plan, health plan premium payments and referral, certification and authorization with an adoption date of 07/01/14 and effective date of 01/01/16.

[6] NCVHS Letter to the Secretary - Affordable Care Act (ACA), Administrative Simplification: Recommendation for entity to submit proposed operating rules to support the Standards for Health Care Electronic Funds Transfers and Health Care Payment and Remittance Advice 03/23/11.

[7] CMS-0024-IFC: Administrative Simplification: Adoption of Standards for Health Care Electronic Funds Transfers (EFTs) and Remittance Advice, 01/10/12.

[8] The IFC requires health plans to input the X12 835 TR3 TRN Segment into the Addenda Record of the CCD+; specifically, the X12 835 TR3 TRN Segment must be placed in Field 3 of the Addenda Entry Record (''7 Record'') of a CCD+.



The v5010 X12 835 provides a range of information to the provider regarding the payment of a claim, why the total charges originally submitted on a claim have not been paid in full and/or information about denied claims. The denial or adjustment of a claim is identified by the health plan or its PBM agent using the following code sets that, when used in combination, should supply the provider with necessary detail regarding the payment of the claim:

- CARCs (Required/external code list)[9]
- RARCs (Required/external code list)[10]
- CAGCs (Required/internal code list)[11]
- NCPDP External Code List (Required/external code list)[12]

NOTE*: The first two code lists above (CARCs and RARCs) are used to explain payment adjustments in remittance advice transactions. CARCs identify reasons why healthcare claims or services are not being paid at submitted charges; RARCs provide supplemental information about the adjudication of claims or services. The reason for pursuing this rule area for the Federally mandated EFT & ERA transactions is further defined in §2.1 and centers around requirements for the consistent use of specific combinations of CAGCs/CARCs/RARCs and CAGCs/CARCs/NCPDP Reject Codes based on four specific business scenarios.*

[9] http://www.wpc-edi.com/content/view/695/1
[10] http://www.wpc-edi.com/content/view/739/1
[11] ASC X12 005010X221A1 Health Care Claim Payment/Advice (835) Technical Report Type 3 and associated errata
[12] http://www.ncpdp.org/members/members_download.aspx. NCPDP Reject Codes are in Appendix A.

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2 Issue to be Addressed and Business Requirement Justification

The v5010 X12 835 implementation guide provides a range of information to the provider regarding the adjudication and payment information of a claim: the v5010 X12 835 can be used to make a payment, send an Explanation of Payment (EOP) remittance advice or make a payment and send an EOP jointly.

2.1 Problem Space: Medical

As a remittance advice, the v5010 X12 835 provides detailed payment information relative to adjudicated healthcare claim(s) and describes why payment for a submitted claim has been adjusted or denied. The v5010 X12 835 requires health plans or their PBM agents to use CARCs, RARCs, NCPDP Reject Codes and CAGCs to convey the rationale for claim payment adjustments to providers. If a claim payment has been adjusted, health plans or their PBM agents provide the reasons for such adjustments using a combination of:

- **CAGC:** Categorizes the associated CARC based on financial liability. Unlike CARCs and RARCs, which number in the hundreds, there are only 4 CAGCs identified for use in the v5010 X12 835: PR – Patient Responsibility; CO – Contractual Obligations; PI – Payor Initiated Reductions; OA – Other Adjustments. CARCs are always associated with a specific CAGC in the v5010 X12 835. The CAGCs are maintained by the ASC X12 Standards Committee.
- **CARC:** Provides the reason for the positive or negative financial adjustment specific to particular claim or service referenced in the transmitted v5010 X12 835. The external list of CARCs is maintained by the Codes Maintenance Committee established by the Blue Cross and Blue Shield Association, with a multi-stakeholder voting membership.
- **RARC:** Provides supplemental information about why a claim or service line is not paid in full. The external list of RARCs is maintained by the Centers for Medicare & Medicaid Services (CMS). The majority of CARCs do not require RARCs to complete the message; however, there are some specific CARCs that require use of an explanatory RARC.
- **NCPDP Reject Code**: Provides reasons why a retail pharmacy claim was rejected. The external list is maintained by NCPDP.

Often, providers do not receive the same uniform and consistent CARC/RARC/CAGC combinations for the same or similar business scenarios from all health plans and, as a result, are unable to automatically post claim payment adjustments and claim denials accurately and consistently. Two primary causes of the problem surrounding the reporting of claim payment adjustments include:

1. Use of code combinations based on proprietary, health plan specific business scenarios
2. Use of unique, individual health plan approaches to mapping of internal proprietary codes to CARCs/RARCs

Providers are challenged to understand the hundreds of different CARC/RARC/CAGC combinations, which can vary based on health plans' internal proprietary codes and business scenarios.

The v5010 X12 835 does not provide guidance for health plans around the selection of appropriate CARCs or RARCs; decisions on the CARC and/or RARC to explain a claim payment business scenario are left to the health plans. There is a high level of subjectivity to both the interpretation of the codes and their combinations. The various interpretation of the meaning of each code leads to a wide variety of code combinations used to address similar business situations.

Health plans and providers are also challenged by familiarity with the full scope of the CARC and RARC codes sets. Many health plans do not use the most current codes as the codes may be updated three times a year. This results in the inconsistent use of new or modified codes, as well as use of deactivated codes. Many providers are also unfamiliar with the current codes and their use.

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CAQH CORE and NACHA co-sponsored multi-stakeholder research to identify the barriers to achieving industry-wide rapid adoption of EFT and ERA and to develop initial recommendations on topics that operating rules and other industry efforts must address in order to facilitate adoption of EFT and ERA. The findings identified the challenges faced by providers due to inconsistent and non-uniform use of CARCs, RARCs and CAGCs.

First, due to the variations across health plans in the use of CARC/RARC/CAGC code combinations, provider interpretation is required to make sense of confusing and often contradictory reporting of claim payment adjustments. This may result in unnecessary manual provider follow-up, faulty electronic secondary billing and inappropriate write-offs of billable charges. Incorrect billing of patients for co-pays and deductibles may often result. Each of these outcomes costs providers and patients time and money.

Secondly, inconsistent or incomplete utilization of the CARCs/RARCs/CAGCs across the industry makes it difficult for providers to understand payment decisions and to automate posting to patient accounts. As a consequence, providers are often reluctant to implement the v5010 X12 835 transaction, or resort to developing their own tools to support payer-specific code mapping, reducing the return on investment for both providers and payers.[13]

2.2 Retail Pharmacy Claim Process Overview

The pharmacy industry adjudicates claims differently than the medical sector of health care, both with regard to process as well as with regard to codes used in that process.

In pharmacy, there are two key steps to claims adjudication that occur consistently across the millions of claims processed each day:

1. The service (claim) is adjudicated in real-time using the NCPDP Telecommunication Standard.
2. The v5010 X12 835 is then sent on the appropriate cycle.

Using the NCPDP Telecommunication Standard, pharmacies send a real-time request and receive an immediate real-time response from the processor.[14] If the claim is rejected, the NCPDP Reject Codes must be used consistently and uniformly across all trading partners; each NCPDP Reject Code is tied to a specific reason/field in the NCPDP Telecommunication Standard. Agreement on the use of these Reject Codes allows the pharmacy to ensure all required data for real-time adjudication are available. Once the adjudication process is completed, the processor then reports the final result of adjudication via a real-time response which includes payment information, payment reductions, etc.

At the appropriate timeframe (most processors have weekly or two week payment cycles) the processor generates the v5010 X12 835.

If necessary, adjustments are reported on the v5010 X12 835 using an appropriate CARC that the pharmacy industry has agreed upon. NCPDP has created a mapping document to tie claim response fields to CARCs in the v5010 X12 835.

The reporting of a rejected claim in a v5010 X12 835 transaction occurs only rarely given that the pharmacy already has the rejection information from the real-time processing of the claim and the v5010 X12 835 does not require the subsequent reporting of a rejected claim. Any such reporting is based on non-real-time claims processing and mutual trading partner agreement using the NCPDP Reject Codes combined with CARC 16.

[13] CAQH CORE/NACHA White Paper: Adoption of EFT and ERA by Health Plans and Providers: A White Paper Identifying Business Issues and Recommendations for Operating Rules (2011)

[14] For the purposes of this overview, the term processor refers to the adjudication entity, whether health plan, pharmacy benefit manager (PBM), payer, etc.

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Overview of NCPDP Reject Codes and Process

Over 21 years ago, NCPDP created Reject Codes for pharmacy claims processing. As the industry evolved and the number of codes increased and pharmacy adjudication moved to real-time, the industry agreed upon consistency in how the Reject Codes are applied and what fields are identified that need correction in the standard so IT systems could be built using this consistent list.

Currently, new NCPDP Reject Codes are requested by the industry via a submission process and are discussed and voted on for approval during NCPDP Work Group meetings which occur four times a year. An NCPDP Reject Code is approved upon a demonstrated business need by a consensus process which includes providers, payers, vendors, etc. An NCPDP Reject Code corresponds to a field in the NCPDP standards. Approved NCPDP Reject Codes are published in the NCPDP External Code List document quarterly.

The NCPDP Reject Codes are used consistently, as required under HIPAA, across the pharmacy industry. The reporting of rejects on claims requires all processors to use the NCPDP Reject Codes in the same manner. For example, if the plan requires Prescriber ID, but it is not present on the claim, the processor must reject with code "25" (Missing/Invalid Prescriber ID). It is recognized that not all processors may have the need to use all of the approximately hundreds of NCPDP Reject Codes but if used they must be used in the same manner. For example, one processor may have a business need for a given plan to require the Prescriber ID on a claim and edit for the proper ID; another processor may not need the Prescriber ID on a claim and ignore the field. To ensure consistent and uniform use, the NCPDP Reject Codes are located in a table that contains a reference to the field(s) in error.

Example Table

NCPDP Reject Code	Explanation	D.0 Field # and Name Possibly in Error
Ø7	M/I Cardholder ID	3Ø2-C2 (Cardholder ID)
25	M/I Prescriber ID	411-DB (Prescriber ID)

2.3 CORE Process in Addressing the Problem Space

To address this Problem Space associated with the v5010 X12 835 transaction, the CORE EFT & ERA Subgroup conducted a series of three surveys, numerous Subgroup discussions and significant review of research related to existing industry initiatives (e.g., CMS, Minnesota, NCPDP, Washington State, WEDI, etc.) to ultimately identify and agree on a single CORE Rule Option for which to develop Rule Requirements to address the Rule Opportunity Area: *Uniform Use of CARCs and RARCs.* The CORE Rule Option identified was:

- Identify and agree on a targeted *minimum* set of common or problematic Business Scenarios with a *maximum* specified set of code combinations for each Business Scenario based on those identified via existing efforts (CARC/RARC/CAGC or CARC/NCPDP Reject Codes/CAGC). (Note: CARC and RARC requirements do not include business scenarios in the v5010 X12 835 standard.)

Therefore, this Phase III CORE rule addresses the consistent use of these *maximum* CARC/RARC/CAGC and CARC/NCPDP Reject Code/CAGC code combinations mapped to a *minimum* set of CORE-defined Business Scenarios for reporting claim payment adjustments and denials in the v5010 X12 835. A health plan may develop additional Business Scenarios and associated code combinations for such Business Scenarios to meet its business needs.

The figure below depicts a high-level process and key steps that CAQH CORE used to complete its work. It should be noted that this rule is the first *national* approach to create operating rules to address the critical area of uniform use of CARC/RARC/CAGC code combinations. Establishing CORE's long-term commitment to regular enhancements of this operating rule is similar to the process that has been taken with other CORE rules, which state that the initial rule is the starting point and future CORE phases will expand upon the initial rule to ensure the industry meets its goal of administrative simplification. This milestone-driven approach addresses the ongoing

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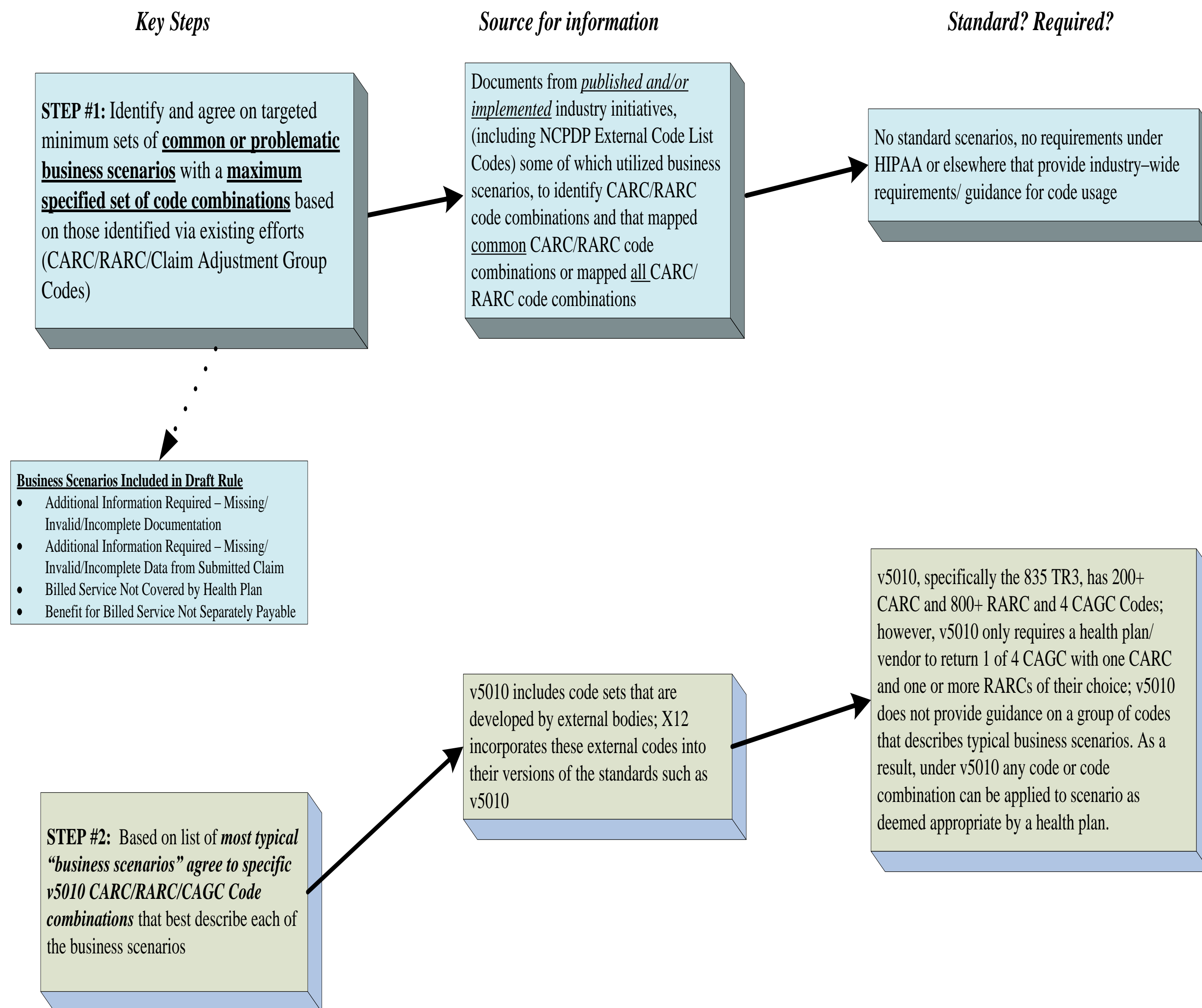
CORE goal that the industry must begin to reduce administrative costs today and not wait until 100% of all issues and associated costs can be resolved.

Overview of Rule Development Process for Phase III Uniform Use of CARCs & RARCs Rule



Upon agreement on a Rule Option, the Subgroup agreed the next step in the rule development process was to identify and review detailed Rule Requirements focused on a *minimum* set of Business Scenarios with a *maximum* set of CARC/RARC/CAGC or CARC/NCPDP Reject Code/CAGC code combinations for each Business Scenario. The Subgroup also noted that key to identification of Rule Requirements is building on *existing published and/or implemented industry initiatives* for which data source/analysis methods are verifiable. CAQH CORE conducted substantial analysis to compare the business scenarios related to the initiatives below to identify common business situations:

- Washington State Healthcare Forum: The WorkSMART Institute's Business & Technology Workgroup identified problematic situations for provider organizations where health plans use different CARCs/RARCs

on the v5010 X12 835 for the same denial/adjustment reason. The result was identification of three global business reasons for denial/payment adjustment within each of which were more specific situations (e.g., pathology report is missing for Business Scenario 1: *Provided information had invalid or missing information*). After identifying the common problematic business situations, the Work Group provided a mapping of the appropriate CARC/RARC/CAGC code combination to be used for each of the specific situations within the three global business reasons.

- WEDI: WEDI's Strategic National Implementation Process (SNIP) 835 Subworkgroup developed a white paper to provide a guidance tool for health plans mapping their internal proprietary codes to industry standard CARCs/RARCs. As part of this effort, the Subworkgroup created an associated CARC/RARC code combinations mapping tool in which they identified nine common business scenarios based on mapping proprietary codes from various health plans to all of the standard CARCs with associated CAGCs and RARCs. WEDI's effort built on the work done by LINXUS, a Greater New York Hospital Association effort, in 2008.
- Business Scenarios currently used by the CORE Participants.

Findings of this analysis identified four CORE-defined Claim Adjustment/Denial Business Scenarios. For each of the four CORE-defined Claim Adjustment/Denial Business Scenarios, an analysis of common CARC/RARC/CAGC and CARC/NCPDP Reject Code/CAGC code combinations between the WEDI and Washington State efforts was conducted to identify a maximum set of code combinations, which was compared to code combinations used by additional industry initiatives:

- Centers for Medicare and Medicaid Services (CMS): For Medicare, CMS analyzed CARCs utilized in FY 2010, and their associated RARCs. Their analysis showed that the top ten CARCs most frequently reported on the v5010 X12 835 accounted for 75% of total annual CARC usage across all v5010 X12 835 transactions. CMS also reported that the top 25 CARCs account for 85% of total CARC usage on an annual basis.
- Minnesota Department of Health: The Minnesota Uniform Companion Guide for the Implementation of the ASC X12/005010X221A1 Health Care Claim Payment/Advice v2.0 (the use of which is required by law in MN) addresses all allowed CARCs and RARCs combinations, excluding RARC Alerts, in the Minnesota Crosswalk for CARCs, CAGCs and RARCs.
- Code combinations currently used by the CORE Participants.

Out of this cross-industry analysis, the maximum set of CARC/RARC/CAGC or CARC/NCPDP Reject Code/CAGC combinations included in this rule for each of the four CORE-defined Claim Adjustment Business Scenarios was identified.

3 Scope

3.1 What the Rule Applies To

This CORE rule conforms with and builds upon the v5010 X12 835 by specifying that health plans or their PBM agents use a uniform set of CAGCs, CARCs, RARCs and NCPDP Reject Codes for specified CORE-defined Claim Adjustment/Denial Business Scenarios.

3.2 Applicable Loops, Data Elements & Code Sources

This rule covers the following data elements and loops in the v5010 X12 835 transaction. The scope of this rule is limited to the detail level, Table 2, Loop ID 2100 and Loop ID 2110 and applies to use of CAGCs, CARCs, RARCs and NCPDP Reject Codes at the claim and service levels.

Loop ID and Name
Loop 2100 Claim Payment Information
Data Element Segment Position, Number & Name
CAS01 – 1033 Claim Adjustment Group Code
CAS02 – 1034 Claim Adjustment Reason Code
CAS05 – 1034 Claim Adjustment Reason Code
CAS08 – 1034 Claim Adjustment Reason Code
CAS11 – 1034 Claim Adjustment Reason Code
CAS14 – 1034 Claim Adjustment Reason Code
CAS17 – 1034 Claim Adjustment Reason Code
MIA05, 20, 21, 22, 23 – 127 Reference Identification (Claim Payment Remark Code)
MOA03, 04, 05, 06, 07 – 127 Reference Identification (Claim Payment Remark Code)

Loop ID and Name
Loop 2110 Service Payment Information
Data Element Segment Position, Number & Name
CAS01 – 1033 Claim Adjustment Group Code
CAS02 – 1034 Claim Adjustment Reason Code
CAS05 – 1034 Claim Adjustment Reason Code
CAS08 – 1034 Claim Adjustment Reason Code
CAS11 – 1034 Claim Adjustment Reason Code
CAS14 – 1034 Claim Adjustment Reason Code
CAS17 – 1034 Claim Adjustment Reason Code
LQ01 – 1270 Code List Qualifier Code
LQ02 – 1271 Remark Code
MIA05, 20, 21, 22, 23 – 127 Reference Identification (Claim Payment Remark Code)
MOA03, 04, 05, 06, 07 – 127 Reference Identification (Claim Payment Remark Code)

This rule covers the following external code sources specified in the v5010 X12 835 transaction for the data elements listed in the table above:

v5010 X12 835 Code Source Reference # and Name
139 – Claim Adjustment Reason Code
411 – Remittance Advice Remark Codes
530 – NCPDP Reject/Payment Code [sic]

3.3 When the Rule Applies

This rule applies when an entity uses, conducts or processes the v5010 X12 835.

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3.4 What the Rule Does Not Require

This rule does not require any entity to conduct, use or process the v5010 X12 835 if it currently does not do so or is not required by Federal or state regulation to do so.

3.5 CORE Process for Maintaining CORE-defined Claim Adjustment Reason Code, Remittance Advice Remark Code & Claim Adjustment Group Code Combinations

The CARC, RARC and NCPDP Reject Code codes sets are used to report payment adjustments and denials in the v5010 X12 835. The CARC, RARC and NCPDP Reject Codes are maintained by organizations external to the ASC X12 Standards Committee. As such, these code lists are subject to revision and maintenance three or more times a year. Such revision and maintenance activity can result in new codes, revision to existing codes' definitions and descriptions, or a stop date assigned to a code after which the code should no longer be used.

Given this code list maintenance activity, CORE recognizes that the focus of this rule, coupled with this unique maintenance activity, will require a process and policy to enable the various CARC/RARC/CAGC and CARC/NCPDP Reject Code/CAGC combinations specified in the companion document to this rule, *CORE-required Code Combinations for CORE-defined Business Scenarios.doc,* to be revised and modified. CAQH CORE will establish an open process for soliciting feedback and input from the industry on a periodic basis, no less than three times per year, on the CARC/RARC/CAGC and CARC/NCPDP Reject Codes/CAGC combinations in the *CORE-required Code Combinations for CORE-defined Business Scenarios.doc* and convene a Subgroup to agree on appropriate revisions.[15] As part of this process, it will be expected that health plans/providers/vendors will report to CORE additional Business Scenarios that health plans or their PBM agents may be using on a frequent basis that are not covered by this CORE rule for consideration for additional Business Scenarios. A public request will be made to receive this real-world data and the analysis of the data will incorporate traditional Quality Improvement (QI) reviews as well as commitment to CORE Guiding Principles.

Both retail pharmacy and medical sectors are committed to continue to improve the process for reporting claim rejections and adjustments to providers consistently and uniformly across the industry. To further this commitment, both sectors will continue to collaborate and to take lessons learned from the industry to develop and enhance an ongoing QI process for maintaining, updating and supporting a stable industry-wide claim payment adjustments/denials code combination and code/field set.

3.6 Abbreviations and Definitions Used in this Rule

CORE-defined Claim Adjustment/Denial Business Scenarios: In general, a business scenario provides a complete description of a business problem such that requirements can be reviewed in relation to one another in the context of the overall problem. Business scenarios provide a way for the industry to describe processes or situations to address common problems and identify technical solutions. By making obvious what is needed, and why, the trading partners and vendors are able to solve problems using open standards and leveraging each other's skills.

Thus, in the context of this CORE rule, a CORE-defined Claim Adjustment/Denial Business Scenario describes at a high level the category of the denial or payment adjustment of a healthcare claim within the health plan's or PBM agent's adjudication system to which various combinations of CARC/RARC/CAGC or CARC/NCPDP Reject Code/CAGC can be applied so that details can be conveyed to the provider using the v5010 X12 835. The CORE-defined Claim Adjustment/Denial Business Scenarios are specified in §4.1.1.

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[15] Research shows that there has been little volatility in the code sets.

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3.7 How the Rule Relates to Phase I and II CORE

This rule builds upon and extends the Phase III CORE 350 Health Care Claim Payment/Advice (835) Infrastructure Rule Version 3.0.0 by requiring the v5010 X12 835 to use a uniform set of CAGC, CARC, RARC or CARC/NCPDP Reject Code/CAGC codes for specified CORE-defined Claim Adjustment/Denial Business Scenarios.

As with other Phase I and Phase II CORE rules, general CORE policies also apply to Phase III CORE EFT & ERA rules and will be outlined in the Phase III CORE EFT & ERA Rule Set.

This rule supports the CORE Guiding Principles that CORE rules will not be based on the least common denominator but rather will encourage feasible progress, and that CORE rules are a floor and not a ceiling, e.g., entities can go beyond the Phase III CORE Rules.

3.8 Assumptions

A goal of this rule is to establish a foundation for semantic interoperability of EDI in assuring that content of the transactions being exchanged conveys a consistent business message about any claim payment, adjustments or denials by the uniform use of a set of specified codes.

The following assumptions apply to this rule:

- A successful communication connection has been established
- This rule is a component of the larger set of Phase III CORE EFT & ERA Rules; as such, all the CORE Guiding Principles apply to this rule and all other rules
- This rule is not a comprehensive companion document of the v5010 X12 835 Health Care Claim Payment/Advice transaction set

4 Rule Requirements

4.1 Basic Requirements for Uniform Use of Claim Adjustment Reason Codes, Remittance Advice Remark Codes & Claim Adjustment Group Codes

This section addresses the requirements for a health plan or its PBM agent when sending a v5010 X12 835 with a claim payment adjustment or claim denial, submitted either in real time or in batch.

4.1.1 CORE-defined Claim Adjustment/Denial Business Scenarios

A CORE-defined Claim Adjustment/Denial Business Scenario describes, at a high level, the category of the denial or payment adjustment of a healthcare claim within the health plan’s or its PBM agent’s adjudication system. For each business scenario, specific combinations of CARC/RARC/CAGC or CARC/NCPDP Reject Code/CAGC codes can be applied to convey details of the claim denial or payment to the provider using the v5010 X12 835.

The four CORE-defined Claim Adjustment/Denial Business Scenarios represent a *minimum* set of Business Scenarios. When a specific CORE-defined Business Scenario is not applicable to meet the health plan’s or its PBM agent’s business needs, a health plan or its PBM agent may develop additional Business Scenarios and code combinations for them. Any additional Business Scenarios must not conflict with the CORE-defined Claim Adjustment/Denial Business Scenarios defined in this section.

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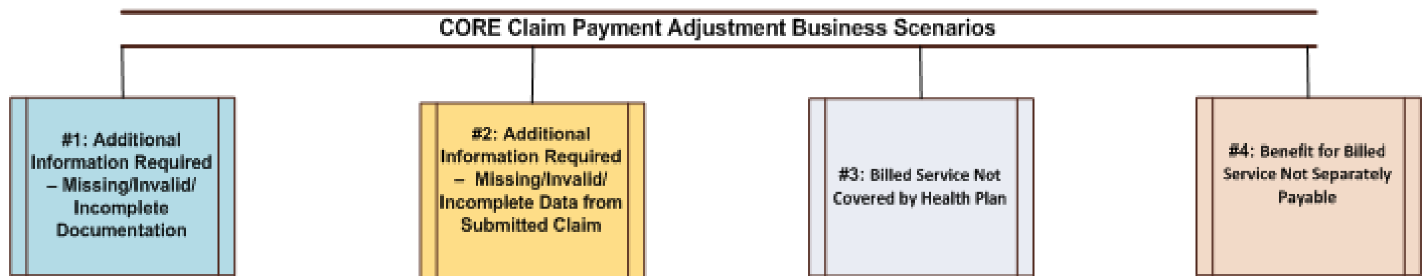
Table 4.1.1-1 defines four Claim Adjustment/Denial Business Scenarios.

Table 4.1.1-1	
CORE-defined Claim Adjustment/Denial Business Scenario	**CORE Business Scenario Description**
Scenario #1: Additional Information Required – Missing/Invalid/Incomplete Documentation	Refers to situations where additional documentation is needed from the billing provider or an ERA from a prior payer. The maximum set of CORE-defined code combinations to convey detailed information about the denial or adjustment for this business scenario is specified in *CORE-required Code Combinations for CORE-defined Business Scenarios.doc.*
Scenario #2: Additional Information Required – Missing/Invalid/Incomplete Data from Submitted Claim	Refers to situations where additional data are needed from the billing provider for missing or invalid data on the submitted claim, e.g., an 837 or D.0. The maximum set of CORE-defined code combinations to convey detailed information about the denial or adjustment for this business scenario is specified in *CORE-required Code Combinations for CORE-defined Business Scenarios.doc.*
Scenario #3: Billed Service Not Covered by Health Plan	Refers to situations where the billed service is not covered by the health plan. The maximum set of CORE-defined code combinations to convey detailed information about the denial or adjustment for this business scenario is specified in *CORE-required Code Combinations for CORE-defined Business Scenarios.doc.*
Scenario #4: Benefit for Billed Service Not Separately Payable	Refers to situations where the billed service or benefit is not separately payable by the health plan. The maximum set of CORE-defined code combinations to convey detailed information about the denial or adjustment for this business scenario is specified in *CORE-required Code Combinations for CORE-defined Business Scenarios.doc.*

***Note**: Business Scenario 4 does not apply to Retail Pharmacy because a prescription drug claim is reported at the service level as one Rx, e.g., prescription, which corresponds to the claim billed via the NCPDP Telecommunication standard.*

Below is a graphical representation of the CORE Claim Adjustment/Denial Business Scenarios.



4.1.2 Uniform Use of Claim Adjustment Reason Codes, Remittance Advice Remark Codes, Claim Adjustment Group Codes & NCPDP Reject Codes

A health plan or its PBM agent must align its internal codes and corresponding business scenarios to the CORE-defined Claim Adjustment/Denial Business Scenarios specified in §4.1.1 and the CARC, RARC, CAGC and NCPDP Reject Code combinations specified in the *CORE-required Code Combinations for CORE-defined Business Scenarios.doc.*

4.1.3 Use of CORE-required CARC/RARC/CAGC/NCPDP Reject Code Combinations

Specific details about a claim payment adjustment or denial are conveyed to the provider by the health plan or its PBM agent in the v5010 X12 835 by the combined use of a:

- Specified CAGC, a specified CARC and optionally one or more RARCs

Or

- Specified CAGC, a specified CARC with one or more NCPDP Reject Codes

These code combinations are defined as CORE-required CARC/RARC/CAGC or CARC/NCPDP Reject Code/CAGC combinations. The CORE required *maximum* CORE CARC/RARC/CAGC or CARC/NCPDP Reject Code/CAGC Code Combinations for each CORE-defined Claim Adjustment/Denial Business Scenario are specified in the *CORE-required Code Combinations for CORE-defined Business Scenarios.doc.* This document is available at http://www.caqh.org/Host/CORE/EFT-ERA/CORE-required_CodeCombos.xlsx.

A health plan or its PBM agent must support the maximum CORE-required CARC/RARC/CAGC or CARC/NCPDP Reject Code/CAGC combinations in the v5010 X12 835 as specified in *CORE-required Code Combinations for CORE-defined Business Scenarios.doc*; no other CARC/RARC/CAGC or CARC/NCPDP Reject Codes/CAGC combinations are allowed for use in the CORE-defined Claim Adjustment/Denial Business Scenarios. When specific CORE-required CARC/RARC/CAGC or CARC/NCPDP Reject Code/CAGC combinations are not applicable to meet the health plan's or its PBM agent's business requirements within the CORE-defined Business Scenarios, the health plan and its PBM agent is not required to use them.

The only exception to this maximum set of CORE-required CARC/RARC/CAGC or CARC/NCPDP Reject Code/CAGC combinations is when the respective code committees responsible for maintaining the codes create a new code or adjust an existing code. Then the new or adjusted code can be used with the Business Scenarios and a CORE process for updating the Code Combinations will review the ongoing use of these codes within the maximum set of codes for the Business Scenarios. A deactivated code must not be used.

In the case where a health plan or its PBM agent wants to use an existing code combination that is not included in the maximum code combination set for a given CORE-defined Business Scenario, a new CARC/RARC code combination must be requested in accordance with the CORE process for updating the *CORE-required Code Combinations for CORE-defined Business Scenarios.doc.*

4.2 Basic Requirements for Receivers of the v5010 X12 835

When receiving a v5010 X12 835, a product extracting the data (e.g., a vendor's provider-facing system or solution) from the v5010 X12 835 for manual processing must make available to the end user:

- Text describing the CARC/RARC/CAGC and CARC/NCPDP Reject Codes *included in the remittance advice,* ensuring that the actual wording of the text displayed accurately represents the corresponding code description specified in the code lists without changing the meaning and intent of the description

And

- Text describing the corresponding CORE-defined Claim Adjustment/Denial Business Scenario.

The requirement to make available to the end user text describing the corresponding CORE-defined Claim Adjustment/Denial Business Scenario does not apply to retail pharmacy.

This requirement does not apply to an entity that is simply forwarding the v5010 X12 835 to another system for further processing.

5 Conformance Requirements

Separate from any HHS certification/compliance program to demonstrate conformance as mandated under ACA Section 1104, CAQH CORE offers *voluntary* CORE Certification for all Phases of the CAQH CORE Operating Rules. CORE Certification is completely optional. Pursuing *voluntary* CORE Certification offers an entity a mechanism to test its ability to exchange EFT and ERA transaction data with its trading partners. A CORE-certified Seal is awarded to an entity or vendor product that voluntarily completes CORE certification testing with a CAQH CORE-authorized testing vendor. Key benefits of *voluntary* CORE Certification include:

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- Demonstrates to the industry adoption of the Phase III CORE EFT & ERA Operating Rules via a recognized industry "Seal"
- Encourages trading partners to work together on transaction data content, infrastructure and connectivity needs
- Reduces the work necessary for successful trading partner testing as a result of independent testing of the operating rules implementation
- Promotes maximum ROI when all stakeholders in the information exchange are known to conform to the CORE Operating Rules

For more information on achieving *voluntary* CORE Certification for the CAQH CORE EFT & ERA Operating Rules, refer to the Phase III CORE EFT & ERA Operating Rules Voluntary Certification Master Test Suite Version 3.0.0 or contact CORE@caqh.org.

6 Appendix

6.1 References

- ASC X12 005010X221A1 Health Care Claim Payment/Advice (835) Professional Technical Report Type 3 and associated errata
- Claim Adjustment Reason Codes: http://www.wpc-edi.com/content/view/695/1
- Remittance Advice Remark Codes: http://www.wpc-edi.com/content/view/739/1
- CAQH CORE/NACHA White Paper: Adoption of EFT and ERA by Health Plans and Providers: A White Paper Identifying Business Issues and Recommendations for Operating Rules (2011)
- Minnesota Uniform Companion Guide for the Implementation of the ASC X12/005010X221A1 Health Care Claim Payment/Advice v2.0 (2010)
- NCPDP External List Code: http://www.ncpdp.org/members/members_download.aspx. NCPDP Reject Codes are in Appendix A.
- Washington State Healthcare Forum. Best Practice Recommendation for Standard Coding of Denials and Adjustments in the HIPAA 835 Remittance Advice Transaction (835 v4010A1 & 5010) (2010)
- WEDI. A Practical Guide for the Mapping and Use of Claim Adjustment Reason Codes and Remittance Advice Remark Codes (2010)

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