OREGON HEALTH AUTHORITY
OREGON HEALTH LEADERSHIP COUNCIL
ADMINISTRATIVE SIMPLIFICATION GROUP

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# Oregon Companion Guide

*For the Implementation of the*

## *ASC X12N/005010X221*

### *HEALTH CARE CLAIM PAYMENT/ADVICE (835)*

*(Based on Version 5, Release 1 - April 2006)*

***And the published errata:***

- *ASC X12N/005010X221E1 (January 2009)*
- *ASC X12N/005010X221A1 (June 2010)*

**AUGUST 2013**
**VERSION 1.1**

**Disclaimer**
The following Oregon Companion Guide is intended to serve as a companion document to the corresponding *ASC X12N/005010X221 Health Care Claim Payment/Advice (835).* Throughout the rest of the document, the ASC X12 technical report and attendant errata are referred to as 005010X221 or as the 835.

The document further specifies the requirements to be used when preparing, submitting, receiving and processing electronic health care administrative data. The document supplements, but does not contradict, disagree, oppose, or otherwise modify the *005010X221* in a manner that will make its implementation by users to be out of compliance. Further, this guide is not a replacement for using the Technical Report 3 (TR3): the TR3 is required for the compliant implementation of this transaction. Using this companion guide does not mean that a claim will be paid. It does not imply payment policies of payers or the benefits that have been purchased by the employer or subscriber.

**Statutory Authority**
It is intended that this companion guide will be adopted and its use will be mandated for all HIPAA covered entities (payers, providers, and clearinghouses) conducting business or licensed in the state of Oregon. See section 2.4 for details on covered entities.

**Document Changes**
The content of this companion guide is subject to change. The version, release and effective date of the document are included in the document, as well as a description of the process for handling future updates or changes.

**About the Oregon Health Authority**
The Oregon Health Authority (OHA) was created by the 2009 Oregon legislature to bring most health-related programs in the state into a single agency to maximize its purchasing power. The OHA works with a nine-member, citizen-led board called the Oregon Health Policy Board. Members are appointed by the Governor and confirmed by the Senate. The Health Authority will transform the health care system in Oregon by; improving the lifelong health of Oregonians; Increasing the quality, reliability, and availability of care for all Oregonians; Lowering or containing the cost of care so it is affordable to everyone in the state.
http://www.oregon.gov/OHA/

**About the Oregon Health Leadership Council**
The Oregon Health Leadership Council is a collaborative organization working to develop practical solutions that reduce the rate of increase in health care costs and premiums so health care and insurance is more affordable to people and employers in the state. Formed in 2008 at the request of the Oregon business community, the council brings together health plans, hospitals and physicians to identify and act on cost-saving solutions that maximize efficiencies while delivering high quality patient care.
http://www.orhealthleadershipcouncil.org

**About the Administrative Simplification Group**
The Administrative Simplification group was first formed in the spring of 2008 by the Oregon Medical Association, Oregon Association of Hospitals & Health Systems and Regence BlueCross BlueShield of Oregon. After the formation of the Oregon Health Leadership Council, the workgroup became one of the four Leadership Council's workgroups.

This group identifies effective ways to simplify the administrative challenges faced by physicians and other healthcare professionals in order to streamline the business side of health care and provide cost-savings to the entire system. Three sub-groups were formed to explore increasing use of web sites for eligibility and claims information, investigate a common credentialing solution, and work toward standardization and automation of key processes.
http://www.orhealthleadershipcouncil.org/administrative-simplification

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**All published Oregon Companion Guides may be found at the following location:**
**http://www.oregon.gov/oha/OHPB/pages/health-reform/admin/index.aspx**

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## Oregon Companion Guide Revision History

| Ver. | Revision Date | Summary Changes |
|---|---|---|
| 1.0 | March 20 2013 | Version 1 of the 835 Oregon Companion Guide (ERA and EFT) |
| 1.1 | August 31, 2013 | Format changes and correction for consistency across all OCGs |
| | | |
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| | | |

# 1 EXCERPT FROM STATEMENT: OREGON HEALTH AUTHORITY

The 2009 Oregon Legislative Assembly directed the Office for Oregon Health Policy and Research (OHPR) to bring together a work group to recommend uniform standards for insurers for, at a minimum, eligibility verification, claims processes, payment remittance advice, and claims payment. The Oregon Health Policy Board asked the work group to expand the legislative direction and include a broad strategy for administrative simplification, including specifying the appropriate role for the state, and to estimate the potential for cost savings that can be achieved through administrative simplification.

The goal of administrative simplification is to reduce total system costs and reduce the amount of provider resources that must be devoted to administrative transactions between providers of care and payers by simplifying and streamlining these activities.

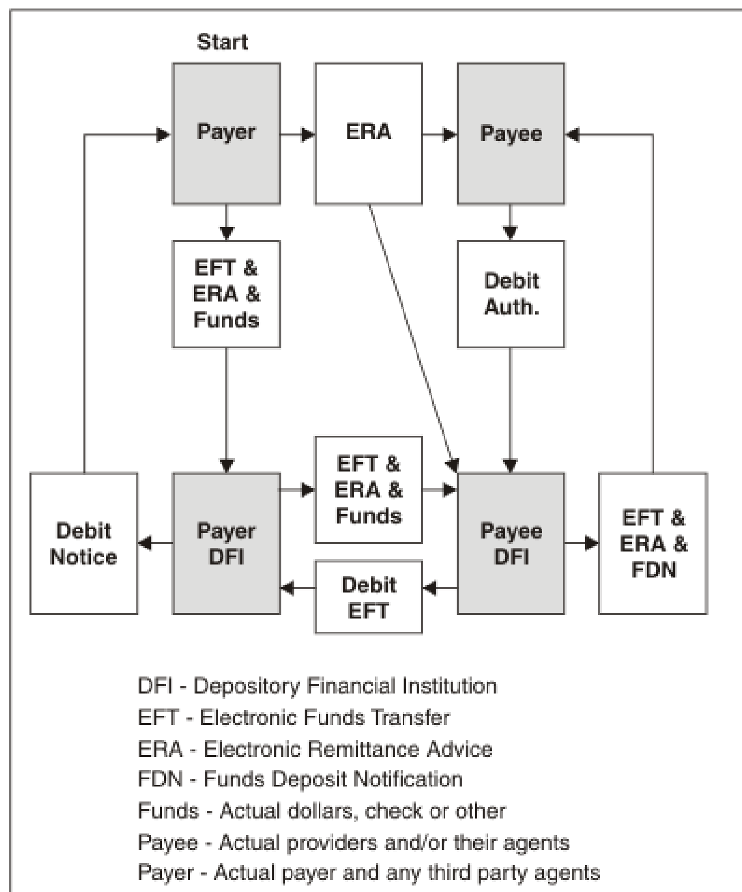
# 2 OVERVIEW

On January 16, 2009, the U.S. Department of Health and Human Services (HHS) published rules (CMS–0009–F) announcing the adoption of new versions of the federal transaction standards, known as ASC X12/005010 ("Version 5010"). The compliance deadline to implement the 5010 version of the transaction standards, on a nationwide basis, was January 1, 2012. One of the major transactions included in this version upgrade is the Health Care Claim Payment/Advice (835). The 835 is initiated by the payer and is received by the payee (provider) – or their respective third party agents.

The following definition and diagram is reproduced from the X12 Technical Report Type 3 - 005010X221 – Healthcare Claim Payment/Advice (835) - April 2006, Section 1.4

*The 835 is intended to meet the particular needs of the health care industry for the payment of claims and transfer of remittance information. The 835 can be used to make a payment, send an Explanation of Benefits (EOB) remittance advice, or make a payment and send an EOB remittance advice from a payer to a payee, either directly or through a DFI.*

The diagram below illustrates the flow of information from payer to payee directly or through their DFIs



Beginning January 1, 2012, Providers and Health Plans executing the Health Care Claim Payment/Advice (835) transactions may only use the 5010 version of the transaction (005010X221).

## 2.1 Purpose of the Oregon Companion Guide

The purpose of the Oregon Companion Guide is to clarify, supplement, and further define specific requirements to be used in conjunction with the 005010X221 (835) Technical Report Type 3 (TR3) created for the electronic transaction standard, mandated by the HIPAA regulations. Its purpose is to provide a common standard that can be easily and consistently applied by all Health Plans and Health Care Providers (refer definitions in Section 2.4) and yet, would continue to be fully compliant with federal regulations.

The term "Oregon Companion Guide" or its abbreviation "**OCG**" will be used consistently throughout this document to refer to the OCG being created at the request of the Oregon Health Authority.

## 2.2 Key Abbreviations

The following abbreviations are used extensively throughout this document

| | |
|---|---|
| **835** | The 005010X221 Health Care Claim Payment/Advice transaction |
| **005010X221** | Collective reference for the Health Care Claim Payment/Advice:<br>ASC X12N/005010X221<br>This OCG includes all errata and updates to the transaction published prior to the publication of this OCG. These are as follows:<br>ASC X12N/005010X221E1 (January 2009)<br>ASC X12N/005010X221A1 (June 2010) |
| **TR3** | Technical Report Type 3 – formerly known as the Implementation Guide (IG) |
| **OCG** | Oregon Companion Guide – this guide |

## 2.3 Applicability

**Effective January 1, 2014**, all Health Plans licensed or doing business in Oregon and Health Care Providers providing services for a fee or as an encounter in Oregon, must exchange health care claim payment/advice information electronically using

- 835 transaction as defined in the 5010 version
- The requirements included in this OCG (refer to section 3. Transaction Requirements)
- Implement fully operational transactions within the timelines that will be required under Oregon Statutes (section 2.3.1). The only exceptions to the statutory requirements are as follows:

- The requirements do not apply to the exchange of electronic claims status inquiry and response transactions with:
- Medicare
- Federally Administered programs
- Workers' Compensation programs
- Property and Casualty insurance plans

### 2.3.1 OREGON SENATE BILL 94

The Oregon Companion Guides are authorized by OHA and DCBS regulations established under Oregon's Senate Bill 94. The next paragraph is quoted from the Oregon Legislative Senate measure summary. The complete text of the bill is available at the following location:
http://www.leg.state.or.us/11reg/measpdf/sb0001.dir/sb0094.intro.pdf

*WHAT THE MEASURE DOES: Authorizes the Department of Consumer and Business Services (DCBS) to adopt uniform standards for health care financial and administrative transactions, including uniform standards for: (a) eligibility inquiry and response; (b) claim submission; (c) payment remittance advice; (d) claims payment or electronic funds transfer; (e) claims status inquiry and response; (f) claims attachments; (g) prior authorization; (h) provider credentialing; or, (i) other health care financial and administrative transactions identified by a stakeholder workgroup. Requires that uniform standards to apply to: (a) health insurers; (b) prepaid managed care health services organizations; (c) third party administrators; (d) self-insurance plans; (e) health care clearinghouses; and, (f) other persons that process health care financial and administrative transactions. Requires the Oregon Health Authority (OHA) to convene a stakeholder workgroup to recommend standards. Requires work group to consider applicable national standards when developing recommendations. Requires DCBS and OHA to confer and reconcile any differences between their respective requirements for health care financial and administrative transactions. Makes the Department of Human Services (DHS) subject to uniform standards. Declares emergency, effective on passage.*

## 2.4 Covered Entities - Definitions

The following definitions apply to HIPAA covered entities that will establish trading relationships using this OCG and are consistent with the definitions in the Code of Federal Regulations (CFR) 160 and 164.

### 2.4.1 HEALTH PLAN

***Health Plan*** *is defined as follows:*
**Note**: *This definition reproduced from Subtitle D—Privacy, Section 13400. Definitions, that appear in the Conference Report on page H1345 of Congressional Record—House, February 12, 2009.*

An individual or group plan that provides, or pays the cost of, medical care (as defined in section 2791(a)(2) of the Public Health Service Act, 42 U.S.C. 300gg-91(a)(2)).
(1) Health plan includes the following, singly or in combination:

- A group health plan
- A health insurance issuer

- An HMO
- Part A or Part B of the Medicare program under title XVIII of the Act.
- The Medicaid program under title XIX of the Act, 42 U.S.C. 1396, et seq.
- An issuer of a Medicare supplemental policy (as defined in section 1882(g) (1) of the Act, 42 U.S.C. 1395ss (g) (1)).
- An issuer of a long-term care policy, excluding a nursing home fixed- indemnity policy.
- An employee welfare benefit plan or any other arrangement that is established or maintained for the purpose of offering or providing health benefits to the employees of two or more employers.
- The health care program for active military personnel under title 10 of the United States Code.
- The veterans' health care program under 38 U.S.C. chapter 17.
- The Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) (as defined in 10 U.S.C. 1072(4)).
- The Indian Health Service program under the Indian Health Care Improvement Act, 25 U.S.C. 1601, et seq.
- The Federal Employees Health Benefits Program under 5 U.S.C. 8902, et seq.
- An approved State child health plan under title XXI of the Act, providing benefits for child health assistance that meet the requirements of section 2103 of the Act, 42 U.S.C. 1397, et seq.
- The Medicare + Choice program under Part C of title XVIII of the Act, 42 U.S.C. 1395w-21 through 1395w-28.
- A high-risk pool that is a mechanism established under State law to provide health insurance coverage or comparable coverage to eligible individuals.
- Any other individual or group plan, or combination of individual or group plans, that provides or pays for the cost of medical care (as defined in section 2791(a)(2) of the PHS Act, 42 U.S.C. 300gg-91(a)(2)).

- "Health Plan" includes an employee welfare benefit plan (as defined in section 3(1) of the Employee Retirement Income Security Act of 1974(ERISA)(29 U.S.C. 1002(1)), including insured and self-insured plans, to the extent that the plan provides medical care, as defined in section 2791(a)(2) of the Public Health Service (PHS) Act, 42U.S.C. 300gg–91(a)(2), including items and services paid for as medical care, to employees or their dependents directly or through insurance, reimbursement, or otherwise, that (1) Has 50 or more participants (as defined in section 3(7) of ERISA, 29 U.S.C. 1002(7)); or (2) Is administered by an entity other than the employer that established and maintains the plan. *45 CFR 160 Subpart A 160.103*

(2) Health plan excludes:

- Any policy, plan, or program to the extent that it provides, or pays for the cost of, excepted benefits that are listed in section 2791(c)(1) of the PHS Act, 42 U.S.C. 300gg-91(c)(1); and
- A government-funded program (other than one listed in section 1 of this definition):
  **(A)** Whose principal purpose is other than providing, or paying the cost of, health care; OR
  **(B)** Whose principal activity is
    a. The direct provision of health care to persons; or

b. The making of grants to fund the direct provision of health care to persons.

Health Plans may also be referred by the industry colloquial - **payers.**

### 2.4.2 HEALTH CARE PROVIDER

***Health Care Provider** is defined as follows:*
A person or organization that provides health care or medical care services within Oregon for a fee and is eligible for reimbursement for these services. For purposes of this subdivision, "for a fee" includes traditional fee-for-service arrangements, capitation arrangements, and any other arrangement in which a provider receives compensation for providing health care services or has the authority to directly bill a Health Plan, health carrier, or individual for providing health care services. This definition includes licensed nursing homes, licensed boarding care homes, and licensed home care providers.

Health Care Providers may also be referred by the industry colloquial - **providers.**

### 2.4.3 CLEARINGHOUSE

***Clearinghouse** is defined as follows:*
Entity contracted by Health Plans and Health Care Providers to create, send, receive, process, manage, or administrate standard electronic transactions are also subject to comply with the OCG. This would include entities that process the Health Care Claim Payment/Advice (835) and other HIPAA standard X.12 transactions as or on behalf of a HIPAA covered entity.

### 2.4.4 TRADING PARTNER

The term Trading Partner is used in the most general sense of its meaning, in EDI terms, within this document. It essentially means any entity that exchanges EDI transactions with another entity, addressed by the scope of the OCG. The entity could be a direct submitter (such as a **Health Plan** or **Health Care Provider**) or an entity that provides EDI and billing services (such as a **Clearinghouse**).

As described in the beginning of this section, this OCG applies to all claims payments/advice submitted electronically on or after January 2014 that use the transaction standard and corresponding *005010X221 (835).* The Code of Federal Regulations , title 45, part 162, subpart L specifies that the standard Health Care Claim Payment/Advice is this transaction standard.

## 2.5 Usage of Oregon Companion Guide – Consistency of Application

This document provides the agreed upon ‘foundation’ for the transmission of the 835 transaction. This document does not prevent trading partners from agreeing to make more specific/detailed information available in the transaction. However, covered entities must all be in compliance with the requirements included in this document – refer to section 3.

1. No trading partner may unilaterally or collectively require any other trading partner(s) to conform to standards that are not included in this OCG or the 835 TR3.

2. Once adopted through Oregon State mandates, no additions or modifications may be made to this OCG by Health Plans or Health Care Providers through their own companion guides or by establishing other requirements.

3. All transactions must fully comply with the current version of the HIPAA 835 transaction TR3 (current version - 005010X221- published in April 2006 and updated through erratas) in force at the time of executing the transactions.

## 2.6 Updating the Oregon Companion Guide

This OCG will be reviewed and updated periodically to conform to prevailing rules and standards that change and evolve over time. The current set of rules and guidelines are described in the TR3 for the 835 transaction and one follow up errata that are incorporated in this version of the OCG.

### 2.6.1 Future Updates to Oregon Companion Guide--Process

The EDI Workgroup undertook responsibility to develop this OCG and it is intended that the group will continue to track industry changes and best practices in the implementation of this, and other Oregon Companion Guides ( 270/271, 276/277, 835, and 837 transactions).

Once approved and published, the OCGs are operationally regulated and executed by the OHA. OHA may request a review, changes, or updates to operational OCGs based on industry and related developments. The OHA is the owner of these OCGs and any updates/changes to published guides must be conducted with their approval and involvement.

In order to incorporate relevant changes or updates to the OCGs, the workgroup will retain its membership and organizational structure even after the first versions of the OCGs are completed.

The workgroup will schedule to meet once every quarter, at the minimum, to review industry news during the quarter, and make any recommendations to the Administration Simplification Executive Committee that may result in a change to the guide or operational aspects of executing transactions.

The EDI Workgroup co-Chairs will retain the option of not calling the meeting if there are no newsworthy or pressing items that need discussion. Interest in scheduling a quarterly meeting may also be confirmed by polling the group sometime before the meeting.

When issues or changes come to light that must be addressed by the workgroup, the team will collectively make appropriate recommendations to the Executive Committee, for their approval, with a new schedule and resource requests necessary to complete the work or resolve the issue(s) or incorporate valid changes to the OCG(s).

The specific process for updating OCG documents, including submitting and collecting change requests, reviewing and evaluating requests and making recommendations, adopting and publishing a new version of the guide will be available from the OHA's - Oregon Office of Health Information Technology. Their website is as follows:
http://www.oregon.gov/oha/OHPB/pages/health-reform/admin/index.aspx

## 2.7 Addressing Code Set Issues in the Oregon Companion Guide

Code sets utilized in HIPAA electronic transactions are classified as:

- Internal Transaction Codes (included and defined inside the *005010X221*).
- External Code Sets (referenced by *005010X221* defined and maintained by external bodies) including:
  1. Non-Medical External Code Sets (such as Claims Adjustment Reason Codes, Remark Codes, Zip Codes etc). These values must be valid on the date the transaction is created. In the case of a reversal, the codes used must be valid based on the original transaction date.
  2. Medical and Dental External Code Sets (such as ICD-9, ICD-10, HCPCS; CDT). These values are effective based upon service date.

***Complete list of External Code Sources is included in Appendix A of the TR3 for this transaction.***

# 3 TRANSACTION REQUIREMENTS

## 3.1 Oregon Requirements for Transaction Implementation

This OCG requires all covered entities to be fully compliant with the CORE phase III rules and the standards described in the 005010X221 TR3, by the required date of January 1, 2014. This OCG adds no additional requirements to the federal standards.

### 3.1.1 CORE PHASE III RULES

All 835 transactions must conform to the following set of CORE rules included in phase III. The rules address the 835 transaction and the associated CCD+ standard for EFTs. The federal register interim final rule incorporates the CORE rules.

**Link to complete set of CAQH CORE phase III rules**
– *Rule requirements are found in section 4 within the corresponding rules section*
*http://www.caqh.org/Host/CORE/EFT-ERA/EFTERA_CompleteRuleSet.pdf*

**Link to Federal Register – Interim Final Rule**
– *Register / Vol. 77, No. 155 / Friday, August 10, 2012*
*http://www.gpo.gov/fdsys/pkg/FR-2012-08-10/pdf/2012-19557.pdf*

The Claim Adjustment Reason Codes (CARCs) and the Remittance Advice Remark Codes (RARCs) are subject to updates on a periodic basis. The updated list is available at the Washington Company website and may be accessed by following the link below:
CARCs - http://www.wpc-edi.com/reference/codelists/healthcare/claim-adjustment-reason-codes/
RARCs - http://www.wpc-edi.com/reference/codelists/healthcare/remittance-advice-remark-codes/

Please refer to the next section - **Appendix A: Summary of Phase III CORE EFT & ERA Rules** for a high-level description of the rules as released on August 10, 2012.

### 3.1.2 X.12 005010X221 TR3

All 835 transactions must conform to the current X.12 HIPAA standard transaction guide – TR3. A copy of the full *005010X221 (and erratas ASC X12N/005010X221E1 -January 2009 and ASC X12N/005010X221A1 -June 2010)* can be obtained from the Washington Publishing Company at http://www.wpc-edi.com.

## 3.2 Implementation Schedule

This OCG for the 835 (ERA & EFT) transaction, based on the Oregon Health Authority direction, requires covered entities to conform as per the following schedule:

| | |
|---|---|
| **January 1, 2014** | **All trading partners must use the 835 transactions and conform to this OCG**. **All Claims Payment/Advice transactions must be exchanged electronically using the 835 transaction** (005010X221, 005010X221E1, and 005010X221A1) **by this date**. |

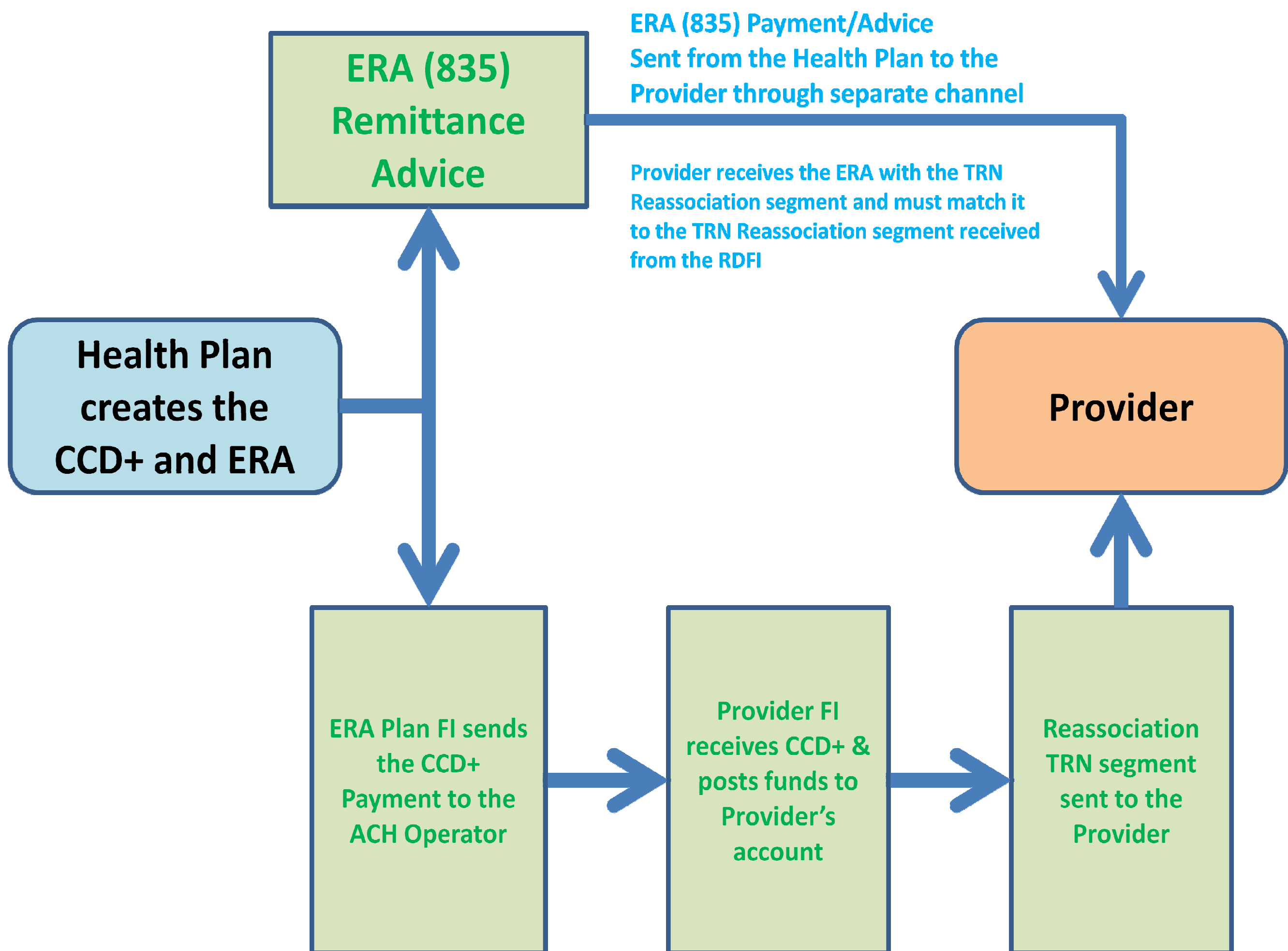
# 4 APPENDIX A: SUMMARY OF PHASE III CORE EFT & ERA RULES

This section presents a high-level summary of the CORE rules that form the basis of the regulations identified in section 3.1 in this Oregon Companion Guide. Follow this link to find additional information and educational opportunities relating to these rules:

http://www.caqh.org/CORE_Education_Events.php

***The content presented in this section is quoted from the Interim Final Rule legislation and from materials made publicly available by NACHA and CAQH.***

## 4.1 EFT and ERA Process Flow



## 4.2 Summary of CAQH CORE Operating Rules

The following table includes a summary of the CAQH CORE Operating Rules for the 835.

**Compliance date for requirements scope - January 1, 2014**

| Rule | High Level Requirements |
|---|---|
| **Uniform Use of CARCs and RARCs (835) Rule**<br>*Claim Adjustment Reason Code (CARC)*<br>*Remittance Advice Remark Code (RARC)* | • Identifies a *minimum* set of four CAQH CORE-defined Business Scenarios with a *maximum* set of CAQH CORE-required code combinations that can be applied to convey details of the claim denial or payment to the provider |
| **EFT Enrollment Data Rule** | • Identifies a maximum set of standard data elements for EFT enrollment<br>• Outlines a straw man template for paper and electronic collection of the data elements<br>• Requires health plan to offer electronic EFT enrollment |
| **ERA Enrollment Data Rule** | • Similar to EFT Enrollment Data Rule |
| **EFT & ERA Re-association (CCD+/835) Rule** | • Addresses provider receipt of the CAQH CORE-required Minimum ACH CCD+ Data Elements required for re-association<br>• Addresses elapsed time between the sending of the v5010 835 and the CCD+ transactions<br>• Requirements for resolving late/missing EFT and ERA transactions<br>• Recognition of the role of *NACHA Operating Rules* for financial institutions |
| **Health Care Claim Payment/Advice (835) Infrastructure Rule** | • Specifies use of the CAQH CORE Master Companion Guide Template for the flow and format of such guides<br>• Requires entities to support the Phase II CAQH CORE Connectivity Rule.<br>• Includes batch Acknowledgement requirements*<br>• Defines a dual-delivery (paper/electronic) to facilitate provider transition to electronic remits |

*** CMS-0028-IFC excludes requirements pertaining to acknowledgements.**

## 4.3 Changes to NACHA Operating Rules

The following changes have been made to NACHA Operating Rules and CCD+ standard to align with Healthcare Operating Rules. These changes will be effective September 20, 2013.

For more information on this subject, please refer to the NACHA (The Electronic Payments Association) website:
https://www.nacha.org/

| Overview of NACHA Rule Changes | Detail |
|---|---|
| Standard Identification of Health Care EFTs | The rule requires health plans to clearly identify CCD+ Entries that are Health Care EFT Transactions through the use of the specific identifier "HCCLAIMPMT" |
| Additional Formatting Requirements for Health Care EFTs | For a CCD+ Entry that contains the healthcare indicator, as described above, the health plan must include an addenda record that contains the ASC X12 Version 5010 835 TRN (Reassociation Trace Number) data segment; and to identify itself in the transaction by its name as it would be known by the provider |
| Delivery of Payment Related Information (Reassociation Number) | The rule requires an RDFI to provide or make available, either automatically or upon request, all information contained within the Payment Related Information field of the Addenda Record, no later than the opening of business on the second Banking Day following the Settlement Date. Further, this Rule would require the RDFI to offer or make available to the healthcare provider an option to receive or access the Payment Related Information via a secure, electronic means |
| Addition of New EDI Data Segment Terminator | The rule provides for the use of a second data segment terminator, the tilde ("~"), to any data segments carried in the Addenda Record of the CCD+ Entry |
| Health Care Terminology within the NACHA Operating Rules | The rule includes healthcare-related definitions |

# 5 APPENDIX B: REFERENCES AND BIBLIOGRAPHY

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