Committee on Operating Rules For Information Exchange (CORE®)

A CAQH CORE Open Mic Session With OESS
- Federally Mandated Operating Rules -

January 16, 2013
2:00 pm – 3:00 pm ET
Participating in Today’s Interactive Event

• Download a copy of today’s presentation
• The phones will be muted upon entry and during the presentation portion of the session
• At any time throughout today’s session, you may communicate with our panelists via the web
  – Submit your questions on-line at any time by entering them into the Q&A panel on the right-hand side of the WebEx desktop
  – On-line questions will be addressed first
• At scheduled intervals during this education session, the audience will be invited to submit questions through the telephone
  – Ask your question by phone at the designated time by pressing * followed by the number one(1) on your keypad
Welcome and Introductions
ACA Section 1104: Mandated Operating Rules Compliance
  - Q&A
CAQH CORE Infrastructure Operating Rule Requirements
  - Q&A
CAQH CORE Eligibility Data Content Operating Rule Requirements
  - Q&A
Wrap-Up
ACA Section 1104:
Mandated Eligibility and Claim Status Operating Rules

Timeline and Compliance
ACA Mandated Operating Rules Compliance Dates: Required for all HIPAA Covered Entities

Operating rules encourage an interoperable network and, thereby, are vendor agnostic

Compliance in Effect as of January 1, 2013

- Eligibility for health plan
- Claims status transactions

HIPAA covered entities comply with the CAQH CORE Operating Rules when conducting these transactions

Implement by January 1, 2014

- Electronic funds transfer (EFT) transactions
- Health care payment and remittance advice (ERA) transactions

Implement by January 1, 2016

- Health claims or equivalent encounter information
- Enrollment and disenrollment in a health plan
- Health plan premium payments
- Referral certification and authorization
- Health claims attachments

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**ACA Federal Compliance Requirements: Highlights & Key Dates**

Three dates are critical for implementation of the first set of ACA mandated Operating Rules

There are two types of penalties related to compliance

<table>
<thead>
<tr>
<th>Key Area</th>
<th>HIPAA Mandated Implementation</th>
<th>ACA-required Health Plan Certification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dates</td>
<td>First Date&lt;br&gt;January 1, 2013&lt;br&gt;Compliance Date&lt;br&gt;Enforcement Date Extension&lt;br&gt;March 31, 2013&lt;sup&gt;4&lt;/sup&gt;</td>
<td>Second Date&lt;br&gt;December 31, 2013&lt;br&gt;Health Plan Certification Date</td>
</tr>
<tr>
<td>Description</td>
<td>Who: All HIPAA covered entities&lt;br&gt;Action: Implement CAQH CORE Eligibility &amp; Claim Status Operating Rules</td>
<td>Who: Health plans&lt;br&gt;Action: File statement with HHS certifying that data and information systems are in compliance with the standards and operating rules&lt;sup&gt;2&lt;/sup&gt;</td>
</tr>
<tr>
<td>Applicable Penalties</td>
<td>Amount: Due to HITECH, penalties for HIPAA non-compliance have increased, now up to $1.5 million per entity per year</td>
<td>Amount: Fee amount equals $1 per covered life&lt;sup&gt;3&lt;/sup&gt; until certification is complete; penalties for failure to comply cannot exceed on an annual basis an amount equal to $20 per covered life or $40 per covered life for deliberate misrepresentation</td>
</tr>
</tbody>
</table>

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<sup>1</sup> CMS OESS is the authority on the HIPAA and ACA Administrative Simplification provisions and requirements for compliance and enforcement. The CMS website provides information on the ACA compliance, certification, and penalties and enforcement process.

<sup>2</sup> According to CMS, regulation detailing the health plan certification process is under development, and they will release details surrounding this process later this year; CAQH CORE will continue to offer its voluntary CORE Certification program and will share lessons learned with CMS as the Federal process is developed.

<sup>3</sup> Covered life for which the plan’s data systems are not in compliance; shall be imposed for each day the plan is not in compliance

<sup>4</sup> Per the Jan 2, 2013 CMS OESS announcement of the 90-day Period of enforcement extension Discretion for Compliance with Eligibility and Claim Status Operating Rules.
Mandated EFT & ERA Operating Rules: Status and Next Steps:

Implement by January 1, 2014

- Electronic funds transfer (EFT) transactions
- Health care payment and remittance advice (ERA) transactions

349 days remaining to complete implementation

- This second set of operating rules has been proposed for Federal regulation
- Entities should be actively working towards the January 2014 adoption date
- CAQH CORE will offer EFT & ERA Operating Rule implementation tools
  - Analysis & Planning Guide for adoption of CAQH CORE EFT & ERA Operating Rules
  - Voluntary CORE Certification Test Site, jointly with CAQH CORE-authorized testing entity Edifecs
  - Repository of EFT & ERA FAQs based on lessons learned & industry questions received through CAQH CORE’s Formal Request Process
  - Formal multi-stakeholder CAQH CORE Code Combination Maintenance Process*
    - First compliance-adjustment and straw poll already conducted

* Applies to the CORE-required Code Combinations for CORE-defined Business Scenarios for CAQH CORE Rule 360
Available CMS OESS Implementation Tools:
Examples

- **HIPAA Covered Entity Charts**
  - Determine whether your organization is a HIPAA covered entity

- **CMS FAQs**
  - Frequently asked questions about the ACA, operating rules, and other topics

- **Affordable Care Act Updates**
  - Updates on operating rules; compliance, certification, and penalties; and engagement with standards and operating rules

- **Additional Questions**
  - Questions regarding HIPAA and ACA compliance can be addressed to:
    - Chris Stahlecker, OEM/OESS/ASG Acting Director, Administrative Simplification Group, Christine.Stahlecker@cms.hhs.gov
    - Geanelle Herring, Health Insurance Specialist, Geanelle.Herring@cms.hhs.gov
Compliance with Eligibility & Claim Status Operating Rules: 90-Day Period of Enforcement Discretion

- On January 2, 2013 CMS OESS* announced a 90-Day Period of Enforcement Discretion to reduce the potential of significant disruption to the healthcare industry
  - Notwithstanding OESS’ discretionary application of its enforcement authority, the compliance date for using the operating rules remains January 1, 2013
- Enforcement action will begin March 31, 2013 with respect to HIPAA covered entities (including health plans, health care providers, and clearinghouses, as applicable) that are not in compliance with the Federally mandated Eligibility and Claim Status Operating Rules
- HIPAA covered entities that are prepared to conduct transactions using the adopted operating rules and all applicable covered entities that are preparing to do so, are encouraged to determine their readiness to use the operating rules as of January 1, 2013 and expeditiously become compliant
- OESS will accept complaints associated with compliance with the operating rules beginning January 1, 2013
  - If requested by OESS, covered entities that are the subject of complaints (known as “filed-against entities”) must produce evidence of either compliance or a good faith effort to become compliant with the operating rules during the 90-day period.

* OESS is the U.S. Department of Health and Human Services’ (HHS) component that enforces compliance with HIPAA transaction and code set standards, including operating rules, identifiers and other standards required under HIPAA by the Affordable Care Act.
Q&A

ACA Federal Compliance

Please submit your question:
• By Phone: Press * followed by the number one (1) on your keypad
• Via the Web: Enter your question into the Q&A pane in the lower right hand corner of your screen
ACA Section 1104:
Mandated Eligibility and Claim Status Operating Rules

Rule Requirements
Mandated Eligibility & Claim Status Operating Rules: Scope – Effective as of January 1, 2013

**Mandated Eligibility & Claim Status Operating Rules**

- Compliance date January 1, 2013

**Type of Rule** | **Addresses** | **CAQH CORE Eligibility & Claim Status Operating Rules** | **Voluntary Eligibility & Claim Status Operating Rule**
--- | --- | --- | ---
**Data Content: Eligibility** | Need to drive further industry value in transaction processing | More Robust Eligibility Verification Plus Financials | Enhanced Error Reporting and Patient Identification
**Infrastructure: Eligibility and Claim Status** | Industry needs for common/accessible documentation | Companion Guides | System Availability
 | Industry-wide goals for architecture/performance/connectivity | Response Times | Connectivity and Security

*Please Note: In the Final Rule for Administrative Simplification: Adoption of Operating Rules for Eligibility for a Health Plan and Health Care Claim Status Transaction, CORE 150 and CORE 151 are not included for adoption. HHS is not requiring compliance with any operating rules related to acknowledgement, the Interim Final Rule.

**Enforcement Action Begins March 31, 2013**
Federally Mandated CAQH CORE Connectivity Rules: Requirements Scope for HIPAA Covered Entities

Mandated healthcare operating rules build upon a range of standards – healthcare-specific (e.g., ASC X12) and industry-neutral (e.g., OASIS, W3C, ACH CCD+).

<table>
<thead>
<tr>
<th>Rule Types</th>
<th>Transactions</th>
<th>Rule Areas</th>
<th>CAQH CORE Rule Numbers</th>
<th>Key Considerations</th>
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<tr>
<td><strong>Infrastructure</strong></td>
<td>X12 270/271 Eligibility &amp; Benefits and X12 276/277 Claims Status</td>
<td>Response Time Rules (Batch &amp; Real-Time) &amp; System Availability Rule</td>
<td>155, 156, 157, &amp; 250*</td>
<td>Interdependencies of the CAQH CORE Infrastructure Rules must be considered during implementation</td>
</tr>
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<td></td>
<td></td>
<td>Connectivity Rules</td>
<td>153, 270 &amp; 250*</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Companion Guide Rule</td>
<td>152 &amp; 250*</td>
<td></td>
</tr>
<tr>
<td><strong>Data Content</strong></td>
<td>X12 270/271 Eligibility &amp; Benefits</td>
<td>Patient Financial Data Content Rules</td>
<td>154 &amp; 260</td>
<td>Data Content Rules apply only to the Eligibility &amp; Benefits transaction</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Normalizing Patient Last Name &amp; AAA Error Code Reporting Rules</td>
<td>258 &amp; 259</td>
<td></td>
</tr>
</tbody>
</table>

*CAQH CORE Rule 250 applies the CAQH CORE Infrastructure Rules to the X12 276/277 Claims Status transaction.
CAQH CORE Eligibility & Claim Status: 
_Federally Mandated Infrastructure Operating Rules_

Mandated infrastructure requirements apply to **both** ASC X12 270/271 eligibility and ASC X12 276/277 claim status transactions

- **Companion Guide**
  - Specify flow and format in health plan companion guide following the CORE v5010 Master Companion Guide Template

- **Response Time**
  - Require entities to conduct real-time processing; Batch processing is optional; however, if entity performs batch processing, then they must conform to requirements for batch
  - Specify maximum response time for both real-time and batch processing
    - Real-time: Maximum response time from submission must be 20 seconds (or less)
    - Batch: Response to transaction submitted by 9 pm E.T. must be returned by 7AM E.T. on the following business day

- **System Availability Rule**
  - Require minimum of 86 percent system availability per calendar week

- **Connectivity Rules**
  - Establish “Safe Harbor” connectivity rule using internet as delivery option to standardize transaction flow between health plan and provider; common transport and envelope standards

**NOTE:** Many of the Federally mandated CAQH CORE Infrastructure Rules also apply to the ASC X12 v5010 835 per **CMS-0028-IFC**.
CAQH CORE Infrastructure Q&A

Companion Guide
Response Time
Connectivity
Security
System Availability

Please submit your question:
• By Phone: Press * followed by the number one (1) on your keypad
• Via the Web: Enter your question into the Q&A pane in the lower right hand corner of your screen
CAQH CORE Eligibility & Claim Status

Data Content Operating Rules
Foundation of *Eligibility Data Content* Operating Rules: ASC X12 Standards

Building on the requirements of the ASC X12 standards and industry neutral standards, CAQH CORE Operating Rules add value as industry stakeholders gain the additional benefits of using a consistent infrastructure to deliver and receive robust and important patient eligibility and benefit data.

**ASC X12 270/271 Requirements in v5010**
- Eligibility Status (yes/no)
- Date
- Health Plan Name (if known)

**CAQH CORE Rule Requirements**
- Health Plan Name (if available in responding system)
- Patient financials (deductible, co-pay, co-insurance)
  - In and out of network variances
  - Family and individual
  - Health Plan and benefit variances
- Enhanced Patient Name Verification
- Standard use of AAA Error Codes

PLUS infrastructure rules to generate data flow: response time, connectivity, system availability
CAQH CORE Eligibility & Claim Status
Key Requirements: *Data Content Operating Rules*

- An ASC X12 271 eligibility response to a *generic & explicit* ASC X12 270 eligibility request must include health plan name and patient financials for co–insurance, co–payment, base & remaining deductibles (with network variance if applicable), e.g.,
  - Must return CORE-required data for explicit inquiry requests including one of 51 total CORE-required Service Type Codes (STCs):

<table>
<thead>
<tr>
<th>STC Code</th>
<th>Service Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Medical Care</td>
</tr>
<tr>
<td>2</td>
<td>Surgical</td>
</tr>
<tr>
<td>4</td>
<td>Diagnostic X–Ray</td>
</tr>
<tr>
<td>5</td>
<td>Diagnostic Lab</td>
</tr>
<tr>
<td>6</td>
<td>Radiation Therapy</td>
</tr>
<tr>
<td>7</td>
<td>Anesthesia</td>
</tr>
<tr>
<td>8</td>
<td>Surgical Assistance</td>
</tr>
<tr>
<td>12</td>
<td>Durable Medical Equipment Purchase</td>
</tr>
<tr>
<td>13</td>
<td>Facility</td>
</tr>
<tr>
<td>18</td>
<td>Durable Medical Equipment Rental</td>
</tr>
<tr>
<td>20</td>
<td>Second Surgical Opinion</td>
</tr>
<tr>
<td>33</td>
<td>Chiropractic</td>
</tr>
<tr>
<td>35</td>
<td>Dental Care</td>
</tr>
<tr>
<td>40</td>
<td>Oral Surgery</td>
</tr>
<tr>
<td>42</td>
<td>Home Health Care</td>
</tr>
<tr>
<td>45</td>
<td>Hospice</td>
</tr>
<tr>
<td>47</td>
<td>Hospital</td>
</tr>
<tr>
<td>48</td>
<td>Hospital – Inpatient</td>
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<tr>
<td>50</td>
<td>Hospital – Outpatient</td>
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<tr>
<td>51</td>
<td>Hospital – Emergency Accident</td>
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<td>Hospital – Emergency Medical</td>
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<td>Hospital – Ambulatory Surgical</td>
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<td>62</td>
<td>MRI/CAT Scan</td>
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<td>65</td>
<td>Newborn Care</td>
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<td>68</td>
<td>Well Baby Care</td>
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<td>73</td>
<td>Diagnostic Medical</td>
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<td>76</td>
<td>Dialysis</td>
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<td>78</td>
<td>Chemotherapy</td>
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<td>80</td>
<td>Immunizations</td>
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<td>81</td>
<td>Routine Physical</td>
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<td>82</td>
<td>Family Planning</td>
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<td>86</td>
<td>Emergency Services</td>
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<td>88</td>
<td>Pharmacy</td>
</tr>
<tr>
<td>93</td>
<td>Podiatry</td>
</tr>
<tr>
<td>98</td>
<td>Professional (Physician) Visit – Office</td>
</tr>
<tr>
<td>99</td>
<td>Professional (Physician) Visit – Outpatient</td>
</tr>
<tr>
<td>A0</td>
<td>Professional (Physician) Visit – Home</td>
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<tr>
<td>A3</td>
<td>Professional (Physician) Visit – Home</td>
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<tr>
<td>A6</td>
<td>Psychotherapy</td>
</tr>
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<td>A7</td>
<td>Psychiatric Inpatient</td>
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<td>A8</td>
<td>Psychiatric Outpatient</td>
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<tr>
<td>AD</td>
<td>Occupational Therapy</td>
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<tr>
<td>AE</td>
<td>Physical Medicine</td>
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<td>AF</td>
<td>Speech Therapy</td>
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<td>AG</td>
<td>Skilled Nursing Care</td>
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<tr>
<td>AI</td>
<td>Substance Abuse</td>
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<tr>
<td>AL</td>
<td>vision (Optometry)</td>
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<td>BG</td>
<td>Cardiac Rehabilitation</td>
</tr>
<tr>
<td>BH</td>
<td>Pediatric</td>
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<tr>
<td>MH</td>
<td>Mental Health</td>
</tr>
<tr>
<td>UC</td>
<td>Urgent Care</td>
</tr>
</tbody>
</table>

- Health plan must normalize submitted and stored last names; if normalized name is not validated, must return a specified AAA code
- Health plans must return specified AAA Error Codes with submitted patient identifying data elements to communicate certain error conditions
Q&A

Eligibility Verification Plus Financials
Enhanced Error Reporting
Patient Identification

Please submit your question:
• By Phone: Press * followed by the number one (1) on your keypad
• Via the Web: Enter your question into the Q&A pane in the lower right hand corner of your screen
CAQH CORE Implementation Tools: Examples

• **CORE Operating Rule Readiness**: If you are ready to test your implementation of operating rules with trading partners, then, **take 5 minutes** and tell others about your readiness
  – *Add your organization* to the [CORE Partner List](#) located on the [CAQH](#) website
  – *It take 5 minutes!*

• **Request Process**: Contact technical experts as needed at [CORE@caqh.org](mailto:CORE@caqh.org)

• **Voluntary CORE Certification**: *Phase I & Phase II*
  – Learn more about *voluntary* CORE Certification [here](#)
  – *Voluntary* CORE Certification provides verification that your IT systems or product operates in accordance with the federally mandated operating rules

• **FAQs**: CAQH CORE has a list of FAQs to address typical questions regarding the operating rules; updated FAQs being loaded to website on a regular basis
Free 2013 CAQH CORE Education

• Mark your calendars & join us again at an upcoming webinar
  – CAQH CORE Town Hall – a bi-monthly information session open to the public
    • January 22, 2013, 3-4 PM ET
    • March 12, 2013, 3-4 PM ET
  – ASC X12 and CAQH CORE Webinar: An In-Depth Look at the ASC X12 270/271 Transaction - Eligibility Data Content Standards and Operating Rules
    • Tuesday, January 31, 2013 from 2:00 - 3:00 pm ET
  – NACHA and CAQH CORE Webinar: Learn from the Experts- Mandated Electronic Funds Transfer (EFT) Standard and Healthcare Operating Rules for EFT and Electronic Remittance Advice (ERA)
    • Thursday, February 7, 2013 from 1:00 - 2:00 pm ET
  – InstaMed and CAQH CORE Webinar: EFT and ERA Implementation Insights- Models to Deliver EFT and ERA
    • Tuesday, February 12, 2013 from 3:00 – 4:00 pm ET
• Visit the CORE Education Events page of the CAQH website to access recordings of previous education events
Thank You for Joining Us
APPENDIX
The CAQH CORE Companion Guide Rule and Claim Status Rule require that Companion Guides covering v5010 270/271 and v5010 276/277 transactions follow the format and flow of the CORE v5010 Master Companion Guide Template.

The Companion Guide Template* organizes information into distinct sections:

- General Information
- Connectivity with the payer
- Transaction-Specific Information
- Key contact information
- Testing with the payer
- Control segment details
- Payer specific business rules
- Allows health plans (information sources) to tailor the document to meet their particular needs while still maintaining a standard template/common structure

For more detail, see CORE Rules 152 and 250
The CAQH CORE System Availability Rule and the Claim Status Rule establish guidelines for system availability and provider support for health plan eligibility and claim status transactions including:

- Minimum of **86 percent system availability** (per calendar week)
- Publish regularly scheduled downtime
- Provide one week advance notice on non-routine downtime
- Provide information within one hour of emergency downtime

For more detail, see CORE Rules 157 and 250
FAQs: Infrastructure Operating Rules

Response Time Requirements

- When processing in real time, *maximum* response time for receipt of a v5010 X12 271 or X12 276 by the provider in response to a v5010 X12 270 or X12 276 must be 20 seconds.

- To conform to response time requirement, *90 percent* of all transactions, as measured within a calendar month, must be returned within the 20-second maximum response time.

**NOTE:** The rules hold the health plan and its *contracted* business associates responsible for the conduct of the transaction that is applicable to them.

CAQH CORE Rules 156 & 250

When Do the 20-Seconds Begin and End?

- The 20-second requirement is the duration for the *entire round trip* of the transaction:
  - The 20 seconds begin when the v5010 X12 270 Inquiry or X12 276 Request is first submitted by the provider, and end when the X12 271 or X12 277 Response is received by the provider.
  - *All ensuing hops between the provider and the health plan are included in these 20 seconds.*

- ACA Administrative Simplification provisions require all HIPAA covered entities (i.e., health plans, providers, clearinghouses, etc.) to comply with the Federally mandated CAQH CORE Eligibility & Claim Status Operating Rules:
  - Each HIPAA covered entity within the transaction flow is bound by the CAQH CORE requirements for meeting the 20-second round trip of the transaction.

- CAQH CORE recommends a *maximum* of 4 seconds per hop to meet the 20-second round trip requirement.
CAQH CORE Real Time Processing: Potential Real Time Transaction Paths

End-to-End: 20-Second Round Trip
(CAQH CORE recommends no more than 4 seconds per hop)

Path #1: Direct Connection: A+B = 20 seconds or less

Path #2: Single Clearinghouse: A+B+C+D = 20 seconds or less

Path #3: Dual Clearinghouse: A+B+C+D+E+F = 20 seconds or less

At starred receipt and transmit points each entity must capture, log, audit, match, & report date, time, and control numbers from its own internal systems and corresponding data received from its trading partners.
CAQH CORE Eligibility & Claim Status Operating Rules: *Infrastructure Operating Rules - Connectivity*

**Connectivity**

**Key Requirements**

Entities must support HTTP/S 1.1 over the public Internet as a transport method for both batch and real-time eligibility inquiry and response transaction, and claim status; they must follow:

- Real-time and/or batch request submission and response pickup guidelines
- Security and authentication requirements
- Response message options and error notification
- Response time, time out parameters and re-transmission guidelines
- Prescriptive submitter authentication, envelope specifications, etc.
- Payload-agnostic, can use to send any type of data

*For more detail, see CORE Rules 153, 250 and 270*

**Safe Harbor**

**Key Requirements**

Phase I & II CAQH CORE Connectivity Rules constitute a *Safe Harbor* rule which provides for a uniform method of exchanging administrative transaction data between health plan and provider – *but other methods may be used.* The rules:

- Apply to information sources performing the role of an HTTP/S server and information receivers performing the role of an HTTP/S client
- Apply to real-time transactions (and batch, if offered; batch NOT required)
- Do not require trading partners to remove existing connections that do not match the rule
- Include prescriptive submitter authentication, envelope specifications, etc., (SOAP and WSDL, Name/Password or X.509 Certificate)

*For more detail, see CORE Rules 153, 250 and 270*

*Specifically designed to align with key Federal efforts, e.g., NwHIN.*
# Federally Mandated CAQH CORE Connectivity Rules: High Level Rule Requirements

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<td>Transport</td>
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<td>Transport Security</td>
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<td>Submitter (Originating System or Client) Authentication</td>
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<td>Basic Conformance Requirements</td>
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<td>System Availability</td>
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<td>Companion Implementation Guide</td>
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Federally Mandated CAQH CORE Connectivity Rules: Stakeholder Conformance Guidelines

- CAQH CORE Connectivity Rules apply to health plans (HTTP/S server) and health care providers (HTTP/S client)
  - The rules define conformance requirements for stakeholders based on typical role (client, server) for envelope and authentication standards
  - Diagram illustrates the typical (minimal) roles played by stakeholders (e.g., providers typically clients, health plans typically servers, clearinghouses can act as client or server)
Federally Mandated CAQH CORE Connectivity Rules: Envelope Standards

- Stakeholders in server role (e.g., health plans and clearinghouses/switches) must implement both envelope standards (SOAP+WSDL and HTTP MIME Multipart)
- Stakeholders in client role (e.g., healthcare providers or provider vendors) must implement one of the envelope standards

If your organization is a:

<table>
<thead>
<tr>
<th>Health Plan</th>
<th>Clearinghouse/Switch</th>
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<tbody>
<tr>
<td>Server Conformance Requirements</td>
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then you must implement both of these envelope standards

- HTTP Multipart MIME
- SOAP

<table>
<thead>
<tr>
<th>Healthcare Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client Conformance Requirements</td>
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</tbody>
</table>

then you must implement one of these envelope standards

- HTTP Multipart MIME
- SOAP
Federally Mandated CAQH CORE Connectivity Rules: 
Submitter Authentication

- CAQH CORE Connectivity Rules support two methods for Submitter Authentication:
  - Username/Password, using CORE-conformant Envelope to send CORE-conformant Envelope Metadata Username and Password
  - X.509 Certificate based authentication over SSL standard for client certificate based authentication
- Stakeholders in server role (e.g., health plans) choose to implement one of the standards
- Stakeholders in client role (e.g., healthcare providers/provider vendors and clearinghouse components handling submissions to plans) must implement both standards

If your organization is a: 

Server Conformance Requirements

Health Plan

then implement one of these authentication standards

Username/Password

X.509 Certificate over SSL

Clearinghouse/Switch

Healthcare Provider

Client Conformance Requirements

then you must implement both of these authentication standards

Username/Password

X.509 Certificate over SSL
### Mandated EFT & ERA Operating Rules Scope:

**Effective January 1, 2014**

<table>
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<tr>
<th>Rule</th>
<th>High-Level Requirements</th>
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<tbody>
<tr>
<td><strong>Data Content</strong></td>
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</table>
| **Uniform Use of CARCs and RARCs (835) Rule**  
Claim Adjustment Reason Code (CARC)  
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  
• Outlines a straw man template for paper and electronic collection of the data elements  
• Requires health plan to offer electronic EFT enrollment |
| **ERA Enrollment Data Rule** | • Similar to EFT Enrollment Data Rule |
| **EFT & ERA Reassociation (CCD+/835) Rule** | • Addresses provider receipt of the CAQH CORE-required Minimum ACH CCD+ Data Elements required for re-association  
• Addresses elapsed time between the sending of the v5010 835 and the CCD+ transactions  
• Requirements for resolving late/missing EFT and ERA transactions  
• 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  
• Requires entities to support the Phase II CAQH CORE Connectivity Rule.  
• Includes batch Acknowledgement requirements*  
• Defines a dual-delivery (paper/electronic) to facilitate provider transition to electronic remits |

* [CMS-0028-IFC](#) excludes requirements pertaining to acknowledgements.