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TODAY'S MESSAGE

IMPORTANT CHANGES EFFECTIVE OCTOBER 11, 2013: ELECTRONIC REMITTANCE ADVICE (ERA) AND ELECTRONIC FUNDS TRANSFER (EFT) ENROLLMENT

This message informs providers of changes being implemented by Highmark Blue Cross Blue Shield Delaware (Highmark Delaware) to meet the Patient Protection and Affordable Care Act (PPACA) January 1, 2014 operating rule mandate. Providers will experience these changes beginning October 11, 2013.

In a final rule published August 10, 2012, HHS requires that health plans follow specified Phase III CAQH Committee on Operating Rules for Information Exchange (CORE) EFT & ERA Operating Rules. Two of the rules, for which providers may notice changes, are the "Uniform Use of CARCs and RARCs (835) Rule" and the "EFT Enrollment Data Rule." Providers may find more information on the rules, including the provider's obligations under the rules, by accessing the CAQH Operating Rules Mandate - EFT and ERA website at: http://www.caqh.org/ORMandate_EFT.php.

The goals of the CORE Rules are to enhance interoperability between providers and payers, streamline eligibility, benefits, and claims data transactions, and reduce the amount of time and resources providers spend on administrative functions. The CAQH CORE Guiding Principles require that the CAQH CORE Operating Rules align with current standards, code sets, and other federal initiatives.

Uniform Use of CARCs and RARCs (835) Rule Impact

The Uniform Use of CARCs and RARCs (835) Rule enables a more uniform use of the Claim Adjustment Reason Codes (CARCs), Remittance Advice Remark Code (RARCs), and Claim Adjustment Group Codes (CAGCs) by targeting a minimum set of common or problematic business scenarios with a maximum specified set of code combinations for each business scenario. There are two primary business scenarios for which provider action is needed:

- Additional Information Required - missing/invalid/incomplete documentation to support a claim
- Additional Information Required - missing/invalid/incomplete data from submitted claim

For these two business scenarios, the rule requires use of a Claim Adjustment Group Code "CO, Contractual Obligation" indicating that the provider is responsible for further action on claims rejected due to missing information. The use of Claim Adjustment Group Code "PR, Patient Responsibility," can no longer be associated with rejections for missing information when that information needs to be submitted by the provider. **For information that is typically determined and reported by the provider, the operating rule requires that the provider is responsible to correct and resubmit the claim; the provider cannot simply bill the patient.**

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Highmark Delaware is in the process of reviewing its use of group code “PR” and "CO" on these types of claim rejections and will make changes where “PR” is currently used for missing provider-reported information.

What does this mean to providers?
Since Highmark Delaware will be reassigning any codes that may fit more appropriately into another CAGC or CARC, providers may see a shift in the CAGC assigned to claims.

Example: A claim rejected for missing or invalid patient name. Initially this may have been coded with CAGC of "PR" because the member may need to validate the spelling of his/her name. The rule now requires that this type of rejection is assigned as "CO" as the provider is ultimately responsible for gathering accurate member information for claim submission. It is the provider's responsibility to first check their records to see if the missing information was a reporting error or if the member needs to be contacted and then resubmit the claim with the missing information.

Most codes currently used by Highmark Delaware on remittance advices are consistent with the CORE Operating Rules, and therefore will not change. Additionally, providers already receive denials for claims with missing data where the CAGC is "CO" and the claims data must be corrected and resubmitted. However, there are situations where the combination of CAGC, CARC, and RARC currently used are not permitted by the operating rule, and will be changed. The updated ERA codes will be effective for claims finalized on or after October 11, 2013.

EFT Enrollment Data Rule Impact
Effective October 11, 2013, NaviNet screens used to capture data for new EFT enrollees and for data modifications to current EFT enrollees will have cosmetic changes to be consistent with the common screen layout and terminology mandated by this operating rule for all payers. Providers are **NOT** required to re-enroll or modify any of their EFT information as a result of this rule. Additionally, no changes are being made to our EFT payment processing or schedules as a result of this rule. Providers currently enrolled for EFT will notice some website page and functionality changes with the EFT Enrollment process, if accessed for the purpose of modifying their existing EFT enrollment information (bank info, providers, etc.).

Timeframe
The changes described in this message will be effective with Highmark Delaware's October 11, 2013 system release.

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