CORE Payment & Remittance ERA Enrollment Data Rule

Version PR.2.0

November 2023

Revision History For CORE Payment & Remittance ERA Enrollment Data Rule

Version	Revision	Description	Date
3.0.0	Major	CORE 382 ERA Enrollment Data Rule balloted and approved via CORE Voting Process.	June 2012
3.0.1	Minor	Non-substantive adjustments to the CORE-required Maximum ERA Enrollment Data Set to improve usability: • Further distinguished Data Elements that do not obligate the provider to submit any associated data but provide essential context for related Sub-elements • Addressed table formatting inconsistencies • Ensured consistency between data elements • Corrected two minor typographical errors	July 2014
PR.1.0	Minor	• Non-substantive adjustments to support re-organization of operating rules into rule sets organized by business transaction (e.g., Eligibility & Benefits, Claim Status, etc.) rather than phase (e.g., Phase I, II, etc.) as approved by the CORE Board in 2019. • Operating rule naming, versioning and numbering methodologies updated to align with business transaction-based rule sets.	May 2020
PR.2.0	Major	Draft substantive updates to the CORE-required Maximum ERA Enrollment Data Set and rule requirements to address current and emerging business needs.	November 2023

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1. Background Summary

The CORE Payment & Remittance Operating Rule Set addresses 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 X12 v510 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]).

Along with the ERA, the EFT or electronic payment made to the provider from the health plan furthers the automated processing of healthcare payments; paper checks and their manual processing are eliminated. In addition to the aforementioned rules, the CORE Payment & Remittance Operating Rule Set includes a CORE Payment & Remittance EFT Enrollment Data Rule which builds upon the other CORE EFT-and ERA-related rules by addressing a key barrier to the use of EFT by providers – a cumbersome, and in many cases, incomplete EFT enrollment data set that doesn't speak to the electronic needs of the system – and further enables the automated processing of healthcare payments. This rule addresses similar challenges related to provider ERA enrollment.

Currently, healthcare providers or their agents[2] face significant challenges when enrolling to receive ERAs from a health plan including:

- A wide variety in data elements requested for enrollment
- Variety in the enrollment processes and approvals to receive the ERA
- Absence of critical elements that would address essential questions regarding provider preferences on payment options

Conversely, health plans are also challenged by the effort and resources required to enroll providers and maintain changes in provider information over time. As a result, some plans may prioritize converting high volume claim submitters to ERA over converting lower volume submitters, even though the low volume submitters may account for most providers submitting claims.

Consistent and uniform operating rules enabling providers to enroll for ERA quickly and efficiently helps to mitigate:

- Complex and varied enrollment processes
- Variation in data elements requested for enrollment
- Lack of electronic access to enrollments
- Missing requests for critical elements that help address system-wide automation

And provide for:

- Less staff time spent on phone calls and websites
- Increased ability to conduct targeted follow-up with health plans
- Broader adoption of ERA by providers
- An ability to ensure the enrollment process is coordinated with the next steps in payment process

[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] One who agrees and is authorized to act on behalf of another, a principal, to legally bind an individual in particular business transactions with third parties pursuant to an agency relationship. Source: West's Encyclopedia of American Law, edition 2. Copyright 2008 The Gale Group, Inc. All rights reserved.

In 2023, the CORE Enrollment Data Task Group evaluated opportunity areas for enhancing the CORE Payment & Remittance EFT & ERA Enrollment Data Rules. For ease of reference, new and updated rule language approved via this maintenance process is highlighted in gray.

~~***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 EFT and ERA transactions; the NCVHS request was made in response to NCVHS' role in Section 1104 of the Affordable Care Act (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.[3] 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,[4] 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)[5] adopting the CCD+ and the X12 835 TR3 TRN Segment[6] as the Healthcare EFT Standards. These standards must be used for electronic claims payment initiation by all health plans that conduct healthcare EFT.~~

2. Issue to be Addressed and Business Requirement Justification

It is a challenge for each provider, whether large or small, to complete enrollment and maintain changes in their information for ERA uniquely with each health plan. It is equally challenging for each health plan to collect and implement identification and other information from every provider for ERA – moreover, common lessons learned on necessary requests to streamline the process are not being identified due to all this variation. Providers seeking to enroll for ERA often face different enrollment formats and requirements. For many providers the enrollment process is cumbersome and time-consuming.

~~[3] 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.~~

~~[4] 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.~~

~~[5] CMS-0024-IFC: Administrative Simplification: Adoption of Standards for Health Care Electronic Funds Transfers (EFTs) and Remittance Advice, 01/10/12.~~

~~[6] 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+.~~

2.1. Problem Space

During initial rule development, CORE EFT & ERA Subgroup Participant surveys and discussion have identified significant barriers to achieving industry-wide rapid adoption of EFT and ERA; much of these findings were reiterated by CORE and Nacha research as well as research by other industry efforts. One of the key barriers identified is the challenge faced by providers due to the variances in the processes and data elements requested when enrolling in ERA with a health plan.

Due to variations across health plans in the data elements requested, providers manually process enrollment forms for each plan to which they bill claims and from which they wish to receive an ERA. This results in unnecessary manual processing of multiple forms requesting a range of information – not necessarily the same – as noted by research findings – and, in the case when it is the same, often using a wide variety of data terminology for the same semantic concept (i.e., "Provider" vs. "Name").

This inconsistent terminology for the same data element during ERA enrollment can cause confusion and incorrect data to be entered during the enrollment process resulting in further delays as manual processes are used to clarify the inaccurate data – telephone calls, faxes, emails and original enrollment documents are returned to the provider for review, correction and resubmission to the health plan.

The manual and time-consuming process required by many of the current enrollment processes today and the variety of enrollment forms and data requirements cost the industry time and money – and, in many cases, does not address the key items that are needed to use the ERA enrollment information to fully automate both claims payment and remittance advice posting processes. As a consequence, providers are often reluctant to implement ERA with many health plans, particularly those plans that have seemingly difficult or extensive requirements for enrollment.[7] It is well understood that ERA enrollment is not the only challenge with regard to provider adoption of ERA; however, it is one of the pieces of the puzzle and thus does need to be addressed, especially given the significant challenges that the other CORE Payment & Remittance Operating Rules are working to improve.

2.2. CORE Process in Addressing the Problem Space

To address the Problem Space associated with ERA enrollment, the initial CORE EFT & ERA Subgroup and its Work Group conducted a series of surveys, numerous Subgroup discussions and significant review of industry ERA enrollment forms and research related to existing industry initiatives (e.g., Workgroup for Electronic Data Interchange [WEDI], etc.) to inform development of this CORE Payment & Remittance ERA Enrollment Data Rule.

In the ten years following initial publication of this rule, CORE conducted annual maintenance of the ERA Enrollment Data Set, although no substantive adjustments were made. In 2023, the CORE Enrollment Data Task Group launched a comprehensive review of the rule requirements and associated enrollment data set to address industry needs to drive greater EFT and ERA adoption and enhance security and fraud detection.

2.2.1. Research and Analysis of EFT & ERA Enrollment Forms

The CORE EFT & ERA Subgroup completed several research steps to determine a set of data elements to serve as a maximum data requirement for ERA enrollment during initial rule development. These key research steps included:

- Created source list for representative sample of ERA enrollment forms
- Using source list, obtained a representative sample of approximately 45 enrollment forms from eight key industry sectors (National Plans, Regional Plans, State Medicaid, Medicare,

[7] 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)

Clearinghouses, Worker's Compensation, Employer Owned [including Provider Owned], Third-Party Administrators)

- Identified frequency of data elements and key semantic concepts across source list enrollment forms and elements needing clarity; considered data elements utilized by external resources, e.g., the U.S. Postal Service, *NACHA Operating Rules*, etc.
- Using direct research findings and indirect sources (i.e., related white papers by WEDI, etc.), created a list of required data elements with definitions and other rule requirements using agreed-upon evaluation criteria
- Outlined the essential elements needed to address provider preferences and electronic transaction needs

CORE conducted substantial analysis to compare ERA enrollment forms from across the industry and follow-up with specific industry sectors such as pharmacy. Using Subgroup-approved evaluation criteria, a set of universally necessary ERA enrollment data elements was identified by the CORE Participants as well as the detailed Rule Requirements around these ERA enrollment data elements. The CORE Participants agreed that these data elements represented the *maximum* set of data elements required for successful ERA enrollment; therefore, this rule addresses the maximum set of data elements required for providers enrolling for receipt of the ERA from a health plan.

2.2.1.1. Evaluation Criteria to Identify Required ERA Enrollment Data Elements

The following evaluation criteria were used by the Subgroup to identify the list of required ERA enrollment data elements using direct (e.g., ERA enrollment forms utilized by health plans and vendors) and indirect (e.g., white papers that address the topic of standardization of ERA enrollment) sources:

- Quantitative findings of research:
  - Include data elements that are frequently included across direct and indirect sources; e.g., elements included in 65% or more of all enrollment forms or research
  - For data elements that have different terms used for the same semantic concept, e.g., meaning/intent, select one term for each data element; i.e., term selected would be used on 65% of forms; e.g.,"Bank Transit Number" vs. "Bank Routing Number" vs. "Transit/Routing Number"
- Qualitative discussions for elements that are unclear in the quantitative findings, but are directly related to agreed-upon CORE EFT & ERA Subgroup high priority goals:
  - Identified strong business need to streamline the collection of data elements; e.g., Taxpayer Identification Number [TIN] vs. National Provider Identifier [NPI] provider preference
  - Essential data for populating the Healthcare EFT Standards and the X12 v5010 835
  - Balance between time and resources (cost) to provide enrollment data versus necessity (benefit) to procure data element
  - Consistent with CORE Guiding Principles

3. Scope

3.1. When the Rule Applies

This rule applies when a health plan or its agent is enrolling a healthcare provider or its agent for the purpose of engaging in the receipt by the provider of the claim payment remittance advice electronically (ERA) from a health plan.

3.2. CORE-required Maximum ERA Enrollment Data Element Set

The data elements identified in the *CORE-required Maximum ERA Enrollment Data Set Companion Document* ~~Table 4.2-1 in §4.2~~ are the maximum number of data elements that a health plan or its agent may require a healthcare provider or its agent to submit to the health plan for the purpose of engaging in receipt by the provider of the claim payment remittance advice electronically (ERA) from a health plan.

These enrollment data elements represent a "controlled vocabulary" to provide a common, uniform and consistent way for health plans to collect and organize data for subsequent collection and use. A controlled vocabulary reduces ambiguity inherent in normal human languages (where the same concept can be given different names), ensures consistency and is potentially a crucial enabler of semantic interoperability.

The CORE-required Maximum ERA Enrollment Data Set (i.e., a controlled vocabulary) mandates the use of predefined and authorized terms that have been preselected by CORE Participants.

3.2.1. Data Element Group: Elements that May Need to be Requested Several Times

Several of the data elements in the *CORE-required Maximum ERA Enrollment Data Set Companion Document* ~~Table 4.2~~ 1 can be logically related where each single discrete data element can form a larger grouping or a set of data elements that are logically related, e.g., a provider contact name and a contact number are typically requested together or should be. Such logical Data Element Groups are shown by assigning a Data Element Group identifier (e.g., DEG1, DEG2, etc.) to the discrete data element included in the set of logically related data elements.

Each Data Element Group (DEG) represents a set of data elements that may need to be collected more than once for a specific context, e.g., multiple provider contacts. Examples of the DEGs are: Provider Information, Provider Identifiers, and Electronic Remittance Advice Information ~~Provider's Agent Name and Address~~. Multiple uses of the same Data Element Group to collect the same data for another context are allowed by this rule and do not constitute a non-conforming use of the CORE-required Maximum ERA Enrollment Data Set.

3.2.2. Repeatable Data Elements

Bulk enrollment processes may involve enrolling multiple providers simultaneously, necessitating the repetition of certain data elements for each provider record within a collective submission. For example, multiple National Provider Identifiers (NPIs) may need to be enrolled under a single Taxpayer Identification Number (TIN). The CORE-required Maximum EFT Enrollment Data Elements are designed to be repeatable at the DEG or discrete data element level. Repetition of data elements to accommodate diverse enrollment contexts is allowed by this rule and does not constitute a non-conforming use of the CORE-required Maximum EFT Enrollment Set.

3.3. What the Rule Does Not Require

This rule does not require any health plan to:

- Engage in the process of paying for healthcare claims electronically
- Conduct either the X12 v5010 835 or the Healthcare EFT Standards transactions
- Combine EFT with ERA enrollment
- Re-enroll a provider if the provider is already enrolled and receiving the ERA

3.4. CORE Process for Maintaining CORE-required Maximum ERA Enrollment Data Set

CORE recognizes that ERA changes in the marketplace and the experience gained from ERA enrollment may indicate a need to modify the CORE-required ERA Enrollment Data Set to meet emerging or new industry needs and will require a process for soliciting feedback from the industry on a periodic basis.

CORE accepts maintenance submission requests for the CORE-required ERA Enrollment Data Set on a rolling basis and will convene the Enrollment Data Task Group if substantive submissions and/or critical needs are identified as defined below:

- Substantive submissions are more than one of the same, in-scope submissions that meet the

Enrollment Data Evaluation Criteria for Ongoing Maintenance.

- Critical needs are any adjustment necessary to resolve an issue prohibiting implementation of the currently Enrollment Data Set for multiple implementers and/or to address a regulatory requirement.

If the Enrollment Data Task Group convenes to review a submitted substantive submission or critical need and agrees to the substantive adjustment(s) to the ERA Enrollment Data Set, a notification will be shared with the industry announcing the publication of an updated ERA Enrollment Data Set. Health plans or their business agents have nine calendar months to update their electronic enrollment systems/forms and twelve calendar months to update their paper-based enrollment forms to comply with published, updated a version of the CORE-required Maximum ERA Enrollment Data Set. The timeframe starts on the date that CORE publishes the updated version of the ERA Enrollment Data Set to the industry.

~~The CORE-required Maximum ERA Enrollment Data Set is a set of data elements determined by CAQH CORE to be the most appropriate data set to achieve uniform and consistent collection of such data at the time this rule was developed. CAQH CORE recognizes that as this rule becomes widely adopted and implemented in healthcare – and as ERA changes in the marketplace – the experience and learning gained from ERA enrollment may indicate a need to modify the maximum data set to meet emerging or new industry needs.~~

~~Given this anticipated need for data set maintenance activity, CAQH CORE recognizes that the focus of this rule, coupled with this need for unique modification of the data set, will require a process and policy to enable the data set to be reviewed on an annual or semi-annual basis. Any revisions to the data set will follow standard CAQH CORE processes for rule revisions. CAQH CORE will develop such a process and policy in accordance with CAQH CORE Guiding Principles following the approval of the CAQH CORE Payment & Remittance Operating Rules for first review of potential revisions to the data set. The first review shall commence one year after the passage of a Federal regulation requiring implementation of this rule. Substantive changes necessary to the data set will be reviewed and approved by CAQH CORE as necessary to ensure accurate and timely revision to the data set.~~

3.5. Outside the Scope of This Rule

This rule does not address any business relationship between a health plan and its agent or a healthcare provider and its agent.

Outside the scope of this rule is:

- The need to collect other data for other business purposes and such data may be collected at the health plan's discretion
- The method or mechanism for how a health plan exchanges ERA data internally
- The method or mechanism for how a health plan collects ERA data externally

3.6. How the Rule Relates to other Operating Rule Sets

As with other CORE Operating Rules, general CORE policies apply to CORE Payment & Remittance Operating Rules.

3.7. Assumptions

A goal of this rule is to establish a foundation for the secure, successful and timely enrollment of healthcare providers by health plans to engage in the ERA.

The following assumption applies to this rule:

- This rule is a component of the larger set of CORE Payment & Remittance Operating Rules; as such, all the CORE Guiding Principles apply to this rule and all other rules.

4. Rule Requirements

4.1. Requirements for a Health Plan, its Agent or Vendors Offering ERA Enrollment

A health plan or its agent or vendors offering ERA enrollment must comply with all requirements specified in this rule when collecting from a healthcare provider or its agent the data elements needed to enroll the healthcare provider for ERA.

4.2. CORE-required Maximum ERA Enrollment Data Elements

A health plan or its agent or vendors offering ERA enrollment is required to collect no more data elements than the maximum data elements defined in the *CORE-required Maximum ERA Enrollment Data Set Companion Document.* ~~Table 4.2-1 CORE-required Maximum ERA Enrollment Data Set.~~

The *CORE-required Maximum ERA Enrollment Data Set Companion* Document ~~Table 4.2-1~~ lists all of the CORE-required maximum Individual Data Elements and data element descriptions, organized by categories of information (Data Element Groups), e.g., Provider Information, Provider Identifiers Information, Federal Agency Information, Retail Pharmacy Information, Electronic Remittance Advice Information and Submission or its agent or vendors offering ERA enrollment when collecting ERA enrollment data either electronically or via a manual paper-based process. The Individual Data Element Name and its associated description must not be modified.

~~Table 4.2-1 includes ten~~ Data Element Groups represent a set of data elements that may need to be collected more than once for a specific context (Reference §3.2.1 and §3.2.2 above). Multiple uses of the same DEG to collect the same data for another context are allowed by this rule and do not constitute a non-conforming use of the CORE-required Maximum Enrollment Data Set. ~~These ten Data Element Groups are:~~

- ~~DEG1: Provider Information~~
- ~~DEG2: Provider Identifiers Information~~
- ~~DEG3: Provider Contact Information~~
- ~~DEG4: Provider Agent Information~~
- ~~DEG5: Federal Agency Information~~
- ~~DEG6: Retail Pharmacy Information~~
- ~~DEG7: Electronic Remittance Advice Information~~
- ~~DEG8: Electronic Remittance Advice Clearinghouse Information~~
- ~~DEG9: Electronic Remittance Advice Vendor Information~~
- ~~DEG10: Submission Information~~

~~Within each information category some data elements may be grouped into specific Data Element Groups (Reference §3.2.1).~~ A DEG may be designated as required or optional for data collection. Within each DEG, Individual Data Elements are designated as required or optional for data collection.

- When a DEG is designated as required, all the required Individual Data Elements within the DEG must be collected by the health plan; Individual Data Elements designated as optional may be collected depending on the business needs of the health plan.
- When a DEG is designated as optional, the collection of the optional DEG is at the discretion of the health plan. When a health plan exercises its discretion to collect an optional DEG, any included Individual Data Element designed as required must be collected.
- Some required or optional Individual Data Elements are composed of one or more Sub-elements, where a Sub-element is designated as either required or optional for collection. When a health plan collects an optional Individual Data Element that is composed of one more optional Sub-elements, the optional Sub- element may be collected at the discretion of the health plan. When a health plan collects a required Individual Data Element that is composed of one or more optional Sub-elements, the optional Sub-element may be collected at the discretion of the health plan.

Not collecting an individual data element identified as optional does not constitute a non-conforming use of the CORE-required Maximum ERA Enrollment Data Set. ~~As specified in §3.2.1, the collection of~~

multiple occurrences of DEGs for another context does not constitute a non-conforming use of the CORE-required Maximum ERA Enrollment Data Set.

The data elements in the *CORE-required Maximum ERA Enrollment Data Set Companion Document* Table 4.2-1 are for new enrollments. When an enrollment is being changed or cancelled, the health plan must make available to the provider instructions on the specific procedure to accomplish a change in their enrollment or to cancel their enrollment.

Table: 4.2-1 CORE-required Maximum ERA Enrollment Data Set

Individual Data Element Name[8] (Term)	Sub-element Name (Term)	Data Element Description	Data Type and Format (Not all data elements require a format specification)	Data Element Requirement for Health Plan Collection (Required/ Optional for plan to collect)	Data Element Group Number (DEG#)[9]
PROVIDER INFORMATION (Data Element Group 1 is a Required DEG)					
Provider Name		Complete legal name of institution, corporate entity, practice or individual provider	Alphanumeric	Required	DEG1
Doing Business As Name (DBA)		A legal term used in the United States meaning that the trade name, or fictitious business name, under which the business or operation is conducted and presented to the world is not the legal name of the legal person (or persons) who actually own it and are responsible for it[10]	Alphanumeric	Optional	DEG1

[8] Shaded Individual Data Element Names provide essential context for related Sub-element Names but do not obligate providers to submit any associated data for that specific Data Element on the enrollment form/system. Individual Data Element Names that are not shaded do obligate the provider to submit associated data.

[9] There are ten of these Data Element Groups, and each represents a set of data elements that may need to be collected more than once for a specific context. Multiple uses of the same Data Element Group to collect the same data for another context are allowed by this rule and do not constitute a non-conforming use of the CORE-required Maximum ERA Enrollment Data Set.

[10] https://en.wikipedia.org/wiki/Doing_business_as

Table: 4.2.1 CORE-required Maximum ERA Enrollment Data Set					
Individual Data Element Name (Term)	**Sub-element Name** (Term)	**Data Element Description**	**Data Type and Format** (Not all data elements require a format specification)	**Data Element Requirement for Health Plan Collection** (Required/ Optional for plan to collect)	**Data Element Group Number** (DEG#)
PROVIDER INFORMATION *(Continued)* **(Data Element Group 1 is a Required DEG)**					
Provider Address				Optional	DEG1
	Street	The number and street name where a person or organization can be found	Alphanumeric	Required	DEG1
	City	City associated with provider address field	Alphanumeric	Required	DEG1
	State/Province	ISO 3166-2 Two Character Code associated with the State/Province/Region of the applicable Country[11]	Alpha	Required	DEG1
	ZIP Code/ Postal Code	System of postal zone codes (zip stands for "zone improvement plan") introduced in the U.S. in 1963 to improve mail delivery and exploit electronic reading and sorting capabilities[12]	Alphanumeric, 15 characters	Required	DEG1
	Country Code[13]	ISO 3166-1 Country Code[14]	Alphanumeric, 2 characters	Optional	DEG1

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[11] http://www.iso.org/iso/search.htm?qt=ISO+3166-2&searchSubmit=Search&sort=rel&type=simple&published=on

[12] http://www.britannica.com/EBchecked/topic/657522/ZIP-Code

[13] See Footnote #4 above regarding *NACHA Operating Rules* International ACH Transactions (IAT)

[14] http://www.iso.org/iso/search.htm?qt=ISO+3166-1&searchSubmit=Search&sort=rel&type=simple&published=on

Table: 4.2.1 CORE-required Maximum ERA Enrollment Data Set					
Individual Data Element Name (Term)	**Sub-element Name** (Term)	**Data Element Description**	**Data Type and Format** (Not all data elements require a format specification)	**Data Element Requirement for Health Plan Collection** (Required/ Optional for plan to collect)	**Data Element Group Number** (DEG#)
PROVIDER IDENTIFIERS INFORMATION (Data Element Group 2 is a Required DEG)					
Provider *Identifiers*				Required	DEG2
	Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN)	A Federal Tax Identification Number, also known as an Employer Identification Number (EIN), is used to identify a business entity[15]	Numeric, 9 digits	Required	DEG2
	National Provider Identifier (NPI)[16]	A Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for covered healthcare providers. Covered healthcare providers and all health plans and healthcare clearinghouses must use the NPIs in the administrative and financial transactions adopted under HIPAA. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). This means that the numbers do not carry other information about healthcare providers, such as the state in which they live or their medical specialty. The NPI must be used in lieu of legacy provider identifiers in the HIPAA standards transactions[17]	Numeric, 10 digits	Required when provider has been enumerated with an NPI	DEG2

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[15] A Taxpayer Identification Number (TIN) is an identification number used by the Internal Revenue Service (IRS) in the administration of tax laws. It is issued either by the Social Security Administration (SSA) or by the IRS. A Social Security number (SSN) is issued by the SSA whereas all other TINs are issued by the IRS. https://www.irs.gov/individuals/international-taxpayers/taxpayer-identification-numbers-tin

[16] An atypical provider not eligible for enumeration by an NPI must supply its EIN/TIN

[17] https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/NationalProvIdentStand

Table: 4.2.1 CORE-required Maximum ERA Enrollment Data Set					
Individual Data Element Name (Term)	**Sub-element Name** (Term)	**Data Element Description**	**Data Type and Format** (Not all data elements require a format specification)	**Data Element Requirement for Health Plan Collection** (Required/ Optional for plan to collect)	**Data Element Group Number** (DEG#)
PROVIDER IDENTIFIERS INFORMATION *(Continued)* (Data Element Group 2 is a Required DEG)					
Other Identifier(s)			Alphanumeric	Optional	DEG2
	Assigning Authority	Organization that issues and assigns the additional identifier requested on the form, e.g., Medicare, Medicaid	Alphanumeric	Required if Identifier is collected	DEG2
	Trading Partner ID	The provider's submitter ID assigned by the health plan or the provider's clearinghouse or vendor	Alphanumeric	Optional	DEG2
Provider License Number			Alphanumeric	Optional	DEG2
	License Issuer		Alphanumeric	Required if License Number is collected	DEG2
Provider Type		A proprietary health plan- specific indication of the type of provider being enrolled for ERA with specific provider type description included by the health plan in its instruction and guidance for ERA enrollment (e.g., hospital, laboratory, physician, pharmacy, pharmacist, etc.)		Optional	DEG2
Provider Taxonomy Code		A unique alphanumeric code, ten characters in length. The code set is structured into three distinct "Levels" including Provider Type, Classification and Area of Specialization[18]	Alphanumeric, 10 characters	Optional	DEG2

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[18] http://www.nucc.org/index.php

Table: 4.2.1 CORE-required Maximum ERA Enrollment Data Set					
Individual Data Element Name (Term)	Sub-element Name (Term)	Data Element Description	Data Type and Format (Not all data elements require a format specification)	Data Element Requirement for Health Plan Collection (Required/ Optional for plan to collect)	Data Element Group Number (DEG#)
PROVIDER CONTACT INFORMATION (Data Element Group 3 is an Optional DEG)					
Provider Contact Name	*NOTE: In v3.0.0 of this rule, the data element "Contact" was inadvertently included in this cell. Entities that accommodated this error do not need to adjust their data sets to comply with v3.0.1 in which "Contact" has been removed from this cell for clarity.*	Name of a contact in provider office for handling ERA issues	Alphanumeric	Required	DEG3
	Title		Alphanumeric	Optional	DEG3
	Telephone Number	Associated with contact person	Numeric, 10 digits [19]	Required	DEG3
	Telephone Number Extension			Optional	DEG3
	Email Address	An electronic mail address at which the health plan might contact the provider		Required; not all providers may have an email address	DEG3
	Fax Number	A number at which the provider can be sent facsimiles		Optional	DEG3

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[19] ASC X12 005010X221 Health Care Claim Payment/Advice Technical Report Type 3

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Table: 4.2-1 CORE-required Maximum ERA Enrollment Data Set					
Individual Data Element Name (Term)	**Sub-element Name (Term)**	**Data Element Description**	**Data Type and Format (Not all data elements require a format specification)**	**Data Element Requirement for Health Plan Collection (Required/ Optional for plan to collect)**	**Data Element Group Number (DEG#)**
PROVIDER AGENT INFORMATION (Data Element Group 4 is an Optional DEG)					
Provider Agent Name		Name of provider's authorized agent	Alphanumeric	Required	DEG4
Agent Address				Optional	DEG4
	Street	The number and street name where a person or organization can be found	Alphanumeric	Required	DEG4
	City	City associated with address field	Alphanumeric	Required	DEG4
	State/Province	ISO 3166-2 Two Character Code associated with the State/Province/Region of the applicable Country[20]	Alpha	Required	DEG4
	ZIP Code/ Postal Code	System of postal zone codes (zip stands for "zone improvement plan") introduced in the U.S. in 1963 to improve mail delivery and exploit electronic reading and sorting capabilities[21]	Alphanumeric, 15 characters	Required	DEG4
	Country Code	ISO 3166-1 Country Code[22]	Alphanumeric, 2 characters	Optional	DEG4

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[20] http://www.iso.org/iso/search.htm?qt=ISO+3166-2&searchSubmit=Search&sort=rel&type=simple&published=on

[21] http://www.britannica.com/EBchecked/topic/657522/ZIP-Code

[22] http://www.iso.org/iso/search.htm?qt=ISO+3166-1&searchSubmit=Search&sort=rel&type=simple&published=on

Table: 4.2.1 CORE-required Maximum ERA Enrollment Data Set					
Individual Data Element Name (Term)	**Sub-element Name** (Term)	**Data Element Description**	**Data Type and Format** (Not all data elements require a format specification)	**Data Element Requirement for Health Plan Collection** (Required/ Optional for plan to collect)	**Data Element Group Number** (DEG#)
PROVIDER AGENT INFORMATION *(Continued)* **(Data Element Group 4 is an Optional DEG)**					
Provider Agent Contact Name		Name of a contact in agent office for handling ERA issues	Alphanumeric	Required	DEG4
	Title		Alphanumeric	Optional	DEG4
	Telephone Number	Associated with contact person	Numeric, 10 digits [23]	Required	DEG4
	Telephone Number Extension			Optional	DEG4
	Email Address	An electronic mail address at which the health plan might contact the provider		Required; not all providers may have an email address	DEG4
	Fax Number	A number at which the provider can be sent facsimiles		Optional	DEG4
FEDERAL AGENCY INFORMATION **(Data Element Group 5 is an Optional DEG)**					
Federal Agency Information		Information required by Veterans Administration		Optional	DEG5
	Federal Program Agency Name		Alphanumeric	Optional	DEG5
	Federal Program Agency Identifier		Alphanumeric	Optional	DEG5
	Federal Agency Location Code		Alphanumeric	Optional	DEG5

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[23] ASC X12 005010X221 Health Care Claim Payment/Advice Technical Report Type 3

Table: 4.2.1 CORE-required Maximum ERA Enrollment Data Set					
Individual Data Element Name (Term)	**Sub-element Name** (Term)	**Data Element Description**	**Data Type and Format** (Not all data elements require a format specification)	**Data Element Requirement for Health Plan Collection** (Required/ Optional for plan to collect)	**Data Element Group Number** (DEG#)
RETAIL PHARMACY INFORMATION (Data Element Group 6 is an Optional DEG)					
Pharmacy Name		Complete name of pharmacy	Alphanumeric	Required (if DEG6 is utilized)	DEG6
	Chain Number	Identification number assigned to the entity allowing linkage for a business relationship, i.e., chain, buying groups or third party contracting organizations. Also may be known as Affiliation ID or Relation ID	Alphanumeric	Optional	DEG6
	Parent Organization ID	Headquarter address information for chains, buying groups or third party contracting organizations where multiple relationship entities exist and need to be linked to a common organization such as common ownership for several chains	Alphanumeric	Optional	DEG6
	Payment Center ID	The assigned payment center identifier associated with the provider/corporate entity	Alphanumeric	Optional	DEG6
NCPDP Provider ID Number		The NCPDP assigned unique identification number	Alphanumeric	Optional	DEG6
Medicaid Provider Number		A number issued to a provider by the U.S. Department of Health and Human Services through state health and human services agencies		Optional	DEG6

Table: 4.2.1 CORE-required Maximum ERA Enrollment Data Set					
Individual Data Element Name (Term)	Sub-element Name (Term)	Data Element Description	Data Type and Format (Not all data elements require a format specification)	Data Element Requirement for Health Plan Collection (Required/ Optional for plan to collect)	Data Element Group Number (DEG#)
ELECTRONIC REMITTANCE ADVICE INFORMATION (Data Element Group 7 is a Required DEG)					
Preference for Aggregation of Remittance Data (e.g., Account Number Linkage to Provider Identifier)		Provider preference for grouping (bulking) claim payment remittance advice – must match preference for EFT payment		Required; select from below	DEG7
	Provider Tax Identification Number (TIN)		Numeric, 9 digits	Optional – required if NPI is not applicable	DEG7
	National Provider Identifier (NPI)		Numeric, 10 digits	Optional – required if TIN is not applicable	DEG7
Method of Retrieval		The method in which the provider will receive the ERA from the health plan (e.g., download from health plan website, clearinghouse, etc.)		Optional (Required if the provider is not using an intermediary clearinghouse or vendor)	DEG7
ELECTRONIC REMITTANCE ADVICE CLEARINGHOUSE INFORMATION (Data Element Group 8 is an Optional DEG)					
Clearinghouse Name		Official name of the provider's clearinghouse	Alphanumeric	Required	DEG8
Clearinghouse Contact Name		Name of a contact in clearinghouse office for handling ERA issues	Alphanumeric	Optional	DEG8
	Telephone Number	Telephone number of contact	Numeric, 10 digits	Optional	DEG8

Table: 4.2.1 CORE-required Maximum ERA Enrollment Data Set					
Individual Data Element Name (Term)	Sub-element Name (Term)	Data Element Description	Data Type and Format (Not all data elements require a format specification)	Data Element Requirement for Health Plan Collection (Required/ Optional for plan to collect)	Data Element Group Number (DEG#)
ELECTRONIC REMITTANCE ADVICE VENDOR INFORMATION (Data Element Group 9 is an Optional DEG)					
Vendor Name		Official name of the provider's vendor	Alphanumeric	Required	DEG9
Vendor Contact Name		Name of a contact in vendor office for handling ERA issues	Alphanumeric	Optional	DEG9
	Telephone Number	Telephone number of contact	Numeric, 10 digits	Optional	DEG9
	Email Address	An electronic mail address at which the health plan might contact the provider's vendor		Optional	DEG9
SUBMISSION INFORMATION (Data Element Group 10 is a Required DEG)					
Reason for Submission				Required; select from below	DEG10
	New Enrollment			Optional	DEG10
	Change Enrollment			Optional	DEG10
	Cancel Enrollment			Optional	DEG10

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Table: 4.2.1 CORE-required Maximum ERA Enrollment Data Set					
Individual Data Element Name (Term)	Sub-element Name (Term)	Data Element Description	Data Type and Format (Not all data elements require a format specification)	Data Element Requirement for Health Plan Collection (Required/ Optional for plan to collect)	Data Element Group Number (DEG#)
SUBMISSION INFORMATION *(Continued)* (Data Element Group 10 is a Required DEG)					
Authorized Signature		The signature of an individual authorized by the provider or its agent to initiate, modify or terminate an enrollment. May be used with electronic and paper-based manual enrollment		Required; select from below	DEG10
	Electronic Signature of Person Submitting Enrollment			Optional	DEG10
	Written Signature of Person Submitting Enrollment	A (usually cursive) rendering of a name unique to a particular person used as confirmation of authorization and identity		Optional	DEG10
	Printed Name of Person Submitting Enrollment	The printed name of the person signing the form; may be used with electronic and paper-based manual enrollment		Optional	DEG10
	Printed Title of Person Submitting Enrollment	The printed title of the person signing the form; may be used with electronic and paper-based manual enrollment		Optional	DEG10
Submission Date		The date on which the enrollment is submitted	CCYYMMDD[24]	Optional	DEG10
Requested ERA Effective Date		Date the provider wishes to begin ERA; per CAQH CORE Health Care Claim (837) Infrastructure Rule: there may be a dual delivery period depending on whether the entity has such an agreement with its trading partner	CCYYMMDD	Optional	DEG10

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[24] ASC X12 Standards Version 005010 for X12 Data Element 373 Date used in the ASC X12 005010X221 Health Care Claim Payment/Advice Technical Report Type 3

4.3. CORE Master Template for Collecting ERA Enrollment Data

4.3.1. Master Template for Manual Paper-Based Enrollment

The name of the health plan or its agent or the vendor offering ERA and the purpose of the form will be on the top of the form, e.g., Health Plan X: Electronic Remittance Advice (ERA) Authorization Agreement.

A health plan or its agent or a vendor offering ERA is required to use the format, flow and data set including data element descriptions in the CORE-required Maximum ERA Enrollment Data Set ~~Table 4.2-1~~ as the CORE Master ERA Enrollment Submission form when using a manual paper-based enrollment method. All CORE-required ERA Enrollment data elements must appear on the paper form in the same order as they appear in the *CORE-required Maximum ERA Enrollment Data Set Companion Document* ~~Table 4.2-1.~~

A health plan or its agent cannot revise or modify:

- The name of a CORE Master ERA Enrollment Data Element Name
- The usage requirement of a CORE Master ERA Enrollment Data Element
- The Data Element Group number of a CORE Master ERA Enrollment Data Element

Beyond the data elements and their flow, a health plan or its agent must:

- Develop and make available to the healthcare provider or its agent specific written instructions and guidance for the healthcare provider or its agent when completing and submitting the enrollment form, including when using paper
- Provide a number to fax and/or a U.S. Postal Service or email address to send the completed form
- Include contact information for the health plan, specifically a telephone number and/or email address to send questions
- Include authorization language for the provider to read and consider
- Include a section in the form that outlines how the provider can access online instructions for how the provider can determine the status of the ERA enrollment
- Clearly label any appendix describing its purpose as it relates to the provider enrolling in ERA

4.3.2. Master Template for Electronic Enrollment

When electronically enrolling a healthcare provider in ERA, a health plan or its agent must use the CORE Master ERA Enrollment Data Element Name and Sub-element Name as specified in the *CORE-required Maximum ERA Enrollment Data Set Companion Document* ~~Table 4.2-1~~ without revision or modification.

When using an XML-based electronic approach, the Data Element Name and Sub-element Name must be used exactly as represented in the table enclosed in angle brackets (i.e., < >) for the standard XML element name and all spaces replaced with an underscore [_] character, e.g., <Provider_Address>.

As noted below in §4.4, a health plan or its agent or vendors offering ERA enrollment will offer an electronic way for provider to complete and submit the ERA enrollment. A health plan may use a web-based method for its electronic approach to offering ERA enrollment. The design of the website is restricted by this rule only to the extent that the flow, format and data set including data element descriptions established by this rule must be followed.

4.4. CORE Electronic Safe Harbor for ERA Enrollment to Occur Electronically

This rule provides an ERA enrollment “Electronic Safe Harbor” by which health plans, healthcare providers, their respective agents, application vendors and intermediaries can be assured will be supported by any trading partner. This ERA Enrollment Data Rule specifies that all health plans and their respective agents must implement and offer to any trading partner (e.g., a healthcare provider) a

secured[25] electronic method (actual method to be determined by health plan or its agent) and process for collecting the CORE-required Maximum ERA Enrollment Data Set. As an ERA enrollment "Safe Harbor," this rule:

- **DOES NOT** require health plans or their agents to discontinue using existing manual and/or paper-based methods and processes to collect the CORE-required Maximum ERA Enrollment Data Set.
- **DOES NOT** require health plans or their agents to use ONLY an electronic method and process for collecting the CORE-required Maximum ERA Enrollment Data Set.
- **DOES NOT** require an entity to do business with any trading partner or other entity.

CORE expects that in some circumstances, health plans or their agents may agree to use non-electronic methods and mechanisms to achieve the goal of the collection of ERA enrollment data – and that provider trading partners will respond to using this method should they choose to do so.

However, the electronic ERA enrollment "Safe Harbor" mechanism offered by a health plan and its agent MUST be used by the health plan or its agent if requested by a trading partner or its agent. The electronic ERA enrollment "Safe Harbor" mechanism is not limited to single entity enrollments and may include a batch of enrollments. If the health plan or its agent does not believe that this CORE ERA Enrollment Safe Harbor is the best mechanism for that particular trading partner or its agent, it may work with its trading partner to implement a different, mutually agreeable collection method; however, if the trading partner insists on conducting ERA Enrollment electronically, the health plan or its agent must accommodate that request. This clarification is not intended in any way to modify entities' obligations to exchange electronic transactions as specified by HIPAA or other Federal and state regulations.

4.5. Instructions for Electronic Enrollment

A health plan must develop and make available to the healthcare provider or its agent specific written instructions and guidance for the healthcare provider or its agent when providing and submitting the data elements in ~~Table 4.2-1~~ the *CORE-required Maximum ERA Enrollment Data Set Companion Document*. The health plan's specific instructions and guidance are not addressed in this rule.

4.6. Notifications for Electronic Enrollment Submissions

4.6.1. Confirmation of Receipt of an Electronic Enrollment Submission

When a provider clicks "submit", or a similar command button on an electronic enrollment form after completing all data fields, the system must return a submission receipt indicating to the provider that the completed enrollment form was successfully received, and information about the "next steps" for enrollment processing in 24 hours or less. This timeframe requirement must be met at least 90 percent of the time per calendar month.

This confirmation of receipt should be provided for initial enrollment, disenrollment and enrollment changes. Examples of such information include:

- Option to print and save a PDF
- View the enrollment status
- The status or an update of a previously submitted request
- Assignment of a transaction or reference control number
- A detailed timestamp, potentially including date, time and time zone of the submission

4.6.2. Confirmation of Completed Processing of an Electronic Enrollment Submission

When a health plan or its agent successfully processes an enrollment, disenrollment or enrollment change it must send an electronic notification to the provider to communicate that the request was

[25] Electronic methods to secure the process for collecting the CORE-required Maximum ERA Enrollment Data Set could include user authentication measures such as multi-factor authentication or the use of security questions.

completed in 2 weeks or less for provider enrollments. This timeframe requirement must be met at least 90 percent of the time per calendar month.

The notification should provide information about enrollment status. Examples of such information include:

- Status of the enrolment, disenrollment or change
- Effective date
- Estimated date of first EFT and/or ERA transaction delivery; or date of last if a disenrollment

4.7. Time Frame for Rule Compliance~~[25]~~

Not later than the date that is six months after the compliance date specified in any Federal regulation adopting this rule, a health plan or its agent that uses a paper-based form to collect and submit the CORE-required Maximum ERA Enrollment Data Set must convert all its paper-based forms to comply with the data set specified in this rule.[26] Should such paper forms be available at provider's offices or other locations, it is expected that such paper-based forms will be replaced.

If a health plan or its agent does not use a paper-based manual method and process to collect the CORE-required Maximum ERA Enrollment Data Set as of the compliance date specified in any Federal regulation adopting this rule, it is not required by this rule to implement a paper-based manual process on or after the compliance date.

It will be expected that all electronic ERA enrollment will meet this rule requirement as of the compliance date, and that the health plan or its agent will inform its providers that an electronic option is now available, if not previously available.

5. Conformance Requirements

Conformance with this rule is considered achieved when all the required detailed step-by-step test scripts specified in the Payment & Remittance CORE Certification Test Suite are successfully passed.

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

- ~~Demonstrates to the industry adoption of the CORE Payment & Remittance Operating Rules via a recognized industry "CORE Certification 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 CORE Certification for the CORE Payment & Remittance Operating Rules, refer to the Payment & Remittance CORE Certification Test Suite or contact CORE@caqh.org.~~

~~[25] Some health plans have expressed concern regarding the timeframe for effective date of EFT and ERA operating rules as specified in ACA Section 1104, i.e., not later than January 1, 2014, as being too restrictive, given the myriad other regulatory mandates currently being confronted by the industry.~~

~~[26] The rule recognizes that some public/Federal entities have review and approval processes that are unique and may require significant planning time and resources to meet the rule requirements.~~